

Dermatology Coding Alert

Neoplasm Coding: Neoplasms May Be Uncertain, But Your Coding Shouldn't Be

There's a difference between "uncertain" and "unspecified" ICD-9 codes and understanding it can mean success for your coding.

If a lesion is non-malignant, it's good news for the patient but it may be bad news for the coder if she can't correctly choose between 238.2 and 239.2.

Check out the answers to these frequently asked "uncertain" vs. "unspecified" questions, and keep your neoplasm diagnoses straight.

Question: What's the difference between the "uncertain" and the "unspecified" codes?

Answer: Using 238.2 (Neoplasm of uncertain behavior of the skin) and 239.2 (Neoplasm of unspecified nature of bone, soft tissue and skin) is a familiar tune in dermatology. It's not unusual that you take one for the other since both codes refer to a lesion that is not certain in nature.

However, if you look closely at their definitions, you'll find that they have slight but very distinct differences.

Don't miss: Code 238.2 belongs to the family described as "neoplasms of uncertain behavior" (235-238), specifically "histomorphologically well-defined neoplasms, the subsequent behavior of which cannot be predicted from the present appearance," according to the ICD-9 book. This code refers to the skin and excludes "(1) anus NOS [not otherwise specified]; (2) skin of genital organs [236.3, 236.6]; and vermilion border of lip [235.1]."

"Uncertain" is used when the pathology report contains words such as "dysplastic," "atypical," or "unusual." In addition, there are some neoplasms that may have a slight chance of becoming malignant at some date, such as congenital nevi or junctional nevi.

On the other hand, 239.2 refers to neoplasms of unspecified morphology or nature of bone, soft tissue and skin, which excludes "(1) anal canal [239.0]; (2) anus [NOS 239.0]; (3) bone marrow [202.9]; (3) cartilage; (4) larynx [239.1]; (5) nose [239.1]; (6) connective tissue of breast [239.3]; skin of genital organs [239.5] and vermilion border of lip [239.0]."

Question: When should you report an "unspecified" code?

Answer: When the pathology report doesn't confirm a specific type of neoplasm — benign, malignant, or uncertain — you should report an unspecified code.

For instance: You'd use an unspecified code if you're billing before you have the biopsy results or when the pathology report does not contain enough information to select a more specific code. "Unspecified" indicates that the pathologist did not reach a specific diagnosis, possibly due to an inadequate specimen.

Coverage alert: Many payers have policies that provide lists of covered diagnoses. Many of these medical necessity policies include codes from category 238 but not from category 239.

Difference: Code 239.2 is a broader descriptor as it could describe a lesion of bone, soft tissue, or skin, whereas 238.2 is limited to skin lesions. It also describes a lesion that has not been pathologically diagnosed, notes **Pamela Biffle, CPC, CPC-P, CPC-I, CCS-P, CHCC, CHCO**, owner of PB Healthcare Consulting and Education Inc. in Austin, Texas. In these cases, no biopsy has been performed so no definitive diagnosis is available.

Question: Should you wait for the pathology report?

Answer: Yes, you should hold all charges until you get the pathology report and confirm the actual diagnosis for codes such as 11100 (Biopsy of skin, subcutaneous tissue and/or mucous membrane [including simple closure], unless otherwise listed; single lesion), 11101 (Biopsy of skin, subcutaneous tissue and/or mucous membrane [including simple closure], unless otherwise listed; each separate/additional lesion...), 11300-11313 (Shaving of epidermal or dermal lesion...), 11400-11446 (Excision, benign lesion including margins...), and 11600-11646 (Excision, malignant lesion including margins...), experts say. Common sense dictates that you can't bill out the malignant excision codes when you don't have a malignant diagnosis.

If the lesion is histologically identified with a certain diagnosis, bill the specific ICD-9 code that reflects that diagnosis.

Example: If the lesion is identified as an inflamed seborrheic keratosis, bill 702.11 (Inflamed seborrheic keratosis) and not 238.2.

Question: How should you find the right diagnosis?

Answer: You should not use an uncertain or unspecified code when you or the coder are uncertain, say experts. Don't simply flip to the neoplasm table and select a code from either of these columns.

Do this: Instead, you should use the alphabetic index to look up the name of the tumor or available diagnostic information. The index directs you to the appropriate column in the neoplasm table.

For example, if you look up "tumor" in the ICD-9 alphabetic index, it states, "see also: neoplasm, by site, unspecified nature." Before assigning a final code, verify the diagnosis you have selected in the tabular index. The tabular list provides additional information that you won't find in the alphabetic listing or neoplasm table.

For instance, a specific category might show a list of terms that the code "includes" or "excludes." Here you may find a term that you see in the pathology report, which helps you confirm an accurate diagnosis or avoid a wrong one.

Tip: "Includes" lists aren't exhaustive, so if a term in the index directs you to a code, that's the correct code even if the term is not in the inclusion list.