Codify
BY AAPC

Internal Medicine Coding Alert

Take 3 Steps to Perfect Your Lesion Excision Claims

CPT code may change once you get that lab data back

For proper claims for lesion excisions, when you submit your claim may be just as important as how you report the codes. That's because you may not be able to determine the most accurate CPT and diagnosis codes until after the lab send you its report. Follow these three steps to guarantee accurate lesion removal coding.

Step 1: Let the Pathology Report Guide You

As many internal medicine coders know, CPT does not include any "suspicious" or "uncertain" lesion excision codes. CPT contains only benign and malignant lesion removal codes. Therefore, you can't effectively select an appropriate CPT code for some lesion removals until you hear from the lab.

Example: Suppose your internist removes a 2-mm suspicious skin lesion from a patient's back using a 1-mm margin. You have to choose between two procedural codes:

• 11400 -- Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 cm or less

• 11600 -- Excision, malignant lesion including margins, trunk, arms or legs; excised diameter 0.5 cm or less.

You could lose about $43 if you preemptively report a benign skin lesion code, because reimbursement is higher for malignant lesions.

Solution: Hold the claim until a pathology report leads you to or confirms your CPT code selection.

"It is not only ethical but recommended to wait for a path report to code a lesion removal," says **Linda Martien, CPC, CPC-H,** coding specialist with National Healing in Boca Raton, Fla. "This is not just for the CPT code but for the best accuracy when coding with ICD-9 as well," she says.

Step 2: Don't Code 'Uncertain' Without Pathologist's Confirmation

Your patient's diagnosis can't be coded to the highest level of specificity if you report an "uncertain" code rather than waiting for the pathology report, Martien says. Therefore, you should find out exactly what the lab says about the lesion before you reach for that "uncertain" code.

Example: Suppose your internist documents the following note: "I removed one approximately 9-mm lesion from the patient's wrist using surgical curettage. Lesion had a red outer crust and an irregular border, but it looked dissimilar from the patient's actinic keratosis spots on her face, so I am uncertain of the lesion's status. Sent lesion to the lab and will await results."

What would you do? Most coders tell us that they would assign 238.2 (Neoplasm of uncertain behavior of other and unspecified sites and tissues; skin) to this claim. But this is actually the wrong code for this physician's documentation.

"You can only code 238.2 if the pathologist who examines the sample states that the lesion exhibits uncertain behavior, not when the physician thinks it might be," says **Chris Felthauser, CPC, CPC-H, ACS-OH, ACS-OR, PMCC,** medical coding instructor for Orion Medical Services in Eugene, Ore. "It has to come from the histopathology, so unless the physician is looking at it under the microscope, that code has to be assigned from the pathologist."

In fact, according to ICD-9, "uncertain behavior" means something totally different than what people think, Felthauser says.

For example: "Sometimes a physician will review a patient's lesion that is growing in size, changing color, or irritating a patient, and from looking at the lesion it is 'uncertain' to the physician whether or not this lesion is benign or malignant, so he elects to remove it and send it to path for review," Felthauser says. "But if the lesion has not yet been histologically assessed, you should not report 238.2."

The pathology report should be the determining factor used in establishing the correct ICD-9 code.

Tip: "If the lesion was irritated, bleeding or had other such features, make sure you have that information documented as well, because most carriers do not cover 'cosmetic' removals of benign skin neoplasms," Felthauser says. "So you need to make sure there is documentation as to why he chose to remove it and remember to code for those services."

If the lesion was benign, the physician may have to send the documentation along with the claim to support the fact that the removal was not for cosmetic reasons.

Step 3: Document Measurements Prior to Excision

According to CPT, to determine the appropriate lesion excision code, you must measure the lesion's diameter at its widest point and add to that measurement double the width of the narrowest margin.

The physician should calculate and document the size of the lesion excision before removing it and sending it to pathology for analysis. This is because the lesion's size will be smaller as soon as the first incision releases some of the tension on the skin, and the sample will likely shrink further when placed in formaldehyde.

Example: The internist excises an irregularly shaped, malignant (as later determined by a pathology report) lesion from just below the patient's right shoulder. The lesion measures 2 cm at its widest point. To ensure removal of all malignancy, the physician allows a margin of at least 1.5 cm on all sides.

To calculate the excised diameter, you should begin with the size of the lesion (2 cm) and add the width of the narrowest margin multiplied by 2 (1.5 x 2, or 3 cm total) for a total of 5 cm (2 + 3 = 5). In this case, therefore, you should report 11606 (Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter over 4.0 cm).

Possible problem: When calculating excision diameter, be careful not to confuse the length of the incision with the size of the excision. Often, the physician will make an incision that is longer than the lesion, but this has no bearing on code selection.

Solution: Base your measurements on the actual size of the lesion before the internist performs the excision and prior to sending it to pathology, not according to the size of the surgical wound left behind.