Part B Insider (Multispecialty) Coding Alert

LESION CODING: Confused by Recent Lesion Coding Directives From NGS? Here's the Scoop

Stick with what you know about lesion excision coding, experts say.

If the recent National Government Services (NGS) information about lesion excision coding has your practice up in arms, youre not alone. Coders have been questioning the local coverage determination (LCD). But dont fret: NGS plans to rescind the LCD advice about lesion excisions, experts say.

Decipher the NGS LCD

The portion of the NGS LCD that has led to controversy is in the general information section toward the bottom of the LCD, which reads:

While it is recognized that some diagnoses resulting from an excision will at times be malignant, the diagnosis at the time the procedure was performed would most likely be 239.2 (Neoplasms of unspecified nature; bone, soft tissue, and skin), and this would be the appropriate code, since proper coding requires the highest level of diagnosis known at the time the procedure was performed. Medical records maintained by the physician must clearly document the medical necessity for the lesion removal(s) if Medicare is billed for the service. & The decision to submit a specimen for pathologic interpretation will be independent of the decision to remove or not remove the lesion. It is assumed, however, that a tissue diagnosis will be part of the medical record when an ultimately benign lesion is removed based on physician uncertainty as to the final clinical diagnosis.

The issue: This advice goes against 2009 ICD-9 coding guidelines, which state: For ambulatory surgery, code the diagnosis for which the surgery was performed. If the postoperative diagnosis is known to be different from the preoperative diagnosis at the time the diagnosis is confirmed, select the postoperative diagnosis for coding, since it is the most definitive.

The wording of the LCD pretty much excludes any use of the malignant excision codes, as they are stating that an unspecified neoplasm diagnosis code should be used, which we cant use with a malignant excision code, says **Joseph A. Lamm,** office manager for Stark County Surgeons in Massillon, Ohio. And then that last statement about the pathologic interpretation being independent of the decision to remove the lesion also closes the door on holding the charges until the path comes back. Its a very, very sneaky way of basically excluding nearly all malignant excision codes. The only way I can see to use the malignant excision codes would be for a re-excision of a known malignancy.

NGS Officials Promise Correction

Good news: NGS plans to print an article soon that will clarify this issue, says **George N. Costantino, MD,** medical director for National Government Services in Syracuse, N.Y. According to Costantino, that article will read: Due to inconsistent and differing interpretations of coding instructions regarding this issue, the paragraphs pertaining to coding for excision of benign vs. malignant skin lesions are being removed from the SIA attached to the LCD for removal of benign skin lesions (L27362/A47397). Providers are encouraged to code according to the coding instructions applicable to their various practice situations. NGS will not make an effort to make this coding more uniform and consistent at this time.

Warning: No retraction has appeared in print from NGS as of press time, so keep an eye out for forthcoming notice directly from NGS. However, on the CMS Web site, superceded is written in red across the lesion excision LCD (www.cms.hhs.gov/mcd/viewlcd.asp?lcd_id=27362&lcd_version=13&show=all).

Bottom line: Despite the confusion generated by the NGS LCD, you should follow ICD-9 guidelines and wait for the pathology report to determine if the lesion was benign or malignant when choosing a code for a lesion excision. Once you have the pathology report, youll choose from 11400-11471 for benign lesions and 11600-11646 for malignant lesions.