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Part B Insider (Multispecialty) Coding Alert

PART B CODING COACH: Play the Lesion Excision Waiting Game Unless Carrier Directs You Otherwise

Pathology report can unlock $57 more for 11620 if it justifies using the malignancy code.

If recent guidance made you question the MO of waiting for the path report, rest assured you can continue to delay assigning the benign or malignant lesion removal until you have the definitive diagnosis.

A new local coverage determination (LCD) related article "indicated that providers are to bill lesion removals based on what is known at the time of excision, regardless of what the pathology report shows," points out **Heather Winters, CPC,** at United Cerebral Palsy Association of the North Country in Malone, N.Y. Now that your eyebrows are raised, here's the scoop.

Prevent Mislabeling by Waiting for Definitive Diagnosis

Traditionally, experts have recommended waiting for the path report before assigning a benign (11400-11446) or malignant lesion excision code (11600-11646). "You don't want to call a lesion malignant unless the pathology report does," says **Jill M. Young, CPC, CEDC, CIMC,** with Young Medical Consulting LLC in East Lansing, Mich.

Why: You could mislabel a patient as having a malignancy. The lesion's appearance may be consistent with a malignancy, but it could ultimately turn out to be benign.

Play It Safe With Unspecified Dx Under Old NGS Plan

A Medicare contractor for 10 states, however, called for a different approach from this "wait for confirmation" protocol. "If a benign skin lesion excision was performed, report the applicable CPT code, even if final pathology demonstrates a malignant or carcinoma in situ diagnosis for the lesion removed.

The final pathology does not change the CPT code of the procedure performed. To report removal of lesions of uncertain morphology, prior to identification of the specimen, report ICD-9-CM code 239.2 (Neoplasms of unspecified nature, bone, soft tissue, and skin), since proper coding requires the highest level of diagnosis known at the time the procedure was performed," according to the National Government Services Inc. article A47397, "Removal of Benign Skin Lesions." (Primary jurisdiction for NGS includes Illinois, Kentucky, Ohio, Wisconsin, Michigan, Virginia, West Virginia, Indiana, Connecticut, and parts of New York.) The document makes the unspecified code the diagnosis to use with a benign excision code, Young explains. Otherwise, the physician could cause these errors:

• If the lesion on visual exam appears consistent with a benign growth but is ultimately malignant, the physician would have still reported a benign lesion excision. "Lesions that are not known to be malignant at the time of excision are to be coded using the benign lesion removal codes," Winters explains.

• If visual inspection suggests that the lesion is malignant and the physician calls the lesion malignant but pathology later determines the lesion is actually benign, the patient has been given a risk factor at the insurance level that may not be appropriate. The malignant codes pay more than the corresponding benign codes. Thus, there is a financial incentive to report a malignancy when the lesion is consistent with that assessment, noted **Jean Acevedo, LHRM, CPC, CHC, CENTC**, in a question and answer session at The Coding Institute's July 2009 National Coding and Reimbursement Conference in Orlando, Fla.

Lose $57 Plus for Refusing to Mislabel

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Waiting for the pathology report to come back removes the financial incentive, says Acevedo, president of Acevedo Consulting Incorporated in Delray Beach, Fla. Money is taken out of the equation when office protocol calls for letting the report determine the definitive diagnosis. But NGS's new policy relied on the physician to call a lesion suspicious of a malignancy as a malignancy. If physicians are not going to give a patient a possibly inappropriate risk factor, their only option under NGS's policy is to report a benign code, Young notes.

Impact: "The policy affected payments," Young reports. Physicians can be paid only the lesser payment associated with removing a benign lesion.

Example: A benign lesion code for a 0.25 cm excision from the hand pays approximately $57* less when reported with the benign code 11420 (Excision, benign lesion including margins, except skin tag [unless listed elsewhere], scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less), rather than the malignant code 11620 (Excision, malignant lesion including margins, except skin tag [unless listed elsewhere], scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less). If a physician is not able to call the lesion malignant, he loses that money.

***Note:** Figures based on the 2009 Medicare Physician Fee Schedule that assigns 2.88 relative value units (RVUs) to 11420 and 4.46 RVUs to 11620 -- a difference of 1.58 RVUs or approximately $56.99 nationally using the 2009 conversion factor of 36.0666. You can use these rates to compare private payers' fees. The policy caused such an uproar that NGS removed the paragraphs pertaining to coding for excision of benign vs. malignant skin lesions from the article as of July 1, 2009. "Providers are encouraged to code according to the coding instructions applicable to their various practice situations," according to NGS www.ngsmedicare.com/NGSMedicare/lcd/L27362_active_sia.htm).

Follow Path Report Unless Your Policy Differs

Some insurers agree that a "wait and confirm" approach is the way to go. The LCD for WPS calls for assigning the excision codes using the diagnosis of the tissue pathology report, Young reports. "The WPS policy is in direct opposition to the one NGS put out." You've got to know your carrier's guidelines. If your contractor does not have an established policy, or your practice does not participate in Medicare, check your office policy, Young recommends.

Does your compliance plan call for following ICD-9 guidelines in the absence of other policies? You've struck gold with this "wait for path" support from Chapter 2: Neoplasms (140-239) General Guidelines: "To properly code a neoplasm it is necessary to determine from the record if the neoplasm is benign, in situ, malignant, or of uncertain histologic behavior."

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