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Neoplasm Guidelines

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Learning Objectives

- Review Chapter 2 Neoplasm coding guidelines and apply Coding Clinic advice for correctly reporting neoplasms Cases.
- Review anatomy and other pertinent clinical information important to understanding new CPT codes.
- Review common outpatient guidelines commonly used in neoplasm coding.

GENERAL GUIDELINES

General Guidelines

Primary malignant neoplasms overlapping site boundaries

- A primary malignant neoplasm that overlaps two or more contiguous (next to each other) sites should be classified to the subcategory/code .8 ('overlapping lesion'), unless the combination is specifically indexed elsewhere.
- For multiple neoplasms of the same site that are not contiguous such as tumors in different quadrants of the same breast, codes for each site should be assigned.

Malignant neoplasm of ectopic tissue

- Malignant neoplasms of ectopic tissue are to be coded to the site of origin mentioned, e.g., ectopic pancreatic malignant neoplasms involving the stomach are coded to malignant neoplasm of pancreas, unspecified (C25.9).

Histological Terms

- The neoplasm table in the Alphabetic Index should be referenced first.
- However, if the histological term is documented, that term should be referenced first, rather than going immediately to the Neoplasm Table, in order to determine which column in the Neoplasm Table is appropriate – for example benign vs. malignant.

SEQUENCING RULES

Admission/Encounter for Treatment of Primary Site

- If the malignancy is chiefly responsible for occasioning the patient admission/encounter and treatment is directed at the primary site, designate the primary malignancy as the principal/first-listed diagnosis.
- The only exception to this guideline is if the administration of chemotherapy, immunotherapy or external beam radiation therapy is chiefly responsible for occasioning the admission/encounter. In that case, assign the appropriate Z51.-- code as the first-listed or principal diagnosis, and the underlying diagnosis or problem for which the service is being performed as a secondary diagnosis.

Primary and Secondary Malignancy Diagnosed Concurrently

Coding Clinic Second Q 2023 P. 6

Question:

- A patient was admitted for workup to rule out malignancy due to diffuse interstitial lung nodules, cervical lymphadenopathy, and thrombus of the right internal jugular vein and the superior vena cava. The patient underwent an excisional biopsy of the supraclavicular lymph node and was found to have stage IV non-small cell lung cancer with metastasis to the cervical lymph nodes. What is the appropriate sequencing for this admission when both primary and secondary malignant neoplasms are diagnosed concurrently?

Answer:

- Sequence the primary non-small cell lung cancer as the principal diagnosis. Assign the appropriate code for the cervical lymph node metastasis as an additional diagnosis.

Rationale

- The newly diagnosed primary non-small cell lung cancer is the condition responsible for the admission, as well as the underlying cause of the metastasis. The primary malignancy is sequenced as the principal diagnosis unless the focus of treatment (diagnostic or therapeutic workup) is only directed to the metastatic (secondary) site.

Admission/Encounter for Treatment of Secondary Site

- When a patient is admitted because of a primary neoplasm with metastasis and treatment is directed toward the secondary site only, the secondary neoplasm is designated as the principal diagnosis even though the primary malignancy is still present.

Esophageal Cancer with Brain Metastases and Cerebral Hemorrhage

Coding Clinic Third Quarter 2022 P. 10

Question:

- A patient with known adenocarcinoma of the lower third of the esophagus was admitted with ataxia and double vision. Work-up revealed new brain hemorrhage and brain metastases as the cause of the patient's symptoms. The patient underwent surgical resection of the metastatic brain lesion. What is the appropriate code assignment and sequencing for this admission?

Answer: Assign code

- C79.31, Secondary malignant neoplasm of brain, as principal diagnosis since the metastatic brain lesion was excised.
- Codes I61.9, Nontraumatic intracerebral hemorrhage, unspecified,
- C15.5, Malignant neoplasm of lower third of esophagus,
- R27.0, Ataxia, unspecified, and
- H53.2, Diplopia, should be assigned as additional diagnoses.

Rationale:

- In this case, although the hemorrhage is a complication of the cerebral brain metastasis, surgical treatment was directed to the brain metastasis (by excision) and not primarily to the hemorrhage.

Metastatic Neoplasm of Lymphoid Tissue

Secondary malignant neoplasm of lymphoid tissue

- When a malignant neoplasm of lymphoid tissue metastasizes beyond the lymph nodes, a code from categories C81-C85 with a final character “9” should be assigned identifying “extra-nodal and solid organ sites” rather than a code for the secondary neoplasm of the affected solid organ.
- For example, for metastasis of diffuse large B-cell lymphoma to the lung, brain and left adrenal gland, assign code C83.39, Diffuse large B-cell lymphoma, extra-nodal and solid organ sites.

Diffuse Large B Cell Lymphoma with Metastasis

Coding Clinic First Quarter 2023 P. 22

Question:

- The patient was recently diagnosed with aggressive, diffuse large B-cell lymphoma in multiple lymphatic sites involving lymph nodes of the right hilum, right iliac and right paracolic gutter areas as well metastasis to the lung, brain and left adrenal gland. How should we report metastatic sites in a patient with lymphoma? Does the 5th character “9,” “Extra nodal and other solid organ sites” capture metastatic sites outside of the lymphatic system or should each non-hematopoietic metastatic site be reported separately with codes from categories C78, Secondary malignant neoplasm of respiratory and digestive organs, and/or C79, Secondary malignant neoplasm of other and unspecified sites? What are the appropriate codes for diffuse large B-cell lymphoma involving lymph nodes of multiple sites with metastases to the lung, brain and left adrenal gland?

Answer: Assign codes

- C83.38, Diffuse large B-cell lymphoma, lymph nodes of multiple sites, for diffuse large B-cell lymphoma in multiple lymphatic sites.
- C83.39, Diffuse large B-cell lymphoma, extra nodal and solid organ sites, for the metastases of B-cell lymphoma to the lung, brain and left adrenal gland.

Rationale:

- Code C83.39 captures metastasis to sites outside of the lymph nodes and includes solid organ sites

Sequencing Complications
Anemia associated with Malignancy

- When admission/encounter is for management of an anemia associated with the malignancy, and the treatment is only for anemia, the appropriate code for the malignancy is sequenced as the principal or first-listed diagnosis followed by the appropriate code for the anemia (such as code D63.0, Anemia in neoplastic disease).

Pancytopenia due to Acute Myeloid Leukemia

Coding Clinic First Q 2023 P.23

Question:

- A 56-year-old patient with refractory relapsed acute myeloid leukemia (AML) presented to the Emergency Department (ED) due to bleeding gums. Labs were performed in the ED and the patient was found to have pancytopenia secondary to AML. The patient failed prior therapies for AML and was not a candidate for standard therapy due to comorbidities. She was admitted for transfusion support only for her pancytopenia. Does the Official Guidelines for Coding and Reporting for anemia associated in malignancy (I.C.2.c.1) apply for pancytopenia? What is the appropriate principal diagnosis for this patient?

Answer: Assign code

- D61.818, Other pancytopenia, as the principal diagnosis as that is the reason for the admission.
- C92.02, Acute myeloblastic leukemia, in relapse, as an additional diagnosis.

Rationale

- The Official Guideline for Coding and Reporting for anemia associated in malignancy (I.C.2.c.1) **does not apply** in this scenario since pancytopenia encompasses more than anemia.

Sequencing Complications
Anemia Associated with Chemo, immunotherapy and RT

- When the admission/encounter is for management of an anemia associated with an adverse effect of the administration of chemotherapy or immunotherapy and the only treatment is for the anemia, the anemia code is sequenced first followed by the appropriate codes for the neoplasm and the adverse effect (T45.1X5-, Adverse effect of antineoplastic and immunosuppressive drugs).
- When the admission/encounter is for management of an anemia associated with an adverse effect of radiotherapy, the anemia code should be sequenced first, followed by the appropriate neoplasm code and code Y84.2, Radiological procedure and radiotherapy as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure.

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Pancytopenia Due to Radium-223 Treatment

Coding Clinic Third Q 2023 P. 4

Question:

- A patient with prostate cancer and bone metastasis was admitted due to multiple medical conditions. During the admission, the provider documented that the patient had worsening pancytopenia, likely related to radium-223 treatments. When referencing “adverse effect” of “radioactive drugs NEC” in the Table of Drugs and Chemicals, subcategory T50.8X5, Adverse effects of diagnostic agents, is provided. However, radium-223 was administered as a therapeutic treatment for metastatic prostate cancer and is not considered a “diagnostic agent.” What are the appropriate code assignments for pancytopenia due to radium-223 treatments?

Answer: Assign codes:

- D61.811, Other drug-induced pancytopenia, followed by code
- T50.995A, Adverse effect of other drugs, medicaments, and biological substances, initial encounter, for pancytopenia due to radium-223 treatments.

Rationale:

- Code T50.995A is the appropriate code assignment for an adverse effect of a drug or medicament that is not specifically classified in ICD-10-CM. This code assignment can be referenced in the Table of Drugs and Chemicals under “drug NEC, specified NEC” or “medicament NEC.” Although adverse effects of radioactive drugs are classified to subcategory T50.8X5, a code from this subcategory is not appropriate since radium-223 is not a diagnostic agent. It is used to treat the cancer.

Acute Myeloid Leukemia and Anemia due to Chemotherapy

Coding Clinic Third Q 2021 P. 4

Question:

- A patient was admitted with anemia due to chemotherapy. The patient had previously received chemotherapy for primary refractory acute myeloid leukemia now in remission. When a patient with acute myeloid leukemia in remission is admitted for treatment of anemia due to chemotherapy, which condition should be sequenced as the principal diagnosis?

Answer: Sequence code

- D64.81, Anemia due to anti-neoplastic chemotherapy, as the principal diagnosis.
- Also assign codes T45.1X5A, Adverse effect of antineoplastic and immunosuppressive drugs, initial encounter, and C92.01, Acute myeloblastic leukemia, in remission.

Rationale:

- Although there is an Excludes 1 note at category D64, Other anemias, which means the two codes cannot be assigned together, both codes are required to capture anemia due to chemotherapy and acute myeloid leukemia. These are separate conditions, which are unrelated, as the anemia was caused by the chemotherapy not the AML and thus an exception to the Excludes 1 note.

Sequencing Complications
Due to the malignancy

Encounter for complication associated with a neoplasm

- When an encounter is for management of a complication associated with a neoplasm, such as dehydration, and the treatment is only for the complication, the complication is coded first, followed by the appropriate code(s) for the neoplasm.
- The exception to this guideline is anemia. When the admission/encounter is for management of an anemia associated with the malignancy, and the treatment is only for anemia, the appropriate code for the malignancy is sequenced as the principal or first-listed diagnosis followed by code D63.0, Anemia in neoplastic disease.

Lung and Brain Metastases, Intracerebral Hemorrhage and Vasogenic Cerebral Edema

Coding Clinic Third Q 2022 P. 9

Question:

- A patient with a past medical history of skin melanoma, and known metastases to the brain and lung, presented with right lower facial droop, aphasia and dysarthria. The provider's diagnostic statement listed, "Intracerebral hemorrhage of known brain metastases, and vasogenic edema, likely causing the patient's presenting symptoms." The patient improved with the initiation of steroids. What are the appropriate code assignments and sequencing for this admission?

Answer: Sequence either code

- I61.9, Nontraumatic intracerebral hemorrhage, unspecified, or code G93.6, Cerebral edema, as the principal diagnosis.
- Codes C79.31, Secondary malignant neoplasm of brain, C78.00, Secondary malignant neoplasm of unspecified lung, R29.810, Facial weakness, R47.01, Aphasia, R47.1, Dysarthria and anarthria, and Z85.820, Personal history of malignant melanoma of skin, should be assigned as additional diagnoses.

Rationale:

- The presenting symptoms of facial droop, aphasia and dysarthria were due to the intracerebral hemorrhage and vasogenic cerebral edema. When an encounter is for management of a complication associated with a neoplasm and the treatment is only for the complication, the complication is coded first, followed by the appropriate code(s) for the neoplasm. This is consistent with the Official Guidelines for Coding and Reporting, section I.C.2.I.4.

Vasogenic Cerebral Edema and Breast Cancer with Brain Metastases

Question:

- A patient with known left breast cancer metastatic to the brain presented to the emergency department with altered mental status (AMS). Diagnostic imaging revealed stable metastatic brain cancer with increased vasogenic cerebral edema. At the time of discharge, the provider suspected that the progressive cerebral edema around known metastatic brain lesions was contributing to the patient's AMS, which improved with steroid therapy. What are the appropriate code assignments and sequencing for this admission?

Answer: Assign code

- G93.6, Cerebral edema, as principal diagnosis. Codes C79.31, Secondary malignant neoplasm of brain, and C50.912, Malignant neoplasm of unspecified site of left female breast, should be assigned as additional diagnoses.

Rationale:

- The presenting symptom of AMS was due to the vasogenic cerebral edema. When an encounter is for management of a complication associated with a neoplasm and the treatment is only for the complication, the complication is coded first, followed by the appropriate code(s) for the neoplasm. This is consistent with the Official Guidelines for Coding and Reporting, section I.C.2.I.4.

Malignant Pleural Effusion

Coding Clinic Third Q 2022 P.14

Question:

- A patient was admitted with recurrent malignant pleural effusion, and thoracentesis with placement of a PleurX™ catheter was performed. Pleural fluid cytology was positive for cancer cells. The patient has a past history of left breast cancer and at that time underwent a lumpectomy. More recently, she was diagnosed with invasive ductal carcinoma of the left breast ER/PR positive, HER2 negative, and had a bilateral mastectomy. The patient also has known metastases to the cervical lymph nodes, liver and bone, and is on adjuvant Tamoxifen therapy. Would it be appropriate to assign code J91.0, Malignant pleural effusion, as the principal diagnosis? The instructional note at code J91.0 directs “Code first the underlying neoplasm.

Answer:

- No. It is not appropriate to assign code J91.0, Malignant pleural effusion, as principal diagnosis, because of the instructional note, “Code first underlying neoplasm.”
- Assign code C50.912, Malignant neoplasm of unspecified site of left female breast, as the principal diagnosis since the patient is still receiving adjuvant treatment for the breast cancer.
- Assign codes J91.0, Malignant pleural effusion, C77.0, Secondary and unspecified malignant neoplasm of lymph nodes of head, face and neck, C78.7, Secondary malignant neoplasm of liver and intrahepatic bile duct, C79.51, Secondary malignant neoplasm of bone, Z17.0, Estrogen receptor positive status [ER+], and Z79.810, Long term (current) use of selective estrogen receptor modulators (SERMs), as additional diagnoses.

Malignant Pleural Effusion

Coding Clinic Third Q 2022 P.14 (continued)

Rationale:

- The Official Guidelines for Coding and Reporting state, “Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. For such conditions, the ICD-10- CM has a coding convention that requires the underlying condition be sequenced first, if applicable, followed by the manifestation. Wherever such a combination exists, there is a “use additional code” note at the etiology code, and a “code first” note at the manifestation code. These instructional notes indicate the proper sequencing order of the codes, etiology followed by manifestation.”

Biliary Obstruction due to Hepatocellular Malignancy

Question:

- A 69 year old patient with non-resect able hepatocellular carcinoma (HCC) status post radioembolization presented with 2 weeks of progressive hyperbilirubinemia. He underwent endoscopic retrograde cholangiopancreatography which revealed biliary obstruction from HCC progression. The provider performed a biliary sphincterotomy and insertion of biliary stent into the common bile duct. There is confusion whether it is appropriate to sequence the carcinoma as the principal diagnosis since it is the underlying cause of the obstruction or whether the obstruction is sequenced as the principal diagnosis, since it was the reason for the admission, and no treatment was directed toward the carcinoma. What is the correct sequencing?

Answer: Assign codes:

- K83.1 Obstruction of the bile duct as the principal diagnosis.
- C22.0 Liver cell carcinoma

Rationale:

- The obstruction was the focus of treatment. Since therapy was directed at the obstruction, and not the malignancy, the obstruction is the principal diagnosis. The liver cell carcinoma is added as an additional diagnosis.

Sequencing Complications
Complications from Surgical Procedure

- When the admission/encounter is for treatment of a complication resulting from a surgical procedure, designate the complication as the principal or first-listed diagnosis if treatment is directed at resolving the complication.

Malignant Neoplasm in Pregnancy

Malignant neoplasm in a pregnant patient

- When a pregnant patient has a malignant neoplasm, a code from subcategory O9A.1-, Malignant neoplasm complicating pregnancy, childbirth, and the puerperium, should be sequenced first, followed by the appropriate code from Chapter 2 to indicate the type of neoplasm.

Encounter for Chemotherapy during Postpartum Period

Coding Clinic Third Q 2015 P. 19

Question:

- The patient was diagnosed with a synovial sarcoma stage III chest mass during pregnancy and treatment was started at that time. The patient is 2 weeks post delivery and is now being admitted for her 3rd cycle of chemotherapy. What codes should be assigned?

Answer: Assign codes:

- Z51.11 Encounter for chemotherapy as principal diagnosis
- O9A.13 Malignant neoplasm complicating the puerperium
- C49.3 Malignant neoplasm of connective and soft tissue of thorax, for the sarcoma that was diagnosed during pregnancy

Rationale:

- It is the providers responsibility to state the condition being treated is **not affecting the pregnancy.** Unless the provider documents that the pregnancy is incidental to the encounter the chapter 15 code is assigned for the condition occurring during the pregnancy. In this case the post partum code is appropriate.

Pathological Fractures

Pathologic fracture due to a neoplasm

- When an encounter is for a pathological fracture due to a neoplasm, and the focus of treatment is the fracture, a code from subcategory M84.5, Pathological fracture in neoplastic disease, should be sequenced first, followed by the code for the neoplasm.
- If the focus of treatment is the neoplasm with an associated pathological fracture, the neoplasm code should be sequenced first, followed by a code from M84.5 for the pathological fracture.

Primary Malignancy Previously Excised

- When a primary malignancy has been previously excised or eradicated from its site and there is no further treatment directed to that site and there is no evidence of any existing primary malignancy at that site, a code from category Z85, Personal history of malignant neoplasm, should be used to indicate the former site of the malignancy.
- Any mention of extension, invasion, or metastasis to another site is coded as a secondary malignant neoplasm to that site.
- The secondary site may be the principal or first-listed diagnosis with the Z85 code used as a secondary code depending on the circumstances of admission.

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Current malignancy versus personal history

Current malignancy versus personal history of malignancy

- When a primary malignancy has been excised but further treatment, such as an additional surgery for the malignancy, radiation therapy or chemotherapy is directed to that site, the primary malignancy code should be used until treatment is completed.
- When a primary malignancy has been previously excised or eradicated from its site, there is no further treatment (of the malignancy) directed to that site, and there is no evidence of any existing primary malignancy at that site, a code from category Z85, Personal history of malignant neoplasm, should be used to indicate the former site of the malignancy.
- Codes from subcategories Z85.0 – Z85.85 should only be assigned for the former site of a primary malignancy, not the site of a secondary malignancy. Code Z85.89 may be assigned for the former site(s) of either a primary or secondary malignancy.

Current Malignancy vs. Previously Excised

- Hierarchical Condition Category (HCC) is a term that describes the grouping of similar diagnoses into one related category (an HCC) to be used in a risk adjustment payment model. Risk adjustment payment models are regulated by the federal government to reimburse participating health insurance plans for the medical care of enrollees.
- Cancer HCCs are considered high risk for improper payments.
- Imperative to accurately assign current vs. history of malignancy diagnosis codes.

In Remission

Leukemia, Multiple Myeloma, and Malignant Plasma Cell Neoplasms in remission versus personal history

- The categories for leukemia, and category C90, Multiple myeloma and malignant plasma cell neoplasms, have codes indicating whether or not the leukemia has achieved remission.
- There are also codes Z85.6, Personal history of leukemia, and Z85.79, Personal history of other malignant neoplasms of lymphoid, hematopoietic and related tissues.
- If the documentation is unclear as to whether the leukemia has achieved remission, the provider should be queried.

History of Lymphoma in Remission

Coding Clinic Third Q 2022 P.28

Question:

- A patient presents for treatment of a normal pressure hydrocephalus. The provider notes in the past medical history, “History of lymphoma, status post radiation and chemotherapy in remission.” Since there is no unique code to capture lymphoma not further specified in remission, what is the correct code assignment for this condition?

Answer: Assign code

- Z85.72, Personal history of non-Hodgkin lymphomas, for history of lymphoma in remission.
- This code assignment can be found in the Index as follows: History personal (of) lymphoma (non-Hodgkin) Z85.72

Rationale:

- ICD-10-CM Official Guidelines for Coding and Reporting, Section I.C.2, d, states, “When a primary malignancy has been previously excised or eradicated from its site and there is no further treatment directed to that site and there is no evidence of any existing primary malignancy at that site, a code from category Z85, Personal history of malignant neoplasm, should be used to indicate the former site of the malignancy.”

Admissions/Encounters For Chemotherapy, Immunotherapy and Radiation therapy

Episode of care involves surgical removal of neoplasm

- When an episode of care involves the surgical removal of a neoplasm, primary or secondary site, followed by adjunct chemotherapy or radiation treatment during the same episode of care, the code for the neoplasm should be assigned as principal or first-listed diagnosis.

Admissions/Encounters For Chemotherapy, Immunotherapy and Radiation therapy

Patient admission/encounter chiefly for administration of chemotherapy, immunotherapy and radiation therapy

- If a patient admission/encounter is chiefly for the administration of chemotherapy, immunotherapy or external beam radiation therapy assign code Z51.0, Encounter for antineoplastic radiation therapy, or Z51.11, Encounter for antineoplastic chemotherapy, or Z51.12, Encounter for antineoplastic immunotherapy as the first-listed or principal diagnosis. If a patient receives more than one of these therapies during the same admission, more than one of these codes may be assigned, in any sequence.
- The malignancy for which the therapy is being administered should be assigned as a secondary diagnosis.
- If a patient admission/encounter is for the insertion or implantation of radioactive elements (e.g., brachytherapy) the appropriate code for the malignancy is sequenced as the principal or first-listed diagnosis. Code Z51.0 should not be assigned.

Encounter for Brachytherapy due to Cervical Malignancy

Coding Clinic Fourth Q 2017 P.103

Question:

- A patient is admitted for brachytherapy due to cervical cancer. Intrauterine tandem and ovoids are placed and brachytherapy is provided. When coding encounters for brachytherapy, should code Z51.0, Encounter for antineoplastic radiation therapy, be assigned as the principal diagnosis, or should a code for the malignancy be assigned as the principal diagnosis? What is the appropriate code assignment for an encounter for brachytherapy due to cervical cancer?

Answer: Assign code:

- C53.9, Malignant neoplasm of cervix uteri, unspecified, as the principal diagnosis for a patient who presents for brachytherapy due to cervical cancer.

Rationale:

- Effective October 1, 2017, the Official Guidelines for Coding and Reporting, Section I.C.2 have been revised to clarify that code Z51.0, Encounter for antineoplastic radiation therapy, is intended for encounters for external beam radiation therapy. Further guidance has been added specifying that for admission/encounters for the insertion or implantation of radioactive elements (e.g., brachytherapy) sequence the appropriate code for the malignancy as the principal or first-listed diagnosis.

Admissions/Encounters For Chemotherapy, Immunotherapy and Radiation therapy

Patient admitted for radiation therapy, chemotherapy or immunotherapy and develops complications

- When a patient is admitted for the purpose of external beam radiotherapy, immunotherapy or chemotherapy and develops complications such as uncontrolled nausea and vomiting or dehydration, the principal or first-listed diagnosis is Z51.0, Encounter for antineoplastic radiation therapy, or Z51.11, Encounter for antineoplastic chemotherapy, or Z51.12, Encounter for antineoplastic immunotherapy followed by any codes for the complications.
- When a patient is admitted for the purpose of insertion or implantation of radioactive elements (e.g., brachytherapy) and develops complications such as uncontrolled nausea and vomiting or dehydration, the principal or first-listed diagnosis is the appropriate code for the malignancy followed by any codes for the complications.

Extent of Malignancy

Admission/encounter to determine extent of malignancy

- When the reason for admission/encounter is to determine the extent of the malignancy, or for a procedure such as paracentesis or thoracentesis, the primary malignancy or appropriate metastatic site is designated as the principal or first-listed diagnosis, even though chemotherapy or radiotherapy is administered.

Symptoms, signs, and abnormal findings listed in Chapter 18 associated with neoplasms

- Symptoms, signs, and ill-defined conditions listed in Chapter 18 characteristic of, or associated with, an existing primary or secondary site malignancy cannot be used to replace the malignancy as principal or first-listed diagnosis, regardless of the number of admissions or encounters for treatment and care of the neoplasm.

Gross Hematuria due to Prostate Malignancy

Coding Clinic First Q 2017 P. 17

Question:

- Coding Clinic for ICD-9-CM, Second Quarter 2010, page 3, provided advice to sequence gross hematuria as the principal diagnosis for a patient, who was currently under treatment for prostate cancer and was admitted for gross hematuria with a significant drop in hemoglobin. The patient had been unable to pass urine and was only passing frank blood and clots. While in the hospital, 12 units of blood were transfused, and bladder irrigation was done. Now that hematuria is a Chapter 18 code in ICD-10-CM does the guideline in Section II.A., regarding codes for symptoms, signs, and ill-defined conditions apply, and change the previously published advice in regards to the principal diagnosis?

Answer:

- The Official Guidelines for Coding and Reporting state, “Codes for symptoms, signs, and ill-defined conditions from Chapter 18 are not to be used as principal diagnosis when a related definitive diagnosis has been established.” Based on this guideline and the fact that hematuria is classified as a symptom in ICD-10-CM, code C61, Malignant neoplasm of prostate, would now be assigned as the principal diagnosis. Code R31.0, Gross hematuria, would be assigned as a secondary diagnosis. This is also consistent with the neoplasm guidelines regarding symptoms, signs, and abnormal findings listed in Chapter 18 associated with neoplasm

Rationale:

- The previously published advice was based on the application of the guideline regarding the selection of principal diagnosis as ICD-9-CM did not classify hematuria in the symptom chapter. This is an example of differences in the ICD-10-CM classification compared to ICD-9-CM

Admission/encounter for pain control/management

Neoplasm Related Pain

- Code G89.3 is assigned to pain documented as being related, associated or due to cancer, primary or secondary malignancy, or tumor. This code is assigned regardless of whether the pain is acute or chronic.
- This code may be assigned as the principal or first-listed code when the stated reason for the admission/encounter is documented as pain control/pain management. The underlying neoplasm should be reported as an additional diagnosis.
- When the reason for the admission/encounter is management of the neoplasm and the pain associated with the neoplasm is also documented, code G89.3 may be assigned as an additional diagnosis. It is not necessary to assign an additional code for the site of the pain.

Contiguous Sites

Malignancy in two or more noncontiguous sites

- A patient may have more than one malignant tumor in the same organ. These tumors may represent different primaries or metastatic disease, depending on the site. Should the documentation be unclear, the provider should be queried as to the status of each tumor so that the correct codes can be assigned.

Noninvasive and Invasive High Grade Papillary Urothelial Carcinoma

Coding Clinic Third Q 2023 P. 15

Question:

- The patient presented for an outpatient bladder biopsy and transurethral resection. The findings demonstrated, “High grade invasive papillary urothelial carcinoma of urinary bladder anterior wall and bladder neck with noninvasive high grade papillary urothelial carcinoma of the right bladder neck, right lateral bladder wall, and left dome.” Would noninvasive high grade papillary urothelial carcinoma of the bladder be coded as carcinoma in situ of the bladder or as a malignant neoplasm of the bladder?

Answer: Assign codes

- C67.3, Malignant neoplasm of anterior wall of bladder, and
- C67.5, Malignant neoplasm of bladder neck, for the high grade invasive papillary urothelial carcinoma of the anterior wall urinary bladder and the bladder neck.
- In addition, assign codes C67.2, Malignant neoplasm of lateral wall of bladder, and C67.1, Malignant neoplasm of dome of bladder, for the urothelial carcinoma of the right lateral wall and left dome of the bladder.

Rationale:

- When there is both carcinoma in situ (noninvasive) and malignant carcinoma (invasive) at the site, a code for the carcinoma in situ neoplasm is not assigned.

Disseminated Malignant Neoplasm

Disseminated malignant neoplasm, unspecified

- Code C80.0, Disseminated malignant neoplasm, unspecified, is for use only in those cases where the patient has advanced metastatic disease and no known primary or secondary sites are specified. It should not be used in place of assigning codes for the primary site and all known secondary sites.

Malignant Neoplasm of Unspecified Site

Malignant neoplasm without specification of site

- Code C80.1, Malignant (primary) neoplasm, unspecified, equates to Cancer, unspecified. This code should only be used when no determination can be made as to the primary site of a malignancy. This code should rarely be used in the inpatient setting.

Transplanted Organs

Malignant neoplasm associated with transplanted organ

- A **malignant neoplasm** of a transplanted organ should be coded as a transplant complication. Assign first the appropriate code from category T86.-, Complications of transplanted organs and tissue, followed by code C80.2, Malignant neoplasm associated with transplanted organ. Use an additional code for the specific malignancy.

Breast Implant Associated Anaplastic Large Cell Lymphoma

Breast Implant Associated Anaplastic Large Cell Lymphoma

- Breast implant associated anaplastic large cell lymphoma (BIA-ALCL) is a type of lymphoma that can develop around breast implants. Assign code C84.7A, Anaplastic large cell lymphoma, ALK-negative, breast, for BIA-ALCL. Do not assign a complication code from chapter 19.

Anaplastic Large Cell Lymphoma, ALK-Negative, Breas

Coding Clinic Fourth Q 2021 P.6

- A new code has been created for anaplastic large cell lymphoma, ALK-negative, of the breast (C84.7A), and there is an inclusion term for breast implant associated anaplastic large cell lymphoma (BIA-ALCL).
- BIA-ALCL is a rare type of non-Hodgkin's lymphoma that can develop around breast implants. It is not a disease of the lymph nodes or the breast tissue. This is a cancer of the immune system, rather than a type of breast cancer. BIA-ALCL occurs most frequently in patients who have breast implants with a textured surface. It has been found with both silicone and saline implants in patients with both breast cancer reconstruction and cosmetic surgery.
- The most common symptoms are swelling of the lymph nodes, unexplained breast enlargement, asymmetry, fluid buildup or a lump or pain in the breast or armpit. These symptoms may occur after the surgical incision has healed, often years after implant placement. A complication code from chapter 19 is not assigned for ALK-negative breast implant associated anaplastic large cell lymphoma

Outpatient Guidelines

Screening

Guidelines:

- Screening is the testing for disease or disease precursors in seemingly well individuals so that early detection and treatment can be provided for those who test positive for the disease (e.g., screening mammogram).
- The testing of a person to rule out or confirm a suspected diagnosis because the patient has some sign or symptom is a diagnostic examination, not a screening. In these cases, the sign or symptom is used to explain the reason for the test.
- A screening code may be a first-listed code if the reason for the visit is specifically the screening exam. It may also be used as an additional code if the screening is done during an office visit for other health problems. A screening code is not necessary if the screening is inherent to a routine examination, such as a pap smear done during a routine pelvic examination

Screening

Guidelines:

- Should a condition be discovered during the screening then the code for the condition may be assigned as an additional diagnosis.
- The Z code indicates that a screening exam is planned. A procedure code is required to confirm that the screening was performed.
- The screening Z codes/categories:
  - Z11 Encounter for screening for infectious and parasitic diseases
  - Z12 Encounter for screening for malignant neoplasms
  - Z13 Encounter for screening for other diseases and disorders Except: Z13.9, Encounter for screening, unspecified
  - Z36 Encounter for antenatal screening for mother

Surveillance Upper Endoscopy

Coding Clinic First Q 2021 P. 14

Question:

- A patient undergoes surveillance upper gastrointestinal (GI) endoscopy due to a personal and family history of familial adenomatous polyposis (FAP). The endoscope is introduced into the mouth and after thorough examination of the upper gastrointestinal tract, no evidence of a mass or polyp is found. What diagnosis codes are assigned for a personal and family history of FAP? Is this surveillance endoscopy considered a screening or a follow-up exam?

Answer: Assign codes

- Z12.89, Encounter for screening for malignant neoplasm of other sites, for the surveillance upper GI endoscopy.
- Z86.010, Personal history of colonic polyps,
- **Z83.71, Family history of colonic polyps,
- Z15.09, Genetic susceptibility to other malignant neoplasm, and
- Z84.81, Family history of carrier of genetic disease, should also be assigned.

Rationale:

- A surveillance endoscopy is still a screening for malignancy, and in this case, the endoscopy is considered a high-risk screening exam, because of the history of FAP.

** Category Z83.7 was expanded 10/1/23

Screening Surveillance and Follow-up Colonoscopy

Coding Clinic First Q 2017 P. 8

Question	Answer	Rationale
A 55-year-old male underwent screening colonoscopy and a large polyp was found. Due to its size, and the inability of the gastroenterologist to visualize the base of the polyp, it was only partially removed. The pathology confirmed tubulovillous adenoma and the provider recommended a follow-up colonoscopy in three months. How would this encounter be coded?	Assign codes: • Z12.11, Encounter for screening for malignant neoplasm of colon, as the first-listed diagnosis for the screening colonoscopy. • D12.6, Benign neoplasm of colon, unspecified, as an additional diagnosis.	Whenever a screening examination is performed, the screening code is the first-listed code. The fact that the test is a screening examination remains, regardless of the findings or any additional procedure that is performed as a result of the findings.

Screening Surveillance and Follow-up Colonoscopy

Coding Clinic First Q 2017 P. 8

Question	Answer	Rationale
The same 55 year old male returns to the gastrointestinal (GI) lab for repeat colonoscopy since the entire polyp could not be removed during the initial encounter. A polypectomy is carried out in which the entire polyp is excised. The provider recommends a surveillance colonoscopy in three years. What are the appropriate diagnosis code(s) for this encounter?	Assign code • D12.6, Benign neoplasm of colon, unspecified, as the first-listed diagnosis.	The reason for the encounter is for removal of the remaining polyp.

Screening Surveillance and Follow-up Colonoscopy

Coding Clinic First Q 2017 P. 8

Question:

- A patient, who is status post removal of adenomatous colon polyps five years ago, presents to the GI lab for surveillance colonoscopy. The colonoscopy is completely normal and the provider recommends surveillance colonoscopy in ten years. What is the correct diagnosis code assignment?

Answer: Assign code

- Z12.11, Encounter for screening for malignant neoplasm of colon, as the first-listed diagnosis for the surveillance colonoscopy.
- Z86.010, Personal history of colonic polyps, should be assigned as an additional diagnosis.

Rationale:

- A surveillance colonoscopy is still a screening, and patients are being screened for malignancy; however, it is considered a high-risk screening exam due to the history of previous polyps.

Aftercare

Guidelines:

- Aftercare visit codes cover situations when the initial treatment of a disease has been performed and the patient requires continued care during the healing or recovery phase, or for the long-term consequences of the disease. The aftercare Z code should not be used if treatment is directed at a current, acute disease. The diagnosis code is to be used in these cases.
- Exceptions to this rule are codes Z51.0, Encounter for antineoplastic radiation therapy, and codes from subcategory Z51.1, Encounter for antineoplastic chemotherapy and immunotherapy. These codes are to be first listed, followed by the diagnosis code when a patient's encounter is solely to receive radiation therapy, chemotherapy, or immunotherapy for the treatment of a neoplasm. If the reason for the encounter is more than one type of antineoplastic therapy, code Z51.0 and a code from subcategory Z51.1 may be assigned together, in which case one of these codes would be reported as a secondary diagnosis.

Aftercare

Guidelines:

- The aftercare codes are generally first listed to explain the specific reason for the encounter. An aftercare code may be used as an additional code when some type of aftercare is provided in addition to the reason for admission and no diagnosis code is applicable. An example of this would be the closure of a colostomy during an encounter for treatment of another condition

Aftercare

Aftercare Code Categories Common For Neoplasms

- Z42 Encounter for plastic and reconstructive surgery following medical procedure or healed injury
  - Z42.1 Encounter for breast reconstruction following mastectomy
- Z43 Encounter for attention to artificial openings
  - Z43.3 Encounter for attention to colostomy
- Z48 Encounter for other postprocedural aftercare
  - Z48.3 Aftercare following surgery for neoplasm
- Z51 Encounter for other aftercare and medical care
  - Z51.11 Encounter for antineoplastic chemotherapy

Aftercare

Coding Clinic Second Q 2019 P.33

Question:

- A patient was discharged with a PleurX® drainage catheter due to malignant pleural effusion. During a home health visit, the nurse drained the catheter and changed the dressing, as well as instructed the patient in self drainage. What ICD-10-CM code is assigned to capture attention to the PleurX® drain? Is this coded to ostomy care or is a PleurX® catheter/ drain considered a nonvascular catheter?

Answer: Assign codes:

- Z48.813, Encounter for surgical aftercare following surgery on the respiratory system,
- Z48.01, Encounter for change or removal of surgical wound dressing.

Rationale:

- Code Z48.813 describes the body system requiring the aftercare and can be used in conjunction with other aftercare codes to fully explain the aftercare encounter.

Follow-up

- The follow-up codes are used to explain continuing surveillance following completed treatment of a disease, condition, or injury. They imply that the condition has been fully treated and no longer exists. They should not be confused with aftercare codes, or injury codes with a 7th character for subsequent encounter, that explain ongoing care of a healing condition or its sequelae. Follow-up codes may be used in conjunction with history codes to provide the full picture of the healed condition and its treatment. The follow-up code is sequenced first, followed by the history code.
- A follow-up code may be used to explain multiple visits. Should a condition be found to have recurred on the follow-up visit, then the diagnosis code for the condition should be assigned in place of the follow-up cod

Follow-up

The follow-up Z codes/categories:

- Z08 Encounter for follow-up examination after completed treatment for malignant neoplasm
- Z09 Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm
- Codes Z08, Encounter for follow-up examination after completed treatment for malignant neoplasm, and Z09, Encounter for follow up examination after completed treatment for conditions other than malignant neoplasm, may be assigned following any type of completed treatment modality (including both medical and surgical treatments).

Refusal of Adjuvant Therapy for Breast Carcinoma Status Post Mastectomy

Coding Clinic Third Q 2020 P.30

Question:

- A patient, who was diagnosed with an infiltrating ductal carcinoma of the right breast of overlapping sites, presents for an outpatient follow-up visit after previously undergoing an excisional lumpectomy with sentinel lymph node dissection. Margins on the pathology report were clear and the sentinel lymph node was benign. During the follow-up visit, the oncologist recommended adjuvant endocrine therapy. However, the patient refused adjuvant therapy because her primary care physician indicated the benefits would be minimal. What is the appropriate code assignment for this visit since the patient is without evidence of any remaining cancer and is refusing adjuvant endocrine therapy?

Answer: Assign codes

- Z08, Encounter for follow-up examination after completed treatment for malignant neoplasm, and
- Z85.3, Personal history of malignant neoplasm of breast, for this visit.

Rationale:

- The patient is not receiving any further treatment and there is no evidence of any remaining malignancy. No additional code is necessary for refusal of adjuvant therapy.

Follow-up

Coding Clinic First Q 2017 P. 8

Question:

- A patient is status post colon polypectomy for an adenomatous polyp. Because of the suspicious nature of the polyp and potential for malignant transformation, the patient is being seen for a follow-up examination six months after excision of the polyp. The colonoscopy is negative for any recurrence of the polyp. What is the correct code assignment for this encounter?

Answer: Assign codes

- Z09, Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm.
- Z86.010, Personal history of colonic polyps, should be assigned as an additional diagnosis.

Prophylactic Organ Removal

- For encounters specifically for prophylactic removal of an organ (such as prophylactic removal of breasts due to a genetic susceptibility to cancer or a family history of cancer), the principal or first-listed code should be a code from category Z40, Encounter for prophylactic surgery, followed by the appropriate codes to identify the associated risk factor (such as genetic susceptibility or family history).
- If the patient has a malignancy of one site and is having prophylactic removal at another site to prevent either a new primary malignancy or metastatic disease, a code for the malignancy should also be assigned in addition to a code from subcategory Z40.0, Encounter for prophylactic surgery for risk factors related to malignant neoplasms.
- A Z40.0 code ***should not*** be assigned if the patient is having organ removal for treatment of a malignancy, such as the removal of the testes for the treatment of prostate cancer.

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Thank you!