

ICD-10-CM Specialty Code Set Training Anesthesia

2014

Module 1



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Clinical Examples Used in this Book

AAPC believes it is important in training and testing to reflect as accurate a coding setting as possible to students and examinees. All examples and case studies used in our study guides and exams are *actual*, *redacted* office visit and procedure notes donated by AAPC members.

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Neoplasm Coding

ICD-10-CM Chapter 2: Neoplasms (C00–D49)

One of the reasons that we are transitioning to ICD-10-CM is the increased specificity to enable conditions to be clearly indicated. Care must be taken to ensure that providers and coders understand where the code set has expanded in order to be able to capture that information and denote it on a claim. Specificity issues include laterality, time parameters, site, and expansion of certain conditions under ICD-10-CM.

Coding of Neoplasms for Anesthesia

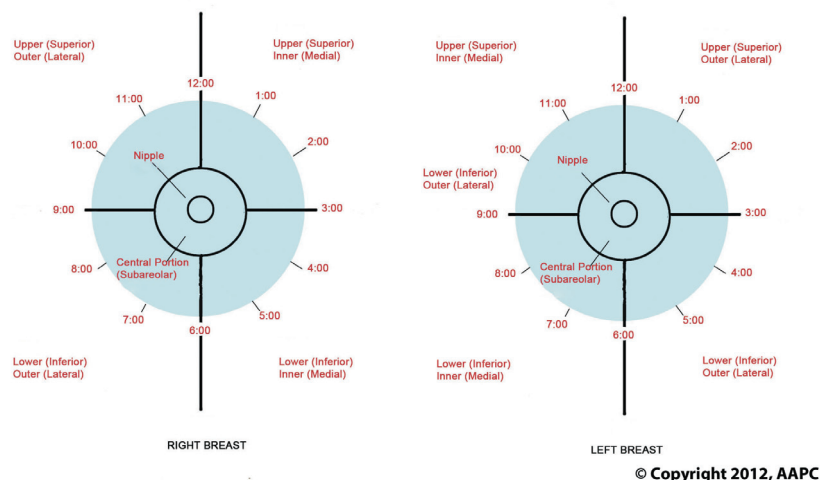
When coding for anesthesia, the primary diagnosis is the reason the patient is having the surgery performed. Because neoplasms are a common diagnosis for surgery, it is important for an anesthesia coder to understand the coding guidelines and proper code selection.

According to the National Cancer Society about ninety percent of breast cancers are adenocarcinomas, which arise from glandular tissue. There are about 30 different subtypes of adenocarcinoma. Ductal carcinoma in situ comprises about 20 percent of all breast cancers and it develops solely in the milk ducts. Invasive ductal carcinoma can be either in situ or it spreads through the duct walls invading breast tissue.

Cancer that begins in the lobes or lobules is called lobular carcinoma. This is a small cell carcinoma and often can be found in both breasts. Other less common types of breast cancers include:

- Inflammatory breast cancer
 - This is diffuse brawny infiltration and the breast appears red or inflamed and it tends to spread quickly
- Medullary carcinoma
 - Originates in the central breast tissue
- Mucinous carcinoma
 - Usually occurs in postmenopausal women it is invasive
- Paget disease of the nipple
 - Originates in the milk ducts and spreads to the skin of the nipples or the areola
- Phyllodes tumor
 - This tumor has a leaf-like appearance that extends into the ducts
- Tubular carcinoma
 - These are small tumors that are often undetected by palpation

Clock and Quadrants of the Breast



The level of specificity found in ICD-10-CM for neoplasm coding will require a greater understanding of A&P as well as additional documentation requirements.

Carcinoma in situ (CIS) identifies cancerous tumors that are noninvasive, or confined. Carcinoma in situ is an early form of carcinoma defined by the absence of invasion of surrounding tissues. The neoplastic cells proliferate in their normal habitat, hence the name “in situ” (Latin for “in its place”). For example, CIS of the skin, also called Bowen’s disease, is the accumulation of neoplastic epidermal cells within the epidermis only.

EXAMPLE:

A 57-year-old patient presents for anesthesia evaluation. The patient has a family history of a mother and sister with premenopausal breast cancer. Digital mammography shows area of calcifications. Magnification views demonstrate intraductal pleomorphic microcalcifications in the right 11:00 area. Final diagnosis indicated intraductal carcinoma in situ.

D05.11 Intraductal carcinoma in situ of right breast

Z80.3 Family history of malignant neoplasm of breast

CIS will usually not form a tumor, the lesion is flat (in the skin, cervix, etc) or follows the existing architecture of the organ (in the breast, lung, etc). Some CIS, however, do form tumors—for example, colon polyps or papillary cancer of the bladder as well as some CIS of the breast (more properly called Ductal Carcinoma in situ).

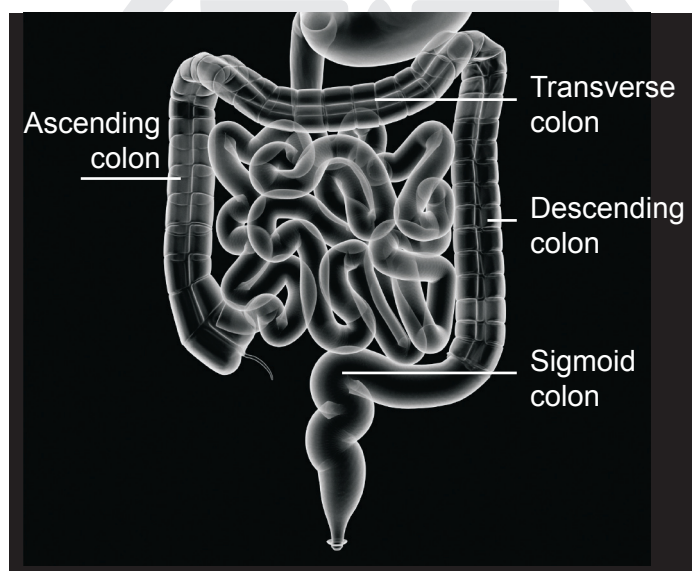
Synonyms for in situ carcinoma of the colon include:

- Adenocarcinoma in an adenomatous polyp with no invasion of the stalk
- Confined to the epithelium
- Noninfiltrating
- Intraepithelial

- Intraepidermal (anus)
- Involvement up to but not including the basement membranes
- Noninvasive
- No stromal involvement
- Papillary noninfiltrating

Benign neoplasms, or tumors, are noncancerous. They do not metastasize, usually have defined edges, and do not grow back once they have been removed. Benign tumors may still pose a threat to a patient. Benign neoplasms include uterine fibroids and melanocytic nevi (skin moles).

Colorectal cancers start in the lining of the bowel. If left untreated, it can grow into the muscle layers underneath, and then through the bowel wall. Most begin as a small growth on the bowel wall: a colorectal polyp or adenoma. These growths are usually benign, but some develop into cancer over time.



Many physicians document by centimeters on procedures involving the colon.

- Anus-0–4 cm
- Rectum 4–16 cm
 - Upper third is covered by peritoneum; the lower third is not and it is also called the rectal ampulla
- Rectosigmoid 15–17 cm
 - From the anal verge
- Sigmoid 17–57 cm
 - Loop extending distally from border of left posterior major psoas muscle
- Descending 57–82 cm
 - Approximately 10–15 cm long and located behind the peritoneum
- Transverse 82–132 cm
 - Lies anterior in the abdomen and attached to the gastrocolic ligament

- Ascending 132–147 cm
 - Approximately 20–25 cm long and located behind the peritoneum
- Cecum 150 cm
 - Approximately 6 x 9 cm pouch covered with peritoneum

In ICD-10-CM the codes for neoplasms are site specific.

C18.0 Malignant neoplasm of cecum

C18.1 Malignant neoplasm of appendix

C18.2 Malignant neoplasm of ascending colon

C18.3 Malignant neoplasm of hepatic flexure

C18.4 Malignant neoplasm of transverse colon

C18.5 Malignant neoplasm of splenic flexure

C18.6 Malignant neoplasm of descending colon

C18.7 Malignant neoplasm of sigmoid colon

C18.8 Malignant neoplasm of overlapping sites of colon

C18.9 Malignant neoplasm of colon, unspecified

A benign neoplasm of the colon (adenomatous colon polyp) is coded to the subcategory of D12 according to the sites listed above.

EXAMPLE:

During a screening colonoscopy Dr. Smith removes a polyp from the descending colon. Pathology reports confirm it is benign.

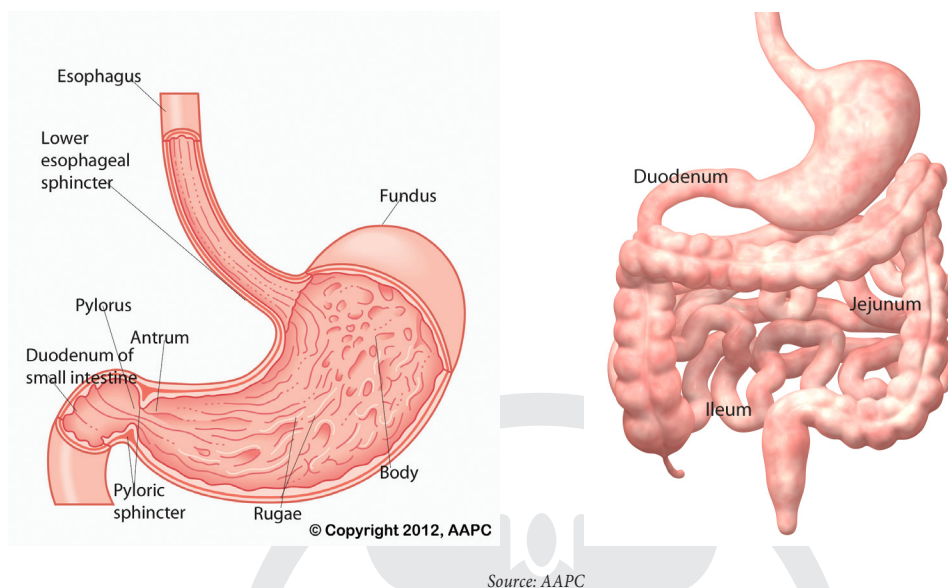
Z12.11 Encounter for screening for malignant neoplasm of colon

D12.4 Benign neoplasm of descending colon

In addition a polyp of the colon that is not considered adenomatous (D12.6), inflammatory (K51.4) or polyposis of colon (D12.6) is coded to K63.5 for polyp of colon.

Adenomatous polyps may develop into cancer over time and they are coded in the neoplasm chapter. Inflammatory polyps not documented as to the site within the colon are coded in the diseases of the digestive system chapter.

Cancers of the esophagus, stomach and small intestine are referred to as upper gastrointestinal tract or UGI cancers. These cancers represent the second most common site of digestive system cancers.



Source: AAPC

There are two main types of esophageal cancer. The majority of cancers in the upper two thirds of the esophagus are squamous cell carcinomas. Adenocarcinomas start in glandular tissues and usually occur in the lower esophagus near the stomach.

Stomach cancers or gastric cancers can develop in any part of the stomach and may spread throughout the stomach and other organs. Most stomach cancers are adenocarcinomas that arise in the glandular cells.

Cancer of the small intestine is rare and the majority of these are adenocarcinomas and most commonly start in the duodenum, jejunum and the small intestines near the stomach. Adenocarcinoma of the small intestine is associated usually with Crohn's disease and celiac disease as well as familial polyposis syndromes.

Leiomyosarcomas most often occur in the ileum and some are carcinoid tumors.

Current Malignancy Versus Personal History of Malignancy

According to ICD-10-CM Draft Official Guidelines for Coding and Reporting 2013, the guidelines for when to code for current malignancy versus personal history of malignancy states the following:

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, a code from category Z85 *Personal history of malignant neoplasm*, should be used to indicate the former site of the malignancy.

Neoplasm Related Pain

According to the World Health Organization, nearly 75 percent of patients with advanced cancer experience pain. When managed correctly, relief from pain can be achieved in 90 percent

of patients. When pain is documented as being related, associated or due to cancer, primary or secondary malignancy, or tumor, code G89.3 is assigned. 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.

EXAMPLE:

Bob is seen today for control of his neoplasm related pain. He has a malignant neoplasm of the lower third of the esophagus.

G89.3 Neoplasm related pain (acute) (chronic)

C15.5 Malignant neoplasm of lower third of esophagus

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.

EXAMPLE:

Mary is being seen for left lower lung cancer. She is continuing to have neoplasm related pain.

C34.32 Malignant neoplasm of lower lobe, left bronchus or lung

G89.3 Neoplasm related pain (acute) (chronic)