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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.

To preserve the real world quality of these notes for educational purposes, we have not re-written or edited the notes to the stringent grammatical or stylistic standards found in the text of our products. Some minor changes have been made for clarity or to correct spelling errors originally in the notes, but essentially they are as one would find them in a coding setting.
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Coding of Neoplasms for General Surgery

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

Neoplasm of the Breast

According to the National Cancer Society about 90 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 and invasive
- Paget disease of the nipple
  - Originates in the mild 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
EXAMPLE

A 57-year-old patient presents for evaluation of right nipple discomfort. The patient has 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 o’clock area. Final diagnosis indicated intraductal carcinoma in situ.

ICD-10-CM D05.11 Intraductal carcinoma in situ of right breast
Z80.3 Family history of malignant neoplasm of 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

Patient was seen in follow up for carcinoma in situ of the skin of the breast.

ICD-10-CM: D04.5 Carcinoma in situ of skin of trunk
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, though. Benign neoplasms include uterine fibroids and melanocytic nevi (skin moles).

**Colorectal Neoplasms**

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 anteriorly 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 6x9 cm pouch covered with peritoneum

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

**EXAMPLE**

- C18.0 Malignant neoplasm of cecum
- C18.1 Malignant neoplasm of appendix
- C18.3 Malignant neoplasm of ascending colon
- C18.4 Malignant neoplasm of hepatic flexure
- C18.5 Malignant neoplasm of transverse colon
- C18.6 Malignant neoplasm of splenic flexure
- 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 as defined by the 4th character.

**EXAMPLE**

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

ICD-10-CM 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.
A polyp documented as adenomatous is considered cancerous as well as one documented as polyposis. Inflammatory and simple benign polyps are coded outside of the neoplasm chapter and found in chapter 11, Diseases of the Digestive System.

A polyp of the colon that is not considered adenomatous (D12.6), inflammatory (K51.4), or polyposis of colon (D12.6) and has no further definition is simply coded K63.5 for polyp of colon.

Adenomatous is considered cancerous as well as polyposis while inflammatory and simple benign polyps are coded outside of the neoplasm chapter and found in chapter 11 Diseases of the Digestive System.

**Upper GI Neoplasms**

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

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 occurs 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.
Neoplasms of Pancreas

Pancreatic ductal adenocarcinoma accounts for 90 percent of cancers of the pancreas. Pancreatic cancer is the fourth and fifth most common cancer in men and women, respectively. It accounts for more than 30,000 new cases and 20,000 cancer-related deaths each year. Most patients are older than 60 years. It has the lowest 5-year survival of any cancer, reflecting late diagnosis and low resection rates.

Pancreatic cancer is aggressive. Of pancreatic cancers, 60 percent develop in the pancreatic head and 40 percent develop in the body and tail. Symptoms include abdominal pain, anorexia, weight loss, and jaundice.

The American Cancer Society reports that only about 23 percent of patients with cancer of the exocrine pancreas are still living one year after diagnosis. Only about 4 percent are still living five years after being diagnosed.

Malignant neoplasms of the pancreas are assigned codes from the category C25 and the location of the neoplasm is essential for proper assignment.

Codes are broken down as:

- C25.0 Malignant neoplasm of head of pancreas
- C25.1 Malignant neoplasm of body of pancreas
- C25.2 Malignant neoplasm of tail of pancreas
- C25.3 Malignant neoplasm of pancreatic duct
- C25.4 Malignant neoplasm of endocrine pancreas
  - Malignant neoplasm of islets of Langerhans
  - Use additional code to identify functional activity

Source: AAPC
C25.7 Malignant neoplasm of other parts of pancreas
   Malignant neoplasm of neck of pancreas
C25.8 Malignant neoplasm of overlapping sites of pancreas
C25.9 Malignant neoplasm of pancreas, unspecified

EXAMPLE
A patient was diagnosed with operable adenocarcinoma of the pancreas tail.
   C25.2 Malignant neoplasm of tail of pancreas