Dermatology Coding Alert

Learn 5 Neoplasm Facts To Facilitate Coding

Take the guesswork out of malignancy coding with our expert advice

Determining an initial diagnosis for malignant neoplasms is a tricky but crucial first step in the treatment of patients. Follow these hints to accurately code malignant neoplasms on the skin and ensure the best for your patients and your bottom line.

Find Your Way Through Path Reports

The pathology report is the single most important resource when determining if a malignant neoplasm is primary, secondary, or in situ. "Generally, the pathologist will tell you straight out" the nature of the malignancy, says **Marcella Bucknam, CPC, CCS, CPC-H**, **CCS-P**, HIM program coordinator at Clarkson College in Omaha, Neb. In cases when a primary, secondary, or in situ designation is not explicitly stated, however, you may still be able to get a handle on the type of malignancy by recognizing common key terms.

Primary: Use a primary neoplasm code to denote "the point of origin of the tumor site," says **Mary I. Falbo, MBA, CPC**, president of Millennium Healthcare Consulting Inc. in Lansdale, Pa. In some cases, a pathology report will document that a neoplasm on the skin is "metastatic from" a specified site, such as the bronchus. The bronchus would be coded as the primary cancer using neoplasm code 162.2 (Malignant neoplasm of trachea, bronchus and lung; main bronchus).

Another type of neoplasm to consider is described by ICD-9 as overlapping two or more contiguous sites and whose point of origin cannot be determined. Such neoplasms are classified as primary with a fourth digit of 8 ("overlapping lesion"), unless the combination is specifically indexed elsewhere. A neoplasm of the skin that overlapped two contiguous sites (such as the scalp and the forehead) would be coded using 173.8 (Other malignant neoplasm of skin; other specified sites of skin).

Secondary: A secondary neoplasm indicates a site that the cancer has spread to. In taking the example above, you may read that a neoplasm is metastatic from the bronchus to the abdominal wall. "Metastatic to" signals that you should include a secondary neoplasm diagnosis for the abdominal wall using 198.2 (Secondary malignant neoplasm of other specified sites; skin). You may not see as many metastatic diseases in dermatology as in some other specialities, but being aware of the terminology can nonetheless clarify your interpretations of pathology reports.

In situ: In situ neoplasms contain cells that are "undergoing malignant changes but are still confined to the point of origin without invasion of the surrounding normal tissue," Falbo says. Hint: Other terms used to describe carcinoma in situ include intraepithelial, noninfiltrating, noninvasive, preinvasive, or specifically confined.

While familiarizing yourself with associated terminology can help, Bucknam strongly suggests that coders rely on the specific definition supplied by the pathologist or dermatologist, particularly for in situ carcinomas. "You really want your pathologist or physician to say it's in situ," she says.

Be careful: One troubling tendency is for coders to equate a lesion diagnosis with a neoplasm, Bucknam says. While certain lesions can be neoplastic, lesions can also be as simple as scars or other inflammatory changes. Tagging a patient with the label of a neoplasm, even a benign one, may raise red flags for insurers.

Navigate ICD-9

Once you have determined the nature of the malignancy, assign an accurate ICD-9 diagnostic code for the system, organ

or site of the neoplasm. Your first step should be to suppress the urge to flip to the neoplasm tabular index. Instead, use the alphabetical index to look up the morphology, such as adenocarcinoma or sarcoma, Bucknam says. Reason: This is an important step because there will be times when the morphology will point you to specific codes or directions that you wouldn't find if you started out with the neoplasm table.

Example: If you look up "melanoma (malignant), lip" in the alphabetical index, you will find code 172.0 (Malignant melanoma of skin; lip). If you began your search with the tabular index looking up "lip," you might have erroneously diagnosed 140.9 (Malignant neoplasm of lip, unspecified, vermilion border). Alternatively, you may have mistakenly chosen 173.0 (Other malignant neoplasm of skin; skin of lip) by consulting the table for "skin, lip."

You've taken the time to properly identify the type and code for a neoplasm. Don't get tripped up and risk a denial with the final step of ordering your diagnoses.

Warning: Be careful not to confuse a primary neoplasm with a principal diagnosis. Your first code should be the site where treatment was chiefly directed for that visit, Bucknam says.

For instance, the physician excises a secondary neoplasm of the mandibular vestibule for a patient with a primary neoplasm of the lower lip, vermilion border. Your principal diagnosis would be 198.89 (Secondary malignant neoplasm of other specified sites; other) for the vestibular neoplasm, followed by 140.1 (Malignant neoplasm of lip; lower lip, vermilion border).

If a patient presents with multiple sites and they are all addressed, such as in an E/M service in which no neoplasm was listed as principal, you should list primary cancers before secondary. In the case of multiple primary neoplasms that have all been equally treated, ordering is at the coder's discretion.

Exception: When the sole purpose of the visit is radiotherapy or chemotherapy, "the primary malignancy is sequenced second," Falbo says. Report the initial diagnosis with V58.0 (Radiotherapy) or V58.11 (Encounter for antineoplastic chemotherapy).