Neurosurgery Coding Alert

ICD-10 Training: Master the Art of CNS Neoplasm Diagnosis Coding

Utilize these two examples to boost your diagnostic coding skills.

Coding neoplasms of the central nervous system (CNS) can pose a challenge to even the most experienced coders. It requires an intricate knowledge of anatomy, scientific terminology, and the ICD-10 index. The degree of difficulty can be compounded due to the fact that some of these diagnoses are non-indexable via the ICD-10 index.

Fortunately, there are working algorithms in place to ease the burden of correctly coding neoplasms of the CNS. However, rather than taking a universal approach for each neoplasm, it's best to treat each diagnosis as a separate entity when deciding upon the correct ICD-10 code.

Becoming an efficient and accurate ICD-10 coder requires a combination of perseverance, critical thinking, and most importantly, experience. But there are still certain tips and techniques coders of any experience level can utilize to help reach their goal of becoming an established ICD-10 coder.

"Neoplasm coding offers an additional degree of difficulty due to the need to incorporate the Table of Neoplasms, rather than the ICD-10 index alone," says **Lindsay Della Vella, COC**, medical coding auditor at Precision Healthcare Management in Media, Pennsylvania. "Coders need to take various factors into consideration when coding neoplasms of various behaviors, such as the areas affected, primary versus secondary status, and cancer in situ," relays Della Vella.

Consider the following examples to help further establish yourself as an expert coder in the field of CNS neoplasm coding.

Example 1: Medulloblastoma

Before attempting to find the correct diagnosis code, you want to make sure you've got a firm understanding of the type of neoplasm you're dealing with. In this case, you know that a medulloblastoma is a malignant neoplasm of the brain ⬚ most often in the cerebellum (but not always).

You won't find the scientific term anywhere in the Table of Neoplasms Index, so you've got to come up with another game plan to determine the most accurate diagnosis code available. Some coders might opt to take the approach of dividing the diagnosis between prefix, root word, and suffix. "Coders need to be careful when going this route," advises **Barry Rosenberg, MD**, chief of radiology at United Memorial Medical Center in Batavia, New York. "If a coder does nothave a fundamental understanding of the anatomy behind the codes they are researching, they may wind up reaching some inaccurate conclusions," says Rosenberg.

For example, if you rely on the prefix in an attempt to find the correct diagnosis code for medulloblastoma, you may wind up reporting an incorrect code. The prefix "medullo" pertains to "medulla," which "Stedman's Medical Dictionary" defines as "any soft marrowlike structure, especially in the center of a part." Do not make the incorrect assumption that the prefix medulla relates to the medulla oblongata, which is an entirely separate entity from the cerebellum.

Code to Degree of Specificity

While medulloblastomas are most primarily affiliated with the cerebellum, they may also "be implanted discretely or coalescently on the surfaces of the cerebellum, brainstem, and spinal cord," according to Stedman's. In the hypothetical scenario that the provider documents the medulloblastoma within the cerebellum, the coding is actually quite simple. When coding neoplasms, especially by their scientific name, make sure you search the ICD-10 index before opting for the Table of Neoplasms. Medulloblastoma is an available term within the index, which you will then see can be coded as C71.6 (Malignant neoplasm of cerebellum) or, if the physician specifies otherwise, can be found by searching the Table of

Neoplasms for "Neoplasm, malignant, by site."

Careful: While ICD-10 directs you to code a default diagnosis of medulloblastoma as C71.6, there should be no circumstance in which the provider does not document an exact location of the malignancy within the operative report.

Example 2: Chordoid Meningioma due to Tuberous Sclerosis

It's highly unlikely you will come across this example often in real time; however, the point of covering the coding elements of this diagnosis is to leave you properly equipped for any and all neoplastic coding scenarios in the future.

You are not necessarily expected to have a complete grasp on either of these diagnoses off the bat. The best diagnosis coders aren't necessarily storage facilities for a vast wealth of knowledge; they simply know what tools and tricks to utilize when a particular circumstance calls for it.

In this example, you first need to understand that while these are two separate diagnoses, one is (highly likely) a result of the other. For the sake of this example, you can assume that the documentation supports the fact that the chordoid meningioma is secondary to the tuberous sclerosis diagnosis.

Definition: Tuberous sclerosis is a genetic disease that can cause benign tumors to grow within the brain, among other areas.

Since you know that a chordoid meningioma is a benign neoplasm of the cerebral meninges (and the documentation supports a conclusive link between diagnoses), your coding should reflect as much. You will code a chordoid meningioma the same way as a cerebral meningioma of any other classification: D32.0 (Benign neoplasm of cerebral meninges). As for tuberous sclerosis, you simply take the route within the ICD-10 index from Sclerosis, sclerotic -> tuberous (brain) -> Q85.1 (Tuberous sclerosis).

Consider all Factors to Determine Primary versus Secondary Dx

Where a coder may get caught up coding these diagnoses is in differentiating primary versus secondary diagnoses. As a coder, you should know that, generally speaking, when one diagnosis is a result of another, you only code the initial, primary diagnosis (consider spondylosis causing stenosis). This is a confounding example, however. You should be especially cautious in coding a scenario where a congenital disease results in a secondary diagnosis, but keep anatomical location in consideration.

Example: A patient with a diagnosis of congenital scoliosis (bony malformation) experiences symptomatic foraminal disc displacement as a result. Here, since you are working with interrelated spinal conditions, you should only code the primary diagnosis of Q76.3 (Congenital scoliosis due to congenital bony malformation) if evaluation and management (E/M) service is primarily related to the congenital scoliosis. If, however, the surgeon opts to surgically treat the disc displacement in addition to the scoliosis, you should code both diagnoses (attach the disc displacement diagnosis as the primary diagnosis on the discectomy CPT® code).

As for the example of chordoid meningioma due to tuberous sclerosis, you will code both diagnoses (Q85.1 and D32.0). In fact, since the patient is presenting for surgical consideration to remove the chordoid meningioma, you will want to code the D32.0 as the primary diagnosis and Q85.1 as the secondary diagnosis.

Which diagnosis you code as the primary in this example is ultimately determined by specialty and whether or not surgery is a consideration. If, for example, the patient is presenting for radiological imaging to determine whether or not the tuberous sclerosis has impacted any other organs, Q85.1 will be the primary diagnosis. From a radiology coding perspective, unless the radiologist performs imaging of the head, you would not include D32.0 as a diagnosis at all. As you can see with this example, deciding when to code primary and secondary diagnoses can be extremely subjective based on the nuances of the scenario.