Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Exam Findings Dictate When 188.x Becomes V10.51

Scour your urologist's documentation for clues.

Deciding when to switch from using an active bladder cancer diagnosis code to using a personal history of cancer code can be a challenge for even veteran coders.

If a patient undergoes a cystoscopic examination every six months because of a previous bladder cancer diagnosis, do you use V10.51 (Personal history of malignant neoplasm of bladder) or 188.x (Malignant neoplasm of bladder ...) for a diagnosis code? Read on to find out.

New, Residual Tumor Means Active Cancer Dx

If your urologist performs a surveillance cystoscopic examination to monitor the disease process in a patient with a history of bladder cancer, you must first determine whether or not the urologist discovers recurrent tumor.

If the urologist finds a recurrent tumor, choose a code in the188.0-188.9 range, depending on the site of the lesion within the bladder. Remember with ICD-9 coding there is no way to indicate the aggressiveness of a malignant tumor (grade) nor its invasiveness (stage). [ICD-10 note: The same will be true under ICD-10 after Oct. 1, 2013.]

"188.x codes are to be used for active cancers that are currently being treated or observed," says **Elizabeth Hollingshead, CPC, CUC, CMC, CMSCS,** corporate billing/coding manager of Northwest Columbus Urology Inc. in Marysville, Ohio.

In other words, if you assign 188.x to a claim, you are indicating that the patient has an active bladder cancer or is receiving treatment for bladder cancer, agrees **Leah Gross, CPC,** coding lead at Metro Urology in St. Paul, Minn.

Tip: Note that if the pathology report identifies the lesion as benign, choose 223.3 (Benign neoplasm of bladder).

No Tumor Means V Code

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, a code from category V10, personal history of malignant neoplasm, should be used to indicate the present status of the malignancy.

"When there's no longer any evidence of the disease we switch to the V code," Hollingshead explains. "It's appropriate to use the V10.51 history code when there is no evidence of cancer remaining."

The notes in the ICD-9 manual state that you should use V10.51 for "history of conditions classifiable to 188 and 189."

Beware: A common misunderstanding is that you can't use a V code as a primary diagnosis. Some coders believe that V codes are only appropriate as secondary codes, but the reality is that you may and, on occasion, should report V codes as a primary diagnosis. In some instances, a V code may even be the only way to be paid for a service.

"You can use V-codes as primary and they are reimbursed," explains **Sally Kouw, CPC,** billing coordinator with HH Service-Bates/Urology in Holland, Mich. You can review the ICD-9 diagnosis coding guidelines in your ICD-9 manual, Kouw

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says. The guidelines explain that you can use V codes as primary diagnosis codes on a claim, she explains.

"We use the V10.51 for patients who are coming for a surveillance cystoscopy with no other symptoms or problems," Hollingshead says. "If the cysto shows no reoccurrence, V10.51 is the only diagnosis reported."

"V codes are status codes," Gross explains. "For example, if a patient is healthy and is coming in for a physical, or immunizations, they do not have a disease and therefore the V code section is appropriate. In the case of V10.51, the patient has a history of a malignancy and is coming in under the recommendation of his or her urologist for appropriate follow up. If there is no active disease or treatment, their status of cancer is the only reportable diagnosis. It is explained at the beginning of the V code section in the ICD-9 manual."

Bottom line: "If no tumor is found on cystoscopic examination, I would then code ICD-9 V10.51," says **Michael A. Ferragamo, MD, FACS,** clinical assistant professor of urology at the State University of New York at Stony Brook. "If tumor is found, I would suggest ICD-9 code 188.x according to where the tumor is located within the bladder."

The Answer is In the Documentation

Your urologist is ultimately the one who makes the decision of which diagnosis code is most appropriate. You, as the coder, should review the documentation to ensure proper diagnosis code selection.

As noted above, "the active code should be switched to the personal history code when there is no clinical evidence of the cancer," Hollingshead says. You'll find the answer the whether there is evidence of a tumor in your urologist's encounter and procedure notes.

"This is information we received from the AUA: Per the AUA, 'the assignment of the diagnosis of cancer is under the judgment of the physician,'" says Gross. "However, the physician should be educated by his or her coder. It was only after our coding team worked with our physicians regarding the assignment of current or history of cancer, the patient's treatment regimen or lack thereof, and how it directly affected the patient in terms of insurance coverage that our physician staff understood how to correctly choose these diagnoses."

Best bet: "If there's ever any question between active and history, defer to the doctor's option and documentation," Hollingshead advises. "It's his name on the claim and his judgment that matters."

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