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AHIMA

June 2019

Alleviating Pain Associated with Coding Neoplasm-Related Admissions: Part 2

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Last month, in Part 1, we looked at some of the Chapter 2 guidelines that highlighted when neoplasm can be principal. Now let's look at some of the guidelines that tell us when cancer does not meet the definition of principal.

Complication of Neoplasm
Section I.C.2.c and I.C.2.l.4 both instruct that when a patient is admitted due to a complication related to a known cancer, and treatment is only for the complication, that complication is the principal diagnosis.[1] This makes sense when you remember the definition of principal diagnosis: "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."[2] The cancer is known—it isn't newly diagnosed or being worked up—and the aim of the treatment during admission is to alleviate and/or address the complication. The complication is the focus of care. Both guidelines specifically mention admissions for treatment of dehydration due to cancer as an example; the dehydration is sequenced first, followed by a code for the underlying malignancy.

If a patient is admitted with biliary obstruction due to known hepatobiliary cancer, and endoscopic retrograde cholangiopancreatography (ERCP) is performed with placement of stent to relieve the obstruction in the common bile duct with no treatment aimed at the underlying cancer, the obstruction would likely be principal diagnosis. Yet another example would be an admission to treat cerebral edema related to known brain metastasis with steroids and/or external ventricular drain (EVD) placement. The cerebral edema would likely be reported as principal diagnosis if it met the definition of principal diagnosis and the treatment was only for the cerebral edema. A review of the entire record is necessary to confirm sequencing for these examples. Biliary obstruction (K83.1) and cerebral edema (G93.6) are not symptom codes. Therefore, the complication of neoplasm guidelines (I.C.2.l.4) apply rather than the signs and symptoms guidelines (I.C.2.g).[3]

Guideline I.C.2.h directs us to section I.C.6 for information about coding and sequencing admissions for control of neoplasm-related pain.[4] When a patient is admitted solely to control or manage neoplasm-related pain, neoplasm-related pain is the principal diagnosis. You may be thinking, "Hey, wait—pain codes are symptom codes, aren't they?" Yes, there are many pain codes that begin with an R, but neoplasm-related pain is coded G89.3. This is not a symptom code—and there is a coding guideline that says when the stated reason for the admission is to control neoplasm-related pain, G89.3 should be assigned as principal.[5]

There is at least one exception to the general rule regarding admissions for treatment of complications of cancer that is not mentioned in the guidelines: an Excludes1 note in the tabular list under code category K56.60- indicates that when the cause of a bowel obstruction is known, only the cause is coded. That means that when bowel obstruction is due to cancer, only the cancer is coded.[6] If the admission was to address the bowel obstruction, then the cancer is principal. Remember, coding conventions take precedence over coding guidelines.

Admissions for Chemotherapy, Immunotherapy, or External Beam Radiation Treatment
Guideline I.C.2.e.2 reminds us that when admissions are solely for chemotherapy, immunotherapy, or external beam radiation treatment, we've got specific principal diagnosis codes that must be assigned: Z51.11, Encounter for antineoplastic chemotherapy; Z51.12, Encounter for antineoplastic immunotherapy; or Z51.0, Encounter for antineoplastic radiation therapy. When admission is for both chemotherapy and radiation therapy, then both encounter codes can be assigned and either can be sequenced first.[7]

Anemia Due to Cancer Treatment
In contrast to the guideline regarding anemia related to neoplasm, when a patient is admitted for treatment of anemia that the provider indicates is due to cancer treatment (chemotherapy, radiation therapy), the anemia code is principal per guideline I.C.2.c.2.[8] Remember, there is an instruction code under anemia in neoplastic disease which instructs that cancer must be seqeunced first. No such coding instruction exists for anemia due to chemotherapyy or anemia due to radiation. We sequence as principal the condition which meets the definition of principal diagnosis.

Condition Unrelated to Neoplasm

Finally, if a patient is admitted for a condition unrelated to cancer—exacerbation of chronic obstructive pulmonary disease, sepsis, or trauma—then that condition is sequenced as principal.

Remember that conventions take precedence over guidelines; always keep in mind the definition of principal diagnosis; and realize that the coding guidelines are repetitive—chapter-specific guidelines reiterate, restate, and cement the general guidelines laid down in sections IA and those in section II regarding selecting the principal diagnosis. Keeping these three things in mind will help alleviate some of the difficulty that arises in selecting a principal diagnosis for admissions for neoplasm and neoplasm related conditions.

NOTES

1. National Center for Health Statistics. “ICD-10-CM Official Guidelines for Coding and Reporting FY 2019.” 2018. Pages 30-32, 34. https://www.cdc.gov/nchs/icd/data/10cmguidelines-FY2019-final.pdf.

2. Ibid, page 107.

3. Ibid, pages 33, 34.

4. Ibid, page 33.

5. Ibid, page 44.

6. American Hospital Association. "Intestinal Obstruction due to Peritoneal Carcinomatosis." *Coding Clinic for ICD-10-CM and ICD-10-PCS*. Chicago, IL: American Hospital Association. Second Quarter 2017, page 12.

7. National Center for Health Statistics. “ICD-10-CM Official Guidelines for Coding and Reporting FY 2019.” 2018. Page 32. https://www.cdc.gov/nchs/icd/data/10cmguidelines-FY2019-final.pdf.

8. Ibid, page 31.

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