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Career-building Resources

Coding for Lymphoma

Audio Seminar / Webinar

February 28, 2008

Practical Tools for Seminar Learning

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The faculty has reported no vested interests or disclosures regarding this presentation.

Faculty

Miriam P. Rogers, EdD, RN, AOCN, CNS

Miriam Rogers' early professional and personal experience in the care of cancer patients broadened into a career decision to specialize in oncology nursing with a master's degree in adult oncology from Emory University in 1984. In 1997, Dr. Rogers completed doctoral studies in continuing and professional adult education. Dr. Rogers has practiced as an oncology clinical nurse specialist/advanced practice nurse in a variety of roles such as disease management, physician extender, researcher and nursing leadership. These roles have been in inpatient/outpatient hospital-based and private practice in both academic and community settings. Most recently, Dr. Rogers has a dual role as the Advanced Practice Nurse in Oncology and Executive Director of Acute Care Inpatient Nursing at a large multi-hospital community medical center.

Concurrent to clinical and administrative experience, Dr. Rogers has taught extensively at the post-RN level, focusing on cancer care. Dr. Rogers has presented nationally to lay and professional audiences on a broad range of cancer-related subjects. Her work has been published in a variety of publications and media. She is active in cancer nursing professional organizations, cancer advocacy organizations, and in collaborative research.

Kimberly R. Yelton, RHIA

Ms. Yelton is the Senior Inpatient Analyst/Coder with WakeMed Health and Hospitals in Raleigh, NC- a 791-bed trauma center. She has had seven years experience in the HIM field, working with coding, reimbursement, and education. She is a member of AHIMA and NCHIMA. She is currently serving on the Editorial Advisory Board for the American Hospital Association Coding Clinic for ICD-9-CM. She has published an article in the Advance for Health Information Professionals Online Magazine about HIM and nursing roles in improving clinical documentation.

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Seminar Objectives

- **Provide clinical information as it relates to the causes, symptoms, types, and treatment of lymphoma.**
- **Review recent ICD-9-CM changes to non-Hodgkin's lymphoma.**
- **Deliver challenging case scenarios that illustrate best coding practices**

1

Lymphoma

66,670 est. new cases*

Men	**34,870**
Women	**31,800**

20,330 est. deaths*

Men	**10,770**
Women	**9,560**

4.7% of all cases –
3.5% of all cancer deaths

***2006 Cancer Facts and Figures, ACS**

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Lymphoma Subgroups

Divided into 2 major groupings

Hodgkin's Lymphoma

Non-Hodgkin's Lymphoma

***2006 Cancer Facts and Figures, ACS**

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Lymphoma

Early Detection\Screening
- **none**

Symptoms
- **Constitutional – fever, weight loss, night sweats**
- **Lymphadenopathy**

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Lymphoma

Survival:

1 yr – NHL 77%, HD 91%

5 yr – NHL 56%, HD 84%

10 yr – NHL 42%, HD 76%

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NHL Subgroupings

WHO classification

- **B-Cell**
  - **B-Cell variants**
  - **Plasmacytomas**
- **T-Cell\NK Cell**
  - **T-Cell Variants**
  - **HTLV I-II**

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Lymphoma (NHL)

Epidemiology (US):

58,870 est. new cases*

Men	**30,680**
Women	**28,190**

18,840 est. deaths*

Men	**10,000**
Women	**8,840**

***2006 Cancer Facts and Figures, ACS**

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Lymphoma (NHL)

Risk factors:

- **Largely unknown**
- **May be more common in immunologically impaired**
- **HIV**

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NHL Treatment Overview

Dependent on subgroup aggressiveness

Influenced by extent of disease

Indivualized to patient condition

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NHL Treatment

Indolent – treat to control

- **Tx may not be curative, but long-term control likely**
- **Begin treatment when symptoms appear**
- **Radiation + / - chemo**
- **May add Rituxan if CD 20 positive**

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NHL Treatment

Aggressive –

- **Tx may/may not be curative, but long-term control likely**
- **Treatment potentially more aggressive**
- **Radiation +/- chemo**
- **May add Rituxan if CD 20 positive**

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Lymphoma (HD)

Epidemiology (US):

7,800 est. new cases*

Men	**4,190**
Women	**3,610**

1,490 est. deaths*

Men	**770**
Women	**720**

***2006 Cancer Facts and Figures, ACS**

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Lymphoma (HD)

Risk factors:

- Largely unknown
- May be more common in immunologically impaired
- Epstein-Barr influence

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Hodgkin's Disease

Treatment – cure likely

Localized – RT

Later stage – Chemo + / - RT

Bone Marrow Transplant

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Summary

Progress has been made in all types

Incidence is rising but treatment improving

Greater understanding brings greater complexity

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Resources

WWW.Cancer.Org (American Cancer Society)

WWW.Cancer.Com (National Cancer Institute)

WWW.Leukemia-Lymphoma.Org or
WWW.lls.Org (Leukemia and Lymphoma Society

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Non-Hodgkin's Lymphoma

- **Non-Hodgkin's Lymphomas**
  - **Heterogeneous group of malignant lymphomas**
  - **Common feature – absence of the giant Reed-Sternberg cells typical in Hodgkin's disease.**
  - **Over 30 sub-types of non-Hodgkin's lymphoma**
    - **Including Mantle cell, mucosa associated lymphoid tissue [MALT] and primary central nervous system lymphoma**

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Non-Hodgkin's Lymphoma

- **Although specific designations of behavior had been defined with newer morphology terms and synonyms**
  - **ICD-9-CM had not been updated to reflect the current revisions.**
- **NCHS received a proposal from a major cancer treatment center requesting that the classification be updated to accommodate the current definitions.**

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Non-Hodgkin's Lymphoma (cont.)

- **Effective October 1, 2007**
- **Category 200, Lymphosarcoma and reticulosarcoma, revised to read:**
- **"Lymphosarcoma and reticulosarcoma and other specified malignant tumors of lymphatic tissue"**

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Non-Hodgkin's Lymphoma (cont.)

- **Category 200 expanded to capture the current classification of lymphomas**
  - **Based on specific designations of behavior**
- **Category 200 requires a fifth digit**
  - **For the specific site(s) involved**
- **When the lymph nodes affected include more than one region of the body**
  - **Such as head and thorax, neck and abdomen, axilla and lower limb, upper limb and pelvis**
  - **Assign fifth digit "8"**

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Non-Hodgkin's Lymphoma (cont.)

New code 200.3 Marginal zone lymphoma

Extranodal marginal zone B-cell lymphoma

Mucosa associated lymphoid tissue [MALT]

Nodal marginal zone B-cell lymphoma

Splenic marginal zone B-cell lymphoma

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Non-Hodgkin's Lymphoma (cont.)

New code	200.4	Mantle cell lymphoma
New code	200.5	Primary central nervous system lymphoma
New code	200.6	Anaplastic large cell lymphoma
New code	200.7	Large cell lymphoma

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Non-Hodgkin's Lymphoma (cont.)

202 Other malignant neoplasms of lymphoid and histiocytic tissue

New code 202.7 Peripheral T-cell lymphoma

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Polling Question #1

- **A 46-year-old man was in his usual state of health when he noticed an enlarged left axillary lymph node. He was admitted for diagnostic work-up. A lymph node biopsy confirmed the presence of follicular giant cell lymphoma and the provider confirmed and documented this in his final diagnostic statement. Chemotherapy was initiated and the patient received CHOP (cyclophosphamide/doxorubicin/vincristine/prednisone) during this admission. Assign the correct codes for this case.**

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Audience Poll #1

***1 202.04, 40.11, 99.25**
***2 202.84, V58.11, 41.31, 99.25**
***3 V58.11, 202.04, 40.11, 99.25**
***4 V58.12, 202.04, 40.11, 99.28**

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Lymphatic and Hematopoietic Neoplasms:

- **Reticuloendothelial and lymphatic system**
- **Blood-forming tissues**
- **Develops in a single site**
- **Or several sites simultaneously**
- **Tumor cells circulate in large numbers in the bloodstream and the lymphatic system**

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Lymphomas

- **Lymphomas do not "metastasize" or spread to secondary sites in the same manner as solid tumors (classified to categories 140-199).**
- **Not confined to a single site.**
  - **Spread to other sites in the hematopoietic and lymphatic system**
  - **Spread not considered metastatic**
  - **Classified as primary neoplasm (200-208)**

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Lymphomas (cont.)

- **The fifth-digit indicates the specific site involved (i.e., lymph nodes of head, face and neck, intrathoracic lymph nodes, etc.)**

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Metastatic Neoplasms

- **Solid malignant neoplasms spread by:**
  - **Direct extension**
  - **Metastasis**
- **Assign a code from category 196, Secondary metastatic neoplasm of lymph nodes when a solid tumor spreads to the lymph nodes**
  - **Carcinoma of the breast with metastasis to the axillary lymph = 174.9 + 196.3**
- **Do not assign codes from categories 200-208 for metastasis to lymph nodes**
- **Codes from category 196 never assigned for lymphomas**

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Polling Question #2

A patient with intestinal lymphoma was admitted with acute abdominal pain and hypotension. The patient had been diagnosed with large cell lymphoma of the gastrointestinal tract one month ago and started on induction chemotherapy. Upon examination, the abdomen is distended, firm in the left lower quadrant where the lymphomatous mass is present. Other diagnoses included acute renal failure, deep vein thrombosis of the left lower leg and neutropenia secondary to chemotherapy. The patient subsequently expired.

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Audience Poll #2

Sequence the principal diagnosis and assign the appropriate codes for this case.

- ***1 288.03, E933.1, 584.9, 453.42, 208.83**
- ***2 200.73, 288.03, E933.1, 584.9, 453.42**
- ***3 427.5, 200.73, 288.03, E933.1, 584.9, 453.42**
- ***4 202.83, 288.03, E933.1, 584.9, 453.42**

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Hodgkin's Disease

- **Category 201**
- **Painless, progressive enlargement of lymph nodes, spleen and general lymph tissue**
- **Generic symptoms such as; fever, weight loss, anemia, night sweats, etc.**
- **201.0x-201.9x**

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Treatment

- **Dependent on type, location, and presentation**
- **Chemotherapy, Radiation, Stem Cell Transplant**
- **If patient is admitted to receive chemotherapy and/or radiation assign V58.x code as principal**

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ICD-9-CM Official Guidelines for Coding and Reporting Malignant Neoplasms

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Treatment

- **If the treatment is directed at the malignancy, designate the malignancy as the principal diagnosis.**

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Coding Clinic Example

- **Question:**

  A 49-year-old male with a high grade, small, non-cleaved cell lymphoma is admitted for peripheral blood stem cell collection that will be used at a later date to speed recovery and decrease the risk of infection and bleeding following high-dose chemotherapy with possible radiation therapy. The patient received high dose Cytoxan and VP-16 and GCSF to mobilize and procure the peripheral blood stem cells. What is the appropriate diagnosis code for this type of admission?

- **Answer:**

  Assign the code for the lymphoma as principal diagnosis since the Cytoxan was administered for the purpose of peripheral blood stem cell mobilization rather than as a therapeutic chemotherapy.

  (*Coding Clinic*, First Quarter 1998, page 7)

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Anemia Associated with Malignancy

- **When admission/encounter is for management of an anemia associated with the malignancy, and the treatment is only for anemia, the appropriate anemia code (such as code 285.22, Anemia in neoplastic disease) is designated at the principal diagnosis and is followed by the appropriate code(s) for the malignancy.**
- **Code 285.22 may also be used as a secondary code if the patient suffers from anemia and is being treated for the malignancy.**

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Anemia Associated with Therapy

- **When the admission/encounter is for management of an anemia associated with chemotherapy, immunotherapy or radiotherapy and the only treatment is for the anemia, the anemia is sequenced first followed by code E933.1.**
- **The appropriate neoplasm code should be assigned as an additional code.**

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Surgical Removal of Neoplasm

- **When an episode of care involves the surgical removal of a neoplasm, primary or secondary site, followed by adjunct chemotherapy or radiation treatment during the same episode of care, the neoplasm code should be assigned as principal or first-listed diagnosis, using codes in the 140-198 series or where appropriate in the 200-203 series.**

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Encounter for Chemotherapy, Immunotherapy/Radiotherapy

- **If a patient admission/encounter is solely for the administration of chemotherapy, immunotherapy or radiation therapy assign:**
  - **V58.0, Encounter for radiation therapy; or**
  - **V58.11, Encounter for antineoplastic chemotherapy; or**
  - **V58.12, Encounter for antineoplastic immunotherapy,**

  as the first-listed or principal diagnosis.
- **If a patient receives more than one of these therapies during the same admission, more than one of these codes may be assigned, in any sequence.**

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Cancer Treatment with the Development of Complications

- **When a patient is admitted for the purpose of radiotherapy, immunotherapy or chemotherapy and develops complications such as uncontrolled nausea and vomiting or dehydration, the principal or first-listed diagnosis is**
  - **V58.0, Encounter for radiotherapy, or**
  - **V58.11, Encounter for antineoplastic chemotherapy, or**
  - **V58.12, Encounter for antineoplastic immunotherapy,**

  followed by any codes for the complications.

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Symptoms, Signs, and Ill-defined Conditions

- **Symptoms, signs, and ill-defined conditions listed in Chapter 16 characteristic of, or associated with, an existing primary or secondary site malignancy cannot be used to replace the malignancy as principal or first-listed diagnosis, regardless of the number of admissions or encounters for treatment and care of the neoplasm.**

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Polling Question #3

- **A 50-year-old unfortunate man was admitted to the hospital to receive chemotherapy for anaplastic, large cell lymphoma. His lymphoma is systemic and is therefore affecting several lymph node regions (skin, intrathoracic, etc). After the fourth day of treatment with intravenous chemotherapy, the patient develops a fever, becomes hypotensive, and develops altered mental status. Blood cultures are taken due to the symptoms and are positive and the patient is diagnosed with sepsis. Chemotherapy is stopped and antibiotics initiated. Over the next few days, the patient continues to improve and is discharged. The next chemotherapy session will be set at a later time.**

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Audience Poll #3

- **Sequence the principal diagnosis and assign the appropriate codes for this case.**
- **Also, assign the appropriate POA indicators**
  - ***1 V58.11, 200.68, 038.9, 995.91. 780.6, 458.9, 780.97**
    Procedure 99.25
    All diagnoses with a POA of Yes
  - ***2 200.68, 038.9, 995.92. Procedure 99.25**
    All diagnoses with a POA of No
  - ***3 V58.11 (e), 200.68 (y), 780.6 (n), 458.9 (n), 780.97, (n)**
  - ***4 V58.11 (e), 200.68 (y), 038.9 (n), 995.91 (n)**
    Procedure 99.25

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Coding Concepts

- **All coding is based on physician documentation.**
- **Do not code on the basis of laboratory or radiological findings alone.**
- **When assigning ICD-9-CM codes issues related to inconsistent, missing, conflicting or unclear documentation must be resolved by the provider.**
- **Whenever there are concerns about a diagnosis and/or treatment, query the physician for clarification.**

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Coding Guidelines Approved by the Cooperating Parties of ICD-9-CM

- **American Hospital Association (AHA)**
- **American Health Information Management Association (AHIMA)**
- **Centers for Medicare and Medicaid Services (CMS)**
- **National Center for Health Statistics (NCHS)**

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Official Guidelines for Coding and Reporting

- **Newly revised, effective 10/1/07**
- **The Official Guidelines for Coding and Reporting may be downloaded from the following url:**
  www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/ftpicd9.htm
- **Also available online at www.centraloffice.org**
- **Includes updated V code table**

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Resource/Reference List

AHA Coding Clinic™ for ICD-9-CM

Request for Coding Advice

Subscribers to AHA *Coding Clinic™*, members of the American Hospital Association, or affiliated societies may receive coding advice at no additional charge.

see appendix for complete instructions

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Audience Questions

Audio Seminar Discussion

Following today's live seminar
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Upcoming Seminars/Webinars

Wound Care Coding

Faculty: **Gloryanne Bryant, RHIA, RHIT, CCS and Ella James, MS, RHIT, CPHQ**

Postponed to April 24, 2008

Coding for Interventional Radiology Services

Faculty: **Stacie L. Buck, RHIA, LHRM, CCS-P, RCC and Alicia Franklin, RHIA, CCS-P, RCC**

March 20, 2008

Thank you for joining us today!

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Appendix

AHA Coding Clinic™ for ICD-9-CM

Request for Coding Advice

Subscribers to AHA *Coding Clinic™*, members of the American Hospital Association, or affiliated societies may receive coding advice at no additional charge.

Please formulate and submit the specific question you have regarding appropriate ICD-9-CM coding. **No more than five (5) questions may be submitted per request.** Pertinent documentation that will provide information to assist the Central Office in determining the appropriate code for diagnosis or procedure must be included. Such documentation may include copies of discharge summaries, history and physical examinations, consultations, diagnostic reports, operative reports, or journal articles. Please submit other relevant information in a typed format (i.e., physician notes, nursing notes). Questions submitted without supporting documentation will be returned unanswered.

Kindly be reminded to remove the name of the hospital, the patient's name, date of birth and social security number, and physician identifiers from copies of medical records. **Any requests sent with medical record documentation not complying with HIPAA requirements will be returned to you unanswered.**

Fill out the form below and mail it along with your supporting documents to:

Central Office on ICD-9-CM
Coding Advice
American Hospital Association
One North Franklin
Chicago, IL 60606

You may also fax the question and documentation to: 312/422-4583

Request for Coding Advice

Date:_____

Name:_____

Department:_____

Facility:_____

Address:_____

City: _____ State:_____ Zip Code: _____

Question:

_____

_____

_____

_____

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