ICD-10 Radiology Guidance: BREAST

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ICD-10 ESSENTIALS for BREAST

The following elements are essential for the proper ICD-10-CM coding of conditions found in the **Breast**:

BREAST
- Location
- Laterality

BREAST DISORDERS
- Laterality

NEOPLASMS
- Male vs. Female
- Laterality
- Quadrant
- Anatomical Site

Common Breast Related Diagnoses	ICD-10 Specificity Guidance
Abnormal Findings	• Microcalcification vs. Calcification • Distinguish if Dense Breast on Mammography
Neoplasm, Malignant, Breast	• Laterality • Anatomical Site • Quadrant • Male vs. Female Patient
Breast Cyst(s)	• Laterality • Solitary vs. Cystic
Breast Signs Symptoms, Other	• Specify if Induration, Discharge or Retraction of Nipple

Screening

Screening breasts diagnosis mammography choices of two codes, *other screening mammography* and *high-risk screening mammography* has been condensed into one code *Encounter for screening mammogram for malignant neoplasm of breast.* In this situation the documentation for high risk will be assigned the same diagnosis code as a non-high risk diagnosis. No documentation changes will be necessary in this area.

Breast Disorders

Disorders of the breast has expanded into many codes that now include laterality and are more specific, then categorized into the "other disorders" code in ICD-9.

Unspecified Example:	**Specified Example:**
Indication: **breast cyst**	Indication: **cyst of right breast**
Coded as: *solitary cyst of breast*	Coded as: *solitary cyst of right breast*

Neoplasm

Malignant breast neoplasm is coded to primary unless specified if secondary or metastatic. The anatomical location, quadrant, patient's sex and laterality of breast should be mention for a specific ICD-10 diagnosis code.

Documentation of breast "mass," "nodule" or "lump" is coded to *unspecified lump* in ICD-10 and is not assigned a neoplasm code, unless specially specified as a neoplasm.

Note: Documentation of "history of neoplasm" can often be confused between "active clinical history" and a "personal past history." The clinical history documentation should clearly identify the neoplasm as "past history of neoplasm, patient completed treatment" or "active neoplasm, patient current in treatment." When a primary neoplasm has been excised and no further treatment is pursued, a different code is assigned under "personal history of malignant neoplasm" instead of a functionally active neoplasm.

Abnormal Findings

Reports for which defined diagnoses are not assigned are coded to the highest specificity sign or symptom or abnormal findings for which the investigation has been launched.

Abnormal findings have expanded into many options. If the reason for the exam was based on another abnormal examination, that should be the documented clinical history and should describe method of testing (X-ray, blood, specimens, urine, sputum, diagnostic study, function study, etc.) and specifically what was abnormal (enzymes, hormones, drugs, proteinuria, tumor markers, etc.)

Abnormal findings are often reported for a second examination to which further investigation was ordered such as "inconclusive mammography." Documentation should be detailed as to what the original finding was for further investigation.

Unspecified Example:	**Specified Example:**
Indication: **abnormal mammography**	Indication: **mammographic microcalcifications**
Coded as: *Abnormal mammogram, unspecified*	Coded as: *mammographic microcalcifications found on diagnostic imaging of breast*

Sources:

ICD-10-CM Draft Official Guidelines for Coding and Reporting 2014; Cooperating Parties for the ICD-10-CM: the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), Centers for Medicare and Medicaid Services (CMS), National Center for Health Statistics (NCHS), 2013.

Best Practices for ICD-10-CM Documentation and Compliance; AMA 2012.

Detailed Instructions for Appropriate ICD-10-CM Coding; Optum 2014.

ICD-10-CM Clinical Documentation Improvement Desk Reference; Optum 2014.