The Importance of Histology in Neoplasm Coding

By Charlotte M. Bumgarner, CDIP, CCS, and Jennifer C. Latva, CCS, COC, CPC, CGSC

CODERS OFTEN RELY on a neoplasm's behavior and location for ICD-10-CM code assignment, rather than first referencing histological type. This oversight can lead to the coding error of inappropriately defaulting to the Neoplasm Table, resulting in a lack of specificity and incorrect code selection.

When discussing neoplasms there are two basic groups: solid organ tumors, which originate in a single site or organ; and hematopoietic and lymphatic malignancies, which originate in lymphatic, reticuloendothelial, or blood-forming tissues.[1] Although the correct coding process is apparent for hematopoietic/lymphatic malignancies, such as leukemia and lymphoma, when coding solid organ tumors histological designation may be overlooked in an inclination to highlight behavior and topography. This practice is contradictory to the ICD-10-CM Official Guidelines for Coding and Reporting issued by the Centers for Medicare and Medicaid Services (CMS), which direct coders to reference histological terms first.

Histology and Its Place in the Coding Process

Histology refers to the structure of cells, tissues, and organs in relation to their functions.[2] The terms histology and morphology are typically used interchangeably in coding references. Both terms are also found within notes on the Neoplasm Table. For the purpose of this article the term "histology" will be used primarily since it is the term used in Chapter 2 of the guidelines.

The histological type of a neoplasm may indicate the neoplasm's point of origin in the body and its behavior. Treatment decisions are often individualized to a neoplasm's histology (morphology). Although histological type may indicate behavior, referencing histology involves a distinct step in ICD-10-CM. The classification includes four behavioral types—benign, in-situ, malignant, or of uncertain behavior—in contrast to the numerous histology descriptors found in the Alphabetic Index. Behavioral coding options may be located within the index or the table, while histological descriptors are referenced exclusively through the index.

According to the Chapter 2 guidelines, neoplasm coding involves three distinct steps. First, the histological term (if documented) should be referenced to determine the appropriate column in the Neoplasm Table. By referencing the histological term, the coder may locate the appropriate code, if it is listed under the alphabetic entry. If there is no direct coding instruction, the coder's second step is to follow the instructional notes to reference the appropriate site and behavior column on the Neoplasm Table. Third, after locating the code in the table, the coder should reference the Tabular List for final verification. Each step is vital to correct code selection. If the histological term is not documented, the coder is directed to go straight to the Neoplasm Table in lieu of accessing the Alphabetic Index.

Histology Impacts Code Choice

Histological (morphological) designation impacts code choice in several ways. First, there are several ICD-10-CM codes that are histology-specific. Basal cell carcinomas of the skin, GISTs, Leukemias, Lymphomas, Mesotheliomas, Merkel cell carcinomas, Melanomas, Neuroendocrines, and Squamous cell carcinomas of the skin all have unique primary site codes indicating their histology. Neuroendocrine tumors also have unique secondary (metastasis) codes for carcinoid, Merkel cell, and other. If a solid organ tumor of a specific histological type does not have a unique histological secondary designation in ICD-10-CM, then the standard secondary code is used. This practice is supported by the second quarter 2017 issue of *Coding Clinic*, which indicates that a malignant pleural mesothelioma with chest wall invasion would be coded as C45.00 (mesothelioma of pleura) and C79.89 (secondary malignant neoplasm of other specified sites). No additional code or marker is necessary to indicate the secondary site's histological designation.

Second, histological type can influence code choice with the designation of a specific behavior, location, and/or code. For example, when accessing the histological term "adenoma" in the index if none of the more specific options apply, the coder is

directed to the Table to "See also Neoplasm, benign, by site." In this case, the histological term revealed the appropriate behavior selection. A search for the term "sarcoma" without further specificity results in the coder being directed to "See also Neoplasm, connective tissue, malignant." This entry directs the coder to both a specific location (connective tissue) and behavioral choice (malignant). Once "connective tissue" is located in the Table, the coder will find instructions regarding appropriate steps if the pertinent location is not listed. A search for the term "thecoma" leads to a specific code sub-category: D27-. This default code includes both behavior (benign) and location (ovary). One important caveat: the coder should not default to the listed behavior or code in the index if it means disregarding the provider's documentation. For example, if the previously mentioned thecoma was documented to be malignant, then the malignant code should be used. Similarly, if a lipoma —which defaults to benign in the Index—is documented as a "malignant lipoma," then the coder should choose a code that reflects malignant behavior. The coder should verify that the selected code accurately represents the full-scope of the documentation being coded.

The histological term must be found in acceptable documentation in order to be coded. For inpatient coders, the histological type must be confirmed by the attending physician. For outpatient or physician coders, the provider's statement regarding histology, including the pathologist's histological determination, may be coded as long as it is available at the time of coding. It would be inappropriate to use documentation outside of the coder's allowed scope in an effort to assign a more specific code. It is also inappropriate to make an assumption regarding histological terms. For example, if a provider documented a pleomorphic adenoma, the coder will find an index entry for adenoma, pleomorphic. However, there is no default code alongside this term. Instead, the entry is further specified to these coding options: carcinoma in, specified site, and unspecified site. The additional histological term "carcinoma" must be part of the provider's diagnostic statement to validate coding one of the listed options; otherwise, selection of the specific code(s) is inappropriate. The documentation being coded should clearly indicate all of the histological information included within the code itself. If the code selection cannot be definitively made based on the documentation, then a query may be in order.

Neglecting to reference histological type when coding neoplasms may result in any number of negative outcomes. One of these is non-specific coding. Per the guidelines, "Each healthcare encounter should be coded to the level of certainty known... ." Per CMS, the highest level of specificity is the goal for every encounter. To that end, codes should "accurately reflect the clinical documentation in as much specificity as possible."[3] In order to meet these criteria when coding neoplasms, histological designations should be considered.

Further, coding without specificity may result in incorrect statistics and reporting regarding patient population(s). Incorrect data has the potential to result in misrepresentations of population need, impacts to federal funding and research, and grant availability for communities, institutions, and patients. Finally, because histology impacts code choice, it has the potential to impact DRG assignment (see the coding examples at the end of this article) and insurance coverage determination(s). Whether the oversight of the incorrect code assignment results in underpayment or over-payment—accompanied by the risk of audit and recoupment—it is a deficiency that is easily avoided by following the appropriate coding steps. In summary, referencing histology is vital when assigning ICD-10-CM neoplasm codes.

Coding Example #1

Patient is admitted complaining of shortness of breath. Upon workup a mass is discovered and a CT performed. The patient is diagnosed with a malignant melanoma of the skin of the chest wall, treated symptomatically, and discharged with a referral to an oncologist for further workup and treatment.

Coding Option 1:
C76.1, Malignant neoplasm of thorax

Coding Option 2:
C44.509, Unspecified malignant neoplasm of skin of other part of trunk

Coding Option 3:
C43.59, Malignant melanoma of other part of trunk

Coding Option 3 is correct. The histological term melanoma was appropriately referenced in the Alphabetic Index first. The specifications of organ (skin) and location (chest wall) are both found in the index under the melanoma designation and direct

the coder to C43.59. There is no need to additionally reference the table as direct coding instruction is found in the index.

Options 1 and 2 are incorrect, and are the result of going directly to the Neoplasm Table and referencing either chest wall (Option 1) or skin, chest wall (Option 2). Both codes lack the specificity of the histological type. Additionally, Option 1 also incorrectly identifies the location as the chest wall only, while the documentation specified the skin of the chest wall. Each of the coding options listed above would result in a different DRG, with Option 3 representing the highest level of reimbursement.

Coding Example #2

Male patient with known para-urethral sarcoma is admitted with two-day history of urine retention and fever. The urine retention and fever are found to be due to the malignancy. Foley catheter was placed, infection ruled out, and patient was discharged home.

Coding Option 1:
C49.5, Malignant neoplasm connective and soft tissue of pelvis
R33.8, Other retention of urine
R50.81, Fever presenting with conditions classified elsewhere

Coding Option 2:
C76.3, Malignant neoplasm of the pelvis
R33.8, Other retention of urine
R50.81, Fever presenting with conditions classified elsewhere

Coding Option 1 is correct. The histological term sarcoma was referenced in the Alphabetic Index and instructions to "see connective tissue, malignant" followed. At the Neoplasm Table, under the heading of connective tissue, para-urethral was selected. Because urine retention and fever are documented as due to the malignancy, the malignancy is sequenced first. The other symptoms are coded as manifestations and sequenced per code level notes and etiology manifestation convention.

Coding Option 2 is incorrect, and is the result of going directly to the Neoplasm Table and referencing para-urethral. This code is less specific; it identifies the location as the pelvis only without including the connective tissue component indicated by the histological type. Again, each coding option would result in a different DRG. In this example, the higher level of specificity (Option 1) would result in a higher weighted DRG.

Notes

1. Leon-Chisen, Nelly. *ICD-10-CM and ICD-10-PCS Coding Handbook* 2018. Chicago, IL: American Hospital Association, 2017.
2. Wolters Kluwer. *Stedman's Medical Dictionary for the Health Professions and Nursing, Illustrated Sixth Edition*. Lippincott Williams & Wilkins, April 2018 (p. 723).
3. Centers for Medicare and Medicaid Services. "Clarifying Questions and Answers Related to the July 6, 2015, CMS/AMA Joint Announcement and Guidance Regarding ICD-10 Flexibilities." www.cms.gov/Medicare/Coding/ICD10/Clarifying-Questions-and-Answers-Related-to-the-July-6-2015-CMS-AMA-Joint-Announcement.pdf.

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Charlotte M. Bumgarner (Charlotte.Bumgarner@moffitt.org) is an inpatient coding educator and Jennifer C. Latva (Jennifer.Latva@moffitt.org) is a coder educator and trainer at Moffitt Cancer Center.

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