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THE LIVANTA CLAIMS REVIEW ADVISOR

A monthly publication to raise awareness, share findings, and provide guidance about Livanta's Claim Review Services

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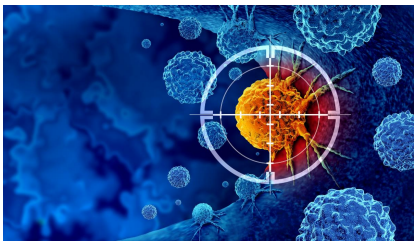
Higher-Weighted Diagnosis Related Groups (HWDRG) Validation – Neoplasms



This month's issue of *The Livanta Claims Review Advisor* addresses the correct reporting of neoplasms on Medicare Part A claims. Coders must follow neoplasm reporting and sequencing guidelines. Having a choice of principal diagnosis on a neoplasm record should be an unusual occurrence. It is a good practice to search the neoplasm guidelines and Coding Clinics before resequencing the principal diagnosis, and this is especially true with a neoplasm case. The following guidelines governing the coding of neoplasms have been extracted based on coding errors Livanta has encountered while performing HWDRG reviews.

Documentation Considerations

The primary site and any secondary site(s) if known should be documented clearly in the medical record. The behavior of the neoplasm should also be documented.
Behavioral options are:

- Malignant primary
- Malignant secondary
- Cancer in situ
- Benign
- Uncertain behavior

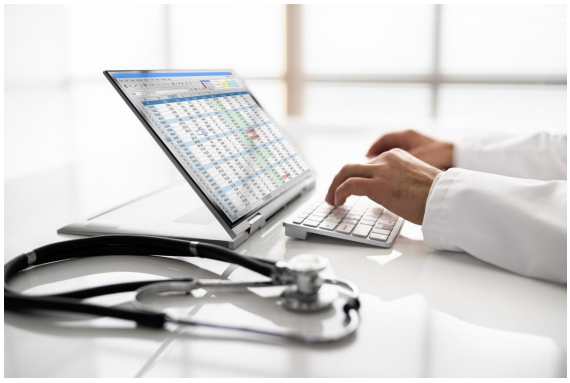
The coder should also look for documentation of clinically significant histological and pathological findings. However, is not appropriate to assign a code directly from the pathology report, or to get more specific information from the pathology report.

Queries for Pathology Findings

Coders and clinical documentation specialists often will submit queries to determine whether the physician agrees with the pathology report. However, agreement with the findings is not the same as indicating clinical significance, which is a requirement outlined in Coding Clinic, Third Quarter 2016, page 25. This Coding Clinic article states that physicians should be queried for the clinical significance of abnormal findings, including any finding in a pathology report. A pathology report can include numerous histopathological findings that had no bearing on the patient's hospital admission. Instead of simply seeking the physician's agreement with the pathologist's findings, coders and clinical documentation specialists should query the attending physician for their determination of the clinical significance of the abnormal findings.

The above referenced Coding Clinic article explains that an interpretation of a tissue biopsy is not equivalent to a medical diagnosis, which must be based on the patient's complete clinical picture. The pathologist is responsible only for reporting histology, not diagnosing disease processes in patients.

Guidelines for Coding Neoplasms



Please see the Official Coding Guidelines, Section I.A.2 and I.A.3.[1] Both of these sections provide details on how to use the coding index and tabular.

Leukemia and Lymphoma

The code range C81 to C96 represents malignant neoplasms of lymphoid, hematopoietic, and related tissue such as leukemia and lymphoma. Leukemia is cancer of the body's blood-forming tissue, including bone marrow and the lymphatic system. It originates in the bone marrow and then spreads through the bloodstream. Lymphoma usually originates in the lymph nodes or spleen and spreads through the lymphatic system. The leukemia and lymphoma section of the ICD-10 tabular does not include solid organ cancers. Therefore, if leukemia or lymphoma spreads to a solid organ, it is only reported with a code from C81 to C85, with a 5th digit of "9."

When a malignant neoplasm of lymphoid tissue metastasizes beyond the lymph nodes, a code from categories C81 to C85 with a final character "9" should be assigned identifying "extranodal and solid organ sites" rather than a code for the secondary neoplasm of the affected solid organ. As an example, if a physician documents metastasis of diffuse large B-cell lymphoma to the lung, brain, and left adrenal gland, do not code each site separately. Instead, assign only C83.39 (diffuse large B-cell lymphoma, extra-nodal and

solid organ sites). This is per Coding Clinic, First Quarter 2023, page 22.

The above section rules also apply to certain rarer types of cancer, including neuroendocrine tumors, mast cell tumors, histiocytosis, and others. It is important that the histology of the cancer be documented, and if it is documented, that term should be referenced in the index first, rather than immediately referencing the neoplasm table. This process allows the coder to choose the correct column of the neoplasm table.

Solid Organ Neoplasms

There are several guidelines for coding solid organ neoplasms, with corresponding codes ranging from C00 to C75. When a primary cancer initially is diagnosed alongside metastasis, the primary site should be designated as the principal diagnosis, unless no treatment was provided for the primary site, or the primary site remains unidentified. Typically, upon initial cancer diagnosis, some form of diagnostic evaluation is undertaken. (See Coding Clinic, Second Quarter 2023, page 6.)

Complications

Patients who are being treated for a malignancy can and usually do develop mild to moderate complications. When the complication is related to the neoplasm and is the reason for admission, the principal diagnosis sequencing is subject to the guidelines below.

- Anemia: When admission is due to the malignancy itself and the treatment was only for the anemia, the malignancy must be sequenced first, as D63.0 (anemia in neoplastic disease) is a manifestation code and may never be sequenced as the principal diagnosis. When anemia is an adverse effect of cancer treatment and the only reason for the admission, assign the anemia code first, then the neoplasm, and either adverse effect of chemotherapy or radiotherapy.
- Dehydration: When the admission or encounter is for management of dehydration due to the malignancy and only the dehydration is being treated (intravenous rehydration), the dehydration is sequenced first, followed by the code(s) for the malignancy.
- Surgical Complication: In this situation, the complication code is sequenced first followed by the neoplasm code(s).
- Symptoms: Chapter 18 codes (Signs, Symptoms, and Ill-defined Conditions) may not be used to replace the malignancy as a principal diagnosis when the symptom is related to, or inherent, to the malignancy.
- Pain: Assign G89.3 (neoplasm related pain) whenever pain is documented as related to, associated with, or due to any type of cancer. Sequence the pain code first when the admission is ordered for the purpose of pain management. Sequence the neoplasm code(s) as additional diagnoses. This pain code may be sequenced as an additional diagnosis when the pain is not the reason for admission.

Physicians often will document that a malignancy is “metastatic to” or “metastatic from” another organ. Using the example of primary breast cancer with secondary brain cancer, this documentation can be worded in either of the following ways:

- breast cancer with metastasis to brain (or brain mets).
- brain cancer, metastatic from breast.

If the site of the primary or secondary cancer is not documented, the physician should be

queried for that detail. Otherwise, C80.1 (malignant neoplasm unspecified) should be reported. This code should rarely be used in the inpatient setting.

Remission and History

The presence of remission should not be assumed. For the code categories that include remission, the codes for remission should not be assigned without clear documentation of remission. If the documentation is unclear, the provider should be queried.

Once a primary malignancy has been excised, it is still coded as current if it is still being treated. For example, if a patient with breast cancer status post total mastectomy is still getting chemotherapy or radiotherapy, current breast cancer would be coded even though the affected breast has been removed.

Z-codes for history of neoplasm may only be used when the referenced site is considered cured. If the patient is still receiving treatment of any type, or if there is evidence of an existing primary malignancy of that site, the history code may not be coded.

[1] https://www.cms.gov/files/document/fy-2023-icd-10-cm-coding-guidelines-updated-01/11/2023.pdf

About Livanta

Livanta is the national Medicare Claim Review Services contractor under the Beneficiary and Family Centered Care – Quality Improvement Organization (BFCC-QIO) Program. As the Claim Review Services contractor, Livanta validates the DRG on hospital claims that have been adjusted to pay at a higher weight. The adjusted claim is reviewed to ensure that the diagnoses, procedures, and discharge status of the patient reported on the hospital's claim are supported by the documentation in the patient's medical record. Livanta's highly trained, credentialed coding auditors adhere to the accepted principles of coding practices to validate the accuracy of the hospital codes that affect the DRG payment. When needed, actively practicing physicians review for medical necessity and clinical validity based on the presence of supporting documentation and clinical indicators.

Post-payment review of these HWDRG adjustments is mandated under statute and in CMS QIO Manual: Perform DRG validation on prospective payment system (PPS) cases (including hospital-requested higher-weighted DRG assignments), as appropriate (see §1866(a)(1)(F) of the Act and 42 CFR 476.71(a)(4)).

Read more: CMS, Quality Improvement Organization Manual, Chapter 4 - Case Review **https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/qio110c04.pdf**

Questions?

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https://www.livantaqio.cms.gov/en/ClaimReview/index.html