Correctly reporting cancer diagnoses

Current cancer vs. history of cancer

Correct reporting of a diagnosis of cancer requires the determination and documentation of whether the patient’s cancer has been eradicated or is currently being treated. ICD-10-CM greatly increases the specificity of the neoplasm code classifications. Many conditions previously classified in ICD-9-CM have either been given unique classifications or have been further specified by type, anatomic site and laterality.

Neoplasms are listed by anatomical site. For each site there are six possible code numbers according to whether the neoplasm in question is malignant, benign, in situ, of uncertain behavior or of unspecified nature. The description of the neoplasm will often indicate which of the six columns is appropriate; for example, malignant melanoma of skin, benign fibroadenoma of breast, carcinoma in situ of cervix uteri.

Where such descriptors are not present, the remainder of the Index should be consulted where guidance is given to the appropriate column for each morphological (histological) variety.

Current cancer

Patients with cancer who are receiving active treatment for the condition should be reported with the malignant neoplasm code corresponding to the affected site. This applies even when a patient has had cancer surgery, but is still receiving active treatment for the disease.

**Example:**

Malignant neoplasm of kidney NOS C64.-

**Primary site with unknown secondary site**

**Example:**

Metastatic carcinoma from lung C34.9- (Primary site - lung)

Unknown secondary site C79.9 (Metastatic cancer NOS)

Secondary site with active primary site

A patient is admitted with metastatic bone cancer. The female patient had a mastectomy two months ago and is currently having radiation treatments for breast cancer. The neoplasm was located in the upper outer quadrant.

**Example:**

Neoplasm, bone, secondary C79.51

Neoplasm, breast, upper-outer quadrant, C50.41-

Carcinoma in situ

Documentation describing patients with tumor cells that are undergoing significant malignant changes but are still confined to the point of origin without invasion of the surrounding normal tissue is to be coded as Ca in situ.

**Example:**

Carcinoma in situ of cervix uteri D06.-

For the ICD-10-CM Official Guidelines for Coding and Reporting FY 2016: “A dash (-) at the end of an Alphabetic Index entry indicates that additional characters are required. Even if a dash is not included at the Alphabetic Index entry, it is necessary to refer to the Tabular List to verify that no 7th character is required.” Thus the bolding of ICD-10-CM codes represents only those fully reportable codes. Even if a dash is not included at the Alphabetic Index entry, it is necessary to refer to the Tabular List to verify that no 7th character is required.

ICD-9-CM have either been given unique classifications or have been further specified by type, anatomic site and laterality.

**History of cancer**

Patients with a history of cancer, with no evidence of current cancer, and not currently under treatment for cancer should be reported as “Personal history of malignant neoplasm.” These codes require additional digits to identify the site of the cancer and should be reported only when there is no evidence of current cancer. If a patient’s presenting problem, signs or symptoms may be related to the cancer history or if the cancer history (personal or family) impacts the plan of care, then report the appropriate Z code and not the code for the active cancer.

**Example:**

Personal history of malignant neoplasm, kidney Z85.5-

**Aftercare following surgery for neoplasm**

Visits to determine the effectiveness of cancer surgery that fall within the global postoperative period should be reported as “Aftercare following surgery for neoplasm,” code Z48.3. The aftercare Z code should be used with the current neoplasm code.

**Example:**

Aftercare following surgery for malignant neoplasm Z48.3

**Follow-up for patients with history of cancer**

Follow-up exams to determine if there is any evidence of recurrent or metastatic cancers that result in no evidence of malignancy and no ongoing treatment should be reported as encounter for follow-up examination after completed treatment for malignant neoplasm with code Z08. This includes surveillance only following completed treatment.

**Example:**

Follow-up examination, following radiotherapy Z08

Cancer drugs prescribed for reason other than malignancy

Patients with no history of cancer who take cancer drugs should not be reported with an active cancer diagnosis or a personal history of malignant neoplasm. Instead, code the reason for the prescription.

**Example:**

Family history of malignant neoplasm, breast Z80.3

*Use of selective estrogen receptor modulators (SERMS) Z79.810

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This guidance is to be used for easy reference; however, the ICD-10-CM code book and the Official Guidelines for Coding and Reporting are the authoritative references for accurate and complete coding. The information presented herein is for general informational purposes only. Neither Optum nor its affiliates warrant or represent that the information contained herein is complete, accurate or free from defects. Specific documentation is reflective of the “thought process” of the provider when treating patients. All conditions affecting the care, treatment or management of the patient should be documented with their status and treatment, and coded to the highest level of specificity. Enhanced precision and accuracy in the codes selected is the ultimate goal. Lastly, on April 4, 2016, CMS announced the CMS-HCC Risk Adjustment model for payment year 2017 driven by 2016 dates of service. For more information see: http://www.cms.gov/Medicare/Health-Plans/MedicareAdvSpecRateStats/Risk-Adjustors.html. Please refer to 2017 Announcement for risk scores, disease interactions and hierarchy (pp 78-87): https://www.cms.gov/Medicare/Health-Plans/MedicareAdvSpecRateStats/Announcements-and-Documents.html