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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 neoplasm conditions have either been given unique classifications or have been further specified by type, anatomic site and laterality.

Neoplasms are listed in the ICD-10-CM Neoplasm Table by type and anatomical site. For each site there are six possible code categories situated within columns 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.

If neoplasms are documented by the histological term, that term should be referenced in the **ICD-10-CM Alphabetic Index** for each variety, rather than going immediately to the **Neoplasm Table**. For example, if documentation indicates "adenoma," refer to the term in the Alphabetic Index and review the entries and cross-referenced tabular instructional notes.

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.

Cancers of unknown primary or secondary site

There are codes available for malignant (primary) neoplasm, unspecified **C80.1**, and malignant (secondary) neoplasm, unspecified **C79.9**. Use when appropriate.

Secondary site with unknown primary site

Example
Metastatic carcinoma of liver **C78.7** (Secondary malignant neoplasm of liver and intrahepatic bile duct)
Unknown primary site **C80.1** (Malignant (primary) neoplasm, unspecified)

Primary site with unknown secondary site

Example
Metastatic carcinoma from lung **C34.9-** (Primary site - lung)
Unknown secondary site **C79.9** (Secondary malignant neoplasm of unspecified site)

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 right upper-outer quadrant.

Example
Secondary malignant neoplasm of bone **C79.51**
Malignant neoplasm of upper-outer quadrant of right female breast **C50.411**

Carcinoma in situ (Ca 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, unspecified D06.9

Current malignancy versus personal history of malignancy

When a primary malignancy has been excised but further treatment, such as an additional surgery for the malignancy, radiation therapy or chemotherapy is directed to that site, the primary malignancy code should be used until treatment is completed.

When a primary malignancy has been previously excised or eradicated from its site, there is no further treatment (of the malignancy) directed to that site, and there is no evidence of any existing primary malignancy, a code from category Z85, Personal history of malignant neoplasm, should be used to indicate the former site of the malignancy. These Z codes require additional digits to identify the site of the historical event of the cancer, and the active cancer code is not reported.

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 prophylactically 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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Per the ICD-10-CM Official Guidelines for Coding and Reporting FY 2019: "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 verity that no 7th character is required." The bolding of the ICD-10-CM codes represents categories, subcategories or codes that map to the CMS-HCC risk adjustment model for payment year 2020.

Optum360 ICD-10-CM: Professional for Physicians 2019. Salt Lake City, UT: 2018.

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This guidance is to be used for easy reference; however, the current ICD-10-CM code classification 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 1, 2019, the Centers for Medicare & Medicaid Services (CMS) announced that 2019 dates of service for the 2020 payment year model are based on 100% of the Centers for Medicare & Medicaid Services Announcement April 1, 2019. Website: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2020.pdf

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