Coding and documenting cancer

To accurately document the type of treatment your patient is receiving in their medical record, use the definitions below.

Definitions
Remission: A decrease in, or disappearance of, signs or symptoms of cancer. Cancer may still reoccur
Partial remission: Some, but not all, signs and symptoms of cancer have disappeared
Complete remission: All signs and symptoms of cancer have disappeared
Surveillance: No cancer is present, however the patient's condition is being closely monitored. No treatment is occurring unless there are changes in test results that show the patient's condition getting worse
Active surveillance: Cancer is present in the body and being monitored. Cancer isn't being treated unless there are changes in test results that show the condition getting worse
Curative treatment: Cancer is being treated
Palliative treatment: Relieving symptoms and reducing suffering caused by cancer without effecting a cure. Palliative treatment may be given when there is evidence of metastatic or recurrent/metastatic disease
Preventive or prophylactic treatment: Keeping cancer from recurring in a person who has already been treated for cancer, or keeping cancer from occurring in a person who's never had cancer but is at increased risk for developing it due to family history or other factors

Priority Health

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Use the guidelines below to determine whether to use **current,** **remission** or **"history of"** when coding and documenting cancer.

Current
Patient is undergoing active therapy for curative or palliative treatment
Cancer is present but unresponsive to treatment
Management plan is observation, active surveillance or "watchful waiting"
Patient refuses treatment
Patient is undergoing palliative or suppressive therapy (e.g. Lupron or Tamoxifen) with evidence of disease present
ICD-10 active cancer codes start with a "C" • **For example:** C61 Malignant neoplasm of the prostate

Note: If you use a "history of" code for an active/current cancer diagnosis, you may receive a request for clarification

Remission
ICD-10 in remission codes apply to leukemia, multiple myeloma and malignant plasma cell neoplasm
When using the term "in remission" for other cancers, the active code will be used unless there is contradictory information in the note/record • **For example:** C91.11 Chronic lymphocytic leukemia of B-cell type in remission

"History of"
"History of" infers the patient is no longer receiving treatment **after** cancer eradication
Patient is "cancer free", "no evidence of disease (NED)" or similar language is used to indicate cancer is no longer present
There's no treatment in place because cancer has been eradicated
NED is shown after treatment is complete but the patient is still on surveillance for reoccurrence
ICD-10 "history of" cancer codes start with a "Z" • **For example:** Z85.41 History of malignant neoplasm of cervix uteri

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How does your patient documentation impact code selection?

Patient A

Patient A has a personal history of breast cancer. She is status post-surgery/chemo/radiation with no current evidence of disease. Patient A is on Tamoxifen for prophylaxis for 5 years.

Code selection: Use the "**history of" z code.** T
Why? Documentation states, "history of" and "no current evidence of disease," and notes the purpose of the adjuvant therapy is for prophylaxis.

Patient B

Patient B has colon cancer. Patient presents status post FOLFOX, radiation and colectomy 1 year ago, with no evidence of disease on most recent colonoscopy. Continue follow up recommendations with oncology.

Code selection: Use the "**history of" Z code**.
Why? The patient presents with "no evidence of disease" after receiving first line treatment.

Patient C

Patient C has prostate cancer, a positive biopsy 3 years ago, low grade, surgery not recommended, under active surveillance. PSA is 5. Continue PSA every 6 months. Continue following up with oncology.

Code selection: Report **active prostate cancer, C61**.
Why? Documentation states, "active surveillance" and "no evidence of eradication". The cancer is still present.

Visit our **Risk Adjustment webpage** for more resources and education on documenting your patients' conditions to the highest level of specificity.

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Sources:

- *Appendix A: ICD-10-CM official guidelines for coding and reporting** ... National Cancer Institute. (2018, December 13). https://training.seer.cancer.gov/icd10cm/appendix-a/
- Bakshi, Maulik. (2022, August 1). *Dissect Z Codes for Oncology.* AAPC. Dissect Z Codes for Oncology - AAPC Knowledge Center
- Bredehoeft, E. (2017, November 1). *Clear up confusion as to when cancer becomes "history of."* AAPC. https://www.aapc.com/blog/40016-clear-up-confusion-as-to-when-cancer-becomes-history-of/
- Centers for Medicare & Medicaid Services. ICD-10-CM Official Guidelines for Coding and Reporting (FY2023): Guidelines I.A.21 C. 3. https://www.cms.gov/files/document/fy-2023-icd-10-cm-coding-guidelines-updated-01/11/2023.pdf pg. 48-49, 60
- Nicoletti, Betsy. (2018, August 17). *Proper diagnosis coding for malignant neoplasms.* AAFP. Proper diagnosis coding for malignant neoplasms | AAFP
- Walker, Penny. (2023, November 1). *Demystify the Challenges of Coding Hematology Oncology.* AAPC. Words Are Important in Oncology Coding - AAPC Knowledge Center
- *Words are Important in Oncology Coding.* (2020, May 1). AAPC. Words Are Important in Oncology Coding - AAPC Knowledge Center