

Correctly Reporting Cancer Diagnoses

Current Cancer vs. History of Cancer

To correctly report a diagnosis of cancer, one must determine whether the patient's cancer has been eradicated or is currently being treated. The neoplasm table in the ICD-9-CM code book establishes three categories of malignancy: primary, secondary and in-situ. These neoplasms should be coded as such and unknown sites must also be coded.

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, **189.0**

Primary Site with Unknown Secondary Site

Example:

Metastatic carcinoma from lung **162.9** (Primary site – lung)

Unknown secondary site **199.1**

Secondary Site with Active Primary Site

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

Example:

Code **198.5** Neoplasm, bone, secondary

Code **174.4** Neoplasm, breast, upper outer quadrant

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:

Code **233.1** Carcinoma in situ of cervix uteri

References:

AHA Coding Clinic, July-August 1985

AHA Coding Clinic, 4th Q 2002; Part B News, published 2/28/2005

Faye Brown's ICD-9-CM Coding Handbook, 2011

History of Cancer

Patients with a history of cancer, 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 impacts the plan of care, report the history code.

Example:

Personal history of malignant neoplasm, kidney, **V10.52**

Aftercare Following Surgery for Neoplasm

Visits to determine the effectiveness of cancer surgery that fall within the global post-operative period should be reported as "Aftercare following surgery for neoplasm," code **V58.42**. The aftercare code should be used with either the current neoplasm code or code from category **V10**, Personal history of malignant neoplasm, whichever is applicable.

Example:

Aftercare following surgery for malignant neoplasm, **V58.42**

Follow-up for Patients with History of Cancer

Follow up exams to determine if there is any evidence of recurring or metastasizing cancers that result in no evidence of malignancy and no ongoing treatment should be reported as "Follow-up exam" using a code from the **V67** category. This includes surveillance only following completed treatment.

Example:

Code **V67.1** Follow-up exam, following radiotherapy

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:

Code **V16.3** Family history of malignant neoplasm, breast

Code **V07.51** Use of selective estrogen receptor modulators (SERMs)