Cancer Coding Guidelines

CMS Coding guidelines state that when a primary malignancy has been previously excised or eradicated from its site, there is no further treatment directed to that site, and there is no evidence of any existing primary malignancy at that site, a Personal History code should be used:

- Personal history codes explain a patient's past medical condition that no longer exists and for which the patient is not receiving any treatment.
- Providers frequently miscode for active malignancies and benign neoplasms that have an Hierarchical Condition Category (HCC) when the patient is merely being monitored for recurrence.

Coding Examples - Cancer Guidelines

ICD-10 Code	Description	Coding Guidelines	Examples
C00 – D49	Malignant neoplasms based on primary site, secondary site (metastasized), and carcinoma in situ.	Malignancy is excised but patient is still undergoing treatment directed to that site. Primary malignancy codes should be used until treatment is complete.	Patient seen for colon cancer; actively on radiation therapy. This is reported as an active cancer; C18.9 Malignant neoplasm of colon, unspecified.
O9A.1 –	Malignant neoplasm in pregnancy	Malignancy is excised during pregnancy, but patient is still undergoing treatment directed to that site. Primary malignancy codes should be used until treatment is complete.	Pregnant woman is seen at an outpatient clinic for active treatment, currently undergoing chemo for breast cancer. This is reported as an active cancer; O9A.311 (code first), C50.911

ICD-10 Code	Description	Coding Guidelines	Examples
Z85.-	Personal history of malignant neoplasm of specified site	Malignancy has been previously excised or eradicated; there is no further treatment directed to that site and no evidence of any existing primary malignancy.	Patient had colon cancer, status post-surgery/chemo/ radiation and patient demonstrates “no evidence of disease” (NED). This is reported with history code Z85.038 Personal history of other malignant neoplasm of large intestine. The cancer has been removed, and the patient’s treatment is finished.

FAQs

When can providers report cancer as active?

According to CMS guidelines, when a primary malignancy has been excised but further treatment, such as additional surgery for the malignancy, radiation therapy, or chemotherapy is directed to that site, the primary malignancy code should be used until treatment is complete. Cancer is coded as current if the record clearly states active treatment is for the purpose of curing or palliating cancer, or states cancer is present but unresponsive to treatment; the current treatment plan is observation or watchful waiting; or the patient refused treatment.

When should providers code malignancy as history of?

When a primary malignancy has been 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.

***Exception*:** Breast Cancer – When a breast cancer patient has completed surgery and chemotherapy but is still on maintenance/prophylactic therapy such as Tamoxifen, Letrozole, or other hormonal therapy for **5 years**, CMS guidelines require the provider to report the cancer as active.

To determine active treatment versus preventive care provider needs to report how the drug is being used. For example:

- **Neoadjuvant chemotherapy** is medicine administered before surgery to reduce the size of a tumor and possibly provide more treatment options.
- **Adjuvant** means "in addition to" and refers to medicine administered after surgery for treatment of cancer. Adjuvant therapy may be chemotherapy, radiation, or hormonal therapy.

  Adjuvant treatment is given after primary treatment has been completed to either destroy remaining cancer cells that may be undetectable; or to lower the risk that the cancer will come back.

  The purpose of adjuvant medicine may be:

  - **Curative** – to treat cancer.
  - **Palliative** – to relieve symptoms and reduce suffering caused by cancer without effecting a cure. It also may be given when there is evidence of metastatic or recurrent/metastatic disease.
  - **Preventative or Prophylactic** – to keep cancer from reoccurring in a person who has already been treated for cancer or to keep cancer from occurring in a person who has never had cancer but is at increased risk for developing it due to family history or other factors.

Personal History vs in remission status?

"Personal history" defers from "in remission status," since a provider reports a patient to be in remission when a decrease in or disappearance of signs or symptoms of cancer or partial remission where some, but not all signs and symptoms of cancer have disappeared. "In remission" generally is coded as current, if there is no contradictory information elsewhere in the record.

***Exception*:** Codes for leukemia, multiple myeloma and malignant plasma cell neoplasms indicate whether the condition has achieved remission.