

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) + 199.1
(secondary site – unknown)

Secondary Site with Active Primary Site

A patient is admitted with metastatic bone cancer. The patient had a mastectomy 2 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

History of Cancer

Patients with a history of cancer and no evidence of current cancer should be reported as "Personal history of malignant neoplasm" using a code from the V10 series. These codes require additional digits to identify the type of cancer and should be reported only when there is no evidence of current cancer and a patient's presenting problem, signs, or symptoms may be related to the cancer history or impact the plan of care. These codes should not be reported routinely.

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 and a second aftercare code to fully identify the reason for the encounter.

Example: Aftercare following surgery for
malignant neoplasm, kidney, V58.42;
Aftercare following surgery of the
digestive system, V58.75

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 should be reported as "Follow-up exam" using a code from the V67 category to identify the most recent therapy carried out.

Example: Follow-up exam following
chemotherapy, V67.2

Cancer Drugs prescribed for reason other than Malignancy

Patients with no history of cancer who take prophylactic 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, V16.3;
Prophylactic use of selective
estrogen receptor modulators
(SERMs), V07.51

References:

AHA Coding Clinic, July-August 1985
AHA Coding Clinic, 4th Q 2002
Part B News, published 2/28/2005