Documenting and coding cancer FAQ

Question: ***When should cancer be documented and coded as current/active?***

Answer: Cancer (malignant neoplasm) of the affected site should be documented and coded as current/active when:[1]

- Patient is under care with an existing cancer, regardless of whether or how the cancer is being treated
- Patient is on adjunct/adjuvant therapy status post excision of the neoplasm

> **Example:** Malignant neoplasm of right breast, unspecified site C50.911
> Patient is s/p excision of breast cancer. She has completed chemotherapy, radiotherapy, and is now on hormone therapy for five years.[2]

Question: ***What is "active" treatment?***

Answer: Active treatment is when there is current treatment directed at the site of the cancer and may include: [1,3]

- Surgery, radiotherapy, chemotherapy, or a combination
- Adjunct/adjuvant therapy following initial treatment of the cancer for the duration of treatment
- ***Active*** surveillance*; without ***any*** surgery or other treatment with "watchful waiting"

**** Routine surveillance*** **(monitoring);** is surveillance of a cancer that has been cured/removed. Use the appropriate Z code for "personal history of…" Monitoring for recurrence of a previously treated cancer is not considered active treatment and should not be documented or coded as current/active cancer.

Question: ***My patient, previously diagnosed with prostate cancer, had a total prostatectomy but no chemo or radiation therapy. Since his PSAs are <0.1 and monitored regularly, I was told this is "watchful waiting" and I can code the prostate cancer as current/active. Is this correct?***

Answer: No, the term "watchful waiting" (active surveillance) only applies if ***no*** treatment of any kind is being or has been directed at the cancer, only monitoring for progression.[4] Since the patient's cancer was treated by having a prostatectomy, this would be considered routine surveillance or monitoring for recurrence and should be documented and coded as Personal history of prostate cancer, Z85.46, unless there were clinical indications documented that the cancer still exists.[1]

Question: ***I submitted a progress note documenting my patient has prostate cancer, s/p permanent seed implants five years ago with no recurrence. Why was I asked to disagree to the prostate cancer?***

Answer: Even though the seed implants remain in place permanently, brachytherapy is only considered "active" treatment while the radioactive implants are in the effective period of the radiation, which varies from a few months up to approximately ten months depending on the type of implant.5 In the above case there is no recurrence, so unless there is current/active treatment documented, this would be coded as Z85.46, Personal history of prostate cancer.[1]

Question: ***My patient has recurrent prostate cancer being treated with cycles of leuprolide and active surveillance. Can I code as current prostate cancer, C61, between leuprolide injections?***

Answer: Yes, the prostate cancer still exists and is being treated with leuprolide and monitored for progression between injections, therefore, the cancer is being actively treated and should be coded as a current cancer. It is very important to document as recurrent prostate cancer and include the treatment plan outlined to support the diagnosis.

Question: ***I documented and coded breast cancer, C50.919, for my patient who had excision of the cancer but will be following with oncology for further treatment of her DCIS. Why was I asked to clarify the diagnosis and disagree if DCIS?***

Answer: You are being asked to clarify the diagnosis because both "Malignant neoplasm of the breast" and "DCIS" are documented. DCIS is documented and coded differently than malignant neoplasm of the breast.

Question: ***My patient's breast cancer was completely excised and tamoxifen was recommended but the patient declined. Can I continue to code the cancer since tamoxifen was recommended?***

Answer: No, once a primary malignancy has been excised or eradicated from its site and there is no further treatment directed to that site and there is no evidence of any existing primary malignancy at that site, a code for Personal history of malignant neoplasm, (Z85.-) should be coded to indicate the former site of the malignancy.[1]

Question: ***I was told I should include the cancer staging when documenting cancer on my patients; that coders can code from that. Is that true?***

Answer: Yes. If staging classes are documented in the medical record, coders can use current classifications for decoding the numerical/alphabetic designations. This assists in correct ICD-10 code selection and can alert them to the presence of any secondary neoplasm.[6]

For example, a provider documents ***breast cancer stage T1N1M0.*** Using the American Joint Committee on Cancer (AJCC) TNM Breast Cancer Staging System, N1 tells the coder there is metastases to movable ipsilateral level I, II axillary lymph node(s) while M0 indicates there is no distant metastases. So, in addition to the primary breast cancer code, C50.-, the coder can code ***C77.3, Secondary and unspecified malignant neoplasm of axilla and upper limb lymph nodes.***

Question: ***How do I address the period when cancer treatment has been completed but the patient is awaiting restaging to see whether the treatment has successfully eradicated the cancer?***

Answer: Continue to document and code as an active/current cancer until the determination has been made that the treatment was successful and there is no longer any evidence of an existing malignancy. Be sure to include the restaging as part of the treatment plan for the cancer.

Question: ***Is high dose thyroid hormone suppression therapy after thyroidectomy for thyroid cancer considered treatment?***

Answer: Thyroid hormone suppression therapy is considered adjuvant therapy after a thyroidectomy. It serves a dual role as both replacement for the missing thyroid hormone (T4) to prevent hypothyroidism and suppression of TSH production to minimize growth of any residual cancer cells and decrease the risk of recurrence. While replacement therapy will be needed for life, the need for and duration of suppression therapy varies based on the thyroid cancer's ATA risk stratification.[7, 8]

Documentation must clearly indicate if the thyroid hormone is being used for adjuvant suppression therapy in order for thyroid cancer (C73) to continue to be coded.

For additional information on treatment guidelines go to: www.UptoDate.com, *Differentiated Thyroid Cancer Overview of Management* or www.thyroid.org, *2015 American Thyroid Association (ATA) Management Guidelines for Adult Patients with Thyroid Nodules and Differentiated Thyroid Cancer.*

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2. AHA Coding Clinic for ICD-9-CM. "Herceptin Therapy for Breast Cancer." 3rd Q, 2009.
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4. Wolf, A.M.D., R.C. Wender, et al. "American Cancer Society Guideline for the Early Detection of Prostate Cancer: Update 2010 ." CA: A Cancer Journal for Clinicians. 60.2 (2010): 70-98. Web. 23 Apr. 2013. <http://onlinelibrary.wiley.com/doi/10.3322/caac.20066/pdf>.
5. "National Cancer Institute Fact Sheet Radiation Therapy for Cancer." National Cancer Institute at the National Institutes of Health. National Cancer Institute, 30 Jun 2010. Web. 23 Apr 2013. <http://www.cancer.gov/cancertopics/factsheet/Therapy/radiation>.
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7. Tuttle, R Michael. "Differentiated Thyroid Cancer: Overview of Management." Edited by Douglas S Ross and Jean E Mulder, UpToDate, Wolters Kluwer, 8 June 2018, www.uptodate.com/contents/differentiated-thyroid-cancer-overview-of-management?search=thyroidcancer&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1.
8. Jones, M Keston. "Management of Papillary and Follicular Thyroid Cancer." Journal of the Royal Society of Medicine, Sage, 1 July 2002, www.journals.sagepub.com/doi/abs/10.1177/014107680209500701#articleCitationDownloadContainer.

Documenting and coding cancer part 2

Question: ***Why are there codes for in remission and in relapse for leukemia and multiple myeloma?***

Answer: Leukemia, Hodgkin's Lymphoma (HL), Non-Hodgkin's Lymphoma (NHL), and myeloma are all considered types of blood cancer. With the exception of HL, treatment of these cancers is aimed at achieving remission rather than curing. Thus, ICD-10 provides codes for leukemia and multiple myeloma to indicate if they have not achieved remission, are in remission, or in relapse. Lymphoma patients who are in remission are still considered to have lymphoma and should be assigned the appropriate code from categories C83-C88 for the active cancer. However, HL is now considered one of the most curable forms of cancer with rates over 80%.1 If the disease is completely cured and documented as "history of" then Z85.71, Personal history of Hodgkin's lymphoma, would be coded.

Question: ***How are "remission" and "relapse" defined for leukemia and multiple myeloma?***

Answer: ***Remission*** is when signs of a disease disappear. The terms "complete" and "partial" are sometimes used to describe the response to treatment; however, ICD-10 only identifies remission and relapse.

- ***Complete remission*** means there is no evidence of the disease
- ***Relapse*** is when the disease returns during therapy or
- after being successfully treated (remission)[1]

If "in remission" or "in relapse" is not documented, a code for not having achieved remission is coded.

Question: ***Under what circumstances is it appropriate to code "unspecified leukemia?"***

Answer: The codes for Leukemia of unspecified cell type (C95.-) are used when the patient's specific diagnosis has not yet been established (although leukemia is certain) or when documentation does not provide sufficient information for a specific leukemia type.[2]

Question: ***Can you code both myelodysplastic syndrome (MDS) and multiple myeloma in the same patient, or is MDS inherent to multiple myeloma?***

Answer: Yes. There is no exclusion in ICD-10 to prohibit MDS (D46.-) from being coded with multiple myeloma (C90.-). They are distinct diagnoses that can occur simultaneously.

Myelodysplastic syndromes can affect red cells, white cells or platelets. They are classified by the number of immature blood cells (blasts) and type of cells. Multiple myeloma is a disorder of the specific type of immunoglobulin-producing white cells known as plasma cells.

Patients with multiple myeloma can develop MDS spontaneously or as a result of chemotherapy or radiation used in treatment, but it would not be inherent so would be coded in addition.[1]

Question: ***Should I document and code thrombocytopenia in a patient with MDS? Is thrombocytopenia inherent to MDS?***
Answer: While thrombocytopenia commonly occurs in MDS, it is not necessarily considered inherent so it should be documented and coded in addition to the MDS (D46.-). However, because it is ***due to*** the MDS, D69.59, Other secondary thrombocytopenia (non-risk), would be assigned.

Question: ***How do I document and code for patients who have had stem cell transplantation?***

Answer: Document and code the current status of the patient's cancer, i.e., not having achieved remission, in remission, or in relapse, and ***Z94.84, Stem cells transplant status.*** Hematopoietic stem cell transplantation (HSCT) is used to reestablish hematopoietic function and achieve remission in many types of leukemia, lymphoma, and multiple myeloma; however, it is only considered curative for a few (e.g., some types of AML, CML, and Hodgkin lymphoma). Only if the cancer is cured should you document and code "personal history of" (Z85.7-).[3]

1. "Facts 2017-2018 Updated Data on Blood Cancers." Leukemia & Lymphoma Society, Leukemia & Lymphoma Society, 30 Apr. 2018, www.lls.org/sites/default/files/file_assets/PS80_Facts2017-2018.pdf.
2. Coder's Desk Reference for ICD-10-CM Diagnoses. 2018, Optum360, 2017., pg. 123
3. Perumbeti, Ajay. "Hematopoietic Stem Cell Transplantation." Edited by Emmanuel C Besa, Medscape, WebMD, 6 Aug. 2018, emedicine.medscape.com/article/208954-overview.