

## **Coding Spotlight: Cancer**

### **A provider's guide to properly code cancers**

Cancer is often coded inaccurately, and there are missed opportunities to show which patients are sicker and are at a higher risk and those that are no longer being treated for this chronic condition.

Documentation and coding of neoplasms has proven over time to be a source of many errors, including incorrect assignment of the morphology of the diagnosis and active cancer versus historical cancer. Neoplasms are classified in ICD-10-CM by anatomical location and morphology. It is essential to document the specific site of cancer and laterality. Words like “mass”, “lump” and “tumor” should be avoided if more specific language is available. If known, the behavior of the neoplasm should be documented, such as benign, primary malignant, secondary malignant, in situ or uncertain.

“History of malignant neoplasm” or “no evidence of disease” should not be documented if the neoplasm is still being actively treated. Instead, the continuation of care should be documented, noting what has been done and what is left to do.

“History of” and “no evidence of disease” indicate an eradicated condition and a complete cure, according to coding guidelines, and would result in a history of malignant neoplasm code instead of an active malignant neoplasm code.

#### **Facts**

- In 2015, 1,633,390 new cases of cancer were reported and 595,919 people died of cancer in the United States.<sup>1</sup>
- Cancer is the second leading cause of death in the United States.
- One of every four deaths in the United States is due to cancer.<sup>1</sup>
- The total global economic cost of cancer in 2010 was estimated at approximately \$1.16 trillion.<sup>2</sup>
- Approximately 70% of deaths from cancer occur in low- and middle-income countries.<sup>2</sup>

#### **Risk factors**

Certain risk factors may increase a person's chances of developing cancer. Some risk factors can be avoided and lower the risk of developing certain types of cancer.

- **Age** — Advancing age is the most important risk factor for cancer overall.
- **Alcohol** — Drinking alcohol can increase the risk of cancer of the mouth, throat, esophagus, larynx, liver and breast.
- **Cancer-causing substances** — Exposure to substances such as radiation, pesticides and asbestos can cause cancer.
- **Chronic inflammation** — Over time, inflammation can cause DNA damage and lead to cancer. For example, people with chronic inflammatory bowel diseases, such as ulcerative colitis and Crohn's disease, have an increased risk of colon cancer.
- **Diet** — Certain dietary components are associated with a reduced risk of cancer.

- **Hormones** — Combination menopausal hormone therapy can increase a woman’s risk of breast cancer; also, unopposed estrogen can cause endometrial cancer.
- **Immunosuppression** — Immunosuppressive drugs make the immune system less able to detect and destroy cancer cells and fight off the infections that cause cancer.
- **Infectious agents** — Viruses, bacteria and parasites can cause cancer or increase the risk.
- **Obesity** — Obese people have an increased risk of several types of cancer, including breast, colon, rectum, endometrium, esophagus, kidney, pancreas and gallbladder.
- **Radiation** — X-Rays, gamma rays and other excessive forms of radiation can damage DNA and cause cancer.
- **Sunlight** — Exposure to UV radiation can lead to skin cancer.
- **Tobacco** — Tobacco use causes many types of cancer, including cancer of the lung, larynx, mouth, esophagus, throat, bladder, kidney, liver, stomach, pancreas, colon, rectum and cervix.<sup>3</sup>

## Diagnosis and treatment

There are several ways to diagnose cancer, such as lab tests, imaging procedures (including CT scans, nuclear scans, ultrasounds, MRIs, PET scans and X-Rays) and biopsy.

Treatment depends on the type of cancer, stage and anatomical location. Most patients receive a combination of treatments. There are many types of cancer treatment:

- Surgery
- Radiation therapy
- Chemotherapy
- Immunotherapy
- Targeted therapy
- Hormone therapy
- Stem cell transplant
- Precision medicine<sup>3</sup>

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### Breast Cancer Screening

Breast Cancer Screening measures the percent of women 50 to 74 years of age who had at least one screening mammogram during the current or prior year.

Documentation of breast cancer screening includes any of the following:

- One or more mammograms any time on or between October 1, two years prior to the measurement year and December 31 of the measurement year
- Mammography results need to be requested and copies of it should be retained with the date of service in the medical record to provide evidence the test was performed
- Evaluation of primary breast cancer screening tomosynthesis (3-D mammography), biopsies and breast ultrasounds
- MRIs will not count as primary breast cancer screening

Helpful tips:

- Discuss mammogram screening with all female members between the ages of 50 and 74 (younger if the patient has a family history of breast cancer or other risk factors).
- Document a history of mastectomy (unilateral or bilateral) on a chart.
- Conduct outreach calls to patients to remind them of the importance of annual wellness visits and assist with scheduling mammograms.
- Request and retain copies of mammography results in patient records or ask patients to make sure they request the mammography center to send a copy.
- Create flags or reminders in the system for members who need mammograms.
- Arrange one-on-one patient education sessions with health care professionals to discuss the importance of breast cancer screening and mammograms.
- Motivate your office staff to use tools within the office to promote awareness of breast cancer screening, such as member reminder cards, chart or electronic medical record (EMR) flags, and educational brochures.
- Display posters and educational messages in waiting areas; they help motivate members to initiate discussions regarding screenings.

**Cervical Cancer Screening**

Cervical Cancer Screening measures the percent of women who were screened for cervical cancer using either of the following criteria:

- 21 to 64 years of age: at least one cervical cytology (Pap) test every three years
- 30 to 64 years of age: Pap test/human papillomavirus (HPV) cotesting every five years

Documentation should reflect the following:

- The date and type of test that was performed
- If the patient had a history of hysterectomy including details if it was a complete, total or radical abdominal or vaginal hysterectomy with no residual cervix
- History of cervical agenesis or acquired absence of cervix (at a minimum, the year when the surgical procedure was performed should be included)

Helpful tips:

- Discuss the importance of well-woman exams, mammograms, Pap tests and HPV testing with all female members 21 to 64 years of age.
- Promote women's health by reminding of the importance of annual wellness visits.
- Refer patients to another appropriate provider if the office does not perform Pap tests and request copies of Pap test/HPV cotesting results.
- Use a tracking mechanism (for example, EMR flags and/or manual tracking tool) to identify members due for cervical cancer screening.
- Display posters and educational messages in waiting areas and treatment rooms to help motivate members to initiate discussions about screening.<sup>4</sup>

**Colorectal cancer screening**

Colorectal cancer screening is a measure that focuses on members 50 to 75 years of age who had an appropriate screening for colorectal cancer.

Documentation must indicate date, the result, and one or more of the following screenings:

- Colonoscopy during measurement year or nine years prior
- FOBT during measurement year
- CT colonography during measurement year or four years prior
- FIT-DNA test during measurement year or two years prior
- Flexible Sigmoidoscopy during measurement year or four years prior

Exclusions:

- Diagnosis of colorectal cancer and total colectomy<sup>5</sup>

Documentation should reflect the following:

- The date when the screening was performed and a pathology report that indicates the date and type of screening that was performed
  - The result is not required if the documentation of the test is clearly part of the medical history.

Note, only one form of screening is required for the member to be compliant.

### **ICD-10-CM: general coding and documentation**

**Neoplasms are classified primarily by anatomic site and by behavior:**

- Benign (adenoma, fibroma, lipoma)
- Malignant (adenocarcinoma, liposarcoma, osteosarcoma)
- Uncertain behavior
- Unspecified behavior
- In situ (in original place)

In ICD-10-CM, clear and detailed provider documentation of the patient's neoplastic disease is needed for complete and accurate reporting and the documentation should include the following:

- Anatomical location
- Related conditions
- Behavior or cell type
- Treatment
- Metastatic sites
- Complications

Conditions related to neoplasms and complications of care must be clearly documented by a provider and linked to the neoplasm. Examples include:

- Anemia due to adenocarcinoma of colon
- Diabetes mellitus secondary to pancreatic carcinoma
- Pathological fracture resulting from metastatic stage 4 ovarian carcinoma.

When a primary malignancy has been previously 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, a code from **category Z85 — personal history of malignant neoplasm** should be

used to indicate the former site of the malignancy.<sup>6</sup> A patient should **never** be assigned a current, active cancer code if the disease is no longer treated.

Documentation must show evidence of current/ongoing treatment of the disease (such as chemotherapy, radiation therapy, suppressive therapy and/or surgical treatment).

When a **primary malignancy** has been excised but further treatment (such as an additional surgery for the malignancy, radiation and/or chemotherapy) is directed to that site, the primary malignancy code should be used until treatment is completed.

The statement “**metastatic to**” indicates that the site mentioned is secondary. For example, a diagnosis of metastatic carcinoma to the lung is coded as secondary malignant neoplasm of the lung (C78.0-). A code for the primary neoplasm should also be assigned when the primary neoplasm is still present. When primary malignancy is not present anymore, assign a history code for the primary malignancy.

The statement “**metastatic from**” indicates that the site mentioned is the primary site. For example, a diagnosis of metastatic carcinoma from the breast indicates that the breast is the primary site (C50.9-). A code for the metastatic site should also be assigned.

A primary malignant neoplasm that overlaps two or more contiguous sites is classified to the **subcategory/code .8**, signifying “overlapping lesion,” unless the combination is specifically indexed elsewhere.

**Code C80.0 — disseminated malignant neoplasm, unspecified** is for use only in those cases where the patient has advanced metastatic disease and no known primary or secondary sites are specified.<sup>7</sup>

**Code C80.1 — malignant (primary) neoplasm, unspecified** equates to cancer, unspecified. This code should only be used when no determination can be made as to the primary site of a malignancy. **C79.9 — secondary malignant neoplasm of unspecified site** is assigned when no site is identified for the secondary neoplasm.<sup>7</sup>

**Malignant neoplasms** of the following sites are classified as secondary when not otherwise specified, except for neoplasm of the liver (ICD-10-CM provides code **C22.9, malignant neoplasm of liver, not specified as primary or secondary** for the use in this situation):

- Bone
- Brain
- Diaphragm
- Heart
- Liver
- Lymph nodes
- Mediastinum
- Meninges
- Peritoneum
- Pleura
- Retroperitoneum
- Spinal cord
- Sites classifiable to C76.7

**Primary neoplasms of lymph nodes or glands** are classified in category C81 through C88 with a fourth character providing more specificity about the particular type of neoplasm and a fifth character indicating the nodes involved.<sup>7</sup>

**Leukemia** is classified in categories C91 through C95 with the fourth character indicating either the stage of the disease (acute or chronic) or the type of leukemia (e.g., adult T-cell).

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- 1 Centers for Disease Control and Prevention. *Leading Cancer Cases and Deaths*, 2014. <https://nccd.cdc.gov/USCSDataViz/rdPage.aspx>.
  - 2 World Health Organization. *Cancer*. Key facts. [www.who.int/mediacentre/factsheets/fs297/en](http://www.who.int/mediacentre/factsheets/fs297/en).
  - 3 National Cancer Institute. *Risk factors for cancer*. <https://www.cancer.gov/about-cancer/causes-prevention/risk>.
  - 4 *HEDIS Benchmarks and Coding Guidelines for Quality Care*. Amerigroup. <https://providers.amerigroup.com>.
  - 5 *HEDIS Measure 2018 Physician Documentation Guidelines and Administrative Codes*. Amerigroup. <https://providers.amerigroup.com>.
  - 6 *ICD-10-CM Expert for Physicians: the complete official code set*. (2017). Optum 360, LLC.
  - 7 Leon-Chisen N. (2017). *ICD-10-CM and ICD-10-PCS Coding Handbook 2018*. Chicago, IL: American Hospital Association.