healthfirst
Health Insurance for New Yorkers

Provider Alert

Documentation and Coding Tips
Cancer: Active vs History of

ACTIVE

- **Neoplasms: Providers are often uncertain how to document and code for neoplasms. Common provider neoplasm coding errors:**
  - Coding active cancer when the correct code is "history of" the specific cancer. This is particularly common when the patient is considered cancer-free and is off all forms of treatment, but is closely followed for recurrence of cancer by an oncologist.
  - Neglecting to document/code for cancer after preliminary treatment, but while the patient is still receiving some active treatment. This is most common with adjuvant therapy given for extended periods of time after the initial treatment for the cancer.
  - Neglecting to code for metastases.
- **Follow ICD10 guideline when reporting suspected or confirmed malignancy and personal history of cancer.**
  - For outpatient encounters, do not code for a suspected, possible, or unconfirmed diagnosis. The symptoms should be coded.
  - Code the cancer condition as **active** or with the malignant neoplasm code if:
    - current pathology revealing cancer
    - a newly diagnosed patient awaiting treatment
    - refusal of cancer therapy by patient
    - patient is still receiving treatment for the malignancy
    - current anti-neoplastic drug therapy
    - current chemotherapy/radiation therapy
    - referral to a specialist/surgeon for treatment options/management
    - affirmation of current disease management (e.g., "patient's chemotherapy being managed by oncologist")
    - existing metastasis of CA
    - refusal of surgical/other treatment by patent due to age factor, etc.
    - documentation of status of terminal CA (palliative or hospice care)

- "Malignant neoplasms should be documented as active only when under current treatment or initial diagnostic work-up."
    - For breast cancer, as long as the patient is using Tamoxifen, Arimidex, or any other means of prolonged adjuvant therapy, then it is considered active.
    - If the PT is no longer taking the meds, then the diagnosis would change to personal history of BR CA.
- For lymphoma and hematological malignancies:
    - "The only exception to this rule is hematological malignancies (leukemia, lymphoma, and multiple myeloma), which should be documented as active even when in remission and the patient is under surveillance only."

HISTORY OF CANCER

- Patients with **history of malignant neoplasm**, and not currently under treatment for cancer, and there is no evidence of existing primary malignancy, a code from category **Z85**, personal history of malignant neoplasm, should be used.
    - **Breast Cancer Scenario**: Should be coded as historical (Z85.3) after the breast cancer has been excised or eradicated, there is no active treatment directed to the breast cancer and there is currently no evidence of disease or recurrence.
    - Encounter for follow-up examination, after treatment for malignant neoplasm has been completed, is coded as ZØ8. This code includes medical surveillance following completed treatment (i.e., monitoring for cancer recurrence) and Excludes1 aftercare following medical care (Z43 – Z49, Z51). Code ZØ8 advises to use an additional code to identify any acquired absence of organs (Z9Ø.-) and personal history of malignant neoplasm (Z85.-).
    - Do not use the phrase "history of" to describe a current primary breast cancer. In diagnosis coding, "history of" means the condition is historical and no longer exists as a current problem.
    - In the final impression, do not document a simple statement of "breast cancer" to describe a historical primary breast cancer that was previously excised or eradicated and for which there is
        - no active treatment; and
        - no evidence of disease or recurrence.
    - In this scenario, it is appropriate to document "history of breast cancer," along with details of past diagnosis and treatment.
- If Leukemia, Multiple Myeloma, and Malignant Cell Neoplasms have achieved **remission**, use code from category **C90**.

TAMPER

- Documentation should be clear and complete to ensure accurate coding
- Put TAMPER in the documentation
  - **T** – treatment
  - **A** – assessment
  - **M** – monitoring or medication
  - **P** – plan
  - **E** – evaluate
  - **R** – referral