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. Neoplasms should be coded to 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

**Secondary Site with an Unknown Primary 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, kidney V16.51


Sharp Healthcare 07/04; Secure Horizons rev. 03/06