Cancer Coding Toolbox

Date of Last Review_032524

2024

Please note:

These tools are to be used as resources only.

These tools are not guarantees for payment.

These tools are not coding instructions.

Always follow CMS guidelines when coding.

Current/In Remission/History of

2024

Cancer-Overview, Diagnosing, and Treatment

Current

- The record clearly states active treatment is for the purpose of curing or palliating cancer
- States cancer is present but unresponsive to treatment
- The current treatment plan is observation or **watchful waiting**
- The patient refused treatment.
- The patient is on suppressive therapy (ex-Lupron or Tamoxifen)

In Remission

- Cancer is coded as current, if there is no contradictory information elsewhere in the record.
- Applies to categories for leukemia, multiple myeloma and malignant plasma cell neoplasms

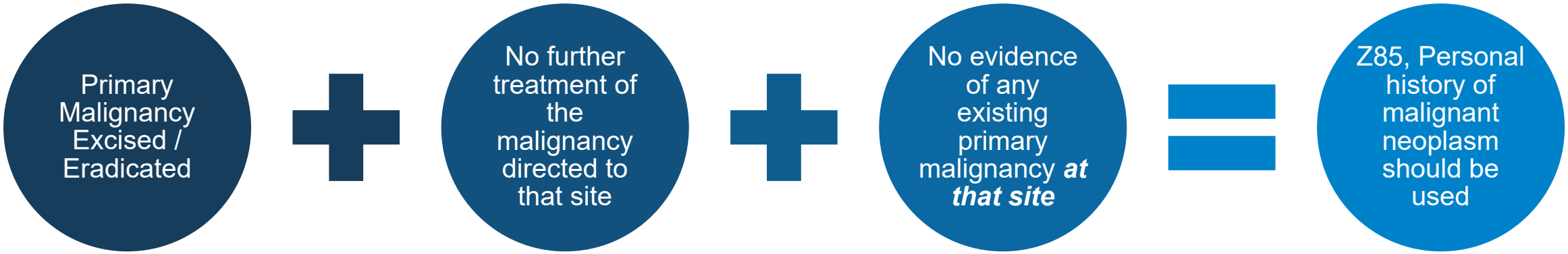
History of Cancer

- Record describes cancer as historical or
- “history of”
- and/or the record states the current status of cancer is “cancer free,” “no evidence of disease,” “NED,”
- or any other language that indicates cancer is not current.
- No treatment in place because there is nothing to treat, it has been eradicated.

Cancer-Overview, Diagnosing, and Treatment

Current malignancy versus personal history of malignancy

- When a primary malignancy has been previously excised or eradicated from its site, there is no further treatment (of the malignancy) directed to that site, and there is no evidence of any existing primary malignancy at that site, a code from category Z85, Personal history of malignant neoplasm, should be used to indicate the former site of the malignancy.
- Codes from subcategories Z85.0 – Z85.85 should only be assigned for the former site of a primary malignancy, not the site of a secondary malignancy.
- Code Z85.89 may be assigned for the former site(s) of either a primary or secondary malignancy.



Coding Screening Tests

2024

Cancer-Overview, Diagnosing, and Treatment

Routine Screening Test vs. Symptoms Present Screening Test Coding

Routine

- ✓Code the CPT code for the test
- ✓Encounter for screening for malignant neoplasms (Z12.xx)
- ✓Family history of malignant neoplasm? (Z80.x)

Symptoms present

- ✓Code the CPT code for the test
- ✓Code the symptom that has triggered the test
- ✓Family history of malignant neoplasm? (Z80.x)

Cancer-Overview, Diagnosing, and Treatment

Chapter 21.5-Official Guidelines Related to Screening Tests:

- The Z code indicates that a screening exam is planned. A procedure code is required to confirm that the screening was performed.
- The testing of a person to rule out or confirm a suspected diagnosis because the patient has some sign or symptom is a diagnostic examination, not a screening. **In these cases, the sign or symptom is used to explain the reason for the test**

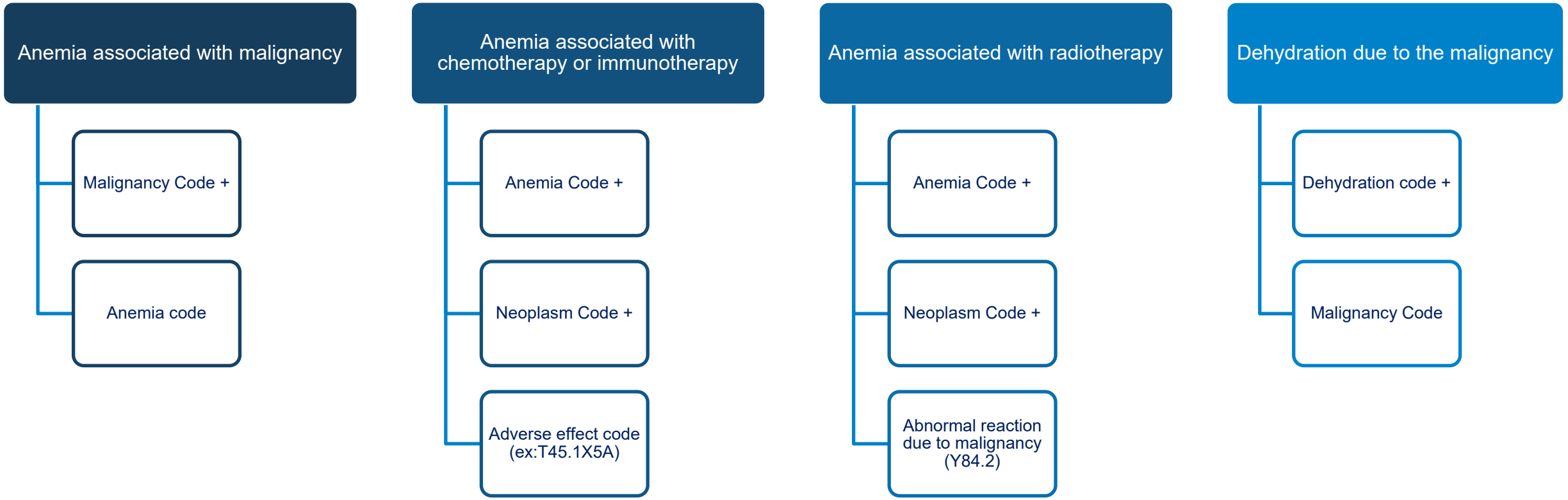
Type of Cancer	ICD-10 Code	Notes
Breast	**Z12.3x**-Encounter for screening for malignant neoplasm of breast	Use additional code to identify any family history of malignant neoplasm **(Z80.-)**
Cervical	**Z12.4**- Encounter for screening for malignant neoplasm of cervix	Excludes 1-when screening is part of general gynecological examination **(Z01.4-)** Excludes 2-encounter for screening for human papillomavirus **(Z11.51)**
Prostate	**Z12.5**- Encounter for screening for malignant neoplasm of prostate	Use additional code to identify any family history of malignant neoplasm **(Z80.-)**
Colorectal	**Z12.11**-Encounter for screening for malignant neoplasm of colon	Use additional code to identify any family history of malignant neoplasm **(Z80.-)**
Lung Cancer	**Z12.2**- Encounter for screening for malignant neoplasm of respiratory organs	Use additional code to identify any family history of malignant neoplasm **(Z80.-)**

https://www.bluecrossnc.com/members/health-and-wellness/preventive-care

Cancer-Overview, Diagnosing, and Treatment

Treatment Side Effects and Code Sequencing for:

Admission or Encounter for Management of an Anemia or Dehydration Associated with Malignancy when the only treatment is for the anemia or the dehydration



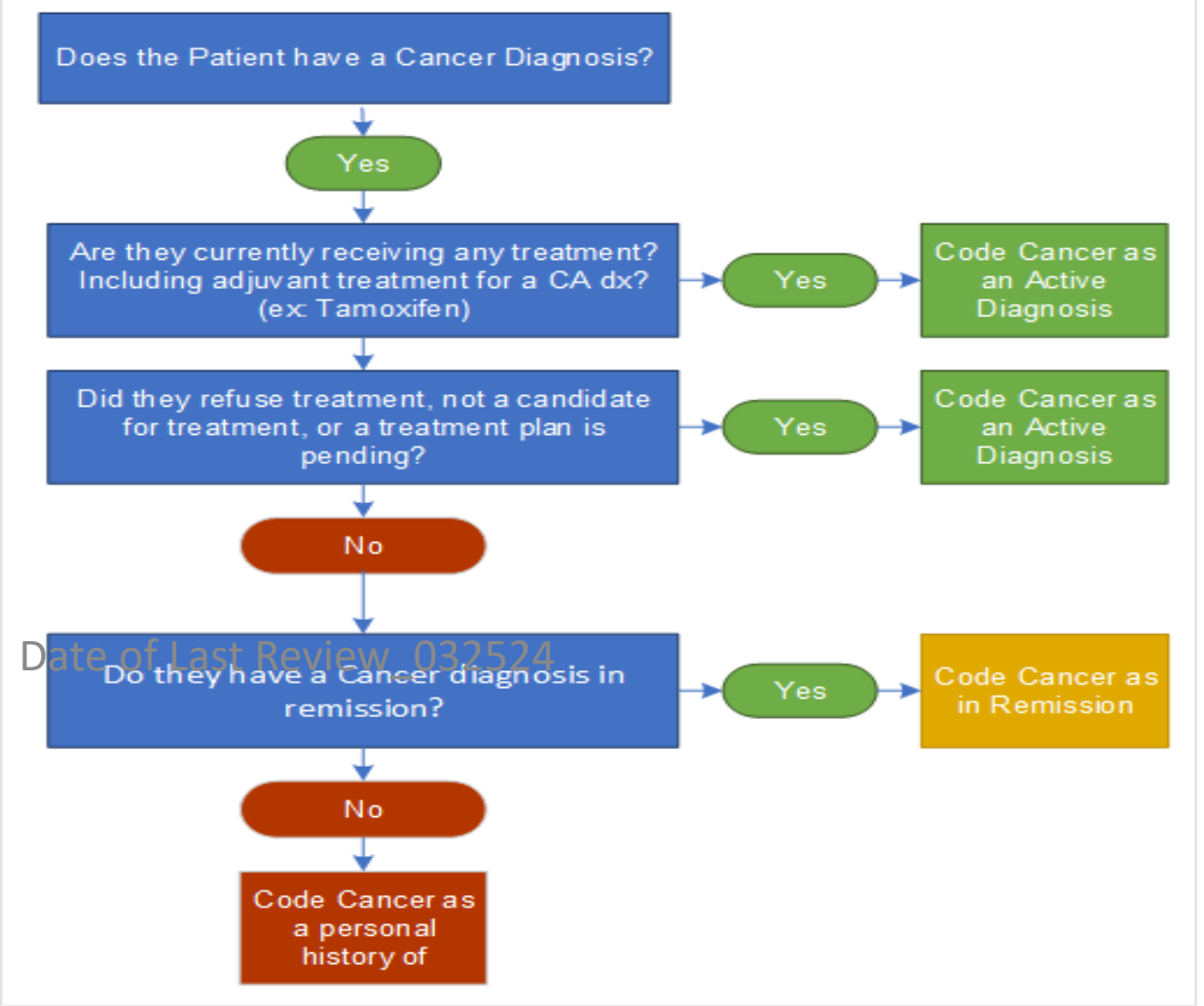
Cancer-Overview, Diagnosing, and Treatment

Additional Cancer Diagnoses & Treatment Side Effects Coding

Malnutrition	E43-E46
Depression	F32.xx-F33.xx
Anxiety	F41.x
Blood Clots	I74.xx
Pain	G89.3
Refuses CA treatment	Z53.x

Additional Resources

Cancer Coding Decision Tree

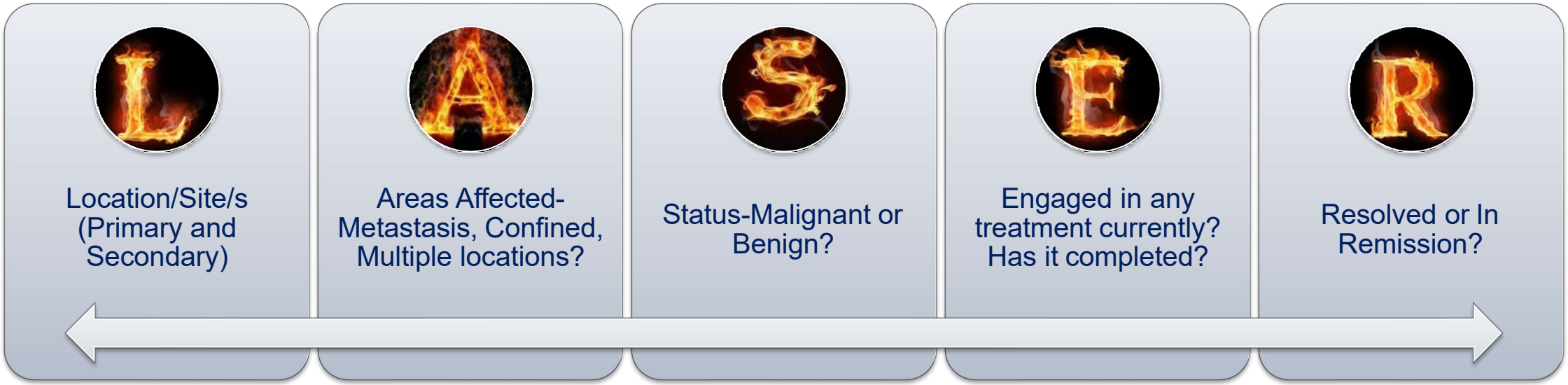


Reference for frequently missed Cancer Codes

Site	Malignant Primary	Malignant Secondary	Ca in situ	Benign	Uncertain Behavior	Unspecified Behavior
• Specified site where the Cancer is found. • Specific location should be documented and coded (Ex- upper/outer breast ; small/large intestine)	• This is the primary site of the Cancer. • Providers should identify and document what site is primary in cases of metastasis. • (Ex-Primary-Colon with Mets to lung- secondary & bladder (secondary))	• Sites of metastasis should be documented and identified. • May have multiple sites of metastasis (Ex-Primary-Colon with Mets to lung- secondary & bladder (secondary))	• In situ-"original place"- a neoplasm that has not have cells found in neighboring tissue • Once malignant cells are identified in adjacent tissues it is no longer in situ and malignant neoplasm codes should be used.	• Non-Cancerous tumors	• Current neoplasm behavior is benign BUT it possesses characteristics giving it the potential to turn malignant	• Used when the nature of the neoplasm is not specified (malignant, benign)
Prostate	C61	C79.82	D07.5	D29.1	D40.0	D49.59
Breast	C50.xx	C79.81	D05.xx	D24.xx	D48.6x	D49.3
Colon*	C26.0	C78.80	D01.40	D13.99	D37.8	D49.0
Lung	C34.xx	C78.0x	D02.2x	D14.3x	D38.1	D49.1

*Intestinal-this can be broken down to small and large. Those are not included on this table.

Cancer Coding Acronym



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Encourage a “LASER” focus to your providers related to Cancer Coding.
This ensures that our Members Cancer Journey’s are accurately reflected and reimbursed.

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Colonoscopy Screen turned Diagnostic Coding

1) Choose the correct CPT® code which describes the procedure that was attempted.

2)Append the –PT modifier to the CPT® code. The –PT modifier indicates a screening colonoscopy has been converted to a diagnostic test or other procedure.

3)Use an appropriate ICD-10 diagnosis code to indicate the procedure was a screening procedure. (Z12.xx)

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