Cancer: Active vs. Historical

OVERVIEW

Solid-tumor cancer diagnoses often result in coding errors identified in medical record audits. Accurate documentation of cancer diagnoses, specifically noting active cancer versus historical cancer, supports accurate coding. This ensures patients' medical records are accurate and reflect the status of their diagnoses, supports public health efforts, and helps guarantee accurate provider payment.

ACTIVE VS. HISTORICAL CANCER DEFINITIONS

Check out Premera's interactive, quick and easy-to-use Documentation and Coding Web Training series for clinicians at www.premera.com/wa/provider/reference/coding-resources/

Cancer is considered **active** when:

- The patient is currently and actively being treated and managed for cancer. Scenarios demonstrating active cancer treatment/status include:
    - Current chemotherapy, radiation, or anti-neoplasm drug therapy
    - Current pathology revealing cancer
    - A newly diagnosed patient awaiting treatment (e.g., surgery to remove cancer)
    - Affirmation of current disease management
    - Refusal of therapeutic treatment by patient or watchful waiting
- The cancerous organ has been removed or partially removed and the patient is still receiving ongoing treatment such as chemotherapy or radiation.

Cancer is considered **historical** when:

- The cancer was successfully treated, and the patient isn't receiving treatment.
- The cancer was excised or eradicated and there's no evidence of recurrence and further treatment isn't needed.
- The patient had cancer and is coming back for surveillance of recurrence.
- The patient is currently on adjuvant therapy (like Lupron or Tamoxifen) for prophylactic purposes.

GUIDELINES FOR DOCUMENTATION AND CODING

Clear provider documentation is essential for accurate code selection. When documenting and selecting diagnosis codes for a visit with a patient who currently has or had cancer, keep the following information in mind.

Clearly document the following information:

- Type of cancer:
    - Primary malignancy and all secondary metastases
    - Carcinoma in situ or benign
- Location of cancer (including laterality, if applicable)

- Status of cancer (active or historical):
    - Avoid using a "history of" statement if the patient is currently receiving active treatment for the cancer. Document the cancer as "active" if the patient had the cancer removed but is still receiving active treatment for the site.
- For active cancers, document the current treatment. If the patient refused treatment or is under watchful waiting, document the reason and the progress, if known.
- If the patient is on adjuvant therapy, indicate if it's prescribed for treatment or prophylactic purposes.
    - If the patient is taking medication to treat the cancer (even after it was removed), code the cancer as active.
    - If patient is taking medication for prophylactic purposes to ensure that treated cancer doesn't come back, code the cancer as historical.
- Select a code from the Personal History section of the ICD-10 coding book if the cancer is documented as historical:
    - Z85.xxx for personal history of malignant neoplasm
    - Z86.01x for personal history of benign neoplasm
    - Z86.00x for personal history of carcinoma-in-situ

MORE INFORMATION

For additional questions about documentation and coding of this (and any other) chronic or complex condition, email your Provider Clinical Consultant at ProviderClinicalConsulting@Premera.com.