Cancer

Coding Tips & Billing Examples

Cancer

Cancer starts when cells grow out of control and crowd normal cells[2]. In all types of cancer, some of the body's cells begin to divide without stopping and spread into surrounding tissues[1]. There are many types of cancer and the causes vary greatly.

Symptoms of Cancer

The signs and symptoms will depend on where the cancer is located, how big it is, and how much it affects the organs or tissues[2]. If a cancer has spread *(metastasized)*, signs or symptoms may appear in different parts of the body[2]. Some signs include noticeable changes such as changes in the skin, breast, or urination[1] while other signs are not known until the cancer has grown quite large[2].

Treatment of Cancer

There are many types of treatment that will depend on the type of cancer and how advanced it is[1]. Common treatments include surgery, chemotherapy, radiation therapy, targeted therapy, and immunotherapy[2].

Visit our website:
https://www.homestatehealth.com/providers/tools-resources/coding-page.html

Resources

1. National Cancer Institute https://www.cancer.gov/
2. American Cancer Association http://www.cancer.org/
3. Elsevier Clinical Solutions (Understanding the ICD-10-CM Neoplasm Coding Guidelines)
4. ICD-10-CM Official Guidelines for Coding and Reporting https://www.cdc.gov/nchs/data/icd/10cmguidelines_fy2018_final.pdf

Malignant Neoplasm Coding Guidance

home state health

TIPS:	ICD-10 Mapping & Education
➢ **ICD-10-CM**	C00 – D49 code series O9A.1- code series (Malignant neoplasm in Pregnancy)
➢ **Specify *Anatomical Site* and *Behavior***	☐ Malignant Primary (original site) ☐ Benign ☐ Malignant Secondary (metastasized) ☐ Uncertain ☐ Carcinoma in situ ☐ Unspecified Behavior
➢ **Primary vs. Secondary**	☐ Exam is for Primary Malignant site(s) with known/unknown secondary site(s): **1st Dx:** *[Primary]* Cancer **2nd Dx:** *[Known/Unknown]* Cancer ☐ Exam is for Secondary Malignant site(s) with an active primary site(s): **1st Dx:** *[Secondary]* Cancer **2nd Dx:** *[Primary]* Cancer
➢ **Admission for treatment**	1. Code **FIRST**: ○ Encounter for radiation therapy *(Z51.0)* ○ Encounter for chemotherapy *(Z51.11)* ○ Encounter for immunotherapy *(Z51.12)* 2. Code **SECOND**: ○ Malignancy for which the therapy is being administered.
➢ **Active vs. "History of"… vs. "in remission"**	***Active:*** Malignancy is excised but patient is still undergoing treatment directed to that site. Primary malignancy codes should be used until treatment is complete. *Example: "Patient with ongoing chemotherapy after right mastectomy for breast cancer."* ***History of:*** Malignancy has been previously excised or eradicated, there is no further treatment directed to that site, and no evidence of any existing primary malignancy. Then malignancy is considered a "history of" for coding purposes *(Z85.-)*. *Example: "Breast cancer treated with mastectomy and adjunct chemotherapy 3 years ago."* ***In Remission:*** Don't confuse personal history with "in remission". Codes for leukemia, multiple myeloma, and malignant plasma cell neoplasms indicate whether the condition has achieved remission[3]. *Example: "Patient with leukemia documented as "in remission" is admitted for autologous bone marrow transplantation."*

Resources

1. Autism Speaks: What is Autism? (https://www.autismspeaks.org/what-autism)
2. WebMD: What is Autism? (http://www.webmd.com/brain/autism/ss/slideshow-autism-overview)
3. 2017 ICD-10-CM Expert for Physicians: The Complete Official Code Set, Optum360. 2016 Optum360, LLC

Billing Sample #1

Primary Care Physician Documentation: Medical record SOAP format (condensed)

home state health

DOS: 07/10/2017
Gender: F **DOB:** XX/XX/1976 **Pulse:** 69 **Temp:**98.8˚F
Weight: 81.40lb **Height:** 4.4 **BMI:** 20.84

HPI: A 41 y.o. female with a history of breast cancer and s/p double mastectomy on 2016 comes in today for follow up of chemotherapy for metastatic cancer to the hip and femur bone.

Patient is having some severe pain which seems to originate from her femur bones.

Problem List/History: Onc Hx : Diagnosed with Breast Cancer in 2015 when a lump was found. A biopsy revealed its malignancy. A double mastectomy was performed in 2016 and given her aggressive tumor she was started on neo-adjuvant chemo with ddAC on 9/20/16.

A PET scan in 2016 showed cancer metastasis to the hip and femur bones. Started chemo and radiation therapy which should also help with the pain.

Medications Reviewed:
Metastron, Bisphosphonates, Maxalt, Tamoxifen, Percocet

Assessment and Plan:
Neuropathy due to chemo – adverse effect of the drug cisplatin. Started on Duloxetine. Percocet for pain management.
Metastatic cancer to hip and femur bone – seeing Oncologist – waiting to start radiation therapy treatments.
S/P Double Mastectomy – performed in 2016.

Claim Diagnosis Codes & Rationale

ICD-10-CM	Description	Medical Record Support
G62.0	Drug-induced Neuropathy	• *Assessment & Plan*: Provider listed Neuropathy due to chemo – adverse effect of the drug cisplatin.
T45.1X5A	Adverse effects of antineoplastic and immunosuppressive drugs	• *Assessment & Plan*: Provider listed Neuropathy due to chemo – adverse effect of the drug cisplatin • *Rationale*: ICD-10-CM guidelines state when G62.0 is used to use additional code for adverse effect, if applicable, to identify drug(T36 – T50 with fifth or sixth character)
G89.3	Neoplasm related pain (acute) (chronic)	• *HPI, Problem List, Assessment & Plan*: Provider listed severe pain in several areas of the note. Patient is taking Percocet for pain management.
C79.51	Secondary Malignant Neoplasm of Bone	• *Assessment & Plan:* Provider listed Metastatic cancer to hip and femur bone and stated patient is waiting to receive radiation therapy treatments. • *Rationale*: Metastatic Cancer points to Neoplasm>Malignant Secondary by site. Both the hip and femur code to C79.51
Z85.3	Personal History of Malignant neoplasms of breast	• *HPI*: Provider stated patient with a history of breast cancer . • *Rationale*: ICD-10-CM guidelines state a cancer becomes historical when patient is no longer receiving treatment or awaiting surgery for that site. Since the treatment given is for the bone cancer and not for the breast, the breast cancer has to be coded as history.
Z79.810	Long term (current) use of SERMS (tamoxifen)	• *Medications*: Tamoxifen listed as current medication. • *Rationale*: Codes from Z79- category indicate a patient's continuous use of prescribed drug for the long-term treatment of a condition or for prophylactic use.
Z90.13	Acquired Absence of bilateral breast and nipples	• *HPI:* Provider documents Double mastectomy done in 2016. • *Assessment & Plan*: **S/P Double Mastectomy** –2016.

Billing Sample #2

GI Specialist Documentation: Medical record SOAP format (condensed)

home state health

DOS: 07/21/2017
Gender: M **DOB:** XX/XX/1982 **Pulse:** 80 **Temp:** 98.8°F **Weight**: 181.40lb **Height:** 5.10 **BMI:** 30.84

HPI: A 35 y.o. male came in for follow up and chemo for his Stage IV Colon cancer. He is s/p C12 of FOLFOX + Bev. Had both Y90 treatment. FOLFIRI + Bev X 7. C7 went well. Pain still not well controlled. Persistent Abd pain. More active over the last 2 weeks.

Assessment/Plan:
Stage IV CRC splenic flexure: S/p C11 of FOLFOX with Avastin held last treatment and today. Course complicated by admission to hospital with ABD PAIN. Worrisome progression of RUQ pain. Finished C12 of therapy and then had Y90 localized therapy to both lobes of the liver mets. New pulm mets, so started on FOLFIRI With bev to regimen. S/P 7 cycles of therapy. Now with pulm progression as above. Scans reviewed with patient and his mother. Explained that the localized treatment with Y 90 continues to improve the liver but systemically there seems to be progression as evidenced in the pulmonary metastatic disease. His CEA starting to rise as well. Still awaiting today's results. Explained that we needed to think systemically and to switch therapy as a result of the progression where seen. Recommended that we stop Avastin and start cetuximab as patient has K-ras wild-type tumor. The side effects including sometimes significant acneiform rash were described in detail. Recommended that we start next week. Patient agreed.

Claim Diagnosis Codes & Rationale

ICD-10-CM	Description	Medical Record Support
Z51.11	Encounter for antineoplastic chemotherapy	• *HPI:* Provider documents patient came in for chemo for Stage IV Colon Cancer. • *Rationale*: ICD-10-CM guidelines state if a patient admission or encounter involves treatment directed at the malignancy, list Z51.- as the principal diagnosis.
C18.5	Malignant neoplasm colon, splenic flexure	• *HPI:* Provider documents Stage IV Colon Cancer. • *Assessment & Plan:* Provider documents Stage IV CRC splenic flexure. • *Rationale*: If provider documents the cancer differently in different parts of the note code the most specified.
C78.7	Secondary malignant neoplasm of the liver	• *Assessment & Plan:* Provider documents patient had Y90 localized therapy to both lobes of the liver mets. • *Rationale*: If a cancer is being actively treated, then it is coded. Metastatic Cancer points to Neoplasm > Malignant Secondary by site.
C78.00	Secondary malignant neoplasm of unspecified lung	• *Assessment & Plan:* Provider documents systemically there seems to be progression as evidenced in the pulmonary metastatic disease.
R10.11	Abdominal Pain Right Upper Quadrant	• *Assessment & Plan:* provider documented worrisome progression of RUQ pain. • *Rationale*: All complications resulting from chemo therapy should be coded additionally.
Z79.899	Other long term (current) drug therapy	• *Assessment & Plan*: Patient had been taking Avastin. • *Rationale*: Codes from Z79- category indicate a patient's continuous use of prescribed drug for the long-term treatment of a condition or for prophylactic use.

Billing Sample #3

Oncologist Documentation: Medical record SOAP format (condensed)

home state health

DOS: 07/12/2017
Gender: F **DOB:** XX/XX/1970 **Pulse:** 70 **Temp:** 98.7˚F
Weight: 196.80lb **Height:** 5.7 **BMI:** 37.93/ 99%

HPI: The patient is a 47-year-old woman with oxygen-dependent COPD who was first seen at this hospital over a month ago complaining of abdominal pain. On chest x-ray, she had a possible infiltrate, and it was thought she might have pneumonia and was treated with antibiotics and prednisone. Symptoms improved temporarily, but did not completely resolve. Her pain eventually worsened, and she returned to the ER where an ultrasound was done. It was noted that her spleen was enlarged at 19 cm. She underwent positron emission tomography (PET) scanning, which showed diffuse hypermetabolic lymph nodes measuring 1–2 cm in diameter, as well as a hypermetabolic spleen that was enlarged. The patient underwent lymph node biopsy on the right neck, pathology consistent with mantle cell lymphoma.

Impression: The patient is being admitted for initiation of chemotherapy to treat newly diagnosed mantle cell lymphoma. Treatment will consist of hyperfractionated cyclophosphamide, vincristine, doxorubicin, and dexamethasone. Toxicities have already been discussed with her including bladder toxicity, myelosuppression, mucositis, diarrhea, nausea, the low risk for cardiac toxicity, neuropathy, constipation, etc. Written materials were provided to her last week. Discussed possibility of increasing daily oxygen doses if necessary.

Claim Diagnosis Codes & Rationale

ICD-10-CM	Description	Medical Record Support
Z51.11	Encounter for antineoplastic chemotherapy	• *Impression:* being admitted for initiation of chemotherapy to treat newly diagnosed mantle cell lymphoma • *Rationale*: ICD-10-CM Guidelines Section I.C.2.a. states, "if a patient admission/encounter is solely for the administration of chemotherapy, immunotherapy or radiation therapy, assign the appropriate Z51.- code as the first-listed or principal diagnosis." This guideline further specifies, as well as an instructional note found under category Z51-, to also code the condition requiring care.
C83.11	Mantle cell lymphoma, lymph nodes of head, face, and neck	
R16.1	Splenomegaly, not elsewhere classified	• *HPI:* She underwent positron emission tomography (PET) scanning, which showed diffuse hypermetabolic lymph nodes measuring 1–2 cm in diameter, as well as a hypermetabolic spleen that was enlarged. • *Rationale*: ICD-10-CM index points Enlarged, Spleen to *see Splenomegaly and Splenomegaly.* Code R16.1 Splenomegaly, not elsewhere classified, as no further specificity documented.
J44.9	Chronic Obstructive Pulmonary Disease	• *HPI:* The patient is a 47-year-old woman with oxygen-dependent COPD. • *Rationale*: ICD-10-CM guidelines state code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management.
Z99.81	Dependence on supplemental oxygen	• *HPI:* The patient is a 47-year-old woman with oxygen-dependent COPD. • *Rationale*: Assign status code Z99.81 when a patient is dependent on Oxygen.

MORE CODING TIPS:

One way to document & code ***chronic conditions*** is by utilizing the acronym MEAT:

Monitor	• symptoms • disease progression/regression • ordering of tests • referencing labs/other tests
Evaluate	• test results • medication effectiveness • response to treatment • physical exam findings
Assess/ Address	• discussion, review records • counseling • acknowledging • documenting status/level of condition
Treat	• prescribing/continuation of medications • surgical/other therapeutic interventions • referral to specialist for treatment/consultation • plan for management of condition

General Notes:

- ❑Chronic Conditions can be coded during any type of visit even if they are stable.
- ❑Verify the condition, any medications, DME, injections, infusions.
- ❑Documentation must support that it was addressed

What are the ICD-10-CM Guidelines?

The ***ICD-10-CM Official Guidelines for Coding and Reporting*** are rules that supplement the conventions and instructions within the ICD-10-CM classification. Adherence to these guidelines is required under the Health Insurance Portability and Accountability Act (HIPAA).

ICD-10-CM Official Guidelines for Coding and Reporting
FY 2018
(October 1, 2017 - September 30, 2018)

Narrative changes appear in bold text
Items <u>underlined</u> have been moved within the guidelines since the FY 2017 version
Italics **are used to indicate revisions to heading changes**

The Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS), two departments within the U.S. Federal Government's Department of Health and Human Services (DHHS) provide the following guidelines for coding and reporting using the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM). These guidelines should be used as a companion document to the official version of the ICD-10-CM as published on the NCHS website. The ICD-10-CM is a morbidity classification published by the United States for classifying diagnoses and reason for visits in all health care settings. The ICD-10-CM is based on the ICD-10, the statistical classification of disease published by the World Health Organization (WHO).

These guidelines have been approved by the four organizations that make up the Cooperating Parties for the ICD-10-CM: the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), CMS, and NCHS.

Physician's Role

Risk adjustment is an important process that allows the State and Federal government to appropriately allocate revenue to health plans for the high risk members enrolled.

- ❑ Physician data (coding information submitted on physician claims) is critical for accurate risk adjustment.
- ❑ Physician claims data is the largest source of medical data for the risk adjustment models which help to determine how resources are allotted for care of the population.
- ❑ Specificity of diagnosis coding is substantiated by the medical record. Accurate coding helps to best reflect the cost of caring for members/patients:
  - ✓ It demonstrates the level of complexity for the patient encounters.
  - ✓ It is vital to a healthy revenue cycle, and more important, to a healthy patient.
- ❑ Each progress note must:
  - ✓ Support what is coded and billed (ICD-10-CM, CPT, and HCPCS).
  - ✓ "Stand alone" making sure a single service date has proficient data to support the medical decision making.
  - ✓ Be complete and contain legible signature & credentials.
  - ✓ Show medical necessity.

"Document for others as you would want them to document for you."