

# Coding and Documentation Guide: Cancer

Accurate coding and documentation are fundamental to the risk adjustment process and crucial to representing each patient’s complex health profile. Bright HealthCare’s coding and documentation guides equip coders and medical staff with the information needed to support complete and accurate coding and documentation.

## Documentation best practices

- Documentation must be provided. Coders cannot assume diagnoses exist based on medication lists or physician orders.
- All conditions that coexist at the time of the encounter, and require or affect patient care, treatment, or management should be documented and coded.
- Coders cannot code current conditions from problem lists, medical history, or superbills.
- Documentation should clearly define cancer status (“active” or “history of”).
- Cancer metastasis and cancer-related complications should be clearly documented.
- Coders must verify clinical documentation for all diagnoses using the MEAT tool (monitor, evaluate, assess, treat). One or more MEAT detail is required for each condition requiring or affecting patient care.

Monitor	Evaluate	Assess	Treat
Symptoms Disease progression/ regression Ordering of tests Referencing labs/tests	Test results Medication effectiveness Response to treatment Physical exam findings	Test ordered Counseling Record review Discussion	Medication Therapies Referral Other modalities
<b>MEAT Examples: Cancer</b>			
Prostate cancer — Improved; continue monitoring with PSA.	Malignant neoplasm of lower-inner quadrant of right breast — Biopsy done on 9/4. Results show stage 2 breast cancer.	Malignant neoplasm of pancreas — Discussed palliative care options.	Malignant neoplasm of pancreas — Getting Lupron injections every 6 mo. Follows with urologist.

# Coding and documentation examples

## Case study #1: Complete documentation

**Gender:** M **DOB:** MM/DD/1958

### History of present illness

62 y.o. man with newly diagnosed rectal cancer, initially evaluated on 7/22/2021. Pt started continuous infusion 5-FU concurrent with radiation therapy on 8/4.

8/5/21 right inguinal node core biopsy: Metastatic carcinoma. Radiation field/plan is being modified by Dr. Y to include left inguinal node and add IMRT.

Pt is here for continuous infusion 5-FU, week 3. He is tolerating treatment well. He reports that rectal bleeding stopped for over 1 week. No abdominal pain, no diarrhea. Less trouble with bowel movements.

### Physical exam

VS: Temp 97.1, BP 120/68, pulse of 71, saturation 94% on room air. Weight 181 pounds.

General: The patient is pleasant, appears well.

HEENT: No scleral icterus, conjunctival injection. No oral lesions.

Neck: Supple. No lymph node enlargement.

Chest: Clear to auscultation. No rhonchi or wheezing.

Cardiovascular: Regular rate and rhythm; no murmur.

Abdomen: Soft, non-tender. No organomegaly.

Extremities: No edema.

Skin and lymphatics: No rash, bruises. 1.5 cm right inguinal node, deeply situated—not easily palpable today.

Neuro: Alert and oriented ×3.

Rectal: Large irregular mass felt at 2 cm from the anal verge anteriorly. No gross bleeding noted.

*Jane Doe, MD*

**Reason for visit is clearly documented.**

**Documentation includes MEAT details: disease progression, biopsy results, and physical exam findings.**

### Assessment & plan

1. Rectal cancer: Poorly differentiated adenocarcinoma, MMR normal. cT4N1 M1a, stage IVa. Biopsy-proven right inguinal lymph node metastasis.
2. Secondary metastatic inguinal lymph node cancer: He has advanced disease with extension to the external and internal iliac nodes. Inguinal lymph node metastasis is not regional lymph node and should be considered distant metastasis, M1a.

Neoadjuvant chemotherapy and radiation to the rectal area and inguinal nodes is planned with consideration of resection of the primary and inguinal lymph node dissection. Discussed neoadjuvant chemotherapy and radiation followed by neoadjuvant chemotherapy, then resection. FOLFOX or preferably FOLFOXIRI x8 will be considered after radiation depending on his PS. The latter is preferred for T4 lesions. Total neoadjuvant therapy will be followed by restaging and assessment for surgical resection and inguinal lymph node dissection. He preferred infusional 5-FU (rather than oral Xeloda) concurrent with radiation therapy. Started continuous infusion 5-FU concurrent with radiation on 8/4/21. Radiation therapy is modified to add IMRT to the inguinal nodes.

#### Plan:

- CBC, CMP today
- Continue neoadjuvant radiation therapy
- Week 3 continued infusion 5-FU to start today
- Plan on neo-adjuvant chemotherapy followed by surgery
- Follow-up in 2 weeks

*John Doe, MD*

**Assessment and plan clearly states patient has primary rectal cancer with secondary inguinal lymph node cancer.**

**Treatment for each site is clearly documented.**

**Documentation supports malignant neoplasm of rectum (C20) and secondary and unspecified malignant neoplasm of inguinal and lower limb lymph nodes (C77.4).**

## Case study #2: Incomplete documentation

**Gender:** F **DOB:** MM/DD/1962

Chief complaint: Thigh pain

### History of present illness

59-year-old female here for bilateral thigh tingling and numbness and right groin pain x 1 month. Pt also has cold and redness of bilateral hands w/o joint pain, swelling. Hands worse in winter. She is on aromasin oral chemo x 5 years after breast cancer treatment including bilateral mastectomy.

### Physical exam

Constitutional: Appearance – She is well-developed.

Eyes: General – Lids are normal.

Cardiovascular: Rate and rhythm – Normal rate and regular rhythm.

Heart sounds – S1 normal and S2 normal.

Pulmonary: Effort – Pulmonary effort is normal. Breath sounds – Normal breath sounds.

Musculoskeletal: Normal range of motion. Left hip – She exhibits normal range of motion, normal strength, no bony tenderness, no swelling and no deformity. Left groin pain. No swelling, pain with palpation. Valgas/vargas movements w/o pain. Flexion/extension w/o pain. Unable to replicate pain. Pt states pain is “deep” in groin.

Skin: General – Skin is warm and dry.

Neurological: Mental status – She is alert and oriented to person, place, and time. Numbness and tingling bilateral thighs. Clinical exam normal.

Psychiatric: Behavior – Behavior normal.

### Assessment & plan

- Left groin pain  
2017 to 2019 dexa imaging showing significant decrease in bone density, however still “normal”  
Will do x-ray of lumbar and groin  
H/o aggressive breast cancer
- Numbness and tingling of both legs  
Lumbar and hip x-ray today  
Pt is on exemestane x 5 years
- Malignant neoplasm of overlapping sites of right female breast (CMS/HCC)  
In remission. Stable x 5 years.  
On exemestane per oncology.  
F/u with breast specialist and oncology as scheduled.
- History of breast cancer in female  
Stable  
Currently on exemestane for prophylaxis.  
F/u with specialist/oncology as scheduled.

*Jane Doe, MD*

**Is breast cancer active or history of?**

**Documentation includes “in remission,” “history of,” and “currently on exemestane for prophylaxis.”**

**Documentation supports history of breast cancer in female (Z85.3).**

# Coding for cancer

## When can cancer be coded as “active”?

Cancer can be coded as “active” when documentation indicates any of the following:

- Patient is currently receiving treatment for cancer (includes “watchful waiting”).
- Patient has been diagnosed with cancer and is not undergoing treatment.

## When does active cancer become “history of”?

Cancer should be coded as “history of” when documentation indicates:

- The primary malignancy has been excised or eradicated; and
- No further treatment is directed to the site; and
- There is no evidence of an existing malignancy.

If the treatment is preventive or prophylactic, in most instances, the correct code to report would be a personal “history of” cancer rather than an active code.

Example: Patient has history of breast cancer. Below is the correct coding for this patient:

Z85.3	Personal history of malignant neoplasm of breast
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## Metastatic cancer

Cancer is described as primary or secondary (metastatic). A primary cancer refers to the original site or point of origin of the malignancy. A secondary cancer refers to the site or sites where the malignancy has spread (metastasis). Documentation should clearly describe any metastasis and call out the primary and secondary sites. Both the primary and secondary cancer should be coded.

Example: Patient has primary prostate cancer that has metastasized to the bones. Below is the correct coding for this patient:

C61	Malignant neoplasm of prostate
C79.51	Secondary malignant neoplasm of bone

## Cancer complications

Conditions related to cancer and complications of care should be clearly documented and linked to the cancer. For example:

- Anemia due to adenocarcinoma of the colon
- Diabetes mellitus secondary to pancreatic carcinoma
- Pathological fracture resulting from metastatic stage 4 ovarian carcinoma

# Clinical indicators

Familiarity with clinical cancer indicators (i.e., testing, treatment, medication, etc.) is helpful in recognizing the potential presence and severity of a condition. **Coders cannot assign diagnosis codes based solely on test results and medication lists**, but these clinical indicators can help highlight opportunities for more complete and accurate documentation.

## Common tests used to diagnose cancer

Test	Purpose
Laboratory body fluid and blood tests	These tests help identify abnormalities that can be caused by cancer.
Imaging tests	Imaging tests allow providers to examine a patient's bones and internal organs in a noninvasive way. Imaging tests used in diagnosing and monitoring cancer may include a computerized tomography (CT) scan, bone scan, magnetic resonance imaging (MRI), positron emission tomography (PET) scan, ultrasound, and x-ray.
Biopsy	During a biopsy, a provider collects a sample of cells for testing in the laboratory. In most situations, a biopsy is the only way to diagnose cancer definitively.

## Goals of cancer treatment

Treatment	Goal
Primary treatment	The goal of a primary treatment is to completely remove cancer from the body or kill the cancer cells. Any cancer treatment can be used as a primary treatment, but the most common primary cancer treatment for the most common cancers is surgery. If a cancer is susceptible to radiation therapy or chemotherapy, these methods may be used as the primary treatment.
Adjuvant treatment	Adjuvant therapy aims to kill any cancer cells that may remain after primary treatment to reduce the cancer's chance of reoccurrence. Any cancer treatment can be used as adjuvant therapy. Common adjuvant therapies include chemotherapy, radiation therapy, and hormone therapy.
Palliative treatment	Palliative treatments may relieve side effects of treatment or signs and symptoms caused by cancer itself. Surgery, radiation, chemotherapy, and hormone therapy can all be used to alleviate symptoms and control the spread of cancer when a cure isn't possible. Medications may relieve symptoms such as pain and shortness of breath. Palliative treatment can be used at the same time as other treatments intended to cure the cancer.

## Cancer treatment options

Treatment	Purpose
Surgery	The goal of surgery is to remove the cancer or as much of the cancer as possible.
Chemotherapy	Chemotherapy uses drugs to kill cancer cells.
Radiation therapy	Radiation therapy uses high-powered energy beams, such as x-rays and protons, to kill cancer cells. Radiation treatment can come from a machine outside the body (external beam radiation) or placed inside the body (brachytherapy).
Bone marrow transplant	Bone marrow transplant is also known as a stem cell transplant. A bone marrow transplant can use the patient's own cells or cells from a donor to replace damaged or diseased bone marrow.
Immunotherapy	Immunotherapy, also known as biological therapy, uses the body's immune system to fight cancer. Cancer can survive unchecked in the body because the immune system doesn't recognize it as an intruder. Immunotherapy can help the immune system "see" cancer and attack it.
Hormone therapy	The body's hormones fuel some types of cancer. Examples include breast cancer and prostate cancer. Removing those hormones from the body or blocking their effects may cause the cancer cells to stop growing.
Targeted drug therapy	Targeted drug treatment focuses on specific abnormalities within cancer cells that allow them to survive.