

Radiation/Oncology Shrinking the Risk

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Learning Objectives

- Explain what radiation oncology is and when it is used
- Discuss the steps of treatment and how to code for each step
- Identify the major types of radiation oncology delivery and indicate the use of each
 - External Beam or Teletherapy
 - Brachytherapy
 - Radionuclide or radioisotope therapy
- Integrating diagnosis coding and medical necessity into the reporting process

What is Radiation Oncology?

- Use of high energy radiation to shrink or kill tumors or cancer cells with a goal to kill cancerous cells by damaging their DNA while minimizing the harmful effects to healthy surrounding cells
- Radiation therapy can be used alone or in combination with chemotherapy and/or surgery
- Three reasons to administer:
 - Curative – hopes to cure the cancer by eliminating the tumor, prevent reoccurrence, or both
 - Palliative - relieve or reduce symptoms but not cure
 - Tumor control

Types of Radiation Oncology

- Three types
 - External beam – delivered from outside the body
 - Internally - brachytherapy
 - Systemic – through the blood

Supervision

- General
- Direct

ASTRO White Paper:

https://www.astro.org/uploadedFiles/Main_Site/Practice_Management/Reimbursement/Medicare/SV_ReqsUpdate6211.pdf

Steps for Radiation Therapy

- Initial Patient exam (99201-99215, 99241-99255)
- Simulation (77280-77295)
- Clinical Treatment Planning (77261-77263)
- Dosimetry (77300-77331)
- Treatment devices (77332-77334 and 77338)
- Medical/Radiation Physics consultation (77336 or 77370)
- Treatment delivery (77371-77373 or 77401-77425)

Tumor Stage vs. Tumor Grade

- Stage – extent or severity based upon primary tumor, size, number and lymph node involvement
- Histological Grade - used to classify cancer cells by how abnormal they appear and the rate with which they grow and spread

GX	undetermined grade
G1	well differentiated (low grade)
G2	moderately differentiated (intermediate grade)
G3	poorly differentiated (high grade)
G4	undifferentiated (high grade)

Cancer Staging

- Once a provider determines the TNM, he/she can assign a staging level.
- Staging describes the severity of the patient's cancer and helps the physician determine treatment and prognosis
- TNM (tumor, nodes, metastasis) – staging system for most but not all cancers

Primary Tumor (T)

TX	Primary tumor cannot be evaluated
T0	No evidence of primary tumor
Tis	Carcinoma in situ (CIS; abnormal cells are present but have not spread to neighboring tissue; although not cancer, CIS may become cancer and is sometimes called preinvasive cancer)
T1, T2, T3, T4	Size and/or extent of the primary tumor

Regional Lymph Nodes (N)

NX	Regional lymph nodes cannot be evaluated
N0	No regional lymph node involvement
N1, N2, N3	Involvement of regional lymph nodes (number of lymph nodes and/or extent of spread)

Distant Metastasis (M)

MX	Distant metastasis cannot be evaluated
M0	No distant metastasis
M1, M2, M3	Distant metastasis is present

Cancer Staging (cont.)

- Stages 0- IV – describes most cancers however some cancers are not staged

Stage	Definition
Stage 0	Carcinoma in situ.
Stage I, Stage II, and Stage III	Higher numbers indicate more extensive disease: Larger tumor size and/or spread of the cancer beyond the organ in which it first developed to nearby lymph nodes and/or organs adjacent to the location of the primary tumor.
Stage IV	The cancer has spread to another organ(s).

Definitions

- **Volume of interest** – common phrase used by radiation oncologist to mean the volume within the body to which the radiation will be directed
- **Treatment volume** – (used by CPT) means same as volume of interest but a less common term by radiation oncologists
- **Block** – a fabricated energy absorbing device used to shape or delineate the treatment portal to match the desired area of treatment and protect normal structures
- **Port or portal** – used to indicate the site on the site where the radiation beam will enter the body
 - Single
 - Simple parallel opposed
 - Converging
 - Tangential

Documentation Requirements for Radiation Therapy

- Documentation must include the planned course, type and delivery of treatment as well as the level of clinical management needed and documentation of any changes to the plan during the treatment course.
- Documentation must be legible, timely, in compliance with regulatory agencies, reviewed for errors and signed or authenticated to ensure confidentiality and security.

Initial Evaluation

- Per CPT, preliminary consultation, evaluation of patient prior to decision to treat, or full medical care when provided by the therapeutic radiologist may be reported using appropriate E&M code (99201-99215; 99241-99255)
- Bear in mind that Medicare views the medical necessity for the service to be the overarching criterion for payment of the service in addition to the individual requirements to meet the level of CPT code billed.

Next Step - Simulation

- Crucial step in treatment planning process
- Simulation is performed prior to beginning radiation therapy to determine the extent and location of the ports (the area where the radiation will enter the skin and concentration on the malignancy)
- Allows Radiation Oncologist to precisely outline the body area that needs treatment and allows Medical Physicist and Dosimetrists to calculate patient's treatment plan
- Simulation can be performed on a dedicated simulator, a radiation therapy treatment unit or diagnostic X-ray machine

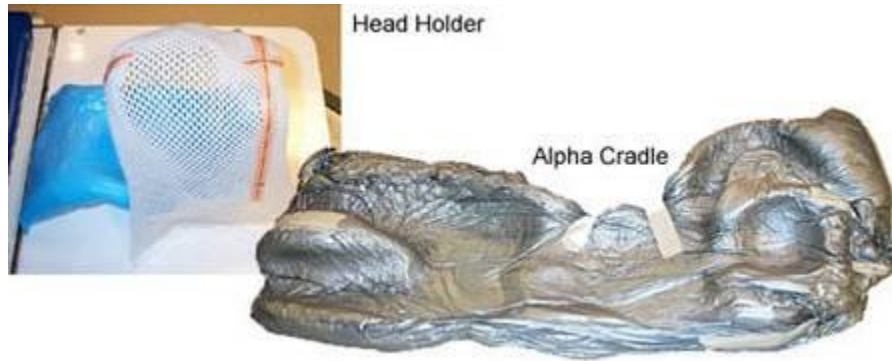
Simulation

- Usually only need one simulation however additional simulations maybe necessary during the course of treatment if changes are made to the treatment plan
- Simulation may be reported more than one time during a course of therapy, but only once per day

Immobilization Assistive Devices

- A thermoplastic or foam mold (a cradle) is created to support the patient's head, neck, back, pelvis, and thighs. This cradle ensures accurate positioning over the course of the radiation treatments.
- Once immobilization devices are in place, images and x-rays are taken
- Next the treatment area is marked on the patient's skin using the x-rays as a guide. These marks are used as a temporary map of the treatment areas. These temporary marks are replaced with tiny tattooed dots after a few treatment sessions.

Immobilization Devices



Bite Block for Frameless Stereotactic Radiosurgery



Bite Block with Attached Infrared Fiducial Array



PET-CT Simulator



Tattooing



Simulation Documentation

- Documentation requirements:
 - Written record of the procedure
 - Hard copy of electronic images
 - Reason for simulation (initial, block check, etc.)
 - Summary of procedure including patient position, identification of field location and critical structures blocked or considered
 - Description of any immobilization designed and/or customized
 - Summarize fluoroscopy and contrast used
 - Evidence of image review by the physician, including:
 - Signature or initials
 - Date of review

Simulation Code Selection

- Select the code for the most complex level if multiple simulations are performed on the same day
- 77280 – simple
- 77285 – intermediate
- 77290 – complex
- 77295 – 3-D

Simulation

77280

- Therapeutic radiology simulation-aided field setting; simple
 - Single treatment area
 - Single port or parallel opposed ports
 - Simple or no blocking

Simulation

77285

- Therapeutic radiology simulation-aided field setting; intermediate
 - 3 or more converging ports
 - 2 separate treatment areas
 - Multiple blocks

Simulation

77290

- Therapeutic radiology simulation-aided field setting; complex
 - Tangential portals
 - Three or more treatment areas
 - Rotation or arc therapy
 - Complex blocking
 - Custom shielding blocks
 - Brachytherapy source verification
 - Hyperthermia probe verification
 - Use of contrast material

Simulation

77295

- Therapeutic radiology simulation-aided field setting; 3D
 - Teletherapy isodose plans on the same date
 - Simulations performed on the same date
 - The generation of dose volume histograms (DVHs)
 - Images or sequences by CT or MRI and the downloading or transferring of the images to the treatment planning software
 - Documented BEV analysis for conformal treatment
 - Virtual simulation, digital 3D volume reconstruction and dose distribution
- The documentation generated by the 3-D software should be signed and dated (paper or electronic signature) by the radiation oncologist and maintained in the patient chart

Simulation – Key Points

- Complexity is based on:
 - Number of ports
 - Volumes of interest
 - The inclusion/type of treatment devices
- Complexity is NOT based on:
 - Number of films taken per treatment
 - Modality from which images are obtained
 - The use of fluoroscopy

Clinical Treatment Planning

- Clinical treatment planning is a professional service only and involves the radiation oncologist's cognitive planning process of all parameters required for a given course of radiation therapy.
- This complex process involves the following determinations:
 - Interpretation of special testing
 - Tumor localization
 - Treatment volume determination
 - Treatment time/dosage determination

Clinical Treatment Planning (cont.)

- Choice of treatment modality and sequencing
- Determination number and size of treatment ports
- Design and/or selection of treatment devices
- Other procedures

Treatment Planning Cont'd

- 77261 - simple
- 77262 - intermediate
- 77263 - complex
- These codes should be coded one time per course of therapy
- Documentation should indicate that the treatment goal is curative, palliative or tumor control

Treatment Planning Simple 77261

- Single treatment area of interest
- Single port or simple parallel opposed ports
- Simple or no blocking

Treatment Planning Intermediate

77262

- 3 or more converging ports
- 2 separate treatment area
- Multiple blocks
- Special time dose constraints

Treatment Planning Complex

77263

- High complexity blocking
- Custom shielding blocks
- Tangential ports
- Special wedges or compensators
- 3 or more separate treatment areas
- Rotational or special beam considerations
- Combination of therapeutic modalities

Basic Dosimetry Documentation

- Documentation requirements:
 - Each calculation should identify:
 - Reason for new calculations when repeated
 - Type of calculation
 - Medical necessity, such as abutting field, off-axis dose, or critical organ dose
 - Physician signature or initials on the dosimetry calculations. Note: Physician signature is in addition to the physicist's signature

Basic Dosimetry

- CPT code 77300
 - Hand or computer calculation of each port by medical physicist, dosimetrist or radiation therapist
 - May be reported for confirmations of estimated values from Isodose plans
 - Additional calculations, such as off-axis, gap or central axis depth dose, may be coded as 77300
 - Basic dosimetry calculations may be reported as many times as the calculations are performed when prescribed by the treating physician due to changes in treatment plan

Basic Dosimetry

- Basic Dosimetry includes:
 - Central axis depth dose
 - Time dose factor (TDF)
 - Nominal standard dose (NSD)
 - Gap calculation
 - Off-axis factor
 - Tissue inhomogeneity factors
 - Calculation of non-ionizing radiation surface and depth dose

Reporting Basic Dosimetry

- One unit of basic dosimetry is reported for each unique Monitor Unit (MU) calculation
 - Multiple control points are not charged as separate units of basic dosimetry when the fields are merged into a single MU calculation
 - Mirror image calculations completed for a pair of opposing ports are reported with one unit of 77300
- Typically reported once per port for standard external beam
- Any calculations retained in the record and not used should be clearly marked “not used” and should not be billed

Basic Dosimetry Professional Component

- The professional service for dosimetry, 77300-26, is used to recognize and report the physician's cognitive efforts in selecting and interpreting the results of the calculations, whether or not the physician was physically involved in these activities
- The medical record must include evidence the calculations were reviewed, approved, signed and dated by the physician and the medical physicist or the dosimetrist working under the supervision of the medical physicist
- Medical necessity for any repeat dosimetry must be clearly documented

Teletherapy Dosimetry

<p>CPT Code 77305 Simple Isodose Plan</p>	<p>One or two parallel opposed unmodified ports directed to a single area of interest Manual or computer calculations</p>
<p>CPT Code 77310 Intermediate Isodose Plan</p>	<p>Three or more treatment ports directed to a single area of interest</p>
<p>CPT Code 77315 Complex Isodose Plan</p>	<p>Mantle or inverted Y, tangential ports, the use of wedges, compensators, complex blocking, rotational beam, or special beam considerations. Typically five or more ports converging on a single area of interest</p>

Note: Only 1 teletherapy isodose plan may be reported for a given course of therapy to a specific treatment area.

Teletherapy Documentation

- Documentation requirements:
 - Physicist signature, if applicable, and date
 - Physician signature or initials on the approved, dated isodose plan
 - Each plan should identify:
 - Date of service
 - Medical necessity
 - Volume of interest
 - Location of tumor(s) treated and number/configuration of involved ports with each volume of interest

Special Dosimetry

<p>CPT Code 77321 Special Teletherapy Port Plan, hemibody, total body</p>	<p>Used when a plan for any special beam consideration is required (e.g., use of electrons as a portion of, or as the main modality for, treatment of a particular problem)</p>
<p>CPT Code 77331 Special Dosimetry</p>	<p>Reported when special radiation measuring and monitoring devices are used (e.g., thermoluminescent dosimeters (TLD), solid state diode probes).</p> <p>Report only when prescribed by the treating physician</p>

Special Dosimetry (cont.)

- Only the teletherapy plan that is selected by the physician and used for patient treatment may be billed
 - Any plans retained in the medical record, but not used for patient treatment should be clearly labeled as “not used”
- One plan per site per course of treatment
- If there are multiple non-contiguous treatment sites each isodose plan may be reported separately
- IMRT and 3D simulation/planning include all isodose plans created as part of the planning process
- Documentation consists of a printed or electronically archived isodose plan that has been signed and dated by the physician and the physicist or dosimetrist

Special Dosimetry Documentation

- Documentation requirements:
 - Each plan should identify:
 - Date of service
 - Procedural note identifying the direct participation of the radiation oncologist in the ordering, calibrating, etc. of the special beams and/or electrons
 - Medical necessity
 - Physicist and Radiation Oncologist signature

Treatment Devices



Treatment Devices

- Treatment devices are used for:
 - Shaping the energy beam
 - Immobilizing the patient
 - Shielding critical structures to ensure the beam only strikes the dose point
- Some types of treatment devices include:
 - Block
 - Compensator
 - Bolus
 - Wedge
 - Collimator
 - Immobilization devices
- Report only one time for the entire course of treatment regardless of the number of times the device is used

Treatment Devices: Simple

**CPT Code
77332**

Treatment
devices,
design and
construction,
simple

- Single block , simple bolus
- Usually pre-made or require no special fabrication
- Independent jaw motion or asymmetric collimation is reported as simple blocking
- Interstitial brachytherapy templates
- The physician must have documented involvement in the selection and place of the devices

Treatment Devices: Intermediate

CPT Code 77333

Treatment devices, design and construction, intermediate

- Multiple blocks, stents, bite blocks, special bolus
- Usually pre-made or require no special fabrication
- Standardized devices that are “customized” and re-used
- The physician must have documented involvement in the design, selection and placement of the devices

Treatment Devices: Complex

CPT Code 77334

Treatment
devices, design
and construction,
complex

- Irregular blocks, special shields, compensators, wedges, molds or casts
- Multi-leaf or dynamic collimator (beam shaping device attached to the treatment machine to form the initial configuration portal)
- Compensator (beam modifying device to reconfigure the beam intensity to match the irregular tissue contours)
- Immobilization devices (alpha cradle or foam cast, aquaplast or thermoplastic device)
- The physician must have documented involvement in the design, selection and placement of the devices

Treatment Devices: IMRT Multi-leaf Collimations

CPT Code 77338

Multi-leaf collimator (MLC) device(s) for Intensity Modulated Radiation Therapy, design and construction per IMRT plan

- Immobilization devices for patients receiving IMRT
- Reported one time with one unit per IMRT planning service
 - If a cone-down boost plan requires a new set of MLC devices, 77338 may be reported a second time

Treatment Device Reminders

- Only one restraining device may be reported for each volume of interest treated
 - The use of passive restraints (e.g., straps, pillows, sandbags, etc.) should not be coded
- If beam modification devices of two separate levels of complexity are utilized for the same treatment port, only the one for the highest complexity should be billed UNLESS each device has been custom-designed for that portal

External Beam

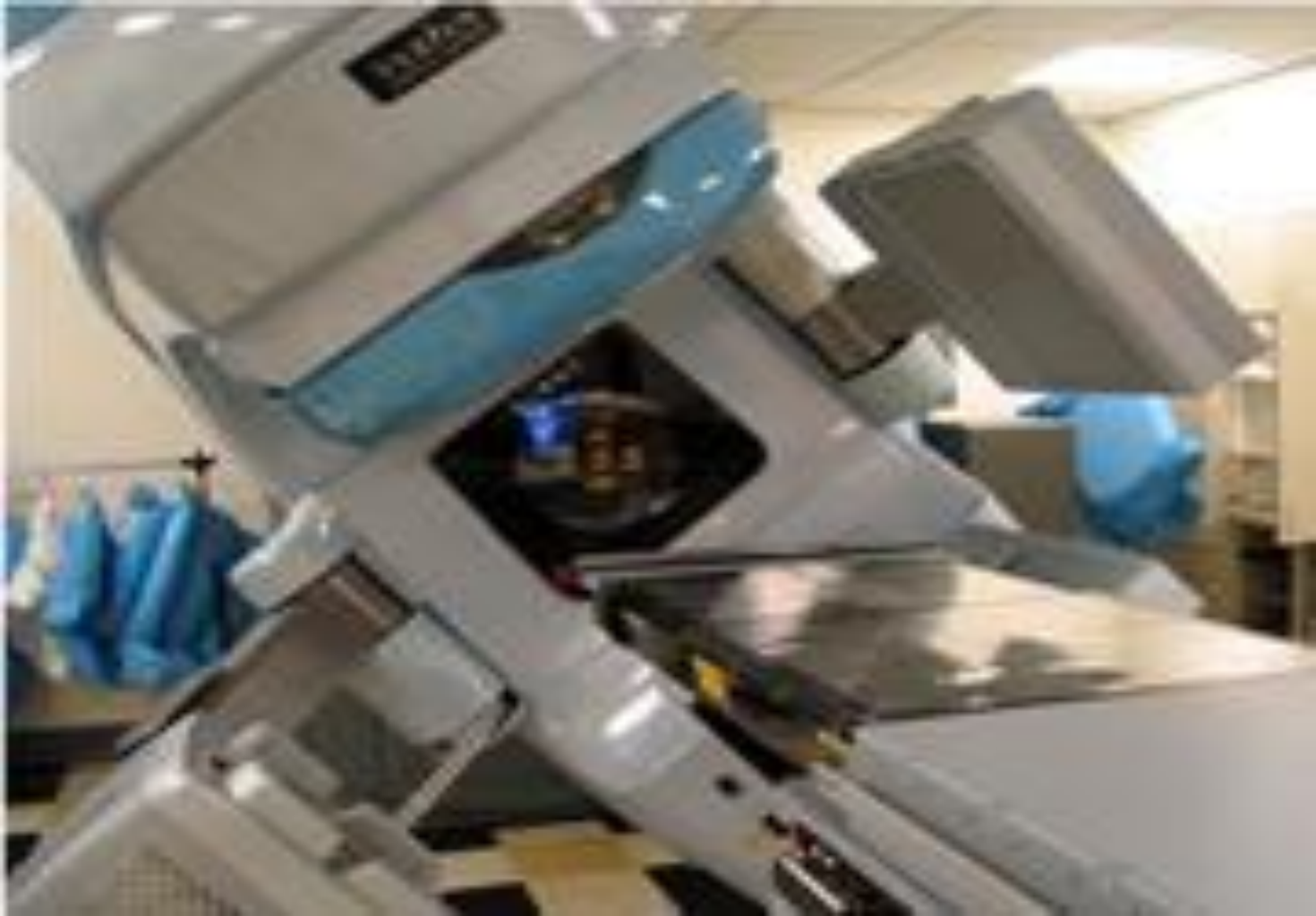
- Also called teletherapy
- Most external beam therapy administered via use of a linear accelerator (LINAC)
- The LINAC uses electricity to generate fast moving subatomic particles thereby creating high energy radiation.
- Several types of external beams:
 - 3-D CRT (Conformal Radiation Therapy)
 - IMRT (Intensity Modulated Radiotherapy)
 - IGRT (Image Guided Radiation Therapy)
 - SRS (Stereotactic Radiosurgery)
 - SBRT (Stereotactic Body Radiotherapy)

3D-CRT

(3-D Conformal Radiation Therapy)

- 3-D CRT is the most common external beam treatment used to delivery radiation to a very specific targeted area

Varion Trilogy Linear Accelerator



IMRT (Intensity Modulated Radiation Therapy)

- IMRT uses hundreds of tiny radiation devices called collimators to deliver a single dose of radiation. Collimators can remain still or move during treatment. This movement allows dose modulation where different parts of the tumor and surrounding tissue receive different amounts of radiation

IGRT

(Image Guided Radiation Therapy)

- IGRT uses repeated CT scans during treatment to identify changes in the tumor size and location thereby allowing for patient repositioning and planned radiation dose to be adjusted during the treatment.

SRS

(Stereotatic Radiosurgery)

- SRS are used on small tumors with well defined edges such as brain tumors
- The patient is placed in a head frame or other device to ensure patient immobility during treatment to ensure accurate delivery of the high dose of radiation
- SRS uses image guided tumor targeting and patient positioning to deliver a high dose of radiation without excess damage to normal tissues
- These tumors are usually inaccessible or unsuitable for open surgery

SBRT

(Stereotactic Body Radiotherapy)

- SBRT is used to treat tumors outside of the brain and spinal cord
- SBRT systems are often referred to by their brand name such as Cyber knife

HDR Brachytherapy Machine



Brachytherapy

- Radiation source that is in contact with or implanted into the tumor for a specified period of time
- Low Dose Rate (LDR)
 - Temporary placement of radioactive source usually from a few minutes to a few hours before they are removed
 - Permanent implantation of seeds involves placement of radioactive seeds which will decay over a few weeks or months and then remain after they are non-longer radioactive
- High Dose Rate (HDR)
 - Catheters are placed into a tumor
 - Catheter connected to a HDR afterloader
 - Radioactive iridium pellet is pushed by a computer into the catheter
 - Computer determines how long the pellet remains (dwell time) and where the pellet should pause to deliver radiation (dwell position)

Systemic

- Radionuclide or Radioisotope therapy
 - Given by mouth, by IV, by instillation

Radiation Treatment Management

- Radiation Treatment Management includes:
 - Review of port films
 - Review of dosimetry, dose delivery, treatment parameters
 - Review of patient treatment set-up
 - Examination of patient for medical evaluation and management (e.g., patient's response to treatment, coordination of care and treatment, review of imaging and/or lab test results)
 - Review/revision of treatment plan
 - Care of infected skin, ostomy site, symptom management
 - Recommendation regarding continuation/suspension/modification of treatment plan

Radiation Treatment Management (cont.)

ASTRO states, “Examination of the patient by the physician is necessary to assess the patient’s response to treatment on an ongoing and regular basis throughout the course of therapy. The patient expects and deserves face-to-face physician time, not only to manage the medical and technical aspects of their treatment, but also to receive the benefit of personal physician contact and emotional support as the patient deals with his/her life-threatening disease.”

“Nevertheless, the radiation oncologist is responsible for the integration of the four components , which requires the radiation oncologist to evaluate and examine the patient each week during the radiation therapy course. However, the required element that an attending physician see the patient and document that contact on a weekly basis is not abrogated. If, in a series of 5 treatments, the only documented clinical contact is with an NPP or resident, the weekly management charges cannot be entered.”

Radiation Treatment Management (cont.)

- Simulation may be carried out on a dedicated simulation, radiation therapy treatment unit, CT scanner, US equipment or diagnostic x-ray machine
- Photographs of patient position and blocking should be maintained to provide a graphic evidence of patient set-up, immobilization, blocking and other treatment parameters
- Simulation is always performed prior to the start of treatment delivery and may be repeated several times during the course of treatment due to the change in the size of the treatment field or when ports are added or changed

Radiation Treatment Management (cont.)

- Report only one treatment plan during the course of therapy. Do not code 77321 with 77305, 77310 or 77315, unless planning involves different volumes of interest
- Ordering and reviewing special tests are integral to treatment planning and should not be reported separately
- Follow-up visits for 90 days after treatment are not separately reported

Radiation Treatment Management (cont.)

- Radiation treatment management, 77427 consists of 5 Treatments
 - Count each fraction (treatment), even if multiple treatments are on the same day as long as there has been a distinct break in therapy sections
 - One or two fractions, beyond a multiple of five, at the end of a course of therapy should not be reported separately
 - Three or four fractions, beyond a multiple of five, at the end of a course should be reported with 77427
 - Services do not need to be furnished on consecutive days
- Radiation treatment management, 77431 consists of One or Two Fractions Only
 - Report if the complete course of therapy has been defined as requiring only 1 or 2 sessions
 - Do not use this code to report 1 or 2 fractions at the end of a long course of therapy

Radiation Treatment Management (cont.)

- Radiation treatment delivery is typically documented by daily entry for each therapy session
 - When there are multiple treatment sessions on the same day (BID or TID), the documentation should indicate that there was a distinct break between therapy applications
 - Modifier 76, repeat procedure, should be appended to the 2nd and subsequent treatment delivery sessions
- Treatment delivery is reported based on the level of complexity and the energy used
- The review of port films is included in the weekly treatment management charge
 - The RO must sign and date to indicate that the port films have been reviewed
 - Any changes to treatment parameters based on review of port films must be documented by the RO in the patient's medical record

Radiation Treatment Management (cont.)

- CPT Code 77470: Special Treatment Procedure covers additional physician effort required for special procedures such as:
 - Hyperfractionation (BID treatments)
 - Proton or neutron therapy used as the main course of therapy or as an adjunct to other types of radiation therapy treatments
 - Certain brachytherapy procedures
 - Concurrent hyperthermia
 - Total body or hemibody irradiation
 - Total skin electron irradiation
 - Combination radiation and chemotherapy regimen

Radiation Treatment Management (cont.)

- CPT Code 77470: Special Treatment Procedure covers additional physician effort required for special procedures such as:
 - Concurrent multiple site treatment
 - Per oral or transvaginal cone use
 - Managing other modalities in combination external beam therapy (e.g., brachytherapy, stereotactic radiosurgery, concurrent hyperthermia)
 - Any other special time consuming treatment plan
- This is reported in addition to complex treatment management. 77263, and is reported one time per course of therapy, even if there is more than one qualifier

Coding Neoplasms – Helpful Hints

- When a patient is scheduled for radiotherapy or chemotherapy, a V code (V58.0, V58.11) is used as the first listed or principal diagnosis
 - The code(s) for primary and secondary malignancy are used as additional codes

V58.0	Radiotherapy
V58.11	Antineoplastic Chemotherapy
V58.12	Antineoplastic immunotherapy

- For example, a patient with upper outer quadrant breast cancer undergoes radiation therapy, the encounter diagnoses should be:
 - Principal dx: V58.0, encounter for radiotherapy
 - Additional dx: 174.4, CA of upper outer quadrant of breast

Coding Neoplasms – Helpful Hints (cont.)

- When a malignancy reoccurs after having been previously removed or eradicated, and it reoccurs at the same site, it is still considered a primary malignancy of that site. For example,
 - 174.4 breast cancer, female, upper-outer quadrant
- If it reoccurs at a different site, then it would be considered a secondary malignant neoplasm and a V code from “History of..” is also used as a secondary diagnosis. For example,
 - 198.5 Metastatic CA of bone
 - V10.3 Personal history of breast cancer

Encounter for Metastatic Cancer

- When a patient encounter is due to a metastasis, the secondary (metastasis) cancer is designated as the principal diagnosis, even though the primary malignancy is still present
 - For example, A patient with primary prostate cancer with metastasis to the sacrum presents for radiation therapy where treatment is directed toward the bone only. Radiation therapy is the principal diagnosis; bone CA is secondary, prostate CA is tertiary.
 - Primary: V58.0 Radiotherapy
 - Secondary: 198.5 Bone, sacrum (Secondary CA)
 - Additional diagnosis: 185 Prostate CA (Primary CA)

Personal History of Malignant Neoplasm

- When a primary cancer has been previously excised or eradicated from its site AND there is no further treatment directed to that site AND there is no evidence of any existing primary malignancy, a personal history ICD-9 code should be assigned (V10 codes)
 - For example, Patient was three years post-mastectomy. No further treatment directed to site
 - V10.3 Personal Hx Breast Ca

Personal History of Malignant Neoplasm

- Any mention of extension, invasion or metastasis to another site is coded as a secondary malignant neoplasm to that site
 - For example, Same patient as previous slide with a history of breast cancer, now seen two years later with metastasis to axillary lymph node
 - 196.3 Secondary CA, lymph node, axilla
 - V10.3 Personal Hx Breast Ca

Personal History of Malignant Neoplasm

- History of Cancer
 - To be coded to a “history of CA”, **all** of the following must be met:
 1. Neoplasm excised or eradicated
 2. No evidence of disease (NED)
 3. No further treatment (no hormone therapy, no drugs, etc.)
 4. No evidence of recurrence at primary site

Active Cancer

- Active Cancer – It is the physician's clinical decision to determine if the cancer is present or not
 - From a coding perspective, cancers are considered active when there is documentation by the physician of:
 1. Evidence of disease
 2. Active treatment (drug, radiation therapy, chemotherapy)
 3. Watchful waiting (observation of disease that is present)

Active Cancer

- Lymphoma, Leukemia, and Multiple Myeloma – These conditions, when in remission, are still coded as active cancers
 - For example, Do not code personal history (V code) if any of these cancers are in remission
 - 204.10 Chronic lymphoid leukemia, without having achieved remission
 - 204.11 Chronic lymphoid leukemia in remission
 - 204.12 Chronic lymphoid leukemia, in relapse

New diagnosis of CA in Patient with History

- When a patient who has had a previous primary carcinoma that has been excised or eradicated develops a new primary carcinoma (not a metastasis), then the new primary site should be reported as the principal diagnosis. A code from category V10, personal history of malignant neoplasm, should be used as a secondary diagnosis
 - For example: the encounter diagnoses for a patient who has lung cancer and history of breast cancer should be reported as:
 - 162.9 CA of lung
 - V10.3 Personal history of malignant neoplasm of breast

Case Study – New Diagnosis of CA

ASSESSMENT: 13 year old female with cT3 (base of skull) N3b (supraclavicular adenopathy) ?M1 (possible left clavicle involvement)(poorly differentiated carcinoma, nasopharyngeal type, EBER positive. Tumor involves the left nasopharynx, fossa of Rosenmeuller, bony extension into the clivus, left pterygoid body, left petrous apex, left occipital condyle and left lateral mass of C1, and effacement of plane below foramen ovale. Left neck adenopathy is clinically almost 15 cm in superior/inferior dimension. KPS 90

ICD-9-CM: 147.8 Malignant neoplasm of nasopharynx, contiguous sites

PLAN: The patient has a locally advanced, possibly metastatic nasopharyngeal cancer. We explained that NP cancers are rare in children.. The patient and her parents have agreed to enroll on ARAR0331 Protocol. This protocol involves 3 cycles of induction chemotherapy with cisplatin and 5-FU followed by concurrent cisplatin + radiation therapy with amifostine. We explained that the effect on the pediatric population is not well studied. The goal is to induce remission. Sides effects of treatment were explained in detail. The patient, mother and father had the opportunity to ask questions. Patient will begin chemo tomorrow and will return at the end of her 3rd cycle of chemo, approximately early February

Case Study New Diagnosis of Ca with History

- Patient presents with diagnosis of Metastatic CA of the bone; previous history of CA of breast (areola), 4 years ago s/p mastectomy and chemotherapy, currently on Tamoxifen
- ICD-9-CM Coding:
 - (P)198.5 CA of bone
 - 174.0 CA of breast (reported as current disease as pt is still under treatment with Tamoxifen)

Case Study New Diagnosis of Ca with History

- Patient presents with diagnosis of Metastatic CA of the bone; previous history of CA of breast (areola), 4 years ago s/p mastectomy and chemotherapy, no current therapy
- ICD-9-CM Coding:
 - (P)198.5 CA of bone
 - V10.3 Hx of CA of breast (reported as history of CA of breast as there is no current/active treatment at this time)

Encounter for Radiation Therapy w/Complications

- The patient is seen by the Radiation Oncologist during treatment for a primary malignancy of the upper outer breast. Patient is also complaining of redness of skin due to radiation application and nausea. The oncologist prescribes cream for the skin irritation and anti-nausea medication.
- Assessment:
 - (P) Encounter for radiation therapy V58.0
 - Breast cancer, upper outer quadrant 174.4
 - Nausea 787.02
 - Erythema secondary to radiation 942.11
 - Effects of radiation therapy 990

QUESTIONS?



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Resources

- <http://www.cancer.gov/cancertopics/factsheet/detection/tumor-grade>
- <http://www.cancer.gov/cancertopics/factsheet/detection/staging>
- <http://www.cancer.gov/cancertopics/factsheet/Therapy/radiation>
- <http://radonc.ucsd.edu/patient-info/Pages/what-to-expect.aspx>
- <http://www.aldermed.com/information/rt-services.pdf> **(Trailblazer Health Enterprises Radiation Therapy Services)**
- CSI Navigator for Radiation Oncology 2012 edition