



Breast cancer – Neoplasms addendum No. 1

ICD-10-CM

Best documentation practices for physicians

Current versus historical breast cancer

- Do not use the phrase “history of” to describe a current primary breast cancer. In diagnosis coding, “history of” means the condition is historical and no longer exists as a current problem.
- In the final impression, do not document a simple statement of “breast cancer” to describe a historical primary breast cancer that was previously excised or eradicated and for which there is:
 - No active treatment; and
 - No evidence of disease or recurrence.

In this scenario, it is appropriate to document “history of breast cancer,” along with details of past diagnosis and treatment.

Breast cancer site(s) – primary and secondary

Document whether current breast cancer is primary, secondary or in situ. Also document:

- Laterality (right or left)
- The specific site of primary cancer, including the location within the breast (areola, nipple, upper outer quadrant, central portion, etc.)
- The specific secondary site(s)

Treatment plan

- Document a clear and concise plan of care.
- Clearly indicate whether current therapy represents:
 - Active treatment of current breast cancer; *versus*
 - Palliative treatment of current breast cancer; *versus*
 - Surveillance of a historical breast cancer to monitor for recurrence
- When adjuvant therapy is used, clearly state its purpose (whether the goal of adjuvant therapy is curative, palliative or preventive).
- If referrals are made or consultations requested, indicate to whom or where the referral is made or from whom consultation advice is requested.
- Document when the patient is to be seen again.

Adjuvant therapy for breast cancer

Adjuvant treatment is additional treatment given after the primary treatment has been completed to:

- Destroy any remaining cancer cells that may be undetectable and/or
- Lower the risk that the cancer will come back.

Adjuvant treatment may include chemotherapy, radiation therapy, hormone therapy, targeted therapy or biological therapy. Examples of drugs used as adjuvant therapy for breast cancer include Tamoxifen, Arimidex, Faslodex, and Femara.

Document the purpose of adjuvant treatment of breast cancer in each individual case, i.e., whether it is:

- **Curative** – given to cure breast cancer
- **Palliative** – given to relieve the symptoms and reduce the suffering caused by breast cancer without affecting a cure
- **Prophylactic/preventive** – given to keep breast cancer from recurring in a person who has completed treatment for breast cancer that is now historical.

Electronic health record (EHR) issues

Unspecified codes with descriptions:

Some electronic health records insert ICD-10-CM code descriptions into the medical record to represent the final diagnosis. Examples:

C50.919 Malignant neoplasm of unspecified site of unspecified female breast

Unspecified diagnosis descriptions should be used only when sufficient clinical information is not known or available to the provider at the time of the encounter.

Mismatch between final diagnosis and EHR-inserted diagnosis code with description:

Another scenario that causes confusion is one in which the assessment section of an office note documents a provider-stated diagnosis *PLUS* an EHR-inserted diagnosis code with description that does not match or may even contradict the stated diagnosis. Example:

Assessment: Right breast cancer, upper outer quadrant
C50.811 Malignant neoplasm of overlapping sites of right female breast



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Here the final diagnosis **in bold** in the Assessment – “Right breast cancer, upper outer quadrant” – codes to **C50.411**, Malignant neoplasm of upper-outer quadrant of right female breast. The EHR-inserted diagnosis code with description that appears just below the final diagnosis is C50.811, Malignant neoplasm of overlapping sites of right female breast. This leads to confusion regarding which diagnosis is correct and which should be reported. Documentation elsewhere in the record does not always provide clarity.

To avoid confusion and ensure accurate diagnosis code assignment, the provider’s final diagnosis must either

- a) match the code with description; OR
- b) it must classify in ICD-10-CM to the EHR-inserted diagnosis code with description.

Note: ICD-10-CM is a statistical classification; it is not a substitute for a healthcare provider’s final diagnostic statement. It is the healthcare provider’s responsibility to provide legible, clear, concise and complete documentation of each final diagnosis described to the highest level of specificity, which is then translated to a code for reporting purposes. It is not appropriate for healthcare providers to simply list a code number or select a code number from a list of codes in place of a written final diagnosis.



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Tips and resources for coders

Category C50, Malignant neoplasm of breast

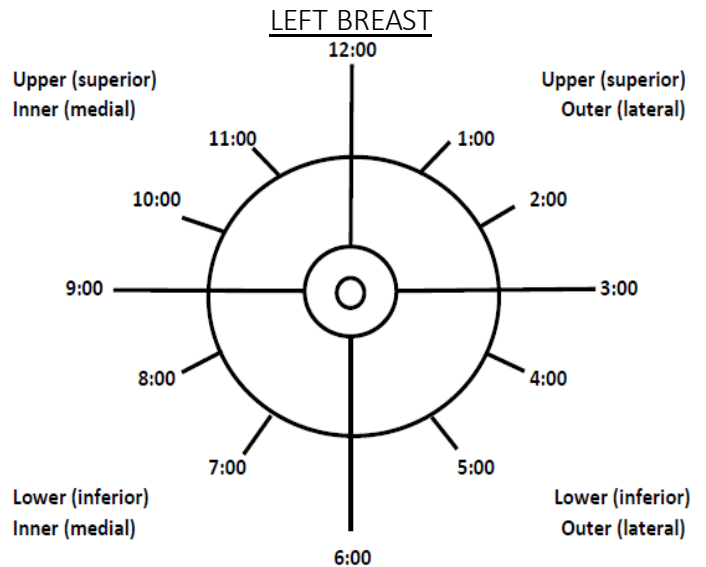
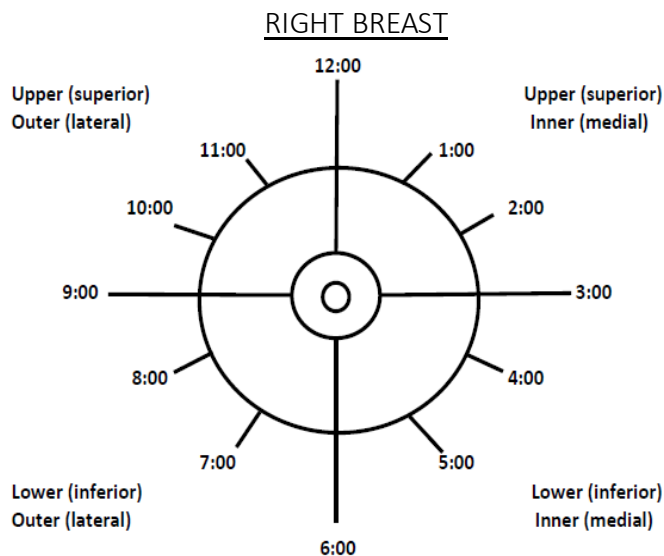
- **Includes:** connective tissue of the breast; Paget’s disease of the breast; Paget’s disease of the nipple
- **Excludes1:** skin of the breast (C44.501, C44.511, C44.521, C44.591)
- Use an additional code to identify estrogen receptor status (Z17.0, Z17.1).
- Fifth and sixth characters are required to specify location, gender and laterality.

Coding the breast cancer site

Always code breast cancer with the highest level of specificity. Carefully review the medical record documentation, noting the particular site of cancer within the breast.

Sometimes physicians and other healthcare providers describe the site of breast cancer as positions on a clock. In those cases, the following illustrations of breast cancer quadrants and “clock” positions can be used to assist in code selection.

Breast cancer quadrants and “clock” positions



Malignant neoplasm of overlapping sites within the breast classifies to subcategory C50.8- with fifth and sixth characters to specify gender and laterality. Subcategory C50.8 includes (but is not limited to) the following:

- 12:00 6:00
- 3:00 9:00
- Midline of breast

Coding breast cancer as current

In general, code breast cancer as current when the medical record clearly documents active breast cancer that is receiving current active treatment (which in some cases may include adjuvant treatment in accordance with the guidelines noted on page 1); and/or when the record clearly shows breast cancer is still present but:

- It is unresponsive to treatment;
- The current treatment plan is observation only or “watchful waiting;” or
- The patient has refused further treatment.



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Coding breast cancer as historical

Breast cancer is coded as historical (Z85.3) after the breast cancer has been excised or eradicated, there is no active treatment directed to the breast cancer and there is currently no evidence of disease or recurrence.

Encounter for follow-up examination after treatment for malignant neoplasm has been completed is coded as Z08. This code includes medical surveillance following completed treatment (i.e., monitoring for cancer recurrence) and **Excludes1** aftercare following medical care (Z43 – Z49, Z51). Code Z08 advises to use an additional code to identify any acquired absence of organs (Z90.-) and personal history of malignant neoplasm (Z85.-).

References: ICD-10-CM Official Guidelines for Coding and Reporting; Mayo Clinic; MedlinePlus; National Cancer Institute