Prostate cancer – Neoplasms addendum No. 2

ICD-10-CM

Best documentation practices for physicians

American Cancer Society and other resources

- The American Cancer Society website provides in-depth information about prostate cancer, including but not limited to, causes, risk factors and prevention; early detection, diagnosis and staging; and treatment. https://www.cancer.org/cancer/prostate-cancer.html
- There are many other respected sources for prostate cancer information. See the references section at the end of this guideline.

Prostate-specific antigen (PSA)

- PSA is a protein produced by cells of the prostate gland that often is elevated in men with prostate cancer. The PSA laboratory test measures the level of PSA in a man's blood. PSA testing often is used with a digital rectal examination of the prostate gland to screen for prostate cancer. Other noncancerous conditions, however, can cause an elevated PSA, for example, inflammation or enlargement of the prostate gland.
- Generally, a PSA level of 4.0 ng/mL or less is considered normal. Recent studies have shown, however, that some men with PSA levels below 4.0 have prostate cancer, while other men with higher levels do not have prostate cancer. There are various causes of fluctuations in PSA levels, but generally the higher the PSA level, the more likely the diagnosis of prostate cancer. A continuous rise in PSA level over time may be a sign of prostate cancer.

Prostate cancer treatment options

- Watchful waiting and active surveillance
- Surgical removal of the prostate (prostatectomy)
- Cryosurgery (freezing cancer cells with cold metal probes)
- Chemotherapy
- Hormonal therapy
- External radiation
- Internal radiation (radioactive seed implantation)

Hormone therapy for prostate cancer

Most prostate cancer cells rely on testosterone to help them grow. Hormone therapy (also known as androgen deprivation therapy [ADT] or androgen suppression therapy) stops the body from producing testosterone or stops testosterone from reaching prostate cancer cells, which often makes prostate cancers shrink or grow more slowly for a time.

Hormone therapy alone, however, does not cure prostate cancer. Hormone therapy includes:

- **Orchiectomy** (surgical castration) – Surgical removal of the testicles, which reduces testosterone levels in the body quickly and significantly. This option is permanent and irreversible.
- **Drug therapy** (sometimes called chemical or medical castration)
  - **Luteinizing hormone-releasing hormone (LHRH) agonists and antagonists** – Medications that stop the body from producing testosterone.
    - LHRH agonist examples: Lupron, Eligard, Zoladex, Trelstar, Vantas
    - LHRH antagonist examples: Firmagon, Zytiga
  - **Anti-androgens** – Medications that block testosterone from reaching prostate cancer cells. They are usually given in conjunction with LHRH agonists, as LHRH agonists can cause a temporary increase in testosterone before levels decrease. Anti-androgen examples: Eulexin, Casodex, Nilandron, Xtandi
  - **Other medications** – When prostate cancer persists or recurs despite hormone therapy, other medications can be used to block testosterone in the body. Each medication targets testosterone in the body in a different way. Examples include corticosteroids such as prednisone and the anti-fungal drug ketoconazole.

Radioactive seed implantation

Radiation therapy for prostate cancer using implanted radioactive seeds is called brachytherapy. There are two types of brachytherapy:

- Permanent: Implanted seeds are left in place, but they become inert (no longer release radiation) after a period of weeks or months.
- Temporary: Seeds are implanted and left in place for about 30 minutes; the seeds and radioactive material then are removed.

The general consensus among respected sources is that, with permanent brachytherapy, the radioactive seeds are completely inactive in a year or less, and the cure rates are as effective as radical prostatectomy and external radiation.

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Overview

Documentation and coding of prostate cancer presents a special challenge, since most cases of prostate cancer are slow-growing and can be observed and monitored for many years with no active treatment. This situation may lead to vague documentation that in turn may lead to erroneous ICD-10-CM coding.

Current versus historical prostate cancer

- Do not use the phrase "history of" to describe current prostate cancer. In diagnosis coding, "history of" means the condition is historical and no longer exists as a current problem.
- On the other hand, do not document a final diagnosis of simply "prostate cancer" to describe a historical prostate 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 prostate cancer" with details of past diagnosis and treatment.

Purpose of PSA blood testing

After successful treatment of prostate cancer that results in complete eradication of the disease, regular monitoring for recurrence typically continues and includes ongoing laboratory testing of PSA. Documentation of ongoing PSA monitoring by itself without evidence that the prostate cancer is still present does not clearly support current prostate cancer. A final impression and plan of "prostate cancer – check PSA" is vague and ambiguous; it does not clearly indicate current versus historical prostate cancer or the purpose of checking the PSA level.

Metastatic prostate cancer

The final diagnosis should clearly indicate the primary and secondary sites. Consider these examples:

Example 1	
Final diagnosis	Metastatic prostate cancer
Comment	This diagnostic statement is ambiguous. It is not completely clear whether the prostate is the primary or secondary site.

Example 2	
Final diagnosis	Primary prostate cancer metastatic to pelvic bone
Comment	This diagnostic statement clearly identifies the prostate as the primary site and the pelvic bone as the secondary site.

Treatment with outcomes

Document the details of prostate cancer treatment along with the outcome and current status.

- Include beginning and ending dates of all treatment.
- For permanent radioactive seed implantation (also known as brachytherapy or internal radiation therapy):
  - Include the date seed implantation was performed
  - Indicate when seeds are considered no longer active and thus, therapy is complete.
- Clearly document when prostate cancer has been eradicated.

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Tips and resources for coders

Coding prostate cancer

Cancer or carcinoma of the prostate codes as follows:

- C61 Malignant neoplasm of prostate
- C79.82 Secondary malignant neoplasm, genital organs
- DØ7.5 Carcinoma in situ of prostate

Carefully review and follow all instructional notes.

Coding prostate cancer as current

Generally, prostate cancer is coded as current when the medical record clearly documents active treatment directed to the cancer for the purpose of cure or palliation and/or when the record clearly shows prostate cancer is still present but:

- Is unresponsive to treatment;
- The current treatment plan is observation only or "watchful waiting;" or
- The patient has refused any further treatment.

Coding prostate cancer as historical

Prostate cancer is coded as historical (Z85.46) after the prostate cancer has been excised or eradicated, there is no active treatment directed to the prostate 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 ZØ8. Carefully review and follow all instructional notes.

Metastatic prostate cancer

For a current diagnosis of "metastatic prostate cancer" without further specification – and no more definitive information regarding the primary versus secondary site is obtained upon review of the entire medical record – the prostate is coded as the primary site (C61) with the secondary/metastatic site unknown (C79.9).

References: American Cancer Society; American Hospital Association (AHA) Coding Clinic; ICD-10-CM Official Guidelines for Coding and Reporting; Mayo Clinic; MD Anderson Cancer Center; MedlinePlus; National Cancer Institute; WebMD