Codify by AAPC

Home Health ICD-9/ICD-10 Alert

Reader Questions: V10: List V10 When Patient Has Cancer History

Question: We have a patient who had a colon resection for cancer over six months ago. Two months following surgery, he had a Mediport inserted for chemotherapy. The patient has completed the course of treatment and is in remission. Should we report a "history of colon cancer" code or do we need to list a cancer diagnosis code?

Massachusetts subscriber

Answer: If all treatment directed toward the cancer is complete and there are no indications of current disease, you should use a history of cancer code instead of a cancer code for this patient.

Do this: Report V10.05 (Personal history of malignant neoplasm of large intestine) to indicate that your patient has a history of colon cancer. Take care to choose the "personal" history code and not the family history code (V16.0, Family history of malignant neoplasm of gastrointestinal tract). You should not report the cancer diagnosis, 153.3 (Malignant neoplasm of sigmoid colon), for this patient.

There is no advantage to placing the 153.3 code in M1024 across from the history code because the V10 codes are not "eligible" V codes according to Medicare's case mix information. Only eligible V codes result in the grouper counting points in M1024.

Support: ICD-9 official guidelines state, "When a primary malignancy 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 code from category V10, Personal history of malignant neoplasm, should be used to indicate the former site of the malignancy" (section I.C.2.d).

Bonus tip: If the primary neoplasm is no longer present and no longer treated, but the physician documents metastasis to another site, you should report a code for the secondary neoplasm and then the V10 code, the guidelines instruct. (You may download the guidelines from www.cdc.gov/nchs/icd/icd9cm_addenda_guidelines.htm.)

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