# Home Health ICD-9/ICD-10 Alert

## Reader Questions: V10.xx: Look to History Codes for Colon Cancer

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 code for his cancer with a "history of colon cancer" code?

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.

Do this: List V10.05 (Personal history of malignant neoplasm of large intestine) to describe this patient's 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 also should not report the cancer diagnosis, 153.3 (Malignant neoplasm of sigmoid colon), for this patient.

Note: You won't need to complete M1024 for this patient because CMS does not indicate that the V10 codes are "eligible" V codes so M1024 will not be checked.

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.)