CareSource PARTNER with Purpose

Risk Adjustment Coding Guidance
Coding Cancer Diagnoses

Context
CareSource reviews provider documentation to ensure the accuracy of diagnoses codes reported. Recent reviews have demonstrated an opportunity to improve the accuracy of ICD-10-CM codes reported specific to cancer diagnoses.

When can a cancer be coded as current?
Cancers can be coded as current if the documentation in the medical record demonstrates active treatment of the disease for the purpose of curing the illness, palliative treatment, when the cancer is not responding to the treatment, treatment is refused, or the current treatment plan of "watchful waiting" is documented**.**

When does an active cancer become "history of"?
Per the ICD-10-CM Official Guidelines for Coding and Reporting, 2021
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 at that site, a code from the Z85 category, Personal history of malignant neoplasm should be reported to indicate the former site of the malignancy.

If the treatment is preventive or prophylactic, in most instances, the correct code to report would be a personal "history of' cancer rather than an active cancer code.

Importance
Complete, specific and accurate coding helps to ensure CareSource is able to connect our members, your patients, to appropriate disease management and case management resources.

Questions
For questions about risk adjustment coding, please send your inquiries to:
raprovidereducation@caresource.com

Source
ICD-10-CM Official Guidelines for Coding and Reporting 2021

Multi-Multi-P-569697