ICD-10-CM Documentation and Coding Best Practices
Neoplasm Coding

Overview

Cancer begins in cells, the building blocks of the body. Normally, the body forms new cells to replace old cells that die. Sometimes this process goes wrong. New cells grow while the old cells don't die when they should. These extra cells can form a mass called a tumor. Tumors can be benign or malignant. Benign tumors grow in one place and do not spread to other body parts. Malignant tumors grow, spread and invade other body parts *(metastasis)*. Symptoms and treatment depend on the cancer type and how advanced it is.

Treatment

- **Surgery**
- **Chemotherapy**
- **Radiotherapy**
- **Targeted Therapy** – Drugs or other substances that combat cancer by interfering with specific molecules involved in the growth, progression, and spread of cancer.
  - *Immunotherapies (Biological Therapies)* trigger the body's immune system to help fight cancer.
- **Watchful Waiting** – May be recommended in situations where the risks of intervention or therapy may outweigh the benefits.

Coding Concepts

- **Primary Cancer** – The stated or presumed site of origin of a malignant neoplasm.
- **Secondary Cancer** – The site(s) to which the tumor has spread or metastasized from its site of origin. The term 'metastasis' is often used interchangeably with 'direct extension' when documenting secondary malignancies in the medical record. ICD-10-CM classifies both as secondary malignant neoplasms.
- **Overlapping/Contiguous Sites** – A primary malignant neoplasm that overlaps two or more contiguous sites should be classified to subcategory .8, 'overlapping lesion.'
- **Recurrence of Primary Malignancy** – If the primary malignant neoplasm previously excised/eradicated has recurred, code it as a primary malignancy. (Ex., recurrence of previously excised anterior wall bladder carcinoma, now lateral wall.)
- **No recurrence at primary site** – When the primary malignancy has been previously excised or eradicated and there is no treatment directed to that site and no evidence of any remaining malignancy at the primary site, use the appropriate Z-code to indicate a personal history of malignant neoplasm. Code any mention of current secondary sites.
- **Uncertain vs. unspecified neoplasm** – These should not be confused or used interchangeably. An uncertain neoplasm has been examined microscopically but its nature cannot be predicted. An unspecified neoplasm has an unknown etiology because no microscopy examination has been documented.

Note: Providers should avoid words like "mass," "lump," "tumor," and "growth" if more specific language is available.

To differentiate between active cancer and a 'personal history,' look for the following:

Active Cancer

Active Treatment –If the patient is currently undergoing treatment (ex., surgery, chemotherapy, radiotherapy, targeted therapy, watchful waiting) you may code as active cancer.

Patient Choice - A patient who is diagnosed with cancer and has been counseled in regards to his diagnosis may elect not to undergo treatment. You may code as active cancer.

Newly diagnosed – A newly diagnosed patient may not have a treatment plan developed yet. You may code as active cancer.

Unresponsive to treatment – A patient who is actively receiving treatment but is not responding clinically as expected.

Watchful Waiting – May be recommended in situations where the risks of intervention or therapy may outweigh the benefits.

Personal History

When cancer has been excised or eradicated from its site and there is no further treatment directed to the site and there is no evidence of malignancy, a code from category Z85, personal history of malignant neoplasm, should be assigned.

Providers should use language that would allow the coder to abstract the appropriate diagnosis.

In ICD-10-CM, the only malignant conditions that can be categorized as "in remission" are multiple myeloma and leukemia. Other cancers are identified as active disease, meaning the condition is still present or still being treated, or history of cancer , meaning the condition has been eradicated and all treatment completed.

Metastasis vs. Metastatic – The medical record should be reviewed carefully to identify the primary site and the secondary site. The term "metastatic to" refers to the secondary site. The term "metastatic from" refers to primary site. If a patient is receiving active treatment for a secondary (metastatic) cancer and the primary cancer is no longer present, ensure that your code selection properly reflects this scenario (active cancer code = secondary cancer + personal history code of primary cancer).

Coding and Documentation Guidance

Cancer is considered an active condition when the medical record documentation clearly reflects active treatment directed to the cancer for curative or palliative purposes. Documentation should include the following:

- Presence or absence of complaints or symptoms related to cancer.
- Associated physical findings related to cancer.
- Results of diagnostic testing with dates.
- For active cancer diagnosis, avoid the phrase "history of" as this means the condition no longer exist.
- Describe the cancer to the highest level of specificity by documenting:
    - Histological type or behavior
    - Anatomical location including laterality
    - Indicate if cancer is primary, secondary or carcinoma in situ
- When using the terms "metastatic" and "metastasis," be sure the documentation clearly reflects the primary site and secondary site(s).
- Document in your plan the current treatment for cancer – "follow up with oncologist" is not enough information to determine if cancer is active.
- Update the PMH section of the note to include any surgical procedures related to cancer along with the date, if known.