NEOPLASMS

Physician Documentation

Neoplasms are classified in ICD-10-CM by anatomical location and histology. Essential to proper coding and documentation is noting the specific site including any laterality, and whether the neoplasm is benign, primary malignant, secondary malignant, in situ, uncertain, or unspecified.

Documentation Tips

- **Avoid words like *mass, lump, tumor, lesion,* or *growth*** if more specific language is available.

  According to ICD-10-CM nomenclature:
  - An uncertain neoplasm has been examined microscopically. Its nature cannot be predicted.
  - An unspecified neoplasm is unknown and no microscopic examination has occurred.

Active Disease, Remission, and History

Use language that allows the coder to abstract the appropriate diagnosis for the patient. In ICD-10-CM, the only malignant conditions that can be categorized as "in remission" are multiple myeloma and leukemia. Documentation of "minimal residual disease" is insufficient for coders to determine whether remission has been achieved.

Other types of cancers are identified as active disease, meaning the condition is still present or still being treated, or history of disease, meaning the condition has been eradicated and all treatment completed.

- **Do not document "history of malignant neoplasm" or "NED"** if the neoplasm is still being treated. Instead, document the continuum of care with what has been done and what is left to do. "History of" and "no evidence of disease" indicate an eradicated condition, according to coding rules.
- **If a selective estrogen receptor modulator (SERM) such as tamoxifen is being administered,** indicate whether the medication is treatment for active cancer or prophylaxis against cancer.

Metastatic Disease

Documentation of metastatic disease requires special care, as "metastatic" and "metastasis" can be ambiguous in describing the primary and secondary sites. Use of the words "to" and "from" in notes will clarify the origin of neoplasms (eg, "breast cancer with metastases to the lung" or "metastatic lung cancer from the breast"). Or, simply use the terms "secondary" and "primary."

- **Connect the dots.** For example, document anemia as caused by cancer or by cancer treatment. Document diabetes due to pancreatic carcinoma, or pathologic fracture due to breast cancer metastasizing to bone. Always document etiology and manifestation of cancer and its complications.
- **If the staging of the malignancy is known,** document this in the medical record. This helps the coder understand the severity of the patient's condition.
- **Leukemia and multiple myeloma** are the only types of cancers classified in ICD-10-CM with "remission." For other types of cancers, state "active" or "history of." For example, do not report "colon cancer in remission."
- **Differentiate in documentation** between a malignant neoplasm growing within a certain site and one that is advancing to adjacent sites (metastasizing).

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Coder Abstraction

Neoplasms can be documented in many ways. Do not make assumptions about coding "mass," "growth," "tumor," "polyp," or other terms documented. Be sure to start in the Alphabetic Index and use the exact words from the documentation. For example, a "polyp" may be indexed to a benign neoplasm, a neoplasm of uncertain behavior, an "other or unspecified disorder," and for some sites, a unique polyp code. From the Alphabetic Index, go to the Table of Neoplasms if so directed, and then to the Tabular Section of ICD-10-CM.

Coding Tips

- **Do not confuse uncertain and unspecified neoplasms.** An uncertain neoplasm has been examined microscopically, but its nature cannot be predicted. An unspecified neoplasm has an unknown etiology because no microscopic examination has been documented.
- **A cancer-staging form** is an acceptable form of documentation if authenticated by the physician.

History vs Active Cancer

A cancer becomes "history of cancer" when treatment is completed (ie, excision, radiotherapy, chemotherapy), for coding purposes. For example, following mastectomy and chemotherapy, a patient is diagnosed with secondary bone cancer, originating in the breast. The patient is reported with secondary bone cancer, and history of breast cancer.

- **"Metastatic from . . ."** indicates a primary malignancy: the original site of the cancer. "Metastatic to . . ." indicates a secondary malignancy: a new site for cancer that has grown from seeds from the original site. Query the physician if the documentation is unclear whether a site is primary or secondary. When a growing malignancy advances beyond the boundaries of its anatomic site, it is metastatic (eg, when a cancer in the ascending colon extends into the cecum).
- **Only leukemia and multiple myeloma have "remission" codes** in ICD-10-CM cancer coding. If the physician documents another form of cancer as "in remission," query to see if the patient has a history of malignancy or active disease.
- **Comorbidities are sometimes caused by the neoplasm.** Look for linking language in documentation and report related conditions when they are associated with the neoplasm.
- **Melanoma and Merkel cell carcinoma** have unique codes, as do squamous cell and basal cell carcinomas. Do not use other malignant skin neoplasm codes to report these conditions. Melanoma and Merkel cell carcinoma risk-adjust; other skin cancers do not.
- **Prostate-cancer patients and breast-cancer patients** may be treated with long-term selective estrogen receptor modulators (SERMs). These medications may be prescribed to treat an existing cancer, or to prevent cancer in a patient at risk for cancer. Read documentation carefully before assuming that a "history of cancer" is active for a patient being treated with SERMs, and query the physician if the status of the patient's cancer is unclear.