Neoplasms are classified in ICD-10-CM by anatomical location and histology. Essential to proper coding and documentation is noting 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,” “neoplasm,” “lesion,” or “growth”** if more specific language is available.
- **An uncertain neoplasm** has been examined microscopically, and its nature cannot be predicted.
- **An unspecified neoplasm** is unknown and no microscopic examination has occurred.

### Active disease, Remission, and History

Document using language that allows the coder to abstract the appropriate diagnosis for your patient. 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 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 SERM like tamoxifen is being administered**, indicate whether the medication is treatment for active cancer, or prophylaxis against the cancer’s return.

### 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 your notes will clarify the origin of the neoplasm; for example, “breast cancer with metastases to the lung,” or “metastatic lung cancer from the breast.” Or, simply use the descriptors “secondary” and primary.

- **Clearly link complications** of the neoplasm. For example, document anemia as caused by the cancer, or by the cancer treatment. Document diabetes due to pancreatic carcinoma, or pathologic fracture due to breast cancer metastasizing to bone. Always document etiology and manifestation.
- **Leukemia and multiple myeloma** should be noted by histology, and as one of the following:
  - Not having achieved remission
  - In remission
  - In relapse.
  These are the only cancers classified in ICD-10 with “in remission.” For other cancers, state “active” or “history of.” Do not report, for example, “colon cancer in remission.”
NEOPLASMS
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 Index and use the exact words from 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 Index, go to the Table of Neoplasms, 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 provider.

### History vs active cancer

**A cancer becomes history of cancer when** treatment is completed (i.e., excision, radiotherapy, chemotherapy is completed), 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 growth from seeds from the original site. Query your provider if the documentation is unclear whether a site is primary or secondary.
- **Only leukemia and multiple myeloma have “remission” codes in ICD-10-CM cancer coding.** If your provider documents another form of cancer as “in remission,” query to see if the patient has a history of malignancy, or active disease.

### Assuming a secondary cancer

**If the primary/secondary status is not stated in documentation,** the following sites should be considered secondary sites of malignancy:

<table>
<thead>
<tr>
<th>Bone</th>
<th>Heart</th>
<th>Lymph nodes</th>
<th>Pleura</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brain</td>
<td>Liver</td>
<td>Mediastinum</td>
<td>Spinal cord</td>
</tr>
<tr>
<td>Diaphragm</td>
<td>Meninges</td>
<td>Retroperitoneum</td>
<td>Peritoneum</td>
</tr>
</tbody>
</table>

Consider all other sites primary, if primary/secondary is not stated.

- **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. Do not use other malignant skin neoplasm codes to report these two conditions, which are more invasive forms of skin cancer.

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