

Neoplasms

ICD-10-CM

Clinical overview

Basic definitions

- **Neoplasm:** A new growth of tissue that serves no physiological function. A neoplasm may be:
 - **Benign** (grows in only one place; does not spread or invade other body parts but can cause problems by pressing on vital organs; does not usually recur); or
 - **Malignant** (grows, spreads and invades other body parts and can recur)
- **Cancer:** A malignant neoplasm of potentially unlimited growth that expands locally by invasion and systemically by metastasis.
- **Metastasis:** The spread of cancer from one part of the body to another. The cells of the metastatic (or secondary) cancer look like the cells of the original (or primary) cancer. Thus, pathologists can determine whether a cancer in a particular site is primary or secondary; for example, cells from a lung tumor that is a primary lung cancer look like lung cancer cells, while cells from a lung tumor that is a secondary cancer from the breast look like breast cancer cells.

For more cancer definitions, see the National Cancer Institute Dictionary of Cancer Terms at www.cancer.gov/dictionary.

Types of cancer

More than 100 different types of cancer are grouped into broader categories. The main categories are:

- Carcinoma
- Sarcoma
- Leukemia
- Lymphoma
- Myeloma
- Central nervous system cancers

Causes and risk factors for cancer

The particular cause of many cancers is unknown. Risk factors include:

- Age older than 55 (but can occur at any age)
- Lifestyle and habits (smoking, sun exposure, alcohol use, etc.)
- Family history of cancer
- Some chronic health conditions
- Environmental exposure to toxins, radiation, etc

Signs and symptoms of cancer

Signs and symptoms of cancer depend on the type, location and stage. (Stage refers to how much the cancer has grown and spread.)

Diagnostic tools

- Medical history and physical exam
- Biopsy and pathological analysis
- Blood tests
- Diagnostic imaging (CT scans, MRI, PET scans, etc.)

Treatment

Treatment varies based on the cancer type, location and stage and may include surgical excision, chemotherapy, radiation or a combination of all three.

Neoplasms

ICD-10-CM

Best documentation practices for physicians

Abbreviations

A good rule of thumb for any medical record is to limit – or avoid altogether – the use of acronyms and abbreviations. Use only industry-standard abbreviations. (Maintain a current list from a respected source.)

Remember that some standard abbreviations have multiple meanings. The meaning of the abbreviation can often be determined based on context, but this is not always true. Best practice is as follows:

- The initial notation of a diagnosis should be spelled out in full with the abbreviation in parentheses. For example: Prostate cancer (PCa)
- Subsequent mention of the condition can be made using the abbreviation (PCa).
- The diagnosis should always be spelled out in full in the final impression (“prostate cancer”).

Subjective

The subjective section of the office note should document the presence or absence of any current complaints or symptoms related to the neoplasm.

Objective

The objective section should include any current associated physical exam findings and results of diagnostic testing with clear dates and timelines.

Current versus historical versus remission

- Do not use the phrase “history of” to describe a current neoplasm. In diagnosis coding, “history of” means the condition is historical and no longer exists as a current problem.
- Do not use the phrase “history of” to describe a current neoplasm that is in remission. Rather, specifically describe the neoplasm as “currently in remission.”

Suspected versus confirmed

- Avoid terms that imply uncertainty (“likely”, “probable,” “apparently,” “consistent with,” etc.) to describe a current, confirmed neoplasm.
- Do not document a suspected and unconfirmed neoplasm as if it were confirmed. Document the signs and symptoms in the absence of a confirmed diagnosis.

Final impression

In the final diagnostic statement, describe current neoplasms to the highest level of specificity, including all of the following information:

- The histological type (adenocarcinoma, squamous cell, etc.) or behavior (benign, malignant, uncertain, unspecified)
- The exact location, including laterality and the specific site within a body part (such as inner, outer quadrant of right breast)
- Whether the neoplasm is primary, secondary or carcinoma in situ (confined to its original site with no spread)

When using the terms “metastatic” and “metastasis,” clearly identify the primary and secondary sites. Consider the following examples:

Example 1

Final diagnosis	Metastatic lung cancer
Comment	In this diagnostic statement, it is not completely clear whether the lung is the primary or secondary site.

Example 2

Final diagnosis	Primary adenocarcinoma of the sigmoid colon with metastasis to the lung
Comment	This diagnostic statement clearly identifies the primary site (sigmoid colon) and the secondary site (lung).

Electronic medical record (EMR) reminder

- Some electronic medical records insert ICD-10-CM code descriptions into the medical record to represent the final diagnosis. Example: C83.8Ø Other non-follicular lymphoma, unspecified site.
- With these types of vague descriptions, the diagnosis will not be complete unless the physician clearly documents the specific “other” non-follicular lymphoma and sites involved.

Note: ICD-10-CM is a statistical classification; it is not a substitute for a healthcare provider’s final diagnostic statement. It is the healthcare provider’s responsibility to

Neoplasms

ICD-10-CM

Best documentation practices for physicians

Electronic medical record (EMR) reminder – (continued)

provide legible, clear, concise and complete documentation of a diagnosis described to the highest level of specificity, which is then translated to a code for reporting purposes. It is not appropriate for healthcare providers to simply list a code number or select a code number from a list of codes in place of a written final diagnosis.

Treatment plan

- Document a clear and concise plan.
- Clearly state the goal of the current plan, as in:
 - Active treatment of a current cancer; versus
 - Surveillance of a historical cancer to monitor for recurrence
- When adjuvant therapy is used, clearly state its purpose (whether the goal of adjuvant therapy is curative, palliative or preventive).
- If referrals are made or consultations requested, indicate to whom or where the referral is made or from whom consultation advice is requested.
- Document when you plan to see the patient again.

Neoplasms

ICD-10-CM

Tips and resources for coders

Coding basics

For accurate and specific code assignment:

- Review the entire medical record to verify the neoplasm is a current condition and not historical.
- Note the exact diagnosis description documented in the medical record; then, in accordance with ICD-10-CM official coding conventions and guidelines:
 - Search the alphabetic index for that description.
 - Verify the code in the tabular list, carefully following all instructional notes.

Coding neoplasms

Most benign and all malignant neoplasms are coded from ICD-10-CM Chapter 2. Certain other benign neoplasms are found in specific body system chapters. To accurately code a current neoplasm, review the entire medical record and search for the following information regarding the neoplasm:

- Histological type (adenocarcinoma, squamous cell, etc.) or behavior (benign, malignant, uncertain)
- The exact location, including laterality if applicable, and the site within a body part (e.g., upper outer quadrant)
- Whether the neoplasm is primary, secondary or carcinoma in situ (confined to its original site with no spread)

Once the above information is located, consider the following:

- If the histological type of neoplasm is documented, locate the histological term in the alphabetic index of the ICD-10-CM manual and follow the instructional notes (for example, “see also neoplasm by site, benign”).
- If the histological type is not documented, look for the neoplasm site in the neoplasm table and reference the appropriate column (malignant primary, malignant secondary, carcinoma in situ, benign, uncertain behavior, unspecified) to identify the code.
- Then, confirm the code in the tabular list, carefully reviewing all instructional notes.

Also, review and become familiar with the ICD-10-CM Official Guidelines for Coding and Reporting for Chapter 2. These guidelines can be found in the front of the

ICD-10-CM manual; the most current version for each year can be found on the Centers for Disease Control and Prevention (CDC) website. Be sure to use the official guidelines that cover the date of service being coded.

Unspecified cancer site

- Code **C80.0**, disseminated malignant neoplasm, unspecified, is assigned only in those cases in which the patient has advanced metastatic disease and no known primary or secondary sites are specified. It should not be used in place of assigning codes for the primary site and all known secondary sites.
- Code **C80.1**, malignant (primary) neoplasm, unspecified, is assigned only when no determination can be made as to the primary site of a malignancy.
- Code **C79.9**, secondary malignant neoplasm of unspecified site, is assigned when no site is specified for the secondary neoplasm.
- When no site is indicated in the diagnostic statement but the morphology type is stated as metastatic, the code provided for that morphological type is assigned for the primary diagnosis along with an additional code for secondary neoplasm of unspecified site.

Example	
Diagnosis	Metastatic apocrine adenocarcinoma
ICD-10-CM codes	This diagnosis is coded as a primary malignant neoplasm of the skin, site unspecified – C44.99 plus code C79.9 for the unspecified secondary site.
Rationale	Code C44.99 is obtained by referring to the main term “adenocarcinoma” followed by subterms “apocrine” and “unspecified site.”

Primary versus secondary site

The terms “metastatic” and “metastasis” are often used ambiguously in describing neoplasms, sometimes meaning that the site named is primary and sometimes meaning it is secondary. When the diagnostic statement is not clear in this regard, the coder should review the medical record for further information. When none is available, however, the following guidelines apply.

- **“Metastatic to”** means the site mentioned is secondary. For example, “metastatic carcinoma to the lung” is coded as secondary malignant neoplasm of the lung (C78.0-).

Neoplasms

ICD-10-CM

Tips and resources for coders

Primary versus secondary site - continued

- **“Metastatic from”** means the site mentioned is the primary site. For example, “metastatic carcinoma from the breast” indicates the breast is the primary site (C50.9-). An additional code for the metastatic site also should be assigned.
- **Multiple metastatic sites** – When two or more sites are described in the diagnosis as “metastatic,” each of the stated sites should be coded as secondary or metastatic. A code also should be assigned for the primary site when this information is available; it should be coded as C80.1 when it is not.
- **Single metastatic site** – When only one site is described as metastatic without any further qualification and no more definitive information can be obtained by reviewing the medical record, the following steps should be used:

Step 1

- Refer first to the morphology type in the alphabetic index; code to primary condition of that site.
Example: “Metastatic renal cell carcinoma of the lung” indicates the primary site is the kidney (C64.9); secondary site is the lung (C78.00).
- When a specific site for morphology type is not indicated in a code entry or not indexed, assign the code for unspecified site within that anatomical site. For example, “oat cell carcinoma” codes to C34.90, malignant neoplasm of unspecified part of unspecified bronchus or lung, when no more specific site is stated.

Step 2

- When the morphology type is not stated or the only code that can be obtained is either C80.0 or C80.1, code as a primary malignant neoplasm, unless the site is one of the following:

• bone	• liver	• peritoneum
• brain	• lymph nodes	• pleura
• diaphragm	• mediastinum	• retroperitoneum
• heart	• meninges	• spinal cord
• Sites classifiable to category C76, malignant neoplasms of other and ill-defined sites		
Malignant neoplasms of these sites are coded as secondary sites when not otherwise specified, except neoplasm of the liver, for which ICD-10-CM provides the following code: C22.9, malignant neoplasm of liver, not specified as primary or secondary.		

Example 1	
Diagnosis	Metastatic carcinoma of the lung
ICD-10-CM codes	Lung is not in the list under Step 2; therefore, the lung is coded as the primary site (C34.90) with the secondary site unknown (C79.9).

Example 2	
Diagnosis	Metastatic bone cancer
ICD-10-CM codes	Bone is in the list under Step 2; therefore, bone is coded as secondary (C79.51) with the primary site unknown (C80.1).

Example 3	
Diagnosis	Metastatic prostate cancer
ICD-10-CM codes	The prostate is not in the list under Step 2; therefore, the prostate is coded as the primary site (C61) with the secondary site unknown (C79.9).

Coding cancer as current

Generally, cancer is coded as current when the medical record clearly shows active treatment directed to the cancer for the purpose of cure or palliation and/or when the record clearly shows the cancer is present but:

- It is unresponsive to treatment;
- The current treatment plan is watchful waiting or observation only; or
- The patient has refused any further treatment.

Active cancer treatment can include adjuvant therapy for cure or palliation. Adjuvant therapy (any treatment given after the primary therapy to increase the chance of long-term disease-free survival) may include chemotherapy, radiation therapy, hormone therapy, targeted therapy or biological therapy.

Coding cancer in remission

The National Cancer Institute defines “remission” as:

A decrease in or disappearance of signs and symptoms of cancer. In partial remission, some, but not all, signs and symptoms of cancer have disappeared. In complete remission, all signs and symptoms of cancer have disappeared, although cancer still may be in the body.

Neoplasms

ICD-10-CM

Tips and resources for coders

Coding cancer in remission (continued)

As a general rule, a cancer described in the final diagnostic statement as currently in remission is coded as a current cancer, as long as there is no conflicting or contradictory information documented elsewhere in the record.

However, if the overall context of the medical record suggests the cancer described as “in remission” is actually an historical cancer, the physician should be queried for clarification. For example, documentation of unrealistic time frames may indicate an historical diagnosis, such as cancer “in remission” noted as eradicated many years ago with no current treatment and no documented evidence of current cancer. When there is no option to query the physician for clarification, no code can be assigned.

Coding lymphoma

The Lymphoma Research Foundation advises as follows: Lymphoma – the most common blood cancer – has two main forms: Hodgkin lymphoma and non-Hodgkin lymphoma. Lymphoma occurs when cells of the immune system called lymphocytes, a type of white blood cell, grow and multiply uncontrollably. Cancerous lymphocytes can travel to many parts of the body – including the lymph nodes, spleen, bone marrow, blood or other organs – and form a tumor. The body has two main types of lymphocytes that can develop into lymphomas: B-lymphocytes (B-cells) and T-lymphocytes (T-cells).

- ICD-10-CM has many categories and subcategories for lymphomas with fourth and fifth characters that provide further specificity, including the particular type of lymphoma and the affected sites.
- Lymphomas can be malignant or benign. Benign lymphomas classify to code **D36.0**, benign neoplasm of lymph nodes.
- Malignant lymphomas classify to the following categories:

Hodgkin lymphoma	Non-Hodgkin lymphoma
C81	C82, C83, C84, C85, C86, C88

- Lymphomas are systemic diseases that do not metastasize in the same way as solid tumors, which are not lymphomas. A lymphoma, regardless of the number of sites involved, is not considered metastatic and is never coded as secondary cancer.
- Lymphoma patients in remission are still considered to have lymphoma, and the appropriate ICD-10-CM code representing current lymphoma should be assigned.

Coding historical cancer

A primary malignancy is coded as historical (category **Z85**, personal history of malignant neoplasm) after the primary malignancy has been excised or eradicated, there is no further treatment directed to that site and there is no current evidence of any existing primary malignancy at that site.

Encounter for follow-up examination after treatment for malignant neoplasm has been completed is coded as **Z08**. This code includes medical surveillance following completed treatment (i.e., monitoring for cancer recurrence) and **Excludes1** aftercare following medical care (**Z43–Z49, Z51**). Code **Z08** advises to use an additional code to identify any acquired absence of organs (**Z90.-**) and personal history of malignant neoplasm (**Z85.-**).

References: American Hospital Association Coding Clinic; ICD-10-CM and ICD-10-PCS Coding Handbook; ICD-10-CM Official Guidelines for Coding and Reporting; Lymphoma Research Foundation; Mayo Clinic; MedlinePlus; National Cancer Institute