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. Under pathological analysis, the cells of the metastatic (or secondary) cancer are the same as 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

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 Computed tomography (CT) scans, Magnetic resonance imaging (MRI), Positron emission tomography (PET) scans, etc.

Treatment

Treatment varies based on the cancer type, location and stage and may include surgical excision, chemotherapy, immunotherapy, radiation or some combination of these.

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Best documentation practices for physicians

Subjective

In the subjective section of the office note, document the presence or absence of any current patient 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.

Assessment

Specificity: 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 original site, 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 clear whether the lung is the primary or secondary site.

Example 2	
Final diagnosis	Primary adenocarcinoma of sigmoid colon with metastasis to the lung
Comment	This diagnostic statement clearly identifies the primary site (sigmoid colon) and the secondary site (lung).

Suspected versus confirmed:

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

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").

Current versus historical versus remission

- For current neoplasms, clearly show the condition is still present and being managed as a current problem. For example: "Malignant adenocarcinoma of head of pancreas currently on chemotherapy per oncologist, Dr. Smith."
- 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."

Treatment plan

- Document a clear and concise treatment plan (surgical excision, chemotherapy, radiation therapy, etc.). Include the purpose or goal of the current treatment plan. For example:
  - Active treatment of a current neoplasm
  - Watchful waiting for a current cancer, monitoring for signs of progression
  - Monitoring a historical cancer for recurrence
  - Palliative care for terminal cancer
- When adjuvant therapy is used, clearly state its purpose (i.e., whether the goal of adjuvant therapy is curative, palliative or preventive).
- Document details of referrals to other specialties.
- Include the date or timeline for the patient's next visit.

Electronic health record (EHR) issues

Other and unspecified codes with descriptions:

Some electronic health records insert ICD-10-CM code descriptions into the medical record to represent the final diagnosis. Examples:

C83.8Ø Other non-follicular lymphoma, unspecified site

C18.9 Malignant neoplasm of colon, unspecified

These are vague descriptions and incomplete diagnoses.

- Codes titled "other" or "other specified" are for use when the information in the medical record provides a specific diagnosis description for which a specific code does not exist.
- The "other" ICD-10-CM code with description should not be used, by itself, as a final diagnosis without clear documentation of the particular "other" non-follicular lymphoma.
- Unspecified diagnosis descriptions should be used only when sufficient clinical information is not known or available to the provider at the time of the encounter.

Mismatch between final diagnosis and EHR-inserted diagnosis code with description:

Another scenario that causes confusion is one in which the assessment section of an office note documents a provider-stated diagnosis *PLUS* an EHR-inserted diagnosis code with description that does not match or may even contradict the stated diagnosis. Example:

Assessment: Endocervical cancer
C53.1 Malignant neoplasm of exocervix

Here the final diagnosis in **bold** in the Assessment is "Endocervical cancer", which codes to C53.Ø, Malignant neoplasm of **endo**cervix. The EHR-inserted diagnosis code with description that appears just below the final diagnosis is C53.1, Malignant neoplasm of **exo**cervix. This leads to confusion regarding which diagnostic statement is correct and which diagnosis code should be reported. Documentation elsewhere in the record does not always provide clarity.

To avoid confusion and ensure accurate diagnosis code assignment, the provider's final diagnosis must either

a) match the code with description; OR
b) it must classify in ICD-10-CM to the EHR-inserted diagnosis code with description.

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 provide legible, clear, concise and complete documentation of each final diagnosis described to the highest level of specificity, which is then translated to a diagnosis 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.

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Tips and resources for coders

Coding basics

For accurate and specific code assignment, the coder must first review the entire medical record and note the exact neoplasm description documented in the 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, 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.

The guidelines for coding neoplasms in Chapter 2 of the ICD-10-CM Official Guidelines for Coding and Reporting are extensive. It is not practical to include all of them here. It is important to become familiar with these guidelines. Be sure to use the official guidelines that cover the date of service for which you are assigning codes. While these guidelines can be found within the hard copy version of the ICD-10-CM coding manual, the most current and up-to-date version for each year can be found on the websites of the Centers for Medicare & Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC).

Unspecified cancer site

- Code C8Ø.Ø, 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 a known primary site and all known secondary sites.
- Code C8Ø.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	C44.99 Other specified malignant neoplasm of skin, unspecified C79.9 Secondary malignant neoplasm of unspecified site
Comments	Code C44.99 is obtained by following the coding path in the Alphabetic index: **Adenocarcinoma** > apocrine > unspecified site C44.99

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.Ø-).

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 (C5Ø.9-). An additional code for the metastatic site should also 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. Also assign a code for the primary site when this information is available – assign C8Ø.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 the primary condition of that site. Example: "Metastatic renal cell carcinoma of the lung" indicates the primary site is the kidney (C64.9) and the secondary site is the lung (C78.ØØ).

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, a final diagnosis of "Metastatic oat cell carcinoma" codes to C34.9Ø, Malignant neoplasm of unspecified part of unspecified bronchus or lung, when no more specific site is stated. The secondary site is coded C79.9, Secondary malignant neoplasm of unspecified site

STEP 2: When the morphology type is not stated or the only code that can be obtained is either C8Ø.Ø or C8Ø.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	
Final diagnosis	Metastatic carcinoma of the lung
ICD-10-CM code	Lung is not in the list under Step 2; therefore, lung is coded as the primary site (C34.9Ø) with the secondary site unknown (C79.9).

Example 2	
Final diagnosis	Metastatic bone cancer
ICD-10-CM code	Bone is in the list under Step 2; therefore, bone is coded as secondary (C79.51) with the primary site unknown (C8Ø.1).

Example 3	
Final diagnosis	Metastatic prostate cancer
ICD-10-CM code	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:

a) It is unresponsive to treatment;
b) The current treatment plan is watchful waiting or observation only; or
c) 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.

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Tips and resources for coders

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.

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 a historical cancer, the physician should be queried for clarification. For example, documentation of unrealistic time frames may indicate a 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.Ø, 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.
- *In general*, lymphoma patients in remission are still considered to have lymphoma, and the appropriate ICD-10-CM code representing current lymphoma should be assigned – unless overall context of the medical record indicates lymphoma described as "in remission" is actually a historical lymphoma.

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.

Codes from subcategories Z85.Ø – Z85.85 should only be assigned for the former site of a primary malignancy, not the site of a secondary malignancy. Code Z85.89 may be assigned for the former site(s) of either a primary or secondary malignancy.

Encounter for follow-up examination after treatment for malignant neoplasm has been completed is coded as ZØ8. This code includes medical surveillance following completed treatment (i.e., monitoring for cancer recurrence) and ***Excludes 1*** aftercare following medical care (Z43–Z49, Z51).

Code ZØ8 advises to use an additional code to identify any acquired absence of organs (Z9Ø.-) and personal history of malignant neoplasm (Z85.-).

References: American Cancer Society; 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; MD Anderson Cancer Center; MedlinePlus; Merck Manual; National Cancer Institute; WebMD