Coding and Documentation Tips for Neoplasm

To accurately assign a code for neoplasm in ICD-10-CM, it is necessary to determine behavior, location, laterality, gender (if applicable) and anatomic site from the documentation.

<table>
<tr><th colspan="2">Documentation requirements for coding neoplasm in ICD-10-CM</th></tr>
<tr><td rowspan="4">Behavior:

• Malignant primary
• Malignant secondary
• Carcinoma in situ
• Benign
• Uncertain behavior
• Unspecified behavior</td><td>Anatomic sites: Location, quadrant, laterality, multiple and contiguous sites</td></tr>
<tr><td>Behavior: Malignant (primary, secondary, unknown), neuroendocrine, benign, carcinoma in situ, uncertain behavior or unspecified behavior</td></tr>
<tr><td>Morphology: Histological type, stage and grade</td></tr>
<tr><td>Laterality: Right, left, bilateral</td></tr>
<tr><td colspan="2">Gender (if applicable): Male or female</td></tr>
<tr><td colspan="2">Note: ICD-10-CM classifies codes for reporting neoplasm sites with much greater precision and specificity.</td></tr>
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Neoplasm Documentation Tips:

- Correct reporting requires the documentation to support whether the patient's cancer has been **eradicated or is currently being treated**. Patients receiving active treatment should be reported with malignant neoplasm codes showing:
  - Patient has undergone cancer surgery but is still receiving active treatment (chemotherapy, radiation therapy, hormone therapy, targeted therapy and immunotherapy).
  - Patient is on "watchful waiting" and "active surveillance" with evidence of disease.
  - Patient is on adjuvant therapy, with documentation of the intent of the therapy, i.e., curative/palliative (current active cancer).
  - Patient refuses treatment (surgery, chemotherapy, radiation therapy).
- Patients with a history of cancer, but have no evidence of cancer, are not under treatment for cancer or not in preventive/prophylactic adjuvant therapy should be reported as **personal history of malignant neoplasm** with the appropriate code from category **Z85-**.
- If the stage of cancer is known, please document this in the medical record.

Diagnosis: Document the patient's concurrent condition or illness with the greatest specificity, complexity and severity of illness possible.
Status: Document the patient's status and clinical evidence/indicators for each active chronic condition, assessing the patient's health and overall risk profile and determining the appropriate level of care and coding (translating person-centered and whole-person care into medical decision-making).
Plan: Document the course of action to manage the diagnosis and the continuity of care (e.g., medication, diagnostic tests, referrals, other treatment and follow-up instructions).

Coding Scenario 1:

An 80-year-old female patient comes in for her annual wellness visit. During that visit, the provider documents “lung mets, left lower lobe to bone, undergoing radiation therapy.” Patient has a history of smoking one pack per day, a 30-pack-a-year smoker. Quit 10 years ago.

Secondary malignant neoplasm, bone	C79.51
Malignant neoplasm of lower lobe, left bronchus or lung	C34.32
History of tobacco dependence	Z87.891

Coding Scenario 2:

A 54-year-old postmenopausal woman follows up on her mammogram/ultrasound results. She noticed a firm, nontender lump in the upper-outer quadrant of her right breast a month ago. No family history of breast cancer. No nipple discharge, skin changes or pain. Breast exam found a 2 cm firm, nontender mass at the 2 o’clock position in the right breast. Axillary lymph nodes were palpable. Mammogram: BI-RADS 5. Biopsy: Metastatic carcinoma of the breast (Grade 2), Stage 3, infiltrating N2 (lymph nodes). ER+.

Malignant neoplasm of upper-outer quadrant of right female breast	C50.411
Estrogen receptor positive status [ER+]	Z17.0
Secondary malignant neoplasm of other specified sites	C79.89
Postmenopausal state	Z78.0

References:

1. CDC National Center for Health Statistics ICD-10-CM:https://icd10cmtool.cdc.gov/?fy=FY2026#neoplasms-table