Coding and Documentation Tips for Neoplasm

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

Documentation requirements for coding neoplasm in ICD-10-CM

Behavior: Malignant ➢ Primary ➢ Secondary ➢ Ca in situ Benign Uncertain Unspecified behavior	Location: (Anatomical site — Topography)	Site specific: (e.g., upper-outer quadrant)
	(If) Metastatic →	Secondary sites (e.g., metastatic bone cancer)
	Laterality	Specify: (left or right)
	Gender (if applicable)	Male or Female

Note: ICD-10-CM classifies codes for reporting neoplasm sites with much greater precision and specificity.

Neoplasm Documentation Tips:

- Correct reporting of cancer requires the documentation to support whether the patient's cancer has been **eradicated or is currently being treated**. Patients who are receiving active treatment should be reported with malignant neoplasm code:
  - ➢ Patient has undergone cancer surgery but is still receiving active treatment. (chemotherapy, radiation therapy, etc.)
  - ➢ Patient is currently taking anti-neoplastic medications.
- Patients with a history of cancer, with no evidence of cancer, and currently not under treatment for cancer should be reported as**: personal history of malignant neoplasm** with the appropriate code from category Z85-.
- If staging of the cancer is known, please document the stage of cancer in the medical record.

Coding Scenario:

An 80-year-old female patient comes in for her annual wellness visit. During that visit, the provider documents, "lung cancer, left lower lobe, secondary bone CA, undergoing radiation therapy."

C79.51 Secondary malignant neoplasm, bone

C34.32 Malignant neoplasm of lower lobe, left bronchus, or lung