Neoplasm Coding Quick Reference Guide

Risk Stratification refers to the alignment of patients with the right clinical initiatives, according to their clinical complexity. Accurately and completely documenting and communicating a patient's chronic diagnoses drives such care coordination and high-quality clinical care. Diagnosis coding and documentation should always capture the complete picture of a patient's health status at the highest level of specificity appropriate for the patient.

Clinical Information and Documentation Tips

Patients who are diagnosed with cancer frequently see several specialists. For these patients, the primary care physician serves a critical role; making sure that the care is coordinated, non-redundant and that the patient's other medical problems and preventative care continues to be addressed.

Questions to Ask Before Choosing a Code:

- ✓ What is the primary cancer?
- ✓ What is the stage?
- ✓ Is there metastatic disease?
- ✓ Are there complications from treatment?

Reminders + Tips:

- Use cancer diagnoses when the patient has active disease
- Use cancer in remission codes when a patient is in remission
- When a patient is cured of their disease, use "history of" codes. These codes do not carry weight.
- If a patient is immunosuppressed due to treatment, make sure to include it in the documentation and code selection.

Neoplasm Coding Quick Reference Guide

Best Documentation Practices

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

- 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

- This diagnostic statement clearly identifies the primary site (sigmoid colon) and the secondary site (lung).

Suspected vs. 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 vs. Historical vs. 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 verbiage for a current neoplasm that is actually a “history of.”
- 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.”

Neoplasm
Coding Quick Reference Guide

Best Documentation Practices

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.

Neoplasm
Coding Quick Reference Guide

Common ICD-10 Diagnosis Codes

Active Cancer Code Categories (Not All-Inclusive)	ICD-10	V24 HCC	V28 HCC
Anus	C21*	11	22
Bladder	C67*	11	23
Bone	C40*-C41*	10	21
Brain	C71*	10	20
Benign Brain	D33*	12	23
Breast	C50*	12	23
Cervical	C53*	11	22
Colon (Large Intestine)	C18*	11	22
Esophagus	C15*	9	20
Endometrium	C54*	12	23
Kidney	C64*	11	22
Leukemia	C91*-C95*	8,9,10	17,18,19,20,22
Lung	C34*	9	20
Lymphoma	C81*-C85*	10	17,19,20,21
Melanoma	C43*	12	23
Melanoma In-Situ	D03*	12	23
Meninges	C70*	10	20
Benign Meninges	D32*	12	23
Multiple Myeloma	C90*	9	19
Nervous System	C72*	10	20

Neoplasm Coding Quick Reference Guide

Common ICD-10 Diagnosis Codes

Active Cancer Code Categories, Continued (Not All-Inclusive)	ICD-10	V24 HCC	V28 HCC
Ovary	C56*	10	22
Pancreas	C25*	9	20
Prostate	C61	12	23
Rectum	C20	11	22
Rectosigmoid Junction	C19*	11	22
Secondary (Metastasis)	C77*-C79*	8,10	17,18,20
Small Intestine	C17*	9	20
Thyroid	C73*	12	23
Uterine	C54*-C55	12	23

"History Of" Cancer Codes (Not All-Inclusive)	ICD-10	V24 HCC	V28 HCC
Anus/Rectum/Rectosigmoid Junction	Z85.04*	_	_
Bladder	Z85.51	_	_
Bone	Z85.830	_	_
Brain/Meninges	Z85.841	_	_
Benign Brain	Z86.011	_	_
Breast	Z85.3	_	_
Cervical	Z85.41	_	_
Colon (Large Intestine)	Z85.03*	_	_
Esophagus	Z85.01	_	_

*Indicates additional character(s) required to complete code assignment

Neoplasm
Coding Quick Reference Guide

Common ICD-10 Diagnosis Codes

"History Of" Cancer Codes Continued (Not All-Inclusive)	ICD-10	HCC	V28 HCC
Endometrium	Z85.42	_	_
Kidney	Z85.52*	_	_
Leukemia **(in remission, use active code with the 5th character of 1)**	Z85.6	_	_
Lung	Z85.11*	_	_
Lymphoma	Z85.7*	_	_
Melanoma	Z85.820	_	_
Multiple Myeloma **(in remission, use active code with the 5th character of 1)**	Z85.79	_	_
Nervous System	Z85.848	_	_
Ovary	Z85.43	_	_
Pancreas	Z85.07	_	_
Prostate	Z85.46	_	_
Small Intestine	Z85.06*	_	_
Thyroid	Z85.850	_	_
Uterine	Z85.42	_	_

*Indicates additional character(s) required to complete code assignment