Clinical documentation and coding tips

Cancer

Cancer is a complex group of diseases characterized by the uncontrolled growth and spread of abnormal cells in the body. These cells can invade and damage surrounding tissues and organs. Cancer can arise in various forms, depending on the type of cells involved, and is often categorized by its origin:

- **Carcinomas:** Originate from epithelial cells.
- **Sarcomas:** Originate from connective tissues.
- **Leukemias:** Originate from blood-forming tissues.
- **Lymphomas:** Originate from the immune system.

ICD-10 documentation guidance for cancer

To ensure accurate documentation, follow these guidelines:

General documentation requirements	• Document to the highest specificity and severity, including laterality when relevant. • Clearly differentiate whether the neoplasm is: — Benign — In-situ — Malignant — Of uncertain histologic behavior — Laterality
For malignant neoplasm	• Document the primary site (original site of the cancer). • Document any secondary sites (locations where cancer has spread). • Include details of current treatments which may involve: — Chemotherapy — Radiation — Hormonal Therapy — Surgery — Watchful Waiting — Refusal of Treatment
When malignant neoplasms are no longer active	If the neoplasm has been excised or eradicated and the patient is not receiving further treatment: • Use a code from category Z85 (Personal history of malignant neoplasm). • This applies only if the patient is not receiving **active treatment** and there are **no indications of current disease.**

Documentation best practices

For Metastatic Neoplasms	Invalid documentation	Proper documentation
Ensure documentation includes both the **primary site** and **secondary sites**, along with the patient's current treatment. **Note:** Refer to ICD-10 Official Guidelines for Coding and Reporting 1.C.2.l for proper sequencing of the main diagnosis.	Z85.3 *"History of breast cancer, no recurrence, cont. current Tamoxifen tx"* **Why it is invalid:** The patient is still being treated with Tamoxifen, so this condition should be documented as **active cancer**, not history.	C50.- *"Breast cancer, no recurrence, continue current Tamoxifen treatment."*

Note: A dash (-) indicates that additional characters are required to complete the code.

References

- Contract-Level Risk Adjustment Data Validation Medical Record Reviewer Guidance In effect as of 03/20/2019. Yew, K.S. & Cheng, E.M. (2015).
- Optum (2025). ICD-10-CM Expert for Physicians: The Complete Official Code Set (2025)
- ICD-10-CM Official Guidelines for Coding and Reporting FY 2025; Section I.A.15