



### Documentation and Coding

# Cancer and Cancer-Related Treatments

One in three people in the U.S. will be diagnosed with cancer in their lifetime, according to the [American Cancer Society](#). Accurately and completely coding and documenting cancer and cancer-related treatments may help improve member outcomes and continuity of care. Below is information for outpatient and professional services from the [ICD-10-CM Official Guidelines for Coding and Reporting](#).

### Coding Cancer and Cancer-Related Treatments

- To properly code a neoplasm, specify if the neoplasm is benign, in situ, malignant or of uncertain histology. Any metastases should be noted.
- All known treatments and complications should be documented.
- A statement of "History of" indicates the condition is resolved. Don't document "History of" for members with active cancer or current treatment.
- A code from Z85.x, Personal history of malignant neoplasm, is appropriate if a primary malignancy has been previously excised or eradicated from its primary site and there is no further treatment.

### Tips to Consider

- Include patient demographics such as name, date of birth and date of service in all progress notes.
- Document legibly, clearly and concisely.
- Ensure a credentialed provider signs and dates all documents.
- Document how each diagnosis was monitored, evaluated, assessed and/or treated on the date of service.
- Note complications with an appropriate treatment plan.
- Take advantage of the Annual Health Assessment or other yearly preventative exam as an opportunity to capture conditions impacting member care.

Sample ICD-10-CM Codes for Neoplasms	
C00-C96	Malignant neoplasms
D00-D09	In situ neoplasms
D10-D36	Benign neoplasm
D3A	Benign endocrine tumors
D37-D48	Neoplasm of uncertain behavior
D49	Neoplasms of unspecified behavior
Z85.0–Z85.9	Personal history of malignant neoplasm

### Resources

- [ICD-10-CM Official Guidelines for Coding and Reporting](#)
- [Chapter 2: Neoplasms \(C00-D49\)](#)

The material presented here is for informational/educational purposes only, is not intended to be medical advice or a definitive source for coding claims and is not a substitute for the independent medical judgment of a physician or other health care provider. Health care providers are encouraged to exercise their own independent medical judgment based upon their evaluation of their patients' conditions and all available information, and to submit claims using the most appropriate code(s) based upon the medical record documentation and coding guidelines and reference materials. References to other third-party sources or organizations are not a representation, warranty or endorsement of such organization. Any questions regarding those organizations should be addressed to them directly.

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