

The following may be used as a reference guide for Malignant Neoplasm documentation and coding. It is important to note that **solid tumor cancer** should be coded only when it is considered **active**.

Cancer is considered active when:

- Patient is currently undergoing chemotherapy, radiation, or anti-neoplasm drug therapy (adjuvant therapy such as Arimidex)
- Current pathology revealing cancer
- Newly diagnosed patient awaiting treatment
- Refusal of therapeutic treatment by patient or watchful waiting
 - If a patient declines adjuvant therapy, the cancer would then be considered "history of" since initial treatment has been completed if there is no evidence of any remaining malignancy
 - The term "watchful waiting" (active surveillance) only applies if no treatment is directed at the cancer and is only monitored for progression
- The cancerous organ has been removed or partially removed, and the patient is still receiving ongoing treatment

Cancer Documentation

- Type of cancer
- Malignant primary and secondary metastases
 - If multiple metastatic sites are involved, each site should be documented and coded
 - Include laterality when applicable
- Status of cancer (active or historical)
 - Avoid using "history of" if the patient receives active treatment
 - Cancer that has been fully eradicated and is no longer getting active treatment can be assessed with a "Personal History of" code
- Current treatment
- Remember to document and code any complications due to cancer that are present, such as malnutrition, cachexia, or secondary immunodeficiency due to cancer or chemotherapy

Leukemias, Lymphomas, and Myelomas

- Ensure to document remission codes, as these codes also risk adjust
- Indicate:
 - Not having achieved remission
 - In remission
 - In relapse

If no recurrence is documented, or if the record states no evidence of recurrence, then it would not be appropriate to code the cancer as active, even if treatment is being provided.

For questions or more information, please contact:

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