Provider CQDocumentation Guide

Malignant (primary) Neoplasm, Unspecified

Also known as Carcinoma of Unknown Primary (CUP) or Occult Primary Tumor. Malignant neoplasm without specification of site, equates to cancer, unspecified. This code should only be used when no determination can be made as to the primary site of a malignancy.

Documentation Requirements	
Site:	When possible, documentation should always provide the primary neoplasm origin. If site is truly unknown, this should be clearly documented as such in the medical record.
Laterality:	When appropriate, anatomic laterality should be assigned to the site of neoplasm. In the case of Malignant (primary) Neoplasm, Unspecified/CUP, this may not be possible.

EMR Diagnosis Key Search Term	
Diagnosis Etiology	**Diagnosis Complication**
Key Search Term: Key Search Term:	Key Search Term: Key Search Term:

Documentation and Reporting Guidelines

Best Practice Documentation Recommendations for Documenting Neoplasms

- When using the terms “metastatic” and “metastasis,” be sure the documentation clearly reflects the primary site and secondary site(s). Use of the words “to” and “from” or “primary” and “secondary” will help clarify the origin of the neoplasm
- For active cancer diagnosis, avoid the phrase “history of” as this indicates a” past history” rather than an ongoing history
- When cancer has been excised or eradicated from its site and there is no further treatment directed to the site and there is no evidence of active malignancy, designate this as “personal history of malignant neoplasm”
- Update the PMH section of the note to include any surgical procedures related to cancer along with the date, if known

Chronic Diseases

- Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s).

Conditions that Co-exist at the time of the encounter

- Code all documented conditions that coexist at the time of the encounter and requires or affects patient care treatment or management.
- Do not code conditions that were previously treated and no longer exist.
- History codes may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.