



Government of **Western Australia**
Department of **Health**

Clinical coding guidelines: Malignant neoplasms

ICD-10-AM/ACHI/ACS Eleventh Edition

WA Clinical Coding Authority

Purchasing and System Performance Division

January 2020

Lymphoid, haematopoietic and related tissues

These malignancies are systemic with the malignant cells circulating through the lymphatic or haematopoietic systems. They do not metastasise in the same way as solid tumours. See ACS 0222 *Lymphoma* and ACS 0245 *Remission in malignant immunoproliferative diseases and leukaemia* for further information.

Histology and behaviour

Histological type is usually determined via microscopic examination of a bone marrow or lymph node specimen. Flow cytometry, chromosomal analysis, cytogenetics and molecular studies provide further diagnostic information (Bradstock 2008).

Solid neoplasms

Coding solid malignant neoplasms involves abstracting information about the anatomical site(s) of the tumour(s) and the histological type(s).

Primary site

The site where cancer originates is known as the primary site. A neoplasm is always described in terms of the primary site, even if it has spread (metastasised) to another part of the body. For example, colon cancer that has metastasised to the liver is always described as colon cancer (not liver cancer) even if the colon tumour has been surgically excised.

Secondary site

When cancer cells spread to other parts of the body and form secondary deposits/tumours, these are referred to as secondary sites or metastases. Spread can occur through the lymphatic system and the bloodstream. Initial metastatic spread is usually to the regional (nearby) lymph nodes, and subsequently to other organs or seeding through the peritoneum. Peritoneal seeding can occur after abdominal surgery due to direct mechanical contamination or local peritoneal trauma.

Ectopic

Malignant neoplasms of ectopic tissue are to be coded to the site where they are found e.g. ectopic pancreatic malignant neoplasms of ovary are coded to ovary (C56), as per Tabular List note 6 at C00-D48. In Tenth Edition there was a change in practice for coding malignant neoplasms of ectopic tissue. Prior to Tenth Edition, this same example would have been coded to pancreas (C25.9).

Hints

- Metastases should not be confused with invasion of adjacent organ by the primary tumour. For example, prostate adenocarcinoma invading bladder neck is local invasion and not a metastasis to the bladder. Only the primary site (prostate) is coded.
- See ACS 0239 *Metastases* and ACCD Coding Rule Q3206 *TNM Stage documentation* (July 2018) for further information and guidelines about interpreting metastasis documentation.
- A reasonable practical effort should be made to locate past documentation (e.g. histopathology report) to provide additional specificity to a documented neoplasm in the current admitted episode. This may include gaining specificity about primary site, secondary site and/or morphology.

Solid neoplasms (continued)

Histology and behaviour

A solid tumour's histological type and behaviour is determined by a histopathologist via microscopic examination of a tissue specimen, and detailed in the histopathology report. The specimen may be from the primary or secondary site. Coders should abstract the histological type and behaviour from the body and/or conclusion of the histopathology report in accordance with ACCD Coding Rule Q3147 *Selection of morphology codes from pathology reports* (April 2017, updated 15 Jun 2019). This information may be used to assign site(s) codes and morphology code(s). See also ACS 0233 *Morphology* for further information.

Histopathology specimens provide a more specific diagnosis than cytology specimens, and if both are available, code only the information from the histopathology result.

Diagnostic terminology that may be used to describe neoplasms is provided in the below table as a general guide for coders. Abstraction should be performed in accordance with ACS 0010 *Clinical documentation and general abstraction guidelines*.

Terms likely to indicate malignancy	Uncertain terms - clinician clarification required before coding malignancy
apparent(ly)	cannot be ruled out
appears (to)	equivocal
compatible with	possible
consistent with	potentially malignant
favour(s) / favouring	questionable
features (are those) of	raising the possibility of
in keeping with	suspicious (for)
malignant appearing	worrisome
most likely	
presumed	
probable	
suspected	
strongly suggestive of	
supports a diagnosis of	
highly suspicious (for)	
typical of	

(SEER Training Modules 2012)

Current cancer versus personal history of cancer

Follow the instructions in ACS 0236 *Neoplasm coding and sequencing* to determine whether cancer should be coded as a current condition or as personal history.

Sequencing neoplasm codes

ACS 0236 *Neoplasm coding and sequencing* directs that sequencing of primary and secondary sites for metastatic cancer cases is dependent on the treatment at each episode. Therefore it may be appropriate to sequence the secondary code(s) before the primary code(s) in some episodes.

Example: Patient admitted for drainage of malignant ascites (metastatic from ovarian carcinoma). The metastasis is the reason for admission and is sequenced as principal diagnosis:

C78.6 *Secondary neoplasm of peritoneum and retroperitoneum*

M8010/6 *Carcinoma, metastatic NOS*

C56 *Primary malignant neoplasm of ovary*

M8010/3 *Carcinoma NOS*

Principal diagnosis selection should be in accordance with ACS 0001 *Principal diagnosis*, except for same-day chemotherapy or same-day radiotherapy where the following standards should be followed:

ACS 0044 *Pharmacotherapy*

ACS 0229 *Radiotherapy*

See also WA Clinical Coding Authority *Clinical Coding Guidelines: Chemotherapy*.

Recurrence

The term 'recurrence' refers to malignancy returning after it has been previously eradicated. The recurrence may occur in the same site as the original primary, and/or as a metastasis. Regardless of where the recurrence occurs, assign a code for the original primary site. Code also any other metastatic sites.

See also ACS 0237 *Recurrence of malignancy* which includes examples illustrating coding of morphology, behavior and site. A reasonable practical effort should be made to locate past documentation (e.g. histopathology report) to gain specificity about a documented recurrent neoplasm i.e. gain specificity about the original primary site.

Unknown primary

In some situations it cannot be determined where a cancer originated. For example, metastases are discovered but further investigations reveal no primary site; or a decision is made not to perform investigations. For these cases assign the appropriate code from C80 *Malignant neoplasm without specification of site* as the primary site.

Overlapping sites

'Overlapping' implies that the sites involved are contiguous (next to each other). A neoplasm that overlaps contiguous sites and whose point of origin cannot be determined should be classified to the subcategory .8 ('overlapping lesion'), unless the combination is specifically indexed elsewhere.

See examples below, and also refer to ACS 0234 *Contiguous sites* for further information.

Example 1: Overlapping tongue primary

Carcinoma of the tip and ventral surface of the tongue.

It is not known which of the sites the tumour originated: tongue tip (C02.1) or ventral surface (C02.2).

Assign:

C02.8 Malignant neoplasm of *overlapping lesion of tongue*

M8010/3 *Carcinoma NOS*

Example 2: Tip of tongue primary extending to contiguous site

Carcinoma of the tip of the tongue extending to involve the ventral surface. The point of origin (tip of tongue) is known, assign:

C02.1 Malignant neoplasm of *border of tongue*

M8010/3 *Carcinoma NOS*

Example 3: Overlapping breast primary

Ductal carcinoma 3 o'clock left breast. It is not known which of the sites the tumour originated: upper outer quadrant (C50.4) or lower outer quadrant (C50.5). Assign:

C50.8 *Overlapping malignant lesion of breast*

M8500/3 *Infiltrating duct carcinoma NOS*

Multiple tumours

Occasionally multiple primaries occur with separate tumours in the same organ or in different organs. The separate tumours may have the same or different morphology. When there are multiple tumours, the documentation should be carefully checked to determine whether the tumours are considered to be multiple separate primaries, or a primary tumour with metastatic spread. The clinical coder should be guided by the clinical documentation and query with the clinician if unsure. The terms multi-focal or multi-centric may be used to describe multiple tumours, particularly of the breast. In cases of primary skin melanoma the terms sateliosis, satellite nodule, satellite tumour, and satellite deposit generally refer to a local metastasis rather than multiple tumours.

A separate site code for each primary site should be assigned as per the following examples:

Example 1: Multiple primaries of breast

Left breast tumour at 11 o'clock and two tumours at 2 o'clock. Histology showed all cancers were invasive ductal carcinomas, all were ER and PR positive, HER2 negative, and 1/14 axillary lymph nodes contained tumour.

C50.2 *Malignant neoplasm of upper-inner quadrant of breast*

C50.4 *Malignant neoplasm of upper-outer quadrant of breast*

M8500/3 *Infiltrating duct carcinoma NOS*

C77.3 *Secondary and unspecified malignant neoplasm of axillary and upper limb lymph nodes*

M8500/6 *Infiltrating duct carcinoma NOS, metastatic*

Multiple tumours (continued)

Example 2: Multiple primaries of lung

Two poorly differentiated nodules in the left lung (one in upper lobe and one in lower lobe), as well as contralateral scalene lymphadenopathy. Biopsy of scalene node showed adenocarcinoma.

C34.1	<i>Malignant neoplasm of upper lobe, bronchus or lung</i>
C34.3	<i>Malignant neoplasm of lower lobe, bronchus or lung</i>
M8140/3	<i>Adenocarcinoma NOS</i>
C77.0	<i>Secondary and unspecified malignant neoplasm of lymph nodes of head, face and neck</i>
M8140/6	<i>Adenocarcinoma, metastatic NOS</i>

Example 3: Multiple primaries of bladder

TURBT lesion bladder wall and lesion LUO. Histology showed TCC.

C67.9	<i>Malignant neoplasm of bladder, unspecified</i>
C67.6	<i>Malignant neoplasm of ureteric orifice</i>
M8120/3	<i>Transitional cell carcinoma NOS</i>

Example 4: Lung primary with metastases in lung

Infiltrating spiculated mass measuring 30mm in right apex, with multiple nodules throughout right upper and middle lobes consistent with intrapulmonary metastases, and positive mediastinal lymphadenopathy.

C34.1	<i>Malignant neoplasm of upper lobe, bronchus or lung</i>
M8000/3	<i>Neoplasm malignant</i>
C77.1	<i>Secondary and unspecified malignant neoplasm of intrathoracic lymph nodes</i>
C78.0	<i>Secondary malignant neoplasm of lung</i>
M8000/6	<i>Neoplasm, metastatic</i>

Example 5: Colon primary with metastasis in liver

Ascending colon adenocarcinoma with 3/10 positive regional lymph nodes. CT showed solitary liver lesion, confirmed as metastasis on PET scan.

C18.2	<i>Malignant neoplasm of ascending colon</i>
M8140/3	<i>Adenocarcinoma NOS</i>
C77.2	<i>Secondary and unspecified malignant neoplasm of intra-abdominal lymph nodes</i>
C78.7	<i>Secondary malignant neoplasm of liver and intrahepatic bile duct</i>
M8140/6	<i>Adenocarcinoma, metastatic NOS</i>

Wider excision of skin cancer

If histopathology shows inadequate margins, the patient may be re-admitted for wider excision to ensure any remaining cancer is removed. If no residual malignancy is found in the subsequent sample, the original primary malignancy should still be coded as a current condition, as per ACS 0236 *Neoplasm coding and sequencing*.

Multiple skin lesions

Multiple skin lesions may be removed during the same visit to theatre. This can present a problem for coders due to the limitation of only being able to use each ICD-10-AM diagnosis code ONCE per episode.

Example

Neck x1 lesion (C44.4): basal cell carcinoma

Ear x2 lesions (C44.2): 1x squamous cell carcinoma and 1x basal cell carcinoma

Relevant codes:

C44.4	<i>Malignant neoplasm of skin of scalp and neck</i>
M8090/3	<i>Basal cell carcinoma NOS</i>
C44.2	<i>Malignant neoplasm of skin of ear and external auricular canal</i>
M8070/3	<i>Squamous cell carcinoma NOS</i>
C44.2	<i>Malignant neoplasm of skin of ear and external auricular canal</i>
M8090/3	<i>Basal cell carcinoma NOS</i>

Coders are unable to assign the same diagnosis code more than once per episode – hence in the above example C44.2 and M8090/3 cannot be assigned twice. Coders are forced to omit codes but try to capture as many elements as possible. In order to capture the two different sites and morphologies, omit the codes for BCC of the ear:

C44.4	<i>Malignant neoplasm of skin of scalp and neck</i>
M8090/3	<i>Basal cell carcinoma NOS</i>
C44.2	<i>Malignant neoplasm of skin of ear and external auricular canal</i>
M8070/3	<i>Squamous cell carcinoma NOS</i>
C44.2	<i>Malignant neoplasm of skin of ear and external auricular canal <u>OMIT</u></i>
M8090/3	<i>Basal cell carcinoma NOS <u>OMIT</u></i>

The final code assignment captures as many elements as possible (two sites and two morphologies):

C44.4	Malignant neoplasm of skin of scalp and neck
M8090/3	Basal cell carcinoma NOS
C44.2	Malignant neoplasm of skin of ear and external auricular canal
M8070/3	Squamous cell carcinoma NOS

The procedure coding reflects the exact number of separate lesions excised. As per ACS 0020 *Multiple/bilateral procedures*, assign:

31235-01 [1620]	Excision of lesion(s) of skin and subcutaneous tissue of neck
31230-02 [1620]	Excision of lesion(s) of skin and subcutaneous tissue of ear
31230-02 [1620]	Excision of lesion(s) of skin and subcutaneous tissue of ear

Palliative care

ACS 2116 *Palliative care* should be followed where there is documented evidence that the patient has been provided with palliative care. Z51.5 *Palliative care* should only be assigned as an additional diagnosis, and can be assigned independent of care type.

Reconstruction of breast following mastectomy

Reconstruction of the breast may be performed at the same time as mastectomy or in a subsequent admission.

ACS 1204 *Plastic surgery* provides guidance for coding of reconstructive plastic surgery. For admission specifically for post-mastectomy breast reconstruction refer first to ACS 0236 *Neoplasm coding and sequencing* to determine whether breast cancer should be coded as a current condition or as personal history.

- If coding current breast cancer, this will be the principal diagnosis as per ACS 1204 *Plastic surgery*.
- If coding personal history of breast cancer, Z42.1 *Follow-up care involving plastic surgery of breast* should be assigned as principal diagnosis, as per Alphabetic Index pathway: Aftercare, following surgery, breast.

Incidental diagnosis of malignancy

ACS 0010 *Clinical documentation and general abstraction guidelines* instructs that findings on test results should not be routinely coded unless a clinician can indicate that a test result is significant and/or indicates the relationship between the test result and a condition. Examples from TN198 *Coding of findings on pathology results* (effective 15 December 2009, retired 30 June 2019) include:

- **A patient is admitted with chronic ongoing pelvic pain for abdominal hysterectomy. Pathology results show CIN III, would you code CIN III as an additional diagnosis?**

Clinical advice confirms that CIN III in the scenario cited is an unexpected finding:

'CIN III usually does not produce any symptoms at all, and certainly not pelvic pain. It results in an abnormal smear test, which then requires assessment by colposcopy and biopsy. It is usually treated by laser or cone biopsy, rarely by hysterectomy. In this instance it was likely to be an unexpected finding on histologic examination of the excised uterus, where the uterus was removed for pain not the CIN III.'

Therefore, in the scenario cited CIN III should not be coded as per the guidelines in ACS 0010 *Clinical documentation and general abstraction guidelines*.

- **A patient is admitted with breast hypertrophy for reduction mammoplasty. After discharge pathology of the breast reveals ductal carcinoma in situ (DCIS). Would you code the DCIS?**
In the scenario cited the finding of DCIS on pathology is an unexpected finding and should not be coded, as per the guidelines in ACS 0010 *Clinical documentation and general abstraction guidelines*.

The above scenarios have also highlighted an issue where coders may consider it necessary to assign a cancer code to generate a cancer notification for the cancer registry. Coders should be aware that the pathology department will do this automatically, irrespective of whether the condition is coded in the admitted episode of care.

See also ACS 0002 *Additional diagnoses, Incidental findings and conditions*.

Prophylactic organ removal

When a patient is admitted for prophylactic surgery, follow ACS 2114 *Prophylactic surgery* which instructs that a code from Z40 *Prophylactic surgery* may be assigned as principal diagnosis; and any risk factor necessitating prophylactic surgery be assigned as additional diagnosis.

Example 1

Patient admitted for mastectomy for ductal carcinoma of left breast, and prophylactic mastectomy of right breast.

Diagnosis code assignment:

C50.9 *Malignant neoplasm of breast, unspecified part*
M8500/3 *Infiltrating duct carcinoma NOS*
Z40.00 *Prophylactic surgery for risk-factors related to malignant neoplasm, breast*

As per ACS 0001 *Principal diagnosis*, the reason chiefly responsible for occasioning this episode is breast cancer which is sequenced as principal diagnosis.

Example 2

Consider again example 1, however the planned prophylactic right mastectomy is not performed at the same time as the left mastectomy. Instead it is scheduled for 6 weeks later (staged surgery).

Diagnosis code assignment:

Z40.00 *Prophylactic surgery for risk-factors related to malignant neoplasm, breast*
C50.9 *Malignant neoplasm of breast, unspecified part*
M8500/3 *Infiltrating duct carcinoma NOS*

As per ACS 0001 *Principal diagnosis*, the reason chiefly responsible for occasioning this episode is prophylactic surgery, therefore Z40.00 is sequenced as principal diagnosis. ACS 0236 *Neoplasm coding and sequencing* provides guidance in determining whether the cancer should be coded as a current condition. As per ACS 0236, because the episode is for staged prophylactic surgery, the cancer is coded as a current condition irrespective of whether it is considered 'cured' or is receiving current treatment.

Example 3

Patient previously underwent a left mastectomy for breast cancer, followed by chemotherapy. Follow-up investigations confirmed the cancer was cured and no further treatment was required. Due to patient's anxiety regarding possible cancer recurrence, the patient decides to have a prophylactic right mastectomy.

Diagnosis code assignment:

Z40.00 *Prophylactic surgery for risk-factors related to malignant neoplasm, breast*
Z85.3 *Personal history of malignant neoplasm of breast*

Prophylactic surgery was not part of the initial treatment plan and is therefore not considered staged, so the 'staged prophylactic surgery' criteria in ACS 0236 do not apply in this instance and cancer is not automatically coded as a current condition. None of the other criteria in ACS 0236 are met either - the cancer has been cured and is not receiving any current management so it is coded as personal history.

Prophylactic organ removal (continued)

Example 4

Treatment plan decided for newly diagnosed breast cancer patient: mastectomy followed by prophylactic oophorectomy 6 months later. Patient admitted for prophylactic bilateral oophorectomy.

Diagnosis code assignment:

Z40.01 *Prophylactic surgery for risk-factors related to malignant neoplasm, ovary*
C50.9 *Malignant neoplasm of breast, unspecified part*
M8000/3 *Neoplasm, unspecified*

As per ACS 0001 *Principal diagnosis*, the reason chiefly responsible for occasioning this episode is prophylactic surgery, therefore Z40.01 is sequenced as principal diagnosis. ACS 0236 *Neoplasm coding and sequencing* provides guidance in determining whether the cancer should be coded as a current condition. As per ACS 0236, because the episode is for staged prophylactic surgery, the cancer is coded as a current condition irrespective of whether it is considered 'cured' or is receiving current treatment.

Hints

- There is no ICD-10-AM code for gene mutation. If this is the only risk factor for which prophylactic surgery is being performed, assign the appropriate code from Z40 *Prophylactic surgery* alone.
- When selecting the appropriate code from Z40 *Prophylactic surgery*, select the code that corresponds with the healthy organ being removed in this episode (see example 4 above).
- When both Z40 *Prophylactic surgery* and Z42.1 *Follow-up care involving plastic surgery of breast* equally meet the definition for principal diagnosis, apply ACS 0001 *Principal diagnosis* to determine sequencing.

Acknowledgment

The WA Clinical Coding Authority acknowledges the WA Clinical Coding Technical Advisory Group for their contribution in development of this document.

References

Bradstock, Kenneth. 2008. "Early diagnosis and referral of lymphoma is critical." Leukaemia Foundation. Accessed June 4, http://www.leukaemia.org.au/fileadmin/dl-docs/special/Early_diagnosis_of_lymphoma.pdf

SEER Training Modules. 2012. "Abstracting the Medical Records". U.S. National Institutes of Health, National Cancer Institute. Accessed June 4, <http://training.seer.cancer.gov/abstracting/intro/>

This document can be made available in alternative formats on request for a person with a disability.

© Department of Health 2020

Copyright to this material is vested in the State of Western Australia unless otherwise indicated. Apart from any fair dealing for the purposes of private study, research, criticism or review, as permitted under the provisions of the *Copyright Act 1968*, no part may be reproduced or re-used for any purposes whatsoever without written permission of the State of Western Australia.