Coding Pitfalls

NAACCR 2016-2017 Webinar Series

Presented by:

Steve Peace

Angela Martin

Jim Hofferkamp jhofferkamp@naaccr.org

Q&A

- Please submit all questions concerning webinar content through the Q&A panel.
- Reminder:
  - If you have participants watching this webinar at your site, please collect their names and emails.
  - We will be distributing a Q&A document in about one week. This document will fully answer questions asked during the webinar and will contain any corrections that we may discover after the webinar.

Fabulous Prizes

Agenda

- Coding Pitfalls in the Context of Text Documentation
- Purpose and Use of Text Documentation
- NCRA Informational Abstracts Series
- Other Documentation Resources
- Coding Pitfalls and Text
  - Lung
  - Colon
  - Melanoma
  - Brain and CNS
- Text Pointers for Changing Registry Standards
- Coding Pitfalls and Text – Quiz

Coding Pitfalls in Context of Text Documentation

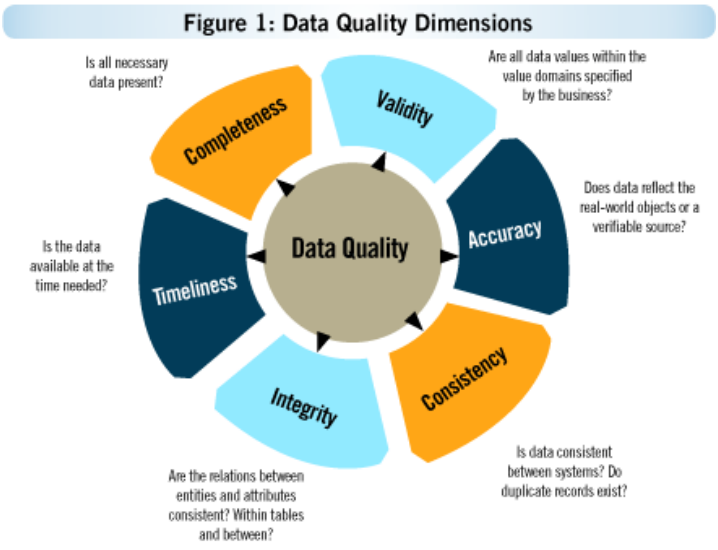
- Text Documentation as a Requirement for Abstracting
- We All Make Abstracting and Coding Mistakes
- Our Abstracts are Not Just a Bunch of Codes
- Explains the Continuum of Cancer Care
- Helps Identify Missing Information
- Helps Improve Abstract Quality
- Improves Overall Data Quality
- Not Everything Gets Coded
- Text is a Valuable Resource
- Codes are Just Numbers…

D.I.K.W.

- ✓ Data
- ✓ Information
- ✓ Knowledge
- ✓ Wisdom

NAACCR

Coding Pitfalls in Context of Text Documentation



http://www.realisedatasystems.com/3-reasons-why-data-quality-should-be-your-top-priority-this-year/

D.I.K.W.

- ✓ Data
- ✓ Information
- ✓ Knowledge
- ✓ Wisdom

NAACCR

Purpose and Use of Text Documentation

- Purpose: Describe the patient's continuum of cancer care from presentation symptoms to diagnosis, from workup to staging, from treatment to progression and any care post-treatment until the end of life whether due to cancer or not.
- Explain/Confirm/Validate/Supplement Codes
- Who Uses Text and How Do They Use It?
  - New Registrar Learning to Abstract
  - Hospital Registrar and Physicians
  - Central Registry and Data Quality
  - Clinical Research and Other Data Users
  - Epidemiologist and Use of Text
  - Feedback to Individual
  - Feedback for Training

NAACCR

Purpose and Use of Text Documentation

- Your Text Should Tell a Story…
- Overall: helps reinforce critical data items and helps identify where abstractors and coders have problems or do not understand certain new (and older) concepts, instructions, etc.
- New Registrar: Used as a check on your learning progress
- Hospital Registrar: When you are no longer there & physician QC
- Registry Manager: Quality Control of Contractors and FTE Staff
- Central Registry: Quality Control, Setting Override Fields, Visual Editing, Data Quality Audits and New Abstractor Review
- Data User & Researchers: Clinical Summary in English for quick view of cases in language they understand and Use in Patient Contact Studies

NAACCR

Purpose and Use of Text Documentation

- Text documentation should always include the following components:
  - Date(s) – include date(s) references – this allows the reviewer to determine event chronology
  - Date(s) – note when date(s) are estimated [i.e. Date of DX 3/15/2014 (est.)]
  - Location – include facility/physician/other location where the event occurred (test/study/treatment/other)
  - Description – include description of the event (test/study/treatment/other) – include positive/negative results
  - Details – include as much detail as possible – document treatment plan even if treatment is initiated as planned
  - Include "relevant-to-this-person/cancer" information only
  - DO EDIT your text documentation
  - DO NOT REPEAT INFORMATION from section to section
  - DO USE NAACCR Standard Abbreviations
  - DO NOT USE non-standard or stylistic shorthand
- When Information is Missing or Incomplete in the Medical Record – document info is not there

Pop Quiz 1

- Text Documentation accounts for what percent of a typical analytic case abstract?
  - A. 0%-24%
  - B. 24%-49%
  - C. 50%
  - D. 50%-75%
  - E. 75%-100%
- Should I include a date for each tumor marker test or diagnostic image (CT, PET, MRI or chest x-ray) or surgical procedure performed that is pertinent to my case?

NCRA Informational Abstracts Series

- http://www.cancerregistryeducation.org/rr

Informational Abstracts

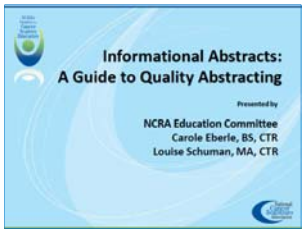
- Informational Abstract: Adult Primary: Benign Brain
- Informational Abstract: Adult Primary: Malignant Brain
- Informational Abstract: Bladder
- Informational Abstract: Breast
- Informational Abstract: Cervical
- Informational Abstract: Colon
- Informational Abstract: Endometrial
- Informational Abstract: Kidney
- Informational Abstract: Lung
- Informational Abstract: Melanoma
- Informational Abstract: Ovarian
- Informational Abstract: Pancreas
- Informational Abstract: Prostate
- Informational Abstract: Renal/Pelvis/Ureter

To test your knowledge of the Informational Abstracts and earn CE credit, go to Other CE Opportunities.

Video Presentation Materials

- PowerPoint Slides
- Where to Find Information to Abstract Various Data Items PDF
- Medical Record - Breast
- Medical Record - Colon

These site-specific abstracts provide an outline to follow when determining what text documentation to include.



NCRA Informational Abstracts Series

- **Text Documentation is Not Just for Cancer Information**
  - Demographic – including sex of patient and race/ethnicity
  - Exposures to Toxic Chemicals and Lifestyle Information
  - Characteristics of Neoplasm – Cancer Information
  - Diagnostic Workup Sections – including dates
  - Staging Documentation (including SSF/SSDI)
  - Treatment Detail – including dates
  - No Field to Code New Information
  - Non-Standard Information
  - Unique Characteristics
  - Other

INCLUDES: Where to Find Information in the Medical Record and What You Need to Document in the Abstract Text

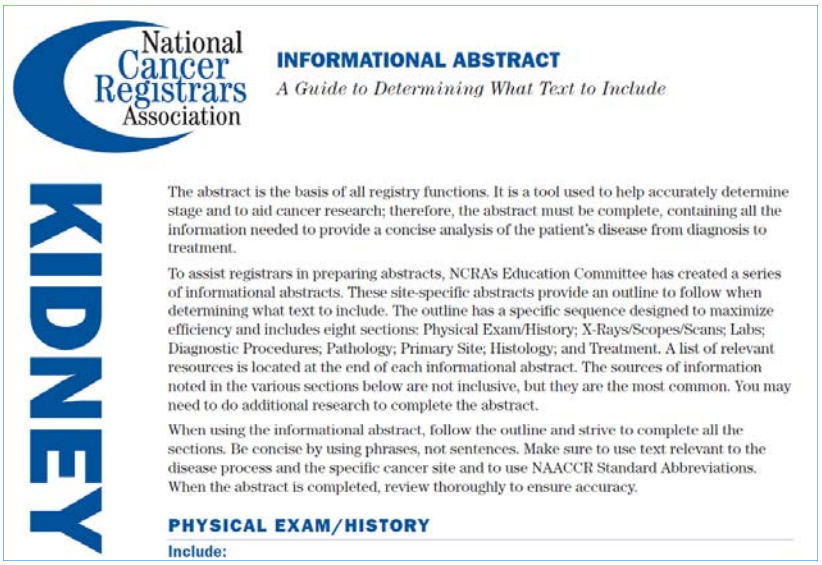
NCRA Informational Abstracts Series

- **THIS INFORMATION IS NOT JUST FOR THE NEW ABSTRACTOR**
  - ✓ Follow the outline.
  - ✓ Strive to complete all the sections.
  - ✓ Be concise by using phrases, not sentences.
  - ✓ Use text relevant to the disease process and the specific cancer site.
  - ✓ Use NAACCR Standard Abbreviations – don't just make things up.
  - ✓ When the abstract is completed, review thoroughly to ensure accuracy.

NCRA Informational Abstracts Series - Sections

- **Physical Exam and History** - today and leading up to diagnosis
- **Physical Exam and History** – chronology of care for non-analytic
- **Primary Site** – small field for what you coded as primary site
- **Histology** – small field for what you coded as histology
- **Diagnostic Procedures** – beyond imaging, labs and pathology
- **X-Rays/Scopes/Scans** – Any Imaging
- **Labs – Includes Site-Specific Data Items** - SSFs
- **Pathology** – dates, final diagnosis, comments and addenda
- **Treatment** – each treatment type has own section for text

NCRA Informational Abstracts Series - Sections



National Cancer Registrars Association

INFORMATIONAL ABSTRACT

A Guide to Determining What Text to Include

KIDNEY

The abstract is the basis of all registry functions. It is a tool used to help accurately determine stage and to aid cancer research; therefore, the abstract must be complete, containing all the information needed to provide a concise analysis of the patient's disease from diagnosis to treatment.

To assist registrars in preparing abstracts, NCRA's Education Committee has created a series of informational abstracts. These site-specific abstracts provide an outline to follow when determining what text to include. The outline has a specific sequence designed to maximize efficiency and includes eight sections: Physical Exam/History; X-Rays/Scopes/Scans; Labs; Diagnostic Procedures; Pathology; Primary Site; Histology; and Treatment. A list of relevant resources is located at the end of each informational abstract. The sources of information noted in the various sections below are not inclusive, but they are the most common. You may need to do additional research to complete the abstract.

When using the informational abstract, follow the outline and strive to complete all the sections. Be concise by using phrases, not sentences. Make sure to use text relevant to the disease process and the specific cancer site and to use NAACCR Standard Abbreviations. When the abstract is completed, review thoroughly to ensure accuracy.

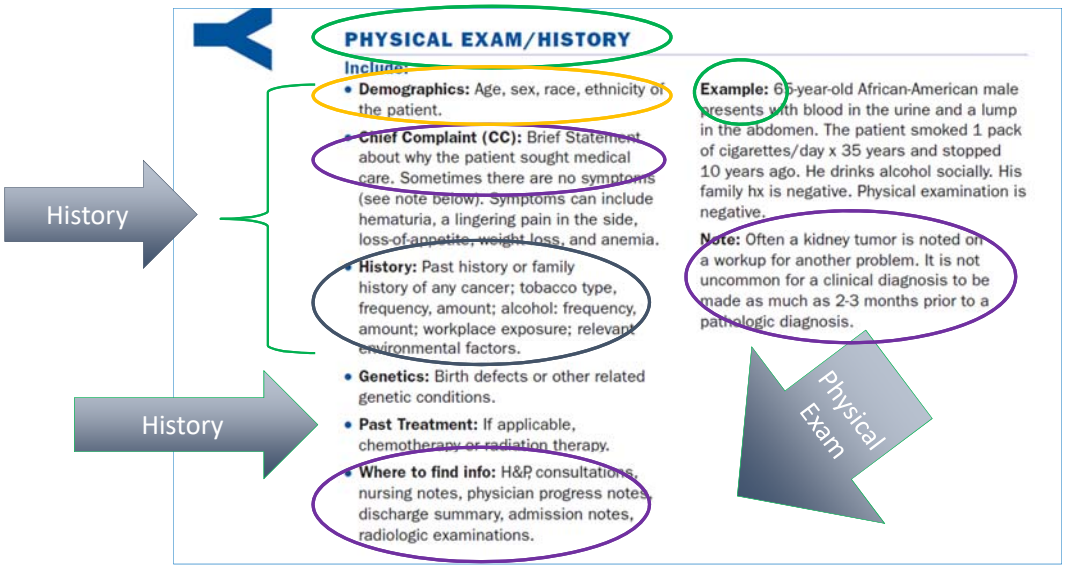
PHYSICAL EXAM/HISTORY

Include:

Intro

NAACCR

NCRA Informational Abstracts Series - Sections



PHYSICAL EXAM/HISTORY

Include:

- **Demographics:** Age, sex, race, ethnicity of the patient.
- **Chief Complaint (CC):** Brief Statement about why the patient sought medical care. Sometimes there are no symptoms (see note below). Symptoms can include hematuria, a lingering pain in the side, loss of appetite, weight loss, and anemia.
- **History:** Past history or family history of any cancer; tobacco type, frequency, amount; alcohol: frequency, amount; workplace exposure; relevant environmental factors.
- **Genetics:** Birth defects or other related genetic conditions.
- **Past Treatment:** If applicable, chemotherapy or radiation therapy.
- **Where to find info:** H&P, consultations, nursing notes, physician progress notes, discharge summary, admission notes, radiologic examinations.

Example: 65-year-old African-American male presents with blood in the urine and a lump in the abdomen. The patient smoked 1 pack of cigarettes/day x 35 years and stopped 10 years ago. He drinks alcohol socially. His family hx is negative. Physical examination is negative.

Note: Often a kidney tumor is noted on a workup for another problem. It is not uncommon for a clinical diagnosis to be made as much as 2-3 months prior to a pathologic diagnosis.

History

History

Physical Exam

NAACCR

NCRA Informational Abstracts Series - Sections

INCLUDE:
- ✓ Date of Test
- ✓ Name of Test
- ✓ Pos Results &
- ✓ Neg Results

SSFs & Markers

KIDNEY

X-RAYS/SCOPES/SCANS

Include:

- **Imaging tests:** Date, name, and brief summary of test results.
- Intravenous Pyelogram (IVP):
- Computed Tomography (CT) Scan: Abdomen/pelvis: may have been done prior to admission to the hospital.
- Magnetic Resonance Imaging (MRI): Abdomen, pelvis
- Ultrasound: Abdomen; may have been done prior to admission to the hospital.
- Chest x-ray
- Bone scan
- MRI of the brain
- Positron Emission Tomography (PET) Computed Tomography (CT): If clinically indicated, this is to rule out metastatic disease.

Note: The clinical diagnosis of renal cell carcinoma (RCC) is often made incidentally prior to a pathologic diagnosis.

Example: Prior to Admission (PTA): CT abdomen, pelvis – 6 cm lesion in upper pole R kidney highly suspicious for renal cell carcinoma. (On rare occasions, RCC may be described as hypernephroma. (However, this is an obsolete term, which is seldom used today.) Renal US solid lesion in upper pole R kidney. No lymphadenopathy (LAD). CXR – negative.

LABS

Include:

- **Complete Blood Count (CBC):** Date, name, and brief summary of test results.
- **Comprehensive Metabolic Panel (CMP):** Date, name, and brief summary of test results.
- **Urinalysis:** Date, name, and brief summary of test results.
- **Liver Function Tests (LFTs):** Date, name, and brief summary of test results.

Note: There are no specific tumor markers for kidney cancer.

Imaging

LABS

NAACCR

Pop Quiz 2

- The patient was admitted to my facility for biopsy and diagnostic workup of suspected lung cancer. Pathology ran multiple gene tests on the biopsy material to further classify the cancer and identify the best treatment for the patient. The tests that they ran were; EGFR, ROS1, KRAS, ALK plus a few others. There are no SSFs for these tests – but they sound important to the case. Do I include these tests in my abstract? How do I record them?

- **Lung Cancer Panel**
- **Somatic mutation testing**
  - *KRAS (NRAS/HRAS)*
  - *EGFR*
  - *BRAF*
  - *PIK3CA*
  - *ERBB2*
  - *MET*
  - *TP53*
  - *AKT1*
  - *MAP2K1*
  - *EGFRvIII* (RT-PCR assay)
- **Translocation**
  - *ALK* (EML4-ALK, but other partners up to 20)
  - *ROS* (up to 7 partners)
  - *KIF5B/RET*
  - *CCDC6/RET* (aka RET/PTC1)
- **Amplification**
  - *EGFR*
    - *MET*
    - *MAPK1* (p42/ERK2)
    - *FGFR1*
    - *FGFR2*

NAACCR

Pop Quiz 2

- **Lung Cancer Panel**
- **Somatic mutation testing**
  - *KRAS (NRAS/HRAS)*
  - *EGFR*
  - *BRAF*
  - *PIK3CA*
  - *ERBB2*
  - *MET*
  - *TP53*
  - *AKT1*
  - *MAP2K1*
  - *EGFRvIII* (RT-PCR assay)
- **Translocation**
  - *ALK* (EML4-ALK, but other partners up to 20)
  - *ROS* (up to 7 partners)
  - *KIF5B/RET*
  - *CCDC6/RET* (aka RET/PTC1)
- **Amplification**
  - *EGFR*
    - *MET*
    - *MAPK1* (p42/ERK2)
    - *FGFR1*
    - *FGFR2*

- Currently, Genomic Testing in Lung Cancers includes mutation testing for several genetic abnormalities for which targeted therapies have been identified. We do not have a designated field or fields to record these tests. Not in the SSFs or in any other site-specific data item. However, it is important to capture tests and results [positive (+) or negative (neg)] in the LAB Section of your abstract. Include date the tests were run, name of the genes tested, and the results + or neg.

NCRA Informational Abstracts Series - Sections

DX Procedures

INCLUDE:
- ✓ Date of Procedure
- ✓ Name of Procedure
- ✓ Pos Results &
- ✓ Neg Results
- ✓ And DETAILS

DIAGNOSTIC PROCEDURES

Include:
- **Biopsy:** Date, name, and brief summary of test results.

Note: Because RCC is often diagnosed clinically by radiologic examination, a biopsy is not often performed.

PATHOLOGY

Include:
Date of test and brief summary of findings of all pathological studies. List in chronological order – first to most recent.
- Size of the primary tumor
- Depth of invasion
- Extension outside the kidney, especially into the renal artery or vein, the adrenal gland and/or other adjacent structures.
- Status of lymph nodes removed, if any.

Example: Right kidney TS (tumor size) 5 cm. Tumor limited to the parenchyma of the kidney with no extension outside the kidney. Adrenal gland not included in the specimen. Margins negative. No lymphvascular invasion (LVI) or perineural invasion (PNI). 0+/6 LN.

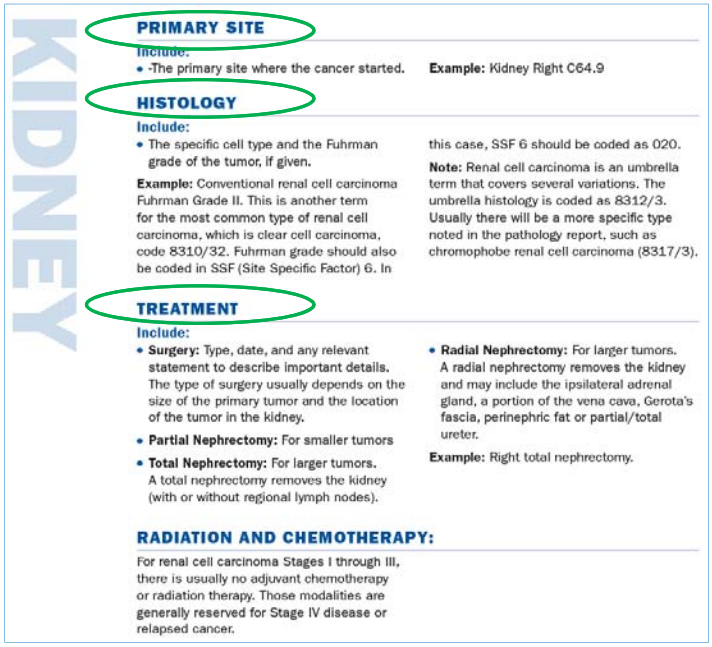
PATH

National Cancer Registrars Association • 1330 Braddock Place, Suite 520 • Alexandria, VA 22314
703-299-6640 • info@ncra-usa.org • www.ncra-usa.org • www.CancerRegistryEducation.org

NCRA Informational Abstracts Series - Sections

Primary Site

Histology



KIDNEY

PRIMARY SITE

Include:

- The primary site where the cancer started.

Example: Kidney Right C64.9

HISTOLOGY

Include:

- The specific cell type and the Fuhrman grade of the tumor, if given.

Example: Conventional renal cell carcinoma Fuhrman Grade II. This is another term for the most common type of renal cell carcinoma, which is clear cell carcinoma, code 8310/32. Fuhrman grade should also be coded in SSF (Site Specific Factor) 6. In this case, SSF 6 should be coded as 020.

Note: Renal cell carcinoma is an umbrella term that covers several variations. The umbrella histology is coded as 8312/3. Usually there will be a more specific type noted in the pathology report, such as chromophobe renal cell carcinoma (8317/3).

TREATMENT

Include:

- **Surgery:** Type, date, and any relevant statement to describe important details. The type of surgery usually depends on the size of the primary tumor and the location of the tumor in the kidney.
- **Partial Nephrectomy:** For smaller tumors
- **Total Nephrectomy:** For larger tumors. A total nephrectomy removes the kidney (with or without regional lymph nodes).
- **Radial Nephrectomy:** For larger tumors. A radial nephrectomy removes the kidney and may include the ipsilateral adrenal gland, a portion of the vena cava, Gerota's fascia, perinephric fat or partial/total ureter.

Example: Right total nephrectomy.

RADIATION AND CHEMOTHERAPY:

For renal cell carcinoma Stages I through III, there is usually no adjuvant chemotherapy or radiation therapy. Those modalities are generally reserved for Stage IV disease or relapsed cancer.

TREATMENT

Other Documentation – Tips & Resources

- Your Software's Auto-Text Description is NOT Valid Text Documentation
- Copy/Paste - How Much Text Do I Need to Enter?
- Copy/Paste – How Do I Know What is Most Important?
- Copy/Paste – Please EDIT Your Text – is it complete, accurate, run-on, necessary
- Please Be Careful With Abbreviations – your abbreviation could have a different or unknown meaning – or could have multiple meanings even for this cancer
- Your Text MUST include enough information to support codes
- Registry Software – Local* Text Fields versus Registry-Exported Text Fields

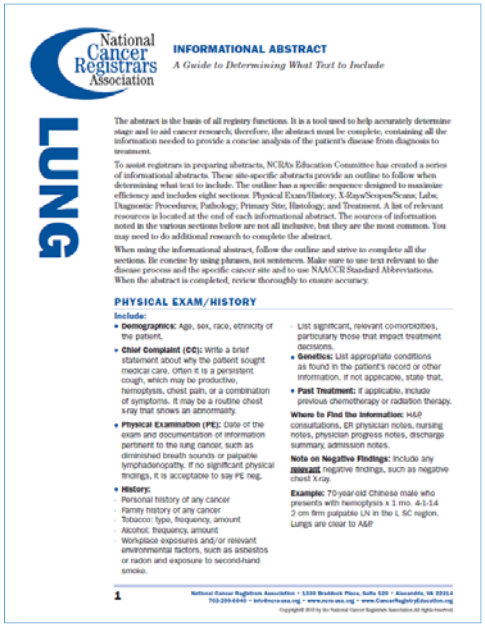
  *Note Pad Fields Usually Do Not Transfer to the Central Registry
- When Setting Override Fields – Text MUST support any Override
- Treatment Given MUST be supported by Text – Treatment Targets Especially
- Validate that Treatment Given is Consistent with Treatment Guidelines (NCCN)

Other Documentation – Tips & Resources

- CDC NPCR Program Standards and Requirements
- NCI SEER Program Standards and Requirements
- NAACCR Volume II: Data Standards and Data Dictionary
- Your State Cancer Registry Program Standards and Requirements
- NAACCR Volume III: Standards for Completeness, Quality, Analysis, Management, Security and Confidentiality of Data – Standards for Text Data Items & Standards for Data Edits
- NAACCR Standard Abbreviations – PLEASE USE THE CURRENT LIST
- SEER Training Modules – Abbreviations, Symbols & Acronyms
- NPCR Education/Training Series (NETS) – Module 4 – The Value of Accurate Text in Cancer Registry
- California Cancer Registry – Text Documentation Guidelines
- Texas Cancer Registry – Cancer Reporting Handbook – Documentation of Cancer Diagnosis, Extent of Disease, and Treatment
- MRA Thought of the DAY – Cancer Registry Section
- FCDS Text and Documentation Requirements: A Key Component to Providing High Quality Data
- Florida Cancer Data System Text Coding Requirements – FCDS DAM – Appendix L

Quiz 1 - Introduction

Coding Pitfalls and Text - Lung



National Cancer Registrars Association

INFORMATIONAL ABSTRACT

A Guide to Determining What Text to Include

LUNG

The abstract is the basis of all registry functions. It is a tool used to help accurately determine stage and to aid cancer research; therefore, the abstract must be complete, containing all the information needed to provide a concise analysis of the patient's disease from diagnosis to treatment.

To assist registrars in preparing abstracts, NCRA's Education Committee has created a series of informational abstracts. These site-specific abstracts provide an outline to follow when determining what text to include. The outline has a specific sequence designed to maximize efficiency and includes eight sections: Physical Exam/History; X-Rays/Scopes/Scans; Labs; Diagnostic Procedures; Pathology; Primary Site; Histology; and Treatment. A list of relevant resources is located at the end of each informational abstract. The sources of information noted in the various sections below are not all inclusive, but they are the most common. You may need to do additional research to complete the abstract.

When using the informational abstract, follow the outline and strive to complete all the sections. Be concise by using phrases, not sentences. Make sure to use text relevant to the disease process and the specific cancer site and to use NAACCR Standard Abbreviations. When the abstract is completed, review thoroughly to ensure accuracy.

PHYSICAL EXAM/HISTORY

Include:

- **Demographics:** Age, sex, race, ethnicity of the patient.
- **Chief Complaint (CC):** Write a brief statement about why the patient sought medical care. Often it is a persistent cough, which may be productive, hemoptysis, chest pain, or a combination of symptoms. It may be a routine chest x-ray that shows an abnormality.
- **Physical Examination (PE):** Date of the exam and documentation of information pertinent to the lung cancer, such as diminished breath sounds or palpable lymphadenopathy. If no significant physical findings, it is acceptable to say PE neg.
- **History:**
  - Personal history of any cancer
  - Family history of any cancer
  - Tobacco: type, frequency, amount
  - Alcohol: frequency, amount
  - Workplace exposures and/or relevant environmental factors, such as asbestos or radon and exposure to second-hand smoke.
  - List significant, relevant co-morbidities, particularly those that impact treatment decisions.
- **Genetics:** List appropriate conditions as found in the patient's record or other information. If not applicable, state that.
- **Past Treatment:** If applicable, include previous chemotherapy or radiation therapy.

Where to Find the Information: H&P consultations, ER physician notes, nursing notes, physician progress notes, discharge summary, admission notes.

Note on Negative Findings: Include any **relevant** negative findings, such as negative chest X-ray.

Example: 70-year-old Chinese male who presents with hemoptysis x 1 mo. 4-1-14 2 cm firm palpable LN in the L SC region. Lungs are clear to A&P

1

PHYSICAL EXAM/HISTORY

Include:

- **Demographics:** Age, sex, race, ethnicity of the patient.
- **Chief Complaint (CC):** Write a brief statement about why the patient sought medical care. Often it is a persistent cough, which may be productive, hemoptysis, chest pain, or a combination of symptoms. It may be a routine chest x-ray that shows an abnormality.
- **Physical Examination (PE):** Date of the exam and documentation of information pertinent to the lung cancer, such as diminished breath sounds or palpable lymphadenopathy. If no significant physical findings, it is acceptable to say PE neg.
- **History:**
  - Personal history of any cancer
  - Family history of any cancer
  - Tobacco: type, frequency, amount
  - Alcohol: frequency, amount
  - Workplace exposures and/or relevant environmental factors, such as asbestos or radon and exposure to second-hand smoke.
  - List significant, relevant co-morbidities, particularly those that impact treatment decisions.
- **Genetics:** List appropriate conditions as found in the patient's record or other information. If not applicable, state that.
- **Past Treatment:** If applicable, include previous chemotherapy or radiation therapy.

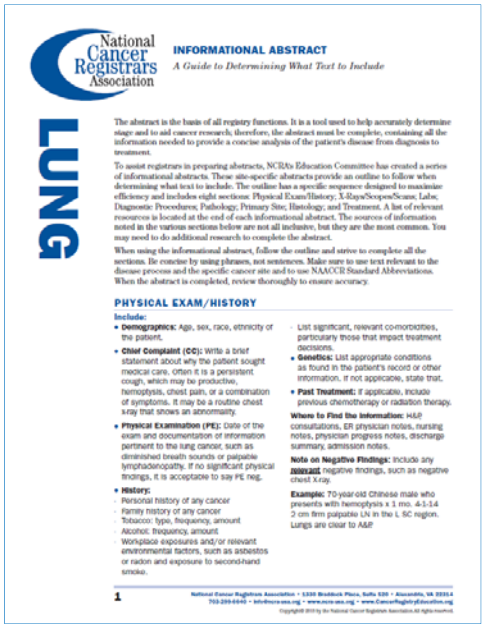
Where to Find the Information: H&P consultations, ER physician notes, nursing notes, physician progress notes, discharge summary, admission notes.

Note on Negative Findings: Include any **relevant** negative findings, such as negative chest X-ray.

Example: 70-year-old Chinese male who presents with hemoptysis x 1 mo. 4-1-14 2 cm firm palpable LN in the L SC region. Lungs are clear to A&P

NAACCR

Coding Pitfalls and Text - Lung



National Cancer Registrars Association

INFORMATIONAL ABSTRACT

A Guide to Determining What Text to Include

LUNG

The abstract is the basis of all registry functions. It is a tool used to help accurately determine stage and to aid cancer research; therefore, the abstract must be complete, containing all the information needed to provide a concise analysis of the patient's disease from diagnosis to treatment.

To assist registrars in preparing abstracts, NCRA's Education Committee has created a series of informational abstracts. These site-specific abstracts provide an outline to follow when determining what text to include. The outline has a specific sequence designed to maximize efficiency and includes eight sections: Physical Exam/History; X-Rays/Scopes/Scans; Labs; Diagnostic Procedures; Pathology; Primary Site; Histology; and Treatment. A list of relevant resources is located at the end of each informational abstract. The sources of information noted in the various sections below are not all inclusive, but they are the most common. You may need to do additional research to complete the abstract.

When using the informational abstract, follow the outline and strive to complete all the sections. Be concise by using phrases, not sentences. Make sure to use text relevant to the disease process and the specific cancer site and to use NAACCR Standard Abbreviations. When the abstract is completed, review thoroughly to ensure accuracy.

PHYSICAL EXAM/HISTORY

Include:

- **Demographics:** Age, sex, race, ethnicity of the patient.
- **Chief Complaint (CC):** Write a brief statement about why the patient sought medical care. Often it is a persistent cough, which may be productive, hemoptysis, chest pain, or a combination of symptoms. It may be a routine chest x-ray that shows an abnormality.
- **Physical Examination (PE):** Date of the exam and documentation of information pertinent to the lung cancer, such as diminished breath sounds or palpable lymphadenopathy. If no significant physical findings, it is acceptable to say PE neg.
- **History:**
  - Personal history of any cancer
  - Family history of any cancer
  - Tobacco: type, frequency, amount
  - Alcohol: frequency, amount
  - Workplace exposures and/or relevant environmental factors, such as asbestos or radon and exposure to second-hand smoke.
  - List significant, relevant co-morbidities, particularly those that impact treatment decisions.
- **Genetics:** List appropriate conditions as found in the patient's record or other information. If not applicable, state that.
- **Past Treatment:** If applicable, include previous chemotherapy or radiation therapy.

Where to Find the Information: H&P consultations, ER physician notes, nursing notes, physician progress notes, discharge summary, admission notes.

Note on Negative Findings: Include any **relevant** negative findings, such as negative chest X-ray.

Example: 70-year-old Chinese male who presents with hemoptysis x 1 mo. 4-1-14 2 cm firm palpable LN in the L SC region. Lungs are clear to A&P

1

X-RAYS/SCOPES/SCANS

Include:

- X-rays and scans pertinent to the diagnosis of cancer and metastases, if any.
- Each exam dated and listed in chronological order, if possible.
- Most commonly these will include a chest x-ray and a CT of the chest.
- Other studies may be done to rule out metastases and may include a bone scan, an MRI of the brain, a CT of the abdomen and pelvis, a PET/CT.
- Endobronchial ultrasound (EBUS) to look for adenopathy. If negative, it might lead to a mediastinoscopy to determine resectability.

Example: 2-15-14 CXR 2 cm mass in LUL. 2-18-14 CT chest 2.5 cm mass in LUL extending to pleural surface. L hilar LAD. 1.5 cm mass in L SC region which may be nodal met. 3-1-14 B/S (bone scan) – neg. MRI brain neg. 3-15-14 PET/CT 3 cm hypermetabolic mass in LUL. FDG-avid mass in L SC region and FDG-avid L hilar LNs. Findings concerning for primary lung malig with nodal mets.

LABS

Include:

- There are no pertinent lab tests for lung cancer. There may be lab tests which indicate mets, such as elevated LDH.

DIAGNOSTIC PROCEDURES

Include:

- Procedures such as bronchoscopy to look for endobronchial lesions. Occasionally mediastinscopy will be done to determine the possibility of resection of the primary.
- Information about a possible palpable lymph node that may have been biopsied first before biopsying a suspected primary site.

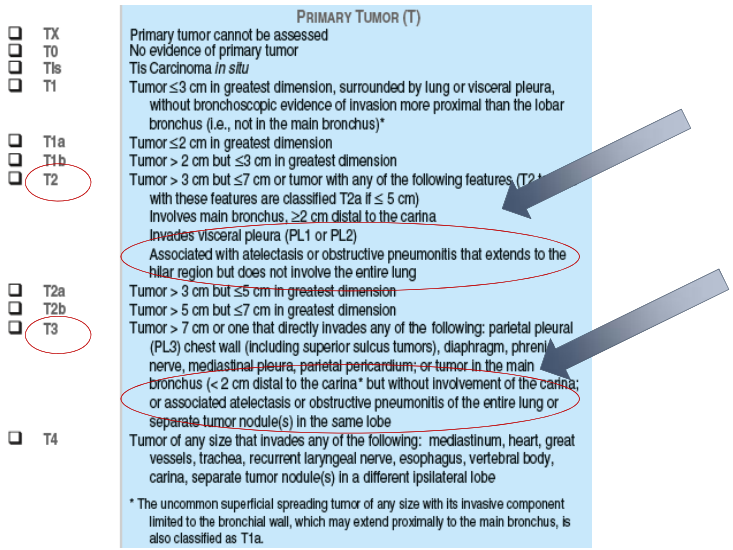
Example: 4-1-14 Bronchoscopy. Carina normal. No endobronchial lesions. 4-2-14 CT-guided bx L SC LN.

NAACCR

Coding Pitfalls and Text - Lung

- **Atelectasis/Pneumothorax** = Complete or Partially Collapsed Lung
- **Pneumonitis** - inflammation of the walls of the alveoli in the lungs, often caused by virus.
- **Obstructive Pneumonitis** – pneumonitis resulting in bronchial obstruction
- **Consolidation** - a region of lung tissue filled with liquid or blood or pus instead of air
- **Pleural Effusion/Hemothorax** - a buildup of extra fluid in the space between the lungs and the chest wall.
  - Most pleural effusions are hemorrhagic or bloody which indicates malignant pleural effusion
  - Any pleural effusion in lung cancer is deemed "malignant" and must be proven "negative" x 2-3 cytology examinations
  - When pleural effusion described as "minimal" or "small" it may not be 'treated' as with involvement – still code as malignant pleural effusion for consistency in staging cases
- **Primary Tumor Extension to either Pleura is not the same as pleural effusion**
- **What is a Pleural-Based Mass – is this a lung primary or a pleura primary?**

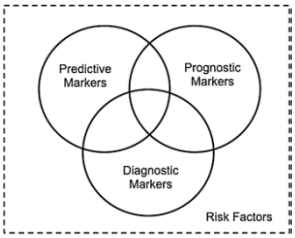
Coding Pitfalls and Text - Lung



	PRIMARY TUMOR (T)
☐ TX	Primary tumor cannot be assessed
☐ T0	No evidence of primary tumor
☐ Tis	Tis Carcinoma *in situ*
☐ T1	Tumor ≤3 cm in greatest dimension, surrounded by lung or visceral pleura, without bronchoscopic evidence of invasion more proximal than the lobar bronchus (i.e., not in the main bronchus)*
☐ T1a	Tumor ≤2 cm in greatest dimension
☐ T1b	Tumor > 2 cm but ≤3 cm in greatest dimension
☐ T2	Tumor > 3 cm but ≤7 cm or tumor with any of the following features (T2 with these features are classified T2a if ≤ 5 cm)
	Involves main bronchus, ≥2 cm distal to the carina
	Invades visceral pleura (PL1 or PL2)
	Associated with atelectasis or obstructive pneumonitis that extends to the hilar region but does not involve the entire lung
☐ T2a	Tumor > 3 cm but ≤5 cm in greatest dimension
☐ T2b	Tumor > 5 cm but ≤7 cm in greatest dimension
☐ T3	Tumor > 7 cm or one that directly invades any of the following: parietal pleural (PL3) chest wall (including superior sulcus tumors), diaphragm, phrenic nerve, mediastinal pleura, parietal pericardium; or tumor in the main bronchus (< 2 cm distal to the carina* but without involvement of the carina; or associated atelectasis or obstructive pneumonitis of the entire lung or separate tumor nodule(s) in the same lobe
☐ T4	Tumor of any size that invades any of the following: mediastinum, heart, great vessels, trachea, recurrent laryngeal nerve, esophagus, vertebral body, carina, separate tumor nodule(s) in a different ipsilateral lobe
	* The uncommon superficial spreading tumor of any size with its invasive component limited to the bronchial wall, which may extend proximally to the main bronchus, is also classified as T1a.

Coding Pitfalls and Text - Lung

- When to Use Imaging Date as Date of Diagnosis
- When to Use Biopsy Date as Date of Diagnosis
- Coding and Documenting Lung Subsite – hilum or upper lobe
- What Qualifies as Multiple Tumor Nodules – same lobe, different lobe, contralateral lung – are any of these "bilateral" lung cancer
- Primary Hilar Extension versus Hilar Node Involvement
- Primary Mediastinal Extension versus Mediastinal Node Involvement
- Critical but Absent Site-Specific Data Items
  - New Standard Genetic Tests for Targeted Therapies
    - **ALK** Rearrangement – EML4-ALK, KIF5B-ALK, TFG-ALK, KLC1-ALK
    - **EGFR** Mutations – Exon 18, 19, 20 and/or 21 Mutation
    - **ROS1** Rearrangement
    - **RET, KRAS, BRAF, MET and ERBB2** Mutations

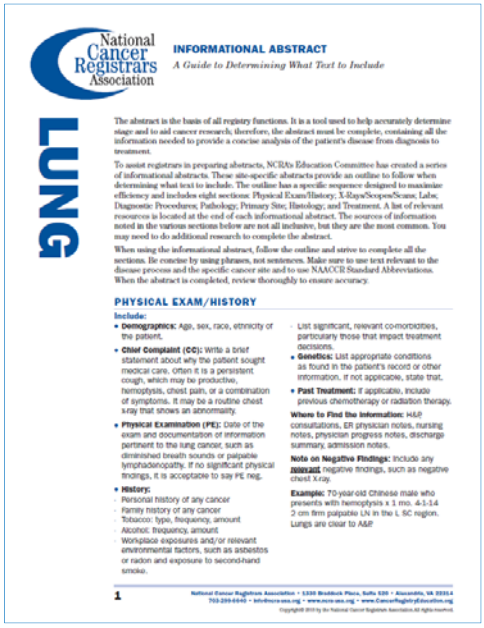


Pop Quiz 3

- A Pet CT showed a 2cm tumor in the peripheral portion of the right upper lobe lung. No metastasis was identified.
  - A biopsy of the tumor confirmed adenocarcinoma.
- The patient had a right upper lobectomy that showed adenocarcinoma measuring 2cm's with extension into, but not through the visceral pleura. 12 lymph nodes were negative for metastasis.

Data Item	Value
Clinical T	
Clinical N	
Clinical M	
Clinical Stage	
Pathologic T	
Pathologic N	
Pathologic M	
Pathologic Stage	

Coding Pitfalls and Text - Lung



National Cancer Registrars Association

INFORMATIONAL ABSTRACT

A Guide to Determining What Text to Include

LUNG

The abstract is the basis of all registry functions. It is a tool used to help accurately determine stage and to aid cancer research; therefore, the abstract must be complete, containing all the information needed to provide a concise analysis of the patient's disease from diagnosis to treatment.

To assist registrars in preparing abstracts, NCRA's Education Committee has created a series of informational abstracts. These site-specific abstracts provide an outline to follow when determining what text to include. The outline has a specific sequence designed to maximize efficiency and includes eight sections: Physical Exam/History; X-Rays/Scopes/Scans; Labs; Diagnostic Procedures; Pathology; Primary Site; Histology; and Treatment. A list of relevant resources is located at the end of each informational abstract. The sources of information noted in the various sections below are not all inclusive, but they are the most common. You may need to do additional research to complete the abstract.

When using the informational abstract, follow the outline and strive to complete all the sections. Be concise by using phrases, not sentences. Make sure to use text relevant to the disease process and the specific cancer site and to use NAACCR Standard Abbreviations. When the abstract is completed, review thoroughly to ensure accuracy.

PHYSICAL EXAM/HISTORY

Include:

- **Demographics:** Age, sex, race, ethnicity of the patient.
- **Chief Complaint (CC):** Write a brief statement about why the patient sought medical care, often it is a persistent cough, which may be productive, hemoptysis, chest pain, or a combination of symptoms. It may be a routine chest x-ray that shows an abnormality.
- **Physical Examination (PE):** Date of the exam and documentation of information pertinent to the lung cancer, such as diminished breath sounds or palpable lymphadenopathy. If no significant physical findings, it is acceptable to say PE neg.
- **History:**
  - Personal history of any cancer
  - Family history of any cancer
  - Tobacco: type, frequency, amount
  - Alcohol: frequency, amount
  - Workplace exposures and/or relevant environmental factors, such as asbestos or radon and exposure to second-hand smoke.
- List significant, relevant co-morbidities, particularly those that impact treatment decisions.
- **Genetics:** List appropriate conditions as found in the patient's record or other information. If not appicable, state that.
- **Past Treatment:** If applicable, include previous chemotherapy or radiation therapy.

Where to Find the Information: H&P consultations, ER physician notes, nursing notes, physician progress notes, discharge summary, admission notes.

Note on Negative Findings: Include any relevant negative findings, such as negative chest X-ray.

Example: 70-year-old Chinese male who presents with hemoptysis x 1 mo. 4-1-14 2 cm firm palpable LN in the L SC region. Lungs are clear to A&P

1

PATHOLOGY

Include:

- Results of biopsies and surgical resection, if any. List in chronological order. EGFR and ALK-/KRAS tests, if the histology is adenocarcinoma.

Example: 4-1-14 Bronch washings and brushings. Atypical cells suspicious for squamous cell carcinoma (SCC). 4-2-14 CT-guided bx L SC LN – met MD SCC c/w primary lung origin. 4-4-14 CT-guided bx LUL PD SCC.

PRIMARY SITE

Include:

- Primary site, including laterality.

Example: Lung Left Upper Lobe C34.1.

HISTOLOGY

Include:

- Histology of the primary site, including the morphology, the behavior, and the grade of the primary site. If there is no histology from the primary site, do not code the grade of a metastatic site.

Example: Squamous Cell Carcinoma PD 8070/33.

TREATMENT

Include:

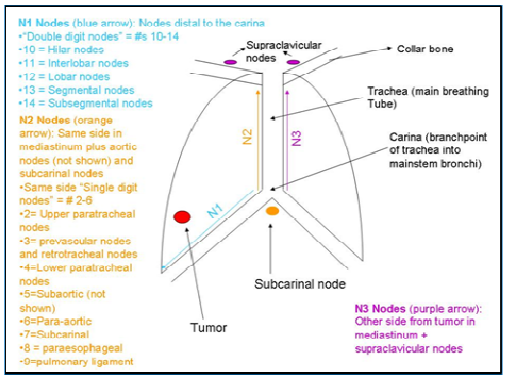
- List all treatment given in chronological order.
- Date of surgical procedure, if surgery is done.
- Surgical approach, such as endoscopic, open, robotic. If a surgical resection, list the method of entering, such as thoracotomy or video-assisted thoracoscopic surgery (VATS) and the findings. Include the location of the tumor, attachment or invasion of the pleura, the status of the lymph nodes. Document what was removed, such as the entire lobe and which lymph nodes, if any.
- Significant findings as dictated by the surgeon. If the surgeon does not give any significant findings, it is acceptable to say "no significant findings."
- Is the patient enrolled in any clinical trials? If so, include the name, trial numbers, and any other available details, including the date of enrollment.

Example: 4-15/5-30-14 5040 cGy to L lung and regional lymph nodes and L SC region w/ 6 MV IMRT (28 tx/46 days). If the radiation discharge summary does not include the number of treatment days, go to www.timeanddate.com/date/duration/html. 6-2-14 Carboplatin, etoposide with Dr. Oncology.

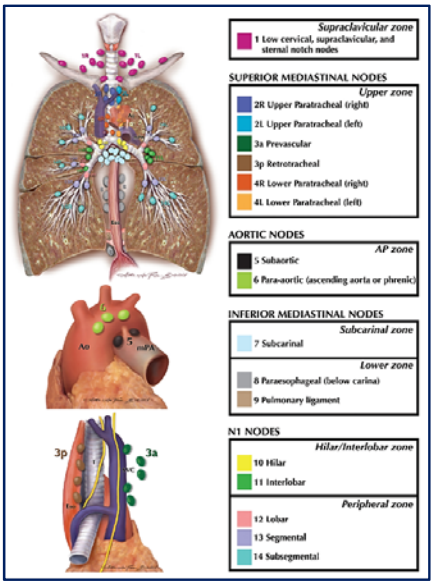
NAACCR

Coding Pitfalls and Text - Lung

- New Terminology & Codes for "bronco-alveolar"
- N1, N2 and N3 are ALL "regional lymph nodes"



IASLC Lymph Node Map



- Are there hilar or mediastinal nodes – do not treat as same
- Code FNA of Regional Lymph Node in Scope of LN Surgery
- Regional Lymph Nodes Examined/Regional Lymph Nodes Positive

NAACCR

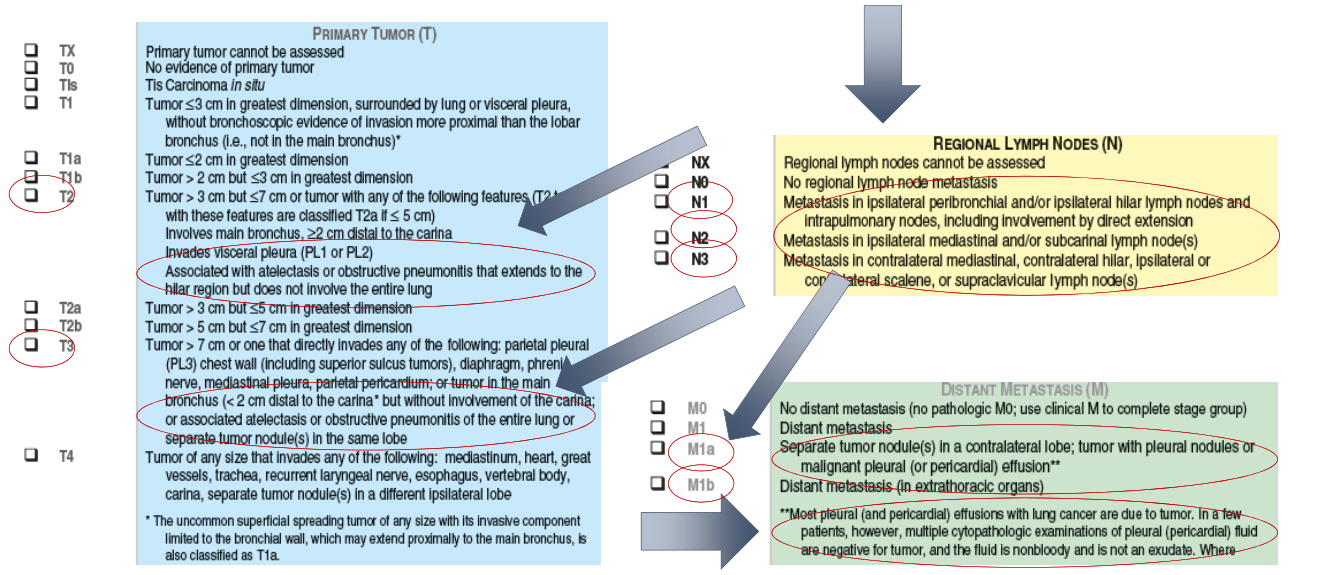
Coding Pitfalls and Text - Lung

- Grade for Lung Cancer – Not the Same as Breast/Prostate
- Palliative Treatment can be part of 1st COURSE TREATMENT
- New Targeted Therapies for Lung Cancer

Lung Adenocarcinoma		
EGFR exons 18–21	Mutation	Response to EGFR inhibitors
EGFR	p.T790M and some exon 20 insertion mutations	Resistance to EGFR inhibitors
KRAS codons 12, 13, 61	Mutation	Exclusion of *EGFR* mutation
BRAF p.V600E	Mutation	Possible response to BRAF inhibitor
ALK	Rearrangement	Response to TKI
RET	Rearrangement	Response to TKI
ROS1	Rearrangement	Response to TKI
MET	Amplification	Resistance to EGFR inhibitors

College of American Pathologists - Clinical Solid Tumor Molecular Oncology: Selected Tests by Tumor Type

Coding Pitfalls and Text - Lung



Pop Quiz 4

- A Pet CT showed a 4 cm tumor in the right upper lobe and associated pleural effusion. Also noted was right sided mediastinal lymphadenopathy.
  - Thoracentesis was positive for malignancy.
  - A mediastinoscopy and biopsy of a 4R lymph node was positive for metastatic small cell carcinoma.
- A CT of the head showed brain metastasis.
- The patient was treated with radiation and chemotherapy

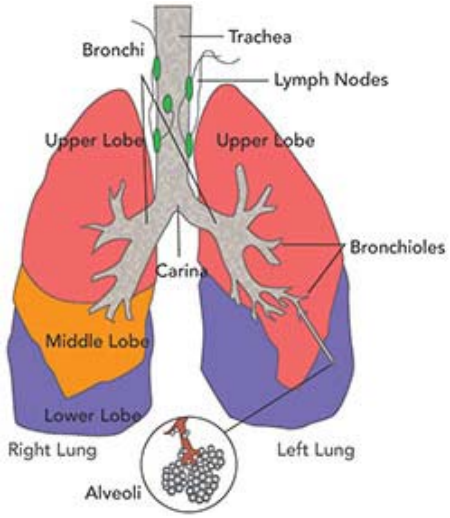
Data Item	Value
Clinical T	
Clinical N	
Clinical M	
Clinical Stage	
Pathologic T	
Pathologic N	
Pathologic M	
Pathologic Stage	

Pop Quiz 4…8th edition

- A Pet CT showed a 4 cm tumor in the right upper lobe and associated pleural effusion. Also noted was right sided mediastinal lymphadenopathy.
  - Thoracentesis was positive for malignancy.
  - A mediastinoscopy and biopsy of a 4R lymph node was positive for metastatic small cell carcinoma.
- A CT of the head showed brain metastasis.
- The patient was treated with radiation and chemotherapy

Data Item	Value
Clinical T	
Clinical N	
Clinical M	
Clinical Stage	
Pathologic T	
Pathologic N	
Pathologic M	
Pathologic Stage	

Q&A – Lung Cancer Coding Pitfalls



Coding Pitfalls and Text - Colon

National Cancer Registrars Association

INFORMATIONAL ABSTRACT
A Guide to Determining What Text to Include

COLON

The abstract is the basis of all registry functions. It is a tool used to help accurately determine stage and to aid cancer research; therefore, the abstract must be complete, containing all the information needed to provide a concise analysis of the patient's disease from diagnosis to treatment.

To assist registrars in preparing abstracts, NCRA's Education Committee has created a series of informational abstracts. These site-specific abstracts provide an outline to follow when determining what text to include. The outline has a specific sequence designed to maximize efficiency and includes eight sections: Physical Exam/History; X-Rays/Scopes/Scans; Labs; Diagnostic Procedures; Pathology; Primary Site; Histology; and Treatment. A list of relevant resources is located at the end of each informational abstract. The sources of information noted in the various sections below are not all inclusive, but they are the most common. You may need to do additional research to complete the abstract.

When using the informational abstract, follow the outline and strive to complete all the sections. Be concise by using phrases, not sentences. Make sure to use text relevant to the disease process and the specific cancer site and to use NAACCR Standard Abbreviations. When the abstract is completed, review thoroughly to ensure accuracy.

PHYSICAL EXAM/HISTORY

Include:

- **Demographics:** Age, sex, race, ethnicity of the patient.
- **Chief Complaint (CC):** Write a brief statement about why the patient sought medical care.
- **Physical Examination (PE:)** Date of the exam and documentation of information pertinent to the colon cancer.
- **History:**
  - Personal history of any cancer
  - HNPCC or Lynch Syndrome in patient or family member(s).
  - Family history of any cancer
  - Tobacco: type, frequency, amount
  - Alcohol: frequency, amount
  - List significant, relevant co-morbidities, particularly those that impact treatment decisions.

Genetics: List appropriate conditions as found in the patient's record or other information. If not applicable, state that.

Past Treatment: If applicable, include previous chemotherapy or radiation therapy.

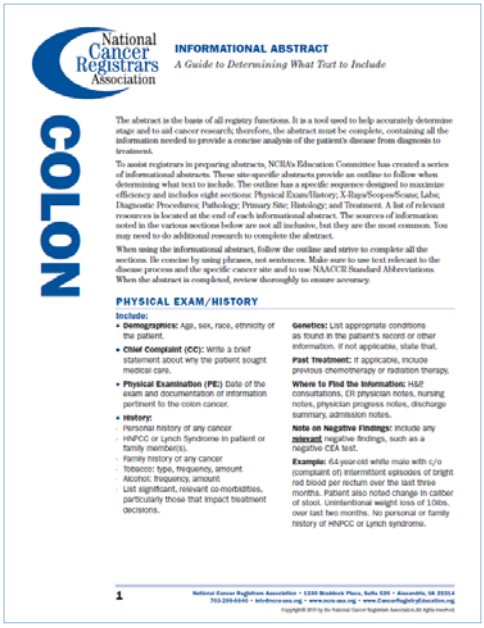
Where to Find the Information: H&P, consultations, ER physician notes, nursing notes, physician progress notes, discharge summary, admission notes.

Note on Negative Findings: Include any relevant negative findings, such as a negative CEA test.

Example: 64-year-old white male with c/o (complaint of) intermittent episodes of bright red blood per rectum over the last three months. Patient also noted change in caliber of stool. Unintentional weight loss of 10lbs. over last two months. No personal or family history of HNPCC or Lynch syndrome.

1

Coding Pitfalls and Text - Colon



National Cancer Registrars Association

INFORMATIONAL ABSTRACT

A Guide to Determining What Text to Include

COLON

The abstract is the basis of all registry functions. It is a tool used to help accurately determine stage and to aid cancer research; therefore, the abstract must be complete, containing all the information needed to provide a concise analysis of the patient's disease from diagnosis to treatment.

To assist registrars in preparing abstracts, NCRA's Education Committee has created a series of informational abstracts. These site-specific abstracts provide an outline to follow when determining what text to include. The outline has a specific sequence designed to maximize efficiency and includes eight sections: Physical Exam/History; X-Rays/Scopes/Scans; Labs; Diagnostic Procedures; Pathology; Primary Site; Histology; and Treatment. A list of relevant resources is located at the end of each informational abstract. The sources of information noted in the various sections below are not all inclusive, but they are the most common. You may need to do additional research to complete the abstract.

When using the informational abstract, follow the outline and strive to complete all the sections. Be concise by using phrases, not sentences. Make sure to use text relevant to the disease process and the specific cancer site and to use NAACCR Standard Abbreviations. When the abstract is completed, review thoroughly to ensure accuracy.

PHYSICAL EXAM/HISTORY

Include:

- **Demographics:** Age, sex, race, ethnicity of the patient.
- **Chief Complaint (CC):** Write a brief statement about why the patient sought medical care.
- **Physical Examination (PE):** Date of the exam and documentation of information pertinent to the colon cancer.
- **History:**
  - Personal history of any cancer
  - HNPCC or Lynch Syndrome in patient or family member(s).
  - Family history of any cancer
  - Tobacco: type, frequency, amount
  - Alcohol: frequency, amount
  - List significant, relevant co-morbidities, particularly those that impact treatment decisions.

Genetics: List appropriate conditions as found in the patient's record or other information. If not applicable, state that.

Past Treatment: If applicable, include previous chemotherapy or radiation therapy.

Where to Find the Information: H&P, consultations, ER physician notes, nursing notes, physician progress notes, discharge summary, admission notes.

Note on Negative Findings: Include any relevant negative findings, such as a negative CEA test.

Example: 64-year-old white male with c/o (complaint of) intermittent episodes of bright red blood per rectum over the last three months. Patient also noted change in caliber of stool. Unintentional weight loss of 10lbs. over last two months. No personal or family history of HNPCC or Lynch syndrome.

1

X-RAYS/SCOPES/SCANS

Include:

- **Date(s) of Procedure(s)**
- **Type(s) of Procedure(s):** A description of what was found during examination, including segment of the colon, evidence of perforation, biopsy taken. Include the name of the facility/provider performing these tests, especially if outside of your facility.
- **Studies Common to Work-Up**
  - **Ultrasound (U/S):** helpful in determining solid from cystic structures.
  - **Computerized Tomography (CT) Abdomen/ Pelvis:** useful in determining extent of disease, if lymph nodes are involved or there is distant spread.
  - **Magnetic Resonance Imaging (MRI):** produces images that may identify extent of disease not seen on CT or U/S.
  - **Positron Emission Tomography (PET):** identifies "hot" areas of uptake throughout the body and are useful in assessing regional and distant mets.

Example: 5/18/14: CT A/P (River Radiology). Wall thickening involving the short segment of the sigmoid colon. Approximately 5.0cm mass involving the sigmoid colon. No evidence of pericolic lymph nodes noted. No evidence of hepatic lesions.

Make sure to include the dates and findings of all endoscopies (scopes).

- **Colonoscopy:** Findings may include polyps (benign or suspicious); masses and/or obstruction.
- **Sigmoidoscopy:** Similar to a colonoscopy, but is able to examine only the rectum and lower part of the colon.

Example: 5/20/14: Colonoscopy: Sigmoid stricture at 30cm. Nearly circumferential mass involving the posterior port of the sigmoid colon. Benign appearing polyp noted in the cecum. No other significant findings noted. Biopsy taken of mass at stricture. Biopsy taken of cecal polyp.

LABS

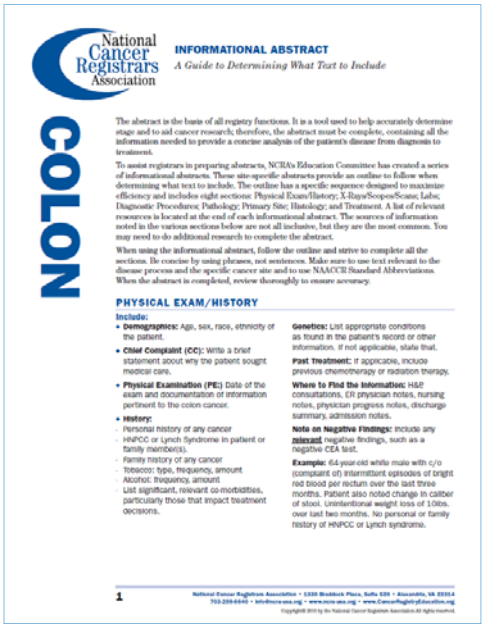
Include:

- **Dates and Tests:** Relevant lab tests and dates. For example, pre-operative CEA, KRAS, DNA Mismatch Repair. Include lab value and lab value range of normal.
- **References:** Include reference: CS v02.05 (effective 1/1/14 CS Manual Part 1, Section 2.

Example: 5/17/14: CEA 6.18 (range 0-4.0).

NAACCR

Coding Pitfalls and Text - Colon



National Cancer Registrars Association

INFORMATIONAL ABSTRACT

A Guide to Determining What Text to Include

COLON

The abstract is the basis of all registry functions. It is a tool used to help accurately determine stage and to aid cancer research; therefore, the abstract must be complete, containing all the information needed to provide a concise analysis of the patient's disease from diagnosis to treatment.

To assist registrars in preparing abstracts, NCRA's Education Committee has created a series of informational abstracts. These site-specific abstracts provide an outline to follow when determining what text to include. The outline has a specific sequence designed to maximize efficiency and includes eight sections: Physical Exam/History; X-Rays/Scopes/Scans; Labs; Diagnostic Procedures; Pathology; Primary Site; Histology; and Treatment. A list of relevant resources is located at the end of each informational abstract. The sources of information noted in the various sections below are not all inclusive, but they are the most common. You may need to do additional research to complete the abstract.

When using the informational abstract, follow the outline and strive to complete all the sections. Be concise by using phrases, not sentences. Make sure to use text relevant to the disease process and the specific cancer site and to use NAACCR Standard Abbreviations. When the abstract is completed, review thoroughly to ensure accuracy.

PHYSICAL EXAM/HISTORY

Include:

- **Demographics:** Age, sex, race, ethnicity of the patient.
- **Chief Complaint (CC):** Write a brief statement about why the patient sought medical care.
- **Physical Examination (PE):** Date of the exam and documentation of information pertinent to the colon cancer.
- **History:**
  - Personal history of any cancer
  - HNPCC or Lynch Syndrome in patient or family member(s).
  - Family history of any cancer
  - Tobacco: type, frequency, amount
  - Alcohol: frequency, amount
  - List significant, relevant co-morbidities, particularly those that impact treatment decisions.

Genetics: List appropriate conditions as found in the patient's record or other information. If not applicable, state that.

Past Treatment: If applicable, include previous chemotherapy or radiation therapy.

Where to Find the Information: H&P, consultations, ER physician notes, nursing notes, physician progress notes, discharge summary, admission notes.

Note on Negative Findings: Include any relevant negative findings, such as a negative CEA test.

Example: 64-year-old white male with c/o (complaint of) intermittent episodes of bright red blood per rectum over the last three months. Patient also noted change in caliber of stool. Unintentional weight loss of 10lbs. over last two months. No personal or family history of HNPCC or Lynch syndrome.

1

DIAGNOSTIC PROCEDURES

Include:

- List procedure, including the date and location (if outside your facility).

Example: Biopsy performed during colonoscopy procedure. Biopsy taken of mass at stricture. Biopsy taken of cecal polyp.

PATHOLOGY

Include:

- Size of tumor, histology, histologic grade, location of tumor, depth of invasion
- Angiolymphatic invasion (present/not present)
- Perineural invasion (present/not present)
- Lymph Node Status (number positive/ number taken)
- Margin Status (distal, proximal and radial)
- Other Findings
- Pathologic Stage

Example: 4 x 3 x 1cm poorly differentiated invasive adenocarcinoma of the sigmoid, carcinoma invades through muscularis propria to serosal surface (T4), AGI (+), PNI (+); 1/33 pericolic LNs; 3 TDs (tumor deposits) in pericolic soft tissue identified (N1c); 0/20 perienteric LNs; Total: 1/53 LNs. Distal margin (-); proximal margins (-); radial margin (+); terminal ileum: ileal serosa & adipose tissue positive; ileocecal valve (-); appendix (-); pT4b, pN1c, M1.

PRIMARY SITE

Include:

- Identify the segment of colon involved by the tumor

Example: C18.7 Sigmoid colon.

HISTOLOGY

Include:

- Histology, differentiation, grade

Example: Moderately Differentiated adenocarcinoma, GR 2.

NAACCR

Coding Pitfalls and Text - Colon

National Cancer Registrars Association

INFORMATIONAL ABSTRACT

A Guide to Determining What Text to Include

COLON

The abstract is the basis of all registry functions. It is a tool used to help accurately determine stage and to aid cancer research; therefore, the abstract must be complete, containing all the information needed to provide a concise analysis of the patient's disease from diagnosis to treatment.

To assist registrars in preparing abstracts, NCRA's Education Committee has created a series of informational abstracts. These site-specific abstracts provide an outline to follow when determining what text to include. The outline has a specific sequence designed to maximize efficiency and includes eight sections: Physical Exam/History; X-Rays/Scopes/Scans; Labs; Diagnostic Procedures; Pathology; Primary Site; Histology; and Treatment. A list of relevant resources is located at the end of each informational abstract. The sources of information noted in the various sections below are not all inclusive, but they are the most common. You may need to do additional research to complete the abstract.

When using the informational abstract, follow the outline and strive to complete all the sections. Be concise by using phrases, not sentences. Make sure to use text relevant to the disease process and the specific cancer site and to use NAACCR Standard Abbreviations. When the abstract is completed, review thoroughly to ensure accuracy.

PHYSICAL EXAM/HISTORY

Include:

- **Demographics:** Age, sex, race, ethnicity of the patient.
- **Chief Complaint (CC):** Write a brief statement about why the patient sought medical care.
- **Physical Examination (PE):** Date of the exam and documentation of information pertinent to the colon cancer.
- **History:**
  - Personal history of any cancer
  - HNPCC or Lynch Syndrome in patient or family member(s).
  - Family history of any cancer
  - Tobacco: type, frequency, amount
  - Alcohol: frequency, amount
  - List significant, relevant co-morbidities, particularly those that impact treatment decisions.

Genetics: List appropriate conditions as found in the patient's record or other information. If not applicable, state that.

Past Treatment: If applicable, include previous chemotherapy or radiation therapy.

Where to Find the Information: H&P, consultations, ER physician notes, nursing notes, physician progress notes, discharge summary, admission notes.

Note on Negative Findings: Include any relevant negative findings, such as a negative CEA test.

Example: 64-year-old white male with c/o (complaint of) intermittent episodes of bright red blood per rectum over the last three months. Patient also noted change in caliber of stool. Unintentional weight loss of 10lbs. over last two months. No personal or family history of HNPCC or Lynch syndrome.

1

TREATMENT

Include:

- **Operative Procedures:** Date(s) of the procedure (s); type of procedure(s); approach; and colon segment involved.
- **Findings by Surgeon:** Surgical approach; findings by surgeon at time of surgery, perforation, lymph node status, regional organ involvement, and definitive treatment vs. palliation.

Example: 5/22/14 Laparoscopic Sigmoid colectomy (partial resection). Mass adherent to pelvic peritoneum.

- **Definitive Treatment:** Detailed information on current antineoplastic drugs and drug regimens (see Resources for link to SEER RX Antineoplastic Drugs Database). Include dates, agents used. Indicate if adjuvant or neoadjuvant.

Example: 7/1/14: FOLFOX 6 administered by Dr. Smith, Medical Oncology Associates

- **Radiation Treatment:** Start and stop dates; location of treatment, if administered by another facility; treatment modality; regional and boost dosages, where applicable; number of fractions; number of days of treatment. Was the treatment pre-operative or post-op? If not administered, document the reason why.

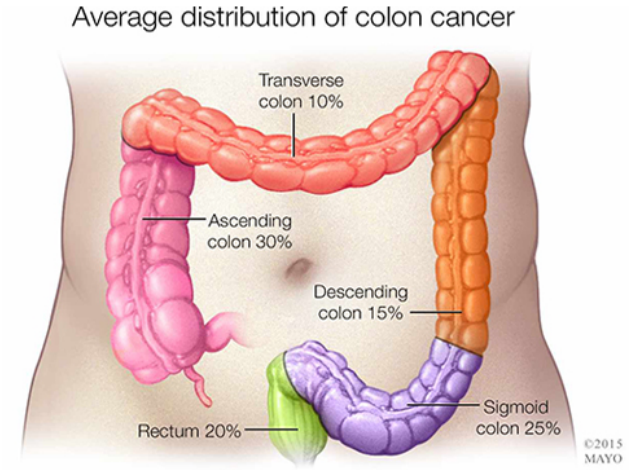
Note: The use of radiation is limited in colon cancer since it has a relatively small impact on the disease process.

Example: 2/4/14 – 3/28/14: 5000cGy to pelvis for xx fractions over xx days utilizing 3D approach.

- **Clinical Trials:** Is the patient enrolled in any clinical trials? If so, include the name, trial numbers, and any other available details, including the date of enrollment.

NAACCR

Q&A – Colon Cancer Coding Pitfalls



NAACCR

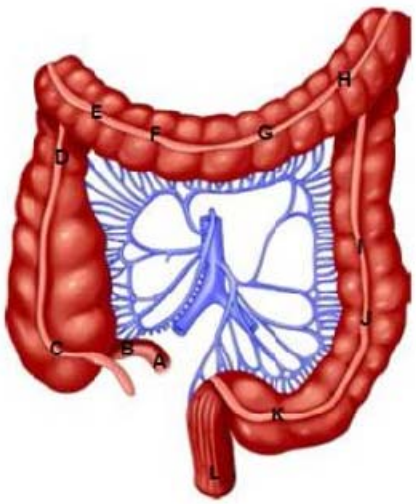
Pop Quiz 5

- Could you explain the difference between Segmental Resection (30) vs Hemicolectomy (40)?
- What do we do if they remove more than a single segment but less than a full hemicolectomy?

DEFINITIONS OF COMMON COLORECTAL RESECTIONS

The extent of colorectal resection depends on the location of the tumor, any underlying condition (eg, inflammatory bowel disease, hereditary syndrome), and the vascular supply to the colorectum.

Definitions of common colorectal resections are as follows:[1]



A through C	Ileocecectomy
A through D	Ascending colectomy
A through F	Right hemicolectomy
A through G	Extended right hemicolectomy
E through H	Transverse colectomy
G through I	Left hemicolectomy
F through I	Extended left hemicolectomy
J through K	Sigmoid colectomy
A through J	Subtotal colectomy
A through K	Total colectomy
K through L	Low anterior resection with sphincter preservation
K through L	Abdominoperineal resection without sphincter preservation

[1] Adapted and reprinted with permission from Bullard KM and Rothenberger DA. (2005). Colon, Rectum, and Anus. In Brunicardi C (Ed.) Schwartz's Principles of Surgery, 8th Edition, page 1069. McGraw Hill: New York, NY.

44

Colon Coding Pitfalls

- Partial Colectomy, Segmental Resection (30)
- Subtotal Colectomy/hemicolectomy (40)
  - Total right or left colon and a portion of transverse colon
- Total Colectomy (50)
  - Removal of colon from cecum to the Rectosigmoid junction may include a portion of the rectum

Colon Coding Pitfalls

- Operative Report
- **OPERATION PERFORMED:** Right hemicolectomy.
- **DESCRIPTION OF OPERATION:** After appropriate preparation, signed informed consent, the patient was brought to the operating room, prepped and draped in the supine position. Under satisfactory endotracheal anesthesia, Foley catheter and NG tube were inserted. A midline incision was utilized, carried down to the subcutaneous tissue. The linea alba was split with a scalpel. The abdomen was entered in the usual fashion obtaining hemostasis in the subcutaneous tissues. Exploration revealed a normal liver and gallbladder. The colon was mobilized with a retractor along the right side, along the right colic gutter, using the ACE Harmonic scalpel. We divided the hepatocolic ligament and entered into the lesser sac and took the dissection down to the mid transverse colon, entering the lesser sac. At this juncture, the ileum was also freed up by dissecting and freeing up its attachments to the lateral wall. The terminal ileum was brought up into the wound and a little otomy was made in the mesentery of the transverse colon and the GIA was fired across it dividing the transverse colon. Next, using the ACE Harmonic scalpel, we took down the mesentery and its vessels. Larger vessels were clamped with Kelly clamps and tied with silk suture material. We took this all the way up to the terminal ileum and then divided the terminal ileum with a GIA. With the specimen off the table, we opened it up on the back table and found several scattered flat polyps, none of which appeared to be ominous. A standard anastomosis was then made between the terminal ileum and the transverse colon in a side-to-side fashion using the GIA and TA60. Lembert sutures of 3-0 silk were placed in the dependent portion of the anastomosis and the crotch of the anastomosis and then the mesentery was closed with running locking suture of 3-0 Vicryl. Right colic gutter was copiously irrigated with saline solution. Omentum was brought back down over the anastomosis. Small bowel was placed back in its normal anatomical position. The area was checked for hemostasis and irrigated with saline solution. Two layers of Seprafilm were placed in the abdomen over the omentum. The abdomen was closed with running suture of #1 PDS from above and below. The skin was closed with stainless steel staples. Dry sterile dressing was placed on the wound. The patient tolerated the procedure well and left the operating room in good condition.

Colon Coding Pitfalls

COLLEGE of AMERICAN PATHOLOGISTS

Protocol for the Examination of Specimens From Patients With Primary Carcinoma of the Colon and Rectum

Version: Colon Rectum 4.0.0.0 **Protocol Posting Date:** June 2017
Includes pTNM requirements from the 8th Edition, AJCC Staging Manual

COLON AND RECTUM: Excisional Biopsy (Polypectomy)

Note: This case summary is recommended for reporting biopsy specimens, but is not required for accreditation purposes.

Select a single response unless otherwise indicated.

Tumor Site (Note A)
___ Cecum
___ Ileocecal valve
___ Right (ascending) colon
___ Hepatic flexure
___ Transverse colon
___ Splenic flexure
___ Left (descending) colon
___ Sigmoid colon
___ Rectosigmoid region
___ Rectum
___ Other (specify): _____
___ Not specified

COLON AND RECTUM: Resection, Including Transanal Disk Excision of Rectal Neoplasms

Note: This case summary is recommended for reporting transanal disc excision specimens, but is not required for accreditation purposes.

Select a single response unless otherwise indicated.

Procedure
___ Right hemicolectomy
___ Transverse colectomy
___ Left hemicolectomy
___ Sigmoidectomy
___ Low anterior resection
___ Total abdominal colectomy
___ Abdominoperineal resection
___ Transanal disk excision (local excision)
___ Endoscopic mucosal resection
___ Other (specify): _____
___ Not specified

Tumor Site (select all that apply) (Note A)
___ Cecum
___ Ileocecal valve
___ Right (ascending) colon
___ Hepatic flexure
___ Transverse colon
___ Splenic flexure
___ Left (descending) colon
___ Sigmoid colon
___ Rectosigmoid region
___ Rectum
___ Colon, not otherwise specified
___ Cannot be determined (explain): _____

NAACCR

Colon Coding Pitfalls

- Operative Report
- **DESCRIPTION OF OPERATION:** After appropriate preparation, signed informed consent, the patient was brought to the operating room, prepped and draped in the supine position. Under satisfactory endotracheal anesthesia, Foley catheter and NG tube were inserted. A midline incision was utilized, carried down to the subcutaneous tissue. The linea alba was split with a scalpel. The abdomen was entered in the usual fashion obtaining hemostasis in the subcutaneous tissues. Exploration revealed a normal liver and gallbladder. The colon was mobilized with a retractor along the right side, along the right colic gutter, using the ACE Harmonic scalpel. We divided the hepatocolic ligament and entered into the lesser sac and took the dissection down to the mid transverse colon, entering the lesser sac. At this juncture, the ileum was also freed up by dissecting and freeing up its attachments to the lateral wall. The terminal ileum was brought up into the wound and a little otomy was made in the mesentery of the transverse colon and the GIA was fired across it dividing the transverse colon. Next, using the ACE Harmonic scalpel, we took down the mesentery and its vessels. Larger vessels were clamped with Kelly clamps and tied with silk suture material. We took this all the way up to the terminal ileum and then divided the terminal ileum with a GIA. With the specimen off the table, we opened it up on the back table and found several scattered flat polyps, none of which appeared to be ominous. A standard anastomosis was then made between the terminal ileum and the transverse colon in a side-to-side fashion using the GIA and TA60. Lembert sutures of 3-0 silk were placed in the dependent portion of the anastomosis and the crotch of the anastomosis and then the mesentery was closed with running locking suture of 3-0 Vicryl. Right colic gutter was copiously irrigated with saline solution. Omentum was brought back down over the anastomosis. Small bowel was placed back in its normal anatomical position. The area was checked for hemostasis and irrigated with saline solution. Two layers of Seprafilm were placed in the abdomen over the omentum. The abdomen was closed with running suture of #1 PDS from above and below. The skin was closed with stainless steel staples. Dry sterile dressing was placed on the wound. The patient tolerated the procedure well and left the operating room in good condition.

NAACCR

Pop Quiz 6

- Could please discuss/explain a case in which a polypectomy was done and then a resection with no residual. All we know is the cancer was confined to the polyp. What would be the TNM and stage group for a case such as this?

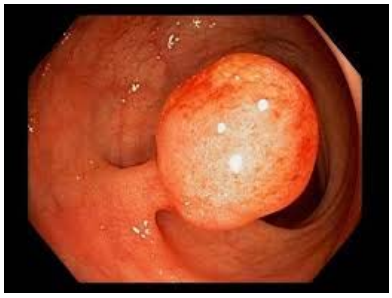
Answer/Guidelines

- Sessile polyp
  - Colonoscopy with a biopsy is usually diagnostic, incomplete resection, cTX
  - Surgical resection is treatment, pT
- Pedunculated polyp
  - Colonoscopy snare polypectomy is treatment, pT
  - No diagnosis prior to snare, therefore no clinical stage assigned
- General guideline for polyp removal during colonoscopy
  - Incomplete resection – cTNM
  - Complete resection of polyp, treatment – pTNM
  - Not dependent on margins, but on purpose/intent of resection

http://cancerbulletin.facs.org/forums/node/69606

Pop Quiz 7

- A patient present for routine colonoscopy and is found to have a pedunculated polyp in the sigmoid colon. A hot snare is used to remove the polyp.
- Pathology from the polypectomy shows an invasive adenocarcinoma extending into, but not beyond the submucosa.



Data Item	Value
Clinical T	
Clinical N	
Clinical M	
Clinical Stage	
Pathologic T	
Pathologic N	
Pathologic M	
Pathologic Stage	

Pop Quiz 7 (part 2)

- A patient present for routine colonoscopy and is found to have a pedunculated polyp in the sigmoid colon. A hot snare is used to remove the polyp.
- Pathology from the polypectomy shows an invasive adenocarcinoma extending into, but not beyond the submucosa.
- The patient returns for a sigmoidectomy.
- Pathology did not reveal any residual tumor. 22 lymph nodes negative for metastasis.

Data Item	Value
Clinical T	
Clinical N	
Clinical M	
Clinical Stage	
Pathologic T	
Pathologic N	
Pathologic M	
Pathologic Stage	

Pop Quiz 8

- Patient presented with rectal bleeding.
  - Rectal endoscopic US showed large pedunculated polyp in rectosigmoid junction 4cm in size. The mass appears to arise from mucosal layer with no signs of deeper invasion. No abnormal perirectal, iliac or pericolonic lymph nodes were seen.
  - Biopsy showed tubulovillous adenoma polyp with severe dysplasia *(carcinoma in situ).*
  - PET showed a lung nodule, colon mass, no other mets.
  - Biopsy of lung mass showed metastatic adenocarcinoma of enteric primary origin.
  - Managing Oncologist states stage IV, treated with neoadjuvant chemo with planned surgery of colon and lung nodule (surgery results are not available to me yet).
  - Note from pathologist: It's likely the biopsy of the polyp was a superficial biopsy and it just didn't hit the area in the polyp where the invasive carcinoma is lurking.

Pop Quiz 8 (cont)

- Biopsy of rectal mass showed tubulovillous adenoma polyp with severe dysplasia (carcinoma in situ).
- Lymph nodes clinically negative
- Biopsy of lung mass showed metastatic adenocarcinoma of enteric primary origin
- A CT of the head showed brain metastasis.
- The patient was treated with radiation and chemotherapy

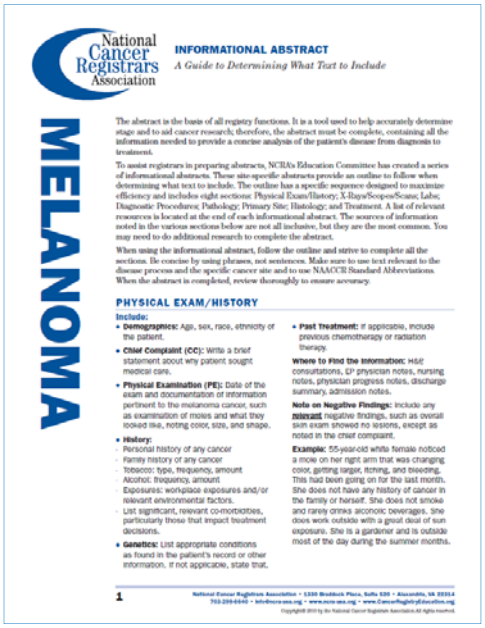
Data Item	Value
Clinical T	
Clinical N	
Clinical M	
Clinical Stage	
Pathologic T	
Pathologic N	
Pathologic M	
Pathologic Stage	

Pop Quiz 8…8th edition

- Biopsy of rectal mass showed tubulovillous adenoma polyp with severe dysplasia (carcinoma in situ).
- Lymph nodes clinically negative
- Biopsy of lung mass showed metastatic adenocarcinoma of enteric primary origin
- A CT of the head showed brain metastasis.
- The patient was treated with radiation and chemotherapy

Data Item	Value
Clinical T	
Clinical N	
Clinical M	
Clinical Stage	
Pathologic T	
Pathologic N	
Pathologic M	
Pathologic Stage	

Coding Pitfalls and Text - Melanoma



National Cancer Registrars Association

INFORMATIONAL ABSTRACT

A Guide to Determining What Text to Include

MELANOMA

The abstract is the basis of all registry functions. It is a tool used to help accurately determine stage and to aid cancer research; therefore, the abstract must be complete, containing all the information needed to provide a concise analysis of the patient's disease from diagnosis to treatment.

To assist registrars in preparing abstracts, NCRA's Education Committee has created a series of informational abstracts. These site-specific abstracts provide an outline to follow when determining what text to include. The outline has a specific sequence designed to maximize efficiency and includes eight sections: Physical Exam/History; X-Rays/Scopes/Scans; Labs; Diagnostic Procedures; Pathology; Primary Site; Histology; and Treatment. A list of relevant resources is located at the end of each informational abstract. The sources of information noted in the various sections below are not all inclusive, but they are the most common. You may need to do additional research to complete the abstract.

When using the informational abstract, follow the outline and strive to complete all the sections. Be concise by using phrases, not sentences. Make sure to use text relevant to the disease process and the specific cancer site and to use NAACCR Standard Abbreviations. When the abstract is completed, review thoroughly to ensure accuracy.

PHYSICAL EXAM/HISTORY

Include:

- **Demographics:** Age, sex, race, ethnicity of the patient.
- **Chief Complaint (CC):** Write a brief statement about why patient sought medical care.
- **Physical Examination (PE):** Date of the exam and documentation of information pertinent to the melanoma cancer, such as examination of moles and what they looked like, noting color, size, and shape.
- **History:**
  - Personal history of any cancer
  - Family history of any cancer
  - Tobacco: type, frequency, amount
  - Alcohol: frequency, amount
  - Exposures: workplace exposures and/or relevant environmental factors.
  - List significant, relevant co-morbidities, particularly those that impact treatment decisions.
- **Genetics:** List appropriate conditions as found in the patient's record or other information. If not applicable, state that.
- **Past Treatment:** If applicable, include previous chemotherapy or radiation therapy.

Where to Find the Information: H&P, consultations, EP physician notes, nursing notes, physician progress notes, discharge summary, admission notes.

Note on Negative Findings: Include any relevant negative findings, such as overall skin exam showed no lesions, except as noted in the chief complaint.

Example: 55-year-old white female noticed a mole on her right arm that was changing color, getting larger, itching, and bleeding. This had been going on for the last month. She does not have any history of cancer in the family or herself. She does not smoke and rarely drinks alcoholic beverages. She does work outside with a great deal of sun exposure. She is a gardener and is outside most of the day during the summer months.

1

National Cancer Registrars Association • 1330 Braddock Place, Suite 520 • Alexandria, VA 22314
703-299-3640 • info@ncra-usa.org • www.ncra-usa.org • www.CancerRegistryEducation.org

PHYSICAL EXAM/HISTORY

Include:

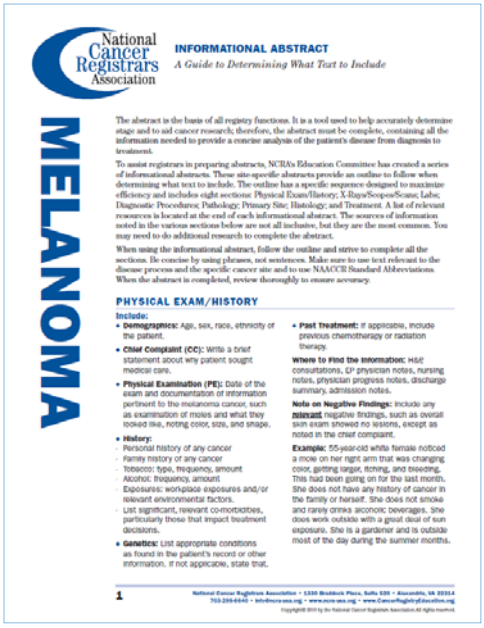
- **Demographics:** Age, sex, race, ethnicity of the patient.
- **Chief Complaint (CC):** Write a brief statement about why patient sought medical care.
- **Physical Examination (PE):** Date of the exam and documentation of information pertinent to the melanoma cancer, such as examination of moles and what they looked like, noting color, size, and shape.
- **History:**
  - Personal history of any cancer
  - Family history of any cancer
  - Tobacco: type, frequency, amount
  - Alcohol: frequency, amount
  - Exposures: workplace exposures and/or relevant environmental factors.
  - List significant, relevant co-morbidities, particularly those that impact treatment decisions.
- **Genetics:** List appropriate conditions as found in the patient's record or other information. If not applicable, state that.
- **Past Treatment:** If applicable, include previous chemotherapy or radiation therapy.

Where to Find the Information: H&P, consultations, EP physician notes, nursing notes, physician progress notes, discharge summary, admission notes.

Note on Negative Findings: Include any relevant negative findings, such as overall skin exam showed no lesions, except as noted in the chief complaint.

Example: 55-year-old white female noticed a mole on her right arm that was changing color, getting larger, itching, and bleeding. This had been going on for the last month. She does not have any history of cancer in the family or herself. She does not smoke and rarely drinks alcoholic beverages. She does work outside with a great deal of sun exposure. She is a gardener and is outside most of the day during the summer months.

Coding Pitfalls and Text - Melanoma



National Cancer Registrars Association

INFORMATIONAL ABSTRACT

A Guide to Determining What Text to Include

MELANOMA

The abstract is the basis of all registry functions. It is a tool used to help accurately determine stage and to aid cancer research; therefore, the abstract must be complete, containing all the information needed to provide a concise analysis of the patient's disease from diagnosis to treatment.

To assist registrars in preparing abstracts, NCRA's Education Committee has created a series of informational abstracts. These site-specific abstracts provide an outline to follow when determining what text to include. The outline has a specific sequence designed to maximize efficiency and includes eight sections: Physical Exam/History; X-Rays/Scopes/Scans; Labs; Diagnostic Procedures; Pathology; Primary Site; Histology; and Treatment. A list of relevant resources is located at the end of each informational abstract. The sources of information noted in the various sections below are not all inclusive, but they are the most common. You may need to do additional research to complete the abstract.

When using the informational abstract, follow the outline and strive to complete all the sections. Be concise by using phrases, not sentences. Make sure to use text relevant to the disease process and the specific cancer site and to use NAACCR Standard Abbreviations. When the abstract is completed, review thoroughly to ensure accuracy.

PHYSICAL EXAM/HISTORY

Include:

- **Demographics:** Age, sex, race, ethnicity of the patient.
- **Chief Complaint (CC):** Write a brief statement about why patient sought medical care.
- **Physical Examination (PE):** Date of the exam and documentation of information pertinent to the melanoma cancer, such as examination of moles and what they looked like, noting color, size, and shape.
- **History:**
  - Personal history of any cancer
  - Family history of any cancer
  - Tobacco: type, frequency, amount
  - Alcohol: frequency, amount
  - Exposures: workplace exposures and/or relevant environmental factors.
  - List significant, relevant co-morbidities, particularly those that impact treatment decisions.
- **Genetics:** List appropriate conditions as found in the patient's record or other information. If not applicable, state that.
- **Past Treatment:** If applicable, include previous chemotherapy or radiation therapy.

Where to Find the Information: H&P, consultations, CP physician notes, nursing notes, physician progress notes, discharge summary, admission notes.

Note on Negative Findings: Include any relevant negative findings, such as overall skin exam showed no lesions, except as noted in the chief complaint.

Example: 55-year-old white female noticed a mole on her right arm that was changing color, getting larger, itching, and bleeding. This had been going on for the last month. She does not have any history of cancer in the family or herself. She does not smoke and rarely drinks alcoholic beverages. She does work outside with a great deal of sun exposure. She is a gardener and is outside most of the day during the summer months.

1

X-RAYS/SCOPES/SCANS

Include:

List names of all X-rays, scopes, and scans. Include the dates and results.

- **Imaging Reports:** Chest x-ray, MRI, CT scan, PET scan (detect disease and/or metastatic spread).
- **Scopes:** Endoscopies, bronchoscopies (may be used to detect/confirm metastatic spread).

Example: 1/22/14 Chest x-ray showed an area suspicious for spread of disease in a patient with known melanoma of the right arm.

LABS

Include:

List names of all tests, dates, and results.

- Lactate dehydrogenase (LDH): A blood test used to detect if the melanoma has spread to distant sites. A higher level than normal level may indicate the cancer is harder to treat.
- Blood cell counts and blood chemistry done in advanced melanoma to determine how well the bone marrow, liver, and kidneys are working during treatment.
- Testing for targeted treatments.

Example: 1/21/14 LDH was negative.

DIAGNOSTIC PROCEDURES

Include:

List names of all diagnostics procedures, dates, and summary of findings.

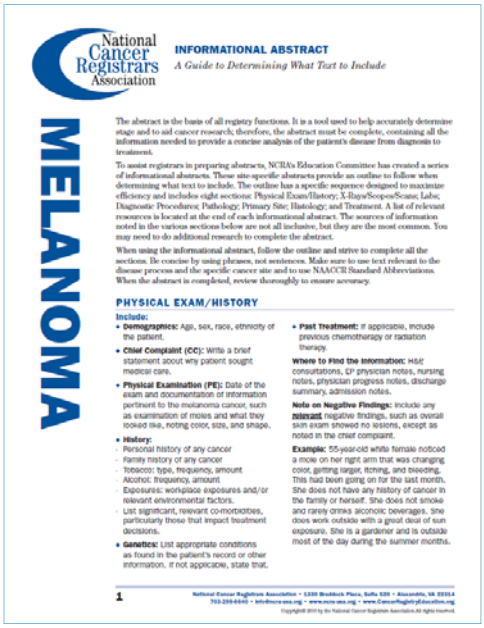
- Biopsy only: shave, punch, incisional, fine needle, aspiration, sentinel lymph node biopsy.

Note: These procedures are used to identify the cancer, not treat it. If the biopsy is excisional or removes the cancer, the information is placed in the *Treatment* section. Also, if excisional lymph node biopsy is done note in the *Treatment* section, since cancer was removed from the lymph nodes.

Example: 1/7/14 Incisional biopsy of right arm mole.

NAACCR

Coding Pitfalls and Text - Melanoma



National Cancer Registrars Association

INFORMATIONAL ABSTRACT

A Guide to Determining What Text to Include

MELANOMA

The abstract is the basis of all registry functions. It is a tool used to help accurately determine stage and to aid cancer research; therefore, the abstract must be complete, containing all the information needed to provide a concise analysis of the patient's disease from diagnosis to treatment.

To assist registrars in preparing abstracts, NCRA's Education Committee has created a series of informational abstracts. These site-specific abstracts provide an outline to follow when determining what text to include. The outline has a specific sequence designed to maximize efficiency and includes eight sections: Physical Exam/History; X-Rays/Scopes/Scans; Labs; Diagnostic Procedures; Pathology; Primary Site; Histology; and Treatment. A list of relevant resources is located at the end of each informational abstract. The sources of information noted in the various sections below are not all inclusive, but they are the most common. You may need to do additional research to complete the abstract.

When using the informational abstract, follow the outline and strive to complete all the sections. Be concise by using phrases, not sentences. Make sure to use text relevant to the disease process and the specific cancer site and to use NAACCR Standard Abbreviations. When the abstract is completed, review thoroughly to ensure accuracy.

PHYSICAL EXAM/HISTORY

Include:

- **Demographics:** Age, sex, race, ethnicity of the patient.
- **Chief Complaint (CC):** Write a brief statement about why patient sought medical care.
- **Physical Examination (PE):** Date of the exam and documentation of information pertinent to the melanoma cancer, such as examination of moles and what they looked like, noting color, size, and shape.
- **History:**
  - Personal history of any cancer
  - Family history of any cancer
  - Tobacco: type, frequency, amount
  - Alcohol: frequency, amount
  - Exposures: workplace exposures and/or relevant environmental factors.
  - List significant, relevant co-morbidities, particularly those that impact treatment decisions.
- **Genetics:** List appropriate conditions as found in the patient's record or other information. If not applicable, state that.
- **Past Treatment:** If applicable, include previous chemotherapy or radiation therapy.

Where to Find the Information: H&P, consultations, CP physician notes, nursing notes, physician progress notes, discharge summary, admission notes.

Note on Negative Findings: Include any relevant negative findings, such as overall skin exam showed no lesions, except as noted in the chief complaint.

Example: 55-year-old white female noticed a mole on her right arm that was changing color, getting larger, itching, and bleeding. This had been going on for the last month. She does not have any history of cancer in the family or herself. She does not smoke and rarely drinks alcoholic beverages. She does work outside with a great deal of sun exposure. She is a gardener and is outside most of the day during the summer months.

1

PATHOLOGY

Include:

Brief summary of all pathologic studies/reports. Include dates and list chronologically from earliest to latest.

- Cancer Cell Type
- Grade
- Size of the tumor (not the specimen size).
- Extent (extension) of primary tumor. (Usually found in the microscopic description on the pathology report.)
- Lymph node involvement or lack of it. (Number of lymph nodes examined and
- Evidence or indication of further spread of cancer.
- Breslow measurement (thickness or depth to which the cancer has grown).
- Ulceration noted.
- Mitotic count/rate (measurement of how quickly the cancer cells have divided or grown).
- Margins (are they clear of cancer; size of margin).

Example: 1/8/14 superficial spreading

PRIMARY SITE

Include:

- Site where cancer started. For skin, state part of body where cancer is occurring as well as the laterality of the site.

Example: Right forearm skin.

HISTOLOGY

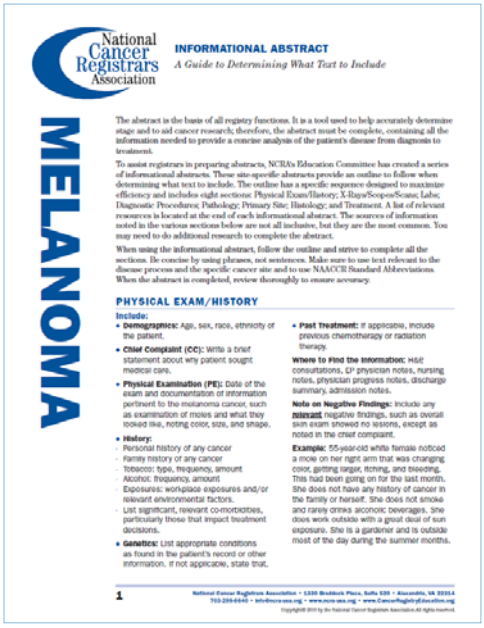
Include:

- Cancer cell type

Example: Superficial spreading Melanoma.

NAACCR

Coding Pitfalls and Text - Melanoma



National Cancer Registrars Association

INFORMATIONAL ABSTRACT

A Guide to Determining What Text to Include

MELANOMA

The abstract is the basis of all registry functions. It is a tool used to help accurately determine stage and to aid cancer research; therefore, the abstract must be complete, containing all the information needed to provide a concise analysis of the patient's disease from diagnosis to treatment.

To assist registrars in preparing abstracts, NCRA's Education Committee has created a series of informational abstracts. These site-specific abstracts provide an outline to follow when determining what text to include. The outline has a specific sequence designed to maximize efficiency and includes eight sections: Physical Exam/History; X-Rays/Scopes/Scans; Labs; Diagnostic Procedures; Pathology; Primary Site; Histology; and Treatment. A list of relevant resources is located at the end of each informational abstract. The sources of information noted in the various sections below are not all inclusive, but they are the most common. You may need to do additional research to complete the abstract.

When using the informational abstract, follow the outline and strive to complete all the sections. Be concise by using phrases, not sentences. Make sure to use text relevant to the disease process and the specific cancer site and to use NAACCR Standard Abbreviations. When the abstract is completed, review thoroughly to ensure accuracy.

PHYSICAL EXAM/HISTORY

Include:

- **Demographics:** Age, sex, race, ethnicity of the patient.
- **Chief Complaint (CC):** Write a brief statement about why patient sought medical care.
- **Physical Examination (PE):** Date of the exam and documentation of information pertinent to the melanoma cancer, such as examination of moles and what they looked like, noting color, size, and shape.
- **History:**
  - Personal history of any cancer
  - Family history of any cancer
  - Tobacco: type, frequency, amount
  - Alcohol: frequency, amount
  - Exposures: workplace exposures and/or relevant environmental factors.
  - List significant, relevant co-morbidities, particularly those that impact treatment decisions.
- **Genetics:** List appropriate conditions as found in the patient's record or other information. If not applicable, state that.
- **Past Treatment:** If applicable, include previous chemotherapy or radiation therapy.

Where to Find the Information: H&P, consultations, ED physician notes, nursing notes, physician progress notes, discharge summary, admission notes.

Note on Negative Findings: Include any relevant negative findings, such as overall skin exam showed no lesions, except as noted in the chief complaint.

Example: 55-year-old white female noticed a mole on her right arm that was changing color, getting larger, itching, and bleeding. This had been going on for the last month. She does not have any history of cancer in the family or herself. She does not smoke and rarely drinks alcoholic beverages. She does work outside with a great deal of sun exposure. She is a gardener and is outside most of the day during the summer months.

1

TREATMENT

Include:

- **Surgery:** Name of procedure, date, and any pertinent findings noted by surgeon. Possibilities include excisional biopsy, electrocautery, fulguration, cryosurgery, polypectomy, laser excision, MOHS surgery, wide excision, re-excision. If lymph nodes involved, note lymph node dissection, regional lymphadenectomy.
- **Chemotherapy:** Dates of beginning and ending of treatment, names of drugs, route of administration, and note response, if given. If any drugs were changed, note new drugs, why drugs were changed, and when the new drug started.
- **Radiation:** Note beginning and ending dates of treatment, type of radiation, to what part of the body it was given, and reaction, if given. Note any boost doses, the dosage, where it was given, and when it was started.
- **Immunotherapy:** Drugs used to help boost the immune system. Note drugs given, the date they were started and finished, route of administration, and response, if given.
- **Targeted Therapy:** Dates, names, and route of administration, and response to them if given.
- **Clinical Trials:** Is patient enrolled in any clinical trials? If so, include the name, trial numbers, and any other available details, including the date of enrollment.
- **Other:** Dates and names of other treatment that does not fit in the above categories.

Example: Surgery: 3/17/14 MOHS procedure –mole right arm; Immunotherapy: First dose of Ipilimumab was started on 3/25/14 given IV; last dose given 6/24/14, responded well to the treatment.

NAACCR

Q&A – Melanoma Coding Pitfalls

NAACCR

Pop Quiz 9

- Are the CoC rules different than SEER for coding biopsies of a melanoma?
- No. Rules from CoC, SEER, and NPCR are all consistent.
  - If biopsy is done and it removes all visible tumor, it is a surgical procedure.
  - If a biopsy does not remove all visible tumor (only a sample), code it as a diagnostic staging procedure.

Pop Quiz 9 (cont)Shave Biopsy

- Would a shave biopsy for melanoma insitu with positive margins be coded as a surgical procedure or diagnostic staging procedure?
  - If the pathology report from the shave biopsy indicates macroscopic involvement, code it in Surgical Diagnostic and Staging Procedure, 02.
  - If the pathology report shows clean margins or the presence of microscopic involvement - code it as an excisional biopsy 27

http://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/fords/first-course-of-treatment/surgery/8595-how-is-shave-bx-to-be-coded

Pop Quiz 10

- For T1 tumors: If we have information only about ulceration but no information about mitosis can we assign a T1 and no subcategory?

Pop Quiz 10 Answer

- To assign T1a you would need info on both ulceration AND mitotic rate.
  - An elevated mitotic rate could push this into the T1b category.
- If ulceration is present a T1b can be assigned without information concerning mitosis.
  - If mitosis is <1/mm2, T1b is assigned due to the ulceration.
  - If mitosis is ≥1/mm2, T1b is assigned due to the ulceration.
    - The higher mitosis rate does not push this into the T2 category.
- If no information on ulceration, a subcategory for T1 cannot be assigned.

Pop Quiz 10 Answer…8th edition

- Mitotic rate has been removed as a staging factor for T1 tumors.
  - Still an important prognostic factor
  - T1a and T1b definitions have been modified slightly, but are still dependent on ulceration status.

Pop Quiz 11

- Could you explain the difference between Micrometastasis (N1a) and Macrometastasis (N1b) when it comes to lymph nodes?

Pop Quiz 11 Answer

- Micrometastasis and macrometastasis only influence the pN.
- Micrometastasis indicates that clinically there was no indication of lymph node metastasis (cN0). However, when a lymph node was surgically removed, metastasis was identified.
  - This could be identified in a sentinel lymph node biopsy.
  - A sentinel lymph node biopsy is always part of the pN.
- Macrometastasis indicates that clinically lymph node metastasis was identified and was verified pathologically in at least one lymph node.

Pop Quiz 10 Answer…8th edition

- In 8th edition
  - Micrometastasis is defined as *clinically occult* a
  - Macrometastasis is defined as *clinically detected lymph node metastasis*

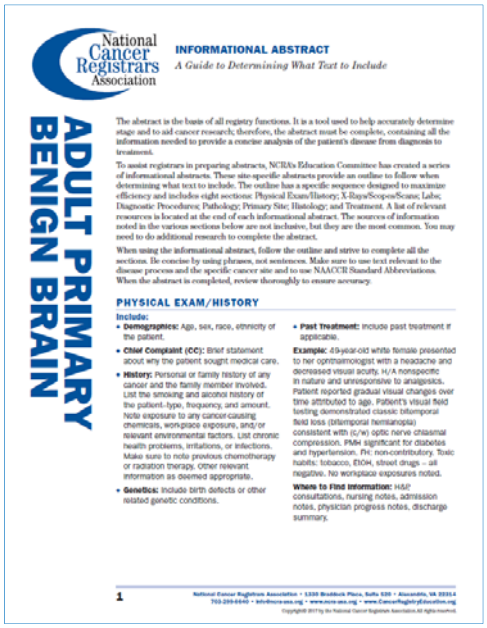
Pop Quiz 11

- A patient presents for annual screening and is found to have a suspicious mole. The mole is excised and found to be malignant melanoma (cT1b). No palpable lymph nodes were present.
- The patient returned two weeks later for a sentinel lymph node biopsy and wide excision.
- Pathology
  - Wide excision: Negative for residual melanoma
  - Sentinel node biopsy:
    - 4 lymph nodes removed. Micrometastasis measuring less than 0.1mm in a single lymph node. 3 lymph nodes negative for metastasis.

Data Item	Value
Clinical T	
Clinical N	
Clinical M	
Clinical Stage	
Pathologic T	
Pathologic N	
Pathologic M	
Pathologic Stage	

Page 335 and 336

Coding Pitfalls and Text – Brain & CNS – Part I



National Cancer Registrars Association

INFORMATIONAL ABSTRACT

A Guide to Determining What Text to Include

ADULT PRIMARY BENIGN BRAIN

The abstract is the basis of all registry functions. It is a tool used to help accurately determine stage and to aid cancer research; therefore, the abstract must be complete, containing all the information needed to provide a concise analysis of the patient's disease from diagnosis to treatment.

To assist registrars in preparing abstracts, NCRA's Education Committee has created a series of informational abstracts. These site-specific abstracts provide an outline to follow when determining what text to include. The outline has a specific sequence designed to maximize efficiency and includes eight sections: Physical Exam/History; X-Rays/Scopes/Scans; Labs; Diagnostic Procedures; Pathology; Primary Site; Histology; and Treatment. A list of relevant resources is located at the end of each informational abstract. The sources of information noted in the various sections below are not inclusive, but they are the most common. You may need to do additional research to complete the abstract.

When using the informational abstract, follow the outline and strive to complete all the sections. Be concise by using phrases, not sentences. Make sure to use text relevant to the disease process and the specific cancer site and to use NAACCR Standard Abbreviations. When the abstract is completed, review thoroughly to ensure accuracy.

PHYSICAL EXAM/HISTORY

Include:

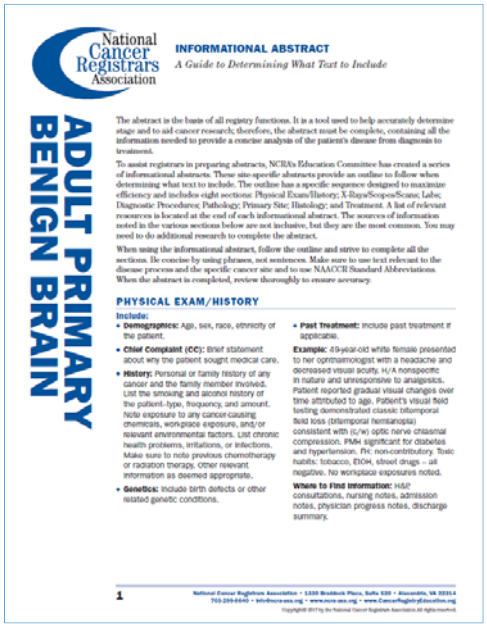
- **Demographics:** Age, sex, race, ethnicity of the patient.
- **Chief Complaint (CC):** Brief statement about why the patient sought medical care.
- **History:** Personal or family history of any cancer and the family member involved. List the smoking and alcohol history of the patient–type, frequency, and amount. Note exposure to any cancer-causing chemicals, workplace exposure, and/or relevant environmental factors. List chronic health problems, irritations, or infections. Make sure to note previous chemotherapy or radiation therapy. Other relevant information as deemed appropriate.
- **Genetics:** Include birth defects or other related genetic conditions.
- **Past Treatment:** Include past treatment if applicable.

Example: 49-year-old white female presented to her ophthalmologist with a headache and decreased visual acuity. H/A nonspecific in nature and unresponsive to analgesics. Patient reported gradual visual changes over time attributed to age. Patient's visual field testing demonstrated classic bitemporal field loss (bitemporal hemianopia) consistent with (c/w) optic nerve chiasmal compression. PMH significant for diabetes and hypertension. FH: non-contributory. Toxic habits: tobacco, EtOH, street drugs – all negative. No workplace exposures noted.

Where to Find Information: H&P, consultations, nursing notes, admission notes, physician progress notes, discharge summary.

1

Coding Pitfalls and Text – Brain & CNS – Part I



National Cancer Registrars Association

INFORMATIONAL ABSTRACT

A Guide to Determining What Text to Include

ADULT PRIMARY BENIGN BRAIN

The abstract is the basis of all registry functions. It is a tool used to help accurately determine stage and to aid cancer research; therefore, the abstract must be complete, containing all the information needed to provide a concise analysis of the patient's disease from diagnosis to treatment.

To assist registrars in preparing abstracts, NCRA's Education Committee has created a series of informational abstracts. These site-specific abstracts provide an outline to follow when determining what text to include. The outline has a specific sequence designed to maximize efficiency and includes eight sections: Physical Exam/History; X-Rays/Scopes/Scans; Labs; Diagnostic Procedures; Pathology; Primary Site; Histology; and Treatment. A list of relevant resources is located at the end of each informational abstract. The sources of information noted in the various sections below are not inclusive, but they are the most common. You may need to do additional research to complete the abstract.

When using the informational abstract, follow the outline and strive to complete all the sections. Be concise by using phrases, not sentences. Make sure to use text relevant to the disease process and the specific cancer site and to use NAACCR Standard Abbreviations. When the abstract is completed, review thoroughly to ensure accuracy.

PHYSICAL EXAM/HISTORY

Include:

- **Demographics:** Age, sex, race, ethnicity of the patient.
- **Chief Complaint (CC):** Brief statement about why the patient sought medical care.
- **History:** Personal or family history of any cancer and the family member involved. List the smoking and alcohol history of the patient–type, frequency, and amount. Note exposure to any cancer-causing chemicals, workplace exposure, and/or relevant environmental factors. List chronic health problems, irritations, or infections. Make sure to note previous chemotherapy or radiation therapy. Other relevant information as deemed appropriate.
- **Genetics:** Include birth defects or other related genetic conditions.
- **Past Treatment:** Include past treatment if applicable.

Example: 49-year-old white female presented to her ophthalmologist with a headache and decreased visual acuity. H/A nonspecific in nature and unresponsive to analgesics. Patient reported gradual visual changes over time attributed to age. Patient's visual field testing demonstrated classic bitemporal field loss (bitemporal hemianopia) consistent with (c/w) optic nerve chiasmal compression. PMH significant for diabetes and hypertension. FH: non-contributory. Toxic habits: tobacco, ETOH, street drugs – all negative. No workplace exposures noted.

Where to Find Information: H&P, consultations, nursing notes, admission notes, physician progress notes, discharge summary.

1

X-RAYS/SCOPES/SCANS

Include:

- **Imaging Tests:** Date, name, and a brief summary of test results. MRI is the preferred imaging modality for pituitary adenomas.

Note: Pituitary adenomas are classified based on size as either a microadenoma (<10mm) or a macroadenoma (>10mm). The optic chiasm lies directly above the pituitary.

Example: 10/20/2015: MRI-Brain: 4x4mm sella/suprasellar homogeneous mass in keeping with a pituitary microadenoma.

LABS

Include:

- List each test, date, and results. Include pituitary function tests and endocrine studies for hormone hyposecretion or hypersectetion.

Note: The pituitary gland produces hormones that can be characterized as secretory or non-secretory (functioning or non-functioning) based on the presence or absence of those hormones. Non-secretory tumors usually present with vision loss. Patients with secretory tumors usually present after evaluation by an endocrinologist for symptoms related to hormonal imbalances (weight changes, mood changes, fatigue, loss of libido, etc).

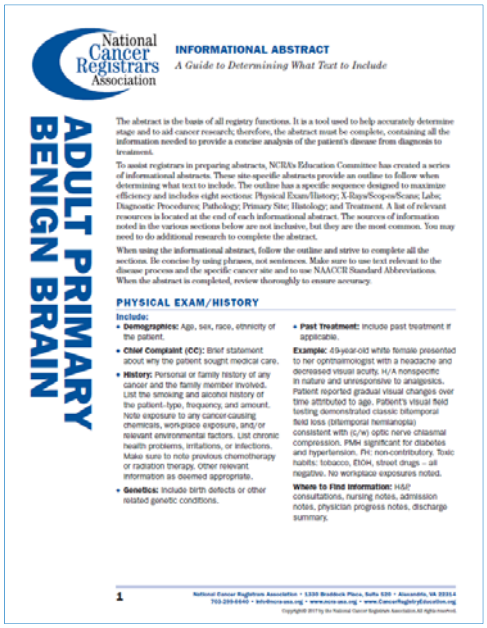
The anterior lobe of the pituitary secretes six (6) hormones: thyroid stimulating hormone (TSH), adrenocorticotropic hormone (ACTH); follicle stimulating hormone (FSH); leutilzing hormone (LH), growth hormone (GH), and prolactin (PRL), the most common pituitary adenoma.

The posterior lobe of the pituitary secretes two (2) hormones: vasopressin and oxytocin.

Example: 10/9/15 Prolactin 19.7 (H); range (4-15.2).

NAACCR

Coding Pitfalls and Text – Brain & CNS – Part I



National Cancer Registrars Association

INFORMATIONAL ABSTRACT

A Guide to Determining What Text to Include

ADULT PRIMARY BENIGN BRAIN

The abstract is the basis of all registry functions. It is a tool used to help accurately determine stage and to aid cancer research; therefore, the abstract must be complete, containing all the information needed to provide a concise analysis of the patient's disease from diagnosis to treatment.

To assist registrars in preparing abstracts, NCRA's Education Committee has created a series of informational abstracts. These site-specific abstracts provide an outline to follow when determining what text to include. The outline has a specific sequence designed to maximize efficiency and includes eight sections: Physical Exam/History; X-Rays/Scopes/Scans; Labs; Diagnostic Procedures; Pathology; Primary Site; Histology; and Treatment. A list of relevant resources is located at the end of each informational abstract. The sources of information noted in the various sections below are not inclusive, but they are the most common. You may need to do additional research to complete the abstract.

When using the informational abstract, follow the outline and strive to complete all the sections. Be concise by using phrases, not sentences. Make sure to use text relevant to the disease process and the specific cancer site and to use NAACCR Standard Abbreviations. When the abstract is completed, review thoroughly to ensure accuracy.

PHYSICAL EXAM/HISTORY

Include:

- **Demographics:** Age, sex, race, ethnicity of the patient.
- **Chief Complaint (CC):** Brief statement about why the patient sought medical care.
- **History:** Personal or family history of any cancer and the family member involved. List the smoking and alcohol history of the patient–type, frequency, and amount. Note exposure to any cancer-causing chemicals, workplace exposure, and/or relevant environmental factors. List chronic health problems, irritations, or infections. Make sure to note previous chemotherapy or radiation therapy. Other relevant information as deemed appropriate.
- **Genetics:** Include birth defects or other related genetic conditions.
- **Past Treatment:** Include past treatment if applicable.

Example: 49-year-old white female presented to her ophthalmologist with a headache and decreased visual acuity. H/A nonspecific in nature and unresponsive to analgesics. Patient reported gradual visual changes over time attributed to age. Patient's visual field testing demonstrated classic bitemporal field loss (bitemporal hemianopia) consistent with (c/w) optic nerve chiasmal compression. PMH significant for diabetes and hypertension. FH: non-contributory. Toxic habits: tobacco, ETOH, street drugs – all negative. No workplace exposures noted.

Where to Find Information: H&P, consultations, nursing notes, admission notes, physician progress notes, discharge summary.

1

DIAGNOSTIC PROCEDURES

These are procedures that detect the cancer, but do **not** remove it.

Include:

- **Biopsy:** List date, name of procedure, and brief description of findings.

  Most often performed at the time of surgical resection. Stereotactic CT or MRI guided biopsy may be performed without surgical resection in patients considered surgically unresectable or not considered a good surgical candidate.

- **Example:** 10/20/2015: (performed during surgery): Biopsy of the abnormal tissue submitted to pathology. Dx-pituitary microadenoma.

PATHOLOGY

Include:

Date and a brief summary of findings of all pathological reports, particularly the three listed below.

List in chronological order (i.e. first to most recent).

- **Extent (extension) of the primary tumor:** Often found in the microscopic description of the pathology report.
- **Any evidence of further spread:** Often found in the microscopic description of the pathology report.
- **Margins:** note extent of involvement of surgical margins.

Example: Microscopic, macroscopic, extent of involvement not stated.

- Specific lobe of the brain
- Laterality
- Cancer cell type
- Grade of the tumor
- Size of tumor (not specimen size)

PRIMARY SITE

Include:

- The primary site where the cancer started.

Example: Pituitary gland – C75.1

Where to Find Information: Surgical and diagnostic (imaging and biopsy) reports.

HISTOLOGY

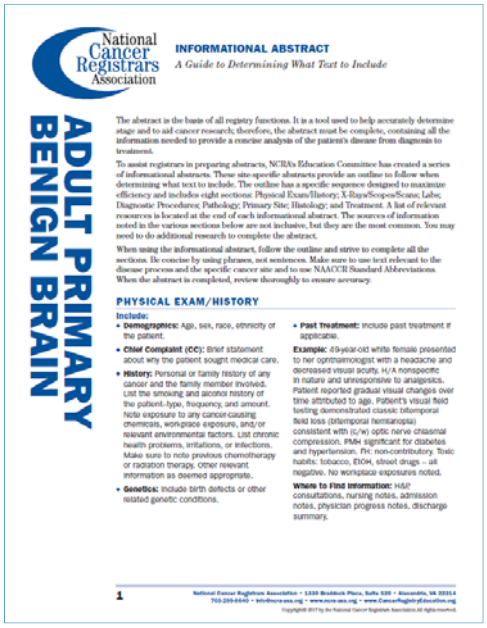
Include:

- The exact cell type of the cancer.

Example: Pituitary adenoma (M-8272/0/9)

NAACCR

Coding Pitfalls and Text – Brain & CNS – Part I



National Cancer Registrars Association

INFORMATIONAL ABSTRACT

A Guide to Determining What Text to Include

ADULT PRIMARY BENIGN BRAIN

The abstract is the basis of all registry functions. It is a tool used to help accurately determine stage and to aid cancer research; therefore, the abstract must be complete, containing all the information needed to provide a concise analysis of the patient's disease from diagnosis to treatment.

To assist registrars in preparing abstracts, NCRA's Education Committee has created a series of informational abstracts. These site-specific abstracts provide an outline to follow when determining what text to include. The outline has a specific sequence designed to maximize efficiency and includes eight sections: Physical Exam/History; X-Rays/Scopes/Scans; Labs; Diagnostic Procedures; Pathology; Primary Site; Histology; and Treatment. A list of relevant resources is located at the end of each informational abstract. The sources of information noted in the various sections below are not inclusive, but they are the most common. You may need to do additional research to complete the abstract.

When using the informational abstract, follow the outline and strive to complete all the sections. Be concise by using phrases, not sentences. Make sure to use text relevant to the disease process and the specific cancer site and to use NAACCR Standard Abbreviations. When the abstract is completed, review thoroughly to ensure accuracy.

PHYSICAL EXAM/HISTORY

Include:

- **Demographics:** Age, sex, race, ethnicity of the patient.
- **Chief Complaint (CC):** Brief statement about why the patient sought medical care.
- **History:** Personal or family history of any cancer and the family member involved. List the smoking and alcohol history of the patient–type, frequency, and amount. Note exposure to any cancer-causing chemicals, workplace exposure, and/or relevant environmental factors. List chronic health problems, irritations, or infections. Make sure to note previous chemotherapy or radiation therapy. Other relevant information as deemed appropriate.
- **Genetics:** Include birth defects or other related genetic conditions.
- **Past Treatment:** Include past treatment if applicable.

Example: 49-year-old white female presented to her ophthamologist with a headache and decreased visual acuity. H/A nonspecific in nature and unresponsive to analgesics. Patient reported gradual visual changes over time attributed to age. Patient's visual field testing demonstrated classic bitemporal field loss (bitemporal hemianopia) consistent with (c/w) optic nerve chiasmal compression. PMH significant for diabetes and hypertension. FH: non-contributory. Toxic habits: tobacco, ETOH, street drugs – all negative. No workplace exposures noted.

Where to Find Information: H&P consultations, nursing notes, admission notes, physician progress notes, discharge summary.

1

TREATMENT

Include:

- **Surgery:** The most commonly performed surgery is trans-sphenoidal resection. It addresses tumors confined within the sella turcica and that are Adrenocorticotropic hormone (ACTH) secreting. This is a definitive surgery that removes the TUMOR. It removes visibly abnormal tissue as seen on imaging or intraoperatively and is completed to a degree that is consistent with preservation of functional neurologic tissue.

Example: 10/25/15: Trans-sphenoidal resection performed using an endoscopic endonasal approach. Pituitary adenoma is noted compressing the optic chiasm. Gross resection is performed with successful decompression of the anterior visual pathways, leading to visual recovery.

- **Radiation:** Beginning and end dates of treatment, type of radiation, to what part of body it was given, dosage and reaction to treatment, if noted. Note: any boost dosages, date, and to where it was administered.

Note: Radiation therapy is most often reserved for incomplete resection or for patients who continue to be hypersecretory after surgery.

Indications for Radiation Therapy:

- **Non-functioning adenomas:**
  1. non-surgical candidate
  2. recurrence of progression after surgery
  3. surgically inaccessible (e.g. cavernous sinus)
- **Functioning adenomas:**
  1. hormonally uncontrolled after maximal surgical or medical therapy
  2. tumor growth or extension that cannot be surgically addressed.

Radiation Therapy Options:

These are examples of common approaches, but do not address variances in dosage or duration or modality.

- **Stereotactic Radiosurgery (SRS):** At least 3-5mm from optic chiasm and less than 3cm in diameter. SRS for non-functioning adenoma, 18Gy (180cGy), for functioning adenoma, 20Gy (200cGy).
- **Fractionated Radiation Therapy:** May be the only option if less than 5mm from optic nerve or greater than 3cm in diameter. Fractionated Radiotherapy for non-functioning adenoma, 45-50.4Gy (4500-5040cGy) at 18Gy (180cGy) daily. Slightly higher dosage for functioning adenoma 50.4 – 54Gy (5040 – 5400cGy) also at 18Gy (180cGy) daily.

Example: 12/1/15-12/31/15: 45Gy (4500cGy) to Gross Tumor Volume at 18Gy (180cGy) in 25 fxs over 30 days.

- **Chemotherapy/Hormone Therapy:** Beginning and end dates of chemotherapy, names of drugs, and route of administration. If available, include response to treatment. Note if any changes in drugs: state new drug names and why the drug was changed and when the new drug started.

Note: Responses may evolve slowly over many years, so continued endocrine surveillance and medical management are required.

Example: Bromocriptine (Parlodel) initially 1.25mg nightly with food, gradually increasing to 2.5mg BID (twice daily) as tolerated within 1-2 weeks.

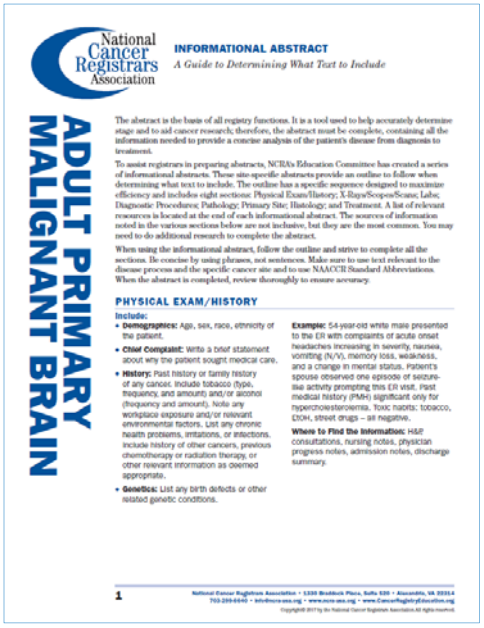
NAACCR

Coding Pitfalls and Text – Brain & CNS – Part I

- Transformation to Malignant is Very Rare
- Coding Primary Site for Meningioma
  - C70.0 – Cerebral Meninges
  - C70.1 – Spinal Meninges
  - C70.9 – Meninges, NOS
- Sphenoid Wing Meningioma arise in the arachnoid layer of the cranial meninges covering the sphenoid wing. Called sphenoid wing meningioma because of location – part of cranial meninges included as undersurface of the skull and are reportable tumors.
- Why are some brain tumors classified using laterality and some are not? What about Cranial Nerve Tumors and CNS tumors?

NAACCR

Coding Pitfalls and Text – Brain & CNS – Part II



National Cancer Registrars Association

INFORMATIONAL ABSTRACT

A Guide to Determining What Text to Include

ADULT PRIMARY MALIGNANT BRAIN

The abstract is the basis of all registry functions. It is a tool used to help accurately determine stage and to aid cancer research; therefore, the abstract must be complete, containing all the information needed to provide a concise analysis of the patient's disease from diagnosis to treatment.

To assist registrars in preparing abstracts, NCRA's Education Committee has created a series of informational abstracts. These site-specific abstracts provide an outline to follow when determining what text to include. The outline has a specific sequence designed to maximize efficiency and includes eight sections: Physical Exam/History; X-Rays/Scopes/Scans; Labs; Diagnostic Procedures; Pathology; Primary Site; Histology; and Treatment. A list of relevant resources is located at the end of each informational abstract. The sources of information noted in the various sections below are not inclusive, but they are the most common. You may need to do additional research to complete the abstract.

When using the informational abstract, follow the outline and strive to complete all the sections. Be concise by using phrases, not sentences. Make sure to use text relevant to the disease process and the specific cancer site and to use NAACCR Standard Abbreviations. When the abstract is completed, review thoroughly to ensure accuracy.

PHYSICAL EXAM/HISTORY

Include:

- **Demographics:** Age, sex, race, ethnicity of the patient.
- **Chief Complaint:** Write a brief statement about why the patient sought medical care.
- **History:** Past history or family history of any cancer. Include tobacco (type, frequency, and amount) and/or alcohol (frequency and amount). Note any workplace exposure and/or relevant environmental factors. List any chronic health problems, irritations, or infections. Include history of other cancers, previous chemotherapy or radiation therapy, or other relevant information as deemed appropriate.
- **Genetics:** List any birth defects or other related genetic conditions.

Example: 54-year-old white male presented to the ER with complaints of acute onset headaches increasing in severity, nausea, vomiting (N/V), memory loss, weakness, and a change in mental status. Patient's spouse observed one episode of seizure-like activity prompting this ER visit. Past medical history (PMH) significant only for hypercholesterolemia. Toxic habits: tobacco, EtOH, street drugs – all negative.

Where to Find the Information: H&P consultations, nursing notes, physician progress notes, admission notes, discharge summary.

1

PHYSICAL EXAM/HISTORY

Include:

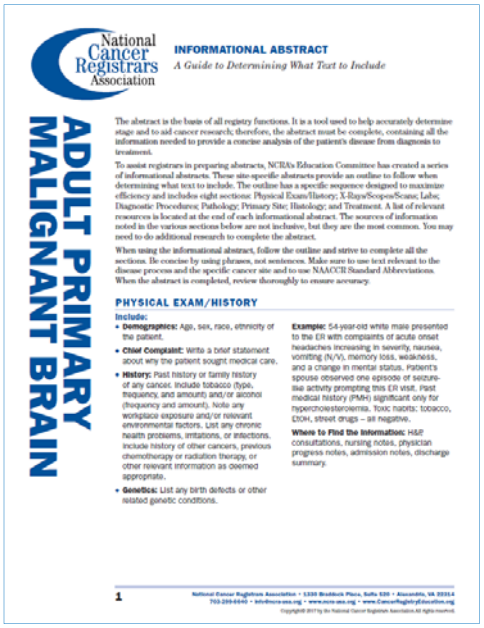
- **Demographics:** Age, sex, race, ethnicity of the patient.
- **Chief Complaint:** Write a brief statement about why the patient sought medical care.
- **History:** Past history or family history of any cancer. Include tobacco (type, frequency, and amount) and/or alcohol (frequency and amount). Note any workplace exposure and/or relevant environmental factors. List any chronic health problems, irritations, or infections. Include history of other cancers, previous chemotherapy or radiation therapy, or other relevant information as deemed appropriate.
- **Genetics:** List any birth defects or other related genetic conditions.

Example: 54-year-old white male presented to the ER with complaints of acute onset headaches increasing in severity, nausea, vomiting (N/V), memory loss, weakness, and a change in mental status. Patient's spouse observed one episode of seizure-like activity prompting this ER visit. Past medical history (PMH) significant only for hypercholesterolemia. Toxic habits: tobacco, EtOH, street drugs – all negative.

Where to Find the Information: H&P consultations, nursing notes, physician progress notes, admission notes, discharge summary.

NAACCR

Coding Pitfalls and Text – Brain & CNS – Part II



National Cancer Registrars Association

INFORMATIONAL ABSTRACT

A Guide to Determining What Text to Include

ADULT PRIMARY MALIGNANT BRAIN

The abstract is the basis of all registry functions. It is a tool used to help accurately determine stage and to aid cancer research; therefore, the abstract must be complete, containing all the information needed to provide a concise analysis of the patient's disease from diagnosis to treatment.

To assist registrars in preparing abstracts, NCRA's Education Committee has created a series of informational abstracts. These site-specific abstracts provide an outline to follow when determining what text to include. The outline has a specific sequence designed to maximize efficiency and includes eight sections: Physical Exam/History; X-Rays/Scopes/Scans; Labs; Diagnostic Procedures; Pathology; Primary Site; Histology; and Treatment. A list of relevant resources is located at the end of each informational abstract. The sources of information noted in the various sections below are not inclusive, but they are the most common. You may need to do additional research to complete the abstract.

When using the informational abstract, follow the outline and strive to complete all the sections. Be concise by using phrases, not sentences. Make sure to use text relevant to the disease process and the specific cancer site and to use NAACCR Standard Abbreviations. When the abstract is completed, review thoroughly to ensure accuracy.

PHYSICAL EXAM/HISTORY

Include:

- **Demographics:** Age, sex, race, ethnicity of the patient.
- **Chief Complaint:** Write a brief statement about why the patient sought medical care.
- **History:** Past history or family history of any cancer. Include tobacco (type, frequency, and amount) and/or alcohol (frequency and amount). Note any workplace exposure and/or relevant environmental factors. List any chronic health problems, irritations, or infections. Include history of other cancers, previous chemotherapy or radiation therapy, or other relevant information as deemed appropriate.
- **Genetics:** List any birth defects or other related genetic conditions.

Example: 54-year-old white male presented to the ER with complaints of acute onset headaches increasing in severity, nausea, vomiting (N/V), memory loss, weakness, and a change in mental status. Patient's spouse observed one episode of seizure-like activity prompting this ER visit. Past medical history (PMH) significant only for hypercholesterolemia. Toxic habits: tobacco, EtOH, street drugs – all negative.

Where to Find the Information: H&P consultations, nursing notes, physician progress notes, admission notes, discharge summary.

1

X-RAYS/SCOPES/SCANS

Include:

- **Imaging tests:** Date, name, and a brief summary of test results. Most commonly used imaging is contrast-enhanced Gadolinium MRI and Computer Tomography (CT).

Example: 10/20/2015: CT-Head w/o contrast: Examination reveals 1.8cm right-sided hypodense mass. Evidence of edema causing mid-line shift to left, compression of right lateral and third ventricles. Recommend Gadolinium MRI for further evaluation.

Example: 10/22/15: MRI w/Gadolinium – Brain: Heterogeneously ring-enhancing mass noted - region of right frontal lobe. The mass measures 2.0cm with surrounding severe vasogenic edema, midline shift and compression of ventricles. Mass has irregular borders and evidence of central necrosis.

Where to Find the Information: This information might appear in the H&P or scans included in the chart.

LABS

Include:

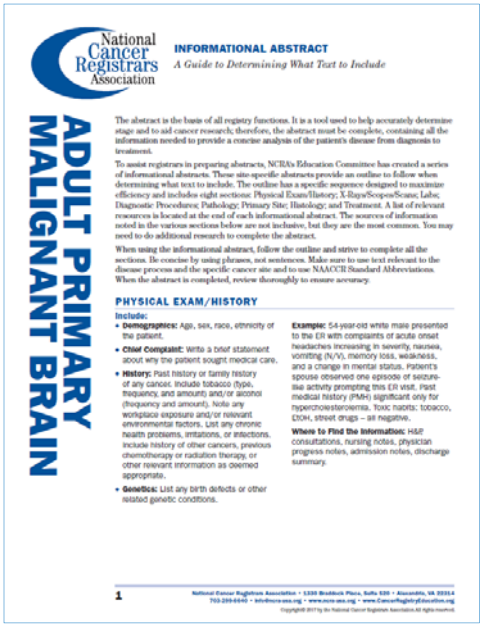
List all tests and dates.

- Immunohistochemical (IHC) and molecular genetic studies are often performed to assist with diagnosis, prognosis, or to predict therapeutic response.
- Common ancillary molecular testing in neuro-oncology includes testing for 1p and 19q co-deletion
- Methylguanine-DNA methyltransferase (MGMT) promoter methylation studies
- p53 expression
- Copy number alterations in epidermal growth factor (EGFR) and phosphatase and tensin homolog (PTEN) (CAP CNS Protocol Brain/Spinal Cord background documentation, ancillary studies).

Example: Part C: Right Frontal Lobe Subtotal Resection: Glioblastoma multiforme (GBM), WHO Grade IV; 3% of tumor necrosis; 95% of tumor cellularity. IHC: MGMT 20%; PTEN retained (2+).

NAACCR

Coding Pitfalls and Text – Brain & CNS – Part II



National Cancer Registrars Association

INFORMATIONAL ABSTRACT

A Guide to Determining What Text to Include

ADULT PRIMARY MALIGNANT BRAIN

The abstract is the basis of all registry functions. It is a tool used to help accurately determine stage and to aid cancer research; therefore, the abstract must be complete, containing all the information needed to provide a concise analysis of the patient's disease from diagnosis to treatment.

To assist registrars in preparing abstracts, NCRA's Education Committee has created a series of informational abstracts. These site-specific abstracts provide an outline to follow when determining what text to include. The outline has a specific sequence designed to maximize efficiency and includes eight sections: Physical Exam/History; X-Rays/Scopes/Scans; Labs; Diagnostic Procedures; Pathology; Primary Site; Histology; and Treatment. A list of relevant resources is located at the end of each informational abstract. The sources of information noted in the various sections below are not inclusive, but they are the most common. You may need to do additional research to complete the abstract.

When using the informational abstract, follow the outline and strive to complete all the sections. Be concise by using phrases, not sentences. Make sure to use text relevant to the disease process and the specific cancer site and to use NAACCR Standard Abbreviations. When the abstract is completed, review thoroughly to ensure accuracy.

PHYSICAL EXAM/HISTORY

Include:

- **Demographics:** Age, sex, race, ethnicity of the patient.
- **Chief Complaint:** Write a brief statement about why the patient sought medical care.
- **History:** Past history or family history of any cancer. Include tobacco (type, frequency, and amount) and/or alcohol (frequency and amount). Note any workplace exposure and/or relevant environmental factors. List any chronic health problems, irritations, or infections. Include history of other cancers, previous chemotherapy or radiation therapy, or other relevant information as deemed appropriate.
- **Genetics:** List any birth defects or other related genetic conditions.

Example: 54-year-old white male presented to the ER with complaints of acute onset headaches increasing in severity, nausea, vomiting (N/V), memory loss, weakness, and a change in mental status. Patient's spouse observed one episode of seizure-like activity prompting this ER visit. Past medical history (PMH) significant only for hypercholesterolemia. Toxic habits: tobacco, EtOH, street drugs – all negative.

Where to Find the Information: H&P, consultations, nursing notes, physician progress notes, admission notes, discharge summary.

1

DIAGNOSTIC PROCEDURES

For any of these diagnostic procedures—procedures that detect the cancer, but do not remove it—make sure to include the date, name of procedure, and brief description of findings.

Include:

- **Biopsy:** Most often performed at the time of surgical resection. Rarely Stereotactic CT or MRI guided biopsy may be performed without surgical resection in patients considered surgically unresectable or not considered a good surgical candidate.

Example: 10/20/2015: (performed during surgery): Biopsy of the abnormal tissue submitted to pathology. Frozen section diagnosis. Dx - GBM.

PATHOLOGY

Include:

Date and a brief summary of findings of all pathological reports. List in chronological (i.e. first to most recent).

- Extent (extension) of the primary tumor
- Cancer cell type
- Grade of the tumor
- Laterality
- Size of tumor (not specimen size)

PATHOLOGY *(continued)*

- Evidence of further spread (often found in the microscopic description of the pathology report).

Margins: Note extent of involvement of surgical margins.

Example: 10/23/15 S15-2205: RT Frontal Lobe Subtotal Resection: GBM, WHO Grade IV; 3% of tumor necrosis; 95% of tumor cellularity. Infiltrating astrocytoma shows a small irregularly shaped angular and hyperchromatic nuclei associated with mitotic figures, endothelial proliferation and necrosis. IHC: MGMT 20%; PTEN retained (2+).

PRIMARY SITE

Include:

The primary site where the cancer started. If the exact location within the brain is not apparent, document as Brain NOS (C71.9).

Example: Brain – Right Frontal Lobe (C71.1)

Where to Find the Information: Usually found in the surgical report and/or diagnostic reports (imaging or biopsy).

HISTOLOGY

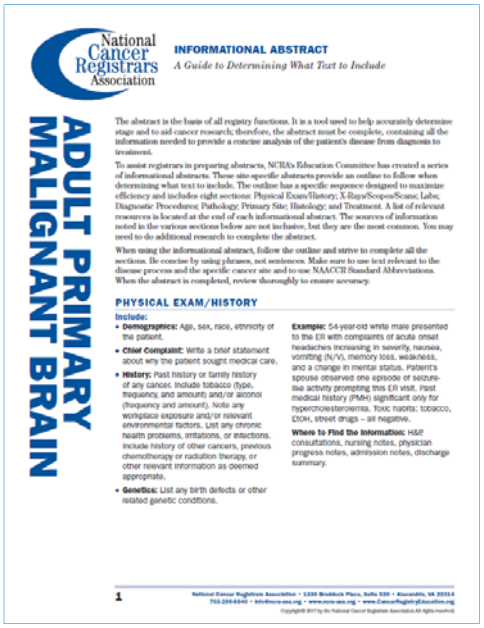
Include:

- The exact cell type of the cancer.

Example: GBM, WHO Grade IV (M-9440-3)

NAACCR

Coding Pitfalls and Text – Brain & CNS – Part II



National Cancer Registrars Association

INFORMATIONAL ABSTRACT

A Guide to Determining What Text to Include

ADULT PRIMARY MALIGNANT BRAIN

The abstract is the basis of all registry functions. It is a tool used to help accurately determine stage and to aid cancer research; therefore, the abstract must be complete, containing all the information needed to provide a concise analysis of the patient's disease from diagnosis to treatment.

To assist registrars in preparing abstracts, NCRA's Education Committee has created a series of informational abstracts. These site-specific abstracts provide an outline to follow when determining what text to include. The outline has a specific sequence designed to maximize efficiency and includes eight sections: Physical Exam/History; X-Rays/Scopes/Scans; Labs; Diagnostic Procedures; Pathology; Primary Site; Histology; and Treatment. A list of relevant resources is located at the end of each informational abstract. The sources of information noted in the various sections below are not inclusive, but they are the most common. You may need to do additional research to complete the abstract.

When using the informational abstract, follow the outline and strive to complete all the sections. Be concise by using phrases, not sentences. Make sure to use text relevant to the disease process and the specific cancer site and to use NAACCR Standard Abbreviations. When the abstract is completed, review thoroughly to ensure accuracy.

PHYSICAL EXAM/HISTORY

Include:

- **Demographics:** Age, sex, race, ethnicity of the patient.
- **Chief Complaint:** Write a brief statement about why the patient sought medical care.
- **History:** Past history or family history of any cancer. Include tobacco (type, frequency, and amount) and/or alcohol (frequency and amount). Note any workplace exposure and/or relevant environmental factors. List any chronic health problems, irritations, or infections. Include history of other cancers, previous chemotherapy or radiation therapy, or other relevant information as deemed appropriate.
- **Genetics:** List any birth defects or other related genetic conditions.

Example: 54-year-old white male presented to the ER with complaints of acute onset headaches increasing in severity, nausea, vomiting (N/V), memory loss, weakness, and a change in mental status. Patient's spouse observed one episode of seizure-like activity prompting this ER visit. Past medical history (PMH) significant only for hypercholesterolemia. Toxic habits: tobacco, EtOH, street drugs – all negative.

Where to Find the Information: H&P, consultations, nursing notes, physician progress notes, admission notes, discharge summary.

1

TREATMENT

Include:

- **Surgery:** Type, date, and any relevant statement to describe important details.
- **Most Commonly Performed Surgery:**

Note: This is the definitive surgery that removes the cancer.

Subtotal Resection of tumor, mass, or lesion in the brain and refers to removal of visibly abnormal tissue as seen on imaging or intraoperatively. It is completed to a degree that is consistent with preservation of functional neurologic tissue.

Example: 10/25/15: Dr. T.E. Best – Subtotal Resection of Right Frontal Lobe Mass. Operative Findings: Large cystic mass noted in right frontal lobe, just below the cortex in white matter, just anterior to trigone of the ventricle. Biopsy of abnormal tissue sent to pathology and returned on frozen as GBM. All visible tumor was removed.

- **Novocure® Optune treatment** – Code to surgery (Code 10)

- **Chemotherapy:** Include beginning and end dates of chemotherapy, names of drugs, and route of administration, if available. Note any response to treatment.

Systemic is the administration of a chemotherapy drug into the circulatory system so that the entire body is affected. Note any new drugs, why the drug was changed, and when the new drug was started.

Example: 10/25/15 Dr. B. Gentile: Temodar (temozolomide) with concurrent EBRT. Continue Temodar post-RT for one year.

- **Clinical Trials:** The name and number of the clinical trial and the date patient was enrolled. Include other details of the patient's experience in the trial.

Do Not Record Stereotactic Radiosurgery (SRS), Gamma Knife, Cyberknife, or Linac Radiosurgery as surgical tumor destruction. Each of these modalities are coded in radiation treatment fields.

- **Radiation:** Beginning and ending of treatment, type of radiation, to what part of body it was given, dosage and reaction to treatment, if noted. Record any boost dosages, date, and to where it was administered.

Radiation may be used alone or in combination with surgery and/or chemotherapy. Radiation treatment options often include external beam (EBRT) using 3D conformal or intensity Modulated Radiation Therapy (IMRT) or stereotactic radiosurgery (SRS) also described as stereotactic radiotherapy (SRT). These are most often identified as Gamma Knife, Cyberknife, or linear accelerator (LINAC).

Example: 12/7/15-1/11/16: Dr. M. Curie: 6000cGy to whole brain at 200cGy IMRT in 30fx over 35days.

Note: May include patients who have not yet been treated.

Example: 12/75/2015: Patient enrolled in NCI 2014-00616: Phase III Trial of Temozolomide with or with Veliparib in treating patients with newly diagnosed GBM.

- **Other:** Any other treatment that does not fit into one of the categories above.

Note: Any changes in drugs: state new drug names and why the drug was changed and when the new drug was started.

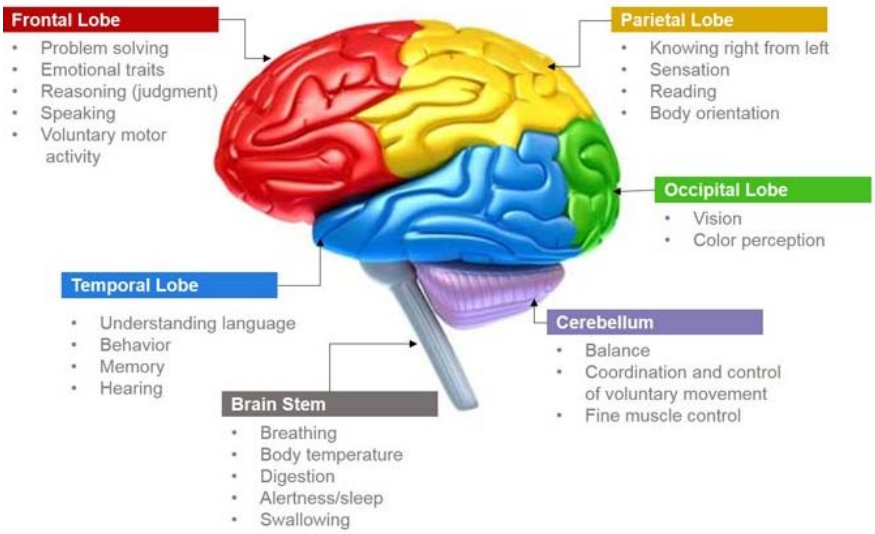
Example: 10/25/15 Dr. A. Miracle: Gemcitabine

NAACCR

Pop Quiz 12 Coding Pitfalls and Text – Brain & CNS – Part II

- Does a neoplasm have to be microscopically confirmed to have a WHO Grade? What do we use if 'g rade' is stated on imaging?
- Astrocytoma and Glioma terminology can be confusing because these neoplasms are all of glial origin. The difference is grade.
- Progression to a higher WHO Grade can occur and most often associated with glioma/astrocytoma neoplasms becoming higher grade and more aggressive over time when diagnosed early in life

Q&A – Brain & CNS Neoplasms Coding Pitfalls



Miscellaneous Questions

- Benign Tumors of the spinal vertebra – reportable or not reportable?
  - Tumors of the spinal vertebra like Osteoid osteoma and osteoblastoma would be coded to primary sites C41.2
  - Since this would be a benign tumor in the bone it would be not reportable

Pop Quiz 13 Question

- Patients with kidney primaries often have a kidney removed, but rarely are nodes removed. Are there circumstances where a pathologic stage group can be assigned with lymph nodes being excised?

Pop Quiz 13

- A 63 year old white male presents with a history of right flank pain for the last month. An abdominal CT showed a large complex right renal mass (10 x 8 x 7.8 cm) highly suspect for renal cell carcinoma. The tumor extends into the renal vein, but does not extend beyond the Gerota's fascia. Biopsy confirmed renal cell carcinoma. Additional workup was negative. Patient went on to have a radical nephrectomy
- Pathology from radical nephrectomy:
  - Specimen: Kidney and adrenal gland, left, radical nephrectomy.
  - Histologic Tumor Type: Sarcomatoid renal cell carcinoma
  - Histologic Tumor Grade: Fuhrman grade 4 (of 4)
  - Tumor Size: 10.0 X 8.3 X 8.0 CM.
  - Tumor Extension: Tumor extends along the renal vein into the inferior vena cava. Tumor does not extend beyond the Gerota's fascia.
  - Margins: All margins negative

Data Item	Value
Clinical T	
Clinical N	
Clinical M	
Clinical Stage	
Pathologic T	
Pathologic N	
Pathologic M	
Pathologic Stage	

NAACCR

Pop Quiz 13 (cont)

- A 63 year old white male presents with a history of right flank pain for the last month. An abdominal CT showed a large complex right renal mass (4 x 3.5 x 3.2 cm) highly suspect for renal cell carcinoma. The tumor extends into the renal vein, but does not extend beyond the Gerota's fascia. Biopsy confirmed renal cell carcinoma. Additional workup was negative. Patient went on to have a radical nephrectomy
- Pathology from radical nephrectomy:
  - Specimen: Kidney and adrenal gland, left, radical nephrectomy.
  - Histologic Tumor Type: Sarcomatoid renal cell carcinoma
  - Histologic Tumor Grade: Fuhrman grade 4 (of 4)
  - Tumor Size: 4 x 3.5 x 3.2 cm
  - Tumor Extension: Confined to the kidney.
  - Margins: All margins negative

Data Item	Value
Clinical T	
Clinical N	
Clinical M	
Clinical Stage	
Pathologic T	
Pathologic N	
Pathologic M	
Pathologic Stage	

NAACCR

Text Pointers for Changing Registry Standards

- New Terminology Used to Describe Cancer Characteristics
- New and Revised Staging Clarifications
- New ICD-O-3 Codes
- Changes to Behavior of Neoplasm
- New Details for Cancer Staging
- New Site Specific Data Items
- New Molecular/Genetic Tumor Tests without Fields
- Fast-Paced Technology – Not the Same Pace as Cancer Registry
- When you feel like you are placing a square peg in a round hole – you need to document what is in the record and ask for guidance

Coding Pitfalls and Text - Quiz

Questions

Fabulous Prizes

CE Certificate Quiz Survey

- Phrase

- Link

http://www.surveygizmo.com/s3/3818168/Coding-Pitfalls-2017

Jim Hofferkamp jhofferkamp@naaccr.org
Angela Martin amartin@naaccr.org
Steve Peace SPeace@med.miami.edu