Coding Pitfalls

2014-2015 NAACCR Webinar Series
September 3, 2015

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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.

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FABULOUS PRIZES

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GUEST SPEAKER

- Angela Martin, BS, CTR
  - Missouri Cancer Registry

AGENDA

- Updates
- Staging
- Epi Moment
- Quiz 1
- Questions from this year's webinars
- Other
- Quiz 2

UPDATES

- 2017 Updates
  - MP/H
  - Summary Stage
  - AJCC
- CS Site Specific Factors
- FORDS
- Death Clearance Manual

TNM and Summary Stage

SUMMARY STAGE

SUMMARY STAGE

- Do not use SS2000 references to TNM, FIGO or other staging systems
  - Summary Stage has not been updated since 2001
  - FIGO and TNM have been updated since 2001

INTRAMUCOSAL

Code	Description	TNM 7 Map	TNM 6 Map	SS77 Map	SS2000 Map
000	In situ, intraepithelial, noninvasive	Tis	Tis	IS	IS
050	(Adeno)carcinoma, noninvasive, in a polyp or adenoma	Tis	Tis	IS	IS
100	Invasive tumor confined to mucosa, NOS, including intramucosal, NOS	Tis	Tis	L	L
110	Invades lamina propria, including lamina propria in the stalk of a polyp	Tis	Tis	L	L
120	Confined to and not through the muscularis mucosae, including muscularis mucosae in the stalk of a polyp.	Tis	Tis	L	L
130	Confined to head of polyp, NOS	T1	T1	L	L
140	Confined to stalk of polyp, NOS	T1	T1	L	L
150	Invasive tumor in polyp, NOS	T1	T1	L	L
160	Invades submucosa (superficial invasion), including submucosa in the head or stalk of a polyp	T1	T1	L	L

CNS AND LYMPHOMA

- 1 Local
- 5 Regional
- 7 Distant
- 8 Benign (CNS)
- 9 Unknown
- Codes 0, 2, 3, 4 are not applicable

LUNG-SUPRACLAVICULAR LYMPH NODES

- Summary Stage
  - Distant Metastasis
- TNM Stage
  - Included in the N category

REG NODES POPS/EXAMINED

- Q: If AJCC lists a lymph node as regional and Summary lists the lymph node as distant, how do we code Regional Lymph Nodes Positive and Regional Lymph Nodes Examined?

- A: All of the standard setters agree…go with AJCC.

LYMPH NODE INVOLVEMENT

LYMPHOMA	SOLID TUMORS	LUNG
• Any mention of lymph nodes is indicative of involvement	• Fixed matted mass in the mediastinum, retroperitoneum and/or mesentery (no specific info as to tissue involved – consider involvement	• Enlarged and lymphadenopathy indicate regional involvement for lung ONLY

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INVOLVEMENT TERMS

INVOLVEMENT	NON-INVOLVEMENT
• Adherent	• Abuts
• Appears to	• Approaching
• Comparable with	• Approximate
• Compatible with	• Attached
• ….	• ….

See page 15 of the Summary Stage Manual

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AJCC STAGING

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PRIOR TO ASSIGNING STAGE…

- Registrars must have access to their staging manuals
- Are HIGHLY encouraged to view the AJCC Curriculum for Cancer Registrars
  - https://cancerstaging.org/CSE/Registrar/Pages/AJCC-Curriculum.aspx
- Understand how to use the CAnswer forum
  - http://cancerbulletin.facs.org/forums/forum

QUESTION-TERMINOLOGY

- Can the term "adenopathy" be considered as positive lymph node involvement when assigning cN? Are there any primary site exceptions?

ANSWER

- AJCC does not have ambiguous terminology lists, and does not mandate how words should be interpreted.

http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging/general-rules-chapters-1-2/8603-adenopathy?9257-Adenopathy_%C2%AC=

QUESTION

- A physician assigned a pT in a situation where the patient clearly did not meet the rules for classification for a pT….how should I enter that into the registry database?

ANSWER

- The hospital registrar will be responsible for recording the physician-assigned stage in the registry database.
  - If the stage assigned by the physician is not accurate, the registrar should assign the stage and record the registrar-assigned stage in the registry database
  - If no physician-assigned stage can be found in the medical record, the registrar should assign the stage and record it in the registry database.

Collaborative Stage Transition Newsletter

August 21, 2015

ENTERING DATA

- Stage is assigned

- The assigned stage is entered in data items
  - Clinical stage data should only be entered into clinical data fields
  - Pathologic stage data into pathologic data fields

	Data Items as Coded in Current NAACCR Layout			
	T	N	M	Stage Group
Clin	1	0	0	I
Path	1	0	cM0	I

QUESTION

- What are the valid M values that should be considered when assigning a clinical stage group?
  - A. cM0
  - B. cM1
  - C. pM1
  - D. A and B
  - E. All of the above

CASE SCENARIO

- A patient is found to have a liver lesion via imaging that is suspicious for malignancy. A CT guided biopsy is done and he is found to have metastatic cancer most likely from a colon primary. Patient refused any further work-up or treatment. How would this be staged?

	Data Items as Coded in Current NAACCR Layout			
	T	N	M	Stage Group
Clin			pM1	IV
Path			1	IV

QUESTION

- Imaging done prior to surgery showed distant metastasis.

- The patient went on to have surgery and at that time the distant metastasis was confirmed microscopically.
  - What is cM and pM?

ANSWER
- It is about the timeframe in which the information was known.
  - Prior to treatment we only had clinical evidence of distant metastasis.

	Data Items as Coded in Current NAACCR Layout			
	T	N	M	Stage Group
Clin			1	IV
Path			1	IV

http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging/ajcc-curriculum-for-registrars/module-iii/58339-cm-and-pm

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BLANKS vs X'S FOR T AND N DATA ITEMS
- Has the criteria for stage classification been met?
  - No-Blank
  - Yes-X or valid known value (1,2, 3, 4, etc)
- What if it is "unknown" if stage classification rules have been met?
  - Unknown to physician-X
  - One of the treating physicians knows the stage, but another does not-blank
  - Unknown to registrar due to poor documentation-Blank

BLANKS vs X'S FOR T AND N DATA ITEMS
- Criteria for Rules for Classification
  - Every chapter in the manual has rules for clinical and rules for pathologic stage
  - Must at least meet the criteria for the T value to use an X

BLANKS vs X'S FOR T AND N DATA ITEMS

- Colonoscopy with a biopsy. No further clinical information.
  - Met the criteria for cT. code cTX cNX
- Cystectomy for bladder cancer was done, path showed a T2a tumor. No lymph nodes were removed.
  - Met the rules for pT. pT2a pNx

QUESTION FROM CENTRAL REGISTRY STAFF

- Patient comes to facility for radiation treatment after having biopsy and prostatectomy elsewhere.
  - The only information in the chart is the dates of biopsy, prostatectomy, and the radiation treatment information.
- Should we use X or Blanks for the clinical and pathological staging?

ANSWER

- Since TX or NX indicate the information was unknown to the physician, you cannot use this.
  - The physician does know the stage or they wouldn't be able to choose the appropriate treatment for the patient.
  - In this case, and it is the only option since you cannot use X, you would leave all of the information blank.

http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging/ajcc-registrar-education-presentations/explaining-blanks-and-x-ambiguous-terminology-and-support-for-ajcc-staging/58490-clarification-on-using-x-vs-blanks

QUESTION

- A patient is found to have a 2cm squamous cell carcinoma of the lung and enlarged hilar lymph nodes.
  - A mediastinoscopy was done and 2 hilar lymph nodes were removed and found to be positive for malignancy.
  - The patient was treated with radiation (no further surgery).
- What is the pathologic stage?

ANSWER

- Must establish pT in order to assign the pN if the pN is not the highest N category. T and N are blank.
  - Hilar node is N1
  - N values for lung are 1, 2, and 3

	Data Items as Coded in Current NAACCR Layout			
	T	N	M	Stage Group
Clin	1a	1	0	IIA
Path				99

QUESTION

- A patient with a clinical T2a N0 M0 prostate cancer opts for prostatectomy. During the procedure 2 lymph nodes are removed and found to be positive. The prostatectomy was cancelled.
- What is the pathologic stage?

ANSWER

- Criteria for pT not met
- Highest pN value confirmed pathologically
- Any T, N1, M0 is Stage IV

	Data Items as Coded in Current NAACCR Layout			
	T	N	M	Stage Group
Clin	2a	0	0	IIA
Path				99

SUBCATEGORIES

- Subcategories may be required to assign a stage group.
  - For prostate T2 is not sufficient to assign a stage group. Must have t2a or T2b.

QUESTION

- A patient had DRE due to an elevated PSA (5.4). The urologist felt a nodule in the left lobe. The urologist did not indicate if it was more or less than half a lobe. Bx confirmed adenocarcinoma Gleason 3+3. No indication of any additional disease

ANSWER

- If there is no description that would guide selection of the subcategory it would be correctly assigned cT2.

- This would not allow a clinical stage group to be assigned.

	Data Items as Coded in Current NAACCR Layout			
	T	N	M	Stage Group
Clin	2	0	0	99
Path				99

QUESTION

- A patient had a bronchial washing positive for squamous cell carcinoma of the lung.
  - Imaging failed to show a mass within the lung, but did show mediastinal and hilar lymphadenopathy.
  - Mediastinoscopy was positive for two metastatic mediastinal lymph nodes.

- How is this staged?

OCCULT LUNG PRIMARIES

- TX definition includes a primary that has been confirmed by sputum or bronchial washings, but not visualized by imaging.

- T0 would be a tumor not confirmed by sputum, washings, or imaging

- Occult is Tx N0 M0

ANSWER

- Criteria for cT has been established
- Tumor has been confirmed by washings, but not visualized by imaging
- Mediastinoscopy is positive for lymph node mets

	Data Items as Coded in Current NAACCR Layout			
	T	N	M	Stage Group
Clin	X	2	0	IIIA
Path				99

QUESTION

- Can you clarify how to assign cN and pN for a patient that had a sentinel lymph node biopsy for a breast primary?

ANSWER

- If the sentinel lymph node (SLN) biopsy is done *prior* to establishing the pT, then the SLN information can be used to assign the cN.
  - At that point the SLN status can be used to determine treatment.
  - SLN can also be used to assign pN.
  - pN includes clinical information plus information from removal of lymph nodes
- If the SLN is removed during or after removal of the primary tumor, it can only be used to assign the pN.

QUESTION

- I have a patient with a lung primary that has clinical evidence of brain metastasis(M1b) and path evidence of pleural effusion (M1a).
  - Both were diagnosed prior to any treatment.

- How should I enter this into my registry software?

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ANSWER

- AJCC rules state that the pM requires a biopsy positive for cancer at the metastatic site. However, there are no specifications regarding the subcategories.

- It is probably best to assign the clinical stage as cT4 cN2 pM1b clinical stage IV.

http://cancerbulletin.facs.org/forums/showthread.php?9042-Pericardial-Effusion-and-Bone-Mets-p-M1-M1a-or-M1b&highlight=subcategories.

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QUESTIONS?

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AND NOW A BRIEF PAUSE FOR...
AN EPI MOMENT BY
RECINDA SHERMAN

(insert *Swan Lake* here)

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DIFFICULT VARIABLES

• Incomplete
  • Stage
  • Treatment
  • Site Specific
    • SSF1, SSF2, SSF15—breast ER/PR/HER2

• Incomplete & coding errors
  • **Primary Payer**
  • **Address at DX**

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PRIMARY PAYER: DISPARITIES RESEARCH

• Research questions
  • Proxy for class/income, access to care, quality of care
• Condensed groups for analysis
  • Insured vs uninsured; private insurance vs public insurance
  • Still important even if healthcare universal
• No insurance: 01 versus 02
• Do **NOT** wait for most current information
  • Do **NOT** include insurance obtained after diagnosis
    • Eg disease specific insurance or public insurance applied for after diagnosis
  • 99 is a valid code
• Combo codes
  • Medicare 65+

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POP QUIZ

A 55 yo Virginia woman is diagnosed with stage IV breast cancer. Her treatment is paid for by the state Breast and Cervical Cancer Prevention Program. How do you code primary payer?

A. 02, not insured, self-pay

B. 10, insurance, NOS

C. 31, Medicaid

D. None of the above

ADDRESS AT DX: GEOSPATIAL RESEARCH

- Incidence, mortality, treatment, and survival
  - Vary by geography
- Map data, visualize relationships, generate hypotheses
- Geospatial research
  - Relationships among place and health
    - Proxy for class/income, physical access to care, regional systems
    - Environmental, demographic, proximity to care, group-level effects, cancer clusters

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ADDRESS AT DX

- Street address, supplemental address, city, zip
  - No PO Boxes
    - Do not preface address with PO Box; place PO Box in Supplemental
    - Florida edits
    - Google, DMV or other external sources
  - Not Current address
- Homeless—address of hospital diagnosis
  - homeless in supplemental address field

QUESTION

• What do we do if all we have is a PO Box listed?

ANSWER

• Verify that the street address isn't stored elsewhere.
   • If not, turn to external data sources like DMV, Voter Registration Records, or google patient.
   • If no luck, use PO Box for street address and use the city, state and zip code from the PO Box address.
   • This provides a proxy for the county at diagnosis.
   • *Please make every effort to minimize the use of the PO Box as the street address.*

"GIGO"

• Geography specific rates
   • County, census tract, block group
• Cluster analysis
   • Geocoding (long/lat)
• Area-based data
   • poverty, urban/rural status, urban/rural commuting codes
• Linkage variables
   • Cohort studies, drug safety studies

MISC…

- Q: How do we code race if the race documents the patient's race as "other"?

- A: Code as unknown if you don't have any additional information. Do not code as 98-Other!

- Q: How should Alias be entered?

- A: Alias should be entered last name then first name without punctuation

Quiz 1

QUESTIONS?

MP/H

WHEN SHOULD THE MP/H RULES BE USED?

• **DO** use to determine multiple primaries

• **DO** use to coding histology.

• **DO NOT** use for casefinding.

• **DO NOT** use for coding tumor grade.

• **DO NOT** use them for any data items other than histology or for any use other than determining multiple primaries

POP QUIZ

• 2/19/13 TURBT: Papillary urothelial carcinoma, high grade, noninvasive of right lateral bladder wall

• 3/18/13 Left renal pelvis biopsy: High grade papillary transitional cell carcinoma of calyx

• What is the code for primary site
  • C65.9 Renal pelvis
  • C67.2 Lateral wall of bladder
  • C68.9 Urinary system NOS

CODING PRIMARY SITE

• Rule 4
  • Code the site of the invasive tumor when there is an invasive tumor and insitu tumor in **different** subsites of the **same anatomic site**.

CODING PRIMARY SITE

• Rule 5
  • Code the last digit of the primary site code to '9' for **single primaries**, when **multiple tumors arise in different subsites** of the same anatomic site and the point or origin cannot be determined.

CODING PRIMARY SITE

• Rule 8
  • See the site-specific coding guidelines in Appendix C for primary site coding guidelines for the following sites:
    • Bladder
    • Kaposi sarcoma
    • Breast
    • Lung
    • Colon
    • Rectosigmoid, Rectum
    • Esophagus

CODING PRIMARY SITE

• Rule 13
  • When the medical record does not contain enough information to assign a primary site
    • Consult a physician advisor to assign the site code
    • Use the NOS category for the organ system OR the Ill-defined sites if the physician advisor cannot identify a primary site
    • Code Unknown Primary Site (C809) if there is not enough information to assign an NOS or Ill- Defined Site Category

CODING PRIMARY SITE

SECTION TWO: CODING INSTRUCTIONS / Cancer Identification   121

PRIMARY SITE   Item Length: 4
                                                     NAACCR Item #400
                                                     Revised 01/04, 09/08, 01/10

Description
Identifies the primary site.

Rationale
Primary site is a basis for staging and the determination of treatment options. It also affects the prognosis and course of the disease.

Instructions for Coding
• Record the ICD-O-3 topography code for the site of origin.
• Consult the physician advisor to identify the primary site or the most definitive site code if the medical record does not contain that information.
• Topography codes are indicated by a "C" preceding the three-digit code number. Do not record the decimal point.
• Follow the Instructions for Coding in ICD-O-3, pages 20–40 and in the current *SEER Multiple Primary and Histology Coding Rules* to assign site for solid tumors.
• Follow the instructions in *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual* and the Hematopoietic and Lymphoid Neoplasm Database (Hematopoietic DB) for assigning site for lymphomas, leukemia and other hematopoietic neoplasms.
• Use subcategory 8 for single tumors that overlap the boundaries of two or more sub-sites and the point of origin is not known.
• Use subcategory 9 for multiple tumors that originate in different subsites of one organ.

QUESTION

• 01/27/15 Colonoscopy done. Biopsy of Sigmoid colon.
  • Final Diagnosis Adenocarcinoma with mucinous features.
  • Microscopic description states 45% of cells are mucinous

• How do we code the histology?

COLON HISTOLOGY RULES – H5

Code **8480** or **8490** when the final diagnosis is:
• mucinous or colloid adenocarcionma(8480)
• signet ring cell adenocarcinoma (8490)
• Adenocarcinoma, NOS and microscopic description says 50% or more of the tumor is mucinous or colloid (8480)
• Adenocarcinoma, NOS and the microscopic description says 50% or more of the tumor is signet ring cell adenocarcinoma (8490)

COLON HISTOLOGY RULES – H6

Code **8140** (adenocarcinoma, NOS) when the final diagnosis is **adenocarcinoma** and:

- The microscopic diagnosis states that **less than 50%** of the tumor is **mucinous/colloid** or
- The microscopic diagnosis states that **less than 50%** of the tumor is **signet ring cell** carcinoma or
- The **percentage** of mucinous/colloid or signet ring cell carcinoma is **unknown**

COLON HISTOLOGY RULES – H7

- Code **8255** (adenocarcinoma with mixed subtypes) when there is a **combination** of **mucinous/colloid and signet ring cell** carcinoma

COLON HISTOLOGY RULES – H13

Code the most **specific** histologic **term when** the diagnosis is:
- Cancer/malignant neoplasm, NOS (8000) and a more specific histology or
- Carcinoma, NOS (8010) and a more specific carcinoma or
- Adenocarcinoma, NOS (8140) and a more specific adenocarcinoma or
- Sarcoma, NOS (8800) and a more specific sarcoma (invasive only)

QUESTION

- Q: How do we code a breast primary with intraductal carcinoma with comedo and solid features?
- A: Per rule H4 we code 8501/2 comedocarcinoma
- Q: How do we code a breast primary with a histology described as carcinoma with comedo necrosis.
- A: Carcinoma NOS
  - Not comedocarcinoma!

QUESTION

- Q: How do I code clear cell renal cell carcinoma of the kidney?
- A: Renal cell is an NOS code. Clear cell is the more specific code 8310/3.

HEMATOPOIETIC AND LYMPHOID NEOPLASMS

QUESTION

- If a patient is diagnosed with acute leukemia, most likely acute myeloid leukemia (AML), and the clinic notes always refer to the patient being treated as AML, is this case coded as acute leukemia, NOS or acute myeloid leukemia?

ANSWER

- This case would be coded as AML.
  - Per the primary site and histology coding instructions and rules, if you have ambiguous terminology used with a specific histology and then the physician states that they are treating for the specific disease, then you can assign the specific histology.

QUESTION

- Can you review the difference between Chronic and Acute hematopoietic malignancies?

CHRONIC VS ACUTE-HEMATOPOIETIC

• If a chronic neoplasm can transform to an acute/more severe neoplasm, the Heme DB will show the acute neoplasm in the "Transformations to" section.

• If an acute neoplasm can transform to a chronic form of the neoplasm, the Heme DB will show the acute neoplasm in the "Transformation from" section.

HEMATOPOIETIC MANUAL

• Rules M8-13 deal with transformation to and from
  • You must use the manual before you use the multiple primary calculator!!!

QUESTION

• 66 year old white male was diagnosed on 7/17/2013 at Hospital A with Stage I follicular lymphoma involving only retroperitoneal and periaortic lymph nodes.

• In October, 2014, the same patient developed discomfort in his right hard palate.
  • A biopsy of the right maxillary parasinus was performed on 10/2/2014 at Hospital B, and pathology revealed diffuse large B-cell lymphoma.
  • The patient is seen by another oncologist at Hospital B, who calls this disease process a transformation from the patient's previously diagnosed follicular center cell lymphoma-up.

• Should Hospital B report this as a new primary?

REASONING

- Diffuse large B-cell lymphoma is the acute phase of follicular lymphoma
- Each histology was diagnosed more than 21 days apart
- Rule M10
  - Abstract as multiple primaries** when a neoplasm is originally diagnosed as a chronic neoplasm AND there is a second diagnosis of an acute neoplasm more than 21 days after the chronic diagnosis.

ANSWER

- Hospital B will abstract as a second primary
  - Date of Diagnosis: 10/2/2014
  - Histology: 9680/3

QUESTION

- I often see the abstractor code the lymph node regions where the biopsy was taken but the CT reveals lymphadenopathy above and below the diaphragm.
- Could you stress that this should be coded to C77.8?

ANSWER

• See Module 7 of the hematopoietic manual

• Rule PH21
  • Code the primary site to multiple lymph node regions, NOS (C77.8) when multiple lymph node regions, as defined by ICD-O-3, are involved and it is not possible to identify the lymph node region where the lymphoma originated.

TESTIS

MATURE TERATOMA

• When is mature teratoma of the testis reportable?

MATURE TERATOMA

- Reportable vs Non-Reportable
- Pre-puberty vs post–puberty
- Physician Statement

http://seer.cancer.gov/manuals/2015/SPCSM_2015_maindoc.pdf

SERUM TUMOR MARKER LEVEL

- Serum tumor marker levels should be measured prior to orchiectomy, **but levels after orchiectomy are used for assignment of S category**, taking into account the half life of AFP and hCG. Stage grouping classification of Stage IS requires persistent elevation of serum tumor markers following orchiectomy.

- The Serum Tumor Markers (S) category comprises the following:
  - Alpha fetoprotein (AFP) – half life 5-7 days
  - Human chorionic gonadotropin (hCG) – half life 1-3 days
  - Lactate dehydrogenase (LDH)

S DEFINITIONS

SX	Marker studies not available or not performed
S0	Marker study levels within normal limits
S1	LDH < 1.5 x N* *and* hCG (mIu/ml) < 5,000 *and* AFP (ng/ml) <1,000
S2	LDH 1.5-10 x N *or* hCG (mIu/ml) 5,000-50,000 *or* AFP (ng/ml) 1,000-10,000
S3	LDH >10xN *or* hCG (mIu/ml) >50,000 *or* AFP (ng/ml)>10,000

*N indicates the upper limit of normal for the LDH assay

SSF THAT DETERMINE S CATEGORY

SSF 13 – Post Orchiectomy AFP Range

SSF 15 – Post Orchiectomy hCG Range

SSF 16 – Post Orchiectomy LDH Range

CODES FOR SSF 13,15,16

000	Within normal limits
010	Range 1 (S1)
020	Range 2 (S2)
030	Range 3 (S3)

CODES FOR SSF 13,15,16

990	Post-orchiectomy test unknown but pre-orchiectomy test normal
991	Post –orchiectomy test still elevated
992	Post-orchiectomy test unknown but post orchiectomy serum tumor makers, NOS normal
993	Post-orchiectomy test unknown but post –orchiectomy serum tumor makers, NOS still elevated; Stated as Stage IS

CODES FOR SSF 13,15,16

988	Not applicable: Information not collected for this case
997	Test ordered results not in chart
998	Test not done (test not ordered and not performed)
999	Unknown or no information; Not documented in patient record

S CATEGORY

- Q: Patient has AFP test done post orchiectomy with a result of 3,365 ng/ml. hCG and LDH were within normal limits. What would the S category be?

- A: The S category would be S2. S2 LDH 1.5-10 x N *or* hCG (mIu/ml) 5,000-50,000 *or* AFP (ng/ml) 1,000-10,000

UTERUS

UTERUS

What is the difference between AJCC Stage and FIGO Stage? FIGO grade and histologic grad?

UTERUS

- International Federation of Gynecology and Obstetrics
- No Stage O in the FIGO Staging System

UTERUS

FIGO GRADE

GX	The grade cannot be evaluated
G1	Well Differentiated
G2	Moderately Differentiated
G3	Poorly Differentiated
G4	Undifferentiated

HISTOLOGIC GRADE

1	Well differentiated
2	Moderately differentiated
3	Poorly differentiated
4	Undifferentiated
9	Not determined, not stated or not applicable

STOMACH AND ESOPHAGUS

REGIONAL LYMPH NODES

Q: When CS goes away, which list of regional lymph nodes will we use between AJCC & SEER Summary Stage for the coding the fields Regional Nodes Positive and Regional Nodes Examined?

A: Use the regional lymph nodes listed in the AJCC manual. All of the standard setters have agreed to this.

LARYNX AND THYROID

PAPILLARY CARCINOMA OF THE THYROID

- Q: How should I code papillary carcinoma of the thyroid?
- A: Code to 8260/3
  - Do not code to papillary microcarinoma (8341/3)

QUESTION

- In the rules for clinical staging for thyroid it is stated that the diagnosis of thyroid cancer must be confirmed by needle biopsy or open biopsy of the tumor.
  - If a patient presents with a measurable mass in the thyroid but no biopsy is done, can a clinical stage be assigned?
  - In our example the patient went on to have surgery that confirmed malignancy.

ANSWER

- Without a biopsy confirming cancer, the patient cannot be assigned a clinical stage. Especially since the staging is so dependent on the histology, without knowing the type of cancer you cannot assign stage.
  - This was verified with an AJCC expert panel member.

http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging/education-developed-by-partner-organizations/naaccr-webinars/56673-clinical-stage-thryroid-no-bx

QUESTION

- If a patient with thyroid cancer is given synthroid prior to surgery, is it coded as neoadjuvant treatment?

ANSWER

- Synthroid is NOT neoadjuvant therapy
  - Some physicians (not many endocrinologists) try to shrink thyroid nodules with Synthroid.
    - Not only does this rarely work, but it is also not diagnostic- both benign and malignant nodules can grow, shrink, or stay the same.
    - This should not be considered a neoadjuvant treatment of cancer.
- NCCN guidelines also show that there is NOT neoadjuvant therapy for this disease.

http://cancerbulletin.facs.org/forums/forum/collaborative-stage/larynx-and-trachea/thyroid/6108-synthroid-after-diagnosis-but-before-treatment

QUESTION

- A patient with a small laryngeal primary had surgery of the primary site, but no lymph nodes were removed. According to the NCCN guidelines removing lymph nodes is not recommended.
  - How do we code pN?

ANSWER

- If resection of the primary site meets the pathologic stage criteria and is performed, if lymph nodes were not removed, N category would be pNX, not blank.

http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging/education-developed-by-partner-organizations/naaccr-webinars/56581-x-and-blank

CNS

LOW GRADE GLIOMA

- Q: If all we have is a radiology report with a low grade glioma is this consistent with malignant behavior (/3)?

- A: We sent this off to SEER and they said we should code low grade glioma to glioma, nos (9380/3).

MEDULLOBLASTOMA

- Q: I was taught that Medulloblastoma was always coded to the cerebellum.
  - I believe the American Brain Tumor Assoc has this documented.

- A: Medulloblastoma should be assigned to the site from where they arose. Most occur either within the cerebellum or the fourth ventricle.

  http://seer.cancer.gov/seerinquiry/index.php?page=view&id=20140013&type=q

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WHO GRADE AND SSF 1

- Is tissue diagnosis required to code the WHO grade, or can we code based on imaging (i.e. meningioma) and use table 56.3 in the AJCC Manual?

WHO GRADE AND SSF 1

- *What I've told our registrars here is to code the WHO grade as documented on the pathology report in SSF 1.*

- *If there is a pathology report but the WHO grade is not documented, then they should refer to Table 56.3 and use the WHO grade indicated for the histology if it is listed on the table; otherwise, assign 999.*

- *If, however, the case is only clinical, they should assign code 998.*

TREATMENT - SURGERY

What surgery code should I use when the tumor was grossly resected but a lobectomy was not done?

NAACCR

TREATMENT – SURGERY

CNS Codes	Procedure
20	Local excision of tumor, lesion or mass; excisional biopsy
21	Subtotal resection of tumor, lesion or mass in brain
22	Resection of tumor or spinal cord nerve
30	Radical, total, gross resection of tumor, lesion or mass in brain
40	Partial resection of lobe of brain, when the surgery cannot be coded as 20-30
55	Gross total resection

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TREATMENT – SURGICAL APPROACH

When coding surgical approach, if the patient had a robotic assisted-laparoscopic procedure, which takes precedence? The robotic assisted approach or the laparoscopic approach?

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TREATMENT – SURGICAL APPROACH

Code	Definition
0	No surgical procedure of primary site at this facility, Diagnosed at autopsy
1	Robotic Assisted
2	Robotic converted to open
3	Minimally invasive (such as endoscopic or laparoscopic)
4	Minimally invasive (endoscopic or laparoscopic) converted to open
5	Open or approach unspecified
9	Unknown whether surgery was performed at this facility

STEREOTACTIC BIOPSY

- Q: For surgery does code 20 include a stereotactic biopsy?
  - 20 Local excision of tumor, lesion, or mass, excisional biopsy 21 Subtotal resection of tumor, lesion or mass in brain 22 Resection of tumor in spinal cord or nerve
    - [SEER Note: Assign code 20 for stereotactic biopsy of brain tumor]

STEREOTACTIC BIOPSY

- A: We checked with both SEER and CoC and they both agree a biopsy being done for diagnostic purposes only (i.e. an incisional biopsy), would not be coded as surgery, but an excisional biopsy would.
  - In coding a case such as this it is important to remember the significance of reading the surgery/op report to see what amount of tissue was removed.
  - Often times, the surgeon will state the intended procedure, but the actual report may show that a more definitive procedure or excision was done.

MENINGIOMA

• Q: When does one use meninges, nos (C70.9)?

• A: Only if one doesn't know if it started in cerebral meninges (C70.0) or the spinal meninges (C70.1).
  • Would be unusual to use C70.9
  • C70.9 is not considered a paired site so laterality would be 0. This could impact the multiple primary rules.

MIDLINE SHIFT

• Q: Does a "midline shift" indicate a tumor has metastasized from one hemisphere to another?

• A: No. It just means that the tumor is pushing against the contralateral hemisphere.

OTHER QUESTIONS

ADM WITHIN 30 DAYS AFTER SURG DISCHARGE

- Is a second surgery, for a breast primary for instance-to get clean margins, considered planned readmission and coded 2.

- I understood unplanned readmissions were for complications.

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ADM WITHIN 30 DAYS AFTER SURG DISCHARGE

- No, the second surgery cannot be considered planned readmission, because the item "Readm to the same hosp within 30 days of surg discharge" evaluates the presence or absence of complications (signs and symptoms) related to surgical treatment.

- The planned readmission within 30 days to the same hospital is counted only if the patient was admitted for disease-related purposes.

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LUPRON

- A patient with metastatic breast cancer is given Lupron. How should you code this?

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SEER*RX

- Does not list all sites or histologies that a drug is approved for
- Read the remarks to see if any sites/histologies are excluded.
- Otherwise they are ok to code for all sites.

SEER RX NOTES

The use of *Lupron* has not received FDA approval for treatment of breast cancer. While it may not have received FDA approval, it can be used "off label" for other conditions. Lupron should be coded as "Other Therapy" until such time that it receives FDA approval.

LUPRON

- Patient received Lupron one week prior to prostatectomy. When assigning AJCC pathological stage, should I use the y descriptor?
- No.

MELANOMA SURGERY

- Please clarify the revision addition in FORDs 2015 regarding Melanoma Surgery codes 45-47- "If the excision does not have clinically negative margins during surgery greater than 1cm, use the appropriate code, 20-36"

ANSWER

- This was a typo. It should state "If the excision does not have **microscopically** negative margins during surgery greater than 1cm, use the appropriate code, 20-36"

  Margins are based on path report not on information from the operative report.

FINAL PITFALL

- Text(or lack of it)!
  - Text is part of your abstract! Be sure to give it the same attention you would give to assigning primary site or staging!!!

Quiz 2

QUESTIONS?

NAACCR   130

COMING UP…
- Collecting Cancer Data: Unusual Sites and Histologies
  - 10/1/15
- Collecting Cancer Data: Pharynx
  - 11/5/15

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AND THE WINNERS ARE…..

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CE CERTIFICATE QUIZ/SURVEY

• Phrase
  • STaging
• Link
  • http://www.surveygizmo.com/s3/2309936/Coding-Pitfalls-2015

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