**Q&A Session**

**Abstracting and Coding Boot Camp: Cancer Case Scenarios**

**March 05, 2015**

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Q: ­Czechoslovakia was divided into 2 countries in 1993. I saw a code for Slovakia, but not for the Czech Republic. What would that be?­

A: The country code for the Czech Republic is CZE. That is documented in Appendix E of FORDS 2015 and Appendix B of the SEER Program Coding and Staging Manual 2015.

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Q: ­If a patient is diagnosed with carcinoid of the appendix prior to 2015 (when it wasn't reportable) and diagnosed with a subsequent tumor after 2015, would the 2015 tumor sequence number be 00 or 02?­

A: ­Unless you were collecting carcinoid of the appendix as reportable by agreement prior to 1/1/2015, the subsequent tumor would be 00.­

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Q: ­How do you code insurance for state prisoners?­

A: ­This is a difficult one from a research perspective. I would like to have a specific code. Most prisoners did not have insurance prior to incarceration, but we don’t have enough information to distinguish which ones. And they are not eligible for Medicaid while imprisoned. In the past, private insurance could drop incarcerated individuals (this has changed with the Affordable Care Act). However, because the insurance in prison is based on incarceration not medical condition, and because it is required by law to provide prisoner medical care, **10 Insurance, NOS** is the most appropriate code.

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Q: ­If patient has Medicare & Tricare what is preferred code? Is there a hierarchy to be used for these codes?

A: By law, TRICARE pays after all other health insurance (unless it is Medicaid or a few there specialized programs). TRICARE is an employer (military) based, managed care style insurance. TRICARE is a separate code to ensure TRICARE patients are not lumped into VA coverage patients who must be a Veteran and seen at a VA facility. It is important to know that the American Community Survey (ACS) data we link by county or tract to the cancer record also classifies TRICARE as a private insurance. Use a combo codes here: **63, Medicare with private supplement**.

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Q: ­Why would you not code "10 insurance, NOS" as the state is paying for the treatment?­

A: The variable is Primary Payer at DX. There is discussion regarding adding Primary Payer at Treatment. If the state is paying for treatment via Medicaid and the patient was not enrolled by hospital during time of diagnosis, then use the Medicaid codes. If the state is paying for treatment for a prisoner, then, yes, use 10, Insurance, NOS as explained above. However, if the state is paying for treatment through programs like the Breast and Cervical Cancer Program (BCCP), by definition the patient did not have insurance at time of diagnosis. The patient is only eligible for treatment to be paid for by the BCCP if the patient meets specific eligibility criteria including no other insurance and a cancer diagnosis. BCCP, other site-specific funding like through Lymphoma and Leukemia Foundation, and patients who are enrolled in Medicaid after a cancer diagnosis are coded as **01, Not Insured**.

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Q: ­If insurance is pending, do we code it to code 99?­

A: If “insurance is pending” means the patient has enrolled in a Medicaid or other insurance and the paperwork is processing, then code **01, Not insured**. Again, the variable collects Primary Payer at DX not necessarily at treatment. Only use 99 if there is no way to determine if the patient has or does not have insurance. This situation should be rare. In most cases, the patient is either uninsured or can be classed into Insurance, NOS.

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Q: ­Re: Fee for service insurance; are you saying we should default to fee for service instead of NOS? Blue cross 80/20 could be a PPO as well.

A: You are correct, an 80/20 plan could be a PPO. If you are unable to distinguish between a fee for service plan (most flexible) and a managed care plan (less flexible), then code **10, Insurance NOS**. But first I would google the plan (or call) to see if by using the plan name and coverage area a distinction could be made.

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Q: ­Please define "private insurance-fee for service."

A: Fee for service plans are private insurance plans that have no restrictions on who, when, or where a patient can be seen. A patient has 100% control over the providers they see, but they generally have to pay higher premiums. This is contrasted with a managed care plan where a set of providers or specific clinics are specified so that a patient either pays additional to see a practitioner “out of network” or the insurance doesn’t cover at all. By limiting eligible providers, the insurance company controls costs which often translates to lower premiums.

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

A: 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, then “Unknown” in street address, the PO Box in the Supplemental Field, and use the city, state and zip code from the PO Box address. This provides a proxy for the county at diagnosis.

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Q: ­What would you use for address at diagnosis if the patient was diagnosed in a foreign country and comes to here to get further treatment?

A: The street address at diagnosis is the patient’s home address. The county at dx should be coded 998 (address known but outside of reporting state) and the state at dx should be coded CD for a Canadian patient, XX if foreign country is known, and YY if foreign country is unknown.

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Q: ­For Address @ DX, if patient lives in one state 6 months and another state for 6 months, are we to enter the address from the other state if they had a positive biopsy in the other state? We usually have the address where they are currently living on file.­

A: If it is truly a situation where they are living equal time at each location, I would just go with the address on file.

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Q: ­Would you please clarify why you would not enter just the city where the person was homeless versus using the address of the facility where diagnosed.

A: This practice is to ensure consistency in coding. “Homeless” should be placed in the supplemental field so that central registries can accommodate for this in geographic studies. If a homeless patient is seeking treatment, the location of the facility serves as a proxy for his/her “home”. If you only include city, we lose data instead of coding what we have to allow flexibility in research. Sometimes cities cross county-lines, so the patient could be excluded from county statistics.

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Q: ­Our office has mail coming back where we have used the street address and not the PO Box address and stamped on the envelope is "No Receptacle for Mail". I had called the Post Office and they told me they only have a post office box. What to do?­

A: The street address should be entered in the address at diagnosis. We suggest entering the post office box in the current address.

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Q: ­For quiz 2 question 2, would you explain the difference between c and d­.

A: Managed Care: general term for a health insurance that restricts patient access, emphasizes preventive care (reduces a doctor’s conflict of interest with regard to incentivized health care utilization), and provides financial incentives for patients to use care efficiently.

HMO (Heath Maintenance): specific type of managed care, uses special state license rather than insurance license, is a coordinated health care system that combines both the financing and the delivery of care. Kaiser is an example of private managed care and the VA is an example of governmental managed care.

PPO (Preferred Provider): either contracts for rates with specific providers or health systems, only allows patients to seek care from those providers or health systems (pay an additional fee for out of network or won’t cover)

Fee for Service—health care providers charge a fee for each service, billing is made after services are provided, is least restrictive in terms of access but least efficient financially since health providers have incentive to promote health care utilization regardless of patient outcome.

\*Please note, for question 2, the answer should be **B 10 Insurance, NOS** because there was not enough information in the text to determine if the plan is fee for service or a managed care plan. Use internet resources or call health plan to see if the distinction can be made.

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Q: ­For quiz #2 question #3, how come it's not veteran affairs instead of not insured? His coverage was retroactive back to 1/15/15 a day before his visit­.

A: Although his coverage is retroactive, ensuring his treatment is paid for, he had no insurance at time of diagnosis. And due to having no insurance he postponed medical care (he refused chest x-ray). Although he did receive chest x-ray a few days later, the decision to postpone was not based on medical best practices but on a financial decision. In many cases, patients will prolong seeking medical care for months or even years, leading to poorer health outcomes. Again, Primary Payer at Diagnosis not for treatment.

Consider this research question, Are there access issues in the VA system that lead to patients being more likely to be diagnosed at a late-stage? In order to answer this question, we need to correctly define VA patients. If we lump in patients covered by VA only after a cancer diagnosis, we could erroneously come to the conclusion that VA has barriers in access to care that lead to more patients getting diagnosed at late-stage. When, in fact, the barrier to timely treatment wasn’t the VA but the lack of insurance.

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Q: ­Question 9 quiz 2: Please give rationale why code should be 10 versus 00.­

A: The code should be 10 per the following coding instruction from page 113 of FORDS 2015: “Code 00 applies only when it is known the patient went elsewhere for treatment. If it is not known that the patient actually went somewhere else, code *Class of Case* 10.”

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Q: ­Looking at question 10 on Quiz 2, if a sentinel node biopsy of a regional node change the class of case?­

A: I do not think so. In the scenario in quiz 2 the sentinel lymph node biopsy was not done to diagnose the case, and it was not treatment.

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Q: ­5/15/14 is date of clinical staging. Wouldn't you want that date due to staging info for question 12 in quiz 2?­

A: No. This is an analytic case. For an analytic cases Date of First Contact is the date the case becomes analytic. The case became analytic on 1/12/15.

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Q: ­In the scenario in quiz 2 question 13 with the answer being that correct laterality is 4 with no other metastasis, how would you code CS Mets @ Dx?­

A: I would code as a 23-Separate tumor nodule(s) in contralateral lung.

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Q: ­Quiz 2 question 13-Why isn’t the answer "B"?­

A: I don’t think there is enough information to assign it to either the left or right lung.

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Q: ­On Question #15 from quiz 2, isn't the prostatectomy the most representative sample and this showed a ­­Gleason of 5?

A: ­The histology is coded from the most representative specimen, not the grade. Per the 2014 grade coding instructions, if there is more than 1 grade, the highest grade within the applicable system is coded (instruction 5 for solid tumors).­

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Q: Patient diagnosed at another facility with breast cancer. Patient subsequently came to my facility for insertion of port-a-cath (patient went elsewhere for chemo). Patient came back to my facility later date for double mastectomy. Is date of 1st contact port cath insertion OR double mastectomy?­

A: If the double mastectomy was part of first course treatment, the Date of First Contact would be the date of the double mastectomy.

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Q: ­Question on number 5 from quiz 3: If the tumor overlaps two boundaries, it should be coded to ".8" (page 45 in ICD-O-3). Why would it be coded as a .9?­

A: In the case scenario for question 5 from quiz 3, there are 3 separate breast tumors determined to be a single primary. The .8 is used for sub-site if there is a single tumor that overlaps site boundaries, and that is not the case. There is no indication of which of the 3 tumors is the primary so primary site code is C50.9.

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Q: ­Back to question 5 from quiz 3. In the ICD-O-3 Manual on page 45 it explains using ".8" overlapping and whose point of origin cannot be determined. The way the question was written could not determine the point of origin and under 50.8 (sub-categories)­ ­both are listed under the categories. Per that rule, it would be coded as .8­

A: The note on page 45 states that the sub-category “.8” should be used for a tumor that overlaps the boundaries of 2 or more sub-categories and whose point of origin cannot be determined. In question 5, there are 3 separate tumors. None of them overlaps a sub-category boundary. Sub-category “­.8” would be used if there was a single tumor that overlapped a boundary. For example a tumor at 3 o’clock would involve the upper outer quadrant and lower outer quadrant. Sub-category “.9” would be used for tumors in multiple quadrants. This is verified in the *SEER Program Coding and Staging Manual 2015 Appendix C: Coding Guidelines Breast*. The description for C50.9 in Appendix C includes: “Multiple tumors in different subsites within breast”.

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Q: ­If there are two tumors in the right and left lung of the same histology but the doctor doesn't state that this is metastatic spread are these considered two primaries?­

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A: ­A single tumor in each lung would be two primaries (M6). If bilateral involvement and two or more tumors are present in either lung, it is a single primary (M12). ­

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Q: ­Could you please ask Jim to go through the rationale for Take Home Quiz 1, Case 2.

A: ­First step is assign a temporary histology code to each tumor. That would be 8310/3 and 8070/3. Once you have done that you can apply the rules. Second, go through the multiple primary rule for multiple tumors. Start with rule M3. The first rule that applies is rule M11 that tells us we have two primaries. Since we have two primaries and each primary only has one tumor, we would start with rule H1. The first rule that applies would be rule H3 for both of these primaries.

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Q: ­Take home quiz 1 case 4 question #8: supposed to code histology from most representative specimen, which should be 8500/2 per the mastectomy specimen.

A: The histology should be based on specimen that gives the pathologist the most tissue to examine. Even though it says extensive residual, I would think that the original excisional biopsy would have more tumor than mastectomy.

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Q: In quiz 4 melanoma scenario, if the site isn't known, how do you know the node is regional and not distant?­

A: ­There is documentation on page 334 of *AJCC Cancer Staging Manual, 7th Ed.* that tells us to assume the lymph nodes are regional if there is no sign of other distant metastasis. “When patients have an initial presentation of metastases in the lymph nodes, these should be presumed to be regional (Stage III instead of Stage IV) if an appropriate staging workup does not reveal any other sites of metastases.”

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Q: Quiz 4 question 1: Primary site MUST be known in order to stage according to SEER Summary Stage rules. Would code site to C44.9 but stage 9 – unknown.­

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A: I felt that Summary Stage could be coded as something other than unknown because C44.9 is included in applicable primary site codes for summary stage for melanoma.­ I contacted SEER after the webinar for clarification. SEER agreed that the summary stage for a patient with unknown skin primary (C44.9), lymph node involvement, and no distant metastasis per work-up for distant metastasis would be ‘3 Regional lymph node(s) involved only’. If there had not been a work-up for distant metastasis, the summary stage would have been ‘9 Unknown if extension or metastasis’. In the scenario it states that all imaging was normal, which is a workup for metastasis.

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Q: In quiz 4 colon/rectum, shouldn’t the case be clinically staged T1 because there was no exploration of the abdomen?

A: Clinical assessment for colon/rectum includes sigmoidoscopy or colonoscopy with biopsy. The polypectomy is resection of the primary tumor and considered part of pathologic stage because the primary tumor was resected. So, the results of the polypectomy cannot be used in clinical stage and are used in pathologic stage in this case.

<http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging/digestive-system-chapters-10-24/8418-clinical-and-pathologic-stage-for-polypectomy-only>

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Q: ­For the liver scenario on Quiz 4 Staging, I don't believe we can get a pathologic stage (cM1 cannot be brought forward when there is no surgery)?? Seehttp://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging/general-rules-chapters-1-2/3759-clinical-m1-p­

A: ­You are right! Pathologic stage for liver consists of evaluation of the primary tumor including histologic grade, regional lymph node status, and underlying liver disease. There was histologic evaluation of the primary liver tumor but not of the lymph nodes.

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Q: ­Take Home Quiz 2 lung question 7; it was the contralateral mediastinal nodes that were positive so would code be 600?­

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A: ­That was a typo I thought I corrected. It was meant to say right to get code 200. Sorry about the confusion.­ The point I was trying to make is that the node sampling was part of the workup, not treatment, so is not part of pathologic staging (eval code 1).

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Q: ­Also in take home quiz 2 lung question 8 as this is N3 would LN Eval = 3 as the highest N was proven?­

A: ­That was a typo I thought I corrected. It was meant to say right to get code 200. Sorry about the confusion. If contralateral nodes were involved, the eval code would be 3.­

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