**Q&A Session**

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

**Thursday, March 07, 2013**

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Q: ­Currently the Birthplace country and state is a combined list. Will a separate list be released for our IS department­?

A: ­ The ISO Country Codes and v13 Conversion Crosswalk on the NAACCR website provides separate lists. (<http://www.naaccr.org/StandardsandRegistryOperations/VolumeII.aspx>)

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Q: ­Regarding cytology report diagnosing most likely metastatic cancer is reportable if there is further information about the case found elsewhere in the medical record. Please clarify that the path report doesn't need reportable words to pick up the case.­

A: Good reminder. Ambiguous terminology on the list that constitutes a cancer diagnosis is reportable on pathology reports.

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Q: If you have a reportable ovarian or endometrial primary with ambiguous cytology as in Quiz 1 question 2, would the SSF codes pertaining to cytology be coded as positive or unknown?­

A: ­I would code them positive because the ambiguous terminology is in reference to reportability of the case, not the SSF.­

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Q: ­If you're submitting data to standard setters, do you have to change sequencing to 00, 60 with in situ of cervix NA?­

A: ­No.­

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Q: ­Please clarify a staff physician vs. a staff physician with privileges. Is a staff physician considered a physician employed by the hospital?­

A: Per FORDS 2012 page 86 and FORDS 2013 page 110, a staff physician (class of case codes 10-12, 41) is a physician who is employed by the reporting facility, under contract with it, or a physician who has routine privileges there.

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Q: ­Still a little confused about quiz 2 question 6. Because it was retroactive back to 1/15/13, wouldn't the Primary Payer be Veterans Affairs? I understand that he didn't have insurance but because it's retroactive, I would have coded it to the VA.­

A: ­The source of the answer to that question is: <http://cancerbulletin.facs.org/forums/showthread.php?5399-Primary-Payer-at-Dx&highlight=primary+payer>. Also coding instructions for this data item found in FORDS 2012 on page 67 and in FORDS 2013 on page 71 document to record the payer at diagnosis if patient is diagnosed at reporting facility and not to change the code if the patient’s payer or insurance carrier changes.

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Q: ­If cutting and pasting text from EMR, pay attention to extraneous info and don't include it. If your facility needs/wants more info for internal needs, enter it into the local/facility text only section.­

A: ­Thanks for the tip.­

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Q: The purpose of text is to back up codes. Unlike head & neck where you code lymph nodes in SSF, why did you list each lymph node region for the lung? Why not just list 2/5 regional lymph nodes?

A: I was justifying the CS Lymph Nodes code. The nodes involved would be assigned code 100 while other nodes removed if they had been involved would have been assigned code 200. I listed the nodes to justify the CS Lymph Nodes code.

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Q: ­In regards to the synchronous primary rule, is there a timeframe on this? Most of us would still code the Lymphoma as sequence 01 as it is more aggressive.

A: Because these cases were not diagnosed at the same time, the prostate should be sequence 01 because it was diagnosed first, even though the lymphoma is more aggressive.­

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Q: ­We just want to reiterate that from a central registry perspective we would prefer that you would mention in text that the patient was simultaneously diagnosed with another primary but keep the pertinent facts for each primary separate in both abstracts for the primary. It creates a lot of confusion when we go to consolidate cases. We understand that different people text differently, but because you have a national voice usually what you say people follow.

A: ­In this case I felt the two cases impacted each other enough to justify going overboard a little with duplication of information. If this had been a lung cancer diagnosed 2 years prior and a prostate case recently diagnosed, I would have done little more­ ­than mention that the patient had a previous primary. In this case the imaging, the type of chemotherapy, the sequence of the diagnosis all could potentially impact how both cases are coded. That being said, I too agree that including non-essential information is a waste of time for the abstractor and a pain for the central registry.­

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Q: Why would you take the time to put chemotherapy info not related to the primary in the text? You already gave the info in the physical exam. It is duplicate work, time consuming and not productive.

A: I wanted to make clear that chemotherapy that was given for the lymphoma was not impacting the stage of the prostate case (i.e. eval would not be 5 or 6). This was an unusual circumstance and I felt it should be thoroughly documented.

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Q: ­Re: Quiz 5, question 4 - it's always bothered me to use C14.8 when this does not include C30-32 range (part of H&N) and, other than text, we can't distinguish between true C14.8 and primary unknown H&N C14.8. Has a good rationale been provided for using C14.8?­

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A: ­This was forwarded some time ago to the standard setters group that addresses coding issues. The following is documented at <http://seer.cancer.gov/registrars/data-collection.html>.

15. Code C148 assigned for squamous cell carcinoma diagnosed from lymph node and deemed to be a head and neck primary but specific site could not be identified. Code C148 is based on note in ICD-O-3 indicating it should be used when a code between C000 and C142 cannot be assigned. I & R (46158) indicated it should be coded to C760.

Decision: Assign C148 based on the note in ICD-O-3. C148 is a more specific site code than C760. The I & R answer has been revised.

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Q: ­Please explain why quiz 5 question 4 would not be answer B­.

A: ­It was the answer from a standard setters group. The answer can be found at <http://seer.cancer.gov/registrars/data-collection.html>.

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Q: ­In quiz 5 question 4, unknown primary of head & neck should be coded C76.0, not C14.8. You don't know whether the primary is coming from part of the overlapping (adjacent) sites. It could be from ethmoid sinus, for example. C76.0 is the better code.­

A: ­The standard setters technical workgroup decided that C14.8 is the preferred code. You can access their answer at <http://seer.cancer.gov/registrars/data-collection.html>.

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Q: ­For quiz 5 question 7 - are you aware whether the updates planned for MP/H provide more direction for topography coding like the "most invasive" concept?

A: No, I don’t know if that will be included in the 2015 planned revision to the MP/H rules.

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Q: Where did the rule come from for quiz 5 question #7?­

A: ­ SEER Inquiry System Question: 20120086: <http://seer.cancer.gov/seerinquiry/index.php>.

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Q: ­For quiz 5 question 9, would you explain your reasoning for the answer. Where did you get justification­?

A: This is a malignant skin tumor with both melanoma and basal cell carcinoma histologies. There is no ICD-O-3 code for this entity. Since melanoma is reportable, and basal cell is not reportable, code this to 8720/3 and document in a text field.

SEER Inquiry System (<http://seer.cancer.gov/seerinquiry/index.php> )Question 20110137

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Q: ­On quiz 7 question 2, I had letter b which is no resection. According to the CS website, code 1 would be no resection done based on endoscopic exam. Wouldn't the answer be 1 then?­

A: ­The information coded in CS Extension was based on the clinical information from the ultrasound, which is assigned code 0. Endoscopy was performed to introduce the ultrasound. It did not determine what the CS Extension was. This was tested on the last CS reliability study and the answer was 0.

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Q: Quiz 7 question 8, LVI post neoadjuvant treatment makes sense, but I could not find the reference. Could you please provide this?

A: Yes. It was an answer from CAnswer Forum.

<http://cancerbulletin.facs.org/forums/showthread.php?1848-Lymph-vascular-invasion-preop-and-neo-adjuvant-chemo>

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Q: ­There was a recent CAnswer Forum that states answer to quiz 7 question 10 should be code 100.­

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A: Question 10 was taken from the CAnswer Forum and at the time the answer was CS Extension code 410. However, since then the answer has been changed to code 100. Thanks for making us aware of this. The answer has been corrected on the answer sheet for quiz 7.

<http://cancerbulletin.facs.org/forums/showthread.php?6586-Lung-CS-Extension-and-SSF-2>

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Q: ­The CAnswer Forum is reviewing the answer to quiz 8 question 4, and they are consulting with AJCC. The AJCC refers to measured mass. CS refers to LN(s). The answer is pending in CAnswer Forum­

A: ­The CS coding instructions documented that the size of the largest malignant regional lymph node should be coded in SSF1 for head and neck cases. However, as stated above this was referred to AJCC. The answer was documented on CAnswer Forum on March 11, 2013 after the webinar: <http://cancerbulletin.facs.org/forums/showthread.php?6484-Head-and-neck-lymph-nodes&p=16888#post16888> There are a lot of specifics in the answer, but ultimately it said that if there is a measurement for a lymph node and a mass of lymph nodes, code the largest size. Thanks for making us aware of this.

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Q: ­For quiz 8 question 7, is the hilum considered a lung lobe?­

A: ­Hilum is a different sub-site from upper lung so it would be appropriate to code in SSF1 as separate lobes.­ The scenario is from a question in the CAnswer Forum at <http://cancerbulletin.facs.org/forums/showthread.php?1824-SSF1-for-lung-cancer-in-hilum&highlight=SSF1>.

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Q: ­Please confirm answer on quiz 8 question 9, oncotype question. ­

A: ­The coding instructions for SSF23 for breast in CS Part I Section 2 state to code the actual score. There is an answer in the CAnswer Forum that documents that when there is both a recurrence score and percentage of distant recurrence, the actual score should be coded in SSF23.

<http://cancerbulletin.facs.org/forums/showthread.php?5412-SSF-23-Multigene-Signature-Results&highlight=oncotype>

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Q: ­In case scenario 2 prostate primary, shouldn’t the code for SSF3, CS Extension - Pathologic Extension, be assigned code 420 because of the unilateral extraprostatic extension on the right side only?­

A: Jim and I went back and forth on that. He thought 420. I didn't think there was enough info for 420. I guess he was right! Both codes 415 and 420 derive the same T category and summary stage.

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Q: ­In case scenario 2 lymphoma primary, do you code lymph node dissection (7) LNs a excision of LN chain and code surgery for the lymphoma?­

A: No, do not code the resection of the lymph nodes as surgery for the lymphoma. The lymph nodes were removed in conjunction with surgery for the prostate primary, not as a treatment for the lymphoma.

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