**Q&A Session**

**Abstracting and Coding Boot Camp**

**March 6, 2014**

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Q: ­When a tumor extends into the subserosa, isn't that considered pericolonic fat?­

A: Subserosa/subserosal fat would indicate a part of the colon covered by serosa/peritoneum. Subserosal fat is the fat layer between the muscularis propria and the serosa. If the section of colon is not covered by serosa, the layer of fat outside the ­muscularis is referred to as the pericolic fat. Extension to this layer of fat without involvement of anything else outside the colon is an AJCC T3.­

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Q: ­For solid tumor grade rule 5 (highest grade even if focus and priority order), which takes precedence - highest grade or priority order? That is, if terminology gives the highest grade and nuclear grade gives a lower grade, what do we use?­

A: ­The priority order takes precedence. Code the highest grade from the applicable system. The applicable system is identified in the priority order. In the example you give, nuclear grade would be coded.­

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Q: Are in situ bladder grades coded if given?­

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A: ­According to instruction #4, grade is coded for an in situ tumor if it is given.­

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Q: ­Can we use Fuhrman's grade for bladder tumor as grade/differentiation?­

A: ­Fuhrman grade is not defined in instruction #6 as a special grade system for bladder.­

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Q: ­Please explain difference between "differentiation" and "terminology" in regard to grade and priority use.­

A: ­­In grade instruction #5 I believe by differentiation they mean the description as documented in the 2, 3, and 4 grade system tables.­

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Q: ­If all we see is FIGO grade 1, 2, 3, do we assign grade code 1, 2, 3, or 9?­

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A: If the only description of grade for a gynecologic primary is FIGO grade 1, 2, or 3, assign code 9 in the grade data item. The FIGO grade system is different in that it describes the amount of non-squamous or non-morular solid growth pattern.

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Q: ­Does the two-grade system for breast apply to both invasive and in situ tumors? ­

A: ­Instruction #4 says to code the grade for in situ tumor if it is documented. So if a grade was documented for an in situ tumor and it was documented using a 2-grade system, not BR score or grade, then it should be coded. Remember that for breast BR ­score/grade as coded in CS SSF7 is the first priority for coding the grade data item.­

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Q: It is my understanding that these new grade coding rules are somewhat "hierarchical". You stop at the first rule that applies. Is this true? Please clarify.

A: For solid tumors, rules 1-5 apply across the board. Rules 6-9 are a hierarchy; you stop at the 1st rule that applies.

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Q: In reference to ­quiz 2 question #4, if patient is seen at a large clinic with lots of physicians some on staff at our facility and some not, if a biopsy or x-ray was read at that facility, would you still use class of case 12? ­

A: ­I got a clarification on this from Anna at the CoC. If the clinic that did the imaging was not affiliated with your facility or any other facility and the diagnosis was made by a staff physician, class of case would be 12. If the imaging center was affiliated with a different hospital, the class of case would be 21 in the case scenario presented in question 4. In the original quiz this was not clear so I would accept Class of Case 12 or 21 as correct. A corrected version of the quiz has been posted and we clarified that the imaging center was not affiliated with any other hospital so Class of Case would be 12.

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Q: In quiz 2 ­question #8, if it stated MID back not central, would you still assign code 5? Mid back could be horizontal or vertical so not necessarily in the exact middle of the back. ­

A: ­I would probably still say use a code 5 unless it said left mid or right mid back.­

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Q: ­In 1st case scenario in quiz 3, is the additional radiation to the high risk area considered boost?­

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A: ­I don't think so. I interpreted it to mean that one particular area just received a higher dose in the same number of fractions as the low risk areas.

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Q: In quiz 5 question 4, the answer was to use site code for skin. Doesn't Kaposi sarcoma also occur in the visceral organs? If so, why wouldn't we use site code C809? Or are all Kaposi sarcomas coded to skin?­

A: In question 4, the diagnosis was Kaposi sarcoma with site unspecified. The site was assigned code C44.9, skin NOS, based on the following information found in FORDS and SEER Program Coding and Staging Manual (PCSM).

FORDS 2013 page 7

***Kaposi Sarcoma***

* Code Kaposi sarcoma to the site in which it arises.
* Code to Skin, NOS (C44.9) if Kaposi sarcoma arises simultaneously in the skin and another site or the primary site is not identified.

SEER PCSM 2013 page 66

**Kaposi Sarcoma**

Kaposi sarcoma that is not AIDS-related is a rare condition. It usually presents as localized disease with an easily recognized primary site.

AIDS-related Kaposi sarcoma usually presents as a disseminated disease with involvement of mucosal surfaces, visceral surfaces of organs, and skin. It is important to review consecutive records carefully to determine the extent of involvement at diagnosis. Review of a single record may reveal only the site being treated during that admission.

1. Code the Kaposi sarcoma to the primary site in which it arises.
2. If the Kaposi sarcoma is present in the skin and another site simultaneously, code to the specified skin site, (C44\_).
3. If the primary site is unknown or cannot be determined, code skin, NOS (C449).

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Q: In quiz 5 questions 11 and 13, lesion, mass, and tumor are reportable for brain and CNS.

A: Lesion and mass are not reportable terms for CNS non-malignant tumors; however, neoplasm and tumor are reportable terms for CNS non-malignant tumors as documented in the ambiguous terms that constitute a diagnosis documented in FORDS page 3. I believe what causes confusion is that tumor, mass, lesion, and neoplasm are defined as equivalent terms for the MP/H rules. However, we do not use the multiple primary rules to determine reportability.

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Q: ­Should the answer to question 34 in quiz 6 be eval code 1 since TURB is more extensive than the cystectomy?­

A: ­No. If cystectomy was performed, even though only in situ disease remained, you have pathologic stage because pathologic stage includes info from both info before treatment and surgical treatment.­

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Q: ­For quiz 6 question 35, can we use T2b from the TURBT only?

A: Yes; the information from TURB for bladder cancer can be used to assign clinical T. However, T2b can only be determined pathologically based on the definitions for T for the bladder in the AJCC Manual. So, the better code for clinical T would be T2. The code for pathologic T can be assigned T2b because pathologic classification is based on information acquired before treatment supplemented and modified by the additional evidence acquired from surgery and pathologic examination of resected tissues (AJCC Staging Manual 7th Ed. page 10).

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Q: ­When determining reportability for NHL, please clarify why we do not report cases where FNA is used to determine diagnosis even if ambiguous terminology is used. This is referenced on page 20-21 in the Hematopoietic Coding Manual. Note 6: do not report ­cases diagnosed only by ambiguous cytology (cytology diagnosis preceded by ambiguous term). Example: Parotid U/S guided FNA: consistent with Non-Hodgkin Lymphoma. This case was diagnosed based on cytology/FNA preceded by ambiguous terminology (consist­ent ­with). Do not report this case based on ambiguous cytology.­

A: I am not certain why this rule was developed. It is consistent for both solid tumors and hematopoietic malignancies.

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