# Q&A Session for Coding Pitfalls

Thursday, September 3, 2015

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Q: ­Could you send out the slide on intramucosal in a larger format? ­

A: The screen shot was from the CS Ext page for colon

<http://web2.facs.org/cstage0205/colon/Colon_bao.html>

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Q: ­For SS200, lung primary - Is it necessary to have serial exams of pleural fluid in order to consider a pleural effusion negative? Is one negative thoracentesis adequate to prove negative pleural effusion for SEER General Stage? ­

A: No. There are many errata to the Summary Stage Manual that are not included in the printed version. One of the errata for lung states…

*Note 4: Ignore pleural effusion which is negative for tumor. Assume that a pleural effusion is negative if a resection is done.*

You can find all of the updates and errata at <http://seer.cancer.gov/tools/ssm/>

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Q: ­Regarding physician vs registrar assigned stage info in August CS transition newsletter was listed under "E. COC"...what about other standard setters such as SEER, etc? ­

A: I think that it was under the CoC update because the CoC and AJCC are taking the lead on this issue. All of the standard setters are in agreement.

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Q: ­Could you clarify the statement about changing the physician stage? Isn’t that illegal? Should you have the physician make the change? ­

A: The example we gave during the webinar was a physician that assigned a pStage to bladder case when the patient did not have a cystectomy. In that case the criteria for staging has not been met so there should not be a pStage. The registrar should not knowingly enter incorrect information into their registry.

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Q: If we are entering only a path report, no other information is available (melanoma) at this time, how do we AJCC stage for our central registry? ­

A: You can only code what you know and what meets the rules for classification. If all you have is the path from excision, you might be able to get a cT. If the path report shows an insitu tumor with neg margins you might even be able to get a full cStage and pStage.

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Q: ­Why is a mediastinoscopy not considered pathologic in first question? ­

A: It was part of the clinical work-up. Mediastinoscopy is listed as part of the clinical workup in the rules for classification. If the patient went on to have surgery that met the rules for classification for pStage, then the information from the mediastinoscopy would be used for the pStage as well.

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Q: Does PSA affect T­

A: No, but it does affect the stage.

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Q: ­PG 11 Lung Example: Nodes were removed but recorded in cN1. Pg 12 Prostate Example: Nodes removed but recorded in pN1.

A: The difference is the point in time when we knew the information. In the lung case the lymph nodes were removed as part of the clinical work-up. A decision on the type of first course treatment had not yet been made. For the prostate case, they had already decided to do surgery. At the point they removed the lymph nodes they were no longer in the clinical “realm”.

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Q: Why would it not be T1c, biopsy for elevated PSA­?

A: A T1c means the tumor is so small that it can’t be felt with a DRE or TRUS. In the example we gave the physician could feel a tumor and said it was confined to one lobe, but didn’t say if it was less than or more than half of one lobe. In the AJCC Manual pg 461 there is a note that states ‘Tumor found in one or both lobes by needle biopsy, but not palpable or reliably visible by imaging, is classified as T1c’

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Q: ­For the lung example with TX N2 M0, this could be IIIA or IIIB so should the stage group be 99 instead of your answer of IIIA? ­

A: Yes. Thank you.

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Q: ­On the prostate example the removal of the nodes established an N1 which is the highest category, so it should be recorded in the pathologic N category, correct? ­

A: We sent this to Canswer forum for clarification. See the response below.

<http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging/education-developed-by-partner-organizations/naaccr-webinars/58964-pstage-when-highest-pn-confirmed-but-no-pt>

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Q: ­I still am concerned about the answer to the Prostate case (cancelled prostatectomy).On AJCC page 10 (Table 1.6) it does say that pN cannot be assigned if the pT is not met.

A: You are correct. The rule you site is the rule that I should have used!

It is difficult sometimes to know which rules take precedence. I was confused by the rule in the same table that says a pN can be assigned if the N value is pathologically confirmed even in the absence of pathologic information on other nodes. The rule you site takes precedence over the rule I sited. pN should not be assigned if the pT has not been established. That also means no stage can be assigned.

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Q: ­ Per the AJCC Manual "If N is based on microscopic confirmation of the highest N category, it is pN regardless of whether T is pT or cT. "Then they give a breast example.

So I think AJCC gives us the exception needed to go ahead and code pN1 and pStage IV for­ ­the prostate case and allow the database to reflect the reality of the case with stage and treatment congruity.

A: See the response above.

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Q: Can you explain again why the answer for question 6 is leave it blank? You have an imaging study that shows mets bone lesions??­

A: We want to make it clear that the value being used to calculate the clinical stage is the pN. The only way to do that is to leave the cM blank. It’s the best we can do with an imperfect system for entering information into our database.

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Q: ­I find that substituting the phrase, "Has clin/path WORK UP" been done rather than "is the criteria for stage met" helps me­

A: Good idea! I also like to think of them as pre-treatment (cStage) and post-surgery (pStage).

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Q: ­Could you clarify the scenario where one physician would know the stage and another does not (in order to leave it blank) ­

A: Maybe the primary care physician doesn’t know the stage, but the radiation oncologist who delivered radiation to the patient does know the stage. If all you have is the record from the primary care physician, you could assume that the radiation oncologist knew the stage before treating. Therefore, you would use blanks rather than X’s.

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Q: ­Another thing to consider, for intramucosal tumors is the behavior of the tumor. Do we not coordinate the behavior of the tumor with the Summary Stage? If an intramucosal tumor is Tis and SEER SS local what is the behavior code? ­

A: Good point. If the behavior code is /2 then the Summary Stage will be in situ. That is not necessarily the case with AJCC Stage. If the tumor is intramucosal the behavior would be /3 and the Summary Stage would be localized, but the T value would be pTis. The reason AJCC makes the intramucosal tumors in situ is they feel these tumors should be treated like true insitu tumors. Treating them like a T1 might be overtreatment.

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Q: ­Can you review the TNM answer where the patient had a 2cm squamous cell ca of the lung? See page 11 in handout.­

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?

A: The mediastinoscopy was done pre-treatment as part of the clinical work-up to determine treatment options. Since the lymph nodes were removed prior to removal of the primary tumor we can use them for both the cN and pN (see table 1.6 in AJCC manual pg 10). Since the primary tumor was never removed, we cannot enter anything in the pN. Therefore the pT, pN, pM should all be blank.

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Q: ­If the case is a class 30-34, are we to code the primary payer as unknown? Patient diagnosed elsewhere.­

A: I don’t think you can say as a rule you can’t code primary payer, but I’m guessing it will be difficult to get insurance status at the time of diagnosis if the patient wasn’t diagnosed at your facility. Do the best you can do with the resources you have available. If you don’t know what the insurance status was at time of diagnosis, code as unknown.

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Q: ­Many hospitals have discontinued collecting Place of Birth. Please explain the importance of Place of Birth.­

A: Place of birth (POB) is an important variable. It is used in algorithms that identify race and for specifying ethnic subtypes. It is also used in research focusing on immigration—by identifying specific issues among immigrants and for generating hypotheses about etiology and the differences in cancer risk by countries. In practice, this data element is generally collected from a death certificate, usually at the central cancer registry level. Although this can bias studies since POB will only be uniformly collected among the deceased, it can still be an important variable in survival studies when the research question can accommodate using deceased patients only. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q: ­How are we supposed to determine if a patient can afford or cannot afford, for insurance codes 01 and 02 ?­

A: My rule of thumb would to be to code a 01 unless you have information to indicate 02. This information is often located in the doctor’s notes and not necessarily on the facesheet. For cases diagnosed after the Affordable Healthcare Act became law, it is likely that individuals who can pay for their own insurance (often small business owners or employees or the self-employed which are often 02) are now paying for insurance instead of out of pocket medical care.

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Q: ­Cluster studies as it applies to the street address only apply to analytic class of cases ....correct? Or are non-analytic cases included as well? If non analytic how true is data from address­?

A: Definitions of analytic and non-analytic vary by facility and registry and all cases may be included in a cluster study. It is ideal to collect a full street address at diagnosis for all cases. However, obviously identifying the diagnosis address for cases that were diagnosed and treated elsewhere is often difficult. For full-blown cluster studies, all cases in the area will be investigated initially—following up with the physician or patient/family or both.  These studies start by being inclusive, including all potential cases and ruling out ones that don’t meet the criteria. So it is still important to include street address for non-analytic cases. For pilot cluster studies, a researcher also often initially uses all cases and then generate rates including the non-analytic and then excluding non-analytic to identify a potential range of risk. So all address at dx associated with non-analytic cases should be valid.

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Q: ­So many facilities only make the last 4 digits of the SSN available in the EMR...How should this be entered in this situation? ­

A: This is a question that has started a great deal of discussion! This issue is currently being discussed by UDS and among the standard setters.  We will update once this issue has been resolved.

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Q: ­How do you deal with addresses of "snowbirds" who are diagnosed in the south during their stay there, but "main" home is in the Midwest? ­

A: Do the best you can with the information available. If you can determine where they spend the majority of their time, code to that address.  If not, make an educated guess. For patients that are 50/50, use the address associated with your facility. For instance, if they are in Florida in the winter and are seen by a Florida facility in winter, use the Florida address. In the future, we intend to do national deduplication. While this won’t completely solve the issue of where the patient actually resides, we will be able to ensure they are not counted in both registries.

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Q: ­Do you have examples of i.e.-Asian only? ­

A: Asian is a broad racial category that covers the population of many different countries. If a patient only has Asian indicated in the chart or is from an Asian country or region not listed in a category, like Vanuatu, code race as a 96—Asian Other/Asian, NOS. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q: ­Example: 2013 diagnosis of noninvasive urothelial carcinoma of the bladder; 2015, a noninvasive urothelial renal pelvis primary is diagnosed. MP/H Rules state these constitute a single primary. Question: Do we change the primary site to C689? ­

Priority: ­In that situation you have two primaries per rule M5. The first would be coded to the bladder and the second to the renal pelvis. You would not go back and change the primary site. Even if we had another tumor of the bladder at a later time we would NOT go back and change the primary site.

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Q: ­continued Q: The CCR in our state does not accept follow-up data. Should the consolidation on these retain the original bladder info or recode to C689? ­

A: In the situation above you have two primaries. You would not need to change primary site.

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Q: ­On page 22, the colonoscopy, how do we code the histology? What was the actual answer? Did you decide rule H13, adenocarcinoma, NOS? ­ I was under the impression that when you hit a rule that was applicable, you stopped (Why would you continue)?

A: The final diagnosis in our case scenario was “adenocarcinoma with mucinous features”. Rule H5 applies if we have “mucinous adenocarcinoma” or “adenocarcinoma, nos” and a description of 50% or more of the tumor being mucinous. We are probably splitting hairs, but technically “adenocarcinoma with mucinous features” does not fit rule H5 or H6. Therefore, we keep going until we run into rule H13.

I think we have become so familiar with the rule that tells a histology such as “adenocarcinoma with mucinous features” should be coded as “mucinous adenocarcinoma”, that we automatically make that jump in logic and think of it as “mucinous adenocarcinoma” when technically it is rule H13 that tells us that we can do it.

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Q: ­what is the answer for the colonoscopy question­?

A: ­code to mucinous adenocarcinoma per rule H13­‑

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Q: ­Concerning MPH Rules: why is comedo not in Table 3 for Breast. Most of the histologies in Column 2 are in Table 1 just like comedo. p. 50 of MPH. ­

A: The tables don’t include all histologies that are subtypes of DCIS or invasive ductal carcinoma. Invasive comedo carcinoma should be considered a specific type of ductal carcinoma.

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Q: ­What set of rules are you referring to when Coding primary site, pg 20 ­

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Q: ­I see cases where a total thyroidectomy was done but no hormone was listed as TX. Is this a given that if they have their thyroid removed they would HAVE to be on hormone TX? ­

A: They will probably have to be on some kind of hormone replacement therapy, but it is not necessarily going to be coded as first course treatment. Synthroid is not used as a tumor suppressant for all types of thyroid malignancies. The best bet would be to ask the physician if the drug is being given to suppress tumor growth. If that is not an option, would code it as hormone treatment if it you know it is being given after surgery. However, I would not code it as being given unless I had some kind of documentation saying it was being administered.

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Q: ­if a patient receives synthroid post RT is it coded as hormone treatment? ­

A: It is best to ask the physician if it is being given as a cancer suppressant but if that is not an option, I would code it as hormone treatment if it is given post RT.

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Q: ­Why can’t we use MPH rules for casefinding? ­

A: They weren’t designed for casefinding. If you try to apply some of the MP/H rules to casefinding, you may end up with cases that should not be reported or not reporting cases that should be reported. MP/H rules should on be used for determining multiple primaries and histologies.

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Q: ­I thought that if you had a urinary system in situ followed by invasive, you had 2 primaries.­

A: Only if diagnosed more than 60 days apart. In this scenario they were only about a month apart. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q: ­You made the point of 1-week prior to prostatectomy Lupron is not neoadjuvant TX - it there a time constraint? What if Lupron is given earlier? ­

A: We sent this one to the Canswer forum. The response can be found at <http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging/education-developed-by-partner-organizations/naaccr-webinars/58962-lupron-given-prior-to-prostatectomy>

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Q: ­Did this question get answered? Can you direct me to where you find the rule re: clinical M being left blank with a bone biopsy showing mets; in the AJCC manual? As in question 6 of the quiz.­

A: Many of the instructions for entering AJCC stage data into our software can only be found in the training materials or on the Canswer forum. This is a good example. This is covered in the AJCC Curriculum for Cancer Registrars and on the Canswer forum.

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Q: If there is a LN biopsy for C77.8 primary lymphoma, do we code the bx as "bx of primary site" or "bx of other site"?

A: I’ve always coded as biopsy of the primary site. When we use code C77.8 we are saying the primary originated in the lymph nodes. I wouldn’t code as biopsy of other site unless the biopsy was of something other than the lymph nodes (bone marrow, extranodal site, etc).