**Q&A Session for Coding Pitfalls**

**September 5, 2019**

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**Q:**­ How would you code shave bx followed by MOH's?

**A:** It depends on the margin status. You would use codes 34-36

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**Q:**­ ­ Quiz#23 on melanoma, scenario refers to two sites, left arm and skin of back?

**A:** Thanks, I’ll make that all skin of left arm or skin … just a typo.

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**Q:**­ ­ Do you know if the online Kindle version of the AJCC manual is updated online?

**A:** This is the response from Donna Gress: This is on the AJCC website: <https://cancerstaging.org/About/news/Pages/AJCC-Cancer-Staging-Manual,-Eighth-Edition-Kindle-Version-Available-Now.aspx>

**If content changes, will it automatically update on in my Kindle?**

No. Changes will not be automatically pushed to those who purchased an original version. Only major errors will be corrected.

**What is the process for making major corrections available to the Kindle customers?**

Customers who bought the eBook before changes keep the original version. If the AJCC corrects serious errors in the eBook and wants Amazon to notify customers of updates, the AJCC must meet Amazon’s criteria for notification of changes. Those criteria can be found [here](https://kdp.amazon.com/en_US/help/topic/G200966010). Sending customers updated content may erase notes or highlights they entered, so the improvements must outweigh the disadvantages.

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**Q:** ­ I find that I have great difficulty in ease of locating documentation in CAnswer Forum...any great tips or suggestions?

**A:** I personally don’t have much luck with the search, I usually just end up doing a lot of reading. However, Donna Gress did do a webinar on the CAnswer Forum & Staging Questions, perhaps give that a try for some helpful hints. https://cancerstaging.org/CSE/Registrar/Pages/Eight-Edition-Webinars.aspx

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**Q:**­ Even with an eight yr difference, it's still a 21?

**A:** If you are referring to Class of Case, that’s the answer posted by the Standard Setters. (Whether, we agree with those instructions or not, we all must code consistently, so we need to consistently follow the guidance provided by the Standard Setters.)

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**Q:**­ Coding the date of decision for date of first course of treatment is only for palliative care, correct? Since if chemo was recommended and given it would be date chemo started.

**A:** Yes, if they actually got surgery/chemo/hormone/immuno etc.. it would be the date that treatment started.

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**Q:**­ ­ STORE Manual states: Record the date the patient first had contact with the facility as either an inpatient or outpatient for diagnosis and/or first course treatment of a reportable tumor. The date may be the date of an outpatient visit for a biopsy, x-ray, or laboratory test, or the date a pathology specimen was collected at the hospital. Which contradicts Pop Quiz #17 rationale?

**A:** Refer to page 18-19 of the STORE (most of your State Manuals will also advise the same) *For analytic cases,* ***the Date of First Contact is the date the patient qualifies as an analytic case Class of Case 00-22.*** *Usually, the Date of First Contact is the date of admission for diagnosis or for treatment. If the patient was admitted for noncancer-related reasons, the Date of First Contact is the date the cancer was first suspected during the hospitalization. If the patient’s diagnosis or treatment is as an outpatient of the facility, the Date of First Contact is the date the patient first appeared at the facility for that purpose….If the Class of Case changes from nonanalytic (for example, consult only, Class of Case 30) to analytic (for example, part of first course treatment administered at the facility, Class of Case 21), the Date of First Contact is updated to the date the case became analytic (the date the patient was admitted for treatment).*

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**Q:** ­­How can we have a clean database with so many updates occurring throughout the year????

**A:** ­2018 is kind of a learning year, don't get discouraged. We will eventually get all this figured out. (I probably wouldn't use 2018 in any studies though in the future without a little clean up :( It's a bummer for sure!

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**Q:**­ ­Another helpful change log: https://staging.seer.cancer.gov/eod/news/1.7/­

**A:** Thanks! I’ll add to the slides.

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**Q:**­ ­­Question about radiation data items. Per section 7.1.4 of NAACCR 2018 Implementation Guide several of the previous radiation data items are "no longer required as of 2018, regardless of the date of diagnosis." ­

**A:** Thanks for the information. Always check with your State Registry as well for further clarifications.

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**Q:**­ ­­Does this mean even for older cases we are to use the new radiation data items? In various software for older cases both the old & new radiation data items show up. ­

**A:** No the new radiation data items should not be required for cases diagnosed prior to 2018. Fortunately, most of the software out there will “hide” the fields or “move” them to a retired section of the abstract depending on how the date of diagnosis is coded, or sometimes they will allow you to color code the fields differently to help remind you what’s required or not, talk to your vendor. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Q:** ­­About the Chemo-BRM drugs, I had a class of case 32 original dx BEFORE 2013 & pt had multiple rounds of Avastin & Herceptin that crossed the "2013" yr. I submitted AskSEER & was told to code by date drug was GIVEN - code BRM when given post-2013. ­

**A: Per SEER\*RX** For **cases diagnosed prior to January 1, 2013** continue coding this drug as chemotherapy. Recently however this question was posed to AskSEERCTR and their response was “*we are in the process of reviewing all of the single agents and regimens in SEER\*RX and will be updating or adding remarks as needed.”* So, for now, follow the guidelines we have available, but don’t commit it to memory because it might change.

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**Q:**­ : ­Pop quiz 1: If the patient was NOT diagnosed at your facility and the decision was made for palliative pain management only, would the Rx Summ – Treatment Status be coded to 0 No treatment Given, and what would the class of case be in this situation? ­

**A:** ­It would 0 and would be analytic class of case. ­­Class of 22.

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**Q:**­ ­ ­So the online store manual does not get updated? And we have to keep track of changes on our own pdf version? ­

**A:** ­Unfortunately, that's what we have to do right now, it's not a perfect system. :(­‑

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**Q:** ­­Confused by example of not coding removal of uninvolved contralateral breast. Why wouldn't you use one of the surgical codes (42) that includes removal of uninvolved contralateral breast? ­

**A:** ­You would use the correct surgical code, but you would not code it in the Surgery of Other Sites field. (Your STORE tell you do to that, but cross it out.)

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**Q:**­ ­If only Hospice is recommended to patient do we need code in palliative therapy?

**A:** ­Yes, surprising isn't it! If Hospice is recommended as palliative treatment for the cancer. (I haven't been doing that myself.)

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**Q:**­ ­­How would you code the 6/25/18 shave biopsy in the melanoma pop quiz? ­

**A:** ­27 Excisional biopsy

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**Q:**­ ­­When a breast patient (or any site but happens often at breast) has a bx of the primary site and a bx/fna of a reg LN at the same time, is it still coded as 2 separate instances on the treatment grid (sx &dx) or 1 (dx only)?­

**A:** ­bx of breast 02 in diagnostic & staging procedure, fna of reg ln coded as 1 in Scope of Regional Lymph Node field (2 separate fields) ­

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**Q:** ­­Palliative/Hospice helpful explanation that I learned years ago - Hospice always includes some aspect of palliative care, but palliative care does not always include hospice­.

**A:** Thanks.

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**Q:**­ ­SEER Rx states that you go off of the date of diagnosis for coding chemo vs. biologic. It does not go off of the date the drug was given.

**A:** Agree it does state that currently.

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**Q:**­ ­In reference to breast surgery - how do you code inflammatory cancer with bilateral involvement and both breasts removed? Would you code the contralateral breast in Other then? ­

**A:** No, use code 76 Bilateral mastectomy for a single tumor involving both breasts, as for bilateral inflammatory carcinoma.

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**Q:**­ ­For breast bilat subcutaneous or nipple sparing mastectomy where there isn't a surgery code for contralateral breast do you still leave the surgery code other field blank for the uninvolved contralateral breast? ­

**A:** Great question, please submit it to the CAnswer Forum for clarification after they announced the *Clarifications to Breast Coding Surgery in The Brief on 08-22-2019*, this scenario was not addressed.

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**Q:**­ ­­Please include the info about using code 27 for melanoma in the Q & A document - that would be helpful. Thank you.

**A:** Shave biopsies are rarely coded as a diagnostic and staging procedure 02. Usually the only time you code a shave biopsy as an 02 is the physician left GROSS VISIBLE tumor. (This is not very common in my experience.)

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**Q:** ­­Just a comment: most of the melanoma cases I see my facility is doing re-excision, if I don't have original shave bx notes I can usually tell from my facility's initial phy exam if there is gross residual.

**A:** Most often they don’t leave gross residual.

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**Q:**­ I submitted AskSEERCTR because it states it is by date of diagnosis so was surprised to be told to code by date drug given. I just submitted a follow-back question to see if SEER\*RX will be updated. ­

**A:** We shall see….

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**Q:**­ ­ the STORE manual is also bookmarked. Another way to help navigate is go to table of contents and clicking on the topic/data item­.

**A:** Great tip!

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**Q:**­ ­­Quiz 1: how can first course tx be date of recommendation? there is possibility patient may not receive for some reason. ­

**A:** ­The date of 1st course treatment is the date the patient agreed to it, not the date of the recommendation.... it just coincidentally was the same day in this scenario. ­

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**Q:** ­­Do you have instructions on bookmarking the resources/manuals on the internet that you can share please? ­

**A:** ­For Chrome Add a bookmark: 1. Open up the page you want to add a bookmark to.2. Find the star in the URL box.3.Click the star. A box should pop up.4. Choose a name for the bookmark. Leaving it blank will only show the icon for the site.5. Choose what folder to keep it in.6. Click Done when you're done.­ ­

For IE. Here's a link http://www.basiccomputerinformation.ca/bookmark-web-page-internet-explorer/­‑

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**Q:**­ ­When a breast patient (or any site but happens often at breast) has a bx of the primary site and a bx/fna of a reg LN at the same time, is it still coded as 2 separate instances on the treatment grid (sx &dx) or 1 (dx only)? ­

**A:** ­Biopsy of the Breast would be coded as an 02 in diagnostic and staging procedure. The fna of regional lymph node would be coded as a 1 in Scope of Regional Lymph Node Surgery, those are two different fields.

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**Q:**­ ­How would you then code EOD Mets in regards to clinical pleural effusion only? ­

**A:** ­Great question! Usually these Standard Setters try to follow the same rules/principles, but not always.... I would submit that question to Ask a SEER Registrar for further clarification. Currently this is what the SEER Summary Stage 2000 manual states *Note 8: Most pleural and pericardial effusions with lung cancer are due to tumor. In a few patients, however, multiple cytopathological examinations of pleural and/or pericardial fluid are negative for tumor, and the fluid is nonbloody and is not an exudate. Where these elements and clinical judgment dictate that the effusion is not related to the tumor, the effusion should be excluded as a staging element.*

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**Q:**­ If there was a biopsy of the lymph node and then there was a resection where lymph nodes are taken out for pathological review? 1) do we count the biopsy from the 1st ln to the regional lns examined and positivity? ­

**A:** ­That's covered in the STORE in Regional Lymph Nodes Examined & Regional LN Positive. Check that out, page 167-172

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**Q:** You code scope of surgical regional LNS twice or do we use a combo code for biopsy of ln and then path reviewed LNS?­

**A:** If I'm understanding correctly, the 1st procedure would be a 1 in Scope field, then the 2nd procedure would be a 3-5 (if none of this was Sentinel Lymph Nodes)­.

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**Q:**­ If op report states rectosigmoid, isn't this just the specimen sent to path? the path is stating the exact primary site. ­

**A:** ­No, the path report isn't oriented in the body they can't tell often times, they go off how it's labeled. The definitive should be the operative report. (Granted that's if your surgeon does a good job on their dictation.)

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**Q:**­ ­­Can we assume the CRM is positive if on a colon resection the tumor invades thru the bowel wall and is present at the serosal surface, pT4, even if the CRM is not stated in the pathology report? ­

**A:** ­No we can't assume anything, from SSDI Note 8: Use code XX.9 (CRM not mentioned) if the pathology report describes only distal and proximal margins, or margins, NOS.­‑

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**Q:** ­for cases that were non analytic, can we change the date of 1st of contact when that case becomes analytic? ­

**A:** ­Yes, Page 19 STORE*. If the Class of Case changes from nonanalytic (for example, consult only, Class*

*of Case 30) to analytic (for example, part of first course treatment administered at the facility, Class of*

*Case 21), the Date of First Contact is updated to the date the case became analytic (the date the patient*

*was admitted for treatment).*

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**Q:**­ ­­If the entire Thyroid is not removed, is it still 98? ­

**A:** ­If you are asking about I-131 for thyroid cancer, it's always 98. ­ ­https://www.facs.org/quality-programs/cancer/news/corner-store-040419­

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**Q:** ­­STORE manual p 123 code monitoring of oral treatment started elsewhere as class of case 31 - is this part of the ongoing conversation re class 21 vs 31? ­

**A:** There's a lot of chatter on the Forum about that... I personally don't like coding those cases in Karen's example as 21's, but the CoC seems firm on their answers to us about this issue... It's a little controversial for sure!

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**Q:**­ ­For lung cases if on the path report it states adenocarcinoma predominately lepidic pattern how would you code the histology? Do you disregard the predominately due to the word pattern?

**A:**  Solid Tumor Rules- Do Not Code histology described as Pattern on page 35. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Q:**­ ­The path specimen is ONLY as good as the 'label' given to it in the operating room. The surgeon does visualize it. ­

**A:** Agree.

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**Q:**­ ­Your example for CRM was in cms that is why I asked for clarification. Should it have been 6.0 and not 0.6 in your example­?

**A:** You are correct. Thanks for catching that.

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**Q:**­ Thyroid T suffix: if the us documents multiple thyroid nodules but path only shows 1 as malignant and others benign OR only one tumor is bx'd while the other is not, do we code this as multifocal or solitary malignant tumor? ­

**A:** Excellent question for the CAnswer Forum.

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**Q:** ­­For endometrial primary with HDR IR-192 brachytx given to the vaginal cuff what is the radiation primary tx volume 71 uterus vs 72 vagina?

**A:** With the limited information here, assign code 72 vagina,

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**Q:**­ ­Can you please discuss when to use code 2 or 4 when coding the field, pleural invasion. For example, pathology report states visceral pleura involved but didn't state if it was PL1 or PL2.

**A:** If it does not state (PL1 or PL2), but invasion of pleura present NOS, code 4. You would only use code 2 if you have microscopic confirmation of PL2 or Invasion outside surface of the visceral pleura or Invasion through outer surface of the visceral pleura.

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**Q:**­ ­Can you elaborate further on why we would code hospice care as palliative care 7 in the abstract?

**A:** STORE page 39 *Record as palliative care any of the treatment recorded in the first course therapy items that was provided to prolong the patient’s life by managing the patient’s symptoms, alleviating pain,* ***or making the patient more comfortable.* (**I believe the whole goal of hospice is to make the patient more comfortable, anyway in this particular example, Consult: *Various treatment options were presented to the patient. The decision was made to proceed with in-home hospice, as he did not wish to receive any treatment.)*

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**Q:** ­Our hospice director would challenge that hospice and palliative care are the same­

**A:** In my example however, I believe 7 is the correct choice, I even ran the slides by Susan Kessler prior to this presentation and she agreed. Consult: *Various treatment options were presented to the patient. The decision was made to proceed with in-home hospice, as he did not wish to receive any treatment.* Great question for the CAnswer Forum, please have them elaborate.

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**Q:**­­ Another good source for the references and where to ask questions for each: <https://seer.cancer.gov/registrars/references.html>

**A:** Thanks for that! I added to my slides.

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**Q:** ­ If nodes are negative does this still apply. Slide 46.

**A:** Use the data item Scope of Regional Lymph Node Surgery to code Surgical procedures which aspirate, biopsy, or remove regional lymph nodes in an effort to diagnose and/or stage disease in this data item. **(Positive or Negative bx)**

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**Q:**­ We have a question regarding coding Hospice Care as palliative tx. We have patients who present with advanced disease and are only referred for Hospice Services. They do not refer to Hospice as palliative care nor do they discuss hospice for pain management specifically. They usually refer them for comfort measures through hospice. Are they to be coded as palliative care if the words palliative care or pain management are not documented?

**A:** I think that’s when you use code 7 because you don’t know if any pain meds were given.

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**Q:**­ Regarding radiation fields, on slide 22, you explained that radiation was provided to multiple mets sites, therefore you use the largest dose. During a state training provided to us, we were told to document each phase individually and add the total in the final dose. You just explained not to add, can you please clarify?

**A:** That is incorrect. You do document each phase individually however, you would never add all the doses that different body parts received for the Final Total dose. Please refer to the CTR Guide to Coding Radiation Therapy Treatment in the STORE, see page 6.

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**Q:**­ I frequently see typical mammary carcinoma with ductal and lobular features, (mixed type carcinoma). How is this coded? How would it be coded if it was missing the (mixed type carcinoma) phrase.

**A:**­ Refer to the Solid Tumor Rules for Breast Invasive carcinoma NST/duct carcinoma and invasive lobular carcinoma 8522/3 Note 1: CAP uses the term Invasive carcinoma with ductal and lobular features (“mixed type carcinoma”)

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**Q:**­­ I thought MSI was NOT coded if it was tested only by HIS?

**A:** I don’t know what HIS is?? Please refer to Version 1.7 of the SSDI manual, the instructions for coding MSI have been expanded.

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**Q:**­ ­I would like to clarify. In the Pop Quiz #5 example, would we code the date the pt refused treatment in both the Date No Tx Decision field and the Date of Palliative Treatment (since it is being coded to 7)?

**A:** ­The date patient refused treatment would be recorded in the Date of 1st Course Treatment field. Technically there is no Date of Palliative Treatment in the NAACCR data dictionary, but you probably have to enter one in your software, so you could use that date too.

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**Q:** ­For a breast ca do you add primary radiation and the boost ­

**A:** ­If it's a normal boost to the cavity, yes, but I'd have to see the exact scenario to give an exact answer. ­

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**Q:** ­In Priority Coding for Histology, 1. Tissue/Path: why is synoptic report listed separately from CAP protocol. Are they not the same? ­

**A:** Difference is synoptic is the format and CAP are the data elements. You could have CAP elements in pathology report and not in synoptic format, they could be listed in a free text format. Here is a good explanation

<https://global.gotowebinar.com/pjoin/1685317530871556620/3853475296008671756>

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**Q:** ­Karen's explanation of the priority order for colon primary site is correct. The location is much better assessed visually, via op or endoscopy, then it is on path. The path report gets location info second hand usually.

**A:** Agree.