Coding Pitfalls

NAACCR 2018-2019 WEBINAR SERIES

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Q&A

Please submit all questions concerning the webinar content through the Q&A panel.

If you have participants watching this webinar at your site, please collect their names and emails

We will be distributing a Q&A document in about one week. This document will fully answer questions asked during the webinar and will contain any corrections that we may discover after the webinar.

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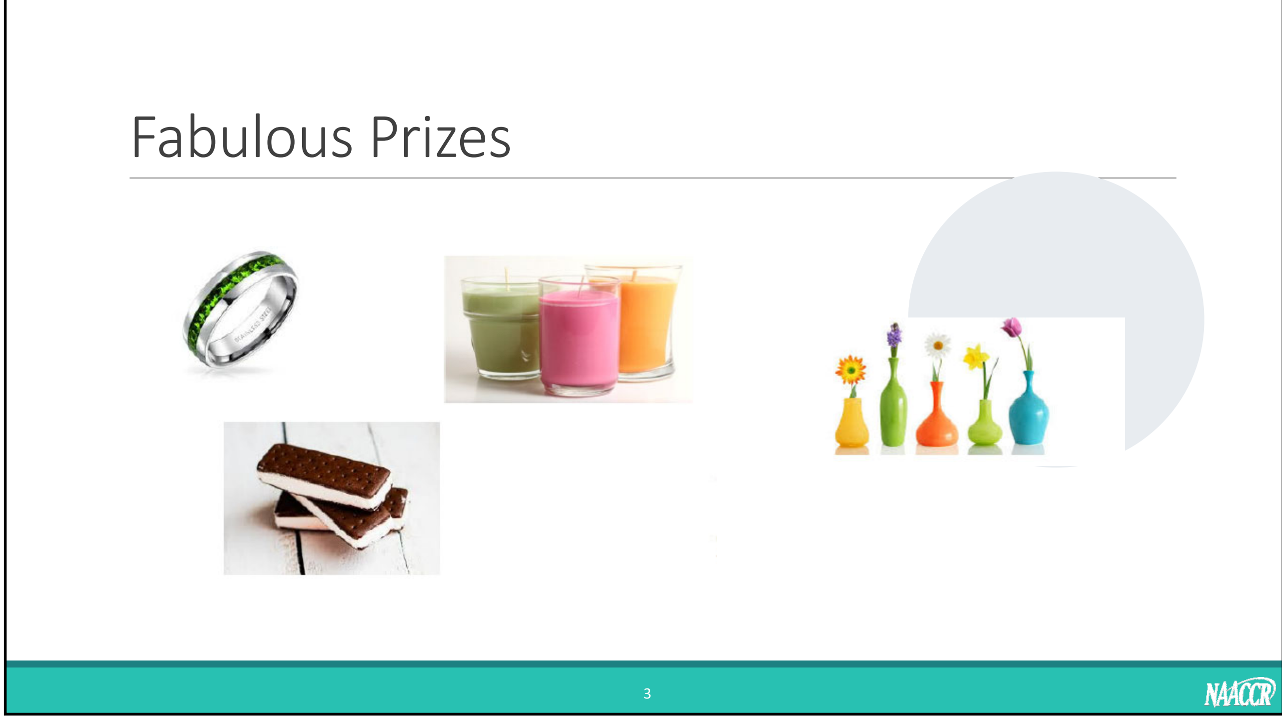

Guest Speakers

Janet Vogel, CTR

- Compliance & Quality Auditor/ Educator-Cancer Registry, himagine solutions inc

Karen Mace, CTR

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Agenda

- Resources
- Palliative Care
- Treatment Refusals
- Tumor Size Summary
- Lymphovascular Invasion
- FNA's –Code or Not
- Breast
- Melanoma
- Lung
- Colorectal

Minimum Resources Required to Abstract

- 2018 Implementation https://www.naaccr.org/2018-implementation/
- 2018 Solid Tumor Manual https://seer.cancer.gov/tools/solidtumor/
- Hematopoietic and Lymphoid Neoplasm Database https://seer.cancer.gov/seertools/hemelymph/
- Hematopoietic and Lymphoid Neoplasm Coding Manual https://seer.cancer.gov/tools/heme/Hematopoietic_Instructions_and_Rules.pdf
- NAACCR Site Specific Data Items and Grade https://apps.naaccr.org/ssdi/list/
- SEER*RSA https://staging.seer.cancer.gov/eod_public/list/1.7/
- EOD 2018 https://seer.cancer.gov/tools/staging/
- Summary Stage 2018 https://seer.cancer.gov/tools/staging/
- AJCC Cancer Staging Manual 8th Edition https://cancerstaging.org/Pages/default.aspx
- ICD 0 3 Histology Revisions https://www.naaccr.org/implementation-guidelines/#ICDO3
- NAACCR http://datadictionary.naaccr.org/
- SEER*Rx Interactive Antineoplastic Drugs Database https://seer.cancer.gov/seertools/seerrx/
- STORE Manual https://www.facs.org/quality-programs/cancer/ncdb/registrymanuals/cocmanuals
- SEER Program Coding and Staging Manual https://seer.cancer.gov/tools/codingmanuals/index.html
- CTR Guide to Coding Radiation Therapy Treatment in the STORE https://www.facs.org/~/media/files/quality%20programs/cancer/ncdb/case_studies_coding_radiation_treatment.ashx
- NCDB: The Corner STORE Updates and Alerts https://www.facs.org/quality-programs/cancer/news
- Appropriate State Manual

2018 Implementation

https://www.naaccr.org/2018-implementation/

- One stop shop for all things 2018+
  - Links to various manuals required to abstract in 2018 & beyond
  - Links to educational activities

SEER Manual Reference Guide

https://seer.cancer.gov/registrars/references.html

Another one stop shop for links to various resources

Update

SSDI's
- Update to SSDI coding notes
- Updated SSDI Manual
- Change log
- https://apps.naaccr.org/ssdi/list/

NAACCR Edits Metafile 18D
- Corrections to layout, tables, and edits already in v18C
- 4 new edits
  - 2 related to Tumor size
  - 1 Summary Stage
  - 1 related to schema discriminator.
- Detailed information is available at https://www.naaccr.org/standard-data-edits/

Updates to TNM.dll and SEER RSA-*tools used by software vendors*

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Resources

SEER*RSA

https://staging.seer.cancer.gov/eod_public/home/1.6/

In each Cancer Schema List valid values, definitions, and registrar notes are provided for

- EOD Primary Tumor
- EOD Lymph Nodes
- EOD Mets
- Summary Stage 2018
- Site-Specific Data Items (SSDIs)
- Grade

NAACCR SSDI/GRADE

https://apps.naaccr.org/ssdi/list/

SSDI Manual

Grade Manual

In each Cancer Schema List valid values, definitions, and registrar notes are provided for:

- Grade
- SSDI's

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AJCC Cancer Staging Manual Education

https://cancerstaging.org/CSE/Registrar/Pages/Staging%20Moments.aspx

TIP: PRINT the 3 documents under the heading AJCC 8th Edition Staging Critical Clarifications for Registrars & PLACE THEM IN YOUR AJCCC MANUAL!

Staging Moments

The Staging Moments® series offers succinct, contemporary case-based presentations following the cancer conference (tumor board) format of: symptom presentation; imaging work-up; and pathology diagnosis. Clinical stage is assigned and used in discussing treatment options based on national guidelines. The series provides surgical and pathology findings to assign pathological or posttherapy /postneoadjuvant therapy stage.

New Eight Edition Staging Moments can be found here.

AJCC 8th Edition Staging Critical Clarifications for Registrars

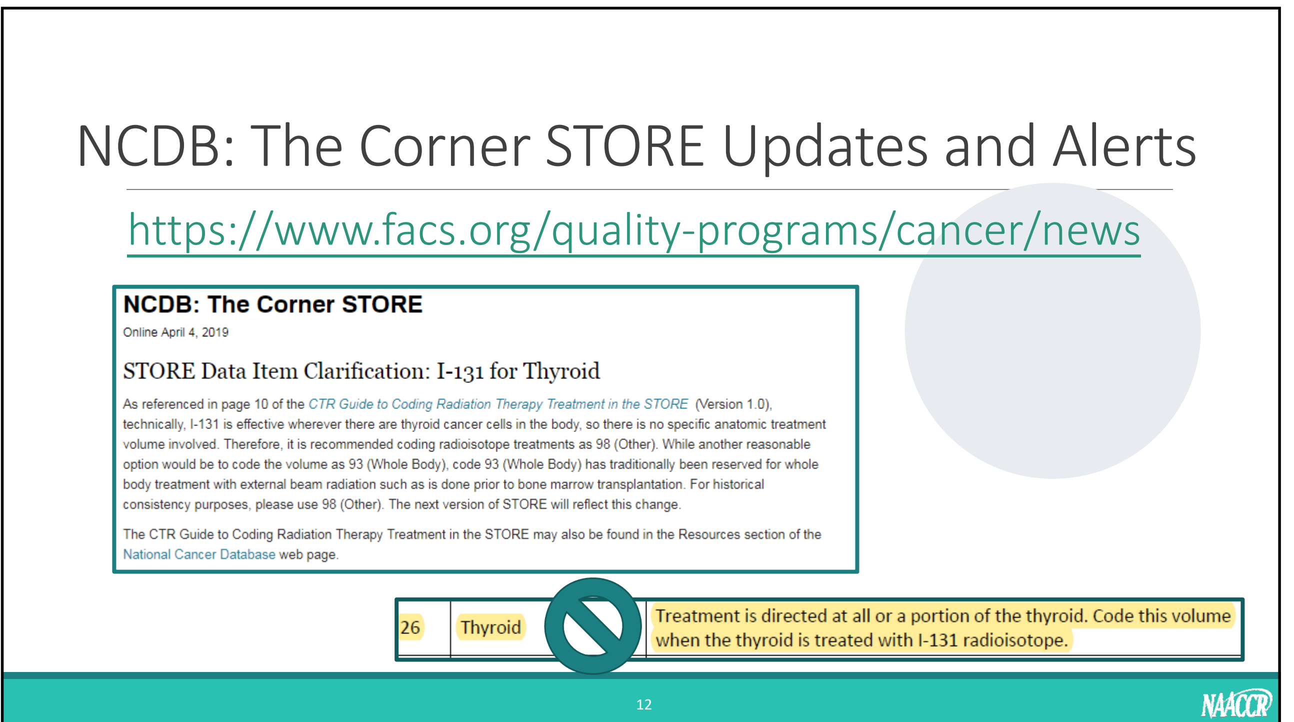
In situ neoplasia change in T category assignment. The clinical T category will now be cTis and the pathological T category will be pTis.

Quick 1-page resource highlighting the general rules and rationale for Chapter 1 of the AJCC Cancer Staging Manual.

Node status is not required in circumstances where lymph node involvement is rare. This is limited to specific chapters.

AJCC Eighth Edition Webinars

The AJCC Eighth Edition webinars are designed to provide instruction on staging rules, common questions, and disease site specifics. The staging rules will encompass examples from disease site chapters.



NCDB: The Corner STORE Updates and Alerts

https://www.facs.org/quality-programs/cancer/news

NCDB: The Corner STORE

Online April 4, 2019

STORE Data Item Clarification: I-131 for Thyroid

As referenced in page 10 of the *CTR Guide to Coding Radiation Therapy Treatment in the STORE* (Version 1.0), technically, I-131 is effective wherever there are thyroid cancer cells in the body, so there is no specific anatomic treatment volume involved. Therefore, it is recommended coding radioisotope treatments as 98 (Other). While another reasonable option would be to code the volume as 93 (Whole Body), code 93 (Whole Body) has traditionally been reserved for whole body treatment with external beam radiation such as is done prior to bone marrow transplantation. For historical consistency purposes, please use 98 (Other). The next version of STORE will reflect this change.

The CTR Guide to Coding Radiation Therapy Treatment in the STORE may also be found in the Resources section of the National Cancer Database web page.

26	Thyroid	Treatment is directed at all or a portion of the thyroid. Code this volume when the thyroid is treated with I-131 radioisotope.

CTR Guide to Coding Radiation Therapy

NCDB: The Corner STORE

Online March 28, 2019

CTR Guide to Coding Radiation Therapy

The Commission on Cancer Radiation Oncology Working Group is pleased to announce the distribution of the *CTR Guide to Coding Radiation Therapy Treatment in the STORE* version 1.0 to aid registrars in the coding of the 31 Radiation Data items defined in STORE. This document may also be found in the Resources section of the National Cancer Database web page.

"It is our hope that the clinical examples provided will lead the way to efficient and uniform reporting of radiation data. This initial effort should provide guidance for 95% or more of the clinical situations you will encounter. We hope it will become a living document that evolves as technology changes or we are presented with new clinical situations. To that end, we invite the CTR community to submit cases that do not seem to be covered within to the Commission on Cancer CA Forum." *CTR Guide to Coding Radiation Therapy Treatment in the STORE Version 1.0 March 15, 2019*

Errata/Revisions/Clarifications

- READ THE MANUALS!
  - However do so with caution! There have been multiple updates/clarifications/changes to the original documents.
    - Know how to find the errata/revisions/clarifications
      - AJCC 8th Edition Errata https://cancerstaging.org/references-tools/deskreferences/Pages/8EUpdates.aspx
      - ICD 0 3 Revisions https://www.naaccr.org/implementation-guidelines/#ICDO3
      - Radiation Coding https://www.facs.org/-/media/files/quality-programs/cancer/ncdb/case_studies_coding_radiation_treatment.ashx?la=en
      - STORE Manual Clarifications https://www.facs.org/quality-programs/cancer/news
      - Solid Tumor Rules Revisions https://seer.cancer.gov/tools/solidtumor/revisions.html
      - SSDI/Grade 2018 http://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018
      - EOD v1.7 changes https://staging.seer.cancer.gov/eod/news/1.7/

Pop Quiz #1 Palliative Care

A patient was admitted to your facility on 2/15/18 and was diagnosed with stage 4 pancreatic cancer. On 2/18/18 the managing physician (staff physician) recommends palliative care only. The patient and the patient's family agree that she will only be given pain medications to keep her comfortable. She is started on pain medications on 2/19/18.

What is Date First Course of Treatment?

- 2/18/18
- 2/19/18
- Blank

Rationale

02/18/2018 Pick the date in which a patient decides on palliative care for pain management only, as recommended by the physician.

From NCDB: The Corner STORE Online February 28, 2019

https://www.facs.org/quality-programs/cancer/news/corner-store-022819

STORE Data Item Clarification: Palliative Care

When a patient receives *palliative care for pain management only* with no other cancer-directed treatment, Date of First Course of Treatment, NAACCR Data Item #1270, would be the date in which a patient decides on palliative care for pain management only, as recommended by the physician. "No therapy" is a treatment option that occurs if the patient refuses treatment, the family or guardian refuses treatment, the patient dies before treatment starts, or the physician recommends no treatment be given, or the physician recommends palliative care for pain management only.

Pop Quiz #2 Palliative Care

A patient was admitted to your facility on 2/15/18 and was diagnosed with stage 4 pancreatic cancer. On 2/18/18 the managing physician (staff physician) recommends palliative care only. The patient and the patient's family agree that she will only be given pain medications to keep her comfortable. She is started on pain medications on 2/19/18.

How would you code the field Palliative Care?

Code	Label
0	No palliative care provided. Diagnosed at autopsy.
1	Surgery (which may involve a bypass procedure) to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made.
2	Radiation therapy to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made.
3	Chemotherapy, hormone therapy, or other systemic drugs to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made.
4	Patient received or was referred for painmanagement therapy with no other palliative care.
5	Any combination of codes 1, 2, and/or 3 without code 4.
6	Any combination of codes 1, 2, and/or 3 with code 4.
7	Palliative care was performed or referred, but no information on the type of procedure is available in the patient record. Palliative care was provided that does not fit the descriptions for codes 1–6.
9	It is unknown if palliative care was performed or referred; not stated in patient record.

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Pop Quiz #3 Palliative Care

A patient was admitted to your facility on 2/15/18 and was diagnosed with stage 4 pancreatic cancer. On 2/18/18 the managing physician (staff physician) recommends palliative care only. The patient and the patient's family agree that she will only be given pain medications to keep her comfortable. She is started on pain medications on 2/19/18.

Would you code the pain medication received in the Other Treatment Field?

Code	Label	Definition
0	None	All cancer treatment was coded in other treatment fields (surgery, radiation, systemic therapy). Patient received no cancer treatment. Diagnosed at autopsy.
1	Other	Cancer treatment that cannot be appropriately assigned to specified treatment data items (surgery, radiation, systemic therapy).
2	Other–Experimental	This code is not defined. It may be used to record participation in institution-based clinical trials.
3	Other–Double Blind	A patient is involved in a double-blind clinical trial. Code the treatment actually administered when the double-blind trial code is broken.
6	Other–Unproven	Cancer treatments administered by nonmedical personnel.
7	Refusal	Other treatment was not administered. It was recommended by the patient's physician, but this treatment (which would have been coded 1, 2, or 3) was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in the patient record.
8	Recommended; unknown if administered	Other treatment was recommended, but it is unknown whether it was administered.
9	Unknown	It is unknown whether other treatment was recommended or administered, and there is no information in the medical record to confirm the recommendation or administration of other treatment. Death certificate only.

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DO NOT CODE PAIN MEDS IN OTHER TX

NO

Pop Quiz #4 Palliative Care

11-8-2018 A 65-year-old male smoker presents with Stage IV adenocarcinoma of the lung and multiple symptomatic sites of metastases.

11-9-2018 Med Onc Consult: **Any therapy in this situation would be palliative**, with goals to improve her pain & prevent SVC obstruction.

11-9-2018 Given Morphine for pain due to metastatic disease

11-10-2018 Began Carboplatin, Keytruda

11-10-2018 to 11-21-2018 Spine 3000 x 10 fractions

11-12-2018 to 11-23-2018 Right Femur 3000 x 10 fractions

11-12-2018 to 11-23-2018 Right Humerus 2000 x 5 fractions

11-12-2018 to 11-16-2018 Left hip 2000 x 5 fractions

How would you code the field Palliative Care?

Code	Label
0	No palliative care provided. Diagnosed at autopsy.
1	Surgery (which may involve a bypass procedure) to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made.
2	Radiation therapy to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made.
3	Chemotherapy, hormone therapy, or other systemic drugs to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made.
4	Patient received or was referred for painmanagement therapy with no other palliative care.
5	Any combination of codes 1, 2, and/or 3 without code 4.
6	Any combination of codes 1, 2, and/or 3 with code 4.
7	Palliative care was performed or referred, but no information on the type of procedure is available in the patient record. Palliative care was provided that does not fit the descriptions for codes 1–6.
9	It is unknown if palliative care was performed or referred; not stated in patient record.

Other Treatment

11-9-2018 Given Morphine for pain due to metastatic disease

Would you code the pain medication received in the Other Treatment Field?

NO

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Chemotherapy

11-10-2018 Began Carboplatin, Pembrolizumab

Field	
Date Chemotherapy Started	11-10-2018
Chemotherapy	02 Single-agent chemotherapy
Date Immunotherapy Started	11-10-2018
Immunotherapy	01 Immunotherapy administered

TIP: Utilize SEER*Rx Interactive Antineoplastic Drugs Database for coding instructions.

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Radiation [1]

- 11/10/2018 to 11/21/2018. Treatment to thoracic spine, Unblocked photon field, 3000 cGy in 10 fractions
- 11/12/2018 to 11/23/2018: Treatment to right femur, unblocked photon field, 3000 cGy in 10 fractions
- 11/12/2018 to 11/16/2018: Left hip treated with conformal fields designed to spare adjacent bowel, bladder, and soft tissues. 2000 cGy in 5 equal fractions.
- 11/12/2018 to 11/16/2018: Right humerus, open square field, 2000cGy in 5 equal fractions

Seg	#	Field	Code/Definition
Summary	1	Rad/Surg Sequence	0 No radiation and/or sur
	2	Reason No Rad	0 Radiation was administered
	3	Location of Rad	02 Regional RT at this Facility
	4	Date Started/Flag	11/10/2018
	5	Date Finished/Flag	11/23/2018
	6	Number of Phases	04 '4 or more phases'
	7	Discontinued Early	01 Completed
	8	Total Dose	003000
Phase 1	9	Volume	81 Spine
	10	Rad to Nodes	00 No RT to nodes
	11	Modality	02 External beam, photons
	12	Planning Technique	03 2-D therapy
	13	Number of Fractions	10
	14	Dose per Fraction	00300
	15	Total Phase 1 Dose	003000
Phase e 2	16	Volume	88 Extremity Bone, NOS
	17	Rad to Nodes	00 No RT to nodes
	18	Modality	02 External beam, photons
	19	Planning Technique	03 2-D therapy
	20	Number of Fractions	010
	21	Dose per Fraction	00300
	22	Total Phase 2 Dose	003000
Phase 3	23	Volume	84 Hip
	24	Rad to Nodes	00 No RT to nodes
	25	Modality	02 External beam, photons
	26	Planning Technique	03 2-D therapy
	27	Number of Fractions	05
	28	Dose per Fraction	00400
	29	Total Phase 3 Dose	002000

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Summary of Pop Quiz #4 – All Treatment Fields

Field	Code/Definition
Date Chemotherapy Started	11-10-2018
Chemotherapy	02 Single-agent chemotherapy
Date Immunotherapy Started	11-10-2018
Immunotherapy	01 Immunotherapy administered
Palliative Therapy	6 Any combination of codes 1, 2, and/or 3 with code 4. (Chemo+XRT+Pain Meds)
Date of First Course Treatment	11-10-2018
Rx Summ-Treatment Status	1 Treatment given

Seg	#	Field	Code/Definition
Summary	1	Rad/Surg Sequence	0 No radiation and/or sur
	2	Reason No Rad	0 Radiation was administered
	3	Location of Rad	02 Regional RT at this Facility
	4	Date Started/Flag	11/10/2018
	5	Date Finished/Flag	11/23/2018
	6	Number of Phases	04 '4 or more phases'
	7	Discontinued Early	01 Completed
	8	Total Dose	003000
Phase 1	9	Volume	81 Spine
	10	Rad to Nodes	00 No RT to nodes
	11	Modality	02 External beam, photons
	12	Planning Technique	03 2-D therapy
	13	Number of Fractions	10
	14	Dose per Fraction	00300
	15	Total Phase 1 Dose	003000
Phase e 2	16	Volume	88 Extremity Bone, NOS
	17	Rad to Nodes	00 No RT to nodes
	18	Modality	02 External beam, photons
	19	Planning Technique	03 2-D therapy
	20	Number of Fractions	010
	21	Dose per Fraction	00300
	22	Total Phase 2 Dose	003000
Phase 3	23	Volume	84 Hip
	24	Rad to Nodes	00 No RT to nodes
	25	Modality	02 External beam, photons
	26	Planning Technique	03 2-D therapy
	27	Number of Fractions	05
	28	Dose per Fraction	00400
	29	Total Phase 3 Dose	002000

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Pop Quiz #5 Palliative Care

1-12-2018 A 75 year old man presents to your facility found to have Stage IV prostate Adenocarcinoma.

1-13-2018 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.

How would you code the field Palliative Care?

Code	Label
0	No palliative care provided. Diagnosed at autopsy.
1	Surgery (which may involve a bypass procedure) to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made.
2	Radiation therapy to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made.
3	Chemotherapy, hormone therapy, or other systemic drugs to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made.
4	Patient received or was referred for painmanagement therapy with no other palliative care.
5	Any combination of codes 1, 2, and/or 3 without code 4.
6	Any combination of codes 1, 2, and/or 3 with code 4.
7	Palliative care was performed or referred, but no information on the type of procedure is available in the patient record. Palliative care was provided that does not fit the descriptions for codes 1–6.
9	It is unknown if palliative care was performed or referred; not stated in patient record.

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Pop Quiz #6 Multiple TX Options

Various treatment options were discussed with the patient, Radiation or brachytherapy alone, Radical Prostatectomy, or Active Surveillance. Patient chose Active Surveillance.

How would you code Reason No for No Surgery Of Primary Site?

Code	Label
0	Surgery of the primary site was performed.
1	Surgery of the primary site was not performed because it was not part of the planned first course treatment. Diagnosed at autopsy.
2	Surgery of the primary site was not recommended/performed because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, progression of tumor prior to planned surgery etc.)
5	Surgery of the primary site was not performed because the patient died prior to planned or recommended surgery.
6	Surgery of the primary site was not performed; it was recommended by the patient's physician, but was not performed as part of the first course of therapy. No reason was noted in patient record.
7	Surgery of the primary site was not performed; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in patient record.
8	Surgery of the primary site was recommended, but it is unknown if it was performed. Further follow-up is recommended.
9	It is unknown whether surgery of the primary site was recommended or performed. Death certificate only.

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Rationale-Reason No Surgery (SEER/COC)

SEER Program Coding and Staging Manual 2018

Assign code 1 when

ii. The treatment plan offered multiple treatment options and the patient selected treatment that did not include surgery of the primary site

STORE

Code 1 if the treatment plan offered multiple alternative treatment options and the patient selected treatment that did not include surgery of the primary site, or if the option of "no treatment" was accepted by the patient.

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Pop Quiz #7 Treatment Refusals

During admission to your facility patient is found to have Stage 3 Rectal Primary. Patient refuses all further workup or treatment.

How would you code the field Reason No Radiation?

Code	Label
0	Radiation therapy was administered.
1	Radiation therapy was not administered because it was not part of the planned first course treatment. Diagnosed at autopsy.
2	Radiation therapy was not recommended/administered because it was contraindicated due to other patient risk factors (comorbid conditions, advanced age, progression of tumor prior to planned radiation etc.).
5	Radiation therapy was not administered because the patient died prior to planned or recommended therapy.
6	Radiation therapy was not administered; it was recommended by the patient's physician, but was not administered as part of first course treatment. No reason was noted in patient record.
7	Radiation therapy was not administered; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in patient record.
8	Radiation therapy was recommended, but it is unknown whether it was administered.
9	It is unknown if radiation therapy was recommended or administered. Death certificate cases only.

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Rationale-Reason No Radiation (SEER/COC)

SEER Program Coding and Staging Manual 2018

Assign Code 7 if the patient refused recommended radiation therapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.

STORE

Code 7 if the patient refused recommended radiation therapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.

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Pop Quiz #8 Treatment Refusals

01-01-2019 During admission to your facility patient is found to have Stage 3 Rectal Primary. Patient refuses all further workup or treatment.

How would you code Reason No Chemotherapy?

YOU WOULD NOT!!!

Reason No Chemotherapy is a retired field, it was retired as of January 1,2006.

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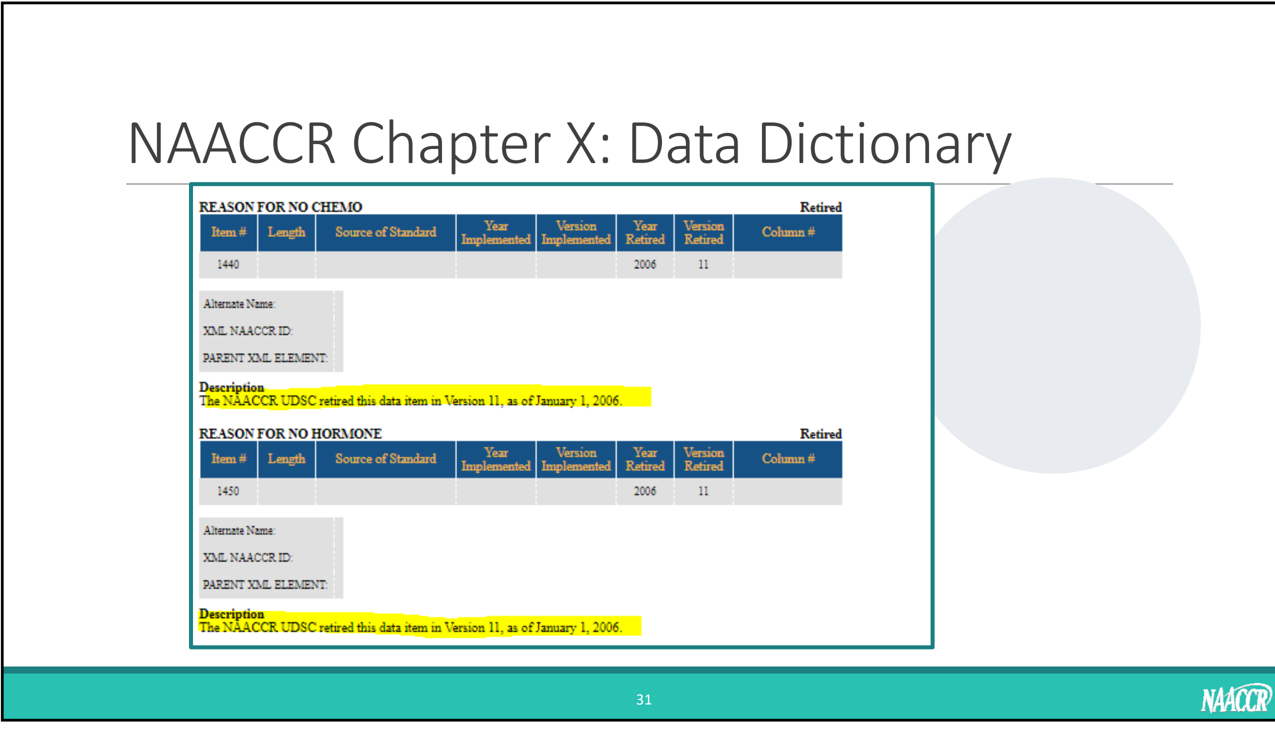

NAACCR Chapter X: Data Dictionary
REASON FOR NO CHEMO
Retired
Item # | Length | Source of Standard | Year Implemented | Version Implemented | Year Retired | Version Retired | Column #
1440 | 2006 | 11
Alternate Name:
XML NAACCR ID:
PARENT XML ELEMENT:
Description
The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.
REASON FOR NO HORMONE
Retired
Item # | Length | Source of Standard | Year Implemented | Version Implemented | Year Retired | Version Retired | Column #
1450 | 2006 | 11
Alternate Name:
XML NAACCR ID:
PARENT XML ELEMENT:
Description
The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.
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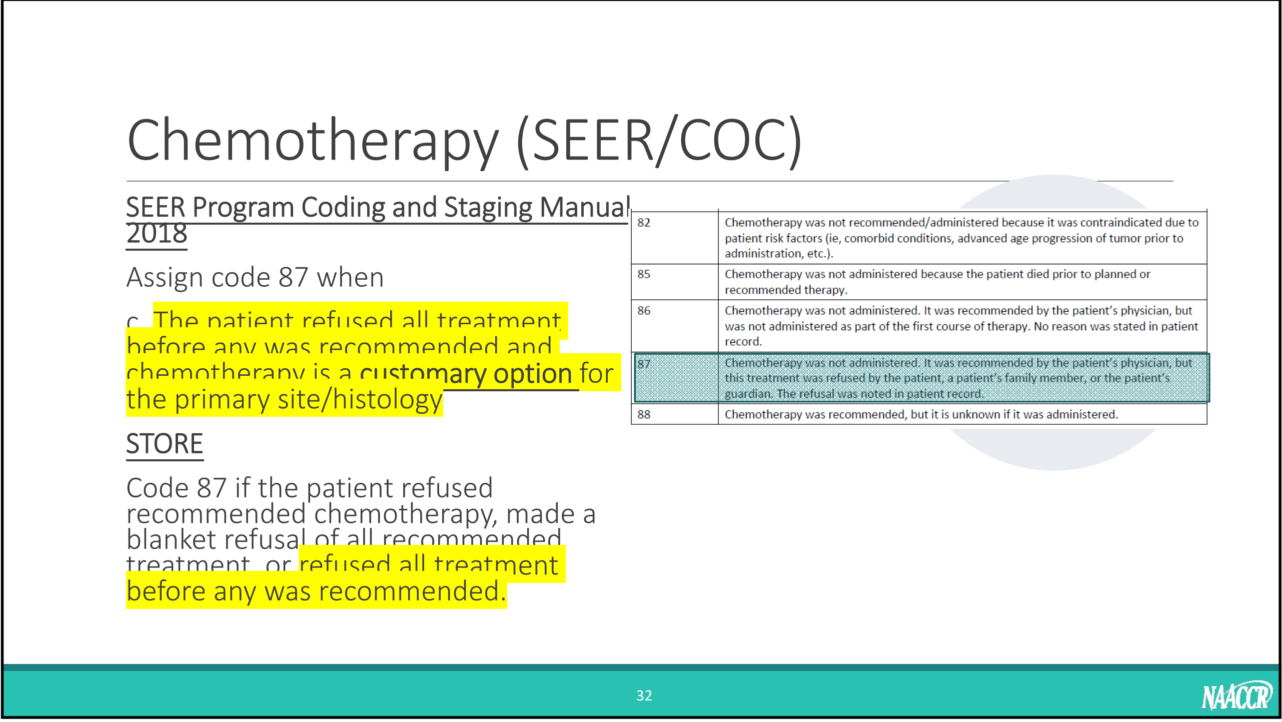

Chemotherapy (SEER/COC)
SEER Program Coding and Staging Manual 2018
Assign code 87 when
c. The patient refused all treatment before any was recommended and chemotherapy is a customary option for the primary site/histology
STORE
Code 87 if the patient refused recommended chemotherapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
82 | Chemotherapy was not recommended/administered because it was contraindicated due to patient risk factors (ie, comorbid conditions, advanced age progression of tumor prior to administration, etc.).
85 | Chemotherapy was not administered because the patient died prior to planned or recommended therapy.
86 | Chemotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in patient record.
87 | Chemotherapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88 | Chemotherapy was recommended, but it is unknown if it was administered.
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Summary-When refuses all treatment

06-01-2018 During admission to your facility patient is found to have Stage 3 Rectal Primary. 06-11-2018 Patient refuses all further workup or treatment.

Field	Code/Definition
Reason No Surgery	7 refused by the patient
Reason No Radiation	7 refused by the patient
Chemotherapy	87 refused by the patient
Date of First Course of Treatment	06/11/2018
Rx Summ – Treatment Status	0 No Treatment Given

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Pop Quiz #9 Tumor Size Summary

2-2-2018 Patient found to have a 2.2 cm mass in the oropharynx

2-4-2018 FNA confirms squamous cell carcinoma.

2-15-2018 Patient receives a course of neoadjuvant combination chemotherapy.

6-15-2018 Pathologic size after total resection is 2.8 cm.

What is the Tumor Size Summary?

- 022
- 028

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Neoadjuvant TX=do not record from Path

Answer: 022

Per STORE If neoadjuvant therapy followed by surgery, do not record the size from the pathologic specimen. Code the largest size of tumor prior to neoadjuvant treatment; if unknown code size as 999.

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Pop Quiz #10 Tumor Size Summary

Patient found to have 2.6cm positive cervical lymph nodes felt to be from an unknown head and neck primary. Lymph nodes are p16 positive, EBV Unknown. (Primary Site is coded to C10.9 Oropharynx) [2]

What is the Tumor Size Summary?

- 000 No mass/tumor found
- 026 2.6cm
- 999 Unknown; size not stated/ Not applicable

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Occult Tumors

000 No mass/tumor found

Reminder: cT category would be assigned:

cT0-No primary identified

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Pop Quiz #11 Tumor Size Summary

9-15-2018 left uoq breast lumpectomy: 1.4 mm infiltrating ductal carcinoma, 2 sentinel node nodes(-), margins(-)

What is the Tumor Size Summary?

- 001
- 002

NAACCR

Exception to the round rules for Breast

002

STORE –Tumor Size Summary- *For breast cancer, please follow the AJCC 8th Edition, Breast Chapter.*

AJCC 8th Edition, Breast Chapter *The general rules for rounding to the nearest millimeter do not apply for tumors between 1.0 and 1.5mm, so as to not classify these cancers as microinvasive (T1mi) carcinomas (defined as invasive tumor foci 1.0 mm or small). Tumors >1mm and <2mm should be reported rounding to 2mm.*

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Pop Quiz #12 Lymphovascular Invasion

2/15/18 breast biopsy showed invasive ductal carcinoma and **no mention of lymphovascular invasion**. Patient has neoadjuvant chemotherapy and radiation. **After chemo and radiation** patient has mastectomy which shows .5mm invasive ductal carcinoma with **NO lymphovascular invasion**.

How would you code Lymphovascular Invasion for this case?

- 9, Unknown
- 0, Negative

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STORE-Coding LVI - neoadjuvant therapy

9, Unknown

LVI on pathology report PRIOR to neoadjuvant therapy	LVI on pathology report AFTER neoadjuvant therapy	*Code LVI to:*
0 - Not present/Not identified	0 - Not present/Not identified	*0 - Not present/Not identified*
0 - Not present/Not identified	1 - Present/Identified	*1 - Present/Identified*
0 - Not present/Not identified	9 - Unknown/Indeterminate	*9 - Unknown/Indeterminate*
1 - Present/Identified	0 - Not present/Not identified	*1 - Present/Identified*
1 - Present/Identified	1 - Present/Identified	*1 - Present/Identified*
1 - Present/Identified	9 - Unknown/Indeterminate	*1 - Present/Identified*
9 - Unknown/Indeterminate	0 - Not present/Not identified	*9 - Unknown/Indeterminate*
9 - Unknown/Indeterminate	1 - Present/Identified	*1 - Present/Identified*
9 - Unknown/Indeterminate	9 - Unknown/Indeterminate	*9 - Unknown/Indeterminate*

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Pop Quiz #13 Lymphovascular Invasion

5-15-2018 Colon Resection CAP Checklist:

Lymphovascular Invasion

___ Not identified

_X__ Present

_X__ Small vessel lymphovascular invasion

_X__ Large vessel (venous) invasion)

How would you code Lymphovascular Invasion?

- 1 Lymphovascular Invasion Present/Identified
- 2 Lymphatic and small vessel invasion only (L)
- 3 Venous (large vessel) invasion only (V)
- 4 BOTH lymphatic and small vessel AND venous (large vessel) invasion

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Pop Quiz #14 FNA's –Code or Not

- 1/26/2018 FNA **cytology** of the thyroid nodule showed papillary carcinoma.

How do you code the 1/26/2018 FNA of the Thyroid Nodule?

- Code 02 in in the Diagnostic & Staging Procedure
- Do not code the procedure, but list it in the text.

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Do not code +cytology of primary site

Do not code the procedure, but list it in the text.

STORE-Surgical Diagnostic & Staging Procedure=Code brushings, washings, cell aspiration, and hematologic findings (peripheral blood smears) as positive cytologic diagnostic confirmation in the data item Diagnostic Confirmation. ***These are not considered surgical procedures and should not be coded in this item.***

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Pop Quiz #15 FNA's –Code or Not

- 1/26/2018 FNA **core biopsy** of the thyroid nodule showed papillary carcinoma.

How do you code the 1/26/2018 FNA core biopsy of the Thyroid Nodule?

- Code 02 in in the Diagnostic & Staging Procedure
- Do not code the procedure, but list it in the text.

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Code +FNA **Histology** of primary site

Code 02 A biopsy (incisional, needle, or aspiration) was done to the primary site; or biopsy or removal of a lymph node to diagnose or stage lymphoma.

STORE-Surgical Diagnostic & Staging Procedure - Only record positive procedures. For benign and borderline reportable tumors, report the biopsies positive for those conditions. For malignant tumors, report procedures if they were positive for malignancy.

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Pop Quiz #16 FNA's –Code or Not

1/12/2018 patient is diagnosed with Adenocarcinoma of the RUL of the lung.

1/28/2018 patient has FNA of a right hilar lymph node which was negative for adenocarcinoma.

How do you code the FNA Cytology of the Regional Lymph Node?

- Code Scope of Regional Lymph Nodes to 1 (Bx or Aspiration of Regional LN)
- Do not code the procedure, but list it in the text.

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Code +/- Cytology of LN

Code Scope of Regional Lymph Nodes to 1 (Bx or Aspiration of Regional LN)

STORE-Scope of Regional Lymph Node Surgery- *Record surgical procedures which aspirate, biopsy, or remove regional lymph nodes in an effort to diagnose or stage disease in this data item. Record the date of this surgical procedure in data item Date of First Course of Treatment [1270] and/or Date of First Surgical Procedure [1200] if applicable.*

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Summary- FNA's –Code or Not

If the specimen other than lymph node is obtained using FNA technique and issued in as a **cytology** report, it is **not coded** in the item Surgical Diagnostic and Staging Procedure.

If the specimen other than lymph node is obtained using FNA technique and issued in a **pathology** report, it **is coded** in the item Surgical Diagnostic and Staging Procedure. (Positive bx only)

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)

Pop Quiz#17 Breast Multiple Tumors, 1 Abstracted Primary

Scenario: 3 breast tumors (size 3.2cm, 1.1cm, 1.5cm)

From needle biopsy of larger tumor
HER2 Negative
ER Positive >90% moderate intensity, Allred 7
PR Negative 0%, Allred 0

From excision of one of the smaller tumors
HER2 Negative
ER Positive >80 Strong Intensity Allred 8
PR Positive 50%,Strong Intensity Allred 8

From excision of one of the smaller tumors
HER2 Positive
ER Positive ~50%, Moderate Intensity, Allred 6
PR Negative <1%,Weak Intensity, Allred 2

How do you code the SSDI's?

- From the Largest Tumor HER2 Negative, ER Positive, PR Negative
- Mix and Match HER2 Positive, ER Positive, PR Positive

Updated instructions for ER, PR, HER2 (IHC, ISH, Overall) Summary SSDIs 07-17-19

From the Largest Tumor HER2 Negative, ER Positive, PR Negative

CAnswer Forum Post
http://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/93658-updated-instructions-for-er-pr-her2-ihc-ish-overall-summary-ssdis

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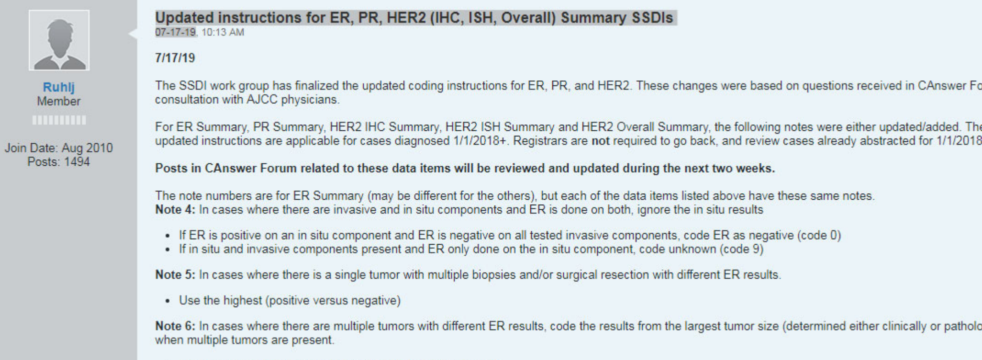
Updated instructions for ER, PR, HER2 (IHC, ISH, Overall) Summary SSDIs 07-17-19

http://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/93658-updated-instructions-for-er-pr-her2-ihc-ish-overall-summary-ssdis



Ruhlj
Member

Join Date: Aug 2010
Posts: 1494

Updated instructions for ER, PR, HER2 (IHC, ISH, Overall) Summary SSDIs #1
07-17-19, 10:13 AM

7/17/19

The SSDI work group has finalized the updated coding instructions for ER, PR, and HER2. These changes were based on questions received in CAnswer Forum and consultation with AJCC physicians.

For ER Summary, PR Summary, HER2 IHC Summary, HER2 ISH Summary and HER2 Overall Summary, the following notes were either updated/added. These updated instructions are applicable for cases diagnosed 1/1/2018+. Registrars are **not** required to go back, and review cases already abstracted for 1/1/2018+.

Posts in CAnswer Forum related to these data items will be reviewed and updated during the next two weeks.

The note numbers are for ER Summary (may be different for the others), but each of the data items listed above have these same notes.
Note 4: In cases where there are invasive and in situ components and ER is done on both, ignore the in situ results

- If ER is positive on an in situ component and ER is negative on all tested invasive components, code ER as negative (code 0)
- If in situ and invasive components present and ER only done on the in situ component, code unknown (code 9)

Note 5: In cases where there is a single tumor with multiple biopsies and/or surgical resection with different ER results.

- Use the highest (positive versus negative)

Note 6: In cases where there are multiple tumors with different ER results, code the results from the largest tumor size (determined either clinically or pathologically) when multiple tumors are present.

- Do not use specimen size to determine the largest tumor size

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What to Do When Scores Don't Fit

Below are the recommendations from the SSDI work group as of 2/14/19. This is for ER and PR percent positive and applies to cases diagnosed 1/1/2018 and forward. Registrars are not required to go back and review cases already abstracted. [4]

• If the range on the report uses steps smaller than 10 and the range is fully or at least 80% contained within a range provided

in the table, code to that range in the table

• If the range on the report uses steps larger than 10 or uses steps of 10 that are different from those provided in the table,

code to the range that contains the low number of the range in the report

• When "greater than" is used, code one above. For example, "greater than 95," code 96

• When "less than" is used, code one below. For example, "less than 95," code 94

Examples ER/PR Percent Positive

- >95% Code 96 because when greater than" is used, code one above.
- <95% Code 94 because when the term "less than" is used, code one below.
- 1-5%. Code R10 if the range on the report uses steps smaller than 10 and the range is fully or at least 80% contained within a range provided in the table, code to the range that contains the low number of the range in the report.
- 75-85%. Code R80 almost all the range is contained with code R80.
- 76-100% Look at the lowest value an find the range that would fall in, code R80
- Close to 100% Code 99 ("close to" means almost that value, code one less than stated value) [5]
- Approximately 1% Code 001 (Since they are staging a single value, code to that value)[6]

Examples Ki-67

- <10% Code 9.9 (When “less than” is used, code the next lowest number.)
- >90% Code 90.1 (When “greater than” is used, code the next highest number.)
- 30-40% Code 30.1 (Since Ki-67 doesn’t have range codes code one above the lower range) [7]

Pop Quiz #18 Breast Surgery

Scenario: Patient diagnosed with invasive ductal carcinoma of the right breast, treated with Bilateral total (simple) mastectomy & sentinel lymph node biopsy.

Question: Would you code the removal of the uninvolved contralateral breast under the data item Surgical Procedure/Other Site?

STORE surgery coding for breast revised

NO!

8-22-2019 The Brief

STORE surgery coding for breast revised

Tip: Cut/Paste this information into a Sticky Note in your saved copy of the STORE. Cross Out the instructions in yellow on page 468 & 469.

The surgery coding instructions for the breast primary site will be updated in the next STORE 2018 revision to reflect the following:

- A total (simple) mastectomy removes all breast tissue, the nipple, and areolar complex. An axillary dissection is not done, but sentinel lymph nodes may be removed.
- For single primaries involving both breasts use code 76.
- If the contralateral breast reveals a second primary, each breast is abstracted separately. The surgical procedure is codded 41 for the first primary. The surgical code for the contralateral breast is coded to the procedure performed on that site.

The prior instruction in FORDS/STORE for single primaries only — code removal of the contralateral breast under the data item Surgical Procedure/Other Site (NAACCR Item #1294) and/or Surgical Procedure/Other Site at This Facility (NAACCR Item #674) — will be removed. It is not applicable.

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Pop Quiz #19 Melanoma

Workup shows a .5cm pigmented lesion and no evidence of lymphadenopathy. Patient presents with a punch biopsy on 5/15/19 that shows in situ melanoma that extends to inked margin. 6/3/19 Wide Local Excision with 1cm margin performed which shows no residual tumor.

What is the clinical stage?

- cTis cN0 cM0 Stage 0
- pTis cN0 cM0 Stage 0

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In Situ Neoplasia

cTis cN0 cM0 Stage 0

Resources: In Situ Neoplasia-AJCC Cancer Staging Manual 8th Edition https://cancerstaging.org/About/news/Documents/In%20Situ%20Neoplasia%20-%20AJCC%208th%20Edition_02052018.pdf

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Pop Quiz #20 Melanoma

Workup shows a .5cm pigmented lesion and no evidence of lymphadenopathy. Patient presents with a punch biopsy on 5/15/19 that shows in situ melanoma that extends to inked margin. 6/3/19 Wide Local Excision with 1cm margin performed which shows no residual tumor.

What is the Pathological stage?

- pTis cN0 cM0 Stage 0
- pTis cNX cM0 Stage 99

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In Situ Neoplasia

pTis cN0 cM0 Stage 0

Resources: In Situ Neoplasia-AJCC Cancer Staging Manual 8th Edition
https://cancerstaging.org/About/news/Documents/In%20Situ%20Neoplasia%20-%20AJCC%208th%20Edition_02052018.pdf

Pop Quiz #21 Melanoma

Shave biopsy right arm 2/16/19 showed superficial spreading melanoma with Breslow thickness of .23mm, no ulceration. On 3/13/19 Wide Local Excision with 2cm margins showed 2 in transit metastasis. No regional lymph nodes were examined.

What is the pN category for this case?

- pN0
- pN1c

Microsatellite, Satellite, and/or in-transit mets

pN1c

AJCC Cancer Staging Manual, Eighth Edition (Page 592). American College of Surgeons. Kindle Edition. *Patients with microsatellite, satellite, and/or in-transit metastases are categorized as N1c, N2c, or N3c disease according to the number of positive regional lymph nodes (irrespective of whether they were clinically occult or clinically detected). N1c designates patients with microsatellite, satellite, and/or in-transit metastases but with no tumor-involved regional lymph nodes; N2c designates those with one involved node; and N3c designates those with two or more involved nodes.*

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Pop Quiz #22 Melanoma

3-17-2019 Shave biopsy of left arm lesion showed superficial spreading melanoma with a Breslow Thickness of .5mm, and no ulceration found. Tumor extended to inked margin.

4-2-2019 Wide Local Excision shows no residual tumor.

How is the pathological stage coded?

- pT1a cN0 cM0 Stage Group 1A
- pT1a pNX cM0 Stage Group 99

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Node Status Not Required in Rare Circumstances

pT1a cN0 cM0 Stage Group 1A

- AJCC Cancer Staging Manual, Eighth Edition -*Pathological Stage 0 and pathological T1 without clinically detected regional or distant metastases (pTis/pT1 cN0 cM0) do not require pathological evaluation of lymph nodes to complete pathological staging; use cN0 to assign pathological stage.*
- Node Status Not Required in Rare Circumstances https://cancerstaging.org/CSE/Registrar/Documents/Node%20Status%20Not%20Required%20Rare%20Circumstances%20(1).pdf

Limited exception where cN0 may be used for pN category

- 47 Melanoma: only used for pT1

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Pop Quiz# 23 Melanoma Op margin >1cm, Path Margin - but not measured

Scenario: 6/25/2018 **Path report**: Excisional SHAVE biopsy skin lesion left arm: Malignant melanoma, skin of left arm: 0.9mm thick, no ulceration, mitosis 2/mm2; negative margins (NO MEASUREMENT NOTED ON PATH REPORT, IT'S JUST STATED NEGATIVE)
8/15/2018 **Op Report**: Wide excision of melanoma, left forearm, **with 1.5cm margin**; left axilla sentinel lymph node was identified with two large hot lymph nodes
8/15/2018 **Path Report**. Wide excision, left arm: no residual melanoma, previous biopsy site skin of left arm, Left axillary SLN: 0/2 (NOTE: NO MEASUREMENT IS NOTED ON PATH REPORT, IT JUST STATES NO RESIDUAL MELANOMA)

Question: How would the 8-15 Wide Excision be coded?

- 31 Shave biopsy followed by a gross excision of the lesion
- 46 Wide excision or re-excision of lesion or minor (local) amputation with margins more than 1 cm and less than or equal to 2 cm

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Technical Advisory Group (TAG)-Clarification on Melanoma Surgery

This was discussed last week at a meeting of the Technical Advisory Group (TAG), an ad hoc group with representation from all of the standard setters. The consensus decision is: For assigning melanoma surgery codes, use the path report as the first priority. If info not available on path report, op report may be used when margins are specified. Exception is for code 47 where specific instructions about microscopic confirmation are included. Important: this does not apply to the margins data item, only to surgery codes.

I will add to this: do not compute margins from path or op report. Use margins when stated. If not stated, margins are unknown.

I have sent this information to the SEER*Educate leads.

Thank you,

The SEER Data Quality Team

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Rationale

1. Review Path Report-margins are negative but not measured.
2. Review Op note to assist when no residual tumor on pathology. Op margins were 1.5cm
3. Thus appropriate Code would be **46** Wide excision or re-excision of lesion or minor (local) amputation with margins more than 1 cm and less than or equal to 2 cm

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Pop Quiz#24
Op margin>1cm, Path margin <1cm

Scenario: 6/25/2018 **Path report**: Excisional SHAVE biopsy skin lesion left arm: Malignant melanoma, skin of left arm: 0.9mm thick, no ulceration, mitosis 2/mm2; **margins positive**

8/15/2018 **Op Report**: Wide excision of melanoma, left forearm, **with 1.5cm margin**; left axilla sentinel lymph node was identified with two large hot lymph nodes

8/15/2018 **Path Report**. Wide excision, left arm: Malignant melanoma, skin of left arm: 0.9mm thick, no ulceration, mitosis 2/mm2, **margins .9 cm** , Left axillary SLN: 0/2

Question: How would the 8-15 Wide Excision be coded?

- 31 Shave biopsy followed by a gross excision of the lesion
- 46 Wide excision or re-excision of lesion or minor (local) amputation with margins more than 1 cm and less than or equal to 2 cm

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Rationale

1. Review Path Report-margins are .9cm
2. Thus appropriate Code would be 31 Shave biopsy followed by a gross excision of the lesion

*Margins from path report are key, you would only utilize the op note to assist when the margins are negative on path, but the distance from the margins are not noted on the path report.

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Resources

[1] *CTR Guide to Coding Radiation Therapy Treatment in the STORE Version 1.0 March 15, 2019* # 7 Multiple Metastatic Sites Treated Concurrently https://www.facs.org/~/media/files/quality%20programs/cancer/ncdb/case_studies_coding_radiation_treatment.ashx

[2] Reference *NAACCR 2018-2019 Webinar Series-Pharynx*

[3] 2019 NCRA Annual Conference presentation MELANOMA NCRA 05/22/2019 presented by Melissa Riddle, CTR, Arkansas Central Cancer Registry

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Resources

[4] CAnswer Forum Post http://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/86277-er-pr-percent-positive

[5] CAnswer Forum Post http://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/90045-er-strongly-positive-close-to-100-of-the-cells

[6] CAnswer Forum Post http://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/89580-er-approximately-1-positive

[7] CAnswer Forum Post http://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/89752-ssdi-breast-schema-ki-67-mib-1-percentage-range

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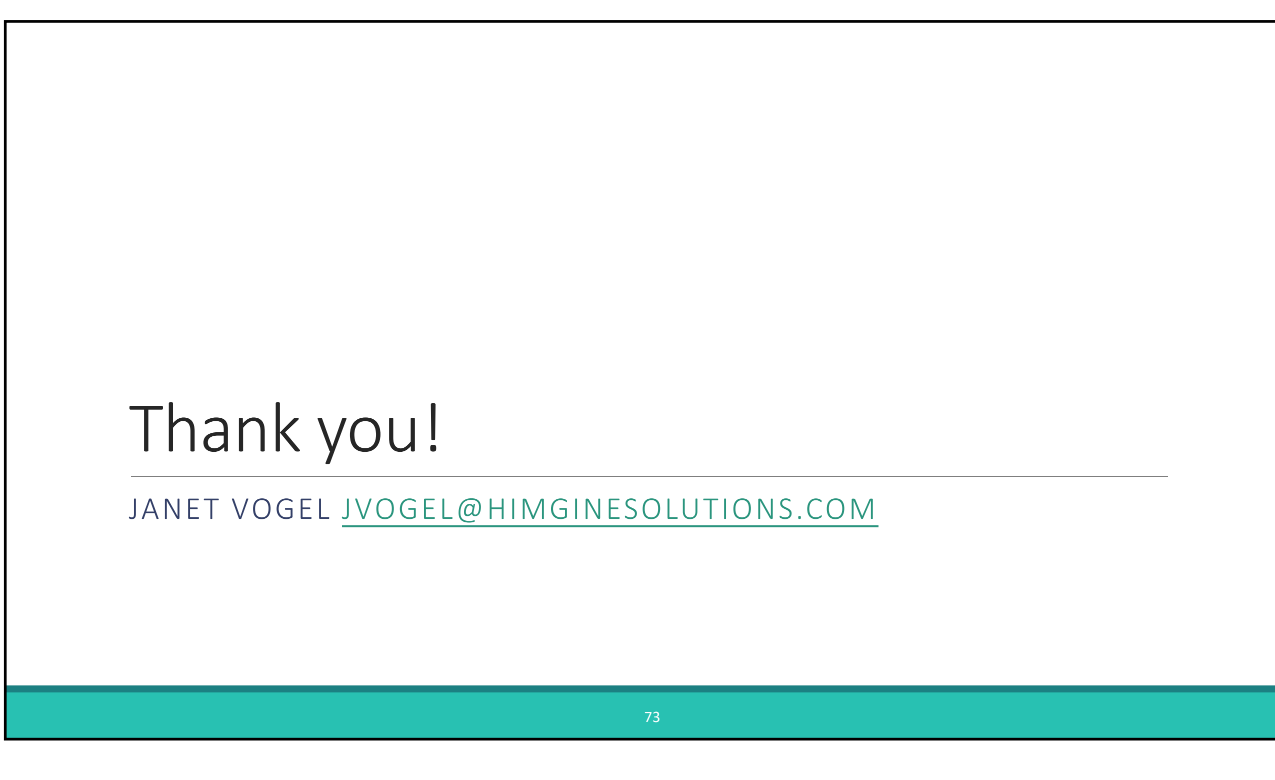

Coding Pitfalls

NAACCR 2018-2019 WEBINAR SERIES

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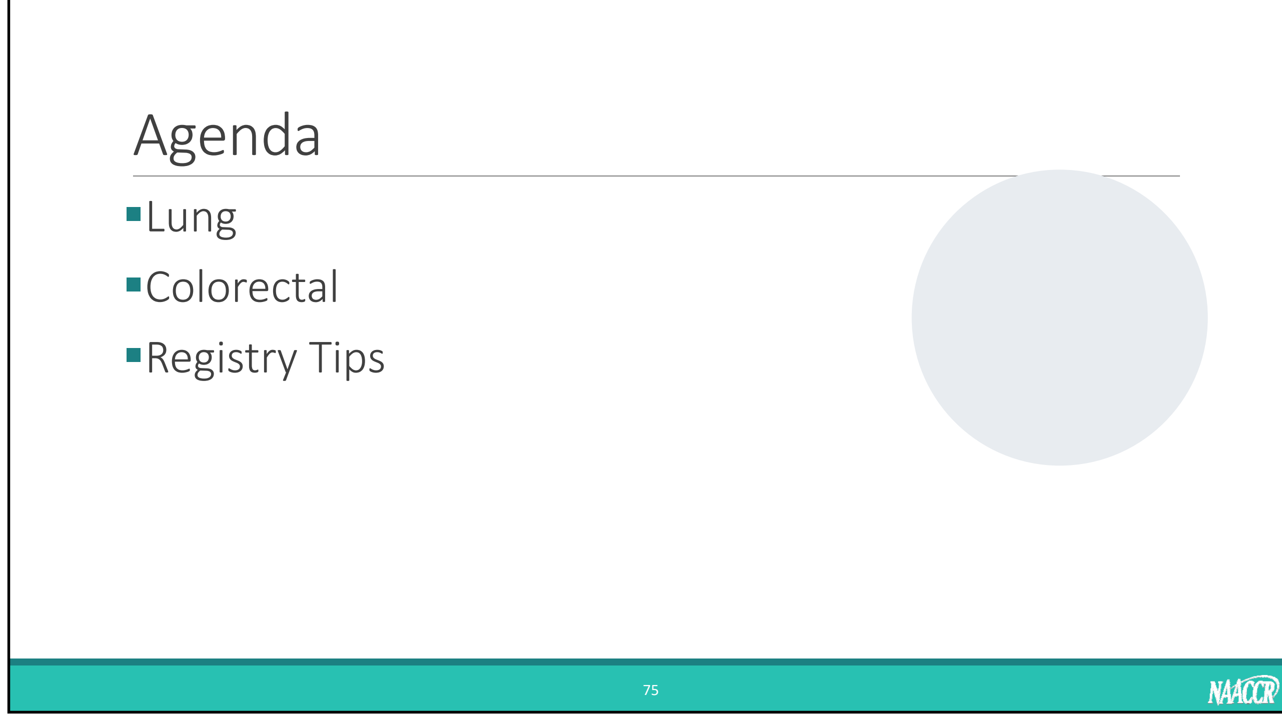
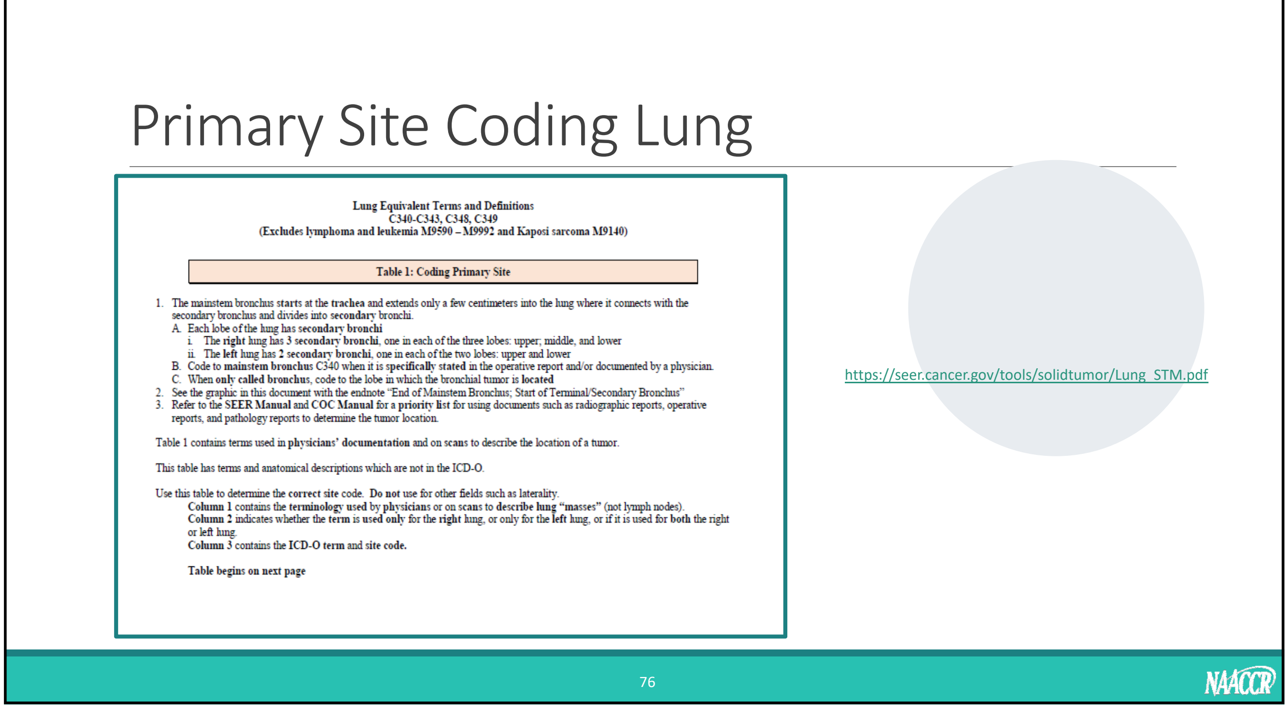




Lung Equivalent Terms and Definitions
C340-C343, C348, C349
(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)

Table 1: Coding Primary Site

1. The mainstem bronchus **starts** at the **trachea** and extends only a few centimeters into the lung where it connects with the secondary bronchus and divides into **secondary** bronchi.
   A. Each lobe of the lung has **secondary bronchi**
      i. The **right** lung has **3 secondary bronchi**, one in each of the three lobes: upper; middle, and lower
      ii. The **left** lung has **2 secondary bronchi**, one in each of the two lobes: upper and lower
   B. Code to **mainstem bronchus** C340 when it is **specifically stated** in the operative report and/or documented by a physician.
   C. When **only called bronchus**, code to the lobe in which the bronchial tumor is **located**
2. See the graphic in this document with the endnote "End of Mainstem Bronchus; Start of Terminal/Secondary Bronchus"
3. Refer to the **SEER Manual** and **COC Manual** for a **priority list** for using documents such as radiographic reports, operative reports, and pathology reports to determine the tumor location.

Table 1 contains terms used in **physicians' documentation** and on scans to describe the location of a tumor.

This table has terms and anatomical descriptions which are not in the ICD-O.

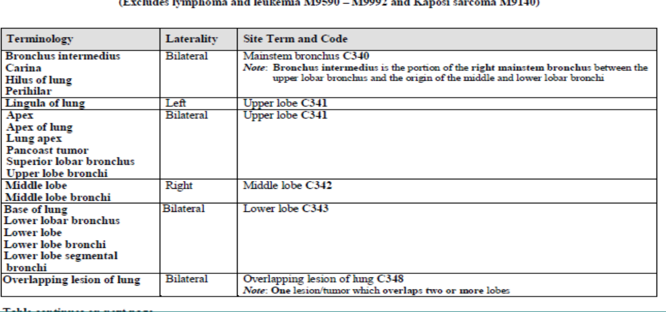
Use this table to determine the **correct site code**. **Do not** use for other fields such as laterality.
Column 1 contains the **terminology used** by **physicians** or on scans to **describe lung "masses"** (not lymph nodes).
Column 2 indicates whether the **term** is **used only** for the **right** lung, or only for the **left** lung, or if it is used for **both** the right or left lung.
Column 3 contains the **ICD-O term** and **site code.**

Table begins on next page

Primary Site Coding Lung

Remember Lingula is only on the left and is the left upper lobe. If they stated Lingula of the Lung this is to be coded C34.1.

https://seer.cancer.gov/tools/solidtumor/Lung_STM.pdf



Lung Equivalent Terms and Definitions
C340-C343, C348, C349
(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)

Terminology	Laterality	Site Term and Code
Bronchus intermedius **Carina** **Hilus of lung** **Perihilar**	Bilateral	Mainstem bronchus C340 *Note*: Bronchus intermedius is the portion of the right mainstem bronchus between the upper lobar bronchus and the origin of the middle and lower lobar bronchi
Lingula of lung	Left	Upper lobe C341
Apex **Apex of lung** **Lung apex** **Pancoast tumor** **Superior lobar bronchus** **Upper lobe bronchi**	Bilateral	Upper lobe C341
Middle lobe **Middle lobe bronchi**	Right	Middle lobe C342
Base of lung **Lower lobar bronchus** **Lower lobe** **Lower lobe bronchi** **Lower lobe segmental bronchi**	Bilateral	Lower lobe C343
Overlapping lesion of lung	Bilateral	Overlapping lesion of lung C348 *Note*: One lesion/tumor which overlaps two or more lobes

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Primary Site Coding Lung

Lung Equivalent Terms and Definitions
C340-C343, C348, C349
(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)

Terminology	Laterality	Site Term and Code
Bronchus NOS Bronchogenic Extending up to the hilum Extending down to the hilar region Lung NOS Pulmonary NOS Suprahilar NOS	Bilateral	Lung NOS C349 *Note*: Includes • Multiple tumors in different lobes of ipsilateral lung **OR** • Multiple tumors in ipsilateral lung; unknown if same lobe or different lobe **OR** • Tumor in bronchus, unknown if mainstem or lobar bronchus **OR** • Tumor present, unknown which lobe
Lobar bronchi NOS Lobar bronchus NOS	Bilateral	Code the lobe in which the lobar bronchus tumor is present C34_ *Note*: When lobe of origin is not documented/unknown, code to lung NOS C349

https://seer.cancer.gov/tools/solidtumor/Lung_STM.pdf

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Priority for Coding Histology

Code histology prior to neoadjuvant therapy; code histology using priority list and H rules; do not change histology to make the case eligible for staging

1. Tissue/Path from primary
   a. Addendum and/or comment
   b. Final diagnosis/synoptic report
   c. CAP protocol
2. Cytology (FNA, pleural fluid)
3. Tissue/path from metastatic site
4. Scans Priority (CT>PET>MRI>CXR)
5. Physician documentation
   a. Treatment Plan
   b. Tumor Board
   c. Medical Record documentation, original path, cytology, scan
   d. MD reference to histology

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Coding Histology

Code histology
- Before Neoadjuvant therapy
- Using Priority list and H rules
- Do not change histology to be able to stage

Multiple Histologies
- Code most specific histology or subtype/variant whether described as majority, predominately, minority or component
- Code NOS w/features of diff ONLY when specific code given
- Use ambiguous terms ONLY when criteria is met
- Do NOT code based on pattern, architecture, focus/foci/focal

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Non-Small Cell Lung Histology

If a pathologist states non-small cell lung carcinoma on pathology report and after discussion with managing md, they state these are just Carcinoma, NOS. It must be documented as 8046/3 Non Small Cell Lung Carcinoma unless you talk to pathologist, and have it documented in Policy and Procedure manual this is in fact just 8010/3 Carcinoma, NOS so that it can be staged.

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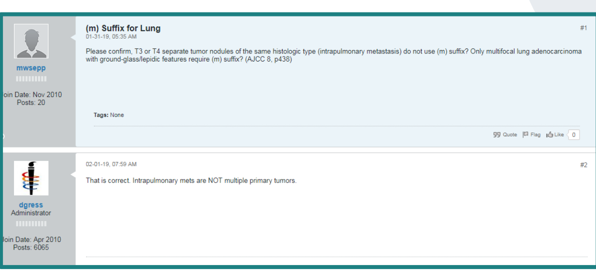
M Suffix

(m) for T Suffix is only used for ground-glass/lepidic nodules.

Intrapulmonary metastasis are not multiple primary tumors



(m) Suffix for Lung #1

01-31-19, 05:35 AM

mwsepp

Join Date: Nov 2010

Posts: 20

Please confirm, T3 or T4 separate tumor nodules of the same histologic type (intrapulmonary metastasis) do not use (m) suffix? Only multifocal lung adenocarcinoma with ground-glass/lepidic features require (m) suffix? (AJCC 8, p438)

Tags: None

Quote Flag Like 0

02-01-19, 07:59 AM #2

dgress

Administrator

Join Date: Apr 2010

Posts: 6065

That is correct. Intrapulmonary mets are NOT multiple primary tumors.

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Tumor Laterality and N Category by Lymph Node Station

Tumor in Right Lung	Tumor in Left Lung
N1 10R -14R	**N1** 10L -14L
N2 2R, 4R, 7, 9R 3A (Rt of midline of trachea) 3P 8 (Rt of midline of esophagus)	**N2** 2L, 4L, 5, 6, 7, 9L 3A (Lt midline of trachea) 3P 8 (Lt of midline of esophagus)
N3 1R, 1L, 2L, 4L, 5, 6, 9L, 10L -14L 3A (Lt of midline of trachea) 8 (Rt of midline of esophagus)	**N3** 1L, 1R, 2R, 4R, 9R, 10R -14R 3A (Rt of midline of trachea) 8 (Lt of midline of esophagus)

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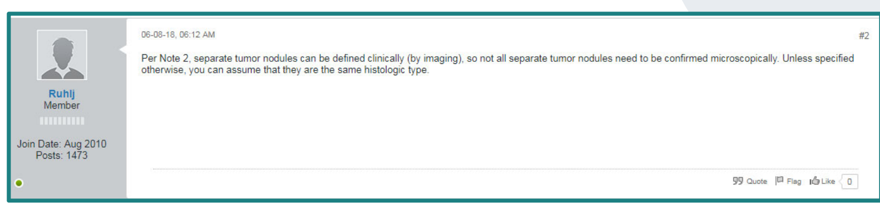
Separate Tumor Nodules

http://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/80505-ssdi-lung-separate-tumor-nodules



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Pop Quiz #1 Multiple Nodules

How is the SSDI Separate Tumor Nodules coded?

- 1, Separate tumor nodules of same histologic type in ipsilateral lung, same lobe
- 7, Multiple nodules or foci or tumor present, no classifiable based on Notes 3 and 4

TUMOR SITE: UPPER LOBE, 3.0 CM X 1.3 CM X 1.3CM X 1.0 CM. TWO SEPARATE TUMOR NODULES IN SAME LOBE. ADENOCARCINOMA WITH MUCINOUS DIFFERENTIATION. GRADE 2, CONFINED WITHIN LUNG. VISCERAL PLEURAL AND LVI NOT IDENTIFIED. MARGINS NEG. 0/7 NEG HILAR/PERIBRONCHIAL NODES. 0/14 NEG MEDIASTINAL/SUBCARINAL NODES. PT3N0.

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Answer

1, Separate tumor nodules of same histologic type in ipsilateral lung, same lobe

Note 3: For this item, only code separate tumor nodules of the same histologic type as the primary tumor, also referred to as intrapulmonary metastases.

- In the case of multiple tumor nodules determined to be the same primary, if not all nodules are biopsied, assume they are the same histology

Note 4: Other situations that display multiple lesions are NOT coded in this item. Assign code 0 if the multiple lesions belong to one of these other situations. Refer to the AJCC Staging Manual 8th Edition for standardized and precise definitions of the situations which aren't separate tumor nodules. They are

- second primary tumors, also called synchronous primary tumors (not the same histology as the primary tumor)
- multifocal lung adenocarcinoma with ground glass/lepidic features
- diffuse pneumonic adenocarcinoma

https://www.naaccr.org/SSDI/SSDI-Manual.pdf?v=1527608547

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Lung with multiple sites of involvement

AJCC Staging Manual 8th ed. Lung Chapter

Tables 36.3, 36.11

Pop Quiz #2 SSDI Visceral Pleura

2. Poorly differentiated non-small cell lung cancer of the right lower lobe, AJCC Stage IB, cT2a N0 M0, 3.7 cm max dimension involving the posterior visceral pleural surface

This was stated on a 2/7/18 Progress Note. No surgery of lung was planned or performed. How would you code SSDI for Visceral Parietal Pleural Invasion?

- 4, Invasion of visceral pleura present, NOS; not stated if PL1 or PL2
- 9, Not documented in medical record
  No surgical resection of primary site is performed
  Visceral Pleural Invasion not assessed or unknown if assessed or cannot be determined

Answer

9, Not documented in medical record

No surgical resection of primary site is performed

Visceral Pleural Invasion not assessed or unknown if assessed or cannot be determined

Rationale

9	Not documented in medical record No surgical resection of primary site is performed Visceral Pleural Invasion not assessed or unknown if assessed or cannot be determined

https://www.naaccr.org/SSDI/SSDI-Manual.pdf?v=1527608547

Pop Quiz #3 Lung Staging

Patient presents with SOB and had CXR 4/3/19 which showed left upper lobe mass. FNA cytology of LUL mass 4/5/19 showed Squamous Cell Carcinoma. Chest CT was performed for staging work up and showed hilar lymphadenopathy and left sided pleural effusion.

Based on the CT information how would you code the cM category?

- cM0; No Distant Metastasis
- cM1a; Separate tumor nodules in contralateral lobe; tumor with pleural or pericardial nodules or malignant pleural or pericardial effusion.

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Answer

cM0; No Distant Metastasis

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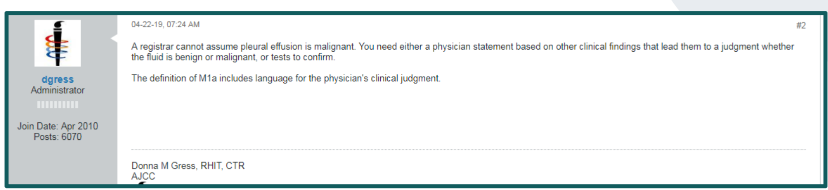
Rationale

http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging-8th-edition/thorax-chapters-35-37/lung-chapter-36/90746-pleural-effusion-cm1a



dgress
Administrator
Join Date: Apr 2010
Posts: 6070

04-22-19, 07:24 AM #2

A registrar cannot assume pleural effusion is malignant. You need either a physician statement based on other clinical findings that lead them to a judgment whether the fluid is benign or malignant, or tests to confirm.

The definition of M1a includes language for the physician's clinical judgment.

Donna M Gress, RHIT, CTR
AJCC

Pop Quiz #4 FNA Coding

Patient has FNA cytology of the RUL and is diagnosed with adenocarcinoma. **How is this procedure coded?**

- 02, Biopsy of Primary Site
- Not coded and is documented in text

Answer

Not coded and is documented in text

95 NAACCR

Rationale

STORE page 148 bullet 6

- Code brushings, washings, cell aspiration, and hematologic findings (peripheral blood smears) as positive cytologic diagnostic confirmation in the data item *Diagnostic Confirmation* [490]. These are not considered surgical procedures and should not be coded in this item.

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Pop Quiz #5 FNA Coding

Patient presents with RUL lobe mass on 3/5/19 and mediastinal lymphadenopathy on the right. Physician does an FNA on one mediastinal lymph node which returns positive for metastatic lung carcinoma.

How is this procedure coded?

- 01, Biopsy Other than Primary Site
- 00 No Surgery of Primary Site and Scope of Regional Lymph Nodes, 1

97

Answer

00 No Surgery of Primary Site and Scope of Regional Lymph Nodes, 1

98

Rationale

STORE manual page 148, bullet 4

- Do not code surgical procedures which aspirate, biopsy, or remove *regional lymph nodes* in an effort to diagnose and/or stage disease in this data item. Use the data item *Scope of Regional Lymph Node Surgery* [1292] to code these procedures. Do not record the date of surgical procedures which aspirate, biopsy, or remove regional lymph nodes in the data item *Date of Surgical Diagnostic and Staging Procedure* [1280]. See instructions for *Scope of Regional Lymph Node Surgery* [1292].

Pop Quiz #6 FNA Coding

Patient presents with RUL lobe mass suspicious for lung adenocarcinoma on 3/5/19 and suspicious mediastinal lymphadenopathy on the right. Physician does an FNA on one mediastinal lymph node which returns negative for metastatic lung carcinoma.

How is this procedure coded?

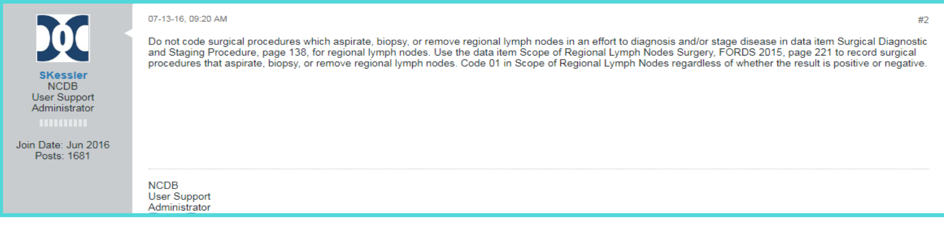
- Not Coded
- 00 No Surgery of Primary Site and Scope of Regional Lymph Nodes, 1

Answer

00 No Surgery of Primary Site and Scope of Regional Lymph Nodes, 1

Rationale

http://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/fords/initial-diagnosis/scope-of-regional-lymph-nodes/65014-do-we-code-negative-results-in-scope-of-regional-lymph-nodes



Pop Quiz #7 Primary Site

Patient presents for colon surgery on 8/1/18 and Operative Note stated Rectosigmoid Colon and the Pathology Report stated Sigmoid Colon.

How would Primary Site be coded?

- Rectosigmoid Colon
- Sigmoid Colon

Answer

Rectosigmoid Colon

Rationale

Colon
C180–C189

The prognosis of patients with colon cancer is related to the degree of penetration of the tumor through the bowel wall, the presence or absence of nodal involvement, and the presence or absence of distant metastases.

Primary Site

Priority Order for Coding Primary Site

Use the information from reports in the following priority order to code the primary site when there is conflicting information:

Resected cases
- Operative report with surgeon's description
- Pathology report
- Imaging

Polypectomy or excision without resection
- Endoscopy report
- Pathology report

Subsites

Code the subsite with the most tumor when the tumor overlaps two subsites.
Code C188 when both subsites are equally involved.

https://seer.cancer.gov/manuals/2018/appendixc.html

Pop Quiz #8 Circumferential Resection Margin (CRM)

Patient presents for right hemicolectomy and is diagnosed with adenocarcinoma .7cm, invades muscularis propria. All margins negative.

How is the CRM SSDI coded?

- XX.9; Not documented in medical record CRM margin not assessed
- XX.1; Margins clear, distance from tumor not stated CRM margin negative

Answer

XX.9; Not documented in medical record CRM margin not assessed

Rationale

Coding guidelines

- Code 0.0 is for positive margins
- Codes 0.1-99.9 is for coding the exact measurement in millimeters of the negative margin
- Code XX.0 for margins described as greater than 100 mm
- Code XX.1 when the margin is stated as clear, but the distance is not available
- Code XX.2 when the margins cannot be assessed
- Codes XX.3-XX.6 is for when the pathology uses "at least" categories
- Code XX.7 when there is no surgical resection of the primary site
- Code XX.9 when
    - Not documented in the medical record
    - CRM is not evaluated (assessed)
    - Unknown if CRM is evaluated (assessed)

https://www.naaccr.org/SSDI/SSDI-Manual .pdf?v=1527608547

Pop Quiz #9 CRM Margin

Patient presents for right hemicolectomy and is diagnosed with adenocarcinoma .7cm, invades muscularis propria. Tumor is .2cm from distal margin, .1cm from proximal margin, and .6cm from mesenteric margin. **How is CRM SSDI coded?**

- XX.9; Not documented in medical record CRM margin not assessed
- 0.6

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Answer

0.6

110

NAACCR

Rationale

https://www.naaccr.org/SSDI/SSDI-Manual.pdf?v=1527608547

Definition

The CRM, also referred to as the radial margin or the mesenteric resection margin, is the measurement of the distance from the deepest invasion of the tumor to the margin of resection in the retroperitoneum or mesentery. In other words, the CRM is the width of the surgical margin at the deepest part of the tumor in an area of the large intestine or rectum without serosa (non-peritonealized rectum below the peritoneal reflection) or only partly covered by serosa (upper rectum, posterior aspects of ascending and descending colon).

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Pop Quiz #10 What is the Histology?

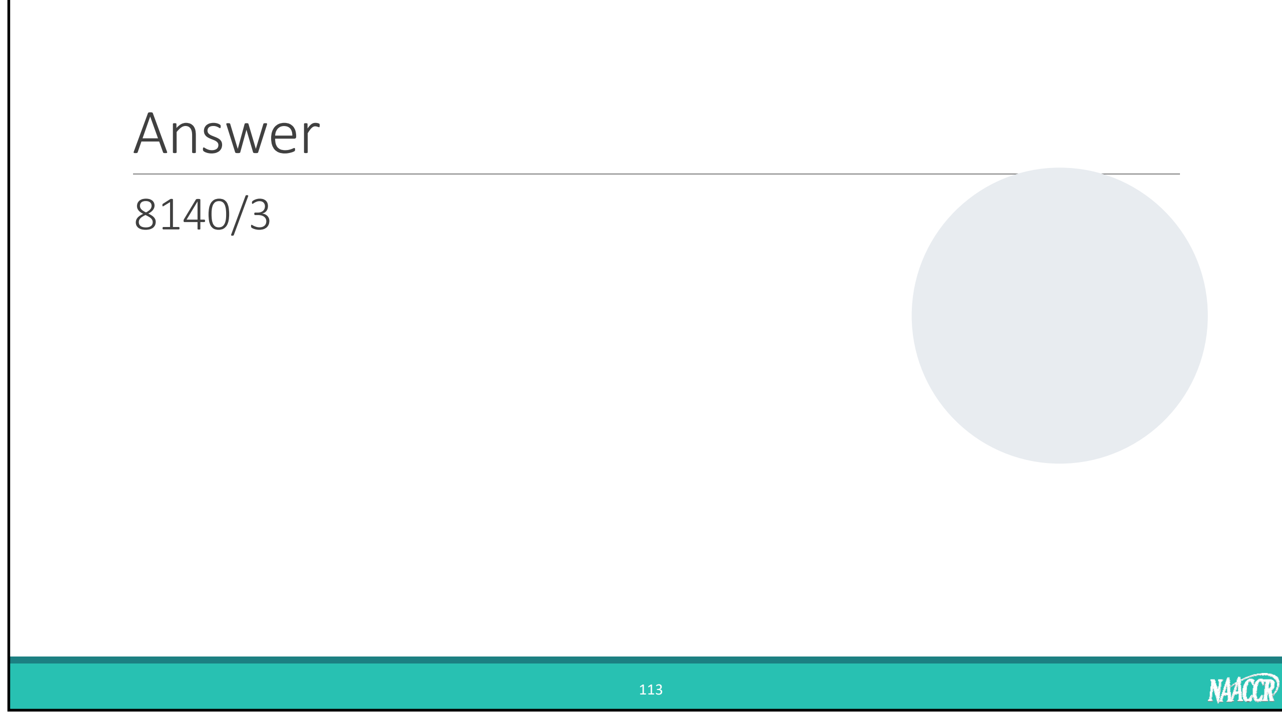
9-14-2018 presents for Right hemicolectomy, Scans showed no metastatic disease, Path: 3.5 well differentiated adenocarcinoma with mucinous differentiation at the anastomotic site: invades muscularis

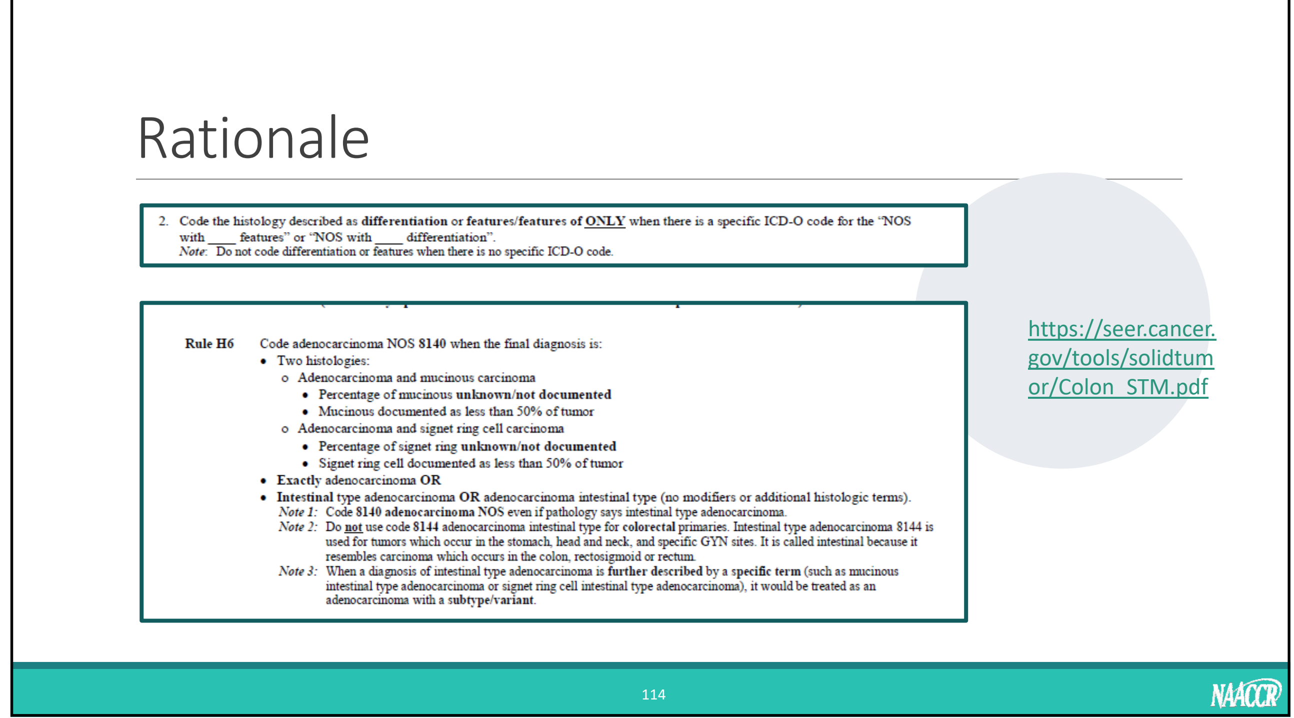
What is the histology coded?

8140/3 Adenocarcinoma

8480/3 Mucinous Adenocarcinoma

112 NAACCR





2. Code the histology described as **differentiation** or **features/features of ONLY** when there is a specific ICD-O code for the "NOS with ____ features" or "NOS with ____ differentiation".
Note: Do not code differentiation or features when there is no specific ICD-O code.

Rule H6 Code adenocarcinoma NOS 8140 when the final diagnosis is:

- Two histologies:
  - Adenocarcinoma and mucinous carcinoma
    - Percentage of mucinous **unknown/not documented**
    - Mucinous documented as less than 50% of tumor
  - Adenocarcinoma and signet ring cell carcinoma
    - Percentage of signet ring **unknown/not documented**
    - Signet ring cell documented as less than 50% of tumor
- **Exactly** adenocarcinoma **OR**
- **Intestinal** type adenocarcinoma **OR** adenocarcinoma intestinal type (no modifiers or additional histologic terms).

Note 1: Code **8140 adenocarcinoma NOS** even if pathology says intestinal type adenocarcinoma.

Note 2: Do **not** use code **8144** adenocarcinoma intestinal type for **colorectal** primaries. Intestinal type adenocarcinoma 8144 is used for tumors which occur in the stomach, head and neck, and specific GYN sites. It is called intestinal because it resembles carcinoma which occurs in the colon, rectosigmoid or rectum.

Note 3: When a diagnosis of intestinal type adenocarcinoma is **further described** by a **specific term** (such as mucinous intestinal type adenocarcinoma or signet ring cell intestinal type adenocarcinoma), it would be treated as an adenocarcinoma with a **subtype/variant**.

Pop Quiz #11 CEA

Patient had polypectomy which showed adenocarcinoma of the sigmoid colon 3/17/19 and had a CEA performed 3/18/19 which was 7ng/ml. Patient had sigmoid colectomy on 4/15/19 and it showed 1.4cm moderately differentiated adenocarcinoma. Post op CEA was 3ng/ml. What is the Pretreatment CEA Lab Value?

- 7.0
- XXXX.9

115 NAACCR

Answer

XXXX.9

116 NAACCR

Rationale

Coding Instructions and Codes

Note 1: Physician statement of CEA (Carcinoembryonic Antigen) Pretreatment Lab Value can be used to code this data item when no other information is available.

Note 2: Record the lab value of the highest CEA test result documented in the medical record prior to treatment or polypectomy. The lab value may be recorded in a lab report, history and physical, or clinical statement in the pathology report.

Note 3: CEA is a tumor marker that has value in the management of certain malignancies.

Note 4: Record to the nearest tenth in nanograms/milliliter (ng/ml) the highest CEA lab value documented in the medical record prior to treatment or polypectomy.

- *Example:* Code a pretreatment CEA of 7 ng/ml as 7.0.

Note 5: Record 0.1 when the lab results are stated as less than 0.1 ng/ml with no exact value.

https://www.naaccr.org/SSDI/SSDI-Manual.pdf?v=1527608547

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Pop Quiz #12 Microsatellite Instability (MSI)

Immunohistochemical stains on the colonic adenocarcinoma demonstrate the presence of MLH1, PMS2, MSH2 and MSH6 protein expression.
Interpretation: Mismatch Repair Protein Panel ABNORMAL

How is the SSDI for MSI coded?

- 9, Not documented in medical record/MSI-indeterminate/Microsatellite instability no assessed or unknown if assessed
- 2, MSI unstable high (MSI-H) AND/OR MMR-D (loss of nuclear expression of one of more MMR proteins, MMR protein deficient)

118 NAACCR

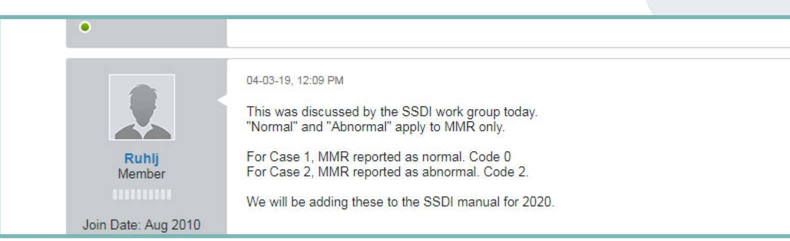
Answer

2, MSI unstable high (MSI-H) AND/OR MMR-D (loss of nuclear expression of one of more MMR proteins, MMR protein deficient)

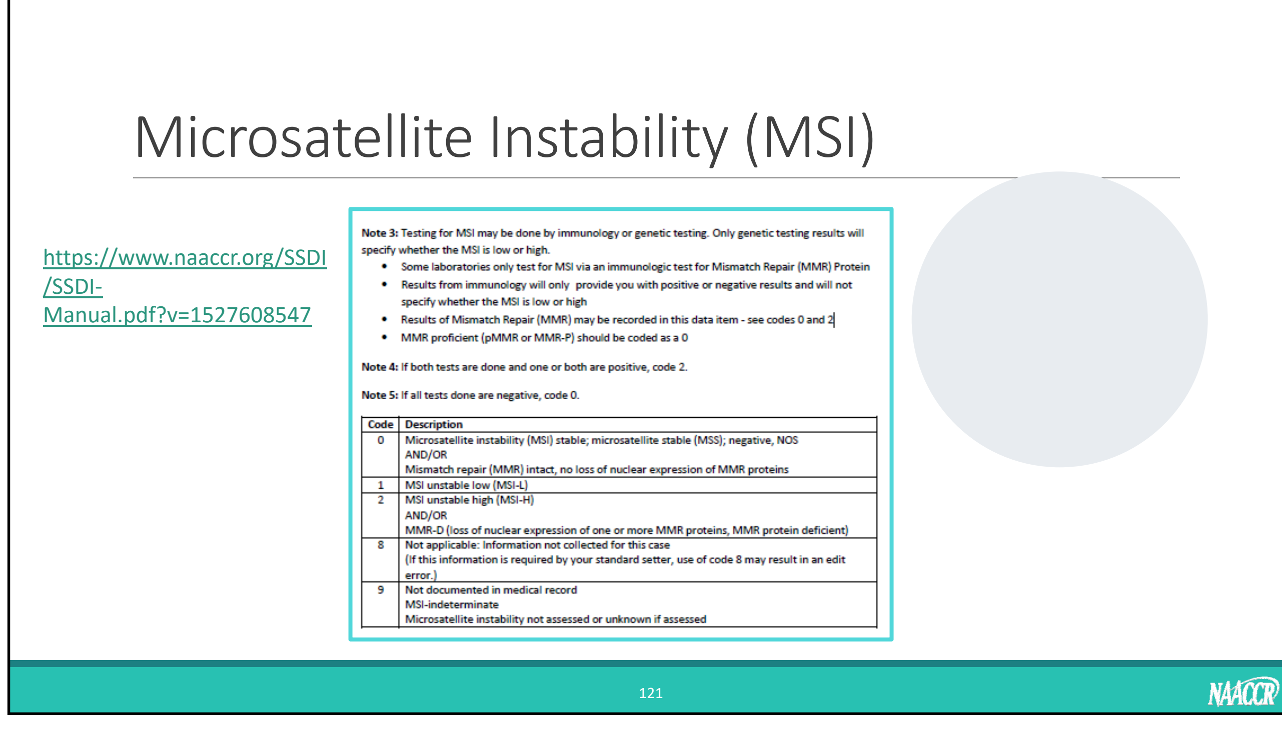
119

Rationale

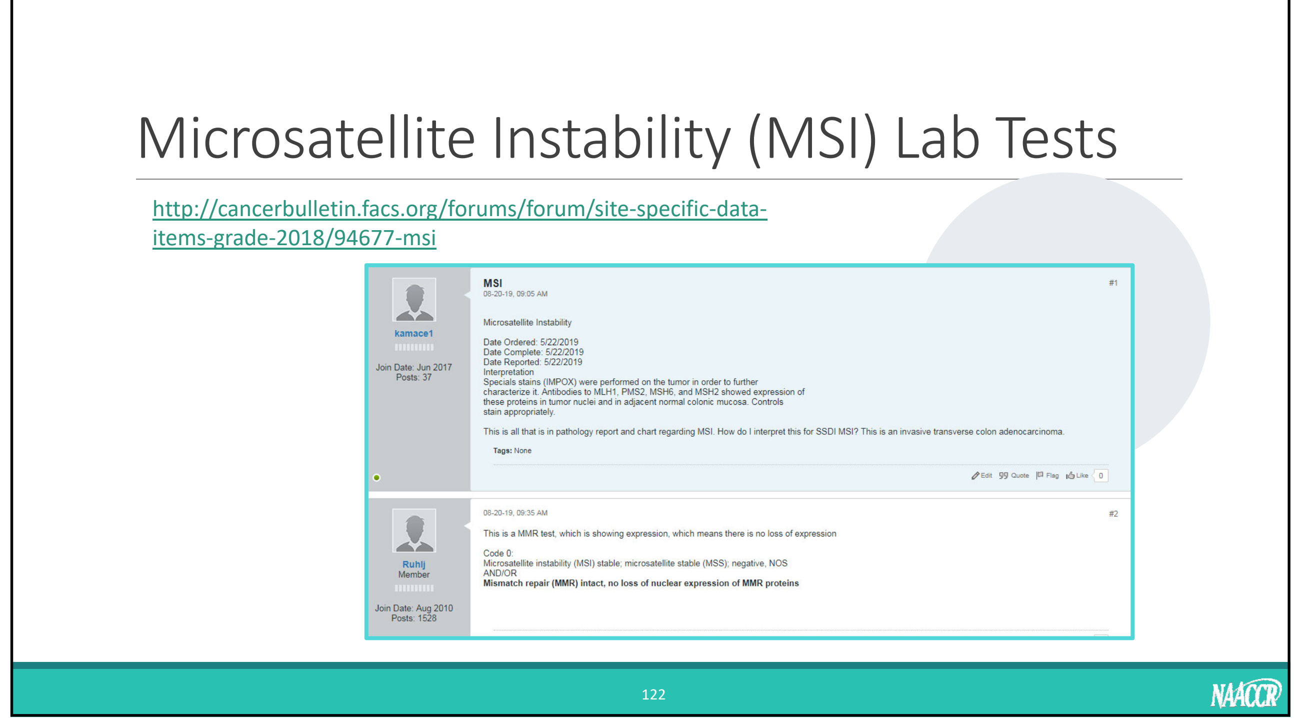
http://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/82942-msi-and-mmr-tests



120



Code	Description
0	Microsatellite instability (MSI) stable; microsatellite stable (MSS); negative, NOS AND/OR Mismatch repair (MMR) intact, no loss of nuclear expression of MMR proteins
1	MSI unstable low (MSI-L)
2	MSI unstable high (MSI-H) AND/OR MMR-D (loss of nuclear expression of one or more MMR proteins, MMR protein deficient)
8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code 8 may result in an edit error.)
9	Not documented in medical record MSI-indeterminate Microsatellite instability not assessed or unknown if assessed



Pop Quiz #13 Histology

Patient has a polypectomy performed on 4/17/19 which showed invasive adenocarcinoma in an adenomatous polyp. What would the histology be coded?

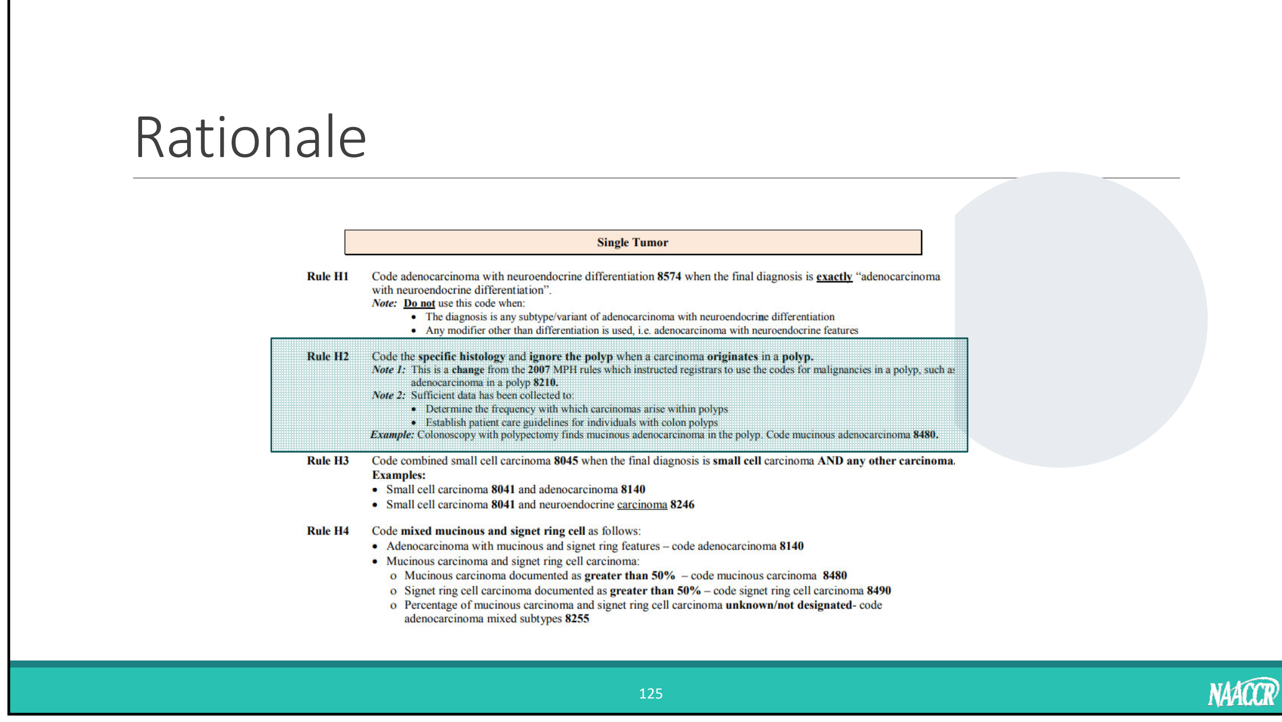
- 8210/3 Adenocarcinoma in adenomatous polyp
- 8140/3 Adenocarcinoma

123 NAACCR

Answer

8140/3

124 NAACCR



Rationale

Single Tumor

Rule H1 Code adenocarcinoma with neuroendocrine differentiation **8574** when the final diagnosis is **exactly** "adenocarcinoma with neuroendocrine differentiation".
Note: **Do not** use this code when:
- The diagnosis is any subtype/variant of adenocarcinoma with neuroendocrine differentiation
- Any modifier other than differentiation is used, i.e. adenocarcinoma with neuroendocrine features

Rule H2 Code the **specific histology** and **ignore the polyp** when a carcinoma **originates** in a **polyp.**
Note 1: This is a **change** from the **2007** MPH rules which instructed registrars to use the codes for malignancies in a polyp, such as adenocarcinoma in a polyp **8210.**
Note 2: Sufficient data has been collected to:
- Determine the frequency with which carcinomas arise within polyps
- Establish patient care guidelines for individuals with colon polyps

Example: Colonoscopy with polypectomy finds mucinous adenocarcinoma in the polyp. Code mucinous adenocarcinoma **8480.**

Rule H3 Code combined small cell carcinoma **8045** when the final diagnosis is **small cell** carcinoma **AND any other carcinoma.**
Examples:
- Small cell carcinoma **8041** and adenocarcinoma **8140**
- Small cell carcinoma **8041** and neuroendocrine carcinoma **8246**

Rule H4 Code **mixed mucinous and signet ring cell** as follows:
- Adenocarcinoma with mucinous and signet ring features – code adenocarcinoma **8140**
- Mucinous carcinoma and signet ring cell carcinoma:
  - Mucinous carcinoma documented as **greater than 50%** – code mucinous carcinoma **8480**
  - Signet ring cell carcinoma documented as **greater than 50%** – code signet ring cell carcinoma **8490**
  - Percentage of mucinous carcinoma and signet ring cell carcinoma **unknown/not designated**- code adenocarcinoma mixed subtypes **8255**

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Pop Quiz #14 Staging

Patient has left colectomy which shows invasive adenocarcinoma with invasion through muscularis propria into pericolorectal tissues. There are 0/12 lymph nodes involved. There are tumor deposits in the nonperitonealized pericolic tissues. What is the pN category for this patient?

- pN0
- pN1c

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NAACCR

Answer

pN1c

Rationale

AJCC Staging Manual 8th ed.

- pN1c – No regional lymph nodes are positive, but there are tumor deposits in the
  - Subserosa
  - Mesentery
  - Or nonperitonealized pericolic, or perirectal/mesorectal tissues

Pop Quiz #15 Staging

CT scan of Abdomen and Pelvis 3/12/19 which showed 1.2cm transverse colon that extends into surrounding pericolonic tissues. There are pathologically enlarged pericolic lymph nodes consistent with involvement. There is also right lung metastasis and liver metastasis seen on CT. Patient has liver biopsy performed on 3/14/19 which shows adenocarcinoma consistent with metastasis from colon primary.

What is the clinical M category?

- cM1 Metastasis to one or more distant sites or organs or peritoneal metastasis is identified
- pM1b Metastasis to two or more sites or organs is identified without peritoneal metastasis

Answer

pM1b Metastasis to two or more sites or organs is identified without peritoneal metastasis

Rationale

Use of pM1 for multiple distant metastases pM1 In patients who have distant metastases in multiple sites and have a cancer type for which M subcategories distinguish between one or more metastatic sites, microscopic evidence of one of these sites is necessary to assign the higher pM subcategory. In general, metastases to both sides of a paired organ are considered a single metastatic site of involvement (e.g., metastases to both lungs are designated metastasis to one distant site—lung). If clinical evidence of distant metastasis remains in other areas that are not or cannot be microscopically confirmed, cM1 is assigned.

Amin, Mahul B.; Gress, Donna M.; Meyer Vega, Laura R.; Edge, Stephen B.. AJCC Cancer Staging Manual, Eighth Edition (Page 36). American College of Surgeons. Kindle Edition

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Pop Quiz #16 Staging

CT scan of Abdomen and Pelvis 3/12/19 which showed 1.2cm transverse colon that extends into surrounding pericolonic tissues. There are pathologically enlarged pericolic lymph nodes consistent with involvement. There is also right lung metastasis and liver metastasis seen on CT. Patient has liver biopsy performed on 3/14/19 which shows adenocarcinoma consistent with metastasis from colon primary. Clinical stage is cT3 cN1 pM1b. **What is the pathologic stage?**

- cT3 cN1 pM1b
- pT blank pN blank pM1b

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Answer

cT3 cN1 pM1b

133

Rationale

pM1 may be used for both clinical and pathological Stage IV pM1 A patient may be staged as both clinical and pathological Stage IV if there is: • confirmatory microscopic evidence of a distant metastatic site during the diagnostic workup, which is categorized as pM1, and • T and N may be categorized only clinically. Example: cT3 cN1 pM1 clinical Stage IV, and cT3 cN1 pM1 pathological Stage IV

Amin, Mahul B.; Gress, Donna M.; Meyer Vega, Laura R.; Edge, Stephen B.. AJCC Cancer Staging Manual, Eighth Edition (Page 41). American College of Surgeons. Kindle Edition.

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Pop Quiz #17 Date of 1st Contact

Patient was diagnosed at an outside facility with thyroid carcinoma on 1/15/19 . Patient comes to your facility on 1/20/19 for lab tests and ultrasound, and has Total Thyroidectomy on 1/22/19.

What is the Date of 1st Contact?

- 1/20/19
- 1/22/19

135

Answer

1/22/19

136

Rationale

STORE page 18 & 128

Description

Date of first contact with the reporting facility for diagnosis and/or treatment of this cancer.

The *Date of First Contact* [580] is the date of the facility's first inpatient or outpatient contact with the patient for diagnosis or treatment of the cancer. 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.

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Pop Quiz #18 Pelvis Radiation

Patient presents with Endometrial Cancer of the Uterus in 2018 and received 4500 cGy to the Pelvis in 25 Fractions using 6MV. No TAH/BSO performed.

How is the treatment volume coded?

- 71 Uterus or Cervix
- 86 Pelvis

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Answer

71 Uterus or Cervix

86	Pelvis (NOS, non-visceral)	The treatment volume is directed at a primary tumor of the pelvis, but the primary sub-site is not a pelvic organ or is not known or indicated. For example, this code should be used for sarcomas arising from the pelvis.

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Pop Quiz #19 Draining Lymph Nodes

Patient presents with Endometrial Cancer of the Uterus in 2018 and received 4500 cGy to the Pelvis in 25 Fractions using 6MV.

How are the draining lymph nodes coded?

- 00, No Radiation to Draining Lymph Nodes
- 06, Pelvic Lymph Nodes

140 NAACCR

Answer

06, Pelvic Lymph Nodes

141

Rationale

http://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/fords/first-course-of-treatment/radiation/81765-coding-cervical-cancer-radiation-tx-2018

Phase I Radiation: Whole pelvis
Phase I Primary Treatment Volume (1504) - 71: Uterus or Cervix
Phase I to Draining Lymph Nodes (1505) - 06: Pelvic lymph nodes
Phase I Treatment Modality (1506) - 02: External beam, photons
Phase I External Beam Planning Technique (1502) - 04: Conformal or 3D conformal therapy
Phase I Dose Per Fraction (cGy) (1501) - 00180
Phase I Number of Fractions (1503) - 025
Phase I Total Dose (cGy) (1507) - 004500

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Pop Quiz #20 Pelvis Radiation

Patient has a prostatectomy and was then treated with 4 field conformal 4500 cGy 15Mv photons to the Pelvis. **What is the treatment volume coded?**

- 64 Prostate
- 86 Pelvis

143

Answer

86 Pelvis

144

Rationale

CTR Guide to Coding Radiation Therapy Treatment in the STORE

https://www.facs.org/~/media/files/quality%20programs/cancer/ncdb/case_studies_coding_radiation_treatment.ashx

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Pop Quiz #21 Thyroid Radiation

Scenario: 37-year-old female diagnosed with T2 N0 M0 Follicular carcinoma in 2018 and treated with Thyroidectomy and a single injection of 150 millicuries of I-131.

Question: How would you code Phase 1 Radiation Primary Treatment Volume?

- 26 Thyroid
- 93 Whole Body
- 98 Other

146

Answer

98 Other

NCDB: The Corner STORE Online April 4, 2019 https://www.facs.org/quality-programs/cancer/news/corner-store-040419

STORE Data Item Clarification: I-131 for Thyroid As referenced in page 10 of the *CTR Guide to Coding Radiation Therapy Treatment in the STORE* (Version 1.0).

147 NAACCR

Rationale

 # 3 Thyroid Cancer Treated with Radioiodine

Clinical

- Thirty-seven-year-old female
- Painless lump in her right lower neck (level VI)
- Ultrasound guided needle biopsy
- Follicular carcinoma, clinical T1bN0M0.

Treatment

- Thyroidectomy, pathologic T2N0M0
- Radiation treatment is delivered with a single injection of 150 millicuries of radioiodine (I-131) on August 7.

Seg	#	Field	Code/Definition
Summary	1	Rad/Surg Sequence	3 Radiation after surgery
	2	Reason No Rad	0 Radiation was administered
	3	Location of Rad	1 All RT at this facility
	4	Date Started/Flag	08/07/2018
	5	Date Finished/Flag	08/07/2018
	6	Number of Phases	01
	7	Discontinued Early	01 Completed
	8	Total Dose	999998
Phase 1	9	Volume	98 Other
	10	Rad to Nodes	00 No RT to draining nodes
	11	Modality	13 Radioisotopes, NOS
	12	Planning Technique	88 Not applicable
	13	Number of Fractions	1
	14	Dose per Fraction	99998
	15	Total Phase 1 Dose	99998
e 2	16	Volume	
	17	Rad to Nodes	
	18	Modality	

https://www.facs.org/-/media/files/quality-programs/cancer/ncdb/case_studies_coding_radiation_treatment.ashx

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Pop Quiz #22 Class of Case

Hospital A: 1/1/11 DX w/prostate CA, First course of treatment is hormone, Started Lupron.
Hospital B: 1/1/19 New consult, prostate CA DX in 2011 and started hormone treatment at Hospital A. Will continue hormone, script written.
Hospital B: 4/1/19 Pt on Lupron

How would you code Class of Case?

21 Initial diagnosis elsewhere AND part of first course treatment was done at the reporting facility; part of first course treatment was done elsewhere.

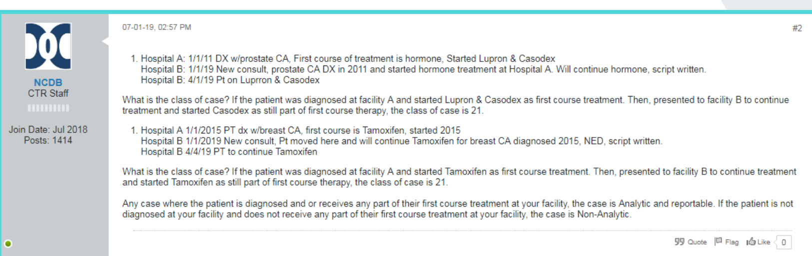
31 Initial diagnosis and all first course treatment elsewhere AND reporting facility provided intransit care; or hospital provided care that facilitated treatment elsewhere (for example, stent placement)

NAACCR

Answer

21 Initial diagnosis elsewhere AND part of first course treatment was done at the reporting facility; part of first course treatment was done elsewhere.

http://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/store/case-eligibility-patient-identification-cancer-identification-stage-of-disease-at-diagnosis-tumor-size-and-mets/92838-analytic-vs-non-analytic


NCDB
CTR Staff
Join Date: Jul 2018
Posts: 1414

07-01-19, 02:57 PM #2

1. Hospital A: 1/1/11 DX w/prostate CA, First course of treatment is hormone, Started Lupron & Casodex
   Hospital B: 1/1/19 New consult, prostate CA DX in 2011 and started hormone treatment at Hospital A. Will continue hormone, script written.
   Hospital B: 4/1/19 Pt on Luprron & Casodex

What is the class of case? If the patient was diagnosed at facility A and started Lupron & Casodex as first course treatment. Then, presented to facility B to continue treatment and started Casodex as still part of first course therapy, the class of case is 21.

1. Hospital A 1/1/2015 PT dx w/breast CA, first course is Tamoxifen, started 2015
   Hospital B 1/1/2019 New consult, Pt moved here and will continue Tamoxifen for breast CA diagnosed 2015, NED, script written.
   Hospital B 4/4/19 PT to continue Tamoxifen

What is the class of case? If the patient was diagnosed at facility A and started Tamoxifen as first course treatment. Then, presented to facility B to continue treatment and started Tamoxifen as still part of first course therapy, the class of case is 21.

Any case where the patient is diagnosed and or receives any part of their first course treatment at your facility, the case is Analytic and reportable. If the patient is not diagnosed at your facility and does not receive any part of their first course treatment at your facility, the case is Non-Analytic.

Quote Flag Like 0

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T suffix Thyroid

Remember that T Suffix is **required** for Thyroid Cancer, and cannot be blank.

If patient has a clinical stage, make sure that clinical T Suffix is completed.

If patient has a pathologic stage, make sure that pathologic T Suffix is completed.

Code	Label
(blank)	No information available; not recorded
(m)	Multiple synchronous tumors OR Multifocal tumor (differentiated and anaplastic thyroid only)
(s)	Solitary tumor (differentiated and anaplastic thyroid only)

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Pop Quiz #23 Kidney SSDI Ipsilateral Adrenal Gland Involvement

Patient has a partial nephrectomy and adrenal gland was not removed. The pathology report states clear cell adenocarcinoma. Adrenal Gland present: no

How is the SSDI for Ipsilateral Adrenal Gland Involvement coded?

- Code 0: There is no involvement of the ipsilateral adrenal gland
- Code 9 when There is no documentation in the medical record Clinical diagnosis only Evaluation of ipsilateral adrenal gland involvement not done or unknown if done

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Answer

Code 9 when There is no documentation in the medical record Clinical diagnosis only Evaluation of ipsilateral adrenal gland involvement not done or unknown if done

https://www.naaccr.org/SSDI/SSDI-Manual.pdf?v=1527608547

Coding Instructions and Codes

Note 1: Physician statement of Ipsilateral Adrenal Gland Involvement can be used to code this data item.

Note 2: Information about contiguous ipsilateral adrenal gland involvement is collected in primary tumor, and discontiguous ipsilateral adrenal gland involvement is collected in distant metastasis, as elements in anatomic staging. This information is also collected in this field as it may have an independent effect on prognosis.

Note 3: Record ipsilateral adrenal gland involvement as documented in the pathology report.

Note 4: Do not use imaging findings to code this data item.

Note 5: Code 9 if surgical resection of the primary site is performed and there is no mention of ipsilateral adrenal gland involvement.

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Thank you!

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