Abstracting and Coding Boot Camp: Cancer Case Scenarios

2019-2020 NAACCR WEBINAR SERIES

2

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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.

3

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Fabulous Prizes

4

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Agenda

Quiz 1
Quiz 2
Big Picture Abstracting
Quiz 3
Quiz 4
Using Canswer Forum/SEER Inquiry System
Review of Take Home Quiz

5

Quiz 1

COMPLETE QUIZ

REVIEW ANSWERS

6

Quiz 2

COMPLETE QUIZ

REVIEW ANSWERS

7

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Big Picture Abstracting

From Patient-to-Payment,℠ nThrive empowers health care for every one in every community.®

Big Picture Abstracting

NAACCR Webinar Series: 2020 Abstracting Bootcamp

Marla Cole, CTR, Registry Education Supervisor

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Objectives

- Define “Big Picture Abstracting”
- Big Picture resources
- Convey Source of Standard importance
- Demonstrate how the Rationale and Description informs our understanding
- Identify data items that relate to one another and how being aware of these relationships informs our coding decisions

9

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What is Big Picture Abstracting?

Big Picture Abstracting is understanding:

- The data item’s rationale
  - How researchers and others use the data item
    - How certain data items work together
      - Who the Source of Standard is

Who What Why How

10

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Why is the Big Picture important?

PATIENT'S ABSTRACT = PATIENT'S CANCER STORY

BIG PICTURE ABSTRACTING = FULLY INFORMED CODING

CANCER SURVEILLANCE COMMUNITY INTENT

11

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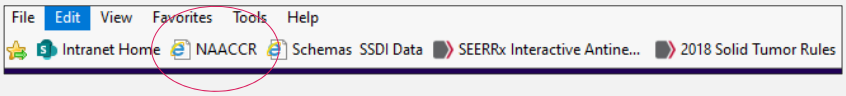
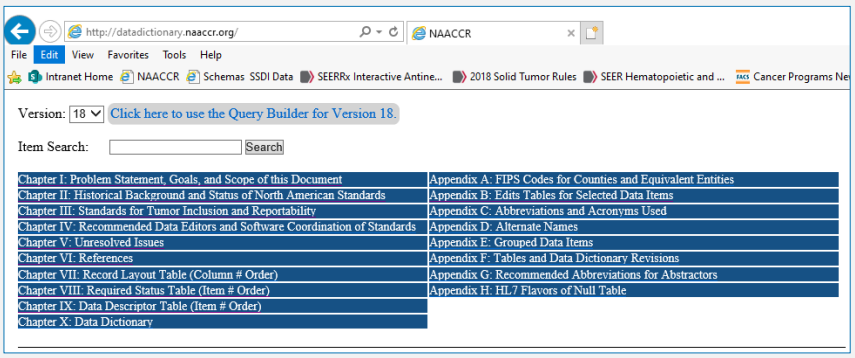
NAACCR Data Standards and Data Dictionary





13

A Bit of Cancer Surveillance History

THE PROBLEM
CONFLICTING STANDARDS

Late 1980's: Efforts to combine data = problems due to lack of data standardization

Example: data item names and intent supposed to be the same but registries and/or software companies varied in their definitions and codes

14

A Bit of Cancer Surveillance History

THE SOLUTION
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15

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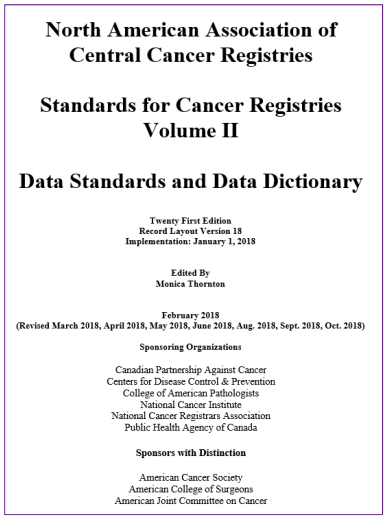
The Solution
NAACCR Standards for Cancer Registries

Goal of Document

Define NAACCR cancer registration data standards for use by central registries, hospital-based registries, and other groups in North America to abstract cancer diagnosed on or after January 1, 2018.

Objectives of standardization effort, and NAACCR standards document, are to:

- Provide a comprehensive reference to ensure uniform data collection
- Reduce the need for redundant coding and data recording between agencies
- Facilitate the collection of comparable data among groups
- Provide a resource document to help registries that are establishing or revising their databases



North American Association of Central Cancer Registries

Standards for Cancer Registries Volume II

Data Standards and Data Dictionary

Twenty First Edition
Record Layout Version 18
Implementation: January 1, 2018

Edited By
Monica Thornton

February 2018
(Revised March 2018, April 2018, May 2018, June 2018, Aug. 2018, Sept. 2018, Oct. 2018)

Sponsoring Organizations

Canadian Partnership Against Cancer
Centers for Disease Control & Prevention
College of American Pathologists
National Cancer Institute
National Cancer Registrars Association
Public Health Agency of Canada

Sponsors with Distinction

American Cancer Society
American College of Surgeons
American Joint Committee on Cancer

16

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The Solution – Part Deux
NAACCR Standards Volume II

NAACCR North American Association of Central Cancer Registries

Goal of Document

Who:
This document will be used by new and existing facility-based and central cancer registries

Why:
To ensure that their program's standard definitions and codes are consistent with those used by regional and national databases.

Other potential users include registry software providers and those using registry data, especially if they are combining data from multiple sources or exchanging data. National standard-setting groups, such as CoC, CDC, NAACCR, NCI and the Canadian Council of Cancer Registries (CCCR) also will benefit.

17

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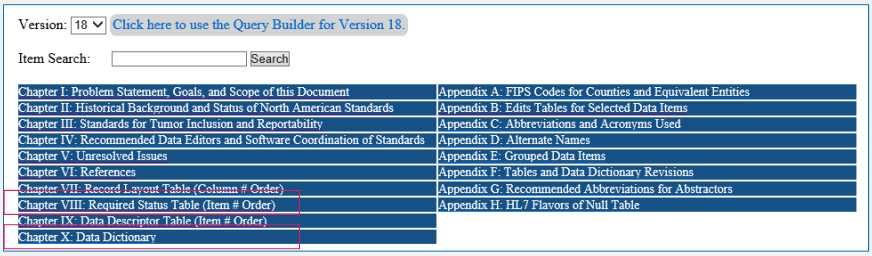
Back to our regularly scheduled programming

Big Picture Resources

NAACCR Data Standards and Data Dictionary Chapters VIII and X



19

NAACCR Data Dictionary

Chapter VIII – Required Status Table

Item #	Item Name	NPCR	CoC		SEER		CCCR		Source of Standard	Note
		Collect	Collect	Transmit	Collect	Transmit	Collect	Transmit		
10	Record Type	R	.	R	.	R	R	R	NAACCR	
20	Patient ID Number	R	.	.	R	R	R*	R*	Reporting Registry	
21	Patient System ID-Hosp	.	.	.	.	.	.	.	NAACCR	
30	Registry Type	.	.	.	.	.	.	.	NAACCR	
35	FIN Coding System									Retired
37	Reserved 00									
40	Registry ID	R	.	.	R	R	R	R	NAACCR	
45	NPI--Registry ID	.	.	.	R*	.	.	.	CMS	
50	NAACCR Record Version	R	.	R	R	R	.	.	NAACCR	
60	Tumor Record Number	.	.	.	S	S	R*	R*	NAACCR	
70	Addr at DX--City	R	R	R	R	.	R*	R*	CoC	

20

NAACCR Data Dictionary

Chapter VIII – Required Status Table

Item #	Item Name	NPCR	CoC		SEER		CCCR		Source of Standard	Note
		Collect	Collect	Transmit	Collect	Transmit	Collect	Transmit		
10	Record Type	R	.	R	.	R	R	R	NAACCR	
20	Patient ID Number	R	.	.	R	R	R*	R*	Reporting Registry	
21	Patient System ID-Hosp	.	.	.	.	.	.	.	NAACCR	
30	Registry Type	.	.	.	.	.	.	.	NAACCR	
35	FIN Coding System									Retired
37	Reserved 00									
40	Registry ID	R	.	.	R	R	R	R	NAACCR	
45	NPI--Registry ID	.	.	.	R*	.	.	.	CMS	
50	NAACCR Record Version	R	.	R	R	R	.	.	NAACCR	
60	Tumor Record Number	.	.	.	S	S	R*	R*	NAACCR	
70	Addr at DX--City	R	R	R	R	.	R*	R*	CoC	

21

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NAACCR Data Dictionary

Chapter VIII – Required Status Table

Item #	Item Name	NPCR	CoC		SEER		CCCR		Source of Standard	Note
		Collect	Collect	Transmit	Collect	Transmit	Collect	Transmit		
10	Record Type	R	.	R	.	R	R	R	NAACCR	
20	Patient ID Number	R	.	.	R	R	R*	R*	Reporting Registry	
21	Patient System ID-Hosp	.	.	.	.	.	.	.	NAACCR	
30	Registry Type	.	.	.	.	.	.	.	NAACCR	
35	FIN Co									Retired
37	Reserv									
40	Registry ID	R	.	.	R	R	R	R	NAACCR	
45	NPI--Registry ID	.	.	.	R*	.	.	.	CMS	
50	NAACCR Record Version	R	.	R	R	R	.	.	NAACCR	
60	Tumor Record Number	.	.	.	S	S	R*	R*	NAACCR	
70	Addr at DX--City	R	R	R	R	.	R*	R*	CoC	

For each data item, Chapters VIII and X list a 'Source of Standard,' and the documentation from this source should be consulted for coding rule standards."

22

Chapter I - NAACCR Standards for Cancer Registries Volume II Data Standards and Data Dictionary (21st edition)

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Reporting Manual Discrepancies

Contact your central registry

Contact NAACCR info@naaccr.org

23

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NAACCR Data Dictionary – Source of Standard

Birthplace State and Birthplace Country

Patient born in Korea (not specified as north or south).

Ask yourself two questions:

1. Who is the Source of Standard?
2. What manual(s) should be used as reference to determine the correct codes?

Who is the Source of Standard?
CoC
CDC
NAACCR
SEER

24

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NAACCR Data Dictionary – Source of Standard

Birthplace State and Birthplace Country

Patient born in Korea (not specified as north or south).

Who is the Source of Standard?

Item #	Item Name	NPCR	CoC		SEER		CCCR		Source of Standard	Note
		Collect	Collect	Transmit	Collect	Transmit	Collect	Transmit		
252	Birthplace--State	R*	R	R	R	R	R	R	NAACCR	Revised
254	Birthplace--Country	R*	R	R	R	R	R	R	NAACCR	Revised

25

Birthplace - Country

BIRTHPLACE--COUNTRY **Revised**

Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
254	3	NAACCR	2013	13			472 - 474

Alternate Name:	
XML NAACCR ID:	birthplaceCountry
PARENT XML ELEMENT:	Patient

Description
Code for the country in which the patient was born. If the patient has multiple tumors, all records should contain the same code. This data item became part of the NAACCR transmission record effective with Volume II, Version 13 in order to include country and state for each geographic item and to use interoperable codes. It supplements the item BIRTHPLACE--STATE [252]. These two data items are intended to replace the use of BIRTHPLACE [250].

Rationale
Place of Birth is helpful for patient matching and can be used when reviewing race and ethnicity. It is an important item in algorithms for imputing race and ethnicity. In addition, adding birthplace data to race and ethnicity allows for a more specific definition of the population being reported. Careful descriptions of ancestry, birthplace, and immigration history of populations studied are needed to make the basis for classification into ethnic groups clear. Birthplace has been associated with variation in genetic, socioeconomic, cultural, and nutritional characteristics that affect patterns of disease. A better understanding of the differences within racial and ethnic categories also can help states develop effective, culturally-sensitive public health prevention programs to decrease the prevalence of high-risk behaviors and increase the use of preventive services.

26

Birthplace - Country

Codes

Custom codes for historic use only

ZZN	North America NOS
ZZC	Central American NOS
ZZS	South America NOS
ZZP	Pacific NOS
ZZE	Europe NOS
ZZF	Africa NOS
ZZA	Asia NOS
ZZX	Non-US NOS
ZZU	Unknown

Custom codes for historic use only

XNI	North American Islands
XCB	Other Caribbean Islands
XEN	England, Channel Islands, Isle of Man
XSC	Scandinavia
XGR	Germanic Countries
XSL	Slavic Countries
CSK	Czechoslovakia (former)
YUG	Yugoslavia (former)
XUM	Ukraine and Moldova
XNF	North Africa
XSD	Sudanese Countries
XWF	West Africa
XSF	South Africa
XEF	East Africa
XIF	African Islands
XET	Ethiopia and Eritrea
XAP	Arabian Peninsula
XIS	Israel and Palestine

XCR	Caucasian Republics of former USSR
XOR	Other Asian Republics of former USSR
XSE	Southeast Asia
XMS	Malaysia, Singapore, Brunei
XCH	China, NOS
XML	Melanesian Islands
XMC	Micronesian Islands
XPL	Polynesian Islands

See Appendix B for numeric and alphabetic lists of places and codes (also see Appendix B of the *SEER Program Code Manual* at seer.cancer.gov/tools/codingmanuals/index.html).

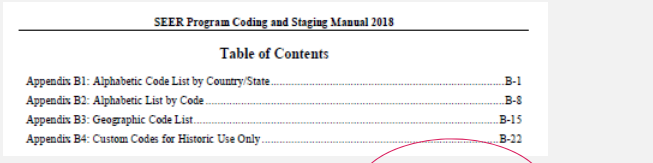
27

NAACCR Data Dictionary – Source of Standard

Birthplace State and Birthplace Country – Quiz Question #3

What are the correct Birthplace Country and Birthplace State codes for a patient born in Korea, NOS (country/state)?

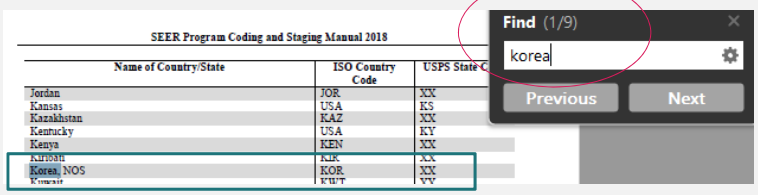
SEER Program Coding and Staging Manual Appendix B



SEER Program Coding and Staging Manual 2018

Table of Contents

Appendix B1: Alphabetic Code List by Country/State B-1
Appendix B2: Alphabetic List by Code B-8
Appendix B3: Geographic Code List B-15
Appendix B4: Custom Codes for Historic Use Only B-22



SEER Program Coding and Staging Manual 2018

Name of Country/State	ISO Country Code	USPS State C
Jordan	JOR	XX
Kansas	USA	KS
Kazakhstan	KAZ	XX
Kentucky	USA	KY
Kenya	KEN	XX
Kiribati	KIR	XX
Korea, NOS	KOR	XX
Kuwait	KWT	XX

Find (1/9)

korea

Previous Next

28

What if you had used the STORE manual?

Appendix D has a list of all country codes and corresponding state codes. State codes for all U.S. states and possessions and all Canadian provinces are included in Appendix D. State codes for the United States and its possessions are those used by the United States Postal Service. Canadian province or territory codes are from Canada Post sources. Country codes are based on the International Standards Organization (IS) 3166-1 Country Three Character Codes. State and country codes also include some custom codes, which are included in Appendix D.

The list in Appendix D is divided into three parts.

- The first part is the preferred codes to use when sufficient detail is known to identify the U.S. state, Canadian province, or other country to assign precise codes.
- The second part consists of codes for more general regions for use when a precise code cannot be assigned (for example, "Near East"). If there is no indication at all of location in the patient record, the country is coded ZZU and the state will be ZZ.
- The third section is a list of obsolete codes that may have been assigned when the registry data were upgraded from former codes. This information is provided to assist registries in

29

Example – Country of Birth

STORE 2018 *APPENDIX D: Country and State Codes*

Find (1/2) korea Previous Next

Obsolete

Geographic Area	Country Code	State Province Code
Obsolete: State/Province or Country Codes That Must Not Be Used for Current Coding (May have been assigned during conversion, so may be present in pre-2013 data)		
New England and New Jersey	USA	NN
Maritime Provinces (New Brunswick, Newfound, Nova Scotia, PE)	CAN	MM
Northwest Territories, Yukon Territory	CAN	YN
Prairie Provinces (Alberta, Manitoba, Saskatchewan)	CAN	PP
African Coastal Islands (previously in South Africa, NOS)	XIF	YY
Arabian Peninsula	XAP	YY
Caucasian Republics of the USSR	XCR	YY
China, NOS	XCH	YY
East Africa	XEF	YY
England, Channel Islands, Isle of Man	XEN	XX
Ethiopia (Abyssinia), Eritrea	XET	YY
Germanic Countries	XGR	YY
Indochina	XSE	YY
Israel and former Jewish Palestine	XIS	YY
Korea (Not Specified whether North or South)	KOR	XX

30

Example – Country of Birth

STORE 2018 *APPENDIX D: Country and State Codes*

Geographic Area	Country Code	State or Province Code
Preferred: Specific Codes for Use Where the Detail is Known		
Montenegro	MNE	XX
Montserrat	MSR	XX
Morocco	MAR	XX
Mozambique	MOZ	XX
Namibia	NAM	XX
Nampo-Shoto, Southern (Japan)	JPN	XX
Nauru	NRU	XX
Nepal, Bhutan, Sikkim	NPL	XX
Netherlands	NLD	XX
New Caledonia	NCL	XX
New Zealand	NZL	XX
Nicaragua	NIC	XX
Niger	NER	XX
Nigeria	NGA	XX
Niue	NIU	XX
Norfolk Island	NFK	XX
North Korea	PRK	XX

31

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Example – Country of Birth

General

Geographic Area	Country Code	State or Province Code
General: Codes to Use In the Absence of More Specific Information		
United States, NOS	USA	US
Canada, NOS	CAN	CD
Africa, NOS (Central, Equatorial)	ZZF	YY
Asia, NOS	ZZA	YY
Asian and Arab Countries	ZZA	YY
Atlantic/Caribbean Area	ZZN	YY
Baltic Republic(s), NOS (Baltic States, NOS)	ZZE	YY
Central America	ZZC	YY
Czechoslovakia	CSK	YY
East Asia	ZZA	YY

32

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Know and Go to the Source of Standard!

- Ensures you're following the correct instructions and codes
- Report inconsistencies
- Abstract for entire cancer standards and surveillance community

33

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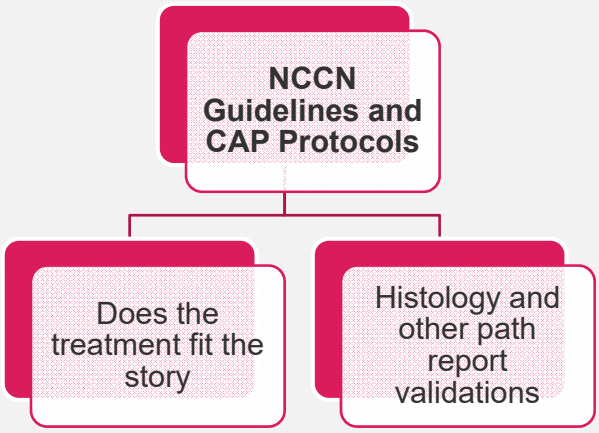
Other Big Picture Resources

Other Big Picture Resources



35

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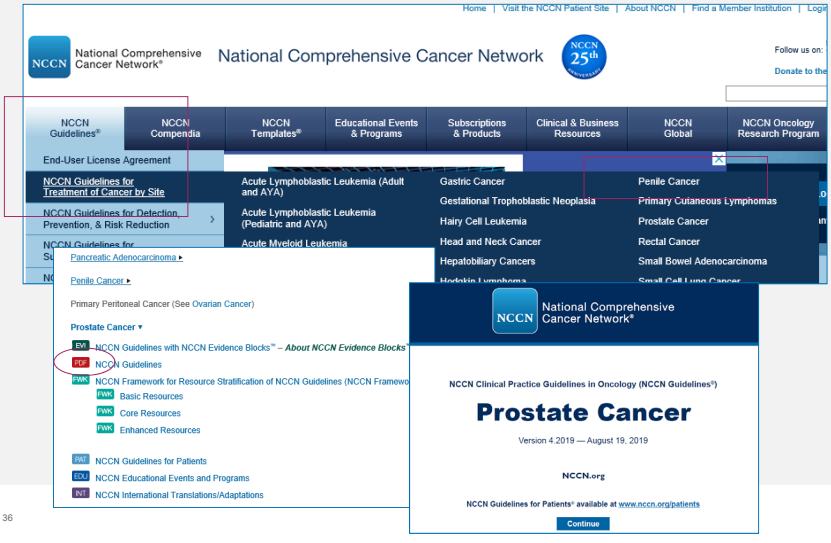
NCCN Guidelines NCCN.org



36

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NCCN Guidelines

National Comprehensive Cancer Network®

NCCN Guidelines Version 4.2019
Prostate Cancer

NCCN Guidelines Index
Table of Contents
Discussion

PRINCIPLES OF RADIATION THERAPY

Table 1: Regimens that have shown acceptable efficacy and toxicity. The optimal regimen for an individual patient warrants evaluation of comorbid conditions, voiding symptoms and toxicity of therapy. Additional fractionation schemes may be used as long as sound oncologic principles and appropriate estimate of BED are considered.

Regimen for Definitive Therapy	NCCN Risk Group (✓ indicates an appropriate regimen option if radiation therapy is given)					
	Very Low[a]	Low[a]	Favorable or Good Prognostic[b] Intermediate	Unfavorable, or Poor Prognostic[b], Intermediate	High and Very High[c]	Node Positive
Beam Therapies						
72–80 Gy at 2 Gy per fraction	✓	✓	✓	✓ ± 4 mo ADT	✓ with 1.5–3 y ADT	✓ with ADT
75.6–81.0 Gy at 1.8 Gy per fraction	✓	✓	✓	✓ ± 4 mo ADT	✓ with 1.5–3 y ADT	✓ with ADT
70.2 Gy at 2.7 Gy per fraction	✓	✓	✓	✓ ± 4 mo ADT	✓ with 1.5–3 y ADT	✓ with ADT
70 Gy at 2.5 Gy per fraction	✓	✓	✓	✓ ± 4 mo ADT	✓ with 1.5–3 y ADT	✓ with ADT
60 Gy at 3 Gy per fraction	✓	✓	✓	✓ ± 4 mo ADT	✓ with 1.5–3 y ADT	✓ with ADT
51.6 Gy at 4.3 Gy per fraction	✓	✓	✓			
37 Gy at 7.4 Gy per fraction	✓	✓	✓			
40 Gy at 8 Gy per fraction	✓	✓	✓			
36.25 Gy at 7.25 Gy per fraction	✓	✓	✓			
Brachytherapy Monotherapy						
Iodine 125 implant at 145 Gy	✓	✓	✓			
Palladium 103 implant at 125 Gy	✓	✓	✓			
Cesium implant at 115 Gy	✓	✓	✓			
HDR 27 Gy at 13.5 Gy in 2 implants	✓	✓	✓			
HDR 38 Gy at 9.5 Gy BID in 2 implants	✓	✓	✓			
Combined EBRT and Brachytherapy (EBRT 45–50.4 Gy at 1.8–2.0 Gy/fx, unless otherwise noted)						
Iodine 125 implant at 110–115 Gy				✓ ± 4 mo ADT	✓ with 1–3 y ADT	
Palladium 103 implant at 90–100 Gy				✓ ± 4 mo ADT	✓ with 1–3 y ADT	
Cesium implant at 85 Gy				✓ ± 4 mo ADT	✓ with 1–3 y ADT	
HDR 21.5 Gy at 10.75 Gy x 2				✓ ± 4 mo ADT	✓ with 1–3 y ADT	
EBRT 37.5 Gy at 2.5 Gy + 12–15 Gy single HDR				✓ ± 4 mo ADT	✓ with 1–3 y ADT	

[a] Active surveillance is preferred for men with very low risk and life expectancy ≥20 y and for men with low risk and life expectancy ≥10 y.
[b] "Good" or "Poor" prognostic is not strictly defined. Predictive nomograms and/or molecular testing can be used to prognosticate PSA persistence/recurrence, prostate cancer-specific mortality, and metastasis-free survival after definitive external beam radiation therapy. Although the prognostic value has been established, the predictive value of these tests remains unknown.
[c] Prophylactic nodal radiation may be considered if estimate of nodal metastasis is high.

Continued

37

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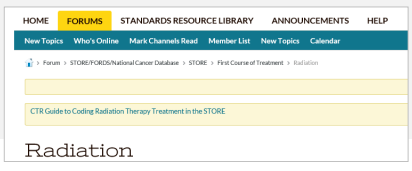
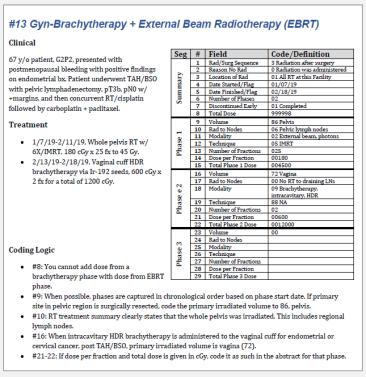
Coding Brachytherapy Side-bar

***The Brief*, Feb. 6, NCDB News:**
CTR Guide to Coding Radiation Therapy v2.0 now available

Pg 6 - Brachytherapy, radioisotopes and infusion therapy:

- If any phase of treatment to a volume has the Treatment Modality coded to anything between 07 and 16, phase dose coded in cGy, when available.
- If only one phase in entire course, then phase dose can be used to record course Total Dose.
- Effective with any cases diagnosed January 1, 2020, that received brachytherapy.





#13 Gyn-Brachytherapy + External Beam Radiotherapy (EBRT)

Clinical

67 y/o patient, G2P2, presented with postmenopausal bleeding with positive findings on endometrial bx. Patient underwent TAH/BSO with pelvic lymphadenectomy. pT1b, pN0 w/ +margins. and then concurrent RT/cisplatin followed by carboplatin + paditaxel.

Treatment

- 1/7/19-2/11/19. Whole pelvis RT w/ 6X/IMRT. 180 cGy x 25 fx to 45 Gy.
- 2/13/19-2/18/19. Vaginal cuff HDR brachytherapy via Ir-192 seeds, 600 cGy x 2 fx for a total of 1200 cGy.

Coding Logic

- #8: You cannot add dose from a brachytherapy phase with dose from EBRT phase.
- #9: When possible, phases are captured in chronological order based on phase start date. If primary site in pelvic region is surgically resected, code the primary irradiated volume to 86, pelvis.
- #10: RT treatment summary clearly states that the whole pelvis was irradiated. This includes regional lymph nodes.
- #16: When intracavitary HDR brachytherapy is administered to the vaginal cuff for endometrial or cervical cancer, post TAH/BSO, primary irradiated volume is vagina (72).
- #21-22: If dose per fraction and total dose is given in cGy, code it as such in the abstract for that phase.

Seg	#	Field	Code/Definition
Summary	1	Rad/Surg Sequence	3 Radiation after surgery
	2	Reason No Rad	5 Radiation was administered
	3	Location of Rad	01 All RT at this Facility
	4	Date Started/Flag	01/07/19
	5	Date Finished/Flag	02/18/19
	6	Number of Phases	02
	7	Discontinued Early	01 Completed
	8	Total Dose	999998
Phase 1	9	Volume	86 Pelvis
	10	Rad to Nodes	06 Pelvic lymph nodes
	11	Modality	02 External beam, photons
	12	Technique	05 IMRT
	13	Number of Fractions	025
	14	Dose per Fraction	00180
	15	Total Phase 1 Dose	004500
Phase 2	16	Volume	72 Vagina
	17	Rad to Nodes	00 No RT to draining LNs
	18	Modality	09 Brachytherapy; intracavitary, HDR
	19	Technique	88 NA
	20	Number of Fractions	02
	21	Dose per Fraction	00600
	22	Total Phase 2 Dose	0012000
Phase 3	23	Volume	00
	24	Rad to Nodes	
	25	Modality	
	26	Technique	
	27	Number of Fractions	
	28	Dose per Fraction	
	29	Total Phase 3 Dose	

38

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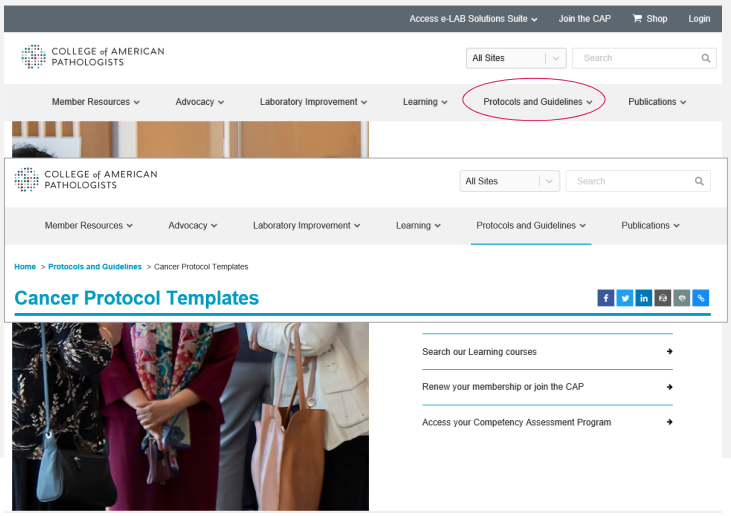
CAP Protocols – How to Access

https://www.cap.org/protocols-and-guidelines/cancer-reporting-tools/cancer-protocol-templates



39

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CAP Protocols – How to access

Cancer Reporting and Biomarker Reporting Protocols

Breast

Breast DCIS, Resection	**Current Version** PDF (v4.3.0.1) Word (v4.3.0.1) *September 2019*	**Previous Version** 2019 (v4.3.0.0) 2019 (v4.2.0.0) 2018 (v4.1.0.0) 2017 (v4.0.0.0) 2013 (v3.2.0.0)
Breast DCIS, Biopsy	**Current Version** PDF (v1.0.0.0) Word (v1.0.0.0) *February 2019*	
Breast Invasive, Resection	**Current Version** PDF (v4.3.0.1) Word (v4.3.0.1) *September 2019*	**Previous Version** 2019 (v4.3.0.0) 2019 (v4.2.0.0) 2018 (v4.1.0.0) 2017 (v4.0.0.0) 2016 (v3.3.0.0) 2013 (v3.2.0.0)
Breast Invasive, Biopsy	**Current Version** PDF (v1.0.0.1) Word (v1.0.0.1) *August 2019*	**Previous Version** 2019 (v1.0.0.0)
Breast Biomarker Reporting	**Current Version** PDF (v1.3.0.0) Word (v1.3.0.0) *August 2019*	**Previous Version** 2018 (v1.2.0.1) 2018 (v1.2.0.0) 2014 (v1.1.0.0) 2013 (v1.0.0.0)

40

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CAP Protocols

BREAST BIOMARKERS

Select a single response unless otherwise indicated.

Note: *Core data elements in this template comply with the CAP Accreditation requirements for HER2 and hormone receptor testing.* ***Core data elements should be reported only for tests performed.*** *If some studies were performed on different specimen(s), the specimen number(s) should be provided.*

RESULTS (NOTE A)

Estrogen Receptor (ER) Status (Note B)

___ Positive

~~Percentage of cells with nuclear positivity#~~

Specify: ___ %

-OR-

Range (Note A)

___ 1-10% (specify): ____ %#

___ 11-20%

___ 21-30%

___ 31-40%

___ 41-50%

___ 51-60%

___ 61-70%

___ 71-80%

___ 81-90%

___ 91-100%

Average intensity of staining:

___ Weak

___ Moderate

___ Strong

___ Negative (less than 1%)

___ Internal control cells present and stain as expected

___ Internal control cells absent##

___ Other (specify): _____

___ Cannot be determined (indeterminate)###

___ Internal control cells present; no immunoreactivity of either tumor cells or internal controls

___ Other (specify): _____

Coding Instructions and Codes

Note 1: Physician statement of ER Percent Positive or Range can be used to code this data item.

Note 2: Code this data item using the same report used to record Estrogen Receptor Summary [NAACCR Data Item #3827].

Note 3: If ER is negative, or percentage is less than 1%, code 000.

Note 4: The actual ER (1-100%) percent takes priority over the range codes.

Note 5: If ER is positive but percentage is unknown, code XX9.

Code	Description
000	ER negative, or stated as less than 1%
001-100	1-100 percent
R10	Stated as 1-10%
R20	Stated as 11-20%
R30	Stated as 21-30%
R40	Stated as 31-40%
R50	Stated as 41-50%
R60	Stated as 51-60%
R70	Stated as 61-70%
R80	Stated as 71-80%
R90	Stated as 81-90%
R99	Stated as 91-100%
XX8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code XX8 will result in an edit error.)
XX9	Not documented in medical record ER (Estrogen Receptor) Percent Positive or Range not assessed or unknown if assessed

41

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CAP Protocols

Explanatory Notes

A. Results

It is recommended that hormone receptor and HER2 testing be done on all primary invasive breast carcinomas and on recurrent or metastatic tumors.[1-4] If hormone receptors and HER2 are both negative on a core biopsy, repeat testing on a subsequent specimen should be considered, particularly when the results are discordant with the histopathologic findings. When multiple invasive foci are present, the largest invasive focus should be tested. Testing smaller invasive carcinomas is also recommended if they are of different histologic type or higher grade. Other biomarker tests (eg, Ki-67 or multigene expression assays) are optional and are not currently recommended for all carcinomas. Fresh tissue should not be used for special studies (eg, RNA expression profiling or investigational studies) unless the invasive carcinoma is of sufficient size that histologic evaluation and ER, PgR, and HER2 assessment will not be compromised.

B. Estrogen Receptor and Progesterone Receptor Testing

Scientific rationale: Normal breast epithelial cells have receptors for estrogen and progesterone and proliferate under their influence. Most breast carcinomas also express these receptors and may be stimulated to grow by these hormones. Removal of endogenous hormones by oophorectomy or blocking hormonal action pharmaceutically (eg, with tamoxifen or aromatase inhibitors) can slow or prevent tumor growth and prolong survival.

Clinical rationale: Hormone receptor status is determined primarily to identify patients who may benefit from hormonal therapy.[1] About 75% to 80% of invasive breast cancers are positive for ER and PgR, including almost all well-differentiated cancers and most moderately differentiated cancers, and studies have shown a substantial survival benefit from endocrine therapy among patients with ER-positive tumors.[2] True ER-negative, PgR-positive carcinomas are extremely rare, but patients with such tumors are also considered eligible for hormonal therapy. Receptor status is only a weak prognostic factor.

42

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Resources Wrap-Up

- Use coding guidelines as directed by Source of Standard (SoS)
- Keep in mind the patient story
  - Does the work-up and treatment fit
  - Use NCCN Guidelines and CAP Protocols to inform and verify
- Abstract for the cancer standards and surveillance community
  - No single standard setter/data collector dictates what and how data is collected

43

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Description and Rationale

Why, What, and How

- What's being collected
- Provide relational information
- Why the data item is collected
- How researchers and others use the data

Rationale gives the data item meaning

45

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Data Item Description

Item #	Item Name	NPCR	CoC		SEER		CCCR		Source of Standard	Note
		Collect	Collect	Transmit	Collect	Transmit	Collect	Transmit		
390	Date of Diagnosis	R	R	R	R	R	R	R*	SEER/CoC	

DATE OF DIAGNOSIS **Revised**

Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
390	8	SEER/CoC					544 - 551

Alternate Name:	Date of Initial Diagnosis (CoC)
XML NAACCR ID:	dateOfDiagnosis
PARENT XML ELEMENT:	Tumor

Description
Date of initial diagnosis by a recognized medical practitioner for the tumor being reported whether clinically or microscopically confirmed. See Chapter X for date format.

For more discussion on determining date of diagnosis, consult the *SEER Program Coding and Staging Manual* or CoC *STORE* manual.

46

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Data Item Description

Item #	Item Name	NPCR	CoC		SEER		CCCR		Source of Standard	Note
		Collect	Collect	Transmit	Collect	Transmit	Collect	Transmit		
390	Date of Diagnosis	R	R	R	R	R	R	R*	SEER/CoC	

SEER Program Coding and Staging Manual 2018

Date of Diagnosis

Item Length: 8
NAACCR Item #: 390
NAACCR Name: Date of Diagnosis

The date of diagnosis is the month, day, and year the reportable neoplasm was first identified, clinically or microscopically, by a recognized medical practitioner.

Description
Date of initial diagnosis by a recognized medical practitioner for the tumor being reported whether clinically or microscopically confirmed. See Chapter X for date format.

47

Data Item Description

STORE 2018 *Date of Initial Diagnosis*

Date of Initial Diagnosis

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
390	8	544-551	CCYYMMDD	All Years	09/04, 09/08, 1/10, 01/11

Description
Records the date of initial diagnosis by a physician for the tumor being reported.

Rationale
The timing for staging and treatment of cancer begins with the date of initial diagnosis for cancer.

SEER Manual

Description
Date of initial diagnosis by a recognized medical practitioner for the tumor being reported whether clinically or microscopically confirmed. See Chapter X for date format.

48

Rationale

Item #	Item Name	NPCR	CoC		SEER		CCCR		Source of Standard	Note
		Collect	Collect	Transmit	Collect	Transmit	Collect	Transmit		
580	Date of 1st Contact	R	R	R	.	.	.	.	CoC	

What is the main usage purpose of the data item Date of First Contact?

1. It's used to track the number of days from first contact to when patient initiates treatment
2. It's used to track number of new patients within a given week and month by facility administration
3. It's used to track timeliness of individual registry reporting to central cancer registries
4. All of the above

49

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Rationale

Item #	Item Name	NPCR	CoC		SEER		CCCR		Source of Standard	Note
		Collect	Collect	Transmit	Collect	Transmit	Collect	Transmit		
580	Date of 1st Contact	R	R	R	.	.	.	.	CoC	

What is the main usage purpose of the data item Date of First Contact?

1. It's used to track the number of days from first contact to when patient initiates treatment
2. It's used to track number of new patients within a given week and month by facility administration
3. It's used to track timeliness of individual registry reporting to central cancer registries
4. Any and all of the above

50

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Rationale

Item #	Item Name	NPCR	CoC		SEER		CCCR		Source of Standard	Note
		Collect	Collect	Transmit	Collect	Transmit	Collect	Transmit		
580	Date of 1st Contact	R	R	R	.	.	.	.	CoC	

Rationale
Timeliness of abstracting (and reporting) is a concern for all standard-setting organizations. Date of 1st Contact is one of several data items that can be used to measure timeliness of reporting to central cancer registries by individual facilities. For tumors that are not diagnosed at the reporting facility following its Reference Date (Class of Case 20-22, 30-37), the Date of 1st Contact [580] can be used in conjunction with the Date Case Report Received [2111] to measure timeliness of reporting by individual facilities.

Comment: To accurately measure the timeliness of data collection and submission of abstracts that are first diagnosed at autopsy (Class of Case 38, Type of Reporting Source 6) the date of death should be used as the Date of 1st Contact since the diagnosis was not determined until the autopsy was performed. Death Certificate Only cases (Class of Case 49, Type of Reporting Source 7) are created only by the central registry. For these cases, Date of 1st Contact should be filled with the date of death, and timeliness for DCO cases should be measured by different criteria.

Rationale

This data item can be used to measure the time between first contact and the date that the case was abstracted. It can also be used to measure the length of time between the first contact and treatment for quality of care reports.

51

Using Rationale to Inform Coding

Question: I have a question about the surgical margins for a resection of an acoustic neuroma. The op report documents residual disease. Surgeon states that he left a very minimal amount of tumor along the nerve since it was adherent and could not be safely dissected off the nerve, about 90-95% of tumor removed.

Path report does not mention margins and there is no synoptic reporting done

Path report final diagnosis:

```
FINAL DIAGNOSIS:
A. BRAIN, LEFT CP ANGLE-RESECTION
SCHWANNOMA.
(maw)
B. BRAIN, LEFT CP ANGLE-RESECTION
SCHWANNOMA.

IMMUNOHISTOCHEMICAL MARKER PROFILE:
EMA  Negative.
S100  Positive.
NF  There is residual non- neoplastic nerve at the periphery of the tumor.
GFAP  Negative.
Ki67  3%, in the highest density areas.
(vc[maw])
C. BRAIN, LEFT CP ANGLE, CUSA-RESECTION
SCHWANNOMA.
(maw)
```

52

Using Rationale to Inform Coding

```
FINAL DIAGNOSIS:
A. BRAIN, LEFT CP ANGLE-RESECTION
SCHWANNOMA.
(maw)
B. BRAIN, LEFT CP ANGLE-RESECTION
SCHWANNOMA.

IMMUNOHISTOCHEMICAL MARKER PROFILE:
EMA  Negative.
S100  Positive.
NF  There is residual non- neoplastic nerve at the periphery of the tumor.
GFAP  Negative.
Ki67  3%, in the highest density areas.
(vc[maw])
C. BRAIN, LEFT CP ANGLE, CUSA-RESECTION
SCHWANNOMA.
(maw)
```

Per the rules for margins - you'd use the gross description to code 3 macroscopic margins. Which the gross does not mention margins, but the surgeon literally saw that there was residual tumor.

After looking at the rules, etc. I'm confused as what the margins would be coded as. 9? 3? or 0?

0 = no residual tumor
3 = macroscopic residual tumor
9 = unknown or n/a

53

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Using Rationale to Inform Coding

Item #	Item Name	NPCR	CoC		SEER		CCCR		Source of Standard	Note
		Collect	Collect	Transmit	Collect	Transmit	Collect	Transmit		
1320	RX Summ--Surgical Margins	.	R	R	R*	R*	.	.	CoC	

RX SUMM--SURGICAL MARGINS **Revised**

Item #	Length	Source of Standard	Year Implemented	Version Implemented	Year Retired	Version Retired	Column #
1320	1	CoC					2232 - 2232

Alternate Name:	Surgical Margins (CoC) Residual Primary Tumor Following Cancer-Directed Surgery (pre-96 CoC)
XML NAACCR ID:	rxSummSurgicalMargins
PARENT XML ELEMENT:	Tumor

Description
Codes describe the final status of surgical margins after resection of the primary tumor. See also RX Summ--Surg Prim Site [1290].

Rationale
This item serves as a quality measure for pathology reports, is used for staging, and may be a prognostic factor in recurrence. This item is not limited to cases that have been staged. It applies to all cases that have a surgical procedure of the primary site.

Codes (Refer to the most recent version of *STORE* for additional instructions.)

0 No residual tumor
1 Residual tumor, NOS
2 Microscopic residual tumor
3 Macroscopic residual tumor
7 Margins not evaluable
8 No primary site surgery
9 Unknown or not applicable

54

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Using Rationale to Inform Coding

Description

Records the final status of the surgical margins after resection of the primary tumor.

Rationale

This data item serves as a quality measure for pathology reports and is used for staging, and may be a prognostic factor in recurrence.

Coding Instructions

- Record the margin status as it appears in the pathology report.
- Codes 0–3 are hierarchical; if two codes describe the margin status, use the numerically higher code.
- Code 7 if the pathology report indicates the margins could not be determined.
- If no surgery of the primary site was performed, code 8.
- Code 9 if the pathology report makes no mention of margins or no tissue was sent to pathology.
- For lymphomas (M-9590-9726, 9728-9732, 9734-9740, 9750-9762, 9811-9831, 9940, 9948 and 9971) with a lymph node primary site (C77.0–C77.9), code 9.
- For an unknown or ill-defined primary site (C76.0–C76.8, C80.9) or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease (C42.0, C42.1, C42.3, C42.4, or M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992), code 9.

55

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Answer

- Use code 9
  - Pathology report didn't mention the margins
  - No CAP Protocol for benign CNS tumors
- Data item Rationale "…serves as a quality measure for pathology reports, is used for staging, and may be a prognostic factor in recurrence. It applies to all cases that have a surgical procedure of the primary site."

```
FINAL DIAGNOSIS:
A. BRAIN, LEFT CP ANGLE-RESECTION
SCHWANNOMA.
(maw)
B. BRAIN, LEFT CP ANGLE-RESECTION
SCHWANNOMA.

IMMUNOHISTOCHEMICAL MARKER PROFILE:
EMA  Negative.
S100  Positive.
NF  There is residual non- neoplastic nerve at the periphery of the tumor.
GFAP  Negative.
Ki67  3%, in the highest density areas.
(vc[maw])
C. BRAIN, LEFT CP ANGLE, CUSA-RESECTION
SCHWANNOMA.
(maw)
```

56

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Understanding How Data Items Relate to One Another

Date of Regional Lymph Node Dissection

Item #	Item Name	NPCR	CoC		SEER		CCCR		Source of Standard	Note
		Collect	Collect	Transmit	Collect	Transmit	Collect	Transmit		
682	Date Regional Lymph Node Dissection	.	R	R	RC	RC	.	.	NAACCR	New

Rationale
It is a known fact that sentinel lymph node biopsies have been under-reported. Additionally, the timing and results of sentinel lymph node biopsy procedures are used in quality of care measures. This data item can be used to more accurately assess the date of regional node dissection separate from the date of sentinel lymph node biopsy if performed.

STORE Coding Instructions
Record the date of regional lymph node dissection documented in the *Regional Lymph Nodes Examined* [830].

58

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Six Degrees (Really Only Three for This Example) of Separation

Date of Regional Lymph Node Dissection

1st Degree Relationship: Regional Lymph Nodes Examined

830	Regional Nodes Examined	R	R	R	R	R	R*	R*	SEER/CoC

Rationale
This data item serves as a quality measure of the pathologic and surgical evaluation and treatment of the patient.

2nd Degree Relationship: Regional Lymph Nodes Positive

820	Regional Nodes Positive	R	R	R	R	R	R*	R*	SEER/CoC

Rationale
This data item is necessary for pathologic staging, and it serves as a quality measure for pathology reports and the extent of the surgical evaluation and treatment of the patient.

59

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More Relatives

Date of Regional Lymph Node Dissection

3rd Degree Relationship: AJCC pN category assignment

1012	AJCC TNM Path N	.	R	R	RC	.	R*	R*	AJCC	New

Rationale
CoC requires that AJCC TNM staging be used in its approved cancer programs. AJCC developed its staging system for evaluating trends in the treatment and control of cancer. This staging is used by physicians to estimate prognosis, to plan treatment, to evaluate new types of therapy, to analyze outcome, to design follow-up strategies, and to assess early detection results.

Other related items

Scope of Regional LN Surgery

Sometimes related, sometimes not

Date of SLN bx

60

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Sometimes Related, Sometimes Not

Case Scenario:

A patient has a sentinel lymph node biopsy on January 1, 2019, for breast cancer that reveals 0/2 sentinel lymph nodes positive. No RLN biopsy is performed at any time.

The relevant data items are completed as follows (breast and melanoma):

Sentinel Lymph Nodes Examined: 02
Sentinel Lymph Node Positive: 00
Date of Sentinel Lymph Node Biopsy: 20190101
Regional Lymph Nodes Examined: 02
Regional Lymph Nodes Positive: 00
Date Regional Lymph Node Dissection: blank
Scope of Regional Lymph Node Surgery: 2
AJCC pN Category: pN0(sn)

61

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Sometimes Related, Sometimes Not

Case Scenario:

A patient has a sentinel lymph node biopsy on January 1, 2019, for breast cancer that reveals during surgery 2/2 sentinel lymph nodes positive. Because of the positive finding, a regional lymph node dissection is performed during the same procedure showing 2/6 regional lymph nodes positive.

The relevant data items are completed as follows (breast and melanoma):

Sentinel Lymph Nodes Examined: 02
Sentinel Lymph Node Positive: 97
Date of Sentinel Lymph Node Biopsy: 20190101
Regional Lymph Nodes Examined: 08
Regional Lymph Nodes Positive: 04
Date Regional Lymph Node Dissection: 20190101
Scope of Regional Lymph Node Surgery: 6
AJCC pN Category: pN2a

62

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Sometimes Related, Sometimes Not

Case Scenario:

A breast cancer patient has known axillary regional lymph node mets seen on imaging. The patient undergoes an MRM (includes RLN dissection) on January 1, 2019, that reveals 4/10 positive regional lymph nodes.

The relevant data items are completed as follows (breast and melanoma):

Sentinel Lymph Nodes Examined: 00
Sentinel Lymph Node Positive: 98
Date of Sentinel Lymph Node Biopsy: blank
Regional Lymph Nodes Examined: 10
Regional Lymph Nodes Positive: 04
Date Regional Lymph Node Dissection: 20190101
Scope of Regional Lymph Node Surgery: 5
AJCC pN Category: pN2a

63

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Big Picture Abstracting

Bonus! Using the right tool for the job

Using the Right Tool for the Job

Why SEER*RSA should not be used as a one stop coding shop

1. Primary purpose is for coding EOD
2. AJCC Staging ≠ EOD Staging
   a) EOD does not use "pure" AJCC staging
   b) Can't "crosswalk" guidelines from different manuals
3. Does not contain complete coding instructions
   a) Contains "notes" only

65

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Using the Right Tool for the Job

Why the SEER*RSA site should not be used as a one stop coding shop

AJCC staging calculator shows TX as an option for oropharynx HPV mediated (p16+) c099 histology 80853 dx date 2018 cancers

Question:
AJCC 8th edition page 120 does not allow for cTx as an option. If we manually enter it we get edits. Staging calculator for Oropharynx HPV Mediated (p16+) primary site C099 Histology 80853 dx 2018 Tumor size 999 regional nodes + 98 EOD primary tumor 100 EOD regional nodes 000 EDO mets 00 IN Size of mets . This gives naaccr schema id 00100, ajcc id 10, derived version 1.6, eod 2018 t = Tx cN0 cM0 stage group 1 ss 2018 derived 1.

I was wondering how to code the clinical T. If we do not have a measurement which would be correct cT0/cTx/or leave it blank. Please advise.

66

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Using the Right Tool for the Job

Why the SEER*RSA site should not be used as a one stop coding shop

AJCC staging calculator shows TX as an option for oropharynx HPV mediated (p16+) c099 histology 80853 dx date 2018 cancers

Question:
AJCC 8th edition page 120 does not allow for cTx as an option. If we manually enter it we get edits. Staging calculator for Oropharynx HPV Mediated (p16+) primary site C099 Histology 80853 dx 2018 Tumor size 999 regional nodes + 98 EOD primary tumor 100 EOD regional nodes 000 EDO mets 00 IN Size of mets . This gives naaccr schema id 00100, ajcc id 10, derived version 1.6, eod 2018 t = Tx cN0 cM0 stage group 1 ss 2018 derived 1.

I was wondering how to code the clinical T. If we do not have a measurement which would be correct cT0/cTx/or leave it blank. Please advise.

Donna Gress Response:
TX is not valid for this chapter. EOD does not use the pure AJCC staging…

67

Using the Right Tool for the Job

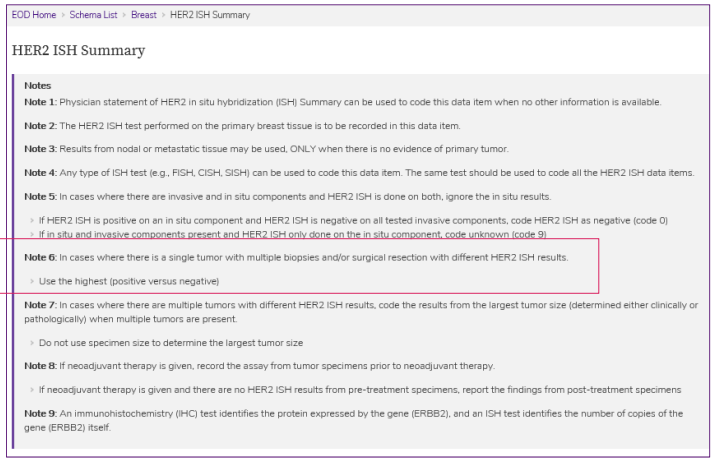
Question:
01/01/2019 core bx #1 HER2 FISH: dual probe ratio 5.5, dual probe copy number 17.90.
01/01/2019 core bx #2 HER2 FISH: dual probe ratio 4.7, dual probe copy number 19.50.

Two core biopsies were performed on one breast mass showing invasive ductal carcinoma. FISH was performed on both core biopsy specimens. Per the Seer RSA website Note 6 instructions, I'm looking to document the "highest" result. Could you please advise which would be the highest?

Also, is it appropriate to document dual probe ratio 5.5 and dual probe copy number 19.5 in the respective SSDI data item fields since they come from different biopsy specimens? If the answer is no, which set would be considered the highest?

68

SEER*RSA
HER2 ISH Summary



EOD Home › Schema List › Breast › HER2 ISH Summary

HER2 ISH Summary

Notes

Note 1: Physician statement of HER2 in situ hybridization (ISH) Summary can be used to code this data item when no other information is available.

Note 2: The HER2 ISH test performed on the primary breast tissue is to be recorded in this data item.

Note 3: Results from nodal or metastatic tissue may be used, ONLY when there is no evidence of primary tumor.

Note 4: Any type of ISH test (e.g., FISH, CISH, SISH) can be used to code this data item. The same test should be used to code all the HER2 ISH data items.

Note 5: In cases where there are invasive and in situ components and HER2 ISH is done on both, ignore the in situ results.

- If HER2 ISH is positive on an in situ component and HER2 ISH is negative on all tested invasive components, code HER2 ISH as negative (code 0)
- If in situ and invasive components present and HER2 ISH only done on the in situ component, code unknown (code 9)

Note 6: In cases where there is a single tumor with multiple biopsies and/or surgical resection with different HER2 ISH results.

- Use the highest (positive versus negative)

Note 7: In cases where there are multiple tumors with different HER2 ISH 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

Note 8: If neoadjuvant therapy is given, record the assay from tumor specimens prior to neoadjuvant therapy.

- If neoadjuvant therapy is given and there are no HER2 ISH results from pre-treatment specimens, report the findings from post-treatment specimens

Note 9: An immunohistochemistry (IHC) test identifies the protein expressed by the gene (ERBB2), and an ISH test identifies the number of copies of the gene (ERBB2) itself.

69

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SEER*RSA
HER2 ISH Summary

Breast

HER2 ISH Summary

Item Length: 1
NAACCR Item #: 3854
NAACCR Alternate Name: None
AJCC 8th Edition Chapter(s): Chapter 48, Breast

Description

HER2 in situ hybridization (ISH) Summary is the summary score for results of testing for ERBB2 gene copy number by any ISH method. An immunohistochemistry (IHC) test identifies the protein expressed by the gene (ERBB2), and an ISH test identifies the number of copies of the gene (ERBB2) itself.

Rationale

HER2 ISH Summary is a Registry Data Collection Variable in AJCC. It is a new data item for cases diagnosed 1/1/2018+.

See HER2 for additional information.

Coding Instructions and Codes

Note 1: Physician statement of HER2 in situ hybridization (ISH) Summary can be used to code this data item when no other information is available.

70

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Using the Right Tool for the Job

01/01/2019 core bx #1 HER2 Fish: dual probe ratio 5.5, dual probe copy number 17.90
01/01/2019 core bx #2 HER2 Fish: dual probe ratio 4.7, dual probe copy number 19.50

Description

HER2 in situ hybridization (ISH) Summary is the summary score for results of testing for ERBB2 gene copy number by any ISH method. An immunohistochemistry (IHC) test identifies the protein expressed by the gene (ERBB2), and an ISH test identifies the number of copies of the gene (ERBB2) itself.

Note 6: In cases where there is a single tumor with multiple biopsies and/or surgical resection with different HER2 ISH results.

- Use the highest (positive versus negative)

HER2 ISH Dual Probe Ratio and Dual Probe Copy Number

Note 5: Any type of ISH test (e.g., FISH, CISH, SISH) can be used to code this data item. Code this data item using the same report used to record HER2 ISH Summary [NAACCR Data Item #3854].

71

Using the Right Tool for the Job

Data item: HER2 ISH Summary
Question:
Breast cancer dx'd via two core bx's of one breast mass (at the same time), followed by initiation of neoadj tx. HER2 Fish performed on both core bx specimens. Per the SEER*RSA website (Note 6), we're to document the "highest" HER2 Fish result. Since the ratio is higher in bx #1 and the copy number is higher in bx #2, which would be considered the highest? (check one)

_____01/01/2019 core bx #1 HER2 Fish: dual probe ratio 5.5, dual probe copy number 17.90.
__✓__01/01/2019 core bx #2 HER2 Fish: dual probe ratio 4.7, dual probe copy number 19.50.

SEER*RSA can be used to accurately code what data items? (circle one)

(EODs)

SSDIs

Grade

All of the above

72

Using the Right Tool for the Job
Primary Site/Histology/Staging

- Don't use AJCC to code topography/histology — Klatskin Tumor, NSCLC
- Think about who "owns" topography and histology coding rule manuals: SEER
- If a path report lists a histology for a primary site not found in the corresponding AJCC 8th Edition chapter, we are to assign an NOS histology listed in the AJCC manual so the case can be staged. True/False
- They're working on it

73

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Summary

- ✓Define "Big Picture Abstracting"
- ✓Big Picture resources
- ✓Convey Source of Standard importance
- ✓Demonstrate how the Rationale and Description informs our understanding
- ✓Identify data items that relate to one another and how being aware of these relationships informs our coding decisions

74

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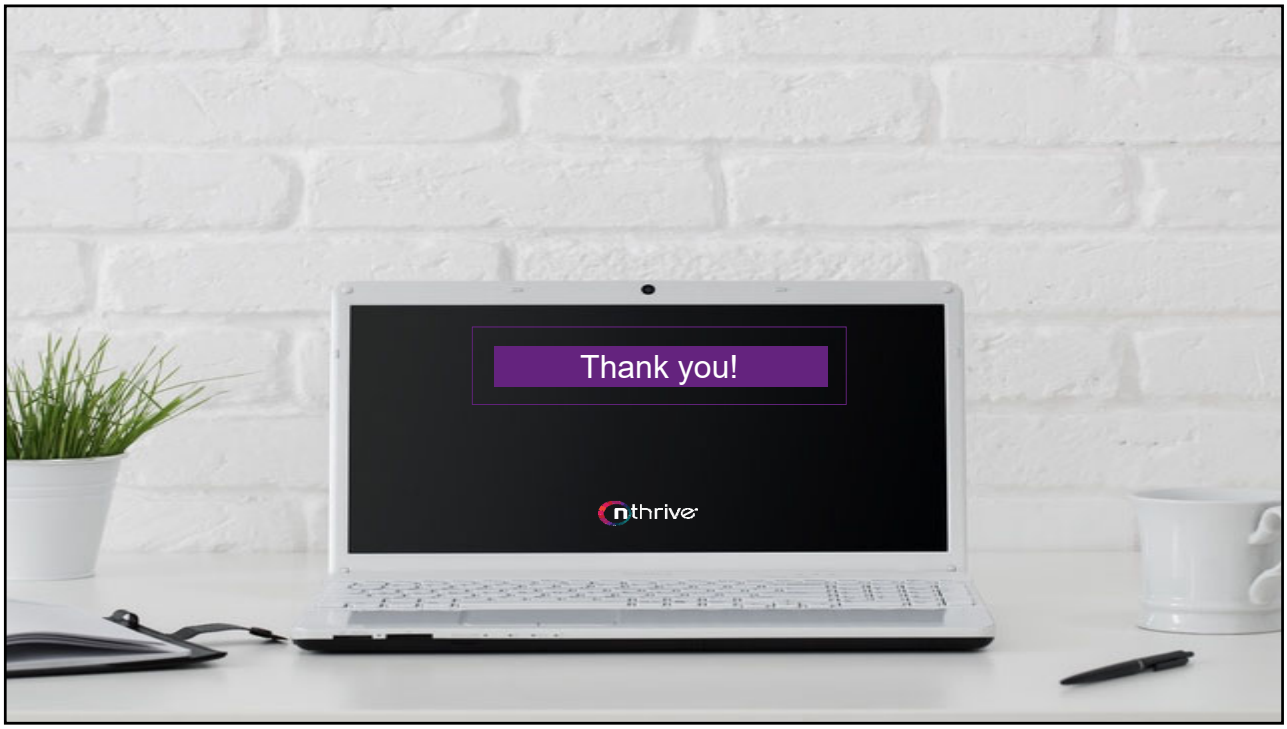

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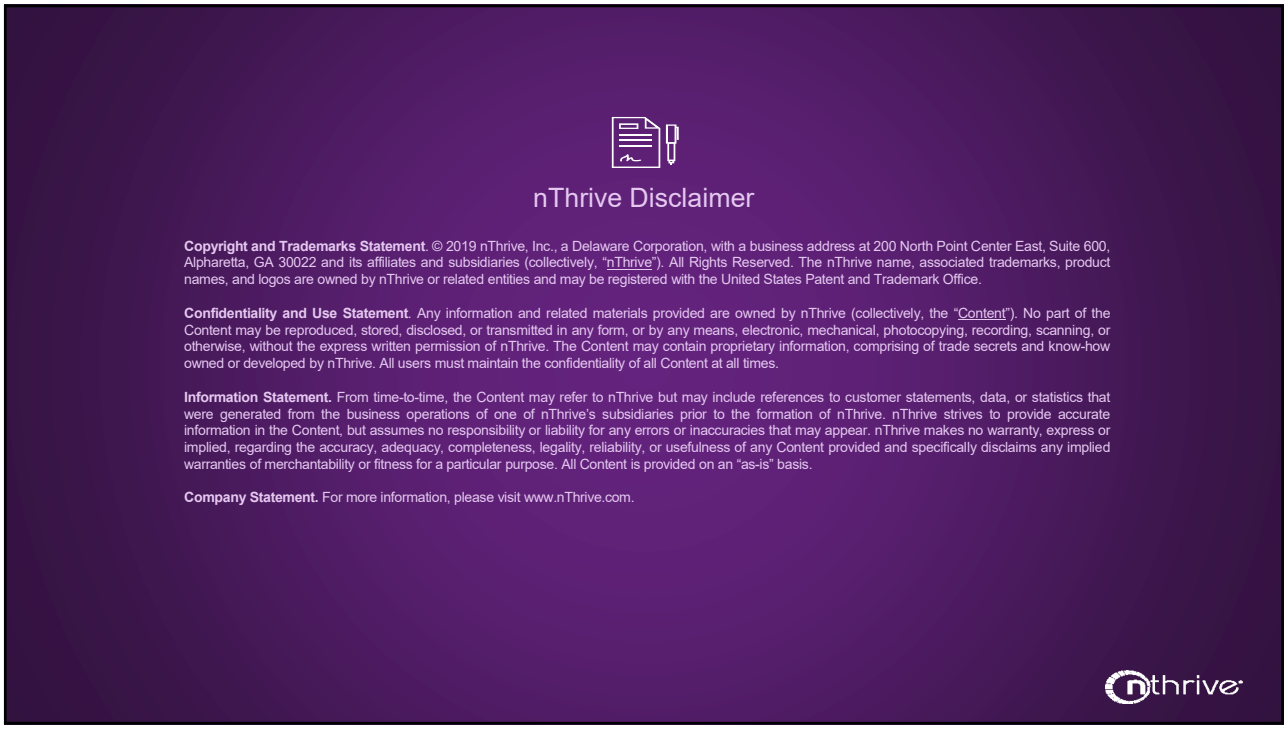
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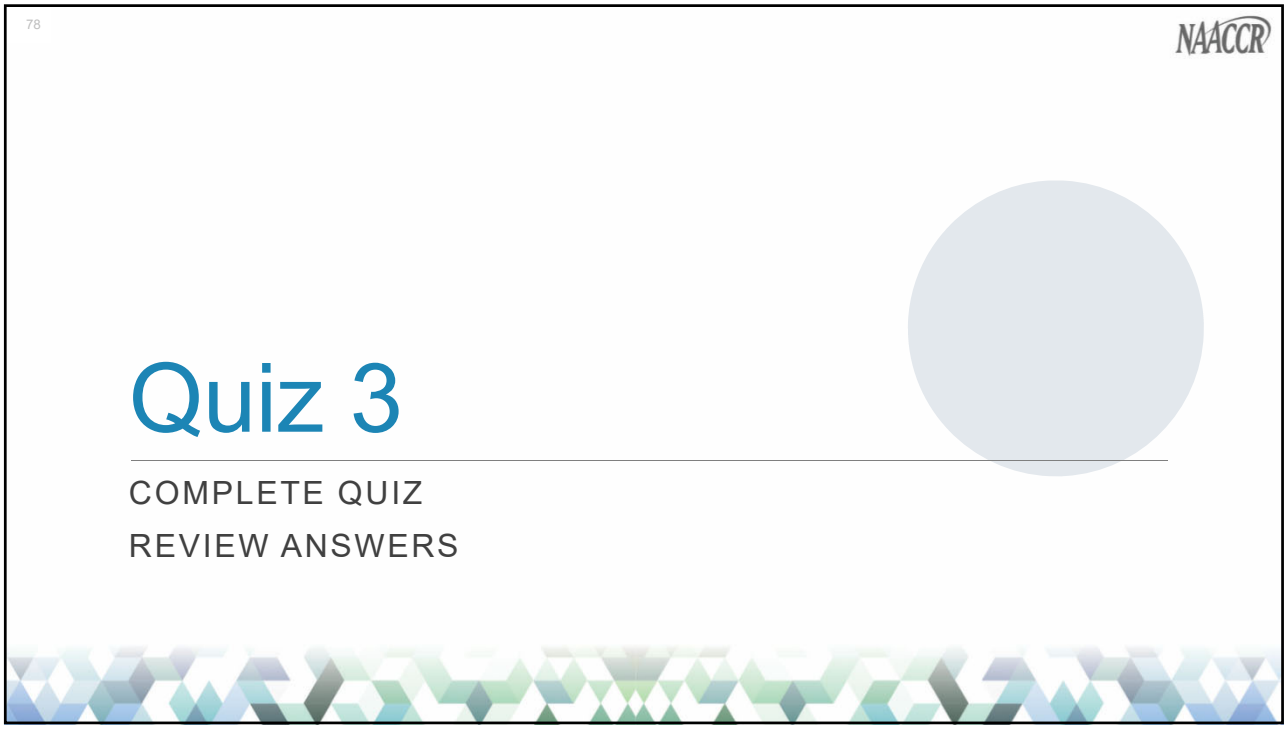
78
NAACCR
Quiz 3
COMPLETE QUIZ
REVIEW ANSWERS

79

Quiz 4

COMPLETE QUIZ

REVIEW ANSWERS

80

Using CAnswer Forum/ SEER SINQ

81

Ask a SEER Registrar/How to use SINQ

Home / Training Menu / Q&A Resources

Q&A Resources

Q&A Resources

SEER provides two Question and Answer Resources:

- Ask A SEER Registrar, which allows you to ask SEER coding questions (1 video)
- SEER Inquiry (SINQ) System, which allows you to search a database of previously answered questions (2 videos)

These videos provide step-by-step instruction in how to use both resources.

Ask a SEER Registrar (11:45 mins)

How to use SINQ (22:54 mins)

Creating SINQ Reports (8:39 mins)

https://educate.fredhutch.org/Assessments/QAResources.aspx

82

CAnswer Forum & Staging Questions

Eighth Edition Webinars

Lesson Approach

Live Webinar

The registration for the live webinar will include a pre-education quiz. A post-education quiz will be sent approximately four weeks after the live webinar. The handout will be posted by the morning of the webinar.

Space is limited to 1000 live participants. Attendees should join early to ensure a live spot.

Recorded Webinar

The recorded webinars will be available approximately three business days following the live webinar. The recorded webinar registration will include a pre-education quiz and then the webinar will begin. A post-education quiz will be sent approximately four weeks after registering for the recorded webinar.

Content

The webinars will provide information on the staging rules with examples from disease site chapters, answering common questions during the demonstration of using CAnswer Forum, and specific disease site lecture.

CE Hours – *Category A* Requirement

One hour of continuing education (CE) has been pre-approved by NCRA for each of the webinars.

This 1 CE hour meets the *Category A* requirement for continuing education (CE).

Eighth Edition Webinars and Learning Objectives

Introduction & Descriptors

- Demonstrate purpose and approach to AJCC staging
- Outline use of stage descriptors and guidelines
- Dissect 8th edition 1-page guide

Minor Rule Changes

- Examine key rules with their rationale
- Identify minor rule changes between 7th & 8th editions
- Dissect reasons for minor changes

Major Rule Changes

- Examine major rule changes between 7th & 8th editions
- Dissect reasons for major changes
- Identify differences between stage for patient care and data analysis

CAnswer Forum & Staging Questions

- Examine search techniques for CAnswer Forum
- Develop new knowledge while inspecting forum function

Head & Neck Staging

https://cancerstaging.org/CSE/Registrar/Pages/Eight-Edition-Webinars.aspx

83

Review of "Search" Exercise

84

Submitting Questions

Give complete and specific examples
- Include dates
- Be as specific as possible

Give references
- Manuals (include page numbers)
- Other posts (include links to posts)

Avoid hypothetical questions
- Questions should be based on real case situations

85

Submitting Questions

Make sure the question you are asking is clear.

- Don't expect the person answering the question will intuitively know what you are asking!

Try to frame the question so there are only a few possible answers to the question.

- Don't give the person answering the question any wiggle room!

86

Submitting Questions

Explain why you have a question…

- Is the scenario not covered in the coding rules?
- Do the instructions in the coding lead you to a code you feel is incorrect?
- Are there conflicting coding rules?

If possible, have someone read the question before you submit it.

- Would someone reading the question for the first time understand the issue without you providing additional background?

87

When to Reply to a Response

You should reply back requesting a clarification if the response did not answer the question you asked or only partially answered your question.

- Clearly state what you had expected to have been answered
- If necessary, provide additional information
- Be persistent

88

When NOT to Reply to a Response

When the question is answered, but the response is not what you wanted.

When the response generates another question

- Should probably send in a new question not a reply.
- Make sure your new question is based on a real situation and not a hypothetical situation.

89

How Could the Question be Improved?

Date of Diagnosis

- What would be the date of diagnosis in the following scenario?
- 01/01/19 PET states finding is consistent with colon cancer. Biopsy of lesion is dysplasia. Physician summarized the imaging finding in the HPI on 01/15/19 including the ambiguous terminology from the PET (consistent with colon ca) and states a strong possibility exists that invasive disease is present. 02/01/19 surgeon states pt is being evaluated for colon cancer. Hemicolectomy on 02/15/19 is positive for invasive cancer.

http://cancerbulletin.facs.org/forums/node/100958

90

Improved Title

Date of Diagnosis/ Ambiguous terminology

- or

Ambiguous terminology/ Negative biopsy

- or

Date of Diagnosis/ Negative biopsy

91

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Improved Question

In the scenario below the patient has a PET scan that is diagnostic of malignancy based on ambiguous terms.

However, a biopsy of the suspected malignancy was negative. Can I still use the date of the 1/1/19 PET as the date of diagnosis even though the biopsy was negative?

92

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Response

Date of Initial Diagnosis [390] records the first date of diagnosis by a physician for the tumor being reported whether clinically or histologically established. Per the 2nd bullet, STORE, page 131, if the physician states that, in retrospect, the patient had cancer at an earlier date, use the earlier date as the date of diagnosis.

Based on the limited information in this post, 1/1/19 PET (consistent with colon cancer--ambiguous terminology constituting diagnosis) was later confirmed by 2/15/19 hemicolectomy positive for invasive cancer.

The Date of Initial Diagnosis [390] is 1/1/19.

Does this response warrant a reply for further clarification?

93

Grade-Multiple Tumors

Per the SSDI manual, in cases where there are multiple tumors with different ER, PR, and HER 2 results, we are to code the results from the largest tumor size (determined either clinically or pathologically) when multiple tumors are present.

- Is the same true for grade? Do we take the grade from the largest tumor when multiple tumors are present?
- Are the rules for coding grade when multiple tumors are present different for breast than for other sites?

http://cancerbulletin.facs.org/forums/101210

Where is the conflict?

- Is the scenario covered in current coding rules?
- Do the current instructions lead you to a code you feel is incorrect?
- Are there conflicting coding rules?

94

Grade-Multiple Tumors

This issue was forwarded to the CAP Cancer Committee.

- Their decision was that when multiple tumors are present, and abstracted as one primary, that you take the highest grade. This applies to all sites.
- This statement will be added to the Grade manual for the 2021 update and can be applied to cases diagnosed 2018+.

Was the question answered?

Is follow-up response warranted?

95

Additional Considerations

Be professional!

- NCRA Code of Ethics

CoC/AJCC-Do NOT put these in a newsletter – you can put the question number, but not the actual Q&A.

- CAnswer forum is a living bulletin board
- Posts are updated and clarified online
- Posting questions to a newsletter or other document defeats that purpose

96

Questions?

97

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Fabulous Prizes

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Coming UP…

Melanoma

- Guest Host: Denise Harrison and Louanne Currence
- 04/02/2020

Central Nervous System

- Guest Host: Denise Harrison and Louanne Currence
- 05/07/2020

CE Certificate Quiz/Survey

Phrase

Link

- https://www.surveygizmo.com/s3/5311387/Boot-Camp-2020

100

Thank You!!!