TREATMENT

2020

NAACCR 2020-2021 WEBINAR SERIES

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.

FABULOUS PRIZES

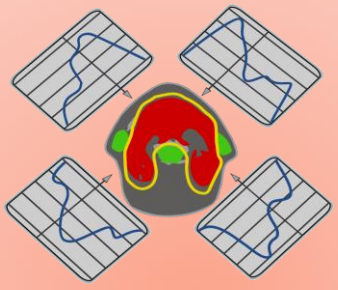



GUEST PRESENTERS

- Amanda Francescatti, MS
  - Senior manager of the Cancer Surgery Standards Program and the Cancer Research Program of the American College of Surgeon
- Wilson Apollo, MS, CTR
- Jennifer Ruhl, Chair SSDI WG, Public Health Analyst NIH/NCI SEER

AGENDA

- 2021 Radiation Therapy Coding: Challenges and Solutions
  - Wilson Apollo
- CoC Operative Standards 5.3-5.8: Updates on Resources and Compliance
  - Amanda Francescatti
- Neoadjuvant Data Items
  - Jennifer Ruhl
- Biopsy of Lymph Nodes
  - Jim Hofferkamp



2021 Radiation Therapy Coding: Challenges and Solutions

Wilson Apollo, MS, CTR
WHA Consulting

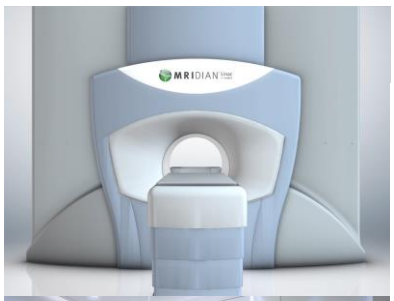
NAACCR Webinar

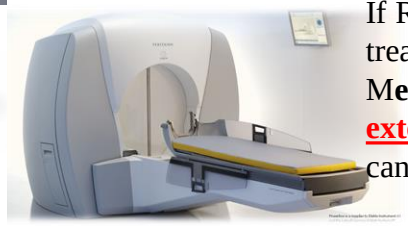
January 7, 2021

Objectives

- RT Delivery systems/approaches & coding,
- Common RT coding errors,
- STORE 2021 RT items/CTR Guide
- Challenging scenarios

RT DELIVERY SYSTEMS





LINEAR ACCELERATOR-Linac

If the RT treatment summary refers to beam energies, such as:

- 6X or 6MV,10X or 10MV,
- 12X or 12MV,15X or 15MV,

Then the treatment modality will always be **02, external beam, photons** (a Linac was used to deliver the EBRT treatment).

If RT treatment summary refers to treatment delivery as E, eboost, M**e**V or "en face", code it to **04: external beam, electrons** (A Linac can also deliver electron therapy).

IORT Delivery Technology & Coding

Equipment	RT Delivery Method	Treatment Modality	Planning Technique	Comments
Zeiss Intrabeam	50 kVp Linac	02-Photons	02: Low energy x-ray/photon therapy	*Isotope-free. No radioactive source used*
XOFT Axxent	50 kVp Linac	02-Photons	02: Low energy x-ray/photon therapy	*Isotope-free. No radioactive source used*
LIAC 10/12 by Sordina IORT	Electron accelerator	04-Electrons	In most cases, 04-3D conformal	*Max energy: 10 MeV, 12 MeV*
NOVAC by Sordina IORT	Electron accelerator	04-Electrons	In most cases, 04-3D conformal	*Check with Rad Onc for planning technique*
Mobetron	Electron accelerator	04-Electrons	In most cases, 04-3D conformal	*Energies: 6, 9, 12 MeV*
Strut Assisted Volume Implant (SAVI)	Ir-192 Sources (HDR)	09-Brachy, intracavitary HDR	88-NA	*Accelerated partial breast irradiation (PBI)*
Mammosite	Ir-192 Sources (HDR)	09-Brachy, intracavitary HDR	88-NA	*Accelerated partial breast irradiation (PBI)*
Contura MLB	Ir-192 Sources (HDR)	09-Brachy, intracavitary HDR	88-NA	*Accelerated partial breast irradiation (PBI)*

IORT Delivery Technology & Coding

02: External beam, photons

- Zeiss Intrabeam
- XOFT Axxent
- Esteya (skin ca)

Small-scale Linacs.
Do not use radioactive isotopes (seeds).
Planning Technique: 02

04: External beam, electrons

- Liac 10, Liac 12
- Novac
- Movetron

All units deliver electron therapy.
Planning Technique: Can be 2D or 3D conformal.

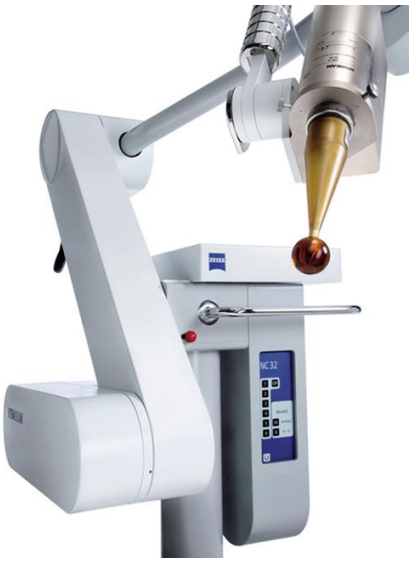
09: Brachytherapy, Intracavitary, HDR

- Strut Assisted Volume Implant (SAVI),
- Mammosite
- Contura MLB

Units use Ir-192 seeds.
Inserted into cavity created by breast conservation therapy (BCT)
Planning Technique: 88,NA

IORT FOR BREAST CANCER, Volume: 41-Partial Breast. Lymph nodes not targeted!

Zeiss INTRABEAM/XOFT Axxent eBx IORT Delivery Systems



Known as Electronic brachytherapy. Deliver low-energy photon therapy (50 kV range)

Modality code: 02, photons.
Planning technique: 02, Low energy x-ray/photon therapy

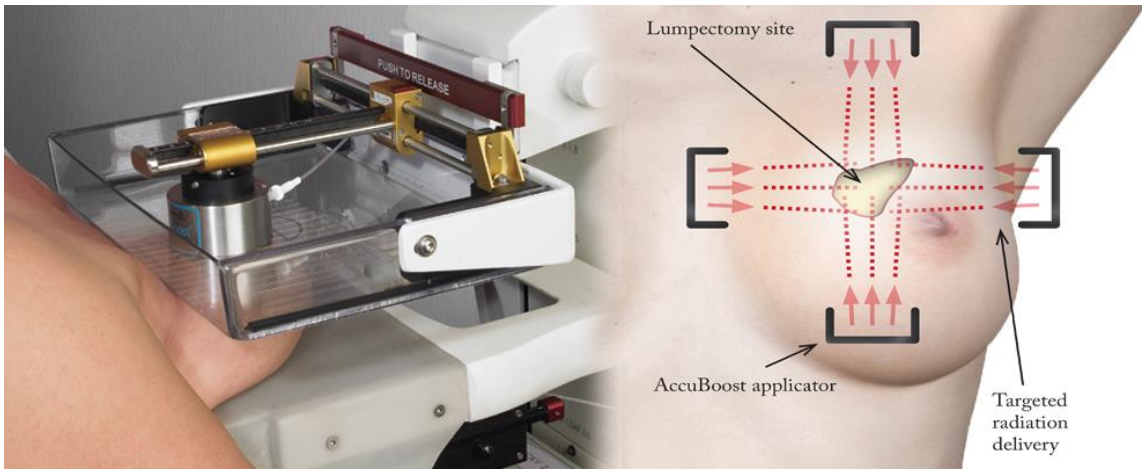
7

RT DELIVERY SYSTEMS
Brachytherapy

Isotopes used in brachytherapy

Element	Isotope	Energy (MeV)	Half-Life	Clinical Application
Cesium	^{137}Cs	0.662	30 years	LDR intracavitary and interstitial
Iridium	^{192}Ir	0.397 (average)	73.8 days	LDR & **HDR**, interstitial and intracavitary
Cobalt	^{60}Co	1.25	5.26 years	HDR intracavitary
Iodine	^{125}I	0.028	59.6 days	LDR permanent interstitial
Palladium	^{103}Pd	0.02	17 days	LDR permanent interstitial
Cesium	^{131}Cs	0.03	9.69 days	LDR permanent
Ytterbium	^{169}Yb	0.093	32 days	LDR temporary interstitial
Gold	^{198}Au	0.412	2.7 days	LDR permanent
Strontium	^{90}Sr	0.5	29 yrs	HDR (beta emitter)
Ytrium	^{90}Y	2.27 (max)	64 hrs	HDR (beta emitter)

Accuboost: Non-invasive Breast Brachytherapy (NIBB)



Accuboost: Non-invasive Breast Brachytherapy (NIBB)

- Allows for non-invasive approach to delivering a boost dose to lumpectomy cavity for breast cancer pts,
- Dose is delivered via **Ir-192 HDR** sources,
- Note that sources are not inserted into patient,
- Utilizes mammography for treatment planning,
- Advantage of technique is that it avoids irradiating lung, heart,
- Cosmesis is comparable to that of conventional electron & photon boost.
- How do you code this modality? Best choice: **07, Brachytherapy, NOS.**

J. Schuster, *et al*. Updated feasibility and reproducibility results of multi-institutional study of noninvasive breast tumor bed boost. *Brachytherapy* 2016; 2-8.

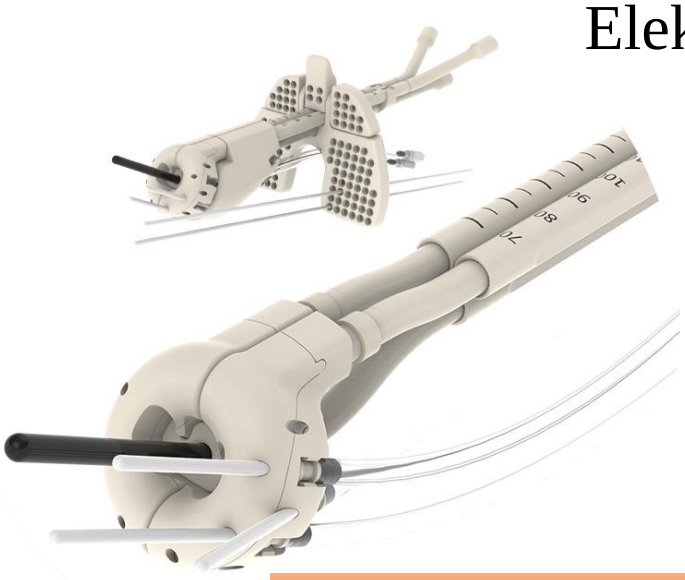
Brachytherapy for gyn cancers

- Use of tandem and ovoid (T&O) applicators, or tandem and ring (T&R) applicators, also used for intracavitary **LDR (^{137}C)**.
- Applicators connected to remote afterloaders for delivery of HDR brachytherapy (^{192}**Ir**).
- Dwell time range from 15-25 min.

Vaginal Cuff Brachytherapy Ir-192

Treatment Modality	**09**-Brachytherapy, intracavitary, HDR
Planning Technique	**88**-NA
Treatment Volume	**72**-Vagina
RT to draining lymph nodes	**00**-No RT to draining lymph nodes

Elekta Venezia



Uses Ir-192 seeds, interstitial & Intracavitary!

Elekta Venezia Brachytherapy

- Elekta Venezia is a hybrid system that can deliver interstitial and/or intracavitary HDR brachytherapy. *If the device is used to perform interstitial HDR with a simultaneous intracavitary treatment, then code as 07, brachytherapy, NOS*.
- If treatment summary states "Vaginal Cuff Brachytherapy", code it *intracavitary*.

15

STORE 2021/CTR GUIDE HIGHLIGHTS

RT primary treatment Volume
STORE p. 267

- *Note that for many of the treatment volumes, the same code should be used when the anatomic structure is targeted or when the surgical bed of the resected anatomical structure is targeted. For example, when prostate cancer is treated with radiation alone, code 64 will be the Primary Treatment Volume. Similarly, when prostate cancer is treated with radiation alone after radical prostatectomy, code 64 will be the Primary Treatment Volume. There is an exception to the rule for breast cancer. In patients with breast cancer, code 41 (Breast-partial) in patients who have had a lumpectomy and were treated with partial breast irradiation (sometimes called accelerated partial breast irradiation, APBI). Code 40 (Breast-whole) in patients who had a lumpectomy and whole breast radiation, and code 42(chest wall) in patients who had a mastectomy and post-mastectomy radiation.*

1-Phase RT
STORE, p. 268

- *If the patient received just one phase of treatment, code the phase II Radiation Treatment Volume to "00" and leave all other phase III data fields blank.*
- 12/3/19-12/20/19 @ Anywhere, USA:
- VAGINAL CUFF HDR Ir-192 INTRACAVITARY BRACHYTHERAPY. 700 cGy x 3 fx= 21 Gy.

Seg	#	Field	Code/Definition
Summary	1	Rad/Surg Sequence	00 No RT and/or surgical …
	2	Reason No Rad	0 Radiation was admin..
	3	Location of Rad	1 All RT at this facility
	4	Date Started/Flag	12/03/19
	5	Date Finished/Flag	12/20/19
	6	Number of Phases	02
	7	Discontinued Early	01 Radiation completed
	8	**Total Dose**	**002100**
Phase 1	9	RT Treatment Volume	72 Vagina
	10	Rad to Nodes	00 No RT
	11	Modality	09 Brachy, intracavitary, HDR
	12	Planning Technique	88 NA
	13	Number of Fractions	003
	14	Dose per Fraction	00700
	15	Total Phase 1 Dose	002100
Phase 2	16	RT Treatment Volume	**00**
	17	Rad to Nodes	
	18	Modality	
	19	Planning Technique	
	20	Number of Fractions	
	21	Dose per Fraction	
	22	Total Phase 2 Dose	
Phase 3	23	RT Treatment Volume	
	24	Rad to Nodes	
	25	Modality	
	26	Planning Technique	
	27	Number of Fractions	
	28	Dose per Fraction	
	29	Total Phase 3 Dose	

2-Phase RT

STORE, p. 268

If the patient received just two phases of treatment, code the phase III Radiation Treatment Volume to "00" and leave all other phase III data fields blank.

6/1/20-7/13/20 @ Anywhere/USA:
1. RT BREAST, 15X/6X/3D, 2.0 Gy x 25 fx= 50 Gy.
2. RT BREAST BOOST, 6X/3D, 2 Gy x 5 fx= 10 Gy.

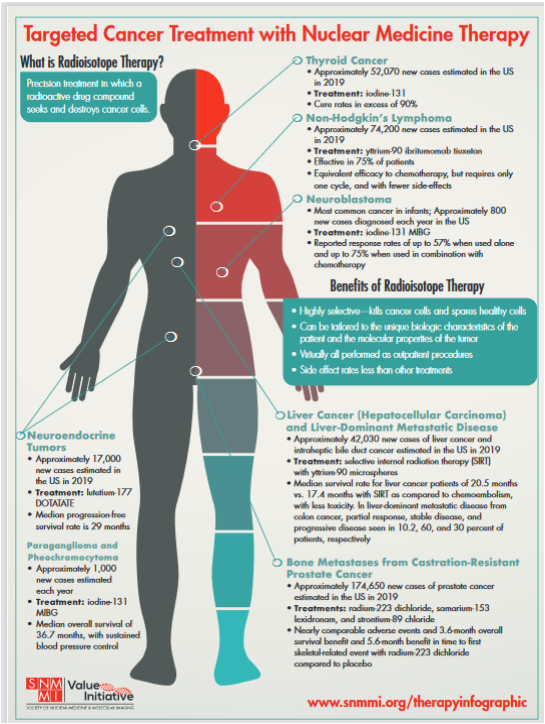
TOTAL DOSE= 60 Gy.

Descriptive Name	Field Value
Location of Radiation Treatment	(1) All radiation treatment at this facility
Date RT Started	06/01/2020
Date RT Ended	07/13/2020
Phase I Radiation Primary Tre...	(40) Breast - whole
Phase I Radiation to Draining ...	(00) No radiation treatment
Phase I Radiation Treatment M...	(02) External beam, photons
Phase I Radiation External Be...	(04) Conformal or 3-D conformal therapy
Phase I Dose per Fraction	(00200)
Phase I Number of Fractions	(025)
Phase I Total Dose	(005000)
Phase II Radiation Primary Tre...	(41) Breast - partial
Phase II Radiation to Draining ...	(00) No radiation treatment to draining lymph nodes
Phase II Radiation Treatment ...	(02) External beam, photons
Phase II Radiation External Be...	(04) Conformal or 3-D conformal therapy
Phase II Dose per Fraction	(00200)
Phase II Number of Fractions	(005)
Phase II Total Dose	(001000)
Phase III Radiation Primary Tr...	(00) No radiation treatment
Phase III Radiation to Draining...	
Phase III Radiation Treatment ...	
Phase III Radiation External Be...	
Phase III Dose per Fraction	
Phase III Number of Fractions	
Phase III Total Dose	

Radiation Treatment Modality

STORE, p. 275, 3rd bullet

- *Use code 13-Radioisotopes, NOS for radioembolization procedures, e.g. intravascular Yttrium-90 for cases diagnosed January 1, 2019 and later…"*
- Apply this rule to targeted radionuclide therapy, molecular radiotherapy, radio-pharmaceuticals (RPs), alpha radioimmunotherapy, SIRT(Selective Internal Radiation Therapy).
- Numerous radionuclide available and site specific.
- Do not confuse with <u>diagnostic</u> radiopharmaceuticals:
  - Thallium-201, chloride, or Tc-99 is used for myocardial perfusion imaging,
  - FDG, incorporating F18, used for PET/CT imaging



Code 13-Radioisotopes, NOS

- Diagram identifies most commonly used radionuclides for **<u>therapeutic</u>** purpose. Among these:
  - Yttrium90,
  - I-131
  - Radium 223
  - Strotium-89
  - Lutetium-177

- https://s3.amazonaws.com/rdcms-snmmi/files/production/public/images/2020%20TRT%20Infographic%20%281%29.pdf

Radiation Treatment Modality

RADIOISOTOPES

- Do not overlook following codes:

CODE	LABEL
14	Radioisotopes, Radium-223
15	Radioisotopes, Strontium-89
16	Radioisotopes, Strontium-90

STORE p. 281 (on dose/fx): *Code 99998 when radioisotopes were administered to the patient (codes 13-16) for Phase I-III…*

- **<u>Plaque radiotherapy</u>** or episcleral plaque radiotherapy (also referred to as episcleral plaque <u>brachytherapy</u>, EPBRT):
  - Use of radioactive <u>seeds</u> (I-125) in a plaque sewn to the eyeball, temporarily, for management of retinoblastoma, uveal melanoma.
  - Code to **07-Brachytherapy, NOS**

COMMON RT CODING ERRORS

Treatment Modality code

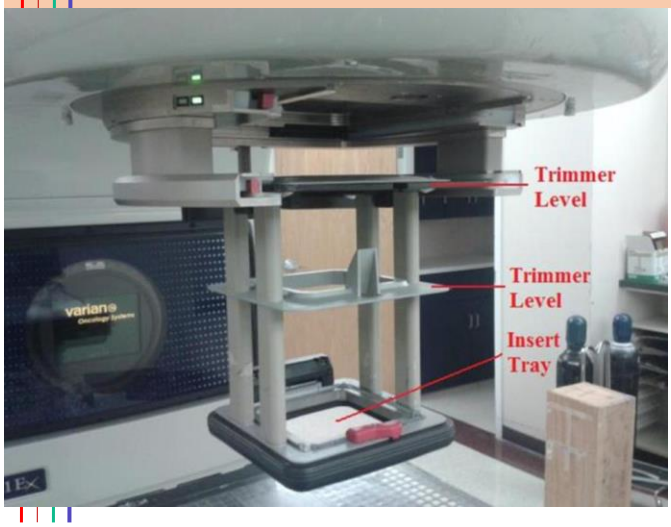
- Treatment summary refers to beam energy such as 6X, 12 MV.
- CTR codes treatment modality to **01**: External beam, NOS- **Incorrect!**
- The X or MV in the treatment summary tells us that photon therapy was delivered. Treatment modality code should be **02: External beam, photons**

Planning Technique code

- Treatment summary refers to planning technique as IMRT/VMAT/SBRT. 1200 cGy x 3 fx.
- CTR codes planning technique to 05: IMRT- **Incorrect!**

- VMAT refers to rotational/arc therapy. When used w/ conventional fractionation, code to 05: IMRT
- When delivered via SBRT w/ hypofractionation, code to **06: Stereotactic radiotherapy or radiosurgery, NOS**

"En Face" technique



- "en face" refers to electron therapy.

- Treatment modality code is **04: Electrons**
- Most electron boost are 3D conformal (04). Check with your facility for the policy on these.

FnF (Field-in-Field), e-comp

- Treatment technique coded to 01: External beam, NOS – **Incorrect!**
- If the treatment summary alludes to FnF or e-comp for the planning technique, code to 04: 3D Conformal.

Total Dose Summary for Simultaneous Integrated Boost (SIB)

- Pt w/ base of tongue SCC treated w/ EBRT/VMAT:

Txt Site	Energy	Dose/Fx (cGy)	Fractions	Total Dose (cGy)
PTVp1_70Gy. Primary & LN	6X	200	35	7000
PTVp_66.5Gy Primary subclinical	6X	190	35	6650
PTVn_60Gy RT neck	6X	171	35	5895
PTVn_56Gy LT neck	6X	160	35	5600

Total Dose Summary for SIB

#	Field	Code/Definition
1	Rad/Surg Sequence	0 No radiation and/or surg
2	Reason no RT	0 RT was administered
3	Location of RT	1 All RT at this facility
4	Date Started/Flag	10/23/20
5	Date Finished/Flag	12/17/20
6	Number of Phases	3
7	Discontinued Early	01 RT completed
8	Total Dose	025145

- CTR codes total dose and number of phases as follows:

# of phases incorrect.

Total Dose incorrect

Total Dose Summary for SIB

- Correct codes:
- While we can only capture and code three phases, we must enter the total # of phases in item #6.
- When Simultaneous Integrated Boost (SIB) is used, the total dose entered in item #8 is the highest PTV dose delivered. Do not add the dose for each PTV to get the total dose.

#	Field	Code/Definition
1	Rad/Surg Sequence	0 No radiation and/or surg
2	Reason no RT	0 RT was administered
3	Location of RT	1 All RT at this facility
4	Date Started/Flag	10/23/20
5	Date Finished/Flag	12/17/20
6	Number of Phases	**4**
7	Discontinued Early	01 RT completed
8	Total Dose	**007000**

Irradiated volume: CNS-Glioblastoma multiforme

- 65 y/o male who presented to ER w/ RT focal arm seizures, unsteady gait, loss of balance, short-term memory loss. Pt denies nausea, vomiting, headaches.
- Brain resection: glioblastoma, IDH Wild-type, WHO grade 2.
- Prescribed concurrent temozolomide + EBRT/VMAT

Site	Energy	Dose/fx (cGy)	# fx	Total dose (cGy)	Start	End
Brain 4600	6X	200	23	4,600	8/3/20	9/2/20
Brain CD6000	6X	200	7	1,400	9/3/20	9/14/20
Total			**30**	**6,000**		

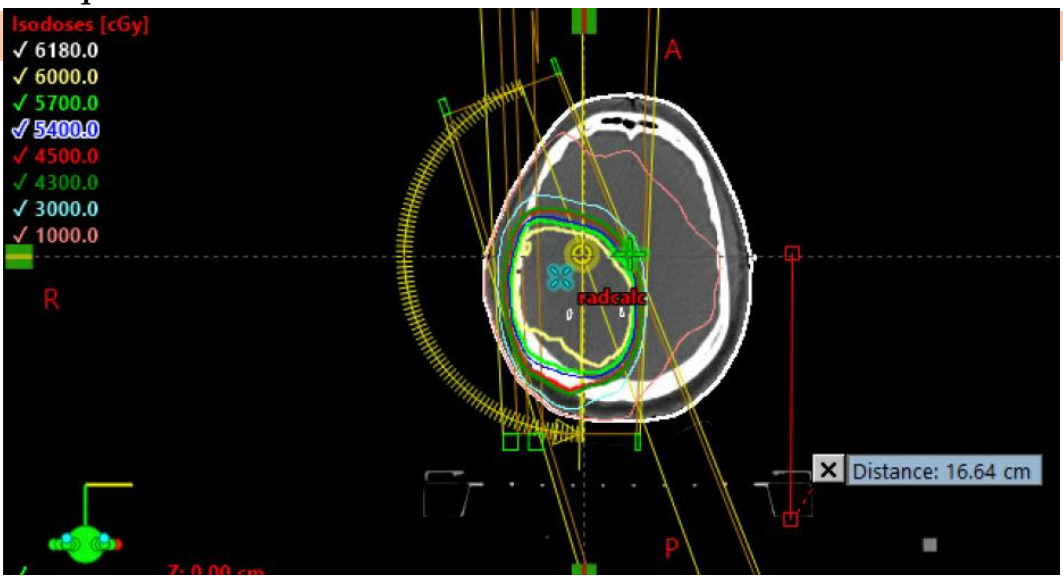
Case - GBM

Seg	#	Field	Code/Definition
Summary	1	Rad/Surg Sequence	3 Radiation after surgery
	2	Reason No Rad	0 Radiation was admin..
	3	Location of Rad	1 All RT at this facility
	4	Date RT Started/Flag	08/03/20
	5	Date RT Ended/Flag	09/14/20
	6	Number of Phases of RT	02
	7	RT Discontinued Early	01 Radiation completed
	8	**Total Dose**	**006000**
Phase 1	9	Primary Treatment Volume	12 Whole brain
	10	Rad to Draining LNs	00 No RT to draining lymph nodes
	11	Treatment Modality	02 External beam, photons
	12	Planning Technique	05 IMRT
	13	Dose per Fraction	00200
	14	Number of Fractions	023
	15	Phase I Total Dose	004600
Phase 2	16	Primary Treatment Volume	12 Whole brain
	17	Rad to Draining LNs	00 No RT to draining lymph nodes
	18	Treatment Modality	02 External beam, photons
	19	Planning Technique	05 IMRT
	20	Dose per Fraction	00200
	21	Number of Fractions	007
	22	Phase II Total Dose	001400
Phase 3	23	Primary Treatment Volume	00
	24	Rad to Draining LNs	
	25	Treatment Modality	
	26	Planning Technique	
	27	Dose per Fraction	
	28	Number of Fractions	
	29	Phase III Total Dose	

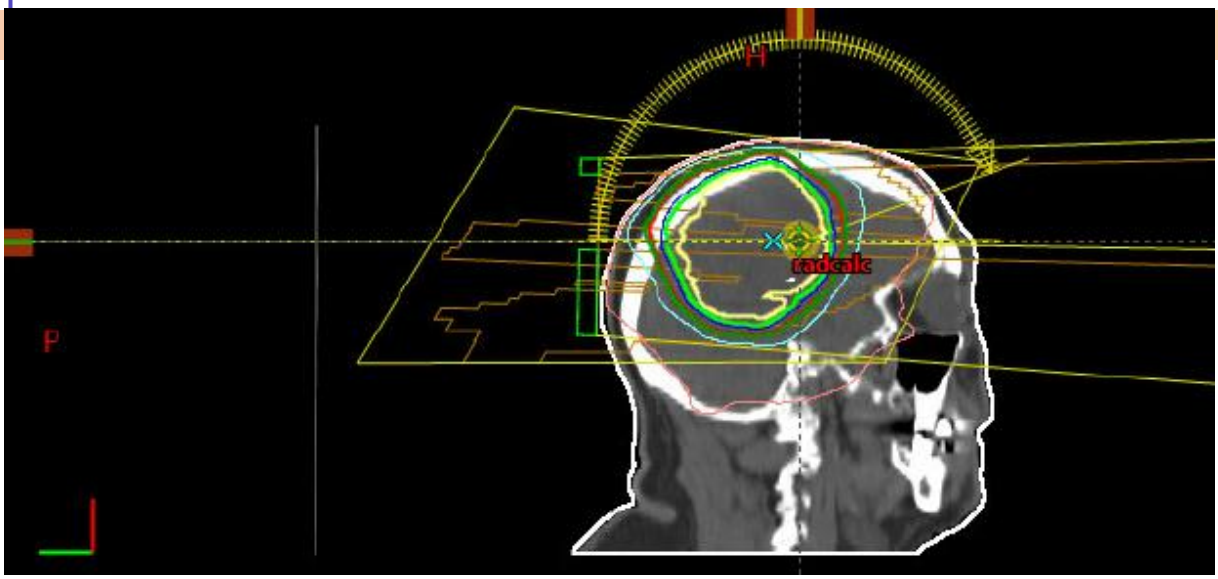
CTR coded irradiated volume for both phases to 12: Whole brain.

Incorrect!

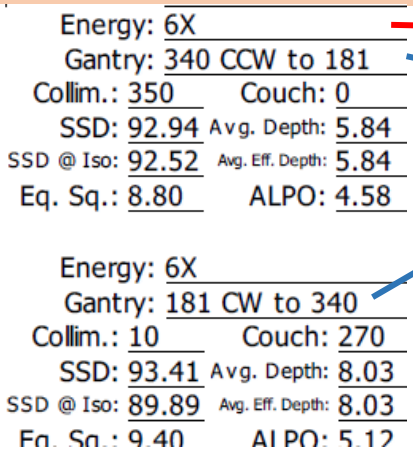
Clinical Scenario 2: Treatment planning images. Mosaiq/ARIA



Clinical Scenario 2: Treatment planning images- Mosaiq/ARIA



Clinical Scenario 2: Interpreting treatment planning information



Planning modality= 02, photons

CCW: counterclockwise, indicative of rotational therapy (VMAT). Gives range of rotation/arc.
CW: Clockwise

Information confirms IMRT planning technique (05)!

Case - GBM

Seg	#	Field	Code/Definition
Summary	1	Rad/Surg Sequence	3 Radiation after surgery
	2	Reason No Rad	0 Radiation was admin..
	3	Location of Rad	1 All RT at this facility
	4	Date RT Started/Flag	08/03/20
	5	Date RT Ended/Flag	09/14/20
	6	Number of Phases of RT	02
	7	RT Discontinued Early	01 Radiation completed
	8	**Total Dose**	**006000**
Phase 1	9	Primary Treatment Volume	13 Brain (limited)
	10	Rad to Draining LNs	00 No RT to draining lymph nodes
	11	Treatment Modality	02 External beam, photons
	12	Planning Technique	05 IMRT
	13	Dose per Fraction	00200
	14	Number of Fractions	023
	15	Phase I Total Dose	004600
Phase 2	16	Primary Treatment Volume	13 Brain (limited)
	17	Rad to Draining LNs	00 No RT to draining lymph nodes
	18	Treatment Modality	02 External beam, photons
	19	Planning Technique	05 IMRT
	20	Dose per Fraction	00200
	21	Number of Fractions	007
	22	Phase II Total Dose	001400
Phase 3	23	Primary Treatment Volume	00
	24	Rad to Draining LNs	
	25	Treatment Modality	
	26	Planning Technique	
	27	Dose per Fraction	
	28	Number of Fractions	
	29	Phase III Total Dose	

Correct Coding:

#6: There are two separate volumes being irradiated, which makes each a separate phase.
#9/16: Reviewing planning images can assist us in determining irradiated volumes. In general, irradiated brain volume is limited when treating gliomas. Do not use code 12 (whole brain)
#12/19: VMAT was clearly specified. In addition, planning information refers to rotational therapy.
#16: Cone down (CD) boost focuses on small volume within the primary site.

Electronic brachytherapy

- Treatment summary: Following RT breast lumpectomy, pt undergoes IORT via electronic brachytherapy with Zeiss Intrabeam, to a total dose of 20 Gy.

- CTR codes as follows:
  - Treatment modality= 12-Brachytherapy, electronic
  - Planning technique= 88-NA, treatment not by external beam.
  - Total dose= 999998

Incorrect!

Zeiss INTRABEAM

Electronic Brachytherapy

Because of the manner in which the x-rays are generated in this system (very much like a linac), and taking into account the low photon energies produced, this treatment modality ***should be coded 02, external beam, photons***.
Planning Technique: ***02, low energy x-ray/photon therapy***.

Electronic brachytherapy

- Should be coded as follows:
  - Treatment modality= **02 – External beam, photons**
  - Planning technique= **02 – Low energy x-ray/photon therapy**
  - Total dose= **002000**

CHALLENGING SCENARIOS

Thyroid Radioablative Therapy

• Nuclear medicine thyroid med uptake scan:

"After the oral administration of **4.2 mCi I-131** sodium iodide, anterior and posterior whole-body images were performed at 48 hours. Radioiodine uptake was measured and calculated at 48 hours"

Therapeutic or diagnostic dose??

Thyroid Radioablative Therapy 1

- 6/2/20 @ XXX: I-131 RADIOABLATIVE THERAPY FOR METS THYROID CA. ACTIVITY= **150.1 mCi** IN CAPSULE FORM.

Descriptive Name		Field Value
Location of Radiation Treatment		1
Date RT Started		06/02/2020
Date RT Ended		06/02/2020
Phase I Radiation Primary Tre...		(98) Other
Phase I Radiation to Draining ...		(00) No radiation treatment
Phase I Radiation Treatment M...		(13) Radioisotopes, NOS
Phase I Radiation External Be...		(88) Not Applicable
Phase I Dose per Fraction		(99998) Not applicable, radioisotopes administered to the patient
Phase I Number of Fractions		(001)
Phase I Total Dose		(999998) Not applicable, radioisotopes administered to the patient
Phase II Radiation Primary Tre...		(00) No radiation treatment

Thyroid Radioablative Therapy 2

- 2/12/20 @ YYY: IODINE-131 CAPSULE ABLATIVE THYROID TREATMENT. **29 mCi**.

Descriptive Name		Field Value
Location of Radiation Treatment		1
Date RT Started		02/12/2020
Date RT Ended		02/12/2020
Phase I Radiation Primary Tre...		(98) Other
Phase I Radiation to Draining ...		(00) No radiation treatment
Phase I Radiation Treatment M...		(13) Radioisotopes, NOS
Phase I Radiation External Be...		(88) Not Applicable
Phase I Dose per Fraction		(99998) Not applicable, radioisotopes administered to the patient
Phase I Number of Fractions		(001)
Phase I Total Dose		(999998) Not applicable, radioisotopes administered to the patient
Phase II Radiation Primary Tre...		(00) No radiation treatment

Thyroid Radioablative Therapy

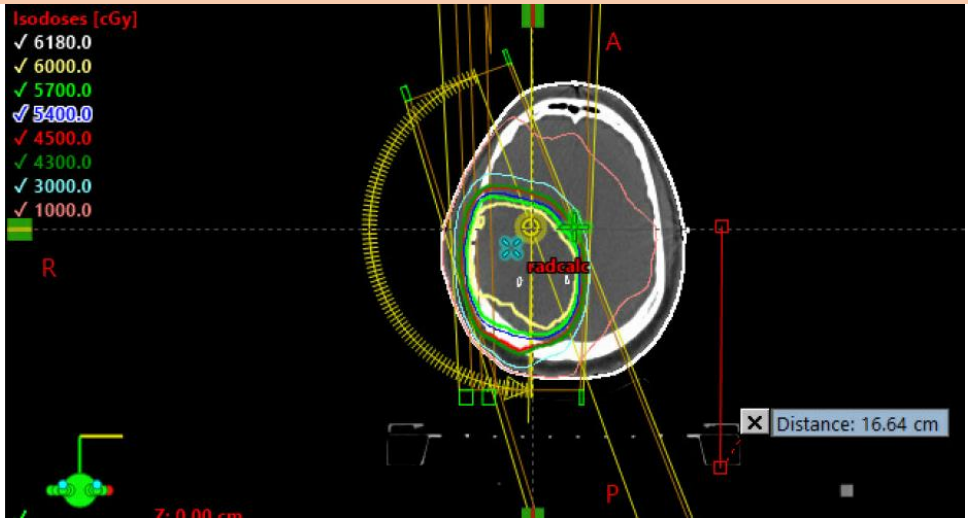
- **Diagnostic** levels of I-131 typically < 5 mCi
- **Therapeutic** levels of I-131 > 20 mCi.

Clinical Scenario 1: CNS-Glioblastoma multiforme

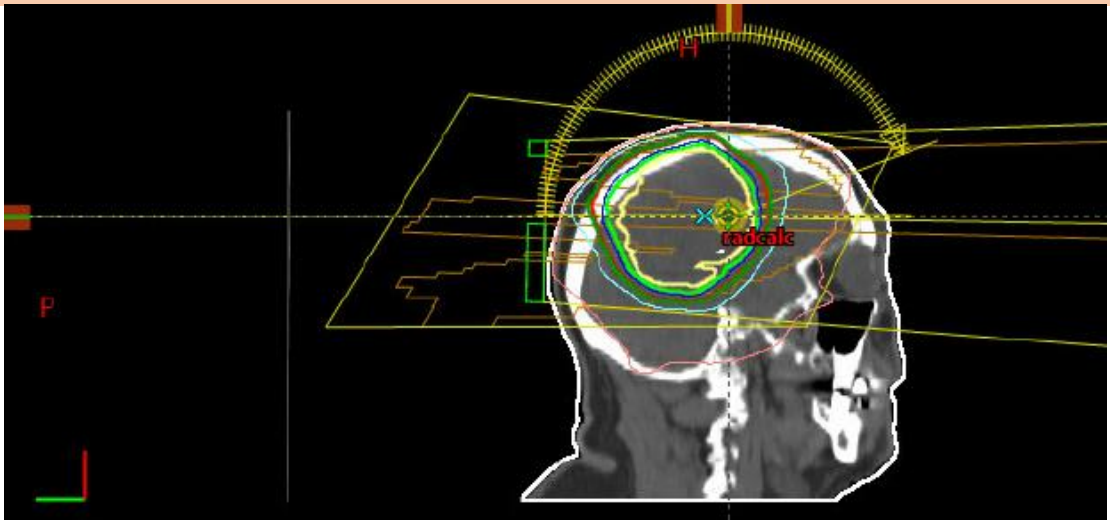
- 65 y/o male who presented to ER w/ RT focal arm seizures, unsteady gait, loss of balance, short-term memory loss. Pt denies nausea, vomiting, headaches.
- Brain resection: glioblastoma, IDH Wild-type, WHO grade 2.
- Prescribed concurrent temozolomide + EBRT/VMAT

Site	Energy	Dose/fx (cGy)	# fx	Total dose (cGy)	Start	End
Brain 4600	6X	200	23	4,600	8/3/20	9/2/20
Brain CD6000	6X	200	7	1,400	9/3/20	9/14/20
Total			**30**	**6,000**		

Clinical Scenario 1: Treatment planning images. Mosaiq/ARIA



Clinical Scenario 1: Treatment planning images- Mosaiq/ARIA



Clinical Scenario 1: Interpreting treatment planning information in Mosaiq or ARIAS

Energy:	6X		
Gantry:	340 CCW to 181		
Collim.:	350	Couch:	0
SSD:	92.94	Avg. Depth:	5.84
SSD @ Iso:	92.52	Avg. Eff. Depth:	5.84
Eq. Sq.:	8.80	ALPO:	4.58

Energy:	6X		
Gantry:	181 CW to 340		
Collim.:	10	Couch:	270
SSD:	93.41	Avg. Depth:	8.03
SSD @ Iso:	89.89	Avg. Eff. Depth:	8.03
Eq. Sq.:	9.40	ALPO:	5.12

Planning modality= 02, photons

CCW: counterclockwise, indicative of rotational therapy (VMAT). Gives range of rotation/arc.
CW: Clockwise

Information confirms IMRT planning technique (05)!

Case 1- GBM

Seg	#	Field	Code/Definition
Summary	1	Rad/Surg Sequence	3 Radiation after surgery
	2	Reason No Rad	0 Radiation was admin..
	3	Location of Rad	1 All RT at this facility
	4	Date RT Started/Flag	08/03/20
	5	Date RT Ended/Flag	09/14/20
	6	Number of Phases of RT	02
	7	RT Discontinued Early	01 Radiation completed
	8	**Total Dose**	**006000**
Phase 1	9	Primary Treatment Volume	13 Brain (limited)
	10	Rad to Draining LNs	00 No RT to draining lymph nodes
	11	Treatment Modality	02 External beam, photons
	12	Planning Technique	05 IMRT
	13	Dose per Fraction	00200
	14	Number of Fractions	023
	15	Phase I Total Dose	004600
Phase 2	16	Primary Treatment Volume	13 Brain (limited)
	17	Rad to Draining LNs	00 No RT to draining lymph nodes
	18	Treatment Modality	02 External beam, photons
	19	Planning Technique	05 IMRT
	20	Dose per Fraction	00200
	21	Number of Fractions	007
	22	Phase II Total Dose	001400
Phase 3	23	Primary Treatment Volume	00
	24	Rad to Draining LNs	
	25	Treatment Modality	
	26	Planning Technique	
	27	Dose per Fraction	
	28	Number of Fractions	
	29	Phase III Total Dose	

Case 1 Rationale:

#6: There are two separate volumes being irradiated, which makes each a separate phase.
#9/16: Reviewing planning images can assist us in determining irradiated volumes. In general, irradiated brain volume is limited when treating gliomas. Do not use code 12 (whole brain)
#12/19: VMAT was clearly specified. In addition, planning information refers to rotational therapy.
#16: Cone down (CD) boost focuses on small volume within the primary site.

Clinical Scenario 2a-Prostate VMAT & SBRT

STORE 2018-2020

- 67 y.o. male with high risk prostatic adenocarcinoma (cT3a by MRI (suspicious for EPE), Gleason 4+3=7, 14/17 total cores, PSA 14.5). Underwent prostatectomy & was referred for radiation therapy. How would you code the VMAT (05) & SBRT/SRS (06)?

Site	Dose (cGy)	FxDose (cGy)	Fx	Technique	Start	End
Tumor bed/pelvis	4,500	180	25/25	VMAT	5/14/19	6/18/19
Tumor bed CD	1,950	650	3/3	VMAT/SBRT	6/19/19	6/25/19

50

Case 2a- Prostate

Seg	#	Field	Code/Definition
/Summary	1	Rad/Surg Sequence	0 No radiation and/or sur
	2	Reason No Rad	0 Radiation was admin..
	3	Location of Rad	01 All RT at this facility
	4	Date Started/Flag	05/14/2019
	5	Date Finished/Flag	06/25/2019
	6	Number of Phases	02
	7	Discontinued Early	01 Radiation completed
	8	Total Dose	006540
Phase 1	9	Volume	86 Pelvis
	10	Rad to Nodes	06 Pelvic lymph nodes
	11	Modality	02 External beam, photons
	12	Planning Technique	05 IMRT
	13	Number of Fractions	025
	14	Dose per Fraction	00180
	15	Total Phase 1 Dose	005040
Phase 2	16	Volume (boost)	86 Pelvis
	17	Rad to Nodes	00 No RT to draining LNs
	18	Modality	02 External beam, photons
	19	Planning Technique	06 SBRT
	20	Number of Fractions	003
	21	Dose per Fraction	00650
	22	Total Phase 2 Dose	001950
Phase 3	23	Volume	00
	24	Rad to Nodes	
	25	Modality	
	26	Planning Technique	
	27	Number of Fractions	
	28	Dose per Fraction	
	29	Total Phase 3 Dose	

Case 2a Rationale:

#8: Sum of all phases.
#10: Pelvis is mentioned, which means that the regional lymph nodes are included/targeted in the irradiated field.
#12: VMAT= IMRT
#17: When SBRT is used, lymphatics are not included.
#19: When VMAT (or IMRT) and SBRT are mentioned in the treatment summary for a phase, select SBRT (06)

Clinical Scenario 2b-Prostate VMAT & SBRT

STORE 2021+

- 67 y.o. male with high risk prostatic adenocarcinoma (cT3a by MRI (suspicious for EPE), Gleason 4+3=7, 14/17 total cores, PSA 14.5). Underwent prostatectomy & was referred for radiation therapy. How would you code the VMAT (05) & SBRT/SRS (06)?

Site	Dose (cGy)	FxDose (cGy)	Fx	Technique	Start	End
Tumor bed/pelvis	4,500	180	25/25	VMAT	5/14/21	6/18/21
Tumor bed CD	1,950	650	3/3	VMAT/SBRT	6/19/21	6/25/21

52

Case 2b- Prostate

Seg	#	Field	Code/Definition
/Summary	1	Rad/Surg Sequence	0 No radiation and/or sur
	2	Reason No Rad	0 Radiation was admin..
	3	Location of Rad	01 All RT at this facility
	4	Date Started/Flag	05/14/2021
	5	Date Finished/Flag	06/25/2021
	6	Number of Phases	02
	7	Discontinued Early	01 Radiation completed
	8	Total Dose	006540
Phase 1	9	Volume	**64 Prostate-whole**
	10	Rad to Nodes	06 Pelvic lymph nodes
	11	Modality	02 External beam, photons
	12	Planning Technique	05 IMRT
	13	Number of Fractions	025
	14	Dose per Fraction	00180
	15	Total Phase 1 Dose	005040
Phase 2	16	Volume (boost)	**64 Prostate-whole**
	17	Rad to Nodes	00 No RT to draining LNs
	18	Modality	02 External beam, photons
	19	Planning Technique	06 SBRT
	20	Number of Fractions	003
	21	Dose per Fraction	00650
	22	Total Phase 2 Dose	001950
Phase 3	23	Volume	00
	24	Rad to Nodes	
	25	Modality	
	26	Planning Technique	
	27	Number of Fractions	
	28	Dose per Fraction	
	29	Total Phase 3 Dose	

Case 2b (2021) Rationale:

#8: Sum of all phases.
#10: Pelvis is mentioned, which means that the regional lymph nodes are included/targeted in the irradiated field.
#12: VMAT= IMRT
#17: When SBRT is used, lymphatics are not included.
#19: When VMAT (or IMRT) and SBRT are mentioned in the treatment summary for a phase, select SBRT (06)

Clinical Scenario 3a: Endometrial cancer 2019 case

- 67 y/o pt, presented w/ postmenopausal bleeding w/ positive findings on endometrial bx. Pt underwent TAH/BSO with pelvic lymphadenectomy.
- Pathology revealed 6.5 cm endometrioid adenocarcinoma with 89% Myometrial invasion, high histologic grade. Involvement of uterine serosa, upper endocervix with positive margins on inf endocervical. LVI-. Pelvic LNs = 0/11 neg. Stage pT3b, N0.
- Pt underwent concurrent cisplatin/RT followed by carboplatin + paclitaxel.

54

Clinical Scenario 3a: Endometrial cancer

- Radiation Therapy Treatment Summary:

Txt Site	Total Dose	Modality	Fx	Start date	End date
Whole pelvis	4500 cGy	6X/IMRT	25	1/7/19	2/11/19
Vaginal cuff	1200 cGy	Ir-192	2	2/13/19	2/18/19

- "Whole Pelvis" implies RT to primary site or tumor bed **and** regional lymph nodes.
- "Vagina cuff" implies intracavitary brachytherapy.

55

Case 3a: Endometrial

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	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	Planning 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	Planning Technique	88 NA
	20	Number of Fractions	02
	21	Dose per Fraction	00600
	22	Total Phase 2 Dose	001200
Phase 3	23	Volume	00
	24	Rad to Nodes	
	25	Modality	
	26	Planning Technique	
	27	Number of Fractions	
	28	Dose per Fraction	
	29	Total Phase 3 Dose	

Case 3a Rationale(2019):

#8: You cannot add dose from brachytherapy procedure with EBRT dose.
#9: Phases in chronological order. If primary site in pelvic region is surgically removed, code to 86.
#10: RT treatment summary clearly states that the whole pelvis was irradiated. This includes regional LNs.
#16: When intracavitary HDR brachytherapy is administered to the vaginal cuff for endometrial cancer or cervical cancer, post TAH/BSO, primary treatment volume is Vagina.

Clinical Scenario 3b: Endometrial cancer
STORE **2021**

- 67 y/o pt, presented w/ postmenopausal bleeding w/ positive findings on endometrial bx. Pt underwent TAH/BSO with pelvic lymphadenectomy.
- Pathology revealed 6.5 cm endometrioid adenocarcinoma with 89% Myometrial invasion, high histologic grade. Involvement of uterine serosa, upper endocervix with positive margins on inf endocervical. LVI-. Pelvic LNs = 0/11 neg. Stage pT3b, N0.
- Pt underwent concurrent cisplatin/RT followed by carboplatin + paclitaxel.

57

Clinical Scenario 3: Endometrial cancer
2021 case

- Radiation Therapy Treatment Summary:

Txt Site	Total Dose	Modality	Fx	Start date	End date
Whole pelvis	4500 cGy	6X/IMRT	25	1/7/21	2/11/21
Vaginal cuff	1200 cGy	Ir-192	2	2/13/21	2/18/21

- "Whole Pelvis" implies RT to primary site or tumor bed **and** regional lymph nodes.
- "Vaginal cuff" implies intracavitary brachytherapy.

58

Case 3b: Endometrial

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	**01/07/21**
	5	Date Finished/Flag	**02/18/21**
	6	Number of Phases	02
	7	Discontinued Early	01 Completed
	8	Total Dose	999998
Phase 1	9	Volume	**71 Uterus or cervix**
	10	Rad to Nodes	06 Pelvic lymph nodes
	11	Modality	02 External beam, photons
	12	Planning 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	Planning Technique	88 NA
	20	Number of Fractions	02
	21	Dose per Fraction	00600
	22	Total Phase 2 Dose	001200
Phase 3	23	Volume	00
	24	Rad to Nodes	
	25	Modality	
	26	Planning Technique	
	27	Number of Fractions	
	28	Dose per Fraction	
	29	Total Phase 3 Dose	

Case 3b Rationale(2021):

#8: You cannot add dose from brachytherapy procedure with EBRT dose.
#9: Phases in chronological order. For cases diagnosed 2021 forward, if primary site in pelvic region is surgically removed, code to resected primary site.
#10: RT treatment summary clearly states that the whole pelvis was irradiated. This includes regional LNs.
#16: When intracavitary HDR brachytherapy is administered to the vaginal cuff for endometrial cancer or cervical cancer, post TAH/BSO, primary treatment volume is Vagina.

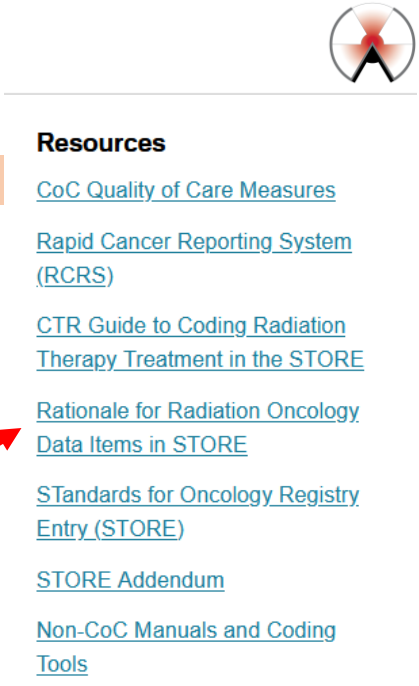
Radiation Oncology Working Group, Commission on Cancer

- John Christodouleas, MD, MPH
  - Dept. of Radiation Oncology
  - Hospital of the Univ. of Pennsylvania
  - Medical Affairs, Elekta, Inc.
- Ted Williamson, MD, PhD, CTR
  - Salem Health Radiation Oncology (Emeritus)
  - Medical Director, Onco, Inc.
  - Wilson Apollo, MS, CTR
    - WHA Consulting
- Susanne Kessler, MSM, RHIT, CTR
- Manager, NCDB Information and Data Standards
  - Commission on Cancer

Resources

Dr. John Cristodouleas, radiation oncologist, has an informative webinar (**free**) on the RT items, interpreting RT prescriptions, treatment modality, planning techniques, just to name a few.

https://www.facs.org/Quality-Programs/Cancer/NCDB



Resources

- Dr. Ted Williamson will be contributing a presentation on the upcoming CTR Guide revisions, highlighting some of the new case scenarios (also free).
- Tentative publication date: January 2021

STORE 2021, p.270

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.

- Upcoming revision to this entry (oversight). I-131 treatment to thyroid **should be coded to 98-Other**, as previously instructed.

Cancer Surgery Standards PROGRAM
AMERICAN COLLEGE OF SURGEONS

CoC Operative Standards 5.3-5.8: Updates on Resources and Compliance

Amanda Francescatti, MS
Senior Manager, Cancer Surgery Standards Program

NAACCR Treatment Webinar– January 7, 2021

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Cancer Surgery Standards Program Overview

Mission

To improve the quality of surgical care for persons with cancer

Goals

- Collaborate with the ACS Cancer Research Program to develop evidence-based standards for the technical conduct of oncologic surgery
- Create and disseminate tools that support implementation and adherence to standards, including synoptic operative report templates and electronic protocols for cancer surgery
- Educate surgeons on the technical conduct of oncologic surgery

Leadership

CSSP Chair:	Matthew H.G. Katz, MD FACS
CSSP Vice-Chair:	Kelly K. Hunt, MD, FACS
Senior Manager:	Amanda B. Francescatti, MS

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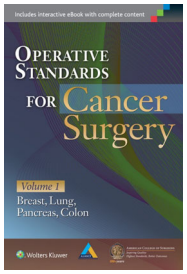
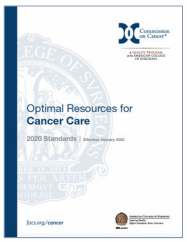
The CoC Operative Standards





Standard	Disease Site	Procedure	Documentation
5.3	Breast	Sentinel node biopsy	**Operative report**
5.4	Breast	Axillary dissection	**Operative report**
5.5	Melanoma	Wide local excision	**Operative report**
5.6	Colon	Colectomy (any)	**Operative report**
5.7	Rectum	Mid/low resection (TME)	Pathology report (CAP)
5.8	Lung	Lung resection (any)	Pathology report (CAP)

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Standard 5.3 - Breast Sentinel Node Biopsy

Standard

All sentinel nodes for breast cancer must be identified, removed, and subjected to pathologic analysis to ensure that sentinel lymph node mapping and sentinel lymphadenectomy provide accurate information for breast cancer staging.

Measures of Compliance

1. **All sentinel nodes for breast cancer are identified, removed, and subjected to pathologic analysis.**
2. **Operative reports for patients undergoing breast sentinel node biopsy includes required minimum elements in synoptic format.**

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Standard 5.4 - Breast Axillary Dissection

Standard

Axillary dissection for breast cancer constitutes removing level I and II lymph nodes within an anatomic triangle comprised of the axillary vein, chest wall, and latissimus dorsi, while preserving key neurovascular structures.

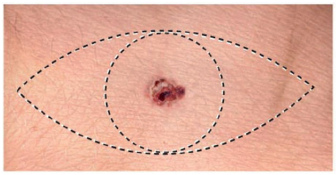
Measures of Compliance

1. Axillary dissections for breast cancer remove level I and II lymph nodes within an anatomic triangle comprised of the axillary vein, chest wall, and latissimus dorsi, while preserving key neurovascular structures.
2. Operative reports for patients undergoing axillary dissection include the required minimum elements in synoptic format.

Standard 5.5 - Primary Cutaneous Melanoma

Standard

Margin width for melanoma wide local excision is based on the Breslow thickness of the primary tumor and is measured circumferentially at the level of the skin from either residual gross tumor and/or the previous biopsy scar.



Measures of Compliance

1. Clinical margin width for wide local excision of invasive melanoma is 1 cm for melanomas less than 1 mm thick.
2. Clinical margin width for wide local excision of invasive melanoma is 1 to 2 cm for melanomas 1 to 2 mm thick.
3. Clinical margin width for wide local excision of invasive melanoma is 2 cm for melanomas greater than 2 mm thick.
4. The clinical margin width for wide local excision of a melanoma in situ is at least 5 mm.
5. Operative reports for patients undergoing a wide local excision of a primary cutaneous melanoma include the required minimum elements in synoptic format

Standard 5.6 - Colon Resection

Standard

Resection of the tumor-bearing bowel segment and complete lymphadenectomy is performed en bloc with proximal vascular ligation at the origin of the primary feeding vessel(s).

Measures of Compliance

1. Resection of the tumor-bearing bowel segment and complete lymphadenectomy is performed en bloc with proximal vascular ligation at the origin of the primary feeding vessel(s).
2. Operative reports for patients undergoing resection for colon cancer include the required minimum elements in synoptic format.

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Standard 5.7 - Total Mesorectal Excision

Standard

Total mesorectal excision (TME) is performed for all patients undergoing radical surgical resection of mid and low rectal cancers. Per College of American Pathologists (CAP) cancer protocol template for rectal cancer resections, the quality of TME resection (complete, near complete, or incomplete) must be documented in curative resection of rectal adenocarcinoma pathology reports in synoptic format.

Measures of Compliance

1. Total mesorectal excision is performed for all patients undergoing radical surgical resection of mid and low rectal cancers and results in a complete or near complete mesorectal excision.
2. The quality of TME resection (complete, near complete, or incomplete) is documented in curative resection of rectal adenocarcinoma pathology reports in synoptic format.

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Commission on Cancer Operative Standards 2020

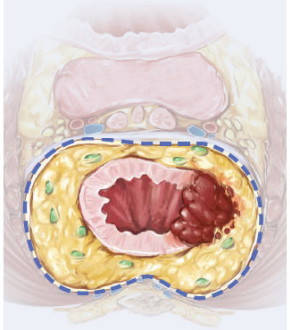
Standard 5.7: Total Mesorectal Excision

Operation

Total mesorectal excision (TME) is performed for mid and low rectal tumors, resulting in **complete** or **near-complete** TME

Keep fascia propria of rectum intact, operate in plane between rectum and presacral fascia
- *Ensures negative margins*
- *Protects neurovascular structures*

Maintain the 'Holy Plane'



Pathology Documentation

Quality of TME documented in synoptic report:

- ☑ Complete
- ○ Near-Complete
- ○ Incomplete

When?

2021:
Implementation

2022 site visits:
70%
Compliance

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Commission on Cancer®

Commission on Cancer® National Accreditation Program for Rectal Cancer

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Standard 5.8 - Pulmonary Resection

Standard

The surgical pathology report following any curative intent pulmonary resection for primary lung malignancy must contain lymph nodes from at least one (named and/or numbered) hilar station and at least three distinct (named and/or numbered) mediastinal stations.

Measures of Compliance

1. The surgical pathology report following any curative intent pulmonary resection for primary lung malignancy must contain lymph nodes from at least one (named and/or numbered) hilar station and at least three distinct (named and/or numbered) mediastinal stations.

2. The nodal stations examined by the pathologist must be documented in curative pulmonary resection pathology reports in synoptic format.

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Standard 5.8: Pulmonary Resection

Operation

For any primary pulmonary resection performed with curative intent
(including non-anatomic parenchymal-sparing resections)

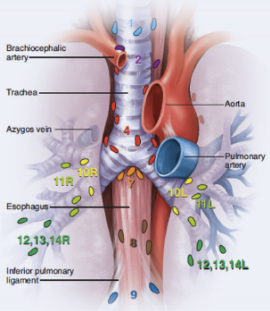
Resect nodal stations from:

Mediastinum
(Stations 2-9)
≥3 distinct stations

Hilum
(Stations 10-14)
≥1 station

Pathology Documentation

Synoptic report documents lymph nodes from:



≥ 1 hilar station

≥ 3 mediastinal stations

with names and/or numbers of stations

Figure adapted from Mountain CF, Dresler CM. Regional lymph node classification for lung cancer staging. *Chest* 1997;111:1718–1723.

When?

2021:
Implementation

2022 site visits:
70%
Compliance

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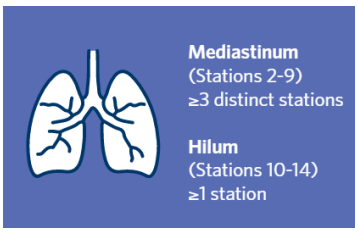
Clarifications for CoC Standards 5.7 and 5.8

- The following clarifications were recently made for Standards 5.7 and 5.8:
  - To align with the College of American Pathologists cancer protocol template for rectal cancer resections, Standard 5.7 does not apply to primary resection specimens with no residual cancer (e.g., following neoadjuvant therapy).
  - Nodes taken from station 1 are not mediastinal and will not count toward Standard 5.8 requirements. The definition of mediastinal lymph node stations is 2–9.
  - Edits will be reflected in *Optimal Resources for Cancer Care (2020 Standards)* in early 2021



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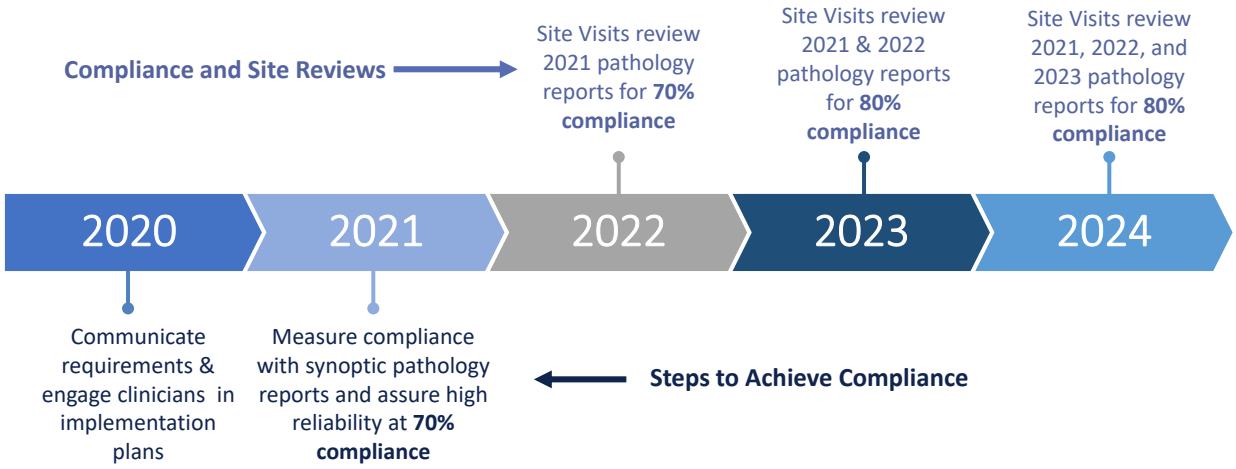
Standards 5.7 and 5.8 Requirements



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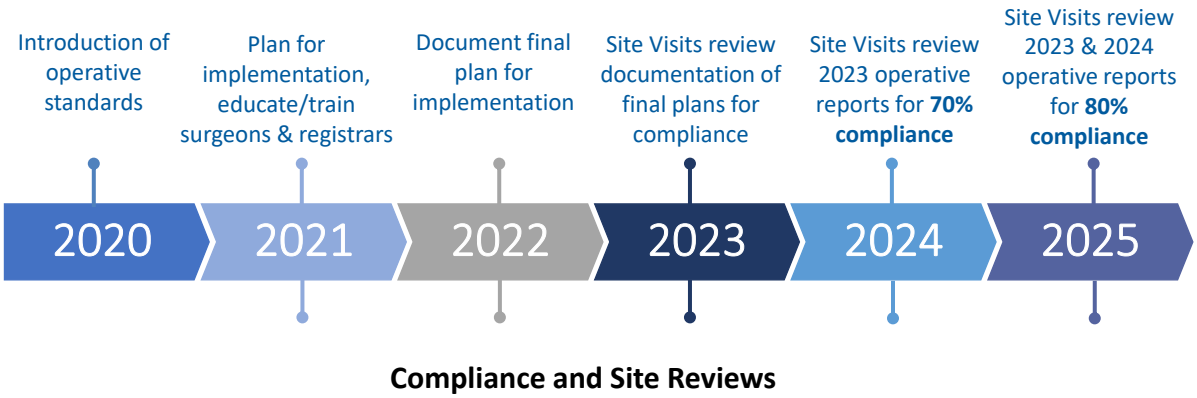
Standards 5.3 — 5.6 Requirements



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CoC Facility Compliance with Standards 5.3 — 5.6

- Compliance rates with the operative standards are estimated at 50-60% yet facilities need to be at 70% compliance by January 2023
- Preparedness survey of CoC sites
  - Results show many sites have had minimal to no communication/engagement with surgeons regarding CoC Operative Standards 5.3-5.6
  - Sites estimate it would take 6-12 months for surgeons to achieve routine use of synoptic operative reports
  - Survey results show promotion and educational content are crucial to the success of CoC sites with compliance to standards

What is the CSSP doing to help CoC accredited programs?

- Communications
  - via ACS channels and social media to raise awareness of the CoC operative standards
  - Presenting updates at quarterly State Chair Town Halls and CLP meetings
  - Cancer Programs-sponsored educational workshops and webinars
- Creating videos and visual abstracts on compliance and technical components that can be shared at tumor boards
- Drafting resources for registrars, State Chairs and CLPs to distribute at CoC facilities
- Developing synoptic operative reporting templates for Standards 5.3-5.6
  - Working with major EHR vendors to integrate required data elements for synoptic operative reporting
- Submitting proposals for presentations at national meetings

What Should CoC Accredited Programs Do Right Now?

- Contact EHR vendors
  - To confirm plans are underway to include synoptic operative reports/CoC elements for surgeons and to learn about the release timelines
- Ensure surgeons are aware of the operative standards
- Distribute communications and tools/resources developed by the CSSP to appropriate individuals
- Share information on upcoming workshops, webinars and surveys when available

Recently Released Resources as of 1/7/21

- CoC Operative Standards Introduction Video: 6-minute overview that can be shared during tumor board
- Featured episode on Society of Surgical Oncology podcast SurgOnc Today: "American College of Surgeons Operative Standards for Cancer Surgery – Why we need them and how to put them into practice"
- Recording and slides from 12/7 multidisciplinary webinar on Standard 5.7
  - Coming soon: One-page summary with questions/answers from 12/7 webinar
- Recording and slides from 12/15 multidisciplinary webinar on Standard 5.8
  - Coming soon: One-page summary with questions/answers from 12/15 webinar
- Resources available on CSSP Resources webpage
- Updates and communications about CoC operative standards posted on CoC 2020 Standards and Resources page

Resources and Events Coming Soon

- One-page visual abstracts for Standards 5.3-5.8
- Comprehensive FAQ document for Standards 5.3-5.8
- Multidisciplinary webinars on Standards 5.3-5.8
- SurgOnc Today Podcasts and Tweet Chats on Standards 5.7 and 5.8
- "Toolkit" of available resources, checklists
- Survey to assess surgeon knowledge/awareness of the operative standards
- Resources will be posted on CSSP Resources webpage and CAnswer Forum, shared in Cancer Programs News and through Cancer Programs social media accounts (Facebook @AmColSurgCancer | Twitter @AmColSurgCancer)

Questions?

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Cancer Surgery Standards PROGRAM

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100+years

Neoadjuvant Data Items

Jennifer Ruhl, MSHCA, RHIT, CCS, CTR

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9/25/2020

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  - Peggy Adamo (NCI SEER)
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  - Serban Negoita (NCI SEER)

Neoadjuvant Data Items

- Neoadjuvant Therapy (NAACCR #1632)
- Neoadjuvant Therapy -- Clinical Response (NAACCR #1633)
- Neoadjuvant Therapy -- Treatment Effect (NAACCR #1634)

- Applicable for **all** cases with diagnosis date of 1/1/2021+
  - Edits will prevent you from collecting these data items with diagnosis date prior to 1/1/2021
  - Note: The only other edits on these data items are for the allowable values

- For 2021, SEER is the only standard setter that is requiring these data items

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Defining Neoadjuvant Therapy

- Also referred to as pre-surgical treatment or preoperative treatment
- Neoadjuvant Therapy administered to
  - Reduce disease burden
  - Eradicate or control undiscovered metastases
  - Improve outcomes of overall survival and disease-free survival

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Defining Neoadjuvant Therapy

The new neoadjuvant data items are all based on the following definition of neoadjuvant therapy:

systemic treatment (chemotherapy, endocrine / hormone therapy, targeted therapy, immunotherapy, or biological therapy) and/or radiation therapy before intended or performed surgical resection to improve local therapy and long-term outcomes

Defining Neoadjuvant Therapy

- A full course of neoadjuvant therapy is generally 4-6 months long
- Treatment must follow the recommended guidelines for the type and duration of treatment for that primary site and/or histology
- The length of a full course of treatment may vary depending on the primary site and/or histology
  - For example, some sites only require 2-3 months of neoadjuvant therapy
  - Refer to NCCN guidelines for further information on what is a full course of neoadjuvant therapy
  - A physician's statement that a patient has completed neoadjuvant therapy must be used for this data item

Neoadjuvant Therapy (NAACCR Item #1632)

This data item records whether the patient had neoadjuvant therapy prior to planned definitive surgical resection of the primary site

Code	Description
0	No neoadjuvant therapy, no treatment before surgery, surgical resection not part of first course of treatment plan Autopsy only
1	Neoadjuvant therapy completed according to treatment plan and guidelines
2	Neoadjuvant therapy started, but not completed OR unknown if completed
3	Limited systemic exposure when the intent was not neoadjuvant; treatment did not meet the definition of neoadjuvant therapy
9	Unknown if neoadjuvant therapy performed Death certificate only (DCO)

Neoadjuvant Therapy (NAACCR Item #1632)

- **Code 0:** No neoadjuvant therapy, no treatment before surgery, surgical resection not part of first course of treatment plan, autopsy only
  - Surgical resection not part of planned first course of treatment
    - ***Example 1*:** Patient diagnosed; only chemotherapy and/or radiation planned
    - ***Example 2*:** Patient diagnosed; active surveillance only
    - ***Example 3*:** Patient diagnosed; no treatment planned, sent to hospice
    - ***Example 4*:** Patient diagnosed; treatment refused

Neoadjuvant Therapy (NAACCR Item #1632)

- **Code 0:** No neoadjuvant therapy, no treatment before surgery, surgical resection not part of first course of treatment plan, autopsy only
  - Patient did not have neoadjuvant therapy based on sequence of treatment
    - ***Example 1*:** Patient diagnosed; surgery done two weeks later
    - ***Example 2*:** Patient diagnosed; surgery done, followed by chemotherapy and/or radiation
    - ***Example 3:*** Patient diagnosed, surgery done, followed by hormone therapy

Neoadjuvant Therapy (NAACCR Item #1632)

- **Code 0:** Neoadjuvant therapy not part of standard treatment
  - Primary Sites: C420, C421, C423, C424, C809
  - Schemas:
    - 00830 HemeRetic
    - 99999 Ill-Defined Other
    - 00790: Lymphoma
    - 00795: Lymphoma (CLL/SLL)
    - 00811: Mycosis Fungoides
    - 00822: Plasma Cell Disorders
    - 00822: Plasma Cell Myeloma
    - 00812: Primary Cutaneous Lymphomas (excluding MF and SS)

Neoadjuvant Therapy (NAACCR Item #1632)

- **Code 1:** Neoadjuvant therapy completed according to treatment plan and guidelines
  - Defined as any tumor directed therapy meeting the definition of neoadjuvant treatment AND
  - Occurring prior to an intended or performed definitive surgical resection AND
  - Documented as neoadjuvant treatment by a treating physician OR part of patient's documented treatment regimen/protocol
- Note: As long as the planned first course of treatment **was neoadjuvant therapy followed by surgical resection**, it does **not** matter if the surgical resection was done for this data item

Neoadjuvant Therapy (NAACCR Item #1632)

- **Code 1:** Neoadjuvant therapy completed according to treatment plan and guidelines (for all examples, planned first course of treatment is neoadjuvant therapy followed by surgical resection)
  - ***Example 1:*** Patient completes neoadjuvant therapy, planned surgical resection performed
  - ***Example 2:*** Patient completes neoadjuvant therapy, complete response, planned surgical resection cancelled
  - ***Example 3:*** Patient completes neoadjuvant therapy, during post neoadjuvant clinical work up, found to have extensive metastasis, planned surgical resection cancelled

Neoadjuvant Therapy (NAACCR Item #1632)

- **Code 2:** Neoadjuvant therapy started, but not completed OR unknown if completed
  - Defined as any tumor directed therapy (excluding surgical resection) meeting the definition of neoadjuvant therapy AND
  - Whose intent was neoadjuvant therapy AND
  - Patient did not complete the full course of neoadjuvant therapy

Neoadjuvant Therapy (NAACCR Item #1632)

- **Code 2:** Neoadjuvant therapy started, but not completed OR unknown if completed
  - ***Example 1:*** Planned neoadjuvant therapy, 6 cycles of chemotherapy. After 4th cycle, patient's tumor growing and neoadjuvant therapy stopped, surgical resection cancelled (neoadjuvant therapy failed)
  - ***Example 2:*** Patient diagnosed. Planned neoadjuvant therapy. Patient completed 3 of 6 cycles and refused further treatment
  - ***Example 3:*** Planned neoadjuvant therapy. Patient completed 2 of 4 cycles and developed complications. Treatment stopped

Neoadjuvant Therapy (NAACCR Item #1632)

- **Code 3:** Limited systemic exposure when the intent was not neoadjuvant; treatment did not meet the definition of neoadjuvant therapy
  - Defined as any tumor directed therapy (excluding surgical resection) AND
  - Not documented as neoadjuvant in the treatment plan AND
  - Does not meet treatment guidelines for recommendations for neoadjuvant therapy

Neoadjuvant Therapy (NAACCR Item #1632)

- **Code 3:** Limited systemic exposure when the intent was not neoadjuvant; treatment did not meet the definition of neoadjuvant therapy
  - Patients receive some type of therapy prior to surgical resection, but not enough to qualify for a full course of neoadjuvant therapy
- Limited exposure to systemic therapy:
  - May be given prior to surgery OR
  - Occur in clinical trials to study biology of cancer OR
  - Impacts the biology of a cancer
- It is not a full course of neoadjuvant therapy with the intent to impact extent of surgical resection or other outcomes
  - Do not code this as neoadjuvant therapy (codes 1 or 2)

Neoadjuvant Therapy (NAACCR Item #1632)

- **Code 9:** Unknown if neoadjuvant therapy performed or DCO (Central registries only for DCO)
  - Neoadjuvant therapy planned, but unknown if given

- ***Note:*** Code 9 (unknown) should be rarely used
- ***Reminder:*** Use code 0 when it is clear that the patient did not have neoadjuvant therapy based on the sequence of diagnosis and treatment
  - You do not need a physician's statement that no neoadjuvant therapy was administered
  - If patient did not have any treatment, code 0
  - Code 9 should be used mostly for when a patient had an initial plan of neoadjuvant therapy, but you don't know if it was administered

Neoadjuvant Therapy-Clinical Response (NAACCR #1633)

This data item records the clinical outcomes of neoadjuvant therapy prior to planned surgical resection

Code	Description
0	Neoadjuvant therapy not given
1	Complete clinical response (CR) (per managing/treating physician statement)
2	Partial clinical response (PR) (per managing/treating physician statement)
3	Progressive disease (PD) (per managing/treating physician statement)
4	Stable disease (SD) ((per managing/treating physician statement)
5	No response (NR) (per managing/treating physician statement) Not stated as progressive disease (PD) or stable disease (SD)
6	Neoadjuvant therapy done, managing/treating physician interpretation not available, treatment response inferred from imaging, biomarkers, or yc stage
7	Complete clinical response based on biopsy results from a pathology report (per pathologist assessment)
8	Neoadjuvant therapy done, response not documented or unknown
9	Unknown if neoadjuvant therapy performed Death certificate only (DCO)

Neoadjuvant Therapy -- Clinical Response (NAACCR #1633)

- This data item records the clinical outcomes of neoadjuvant therapy prior to planned surgical resection
- **For codes 1-5, a statement from the managing/treating physician is required**
  - Evaluation is based on clinical work up, including imaging, biopsy, etc.

Neoadjuvant Therapy -- Clinical Response (NAACCR #1633)

- Code 0: Defined as patient not receiving neoadjuvant therapy
  - Neoadjuvant Therapy (NAACCR #1632) is coded to 0 or 3
    - 0: No neoadjuvant therapy given
    - 3: Limited systemic exposure when the intent was not neoadjuvant, treatment did not meet definition of neoadjuvant therapy

Neoadjuvant Therapy -- Clinical Response (NAACCR #1633)

- Code 1: Defined as complete (total) clinical response
  - Neoadjuvant Therapy (NAACCR #1632) is coded to 1 or 2
  - Complete response is defined as the disappearance of all known tumors/lesions and lymph nodes
- A statement from the managing/treating physician is required to code 1
  - Evaluation is based on clinical work up, including imaging, biopsy, etc.

Neoadjuvant Therapy -- Clinical Response (NAACCR #1633)

- Code 2 defined as partial response (PR)
  - Neoadjuvant Therapy (NAACCR #1632) is coded to 1 or 2
  - Partial response is defined as a decrease in the size/extent of the tumor and/or presence of lymph nodes or metastatic disease
  - Also defined as not being complete clinical response (CR) or progressive response (PD)
- A statement from the managing/treating physician is required to code 2
  - Evaluation is based on clinical work up, including imaging, biopsy, etc.

Neoadjuvant Therapy -- Clinical Response (NAACCR #1633)

- Code 3 defined as no response due to progressive disease (PD)
  - Neoadjuvant Therapy (NAACCR #1632) is coded to 1 or 2
  - PD is defined as an increase in the size/extent of the tumor and/or presence of lymph nodes and/or metastatic disease
  - Use this code when the physician
    - Documents no clinical response
    - States that there is no change in the size/extent of the tumor and/or the presence of lymph nodes or metastatic disease
- A statement from the managing/treating physician is required to code 3
  - Evaluation is based on clinical work up, including imaging, biopsy, etc.

Neoadjuvant Therapy -- Clinical Response (NAACCR #1633)

- Code 4 defined as no response due to stable disease (SD)
  - Neoadjuvant Therapy (NAACCR #1632) is coded to 1 or 2
  - SD is defined as no changes in the size/extent of the tumor and/or presence of lymph nodes or metastatic disease
  - Use this code when the physician
    - Documents no clinical response based on clinical findings due to stable disease
    - Or states that there is no change in the size/extent of the tumor and/or the presence of lymph nodes metastatic disease
- A statement from the managing/treating physician is required to code 4
  - Evaluation is based on clinical work up, including imaging, biopsy, etc.

Neoadjuvant Therapy -- Clinical Response (NAACCR #1633)

- Code 5 defined as no response (NR), NOS
  - Neoadjuvant Therapy (NAACCR #1632) is coded to 1 or 2
  - No response (NR), NOS is defined as no response without further indication of progression or that the tumor is stable
  - Use this code when the physician
    - Does not document that the tumor has progressed (code 3)
    - Does not document that there was a change in the tumor size/extent, or the tumor was stable (code 4)
- A statement from the managing/treating physician is required to code 5
  - Evaluation is based on clinical work up, including imaging, biopsy, etc.

Neoadjuvant Therapy -- Clinical Response (NAACCR #1633)

- Code 6 is defined as
  - Neoadjuvant Therapy completed
  - No statement from the managing/treating physician based on clinical evaluation
  - Clinical response is 'inferred' from imaging impressions, changes in biomarkers or 'yc' stage
  - Neoadjuvant Therapy (NAACCR #1632) is coded to 1

Neoadjuvant Therapy -- Clinical Response (NAACCR #1633)

- Code 7 is defined when a biopsy of the primary site and the pathology report state complete response and there is no statement regarding clinical response from the managing physician
  - Neoadjuvant Therapy (NAACCR #1632) is coded to 1
- Code 8 is when neoadjuvant therapy is completed, response not documented or unknown
  - Neoadjuvant Therapy (NAACCR #1632) is coded to 1
- Code 9 is when it is unknown whether neoadjuvant therapy was administered
  - Neoadjuvant Therapy (NAACCR #1632) is coded to 9

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Neoadjuvant Therapy -- Treatment Effect (NAACCR #1634)

This data items records the pathologist's statement of neoadjuvant treatment effect on the primary tumor or site, with or without lymph nodes and/or distant metastasis from the surgical pathology report. Whenever treatment effect definitions are recommended by, or available in, the College of American Pathologists (CAP) Cancer Protocols, this data item follows the CAP definitions indicating absent or present effect. When site-specific CAP definitions are not available, use treatment effect codes for All Other Schemas in Appendix C. Site-specific codes are also included in Appendix C of this manual

Code	Description
0	Neoadjuvant therapy not given
1-4	Site specific code; type of response
6	Neoadjuvant therapy completed and surgical resection performed, response not documented or unknown Cannot be determined
7	Neoadjuvant therapy completed and planned surgical resection not performed
9	Unknown if neoadjuvant therapy performed Unknown if planned surgical procedure performed after completion of neoadjuvant therapy Death certificate only (DCO)

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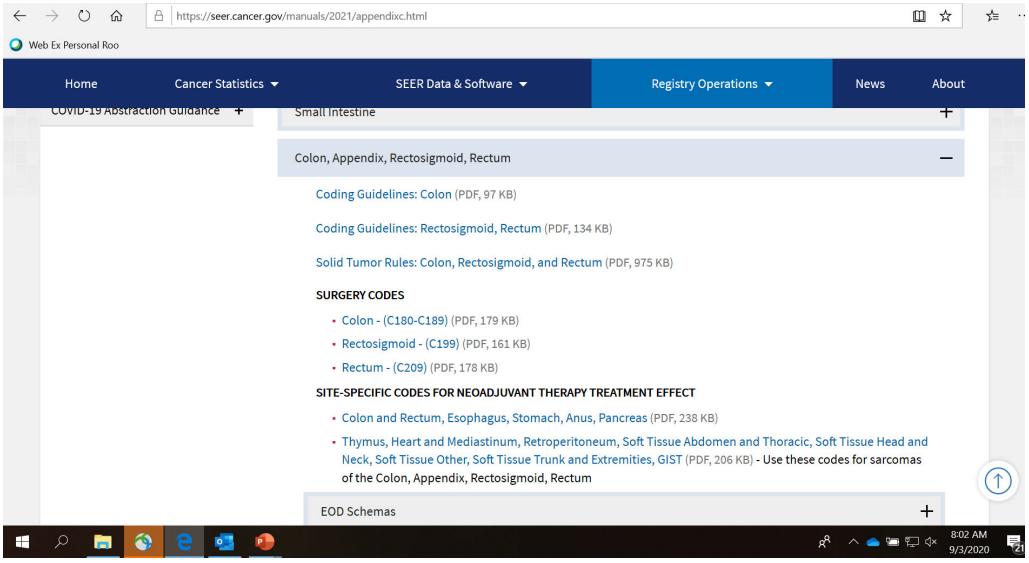
Neoadjuvant Therapy -- Treatment Effect (NAACCR #1634)



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Neoadjuvant Therapy -- Treatment Effect (NAACCR #1634)

- This data item records the **pathologist's statement** of neoadjuvant treatment effect on the primary tumor or site, with or without lymph nodes and/or distant metastasis
- Note: This data item is **not** the same thing as AJCC's Post Therapy Path (yp) Pathological Response
  - AJCC's post therapy is based on the managing/treatment physician's evaluation from the surgical pathology report and clinical evaluation after the neoadjuvant therapy
- This data item is only looking at the results from the **surgical pathology report**

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Neoadjuvant Therapy -- Treatment Effect (NAACCR #1634)

- Code 0 is defined as patient not receiving neoadjuvant therapy prior to surgical resection
- Pay attention to how you coded Neoadjuvant Therapy (NAACCR #1632). If that is coded to 0, then code this to 0. The coding guidelines are the same for both data items
- Cases coded to Neoadjuvant Therapy, code 3 (limited exposure) would also be coded to 0.

Neoadjuvant Therapy -- Treatment Effect (NAACCR #1634)

- Codes 1-4
  - These codes are site-specific
  - Some of the treatment effect code definitions are schema specific based on definitions from treatment effect sections in the CAP protocols
  - General Table
    - Remaining schemas are based on a General Definition
    - Have no definitions from the CAP protocols

Neoadjuvant Therapy -- Treatment Effect (NAACCR #1634)

- Specific Treatment Effect Tables include:
  - Colon and Rectum, Esophagus, Stomach, Anus, Pancreas
  - Thymus, Heart and Mediastinum, Retroperitoneum, Soft Tissue Abdomen and Thoracic, Soft Tissue Head and Neck, Soft Tissue Other, Soft Tissue Trunk and Extremities
  - Lung
  - Bone Appendicular, Bone Pelvis, Bone Spine
  - Breast
  - Ovary, Fallopian Tube, Primary Peritoneal Carcinoma
  - Prostate
- All Other Schemas (General Table)
  - Schemas not covered by site-specific codes

Neoadjuvant Therapy -- Treatment Effect (NAACCR #1634)

- Code 6: When neoadjuvant therapy was completed, and the response is not documented in the surgical pathology report or is unknown
- Use this code when the surgical pathology report is available, and there is no documented response in the surgical pathology report

Neoadjuvant Therapy -- Treatment Effect (NAACCR #1634)

- Code 7: Neoadjuvant therapy completed and planned surgical resection not performed
- There are several reasons why surgery may be cancelled
  - Patient completed neoadjuvant therapy and had a complete clinical response, surgical resection is cancelled
  - Patient completed neoadjuvant therapy, had progressive disease or presence of mets after neoadjuvant therapy, surgical resection was cancelled
  - Patient completed neoadjuvant therapy and patient refused surgical resection

Neoadjuvant Therapy -- Treatment Effect (NAACCR #1634)

- **All Other Schemas (General Table)**
  - Code 1: Complete pathological response
    - No viable cancer cells/no residual invasive carcinoma identified
    - Residual in situ carcinoma only
  - Code 2: Near complete pathological response
    - Single cells or rare small groups of invasive cancer cells
  - Code 3: Partial or minimal response
    - Residual invasive cancer cells present with evidence of tumor regression, more than single cells or rare small groups of cancer cell
  - Code 4: Poor or no pathological response
    - Extensive residual cancer with no evident tumor regression

Case Example 1

- Patient diagnosed with prostate cancer on 2/4/19. Started on Eligard (6-month injection) on 3/7/19. On June 12, patient confirms that he has chosen to have surgery. In October, cancer clinical confirms the surgery is for December. Patient receives another 6-month Eligard injection in October. Surgery delayed until March. Pathologists states that patient has undergone a year of androgen deprivation and the prostatectomy reveals areas of prostatic adenocarcinoma with neoadjuvant therapy related changes and stages using yp.

- Neoadjuvant Therapy – Code 3 (Limited systemic therapy)
  - Although patient had hormones for over a year, the Eligard was not intended to be neoadjuvant therapy (per AJCC, this would also not qualify for neoadjuvant therapy
- Neoadjuvant Therapy – Clinical Response- Code 0 (No neoadjuvant therapy)
- Neoadjuvant Therapy – Treatment Effect – Code 0 (No neoadjuvant therapy)
  - Pathologist did stage this as yp; however, it does meet the qualifications for neoadjuvant therapy

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Case Example 2

- Pt diagnosed with 3cm Lt breast nodule and core bx c/w High Grade DCIS w/apocrine features and Lt axillary LN core bx c/w mets invasive ductal ca. Pt had neoadjuvant treatment f/u w/Lt skin sparing mastectomy w/SLN bx with no residual ds on pathology report

- Neoadjuvant Therapy-Code 1 (Neoadjuvant therapy completed)
- Neoadjuvant Therapy-Clinical Response-Code 8 (no information on the response)
- Neoadjuvant Therapy-Treatment Effect – Code 1 (No residual invasive carcinoma present in breast)
  - As a reminder, we code the treatment effect based only on the pathology report, which stated no residual disease
  - Also noted, Breast has their own definitions for treatment effect for the primary tumor, and this fits the definition for code 1

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Case Example 3

- Patient diagnosed with Lung Cancer, cT2b, cN2, cM0. Stage 3A. Planned neoadjuvant therapy followed by surgical resection. Neoadjuvant therapy completed. Prior to surgical resection, PET/CT scan shows slight decrease in RUL lung mass and response in mediastinal adenopathy. Patient presents for VATS w/RUL lobectomy. Surgery aborted to multiple pleural nodules identified. Pleura biopsies done and show mets Adenocarcinoma c/w lung primary

- Neoadjuvant Therapy-Code 1 (Neoadjuvant Therapy completed)
- Neoadjuvant Therapy-Clinical Response- Code 3 (Progressive disease)
  - Per the operative notes, pleural nodules identified, biopsied and confirmed to be mets
- Neoadjuvant Therapy-Treatment Effect Code 7 (Neoadjuvant therapy completed and planned surgical resection not performed)
  - Surgical resection started, but aborted due to the presence of mets

Case Example 4

- Patient with breast cancer. Patient completed their full course of neoadjuvant therapy. Noted to have a partial response, scheduled for surgery. Patient no show twice for schedule breast surg.

- Neoadjuvant Therapy-Code 1 (patient completed neoadjuvant therapy)
- Neoadjuvant Therapy-Clinical Response- Code 1 (Partial clinical response)
- Neoadjuvant Therapy-Treatment Effect- Code 7 (Neoadjuvant therapy completed and planned surgical resection not performed)
  - Based on the information that the patient was a no show for two appointments, assume that the planned surgical resection was not performed

Case Example 5

- Bladder cancer patient has neoadjuvant therapy. Per physician, noted to have significant response, cystectomy still recommended by physician. Patient declines cystectomy; however, does agree to have concurrent chemoradiation instead

- Neoadjuvant Therapy: Code 1 (neoadjuvant therapy administered)
  - Reminder: Initial plan was neoadjuvant therapy followed by cystectomy
- Neoadjuvant Therapy-Clinical Response: Code 2: Partial clinical response
  - Since physician still recommended the cystectomy, patient did not have a complete response. "Significant response" documented by the physician can be used to code "partial clinical response"
- Neoadjuvant Therapy-Treatment Effect: Code 7, Neoadjuvant therapy completed and planned surgical resection not performed
  - Patient refused the recommended surgery

Case Example 6

- Patient with pancreatic cancer that is resectable undergoes neoadjuvant chemo but only 1 cycle (3 treatments) is given due to intolerance. Pt then goes on to have surgery. Notes before surgery state some response to cycle of chemo. Pathologist stages yp, mentions response. Is this enough to be able to yp stage the case even though only 1 cycle was given?

- Neoadjuvant Therapy-Code 2 (Neoadjuvant therapy started, but not completed)
  - Patient did not complete the intended full course of neoadjuvant therapy, even though the pathologist stages this as yp and mentions response
- Neoadjuvant Therapy-Clinical Response- Code 0 (no neoadjuvant therapy)
  - Cannot code a response since patient did not complete neoadjuvant therapy
- Neoadjuvant Therapy-Treatment Effect- Code 0 (no neoadjuvant therapy)
  - Cannot code a response since patient did not complete neoadjuvant therapy

Example 7

- Patient with breast cancer. Due to COVID, surgical resection was delayed. Patient had short-term unconventional neoadjuvant endocrine therapy due to delayed surgery.
- Neoadjuvant Therapy: Code 0 (No neoadjuvant therapy)
  - The intention of the endocrine therapy was not neoadjuvant, but given to patient until the surgery could be done
- Neoadjuvant Therapy-Clinical Response: Code 0 (No neoadjuvant therapy)
- Neoadjuvant Therapy-Treatment Effect: Code 0 (No neoadjuvant therapy)

Moving Forward

- New Edits
  - Edits exist for schemas that are always 0
  - Edits planned based on relationships to other data items
- Questions
  - Determine what instructions need to be added or clarified based on questions received
  - Obtain more examples from questions
- Post some questions to SINQ so that registrars will have SINQ to refer to

For questions about coding the Neoadjuvant Therapy data items

Please post to Ask SEER Registrar
https://seer.cancer.gov/registrars/contact.html

Choose: SEER Manual

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Questions??

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TREATMENT CODING UPDATES

Jim Hofferkamp, CTR

INCISIONAL BIOPSY OF LYMPH NODE: CHANGES FOR 2021

- There are revised instructions related to Scope of Lymph Node Surgery code 1 (Biopsy or aspiration of regional lymph node, NOS).
- Do not count Scope of Lymph Node Surgery code 1 as surgery for the purpose of coding these data items.

- Date First Course Treatment [CoC]
- Treatment Status
- Date of First Surgical Procedure
- Radiation Sequence with Surgery
- Systemic Sequence with Surgery

Pre-2021 Scenario

Example 1 Needle Biopsy Regional LN +

- 1/03/2020 RUL biopsy+ adenocarcinoma done at outside facility
- 1/06/2020 Fine Needle Aspirate cytology of right hilar lymph node + metastatic adenocarcinoma done at my facility.
- 02/07/2020 Began Chemo & Radiation at my facility

Slide 1 of 2 for Example 1

Date of diagnosis:	01/03/2020
Date of First Contact:	02/07/2020
Class of Case:	22 Initial diagnosis elsewhere AND all first course treatment or a decision not to treat was done at the reporting facility
Scope of Regional Lymph Node Surgery:	1 (Bx or Aspiration of Regional LN)
Date of First Course Treatment:	01/06/2020

Case scenario from NAACCR Coding Pitfalls webinar 9/20

3

Pre-2021 Scenario

Example 1 Needle Biopsy Regional LN +

- 1/03/2020 RUL biopsy+ adenocarcinoma done at outside facility
- 1/06/2020 Fine Needle Aspirate cytology of right hilar lymph node + metastatic adenocarcinoma done at my facility.
- 02/07/2020 Began Chemo & Radiation at my facility

Slide 2 of 2 for Example 1

Date of First Surgical Procedure:	01/06/2020 (most software's auto-populate this field)
Date of Most Definitive Surgical Resection of the Primary Site:	BLANK (most software's auto-populate this field)
Regional Lymph Nodes Examined:	95 No regional nodes were removed, but aspiration of regional nodes was performed
Regional Lymph Nodes Positive:	95 No regional nodes were removed, but aspiration of regional nodes was performed
Date of Regional Lymph Node Surgery:	BLANK
AJCC Clinical N Suffix:	(f)
Systemic Surgery Sequence:	3 Systemic therapy after surgery
Radiation Surgery Sequence:	3 Radiation therapy after surgery

4

2021+ Scenario

Example 1
Needle Biopsy Regional LN +

- 1/03/2021 RUL biopsy+ adenocarcinoma done at outside facility
- 1/06/2021 Fine Needle Aspirate cytology of right hilar lymph node + metastatic adenocarcinoma done at my facility.
- 02/07/2021 Began Chemo & Radiation at my facility

Slide 1 of 2 for Example 1

Date of diagnosis:	01/03/2021
Date of First Contact:	02/07/2021
Class of Case:	22 Initial diagnosis elsewhere AND all first course treatment or a decision not to treat was done at the reporting facility
Scope of Regional Lymph Node Surgery:	1 (Bx or Aspiration of Regional LN)
Date of First Course Treatment: Δ	2/7/21 STORE 2021

Case scenario from NAACCR Coding Pitfalls webinar 9/20

5

2021+ Scenario

Example 1
Needle Biopsy Regional LN +

- 1/03/2020 RUL biopsy+ adenocarcinoma done at outside facility
- 1/06/2020 Fine Needle Aspirate cytology of right hilar lymph node + metastatic adenocarcinoma done at my facility.
- 02/07/2020 Began Chemo & Radiation at my facility

Slide 2 of 2 for Example 1

Date of First Surgical Procedure: Δ	BLANK (most software's auto-populate this field)
Date of Most Definitive Surgical Resection of the Primary Site:	BLANK (most software's auto-populate this field)
Regional Lymph Nodes Examined:	95 No regional nodes were removed, but aspiration of regional nodes was performed
Regional Lymph Nodes Positive:	95 No regional nodes were removed, but aspiration of regional nodes was performed
Date of Regional Lymph Node Surgery:	BLANK
AJCC Clinical N Suffix:	(f) STORE FNA or core needle biopsy only
Systemic Surgery Sequence: Δ	0 No systemic therapy and/or surgical procedure
Radiation Surgery Sequence: Δ	0 No radiation therapy and/or surgical procedure

6

MISC TREATMENT ISSUES-SEER

- Use the entire operative report as your primary source for determining the correct code to assign for surgery of primary site. Read the body of the operative report to determine exactly what was removed and what procedure was performed." (SEER)
  - SINQ 20200058
- A researcher pointed out that CNS surgery codes 30, 40 and 55 have been used for spinal primaries even though the codes are specified as resection of tumor or lobe of **brain**.
  - SEER notified registries with cases coded to surg codes 30, 40, and 55 with primary site of spinal cord

MISC TREATMENT ISSUES-SEER

- SEER collects one surgery of primary site for each case: the most definitive, or the cumulative result of all surgeries performed on primary site during first course of treatment or prior to the cancer diagnosis. If your question is about recording more than one surgery of primary site for a case, please refer to the CoC CAnswer Forum.
- With the new SLN data items, we are getting some questions about where to record LNs removed when both SLN bx and regional node dissection are performed and how to count in # exam and # pos.
  - https://seer.cancer.gov/tools/codingmanuals/2021manual.html

MISC TREATMENT ISSUES-COC SLN BX FOR ENDOMETRIAL PRIMARIES

- 11-09-20, 05:32 AM
- If a patient with endometrial cancer has a TAH-BSO and sentinel lymph node biopsy: **Question - what is the correct code to enter for "Scope of Regional Lymph Node Surgery"?** (I believe it should be 2, but I can't find a direct answer in the above responses. If not 2, why?). http://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/store/sentinel-and-regional-nodes/107547-sln-bx-for-endometrial-primaries/page2

MISC TREATMENT ISSUES-COC PALLIATIVE

- 10-27-20, 08:34 AM
- Patient had a Right maxillary mass and the biopsy showed Myeloid sarcoma. blood work shows no significant cytopenia, there was only mild leukocytosis, Per medical oncologist even though blood counts are unremarkable and patient is minimally symptomatic other than the mass, this is considered an advanced disease. At this point patient has a new diagnosis of AML per the oncologist.
  Patient was offered low dose chemo due to age and frail status. Patient refused chemo and opted for end -of-life care /hospice.
- Would the Rx treatment status be coded to No tx given and would the palliative care be coded to 7?

http://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/store/first-course-of-treatment-aa/palliative-aa/109644-palliative-care

MISC TREATMENT ISSUES-COC HOSPICE

- When is Hospice Coded and When isn't it?
- 11-13-20, 12:08 PM
- I have seen some conflicting information in these threads and would like clarification please. When is hospice coded under palliative care and when isn't it?
- For example, I've seen the following as I've read through threads...
  - Patient diagnosed with glioblastoma who was unable to receive treatment and referred to hospice. Palliative treatment coded to 0.
  - Patient with stage IV lung cancer for whom chemotherapy was contraindicated and was referred to hospice. Code palliative care to 7 as it was unknown what care/treatment patient received at hospice.
- Does this make a difference? If so, might that have been the case for the glioblastoma patient...couldn't he have been placed on pain medication?.
  - http://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/store/first-course-of-treatment-aa/palliative-aa/110274-when-is-hospice-coded-and-when-isn-t-it

MISC TREATMENT ISSUES-COC HOSPICE

- 11-03-20, 08:22 AM
- Good morning. We learned in a NAACCR webinar that we can code hospice care as palliative code 7. We are unsure how to code the locations of where the treatment took place. How would we code Rx hospital for the following?

  1. An inpatient at our hospital is diagnosed with stage IV breast cancer. She has significant comorbidities and chooses hospice care only. She is then transitioned into hospice care at a nearby facility. Would the location for the palliative care (rx hospital) be coded as our hospital? Or the hospice facility?

  2. If a patient chooses hospice care, and the hospice care is provided in her own home, how would the location for the hospice care (rx hospital) be coded?

  Thank you.
- http://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/store/other-general-questions/109874-hos