Q&A Session for 2021 Updates: SSDI

December 2, 2021

#	Question	Answer
1.	Have the standard setters agreed on definition for disease progression (especially when disease "progresses" during neoadjuvant tx)?	Yes and no. The standard setters do agree on the definition of disease progression when it comes to coding treatment fields. They also agree on "disease progression" when it comes to AJCC staging. However, the definition for AJCC staging doesn't always match what we use for coding treatment.
2.	When a patient is on "observation" with regular lab work for their hematopoietic cancer (for example low stage CLL) that is also coded as "active surveillance / watching waiting" although the managing MD doesn't use those words, right?	That is my understanding.
3.	In colon cancer, seeing more cases of Total neoadjuvant therapy (TNT) where tx plan is contingent on response to systemic tx whether or not pt will have surgery. Hard to tell sometimes when to stop checking back whether pt had surgery.	Participants stated they are seeing delays of more than 6 months between time of diagnosis and time of surgery due to neoadjuvant chemotherapy. She stated that it is easy to forget to go back and add surgery do to this delay.
4.	For clinical trials that use chemo/BRM (categorized per SEER*RX) is that coded as chemo/BRM INSTEAD of clinical trial under Other tx or BOTH? When the trial involves experimental drug(s) not defined in SEER*RX it would only be coded in "other treatment"?	Personally, i would send a question to SEER RX before classifying it to Other.
5.	Is there uniform guidance on what falls as palliative treatment and how to code? Specifically, things such as stents for pancreatic/biliary cancers, stents for urological cancers, paracentesis/thoracentesis for various cancers? There's some conflicting posts in CAnswer Forum about stents for example.	I have a tough time with that data item. I would continue to ask for clarifications and submit questions to CAnswer forum asking for clarification. They will get it worked out. I would be interested in finding out how this data item is used for analysis. That might help provide some clarification.
6.	Maybe it would be helpful in a future site-specific webinar to include showing the NCCN guidelines from the NCCN website and how to	I had planned on doing some of that on this one, but ran out of time. Definitely a good idea.

	navigate/read the guidelines? Very rich resource especially for registrars who do not have ready access to physicians to ask questions.	
7.	Really appreciate you showing definitions from both STORE and SEER manuals. Especially in light of STORE reduction it is important to read the SEER manual even when not reporting in a SEER state.	Good to hear! We'll try to do more of that in the future.
8.	What was the answer to question two?	00 No surgical dx staging procedure done
9.	If pathology report has FNA/biopsy, can we consider this as biopsy of the site and code it?	If you are certain it is tissue and not just cells, you can code it as a dx staging procedure.
10.	You are speaking about NEEDLE bx specifically right (per the way STORE rule written)? Shave/punch biopsies for melanoma that removes all the melanoma would still be coded as surgery instead of being diagnostic procedure?	Correct!
11.	SEER breast surgery code has a very nice note about the additional margin being done during same procedure.	Great tip!
12.	How do you enter a lung VATS wedge resection when physician states it's for more tissue to run tests? Is it entered as a diagnostic procedure or surgery code?	I would code Video Assisted Technology Surgery (VATS) wedge resection as a wedge resection. This sounds like one of those procedures with both a diagnostic/staging and therapeutic intent. That is a good thing to keep in mind as you are abstracting, but for coding surgery it doesn't really matter. A wedge resection was done so that is how I would code it.
13.	Q7: for accredited facilities if info available in EMR recommend coding to surg codes w/ reconstruction info to facilitate NAPBC Std 2.18 compliance review	Great point!
14.	Please clarify, whether a skin sparing mastectomy, or a subcutaneous mastectomy, is code 30, or does code 30 have to be a nipple sparing mastectomy?	Based on what I've seen on the CAnswer forum, the "Skin sparing" doesn't impact the code. If the nipple is left code 30. If the nipple was not preserved, then it could be a simple mastectomy or modified radical depending on whether nodes were removed.

15.	Pop quiz #5, if it was a PRE-2021 diagnosis case, would answers be: Q10: b (same as 2021 dx), Q11: a (same as 2021 dx), Q12: a (different from 2021 dx), Q13: a (different from 2021 dx), Q14: b (different from 2021 dx)?	That is correct.
16.	Pop quiz 4: if slns failed to map and additional 3 non sentinel axillary node removed is this still coded as code 02 (sln bx)?	Yes. Code as 02. Those 3 sentinel nodes were removed during a sentinel node procedure.
17.	2/15/21: The patient opted for hospice care based on physician (at other facility) recommendation. No further work-up or treatment done. In cases of non-treatment (RX Summ–Treatment Status [1285] = 0), in which a physician decides not to treat a patient, a patient's family or guardian declines all treatment, or patient receives palliative care for pain management only, the date of first course of treatment is the date this decision was made. Does this include Hospice?	As a rule of thumb, I would count the date they decided on hospice if no other treatment was done. There may be some exceptions, but I can't think of any now.
18.	For Date of Regional LN Dissection, if a number of nodes are removed during surgery, but the op report does not indicate that a dissection was done, would we leave that date blank then?	I am not aware of rule saying that a dissection must be documented to assign the date. I think the registrar has some latitude in determining if lymph nodes were removed as a part of a dissection.
19.	Why do you use 97 for SLN pos/ex?	For breast only, if a sentinel node procedure is done and then an axillary node dissection, you should code sent nodes pos as 97. If no axillary node dissection is done after the SLN, then you can code the number of pos nodes. I incorrectly used code 97 in pop quiz 7.
20.	Is FNA always considered a cytologic exam?	Not always, there are some that collect actual tissue.
21.	Text, text, text....when do you stop because of too much text for example radiology report data.	Great question! More text is just more text. Justify what you have coded. Everything else is bonus.
22.	Clarification to my question: using the example in pop quiz 4, if SLNS failed to map and 3 additional non-sentinel axillary LNs are removed (OP note does not state that a dissection was done), would this still be coded as 02 (SLN BX)?	In my opinion, you fall back on the core concept that you are coding how many lymph nodes that are removed during the procedure, not how many sentinel nodes are removed. Code it as 02 in scope reg ln surgery. Count the 3 non-sentinel nodes in sentinel nodes examined.

23.	Can you explain how to code SBRT like in prostate cancer? I'm talking about the extended radiation detailed screen.	Without any specifics on the case, I can only provide a general response on SBRT. Note that SBRT requires IMRT planning technique. In addition, you should expect hypofractionation, larger fractions size combined with a few fractions.
24.	So when Bx of primary site and bx of metastatic site is done on the same day and are both positive.... we do not code the 01 for metastatic site bx, just the 02 for primary site bx? Then document them both in Text area.	That depends on whether you can code only one procedure or multiple procedures. If you can code multiple procedure, code them both. However, only the 02 will go to NCDB and state registry. If you can only code 1, code 02.
25.	Are certain radiation regimens usually done with a certain technique? Had a breast case yesterday where RXT done elsewhere the very common 4256 cGY in 16 FX (no boost) w/ 6MV photons but technique was mentioned as "opposed tangents". I think you said on another webinar that only describes beam orientation. Is planning technique external beam nos or assume it is 3D?	There are definite guidelines for the delivery of EBRT to certain sites. The NCCN Guidelines is a good place to start. As per your reference to the breast case, the APBI (accelerated partial breast irradiation) approach is generally delivered via 3D-conformal plans. But some facilities do use IMRT plans. You need to confirm this with your facility.
26.	About text - are we allowed to use abbreviations used by RadOnc but not listed in the NAACCR recommended abbreviations? For example IMN for intermammary nodes and CW for chest wall?	I would try to avoid it. If the person reviewing the text is not familiar with the abbreviations, it will be difficult for them to understand the text. If they can't understand the text, you are wasting your time entering it.
27.	Partial breast is not listed on the RAD ONC notes, how do we know when to code it to 41	If the reference is only to "breast", assume it's the whole breast. If you have access to ARIA or Mosaiq, you can review the actual planning CT images and determine the actual volume of breast irradiated.
28.	How would this be coded for each phase: RT NECK SUPRA & SUBCLAVICULAR LNS & AXILLA EXTERNAL BEAN PHOTONS 4500CGY X 25FX @ 180CGY/FX. RT CHEST WALL IMRT 5040 CGY X 28 FX @ 180CGY/FX. BREAST TUMOR BED BOOST 3D CONFORMAL 1000CGY X 5 FX @ 200CGY/FX.	The RT neck/Sclav/axillary LN treatment can be included in a single phase with the RT chest wall treatment. Planning technique of IMRT applies to both. The breast boost is a separate phase, with a 3D-conformal planning technique. Total dose= 60.4 Gy.

29.	Would it be possible to have a future webinar address Surgery Codes for "All Other Sites"? I struggle with trying to figure out which code to use because the descriptions are so basic. I just would like examples of what code to use for sites such as fallopian tubes, vulva, small intestine...	That would be great! Could you email me some examples of what you are seeing? i.e. the site and description of the surgery you are seeing in the record?
30.	So when Bx of primary site and bx of metastatic site is done on the same day and are both positive.... we do not code the 01 for metastatic site bx, just the 02 for primary site bx? Then document them both in Text area.	Are you able to code multiple procedures in your software? If yes, then code them both. However, only code 02 will be transmitted to NCDB.
31.	If patient has a prostatectomy and then EBRT to the 'prostate fossa' - what is the volume code?	Depends on date of diagnosis. If this is a 2021 case, you code the irradiate volume to the prostate. If case precedes 2021, you would code the irradiated volume to the Pelvis.
32.	Recently I had a lung malignancy. 3 separate nodules (2 RUL & 1 LUL) were treated with SBRT, all were treated with 1000 cGy dose per fraction, 5 fractions, total of 5000 cGY per lung nodule. Since the treatment was the same for each of the nodules, we would code as 1 phase rather than 3 phases?	First, a determination needs to be made if this case reflects a single primary or two lung primaries. If a single primary, you are looking at a minimum of two phases. You cannot include the LUL lesion in the same phase as the RUL as they represent two totally different sites/volumes.
33.	On the Cyber Knife SRS example, there are 3 phases; however, we coded 2 phases. In the Total Phase Summary would we count 2 or 3 phases completed?	This case will be reviewed and revised, as needed.
34.	Is there a list or a way to determine what is LDR versus HDR Brachytherapy? I often cannot find this info, and resort to using Brachytherapy NOS.	I will see about putting up a reference sheet on the most commonly used brachytherapy sources on the CoC forum.
35.	Did a QC on my breast cases just now where SLN mapping failed and I did not code a date of SLN bx. However, software defaults the date SLN bx flag to 11 based on number of SLN examined = 00 so I get edit (N2514). I have to trick it as if SLN were examined - pass edits then go back & correct & re-save. Will reach out to vendor.	Great tip.
36.	Tip for breast mastectomy - remember skin sparing technique can be used with any mastectomy, must look to see if the operative note states "nipple sparing" to use code 30 and if it is not stated in the operative	Thank you!

	note look in the path report to see if the nipple was removed - think macroscopic part of the path report	
37.	F/U question to my Date of Regional LN Dissection question: Recently we were reviewing some breast cases and looking at lymph node fields. There was a case in which an excisional bx of a breast tumor was done, then a sentinel LN bx was done. On a different date, a Mastectomy was done and 7 LNs were removed that were part of the Mastectomy. No axillary lymph node dissection was done since the previous SLN bx showed neg nodes. We felt the date for Reg LN Dissection should be left blank since those lymph nodes were incidental, but questioned if there should be a date since so many lymph nodes were removed.	Personally, i think you coded this correctly. The lymph nodes were not removed as part of LN dissection. Leaving Date LN Dissection blank is what i would have done.
38.	Can we consolidate phases in breast cases when all criteria is similar when treating breast and lymph node regions?	If you are irradiating the same side (RT breast, RT axillary LNs/S'clav, and the start/end dates are the same & dose fractionation are also the same for both regions, then code it as a single phase.
39.	When doing QC at State see registrars coding bilateral skin/nipple sparing mastectomy for one-sided breast cancer using codes in the 40-range (the ones for simple mastectomy), so very glad to see new breast surg codes in 2022!	Looks like "skin sparing" could be coded as 40 (simple mastectomy) if the nipple is removed. https://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/store/first-course-of-treatment-aa/surgery-aa/100713-skin-sparing-mastectomy
40.	Thank you for helping to explain that I would Code it as 02 in scope reg ln surgery which makes sense…however I am a little confused about your statement "I would count the 3 non-sentinel nodes in sentinel nodes examined". I am thinking those 3 non-sentinel nodes would be counted in total regional LNs examined (and not counted in SLN counts since they failed to map)??	They would be counted in both places. Remember, we are coding the number of nodes removed during the SLN. We are not coding the number of sentinel nodes.
41.	There is a contradiction between SEER and the CoC on how to code Lutathera. SEER has it being coded as PRRT (Other Therapy) and instructs to code this as Other in the SEER RX Database. The CoC instructs that it is to be coded as Radioisotopes and coded as Radiation. Will the Radiation work group be addressing this issue with SEER and the	This question made it to SEER and CoC early this week. SEER said they would update SEER Rx and classify it as radioisotope. I believe SEER has already updated SEER Rx!

	CoC to unify the coding between the two standard setters? Also, with this issue be addressed in the upcoming CTR Guide?	
42.	What does DCO stand for?	Death Certificate Only. That is a case that was not reported to a central registry by a reporting facility. The case was identified through review of death certificates. Only really applies to central registries.
43.	For response to neoadjuvant therapy, is a pathology report with no residual cancer sufficient to code complete response? After surgery, other doctors often just tell us that the pathology showed no residual cancer.	If this is for treatment effect, the pathology report with no residual cancer is enough to code complete response. As a reminder, the surgical pathology report is the only thing you need for treatment effect. You don't need a statement from the managing physician.
44.	What do you code for chemotherapy/radiation therapy prescribed and the decision to perform surgery will be decided after chemotherapy/radiation therapy is completed? So there is no definitive statement surgery will be performed after chemotherapy/radiation therapy or if patient will consent to surgery after chemotherapy/radiation therapy.	We have consulted with AJCC on this since the surgery would be conditional based on how well the chemotherapy/radiation works. Even if surgery is conditional, this would be coded as neoadjuvant therapy, not only for AJCC, but also for the SEER Neoadjuvant data items.
45.	I think this question has been asked & answered in CAnswer Forum but don't recall answer off hand. Due to more concurrent abstracting, for abstracts where patient is undergoing neoadjuvant tx but still pending surgery, are the neoadjuvant data fields coded as if it is not done then updated when abstract revisited after surgery is done/cancelled?	Neoadjuvant therapy is coded as 1 Clinical Response: 8 Treatment effect: 9 Then once the neoadjuvant therapy is completed, you would update the fields.

46.	I missed when are the NEOADJ fields to be collected - what year?	Starting with 2021 cases. However, they are only collected by facilities in SEER states. If you are not seeing them on your abstract, you are probably not in a SEER state.
47.	Jennifer - I just had a similar case like what you just described. It wasn't a pancreatic but a bile duct cancer. They did the neoadjuvant to shrink the tumor (it was borderline/unresectable at presentation) attempted surgery as imaging showed response but aborted as they discovered it was not resectable. Some LN were removed but primary site was not removed. This just happened so waiting to see if patient will be getting more systemic tx.	This would be coded as neoadjuvant therapy. We received confirmation from AJCC that chemotherapy/radiation given and that surgery is conditional based on the response, is coded as neoadjuvant therapy
48.	What if you know the pt refused but no date is noted in the chart? Can we estimate a date?	I suggest contacting your state registry with that question.
49.	Patient had a neg breast bx that showed ADH in 2018. Pt seen in our facility in 2020 and pulls the original bx slides because the patient does not want a bx. Review (over read) of the 2018 path shows DCIS. Pt goes to surgery in 2020 and path shows DCIS. Is the surgery coded as 1st course??	I'm not sure. If this is a real case, I would send it CAnswer forum.
50.	What if the surgery was not initially recommended/planned but later performed due to residual/disease progression	That does not sound like neoadjuvant therapy. If this is a real case, I would suggest sending it to Ask a SEER Registrar.
51.	First case - Systemic/Surgery Sequence: Per the STORE manual "Code the administration of systemic therapy in sequence with the first surgery performed, described in the item Date of First Surgical Procedure. Shouldn't the first case be Systemic/Surgery Sequence 02 - Systemic therapy before surgery? The TURBT would be the first surgery performed.	In that case the patient had a TURBT first. Then had systemic treatment and then had surgery. They had surgery before and after systemic. I believe that fits the definition for code 7. The TURB was the first tx done.
52.	Tip: briefly documenting the treatment plan in abstract text can save a lot of time later if the case comes up for quality review.	Great tip!
53.	How do you explain a partial mastectomy?	It is an NOS code describe removal of less than the full breast. Use a more specific code if available.

54.	Can you explain why question 23 is 97 for SLN examined?	STORE says to use code 97 for sentinel nodes pos if the SLN procedure is followed by a node dissection. I think they were worried that the pos nodes from the SLN procedure would get mixed in with pos nodes from the axillary node procedure.
55.	does the DIBH impact our coding?	DIBH (Deep inspiration breath hold) is a technique used in the delivery of EBRT to minimize dose to organs at risk (OARs) by reducing organ motion while the photon beam is on. It does not impact coding per say, but it does lead us to consider IMRT as the planning technique as DIBH is often delivered via IMRT/VMAT.
56.	Question for Jim...You stated that the chemotherapy given to a patient who had a TURB followed by Chemo and then cystectomy is a considered neoadjuvant treatment. Would the same thing apply to a melanoma case? You have a shave bx coded as 27, and then the patient is treated with 6 months of aldara and then comes back in for a re-exc. Would the aldara also be considered neoadjuvant?	I don't know! Do you have a case where this occurred? I'm assuming you are asking whether you could code the re-excision with a yp stage.
57.	How many phases are coded for a 5 field breast radiation?	Without any details of the case, I cannot offer a response.
58.	How do you explain a partial mastectomy vs lumpectomy vs excisional biopsy?	We went over the difference between lumpectomy and excisional biopsy. At this point it doesn't really matter for coding purposes. I don't have a further explanation for partial mastectomy.