Q&A Coding Pitfalls 2022 – Updated Link

September 2, 2022

#	Question	Answer
1.	For the rectal T3/4 example - what if the managing physician completes the staging form with T3 and the N and M categories completed also - can we record this in the registry for the clinical staging?	If the managing physician makes a definitive determination, then you can record that stage.
2.	There was an announcement when the Curriculum was updated for 8th edition and Version 9	Thank you for that information. Everyone should review the Curriculum again. It has some useful information.
3.	Will edits allow for blanks? There have been times when blank is a correct value, but the edits fail.	A "BLANK" is a valid choice in TNM categories, there should be no edit to prevent this, but if you are receiving, edits I would love to review it so we can ascertain why. {One software I am aware of throws a message, but you just ignore it and manually enter the correct stage values using your AJCC manual for guidance.}
4.	I have investigated this topic through multiple avenues--even Canswer forum. Canswer forum along with the STORE manual, according to my understanding and clarification, states to assign TNM Stage as is documented by the managing / treating physician. If there are discrepancies, the registrar will document the discrepancies in the abstract. It is only when there is no TNM Stage documented by physician are registrars to assign TNM Stage according to documentation at hand.	Janet- It is hard to make a blanket statement. I have seen when physicians clearly dictate the incorrect stage, they are not using the correct schema, stage categories that cannot possibly derive the correct group, etc.… I have seen it all. If I know in fact what the physician dictated is wrong, I will not enter that information into the abstract, because I will not personally contribute to compromising the data within the NCDB. It is best to consult that physician and get clarification, but if that is not possible, I believe a blank is better. I would rather record no information that blatantly incorrect information.
5.	Wonder if any thought has ever been given for AJCC staging when leaving T or N or M blank to have some type of box in the software to click that the fields were indeed reviewed and purposefully left blank - my point is some type of way to know the fields were indeed reviewed and not just skipped	Great suggestion, please be sure to make it on the CAnswer forum.

	over entirely - when we see blanks in the abstract it is difficult to know what was accidentally skipped verses left blank on purpose	
6.	For scenario #2 - on the LN, we can capture the LN involvement in the Summary Staging	Absolutely! Great point!
7.	I thought the cNx did indicate the imaging was done but, was unable to provide any staging?	It is very tricky, but according to the AJCC Curriculum for registrars, if physicians state NX, registrar assigns NX, without evidence unknown to physicians, registrars assign N blank.
8.	Are we implying cTX because there is a physician statement?	If you are referring to the Workup done but not enough info slide regarding assigning a cTX when colonoscopy is done-Refer to Lesson 23 AJCC Curriculum for registrars and this CAnswer Forum post https://cancerbulletin.facs.org/forums/node/131084
9.	For the colonoscopy scenario I took it to be an example of where the physician knew the T but simply did not document it...so not a lack of findings on examination but rather a lack of documentation i.e., T blank	This colonoscopy alone did not provide the physician with enough information to adequately assign how far through the wall the tumor went, it's not possible based on this test.
10.	How about for Gyne? You usually don't know the invasion. Would it also be cTx?	I would need an exact scenario to be able to answer.
11.	For the colon example case - colonoscopy = cTX, imaging for the nodes = cN blank due to the number of pos nodes was not stated, so for this case cTX cN blank and cM0 group 99? My point is - is it correct to have a cN blank in the face of a cTX? Thanks - hope that made sense.	If you had a colonoscopy, nothing further to ascertain how far through the wall the tumor extended cTX. If you had a scan that stated positive nodes, but not how many it would be a cN BLANK. Remember registry data is utilized for research and you do not want to inaccurately classify a tumor.
12.	In addition to the radiologist statement also check physician notes - physician sometimes do a "personal review" of the imaging and gives their own impression which may also have diagnostic terms	Great tip!
13.	Can we discuss what people should do when maybe the mammogram does NOT specifically say "consistent with malignancy" but a physician note one week later says the mammogram was "consistent with malignancy". let people	Great point. In the example you give, the date of diagnosis would be the date of the mammogram. The physician made a statement using reportable terms when referring to the mammogram results. This is a long-standing rule.

	know if they take the date of the mammogram or date of the physician statement about the mammogram.	
14.	Can you tell us when Li-RADS, Pi-Rads, etc. became effective for diagnosis date? Since there is a question asked on SEER Inquiry about them and goes back to 2017.	The SEER guidelines are based on the current ambiguous terminology rules. I think they would argue the guidelines are not a change. However, the first time I'm aware of the guidelines including specific instructions for Li-RADS and Pi-RADS is 2017. The CoC guidance is relatively new (as far as I know). They have a statement in STORE 2023 so I would assume the guidance would apply to cases diagnosed 2023 forward. They also have a statement on the CAnswer forum in response to a question asked in 2022.
15.	If we are not a SEER state, do we still follow SEER guidance?	In most cases guidance from standard setters is in sync. The RADS situation is one of the few things were they not 100% in step. In this situation, there is not hierarchy when it comes to who's guidance takes precedence. I suggest waiting until you come across an actual case where SEER and CoC guidance to not agree. Then contact your state registry to see what they suggest. If they still do not agree, then the next step would be to post the scenario to the CAnswer forum. Hopefully, this will get worked out soon!
16.	LI-RADS 5, PI-RADS 4&5 used for diagnosis date been around since 2016/2017 (SINQ20160008, SINQ20170023) - do the new 2023 STORE statements affect cases diagnosed 2016-2022?	I have not seen anything specifically stating that they should apply to cases diagnosed prior to 2023. I assumed they would apply based on a CAnswer forum post.
17.	Remember to include your "rads" score in your Xray text when the "rads" score is given.	Great tip!
18.	Agree w/ Janet - rarely ever see diagnostic ambiguous term on breast imaging! First physician meeting also tends to happen after the bx happens.	
19.	I may have missed this. (On slide 22) you mentioned that hospital A would be class 00 but didn't say what/how to	They would use the date of radiology.

	determine the date of dx. Would they use the radiology Date?	
20.	What do you do with a breast biopsy in Jan 2023, but the BIRADS imaging was in Dec 2022????	Following CoC, this would be a dx year of 2022. If following SEER, it would be a dx year of 2023.
21.	SLIDE 23 QUESTION - How would hospital know about the bx if the patient did not return for further care? Still report?	In the scenario, we assume the registrar in Hospital A was aware of the results of the biopsy done at hospital B. If the registrars were not aware of the bx results, the case would not be reportable to hospital A.
22.	How is a NON-SEER State/Central registry going to consolidate date of diagnosis when CoC facility reports a case with a 2022 dx yr based on date of BIRADS but a non-CoC facility reports on the same case with 2023 diagnosis year based on biopsy that shows cancer?	The central registry will need to determine ahead of time whether they consider a Bi-RADS score diagnostic if a bx confirms malignancy. The central registry may want to contact their funding agency for guidance on how to handle these cases.
23.	For the RADS, what if hospital A does not know anything about hospital B? Is it reportable based on RAD scores alone?	According to CoC, it would not be reportable. According to SEER, Pi-RADS and Li-RADS would be reportable, Bi-RADS would not.
24.	Did you know Bi-RADS was first published in 1993? ACR wanted to update the terminology to match their more recent terminology used in RADS. The US Government would not allow this change due to regulations for Medicare and other federal programs that would all have to be updated.	Thank you!
25.	Why are we using 2023 rules (STORE 2023) on 2022 cases?	At the time of the presentation, we were under the impression that the rules applied to 2022 cases. This was based on a response to a question posted to CAnswer forum in 2022.
26.	According to the CAnswer Forum (https://cancerbulletin.facs.org/forums/node/126952), the Rads rule is in effect as of now: "Does this change go into effect with cases diagnosed 6/23/22 forward, or should we use it for older cases that have not yet been abstracted? This should be applied to all cases. This is not a change to reporting; the clarification was posted to CA Forum July 2021."	Thank you!

27.	I agree with Jim - we do see on occasion on breast imaging "suspicious for ca" and the bi-rads 4 or 5 - we use the date of the mammogram due to the "suspicious for ca" statement from the radiologist and the bi-rads is irrelevant in cases such as this - but we put the bi-rads score in our text and of course the "suspicious for ca" text.	
28.	For CoC, the rule is only for PI-Rads, BI Rads, and Li Rads. Per CAnswer Forum (https://cancerbulletin.facs.org/forums/node/129474): The rules only apply to Pi-RADs, BI RADS, and LI RADS.	Thanks!
29.	If you have a suspicious cytology and then the bx is not done until 8 months later, we would not go back to the cytology for dx date, would we? Is there a timing rule?	8 months seems like an excessive amount of time, depending on circumstances, not sure I would go that far back, but I would have to look at the exact scenario to determine. I did however pose a similar question to AskSEERCTR, their response is below… Questions: Hi, I did a webinar on the changes in 2022 yesterday & I got some good questions that I do not know how to answer. These pertain to the Summary of Changes 2022 where the date of suspicious cytology is now used as date of diagnosis if confirmed 2022+ 1. What happens if suspicious cytology in 2021 & confirmation is in 2022? Ex. suspicious cytology 12-01-2021 and confirmed by positive biopsy 01-01-2022, what would date of dx be? 2. Is there a timing rule for the cytology & proven by? Answer: Registrars ask great questions! 1. It should be fine to use the date of the 2021 suspicious cytology when the diagnosis is confirmed in 2022. Details should be recorded in text fields.

		2. No, there is no timing rule for confirmation of the suspicious cytology diagnosis; however, we would expect the two events to be close enough in time to know that the suspicious cytology diagnosis was in fact confirmed. If there is a case for which there is a lengthy delay between the suspicious cytology diagnosis and the confirmation, we would ask why there was such a delay. The suspicious cytology situation should be handled similarly to a situation where there is a reportable ambiguous diagnosis on imaging with later confirmation. The date of the imaging report is used as the date of diagnosis unless there is some reason to discount it. Thank you, The SEER Data Quality Team
30.	Our facility decided to wait until 2023 to implement the CoC Rads changes since it would not be in the STORE manual until 2023. Who knows if they could change something or clarify it more between now and 2023.	Janet-good plan ☺ We need a clarification of the clarification!
31.	How about a malignant melanoma of the eye on FNA only?	I believe an fna of a melanoma of the eye using amb terms, would be diagnostic.
32.	for Scenario 3 PI-RADS. If you don't know what was done at Hosp B and C, wouldn't it be class 10 for hops A? and same for Hosp B, if you don't know if tx is done, wouldn't this be class 10?	We did assume that Hospital A knew what happened at hospitals B and C. Since we are discussing class of case and class of case reflects whether a case is reportable to CoC, then scenario 3 would not b reportable to Hospital A. If the registry is required to pick the case up for their central registry, the class of case would be non-analytic.
33.	SEER Appendix E & prior SINQ are based on definitions of the RADS which include use of diagnostic ambiguous terminology, which makes sense. I think of it like "aka" as RADS are being translated to the full description they represent. How do we reconcile that w/ STORE 2023 where we would report a lung cancer to CoC where radiologist says "suspicious for adenocarcinoma" & patient refused further	Hopefully, we can get reconciled guidance on this in the future!

	w/u & tx, but we would NOT report a PIRADS 5 where pt refused further w/u & tx?	
34.	As stated in the presentation, the Standard Setters are meeting to discuss the Rads rules and instructions-more to come on this :)	So glad to see the Standard Setters working together for this complex issue!
35.	I just want to note that the CoC Rads changes would be a big change for our facility because it can affect reportability, date of diagnosis, and class of case. It would also require us to follow up on cases we only did imaging for. It could potentially change our referral patterns data as well.	Thanks! Great point about the change potential changes to patterns of care!
36.	Neuroendocrine carcinoma of lung: I asked the same question to SEER in 2018 and the answer was to code to 8240/3 as 8246/3 ''does not apply to lung!!! Very hard to keep up...	Remember Terminology related to neuroendocrine tumors (NET) and neuroendocrine carcinomas (NEC) is fluid and inconstantly used in pathology reports. We constantly must adapt and it's not easy!
37.	I am unable to access the FCDS link here in Canada. For cervix you have now changed the rules mid-year. 2021 cervix cases have already been coded in our facility.	Please note, only CoC facilities are being asked to go back and make changes.
38.	For the cervix 2021, you only need the p16 to determine the histology. you do not need an HPV test - those are more expensive, not as reliable, and there are hundreds of HPV varieties, and they won't be testing for all of them. so, an HPV negative but p16 positive should be an HPV positive/associated histology	
39.	You only have to go back and change these cervix cases if you are a COC facility? If you are not, then not necessary and we can start in 2022?	Correct.
40.	Where can the 2022 ICD addendum be found? I'm looking on https://www.naaccr.org/icdo3/ "previous guidelines" and not able to find it.	It is included on the 2023 page. https://www.naaccr.org/icdo3/
41.	This is confusing for those Cervix histologies that go back to Jan 2021 now. Per the implementation guide, you need to go back and do a manual review, but in the ICD-O-3.2	It is confusing. I'd also like to point out that edits will not allow the histology codes for cervix for 2021. You have to wait until you upgrade to v23.

	Addendum, it says "manual review is not required. Registries may elect to review and recode cases."	
42.	For Vulva and Vagina, I thought you are supposed to code the histologies as 8085 and 8086, note the stage in your text, and go back and review after the v23 update? Would it be correct to do it that way too? We started doing it this way before the implementation guidelines came out.	Either way is fine as long as they get updated in the end.
43.	Ruth Li, you have to look under the ICD O 2023 tab for 2022 ICD addendum.	Correct the Addendum to 2022 ICD O 3.2 document is listed under the 2023 changes. This is because they cannot be made until you upgrade to v23 next year. If you make the change now, you will probably get an edit.
44.	Is this small cell lung grade going to be in the manual at some point? Instructions were if it's not in the manual don't do it, don't code from CAnswer.	The whole “don’t code unless it is in the manual” is a good idea in theory, but in practice it doesn’t always work. In this case I would recommend coding it based on what is in the CAnswer forum. I would not go back and update any cases, but I would use the rule moving forward.
45.	For these rules we are learning today, specifically small cell of lung is always grade 4 anaplastic, would this be the answer on the CTR exam as well if this was asked?	I personally do not think the CTR Exam would cover anything that is not in a manual, you do not have access to the CAnswer forum during the exam.
46.	For the lung example regarding gr 4 for small cell ca - if you have a bx of the lung (primary tumor) pos for small cell ca AND you have a bx of a met (liver for example) - at this point you can use both clin gr 4 and path gr 4 - is this correct? Thanks!	Yes, per Grade Coding Instructions: Use the grade from the clinical work up from the primary tumor in different scenarios based on behavior or surgical resection… •Surgical resection of the primary tumor has not been done, but there is positive microscopic confirmation of distant metastases during the clinical time frame
47.	Default grade for CNS behavior /0 did make it into Grade manual (page 185 on ver 2.01, page 193 in ver 2.1)	Thank you!
48.	For slide 51, "Underlying assumption for the STR's is we assume the patient does not have recurrence until we find something saying there is recurrence" This seems like such an ambiguous statement to me. Does that mean after they completed treatment and go into surveillance? Is this if the	Don’t over think this one. All you are looking for is if there is a new tumor in the primary site.

	physician neither says they have or do not have evidence of disease, you assume no disease after the completion of therapy?	
49.	There is a note on Appendix B in the CTR guide to use the table when the name of the equipment is all the registrar has. The radiation oncologist is best person to ask what occurred or review the treatment summary before following this table.	Excellent tip! I wish we all had access to our radiation oncologist, but sometimes it is just not possible.
50.	If there isn't hpv test done, do you code SCC to 8070/3??	Yes.
51.	Slide 62 SVC is that superior vena cava nodes? Or is it Supraclavicular? SVC on NAACCR abbreviations is Superior Vena Cava.	I am ashamed! I should have checked that list first before using the abbreviation. Thank you for the reminder. The slide is talking about supraclavicular nodes. Great reminder, only use abbreviations from this list. NAACCR APPENDIX G: RECOMMENDED ABBREVIATIONS FOR ABSTRACTORS http://datadictionary.naaccr.org/default.aspx?c=17&Version=23
52.	Also, positive HPV but insitu?? How is histology coded?	I have not seen anything to indicate any of the "HPV" histologies cannot be assigned to in situ cases.
53.	This is Summary Stage 7 because at one time the Supraclavicular nodes were M1 for AJCC, but then they were moved to the N category. Summary Stage does not change their classification when AJCC moves something from the M category to the T or N category. This is why you see differences between AJCC and Summary Stage.	Janet-Thank you, I love SEER's consistency through the years, it makes comparisons a whole lot easier!
54.	About Cancer Status at last contact. We've looked many times at Cancer Forum and concluded that nearly all Cancer Status is either "unknown," or with evidence of cancer. This is only because physicians hardly ever make a statement that the patient has no evidence of this cancer. More typically there will be radiology that doesn't show a suspicion of cancer, and the doctor will just recommend that the patient returns in one year, or whatever time frame they recommend. For years, if there was surgery with negative	Janet-As a registrar, I find a huge disconnect in what the CoC requires for us to code cancer status and what physicians document. In my personal experience, physicians rarely if ever state the patient has no evidence of disease. I asked a Physician representative from the CoC during a regional meeting about this directly and he said he personally would never dictate a patient was cancer free because it might mess with reimbursement and discourage a patient from continuing with follow up. I know for a fact that facilities code cancer status

	margins, appropriate treatment, and follow up radiology not showing anything suspicious, we considered those patients "NED." Cancer Forum doesn't seem to directly answer this question.	using their own rules and guidelines as well. It's a real problem. I know at one time they were going to address this with a special meeting, but the meetings got cancelled due to COVID, I don't know if they ever rescheduled or not.
55.	Lingula sparing not including Lingula?	Yes, lingula was not removed.
56.	It looks like the P16 rule is in use with C53 only. We are just wondering why it is not in effect for head and neck. Head and neck, p16 test results can be used to code 8085 and 8086 for cases diagnosed 1/1/2022.	I think the intent was for both of them to go into effect for cases dx'd 2022 forward. However, AJCC requested the change for cervix go back to 1/1/21.
57.	Just FYI other tx for heme also in page 26 of the Heme Manual (there's also very important corrections there about aspirin/anti-clotting agents no longer being coded for histologies where they were previously coded)	Thank you. It is important to read the manual!
58.	The aspirin is prophylaxis for the thrombocythemia. It does not affect the actual platelet count; therefore, it is not actually a treatment for the disease--rather just prophylaxis for potential complications of the disease.	According to our Hem & Lymphoid Neoplasm database, Aspirin, in low dose only (< 100 mg/day) is used as treatment for Essential thrombocythemia- per STORE code as Other Treatment 1.
59.	When you search the SEER RX Drug Database "aspirin", there is no mention of how-to code.	The STORE manual states "Supportive care may include phlebotomy, transfusion, or aspirin. In order to report the hematopoietic cases in which the patient received supportive care, SEER and the Commission on Cancer have agreed to record treatments such as phlebotomy, transfusion, or aspirin as "Other Treatment" (Code 1) for certain hematopoietic diseases ONLY. **Consult the most recent version of the Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual for instructions for coding** care of specific hematopoietic neoplasms in this item" Then consult the Hematopoietic and Lymphoid Neoplasm Database and look up essential thrombocythemia. Review the Abstractor Notes…**Aspirin, in low dose only (< 100 mg/day) is used as treatment for this disease.**

60.	Would you code the Xgeva in the palliative field? Thanks	This is from an old CAnswer Forum post#1824 - Xgeva (denosumab) has been approved by the U.S. Food and Drug Administration to prevent fractures and other skeletal complications in people with advanced cancer that has metastasized (spread) to the bones. The palliative treatments reduce suffering from existing symptoms caused by cancer, but Xgeva is given for the purpose to prevent fractures that may or may not happen in the future. So, it is not palliative Tx but preventative. Do not code.
61.	There's also "Lanreotide Acetate" - from the remarks hard to figure out sometimes if it is treating cancer vs carcinoid syndrome or both	Yes, it's hard, be sure to consult the physician prescribing to determine.
62.	Diagnostic confirmation will need to be carefully thought about if you only have PI-Rads 5 for example - and you do NOT know if proven via biopsy - you would code diagnostic confirmation as 7 radiographic only -	Correct
63.	Should registrars be assigning clinical TNM based on imaging when the MD does not stage?	If you have all the information needed to determine the appropriate TNM Categories/Stage
64.	The problem with ambiguous terminology is that physicians that I have talked to about it states that no one ever told them about our ambiguous rules. So consistent with may mean something different to us vs them.	I have heard other registrars that they send the list of ambiguous terminology to their pathologist, so they are aware of those terms.
65.	If Imaging -RADs imaging is done at another facility - this would change the Class of case also? - if the Bx is done at your facility.	Correct
66.	At hospital A we may not receive a list of imaging with this type of LI, PI Rads 4 or 5 information etc. This may be a change for some hospitals.	Correct
67.	Angela, regarding ambiguous terminology - I was referring to Xray in my statement, but either way I feel that physicians would need to ALL be taught this...at the medical school level...for it to be "official" to them.	That would be wonderful if they would, but I don't know if that will happen. :(

68.	Jim, you keep saying Store 2023 and your slides say Store 2023 when discussing the RADS info. Is Store 2023 published already or do you mean 2022?	I believe he said he received a copy and used the STORE 2023 for this webinar. I will clarify with him. STORE 2023 is available on the ACS website NCDB Call for Data page https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/
69.	if the scenario 2 bx is neg, but has lumpectomy at Hosp B, what would be date of dx- the mammo or lumpectomy?	According to CoC, it would be the date of the mammo.
70.	Can we use the TI-RADS to assign the m for multiple tumors on the Thyroid??	Yes, you can use it for Staging because per AJCC Chapter 1 page 12 Clinical Classification: it is composed of diagnostic workup info until first treatment....
71.	I was under the impression we could use TI-RADS 5 as a date of diagnosis. Question: Reportability/Date of diagnosis--Thyroid: Is category Thyroid imaging reporting and data system (TI-RADS) 4 (4a/4b) or TI-RADS 5 on imaging diagnostic of thyroid cancer, and if so, and we use the date of the impression on the scan that states either of these categories as the diagnosis date? Discussion: Answer: TI-RADS 5 is reportable for thyroid cancer unless disproven by other documentation and the date of the TI-RADS 5 scan may be used as the date of diagnosis if this is the earliest mention of the malignancy. TI-RADS 5 is "probably malignant nodules (>80% malignancy)." TI-RADS 4 (including 4a and 4b) is not reportable for thyroid cancer. TI-RADS 4 is "suspicious nodules (5-80% malignancy)." TI-RADS 4b is "suspicious (10-80% malignancy)." References: SINQ & American College of Radiology TI-RADS Reporting System	I had not seen that post!
72.	Since we can't use Thyroid TI-Rads 4/5 as a dx date, when a biopsy confirms thyroid cancer can we use this radiology to assign clinical staging information such as tumor size or multifocal tumors?	Yes, you can use it for Staging because per AJCC Chapter 1 page 12 Clinical Classification: it is composed of diagnostic workup info until first treatment....

73.	Can we use suspicious urine cytology as well when confirmed to be ca?	We got this from one of our participants… *Urine cytology positive for malignancy is reportable. Code the primary site to C689 in the absence of any other information. Page 10 SEER manual. Do not report cytology cases with ambiguous terminology (see page 9 for ambiguous terms).*
74.	Does that confirmation of a suspicious cytology have to be a positive bx or can it be a statement by the MD?	Either
75.	HPV-independent means (-) and HPV-associated means (+)???	Correct.
76.	Doesn't lingula sparing mean it was spared - not resected as in a lingulectomy?	Yes, but there isn't an exact code to fit for a lingula spring LUL lobectomy- so I contacted AskSEERCTR that states "We obtained input from an expert who agrees with code 22 for LUL wedge Resection followed by a Lingular-Sparing LUL lobectomy & Mediastinal Lymph Node Dissection. Code the LN Surgery in scope of regional LNs." I asked Jim Hofferkamp about this because I wanted to understand and he told me, "An upper lobectomy in the right lobe is the removal of three segments (apical, anterior, and posterior). In the left lobe there are 4 segments (anterior, apicoposterior, inferior and the lingula.) So, removing three segments from the right lung is a lobectomy. Three segments from the left lung without the lingula is a segmental resection. And both SEER & COC are on the same page. They discussed the issue and agreed 22 is a better of the two options."
77.	If the surgery code 22 is wedge resection INCLUDING lingulectomy - i take this to mean the wedge resection includes the removal of the lingular part - but this example they spared it - so, why is it 22? and there is no mention of LN's?	There isn't an exact code to fit for a lingula spring LUL lobectomy- so I contacted AskSEERCTR that states "We obtained input from an expert who agrees with code 22 for LUL wedge Resection followed by a Lingular-Sparing LUL lobectomy & Mediastinal Lymph Node Dissection. Code the LN Surgery in scope of regional LNs."

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