Coding Pitfalls 2022

September 1, 2022

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Q&A

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

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

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

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Fabulous Prizes



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Guest Presenter

- Janet Vogel, CTR
  - Compliance and Quality Auditor/Educator-Cancer Registry, Omega Healthcare

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Agenda

- AJCC Adventures
  - Blank vs X
- Date of Diagnosis Dilemma
  - RADS
  - Ambiguous Cytology
- Histology Hole
  - Pulmonary Neuroendocrine Tumors
  - p16
  - Default Grades
- Radiation Rapids
  - Pelvis
  - Accuboost
- Summary Stage Snare
  - Colon-in situ but Localized
  - Lung-SVC
- Treatment Trench
  - Lingula Sparing LUL lobectomy
  - ET-aspirin
  - Xgeva

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Minimum Resources Required to Abstract

- *2023*, 2022, or previous Implementation Guidelines https://www.naaccr.org/implementation-guidelines/
- Solid Tumor Rules https://seer.cancer.gov/tools/solidtumor/
- Hematopoietic and Lymphoid Neoplasm Database https://seer.cancer.gov/seertools/hemelymph/
- Hematopoietic and Lymphoid Neoplasm Coding Manual https://seer.cancer.gov/tools/heme/Hematopoietic_Instructions_and_Rules.pdf
- NAACCR Site Specific Data Items and Grade https://apps.naaccr.org/ssdi/list/
- SEER*RSA https://staging.seer.cancer.gov/eod_public/home/2.0/
- or https://staging.seer.cancer.gov/eod_public/home/2.1/
- EOD 2018 https://seer.cancer.gov/tools/staging/
- Summary Stage 2018 https://seer.cancer.gov/tools/staging/
- American Joint Committee on Cancer/AJCC https://www.facs.org/quality-programs/cancer/ajcc
- ICD 0 3 Histology Revisions https://www.naaccr.org/icdo3/
- NAACCR Vol II Data Dictionary https://www.naaccr.org/data-standards-data-dictionary/
- SEER*Rx Interactive Antineoplastic Drugs Database https://seer.cancer.gov/seertools/seerrx/
- STORE Manual https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/
- SEER Program Coding and Staging Manual https://seer.cancer.gov/tools/codingmanuals/
- CTR Guide to Coding Radiation Therapy Treatment in the STORE https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/
- Cancer Program News https://www.facs.org/quality-programs/cancer/news
- Appropriate State Manual

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AJCC ADVENTURES

THESE TOPICS JUST KEEP GETTING DEEPER!

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Uncertain Information

- **Scenario:** 2022 rectal cancer 5.0cm from the anal verge on imaging the cancer is stated T3/4 - involving possible involvement of prostate and positive mesorectal lymph nodes.
- Patient was presented to Tumor Board, the managing physician, medical oncologist, and radiation oncologist state: T3/4 N1 stage IIIB.

- **Question:** How would you assign AJCC cT category?
  - cT3
  - cT4
  - cTX
  - cT BLANK

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Answer & Rationale

- cT BLANK
- AJCC Manual 8th Edition Chapter 1-Uncertainty rules do not apply to cancer registry
- AJCC Curriculum for Registrars https://www.facs.org/quality-programs/cancer-programs/american-joint-committee-on-cancer/staging-education/registrar/
  - Refer to Lessons 9,10,18,23,24,25
- CAnswer Forum Post 3-26-2021 https://cancerbulletin.facs.org/forums/node/114814

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Incomplete Information

- **Scenario:** 2022 CT scan of Abdomen and Pelvis: 1.2cm transverse colon that extends into surrounding pericolonic tissues. There are **enlarged pericolic lymph nodes consistent with involvement**. There is also right lung metastasis and liver metastasis seen on CT. Patient has liver biopsy performed on 04-19-2021 which shows adenocarcinoma consistent with metastasis from colon primary. No further resection done.)

- **Question:** How would you assign AJCC cN category? [enlarged pericolic lymph nodes consistent with involvement.]
  - cN1 One to three regional lymph nodes are positive (tumor in lymph nodes measuring ≥0.2mm), or any number of tumor deposits are present and all identifiable lymph nodes are negative
  - cN2 Four or more regional nodes are positive
  - cNX
  - cN BLANK

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Answer & Rationale

- cN BLANK
- AJCC Manual 8th Edition Chapter 1-Uncertainty rules do not apply to cancer registry
- AJCC Curriculum for Registrars https://www.facs.org/quality-programs/cancer-programs/american-joint-committee-on-cancer/staging-education/registrar/
  - Refer to Lessons 9,10,18,23,24,25
- Discussion:
  - Nodes are positive but it is unknown the exact number of nodes positive. When using data for analysis, you cannot mix in this type of uncertain data without skewing the results. To make data useful, it must be accurate.

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Workup done-but not enough info

- **Scenario 1:** 2022 colonoscopy+ adenocarcinoma in ascending colon, patient goes on to have resection & chemo for pT3 pN1a cM0 Stage 3B colon cancer

- **Question**: How would you assign AJCC cT category? [based on colonoscopy]
  - cTX
  - cT BLANK

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Answer & Rationale

- cTx
  - AJCC Curriculum for Registrars https://www.facs.org/quality-programs/cancer-programs/american-joint-committee-on-cancer/staging-education/registrar/
    - Refer to Lesson 23
  - CAnswer Forum Post https://cancerbulletin.facs.org/forums/node/131084
    - Colon is a little different as most of the time the physician is not able to evaluate the extension of the tumor on the colonoscopy. Also, imaging is only useful in some cases.

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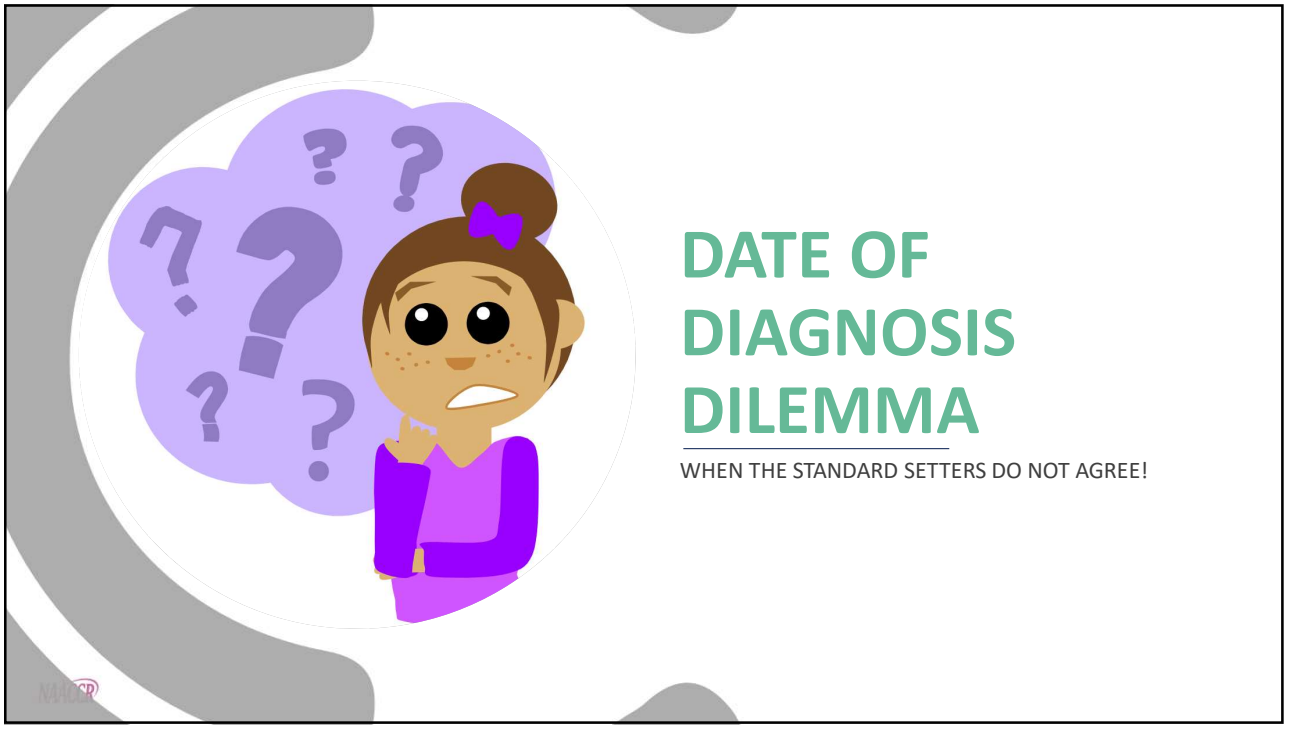

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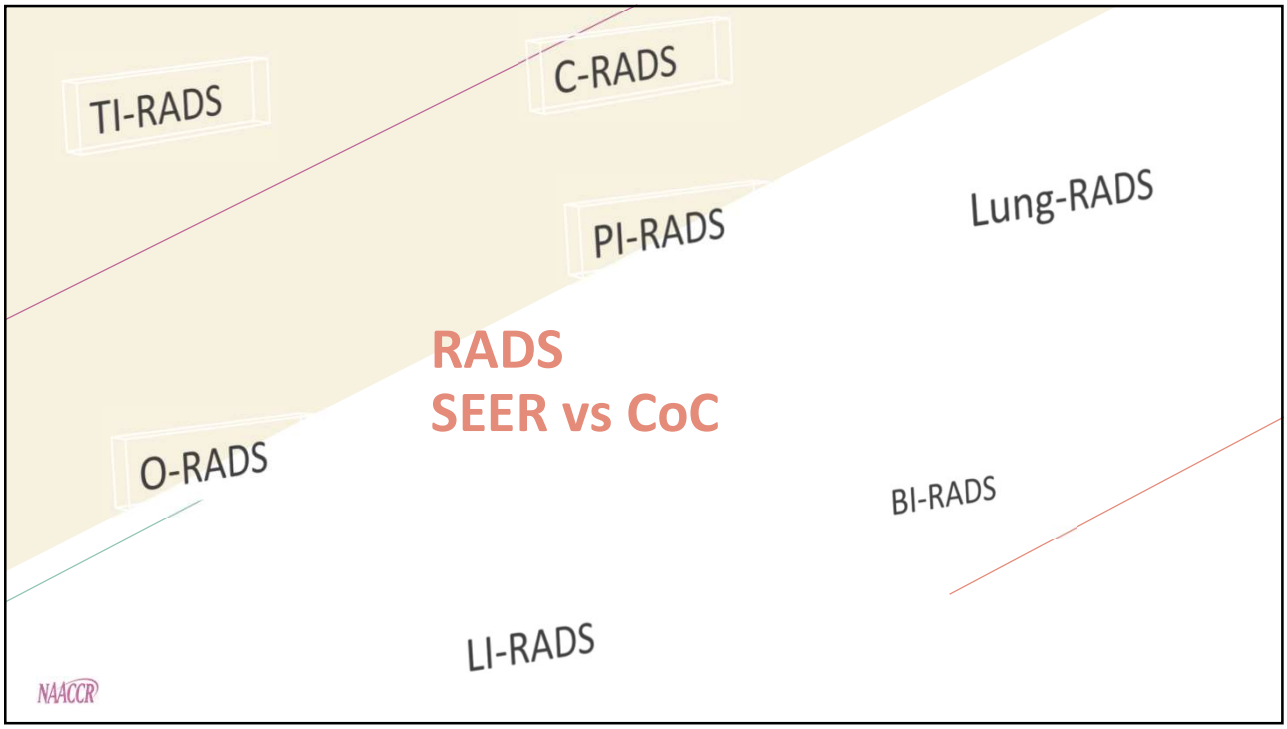

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Sample Mammogram

2/2/22 Mammogram

Reason for exam: Screening

Patient History: Patient is postmenopausal. No known family history of cancer. Last mammogram peformed 1 year ago.

Bilateral digital CC and MLO view were taken.

Prior study comparison: 2019, 2020

BI RAD Score

BI RAD Score Definition

Impression: BIRADS 5 HIGHLY SUGGESTIVE OF MALIGNANCY

Radiologist Statement

Spiculated 2.2cm mass with associated microcalcifications and architectural distortion at 9 o'clock in the right breast, consistent with breast cancer. Ultrasound guided core needle biopsy is recommended.

Statement is diagnostic of cancer.
BIRAD Score is irrelevant.

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Date of Diagnosis-SEER

- ***Note:*** Do **not** change the date of diagnosis when a clinical diagnosis is subsequently confirmed by positive histology or cytology.

- ***Example 1:***
  - On May 15, 2023, physician states that patient has lung cancer based on clinical findings.
  - The patient has a positive biopsy of the lung in June 3, 2023.
  - The **date of diagnosis** remains **May 15, 2023**.
- ***Example 2:***
  - Radiologist reports Liver Imaging Reporting and Data System (LI-RADS) Category 5 on imaging.
  - Later biopsy confirms hepatocellular carcinoma (HCC).
  - Record date of diagnosis as date of LI-RADS imaging.

- ***Note:*** Appendix E in the 2023 SEER Program Manual lists which PI-RADS, BI-RADS, and LI-RAD are reportable versus non-reportable. **If reportable, use the date of the imaging procedure as the date of diagnosis when this is the earliest date and there is no information to dispute the imaging findings.**

SEER Program Coding and Staging Manual pg 84

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Appendix E

Appendix E1 - 2022 SEER Program Coding and Staging Manual

Reportable Examples

As referenced in the Reportability instructions of the 2022 SEER Program Coding and Staging Manual

14	Liver cases with an LI-RADS category LR-4 or LR-5	Report based on the American College of Radiology Liver Imaging Reporting and Data System (LI-RADS) definitions. Use the date of the LR-4 (probable HCC; high probability but not 100% certainty observation is HCC) or LR-5 (definitely HCC; 100% certainty observation is HCC) scan as the date of diagnosis when it is the earliest confirmation of the malignancy. If there is no statement of the LI-RADS score but there is reference that a lesion is in the Organ Procurement and Transplantation Network (OPTN) 5 category, report based on the OPTN class of 5. OPTN class 5 indicates that a nodule meets radiologic criteria for hepatocellular carcinoma.

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LI-RADS (Liver) for CT and MRI

- Liver lesions seen on CT and MRI are categorized from 1 to 5:
  - LR-1: definitely not cancer (benign)
  - LR-2: probably not cancer
  - LR-3: intermediate probability of HCC
  - **LR-4: Probably Hepatocellular Carcinoma**
  - **LR-5: Definitely Hepatocellular Carcinoma**
- Use the date of the LR-4 (probable HCC or LR-5 scan as the **date of diagnosis** when it is the earliest confirmation of the malignancy.
- If there is no statement of the LI-RADS score but there is reference that a lesion is in the Organ Procurement and Transplantation Network (OPTN) 5 category, report based on the OPTN class of 5. OPTN class 5 indicates that a nodule meets radiologic criteria for hepatocellular carcinoma.

https://www.radiologyinfo.org/en/info/article-lirads-liver-imaging

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PI-RADS (Prostate)

- Each lesion is assigned a score from 1 to 5 indicating the likelihood of clinically significant cancer:
  - **PI-RADS 1**: very low (clinically significant cancer is highly unlikely to be present)
  - **PI-RADS 2**: low (clinically significant cancer is unlikely to be present)
  - **PI-RADS 3**: intermediate (the presence of clinically significant cancer is equivocal)
  - **PI-RADS 4**: high (clinically significant cancer is likely to be present)
  - **PI-RADS 5**: very high (clinically significant cancer is highly likely to be present)
  - **PI-RADS X**: component of exam technically inadequate or not performed
- SEER Program Manual Appendix E
- PI-RADS categories
  - 4 (high-clinically significant cancer is likely to be present) and
  - 5 (very high-clinically significant cancer is highly likely to be present)
- are **reportable**, **unless** there is other **information to the contrary**.

https://www.acr.org/Clinical-Resources/Reporting-and-Data-Systems/PI-RADS

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BI-RADS (Breast)

- Category 1: Negative
- Category 2: Benign
- Category 3: Probably Benign
  - ≥ 0% but ≤ 2% likelihood of malignancy
- Category 4: Suspicious
  - > 2% but < 95% likelihood of malignancy
- Category 5: Highly Suggestive of Malignancy
  - ≥ 95% likelihood of malignancy

Suspicious of what?

Not-Reportable ambiguous term

- The American College of Radiology defines Category 4 as "Suspicious."
  - The descriptions in categories 4, 4a, 4b, and 4c are not diagnostic of malignancy. They all represent a percentage of likelihood, the highest being 4c which is greater than 50% but less than 95% likelihood of malignancy.
  - Category 5 is "**Highly Suggestive of Malignancy**." "*Suggestive" is not reportable ambiguous terminology*.
  - ACR states that Category 5 has a "very high probability" of malignancy, but again, it is **not diagnostic**.

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CoC Statement

Question: If a patient has a biopsy confirming prostate cancer at a different hospital but the biopsy was performed based on a PI-RADS 5 MRI done at my facility, is it reportable to me?

Answer:

- Per guidance from CoC, PI-RADS, BI-RADS, and LI-RADS alone are not reportable to CoC. However, if the PI-RADS, BI-RADS, and LI-RADS lead to a biopsy confirming cancer, then the date of imaging is the diagnosis date.

https://cancerbulletin.facs.org/forums/node/130147

STORE 2023 page 45

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Scenario 1 PI-RADS

Scenario:

2/2/22- Hospital A: Patient has an MRI of the prostate due to an elevated PSA.

- Impression: Extensive bilateral PIRADS 5 in the peripheral zones, most pronounced at the mid gland and base with left-sided neurovascular bundle invasion and extension into the base of the left seminal vesicle.
- Comment: Bilateral PIRADS 5 (L >R).

2/15/22 Hospital B: patient had bx confirming adenocarcinoma.

- All further staging and tx done at Hospital B. Patient did not return to Hospital A.

Questions:

- What is class of case for Hospital A?
  - 00
- Should Hospital A transmit this case to their central registry?
  - Yes for SEER states. Probably for non-SEER central registries (might want to check first)

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Scenario 2 BI-RADS

Scenario:

2/2/22 Mammogram done at Hospital A

- Impression: BIRADS 5 HIGHLY SUGGESTIVE OF MALIGNANCY
- Spiculated 2.2cm mass with associated microcalcifications and architectural distortion at 9 o'clock in the right breast, *highly concerning** for breast cancer. Ultrasound guided core needle biopsy is recommended.

2/15/22 patient goes to Hospital B for biopsy. Biopsy confirms cancer. Patient does not return to Hospital A

Questions:

- What is class of case for Hospital A?
  - 00 (assuming this is a CoC facility)
- Should Hospital A transmit this case to their central registry?
  - Check with central registry.
  - Be sure to document situation in text!!!

*Not a reportable ambiguous term

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Scenario 3 PI-RADS

- Hospital A-1/1/2022 MRI of prostate
  - Impression:
    - Prostate volume 100 ml. PSA density 0.04 ng/ml.
    - Extensive bilateral PIRADS 5 in the peripheral zones, most pronounced at the mid gland and base with left-sided neurovascular bundle invasion and extension into the base of the left seminal vesicle. The burden is significantly larger on the left and invades the transitional zone.
    - BPH.
    - Comment: Bilateral PIRADS 5 (L >R).
- Hospital B-2/15/2022
  - Biopsy of the prostate
    - Adenocarcinoma
- Hospital C-3/15/2022
  - Watchful waiting prescribed

- Is this reportable per SEER Guidelines? Yes
- Is this case reportable per CoC Guidelines? Yes
- Date of Diagnosis
  - 1/1/2022 ⬅
  - 2/15/2022
- Class of Case
  - Hospital A 00
  - Hospital B 30
  - Hospital C 22

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Scenario 4 PI-RADS

- 1/2/2022 PSA 3.36. DRE benign
- 2/14/2022 MRI
  - Prostate volume 82 mls.
  - 9 mm **PIRADS 4** lesion in the left peripheral zone at the apex.
  - Extensive BPH.
  - Normal seminal vesicles. No pelvic nodes. No bone lesions.
- 2/30/2022-Physician notes patient has opted for no further work-up or treatment at this time.

- Is this reportable per SEER Guidelines? Yes
- Is this case reportable per CoC Guidelines? No
- Date of Diagnosis
  - 1/2/2022
  - 2/14/2022 ⬅
  - 2/30/2022
- What is Class of Case? 34

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Scenario 5 LI-RADS

- 1/2/2022
  - The patient is known to have cirrhotic liver, with a suspicious lesion detected on contrast enhanced CT scan.
- 1/5/2022 CT Scan
  - There is a well-defined lesion in segment II of the liver, it appears hypo/isointense on T1, hyperintense on T2, with diffusion restriction on DWI images. This lesion measures about 13 x 13 x 14 mm (AP.TRANS.CC).
  - Features are consistent with LI-RADS 5 lesion (definitely HCC).
- 1/27/2022
  - Due to multiple comorbid conditions, the patient did not have any additional follow-up

- Is this reportable per SEER Guidelines? Yes
- Is this case reportable per CoC Guidelines? No
- Date of Diagnosis
  - 1/2/2022
  - 1/5/2022 ←
  - 1/27/2022

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LUNG-RADS

Categories

- Category 0 (Incomplete)
- Category 1 (negative, <1% chance of malignancy)
- Category 2 (benign appearance or behavior, <1% chance of malignancy)
- Category 3 (probably benign, 1-2% chance of malignancy)
- Category 4A (suspicious, 5-15% chance of malignancy) (version 1.1 change previously suspicious)
- Category 4B (very suspicious, >15% chance of malignancy)

SEER Appendix E

- **Do not use** the ACR Lung Imaging Reporting and Data System (**Lung-RADS™**) to determine reportability. Look for reportable terminology from the managing physician or other sources.

https://www.acr.org/-/media/ACR/Files/RADS/Lung-RADS/LungRADSAssessmentCategoriesv1-1.pdf

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TI-RADS (Thyroid)

Categories

- TR1-Benign
  - Risk of malignancy 0.3%
- TR2-Not Suspicious
  - Risk of malignancy 1.5%
- TR3-Mildly suspicious
  - Risk of malignancy 4.8%
- TR4-Moderately suspicious
  - Risk of malignancy 9.1%
- TR5-Highly suspicious
  - Risk of malignancy 35%

SEER Appendix E

- Not mentioned

https://radiologyassistant.nl/head-neck/ti-rads/ti-rads

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RADS Conclusion

- In most situations, CoC and SEER guidelines will lead to the same diagnosis date.
  - Check CAnswer forum or Ask a SEER Registrar/SINQ for guidance if they don't.
- Standard timing rules for staging and treatment do not change.
- Standard setters are working on standardized rules

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Date of Dx-Ambiguous Cytology

- **Scenario:** 01-01-2022 Cytology "suspicious" for cancer; 2-15-2022 pathology positive for adenocarcinoma

- **Question:** What is the date of diagnosis?
  - 01-01-2022
  - 02-15-2022

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Answer & Rationale

- 01-01-2022
- SEER Program Coding and Staging Manual 2022 - Summary of Changes

SEER Program Coding and Staging Manual 2022 - Summary of Changes
This table lists the changes in the 2022 manual by page number.

Page	Section	Data Item	Change	Notes/Comments
10	Reportability	Ambiguous Terminology	Text revised and exception added.	**Cytology** Do **not** accession a case based ONLY on **suspicious** cytology. Follow back on cytology diagnoses using ambiguous terminology is strongly recommended. Accession the case when a reportable diagnosis is confirmed later. The date of diagnosis is the date of the suspicious cytology.***Exception:*** This is a change to previous instructions. The date of a suspicious cytology may be used as the date of diagnosis when a definitive diagnosis follows the suspicious cytology. See Date of Diagnosis for more information.
84	Section IV: Description of this Neoplasm	Date of Diagnosis	Coding Instruction 1 exception deleted.	Deleted: ***Exception:*** Do not use the date of diagnosis from a cytology report using ambiguous terminology. See Coding Instruction #5 below.
84	Section IV: Description of this Neoplasm	Date of Diagnosis	Coding Instruction 5 and note 1 revised; example added.	5. Use the date of suspicious cytology when the diagnosis is proven by subsequent biopsy, excision, or other means ***Example:*** Cytology suspicious for malignancy 01/12/2022. Diagnosis of carcinoma per biopsy on 02/06/2022. Record 01/12/2022 as the date of diagnosis. ***Note 1:*** "Suspicious" cytology means that the diagnosis is preceded by an ambiguous term such as apparently, appears, compatible with, etc.

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Caution

- Scenario: 2022 cytology: Suspicious for malignancy

- **SEER Program Coding & Staging Manual 2022**
  - Do not accession a case based ONLY on suspicious cytology. Follow back on cytology diagnoses using ambiguous terminology is strongly recommended. Accession the case when a reportable diagnosis is confirmed later. The date of diagnosis is the date of the suspicious cytology.
- **STORE 2022**
  - EXCEPTION: If cytology is identified only with an ambiguous term, do not interpret it as a diagnosis of cancer.
    - Abstract the case only if a positive biopsy or a physician's clinical impression of cancer supports the cytology findings.

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STORE-infer from example

- It's not listed as a STORE 2022 Summary of Changes however the example under Date of Initial Diagnosis was updated in STORE 2022, because in 2010 those instructions would not have been appropriate, submitted question to CAnswer Forum, they confirmed the example on page 126 is correct.
- **STORE 2022** Example page 126- Used the date of ambiguous cytology after it was confirmed by positive pathology.

Examples

Code	Label	Definition
20100612	June 12, 2010	Cytology "suspicious" for cancer June 12, 2010; pathology positive July 2, 2010. Do not consider cytology with ambiguous terms to be diagnostic, however positive pathology supports the cytology diagnosis.

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Steps for Coding Histology

- Refer to Solid Tumor Rules Histology rules or Hematopoietic and Lymphoid Database whichever is appropriate and follow the histology rules to code the histology. https://seer.cancer.gov/tools/solidtumor/
- Refer to the ICD 0 3.2 Coding Tables to see if histology is listed. (This table is available in a PDF file sorted by numeric order, a PDF sorted by alpha order, or Excel Table) https://www.naaccr.org/icdo3/ [Review the Previous Guidelines as well.] **{Annotated Histology List}**
- If it is not in the coding tables, check your ICD-O 3.0 manual (purple book), check the online version of ICDOTHIRD EDITION http://www.iacr.com.fr/index.php?option=com_content&view=category&layout=blog&id=100&Itemid=577
- SINQ /ASK A SEER Registrar https://seer.cancer.gov/registrars/contact.html

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High Grade Neuroendocrine Carcinoma of the Lung

- **Scenario:** 2022 Lung bx: high grade neuroendocrine carcinoma

- **Question**: What would you code histology?
  - 8240 Neuroendocrine carcinoma, NOS [indented term in Table 3 Solid Tumor Rules Lung]
  - 8041 High-grade neuroendocrine carcinoma (C54. , C55.9) [2018+]

Small cell carcinoma 8041/3 *Note 1:* This row applies to neuroendocrine tumors (NET). *Note 2:* Large cell carcinoma with neuroendocrine differentiation lacks NE morphology and is coded as large cell carcinoma, not large cell neuroendocrine carcinoma.	Reserve cell carcinoma Round cell carcinoma SCLC Small cell carcinoma NOS Small cell neuroendocrine carcinoma	Atypical carcinoid **8249/3** Combined small cell carcinoma **8045/3** Typical carcinoid **8240/3** Neuroendocrine carcinoma, NOS Well-differentiated neuroendocrine carcinoma

Value	strHistologyBehaviour	Preferred	label
8041	3	FALSE	High-grade neuroendocrine carcinoma (C54._, C55.9) [2018+]
8041	3	FALSE	Neuroendocrine carcinoma, high grade (C54._, C55.9) [2018+]
8041	3	FALSE	Neuroendocrine carcinoma, poorly differentiated [OF BREAST] (C50._) [2018+]
8041	3	FALSE	Neuroendocrine carcinoma, small cell
8041	3	FALSE	Small cell neuroendocrine carcinoma
8240	3	FALSE	Neuroendocrine carcinoma, low grade
8240	3	FALSE	Neuroendocrine carcinoma, well-differentiated
8246	3	TRUE	Neuroendocrine carcinoma, NOS

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Answer & Rationale

- 8246 Neuroendocrine carcinoma, NOS
- Rationale: Ask SEER CTR #31124
  - Terminology related to neuroendocrine tumors (NET) and neuroendocrine carcinomas (NEC) is fluid and inconsistently used in pathology reports. The Solid Tumor Histology Tables are based on WHO Blue Books and may not list all possible histologies that may occur in that site or sites. Grade and/or differentiation contributes to the confusion. Lung is an outlier due to the various neuroendocrine variants such as small cell, large cell, etc. All of the solid tumor site rules instruct you to refer to ICD-O and updates if the histology is not found in the solid tumor rules. It is important to understand the ICD-O updates are based on specific blue books and some terms may be site specific at the time of publication. By the time ICD-O-3.2 was released the editors either removed applicable sites or added some.
  - For high grade neuroendocrine carcinoma of the lung, code to neuroendocrine carcinoma, NOS 8246/3. Refer to the Grade Manual for instructions on coding "high grade".

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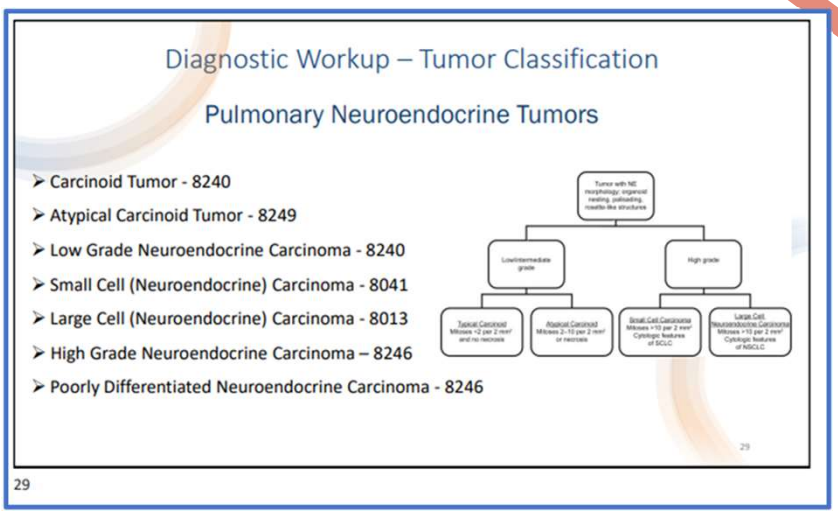
Tip from FCDS/Florida Cancer Data System

- Watch the 01/20/2022, FCDS Educational Webcast Series - *Lung Cancer - 2022 Updates and How to Use the Latest Resources when Abstracting Cases*, presented by Steve Peace, CTR https://fcds.med.miami.edu/inc/educationtraining.shtml



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P16 and Assigning Histology

- 8085 Squamous cell carcinoma, HPV-Positive and 8086 Squamous cell carcinoma, HPV-Negative
  - May be used starting in 2018 for the following head and neck sites:C01.9, C09.9, C10.2, C10.3, C10.8, C10.9, C31.0–C31.3, C31.9
    - The 2018 Solid Tumor Head and Neck Rules, Table 5, instruct squamous cell carcinoma, HPV positive (8085) and squamous cell carcinoma, HPV negative (8086) are coded only when HPV status is determined by tests based on ISH, PCR, RT-PCR technologies to detect the viral DNA or RNA. P16 was not a valid test to assign these codes. **Beginning with cases diagnosed 1/1/2022 forward, p16 test results can be used to code squamous cell carcinoma, HPV positive (8085) and squamous cell carcinoma, HPV negative (8086).**
  - May be used starting in ~~2022~~ 2021 for Cervix (C53._)

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Addendum to 2022 ICD-O-3.2 Update, Tables 1 and 2

ICD-O Code	Term	Required SEER	Required NPCR	Required CoC	Required CCCR	Remarks
8085/3	Squamous cell carcinoma, HPV-associated	See remarks	See remarks	See remarks	See remarks	Valid for uterine cervix 1/1/2021 forward
8086/2	Squamous cell carcinoma, HPV-independent	See remarks	See remarks	See remarks	See remarks	Valid for uterine cervix 1/1/2021 forward
8310/3	Adenocarcinoma, HPV-independent, clear cell type	See remarks	See remarks	See remarks	See remarks	Valid for uterine cervix 1/1/2021 forward
8380/3	Adenocarcinoma, HPV-independent, endometrioid type Note: This term is AJCC specific and is not included in WHO 5th Ed GYN book or CAP protocol	See remarks	See remarks	See remarks	See remarks	Valid for uterine cervix 1/1/2021 forward
8482/3	Adenocarcinoma, HPV-independent, gastric type	See remarks	See remarks	See remarks	See remarks	Valid for uterine cervix 1/1/2021 forward
8483/3	Adenocarcinoma, HPV-associated	See remarks	See remarks	See remarks	See remarks	Valid for uterine cervix 1/1/2021 forward
8484/3	Adenocarcinoma, HPV-independent, NOS	See remarks	See remarks	See remarks	See remarks	Valid for uterine cervix 1/1/2021 forward
9110/3	Adenocarcinoma, HPV-independent, mesonephric type	See remarks	See remarks	See remarks	See remarks	New related term for 9110/3 and is not site specific. The term may be coded for cervix cases diagnosed prior to 1/1/2022.

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2023 Implementation Guidelines

- 13.4 AJCC Version 9 Cervix Uteri Histologies
- The following histology terms and codes were used by pathologists in 2021 in the CAP Protocol, but registrars did not have access to these codes. Cervix (C530 – C539) cases diagnosed in 2021 should be flagged for review to identify when the pathology report used the following histologies so they can be recoded.
- Recommend manual review for all cases where AJCC ID [995] = 52 (Cervix Uteri), all Histology ICD-O-3 [522] codes and Date of Diagnosis [390] on or after January 1, 2021. Review all cases to see if they should have been more appropriately coded to one of the following histologies:
  - 8085 Squamous cell carcinoma, HPV-associated
  - 8086 Squamous cell carcinoma, HPV-independent
  - 8483 Adenocarcinoma, HPV-associated
  - 8484 Adenocarcinoma, HPV-independent, NOS
  - 8482 Adenocarcinoma, HPV-independent, gastric type
  - 8310 Adenocarcinoma, HPV-independent, clear cell type
  - 9110 Adenocarcinoma, HPV-independent, mesonephric type
- As these are being reviewed, if p16 [3956] is blank, the text should also be reviewed and p16 must be set.

NAACCR https://www.naaccr.org/implementation-guidelines/ 42

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2023 Implementation Guidelines

- 13.5 AJCC 8th Edition Vulva and Vagina Histologies
  - Similar to 13.4 above, registrars did not have access to two codes being used by pathologists in 2022.
  - Recommend manual review for all cases where Primary Site [400] = C510-C529 and Histology ICD-O-3
  - [522] = 8070 and Date of Diagnosis Year [390] on or after January 1, 2022. Review all cases to see if they should have been more appropriately coded to one of the following histologies:
    - 8085 Squamous cell carcinoma, HPV-associated
    - 8086 Squamous cell carcinoma, HPV-independent
- 13.6 AJCC 8th Edition Vulva and Vagina Histology and AJCC ID
  - The two histologies from Section 13.5 (8085 and 8086) are eligible for AJCC staging. Therefore, after the review from that section is completed, any cases with those histologies will need to be converted to adjust the AJCC fields.

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Coding Clarifications p16 Histologies

- Cervix: For cases diagnosed 1/1/202~~2~~1 and later, how is histology coded for the following three cervix cases relating to p16?
  1. Final diagnosis is adenocarcinoma (NOS), but the immunohistochemistry is p16 negative?
     - Adenocarcinoma, HPV-independent, NOS (C53._) (8484/3)
  2. Histology coded when the Pap smear is positive for squamous cell carcinoma, p16 positive, but the most representative specimen from the primary tumor (the subsequent cervix biopsy) is only stated to be squamous cell carcinoma (NOS)?
     - Carcinoma, squamous cell, HPV-associated (C53._) (8085/3)
  3. Biopsy of a metastasis (e.g., a lymph node metastasis) proved squamous cell carcinoma, p16 negative, but a subsequent biopsy of the primary cervix tumor proved squamous cell carcinoma (NOS) without additional IHC studies?
     - Carcinoma, squamous cell, HPV-independent (C53._) (8086/3)

NAACCR https://seer.cancer.gov/seer-inquiry/inquiry-detail/20220002/ 44

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Default Grade-Small Cell Carcinoma Lung

Question:

- A patient has a biopsy of a lung tumor that comes back small cell carcinoma. However, no grade information is provided. Should I assign a grade of 9?

Answer:

- The SSDI WG confirmed with pathologists from CAP and AJCC that small cell carcinoma is, by definition, anaplastic.
  - The WG recommended that if **tissue from the primary tumor (which is the first criteria for assigning any grade)** shows small cell carcinoma, no grade information is available, and the rules for classification have been met, a grade of 4 may be assigned.
  - Registrars are not required to assign a grade of 4 for small cell carcinoma if no grade information is stated on the pathology report, but it is recommended.
  - The recommendation is for cases diagnosed 2018 forward. However, registrars are not being asked to go back and change grade for cases that have already been abstracted.

https://cancerbulletin.facs.org/forums/node/124735

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Default Grade-CNS

- **Question**:
  - If the initial clinical imaging had only 1 differential of glioblastoma, would we then have clinical grade of 4 per grade manual & AJCC table 72.2?
- **Answer:**
  - Yes! a clinical grade can be assigned for CNS tumors even if no bx of primary tumor. This only applies to CNS.

Histology	WHO Grade
Atypical meningioma	2
Atypical teratoid/rhabdoid tumor	4
Central neurocytoma	2
Cerebellar liponeurocytoma	2
Chordoid glioma of third ventricle	2
Choroid plexus carcinoma	3
Choroid plexus papilloma	1
CNS embryonal tumor NOS	4
CNS embryonal tumor with rhabdoid features	4
Craniopharyngioma	1
Desmoplastic infantile astrocytoma and ganglioglioma	1
Diffuse astrocytoma, IDH-mutant	2
Diffuse midline glioma, H3K27M-mutant	4
Dysembryoplastic neuroepithelial tumor	1
Dysplastic gangliocytoma of cerebellum (Lhemitte-Duclos)	1
Ependymoma	2
Ependymoma, RELA fusion-positive ***Note:*** Tissue/pathology reports or CAP protocol/summary will specify whether this is WHO Grade 2 or 3	2 or 3
Extraventricular neurocytoma	2
Gangliocytoma	1
Glioblastoma, IDH-mutant	4
Glioblastoma, IDH-wildtype	4

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Scenario 1

- **Question**:
  - Imaging showed a tumor thought to be a glioblastoma (grade IV), but it turns out to be a borderline tumor on resection.
    - Do we code the actual WHO grade that was on the resection for both clinical and pathologic or is it ok to have a clinical grade IV on a benign/borderline case?
- **Answer**:
  - During the clinical work up, it was thought this was a glioblastoma, which is a Grade IV according to Table 72.2 in the AJCC chapter *or in the Solid Tumor Rules*. This is what you would record in the clinical grade field.
  - The fact that it was determined to be a benign tumor on resection does not change the clinical grade. Pathological Grade would be based on resected tumor.

https://cancerbulletin.facs.org/forums/node/91794

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Scenario 2

- **Question**:
  - If a case is thought to be benign/borderline on imaging, but turns out to be a malignant histology with a WHO Grade IV, do we code the clinical grade based on the histology they thought it was on imaging?
- **Answer**:
  - During the clinical work up, it was thought this was a benign/borderline tumor. Benign/borderline tumors are Grade 1. This is what you would record. The fact that it was determined to be a malignant histology, Grade IV on resection does not change the clinical grade.

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https://cancerbulletin.facs.org/forums/node/91794

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Default Grade-CNS

- **Question**:
  - Are all Meningiomas a WHO grade 1? If not stated, do you assume a grade 1?
- **Answer**:
  - All meningiomas with a behavior of /0 are WHO Grade 1. Meningiomas, such as an atypical meningioma, with a /1 behavior are WHO grade 2. A meningioma with a behavior of /3 would probably have a WHO Grade of 3 or higher.

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Default Grade-CNS

Question:

- Should a grade determined by stereotactic brain biopsy alone be considered Grade Clinical or Grade Pathological?

Answer:

- To qualify for a pathological grade, there must be a surgical resection. A stereotactic biopsy for a brain tumor does not qualify for a surgical resection. Although this is listed in the surgery code section (code 20), this is not a surgical resection. Usually, codes under 30 are not surgical resections (there are some exceptions though). This is the same situation that you see with TURB's and TURP's for bladder and prostate (both those procedures have surgery codes less than 30).
- For your example, clinical grade would be 2 (based on the biopsy) and pathological grade would be 9 (unknown, no surgical resection done).

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Solid Tumor Rules-Timing

Question:

- How do you determine if a patient is disease free for the timing rules?
  - The CAnswer Forum seems to indicate that the Cancer Status can only be changed to code 1-No evidence of this tumor if the physician states that the patient is NED.

Answer:

- The underlying assumption for the STR's is we assume the patient does not have recurrence until we find something saying there is recurrence.
- The underlying assumption for Cancer Status is that patient still has disease until we have a physician statement of no disease.
- Because the underlying assumptions are so different you cannot apply the STR rules to Cancer Status or vice versa.

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RADIATION RAPIDS

DIFFICULT TO NAVIGATE!

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Pelvis Radiation

- **Scenario:** 2022 Endometrioid Adenocarcinoma pT3b pN0 treated with TAH/BSO + XRT
  - 1/7/22 to 2/11/22, Whole pelvis RT w/ 6X/IMRT, 180 cGy x 25 fx to 45 Gy.
  - 2/13/22 to 2/18/22, Vaginal cuff HDR brachytherapy via Ir-192 seeds, 600 cGy x 2 fx for a total of 1200 cGy.
- **Question:** How would you code Phase I Volume?
  - 71 Uterus or Cervix
  - 86 Pelvis Nos

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Answer & Rationale

- 71 Uterus or Cervix
- **CTR Guide to Coding Radiation Therapy Treatment in the STORE Version 4.0 February 2022**
  - Example #16 Gyn-Brachytherapy + External Beam Radiotherapy (EBRT) . If a primary site in the pelvic region is surgically resected, code the primary irradiated volume to the primary site
  - Appendix D – Summary of Coding Rules
    - Coding Volume when the Site of Cancer Organ has been Removed:
      - a. In most cases code the volume to the organ removed. After prostatectomy, code the volume to prostate. If the whole pelvis is treated after prostatectomy, hysterectomy or cystectomy, code the volume to the organ of origin and lymph nodes to pelvic.
      - b. Important clarification: Brachytherapy after hysterectomy is a grey area. We advise that if the vaginal apex is treated with brachytherapy after hysterectomy for cervical or uterine cancer, code the volume to 72 – Vagina because that is the target organ for treatment.

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Pelvis Radiation-Draining Lymph Nodes

- **Scenario:** 2022 Endometrioid Adenocarcinoma pT3b pN0 treated with TAH/BSO + XRT
  - 1/7/22 to 2/11/22, Whole pelvis RT w/ 6X/IMRT, 180 cGy x 25 fx to 45 Gy.
  - 2/13/22 to 2/18/22 Vaginal cuff HDR brachytherapy via Ir-192 seeds, 600 cGy x 2 fx for a total of 1200 cGy.
- **Question:** How would you code Phase I Radiation to Draining Lymph Nodes?
  - 00 No radiation treatment to draining lymph nodes
  - 06 Pelvic lymph nodes

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Answer & Rationale

- 06 Pelvic Lymph nodes
- STORE 2022
  - Phase I-II-III Radiation to Draining Lymph Nodes page 270 Example: Prostate cancer patient declines surgery for management of his prostate cancer, and opts for EBRT. The treatment summary states that pelvis/prostate were targeted on phase 1 with 180 cGy X 25 fx= 45 Gy. **Record Phase I Radiation to Draining Lymph Nodes as 06 because when the pelvis is specifically mentioned in the treatment summary, we can assume that regional lymph nodes were targeted.**
- CTR Guide to Coding Radiation Therapy Treatment in the STORE Version 4.0 February 2022
  - When a region like the pelvis is treated, code the primary site. Pelvic lymph nodes are identified as a target in Rad to Nodes Example #6, #8, #16, #24, #26

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Accuboost

- **Scenario:** 2022 diagnosis of breast cancer treated with lumpectomy & radiation. Radiation specifics below:
  - 01/10/2022 to 01/31/2022: Tangential opposed fields to left breast, 16 fractions, 4256 Gy (commonly called "the Canadian protocol").
  - 02/01/2022 – 02/04/2021: 1000 cGy boost to surgical bed in 4 fractions using Accuboost™ technology.

- **Question:** How would you code Phase 2 (boost) Modality and technique?

  Note there are different coding instructions in Version 4.0 CTR Guide to Coding Radiation Therapy Treatment in the STORE opposed to earlier version 3.0 regarding the recording of Accubost

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Answer & Rational

- Phase 2 Modality =02 External beam, Photons
- Phase 2 technique= 02 Low Energy X-ray

CTR Guide to Coding Radiation Therapy Treatment in the STORE Version 4.0 February 2022
Example #28 Breast: Lumpectomy, External Beam, Accuboost™
Appendix B – Coding Modality for the Heavy Equipment of Modern Radiation Therapy 4.0 {note 3.0 instructions were different for Accubost, be sure to note change}

Product	Modality	Applicable Planning Technique(s)
Varian TrueBeam, Halcyon or Ethos	02	03,04,05, 06, 09
ViewRay MRIdian MR-Linac	02	10
Elekta Unity MR-Linac	02	10
Elekta VersaHD, Infinity, Synergy	02	03,04,05, 06, 09
GammaKnife	02	08
GammaPod	02	06
Cyberknife	02	07
Tomotherapy	02	05, 06, 09
VMAT, RapidArc, Hyperarc	02	05, 06
Zeiss, Xoft, Esteya	02	02
Accuboost	02	02
LIAC, NOVAC	04	03, 04
MammoSite, SAVI, Contura	09	88

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SUMMARY STAGE SNARE

DON'T GET CAUGHT IN THESE TRAPS!

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Bizarre Polypectomy Behavior

- **Scenario**: Colon Polypectomy: invasive adenocarcinoma limited to the lamina propria, margin clear
- Physician stated, No further treatment needed
- AJCC Path Stage pTis cN0 cM0 Stage 0

- **Question**: How would you code Summary Stage?
  - 0 In Situ
  - 1 Localized

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Answer & Rationale

- 1 Localized

Field	Rationale
Histology/Behavior	8140/3
AJCC Stage	pTis cN0 cM0 Stage 0 [Read section in AJCC Manual Chapter 20 page 256-260Carcinoma in a Polyp
EOD Primary Tumor	050 Invades Lamina propria
SEER Summary Stage	1 LocalizedInvasion of Lamina propria

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Lung with +SVC Nodes

- **Scenario**: 2022 1.2cm LUL cancer + SVC nodes, no other sites of disease noted on scans Med Onc Staged cT1b cN3 cM0 Stage 2B

- **Question**: How would you code Summary Stage?
  - 3 Regional lymph node(s) involved only
  - 7 Distant site(s)/lymph node(s) involved

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Answer & Rationale

- 7 Distant site(s)/lymph node(s) involved
- SEER Summary Staging Manual 2018
  - 7 Distant site(s)/lymph node(s) involved
    - IPSILATERAL or CONTRALATERAL
      - Supraclavicular (transverse cervical)

Field	Code	Rationale
AJCC clinical N	cN3	AJCC Manual N3 Mets supraclavicular Lymph Node(s)
EOD Regional Node	600	Supraclavicular (transverse cervical)
EOD Mets	00	No distant metastasis
SEER Summary Stage	7	SEER Summary Staging Manual 2018

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TREATMENT TRENCH

WE ARE ALL IN THIS BATTLE TOGETHER!

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Lingula Sparing Left Upper Lobectomy

- **Scenario:**
  - **Surgery Text:** 1-21-2022 (St Elsewhere) Left upper lobe wedge resection for frozen section. Completion lingula sparing left upper lobectomy. Lymph nodes from stations 5, 6, and 7.
  - **Operative Text:** 1-21-2022 LUL wedge resection followed by lingula sparing LUL lobectomy: At thoracoscopy, we identified the mass LUL. This was wedged out and came back positive for non-small cell lung cancer, favoring adeno. Then performed completion lingula sparing left upper lobectomy. This cannot be done thoracoscopically and was eventually performed as an open operation. Bronchial margin was negative. At thoracic lymphadenectomy, we took lymph nodes from stations 5, 6, and 7.
- **Question:** How would you assign surgery code?
  - 21 Wedge resection
  - 22 Segmental resection, including lingulectomy
  - 33 Lobectomy WITH mediastinal lymph node dissection

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Answer & Rationale

- 22 Segmental Resection, Including lingulectomy

Question sent to AskSEERCTR Their response below…

FROM: AskSEERCTR <askseerctr@imsweb.com>
Date: September 22m 2021 at 8:42:08 AM CDT
Subject: (External Mail) RE: Ask SEER CTR#29826

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.

Thank you,
The SEER Data Quality Team

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ET-aspirin

- **Scenario:** 2022 clinical diagnosis of Essential Thrombocythemia. Med Oncologist Treat with Aspirin 81mg PO daily
- **Question:** How would the Aspirin be coded?
  - 1 Other treatment
  - Not coded but just listed in text

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Answer & Rationale

- 1 Other
- **Hematopoietic and Lymphoid Neoplasm Database** essential thrombocythemia
  - Abstractor Notes…Aspirin, in low dose only (< 100 mg/day) is used as treatment for this disease.

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Xgeva

- **Scenario:** 2022 patient presents with metastatic prostate adenocarcinoma to the bones, receiving Xgeva
- **Question:** Would you code the Xgeva to BRM/Immunotherapy?
  - Yes
  - No

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Answer & Rationale

- No
- SEER*Rx Interactive Antineoplastic Drugs Database https://seer.cancer.gov/seertools/seerrx/

Remarks

IMPORTANT CODING NOTE (JULY 12, 2013): This drug was approved by the FDA on June 13, 2013 to treat unresectable giant cell tumors of the bone in both adults and skeletally mature adolescents. If this drug is being prescribed to treat this type of tumor, code as BRM/Immunotherapy. For all other conditions listed in the November release information below, do not code, the drug is considered ancillary.

November 18, 2010: Received FDA approval for the prevention of skeletal-related events in patients with bone metastases from solid tumors.

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Conclusion

USE THE MANUALS!

- Refer to CAnswer Forum for clarification about what is in these manuals
  http://cancerbulletin.facs.org/forums/help
  - AJCC TNM Staging 8th Edition
  - Grade
  - Site-Specific Data Items
  - STORE
- Refer to SINQ/Ask a SEER Registrar for clarification about what is in these manuals
  https://seer.cancer.gov/registrars/contact.html
  - EOD
  - Hematopoietic Rules
  - ICD-0-3 Updates (for cases diagnosed 2018+)
  - SEER*RX
  - Solid Tumor Rules (for cases diagnosed 2018+)
  - Summary Stage 2018

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Questions

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Fabulous Prize Winners



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CE Certificate Quiz/Survey

CE Phrase

Link
https://survey.alchemer.com/s3/6563890/Solid-Tumor-Rules-2022

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Upcoming 2022-2023 Webinar Series begins in October!

- Breast 2022 Part 1
  - Guest Host: Wilson Apollo
  - 10/6/2022
- Breast 2022 Part 2
  - Guest Host: Denise Harrison
  - 11/3/2022

If you haven't purchased a webinar subscription you can do so here:
https://education.naaccr.org/next-year-webinar-series

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Thank you!

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