NAACCR Webinar Series: Coding Pitfalls
November 6, 2008
Q&A Session

Q: For the question regarding keeping the original histology, why wouldn't you use the histology rules and use rule H29 and code the comedocarcinoma?

A: In the example the 1st occurrence was in 2006. Most likely that abstract was completed prior to the next occurrence in 2007. We do not update the histology. However, if the tumors had been diagnosed at the same time and determined to be a single primary, use the histology coding rules.

Q: If unable to tell metastasis vs. new primary when pathologist states metastasis vs. new primary, is it best to under code (1 primary)?

A: If you are unable to determine if the patient has a new tumor in the primary site or metastasis refers to the unknown if single or multiple tumor module.

Q: I am confused with updating the multiplicity counter. If the multiple primary rules state that this is a new primary, then would the multiplicity counter be the same? If it is a recurrence, would the multiplicity counter be the same on the original abstract?

A: The only time you would update the multiplicity count is when the new tumor is in the same primary site and the rules tell you it is the same primary.

Q: What is the cancer case summary? Does this refer to the CAP protocol?

A: Yes it does.

Q: Polypectomy question: If a negative polypectomy is done and a resection is done at a later time and it is positive, what is the date of dx?

A: The first date a malignant tumor is diagnosed.

Q: Can you provide guidance for determining whether to use the single/multiple/unknown tumor module when one document indicates two tumors (multiple tumor module) but another document indicates they are contiguous (single tumor module)?

A: Refer to the Unknown if Single or Multiple Tumors module of the multiple primary rules.

Q: We have a single tumor with squamous cell and neuroendocrine. Dr called it mixed. Do you still code to the higher histology code?

A: Yes; these two histologies are on different branches of the histology tree so rule H5 wouldn't used and there is not a combination code. Follow rule H7 and code to the numerically higher ICD-O-3 code.

Q: Slide 46 states the histology code for large cell neuroendocrine carcinoma with areas of small cell carcinoma of the right upper lobe is 8041/3 using rule H7. Why not assign code 8045/3, combined small cell large cell?
A: We will send this in for a clarification.

Q: You've stated not to use "focal" for histology but can we use "foci" or "focus"?

A: This has been sent to SEER for clarification

Q: For determining histology I have found the Coding Complex Morphologic Diagnoses from SEER Training Materials, revised 8/02 pages 1-13 to be very helpful also.

A: These should not be used for cases diagnosed 1/1/2007 or after. They should only be used for cases diagnosed prior to this date.

Q: If there are two tumors in one quadrant of the breast, do you code that quadrant or C50.9?

A: If the 2 tumors are a single primary and are in the same quadrant of the same breast, assign primary site to that quadrant.
If the 2 tumors are different quadrants use code C50.9

Q: If a patient has a cystoscopy with BCG at a MD's office then goes to hospital for TURBT, would we code surgery code 16 and BRM 01 for the procedure done in the doctor's office and then assign Surgery code 27 for the procedure done at the doctor's office?

A: We will get this confirmed by CoC.

Q: Regarding the coding of the TURB, S16, B01, and S27, we really want to know if all of these should be coded?

A: Instructions for the surgical procedure of primary site data item document: 'If registry software allows only one procedure to be collected, document the most invasive surgical procedure for the primary site' and 'for codes 00 through 79, the response positions are hierarchical. Last-listed responses take precedence over responses written above.' So, if you can only record one procedure, assign code 27 for the TURB in the data item, surgical procedure of primary site.

Q: Where does it specifically state in FORDS or MPH rules that the multiplicity counter is updated?

A: It is not specifically stated in FORDS. In the MP/H rules in the coding instructions for Date of Multiple Tumors, it is documented: "When subsequent tumor(s) are counted as the same primary.

Example: Patient has an excisional biopsy of a single tumor in the soft palate on January 2, 2007. The pathology shows clear margins. Record 01 in Multiplicity Counter. On July 10, 2007 another tumor is excised from the soft palate. The multiple primary rules for head and neck state that this tumor is the same primary. Change the 01 in Multiplicity Counter to 02 and enter 07102007, the date the second tumor was diagnosed in Date of Multiple Tumors."

Q: General rules state "only count tumors that are used to prepare the abstract" when determining MPH? Would it not be more appropriate to also only use those tumors at initial time of diagnosis when determining multiplicity counter?

A: When the MP/H rules were written, some of the physicians involved wanted to count every tumor as a new primary. This change would drastically change our statistics. The multiplicity counter was a compromise to try to determine if we should be counting every tumor as an individual primary site. The following was found in the SEER Inquiry System (SINQ).

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References

2007 SEER Manual ;pgs 90

Brief

Question

Multiplicity Counter: Is there a time frame for the Multiplicity Counter or is it related to the duration for counting new tumors (i.e. 5 years for breast, etc) to capture the number of "local recurrences"?

Answer

Record the number of tumors counted as a single primary at the time the case is abstracted. Later, if additional tumors are determined to be the same primary, update this field once. Do not update the multiplicity counter more than once.

Q: Multiplicity counter - How do registries that do not record subsequent treatment or do follow-up ever update this? Seems this would give a very inconsistent use of this data field.

A: If you come across a case during casefinding that you determine is not a new primary, but rather a new tumor in the same primary site as a previously abstracted case, you should go in and update the original abstract. You should also find out if your state registry wants this updated information.

Q: Does squamous differentiation mean you should code morphology to squamous cell carcinoma?

A: For most sites, carcinoma with squamous differentiation would be coded as squamous cell carcinoma. However, the bladder histology rules specifically state squamous differentiation should be ignored if you are abstracting an urothelial carcinoma.

Q: If a case comes into the central registry with a sequence of 01 or greater with no documentation of another primary on the chart, would it be better to leave as is or change the sequence to 00?

A: This answer has been changed from the one given during the webinar. We contacted a couple of central registries to find out how they would handle this situation.

Everyone we contacted said that they *do* change cases with sequence 01 to 00 if they don't have some kind of documentation or can't get confirmation from the reporting facility that there is another primary out there somewhere.

They did disagree on how to handle sequences of 02 or higher that are without another primary. One registry said that if there is no supporting text they send and inquiry to the registry. If they do not get a

Please note that this question is directed at central registries only and are based on individual registry policy not an established national guideline.

Q: We have a patient on our database with carcinoma in situ of the cervix that was diagnosed when it was reportable. If the patient has another primary how do we code sequence?

A: *This question was submitted by a central cancer registry and the following answer is for a central registry.*
The coding instructions for data item *Sequence Number—Central (NAACCR Data Item 380)* state that carcinoma in situ cases of the cervix with a diagnosis year prior to 1996 should be assigned as sequence number of 00. If the patient has a subsequent reportable malignant primary this should be changed to 01 and the subsequent primary assigned sequence 02.

Q: if the prostate is never more than one primary why wouldn't the multiplicity counter be 01 instead of 99?

A: We still want to know how many tumors are in the prostate. If we don't know, it has to be 99.

Q: Prostate adenocarcinoma, multicentricity present, dominant nodule 2.1cm. How would you code multiplicity counter?

A: Without any further description, I would assume that by multicentricity the pathologist means multiple foci. Therefore, I would have to code this as 01 for multiplicity counter and 00 for type of multiple tumors.

However, if I could establish that the pathologist actually meant that there were multiple grossly apparent tumors the largest of which was 2.1cm's, I would code as 99 for multiplicity counter and 40 for type of multiple tumors.

Q: Multifocal tumors for bladder - wouldn't using 01 for multiple tumors when only 1 is measured now indicate that the patient only has one tumor, rather than indicating that the patient really has multiple tumors?

A: This has been sent to the SEER QI Team for clarification

Q: You stated that the MPH rules for multiplicity only apply to cases diagnosed 2007 or later, and that you do not update the counter for cases diagnosed prior. The breast example states a primary diagnosed in 2006 should be updated? Is this right?

A: That was a typo. Since it was diagnosed in 2006 multiplicity counter should be blank!

Q: Per urinary MPH rule M8, it lists a group of sites that fall under a single primary. What would the site code for this primary be? Is 68.8 correct?

A: If multiple tumors in these sites are diagnosed at the same time, code primary site to C68.9 (for example one tumor in the ureter and another in the bladder).

However, if you have a subsequent tumor determined to be a single primary, do not go back and change the primary site on the abstract.

Q: On your example of incidental prostate cancer discovered on cystoprostatectomy for bladder cancer, if there was a DRE prior to surgery that stated prostate normal, would CS Extension code be 95?

A: Yes, if they assessed the prostate, then CS Extension code could be 95, which is T0.

Q: When would you ever code CS Extension on a prostate incidental finding since it is always on a path report? It's never clinically found incidentally. In the SSF3 (pathological) those incidental codes are obsolete. Please give an example of how to code.

A: "Clinical" information which is what is collected in CS Extension for prostate includes information accumulated prior to a total prostatectomy. This includes information from imaging, ultrasound, biopsies and turp's. Information collected in site specific factor 3 includes all of the clinical information plus information from the prostatectomy. An incidental finding of cancer from a TURP would be coded in CS Extension as it clinical information.

In the example a clinical workup was not so you would code CS Extenstion as 99 unknown.

Q: Bladder is one of those sites with several "recurrences" (several TURB's). Can you provide guidance in terms of timing rule, progression etc. for this site. Example might be May bladder biopsy=81203 (no muscle), July biopsy = 81303 (no muscle), Sept biopsy = 81203 extending to muscularis.

A: When coding the CS data items for this case, use the information from work-up and treatment in May. Do not "update" the stage at diagnosis with information from subsequent tumors.

Q: For CS Mets Eval, example on page 51, shouldn't the eval be 0 due to CT of brain being farthest site.

A: No. The farthest site is from the old rules for CS Mets Eval. In the revision of the coding instructions for CS Mets Eval in CS version 01.04.00, anatomically being farther away has no bearing on the codes.

Q: Why would a replacement chemo drug be considered subsequent therapy if there is no progression of disease but continuation of first course therapy?

I just pulled the statement below from the SEER Instructional Manual pg 188. This seems to go along with what I pulled from the CoC I&R.

> *The physician may change a drug during the first course of therapy because the patient cannot tolerate the original agent. If the chemotherapeutic agent that is substituted belongs to the same group (alkylating, antimetabolites, natural products, or other miscellaneous), this is a continuation of the first course of therapy. If treated with a single agent and this agent is changed to another single agent in the same group code remains 02 single agent.*

Q: Is Therasphere the same as Microspheres and SIRTspheres?

A: They would be coded the same. ***Please note that we have asked the CoC I&R Team for a clarification on the appropriate code to use for this procedure.***

Q: When the patient has a history of bladder cancer and we don't know whether it's invasive or non-invasive, and now has an invasive bladder tumor, how do we code with MP/H rules?

A: Bladder cancer nos would have a histology code of /3. If that is all the information you have to work with code as invasive.

Q: Core biopsy positive for infiltrating ductal carcinoma at a breast center; lumpectomy and sentinel lymph node biopsy performed at my facility. Would this be a class of case 1 or 2? Is sentinel lymph node biopsy considered diagnostic procedure?

A: It would be class of case is 2 because the patient was diagnosed at another facility and received 1st course treatment at your facility. Sentinel lymph node biopsy is recorded in the data item, Scope of Regional Lymph Node Surgery. Lymph node biopsies (other than for lymphoma) are never coded as a diagnostic staging procedure.

Q: In regards to your recurrence example of left breast with another tumor....did the patient have a total mastectomy ? What if there is a recurrence in the scar?

A: If cancer recurs in the breast after mastectomy, determine if that recurrence is in remaining breast tissue. Recurrence in a scar is metastasis.

Q: The MP/H rules are not to be used for casefinding. The rules say to code histology from the final diagnoses. If you collect a case based on information in the body of the path report, how do you apply the MP/H rules for coding histology?

A: You are correct-the MP/H rules are not used for casefinding. Unless stated in site-specific instructions, histology is coded from the final diagnosis.

If all that you have is a pathology report with a reportable term in the microscopic description and a non-reportable term in the final diagnosis, I would say the case is not reportable.

Q: Your last example on the lung with bilateral tumors and 1 is biopsied; I don't think you would use rule M6. Please see Rule M1 note 2...if one tumor is biopsied it is a single primary. Also, noted on p. 33, second paragraph.

A: In the example, there is 1 tumor in the right and one in the left so M6 applies. M1 or M12 would be applied when there are bilateral tumors and there are multiple tumors in at least one of the lungs and only one tumor is biopsied.

Q: CNS MP question: A patient was diagnosed with two spinal cord tumors on x-ray. The larger tumor was removed first, followed by the smaller. Both tumors had same histology. Pathologist said it was impossible to tell if one was mets. Is this one or two primaries?

A: This is an excellent example of when to use the Unknown if single or multiple tumors. Use rule M2 and code as a single primary. Multiplicity counter would be 99.

Q: Follow-up question to spinal cord tumors case: Since it is a single primary, do you consider the smaller tumor to be a drop mets? The CS codes change depending on if it is mets or not.

A: Drop mets is only coded for brain primaries.

Q: Why is the morphology intraductal papillary adenocarcinoma with invasion considered a type of duct ca. table 2 and it is also listed in table 3 with duct and other types of carcinoma?

A: This has been submitted to the SEER Quality Improvement Team.

Q: MP/H Rules, page 55 says that transitional cell carcinoma (TCC) rarely arises in the kidney parenchyma and is usually a renal pelvis primary. If a path report states a TCC tumor is in "the kidney" or in the "upper pole of the kidney", is this renal pelvis or a kidney primary?

A: Verify site with pathologist. TCC is most likely arising in renal pelvis. If you are confident it is arising from the kidney, you may code to TCC.

Q: CS LN Eval field question: What eval code do you use if sentinel nodes are removed (for breast primary) followed by chemotherapy followed by removal of additional nodes? All nodes are negative. What do you do when nodes are removed both before & after treatment?

A: In this example, code eval code 3 because there was pathologic evaluation of lymph nodes prior to chemo. In most cases you will code nodes prior to treatment unless the nodes after treatment are involved further.

Q: With the bladder cancer examples, what about M3 that states 3 years for multiple primary?

A: I believe you are referring to rule M7. The three year rule would only apply if you can get past rule M6.

If you had a patient with a squamous cell carcinoma of the bladder diagnosed in 2001 who returns with another squamous cell carcinoma of the bladder diagnosed in 2007, rule M7 would apply.

Q: What site would be coded for the case you presented where the patient had bladder & ureter tumors that were considered one primary?

A: In that case the patient had a non-invasive urothelial bladder malignancy followed by an invasive ureter case. They were diagnosed within 60 days so they are one primary. Since one was invasive and the other was non-invasive, code the primary site to the invasive tumor (ureter).

Q: If a path report shows melanoma "1mm from the margin" (standard practice requires 2cm clear margins), re-excision is done > 60 days later and is positive, is this a new primary?

A: This question was sent to the SEER QI Team

Q: CNS question: How do you code laterality for a meningioma that overlaps the right & left sides of the brain? If it is followed by a meningioma on just one side of the brain, is it a new primary?

A: Laterality would be 9. The question concerning multiple primaries has been sent to the SEER QI team for clarification.

Q: If there are multiple foci present and the size is given in a range (i.e. 0.3-1.7 mm), how would you code multiplicity counter?

A: If they tell you the number of measurable tumors that is the number you would code in the multiplicity counter. If they don't tell you the number of measurable tumors, enter 99 into multiplicity counter.

Q: Invasive histology but unsure if there is 1 or 2 tumors, rules state to default to single primary. What would you code for Multiplicity Counter, Date of Multiple Tumor & Type of Tumor?

A: Code to 99 for Multiplicity Counter and Date of Multiple Tumors. Code Date of Multiple Tumors as 9999999. See page340 rule 6e of the MP/H manual.

Q: Lung: On a chest x-ray done 3 yrs ago right upper lobe/right lower lobe lesions were seen. This year (2008) the right upper lobe lesion was biopsied and found to be malignant. Is this a single primary or 2 primaries, since I don't have the histology for the right lower lobe lesion?

A: That would be based on terminology that was used. From the information provided this would be a single primary based on rule M12 (see example 5).

Q: Regressive melanoma-in-situ: If this is a single tumor, why would you use the MPH manual to determine the correct ICD-O-3 CODE?

A: There were some issues in the past with coding regressive melanoma so there is a specific histology rule, H6, for this histology.

Q: Histology and AJCC ? How do you code a diagnosis of DCIS found on mastectomy when a malignant axillary lymph node is present?

A: Code as invasive ductal carcinoma. Primary cannot be in situ if regional nodes are involved.
Record code 10 for CS Extension.

Q: Page 63 of the MP/H Manual states the terms papillary and flat describe the structure and architecture, not histology. Why can't you use gross description to use papillary transitional cell carcinoma?

A: We have submitted this question to SEER in the past. They prefer that we use only what is in the final diagnosis for these cases.

Q: Please explain why your answer was B (cribriform carcinoma) on question 3 (MP/H Quiz)...we have had some questions on why it wouldn't be D (intraductal mix w/ other types)...please give the rule used and why.

A: The micropapillary would be ignored because it is referred to as focal. Cribriform is a specific type of DCIS so that is the code we use.

Q: Timing question: patient had a biopsy followed by lumpectomy & node dissection for breast cancer. Stage at diagnosis indicated patient should receive chemo. The work-up prior to beginning chemo shows lung metastasis. Is this disease progression or metastasis at diagnosis?

A: That depends on if the metastasis was present at the time of diagnosis. If based on the information available you believe it was, code the metastasis. If it appears they looked at the lungs and they were clear during the initial staging work-up and the metastasis has developed since then, do not code as metastasis.

Q: If CS Extension for prostate is code 15 - identified by bx, would you use size/ext eval code 0 or 1?

A: The eval code would be 1.

Q: For Reg Nodes Eval, would you use code 3 even if you only had a positive FNA of a supraclavicular node (highest N category - N3c)?

A: If the CS lymph nodes code is based on information from FNA, code CS Reg Nodes Eval as 1.
AJCC requires resection of at least low axillary nodes or resection of one or more sentinel nodes for pathological N.

Q: Please clarify the term "best evidence" for mets eval. We are supposed to use code 1 if there is negative biopsy and negative radiology. However, sometimes radiology seems more extensive, therefore better evidence.

A: I'm not sure that I can. My best advice is to follow the instructions on page I-49 - 50A.

Q: (Example pg.48, second slide) Why is sentinel node mapping positive prior to chemotherapy considered pathological for the nodes eval? We would code 5.

A: Code 3 is used because the sentinel mapping is pathologic staging basis and it was performed prior to the chemotherapy.

Q: If a surgeon states that a resection of the brain is a gross total resection, but no mention is made of a lobectomy, do you code surgery 20 or 55?

A: 20

Q: On biopsy of a lymph node for lymphoma, why is it 01 not 02?

A: I'm not really sure, but that is how we are being instructed to code it.

Q: When a patient is given a number of options for treatment and chooses one over the others (as in quiz question #4) I've always heard (in training sessions) that the patient did not refuse the other treatments. When did this change?

A: This has been sent to the I&R for clarification.