

NAACCR 2009-2010 Webinar Series

Coding Pitfalls
9/2/2010

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Questions

- Please use the Q&A panel to submit your questions
- Send questions to "All Panelist"

2

Fabulous Prizes!



3

Agenda

- New/Revised Data Items
- Collaborative Stage Data Collection System (CSv2) Coding Instructions
- CSv2 Coding Issues
- Hematopoietic Rules

New Data Items in 2010

- Grade Path System
- Grade Path Value
- Lymph-vascular Invasion
- RX Hosp – Surg App 2010 (Approach – Surgery of Primary Site at This Facility)
- CS Site-specific Factors (SSF) 7-25

New Data Items in 2010

- Grade Path System
 - Indicates whether a 2, 3, or 4 grade system was used in path report to describe grade
- Grade Path Value
 - Records numeric grade documented in path report according to grading system recorded in Grade Path System
 - Supplements but does not replace the data item, Grade

New Data Items in 2010

- Grade Path System Coding Instructions
 - Code the number of grades used in the grading system reported in the path report
- Grade Path Value Coding Instructions
 - Code value of numeric grade from path report if Grade Path System was assigned code 2-4
 - Leave blank if numeric grade is given but grading system is not stated

Grade Path System Coding Instructions

- Code the number of grades used in the grading system reported in the path report
 - *Example 1:* Adenocarcinoma, grade 2 of 3
 - Grade Path System = 3

Grade Path Value Coding Instructions

- Code value of numeric grade from path report if Grade Path System was assigned code 2-4
- Leave blank if numeric grade is given but grading system is not stated
 - *Example 2:* Mucinous carcinoma, grade 1/3
 - Grade Path Value = 1
 - *Example 3:* Adenocarcinoma, grade 2
 - Leave Grade Path Value and Grade Path System blank

**Grade Path System and Grade Path Value
Coding Instructions**

- Code from same tissue used to code the data item, Grade
- Leave blank if no pathologic grade is available
- Leave blank if only verbal description of grade is reported
- Leave blank if another grading system is used in the path report
 - Bloom-Richardson, Fuhrman, Gleason, WHO grade

**Grade Path System and Grade Path Value
Coding Instructions**

- Leave blank for lymphomas and hematopoietic malignancies
- Grade Path Value and Grade Path System should both be coded or both be blank
 - Value of Grade data item cannot be 9 if both Grade Path Value and Grade Path System are coded

Case Scenario 1

- Final path diagnosis from endometrial biopsy: adenocarcinoma, grade 2 of 3
- Final path diagnosis from hysterectomy: adenocarcinoma of endometrium, grade 1 of 3
 - Grade = 3
 - Grade Path Value = 2
 - Grade Path System = 3

Case Scenario 2

- Final path diagnosis: invasive adenocarcinoma of the stomach, moderately differentiated
 - Grade = 2
 - Grade Path System = blank
 - Grade Path Value = blank

Case Scenario 3

- Final path diagnosis: infiltrating ductal carcinoma of the right breast, Bloom Richardson score 4
 - Grade = 1
 - Grade Path System = blank
 - Grade Path Value = blank

Case Scenario 4

- The path department in this facility has a written policy that a 3-grade system is used on all cases that are not otherwise documented on the path report.
- Final path diagnosis: adenocarcinoma of the right fallopian tube, grade 2
 - Grade = 2
 - Grade Path Value = blank
 - Grade Path System = blank

Case Scenario 5

- Final path diagnosis: adenocarcinoma of ascending colon, grade 1
- AJCC staging form: surgeon documents grade 1/3
 - Grade = 1
 - Grade Path Value = blank
 - Grade Path System = blank

Case Scenario 6

- Final path diagnosis: moderately differentiated adenocarcinoma of the endometrium, grade 2/3
 - Grade = 2
 - Grade Path Value = 2
 - Grade Path System = 3

New Data Items in 2010

- Lymph-vascular Invasion (LVI)
 - Indicates whether LVI is identified in path report
 - LVI is the presence of tumor cells in lymphatic channels (not lymph nodes) or blood vessels
 - May be an indicator of prognosis
 - Used by CS algorithm to map AJCC T for some primary sites

LVI Coding Instructions

- Code presence or absence of LVI from CAP synoptic report or checklist
 - Code from path report or physicians statement, in that order of priority, if synoptic report is not available

LVI Coding Instructions

Code	Definition
0	Lymph-vascular invasion is not present (absent) or is not identified
1	Lymph-vascular invasion is present or identified
8	Not applicable
9	Unknown or indeterminate

Case Scenario 7

- Sigmoid colon resection: Moderately differentiated invasive adenocarcinoma invades through the muscularis propria into pericolic adipose tissue. Lymphovascular invasion is present.
 - Lymph-vascular Invasion = 1

Case Scenario 8

- CT scan of chest showed large upper lobe lung mass invading pleura. Incisional biopsy positive for squamous cell carcinoma. Patient treated with radiation therapy.
 - Lymph-vascular Invasion = 8

New Data Items in 2010

- RX Hosp – Surg App 2010 (Approach – Surgery of Primary Site at This Facility)
 - Describes the surgical method used to approach the primary site for patients undergoing primary site surgery at this facility
 - Monitors patterns and trends in the adoption and utilization of minimally-invasive surgical techniques

RX Hosp – Surg App 2010
Coding Instructions

Code	Definition
0	No surgical procedure of primary site at this facility Diagnosed at autopsy
1	Robotic assisted
2	Robotic converted to open
3	Endoscopic
4	Endoscopic converted to open.
5	Open or approach unspecified
9	Unknown whether surgery was performed at this facility

Case Scenario 9

- First course treatment for endometrial adenocarcinoma included robotic assisted laparoscopic hysterectomy.
 - RX Hosp – Surg App 2010 = 1

New Data Items in 2010

- CS Site-specific Factors (SSF) 7-25
 - May be required to support TNM mapping
 - May be tumor markers and lab values of prognostic significance for some sites
 - May be included because of their prognostic or predictive value
 - May be of special interest for future research
 - May be clinically significant information

SSF Coding Instructions

1. Select the best code that applies to the case
2. The number of SSFs used varies by schema
3. Code as 988 (not applicable) if the SSF is not defined for a schema
4. Follow the instructions provided for the SSF to code 'test not done'

SSF Coding Instructions

5. Follow the instructions provided for the SSF to code lab tests
 - a. Units of measurement vary in different SSFs
 - b. If there is an implied decimal point
 - i. Round values of 1-4 down to the nearest number
 - ii. Round values of 5-9 up to the next number
6. Use code 999 if the tumor marker, prognostic score, predictive value or other SSF is not in the medical record

Case Scenario 10

- Patient diagnosed with mucinous adenocarcinoma of the appendix. The CA 19-9 lab value is 1.32 U/ml.
 - CS SSF 12 (appendix schema) = 013

Revised Data Items in 2010

- Class of Case
- RX Summ—Treatment Status
- Text

Class of Case Conversion Table

Diagnosis Year ≤ 2009	Diagnosis Year 2010 +
0	00
1	10
2	20
3	32
4	37
5	38
6	40
7	43
8	49
9	99

Class of Case-Analytic

- 00 Initial diagnosis at the reporting facility AND all treatment or a decision not to treat was done elsewhere

Class of Case-Analytic

- Q. If a patient comes to the reporting institution and is diagnosed with cancer, then leaves the reporting institution (no decision not to treat made), and the reporting registry does an earnest search for treatment information and cannot find out what has happened to the patient, why wouldn't this be a class of case 00?

Class of Case-Analytic

- A. This rule is not a change from the former Class of Case 0. If you do not know for certain that the patient went elsewhere, then your facility has no indication it successfully passed the patient on for care. This patient was lost through the cracks by the program, not specifically by the registry.

(I & R Team)

48281

8/18/2010

Class of Case-Analytic

- Q. What Class of Case do we assign for patient's diagnosed at our facility (biopsy only) and received all their treatment in a staff physician's office (chemotherapy)?

Class of Case-Analytic

- A. For 2010 this would be a class of case 00. Initial diagnosis at the reporting facility and all treatment done elsewhere. The chemotherapy at the staff physician's office is considered done elsewhere.

(I & R Team).

47888

7/15/2010

Class of Case-Analytic

- Q. We have a group of radiation oncologists that have their freestanding radiation facility adjacent to our facility. When a patient is in the hospital (our facility) and receives radiation therapy in the adjacent radiation facility, does this qualify for treatment in the hospital (our facility) or is this the new definition of therapy done elsewhere?

Class of Case-Analytic

- A. The freestanding facility is a separate entity and will be billing for the radiation therapy. The radiation therapy notes will not be part of your medical record, so this would be treatment given outside of your facility. Class of case for the scenario described above would be 00, initial diagnosis at reporting facility.

(I & R Team)
48269
8/12/2010

Class of Case-Analytic

- Q. What is the exact definition of a staff physician. Is it a physician who is paid by the hospital?

- A. A staff physician is one who has privileges to admit and treat patients in your facility.

(I & R Team)
47757
6/17/2010

Class of Case-Analytic

- 10 Initial diagnosis AND part or all of first course treatment or a decision not to treat done at the reporting facility, NOS

Class of Case-Analytic

- 11 Initial diagnosis by staff physician AND part of first course treatment was done at the reporting facility
- 12 Initial diagnosis by staff physician AND all first course treatment or a decision not to treat was done at the reporting facility
- 13 Initial diagnosis AND part of first course treatment was done at the reporting facility
- 14 Initial diagnosis AND all first course treatment or a decision not to treat was done at the reporting facility

Class of Case-Analytic

- Q. We have a patient who was diagnosed at our facility and received cancer-directed surgery. The patient then received radiation therapy at the radiation facility located and owned by the hospital. The patient is currently on a clinical trial administered by our hospital which is dictating the chemo being received. The patient receives chemo at a staff physician office that is not located on our campus.

Class of Case-Analytic

- A. For 2010 this would be a class of case 13 for your facility. Initial diagnosis at the reporting facility and part of first course treatment was at the reporting facility. Treatment in a staff physicians office is now considered done elsewhere.

– (I & R Team)
– 47957
– 7/15/2010

Class of Case-Analytic

- 20 Initial diagnosis elsewhere AND all or part of first course treatment was done at the reporting facility, NOS
- 21 Initial diagnosis elsewhere AND part of treatment was done at the reporting facility
- 22 Initial diagnosis elsewhere AND all treatment was done at the reporting facility

Class of Case-Analytic

- Q. A patient presented to our facility with recent diagnosis made at another facility. Our facility developed a treatment and patient agreed to treatment. The patient died before treatment was administered.

Answer

- A. The first course of treatment anticipated to be done at your facility, treatment plan was developed, and patient agreed, but expired during same admission before treatment started. This is class of case 22. Code the reason of no treatment given.

– (I & R Team)
– 47928
– 7/8/2010

Class of Case-Non Analytic

Patient appears in person at reporting facility

- 30 Initial diagnosis and all first course treatment elsewhere AND reporting facility participated in diagnostic workup (for example, consult only, staging workup after initial diagnosis elsewhere)
- 31 Initial diagnosis and all first course treatment elsewhere AND reporting facility provided in-transit care

Class of Case-Non Analytic

- Q. In 2010, lymph node FNA performed at staff MD office, pathology positive for squamous cell carcinoma read by our pathologists. Patient admitted as an outpatient for biopsy of primary tongue lesions. Pathology positive for squamous cell carcinoma. Patient goes elsewhere for chemo/rad. According to the new 2010 class of case codes, what is the class of case for this patient?

Class of Case-Non Analytic

- This would be a class of case 30 for your facility and not reportable to the CoC.

(I & R Team)

47772

6/18/2010

Class of Case-Non Analytic

Patient Appears in person at reporting facility

- 32 Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease recurrence or persistence
- 33 Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease history only

Class of Case-Non Analytic

Patient Appears in person at reporting facility

- 34 Type of case not required by CoC to be accessioned (for example, a benign colon tumor) having initial diagnosis AND part or all of first course treatment by reporting facility
- 35 Case diagnosed before program's Reference Date, having initial diagnosis AND part or all of first course treatment by reporting facility

Class of Case-Non Analytic

Patient appears in person at reporting facility

- 36 Type of case not required by CoC to be accessioned (for example, a benign colon tumor) having initial diagnosis elsewhere AND all or part of first course treatment by reporting facility

Class of Case-Non Analytic

Patient appears in person at reporting facility

- 37 Case diagnosed before program's Reference Date, having initial diagnosis elsewhere AND all or part of first course treatment by facility
- 38 Initial diagnosis established by autopsy at the reporting facility, cancer not suspected prior to death

Class of Case-Non Analytic

*Patient does **not** appear in person at reporting facility*

- 40 Diagnosis AND all first course treatment given at the same staff physician's office
- 41 Diagnosis and all first course treatment given in two or more different staff physician offices

Class of Case-Non Analytic

*Patient does **not** appear in person at reporting facility*

- 42 Non-staff physician or non-CoC approved clinic or other facility, not part of reporting facility, accessioned by reporting facility for diagnosis and/or treatment by that entity (for example, hospital abstracts cases from an independent radiation facility)

Class of Case-Non Analytic

*Patient does **not** appear in person at reporting facility*

- 43 Pathology or other lab specimens only
- 49 Death certificate only
- 99 Case not required by CoC to be abstracted of unknown relationship to facility (not for use by CoC approved cancer programs for analytic cases)

Rx Summ--Treatment Status

- Provides a mechanism for recording active surveillance (watchful waiting) as a form of treatment
- Specifies whether or not the patient received any treatment
- Eliminates searching each treatment modality to determine whether treatment was given

Rx Summ--Treatment Status

- Codes
 - 0 No treatment given
 - 1 Treatment given
 - 2 Active surveillance (watchful waiting)
 - 9 Unknown if treatment was given

Expanded Text Fields

- Name fields
 - Expanded to 40 characters
- City and street address fields
 - Expanded to 50 for City and 60 for Street
- Occupation and industry fields
 - Expanded to 100 characters

Expanded Text Fields

- Primary site and histology text fields
 - Expanded to 100 characters
- Text fields
 - Expanded to **1000** characters!

Text Fields

- | | |
|-----------------------------|------------------------------|
| – Text--Dx Proc--Lab Test | – Rx Text--Surgery |
| – Text--Dx Proc--OP | – Rx Text--Radiation (Beam) |
| – Text--Dx Proc--Path | – Rx Text--Radiation (Other) |
| – Text--Dx Proc--PE | – Rx Text--Chemo |
| – Text--Dx Proc--Scope(s) | – Rx Text--Hormone |
| – Text--Dx Proc--X-ray/Scan | – Rx Text--BRM |
| – Text--Remarks | – Rx Text--Other |
| – Text--Staging | |

**Collaborative Stage Data
Collection System Coding
Instructions**

CSv2 Manual

- Part 1 Available for download at:
 - <http://www.cancerstaging.org/cstage/manuals/index.html>
- Part 2 available at:
 - <http://web2.facs.org/cstage/schemalist.html>

CSv2 Manual

- Hardcopy available from NCRA at:
 - http://www.ncra-usa.org/i4a/ams/amsstore/category.cfm?category_id=9

CSv2 Coding Instructions

- Part I
 - Section 1: General Instructions
 - Section 2: Lab Tests, Tumor Markers, and Site-Specific Factor Notes
- Part II: Site-Specific Schemas

**Collaborative Stage Data
Collection System Coding
Instructions****Part I-Section 1
General Instructions**

CSv2 Part I Section 1: General Instructions

- Eval field code corresponds to highest T, N, or M category, not necessarily to highest code selected in the Tumor Size, Extension, Regional Lymph Nodes or CS Mets at Dx field
- Example
 - Hard palate lesion includes a positive biopsy of the nasal cavity
 - Extension code 745, equivalent to T4a
 - CT scan showing involvement of the skull base
 - Extension code 790, equivalent to T4b
 - CS Tumor Size/Ext field = 0
 - *Imaging documented a higher T value.*

CSv2 Part I Section 1: General Instructions

- Example
 - Hard palate lesion includes a positive biopsy of the nasal cavity
 - Extension code 745, equivalent to T4a
 - CT scan showing involvement of the skull base
 - Extension code 790, equivalent to T4b
 - CS Tumor Size/Ext field = 0
 - *Imaging documented a higher T value*

CSv2 Part I Section 1: General Instructions

- ‘Stated as’ codes have been added
 - Allows coding of T, N, or M information when there is not information in the medical record
 - Examples
 - Stated as T1a
 - Stated as N2b
 - Stated as M1, NOS
 - Assign the appropriate ‘stated as’ code only when there is no information in the record to assign a more specific code

CSv2 Part I Section 1: General Instructions

- CSv2 includes staging systems and schemas that may not be reportable to population-based registries
 - Examples
 - High grade dysplasia of the esophagus
 - Pancreatic intraglandular neoplasia of the pancreas (PAIN)
 - Schema for carcinoid of the appendix
 - Code the CS data items as instructed ONLY if the case is reportable to the state registry

CSv2 Part I Section 1: CS Lymph Nodes

- Coding isolated tumor cells (ITC) in regional nodes
 - Code as negative lymph nodes for breast
 - CS Lymph Nodes = 000 or 050
 - Code as positive lymph nodes for cutaneous melanoma and Merkel cell carcinoma

CSv2 Part I Section 1: CS Lymph Nodes

- Coding discontinuous tumor deposits for colon, appendix, rectosigmoid, and rectum
 - Code as 050 in CS Lymph Nodes if only information is the presence of tumor nodules in pericolic fat and the primary tumor is localized
 - Code information on involved regional nodes in CS Lymph Nodes if there are involved regional nodes and discontinuous tumor deposits
 - Code the total number of discontinuous tumor deposits in the appropriate site-specific factor

CSv2 Part I Section 1: CS Lymph Nodes Eval

- Coded as clinical or pathologic based on the intent of the procedure
 - Clinical staging basis if lymph node procedure is part of workup to choose treatment
 - CS Lymph Nodes Eval = 0, 1, 5, or 9
 - CS Tumor Size and/or CS Extension do not meet criteria for pathologic T

CSv2 Part I Section 1: CS Lymph Nodes Eval

- Coded as clinical or pathologic based on the intent of the procedure
 - Pathologic staging basis if intent of lymph node procedure is therapeutic
 - CS Lymph Nodes Eval = 2, 3, or 6
 - CS Tumor Size and/or CS Extension meet criteria for pathologic T

CSv2 Part I Section 1: CS Lymph Nodes Eval

- Code 1
 - No regional lymph nodes removed for examination; evaluation based on endoscopic examination or other invasive techniques **OR**
 - Fine needle aspiration, incisional or core needle biopsy, or excisional biopsy of regional lymph nodes or sentinel nodes as part of the diagnostic workup **WITHOUT** removal of the primary site adequate for pathologic T classification (treatment)

CSv2 Part I Section 1: CS Lymph Nodes Eval

- Code 3
 - Any microscopic assessment of regional nodes (including FNA, incisional or core needle biopsy, excisional biopsy, sentinel node biopsy or node resection) WITH removal of the primary site adequate for pathologic T classification (treatment) or biopsy assessment of the highest T category
 - OR**
 - Any microscopic assessment of a regional node in the highest N category, regardless of the T category information

Example 1

- Patient had endoscopic paratracheal node biopsy because of hard lump in low neck. Biopsy confirmed metastatic lung cancer. Treatment was chemoradiation.
 - CS Lymph Nodes Eval = 1

77

Example 2

- Core needle biopsy of breast diagnosed ductal carcinoma; axilla clinically negative. Patient had lumpectomy and sentinel node biopsy, which is negative for lymph node metastases.
 - CS Lymph Nodes = 3

CSv2 Part I Section 1:**Regional Nodes Positive**

- Code the cumulative number of positive regional nodes
 - Do not count a positive aspiration or core biopsy of a lymph node in the same lymph node chain removed at surgery as an additional node in Regional Nodes Positive when there are positive nodes in the resection
 - Do include the node in the count of Regional Nodes Positive if the positive aspiration or core biopsy is from a node in a different node region than the positive resected nodes

CSv2 Part I Section 1:**Regional Nodes Positive**

- Code the cumulative number of positive regional nodes
 - Do not include the core-biopsied or aspirated lymph node in the count of Regional Nodes Positive if the location of the lymph node is not known; assume it is part of the surgically removed lymph node chain

CSv2 Part I Section 1:**Regional Nodes Positive**

- Priority of counts of positive regional lymph nodes
 - Final diagnosis
 - Synoptic report
 - Microscopic
 - Gross

CSv2 Part I Section 1:**Regional Nodes Positive**

- Definition of code 95 - positive aspiration or core biopsy of lymph node(s) was performed
 - Use code 95 when the only procedure for regional lymph nodes is a needle aspiration or core biopsy
 - Use code 95 when a positive lymph node is aspirated and surgically resected lymph nodes are negative

CSv2 Part I Section 1:**Regional Nodes Positive**

- Isolated tumor cells (ITCs) in lymph nodes
 - Do not count ITCs found in regional lymph nodes in Regional Nodes Positive
 - *Exception:* Do count nodes with ITCs in regional lymph nodes in Regional Nodes Positive for cutaneous melanoma and Merkel cell carcinoma

CSv2 Part I Section 1:**Regional Nodes Examined**

- Code the cumulative number of nodes removed and examined
 - Do not count a positive aspiration or core biopsy of a lymph node in the same lymph node chain removed at surgery as an additional node in Regional Nodes Examined
 - Do include the node in the count of Regional Nodes Examined if the positive aspiration or core biopsy is from a node in a different node region than the resected nodes

**CSv2 Part I Section 1:
Regional Nodes Examined**

- Code the cumulative number of nodes removed and examined
- Do not include the core-biopsied or aspirated lymph node in the count of Regional Nodes Examined if the location of the lymph node is not known; assume it is part of the surgically removed lymph node chain

**CSv2 Part I Section 1:
Regional Nodes Examined**

- Priority of counts of regional lymph nodes examined
 - Final diagnosis
 - Synoptic report
 - Microscopic
 - Gross

**CSv2 Part I Section 1:
Regional Nodes Examined**

- Use code 95 when only procedure for regional nodes is needle aspiration or core biopsy
- Use code 96 when a limited number of nodes is removed, sampling, and number of nodes removed is unknown
 - Lymph node biopsy, berry picking, sentinel lymph node procedure, sentinel node biopsy, or selective dissection

**CSv2 Part I Section 1:
Regional Nodes Examined**

- Use code 97 when lymph node dissection, removal of most or all of the nodes in the lymph node chains that drain the area around the primary tumor, is performed and number of nodes removed is unknown
 - Lymphadenectomy, radical node dissection, or lymph node stripping

Example 3

- Patient diagnosed with primary of cervical esophagus. Fine needle aspiration biopsy of an enlarged cervical lymph node was positive for carcinoma. No further surgical procedures.
 - Regional Nodes Positive = 95
 - Regional Nodes Examined = 95

Example 4

- Patient with squamous cell carcinoma (SCC) of the lower gum had core biopsy of a submental node positive for SCC followed by radical resection of the tumor, partial mandible resection, and neck dissection; 3 submental nodes positive for SCC out of 20 regional nodes removed.
 - Regional Nodes Positive = 03
 - Regional Nodes Examined = 20

Example 5

- Patient with breast cancer had core biopsy of supraclavicular node that showed ductal carcinoma. Axillary node dissection followed with 4 of 9 nodes positive for ductal carcinoma.
 - Regional Nodes Positive = 05
 - Regional Nodes Examined = 10

Example 6

- Patient with squamous cell carcinoma (SCC) of the lower lip received neck dissection at hospital A; 2 submandibular nodes positive for SCC out of 14 nodes removed. Medical record documents core biopsy of regional node positive for SCC at Hospital C prior to this admission.
 - Regional Nodes Positive = 02
 - Regional Nodes Examined = 14

**Collaborative Stage Data
Collection System Coding
Instructions****Part I-Section 2
Lab Tests, Tumor Markers, and Site-
Specific Factor Notes**

CSv2 Coding Issues

Paget Disease

- Paget disease is a scaly, crusting lesion of the nipple resembling eczema.
 - ICD-O includes morphology codes for Paget disease by itself and combined with ductal or intraductal carcinoma.

Question-Paget Disease of the Breast

- When coding Paget Disease of breast w/ underlying DCIS 8543/3, CS extension code 07, derives Tis. Is there another histology code to use? This path report does not refer to this is an invasive malignancy.

Answer-Paget Disease

- Paget's can be in situ or invasive according to CS. AJCC believes that Paget's is an in situ tumor. Any Paget's without a known underlying tumor is Tis for AJCC - even if the path used the word "invasive", unless the word invasive is referring to an underlying tumor.

(I & R Team)

46845

5/10/2010

Paget Disease

Description	Underlying Tumor	Histology Code	AJCC T	CS Ext
In situ Paget Disease	In situ	8543/2	Tis	070
Paget Disease	None	8540/3	Tis	050
Paget Disease	In situ	8543/3	Tis	070
Paget Disease	Invasive	8541/3	Based on size and extent of invasive tumor	Based on size and extent of invasive tumor

Breast: Lymph Nodes

- Q. A patient with breast cancer case has a positive FNA of an axillary lymph node and then neoadjuvant chemotherapy. This is followed by a modified radical mastectomy and axillary lymph node dissection with 0/12 positive lymph nodes. Is the CS Reg. LN Eval code 1 rather than 5? The verbage for the codes states "no regional lymph nodes removed for examination" which isn't actually the case.

Breast: Lymph Nodes

- A. Eval code 5 would indicate that the patient had neoadjuvant therapy and the nodes were worse on clinical exam than on y pathologic exam.

(I & R Team)

47486

5/4/2010

Breast: Lymph Nodes

- Q. If lymph nodes are described as fixed/matted on a pathology report, can code 520 be used?

Code 520

- *Fixed/matted ipsilateral axillary nodes clinically with pathologic involvement of lymph nodes at least one metastasis greater than 2mm*

Breast: Lymph Nodes

- A. If a pathologist does give a description of fixed or matted lymph nodes, it is in the gross description which is a clinical assessment.

Breast: SSF 7-Nottingham or Bloom-Richardson (BR) Score/Grade

- Q. If a breast biopsy path reads histologic grade III (of III) total score 8 and the surgical path reads Nottingham grade III (of III). What should be recorded for SSF 7 080 - score of 8 or 130 BR grade 3, score not given?

Breast: SSF 7-Nottingham or Bloom-Richardson (BR) Score/Grade

- A. Coding the score is more specific since the score is equated to only a few grades.

(I & R Team)

48114

8/9/2010

Breast: SSF 7-Nottingham or Bloom-Richardson (BR) Score/Grade

- Q. For breast cancer is SSF 7 (Nottingham or Bloom-Richardson Score/Grade) used only for invasive breast cancers? For in-situ cases do we use code 999 (unknown) or do we use 988 (not applicable/information not collected) for this case?

Breast: SSF 7-Nottingham or Bloom-Richardson (BR) Score/Grade

- A. Code 988 not applicable.
- 988 Not applicable: Information not collected for this case.
 - Not required by standard setters (988)
 - Does not apply due to stage, histology, etc (see example)
 - In CSV2, the code 888 was converted to 988.
 - Code 999 could trigger data analysis at a later date to find out why this information was unknown.
 - Code 998 indicates the test or procedure was not performed

Prostate: CS Extension-Clinical Extension

- A clinically inapparent tumor is one that is neither palpable nor reliably visible by imaging. A clinically apparent tumor/nodule/mass is palpable or visible by imaging.

Prostate: CS Extension-Clinical Extension

- Codes 100 to 150 are used only for clinically inapparent tumor not palpable or visible by imaging and/or incidentally found microscopic carcinoma (latent, occult) in one or both lobes.
- Codes 200 to 240 are used only for clinically/radiographically apparent tumor/nodule/mass which is palpable or visible by imaging.
 - To decide among codes 200-240, use only physical exam or imaging information, and **NOT** biopsy information.

Prostate: CS Extension-Clinical Extension

- Q. We have a prostate case where the patient had a digital rectal exam (dre) that was described as "rock hard irregular prostate with cephalad extension. His exam is consistent with prostate cancer." So it is a clinically apparent tumor. However the physical exam is not useful to answer CS extension. The biopsy would answer the questions as to how many lobes/sides are involved.

Prostate: CS Extension-Clinical Extension

- A. The biopsy information cannot be used, regardless of the situation. Doing so would confound the data that is being collected. Since this is clinically apparent, do not use the biopsy information. Code 240 would be appropriate.

(I & R Team)
48381
8/26/2010

Prostate: CS Extension - Pathologic Extension

- Is SSF 3 a field that should be updated if a second course treatment prostatectomy is performed?
 - Example: Patient diagnosed with prostate cancer and is prescribed "watchful waiting". Three years later disease progression is diagnosed via elevated PSA and a prostatectomy is done.
 - Do we return to SSF 3 in the database and change it to 980 - "Prostatectomy performed, but not considered first course of treatment because of for example; disease progression"?

Prostate: CS Extension - Pathologic Extension

- No, this data field is just for the first course of treatment, since it derives the stage, and the stage applies to the time of diagnosis and the first course of therapy. It is not the stage at recurrence or subsequent treatment.

– *(I & R Team)*
– 47766
– 6/17/2010

Prostate: SSF 13- Number of Cores Examined

- Q. A patient underwent a needle core biopsy that appears to be a sextant biopsy (biopsies taken of the base, mid and apex of both sides of the prostate). However, it is not specifically stated to be a sextant biopsy, and the number of cores taken is not specified in the path report.

– Should SSF13 be coded 991 (biopsy cores examined, number unknown) or 006 (6 cores examined, assume that a single core was taken from each biopsy site)?

Prostate: SSF 13- Number of Cores Examined

- A. Do not assume, but code 991.

– This should be discussed with the physicians and the pathologist (or cancer committee) to ensure complete documentation for future cases. This is considered an important item in looking at the prognosis.

I&R Team
47966
– 7/22/2010

Prostate: SSF 15-Clinical Staging Procedures Performed

- Q. A patient underwent a TURP for BPH and was found to have incidental T1b prostatic adenocarcinoma. The patient subsequently underwent work-up for prostate cancer.

Prostate: SSF 15-Clinical Staging Procedures Performed

- Q. Should SSF15 be coded 000 as this field reflects clinical staging procedures performed prior to any needle core biopsy or surgical procedure (Note 3)? Or should SSF15 be coded 999 since the adenocarcinoma was a surprise finding at TURP and CS Ext is always coded as 999 when the malignancy is a surprise finding at prostatectomy?

Prostate: SSF 15-Clinical Staging Procedures Performed

- A. Since the TURP is not considered definitive surgery for prostate cancer and is part of the clinical staging criteria, you can include the workup after this in SSF 15 as they are all part of the clinical staging.

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7/22/2010

Lung: Coding Tumor Size in CSv2

- Primary left lung carcinoma with multiple nodules in both lungs. No size of any of the nodules is documented.
- What is the code for CS Tumor Size?
 - 997 – diffuse (entire lobe)
 - 998 – diffuse (entire lung)
 - 999 – unknown

Lung: Coding Lymph Nodes in CSv2

- CT of chest documented 3.9 cm left lung mass and ipsilateral hilar & mediastinal adenopathy. Patient had bronchoscopy & mediastinoscopy with removal of 2 mediastinal nodes positive for adenocarcinoma. Patient received 2 cycles of chemotherapy. After completion of chemotherapy patient had lobectomy & mediastinal lymph node dissection. Pathology showed 2.2 cm left lower lobe adenocarcinoma; 4 peribronchial nodes and 3 mediastinal nodes were negative.

Lung: Coding Lymph Nodes in CSv2

- CS Lymph Nodes =
 - 200
- CS Lymph Nodes Eval =
 - 5
- Regional Nodes Positive =
 - 02
- Regional Nodes Examined =
 - 09

Lung: Coding Lymph Nodes in CSv2

- Patient diagnosed with small cell carcinoma of the lung, right upper lobe. CT scan of chest documented malignant lymphadenopathy of a right cardiophrenic lymph node. No other lymphadenopathy noted.
 - CS Lymph Nodes =
 - 00 - none
 - CS Mets at DX =
 - 30 – distant nodes

Lung: Coding Rib Involvement

- CT scan of chest and abdomen shows large mass of the lung directly extends into rib. No other abnormalities. Biopsy of large mass positive for adenocarcinoma.
 - CS Extension =
 - 730 – adjacent rib
 - CS Mets at DX =
 - 00 - none

Lung: Coding Pleural Effusion in CSv2

- CT scan documents 2 cm left upper lobe lung mass, probably malignant, with right pleural effusion. Cytology of pleural fluid is positive for adenocarcinoma.
 - CS Tumor Size =
 - 020
 - CS Extension =
 - 100 – confined to 1 lung
 - CS Mets at DX =
 - 16 – Contralateral malignant pleural effusion

Lung: Coding Separate Tumor Nodules in CSv2

- Primary adenocarcinoma is in the left upper lobe of the lung with metastases to the right lung, 1 nodule in the right upper lobe and 1 nodule in the right lower lobe.
 - CS Mets at DX =
 - 23 - separate tumor nodule(s) in contralateral lung
 - CS SSF 1 (Separate Tumor Nodules/Ipsilateral Lung) =
 - 000 - no separate tumor nodules noted

**Appendix Carcinoma:
Coding Lymph Nodes**

- Abdominal CT documented liver metastasis and inflamed appendix; no lymphadenopathy. Appendectomy path diagnosed adenocarcinoma of the appendix.
 - CS Lymph Nodes =
 - 00 - none
 - CS Lymph Nodes Eval =
 - 0 – CT scan

Hematopoietic Coding

- New reportability instructions and data collection rules for hematopoietic and lymphoid neoplasms go into effect for cases diagnosed beginning January 1, 2010.
- Two tools have been developed for use beginning in 2010:
 - The *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual*
 - The Hematopoietic Database

Hematopoietic Coding

- Use Multiple Primary Rules M1 through M12 **before** using the Hematopoietic DB.
 - A patient with a history of myelodysplastic syndrome (9989/3) diagnosed in 2001 now presents for a bone marrow biopsy and is diagnosed with acute myeloid leukemia(9861/3) in January of 2010.
 - How many primaries?
 - Rule M13
 - Use the Hematopoietic DB to determine the number of primaries for all cases that do **not** meet the criteria of M1-M12.
 - New primary

Hematopoietic Coding

- Primary site and histology coding
- Rule PH14
 - Code the primary site bone marrow (C421) and code the histology 9861/3 when the diagnosis is myeloid neoplasm or acute myeloid leukemia, NOS AND the involvement is limited to bone marrow.

Questions?


