

Coding Pitfalls

NAACCR 2008-2009 Webinar Series



Agenda

- Introduction
- Multiple Primary Rules
 - Quiz
- Break
- Collaborative Staging
 - Quiz
- Treatment
 - Quiz



Shannon & Jim

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Prizes!

Question of the Month!

- The participant that submits the best question of the session will receive a fabulous Prize!
- Shannon and Jim will announce the winner at end of the session.



Tip of the Month!

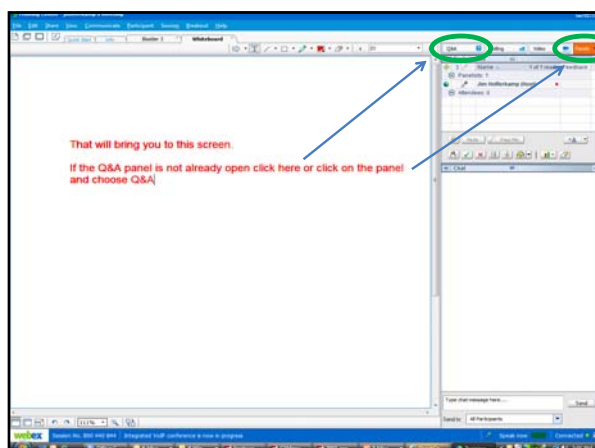
- The participant that sends in the best tip related to the topic will win a spectacular prize!
- Shannon and Jim will announce the winner at the end of the session.

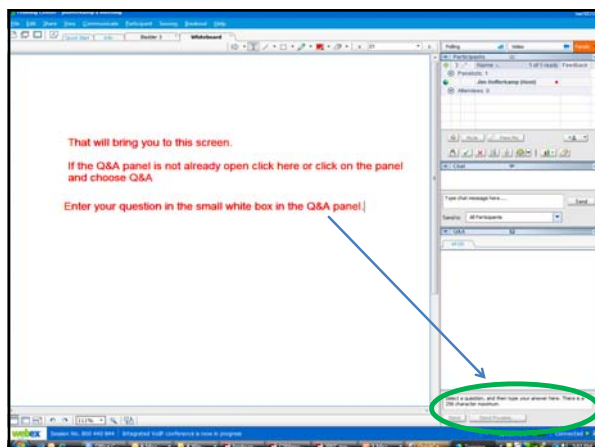
Q&A

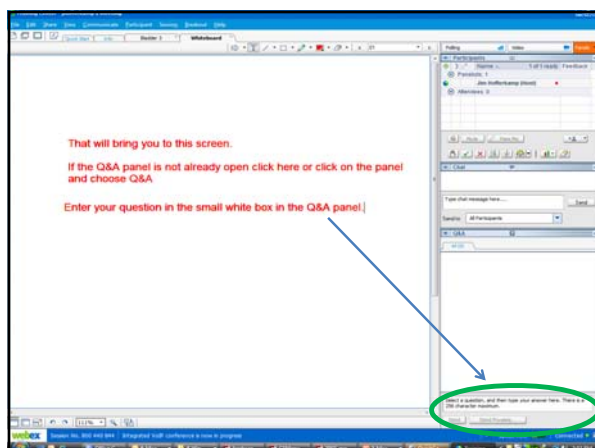
Please submit all questions concerning webinar content through the Q&A panel



If the presentation is at full screen and you have a question, hit the escape key on your key board







2007 Multiple Primary Rules

- General Questions
- Colon
- Lung
- Breast
- Urinary
- Other
- Central Nervous System
- Multiplicity Counter



Sources of Questions

- You!
- Previous Webinars
- CoC I&R
 - <http://www.facs.org/cancer/>
- SEER Quality Improvement Meeting August 2008
 - http://seer.cancer.gov/tools/mphrules/training/additional_cases_082008.pdf



General Instructions



Question

- A patient was first diagnosed with breast cancer in 1996. She presents with a new tumor in the same breast in 2008.
 - Would we use the 2007 Multiple Primary Rules to determine if the 2008 tumor is a new primary?



Answer

- Yes
 - Since one of the tumors presented after 1/1/2007 the 2007 Multiple Primary Rules apply.



Question

- If we determine a patient has multiple primaries, how do we sequence?



Answer

- Sequencing should be based on chronology then on worst prognosis.



Question

- We have a patient with a history of ductal carcinoma of the left breast (diagnosed in 2006).
- She returned in 2007 with a new tumor in the same breast with a more specific histology (comedocarcinoma). According to the MP/H rules this is the same primary.
 - Do we update histology on the original abstract?



Answer

- No
 - You would **not** update the histology, but you would update the multiplicity counter.



Question

- Can information from the CAP Protocol portion of the pathology report be used to code histology?



Answer

- Yes
 - If your pathologist follows the CAP protocol to create a summary of the pathologic findings, you can use this information to code histology.
 - The “final diagnosis” rule on page 13 only applies to coding histology.



Recurrence

- Recurrence (if in the same site as the original primary).
 - Ignore the term “recurrence”.
 - Apply the multiple primary rules.
- Metastasis-may be in the same site or another site.
 - Multiple primary rules do not apply.



Question

- A patient with a history of ductal carcinoma of the left breast returns for a follow-up mammogram. She is found to have a new mass in the left breast. This probably represents a recurrent malignancy.
 - Would we apply the 2007 MP/H?



Answer

- Yes
 - We would ignore the term “recurrence”.
 - The new tumor occurred in the same primary site as the original so we would apply the 2007 MP/H rules.



Question

- A patient with a history of ductal carcinoma of the left breast returns complaining of pain in her ribs. A bone scan was performed and she was found bone metastasis. The physician felt this was most likely recurrent breast cancer.
 - Do we apply the 2007 MP/H Rules?



Answer

- No
 - The cancer did not occur in the same primary site. Therefore, we rely on the physicians statement that this was metastasis from the original primary.



Question

- A patient with a history of adenocarcinoma of the cecum now presents with a biopsy proven adenocarcinoma in the sigmoid colon. The path states this could represent a primary malignancy or metastasis.
 - Can I use clinical information in the chart to confirm mets vs. new primary or do I follow 2007 MP/H rules only?



Answer

- Use all information available to you to determine if the new tumor is metastasis.
 - If it is metastasis, then you would **not** apply the 2007 MPH Rules.
 - If it is not metastasis, then you **would** use the rules.



Question

- In the manual it states:
Rules are in hierarchical order within each module (Unknown if Single or Multiple Tumors, Single Tumor, and Multiple Tumors). Use the first rule that applies and **STOP**.
- In a previous webinar you said that some times it is necessary to make multiple passes through the rules. Please explain.



Answer

- Example:
 - A single tumor stated to be infiltrating duct carcinoma with tubular and apocrine features on a background of DCIS.



Answer

- Rule M11 tells us this is one primary.
- Rule H9 tells us that we code to the invasive portion, but does not give us directions on what combination code to use.
- **We have to make a second pass through the histology rules to get a specific code.**
- H17 tells us that we would code the invasive portion to 8523.



Colon



Question

- A polypectomy is done, but results are negative. The patient returned two weeks later for a colon resection and was found to have a malignancy at the site of the polypectomy.
 - Do you still code adenocarcinoma in polyp (the time frame is very short - 2 weeks)?



Answer

- Yes
- Per SEER:
 - *If the invasive adenocarcinoma arises in the polypectomy site or if there is documentation of residual polyp it would be coded to adenocarcinoma in a polyp. Otherwise it would be coded as adenocarcinoma.*



Question

- If in the Cancer Summary the final histology is mucinous adenocarcinoma, but the percentage of the tumor that is mucinous is not documented, can I still code to mucinous adenocarcinoma?



Answer

- Yes
 - A definitive statement of mucinous adenocarcinoma or signet ring cell adenocarcinoma in the final diagnosis (including the cancer case summary) allows us to code to that histology.
 - We only refer to the microscopic if the final diagnosis is adenocarcinoma, nos.



Question

- The final pathology from a colon resection showed adenocarcinoma with mucinous and neuroendocrine features.
 - How would you code the histology?



Answer

- Mucinous adenocarcinoma (8480)
 - If the final diagnosis is adenocarcinoma with mucinous and neuroendocrine features go to rule H14 and code to the histology with highest numeric code.

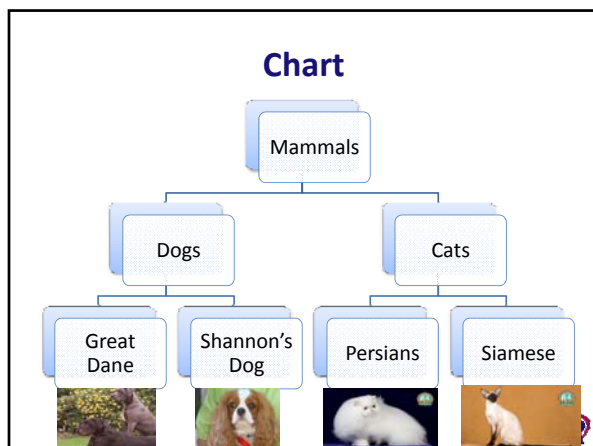


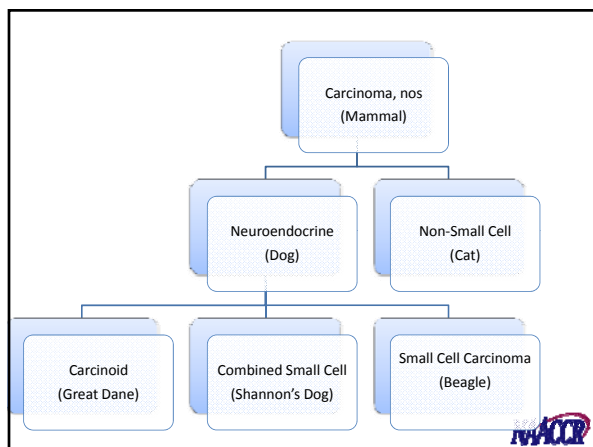
Lung

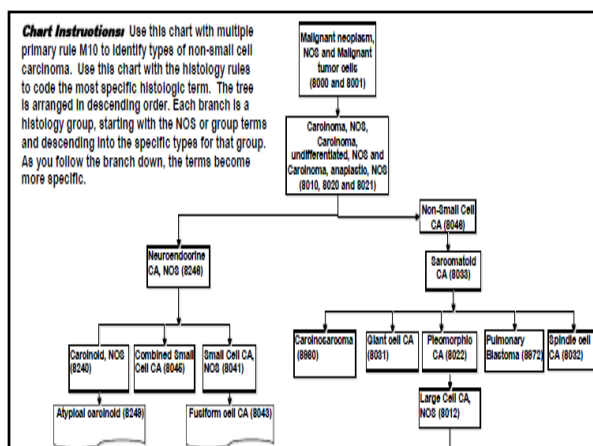
Question

- We are still having problems reading the histology charts for lung and brain. Could you please review?









Example

- Alveolar adenocarcinoma is a more specific type of adenocarcinoma.
- Alveolar adenocarcinoma is not a more specific type of squamous cell carcinoma.

See page 35 of your 2007 MP/H Manual



Question

- What is the histology code for large cell neuroendocrine carcinoma with areas of small cell carcinoma of right upper lobe lung and why?



Answer

- Large cell neuroendocrine carcinoma (8013/3) and small cell carcinoma, NOS (8041) are on different branches of the histology tree. Large cell neuroendocrine is on the non-small cell branch and small cell is on the small cell branch.
- Go to rule H7 and code the higher numeric histology (small cell carcinoma 8041). Curator.



Question

- If a patient has one tumor in the left lung and one in the right lung and only one tumor is biopsied, is this a single primary or multiple tumor?
- If only one primary, what would be the histology for the one that was not biopsied?



Answer

- Rule M6 states that a single tumor in each lung is multiple primaries. In your example, this would be 2 primaries unless there is specific documentation that one of the tumors is metastatic from the other.
- It would be based on the description by the radiologist or physician.



Question

- A patient had a right lower lobe lung resection 5/3/06 that was positive for a 2.0 cm mod/diff adenocarcinoma. On 4/2/08 the patient was found to have a right upper lobe lung resection. Pathology showed a 1.5 cm mod/diff adenocarcinoma.
 - Is the right upper lobe tumor a second primary?



Answer

- No. This would not be counted as a second primary.
 - Two tumors in the same lung with the same histology diagnosed less than three years apart.
 - Rule M12 would be the first rule that applied. See example 5.



Question

- A patient diagnosed with lesions in the LUL lung and the LLL lung. Resection of the LUL lesion was completed and a wedge resection of the LLL lesion was done. The LUL lesion squamous cell carcinoma and the LLL squamous cell carcinoma with focal features of adenocarcinoma.
 - Is this one or two primaries?



Answer

- Per the Definitions in the General Instructions, **Focal** means limited to one specific area (see page 9 of your MP/H Manual), so we do not include that information in choosing our histology code.
- Therefore, we have two tumors that are both squamous cell carcinoma. We follow Rule M12 (Example 5: multiple tumors in one lung) and have a single primary. Curator



Question

- A lung cancer patient had a 1.4cm well differentiated adenocarcinoma in the RUL and a 5.0cm moderately differentiated adenocarcinoma in the RLL.
 - Do the different grades in each tumor cause this to be two separate primaries?



Answer

- No
 - The grade of the tumor is not included in the rules as a factor for making a decision about the number of primaries.
 - Follow Rule M12, where one of the examples is noted to be multiple tumors in one lung, and abstract this as a single primary. Curator.



Breast

Question

- What if a patient has a breast tumor biopsied and the initial diagnosis was ductal carcinoma in situ, but due to other co-morbid conditions/work up, definitive surgery is delayed until more than 60 days out, and the path comes back as being invasive, is this one primary or two?
 - Would this be one or two primaries?



Answer

- This would be one primary.
 - When definitive surgery is delayed due to co-morbid conditions it is still part of the planned first course of therapy.
 - It would be a single primary and the histology would be based on the invasive component.



Question

- A pathology report states the patient has Paget's disease of the nipple with an underlying ductal carcinoma in situ.
 - Is this one or two primaries?
 - What histology code would be used?



Answer

- One primary.
 - According to rule M9 “Tumors that are intraductal or duct and Paget’s Disease are a single primary”.
- Code to 8543/3 Paget’s with underlying intraductal carcinoma.
 - Only code Paget’s as 8543/2 if the pathologist specifically state that the Paget’s is in situ (In situ Paget’s with underlying DCIS).
 - If the Paget’s is not stated to be in situ, use a /3 behavior code.



Question

- How is the histology of a breast primary with pleomorphic type of lobular carcinoma in situ coded?



Answer

- Pleomorphic carcinoma is a specific type of duct carcinoma (see Table 2). That means that you have a duct and lobular carcinoma.
- Use rule H5 and code 8522. Curator



Question

- A patient has a duct carcinoma of the breast, mucinous type. Would I use rule H12 on this case and code to mucinous carcinoma (8480/3)?



Answer

- No.
 - Mucinous is not a more specific type of ductal carcinoma (see table 2). Rule M12 would not apply.
 - A combination code is available for tumors with both ductal and mucinous carcinoma (see table 3).
 - This tumor would be assigned a histology of Infiltrating duct mixed with other types of carcinoma 8523/3.



Question

- What is the difference between ductal carcinoma (8500/3) and ductular carcinoma (8521/3) of the breast?



Answer

- Duct carcinoma, NOS (8500) is the largest group of breast cancers.
 - Duct carcinoma is not a specific histological type because it lacks features used to better classify the tumor.
- Ductular carcinoma (8521) is a malignancy that is infrequently found in the breast and may be found with greater frequency in other organs such as pancreas or prostate.
 - Code 8521 is seldom, if ever, applied to the breast.



Question

- We were recently told C50.8 should be used for breast cancer at the 3, 6, 9 or 12 o'clock position for overlapping subcategories where the point of origin cannot be determined. Is this correct?



Answer

- Yes.
 - C50.8 should be used for tumors that **overlap** site boundaries.
 - A single tumor involving a portion of both the upper outer quadrant of the breast and the lower outer quadrant of the breast would be code C50.8.
 - If the patient has multiple tumors in the same breast we would use C50.9.



Urinary



Question

- A patient with a history of invasive urothelial bladder cancer diagnosed in 2003 now presents for TURB and is found to have a non-invasive papillary transitional cell carcinoma of the bladder wall.
 - Is this a second primary?



Answer

- No.
 - The non-invasive or in situ tumor must occur first for rule M5 to apply.
 - If the invasive tumor occurs first and then a non-invasive or in situ tumor arises, rule M5 would not apply.



Question

- Patient has a history of papillary transitional cell carcinoma of the bladder diagnosed several years ago. The patient returned for a follow-up exam and was found to have recurrent urothelial carcinoma of the bladder.
 - Is this a second primary?



Answer

- No.
 - Rule M6 would apply.
 - A patient should only have one invasive urothelial carcinoma per lifetime.
 - This includes:
 - Transitional cell carcinoma (8120-8124)
 - Papillary transitional cell carcinoma (8130-8131)
 - Papillary carcinoma (8050)
 - Not a urothelial carcinoma, but was included as it may have been miscoded in the past.



Pop Quiz

- Patient has a history of invasive transitional cell carcinoma of the bladder diagnosed 1/15/03.
- She is found to have a recurrent bladder tumor on 11/6/2008.



Pop Quiz

- Which of the following histologies would be considered a second primary:
 - Non-invasive papillary transitional cell carcinoma
 - Papillary transitional cell carcinoma
 - Urothelial carcinoma
 - Urothelial carcinoma with sarcomatoid features
 - Transitional cell carcinoma with squamous differentiation
 - Papillary carcinoma
 - Squamous cell carcinoma



Question

- If the final diagnosis for a bladder primary is papillary carcinoma, do we code to 8050?



Answer

- No.
 - Papillary carcinoma is one of the definitions in the bladder that is coded 8130.
 - See rule H4



Question

- A patient was diagnosed 1/3/07 with a noninvasive papillary urothelial carcinoma of the bladder.
- On 2/2/07 he was diagnosed with an invasive papillary urothelial carcinoma of the ureter.
 - How many primaries does this patient have?



Answer

- One primary
 - The patient had an in situ and an invasive lesion in the urinary tract within 60 days. M8 tells you that the tumors in the renal pelvis and bladder would be abstracted as a single primary. Code the invasive tumor, the papillary urothelial carcinoma. Curator.



Other

Question

- A patient was diagnosed and treated in 1996 at another facility for adenocarcinoma of the prostate.
- He was admitted to our facility in February of 2007 for treatment of "recurrent prostate cancer." The recurrence was an adenocarcinoma and was confined to the prostate.
 - Is this a new primary?



Answer

- No
 - Rule M3 tells us to report only one adenocarcinoma of the prostate per patient per lifetime. This is considered the same primary.



Question

- A patient was found to have a tumor in the endometrium. The histology was endometrioid adenocarcinoma with squamous differentiation.
 - How would we code this histology?



Answer

- 8323/3
 - We would use rule H16 which refers us to Table 2 (page 80).
 - Table 2 has a combination code that fits this histology.



Question

- How do I code papillary serous adenocarcinoma of the ovary?



Answer

- Use rule H11 and code as papillary serous adenocarcinoma 8460/3. Curator.



Question

- Pathology states: "Left ovary, high grade carcinoma with small cell features, measuring 21 cm, and Right ovary, high grade papillary serous carcinoma , measuring 14cm?"
 - Is this 1 primary?



Answer

- Yes, this is one primary
 - Before we can apply the multiple primary rules, we have to assign each tumor a histology.
 - Left ovary-8041/3
 - Right ovary-8460/3
 - According to rule M7 this is one primary.
 - Rule H30 refers us to Table 2 which gives us a combination code of Combined Small cell carcinoma 8045/3



Melanoma

Question

- A patient had a skin lesion removed from the left arm. The final diagnosis from the pathology was ***Malignant melanoma in situ; histological features of regression.***
 - I coded this as regressing melanoma in situ 8723/2, but an edit was generated. Did I code this correctly?



Answer

- Yes, you did code this correctly see rule (H5 and H6).
 - There is an over-ride for this edit.
 - Even though regressing melanoma does not have an in situ code in the ICD O 3 manual, it is ok to assign a /2 behavior code.



Central Nervous System



Question

- If a physician said a patient had a left parietal meningioma, is it coded C71.3 parietal lobe or C70.0 cerebral meninges?



Answer

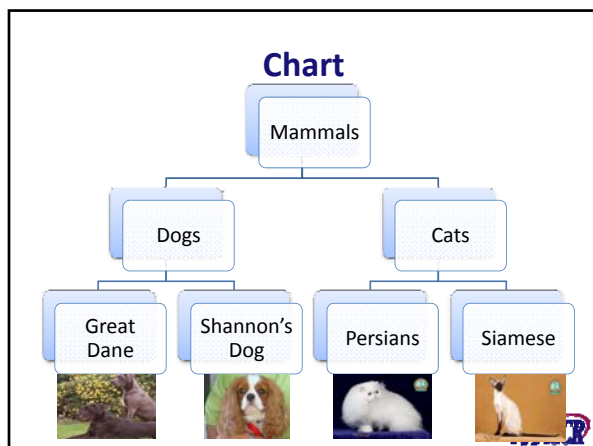
- Per the CoC I&R:
 - The only time a meningioma is not coded to the meninges is that very rare circumstance when meningeal tissue is present somewhere else.
- NPCR requires all meningiomas to be sited to the meninges.
- Many states require all meningiomas to be sited to the meninges.

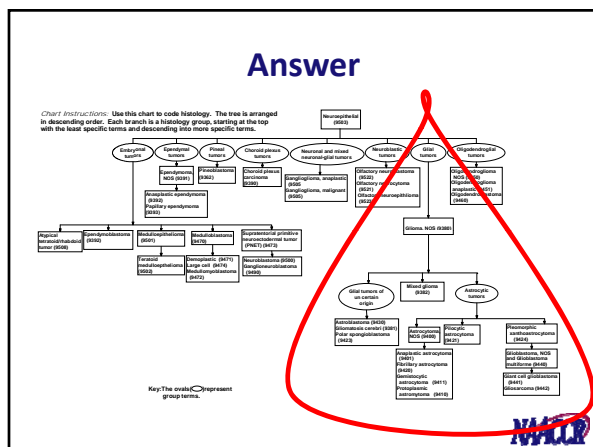


Question

- Could you explain the rule about a glioblastoma or glioblastoma multiforme (9440) following a glial tumor being a single primary?







Answer

- **Glioblastoma:** A malignant rapidly growing Astrocytoma of the central nervous system.
 - These neoplasms grow rapidly, invade extensively, and occur most frequently in the cerebrum of adults.
 - Glioblastoma multiforme is an undifferentiated glioblastoma. Any of the glial tumors can recur as a glioblastoma or glioblastoma multiforme.
 - If the original tumor was glial, a subsequent glial tumor of any type is a recurrence, not a new primary.



Multiple Tumors

Type of Multiple Tumors Reported as
One Primary
Date of Multiple Tumors
Multiplicity Counter



Question

- Could you explain how to code multiplicity counter when the tumor is multifocal or multiple foci are present?



Answer

- When the tumor is multifocal or multicentric and the foci of tumor are measured, count them as tumors.
- When the tumor is multifocal or multicentric and the foci of tumor are not measured, code as 99.



Answer

- When the tumor is multifocal or multicentric and some of the tumors are measured, but others are not, count the tumors that are measured.
- Example:
 - The specimen shows multiple foci of carcinoma the largest of which is 2.2mm.
 - Multiplicity counter would be 01.



Question

- How do I code Multiplicity Counter when a patient has a prostate biopsy that is positive, on the right and left. I have no more information about the number of tumors?



Answer

- Use code 99
 - Do not assume there are multiple tumors just because more than one lobe is involved.
 - When there is no information about the number of tumors you would code multiplicity counter as 99.



Question

- If a patient has bilateral ovarian carcinoma, we are instructed to code as a single primary.
 - If there is a single tumor on each ovary, how do we code Multiplicity Counter?



Answer

- Code Multiplicity Counter as 02
- Type of Multiple Tumors Reported as One Primary as 40



Question

- Which Multiple Tumors Reported as One Primary code is used for a breast lumpectomy specimen showing 2 areas of invasive duct ca, 1.2mm and 1mm, in the background of a measurable 3.6cm in situ duct ca?



Answer

- Use code 40
 - The codes are hierarchical. Multiple invasive tumors have a worse prognosis than invasive and in situ. When a researcher or clinician searches the database they want to identify those cases where there are multiple invasive tumors because the presumption is that these cases may have a worse prognosis and/or more extensive treatment.
 - Therefore, we would code the multiple invasive rather than invasive and in situ in this case. Curator



Questions?



Quiz



Collaborative Staging

Collaborative Staging Manual and
Coding Instructions (CSM)
Version 01.04.00



General Instructions

- The timing rule effective 1/1/2004 for Collaborative Staging is: "Use all information gathered through completion of surgery(ies) in first course of treatment, or all information available within four months of the date of diagnosis in the absence of disease progression, whichever is *longer*."

Source: CSM p. I-2



Timing of Data Collection for Collaborative Staging Data Items

- *Example*
 - Patient diagnosed with lung cancer in 3/2007 and referred to specialists for surgical evaluation and evaluation of extent of disease; referrals were delayed and further CT scans showed progression of disease; patient was inoperable
 - What information is used to complete collaborative staging date items?
 - All information gathered up to the time disease progression was identified



Coding Instructions for Collaborative Staging Data Items



CS Tumor Size

Code	Description
000	No mass found
001-988	Exact size in millimeters (mm)
989	989 mm or larger
990	Microscopic focus or foci only; no size of focus given
991	Less than 1 cm
992	Less than 2 cm OR greater than 1 cm OR between 1 cm and 2 cm
993	Less than 3 cm OR greater than 2 cm OR between 2 cm and 3 cm
994	Less than 4 cm OR greater than 3 cm OR between 3 cm and 4 cm
995	Less than 5 cm OR greater than 4 cm OR between 4 cm and 5 cm
SITE-SPECIFIC CODES WHERE NEEDED	
999	Unknown



CS Tumor Size

- How is CS tumor size recorded when the size is recorded as fractions of a mm?
 - Use basic mathematical principles; 1-4 round down; 5-9 round up
- *Example*
 - What is the code for CS Tumor Size when the tumor size is 6.3 mm?
 - CS Tumor Size = 006



CS Tumor Size

- What is the CS Tumor Size code when the only documentation of tumor size is greater than 5 cm?
 - CS Tumor Size = 051
- What information is used to code CS Tumor Size when path report documents a specific tumor size but the margins are positive?
 - Code CS tumor size using the specific tumor size documented in the path report



CS Tumor Size

- *Example*
 - Patient diagnosed with multi-focal right breast cancer. Right breast mastectomy path report: 1.3 cm infiltrating duct carcinoma at 11 o'clock; 5 cm intraductal carcinoma at 3 o'clock; 6 cm tumor, intraductal and infiltrating duct carcinoma, infiltrating less than 1 cm. What is the code for CS tumor size?
 - CS Tumor Size = 013
 - CSM 4c page I-26: code size of invasive component
 - CSM 4l page I-27: code size of largest tumor for multi-focal tumor



CS Tumor Size

- *Example*
 - Mammogram stated 3mm distribution of calcifications; core biopsy documented 0.2 cm tumor size. What is the code for CS tumor size?
 - CS Tumor Size = 002 IF the core biopsy removed the entire tumor; if not, CS Tumor Size = 999



CS Tumor Size

- *Question*
 - Is the code for CS Tumor Size 990 or 999 when the pathologist states 'focal invasive cancer'?
 - CS Tumor Size = 999 if the size of focal area is not stated
 - Focal does not equal focus



CS Extension

Code	Description
00	In situ; non-invasive
SITE/HISTOLOGY SPECIFIC CODES	
80	Further contiguous extension
95	No evidence of primary tumor
99	Unknown extension



CS Extension

- Code the farthest extension of the primary tumor in the data item, CS Extension
 - Code discontinuous metastasis to distant sites, except for ovary and corpus uteri, in the data item, CS Mets at Dx
- *Examples*
 - Adenocarcinoma of ascending colon with extension to right lobe of liver; rest of work-up negative
 - CS Extension = 60; CS Mets at Dx = 00
 - Adenocarcinoma of ascending colon extends through wall; surgeon documented metastatic lesions in liver
 - CS Extension = 40; CS Mets at Dx = 40



CS Extension

- Code the farthest extension of the primary tumor in the data item, CS Extension
 - Code the highest applicable number per CSM general guidelines #6 page I-12
 - *Exception*
 - Codes for unknown, not applicable, and NOS category such as localized, NOS, do not take priority over more specific codes
 - Use lower code when extension falls into two codes and the lower code derives a higher T category



CS Extension

- *Example*
 - Single lesion, papillary carcinoma, of thyroid extends into the carotid artery and the trachea
 - Extension from thyroid to carotid artery is assigned CS Extension code '62' and derives T4b
 - Extension from thyroid to trachea is assigned CS Extension code '72' and derives T4a
 - CS Extension = 62
 - Exception to code the highest applicable number guideline because lower number derives a higher T category



CS Extension

- Do not code CS Extension as in situ if there is any evidence of nodal or metastatic involvement (CSM page I-29 #9)
- *Example*
 - Mammogram: Areas of calcification suspicious for malignancy; dense axillary lymph nodes suspicious for malignancy
 - Path from lumpectomy: ductal carcinoma in situ
 - CS Extension = 10
 - Histology = 8500/39



CS Extension – Clinical Extension Prostate

- Clinically apparent vs. clinically inapparent
 - Do not infer clinically apparent or inapparent tumor based on registrar's interpretation of DRE or imaging reports
 - Do not use guidelines from SEER Extent of Disease 1998-2003 to determine apparent or inapparent tumor
 - Code clinically apparent or inapparent based on physician's statements in record
 - Physician assignment of cT1 or cT2
 - Code CS Extension 30 if physician statements do not indicate clinically apparent or inapparent tumor



CS Extension – Clinical Extension Prostate

- Clinically inapparent CS Extension codes
 - 10: Clinically inapparent, percent involved not specified; Stage A, NOS
 - 13: Incidental finding 5% or less (clinically inapparent); stated cT1a
 - 14: Incidental finding more than 5% (clinically inapparent); stated cT1b
 - 15: Identified by needle biopsy for elevated PSA (clinically inapparent); stated as cT1c



CS Extension – Clinical Extension Prostate

- Clinically apparent CS Extension codes
 - 20: One lobe, NOS (clinically apparent only)
 - 21: Half of one lobe or less (clinically apparent only); stated cT2a
 - 22: More than half of one lobe, but not both lobes (clinically apparent only); stated cT2b
 - 23: Both lobes (clinically apparent only); stated cT2c
 - 24: Clinically apparent tumor, confined to prostate, NOS; stated cT2 without subcategory; Stage B, NOS
- Not stated clinically apparent or inapparent
 - 30: Localized, NOS



CS Extension – Clinical Extension Prostate

- Registrar can code prostate cancer case as clinically inapparent
 - Physician documents stage A or cT1 (NOS, a, b, or c)
 - Physician documents prostate is normal on DRE and/or imaging



CS Extension – Clinical Extension Prostate

- Registrar can code prostate cancer case as clinically apparent
 - Physician documents as cT2 (NOS, a, b, or c) or stage B
 - Physician documents palpable tumor on DRE
 - Documentation in health record of visible prostate tumor on imaging



CS Extension – Clinical Extension Prostate

- Code CS Extension 30 because there is not enough documentation to determine clinically apparent or inapparent for prostate cancer case
 - No documentation of DRE or prostate imaging
 - Prostate described as smooth without nodule
 - Investigate further because registrar cannot code apparent based on the word 'nodule'
 - Abnormal DRE and prostate nodule on right
 - Investigate further because abnormal DRE is not necessarily cancer and registrar cannot code apparent based on the word 'nodule'



CS Extension – Clinical Extension Prostate

- *Question*
 - Patient treated for bladder cancer with cystoprostatectomy; incidental finding of adenocarcinoma in < 5% of tissue; no suspicion of prostate cancer prior to surgery
 - What is the code for CS Extension – Clinical Extension?
 - CS Extension = 99



CS Extension Bladder

- Code 01
 - Papillary transitional cell carcinoma stated to be noninvasive
 - Derived Ta
- Code 03
 - Papillary transitional cell carcinoma with inferred description of non-invasion
 - Derived Ta
- Code 06
 - Sessile carcinoma in situ
 - Derived Tis



CS Extension Bladder

- *Examples*
 - TURB: Multifocal noninvasive urothelial carcinoma, papillary type
 - CS Extension = 01; Histology = 8130/29
 - TURB: Papillary transitional cell carcinoma of lateral wall, tissue insufficient to judge depth of invasion
 - CS Extension = 03; Histology = 8130/29
 - TURB: Urothelial carcinoma; physician recorded as Tis
 - CS Extension = 06; Histology = 8120/29



CS Tumor Size/Ext Eval

Code	Description	Staging Basis
0	Clinical only	c
1	Invasive techniques	c*
2	Autopsy (known or suspected diagnosis)	p
3	Pathology	p
5	Pre-operative treatment; clinical evidence	c
6	Pre-operative treatment; pathological evidence	y
8	Autopsy (tumor unsuspected)	a
9	Unknown	c

*For some sites, code 1 may be pathologic staging basis.



**CS Tumor Size/Ext Eval
Bladder**

- According to AJCC, staging basis for transurethral resection of bladder (TURB) is clinical
 - Code CS Tumor Size/Ext Eval 1 when information used to assign code for CS Tumor Size or CS Extension was from TURB
- *Example*
 - Patient had TURB of bladder showing transitional cell carcinoma of bladder wall; procedure coded as 27 in surgical procedure of primary site data item. What is the code for CS Tumor Size/Ext Eval?
 - CS Tumor Size/Ext Eval = 1



**CS Tumor Size/Ext Eval
Prostate**

Code	Description	Staging Basis
0	Clinical only	c
1	Invasive techniques; no surgical resection done	c
2	No surgical resection done but positive biopsy of extraprostatic tissue allows CS Extension codes 41-70	p
3	Autopsy (known or suspected diagnosis)	p
4	Pathology	p
5	Pre-operative treatment; clinical evidence	c
6	Pre-operative treatment; pathological evidence	y
8	Autopsy (tumor unsuspected)	a
9	Unknown	c



CS Tumor Size/Ext Eval**Prostate**

- Use CS Tumor Size/Ext Eval to evaluate coding of tumor size and extension as coded in both CS Extension Clinical Extension and SSF3 CS Extension Pathologic Extension
- According to AJCC staging basis for transurethral resection of prostate (TURP) is clinical
 - Code CS Tumor Size/Ext Eval 1 when information used to assign code for CS Tumor Size or CS Extension Clinical Extension was from TURP



CS Tumor Size/Ext Eval**Prostate**

- *Examples*
 - Elevated PSA, normal prostate by DRE, needle biopsy showed adenocarcinoma; radical prostatectomy showed adenocarcinoma in 10% of left lobe
 - CS Extension = 15; SSF3 = 021; CS TS/Ext Eval = 4
 - TURP for clinically inapparent tumor, adenocarcinoma in 3% of resected tissue; no prostatectomy
 - CS Extension = 13; SSF3 = 097; CS TS/Ext Eval = 1



CS Lymph Nodes

Code	Description
00	None; no regional lymph node involvement
SITE/HISTOLOGY SPECIFIC CODES	
99	Unknown



CS Lymph Nodes

- Record CS Lymph Nodes as code 00 rather than code 99 for inaccessible sites when the clinician proceeds with treatment for localized or early stage disease

– *Example*

- Colon cancer diagnosed by colonoscopy with polypectomy; no documentation about status of lymph nodes
- CS Lymph Nodes = 00
 - Inaccessible sites rule



CS Lymph Nodes

• *Question*

- What is the difference between regional lymph nodes, NOS, (site-specific code) and lymph nodes, NOS, (usually code 80)?
 - Use the site-specific code for regional nodes, NOS, when it is known that nodes involved are regional even if unnamed
 - Code unidentified lymph nodes included with resected primary site as regional nodes, NOS
 - Use code 80 when it cannot be determined if the nodes involved are regional or distant



CS Lymph Nodes Breast

• *Question*

- Some clinicians use the terms level III axillary nodes and infraclavicular nodes synonymously, but there are different breast CS Lymph Nodes codes for involvement of these nodes. How should CS Lymph Nodes be coded when these descriptions are used synonymously?

– *Answer*

- Infraclavicular nodes are level III axillary nodes medial to the pectoralis minor muscle. Code to infraclavicular based on the anatomic location.



CS Reg Nodes Eval

Code	Description	Staging Basis
0	Clinical only	c
1	Invasive techniques	c
2	Autopsy (known or suspected diagnosis)	p
3	Pathology	p
5	Pre-operative treatment; clinical evidence	c
6	Pre-operative treatment; pathological evidence	y
8	Autopsy (tumor unsuspected)	a
9	Unknown	c



CS Reg Nodes Eval

- *Example*
 - Breast cancer diagnosed by biopsy; patient decided on pre-op chemotherapy but had sentinel node mapping prior to chemotherapy that showed 2/3 nodes positive; patient had chemotherapy followed later by modified radical mastectomy with 0/12 nodes positive
 - CS Reg Nodes Eval = 3



Regional Nodes Positive

Code	Description
00	All nodes examined are negative
01-89	1-89 nodes are positive; code exact number of nodes positive
90	90 or more nodes are positive
95	Positive aspiration or core biopsy of lymph node(s) was performed
97	Positive nodes are documented, but the number is unspecified
98	No nodes were examined
99	Unknown



Regional Nodes Positive

- Record the total number of regional nodes removed and found to be positive by pathologic examination
 - Record the cumulative number of positive regional nodes from all 1st course treatment procedures
 - Code this field even if the patient received pre-operative treatment



Regional Nodes Examined

Code	Description
00	No nodes were examined
01-89	1-89 nodes were examined; code number of regional nodes examined
90	90 or more nodes were examined
95	No regional nodes removed; aspiration or core biopsy of regional nodes performed
96	Regional lymph node removal documented as a sampling; the number of nodes is unknown
97	Regional node removal was documented as dissection; the number of nodes is unknown
98	Regional lymph nodes were surgically removed; number of lymph nodes is unknown & not documented as sampling or dissection; nodes were examined but the number is unknown
99	Unknown



Regional Nodes Examined

- Record the total number of regional nodes removed and examined by a pathologist
 - Record the cumulative number of regional nodes examined from all 1st course treatment procedures
 - Use code 98 if lymph nodes are aspirated and other lymph nodes are removed (CSM page I-46 #4b)
 - Code this field even if the patient received pre-operative treatment



Regional Nodes Positive Regional Nodes Examined

- *Example*
 - Primary breast cancer; FNA of axillary lymph node positive for malignancy; modified radical mastectomy with axillary node dissection, 2/10 nodes positive for malignancy
 - Regional Nodes Positive = 97
 - Cannot determine if the aspirated node was one of the positive dissected nodes
 - Regional Nodes Examined = 98
 - Use code 98 if lymph nodes are aspirated and other lymph nodes are removed



CS Mets at Dx

Code	Description
00	No; none
10	Distant lymph node(s)
40	Distant metastases except code 10 Distant metastasis, NOS Carcinomatosis
SITE/HISTOLOGY SPECIFIC CODES	
50	(40) + (10)
99	Unknown



CS Mets at Dx

- Code distant metastases, tumor spread indirectly to a site remote from primary tumor, at time of cancer diagnosis
 - Do not code direct tumor extension from the primary tumor in this data item unless instructed to do so in the site-specific schema



CS Mets at Dx

- *Examples*

- Adenocarcinoma of ascending colon with extension to right lobe of liver; rest of work-up negative
 - CS Mets at Dx = 00
- Adenocarcinoma of ascending colon extends through wall; surgeon documented metastatic lesions in liver
 - CS Mets at Dx = 40
- Squamous cell carcinoma, left lung, extends through the chest wall into the skin of the chest
 - CS Mets at Dx = 37



CS Mets Eval

Code	Description	Staging Basis
0	Clinical only	c
1	Invasive techniques	c
2	Autopsy (known or suspected diagnosis)	p
3	Pathology	p
5	Pre-operative treatment; clinical evidence	c
6	Pre-operative treatment; pathological evidence	y
8	Autopsy (tumor unsuspected)	a
9	Unknown	c



CS Mets Eval

- Used to assign a 'c' or 'p' to the M category derived from data item, CS Mets at Dx
 - Choose an eval code that derives 'c' if M0 will be derived
 - There is no pM0 because it is impossible to disprove all possible sites of metastasis
 - *Example:* Primary carcinoma of lung; CT scan of brain, negative; biopsy of cervical lymph node, negative.
 - CS Mets at Dx code = 00
 - CS Mets Eval code = 1
 - Maps to cM0



CS Mets Eval

- Used to assign a 'c' or 'p' to the M category derived from data item, CS Mets at Dx
 - Choose an eval code that derives 'c' if MX will be derived
 - *Example:* Primary carcinoma of lung diagnosed by imaging; CT scan of brain cannot rule out brain metastasis
 - CS Mets at Dx code = 99
 - CS Mets Eval code = 0
 - Maps to cMX



CS Mets Eval

- Used to assign a 'c' or 'p' to the M category derived from data item, CS Mets at Dx
 - Choose an eval code that derives 'p' if pathologic evidence was used and M1 will be derived and there are no subcategories of M1
 - *Example:* Primary carcinoma of lung; CT scan of brain, negative; biopsy of cervical node, positive for metastasis
 - CS Mets at Dx code = 10
 - CS Mets Eval code = 3
 - Maps to pM1



CS Mets Eval

- Used to assign a 'c' or 'p' to the M category derived from data item, CS Mets at Dx
 - Choose an eval code that derives 'c' if only clinical evidence was used to derive M1
 - *Example:* Primary carcinoma of lung; CT scan of brain shows brain metastasis; biopsy of cervical node, negative for metastasis.
 - CS Mets at Dx code = 40
 - CS Mets Eval code = 0
 - Maps to cM1



CS Mets Eval

- Used to assign a 'c' or 'p' to the M category derived from data item, CS Mets at Dx
 - Choose an eval code that derives 'p' if pathologic evidence was used and a specific subcategory of M1 will be derived
 - *Example 1:* Prostate carcinoma with positive biopsy of aortic lymph node; negative bone scan; negative brain scan
 - CS Mets at Dx = 12
 - CS Mets Eval = 3
 - Maps to pM1a



CS Mets Eval

- Used to assign a 'c' or 'p' to the M category derived from data item, CS Mets at Dx
 - Choose an eval code that derives 'c' if only clinical evidence was used and a specific subcategory of M1 will be derived
 - *Example 2:* Prostate carcinoma with negative biopsy of aortic lymph node; positive bone scan; negative brain scan
 - CS Mets at Dx = 30
 - CS Mets Eval = 0
 - Maps to cM1b



CS Mets Eval

- Used to assign a 'c' or 'p' to the M category derived from data item, CS Mets at Dx
 - Choose an eval code that derives 'c' if both pathologic and clinical evidence are available, but the clinical evidence derives a higher subcategory of M1
 - *Example 3:* Prostate carcinoma with positive biopsy of aortic lymph node; positive bone scan; positive brain scan
 - CS Mets at Dx = 55
 - CS Mets Eval = 0
 - Maps to cM1c



CS Site-Specific Factors (SSF) 1-6

Code	Description
000	None
SITE/HISTOLOGY SPECIFIC CODES	
999	Unknown

For schemas that do not use this site-specific factor:

Code	Description
888	Not applicable for this site



**CS SSF1 Size of Lymph Nodes
Head & Neck**

Code	Description
000	No involved regional nodes
001-988	Exact size in millimeters (mm)
989	989 mm or larger
990	Microscopic focus or foci only; no size of focus given
991	Less than 1 cm
992	Less than 2 cm OR greater than 1 cm OR between 1 cm and 2 cm
993	Less than 3 cm OR greater than 2 cm OR between 2 cm and 3 cm
994	Less than 4 cm OR greater than 3 cm OR between 3 cm and 4 cm
995	Less than 5 cm OR greater than 4 cm OR between 4 cm and 5 cm
996	Less than 6 cm OR greater than 5 cm OR between 5 cm and 6 cm
997	Described as more than 6 cm
999	Unknown



**CS SSF1 Size of Lymph Nodes
Head & Neck**

- *Questions*
 - What is the code for CS SSF1 when the CS Lymph Nodes code is 99, unknown?
 - CS SSF1 = 999
 - What is the code for CS SSF1 when the only information about regional node involvement is that regional nodes, NOS, are involved?
 - CS SSF1 = 999
 - What is the code for CS SSF1 when the code for CS Lymph Nodes is based only on the physician's statement of N_?
 - CS SSF1 = 999



CS SSF2 Extracapsular Extension, Lymph Nodes for Head & Neck

Code	Description
000	No extracapsular extension
001	Extracapsular extension clinically, not assessed pathologically Nodes described as 'fixed', not assessed pathologically
005	Extracapsular extension present pathologically
888	Not applicable; no lymph node involvement
999	Unknown



CS SSF2 Extracapsular Extension, Lymph Nodes for Head & Neck

- Code status of extracapsular extension of lymph nodes coded in CS Lymph Nodes data item
 - Code SSF2 as 888 (no lymph node involvement) if CS Lymph Nodes = 00 (no regional lymph node involvement)
 - *Example*
 - 2 cm squamous cell carcinoma, upper lip, with extension into the vermillion surface; no lymphadenopathy of head and neck
 - CS Lymph Nodes = 00; CS SSF2 = 888



CS SSF2 Extracapsular Extension, Lymph Nodes for Head & Neck

- *Question*
 - What is the code for CS SSF2 when the CS Lymph Nodes code is 99, unknown?
 - CS SSF2 = 999
 - What is the code for CS SSF2 when the only information about regional node involvement is that regional nodes, NOS, are involved?
 - CS SSF2 = 999
 - What is the code for CS SSF2 when the code for CS Lymph Nodes is based only on the physician's statement of N_?
 - CS SSF2 = 999



CS SSF3-6 Head & Neck Lymph Node Levels and Other Groups

- Code presence or absence of lymph node involvement in 7 levels and other groups defined by AJCC
 - One digit represents lymph nodes of a single level
 - Code 1 in each digit means nodes are involved
 - SSF3 represents lymph nodes of levels I-III
 - SSF4 represents lymph nodes of levels IV, V, and retropharyngeal nodes
 - SSF5 represents levels VI, VII, and facial nodes
 - SSF6 represents remaining Other groups defined by AJCC



CS SSF3-6 Head & Neck Lymph Node Levels and Other Groups

- Unknown regional node involvement
 - Code CS SSF3-6 999, unknown, when CS Lymph Nodes = 99 (unknown)
 - Do not code 9 in some positions of SSF3-6 and 0 or 1 in other positions
- Non-specific regional node involvement
 - Code '0' for all digits of CS SSF3-6 when the only information about regional node involvement is 'regional nodes, NOS', 'cervical nodes, NOS', 'internal jugular nodes, NOS', or 'lymph nodes, NOS'



CS SSF3-6 Head & Neck Lymph Node Levels and Other Groups

- *Questions*
 - What are the codes for CS SSF3-6 when the CS Lymph Nodes code is 99, unknown?
 - CS SSF3-6 = 999
 - What are the codes for CS SSF3-6 when the only information about regional node involvement is that regional nodes, NOS, are involved?
 - CS SSF3-6 = 000
 - What are the codes for CS SSF3-6 when the code for CS Lymph Nodes is based only on the physician's statement of N_?
 - CS SSF3-6 = 000



**CS SSF1-6
Head & Neck**

- *Example 1*
 - 2 cm squamous cell carcinoma, upper lip, with extension into the vermillion surface; swelling of submandibular node; patient refused further work-up or treatment
 - CS Lymph Nodes = 99
 - CS SSF1 = 999
 - CS SSF2 = 999
 - CS SSF3-6 = 999



**CS SSF1-6
Head & Neck**

- *Example 2*
 - 2 cm squamous cell carcinoma, upper lip, with extension into the vermillion surface; malignant cervical lymphadenopathy
 - CS Lymph Nodes = 51
 - CS SSF1 = 999
 - CS SSF2 = 999
 - CS SSF3-6 = 000



**CS SSF1-6
Head & Neck**

- *Example 3*
 - 2 cm squamous cell carcinoma, upper lip, with extension into the vermillion surface; cervical lymphadenopathy; physician documented pT1cN1cM0
 - CS Lymph Nodes = 18
 - CS SSF1 = 999
 - CS SSF2 = 999
 - CS SSF3-6 = 000



CS SSF3 CS Extension – Pathologic Prostate

- Include information from radical prostatectomy in this field
- Code field using all histologic information plus information from radical prostatectomy if part of 1st course treatment



CS SSF3 CS Extension – Pathologic Prostate

- *Example*
 - TRUS biopsy of prostate: focus of adenocarcinoma in right lobe; radical prostatectomy: focus of adenocarcinoma in left lobe
 - CS SSF3 = 023 (involves both lobes)
 - Use all histologic information plus prostatectomy



CS SSF4 Prostate Apex Involvement Prostate

- In codes 110-550, 1st digit represents clinical status of apex involvement; 2nd digit represents apex involvement found at prostatectomy
 - 1: No involvement of apex
 - 2: Into prostatic apex/arising in prostatic apex, NOS
 - 3: Arising in prostatic apex
 - 4: Extension into prostatic apex
 - 5: Apex extension unknown



CS SSF4 Prostate Apex Involvement Prostate

- *Examples*
 - Multiple prostate biopsies: adenocarcinoma of prostate, apex positive; no prostatectomy
 - CS SSF4 = 250
 - TURP: adenocarcinoma arising in apex of prostate; prostatectomy: no residual adenocarcinoma
 - CS SSF4 = 310
 - Multiple prostate biopsies: adenocarcinoma; prostatectomy: adenocarcinoma in right lobe extends into apex of prostate
 - CS SSF4 = 540



CS SSF6 Size of Tumor – Invasive Component: Breast

Code	Description
000	Entire tumor invasive
010	Entire tumor in situ
020	Invasive & in situ components present, invasive size coded
030	Invasive & in situ components present, entire size coded because size of invasive component not stated AND in situ is minimal (<25%)
040	Invasive & in situ components present, entire size coded because size of invasive component not stated AND in situ is extensive (25% or more)
050	Invasive & in situ components present, entire size coded because size of invasive component not stated AND proportions of in situ and invasive not known
060	Invasive & in situ components present, unknown tumor size
888	Unknown if invasive & in situ components present Clinical tumor size coded



CS SSF6 Size of Tumor – Invasive Component: Breast

- *Example*
 - Breast lumpectomy: infiltrating ductal carcinoma, tumor size 2 cm, EIC negative, margins negative.
 - The pathologist and abstractor discussed case, and pathologist stated that EIC (extensive intraductal component) negative is never mentioned unless there is a minor component of ductal carcinoma in situ. What is the code for SSF6?
 - If the instructions for coding are approved by the cancer committee and included in registry policies and procedures, assign code 050 for SSF6



Treatment



Question

- Is there a time-limit on first-course therapy?



Answer

- The first course of treatment includes all methods of treatment recorded in the treatment plan and administered to the patient before disease progression or recurrence.
- If there is no treatment plan, established protocol, or management guidelines and consultation with a physician advisor is not possible, use the principle: initial treatment must begin within four months of the date of initial diagnosis.



Question

- Could you review the difference between a diagnostic/staging procedure and a surgical procedure?



Answer

- A diagnostic/ staging procedure identifies surgical procedure(s) performed in an effort to diagnose and/or stage disease.
- A surgical procedure of the primary site is a procedure done to treat the cancer.



Answer

- Colonoscopy with biopsy is considered a diagnostic/staging procedure.
- Colonoscopy with polypectomy is considered surgical treatment.
- A core biopsy of a large tumor in the breast is considered a diagnostic/staging procedure.
- A core biopsy of a small breast tumor that actually removes all of the tumor is surgical treatment.



Surgery



Question

- If a melanoma patient has a shave biopsy done in the doctors office and then comes to our facility for an excisional biopsy, how would we code the shave biopsy?



Answer

- Code the gross excision as a 31.
 - The date of initial treatment would be the date of the shave biopsy.



Question

- How do we code a gross resection of a brain tumor?



Answer

- Use code 20 to code a gross excision of a brain tumor.
 - If you once used ROADS, it may help to know that ROADS codes 20-23 (which include debulking as well as subtotal resection of the tumor) and codes 30-32 (which include gross or total resection of the tumor) were collapsed into FORDS code 20. ROADS codes 40-43 (partial resection of lobe or meninges) became FORDS code 40.
 - ROADS codes 50 (brain lobectomy) and 60 (radical resection) were collapsed into FORDS code 55. Debulking is generally used in preparation for systemic or radiotherapy, and can be identified that way. CoC I&R.



Question

- Where do you code a lymph node biopsy/excision for lymphoma?
 - Example patient has extensive adenopathy and surgeon removes a single lymph node.



Answer

- Code Surgical Diagnostic and Staging Procedure code 01.
- Code to Surgical Procedure of the Primary Site 25 only if the procedure was performed for treatment (for example, it was determined that the only evidence of lymphoma was in the node(s) removed).
 - This rule only applies to lymphoma!



Question

- How would I code a left total mastectomy w/prophylactic right mastectomy?
 - A new cancer was found incidentally in the right breast during this prophylactic procedure.
 - There was no suspicion of malignancy prior to the surgery.



Answer

- If the contralateral breast reveals a second primary, the surgical procedure is 41 for the first primary.
- The surgical code for the contralateral breast is coded to the procedure performed on that site.



Question

- How should we code Reason for No Surgery If a patient consults with an oncologist and treatment options are observation, surgery, radiation, chemo or hospice, and the patient opts for hospice.



Answers

- Code 7 Recommended, but patient refused



Question

- How do I code Reason No Surgery If a patient was admitted to our facility for a planned resection, but the procedure was aborted in the operating room due to adverse medical reaction/complications?



Answer

- Code 2-Contraindicated due to patient risk factors
 - The decision to abort the surgery because of contraindications becomes the treatment for this person.
 - The reason that there was no surgery is recorded in the field Reason for No Surgery of Primary Site.



Radiation and Chemotherapy

Question

- If chemotherapy was given with radiation therapy and qualified as a radiosensitizing drug by the physician, is it coded as chemotherapy?
- Is any chemotherapy drug given with radiation therapy considered radiosensitizing?



Answer

- This depends on the site and agent. Please check with SEER Rx and the physician.
- Generally, you do not code radiosensitizers as chemotherapy. The low dose of the drug only enhances the effect of the radiation and does not kill cancer cells by itself. Curator



Question

- If a patient only completes one cycle of chemotherapy vs. the four cycles recommended, do we still code they received chemotherapy?



Answer

- Yes.



Question

- If a patient received 5-FU (antimetabolite) and was changed to Xeloda (antimetabolite) due to side effects, is this still first course treatment?



Answer

- Yes
 - If a patient is receiving a chemotherapy regimen and one of the drugs is changed but belongs to the same group as the original drug, there is no change in the regimen.
 - If the replacement drug is in a different group than the original drug, code the new regimen as subsequent therapy.



Question

- A pt with planned mammosite was denied placement due to an infection. If there was a new plan for beam radiation, is it first course treatment?



Answer

- Yes
 - This would still be first course treatment. The change was not due to progression of disease.



Question

- How do I code Therasphere radiation therapy for hepatocellular carcinoma?



Answer

- Per the SEER Rx database, TheraSphere is coded as radioisotopes (60).



Questions?



Quiz



Thank you for participating in today's webinar!

- The next webinar is scheduled for 12/4/08, and the topic is 'Collecting Cancer Data: Leukemia, Lymphoma, and other Hematopoietic Malignancies'.
- Forward questions from today's webinar to us. Per request of CoC, we will forward questions to them.
- Contact us at
 - Shannon Vann – svann@naaccr.org; 217-698-0800 X9
 - Jim Hofferkamp – jhofferkamp@naaccr.org; 217-698-0800 X5