Coding Pitfalls 2010-2011

September 1, 2011

NAACCR 2010-2011 Webinar Series

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Questions

- Please submit questions about today's presentation through the Q&A (?) panel

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Fabulous Prizes!!!

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For the best question and tip

Webinar Agenda

- Collaborative Stage
- Quiz
- General Questions
- MPH/ Hematopoietic
- Treatment
- Quiz

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Collaborative Stage Data Collection System

v02.03

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Part I Section I

CS v02.03

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CS Lymph Nodes Eval

- Code CS Lymph Nodes Eval as clinical or pathologic based on intent of procedure and match to assessment of T classification
  - CS Lymph Nodes Eval = 0, 1, 5, or 9 when lymph node procedure is part of workup (staging basis is clinical)
  - CS Lymph Nodes Eval = 2, 3, or 6 when lymph node procedure is treatment (staging basis is pathologic)

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7

CS Lymph Nodes Eval

Code	Description	Staging Basis
0	Clinical only	c
1	Invasive techniques that do not meet pathologic criteria	c
2	Autopsy (known or suspected diagnosis)	p
3	Pathology	p
5	Pre-op treatment, clinical evaluation	c
6	Pre-op treatment, pathologic evaluation	yp
8	Autopsy (diagnosis not suspected or diagnosed)	a
9	Unknown	c

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CS Lymph Nodes Eval

- Code 1
  - Microscopic assessment of lymph nodes as part of diagnostic workup WITHOUT removal of primary site adequate for pathologic T classification
- Code 3
  - Microscopic assessment of lymph nodes that is therapeutic WITH removal of primary site adequate for pathologic T classification

    OR

    Microscopic assessment of regional node in highest N category regardless of T category information

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CS Lymph Nodes Eval

- *Case Scenario:* Patient presented with an enlarged cervical lymph node. The entire lymph node was excised and the patient was found to have squamous cell carcinoma from a laryngeal primary. The patient was treated with radiation only.
  - What is the code for CS Lymph Nodes Eval?
    - 1

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CS Lymph Nodes Eval

- *Case Scenario:* Patient had a large palpable breast mass as well as palpable lymph nodes. Sentinel lymph node biopsy showed metastasis to one of three lymph nodes. The patient opted for neoadjuvant chemotherapy followed by modified radical mastectomy. No positive lymph nodes were found.
  - What is the code for CS Lymph Nodes Eval?
    - 5

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CS Lymph Nodes Eval

- *Case Scenario:* Patient with breast cancer was diagnosed by mammography and core needle biopsy. Clinically the axillary nodes were negative. The patient opted for a lumpectomy and sentinel node biopsy, which was negative.
  - What is the code for CS Lymph Nodes Eval?
    - 3

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12

CS Lymph Nodes Eval

- *Case Scenario:* Patient presents with a hard supraclavicular mass, which was excised and showed metastatic squamous carcinoma. Further diagnostic workup showed a mass in the left upper lobe of the lung with several satellite nodules. Final diagnosis is lung cancer with metastasis to supraclavicular nodes.
  - What is the code for CS Lymph Node?
    - 3

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13

Site-specific Factors (SSF)

- Use of code 988 (not applicable)
  - Assign code 988 if the SSF is not defined for the schema
    - *Example:* SSF 1 and 2 are defined in lung schema; SSF 3-25 are not defined in lung schema
      - Assign code 988 to SSF 3-25 for lung
  - Assign code 988 for a defined SSF if you are not collecting it because it is not required to be collected by your standard setter

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Site-specific factors

- *Case scenario:* Patient is diagnosed with colon cancer and is treated with hemicolectomy. There is no information in the record about a microsatellite instability (MSI)test. However, your standard setter and cancer committee do not require submission of MSI test results.
  - What is the correct code for SSF7 (MSI)?
    - 988: not applicable
    - 998: test not done
    - 999: unknown

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Site-specific Factors

- *Case scenario:* Note 3 preceding SSF7 for breast, Nottingham or Bloom-Richardson Score/Grade, states that the score is based on 3 morphologic features of "invasive no-special-type" breast cancers. The final diagnosis is ductal carcinoma in situ, right breast. Your standard setter requires submission of SSF7 for breast cases
  - What is the code for SSF7?
    - 988: not applicable
    - 999: unknown

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Part I Section 2

CS v02.03

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Recording Lab Tests in Site-specific Factors

- How to code interpretation of lab test results
  - Code clinician's/pathologist's interpretation
- *Example:* Discharge summary: Patient with breast cancer; HER2 IHC was positive at 3+
  - What is the code for SSF9 (HER2: IHC Test Interpretation)?
    - 010 (positive/elevated)

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Recording Lab Tests in Site-specific Factors

- How to code interpretation of lab test results
  - Use the clinician's statement of T, N, M, or stage group to code interpretation if it implies a lab value interpretation
- *Example:* Physician documents prostate cancer patient's PSA was 4.5; biopsy results positive; case staged as T1c (tumor identified by needle biopsy, e.g., because of elevated PSA)
  - What is the code for SSF2 (PSA Interpretation)?
    - 010 (positive/elevated)

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Recording Lab Tests in Site-specific Factors

- How to code interpretation of lab test results
  - Use the reference range for the lab if it is listed on the test report to interpret the lab test results and assign the appropriate code
- *Example:* Lab report shows ovarian cancer patient's CA-125 as 235; normal range < 35 U/ml
  - What is the code for SSF1 (CA-125 Interpretation)?
    - 010 (positive/elevated)

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Site-specific schemas

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Prostate

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CS Extension – Clinical Extension: Prostate

- Clinically inapparent tumor
  - Is not palpable or visible by imaging
  - Includes physician assignment of cT1
  - Assigned codes 100 – 150
    - Codes 100 – 140
      - Incidental histologic finding
    - Code 150
      - Tumor identified by needle biopsy

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23

CS Extension – Clinical Extension: Prostate

- *Example:* Transurethral resection of prostate (TURP): Gleason 3 + 4 (7) adenocarcinoma of the prostate. Physician documents cT1 prostate tumor.
  - What is the code for CS Extension – Clinical Extension?
    - 100: Incidental histologic finding, number of foci or percent of involved tissue not specified
    - 130: Incidental histologic finding in 5 percent or less of tissue resected
    - 140:Incidental histologic finding in more than 5 percent of tissue resected
    - 150: Tumor identified by needle biopsy

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24

CS Extension – Clinical Extension: Prostate

- Clinically apparent tumor
  - Is palpable or visible by imaging
    - Clinician documentation of tumor, mass, or nodule of prostate
  - Includes physician assignment of cT2
  - Assigned codes 200 – 240
    - Use physical exam or imaging information to decide among codes 200-240
    - Do not use biopsy information

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25

CS Extension – Clinical Extension: Prostate

- *Example:* DRE showed palpable nodule on right lobe of prostate. TRUS guided biopsy showed adenocarcinoma in right and left lobes of prostate.
  - What is the code for CS Extension – Clinical Extension?
    - 200: Involvement in one lobe/side, NOS
    - 210: Involves one half of one lobe/side or less
    - 220: Involves more than one half of one lobe/side, but not both lobes/sides
    - 230: Involves both lobes/sides
    - 240: Clinically apparent tumor confined to prostate, NOS

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CS Extension – Clinical Extension: Prostate

- Assign code 300 (localized, NOS) if it is unknown if prostate tumor is clinically or radiographically apparent

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CS Extension – Clinical Extension: Prostate

- *Example*: Patient presents at facility A for treatment. Documented information: the patient was recently diagnosed with prostate cancer following a biopsy done because of elevated PSA.
  - What is the code for CS Extension – Clinical Extension?
    - 100: Incidental histologic finding, number of foci or percent of involved tissue not specified
    - 150: Tumor identified by needle biopsy
    - 240: Clinically apparent tumor confined to prostate, NOS
    - 300: Localized NOS

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Breast

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SSF1: Estrogen Receptor (ER) Assay
SSF2: Progesterone Receptor (PR)Assay

- Q: If multiple tissue samples are sent for ERA and one is negative and one is positive (all pre-operative) which result should we code in SSF1?
  - If any sample is positive record as positive per Note 1A preceding the codes and definitions for SSF1
- Q: Per Note 1D preceding codes for SSF1 (ERA) and SSF2 (PRA) we are not to code ERA and PRA results from multigene signature tests in SSF1 and/or SSF2. Why?
  - ERA and PRA measurements recorded in multigene signature test are not compatible with measurements coded in SSF1 and SSF2

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30

SSF10: HER2 FISH Lab Value
SSF11: HER2 FISH Interpretation

- *Case scenario:* HER2 FISH results from breast pathology specimen
  - Larger area (>25 mm): Negative for HER2/neu (ratio = 1.21)
  - Smaller area (20 mm): Positive for HER2/neu (ratio = 4.50)
- What is the code for SSF10?
  - 450
- What is the code for SSF11:
  - 010 (positive/elevated)

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Coding HER2 Test Results

- *Case scenario:* Patient has bilateral breast primaries. HER2 test was performed on specimen from the right breast.
- Do we record this HER2/neu result for the left sided primary as well?
  - Do not record results of HER2 from right breast primary in abstract of left breast primary

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Colon

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CS Lymph Nodes

- *Case scenario:* Path report for transverse colon adenocarcinoma states: "4 of 14 lymph nodes positive with lymph node positivity based on immunostain; in staging of other organs, these would be classified as ITCs. In any of the 1 to 4 LNs, there are between 1 and approximately 20 tumor cells." Clinician staged as N2a.
- What is the code for CS Lymph Nodes?
  - 000

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Lung

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CS Extension

- *Case scenario:* Left upper lung lobe malignancy that encircles and invades the carotid artery.
- Should CS Extension be assigned code 700 or code 800?
  - Code is dependent on which side of carotid is involved

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Brain

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SSF7: Surgical Resection

- Record details of surgical resection to primary of brain
  - Codes are similar to but NOT the same as surgical procedure of primary site codes

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SSF7: Surgical Resection

- Code 030
  - Radical, total, gross resection of tumor, lesion or mass in brain (Less than half of lobe involved with tumor)
- Code 040
  - Partial resection of lobe of brain (Tumor involves more than half of lobe)
- Code 055
  - Gross total resection of lobe of brain (lobectomy) (Tumor involves more than half of lobe)

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SSF7: Surgical Resection

- *Scenario:* Procedure performed is craniotomy with total resection of tumor of the temporal lobe. The tumor involved more than half of the temporal lobe.
- What is the code for SSF7?
  - 020 (local excision of tumor)
  - 030 [total resection of tumor (less than half of lobe involved with tumor)]
  - 040 [partial resection of lobe of brain (tumor involves more than half of lobe)]
  - 090 (surgery, NOS)

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CorpusCarcinoma

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SSF8: Omentectomy

- *Scenario:* Patient admitted to hospital with adenocarcinoma of corpus uteri. Treatment included total abdominal hysterectomy, bilateral salpingo-oophorectomy, partial omentectomy, and bilateral lymph node dissection.
- What is the code for SSF8?
  - 000 (no omentectomy performed)
  - 010 (omentectomy performed)
  - 998 (no surgery performed)
  - 999 (unknown)

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General Questions

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Date of First Contact

- Q: A breast cancer patient had a lumpectomy at an outside hospital on 11/10.
- She was referred to our hospital for genetic counseling for BRCA (+) disease in 11/10.
- She then went for adjuvant chemotherapy at another facility.
- She came to our facility for a bilateral mastectomy in 6/11 because of the BRCA (+). Tissue was negative for Cancer.
  - *Is the Date of First Contact 11/10 for the genetic counseling or 6/11 for the mastectomies? She was identified from pathology report review in 6/11.*

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Date of First Contact

- A: According to the instructions in FORDS if the patient was diagnosed at another facility, the date of first contact for your facility is the date TREATMENT BEGAN *(date she became analytic)* at your facility.
- The Date First Contact for this patient would be 6/11.

CAnswer Forum

Cingram

http://cancerbulletin.facs.org/forums/showthread.php?2319-Date-of-First-Contact&highlight=contact

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Date of First Contact

- Q: A patient undergoes a biopsy in a staff physician's office on September 12, 2010.
- The pathology specimen was sent to my facility and was read as malignant melanoma.
- The patient comes to my facility on September 16, 2010 for a wide reexcision.
  - *What is Date First Contact?*

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Date of First Contact

- A: The Date of First Contact is the date the case became analytic to your facility. This case became analytic to your facility on September 16, 2010.
  - Date of First Contact 9/16/10

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Date of First Contact

- Q: Patient came in with signs and symptoms of cancer on May 1, 2011, but didn't get a biopsy for a few days after admission for diagnosis.
  - *Should the date of the biopsy be used as the date of first contact instead of the admission date?*

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Date First Contact

- A: If the patient was diagnosed at biopsy, then the date of first contact would be the date of the biopsy, not the date of admission.

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Date of Diagnosis

- Q: Patient had a prostate biopsy done at our facility in 2008 and was told the biopsy was benign. In 2010 the patient presented to our facility with new symptoms. Our facility reviewed the 2008 biopsy and found that it was misread and that malignancy was present.
  - *What is the Date of Diagnosis?*

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Date of Diagnosis

- A: If the physician states that in retrospect the patient had cancer at an earlier date, use the earlier date as the date of diagnosis. The date of diagnosis would be the date of the 2008 biopsy.

Anna Delev, RHIT, CTR
User Support Specialist, NCDB
http://cancerbulletin.facs.org/forums/showthread.php?1807-Date-of-diagnosis-on-a-prior-misdiagnosis&highlight=retrospect

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Date of Diagnosis

- Q: A patient had a total hysterectomy and a bilateral salpingo oophorectomy (BSO) in June 2010 with pathology diagnosis of papillary cystadenoma of the ovaries.
- In December 2010 the patient is diagnosed with widespread metastatic papillary cystadenocarcinoma.
- The slides from June 2010 are not re-reviewed and there is no physician statement saying the previous tumor was malignant.
  - *What is the date of diagnosis?*

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Date of Diagnosis

- A: The diagnosis date would be December of 2010. Do **not** back date the diagnosis…
  - When the information on the previous tumor is unclear **AND/OR**
  - There is **no review** of previous slides **AND/OR**
  - There is **no physician's statement** that, in retrospect, the previous tumor was malignant

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Anna Delev, RHIT, CTR
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http://cancerbulletin.facs.org/forums/showthread.php?1807-Date-of-diagnosis-on-a-prior-misdiagnosis&highlight=retrospect

Class of Case

- Q: What is the difference between class of case 10 and classes of case 13 and14?

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Class of Case

- A: Class of case code 10 is less specific than codes 13 and 14 and acts like an NOS code.
  - All class 1 cases diagnosed prior to 1/1/10 were converted to class 10.
  - Class 10 is also used if a patient is diagnosed at your facility, and you don't know what happened to the patient after that.
  - Code 13 is used if the patient was diagnosed at your facility and received part of first course treatment at your facility.
  - Code 14 is used if the patient was diagnosed at your facility and received all first course treatment at your facility.

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Class of Case

- Q: A patient is diagnosed by ambiguous terminology at another facility in 2011. The patient then comes to our facility for a biopsy which histologically confirms a positive diagnosis of cancer.
  - *What is the Class of Case?*

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Class of Case

- If the patient has not been initially diagnosed or treated at your facility and you do not have the info where the patient got treated or whether treatment was refused elsewhere, this is not reportable to CoC.
  - If it is not required by your state central registry, it is your facility's choice to abstract or not.

    Anna Delev, RHIT, CTR
    User Support Specialist
    CAnswer Forum

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Class of Case

- Q: A patient was diagnosed with lung cancer and mediastinal adenopathy at another facility.
- The patient presented to my facility and had a mediastinoscopy with a biopsy of a single mediastinal lymph node that was positive for metastatic lung cancer.
- The patient then went elsewhere for chemotherapy. No additional treatment done"
  - *Is the Class of Case 30 (workup here, no treatment) or 21 (LN biopsy coded as treatment)?*

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Class of Case

- This should be coded as a Class of Case 30 since the patient was seen at your facility only for confirmation of another facility's diagnosis.

Anna Delev, RHIT, CTR
User Support Specialist
CAnswer Forum
http://cancerbulletin.facs.org/forums/showthread.php?2062-Class-of-Case-and-LN-biopsy&highlight=surgery

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Class of Case

- Q: We have a case where the patient was diagnosed with metastatic liver cancer by CT scan at one hospital and went to another facility for liver biopsy which was positive for metastatic disease.
- The patient came to our hospital for a port placement and was later treated by our physician in his office with chemotherapy.
  - *What class of case should be assigned?*

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Class of Case

- A: The patient was diagnosed elsewhere, came to your facility for insertion of mechanical device, and treated elsewhere (private physician office). This is a class of case 31 to your facility. I would not report unless your state requires reportable-by agreement cases.

Anna Delev, RHIT, CTR
User Support Specialist, NCDB
CAnswer Forum
http://cancerbulletin.facs.org/forums/showthread.php?1941-What-is-the-class-of-case&highlight=class+case

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Class of Case

- Q: A patient is admitted to our facility for myocardial infarction.
- H&P states patient was recently diagnosed with lung cancer and is undergoing chemo/radiation at another facility.
- Patient has cancer so I'm required to submit info to our state registry.
  - *What Class of Case should I use since we didn't treat for the cancer only for his MI?*

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Class of Case

- A: It is Class of Case 32 - patient is diagnosed elsewhere, and presents at your facility with persistence of disease (active), but not treated.
  - If he were continuing chemo/radiation started elsewhere and presents to your facility so as not to interrupt treatment, then it would be class of case 31 (transient).
  - If he had a history of lung cancer (not current), class of case would be 33 would be assigned.

Anna Delev, RHIT, CTR
User Support Specialist, NCDB
CAnswer Forum
http://cancerbulletin.facs.org/forums/showthread.php?849-Class-of-case-31-or-33&highlight=class+case

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Diagnostic Confirmation

- Q: Could you please make mention of appropriate use of code (5) positive laboratory test/marker study?

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Diagnostic Confirmation

- Code 5 should be used if a positive laboratory test/marker study is the only diagnostic confirmation of the disease.
  - For example; if the disease were diagnosed by JAK2 , but not by bone marrow blood smear, code 5 would be used.
- Code 3 should be used if there is a positive histology plus positive immunophenotyping and/or positive genetic studies
  - For example, bone marrow examination is positive for acute myeloid leukemia. (9861/3) Genetic testing shows AML with inv(16)(p13.1q22) (9871/3).
  - *Code 3 is only used for hematopoietic and lymphoid neoplasms*

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Diagnostic Confirmation

- Q: Bone marrow biopsy done on 2/11/10:
  - Mild trilineal dysplastic changes in conjunction with chronicity of cytopenias is worrisome for myelodysplastic syndrome.
  - Cytogenetics + for 5q deletion, clinicopathologic correlation required for final diagnosis.
- On 2/25/10 the physician confirms Refractory cytopenia with multilineage dysplasia.
  - *Is the date of diagnosis 2/11/10 with diagnostic confirmation of 3 or 2/25/10 w with diagnostic confirmation of 8?*

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Diagnostic Confirmation

- A: The date of diagnosis is 2/25/10 and diagnostic confirmation is 8.
  - As the cytogenetics state, you need clinicopathologic correlation to get an actual diagnosis; there is no actual diagnosis from the bone marrow. The cytogenetics were done (the pathologic part) and then the physician confirmed refractory cytopenia with multilineage dysplasia 9985/3 (the clinical part).

    SEER SINQ

    20110009

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Multiplicity Counter

- Q: If a patient presents for core biopsies of the prostate and tumor is only found in one lobe, how should I code the multiplicity counter?

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Answer

- A: Although it appears the tumor is confined to one lobe, we still don't know if there is one tumor or multiple tumors in that one lobe. Therefore the multiplicity counter should be coded 99 (unknown).

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Multiplicity Counter

- Q:What if the patient has a prostatectomy and pathology indicates adenocarcinoma is present, but does not indicate if a single tumor or multiple tumors are present.
  - *How should I code the multiplicity counter?*

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Multiplicity Counter

- A: Just as in the previous scenario, we still don't have a confirmation of the number of tumors present in the prostate. Therefore the multiplicity counter must be coded 99 (unknown).

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Date of Multiple Tumors

- Q: If I have a patient with prostate cancer and I can't determine if there is a single or multiple tumors present (Multiplicity Counter is 99), how should I code Date of Multiple Tumors?

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Date of Multiple Tumors

- A: If the number of tumors is unknown or it is unknown if there is a single or multiple tumors present (code 99 in Multiplicity Counter), enter the date of diagnosis in the Date of Multiple Tumors field.
  - 2007 MP/H Multiple Primary Rules, page 341c

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Type of Multiple Tumors

- Q: If one breast tumor is described as infiltrating ductal carcinoma and ductal carcinoma in situ and the infiltrating portion is given a specific size, is this one tumor assigned code 00 (single tumor) or code 30 (in situ and invasive tumors) in types of multiple tumors?

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Type of Multiple Tumors

- A: If it is a single tumor with both in situ and invasive portions, assign code 00 in types of multiple tumors, even if the invasive portion is measured.

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Multiple Primary Rules

- Q: 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.*

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Multiple Primary Rules

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

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Multiple Primary Rules

- Rule M3 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.

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Multiple Primary Rules

- Q: Patient was diagnosed in 2007 with transitional cell carcinoma of the ureter. There are recurrences of transitional cell carcinoma in 2008 and 2009. In 2010 the patient is diagnosed with transitional cell carcinoma of the ureter.
  - *Is this a new primary?*

Rule M7

Tumors diagnosed **more than three (3) years** apart are multiple primaries

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Multiple Primary Rules

- A: No, this would not be a second primary.
  - In order for rule M7 to apply the patient must be clinically free-of-disease during that three-year interval.

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Multiple Primary Rules

- Q: In the following situation would rule H12 apply or rule H14?
  - Two bladder tumors diagnosed at the same time. One is papillary urothelial carcinoma invading the muscularis mucosa the other urothelial nos invading the muscularis propria (more invasive of the two).

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Multiple Primary Rules

- A: H12 would apply (the first rule that fits the case).
  - When there is both papillary and transitional cell/urothelial CA, they are coded to 8130, papillary transitional cell carcinoma, even if multiple tumors (one papillary, the other urothelial CA).

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Multiple Primary Rules

- Q: 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 a polyp (the time frame is very short - 2 weeks)?

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Multiple Primary Rules

- A: 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.

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Multiple Primary Rule

- Q: I have a patient with history of papillary transitional cell carcinoma of the bladder diagnosed in 2009. They just recently presented for a TURB and were found to have another papillary transitional cell carcinoma of the bladder.
  - Does rule M6 apply?

Rule M6

Bladder tumors with any combination of the following histologies: papillary carcinoma (8050), transitional cell carcinoma (8120-8124), or papillary transitional cell carcinoma (8130-8131), are a single primary. *

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Multiple Primary Rules

- A: Yes.
  - Any combination means the tumors can be the same or they can be different histologies as long as they are listed in rule M6.

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Multiple Primary Rules

- Q: Should the primary site be changed to C68.9 (Urinary system, NOS) for a primary renal pelvis tumor after additional tumors are found months later in different urinary sites (e.g., bladder or ureter) and the MP/H Rules indicate these are all the same primary?

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Multiple Primary Rules

- A: This is a single primary per rule M8. The primary site was coded to C659 in 2008. Do not change the primary site code.
  - *SEER SINQ Question 20100025*

Rule M8

Urothelial tumors in two or more of the following sites are a single primary* (See Table 1)

Renal pelvis (C659)

Ureter(C669)

Bladder (C670-C679)

Urethra /prostatic urethra (C680)

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Multiple Primary Rules

- Q: Is a benign brain tumor that recurs as a malignant tumor one or two primaries? What rule is used to determine this?

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Multiple Primary Rules

- A: This would be considered a second primary per rule M3
  - Rule M3
    - An invasive brain tumor (/3) and either a benign brain tumor (/0) or an uncertain/borderline brain tumor (/1) are always multiple primaries.

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Multiple Primary Rules

- Q: A patient with a history of breast cancer diagnosed in 2005 presented in 2011 with an enlarged axillary lymph node.
- The lymph node was biopsied and found to be cancer.
- The oncologist referred to this as metastasis. He said it was a recurrence from the patients 2005 breast primary.
  - *Would this be considered a second primary? If so, which MP/H rule would I use?*

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Multiple Primary Rules

- A: No, this would not be a second primary.
  - Do not use the 2007 MP/H rules for tumors described as metastases. This means that you don't use the rules for:
    - Regional LN metastases
    - Discontinuous metastases in regional sites
    - Distant metastases
    - Metastases to distant LN
  - See note 1 under the Multiple Tumors header

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Histology Rules

- Q: I have a patient who had a recent excisional biopsy that revealed a single tumor with invasive ductal carcinoma with solid and papillary features. Would I consider solid and papillary subtypes of ductal carcinoma even though they are not listed in Table 2?

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Histology Rules

- A: Rule H15 would apply
  - Rule H15:Code the histology with the numerically higher ICD-O-3 code when there are two or more specific duct carcinomas.
- Both solid (8230) and papillary(8503) are listed in Table 1 as specific intraductal carcinomas. The note preceding Table 1 states:
  - ***Note:*** *These are the most common specific intraductal carcinomas**.** This is not intended to be a complete list of all possible intraductal types. If a histology appears only on table 1, it does not mean that it is impossible for that histology to occur with a malignant behavior (/3).*
- Code this tumor to 8503/3

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Histology

- Q: I have a patient who had a recent excisional biopsy that revealed a single tumor with invasive ductal carcinoma with neuroendocrine features.
  - *Should I code this to ductal carcinoma (8500/3) or neuroendocrine carcinoma (8246)?*
  - *Which rule would apply?*

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Histology

- A: The rule that would apply is rule H17 and the correct code would be 8523/3.
  - Rule H17 Code 8523 (duct mixed with other types of carcinoma) when there is a combination of duct and any other carcinoma (Table 3).
  - Neuroendocrine is not listed as a duct carcinoma on either table 1 or table 2.

SEER SINQ

20110097

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Histology Rules

Q: Is the correct code for the scenario below 8500/3 (Ductal Carcinoma) or 8530/3 (Inflammatory Carcinoma)?

- Final Diagnosis: infiltrating ductal carcinoma.
  Note: patient had neoadjuvant chemo for inflammatory carcinoma.

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Histology Rules

- A: Assign code 8500/3.
  - Although the pathologist mentioned inflammatory carcinoma on the pathology report, the note is a clinical description.

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Histology Rules

- Q: In the following situation would rule H12 apply or rule H14?
  - Two bladder tumors diagnosed at the same time.
    - One is papillary urothelial carcinoma invading the muscularis mucosa.
    - The other is urothelial carcinoma, nos invading the muscularis propria (more invasive of the two).

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Histology Rules-Bladder

- Rule H12 Code 8130 (papillary transitional cell carcinoma) (Table 1 – Code 8130) when there is:
  - Papillary carcinoma or
  - Papillary transitional cell carcinoma or
  - Papillary carcinoma and transitional cell carcinoma
- Rule H14 Code the histology of the most invasive tumor.
  - If one tumor is in situ and one is invasive, code the histology from the invasive tumor.
  - If both/all histologies are invasive, code the histology of the most invasive tumor.

NAACCR

Histology rules

- A: H12 would apply (the first rule that fits the case).
  - When there is both papillary ad transitional cell/urothelial CA, they are coded to 8130 papillary transitional cell carcinoma even if multiple tumors (one papillary, the other urothelial CA).

    Carol Johnson, SEER

NAACCR

Histology Rules

- The final diagnosis on a pathology report from radical orchiectomy is mature teratoma.
  - The report does not state "malignant" but pathologist's comment states "testicular teratomas in adults are NOT designated as benign tumors."
  - Should I apply this statement to all cases of adult testicular teratomas and code as 9080/3? Index pg. states 9080/0 for "teratoma, adult" and "teratoma, mature."

NAACCR

Histology Rules

- All adult (post-puberty) pure mature teratomas tumors are malignant; code to 9080/3. This does NOT apply to children (pre-puberty); pure teratoma in children which is not always malignant.

(*I & R Team*)
47678
6/11/10

NAACCR

Histology Rules

- Q: Could you provide further guidance on rule H6 in benign brain module.
  - *Does path need to indicate "uncertain behavior" and that simply having multiple meningioma's is NOT coded 9530/1?*

NAACCR

Histology Rules

- A: Use 9530/1 only for meningiomas with uncertain behavior; do not use this code for multiple benign or malignant meningiomas.
  - This is a rare condition that is usually associated with neurofibromatosis type 2 and other genetic disorders.

Rule H6 Code multiple meningiomas of uncertain behavior to 9530/1

- *Note 1:* This is a rare condition that is usually associated with neurofibromatosis type 2 and other genetic disorders
- *Note 2*: Use this code only for meningiomas with uncertain behavior; do not use this code for multiple benign or malignant meningiomas

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Grade

- Q: I have a prostate cancer patient that had a core needle biopsy of the prostate that came back as Gleason 3+4.
- The patient then had a prostatectomy that came back with Gleason 3+3.
  - *Should I code grade based on the higher histology or the one from the most representative specimen?*

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Grade

- A:Per the instructions in FORDS 2011 page 103, code the highest grade when pathology reports list more than one tumor grade.
  - The rule for coding from the pathology of most representative tumor specimen is from the MP/H coding rules for histology.
    - The MP/H rules are not used for coding grade.

NAACCR

Grade

- Q: The AJCC 7th Edition chapter on prostate shows a different interpretation of Gleason Score for grade.
  - It shows Gleason 6 as well differentiated.
  - *Which way should grade be coded?*

NAACCR

Grade

- A: The grade data item (NAACCR item # 440) should be coded using instructions from FORDS or the SEER Program Coding and Staging Manual, not the AJCC Cancer Staging Manual.

NAACCR

Grade

- Q: I have a patient that is presenting to my facility for treatment and all I know is that the patient has follicular lymphoma (9690/3). How should I code grade?

NAACCR

Grade

- A: Instructions for coding grade are included in the Hematopoietic Coding Manual.
  - According to Rule G6, 9690/3 should be assigned a grade of 6 (B-cell).

NAACCR

Grade

- Q: How should Grade be coded for urothelial bladder cancers when the pathologic diagnosis is "high grade" (or low grade) "papillary urothelial carcinoma of the bladder"?

NAACCR

Grade

- A: Per the FORDS 2011 Manual page 11…
  - If the only grade information available for urinary bladder (C67._), colon, rectosigmoid junction, rectum (C18.0–C20.9), or heart (C38.0) is supplied as a two-grade system ("high" or "low"), convert them as shown below.

Code	Terminology	Histologic Grade
2	Low Grade	1/2
4	High Grade	2/2

NAACCR

Diagnostic Staging Procedure

- Q: Can you explain the difference between coding a diagnostic biopsy of a lymph node for a lymphoma versus a solid tumor?

NAACCR

Diagnostic Staging Procedure

- A: For lymphoma cases, a biopsy of a lymph node for diagnostic purposes should be coded as a diagnostic staging procedure code 01.
  - The exception would be if the lymph node removed was the only lymph node involved with lymphoma. In that situation the biopsy would be considered treatment, and the procedure would be coded under surgery of primary site using surgery code 25.

NAACCR

Diagnostic Staging Procedure

- A: For solid tumors, biopsies of lymph nodes (incisional or excisional) are always coded under Scope of Regional Lymph Nodes.
  - Even if the intent is diagnostic or for staging purposes, the information is collected in Scope of Regional Lymph Nodes.

NAACCR

Surgery of Primary Site

- Q: How would you code an endoscopic mucosal resection for an esophageal and or a rectal primary?
  - Is 27 (excisional biopsy) an appropriate code?

NAACCR

Surgery of Primary Site

- A: Endoscopic mucosal resection (EMR) can directly resect full-thickness mucosa including epithelium, lamina propria, muscularis mucosa and 2/3 of submucosal layer of the esophagus or rectum.
  - For esophagus, surgical code in series 20; if not specified otherwise, code 20 NOS.
  - For rectum, same code in series 20.

Anna Delev, RHIT, CTR
User Support Specialist
CAnswer Forum

NAACCR

Surgery

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

NAACCR

Surgery

- A: 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.

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Surgery

- Q:If a patient with a urothelial bladder primary has a TURB followed immediately by BCG how would we code treatment?
  - Would we assign surgery as 27 and immunotherapy as 01 OR
  - Would we assign two surgical procedures and give one a code of 16 and the other a code of 27 and then also code immunotherapy as 01?

NAACCR

Bladder Surgery Codes

- 10 Local tumor destruction, NOS
  - 11 Photodynamic therapy (PDT)
  - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
  - 13 Cryosurgery
  - 14 Laser
  - 15 Intravesical therapy
  - 16 Bacillus Calmette-Guerin (BCG) or other immunotherapy
- 20 Local tumor excision, NOS
  - 26 Polypectomy
  - 27 Excisional biopsy
- Combination of 20 or 26–27 WITH
  - 21 Photodynamic therapy (PDT)
  - 22 Electrocautery
  - 23 Cryosurgery
  - 24 Laser ablation

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Surgery

- If any surgery with a code 20 or above also applies, it should be coded for surgery and the applicable systemic code also assigned.
- If a hospital performs multiple primary site surgeries, each successively is coded so that it includes all tissue previously surgically removed (BCG does not do its thing surgically).

Anna Delev, RHIT, CTR
User Support Specialist, NCDB

http://cancerbulletin.facs.org/forums/showthread.php?1798-TURB-followed-by-BCG&highlight=code+bladder

NAACCR

Radiation

- Q: If a thyroid cancer patient receives I-131 for radiation following thyroidectomy, what is the radiation treatment volume? (We have arguments going towards 2 different volume codes.) Thanks!

NAACCR

Radiation

- A: It is coded to whole body because it is systemic treatment and affects the whole body.
  - The I-131 is systemic radiation treatment, which is different from the loco-regional radiation therapy that is administered to the tissue of interest. In systemic radiation therapy, the patient swallows or receives an injection of a radioactive substance, such as radioactive iodine or other radioactive substance that travels throughout the body. The radiation using I-131 is coded to volume Whole Body.

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http://cancerbulletin.facs.org/forums/showthread.php?353-I-131-radiation-ablation-therapy-for-thyroid-CA&highlight=body

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Reason No Radiation

- A patient with a previous breast primary that was treated with surgery and radiation now presents with a second breast primary (per 2007 MP/H rules).
- The standard treatment for her second primary includes radiation, but due to the fact that she had previous radiation she is not eligible.
  - *Would reason for no radiation be 1 - not recommended or 2 - contraindicated?*

NAACCR

Reason No Radiation

- Code 2 (contraindicated) would be the correct code.
  - Code 2 is used if the patients past medical history affects 1st course of treatment plan.

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http://cancerbulletin.facs.org/forums/showthread.php?1961-Reason-no-radiation&highlight=radiation

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Questions?

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Coming up…

- October 6, 2011
  - Collecting Cancer Data: Larynx Including Mucosal Melanoma of Larynx
- Registration is still open for the 2011-2012 NAACCR Webinar Series
  - http://www.naaccr.org/EducationandTraining/WebinarSeries.aspx

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Thank You!!!!

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