

## Coding Pitfalls

NAACCR 2011-2012 Webinar Series  
9/6/12

1



---

---

---

---

---

---

---

---

## Q&A

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

Reminder:

- If you have participants watching this webinar at your site, please collect their names and emails.
  - We will be distributing a Q&A document in about one week. This document will fully answer questions asked during the webinar and will contain any corrections that we may discover after the webinar.

2



---

---

---

---

---

---

---

---

## Fabulous Prizes



3



---

---

---

---

---

---

---

---

### 2012 Checklist

- 2012 Hematopoietic Database and Manual
  - <http://seer.cancer.gov/seertools/hemelymph/>
- 2007 Multiple Primary and Histology Coding Rules
  - Revised August 24, 2012
- Collaborative Stage v02.04
  - Must be used for all cases diagnosed 1/1/2012 and after
  - Once conversion is complete, use for all cases

4




---

---

---

---

---

---

---

---

### 2012 Checklist

- Facility Oncology Registry Standards (FORDS): Revised for 2012
  - <http://www.facs.org/cancer/coc/fordsmanual.html>
- Cancer Program Standards 2012: Ensuring Patient-Centered Care
  - <http://www.facs.org/cancer/coc/programstandards2012.html#>
- SEER Program Coding and Staging Manual 2012
  - <http://seer.cancer.gov/tools/codingmanuals/>
- State Reporting Manuals

5




---

---

---

---

---

---

---

---

### 2012 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual

- Rule PH30
  - Code the primary site as multiple lymph node regions, NOS **C77.8** when multiple lymph node regions as defined by ICD-O-3 are involved and it is not possible to identify the lymph node region where the lymphoma originated.
- Rule PH31
  - Code the primary site to lymph nodes, NOS **C77.9** when Multiple lymph node region(s) **and organ(s)** are involved AND No primary site (lymph node region or organ) is identified

6




---

---

---

---

---

---

---

---

**2012 Hematopoietic and Lymphoid Neoplasm  
Case Reportability and Coding Manual**

- Lymphoma Patient 1
  - CT showed lymphadenopathy throughout the neck, chest, and abdomen.
    - Code C77.8 Lymph Nodes NOS
- Lymphoma Patient 2
  - CT showed lymphadenopathy throughout the neck, chest, and abdomen. An additional mass was identified in the stomach. This is highly suspicious for lymphoma.
    - Code C77.9

7



---

---

---

---

---

---

---

---

**2012 Hematopoietic and Lymphoid Neoplasm  
Case Reportability and Coding Manual**

- Do not collect blood transfusions (whole blood, platelets, etc.) as treatment
- Collect phlebotomy for polycythemia vera ONLY
- Collect blood-thinners and/or anti-clotting agents for histologies listed on page 13 of the manual.

8



---

---

---

---

---

---

---

---

**2012 Hematopoietic and Lymphoid Neoplasm  
Case Reportability and Coding Manual**

- Q: A patient has a biopsy of a lymph node that comes back as nodular sclerosis classical Hodgkin lymphoma (9663/3). The pathologist then sends the specimen for immunophenotyping which confirms the diagnosis. Would the diagnostic confirmation be a 1 or 3? The hematopoietic database only lists histologic confirmation under Definitive Diagnostic Method.

9



---

---

---

---

---

---

---

---

**2012 Hematopoietic and Lymphoid Neoplasm  
Case Reportability and Coding Manual**

- A: Immunophenotyping is not required to definitively diagnose nodular sclerosis classical Hodgkin lymphoma. This test may have been done to rule out another type of lymphoma, but the bone marrow was enough to definitively diagnose this case. Assign code 1.

## Definitive Diagnostic Methods

Histological confirmation

Genetics

None

Immunophenotyping

CHL phenotype

10



---

---

---

---

---

---

---

---

**2012 Hematopoietic and Lymphoid Neoplasm  
Case Reportability and Coding Manual**

- Q: If a patient is diagnosed with chronic lymphocytic leukemia by FISH should the diagnostic confirmation code be "1"?
  - The patient did not have a bone marrow biopsy. Peripheral blood reveals a CD5 positive monoclonal B cell population
  - FISH analysis was consistent with chronic lymphocytic leukemia.

11



---

---

---

---

---

---

---

---

**2012 Hematopoietic and Lymphoid Neoplasm  
Case Reportability and Coding Manual**

- A: The diagnostic confirmation should be 5-positive marker study
  - The peripheral blood smear was not diagnostic of CLL

12



---

---

---

---

---

---

---

---

### 2012 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual

- Q: What rules do I use to assign the primary site and histology to the case below?
  - 1/13/12-A patient has an axillary lymph node dissection and is found to have two lymph nodes with Diffuse large B-cell lymphoma (9680/3) and four lymph nodes with Follicular Lymphoma (9690/3)

13




---

---

---

---

---

---

---

---

### 2012 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual

1. Assign a provisional code to each histology
  - Diffuse large B-cell lymphoma (9680/3)
  - Follicular Lymphoma (9690/3)
2. Determine if one primary or two
  - Per rule M5 this is one primary
3. Assign the primary histology (Module 6)
  - Per rule PH16 the histology is diffuse large B-cell lymphoma (9680/3)
4. Assign the primary site
  - Per rule PH16 assign primary site to axillary lymph nodes (C77.3)
  - If additional assistance is needed refer to Module 7

14




---

---

---

---

---

---

---

---

### 2012 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual

- 1/1/12-A patient has a biopsy of a lymph node in the groin that is positive for chronic lymphocytic leukemia/small lymphocytic lymphoma. Imaging showed adenopathy in the iliac and inguinal region. Bone marrow biopsy was negative.
  - Histology
    - 9823/3 per module 3 rule PH8
  - Primary Site
    - C77.8 per rule module 7 rule Ph30
  - Grade
    - B-cell per rule G3/ Hematopoietic Database

15




---

---

---

---

---

---

---

---

## High Grade Dysplasia/Neoplasia of GI Sites

- IARC WHO ICD-O-3 2012 updates
  - Updates have not yet been accepted by US standard setters
    - In situ behavior includes 'high grade dysplasia/neoplasia' for specific histologies: 8077/2, 8148/2, 8453/2, 8470/2, 8503/2
    - NAACCR workgroup created to plan implementation
  - Canadian Council of Cancer Registries recommended collection of high grade dysplasia/neoplasia of GI system sites for 2012 cases

16




---

---

---

---

---

---

---

---

## Scope of Regional Lymph Node Surgery

- Extensive revisions to coding instructions
  - Effective for cases diagnosed in 2012 and later
  - Agencies involved: ACoS/CoC, NCI/SEER, CDC/NPCR, NAACCR
- Background report with reasons for new instructions
  - <http://www.facs.org/cancer/coc/fordsmanual.html>
- Scope it Out: A Change in Sentinel Lymph Node Surgery Coding Practice, Jerri Linn Phillips, MA, CTR; Andrew Stewart, MA. Journal of Registry Management 2012 Volume 39 Number 1

17




---

---

---

---

---

---

---

---

## Scope of Regional Lymph Node Surgery

- Record removal, biopsy, or aspiration of regional lymph nodes
  - Performed at time of surgery of primary site or during separate surgical event
  - Performed in an effort to diagnose or stage disease
  - If 2 or more lymph node procedures are performed, each subsequent procedure must include cumulative effect of all preceding procedures

18




---

---

---

---

---

---

---

---

### Scope of Regional Lymph Node Surgery

- Record removal, biopsy, or aspiration of regional lymph nodes
  - Use **operative report** as primary source to determine if procedure was sentinel lymph node biopsy or more extensive dissection or combination of both
    - Path report may complement information
    - Breast
      - Sentinel lymph node biopsy (SLNBx) vs. axillary lymph node dissection (ALND) vs. both SLNBx and ALND

19



---

---

---

---

---

---

---

### Scope of Regional Lymph Node Surgery

- Code 0: No regional lymph node surgery
- Code 1: Biopsy or aspiration of regional lymph nodes
  - If excisional biopsy or aspiration AND additional procedures performed, use appropriate code 2-7

20



---

---

---

---

---

---

---

### Pop Quiz

- Patient presents with an enlarged axillary lymph node. A fine needle aspiration is performed and the pathology report indicates ductal carcinoma. The patient goes to a different hospital for additional work-up and treatment
  - How do we code the fine needle aspiration?
    - Scope of Regional Lymph Node Surgery code 1
    - Diagnostic/Staging Procedure code 01

21



---

---

---

---

---

---

---

## Scope of Regional Lymph Node Surgery

- Code 2: Sentinel Lymph Node Biopsy (SLNBx)
  - Op report describes procedure using injection of dye, radio label, or combination to identify lymph node(s) for removal
  - Additional non-sentinel nodes may be removed as part of SLNBx
  - Breast
    - Confirm from op report that procedure was SLNBx if large number of nodes (5 or more) pathologically examined
    - SLNBx fails to map and no sentinel nodes removed and no ALND

22

NAACCR

---

---

---

---

---

---

---

---

## Scope of Regional Lymph Node Surgery

- CENTRAL REGISTRIES ONLY
  - If you do not have access to the operative report and the path report does not contain enough information, use code 2 (SLNBx) when a small number of lymph nodes was examined and none were positive.
    - This note is not in FORDS and should not be applied by CoC accredited programs.
      - Scope it Out: A Change in Sentinel Lymph Node Surgery Coding Practice, Jerri Linn Phillips, MA, CTR; Andrew Stewart, MA. Journal of Registry Management 2012 Volume 39 Number 1

23

NAACCR

---

---

---

---

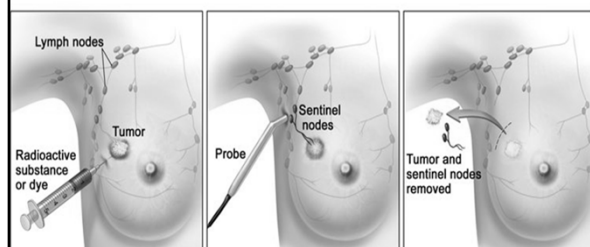
---

---

---

---

## Sentinel Lymph Node Biopsy



24

NAACCR

---

---

---

---

---

---

---

---



### Scope of Regional Lymph Node Surgery

- Code 3
  - Number of regional nodes removed unknown or not stated; regional nodes NOS removed
- Code 4
  - 1-3 regional lymph nodes removed
- Code 5
  - 4 or more regional lymph nodes removed

25




---

---

---

---

---

---

---

---

### Scope of Regional Lymph Node Surgery

- Code 6:
  - Sentinel node biopsy & code 3, 4, or 5 at same time or timing not stated
- Code 7:
  - Sentinel node biopsy and code 3, 4, or 5 at different times
- Code 9:
  - Unknown or not applicable

26




---

---

---

---

---

---

---

---

### Scope of Regional Lymph Node Surgery

- *Example*
  - 3/1/12 Op report: Right breast lumpectomy with sentinel node biopsy (2 nodes)
    - Path report: 4 cm ductal carcinoma with margins involved; 2 of 2 nodes positive for metastatic carcinoma
  - 3/15/12 Op report: Modified radical mastectomy with axillary node dissection
    - Path report: Ductal carcinoma; 1 of 6 axillary nodes positive for metastasis

27




---

---

---

---

---

---

---

---

### Scope of Regional Lymph Node Surgery

#### Procedure 1

- Surgery of Primary Site
  - 22
- Scope of Regional Lymph Node Surgery
  - 2
- Surgical Procedure/Other Site
  - 0

#### Procedure 2

- Surgery of Primary Site
  - 51
- Scope of Regional Lymph Node Surgery
  - 7
- Surgical Procedure/Other Site
  - 0

28




---

---

---

---

---

---

---

---

### Scope of Regional Lymph Node Surgery

- Pathology Report
  - Procedure: Modified Radical Mastectomy
  - Tumor Size: 2.1cm
  - Lymph Nodes Examined: 12
  - Lymph Nodes with Metastasis: 3
- Based on this information, what is Scope of Regional Lymph Node Surgery?
- Operative Report
  - Sentinel lymph node biopsy, mastectomy, axillary node dissection.
- What is Scope of Regional Lymph Node Surgery?

29




---

---

---

---

---

---

---

---

### Pop Quiz

- Operative Report
    - Sentinel lymph node biopsy
  - Path Report
    - Specimen: Axillary lymph nodes
      - Three axillary lymph nodes were removed. No metastasis identified.
- How would we code Scope of Regional Lymph Node Surgery?
- 2 Sentinel lymph node biopsy
  - 4 1-3 regional lymph nodes removed
  - 6 SLNBx and code 3,4, or 5 at same time or timing not stated

30




---

---

---

---

---

---

---

---

**Scope of Regional Lymph Node  
Surgery/Class of Case**

- Coding information in Scope of Regional Lymph Node Surgery does not necessarily qualify as “treatment” when coding Class of Case.

31



---

---

---

---

---

---

---

---

**Scope of Regional Lymph Node  
Surgery/Class of Case**

- Patient presents to Hospital A with an enlarged cervical lymph node.
- A fine needle aspiration is performed and the pathology returns as adenocarcinoma, most likely from an esophageal primary.
- The patient goes to Hospital B for additional work-up and treatment.

32



---

---

---

---

---

---

---

---

**Scope of Regional Lymph Node  
Surgery/Class of Case**

- Surgery of Primary Site
  - 00
- Scope of Regional Lymph Node Surgery
  - 1
- Surgical Procedure/Other Site
  - 0
- Class of Case
  - 00 Initial diagnosis at the reporting facility AND all treatment or a decision not to treat was done elsewhere

33



---

---

---

---

---

---

---

---

### Scope of Regional Lymph Node Surgery

- Summary
  - Use the operative report to code Scope of Regional Lymph Node Surgery
  - The code should reflect when a sentinel lymph node procedure is done at the same time as an axillary node dissection (code 6)
  - The code should reflect when a sentinel lymph node procedure is done and a different time than an axillary node dissection (code 7)
  - A sentinel lymph node procedure that fails to map and does not result in the removal of any lymph nodes should still be coded in Scope of Regional Lymph Node Surgery
  - Scope of Regional Lymph Node Surgery does not necessarily effect class of case

34



---

---

---

---

---

---

---

### Grade

- CoC
  - New coding instructions in FORDS
    - See “Overview of Coding Principles” pages 10-13
    - “Grade/Differentiation” pages 99-100
    - “Grade Path System” and “Grade Path Value” 101-102

35



---

---

---

---

---

---

---

### Grade

- Some state or regional registries require recording or converting special grades or Grade Path System and Grade Path Value for Grade/Differentiation; if you are required to do so, use the instructions provided by that source.

FORDS 2012  
Page 12

36



---

---

---

---

---

---

---

### Hematopoietic and Lymphatic Grades

1. All hematopoietic and lymphatic cancers must be coded 5-8 or 9 in accordance with the current Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual.
  - Code this lineage information in the data item *Grade/Differentiation*.
  - Leave the items *Grade Path System* and *Grade Path Value* blank.

37



---

---

---

---

---

---

---

### Special Grades

2. Code all special grades that are collected as part of the Collaborative Stage Data Collection System according to the current CS coding instructions.
  - Do NOT code the special grades in the data item *Grade/Differentiation*.
  - Do NOT code special grades in the *Grade Path System* and *Grade Path Value* items.
  - See page 11 of FORDS for list of Special Grades Coded in the Collaborative Stage Data Collection System.

38



---

---

---

---

---

---

---

### Grade Path System/Grade Path Value

3. If a known grade (other than a hematopoietic and lymphatic grade or a special grade coded in CS) is available in numeric form and the number of grades in the system is known, code these two values in *Grade Path System* and *Grade Path Value*.
  - If the pathology record indicates both the *Grade Path System* and *Grade Path Value*, code the histologic grade in those items, and code *Grade/Differentiation* 9.
  - If the grade system is not available, leave these items blank and code the value indicated in the *Grade/Differentiation* item, as described in the table on page 12 of the FORDS Manual.

39



---

---

---

---

---

---

---

## All Other Grades

4. If the grade cannot be recorded according to instructions 1 through 3, apply the following to code Grade/Differentiation.
- Use the table on page 12 of FORDS for verbal descriptions or when a grade is found in the record without specification of number of grades in the grading system, and when a special grade does not apply.
  - If sufficient information is available to code Grade Path System and Grade Path Value, code Grade/Differentiation 9.

40




---

---

---

---

---

---

---

---

## Example 1

- 1/15/12 TRUS and biopsy: Prostate adenocarcinoma; Gleason 3+4=7 right lateral mid gland, 4+3=7 right lateral base; only 2 cores positive.
- 2/1/12 Prostatectomy: Prostate adenocarcinoma; Gleason 4+4=8, tertiary 3

41




---

---

---

---

---

---

---

---

## Example 1

### State registry follows CoC

- Grade coded to: 9
- Grade path value coded to: (Blank)
- Grade path system coded to: (Blank)
- SSF 7: 043
- SSF 8: 007

Gleason Conversion Table

Gleason Score	Gleason Pattern	Histologic Grade	Terminology	SEER Code
2, 3, 4	1, 2	I	Well differentiated	1
5, 6	3	II	Moderately differentiated	2
7, 8, 9, 10	4, 5	III	Poorly differentiated	3

42

### State registry requires conversion

- Grade coded to: 3 poorly diff
- Grade path value coded to: (Blank)
- Grade path system coded to: (Blank)
- SSF 7: 043
- SSF 8: 007

---

---

---

---

---

---

---

---

### Example 2

- Moderately differentiated ductal carcinoma  
Bloom Richardson Score of 4.
  - Grade coded to: 2
  - Grade path value coded to: (Blank)
  - Grade path system coded to: (Blank)
  - SSF 7: 040

43




---

---

---

---

---

---

---

---

### Example 3

Adenocarcinoma of the cecum grade 1 of 2.

- |  |  |
|--|--|
| <b>State registry follows CoC</b> <ul style="list-style-type: none"> <li>• Grade coded to: 9</li> <li>• Grade path value coded to: 1</li> <li>• Grade path system coded to: 2</li> </ul> | <b>State registry requires conversion</b> <ul style="list-style-type: none"> <li>• Grade coded to: 2</li> <li>• Grade path value coded to: 1</li> <li>• Grade path system coded to: 2</li> </ul> |
|--|--|

Two-Grade Conversion Table

Grade	Differentiation / Description	SEER Code
1/2, I/II	Low grade	2
2/2, II/II	High grade	4

44




---

---

---

---

---

---

---

---

### Date of Diagnosis

- Q: For the date of diagnosis when you have 'suggestive of cancer' in January and in February they do a biopsy that proves patient has cancer, what would your date of diagnosis be? Can you take it back to January, when 'cancer' was first mentioned?

45




---

---

---

---

---

---

---

---

### Date of Diagnosis

- A: The diagnosis date should be the date the cancer was proven using terminology that constitutes a diagnosis of cancer. In this case, the diagnosis date would be February unless the physician documents that in retrospect the patient had cancer at the earlier date.

46



---

---

---

---

---

---

---

### Date of First Contact

- Q: We were trained that date of 1st contact for a patient diagnosed during an inpatient admission should be the date of admission. Can you please confirm?

47



---

---

---

---

---

---

---

### Date of First Contact

- A: The Date of First Contact is the date of the facility's first inpatient or outpatient contact with the patient for diagnosis or treatment of the cancer.
  - For analytic cases, the Date of First Contact is the date the patient qualifies as an analytic case (Class of Case 00-22).
  - Usually, the Date of First Contact is the date of admission for diagnosis or for treatment.
    - If the patient was admitted for non-cancer-related reasons, the Date of First Contact is the date the cancer was first suspected during the hospitalization (FORDS 2012 page 4).

48



---

---

---

---

---

---

---



### Revising the Original Diagnosis

- Q: I have a patient that presented with widespread metastasis. Initial work-up failed to review the primary so I assigned primary site as C80.9. Nine months later the patient had a paracentesis that was positive for serous cystadenocarcinoma. Based on this the physician referred to this as an ovarian primary.
  - Can I still go back and change the primary site?

49



---

---

---

---

---

---

---

---

### Revising the Original Diagnosis

- Yes.
  - You will need to update
    - Primary site
    - Histology
    - Staging fields
    - Treatment fields
    - Any other relevant fields
  - Send an update to your Central Registry

50



---

---

---

---

---

---

---

---

### Ambiguous Terminology

- Q: If you have cytology that is suspicious for malignancy followed by a tissue biopsy that is positive for malignancy, is the diagnosis date the date of the cytology or tissue biopsy?
- A: The diagnosis date in this example would be the date of the positive biopsy.
  - If a cytology is identified only with an ambiguous term, do not interpret it as a diagnosis of cancer. Abstract the case only if a positive biopsy or a physician's clinical impression of cancer supports the cytology findings.
    - *FORDS Section 1 page 3*

51



---

---

---

---

---

---

---

---

### Ambiguous Terminology

- Q: “Mass” and “lesion” are synonymous terms with “neoplasm” and “tumor” for the multiple primary and histology (MPH) coding rules. Does that mean we should interpret them as reportable terms even though they are not on the list of reportable terms?

52



---

---

---

---

---

---

---

---

### Ambiguous Terms

- A: No.
  - Mass and lesion are synonymous with neoplasm and tumor when it comes to determining one primary or multiple primaries per the MPH rules.
  - The MPH rules **should not** be used to determine *reportability*.

53



---

---

---

---

---

---

---

---

### CS QUESTIONS

54



---

---

---

---

---

---

---

---

### CS Tumor Size/Ext Eval

- The underlying purpose of this field is to capture the staging basis for the highest T category assigned to the case.
- In the infrequent situation where there is both clinical and pathologic documentation of the same T category, **pathologic information takes priority.**
  - CS Manual Part I – Section 1 – Pages 38 and 39

55




---

---

---

---

---

---

---

---

### CS Tumor Size/Ext Eval

- Primary tumor of glottic larynx resected and pathologically extends into the subglottis. Impaired vocal cord mobility was diagnosed clinically.
- What is the code for CS Extension?
  - 300 (involves subglottis; maps to T2)
  - 350 (impaired vocal cord mobility; maps to T2)
- What is the code for CS Tumor Size/Ext Eval?
  - 3

56




---

---

---

---

---

---

---

---

### CS Extension – Colon & Rectum

- Q: The CS Extension codes in colon & rectum schemas for intramucosal derive a Summary Stage of local and a T value of Tis. Is it correct to make the behavior a /3?
  - For example, the code for intramucosal adenocarcinoma would be 8140/3, but the AJCC T category would be Tis.
- A: Yes; in the situation described the behavior code is 3. The CS data items will derive the correct AJCC T category and summary stage.

57




---

---

---

---

---

---

---

---

### CS TS/Ext Eval - Colon

- Q: What is the code for CS TS/Ext Eval when transanal endoscopic microsurgery (TEM) is performed?
- A: The intent of TEM is to remove the whole tumor. If more than just a sample of the tumor is removed, the CS TS/Ext Eval code should be 3.

58




---

---

---

---

---

---

---

---

### SSF6 – Colon & Rectum

- Q: What is the definition of circumferential resection margin (CRM), which is collected in SSF 6 for colon & rectum?
- A: The CRM is the measurement of the distance from the deepest invasion of the tumor to the closest soft tissue margin of the specimen. The CRM is the width of the surgical margin at the deepest part of the tumor in an area of the large intestine or rectum without serosa or only partly covered by serosa.

59




---

---

---

---

---

---

---

---

### SSF8 – Colon & Rectum

- Q: Is perineural invasion for colon, SSF8, coded based on any tissue such as biopsy or polypectomy?
- A: Perineural invasion can be coded from biopsy or polypectomy if it is documented, but it would be rare from biopsy.
- Q: If the only procedure performed on colorectal primary is a biopsy of the primary site, should SSF 8 (perineural invasion) be assigned code 998 (no histologic exam of primary site) or 999 (unknown)?
- A: If the only procedure was biopsy and there was no mention of perineural invasion, assign code 999 for SSF8.

60




---

---

---

---

---

---

---

---

### CS Tumor Size - Lung

- Q: Are the CS rules still correct in reference to no hierarchy between different imaging tests of lung/chest; i.e. CT vs. x-ray?
- A: The following is documented in the instructions for coding CS Tumor Size found in Collaborative Stage Data Collection System User Documentation and Coding Instructions Part I Section 1 v02.03.02 and v02.04: "3d) Tumor size discrepancies among reports. If there is a difference in reported tumor size among imaging and radiographic techniques, record the largest size of tumor reported in the record, regardless of which imaging technique reports it."

61



---

---

---

---

---

---

---

### CS Extension - Lung

- Q: Does the term consolidation documented on imaging indicate atelectasis?
- A: Consolidation and atelectasis are not synonyms. Atelectasis of the lung is collapse of the lung. Consolidation of the lung is the filling of the air spaces within the lung. Consolidation is ignored for staging purposes.

62



---

---

---

---

---

---

---

### CS Extension & SSF2 - Lung

- Q: When you have clinical evidence of pleural invasion (but no exam of the pleura), do you still code the pleural invasion in CS Extension?
- A: Yes; clinical evidence of pleural invasion is coded in CS Extension. However, if there is clinical evidence of pleural invasion but no pathologic examination of the pleura, assign code 998 (no histologic exam of pleura) in SSF2 (Visceral Pleural Invasion (PL)/Elastic Layer).

63



---

---

---

---

---

---

---

**CS Mets at DX - Lung**

- Q: Lung primary with pleural effusion that was not biopsied; what are the guidelines?

64



---

---

---

---

---

---

---

---

**CS Mets at DX - Lung**

- A: Per Note 1 preceding the codes in the CS Mets at DX code table for lung:
  - “Most pleural and pericardial effusions with lung cancer are due to tumor. In a few patients, however, multiple cytopathologic examinations of pleural and/or pericardial fluid are negative for tumor, and the fluid is non-bloody and is not an exudate. Where these elements and clinical judgment dictate that the effusion is not related to the tumor, the effusion should be excluded as a staging element and the tumor should be classified as M0.”

65



---

---

---

---

---

---

---

---

**CS Mets at DX - Lung**

- Q: In reference to coding the data item, CS Mets at DX, for lung, what is considered multiple biopsies on the effusion - two or more?
- A: Yes; more than 1 cytopathologic examination of pleural and/or pericardial fluid is considered multiple.

66



---

---

---

---

---

---

---

---

### CS Mets at DX - Ovary

- Q: Please address the term 'carcinomatosis' for ovarian primaries. This term is listed under CS Mets at DX code 40 in the ovary CS schema. Should it ever be coded to CS Extension depending on the location of the 'carcinomatosis'?
- A: Carcinomatosis to pelvic or abdominal (intraperitoneal) organs with an ovarian primary should be coded in CS Extension as implant or seeding.

67



---

---

---

---

---

---

---

---

### SSF2 - Ovary

- Q: Is FIGO stage the same as FIGO grade? Pathologists here use only grade.
- A: No; FIGO stage and FIGO grade are not the same thing. FIGO stage describes the spread of the primary gynecologic cancer, and FIGO grade describes the structure and growth patterns of the cancer cells.

68



---

---

---

---

---

---

---

---

### CS TS/Ext Eval - Thyroid

- Q: If a patient receives hormone (synthroid) therapy prior to diagnosis of a papillary carcinoma of the thyroid, would the CS TS/Ext Eval code be 6 or 3 (entire thyroid was removed)? According to another post hormone treatment give prior to diagnosis should be considered first course treatment and the date treatment starts is the date of diagnosis.

69



---

---

---

---

---

---

---

---

### CS TS/Ext Eval - Thyroid

- A: The use of Synthroid in this case does not appear to be treatment related to the diagnosis of papillary carcinoma of the thyroid, as the patient received hormone therapy prior to the cancer diagnosis. We are also not aware of the use of hormone therapy as a neoadjuvant treatment for thyroid cancer; you could check treatment guidelines to help determine if a particular therapy is recommended as a neoadjuvant treatment. Code staging parameters as of the time of diagnosis and use Eval code of 3 if staging information obtained from the surgical specimen.

*CAnswer Forum – CTAP Team member*

70




---

---

---

---

---

---

---

---

### CS Lymph Nodes & CS Mets at DX - Melanoma

- Q: For primary unknown metastatic melanoma, you indicated that lymph nodes and subcutaneous/skin metastasis are regional unless there are other metastases. To clarify, if there are lymph node metastases and liver metastases, are the lymph nodes coded regional and the liver coded distant?
- A: If there is positive lymph node and liver metastasis from melanoma and primary site is unknown, code the lymph node involvement in CS Lymph Nodes and the liver metastasis in CS Mets at DX. See the CAnswer Forum thread concerning this issue at: <http://cancerbulletin.facs.org/forums/showthread.php?4771-Metastatic-Unknown-Primary-Melanoma&p=11169#post11169>

71




---

---

---

---

---

---

---

---

### SSF4 - Melanoma

- Q: Patient diagnosed with melanoma. Two serum lactate dehydrogenase (LDH) tests performed prior to treatment. The first test was elevated, and the second test was within normal limits. What is the code for SSF4, Serum LDH?
- A: The code for SSF4 is 000 (within normal limits). Note 2 preceding the codes for SSF4 in CS v02.04 states that 2 positive results are required to code a positive value in SSF4. If the 1st test is positive and the 2nd test is negative, code the results as negative or within normal limits unless an additional test with positive results is performed.

72




---

---

---

---

---


---

---

---



**TREATMENT**

73


---

---

---

---

---


---

---

---

**Fine Needle Aspiration (FNA)**

- The FNA needles are differentiated by their tip angle, the cannula wall-thickness, the diameter, and the storage compartments.
  - The standard needle has outer diameters 0.6 mm and 0.7 mm.
  - Some other needles can provide three times more material than did standard needle.

74


---

---

---

---

---


---

---

---

**Fine Needle Aspiration (FNA)**

- If FNA needle is small, it can grasp just a few tissue cells that are not organized in the piece of tissue - it means, their histological architecture is not preserved.
  - This specimen would be issued by cytology report, and coded in Diagnostic Confirmation
- If FNA needle is large, it can grasp larger specimen that would show histologically preserved architecture.
  - This specimen would be pathologically examined, and you would code it in the Surg Diagnostic and Staging Procedure.
    - CAnswer Forum
      - <http://cancerbulletin.facs.org/forums/showthread.php?702-Surgical-Diagnostic-and-Staging-Procedure&highlight=cytology>

75


---

---

---

---

---

---

---

---

## Surgical Procedures for Melanoma

- Diagnostic Staging Procedure
  - If the tumor is very large or in a site that is difficult to biopsy, the physician may choose to take a sample of the tumor rather than remove the entire tumor.
    - If this is done, the margins on the specimen sent to pathology will be grossly positive.
    - This would be coded as a diagnostic staging procedure code 02.

76



---

---

---

---

---

---

---

---

## Surgical Procedures for Melanoma

- Excisional biopsy
  - If a physician suspects melanoma, they will probably try to remove the entire lesion.
    - This may be done as a standard excisional biopsy, punch biopsy, or a shave biopsy.
    - Regardless of the approach, this procedure should be coded using the surgery code 27.
  - If the margins of the biopsy are microscopically positive or there is no information about the margins, assume it was an excisional biopsy.

77



---

---

---

---

---

---

---

---

## Surgical Procedures for Melanoma

- Following the excisional biopsy the patient will probably have a wide excision.
  - A wide excision removes a margin of healthy tissue from around the melanoma site.
    - If the margin of healthy tissue is 1cm or less, code this procedure using codes 30-33.
    - Codes 30-33 would also be used if the margin of healthy tissue is not stated.

78



---

---

---

---

---

---

---

---

### Surgical Procedure of Melanoma

- Q: If the procedure is called a wide excision, yet the margins are not stated how would you code the procedure?
- A: Use code 30.

79

NAACCR

---

---

---

---

---

---

---

---

### Surgical Procedures for Melanoma

- Q: If a punch or shave biopsy done on 1/15/11 is followed by a wide excision on 1/30/11, would you code the first procedure as 27 or 30-33?

80

NAACCR

---

---

---

---

---

---

---

---

### Surgical Procedures for Melanoma

#### CoC Hospital

- Surgical Procedure of Primary Site  
– 27
- Surgical Procedure of Primary Site  
– 33

#### Facility Reporting to State Registry Only

- Surgical Procedure of Primary Site  
– 33

81

NAACCR

---

---

---

---

---

---

---

---

### Surgical Diagnostic and Staging Procedure

- Q: Should an incisional biopsy that is negative for malignancy be coded as a *Surgical Diagnostic and Staging Procedure*?

82



---

---

---

---

---

---

---

---

### Surgical Diagnostic and Staging Procedure

- A: No
  - Only record positive procedures.
  - For benign and borderline reportable tumors, report the biopsies positive for those conditions. For malignant tumors, report procedures if they were positive for malignancy.
    - FORDS 2012 Section Two page 123

83



---

---

---

---

---

---

---

---

### Radiation Treatment

- Q: There are conflicting opinions regarding the code for radiation treatment volume for I-131 treatment. Should this be coded to thyroid or whole body?
- A: The CoC has definitively stated that I-131 radiation treatment volume should be coded to whole body, code 33.
  - CAnswer Forum  
<http://cancerbulletin.facs.org/forums/showthread.php?353-I-131-radiation-ablation-therapy-for-thyroid-CA&highlight=i-131>

84



---

---

---

---

---

---

---

---

### Brachytherapy

- Q: If the physician gives the dosage, how do you code Regional Dose for brachytherapy codes 50-54 (Regional Modality)?
- A: 88888-Not applicable, brachytherapy or radioisotopes administered to the patient.

85



---

---

---

---

---

---

---

### New Codes for Existing Data Items 2012

- Radiation/Surgery Sequence
  - Code 7 = Surgery both before and after radiation
- Systemic/Surgery Sequence
  - Code 7 = Surgery both before and after systemic therapy

86



---

---

---

---

---

---

---

### QUESTIONS?

87



---

---

---

---

---

---

---

Coming up!

- 2012-2013 Cancer Registry & Surveillance Webinar Series
  - Still time to register
- October 4, 2012
  - Collecting Cancer Data: Stomach & Esophagus

**And the winners of the fabulous prizes are....**

88



---

---

---

---

---

---

---

---

Thank You!

- Thank you for participating in the 2011-2012 Cancer Registry & Surveillance Webinar Series

89



---

---

---

---

---

---

---

---