

FCDS Lung Cancer Re-Abstracting Audit Coding Tips

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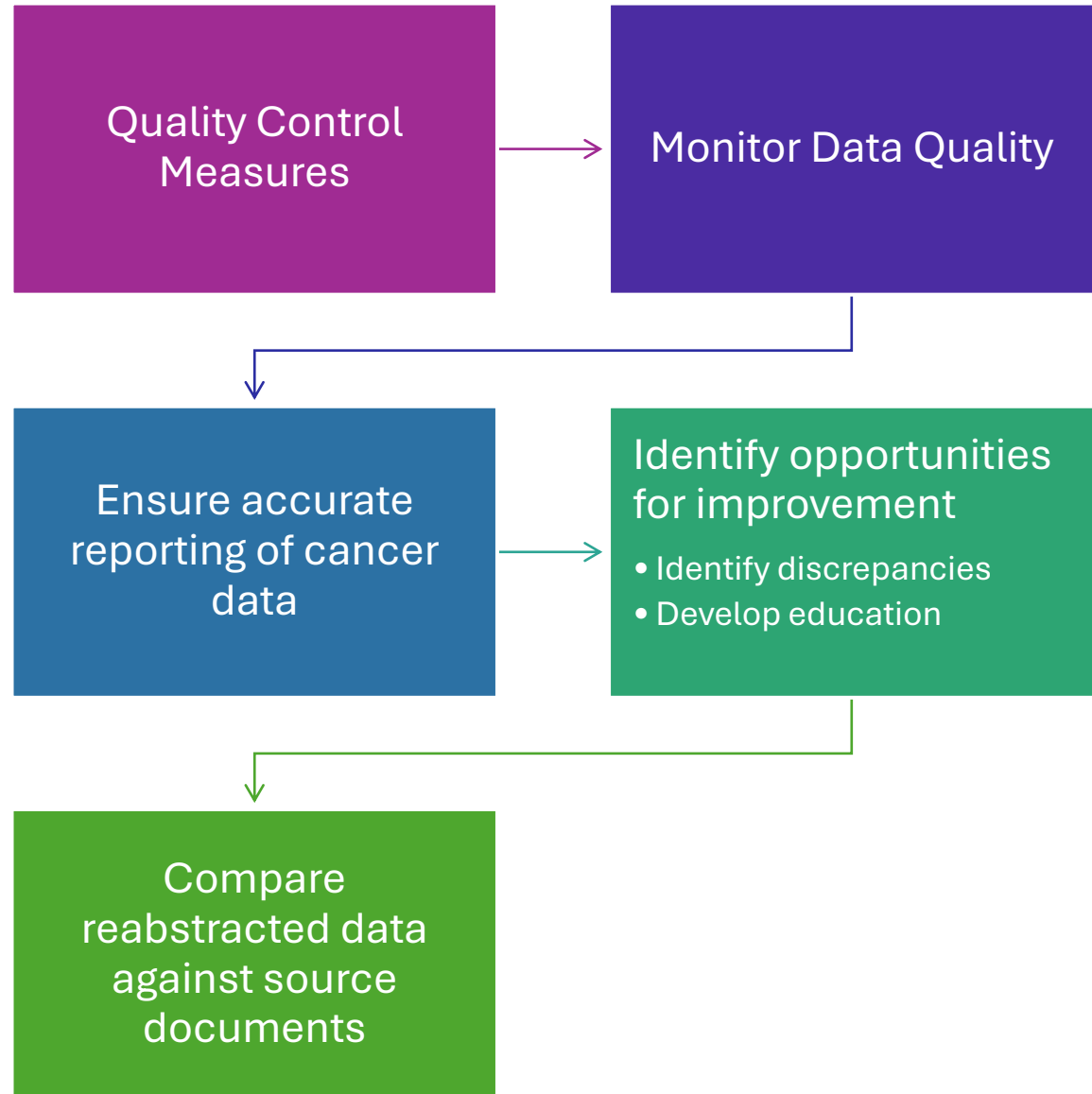




Objectives

- Review common lung re-abstracting audit issues.
- Clarify coding rules for surgery, tumor size, lymph nodes, histology, grade, and summary stage.
- Strengthen consistency in applying STORE, SEER, Solid Tumor Rules, and Summary Stage 2018 guidance

Purpose of Reabstracting Audits



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Lung Audit Overall Discrepancies

The Tumor/Case category had the most discrepancies overall, followed by Stage and then Treatment. The most prominent problem areas are:

- 1. Tumor Size Summary
- 2. Morphology ICDO3
- 3. Dir Coded SS2018
- 4. Diagnosis Date
- 5. Selected treatment coding fields
 - Rad Rx Modality
 - Surgery
 - Surg Oth Dist
 - Chemo

What To Look For & Document When Reviewing Lung Cancer Cases

- Screening CT and PET Scan Findings & Tumor Characteristics
- Physical Exam – paraneoplastic syndrome, nerve or vessel obstruction
- CT Chest – tumor location, tumor size, nodes, pleural effusion
- CT Abdomen – liver or adrenal mets
- CT/MRI Brain – brain mets
- Resectable or Unresectable Tumor
- Pathology Report(s)
 - Histology, tumor size summary, grade
 - Resection of Primary and Nodal Status
 - Extension to/thru layers of visceral pleura
 - Extension to or through parietal pleura
- Cytology Report(s) – Pleural Fluid (blood/exudate)
- Genetic Abnormalities – EGFR, KRAS, BRAF, ALK, ROS1, MET, RET, PDL-1, HER2



Tumor Size Coding Priorities



- Use the most accurate measurement available, with surgical resection size taking priority when applicable.
 - If no surgical resection is performed, code the largest tumor measurement from imaging, physical exam, or other diagnostic procedures prior to treatment.
 - For multifocal or multicentric disease reported as a single primary, code the size of the largest invasive tumor. Current SEER coding guidance continues to prioritize pre-treatment imaging size when no resection specimen is available
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STRs Coding Primary Site

Table 1: Coding Primary Site

Terminology	Laterality	Site Term and Code
Middle lobe Middle lobe bronchi	Right	Middle lobe C342
Base of lung Lower lobar bronchus Lower lobe Lower lobe bronchi Lower lobe segmental bronchi	Bilateral	Lower lobe C343
Overlapping lesion of lung	Bilateral	Overlapping lesion of lung C348 ⁴
Bronchus NOS Bronchogenic Extending up to the hilum Extending down to the hilar region Infrahilar NOS Lung NOS Pulmonary NOS Suprahilar NOS	Bilateral	Lung NOS C349 ⁵

⁴ One lesion/tumor which overlaps two or more lobes

⁵ C349 includes

- Multiple tumors in ipsilateral lobe, different lobes **OR** unknown if same/different lobe
- Tumor in bronchus, unknown if mainstem or lobar bronchus
- Tumor present, unknown which lobe
- Multiple tumors abstracted as a single primary

Tumor Information	
Class of Case	00 Initial diagnosis at the reporting facility AND all treatment or a decision not to treat was done elsewhere
Dx Confirmation	1 - Hist +
COC Accredited	0-Facility WITHOUT CoC Accredita

Text - Dx Procedures - Pathology Report

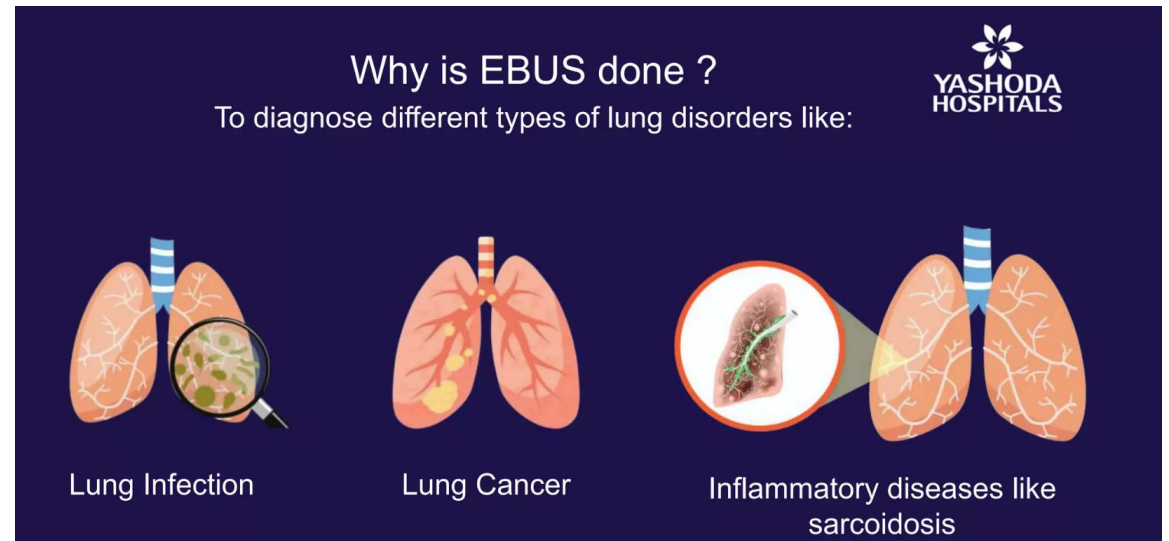
1/24/2024 . BRONCHOSCOPY: [SP-24-001431]: LUNG, RML, ENDOBRONCHIAL BX: NED. COMMENT: MULTIPLE DEEPER SECTIONS SHOW SIMILAR FINDINGS. IMMUNOPEROXIDASE STAINS FOR P40, CK5/6, TTF-1 & INSM1 SUPPORT THE DX. BX TISSUE MAY NOT BE REPRESENTATIVE OF TARGET LESION. 4/3/2024 . U/S GUIDED THORACENTESIS: [CWN24-00114]: POSITIVE FOR MALIGNANCY. THORACENTESIS, RT: NO FNA OR BX DONE. /

Coding FNA – Diagnostic Confirmation

- Code 1 when the microscopic diagnosis is based on tissue specimens from biopsy, frozen section, surgery, autopsy or D&C or from aspiration of biopsy of bone marrow specimens
- Code 1 is the preferred coding for Fine Needle Aspiration (FNA).
- FNA is not classified as ‘cytology’ in cancer registry. FNA is treated as a biopsy Code 1.
- Code 2 when the microscopic diagnosis is based on cytologic examination of cells suspended in body fluids such as sputum smears, bronchial brushings, bronchial washings, pleural fluid

Mediastinal Lymph Node Sampling

Mediastinal Lymph Node Sampling
Endobronchial Ultrasound (EBUS)
Mediastinoscopy
Endoscopic Ultrasound (EUS)
Video-Assisted Thoracoscopic Surgery (VATS)



<https://image.slidesharecdn.com/ebus-201021045152/75/Endobronchial-Ultrasound-Bronchoscopy-EBUS-3-2048.jpg>

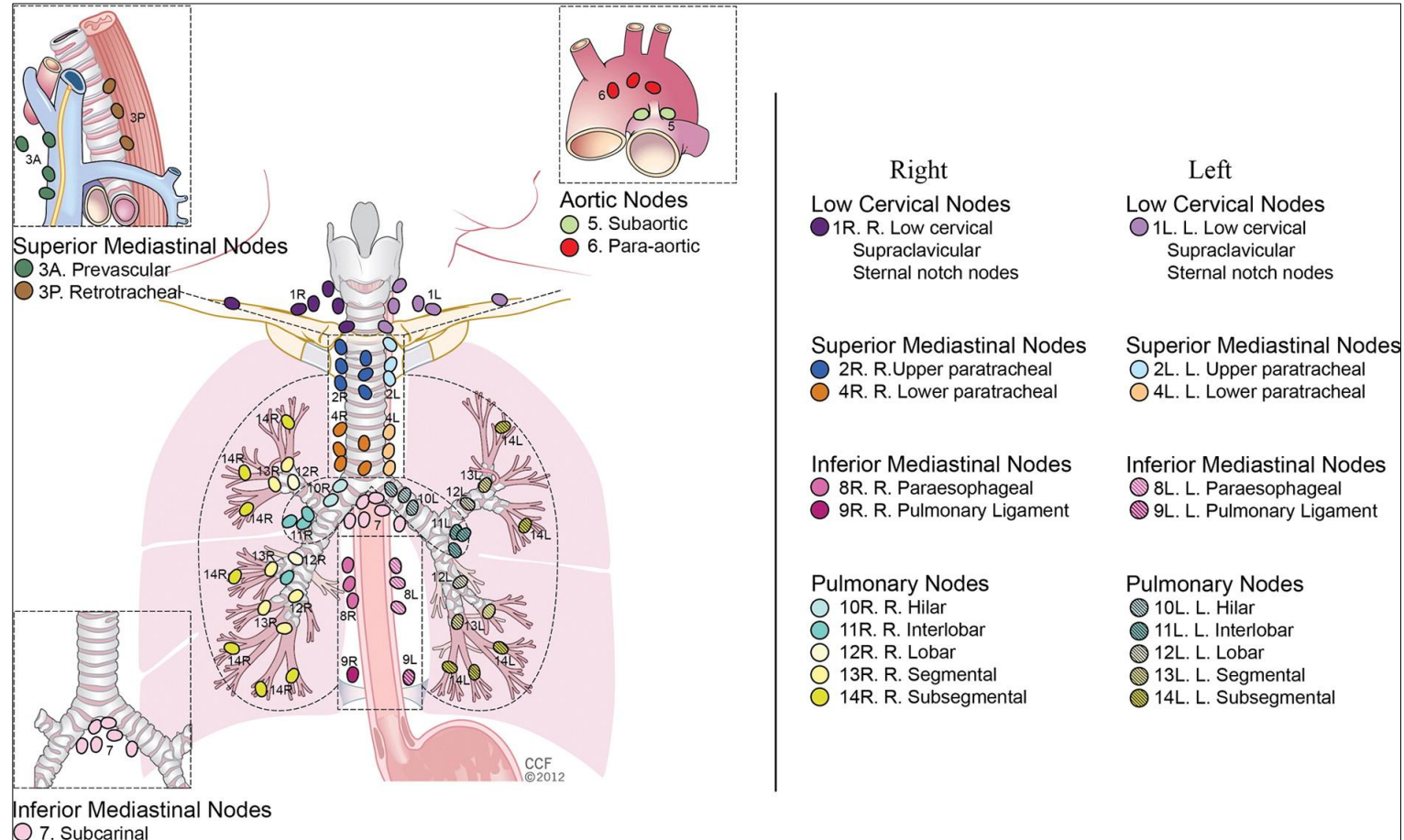


Regional Lymph Nodes Examined: Cumulative Coding

- Regional lymph nodes examined are cumulative across all qualifying first-course surgical procedures.
- Add the total number of pathologically examined regional nodes from separate procedures, excluding aspiration or core biopsy situations coded to 95.
- Stress that this data item is based on pathologic information only and should reflect final cumulative surgical evaluation.

Example 1: Lung cancer patient has a mediastinoscopy and positive core biopsy of a hilar lymph node. Patient then undergoes right upper lobectomy that yields 3 hilar and 2 mediastinal nodes positive out of 11 nodes dissected. **Code *Regional Nodes Positive* as 05 and *Regional Nodes Examined* as 11 because the core biopsy was of a lymph node in the same chain as the nodes dissected.**

IASLC Lymph Node Classification for Lung Cancer Staging





Histology Coding Essentials for Lung



- Review examples such as **8072** for squamous cell carcinoma, large cell non-keratinizing; **8071** for keratinizing squamous cell carcinoma; and **8551** for acinar adenocarcinoma when appropriately documented.
 - Code the most specific histology or subtype available.
 - STR rule exception allowing use of the predominant histologic pattern when specifically supported in current lung pathology protocols
 - DO NOT CODE histology described as:
 - Architecture
 - Foci; focus; focal
 - Pattern
- 

Lung Histology Coding Rules

Lung Histology Coding Rules
C340-C343, C348, C349
(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Table 25: List of Definitive Terminology

Definitive Terminology	
Comparable with	Most likely
Compatible with	Probable
Consistent with	Typical (of)

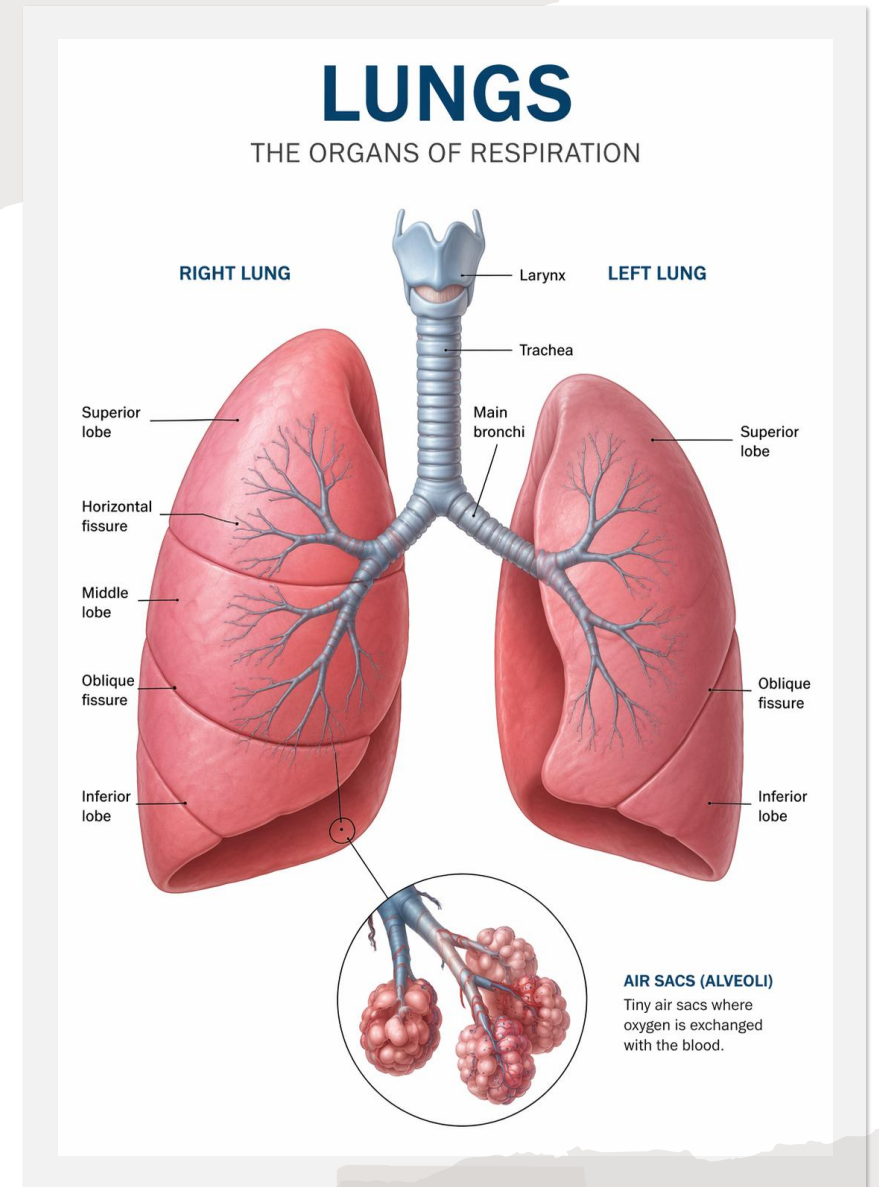
4. **DO NOT CODE** histology described as:

- Architecture
- Foci; focus; focal
- Pattern (**Exceptions** below)
 - Acinar pattern: Adenocarcinoma, acinar predominant **8551**
 - Lepidic (growth) pattern: Adenocarcinoma, lepidic predominant **8250**
 - Micropapillary pattern: Adenocarcinoma, micropapillary predominant **8265**
 - Papillary pattern: Adenocarcinoma, papillary predominant **8260**
 - Solid pattern: Adenocarcinoma, solid predominant **8230**

Rule H7 Code the histology that comprises the greatest percentage of tumor when two or more of the following histologies present

Lung Histology Coding Rules

- 1. Code the most specific histology or subtype/variant, regardless of whether it is described as:
 - A. The majority or predominant part of tumor
 - B. The minority of tumor
 - C. A component
- **Example 1:** Diagnosis for a single tumor is adenocarcinoma 8140 with the majority or predominant part of tumor being acinar adenocarcinoma 8551. Code the subtype/variant: acinar adenocarcinoma 8551
- **Example 2:** Code histology to 8230, for example, RUL LOBECTOMY with INVASIVE ADENOCARCINOMA WITH A PREDOMINANTLY SOLID GROWTH PATTERN



Do Not Code Features (Only)

Date of DX 2024-08-12

Primary Site C 341 Histology 8045 Behavior 3 - Malignant

Discriminator1  Discriminator2 [

Schema 00360 Lung [8th: 2018-2024]

Text - Dx Procedures - Pathology Report

12/03/2024 (SM24-09065): LUNG, RIGHT UPPER LOBE, BIOPSY OF NODULE: - PULMONARY ADENOCARCINOMA WITH ACINAR AND MICROPAPILLARY FEATURES. THE DIAGNOSIS OF PULMONARY ADENOCARCINOMA IS SUPPORTED BY IMMUNOSTAINS FOR CYTOKERATIN7, CYTOKERATIN 20, TTF-1, AND CDX2. THE TUMOR CELLS ARE POSITIVE FOR CYTOKERATIN 7 AND TTF-1, AND THEY ARE NEGATIVE FOR CYTOKERATIN 20 AND CDX2. VENTANA PD-L1 [CLONE SP263]: 35-40% EXPRESSION IN TUMOR CELLS;

Laterality 1 - Right

Text-Primary Site LUNG, RIGHT UPPER LOBE

Text-Histology ADENOCARCINOMA

Code the histology described as **differentiation** or **features/features of ONLY** when there is a specific ICD-O code for the “NOS with ____ features” or “NOS with ____ differentiation”.

Note: Do not code differentiation or **features** when there is no specific ICD-O code.

Lung Coding Mixed Histology 8255

Lung Site-group Instructions

C340-C343, C348, C349

(Excludes lymphoma and leukemia M9590 – M9993 and Kaposi sarcoma M9140)

Table 2: Combination/Mixed Histology Codes

Required Terms	Combination Histologies and Code
Diagnosis must be a single tumor which meets one of the following two criteria: 1. <u>At least two</u> of the below subtypes/variants of adenocarcinoma ⁶ AND percentages of each type are unknown/not stated OR they are equal percentages • Acinar adenocarcinoma (including acinar pattern) • Clear cell adenocarcinoma • Lepidic adenocarcinoma ⁷ (including lepidic (growth) pattern) • Micropapillary adenocarcinoma (including micropapillary pattern) • Papillary adenocarcinoma (including papillary pattern) • Solid adenocarcinoma (including solid pattern) • Well-differentiated fetal adenocarcinoma 2. A combination of histologies not listed on previous rows of this table.	Adenocarcinoma with mixed subtypes 8255 (/3) ^{8 9 10}

8255 is a “last resort” code and does not apply to squamous cell carcinoma NOS and/or subtype/variants of SCC

Lung Coding Mixed Histology 8255

- **Note 7:** Lepidic adenocarcinoma may or may not have mucinous components
- **Note 8:** 8255 is a “last resort” code and does not apply to squamous cell carcinoma NOS and/or subtype/variants of SCC. See the Histology Rules to determine when it is appropriate to use this code for combination histologies other than adenocarcinoma subtypes/variants.
- **Note 9: Cancer PathCHART has determined that 8255 is an “unlikely” histology for lung.** If 8255 is the correct code per the histology rules, override inter-field edit 25.
- **Note 10:** 10 The histology terms may be identified as pattern or predominantly

Coding Neuroendocrine Tumors

Neuroendocrine tumor, NOS 8240 GRADE 1 (TYPICAL CARCINOID)

- Bronchial adenoma, carcinoid
- Carcinoid NOS
- Carcinoid tumor NOS
- NET
- Neuroendocrine tumor, grade 1
- Neuroendocrine tumor, low grade
- Neuroendocrine carcinoma, well differentiated
- Typical carcinoid

Atypical Carcinoid code 8249 for NET, grade 2 or grade 3

- Neuroendocrine carcinoma, moderately differentiated

Neuroendocrine carcinoma (NEC) code 8246

- Combined small cell carcinoma 8045
- Small Cell Carcinoma 8041
 - Small cell neuroendocrine carcinoma

Definitive Terminology and Ambiguous Language

Source & Intended Use

Each source should be used only for its intended purpose



STORE	Ambiguous terms that constitute a diagnosis
SPCSM	Ambiguous terms for reportability
STR	Ambiguous terminology for coding histology
STR	Definitive terminology for coding histology
Heme Manual	Ambiguous terms for reportability, diagnostic confirmation, and histology
Heme Manual	Definitive terminology for coding histology
SS 2018	Ambiguous terminology for determining involvement
EOD	Ambiguous terminology for determining involvement

Ambiguous Terms - Reportability

- In the absence of definitive evidence, **the following Definitive terms should be interpreted as diagnostic of cancer:**
 - Comparable with
 - Most likely
 - Compatible with
 - Probable
 - Consistent with
 - Typical (of)
- * Use of the terms “neoplasm” and “tumor” begins with cases diagnosed 1/1/2004 and later and is to be used in conjunction with nonmalignant (benign or borderline) intracranial and CNS primary tumors only (C70.0-C72.9, C75.1-C75.3).

Ambiguous Terminology – Coding Histology

- Pathology from a biopsy of a lung mass returns carcinoma, **likely** small cell carcinoma.
- **The oncologist's note references she is treating the patient's small cell carcinoma.**
- When there is an NOS and a more specific histology that is modified by an ambiguous term (**likely in this case**), the more specific histology should be assigned when either of the following conditions are met:
 - A physician clinically confirms the more specific histology OR
 - The patient is being treated for the more specific histology.
- Assign **8041/3 Small cell carcinoma** per the oncologist's note

Example of Definitive Terminology

- A patient undergoes lobectomy of the right lung.
- The diagnosis on the pathology report was adenocarcinoma **consistent** with lepidic adenocarcinoma.
- “**Consistent with**” is included in the list of Definitive Terminology. Further clinical correlation or treatment information is not required.
- Assign **8250/3 Lepidic adenocarcinoma**.

Laterality, and Summary Stage 2018

- Review laterality coding when both lungs are involved
- Connect this to the Summary Stage 2018 regional versus distant assignment.
- Summary Stage 2018 classifies separate tumor nodules in a different ipsilateral lobe or contralateral lung as distant disease

DX Date	2025-08-22	Primary Site	C341	Histology	8140	Behavior:	3	Disc 1:		Disc 2:	
		Regional Nodes Positive	98			Regional Nodes Examined	00				
		Lymph Vascular Invasion	9-Unknown/Indeterminate								
		Direct Coded SEER Summary Stage 2018	3	**Regional lymph node(s) involved only**							

Text - Staging

MEDONC/REG TO LN: CLINICAL STAGE ONLY: PD LUL LUNG ADENOCARINOMA PER BX; T1C N3M0 STAGE 3B BASED ON IMG TS 2.3 CM LUL MASS W ADJACENT 1.6 CM NODULE, MULTIPLE SCATTERED SMALL NODULES, AND EXTENSIVE LYMPHADENOPATHY (LEFT HILAR, SUBCARINAL, RIGHT PARATRACHEAL). PET SCAN DEMONSTRATES HIGH METABOLIC ACTIVITY WITH SUV 12.5 IN PRIMARY LESION AND SUV 4.614.7 IN LYMPH NODES.

Laterality

- Code 4 is seldom used EXCEPT for the following
 - a. Both ovaries involved simultaneously with a single histology; a single primary according to the Solid Tumor Rules
 - **b. Diffuse bilateral lung nodules**
 - c. Bilateral retinoblastomas
 - d. Bilateral Wilms tumors
 - e. Both breasts when inflammatory carcinoma is bilateral at diagnosis

<i>Laterality describes the side of a paired organ or side of the body on which the reportable tumor originated. Determine whether laterality should be coded for each primary.</i>	
Code	Description
0	Not a paired site
1	Right: origin of primary
2	Left: origin of primary
3	Only one side involved, right or left origin unspecified
4	Bilateral involvement at time of diagnosis, lateral origin unknown for a single primary; or both ovaries involved simultaneously, single histology; bilateral retinoblastomas; bilateral Wilms tumors
5	Paired site: midline tumor (effective with 01/01/2010 dx)
9	Paired site, but no information concerning laterality

Using the Solid Tumor Manual – Lung

Using Multiple Primary Rules

- Determine the number of primaries using M Rules
- Determine if the patient has a single or multiple primary
- Begin with the first rule in that module and follow the rules in order
- **STOP at the rule that applies to single or multiple primary**

Using Histology Rules

- Next, determine the histologies using the H Rules to assign histology for each primary. Select the correct module within Histology Rules
 - Single
 - Multiple Tumors Abstracted as a Single Primary
- Begin with the first rule in the module and follow the rule order
- **Once you reach a rule that can be applied, assign histology STOP**



Lung – STR Multiple Primaries Rule M9

Example.

Patient presents with RML and RUL, 4/17/23 RML lesion bx positive adenoca and , 6/16/23 LUL wedge resection w/MLND pos adenoca visceral pleura and 4 nodes negative

- STRs states a single primary Rule M9 Abstract a single primary when there are simultaneous multiple tumors:
 - In both lungs (multiple in right and multiple in left) OR
 - In the same lung OR
 - Single tumor in one lung; multiple tumors in contralateral lung

Steps to Determine Number of Primaries

- Where did cancer originate
- How many tumors are present
- How many histologies present
- Open STR manual

Steps to Determine the Number of Primaries	
Site group	Lung
Section	Multiple Primary Rules
Module	Multiple Tumors
First Rule in Module	M3
First Rule that Applies	M9

- Rule M9** Abstract a **single primary** when there are **simultaneous multiple** tumors:
- In **both** lungs (multiple in right and multiple in left) **OR**
 - In the **same** lung **OR**
 - **Single** tumor in one lung; **multiple** tumors in **contralateral** lung

<https://seer.cancer.gov/tools/solidtumor/training.html>

Steps to Determine the Histology

Steps to Determine the Histology	
Site Group	Lung
Section STR	Histology Rules
Module	Multiple Tumors Abstracted as Single Primary
First Rule in Module	H10
First Rule that Applies	H13
Histology	8140/3

Rule H13 Code the histology when only **one** histology is present in **all** tumors.

Note 1: Use [Table 3](#) to code histology. New codes, terms, and synonyms are included in **Table 3** and coding errors may occur if the table is not used.

Note 2: When the histology is **not listed** in **Table 3**, use the **ICD-O** and all **updates**.

Note 3: Submit a question to [Ask a SEER Registrar](#) when the histology code is not found in Table 3, ICD-O or all updates.

Note 4: When the histology is **carcinoma in situ NOS**, code histology to 8010/3. Cancer PathCHART review has determined carcinoma in situ 8010/2 is biologically impossible and will not pass edits.

Procedure Coding Pitfalls

1

Differentiate diagnostic bronchoscopy from reportable tumor destruction procedures such as debulking or laser ablation.

2

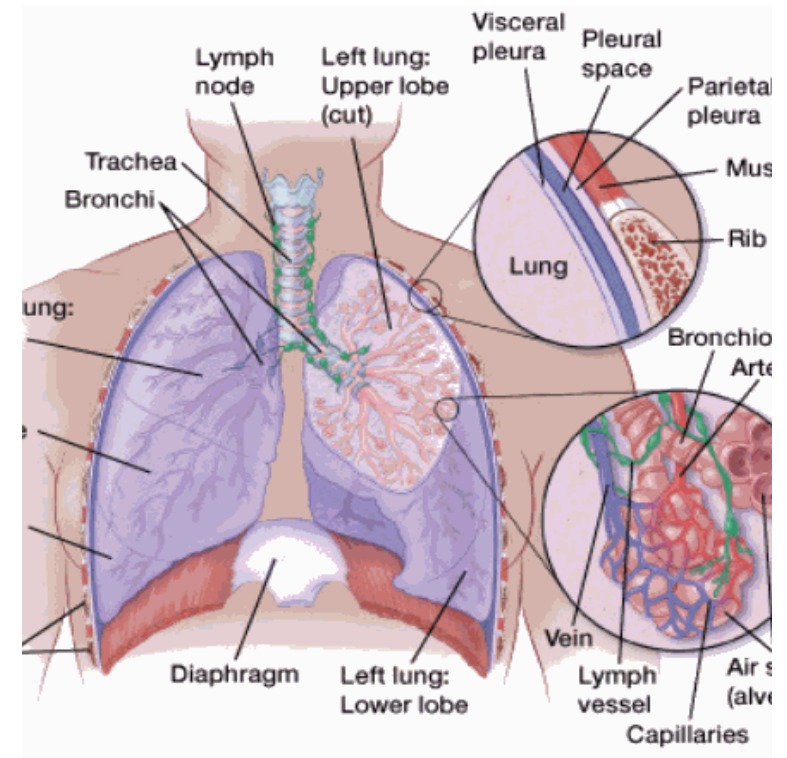
Review pleural peel and partial pulmonary decortication coding, especially when the primary site is lung versus pleura.

3

Clarify thoracic and mediastinal lymphadenectomy coding and reinforce when procedures do or do not qualify as surgery of the primary site.

Surgery Coding: Wedge Resection, Lobectomy, and Lymph Node Dissection

- Distinguish wedge resection, segmental resection, lobectomy, and lobectomy with mediastinal lymph node dissection.
- Highlight key surgery codes such as A210, A220, A300, and A330.
 - A330 Lobectomy w/MLND
 - A330 Lobectomy w/thoracic lymphadenectomy
- Emphasize that coding is based on the definitive cancer-directed procedure performed and documented in the operative record



Lung Cancer Directed Surgery Codes

2024 and Forward

B200 Excision or resection of less than one lobe, NOS

B210 Wedge resection

B220 Segmental resection, for example a lingulectomy

B230 Excision, NOS

B240 Laser excision

B250 Bronchial sleeve resection ONLY

B300 Resection of lobe or bilobectomy, but less than the whole lung (partial pneumonectomy, NOS)

B320 Bronchial sleeve lobectomy/bilobectomy

B330 Lobectomy WITH mediastinal lymph node dissection

Note: A sleeve lobectomy/bilobectomy includes resection of the entire lobe(s) in addition to part of the bronchus.

A sleeve lobectomy is distinct from a typical lobectomy or bilobectomy, in which the bronchus is not resected.

The lymph node dissection should also be coded under *Scope of Regional Lymph Node Surgery* (NAACCR Item #1292) or *Scope of Regional Lymph Node Surgery at This Facility* (NAACCR Item #672).

B450 Lobe or bilobectomy extended, NOS

B460 WITH chest wall

B470 WITH pericardium

B480 WITH diaphragm

2023 Cases

A200 Excision or resection of less than one lobe, NOS

A230 Excision, NOS

A240 Laser excision

A250 Bronchial sleeve resection ONLY

A210 Wedge resection

A220 Segmental resection, including lingulectomy

A300 Resection of lobe or bilobectomy, but less than the whole lung (partial pneumonectomy, NOS)

A330 Lobectomy WITH mediastinal lymph node dissection

The lymph node dissection should also be coded under *Scope of Regional Lymph Node Surgery* (NAACCR Item #1292) or *Scope of Regional Lymph Node Surgery at This Facility* (NAACCR Item #672).

A450 Lobe or bilobectomy extended, NOS

A460 WITH chest wall

A470 WITH pericardium

A480 WITH diaphragm

Lung Summary Stage – Coding Tips

- **Code 2 Regional Direct Extension**

- Separate tumor nodule(s) in the same lobe as the primary

- **Code 7 Distant for**

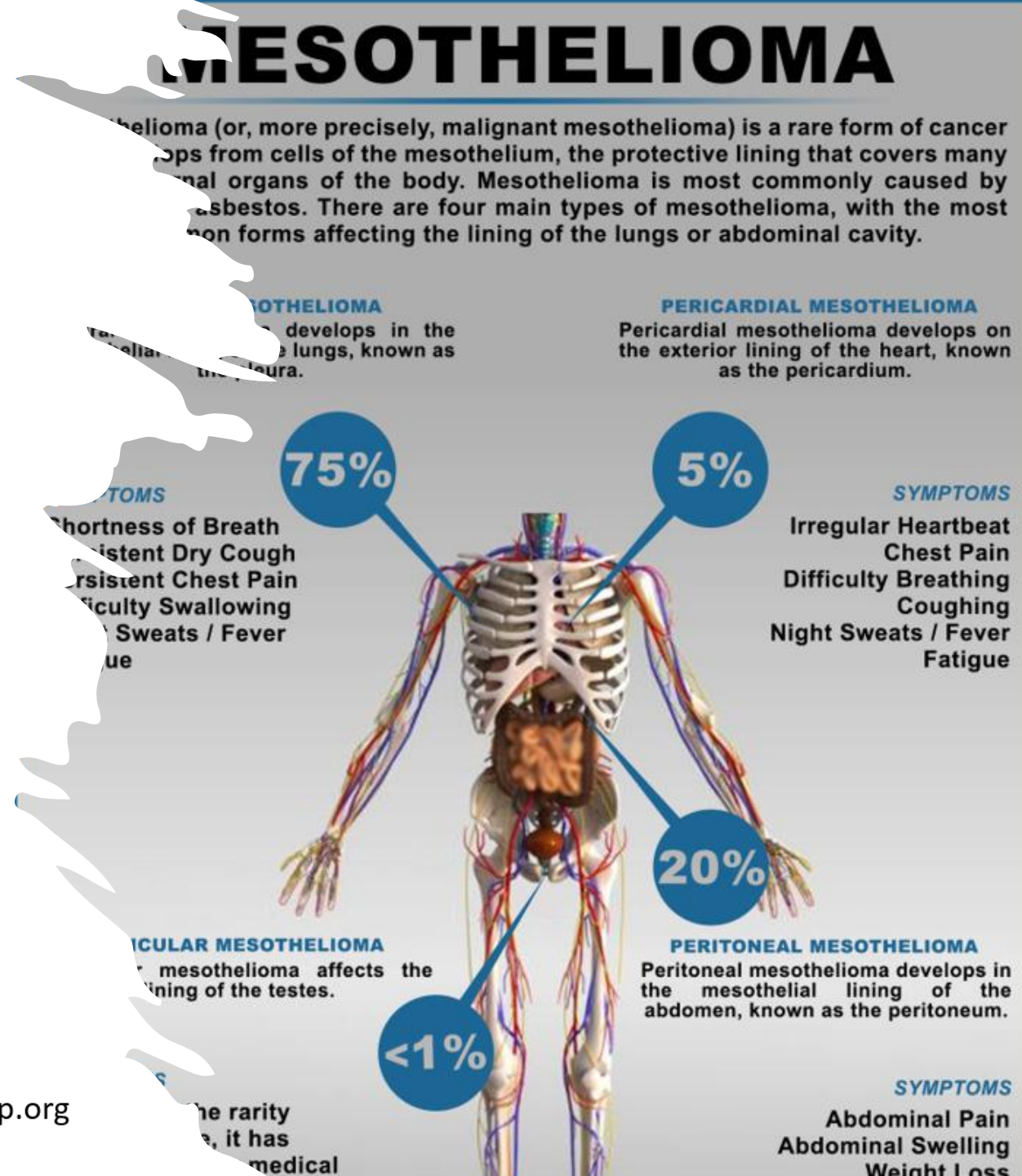
- Separate tumor nodule(s) in a different ipsilateral lobe
- Separate tumor nodule(s) in contralateral lung
- Distant lymph node(s), NOS
 - o IPSILATERAL or CONTRALATERAL
- Low cervical
- Proximal root
- Scalene (inferior deep cervical)
- Sternal notch
- Supraclavicular (transverse cervical)
 - o CONTRALATERAL/BILATERAL nodes

- Bronchial
- Peri/parabronchial
- Carinal
- Hilar (bronchopulmonary) (proximal lobar) (pulmonary root)
- Intrapulmonary
- Interlobar
- Lobar
- Segmental
- Subsegmental
- Superior mediastinal
- Paratracheal (left, right, upper, low, NOS)
- Azygos (lower paratracheal)

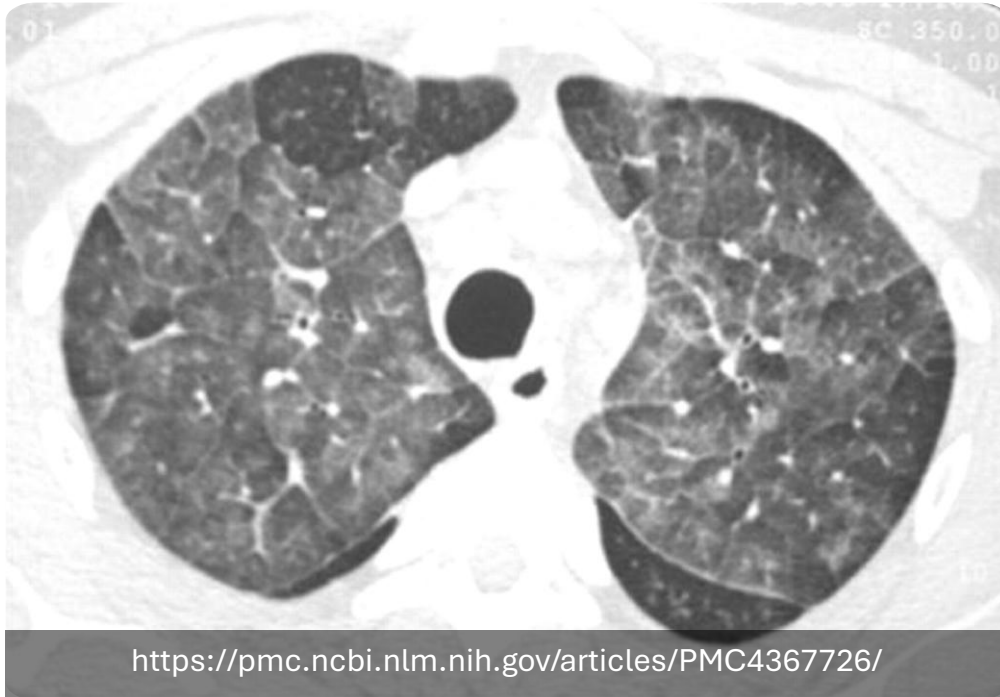
Pleural Decortication Procedure

- Pleural peel/partial pulmonary decortication should be coded as surgery B200 or B300 if the primary site is PLEURA.
- -However, when the primary site is LUNG
- There is no lung tissue removed in pleural peel/partial pulmonary decortication; therefore, it should not be coded as primary site surgery in lung.
- Code it in RX SUMM SURG OTHER REG/DISTANT as NON-PRIMARY Surgical PROCEDURE to other regional sites

Sources: <http://www.mesothelioma.com> and <http://www.usaep.org>



Ground Glass Opacities - Lung



<https://pmc.ncbi.nlm.nih.gov/articles/PMC4367726/>

- Ground-glass opacity (GGO) is a radiological finding
- GGO can be observed in both benign and malignant conditions, including lung cancer and its preinvasive lesions.
- Atypical adenomatous hyperplasia and adenocarcinoma in situ are typically manifested as pure GGOs, whereas more advanced adenocarcinomas may include a larger solid component within the GGO region.

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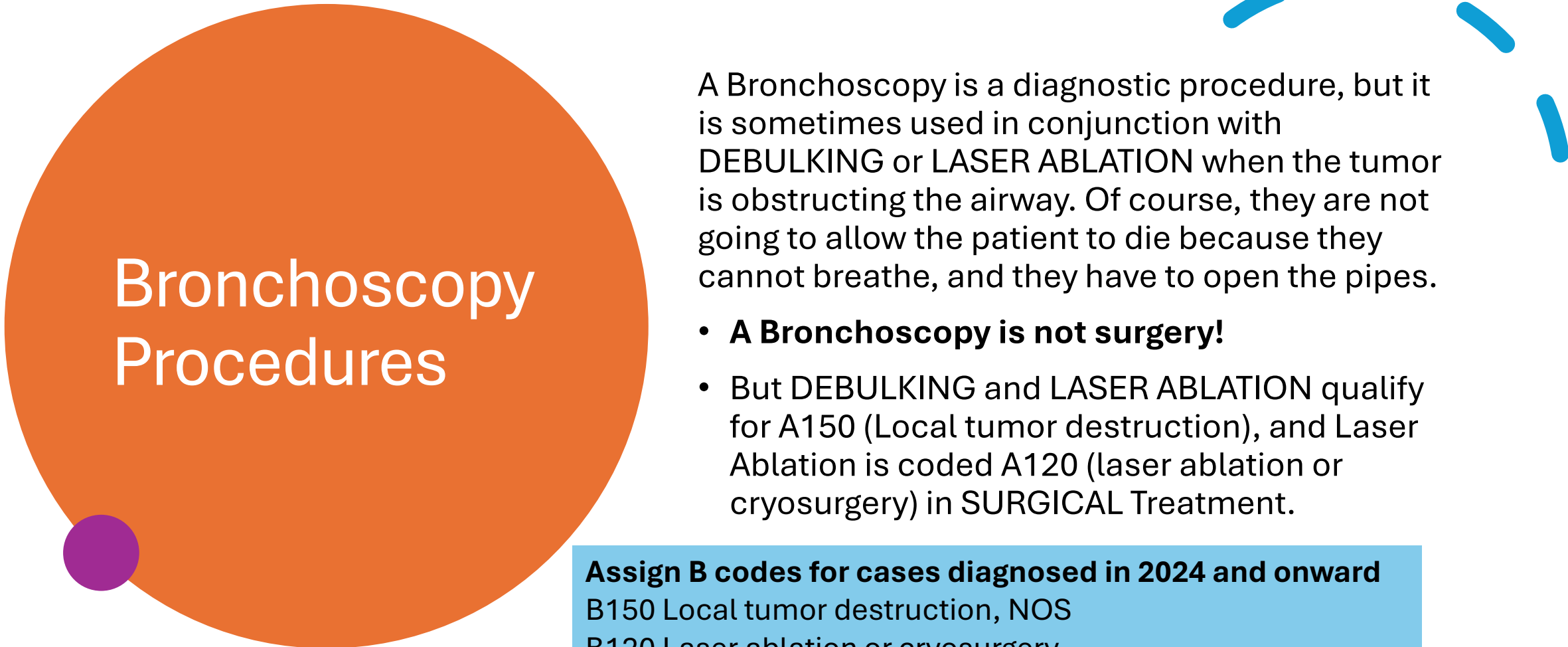
Summary Stage – Lung

- **Note 3:**
- Ground-glass opacities (GGO),
- Ground-glass nodules (GGN), and
- Ground/glass lepidic (GG/L) are frequently observed on CT and are increasingly detected with advancements in imaging, and are described as an area of hazy increased lung opacity. GGO, GGN, and GG/L can be observed in both benign and malignant lung conditions along with pre-invasive lesions (adenocarcinoma in situ, minimally invasive adenocarcinoma, and lepidic carcinoma).

Coding Grade Clinical and Pathologic

- **Example: Biopsy of primary site shows a moderately differentiated adenocarcinoma. The surgical resection states a high-grade adenocarcinoma**
- Grade Clinical would be coded as G2 (code 2) since moderately differentiated (G2) is the preferred grading system
- Grade Pathological would be coded as 9 since the preferred grading system was not used and the Generic Grade Categories do not apply to this grade table
 - Use the grade from the clinical workup from the primary tumor in different scenarios based on behavior or surgical resection
- No Surgical Resection
 - Surgical resection of the primary tumor has not been done, but there is positive microscopic confirmation of distant metastases during the clinical time frame

Code	Description
1	G1: Well differentiated
2	G2: Moderately differentiated
3	G3: Poorly differentiated
4	G4: Undifferentiated
9	Grade cannot be assessed (GX); Unknown



Bronchoscopy Procedures

A Bronchoscopy is a diagnostic procedure, but it is sometimes used in conjunction with DEBULKING or LASER ABLATION when the tumor is obstructing the airway. Of course, they are not going to allow the patient to die because they cannot breathe, and they have to open the pipes.

- **A Bronchoscopy is not surgery!**
- But DEBULKING and LASER ABLATION qualify for A150 (Local tumor destruction), and Laser Ablation is coded A120 (laser ablation or cryosurgery) in SURGICAL Treatment.

Assign B codes for cases diagnosed in 2024 and onward

B150 Local tumor destruction, NOS

B120 Laser ablation or cryosurgery

B130 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)

Lung Cancer Abstracting Resources

- AJCC 8th Edition and Version 9 Updates and Histologies
- CAnswer Forum
- Cancer PathCHART ICD-O-3 Site Morphology Validation List: Cancer PathCHART ICD-O-3 Site
- Commission on Cancer STORE Manual
- Extent of Disease (EOD) 2018
- Grade Manual
- Hematopoietic and Lymphoid Neoplasm Database-Manual
- Ask a SEER Registrar
- ICD-O-3.2 Histology changes
- NAACCR Data Standards and Dictionary
- SEER Program Coding Manual
- SEER Registrar Staging Assistant (SEER*RSA):
- SEER*Rx
- Site-Specific Data Items Manual
- Solid Tumor Rules
- Summary Stage 2018
- FCDS Data Acquisition Manual

Key Takeaways and Audit Reminders



Use the most specific documented information and follow current standard-setter guidance.



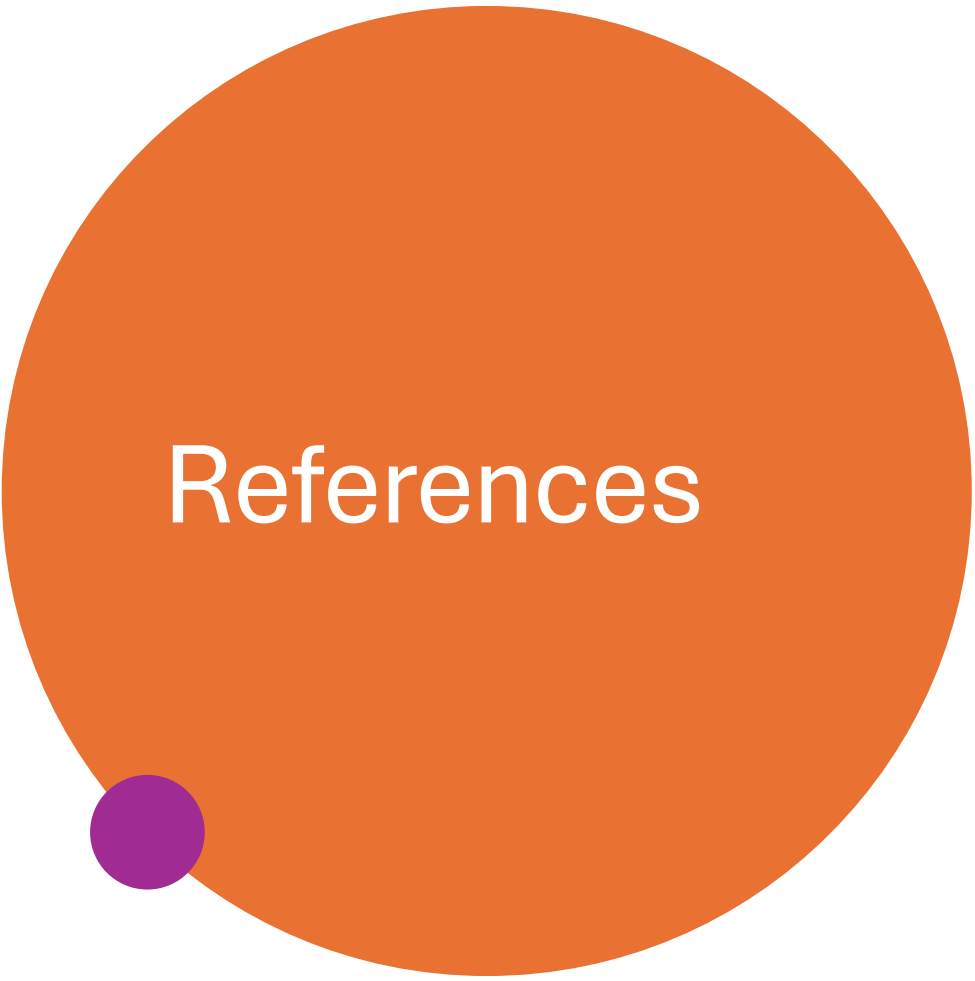
Code surgery, tumor size, nodes, histology, grade, and stage in the correct priority sequence.



Watch for common pitfalls involving ambiguous terminology, multiple tumors, ground-glass findings, and non-primary procedures.



When in doubt, verify coding against current STORE, SEER, Solid Tumor Rules, and Summary Stage references.



References

- Solid Tumor Rules
- Cancer Registry Management Principles and Practices for hospital and central registries
- Summary Stage 2018
- STORE Manual
- Florida Cancer Data Systems Manual