Coding Pitfalls 2023

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9/7/2023

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Q&A

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

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.

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Fabulous Prizes

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Guest Presenter

- Janet Vogel, CTR
  - Compliance and Quality Auditor/Educator – Cancer Registry; Omega Healthcare

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Agenda

Identify the Most Common Pitfalls by Site

- Breast
- Prostate
- Bladder
- Kidney

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Minimum Resources Required to Abstract

•2024, 2023 or previous NAACCR Implementation Guidelines https://www.naaccr.org/implementation-guidelines/
•Solid Tumor Rules https://seer.cancer.gov/tools/solidtumor/
•Hematopoietic and Lymphoid Neoplasm Database https://seer.cancer.gov/seertools/hemelymph/
•Hematopoietic and Lymphoid Neoplasm Coding Manual https://seer.cancer.gov/tools/heme/Hematopoietic_Instructions_and_Rules.pdf
•NAACCR Site Specific Data Items and Grade https://apps.naaccr.org/ssdi/list/
•SEER*RSA https://staging.seer.cancer.gov/eod_public/list/3.0/
•EOD 2018 https://seer.cancer.gov/tools/staging/
•Summary Stage 2018 https://seer.cancer.gov/tools/staging/
•American Joint Committee on Cancer/AJCC https://www.facs.org/quality-programs/cancer/ajcc
•ICD 0 3.2 Histology Revisions & Annotate Histology List https://www.naaccr.org/icdo3/
•NAACCR https://www.naaccr.org/data-standards-data-dictionary/
•SEER*Rx Interactive Antineoplastic Drugs Database https://seer.cancer.gov/seertools/seerrx/
•STORE Manual https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/
•CTR Guide to Coding Radiation Therapy Treatment in the STORE 5.0 **Now available in STORE 2023 Appendix R https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/
•SEER Program Coding and Staging Manual https://seer.cancer.gov/tools/codingmanuals/
•Cancer Program News https://www.facs.org/quality-programs/cancer/news
•Appropriate State Manual

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Facebook pages I follow for Info & Fun

- NAACCR, Inc.
- National Cancer Registrars Association
- National Cancer Registrars Association (NCRA)
- Institute of Human Anatomy
- Cancer Registry Comics
- Several Outsourcing & Vendor pages

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Best Tips of the Day

- READ THE MANUALS!
- Create a Survival Guide

*Comic used with permission from @cancerregistrycomics #lookitup #doublecheck }

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Review Your Abstract

- Once you are done, review the abstract
  - Review the pre-populated fields
  - Check the date of diagnosis against your text
  - Check Class of Case
  - Check Primary Site
  - Check Histology

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Class of Case/Date of First Contact

For Class of Case 00,10,13,14

Date of Diagnosis will be the same as Date of first contact

For Class of case 20-22

Date of first contact will be the date the patient either began or refused treatment at the facility

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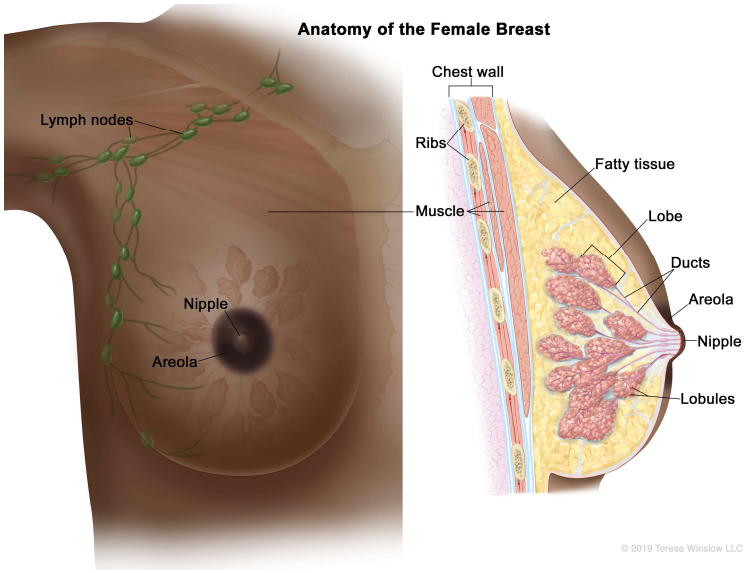
Breast Cancer Tips



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Poll#1Where in the Breast is That?

<u>Scenario:</u>

- Mammogram: 1.7cm mass **lower inner quadrant** right breast
- Operative Report: Mass excised from right breast tumor noted to be **behind the nipple**
- Path Report Checklist: Tumor Site: **Breast, nos**

<u>Question:</u>

How would you code primary site?

- C500 Nipple
- C501 Central Portion of breast
- C503 Lower inner quadrant

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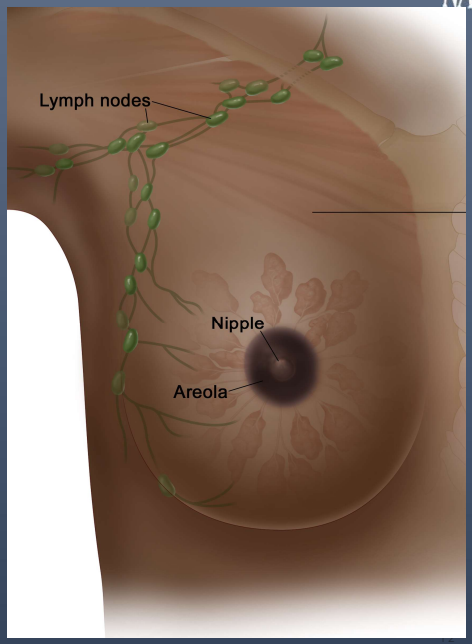

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Poll#1 Rationale

Solid Tumor Rules Table 1: Primary Site Codes

- Refer to the SEER Manual and COC Manual for a priority list for using documents such as mammograms, operative reports, and pathology reports to determine the tumor location

Coding Subsites

Use the information from reports in the following priority order to code a subsite when there is conflicting information:

1. Operative report
2. Pathology report
3. Mammogram, ultrasound (ultrasound becoming more frequently used)
4. Physical examination

Appendix C: Coding Guidelines **1**

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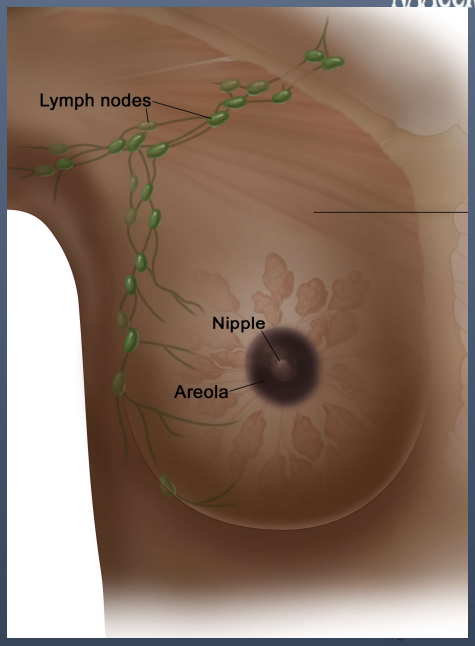
Poll #1 Answer

C501 Central Portion of breast

- Use the information from the Operative report to code primary site
  - Op report stated: (behind the nipple)
    - Refer to Table 1 Primary Site Codes in the Breast Solid Tumor Rules

Terms and Descriptive Language	Site Term and Code
Above nipple Area extending 1 cm around areolar complex Behind the nipple Below the nipple Beneath the nipple Central portion of breast Cephalad to nipple Infra-areolar Lower central Next to areola NOS Next to nipple Retroareolar Subareolar Under the nipple Underneath the nipple	Central portion of breast **C501**



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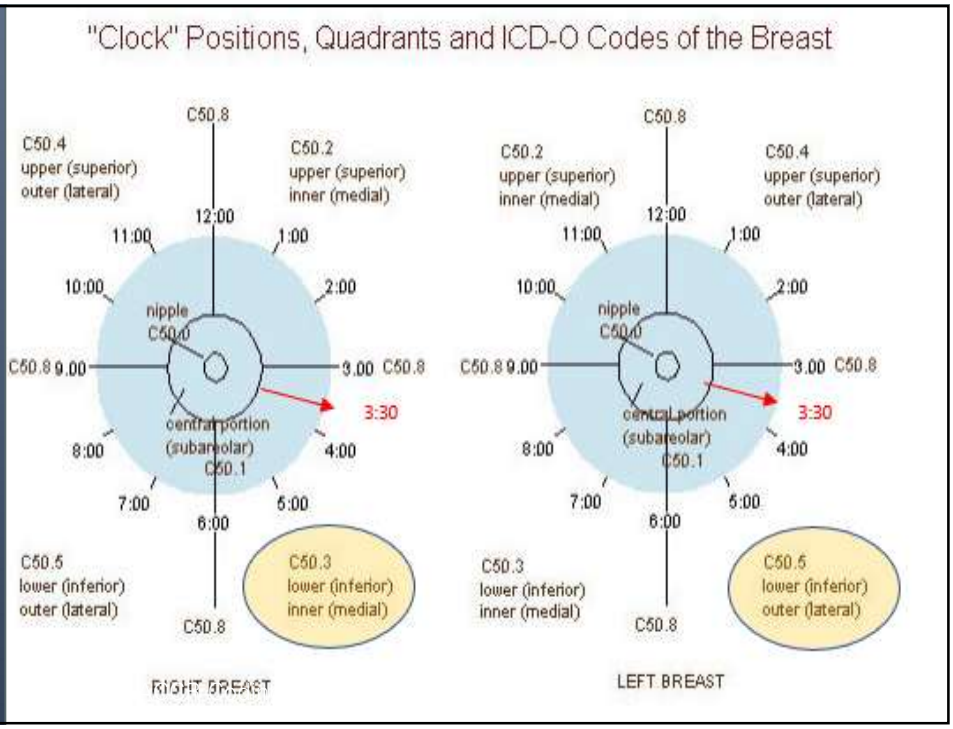
Half past the hour

- Tumor located at 3:30



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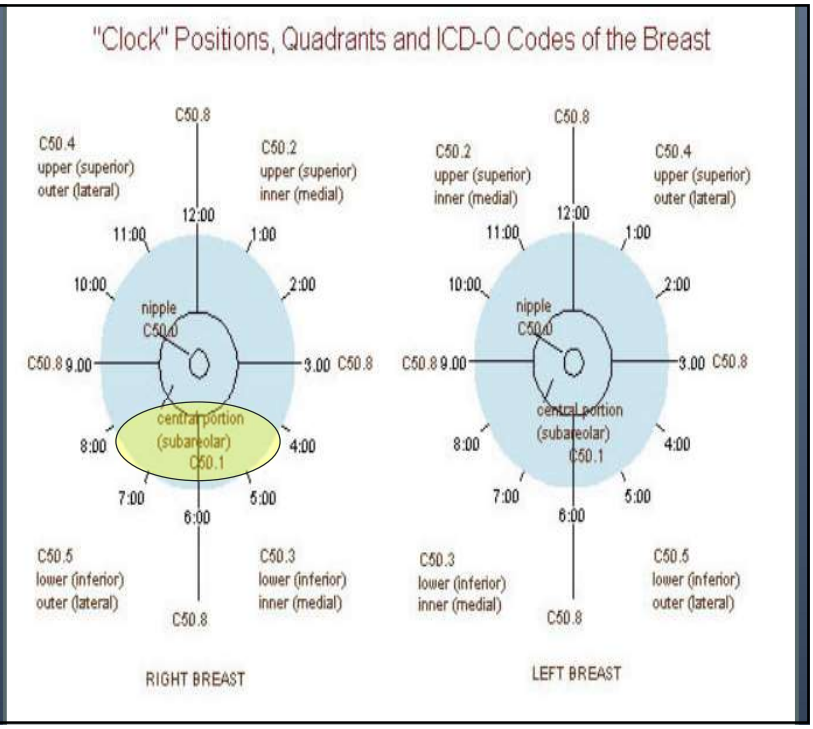
Clock & Location

- Tumor located at 6 o'clock Subareolar Right Breast



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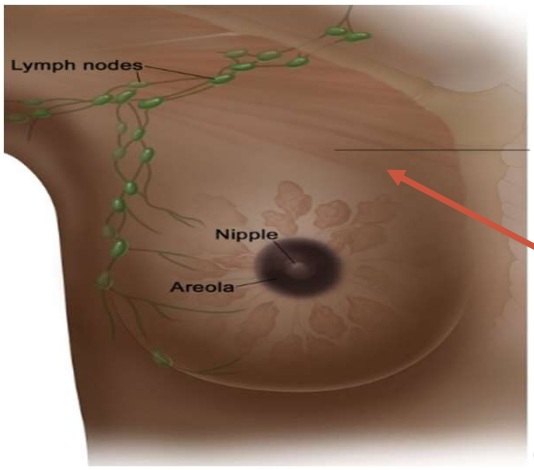
Upper Medial

- Upper Medial Right Breast



Coc

Terms and Descriptive Language	Site Term and Code
Above nipple Area extending 1 cm around areolar complex Behind the nipple Below the nipple Beneath the nipple Central portion of breast Cephalad to nipple Infra-areolar Lower central Next to areola NOS Next to nipple Retroareolar Subareolar Under the nipple Underneath the nipple	Central portion of breast **C501**
Superior inner Superior medial Upper inner quadrant (UIQ) Upper medial	Upper inner quadrant of breast **C502**
Inferior inner Inferior medial Lower inner quadrant (LIQ) Lower medial	Lower inner quadrant of breast **C503**
Superior lateral Superior outer Upper lateral Upper outer quadrant (UOQ)	Upper outer quadrant of breast **C504**

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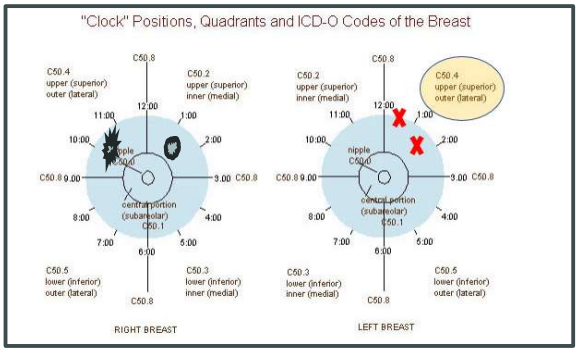
Multiple Tumors Abstracted as 1 Primary

- Multiple tumors abstracted as one primary
  - 2.1cm Mass 12:30 left breast
  - 1.1 cm mass Left Upper Outer Quadrant
- If they had been in different quadrants of the same breast, you would have coded C509 per Table 1.



Terms and Descriptive Language	Site Term and Code
¾ or more of breast involved with tumor Diffuse (tumor size 998) Entire breast Inflammatory without palpable mass Multiple tumors in different subsites (quadrants) within the same breast	Breast NOS **C509** ***Note:*** Used for: • Non-contiguous **multiple** tumors in **different quadrants/subsites** of same breast **OR** • **Unknown/unable to identify** in which **quadrant/subsite** the tumor is **located** (Example: Outpatient biopsy with no quadrant identified. Patient lost to follow-up.) • Inflammatory carcinoma; diffuse tumor

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Poll#2 Use the STR, Not Your Memory

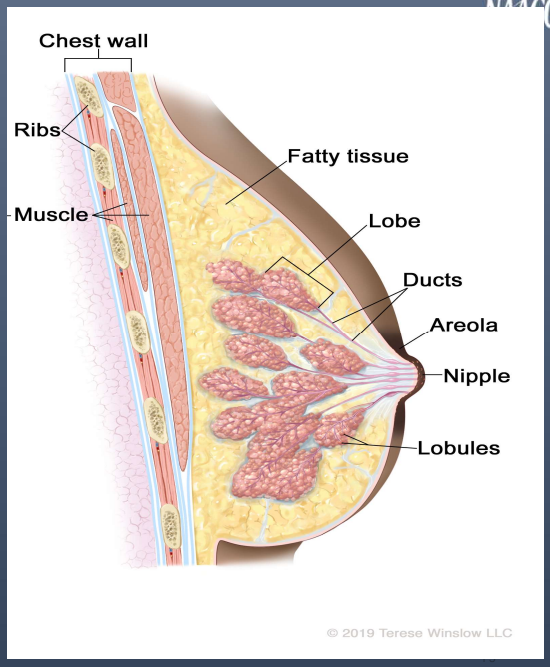
Scenario 2023:

Patient diagnosed Breast Cancer - DCIS, solid type

Question:

How will you code histology?

- 8500/2 Duct/ductal carcinoma in situ
- 8230/2 Ductal carcinoma in situ, solid type



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Poll#2 Answer & Rationale

Breast Solid Tumor Rules 2023 Update

- Rule H2 Code the histology when only one histology is present.
  - 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.

Carcinoma NST 8500 *Note*: Cribriform carcinoma may consist of up to 50% tubular formations. The term cribriform/tubular carcinoma is coded as cribriform carcinoma.	Carcinoma, NOS Carcinoma of no special type (ductal/NST) Carcinoma/carcinoma NST with choriocarcinomatous features Carcinoma/carcinoma NST with cribriform features Carcinoma/carcinoma NST with melanotic features Carcinoma/carcinoma NST with neuroendocrine features Carcinoma/carcinoma NST with signet ring cell differentiation DCIS **8500/2** DCIS of high nuclear grade 8500/2	Carcinoma with osteoclastic-like stromal giant cells **8035** Cribriform carcinoma/Ductal carcinoma, cribriform type **8201/3;** Cribriform carcinoma in situ **8201/2** Pleomorphic carcinoma **8022/3** Ductal carcinoma in situ, solid type/intraductal carcinoma, solid type **8230/2** Solid carcinoma/solid adenocarcinoma **8230/3**

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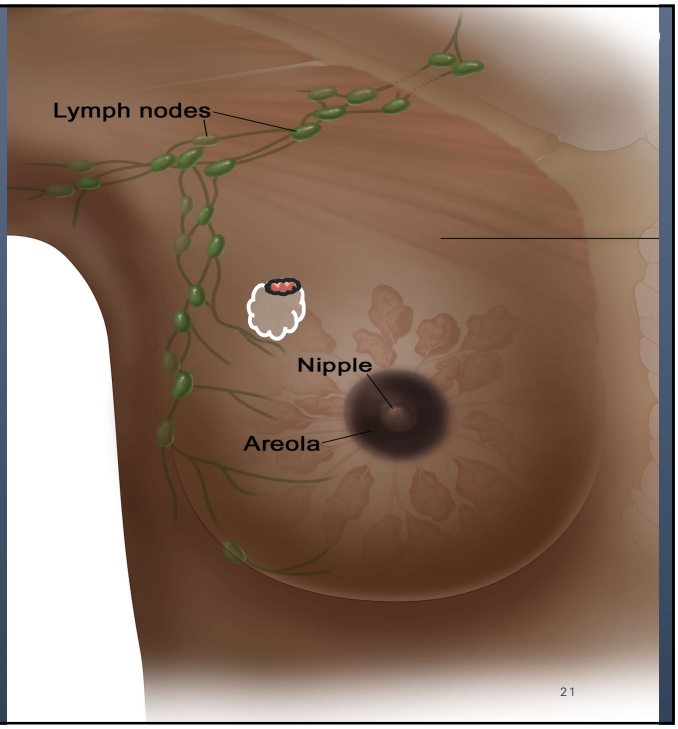
Poll#3 Ductal & Lobular Carcinoma

Scenario: 2023
Patient diagnosed with single tumor Right UOQ Breast 1.9 cm DCIS & 2mm invasive lobular carcinoma

Question:
How would you code histology?

- 8520/3 Lobular carcinoma, nos
- 8522/3 Infiltrating duct and lobular carcinoma



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Poll#3 Rationale

2. Different histologies
   A. Code the histology which comprises the majority of tumor.
   Note 1: This instruction **does not apply** to:
   - Invasive carcinoma NST/ductal and lobular carcinoma (use the combination code 8522/3).
   - Mucinous carcinoma and a different histology (see Histology Rules)
   - Metaplastic carcinoma, NOS and subtypes/variants and invasive carcinoma, NST (see Histology Rules)

Single Tumor: Invasive and In Situ Components

Rule H8 Code the **invasive** histology when both invasive and in situ components are present (see Notes 2 and 3 for exceptions).
Note 1: **Ignore** the in situ term.
- This is consistent with the 2007 MPH Rules.

Note 2: The following histologies are exceptions to this rule. When a single tumor has one of the histologies listed, continue through the rules.
- Encapsulated papillary carcinoma with invasion/with invasive carcinoma, NST/invasive duct carcinoma
- Solid papillary carcinoma with invasion

Note 3: When a single tumor has carcinoma NST/duct and lobular with different behaviors, continue through the rules.

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Poll#3 Answer

Rule H15 Code duct carcinoma and lobular carcinoma **8522/3** when the final diagnosis is any of the following:

- Invasive carcinoma NST/duct carcinoma and invasive lobular carcinoma (includes invasive pleomorphic lobular carcinoma)
- Intraductal and invasive lobular carcinoma (includes invasive pleomorphic lobular carcinoma)
- Infiltrating duct and lobular carcinoma in situ (LCIS)
- Infiltrating duct and pleomorphic lobular carcinoma in situ
- Infiltrating lobular carcinoma and ductal carcinoma in situ (DCIS)
- Infiltrating pleomorphic lobular carcinoma and ductal carcinoma in situ (DCIS)

Note 1: Assign behavior code /3 even when an **in situ** histology is mixed with an **invasive**. This aligns with ICD-O-3.2 and was vetted with specialty matter experts.

Note 2: CAP uses the term **Invasive carcinoma with ductal and lobular features** ("mixed type carcinoma") as a synonym for duct carcinoma/carcinoma NST AND lobular carcinoma 8522/3.

Note 3: Although the instructions in the "Coding Multiple Histologies in a Single Tumor" section state, "Code the histology that comprises the majority of tumor", 8522/3 identifies both invasive carcinoma NST/duct carcinoma and invasive lobular carcinoma and is the most accurate description.

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2022 Revision History Solid Tumor Rules

Breast

Terms and Definitions

- New Section: New for 2023
- Table 2: Histology Combination Codes
  - Duct + Lobular row
    - 8519 (Pleomorphic lobular carcinoma) added
    - Note 1 deleted: Both histologies, duct and lobular, must have the same behavior code.
    - "Additional Combinations of duct and lobular" section added
- Table 3: Specific Histologies, NOS, and Subtypes/Variants
  - Carcinoma NST 8500 row
    - Clarification: "Cribriform carcinoma in situ 8201/2" added to the subtypes/variants
  - Papillary Carcinoma row
    - Clarification: "Encapsulated papillary carcinoma" and "non-infiltrating/intracystic" combined into the same line 8504/2
  - Sarcoma row
    - "Post radiation angiosarcoma of breast" added as a synonym of angiosarcoma
    - Note 3 added regarding angiosarcoma synonyms

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EOD Nodes

CODE	Description	AJCC N Category
000	CLINICAL assessment only No clinical regional lymph node involvement	cN0
030	PATHOLOGICAL assessment only ITCs only (malignant cell clusters no larger than 0.2 mm) in regional lymph node(s)	pN0(i+)
050	PATHOLOGICAL assessment only Positive molecular findings by reverse transcriptase polymerase chain reaction (RT-PCR), no ITCs detected	pN0 (mol+)
070	PATHOLOGICAL assessment only **No regional lymph node involvement pathologically (lymph nodes removed and pathologically negative)** WITHOUT ITCs or ITC testing unknown	pM-

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SSDI ER/PR

Result	Code	Rationale
>95%	96	When "greater than" is used, code one above
<95%	94	When "less than" is used, code one below
1-5%	R10	If the range is less than or equal to 10, then code the appropriate R code based on the lower number
10-25%	XX9	If the range is greater than 10, then code to unknown
<1%	000	If ER/PR is negative, or percentage is less than 1%, code 000.
Close to 100%	99	"Close to" means almost that value, code one less than stated value
Approximately 1%	001	Since they are staging a single value, code to that value

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SSDI Ki-67

Result	Code	Rationale
<10%	9.9	When "greater than" is used, code one above
>90%	90.1	When "less than" is used, code one below
30-40%	30.1	For Breast when Ki-67 uses ranges: Code the same as greater than, coding 1 above the lowest value.

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SSDI ER/PR Allred Score

- ER/PR Total Allred only required years 2018-2022

Result	Code	Rationale
	<BLANK>	N/A-Diagnosis year is after 2022
ER Positive 85% Intensity 2-3	X9	• Proportion Score of 85% Equates to a 5 • Intensity Score listed as a range 2-3, thus you cannot use this to assign a Score • Allred Score= X9 [Allred score cannot be assigned because Intensity Score is unknown]

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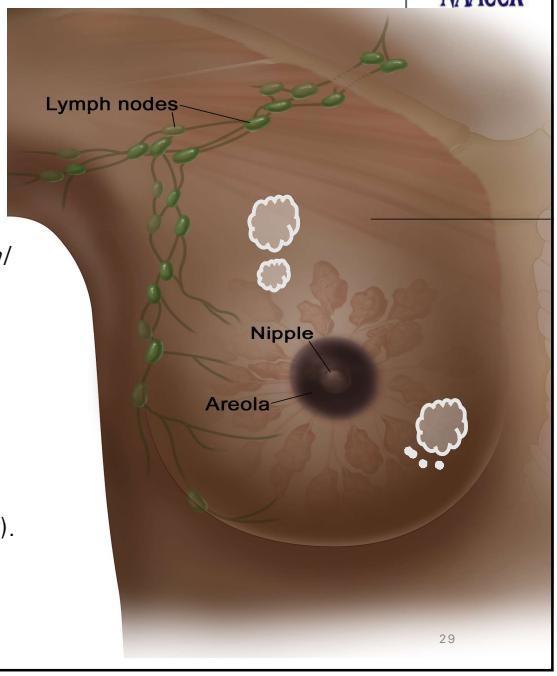
AJCC T Suffix

- Read Chapter 1 of the AJCC manual
- If the case is not eligible for AJCC staging, leave the data item blank.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules
- Code AJCC T Suffix as (m) when there are multiple synchronous tumors
  - Be careful, "Multifocal" does not have the same meaning as "synchronous" primary tumors.
  - Code the data item AJCC T Suffix as (m) when multiple invasive cancers are present (single primary).
  - Do not use for multiple foci of in situ cancer or for a mixed invasive and in situ cancer.



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Poll#4 FNA (-)

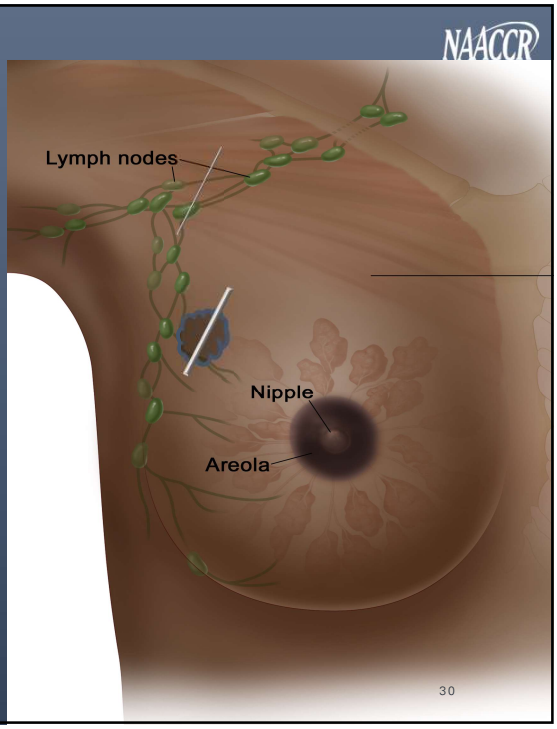
Scenario:

- Scans show RUOQ R breast mass, fullness in right axilla questionable for mets
- Biopsy of RUOQ Breast Mass+ Infiltrating Ductal
- FNA Right Axillary Node (-)

Question:

How will you assign the AJCC Clinic N Suffix?

- Blank
- (f) FNA or Core needle biopsy only



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Poll#4 Answer & Rationale

- (f) FNA or Core needle biopsy only
  - AJCC TNM Clin N Suffix
    - *Code (f) if an FNA or core biopsy of a regional node is done as part of the diagnostic work-up.*

Note: It does not matter if the FNA of the regional node was positive or negative, that information is recorded in the Regional Lymph Nodes Positive Field, this field just records whether an FNA or Core biopsy was done as part of the diagnostic workup.

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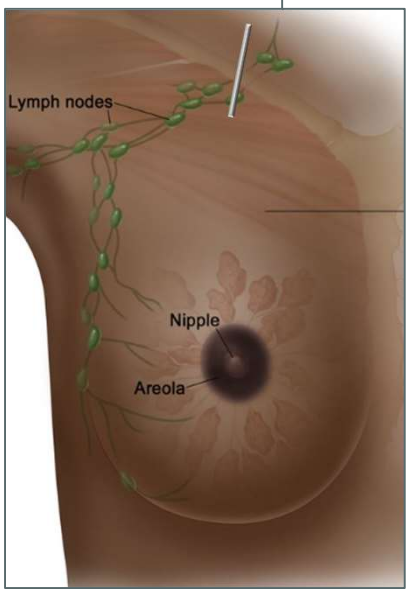
AJCC N Suffix

- The N Suffix data item should include the (f) suffix if an FNA or core biopsy is done on regional nodes as part of the staging work-up.
- The N Suffix data item should include the (sn) suffix if a SLN biopsy is performed and based on that information, an axillary node dissection is NOT done.



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AJCC N Suffix

- If a sentinel lymph node biopsy and regional node dissection are both performed:
  - Leave the n suffix BLANK
  - Do not code (sn)
  - (SN) is only coded when sentinel lymph node biopsy is done and no regional dissection.
- Sometimes, during a SLN bx non-sentinel nodes (no dye) are taken during the same operative procedure.
  - Consider these nodes part of the SLN biopsy and not an axillary dissection, and code the (sn) suffix.

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STORE 2023- Appendix R

- Refer to STORE 2023 APPENDIX R: CTR Guide to Coding Radiation Therapy Treatment in the STORE
  - 30 Case Studies
  - Coding Modality for the Heavy Equipment of Modern Radiation Therapy Table
  - Radiation Therapy Useful Abbreviations
  - Summary of Radiation Coding Rules

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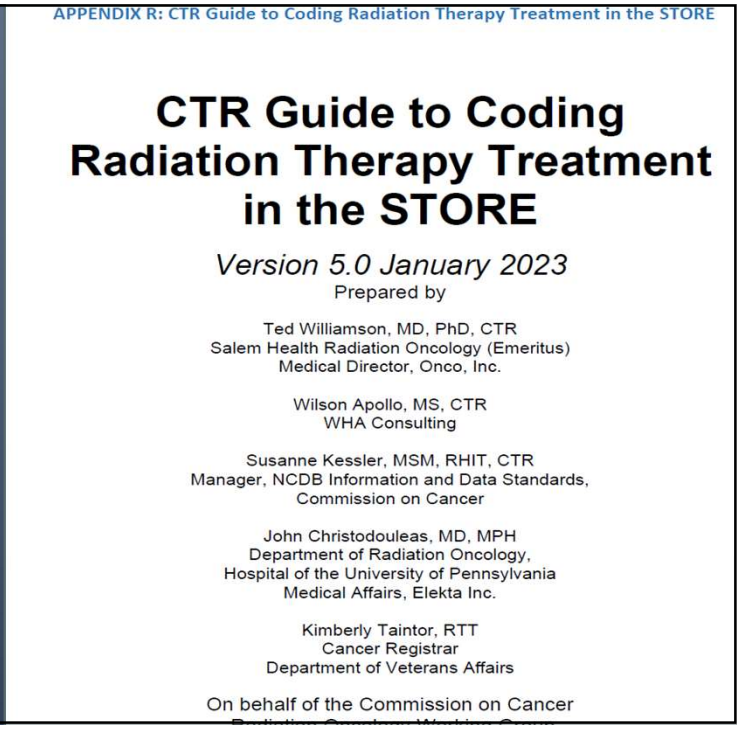
APPENDIX R: CTR Guide to Coding Radiation Therapy Treatment in the STORE

CTR Guide to Coding Radiation Therapy Treatment in the STORE

Version 5.0 January 2023

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Department of Veterans Affairs

On behalf of the Commission on Cancer

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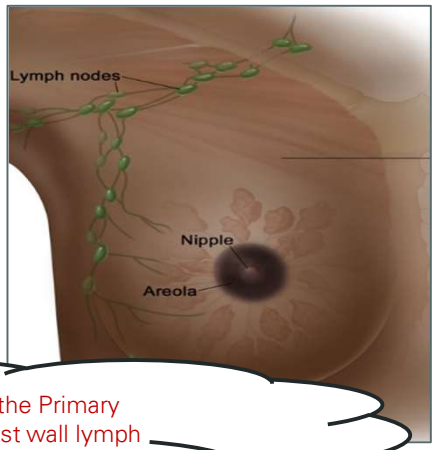
Phase I-II-III Radiation Primary Treatment Volume

- Code 40 (Breast – whole)
  - Assign 40 for patients who had whole breast radiation after a lumpectomy or partial mastectomy.
- Code 41 (Breast- partial)
  - Assign 41 for patients who had partial breast radiation after a lumpectomy
    - Consider the possibility of partial breast irradiation when "IMRT" is documented in the record.
- Code 42 (chest wall)
  - Assign 42 radiation after mastectomy.



If the breast AND lymph nodes are being treated, then code the Primary Treatment Volume to Breast (codes 40 or 41) and Breast/chest wall lymph nodes (code 04) in Radiation to Draining Lymph Nodes.

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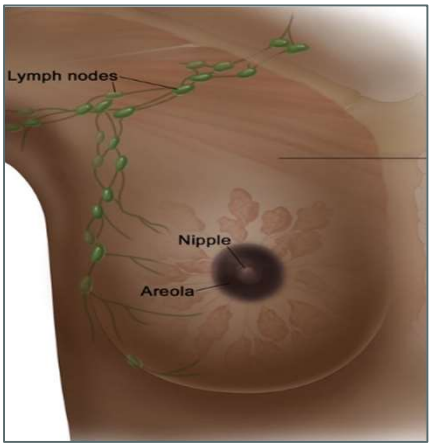
Poll#5 IORT-Electronic Brachytherapy

<u>Scenario:</u>

High dose rate intraoperative radiation treatment/IORT of 20 Gy, prescribed at the balloon surface, was delivered via the 50 kV x-ray electronic brachytherapy source, with XOFT Electronic Brachytherapy controller



<u>Question:</u>

How would you code Radiation Modality & Planning Technique?

•Modality: 02 External Beam, photon. Planning Technique: 02 Low energy x-ray photon therapy

•Modality: 12 Brachytherapy, electronic Planning Technique: 88 Not Applicable Treatment not by external beam

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Poll#5 Answer & Rationale

- Modality: 02 External Beam, photon. Planning Technique: 02 Low energy x-ray photon therapy
- Refer to STORE 2023 Appendix R CTR Guide to Coding Radiation Therapy Treatment in the STORE
  - Coding Modality for the Heavy Equipment of Modern Radiation Therapy Table

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Poll#6 Breast Surgery Codes

Question:

How would you code the following surgeries done at your facility?

- Unknown if contralateral breast removed
- No reconstruction done
- All had Needle bx+Infil ductal prior to surgery

A. Lumpectomy
B. Nipple Sparing Mastectomy
C. Skin Sparing Mastectomy
D. Simple Mastectomy w/ SLN
E. Mastectomy w/ SLN +Axillary Dissection

A200 Partial mastectomy, NOS; less than total mastectomy, NOS
A220 Lumpectomy or excisional biopsy
A300 Subcutaneous mastectomy
- A subcutaneous mastectomy, also called a nipple sparing mastectomy, is the removal of breast tissue without the nipple and areolar complex or overlying skin. It is performed to facilitate immediate breast reconstruction. Cases coded A300 may be considered to have undergone breast reconstruction.

A400 Total (simple) mastectomy
- A total (simple) mastectomy removes all breast tissue, the nipple, and areolar complex. An axillary dissection is not done, but sentinel lymph nodes may be removed.

A500 Modified radical mastectomy
- Removal of all breast tissue, the nipple, the areolar complex, and variable amounts of breast skin in continuity with the axilla. The specimen may or may not include a portion of the pectoralis major muscle

Excerpts from the SEER Program Coding and Staging Manual 2023

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Poll#6 Answer & Rationale

Surgery	Rx Summ-Surg 2023	Rx Summ-Surg Breast
Lumpectomy	A220	B200
Nipple Sparing Mastectomy	A300	B400
Skin Sparing Mastectomy	A400	B300
Simple Mastectomy w/ SLN	A400	B600
Mastectomy w/ SLN +Axillary Dissection	A500	B600

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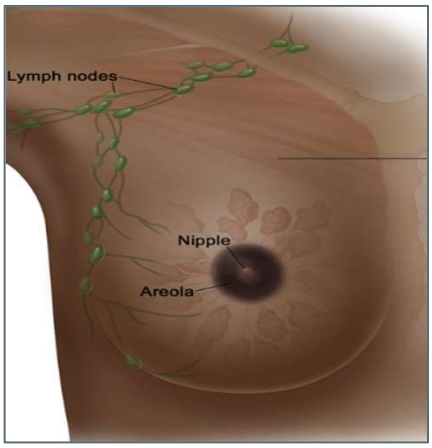
Mastectomy-Review

- Nipple Sparing Mastectomy
- Areola Sparing Mastectomy
- Skin Sparing Mastectomy
- Simple Mastectomy
- Modified Radical Mastectomy
- Radical Mastectomy



https://www.ypo.education/general/mastectomy:-simple,-skin-sparing-and-nipple-sparing-t399/video/

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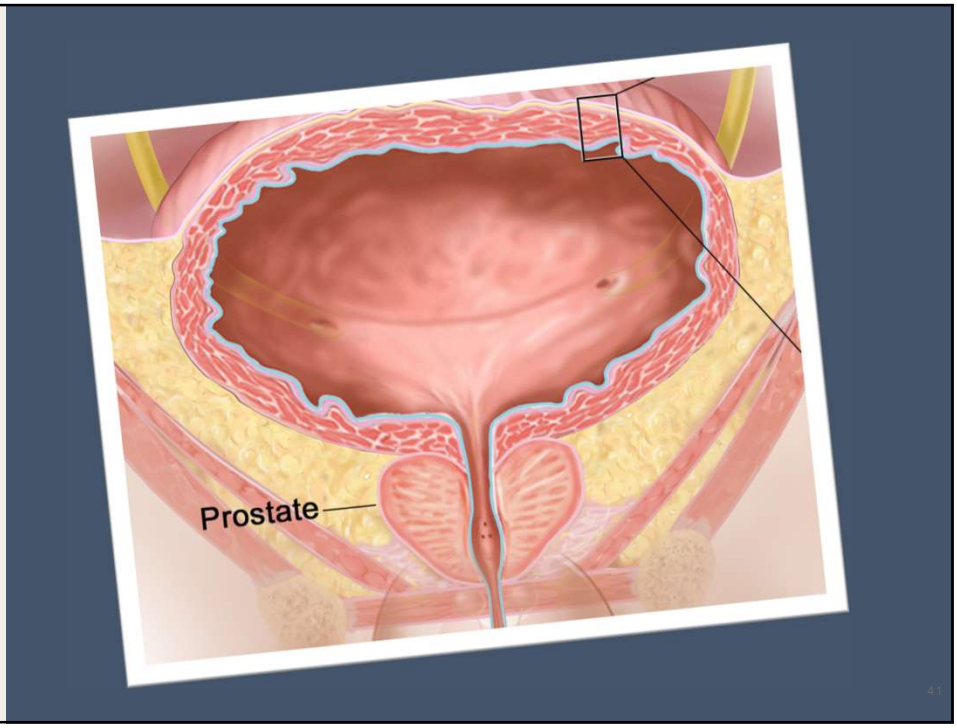
Prostate Cancer Tips



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Poll#7 cT Category

- Refer to the AJCC 8th Edition Chapter 58 Prostate Rules for Clinical Classification & Assign the cT category for each of the Scenario's below:

Scenario	cT
A. PSA Elevated 7.5. No DRE available in the EMR, Prostate biopsy confirmed bilateral Adenocarcinoma Gleason 3+3	
B. PSA Elevated 7.5. No DRE available in the EMR, Prostate biopsy confirmed bilateral Adenocarcinoma Gleason 3+3, Radiation Oncologist stages as cT1c cN0 cM0 Stage 1	
C. PSA Elevated 7.5, DRE: Prostate nodule present right lobe suspicious for malignancy. Prostate biopsy confirmed bilateral Adenocarcinoma Gleason 3+3	
D. PSA Elevated7.7.Per Urologist, DRE not done - telemedicine surgical consult only due to COVID.MRI 2.3cm suspicious area throughout majority of right gland & peripheral zone, extension into seminal vesicles, Pi-Rads 5,Biopsy: Gleason 7/4+3 in 12/12 cores both lobes of the prostate	
E. Patient had TURP for chronic urinary retention and removal of bladder calculi. [No mention of DRE or PSA being performed in any documentation.] Path: Adenocarcinoma in less than 5% of tissue resected.	

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Poll#7 Answer & Rationale

Scenario & cT	Janet Rationale
A. cT BLANK	The T category would be left blank since the registry doesn't have the information about the DRE.
B. cT BLANK or cT1c	I personally prefer cT BLANK, but cT1c is acceptable for the quiz.
C. cT2	The DRE only stated "right nodule present" without any indication of how much of the lobe was involved. We also cannot use the information from the biopsy which indicated bilateral disease, so the best we can do is assign a cT2.
D. cT BLANK	Clinical T category should always reflect DRE findings only, cannot use info from the MRI.
E. cT BLANK	NO DRE, NO Clinical T.

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Poll#8 Difference Between M1a,M1b,M1c

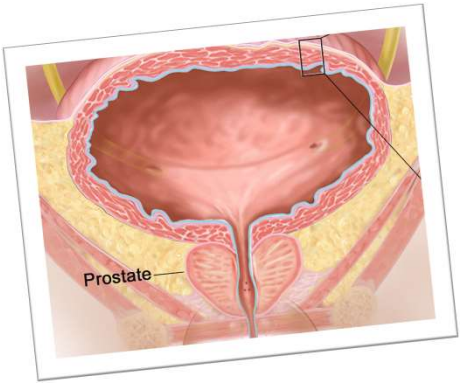
Scenario:

Elevated PSA, DRE (-) Biopsy+ Adenocarcinoma Gleason 4+4, Scans show **Bone Mets & Retroperitoneal Lymph Node Mets**

Question:

How would you assign cM1?

- cM1Distant Mets
- cM1a Nonregional Lymph node(s)
- cM1b Bone(s)
- cM1c Other site(s) with or without bone disease



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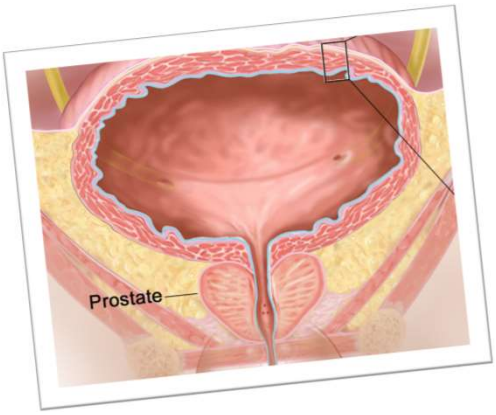
Poll#8 Answer & Rationale

- cM1b Bone(s)
  - *When a patient has multiple sites of distant metastasis, code the site with the highest code.*
  - *M1c indicates the patient has a metastatic site other than distant lymph nodes or bone mets.*



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SSDI #of Cores Examined

Note 2: Record the number of prostate core biopsies examined from the first prostate core biopsy diagnostic for cancer. If the number of cores examined is not specifically documented, code X6.

- Information from the first core biopsy is preferred since the physician is usually examining the entire prostate. If a second core biopsy is done, this is usually done on a specified area, so more cores will be found to be positive.

Note 3: If the pathology report contains a summary of the number of cores positive and examined, use the summary provided. If Summary Report is not available and multiple biopsy cores are obtained on the same day, the number of cores examined should be added.

- Do not include cores of other area like seminal vesicles
- Information from the gross description of the core biopsy pathology report can be used to code this data item when the gross findings provide the actual number of cores and not pieces, chips, fragments, etc.

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Prostate Radiation Volume

Scenario	Code Phase I-II-III Radiation Primary Treatment Volume as
Radiation treatment directed at the prostate **with or without seminal vesicles**	64 Prostate Whole
Radiation treatment directed at a **portion of the prostate**	65 Prostate Partial
Radiation treatment directed at **seminal vesicles only**	98 Other
Patient Status post Radical Prostatectomy, then treated with Radiation of the **entire pelvis**	64 Prostate Whole Draining Lymph Nodes:06 Pelvic Lymph nodes
Treated with iodine seed implant	64 Prostate Whole

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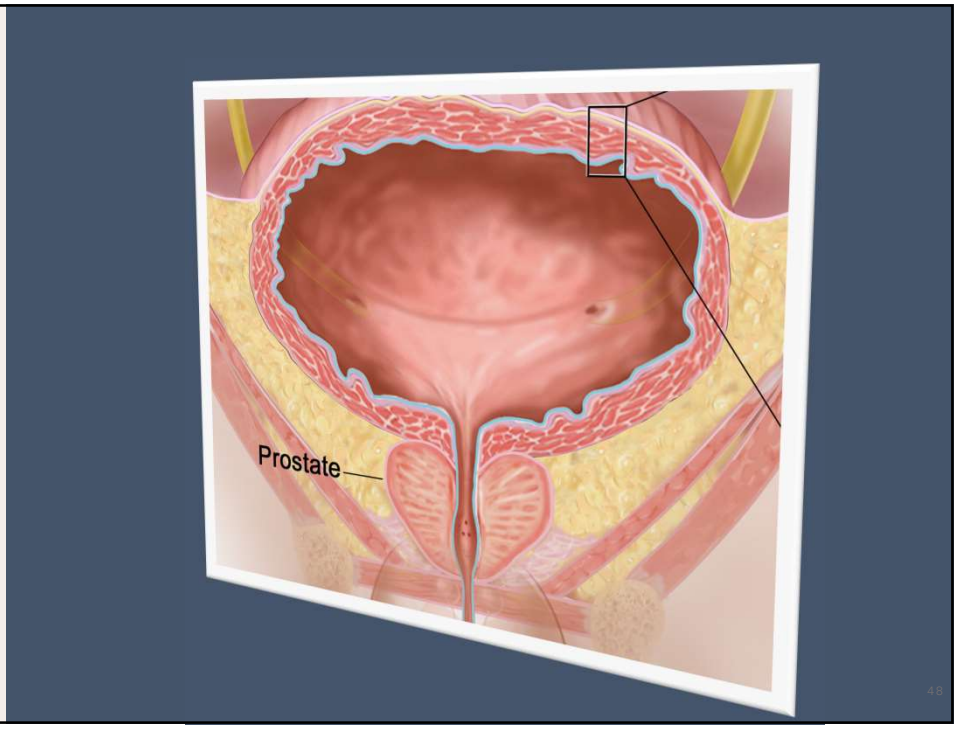
Bladder Cancer Tips



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Poll#9 Primary Site

Scenario:

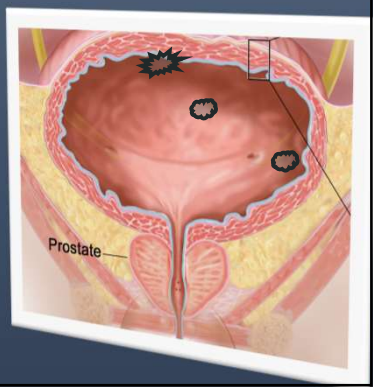
Op report: TURB: 3cm tumor in the dome of the bladder & several smaller tumors covering the posterior and lateral walls sent for biopsy

Path Report: Bladder Tumor TURBT: Invasive high grade papillary urothelial carcinoma positive for lamina propria invasion muscularis propria present negative for invasion. papillary urothelial carcinoma Right Lateral and Anterior Wall biopsy: Papillary urothelial ca, grade 1/3. No definitive evidence of invasion in subepithelial connective tissue. Muscularis propria is present, neg for ca.

Question:

What is the primary site?

- C671 Dome of the Bladder
- C678 Overlapping lesion of bladder
- C679 Bladder, NOS



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Poll#9 Answer & Rationale

- C671 Dome of the Bladder
- SEER Program Coding and Staging Manual Appendix C: Coding Guidelines-Bladder

Priority Order for Coding Subsites

Use the information from reports in the following priority order to code a subsite when the medical record contains conflicting information:

Operative report (TURB)
Pathology report

Multifocal Tumors

Assign site code C679 when there are multifocal tumors all of the same behavior in more than one subsite of the bladder and the specific subsite of origin is not known.

If the TURB or pathology proves invasive tumor in one subsite and in situ tumor in all other involved subsites, code to the subsite involved with **invasive** tumor.

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Poll#10 AJCC Pathological Stage

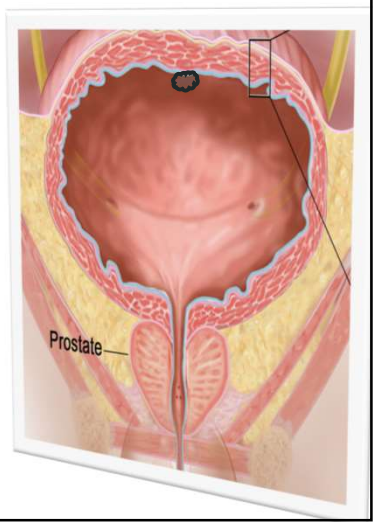
Scenario:

Path: urinary bladder, transurethral resection:

- **Histologic type:** Urothelial carcinoma
- **Variant histology: No**
- **Grade (WHO 2004)** Low-Grade
- **Tumor configuration**: Papillary
- **Microscopic extent of tumor:** Noninvasive
- **Muscularis propria Present**: Yes

Question: How would pathological stage be assigned?

A. pTa cN0 cM0 Stage 0A
B. pTa pNX cM0 Stage 99
C. pT BLANK pN BLANK pM BLANK Stage 99



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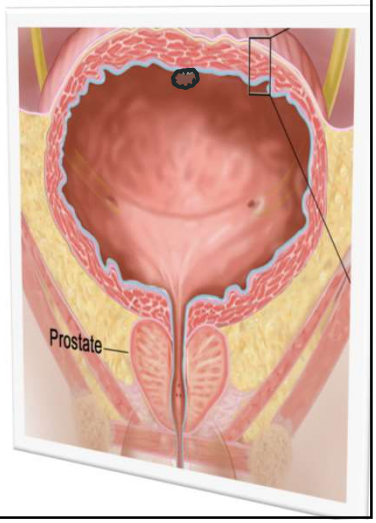
Poll#10 Answer & Rationale

- pT BLANK pN BLANK pM BLANK Stage 99
- TURB does not meet pathologic rules for classification.

Pathologic Grade will also be a 9 Grade Manual

If AJCC staging is being assigned, the tumor must meet the surgical resection requirements in the AJCC manual.



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Poll#11 T Suffix

Scenario:

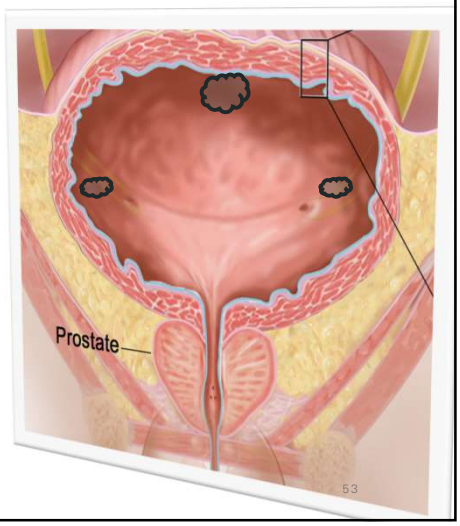
TURB : 1 cm bladder tumor on left wall, 1cm bladder tumor on posterior wall which were both fulgurated, and 3 cm bladder tumor on the bladder dome which was resected, and the base was fulgurated.

Pathology from TURB showed non-invasive urothelial cTa bladder cancers for all 3 tumors

Question:

How would the clinical T suffix be coded?

- (m) multiple tumors
- BLANK



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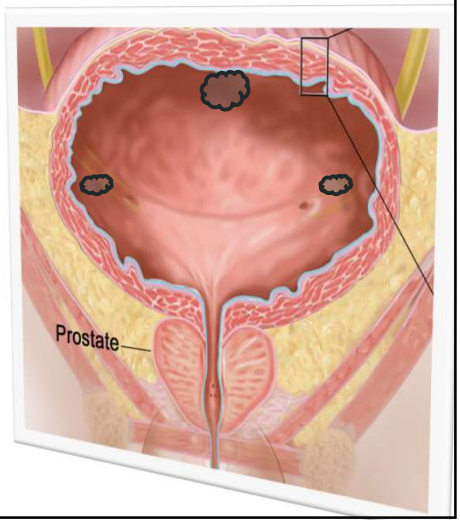
Poll#11 Answer & Rationale

- BLANK
  - The (m) suffix **does not** apply to non-invasive tumors
  - The (m) suffix should only be used when multiple **invasive** tumors are present



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TURB

Surgery	Code
TURB: 2cm right lateral wall lesion. The bladder **mass was resected and sent off for permanent pathology**	A270
TURB: 2cm right lateral wall lesion. The bladder mass was resected and sent off for permanent pathology. The **tumor base was then fulgurated to ensure tumor removed entirely.**	A220
TURB: 2cm right lateral wall lesion. The bladder mass was resected and sent off for permanent pathology. **Hemostasis was achieved using electrocautery**	A270

A200 Local tumor excision, NOS
A260 Polypectomy
A270 Excisional biopsy
[*SEER Note:* Code TURB as A270.]

Any combination of A200, A260, or A270 WITH
A210 Photodynamic therapy (PDT)
A220 Electrocautery
A230 Cryosurgery
A240 Laser ablation
A250 Laser excision

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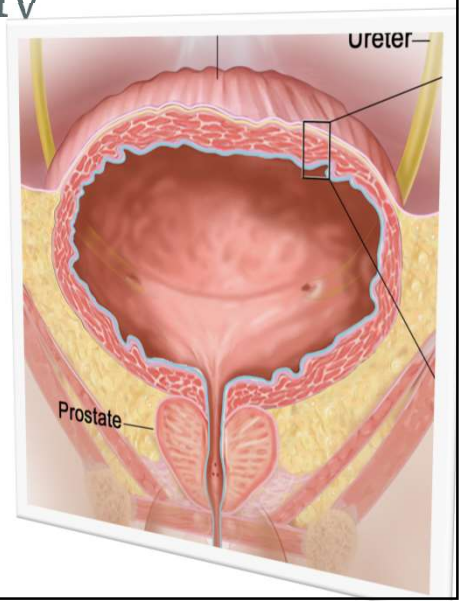
Poll#12 Cystoprostatectomy

<u>Scenario:</u> Radical cystoprostatectomy with ileal conduit conversion and incidental appendectomy (appendix was not involved)

<u>Question:</u> How would primary surgery be coded?

- A610 Radical cystectomy PLUS ileal conduit
- A710 Radical cystectomy including anterior exenteration



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Poll#12 Answer & Rationale

- A710 Radical cystectomy including anterior exenteration

A600 Complete cystectomy with reconstruction

[***SEER Note:*** Use code A710 for cystoprostatectomy. Use code A710 for cystectomy with hysterectomy.]

A610 Radical cystectomy PLUS ileal conduit

A700 Pelvic exenteration, NOS

A710 Radical cystectomy including anterior exenteration

[***SEER Note:*** Use code A710 for cystoprostatectomy. Use code A710 for cystectomy with hysterectomy.]

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Coding BCG

- How would you code the scenario's below if your software allows for multiple surgical entries.

Scenario	Coding
7-08-2023 TURB + BCG on same day	07-08-2023 Surgery Code A270 07-08-2023 Immunotherapy Code 01
07-08-2023 TURB 08-08-2023 comes back for BCG	07-08-2023 Surgery Code A270 08-08-2023 Surgery Code A160 08-08-2023 Immunotherapy Code 01
07-15-2023 TURBT w/ mitomycin instillation 08-25-2023 TURBT 11-09-2023 TURBT 11-17-2023 BCG	07-15-2023 Surgery Code A270 07-15-2023 Chemo Code 02 08-25-2023 Surgery Code A270 11-09-2023 Surgery Code A270 11-17-2023 Surgery Code A160 11-17-2023 Immunotherapy Code 01

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Rationale

- SEER Appendix C
  - [SEER Note: Code BCG as both surgery and immunotherapy.]
  - Also code the introduction of immunotherapy in the immunotherapy items. If immunotherapy is followed by surgery of the type coded A200-A800, code that surgery instead and code the immunotherapy only as immunotherapy.

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Reminders for Chemo/Immuno/Hormone

Mitomycin C should be recorded as chemotherapy (Sometimes you will see it noted in the Operative Report for TURB for Bladder Cancer cases)

Reminder for CoC Programs:

If a patient has hormone, chemotherapy, or immunotherapy at your facility, remember to enter the physician's NPI that performed/prescribed the therapy into the Med Onc Physician Field, it may or may not be a Medical Oncologist.

Don't forget those Bladder Patients that get chemo or those Prostate Patients that get Lupron. [This is noted on the NCDB Completeness and Default Overuse Report.]

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Neoadjuvant therapy

- Systemic only
- Do not code BCG/Mitomycin as neoadjuvant
- TURB is not "surgery" following neoadjuvant tx (does not qualify for ypT) may be used for ycT.

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Reminders about Text

- READ ENTIRE OP REPORT!
- **Operative text:** Note what was found in your text. Note information that supports primary site, extent of disease, tumor size and/or stage.
  - Date/Facility or Location/Physician Type/Surgery Performed
  - Findings from the Surgery-(Information that supports primary site, extent of disease, tumor size and/or stage.)
- **Surgery Text:** This field used to substantiate surgery coding
  - Date/Facility or Location/Physician Type /Surgery performed/Include lymph node status

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Poll#13 Primary Site

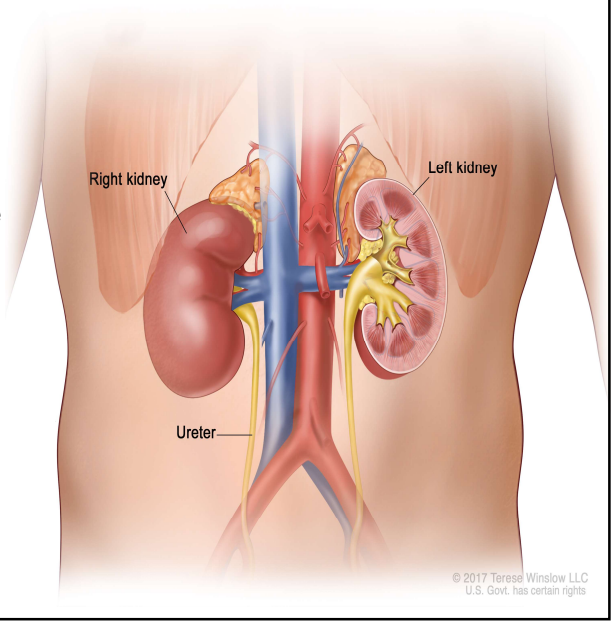
Scenario:

- CT Abdomen/Pelvis:13.1 cm right renal mass suspicious for renal cell carcinoma. Retroperitoneal lymphadenopathy. Soft tissue mass left adrenal gland concerning for mets.
- Renal biopsy: transitional cell carcinoma

Question:

What is the primary site?

- C649 Kidney
- C659 Renal Pelvis



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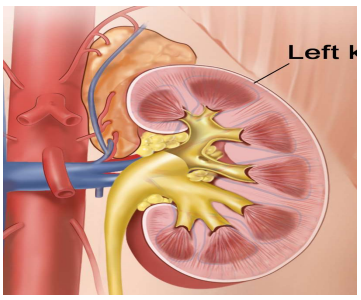
Poll#13 Answer & Rationale

- C659 Renal Pelvis
- Kidney Solid Tumor Rules Introduction page 1
  - Note 4: Transitional cell carcinoma rarely arises in the kidney C649. Transitional cell carcinoma of the upper urinary system usually arises in the renal pelvis C659. Only code a transitional cell carcinoma for kidney in the rare instance when pathology confirms the tumor originated in the kidney.

QA TIP: Review the cases with primary site coded to C649 and histology coded to 81203 (Transitional) or 81303 (Papillary Transitional) to see if the primary site was coded correctly.



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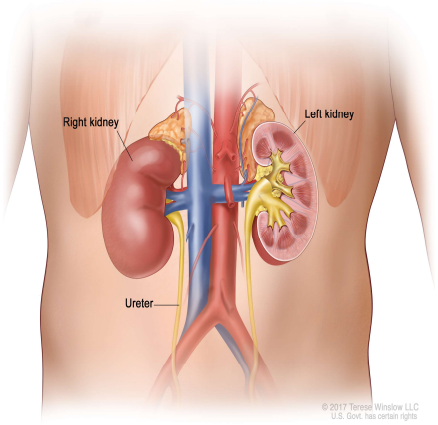
Poll#14 Histology

Scenario:

Nephrectomy, Histology: Clear cell papillary renal cell carcinoma

Question: How would you code histology?

- 8310 Clear cell renal cell carcinoma
- 8260 Papillary renal cell carcinoma
- 8323 Clear cell papillary renal cell carcinoma
- 8050 Papillary carcinoma, NOS



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Poll#14 Answer & Rationale

- 8323 Clear cell papillary renal cell carcinoma per STR

Histology	Histology	Number of Cases	Percent
Renal cell carcinoma, NOS (C64.9)	83123	290	76.52%
Clear cell adenocarcinoma, NOS	83103	25	6.60%
Transitional cell carcinoma, NOS	81203	12	3.17%
Papillary adenocarcinoma, NOS	82603	11	2.90%
Carcinoma, NOS	80103	13	3.43%
Papillary transitional cell carcinoma (C67._)	81303	10	2.64%
Renal cell carcinoma, chromophobe type (C64.9)	83173	7	1.85%
Papillary carcinoma, NOS	80503	5	1.32%
Adenocarcinoma, NOS	81403	1	0.26%
Renal cell carcinoma, sarcomatoid (C64.9)	83183	1	0.26%
Nephroblastoma, NOS (C64.9)	89603	1	0.26%
Cyst-associated renal cell carcinoma (C64.9)	83163	1	0.26%
Malignant tumor, clear cell type	80053	1	0.26%
Non-small cell carcinoma (C34._)	80463	1	0.26%

QA TIP: Review the cases with primary site coded to C649 and review the histology codes, see if anything looks like it doesn't belong… i.e.. Papillary Carcinoma, Transitional Cell carcinoma, Non Small Cell Carcinoma, etc.…

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Poll#15 SSDI Invasion Beyond Capsule

Scenario:

Procedure: Right Nephrectomy
Tumor Size: 11.5 cm
Histologic Type: Renal Cell Carcinoma
Histologic Grade: WHO Grade 4
Extent of Invasion: Tumor extending through renal capsule and into hilar adipose tissue
Perirenal Adipose Tissue: Invades
Gerota's fascia: Involves
Renal Vein: Involves
Ureter: Does not involve
Renal Sinus: Involves
Pelvicalyceal: Involves
Adrenal: NA
Other Organs: N/A
Lymph Nodes: No lymph nodes submitted or found
AJCC: pT4 pNX

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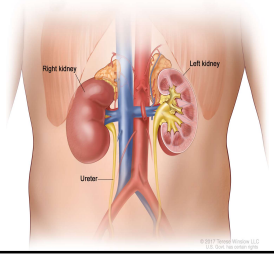
Question:
How would you assign SSDI Invasion Beyond Capsule?

1. Perinephric (beyond renal capsule) fat or tissue
2. Renal sinus
3. Gerota's fascia
4. Any combination of codes 1-3



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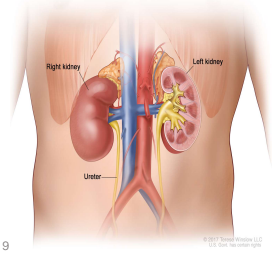
Poll#15 Answer & Rationale

- 4 Any combination of codes 1-3
  - 1 Perinephric (beyond renal capsule) fat or tissue
  - 2 Renal sinus
  - 3 Gerota's fascia
  - 4 Any combination of codes 1-3



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Procedure: Right Nephrectomy
Tumor Size: 11.5 cm
Histologic Type: Renal Cell Carcinoma
Histologic Grade: WHO Grade 4
Extent of Invasion: Tumor extending through renal capsule and into hilar adipose tissue
Perirenal Adipose Tissue: Invades
Gerota's fascia: Involves
Renal Vein: Involves
Ureter: Does not involve
Renal Sinus: Involves
Pelvicalyceal: Involves
Adrenal: NA
Other Organs: N/A
Lymph Nodes: No lymph nodes submitted or found
AJCC: pT4 pNX

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SSDI Ipsilateral Adrenal Gland Involvement Non-Localized Disease

9 involvement not assessed or unknown if assessed

Procedure: Right Nephrectomy
Tumor Size: 11.5 cm
Tumor Focality: Unifocal
Histologic Type: Renal Cell Carcinoma
Sarcomatoid Features: Not identified
Rhabdoid Features: Not identified
Histologic Grade: WHO Grade 4
Tumor Necrosis: Present
Extent of Invasion: **Tumor extending through renal capsule and into hilar adipose tissue**
Perirenal Adipose Tissue: Invades
Gerota's fascia: Involves
Renal Vein: Involves
Ureter: Does not involve
Renal Sinus: Involves
Pelvicalyceal: Involves
Adrenal gland: Not present
Other Organs: N/A
Margins: Uninvolved
Lymphovascular Invasion: Not Identified
Lymph Nodes: No lymph nodes submitted or found
AJCC: pT4 pNX

SSDI Manual:

Note 3: Record ipsilateral adrenal gland involvement as documented in the pathology report.

Note 4: Do not use imaging findings to code this data item.

Note 5: Code 9 if surgical resection of the primary site is performed and there is no mention of ipsilateral adrenal gland involvement.

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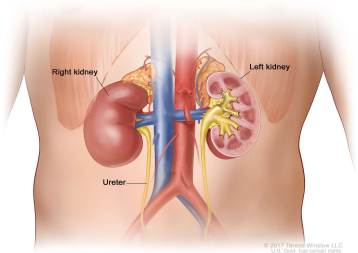
SSDI's Confined Kidney-Surgically Resected

Ipsilateral Adrenal Gland Involvement- 0

Invasion Beyond the Capsule-0

Major Vein Involvement-0

Refer to Note 2 in SSDI manual



Procedure: Right Nephrectomy
Tumor Size: 2.5cm
Tumor Focality: Unifocal
Histologic Type: Renal Cell Carcinoma
Sarcomatoid Features: Not identified
Rhabdoid Features: Not identified
Histologic Grade: WHO Grade 2
Tumor Necrosis: Present
Extent of Invasion: Tumor limited to the kidney
Margins: Uninvolved
Lymphovascular Invasion: Not Identified
Lymph Nodes: No lymph nodes submitted or found
AJCC: pT4 pNX

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Poll#16 SSDI's Confined Kidney-No Surgery

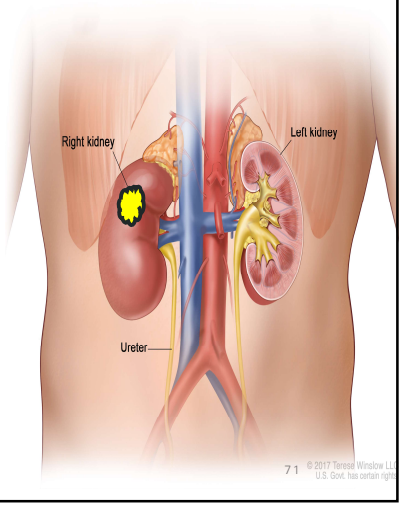
Scenario:

- CT ab: 2.5cm mass right kidney consistent with renal cell carcinoma **limited to the kidney**, no evidence of lymphadenopathy or distant metastatic disease
- Physician staged as cT1a cN0 cM0 Stage 1
- Plan: Due to patient's age and comorbid conditions no active treatment recommended at this time will continue follow the patient with surveillance.

Question:

How would you assign SSDI Ipsilateral Adrenal Gland Involvement?

- 0 involvement not present/not identified
- 9 involvement not assessed or unknown if assessed



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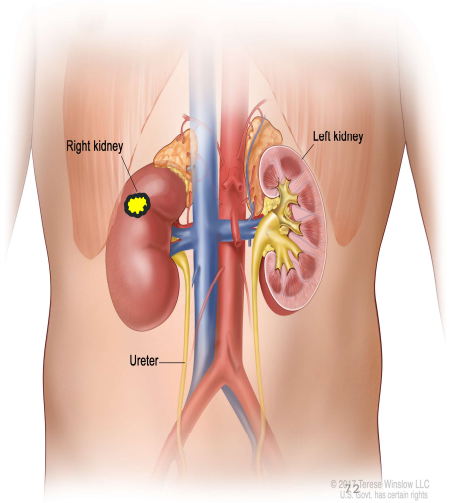
Poll#16 Answer & Rationale

- Ipsilateral Adrenal Gland Involvement
  - 9 involvement not assessed or unk if assessed
- Invasion Beyond the Capsule
  - 9 involvement not assessed or unk if assessed
- Major Vein Involvement
  - 9 involvement not assessed or unk if assessed

SSDI Manual:

- *Do not use imaging findings to code this data item.*



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Conclusion

Refer to SINQ/Ask a SEER Registrar for clarification about what is in these manuals	Refer to CAnswer Forum for clarification about what is in these manuals
• EOD • Hematopoietic Rules • ICD-0-3 Updates (for cases diagnosed 2018+) • SEER*RX • Solid Tumor Rules (for cases diagnosed 2018+) • Summary Stage 2018	• AJCC TNM Staging 8th Edition • Grade • Site-Specific Data Items • STORE
https://seer.cancer.gov/registrars/contact.html	http://cancerbulletin.facs.org/forums/help

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Questions?

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Fabulous Prizes



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CE Certificate Quiz/Survey

CE Phrase

- Phrase:

Link

- Link:

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- Wilson Apollo
- Thursday October 5, 2023

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- Denise Harrison
- Wednesday November 1, 2023 (PM Session)
- Thursday November 2, 2023 (AM Session)

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