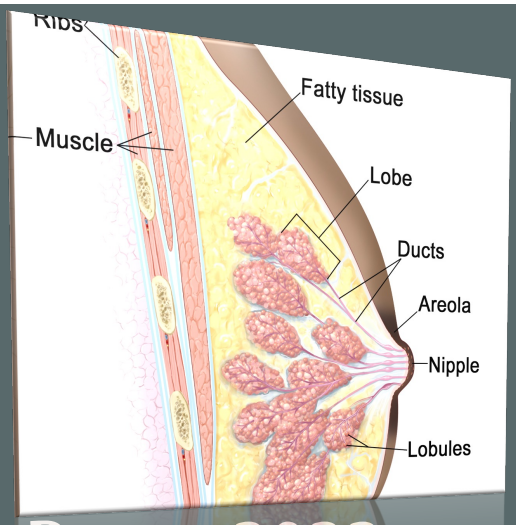


Breast 2022 Part 2

DENISE HARRISON, BS,CTR
JIM HOFFERKAMP, BA, CTR

11/10/2022

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.

Fabulous Prizes

Guest Presenter

- Denise Harrison, BS, CTR
  - Cancer Registrar Educator and Trainer

Agenda

Appendix A Surgery Codes for Breast
Breast Surgery Field Study
Breast Reconstruction Field Study
Grade
SSDI

Poll 1 - LCIS

Lobular carcinoma in situ (LCIS) and it subtypes/variants are no longer reportable to the CoC.

A. True
B. False

Breast In-situ Histologies

Histology		Reportable	AJCC Staging	Notes
8201/2	Cribriform carcinoma in situ	CoC/NPCR/SEER	Yes	
8500/2	Ductal carcinoma in situ	CoC/NPCR/SEER	Yes	
8501/2	Comedocarcinoma, noninfiltrating	CoC/NPCR/SEER	Yes	
8503/2	Intraductal papilloma w/ DCIS	CoC/NPCR/SEER	Yes	
8504/2	Encapsulated papillary carcinoma	CoC/NPCR/SEER	Yes	
8507/2	Intraductal micropapillary carcinoma	CoC/NPCR/SEER	Yes	
8509/2	Solid papillary carcinoma	CoC/NPCR/SEER	Yes	
8540/2	Paget disease of the nipple	CoC/NPCR/SEER	Yes	
8543/2	Paget disease and intraductal carcinoma	CoC/NPCR/SEER	Yes	
8520/2	**Lobular carcinoma in situ**	**NPCR/SEER**	**No**	**Class of Case 34 or 36 for 2018+ diagnoses**
8519/2	**Pleomorphic lobular carcinoma in situ**	**CoC/NPCR/SEER**	**No**	

Breast Surgery

APPENDIX A Surgery Codes 2003-2022 vs. 2023+

- 2003-2022: 2-digit numeric code (example: 20)
- 2023+: 4-digit alphanumeric code (example: A200)
  - All sites (except skin) start with an **A**
  - Code structure: **A** + old 2-digit code + **0**
    - 20 – **A20 0**
    - 30 – **A30 0**

Surgery Codes Comparison of pre-2023 to 2023+ Codes

	Code	Description
2022	2023+	
20	A**20**0	Partial mastectomy; less than total mastectomy, NOS
21	A**21**0	Partial mastectomy WITH nipple resection
22	A**22**0	Lumpectomy or Excisional biopsy
23	A**23**0	Re-excision of bx site for gross or microscopic residual dz
24	A**24**0	Segmental mastectomy (including wedge resection, quadrantectomy, tylectomy)

Breast Surgical Codes – Appendix A STORE 2023+ Diagnoses

Code	Description
A000	No surgery of primary site
A190	Local tumor destruction, NOS (primarily for cases dx'd < 2003
Breast Conserving/Preserving Surgeries (A200-A240)	
A200	Partial mastectomy; less than total mastectomy, NOS
A210	Partial mastectomy WITH nipple resection
A220	Lumpectomy or Excisional biopsy
A230	Re-excision of bx site for gross or microscopic residual dz
A240	Segmental mastectomy (including wedge resection, quadrantectomy, tylectomy)

Partial mastectomy versus Lumpectomy/Excisional Biopsy

When is a partial mastectomy coded as 20 (A200) partial mastectomy, NOS vs Lumpectomy 22 (A220)?

- Use the NOS surgical codes when there is very limited information available about what procedure the patient had and a more definitive surgical code cannot be used
- Review the **BODY** of the op report to sort out which procedure is done
- For codes 00 through 79, the response positions are **hierarchical**. Last-listed responses take precedence over responses written above.

Vocabulary

- **Lumpectomy** – removes breast tumor and a **small** amount of healthy breast tissue
- **Partial mastectomy** – removes breast tumor and a **larger** amount of healthy breast tissue and some skin (margins wider than lumpectomy)
  - May also include the fascia (lining over the chest muscles)
- **Segmental mastectomy** (quadrantectomy, tylectomy) – removes a 2-3 cm radius of normal tissue around the tumor plus a portion of the skin and underlying fascia

Technically, all are partial mastectomy procedures because part of the breast tissue is removed; the difference is the amount of tissue removed.

APPENDIX A

Mastectomy Types and Tissue(s) Removed

Type of Mastectomy					
Codes (2003-2022)	30	41, 42	51, 52	61, 62	71, 72
Codes (2023+)	A300	A410, A420	A4510, A520	A610, A620	A710, A720
Tissue Removed	Subcu-taneous	Simple	Modified	Radical	Extended
Breast tissue	Y	Y	Y	Y	Y
Nipple		Y	Y	Y	Y
Areola		Y	Y	Y	Y
Skin (amount varies)		Y	Y	Y	Y
SLN		Y/N	Y/N		
En bloc AxLND		N	Y	Y	Y
Pectoralis major		Fascia+/-	Fascia +/-	Y	Y
Pectoralis minor				Y	Y
Internal mamm LNs					Y

Bilateral Subcutaneous Mastectomies

- Contralateral breast INVOLVED
  - 2 primaries and each breast is assigned a surgery code of 30
  - Do **NOT** record the **IN**VOLVED contralateral breast in Surgical Procedure/Other Site

- Contralateral breast **UN**INVOLVED
  - Assign code 30 to INVOLVED breast
  - Do **NOT** record the **UN**INVOLVED contralateral breast in Surgical Procedure/Other Site

Bilateral Mastectomies*

- Patient with Lt breast cancer undergoes bilateral simple mastectomy. There is no cancer found or suspected in the Rt breast.
- How is the field "Surgical Procedure/Other Site" coded?
  A. 0 None
  B. 1 Non-primary surgical procedure performed
  C. 2 Non-primary surgical procedure to other regional sites
  D. 4 Non-primary surgical procedure to distant site

Combination Mastectomy and Reconstruction Codes (APPENDIX A)

Mastectomy Type	Simple		Modified Radical		Radical		Extended Radical	
Removal of uninvolved contralateral breast	NO	**YES**	NO	**YES**	NO	**YES**	NO	**YES**
No Reconstruction	A410	A420	A510	A520	A610	A620	A710	A720
Reconstruction NOS	A430	A470	A530	A570	A640	A680		
Tissue	A440	A480	A540	A580	A650	A690		
Implant	A450	A490	A550	A590	A660	A**73**0		
Combined	A460	A**75**0	A560	A**63**0	A670	A**74**0		

Lumpectomy with Reconstruction

- Pt undergoes Lt lumpectomy with reconstruction using abdominal fat (DIEP flap).
- How is surgery of primary site coded?
  A. A200 Partial mastectomy, less than total mastectomy, NOS
  B. A220 Lumpectomy/Excisional biopsy
  C. A430 Simple mastectomy w/out removal of contralateral breast w/ reconstruction, NOS
  D. A440 Simple mastectomy w/out removal of contralateral breast w/ tissue reconstruction

Breast Conserving/Preserving Surgery Codes- SEER Notes

[SEER Note: When a patient has a procedure coded to 20-24 (e.g., lumpectomy) **with reconstruction**, code **only the procedure** (e.g., lumpectomy, code 22) as the surgery.]

[SEER Note: **Assign code 22** when a patient has a lumpectomy and an additional margin excision **during the same procedure**.

According to the Commission on Cancer, re-excision of the margins intraoperatively during same surgical event does not require additional resources; it is still 22. **Subsequent re-excision of lumpectomy margins during separate surgical event** requires additional resources: anesthesia, op room, and surgical staff; it **qualifies for code 23**.]

Other Breast Surgery Codes: APPENDIX A

Other Surgery Codes	Description
A760	Bilateral mastectomy for a single tumor involving both breasts, as for bilateral inflammatory carcinoma.
A800	Mastectomy, NOS
A990	Surgery, NOS
A999	Unknown if surgery performed; death certificate ONLY

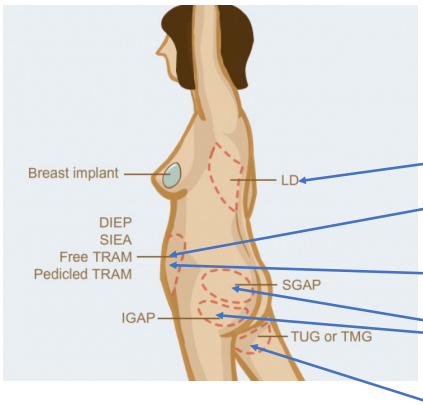
Bilateral Mastectomies

- Patient with Lt breast cancer undergoes bilateral simple mastectomy for bilateral inflammatory breast carcinoma.
- What is the surgery of primary site code?
  A. 41 (A410) Simple mastectomy w/o removal of uninvolved contralateral breast (through 2022 dx)
  B. 42 (A420) Simple mastectomy w/ removal of uninvolved contralateral breast
  C. 76 (A760) Bilateral mastectomy for a single tumor involving both breasts, as for bilateral inflammatory carcinoma (2023+ dx)

Bilateral Mastectomies

- Patient with Lt breast cancer undergoes bilateral simple mastectomy for inflammatory breast carcinoma involving both breasts.
- How is the field "Surgical Procedure/Other Site" coded:
  A. 0 None (2023+ dx)
  B. 1 Non-primary surgical procedure performed (through 2022 dx)
  C. 2 Non-primary surgical procedure to other regional sites
  D. 4 Non-primary surgical procedure to distant site

Reconstruction Words



https://www.breastcancercare.org.uk/information-support/facing-breast-cancer/living-beyond-breast-cancer/types-breast-reconstruction#SGAP flap

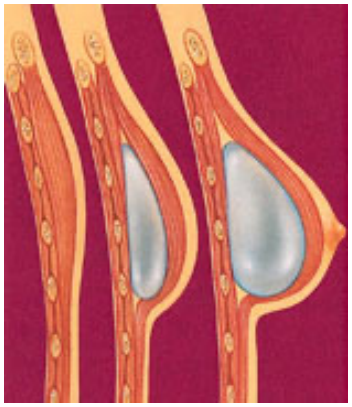
- Implants
  - Silicone, saline, expander
- Tissue
  - Latissimus dorsi
  - Deep inferior epigastric perforator/Super inferior epigastric artery flap
  - Transverse rectus abdominis muscle (free or pedicled)
  - Super gluteal artery perforator/Inferior gluteal artery perforater
  - Transverse myocutaneous gracilis/Transverse upper gracilis

Poll 2-Bilateral Mastectomies

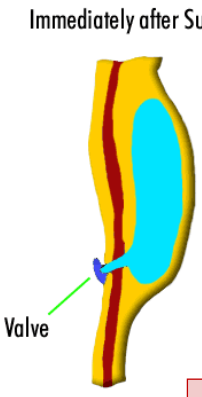
- Patient had a Rt. simple mastectomy with placement of tissue expander and acellular dermal matrix.
- How is the surgery coded?

A. 41 (A410) No reconstruction
B. 43 (A430) Reconstruction, NOS
C. 44 (A440) Tissue reconstruction
D. 45 (A450) Implant reconstruction
E. 46 (A460) Combined Tissue and Implant

Breast Reconstruction – Tissue Expander



www.plasticsurgery.org/public_education/procedures/BreastReconstruction.cfm



www.sghhealth4u.com.sg /.../ breast/breast4.htm

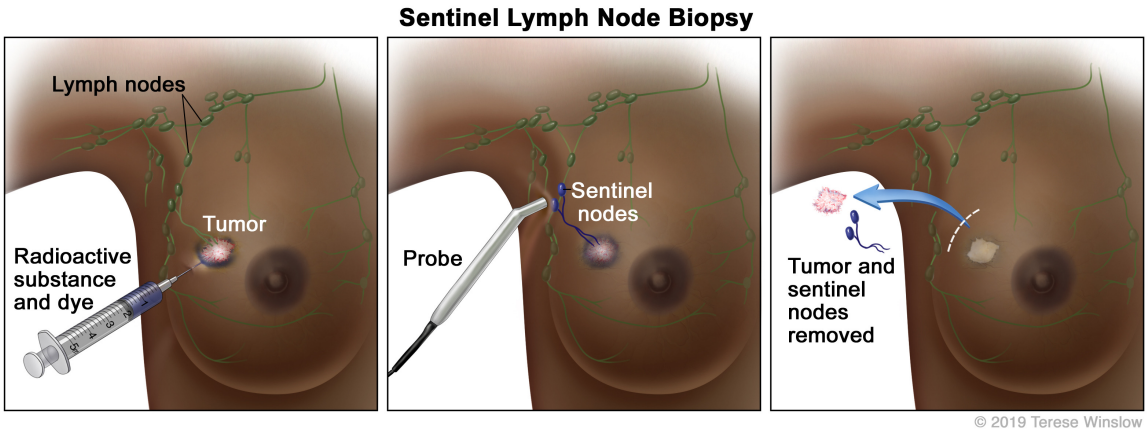
Reasons?
1. Stretch skin
2. Act as space-saver, & prevent scarring down to chest wall after RT
3. "Buy time" to explore reconstruction options

If only the tissue expander is placed, code reconstruction, NOS

Date Sentinel LN Biopsy

Date SLN Bx

- Breast and cutaneous melanoma cases ONLY
- **Only SLN** – do NOT code FNA, core needle bx, or core bx LN
- "SLN" suffix (sn) added to N in AJCC fields (unless RLN procedure performed during **same** staging timeframe: c, p, yc, or yp)



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Sentinel LN Examined / Positive: Breast

SLN

- If non-SLN in specimen, document <u>total nodes</u> removed / (+) during **SLN** procedure
- Subsequent RLN dissection, record removed / (+) **<u>SLN</u>** ONLY in this field
- Aspiration RLN and SLNBx, record results from SLNBx only

BREAST ONLY

- SLN during same procedure as RLND, use 97 for SLN (+)
- If <u>ITC</u> in SLN, those LN are **<u>negative</u>**

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Sentinel LN Examined / *Positive:* Breast

Code	SLN Examined	*SLN Positive*
00	No SLN examined	*All SLN examined are (-)*
01 – 90	SLN are examined (EXACT #)	SLN are *positive* (EXACT #)
95	Aspiration only of SLN performed	Aspiration only of SLN *positive*
97		*Positive SLN documented but # unk; **BREAST ONLY**, SLN & RLND occurred during **same** procedure*
98	SLN biopsied, # unknown	*No SLN biopsied*
99	Unknown if SLN examined; N/A or ~~negative~~; not stated in patient record	Unknown if SLN *positive*; N/A; not stated in patient record

Scope of Regional Lymph Node Surgery

Operative report is the primary source document to determine whether the operative procedure was a SLNBx, **or** a more extensive dissection of regional lymph nodes, **or** a combination of both SLNBx and regional lymph node dissection.

Code	Label	
1	Biopsy or aspiration of regional lymph node(s)	
2	Sentinel Lymph Node Biopsy	
3	# of RLNs removed unknown or not stated; RLNs removed, NOS	**No SLN procedure performed for codes 3-5!**
4	1-3 regional lymph nodes removed	
5	4 or more regional lymph nodes removed	
6	Sentinel node biopsy and code 3, 4, or 5 at same time, or timing not stated	
7	Sentinel node biopsy and code 3, 4, or 5 at different times	
9	Unknown or not applicable	

Practice: Coding SRLNP

- Op report: Lt breast skin sparing mastectomy and SLNbx procedure. Pathology: 0+/2 Lt Ax SLNs (in specimen A); Lt breast mastectomy (no axilla contents in specimen B): 0+/2 intramammary nodes
- How would the Scope of Regional Lymph Node Surgery be coded?
  a. 2 (SLN biopsy)
  b. 5 (4 or more RLNs removed)
  c. 6 (code 2 + 4) to capture the actual type and number of *nodes* removed

Regional LN Examined/Positive

- RLN only based on pathologic info ONLY (incl. post-neoadj.)
- Cumulative fields
- Aspiration/Core bx LN
  - Do NOT count in total if:
    - in same LN chain as dissection
    - in unknown LN region
  - Count in total if in different LN region
- Discrepency regarding the # LNs
  - Final dx > synoptic/CAP checklist) > microscopic > gross
- Mult. Primaries in same organ w/ (+) RLNs
  - Code to primary if can be determined, else, code (+) LNs to all primaries
- Definition of RLNs differs in AJCC versus SPCSM, use **AJCC** definition

Regional LN Examined / *Positive*

Code	RLN Examined	*RLN Positive*
00	No RLNs examined	*All RLN examined are (-)*
01 – 89	1 to 89 RLNs examined (EXACT #)	1 to 89 RLN are *positive* (EXACT #)
90	90 or more RLNs examined	90 or more RLNs *positive*
95	Aspiration or CNBx RLN performed	Aspiration or CNBx RLN *positive*
96	Sampling (limited #) and # unknown	
97	Dissection (LN chain) and # nodes unk.	*Positive* nodes - # unspecified
98	RLNs surgically removed but # unknown and not documented as sampling or dissection; nodes examined, # unknown	No RLNS examined
99	Unknown if RLN examined; N/A or negative; not stated in patient record	Unknown if RLN *positive*; N/A; not stated in patient record

Practice: What if SLN Procedure Fails to Map?

- 2/14/22: Lymphoscintigraphy w/ Neoprobe: No radioactive nodes identified. Lumpectomy w/ SLN bx: Ax incision and node exploration performed; no SLNs identified. Lumpectomy performed. Path: IDC, Nottingham G2, 1.3 cm, margins clear, no DCIS, no LVI.

Answers	
SRLNP	**2**
Date SLN Bx	**02/14/2022**
SLNs Examined	**00**
SLNs Positive	**98**
Date RLND	**<Blank>**
RLNs Examined	**00**
RLNs Positive	**98**

Practice: What if SLN Procedure Fails to Map?

2/14/22: Lymphoscintigraphy: No radioactive nodes identified. Lumpectomy w/ SLN bx: Ax incision and node exploration performed; no SLNs identified. AxLND performed. Lumpectomy performed. Path: IDC, Nottingham G2, 1.3 cm, margins clear, no DCIS, no LVI; 0+/3 AxLNs, IHC studies negative.

Answers	
SRLNP	**6**
Date SLN Bx	**02/14/2022**
SLNs Examined	**00**
SLNs Positive	**98**
Date RLND	**02/14/2022**
RLNs Examined	**03**
RLNs Positive	**00**

Mastectomy Practice (APPENDIX A)

2/20/22: Rt breast, Simple mastectomy, SLN 2+/3

2/25/22: AxLND 1+/8

Most Definitive Surgery code? **41 (A410)**

2022 (If 2023 dx)

3/15/22: Lt breast, Lumpectomy, AxLND, margins +, disseminated DCIS in the path report

3/25/22: Lt Breast, Simple mastectomy

Most Definitive Surgery code? **41 (A410)**

2022 (If 2023 dx)

Total or Final Results

- "If a previous surgical procedure to remove **a portion of the primary site** is followed by surgery to remove **the remainder of the primary site**, then code the total or final results. Do not rely on registry software to perform this task for you." STORE 2022 page 219; STORE 2023 page 217

Practice: Coding Multiple Breast Surgeries APPENDIX A

- 4/7/22: Bil Nipple-sparing mastectomy; SLNbx, reconstruction w/ abdominal free flap (Path found focal DCIS w/in 1 mm of nipple margins)
- 4/14/22: Excision of nipple/areolar complex

2022 (If 2023 dx)

30 (A300)

2022 (If 2023 dx)

44 (A440

Breast Surgery & Reconstruction

- "Field study" with voluntold involvement from every CoC facility
  - To update surgery codes in Appendix A
  - To support Synoptic Operative Reporting
  - To compare efficacy of treatment options
- Separate fields for surgery and reconstruction **at this facility** vs **at any facility**
- Code *most definitive* surgical procedure for primary site
  - Codes do **NOT** exactly align with Surg Prim Site codes in Appendix A
- These fields must be answered in addition to the Surg Prim Site fields

Breast Surgery Fields 

Which fields do I need to complete? 

Surgery Field	Diagnosis Year(s)	Location of Codes	Notes
RX Hosp--Surg Prim Site 2023	2023+	Appendix A	Code for ALL diagnoses 2023+ (Breast and other sites)
RX Summ--Surg Prim Site 2023	2023+	Appendix A	
RX Hosp--Surg Prim Site 03-2022	2003- 2022	Appendix A	Code for ALL diagnoses ≤ 2022 (Breast and other sites)
RX Summ--Surg Prim Site 03-2022	2003- 2022	Appendix A	
RX Hosp—Surg Breast	2022-2023	CoC-Specific Field	CoC-accredited facilities ONLY: **Code all 4 fields** for **BREAST** diagnoses 2022-2023 – Fields do **not** default to 000 codes when they are left blank
RX Summ—Surg Breast	2022-2023	CoC-Specific Field	
RX Hosp—Recon Breast	2022-2023	CoC-Specific Field	
RX Summ—Recon Breast	2022-2023	CoC-Specific Field	

The RX Summ fields include surgery/reconstruction at your facility because **any** facility includes **your** facility.

Breast Surgical Codes

2022-2023 Cases ONLY

Code	Description
B000	No surgery of primary site
B200	Partial mastectomy; less than total mastectomy; lumpectomy, segmental mastectomy, quadrantectomy, tylectomy, with or without nipple resection
B210	Excisional breast biopsy (**no pre-op bx-proven dx of cancer**)
B215	Excisional breast biopsy, **for atypia**
B240	Re-excision of margins from primary tumor site for gross or microscopic residual disease when less than total mastectomy performed
B290	Central lumpectomy, **only performed for a prior diagnosis of cancer**, which includes removal of the nipple areolar complex

Breast Surgical Codes: Mastectomy

2022 - 2023 Cases ONLY

Type of Mastectomy					
Codes	B300,10,20	B400,10, 20	B500,10,20	B600,10,20	B700,10,20
Tissue Removed	Skin-sparing	Nipple-sparing	Areolar-sparing	Simple and MRM	Radical
Breast tissue	Y	Y	Y	Y	Y
Nipple	Y	N	Y	Y	Y
Areola	Y	N	N	Y	Y
Skin	N	N	N	Y	Y
Pectoralis muscle	N	N	N	N (simple) Y/N (MRM)	Y
SLN	Y/N	Y/N	Y/N	Y/N	N
AxLND	Y/N	Y/N	Y/N	N (simple) Y (MRM)	Y (I-III)

Mastectomy, cont.

2022 - 2023 Cases ONLY

B300 – B700 (Mastectomy codes)

- 2 subcategories of each code based on whether uninvolved contralateral breast removed
  - B_10 – **W/O** removal of uninvolved contralateral breast
    - Ex: B310 Skin-sparing mastectomy w/o removal of uninvolved contralateral breast
  - B_20 – **WITH** removal of uninvolved contralateral breast
    Ex: B620 Simple mastectomy with removal of uninvolved contralateral breast

Other Breast Surgery Codes

Other Surgery Codes	Description
B760	Bilateral mastectomy for a single tumor involving both breasts, as for bilateral inflammatory carcinoma.
B800	Mastectomy, NOS (including extended radical mastectomy
B990	Surgery, NOS
B999	Unknown if surgery performed; death certificate ONLY

RX Hosp – Recon Breast RX Summ – Recon Breast

2022 - 2023 Cases ONLY

- Records **immediate** reconstruction procedure to the involved breast performed on the same day as surgical procedure
  - If reconstruction performed on DIFFERENT day, it is not collected/coded
- Dx Date 2022 and 2023 ONLY
- One surgeon may do resection and one may do reconstruction
- Multiple terms for oncoplastic surgery

Reconstruction Codes

2022-2023 Cases Only

Code	Description	Code	Description
A000	No Reconstruction	A600	Mastectomy reconstruction with autologous tissue, source not specified
A100	Tissue expander placement		
A200	Direct to implant placement	A610	WITH abdominal tissue
A300	Oncoplastic tissue rearrangement (not a formal mastopexy/reduction)	A620	WITH thigh tissue
		A630	WITH gluteal tissue
A400	Oncoplastic reduction and/or mastopexy	A640	WITH back tissue
A500	Oncoplastic reconstruction with regional tissue flaps		
A900	Reconstruction performed, method unknown		
A970	Implant based reconstruction, NOS		
A980	Autologous tissue-based reconstruction, NOS		
A990	Unknown if reconstruction performed		

Vocabulary Lesson

- **Oncoplastic** – combines plastic surgery techniques w/ the cancer surgery to give a better cosmetic outcome
- **Mammoplasty** - a group of surgical procedures, the goal of which is to reshape, resize, or otherwise modify the appearance of the breast
  - Augmentation
  - Reduction
  - Reconstruction
- **Mastopexy** – breast lift (removal of excess skin)
  - Wise pattern – anchor-shaped incision that goes around the chest and below the breast
  - LeJour – incision goes around the areola and down
  - Donut (peri—areolar) – incision goes around the areola only

Poll 3 Mammoplasty

- 2022 Lumpectomy, w/ "Wise-pattern reduction mammaplasty" during the same procedure. What is the reconstruction code?
  A. A000 No reconstruction
  B. A300 Oncoplastic tissue rearrangement (not a formal mastopexy/reduction)
  C. A400 Oncoplastic reduction and/or mastopexy
  D. A500 Oncoplastic reconstruction w/ regional tissue flaps

Poll 4 Which Reconstruction Code?

- Lt breast lumpectomy w/ Lt breast reconstruction w/ adjacent tissue transfer. What is the reconstruction code?
  A. A300 Oncoplastic tissue rearrangement (not a formal mastopexy/reduction)
  B. A400 Oncoplastic reduction and/or mastopexy
  C. A500 Oncoplastic reconstruction w/ regional tissue flaps

Which Surgery and Reconstruction Codes?

- 2022: Lt breast DCIS. Treatment: Lt segmental mastectomy, Lt breast oncoplastic reduction and Rt breast reduction for symmetry; Incidental finding of Rt breast IDC (margins +).
- Per MD – Rt breast MRI and MMG in ~ 4 wks; SLNBx needed, given the invasive cancer and (+) margin, re-excision is SOC (not possible due to unoriented margins, rearrangement of her tissues during the reduction surgery); mastectomy recommended (She did not favor that idea); whole breast radiation recommended to help to decrease recurrence.

Lt Breast Segmental Mastectomy: Surgery Code

A. B200 Partial mastectomy; less than total mastectomy; lumpectomy, segmental mastectomy, quadrantectomy, tylectomy, with or without nipple resection

B. B210 Excisional breast biopsy - Diagnostic excision, no pre-operative biopsy proven diagnosis of cancer

C. B215 Excisional breast biopsy, for atypia

D. B240 Re-excision of margins from primary tumor site for gross or microscopic residual disease when less than total mastectomy performed

Lt Breast Segmental Mastectomy and Oncoplastic Reduction: Reconstruction Code

A. A000 No reconstruction

B. A300 Oncoplastic tissue rearrangement (not a formal mastopexy/reduction)

C. A400 Oncoplastic reduction and/or mastopexy

D. A500 Oncoplastic reconstruction w/ regional tissue flaps

Rt Breast Reduction: Surgery Code

A. B200 Partial mastectomy; less than total mastectomy; lumpectomy, segmental mastectomy, quadrantectomy, tylectomy, with or without nipple resection

B. B210 Excisional breast biopsy - Diagnostic excision, no pre-operative biopsy proven diagnosis of cancer

C. B215 Excisional breast biopsy, for atypia

D. B240 Re-excision of margins from primary tumor site for gross or microscopic residual disease when less than total mastectomy performed

Rt Breast Reduction: Reconstruction Code

A. A000 No reconstruction

B. A300 Oncoplastic tissue rearrangement (not a formal mastopexy/reduction)

C. A400 Oncoplastic reduction and/or mastopexy

D. A500 Oncoplastic reconstruction w/ regional tissue flaps

Unilateral Skin-Sparing Mastectomy with Contralateral Reduction/Mastopexy

- Unilateral skin-sparing mastectomy with immediate reconstruction w/ tissue expander placement; contralateral (non-cancerous) breast received a reduction/mastopexy with implant insertion.

Surgery	**B310**
Reconstruction	**A100**

Grade Timeframes (Rooted in AJCC Timeframes)

- Grade **Clinical** (c)
  - Info during "clinical" time frame
    - Usually bx or FNA
    - **Before** any treatment
- Grade **Post-Therapy Clin** (**yc**)
  - Info **after** neoadjuvant Tx but **before** post-therapy surgical resection
  - Bx or FNA

Note: neoadjuvant therapy includes (primary systemic and/or radiation therapy

- Grade **Pathological** (p)
  - Info from a primary tumor that has been resected (in absence of neoadjuvant Tx)
  - Includes clinical info
- Grade **Post-Therapy Path** (**yp**)
  - Info from resected tumor POST neoadjuvant
  - Includes yc info

For grades (**p**) and (**yp**), resection of primary tumor with no macroscopic tumor at margins required: exception for pM1 for grade **(p)**

Neoadjuvant Endocrine Treatment

- https://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging-8th-edition/breast-chapter-48/breast-chapter-48-aa/118677-stage-classification-for-surgery-after-induction-endocrine-therapy

- Limited EXCEPTION to endocrine as neoadjuvant treatment: Per NCCN guidelines Version 4.2022 "Preoperative endocrine therapy alone may be considered for patients with ER-positive disease based on comorbidities or low-risk luminal biology based on clinical characteristics and/or genomic signatures."
  - Example: patient needs to be on Plavix for 6-12 months prior to surgey

Grade Coding Guidelines: Table 02

- Coding guidelines are set up as numbered notes
  - Notes listed in priority order
  - Many notes are common to all four timeframes
    - Grade pathological and grade post-therapy path have a special notes 2 and 6
    - Numbering for the notes in grade clinical and grade post-therapy clin will be different because of the extra notes in the grade pathological and grade post therapy path fields
  - Since most notes are shared, we will talk about the instructions by note number
    - This avoids repetition of the same note and helps us see the consistency among the various notes

Note 1: All Grade Timeframes

<table>
<tr><th>c</th><th>p</th><th>yc</th><th>yp</th></tr>
<tr><td colspan="2">Must not be blank</td><td colspan="2">Leave grade blank when:</td></tr>
<tr><td colspan="2" rowspan="5"></td><td colspan="2">• No neoadjuvant therapy</td></tr>
<tr><td colspan="2">• Clinical or pathological case only</td></tr>
<tr><td colspan="2">• Neoadjuvant therapy completed and:</td></tr>
<tr><td>• No microscopic exam prior to surgical resection</td><td>• No surgical resection</td></tr>
<tr><td colspan="2">• Only 1 grade available and it cannot be determined if it is c, p, yc or yp</td></tr>
</table>

Neoadjuvant therapy must meet the definition of neoadjuvant therapy

Note 2: p and yp Timeframes

p	yp
There is a preferred grading system for this schema.	
If **c** grade uses preferred grading system and **p** grade does not, do NOT record grade **c** in grade **p** field. Use the generic grade codes A-D.	If **yc** grade uses preferred grading system and **yp** grade does not, do NOT record grade **yc** in grade **yp** field. Use the generic grade codes A-D.

Notes 2, 3, and 4: c and yc Timeframes
Notes 3, 4, and 5: p and yp Timeframes

c	p	yc	yp
Note 2 (3) Assign the highest grade from the:			
primary tumor assessed during **c** timeframe	**primary tumor**	microscopically sampled specimen of **primary site** after neoadjuvant therapy (but before resection)	resected **primary tumor** assessed after the completion of neoadjuvant therapy
Note 3 (4): If there are multiple tumors with different grades abstracted as one primary, code the highest grade (**within each specified timeframe**)			
Note 4 (5): Invasive cancers: Codes 1-3 have priority over codes A-D In situ cancers: Codes L, M, and H have priority over codes A-D			

Breast Grades (Grade Table 12)

1	G1: low, favorable, SBR 3-5 pts
2	G2: intermediate, SBR 6-7 pts
3	G3: high (unfavorable), SBR 8-9 pts
L	Nuclear grade I (**L**ow, in situ only)
M	Nuclear grade II (inter**M**ediate, in situ only)
H	Nuclear grade III (**H**igh, in situ only)
A	Well differentiated
B	Moderately differentiated
C	Poorly differentiated
D	Undifferentiated, anaplastic
9	Grade not assigned (GX), unknown

Poll

- Breast biopsy, invasive ductal carcinoma, Nottingham grade 2. Lumpectomy, invasive ductal carcinoma, nuclear grade 3
- What grade is entered for Grade Pathological?
  A. 2
  B. 3
  C. 9
  D. C

Poll 5-Grade

- Breast biopsy, well to moderately differentiated mammary carcinoma (Oncology consult; Patient has a grade 1 invasive ductal carcinoma.); Lumpectomy, invasive ductal carcinoma, Nottingham grade 2.
- What grade is entered for Grade Clinical?
  A. 1
  B. 2
  C. A
  D. B

Notes 5, 6: c and yc Timeframes
Notes 6, 7: p and yp Timeframes

c	p	yc	yp
Note 5 (6): Scarff-Bloom-Richardson (SBR) score is used for grade. SBR is also referred to as: Bloom-Richardson, Nottingham, Nottingham modification of Bloom-Richardson score, Nottingham modification, Nottingham-Tenovus grade, or Nottingham score.			
Note 6 (7): All invasive breast carcinomas should be graded. Nottingham is based on tubule formation, nuclear pleomorphism, and mitotic count, which each morphologic feature scored 1 (favorable) to 3 (unfavorable). Do **not** calculate the score unless all three components are available. G1 - combined score of 3-5 points G2 - combined score of 6-7 points G2 - combined score of 8-9 points			

Poll 6-Grade

- No breast tumor identified, but 2/3 axillary nodes were positive from breast primary. Nodes were described as poorly differentiated with a high mitotic rate.
- What grade is coded in grade clinical?
  A. C
  B. 3
  C. 9

Notes 7: c and yc Timeframes
Notes 8: p and yp Timeframes

c	p	yc	yp
Note 7 (8): Grade from nodal tissue may be used **ONLY** when there was **never** any evidence of primary tumor (T0). Grade would be coded using G1, G2, or G3, even if the grading is not strictly Nottingham, which is difficult to perform in nodal tissue. Some of the terminology may include differentiation terms without some of the morphologic features used in Nottingham (e.g., well differentiated (G1), moderately differentiated (G2), or poorly/undifferentiated (G3)).			

Note 9: p and yp Timeframes

p	yp
Use the **c** grade from the primary	Use the y**c** grade from the primary tumor
in different scenarios based on **behavior** or **surgical resection**:	
Behavior	
• **c** and **p** diagnoses are same behavior AND the **c** grade is higher • **c** behavior is invasive and **p** is in situ	• **yc** and **yp** diagnoses are same behavior AND the **yc** grade is higher • **yc** behavior is invasive and y**p** is in situ
Surgical resection is done of the primary tumor	
	• After neoadjuvant Tx completed
• No grade documented from resection • No residual tumor	
No surgical resection of primary tumor but (+) micro conf. of distant mets during **c** timeframe	

Note 8 c and Timeframes
Note 10: p and yp Timeframes

c	yc	p	yp
Note 8 (10): **Code 9 (unknown) when:**			
Grade from primary site is not documented			
		Neoadjuvant therapy completed and	
	• Micro exam done	• Resection done after neoadjuvant	• Resection done and no yc grade
		• No resection (except pM1 per Note 9)	
• **c** w/up not done	• No residual	• No residual & no c grade	• No residual no yc grade
• Grade checked N/A on CAP Protocol and not other grade information available			
		• Only 1 grade available and ? if it is c, p, yc or yp	

Note 9: c and yc Timeframes
Note 11: p and yp Timeframes

c	p	yc	yp
Note 9 (11): If you are assigning an AJCC Staging System stage group Grade is required to assign stage group Codes A-D are treated as an unknown grade when assigning AJCC stage group An unknown grade **may** result in an unknown stage group			

Poll 7 - Stage Group

- cT1b cN0 cM0 High nuclear grade, Her2+, ER-, PR-
- What is the AJCC Prognostic Stage Group?
  - A. 99
  - B. IA

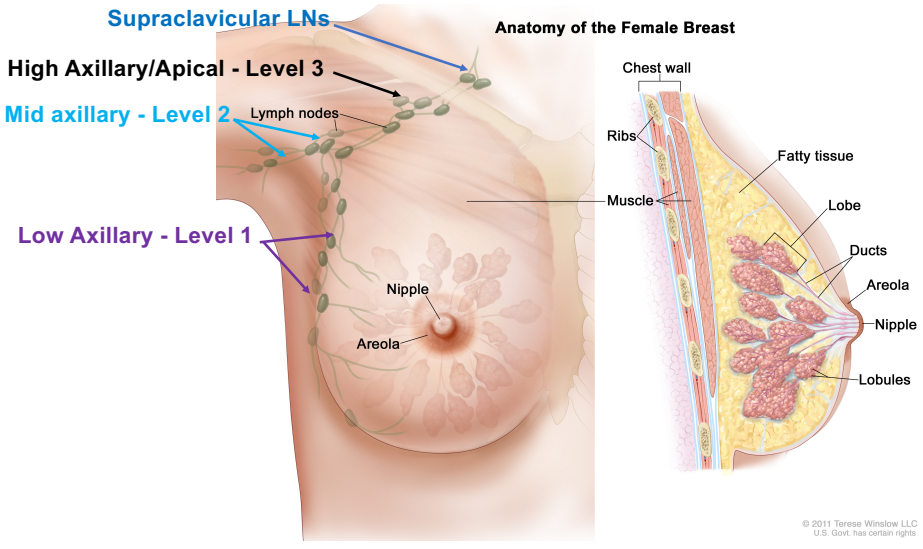
Breast SSDI

SSDI: LN Positive Axillary Level I – II

- MD statement when no other info available
- Include only Levels I & II, and INTRAmammary LNs
- Micro info only
- Do NOT count ITC+ LN
- Neoadjuvant given, code greatest involvement (clinical vs post-neoadjuvant tx)

Code	Description
00	All ipsilateral AxLN neg
01 - 99	EXACT number + AxLN
X1	≥ 100 AxLN
X5	+ AxLN, number unknown
X6	+ aspiration or CNBx AxLN
X8	N/A, info not collected
X9	Not documented in med record; unk if AxLN assessed; *AxLN drainage area removed but no LNs found*

Regional Lymph Nodes for Breast



Poll 8-SSDI

- Positive FNA of axillary lymph node; neoadjuvant therapy administered; LND revealed negative LNs
- How is the SSDI: LN Positive Axillary Level I – II assigned?
  A. 00
  B. 01
  C. X6

Poll 9-SSDI

- Patient w/ large breast mass; LNs negative on clinical exam; Neoadjuvant therapy administered; Mastectomy and SLNBx done, 1+/2 SLNs.
- How is the SSDI: LN Positive Axillary Level I – II assigned?
  A. 00
  B. 01
  C. X6

ER, PR, and Her2 Summary Fields

- MD statement can be used if no other info available
- Code Result from primary tumor
  - Use result from LN or other mets **ONLY** if no primary tumor found (T0)
- If neoadjuvant tx given, record assay from specimens **PRE** neoadj tx
  - Unless no pre-tx results
- If ER positive, LN negative, multigene test may be performed
  - Do **NOT** record test from multigene test

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ER, PR, and Her2 Summary Fields, cont.

Invasive and in situ components and test done on both

- Ignore the in situ results;
  - If neg. on invasive and positive on in situ, code 0
  - if only in situ is tested, code 9

Single tumor w/ multiple bxs and/or surgical resection with different results

- Use the highest (positive versus negative)

Multiple tumors w/ different test results

- Use result from largest TS (determined either clinically or pathologically) (use TS, not specimen size)

ER, PR, and Her2 Summary Codes

Code	ER	PR	Her 2
0	Negative		
			Equivocal
1	Positive		
7	Test ordered, results not in chart		
9	Not documented in medical record; Cannot be determined (indeterminate) (not listed for PR) Not assessed or unknown if assessed		
			Borderline

Poll 10-ER, PR, Her2 Summary

- Mastectomy: 3 masses identified: #1: IDC, G3, TS 1.3 cm, ER-, PR- Her2-; #2 DCIS, High grade, several foci spanning a 1.5 cm area and associated with calcifications, ER+, PR+, Her2 equivocal; #3: IDC, G2, TS 1.1 cm, ER+, PR+, Her2+.
- How are the ER, PR, and Her2 Summary fields coded?
  - A. 0, 0, 0
  - B. 1, 1, 0
  - C. 1, 1, 1

Poll 11-ER, PR, Her2 Summary

- Lt breast bx @ 9 o'clock: IDC, G2, ER+, PR-, Her2+
- Lt breast, lumpectomy: IDC, G2, ER-, PR+, Her2-
- How are ER, PR, and Her2 Summary Coded?
  - A. 1, 0, 1
  - B. 0, 1, 0
  - **C. 1, 1, 1**

ER(PR) % Positive or Range

- MD statement of ER(PR) positive % or range can be used
  - Actual % takes precedence over range
- ER(PR) negative or <1%, code 000
- If range given in steps ≤ 10, code to the range that contains the lowest # of the range
- If range is in steps >10, code XX9

Code	Description
XX7	Test done, results not in chart
XX8	N/A Info not collected
XX9	Not documented in med record; % or Range unknown

Code	Description
000	(-); Stated as < 1%
001-100	1-100%
R10	Stated as 1 – 10%
R20	Stated as 11 – 20%
R30	Stated as 21 – 30%
R40	Stated as 31 – 40%
R50	Stated as 41 – 50%
R60	Stated as 51 – 60%
R70	Stated as 61 – 70%
R80	Stated as 71 – 80%
R90	Stated as 81 – 90%
R99	Stated as 91 – 100%

How is the Percent Positive or Range Coded?

1. ER 25-34%
   A. 025
   B. R30 (21-30%)
   C. XX9

2. ER 45-75%
   A. 045
   B. R50 (41-50%)
   C. XX9 (per v3.0 updates)

ER(PR) Allred Score (2018-2022 dx only)

- MD statement of Allred score can be used
- Use same report as ER(PR) Summary
- Allred looks at % cells that test positive along with how well receptors show up after staining ("intensity")
- Can calculate Allred score from proportion **and** intensity scores

Code	Description
00	Total ER(PR) Allred score 0
01	Total ER(PR) Allred score 1
02	Total ER(PR) Allred score 2
03	Total ER(PR) Allred score 3
04	Total ER(PR) Allred score 4
05	Total ER(PR) Allred score 5
06	Total ER(PR) Allred score 6
07	Total ER(PR) Allred score 7
08	Total ER(PR) Allred score 8
X8	N/A, Info not collected
X9	Not documented in med record; ER(PR) Allred not assessed or unk if done

SSDI: Allred Score – How to Calculate (ER or PR)

Proportion Score	Positive Cells, %
0	0
1	< 1
2	1 to 10
3	11 to 33
4	34 to 66
5	≥ 67

Intensity	Intensity Score
None	0
Weak	1
Intermediate / Moderate	2
Strong	3

SSDI: Ki-67 (MIB-1)

- MD statement can be used
- Ki-67 marker of cell proliferation
- Reported as % cell nuclei that stain positive
- Results from LNs or metastatic tissue may be use only when there is no evidence of the primary tumor
- Invasive and in situ components and test is done on both, ignore in situ results
  - If test is (+) on an in situ component and (-) on all tested invasive components, code result as (-) [code 0.0]
  - If test only done on the in situ component, code unknown (code XXX.9)
- For Ki-67 in ranges: Code the same as greater than, coding 1 above the lowest value.

Code	Description
0.0 – 100.0	0.0 to 100.0 percent positive; enter % positive
XXX.7	Test done, % not stated
XXX.8	N/A, Info not collected
XXX.9	Not documented in med record. Ki-67 (MIB-1) not assessed or unk if assessed

Poll 12-Ki-67

1. Ki-67 < 10%
   A. 9.9
   B. 9.0
   C. XXX.9

2. Ki-67 10-15%
   A. 10.1
   B. 11
   C. XXX.9

SSDI: Oncotype Dx **INVASIVE**

- Genomic test that predicts likelihood of distant recurrence based on 21 genes (multigene panel)
- May be included in AJCC staging information
- Value < 11 with T1-T2, N0, M0, any grade, Her2 neg, ER+, PR any is Stage IA

Oncotype Recurrence Score: (Invasive and DCIS)

- MD statement of score can be used
- Reported as **whole** number 0 – 100.
  - INVASIVE: Actual score takes precedence over XX4 and XX5
- Only Oncotype DX recorded here; else, code XX9
  - INVASIVE : **Predicted** Oncotype DX based on linear regression models and Magee equations (~~code Magee score in Multigene Signature Method/Results fields~~)
  - IN SITU: Code XX9 for LCIS
- If only info is Oncotype Dx Risk Level, use XX7
- Use the same report as for Oncotype Risk Level
- If performed on > 1 tumor specimen, use HIGHEST

Magee Score Instructions

- https://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/81162-magee-ihc4-score

- Summary
- For a Magee score
  1. Assign code 9 for Multigene Signature method
  2. Assign code X9 for Multigene Signature results

Oncotype Recurrence Score Invasive and DCIS

Code	Description Invasive	Description DCIS
000 - 100	Record actual recurrence score	
XX4	Stated as < 11	
XX5	Stated as ≥ 11	
XX6	N/A, in situ case	N/A, invasive case
XX7	Test ordered, results not in chart	
XX9	Not documented in med record, Oncotype DX recurrence score unknown/not assessed	
		LCIS (per table notes)

SSDI: Oncotype Dx Risk Level Invasive and DCIS

- MD statement can be used
- INVASIVE: Stratifies score into risk level of low (< 17), intermediate (18 – 30), high risk (≥ 31) of distant recurrence
- DCIS: Stratifies score into risk level of low (< 39), intermediate (39 – 54), high risk (> 54) of local recurrence
- If only the score is given, assign based on the score
- Only Oncotype DX recorded here
- Risk level-DCIS: Assign 9 for LCIS
- Use same report used for Oncotype Dx Recurrence score

SSDI: Oncotype Dx Risk Level Invasive and DCIS

Code	Description - Invasive	Description - DCIS
0	Low risk: (recurrence score 0 – 17)	Low risk: (recurrence score <39)
1	Intermediate risk (recurrence score 18 – 30)	Intermediate risk (recurrence score 39 – 54)
2	High risk: (recurrence score ≥ 31)	High risk: (recurrence score > 54)
6	N/A, DCIS case	N/A, Invasive case
7	Test ordered, results not in chart	
8	N/A, info not collected	
9	Not documented in med record, risk level unknown	
	[redacted]	LCIS (per table notes)

2 SSDI: Multigene Signature Method Multigene Signature Result

- MD statement can be used
- Multigene signatures/classifiers are assays of a panel of genes from tumor
  - Quantify likelihood of response to chemotherapy
  - Evaluate prognosis or likelihood of future metastasis
- METHOD: Record **type** of test performed
- RESULT: Record:
  - **Score or risk** for PAM 50 (Prosigna) – score has priority over risk
  - **Risk level** for Mammaprint, EndoPredict, and Breast Cancer Index
- Do not code
  - Oncotype
  - Test that evaluate hereditary mutations (myRisk, BRCA)
- Use same test for both SSDI

Multigene Signature

Method

Code	Description
1	Mammaprint
2	PAM50 (Prosigna)
3	Breast Cancer Index
4	EndoPredict
5	Test performed, unknown type
6	Multiple tests, any codes 1-4
7	Test ordered, results not in chart
8	N/A, info not collected
9	Not documented in med record; unknown/not assessed

Result

Code	Description
00 – 99	Actual recurrence score
X1	Score 100
X2	Low risk
X3	Moderate (intermediate) risk
X4	High risk
X7	Test ordered, results not in chart
X8	N/A, info not collected
X9	Not documented in med record, results unknown/not assessed

SSDI: Response to Neoadjuvant Therapy

- MD statement **MUST** be used
- Code 1 ONLY when MD states "total" or "complete" response
- Response will be documented by physician based on **path report**, **imaging**, and **clinical findings**

Code	Description
0	Neoadjuvant therapy not given; in situ
1	Stated as complete (total) response (CR)
2	Stated as partial response (PR)
3	Stated as response to treatment, but not noted if complete or partial
4	Stated as no response
8	N/A, info not collected
9	Not documented in med record, response to neoadjuvant therapy unknown

Poll 13-Response to Neoadjuvant Therapy

- Breast: Pathology states

- Treatment effect in the breast: Probable treatment effect.
  - Treatment effect in the lymph nodes: No treatment effect.

- How is the SSDI Response to Neoadjuvant Therapy Coded?
  A. 2 Partial response
  B. 3 Response, but not noted if complete or partial
  C. 4 No response
  D. 9 Not documented

CE Certificate Quiz/Survey

CE Phrase

Link

- https://survey.alchemer.com/s3/7032777/Breast-2022-Part-2

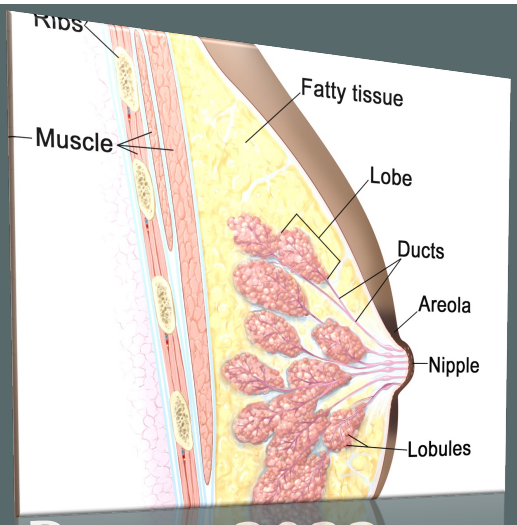
Coming UP...

Esophagus 2022

- Guest Host: Wilson Apollo, CTR
- 12/01/2022

Head and Neck 2023

- Guest Host: Vicki Hawhee
- 1/12/2023



Breast 2022 Part 2

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11/10/2022