ICRA Virtual Conference: 8.27.2020

Tumor Talk: Overview of Various Sites & Valuable Resources

Presenter: Gina McNellis, MA, RHIA, CTR, CHP

himagine solutions, inc

DISCLAIMER

This webinar is a compilation of previous webinars written between early June 2019 and June 2020. This webinar was written with the best information available to us at the time.

The 2018+ rules are still changing. When abstracting please be sure to note any changes or updates that might be available.

Objectives

- Discuss tips for more efficient abstracting
- Discuss the nuances of abstracting breast, colorectal, and thyroid cancers.
- Highlight areas where registrars struggle abstracting.
- Identify various resources available to the registrar when coding cases and how to use them

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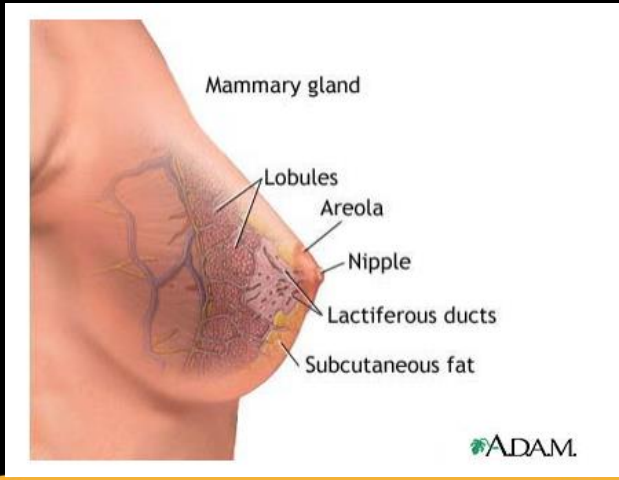
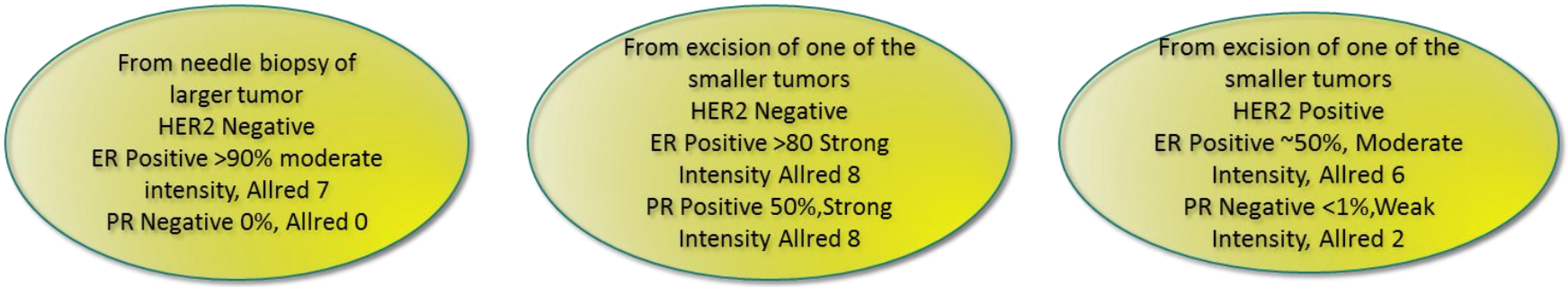
BREAST



Breast: Multiple Tumors, Abstracted Primary

- **Scenario:** 3 breast tumors (size 3.2cm, 1.1cm, 1.5cm)



- **Question:** How do you code the SSDI's?
  - From the Largest Tumor HER2 Negative, ER Positive, PR Negative
  - Mix and Match HER2 Positive, ER Positive, PR Positive

Answer & Rationale

- From the Largest Tumor HER2 Negative, ER Positive, PR Negative
- Revised SSDI Manual Version 1.7 *updated on website 09-04-2019
- https://apps.naaccr.org/ssdi/list/
  - Note 6 (7): In cases where there are multiple tumors with different ER (PR,HER2 IHC, HER2 ISH, HER2) results, code the results from the largest tumor size (determined either clinically or pathologically) when multiple tumors are present
  - • Do not use specimen size to determine the largest tumor size

Breast SSDI's

- **Scenario:** 09-15-2019 patient diagnosed with both invasive and Insitu ductal carcinoma of the right breast. ER is done on both components.
  - Invasive tumor-ER is 0% negative
  - In Situ tumor –ER is 90% positive

- **Question:** How would you code the SSDI ER Summary?
  - 0 ER negative
  - 1 ER positive
  - 9 Not documented in medical record. Cannot be determined (indeterminate) ER (Estrogen Receptor) Summary status not assessed or unknown if assessed

Answer & Rationale

- 0 ER negative

- SSDI Manual Version 1.7
  - Note 4: In cases where there are invasive and in situ components and ER is done on both, ignore the in-situ results
    - If ER is positive on an in-situ component and ER is negative on all tested invasive components, code ER as negative (code 0)

SSDI ER Percent Positive

- **Scenario:** ER: strongly positive, **close to** 100% of the cells

- **Question:** How would you code SSDI ER Percent Positive?

  100

  099

Answer & Rationale

- 99
- **"Close to"** means almost that value, so I would go with one less than the stated value.
- CAnswer Forum Post http://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/90045-er-strongly-positive-close-to-100-of-the-cells

ER/PR Percent Positive Examples

- >95% Code 096
- <95% Code 094
- 1-5%. Code R10
- 90-95%. Code R99
- 75-100%. Code R80
- 75-85%. Code R80
- Close to 85% code 084
- Approximately 1% code 001

001-100	1-100 percent
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%
XX8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code XX8 will result in an edit error.)

Multiple Test Results

- **Scenario:** ER performed on biopsy & on lumpectomy

  Biopsy: **ER 90%,** Moderate Intensity **Allred 7**

  Lumpectomy **ER 80%** Strong Intensity **Allred 8**

- **Question:** How would you code SSDI ER Percent Positive?

  090

  080

Answer & Rationale

- 80
- Per CAnswer Forum Post: We've had several questions like this and have consulted with AJCC.
  1. Invasive takes priority over in situ (if there are invasive & in-situ components, results from the in-situ are ignored)
  2. Positive takes priority over negative
  3. Highest values takes priority (if all from same specimen)
  4. If the highest values are not from the same specimen, record the results from the largest tumor (which is how stage would be done).
  http://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/87715-er-allred-score-multiple-test-results

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Radiation

Radiation to Draining Lymph Nodes

- **Scenario:** Patient undergoes **TAH/BSO** for Stage pT3b N0 adenocarcinoma. Treated with post op Radiation

  1-7-19 to 2-11-19 Whole Pelvis 4500 cGy x 25 6x/IMRT,

  2-13-19 to 2-18-19 Vaginal Cuff 1200 cGy x 2 IR-192

- **Question:** How is Phase 1 Radiation to Draining Lymph Nodes coded?

  00 No radiation treatment to draining lymph nodes
  06 Pelvic lymph nodes

Answer & Rationale

- 06 Pelvic lymph nodes

- RT treatment summary clearly states that the whole pelvis was irradiated. This includes regional LNs.

Radiation Treatment Volume

- **Scenario:** Patient undergoes **TAH/BSO** for Stage pT3b N0 adenocarcinoma. Treated with post op Radiation

  1-7-19 to 2-11-19 Whole Pelvis 4500 cGy x 25 6x/IMRT,

  2-13-19 to 2-18-19 Vaginal Cuff 1200 cGy x 2 IR-192

- **Question:** How is Phase 1 Radiation Primary Treatment Volume coded?
  - 86 Pelvis (NOS, nonvisceral) The treatment volume is directed at a primary tumor of the pelvis, but the primary sub-site is not a pelvic organ or is not known or indicated. For example, this code should be used for sarcomas arising from the pelvis.
  - 71 Uterus or Cervix Treatment is directed at all or a portion of the uterus, endometrium or cervix.

Answer & Rationale

- 86 Pelvis

- If primary site in pelvic region is surgically removed, code to 86.

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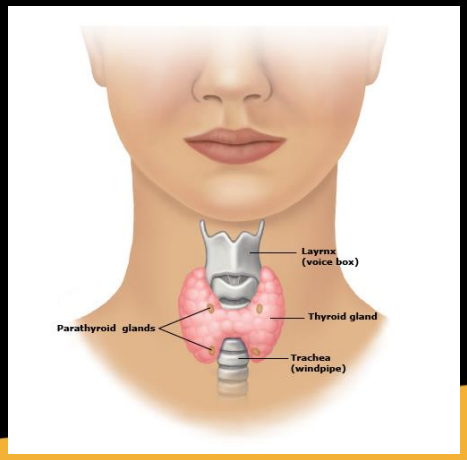
Thyroid Cancer



Coding of FNA Cytology

- **Scenario:**
  - 12/15/2018 Patient presented to Staff physician with a nodule in the left thyroid.
  - 12/18/2018 US thyroid showed a nodule left thyroid
  - 1/6/2019 FNA **cytology** of the thyroid nodule showed papillary carcinoma.
  - 1/31/2019 patient presented to the facility for Total Thyroidectomy, pathology reveals papillary carcinoma.

- **Question: How do you code the 1/6/2019 FNA of the Thyroid Nodule?**
  - Code 02 in in the Diagnostic & Staging Procedure
  - Do not code the procedure, but list it in the text.

Answer & Rationale

- Do not code the procedure, but list it in the text

- STORE, **Surgical Diagnostic and Staging Procedure-**Code brushings, washings, cell aspiration, and hematologic findings (peripheral blood smears) as positive cytologic diagnostic confirmation in the data item *Diagnostic Confirmation* [490]. These are not considered surgical procedures and should not be coded in this item.

FNA Cytology

- **Scenario:** 1/26/2018 FNA **core biopsy** of the thyroid nodule showed papillary carcinoma

- **Question:** How do you code the 1/26/2018 FNA core biopsy of the Thyroid Nodule?
  - Code 02 in in the Diagnostic & Staging Procedure
  - Do not code the procedure, but list it in the text.

Answer & Rationale

- Code 02 A biopsy (incisional, needle, or aspiration) was done to the primary site; or biopsy or removal of a lymph node to diagnose or stage lymphoma.

- STORE-Surgical Diagnostic & Staging Procedure - Only record positive procedures. For benign and borderline reportable tumors, report the biopsies positive for those conditions. For malignant tumors, report procedures if they were positive for malignancy.

FNA-Lymph Node

- **Scenario:** 1/12/2018 patient is diagnosed with papillary follicular carcinoma of the thyroid. 1/28/2018 patient has FNA of a right neck lymph node which was negative

- **Question:** How do you code the FNA Cytology of the Regional Lymph Node?
  - Code Scope of Regional Lymph Nodes to 1 (Bx or Aspiration of Regional LN)
  - Do not code the procedure but list it in the text.

Answer & Rationale

- Code Scope of Regional Lymph Nodes to 1 (Bx or Aspiration of Regional LN)

- STORE-Scope of Regional Lymph Node Surgery- *Record surgical procedures which aspirate, biopsy, or remove regional lymph nodes in an effort to diagnose or stage disease in this data item. Record the date of this surgical procedure in data item Date of First Course of Treatment [1270] and/or Date of First Surgical Procedure [1200] if applicable.*

FNA's- Code or Not

- If the specimen other than lymph node is obtained using FNA technique and issued in as a **cytology** report, it is **not coded** in the item Surgical Diagnostic and Staging Procedure

- If the specimen other than lymph node is obtained using FNA technique and issued in a **pathology** report, it **is coded** in the item Surgical Diagnostic and Staging Procedure. (Positive bx only)

- Use the data item **Scope of Regional Lymph Node Surgery** to code Surgical procedures which aspirate, biopsy, or remove **regional lymph nodes** in an effort to diagnose and/or stage disease in this data item. (Positive or Negative bx)

I-131 & Thyroid

- **Scenario:** 37-year-old female diagnosed with T2 N0 M0 Follicular carcinoma in 2018 and treated with Thyroidectomy and a single injection of 150 millicuries of **I-131.**

- **Question:** How would you code Phase 1 Radiation Primary Treatment Volume?

  26 Thyroid

  93 Whole Body

  98 Other

Answer & Rationale

- 98 Other

- NCDB: The Corner STORE Online April 4, 2019 https://www.facs.org/quality-programs/cancer/news/corner-store-040419

- STORE Data Item Clarification: I-131 for Thyroid As referenced in page 10 of the *CTR Guide to Coding Radiation Therapy Treatment in the Store (Version 2.0 February 2020)*: https://www.facs.org/-/media/files/quality-programs/cancer/ncdb/case_studies_coding_radiation_treatment.ashx

Date of Diagnosis-Ambiguous Cytology

- **Scenario**
  - 12-15/2018 Patient presented to Staff physician with a nodule in the left thyroid.
  - 12/18/2018 US thyroid showed a nodule left thyroid
  - 1/6/2019 FNA **cytology** of the thyroid nodule **suspicious** for carcinoma. 1/31/2019 patient presented to the facility for Total Thyroidectomy, pathology reveals papillary carcinoma

- **Question: What is the Date of Diagnosis?**
  - 12/15/2018
  - 12/18/2018
  - 01/06/2019
  - 01/31/2019

Answer & Rationale

- 01/31/2019 date of the Total Thyroidectomy where the pathology reveals papillary carcinoma
  - Cannot use the Date of the FNA because we can not consider cytology with ambiguous terms to be diagnostic

- STORE- *EXCEPTION: If cytology is identified only with an ambiguous term, do not interpret it as a diagnosis of cancer.*

STORE 2018 *Case Eligibility*

Ambiguous Terms that Constitute a Diagnosis	
Apparent(ly)	Presumed
Appears	Probable
Comparable with	Suspect(ed)
Compatible with	Suspicious (for)
Consistent with	Tumor* (beginning with 2004 diagnoses and only for C70.0–C72.9, C75.1–75.3)
Favors	Typical of
Malignant appearing	
Most likely	
Neoplasm* (beginning with 2004 diagnoses and only for C70.0–C72.9, C75.1–75.3)	

*additional terms for nonmalignant primary intracranial and central nervous system tumors only

EXCEPTION: If cytology is identified only with an ambiguous term, do not interpret it as a diagnosis of cancer.

Abstract the case only if a positive biopsy or a physician's clinical impression of cancer supports the cytology findings.

Date of First Contact

- **Scenario:**
  - 12/15/2018 Patient presented to **your Staff physician** with a nodule in the left thyroid.
  - 12/18/2018 US thyroid done **at your facility** showed a nodule left thyroid
  - 1/6/2019 FNA **cytology** of the thyroid nodule **suspicious** for carcinoma done **at your facility**.
  - 1/31/2019 patient presented to **your facility** for Total Thyroidectomy, pathology reveals papillary carcinoma.

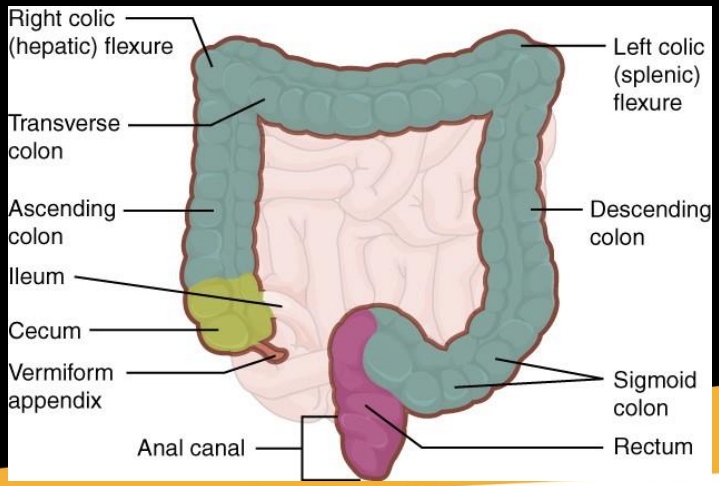
- **Question**: **What is the Date of First Contact?**
  - 12/15/2018
  - 12/18/2018
  - 01/06/2019
  - 01/31/2019

Answer & Rationale

- 1/31/2019 the date the patient presented to your facility for Total Thyroidectomy

- STORE, Date of First Contact, page 18 For analytic cases, the *Date of First Contact* is the date the patient qualifies as an analytic case *Class of Case* 00-22.

Colorectal


Right colic (hepatic) flexure
Transverse colon
Ascending colon
Ileum
Cecum
Vermiform appendix
Anal canal
Left colic (splenic) flexure
Descending colon
Sigmoid colon
Rectum

Colonoscopy Measurements

- **Scenario:** Patient presents to your facility 04-01-2020 Colonoscopy reveals 2.5 cm ulcerated lesion 10cm from the anal verge, biopsy positive for moderately differentiated squamous cell carcinoma. Patient did not return to facility for treatment, no other information available.

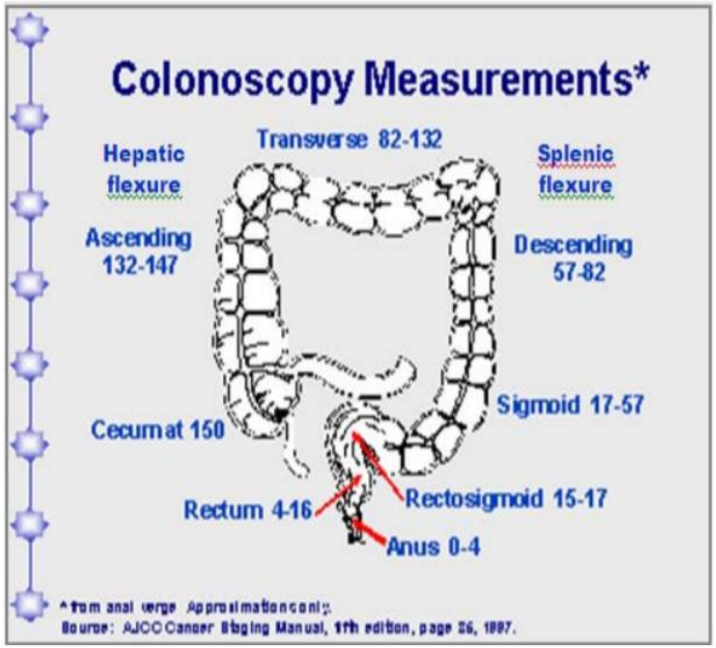
- **Question:** How would the Primary Site be coded?
  - C20.9 Rectum
  - C21.0 Anus
  - C21.1 Anal Canal

Answer & Rationale

- C209 Rectum
- Solid Tumor Rules-Colon, Rectosigmoid, and Rectum Equivalent Terms and Definitions C180-C189, C199, C209 https://seer.cancer.gov/tools/solidtumor/Colon_STM.pdf

Illustrations

Colonoscopy measurements which may be used to determine primary site when no site is designated



Solid Tumor Rules

- **Scenario:** 4-2-2020 presents for Right hemicolectomy, Scans showed no metastatic disease, Path: 3.5cm **well differentiated adenocarcinoma with mucinous differentiation** at the anastomotic site

- **Question:** How would the histology be coded?
  - 8140/3 Adenocarcinoma
  - 8480/3 Mucinous Adenocarcinoma

Answer & Rationale

- Adenocarcinoma
- Solid Tumor Rules

Coding Histology

Note 1: The priority is to code the most specific histology. **DO NOT USE BREAST HISTOLOGY CODING RULES FOR THIS SITE.**
Note 2: Only use this section for one or more histologies within a single tumor.
Note 3: Do not use this section in place of the Histology Rules.

1. **Code** the **most specific** histology or **subtype/variant, regardless of whether it is described as:**
   A. The majority or predominant part of tumor
   B. The minority of tumor
   C. A component
   Note 1: Mucinous and signet ring cell carcinoma must meet a percentage requirement in order to be coded. Refer to the Histology Rules if mucinous and/or signet ring cell carcinoma is present.
   Note 2: The terms above (A, B, C) must describe a **carcinoma** or **sarcoma** in order to code a histology described by those terms.
   Example: When the diagnosis is adenocarcinoma with a component of medullary **carcinoma**, code medullary carcinoma 8510.
   Negative Example: When the diagnosis is simply adenocarcinoma with a medullary component, code adenocarcinoma NOS 8140. Do not assume this is a medullary carcinoma. This could be medullary differentiation or features.
   Note 3: When the most specific histology is described as differentiation or features, see #2.
   Example 1: Diagnosis for a single tumor is adenocarcinoma 8140 with the majority or predominant part of tumor being medullary adenocarcinoma 8510. Code the subtype/variant: medullary adenocarcinoma 8510.
   Example 2: Diagnosis for a single tumor is mixed neuroendocrine carcinoma 8244 with minority of tumor being goblet cell carcinoid 8243. Code the subtype/variant: goblet cell carcinoid 8243.
   Example 3: Diagnosis for a single tumor is sarcoma NOS 8800/3 with a component of leiomyosarcoma 8890/3. Code the subtype/variant: leiomyosarcoma 8890/3.
2. Code the histology described as **differentiation** or **features/features of ONLY** when there is a specific ICD-O code for the "NOS with ____ features" or "NOS with ____ differentiation".
   Note: Do not code differentiation or features when there is no specific ICD-O code.
3. Code the specific histology described by **ambiguous terminology** (list follows) **ONLY** when A or B is true:
   A. The only diagnosis available is **one histology** term described by ambiguous terminology
      - CoC and SEER require reporting of cases diagnosed only by ambiguous terminology

Summary Stage 2018

- **Scenario:** 04-20-2020 Patient has left colectomy which shows invasive adenocarcinoma with invasion through muscularis propria into pericolorectal tissues. There are 0/12 lymph nodes involved. There are tumor deposits in the non-peritonealized pericolic tissues. (Scans showed no evidence of distant mets)

- **Question:** How would Summary Stage 2018 be assigned?
  - 1 Localized only
  - 2 Regional by direct extension only
  - 3 Regional lymph node(s) involved only

Answer & Rationale

- 3 - Regional lymph node(s) involved only
- https://seer.cancer.gov/tools/ssm/

1 Localized only (localized, NOS)

- Confined to colon, rectum, rectosigmoid, NOS
- Extension through wall, NOS
- Intraluminal extension to colon and/or anal canal/anus (rectum only)
- Invasion of
  - Intramucosal, NOS
  - Lamina propria
  - Mucosa, NOS
  - Muscularis mucosae
  - Muscularis, NOS
  - Muscularis propria
  - Submucosa (superficial invasion)
- Non-peritonealized pericolic/perirectal tissues invaded (see Regional for peritonealized pericolic/perirectal tissues invaded. See Note 6)
- Pericolic/perirectal tissues invaded, NOS (unknown whether non-peritonealized or peritonealized. See Note 6)
- Perimuscular tissue invaded
- Polyp (head, stalk, NOS)
- Subserosal tissue/(sub)serosal fat invaded
- Transmural, NOS
- Wall, NOS

3 Regional lymph node(s) involved only

- All sites
  - Colic, NOS
  - Epicolic (adjacent to bowel wall)
  - Mesenteric, NOS
  - Mesocolic, NOS
  - Paracolic
  - Pericolic
  - Tumor deposits (TD) in the subserosa, mesentery, mesorectal or nonperitonealized pericolic or perirectal tissues WITHOUT regional nodal metastasis
  - Regional lymph node(s), NOS
    - Lymph node(s), NOS

Extent of Disease (EOD)

- 04-01-2020 hemicolectomy: Cecum 3.5cm moderately differentiated adenocarcinoma invaded pericolic tissue, 12 nodes(-), margins(-)
- How would the EOD Primary Tumor be coded?

300	Extension through wall, NOS Invasion through muscularis propria or muscularis, NOS › Rectum: WITH or WITHOUT intraluminal extension to colon and/or anal canal/anus Non-peritonealized pericolic/perirectal tissues invaded (see Code 400 for peritonealized pericolic/perirectal tissues invaded. See Note 5) Pericolic/perirectal tissues invaded, NOS (unknown whether non-peritonealized or peritonealized. See Note 5) Perimuscular tissue invaded Subserosal tissue/(sub)serosal fat invaded Transmural, NOS Wall, NOS
400	Adjacent (connective) tissue(s), NOS Fat, NOS Gastrocolic ligament (transverse colon and flexures) Greater omentum (transverse colon and flexures) Mesentery (including mesenteric fat, mesocolon) Pericolic fat Perirectal fat Peritonealized pericolic/perirectal tissues invaded (see code 300 for non-peritonealized pericolic/perirectal tissues invaded. See Note 5) Rectovaginal septum (rectum) Retroperitoneal fat (ascending and descending colon only)

Answer & Rationale

- 400
- USE YOUR MANUALS, not just the DROP DOWNS!
- https://staging.seer.cancer.gov/eod_public/input/1.7/colon_rectum/eod_primary_tumor/?breadcrumbs=(~schema_list~),(~view_schema~,~colon_rectum~)

Note 5: Invasion into "pericolonic/pericolorectal tissue" can be either codes 300 or 400, depending on the primary site. Some sites are entirely peritonealized; some sites are only partially peritonealized or have no peritoneum. Code 300 may not be used for sites that are entirely peritonealized (cecum, transverse colon, sigmoid colon, rectosigmoid colon, upper third of rectum).

- Code 300
  - Invasion through muscularis propria or muscularis, NOS
  - Non-peritonealized pericolic/perirectal tissues invaded [Ascending Colon/Descending Colon/Hepatic Flexure/Splenic Flexure: Posterior surface; Middle third of rectum: Anterior surface; Lower third of rectum]
  - Subserosal tissue/(sub)serosal fat invaded

- Code 400
  - Mesentery
  - Peritonealized pericolic/perirectal tissues invaded [Ascending Colon/Descending Colon/Hepatic Flexure/Splenic Flexure: anterior and lateral surfaces; Cecum; Sigmoid Colon; Transverse Colon; Rectosigmoid; Rectum: middle third anterior surface]
  - Pericolic/Perirectal fat

- If the pathologist does not further describe the "pericolic/perirectal tissues" as either "non-peritonealized pericolic/perirectal tissues" vs "peritonealized pericolic/perirectal tissues" fat and the gross description does not describe the tumor relation to the serosa/peritoneal surface, and it cannot be determined whether the tumor arises in a peritonealized portion of the colon, code 300.

SSDI-Circumferential Resection Margin (CRM)

- **Scenario:** Patient presents for right hemicolectomy and is diagnosed with adenocarcinoma. Path report states all margins are negative.

- **Question:** How is the SSDI Circumferential Resection Margin coded?
  - XX.9; Not documented in medical record CRM margin not assessed
  - XX.1; Margins clear, distance from tumor not stated CRM margin negative

Answer & Rationale

- XX.9; Not documented in medical record CRM margin not assessed
- SSDI Manual Version 1.7
  - Note 10: Code XX.9 when
    - Pathology report describes only distal and proximal margins, or margins, NOS
      - Only specific statements about the CRM are collected in this data item
    - CRM not mentioned in the record

SSDI-Circumferential Margin

- **Scenario:** Below is a snip from the hemicolectomy Final Cap checklist:
  - Final Diagnosis & CAP Protocol indicate: Final surgical resection margins:
    - Grossly positive margins: None.
    - Microscopically positive margins: None
  - Below is a snip from the Gross Description:
    - Representative sections are submitted as follows:
    - C1 - perpendicular colon margin
    - C2 - perpendicular ileal margin
    - C8 - radial margin

- **Question:** How would you code the SSDI Circumferential Margin?
  - XX.9; Not documented in medical record CRM margin not assessed
  - XX.1; Margins clear, distance from tumor not stated CRM margin negative

Answer & Rationale

- XX.1; Margins clear, distance from tumor not stated CRM margin negative
- SSDI Manual Version 1.7
  - Note 3: The CRM may be referred to as
    - Circumferential radial margin
    - Circumferential resection margin
    - Mesenteric (mesocolon) margin
    - Radial margin
    - Soft tissue margin
- CAnswer Forum Post http://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/85291-ssdi-crm-xx-9-vs-xx-1
  - Since the pathologist stated that all the margins are negative and then listed the radial margin in the list of margins reviewed, this is enough to code XX.1.

SSDI-CEA Pretreatment Lab Value

- **Scenario:** Patient had polypectomy which showed adenocarcinoma of the sigmoid colon 3/17/2020 and had a CEA performed 3/18/2020 which was 7ng/ml. Patient had sigmoid colectomy on 4/15/2020 and it showed 1.4cm moderately differentiated adenocarcinoma. Post op CEA was 3ng/ml.
- **Question:** What is the Pretreatment CEA Lab Value?
  - 7.0
  - XXXX.9

Answer & Rationale

- XXXX.9

- SSDI Manual **Note 2:** Record the lab value of the highest CEA test result documented in the medical record **prior to treatment or polypectomy**.

SSDI- Microsatellite Instability (MSI)

- **Scenario:** Physician states MMR result normal

- **Question:** How would you code the SSDI Microsatellite Instability (MSI)?
  - 0 Microsatellite instability (MSI) stable; microsatellite stable (MSS); negative, NOS AND/OR Mismatch repair (MMR) intact, no loss of nuclear expression of MMR proteins
  - 9 Not documented in medical record MSI-indeterminate Microsatellite instability not assessed or unknown if assessed

Answer & Rationale

- 0 Microsatellite instability (MSI) stable; microsatellite stable (MSS); negative, NOS AND/OR Mismatch repair (MMR) intact, no loss of nuclear expression of MMR proteins
- SSDI Manual
  - **Note 1:** Physician statement of MSI can be used to code this data item when no other information is available.
  - **Note 4:** MMR normal (code 0)

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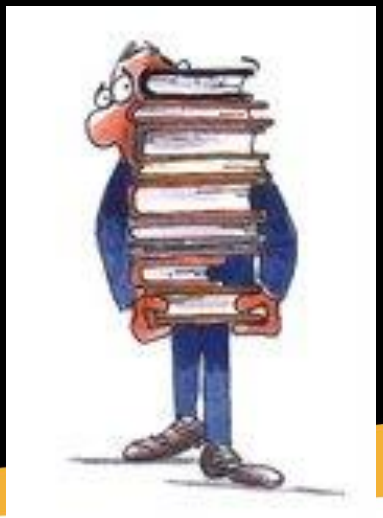
Manuals



SEER Appendix C-Surgery Codes

- **Scenario:** 2018 patient presents for Appendectomy for Adenocarcinoma of the Appendix.
- **Question:** How would you code the primary surgery?
  - 20 Local tumor excision, NOS
  - 27 Excisional biopsy
  - 30 Partial colectomy, segmental resection
  - 40 Subtotal colectomy/hemicolectomy (total right or left colon and a portion of transverse colon)

Answer & Rationale

- **Answer:** 30 Partial colectomy segmental resection
- Refer to 2018 SEER Coding and Staging Manual Appendix C: Surgery Codes for Colon https://seer.cancer.gov/manuals/2018/appendixc.html

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from surgical events 10–14

20 Local tumor excision, NOS
- 27 Excisional biopsy
- 26 Polypectomy, NOS
- 28 Polypectomy-endoscopic
- 29 Polypectomy-surgical excision

Any combination of 20 or 26–29 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

[***SEER Note:*** Codes 21 to 24 above combine 20 Local tumor excision, 27 Excisional biopsy, 26 Polypectomy, NOS, 28 Polypectomy-endoscopic or 29 Polypectomy-surgical excision WITH 21 PDT, 22 Electrocautery, 23 Cryosurgery, or 24 Laser ablation]

25 Laser excision

30 Partial colectomy [but less than hemicolectomy] segmental resection

32 Plus resection of contiguous organ; example: small bowel, bladder

[***SEER Note:*** Code 30 includes but is not limited to the following procedures: Appendectomy (for an appendix primary only), enterocolectomy, ileocolectomy, partial colectomy, NOS, partial resection of transverse colon and flexures, and segmental resection (such as cecectomy or sigmoidectomy). Note that the removal of a short portion of the distal ileum is **not** "removal of a contiguous organ."]

40 Subtotal colectomy/hemicolectomy (total right or left colon and a portion of transverse colon)
- 41 Plus resection of contiguous organ; example: small bowel, bladder

[***SEER Note:*** Code 40 includes extended (but less than total) right or left colectomy. Note that the removal of a short portion of the distal ileum is **not** "removal of a contiguous organ."]

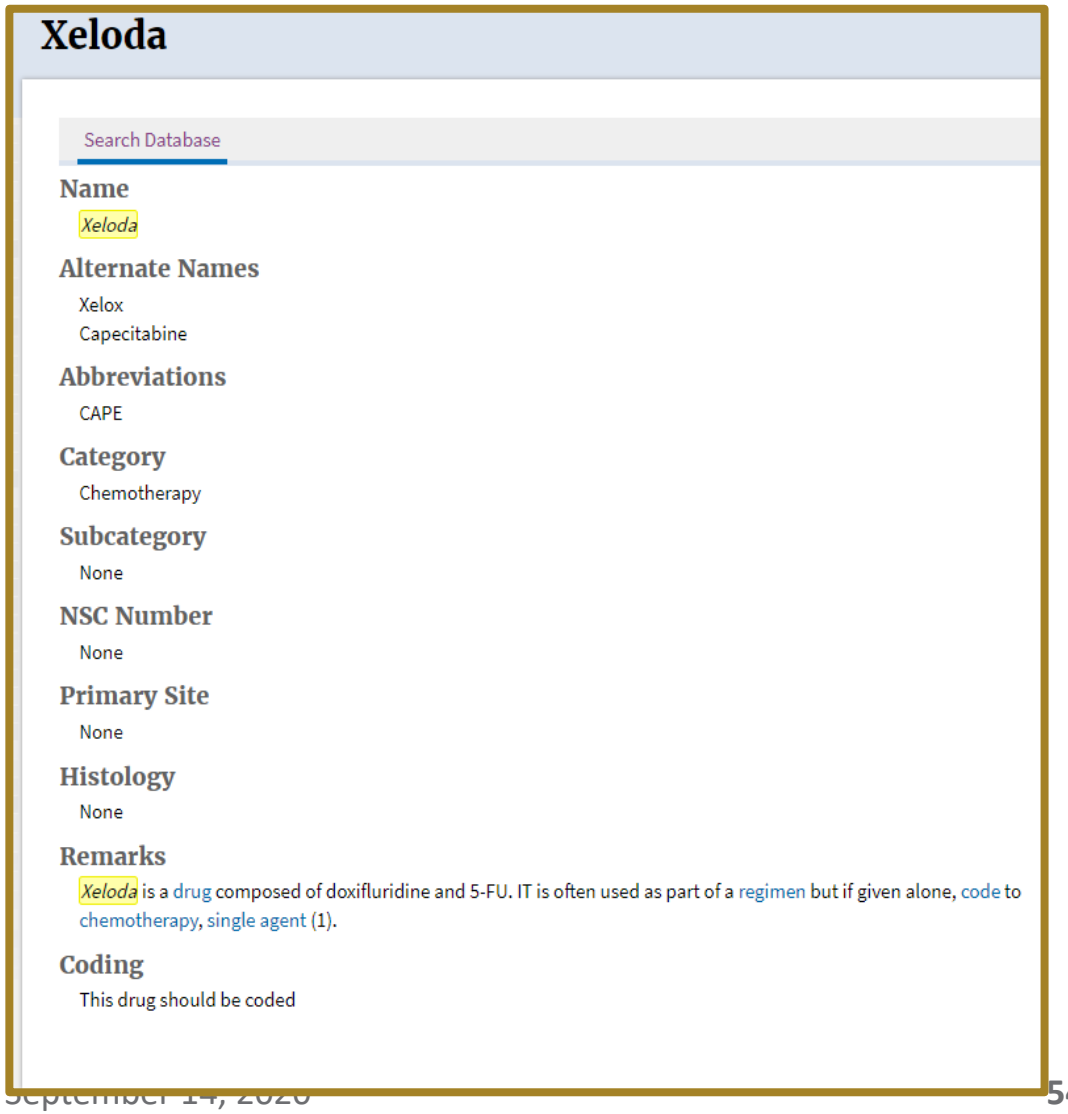
SEER*Rx Interactive Antineoplastic Drugs Database

- **Scenario:** Elderly male with Stage 3 colon cancer starts on 5-FU for postop chemo 08-01-2019. By following January, patient admits that trips to the oncologist's office are too tiring, so we will switch patient to Xeloda 01-15-2020.

- **Question:** How would you code the 01-15-2020 switch to Xeloda?
  - Subsequent Treatment 01-15-2020 Chemo Code 02
  - Just note it in text, do not code as new regimen

Answer & Rationale

- Just note it in text, do not code as a new regimen.
- Look drug up in SEER*Rx Interactive Antineoplastic Drugs Database-*Xeloda* is a drug composed of doxifluridine and **5-FU**. It is often used as part of a regimen but if given alone, code to chemo therapy, single agent.



Xeloda

Search Database

Name
Xeloda

Alternate Names
Xelox
Capecitabine

Abbreviations
CAPE

Category
Chemotherapy

Subcategory
None

NSC Number
None

Primary Site
None

Histology
None

Remarks
Xeloda is a drug composed of doxifluridine and 5-FU. IT is often used as part of a regimen but if given alone, code to chemotherapy, single agent (1).

Coding
This drug should be coded

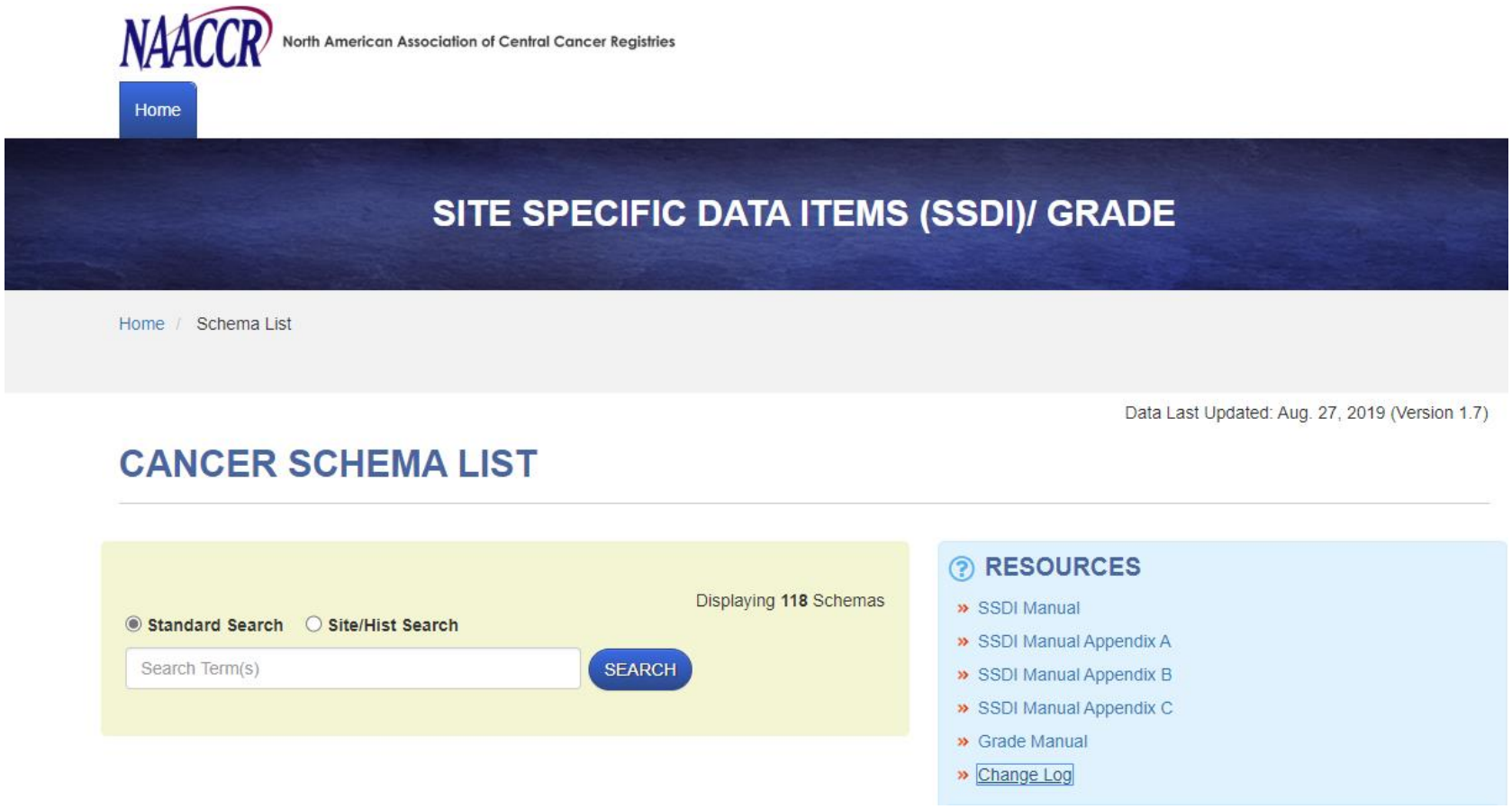
CTR Guide to Coding Radiation Therapy in the STORE

- https://www.facs.org/-/media/files/quality-programs/cancer/ncdb/case_studies_coding_radiation_treatment.ashx

- Version 2.0 February 2020

SSDI Change Log

- https://apps.naaccr.org/ssdi/list/



SSDI Change Log

Schema ID/Name	Data Item # and Description	Original Text	Updated Text
00200: Colon	3890: Microsatellite Instability	**Note 3:** Testing for MSI may be done by immunology or genetic testing. Only genetic testing results will specify whether the MSI is low or high. • Some laboratories only test for MSI via an immunologic test for Mismatch Repair (MMR) Protein. Results from immunology will only provide you with positive or negative results and will not specify whether the MSI is low or high • Results of Mismatch Repair (MMR) may be recorded in this data item - see codes 0 and 2 • MMR proficient (pMMR or MMR-P) should be coded as a 0 **Note 4:** If both tests are done and one or both are positive, code 2.	**Note 3:** Testing for MSI may be done by immunology or genetic testing. Only genetic testing results will specify whether the MSI is low or high. • MSI is looking at instability in informative markers • MSI results are recorded as o MSS (Code 0) o Stable (Code 0) o Negative (Code 0) o Low probability of MSI-H (Code 0) o MSS/MSI-L (Code 0) o MSI-L (Code 1) o Unstable, high (Code 2) o Unstable, NOS (no designation of high or low) (Code 2) o MSI-H (Code 2) o MSI-I (intermediate) (Code 9) **Note 4:** Testing for Mismatch Repair (MMR) is usually done by immunohistochemistry (IHC) • Most common markers are MLH1, MSH2, MSH6, PMS2 • MMR results are recorded as o No loss of nuclear expression (code 0) o Mismatch repair (MMR) intact (code 0) o MMR proficient (pMMR or MMR-P) (code 0) o MMR normal (code 0) o Loss of nuclear expression (code 2) o MMR deficient (pMMR or MMR-P) (code 2) o MMR abnormal (code 2) **Note 5:** If both tests are done and one or both are positive, code 2.

Errata/Revisions/Clarifications

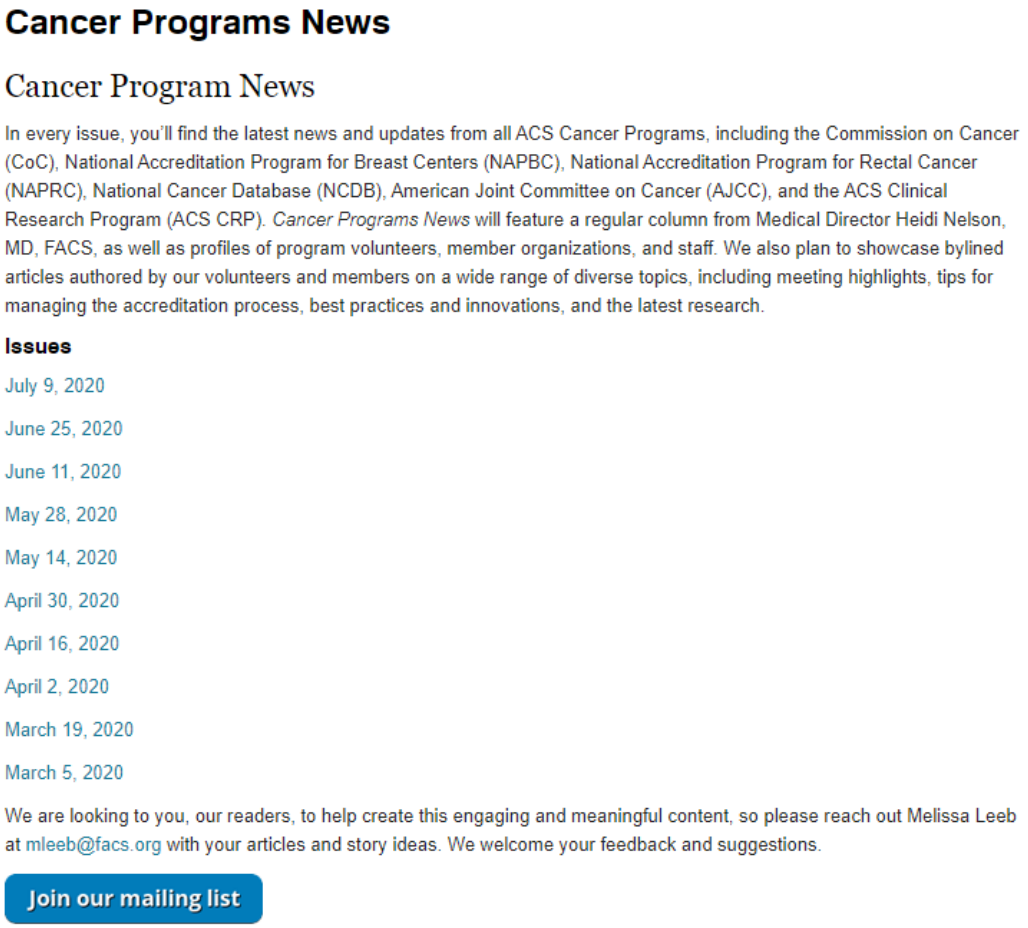
- READ THE MANUALS!
  - However do so with caution! Make sure you know where the changes are located due to there being multiple updates/clarifications/changes to the original documents.
    - Know how to find the errata/revisions/clarifications:
      - **AJCC 8th Edition Errata** https://cancerstaging.org/references-tools/deskreferences/Pages/8EUpdates.aspx
      - **ICD 0 3 Revisions** https://seer.cancer.gov/icd-o-3/
      - **Radiation Coding** https://www.facs.org/-/media/files/quality-programs/cancer/ncdb/case_studies_coding_radiation_treatment.ashx?la=en
      - **STORE Manual Clarifications** https://www.facs.org/quality-programs/cancer/news
      - **Solid Tumor Rules Revisions** https://seer.cancer.gov/tools/solidtumor/revisions.html
      - **SSDI/Grade 2018** http://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018
      - **EOD v1.7 changes** https://staging.seer.cancer.gov/eod/news/1.7/

2018+ Resources

- **2018 Implementation**
  https://www.naaccr.org/2018-implementation/
- **2018 Solid Tumor Manual**
  https://seer.cancer.gov/tools/solidtumor/
- **Hematopoietic & Lymphoid Neoplasm Database**
  https://seer.cancer.gov/seertools/hemelymph/
- **Hematopoietic & Lymphoid Neoplasm Coding Manual**
  https://seer.cancer.gov/tools/heme/Hematopoietic_Instructions_and_Rules.pdf
- **NAACCR Site Specific Data Items & Grade**
  https://apps.naaccr.org/ssdi/list/
- **SEER EOD 2018 General Coding Instructions**
  https://seer.cancer.gov/tools/staging/2018-EOD-General-Instructions.pdf
- **AJCC Cancer Staging Manual 8th Edition**
  https://cancerstaging.org/Pages/default.aspx
- **ICD 0 3 Histology Revisions**
  https://www.naaccr.org/implementation-guidelines/#ICDO3
- **NAACCR** http://datadictionary.naaccr.org/
- **SEER*Rx Interactive Antineoplastic Drugs Database**
  https://seer.cancer.gov/seertools/seerrx/
- **STORE Manual**
  https://www.facs.org/~/media/files/quality%20programs/cancer/ncdb/store_manual_2018.ashx
- **CTR Guide to Coding Radiation Therapy Treatment in the STORE**
  https://www.facs.org/~/media/files/quality%20programs/cancer/ncdb/case_studies_coding_radiation_treatment.ashx
- **NCDB: The Corner STORE Updates & Alerts**
  https://www.facs.org/quality-programs/cancer/news
- **SEER*RSA**
  https://staging.seer.cancer.gov/eod_public/list/1.6/

Cancer Program News

- *Cancer Program News* (AKA *The Brief*) https://www.facs.org/quality-programs/cancer/news



Cancer Programs News

Cancer Program News

In every issue, you'll find the latest news and updates from all ACS Cancer Programs, including the Commission on Cancer (CoC), National Accreditation Program for Breast Centers (NAPBC), National Accreditation Program for Rectal Cancer (NAPRC), National Cancer Database (NCDB), American Joint Committee on Cancer (AJCC), and the ACS Clinical Research Program (ACS CRP). *Cancer Programs News* will feature a regular column from Medical Director Heidi Nelson, MD, FACS, as well as profiles of program volunteers, member organizations, and staff. We also plan to showcase bylined articles authored by our volunteers and members on a wide range of diverse topics, including meeting highlights, tips for managing the accreditation process, best practices and innovations, and the latest research.

Issues

July 9, 2020

June 25, 2020

June 11, 2020

May 28, 2020

May 14, 2020

April 30, 2020

April 16, 2020

April 2, 2020

March 19, 2020

March 5, 2020

We are looking to you, our readers, to help create this engaging and meaningful content, so please reach out Melissa Leeb at mleeb@facs.org with your articles and story ideas. We welcome your feedback and suggestions.

Join our mailing list

NCDB: The Corner STORE Updates & Alerts

- https://www.facs.org/quality-programs/cancer/news
- Visit this website frequently **NCDB: The Corner STORE Updates and Alerts**
- TIP: Download a copy of the STORE, then annotate your copy of the STORE with the clarifications & revisions.

Example of Data Item Clarification

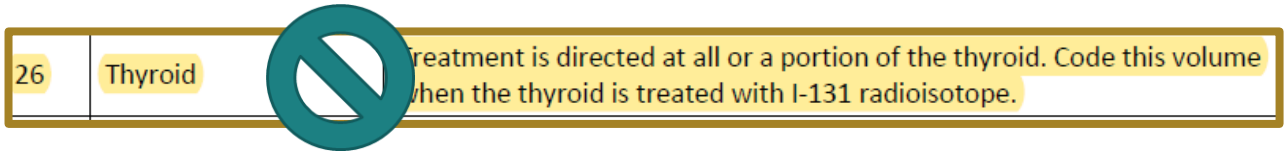
NCDB: The Corner STORE

Online April 4, 2019

STORE Data Item Clarification: I-131 for Thyroid

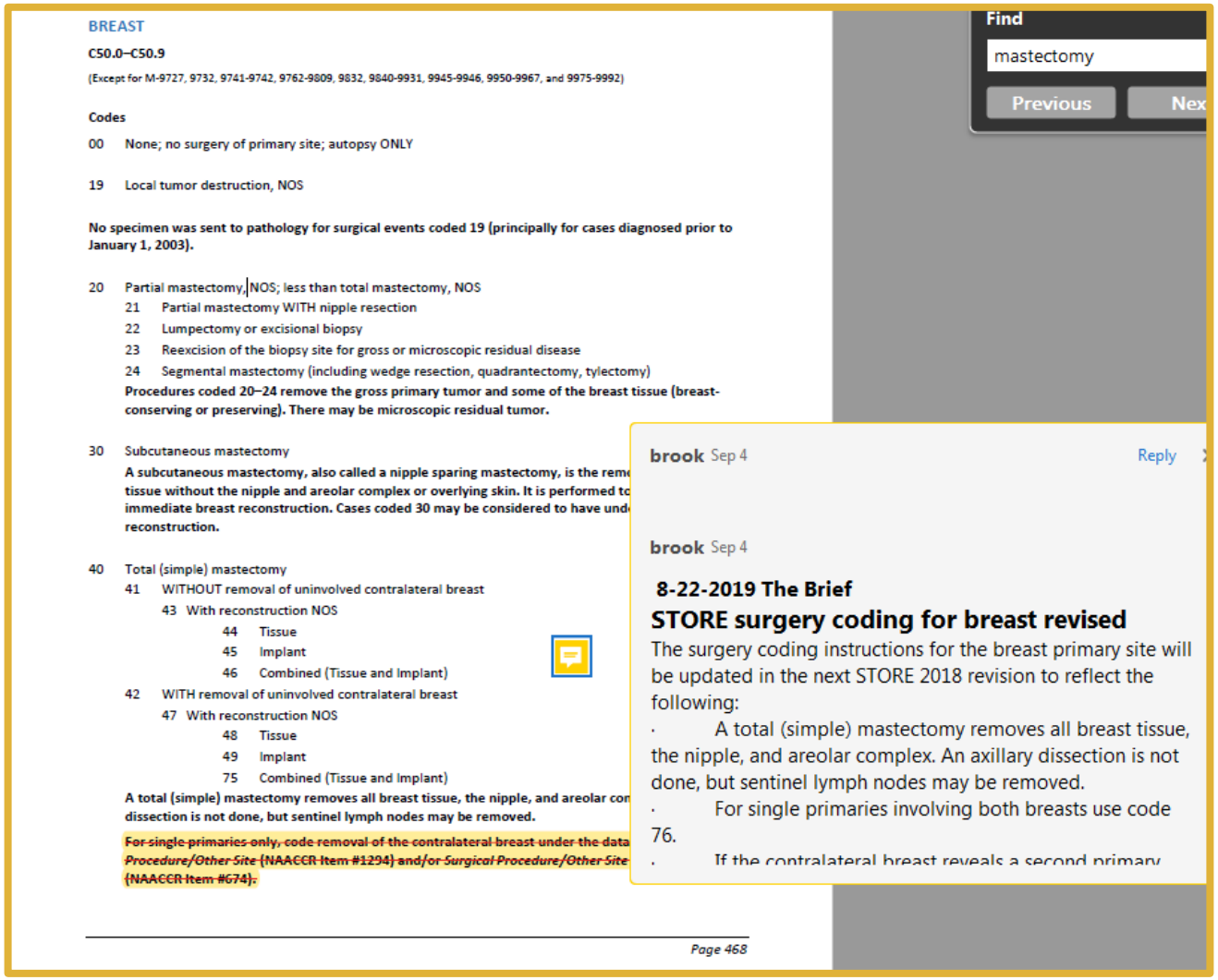
As referenced in page 10 of the *CTR Guide to Coding Radiation Therapy Treatment in the STORE* (Version 1.0), technically, I-131 is effective wherever there are thyroid cancer cells in the body, so there is no specific anatomic treatment volume involved. Therefore, it is recommended coding radioisotope treatments as 98 (Other). While another reasonable option would be to code the volume as 93 (Whole Body), code 93 (Whole Body) has traditionally been reserved for whole body treatment with external beam radiation such as is done prior to bone marrow transplantation. For historical consistency purposes, please use 98 (Other). The next version of STORE will reflect this change.

The CTR Guide to Coding Radiation Therapy Treatment in the STORE may also be found in the Resources section of the National Cancer Database web page.



26	Thyroid	reatment is directed at all or a portion of the thyroid. Code this volume hen the thyroid is treated with I-131 radioisotope.

Manual Modification Tip



BREAST

C50.0–C50.9

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction, NOS

No specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).

20 Partial mastectomy, NOS; less than total mastectomy, NOS
- 21 Partial mastectomy WITH nipple resection
- 22 Lumpectomy or excisional biopsy
- 23 Reexcision of the biopsy site for gross or microscopic residual disease
- 24 Segmental mastectomy (including wedge resection, quadrantectomy, tylectomy)

Procedures coded 20–24 remove the gross primary tumor and some of the breast tissue (breast-conserving or preserving). There may be microscopic residual tumor.

30 Subcutaneous mastectomy

A subcutaneous mastectomy, also called a nipple sparing mastectomy, is the rem tissue without the nipple and areolar complex or overlying skin. It is performed t immediate breast reconstruction. Cases coded 30 may be considered to have und reconstruction.

40 Total (simple) mastectomy
- 41 WITHOUT removal of uninvolved contralateral breast
  - 43 With reconstruction NOS
    - 44 Tissue
    - 45 Implant
    - 46 Combined (Tissue and Implant)
- 42 WITH removal of uninvolved contralateral breast
  - 47 With reconstruction NOS
    - 48 Tissue
    - 49 Implant
    - 75 Combined (Tissue and Implant)

A total (simple) mastectomy removes all breast tissue, the nipple, and areolar cor dissection is not done, but sentinel lymph nodes may be removed.

~~**For single primaries only, code removal of the contralateral breast under the data *Procedure/Other Site* (NAACCR Item #1294) and/or *Surgical Procedure/Other Site* (NAACCR Item #674).**~~

Page 468

Find

mastectomy

Previous Nex

brook Sep 4 Reply

brook Sep 4

8-22-2019 The Brief

STORE surgery coding for breast revised

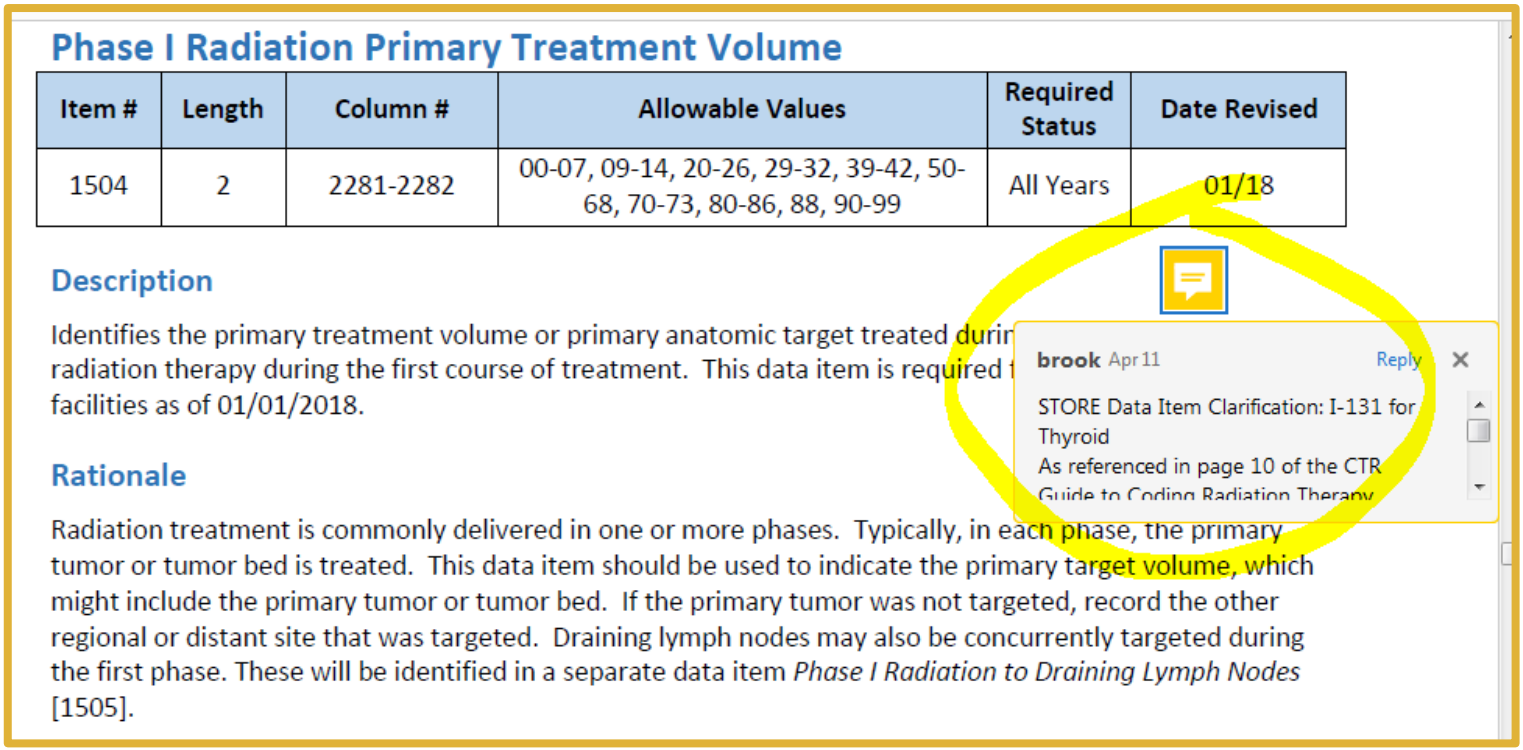
The surgery coding instructions for the breast primary site will be updated in the next STORE 2018 revision to reflect the following:

- 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.
- For single primaries involving both breasts use code 76.
- If the contralateral breast reveals a second primary

Example of Data Item Revised

- 8-22-2019 ***The Brief*** STORE surgery coding for breast revised
  - The surgery coding instructions for the breast primary site will be updated in the next STORE 2018 revision to reflect the following:
    - 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.
    - For single primaries involving both breasts use code 76.
    - If the contralateral breast reveals a second primary, each breast is abstracted separately. The surgical procedure is codded 41 for the first primary. The surgical code for the contralateral breast is coded to the procedure performed on that site.
    - The prior instruction in FORDS/STORE for single primaries only — code removal of the contralateral breast under the data item Surgical Procedure/Other Site (NAACCR Item #1294) and/or Surgical Procedure/Other Site at This Facility (NAACCR Item #674) — will be removed. It is not applicable.

Manual Modification Tip



Phase I Radiation Primary Treatment Volume

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1504	2	2281-2282	00-07, 09-14, 20-26, 29-32, 39-42, 50-68, 70-73, 80-86, 88, 90-99	All Years	01/18

Description

Identifies the primary treatment volume or primary anatomic target treated durin
radiation therapy during the first course of treatment. This data item is required
facilities as of 01/01/2018.

brook Apr 11 Reply

STORE Data Item Clarification: I-131 for Thyroid
As referenced in page 10 of the CTR Guide to Coding Radiation Therapy

Rationale

Radiation treatment is commonly delivered in one or more phases. Typically, in each phase, the primary tumor or tumor bed is treated. This data item should be used to indicate the primary target volume, which might include the primary tumor or tumor bed. If the primary tumor was not targeted, record the other regional or distant site that was targeted. Draining lymph nodes may also be concurrently targeted during the first phase. These will be identified in a separate data item *Phase I Radiation to Draining Lymph Nodes* [1505].

New in SEER*Educate!!

- New in SEER*Educate!!
  - 2018 Histology Coding Drills Under the CTR Prep Tests menu)
    - Dx 2018 Histology (Solid Tumors)
    - Histology (Heme & Lymphoid)
- https://educate.fredhutch.org
- Learn by Doing Continuing Education (CEs) available for 2018 Coding Schemes: EOD and Summary Stage, Grade, Heme, SSDI

Conclusion

- USE THE MANUALS!
- Refer to CAnswer Forum
  - Refer Site-Specific Data Items/Grade 2018
  - AJCC TNM Staging 8th Edition
  - STORE
- Refer to SINQ
  - Hematopoietic Rules
  - ICD-0-3 Updates (for cases diagnosed 2018+)
  - Solid Tumor Rules (for cases diagnosed 2018+)
  - EOD 2018
  - Summary Stage 2018

References

- NCRA Online Education Learning Module **STORE Manual Updates for Coding Radiation Therapy, Part II** presented by April 8, 2019 Wilson Apollo, MS, CTR, RTT, WHA Consulting
- 2019 NCRA Annual Conference presentation **PICTURE PERFECT QA PLAN NCRA 05/22/2019** presented by Vicki Hawhee, MEd, CTR-QC/Education Specialist, Moffitt Cancer Center, Cancer Registry
- 2019 NCRA Annual Conference presentation **Essentials of Navigating the AJCC Cancer Staging Manual 8th Edition 05-21-2019,** presented by Donna Gress, RHIT, CTR Technical Specialist for the American Joint Committee on Cancer. She was also the technical editor of the AJCC Cancer Staging Manual, 8th Edition and author of the manual's Chapter 1 Principles of Cancer Staging.

Questions

Contact Information

- Gina McNellis @ gmcnellis@himaginesolutions.com