DOWN TO THE DETAILS

CODING CLARIFICATIONS & REMINDERS



ICRA Fall Conference

Presented by Autumn Currens ODS-C

Tumor Registry Quality Supervisor – Franciscan Health

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PRIMARY SITE

LUNG SUBSITE – MULTIPLE NODULES

- Lung primary diagnosed in 2025.
- CT Chest: There is a RLL lung mass measuring 4.1 x 5.2 cm. Multiple additional ill-defined nodular opacities and/or airspace opacities are seen in the RLL and RML. There is a nodule in the posterior RUL measuring 1.4 x 0.9 cm.
- RLL & RUL Bxs = Mod Diff Adenocarcinoma

Question: What should the primary site (subsite) be?

Answer: Assign C34.9 for primary site because there are multiple tumors for a single primary that arise in different subsites and point of origin cannot be determined.

Source: Response from Ask a SEER

PRIMARY SITE - ENDOMETRIAL CANCER SP HYSTERECTOMY

- Example 1
  - Female sp hysterectomy for benign reasons.
  - Pathology report shows adenocarcinoma arising in a patch of endometriosis on the sigmoid colon.
  - Code the primary site to C18.7 Sigmoid Colon, the site in which the cancer originated.
- Example 2
  - Female (sp hysterectomy for benign reasons) presents with a retroperitoneal mass. Imaging shows the cervix and uterus are absent.
  - Retroperitoneum Bx: Endometrioid Adenocarcinoma
  - Code primary site to C48.0 Retroperitoneum.

- Explanation
  - Endometrial tissue may "break away" from the uterus and implant throughout the pelvic and abdominal cavities. This can occur in patients who suffer from endometriosis. This tissue remains behind when surgical removal of the uterus is done. Common sites of implantation are colon, peritoneum, retroperitoneum, and bladder. These cells may become malignant. When the uterus is no longer present (patient had surgical removal), code the site where the carcinoma was identified.
  - Tip re: example 2: The site-morphology C48.0 and 8380/3 was designated as an unlikely site-morphology combination by the Cancer PathCHART expert pathologist review, as this is a rare type of tumor. Override the edit.

TUMOR SIZE SUMMARY



TUMOR SIZE SUMMARY – WHEN TO USE 990

- Microscopic focus or foci only and no size of focus is given.

- Code 990
  - C18.7 Sigmoid
  - Sigmoid Colon Resection: Rare microscopic foci of intramucosal adenocarcinoma.

TUMOR SIZE SUMMARY – WHEN TO USE 998

Esophagus (C15.0-C15.5, C15.8-C15.9): Circumferential lesion/tumor (entire circumference) of the esophagus.

Stomach & EGJ (C16.0-C16.6, C16.8-C16.9): If involvement of stomach is described as 3/4 or more of stomach, diffuse, linitis plastica, or widespread.

Lung & Main Stem Bronchus (C34.0-C34.3, C34.8-C34.9): Diffuse, entire lung or NOS.

Breast (C50.0-C50.6, C50.8-C50.9): Diffuse.

Familial/Multiple Polyposis Rectosigmoid and rectum (C19.9, C20.9) Colon (C18.0, C18.2-C18.9)

TUMOR SIZE SUMMARY – ESOPHAGUS EXAMPLES 998 VS. 999

Code 998 (more specific)

- Esophagus C15.4
    - Scope: Large circumferential mass involving mid esophagus extending to the GE Junction.
- Esophagus C15.5
    - Scope: Large fungating mass found in the lower third of the esophagus is completely obstructing and circumferential.

Code 999

- Esophagus C15.8
    - Scope: Large fungating submucosal and ulcerating mass w/ bleeding was found in the upper third of the esophagus, in the middle third and the lower third, whole length-mass was partially obstructing and not circumferential.
- Esophagus C15.5
    - Scope: A large, fungating mass with contact bleeding was found in the distal esophagus, 25 to 39 cm from the incisors. The mass was partially obstructing and partially circumferential (involving one-half of the lumen circumference).
- Esophagus C15.5
    - Scope: Large ulcerating mass lower third of esophagus 35-40 cm from the incisors. Mass was partially obstructing and circumferential. (We don't know if partially is also describing circumferential or not.)

BLADDER – TUMOR SIZE SUMMARY

- TURBT path report is the first place we should look for tumor size in a bladder primary.
  - Per STORE the size measured on surgical resection specimen is the number 1 priority for TSS.
  - A TURBT is an Excisional Biopsy (removes the entire tumor and/or leaves only microscopic margins), so it is considered a surgical resection specimen.
  - Number 1 also confirms we can use the gross examination/description.
  - Do not add pieces or chips together unless the pathologist states an aggregate or composite size.
  - If there is no size that can be used on the path report, the surgeon measurement can be used except for if the surgeon states it as an aggregate or composite size (because aggregate/composite size can only be used from a pathologist).

10/30/25 TURBT Gross Description

- A. Lesion: Received in formalin, labeled with the patient's name and "bladder lesion," are multiple fragments of tan-pink soft tissue measuring in aggregate 2.0 x 2.0 x 0.7 cm. Specimen is wrapped in lens paper and entirely submitted within cassettes A1 and A2.

- Tumor Size Summary = 020 for 2 cm

Tumor size on gross description - CAnswer Forum

Coding Tumor Size from "Bladder Chips" - CAnswer Forum



SLN BX

SLN BX IN SITES OTHER THAN BREAST & MELANOMA

- The LNs should be coded in Reg LNs positive & Reg LNs examined.
- Determine if (sn) suffix should be assigned in staging. (sn) suffix should be assigned in staging when only a SLN Bx was performed. If a RLN Dissection was performed after the SLN Bx, then the (sn) suffix should NOT be assigned.
- Code in Scope of Reg LN Surgery.
    - Code 2, 6 or 7.

- Example: Robotic-Assisted TAH/BSO & SLN Bx 0/7 LNs
    - Reg LNs positive should be 0. Reg LNs examined should be 7.
    - Code (sn) suffix in pN.
    - Code 2 Sentinel LN Biopsy.



GRADE

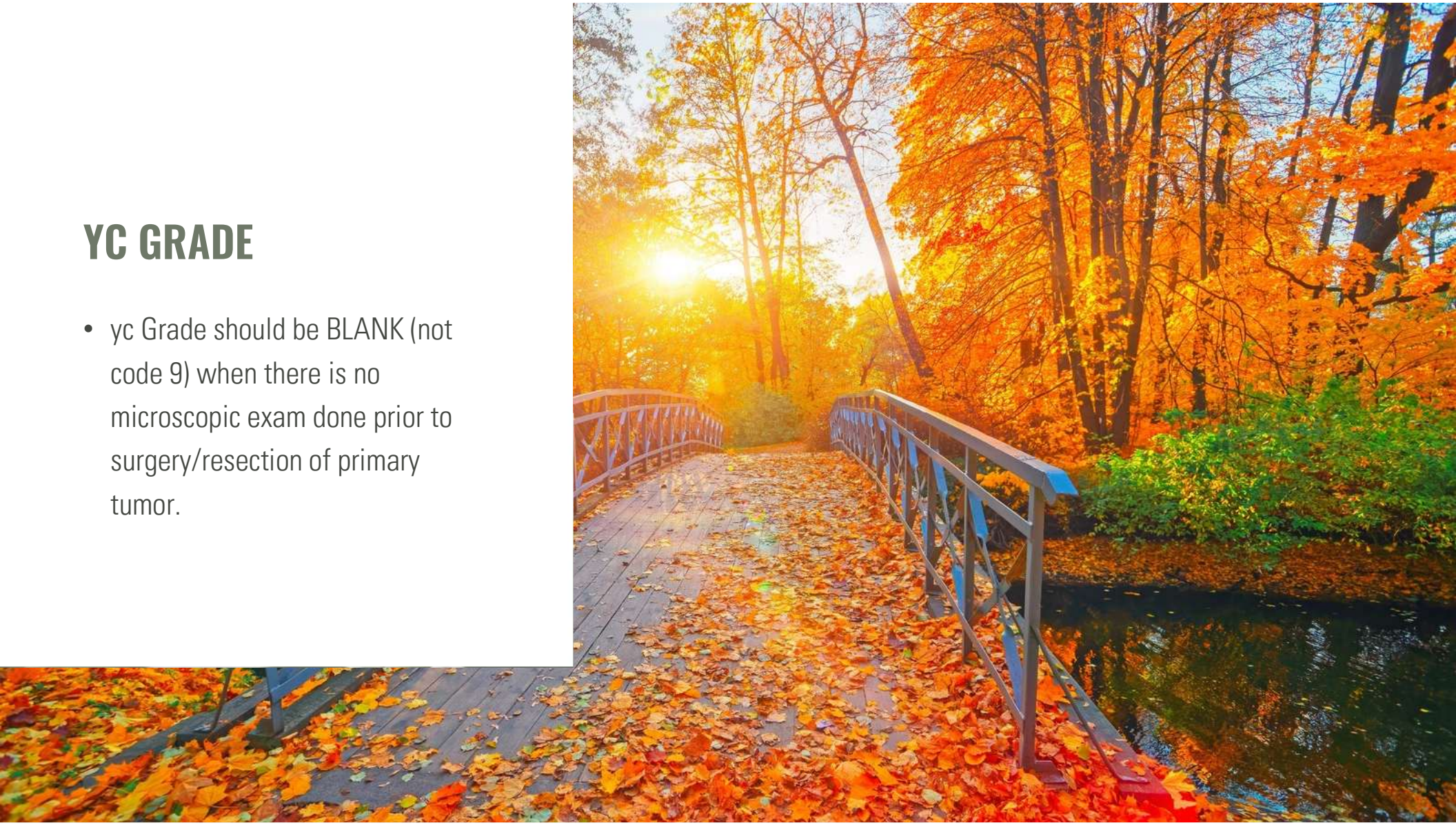
GENERIC GRADE TABLE

- When a pathologist lists nuclear grade for invasive breast cancer a grade CAN be assigned using the Generic Grade Table.
- Example: 3/5/26 R Breast Bx: Infiltrating Ductal Carcinoma, Intermediate Nuclear Grade
    - Code clinical grade to C for “Medium grade, intermediate grade” listed in the Generic Grade Table.
- Can generic grade be used to assign stage in breast cases?
    - In some cases. If the grade is unknown or there is a generic grade, look at the TNM biomarker combinations for EVERY grade and note the stage group. If the stage group for that combination is the same for every grade, then that stage group can be assigned. In those cases, the grade didn't change the stage group.

Invasive Ductal Carcinoma assigned Nuclear Grade - CAnswer Forum

YC GRADE

- yc Grade should be BLANK (not code 9) when there is no microscopic exam done prior to surgery/resection of primary tumor.





STAGING

PROSTATE GRADE 2+ ≠ STAGE GROUP 1

When T is...	And N is...	And M is...	And PSA is...	And Grade Group is...	Then the stage group is...
cT1a-c, cT2a	N0	M0	< 10	1	I
pT2	N0	M0	< 10	1	I
cT1a-c, cT2a, pT2	N0	M0	≥ 10 < 20	1	IIA
cT2b-c	N0	M0	<20	1	IIA
T1-2	N0	M0	<20	2	IIB
T1-2	N0	M0	<20	3	IIC
T1-2	N0	M0	<20	4	IIC
T1-2	N0	M0	≥20	1-4	IIIA
T3-4	N0	M0	Any	1-4	IIIB
Any T	N0	M0	Any	5	IIIC
Any T	N1	M0	Any	Any	IVA
Any T	Any N	M1	Any	Any	IVB

CLINICAL STAGING WITHOUT DIAGNOSIS

- When there is diagnostic work up done on something that could be cancer (lesion, mass, tumor, LAD, etc.) and is then diagnosed as cancer on definitive surgery, assign clinical staging.
- If malignancy (or equivalent) is in the differential assign clinical staging.

- These situations do NOT affect the diagnosis date. Clinical staging can be assigned without a diagnosis.

STAGING – CANCER IN DIFFERENTIAL, BUT NOT DIAGNOSED UNTIL SURGERY

- Example:
  - 7/30/26 65 YOWM presents with 3 weeks of intermittent RLQ pain. Found to have near obstructive lesion in the cecal area.
  - 7/30/26 Surgeon Consult: Patient has evidence of an ileocolonic intussusception on CT Abd/Pelvis that we should repair surgically. There is the potential that this is an occult malignancy causing this intussusception. There are also benign etiologies for intussusception.
  - 7/31/26 Right Hemicolectomy: Adenocarcinoma of the cecum.
- Assign clinical staging because malignancy was in the differential
  - This does NOT affect the diagnosis date. Clinical staging can be assigned without a diagnosis.
- Assign pathological staging because malignancy was found on definitive resection

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Clinical Staging of Kidney cancer - CAnswer Forum

STAGING – INTRAMUCOSAL ADENOCARCINOMA ON EMR

- 2/7/26 Colonoscopy: Large rectal lesion about 4 cm in size.
  - Path revealed superficial fragments of tubulovillous adenoma. No evidence of dysplasia or malignancy seen.
- 2/7/26 Post-colonoscopy: Surgeon stated pt will need EMR or surgical resection of the rectal lesion.
- 3/24/26 Colonoscopy w/ Endoscopic Mucosal Resection (EMR)
  - Indication: Therapeutic procedure for colon polyps
  - Findings: A 65 mm carpet-like polyp was found in the rectum. Piecemeal mucosal resection and retrieval was performed.
  - Path revealed mod diff Intramucosal Adenocarcinoma
- 7/4/26 Rectal Scar EMR: 15 mm post polypectomy scar was found in the rectum. Residual polypoid tissue. EMR and retrieval was performed.
  - Path revealed minute fragments of tubulovillous adenoma. No evidence of HGD or invasive malignancy.

Clinical Staging – cTX cNX cM0 based on 2/7/26 colonoscopy

Pathological Staging – pTis cN0 cM0 based on 3/24/26 EMR and no other treatment

This does NOT affect the diagnosis date. Clinical staging can be assigned without a diagnosis.

Can Colonoscopy w/ EMR be used for Path staging? - CAnswer Forum



SSDIS

CRM COLORECTAL – GROSS DESCRIPTION

- CRM can be taken from the Gross Description of the path report when the final diagnosis and synoptic checklist don't provide the information.
    - Gross Description: The serosa is smooth to shaggy and tank-pink to purple with focal black dye. There is a 5.5 x 4.0 cm circumferential, raised friable, tan-pink mucosal mass, 4.0 cm distal to the ileocecal valve. The mass is 7.2 cm from the distal margin and 13.8 cm from the proximal margin. The cut surface of the mass is pink-white and involves the muscularis and pericolic fat with a depth up to 0.8 cm. The mass is 1.1 cm from the serosa and 4.5 cm from the pericolic fat resection (radial) margin.
    - CRM = 4.5 cm, coded as 45.0 (coded in mm)

PD-L1

- Lung case diagnosed in 2025
  - Path report states:
    - Low PD-L1 expression (TPS 1-49%): Present
      Patient Tumor Proportion Score: **11-20%**
  - SSDI Manual
    - Note 4: (.1-100.0) **An actual tumor proportion score takes priority** over XXX.2 (Stated as negative), XXX.3 (Stated as low), or XXX.4 (Stated as high/positive)
    - Rules for **Recording Ranges** Example 2: CRM is documented as 2-3 cm. Code CRM to 2.1 (Since this SSDI has a decimal point, you code one above the lower value by 0.1 instead of 1)

  - **Code PD-L1 as 11.1**

Ssdi pd-l1 range - CAnswer Forum

FIGO STAGE SSDI UPDATE

In regard to the SSDI rules:

- There must be a statement about FIGO stage from the managing physician in order to code this data item.
- Do not code FIGO stage based on the pathology report.

- If a path report lists the FIGO Stage and a managing physician copies and pastes the path report with FIGO Stage into their note, we can assume the physician agrees with the pathologist's FIGO Stage.

SSDI-FIGO Stage Corpus Carcinoma and Carcinosarcoma Coding Rules - CAnswer Forum



TREATMENT

PATIENT REFUSED TREATMENT

- If the patient refuses all treatment, code "patient refused" (code 7 or 87) for all treatment modalities.



TREATMENT CONTRAINDICATED

- Common scenario
    - NSCLC (Adenocarcinoma, Squamous Cell Carcinoma, etc.)
    - Localized – typically 1 small nodule
    - Pt has comorbidities that make surgery too risky
    - Radiation (often SBRT) is recommended instead of surgery

- Code Reason No Surgery
    - 02 Not Recommended/Performed, Contraindicated
        - Surgery of the primary site was not recommended/performed because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, progression of tumor prior to planned surgery etc.)
- Surgery Text
    - Date and statement from physician that surgery was not recommended due to _____.

PALLIATIVE CHEMO OR HOSPICE

- Patient has Stage IV Pancreatic Cancer.
- Med onc says patient can have palliative chemo or choose hospice.
- Patient chooses hospice.

- Question: What should Chemotherapy be coded to?
- Answer: 00 None, chemo was not part of the planned first course of therapy.

SMALL CELL LUNG CARCINOMA – TREATMENT

- 2/12/26 RLL Lung Bx: Small Cell Carcinoma
- 3/1/26 MRI Brain: No evidence of malignancy.
- Med Onc: Limited Stage SCLC. Plan for concurrent chemoradiation.
- 3/6/26 Cisplatin/Etoposide
- 4/3/26 – 5/21/26 Right Lung Radiation
- 7/10/26 PET: Notable for positive response
- 8/18/26 – 9/3/26 Prophylactic Cranial Irradiation (PCI)

- Remember to look for PCI (radiation) in Small Cell Lung Carcinoma cases.

C16.0 GEJ/EGJ PRIMARY – STAGING & SURGERY

Staging

- Tumors of the EGJ with **≤ 2 cm of proximal stomach involvement** are staged as **esophageal** cancers.
- Tumors that involve the EJG with their tumor epicenter **> 2 cm into the proximal stomach** are staged as **stomach** cancers.

Surgery

3/17/26 Robotic Assisted Ivor Lewis Esophagectomy & Mediastinal Lymph Node Dissection

- Even though the surgeon is calling this an esophagectomy we have to use the Stomach surgery codes because the primary site for GEJ is C16.0.

Look at the Op Note and/or the Path Report for guidance.

- Path Report Gross Description: The specimen is received fresh labeled with the patient's name, date of birth and "proximal stomach distal esophagus." It consists of a gastroesophagectomy specimen including distal esophagus and proximal stomach.

Surgery Code

- A500 Gastrectomy, NOS WITH removal of a portion of esophagus
  - A510 Partial or subtotal gastrectomy
  - A520 Near total or total gastrectomy

Codes A500–A520 are used for gastrectomy resection when only portions of esophagus are included in procedure



STATE QA

STATE QA – FIELDS TO CHECK

- Edits
- SSN – check unknown (9s) to see if available now
- First name & Sex
- Vital Status ≠ 9
- Date 1st Contact vs. Accession Number - Year of 1st contact should = Year of accession number on sequence 00/01 for your facility
- Date 1st Contact = Dx Date on class 00, 13 &14
- Facility Referred From should be coded on all class 30/32
- Meninges ≠ C70.9 NOS
- Testis ≠ C62.9 NOS
- SqCC = 8085 or 8086 depending on p16 results
  - p16 SSDI
    - Cervix (C53) 2021+
    - Anus (C21) 2023+ (doesn't apply to 8077 Sqamous Intraepithelial Neoplasia)
    - Vulva (C51) 2024+ (doesn't apply to 8077 Sqamous Intraepithelial Neoplasia)
  - Discriminator 2 – Oropharynx 2022+
- Pituitary Gland (C75.1) histology ≠ 8140/0
- Sequence ≠ 99
- Laterality should be 0 for non-paired sites
- LVI
  - 0 on behavior /2
  - Benign
    - 9 or per path report for prior to 2018
    - 8 for benign cases dx'd 2018+

STATE QA (CONT)

- Prostate Grade 2+ ≠ Stage 1
- pT1 melanoma - Should be cN0 in pN, NOT pNX; therefore, no stage 99 (AJCC 7 & 8 ed)
- pT0 ≠ stage 0
- Kidney – T3 ≠ stage 99
- pN Endometrium - if cN0, then stage group ≠ 99
- Thyroid - can have pNX and a stage group assigned
- Lung N3 = SEER Summary Stage 7
- M1 = SEER Summary Stage 7
- Separate Tumor Nodules & Summary Stage
  - SSDI 1 (same lobe) should be Summary Stage 2, 4 or 7 & ≠ T1 or T2
  - SSDI 2 or 3 (different lobe[s]) should be Summary Stage 7 & ≠ T1 or T2
- Mets @ Dx should be coded to 0 for all benign brain, CNS, and any other reportable tumor with a behavior of /0, /1, or /2 for cases dx'd 2023+
- Check to see if Date 1st Treatment should truly be blank
- Radiation primary treatment volume for post-mastectomy XRT should be chest wall
- Lymphoma/Leukemia Type 1st Recurrence should be 59, 70 or 00

STATE QA – HOW TO

- Typically, done on the first workday of each month
- Create a report in your data management software with the fields on the previous slides along with the Accessioning Facility, MRN, & Abstractor Initials (or however your software identifies abstractors)
- Include cases marked as Ready to Submit to State (even if not fully complete)
- Export file to spreadsheet
- Add filter to top row and freeze the top row
- Use the filters to compare data (for some it's helpful to hide certain columns to compare side-by-side)
- Create a document for each abstractor (examples from docs on next slide)
    - Copy & paste or list any cases with Edits
    - Copy & paste from spreadsheet findings that need reviewed by abstractor
- Email document to each abstractor including the deadline for making any updates
- Email all who do state submissions notifying them of the deadline abstractors were given for making updates
- Those who do state submissions should not submit to the state until after the deadline has passed

State QA Document Examples

Facility Referred From should be coded on all class 30/32.

Facility Accessioning Case	Abstracted By	Accession Number	MRN	Last	First	Seq	Class Of Case	Institution Referred From
Lafayette - Franciscan Health		2025				1	30	N/A

LVI should be 8 for benign cases dx'd 2018+ per STORE.

Facility Accessioning Case	Abstracted By	Accession Number	MRN	Last	First	Seq	Date Dx	Histo	LVI
Indy - Franciscan Health		2026				60	7/9/2026	9530/0	0

M1 = SEER Summary Stage 7

Facility Accessioning Case	Abstracted By	Accession Number	MRN	Last	First	Seq	Site	SEER Summary Stage	cM
Munster - Franciscan Health		2025				0	C61.9	3	c1c

Prostate Clinical Grade 2+ ≠ Stage 1

Facility Accessioning Case	Abstracted By	Accession Number	MRN	Last	First	Seq	Site	Grade - Clinical (8th Edition)	Clinical Stage Group
Crown Point - Franciscan Health		2025				0	C61.9	2 Grade Group 2: Gleason score 7 Gleason pattern 3+4	1



ONENOTE

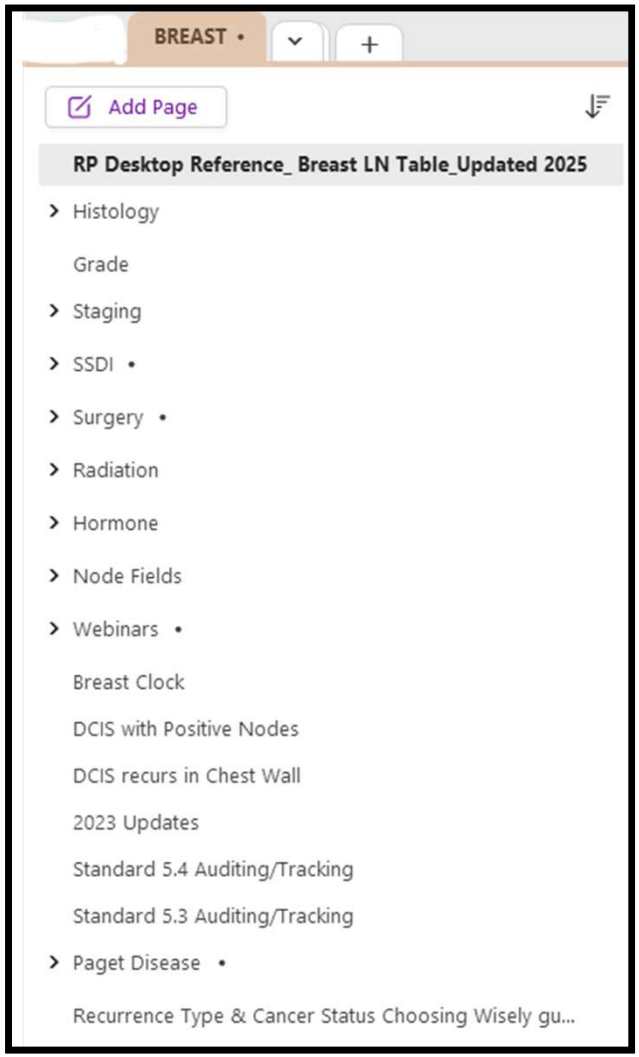
MICROSOFT ONENOTE

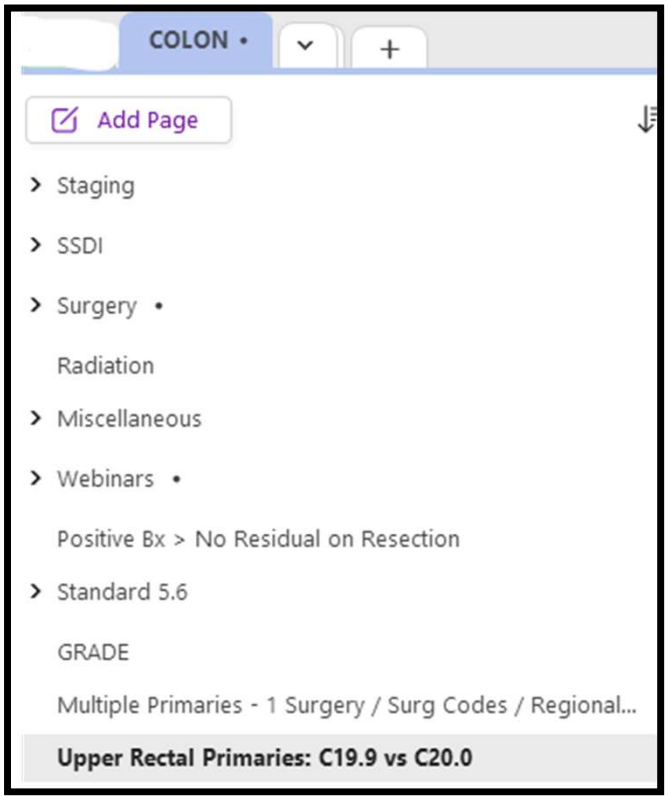
- OneNote is a digital note-taking app from Microsoft that lets you create flexible, free-form digital notebooks for capturing and organizing information.
    - **Notebooks, Sections, Pages, Subpages:** Organize content hierarchically for easy navigation. Can have more than 1 Notebook.
    - **Collaboration:** Share notebooks and edit together in real time or share notebook without allowing others to edit.
    - **Free-form canvas & Web clipping:** Click and type anywhere; move note containers freely. Save articles, images, and snippets directly into notebooks.
    - **E-Mail:** Drag and drop Outlook emails onto a page in OneNote. Click Insert Printout for email to be seen on that page. Also includes an icon where the email can be opened in Outlook and can be forwarded, replied to, etc. even when automatically deleted in Outlook because of organization's retention policy.
    - **Voice transcription:** Record and transcribe audio notes.
    - **Cross-platform sync:** Access notes on any device via OneDrive.
    - **Search:** Can search for text, handwriting, images, or even spoken words in audio and video recording.

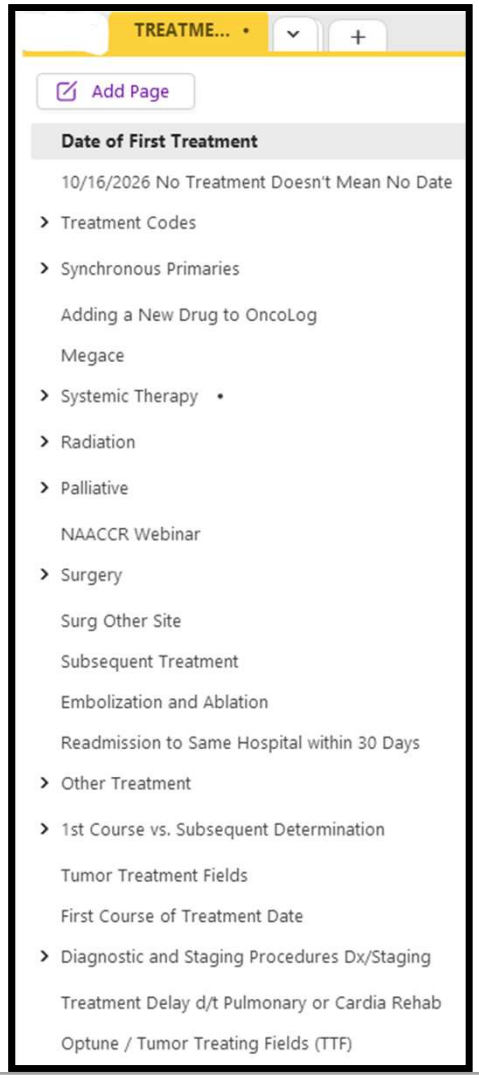
Source: Microsoft Edge AI Overview

ONENOTE SECTIONS (TABS)

- Team Meetings
- Resources
- Network Abstracting Tips
- Network Training
- Webinars
- OncoLog
- Epic
- QA
- Synoptic Op Notes
- Accreditations
- 2026 Updates
- Lymph Node Fields
- Grade
- Staging
- Treatment
- Miscellaneous
- Head & Neck
- Esophagus & Gastric
- Colon
- Rectum
- Anus
- Hepatobiliary
- Pancreas
- Neuroendocrine Tumors
- Lung
- Heme
- Melanoma
- Breast
- Corpus Carcinoma
- Cervix
- Ovary
- Other GYN
- Testis
- Prostate
- Penis
- Kidney
- Bladder
- Brain
- Thyroid
- Lymphoma

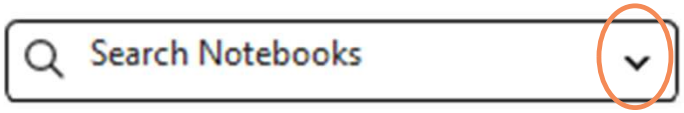






ONENOTE SECTION (TAB) EXAMPLES

ONENOTE SEARCH



- Find on this page
- This Section
- This Section Group
- This Notebook
- All Notebooks

- As you type, OneNote begins returning page results that match your search word or phrase. Choose a search result to retrieve the matching note.
- Matches are highlighted in the text. You can click through to see the different areas the match appears.

SOURCES

AJCC	Ask a SEER Registrar	CAnswer Forum
Grade Manual	SSDI Manual	STORE

QUESTIONS?

AUTUMN.CURRENS@FRANCISCANALLIANCE.ORG