Coding Pitfalls

NAACCR 2016-2017 Webinar Series

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Q&A

- Please submit all questions concerning webinar content through the Q&A panel.
- Reminder:
  - 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**

**Agenda**

- Coding Pitfalls in the Context of Text Documentation
- Purpose and Use of Text Documentation
- NCRA Informational Abstracts Series
- Other Documentation Resources
- Coding Pitfalls and Text
  - Lung
  - Colon
  - Melanoma
  - Brain and CNS
- Text Pointers for Changing Registry Standards
- Coding Pitfalls and Text – Quiz
Coding Pitfalls in Context of Text Documentation

- Text Documentation as a Requirement for Abstracting
- We All Make Abstracting and Coding Mistakes
- Our Abstracts are Not Just a Bunch of Codes
- Explains the Continuum of Cancer Care
- Helps Identify Missing Information
- Helps Improve Abstract Quality
- Improves Overall Data Quality
- Not Everything Gets Coded
- Text is a Valuable Resource
- Codes are Just Numbers...

D.I.K.W.

- Data
- Information
- Knowledge
- Wisdom

Purpose and Use of Text Documentation

- **Purpose:** Describe the patient’s continuum of cancer care from presentation symptoms to diagnosis, from workup to staging, from treatment to progression and any care post-treatment until the end of life whether due to cancer or not.

- **Explain/Confirm/Validate/Supplement Codes**

- **Who Uses Text and How Do They Use It?**
  - New Registrar Learning to Abstract
  - Hospital Registrar and Physicians
  - Central Registry and Data Quality
  - Clinical Research and Other Data Users
  - Epidemiologist and Use of Text
  - Feedback to Individual
  - Feedback for Training

Purpose and Use of Text Documentation

- **Your Text Should Tell a Story...**
- **Overall:** helps reinforce critical data items and helps identify where abstractors and coders have problems or do not understand certain new (and older) concepts, instructions, etc.

- New Registrar: Used as a check on your learning progress
- Hospital Registrar: When you are no longer there & physician QC
- Registry Manager: Quality Control of Contractors and FTE Staff
- Central Registry: Quality Control, Setting Override Fields, Visual Editing, Data Quality Audits and New Abstractor Review
- Data User & Researchers: Clinical Summary in English for quick view of cases in language they understand and Use in Patient Contact Studies
### Purpose and Use of Text Documentation

- Text documentation should always include the following components:
  - Date(s) – include date(s) references – this allows the reviewer to determine event chronology
  - Date(s) – note when date(s) are estimated [i.e. Date of DX 3/15/2014 (est.)]
  - Location – include facility/physician/other location where the event occurred (test/study/treatment/other)
  - Description – include description of the event (test/study/treatment/other) – include positive/negative results
  - Details – include as much detail as possible – document treatment plan even if treatment is initiated as planned
  - Include “relevant-to-this-person/cancer” information only
  - DO EDIT your text documentation
  - DO NOT REPEAT INFORMATION from section to section
  - DO USE NAACCR Standard Abbreviations
  - DO NOT USE non-standard or stylistic shorthand

- When Information is Missing or Incomplete in the Medical Record – document info is not there

### Pop Quiz 1

- Text Documentation accounts for what percent of a typical analytic case abstract?
  - A. 0%–24%
  - B. 24%–49%
  - C. 50%
  - D. 50%–75%
  - E. 75%–100%

- Should I include a date for each tumor marker test or diagnostic image (CT, PET, MRI or chest x-ray) or surgical procedure performed that is pertinent to my case?
**NCRA Informational Abstracts Series**

- [http://www.cancerregistryeducation.org/rr](http://www.cancerregistryeducation.org/rr)

**Informational Abstracts**
- Informational Abstract: Adult Primary: Benign Brain
- Informational Abstract: Adult Primary: Malignant Brain
- Informational Abstract: Bladder
- Informational Abstract: Breast
- Informational Abstract: Cervical
- Informational Abstract: Colon
- Informational Abstract: Endometrial
- Informational Abstract: Kidney
- Informational Abstract: Lung
- Informational Abstract: Melanoma
- Informational Abstract: Ovarian
- Informational Abstract: Pancreas
- Informational Abstract: Prostate
- Informational Abstract: Renal/Pelvis/Ureter

To test your knowledge of the Informational Abstracts and earn CE credit, go to Other CE Opportunities.

**Video Presentation Materials**
- PowerPoint Slides
- Where to Find Information to Abstract Various Data Items PDF
- Medical Record - Breast
- Medical Record - Colon

These site-specific abstracts provide an outline to follow when determining what text documentation to include.

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**NCRA Informational Abstracts Series**

- **Text Documentation is Not Just for Cancer Information**
  - Demographic – including sex of patient and race/ethnicity
  - Exposures to Toxic Chemicals and Lifestyle Information
  - Characteristics of Neoplasm – Cancer Information
  - Diagnostic Workup Sections – including dates
  - Staging Documentation (including SSF/SSDI)
  - Treatment Detail – including dates
  - No Field to Code New Information
  - Non-Standard Information
  - Unique Characteristics
  - Other

INCLUDES: Where to Find Information in the Medical Record and What You Need to Document in the Abstract Text
NCRA Informational Abstracts Series

- THIS INFORMATION IS NOT JUST FOR THE NEW ABSTRACTOR
  - Follow the outline.
  - Strive to complete all the sections.
  - Be concise by using phrases, not sentences.
  - Use text relevant to the disease process and the specific cancer site.
  - Use NAACCR Standard Abbreviations – don’t just make things up.
  - When the abstract is completed, review thoroughly to ensure accuracy.

NCRA Informational Abstracts Series - Sections

- Physical Exam and History - today and leading up to diagnosis
- Physical Exam and History – chronology of care for non-analytic
- Primary Site – small field for what you coded as primary site
- Histology – small field for what you coded as histology
- Diagnostic Procedures – beyond imaging, labs and pathology
- X-Rays/Scopes/Scans – Any Imaging
- Labs – Includes Site-Specific Data Items - SSFs
- Pathology – dates, final diagnosis, comments and addenda
- Treatment – each treatment type has own section for text
The abstract is the basis of all registry functions. It is a tool used to help accurately determine stage and to aid cancer research. Therefore, the abstract must be complete, containing all the information needed to provide a concise analysis of the patient’s disease from diagnosis to treatment.

To assist registries in preparing abstracts, NCRA’s Education Committee has created a series of informational abstracts. These site-specific abstracts provide an outline to follow when determining what text to include. The outline has a specific sequence designed to maximize efficiency and includes eight sections: Physical Exam/Histology, X-Rays/Scans/Scopes, Labs, Diagnostic Procedures, Pathology, Primary Site, Histology, and Treatment. A list of relevant resources is located at the end of each informational abstract. The sources of information noted in the various sections below are not inclusive, but they are the most common. You may need to do additional research to complete the abstract.

When using the informational abstract, follow the outline and strive to complete all the sections. Be concise by using phrases, not sentences. Make sure to use text relevant to the disease process and the specific cancer site and to use NCRA Standard Abbreviations. When the abstract is completed, review thoroughly to ensure accuracy.

Example: A 67-year-old African-American male presents with blood in the urine and a lump in the abdomen. The patient smoked 1 pack of cigarettes/day x 35 years and stopped 10 years ago. He drinks alcohol socially. His family history is negative. Physical examination is negative.

Notes: Often a kidney tumor is noted on a workup for another problem. It is not uncommon for a clinical diagnosis to be made as much as 2-3 months prior to a pathologic diagnosis.
Pop Quiz 2

- The patient was admitted to my facility for biopsy and diagnostic workup of suspected lung cancer. Pathology ran multiple gene tests on the biopsy material to further classify the cancer and identify the best treatment for the patient. The tests that they ran were; EGFR, ROS1, KRAS, ALK plus a few others. There are no SSFs for these tests – but they sound important to the case. Do I include these tests in my abstract? How do I record them?

- Lung Cancer Panel
  - Somatic mutation testing
    - KRAS (NRA/S/RAS)
    - EGFR
    - BRAF
    - PIK3CA
    - ERBB2
    - MET
    - TP53
    - AKT1
    - MAP2K1
    - EGFRvIII (RT-PCR assay)
  - Translocation
    - ALK (EMLA-ALK, but other patients up to 20)
    - ROS (up to 7 partners)
    - KISSB/RET
    - ECDKG/RET (aka RET/PTC1)
  - Amplification
    - EGFR
      - MET
      - MAPK1 (p42, p44)
      - FGFR1
      - FGFR2
Currently, Genomic Testing in Lung Cancers includes mutation testing for several genetic abnormalities for which targeted therapies have been identified. We do not have a designated field or fields to record these tests. Not in the SSFs or in any other site-specific data item. However, it is important to capture tests and results [positive (+) or negative (neg)] in the LAB Section of your abstract. Include date the tests were run, name of the genes tested, and the results + or neg.
## NCRA Informational Abstracts Series - Sections

### KIDNEY

<table>
<thead>
<tr>
<th>PRIMARY SITE</th>
<th>HISTOLOGY</th>
<th>TREATMENT</th>
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<tbody>
<tr>
<td><strong>Example</strong>: Kidney Right 064.9</td>
<td><strong>Example</strong>: Conventional renal cell carcinoma, Fuhrman Grade II. This is another term for the most common type of renal cell carcinoma, which is clear cell carcinoma, code 6990/32. Fuhrman grade should also be coded as 692.0 in this case. Stage T should be coded as T20. Note: Renal cell carcinoma is an umbrella term that covers several variations. The umbrella histology is coded as 8325/3. Usually there will be a more specific type noted in the pathology report, such as chromophobe renal cell carcinoma (6831/3).</td>
<td><strong>Surgery</strong>: Type, date, and any relevant statement to describe important details. The type of surgery usually depends on the size of the primary tumor and the location of the tumor in the kidney. <strong>Partial Nephrectomy</strong>: For smaller tumors. A partial nephrectomy removes the kidney (with or without regional lymph nodes). <strong>Total Nephrectomy</strong>: For larger tumors. A total nephrectomy removes the kidney and may include the ipsilateral adrenal gland, a portion of the vena cava, Gerota’s fascia, perinephric fat or partial/total ureter. <strong>Radiotherapy</strong>: For larger tumors. A radiotherapy removes the kidney and may include the ipsilateral adrenal gland, a portion of the vena cava, Gerota’s fascia, perinephric fat or partial/total ureter. <strong>Example</strong>: Right total nephrectomy.</td>
</tr>
</tbody>
</table>

### Other Documentation – Tips & Resources

- Your Software’s Auto-Text Description is NOT Valid Text Documentation
- Copy/Paste - How Much Text Do I Need to Enter?
- Copy/Paste – How Do I Know What is Most Important?
- Copy/Paste – Please EDIT Your Text – is it complete, accurate, run-on, necessary
- Please Be Careful With Abbreviations – your abbreviation could have a different or unknown meaning – or could have multiple meanings even for this cancer
- Your Text MUST include enough information to support codes
- Registry Software – Local* Text Fields versus Registry-Exported Text Fields
  - *Note Pad Fields Usually Do Not Transfer to the Central Registry
- When Setting Override Fields – Text MUST support any Override
- Treatment Given MUST be supported by Text – Treatment Targets Especially
- Validate that Treatment Given is Consistent with Treatment Guidelines (NCCN)
Other Documentation – Tips & Resources

- CDC NPCR Program Standards and Requirements
- NCI SEER Program Standards and Requirements
- NAACCR Volume II: Data Standards and Data Dictionary
- Your State Cancer Registry Program Standards and Requirements
- NAACCR Volume III: Standards for Completeness, Quality, Analysis, Management, Security and Confidentiality of Data – Standards for Text Data Items & Standards for Data Edits
- NAACCR Standard Abbreviations – PLEASE USE THE CURRENT LIST
- SEER Training Modules – Abbreviations, Symbols & Acronyms
- NPCR Education/Training Series (NETS) – Module 4 – The Value of Accurate Text in Cancer Registry
- California Cancer Registry – Text Documentation Guidelines
- Texas Cancer Registry – Cancer Reporting Handbook – Documentation of Cancer Diagnosis, Extent of Disease, and Treatment
- MRA Thought of the DAY – Cancer Registry Section
- FCDS Text and Documentation Requirements: A Key Component to Providing High Quality Data
- Florida Cancer Data System Text Coding Requirements – FCDS DAM – Appendix L

Quiz 1 - Introduction
Coding Pitfalls and Text - Lung

PHYSICAL EXAM/HISTORY

Include:
- **Demographics:** Age, sex, race, ethnicity of the patient.
- **Chief Complaint (CC):** Write a brief statement about why the patient sought medical care. Often it is a persistent cough, which may be productive, hemoptysis, chest pain, or a combination of symptoms. It may be a routine checkup that shows signs of abnormality.
- **Physical Examination (PE):** Colo of the exam and documentation of information pertinent to the lung cancer, such as diminished breath sounds or parapneumonic laryngitis. If no significant physical findings, it is acceptable to say PE neg.
- **History:**
  - Personal history of any cancer
  - Family history of any cancer
  - Tobacco: type, frequency, amount
  - Alcohol: frequency, amount
  - Workplace exposures and/or relevant environmental factors, such as asbestos or radon and exposure to secondhand smoke.

- List significant, relevant comorbidities, particularly those that impact treatment decisions.
- **Genetics:** List appropriate conditions as found in the patient's record or other information. If not applicable, state that.
- **Post Treatment:** If applicable, include previous chemotherapy or radiation therapy.

Note: Where to find the information: 
- KIP consultations, CT/physical notes, nursing notes, physician progress notes, discharge summaries, admission notes.

- **Note on Negative Findings:** Include any relevant negative findings, such as negative CXR.

Example: 70-year-old Chinese male who presents with hemoptysis x 3 mo. ~4.6.1.1.4
- 2 cm firm parapneumonic L in L 5 region. Lungs are clear to A/E.

X-RAYS/SCOPES/SCANS

Include:
- Scans and scopes pertinent to the diagnostic or treatment modalities, if any.
- Each exam ordered and listed in chronological order if feasible.
- Most commonly those will include a chest x-ray and a CT of the chest.
- Other studies may be done to rule out metastases and may include a bone scan, an MRI of the brain, a CT of the abdomen and pelvis, a PET/CT.

- Examinations/ultrasound (Biopsies) to look for innocuous, if negative, it might lead to a mediastinoscopy to determine resectability.

Example: 3.5-5.1.4 DDR 2 cm mass in LUL, 2.8-5.1.4 CT chest. 2.5 cm mass in LUL, 2.5 cm mass in L 5 8 region where may be metastatic nodular, 3.4-4.6.8.6 (Bone scan) – neg, MRI brain neg, 3.1.5.1.4 PET/CT 3.5 cm (metastases) mass in LUL, 2.0 cm mass in L 5 8 region and 1.5 cm in L 6.9.

**Findings concerning for primary lung malign with nodal mets.**

LABS

Include:
- There are no pertinent lab tests for lung cancer. There may be lab tests which indicate mets, such as elevated LDH.

DIAGNOSTIC PROCEDURES

Include:
- Procedures such as bronchoscopy to look for endobronchial lesions. Occasionally mediastinoscopy will be done to determine the possibility of resection of the primary.
- Information about a positive palpable lymph node that may have been the targeted first tumor implying a suspected primary site.

Example: A.5.5.6 Bronchoscopy, Cigarettes normal. No endobronchial lesions. A.5.5.6 CT guided bx L 5 5 region.
### Coding Pitfalls and Text - Lung

- **Atelectasis/Pneumothorax** = Complete or Partially Collapsed Lung
- **Pneumonitis** - inflammation of the walls of the alveoli in the lungs, often caused by virus.
- **Obstructive Pneumonitis** – pneumonitis resulting in bronchial obstruction
- **Consolidation** - a region of lung tissue filled with liquid or blood or pus instead of air
- **Pleural Effusion/Hemothorax** - a buildup of extra fluid in the space between the lungs and the chest wall.
  - Most pleural effusions are hemorrhagic or bloody which indicates malignant pleural effusion
  - Any pleural effusion in lung cancer is deemed “malignant” and must be proven “negative” x 2-3 cytology examinations
  - When pleural effusion described as “minimal” or “small” it may not be ‘treated’ as with involvement – still code as malignant pleural effusion for consistency in staging cases
- **Primary Tumor Extension to either Pleura is not the same as pleural effusion**
- **What is a Pleural-Based Mass – is this a lung primary or a pleura primary?**

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**Coding Pitfalls and Text - Lung**

<table>
<thead>
<tr>
<th>TX</th>
<th>Primary tumor cannot be assessed</th>
</tr>
</thead>
<tbody>
<tr>
<td>T0</td>
<td>No evidence of primary tumor</td>
</tr>
<tr>
<td>T1a</td>
<td>Tumor ≤ 3 cm in greatest dimension, surrounded by lung or visceral pleura, without bronchoscopic evidence of invasion more proximal than the lobar bronchus (i.e., not in the main bronchus)</td>
</tr>
<tr>
<td>T1b</td>
<td>Tumor &gt; 3 cm but ≤ 7 cm in greatest dimension</td>
</tr>
<tr>
<td>T1c</td>
<td>Tumor &gt; 7 cm or tumor with any of the following features, T2a, T2b, T3e, T4b-c</td>
</tr>
</tbody>
</table>

- **T2a**
  - Involves main bronchi, ≥ 2 cm distal to the carina
  - Involves hilar lymph nodes (PI.1 or PL.2)
  - Associated with obstructive or inflammatory changes that extend to the main bronchi but do not involve the entire lung

- **T2b**
  - Tumor > 7 cm but ≤ 10 cm in greatest dimension
  - Tumor that directly invades any of the following: parietal pleural (PL.3) chest wall (including superior vena cava tumor), diaphragm, pericardium, heart, mediastinum, pericardium or tumor in the main bronchus (< 2 cm distal to the carina) but without involvement of the carina

- **T3**
  - Tumor > 7 cm or tumor that directly invades any of the following: mediastinum, heart, great vessels, trachea, recurrent laryngeal nerve, esophagus, vertebrae, mediastinal pleura, parietal pericardium or tumor in the main bronchus but without involvement of the carina

- **T4**
  - Tumor of any size that invades any of the following: mediastinum, heart, great vessels, trachea, recurrent laryngeal nerve, esophagus, vertebrae, mediastinal pleura, parietal pericardium or tumor in the main bronchus but without involvement of the carina

* The uncommon surgically resectable tumor of any size with its invasive component limited to the bronchial wall, which may extend proximally to the main bronchus, is also classified as T4b.
**Coding Pitfalls and Text - Lung**

- When to Use Imaging Date as Date of Diagnosis
- When to Use Biopsy Date as Date of Diagnosis
- Coding and Documenting Lung Subsite – hilum or upper lobe
- What Qualifies as Multiple Tumor Nodules – same lobe, different lobe, contralateral lung – are any of these “bilateral” lung cancer
- Primary Hilar Extension versus Hilar Node Involvement
- Primary Mediastinal Extension versus Mediastinal Node Involvement
- Critical but Absent Site-Specific Data Items
  - New Standard Genetic Tests for Targeted Therapies
    - ALK Rearrangement – EML4-ALK, KIF5B-ALK, TFG-ALK, KLC1-ALK
    - EGFR Mutations – Exon 18, 19, 20 and/or 21 Mutation
    - ROS1 Rearrangement
    - RET, KRAS, BRAF, MET and ERBB2 Mutations

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**Pop Quiz 3**

- A Pet CT showed a 2cm tumor in the peripheral portion of the right upper lobe lung. No metastasis was identified.
  - A biopsy of the tumor confirmed adenocarcinoma.
- The patient had a right upper lobectomy that showed adenocarcinoma measuring 2cm’s with extension into, but not through the visceral pleura. 12 lymph nodes were negative for metastasis.

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<tbody>
<tr>
<td>Clinical T</td>
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<td>Clinical N</td>
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<td>Clinical Stage</td>
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</table>
• New Terminology & Codes for “bronco-alveolar”
• N1, N2 and N3 are ALL “regional lymph nodes”

Are there hilar or mediastinal nodes – do not treat as same
• Code FNA of Regional Lymph Node in Scope of LN Surgery
• Regional Lymph Nodes Examined/Regional Lymph Nodes Positive
**Coding Pitfalls and Text - Lung**

- Grade for Lung Cancer – Not the Same as Breast/Prostate
- Palliative Treatment can be part of 1st COURSE TREATMENT
- New Targeted Therapies for Lung Cancer

### Lung Adenocarcinoma

<table>
<thead>
<tr>
<th>Protein</th>
<th>Mutation</th>
<th>Response</th>
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<tbody>
<tr>
<td>EGFR exons 18–21</td>
<td>Mutation</td>
<td>Response to EGFR inhibitors</td>
</tr>
<tr>
<td>EGFR</td>
<td>p.T790M and some exon 20 insertion mutations</td>
<td>Resistance to EGFR inhibitors</td>
</tr>
<tr>
<td>KRAS codons 12, 13, 61</td>
<td>Mutation</td>
<td>Exclusion of EGFR mutation</td>
</tr>
<tr>
<td>BRAF p.V600E</td>
<td>Mutation</td>
<td>Possible response to BRAF inhibitor</td>
</tr>
<tr>
<td>ALK</td>
<td>Rearrangement</td>
<td>Response to TKI</td>
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<tr>
<td>RET</td>
<td>Rearrangement</td>
<td>Response to TKI</td>
</tr>
<tr>
<td>ROS1</td>
<td>Rearrangement</td>
<td>Response to TKI</td>
</tr>
<tr>
<td>MET</td>
<td>Amplification</td>
<td>Resistance to EGFR inhibitors</td>
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College of American Pathologists - Clinical Solid Tumor Molecular Oncology: Selected Tests by Tumor Type

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**Coding Pitfalls and Text - Lung**

- Primary Tumor (T)
  - **TX**: Primary tumor cannot be assessed
  - **T0**: No evidence of primary tumor
  - **T1**: Tumor ≤ 2 cm in greatest dimension
  - **T2**: Tumor > 2 cm but ≤ 5 cm in greatest dimension
  - **T3**: Tumor > 5 cm or any tumor with any one of the following: direct invasion of the esophagus, trachea, recurrent laryngeal nerve, vagus nerve, mediastinal pleura, pericardium; or invasion of the trachea or main bronchus (≤ 2 cm distal to the carina) but without invasion of the carina or associated aberrant arteries or obstructive pneumonitis of the entire lung or superior vena cava obstruction in the same case

- Regional Lymph Nodes (N)
  - **NX**: Regional lymph nodes cannot be assessed
  - **N0**: No regional lymph node metastasis
  - **N1**: Metastasis in ipsilateral peri- or hilar lymph nodes
  - **N2**: Metastasis in contralateral mediastinal, contralateral hilar, ipsilateral or contralateral aortic, or subcarinal lymph nodes

- Distant Metastasis (M)
  - **M0**: No distant metastasis (no pathologic M0); use clinical M0 if complete stage group
  - **M1**: Distant metastasis
    - **M1a**: Sequestrated tumor nodules in a contralateral lobe; tumor in pleural nodules or non-pulmonary inoperable (e.g., pericardial) effusion
    - **M1b**: Distant metastasis in extrathoracic organs

*The uncommon extreme spreading tumor of any size with the invasive component limited to the bronchial wall, which may extend proximally to the main bronchus, is also classified as T1a.*
Pop Quiz 4

- A PET CT showed a 4 cm tumor in the right upper lobe and associated pleural effusion. Also noted was right sided mediastinal lymphadenopathy.
  - Thoracentesis was positive for malignancy.
  - A mediastinoscopy and biopsy of a 4R lymph node was positive for metastatic small cell carcinoma.
- A CT of the head showed brain metastasis.
- The patient was treated with radiation and chemotherapy

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Pop Quiz 4...8th edition

- A PET CT showed a 4 cm tumor in the right upper lobe and associated pleural effusion. Also noted was right sided mediastinal lymphadenopathy.
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Q&A – Lung Cancer Coding Pitfalls

Coding Pitfalls and Text - Colon

PHYSICAL EXAM/HISTORY

Include:
- Demographics: Age, sex, race, ethnicity of the patient.
- Chief Complaint (CC): Write a brief statement about why the patient sought medical care.
- Physical Examination (PE): Date of the exam and documentation of information pertinent to the colon cancer.

HISTORY:
- Personal history of any cancer
- HNPCC or Lynch Syndrome in patient or family members
- Family history of any cancer
- Tobacco use: type, frequency, amount
- Alcohol: frequency, amount
- List significant, relevant co-morbidities, particularly those that impact treatment decisions.

Genetics: List appropriate conditions as found in the patient's record or other information. If not applicable, state that.

Past Treatment: If applicable, revise previous chemotherapy or radiation therapy.

When to Find the Information: Physical examination, EHR, physician notes, nursing notes, physician progress notes, discharge summary, admission notes.

Note on Negative Findings: Include any relevant negative findings, such as a negative CEA test.

Examples: 64-year-old white male with c/o (complaint of) intermittent episodes of bright red blood per rectum over the last three months. Patient noted no change in caliber of stool. Unintentional weight loss of 10lbs over last two months. No personal or family history of colorectal or Lynch syndrome.
Coding Pitfalls and Text - Colon

X-RAYS/SCOPES/SCANS

- **Dx(s) or Procedure(s):**
- Type(s) of Procedure(s): A description of what was made during examination, including segment of the colon, evidence of perforation, biopsy, colonoscopy, colonscopy. Include the name of the facility/procedure performing these tests, especially if outside of your facility.
- Relative Contraindication or Work-Up
  - Ultrasound: 16-18 G/s. Helps determine solid from cystic structures.
  - Computed Tomography (CT)
  - Angiography: Primary cause in determining extent of disease. If femoral nodes are involved or there is distant spread.
  - Magnetic Resonance Imaging (MRI): produces images that may identify extent of disease not seen on CT or IV.
  - Position Emission Tomography (PET): identifies `hot spots` or areas of uptake throughout the body and are useful in assessing regional and distant metastasis.

LABS

- Included:
  - Dues and Tissue: relevant to test and date. For example, fine-needle CDA, NSA, etc. Also, negative/positive.
  - Labs: lab range of normal.

DIAGNOSTIC PROCEDURES

- List procedures, including the date and location of each test.

PATHOLOGY

- Include:
  - Site of tumor: histology, histology grade, location of tumor, depth of invasion.
  - Angiographic studies (primary), primary tumor.
  - Pathological findings (present/diagnosis present).
  - Lymph node status (number positive or removed taken).
  - Margin status (tumor, tumor and radial)
  - Other findings

PRIMARY SITE

- Include:
  - Identify the segment of colon involved by the tumor

HISTOLOGY

- Include:
  - Histology, differentiation, grade

Example: 4.5 × 3.0 poorly differentiated invasive adenocarcinoma of the sigmoid, transverse, ascending colon involving approximately 90% of the circumference of the colon. 

Example: 20/21/14 CT A/P (EMR) Radiology. Nodules noted involving the sigmoid colon. No evidence of peritoneal lymph nodes noted. No evidence of peritoneal washings.

Example: Colonoscopy: biopsy may include polyps (benign or suspicious) masses and/or obstruction.

Example: CT colonoscopy: ragged stricture of 5 cm, near circumferential mass involving the posterior port of the sigmoid colon, foreign appearing polyp noted in the colon. No other significant findings noted. Biopsy taken of mass at stricture. Biopsy taken of colon polyp.

Example: Pathology: included: tenderness. CEA 9.05 (other) effective 1/14/05 Manual Part 1, Section 2.

Example: 20/21/14 CEA 0.38 (range 0.0-3).
**Coding Pitfalls and Text - Colon**

**TREATMENT**

- **Operative Procedures:** Date(s) of the procedure(s); type of procedure(s); approach; and colon segment involved.
- **Findings by Surgeon:** Surgical approach; findings by surgeon at time of surgery; perforation; lymph node status; regional organ involvement; definitive treatment vs. palliation.
  

- **Definitive Treatment:** Include information on cancer antimetabolic drugs and drug regimens (see Resources for link to STER Fix Antimetabolic Drugs Database). Include dates, agents used, indicate if adjuvant or neoadjuvant.
  
  Example: 7/1/14: FOLFOX 6 administered by Dr. Smith, Medical Oncology Associates.

- **Radiation Treatment:** Start and stop dates; location of treatment; if administered by another facility; treatment modality; regional and boost dosages, where applicable; number of fractions; number of days of treatment; was this treatment pre-operative or post-op? If not administered, document the reason why.

  Note: The use of radiation is limited in colon cancer since it has a relatively small impact on the disease process.

  Example: 2/4/14 – 3/26/14: 5000cGy to pelvis for 6 fractions over 6.5 days utilizing 3D approach.

- **Clinical Trials:** Is the patient enrolled in any clinical trials? If so, include the name, trial number, and any other available details, including the date of enrolment.

---

**Q&A – Colon Cancer Coding Pitfalls**

**Average distribution of colon cancer**

- Transverse colon 10%
- Ascending colon 30%
- Descending colon 15%
- Rectum 20%
- Sigmoid colon 25%
• Could you explain the difference between Segmental Resection (30) vs Hemicolecotmy (40)?

• What do we do if they remove more than a single segment but less than a full hemicolecotmy?
Colon Coding Pitfalls

- Partial Colectomy, Segmental Resection (30)

- Subtotal Colectomy/hemicolectomy (40)
  - Total right or left colon and a portion of transverse colon

- Total Colectomy (50)
  - Removal of colon from cecum to the Rectosigmoid junction may include a portion of the rectum

Colon Coding Pitfalls

- Operative Report
- OPERATION PERFORMED: Right hemicolectomy.

- DESCRIPTION OF OPERATION: After appropriate preparation, signed informed consent, the patient was brought to the operating room, prepped and draped in the supine position. Under satisfactory endotracheal anesthesia, Foley catheter and NG tube were inserted. A midline incision was utilized, carried down to the subcutaneous tissue. The linea alba was split with a scalpel. The abdomen was entered in the usual fashion obtaining hemostasis in the subcutaneous tissues. Exploration revealed a normal liver and gallbladder. The colon was mobilized with a retractor along the right side, along the right colic gutter, using the ACE Harmonic scalpel. We divided the hepatocolic ligament and entered into the lesser sac and took the dissection down to the mid transverse colon, entering the lesser sac. At this juncture, the ileum was also freed up by dissecting and freeing up its attachments to the lateral wall. The terminal ileum was brought up into the wound and a little otomy was made in the mesentery of the transverse colon and the GIA was fired across it dividing the transverse colon. Next, using the ACE Harmonic scalpel, we took down the mesentery and its vessels. Larger vessels were clamped with Kelly clamps and tied with silk suture material. We took this all the way up to the terminal ileum and then divided the terminal ileum with a GIA. With the specimen off the table, we opened it up on the back table and found several scattered flat polyps, none of which appeared to be ominous. A standard anastomosis was then made between the terminal ileum and the transverse colon in a side-to-side fashion using the GIA and TA60. Lembert sutures of 3-0 silk were placed in the dependent portion of the anastomosis and the crotch of the anastomosis and then the mesentery was closed with running locking suture of 3-0 Vicryl. Right colic gutter was copiously irrigated with saline solution. Omentum was brought back down over the anastomosis. Small bowel was placed back in its normal anatomical position. The area was checked for hemostasis and irrigated with saline solution. Two layers of Seprafilm were placed in the abdomen over the omentum. The abdomen was closed with running suture of #1 PDS from above and below. The skin was closed with stainless steel staples. Dry sterile dressing was placed on the wound. The patient tolerated the procedure well and left the operating room in good condition.
Colon Coding Pitfalls

Colon Coding Pitfalls

Operative Report

DESCRIPTION OF OPERATION: After appropriate preparation, signed informed consent, the patient was brought to the operating room, prepped and draped in the supine position. Under satisfactory endotracheal anesthesia, Foley catheter and NG tube were inserted. A midline incision was utilized, carried down to the subcutaneous tissue. The linea alba was split with a scalpel. The abdomen was entered in the usual fashion obtaining hemostasis in the subcutaneous tissues. Exploration revealed a normal liver and gallbladder. The colon was mobilized with a retractor along the right side, along the right colic gutter, using the ACE Harmonic scalpel. We divided the hepatocolic ligament and entered into the lesser sac and took the dissection down to the mid transverse colon, entering the lesser sac. At this juncture, the ileum was also freed up by dissecting and freeing up its attachments to the lateral wall. The terminal ileum was brought up into the wound and a little oomy was made in the mesentery of the transverse colon and the GIA was fired across it dividing the transverse colon. Next, using the ACE Harmonic scalpel, we took down the mesentery and its vessels. Larger vessels were clamped with Kelly clamps and tied with silk suture material. We took this all the way up to the terminal ileum and then divided the terminal ileum with a GIA. With the specimen off the table, we opened it up on the back table and found several scattered flat polyps, none of which appeared to be ominous. A standard anastomosis was then made between the terminal ileum and the transverse colon in a side-to-side fashion using the GIA and TA60. Lembert sutures of 3-0 silk were placed in the dependent portion of the anastomosis and the crotch of the anastomosis and then the mesentery was closed with running locking suture of 3-0 Vicryl. Right colic gutter was copiously irrigated with saline solution. Omentum was brought back down over the anastomosis. Small bowel was placed back in its normal anatomical position. The area was checked for hemostasis and irrigated with saline solution. Two layers of Seprafilm were placed in the abdomen over the omentum. The abdomen was closed with running suture of #1 PDS from above and below. The skin was closed with stainless steel staples. Dry sterile dressing was placed on the wound. The patient tolerated the procedure well and left the operating room in good condition.
Pop Quiz 6

- Could please discuss/explain a case in which a polypectomy was done and then a resection with no residual. All we know is the cancer was confined to the polyp. What would be the TNM and stage group for a case such as this?

**Answer/Guidelines**

- Sessile polyp
  - Colonoscopy with a biopsy is usually diagnostic, incomplete resection, cTX
  - Surgical resection is treatment, pT
- Pedunculated polyp
  - Colonoscopy snare polypectomy is treatment, pT
  - No diagnosis prior to snare, therefore no clinical stage assigned
- General guideline for polyp removal during colonoscopy
  - Incomplete resection – cTNM
  - Complete resection of polyp, treatment – pTNM
  - Not dependent on margins, but on purpose/intent of resection

[http://cancerbulletin.facs.org/forums/node/69606](http://cancerbulletin.facs.org/forums/node/69606)
Pop Quiz 7

- A patient present for routine colonoscopy and is found to have a pedunculated polyp in the sigmoid colon. A hot snare is used to remove the polyp.
- Pathology from the polypectomy shows an invasive adenocarcinoma extending into, but not beyond the submucosa.

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Pop Quiz 7 (part 2)

- A patient present for routine colonoscopy and is found to have a pedunculated polyp in the sigmoid colon. A hot snare is used to remove the polyp.
- Pathology from the polypectomy shows an invasive adenocarcinoma extending into, but not beyond the submucosa.
- The patient returns for a sigmoidectomy.
- Pathology did not reveal any residual tumor. 22 lymph nodes negative for metastasis.

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Pop Quiz 8

• Patient presented with rectal bleeding.
  – Rectal endoscopic US showed large pedunculated polyp in rectosigmoid junction 4cm in size. The mass appears to arise from mucosal layer with no signs of deeper invasion. No abnormal perirectal, iliac or pericolonic lymph nodes were seen.
  – Biopsy showed tubulovillous adenoma polyp with severe dysplasia (carcinoma in situ).
  – PET showed a lung nodule, colon mass, no other mets.
  – Biopsy of lung mass showed metastatic adenocarcinoma of enteric primary origin.
  – Managing Oncologist states stage IV, treated with neoadjuvant chemo with planned surgery of colon and lung nodule (surgery results are not available to me yet).
  – Note from pathologist: It's likely the biopsy of the polyp was a superficial biopsy and it just didn't hit the area in the polyp where the invasive carcinoma is lurking.

Pop Quiz 8 (cont)

• Biopsy of rectal mass showed tubulovillous adenoma polyp with severe dysplasia (carcinoma in situ).
• Lymph nodes clinically negative
• Biopsy of lung mass showed metastatic adenocarcinoma of enteric primary origin
• A CT of the head showed brain metastasis.
• The patient was treated with radiation and chemotherapy

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**Pop Quiz 8...8th edition**

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**Coding Pitfalls and Text - Melanoma**

Physical Exam/History

- **Examination:** Full skin exam performed. No masses or lesions detected.
- **Note on Negative Findings:** Include any relevant negative findings, such as overall skin exam showed no lesions, except as noted in the chief complaint.
- **Past Treatment:** If applicable, include previous chemotherapy or radiation therapy.
- **Where to Find the Information:** H&E consultations. All clinical notes, nursing notes, physician progress notes, discharge summary, admission notes.

Example: 55-year-old with a 6 month history of a mole on the back. The mole has increased in size and color. The patient is concerned about skin cancer. The patient has no other medical history of note. The patient denies any history of skin cancer in the family. The patient does not use tanning beds or sunlamps. The patient does not use sunscreen regularly. The patient does not drink alcoholic beverages. The patient does not work outside with a risk of sun exposure. The patient's father smoked until age 50. The patient's mother smoked until age 60.

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Coding Pitfalls and Text - Melanoma

X-RAYS/SCOPES/SCANS
Include:
- List names of all X-rays, scopes, and scans.
- Include the dates and results.
- Imaging Reports: Chest x-ray, MRI, CT scan, PET scan (determine disease and/or metastatic spread).
- Biopsies: microscopic, immunohistochemistry may be used to detect/confirm metastatic spread.
Example: 1/23/14 Chest x-ray showed an area suspicious for spread of disease in a patient with known melanoma of the right arm.

LABS
Include:
- List names of all tests, dates, and results.
- Lactate dehydrogenase (LDH): A blood test used to detect if the melanoma has spread to distant areas. A higher level than normal may indicate the cancer is harder to treating.
- Blood cell counts and blood chemistry done in advanced melanoma to determine how well the bone marrow, liver, and kidneys are working during treatment.
- Testing for targeted treatments.
Example: 1/23/14 LDH was negative.

DIAGNOSTIC PROCEDURES
Include:
- List names of all diagnostic procedures, dates, and summary of findings.
- Biopsy only, shave, punch, incisonal, fine needle aspiration, sentinel lymph node biopsy.

Coding Pitfalls and Text - Melanoma

PATHOLOGY
Include:
- Brief summary of all pathologic studies/reports. Include dates and final histologic/histopathologic features.
- Cancer Cell Type
  - Circum
- Site of the tumor (not the specimen size)
- Extent (distribution of primary tumor, presence of metastases or in the microscopic description on the pathology report)
- Lymph node involvement or lack of it.
- Number of lymph nodes removed and number of lymph nodes involved.

PRIMARY SITE
Include:
- Site where cancer started. For skin, stage part of body where cancer is occurring as well as the anastomosis of the site.

HISTOLOGY
Include:
- Cancer cell type
- Example: Superficial spreading melanoma.

NAACCR 2016-2017 Webinar Series 9/7/17
Coding Pitfalls and Text - Melanoma

TREATMENT

Include:
- Surgery: Name of procedure, date, and any pertinent findings noted by surgeon. Procedures include excisional biopsy, electrosurgery, excision, cryosurgery, photodynamic therapy, microwave coagulation, laser excision, Mohs surgery, wide excision, re-excision. If lymph nodes involved, note lymph node dissection, regional lymphadenectomy.
- Chemotherapy: Dates of beginning and ending of treatment, names of drugs, route of administration, and noted response, if given. If any drugs were changed, note new drugs, any drugs were changed, and when the new drug started.
- Radiation: Note beginning and ending dates of treatment, type of radiation, to what part of the body it was given, and reaction. If given, note any boost doses, the dosage, where it was given, and when it was started.
- Immunotherapy: Drugs used to help boost the immune system. Note drugs given, the dose they were started and stopped, route of administration, and response, if given.
- Targeted Therapy: Dates, names, and route of administration, and response to them if given.
- Clinical Trials: Is patient enrolled in any clinical trials? If so, include the name, trial number, and any other available details, including the date of enrollment.
- Other: Dates and names of other treatment that does not fit in the above categories.

Example:
- Surgery: 3/17/14, MOHS procedure
- Immunotherapy: First dose of immunotherapy was started on 3/28/14 given IV; last dose given 6/24/14, responded well to the treatment.

Q&A – Melanoma Coding Pitfalls

Asymmetry:
- One half is unlike the other half.

Border:
- An irregular, scalloped, or poorly defined border.

Color:
- A change from one area to another; has shades of tan, brown, or black; is sometimes white, red, or blue.

Diameter:
- Melanomas are usually greater than 6mm. (The size of a pencil eraser) when diagnosed, but they can be smaller.

Evolving:
- A mole or skin lesion that looks different from the rest or is changing in size, shape, or color.
**Pop Quiz 9**

- Are the CoC rules different than SEER for coding biopsies of a melanoma?
  - No. Rules from CoC, SEER, and NPCR are all consistent.
    - If biopsy is done and it removes all visible tumor, it is a surgical procedure.
    - If a biopsy does not remove all visible tumor (only a sample), code it as a diagnostic staging procedure.

**Pop Quiz 9 (cont) Shave Biopsy**

- Would a shave biopsy for melanoma in situ with positive margins be coded as a surgical procedure or diagnostic staging procedure?
  - If the pathology report from the shave biopsy indicates macroscopic involvement, code it in Surgical Diagnostic and Staging Procedure, 02.
  - If the pathology report shows clean margins or the presence of microscopic involvement - code it as an excisional biopsy 27

Pop Quiz 10

- For T1 tumors: If we have information only about ulceration but no information about mitosis can we assign a T1 and no subcategory?

Pop Quiz 10 Answer

- To assign T1a you would need info on both ulceration AND mitotic rate.
  - An elevated mitotic rate could push this into the T1b category.
- If ulceration is present a T1b can be assigned without information concerning mitosis.
  - If mitosis is <1/mm2, T1b is assigned due to the ulceration.
  - If mitosis is ≥1/mm2, T1b is assigned due to the ulceration.
  - The higher mitosis rate does not push this into the T2 category.
- If no information on ulceration, a subcategory for T1 cannot be assigned.
Pop Quiz 10 Answer...8th edition

• Mitotic rate has been removed as a staging factor for T1 tumors.
  – Still an important prognostic factor
  – T1a and T1b definitions have been modified slightly, but are still dependent on ulceration status.

Pop Quiz 11

• Could you explain the difference between Micrometastasis (N1a) and Macrometastasis (N1b) when it comes to lymph nodes?
Pop Quiz 11 Answer

- Micrometastasis and macrometastasis only influence the pN.
- Micrometastasis indicates that clinically there was no indication of lymph node metastasis (cN0). However, when a lymph node was surgically removed, metastasis was identified.
  - This could be identified in a sentinel lymph node biopsy.
  - A sentinel lymph node biopsy is always part of the pN.
- Macrometastasis indicates that clinically lymph node metastasis was identified and was verified pathologically in at least one lymph node.

Pop Quiz 10 Answer...8th edition

- In 8th edition
  - Micrometastasis is defined as *clinically occult*
  - Macrometastasis is defined as *clinically detected lymph node metastasis*
A patient presents for annual screening and is found to have a suspicious mole. The mole is excised and found to be malignant melanoma (cT1b). No palpable lymph nodes were present.

The patient returned two weeks later for a sentinel lymph node biopsy and wide excision.

Pathology
- Wide excision: Negative for residual melanoma
- Sentinel node biopsy:
  - 4 lymph nodes removed. Micrometastasis measuring less than 0.1mm in a single lymph node. 3 lymph nodes negative for metastasis.

### Pop Quiz 11

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Page 335 and 336

### Coding Pitfalls and Text – Brain & CNS – Part I

**Physical Exam/History**

- **Include:**
  - Demographics: Age, sex, race, ethnicity of the patient.
  - Other Complaints: Brief statement about why the patient sought medical care.
  - History: Personal or family history of any cancer and the family member involved. List the smoking and alcohol history of the patient, type, frequency, and amount.
  - Exposure to any cancer causing chemicals, workplace, and/or relevant environmental factors.
  - List chronic health problems, limitations, or infections. Make sure to note previous chemotherapy or radiation therapy, and other relevant information as seems appropriate.
  - Genetic: Include birth defects or other related genetic conditions.

- **Past Treatment:** Include past treatment if applicable.
  - Example: A 49-year-old white female patient presented to our otolaryngologist with a history of bilateral hearing loss and decreased visual acuity. A R/A mass detection in nature and unresponsive to analgesics. Patient reported gradual visual changes over time attributed to age. Patient's visual field testing demonstrated central temporal field loss (bitemporal hemianopia). Consistent with (c/) optic nerve atrophy.

**Where to Find Information:**
- MRI consultations, nursing notes, admission notes, physician progress notes, discharge summaries.
**Coding Pitfalls and Text – Brain & CNS – Part I**

**INFORMATIONAL ABSTRACT**

**ADULT PRIMARY BENIGN BRAIN**

**X-RAYS/SCOPES/SCANS**

Includes:
- Imaging: Date, time, and a brief summary of test results. MRI is the preferred imaging modality for pituitary adenomas.

Note: Pituitary adenomas are classified based on size as either microadenomas (<10mm) or macroadenomas (>10mm). The optic chiasm lies directly above the pituitary.

**LABS**

Includes:
- List each test, date, and result. Include pituitary function tests and endocrine studies for hormone hypersecretion or hyperfunction.

Note: The pituitary gland produces hormones that can be characterized as either secretory or non-secretory (functioning or non-functioning). Based on the presence or absence of these hormones, non-secretory tumors usually present with vision loss, while tumors with secretory tumors usually present after evaluation by an endocrinologist for symptoms related to hormonal imbalances (weight changes, mood changes, fatigue, loss of libido, etc.).

**PHYSICAL EXAM/HISTORY**

Includes:
- HIPPA-compliant history obtained.

**DIAGNOSTIC PROCEDURES**

These are procedures that details the cancer, but do not remove it.

Includes:
- Biopsy: List date, name of procedure, and brief description of findings.

**PATHOLOGY**

Includes:
- Date and a brief summary of findings of all pathological reports, particularly the those listed below.

**PRIMARY SITE**

Includes:
- The primary site where the cancer started.

**HISTOLOGY**

Includes:
- The exact cell type of the cancer.
• Transformation to Malignant is Very Rare

• Coding Primary Site for Meningioma
  – C70.0 – Cerebral Meninges
  – C70.1 – Spinal Meninges
  – C70.9 – Meninges, NOS

• Sphenoid Wing Meningioma arise in the arachnoid layer of the cranial meninges covering the sphenoid wing. Called sphenoid wing meningioma because of location – part of cranial meninges included as undersurface of the skull and are reportable tumors.

• Why are some brain tumors classified using laterality and some are not? What about Cranial Nerve Tumors and CNS tumors?
### Coding Pitfalls and Text – Brain & CNS – Part II

**Physical Exam/History**

- **Include:**
  - **Demographics:** Age, sex, race, ethnicity of the patient.
  - **Chief complaint:** A brief statement about why the patient sought medical care.
  - **History:** Past history or family history of any cancers, include tobacco (type, frequency, and amount), alcohol (frequency and amount), work exposure to any environmental factors. List any current medications, smoking status, allergies, or infections.
  - **History of other cancers:** Previous chemotherapy or radiation therapy, or other relevant information as deemed appropriate.
  - **Genetics:** List any birth defects or other related genetic conditions.

**Example:** 54 year old white male presented to the ER with complaints of acute onset headaches increasing in severity, nausea, vomiting (N/V), mental confusion, and a change in mental status. Patient’s spouse observed one episode of sudden-onset abnormal gait prompting ER visit. Past medical history (PMH) significant only for hypertension/Hypercholesterolemia. Past surgical: tobacco, ETOH, street drugs – all negative.

Where to Find the Information: Head consultations, nursing notes, physician progress notes, admission notes, discharge summary.

---

**X-rays/Scopes/Scans**

- **Include:**
  - Imaging studies: Date, name, and a brief summary of test results. Most commonly used imaging is contrast-enhanced Gadolinium MRI and Computerized Tomography (CT).

**Example:** 10/20/2015: CT Head w/o contrast: Examination reveals 1.6cm right-sided hyperdense mass, evidence of left shift causing mid-line shift to left, compression of right lateral and third ventricles. Recommend Good Mass MRI for further evaluation.

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**Laboratory**

- **Include:**
  - Data: list all tests and results.
  - Immunohistochemical (IHC) and molecular genetic studies are often performed to assist with diagnosis, prognosis, or to predict therapeutic response.
  - Common ancillary molecular testing in neuro-oncology includes testing for TP53 and 1p/19q codeletion.

**Example:** TP53 expression

- Copy number alterations in epidermal growth factor (EGF) and phosphatase and tensin homolog (PTEN) (CA P CNS (protocol brain/spinal cord) background documentation, ancillary studies).

**Example:** TP53: RIGHT POSTERIOR LOBE SURGICAL RESECTION: Glioblastoma multiforme (GBM), WHO Grade IV, 36% of tumor necrosis, 66% of tumor cellularity, IHC: MGMT 20%, PTEN wildtype (20%).
Coding Pitfalls and Text – Brain & CNS – Part II

DIAGNOSTIC PROCEDURES

For any of these diagnostic procedures—

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PATIENT SITE

Example: Brain – Right frontal (Loc: 67.1, 3.5) where the tumor mass found is the surgical report and/or diagnostic reports imaging or biopsy.

HISTOLOGY

Example: GBM, WHO Grade IV (AM0480-3).

TREATMENT

Example: 1/17/15, 5/14, 1/16 Dr. M. Ommen

Coding Pitfalls and Text – Brain & CNS – Part II

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Pop Quiz 12 Coding Pitfalls and Text – Brain & CNS – Part II

- Does a neoplasm have to be microscopically confirmed to have a WHO Grade? What do we use if ‘grade’ is stated on imaging?

- Astrocytoma and Glioma terminology can be confusing because these neoplasms are all of glial origin. The difference is grade.

- Progression to a higher WHO Grade can occur and most often associated with glioma/astrocytoma neoplasms becoming higher grade and more aggressive over time when diagnosed early in life.
**Miscellaneous Questions**

- Benign Tumors of the spinal vertebra – reportable or not reportable?
  - Tumors of the spinal vertebra like Osteoid osteoma and osteoblastoma would be coded to primary sites C41.2
  - Since this would be a benign tumor in the bone it would be not reportable

**Pop Quiz 13 Question**

- Patients with kidney primaries often have a kidney removed, but rarely are nodes removed. Are there circumstances where a pathologic stage group can be assigned with lymph nodes being excised?
A 63 year old white male presents with a history of right flank pain for the last month. An abdominal CT showed a large complex right renal mass (10 x 8 x 7.8 cm) highly suspect for renal cell carcinoma. The tumor extends into the renal vein, but does not extend beyond the Gerota’s fascia. Biopsy confirmed renal cell carcinoma. Additional workup was negative. Patient went on to have a radical nephrectomy.

Pathology from radical nephrectomy:
- Specimen: Kidney and adrenal gland, left, radical nephrectomy.
- Histologic Tumor Type: Sarcomatoid renal cell carcinoma
- Histologic Tumor Grade: Fuhrman grade 4 (of 4)
- Tumor Size: 10.0 X 8.3 X 8.0 CM.
- Tumor Extension: Tumor extends along the renal vein into the inferior vena cava. Tumor does not extend beyond the Gerota’s fascia.
- Margins: All margins negative

---

A 63 year old white male presents with a history of right flank pain for the last month. An abdominal CT showed a large complex right renal mass (4 x 3.5 x 3.2 cm) highly suspect for renal cell carcinoma. The tumor extends into the renal vein, but does not extend beyond the Gerota’s fascia. Biopsy confirmed renal cell carcinoma. Additional workup was negative. Patient went on to have a radical nephrectomy.

Pathology from radical nephrectomy:
- Specimen: Kidney and adrenal gland, left, radical nephrectomy.
- Histologic Tumor Type: Sarcomatoid renal cell carcinoma
- Histologic Tumor Grade: Fuhrman grade 4 (of 4)
- Tumor Size: 4 x 3.5 x 3.2 cm
- Tumor Extension: Confined to the kidney.
- Margins: All margins negative

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Text Pointers for Changing Registry Standards

• New Terminology Used to Describe Cancer Characteristics
• New and Revised Staging Clarifications
• New ICD-O-3 Codes
• Changes to Behavior of Neoplasm
• New Details for Cancer Staging
• New Site Specific Data Items
• New Molecular/Genetic Tumor Tests without Fields
• Fast-Paced Technology – Not the Same Pace as Cancer Registry
• When you feel like you are placing a square peg in a round hole – you need to document what is in the record and ask for guidance

Coding Pitfalls and Text - Quiz
Questions

Fabulous Prizes
CE Certificate Quiz Survey

• Phrase

• Link

Thank You!

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Steve Peace SPeace@med.miami.edu