Ask April!

Answers to Questions You've Been Wondering About

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Q1. Coding modified radical mastectomy

- **What Surgery of Primary Site code do you use when a simple mastectomy and lymph node removal are done as separate procedures?**
- Example 1
  05/05/11 SLNB: 3 nodes, all negative.
  05/14/11 Simple mastectomy
- Example 2
  03/23/11 Simple mastectomy
  04/05/11 Axillary LN dissection: 2/12 LN positive.

A1. Coding modified radical mastectomy

- Example 1
  05/05/11 SLNB: 3 nodes, all negative.
  05/14/11 Simple mastectomy
- **Code Surg Prim Site 41 and Scope LN 2**

- Example 2
  03/23/11 Simple mastectomy
  04/05/11 Axillary LN dissection: 2/12 LN positive.
- **Code Surg Prim Site 51 and Scope LN 5**

Mastectomy Guidelines

- 40-41 Total (simple) mastectomy
  - removes all breast tissue, the nipple, and areolar complex. No axillary dissection, but sentinel nodes may be removed.
- 50-51 Modified radical mastectomy
  - Removes all breast tissue, the nipple, the areolar complex, and variable amounts of breast skin in continuity with the axilla. The specimen may or may not include a portion of the pectoralis major muscle.
  - If axillary lymph nodes are present in the MRM specimen, code the Surgery of Primary Site field to 51.
  - If there are no axillary lymph nodes present in the MRM specimen, code the Surgery of Primary Site field to 41.

Reminder: Coding Breast Surgeries

- Surg Prim Site is cumulative
  - Code the most extensive/completion surgery
- Code 41 (simple mastectomy) includes LN removal designated as sentinel nodes
- Code 51 (MRM) is for simple mastectomy PLUS axillary *dissection*

Q2a. Cancer Status

- **How do I interpret the following terms when coding Cancer Status?**
  - **"Stable" for heme primaries**
  - **"Stable" for solid tumors**
  - **"No evidence of progression"**
  - **"No evidence of disease" for heme primaries**
- Cancer Status Codes
  - 1 No evidence of this tumor
  - 2 Evidence of this tumor
  - 9 Unknown; indeterminate; not stated

A2a. Cancer Status

- "Stable" for heme primaries
  - Not requiring chemo/tx, not requiring transfusions – not bad enough to treat but not entirely gone (code 2)
- "Stable" for solid tumors
  - Not bad enough to treat but not entirely gone (code 2)
- "No evidence of progression"
  - Still has disease but not actively growing (code 2)
- "No evidence of disease" for heme primaries
  - Think no ^clinical evidence of this tumor (code 1)

Q2b. Post-op cancer status

- **How do you code cancer status when there is no mention of active disease but also no NED statement, and first course surgical treatment indicates all cancer was removed?**

A2b. Post-op cancer status

- Again, think no clinical evidence of tumor.
  - If tumor was completely removed, patient is NED.
  - If no proof of cancer spread (PE and imaging negative), patient is NED.
- Use common sense. Code what you know.
  - If you don't know of disease elsewhere, patient is NED.

Q2c. Post-op cancer status

- **If a patient is undergoing adjuvant treatment, does this mean they have evidence of disease?**
- **Not necessarily.**
  - If patient had surgical removal with no macroscopic tumor left ➔ NED
  - Adjuvant treatment is intended to clean up *possible* tumor cells elsewhere in body; it does not imply residual tumor.
  - If no clinical evidence of disease elsewhere and patient receives adjuvant (post-op) chemo or RT ➔ NED

Q3. Remission

- **Please define "remission" as it relates to various hematopoietic diseases.**
  - **Leukemia**
  - **Lymphoma**
  - **Waldenstrom's macroglobulinemia**
  - **Plasmacytoma**
  - **Other heme diseases**

A3. Remission

These definitions assume patient received some type of treatment

- Leukemia
  - CBC normal
- Lymphoma
  - CT or PET scans: no adenopathy seen
- Waldenstrom's macroglobulinemia
  - CBC normal; no adenopathy on CT or PET
- Plasmacytoma
  - CBC normal; no bone mets; no adenopathy on CT or PET
- Other heme diseases
  - CBC normal

Q4a. "Never disease free"

- Are there any histologies or situations where the patient is always "never disease free"?
- Yes.
  - Untreated solid tumors, leukemias, lymphomas
  - Patients receiving palliative treatment
  - Distant mets at diagnosis (not removed)
  - Systemic disease
  - Unknown primary

Q4b. Stage IV and NED

- Can a patient with Stage IV disease be NED?
- Yes.
  - Example: Stage IV colon cancer treated with hemicolectomy and excision of single liver metastasis
    - One year later, negative CEA and CT scan → NED
  - Example: Parotid gland cancer involving skin (T4a), small positive neck nodes (N1), no distant mets (Stage IVA) treated with parotidectomy, skin grafts, and radical neck dissection.
    - One year later, PE and CT scans neg → NED

Q5a. Type of first recurrence

- Please clarify Type of First Recurrence codes.
- Check MP/H rules first to rule out new primary
- Determine where tumor recurred relative to primary site
- Code first recurrence ONLY.

A5a. Type of First Recurrence

- 00 No recurrence (incl. leuk/lymph in remission)
- 04-06 In situ recurrence
  - 06, 16, 17, 26, 27, 36, 46 ONLY for initial in situ tumors
- 10-15 Local recurrence
- 20-25 Regional recurrence
- 30 Regional and local recurrence
- 40 Distant recurrence, NOS
- 51-59 Specific distant recurrence sites
- 60 Distant and local or regional recurrence
- 62 Multiple distant recurrences
- 70 Never disease free
- 88 Recurrence, NOS (incl. biochemical recur)
- 99 Unknown if recurred or ever disease-free

Q5b. 'Locoregional' Recurrence

- **How do I code 'locoregional' recurrence?**
- Locoregional is MD jargon referring to the surgical area where tumor was excised. In other words, not distant.
  - Example: Breast was removed but tumor cells recurred in scar or chest wall.
    - Same area as primary (local) but in *regional* tissue
  - Example: Nephrectomy for cancer, recurrence in kidney fossa after 2 years.
    - Kidney gone, but tumor cells recurred in fossa (kidney bed) where kidney used to be.

A5b. 'Locoregional' Recurrence

- Local recurrence = tumor return in same organ, anastomosis, or scar tissue where organ previously existed
  - Review MP/H rules!!
- Regional recurrence = tumor return in tissues/structures adjacent to where primary had been
- If recurrence in same organ → 10-15
- If organ no longer exists → 20-25

Q6a. Prostate recurrence

- **When FCOT is observation, how do you code MD statement that patient is NED?**
- Think: is there tumor in the patient?
  - Patient may be asymptomatic and disease has not progressed, but has never been removed. Code as 2, evidence of tumor. Patient is just not requiring treatment at this time.

Q6b. PSA recurrence

- **How do you code recurrence based on a rising PSA (biochemical recurrence)?**
- If patient had prostatectomy and several rises in PSA post-op, code as 88.
  - 01/10 Prostatect; PSA 06/10 0.2, PSA 09/10 0.4. *Recurrence as of 09/10.*
- If no prostatectomy, larger jumps in PSA are needed to say recurrence
  - 01/10 RT seed implants. PSA 06/10 1.2. PSA 09/10 1.6 (still not recurrence) PSA 01/11 3/2. *Recurrence as of 01/11.* Code as 88.

Q7. Long time between FUs

- **What if there is a long time span between the date last seen and the new date. Do you always take the cancer status from the prior date if you have no information?**
  - Example: Date last seen 1/10/1998, NED. Lost to FU. Obituary says patient expired 2/10/2011. No other information.
  - Per FORDS: … cancer status should be changed *only* if new information is received from the patient's MD or other official source.
    - If information is from patient, family member, or other non-MD, cancer status is not updated.

A7. Long time between FUs

- **Yikes!**
- Common sense must prevail here.
  - Which code provides better information for your facility (not COC)?
  - Definition of "assume"
  - Patient may have moved or changed MDs in interval
  - Obituary clues: donation to Cancer Society; "long illness", other wording
  - State or local vital statistics office may be able to provide cause of death
  - *In my opinion*, better to code unknown after long interval.

Q8. Class of Case 00 vs. 10

- **Why do cases that are diagnosed but receive no treatment at our facility have to be coded as Class of Case 10?**
  - Per FORDS 2011
    - Class of Case 00 is reserved for patients who were originally diagnosed by the reporting facility and received all of their treatment elsewhere or a decision not to treat was made elsewhere. If the patient received no treatment, either because the patient refused recommended treatment or a decision was made not to treat, the Class of Case is 14. If there is no information about whether or where the patient was treated, the Class of Case is 10.

A8. Class of Case 00 vs. 10

- Codes
  - 00 Initial diagnosis at the reporting facility AND all treatment or a decision not to treat was done elsewhere
  - 10 Initial diagnosis at the reporting facility or in a staff physician's office AND part or all of first course treatment or a decision not to treat was at the reporting facility, NOS
- Code 00 applies only when it is known the patient went elsewhere for treatment. If that information is not available, code Class of Case 10.

A8. Class of Case 00 vs. 10

- Code 00 requires a "Referred to" code.
  - Analytic, no follow-up required.
- Code 10 is used if you cannot find out where the patient went.
  - Analytic, follow-up required.
  - You're still responsible for the patient
  - Check all sources for a lead on patient
    - Discharge summary, nursing notes, ROI, attending MDs, FU letters; document who you've contacted
- Class of case code can be changed if more information is received.
- Remember: You're as much a part of the patient's continuity of care as the MDs.

Q9. Reason No Treatment

- **Please explain the Reason No [Treatment] codes as they relate to referral and refusal.**
- General code descriptions

  6/86 Tx recommended by not administered*; no reason given

  7/87 Tx recommended but not administered; patient/family refused

  8/88 Tx recommended, unknown if administered

  9/99 Unknown if Tx recommended or administered

  * stated as 'performed' for surgery

A9. Reason No Treatment

- Code 7/87 (refusal)
  - Code only for treatment modalities discussed with patient and refused
    - Example: Patient offered surgery or chemo or RT and selected RT. Code surgery as 1 and chemo as 00. Do not code surgery and chemo as refused.
  - Includes 'blanket' refusal
    - Refused all recommended treatment
    - Refused all treatment before any discussion
  - Date of refusal must be entered into appropriate related field

A9. Reason No Treatment

- Code 8/88 (recommended, unknown if given)
  - Code only for treatment modalities discussed with patient and recommended
    - Example: Patient offered surgery or chemo or RT and referred for chemo. Code surgery as 1, RT as 1, and chemo as 88 until further information obtained. Do not code surgery and RT as refused.
  - Includes referral to specialist (rad onc, med onc)
    - Requires follow-up with specialist to confirm treatment started.
    - If no treatment with specialist, change code to 1.
  - Change code if better information obtained.

A9. Reason No Treatment

- Comments
  - Should contact MD office(s) for outpatient/office/home treatments
  - Emphasizes completion of multi-modality treatment information
  - Good QC tool (8/88)
  - Good QI tool (7/87)

Q10. Invasive ductal carcinoma, sclerosing type

- **What Rule and Histology code should we use for this diagnosis?**
- Breast case: single tumor with the final diagnosis 'Invasive ductal carcinoma, sclerosing type.'

A10. Invasive ductal carcinoma, sclerosing type

- Code as 8500/3, Infiltrating duct carcinoma, NOS.
- 'Sclerosing type' is not a duct carcinoma subtype recognized in the WHO Classification of breast tumors.
- None of the present breast histology coding rules applies.
- In ICD-O-3, when a subtype does not have a unique histology code, revert to the main term and code as Not Otherwise Specified.

Meaning of "NOS" in ICD-O-3

- Not otherwise specified
- Not elsewhere classified
- Term used in a general sense
  - When there are more specific codes
  - To encompass an organ as a whole

Q11. Renal Cell Carcinoma

- **Renal cell carcinoma mixed cell type (8255)** I am finding an overuse of code 8255 in some sites.
- **Please review Renal cell carcinoma histology coding rules**
- How to code this example: Cystic renal cell carcinoma, clear cell type.

A11. Renal Cell Carcinoma

- Code as 8310/3 Clear cell carcinoma.
- Terminology structure
  - Renal cell carcinoma, [something type] is a single histology
  - Cystic is often an adjective describing gross appearance
    - Not related to rare cyst-associated renal cell carcinoma

A11. Renal Cell CA Subtypes

	ICD-O-3 Code
Renal cell carcinoma, NOS (5%)	8312
▪ Papillary (chromophil) (11%)	8260
▪ Clear cell* (83%)	8310
▪ Cyst-associated (cystic) (<1%)	8316
▪ Chromophobe (4%)	8317
▪ Sarcomatoid (spindle cell) (1%)	8318
▪ Collecting duct (Bellini duct) (<1%)	8319
▪ Granular cell	8320
▪ Medullary (rare)	8510
▪ Malignant cystic nephroma	8959

* Also archaic terms hypernephroma, Grawitz tumor and granular cell carcinoma

Code the specific type if only one is mentioned.

A11. Renal Cell CA Subtypes: Adenocarcinoma with Mixed Subtypes

- Kidney H6. Use code 8255 when there is a single tumor containing more than one specific renal cell carcinoma type.
  - *Example:* Renal cell carcinoma, spindle cell and chromophobe types: *use code 8255*

Reminder: Single Histology vs. Combination Code

- Indicators of Single Histology
  - [Something], something type
  - Also subtype, predominantly, with features of, major, or with differentiation
- Indicators of possible combination histology code
  - Usually say “mixed” or “combined” or [something] “and” [something] or hyphenated terms
  - Unique codes for common combinations
    - Ductal carcinoma and lobular carcinoma 8522/3
  - Compound terms
    - Carcinosarcoma 8980/3

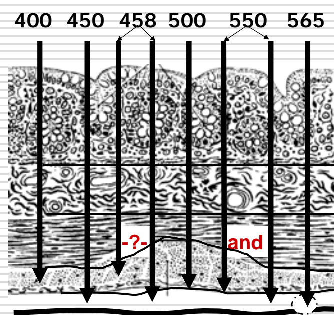
Q12. Colon Extension Codes

- **Please review colon extension codes 400 to 565.**

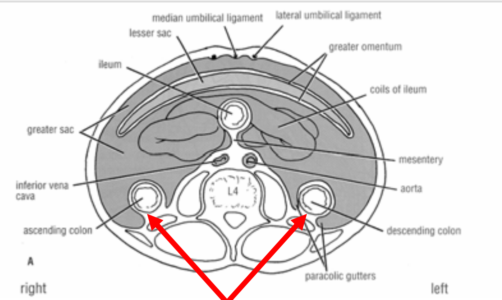
1. [Lumen—inside]
2. Mucosa
   - Surface epithelium
   - Lamina propria (basement membrane)
   - Muscularis mucosae
3. Submucosa
4. Muscularis propria
   - Circular layer
   - Longitudinal layer
5. Subserosa (subserosal fat)
6. Serosa (visceral peritoneum, mesothelium)
7. [Retroperitoneal fat (pericolic fat)]

A12. CS Extension Codes

400 Transmural, NOS; invasion through muscularis into (sub)serosal tissue/ fat; non-peritonealized pericolic tissues (T3)
450 Pericolic fat extension to adj connect tiss (T3)
458 Fat, NOS (T3)
500 Serosa (T4a); Invasion of/through visceral peritoneum
550 Both serosa and adjacent connect tissue (T4a)
565 Adherent to other structures clinically, no micro exam, or micro tumor in adhesions (T4b)



Visceral peritoneum (serosa)



Source: *Clinical Anatomy for Medical Students, 5th Edition,* Richard S. Snell. Little, Brown and Company, 1995.

When to Use NOS Codes 300, 400, 458, 565

300 Localized, NOS
- Within wall, but level of invasion unknown (T1)

400 Extension through wall, NOS
- Might be in subserosa, might be in perimuscular tissue (T3)

458 Fat, NOS
- Can't tell whether involved fat is within colon/rectal wall (subserosal) or beyond full thickness of wall (pericolic) (T3)

565 Adjacent to other organs/structures, NOS
- Stated as adherent, but true involvement of adjacent structure not assessed (no micro exam) (T4b)

Q13. GYN Regional Nodes

- **For GYN sites are retroperitoneal lymph nodes considered regional or distant nodes?**

Q13. GYN Regional Nodes

- The answer varies by primary site.

Primary site	Regional	Distant
Vulva		✓
Vagina		✓
Cervix		✓
Corpus		✓
Ovary	✓	
Primary peritoneal carcinoma	✓	
Fallopian tube	✓	
GTT (Placenta)		✓

Q14. When will this all stop??

- COC Standards
  - New standards coming in 2012
- CS v0204
  - Minor changes—corrections only
- Solid tumor MP/H
  - Revisions for 2012
- TNM8
  - Not for several years
- ICD-O-4
  - 2014 at the *earliest*

Old Indian Saying for Registrars

- Be strong like oak and flexible like willow

Any more questions?