Common Coding Errors

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Breast
Assigning Primary Site
- Refer to SEER Appendix C Coding Guidelines
- Priority Order
  1. Pathology Report
  2. Operative Report
  3. Physical Exam
  4. Mammogram/Ultrasound

Breast
Assigning Primary Site
- Code subsite of invasive tumor if invasive and in situ present in different quadrants of same breast.
- Code specific subsite if multifocal tumors present all within one quadrant.
- Code C509 when multiple tumors in at least 2 quadrants of same breast.
- Code C508 for 12, 3, 6, or 9:00 positions OR if single tumor in 2 or more subsites and unknown from which subsite tumor originated.
- Double-check laterality, support with text.
Breast

- Documentation of Physical Exam
  - Important for identifying:
    1. Primary Site and Laterality
    2. Skin Involvement - very important if dx is inflammatory
    3. Lymph Node Involvement - movable (assume if not mentioned) vs fixed/matted

- Tumor Size
  - Code size of invasive component when in situ and invasive are present even if invasive is only micoinvasive
  - Micoinvasive size = 990
  - If neoadjuvant treatment given code clinical size prior to treatment. For CS, only code post neoadjuvant pathologic size in this scenario if larger size after neoadjuvant treatment increases the T category.
  - If tumor size is clinical or unknown then CS SSF 6 = 987 (clinical size)

- Nottingham Score
  - Score takes priority over grade
  - Often found in CAP portion of path
  - Total of scores for tubule formation + mitotic rate + nuclear pleomorphism = Nottingham score
  - Do not interpret grade as Nottingham grade unless specifically stated as Nottingham grade
  - Nottingham score applies to invasive tumors only, if in situ only code CS SSF 7 = 999
Breast

- **Sentinel Lymph Node Biopsy**
  - Op note takes priority for determining whether this procedure was done.
  - Document in operative text to support whether or not done.
  - Code as done if sentinel procedure attempted, but mapping failed.
  - Use correct coding structure to include sentinel lymph node procedure as appropriate.
  - 2=bx only, 6=bx + simultaneous ax. dis, 7=bx + separate ax dis.
  - Do not code as sentinel node bx and axillary dissection (6) if additional incidental non sentinel nodes found during sentinel node procedure. Refer to the op report to identify the actual procedure.

Breast

- **Staging**
  - Be aware of difference between CS, Summary Stage, & AJCC Staging.
  - CS extent 300, extent to pectoralis muscle, is regional, code 2, in Summary Stage, but is not considered chest wall involvement in AJCC (p.352).
  - Inflammatory cancer is more defined in AJCC-U3 or more of breast.
  - Inflammatory without nodal involvement is regional, code 2 for Summary Stage.
  - Supraclavicular nodes are distant for Summary Stage, but regional for CS and AJCC ( ipsilateral).
  - Contiguous extent to skin over, axilla, contralateral breast, sternum, & upper abdomen is distant for Summary Stage.

Breast

- **Surgery**
  - Code procedure documented on Op report. Don’t take from path report if op report available.
  - Nipple sparing/skin sparing mastectomy=code 30. Reconstruction inferred in the code.
  - Tissue expanders are not considered as implant reconstruction, code this as reconstruction, not implant reconstruction planned.
  - Both breasts involved: do not use code that includes removal of uninvolved contralateral breast. Each breast will be abstracted separately unless contralateral breast is involved in each breast. Code removal of involved contralateral breast in Surgery Other Site.
  - Remember to code lymph node bx in surgery date field and scope of regional nodes if done prior to any other surgical procedure.
  - Include hormonal suppression surgery: code 30 in Hemo/Endo systemic field if stated as first course treatment regardless of timing. If no documented treatment plan found include as first course treatment if within 1 year of breast dx diagnosis or progression.
**Breast**

- **MPH Rules**
  - Be sure to use correct module. Multiple Primaries vs Histology, Single vs Multiple, Invasive vs In situ, etc.
  - M5: Timing: Tumors > 5 years apart=multiple primaries
  - M6: Inflammatory in one OR both breasts=single primary
  - M7: Tumor in each breast=multiple primaries
  - M8: Invasive tumor > 60 days after in situ tumor=multiple primaries
  - M9: Histology code different at 1st, 2nd, or 3rd number=multiple primaries
  - H3: Intraductal + specific type intraductal=specific type
  - H4: Comedo dcis + any other dcis=comedo dcis, 8501/2
  - H9: Invasive + noninvasive histology=code invasive histology
  - H13: Only code inflammatory, 8530, if stated specifically in pathology report. This is normally a clinical diagnosis only.
  - H24-26: Paget disease is considered invasive unless specifically stated as in situ.

**Prostate**

- **PSA**
  - Document with date and range (H, L, or WNL) highest PSA within 3 months prior to bx. If all PSA’s > 3 months, capture most recent.
  - Code in tenths of ng/ml. Round PSA if nanograms are expressed in hundredths. Example: PSA 1.90 ng/ml, SSF 1 coded as 019.
  - Avoid Confusion! Look only at the number in the place you are rounding to. For prostate, this will be tenths of nanograms. Look at the number following; if 5 or greater, round up. If 4 or less, leave number in tenths alone!
  - Exception: If the PSA result is between 0 and 0.1 ng/ml, round up and code as 001. Example PSA 0.08=code 001 (follows normal rounding rule), ALSO PSA 0.03=code 001 (per exception to normal rounding rule).

**Examples:**

- 8.75 ng/ml coded in SSF 1 as 088
- 8.74 ng/ml coded in SSF 1 as 087
- .98 ng/ml coded in SSF 1 as 009
- .92 ng/ml coded in SSF 1 as 009
Prostate

Grade

- If dx equal or less than 2013:
  - Gleason 5 & 6 = grade 2
  - Gleason 7 = grade 3 (grade 2 prior to 2003)
- 2014 dx going forward:
  - Gleason 5 & 6 = grade 1
  - Gleason 7 = grade 2

Prostate Staging

Questions from a day with Donna Gress

- If there is documentation of a physician assigned stage group, but criteria not met for pN (no nodes resected at prostatectomy) should pNX or cN0 be assigned?
  - Donna Gress: pNX. Pathologic criteria met with prostatectomy for pT, but you can’t assign a stage group with pNX. Physicians assign stage groups for treatment planning purposes.

- If there is mention of elevated PSA and it appears to be done due to elevated PSA (elevated PSA on clinical part of path rpt), is this sufficient for coding clinical T1c?
  - Donna Gress: No. cT1-cT4 could still have an elevated PSA. There is no way to know. Documentation of DRE needed whenever possible.

- Takeaway: T1c cannot be assigned without evidence of a negative DRE.

Prostate

More from Donna:

- For prostate, can bx findings supplement surgical path findings? For example, bx indicates bilateral involvement. Surgical path only states no extra-prostatic extension, apical margin focally positive. No statement regarding unilateral or bilateral involvement.
  - Donna Gress: Clinical information may be used with pathologic information to derive pathologic stage. Bx findings cannot be used for clinical staging. Clinical staging is based on DRE findings and physician opinion. If no nodule is felt on DRE, прогноз is not affected. If physician can feel a nodule, the prognosis is worse.
Prostate

- **Staging**
  - Prostatectomy required for pathologic staging
  - For CS, only code clinical extent in CS extent field. Pathologic extent coded in SF 3.
  - If prostatectomy done CS Tumor Size/Extent/Eval code=4
  - Notice differences between localized and regional for Summary Stage.
  - Localized is confined to prostate, regional is beyond the prostate capsule.
  - Any regional nodal involvement=Stage IV for AJCC
  - In CS, Summary Stage & AJCC: internal & external iliac nodes, & lacc nodes, nos are regional. In Summary Stage Common lacc nodes are distant.

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Prostate

- **Treatment**
  - Surgery Code Challenges
    - Niagara Laser Photovaporization=code 15
    - Transurethral Microwave Thermotherapy (TUMT)=code 16
    - High Intensity Focused Ultrasound (HIFU) &/or Transurethral Needle Ablation (TUNA)=17
    - For TURP, differentiate whether cancer incidental finding (code 22) or known/suspected (code 23)

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Prostate

- **Radiation Code Challenges**
  - If both EBRT and brachytherapy administered, code EBRT as regional and brachytherapy as boost regardless of which is first. By definition of boost, brachytherapy is treatment to the smaller reduced size field. 2016 FORDS p. 271.
  - For prostate brachytherapy choose interstitial codes depending on LDR (53) or HDR (54)
  - LDR= single procedure where seed implant remains for a lifetime
  - HDR= multiple procedures where high doses of radiation administered.
Lung

Assigning Primary Site
- Very few site specific coding guidelines for lung
- Laterality must be coded for all subsites except carina.
- Code the last digit of the primary site code to ‘8’ when a single tumor overlaps an adjacent subsite(s) of an organ and the point of origin cannot be determined.
- Code the site of the invasive tumor when there is an invasive tumor and in situ tumor in different subsites of the same anatomic site.
- Code the last digit of the primary site code to ‘9’ for single primaries when multiple tumors arise in different subsites of the same anatomic site and the point of origin cannot be determined.

Infrahilar Lung = C349
- No documentation of priority order, generally observations from surgery or endoscopy are best.
- When the medical record does not contain enough information to assign a primary site:
  a) Consult a physician advisor to assign the site code.
  b) Use the NOS category for the organ system or the Ill-Defined Sites (C760-C768) if the physician advisor cannot identify a primary site.
  c) Code Unknown Primary Site (C809) if there is not enough information to assign an NOS or Ill-Defined Site category.

Staging
- Question from a day with Donna Gress
  For lung, if imaging documents hilar or mediastinal lymphadenopathy and there is no physician’s note, is staging escalate we consider these lymph nodes involved for clinical staging?
  Donna: Gress-NEVER! Registrars need to be aware the staging rules for CS & Summary Stage are different from AJCC staging for this scenario.
- T2 Subclassification: T2a = >3 cm or <5 cm, OR <3 cm with involvement of MSB 2 cm or more, or T2b = 5 cm or more with involvement of MSB 2 cm or more with involvement of MSB 2 cm or more, or T2c = >5 cm with involvement of MSB >2 cm with involvement of MSB >2 cm with involvement of MSB >2 cm or more, or T2d = >5 cm with involvement of MSB >2 cm with involvement of MSB >2 cm or more, or T2e = >5 cm with involvement of MSB >2 cm with involvement of MSB >2 cm or more.
- For Summary Stage, tumor confined to MSB = localized (1).
- Atelectasis + pleural (2)
- Remember to consider atelectasis in CS staging, often gets overlooked.
**Lung**

**Staging**
- T2 Subcategories:
  - T2b= tumor > 5 cm and < 7 cm
  - T3- > 7 cm or directly invades parietal pleura, chestwall (including superior sulcus tumor), diaphragm, phrenic nerve, mediastinal pleura, parietal pericardium; OR tumor in MIB > 2 cm from carina, but without involvement of the carina; OR obstructive pneumonitis of the entire lung; OR separate tumor nodules in the same lobe.
  - For Summary Stage tumor in MIB < 2 cm from carina=regional (2)
- T4- Tumor of any size extending to mediastinum, heart, great vessels, trachea, recurrent laryngeal nerve, esophagus, vertebral body, carina; OR tumor in MSB < 2 cm from carina, but without involvement of the carina; OR separate tumor nodules in a different lobe of ipsilateral lung.

**Lymph Nodes**
- See p. 263 AJCC 7th Edition Manual for diagram of lymph node stations
- Remember to code lymph node bx as a surgical procedure.
- In Summary Stage, contralateral/hilar & mediastinal nodes, scalene nodes, and supraclavicular nodes are distant (7). Regional for AJCC & CS.
- Continuous extent to many structures in Summary Stage are distant (7). Use your manual!
- M category has a and b subcategories. M1a-intrathoracic mets-pleural/pericardial effusion, nodules in contralateral lung, etc. M1b-extrathoracic mets.

**MPH Rules**
- **Equivalent Terms**
  - Low grade neuroendocrine carcinoma, carcinoid
  - Tumor, mass, lesion, neoplasm (MPH coding rules only)
  - Bilateral: This phrase means that there is at least one malignancy in the right lung and at least one malignancy in the left lung. Do not base multiple primary diagnosis on this phrase. Bilateral does not mean this is a single primary. Use the multiple primary rules to decide whether to code bilateral lung cancer as a single or multiple primary.
  - M6- A single tumor in each lung is multiple primaries unless stated or proven to be metastatic. Per SEER, once a case is determined to be reportable, apply the MPH rules; the first tumor has to be reportable by positive histology or reportable term.
  - If you have a patient with bilateral lung cancer and it remains unclear if the second tumor is metastatic or not, submit the case to the SEER Office for confirmation. If the scenario fits the criteria of M6, the case is reportable. A physician statement alone is not sufficient proof. Look for additional information that supports the physician statement. The additional information could come from pathology or imaging, for example.
Lung

- **MPH Rules**
  - M8: Tumors diagnosed more than 3 years apart = multiple primaries
  - M9: Invasive > 60 days after in situ = multiple primaries
  - M11: Histology codes different @ 1st, 2nd, or 3rd number = multiple primaries
  - M12: Single Primary if criteria not met for any previous M rules.

- **Examples of M12**
  1. Solitary tumor in 1 lung, multiple tumors in contralateral lung
  2. Diffuse bilateral nodules: Only condition when both > 4 cm
  3. In situ & invasive within 60 days
  4. Multiple tumors in 1 lung metastatic from the other
  5. Multiple tumors in Lung
  6. Multiple tumors in both lungs

Lung

- **Treatment**
  - Many new drugs in development
  - Use SEER Rx to determine class
    - [https://seer.cancer.gov/seertools/seerrx/](https://seer.cancer.gov/seertools/seerrx/)
  - If not found in SEER Rx, Google!
  - If not found in SEER Rx, let GCCS know to notify SEER.

Colon

- **Assigning Primary Site**
  - Priority order in SEER Appendix C, Coding Guidelines
  - Do not always rely on statement of tumor site on path report.
  - Revised Criteria:
    1. Operative report with surgeon’s description
    2. Pathology report
    3. Imaging
Colon

Assigning Primary Site

Polypectomy or excision without resection
1. Endoscopy Report
2. Pathology Report

Colon

Behavior

In situ and intraepithelial are synonymous and coded with behavior 2
Invasion of lamina propria maps to Tis as it has the same prognosis as an in situ cancer, but behavior is still 3.

Newly Reportable

Remember carcinoid tumor of appendix reportable as of 1/1/15!

Colon

Circumferential Margin

CS SSF 6 Circumferential Margin = Radial & Mesenteric Margins
Most frequently miscoded data item
Cases dx 12/1/18 will no longer collect CS, but SSF 6 will be preserved as a Site Specific Data Item (SSDI)
Currently coded in tenths of millimeters
New coding in dx year 2018 cases will allow less room for error with fields accommodating decimal placement.
Colon

Circumferential Margin

- Do not code CRM neg based on statement in path of margins negative, nos.
- CS Note 6: Use code 909 (CRM not mentioned) if the pathology report describes only distal and proximal margins, or margins, NOS. Only specific statements about the CRM are collected in this data item.
- Code 995 ONLY if CRM specifically stated as negative and no distance is indicated.
- Code 903 if CRM positive
- Code 990 if no residual disease in specimen (as in the case of no residual disease after a colonoscopy/polypectomy identifying CA or after neoadjuvant tx)
- Code 998 for polypectomy: this code only applies if primary site resected
- Look for CRM in CAP portion of path report, often found there.

Examples

- CRM negative by 9 mm: code 090
- Mesenteric margin neg by 2 cm: code 200
- Margins from resected sigmoid colon neg: code 999, no statement specific to CRM
- Polypectomy margins neg: code 999, no reaction of primary site
- CRM neg by < 1 mm: code 000, described as < 1 mm
- CRM neg by 0.5 mm: code 000, described as < 1 mm
- Radial margin neg by 4 cm: code 400
- Sigmoidectomy s/p neoadji chemo neg for residual disease: code 990, no residual tumor on specimen

Colon

Staging

- Colonoscopy cannot assess depth of invasion or regional lymph node involvement.
- If colonoscopy only staging procedure, Clinical staging should be TXNXM0.
- Colonoscopy unable to assess lymph node involvement.
- Clinical staging criteria met with colonoscopy: If T is a valid value or X, then N has to be a valid value or X (not blank).
- Contiguous extent to structures beyond the visceral peritoneum is T4 for AJCC. There are several structures in Summary Stage for this scenario that are considered distant; bladder, adrenal gland, ovary, to name a few. Use your manual!
Colon

- MPH Rules
  - Mucinous & Signet Ring Cell Adenocarcinoma. C180-189 only.
  - Refer to MPH Rules H5-7 for single tumors with any combination of these histologies
  - H5- histology specifically stated as mucinous code 8480, if specifically stated as signet ring cell code 8490.
  - If histology stated as adenocarcinoma with mucinous features, has to be ≥50% mucin to be coded 8480; otherwise code 8440.
  - If histology stated as adenocarcinoma with signet ring cell features, has to be ≥50% signet ring cell to be coded 8490; otherwise code 8440.

- MPH Rules
  - H6- If adenocarcinoma, mucinous or signet ring features, <50% or adenocarcinoma with mucinous or signet ring cell features, % not stated or unknown, code 8140.
  - H7- If final dx is combination of mucinous and signet ring cell adenocarcinoma, code combination code 8255, no % instructions for this scenario.

- Be careful not to overlook polyp findings found in initial bx.
- If polyp histology in bx, but not surgery, still apply polyp code if all from same tumor.
- Refer to ALL scenarios in MPH H4

Colon

- MPH Rules
  - Colon and MPH H4
  - Code 8210 (adenocarcinoma in adenomatous polyp), 8261 (adenocarcinoma in villous adenoma), or 8263 (adenocarcinoma in tubulovillous adenoma) when:
    - The final diagnosis is adenocarcinoma in a polyp
    - There is documentation that the patient had a polypectomy.
    - If polyp histology in bx, but not surgery, still apply polyp code if all from same tumor.
    - Note 1: It is important to know that the adenocarcinoma originated in a polyp.
    - Note 2: Code adenocarcinoma in a polyp only when the malignancy is in the residual polyp (adenoma) or is referred to as a pre-existing polyp or to a pre-existing polyp (adenoma) when the malignancy and the polyp (adenoma) are the same lesion.
Colon

- **MPH Rules**
  - Be sure to use correct module for colon vs rectum/rectosigmoid.
  - Colon M4: Topography—tumors in different segments of colon=multiple primaries. M11 Other Sites Module for rectum/rectosigmoid. This scenario applies to recurrence at anatomic site, new primary site=ICD-10 per SEER (Carol Johnson and Lois Dickey) and NAACCR (Jim Hofferkamp).
  - Colon M5: Tumors diagnosed >3 year apart=multiple primaries. M10 Other Sites Module for rectum/rectosigmoid.
  - Colon M10: Histologies differ @ 1st, 2nd, or 3rd number=multiple primaries. M17 Other Sites Module for rectum/rectosigmoid.

- **Treatment**
  - Polypectomy
  - Only code as surgery IF Op report describes removal of the polyp AND Pathology report describes the status of the margins as free and macroscopically negative. Can be microscopically positive.
  - If margins unknown macro or micro, confirm with pathologist (per Canswer Forum).

- **General Issues**
  - Address at Diagnosis
    - Be sure to update if your research shows patient living out of state at diagnosis!
    - If not corrected can lead to over-counting incident rates across the nation.
  - Class of Case: Post class of case codes at your workstation and take care to code properly, especially analytic versus analytic. This has a direct bearing on how abstracts are processed at the Central Registry.
  - Race: Clarify if race on facesheet is different from race dictated by physician. If race on facesheet is ambiguous or unknown, look for a description from physician's dictation. Document text support for race and marital status.
  - Insurance: Provide text support for type of insurance.
  - Ambiguous Terms—Refer to list in SEER & FORDS and stick to them for reportability only. There are some differing terms for applying MPH rules.
**General Issues**

- **Staging**
  - If there is a discrepancy between documentation in the medical record and the physician's assignment of T, N, or M, the documentation takes precedence. 2016 SEER Section V, Stage @ Dx
  - When there is doubt that the documentation in the medical record is complete and the physician's assignment of the T, N, or M category differs from the stage assignment that the medical record supports, it is the registrar's responsibility to determine the correct T, N, or M category. The registrar is to use all the information available, including review of the treatment plans according to NCCN, ASCO guidelines or the ACR appropriateness.
  - Provide text support for staged by codes. It's important to know who is staging the case!

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**General Issues**

- **Staging - X vs Blank**
  - Blank = Criteria not met for T, N, or M, no documentation in record, no surgery done, patient not eligible for clinical or pathologic staging.
  - X = Criteria met, but unknown.
  - Case meets criteria for pathologic T, but no nodes resected = NX
  - If T is a valid value, then N must = a valid value or X.
  - Category MX has been eliminated. Unless there is clinical or pathologic evidence of distant mets, classify as cM0.

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**General Issues**

- **Criteria for Pathologic Staging**
  - Primary tumor/site resected with or without regional nodes
  - If no nodes examined, pNx (exception - in situ = N0)
  - Diagnostic biopsies of BOTH highest T & highest N
  - All or Nothing - can't have pN without pT
  - Pathologic evidence of M1 disease without resection of primary tumor/site pT & pN blank, but pT & pN stage group can still be assigned.
  - Site specific rules have priority over general rules
  - TURBT considered clinical staging procedure
  - Prostatectomy/Cystectomy required to path stage for prostate & bladder.
General Issues

Staging Example
- Imaging shows large right upper lobe mass of lung extending to the mediastinum with mediastinal lymphadenopathy consistent with regional lymph node mets. Scattered liver lesions concerning for liver mets.
- Liver biopsy positive for metastatic lung cancer
- What is clinical and pathologic stage?
- Clinical T4-extent to mediastinum, N2-mediastinal nodes, pM1b-positive liver biopsy, Stage 4. pM1b captured in clinical stage as it was part of clinical workup.
- Pathologic T3N2bM1b, Stage 4. Remember, a case meets criteria for pathologic stage if positive bx of metastatic site.

General Issues

Treatment
- Remember to code lymph node bx’s in date of first surgical procedure and scope of regional lymph nodes if done prior to any other treatment or if only surgical procedure done.
- Code all treatment in RxSumm fields
- Rx Hosp fields coded with 0’s if treatment not given at your facility. It is correct to code the systemic and radiation dates on the Rx Hosp page, but the actual systemic and radiation fields should be coded 0 for your facility if given elsewhere.
- Code 0’s if treatment not given at your facility rather than 9’s. Coding 9’s will generate inter-record errors if class of case is coded as non-analytic.

Questions?

Thank You!