In the Abstract

December 2017

KCR Annual Fall Conference 2017

The 31st Annual Advanced Cancer Registrars' Workshop was held September 21-22nd at the Griffin Gate Marriott in Lexington, KY. The 2017 Workshop, titled "Staging Cancer Cases: One Piece at a Time", placed emphasis on improving registrars' TNM staging skills and provided a forum for discussing questions relating to this sometimes confusing topic. Nicole Catlett, KCR Regional Coordinator, gave four interactive presentations on TNM Staging by asking the audience to "code along" and provide answers to case scenarios during her talks on lung, colon, kidney and breast. Dr. Tim Mullett, a University of Kentucky physician and Kentucky's Commission on Cancer (CoC) State Chair, spoke about using National Cancer Database (NCDB) data for cancer program improvement and offered tips to help cancer programs avoid some common pitfalls in the CoC accreditation process. Dr. Jessica Moss, a medical oncologist with KentuckyOne Health Lexington, presented an "Update in Management and Treatment of Breast Cancer" describing advances in genetic testing as well as neoadjuvant and adjuvant therapy options. Dr. Jonathan Feddock from the Department of Radiation Medicine at the University of Kentucky described some of the recent advances in the treatment of breast and gynecologic cancers, and how those advances are being used to provide cutting-edge radiation therapy for patients at the Markey Cancer Center. Dr. Eric Durbin and the KCR Informatics group made their annual appearance to provide information and updates about past, current and future IT projects. Other presentations provided information on the emerging fields of molecular tumor boards and narrative medicine.

Stacy Littlepage from Baptist Health Madisonville was the recipient of this year's Judith Ann Cook Award. Congratulations, Stacy!

Special thanks to the Markey Cancer Center Affiliate Network (MCCAN) for providing lunch, fantastic surprise-filled lunch bags, and other prizes for this years' workshop attendees! Also, thanks to Tonya Brandenburg and Marynell Jenkins for organizing another amazing workshop!

KCR 2018 Spring Training Details

In 2018, KCR will offer three in-person Spring Training sessions. As each of the trainings will cover the same material, registrars will only need to attend one of the three sessions. The locations and dates of the trainings will be announced at a later time.

Calendar of Events

December 25, 2017 - Jan 1, 2018 – KCR offices closed – Christmas Holiday
January 15, 2018 KCR offices closed – Martin Luther King Jr Holiday
January 31, 2018 Deadline for NCRA CTR exam
February 11, 2018-March 1, 2018 NCRA CTR exam window

People News

New Hires:
Rachel Maynard, KCR VTR Project Manager
Carolyn Hennessey, St. Elizabeth Healthcare
Kelly Parker, St. Elizabeth Healthcare
Sammantha Bonacci, St. Elizabeth Healthcare
Courtney Sanphasiri, University of Louisville

Resignations:
Rachel Maynard, Frankfort Regional Medical Center
Lee Ann Jordan, KentuckyOne Lexington
Cassie Geiger, St. Elizabeth Healthcare
Virgie Bezold, St. Elizabeth Healthcare

Position Change:
Marilyn Wooten, KCR Treatment Auditor
Stephanie Carmack, KCR Epath Coordinator
Tonya Brandenburg, KCR QA Manager for Casefinding

New CTRs:
Y-Vonnie Foster, Ephraim McDowell Regional Medical Center
Ellen Pardue, The Medical Center of Bowling Green
Ellen Lycan, KCR Pediatric Project Coordinator
Chriselle Pereira, TriStar Greenview Regional Hospital

In Memoriam
Agnes Caudill
April Fritz
Kendra Garvin
Sam Underwood

ACoS Approved Programs

Congratulations to the following on their recent CoC survey:

- Ephraim McDowell Regional Medical Center for passing their first CoC survey with five commendation standards
- Baptist Health Lagrange for passing their first CoC survey
- Flaget Memorial Hospital received full accreditation for three years with Gold Level Commendation
- Georgetown Community Hospital received full accreditation for three years
- Clark County Regional Medical Center received full accreditation for three years with commendation

Coding Hints/Reminders

MARGINS

When coding margins – per FORDS the source document is the PATH report. If the margins are not mentioned on the path report you should code to 9 unknown. Examples: Bladder TURBT, Prostate TURP, Endometrium (hysterectomy), Brain surgical resections.

If the path report states margins are not evaluable or cannot be determined, then you can use code 7.

The data items 'surgical margins' and 'disease free status' are coded independently. Example: Bladder TURBT, path doesn't mention margins, code 9. OP report summary states: all tumor was removed. No residual tumor seen, code disease free based on this statement from MD.

AJCC clinical staging

Thyroid: Must have positive confirmation of cancer on BX/FNA to be eligible for clinical staging. If BX/FNA is non-diagnostic, then your clinical staging will be all blank, group 99.

Melanoma: Per the AJCC site chapter, your clinical staging will include ALL info from complete excision of the melanoma (biopsies and re-excisions/wide excisions). So this means the majority of your melanoma cases will have the same c/p T classification. If LNs are not removed for in-situ or stage IA tumors, then you will bring down the cN0, BUT if the stage is IB or higher you will enter pNx.

Remember cancer must be suspected for clinical staging to apply. Incidental findings will NOT have clinical staging. Example: Appendectomy w/ incidental cancer found.

If a metastatic site is biopsied or confirmed histologically during the workup of the cancer, then your cM will be a pM and cStage IV will be pStage IV, because you have met the criteria for pathologic staging.

Coding Hints/Reminders (continued)

SSFs

For colorectal cases that only have a polypectomy and NO colon resection (for example, hemicolectomy), SSF4 Tumor Deposits and SSF6 CRM will be coded 998 - no surgery of primary site.

For in situ breast cases, SSF7 Bloom-Richardson Score/Grade will be coded 999 as BRS/BRG is for invasive cancers.

Use of 998 for lab tests when it is unknown if they were done or not. Only code 'test not done' when it is KNOWN that test WAS NOT performed.

Melanoma Surgery Coding

Assigning surgery codes for melanoma cases is difficult. Here are some tips to help clarify surgery coding for registrars.

1. Always obtain all pathology reports from all sources and operative or office notes, as this documentation will help in your decision-making process.
2. Try to determine the intent of the procedure performed. Often, shave, punch or excisional biopsies will be done prior to the patient presenting to your facility. If the shave, punch or excision was done with the intent to remove the lesion, then the procedure should be coded as a definitive surgery. If a biopsy is done simply to establish a diagnosis and does not remove the entire lesion, then code the procedure as a non-definitive therapy.
3. Document everything in text. Text documentation will help support your choice of surgery coding and give insight into your thought process when you were coding the procedure.

Examples:

A. Physical Exam shows a 1.5 cm black mole w/ crusted biopsy site at the edge from a recent punch. No lymphadenopathy is appreciated on exam. Patient presents to your facility for a wide local excision. The punch biopsy in this scenario is a non-definitive procedure because the intent was to establish a diagnosis and not to remove the entire mole/lesion.

B. Physical Exam shows a healing biopsy site but no visible lesion and the pathology report shows no residual melanoma then the procedure should be coded as a definitive surgery.

When deciding if a re-excision/wide excision should be coded in the 45 (wide exc) range you must KNOW that the margins are ALL greater than 1 cm. If the path report doesn't state distance from melanoma, you should review the gross description looking at the specimen size. If no residual cancer was identified in this specimen and the report states: specimen size 1.9 x 2.2 cm to a depth of 0.8 cm, you should NOT code to wide excision as the depth was not > 1cm.

Most of the time you will code 27 excisional bx (shave/punch/exc) coded as your first surgical procedure in CPDMS. Then, (based on above instructions for margins) you will either have:

a 31-35 (shave/punch BX followed by gross excision) because the margins are NOT > 1cm, even though the OP report states wide excision.

OR

a 45-47 (wide excision w/ margins > 1 cm, etc.) because the margins ARE > 1cm.

Coding Hints/Reminders (continued)

Lymphvascular Invasion (LVI)

Code 0 for in-situ/non-invasive, they biologically have no access to lymphatic or vascular channels below the basement membrane.

Code 8 for Lymphoma/Leukemia

THYROID HISTOLOGY CODING EXAMPLES

Encapsulated Thyroid carcinomas: You will review the CAP and if tumor stated to be encapsulated you will code:
*Encapsulated Papillary Carcinoma of the thyroid will be coded to 8343.
*Encapsulated Follicular Carcinoma of the thyroid will be coded 8335.
*There is no encapsulated code for Mixed follicular/papillary carcinoma of the thyroid; this will be coded to 8340 per MPH rules.

*Do NOT code partially encapsulated to the encapsulated codes above.

Papillary Thyroid Carcinoma will be coded to 8260 per MPH rules/manual

Papillary Microcarcinoma will be coded to 8260 per SEER SINQ 2011-0027

*Make a note in your ICD-O-3 that you should NOT use 8341 Papillary Microcarcinoma for Thyroid cases.

Coding Hints/Reminders (continued)

TEXT DOCUMENTATION

Remember to include any outside pathology that is used for coding or staging your case. If data items cannot be verified, you will have an error on KCR QA for not backing up your codes. It is a good idea to obtain any outside pathology before abstracting your case on sites:

Melanoma (it is common for the shave/punch to remove all of the cancer)
Prostate (urologists perform biopsies in their offices)

The recommendation from KCR to always leave original text documentation in place and just add any additional text underneath with the date you are updating your text.

EXAMPLES:
#1 Histology code: 8500 DCIS per path.
9/29/17 Histology code changed from 8500 DCIS to 8201 Cribriform DCIS per KCR Regional coordinator QA and per path stating a specific type of DCIS.

#2 9/29/17 CSLN changed from 300 regional LNs, NOS to 110 pericolic LNs per reviewer <name>.
(This will allow the reviewer to know that you initially coded 300 and had direction to change to a different code 110. If the reviewer doesn't agree with your updated code, the error will not be counted against you but will be discussed with the individual who directed the change).

TEXTING RECOMMENDATION:

Need to differentiate between MD and CTR staging. What did the MD(s) stage and what did you add ?

Example: Dr. X stages cStage IA breast cancer on H&P dated _____. CTR stages cT1c(1.5 cm on MRI) cN0 (no LAD on exam) cM0 (no signs/symptoms) cStage IA, pT1c (1.4 cm) pN0 (0/4 SLNs) cM0 pStage IA.

SEER Coding Questions

Question
First Course of Treatment/Surgery of Primary Site--Corpus uteri: Do you code total hysterectomy or radical hysterectomy when a specimen indicates the uterus, cervix, ovaries, fallopian tubes, and right and left parametrium were resected, but shows no portion of the vagina.

Answer
Assign code 50 for total hysterectomy. According to Appendix C Surgery Codes for Corpus Uteri of the 2016 SEER Coding and Staging Manual, total hysterectomy is surgery to remove the entire uterus, including the cervix; whereas, radical hysterectomy includes the vagina.
(SINQ 2017-0055; Date Finalized 11/08/2017; 2016 SEER Manual, SEER Glossary; NCI Definitions of Cancer Terms)

Question
MP/H Rules/Multiple primaries--Brain and CNS: How many primaries should be abstracted for a patient with a 2011 diagnosis of oligodendroglioma followed by biopsy of tumor which demonstrated progression in 2016 with pathology report Final Diagnosis indicating WHO grade III anaplastic astrocytoma?

Answer
Based on the information provided, this is a single primary. The 2011 tumor was not completely removed and progressed over the years. MP/H Rule M3 for malignant brain cancer applies. Do not change the original histology code. Use text fields to document the later histologic type of anaplastic astrocytoma, WHO grade III.
(SINQ 2017-0054; Date Finalized 11/08/2017; 2007 MP/H Rules, Malignant Brain, M Rules)