

CANCER CODING OBSTACLES

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CLASS OF CASE

Class of Case

STORE Manual:

Pages: 45-46 (case eligibility)

Pages: 125-128 (instructions and examples)

Class of Case is assigned to all accessioned cases and is based on the following:

- The nature of involvement of the facility in the care of the patient.
- Whether the cancer is required to be reported by the CoC.
- Whether required by central registry.
- Cases are accessioned after the registry's reference date.

Class of Case tells you who had a hand in caring for the patient

- Who diagnosed the patient
- Where was the patient diagnosed
- Who treated the patient
- Where was the patient treated
- What was done at your facility
- Why was a facility or doctor involved



Class of Case 00 vs 10

Class of Case 00: Patients who are originally diagnosed by the reporting facility and receive all their treatment elsewhere or a decision not to treat is made elsewhere

- Statement in patient's file that the patient was treated elsewhere
- CoC does not require the diagnosing facility to follow-up

If there is no statement indicating treatment...

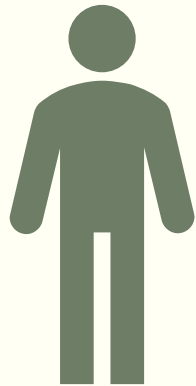
Class of Case 10: (NOS Code): If there is no information about whether the patient was treated or where the patient was treated

- Statement in patient's file stating that there is no treatment information for the patient
- Important to revisit to check for updates
- CoC requires follow-ups

Class of Case 30 vs 43

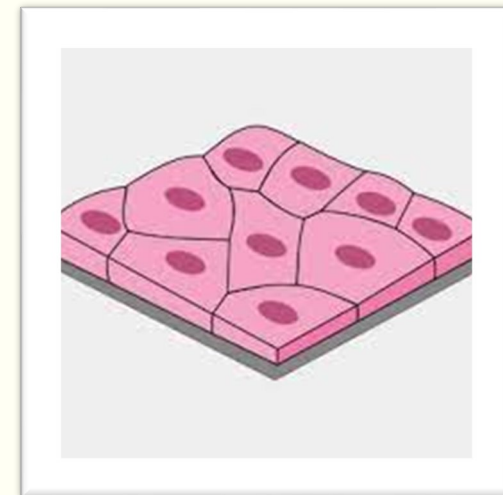
Class of Case 30:

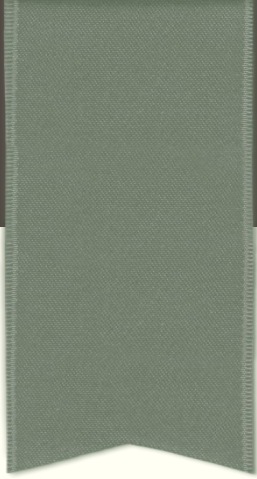
Patient appears in person at the reporting facility



Class of Case 43:

- Pathology or other lab specimens only
- Patient's tissue, cells, or other specimens seen at reporting facility





LABORATORY VALUES

Laboratory Values

All laboratory values must be done no earlier than **approximately** three months before diagnosis

What does this mean?

There is a three month window for laboratory results.

Three months before would be based on the day within the month that the cancer was diagnosed.

Example: If a patient was diagnosed with cancer on 5/6/22. The three month time period would count back from 5/6/22, bringing the beginning of the 3 month window to 2/6/2022.

Any lab results prior to February 6, 2022 would fall outside the three month window and would not be entered. However, put the dates and results of those tests, along with why the value was not entered in the text field. This will not only backs up your coding but it still gives anyone reviewing the file information about the patient's cancer history and also lets them know that the test was done and why the test result was not entered into the data field.

The word approximately can cause confusion.

Due to some months having 30, 31 or 28 days, each 3 month window may not contain the same amount of days.

Recording values when “less than” or “greater than” are used

Less than <

SSDIs with decimals in their code structures:

Example 1: PSA stated as < (less than) 5. Record 4.9

Example 2: hCG lab value resulting findings of < (less than) 1.
Record 0.9

SSDIs without decimals in their code structure:

Example 1: ER Percent Positive stated as < (less than) 60%.
Record 059 (59%)

Example 2: ER Percent Positive < (less than) 50%. Record 049
(49%)

Greater than >

SSDIs with decimals in their code structures:

Example 1: Ki-67 reported as > (greater than) 20%. Record 20.1

SSDIs without decimals in their code structure:

Example 1: PR Percent Positive stated as > (greater than) 75%.
Record 076 (76%)



TOTALLY RAD

Imaging and PI-RADS and LI-RAD



SEER Rule

Prostate and Liver cases with a RADS category of 4 or 5 are reportable

SEER Manual Appendix E

Note 19

- This is based on the American College of Radiology Imaging Report
- RADS 4 (High-clinically significant cancer is likely present)
- RADS 5 (Very high-clinically significant cancer is highly likely to be present)
- These are reportable, unless it is stated otherwise

New for 2023

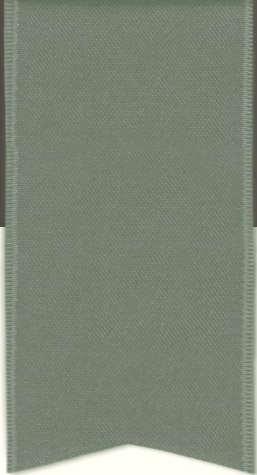


STORE Manual (2023)

Page 45

- PI Rads, BI Rads, LI Rads alone are not reportable for CoC. PI Rads, BI Rads, LI Rads confirmed with biopsy or physician statement are reportable to CoC. Date of diagnosis is the date of the PI Rads, BI Rads, LI Rads imaging. The biopsy makes it reportable to CoC however the date of diagnosis is the date of the imaging.

IMPORTANT: SEER remains unchanged concerning BI-Rads



TEXT

Why Is Text Important?

It gives your abstract strength and integrity!

- It supports your coding decisions
- Supports the accuracy and validity of data
- Supports unusual site /histology combinations
- Explains unusual abstract entries
- Documents the use of ambiguous terminology
- Documents additional information
- Helps establish timeframes
- Helps answer questions



Additional Uses For Text

- Eliminate the need to pull charts or review EMR again
- Edit check verification
- Helps in the consolidation and errata process
- Re-coding /re-staging of historical data
- Re-abstracting audits
- Researcher/facility use

Treatment Text

It is important to document and update treatment information

- It helps to set timeframe
 - First course treatment
 - Second course/ subsequent treatment
- Helps establish class of case
- Helps to validate treatment codes



AJCC

Blank vs X

AJCC Chapter 1

Blank

- When there was a procedure done but not enough information is given to assign T, N, or M

Example: Colon patient has imaging done. Statement of involved nodes but number of nodes not given. The N value for colon/rectum hinges on the number of nodes positive. Since there is no indication to the number of nodes involved you would code cN blank.

Example: Physician states that the T value is T3/4. The tumor was accessed, but the exact value is not stated.

However...

Wording can give enough information to code, such as:

- Node (single)
- Nodes (Plural)
- A couple (2)

But be careful of the words like ***“a few”*** or ***“Several”***, there is no set value for these words

- Uncertain if procedure was done and there is no information in patient's file to support assigning stage.

Example: No statement of DRE in patient's records. Procedure usually done in doctor's office and you do not have access to those records. Thus, Clinical T is left blank.

Using X

- Procedure attempted but unable to access tumor.
- Statement in patient file stating that procedure was not done nor attempted.

Example: Colonoscopy preformed but blockage prevented physician from accessing tumor

Example: Statement in patients file stating patient refused DRE

When there is not enough data to support a code, it is best to leave it blank than run the risk of coding it incorrectly.

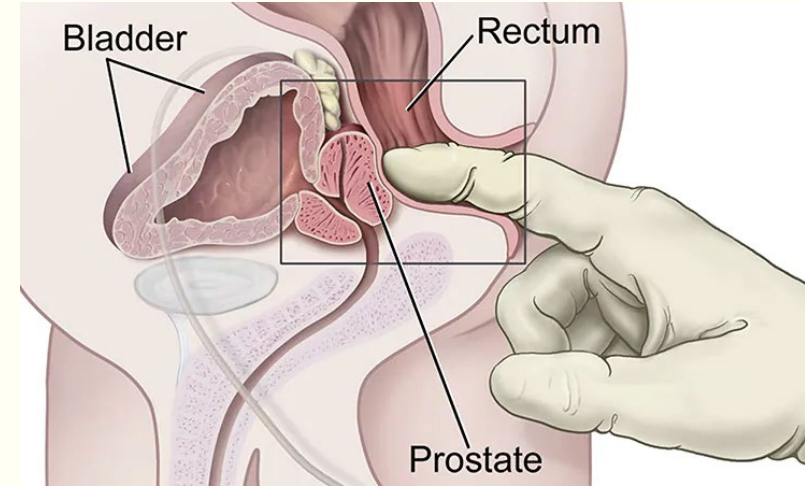
- Coding without the knowing can skews data
- Leaving a code blank allows you to go back and fill in the data item if the supporting information is found.
- Avoids having to change codes.

<https://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging-8th-edition/principles-of-ca-staging-and-general-info-chapters-1-4/principles-of-cancer-staging-chapter-1/89539-x-and-blank-scenarios>

<https://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging-8th-edition/lower-gastrointestinal-tract-chapters-19-21/colon-and-rectum-chapter-20/114814-rectal-uncertain-clinical-t-and-group-stage>

DRE

- Digit Rectum Exam (DRE)
 - The Gold Standard
 - Clinical T cannot be staged without it
 - Most tumors arise in the peripheral zone (outer zone)
 - Whether the tumor is palpable on physical exam is an important clinical indicator



AJCC 8th Edition
Page: 726

The primary clinical tumor assessment includes the information from the DRE of the prostate. Neither imaging information nor tumor laterality information from the prostate biopsy should be used for clinical staging. A tumor that is found in one or both sides by needle biopsy, but is not palpable or visible by imaging, is classified as T1c. Clinical T category should always reflect DRE findings only.

Managing Physician and Stage

AJCC Manual 8th Edition
Pages 726

If the managing physician assigns clinical stage, use the staging values provided.

Even if:

- There is not documentation or result of the DRE
- Managing physician used imaging to clinically stage

The primary clinical tumor assessment includes the information from the DRE of the prostate. Neither imaging information nor tumor laterality information from the prostate biopsy should be used for clinical staging. A tumor that is found in one or both sides by needle biopsy, but is not palpable or visible by imaging, is classified as T1c. Clinical T category should always reflect DRE findings only.



PROSTATE

EOD Primary Tumor

Note 6: If there is no information from the DRE, or the terminology used is not documented in Note 3, but the physician assigns a clinical extent of disease, the registrar can use that.

› *Example:* DRE reveals prostate is "firm." Physician stages the patient as a cT2a.
The T2a can be used since the physician has documented this.

If using the Clinical stage assigned by the managing physician, you would want to do the same for EOD Primary Tumor.

Why?

If AJCC clinical T is assigned it must correlate with the data point coded in EOD Primary Tumor. If these two data fields do not validate each other, you can get an edit.

PSA

- Record the **last pre-diagnosis PSA value prior** to biopsy
- and/or initiation of treatment **and** no earlier than 3 months before dx
- Record to the nearest tenth in nanograms/milliliter
 - Micrograms per liter (ug/L) = nanograms per milliliter (ng/ml)

Number of Cores Positive and Examined

- A diagnostic procedure, such as a needle core biopsy, can take as many as 20 or more core biopsies to determine the extent of the cancer within the prostate
- These 2 data items record the number of positive cores found and the number of cores that were examined
- Do not make assumptions about the number of cores positive or examined based on the number of areas biopsied within the prostate (laterality, lobes, apex, base, or mid-prostate)
 - Several cores may be taken from each area

- Number of Cores Positive must **ALWAYS** be less than or equal to Number of Cores Examined
- The results from the number of cores positive and number of cores examined needs to come from the same diagnostic procedure
- A doctor's statement to the number of cores positive and the number or cores examined can be used
 - Be careful a using the physician statement
 - Make sure the number of positive cores does not exceed the number of cores examined
- Additional biopsy results gathered after diagnosis (follow-ups for watchful waiting) are not included in this data item

It's tricky...*tricky, tricky, tricky*

Examples:

Doctor's statement of 8 cores positive, no additional information given

Cores positive: 08

Cores Examined: X6

Rationale: Number of positive cores but no mention of the number examined

Path report: Apex (positive), Base (positive) Peripheral middle (positive), Center (negative)

Cores positive: X6

Cores Examined: X6

Rationale: Stated areas produced positive cores, but did not give number and stated zone/lobe locations but did not give the number positive or the number of cores taken from each location

Rules:

- If it states the exact number use it
- If it give you the number positive, do not assume the number examined is the same number
- An area examined (zone/lobe) without mention of the number of cores taken does not equal 1 core

Code what you know!

Do not assume!

Cores Positive Codes

Code	Description
00	All examined cores negative
01-99	1 - 99 cores positive (Exact number of cores positive)
X1	100 or more cores positive
X6	Biopsy cores positive, number unknown
X7	No needle core biopsy performed
X8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code X8 may result in an edit error.)
X9	Not documented in medical record Number of cores positive not assessed or unknown if assessed

Cores Examined Codes

Code	Description
01-99	1 - 99 cores examined (Exact number of cores examined)
X1	100 or more cores examined
X6	Biopsy cores examined, number unknown
X7	No needle core biopsy performed
X8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code X8 may result in an edit error.)
X9	Not documented in medical record Number of cores examined not assessed or unknown if assessed

Clinical Diagnosis

- Ultrasound guided Core Biopsy
 - Can also be a TURP or TURBT
 - These are **Clinical results**
- Date of Dx will be which ever of the following occurs **first**
 - Date of positive histologic confirmation
 - Date the physician documented that he/she **suspects** that the patient has prostate cancer
 - Date of MRI imaging stated to be PI RAD 4 or 5, followed by positive histological confirmation

Assigning Stage

AJCC Manual Page 4

The Managing Physician is the only person within the medical team that can assign stage.

Routinely has access to all patient information such as:

- Medical examinations
- Imaging results
- Pathology results
- Biopsies diagnostic procedures
- Surgery findings



BREAST

Breast Laterality

Using the “Breast Clock” diagram can sometimes throw registers off.

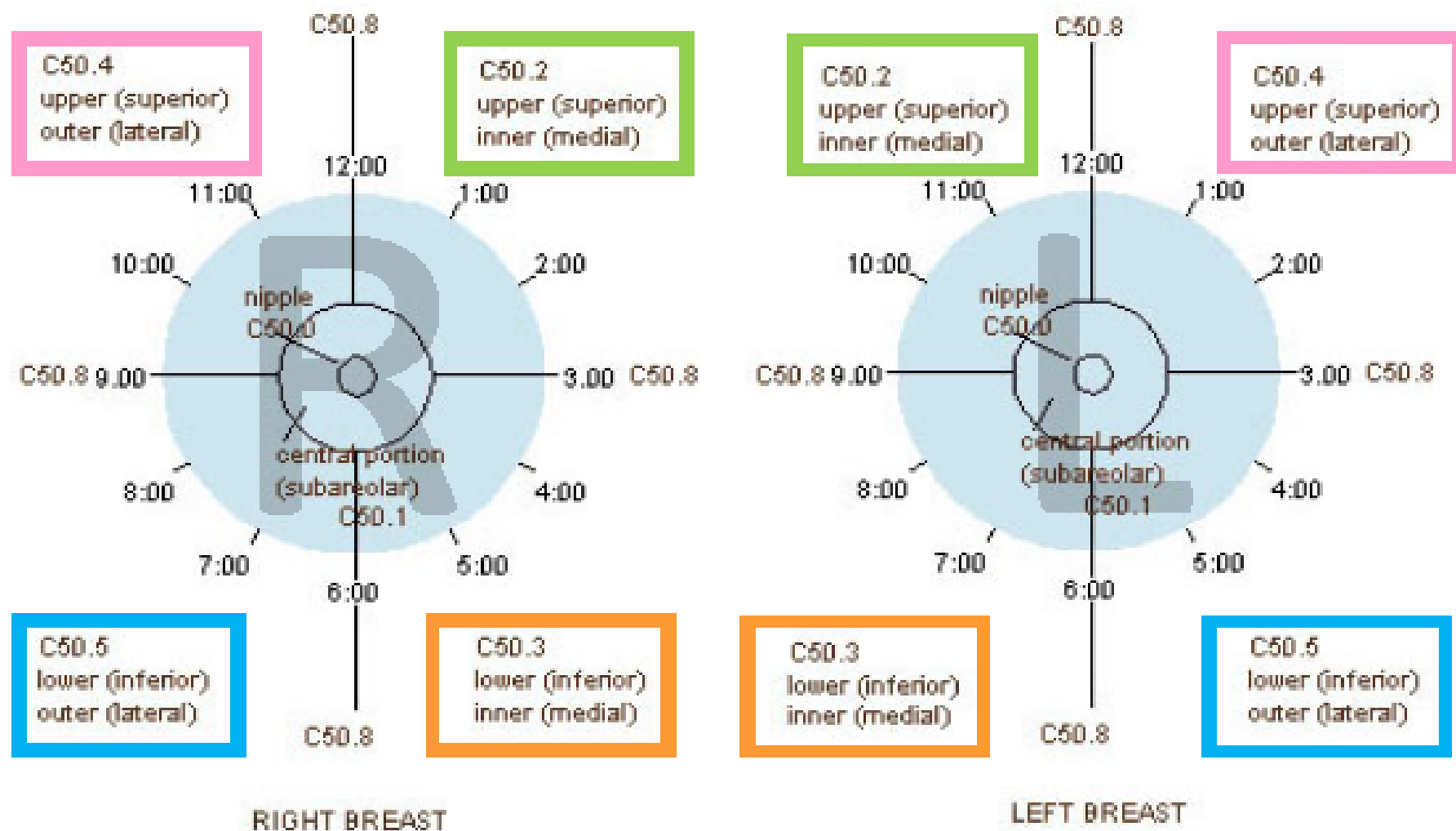
In haste, we can sometimes look at the illustration as though we are “looking in a mirror”.

However, it is designed like you were facing the patient.

Tip: Think of it as shaking the patient’s hand.



"Clock" Positions, Quadrants and ICD-O Codes of the Breast



Note: C50.6 is the code for axillary tail or tail of breast.



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