



TEXT

Cover Your Abstract



Does Text Support Matter ?



You bet your abstract it does!

- Cancer codes tell the patients cancer journey with numbers
- Text tells the patients cancer journey in readable language that supports the coding
- Text should provide an accurate, concise summary of the patient's cancer



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 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



How KCR Uses Your Text

- Validates codes in the abstract
- Sequence
- Extent
- Treatment
- Reconciles coding conflicts and consolidate abstracts from different facilities
- QA/QC audits



Critical Data Items

- DOB
- Sex
- Race
- Date of diagnosis
- Primary Site
- Laterality
- Histology
- Behavior
- Sequence number
- Grade
- Stage
- Dates and types of all treatment



Abbreviations

- It is fine to use abbreviations
- It is important to use accepted abbreviations from KCR's Abstractor's Manual
- It is important to use commonly known/used abbreviations
- Spell out, at least once, any abbreviation that might not be easily recognized
- Be consistent with abbreviation usage

<https://confluence.kcr.uky.edu/display/KAM/Appendix+I+-+Common+Abbreviations>



The Use of Symbols



- It is fine to use symbols
- It is important to use commonly known/used symbols
- Be consistent with symbol usage

Examples:

< (less than)

> (greater than)

= (equal to)

+ (positive)

- (negative)

X (times)

2/7 (two of seven)



Physical Exam

- Begin with Age, Race, & Sex
- Insert information relating to previous primary cancer sequences here (date & type)
- Include symptoms leading to current hospital in or out-patient admission for diagnosis &/or treatment
- Include diagnosis date/ procedure/ facility if this took place prior to current visit
- Remember to include reason for current visit!
- End each text section with your initials & date entered



Tests & Procedures

- X-ray reports: Date, Scan, Facility where performed, & pertinent findings; insert initials & date entered at end of box
- Scopes: Date, Type of Scope, Facility where performed, & pertinent findings; initials & date
- Lab Tests: Date, Test name, Facility where performed, & pertinent results (include normal range); initials & date
- Operative Reports: Date, Name of procedure, Facility where performed, & pertinent findings (may include important site, size or staging information); initials & date



Pathology Reports

- Date
- Report Number
- Facility
- Final diagnosis
- Include results such as:
 - Tumor size
 - Location
 - Histology
 - Behavior
 - Grade
 - Extension information
 - Lymph node results
- **Comments or Addendum** results are equally important to record



- It is helpful to list Path reports in date order. Oldest Paths at top of Path section
- You are not required to repeat this info in an additional text field, if it is already documented once.)
- Path reports can be copied and pasted from E Path in the Path text field.
- Epath can also be attached to your abstract which helps Central and when your abstract is used for Research



Staging

- Record TNM staging
- Who staged clinical &/or pathologic staging
- Extent of Disease (EOD)
- Show original measurements
- Include sources of these data choices
- Include information for all SSDIs (site-specific data items) if not covered in previous text sections
- Reabstracting Audits are often performed using text information only and data not documented will be counted as errors



Treatment Plan

- Use this text field to document what the physician plans for the treatment of the patients cancer.

Example: Per Dr Smith's 1/1/2022 note : after Pt's surgery, plan to have six cycles of Chemo (name drug if known), at name of facility-if other than reporting facility, followed by Radiation Therapy (name of facility-if other than reporting facility). Plan for CT every 6 weeks to verify treatment progress.



General Remarks

- Diagnosis date & source should be included here, if not covered earlier in text
- Treatment information may be included here (type, date started; radiation also requires date ended, tx volume, & tx modality) if not covered thoroughly in Treatment Notes box
- Following physicians/ specialties included here
- Follow-up information is typically added here each year



Initial and Date

- It is important to initial and date each entry you make!
- This shows ownership of your work
- This lets anyone reviewing the abstract know who entered the what text
- Helps to protect you during audits
- This helps to “time stamp” each entry if additional information needs to be added at a later date
- Its separates the entries made when multiple abstractors enter abstract and/or follow-up information



Goal

To accurately recode a case by using the text only and not having to refer back to the chart

If you can do this, then your text is **PERFECT!**

