Common Coding Pitfalls & Tidbits

BREAST

Remember to text physical exam of breast and regional lymph node before first treatment to support clinical coding/findings!!!

Allred Score range (example, moderate-strong intensity score).

- Code SSDI Allred Score to X9 per https://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/129423-weak-to-stong#post129481

Ki-67 stated as range (example, 5-10%).

- Code SSDI to 5.1 in this example per https://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/120872-ki67

SENTINEL LYMPH NODE BIOPSY AND AXILLARY LYMPH NODE DISSECTION PERFORMED DURING THE SAME PROCEDURE.

If a sentinel lymph node biopsy is performed during the same procedure as the regional axillary lymph node dissection, **use code 97** in the data item Sentinel Lymph Node positive. Record the total number of positive lymph nodes biopsied/dissected in both sentinel and regional lymph nodes positive.

Example: 4/1/2022 Pt underwent a right total mastectomy with right sentinel lymph node biopsy & right axillary lymph node dissection. Final path report finds the following lymph node involvement:

REGIONAL LYMPH NODES

Regional Lymph Node Status: Tumor present in regional lymph node(s)

Number of Lymph Nodes with Macrometastases: 1

Number of Lymph Nodes with Micrometastases: 0

Size of Largest Nodal Metastatic Deposit: 8 mm

Extranodal Extension: Present, greater than 2 mm

Amount: focal (4mm) extranodal extension

Total Number of Lymph Nodes Examined (sentinel and non-sentinel): 10

Number of Sentinel Nodes Examined: 2

CODING

EOD Regional Lymph Nodes: 200, pathological assessment only, positive macrometastasis.

200	PATHOLOGICAL assessment only Positive axillary (level I and II) lymph node(s), ipsilateral WITH more than micrometastasis (At least one metastasis greater than 2 mm, or size of metastasis not stated) WITHOUT internal mammary lymph node(s) or not stated

Date Sentinel Lymph Node Biopsy: 04/01/2022

Sentinel Lymph Nodes Positive: 97

97	Positive sentinel nodes are documented, but the number is unspecified; For breast ONLY: SLN and RLND occurred during the same procedure

Sentinel Lymph Nodes Examined: 02

Date Regional lymph Node Dissection: 04/01/2022

Nodes Positive: 01

Nodes Examined: 10

Score Regional LN (STORE): 6, Sentinel node bx and nodes removed at the same time.

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Polychythemia Vera Reportability

Clarification of polycythemia reportability--Is a diagnosis of “polycythemia NOS” reportable if a patient is treated with phlebotomy?

According to SEER, polycythemia (also known as polycythaemia or erythrocytosis) is a disease state in which the proportion of blood volume that is occupied by red blood cells increases. Blood volume proportions can be measured as hematocrit level. It can be due to an increase in the mass of red blood cells, "absolute polycythemia"; or to a decrease in the volume of plasma, "relative polycythemia".

The phlebotomy is a treatment for the excessive blood volume; therefore, a diagnosis of “polycythemia" without one of the modifying terms listed in the Heme DB under Alternative Names is NOT reportable.

(SINQ 20110060, last updated 6/29/12, source 2010 Heme & Lymph Manual & DB)

You may have heard April Fritz advise, during her fall workshop hematopoietic presentation, that if a patient diagnosed with polycythemia vera NOS is treated with phlebotomy, consider the polycythemia to be the reportable condition. However, KCR must follow SEER rules, as published in the SINQ answer.

[Per KCR via SEER SINQ; Published in October 2013 'In the Abstract']

Reportability--Heme & Lymphoid Neoplasms: Is polycythemia vera secondary to volume depletion reportable?

Answer: No, secondary polycythemia vera is not reportable. Primary polycythemia vera is a condition in which there is an overproduction of blood cells due to a neoplastic process. Secondary polycythemia vera is an over production of red blood cells caused by a co-morbidity, in this case, volume depletion.

(SINQ 20120049, last updated 7/17/12, source 2012 Heme & Lymph Manual & DB)

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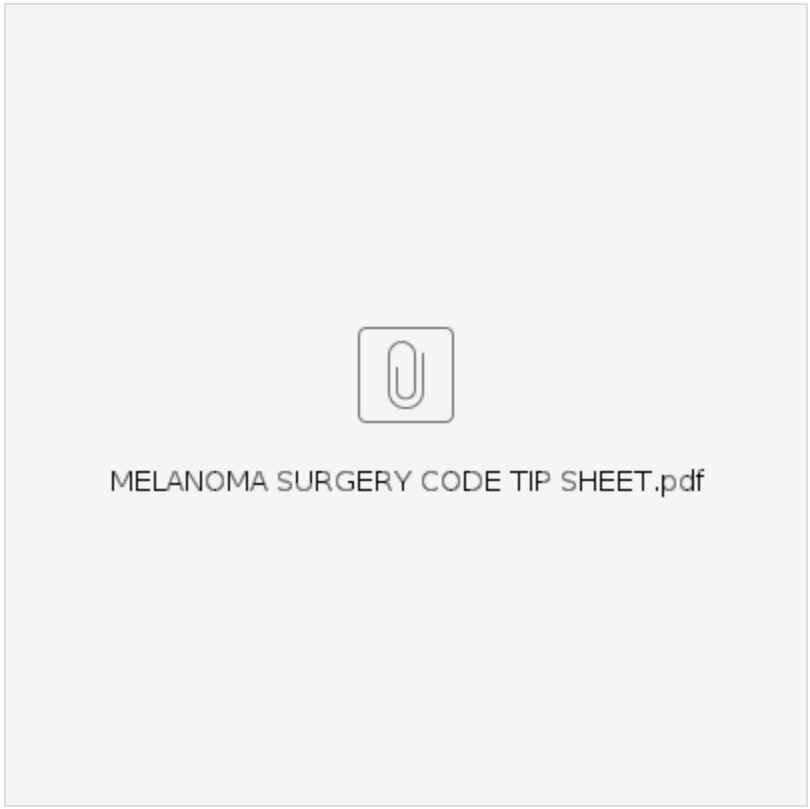
Melanoma



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Prostate

When cancer is diagnosed incidentally (example, a cystoprostatectomy for bladder cancer) code EOD T to 800 (no evidence of primary tumor) in this field. If there is no documentation regarding a normal prostate evaluation (physical examination or imaging) prior to prostatectomy/autopsy, code 999 (unknown; extension not stated) in this field. https://staging.seer.cancer.gov/eod_public/input/2.1/prostate/eod_primary_tumor/?breadcrumbs=(~schema_list~),(~view_schema~,~prostate~)

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Colon / Rectum

Copy and paste the entire Op Note to identify and support your primary site per *priority order for coding primary site* added below.

Coding Guidelines

Colon
C180–C189

The prognosis of patients with colon cancer is related to the degree of penetration of the tumor through the bowel wall, the presence or absence of nodal involvement, and the presence or absence of distant metastases.

Primary Site

Priority Order for Coding Primary Site

Use the information from reports in the following priority order to code the primary site when there is conflicting information.

Resected cases
- Operative report with surgeon's description
- Pathology report
- Imaging

Polypectomy or excision without resection
- Endoscopy report
- Pathology report

Subsites

Code the subsite with the most tumor when the tumor overlaps two subsites.
Code C188 when both subsites are equally involved.

Review the pathology gross description for circumferential radial margin and remember to code CRM to *millimeters*, NOT centimeters.

💡 **RADIO-SENSITIZING CHEMOTHERAPY: If chemotherapy was provided as a radiosensitizer or radioprotectant DO NOT code as chemotherapy treatment. When chemotherapy is given for radiosensitization or radioprotection it is given in low doses that do not affect the cancer. Please review the treatment plan or reach out to the physicians administering treatment for confirmation.**