Coding for FNA in Diagnostic/Staging Procedure Field

According to FORDS & STORE: Surgical Diagnostic and Staging Procedure identifies the positive surgical procedure(s) performed to diagnose and/or stage disease. Surgical Diagnostic and Staging Procedure (NAACCR Item #1350, FORDS, page 138) and STORE, page 148, states that brushings, washings, cell aspiration and hematologic findings (peripheral blood smears) are recorded as positive cytologic diagnostic confirmation in the Diagnostic Confirmation (NAACCR Item #490).

Page 143 (STORE), Diagnostic Confirmation. Coding instructions indicates to Code 1 when the microscopic diagnosis is based on (tissue specimens) from biopsy, frozen section, surgery, or autopsy or bone marrow specimens from aspiration or biopsy. Use code 2 when the microscopic diagnosis is based on cytologic examination of cells (rather than tissue) including but not limited to spinal fluid, peritoneal fluid, pleural fluid, urinary sediment, cervical smears and vaginal smears, or from paraffin block specimens from concentrated spinal, pleural, or peritoneal fluid. These methods are rarely used for hematopoietic or lymphoid tumors.

Yes, the cell aspiration (code 2) in FORDS/STORE does refer to Fine Needle Aspiration (FNA). **Bullet #6 states to code (cell aspirations) as positive cytologic diagnostic confirmation in the data item Diagnostic Confirmation (NAACCR Item #490).** These are not considered surgical procedures and should not be coded in this data items. **Code 1 refers to (tissue aspirations).**

Code 1 Positive histology Histologic confirmation (tissue microscopically examined).
Code 2 Positive cytology Cytologic confirmation (no tissue microscopically examined; fluid cells microscopically examined).


**Neuroendocrine Tumors**
- No SSID's for Neuroendocrine Tumors!
- Somatostatin Analog treatment Lanreotide (LAR) and Sandostatin are ancillary agents for NETs. They relieve symptoms but do not kill the cancer cells.
- In the Pancreatic Neuroendocrine Tumor (pNETS) category be sure to pay attention to Insulinoma’s! A functional Insulinoma is considered malignant due to more hormones. Code 8151/3.

**GRADE!**
The Mitotic rate and/or the Ki-67 index are needed to determine the grade for neuroendocrine tumors.

Check out page 55 of the NAACCR grade manual for more information!

*NAACCR 2018-2019 Webinar Series on Neuroendocrine Tumors*

**Text is important!**
NAACCR has recommendations for abbreviations in the data dictionary Appendix G. Text is required to support the coded information.

Adenopathy: ADENOP
Carcinoma: CA
Cancer: Spell out, do not abbreviate
Grade: GR
Malignant Melanoma: Spell out, do not abbreviate
Sentinel lymph node biopsy: SLNBX

http://datadictionary.naaccr.org/?c=17

**Congrats!**
The External Quality Improvement (EQI) Team at the New Jersey State Cancer Registry won 1st place for their poster titled, “Quality Insiders: A Central Registry’s Quality Improvement Plan” at NCRA’s 45th Annual Conference in Denver, Colorado. The team consists of (left to right) Frances Krol, Amy Cass, Adrian Botchway, Maryanne Burhenne, and Harrine Katz.

You can view their poster abstract in the next issue of The Journal of Registry Management.

Questions can be sent to your facility’s State Representative or by calling 609-633-0500. DO NOT REPLY to this email.
May 2019 E-Tips

New Jersey State Cancer Registry
Cancer Epidemiology Services
http://www.nj.gov/health/ces
(609) 633-0500

Hematopoietic & Lymphoid Neoplasms

- Baby aspirin is coded as other treatment for essential thrombocythemia.
- If there is no mention of B symptoms and/or HIV status in the medical records code unknown.
- Waldeyer’s ring, thymus, and spleen are considered nodal. Do not use E suffix.
- **REMEMBER!** Pathologic staging for Hematopoietic and lymphoid neoplasms requires a Staging Laparotomy.
- The following histology’s have Mets at DX field always coded to 8:
  - Any case coded to primary site: C420, C421, C423, C424
  - Plasma cell Myeloma 00821
  - Plasma Cell Disorders 00822
  - HemeRetic 0083

**Bulky Disease**

- **Hodgkin Lymphoma (HL)**
  - If mediastinal, Bulky is defined as greater than 1/3 the size of the cavity.
  - If not mediastinal, “Bulky” is defined as greater than 10cm.
- **Non-Hodgkin Lymphoma (NHL)**
  - Definition varies based on histology.
  - Look for physician statement of “Bulky”
- Stage 2 Bulky is a new stage category for 8th edition.
  - **Make sure you read the summary of changes in your AJCC Staging Manual**
- Any extralymphatic involvement with nodal disease above and below the diaphragm is Stage IV.

Question!
If there is no clinical information available and all that is available is the post-neoadjuvant information, is it better to code EOD unknown (999) or use the post-neoadjuvant information to code EOD?

**Answer!**
*Code EOD Primary Tumor using the post neoadjuvant information for this case. Since the only information you have is the post neoadjuvant, code that. EOD combines clinical and pathological information.*

Wondering what radiation fields must be filled out when “No Radiation” or “Unknown” if Radiation done?

Radiation items carried over from FORDS to STORE:
- Reason for No Radiation [1430] (required 2003+)
  - RX Summ-Surg/Rad Seq [1380]
- Rad—Location of RX [1550] (Required 2003+)
  - Date Radiation Started [1210]
    - RX Date- Radiation Flag [1211]
  - Date Radiation Ended [3220]
    - RX date Rad Ended Flag [3211]

If No Radiation:
- Phase 1 Radiation Primary Treatment Volume is coded 00
- Phase 1 Radiation treatment Modality is coded 00
- All other “Phase” radiation fields may be blank.

**Check out SEER Educate for 2018 EOD Training**

https://educate.fredhutch.org/Assessments/PracticalApplicationTests.aspx

Sources:
*NAACCR 2018-2019 Webinar Series Hematogenic &Lymphoid Neoplasms
*NAACCR 2018-2019 Webinar Series Abstracting and Coding Boot Camp

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ER and PR Total Allred Score

The total Allred Score uses IHC to determine the percentage of cells that test positive for the hormone receptors, Estrogen Receptor (ER) and Progesterone Receptor (PR). The intensity is how well the receptors show up after staining. The clinician’s interpretation takes priority. If the physician does not state what the Allred score is and both Positive cells % and intensity are available, then the registrar can calculate it. This information is combined to score on a scale from 0 to 8. Find your percentage in the positive cells’ column for your proportion score, followed by finding your intensity score based on information provided in interpretation. Add the proportion score to the intensity score to find your total Allred score.

<table>
<thead>
<tr>
<th>Proportion Score</th>
<th>Positive Cells, %</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1</td>
<td>&lt;1</td>
</tr>
<tr>
<td>2</td>
<td>1 to 10</td>
</tr>
<tr>
<td>3</td>
<td>11 to 33</td>
</tr>
<tr>
<td>4</td>
<td>34 to 66</td>
</tr>
<tr>
<td>5</td>
<td>≥67</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Intensity</th>
<th>Intensity Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
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</tr>
<tr>
<td>Weak</td>
<td>1</td>
</tr>
<tr>
<td>Intermediate/Moderate</td>
<td>2</td>
</tr>
<tr>
<td>Strong</td>
<td>3</td>
</tr>
</tbody>
</table>

• Example:
  ER Positive 100% nuclear staining, strong average intensity **Allred Score: 08**
  PR Positive 10% nuclear staining, moderate average intensity **Allred Score: 04**

*Abstracting and Coding Boot Camp NAACCR 2018-2019 Webinar Series*

Testis

- If post-orchiectomy AFP lab values remain elevated, use lowest post-orchiectomy AFP lab value prior to adjuvant therapy.
- Adjuvant therapy for testicular cancer takes 3 months to decide. This is still considered first course therapy.
- When coding EOD primary tumor remember that code 100 and 150 are for PURE SEMINOMAS ONLY.

**Testis NAACCR 2018-2019 Webinar Series**

Grade 2018 Coding Exercises Now Available in SEER*Educate

With diagnosis year 2018, we now have to code three Grade fields instead of one. In fact, Grade now has its very own manual!

Log in or sign up at SEER*Educate today by visiting [https://educate.fredhutch.org/](https://educate.fredhutch.org/) and Learn by Doing!

**Free CE’s available!**

SEER*Educate is funded by Surveillance, Epidemiology and End Results (SEER) of the National Cancer Institute (NCI) and the Fred Hutchinson Cancer Research Center. (NCI Contract Number HHSN261201800004I)

SEER Releases New Cancer Statistics Review (CSR) and Latest SEER Data

The SEER Cancer Statistics Review (CSR), 1975-2016, published by NCI’s Surveillance Research Program, was released on April 15, 2019. The updated Cancer Statistics Review presents the most recent cancer incidence, mortality, survival, and prevalence statistics.

New materials posted include:
- [Cancer Stat Fact Sheets](https://seer.cancer.gov/csr/factsheets/)
  (now including female breast cancer subtypes!)
- [SEER*Explorer](https://seer.cancer.gov/sexplorer/)
  (now with stats by subtype for breast, esophagus, lung, and thyroid!)
- [The Cancer Query Systems](https://seer.cancer.gov/cq/)
- [Cancer Statistics Animator](https://seer.cancer.gov/animator/)
- [SEER Incidence Data, 1973-2016](https://seer.cancer.gov/edb/)
- [Specialized Databases](https://seer.cancer.gov/specialized/)


Questions can be sent to your facility’s State Representative or by calling 609-633-0500. DO NOT REPLY to this email.
### Basics of External Beam Radiation Therapy (EBRT) & Coding Implications

**What is the difference between IMRT and 3D conformal?**

**ANSWER:** The main difference between IMRT and 3D-Conformal plans is that when the latter is used, the MLC leaves remain stationary. It still uses multiple fields as with IMRT, and each field conforms to the shape of the target as seen from various angles, but the collimator leaves are static through the duration of treatment.

**How do we code the field External Beam Planning Technique if the radiation oncologist just calls it AP/PA?**

**ANSWER:** The term AP/PA refers to the direction of the radiation beam only. It provides no information whatsoever on the planning technique code that should be used. AP/PA means that the patient was irradiated with the gantry @ 0 degrees and @ 180 degrees.

**What is Gamma Knife and how do you code it?**

**ANSWER:** Gamma Knife SRS can target multiple CNS lesions in a single session. Regardless of the number of lesions treated in a single session, abstract as a single phase. Code the maximum prescribed dose use. Remember that Gamma Knife is EBRT and you should code the dose/fx and total dose in cGy.

**Coding Tips for Colon 2018:**

- **Do not** use histology codes: 8210, 8260, 8261, 8263, 8264 for C18.0-C20.9.

- **Types of Polyp, Treatment and Stage:**
  - **Sessile polyp:** Colonoscopy is done giving it a Clinical T. The surgical Resection is treatment.
  - **Pedunculated polyp:** Snare polypectomy is the treatment. This would give you a pathologic T. No clinical stage.

- **Note:** Component is not equivalent to subtype or variant. Component is ONLY coded when the pathologist specifies the component as a second carcinoma.

- **NEW Priority Order for Coding Primary Site Resected cases:**
  - Operative report with surgeon’s description
  - Pathology report
  - Imaging
  - **Polypectomy or excision without resection:**
    - Endoscopy report
    - Pathology report

- Predominantly is more than 50% which is important for coding the subtype!

**Confused on Anastomotic sites. Recurrence or Same Primary?**

**Solid Tumor Rules for Colon:**

**M7:** Abstract multiple primaries when a subsequent tumor arises at the anastomotic site AND: • One tumor is a NOS and the other is a subtype/variant of that NOS OR • The subsequent tumor occurs greater than 24 months after original tumor resection OR • The subsequent tumor arises in the mucosa

Colon 2019 NAACCR 2018-2019 Webinar Series  
**New in SEER*Educate! Earn and Learn.**

**2018 Solid Tumor Rule Coding Exercises** are now available! This is a great way to earn CEs and learn how to apply the 2018 Solid Tumor Rules. Use the 2018 Solid Tumor coding rules to determine the number of primaries to abstract and the histology to code for cases diagnosed 1/1/2018 and forward.

Please note that two remaining sites, Cutaneous Melanoma and Other Sites are currently under revision. Continue to use the 2007 General Instructions, 2007 Other Sites, and 2007 Cutaneous Melanoma for cases diagnosed 2007-2020.

**Your Participation is Needed! March 1 to April 15, 2019.**

**Complete the 2019 EOD/SS/SSDI Reliability Study!**

NCRA has approved 10 CEs for completion of ten cases. The objectives of this study are to determine training needs. Go to SEER Reliability Studies Site during this period. The study will assess how well registrars assign EOD Primary Tumor, EOD Regional Nodes, EOD Mets, SS2018, Grade, SSDIs, Regional Nodes Positive and Tumor Size.

Questions can be sent to your facility’s NJSCR Representative or by calling 609-633-0500. DO NOT REPLY to this email.
**IS THIS REPORTABLE?**

**Atypical small acinar proliferation (ASAP) PIN 4** - is not reportable. Patients with ASAP found on prostate needle biopsy will likely undergo another biopsy. [https://seer.cancer.gov/seerinquiry/index.php?page=view&id=20180094&type=q](https://seer.cancer.gov/seerinquiry/index.php?page=view&id=20180094&type=q)

**Primary hepatic neuroendocrine tumor (PHNET)** - PHNET is reportable as are other digestive system NETs. There is no specific histology code for PHNET. SINQ 20180097 suggests we use histology code 8240/3. For more details see: [https://seer.cancer.gov/seerinquiry/index.php?page=view&id=20180097&type=q](https://seer.cancer.gov/seerinquiry/index.php?page=view&id=20180097&type=q)


**Monoclonal B-cell lymphocytosis (MBL)** - According to SINQ 20180050 monoclonal B-cell lymphocytosis is not reportable. This term will be removed from 9823/3 since it is a /1 (has its own code). MBL is a condition in which a higher than normal number of identical B cells are found in the blood. Lymphocytosis by itself and without further specification means an increase of lymphocytes. This can be caused by many different factors. Monoclonal B-cell lymphocytosis is a condition that resembles chronic lymphocytic leukemia (CLL) and is defined as the presence of CLL-phenotype cells in the peripheral blood in the absence of other features of CLL or SLL. But follow up should be conducted to assure that this has not evolved into a lymphoma.


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**New Treatment for Gastroenteropancreatic Neuroendocrine Cancers**

Peptide Receptor Radionuclide Therapy (PRRT) is a radiopharmaceutical (nuclear medicine therapy) that travels throughout the body looking for a somatostatin receptor within neuroendocrine tumors (NET). NETs that form in the midgut area, from the jejunum to the ascending colon, are the most common cancerous NET. These tumors overexpress receptors for a hormone called somatostatin.

Once absorbed into the tumor the radioactive material starts to break down and kill tumor cells. PRRT was approved in 2018 to treat gastroenteropancreatic neuroendocrine tumors in adult patients. It uses lutetium Lu 177 dotatate, which is being studied in the treatment of other types of cancer. Infusion is typically given every 8 weeks for a total of 4 doses. Look for the drug LUTATHERA®.

According to SINQ 20180106 it is to be coded as Other Therapy, code 1.


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**NJSCR Presents: Spend the Day at the Registry**

Please join the New Jersey State Cancer Registry for this full-day interactive workshop designed to give hospital registrars a better understanding of the central cancer registry. Meet the NJSCR staff and see first-hand how your data becomes part of our research and publications. Topics covered include data linkages and follow-up, special studies, death clearance and quality control.

135 E State St. Trenton NJ 08608

Earn 5.5 CEs!

To register for this informative event, visit: [https://www.state.nj.us/health/ces/documents/Brochure%20revised%20for%202019%20dates.pdf](https://www.state.nj.us/health/ces/documents/Brochure%20revised%20for%202019%20dates.pdf)

Questions can be sent to your facility’s NJSCR Representative or by calling 609-633-0500. DO NOT REPLY to this email.

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**New Jersey State Cancer Registry**

Cancer Epidemiology Services

http://www.nj.gov/health/ces

(609) 633-0500