Coding Factoids and Frequently Asked Questions

Education & Training Team
Collaborative Stage Data Collection System
Version 1 (CSv2)

Learning Objectives

- Understand rationale behind changes and updates
- Understand use of codes and reporting
- Determine proper code use for accurate reporting
- Understand finding specific documentation
  - Site Specific Factors
  - Coding rules

CSv2 FAQ

Q. Is a case reportable just because there is an AJCC chapter and a staging form?

A. The AJCC does not determine reportability. Just because there is a chapter and a staging form does not make the case reportable.

Check with your Standard-Setters. This should be discussed with the Cancer Committee at your facility to determine if these cases should become reportable-by-agreement.

CSv2 FAQ

Q. Why are prognostic factors on the staging form? Many pathologists do not think they should complete this.

A. The prognostic factors are important pieces of information that affect the treatment decisions and the outcome prognosis of the patient.

The staging form is not the sole responsibility of the pathologist, and for many things, such as clinical staging, it cannot be completed by the pathologist. The appropriate physician should complete the appropriate items.

CSv2 FAQ

Q. What about AJCC stage conversions for site code schemas?

A. There will be automatic conversions for new schemas.

For example, adrenal gland has a new schema. When coding a case in CSv2, it will derive the 6th edition based on the schema it utilized for CSv1, and it will derive the 7th edition based on its new schema.

CSv2 FAQ

Q. Will registries be re-abstracting 2011 cases due to the new CSv2 02.03 staging that just came out?

A. Registries will be asked to review a limited number of cases where the code was changed or split in CSv2 02.03.

The conversion specifications developed for CSv2 02.02 to 02.03 lists the specific schemas and codes for the registry to review and recode if necessary.

CSv2 FAQ

Q. Where does one find a listing of all the changes made in the CSv2 manual?

A. Significant changes in Part I Section 1 and Part I Section 2 have a change bar at the margin. Changes in wording or typo corrections are not marked because they did not change the meaning.

CSv2 FAQ

Q. In which CS version were pertinent AJCC Staging Manual errata incorporated, CS version 02.03.02. (Dec 2010) or an earlier release?

A. The AJCC errata were incorporated into CS version 02.03.02.
They were not published until August of 2010, long after CS version 02.02 was posted.

CSv2 FAQ

Q. Can a registrar utilize the physician stage to code the applicable CS data elements if the test results are not in the chart to support the physician stage?

A. Yes, the registrar can utilize the physician stage to code the applicable CS data elements. A “not otherwise specified, NOS” code is offered if one cannot make a more definite determination in coding. It is appropriate to utilize the “NOS” code in this case.

CSv2 FAQ

Q. How does one code vague information when a "NOS" code is not provided?

A. Code to the most accurate and localized component within the coding structure.

For example, if a description of a lung cancer fails to state direct evidence of extension, but also does not give information suggesting extensive involvement, and the physician treats as though it is localized disease, code to the localized, "NOS" code of 300.

CSv2 FAQ

Q. If a skin primary site is unknown, what is the proper topography code?

A. Code to C44.9.

If you have a lymph node showing metastatic malignant melanoma, but the primary site is unknown, the appropriate code is C44.9, not C80.9.

Malignant melanoma's generally arise in the skin. While one might not know the specific site within the skin, coding to C44.9 is more specific than to code to the unknown primary code, C80.9 . Remember that skin is an organ just like the lungs or kidneys.

CSv2 FAQ

Q. Is this true of Merkel Cell carcinoma of the skin as well?

A. Yes, Merkel Cell carcinoma may also arise in a visceral organ or other site. But the primary site for an unknown Merkel Cell primary, is coded to skin "NOS", C44.9.

CSv2 FAQ

Q. It is true that some of the SSF's that are now collected are needed to derive the AJCC stage? Why are SSF's such as HPV status collected for some sites?

A. HPV status is collected for some sites due to the use of the HPV vaccine in preventative medicine. We have seen this with other SSF's collected in years past, such as HER 2 neu and the use of Herceptin.

Coding Factoids

Coding Factoids

- Coding of 988 vs 998 vs 999
- SSF required by Standard Setter
  DO NOT use 988
- 988 is used when SSF is not defined
- 988 is used when SSF is defined but is not required by the appropriate Standard Setter or by your institution

Coding Factoids

- Code 998 is utilized when your facility does not perform a particular test and you know the test was not done
- Clinical indicators show test not needed
- Physician statement of test not performed

Coding Factoids

- Code 999 when information is absent and your facility performs the test or has the ability to perform the test
- Code 999 if the Standard Setter does not require the data element, but your facility does and the information is absent
- www.cancerstaging.org for list of Standard Setter requirements

Coding Factoids

- In situ pathology of primary tumor with nodal or metastatic tumor
- Code the behavior to /3 not /2
- Do not code CS extension as in situ
- Code CS extension as Localized, NOS; if no better information is found
- Code nodes or mets as reflected in the pathology report

Coding Factoids

- Instructions state not to use the Multigene analysis results to code ER/PR. How does one code ER/PR with the following situation?

- ER/PR performed on pathologic specimen
- ER/PR performed on Multigene analysis
- The results from the two analysis are different. The patient is treated based on the results from the Multigene analysis.

Coding Factoids

- With Oncotype Dx, for example, the results are in units, not ng/ml. This means that the Oncotype results are not compatible with the standard ER/PR results that are performed in hospital laboratories. Therefore, ER/PR results from the Oncotype should not be used to document the SSF's.

  In this particular scenario, code the results from the pathology report even though the physician is treating the patient based on the results from the Oncotype report.

Coding Factoids

- A patient is diagnosed clinically with inflammatory breast ca. She does not have pre-operative chemotherapy. She undergoes a mastectomy.
- The operative report states the skin is involved. The pathology report shows no skin involvement.
- How should the CS TS/Ext eval field be coded?

Coding Factoids

- The CS/TS eval code should be coded as 3 based on the following three evidences in this case.
- A clinically diagnosed inflammatory breast cancer (AJCC v7 p354);
- Surgical resection (mastectomy) performed WITHOUT pre-surgical treatment;
- Utilizing information acquired before treatment (the clinical diagnosis), supplemented or modified by the additional evidence acquired during and from surgery (the op report), and finally the pathologic examination of the resected specimen (path report) provide the best code

Coding Factoids

- What is the proper way to code multiple Her 2 tests?
- According to guidelines by the American Society of Clinical Oncology, gene-amplification tests (in situ hybridization) are considered to be a more reliable test of the over-expression of the HER2 gene. Thus, if both an IHC and a gene-amplification test (FISH,CISH, etc.) were done, code the result of the gene-amplification test.
- If the gene-amplification test was given first and the result was borderline/equivocal and an IHC was done to clarify these equivocal results, code the result of the IHC.
- Source: Part I - Section 2 - Page 89 Version 02.03.

Coding Factoids

- What does one code if the same multiple HER 2 tests performed have multiple results?
- If you have multiple outcomes to the HER 2 tests performed, the general rule is to record any positive finding, as the managing physician will use the positive finding information in order to treat the patient.
- However, if the managing physician treats the patient based on the negative findings, code the negative outcome, as this is how he will determine treatment for the patient.

Coding Factoids

- HER 2 IHC test performed was negative, 1+.
- This was followed by multiple HER-2 FISH tests being performed:
- HER 2 (FISH) = 2.4, positive
  HER 2 (FISH) = 1.10, negative
  HER 2 (FISH) = 1.93, equivocal
- The managing physician considered this patient HER 2 negative.
- Code the results based on the managing physicians final determination of the results.

Coding Factoids

- A facility does not utilize specific types of tests that are coded as SSF's
  Examples:
  SSF 12 (CISH)
  SSF 13 (CISH)
  SSF 17 (CTC)
  SSF 18 (DTC)
  What would be the appropriate code for these cases?
  Code 988 - Not Applicable OR
  Code 998 - Test not done

Coding Factoids

- If a facility determines that a particular test is not performed on site, and it is also determined that the physician staff are not having the test performed by a reference lab or other outside source, you may use code 998 for test not done.
- One must investigate, at least annually, the availability of tests listed as SSF. Availability of lab test changes over time and it is possible that a test not offered today may be offered in the future.

Coding Factoids

- A biopsy of the breast shows a Nottingham score of 6. The lumpectomy shows a Nottingham score of 4. Do you take the higher score, or the score where the most tissue was resected?
- The grade plays a role in determining treatment and prognosis. It is important to have the highest score recorded even if it represents a small part of the tumor. The higher grade affects survival.

Coding Factoids

- If a lung cancer patient has a pleural effusion identified on imaging and that effusion is never examined cytopathologically, should it be considered M1a clinically if there is no physician statement regarding the effusion?
- If there is a pleural effusion on imaging that is never examined cytopathologically and not addressed by the managing physician, it should be considered M1a.

Coding Factoids

- If the physician states that the effusion is non-related but it was never cytopathologically examined do we take the physician statement over a general pleural effusion “NOS” code (M0 vs. M1a)?
- For the assignment of the mets at dx code, you would take the physician statement that it is non-related, even if the fluid was never examined. If the physician thought it was possibly due to tumor, making this M1a, there would be further tests and treatment discussions, especially in an otherwise low stage case. Pleural effusion can be due to many reasons, not just tumor related.

Coding Factoids

- Does the effusion in this lung cancer patient still need to be tapped twice and yield cytopathologically negative results both times to be considered non-related WITHOUT a physician statement?
- There has been no change to this rule. The effusion still needs to be tapped twice and cytopathologically negative both times to be considered non-related without a physician statement that it is non related.

Coding Factoids

- Lymph-vascular invasion may affect the patients prognosis.
- The primary sources of information about lymph-vascular invasion are the pathology check lists (synoptic reports) developed by the College of American Pathologists. If the case does not have a checklist or synoptic report, code from the pathology report or a physician's statement, in that order.
- Do not code perineural invasion in this field.
- Information to code this field can be taken from any specimen from the primary tumor.
- If lymph-vascular invasion is identified anywhere in the resected specimen, it should be coded as present.

Coding Factoids

- What is the proper code for a clinically palpable nodule found in the left lobe of the prostate with a needle biopsy showing adenocarcinoma in both lobes of prostate?
- Codes 200 to 240 are used only for clinically/radiographically apparent tumor/nodule/mass which is palpable or visible by imaging. To decide among codes 200-240, use only physical exam or imaging information, and not biopsy information.
- Prostate biopsy information is coded in CS Site-Specific Factor 14.
- CS Version 02.03, Part II Page 43.

Coding Factoids

- The terms nodularity or nodular in the prostate on clinical exam are synonymous with the word nodule.
- The current CS Ext rules for prostate state that "if a clinician documents a "tumor", "mass", or "nodule", this can be inferred as apparent disease. This is the case if the terms nodularity or nodular are used as well.
- This would be coded to CS ext 200-240 for clinically apparent disease.

Coding Factoids

- Gleason Tertiary Pattern Value is coded from the prostatectomy/autopsy.
- When a patient undergoes a radical prostatectomy, the pathologist may look for a third or tertiary pattern in the specimen. When Gleason pattern 5 is present as a tertiary pattern, its presence should be indicated in the pathology report, as a high Gleason pattern appears to be an indicator for worse outcome (shortened time to recurrence). Studies indicate that a Gleason score 7, with tertiary pattern 5, is associated with a worse prognosis than without tertiary pattern 5, and is similar to the prognosis for Gleason score 8 – 10.

Coding Factoids

- Example of tertiary pattern value in a prostatectomy case:
- The primary Gleason pattern is 3, the secondary is 4 (3+4) and there is less than 5% Gleason 5.
- The report should indicate a Gleason score of 7 (3+4) with tertiary Gleason pattern 5.

Coding Factoids

- What is the timing rule on PSA for SSF1 and SSF2?
- If there is a PSA before diagnosis, and a PSA after diagnosis and before first treatment, use the PSA before diagnosis;
  a. If there are 2 or more PSAs within 3 months before diagnosis, use the highest one;
  b. If there are 2 or more PSAs before diagnosis and the most recent two PSAs are more than 3 months apart, use the most recent one.

Coding Factoids

- Timing rule on PSA for SSF1 and SSF2 cont. –
- If only post-diagnosis but pre-treatment PSAs are available, use the earliest one, NOT the highest one to avoid recording a PSA reflecting disease progression, rather than the status at diagnosis.
- For patients under PSA-affecting medications (i.e., for BPH), if pre-medication PSAs are available, use the most recent pre-medication if that is not greater than 6 months before diagnosis.

Coding Factoids

- PSA interpretation has been clarified in CSv02.03.
- Per CSv02.03.02 manual, registrars are permitted to interpret PSA value based on normal range listed in the lab report.
  In the absence of a physician's interpretation of the test, if the reference range for the lab is listed on the test report, the registrar may use that information to assign the appropriate code.

Coding Factoids

- If a patient has multiple prostate needle biopsies, Gleason 4+3=7 and Gleason 3+5=8, in approximately the same number of cores for each score, should the most aggressive primary pattern or the highest score be coded?
- When you have multiple prostate needle biopsies, Gleason 4+3=7 and 3+5=8, you would enter the highest score.
- In this case SSF 7 would be 035, and SSF 8 would be 008.

Coding Factoids

- A prostate biopsy by TURP shows right side 3 cores; left side 2 cores. For SSF12, are these added together and entered as 5 or is the highest coded and entered as 3?
- In this case SSF12 would be coded as 5.
- If multiple needle core biopsy procedures are performed (within the timing rule), do not add the positive cores together from the separate procedures. Record the number of cores positive for cancer from the procedure with the highest number positive.

Coding Factoids

- The tumor markers that are utilized in the Testis schema are to be collected for pre-orchiectomy and post-orchiectomy.
- SSF's 6-10 are utilized for pre-orchiectomy lab values and/or range.
- SSF's 12-16 are utilized for post-orchiectomy lab values and/or range.
- This change occurred in CSv02.03.

Coding Factoids

- Percentage of Non-Endometrioid Cell Type in Mixed Histology Tumors (SSF7)
  - Corresponds to FIGO grade of endometrial cancer (growth pattern) and NOT FIGO stage as coded in SSF1
  - DO NOT translate a verbal grade (well, moderately)
  - DO NOT use grade coded in this field to code grade/differentiation field that is part of ICD-O

Coding Factoids

- Pathology report of a primary endometrial adenocarcinoma reads as histologic grade; FIGO grade 1of 3.
- This cannot be coded under SSF7 as 001, 5% or less of a non-squamous or non-morular solid growth pattern (Grade 1) unless the pathologist has indicated that he is referring to the growth pattern.
- If grade based on growth pattern is not specified, use code 999.

Coding Factoids

- Overview of lecture:
  - Not a one size fits all scenario
  - Focus must be given to each site individually
  - Some uniformity in coding structure
  - Look for synonymous meanings in terms
  - Read the notes provided with the site schema; there may be an exception to the rule listed
  - When in doubt….READ….READ….READ!

Coding Factoids

- Explanations and/or examples are given with many of the Site-Specific Factors and the coding rules.
- Review both Part I Section I and Part I Section II
- Frequent the CAnswer Forum
- www.cancerstaging.org

CAnswer Forum

- Submit questions to CS Forum
  - Located within the CAnswer Forum
  - Provides information for all
  - Allows tracking for educational purposes
  - Includes archives of Inquiry & Response System
- CS Forum: http://cancerbulletin.facs.org/forums/
- CS Web Site: www.cancerstaging.org/cstage

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