

Hematopoietic Coding Tips

New Note for Diagnostic Confirmation for cases diagnosed 2022+

Use **Code 3** "Positive histology PLUS positive immunophenotyping or genetic testing" for histologies:

Myelodysplastic Syndromes

Acute Leukemias of ambiguous lineage

Precursor Lymphoid Neoplasms

Acute Myeloid Leukemia and related Precursor Neoplasms



**Summary Stage 2018 and EOD Primary Tumor for Myeloma and Plasma Cell Disorders
EOD Primary Tumor**

Plasma cell myeloma/multiple myeloma (9732) is a widely disseminated plasma cell neoplasm, characterized by a single clone of plasma cells derived from B cells that grows in the bone marrow.

It is always coded to 700 for systemic involvement.

SEER Summary Stage 2018

Note 4: Lymphoplasmacytic lymphoma (9671) and Waldenstrom Macroglobulinemia (9761) are now collected with the plasma cell disorders. **These are systemic diseases and should always be coded 7.**

** [Summary Stage 2018: Myeloma and Plasma Cell Disorders | EOD Data SEER*RSA \(cancer.gov\)](#)

** NAACCR Hematopoietic and Lymphocytic Neoplasms Webinar

NCRA's Central Registry Badge Program

A new program designed to help hospital registrars understand the general operations and responsibilities of central registries. Earn six (6) CE hours upon successful completion of this program. The enrollment period for this activity is 180 days.

<http://www.cancerregistryeducation.org/products/1739/ncras-central-registry-badge-program>

NEWLY UPDATED!

2022 NJSCR Program Manual and 2022 Reportable List are posted!

Look at the NJSCR website for more information!

<https://www.state.nj.us/health/ces/reporting-entities/njscri/>

SEER SINQ Updated as of 05/27/2022

Question:

Should neoadjuvant chemotherapy be coded for an incidental second primary discovered at the time of surgery? If so, how is the diagnosis date coded?

The patient had neoadjuvant chemotherapy for rectal carcinoma. An AP resection revealed an incidental second primary intramucosal carcinoma in adenomatous polyp in the descending colon. Is the chemotherapy coded as therapy for the intramucosal carcinoma of the descending colon?

Answer:

Record the neoadjuvant therapy only for the first primary and do not record the neoadjuvant therapy for the incidental new primary found on surgery.

History:

Answer for cases diagnosed prior to 2022

The neoadjuvant chemotherapy is recorded for both primaries. For the second primary, code the actual diagnosis date and use the date of diagnosis as the date of systemic therapy.

** <https://seer.cancer.gov/seer-inquiry/inquiry-detail/20110088/>

Lymph Node Coding Tips

Date of First Surgical Procedure for 2021+ for FNA/Biopsy of Regional Lymph Node



Record the date of the first/earliest surgery if Surgery of Primary Site, Sentinel Lymph Node Biopsy, Scope of Regional Lymph Node Surgery (**excluding cases coded to 1**), or Surgical Procedure of Other Site was recorded as part of the first course of therapy.

Scope of Reg LN Surg Code 1 (Biopsy or aspiration of regional lymph node, NOS) **is not considered treatment**.

If surgery was not performed, then RX Date surgery Flag must =11. Surgery is considered “not performed”.

Do not code surgery to distant lymph nodes in scope of regional lymph node surgery.



Coding Sentinel Lymph Nodes Positive for Breast ONLY

Use **code 97** in this data item and record the total number of positive regional lymph nodes biopsied/dissected (both sentinel and regional) in Regional Nodes Positive (NAACCR Item #820) **when a sentinel lymph node biopsy is performed during the same procedure as the regional node dissection**

** <https://seer.cancer.gov/tools/codingmanuals/> SEER Program Coding and Staging Manual 2022

Race abbreviations in Text!

Abbreviations can generate confusion, as they may vary among different institutions and different specialties. Because abbreviations should be understood by any reader, only those that are clear and precise should be used.

Follow NAACCR approved abbreviation list when including text.
<http://datadictionary.naaccr.org/default.aspx?c=17&Version=22>

Do not make up abbreviations to describe race.

If no abbreviation can be found on list, **provide fully texted word**. Text is used to confirm the codes provided within your abstract.

Radiation Updates for 2021+

If primary site in pelvic region is surgically removed, **code to primary site**.

When intracavitary HDR brachytherapy is administered to the vaginal cuff for endometrial cancer or cervical cancer, post therapy, primary treatment volume is Vagina.

**NAACCR Webinar: Treatment 2021

Timing Guidelines for PSA

- Record the last pre-diagnosis PSA lab value prior to diagnostic biopsy of prostate and initiation of treatment
- All lab values must be done no earlier than approximately three months before diagnosis
- Example-
12/5/19 PSA: 44.8
3/2/20 PSA: 42.2
5/5/20 biopsy: +adenocarcinoma
 SSDI PSA= **42.2**

[ps://www.naaccr.org/wp-content/uploads/2021/09/SSDI-Manual_v-2.1-2022.pdf?v=1652909128](https://www.naaccr.org/wp-content/uploads/2021/09/SSDI-Manual_v-2.1-2022.pdf?v=1652909128)

Description:
 35-year-old white female
Proper Text:
 35 YO WF or W/F

Description:
 77-year-old Asian Indian Female
Proper Text:
 77 Y/O Asian Indian Female

Description:
 26-year-old American Indian Male
Proper Text:
 26 YO American Indian Male

Description:
 96-year-old Black Male
Proper Text:
 96 YO BM or B/M

Reasoning:
 No approved abbreviations available for Asian Indian

Reasoning:
 No approved abbreviations available for American Indian

Solid Tumor Rules Changes for 2022 highlights

Colon Solid Tumor Rules

Timing changes to rules M7 and M8:

The timing for subsequent tumors at the anastomosis has changed from 24 months to 36 months.
The change is effective for cases diagnosed beginning 1/1/2022 forward.
For cases diagnosed 1/1/2018 through 12/31/2021, the timing rule remains at 24 months.

Low grade appendiceal neoplasm (LAMN) will become reportable effective for cases diagnosed 1/1/2022 forward.

LAMN may be either in situ 8480/2 or malignant 8480/3 based on physician statement of behavior.
LAMN diagnosed prior to 1/1/2022 are not reportable

Head and Neck Solid Tumor Rules

Cases diagnosed 1/1/2022 forward:

Beginning with cases diagnosed 1/1/2022 forward, **p16 test results can be used to code:**
Squamous cell carcinoma, HPV positive (8085) and Squamous cell carcinoma, HPV negative (8086)

For more information on STR changes, see the SEER Site Specific Modules page

****<https://seer.cancer.gov/tools/solidtumor/revisions.html>**

Common coding issues found on EOD Primary Tumor for Testis Primary

Pay close attention to the extension found on the orchiectomy.

Code 100

Pathologic assessment Only. For Pure Seminomas Only: Tumor **less than 3cm**, limited to the testis **Without** LVI or **unknown** LVI

Code 150

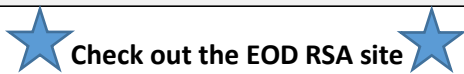
Pathologic assessment only. For pure seminomas only. Tumor **greater than or equal to 3 cm**, limited to the testis **WITHOUT** LVI or **unknown** if LVI

Code 300

Pathological assessment only. Tumor limited to testis (including rete testis invasion) **WITH lymphovascular invasion**

Code 400

Pathological assessment only
Epididymis, **Hilar soft tissue**, Mediastinum (of testis),
Visceral mesothelial layer



to see the other available EOD Primary Tumor codes for Testis

****[https://staging.seer.cancer.gov/eod_public/input/2.1/testis/eod_primary_tumor/?breadcrumbs=\(~schema_list~\),\(~view_schema~,~testis~\)](https://staging.seer.cancer.gov/eod_public/input/2.1/testis/eod_primary_tumor/?breadcrumbs=(~schema_list~),(~view_schema~,~testis~))**

Common coding issues found on Surgery codes for Testis Primary

When coding the surgery, make sure you use the most specific information from the Operative Report.

Code 40 Excision of testicle with cord or cord not mentioned (Radical Orchiectomy)

Code 80 Orchiectomy, NOS (unspecified whether partial or total testicle removed)

****<https://seer.cancer.gov/manuals/2022/appendix.html>**
Select Testis, Surgery codes

Exciting News!

NJSCR is updating the Program Manual and Reportable List for 2022!

Anticipated completion is June 2022.
Hospital Registrars feel free to reach out to your representative with questions.

Curious how cancer registry data items are created?

Check out the NAACCR's poster found in the Journal of Registry Management
<https://www.ncra-usa.org/About/Publications/Journal-of-Registry-Management>

A Standard is Born:
An Inside Look at How Cancer Registry Data Items are Made and Modified



Coding Pathologic Grade

The grade from **clinical work up** from the primary tumor can be used for **grade pathologic** in different scenarios based on behavior or surgical resection:

Behavior	Surgical Resection	No Surgical Resection
Tumor behavior for the clinical and the pathological diagnoses are the same AND the clinical grade is the highest grade. Tumor behavior for clinical diagnosis is invasive, and the tumor behavior for the pathological diagnosis is in situ.	Surgical resection is done of the primary tumor and there is no grade documented from the surgical resection. Surgical resection is done of the primary tumor and there is no residual cancer.	Surgical resection of the primary tumor has not been done, but there is positive confirmation of distant metastases during the clinical time frame.

**https://www.naacrr.org/wp-content/uploads/2021/08/Grade-Manual_v-2.1-2022.pdf?v=1641497051

Question:

Summary Stage 2018/Extension--Prostate:
 Can imaging be used to code SEER Summary Stage 2018? MRI shows tumor involved the seminal vesicles and the patient did not have surgery. AJCC does not use imaging to clinically TNM stage a prostate case.

Answer:

Per Note 5 of the 2018 SEER Summary Stage Prostate chapter: Imaging is not used to determine the clinical extension unless the physician clearly incorporates imaging findings into their evaluation. This note was added to be in line with how AJCC stages; therefore, AJCC and Summary Stage agree. **Do not use the MRI findings when that is all you have, and the physician does not document agreement with the MRI.**

**https://seer.cancer.gov/seer-inquiry/inquiry-detail/20190030/?cancer_site_category.raw=Prostate

★ **Effective for Cases Diagnosed 01/01/2022** ★

Do not accession a case based ONLY on suspicious cytology. Accession the case when a reportable diagnosis is confirmed later.

★ **The date of diagnosis is the date of the suspicious cytology.** ★

*This is a change to previous instructions.
 The date of a suspicious cytology may be used as the date of diagnosis
 when a definitive diagnosis follows the suspicious cytology.
 See Date of Diagnosis for more information.*

Note: "Suspicious cytology" means any cytology report diagnosis that uses an ambiguous term, including ambiguous terms that are listed as reportable in this manual.

Cytology refers to the microscopic examination of cells in body fluids obtained from aspirations, washings, scrapings, and smears; usually a function of the pathology department.

**https://seer.cancer.gov/manuals/2022/SPCSM_2022_MainDoc.pdf

Updated SSDI PSA (Prostatic Specific Antigen) Lab Value

2 new codes have been added for the PSA Lab Value SSDI.

- **XXX.2** Lab value not available, physician states PSA is negative/normal
- **XXX.3** Lab value not available, physician states PSA is positive/elevated/high

A known lab value takes priority over codes XXX.2 and XXX.3

The **lab value takes priority** even if the physician documents the interpretation.

Example: Patient noted to have a PSA of 7.6. Physician notes that the value is elevated
 Code 7.6 instead of XXX.3 (elevated)

**[https://staging.seer.cancer.gov/eod_public/schema/2.1/prostate/?breadcrumbs=\(~schema_list~\)](https://staging.seer.cancer.gov/eod_public/schema/2.1/prostate/?breadcrumbs=(~schema_list~))

Clarification for Coding Liver Fibrosis Score

Note 6: Use code 7 if there is a clinical diagnosis (no microscopic confirmation) of severe fibrosis or cirrhosis.

➔ Physician statement of cirrhosis can be used.

**[https://staging.seer.cancer.gov/eod_public/input/2.1/liver/fibrosis_score/?breadcrumbs=\(~schema_list~\),\(~view_schema~,~liver~\)](https://staging.seer.cancer.gov/eod_public/input/2.1/liver/fibrosis_score/?breadcrumbs=(~schema_list~),(~view_schema~,~liver~))

**<https://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/101713-cirrhosis-nos-for-liver-primary>

**Tips for Coding Primary Site:
 Bladder**

C67.8 Bladder, overlapping lesion

Single tumor (any histology) that overlaps subsites in bladder **OR**

Single or discontinuous tumors which are urothelial CA in situ (8120/2) AND ONLY bladder and 1 or both ureters are involved

C67.9 Bladder, NOS

Multiple non-contiguous tumors within bladder and subsite not documented

C68.8 Overlapping lesions of urinary organs

Single tumor overlaps 2 urinary sites and site of origin unknown (Renal pelvis C68.8 and ureter; bladder and urethra; bladder & ureter*)

C68.9 Urinary system, NOS

Multiple discontinuous tumors in multiple organs within urinary system C68.9 (Renal pelvis and ureter; bladder and urethra; bladder & ureter*)

* See C67.8 for 8120/2 when only bladder and ureter(s) are involved

**NAACCR Cancer Surveillance 2021-2022 Webinar Series: Bladder 2021

**https://seer.cancer.gov/tools/solidtumor/STM_2018.pdf

Radiation Coding Information and Tips

- “Whole Pelvis” implies RT to primary site or tumor bed and regional lymph nodes.
- “Vagina cuff” implies intracavitary brachytherapy.
- If dose/fraction and total dose is provided in Gy or cGy units for any brachytherapy procedure, capture this information in your abstract. **Do not use codes 99998 or 99999 if this information is found in treatment summary!**
- If brachytherapy is only mode of treatment and dose is not provided in cGy, code to 999999 for total dose.
- You cannot, add dose from EBRT phase to that of brachytherapy phase to get total dose!

** GYN Guidelines for Coding EBRT & Brachytherapy Treatments by Wilson Apollo, MS, CTR, RTT WHA Consulting
NAACCR 2021-2022 Webinar Series Uterus 2021

Question:

Cirrhosis, NOS for Liver Primary

Fibrosis Score - SSDI manual states: Use Code 7 for Clinical statement of advanced/severe fibrosis or cirrhosis, AND not histologically confirmed or unknown if histologically confirmed.

Does the cirrhosis also have to be "advanced/severe"?

Is it:

Advanced/severe fibrosis OR

Cirrhosis, NOS

Or is it

Advanced/severe: fibrosis or cirrhosis

Answer:

Cirrhosis, NOS can only be used when it is microscopically confirmed (see code 1).

For a clinical diagnosis only (no microscopic confirmation), it must state advanced/severe fibrosis or cirrhosis.

If the only information you have is Cirrhosis, NOS based on clinical evaluation, then you can't use code 7 and would have to code 9.

Per code 7, it must state "advanced/severe fibrosis or (advanced/severe) cirrhosis" on an imaging report to code 7. A statement of Cirrhosis only (or Cirrhosis, NOS) is not enough to code 7.

** <https://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/101713-cirrhosis-nos-for-liver-primary>

Check out the NJSCR Website

Updated Reportable list, current and previous Etips can be found on the NJSCR website.

<https://www.state.nj.us/health/ces/reporting-entities/registrars/>

Registry Resources

- [2021 NJSCR Program Manual](#)
- [Cancer Registry Statute \(New Updated 2018\)](#)
- [Reportable List, Word Format \(NEW updated 2021\)](#)
- [Reportable List, PDF Format \(NEW updated 2021\)](#)
- [SEER ICD-10-CM Case Finding List](#)

E-Tips

- [Current 2021 E-Tips: Helpful tips from the NJSCR](#)
- [2020 E-Tips](#)
- [2019 E-Tips](#)

★ Hospital Registrars!

The reporting deadline for 2021 cases remains July 1.

Facilities should look to have at least 50% of their cases reported by the end of January 2022.

Make sure to let your NJSCR Representative know if you have had any personnel changes.