

**Participate in NAACCR’s Field Testing for new SSDI’s**

**This is your chance to comment on data items prior to implementation.**

The Field Testing will be implemented using the same software used for the SEER Reliability Studies, with some modifications. **Participation in the Field Testing will not be required by any of the standard setters but is strongly encouraged.**

There are **three new SSDIs and a proposed update to an existing data item** that are being proposed for implementation in 2023.

*The earliest these would be developed into SSDIs if found to be readily available in the cancer registry community would be 2024. They would have to go through the 2022 Field Testing for “Feasibility testing” first to evaluate the codes and coding instructions.*

**Continuing Educate (CE) credits will be available.**



The field testing will take place from 8 a.m. EDT, **November 1, 2021** to 12:00 a.m. EDT, **December 15, 2021**. Participants must have access to the SEER reliability studies site (<https://reliability.seer.cancer.gov>) during this period.

**Registration for Field Testing will open on October 15, 2021**

The objective of this field testing are to determine how well the new data items are understood or if they are available, **individual results will remain confidential** and not released. Results will be de-identified before analysis.

**Question:**

**Update to Current Manual/Neoadjuvant Treatment:**  
 What codes should be used for Neoadjuvant Therapy--Clinical Response and Neoadjuvant Therapy--Treatment Effect when the neoadjuvant therapy is still in progress at the time the case is initially abstracted as with rapid reporting. There is no code for neoadjuvant therapy still in progress and code 9 generates an edit for Neoadjuvant Therapy--Clinical Response.

**Answer:**

Assign code 8 for Neoadjuvant Therapy--Clinical Response and assign a code 9 for Neoadjuvant Therapy--Treatment Effect when the treatment is still in progress. Revise these codes after the treatment has been completed.  
 We will update the manual to include these instructions.

\*\* <https://seer.cancer.gov/seer-inquiry/inquiry-detail/20210045/>

**Tips for Coding Date of Diagnosis**

Code the **month, day, and year** the tumor was first diagnosed, clinically or microscopically, by a recognized medical practitioner.

When the first diagnosis includes reportable ambiguous terminology, record the date of that diagnosis.

**Exception: Do not use the date of diagnosis from a cytology report using ambiguous terminology.** Ambiguous cytology is not diagnostic of cancer. **Use the date of clinical, histologic, or positive cytologic confirmation as the date of diagnosis.**

“Ambiguous” cytology means that the diagnosis is preceded by an ambiguous term such as apparently, appears, compatible with, etc.

Do not use ambiguous cytology alone for case ascertainment.

Positive tumor markers alone are not diagnostic of cancer.

If **no information** about the date of diagnosis is available:

- i. Use the date of admission as the date of diagnosis
- ii. In the absence of an admission date, code the date of first treatment as the date of diagnosis

\*\* SEER Program Coding and Staging Manual 2021  
[https://seer.cancer.gov/manuals/2021/SPCSM\\_2021\\_MainDoc.pdf](https://seer.cancer.gov/manuals/2021/SPCSM_2021_MainDoc.pdf)

**Casefinding Sources**

In 2016-2019, NJSCR conducted 101 audits that identified 10,546 cases (reporting years 2014-2017). The remote process the central registry used to perform these audits was shared in the article, "Remote Auditing of Reporting Facilities by the Central Registry: Challenging but Rewarding" (Fall 2020 Journal of Registry Management (Vol. 47, No. 3, pg. 146) According to the program standards set forth by CDC's National Program of Cancer Registries (NPCR), a facility must be audited at least once every 5 years.

Audits can identify potential casefinding opportunities that can be used to insure greater reporting completeness for a facility. Registrars are encouraged to review these locations for reportable cases:

- Oncology Consults
- Radiology-MRI/scans/iodine therapy/radiation treatments
- Verify e-path settings and output are correct and using updated reportable lists
- Pathology reports: be familiar with the terminology being used by your pathologist. For example:
  - **Gross examination** means the size, shape, weight, and the primary sight of the specimen, etc. This exam does not diagnose the specimen as to whether it is reportable or not.
  - **Microscopic examination** means the facility examines a specific specimen to determine whether the specimen is normal, abnormal, benign, or malignant. The results of this pathology exam does determine reportability by that facility.
- Both analytic and non-analytic cases must be reported to NJSCR
- Automated H&P searches
- Death Certificates/Autopsies
- Review and confirm number of cases submitted on confirmation emails sent from NJSCR
- Review possible gaps in accession numbers, especially when a grouping of cases from any particular year is found missing. (A potential missed transmission).
- Conversions or a transition to new software can effect what is newly available or could be lost
- **Update ICD-10-CM codes each year** when using for casefinding Disease Index reports: use this link: <https://seer.cancer.gov/tools/casefinding/>

\*\*NJSCR Audit Team

**2022 SEER Program Coding Manual**

The 2022 version of the SEER Program Coding Manual is available on the SEER website, <https://seer.cancer.gov/tools/coding/manuals/2022manual.html>

This manual applies to cases diagnosed January 1, 2022 and later. **Continue using the 2021 manual for cases diagnosed through December 31, 2021.**

**Check out the change log for updates!**

A comprehensive change log is available here [https://seer.cancer.gov/manuals/2022/SPCSM\\_2022\\_Changelog.pdf](https://seer.cancer.gov/manuals/2022/SPCSM_2022_Changelog.pdf)

**Hospital Registrars!** ★

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

**Breslow Thickness Coding**

Initial biopsy showed melanoma Breslow thickness 0.5mm. This was followed up with a reexcision. The reexcision showed melanoma Breslow thickness at least 0.9mm.

**Question:**

**Which code would I use for Breslow thickness? 0.5mm or A0.9**

**Answer:**

This is a slight conundrum, because the rules are somewhat conflicting, as you have discovered. Also, depending on which one you use, you end up with a different T value if you are doing AJCC staging.

**In this situation, go with the A0.9, even though it's preceded by "at least."**

\*\* <https://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/119661-breslows-thickness-coding#post119699>

**Question:**

Neoadjuvant treatment: How are the 2021 neoadjuvant therapy fields coded when neoadjuvant therapy and surgery were part of first course plans, but treatment was never completed?

**Example:** Breast case where first course treatment plan is neoadjuvant therapy and surgery after. The patient was hospitalized during neoadjuvant therapy, elected hospice, and later died, so the neoadjuvant therapy was never completed, surgery not done. **How are the 2021 neoadjuvant therapy fields coded in this situation as neoadjuvant therapy and surgery were part of first course plans?** I coded neoadjuvant therapy to 2 - started but not completed, but there are no codes to properly explain the clinical response and therapy treatment effect as the patient did not complete neoadjuvant therapy. Should I use code 9 for clinical response and treatment effect, or should this be left blank for this particular case?

**Answer:**

**Assign code 8 for Neoadjuvant Therapy--Clinical Response.** We will update the SEER manual to allow code 2, in addition to code 1, in Neoadjuvant therapy when Clinical Response is coded 8. We will also add instructions covering a case such as this one.

**Assign code 7 for Neoadjuvant Therapy--Treatment Effect** and use text fields to record the details. We will add instructions to the manual for this scenario.

\*\*<https://seer.cancer.gov/seerinqury/index.php?page=view&id=20210038&type=g>

**Congratulations Registrars!**

The New Jersey State Cancer Registry has been awarded the Registry of Distinction award by the Center for Disease Control and Prevention (CDC) and National Program for Cancer Registries (NPCR). This achievement indicates that the New Jersey State Cancer Registry met the CDC NPCR National Data Completeness and Quality Standard.

**NJSOCR recognizes this achievement would not have been possible without the hard work and dedication of all the registrars of New Jersey. thank you for your continued commitment to providing high quality cancer data.**



**2022 Changes Released August 11, 2021**

Diagnostic confirmation section of the manual updated to indicate which histologies have a default code of 3 (histology plus immunophenotyping/genetics), those that should never have a code 3.

The Hematopoietic database has a new field called "Diagnostic Confirmation." Information for each /3 histology has information about diagnostic confirmation added.

For 9896/3: Alternate name "AML with recurrent genetic abnormalities, NOS" was removed from this code and was moved to 9861/3. a. Due to questions received about a case presented at NCRA and then consultation with a Hematopoietic expert, it was determined that this alternate name was incorrectly placed in code 9896/3 and the appropriate place for this **alternate name was in 9861/3.**

Additional information added in 9861/3 about the "AML with recurrent genetics abnormalities" group. 5. For 9811/3, the more specific B-cell lymphoma/leukemias were added as a reference.

For 9811/3, the more specific B-cell lymphoma/leukemias were added as a reference.

\*\* [Revision History for the Hematopoietic Project - SEER Registrars \(cancer.gov\)](#)

**Question:**

**Breast:** Should Extent of Disease (EOD) Regional Nodes be coded as **150** (Clinical assessment only; Positive needle core biopsy/fine needle aspirate [FNA]) when the patient has a biopsy-proven, clinically apparent, movable ipsilateral axillary lymph node, but no evidence of involvement at surgery after neoadjuvant therapy?

**Answer:**

The clinical assessment code takes priority over the pathological assessment code in this case because the clinical assessment was worse than the pathologic assessment. Although there was a pathological assessment, the clinical assessment is greater. According to the general coding guidelines for neoadjuvant therapy, **code the worst information, which in this case is the clinical assessment.**

The 2018 EOD General Instructions for EOD Regionals Nodes, instruction #4, addresses neoadjuvant therapy as follows. Neoadjuvant (preoperative) therapy: If the patient receives neoadjuvant (preoperative) systemic therapy (chemotherapy, immunotherapy) or radiation therapy, code the clinical information if that is the most extensive lymph node involvement documented.

A new note is being included for the 2022 updates. Exception: **If patient has neoadjuvant therapy, and the clinical assessment is greater than the pathological assessment, the clinical assessment code takes priority.** ←

\* <https://seer.cancer.gov/seerquery/index.php?page=view&id=20210021&type=q>


**Coding Estrogen Receptor (ER), Progesterone Receptor (PR) Summary, and Her2 Overall for Breast**

Physician statement of ER/PR/Her2 Overall Summary status can be used when no other information is available.

Record the result of the ER/PR/Her2 Overall Summary results performed on the primary breast tissue.

Results from nodal or metastatic tissue may be used **ONLY** when there is no evidence of primary tumor.

Record the results from tumor specimens prior to neoadjuvant therapy unless there is no assay performed prior to neoadjuvant treatment.

 **Do not record the ER/PR/Her2 Overall results from a multigene test in this field.**

\* ETC Training 2021 NPCR SSDI Webinar

**Terms That are Not Equivalent**

- Component ≠ subtype/variant  
 Component only coded when a pathologist specifies the component is a second carcinoma
- IHC P16 positive ≠ HPV positive
- IHC P16 negative ≠ HPV negative
- Phenotype ≠ subtype/type/variant
- Squamous Cell Carcinoma with prominent keratinization 8070 ≠ Keratinizing Squamous Cell Carcinoma 8071
- Salivary Gland Adenocarcinoma 8140 ≠ Salivary Duct Carcinoma 8500

**\*NAACCR 2020-2021 Webinar Series Larynx 2021**

NAACCR Webinars are available for **free** on NJSCR's FLccSC Education platform.

**Register today!!!**

[https://njs.fcdslms.med.miami.edu/ords/f?p=105:LOGIN\\_DESKTOP](https://njs.fcdslms.med.miami.edu/ords/f?p=105:LOGIN_DESKTOP)

**SEER Cytology Reporting Rules and Examples**

Do **not** accession a case based **ONLY on suspicious cytology**. Follow back on cytology diagnoses using ambiguous terminology is strongly recommended. Accession the case when a reportable diagnosis is confirmed later. The date of diagnosis is the **date of the later confirmation** in this situation.

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

**Not Reportable Examples:**  
 Urine cytology **consistent with** urothelial cell carcinoma  
 Lymph Node FNA **suspicious** of malignancy

Important: Accession cases with cytology diagnoses that are **positive for malignant cells**.  
**Urine cytology positive for malignancy is reportable**. Code the primary site to C689 in the absence of any other information.

\* [https://seer.cancer.gov/manuals/2021/SPCSM\\_2021\\_MainDoc.pdf](https://seer.cancer.gov/manuals/2021/SPCSM_2021_MainDoc.pdf)

\* NAACCR Bootcamp 2021 Webinar Series

**Question:**

**Endometrium: Is endometrial hyperplasia with atypia equivalent to atypical hyperplasia of the endometrium (8380/2) and thus reportable?**

**Answer:**

Endometrial hyperplasia with atypia is equivalent to atypical hyperplasia of the endometrium (8380/2) and **thus reportable for cases diagnosed 2021 and later**. Our expert pathologist consultant confirmed this for us.

\* <https://seer.cancer.gov/seer inquiry/index.php?page=view&id=20210034&type=q>

**Question:**

**Is Lymphatic Space Invasion considered a synonym for Lymph Vascular Invasion?**

**Answer:**

Per Part I, Section I, pg. 82 (under coding guidelines for v0204), **Lymphatic invasion is a synonym for LVI, so lymphatic space invasion would be also be included.**

\* <https://cancerbulletin.facs.org/forums/forum/collaborative-stage/coding-instructions-part-1/part-1-section-1/3255-lymph-vascular-invasion>

**Date of Diagnosis Tips**

Year of diagnosis **cannot be blank or unknown** for cases transmitted to SEER.

Use whatever information is available to calculate the month of diagnosis.

**Example 1:** Admitted October 2021. History states that the patient was diagnosed 7 months ago. Subtract 7 from the month of admission and code date of diagnosis to March 2021. SEER Program Coding and Staging Manual 2021 Section IV: Description of this Neoplasm page 83.

**Example 2:** Outpatient bone scan done January 2021 that states history of prostate cancer. The physician says the patient was diagnosed in 2021. Assume bone scan was part of initial work-up and code date of diagnosis to January 2021.

**Leave month and/or day blank (or convert 99 to blank) if there is no basis for approximation for the month and/or day.**

\* [https://seer.cancer.gov/manuals/2021/SPCSM\\_2021\\_MainDoc.pdf](https://seer.cancer.gov/manuals/2021/SPCSM_2021_MainDoc.pdf)

\* NAACCR Bootcamp 2021 Webinar Series

## May 2021 E-Tips

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

The **NJSCR External QI team** in conjunction with SEER QIE (Quality Improvement Experts Group) recently completed two data reviews:

- 1) 2018 Prostate Grade Data Review
- 2) Discrepant Surgery Related Data Items 2016-2017 Carcinoma of the Colon/Rectum and Non-small Cell Carcinoma of the Lung.

### Some tips for improved data quality:

- A TURP qualifies for Grade Clinical only for prostate cancer cases.
- Grade E can be assigned if Gleason score 7 is documented with no Gleason patterns documented or any Gleason patterns combination equal to 7 not specified as 3+4 or 4+3.

In order to determine a primary site's regional and/or distant lymph nodes, the following references should be reviewed:

- Pre 2018 diagnosis years: Applicable AJCC Staging manual or Collaborative Staging (CS) manual (2004-2015).
- For diagnosis year 2018 forward: the applicable AJCC staging manual or Extent of Disease (EOD) 2018.

The SEER Program Manual (Surgical Procedure Other Site, Code 3) and SEER SINQ questions 20170078 and 20010091 should be reviewed for additional information on the proper coding of a biopsy of a distant lymph node or excision of a distant lymph node.


- <https://seer.cancer.gov/tools/codingmanuals/index.html>
- <https://seer.cancer.gov/seer inquiry/index.php>



### Coding Neoadjuvant Therapy (NAACCR Item #1632)

**Code 0** when No neoadjuvant therapy, no treatment before surgery, surgical resection not part of first course of treatment plan, autopsy only.

**Code 1** when Neoadjuvant therapy completed according to treatment plan and guidelines.

 **As long as the planned first course of treatment was neoadjuvant therapy followed by surgical resection, it does not matter if the surgical resection was done for this data item.**

**Code 2** when Neoadjuvant therapy started, but not completed OR unknown if completed.

**Code 3** when Limited systemic exposure when the intent was not neoadjuvant; treatment did not meet the definition of neoadjuvant therapy.

**Example:** Patients receive some type of therapy prior to surgical resection, but not enough to qualify for a full course of neoadjuvant therapy.

**Code 9** should **rarely** be used. Unknown if neoadjuvant therapy performed or DCO.

\*\*Treatment 2020 NAACCR 2020-2021 Webinar Series

### Grade Tips for Breast Primary

#### **Priority order for codes:**

Invasive cancers: codes 1-3 take priority over A-D.

In situ cancers: codes L, M, H take priority over A-D

Assign the **highest grade from the primary tumor**. If the clinical grade is the highest grade identified, use the grade that was identified during the clinical time frame for both the clinical grade and the pathological grade.

\*\* [Grade Manual](#)

### Intramucosal Carcinoma of Colon

Intramucosal carcinoma of the colon is assigned **behavior code of /3**. Intramucosal is not the same as in situ in terms of behavior. Behavior and staging are separate concepts, although there is some overlap. Use the instructions for coding behavior to code this field. Do not use stage to determine behavior in this case.



**For purposes of SEER Summary Stage, intramucosal carcinoma is a localized lesion. For purposes of AJCC staging, assign Tis for the stage.**

\*\* SEER Inquiry System Question: 20210006

[SEER Ask A Registrar](#)

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

## April 2021 E-Tips

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

### NCI SRP Releases Latest SEER Data and Statistics

NCI's Surveillance Research Program released SEER's latest data and statistics on April 15, 2021. The [SEER website](#) now has updates based on the November 2020 SEER submission.

This includes: [SEER Incidence Data, 1975-2018](#) [Cancer Stat Fact Sheets](#)  
[The Cancer Query System](#) [SEER\\*Explorer](#)  
[Cancer Statistics Review \(CSR\), 1975-2018](#)

The Surveillance Research Program [website](#) has also been updated to reflect the new statistics, including:

- New versions of Joinpoint and DevCan software

Since the early 1970s, the Surveillance, Epidemiology, and End Results (SEER) Program has been an invaluable resource for statistics on cancer in the United States, tracking and reporting trends in incidence, mortality, survival, and prevalence. SEER is supported by the Surveillance Research Program (SRP) in NCI's Division of Cancer Control and Population Sciences (DCCPS). Researchers at NCI and around the country continue to rely on SEER for the most accurate cancer statistics.

\* [https://seer.cancer.gov/csr/1975\\_2018/](https://seer.cancer.gov/csr/1975_2018/)

### 2021 Reportability Updates

**Are Anal intraepithelial neoplasia (AIN) II-III, AIN II/III; Vaginal intraepithelial neoplasia (VAIN) II-III, VAIN II/III reportable?**

Intraepithelial neoplasia (8077/2 and 8148/2) must be unequivocally stated as Grade III to be reportable.

**Are Breast cases designated BIRADS 4, 4A, 4B, 4C or BIRADS 5 without any additional information reportable?**


The American College of Radiology defines Category 4 as "Suspicious." **The descriptions in categories 4, 4a, 4b, and 4c are not diagnostic of malignancy.** They all represent a percentage of likelihood, the highest being 4c which is greater than 50% but less than 95% likelihood of malignancy. The ACR states "This category is reserved for findings that do not have the classic appearance of malignancy but are sufficiently suspicious to justify a recommendation for biopsy."

Category 5 is "Highly Suggestive of Malignancy." "Suggestive" is not reportable ambiguous terminology. **ACR states that Category 5 has a "very high probability" of malignancy, but again, it is not diagnostic.**

**HGSIL or HSIL, CIS, and AIN III arising in perianal skin are not reportable.**

\*SEER Appendix E <https://seer.cancer.gov/tools/codingmanuals/>

### **2021 SEER Advanced Topics for Registry Professionals Workshop: June 1-2, 2021**

The 2021 SEER Advanced Topics for Registry Professionals Workshop will be held virtually on June 1 and June 2 and is **open to all cancer registrars**. For more information and registration, follow this link: [conta.cc/2PhkO9V](https://conta.cc/2PhkO9V) 

SEER Workshop attendees are **strongly** encouraged to complete the workshop cases found on SEER\*Educate prior to the workshop. See the attached PDF for more information. Cases may be completed even if you are unable to attend the workshop.

**NJSCR follows all SEER Reporting guidelines.**

**New educational material on FLccSC!**

NAACCR Webinars are available for **free** on NJSCR's FLccSC Education platform.

**Register today!!!**

[https://njs.fcdslms.med.miami.edu/ords/f?p=105:LOGIN\\_DESKTOP](https://njs.fcdslms.med.miami.edu/ords/f?p=105:LOGIN_DESKTOP)

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

## March 2021 E-Tips

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

### NCCN guidelines: Coronavirus Disease 2019 (COVID-19) Resources for the Cancer Care Community

"A COVID-19 Vaccine Committee including top hematology and oncology experts with particular expertise in infectious diseases, vaccination development, medical ethics, and health information technology. This committee has established recommendations that can help cancer care providers make informed decisions on how to protect their patients from the ongoing COVID-19 pandemic, based on available evidence plus expert consensus."

Check out the Recommendations here

[https://www.nccn.org/covid-19/pdf/COVID-19\\_Vaccination\\_Guidance\\_V2.0.pdf](https://www.nccn.org/covid-19/pdf/COVID-19_Vaccination_Guidance_V2.0.pdf)

Review <https://www.nccn.org/covid-19/> for updated Treatment Guidelines, and information on Cancer and the COVID Vaccine.

#### Coding Mets at Diagnosis- OTHER NAACCR Item # 1117

Distant (discontinuous) metastases in any site(s) other than bone, brain, liver, lung, or distant lymph node(s).

**Code 1** Includes, but not limited to, the adrenal gland, bone marrow, **pleura, malignant pleural effusion, peritoneum**, and skin.

Malignant pleural effusion and metastases to the pleura are **not coded as 1 in Mets at Diagnosis- Lung #1116**.

\*[https://seer.cancer.gov/manuals/2021/SPCSM\\_2021\\_MainDoc.pdf](https://seer.cancer.gov/manuals/2021/SPCSM_2021_MainDoc.pdf)

#### CoC Standard 6.5 Follow Up on Patients

##### Major Change in Registry Follow-up

**- 1988 to 2004 information no longer required**

You will no longer be required to collect follow-up information for cases diagnosed between **1988 to 2004** effective immediately.

For all eligible cases, an 80 percent follow up rate is maintained **from 2004** or the cancer registry reference date, whichever is shorter.

A 90 percent follow up rate is maintained for all eligible analytic cases diagnosed within the last five years or from the cancer registry reference date, whichever is shorter.

For more information on CoC Standards and changes

<https://www.facs.org/quality-programs/cancer/coc/standards/2020>

#### Question

Is the histology for a serous carcinoma, high-grade endometrial primary 8441/3 (serous carcinoma) or 8461/3 (high grade serous carcinoma)?

#### Answer

Code histology for this endometrial primary to serous carcinoma 8441/3. Capture "high grade" in the grade field as instructed in the grade coding manual. "High grade serous carcinoma" 8461/3 has specific clinical and histopathologic features found in ovarian tumors.

\*[SEER Ask A Registrar](#)

#### Change in Reportability for Thyroid

**Code 8349/1** Non-invasive follicular thyroid neoplasm with papillary-like nuclear features (NIFTP)  
This term was previously coded to 8343/2.

**Code 8349/1** Non-invasive FTP.  
This term was previously coded to 8343/2.

These terms have changed both ICD-O and behavior codes and are **no longer reportable for cases diagnosed 1/1/2021 forward**.

Check out <https://www.naaccr.org/icdo3/>  
For Histology Updates!



**Coding Lightening Rounds available on FLccSC NOW**  
(01/20/2021)

Coding Lightening Rounds are short educational videos (5-10 minutes) developed by NJSCR to provide CTRs with important information on coding specific fields. Keep visiting and look for additional videos to be uploaded!



**All Roads Lead to the NAACCR Summer FORUM!**



NAACCR is working hard to finalize plans for the 2021 Summer FORUM taking place June 15-17, 2021. Our 2021 virtual event cannot offer the in-person experience, but it will offer the high-quality educational content you expect from NAACCR conferences. And you will find more flexibility in how you can participate.

Look for all the content you love – engaging plenary speakers, member presentations, Birds of a Feather, scientific posters – and seek out opportunities to engage with your colleagues in new ways. We fully expect that many more people will participate and possibly from many more parts of the world.

Registration will open in February 2021. CE credits will be requested from NCRA.

**If you cannot attend the live event, fear not! Sessions will be recorded and available for a period of time after the live event.**

\*<https://narrative.naacr.org/article/all-roads-lead-to-the-naaccr-summer-forum/>

**Ambiguous Terminology**

**Do not accession a case based ONLY on suspicious cytology.**

Note: “Suspicious cytology” means any cytology report diagnosis that uses an ambiguous term, including ambiguous terms that are listed as reportable on the preceding page. 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.

**Important: Accession cases with cytology diagnoses that are positive for malignant cells.**

\*[https://seer.cancer.gov/manuals/2021/SPCSM\\_2021\\_MainDoc.pdf](https://seer.cancer.gov/manuals/2021/SPCSM_2021_MainDoc.pdf)

**Lung Histology Rules**

**Priority Order**

Code the histology diagnosed prior to neoadjuvant treatment.

**Note 1:** Histology changes may occur following immunotherapy, chemotherapy, targeted therapy, and radiation therapy.

**Note 2:** Neoadjuvant treatment is any tumor-related treatment given prior to surgical removal of the malignancy.



**Exception:** *If the initial diagnosis is based on histology from FNA, smears, cytology, or from a regional or metastatic site, and neoadjuvant treatment is given and followed by resection of primary site which identifies a different or specific histology, **code the histology from the primary site.***

\*[https://seer.cancer.gov/tools/solidtumor/Lung\\_STM.pdf](https://seer.cancer.gov/tools/solidtumor/Lung_STM.pdf)

**Question:**

How is Diagnostic Confirmation coded for malignancies diagnosed by a FoundationOne Liquid biopsy/assay involving circulating tumor DNA in blood only?

**Answer:**

**Code Diagnostic Confirmation as 7,** Radiology and other imaging techniques without microscopic confirmation for this case. Results of a FoundationOne Liquid biopsy/assay are not specific enough to diagnose this lung malignancy.

\*<https://seer.cancer.gov/seer inquiry/index.php?page=view&id=20190043&type=q>



**Coding Lightning Rounds available on FLccSC NOW (01/20/2021)**

Coding Lightning Rounds are short educational videos (5-10 minutes) developed by NJSCR to provide CTRs with important information on coding specific fields. Keep visiting and look for additional videos to be uploaded!

**2021 Reportability Changes**  
**Check out the link!**



<https://www.naaccr.org/icdo3/>

**Table 1: New behavior codes (Reportable neoplasms)**

WHO has changed behavior codes for the following terms which result in **previously non-reportable neoplasms becoming reportable** for cases diagnosed 1/1/2021 forward. DO NOT report cases diagnosed prior to 1/1/2021.

**Table 2: New behavior codes (Non-reportable neoplasms)**

WHO has changed behavior codes for the following terms which result in **reportable neoplasms becoming non-reportable** beginning with cases diagnosed 1/1/2021. Continue reporting these cases when diagnosed prior to 1/1/2021.

**Table 3: Deleted ICD-O codes in ICD-O-3.2**

Per ICD-O-3.2, several ICD-O **codes have been removed and the histologies moved to other codes.** The comment column provides coding instructions for cases diagnosed prior to 1/1/2021 and 1/1/2021 forward. This table lists only **reportable** neoplasms.

**Table 4: Changes in reportable terminology**

(\*) WHO has revised preferred terminology for these neoplasms **and no longer requires "malignant" to be used in the term in order to code behavior of /3**

**Table 5: New Terms and ICD-O codes**

**Consults**

If a report is sent out for consult and the results are different than the original reports, record the results from the consult.

★ **Consults always take priority** ★

**3936 Ulceration (Melanoma Skin)**

Melanoma ulceration is the absence of an intact epidermis overlying the primary melanoma based upon microscopic (histopathological) examination.

- **Code 1** if any biopsy (punch, shave, excisional, etc.) or wide excision is positive for ulceration in the presence of an underlying melanoma.
- **Code 0** if all specimens are negative OR one specimen is negative and the other is unknown.

Ulceration must be caused by an underlying melanoma.

**Ulceration caused by trauma from a previous procedure should not be coded as positive for this SSDI!**

\*NAACCR 2021 Implementation Webinar Updates 2021: SSDI's

As of 01/01/2021 CoC and SEER are no longer requiring:

- 3850: HER2 IHC Summary (Breast)
- 3851: HER2 ISH Dual Probe Copy Number (Breast)
- 3852: HER2 ISH Dual Probe Ratio (Breast)
- 3853: HER2 ISH Single Probe Copy Number (Breast)
- 3854: HER ISH Summary (Breast)
- 3859: HIV Status (Lymphoma)

\*NAACCR 2021 Implementation Webinar Updates 2021: SSDI's



**Coding Lightening Rounds available on FLccSC NOW**  
*(01/20/2021)*

Coding Lightening Rounds are short educational videos (5-10 minutes) developed by NJSCR to provide CTRs with important information on coding specific fields. Keep visiting and look for additional videos to be uploaded!