**Hematopoietic Coding Tips**

**New Note for Diagnostic Confirmation for cases diagnosed 2022+**

Use **Code 3** “Positive histology PLUS positive immunophenotypating 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.**

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**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.

**SEER**

Answer the question with a reasonable and logical explanation.

**http://www.cancerregistryeducation.org/products/1739/nccrs-central-registry-badge-program**
**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.


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### 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.


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.

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### 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

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### 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


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Questions can be sent to your facility’s NJSCR Representative or by calling 609-633-0500. DO NOT REPLY to this email. The information provided here is correct as the distribution date of the newsletter. Always check your manuals!
**April 2022 E-Tips**

**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)
  - 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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Pathologic assessment Only. For Pure Seminomas Only: Tumor less than 3cm, limited to the testis Without LVI or unknown LVI</td>
</tr>
<tr>
<td>150</td>
<td>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</td>
</tr>
<tr>
<td>300</td>
<td>Pathological assessment only. Tumor limited to testis (including rete testis invasion) WITH lymphovascular invasion</td>
</tr>
<tr>
<td>400</td>
<td>Pathological assessment only Epididymis, Hilar soft tissue, Mediastinum (of testis), Visceral mesothelial layer</td>
</tr>
</tbody>
</table>

**Check out the EOD RSA site 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”)**

**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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>40</td>
<td>Excision of testicle with cord or cord not mentioned (Radical Orchiectomy)</td>
</tr>
<tr>
<td>80</td>
<td>Orchiectomy, NOS (unspecified whether partial or total testicle removed)</td>
</tr>
</tbody>
</table>

**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.

Questions can be sent to your facility’s NJSCR Representative or by calling 609-633-0500. DO NOT REPLY to this email. The information provided here is correct as the distribution date of the newsletter. Always check your manuals!
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

1. Change request submitted
   Changes are proposed or sponsored by standard-setting agencies and may include:
   - New data item(s)
   - New codes for existing data item(s)
   - New SSDI schema(s)

2. MLTG reviews request
   The Mid-Level Tactical Group reviews the request to ensure its validity and justification

3. Technical review & feasibility testing
   - UDS WG reviews proposed codes & definitions
   - Feasibility testing is performed by requesting agency
   - UDS works with requestor to finalize codes & definitions

4. MLTG Votes
   MLTG reviews results of feasibility test and technical review and makes recommendations to HLSG

5. HLSG Votes
   High-Level Strategic Group makes final determination on implementation. Changes that are not approved are sent back to requestor for reconsideration

6. Data Dictionary
   UDS WG incorporates new data item, definition, and codes into the data dictionary. Standard-setters submit updates for Required Status table.

7. Implementation Guidelines
   The Implementation Guidelines Task Force writes recommendations for registries and software vendors to incorporate the changes

8. Edits Metafile(s)
   The Edits WG updates the metafiles to include the new/revised data item

9. Software Development
   - APIs updated
   - Vendors program changes into registry software and issues updates to registries

10. Training Materials
    Standard-setters develop training materials, webinars and workshops to help registrars understand and implement the changes

11. Deployment
    Cancer Registrars throughout North America begin collecting the new data item in a standardized format.

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**
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**
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.

**No Surgical Resection**
Surgical resection of the primary tumor has not been done, but there is positive confirmation of distant metastases during the clinical time frame.

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.


Questions can be sent to your facility’s NJSCR Representative or by calling 609-633-0500. DO NOT REPLY to this email. The information provided here is correct as the distribution date of the newsletter. Always check your manuals!
February 2022 E-Tips

**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.


### 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~)

### 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


### 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~)


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The information provided here is correct as the distribution date of the newsletter. Always check your manuals!
**January 2022 E-Tips**

<table>
<thead>
<tr>
<th>Radiation Coding Information and Tips</th>
</tr>
</thead>
</table>
| • “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 999998 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!  

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| 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.  

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<table>
<thead>
<tr>
<th>Check out the NJSCR Website</th>
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</table>
| Updated Reportable list, current and previous Etips can be found on the NJSCR website.  
[https://www.state.nj.us/health/ces/reporting-entities/registrars/](https://www.state.nj.us/health/ces/reporting-entities/registrars/) |

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<table>
<thead>
<tr>
<th>Registry Resources</th>
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</table>
| • [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 |

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<table>
<thead>
<tr>
<th>E-Tips</th>
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| • Current 2021 E-Tips: Helpful tips from the NJSCR  
• 2020 E-Tips  
• 2019 E-Tips |

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<table>
<thead>
<tr>
<th>Hospital Registrars!</th>
</tr>
</thead>
</table>
| 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. |

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