REGISTRAR PIP

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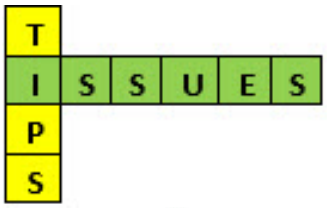
Coding Tips for Extent of Disease (EOD) and Summary Stage
Second Installment: Prostate, Melanoma

As promised, this is the second installment of our series in which we identify and address the issues observed in staging cases. While coding stage can be a complex process, we hope to improve its quality and consistency by identifying issues common to primary sites as well as those that are site-specific. Evaluating performance is a necessary first step toward improving performance. Sharing what we learned is actually the most critical aspect of the quality improvement process required to enhance the usefulness of the data. Useful data allows others to rely on it to gain a better insight regarding the disease process and the impact of treatment on improving cancer patient survival.

This month, we are targeting a couple larger primary sites (prostate and melanoma) to identify needed areas of training. We hope you find this information useful.



Prostate

✦ EOD Primary Tumor

- The most critical thing we can do to improve the coding of this field for prostate primaries is to make certain **we read the eight NOTES** provided in the coding scheme for this primary site. The majority of errors occurred because we seem to have gone directly to the codes and their descriptions to see how to capture the clinical findings for our case and we skipped the important step of determining whether one or more of the NOTES might impact our coding decision.

- We need to remember when coding the EOD Primary Tumor field that **biopsy findings are only used when they prove extraprostatic extension**; otherwise, we base our findings on the digital rectal exam (DRE).

- **Imaging is not always reliable in determining the clinical tumor extension** for prostate primaries. This is the reason the site-specific notes for coding prostate EOD Primary Tumor state, "Do not infer inapparent or apparent tumor based on the registrar's interpretation of other terms in the DRE or imaging reports." The physician's impression/interpretation has priority. Most of our coding errors involved coding the extension mentioned in the imaging report that was not supported by a clinical statement of stage the physician ultimately opted to assign.

  For example, when scans indicate extraprostatic extension (e.g., bladder neck, seminal vesicle(s), or through the prostatic capsule), but the managing physician clinically stages the case ignoring those radiographic comments, we need to assume the managing physician did not believe the findings

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described in the scan accurately described the primary tumor involvement, and we need to assign a code that excludes that type of extension description.

- Another tricky aspect of coding this field has proven to be inadvertently using prostate biopsy results to assess whether more or less than half of one lobe of the prostate is involved. Can we use the number of core biopsies positive and the number taken to determine how much of the prostate lobe is involved? As mentioned previously, we cannot use the prostate biopsy results UNLESS they prove extraprostatic extension.

  ⚠ **Do not use the number of prostate core biopsies positive/taken** to decide whether the tumor involves one-half of one side or less versus more than one-half of one side. In other words, a patient with three of three core biopsies positive for adenocarcinoma on the right side of the prostate is not coded as having more than one-half of one side being involved when the managing physician indicates the patient is clinically a stage T2a. The managing physician's statement of clinical stage T2a implies the tumor can be felt by DRE (or seen with imaging such as transrectal ultrasound) and is in one half or less of only one side (left or right) of the prostate. The three positive cores of the three cores taken on the right is not to be coded as indicating more than one-half of one side as being involved.

✦ **Prostate Pathological Extension**

- The most common error made in this field was simply failing to recognize we should automatically code 900 [No prostatectomy or autopsy performed] when no prostatectomy or autopsy was performed DURING the staging time frame. The first two NOTES associated with this data item clarify this coding requirement. Only **use the pathological information from the prostatectomy or an autopsy** in this field. Keep in mind the autopsy information can be used for cases diagnosed prior to death if the autopsy was performed during the staging time frame.

- Again, we can only use the prostatectomy or autopsy findings to code extraprostatic extension observed pathologically. Information from **biopsy positive extraprostatic sites is coded in the EOD Primary Tumor field**, not this field.

- Cases involving **bladder neck involvement** have proven problematic. Pathological **microscopic** involvement of the bladder neck alone is considered T3a disease which is included in Prostate Pathological Extension code 350 [Bladder neck, microscopic invasion] with extraprostatic extension. When there is indication the patient had **macroscopic**/gross bladder neck invasion per the pathology report or operative report (e.g., pT4 disease), code EOD Prostate Pathological Extension code 600 [Bladder neck, except microscopic bladder neck involvement].

✦ **EOD Regional Nodes**

- A **pathological assessment is not required** to code this field to 000 [No regional lymph node involvement]. If a patient does not undergo a surgical resection that includes lymph nodes, we might be able to code this field to something other than 999 [Unknown, regional lymph nodes not assessed]. Granted, while regional nodes for the prostate are not amenable to assessment by physical exam because the regional nodes are considered deep nodes, they can be assessed using scans or by the surgeon intraoperatively during a procedure, for example, that is limited to removing the prostate. If there is at least one scan of the pelvis indicating no regional node involvement or if the surgeon indicates during a prostatectomy there are no regional lymph nodes seen, the EOD Regional Nodes field is coded 000 [No regional lymph node involvement].

✦ **EOD Mets**

- The most common error in this field indicates we need to be more careful checking whether the lymph nodes involved are considered regional or distant for the prostate. We inadvertently miss the fact that **aortic (lateral [lumbar], para-aortic, periaortic, NOS) and common iliac are distant nodes**, though these are not the only distant lymph nodes listed in the code description for this field. Coding distant lymph node involvement as regional will not only result in an error in this field, but there may be a

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corresponding error in the EOD Regional Nodes field and a likely error in coding the Summary Stage field. To correctly capture the involvement in the appropriate field, when positive specific lymph node chains are listed in reports we are reviewing, we need to ask ourselves the question, "Is that lymph node regional or distant for this primary?"

✦ **Summary Stage 2018**

- This field combines clinical and pathologic findings. As with the EOD fields, reading and applying the guidelines outlined in the **NOTES section** of the Summary Stage 2018 manual for prostate is probably the most effective way to improve our coding of this field for this primary. The reminders address the most common issues that resulted in the majority of coding inconsistencies in the past and include some of the following:

  √ When is it appropriate to **code localized for TURP** only cases? For many prostate primaries, we are often faced with minimal documentation in the medical record. We may be reluctant to code cases as localized stage in these situations. However, according to NOTE 4 under prostate, when the only information available is a TURP, with no other evidence of lymph node involvement or distant metastasis involvement, assign code 1 [Localized].

  √ However, when information from the **DRE is not available**, but the physician assigns a clinical extent of disease (clinical T category), USE IT! As the example in the Summary Stage manual indicates, "DRE reveals prostate is "firm." Physician stages the patient as a cT2a. The T2a (localized) can be used since the physician has documented this."

Melanoma of the Skin

✦ **EOD Primary Tumor**

- ⚠ It's a **Clark Level V case**! Hit the pause button. Avoid the tendency to react quickly and code the glaringly obvious Clark Level V mentioned in the pathology report to 500 [Subcutaneous tissue (through entire dermis) Clark Level V] in this Tumor field. The reason? We need to take a moment to check for any potential further extension. While Clark Level V includes invasion into the subcutaneous tissue (subcutaneous fat), there is no Clark Level that includes invasion beyond the subcutaneous tissues into the underlying cartilage, skeletal muscle, etc. So, we need to hit the brakes to determine whether our Clark Level V is truly the furthest extension or whether the case needs to be upstaged from code 500 to code 700 [Bone, Skeletal Muscle, Underlying Cartilage, or Further Contiguous Extension] to accurately reflect the extension demonstrated by the tumor.

✦ **EOD Regional Nodes**

- We tend to struggle knowing how to appropriately code lymph nodes in the following two situations:

  √ Codes 000 versus 100
  √ Codes 100 versus 200

  These regional lymph node codes are defined in Table 1.

Table 1
Melanoma Skin
EOD Regional Nodes

Code	Description
000	No regional lymph node involvement
100	One clinically occult (detected by SLN biopsy) WITHOUT in-transit, satellite, and/or microsatellite metastasis
200	One clinically detected node WITHOUT in-transit, satellite, and/or microsatellite metastasis

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"Clinically occult" means something cannot be detected by ordinary clinical means; it was not clinically apparent on exam (PE or imaging). Use of either codes 000 [No regional lymph node involvement] or 100 [One clinically occult (detected by SLN biopsy)] indicates there is no evidence of clinically apparent lymph nodes on exam. When a surgeon indicates the procedure includes a sentinel lymph node biopsy, do not use code 100 [One clinically occult (detected by SLN biopsy)] simply because the surgeon removes a sentinel lymph node if the pathology report indicates all nodes are negative. Instead, use code 000 [No regional lymph node involvement] for these cases. Only use code 100 [One clinically occult (detected by SLN biopsy)] if one sentinel lymph node removed was positive for metastasis and was not clinically apparent.

Now that the issue of "clinically occult" has been clarified, it should be easier to distinguish code 100 [One clinically occult (detected by SLN biopsy)] versus code 200 [One clinically detected node]. When the physical exam is negative, it implies any pathologically involved node was not palpable (not clinically detected). If the node is determined to be pathologically malignant, use code 100 if the lymph node was not palpable and code 200 if it was palpable.

✦ **EOD Mets**

- As with all sites, radiographic findings of metastasis should be used to code the fact that the patient presents with distant disease. While a majority of melanoma cases present with either in situ or localized disease, not all of them do. We do a pretty good job of capturing the regional disease which is most often identified with positive lymph nodes identified in a pathology report. It's patients presenting with distant disease only mentioned in a scan that are most likely to be overlooked. For example, when there is **clinical evidence of distant metastasis** per the imaging or a tumor board assessment, CODE IT!

✦ **Summary Stage 2018**

- ⚠ Surprise! The errors made in coding Breslow depth versus Clark Level impact the coding of Summary Stage too. In addition, if we overlook the further extension described for cases that are also stated to be Clark Level V cases, coding errors will crop up in Summary Stage as well. If we improve the coding for the **EOD Primary Tumor field**, it will have a direct and positive effect on improving the coding for the Summary Stage field.

Conclusion

The takeaway message for this month is **"Read the NOTES"** for each field you code! A majority of the coding errors for these sites would be eliminated quickly if we remember to check to see if there are notes that accompany the fields we're coding. It can save us a lot of "dithering" time weighing one coding option over another as well as potential "gotcha" moments from our editors or those performing quality control reviews on our work if we read more than the codes/descriptions in the dropdowns.

As indicated in the last edition of the Registry PIP, we want to encourage everyone to use these summaries to identify potential quality control efforts related to the coding performed for all the registry staff at each of our facilities and as a training document for those of us who need a gentle reminder regarding how to handle selected coding issues by primary site.

Next Edition In January, we will the target urinary tract primary sites for review.

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