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2007 Multiple Primary and Histology Coding Rules Breeze Sessions
New Data Items
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INTRODUCTION

Hello, everybody. This is Steve Peace and I would like to welcome you to the Webcast on the New Data Items. We are switching gears today from what has become our standard type of presentation on the new 2007 Multiple Primary and Histology Coding (MP/H) Rules to this presentation on the New Data Items that have been introduced to support the new MP/H Coding Rules. This presentation will include a description of the New Data Items and their accompanying codes as well as an open forum for questions and answers. The next Breeze Session will be a case practicum on these New Data Items. Since we are discussing the New Data Items today the content and instruction will vary slightly from the previous sessions.

Many of you joining us today have been actively participating in this series of live Web broadcasts. I would like to thank you for your continued interest and attention. Welcome to those of you who are new to these sessions. The NCI-SEER Program is pleased to be able to offer these Webcasts to you both as the live Breeze Sessions and in the recorded sessions. The recorded sessions from previous broadcasts are available on the SEER Website. Click on the MP/H Rules button under “Information for Cancer Registrars” and you will be directed to the recorded sessions. You can also easily access the rules and the New Data Items, coding definitions and instructions. The recorded sessions can be accessed 24/7, free of charge for anyone who is interested. The recorded sessions will be posted on the SEER Website throughout 2007. We encourage you to take advantage of the recorded sessions if you have missed one of the live ones. Downloadable transcripts are available for the hearing-impaired.

If you are joining us through the recorded broadcasts we would like to welcome you. We are happy to have you join us “after-the-fact” using the special features of the recorded Web broadcast. This is an important broadcast on the New Data Items.

Our discussion today will include a description of each New Data Item, a rationale for the development of each item and specific coding instructions. Following today’s presentation we will send instructions on accessing the practicum cases as well as information regarding access to the live broadcast scheduled for next week.

This is the last didactic session and next week's broadcast of the practicum on the New Data Items will be the final broadcast in this series. Again, all the recorded sessions will be available throughout this year, 2007.

In addition to the recorded Breeze Sessions, the SEER Training portal now has a self-instructional Web-based training module on the MP/H Coding Rules. I highly recommend that module. It covers most of the general training information covered in the Breeze Sessions as well as some interesting background information on why the rules were developed and who was involved in the development of these new rules among other interesting pieces of information.

Be sure to join us next week for the Breeze Session on the Practicum for these New Data Items. That will be the concluding broadcast in this series of trainings on the 2007 MP/H Coding Rules. NCI has provided a total of 21 Webcasts in this MP/H Coding Rules series. Each Webcast carries Continuing Education Units (CEU)s for certified tumor registrars (CTR)s through the National Cancer Registrars Association (NCRA).

SLIDE ONE
We will begin today with some background. The Multiple Primary and Histology Coding Rules Committee with leadership provided by Carol Johnson and myself, Steve Peace, was faced with the daunting task of developing a standard set of rules for specific sites and for some site groups. The Committee goals were to create standard rules that:
● registrars would use on a daily basis
● would be easy to understand and use
● would result in consistent determination of the number of primary tumors to be abstracted by registrars
● would result in consistent and correct histology coding that most appropriately represents the tumor type for each cancer case

The Committee recognized that in order to support the new rules and to provide some transition between the old and new rules some New Data Items would be needed.

SLIDE TWO
These are the three New Data Items related to cases with multiple tumors that are abstracted as a single primary:
● Multiplicity Counter
● Date of Multiple Tumors
● Type of Multiple Tumors Reported as One Primary

These New Data Items allow these cases to be flagged for analyses. These cases are relatively rare but were almost impossible to identify in the past. These will be helpful in research and help highlight any changes that might be needed in the rules in the future.

SLIDE THREE
The two other Data Items we will discuss today relate to the certainty surrounding the cancer diagnosis for a case. These items are not part of the MP/H Coding Rules but are being introduced simultaneously with the introduction of the new rules. These New Data Items are:
● Ambiguous Terminology
● Date of Conclusive Terminology

These five New Data Items were presented as a group to the Uniform Data Standards Committee and to the Registry Operations Committee for review and approval. We are presenting these five together as a group in these training sessions. Please keep in mind that the first three New Data Items are directly related to the new MP/H Coding Rules and the other two New Data Items are related to whether or not there is a definitive statement concerning the cancer diagnosis for the case being abstracted.

These New Data Items are collected for all cases diagnosed on or after January 1, 2007.

SLIDE FOUR
Please make sure you have the New Data Items chapter 9 of the MP/H Coding Rules Manual in front of you as we begin so you can follow the presentation and use that chapter for reference during this session. We have had a number of questions on these New Data Items. The Data Items are generally covered at the end of a training session and hence receive little time resulting in questions later from attendees. I hope we can clear up some of the confusion about a couple of these Data Items today.

Are there any questions?

As I said in the Introduction we really have two sets of New Data Items. The first set includes the Multiplicity Data Items, which directly relate to using the new MP/H Coding Rules. Most of the time, as you know from experience, when you abstract a cancer case you have a single tumor that is the primary tumor and you may or may not have metastases. We are only talking about primary tumors now, as is the case with all the new rules and we are excluding metastases. These three Data Items concern whether or not you have a single primary tumor or if you have more than one tumor in a case that is abstracted as a single primary. These Data Items help you count and account for those multiple tumors in those cases abstracted as a single primary tumor.

When we first introduced the New Data Items we found some problems with the definitions and codes as happens with the introduction of New Data Items. They are usually modified after they have been used for a year or two. During that first period of time any problems in coding and usefulness of the data being collected are revealed.

The first three New Data Items again are:
● Multiplicity Counter
● Date of Multiple Tumors
● Type of Multiple Tumors Reported as One Primary

We will discuss these New Data Items in detail.

The two additional New Data Items relate to ambiguous terminology used to accession a case. They concern whether or not a conclusive/definitive cancer diagnosis was made for a particular case. These Data Items are not part of the MP/H Rules but were introduced at the same time as the other three New Data Items. We will talk about these Data Items today although they have nothing to do with the new MP/H Coding Rules.

SLIDE FIVE
Please go ahead and pull out Chapter 9 from the MP/H Coding Rules Manual. We are looking at what starts on page 333. This chapter begins with the Ambiguous Terminology Data Item but I am not going to start there. I would like you to turn to page 339 and look at the Data Item—"Multiplicity Counter."

This Data Item is used to count the number of tumors or "multiplicities" that are counted as a single primary. Again, in most of the cases you do you will have one primary tumor. Occasionally, you will have multiple tumors that are abstracted as a single primary but that won't happen very often. These Data Items are important for those situations.

There is a reminder here that you "do not count metastatic tumors" and that you "use the Multiple Primary Rules to determine if [you have] single or multiple primaries." There is also an instruction to leave this Data Item field blank for cases diagnosed prior to January 1, 2007. There are also some examples on this page (339) to help you.

SLIDE SIX
When we look at the codes we see this Data Item is a counter indicator. Most of the time you will have only one for the primary tumor. So most of the time you will use code 01 since you will only have one tumor. When you have more than one tumor abstracted as a single primary you will record the actual number of tumors present that are considered multiple tumors but are abstracted as a single primary. There is a code 88 that is used when "information on multiple tumors not collected/not applicable for this site." There are some sites where this item is not applicable and those sites are referenced in the rules. Code 99 is used when multiple tumors are present but the number of them is unknown. This is also the code to use if it is unknown whether there are single or multiple tumors. In our MP/H Coding Rules we have that first rule, M1, which says if you don't know if it's a single or multiple tumors you abstract the case as a single primary. That rule is

in every set of rules. So if you don't know if the case concerns a single tumor or multiple tumors and you are abstracting the case as a single primary on one abstract you would use this code, 99. People have been confused about coding this item in part due to the labeling of this Data Item and partly because of an error in the coding instructions, which we will discuss.

SLIDE SEVEN
The coding instructions for this Item start on page 340. I am going to go through each of these instructions so everyone understands them. Number one is "code the number of tumors abstracted as a single primary." That is the intent of this Data Item. Number two in the instructions says, "Do not code metastasis." Number three says when there is a tumor or tumors with a separate or single foci, you ignore/don't count the foci. That has been a source of much confusion so you might want to highlight that instruction in your Manual with a highlighter/marker.

SLIDE EIGHT
The instructions on the next slide have been a bit confusing. Use code 01 when there is:
● a single tumor in the primary site or
● a single tumor with separate foci of tumor or
● not enough information, i.e. it is unknown if there is a single tumor or multiple tumors **and** the MP/H Coding Rules instruct you to default to a single tumor

This last entry was supposed to have been removed from this set of instructions. So, "4 c" on page 340 should be crossed out in your Manual because that actually applies under coding instruction "6." So you can put an arrow down to #6 if you want to add that in your Manual. We apologize. That instruction was supposed to have been removed from point number four; it was an oversight that the instruction was not moved and that has been a source of confusion which we regret. So remember, if it is unknown whether there are single or multiple tumors, use code 99. We will be sending out an update to this item and 4c will be moved under point 6.

SLIDE NINE
Code 88 for the Multiplicity Counter is used for sites where information on multiple tumors is not applicable such as leukemias, lymphomas, immunoproliferative diseases and cases with an unknown primary. Those examples, for the most part, cover the uses of code 88 for this Data Item.

SLIDE TEN
Code 99 is used when:
● the original pathology report is not available and the available documentation does not specify whether there is a single tumor or multiple tumors in the primary site.

This is the same situation where it is unknown whether there is a single or multiple tumors. Does that make sense now that 4c should go under 6 for coding unknown? It fits into that same category.

● Tumor is described as multifocal or multicentric and the number of tumors is not mentioned
● Tumor is described as diffuse
● When the Operative or the Pathology Report describes multiple tumors but does not give an exact number

Code 99 is used when you don't have information. It is used as a normal "unknown." You leave this field blank for cases diagnosed prior to January 1, 2007.

Are there any questions about the Multiplicity Counter Data Item?

SLIDE ELEVEN
We will move on to the next Data Item, which is "Date of Multiple Tumors."

SLIDE TWELVE
This Data Item can be found on page 341 of the Manual. The Date of Multiple Tumors identifies the month, day and year that the patient is diagnosed with multiple tumors that are recorded as a single primary.

SLIDE THIRTEEN
You will see that for single tumors we have a special code that is all 0s. We are trying to record dates only for multiple tumors or unknowns (i.e. cases where the number of tumors is unknown). Again, you use the MP/H Coding Rules to determine if the case is a single or multiple primaries. The date is in the usual month, day, and year format. Use code 99 for "unknown month or day." Use code 9999 for unknown year. Leave this field blank for cases diagnosed prior to January 1, 2007. There will be Edits created to check these codes for your data submissions that will become part of your standard edits package.

SLIDE FOURTEEN
Here are the special date codes which are also listed in chapter 9. Use all 0s (i.e. 00000000) for single tumors. Our standard rule is, "A single tumor is always a single primary." Single tumors represent about 90% or more of the cases you see so you will become very familiar with this 00000000 code. A code of 88888888 is used when information on multiple tumors is not collected or is not applicable for a particular cancer site. And, a code of 99999999 is used for unknown date.

We have had some confusion for Date of Multiple Tumors when you have an unknown number of tumors but you actually have a date. Registrars tend to think if you put 99 in the code that you also have to have all 9s in the date; that is not necessarily the case for these Data Items. Don't automatically code 9s in these Data Items because you will miss some important information if you do that.

Question 1
Steve, I have a quick question. What if we put 99 down because we do not know whether it's one or more tumors? Then we put 99 for the date because we don't necessarily know that we have multiple tumors?

Response to Question 1
The response to your question will come out in an Addendum to this Data Item and the actual answer is still being discussed but as I understand it at this time, the date that you would enter would be the date that that decision was made, i.e. the date of diagnosis.

Follow-up to Question 1
So even if we are not sure if there are multiple tumors or one tumor, you still want a date?

Response to Follow-up to Question 1
Yes, because you do have a date you just don't know how many tumors there are. You have a date of diagnosis. There will be an explanation of this as an Addendum to this Data Item. That Addendum is in process. This has been a point of confusion.

We are still confused. It makes sense to us that if we don't know how many tumors there are, we don't know.

That final decision will come out from NCI after some more discussions I believe, but you can expect that in the near future. In the case examples, which you will be doing in the Practicum you be able to distinguish a date as the date of diagnosis for those cases rather than just unknown.

Question 2
I have a quick question regarding these special date codes. Our IT people are concerned that our system may not accommodate these date codes. Has that been brought forth at all?

Response to Question 2
That has been discussed many times and in many committees. That is something that the Uniform Data Standards Committee is currently addressing and has been trying to solve for some time. Frequently in cancer registry software, dates are not necessarily treated as dates but as character fields. I understand the issue and a subcommittee of the UDSC and Information Technology Committee of NAACCR is trying to provide guidelines on how to use date fields. That information will be forthcoming. At this time and historically SEER and the CoC have used special date codes to mean certain things and they are not necessarily standard date format. You raise an excellent point that is

definitely being considered at the standard-setter level but which we cannot solve today at this presentation.

SLIDE FIFTEEN
The Date of Multiple Tumors is the same as the date of diagnosis when multiple tumors are present at diagnosis. That is the same reasoning for the date of diagnosis when you don't know if there are single or multiple tumors and that is probably where the explanation will be inserted. If you want to write yourself a note it would be the same as the date of diagnosis when it's unknown if there is a single or multiple tumors.

Since the time period during which a new tumor is considered a new primary in the MP/H Coding Rules can stretch out as far as five years in some sites from the original date of diagnosis these Multiplicity Counter fields are useful in that they can modified if you come across a new primary tumor in the same site some years later but it's still supposed to be abstracted as part of that original primary tumor. You will want to account for that new tumor in the same site within the rationale and reasoning of the MP/H Coding Rules. So you can change this Multiplicity Counter and then also enter the date that the second tumor was diagnosed when subsequent tumors are counted as the same primary following the rules at some future point along the way.

We recognize that some special cancer registries are "incident only" registries. The Registry Operations Committee is looking at how those incident registries will accommodate some of these fields that require potential modifications at future points in time. I can't answer questions about what incident registries are to do at this point in time but they should be able to manage these as dynamic fields that can change throughout the history of a particular cancer incident record.

SLIDE SIXTEEN
The third New Data Item we're going to discuss is "Type of Multiple Tumors Reported as One Primary."

SLIDE SEVENTEEN
This Data Item is very interesting because it characterizes the type of tumors in the situation when multiple tumors are abstracted as a single primary. This Data Item, therefore, identifies the type(s) of multiple tumors. Again, you do not count metastatic tumors for this Data Item and you leave this field blank for cases diagnosed prior to January 1, 2007.

SLIDE EIGHTEEN
It is easier to explain what you are doing with this field by looking at the codes. Code 00 is used any time you have a single tumor. It includes single tumors with both in situ and invasive components. Code 10 is used if you have multiple benign tumors in the same organ or primary site. You use this code for reportable

tumors in the intracranial and CNS sites only. For those of you who are interested in the MP/H Coding Rules for Benign and Borderline Intracranial and CNS Tumors, they are being modified and adapted to the MP/H Coding Rules formats. They are almost complete. The instructions in those rules remain the same as when they were first issued but they are being put in the new MP/H Coding Rules format.

Question 3
So, does the content of those rules remain unchanged?

Response to Question 3
That is correct.

Code 11 is used when there are at least two borderline tumors in the same organ or primary site. This code may also be used for reportable tumors in intracranial and CNS sites and for "reportable-by-agreement" cases. You use those Multiple Primary Coding Rules to determine whether or not there is a single or multiple primaries.

SLIDE NINETEEN
Code 12 is used when you have at least one benign and at least one borderline tumor in the same organ or primary--site again for intracranial and CNS sites. Some registries use these codes for "reportable by agreement" tumors that are not in the brain. Code 20 is used when at least two in situ tumors are found in the same organ or primary site and are abstracted as a single tumor.

SLIDE TWENTY
If you have one or more in situ tumors and one or more invasive tumors and you are abstracting those as a single primary use code 30. Codes 31 and 32 are used to document characteristics of polyps and adenocarcinomas or familial polyposis and carcinoma. Code 31 is used when you have one or more polyps with either in situ carcinoma or invasive carcinoma **and** one or more frank adenocarcinoma(s) in the same segment of the colon, rectosigmoid and/or rectum. Of course, you use the new MP/H Rules first before coding this Data Item. Code 32 is used in the situation when there is familial polyposis (FAP) **and** carcinoma (in situ or invasive) present in at least one of the polyps.

SLIDE TWENTY-ONE
Code 40 is used when there are at least two (i.e. multiple) invasive tumors in the same organ. Occasionally you will see, for example, at least two infiltrating duct carcinomas in the same breast at the same time (these used to be called synchronous tumors). That's when you would use this code 40. Code 80 is used when you know there are multiple tumors present in the same organ or primary site but you don't know if they are in situ or invasive. Code 88 is used for the situation in which information on multiple tumors is not collected or is not applicable. Code 99 is used to report a standard unknown.

The Multiplicity Data Items have also been promoted by the Record Consolidation Working Group, which is part of the Registry Operations Committee for NAACCR. Both that Group and the Histology Committee felt that it would be useful to have more information on cases with multiple tumors that are abstracted as one primary; that is the intent of this particular Data Item.

Are there any questions on the Multiplicity Data Items?

Question 4
Steve, I have a question regarding the codes for "Type of Multiple Tumors." I can think of a scenario which I often see with invasive behavior seminomas and at the same time an in situ type of tumor in combination with that. It looks like I won't be able to capture that scenario here.

Response to Question 4
Yes, actually you would be able to capture that information here. If it is abstracted as a single primary and you have in situ and invasive components in that single tumor, that's when you use code 30.

Thank you very much.

SLIDE TWENTY-TWO
If there are no more questions on the Multiplicity Counter, Date of Multiple Tumors of Type of Multiple Tumors Abstracted as One Primary we will now switch gears. I would like you to think about switching gears away from the Multiple Primary and Histology Coding Rules because we are going to be talking about the use of ambiguous terminology when deciding whether or not a case should be abstracted or not. These two ambiguous terminology Data Items have absolutely nothing to do with the Multiple Primary Rules or with the Histology Coding Rules or with the use of ambiguous terms in coding histology or in determining multiple primaries. These two Data Items are related to reportability.

SLIDE TWENTY-THREE
The General Instructions for the Multiple Primary and Histology Coding Rules include a list of ambiguous terms used when coding histology on page 14. That list of terms on page 14 contains ambiguous terms used to code histology; that is **not** what we are talking about here. Some of those terms on that list may be the same but we are trying to make sure you don't confuse the terminology used for reporting a case based on ambiguous terms with ambiguous terms used to code histology. They are different. We recognized this problem when we were developing the rules. That is why we added a list of ambiguous terms to the Histology Coding Rules. There has never been an actual list of such terms before but people were using the ambiguous terms designed for reportability and applying them in coding histology. We thought it prudent to add these ambiguous terms to the histology coding instructions.

What we are talking about in this Ambiguous Terminology Data Item is ambiguous terminology used in accessioning a case. The definition for this Data Item is on page 335 of the Manual. This Data Item identifies all cases including Death Certificate Only (DCO) and autopsy only cases, which are accessioned based on ambiguous terminology. Registrars are required to collect cases based on ambiguous terminology. This Data Item will be useful in identifying these cases in the database.

SLIDE TWENTY-FOUR
Given the current state of technology now most cancer cases are confirmed histologically by needle biopsy or resection or via other means. The cases that will be identified via this Ambiguous Terminology Data Item are cases for which ambiguous terminology is utilized in determining reportability.

What happens when you have just a chest x-ray that says, “probable lung cancer?” You abstract that case as a lung cancer and it goes into the database and is used in analyses as a lung cancer case even though there was no actual confirmation of lung cancer or of the type of lung cancer. There is no certainty regarding that probable diagnosis or the outcome. These two Data Items will be used to identify those cases where no information is available to determine reportability.

One reason to add this Data Item is to exclude these cases from patient contact in research studies. We have learned over the years that every once in a while someone will use the cancer registry files and contact someone who will say, “I never had cancer,” or “They never proved that I had cancer.” This Data Item will help researchers identify those patients and exclude them from patient studies. Direct patient contact is not recommended for these patients and this field should be left blank for cases diagnosed prior to January 1, 2007.

SLIDE TWENTY-FIVE
The Data Item “Ambiguous Terminology” is used when ambiguous terms are used as the basis for a diagnosis of cancer. On page 337 you will find the list of ambiguous terms that are reportable. They have not changed from the terms currently on your reportable list. Reference that list of ambiguous terms that are reportable. You will find detailed instructions on how to make these determinations in both the *2007 SEER Coding and Staging Manual* and in the *FORDS Manual*. Remember, this Data Item applies to cases diagnosed on and after January 1, 2007.

SLIDE TWENTY-SIX
What is conclusive terminology? A clear and definite statement of cancer is a statement from a physician or from a confirmatory lab test, autopsy, cytologic findings or pathology report that says this is cancer. The conclusive diagnosis must be made within 60 days of the date of the initial diagnosis in order to code

the case as positive for cancer. We will talk about the codes shortly. A definition of conclusive terminology and of ambiguous terminology can be found on page 336 of the Manual. Those definitions can help in clarifying whether or not the terminology used is ambiguous; there is also a list of ambiguous terms for reference and coding instructions on the next page, 337.

SLIDE TWENTY-SEVEN
Here is the list of ambiguous terms that are reportable. Again, they are unchanged. These are such terms as:
Apparently
Appears
Comparable with
Compatible with
Consistent with
Favor(s)

SLIDE TWENTY-EIGHT
Malignant appearing
Most likely
Presumed
Probable
Suspect(ed)
Suspicious (for)
Typical (of)

You are familiar with these terms. Registrars have used these terms to also code histology for some time. We are not talking about coding histology here. This is only to use when determining whether or not a case is reportable. I know I keep emphasizing this point but it is very important that people understand this; this is where people are getting confused.

Question 5
Steve, I have a question. I am looking at the list of ambiguous terminology and I have seen several cases of “malignant appearing.” I was wondering for the Histology Coding Rules I know we no longer have a “Do Not Code List.” Is there a “do not code list” of ambiguous terms?

Response to Question 5
Absolutely not and there will not be.

Follow-up to Question 5
So the only “do not code list” that we have now is with the Collaborative Staging ambiguous terms?

Response to Follow-up to Question 5

That's correct and it may be phased out as well. The "Do Not Code Lists" have ended up being more confusing and bringing up more points of contention than the "Do Code/Use Lists."

Clarification for Question 5

Okay. So we have three ambiguous terminology lists; the only one with the "Do Not Code List" is the Collaborative Staging?

Response to Clarification for Question 5

Yes, but they are used for different purposes and I really want to emphasize that. They were developed for different reasons and they are used for different purposes. This set of reportable ambiguous terms is used to determine whether or not a case is reportable based on the ambiguous terminology. The Histology Ambiguous Terms are used to determine how to code histology. The Collaborative Staging ambiguous terminology list is used to determine extent of disease. That's why the lists are different. They have a different intent. They have a different purpose. They are similar but they are not identical.

SLIDE TWENTY-NINE

Let's go to the code list. We only have four codes here so this is pretty simple. You have already heard most of what I have to say about using these two Data Items. When a case is accessioned based on conclusive terminology and there is a clear and definite statement that confirms the malignancy within 60 days of the original diagnosis, use code 0. Sometimes you have a case that has a suspicious chest x-ray and then they do a needle biopsy that carries conclusive terminology because the needle biopsy is positive for malignancy even though you had an ambiguous term used on the chest x-ray or CT scan. The conclusive is the clear, definite term used to describe that case.

There is another Note here: "A patient may undergo a diagnostic workup because there is suspicion of cancer, for example, a mammogram may show calcifications that are suspicious for intraductal carcinoma. The date of the mammogram is the date of the initial diagnosis. When there is a clear and definite diagnosis within 60 days of that mammogram such as the pathology from an excisional biopsy showing intraductal carcinoma, assign a code 0."

SLIDE THIRTY

Code 1 is used when nothing confirms the diagnosis within 60 days. The only information you have is the ambiguous terminology that says something like "suspicious for." Use code 1 when the case is accessioned based only on ambiguous terminology and there is no conclusive terminology within the first 60 days after the initial diagnosis. That includes any diagnostic method except cytology because remember that registrars are not required to collect cases that only have ambiguous terms describing a cytology diagnosis. If something happens later like a needle biopsy or excision that definitely confirms the

diagnosis then that case would be accessioned. An example that comes to mind is when you have a urine suspicious for transitional cell carcinoma and you have that cytology report and you are trying to determine whether or not the person has transitional cell carcinoma or if there are just transitional cells in the urine, if there is no confirmation within those 60 days then those cases are excluded; they are not reportable based only on a suspicious cytology report.

SLIDE THIRTY-ONE
Code 2 is used when originally the case was assigned a code 1. If more than 60 days have passed but you finally receive information with a conclusive diagnosis (i.e. 90 days later or 6 months later, etc.) using the definitions provided, you code 2.

Code 9 is used for those rare cases in which you don't have any information on the ambiguous terminology. Hopefully, you won't have very many of those particular cases.

This is another one of those Data Items that can change over the course of a patient's history.

SLIDE THIRTY-TWO
The Data Item, "Date of Conclusive Terminology," is…

SLIDE THIRTY-THREE
…the date when a definite statement of malignancy was made. This is not necessarily the date of diagnosis, but the date of conclusive terminology. If the conclusive terminology is received later, i.e. not at the time of the initial ambiguous diagnosis, the abstractor must change the code for the Data Item, "Ambiguous Terminology" from a 1 to a 2 and enter the date that the malignancy was described conclusively. Here you are entering a new date, i.e. the date that the malignancy was described conclusively.

SLIDE THIRTY-FOUR
The standard, basic date format of month, day and year is used for this Data Item. We use 9s for unknown month or day or year--going back to the earlier question about using special codes for dates. Leave this field blank for cases diagnosed prior to January 1, 2007.

SLIDE THIRTY-FIVE
We do have special codes:
● use 00000000 when a case is accessioned based only on ambiguous terminology or in other words when code "1" is in the Data Item "Ambiguous Terminology."
● Use 88888888 when the case was accessioned based on a conclusive diagnosis, i.e. when there is a code "0" in the Data Item, "Ambiguous Terminology."

SLIDE THIRTY-SIX
Use our standard, 99999999, when there is unknown date and there is a code 9 in the Data Item, "Ambiguous Terminology" meaning it is unknown if the diagnosis was based on ambiguous terminology or on conclusive terminology.

SLIDE THIRTY-SEVEN
Are there any questions about the Ambiguous Terminology Data Item?

Question 6
I have a question regarding cytology. I know we have some facilities that actually just diagnose and treat based on cytology especially when a CT report notes extensive disease. In this case because it would be clinically considered definitive terminology would it be code 0?

Response to Question 6
Yes, that's correct. It's a conclusive term. You do have a conclusive diagnosis because with the combination of the cytology and the clinical diagnostic imaging they have made a conclusive diagnosis. So you have a clear and definite statement in that medical record that this person has and is being treated for malignancy. So, yes, you do have a conclusive diagnosis in that case.

Follow-up to Question 6
Let's go to another example: You may have a CT that says "probable" but the physician continually does not consider this to be "probable" and he/she thinks this is a definitive diagnosis of cancer. Is that case code 0 also?

Response to Follow-up to Question 6
If the physician is saying this is a definite diagnosis of cancer that is a code 0: conclusive terminology based on that physician's statement.

Okay. Thank you.

Question 7
Could you please give me an example where "unknown term," code 9, would be applicable for "Ambiguous Terminology" [Data Item]. I don't understand the definition.

Response to Question 7
Unfortunately, I don't really have an example of when code 9 would be used. We include a default value for a "filler" in case something doesn't fall into the standard code options. That is the reason that code is included here. It is kind of a "catch-all" in case something does not fit into the other categories but we expect that not to happen.

Follow-up to Question 7
You wouldn't want it filled with 9s if it is not a required item, correct?

Response to Follow-up to Question 7
That's correct, I believe. If I understand your question properly, yes, that's correct.

Question 8
Steve, there have been some references back and forth to the Multiple Primary and Histology Coding Rules throughout the course of this presentation. I am wondering unless there is a rule in with a particular Data Item contradicting it, do we look at these, view these with the General Instructions from the MP/H Coding Rules or not?

Response to Question 8
I am not sure I understand what you are asking. These New Data Items are really independent from the General Instructions in the Multiple Primary and Histology Coding Rules. There are specific instructions on how to code these Data Items.

Follow-up to Question 8
So we do not apply the General Instructions from the MP/H Rules to any of the New Data Items?

Response to Follow-up to Question 8
No; you do not apply the General Instructions from the new MP/H Coding Rules to these New Data Items; that is correct.

Okay.

If there are no other questions we will be sending out information on practice cases for the Breeze Session next week. We will also send out the link to the cases, rationale and answers for the Practicum on the New Data Items.

I appreciate everybody's attention today. These New Data Items present some unique situations for us, as do any New Data Items. I expect that they will be refined over time and that codes may be added in some instances to describe items and information that we may want to collect.

Thank you very much, everybody.