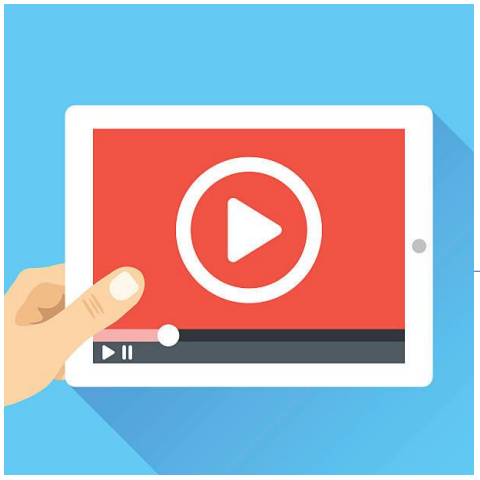

Colon & Rectum
Grade and SSDI v3.1

Presented by Melissa Riddle, ODS-C
ICR Video Training Series | Iowa Cancer Registry
March 2025

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Grade

- Time Frames:
  - Clinical
  - Pathological
  - Post Therapy Clin (yc)
  - Post Therapy Path (yp)
- Grade Table 02 (Colon and Rectum)

Grade manual:

https://www.naaccr.org/wp-content/uploads/2023/10/Grade-Coding-Instructions-and-Tables-v3_printed.pdf?v=1736525261

2

2

Colon and Rectum: Grade Table 02

Code	Description
1	G1: Well Diff
2	G2: Mod Diff
3	G3: Poorly Diff
4	G4: Undiff [includes anaplastic]
9	Grade cannot be assessed (GX); Unknown

3

3

Grade Clinical 2018+

- **Cannot be blank**
- Assign the highest grade during the clinical timeframe
  - Diagnosis until treatment begins
- If there are multiple tumors abstracted as a single abstract with different grades, code the highest grade
- Code as unknown (9)
  - Grade from primary site is not documented
  - Clinical workup is not done (incidental finding during surgery)
  - "Not applicable" marked on CAP protocol and no other grade information available
- If there is only one grade available in the medical record, code it as Grade Clinical

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Grade Post Therapy Clin (yc) 2021+

- Leave blank when:
  - Diagnosed prior to 2021
  - No neoadjuvant therapy
  - Neoadjuvant therapy completed; no microscopic exam done prior to resection
  - Only one grade and cannot determine if clinical, path, yc or yp
- Assign highest grade for microscopic sample of primary site following neoadjuvant therapy or primary systemic/radiation therapy
- Multiple tumors abstracted as one primary, code highest grade
- Code 9 (unknown)
  - Microscopic exam after neoadjuvant therapy, and grade from pri site not documented
  - Micro exam after neoadjuvant therapy and no residual cancer
  - Grade checked not applicable on CAP

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Grade Pathological 2018+

- **Cannot be blank**
- Preferred grading system, generic grade categories do not apply. Code 9 if generic grade given for path. Do not use clinical grade in path grade. [see example in manual]
- Assign highest grade from primary tumor during path timeframe
  - Diagnosis through completion of surgery(ies)
  - No neoadjuvant therapy
- Multiple tumors abstracted as a single abstract with different grades, code highest grade

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Grade Pathological 2018+

Note 6: Use grade from clinical workup from primary tumor based on:

Behavior

- Tumor behavior for clin/path dx same and clinical grade highest
- Tumor behavior for clin is invasive, path is in situ

Surgical Resection

- Resection of primary tumor and no grade from surgical resection
- Resection done of primary tumor and no residual cancer

No Surgical Resection

- No surgery primary site, but positive confirmation of distant mets during clinical time frame

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Grade Pathological 2018+

- **Code 9 (unknown):**
  - Grade from primary site is not documented
  - Surgical resection done and grade from primary site not documented **and** no clinical grade
  - Surgical resection is done **and** there is no residual cancer **and** there is no grade from the clinical work up
  - No resection of the primary site (see exception in Note 6, Surgical resection, last bullet)
  - Neo-adjuvant therapy is followed by a resection (see Grade Post Therapy Path (yp))
  - Grade checked "not applicable" on CAP Protocol (if available) and no other grade information is available
  - Clinical case only (see Grade Clinical)
  - There is only one grade available, and timeframe cannot be determined

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Grade Post Therapy Path (yp) 2018+

- Leave blank when
  - No neoadjuvant therapy
  - Clin or path case only
  - Neoadjuvant therapy completed; surgical resection not done
  - Only one grade and cannot determine if clinical, path, yc or yp
- Generic grade note if not preferred grading system. See Example in manual.
- Assign highest grade from resected primary tumor assessed after completion of neoadjuvant therapy
- Multiple tumors abstracted as one primary, code highest grade

9

9

Please note TYPO note 2 for yp

- **Note 2:** There is a preferred grading system for this schema. If the post therapy clinical grade given uses the preferred grading system and the post therapy pathological grade does not use the preferred grading system, do not record the Grade Post Therapy Clin ~~(yp)~~ should be (yc) in the Grade Post Therapy Path (yp) field. Assign Grade Post Therapy Path (yp) 9.

- PER FORUM 11/3/2022: This was a typo and will not be corrected until v3.0
  - Still present in the v3.1 manual

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Grade Post Therapy Path (yp) 2018+

Note 6: Use grade from post therapy CLINICAL workup of primary tumor based on:

Behavior

- Tumor behavior for yc and yp dx are same and yc is highest grade
- Tumor behavior for yc is invasive, tumor behavior yp in situ

Surgical Resection

- Resection done of primary tumor after neoadjuvant therapy and no grade documented from surgical resection
- Resection done of primary tumor after neoadjuvant therapy and no residual

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Coding Grade – LAMN/HAMN

Per CAnswer Forum:

https://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/general-instructions/139427-coding-the-grade-when-its-part-of-the-histology

- LAMN is G1 or well diff
- HAMN is G2 or mod diff

This was an update that isn't included in the Grade manual. It will be added in 2025 updates. Use with all cases diagnosed 2022+

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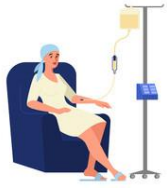
Clinical & Path Grade Coding Timeframe

Grade Pathological: Diagnosis through 1st course surgery without neoadjuvant Tx

Autopsy – Clinical

Autopsy – Path



Grade Clinical: Diagnosis – biopsy, FNA, imaging, etc.

First course surgery

Adjuvant Therapy

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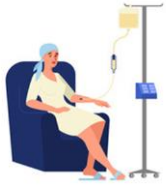
Post-Therapy Grade Coding Timeframe

Autopsy – Clinical



Grade Clinical: Diagnosis – biopsy, FNA, imaging, etc.

Neoadjuvant Therapy

Autopsy – Post Therapy Clin

Autopsy – Post Therapy Path

Grade Post-therapy Clin

Grade Post-therapy Path

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Site Specific Data Items

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Carcinoembryonic antigen (CEA)

- CEA Pre-Treatment Lab Value and Interpretation
  - Take values from same lab test
  - Physician statement can be used when no other info
  - Record highest CEA **prior** to treatment or polypectomy

Example:

- Value: Pretreatment CEA 7 ng/ml. Code as 7.0
- Interpretation: Not documented. Code 3.

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Timing Rule for CEA

SSDI Manual, General Guidelines

- Follow the below guidelines for recording laboratory values:
  - All laboratory values must be done no earlier than approximately three months before diagnosis
  - Only record test results obtained before any cancer-directed treatment is given (neoadjuvant therapy or surgical), unless instructions for a specific laboratory test state otherwise
  - Record the highest laboratory value if multiple laboratory tests results are available, unless instructions for a specific laboratory test state otherwise

Site-specific: Code highest CEA (if multiple) prior to treatment or polypectomy.

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Code	Description
0.0	0.0 nanograms/milliliter (ng/m) exactly
0.1-9999.9	0.1-9999.9 ng/ml Exact value to nearest tenth in ng/ml
XXXX.1	10,000 ng/ml or greater
XXXX.7	Test ordered, results not in chart
XXXX.8	Not applicable
XXXX.9	Not documented in med rec, not assessed or unknown if assessed

CEA PreTX Lab Value

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CEA PreTX Interpretation

Code	Description
0	CEA neg/normal; within normal limits
1	CEA pos/elevated
2	Borderline
3	Undetermined if pos or neg (normal values not avail **AND** no MD interpretation
7	Test ordered, results not in chart
8	Not applicable
9	Not documented in med rec, not assessed or unknown

Code 3 when CEA value documented in record, but no statement CEA is pos/neg/elevated/ normal

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CEA Text Example

- 2-14-23 CEA: 2645 (high)
- 3-17-23 CEA 0.50 (negative)
- 6-14-23 CEA 54 (<2.5)
- 7-4-23 CEA 18.35 (<2.5)

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CEA Examples

Text	#3820 Value	#3819 Interpretation
2-14-22 CEA: 2645 (high)	2645.0	1
3-17-22 CEA 0.50 (negative)	0.5	0
6-14-22 CEA 54 (<2.5)	54.0	1
7-4-22 CEA 18.35 (<2.5)	18.4	1

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H&P: "Pre-op CEA elevated"

CEA Value: **XXXX.7**

- ordered, results not in chart

CEA Interpretation: **1**

- Note 1: Phys statement can be used when no info available

CEA Example

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Tumor Deposits

- Discrete nodule of cancer in pericolic/perirectal fat or adjacent mesentery
  - Not direct extension from the primary tumor
- May be found within the primary lymphatic drainage area
  - Nodule outside the primary lymphatic drainage area is distant metastasis

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Tumor Deposits (TD)

- Source Document: Pathology Report
  - Physician statement can be used to code without more information
  - Review CAP Summary/Protocol
- Record whether tumor deposits are present or absent
- One or more satellite peritumoral nodule(s) in the pericolorectal adipose tissue without histologic evidence of residual LN
- Record the number of TD whether or not there are positive LN
- If primary tumor is resected and pathology report doesn't mention TD code X9

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Code	Description
00	No tumor deposits
01-99	1-99 Tumor deposits (TD) Exact number of TD
X1	100 or more Tumor Deposits
X2	Tumor Deposits identified; number unknown
X8	No applicable
X9	Not documented in record Cannot be determined by pathologist *Pathology report does not mention tumor deposits No surgical resection done Tumor Deposits not assessed

Tumor Deposits

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Perineural Invasion (PNI)

- Infiltration of nerves in the area of the lesion by tumor cells or spread of tumor along the nerve pathway
- Indicator of poor patient prognosis
- Do NOT assume that perineural invasion is negative if not mentioned on path report
- Source document: Pathology Report
  - Physician statement of microscopic confirmed perineural inv can be used to code the data item
  - Presence of PNI can be from biopsy or resection information
    - **Absence PNI must be based on primary resection**

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Perineural Invasion

Code 0: only taken from resection path report

Code	Description
0	Perineural invasion not identified/not present
1	Perineural invasion identified/present {biopsy or resection}
8	Not applicable
9	Not documented in medical record *Path report **does not mention** perineural invasion Cannot be determined by pathologist Perineural invasion not assessed or unknown if assessed

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Circumferential Resection Margin (CRM)

- Distance in mm between the leading edge of the tumor and surgically dissected margin
  - Width of surgical margin at deepest part of tumor in an area without serosa (non-peritonealized) or only partially covered by serosa
  - Segments encased by peritoneum, the mesenteric resection margin is the only relevant circumferential margin
- Other names (*Note 5*): radial margin; mesenteric resection margin; soft tissue margin; circumferential radial margin

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Note 5: Only specific statements about CRM

Code if you find these terms:

- Circumferential radial margin
- Circumferential resection margin
- Mesenteric (mesocolon) (mesorectal) margin
- Radial margin
- Soft tissue margin

Do *NOT* code if these are the only terms found:

- Distal margin
- Proximal margin
- Margins, NOS
- All margins negative
- Resection margins

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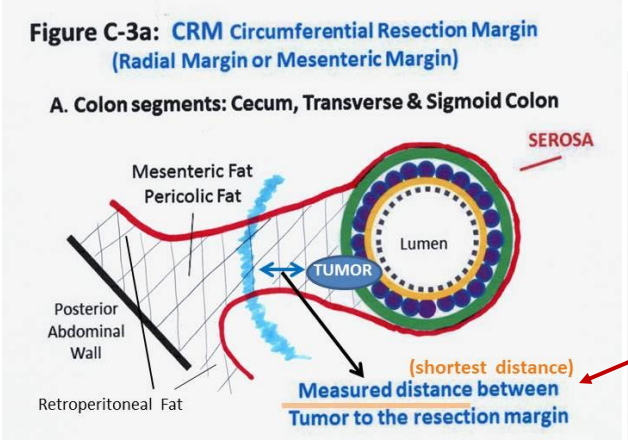

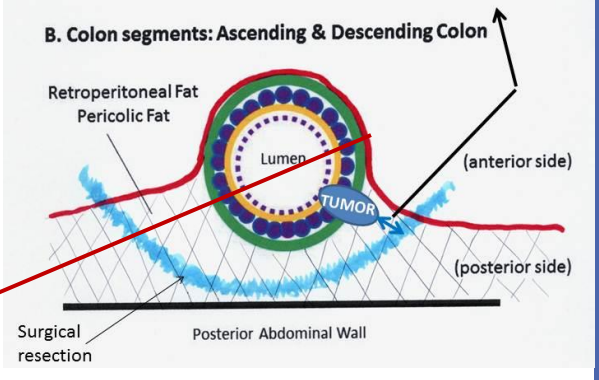

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CRM Guidelines

- **Colon primaries** (C18_), surgery **must be a surgical resection**
  - If it is not a surgical resection (polypectomy, excisional biopsy) then CRM is coded **XX.7**
- **Rectal primaries** (C209), surgery must be **excisional biopsy, transanal excision, or surgical resection**
  - Excisional biopsy/Transanal procedure: **only peritonealized portion of rectum is where you get CRM**
    - Non-peritonealized portion involved or unknown if peritonealized portion involved, **code XX.7**
    - Procedure is **not** excisional biopsy, transanal excision, or resection, **code XX.7**

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CRM Coding Guidelines - Surgery

Primary Site	Surgery Description	Code CRM
Colon C18X	Polypectomy; Local excision (surgery codes less than B300)	XX.7
Colon C18X	Surgical resection primary tumor (B300-B800)	Code CRM as stated
Rectosigmoid C199	Polypectomy; Local excision (surgery codes less than A300)	XX.7
Rectosigmoid C199	Surgical resection primary tumor (A300-A800)	Code CRM as stated
Rectum C209	Surgery codes less than A270 and equal to A280	XX.7
Rectum C209	Peritonealized portion rectum – surgery code A270	Code CRM as stated
Rectum C209	Non-peritonealized portion or unknown if peritonealized portion (A270)	XX.7
Rectum C209	Surgical resection primary tumor (A300-A800)	Code CRM as stated

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CRM Recording Size

- Record in mm to nearest 10th
- If recorded in cm, multiply by 10 to get mm value
- Margin is involved (positive) code 0.0
  - If less than 0.1mm, code 0.0
    - Margins 0-1.0mm are recorded by pathologist as involved
  - **Exception** (*Note 10*): Exact measurement takes priority even if pathologist states margin is positive
    - Example: CRM is 0.3mm, code 0.3 (not 0.0)

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Notes 6-7: CRM SSDI is recorded in millimeters

- Record in millimeters (mm) to the nearest tenth
  - If CRM = 2mm then
    - SSDI code = 2.0
  - If CRM = 2.78mm then
    - SSDI code = 2.8

If given in centimeters (cm)

- Multiply by 10 *or* move your decimal right one
- If CRM = 0.2 cm then

$$0.2\ cm \times 10 = 2.0\ mm$$

0.2 cm	0.2.	2.0 mm

*You can also google "cm to mm" and google will provide you with a conversion calculator

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CRM Range

If you have a range, code 0.1 above the lowest number in the range stated (decimal field)

Example

Distance of invasive carcinoma from closest margin: 3-4 mm

Specified margin: Radial

Code SSDI as: 3.1 mm

http://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/96150-ssdi-colon-and-rectum-circumferential-resection-margin-size

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"Greater than" CRM Value

If you have a "greater than" statement, you code 0.1 above the number provided

**If number is "greater than 3mm" use code XX.6

Example

Margins Examined: Proximal, Distal, Radial or Mesenteric

Distance of Tumor from Radial Margin: >1 cm from resection margin

Code: 10.1 mm

SSDI manual pg. 23

http://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/94152-crm-1mm-from-serosal-surface-1cm-from-resection-margin

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"Less than" CRM

If you have a "less than" statement, you code 0.1 below the number provided

Example

Margins Examined: Proximal, Distal, Radial or Mesenteric

Distance of Tumor from Radial Margin: <3 mm from resection margin

Code: 2.9 mm

SSDI manual pg. 23

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Coding CRM

- If **margins cannot be assessed** and **STATED** on the pathology report/CAP checklist, **code XX.2**
- An exact measurement takes precedence over codes 0.0 and those beginning with XX._
- **Code XX.9** (unknown)
  - Not Applicable: Radial or Mesenteric Margin on CAP checklist is marked
  - Path report describes **ONLY** distal and proximal margins or margins, NOS
    - Only specific statements about the CRM are collected (may be in the gross description of path report)
  - CRM is not mentioned in medical record

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Code	Description
0.0	Circumferential resection margin (CRM) pos. Margin IS involved with tumor. Described as less than 1 mm.
0.1-99.9	Distance of tumor from margin: 0.1-99.9 mm Exact size to nearest tenth of mm
XX.0	100 mm or greater
XX.1	Margins clear, distance from tumor not stated. CRM or radial margin neg, NOS. No residual tumor
XX.2	Margins cannot be assessed

**ONLY when path/CAP states margin cannot be assessed

CRM Codes

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Code	Description
XX.3	Described as 'at least' 1 mm
XX.4	Described as 'at least' 2 mm
XX.5	Described as 'at least' 3 mm
XX.6	Described as 'greater than' 3 mm
XX.7	No resection of primary site
XX.8	Not applicable
XX.9	Not documented in medical record; CRM not assessed. Checked "not applicable" on CAP checklist.

CRM Codes

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FORUM SAYS:

Neoadjuvant example:

Pt had pos colon biopsy. Neoadjuvant therapy followed by resection. Resection CRM was neg after neoadjuvant therapy. Can you use CRM?

Yes. Manual does not state this has to be prior to neoadjuvant therapy. (JRUHL)

http://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/87099-crm-neoadjuvant-tx

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Microsatellite Instability (MSI)

- Form of genetic instability manifested by changes in the length of repeated single- to six-nucleotide sequences
  - DNA microsatellite sequences
  - Makes it difficult to correct mistakes that occur when DNA is copied in the cell
- High MSI is found in about 15% CRC
  - Hallmark of hereditary nonpolyposis CRC (Lynch Syndrome)
- Adverse prognostic factor and predicts poor response to 5-FU

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MSI

- This is based on a genetic test or immunology performed on tumor tissue
  - Physician statement on MSI can be used to code
  - MSI may be recorded for all stages
    - Primarily performed on invasive cancer
    - For non-invasive (in-situ) code 9
  - Results from nodal or metastatic tissue may be used

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MSI Testing

Description	Code
MSS; Stable	0
Negative	0
Low probability MSI-H	0
MSS/MSI-L	0
MSI-L	1
Unstable; Unstable NOS	2
MSI-H	2
MSI – I (intermediate	9

- Immunology or Genetic Testing
  - Genetic Test will specific if MSI is low or high

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Mismatch Repair (MMR)

Description	Code
No loss of nuclear expression	0
MMR intact; MMR normal	0
MMR proficient (pMMR or MMR-P)	0
Loss of nuclear expression	2
MMR deficient (dMMR or MMR-D)	2
MMR abnormal	2

- MMR Testing is usually done by immunohistochemistry (IHC)
  - Most common markers are MLH1, MSH2, MSH6, PMS2

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Microsatellite Instability MSI

Note 1: Physician statement can be used to code this item
Note 2: Genetic test, useful prognostic marker for response to surgery and survival
Note 3: MSI primarily performed for invasive neoplasms. If non-invasive /2, code to 9 if no info available.
Note 4: Results from nodal or metastatic tissue may be used
Note 5: MSI usually done by immunology or genetic testing
See details of notes
Note 6: Testing for MMR usually done by IHC
See details of notes
Note 7: If both tests are done and one or both pos; code 2
Note 8: If all tests done are neg, code 0.

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MSI Codes

Code	Description
0	Microsatellite instability (MSI) stable; microsatellite stable (MSS; neg, NOS; AND/OR Mismatch repair (MMR) intact, no loss of nuclear expression of MMR proteins
1	MSI unstable low (MSI-L)
2	MSI unstable high (MSI-H) AND/OR MMR-D (loss of expression of one or more MMR proteins
8	Not applicable
9	Not documented in record; MSI indeterminate; MSI not assessed or unknown if assessed.

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Example MSI

Path report 2/14/2024: INTACT MISMATCH REPAIR PROTEINS:
MLH-1: Positive staining representing intact mismatch repair proteins.
PMS-2: Positive staining representing intact mismatch repair proteins.
MSH-2: Positive staining representing intact mismatch repair proteins.
MSH-6: Positive staining representing intact mismatch repair proteins.
BRAFV600 E: Negative

What is the correct MSI code?
MSI: 0
What would you include in your text?
2/14/24 MMR intact

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KRAS

- KRAS is an oncogene
  - A gene that when mutated or overexpressed helps tumor a normal cell into a cancer cell
- Indicator that a patient may not respond to an anti-epidermal growth factor receptor (EGFR) drugs
  - Erbitux; Vectibix
- Stage IV colorectal patients should be tested
- KRAS is either Normal (wild type) or Mutated (abnormal)

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KRAS

- Source documents: Path Report or Clinical Lab Report
  - Physician statement of KRAS can be used to code
- Other names: K-Ras; K-ras; Ki-Ras

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Codon	Mutation associated w/ KRAS
Codon 12	Gly12Asp (GGT>GAT) Gly12Val (GGT>GTT) Gly12Cys (GGT>TGT) Gly12Ser (GGT>AGT) Gly12Ala (GGT>GCT) Gly12 Arg (GGT>CGT) Codon 12 mutation, not otherwise specified
Codon 13	Gly13Asp (GGC>GAC) Gly13Arg (GGC>CGC) Gly13Cys (GGC>TGC) Gly13Ala (GGC>GCC) Gly13Val (GGC>GTC) Codon 13 mutation, not otherwise specified
Codon 61	Gln61Leu (CAA>CTA) Gln61His (CAA>CAC) Codon 61 mutation, NOS
Codon 146	Ala146Thr (G436A) (GCA>ACA) Codon 146 mutation, NOS

KRAS Mutations

- 4 KRAS codons commonly mutated in CRC
  - SSDI doesn't record the actual mutation
    - Record the codon or codon group that contains the mutation
    - Specific KRAS mutation reported, codon may be identified from these common mutations grouped by codon

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KRAS Codes

Code	Description
0	Normal (wild type); neg for mutations
1	Abn (mutated) in codon(s) 12, 13, and/or 61
2	Abn (mutated) in codon 146 only
3	Abn (mutated) but not in codon(s) 12, 13, 61, 146
4	Abn (mutated), NOS, codon(s) not specified
7	Test ordered, not in chart
8	Not applicable
9	Not documented in med rec; KRAS not assessed or unknown if assessed

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KRAS Example

EXAMPLE: RESULTS: Pathogenic alteration is DETECTED in the KRAS gene.
Gene:KRAS
Exons Tested: ALL
Genomic Alteration(s): c.35G>T: **p.G12V**
Mutation Effect: MISSENSE
Allele Frequency :35%
Pathogenic: YES
NGS Interpretation A genomic alteration in the KRAS gene is detected (C.35G>T; p.G12V). This missense alteration has been previously reported and is expected to be pathogenic.

- **Answer:** This looks like a G12v, which is a Codon 12. Code 1.

http://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/98522-creative-documentation-of-kras

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KRAS & Neoadjuvant Therapy

Question: For colon and rectum, the SSDI field KRAS Note 5 states record the results from the initial workup((clinical and pathological workup). Please clarify if you code the KRAS after neoadjuvant therapy.

J. Ruhl: I contacted some of the other SSDI work group members, and our ever-faithful CAP representative responded. He presented several different scenarios that the SSDI work group will discuss, but overall, he felt that using KRAS data after neoadjuvant therapy is not reliable and should not be used.
So, if the KRAS is done after the neoadjuvant therapy, do not use it.

https://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/107008-ssdi-kras-neoadjuvant-therapy

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NRAS Mutational Analysis

Cases diagnosed 2021+

- NRAS, like KRAS, are important signaling intermediates in the growth receptor pathway
  - Oncogene
  - Control cell proliferation and survival
- Poor prognosis and predict poor response to anti-EGFR therapy in patients with metastatic CRC
- Source documents: Path Report or Clinical Lab Report
  - Physician statement of NRS can be used to code
  - Can be recorded for all stages, but primarily performed for patients with metastatic disease

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Codon	Mutation associated w/ KRAS
Codon 12	Gly12Asp (GGT>GAT) Gly12Val (GGT>GTT) Gly12Cys (GGT>TGT) Gly12Ser (GGT>AGT) Gly12Ala (GGT>GCT) Gly12 Arg (GGT>CGT) Codon 12 mutation, not otherwise specified
Codon 13	Gly13Asp (GGC>GAC) Gly13Arg (GGC>CGC) Gly13Cys (GGC>TGC) Gly13Ala (GGC>GCC) Gly13Val (GGC>GTC) Codon 13 mutation, not otherwise specified
Codon 61	Gln61Leu (CAA>CTA) Gln61His (CAA>CAC) Codon 61 mutation, NOS

NRAS Mutations

- 3 NRAS Codons commonly mutated in CRC
  - Actual mutation is not coded
  - Record the codon or codon group that contains the mutation

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Code	Description
0	Normal, NRAS negative; NRAS wild type Negative for somatic mutations, no alterations
1	Abnormal (mutated)/detected in codon(s) 12, 13, and/or 61
2	Abnormal (mutated)/detected, codon(s) specified but not in codon(s) 12, 13, or 61
4	Abnormal (mutated), NOS, codon(s) not specified
7	Test ordered, results not in chart
8	Not applicable
9	Not documented in medical record, NRAS not assessed or unknown if assessed
<blank>	N/A – Diagnosis year is prior to 2021

NRAS Codes

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BRAF Mutational Analysis

For cases diagnosed 2021+

- Oncoprotein involved in transmitting cell growth and proliferation signals from KRAS to NRAS
  - Causing growth and spread of cancer cells
- Help plan cancer treatment
  - **BRAF V600E** is associated with poor prognosis and lack of response to anti-EGFR therapies
- Source document: Molecular reports (addendum to original path report)
  - Physician statement on BRAF can be used to code data item

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BRAF Testing Methods

- Most common:
  - Direct Sanger sequencing
  - High-resolution melting analysis
  - Pyrosequencing
  - PCR, allele-specific hybridization
  - Real-time PCR

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BRAF Mutation Analysis

- Tissue from primary, nodal, or metastatic site may be used to test BRAF
- BRAF is positive, but codon unknown or not specified – code 4
- Neoadjuvant therapy administered
  - Code BRAF from specimen prior to neoadjuvant therapy
  - If no testing prior to neoadjuvant Tx, then report post-therapy findings

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Code	Description
0	Normal, BRAF Neg, BRAF wild type Neg for somatic mutations
1	Abnormal (mutated)/detected: BRAF V600E (c.1799T>A) mutation
2	Abnormal (mutated)/detected:, but not BRAF V600E (c.1799T>A) mutation
4	Abnormal (mutated), NOS
7	Test ordered, results not in chart
8	Not applicable
9	Not documented in med record, BRAF not assessed or unknown if assessed
<blank>	N/A – Diagnosis year is prior to 2021

BRAF Codes

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Homework

SSDI and Grade cases on SEER*Edu

- https://educate.fredhutch.org/Identity/Account/Login
- Training | Coding – CEs
- Select DX 2021-2024 EOD, SS, Grade, SSDI Mashup Up
  - Colon and rectum 01-05
  - Colon and rectum 06-10

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Questions

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