Boot Camp 2023

Q&A

3/2/23

	Question	Answer
1.	When is a diagnostic biopsy done at a physician's office w/ admitting privileges but the pathology for the bx is done at the reporting facility and all subsequent treatment at the facility is that a class of case 12 or 14?	Class of case 12
2.	Quiz 1 what is the diagnosis year? Before 2021 scope of regional LN surg 1 was coded as surgical procedure.	n/a as regional ln's not considered surgery even went surg code was 1
3.	Not clear in STORE manual but the more specific class of case takes priority over the NOS codes, right? (21 and 22 over 20 & 11-14 over 10 when details of dx & tx are known)	Yes – more specific takes precedence
4.	When outside imaging does not use diagnostic ambiguous term (ex. concerning for primary lung malignancy) but reporting facility MD review of the same outside imaging uses diagnostic ambiguous term (ex. consistent with primary lung cancer) it is considered diagnosed at the outside facility because the imaging was done there?	Your example uses an ambiguous term (c/w) that would constitute a diagnosis so either your date of diagnosis would be the outside imaging. However, if you meant what if an outside imaging center uses a diagnostic term & your reporting facility MD uses a term that does NOT constitute a diagnosis (i.e. equivocal or worrisome) than I would go with the date of diagnosis that your reporting facility confirms. You might even want to reach out to the physician to confirm with them what date of diagnosis they are going by.
5.	For question #4 COC 21 shouldn't it be PART not ALL?	Class 11 states initial diagnosis in physician's office and Part of 1st course of tx at reporting facility.
6.	Why would 5 be A&C? Isn't it only C?	Class of case 00 – diagnosed at reporting facility and all 1st course tx elsewhere. C -patient was diagnosed at reporting facility and treated elsewhere (non-staff physician's office)
7.	Also wondering why 5 is A and C and not just C.	Class of case 00 – diagnosed at reporting facility and all 1st course

		tx elsewhere. C -patient was diagnosed at reporting facility and treated elsewhere (non-staff physician's office)
8.	I don't think LN Bx was ever considered treatment prior to 2021. It is diagnostic, not a surgery/treatment. What changed in 2021, was the surgery/tx sequences. It would not have changed how we thought of class of case.	You are correct! Thank you for the clarification.
9.	What is the difference between the staff physician and non-staff physician	Per STORE, Physicians who are not employed by the hospital but are under contract with it or have routine admitting privileges are described in codes 10-12 and 41 as physicians with admitting privileges. Treatment provided in the office of a physician with admitting privileges is provided "elsewhere." That is because care given in the physician's office is not within the hospital's realm of responsibility. If the hospital purchases a physician practice, it will be necessary to determine whether the practice is now legally considered part of the hospital (their activity is coded as the hospital's) or not. If the practice is not legally part of the hospital, it will be necessary to determine whether the physicians involved have routine admitting privileges or not, as with any other physician.
10	With regard to the Ambiguous terms with the Radiology Consult at Your facility, If the OSH does not pick up the case then one would think that the date of diagnosis would be the date Your physician Diagnoses it.	It depends, just because another hospital didn't pick up a case doesn't mean they didn't diagnosis it. You would need to confirm with your managing physician what they are using for date of diagnosis.
11	Will the approved abbreviation list ever be updated?	Would say yes, however standard-setters would oversee and distribute.
12	Tip - if you regularly use abbreviations NOT on the official list & getting QC'd by central registry as Jim mentioned, you can add custom entries in Word's AutoCorrect to auto-expand abbreviations (if you use Word to collect text before putting into registry software). Ex. you	Great tip!

	can have Word auto-change WLE to wide local excision.	
13	RUOQ - I totally agree with this abbreviation - but interesting it is NOT on the approved abbreviation list - maybe just an overlook because LUOQ is on the list	You are correct! It really should be included!
14	Quiz #3 - I'm probably overthinking this, do we assume no later definitive dx to confirm the cytology? (there was a change about cytology & date of diagnosis in 2022 STORE & SEER manuals). Would consider ambiguous term cytology as "potentially reportable" & put case in suspense for later review of EMR for physician statement and/or subsequent definitive dx.	That is correct. For the quiz we will assume they did not get a more definitive dx subsequently.
15	FNA OF THE EYE cytology only positive for melanoma is this reportable	Yes reportable. Remember only when cytology is identified with an **ambiguous term** do we not interpret it as a diagnosis of cancer. If it said c/w or appears to be melanoma than you would need a physician's clinical impression of ca to support the findings.
16	Is concerning for an ambiguous term that constitute a diagnosis (example MRI liver states concerning for) no bx done?	No – concerning for is not listed in STORE under the Ambiguous Terms that Constitute a Diagnosis.
17	With cytology, I quite often see "suspicious for adenocarcinoma". Is this considered reportable?	It depends. The case might still be reportable. Suspicious for is a term that constitutes a diagnosis, as we discussed cytology is the exception. So do not interpret it as a diagnosis of cancer, but if there is a positive bx or there is a physician's clinical impression of cancer supporting the cytology, then it becomes reportable and you would want to abstract the case.
18	probable is considered dx so why not for Quiz 3?	
19	Will there be a clarification about "neoplasm" (per store only for benign CNS 2004+)? My facility pathologists regularly refer to multiple myeloma on BM bx reports as "plasma cell neoplasm." The Heme database is also called "hematopoietic & lymphoid NEOPLASM database".	Have you sent this to Ask a SEER Registrar? Sometimes a question on Ask SEER Registrar is what it takes to make change happen.
20	wouldn't the CIS of the cervix be a 34, reportable by agreement?	It could be.

21	"PROBABLY" is a term that I see frequently, but it is not on either list of reportable or non-reportable ambiguous terms. Do you use this term because the word "probable" is on the list of reportable terms?	I've seen posts say it can and cannot be used. I suggest sending an actual case where the term is used to CAnswer forum.
22	Also, I thought urine cytology positive was reportable	As long as it doesn't use an ambiguous term.
23	most likely is reportable?	Yes
24	When diagnostic imaging does not use an ambiguous term that constitutes a diagnosis, but the clinician states it is malignant based on that evidence, do you use the dx date of the imaging or the date of the provider note?	Per STORE, If the physician states that in retrospect the patient had cancer at an earlier date, use the earlier date as the date of diagnosis. So for your question, if the physician states that the case was malignant based on the imaging date then I would use that date for date of diagnosis. As always, if you are unsure you should try to contact that physician.
25	In Canada, we would use cytology date if both cytology and histology confirmed the cancer and cytology date was before histology. But you're correct about us taking the cytology date over radiology.	Thank you!
26	Comment: For ambiguous terms, SEER allows equivalent words such as "favored" rather than "favor(s)" as an example in the manual. CoC is stricter and will only allow you to use the words as listed in STORE.	Good to know!
27	Does Carcinoma in situ of the cervix should be coded as Class of case 34 - reportable by agreement? Casefinding Quiz - question 2.	The "with micro invasion" is what makes this reportable. CIS of the cervix alone would not be reportable to NCDB. It could be a class of case 34 if it is reportable by agreement for your facility
28	pg 10 in seer urine cytology positive for malignancy is reportable code to C689	Yes – if no ambiguous terminology is used than that would be true!
29	There is an example in the STORE manual under Date of Initial Diagnosis which clarifies that if cytology has an ambiguous term and confirmed by pathology on a different date, the date of diagnosis would be they date of the cytology.	Thank you!
30	What does Canada do with cancers that are diagnosed on imaging w/o bx and goes to treatment? (I have seen that with low stage lung cancers and also kidney & liver cancers)	A participant from Alberta Canada stated… *In Alberta we would use the date of imaging if imaging was definite or used ambiguous term considered dx. If that is all we had and treatment was given for lung cancer. We use this often in kidney*

		when imaging says renal cell carcinoma and there is fu imaging in a year following a renal cell carcinoma. We also have access to a provincial emr for all of Alberta and can find urologist documentation
31	'@Amanda - the example in STORE was changed in STORE 2022+. If you look in STORE 2021 and before the same example uses date of the pathology and not the cytology. Janet Vogel did a great job making the change known in one of her 2022 webinars.	Thank you!
32	FYI - I just learned last week from CAnswer Forum that the STORE addendum that was last updated 2020 can NOT be used starting with STORE 2021. I'm still trying to get a clear answer on what to do with the addendum clarifications that didn't make it into STORE 2021-2023.	Let us know what you find.
33	For SEER manual - since the STORE reduction in 2021 don't non-SEER registries also have to use SEER for data items no longer in STORE?	If a data item is not in the STORE manual, either the SEER SPCSM or your state registry manual would be a good resource.
34	The only one available on the website is the version that came out in August 2022. Could not find the one that came out in February 2023, or did I see updated revision date incorrectly?	I suggest bookmarking the link below! https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/
35	Tip: On the SEER site they have a Manual Reference Guide that has links to all manuals used to report cancer cases.	Thank you!
36	Can CRM be taken from the microscopic section of the resection pathology report when it is clearly stated there and NOT stated on the synoptic or final diagnosis?	If that situation comes up, please send to the CAnswer forum!
37	Can the Boot Camp webinars be done in two parts like Breast? There's soooooo much to cover! :)	Thanks for the suggestion! We will take that under consideration!
38	It would be good to describe how a facility knows whether or not an entity, such as a physician's office purchased by the hospital, is considered part of the facility. Is it safe to say it might be included on the facility's state license? Should you rely instead on accreditation listing instead?	I wish I had an answer for you! The only suggestion I have is to send your situation to the Canswer forum.
39	I have a question about the 2023 excel document for histology. Can we use this for 2018 & forward or do we have to use the different excel documents for each year that it is updated?	Yes. You can use it for 2018 forward cases.
40	on Casefinding Quiz, #3, I had 60, 00, 61. Do you go back and change the first benign to 61?	Yes.

41	page 7, question a... tumor in RUL, very likely malignant. very likely is reportable page 8 question 2... why is carcinoma in situ of the cervix not Class of Case 34 - not reportable to CoC? Why is very Likely not reportable?	Regardless of the ambiguous terms used, carcinoma in situ of the cervix is non-analytic
42	To clarify - a PT dx and treated elsewhere for a reportable disease comes to your facility with active disease - we would abstract as 32 (non-analytical). Your last example before the break - you said it is not reportable. Did I hear that correctly?	To be analytic a case must be a site/histology required by CoC and your facility must either dx or tx the patient.
43	The lag time in release of the rules and the software updates are a really good reason to have excellent documentation in your abstract. If you are abstracting a case before the software is updated (such as for RCRS) you can code your case from your text and not have to go back to the EMR.	Great advice!
44	The instructions for coding FIGO Stage changed for Dx Year 2023+, we can no longer code from the pathology report, there has to be a physician statement.	You are correct! Thank you for pointing that out!