

Q&A Session for Boot Camp I

March 6 & 7, 2024

#	Question	Answer
1.	Quiz 2 question #3... another edit you might get coding class of case like that is it will produce an edit w/a conflict of date 1st contact not the same as Date of First Course of Treatment.	I guess the question is how to code the date of first course treatment. I think you would code the date of the shave biopsy. It's my understanding that the only field that is not consistent is Class of Case. I wouldn't be surprised if we get further instructions on this in the future.
2.	Quiz 2 question #3... For Facility A if you continue with your same logic given in this webinar... it would be Class of Case 00.... However, the Surgery at this facility code for Facility A would be B220-Shave Biopsy, NOS, would that even pass Edits?	The answers I presented on the webinar were incorrect. If a patient has a shave biopsy at Facility A and wide excision at facility B, then Class of case for facility A would be 13 and Facility B would be 21. We will discuss this on Boot Camp 2 in April.
3.	Quiz 4 question #4 AJCC defines pathologic time frame from date of diagnosis through surgical resection in the absence of progression. Not sure about yp	The tricky part of that statement is "progression". We should not try to apply the cancer registry world definition of disease progression to AJCC staging.
4.	Quiz 4 question #4 Because the patient has documented progression, how could there be a yp stage?	Part of the issue is the definition of "progression" AJCC does not use the same definition of progression that we use in the registry world.
5.	Quiz 2 Question #3 But if you code the melanoma shave in surgery, by that reasoning this would be class 21; we didn't have residual, so it makes little sense to code it as 22?	The answers I presented on the webinar were incorrect. If a patient has a shave biopsy at Facility A and wide excision at facility B, then Class of case for facility A would be 13 and Facility B would be 21. We will discuss this on Boot Camp 2 in April.
6.	Can you explain lobular neoplasia grade III? I am not seeing in the STRs that this is used interchangeably with the term LCIS?	If you asked a pathologist, they would probably say the terms are synonymous. SEER also considers the terms synonymous. NPCR does not require lobular neoplasia grade 3 at this time. They require LCIS. If you are in a SEER state, you should be picking up lobular neoplasia grade III. If you are not in a SEER state and your state has not provided instruction on Lobular

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		neoplasia, then you probably do not need to pick up a tumor described as lobular neoplasia grade 3. It is a good idea to check with your state registry on this one.
7.	Can you use "suspicious of" for reportability or does it have to be " suspicious for"?	I would consider a tumor suspicious of malignancy reportable.
8.	Quiz 2 question #1 is tricky - we have patients that we diagnose, and they say they are going elsewhere for treatment, and we don't hear back. Shouldn't we at least try to see if they did get treatment elsewhere? Otherwise, we have all these "analytic" cases that we are responsible for following even if we did not provide any treatment, but someone else did?	Absolutely! If on further evaluation you find they have treatment elsewhere, you should go back and change class of case.
9.	Dr. Greene stated in one of his talks that once the patient comes back and starts the surveillance (3 months, 6 months, etc.), then anything after that is subsequent treatment. If they come back before that first surveillance and change their mind, then you can include it in first course.	That seems like a very practical approach. There used to be a post on the CANSWER forum that stated the same thing. However, I think it has been removed.
10.	For active surveillance, in my experience, the understanding for every sight is that eventually treatment of some other sort will be required if/once pt becomes symptomatic or has progression. Much like low stage CLL where they don't require tx right away. But that subsequent treatment would not be first course. Q4 indicates the pt PSA rose significantly and the pt decided that he was anxious about this and terminated the active surveillance (over a year later) he wanted something more proactive done.	Thanks Gail. I have not heard it stated that way, but it makes sense. I think for abstracting purposes we treat active surveillance as the first course treatment and even though additional treatment is anticipated by the physician, that treatment is not coded as first course treatment. If treatment is started, it is usually because of progression or "recurrence", picked up by tumor markers, scans, etc. and therefore not first course.
11.	For class of case 32 (pt presents w active disease) Is all active disease picked up or only if you participate or refer for treatment? If it is, do we just take the patients' word that they have active disease, or do we need confirmation?	Many states do not require Class of Case 32, so check with your state on this one. If your state requires this type of non-analytic class of case, then yes, pick it up if there is documentation that the patient has evidence of disease. If they don't then code to the appropriate class of case.

12.	For question #3 wouldn't you take the c/w lymphoma as the initial diagnosis since this is ambiguous terminology? That conflicts with the differential diagnosis statement and per SEER when there are conflicting statements, you would go with positive ambiguous statement.	I think the SEER statement would be in a situation where they use both positive and negative terms to describe the same tumor. For example, A CT states, "patient has a tumor suspicious for malignancy". And later in the same report they say "the possible malignant tumor". They have used both a reportable and not reportable amb term. Per SEER, the reportable amb term takes precedence. Our situation is different. They describe 3 possible conditions and one of them is not reportable. If any of the possibilities are not reportable, you cannot use the report as the date of diagnosis. Use the ambiguous terminology list from the manual you are using to code that particular field.
13.	For question 6, if D is the answer, then the Class of Case for Facility B is 21??	I believe that would be correct.
14.	For Quiz 3, #4, I agree that with the CT alone, it would not be reportable with the differential dx of sarcoidosis, but if you have confirmation of the cancer, wouldn't the date of diagnosis go back to the date of the CT?	There is definitely a difference between the post you sent me and what we have done in the past. The SEER manual has very specific guidelines on when a dx date can be changed and our scenario does not meet those criteria.
15.	For Quiz 4, question #2, I also thought you should review the class of case.	Yes! It could definitely change class of case.
16.	According to the STORE 2023 manual in regard to reportability to GIST tumors is states GIST and Thymomas that are nonmalignant must be abstracted and assigned a behavior code 3 if they are noted to have multiple foci, metastasis, or positive lymph nodes. Did I not read this right to the question #5 on quiz 1?	You read it correctly. Multiple foci, mets, positive nodes are all signs that a tumor is malignant. If any of those conditions are present or if the physician states the GIST is malignant, then you report the case as malignant. That is true no matter what year the case is diagnosed.
17.	https://cancerbulletin.facs.org/forums/node/149207 ; Jim this was my post to cancer forum, which told me to make my case a 21. What am I missing that is different about my post?	The answers I presented on the webinar were incorrect. If a patient has a shave biopsy at Facility A and wide excision at facility B, then Class of case for facility A would be 13 and Facility B would be 21. We will discuss this on Boot Camp 2 in April.

18.	I asked SEER and they said elevated PSA alone doesn't mean progression of disease, that's not just for active surveillance either	That is my understanding as well.
19.	Could you explain why the patient in quiz 4 question 4 would be eligible for yp stage?	I think this is another situation where we shouldn't tie what is coded in surgery with another coding concept (AJCC Stage). Donna confirmed that the "disease progression" and change in neoadjuvant treatment would not disqualify this patient from a yp stage.
20.	I know I have seen examples of quiz #3, question 3 on the CANSWER Forum such as this post: https://cancerbulletin.facs.org/forums/node/135519	This is not consistent with the coding rules we have used in the past or what SEER has in their manual. I'll try to get it clarified.
21.	I often see "differential considerations." Should this be considered the same as differential "diagnosis?"	I would consider it the same.
22.	I ran across this patient yesterday. She has three tumors. Two in her right 1. invasive ductal carcinoma 2. invasive lobular carcinoma and DCIS in left breast. I know she has two primaries, but I'm going back and forth on the right side as to does she has two primaries there or one. These are not mixed. Both tumors are over 2 cm. Both tumors are on opposite sides from each other. Two primaries or one?? Solid Tumor Rules says one but contradicts. I used rule M10, but it doesn't seem right.	Per rule M10 this is a single primary. It does seem like it should be 2 primaries. We have two tumors, and each is a distinct and separate histology. However, Rule M10 specifically addresses this scenario.
23.	I thought the suspicious urine cytology had to be confirmed by biopsy per SEER?	A suspicious urine cytology would be sufficient to pick up the case. Ambiguous terms were not used in this scenario.
24.	I would've thought 21 because the margins were positive so wouldn't the wide excision be considered treatment.	Margins are not a factor for cases diagnosed 2023 or later. However, I can see how this could be considered treatment. They would remove most if not all of the tumor in the shave bx. We'll double check to make sure the statement is correct.
25.	If patients are initially on Active Surveillance (Dx and tx decided at Facility A) and then transfer care to Facility B and continue on Active Surveillance 3 years later, is this an analytic case for Facility B? (Examples would be Prostate	What I don't know off the top of my head is whether Active Surveillance protocols have a timeline. If they do, then first course treatment spans that timeline and if care for the patient transfers to your facility during that timeline, it is an analytic

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	Cancer, CLL, and other malignancies where active surveillance is considered first-course)	case. If Active Surveillance is a lifetime thing, then the patient is receiving first course treatment their entire life.
26.	If the cytology states: malignant, most consistent w/adenoca, you would report because of the malignancy statement	Yes! That would have been a great question for quiz 3!
27.	If the treatment plan included a prostatectomy if PSA rises would that make it part of the original treatment plan and then a 21 for Facility B?	If the patient is participating in an active surveillance protocol, prostatectomy would not be considered first course treatment. As Gail mentioned, treatment is anticipated when the patient goes on the protocol. However, we don't consider that treatment as first course.
28.	If we code shave bx to surgery code and it removes almost all the cancer, then why not coc 21? I don't think Metriq allows coc 22.	For cases 2023 and later, margins are not a factor in how surgery codes are assigned or how class of case is assigned. However, I can see how you might consider the shave biopsy as both a diagnostic and a treatment. We will confirm 22 is the correct code.
29.	If we have no standard definition of progression from any standard setter, how can we know what "progression" means from one data item to another? It makes it difficult to apply the rules.	We have a standard definition we can use for the treatment fields. The definition also applies to Summary Stage and EOD. AJCC follows a different definition. I agree this makes things difficult.
30.	If you have cases that administrators want to have abstracted and kept track of. Would you abstract that as an R (Reportable) and what class of case would you use?	I'm assuming you mean cases not reportable to CoC. I'm not sure how the "R" reportable works in your software, but if it means reportable to CoC, I would not use it. These would be non-analytic class of cases.
31.	In Quiz 5 number 4 does progression of disease affect this?	Not the definition of progression we use for assigning surgery codes. The patient did not have enough progression that a yp stage could not be assigned. They were able to complete the neoadjuvant treatment and do the hemicolectomy.
32.	Initially after a prostatectomy there is some PSA still circulating in the bloodstream. After a certain period of time there should be no detectable PSA after the prostate has	Great explanation.

	been removed since the produces PSA. When the PSA is detectable for a period of time after surgery it indicates that not all of the prostate was removed, and the cancer is recurring. One PSA of 0.2 may be a fluke so they like to repeat it. If its still detectable upon repeating they consider it a biochemical recurrence meaning it was detected via a blood test.	
33.	Isn't the intent of the shave biopsy to remove all of or most of it? I have always thought of it as treatment unless I was coding it as a diagnostic procedure.	The answers I presented on the webinar were incorrect. If a patient has a shave biopsy at Facility A and wide excision at facility B, then Class of case for facility A would be 13 and Facility B would be 21. We will discuss this on Boot Camp 2 in April.
34.	Letrozole pt in facility B - span was > 1 yr.; this would be reportable on basis of giving them first course although pt presented after 1 year, right? Not timing?	Correct. The timing rule is only used if we don't know about the first course treatment. Hormone treatment is a standard first course treatment.
35.	On #3 what would class of case be for facility A, if class of case is 22 for facility B?	The answers I presented on the webinar were incorrect. If a patient has a shave biopsy at Facility A and wide excision at facility B, then Class of case for facility A would be 13 and Facility B would be 21. We will discuss this on Boot Camp 2 in April.
36.	Quiz 4 Question 2, also may have to update date of last contact.	Yes.
37.	Quiz 2, #2 does not state where pt was diagnosed?	True but we are looking at Facility B and with the information we have Facility B just continued treatment. For me I know if I didn't know exactly where they were diagnosed but know they were not diagnosed at my facility I would assign 21. Until I have more information.
38.	Quiz 3 question 3. Regarding the date of diagnosis and wobbly terminology, my recollection from FORDS was that you could use the earlier date IF AND ONLY IF the provider said that in retrospect the patient had the malignancy as of that earlier date.	That was how I was taught as well. It's still stated that way in the 2023 STORE manual (p. 128): "If the physician states that in retrospect the patient had cancer at an earlier date, use the earlier date as the date of diagnosis".

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39.	Regarding the change of facility, what if the pt transfers her tx after 2 years?	If the patient is still receiving hormone tx as part of first course tx, it's reportable as an analytic case.
40.	Second course is not coded based on progression but based on change of initial treatment plan	That is true. The problem we are running into is many initial treatment plans have variability-built in.
41.	Since we are talking about neoadjuvant therapy..... Per STORE and the CAnswer forum, TARE/TACE prior to a transplant for liver cancer is not neoadjuvant because it is meant to shrink the tumor or reduce the blood flow to tumor or shrink the tumor. The purpose of neoadjuvant is often to shrink the tumor to make it resectable so I don't understand why it wouldn't be neoadjuvant for these cases. If the purpose of TACE or TARE was to reduce the blood supply only, they could just utilize embolization to do that. When embolization is combined with chemo or radiation the purpose is to treat the tumor with chemo or radiation as well cutting off the blood supply. Embolization allows for the chemo and radiation to be held in place. There may be some instances where it is not considered neoadjuvant but to make it a blanket statement that applies to all doesn't seem correct.	You make a good point, but the bottom line is AJCC feels TACE/TARE is not something that should make these cases ineligible for a pathologic stage. I'm not sure the reasoning behind this, but I get the impression they have put some thought into the scenario and they believe patients that had TACE/TARE before a liver transplant should be included in the cohort of patients that have a pathologic stage.
42.	This is an important question we need guidance on and if you can help us would be great. Our administration requested pancreas IPMN nonmalignant to be abstracted and monitored. Should we be using R (reportable) and what Class of Case should we use? Also, after the last pancreas web, noticed the physicians not using pancreatic duct for IPMN and would like to make sure the coding is accurate that we should use Pancreatic duct for IPMN .	As far as primary site...you will need to base primary site on the information that is provided Because most of the manuals don't give guidance on coding primary site.
43.	To be clear. I code shave biopsies as dx procedure regardless of path outcome? OR do I code shaves to surgery if there is no residual? I am completely confused. I typed everything you were saying, and I am still confused. So sorry. As you	The answers I presented on the webinar were incorrect. If a patient has a shave biopsy at Facility A and wide excision at facility B, then Class of case for facility A would be 13 and

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	were talking you appeared very clear. This is on me. I am probably making this harder than it has to be.	Facility B would be 21. We will discuss this on Boot Camp 2 in April.
44.	Treatment quiz #4 so since they didn't mention that they were going to do chemo after the surgery (even though pt had liver mets prior on PET) we are not coding anything but the Immuno as first course? What about the surgery it was in the plan from the start?	The initial treatment plan was neoadjuvant immunotherapy followed by hemicolectomy. Since the immunotherapy did not work and the patient's disease progressed, they changed the neoadjuvant treatment to a chemotherapy regimen. They completed the neoadjuvant treatment and performed the surgery. Since the treatment plan changed to disease progression, all treatment after the immunotherapy stopped was not considered first course based on the standard rules we use for coding treatment fields. For that reason, only the immunotherapy would be coded as first course treatment.
45.	What class of case do you use for LCIS, non-analytic since not reportable to Coc?	It would be a non-analytic class of case. We confirmed this with CoC. Which non-analytic would depend on what role you facility played in the dx and tx of the patient.
46.	What if you have positive cytology with a definitive diagnosis. A full workup is done to try to identify a cancer, and nothing is found. Is it possible to have a false positive on cytology? Would the case still be reportable?	I think that is a "professional judgement" situation. Ideally, you could go back to the physician and get their thoughts. IF they say they think it was a false positive, then it's not reportable.
47.	Just an fyi - Both the 2023 (pg. 45) and 2024 (pg. 34) STORE manuals incorrectly list LAMN as reportable beginning 01/01/2023. However, STORE 2022 correctly included it as required to be collected beginning 01/01/2022 as part of the Reportability Change section (pg. 31).	I noticed that.