



April 2024

THE MCRE-MINDER

~ Text Guidelines & Requirements ~

PE	
Demographics:	⇒ Age, DOB, ethnicity, race, gender/sex, marital status.
Chief Complaint: (CC):	⇒ Symptoms (onset, duration/frequency).
History:	⇒ Exposures, genetic disorders; as appropriate to the primary cancer.
Exam:	⇒ Date, findings, physician, facility; (support SSDI and staging fields as appropriate).
Impression:	⇒ When it stated and pertains to the current cancer diagnosis.
Treatment Plan:	⇒ Date, Initial plan, physician, facility; (once complete work-up is performed).
Post-neoadjuvant:	⇒ PE/ physician statement(s) that evaluate disease as per first course treatment plan; (e.g., post neo-adjuvant PE that supports neoadjuvant treatment & clinical response coding fields).

Example:
 66 YO (01/02/58), NH/W/F, Un-m/DP presented to PCP July 2023 w/ unintended 20LB WT loss over 4 months, onset non-drenching night sweats, painless LT neck mass x 3 weeks. Office FNA revealed B-cell lymphoma; Imaging w/ neck & chest LAD. Pt self referred to MY Hosp. 7/10/23 PE: 2.5cm mobile LT neck mass. WT 130 LB(>10%), denies fevers. No other B SX, no organomegaly on exam or palp LAD other than LT neck mass. Impression: HG lymphoma. Rec: PET, BM eval (Dr. MedOnc, MY Hosp); 7/19/23 Final Impression & Plan: PB w/ low-level Inv by lymphoma & add'l pelvic LAD on PET, Stg IV. Rec: R-CHOP, imaging after 4 cycles, possible XRT to abd mass (Dr. MedOnc, MY Hosp), Per ODS: IPI not stated.

X-ray/Scan	
<ul style="list-style-type: none"> ⇒ Primary site, histology(if given), tumor location, lymph nodes, distant disease or metastasis. ⇒ Include anatomic directional terms; (i.e., superior, inferior, distal, proximal, superficial, deep, anterior/ventral, posterior/dorsal, medial, lateral). ⇒ Include imaging test that evaluate disease as per first course treatment plan; (e.g., post neoadjuvant imaging to evaluate response prior to planned surgery). 	<p>Example: 7/1/23 LT Neck U/S: 2.3cm LT neck mass (Your Hosp), 7/1/23 CT C/A/P: Enlg'd Mediast & subcarinal nodes susp for neoplasm. LT mesenteric mass-like area near/inv cecum; node vs. primary bowel mass. No add'l nodes, hepato- or splenomegaly id'd (Your Hosp), 7/12/23 PET: Abnormal uptake LT mediast, subcarinal, RT hilar, RT iliac nodes. Uptake in Abd mass noted on CT (MY Hosp).</p>

Scopes	
<ul style="list-style-type: none"> ⇒ Types, primary site, histology (if given), tumor location & size, lymph nodes. ⇒ Include anatomic directional terms; (i.e., superior, inferior, distal, proximal, superficial, deep, anterior/ventral, posterior/dorsal, medial, lateral). 	<p>Example: None; 7/13/23 Rev'd PET w/ radiologist, felt to be node rather than primary mass (Dr. MedOnc, MY Hosp).</p>

Lab Tests	
<ul style="list-style-type: none"> ⇒ Types (tumor markers, serum and/or urine electrophoresis, special studies), source of specimen; (e.g., breast cancer receptors performed on lymph node specimen vs. breast tumor; or breast cancer receptors performed only on in-situ component when microinvasion is present). ⇒ Support SSDI fields, including when the same test types & results are available from different timeframes that may effect staging categories; (e.g., document receptors reported from a breast biopsy & from surgical resection). ⇒ Support SSF1 HPV, including specific documentation of test type, as applicable. <i>i.e.</i>, <i>ISH DNA vs. ISH E6/E7 RNA. (Text p16 & HPV tests separately)</i> 	<p>Example 1: 7/20/23 HIV: Neg (My Hosp)</p> <p>Example 1: 7/20/23 Pt declined HIV test (My Hosp)</p> <p>(Note: HIV "lab text" permitted only for cases in which the coding field is required).</p>

Op	
<ul style="list-style-type: none"> ⇒ Descriptions of biopsies and all other surgical procedures that support staging. ⇒ Size of tumor removed, size and # of nodes, documentation of residual tumor, evidence of invasion of surrounding areas, reason primary site surgery could not be completed. 	<p>Example: 7/15/23 Exp Lap w/ BX's: Approx. 5cm, mobile, Sm. bowel mesentery mass, w/o inv of bowel or other structures. Mult. core BXs. No add'l abn findings. (Dr. GI, MY Hosp)</p>



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Path	
<ul style="list-style-type: none"> ⇒ Anatomic source of specimen, type of specimens; tissue vs. cells/cytology. ⇒ Tumor type, grade (including all modifying adjectives, i.e., predominately, with features, with foci of, elements, components, etc.) ⇒ Gross tumor size, extent of spread, margins, # of nodes examined and involved, LVI (list separately: small/lymphatic and large vessel). ⇒ Record differential diagnoses considered & ruled out, comments, addendums. ⇒ Note if report is a slide review, consult, second opinion from outside source. ⇒ Support SSDI fields 	<p>Example:</p> <p>7/1/23 LT Neck Node: Cells susp. for lymphoma, NOS (Dr. PCP Office); (Rev. at MY Hosp: Atyp. lymphoid infiltrate, c/w HG Lymphoma).</p> <p>7/15/23 Abd mass: Inv by HG, Lymphoma, FL vs DLBCL. Comment: Favor DLBCL, GCB type (MY Hosp).</p> <p>7/15/23 Peripheral Blood: Inv w/ lymphoma (My Hosp).</p>
Primary Site	
<ul style="list-style-type: none"> ⇒ Laterality and specific location of the primary site, including subsite. 	<p>Example:</p> <p>Neck, Chest, Abd Nodes</p>
Histology	
<ul style="list-style-type: none"> ⇒ Histologic type, behavior, grade/differentiation. 	<p>Example:</p> <p>DLBCL, Grade N/A</p>
Staging	
<ul style="list-style-type: none"> ⇒ Size, organs involved by direct extension, # & sites of positive nodes, site(s) of distant metastasis. ⇒ Support AJCC, EOD & Summary Stage (including yc findings, as applicable). ⇒ Document whether staging components assigned by the ODS or the physician name/specialty. 	<p>Example:</p> <p>AJCC Stage 3: LN above/below diaphragm (BM Bx not perf); EOD PT & Summ Stg: Inv LN above & below diaphragm, PB Inv. MD: Stg IV but only PB perf, No BM BX.</p>
Surgery	
<ul style="list-style-type: none"> ⇒ Surgical approach and type of procedure, including FNA, peripheral blood, etc. ⇒ Lymph nodes, regional tissue & metastatic sites removed. ⇒ Other information; (e.g., planned procedure aborted, unknown if surgery performed). 	<p>Example:</p> <p>7/1/23 LT Neck Node FNA, Cells (Dr. PCP Office). 7/15/23 Abd mass Core BX (MY Hosp). 7/15/23 Peripheral Blood w/o BM BX (My Hosp).</p>
Radiation (Beam)	
<ul style="list-style-type: none"> ⇒ For each phase: Types of beam radiation, including modality, volume, planning technique, dose/fraction, # of fractions, total dose. ⇒ Total # of phases, total dose. ⇒ Other information; (e.g., discontinued, including reason; unknown if radiation was given). 	<p>Example:</p> <p>None, Not Rec, or N/A</p> <p>Example:</p> <p>8/15/23-9/15/23 (est. dt.) Ph I: Abd mass, 6X, IMRT, 180cgy; 9FX; Total: 1620cgy. (4500cgy planned, but pt refused further tx)</p>
Radiation (Other)	
<ul style="list-style-type: none"> ⇒ For each phase: Types of non-beam radiation, including modality, volume, planning technique, dose/fraction, # of fractions, total dose. ⇒ Total # of phases, total dose. ⇒ Other information, (e.g., discontinued, including reason; unknown if radiation was given). 	<p>Example:</p> <p>None, Not Rec or N/A</p> <p>Hypothetical Example:</p> <p>8/15/23-9/15/23 (est. dt.) PhI: Abd</p>
Chemo, Hormone, BRM	
<ul style="list-style-type: none"> ⇒ Type of agent(s), regimen, protocol. ⇒ For hormone text, include types of endocrine surgery or radiation, as applicable; (e.g., BSO, when performed for ovarian suppression for breast CA). ⇒ BRM procedures; (e.g., bone marrow, or stem cell transplant). ⇒ Other treatment information; (e.g., discontinued, including reason & number of cycles completed; unknown if given). 	<p>Example:</p> <p><u>Chemo</u>: 8/12/23 CHOP (MY Hosp)</p> <p><u>Hormone</u>: 8/12/23 Prednisone (My Hosp)</p> <p><u>BRM</u>: 10/28/23 Rituxan (9/25/23 Rituxan after chemo to prevent tumor lysis per Dr. MedOnc, MY Hosp).</p>
Other	
<ul style="list-style-type: none"> ⇒ Type of other treatment; (e.g., Any therapies coded to other per coding resources, and/or experimental therapies and/or blinded clinical trials). ⇒ Other information; (e.g., discontinued, including reason; unknown if given). 	<p>None</p>



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Remarks

- ⇒ Primary payer *at diagnosis*.
- ⇒ Smoking history (include quit date, unknown when quit; unknown if ever smoker, etc.)
- ⇒ Personal history of cancer(s), including sequence if diagnosed/treated out-of-state or before registry reference date.
- ⇒ Comorbidities
- ⇒ Place of birth, including unknown.
- ⇒ Justification of over-ride flags, if applicable; (e.g., “per CANSWER Forum”, including date of the post). Information clarifying anything unusual such as reason for reporting a case seemingly not reportable for that facility or reason for coding numerous fields as unknown.

Example:
7/10/23 Insurance: Medicare A & BCBS, NOS. Smoker x 25yrs, quit June 2023. PMH Melanoma, COPD, DM2. UNK Birthplace.

Place of Diagnosis

- ⇒ Complete name of hospital, clinic, or physician’s office where diagnosis occurred (Do not use initials).
- ⇒ For out-of-state residents & facilities, include the city & state where the facility is located.

Dr. PCP Office, Jamestown, NJ

General Guidelines

- The only data fields that do not require text documentation: social security number, patient address/contacts, medical record #, NPI facility #'s, and Medicare beneficiary ID #.
- All PE, imaging, labs, scopes, procedures, treatments, and fields for which the original source document result is not available and the data coded is “per physician statements” the text must include: date, type, findings, facility and physician’s name.
- When specific dates are not known, support estimated dates in text with “(Est. Dt.)”.
- All SSDI fields for the primary site schema and/or staging components must be supported with text, including those for which the data item rule requires findings from the physical exam.
Example: Physical exam findings must be documented to support staging components as required for the primary site schema and staging rules. E.g., DRE must be performed to assign AJCC cT and most often for EOD Primary Tumor.
- Record positive and negative clinical findings. Record positive results first.
- Abbreviations are permitted when they can be interpreted, otherwise it is best to type the complete information.
- Do not text findings from exams, imaging, procedures, and/or results “in your own words” or that which changes the integrity or validity of the information.
- Do not copy & paste complete report results without “cleaning up” the text.
- Do not leave text fields blank.
 - If it is certain that an exam/test or documentation was not performed, text “not perf” or “none”, e.g., it is known for certain that a DRE was not performed by external and internal physician(s).
 - If it is unknown if an exam/test or documentation was not performed, text “unknown”, or “UNK”, e.g., no DRE documented by internal physician(s), but no information of whether DRE was performed by external physician(s).
 - If it is certain that an exam/test or documentation is not generally performed for a particular cancer, text “N/A”.
- Do not code data fields and/or text information based on “assumptions”. If information is not available in the source documents, text the appropriate & accurate information, unless the coding instructions otherwise provide guidance.
Example1: Two phases of radiation administered. The radiation/physician note(s) state the phase I technique is “IMRT” and phase II technique is “tangents”. Do not code the phase II technique as “IMRT”, but code “External Beam, NOS”.
Example2: Patient with ovarian cancer has cytoreduction; TAHBSO. The margins are not stated in the path report. Do not text “neg margins”. Text “margins not stated”.

Resources

- SEER Training Modules:
[Cancer Registration & Surveillance Modules | SEER Training](#)
- NAACCR Abbreviations:
[Recommended Abbreviations for Abstractors | NAACCR Data Dictionary](#)