2022 Updates/Coding Pitfalls

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Charting the Course

Topics

- Default Codes
- Surgery

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Default Codes/
V22 Conversions

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Default Codes for Hematopoietic Cases

- Over the last several years there has been a discrepancy between SEER and CoC when it comes to default codes for certain hematopoietic diseases.

- SEER and CoC have worked together to develop consistent and simplified instructions for when to use default codes for the following data items.
  - Surgery of Primary Site
  - Scope of Regional Lymph Nodes
  - Surgical Margins
  - Mets at DX

- These changes are effective for cases diagnosed 2018 forward.

- A data conversion during the v22 software update will set defaults for cases abstracted prior to the conversion.

- No manual updates required

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Surgery of Primary Site

- RX Summ--Surg Prim Site, Primary Site, 2018 (COC) N5015
  - If Surgery codes for Primary Site C420, C421, C423, C424, C760-C768, C809, Then Surgery of primary Site must = 98.

STORE 2021   *APPENDIX A: Site-Specific Surgery Codes*

HEMATOPOIETIC/RETICULOENDOTHELIAL/

IMMUNOPROLIFERATIVE/MYELOPROLIFERATIVE DISEASE

C42.0, C42.1, C42.3, C42.4 (with any histology)

or

9727, 9732, 9741-9742, 9749, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9968, 9975-9993 **(with any site)**

Code

98   All hematopoietic/reticuloendothelial/immunoproliferative/myeloproliferative disease sites and/or histologies, WITH or WITHOUT surgical treatment.

STORE 2022   *APPENDIX A: Site-Specific Surgery Codes*

HEMATOPOIETIC/RETICULOENDOTHELIAL/

IMMUNOPROLIFERATIVE/MYELOPROLIFERATIVE DISEASE

C42.0, C42.1, C42.3, C42.4 (with any histology)

Code

98   All hematopoietic/reticuloendothelial/immunoproliferative/myeloproliferative disease sites and/or histologies, WITH or WITHOUT surgical treatment.

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V22 Conversion

- A. If Primary Site [400] is C420, C421, C423, C424, C760-C768, C809
  - a. If RX Hosp—Surg Prim Site [670] is not blank and not 98, set to 98
  - b. If RX Summ—Surg Prim Site [1290] is not blank and not 98, set to 98
  - c. If RX Summ—Surgical Margins [1320] is not blank and not 9, set to 9
  - d. If Reason for No Surgery [1340] is not blank and not 1, set to 1

  For Date of Diagnosis Year [390] >= 2018

- B. If Primary Site [400] is C420, C421, C423, C424, C589, C700-C729, C751-C753, C761-C768, C770-C779, C809 or Schema ID [3800] is 00790, 00795, 00822 (Lymphoma, Lymphoma CLL/SLL, Plasma Cell Disorders)
  - a. If RX Hosp—Scope Reg LN Sur [672] is not blank and not 9, set to 9
  - b. If RX Summ—Scope Reg LN Sur [1292] is not blank and not 9, set to 9

For all other sites, surgery may be assigned

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Example

- Patient diagnosed with *blastic plasmacytoid dendritic cell lymphoma* occurring in the skin. Patient not a surgical candidate due to comorbid conditions.

Data Item	
Primary Site	C44.9
Surgery of Primary Site	00
Scope of Regional LN Surgery	0
Surgical Margin	8 (No surgical procedure)
Reason no Surgery	2

- Patient diagnosed with blastic plasmacytoid dendritic cell lymphoma based on bone marrow biopsy. No indication of disease in any other site.

Data Item	
Primary Site	C42.1
Surgery of Primary Site	98 (default)
Scope of Regional LN Surgery	9 (default)
Surgical Margins	9 (default)
Reason no Surgery	1 (default)

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Mets at DX-Code 8-Not Applicable

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Use code 8 (Not applicable) for the following site/histology combinations for which a code for distant metastasis is not clinically relevant

ICD-O-3 Site	ICD-O-3 Histology	
C000-C809	9740-9809, 9840-9992	Mast cell, histiocytosis, immunoproliferative, leukemias coded to any site
C420, C421, C424	9811-9818, 9823, 9827, 9837	Specific leukemia/lymphoma histologies coded to blood, bone marrow, hematopoietic
C000-C440, C442-C689, C691-C694, C698-C809	9820, 9826, 9831-9834	Mostly lymphoid leukemias coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS
C000-C440, C442-C689, C691-C694, C698-C809	9731, 9732, 9734	Plasma cell tumors coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS
C420, C421, C423, C424	Any histology	

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ICD-O-3 Site	ICD-O-3 Histology	
C000-C809	9740-9809, 9840-9992	Mast cell, histiocytosis, immunoproliferative, leukemias coded to any site
C420, C421, C424	9811-9818, 9823, 9827, 9837	Specific leukemia/lymphoma histologies coded to blood, bone marrow, hematopoietic
C000-C440, C442-C689, C691-C694, C698-C809	9820, 9826, 9831-9834	Mostly lymphoid leukemias coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS
C000-C440, C442-C689, C691-C694, C698-C809	9731, 9732, 9734	Plasma cell tumors coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS
C420, C421, C424, C770-C779	Any histology	

C770-C779 should have been removed

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Mets at Dx-Distant Lymph Nodes

ICD-O-3 Site	ICD-O-3 Histology	
C000-C809	9740-9809, 9840-9992	Mast cell, histiocytosis, immunoproliferative, leukemias coded to any site
C420, C421, C424	9811-9818, 9823, 9827, 9837	Specific leukemia/lymphoma histologies coded to blood, bone marrow, hematopoietic
C000-C440, C442-C689, C691-C694, C698-C809	9820, 9826, 9831-9834	Mostly lymphoid leukemias coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS
C000-C440, C442-C689, C691-C694, C698-C809	9731, 9732, 9734	Plasma cell tumors coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS
Any primary site		Lymphoma histologies
C420, C421, C424, C770-C779	Any histology	

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Mets at DX-BBDLLO, Schema ID, Primary Site, 2018 (NAACCR) N5017

- 1. This edit is skipped under the following conditions:
  - a. Year of Date of Diagnosis is less than 2018, blank (unknown), or invalid
  - f. Behavior Code ICD-O-3 = 0, 1, or 2

2. Mets at DX-Bone, Mets at DX-Brain, Mets at DX-Distant LN, Mets at DX-Live, Mets at DX-Lung, and Mets at DX-Other must = 8 if Schema ID = 00822 or Primary Site = C420, C421, C423, or C424.

3. If Primary Site = C770-C779, Mets at DX-Distant LN must = 8. All other Mets at DX fields must not = 8.

4. For all other Primary sites, Mets at DX fields must not = 8.

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V22 Conversion
Hematopoietic Conversions and Mets at DX fields [1112-1117]
For Date of Diagnosis Year [390] >= 2018

- A) If **Primary Site [400] = C420, C421, C423 or C424**
  - Set Mets at DX - Bone [1112] = 8
  - Set Mets at DX - Brain [1113] = 8
  - Set Mets at DX - Liver [1115] = 8
  - Set Mets at DX - Lung [1116] = 8
  - Set Mets at DX - Distant Lymph Nodes [1114] = 8
  - Set Mets at DX - Other [1117] = 8

  This applies to ALL histologies, although it will mostly be the leukemia's, and those lymphomas that are only in the bone marrow.

- B) If Primary Site [400] = C770-C779
  - Set Mets at DX - Distant Lymph Nodes [1114] = 8

  This applies to all histologies, but it will mostly be the lymphomas

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V22 Conversion
Hematopoietic Conversions and Mets at DX fields [1112-1117]
For Date of Diagnosis Year [390] >= 2018

- C) If Schema ID [3800] = 00790 or 00795 [Lymphoma, Lymphoma-CLL/SLL] and **Primary Site [400] = C770-C779**

  /* at least one of Clin SG, Path SG, (EOD PT & Derived SS2018) or SS2018 has a specific value which does NOT imply Mets AND NONE of the fields have a specific value which DOES imply Mets*/

  - Set Mets at DX - Bone [1112] = 0
  - Set Mets at DX - Brain [1113] = 0
  - Set Mets at DX - Liver [1115] = 0
  - Set Mets at DX - Lung [1116] = 0
  - **Set Mets at DX - Distant Lymph Nodes [1114] = 8**
  - Set Mets at DX - Other [1117] = 0

- D) If Schema ID [3800] = 00790 or 00795 [Lymphoma, Lymphoma-CLL/SLL] and Primary Site [400] **NOT equal** to C420, C421, C423, C424, C770-C779, C809

  /* at least one of Clin SG, Path SG, (EOD PT & Derived SS2018) or SS2018 has a specific value which does NOT imply Mets AND NONE of the fields have a specific value which DOES imply Mets */

  - Set Mets at DX - Bone [1112] = 0
  - Set Mets at DX - Brain [1113] = 0
  - Set Mets at DX - Liver [1115] = 0
  - Set Mets at DX - Lung [1116] = 0
  - **Set Mets at DX - Distant Lymph Nodes [1114] = 0**
  - Set Mets at DX - Other [1117] = 0

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V22 Conversion
Hematopoietic Conversions and Mets at DX fields [1112-1117]

- E) If Schema ID [3800] = 00822:Plasma Cell Disorders
  - Set Mets at DX – Bone [1112] = 8
  - Set Mets at DX - Brain [1113] = 8
  - Set Mets at DX - Liver [1115] = 8
  - Set Mets at DX - Lung [1116] = 8
  - Set Mets at DX - Distant Lymph Nodes [1114] = 8
  - Set Mets at DX - Other [1117] = 8

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Pop Quiz 6

- Patient is found to have enlarged cervical, axillary, mediastinal, and mesenteric lymph nodes.
- Disseminated metastasis is noted in both lungs.
- A biopsy of a cervical lymph node confirms lymphoma (primary site is C77.8)

6. How do we code Mets at Dx-Bone
- 0-None; no bone metastasis
- 1-Yes; distant metastasis
- 8-Not applicable

How do we code Mets at Dx-Distant Lymph Nodes
- 0-None; no bone metastasis
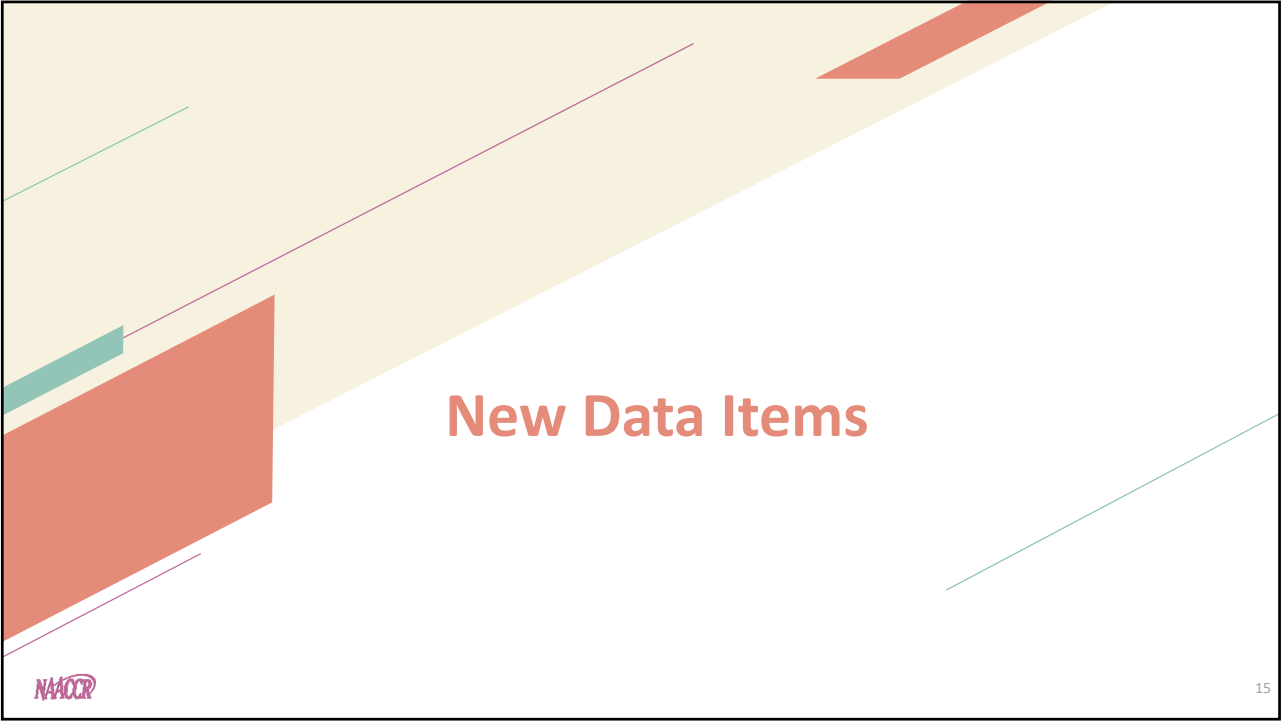- 1-Yes; distant metastasis
- 8-Not applicable

How do we code Mets at Dx-Lung
- 0-None; no bone metastasis
- 1-Yes; distant metastasis
- 8-Not applicable

Mets at Dx bone would be 0
Mets at dx DL would be 8
Mets at dx lung is 1

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New Data Items

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New Data Items

- Macroscopic Evaluation of the Mesorectum
- User Defined Fields
  - Rx Summ-- Surg Breast
  - Rx Hosp-- Surg Breast
  - Rx Hosp-- Recon Breast
  - Rx Hosp-- Recon Breast

- P16
  - Cervix
- LN Status: Femoral Inguinal
- LN Status: Para-aortic
- LN Status: Pelvic

- Cervix Sarcoma Schema ID 00528

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Macroscopic Evaluation

- Information for this data item comes from the pathology report only.

- Leave this field blank if primary site is other than C20.9

- Neoadjuvant therapy does not alter coding of this data item

ColoRectal_4.2.0.0.REL_CAPCP

Macroscopic Evaluation of Mesorectum (required for rectal cancers) (Note A)
___ Not applicable
___ Complete
___ Near complete
___ Incomplete
___ Cannot be determined: _____

Code	Label
00	Patient did not receive TME
10	Incomplete TME
20	Nearly Complete
30	Complete TME
40	TME performed not specified on pathology report as incomplete, nearly complete, or complete TME performed but pathology report not available Physician statement that TME performed, no mention of incomplete, nearly complete or complete status
99	UNKNOWN if TME performed
BLANK	Site not rectum (C20.9)

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Breast Surgery Codes

- For breast cases diagnosed in 2022, CoC registrars will have to assign surgery to sets of code for Surgery of Primary Site
    - **Surgical Procedure of Primary Site**
    - **Rx Summ-- Surg Breast**
    - **Rx Summ-- Recon Breast**

- Surg Breast and Recon Breast are "user defined fields" for 2022.
    - The surgery codes in Surg Breast will replace the current surgery codes in 2023.
    - Feed back from 2022 cases will be used to refine surgery codes and coding instructions.

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New Breast Surgery Codes

B300	Skin-sparing mastectomy
B310	WITHOUT removal of uninvolved contralateral breast
B320	WITH removal of uninvolved contralateral breast
NOTE: A skin sparing mastectomy removes all breast tissue and the nipple areolar complex and preserves native breast skin to cover the immediate reconstruction. It is performed with and without sentinel node biopsy or ALND.	
B400	Nipple-sparing mastectomy
B410	WITHOUT removal of uninvolved contralateral breast
B420	WITH removal of uninvolved contralateral breast
NOTE: A nipple sparing mastectomy removes all breast tissue but preserves the nipple areolar complex and breast skin and is performed with immediate reconstruction. It is performed with and without sentinel node biopsy or ALND.	
B500	Areolar-sparing mastectomy
B510	WITHOUT removal of uninvolved contralateral breast
B520	WITH removal of uninvolved contralateral breast

NAACCR   STORE 2022 pg 226   19

Oncoplastic Surgery

- Oncoplastic surgery techniques are generally used to either:
    - Re-arrange nearby breast tissue to fill in the space left behind after the cancer is removed to prevent "dents" and place the scar where it is less visible
  or
    - Remove the breast tissue containing the cancer and combine this procedure with a breast reduction, a breast lift (mastopexy), or both.

NAACCR   https://www.breastcancer.org/treatment/surgery/reconstruction/types/oncoplastic-lumpectomy   20

Recon Breast

A100	Tissue expander placement
NOTE: Code A100 when tissue expanders were placed without implant or tissue placement.	
A200	Direct to implant placement
NOTE: Code A200 when a permanent implant is placed immediately following resection.	
Example: A mastectomy is performed by the breast surgeon and an implant is placed at the same time by a plastic surgeon (some general /breast surgeons may place implants, but most are placed by plastics).	
A300	Oncoplastic tissue rearrangement (not a formal mastopexy/reduction)
A400	Oncoplastic reduction and/or mastopexy
NOTE: Code A400 when patient has breast conserving resection and a breast reduction/lift is performed.	
A500	Oncoplastic reconstruction with regional tissue flaps

- Records the reconstruction procedure immediately following resection.
  - Performed during the same operative session asthe operative procedure coded in Data item Rx Hosp—Surg Breast.
  - Reconstruction performed on a different day than the breast primary definitive resection is not collected/coded

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Recon Breast

A600	Mastectomy reconstruction with autologous tissue, source not specified.
A610	WITH abdominal tissue
A620	WITH thigh tissue
A630	WITH gluteal tissue
A640	WITH back tissue
NOTE: Code A600 when patient's tissue autologous source is unknown or not specified.	
A900	Reconstruction performed, method unknown
NOTE: Code A900 when reconstruction is done, but the type of reconstruction is not known.	
A970	Implant based reconstruction, NOS
A980	Autologous tissue-based reconstruction, NOS
A990	Unknown if reconstruction performed
NOTE: Code A990 when it's unknown if immediate reconstruction was performed.	

- Autologous reconstruction (sometimes called autogenous reconstruction) uses tissue -- skin, fat, and sometimes muscle -- from another place on your body to form a breast shape.
- The tissue (called a "flap") usually comes from the belly, the back, buttocks, or inner thighs to create the reconstructed breast.

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Breast Reconstruction

- Patient with biopsy proven AJCC clinical stage 1 breast cancer presents for an oncoplastic lumpectomy. This will be followed by radiation.
  - 4/2/22-patient has lumpectomy using oncoplastic mastopexy techniques.

Data Item	Value
Surgery of Primary Site	22
Breast Surg	B200
Breast Recon	A400

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New SSDIs

- 3956: p16
  - CoC
    - Registrars are being asked to complete this SSDI for all Cervix Schema cases starting with diagnosis date 1/1/2021
    - For cases diagnosed 2018-2020, leave this SSDI blank
    - **Manual review of Cervical cases diagnosed 2021 forward is required**
  - NPCR
    - Required for cases diagnosed 1/1/2022 and forward
    - May be blank for or may be completed for 2021 cases
    - For cases diagnosed 2018-2020, leave this SSDI blank
  - SEER
    - Required to collect p16 from CoC facilities for cases diagnosed 2021
    - Required to collect p16 from all reporting facilities for cases diagnosed 2022+

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New SSDIs

- *3884: LN Status, Femoral-Inguinal, Para-aortic, Pelvic*
  - 3884 will no longer be collected for any year.
  - During the v22 conversion process the fields below will be populated for all 2018+ Cervix cases
    - **3959: LN Status: Femoral Inguinal**
      - Vulva
      - Vagina
    - **3958: LN Status: Para-aortic**
      - Vagina
      - Cervix
    - **3957: LN Status: Pelvic**
      - Vulva
      - Vagina
      - Cervix
- No manual review required

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Surgery
Core Concepts

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Coding Surgery-Core Concepts

- First Course Treatment
  - The first course of treatment includes all methods of treatment recorded in the treatment plan and administered to the patient before disease progression or recurrence.
- **Code the treatment that was given, not the results of the treatment**
- Surgery codes are hierarchical and cumulative

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Surgery Data Items

- RX Date–Surgery [1200]
- Date of Most Definitive Surgical Resection of the Primary Site [3170]
- Surgical Procedure of Primary Site [1290]
- Scope of Regional Lymph Node Surgery [1292]
- Surgical Procedure/Other Site [1294]
- Reason for No Surgery of Primary Site [1340]
- Radiation/Surgery Sequence [1380]
- Systemic/Surgery Sequence [1639]

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Sources for Coding Surgery

SEER Manual

- Use the entire operative report as the primary source document to determine the best surgery of primary site code.
  - The body of the operative report will designate the surgeon's planned procedure as well as a description of the procedure that was actually performed.
  - **The pathology report may be used to complement the information appearing in the operative report, but the operative report takes precedence.**
- We are coding the surgical procedure…not the results of the surgical procedure.

  SEER Program Coding and Staging Manual 2021 Page 164

  Exceptions

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- If surgery of the respective type was performed, the code that best describes the surgical procedure is recorded whether or not any cancer was found in the resected portion.
- Incidental removal of tissue or organs, when it is not performed as part of cancer treatment (for example, incidental removal of an appendix), does not alter code assignment.

  STORE Manual 2021 Page 59

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Code the Procedure
Surgical Procedure of Primary Site

- Patient was found to have a small mass in her left breast and presented for a biopsy.
  - Procedure documented on the operative report:
    - Needle guided core biopsy
  - Pathology confirmed ductal carcinoma.
- Patient returned a week later for surgery.
  - Procedure documented on the operative report:
    - Lumpectomy
  - Pathology did not show any residual tumor.

02 ➡️

> 8. How is the first procedure coded?
> - 02 diagnostic staging procedure
> - 22 Lumpectomy/excisional biopsy
> - 23 Re-excision
> - 99 Unknown

22 ➡️

> How is the second procedure coded?
> - 20 Partial mastectomy
> - 22 Lumpectomy/excisional biopsy
> - 23 Re-excision
> - 99 Unknown

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Code the Procedure
Scope of Regional Lymph Node Surgery

- Patient with biopsy confirmed breast cancer presents for sentinel node biopsy.

- Four lymph nodes were removed, but the procedure failed to identify any sentinel nodes (failed to map).

2 ➡

9. How is Scope of Regional Node Surgery coded?
- 0-No regional lymph node surgery
- 1-Biopsy or aspiration of regional lymph node(s)
- 2-Sentinel Lymph Node Biopsy
- 5-4 or more regional lymph nodes removed
- 6-Sentinel node biopsy and code 3, 4, or 5 at same time, or timing not stated
- 9-Unknown or not applicable

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Coding Multiple Procedures

- 20 Partial mastectomy, NOS; less than total mastectomy, NOS
  - 21 Partial mastectomy WITH nipple resection
  - 22 Lumpectomy or excisional biopsy
  - 23 Re-excision of the biopsy site for gross or microscopic residual disease
  - 24 Segmental mastectomy (including wedge resection, quadrantectomy, tylectomy) Procedures coded 20–24 remove the gross primary tumor and some of the breast tissue (breast- conserving or preserving). There may be microscopic residual tumor.
- 30 Subcutaneous mastectomy
  - A subcutaneous mastectomy, also called a nipple sparing mastectomy, is the removal of breast tissue without the nipple and areolar complex or overlying skin.
- 40 Total (simple) mastectomy

- Patient with stage 2 breast cancer had lumpectomy on 2/12/21. Pathology showed positive margins. Patient returned on 3/2/21 for re-excision of margins.
  - Assign first procedure as 22 and second procedure as 23.

- Patient had a Lumpectomy. At the time of the lumpectomy surgery, a pathologist reviewed the slide and determines that patient has positive margins. During the same procedure (lumpectomy procedure) a re-excision of the lumpectomy cavity is completed.
  - Assign code 22. Only one procedure is coded.

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Surgery Codes are Cumulative

- A patient was diagnosed with a large nodule in his right thyroid in 2015.
  - A right lobectomy was performed.
  - The nodule was found to be benign.
- The patient returned in 2020 and was found to have multiple nodule in the left lobe of the thyroid.
  - The left lobe and isthmus were removed.
  - The nodule was found to be papillary-follicular carcinoma.

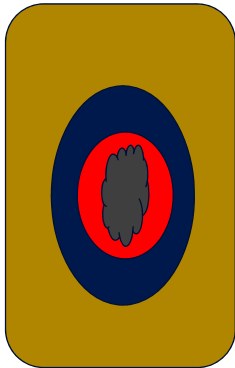12. What surgery code would be assigned?
- 20 Lobectomy and/or isthmectomy
  - 21 Lobectomy ONLY
  - 22 Isthmectomy ONLY
  - 23 Lobectomy WITH isthmus
- 30 Removal of a lobe and partial removal of the contralateral lobe
- 40 Subtotal or near total thyroidectomy
- 50 Total thyroidectomy

Code 50-total thyroidectomy

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Exceptions-Melanoma

- Melanoma is coded primarily based on the results of the procedure, not on what is documented on the operative report.

- Biopsy of a melanoma
  - Diagnostic Staging Procedure if margins grossly positive
  - Surgical procedure if margins negative or microscopically positive
- Wide Excision
  - Codes are based on margins documented in pathology report
  - Margins from operative report may be used if margins not documented on path (except for codes 45-47)

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Melanoma

- Patient presents for excision of a suspicious mole on her left arm
  - Operative Report: Shave biopsy   02
  - Pathology Report: Malignant melanoma, with extension to a single peripheral margin described in the gross and microscopic section of pathology. Breslow's depth 2.1mm
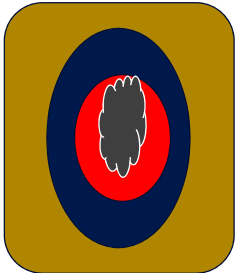
13. Surgical Diagnostic and Staging Procedure
- 02 A biopsy (incisional, needle, or aspiration) was done to the primary site;
Surgery Codes
- 20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

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Melanoma

- Patient returns for wide excision
  - Operative report: Wide excision. Surgical margins 2cm.
  - Pathology report: Code 31
    - Results from wide excision: Microscopic residual melanoma present at site of previous surgery.
    - All other margins negative.

14. How do you code the surgical procedure?
- 30 Biopsy of primary tumor followed by a gross excision of the lesion (does not have to be done under the same anesthesia)
  - 31 Shave biopsy followed by a gross excision of the lesion
- 45 Wide excision or reexcision of lesion or minor (local) amputation with margins more than 1 cm, NOS. Margins MUST be microscopically negative.
  - 46 WITH margins more than 1 cm and less than or equal to 2 cm
  - 47 WITH margins greater than 2 cm

If the excision or re-excision has microscopically confirmed negative margins less than 1 cm
OR the margins are 1cm or more but are not microscopically confirmed; use the appropriate code, 20–36.

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Field Study 2021

- Opens November 1, 2021
- CE eligible
- Test new data items/revised surgery codes for skin
- Provide feedback

Participate in Field Testing of Proposed New Data Items
NAACCR Mid-Level Tactical Group

The NAACCR Mid-Level Tactical Group (MLTG), which includes representations from all standard setters, now requires that field testing be done for proposed new data items, or major changes, before implementation in the registry field. This process will help standard setters to evaluate the feasibility of collecting new data items and clarify codes and coding instructions before implementation. The MLTG strongly encourages participation in this effort, which will facilitate better communication with the registrars in the field and provide critical information to the groups working on these data items.
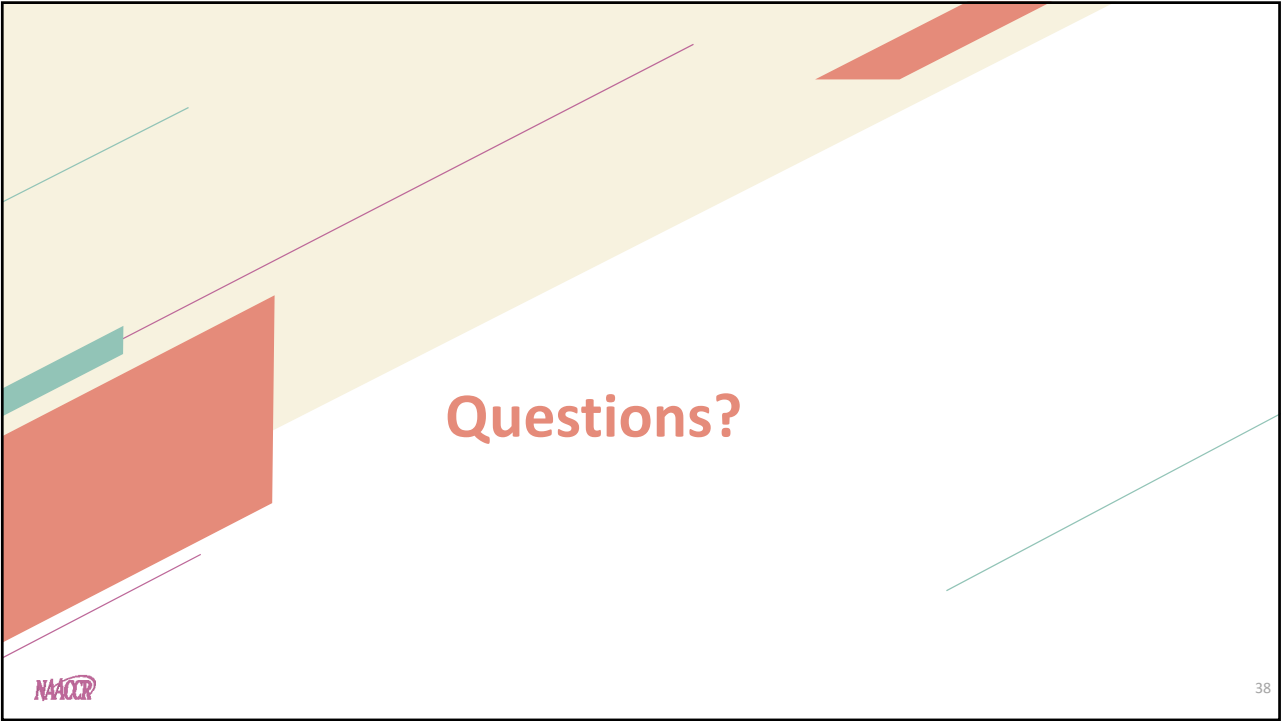
The Field Test will be implemented using the same software used for the SEER Reliability Studies, with some modifications. Participation in the Field Test is not required by any of the standard setters, but it is strongly encouraged. This is your chance to comment on data items prior to implementation. CE credits will be available. *Read more of the details.*

The field testing will take place from 8:00 AM EDT, November 1, 2021 to 12:00 AM EDT, December 15, 2021. Registration for Field Testing is now open. Participants must have access to the *SEER Reliability Studies Site* during this period.

The field testing objectives are to determine how well the new data items are understood. Individual results will remain confidential and not released. Results will be de-identified before analysis.

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Questions?

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Thank you!
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