



**IMPORTANT UPDATES:**

**Please read the new Guidelines ICD-O-3 Guidelines**

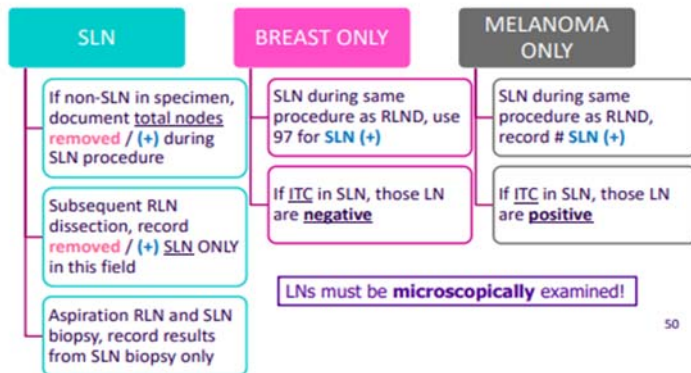


The revised [2018 Guidelines for ICD-O-3 Histology Code and Behavior Update](#) for cases diagnosed 1/1/2018 forward are now available on the NAACCR website. The update includes links to tables listing new codes and other changes and is available in two formats: PDF and Excel. Also available are the 2018 ICD-O-3 Update Guidelines and 1/10/2018 Errata/Change document. <https://seer.cancer.gov/icd-o-3/>

**Coding Lymph Nodes for Melanoma**

- Microscopic LN defined as clinically occult. The nodal metastasis is identified on the sentinel lymph node biopsy
- Macroscopic LN defined as clinically detected
- T1 melanomas use cN0 when no LNs examined microscopically

*Sentinel LN Examined Positive  
 Breast & Cutaneous Melanoma*



\*2019-2020 NAACCR Webinar Series: Melanoma

**Coding Positive Prostate Cores**

- Count the "suspicious for carcinoma" or "suspicious for adenocarcinoma" cores as positive.
- In the event that you have "suspicious for, but not diagnostic of," do not include those cores.
- Only use the "suspicious for" when there is no further information available.
- Do not count fragments, chips or pieces.

\*<http://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/83279-ssdi-prostate-number-of-cores-positive-examined>

**New Primary Site coding for Waldenstrom Macroglobulinemia**

Primary site must be **bone marrow (C421)** for cases diagnosed 1/1/2018 and forward. For cases diagnosed 2010-2017, primary site must be blood (C420).

\*<https://seer.cancer.gov/seertools/hemelymph/51f6cf59e3e27c3994bd5480/?q=waldenstrom%20macrob>

**Question:**

A patient is diagnosed with lung cancer at your facility. The patient does not return for staging work-up or treatment consultation. You do not know if the patient went elsewhere for additional work-up or treatment. What would the class of case be?

*Answer: 10*

*Initial diagnosis at the reporting facility or in a staff physician's office AND part or all of first course treatment or a decision not to treat was at the reporting facility, NOS*

Tip: You must confirm the patient was treated elsewhere to code class of case 00.

**Question:**

Since the LN bx is coded is surgery, wouldn't that be considered part of first course of TX, and a class of case 21?

*Answer:*

**Even though an FNA of a lymph node is coded in scope of regional lymph nodes, an FNA is not treatment.**

\* NAACCR Abstracting and Coding Boot Camp 2019-2020

NAACCR Webinars are available for free on NJSCR's FLccSC Education platform.

**Register today!!!**

[https://njs.fcdslms.med.miami.edu/ords/f?p=105:LOGIN\\_DESKTOP](https://njs.fcdslms.med.miami.edu/ords/f?p=105:LOGIN_DESKTOP)

## SSDI Tips

**Timing for Recording Lab Values**

All lab values must be done no earlier than approximately three months before diagnosis AND unless instructions for a specific laboratory test state otherwise, **record only test result obtained before any cancer-directed treatment is given** (neoadjuvant therapy or surgical) AND if multiple lab tests are available, *record the highest value*.

**New Coding for Kidney- Note 2**

**Invasion beyond Capsule (3864)** must be based on surgical resection. For AJCC staging, if tumor is T1 or T2, then “invasion beyond capsule” would be coded to 0. Invasion beyond capsule is captured in T3a.

**Ipsilateral adrenal Gland Involvement (3861)** must be based on surgical resection and tumor is “confined to kidney” and staging is based on size, then there is no involvement of adrenal gland. For AJCC staging, if tumor is T1 or T2, then “ipsilateral adrenal gland involvement” would be 0. Involvement is captured in T4.

**Major Vein Involvement (3866)** must be based on surgical resection and tumor is “confined to kidney” For AJCC staging T1 or T2, “major vein involvement” would be 0. Major vein involvement is captured in T3a or T3b.

**If surgical resection is done and the tumor is not confined to kidney AND there is no mention of the three SSDIs then Note 6 applies and you code unknown (9).**

**Melanoma**

**Breslow Thickness (3817)** If there are multiple procedures and the **pathologist adds the measurements** together to get a final Breslow’s depth, the registrar can code that. If the pathologist does not add the measurements the registrar CANNOT add them. Record the depth from the procedure that has the larger depth documented.

**Ulceration (3936)** The pathology report must say ulceration is negative or you can infer using the T category is A is present. **DO NOT AUTOMATICALLY ASSIGN CODE 0 (NONE) FOR INSITU TUMORS without statement on pathology report.**

*\*\*2019-2020 NAACCR Webinar series: SSDI an In-Depth Look*

**Clinical Grade Field for Acoustic Neuroma and Meningioma**

A recent review of the accuracy of the coding of the Clinical Grade

field in 44 acoustic neuroma cases and 620 meningioma cases that did not undergo surgical treatment revealed an accuracy rate of 4.5% for acoustic neuroma and 8.7% for meningioma cases.

Benign brain tumors (behavior 0) may automatically be assigned a Grade 1 in the Clinical Grade field.

NOTE: Code the WHO grading system for selected tumors of the CNS as noted in the AJCC 8th edition Table 72.2 where WHO grade is not documented in the record.

NAACCR Grade Coding Instructions and Tables. <https://www.naacr.org/SSDI/Grade-Manual.pdf> pg. 112 Grade ID 24- Clinical Grade Instructions CAnswer Forum.

<http://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/96019-who-grade-for-prolactinoma>

**Congratulations to the New Jersey State Cancer Registry!**

National Program of Cancer Registries

**2019 Registry of Distinction**

The Key to Cancer Control

Awarded to

**NEW JERSEY STATE CANCER REGISTRY**

In recognition of providing complete and timely National Program of Cancer Registries data in

2019

*Vicki Benardi*

May 15, 2020

State Registrar, NPCR  
Chief, Cancer Surveillance Branch  
Division of Cancer Prevention and Control

Date



New Jersey has earned the honor of a Registry of Distinction by NPCR for the 2019 submission of data. This achievement indicates that the New Jersey State Cancer Registry has met the CDC NPCR National Data Completeness and Quality Standard. *We congratulate and thank the Registrars of New Jersey for their dedication to quality data and working together to achieve this honor.*

Questions can be sent to your facility’s NJSCR Representative or by calling 609-633-0500. DO NOT REPLY to this email.

## May 2020 E-Tips

New Jersey State Cancer Registry  
Cancer Epidemiology Services  
<http://www.nj.gov/health/ces>  
(609) 633-0500

### Priority for Coding Histology

Code histology prior to neoadjuvant therapy; code histology using priority list and H rules; do not change histology to make the case eligible for staging

1. Tissue/Path from primary
  - a. Addendum and/or comment
  - b. Final diagnosis/synoptic report
  - c. CAP protocol
2. Cytology (FNA, pleural fluid)
3. Tissue/path from metastatic site
4. Scans Priority (CT>PET>MRI>CXR)
5. Physician documentation
  - a. Treatment Plan
  - b. Tumor Board
  - c. Medical Record documentation, original path, cytology, scan
  - d. MD reference to histology

\*\*2019-2020 NAACCR Webinar Coding Pitfalls

### Reportable Cases for NJSCR

- Patients with a history of cancer with active disease must be reported. (Class of Case 32)
- Analytic/Non-Analytic Cases Both analytic and non-analytic cases with active disease are required to be reported to the NJSCR.
- Registrars are responsible for including all required data items in the abstract, regardless of class of case.
- Consult-only cases are reportable. A consult may be done to confirm a diagnosis or treatment plan.

**Check out the NJSCR website for the Program Manual and other helpful tools and information.**

<https://www.nj.gov/health/ces/reporting-entities/registrars/>

### What is a NAACCR Modified Record?

Tumor records (Abstracts) that have already been transmitted to the state but that have had an update to any field and are resubmitted. They should be resubmitted in "M" format. Please contact your system vendor for information on how to submit a modified record.

\*\* <https://www.naacccr.org/wp-content/uploads/2018/05/Standards-Volume-I-Version-18.pdf>

## Prostate Coding

### Prostate Clinical T

- Clinical T value is based on DRE
- Imaging should not be used for Clinical T

### EOD Primary Tumor

- This is based primarily on the DRE only
- DO NOT use biopsy results UNLESS they prove extraprostatic extension
- DO NOT use imaging UNLESS physician clearly incorporates findings into evaluation
- DRE does not mention a palpable "tumor" "mass" or "nodule", infer the prostate as clinically inapparent

### EOD Regional Nodes

- Prostate is considered an inaccessible site for regional lymph nodes
- Assume negative when workup done with no mention of lymph nodes, low/localized stage and standard therapy done
- Regional nodes include contralateral or bilateral nodes

### Prostate Grading

Code E if stated as "Gleason score 7" with no patterns documented or any Gleason patterns combination equal to 7 not specified in 2 or 3

A TURP does NOT qualify as a surgical resection for pathologic grading purposes

Clinical Grade	Pathological Grade
TURP	Prostatectomy
<i>Assign highest grade from primary tumor even it happens to be a clinical grade</i>	

### General Grading Instructions

- Code the grade from the primary tumor only
- If more than 1 grade available: priority goes to recommended AJCC Grade listed
- If no recommended Grade- record the highest grade
- Do not code grade for dysplasia
- In situ/invasive combination- Code invasive only (even if it is unknown)

\*\*2019-2020 NAACCR Webinar series Prostate

Questions can be sent to your facility's NJSCR Representative or by calling 609-633-0500. DO NOT REPLY to this email.

**Anastomotic Site for Colon, Rectosigmoid and Rectum: Single or Multiple Primary?  
 A new tumor at the anatomic site must be stated to arise in the mucosa to qualify as a new primary. See Solid Tumor Rules.**

**Example:** New tumor at the ileocolic anastomosis, described as a, Circumferential centrally ulcerated mass with raised borders. Tumor extension: Tumor invades through muscularis propria into subserosal adipose tissue, no involvement of the serosal surface identified. The only mention of mucosa on the resection is the uninvolved enteric mucosa or uninvolved colonic mucosa in the otherwise uninvolved portions of the ileum/colon. *If neither bullet 1 or 2 apply, is this a new primary per M7 bullet 3?*

**Answer:** Assuming the first and second tumors are not different histologies or they occurred less than or equal to 24 months apart (M7 Bullets 1 and 2 do not apply), **abstract a single primary** as the pathology states uninvolved enteric mucosa or uninvolved colonic mucosa (no involvement noted).

**Example:** Right colon with anastomosis site. Tumor site: Anastomosis. Tumor extension: Tumor invades through the muscularis propria. Gross description does not describe mucosa, only noting, at the central area of anastomosis is an ill-defined, slightly raised, tan-brown to purple mass measuring 2.2 x 2 cm, which is nearly circumferential, causing obstruction at the site of anastomosis. *If neither bullet 1 or 2 apply, is this a new primary per M7 bullet 3?*

**Answer:** Assuming the first and second tumors are not different histologies or they occurred less than or equal to 24 months apart (M7 bullets 1 and 2 do not apply), **abstract a single primary** as there is no mention of mucosal involvement.

**Example:** Polyp at ileocolonic anastomosis, polyp biopsy final diagnosis was, Invasive moderately differentiated colonic adenocarcinoma in association with adenoma. No mention of mucosa on the biopsy final diagnosis or gross description. Clinical info indicates, There is an ulcerated 5 cm mass at the ileo-colonic anastomosis that was biopsied. *If neither bullet 1 or 2 apply, is this a new primary per M7 bullet 3?*

**Answer:** Assuming the first and second polyps/tumors are not different histologies or they occurred less than or equal to 24 months apart (M7 bullets 1 and 2 do not apply), **abstract a single primary** as there is no mention of mucosal involvement.

**Of note in the case of the polyp, tumors coded as adenocarcinoma in a polyp, should be treated as adenocarcinoma (8140) for cases prior to 2018. Also, if the pathologist states the new tumor/polyp originated in the mucosa, it is a new primary.**

\* <https://seer.cancer.gov/seerquery/index.php?page=view&id=20200013&type=q>  
 \* [https://seer.cancer.gov/tools/solidtumor/Colon\\_STM.pdf](https://seer.cancer.gov/tools/solidtumor/Colon_STM.pdf)

**Radiation Tips**

- SBRT does not target lymph nodes.
- IORT for breast cancer *does not target lymph nodes*.
- Chest wall or lumpectomy tumor bed/cavity boost (either photons or electrons) **does not include** lymph nodes.
- For pelvic sites, if pelvic/whole pelvis irradiation is mentioned, assume the regional lymph nodes for that site are included.
- Interstitial or intracavitary brachytherapy (HDR or LDR) does not target regional lymph nodes.

**When a radiation treatment summary has multiple PHASES (aka delivered prescriptions):**

- Code the phases from the earliest to latest start date.
- If there are multiple phases with the same start date, code the phases from highest to lowest total dose.
- If there are multiple phases with the same start date and same total dose, then any order is acceptable.

\*NAACCR 2019-2020 Webinar- Base of Tongue 2019-Radiation

**Head and Neck: Oropharynx  
 Histology coding for HPV status**

- Squamous Cell Carcinoma **8070**
- Squamous cell carcinoma HPV-positive **8085**
- Squamous cell carcinoma HPV-negative **8086**



**A statement of “Squamous cell carcinoma HPV-Positive” or “Squamous cell carcinoma HPV-Negative” or results from an HPV viral detection test must be noted in to code 8085 or 8086.**

**DO NOT USE A P16 only test to code 8085 or 8086.**

**Chapter 11 Oropharynx (P16-) and Hypopharynx  
 Staging**

- T0 is not valid value for this chapter.
- T values are different for oropharynx and hypopharynx.
- **If neck dissection is completed for lymph nodes, a stage group may be assigned even if the primary site is not resected.**

\*NAACCR 2019-2020 Webinar- Base of Tongue 2019

**March 2020 E-Tips**

New Jersey State Cancer Registry  
 Cancer Epidemiology Services  
<http://www.nj.gov/health/ces>  
 (609) 633-0500

**Coding Lymph Vascular Invasion**

LVI on pathology report PRIOR to neoadjuvant (preoperative) therapy	LVI on pathology report AFTER neoadjuvant (preoperative) therapy	Code LVI to
0 – Not present/Not identified	0 – Not present/Not identified	0 – Not present/Not identified
0 – Not present/Not identified	1 – Present/Identified	1 – Present/Identified
0 – Not present/Not identified	9 – Unknown/Indeterminate	9 – Unknown/Indeterminate
1 – Present/Identified	0 – Not present/Not identified	1 – Present/Identified
1 – Present/Identified	1 – Present/Identified	1 – Present/Identified
1 – Present/Identified	9 – Unknown/Indeterminate	1 – Present/Identified
9 – Unknown/Indeterminate	0 – Not present/Not identified	9 – Unknown/Indeterminate
9 – Unknown/Indeterminate	1 – Present/Identified	1 – Present/Identified
9 – Unknown/Indeterminate	9 – Unknown/Indeterminate	9 – Unknown/Indeterminate

If initial biopsy has no mention of Lymph vascular invasion and patient has neoadjuvant therapy followed by surgery with a statement of **NO lymph vascular invasion code 9**.

\*[https://seer.cancer.gov/manuals/2018/SPCSM\\_2018\\_maindoc.pdf](https://seer.cancer.gov/manuals/2018/SPCSM_2018_maindoc.pdf)

**Question:**

Is an **omentectomy** performed with a hysterectomy for an endometrial primary site recorded under Surgery of Other Site?

**Answer:**

Continue to record an omentectomy performed with a hysterectomy under Surgery of Primary Site and not as a separate procedure under Surgical Procedure of Other Site.

\*<https://seer.cancer.gov/seerquery/index.php?page=view&id=20200009&type=q>

**Question:**

Patient presents for colon surgery on 8/1/18 and Operative Note stated Rectosigmoid Colon and the Pathology Report stated Sigmoid Colon. How would Primary Site be coded?

**Answer:** Rectosigmoid Colon

See Priority order for Coding Primary Site for Resected cases

- Operative report with surgeon’s description
- Pathology report
- Imaging

\*[https://seer.cancer.gov/manuals/2018/AppendixC/Coding\\_Guide\\_lines\\_Colon\\_2018.pdf](https://seer.cancer.gov/manuals/2018/AppendixC/Coding_Guide_lines_Colon_2018.pdf)

\*NAACCR 2018-2019 Webinar Series Coding Pitfalls

**Melanoma Surgery Codes Questions and Answers**

**Question:**

Is a shave biopsy or punch biopsy of a melanoma with negative margins coded as biopsy (diagnostic procedure 02) or as an excisional biopsy (surgical procedure 20 or 27)?

**Answer:**

➡ Code 27 based on the negative margins.

\*<http://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/fords/first-course-of-treatment/surgery/61441-melanoma-biopsy-with-negative-margins>

**Question:**

What surgical codes would I use for the shave biopsy with negative margins followed by a wide excision? Also, would you clarify code 45- wide excision or re-excision of lesion with margins more than 1cm NOS, margins must be microscopically negative. (Does this mean we can use this if there is no mention of the margins size?)

**Answer:**

Shave biopsy 05/14/12, margins clean, code 27.

Wide excision 06/27/12, no residual.

The FORDS says the wide excision is qualified for code 45 IF the microscopically negative margins are more than 1 cm. Clarify with the pathologist whether the margins around the biopsy scar are more than 1 cm and code 45-47, otherwise, if less, code 31.

\*<http://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/fords/surgical-diagnostic-and-staging-procedure/6099-melanoma-clear-margs>

Questions can be sent to your facility’s State Representative or by calling 609-633-0500. DO NOT REPLY to this email.

**SEER Reliability Study Review Release**

The results from the *2019: Extent of Disease (EOD), Summary Stage, and Site-Specific Data Items (SSDI) Reliability Study* have been posted on the SEER website.

<https://seer.cancer.gov/qi/tools/reliability.html>

The study required review and coding of EOD 2018 Data Items (Primary Tumor, Regional Nodes, Mets), SS2018, Grade, SSDI (scheme specific), Regional Nodes Positive and Tumor Size Field. 10 schemas were used: Brain, Breast, Colon/Rectum, Lung, Lymphoma (CLL/SLL), Melanoma/Skin, Ovary, Prostate, Soft Tissue, and Tongue Anterior.

995 data items in the study were distributed among five groups consisting of 199 data items each. Preferred answers with less than 85% agreement by study participants were reviewed as well as all comments provided by study participants.

**Of the 995 items, 77 (7.7%) preferred answers and rationales were modified after review and reconciliation of the preferred answers.**

**Based on feedback, comments and suggestions, many clarifications were added to Version 1.7 released of the SSDI and Grade Manuals, EOD and Summary Stage.** SEER noted an appreciation to the over 800 people that participated in the study.

**EOD Primary Tumor for Breast**

For Extensive Skin involvement, inflammation, erythema, edema, peau d'orange, or other terms describing skin changes without a stated diagnosis of inflammatory carcinoma assign

**CODE 400!**

**EOD Regional Nodes for Breast**

*Codes 030, 050, and 070 are for nodes that are pathologically negative but are positive for ITCs or RT-PCR.*

Code 030: Negative nodes pathologically with positive ITCs OR positive ITCs AND positive RT-PCR

Code 050: Negative nodes pathologically with positive RT-PCR, negative ITCs

Code 070: Negative nodes pathologically, unknown if ITCs or RT-PCR

Lymph Nodes examined and negative!? No mention of ITCs or RT-PCR!?

**Code 070 not 000.**

\*[https://staging.seer.cancer.gov/eod\\_public/schema/1.7/breast/?breadcrumbs=~schema\\_list~](https://staging.seer.cancer.gov/eod_public/schema/1.7/breast/?breadcrumbs=~schema_list~)

**STORE UPDATES!****Radiation:**

- If any phase of treatment to a volume has the **Treatment Modality coded to anything between 07 and 16, the dose for that phase should be coded in cGy, when available.** If there is only one phase in the entire course of radiation, then the phase dose can be used to record the course Total Dose. However, **if there are multiple phases in a radiation course and any of the phases use a brachytherapy, radioisotopes or infusion therapy, then the Total Dose should be coded to 999998** (five 9s).

**Date of First Course Treatment/Palliative Care:**

- When a patient receives *palliative care for pain management* **only** with no other cancer-directed treatment, Date of First Course of Treatment, NAACCR Data Item #1270, **would be the date in which a patient decides on palliative care for pain management only, as recommended by the physician.** "No therapy" is a treatment option that occurs if the patient refuses treatment, the family or guardian refuses treatment, the patient dies before treatment starts, or the physician recommends no treatment be given, or the physician recommends palliative care for pain management only.

**SEE STORE Addendum!**

\*[https://www.facs.org/-/media/files/quality-programs/cancer/ncdb/ncdb\\_store\\_addendum.ashx](https://www.facs.org/-/media/files/quality-programs/cancer/ncdb/ncdb_store_addendum.ashx)

## January 2020 E-Tips

### Coding Lymph node FNA/Biopsy

Removal, biopsy or aspiration (FNA) of a lymph node is considered a surgery. Record all surgical procedures that remove, biopsy, or aspirate regional lymph node(s) whether or not there were any surgical procedures of the primary site. The regional lymph node surgical procedure(s) may be done to diagnose cancer, stage the disease, or as a part of the initial treatment.

Example: Patient has a sentinel node biopsy of a single lymph node. Assign code 2 (Sentinel lymph node biopsy [only]) in Scope of Regional Lymph node Surgery. Use date of lymph node biopsy in surgery date as treatment.

\*[https://seer.cancer.gov/manuals/2018/SPCSM\\_2018\\_maindoc.pdf](https://seer.cancer.gov/manuals/2018/SPCSM_2018_maindoc.pdf)

**Check out SEER SINQ for some coding help with Lymph node Dissection!**  
<https://seer.cancer.gov/seerinqury/index.php?page=view&id=20190092&type=q>

### Solid Tumor Rules

#### Lung histology

Code the histology that comprises the greatest percentage of tumor when two or more of the following histologies are present:

- Acinar adenocarcinoma/  
Adenocarcinoma, acinar predominant  
8551
  - Lepidic adenocarcinoma/  
Adenocarcinoma, lepidic predominant  
8250
  - Micropapillary adenocarcinoma/  
Adenocarcinoma, micropapillary  
predominant 8265
  - Papillary adenocarcinoma/  
Adenocarcinoma, papillary predominant  
8260
  - Solid adenocarcinoma/  
Adenocarcinoma, solid predominant  
8230
- \*[https://seer.cancer.gov/tools/solidtumor/Lung\\_STM.pdf](https://seer.cancer.gov/tools/solidtumor/Lung_STM.pdf)

#### General Equivalent or Equal Terms

These terms can be used interchangeably for all sites:  
Adenocarcinoma; glandular carcinoma;  
carcinoma.

#### Recurrence

Use the Multiple Primary Rules as written to determine whether a subsequent tumor is a new primary or a recurrence. **The ONLY exception is when a pathologist compares slides from the subsequent tumor to the "original" tumor and documents the subsequent tumor is a recurrence of the previous primary.** Never code multiple primaries based only on a physician's statement of "recurrence" or "recurrent".

\*<https://seer.cancer.gov/tools/solidtumor/>

### SSDI Coding Tips

*(from "Coding Pitfalls" NAACCR 2018-2019 Webinar Series)*

#### Breast ER/PR Percent

- >95% Code 96 because when "greater than" is used, code one above
- <95% Code 94 because when the term "less than" is used, code one below.
- 1-5%. Code R10 if the range on the report uses steps smaller than 10 and the range is fully or at least 80% contained within a range provided in the table, code to the range that contains the low number of the range in the report.
- 75-85% Code R80 almost all the range is contained with code R80.
- 76-100% look at the lowest value and find the range that would fall in, code R80.
- Close to 100%, code 99 ("close to" means almost that value, code one less than stated value.)
- Approximately 1% Code 001 (Since they are staging a single value, code to that value).

#### Breast Ki-67

- <10% code 9.9 (when "less than" is used, code the next lowest number.)
- >90% Code 90.1 (When "greater than" is used, code the next highest number.)
- 30-40% Code 30.1. (Since Ki-67 doesn't have range codes, code one above the lower range.)

#### Prostate Cores: Number of Cores Positive/ Number of Cores Examined

Always check to make sure the number of cores positive is less than or equal to the number of cores examined.

### NJSCR hosts Student Day

**When:** March 25th, 2020

**Who:** Cancer registry students who have completed 80 hours of clinical practicum or are nearing the end of their training and need to complete a central registry experience requirement.

**Spots are limited!** If interested in attending, email [Taylor.Hessler@doh.nj.gov](mailto:Taylor.Hessler@doh.nj.gov) to register.