QC Visual Review Findings Overview

2024 FCDS Educational webcast series

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Wednesday, March 13, 2024

FLccSC LMS-CEU Quiz-FCDS IDEA

NCRA CEU# is #2024-031
2 CEUs Awarded, Category A

Login to FLccSC to enroll in the course and get the CEU certificate.

The certificate will be generated after the quiz is completed in FLccSC.

CDC & Florida DOH Attribution

"Funding for this conference was made possible (in part) by the Centers for Disease Control and Prevention. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services, nor does the mention of trade names, commercial practices, or organizations imply endorsement by the US Government."

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FCDS Webinar Series 2024

- QC Visual Review Findings (Part 1) – Part 2 at FCDS Annual Conference
- Lung Cancer
- The Complexity of Coding Grade
- GYN Malignancies

FCDS Quality Control Measures

- Annual Consolidated Follow Back (AHCA/Mortality Casefinding Audit)
- Visual Editing of Abstracts
- Internal Visual Editing during data processing and tumor consolidation process
- Data Quality Annual Audits
- NPCR & FCDS Data Quality Indicator Report
- FCDS Facility Management Reports in IDEA
- FCDS Management Reports

Visual Editing Process & Feedback to Abstractors

GOAL: Evaluate whether the abstract makes sense as coded; if something is missing or unusual that standard electronic edit checks cannot catch.

- Review One of Every 25th Record Processed
- 4% of analytic abstracts from Hospitals, Radiation Treatment Facilities, and Ambulatory Surgery Centers
  - All pediatric cases
  - All male breast cases

Visual Editing Process & Feedback to Abstractors

The QC Visual Abstract Review is a fully automated 3-step process:

- 1. The initial review by FCDS CTR QC Contractor
- 2. Feedback to/from the registrar with an opportunity to comment and correct data
- 3. Final review by the FCDS QC Manager/QC Staff to make final determination on the case
- Records with discrepant data must be resolved by the reporting facilities within three weeks of receipt
- "Agree," "OK", "Done" are NOT Acceptable Responses to Inquiries

What Do FCDS QC Contractors (Visual Editors) Expect When Reviewing Abstracts?

- Supporting text on all coded data (Analytic/Non-analytic)
- • Non-analytic
  - provide a reason why you don't have supporting text on stage and treatment
  - provide a good history of disease AND a reason the patient was at your facility
- All data items must be well documented in the event of an audit
  - Demographics, Tumor, Staging, SSDIs, and Treatment
  - All data items must make sense beyond the standard edit checks
  - The staging, SSDI, and treatment data must make sense together

FCDS Quality Control Visual Editing

All cases are to be reviewed for the accuracy of codes and text documentation. Data must meet the cancer reporting standards as stated in the current FCDS Data Acquisition Manual.

- Accession number
- Patient demographics
- Treatment Information
- Primary Site, Histology, General Stage
- Text documentation
- Coding of data items
- Dates (DOD, first contact date, and date Rx administered), etc.

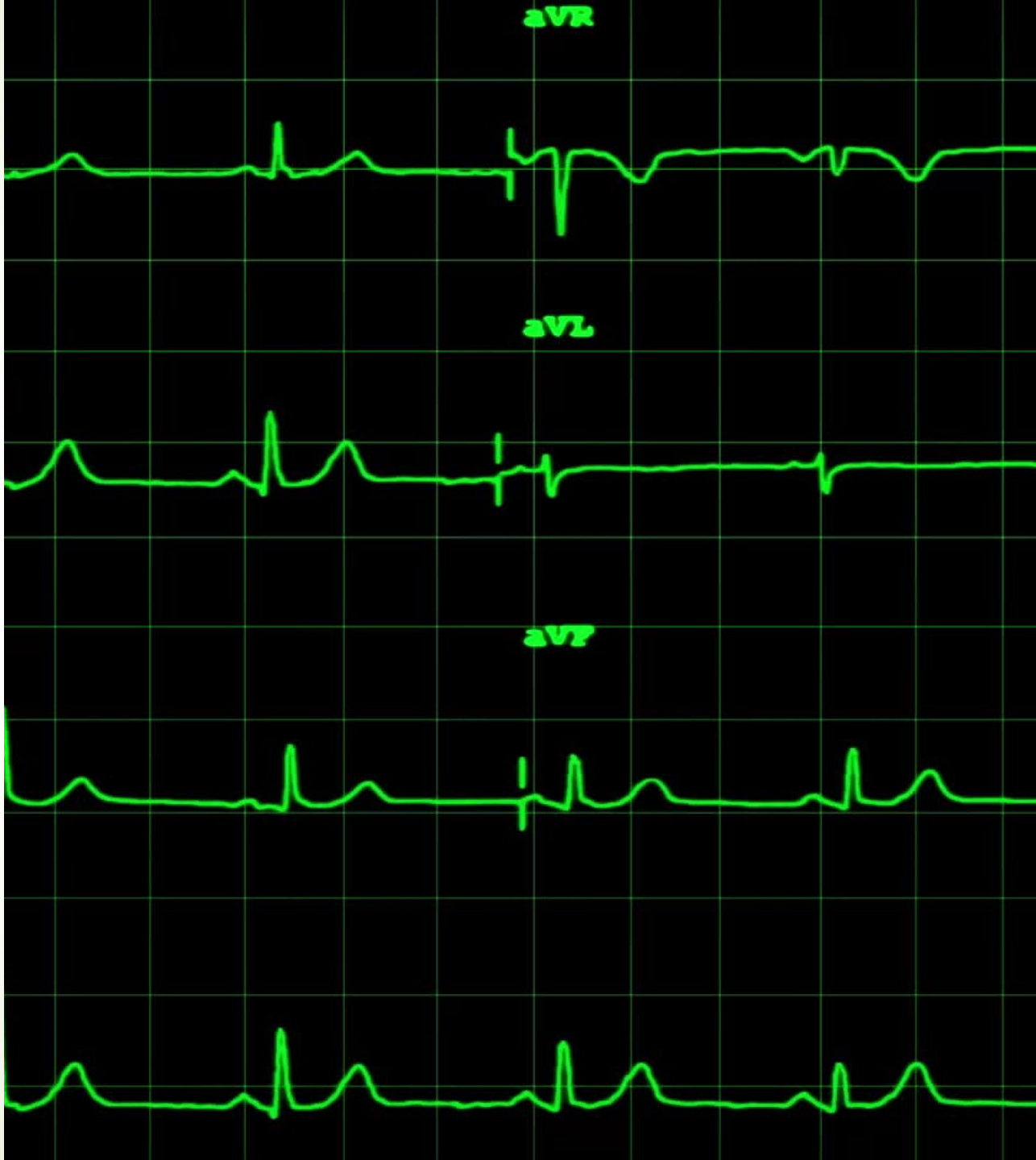
What do you code LVI to for a Benign Meningioma?

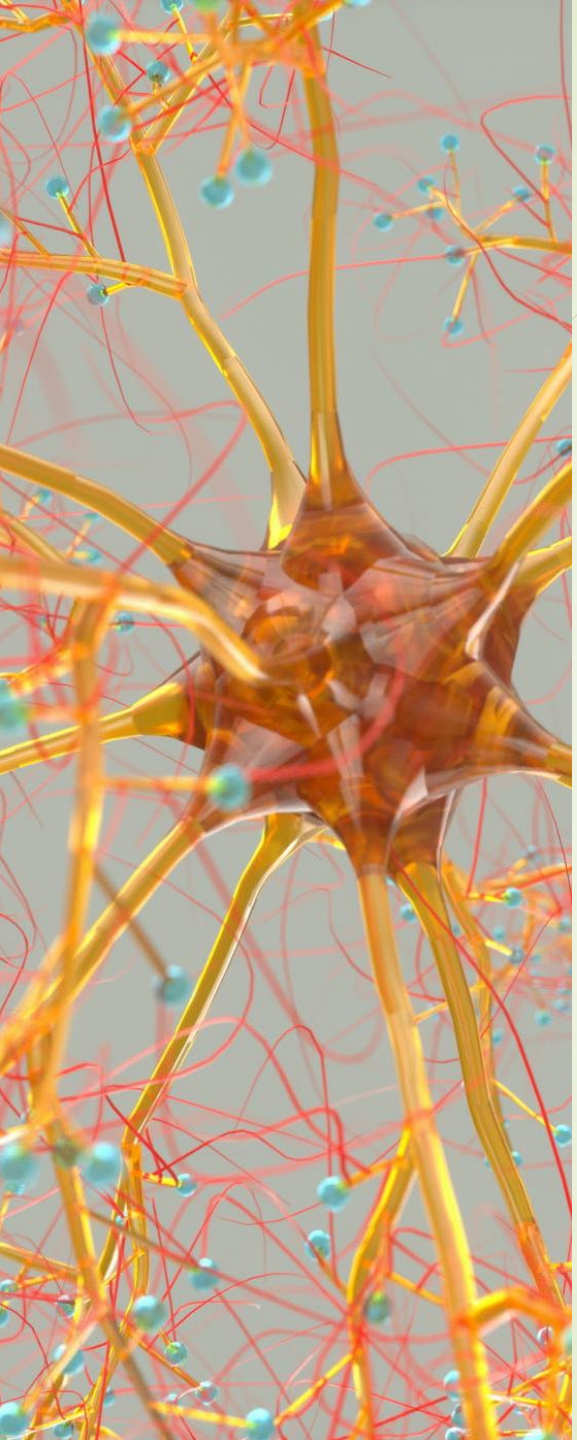
SEER Program Coding Manual

- Use code 8 for non-malignant brain (intracranial) and CNS tumors

STORE Manual 2024

- Benign/borderline brain and/or CNS and GIST use code 8 (not applicable).





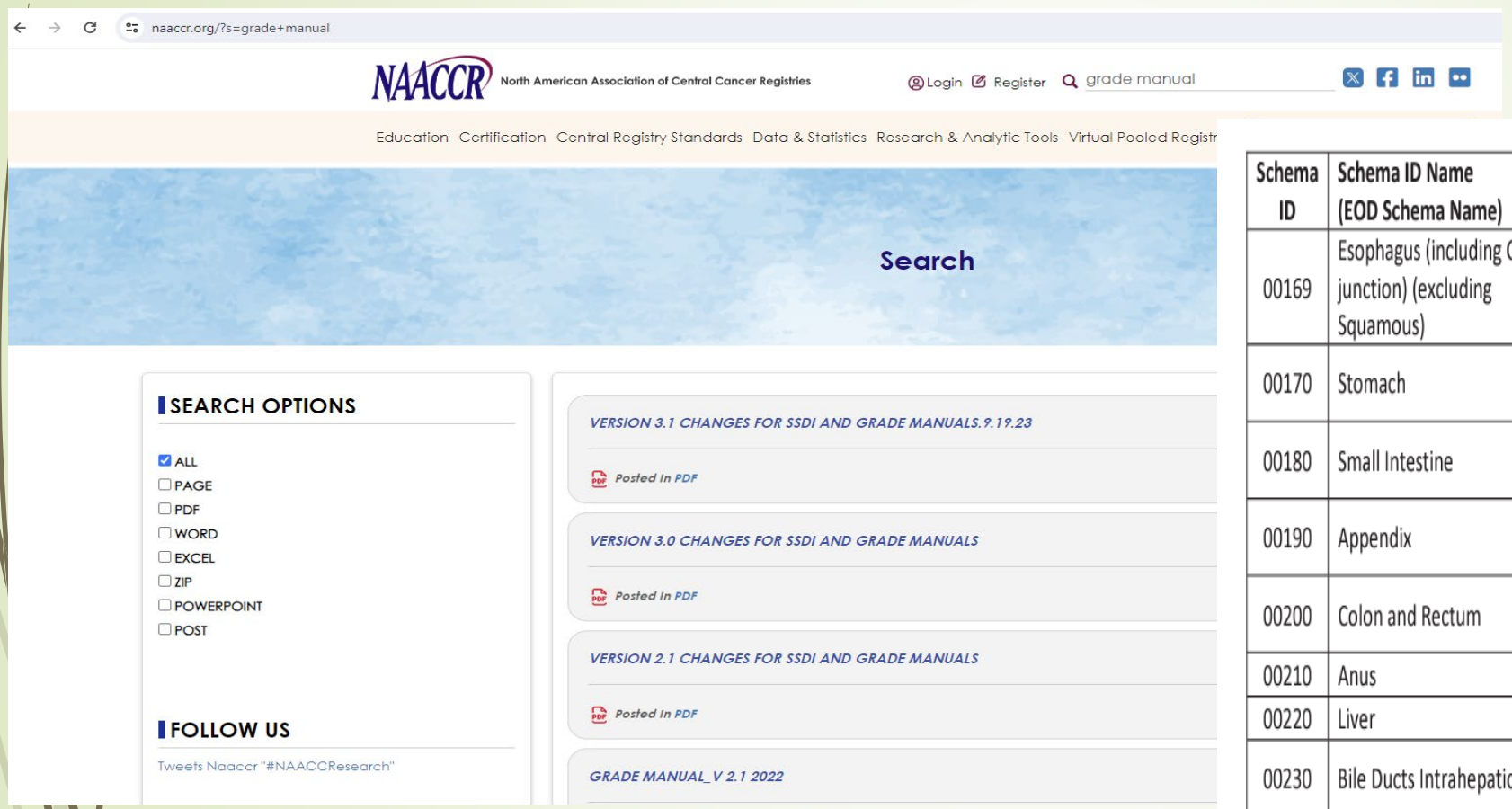
Lymph vascular invasion must be coded 8 (not applicable) for all other Schema IDs

- 00430 GIST (2021+)
- 00710 Lymphoma Ocular Adnexa
- 00790 Lymphoma
- 00795 Lymphoma (CLL/SLL)
- 00811 Mycosis Fungoides
- 00812 Primary Cutaneous Lymphoma
- 00821 Plasma Cell Myeloma
- 00822 Plasma Cell Disorder
- 00830 HemeRetic

Lymph Vascular Invasion (Cont.)

- Use code 0 when the pathology report indicates that there is no lymph vascular invasion.
- This includes cases of purely in situ carcinoma, which biologically have no access to lymphatic or vascular channels below the basement membrane
- Do not code 8 (non-applicable) for non-invasive tumors
- Use code 9
  - No microscopic confirmation
  - Specimen is cytology only
  - Unable to determine whether LVI is present
  - Not mentioned in pathology

Grade Manual Updates



Schema ID	Schema ID Name (EOD Schema Name)	AJCC Chap.	AJCC Chapter Name	SS Chapter	Grade Table
00169	Esophagus (including GE junction) (excluding Squamous)	16	Esophagus and Esophagogastric Junction	Esophagus (including GE junction)	Grade 03
00170	Stomach	17	Stomach	Stomach (including NET)	Grade 04
00180	Small Intestine	18	Small Intestine	Small Intestine (including NET)	Grade 02
00190	Appendix	19	Appendix-Carcinoma	Appendix (including NET)	Grade 05
00200	Colon and Rectum	20	Colon and Rectum	Colon and Rectum (including NET)	Grade 02
00210	Anus	21	Anus	Anus	Grade 06
00220	Liver	22	Liver	Liver	Grade 02
00230	Bile Ducts Intrahepatic	23	Intrahepatic Bile Duct	Intrahepatic Bile Ducts	Grade 01
00241	Gallbladder	24	Gallbladder	Gallbladder	Grade 01
00242	Cystic Duct	24	Gallbladder	Extrahepatic Bile Ducts	Grade 01

https://www.naaccr.org/?s=grade+manual

Coding Grade for Benign CNS Cases

- Grade Clinical must not be BLANK
- If no cancer-directed surgery, code pathologic grade to 9
- For benign tumors ONLY (behavior 0), code 1 can be automatically assigned for all histologies
- Code 9 (unknown) when
  - Grade from the primary site is not documented
  - Clinical workup is not done (for example, cancer is an incidental finding during surgery for another condition)
  - Grade checked "not applicable" on CAP Protocol (if available), and no other grade information is available
  - Codes 1-4 take priority over A-D, L and H.

Brain and CNS WHO Grade

Group	Type	Grade 1	Grade 2	Grade 3	Grade 4
	Desmoplastic myxoid tumor of the pineal region, SMARCB1-mutant*				
Cranial and peripheral nerve tumors	Schwannoma	X			
	Neurofibroma	X			
	Perineurioma	X			
	Hybrid nerve sheath tumor	X			
	Malignant melanotic nerve sheath tumor*				
	Malignant peripheral nerve sheath tumor*				
Meningiomas	Meningioma	X	X		
	Atypical meningioma		X		
	Clear cell meningioma		X		
	Chordoid meningioma		X		
	Anaplastic meningioma				
	Papillary meningioma	X	X		
	Rhabdoid meningioma	X	X		

https://www.cap.org/protocols-and-guidelines/cancer-reporting-tools/cancer-protocol-templates

CAP Approved CentralNervousSystem.Bx.Res_1.0.0.0.REL_CAPCP

CNS WHO Grades for CNS Tumors
CNS WHO grade 1
CNS WHO grade 2
CNS WHO grade 3
CNS WHO grade 4
CNS WHO grade not assigned

Table 1. CNS WHO Grading System for Some of the More Common Tumors of the CNS[1,2]

Group	Type	Grade 1	Grade 2	Grade 3	Grade 4
Adult-type diffuse gliomas	Astrocytoma, IDH-mutant		X	X	X
	Oligodendroglioma, IDH-mutant and, 1p/19q co-deleted		X	X	
	Glioblastoma, IDH-wildtype				X
Pediatric-type diffuse low-grade gliomas	Diffuse glioma, MYB- or MYBL1- altered	X			
	Angiocentric glioma	X			
	Polymorphous low-grade neuroepithelial tumor of the young	X			
	Diffuse low-grade glioma, MAPK pathway-altered*				
iffuse mas	Diffuse midline glioma, H3 K27-altered				X
	Diffuse hemispheric glioma, H3 G34-mutant				X

Coding Grade for Breast

Code	Description
1	G1: Low combined histologic grade (favorable), SBR score of 3-5 points Stated as Nottingham/Scarff Bloom-Richardson Grade 1
2	G2: Intermediate combined histologic grade (moderately favorable); SBR score of 6-7 points Stated as Nottingham/Scarff Bloom-Richardson Grade 2
3	G3: High combined histologic grade (unfavorable); SBR score of 8-9 points Stated as Nottingham/Scarff Bloom-Richardson Grade 3
L	Nuclear Grade I (Low) (in situ only)
M	Nuclear Grade II (interMediate) (in situ only)
H	Nuclear Grade III (High) (in situ only)
A	Well differentiated
B	Moderately differentiated
C	Poorly differentiated
D	Undifferentiated, anaplastic
9	Grade cannot be assessed (GX); Unknown

Note 2: Assign the highest grade from the primary tumor assessed during the clinical time frame.

Note 3: If there are multiple tumors with different grades abstracted as one primary, code the highest grade.

Note 4: Priority order for codes

- Invasive cancers: codes 1-3 take priority over A-D.
- In situ cancers: codes L, M, H take priority over A-D

Note 5: Scarff-Bloom-Richardson (SBR) score is used for grade. SBR is also referred to as: Bloom-Richardson, Nottingham, Nottingham modification of Bloom-Richardson score, Nottingham modification, Nottingham-Tenovus grade, or Nottingham score.

Note 6: All invasive breast carcinomas should be assigned a histologic grade. The Nottingham combined histologic grade (Nottingham modification of the SBR grading system) is recommended. The grade for a tumor is determined by assessing morphologic features (tubule formation, nuclear pleomorphism, and mitotic count), assigning a value from 1 (favorable) to 3 (unfavorable) for each feature, and totaling the scores for all three categories. A combined score of 3–5 points is designated as grade 1; a combined score of 6–7 points is grade 2; a combined score of 8–9 points is grade 3.

Breast Coding Grade DCIS and invasive cancers

Case scenario

- Patient presents with axillary adenopathy suspicious for malignancy and palpable mass right breast FNA of lymph node is positive for metastatic invasive ductal ca grade 2 and breast biopsy positive cancer poorly diff
- **What do you code for clinical grade?**
  - **A. C**
  - **B. 3**
- Patient presents with abnormal mammogram suspicious for cancer biopsy positive of DCIS. The patient had a lumpectomy performed final dx was DCIS nuclear grade 2
- **What do you code for pathologic grade?**
  - **A. 2**
  - **B. M**

Grade Clinical - Bladder

Grade Clinical

This input is used for staging

Notes

Note 1: Grade Clinical must not be blank.

Note 2: Assign the highest grade from the primary tumor assessed during the clinical time frame.

Note 3: If there are multiple tumors with different grades abstracted as one primary, code the highest grade.

Note 4: Priority order for codes

- Urothelial cancers (WHO/ISUP grade): use codes L, H and 9
  - If only G1-G3 are documented, code 9
- Adenocarcinomas and Squamous Cell Carcinomas: use codes 1-3, 9
  - If only L or H are documented, code 9

Note 5: G3 includes undifferentiated and anaplastic.

Note 6: For bladder, a TURB qualifies for a clinical grade only.

Note 7: Code 9 (unknown) when

- Grade from primary site is not documented
- Clinical workup is not done (for example, cancer is an incidental finding during surgery for another condition)
- Grade checked "not applicable" on CAP Protocol (if available) and no other grade information is available

Note 8: If there is only one grade available and it cannot be determined if it is clinical or pathological, assume it is a Grade Clinical and code appropriately per Grade Clinical categories for that site, and then code unknown (9) for Grade Pathological, and blank for Grade Post Therapy Clin (yc) and Grade Post Therapy Path (yp).

Code	Description
1	G1: Well differentiated
2	G2: Moderately differentiated
3	G3: Poorly differentiated
L	LG: Low-grade
H	HG: High-grade
9	Grade cannot be assessed (GX); Unknown

Coding Grade

6/15/23 Patient presents to Centreville Hospital with bladder tumor identified on scope and TURBT reveals invasive urothelial carcinoma with muscle invasion grade 3

What is coded for the clinical and pathologic grade?

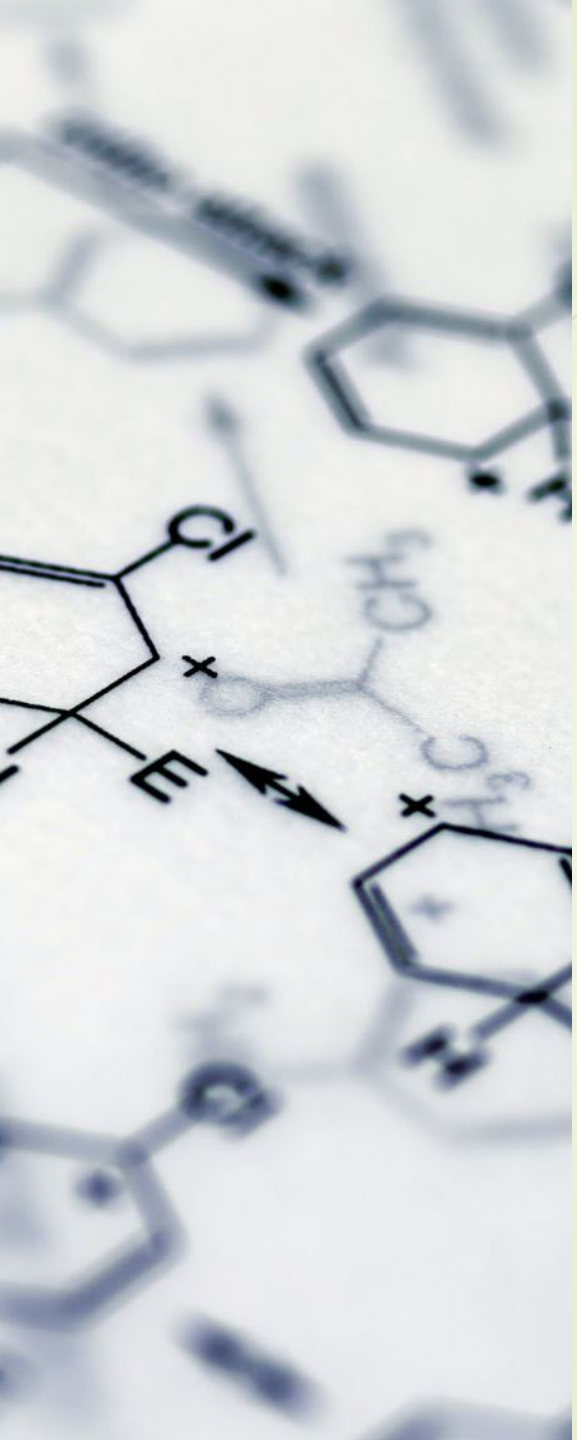
A: L and 3

B: 3 and 3

C: 9 and 9

Non-Small Cell Carcinoma of Lung (STR Histology H3)

- Non-small cell carcinoma 8046; a broad category that includes all histologies in Table 3 except for small cell carcinoma/neuroendocrine tumors (NET Tumors) 8041 and all subtypes
- Code the specific histology when the diagnosis is non-small cell lung carcinoma (NSCLC) consistent with (or any other ambiguous term) a specific carcinoma (such as adenocarcinoma, squamous cell carcinoma, etc.) when:
  - The histology is clinically confirmed by a physician (attending, pathologist, oncologist, pulmonologist, etc.)
  - The patient is treated for the histology described by an ambiguous term



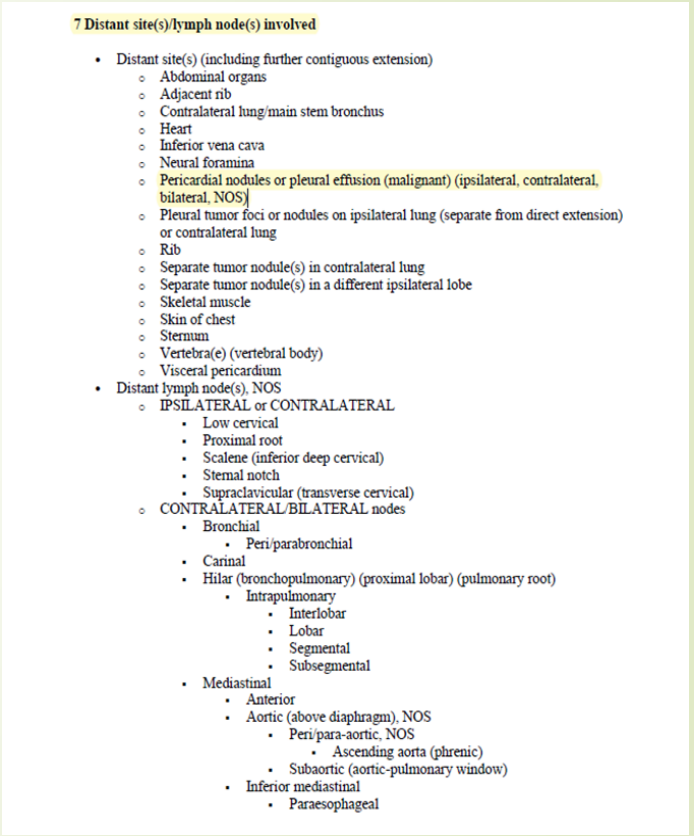
Non-Small Cell Carcinoma of Lung (Cont.)

- If the case does not meet the criteria in the first two bullets, code non-small cell lung cancer (NSCLC) 8046.
- If the case is accessioned (added to your database) based on a single histology described by ambiguous terminology and no other histology information is available/documented, then code that histology cell carcinoma/neuroendocrine tumors (NET Tumors) 8041 and all subtypes

Lung Summary Stage for Pleural Effusion

SEER Summary Stage v3.1

Most pleural and pericardial effusions with lung cancer are due to tumor. In a few patients, however, multiple cytopathological examinations of pleural and/or pericardial fluid are negative for tumor, and the fluid is non-bloody and is not an exudate. Where these elements and clinical judgment dictate that the effusion is not related to the tumor, the effusion should be excluded as a staging element



7 Distant site(s)/lymph node(s) involved

- Distant site(s) (including further contiguous extension)
  - Abdominal organs
  - Adjacent rib
  - Contralateral lung/main stem bronchus
  - Heart
  - Inferior vena cava
  - Neural foramina
  - Pericardial nodules or pleural effusion (malignant) (ipsilateral, contralateral, bilateral, NOS)
  - Pleural tumor foci or nodules on ipsilateral lung (separate from direct extension) or contralateral lung
  - Rib
  - Separate tumor nodule(s) in contralateral lung
  - Separate tumor nodule(s) in a different ipsilateral lobe
  - Skeletal muscle
  - Skin of chest
  - Sternum
  - Vertebra(e) (vertebral body)
  - Visceral pericardium
- Distant lymph node(s), NOS
  - IPSILATERAL or CONTRALATERAL
    - Low cervical
    - Proximal root
    - Scalene (inferior deep cervical)
    - Sternal notch
    - Supraclavicular (transverse cervical)
  - CONTRALATERAL/BILATERAL nodes
    - Bronchial
      - Peri/parabronchial
    - Carinal
    - Hilar (bronchopulmonary) (proximal lobar) (pulmonary root)
      - Intrapulmonary
        - Interlobar
        - Lobar
        - Segmental
        - Subsegmental
    - Mediastinal
      - Anterior
      - Aortic (above diaphragm), NOS
        - Peri/para-aortic, NOS
          - Ascending aorta (phrenic)
        - Subaortic (aortic-pulmonary window)
      - Inferior mediastinal
        - Paraesophageal

https://seer.cancer.gov/tools/ssm/

Date of Diagnosis

- 1/17/2023 FCDS THERE IS AN IRREGULAR MASS MEASURING 0.7 X 0.6 X 0.5 CM IN THE RIGHT BREAST AT 1 O'CLOCK. THE FINDING CORRELATES TO THE ABNORMALITY SEEN ON ULTRASOUND IN THE RIGHT BREAST AT 1 O'CLOCK. IRREGULAR MASS IS HIGHLY SUGGESTIVE OF MALIGNANCY. BI-RADS CATEGORY 5
- 2/26/2023 FCDS BREAST, RIGHT, 1:00, 5 CM FROM NIPPLE ULTRASOUND-GUIDED CORE NEEDLE BIOPSY INVASIVE DUCTAL CARCINOMA TUMOR GRADE: GRADE 1

- **What is the date of diagnosis**?
  - **A. 1/17/23**
  - **B. 2/26/23**

Breast BI-RADS Table

B. ASSESSMENT CATEGORIES

Table 6. Concordance Between BI-RADS® Assessment Categories and Management Recommendations

Assessment	Management	Likelihood of Cancer
Category 0: Incomplete – Need Additional Imaging Evaluation and/or Prior Mammograms for Comparison	Recall for additional imaging and/or comparison with prior examination(s)	N/A
Category 1: Negative	Routine mammography screening	Essentially 0% likelihood of malignancy
Category 2: Benign	Routine mammography screening	Essentially 0% likelihood of malignancy
Category 3: Probably Benign	Short-interval (6-month) follow-up or continued surveillance mammography (Figure 155, see page 152)	> 0% but ≤ 2% likelihood of malignancy
Category 4: Suspicious Category 4A: *Low suspicion* for malignancy Category 4B: *Moderate suspicion* for malignancy Category 4C: *High suspicion* for malignancy	Tissue diagnosis	> 2% but < 95% likelihood of malignancy > 2% to ≤ 10% likelihood of malignancy
Category 5: Highly Suggestive of Malignancy	Tissue diagnosis	
Category 6: Known Biopsy-Proven Malignancy	Surgical excision when clinically appropriate	

STORE 2024 *Case Eligibility*

All gastro-intestinal stromal tumors (GIST) and thymomas with a Behavior Code of 3 are reportable effective January 1, 2021, Gastro-intestinal stromal tumors (GIST) and thymomas that are non-malignant must be abstracted and assigned a Behavior Code of 3 if they are noted to have multiple foci, metastasis or positive lymph nodes.

Effective **January 1, 2023**, low grade appendiceal mucinous neoplasms (LAMN) (8480) are reportable. LAMN is a distinctive histologic subtype of mucinous appendiceal neoplasm and can be in-situ or invasive. Please reference the AJCC Appendix Protocol Version 9 for further information.

PI Rads, BI Rads, LI Rads alone are not reportable for CoC. PI Rads, BI Rads, LI Rads confirmed with biopsy or physician statement are reportable to CoC. Date of diagnosis is the date of the positive biopsy.

Appendix E2 - 2023 SEER Program Coding and Staging Manual

Non-Reportable Examples

As referenced in the Reportability instructions of the 2023 SEER Program Coding and Staging Manual

#	Diagnosis/Condition	Notes
1	Sclerosing hemangioma of the lung with multiple regional lymph nodes involved with sclerosing hemangioma.	The lymph node involvement is non-malignant. According to the WHO Classification of Lung Tumors, 4th edition, sclerosing hemangioma "behaves in a clinically benign fashion...Reported cases with hilar or mediastinal lymph node involvement do not have a worse prognosis."
2	High grade squamous intraepithelial lesion (HGSIL or HSIL), carcinoma in situ (CIS), and AIN III (8077) arising in perianal **skin** (C445)	HGSIL or HSIL, CIS, and AIN III arising in perianal **skin** are not reportable. Refer to the Reportability Section of the main manual.
3	Squamous cell carcinoma of the perianal **skin** (C445)	Squamous cell carcinoma of sites in C44 is not reportable. Squamous cell carcinoma of the anus (C210) **is** reportable.
4	Squamous cell carcinoma of the canthus (C441)	Squamous cell carcinoma in sites coded to C44 is not reportable.
5	Breast cases designated BIRADS 4, 4A, 4B, 4C or BIRADS 5 without any additional information	The American College of Radiology defines Category 4 as "Suspicious." The descriptions in categories 4, 4a, 4b, and 4c are not diagnostic of malignancy. They all represent a percentage of likelihood, the highest being 4c which is greater than 50% but less than 95% likelihood of malignancy. The ACR states "This category is reserved for findings that do not have the classic appearance of malignancy but are sufficiently suspicious to justify a recommendation for biopsy." Category 5 is "Highly Suggestive of Malignancy." "Suggestive" is not reportable ambiguous terminology. ACR states that Category 5 has a "very high probability" of malignancy, but again, it is not diagnostic.
6	Lung cases designated "Lung-RADS 4A," 4B, or 4X	Lung: Do **not** use the ACR Lung Imaging Reporting and Data System (Lung-RADS™) to determine reportability. Look for reportable terminology from the managing physician or other sources.
7	Liver cases based only on an LI-RADS category of LR-3	Do **not** report liver cases based only on an LI-RADS category of LR-3.
8	Diffuse idiopathic pulmonary neuroendocrine cell hyperplasia (DIPNECH)	DIPNECH is a generalized proliferation of scattered single cells, small nodules (neuroendocrine bodies) or linear proliferation of pulmonary neuroendocrine cells (PNCs) according to the WHO classification of lung tumors.
9	Basal cell carcinoma (BCC) with neuroendocrine differentiation of the **skin**	BCC in sites coded to C44 is not reportable to SEER.
10	Lentiginous melanocytic lesion	Not reportable.
11	Intraductal papillary mucinous neoplasms with **low** or **moderate** grade dysplasia (also called IPMN adenomas)	Not reportable.

#	Diagnosis/Condition	Notes
11	Well-differentiated neuroendocrine tumor (NET) of the stomach	The WHO classification of digestive system tumors uses the term NET G1 (grade 1) as a synonym for carcinoid and well-differentiated NET, 8240/3.
12	Cystic pancreatic endocrine neoplasm (CPEN)	Assign 8150/3 unless specified as a neuroendocrine tumor, Grade 1 (8240/3) or neuroendocrine tumor, Grade 2 (8249/3).
13	Solid pseudopapillary neoplasm of the pancreas	Assign 8452/3.
14	Liver cases with an LI-RADS category LR-4 or LR-5	Report based on the American College of Radiology Liver Imaging Reporting and Data System (LI-RADS) definitions. Use the date of the LR-4 (probable HCC; high probability but not 100% certainty observation is HCC) or LR-5 (definitely HCC; 100% certainty observation is HCC) scan as the date of diagnosis when it is the earliest confirmation of the malignancy. If there is no statement of the LI-RADS score but there is reference that a lesion is in the Organ Procurement and Transplantation Network (OPTN) 5 category, report based on the OPTN class of 5. OPTN class 5 indicates that a nodule meets radiologic criteria for hepatocellular carcinoma.

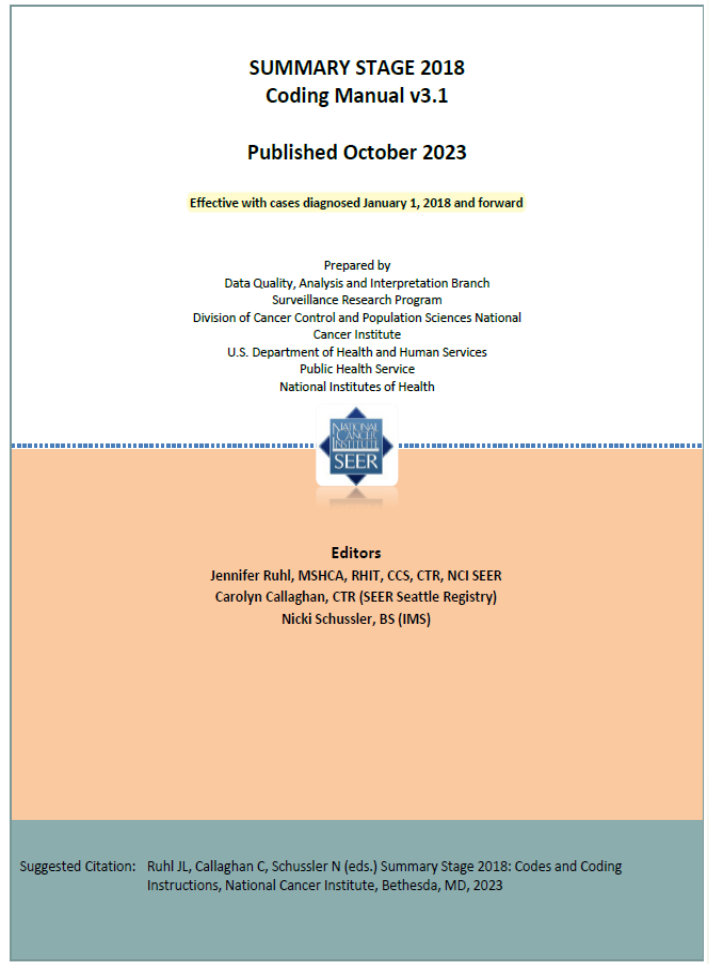
CLL SEER Summary Stage

- CLL summary stage coded should not be coded to UNKNOWN
- Text documentation should not reflect NA
- Code 7 Distant Hematopoietic, immunoproliferative, and myeloproliferative neoplasms are distant

Note 6: The following histologies are systemic (code 7):

9591 Splenic B-cell lymphoma/leukemia, unclassifiable (except C441, C690, C695-C696)
9724 Systemic EBV-positive T-cell lymphoma of childhood
9727 Blastic plasmacytoid dendritic cell neoplasm
9741 Systemic mastocytosis with an associated hematological neoplasm
9742 Mast cell leukemia
9762 Heavy chain diseases
9800 Leukemia, NOS

SEER Summary Stage



SUMMARY STAGE 2018
Coding Manual v3.1

Published October 2023

Effective with cases diagnosed January 1, 2018 and forward

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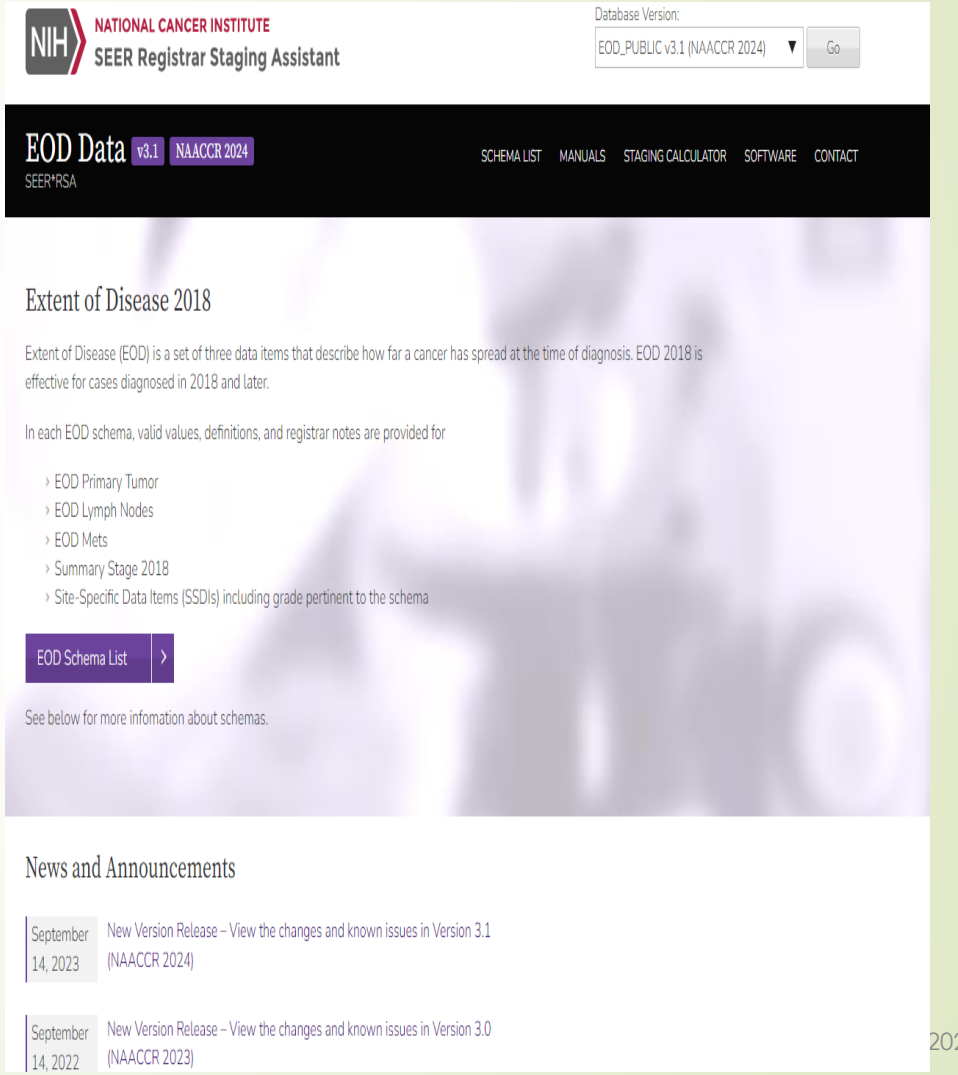


NATIONAL CANCER INSTITUTE
SEER Registrar Staging Assistant

Database Version:
EOD_PUBLIC v3.1 (NAACCR 2024) Go

EOD Data v3.1 NAACCR 2024
SEER*RSA

SCHEMA LIST MANUALS STAGING CALCULATOR SOFTWARE CONTACT

Extent of Disease 2018

Extent of Disease (EOD) is a set of three data items that describe how far a cancer has spread at the time of diagnosis. EOD 2018 is effective for cases diagnosed in 2018 and later.

In each EOD schema, valid values, definitions, and registrar notes are provided for

- EOD Primary Tumor
- EOD Lymph Nodes
- EOD Mets
- Summary Stage 2018
- Site-Specific Data Items (SSDIs) including grade pertinent to the schema

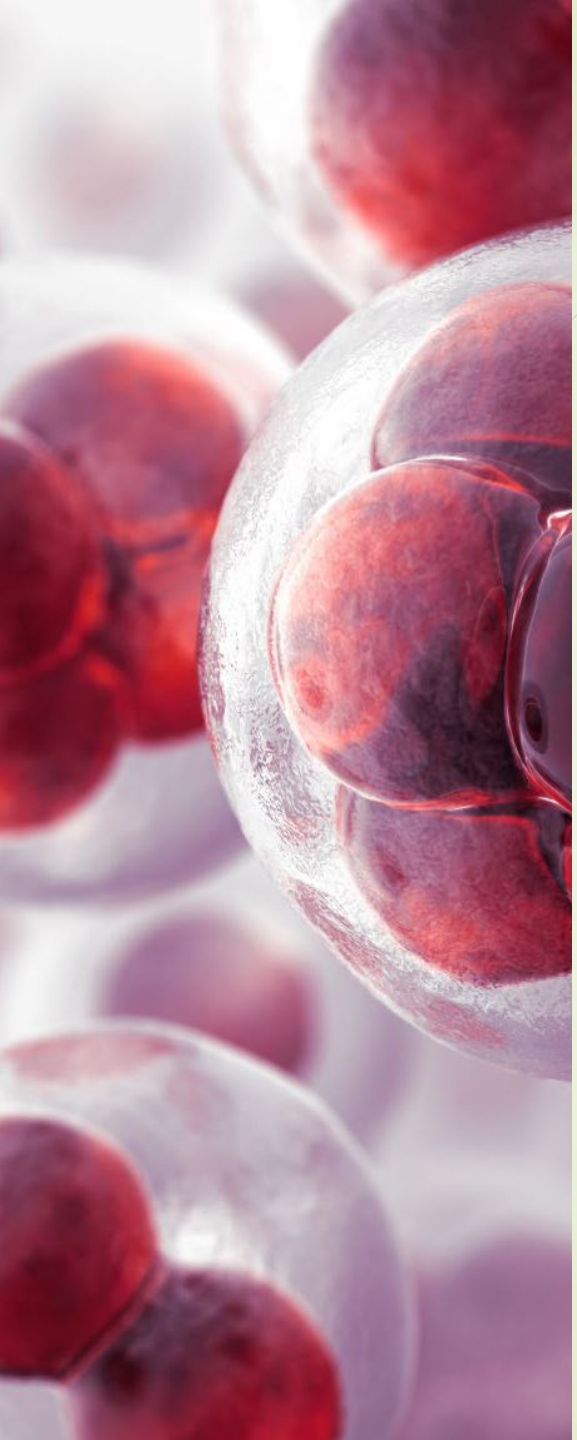
EOD Schema List

See below for more infomation about schemas.

News and Announcements

September 14, 2023 New Version Release – View the changes and known issues in Version 3.1 (NAACCR 2024)

September 14, 2022 New Version Release – View the changes and known issues in Version 3.0 (NAACCR 2023)



Diagnostic Confirmation

- Hematopoietic Neoplasms
- Diagnostic confirmation Code 3 can be used for cases diagnosed 2010+ with histologic confirmation (see code 1) AND immunophenotyping, genetic testing

Hematopoietic and Lymphoid Neoplasm Coding Manual

Effective with Cases Diagnosed 1/1/2010 and Forward

Published August 2021

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https://seer.cancer.gov/tools/heme/

Coding Diagnostic Confirmation (NAACCR Item #490)

Codes for Hematopoietic and Lymphoid Neoplasms (9590/3-9993/3)

Microscopically Confirmed

Code	Description
1	Positive histology • Includes: peripheral blood smear only
2	Positive cytology
3	Positive histology PLUS: • Positive immunophenotyping AND/OR • Positive genetic studies • Includes: peripheral blood smear followed by flow cytometry ***(Effective for cases diagnosed 1/1/2010 and later)***
4	Positive microscopic confirmation, method not specified

Not Microscopically Confirmed

Code	Description
5	Positive laboratory test/marker study ***Note 1:*** Includes cases with positive immunophenotyping or genetic studies and ***no*** histological confirmation ***Note 2:*** This does **not** include cases where a peripheral blood smear is done (code 1) and peripheral blood smear followed by flow cytometry (code 3)
6	Direct visualization without microscopic confirmation
7	Radiology and other imaging techniques without microscopic confirmation
8	Clinical diagnosis only (other than 5, 6 or 7)

Confirmation Unknown

Code	Description
9	Unknown whether or not microscopically confirmed; death certificate only

Coding Instructions continued on next page

Histologies Never Use Diagnostic Confirmation 3

- 9590/3, Lymphoma NOS
- 9655/3, Hodgkin lymphoma, lymphocyte depletion, reticular
- 9800/3, Leukemia NOS
- 9820/3, Lymphoid Leukemia, NOS
- 9860/3, Myeloid Leukemia NOS
- 9863/3, Chronic Myeloid Leukemia, NOS
- 9980/3, Refractory Anemia NOS
- 9982/3, Refractory anemia with sideroblasts/MDS with ring sideroblasts
- 9989/3, Myelodysplastic syndrome, NOS
- 9991/3. myelodysplastic syndrome unclassifiable

Diagnostic Confirmation

- Never Use a '9' – not even for historical cancers
- Most will be a '1' histology – biopsy, bone marrow, blood, lymph, tumor resection, biopsy or resection of metastasis, etc.
- Use a '5' Code Only for urine electrophoresis for Bence Jones Protein for Plasma Cell Myeloma – '5' is INVALID for every other case you abstract
- **Only use a '3' for lymphoid or myeloid neoplasms that have documented immunophenotype test, flow cytometry, PCR testing, FISH, gene panel or other genetic testing**.
  - These tests are used to 'confirm the diagnosis, clarify the type of neoplasm (histologic type or subtype), or identify a targeted drug or specific biological, molecular or immunotherapy (BRM).'
- Use '7' when only IMAGING is done to diagnose cancer – CT, MRI, PET, etc.
- FNA is not a '2' – FNA is a '1' and is just like a bone marrow biopsy

Laterality

- Laterality must be recorded as 1-5 or 9 for paired organs. Organs that are not paired, unless they are recorded “right” or “left” laterality, are coded 0.
- When the primary site is unknown (C80.9), code 0.
- Midline origins are coded 5. ”Midline” in this context refers to the point where the “right” and “left” sides of paired organs come into direct contact, and a tumor forms at that point. Most paired sites cannot develop midline tumors. For example, the skin of the trunk can have a midline tumor, but the breasts cannot
- This includes cerebral meninges, NOS, and brain tumors

STORE Manual 2024

Laterality

Melanoma

C44.1	Skin of eyelid
C44.2	Skin of external ear
C44.3	Skin of other and unspecified parts of face (midline code "9")
C44.4	Skin of Scalp and Neck
C44.5	Skin or trunk (midline code "9")
C44.6	Skin of upper limb and shoulder
C44.7	Skin of lower limb and hip

CNS Tumors

Meningioma

C70.0	Cerebral meninges, NOS (excluding diagnoses prior to 2004)
C71.0	Cerebrum (excluding diagnoses prior to 2004)
C71.1	Frontal lobe (excluding diagnoses prior to 2004)
C71.2	Temporal lobe (excluding diagnoses prior to 2004)
C71.3	Parietal lobe (excluding diagnoses prior to 2004)
C71.4	Occipital lobe (excluding diagnoses prior to 2004)
C72.2	Olfactory nerve (excluding diagnoses prior to 2004)
C72.3	Optic nerve (excluding diagnoses prior to 2004)
C72.4	Acoustic nerve (excluding diagnoses prior to 2004)
C72.5	Cranial nerve, NOS (excluding diagnoses prior to 2004)

Appendix L – 2023 FCDS Text Documentation Requirements

Below is a list of FCDS Required Data Items that carry an additional requirement of complete and accurate text documentation. See Table on Following Page for Specific Examples for each Text Area.

DATA ITEMS REQUIRING COMPLETE TEXT DOCUMENTATION	
Date of DX	
Seq No	**ALL Req'd Site Specific Data Items (SSDI)**
Sex	
Primary Site – MUST INCLUDE SUBSITE	**MUST INCLUDE ANY AND ALL TREATMENT GIVEN AT ANY TX FACILITY**
Laterality	RX Summ – Surg Prim Site (1981-2022) (2023>)
Histologic Type	RX Summ – Scope Reg LN Surgery
Behavior Code	RX Summ – Surg Oth Reg/Distant
Grade – Clinical	RX Date – Surgery
Grade – Pathological	Phase I Radiation Treatment Modality
Grade – Post Treatment – Clinical	RX Date – Radiation
Grade – Post Treatment – Pathological	RX Summ – Chemo – List All Agents
	RX Date – Chemo
COMPLETE WORKUP INCLUDING DATES	RX Summ – Hormone – List All Agents
Imaging, Endoscopys, Labs, Genetics, Path, etc.	RX Date – Hormone
	RX Summ – BRM/Immunotherapy - Agents
Summary Stage 2018, Sept 20223version	RX Date – BRM/Immunotherapy
You may also include AJCC TNM stage	RX Summ – Transplant/Endocrine - details
However, you still must document the	RX Date – Transplant/Endocrine
Rationale for why you assigned SS2018.	RX Summ – Other – include all details
There is no crosswalk from TNM to SS2018.	RX Date - Other
Therefore, it is important BOTH references are included – DO NOT JUST USE TNM IN TEXT.	Use the Grade Manual v2.1 for 2023 Cases Use the SSDI Manual v2.1 for 2023 Cases
ALWAYS DOCUMENT WHY THE PATIENT	*Include Patient History and Reason for Visit*
CAME TO THE FACILITY IN THE FIRST PLACE	*Unique or Unusual Characteristics*
AND WHY CLASS 32 CASES ARE REPORTED	*Specific Statements by Physicians*

NAACCR North American Association of Central Cancer Registries

Log In

Data Standards and Data Dictionary

Home | Implementation Timeline | Data Dictionary | About | Contact

Home / Data Dictionary / Version 24

Version 24
Data Item #2560: Text--DX Proc--Op

Length: 4000
Source of Standard: NPCR
Section Name: Text-Diagnosis
Record Types: A, M

XML NAACCR ID: textDxProcOp
Parent XML Element: Tumor

Required Status:

NPCR Collect: R^ - Required, these text requirements may be met with one or several text block fields
CoC Collect: . - No recommendations
SEER Collect: R - Required
CCCR Collect: . - No recommendations

Description:

https://www.naaccr.org/data-standards-data-dictionary/

Text Documentation (required)

- Text – DX Procedures – Patient History and Physical Exam
- Text – DX Procedures – X-Ray/Scans
- Text – DX Procedures – Scopes
- Text – DX Procedures – Lab Tests (Liquid Biopsy, Genetic Testing, Tumor Markers)
- Text – DX Procedures – Operative Report (not procedure done but details from surgery)

Text Documentation (Cont.)

- Text – Staging
- RX Text – Surgery
- RX Text – Radiation (Beam)/Other
- RX Text – Chemo – include each agent by name, not just protocol name
- RX Text – Hormone – include each agent by name, not just protocol name

Text Documentation (Cont.)

- RX Text – BRM - include each agent by name not just protocol name
- RX Text – Other
- Text – Remark

Complete Text Documentation (Required)

Missing Sequences

- Most common discrepancy when processing cases or identified on visual QC
- Cases being processed with missing sequences 00,01,02,etc
- Facilities must submit a full abstract to FCDS on historical cases or sequences missing

FCDS Receives Only ONE Copy of Each Abstract

- FCDS only receives ONE copy of your abstract.
- Whenever you make a correction on your abstract – FCDS does NOT get an updated copy of your abstract – even if you mark it to resend.
- FCDS only gets the correction/update/additional text information from the Message System within FCDS IDEA for a case.
- Then FCDS Staff Manually enter the corrections or changes
- Please don't forget this and assume FCDS gets automatic updates
- FCDS does not get ANY electronic corrections/updates/changes!!!

Ethnicity

- Code 9
- The use of code 9 is discouraged.
- If a patient has a Hispanic name but there is reason to believe they are not Hispanic (e.g. the patient is Filipino, or the patient is a woman known to be non-Hispanic who has a Hispanic married name) the code in this field should be 0, Non-Spanish, Non- Hispanic

RACE AND NATIONALITY DESCRIPTIONS
FROM THE 2000 CENSUS AND BUREAU OF VITAL STATISTICS

Note: Use these lists only when race is not stated but other information is provided in the medical record.

References:

1. *"Race and Ethnicity Code Set, Version 1.0," Centers for Disease Control and Prevention, March 2000.*
2. *"Instruction manual, part 4: Classification And Coding Instructions For Death Records, 1999-2001," Division of Vital Statistics, National Center for Health Statistics, undated*

Key

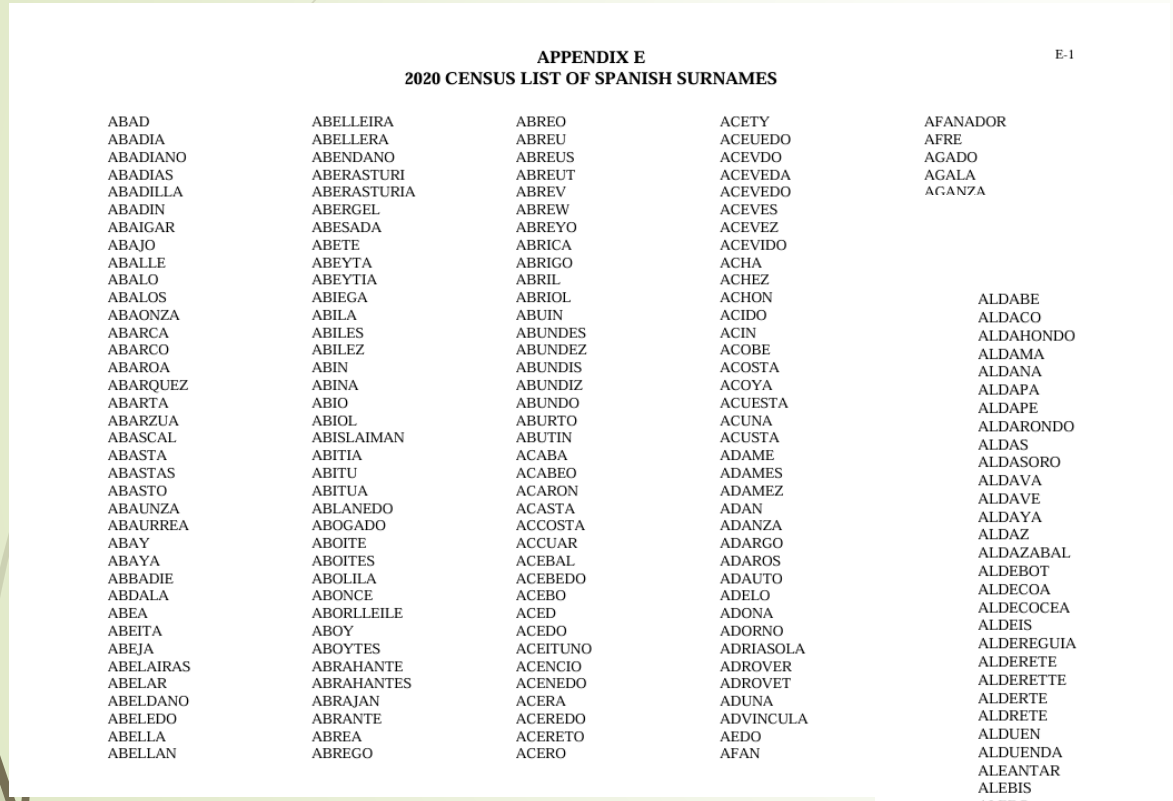
† Use this code unless patient is stated to be Native American (Indian)
* Terms listed in reference 2, above.
‡ Description of religious affiliation rather than stated nationality or ethnicity; should be used with caution when determining appropriate race code.

CODE 01 WHITE

Afghan, Afghanistani
Afrikaner
Albanian
Algerian*
Amish*
Anglo-Saxon*
Arab, Arabian
Argentinian*†
Armenian
Assyrian
Australian*
Austrian*
Azores*
Basque*
Bavarian*
Bolivian*†
Bozniak/Bosnian
Brava/Bravo*
Brazilian†
Bulgarian

Code	Label
0	Non-Spanish; non-Hispanic (including Portuguese and Brazilian)
1	Mexican (includes Chicano)
2	Puerto Rican
3	Cuban
4	South or Central American (except Brazil)
5	Other specified Spanish/Hispanic origin (includes European; excludes Dominican Republic)
6	Spanish, NOS; Hispanic, NOS; Latino, NOS (There is evidence other than surname or r maiden name that the person is Hispanic, but he/she cannot be assigned to any category of 1-5.)
7	Spanish surname only (The only evidence of the person's Hispanic origin is surname or maiden name and there is no contrary evidence that the person is not Hispanic.)
8	Dominican Republic
9	Unknown whether Spanish or not

2020 Census List of Spanish Surnames



APPENDIX E
2020 CENSUS LIST OF SPANISH SURNAMES

E-1

ABAD
ABADIA
ABADIANO
ABADIAS
ABADILLA
ABADIN
ABAIGAR
ABAJO
ABALLE
ABALO
ABALOS
ABAONZA
ABARCA
ABARCO
ABAROA
ABARQUEZ
ABARTA
ABARZUA
ABASCAL
ABASTA
ABASTAS
ABASTO
ABAUNZA
ABAURREA
ABAY
ABAYA
ABBADIE
ABDALA
ABEA
ABEITA
ABEJA
ABELAIRAS
ABELAR
ABELDANO
ABELEDO
ABELLA
ABELLAN
ABELLEIRA
ABELLERA
ABENDANO
ABERASTURI
ABERASTURIA
ABERGEL
ABESADA
ABETE
ABEYTA
ABEYTIA
ABIEGA
ABILA
ABILES
ABILEZ
ABIN
ABINA
ABIO
ABIOL
ABISLAIMAN
ABITIA
ABITU
ABITUA
ABLANEDO
ABOGADO
ABOITE
ABOITES
ABOLILA
ABONCE
ABORLLEILE
ABOY
ABOYTES
ABRAHANTE
ABRAHANTES
ABRAJAN
ABRANTE
ABREA
ABREGO
ABREO
ABREU
ABREUS
ABREUT
ABREV
ABREW
ABREYO
ABRICA
ABRIGO
ABRIL
ABRIOL
ABUIN
ABUNDES
ABUNDEZ
ABUNDIS
ABUNDIZ
ABUNDO
ABURTO
ABUTIN
ACABA
ACABEO
ACARON
ACASTA
ACCOSTA
ACCUAR
ACEBAL
ACEBEDO
ACEBO
ACED
ACEDO
ACEITUNO
ACENCIO
ACENEDO
ACERA
ACEREDO
ACERETO
ACERO
ACETY
ACEUEDO
ACEVDO
ACEVEDA
ACEVEDO
ACEVES
ACEVEZ
ACEVIDO
ACHA
ACHEZ
ACHON
ACIDO
ACIN
ACOBE
ACOSTA
ACOYA
ACUESTA
ACUNA
ACUSTA
ADAME
ADAMES
ADAMEZ
ADAN
ADANZA
ADARGO
ADAROS
ADAUTO
ADELO
ADONA
ADORNO
ADRIASOLA
ADROVER
ADROVET
ADUNA
ADVINCULA
AEDO
AFAN
AFANADOR
AFRE
AGADO
AGALA
AGANZA

APPENDIX E
2020 CENSUS LIST OF SPANISH SURNAMES

E-3

ALDABE
ALDACO
ALDAHONDO
ALDAMA
ALDANA
ALDAPA
ALDAPE
ALDARONDO
ALDAS
ALDASORO
ALDAVA
ALDAVE
ALDAYA
ALDAZ
ALDAZABAL
ALDEBOT
ALDECOA
ALDECOCEA
ALDEIS
ALDEREGUIA
ALDERETE
ALDERETTE
ALDERTE
ALDRETE
ALDUEN
ALDUENDA
ALEANTAR
ALEBIS
ALEDO
ALEGADO
ALEGRE
ALEGRET
ALEGRIA
ALEJANDRE
ALEJANDRES
ALEJANDREZ
ALEJANDRO
ALEJO
ALEJOS
ALELUNAS
ALEMAN
ALEMANIA
ALEMANY
ALEMAR
ALEN
ALENCASTRO
ALEQUIN
ALERS
ALERTE
ALEVEDO
ALEXANDRINO
ALFALLA
ALFARA
ALFARD
ALFARO
ALFASSA
ALFAU
ALFEREZ
ALFONSECA
ALFONSO
ALFONZO
ALFRIDO
ALGARA
ALGARIN
ALGARRA
ALGAVA
ALGEA
ALGECIRAS
ALGORA
ALGORRI
ALGORTA
ALGUACIL
ALGUESEVA
ALIAGA
ALICANTE
ALICCA
ALICEA
ALICIA
ALIJA
ALINAYA
ALIPAZ
ALIRE
ALIRES
ALIREZ
ALLADICE
ALLADO
ALLALA
ALLANDE
ALLARID
ALLEGRANZA
ALLEGUE
ALLEGUEZ
ALLENDE
ALLENEGUI
ALLESANDRO
ALLONGO
ALLOZA
ALMA
ALMADA
ALMADO
ALMADOVA
ALMAGER
ALMAGNER
ALMAGRO
ALMAGUER
ALMANCE
ALMANDOZ
ALMANSA
ALMANZA
ALMANZAN
ALMANZAR
ALMANZO
ALMAQUER
ALMARAS
ALMARAZ
ALMARES
ALMAREZ
ALMARZA
ALMAZAN
ALMEDA
ALMEDINA
ALMEJO
ALMENA
ALMENAR
ALMENARA
ALMENARES
ALMENDARES
ALMENDAREZ
ALMENDARIZ
ALMENDRAL
ALMENDRAS
ALMENGER
ALMENGOR
ALMERA
ALMERAZ
ALMERIA
ALMESTICA
ALMEYDA
ALMEZQUITA
ALMIRALL
ALMIRUDIS
ALMODOBAR
ALMODOUAR
ALMODOVA
ALMODOVAR
ALMOGABAR
ALMOGUERA
ALMOINA
ALMONACID
ALMONDOVAR
ALMONTE
ALMONTES
ALMORA
ALMUINA
ALOMA
ALOMAR
ALONA
ALONSO
ALONZO
ALOY
ALOYO
ALPIZAR
ALPUCHE
ALPUIN
ALQUICIRA
ALSINA
ALTAGRACIA
ALTAMIRA
ALTAMIRANO
ALTARRIBA
ALTENES
ALTIMIRANO
ALTONAGA
ALTOSINO
ALTRECHE
ALTUBE
ALTUNA
ALTUR
ALTURET
ALTUZARRA
ALUAREZ
ALUIZO
ALUSTIZA
ALUYON
ALVA

Abbreviations

- The use of abbreviations is a useful abstracting practice only if universally recognized abbreviations are used
  - IDC is not an approved abbreviation for invasive ductal ca
  - POS is not an approved abbreviation for positive
- Place of diagnosis NAACCR Data Dictionary suggested text
  - The complete name of the hospital or the physician office where diagnosis occurred. The initials of a hospital are not adequate being utilized frequently by cancer abstractors
- Non-Standard Abbreviations may have multiple interpretations and should not be used. Do not customize abbreviations or overuse abbreviations to the point where the information has no meaning or context

VIN III Coding Grade

- Grade for Vulva cases if it does not state grades 1-3 and only high grade you assign code 9 unknown
- Below is response from CAnswer forum
- There is no stated rule that VIN cases are always coded 9. You follow the guidelines for the Grade table your case is in.
- For VIN cases, you are in the Vulva schema and the table includes Grades 1, 2, 3, 9. Since there is no place to code a high grade, code 9

Histology states papillary SCC p16 positive do you code 8085 or 8086?

- Cases diagnosed 1/1/2022 forward with p16 test results can use code squamous cell carcinoma, HPV positive (8085) and squamous cell carcinoma, HPV negative (8086).
- Oropharynx:
  - C100 Vallecula
  - C101 Anterior surface of epiglottis
  - C102 Lateral wall of oropharynx; lateral wall of nasopharynx
  - C103 Posterior wall of oropharynx; posterior wall of nasopharynx
  - C104 Brachial cleft
  - C108 Overlapping lesion of oropharynx; junctional region of oropharynx
  - C109 Oropharynx NOS; nasopharynx NOS.

Coding P16 positive (Cont.)

- Use this code only when the subsite has not been identified a subsite as the origin of the lesion. Note: Code overlapping lesion of oropharynx; junctional region of oropharynx
- C108 when a single tumor overlaps subsites of the oropharynx. For example, a single lesion which overlaps the vallecular and the anterior surface of the epiglottis.
- C019 Base of tongue
- C024 Lingual tonsil Tonsils:
- C090 Tonsillar fossa
- C091 Tonsillar pillar

Coding Histologies P16+ (Cont.)

The following histologies are approved by the Mid-Level Tactical Group for use with primaries of the cervix (C53.X) for diagnosis year 2021. Previously, registrars had been instructed to use these histologies for cervical primaries for cases diagnosed January 1, 2022, and forward.

- 8085 Squamous cell carcinoma, HPV-associated C51.9; C52.9; C53.X_
- 8086 Squamous cell carcinoma, HPV-independent C51.9; C52.9; C53.X_
- 8483 Adenocarcinoma, HPV-associated
- 8484 Adenocarcinoma, HPV-independent, NOS
- 8482 Adenocarcinoma, HPV-independent, gastric type
- 8310 Adenocarcinoma, HPV-independent, clear cell type
- 9110 Adenocarcinoma, HPV-independent, mesonephric type C53.X; C56.9

Cases diagnosed 2024 going forward

Coding Notes for Anus: p16 test results can be used to code squamous cell carcinoma, HPV positive (8085) and squamous cell carcinoma, HPV negative (8086).

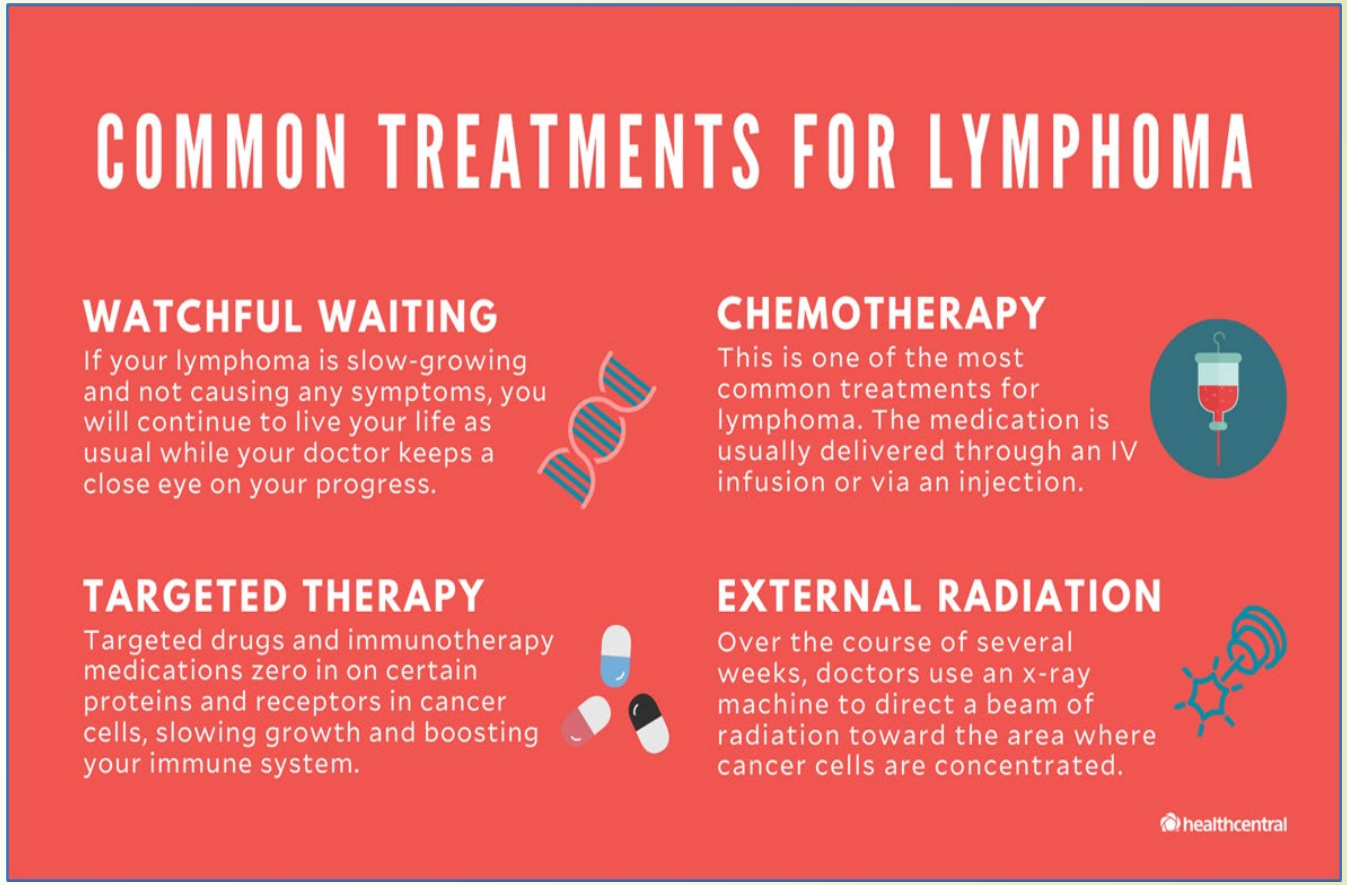
Radiation Therapy

- If patient is actively under treatment when submitting to FCDS please code start date of treatment
- Include type of modality in supporting text documentation
- 6X or 6Mv is acceptable when coding 02 for photons

02	A woman with multiple myeloma is treated using locally opposed conformal 15Mv photons to a total dose of 2000cGy in 5 fractions. Record Phase I Radiation Treatment Modality as 02 (External beam, photons).

02	Low energy x-ray/photon therapy	External beam therapy administered using equipment with a maximum energy of less than one (1) million volts (MV). Energies are typically expressed in units of kilovolts (kV). These types of treatments are sometimes referred to as electronic brachytherapy or orthovoltage or superficial therapy. Clinical notes may refer to the brand names of low energy x-ray delivery devices, e.g. Axxent®, INTRABEAM®, or Esteya®.

Lymphoma – Biopsy or Surgery



Surgical Diagnostic and Staging Procedure

Item #	Length	Allowable Values	Required Status	Date Revised
1350	2	00–07, 09	All Years	09/06, 09/08, 01/12, 01/15

Description

Identifies the positive surgical procedure(s) performed to diagnose and/or stage disease.

Rationale

This data item is used to track the use of surgical procedure resources that are not considered treatment.

Coding Instructions

- Record the type of procedure performed as part of the initial diagnosis and workup, whether this is done at your institution or another facility.
- Only record positive procedures. For benign and borderline reportable tumors, report the biopsies positive for those conditions. For malignant tumors, report procedures if they were positive for malignancy.
- If both an incisional biopsy of the primary site and an incisional biopsy of a metastatic site are done, use code 02 (Incisional biopsy of primary site).
- If a lymph node is biopsied or removed to diagnose or stage lymphoma, and that node is NOT the only node involved with lymphoma, use code 02. If there is only a single lymph node involved with lymphoma, use the data item *Rx Summ – Surg 2023* [1291] to code these procedures.

LYMPH NODES

C77.0–C77.9

Codes

A000 None; no surgery of primary site; autopsy ONLY

A190 Local tumor destruction or excision, NOS

Unknown whether a specimen was sent to pathology for surgical events coded to A190 (principally for cases diagnosed prior to January 1, 2003).

A150 Local tumor destruction, NOS

No specimen sent to pathology from surgical event A150.

A250 Local tumor excision, NOS

Less than a full chain, includes an excisional biopsy of a single lymph node.

A300 Lymph node dissection, NOS

A310 One chain

A320 Two or more chains

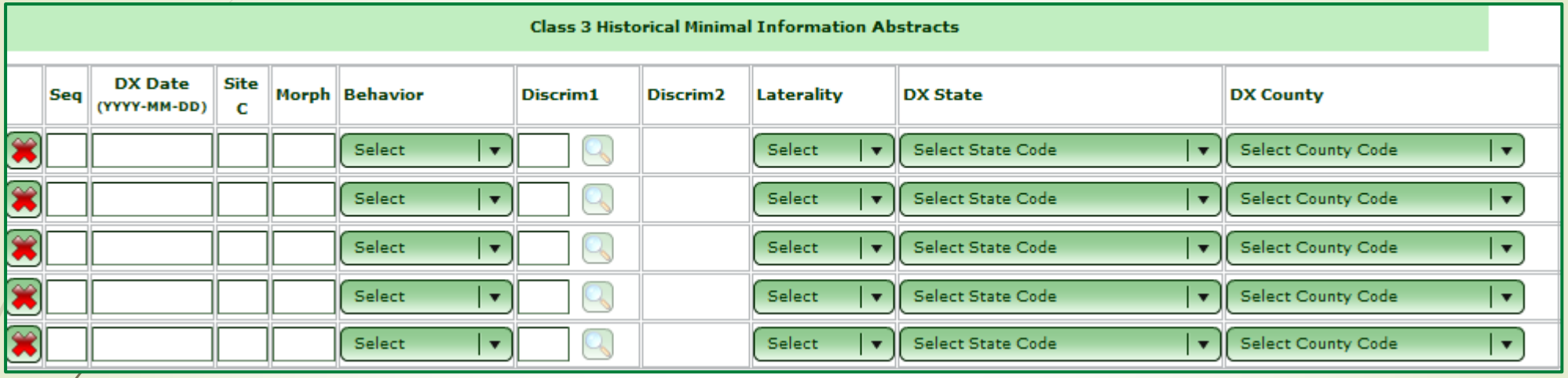
Lymphoma - Surgery vs Diagnostic

- 2/5/24 Patient presents FCDS with cervical adenopathy and CT of abdomen and pelvis reveals cervical and mediastinal adenopathy. Patient proceeds to have an excisional biopsy of the cervical lymph node consistent with diffuse B-cell lymphoma.
- **What is coded for cancer directed surgery?**
  - **A. A000 None; no surgery**
  - **B. A250 local tumor excision**

Active Cancers and Historical Cancers

- Unique to Florida – FCDS keeps track of ALL cancers in a lifetime
- You Must Report All Historical Cancers if You Report Any Cancer
- Then you have to ask 'Do I complete a Full Abstract or Historical Grid?'
- It depends on whether or not the patient has evidence of that cancer.
- If any Cancer has Evidence of Disease or is Receiving Treatment
  - Report ALL Cancers - Active Cancer, Under Treatment, and Not Active Cancer
  - Report the Inactive Cancers (No Evidence of Disease) in the Historical Grid
  - Report ANY Active Cancer or Cancer Receiving Treatment in a Full Abstract
  - Some Cancers are Deemed Not Reportable – see the FCDS DAM which is updated annually
- Annual Updates to Reportable Cancers come from WHO and SEER
- Casefinding Lists are Updated Annually when WHO Updates ICD Codes

Historical Cancers – No Evidence of This Cancer



1. Sequence Number
2. Diagnosis Date
3. Primary Site (ICD-O-3)
4. Histology (ICD-O-3)
5. Behavior (ICD-O-3)
6. Laterality
7. State of Residence at Diagnosis (State Abbreviation)
8. County of Residence at Diagnosis (FIPS County Code)
9. Schema Discriminator 1
10. Schema Discriminator 2

If you forget to include Historical Cancers in the grid on the first complete abstract you send to FCDS, FCDS will delete the 1st abstract and ask you to complete the Historical Case in 'the grid' and resubmit both cases again. Otherwise, FCDS has no information to 'build' a 'dummy' historical case into the cancer sequence chronology to complete it with other(s).

Historical Cancers – WITH Evidence of This Cancer

Some Historical Cancers REQUIRE YOU COMPLETE A FULL ABSTRACT

- The Cancer was Never Treated
- Patient is Undergoing Active Treatment for This Cancer (exceptions)
- Patient has Persistent Active Disease at the Conclusion of 1st Course Treatment
- Recurrence of This Historical Cancer – Must Have Been Treated & Disease Free
- *Recurrence: Use Solid Tumor Rules to Rule Out a New Primary*
- Disease Progression – Different than Disease Recurrence
- Patient was Never Free of Cancer

Where to Go for Questions

- PDF Manuals and Instructions – Required and Recommended
- Website Resources – SINQ, Ask a SEER Registrar, CAnswer Forum
- CALL FCDS – Field Coordinators or QC Manager
- FCDS DAM – Required Desktop Resources – Updated Annually
- FCDS DAM – Resources for Registrars – Updated Annually

Where to Go for Questions

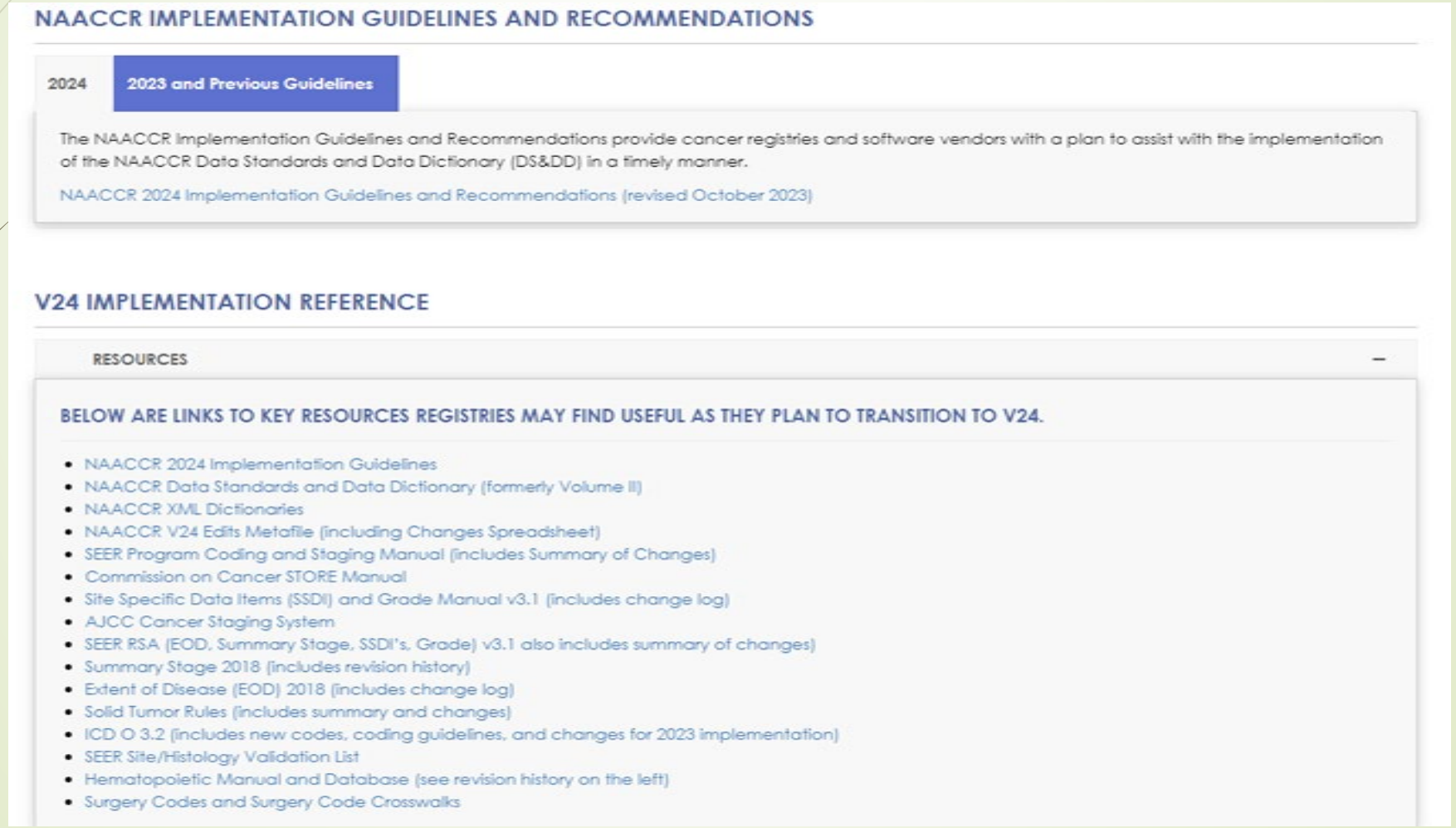
- NCI Webpages – PDQ – General Cancer and Treatment Information
- American Cancer Society – Cancer A-Z
- NCCN Treatment Guidelines - FREE
- Your Vendor Representative or Help Desk
- Call FCDS for Technical Help

APPENDIX P – REFERENCES AND RESOURCES FOR REGISTRARS – updated March 1, 2023

2023 References and Resources for Cancer Registrar		
2023 REQUIRED References	**Web Address For Source**	**Notes**
2023 FCDS Data Acquisition Manual (DAM)	http://www.fcds.med.miami.edu/inc/DAM.shtml	Details cancer data reporting guidelines and casefinding mechanisms for identifying reportable cancers.
2023 Casefinding List of ICD-10-CM Required Codes	http://www.fcds.med.miami.edu/inc/DAM.shtml	ICD-10-CM for 2023 Casefinding - General Range and Individual Code Lists are available in the FCDS DAM
2018 Solid Tumors MPH Rules, 2023 Update	https://seer.cancer.gov/tools/solidtumor/	On the home page click on "Information for Cancer Registrars", Solid Tumor Rules
2021 Heme/Lymph Neoplasm MPH Rules PLUS Interactive Online Heme/Lymph Database for Coding	http://seer.cancer.gov/seertools/hemelymph/	On the home page click on "Information for Cancer Registrars", Hematopoietic & Lymphoid Neoplasm Project
ICD-O-3.2 2023 Updates and Coding Materials Also See 2023 FCDS DAM for ICD-O-3 2023 Updates	https://seer.cancer.gov/icd-o-3/	On the home page click "Data Collection Tools", Errata and Clarifications".
IACR/WHO Master Histology/Behavior – ICD-O-3.2	http://www.iacr.com.fr/index.php?option=com_content&view=article&id=149:icd-o-3-2&catid=80&Itemid=545	Histology Code/Behavior Master List, 2023
Site-Specific Data Items Manual (SSDI Manual), SSDI Coding Instructions, and SSDI Coding Application, v3	https://apps.naaccr.org/ssdi/list/	SSDI Manual, v3
2018 Grade Manual, Grade Coding Instructions and Tables, and Grade Coding Application, v3.0	https://apps.naaccr.org/ssdi/list/	Grade Coding Manual, v2.1
SEER Summary Staging Manual 2018 v3.0	http://seer.cancer.gov/tools/ssm/	SEER Summary Staging Manual, v3.0
SEER *Rx – Online Interactive Drug Database	http://seer.cancer.gov/seertools/seerrx/	A one-step lookup for coding oncology drug and regimen treatment categories in cancer registries
Collaborative Stage Data Collection System – v02.05 Part I Reference for Site-Specific Factor Coding ONLY.	http://www.cancerstaging.org/cstage	Collaborative Stage Data Collection System is no longer supported or in use in the United States beginning 1/1/2016. Used for Cases Dx 2004-2015
SEER*RSA (Registry Staging Assistant)	https://seer.cancer.gov/tools/staging/rsa.html	Assistance and Testing for Cancer Staging; Collaborative Stage Data Collection Summary Stage 2018 SEER EOD – Extent of Disease ALL SSDIs – ALL Grade Items
Brain & CNS Tumor Reporting	http://www.cdc.gov/cancer/npcr/training	Brain Tumor Registry Reporting Materials
TEXT DOCUMENTATION	http://www.cancerregistryeducation.org/rr	Free Download – NCRA Informational Abstracts – Guidelines for Text Documentation by Cancer Site

12/27/2023

NAACCR Implementation Guidelines



NAACCR IMPLEMENTATION GUIDELINES AND RECOMMENDATIONS

2024 | 2023 and Previous Guidelines

The NAACCR Implementation Guidelines and Recommendations provide cancer registries and software vendors with a plan to assist with the implementation of the NAACCR Data Standards and Data Dictionary (DS&DD) in a timely manner.

NAACCR 2024 Implementation Guidelines and Recommendations (revised October 2023)

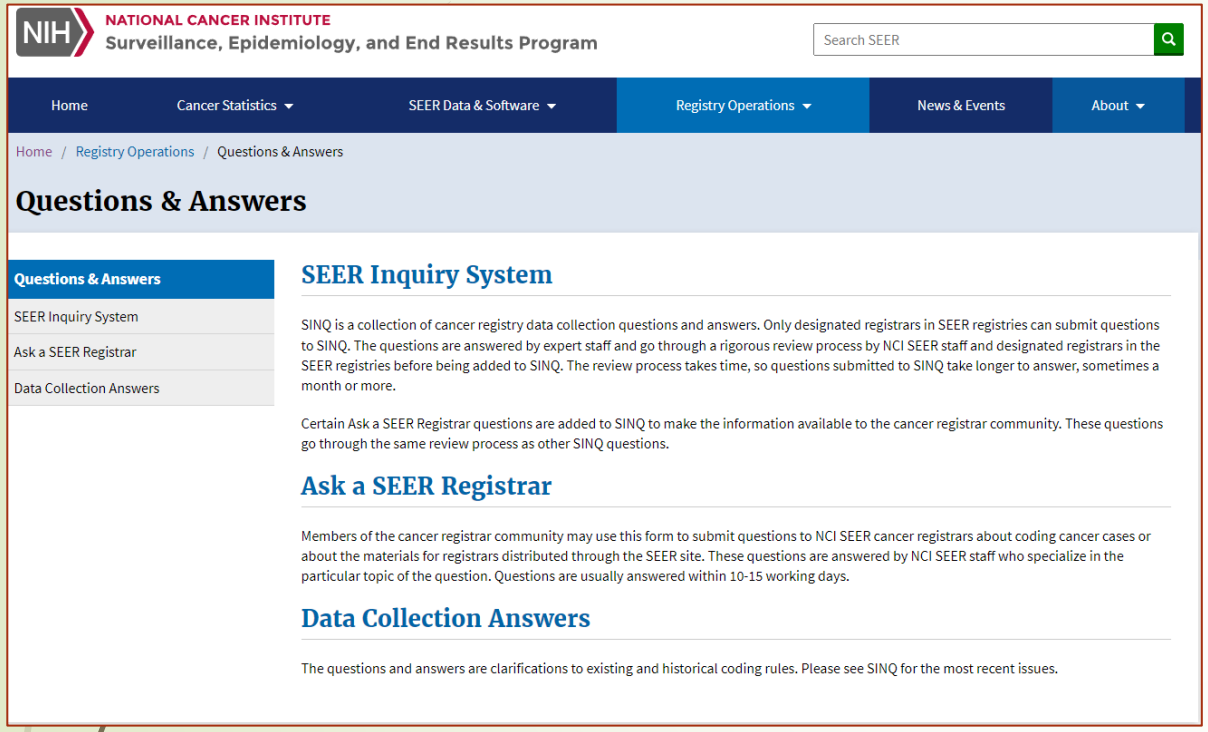
V24 IMPLEMENTATION REFERENCE

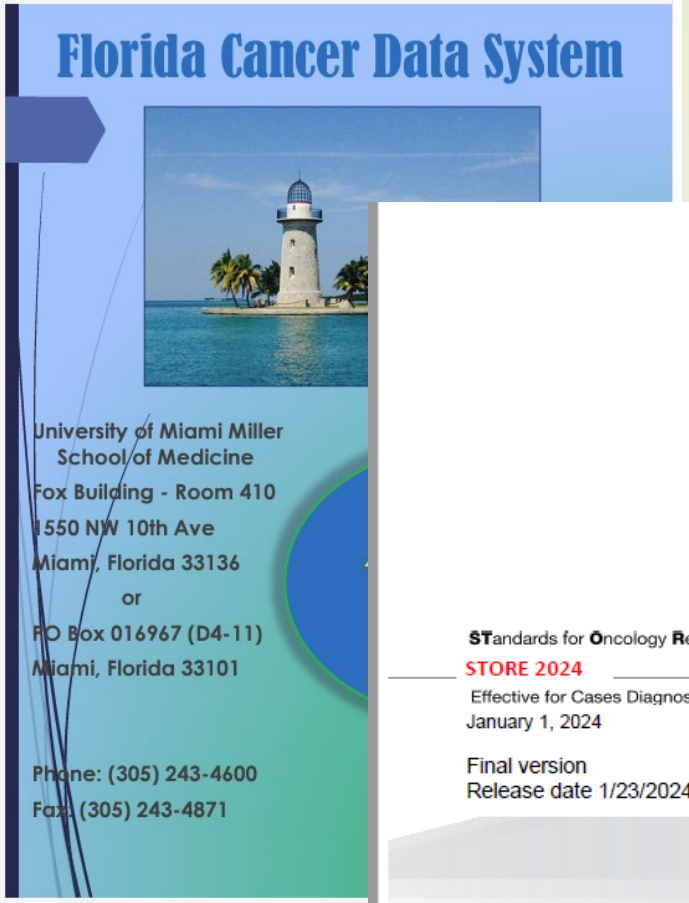
RESOURCES –

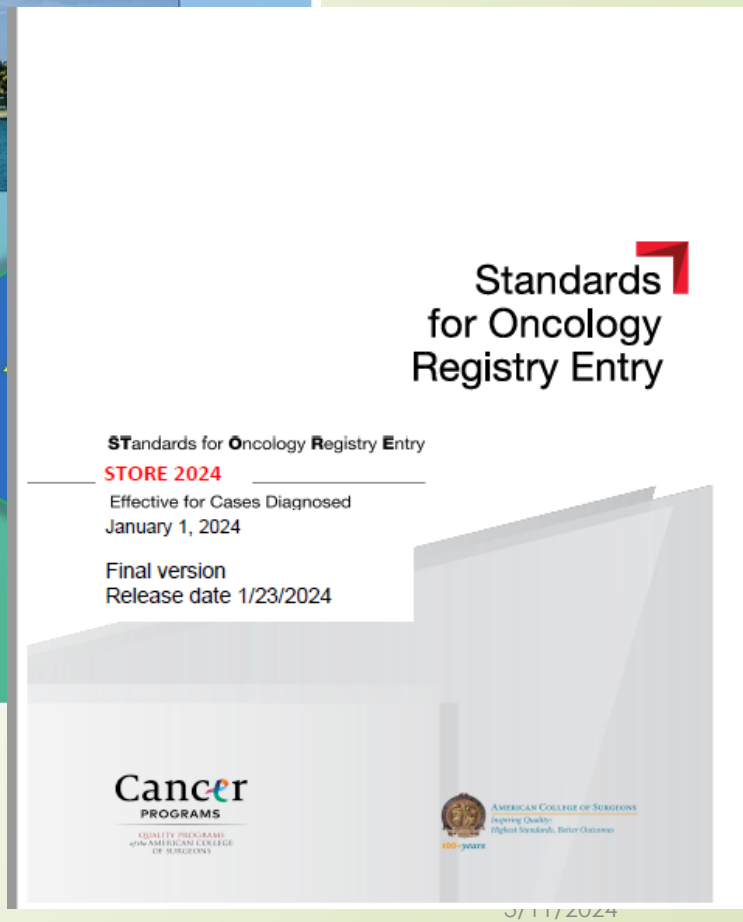
BELOW ARE LINKS TO KEY RESOURCES REGISTRIES MAY FIND USEFUL AS THEY PLAN TO TRANSITION TO V24.

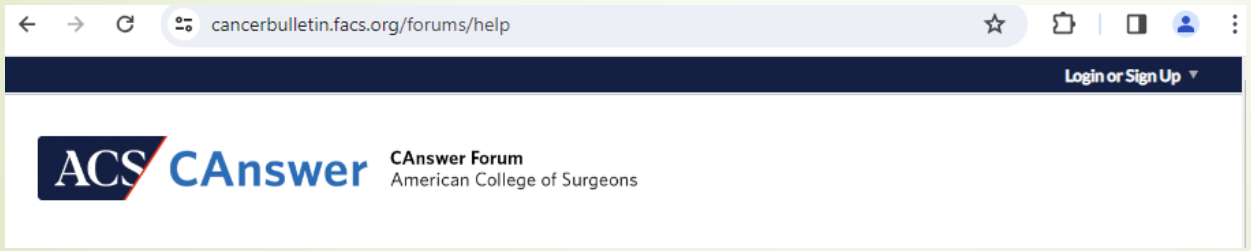
- NAACCR 2024 Implementation Guidelines
- NAACCR Data Standards and Data Dictionary (formerly Volume II)
- NAACCR XML Dictionaries
- NAACCR V24 Edits Metafile (including Changes Spreadsheet)
- SEER Program Coding and Staging Manual (includes Summary of Changes)
- Commission on Cancer STORE Manual
- Site Specific Data Items (SSDI) and Grade Manual v3.1 (includes change log)
- AJCC Cancer Staging System
- SEER RSA (EOD, Summary Stage, SSDI's, Grade) v3.1 also includes summary of changes)
- Summary Stage 2018 (includes revision history)
- Extent of Disease (EOD) 2018 (includes change log)
- Solid Tumor Rules (includes summary and changes)
- ICD O 3.2 (includes new codes, coding guidelines, and changes for 2023 implementation)
- SEER Site/Histology Validation List
- Hematopoietic Manual and Database (see revision history on the left)
- Surgery Codes and Surgery Code Crosswalks

Where to Go for Questions









References

- FCDS Manual 2023
- https://fcds.med.miami.edu/inc/downloads.shtml
- NAACCR Data Dictionary
- https://apps.naaccr.org/data-dictionary/home
- STORE
- https://www.facs.org/for-medical-professionals/news-publications/news-and-articles/cancer-programs-news/101923/new-store-2024-data-items-effective-january-1-2024/
- SEER Summary Stage
- https://seer.cancer.gov/tools/ssm/
- SEER Hematopoietic and Lymphoid Neoplasm

63 Questions?