FCDS Florida Cancer Data System

FLORIDA DEPARTMENT OF HEALTH

Register

UMSylvester Comprehensive Cancer Center

A joint project of the Sylvester Comprehensive Cancer Center and the Florida Department of Health

UNIVERSITY OF Miami SCHOOL OF MEDICINE

Division of Cancer Prevention and Control

Volume XVI, 2002

Part II of Quality Control - Who? What? Where? When? Why?

By Mary, Joy & Steve - The QC Crew

In Part I of our QC Series entitled "Quality Control-Who? What? When? Where? Why?" we described the activities that FCDS uses to encourage accuracy, timeliness and completeness of cancer reporting in Florida. In Part II we will describe how these procedures affect the people who work at the facilities, and what their responsibility is for each part of this process.

General Responsibilities of Each Abstractor

These responsibilities should be addressed on a continuous basis, as each abstractor goes about the daily business of case identification (casefinding) and abstracting. Complete and thorough casefinding by the tumor registrar is essential to identify every potential cancer case and medical record to be reviewed. Adherence to reporting rules and guidelines are critical. This entails a thorough familiarity and understanding of the individual data items described in the FCDS 2001 Data Acquisition Manual; a strong understanding of the rules & guidelines that govern the assignment of codes based on the ICD-O-3 (International Classification of Diseases for Oncology, Third Edition) and the SEER Summary Staging Manual 2000. Vendor-provided drop down menus do not include the rules and guidelines that govern code assignment and without proper and regular reference to the manuals that outline the rules, incorrect codes have become much more commonplace than in the past. Accuracy in transcribing data items such as date of birth and social security number are very important when it comes to case matching and quality control casefinding audits, including AHCA QC Audits and Vital Records QC Audits. Attention to accurate transcription can help insure that nearly all cases are identified and reported in a timely manner, and will limit the number of cases with "matching" problems.

In other words, the way these quality control procedures should affect a facility or registrar is to encourage improvement in casefinding, coding and data entry at the facility level, so that fewer cases will have to be corrected, and fewer cases will be identified and reported late in response to FCDS QC Audits.

Registrars should try to keep up with changes, read newsletters, add errata to manuals when needed, participate in educational conferences including the FCDS Teleconference Series and you will

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be surprised how completeness and data quality will be improved.

One additional pointer that we felt should be included here is the suggestion that you learn to identify and anticipate cases that may need an edit override while you have the medical record in front of you and photocopy pertinent documents from the medical record while you are abstracting the case. This will save the extra time and effort in obtaining the original medical record a second time to verify coded data items and copy supporting documents to submit to FCDS. Also remember that FCDS does not necessarily need a pathology report to 'force' a case. Read the edit and understand what data items need to be verified in order for the case to be 'forced'. Don't just automatically forward a copy of a pathology report, because the path report may not be the documentation that you need to provide in order to support an edit override.

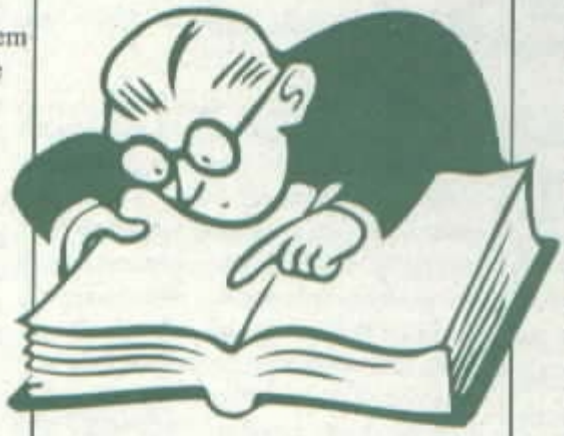
FCDS Data Edits

Review the data edits when you get them back. Don't just make changes on the paper copy and mail it back to FCDS. Understand what edit has been triggered and why. And don't forget to change data in your own database. If you work in a facility with more than one abstractor on staff, be sure that each abstractor corrects her/his own edits so they know where they are making errors and can make improvements in abstracting. Otherwise, the same person will continue to make the same mistakes. This will also help teach new registrars which cases might require edit overrides so that they can make copies of pertinent reports at the time of abstracting as suggested above.

On Site Re-abstracting and Casefinding Audits

FCDS is focusing more and more on our on-site reabstracting and casefinding audits. We have begun making sure that there is time set aside during each site visit to meet with each facility's abstracting staff and each facility's registry manager or administrator during the site visit. This year we will begin providing you with a case-by-case reabstract reconciliation report at the time of the audit so that you can sit down with the QC Auditor and review their findings as they compare to your original abstract while the auditor is still at your facility. This will ensure that time is taken for you and your manager to sit down and discuss registry issues and review the quality control findings with the QC Auditor still there. A formal report will be completed on or shortly after the site visit summarizing the findings so there will be no surprises in the final report.

One thing that each facility can do to facilitate the arrival of the QC Auditor is to make sure that everybody who needs to be contacted prior to the auditor visit has actually been contacted and that at least a half hour has been set aside by the registry manager to meet with the auditor. Verify all arrangements with quality control staff at FCDS to set up day and time of the site visit. And, be involved with your audit.



Reabstracting

During the audit, specific medical records are to be made available, along with a reasonable workspace. Once the original medical record has been reviewed and the auditor has created a reabstract record for comparison to the original record as submitted by your facility, a comparison will be made electronically between the original and the reabstracted record and a reconciliation report will be created. The auditor will then print the reconciliation report and give the abstractor an opportunity to agree or disagree with the auditor's findings.

Casefinding

Arrangements must be made with pathology department in order for QC auditor to have access to the pathology reports requested on the day of the audit. Follow the instructions from the auditor to make sure that all reports are available. If the auditor finds that a significant number of reportable cases were missed in the selected time period, the tumor registrar is required to review the remaining reports for the year audited. The registrar is responsible for reporting any cases that are identified in this process. FCDS will monitor the reporting of these cases to make sure that each case has been reported.

Audit Summary

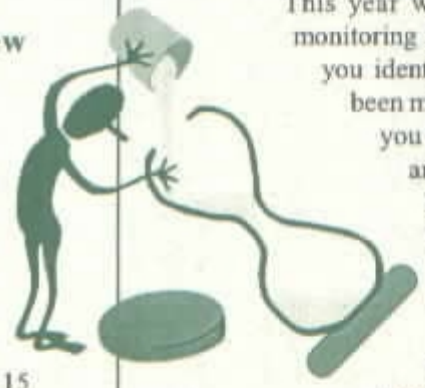
Each facility has its own unique way of identifying, abstracting and reporting cases to FCDS. The on-site QC audits help FCDS and the registry at your facility by providing an outsider's look at how you do your day-to-day activities. These audits should be viewed as an opportunity to exchange information about basic abstracting requirements of FCDS and the feasibility of incorporating some QC fundamentals prospectively. The QC Audits are not a tool to punish the 'bad registrar'. There are no 'bad registrars' only inexperienced registrars.

Often the auditor will find that one of the biggest problems in the registry is that the registrar hasn't had enough or hasn't continued their registry education and training..and yes, this does include some of our experienced registrars. The audit and the time spent with the registry manager can provide each registrar with backing for attending educational conferences as education should be an

active, ongoing process, encouraged by administration.

Occasionally the auditor uncovers a major problem with either cancer case identification or case abstracting during a site visit. FCDS will work closely with any individual or registry manager at any facility to develop a corrective plan of action or to make suggestions to help beef up the registry.

Approval of New Abstractors



We are continually reminding Florida registrars and registry managers that each and every abstractor who is abstracting cases in the state of Florida must be approved by FCDS. It doesn't matter if the new abstractor has been a CTR for 15 years. FCDS wants to look closely at their work before accepting even a single case from that person. For people who are new to abstracting, and experienced abstractors who are new to Florida, it is the individual abstractor's responsibility to submit 25 cases on paper to FCDS. This helps FCDS QC staff identify deficiencies in understanding or using the required reference manuals, and also, helps FCDS reinforce abstracting and coding rules and guidelines, especially for difficult to understand data items.

AHCA Casefinding Audit & Bureau of Vital Statistics Casefinding Audit

You are all well aware of the fact that FCDS performs two critical audits each and every year, the AHCA Casefinding Audit and the Vital Statistics Casefinding Audit. You might refer to these two audits as "this is a total waste of time" or "I hate this *#*@# report" or "I'm not going to do this and you can't make me". With multiple assurances, neither is a waste of time…read on…

FCDS identifies a minimum of 1,500 missed new cancer cases each and every year as a result of these audits. These are not duplicate cases…these are one-time-only-reported cases. These are cases that would have otherwise been completely unreported if it were not for these annual audits.

Please MAKE THE TIME to complete the review of the cases that appear on your audit reports. Please do your best to make the deadline for reporting all of the missed cases.

This year we will begin monitoring the cases that you identify as having been missed and that you will abstract and report. We have found that in more cases than we would like to admit that registrars have identified cases as missed and still never abstract or report them.

We know that the reports do not contain patient names. AHCA does not have the name of any patient in their datafiles, so we cannot provide you with a name.

We know that sometimes the medical record numbers don't match up. AHCA provides us with the medical record number that your facility sent to them. We can't help it if the numbers don't match up…they are your numbers.

We also know that some facilities ignore our requests for these data. Beginning this year, any facility who does not respond to either the AHCA Potentially Missed Cases Report or the Death Certificate Notification Forms will be reported to the Florida Department of Health for corrective action. Please, do not ignore these requests.

The process is pretty simple. Someone at the facility has to take the report generated at FCDS, and identify the patients in order for either the case to be looked up on your Cases Reviewed But Not Reported To FCDS log or have the medical record pulled for review.

The tumor registrar then needs to review the case and determine whether or not each case was actually reported (this happens when there is a discrepancy in demographics), or whether it should have been reported but was missed for some reason during the regular reporting year. The third possibility is that the case was reviewed but determined to be non-reportable. This information is then returned to the FCDS field coordinator (by the stated deadline). The tumor registrar is responsible for submitting an abstract for each missed case that was identified as missed and reportable during the case audit/review cycle.

Fulfillment of these responsibilities at the facility level results in a more complete, high quality database for both the facility registry and the state cancer registry.

In Part III of this series, we will summarize with a review of how the findings from these audits and procedures affect planning for educational activities for FCDS and all Florida registrars and cancer case abstractors, and how you can use the findings from these audits to not only improve the completeness and quality of your registry data, but also how to use these reports to highlight your registry's performance.

Congratulations to the following individuals for Successfully Writing The March, 2002 CTR Exam:

Janice Cuthbert - *Palm Coast, FL*

Ileana Iviricu - *Miami, FL*

Melissa M. Lear - *Cape Coral, FL*

Barbara Machado - *Boynton Beach, FL*

Ginny Y. Riley - *Ocala, FL*

Marta M. Vega - *Orlando, FL*

The following errata list summary pages along with the replacement pages were mailed in May 2002. If you did not receive this mailing you can download the list and replacement pages from our website: http://fcds.med.miami.edu by clicking on Downloads and Data Acquisition Manual.

March 2002
ERRATA List for the 2001 FCDS Data Acquisition Manual

Pages	Changes
Page I-2, Typo	Change Vagina C52.0 to Vagina C52.9
Page I-5, Responsibility for Reporting Modify	**MODIFY** g) Responsibility for Reporting Shared resources present new challenges to cancer reporting. The responsibilities of cancer case reporting lie with the 'owner' of the medical record and the facility that is licensed to administer the patient care that is given **REPLACE** g) Responsibility for Reporting FCDS reviews Agency for Health Care Administration (AHCA) cancer patient data annually as a retrospective quality control completeness tool. The AHCA database provides an after-the-fact case finding mechanism, insuring cancer cases reported to AHCA are also in the FCDS database. For facility identification purposes, AHCA uses a facility identification number that is uniquely assigned to each facility. This number is not the same as the facility's license number and does not have any thing to do with the ownership of the facility. In order for FCDS to match data with AHCA, each facility in the FCDS database must have a unique number that corresponds to the AHCA facility number. Therefore, each facility must report cancer cases to FCDS using the proper FCDS-assigned facility identification number. Whenever AHCA assigns a unique AHCA facility number, then each facility must report to FCDS similarly, using a unique FCDS facility number.
Page II-46, TUMOR SIZE, Add & modify, new in bold	**MODIFY** EOD Tumor size ~~1. Enter the exact size of the primary tumor for all sites except where stated to be 'not applicable'. Record in millimeters (tenths of centimeters as XXXmm. To convert centimeters to millimeters, multiply the dimension by 10. Code '999' is reserved for unknown size or not applicable~~ 1. **Replace**:-Enter the exact size of the primary tumor for all sites except where stated to be 'not applicable'. Record tumor size in whole millimeters (tenths of centimeters as XXXmm) except for melanomas of the skin, vulva, penis, scrotum and conjunctiva To convert centimeters to millimeters, multiply the dimension by 10. Code '999' is reserved for Unknown size, Not applicable, or Not stated in patient record. The depth of invasion of melanomas of the skin, vulva, penis, scrotum and conjuntiva is recorded in HUNDREDTHS o f millimeters. A melanoma with a depth of .5mm is recorded 050, and a 1mm depth is recorded 100

Pages	Changes
	MODIFY 2. Always code the size of the tumor, not the size of the polyp, ulcer, ~~or cyst~~. **Replace**: Always code the size of the tumor, not the size of the polyp, ulcer, **cyst or metastasis**. **ADD line**: 6. If tumor is found but the size rounds to less than 001, record 001. **Page II-46, TUMOR SIZE, continued** **NEW** 7. For purely in situ lesions, code the size as stated. **MODIFY** 8. Enter size of tumor prior to radiation therapy for surgical patients who received preoperative radiation therapy **(use clinical size or 999, as applicable).** **MODIFY** 9. Enter size of tumor prior to chemotherapy for surgical patients who receive preoperative chemotherapy **(use clinical size or 999, as applicable).** **MODIFY** 11.Enter the size of the **invasive component only** when a tumor has both in situ and invasive **components are present, and each is measured, record the size of the invasive component even if it is smaller**. **REMOVE SEE #1** ~~12. Enter the depth of invasion **(thickness of the tumor)** for **malignant melanoma** cases instead of the diameter~~. **NEW** 12. If an excisional biopsy is performed and residual tumor at time of resection of the primary is found to be larger than the excisional biopsy, then code the size of the residual tumor. Do not record tumor size for a needle biopsy specimen; code this as '999'.
Page II-47 SPECIAL TUMOR SIZE CODES—GENERAL GUIDELINES, Add & modify, new in bold	**ADD & MODIFY** **EOD Tumor size** **001-988 Exact size in millimeters.** **001** Enter 001 ONLY when a microscopic focus of tumor, foci of the tumor only or a 1mm-tumor size is noted on a pathology report. **If a tumor is found but the size rounds to less than 001, record 001.** **989** **989 millimeters or larger** **990** **Microscopic focus or foci only; no size is given.** **999** Enter tumor size 999 ONLY when: **Tumor size is not recorded, not available, unknown size, not applicable, or not documented in patient record.**

Pages	Changes
	Do NOT add pieces or chips together to create a whole when prostatic chips or bladder chips are the only measurement; **they may not be from the same location, or they may represent only a very small portion of a large tumor** **If only one size as given for a mixed in situ and invasive tumor, then code size as Unknown (999).** **A needle biopsy specimen is coded as Unknown (999).**
Page II-48, TUMOR SIZE, Add new term in bold	**ADD** **ALWAYS ENTER TUMOR SIZE 999 FOR THE FOLLOWING SITES AND DISEASES:** **Myeloproliferative disease**
Page II 67-69 RX SUMM-SCOPE REG LN SURG, New	**NEW** Instructions for coding RX SUMM- SCOPE REG LN SURG
Page II-68 RX SUMM-SCOPE REG LN SURG, New INSTRUCTIONS FOR CODING RX SUMM - SCOPE REG LN SURG	**ADD** FCDS will prescript coding Scope Regional Lymph Node Surgery = 9 for all leukemia, lymphoma, brain, multiple myeloma, myelodysplastic syndrome, etc. that meet the 2003 criteria as set forth by the COC in order to ensure these data are coded correctly, regardless of date of diagnosis or date of first contact.
Page II-68 RX SUMM-REG LN EXAMINED / REMOVED, Remove	**Remove paragraph** ~~If no regional lymph nodes are identified in the pathology report, code 00 even if the surgical procedure includes a lymph node dissection (i.e., modified radical mastectomy) or if the operative report documents removal of nodes.~~
Appendix B-13, Add	**W, Cont.** 024 WEST VIRGINIA 499 WESTERN EUROPE, NOS 520 WESTERN SAHARA 725 WESTERN SAMOA 457 WHITE RUSSIA 245 WINDWARD ISLANDS 051 WISCONSIN 082 WYOMING **Y** 629 YEMEN 629 YEMEN, PEOPLE'S DEMOCRATIC REPUBLIC OF 453 YUGOSLAVIA (FORMER YUGOSLAVIA REGION) 225 YUKON TERRITORY **Z** 541 ZAIRE 549 ZAMBIA

Pages	Changes
	571 ZANIZIBAR 547 ZIMBABWE
Appendix B-, SEER GEOCODES FOR CODING PLACE OF BIRTH AND RESIDENCE, modify from SEER ERRATA	**CHANGE PAGE B-3** ~~380~~ South American Islands change to 310 381 Falkland Islands change to 311 382 **REMOVE PAGE B-6** ~~580~~ St Helena **CHANGE PAGE B-9 ALPHABETIC LISTING** ~~381~~ Fakland Islands change to 311 **MODIFY PAGE B-15**

GEO	POSSESSION	ABV	ZIPCODES
101	PUERTO RICO	PR	00601-00795, 00901-00988
102	U.S. VIRGIN ISLANDS (St. CROIX, St. JOHN, St. THOMAS) FREDERIKSTED, KINGSHILL	VI	00800-00851 00830-00831 00801-00805 00840-00841 00850-00851
121	AMERICAN SAMOA	AS	996799
129	MARIANA ISLANDS (TRUST TERRITORY OF PACIFIC ISLANDS	MP	96950 - 96959
131	MARSHALL ISLANDS (TRUST TERRITORY OF PACIFIC ISLANDS)	MH	96960 & 96970
132	MIDWAY ISLANDS (Hawaii	UM	96820
137	WAKE ISLANDS (Honolulu)	UM	96898
139	PALAU	PW	96940

NEW PAGE B-15

GEO	POSSESSION	ABV	ZIPCODES
123	MICRONESIA [FEDERATED STATES OF] (CAROLINE ISLANDS, TRUST TERRITORY OF PACIFIC ISLANDS)	FM	96941-96944

DELETE PAGE B-15 NOT US POSSESSIONS AND ARE NOT LISTED IN THE USPS ZIP CODE BOOK

GEO	POSSESION	ABV	ZIPCODES
~~110~~	~~CANAL ZONE~~		
~~120~~	~~PACIFIC AREA~~		
~~122~~	~~KIRIBATI (CANTON & ENDERBURY ISLANDS, GILBERT ISLAND, SOUTHERN LINE ISLANDS, PHOENIX ISLANDS~~	~~TT~~	~~96900 - 96999~~
~~124~~	~~COOK ISLANDS (NEW ZEALAND)~~	~~TT~~	~~96900 - 96999~~
~~125~~	~~TUVALU (ELLICE ISLAND)~~	~~TT~~	~~96900 - 96999~~
~~127~~	~~JOHNSTON ATOLL~~	~~TT~~	~~96900 - 96999~~
~~133~~	~~NAMPO-SHOTE, SOUTHERN~~	~~TT~~	~~96900 - 96999~~
~~134~~	~~RYUKYU ISLANDS (JAPAN)~~	~~TT~~	~~96900 - 96999~~
~~135~~	~~SWAN ISLANDS~~	~~TT~~	~~96900 - 96999~~

Pages	Changes
Appendix B-17-B20, alphabetical order of the 2002 FL State List of Post office and county, new pages, add	**NEW B17-B-20** **2002 FL State List of Post offices and county**
Appendix B20-A & B20-B, Numerical order of the 2002 FL State List of Post office and county, new	**NEW B-20A & B-20B** Numerical List of FL Post offices and county
Appendix H-59, SURGERY OF PRIMARY SITE, Revised	**ADD** **SURGERY OF PRIMARY SITE** **Codes** 00 None; no cancer-directed surgery of primary site

Thanks to all those registrars who noted the discrepancies and if you find any additional discrepancies please contact Mayra Alvarez, Manager of Non-hospital sources (305) 243-4603.

Florida Clinical Pathology Labs
Program Announcement

All Florida Clinical Pathology Laboratories should be in receipt of the program announcement mailed in June (Clinical Laboratory Cancer Identification Program-CLIP) to all Clinical Pathology Labs. The new program is set to start on July 1, 2002. The Teleconference scheduled on Wednesday June 26th is free and will give you detailed instructions for forwarding case identification reports to FCDS. The information on the teleconference is featured in the Calendar of Events section of this newsletter.

Please be sure to complete and forward the **canary yellow-copy of the Clinical Laboratory Information Verification Form** that was included in the packet by July 1, 2002 via fax (305) 243-4871 or mail.

Welcome Back, Lydia!

Lydia Voti has re-joined the FCDS Staff as the Database Technical Specialist.

Calendar of Events

FCDS Teleconference Series:
Clinical Laboratory Cancer Indentification Program
June 26, 2002
2:00 p.m. - 3:00 p.m.
Dial-in Number: 888-476-3757
Call-in Code: 872690
Power Point presentation slides on the above teleconference can be accessed through the "Downloads" button on the FCDS website http://fcds.med.miami.edu

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FCRA/FCDS Combined Conference
July 31 - August 2, 2002
Hyatt Sarasota on Sarasota Bay, FL
Registration Fee: $75.00
Jamie Suarez - FCRA 941-745-7539
Betty Fernandez - FCDS 305-243-4600

♦ ♦ ♦

Advance Cancer Registry Training Program
August 5 - 7, 2002
Emory University in Atlanta, Georgia
Registration Fee: $500.00 (3-day course)
http://cancer.sph.emory.edu
Steven Roffers, PA, CTR at 404-727-4535

♦ ♦ ♦

Principles and Practice of Cancer Registration, Surveillance and Control
November 4 - 8, 2002
Emory University in Atlanta, Georgia
Registration Fee: $900.00 (5-day course)
http://cancer.sph.emory.edu
Steven Roffers, PA, CTR at 404-727-4535

♦ ♦ ♦

UPDATES

"FDA APPROVED ONCOLOGY AGENTS NOT LISTED IN SEER BOOK 8"

Visit the FCDS website (http://fcds.med.miami.edu under **What's New** to get the latest New drugs update "FDA approved Oncology Agents not listed in SEER Book 8". Drugs are listed in alphabetical order by generic name.

If you need to order SEER Book 8, the order information is both in the FCDS DAM in Section I or on the SEER website: http://seer.cancer.gov/cgi-bin/pubs/order1.pl?CODING,BOOK,CONV,MONO,CSR,ABOUT

HIPAA COMPLIANCE CONCERNS

The Administrative Simplification Compliance Act allowed covered entities to request a one year extension to the compliance deadline - until Oct 16, 2003, by submitting a compliance plan to the Department.

The compliance plan MUST be submitted by October 15, 2002.

CMS has developed the HIPAA Model Compliance Plan to meet that need & can be submitted electronically.

This option (and online help) is available at:http://www.cms.gov/hipaa/hipaa2/ASCAForm.asp

All covered entities who submit the plan electronically at the web site will receive a confirmation number as proof of submission.

FALL CTR EXAM SCHEDULE

Below is the letter submitted to NCRA Membership from NBCR in reference to Fall 2002 CTR Exam:

May 15, 2002

Membership, National Cancer Registrars Association

By letter dated May 1, 2002 the National Board for the Certification of Registrars was informed by the National Cancer Registrars Association that its license to grant the CTR credential has been revoked, but that NCRA will allow the credential to be granted to candidates who take the September 14, 2002 examination under certain conditions. NBCR has informed NCRA that NBCR plans to administer the September 14, 2002 CTR examination as announced to the cancer registrar community and according to

Continued on page 10

Continued from page 9: Updates

NBCR's contractual obligations with the Professional Testing Corporation, and will direct PTC to send the results of the September examination to NCRA.

The Directors of NBCR are also volunteers from the cancer registry profession and members of NCRA. We have given much thought to our position in the controversy with the NCRA Board of Directors, and we have been willing to take this stand for the credibility of the cancer registrar credential. NBCR reaffirms its position as stated in its letter to the NCRA Board of Directors dated March 28, 2002 and in its letter to the NCRA membership dated April 15, 2002.

NBCR continues to believe that the credibility of the registrar credential can best be achieved by opening up the control of the certification program to a board composed of voting representatives from all stakeholder groups including the public, by maintaining this board as an independent agency with the professional association fulfilling its role as a stakeholder, and by meeting national or international standards that have been established for certification agencies. NBCR believes that a credentialing program for registrars can best be marketed internationally if it is not tied into the support of an organization devoted to US interests. Furthermore, we believe that with an independent board, the costs for recertification would be substantially lower than figures that have been suggested by NCRA.

We believe that our professional association should be in the forefront of those proclaiming the value of our work, the critical importance of quality data for ongoing research into the diagnosis and treatment of cancer, and our ability to comply with the multitude of standards that govern all aspects of our contribution to the information that drives patient care, including the credentialing of the cancer registry professionals. NBCR and NCRA are agreed that the certification program needs to change. NBCR has looked to process standards for the mechanism of change, has consistently argued for adherence to standards, and continues to do so.

NBCR continues to believe that all certified registrars should be allowed to vote on how their credentialing program will be structured and governed.

National Board for Certification of Registrars

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COMPLETENESS REPORT

As of June 3, 2002
Calendar Year 2001 Admissions
71% Completed
92% Expected

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