



That Thing That You Do

FCDS QC - Visual Editing
NPCR Audit - Visual Editing
Text Documentation & Coding



FCDS 2021 VIRTUAL ANNUAL CONFERENCE

8/19/2021

STEVEN PEACE, CTR



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CDC & Florida DOH Attribution



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Presentation Outline

- Introduction to Visual Editing and the Data Quality Review Process
- The FCDS Visual Editing Process Overview
- Often Ignored and Difficult Concepts
- Problem Data Items Described
- General Observations
- Specific Issues
- 2020 NPCR Data Quality Evaluation Audit
- Resources and References
- Questions



The 2021 Abstract is NOT a 1981 Abstract

AND, neither are the Text Requirements

Introduction to Visual Editing – Why Do It?

FCDS uses a highly automated business rule-based data processing system that relies on the presumption that standard edits will identify any major incident case errors during data processing. FCDS presumes cases that pass edits are of sufficient high quality to presume they are accurate 'as is'. This is a primary assumption of our automation. So, FCDS really counts on YOU to provide excellent data the first time around. HOWEVER.....

Visual Editing identifies both Major and Minor errors that our standard industry edits miss. Visual Editing looks for problems in abstracts that edits cannot identify. The case passes all edits – but may be conceptually or completely incorrect from coding Date of Diagnosis to Primary Site to Histology to Staging and Treatment.

FCDS does not have staff to visually edit 250,000+ abstracts/year. It would take 8 or more FTE to complete this task and each reviewer would need to be a CTR at the top of their game... Instead, FCDS focuses on primary incident record data items and prioritizes major errors over minor ones using analytic case data in priority order with review flags to reconcile discrepancies in our automated Patient and Tumor Consolidation.

FCDS visually edits only a small sample of total abstracts received to monitor these assumptions are valid (that cases are accurate 'as is' – the small sample equates to about 30,000 cases visually edited each year. We cannot identify errors not edited, nor can we manage 250,000+ cases to be visually edited each year.

FCDS knows where our weak case abstracting areas are...and we try to address these areas repeatedly in our webinars, newsletters, blast emails, correspondence, and in-person – especially for new data items. But, we see the same things over and over and over...from Text Support and Coding to replies to QC Review Messages.

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What Do Visual Editors Look for In Abstracts

FCDS Expects ROBUST text on all cases (Analytic/Non-analytic) but not gratuitous text – extra for Analytic Cases

Non-analytic – have you provided a good history of disease AND a reason the patient was at your facility?

Non-analytic – have you provided reason why you don't have good text/stage/treatment?

Are data items well documented for future audit?

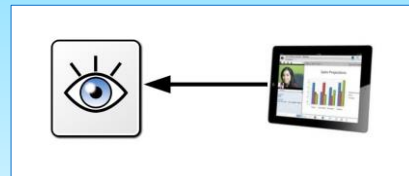
- Demographics
- Tumor
- Staging
- SSDIs
- Treatment

Do the data items make sense beyond EDITS?

Does the staging/SSDI data make sense?

Does the staging/SSDI data make sense with treatment provided?

Does the staging/SSDI data make sense with treatment recommended?



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Text Resources – FCDS DAM (2021)

APPENDIX L – 2021 FCDS TEXT DOCUMENTATION REQUIREMENTS

Text Documentation Requirements have increased every year since they were first required back in 1995. Complete and Accurate Documentation is an essential component of a complete electronic abstract and is utilized heavily in quality control, to validate data at time of FCDS and NPCR Audits, and for special studies by researchers. Text documentation is required to justify coded values and to supplement information not transmitted with coded values. FCDS recommends that abstractors print and post this document for easy reference. Adequate text is a data quality indicator and is a major component of QC.

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 | THIS MUST INCLUDE ANY AND ALL TREATMENT GIVEN ANYWHERE |
| INCLUDE SUBSITE | |
| Laterality | RX Summ – Surg Prim Site |
| 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 – include all agents |
| | RX Date – Chemo |
| COMPLETE WORKUP INCLUDING DATES | RX Summ – Hormone – include all agents |
| Imaging, Endoscopies, Labs, Genetics, Path, etc. | RX Date – Hormone |
| | RX Summ – BRM/Immunotherapy – agents |
| Summary Stage 2018, Sept 2020 version | RX Date – BRM/Immunotherapy |
| You may also include AJCC TNM stage | RX Summ – Transplant/Endocrine – details |
| However, you still must document the Rationale for why you assigned SS2018. | RX Date – Transplant/Endocrine |
| There is no crosswalk from TNM to SS2018. | RX Summ – Other – include all details |
| Therefore, it is important BOTH references are included – DO NOT JUST USE TNM IN TEXT. | RX Date – Other |
| | Any Unique or Unusual Characteristics |
| ALWAYS DOCUMENT WHY THE PATIENT CAME TO THE FACILITY IN THE FIRST PLACE AND WHY CLASS 32 CASES ARE REPORTED | Specific Statements by Physicians Patient History and Reason for Visit |

Text Documentation Requirements have increased every year since they were first required back in 1995.

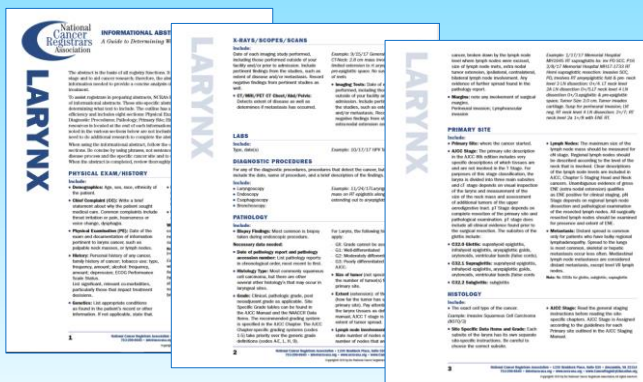
Text documentation should always include the following components:

- Date(s) – include date(s) references – this allows the reviewer to determine event chronology
- Date(s) – note when date(s) are estimated [i.e. Date of DX 3/15/2018 (est.)]
- Location – include facility/physician/other location where the event occurred (test/study/treatment/other)
- Description – include description of the event (test/study/treatment/other) – include positive/negative results
- Details – include as much detail as possible – document treatment plan even if treatment is initiated as planned
- Include “relevant-to-this-person/cancer” information only – edit your text documentation
- DO NOT REPEAT INFORMATION from section to section
- DO USE NAACCR Standard Abbreviations (Appendix C)
- DO NOT USE non-standard or stylistic shorthand
- Enter “N/A” or “not available” when no information is available related to any specific text area.

Text Resources - NCRA

The abstract is the basis of all registry functions. It is a tool used to help accurately determine stage and to aid cancer research; therefore, the abstract must be complete, containing all the information needed to provide a concise analysis of the patient's disease from diagnosis to treatment. To assist registrars in preparing abstracts, NCRA's Education Committee has created a series of informational abstracts and a presentation titled Using the Informational Abstracts in Your Registry that shows registrars how to use these important resources. These site-specific abstracts provide an outline to follow when determining what text to include. The NCRA Informational Abstracts can be found at <http://www.cancerregistryeducation.org/r/> and include;

- Informational Abstract: Adult Primary: Benign Brain
- Informational Abstract: Bladder
- Informational Abstract: Breast
- Informational Abstract: Cervical
- Informational Abstract: Colon
- Informational Abstract: Endometrial
- Informational Abstract: Kidney
- Informational Abstract: Lung
- Informational Abstract: Lymphoma
- Informational Abstract: Adult Primary: Malignant Brain
- Informational Abstract: Melanoma
- Informational Abstract: Ovarian
- Informational Abstract: Pancreas
- Informational Abstract: Prostate
- Informational Abstract: Renal/Pelvis/Ureter
- Informational Abstract: Testis
- Informational Abstract: Thyroid



What Does FCDS Find in Visual Editing?

Generally Speaking Florida Registrars do a GREAT JOB with Text Documentation – especially since the Text Requirements (content and detail) change and grow every year. The expectations continue to change and expand causing confusion and frustration among many more experienced registrars who have been doing the same documentation since FCDS started to require details text back in 1995.

Text Fields used to be nearly non-existent in requirements – just a quick note about histology or stage. Then in the early 2000s the fields were delineated by section and expanded to 250 characters. Then the treatment field text was expanded to 200 characters. It was not until 2010 that the text fields were expanded to 1000 characters (record layout version 12) with roll-over into Text Pad areas. Yet, we still don't have room for all we need or want to document for some cases – and then, it seems like too much space wasted on text for other cases where the patient came in for a biopsy and you have no other info.

So, it is a balancing act and will continue to be. We used to just rely on coding. **TODAY - we rely on both text and coding that match up and clearly explain the story of the person and their cancer.** This continues to come up year after year in particular is because we rely more and more on both the text documentation and the coding – and when they are no in synch or don't make sense...it looks like neither you nor FCDS ever looks at cases to check them for quality abstracting. Additionally, audit methods have changed a lot – there is more visual editing, multiple text-to-code audits, NPCR Audit, FCDS Audits, and more...it results look like a long list of problems – but, the problems are easy to correct and redoing affect the data but in minimal ways most of the time...**that is why we need so much text.**

So we can verify, validate and rest assured we have the best coded and documented cases we can.

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What Does FCDS Find in Visual Editing?

Please take these OBSERVATIONS as simply OBSERVATIONS and NOT PERSONALLY as CRITICISMS...

We are here to help make all abstracting better – and we are all up against more requirements.

Think of this as a “Festivus for the Rest of Us (Registrars)” and an “Airing of Grievances”.

It is not a punishment – just observations that we are obligated to share with you.

Again, in general our Florida Abstractors do a very good job with documentation.

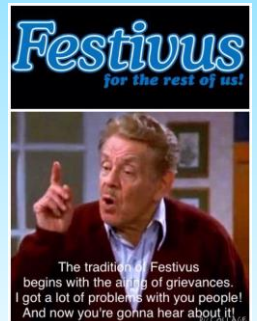
But, it has been a long time since we started requiring text to support codes.

We have been working on this for years...so take it all with a grain of salt.

And, let's have some fun with it...in the spirit of Festivus...

Thank you Jerry Stiller (Frank Costanza) and Jerry Seinfeld...

And remember...we just view a sample...



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What Does FCDS Find in Visual Editing? Difficult Concepts

EVERY ABSTRACT MUST TELL A COMPLETE STORY - ALWAYS PROVIDE A PATIENT HISTORY – why did the patient come to your facility – short & sweet Cancer Staging – [TNM does not translate directly to SS2018 – document both in text](#)

4 Grade Fields – Clinical, Pathological, Post-Treatment Clinical, Post-Treatment Pathological

- Clinical - Clin
- Pathological - Path
- Post-Treatment Clinical – yc
- Post-Treatment Pathological – yp
- [DO NOT CONVERT GRADE TO “FIT” INTO A CODE – IF THE TERM IS NOT THERE – GRADE = 9](#)

Why does FCDS require so much Text? Edits, Corrections, QC, Audits, Data Use – you may be the only person to touch this abstract for several years – do not want to create need to go back to source records – put it in the abstract

DO NOT – I REPEAT – DO NOT JUST TELL US THAT AJCC HAS NO STAGING IN YOUR TEXT – DOCUMENT SS2018 ALWAYS !!

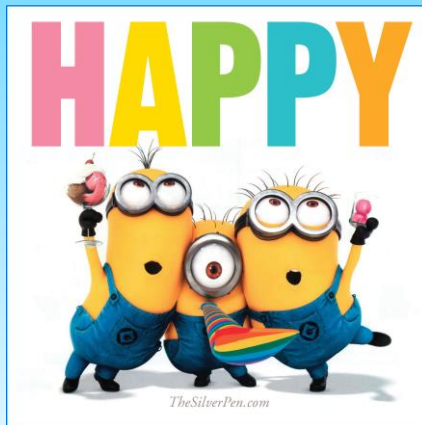
No Instructions for Documenting and Coding Molecular Genetic Testing, Tumor Markers, New Technologies in Dx/WU

[Imaging is just as important when negative as when it is positive – include dates on all imaging - PLEASE](#)

The Schema ID Concept Must be Better Explained to Use Resources like SEER*RSA, Grade Manual, SSDI Manual, AJCC

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HAPPY SLIDE



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What Does FCDS Find in Visual Editing? Problem Data Items

Sex – not paying attention during data entry or downloaded from EMR without conversion and codes don't match

Social Security Number and the new **Medicare Beneficiary ID** – difficult to access for many registrars

Patient Height – people don't bother to look or info not available – some managers instruct staff not to waste time on collecting unimportant data items like height, weight, smoking history – please 'waste time' doing this

Patient Weight – people don't bother to look or info not available– some managers instruct staff not to waste time on collecting unimportant data items like height, weight, smoking history – please 'waste time' doing this

Tobacco Use – people don't bother to look or info not available– some managers instruct staff not to waste time on collecting unimportant data items like height, weight, smoking history – please 'waste time' doing this

Class of Case – continues to be a problem – think of 0, 1, 2, 3, 4 as baseline then add detail in 2nd digit

Diagnostic Confirmation = 9, 5 (don't ever use), 1 or 3 (prefer 1 for edits), 2 is not FNA cytology (discussion with NPCR on our Florida audit), 7 is often the only confirmation for benign/borderline tumors and metastatic tumors

Text of Primary Site and Histology Must Match Code & Pathology Text Documentation

Regional Nodes Positive/Regional Nodes Examined = 99/99 only for hematopoietic and brain, 00/95 or 95/95 for FNA of regional node, do not code biopsy of N3 or distant nodes here – they are not regional lymph nodes.

SEER Summary Stage is STAGE AT DIAGNOSIS – NOT STAGE POST-TREATMENT (Post Neoadjuvant Treatment)

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What Does FCDS Find in Visual Editing? Problem Data Items

AJCC TNM allows for 2 stages to be entered – Clinical Stage Always Required, then 1 of the 3 Pathological Stage, Post-treatment Clinical Stage or Post-Treatment Pathological Stage – only 2 AJCC Stages allowed to be coded in software. And, you should document TNM when available.

When AJCC TNM is not available for a site/histo/behavior –do not write "N/A" or "no stage" – there IS a stage – Summary Stage – document it

Grade is a growing problem – definitions for coding and edits for grade coding go with AJCC Staging Rules – special session

SSDIs – analytic cases – some don't bother to even look them up or don't know where to find certain tests, etc.

Text – don't place key text into your Text Pad because FCDS NEVER GETS IT. Also, when you have a correction or force or QC Inquiry – complete the inquiry – don't just write back 'done' or 'added text' – tell FCDS what you added or changed – FCDS does not receive or even allow update/correction 'U' records or modified 'M' records and we really want to discourage registrars from resubmitting cases multiple times – this gets confusing.

Treatment – folks do not know what some procedures actually are or what is included in the procedure – look it up

RX Modality is still problematic – modality needs to be correct – read up on low/high dose brachytherapy and types of beam

Chemo – When using a standard protocol or research protocol – include the actual agents given – look it up – no protocol # only

Hormone – some code hormone when not treatment for that cancer – use SEER*RX

BRM/Immuno – some folks do not look up classification on SEER*RX and code same thing wrong

Reason for No Surgery & Reason for No Radiation indicate why a patient does not get a specific therapy – code them

LVI = 0 for ALL In-Situ Cancers AND Summary Stage = 8 for all benign/borderline brain/cns tumors – document 'benign' in Staging Text – NOT NA

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HAPPY SLIDE



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What Does FCDS Find in Visual Editing? General Observations

Many Registrars Believe that the CoC/AJCC are the only standard setters that count – CoC/AJCC Priority is down the priority list from SEER and NPCR then the State Registry then comes NCDB – you are not just working for your facility to get Cancer Program Approval from CoC – you are actually working FIRST to meet your state's regulatory and statutory requirements to report cancer – these are legal requirements.

Documenting in Text but not Coding Correctly

Coding correctly but not documenting in text

WHO Brain Tumor Grade Tables are DIFFERENT in AJCC and Solid Tumor Manual – use with caution

Too many unknowns, ill-defined values, and useless codes – do not give us 99 for treatment codes, PLEASE.

Registrars skimp when abstracting non-analytic cases – they feel they are not important because CoC/NCDB does not require them. Same thing for the intraepithelial neoplasia's. These are the Historical with NED Cases and the Historical Diagnosis with Active Recurrence or Disease Progression. THESE ARE REQUIRED BY ALL STATE REGISTRIES except NEDs.

Managers Stress Speed and Productivity over Accuracy and IT SHOWS in the data and in the abstracts reviewed – we can measure it.

Registrars not using proper or most current Manuals, Instructions or Resources or are using the right manual incorrectly

QC for brand new CTRs is lacking until it gets to FCDS QC – FCDS should never be the only QC source – especially for new 'contractor' CTRs

Lack of oversight of staff with peer review or other internal QC – FCDS should never be the only QC source – same as above

Pathology Casefinding and Accurate Up-to-Date Casefinding List for IT for AHCA/Mortality F/B – we miss far too many cases because of poor or nonexistent casefinding – please casefind more than medical records only – 10%-15% missed

DEADLINES – corrections within 60 days of receipt, QC Review within 60 days of receipt, Complete Year June 30th annually

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HAPPY SLIDE



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What Does FCDS Find in Visual Editing? Specific Issues

Meningioma – almost always is C70.0 – cerebral meninges or C70.1 – spinal meninges – NOT C70.9 – see STM for sphenoid wing

All Leukemia Cases – SS2018 = 7 (never = 9) and DX Confirmation = 1 – THIS GOES FOR ANY C42.1 NOT JUST LEUKEMIA

These Cancers Are NOW Reportable

- sphenoid wing meningioma & cavernous sinus meningioma
- peripheral nerve malignant neoplasms (C47.0-C48.9)
 - glomus jugulare tumors
 - carotid body tumors
- Paraganglioma – larynx, carotid body, middle ear, glomus jugulare, vagus nerve
- EUS Diagnosed by Visualization or Ultrasound Tumors of Hepatopancreatobiliary System w/no BX and stated 'non-invasive'

These Cancers Are Now Not Reportable

- NIFTP – Non-invasive follicular thyroid neoplasm with papillary like nuclear features
- Dermatofibrosarcoma Protuberans

Intraepithelial Neoplasia Grade III is Reportable except for Prostate and Cervix

- AIN III – not skin of anus but anus
- PAIN III – pancreas
- VIN III – vulva
- VAIN III – vagina
- PeIN III – penile
- LN III – lobular neoplasia grade III
- LCIS – lobular carcinoma in situ

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What Does FCDS Find in Visual Editing? Specific Issues

Chronic Leukemia, Chronic MPN, Chronic MDS even if stated to be in remission – it is only clinical remission

Use of Definitive Terminology in Imaging versus Use of Ambiguous Terminology – see FCDS Memo

Imaging Report does not have to restate ‘suspicious for neoplasm’ when a definitive term is used – diagnosis is already stated

Unknown Primary with Specific Histology like melanoma – you assign primary site as noted below w/stage 9 or 7

FCDS DAM page 98-99 under Coding Primary Site: Use the table below to assign primary site when the only information available is the histologic type of tumor and the patient has metastatic disease without an identifiable primary site. The primary site is presumed to be the NOS or “not otherwise specified” primary site code when the histology is known but for which no primary can be found. Do not code these cases to C80.9.

| Histologic Type Codes | Histologic Types | Preferred Site Codes for Ill-Defined Primary Sites |
|---|--|---|
| 8720-8790 | Melanoma | C44. _ Skin |
| 8800-8811, 8813-8830, 8840-8921, 9040-9044 | Sarcoma except periosteal fibrosarcoma and dermatofibrosarcoma | C49. _ Connective, Subcutaneous and Other Soft Tissues |
| 8990-8991 | Mesenchymoma | C49. _ Connective Subcutaneous and Other Soft Tissues |
| 8940-8941 | Mixed tumor, salivary gland type | C07. _ for Parotid Gland; C08. _ for Other and Unspecified Major Salivary glands |
| 9120-9170 | Blood vessels tumors, Lymphatic vessel tumors | C49. _ Connective Subcutaneous and other Soft tissues |
| 9240-9252 | Mesenchymal chondrosarcoma and giant cell tumors | C40. _ C41. _ for bone and cartilage |
| 9580-9582 | Granular cell tumor and alveolar soft part sarcoma | C49. _ Connective, Subcutaneous and Other Soft Tissues |

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REVIEW YOUR WORK DO NOT RELY ON EDITS TO FIND ERRORS



**NOT
just edits**

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2020 NPCR Data Quality Evaluation Audit

▪ DQE Findings from FCDS and NPCR (visual editing only - 400 cases reviewed - ovary, melanoma skin, pancreas, bladder, kidney and renal pelvis) – 43 Data Items Reviewed for Each Case. Diagnostic Confirmation, Site, Laterality Histology, Behavior, NEW Grade Fields, Staging, Treatment, DATES.

▪ FCDS relies heavily and expects from all registrars correct coding and complete documentation for many reasons. We do not have resources to Visually Edit every single abstract of the 260,000 we receive each year. NPCR reviewed every single case and found coding/documentation potential discrepancies on >50% of cases. However, the errors were entirely predictable in areas we know we have issues.

▪ **OVERALL ACCURACY** across all sites and all data items was an **OUTSTANDING 97.9%**.

97.9%

▪ **Specific Problem Areas Include the Following Data Items:** Diagnostic Confirmation is 85%. Grade Clin/Path is 88%. Tumor Size Summary is 83.6%. Nodes Positive/Nodes Exam Agreement was only 60%. Date of Initial Dx is 90.4%. Surgery of Primary Site is 76.7%. Treatment Dates is 87.7%. Systemic/Surgery Sequence is 83.6% (problem with neoadjuvant therapies only being recorded as being given before surgery not before & after).

▪ FCDS relies on you to document and code all of the required data items (complete data) and correctly coded data (accurate data) and fully documented data (timeline and timely data) on every single case (completeness of case-finding) because we cannot go back and check on every one of these for you. **Registries should do peer-to-peer review on a regular basis to ensure everybody on your team interprets rules the same.**

▪ Every single abstract must tell a story. You may not have a complete story – so document in detail what you do/not have in chart for diagnostic confirmation, workup, biopsy, surgery, histology, grade, staging, treatment, history, chronology of events, etc. We need to get the whole picture. In addition, document and code what you do have. And, please remember that FCDS only gets some of the text fields. FCDS does not get a single word – no not even one word – from your software ‘text pad’ feature. Nothing. Tell FCDS when you don’t have info, too.

2020 NPCR Data Quality Evaluation Audit

Table 5. Accuracy Proportions for all Errors and Major Errors by Site and Data Element

| Data Elements (NAACCR Item) | Melanoma of the Skin Accuracy Proportions | | Bladder Accuracy Proportions | | Pancreas Accuracy Proportions | | Kidney and Renal Accuracy Proportions | | Ovary Accuracy Proportions | |
|--|---|------------------|------------------------------|------------------|-------------------------------|------------------|---------------------------------------|------------------|----------------------------|------------------|
| | All errors (%) | Major errors (%) | All errors (%) | Major errors (%) | All errors (%) | Major errors (%) | All errors (%) | Major errors (%) | All errors (%) | Major errors (%) |
| Date of Diagnosis NAACCR # 390 | 91.8% | 98.6% | 97.3% | 98.6% | 95.9% | 100.0% | 91.8% | 98.6% | 86.3% | 95.9% |
| Primary Site NAACCR # 400 | 100.0% | 100.0% | 78.1% | 97.3% | 91.8% | 100.0% | 98.6% | 98.6% | 98.6% | 98.6% |
| Laterality NAACCR # 410 | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 98.6% | 98.6% | 97.3% | 97.3% |
| Diagnostic Confirmation NAACCR # 490 | 100.0% | 100.0% | 100.0% | 100.0% | 84.9% | 84.9% | 100.0% | 100.0% | 98.6% | 98.6% |
| Histologic Type ICD-O-3 NAACCR # 522 | 95.9% | 100.0% | 91.8% | 100.0% | 97.3% | 98.6% | 94.5% | 100.0% | 86.3% | 98.6% |
| Behavior Code ICD-O-3 NAACCR # 523 | 98.6% | 98.6% | 98.6% | 98.6% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Grade Clinical NAACCR # 3843 | 98.6% | 98.6% | 89.0% | 89.0% | 98.6% | 98.6% | 94.5% | 94.5% | 94.5% | 94.5% |
| Grade Pathological NAACCR # 3844 | 98.6% | 98.6% | 87.7% | 87.7% | 98.6% | 98.6% | 90.4% | 90.4% | 93.2% | 93.2% |
| Grade Post Therapy NAACCR # 3845 | 98.6% | 98.6% | 95.9% | 95.9% | 98.6% | 98.6% | 98.6% | 98.6% | 93.2% | 93.2% |
| Tumor Size Summary NAACCR # 756 | 100.0% | 100.0% | 79.5% | 83.6% | 83.6% | 95.9% | 75.3% | 94.5% | 91.8% | 94.5% |
| Regional Nodes Positive NAACCR # 820 | 64.4% | 64.4% | 95.9% | 95.9% | 94.5% | 94.5% | 93.2% | 93.2% | 94.5% | 94.5% |
| Regional Nodes Examined NAACCR # 830 | 63.0% | 63.0% | 93.2% | 93.2% | 93.2% | 93.2% | 93.2% | 93.2% | 94.5% | 94.5% |
| Summary Stage 2018 NAACCR # 764 | 95.9% | 95.9% | 93.2% | 93.2% | 94.5% | 94.5% | 100.0% | 100.0% | 95.9% | 95.9% |
| Date of Initial RX—SEER NAACCR # 1260 | 86.3% | 90.4% | 95.9% | 97.3% | 97.3% | 100.0% | 97.3% | 100.0% | 100.0% | 100.0% |
| Date Initial RX SEER Flag NAACCR # 1261 | 100.0% | 100.0% | 98.6% | 98.6% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| RX Summ—Treatment Status NAACCR # 1285 | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| RX Date—Surgery NAACCR # 1200 | 84.9% | 87.7% | 95.9% | 95.9% | 100.0% | 100.0% | 95.9% | 98.6% | 100.0% | 100.0% |
| RX Date Surgery Flag NAACCR # 1201 | 98.6% | 98.6% | 98.6% | 98.6% | 100.0% | 100.0% | 100.0% | 100.0% | 98.6% | 100.0% |
| RX Date Mst Defn Sig NAACCR # 3170 | 90.4% | 90.4% | 94.5% | 95.9% | 100.0% | 100.0% | 97.3% | 100.0% | 98.6% | 98.6% |
| RX Date Mst Defn Sig Flag NAACCR # 3171 | 100.0% | 100.0% | 98.6% | 98.6% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| RX Summ—Surg Prim Site NAACCR # 1290 | 76.7% | 76.7% | 83.6% | 83.6% | 98.6% | 98.6% | 95.9% | 95.9% | 95.9% | 95.9% |
| RX Summ—Scope Reg LN Sur NAACCR # 1292 | 97.3% | 97.3% | 98.6% | 98.6% | 97.3% | 97.3% | 100.0% | 100.0% | 98.6% | 98.6% |
| RX Summ—Surg Other Reg Dis NAACCR # 1294 | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 98.6% | 98.6% | 98.6% | 98.6% |

Red = under 95% accuracy Green = 95% or higher accuracy

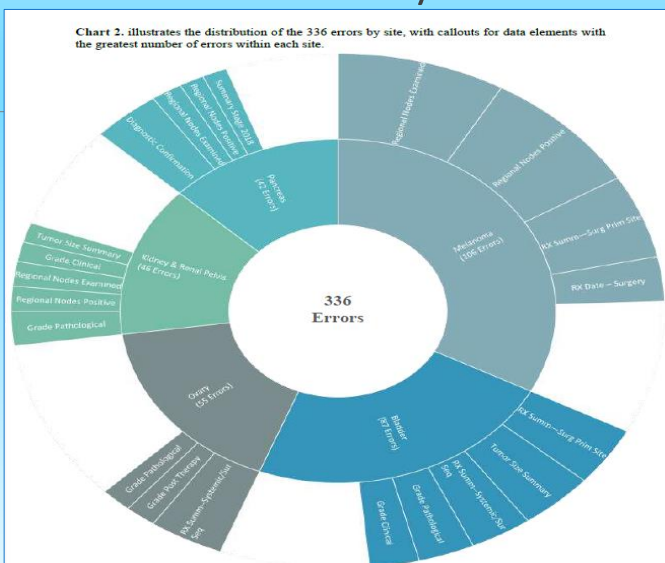
2020 NPCR Data Quality Evaluation Audit

| Data Elements (NAACCR Item) | Melanoma of the Skin Accuracy Proportions | | Bladder Accuracy Proportions | | Pancreas Accuracy Proportions | | Kidney and Renal Accuracy Proportions | | Ovary Accuracy Proportions | |
|--|---|------------------|------------------------------|------------------|-------------------------------|------------------|---------------------------------------|------------------|----------------------------|------------------|
| | All errors (%) | Major errors (%) | All errors (%) | Major errors (%) | All errors (%) | Major errors (%) | All errors (%) | Major errors (%) | All errors (%) | Major errors (%) |
| Reason for No Surgery NAACCR # 1340 | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 95.9% | 100.0% | 100.0% | 100.0% |
| RX Date—Radiation NAACCR # 1210 | 100.0% | 100.0% | 98.6% | 98.6% | 98.6% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| RX Date Radiation Flag NAACCR # 1211 | 100.0% | 100.0% | 97.3% | 98.6% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Phase I Radiation Treatment Modality NAACCR # 1506 | 100.0% | 100.0% | 100.0% | 100.0% | 98.6% | 98.6% | 100.0% | 100.0% | 100.0% | 100.0% |
| RX Summ—Surg/Rad Seq NAACCR # 1380 | 98.6% | 98.6% | 100.0% | 100.0% | 98.6% | 98.6% | 100.0% | 100.0% | 100.0% | 100.0% |
| RX Date—Chemo NAACCR # 1220 | 100.0% | 100.0% | 95.9% | 98.6% | 86.3% | 100.0% | 94.5% | 95.9% | 94.5% | 100.0% |
| RX Date Chemo Flag NAACCR # 1221 | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 97.3% | 97.3% | 100.0% | 100.0% |
| RX Summ—Chemo NAACCR # 1390 | 100.0% | 100.0% | 98.6% | 98.6% | 95.9% | 97.3% | 95.9% | 95.9% | 100.0% | 100.0% |
| RX Date—Hormone NAACCR # 1230 | 100.0% | 100.0% | 100.0% | 100.0% | 98.6% | 98.6% | 100.0% | 100.0% | 100.0% | 100.0% |
| RX Date Hormone Flag NAACCR # 1231 | 100.0% | 100.0% | 100.0% | 100.0% | 98.6% | 98.6% | 100.0% | 100.0% | 100.0% | 100.0% |
| RX Summ—Hormone NAACCR # 1400 | 100.0% | 100.0% | 100.0% | 100.0% | 98.6% | 98.6% | 100.0% | 100.0% | 100.0% | 100.0% |
| RX Date—BRM NAACCR # 1240 | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 97.3% | 98.6% | 100.0% | 100.0% |
| RX Date BRM Flag NAACCR # 1241 | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 98.6% | 98.6% | 100.0% | 100.0% |
| RX Summ—BRM NAACCR # 1410 | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 98.6% | 98.6% | 100.0% | 100.0% |
| RX Summ—Systemic/Sur Seq NAACCR # 1639 | 98.6% | 98.6% | 86.3% | 86.3% | 98.6% | 98.6% | 98.6% | 98.6% | 83.6% | 83.6% |
| RX Date—Other NAACCR # 1250 | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| RX Date Other Flag NAACCR # 1251 | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| RX Summ—Other NAACCR # 1420 | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Reason No Radiation NAACCR # 1430 | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| RX Summ—Transplant/Endocr NAACCR # 3250 | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |

Red = under 95% accuracy Green = 95% or higher accuracy

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Chart 2. illustrates the distribution of the 336 errors by site, with callouts for data elements with the greatest number of errors within each site.



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OKAY or DONE or ADDED TEXT TO ABSTRACT or UPDATED is not an acceptable response to any QC Visual Editing Inquiry – answer the question in detail and as room permits in the messaging area.

FCDS NEVER gets an updated record from you without deleting the old record. FCDS does not allow update/correction or modification records at all. We do not recommend deleting cases and resubmitting as they can get 'lost' in the process and then they show up on AHCA as never sent.

FCDS does not have resources to accept, review, update and re-edit and correct your abstracts more than once – that would be at least 100,000 extra abstracts sent in as Modify or Update Records each year – we would need 5 more people.

Many minor TREATMENT ERRORS because too many registrars coding to NOS surgery or NOS systemic or NOS radiation instead of specific code. And, most are not coding radical surgeries correctly such as cystoprostatectomy = Surg Prim Site = 71 (bladder) 70 (prostate). Use the Notes.

Example: Bladder - TURBT

10 Local tumor destruction, NOS
 11 Photodynamic therapy (PDT)
 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 13 Cryosurgery
 14 Laser
 15 Intravesical therapy
 16 Bacillus Calmette-Guerin (BCG) or other immunotherapy
Also code the introduction of immunotherapy in the immunotherapy items. If immunotherapy is followed by surgery of the type coded 20-80 code that surgery instead and code the immunotherapy only as immunotherapy.

No specimen sent to pathology from surgical events 10-16.

20 Local tumor excision, NOS
 26 Polypectomy
 27 Excisional biopsy
 Combination of 20 or 26-27 WITH
 21 Photodynamic therapy (PDT)
 22 Electrocautery
 23 Cryosurgery
 24 Laser ablation
 25 Laser excision

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HAPPY SLIDE



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2020 NPCR Data Quality Evaluation Audit FINDINGS FROM CDC

More than 50% of 400 Cases Reviewed had a Problem with Coding and/or Text Documentation – most errors were minor

No Documentation in Text to Validate Coding – each counted as an error – major/minor depended upon data item

Documentation in Text does not Match what was Coded by Registrar – major/minor depended upon the data item

Dates Missing from Text Documentation

Date of Diagnosis Often Incorrect – imaging versus biopsy versus treatment

Overuse of NOS and Unknown Codes

Subsite Frequently Not Coded – instead we get lots of breast, NOS (C50.9), lung, NOS (C34.9), bladder, NOS (C67.9), etc.

DX Confirmation = 9 or 5 – NEVER USE THESE CODES - EVER

Grade Coding was Poor – 1st year of new Grade Codes – not good and expect worse with 2 added grade fields in 2021

Stage at Diagnosis – We do NOT want stage after treatment – We DO WANT Stage at Diagnosis

SS2018 far too frequently not substantiated - substituted with only AJCC TNM – no direct crosswalk between TNM and SS2018 exists – use manuals

Tumor Size – should registrar code tumor size at dx or tumor size after treatment – problem with lots of tumor size in text but not coded

Scope of Regional Lymph Node Surgery was Poor and has been for years especially for FNA/Core/Excisional Bx of Nodes or Combination

Registrars Not Using SEER*Rx to Code Anti-Neoplastic Agents to Correct Type of Treatment

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2020 NPCR Data Quality Evaluation Audit FINDINGS FROM CDC

[SSDIs not documented or stated to be 'unavailable' – they should be available on analytic cases](#)

Information from findings on Operative Reports and Consultations are rarely documented. Do registrars still read these reports? Sometimes the operative report is the only place to get accurate primary site or clinical staging information that is visually identified but never biopsied or removed.

- Operative Text is for documenting what the operative findings were - not what the procedure was.
- Operative Text could just say 'no significant findings' – but, you must read the operative reports
- Surgical Text is where you put dates in chronological order for all cancer-related surgical procedures.
- Pathology Text is where you put dates in chronological order for all cancer-related findings on anatomical surgical pathology reports from bx to bone marrow to resection
- Imaging Text is where you put dates in chronological order for positive and negative imaging tests
- Lab Text is where you put diagnostic lab tests, some SSDI tests, and genetics testing if not in path area
- Staging Text is where you put a summary of all the components that were used for staging the case – not just 'localized' or T2N0MX – Stage = 99...summarize the findings so reviewer/researcher does not have to read the entire abstract again and again to find all the parts you used to come up with stage.
- Consultations and Other Reports can go into Remarks or History Section – but include them
- ALWAYS INCLUDE DATES even when coded – we ask for both so we can check you coded correctly.

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HAPPY SLIDE



PLEASE USE ALL CURRENT MANUALS AND REFERENCES

| Reference Name | Medium | Effective Date | Latest Update | URL |
|--|--------------|----------------|----------------------|---|
| FCDS Website | On-line Only | 1/1/2005 | current | https://fcds.med.miami.edu/nc/welcome.shtml |
| Fundamental Learning Collaborative for the Cancer Surveillance Community - FLCoSC | On-line Only | 7/1/2017 | Content Added | https://fls.fcdsims.med.miami.edu/ |
| NAACCR Vol II – Data Standards and Data Dictionary, v21 | On-Line Only | 1/1/2018 | 11/7/2018 | https://www.naacr.org/data-standards-data-dictionary/ |
| 2021 FCDS Data Acquisition Manual – FCDS DAM 2021 | PDF | 1/1/2021 | 6/30/2021 | https://fcds.med.miami.edu/nc/downloads.shtml |
| 2021 FCDS Data Acquisition Manual - Appendix P - Resources for Registrars | PDF | 1/1/2021 | 6/30/2021 | https://fcds.med.miami.edu/nc/downloads.shtml |
| 2021 FCDS Complete Casefinding List (ref. 2021 FCDS DAM, Appendix O for all ICD-10 CM Codes) | PDF | 10/1/2020 | 9/30/2021 | https://fcds.med.miami.edu/nc/downloads.shtml |
| 2021 Guidelines for ICD-O-3 Histology Code and Behavior Updates - SEER | PDF | 1/1/2021 | 12/1/2020 | https://seer.cancer.gov/icd-o-3/ |
| 2021 Guidelines for ICD-O-3 Histology Code and Behavior Updates - FCDS DAM, Appendix R | PDF | 1/1/2021 | 12/1/2020 | https://fcds.med.miami.edu/nc/downloads.shtml |
| 2021 SEER Coding and Staging Manual 2021, September 2020 | PDF | 1/1/2021 | 9/1/2020 | https://seer.cancer.gov/tools/codingmanuals/ |
| Standards for Oncology Registry Entry – STORE | PDF | 1/1/2021 | 1/1/2021 | https://www.facs.org/quality-programs/cancer/ncdb/call-for-data/cocmanuals |
| CTR Guide to Coding Radiation Therapy Treatment in the STORE | PDF | 1/1/2018 | v3.0 - 2/1/2021 | https://www.facs.org/quality-programs/cancer/ncdb/case_studies_coding_radiation_treatment.ashx |
| Optimal Resources for Cancer Care - 2020 Standards | PDF | 1/1/2021 | 1/1/2021 | https://www.facs.org/quality-programs/cancer/coc/standards/2020 |
| 2021 SEER Complete ICD-10-CM Codes for Casefinding Lists (short list and detailed list) | PDF | 10/1/2020 | 9/30/2021 | https://seer.cancer.gov/tools/casefinding/ |
| 2021 SEER Summary Staging Manual - SS2018, v2.0 - September 2020 | PDF | 1/1/2021 | v2.0 | https://seer.cancer.gov/tools/ssm/ |
| 2018 Solid Tumor Rules, December 2020 | PDF | 1/1/2018 | 12/1/2020 | https://seer.cancer.gov/tools/solidtumor/ |
| Grade Coding Manual – Grade Manual, v2.01 - January 2021 | PDF | Aug-19 | v2.01 | https://apps.naacr.org/ssdi/list/ |
| Site-Specific Data Item Manual & Appendix A&B - SSDI Manual, v2.0 - September 2020 | PDF | 1/1/2018 | v2.0 | https://apps.naacr.org/ssdi/list/ |
| ICD-O-3 Complete Code List - ICD-O-3.2 in Excel - be sure to add 2021 Updates from FCDS DAM | Excel | 1/1/2018 | 1/1/2021 | http://www.iacr.com.fr/index.php?itemid=577 |
| ICD-O-3 Manual, 3 rd edition - there are still times when you need the original manual instructions | PDF/printed | 1/1/2000 | Errata & Updates | https://seer.cancer.gov/icd-o-3/ |
| SEER Hematopoietic and Lymphoid Database - online | On-Line Only | 1/1/2010 | 9/1/2021 | http://seer.cancer.gov/seertools/hemelymph/ |
| SEER Hematopoietic Coding Manual - online | PDF | 1/1/2010 | 9/1/2020 | http://seer.cancer.gov/seertools/hemelymph/ |
| SEER [®] Rx Interactive Antineoplastic Drugs Database - online | On-Line Only | Monthly Update | SEER [®] Rx | https://seer.cancer.gov/tools/seer/rx/ |
| SEER [®] NSA Seer Registrar Staging Assistant - online | On-line Only | 1/1/2018 | current | https://seer.cancer.gov/tools/staging/rssa.html |
| AJCC Cancer Staging Manual, 8th edition plus errata - NOT Required by FCDS | Purchase | 1/1/2018 | 1/1/2021 | https://www.springer.com/medicine |
| 2021 CTR Exam Handbook and CTR Exam Resources | PDF | 1/1/2021 | 1/1/2021 | https://www.ncra-usa.org/Portals/68/PDFs/CertificationPDFs/CTRExamHandbook2021.pdf |

QUESTIONS ?

