Florida Cancer Data System
A JOINT PROJECT OF THE SYLVESTER COMPREHENSIVE CANCER CENTER AND THE FLORIDA DEPARTMENT OF HEALTH
Florida's Statewide Population-Based Cancer Registry

What's New in 2012 FCDS Annual Meeting Review

FCDS Educational Webcast Series

August 16, 2012

FCDS Staff
Steven Peace, CTR

NPCR National Program of Cancer Registries

Florida Department of Health

Commission on Cancer
2012 FORDS
Cancer Program Standards

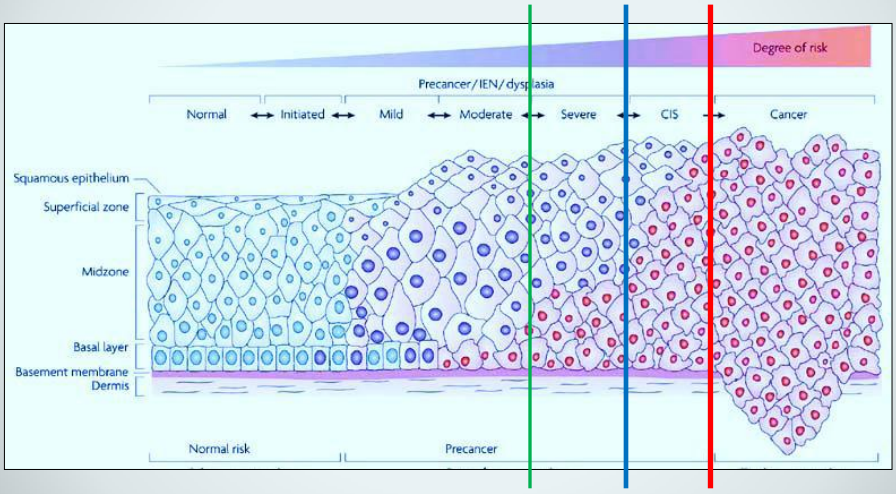
Collaborative Stage Data Collection System
CSv02.04

National Cancer Institute
SEER*Rx 2.0.1

Hematopoietic Database 2.1

1

"What is Cancer"/"What is Reportable"



2

High Grade Dysplasia/Carcinoma In Situ

- **AJCC/TNM 7th edition** – CAP and AJCC in trying to clarify the current use of the term "severe dysplasia" and "carcinoma in situ" occurring anywhere in the GI Tract have made things confusing for registrars.
  - **Esophagus**
  - **Stomach**
  - **Small Intestine**
  - **Colon**
  - **Rectum**
  - **Pancreas**
  - **Liver**
  - **Biliary System**

3

High Grade Dysplasia/Carcinoma In Situ

- **AJCC/TNM 7th edition – Esophagus Chapter**
  - **"High-grade dysplasia includes all non-invasive neoplastic epithelia that was formerly called carcinoma in situ, a diagnosis that is no longer used for columnar mucosae anywhere in the GI tract."**
- **AJCC/TNM 7th edition – Colon Chapter**
  - **"The terms "high grade dysplasia" and "severe dysplasia" may be used as synonyms for in situ adenocarcinoma and in situ carcinoma. These cases should be assigned Tis."**
- **What should registrars do with these cases?**
- Ask pathologist(s) if available – do all use this terminology?
- Document in Cancer Committee Minutes & Abstract(s)

4

Consensus Technical Work Group

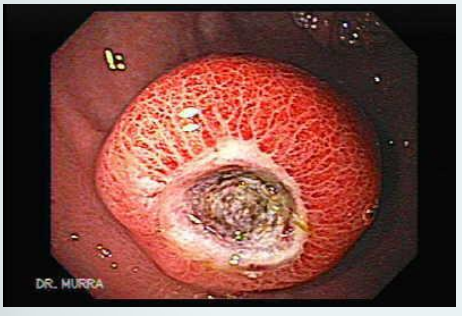
Issue 9	Is high-grade dysplasia of the GI tract reportable? The AJCC and CAP protocols say high-grade dysplasia is synonymous with carcinoma in situ.	Dysplasia is only reportable when it is specified as carcinoma in situ. Refer to the standard setters' manuals and the table in NAACCR Volume II which defines reportability for each of the standard setters.

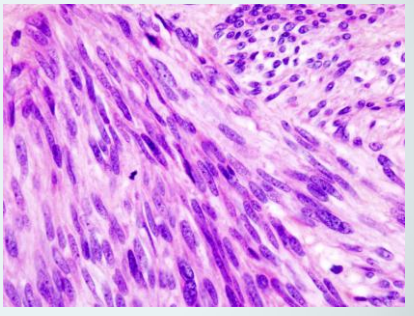
Issue 29	There is some talk in Canada about allowing severe dysplasia of the colon to be equal to in situ cancer of the colon. Canada has a history of collecting /1 behavior neoplasia, so changing the behavior may not have as great an implication there. Yet Canada does want to follow the SEER counting rules and this will greatly increase the number of in situ cancers. SEER still holds to the idea that vocabulary of "dysplasia" is not coded, correct? The case would only be /2 if the words "in situ" also appear, regardless of any reference to dysplasia. Is that still correct? The reasoning was that pathologists did not all agree on the equality of severe dysplasia to in situ disease.	In the US, the only time severe dysplasia is reportable is when it is documented by the pathologist as being synonymous with carcinoma in situ. Hospital registrars may speak with their pathologists to determine whether their individual diagnosis of severe dysplasia is always equal to in situ. If so, written documentation must be included in the registry procedure manual and those cases would be reportable.

GIST

Gastrointestinal Stromal Tumors

All GIST are Sarcomas but are All GIST Reportable?





Source:
http://www.gastrointestinalatlas.com/English/Stomach/Gastric_Gist_/gastric_gist_.html

GIST

Gastrointestinal Stromal Tumors

- Are all GIST tumors reportable, especially when the pathologist does not document the tumor as "malignant GIST"?.
- What if the pathologist describe the tumor as GIST that is KIT positive with a mitotic score less than 5. Is this case reportable?
- AJCC does not determine reportability. That is a decision for the standard setters to which you report - your state and other entities like SEER and CoC/NCDB.
- It is a decision for cancer committee, whether or not they want these cases to be included in your hospital registry, even when they are not reportable to the state registry (FCDS).

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GIST

Gastrointestinal Stromal Tumors

Many GIST are reportable as malignant tumors of the GI Tract

- Both low grade and high grade GIST may exhibit malignant behavior.
- When malignant these should be abstracted and reported to FCDS.
- It is always clear a GIST is malignant clinically because it has already metastasized and is obviously behaving in a malignant manner.
- Characteristics of GISTs that are predictive of aggressive behavior are **mitotic rate greater than 5 per 10 high-power fields (HPF), tumor size larger than 5 cm and 10 cm, and location** (small bowel GISTs of comparable size and mitotic rate are generally more aggressive than gastric GISTs). **However, tumors with low mitotic index (< 5 per 50 HPF) and smaller size (2-5 cm) can also metastasize.**

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Consensus Technical Work Group

Issue 21	Are stage 1 GIST tumors reportable? In the past, tumor size and mitotic rate were used to determine if malignant, not stage.	GISTs are to be reported based on the pathologist's designation of tumor behavior, just as with all sites.
Issue 22	We are collecting some GIST cases at the direction of our pathologists. CoC offered that AJCC's comments can be taken as informational, but they do not define what is required to be reported to any particular standard setter. However, at least from CoC's perspective, any hospital is entitled to collect any non-required cases it chooses, but it may well be that neither NCDB nor the states will want those reported unless they specify in situ or behavior = 2.	GIST is not reportable unless it is identified as being in situ or malignant. This question is an issue of reportability based on behavior and must be reviewed on a case by case basis. Do not enter these cases with a behavior code of /2 unless you have a way to flag them so they are not reported to NCDB or your state as an in situ case.

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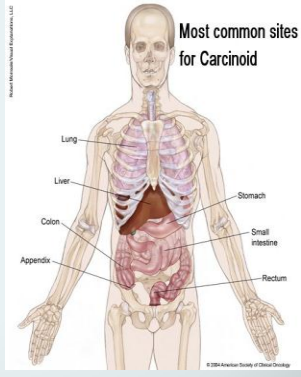
NET
Neuroendocrine Tumors

- Diagnosis and Reporting Principles
  - **Anatomic Site of Primary Tumor**
  - **Diagnosis – carcinoid tumor to PanNET to small cell carcinoma**
  - **Presence of non-neuroendocrine components**
  - **Grade**
  - **Mitotic Rate**
  - **Size of Tumor**
  - **Presence of Multicentric Disease**
  - **Presence of Vascular Invasion**
  - **Presence of Perineural Invasion**
  - **Lymph Node Metastasis**
  - **Margin Status**
  - **Ki-67 Labeling Index**



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NET
Neuroendocrine Tumors

Histologic Classification and Staging of Neuroendocrine Tumors

Neuroendocrine tumors are generally subclassified by site of origin and histologic characteristics. Pancreatic neuroendocrine tumors arise in endocrine tissues of the pancreas; carcinoid tumors most commonly arise in the lungs and bronchi, small intestine, appendix, rectum, or thymus.

Neuroendocrine tumors are classified histologically based on tumor differentiation (well or poorly differentiated) and tumor grade (grades 1–3). Most neuroendocrine tumors fall into 3 broad histologic categories: well-differentiated, low-grade (G1); well-differentiated, intermediate-grade (G2); and poorly differentiated, high-grade (G3). The latter are also sometimes referred to as high-grade neuroendocrine carcinomas or small cell carcinoma.[8] These tumors are characterized by a high mitotic rate and an aggressive clinical course.[9, 10]

Tumor differentiation and tumor grade often correlate with mitotic count and Ki-67 proliferation index. In most cases, well differentiated, low-grade tumors have a mitotic count of less than 2/10 high-power field (HPF) and a Ki-67 index of less than 3%. Well-differentiated, intermediate-grade tumors usually have a mitotic count of 2 to 20/10 HPF and a Ki-67 index of 3% to 20%. In high-grade tumors, the mitotic count usually exceeds 20/10 HPF and the Ki-67 index exceeds 20%.

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NET
Neuroendocrine Tumors

- Other Tests to Assess Disease
  - **IHC for Neuroendocrine Markers**
  - **IHC for Peptide Markers (specific to tumor)**
  - **Presence of non-ischemic tumor necrosis**
  - **Presence of unusual histologic features (oncocytic, gland forming)**
  - **Exact distance of tumor to margin(s) if less than 0,.5cm**
  - **Background pathology of organ (PanIN, ECL cell hyperplasia)**

Table 1

Grade	Mitotic Count (per 10 HPF)	Ki-67 Index (%)	Differentiation
Low grade (G1)	<2	≤3	Well-differentiated NET
Intermediate grade (G2)	2 to 20	3 to 20	Well-differentiated NET
High grade (G3)	>20	>20	Poorly differentiated neuroendocrine carcinoma

Source: NCCN Guidelines, v 1.2012 – Neuroendocrine Tumors

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NET
Neuroendocrine Tumors

IMMUNOHISTOCHEMICAL AND LABORATORY STUDIES POTENTIALLY INDICATED IN THE WORKUP OF NEUROENDOCRINE TUMORS[1]

IMMUNOHISTOCHEMICAL STUDIES[2]
- Chromogranin A
- Synaptophysin
- Cytokeratin
- Ki-67 (MIB-1) and/or mitotic rate

HORMONE-RELATED STUDIES (blood markers)
- Carcinoid tumors
  - 5-HIAA (24-h urine)
  - Chromogranin A (category 3)
- PanNET
  - Chromogranin A (category 3)
  - Gastrinoma
    - Gastrin
  - Insulinoma
    - Proinsulin
    - Insulin/glucose ratio
    - C-peptide
  - VIPoma
    - VIP
  - Glucagonoma
    - Glucagon
    - Blood glucose
    - CBC
  - Other pancreas
    - Somatostatin
    - Pancreatic polypeptide
    - Calcitonin
    - PTH-related peptide
- Pheochromocytoma/ paraganglioma
  - Metanephrines (plasma and urine)
  - Catecholamines (urine)
  - Dopamine (urine) (optional)
- Pituitary
  - Growth hormone/IGF-1
  - Prolactin
  - LH/FSH
  - TSH
  - Alpha subunits
  - ACTH
- Ectopic hormones
  - ACTH
  - GRH
  - GHRH

NET
Neuroendocrine Tumors

Tumors in Patients with Multiple Endocrine Neoplasia

Organ	Neoplasm	Patients Affected (%)
MEN 1		
Parathyroid	Hyperplasia	98
Pituitary	Adenoma	35
Pancreas	Islet cell	50
Multiple	Carcinoid	3
Adrenal	Cortical adenoma	Uncommon
	Cortical carcinoma	rare
Thyroid	Adenoma	Uncommon
	Papillary	Uncommon
Adipocyte	Lipoma	Uncommon
MEN 2A		
Thyroid	Medullary carcinoma	98
Adrenal	Pheochromocytoma	50
Parathyroid	Hyperplasia	25
MEN 2B		
Thyroid	Medullary carcinoma	98
Adrenal	Pheochromocytoma	50
Parathyroid	Hyperplasia	<1
Neuroma	Mucosal neuroma	95
	Intestinal ganglioneuroma	

Non-Melanoma Skin Cancers

Code	Term	Code	Term
8247/3	Merkel Cell Carcinoma	8890/3	Leiomyosarcoma
8400/3	Sweat Gland Adenocarcinoma	9140/3	Kaposi Sarcoma
8410/3	Sebaceous Adenocarcinoma	9591/3	Non-Hodgkin Lymphoma
8800/3	Sarcoma	9650/3	Hodgkin Lymphoma
8810/3	Fibrosarcoma	9680/3	Diffuse Large B-Cell Lymphoma
8832/3	Dermatofibrosarcoma	9700/3	Mycosis Fungoides
8850/3	Liposarcoma	9709/3	Cutaneous T-Cell Lymphoma

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Unknown Primary/Ill-Defined Site

C80.9 – Unknown Primary, NOS

C76.0 – Ill-Defined Sites – head, face or neck, NOS

C76.1 – Ill-Defined Sites – thorax, NOS

C76.2 – Ill-Defined Sites – abdomen, NOS

C76.3 – Ill-Defined Sites – pelvis, NOS

C76.4 – Ill-Defined Sites – upper limb, NOS

C76.5 – Ill-Defined Sites – lower limb, NOS

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Unknown Primary/Ill-Defined Site

Site Title	Site Code	Histology Title	Histology Codes
Skin, Arm	C44.6	Carcinoma, Melanoma, Merkel Cell, Mycosis Fungoides, Cutaneous T-Cell Lymphoma of Arm	8010 8720-8970 8747 9700 9709
Soft Tissue, Arm	C49.1	Sarcoma	8800-8921
Peripheral Nerve, Arm	C47.1	Sarcoma	8800-8921
Bone, Arm	C40.3	Sarcoma (osteo)	9180-9194
Lymph Nodes, Arm	C77.3	Lymphoid Neoplasms	See Heme DB

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Consensus Technical Work Group

Issue 23	Code C148 assigned for squamous cell carcinoma diagnosed from lymph node and deemed to be a head and neck primary but specific site could not be identified. Code C148 is based on note in ICD-O-3 indicating it should be used when a code between C000 and C142 cannot be assigned. I & R (46158) indicated it should be coded to C760.	Assign C148 based on the note in ICD-O-3. C148 is a more specific site code than C760. The I & R answer has been revised.

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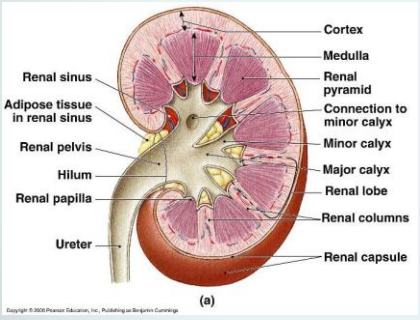
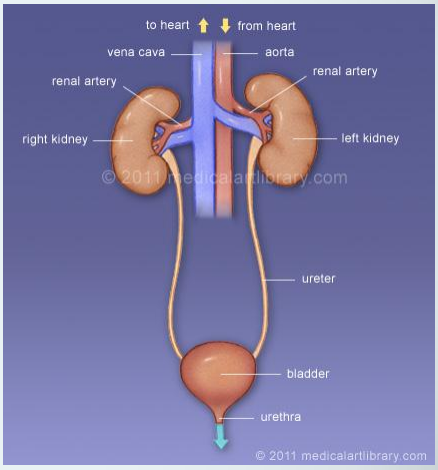
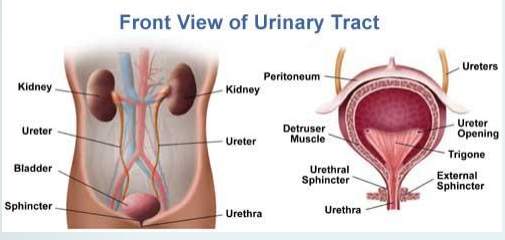
Urinary System MPH Rules

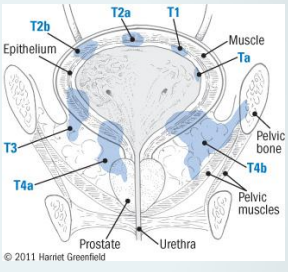




19

Urinary System MPH Rules





Renal Pelvis, Ureter, Bladder, and Other Urinary

The renal pelvis, ureters, bladder and proximal portion of the urethra are lined by transitional epithelium, also known as urothelium. Tumors of the urothelium are more often multifocal compared to other sites. Two mechanisms have been proposed to explain this phenomenon: 1). a "field effect" and 2) tumor cell implantation.

1. The **field effect** theory suggests that the urothelium has undergone a widespread change, perhaps in response to a carcinogen, making it more sensitive to malignant transformations. As a result, multiple tumors arise more easily.
2. The **implantation** theory suggests that tumor cells in one location lose their attachments and float in the urine until they attach (implant) on another site. Transitional cell tumors commonly spread in a head-to-toe direction, for example from the renal pelvis to the ureter.

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Urinary System MPH Rules

Rule M5 An **invasive** tumor **following a non-invasive or in situ** tumor more than 60 days after diagnosis is a multiple primary. **
Note 1: The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed.
Note 2: Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease

Rule M6 Bladder tumors with any **combination** of the following histologies: **papillary carcinoma** (8050), **transitional cell carcinoma** (8120-8124), or **papillary transitional cell carcinoma** (8130-8131), are a single primary. *

Rule M7 Tumors diagnosed **more than three (3)** years apart are multiple primaries. **

Rule M8 Urothelial tumors in two or more of the following sites are a single primary* (See Table 1)

- Renal pelvis (C659)
- Ureter(C669)
- Bladder (C670-C679)
- Urethra /prostatic urethra (C680)

21

Definition/Coding Changes

- **Grade/Differentiation** - new instructions for determining which Grade items require coding, depending on the type of case.
  - **Grade/Differentiation (traditional grade)**
  - **Cell Lineage for hematopoietic and lymphatic tumors (B-cell, T-cell)**
  - **CS special grade items – 30 total**
  - **Grade Path System and Grade Path Value**

22

Grade/Differentiation

Code for Histologic Grading and Differentiation

Rule G. Assign the highest grade or differentiation code described in the diagnostic statement.

ICD-O includes, as the 6th digit of the morphology code, a single-digit code number designating the grade or differentiation of malignant neoplasms as listed in Figure 21. Only malignant tumors are graded.

The practice of grading varies greatly among pathologists throughout the world, and many malignant tumors are not routinely graded. In the grading code listed in Figure 21, the code numbers 1 to 4 are used to designate grades I to IV respectively. Words used to designate degrees of differentiation are listed in a separate column.

Figure 21. 6th Digit Code for Histologic Grading & Differentiation

Code	Grade	Differentiation
1	**Grade I**	Well differentiated Differentiated, NOS
2	**Grade II**	Moderately differentiated Moderately well differentiated Intermediate differentiation
3	**Grade III**	Poorly differentiated
4	**Grade IV**	Undifferentiated Anaplastic
9		Grade or differentiation not determined, not stated or not applicable

Grade/Differentiation

This same 6th digit column may also be used to denote cell lineage for leukemias and lymphomas (Figure 22). This may be useful when comparing data coded according to the Third Edition of ICD-O with data coded according to the Second Edition. As noted in the section on lymphomas, in the Third Edition, the cell lineage is implicit in the four-digit histology code, and an additional grade or differentiation (6th digit) code is not required. However, some registries may wish to retain the additional digit to identify cases in which the diagnosis is supported by immunophenotypic data. In such instances, the immunophenotype code has precedence over other diagnostic terms for grade or differentiation, such as "well differentiated" or "grade III."

Figure 22. 6th Digit Code for Immunophenotype Designation for Lymphomas & Leukemias

Code	Designation
5	**T-cell**
6	**B-cell** Pre-B B-precursor
7	**Null cell** Non T-non B
8	**NK cell** Natural killer cell
9	**Cell type not determined, not stated or not applicable**

Grade/Differentiation

- High Grade Astrocytoma
- Glioblastoma Multiforme

- Is this Implied Grade?
- Code High Grade = 4?

- Does the Implied Grade "rule" still stand?
- What about EDITS and Implied Grade?

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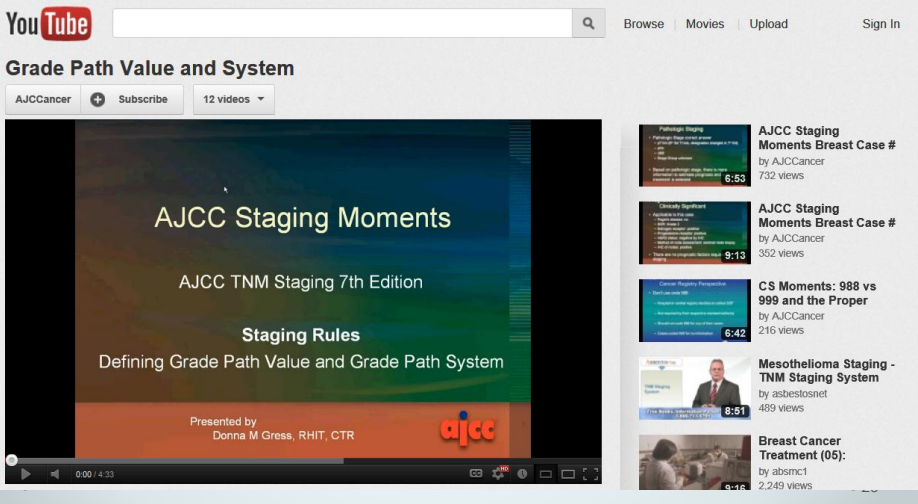
Grade Path Value/Path System



Grade – Site Specific Factors

CS Schema	SSF #	Title
Appendix	11	Histopathologic Grading
Bladder	1	WHO/ISUP Grade
Brain	1	WHO Grade Classification
Breast	7	Nottingham or Bloom-Richardson Score/Grade
CNS Other	1	WHO Grade Classification
Colon	5	Tumor Regression Grade
HeartMediastinum	1	Grade for Sarcomas
IntracranialGland	1	WHO Grade Classification
KidneyParenchyma	6	Fuhrman Nuclear Grade
KidneyRenalPelvis	1	WHO/ISUP Grade
MelanomaConjunctiva	3	Grade - Melanoma Origin
Penis	11	Poorly Differentiated Tumor Percentage
Peritoneum	1	Grade for Sarcomas
Prostate	6,7,8,9,10,11	Variations of Gleason's Pattern/Score
Rectum	5	Tumor Regression Grade
Retroperitoneum	1	Grade for Sarcomas
SoftTissue	1	Grade for Sarcomas
Urethra	1	WHO/ISUP Grade

27

Definition/Coding Changes

- **Scope of Regional Lymph Node Surgery** - items are to be coded from the operative report, not from the pathology report.
  - **Still documents the removal, biopsy, or aspiration of regional lymph node(s) at the time of surgery of the primary site or during a separate surgical event**
  - **Clarification applies to how sentinel lymph node biopsies are coded**
  - **Specific additional instructions are provided for breast primaries**
  - **DO NOT RECODE cases diagnosed prior to 2012**

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Scope of Regional Lymph Node Surgery:
A Review of Data Validity, Revised Coding Directives, and Agency Transition Plans

Hospital and central cancer registries have been collecting information on sentinel lymph node biopsies among patients diagnosed with breast cancer using the registry data item "Scope of Regional Lymph Node Surgery". Clinical investigators working in collaboration with staff at the National Cancer Data Base raised concerns regarding the validity of reported data describing the type of regional lymph node surgery performed for patients undergoing breast cancer operations. Multiple agencies/organizations, including the American College of Surgeons Commission on Cancer (CoC), National Cancer Institute's Surveillance Epidemiology and End Results (SEER) program, the Centers for Disease Control and Prevention's National Program for Cancer Registries (NPCR), and the North American Association of Central Cancer Registries (NAACCR) have concluded that under coding instructions in use by registry abstractors, sentinel lymph node biopsies for breast cancer have been significantly under-reported. In a collaborative effort, these agencies have designed new instructions and clarifications to guide the coding for this data element for implementation for cases diagnosed January 1, 2012 and later. The CoC tested the clarifications in over a dozen hospitals.

Instructions Scope LN Surg

General Instructions

Use the operative report as the primary sources document to determine whether the operative procedure was a sentinel lymph node biopsy (SLNBx), or a more extensive dissection of regional lymph nodes, or a combination of both SNLBx and regional lymph node dissection. The operative report will designate the surgeon's planned procedure as well as a description of the procedure that was actually performed. The pathology report may be used to complement the information appearing in the operative report, but the operative report takes precedence when attempting to distinguish between SLNBx and regional lymph node dissection or a combiatnion of these 2 procedures. Do not use the number of lymph nodes removed adnad pathologically examined as the sole means of distinguishing between a SLNBx and a regional lymph node dissection.

30

Fewer FCDS Data Items

Data Items Removed from Core FCDS Requirements

Item #	Item Name	Start	End	Length	Year Start/End
940	TNM Clin T	958	961	4	2011 only
950	TNM Clin N	962	965	4	2011 only
960	TNM Clin M	966	969	4	2011 only
970	TNM Clin Stage Group	970	973	4	2011 only
980	TNM Clin Descriptor	974	974	1	2011 only
990	TNM Clin Staged By	975	975	1	2011 only
1060	TNM Edition Number	938	939	2	2011 only

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Fewer Site Specific Factors

Schema Number	Schema Name	TNM/SS Required	2012 FCDS Required	Additional CoC Required
116	AdnexaUterineOther	None	None	None
147	AdrenalGland	None	None	None
66	AmpullaVater	None	None	None
59	Anus	None	None	None
50	Appendix	2,11	2,11	1,3
65	BileDuctsDistal	25	25	None
61	BileDuctsIntraHepat	10	10	1,2,11
63	BileDuctsPerihilar	25	25	11
68	BiliaryOther	None	None	None
128	Bladder	2	2	1,3
95	Bone	None	None	3
143	Brain	None	1	4,5,6
106	Breast	3,4,5	1,2,3,4,5,8,9,10,11,12,13,14,15,16	6,7,21,22,23
25	BuccalMucosa	1	1	3,4,5,6,9,11
51	CarcinoidAppendix	2	2	None
110	Cervix	None	None	1
144	CNSOther	None	1	4,5,6
53	Colon	2	2	1,3,4,6,8,9
131	Conjunctiva	1	1	None
112	CorpusAdenosarcoma	2	2	1,3,4,5,6
111	CorpusCarcinoma	2	2	1,3,4,5,6
113	CorpusSarcoma	2	2	1,3,4,5,6

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SSF No Longer Required

Schema	SSF NO LONGER REQUIRED
Appendix	SSF 7,10
Breast	SSF 21,22,23
Colon	SSF 7,9,10
Heme-Retic	SSF 1
Rectum	SSF 5,7,9,10

33

A Few 2011 Items Remain

- Height (inches)
- Weight (pounds)
- Tobacco Use Cigarette
- Tobacco Use Other Smoke
- Tobacco Use Smokeless
- Tobacco Use NOS

34

A Few 2011 Items Remain

- NPI--Physician -- Managing – As Available
- NPI--Physician 1 -- Follow-Up – As Available
- NPI--Physician 2 -- Primary Surg – As Available
- NPI--Physician 3 -- Radiation Onc – As Available
- NPI--Physician 4 -- Medical Onc – As Available

35

Two Treatment Codes Added

- RX Summ – Systemic/Surg Seq = 7
  - Surgery both before and after systemic
- RX Summ – Surg/Rad Seq = 7
  - Surgery both before and after radiation

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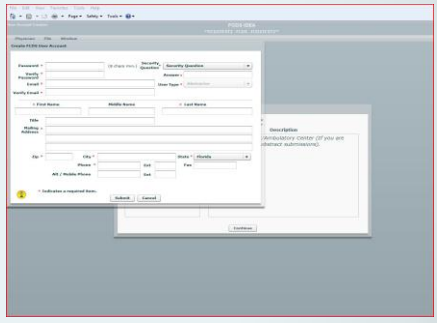
New Procedures

4 New Procedures

- **On-Line Registration - Facility Profile / User Access**
  - Self Registration – two month sign-up period
  - Facility Maintenance Includes Assigning User Roles to Grant Access to FCDS IDEA, Upload, QC Review, etc.
- **On-Line Incidence Abstractor Training Course**
- **New FCDS Abstractor Code - NO PAPER ABSTRACTS**
  - 20-25 question examination – 5 Core Areas
  - Two attempts then wait 3 months
  - Pass Rate = 75%
- **Annual Renewal Abstractor Code – 10 Question Quiz**

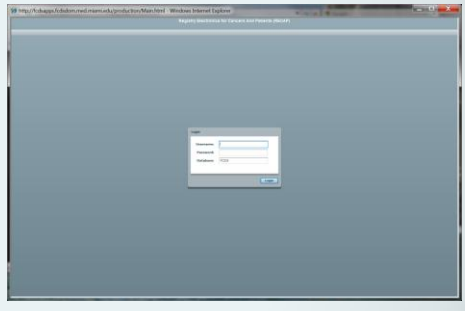
User Access / Facility Maintenance

- **Automated User Access**
  - Everyone that uses the FCDS system must have a login
- **Basic Users (Roles)**
  - Abstractor
  - Administrators
  - Researchers
- **Facility Administrators**
  - Control all personnel for that facility
    - Add/Delete/Modify
    - Assign data access



User Access/Facility Maintenance

- **Existing Users**
  - Import all existing data to new system
  - First time logging in
    - All fields must be reviewed
    - Some new fields that must be completed
  - Everyone MUST have a valid e-mail address
- **New Users**
  - Log on and complete forms



User Access/Facility Maintenance

Abstractor Code/User Access Increasingly Important

QC Edits

- Edits will be put into place that associates the abstractor to the facility

QC Reports

- New data quality indicator reports will soon be facility and abstractor specific

Incidence Abstracting Course

- This is a BASIC Abstracting Course
- This is NOT a CTR Training Course
- When a cancer abstractor's ultimate goal is to become a Certified Tumor Registrar (CTR)
  - The Course refers students to the Florida Cancer Registrars Association, National Cancer Registrars Association and the American College of Surgeons Commission on Cancer for details on CTR Exam.
    - http://www.fcra.org/
    - http://www.ncra-usa.org/
    - http://www.facs.org/cancer/

Course Modules and Content

- **Based on**
  - Original 2½ day face-to-face meeting
  - Revised to be a semi-online course

} Replaces

- **Web Course - 10 Modules/Content Areas**
  - Power Point slides with voice over's
  - PDF copies of Power Point slides
  - Interactive quiz
    - Graded – requires 80% or higher for credit
  - Certificate of Completion
    - Upon completion the student will receive a Certificate of Completion

Obtaining New Abstractor Code

New or Expired FCDS Abstractors

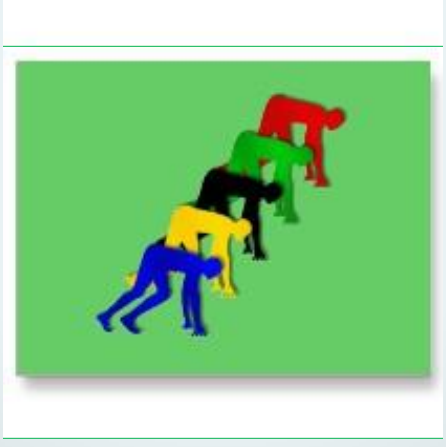
- Establish User Account via User Access System
- Log on to LMS (Moodle)
- Answer 20-25 questions
  - General abstracting
  - General coding
  - Florida state specific rules
- Must pass with a grade of 75% or higher
- Receive abstractor code within 24 hours

Annual Abstractor Renewal

Existing Abstractors - Annual

- Update profile via User Access System
- Log on to LMS (Moodle)
- Answer 10 questions
  - General abstracting
  - General coding
  - Florida state specific rules
- Must pass with a grade of 80% or higher
- Immediately resets expiration date for one year

New Procedures
Consolidated Follow-Back



What is Consolidated Follow Back?

- Consolidation of……..
  - AHCA Follow Back
  - Ambulatory Surgery Center Follow Back
  - Death Clearance Follow Back
- …into a single, once a year process

Why a Consolidated Follow Back?

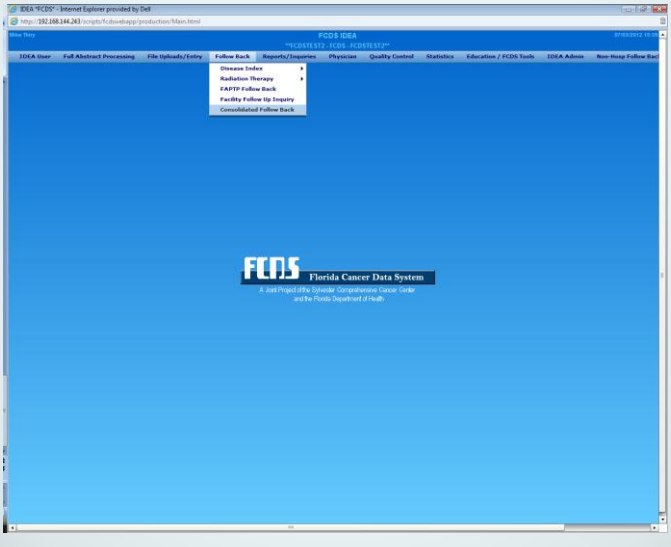
- AHCA Follow Back processing was interfering with annual case reporting deadline distracting facilities from getting cases in by June 30 deadline
- Agency for Health Care Administration (AHCA) informed us of hospital surgery items of stays less than 24 hours would appear on the AMBI data feed. Therefore, hospital's would need to check multiple follow back sources (AHCA and AMBI) to work their items

What's Changed?

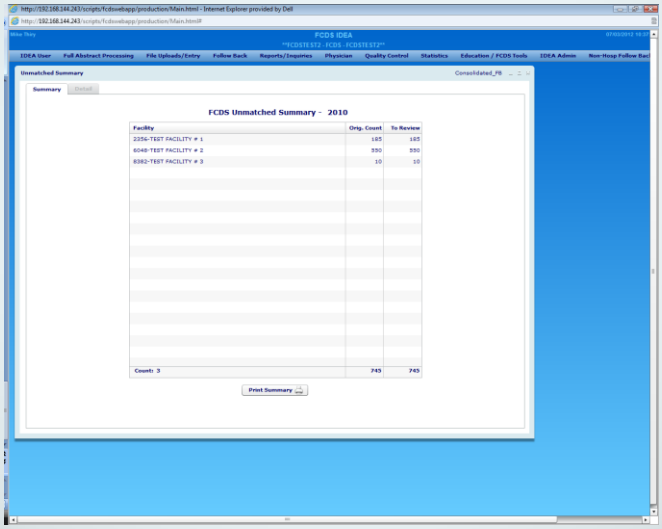
- Deadline
  - New single processing deadline for AHCA, AMBI and Death Clearance
  - July 15 to October 15 each year

- Combined Follow Back Display
  - Single line for each patient even if multiple items exist (AHCA, AMBI and Death Clearance)
  - Facilities work each patient once even if multiple items exist

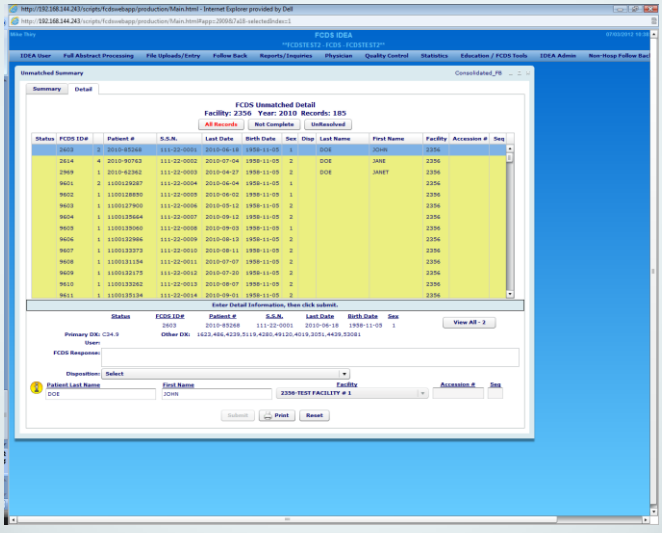
Consolidated Follow Back



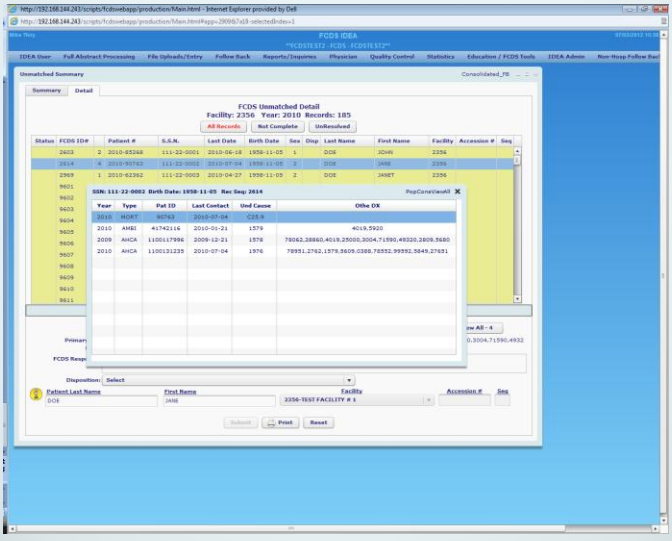
Consolidated Follow Back



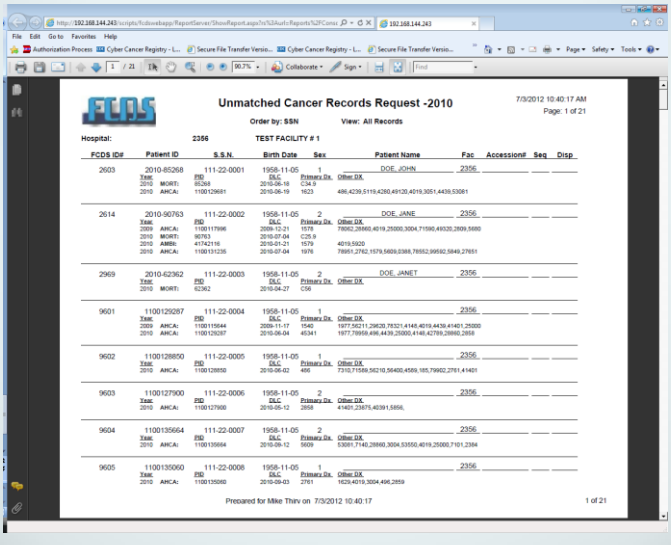
Consolidated Follow Back



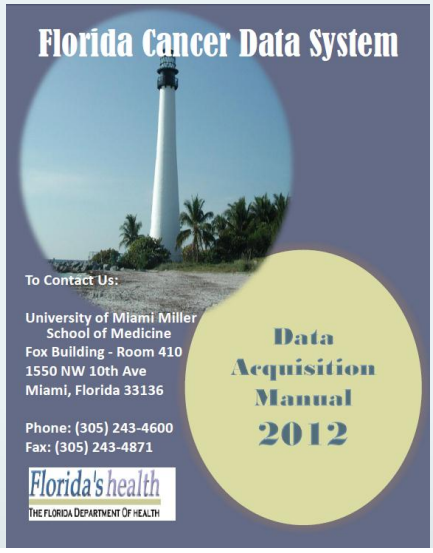
Consolidated Follow Back



Consolidated Follow Back



ALL Covered in 2012 DAM



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New FCDS EDITS Metafile

- FCDS EDITS Metafile v12.2B
- Excel File of EDITS Changes by date
- Master List of FCDS EDITS Messages

FCDS_modifications_May_31_2012_To_Post.xlsx [Read-Only] - Microsoft

	A	B	C	D	E
1	Metafile Version	Modification Date	Edit	Edit Name	Comments
2					yellow = new and changed edits
3					orange = SSFs defaulted by FCDS
4					green = deleted
5	12.2B	05/31/12			Reserved 00 [37] changed from 13 to 14 characters
6	12.2B	05/31/12			FIN Coding System [35] deleted from record layout since it has been retired
7	12.2B	05/31/12		_Verify CStage Version 0203xx (NAACCR)	DELETED
8	12.2B	05/31/12	1269	Casefinding Source (NAACCR)	Added to both edit sets
9	12.2B	05/31/12		CS Extension, KidneyRenalPelvis Schema (CS)	Fixed typos in Administrative Notes
10	12.2B	05/31/12	1270	CS Extension, Primary Site, Behavior ICDO3 (CS)	Added: If schema = MelanomaConjunctiva and CS Extension = 100 or 120, then Behavior Code ICD-O-3 must = 2 or 3.
11	12.2B	05/31/12	1301	CS Extension, SSF 1, MelanomaSkin Schema (FCDS)	New edit added to both edit sets
12	12.2B	05/31/12		CS Items - NPCR Required - SSF 16 (CS)	CS versioning updated to work for CSv02.04.
13	12.2B	05/31/12		CS Items - SEER/COC Required - SSF 1 (CS)	CS versioning updated to work for CSv02.04.
14	12.2B	05/31/12		CS Items - SEER/COC Required - SSF 2 (CS)	CS versioning updated to work for CSv02.04. Edit logic corrected: two brackets removed so that pre-2010 cases originally entered in CSv01 and updated to CSv02 will correctly fail for a code of 988.
15	12.2B	05/31/12		CS Items - SEER/COC Required - SSF 3 (CS)	CS versioning updated to work for CSv02.04.
16	12.2B	05/31/12		CS Items - SEER/COC Required - SSF 4 (FCDS)	CS versioning updated to work for CSv02.04. Edit logic corrected: two brackets removed so that pre-2010 cases originally entered in CSv01 and updated to CSv02 will correctly fail for a code of 988.
17	12.2B	05/31/12		CS Items - SEER/COC Required - SSF 5 (FCDS)	Deleted from edit sets - FCDS version added for 2011 to enforce additional CER requirements is no longer needed.
18	12.2B	05/31/12		CS Items - SEER/COC Required - SSF 5 (CS)	CS versioning updated to work for CSv02.04. Added to both edit sets.
19	12.2B	05/31/12		CS Items - SEER/COC Required - SSF 6 (CS)	CS versioning updated to work for CSv02.04.
20	12.2B	05/31/12		CS Items - SEER/COC Required - SSF 7 (FCDS)	Deleted from edit sets - FCDS version added for 2011 to enforce additional CER requirements is no longer needed.

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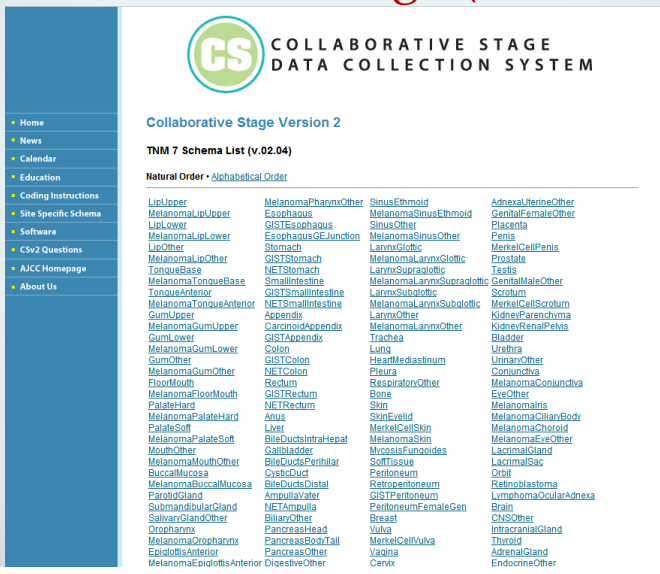
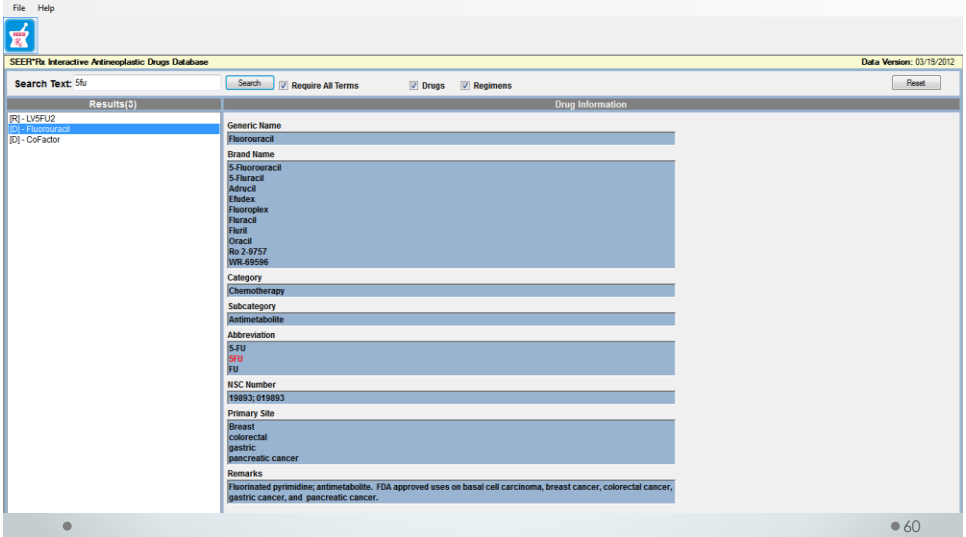
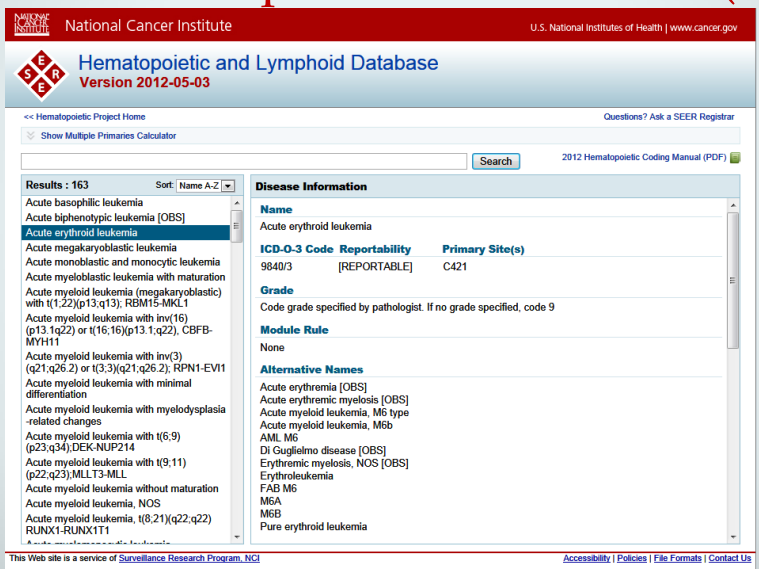
Collaborative Stage (CS v02.04)



2012 SEER*Rx (v2.0.1)



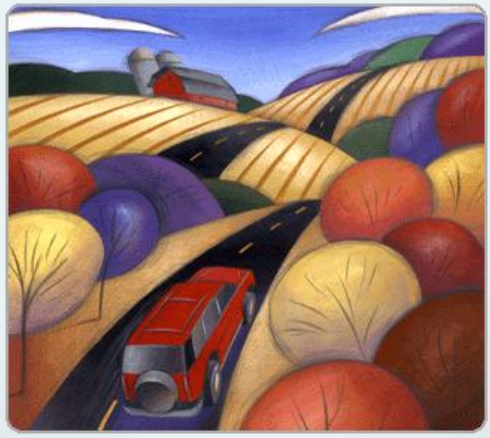
2012 Hematopoietic Rules & DB (v2.1)



Timeline

- FCDS will accept **v12.1 through August 31, 2012**
- FCDS will begin accepting **v12.2 early July 2012**
- **FCDS will no longer accept v12.1 on September 1**
- FCDS will not accept converted CSv02.03 cases
- ICD-10-CM Implementation has been delayed
  - New Implementation Date is fluid (changes)

FCDS Quality Improvement & Education/Training Program



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FCDS Quality Improvement Pyramid

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Communication is the Foundation

- Technical Answers by Telephone or E-mail
  - Many Q&A are added to Monthly Memo for all to learn
- Email (E-Mail Blast for Urgent or Timely Information)
- Email (individual – if you are in trouble or have to do something in FCDS IDEA (QC Review, Edits/Corrections, Documentation)
- RECAP – FCDS Primary Tool for Data Processing
- FCDS Monthly Memo
- The Register – FCDS' Quarterly Newsletter
- FCDS Annual Meeting
- FCDS Web Broadcasts and On-Line Abstractor Training Course

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FCDS QC Program Components

The FCDS Abstractor Code – A National Model for QC

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FCDS QC Program Components

FCDS EDITS Metafile and EDITS PASS Requirement

FCDS transitioned from an Oracle-based edits program written by FCDS contractors to the National Standard EDITS Metafile in September 2010.

Standard EDITS include Field-Item, Inter-Item and Intra-Item Edits

- Edits validate codes, crosscheck relationships between data items (male with prostate cancer) and checks for blank fields.
- The FCDS EDITS Metafile was created for Florida, specifically to accommodate the reporting of historical cases among other FCDS special coding requirements
- FCDS has also included edits in the metafile for common abstracting errors identified through re-abstracting audits.

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FCDS QC Program Components

QC Visual Review - Every 25th Record – Minimum

GOAL: Evaluate whether or not the case makes sense as coded or is something missing or unusual that edits would not catch. Does the case make sense as coded or is something missing or "off" with case as coded.

- **The QC Abstract Review Process is a 3-step process - fully automated**
  - **Step 1: initial review**
  - **Step 2: feedback to/from the registrar with opportunity to defend coding**
  - **Step 3: third party mediation to assess the first reviewer's findings and the facility's comments, corrections, or feedback and come to a final determination on the case**
- **Records with discrepant data must be resolved by the reporting facilities.**
- **"Agree", "OK", "Done" are NOT Acceptable Responses to Inquiries**

Note: By selecting one of every 25th record processed, FCDS visually edits a minimum of 4% of records each year (around 7,000 cases). Other cases that are visually edited include records evaluated as possible FORCES, Corrections, Duplicates and records reviewed as part of a Special Study (an additional 5% of cases or about 9,000 cases).

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FCDS QC Program Components

FCDS/AHCA Casefinding Audits

- AHCA is the Agency for Health Care Administration with a primary function of tracking ALL patient encounters (diagnosis, treatment, billing, etc. for nearly all healthcare facilities in the state of Florida
- ANNUAL Match the FCDS Master File to the Florida AHCA files for both inpatient and outpatient/ambulatory patient encounters.
- FCDS provided reporting facility with a list of Unmatched AHCA Cases (cases that appear in the AHCA files but have no matching record in the FCDS Master File) available on the FCDS website.
- Facilities must explain why they did not report the case – or must report the case as a "late report".

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FCDS QC Program Components

FCDS/Death Clearance

- Many registrars do not recognize this as an audit, but it is. The Florida Bureau of Vital Statistics tracks every birth and death in the state of Florida and has for many years.
- FCDS Conducts an ANNUAL matching of the entire FCDS Masterfile (3.5 million records) to the annual Vital Statistics Listing
- Any records found not to match the FCDS Masterfile but having died in a hospital are followed back to the hospital to determine why the hospital did not submit the case. If the case was missed it is abstracted as a "late report".

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FCDS QC Program Components

On-Site Casefinding Audits

- QC staff will periodically perform on-site review of casefinding procedures by auditing the casefinding sources within each facility. (AHCA has basically replaced this audit)
- If any case is found to meet the cancer reporting requirements outlined in Section I, the case must be abstracted and reported to FCDS.
- For any case found that does not meet the cancer reporting requirements outlined in Section I, an explanation must be submitted to FCDS detailing the reason it will not be reported.

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FCDS QC Program Components

On-Site Re-abstracting Audits

- The FCDS Quality Control staff and/or outside contract agents working on behalf of FCDS perform on-site review of abstracting procedures by reviewing paper and/or electronic medical records and clinic visits of cases previously submitted to FCDS.
- Field re-abstract audits allow evaluation of degree of standardized interpretation of data definitions, coding rules and guidelines, policies and procedures and serve to identify areas that may require further education and training
- Reconciliation of Re-abstracting Audit Inconsistencies between original data and audited data is an Important Component: Key data items are evaluated and any discrepancy noted between the auditor's findings and the original abstract findings are returned to the facility for reconciliation. If the auditor's findings are disputed, documentation must be submitted to clarify the originally abstracted codes. A third party reconciles the discrepant data based on the information provided.

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FCDS Education and Training

- **New Registrar Recruitment**
- **Instruction:** FCDS/National Coding Rules and Guidelines
- **Instruction:** FCDS/National Policy/Procedures
- **Re-Instruction:** Existing Rules/Procedures – **Correct Problems**
- **Instruction:** Changes To / New Rules/Procedures
- **Continuing Education – Increase Knowledge Base**
- **Retention of Qualified Staff**

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FCDS Education and Training

- On-Line Abstracting Course for New Registrars
- Obtaining an FCDS Abstractor Code
- 2-Day FCRA Annual Conference
- 2-Day FCDS Annual Conference
- 6-8 FCDS Annual Webcast Series
- 12 NAACCR Hosted Annual Webinar Series
- Ad Hoc Webcasts for New Programs/Policy/Procedure/etc
- Monthly In-Services – Cancer Registry Principles & Practices
- Monthly FCDS EDITS – Review FCDS and National EDITS
- Personalized Instruction

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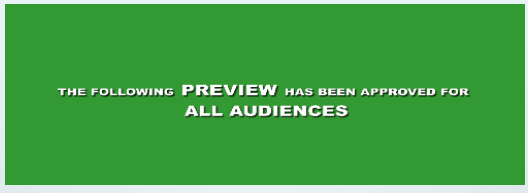
Tentative 2012 FCDS Webcast Series – 3rd Thursday from 1pm-3pm	
August 16, 2012	What's New for 2012 and More – Annual Meeting Review
September 20, 2012	FCDS Abstractor Code: 2012 Testing and Maintenance Requirements for All New and Current Florida Abstractors
October 18, 2012	GYN Neoplasms – Background/Anatomy/Risk Factors/MPH Rules/CSv02.04/Site Specific Factors and Treatment
November 15, 2012	Improving Data Quality Using FCDS Data Quality Reports
December 2012	Break
January 17, 2013	Pediatric Neoplasms: Background/Anatomy/Risk Factors/MPH Rules/CSv02.04/Site Specific Factors and Treatment
February 21, 2013	Genitourinary Neoplasms: Background/Anatomy/Risk Factors/MPH Rules/CSv02.04/Site Specific Factors and Treatment

Coming Soon !!!

- ICD-O-3 Updates
- New National and FCDS EDITS
- Updated MPH Rules for Solid Tumors
- CS Evaluate and Simplify Work Group (CS EaS-WG)
- CS Lite – Proposal to "Prune" CS Core and SSFs



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Questions ???