FCDS Florida Cancer Data System

Florida Statewide Cancer Registry

2014 Reporting Requirements
2014 FCDS Annual Meeting Highlights

Florida HEALTH

2014-2015 FCDS Webcast Series

Steven Peace, CTR

August 21, 2014

NPCR NATIONAL PROGRAM OF CANCER REGISTRIES

SYLVESTER COMPREHENSIVE CANCER CENTER
UNIVERSITY OF MIAMI HEALTH SYSTEM

MILLER SCHOOL OF MEDICINE
UNIVERSITY OF MIAMI

2014 FCDS Annual Conference – Recordings & Handouts

http://fcds.med.miami.edu/inc/educationtraining.shtml

Day 1

- All the Slides/Handouts/PDFs from the Annual Meeting in one zip file
- Agenda
- Welcome to the FCDS Annual Meeting
- FCDS Updates - State of the State, Dr. Jill MacKinnon, Slides, Recording
- Cancer Data Uses and Dissemination, Joseph Lowry, MPH, Slides, Recording
- Individual and Neighborhood-Level Predictors of Mortality in Florida Colorectal Cancer Patients, Dr. David Lee, Slides, Recording
- Patterns of Care - Initial Assessment of Adherence to Evidence-Based Cancer Treatment Guidelines - Colon, Dr. Monique Hernandez and Judy Bonner, MSN, CTR, Slides, Recording
- SART Data Linkage, Brad Wohler, Slides, Recording
- Highlights from the NAACCR 2014 Annual Conference, Dr. Jill MacKinnon, Slides, Recording
- Update on Meaningful Use Stage II and CDA Validation, Dr. Monique Hernandez, Slides, Recording
- Data Acquisition Update, Mike Thiry, Slides, Recording
- Transition from CSv2 to Direct-Coded TNM and Summary Stage, Dr. Jill MacKinnon, Recording only, no slides with this session
- 2014 Reporting Requirements - 2014 FCDS DAM Highlights, Steve Peace, Slides, Recording
- 2014-2015 FCDS Education and Training Plan, Steve Peace, Slides, Recording
- Physician Claims and Treatment Data Validation Study, Dr. Monique Hernandez, Slides, Recording
- Introducing the FCDS IDEA Follow-Up System, Gary Levin, Kelly King, CTR, Cleveland Clinic, Sara Holton, CTR, Mayo Clinic, Slides, Slides (Sara Holton), Recording
- 2014 FCDS Data Validation Audit - 2012 Dx, Steve Peace, Slides, Recording
- Jean Byers Award Presentation, Mike Thiry, Slides, Recording
- The FCDS Annual Meeting of the Future and Round Table Discussion, Dr. Jill MacKinnon, Slides, Recording

Day 2

- 2013 FCDS QC Activities Summary, Steve Peace, Slides, Recording
- 2014 Grade Coding Instructions and ICD-O-3 Updates, Steve Peace, Slides, Recording
- 2014 Hematopoietic Rules and Data Base Updates, Steve Peace, Slides, Recording
- Coding Instructions for Surgery Fields Including Scope Reg LN, Steve Peace, Slides, Recording
- Recurring Issues and Problem Areas for Florida Registrars, Steve Peace, Slides, Recording
- Recent Developments in Cancer Diagnosis and Treatment, Steve Peace, Slides, Recording

Handouts

- Cancer Surveillance Community TimelineAs of June 9, 2014
- Collaborative Stage Data Collection System Coding instructions
- Installation Instructions Collaborative Stage Coding Instructions v02.05
- Free TNM 7th Edition Webinar Series Recordings and Other Resources
- FCDS Data Quality Indicator Report
- Guidelines for ICD-O-3 update implementation Effective January 1, 2014
- Users Guide for NCI's Online Hematopoietic and Lymphoid Database
- Instructions for Coding Grade for 2014+
- FCDS DAM LVI Errata
- Scope of Regional Lymph Node Surgery: A review of Data Validity, Revised Coding Directives, and Agency Transition Plans

State of the State
Florida Cancer Data System
2013-2014

Jill A. MacKinnon, PhD, CTR
Epidemiologist and Project Director

Certification

- Florida is NAACCR Gold Certified for the 11th consecutive year
  - Confers assurance of data completeness and quality
  - A central registry meets or exceeds the minimum data quality standard as established by the Cancer Surveillance Community

Cancer Data Uses and Dissemination

Joseph Lowry, MPH
Chronic Disease Epidemiologist
Bureau of Epidemiology
Florida Department of Health

July 24, 2014

Presentation Outline

- Introduction
- Florida Cervical Cancer Special Topic Report
- Female Breast Cancer in Florida, 2010
- Late-Stage Breast and Colorectal Cancer Maps

The Role of Socioeconomic Status and Colorectal Cancer Risk in Florida

DJ Lee, R Sherman, M Hernandez, J MacKinnon and many others!

Characterize communities at risk for late-stage CRC

Evaluate demographic & screening correlates that predict a case being diagnosed in a cluster (1996-2010 cases)

- Individual-level Predictors:
  - Age, sex, insurance type from registry data
- Tract-level Predictors:
  - American Community Survey (06-10)
  - Poverty, education, language, nativity, racial/ethnic segregation
- County-level Predictors:
  - BRFSS (2010)
    - Screening FOBT, sig/colonoscopy

SES Predictors of CRC Mortality

Data linkage study with FDCS, ACHA, and Census information

- ~48,000 CRC cases diagnosed between 2007-2011
- Cox hazard regression models were fitted with candidate predictors of CRC survival and stratified by age group (18-49, 50-64, 65+)

Next Steps

National Cancer Institute
U.S. National Institutes of Health | www.cancer.gov

- NCHS Report in press
- Need to create an infrastructure leading to a national consortium
- Just obtained NCI funding to support these efforts

Estimated Cases from Nationwide linkage	
Cancer Diagnosed Prior to NHIS Interview (Prevalent Cases)	Cancer Diagnosed Subsequent to NHIS Interview (Incident Cases)
6,167	15,767
6,550	16,567
1,533	15,000
3,717	11,300
1,900	5267
28,000	**96,717**

Patterns of Care in Colon Cancer (2010-2012)

Florida Cancer Data Compliance with NCCN Guidelines

FCDS Annual Meeting
July 24-25, 2014
Caribe Royale Resort
Orlando, Florida

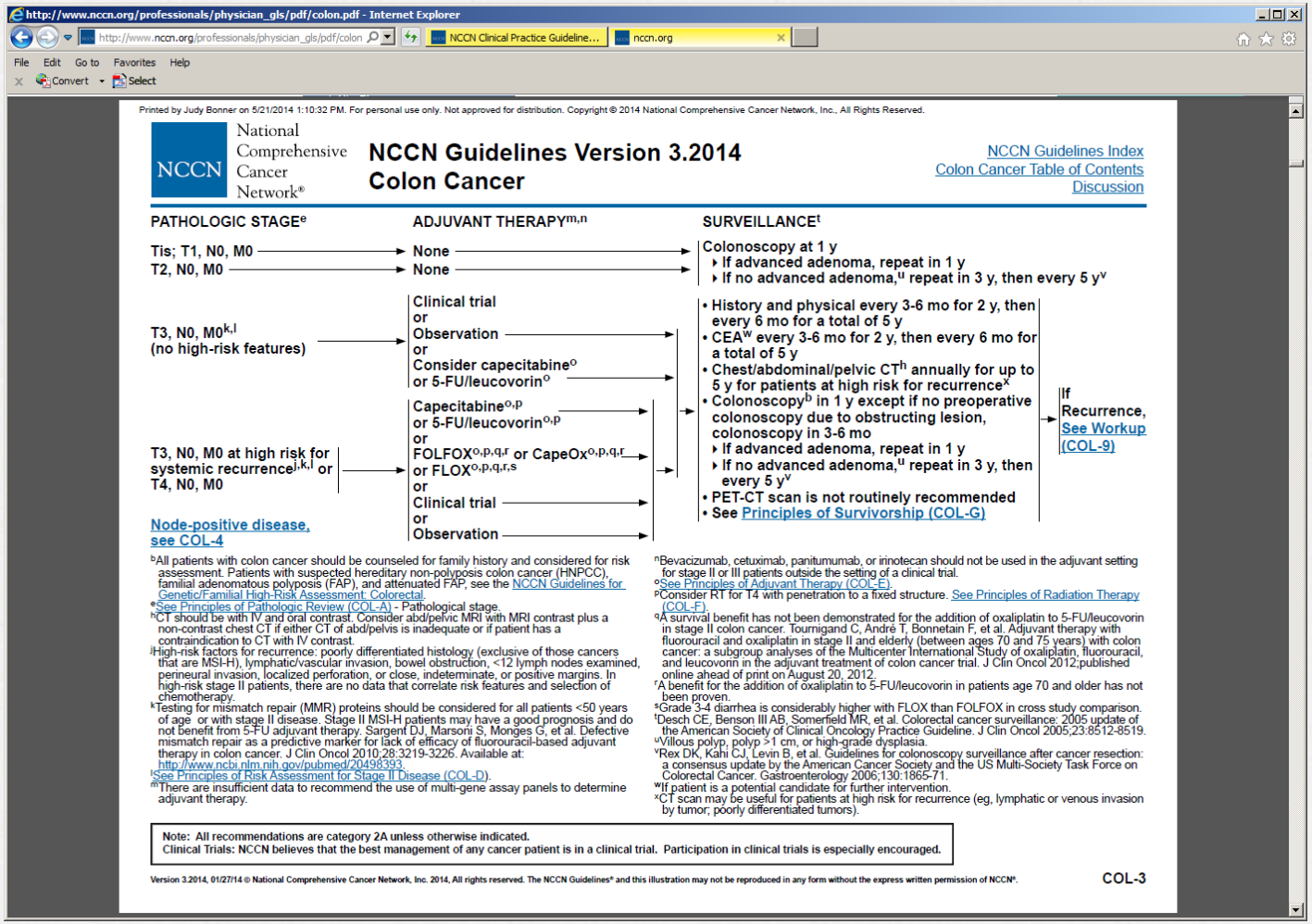
Goals

- Capture baseline treatment patterns for colon cancer from FCDS data
- Analyze treatment delivered to assess compliance with NCCN guidelines
- Describe treatment by demographic and comorbid status
- Identify areas for targeted quality control review

Methods

- Select 2010, 2011, and 2012 colon cancer cases in FCDS database using defined inclusion criteria
- Separate cases by AJCC group stage
- Analyze each stage group's cases according to recommended treatment for that stage as defined by NCCN guidelines
- Treatments reviewed included surgery, chemotherapy, and radiation
- Elixhauser comorbidity index created from AHCA
- *Computer algorithm developed to process cases*

Methods



http://www.nccn.org/professionals/physician_gls/pdf/colon.pdf - Internet Explorer

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National Comprehensive Cancer Network®

NCCN Guidelines Version 3.2014
Colon Cancer

NCCN Guidelines Index
Colon Cancer Table of Contents
Discussion

PATHOLOGIC STAGE[e]	ADJUVANT THERAPY[m,n]	SURVEILLANCE[t]
Tis; T1, N0, M0	None	Colonoscopy at 1 y ▸ If advanced adenoma, repeat in 1 y ▸ If no advanced adenoma,[u] repeat in 3 y, then every 5 y[v]
T2, N0, M0	None	
T3, N0, M0[k,l] (no high-risk features)	Clinical trial or Observation or Consider capecitabine[o] or 5-FU/leucovorin[o]	• History and physical every 3-6 mo for 2 y, then every 6 mo for a total of 5 y • CEA[w] every 3-6 mo for 2 y, then every 6 mo for a total of 5 y • Chest/abdominal/pelvic CT[h] annually for up to 5 y for patients at high risk for recurrence[x] • Colonoscopy[b] in 1 y except if no preoperative colonoscopy due to obstructing lesion, colonoscopy in 3-6 mo ▸ If advanced adenoma, repeat in 1 y ▸ If no advanced adenoma,[u] repeat in 3 y, then every 5 y[v] • PET-CT scan is not routinely recommended • See Principles of Survivorship (COL-G)
T3, N0, M0 at high risk for systemic recurrence[j,k,l] or T4, N0, M0	Capecitabine[o,p] or 5-FU/leucovorin[o,p] or FOLFOX[o,p,q,r] or CapeOx[o,p,q,r] or FLOX[o,p,q,r,s] or Clinical trial or Observation	
Node-positive disease, see COL-4		If Recurrence, See Workup (COL-9)

[b] All patients with colon cancer should be counseled for family history and considered for risk assessment. Patients with suspected hereditary non-polyposis colon cancer (HNPCC), familial adenomatous polyposis (FAP), and attenuated FAP, see the NCCN Guidelines for Genetic/Familial High-Risk Assessment: Colorectal.

[e] See Principles of Pathologic Review (COL-A) - Pathological stage.

[h] CT should be with IV and oral contrast. Consider abd/pelvic MRI with MRI contrast plus a non-contrast chest CT if either CT of abd/pelvis is inadequate or if patient has a contraindication to CT with IV contrast.

[j] High-risk factors for recurrence: poorly differentiated histology (exclusive of those cancers that are MSI-H), lymphatic/vascular invasion, bowel obstruction, <12 lymph nodes examined, perineural invasion, localized perforation, or close, indeterminate, or positive margins. In high-risk stage II patients, there are no data that correlate risk features and selection of chemotherapy.

[k] Testing for mismatch repair (MMR) proteins should be considered for all patients <50 years of age or with stage II disease. Stage II MSI-H patients may have a good prognosis and do not benefit from 5-FU adjuvant therapy. Sargent DJ, Marsoni S, Monges G, et al. Defective mismatch repair as a predictive marker for lack of efficacy of fluorouracil-based adjuvant therapy in colon cancer. J Clin Oncol 2010;28:3219-3226. Available at: http://www.ncbi.nlm.nih.gov/pubmed/20498393.

[l] See Principles of Risk Assessment for Stage II Disease (COL-D).

[m] There are insufficient data to recommend the use of multi-gene assay panels to determine adjuvant therapy.

[n] Bevacizumab, cetuximab, panitumumab, or irinotecan should not be used in the adjuvant setting for stage II or III patients outside the setting of a clinical trial.

[o] See Principles of Adjuvant Therapy (COL-E).

[p] Consider RT for T4 with penetration to a fixed structure. See Principles of Radiation Therapy (COL-F).

[q] A survival benefit has not been demonstrated for the addition of oxaliplatin to 5-FU/leucovorin in stage II colon cancer. Tournigand C, André T, Bonnetain F, et al. Adjuvant therapy with fluorouracil and oxaliplatin in stage II and elderly (between ages 70 and 75 years) with colon cancer: a subgroup analyses of the Multicenter International Study of oxaliplatin, fluorouracil, and leucovorin in the adjuvant treatment of colon cancer trial. J Clin Oncol 2012;published online ahead of print on August 20, 2012.

[r] A benefit for the addition of oxaliplatin to 5-FU/leucovorin in patients age 70 and older has not been proven.

[s] Grade 3-4 diarrhea is considerably higher with FLOX than FOLFOX in cross study comparison.

[t] Desch CE, Benson III AB, Somerfield MR, et al. Colorectal cancer surveillance: 2005 update of the American Society of Clinical Oncology Practice Guideline. J Clin Oncol 2005;23:8512-8519.

[u] Villous polyp, polyp >1 cm, or high-grade dysplasia.

[v] Rex DK, Kahi CJ, Levin B, et al. Guidelines for colonoscopy surveillance after cancer resection: a consensus update by the American Cancer Society and the US Multi-Society Task Force on Colorectal Cancer. Gastroenterology 2006;130:1865-71.

[w] If patient is a potential candidate for further intervention.

[x] CT scan may be useful for patients at high risk for recurrence (eg, lymphatic or venous invasion by tumor; poorly differentiated tumors).

Note: All recommendations are category 2A unless otherwise indicated.
Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.

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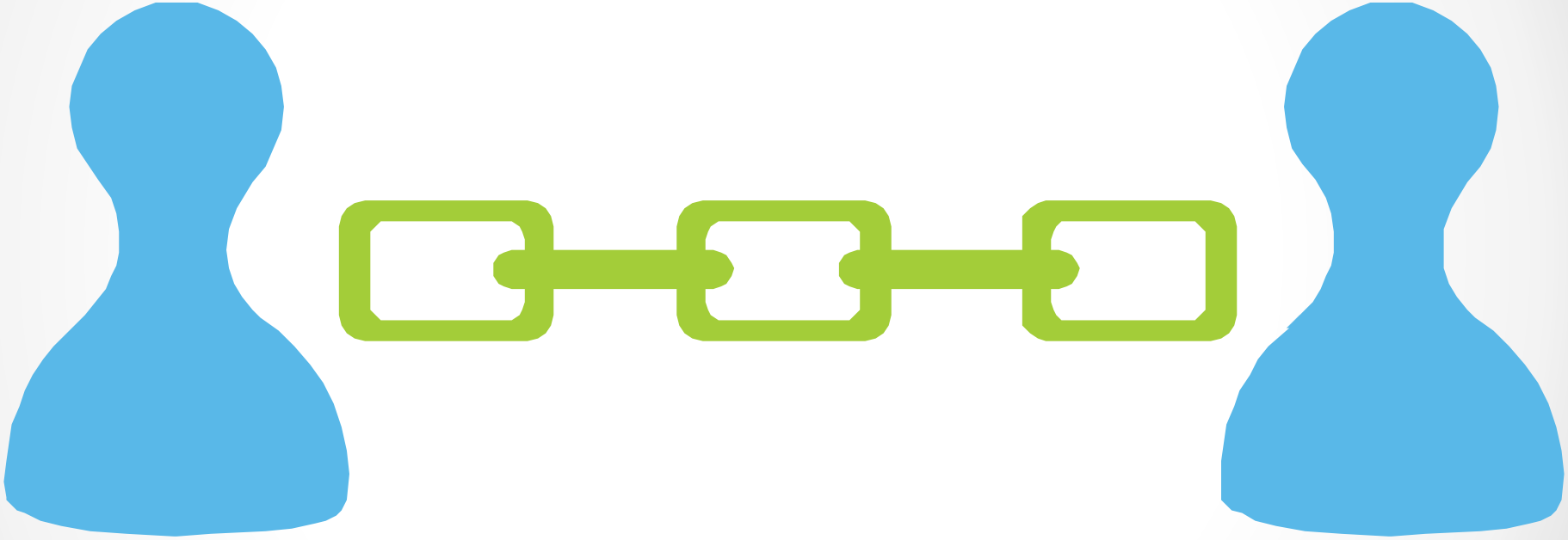
Methods

COLON CANCER	T1, N0 Stage I	T2, N0 Stage I	T3, N0 Stage IIA (no high risk features)	T3, N0 Stage IIA (high risk)	T4, N0 Stage IIB,C	N1-2-any T Stage III	M1-any T,N Stage IV	Advanced Disease
Surgery								
Polypectomy								
Resection w/nodes	X	X	X	X	X	X		
Resection liver/lung mets							X	
Neoadjuvant Therapy								
NeoAdjv Chemo					X		X	
NeoAdjv XRT					X			
NeoAdjv Other								
NO ADJUVANT THERAPY	X	X						
Adjuvant Chemotherapy (see preferred chemotherapy regimens sheet)			CONSIDER capecitabine or 5FU/lcv	X or Clinical Trial or Observation	X or Clinical Trial or Observation	X	X	X
Adjuvant BRM (cetuximab) -- panitumumab is classified as chemotx								
Adjuvant Radiation Therapy					consider		consider	

Summary

- Compliance with NCCN guidelines varied by stage
- Compliance affected by multiple factors
- Results are impacted by data capture limits
- Future work could use NCCN guidelines as the basis for quality control studies
- Future analysis to include physician reported cases for comparative analysis

Record Linkage



FCDS Annual Meeting

Orlando, FL 2014

Record Linkage

- **Refers to:**
  - Task of finding records in a data set that refer to the same entity across different data sources.
    - Example: Admissions & Path report @ hospital
    - Example: Cancer Abstract & Death certificate @state registry
  - Joining datasets based on entities that may or may not share a common identifier.
    - Example: @State Registry: SSN

Notable Linkages

- World Trade Center Health Registry Linkage
  - 3 linkages so far since 2008
- Cancer Risk among Firefighters and Emergency Service Rescuers and Officers Exposed to the World Trade Center Disaster
  - 2 linkages to date since 2010
- Cancer in WTC Responders participating in the WTC Medical Monitoring and Treatment Program
  - 1 linkage to date since 2011
- Camp Lejeune Health Survey
  - Assess whether there is an association between exposure to contaminated water at Camp Lejeune and cancer and other specified health conditions
  - 1 linkage to date since 2013

Notable Linkages

- **Cancer Epidemiology in Adventists**
  - Cohort of 96,000 participants to address broad question of dietary factors that reduce or increase the risk of common cancers.
  - 2 linkages to date since 2011
- **Infertility Follow-up study**
  - Follow-up on cohort of 12,000+ women to assess cancer risk in relation to causes of infertility and therapeutic regimens used to treat these causes
  - 1 linkage to date since 2011
- **Black Women's Health Study**
  - Evaluate causes and preventives of cancers and other serious illnesses in African-American women
  - 5 Linkages to date since 2005
- **HIV/AIDS registry match**
  - 2 linkages since 2001

Conclusion

- Good demographics vital
  - ⇧ reliability of match
  - ⇩ time involved
- Affects quality of match
  - Outside
  - Internal
- Linkages are vital in studying cancer etiology
- ⇩ $

HIGHLIGHTS FROM THE NAACCR 2014 ANNUAL MEETING

Jill A. MacKinnon, PhD, CTR
Epidemiologist and Project Director, FCDS
NAACCR President

NAACCR 2014

- Ottawa, Ontario, Canada

- Conjoined the meetings of the North American Association of Central Cancer Registries (NAACCR) and the International Association of Cancer Registries (IACR).

NAACCR 2014

- Conference theme, ***Capitalizing on Cancer Surveillance Data for Improved Cancer Control***, was shared by both conferences

- This unique educational opportunity provided amazing educational opportunities to learn from local, national, and international experts in cancer surveillance, cancer registry operations, analytical methods, research, and novel ways to use data for cancer control

Meaningful Use Cancer Reporting

FCDS Annual Meeting

Orlando, Florida

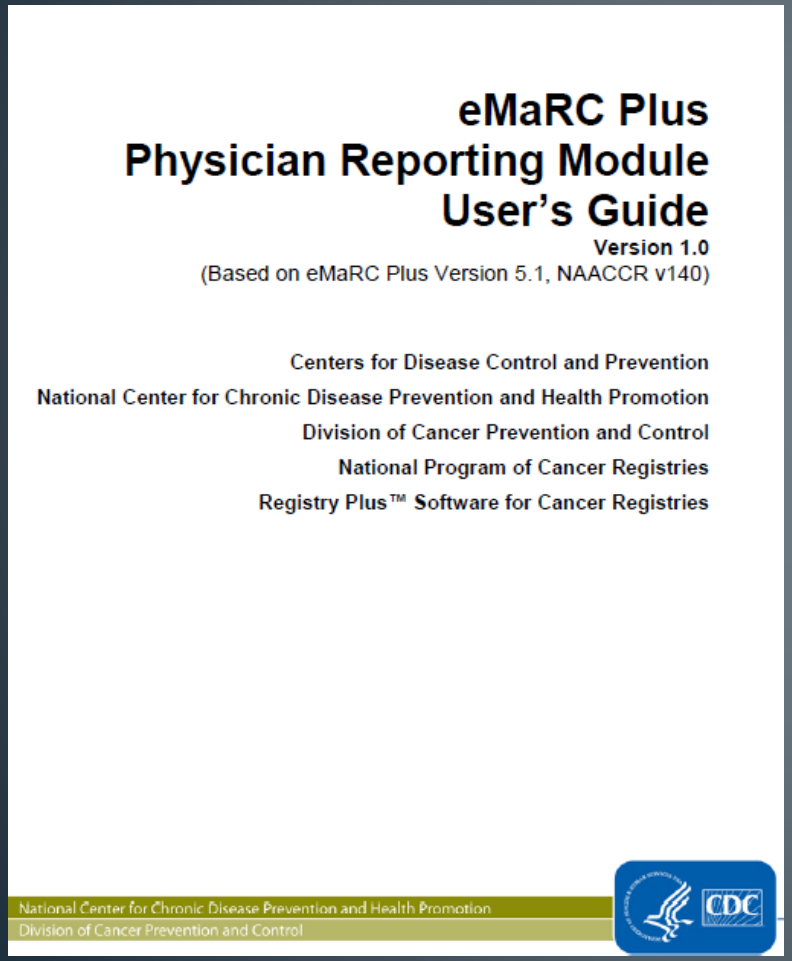
July 24-25th, 2014

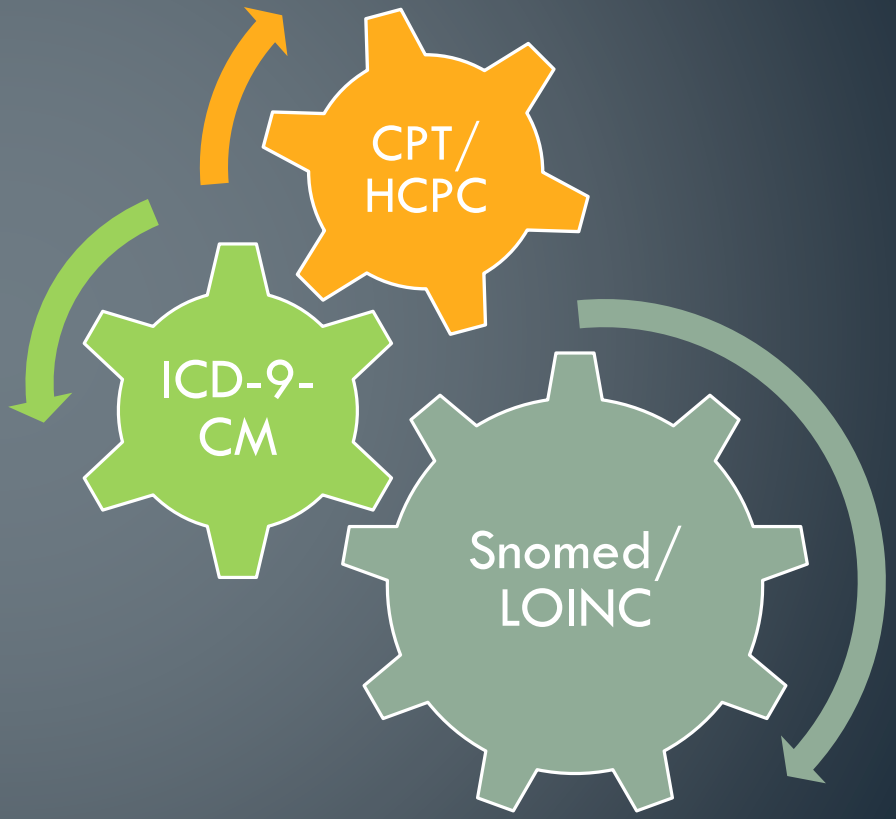
What is Meaningful Use?

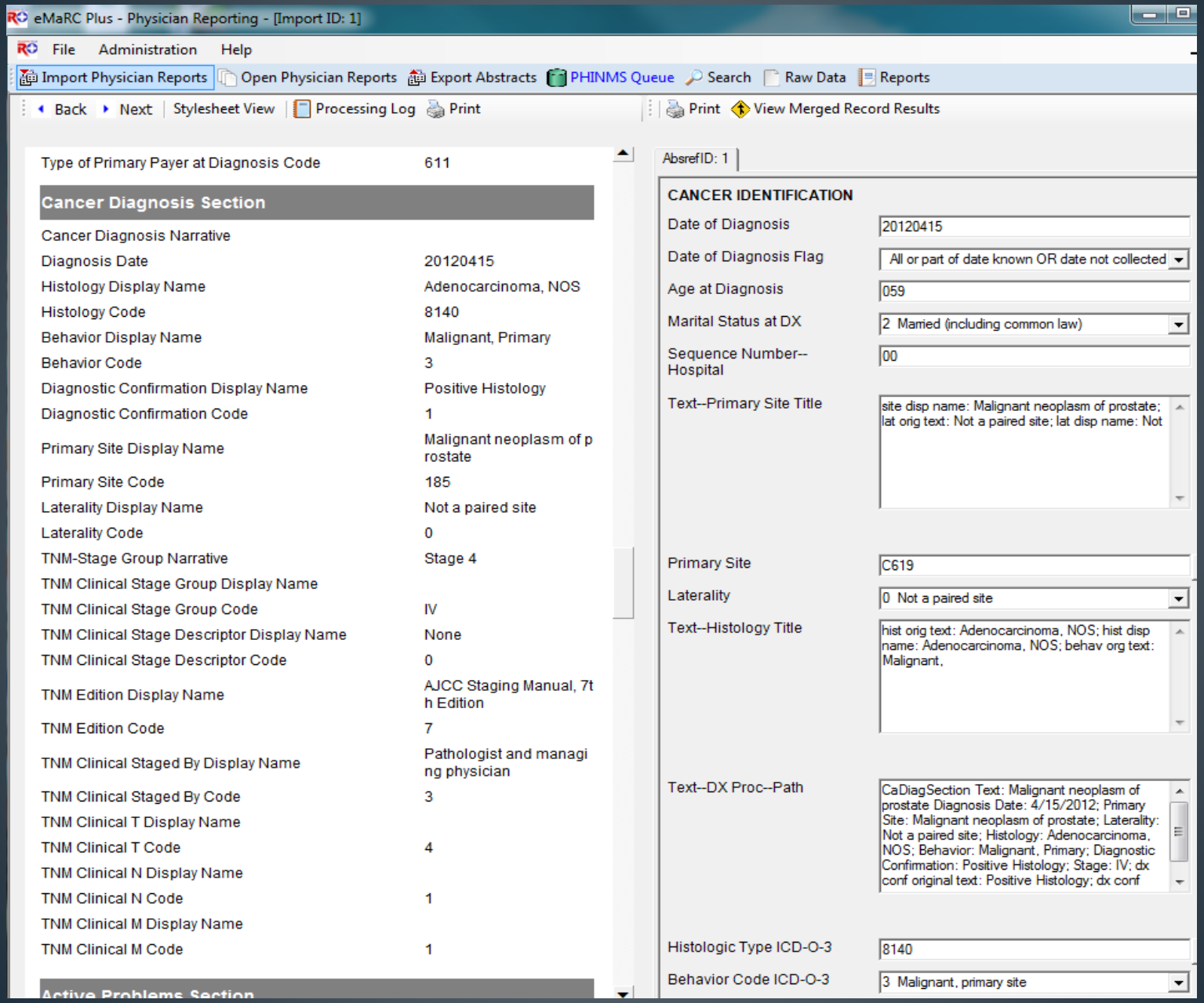
- Meaningful Use (MU) is a program through the Centers for Medicare and Medicaid Services (CMS) that provides incentives ($) to healthcare providers who use electronic health record (EHR) technology in a specific and ‘meaningful’ way.

- Goal is to improve healthcare in the U.S.

How does the CDA get processed?



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Administration
Help
Import Physician Reports
Open Physician Reports
Export Abstracts
PHINMS Queue
Search
Raw Data
Reports
Back
Next
Stylesheet View
Processing Log
Print
Print
View Merged Record Results
Type of Primary Payer at Diagnosis Code 611
Cancer Diagnosis Section
Cancer Diagnosis Narrative
Diagnosis Date 20120415
Histology Display Name Adenocarcinoma, NOS
Histology Code 8140
Behavior Display Name Malignant, Primary
Behavior Code 3
Diagnostic Confirmation Display Name Positive Histology
Diagnostic Confirmation Code 1
Primary Site Display Name Malignant neoplasm of prostate
Primary Site Code 185
Laterality Display Name Not a paired site
Laterality Code 0
TNM-Stage Group Narrative Stage 4
TNM Clinical Stage Group Display Name
TNM Clinical Stage Group Code IV
TNM Clinical Stage Descriptor Display Name None
TNM Clinical Stage Descriptor Code 0
TNM Edition Display Name AJCC Staging Manual, 7th Edition
TNM Edition Code 7
TNM Clinical Staged By Display Name Pathologist and managing physician
TNM Clinical Staged By Code 3
TNM Clinical T Display Name
TNM Clinical T Code 4
TNM Clinical N Display Name
TNM Clinical N Code 1
TNM Clinical M Display Name
TNM Clinical M Code 1
Active Problems Section
AbsrefID: 1
CANCER IDENTIFICATION
Date of Diagnosis 20120415
Date of Diagnosis Flag All or part of date known OR date not collected
Age at Diagnosis 059
Marital Status at DX 2 Married (including common law)
Sequence Number--Hospital 00
Text--Primary Site Title site disp name: Malignant neoplasm of prostate; lat orig text: Not a paired site; lat disp name: Not
Primary Site C619
Laterality 0 Not a paired site
Text--Histology Title hist orig text: Adenocarcinoma, NOS; hist disp name: Adenocarcinoma, NOS; behav org text: Malignant,
Text--DX Proc--Path CaDiagSection Text: Malignant neoplasm of prostate Diagnosis Date: 4/15/2012; Primary Site: Malignant neoplasm of prostate; Laterality: Not a paired site; Histology: Adenocarcinoma, NOS; Behavior: Malignant, Primary; Diagnostic Confirmation: Positive Histology; Stage: IV; dx conf original text: Positive Histology; dx conf
Histologic Type ICD-O-3 8140
Behavior Code ICD-O-3 3 Malignant, primary site

Data Acquisition Update

FCDS Annual Meeting

July 24 and 25

Data Acquisition Update

- Facility Reporting Counts
- Physician Registration Counts
- Physician Reporting
  - Dermatology Cases Reported
  - Insurance Claims Received
- Facility Reporting
  - Abstracts Received
  - 5 year Review
    - Abstracts received at deadline vs. one year late
- IDEA Batch Receipt for Single Entry - Enhancement

Facility Reporting Counts

- As of July 1, 2014
  - Hospitals 245
  - Radiation Treatment Centers 140
  - Surgery Centers 473
- Net growth since July 2013
  - Hospitals +1
  - Radiation Treatment Centers +4
  - Surgery Centers +44

Scope of Reporting Delay

	Deadline	1 Year Later
• 2009 Data (6/2010)	166,303	185,703
• 2010 Data (6/2011)	136,610	174,701
• 2011 Data (6/2012)	149,368	185,969
• 2012 Data (6/2013)	165,991	189,693
• 2013 Data (6/2014)	171,179	TBD

- Average 29K cases up to one year late…..

Physician Registration Counts

- Registered as of July 1, 2014
  - HEMA/ONC 491
  - Hematology 14
  - Oncologists 160
  - Urologists 471
  - Dermatologists 729
  - Other (MU2) 26

  TOTAL 1891
- Growth since July 2013 +557

Physician Registration Success

- Dermatology
  - Revised state database identified 891
  - Registered by FCDS 729
  - Registration success rate percentage 82%
- Oncology, Hematology, Urology
  - Revised state database identified 1442
  - Registered by FCDS 1162
  - Registration success rate percentage 80%

Physician Reporting

- Dermatology
  - 2011 — 5691 cases reported
  - 2012 — 7647 cases reported
  - 2013 — 7750 cases reported
  - 2014(as of July 1) — 5030 cases reported

  Total since inception…..26,118 cases

  - 576 of 729 have sent data (79% of registered)

Physician Reporting

- Oncologists 1,125,159 Claims Received
- Urologists 483,570 Claims Received
- HEMA/ONC 4,855,669 Claims Received
- Hematologists 49,690 Claims Received

Total Physician Claims Received 6,514,088

- (as of July 1, 2014)

FCDS Florida Cancer Data System

2014 Cancer Reporting Requirements
2014 FCDS DAM – Summary of Changes

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2014 CANCER REPORTING REQUIREMENTS
2014 FCDS DAM – SUMMARY OF CHANGES

FCDS ANNUAL CONFERENCE
ORLANDO, FL
7/24/2014

STEVEN PEACE, CTR

Florida HEALTH

2014 Cancer Reporting Requirements

- NAACCRv14 Required
- FCDS EDITSv14 Metafile

- No New Reportable Cancers
- No New Required Data Items
- Collaborative Stage - Updated to CSv02.05 – Derived TNM/Summary Stage

Collaborative Stage Data Collection System

- 2 Fewer Breast SSFs – HER2 Test – FISH/CISH lab value
  - HER2 FISH/CISH Test Interpretation (+ or –) Still Required
  - When to code SSF14 - HER2: Result of Other or Unknown Test

Collaborative Stage Data Collection System

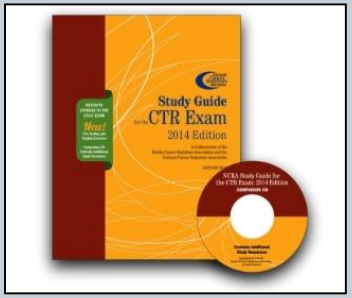
- AJCC TNM Cancer Staging Items (clinical & pathologic) – Direct Coded TNM
  - Optional for 2014 Cases
  - Basic TNM EDITS will be run
  - FCDS will not include in QC Review
  - CoC-Accredited Facilities Already Code
  - Not Available for FCDS IDEA Single Entry Cases
  - ALL Collaborative Stage Core Items Still Required for 2014 Cases
  - TNM data will be used for Central Registry Planning, Applications Testing, and Training

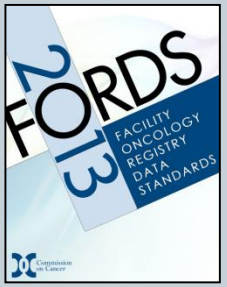
TNM

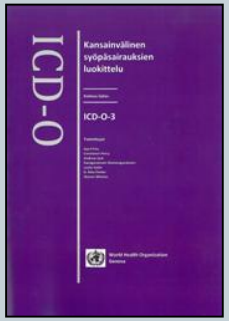
AJCC
American Joint Committee on Cancer

National Abstracting Coding References

- MPH Rules
- ACOS/CoC FORDS
- SEER*Rx version 2.2.0
- CSv02.05 and Conversion Files
- Instructions for Coding Grade for 2014+
- 2014 Hematopoietic Manual and Database
- ICD-O-3 Updates for United States for 2014







AJCC TNM 7th edition

- The **AJCC TNM Cancer Staging System** is based on the clinical, operative, and pathologic assessment of the anatomic extent of disease at the time of initial cancer diagnosis and is used to make appropriate treatment decisions, determine prognosis, and measure end results.

- **2014-2015 Transition Years Requirement:** The AJCC TNM Cancer Staging data items may be left blank or may be reported as "Optional" for cancers diagnosed, treated, or else reported to FCDS 1/1/2014-12/31/2015.
  - Only CoC-Accredited Facilities can submit "Optional" TNM fields.
  - TNM staging requires use of the *AJCC Cancer Staging Manual*, 7th edition.
  - TNM Data will not be included in QC Review for 2014-2015.

- **2016 Requirement:** AJCC TNM staging requires use of the *AJCC Cancer Staging Manual*, 7th edition for all cancers diagnosed, treated, or otherwise reported to FCDS on or after patient encounters 1/1/2016.

AJCC TNM 7th edition

Staging Rules and Definitions of T, N, M (clinical and pathologic) vary across primary sites. You MUST refer to the current *AJCC Cancer Staging Manual* to code AJCC TNM Stage.

- *Clinical Staging* includes any information obtained about the extent of cancer before initiation of definitive treatment (surgery, systemic or radiation therapy, active surveillance, or palliative care) or within four months after the date of diagnosis, whichever is *shorter*, as long as the cancer has not clearly progressed during that time frame.

- *Pathologic Staging* includes any information obtained about the extent of cancer through completion of definitive surgery as part of first course treatment or identified within four months after the date of diagnosis, whichever is *longer*, as long as there is no systemic or radiation therapy initiated or the cancer has not clearly progressed during that time frame.

AJCC TNM 7th edition

If you want to abstract, code and send FCDS any 2014 TNM data;
You must include all of the TNM Data Items Required.

Item Number	Item Name
940	Clinical T
950	Clinical N
960	Clinical M
970	Clinical Stage Group
980	Clinical Stage (Prefix/Suffix) Descriptor
990	TNM Clin Staged By
880	Pathologic T
890	Pathologic N
900	Pathologic M
910	Pathologic Stage Group
920	Pathologic Stage (Prefix/Suffix) Descriptor
930	TNM Path Staged By
1060	TNM Edition Number

DO NOT ENTER ANY OF THE COLLABORATIVE STAGE DERIVED TNM VALUES IN THESE FIELDS – THESE ARE FOR DIRECT-CODED TNM ONLY

FCDS References

FCDS Florida Cancer Data System

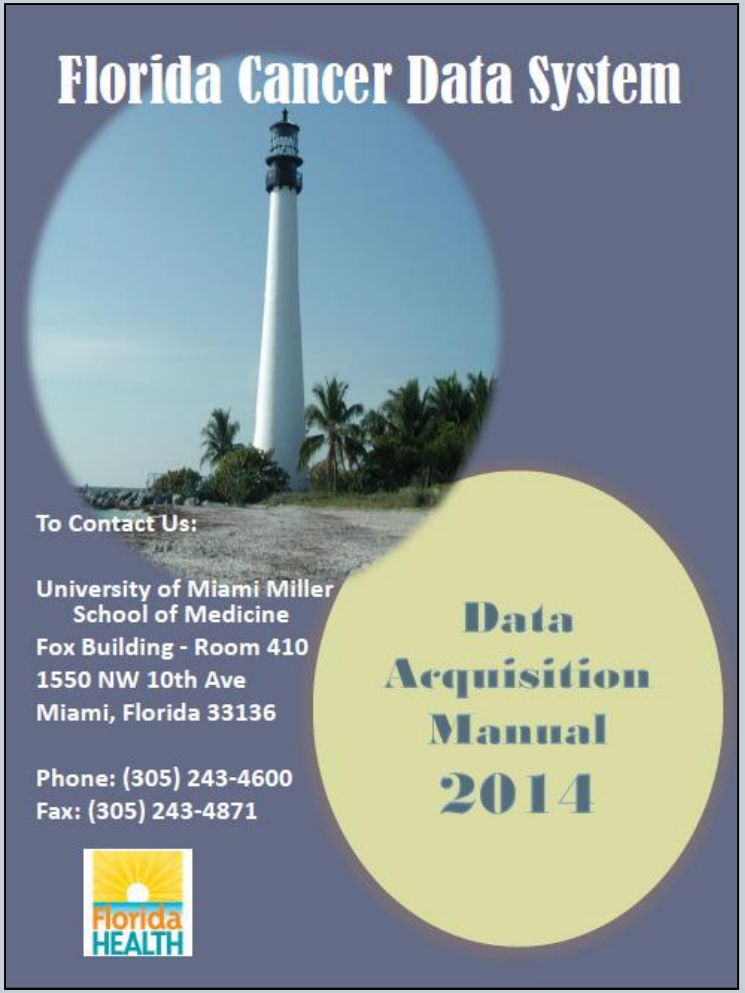
Florida Statewide Cancer Registry

Florida Cancer Data System
2014 Implementation Guideline
NAACCR Version 14

Record Layout and Data Standard Recommendations

July 1, 2014 (original)
(Date of Last Update - 4/10/2014)

Florida HEALTH



2014 FCDS DAM - Summary of Changes

2014 FCDS Data Acquisition Manual (FCDS DAM)
Summary of Changes

NEW OR ADDED SECTION OR DATA ITEM(s)

SECTION II – Abstracting and Coding Instructions

- AJCC TNM Cancer Staging System Section – TNM is "Optional" for CoC-Accredited Facilities Only in 2014
  - Clinical T, N, M and AJCC Clinical Stage Group Items
  - Clinical TNM – Staged By
  - Pathologic TNM and AJCC Pathologic Stage Group Items
  - Pathologic TNM – Staged By
  - Prefix Descriptors (clinical and pathologic)
  - TNM Edition Number

APPENDICES

- Appendix N – Instructions for Coding Grade for 2014+ (from the CoC/SEER/NPCR Technical WG)
- Appendix O - ICD-10-CM Casefinding List for Reportable Tumors (MUST BE USED 10/1/2015 forward)

UPDATED OR CLARIFICATION OF SECTION or DATA ITEM(s)

SECTION I – General Instructions

- Section IA - Reportable Neoplasms (clarify reporting of GIST, Thymoma, cancers of genital sites, VAIN III, VIN III, PAIN III, AIN III, historical /0 and /1 brain and CNS tumors, and in utero cancer)
- Section IA - Annual Reporting Deadline – June 30th
- Section IB - Casefinding - Implementation of ICD-10-CM/PCS with Casefinding Instructions
- Section IB - Casefinding - Pathology Casefinding Is Required
- Section IB - ICD-10-CM Casefinding List for Reportable Tumors
- Section IC - FCDS Abstractor Code Policy and Testing Requirements
- Section IC - CoC RQRS and the FCDS 6-month Case Abstracting Requirement (Timeliness)
- Section IC - Required/Recommended Desktop References
- Section ID - Data Transmission and Quarterly Reporting to FCDS
- Section ID – Data Acceptance Policy – FCDS EDITS
- Section IJ – FCDS Data Quality Indicator Report (DQIR)
- Section IL – Awards – Pat Strait Award for Excellence in Cancer Registry Abstracting
- Section I – Sample 2014 FCDS Reporting Calendar
- Section I – Sample 2014 FCDS Abstract (do not send to FCDS)

SECTION II – Abstracting and Coding Instructions

- Several Data Item Definitions Were Updated/Clarified
  - Reporting Facility
  - Accession Number – Hospital
  - Sequence Number – Hospital
  - Date Case Completed/Date Abstracted
  - Social Security Number – No Partial SSNs Allowed
  - Birthplace State and Birthplace Country – clarification
  - Address at DX State and Address at DX Country – clarification
  - Address Current State and Address Current Country – clarification
  - Text Usual Occupation and Text Usual Industry
  - Primary Site
    - Use of C76.* as Primary Site Discouraged
    - Head and Neck Cancers with No Primary Site Identified
    - Metastatic Neoplasm of Specific Type with No Primary Site Identified
  - Grade/Differentiation/Immunophenotype
    - entire section rewritten for "Grade Coding Instructions for 2014+"
  - Lymph Vascular Invasion – clarified
  - Treatment – Clarification for coding Aspirin, Phlebotomy, and Transfusion

APPENDICES – NEW and UPDATED

- Appendix A – Updated - Facility Listings – Hospitals/Surgery Centers/Radiation Therapy Centers
- Appendix C – Updated – Breast Cancer Profile Explaining ER/PR/EHR2 Prognostic Factors
- Appendix G – Updated - 2014 FCDS Record Layout (NAACCR Version 14)
- Appendix H – Updated - 2014 FCDS Required CSv02.05 Site Specific Factors (SSFs)
- Appendix N – NEW – Grade Coding Instructions for 2014+ (from the CoC/SEER/NPCR Technical WG)
- Appendix O – Updated - ICD-10-CM Casefinding List for Reportable Tumors
- Appendix P – Updated - 2014 Resources for Registrars
- Appendix Q – Updated - FCDS Frequently Asked Questions
  - FCDS IDEA User Accounts
  - Facility Access Administrator (FAA) and Responsibilities
  - FCDS Abstractor Code

NO LONGER REQUIRED DATA ITEM(s)

- BREAST SSF10 (HER2 FISH Lab Value) No Longer Required
- BREAST SSF12 (HER2 CISH Lab Value) No Longer Required

2014 FCDS DAM – Stage at Diagnosis

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CSv02.05 Required

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COLLABORATIVE STAGE DATA COLLECTION SYSTEM (CSv2)

Collaborative Staging (CS) is to be used for all cases regardless of date of diagnosis until 12/31/2015. For Collaborative Staging, registrars code discrete pieces of information once and the CS computer algorithm derives the values for the 6th and 7th editions of the AJCC Cancer Staging Manual T, N, M, and Stage Group, and descriptors, as well as Summary Stage 1977 and Summary Stage 2000. The timing rule for CS coding was designed to make use of the most complete information possible to yield the "best stage" information for the tumor at the time of diagnosis– "use all information gathered through completion of surgery(ies) in first course of treatment or all information available within four months of the date of diagnosis in the absence of disease progression, whichever is longer." Disease progression is defined as further direct extension or distant metastasis known to have developed after the diagnosis was established. Information about tumor extension, lymph node involvement, or distant metastasis obtained after disease progression is documented should be excluded from the CS coding.

FCDS will collect all the required CS fields in accordance with the latest version of CS, currently version 02.05, and necessary to derive AJCC TNM Staging 6th and 7th edition and SEER Summary Stage 2000. This includes CS data collection for all schemas and schema discriminator (SSF25) for applicable sites consistent with CDC NPCR and the Florida Department of Health requirements.

The following CS data items are to be coded for all schemas. Items with an asterisk (*) have site-specific variations for some codes.

CS Tumor Size (NAACCR Item #2800) *
CS Extension (NAACCR Item #2810) *
CS Tumor Size/Ext Eval (NAACCR Item #2820)
CS Lymph Nodes (NAACCR Item #2830) *
CS Reg Lymph Nodes Eval (NAACCR Item #2840)
Regional Lymph Nodes Examined (NAACCR Item #830)
Regional Lymph Nodes Positive (NAACCR Item #820)
CS Mets at DX (NAACCR Item #2850) *
CS Mets Eval (NAACCR Item #2860)

CS Site-Specific Factors 1-25 is required for collection based on the site specific schema selection. See Appendix H for a complete of site-specific SSF requirements for 2012 or go to http://fcds.med.miami.edu/inc/downloads.shtml to see all site specific schemas and their required Site-Specific Factors. This spreadsheet is subject to change based on AJCC CSv2 revisions.

Coding CS Data Items
The complete instructions and site-histology defined codes are available in the current version of **Collaborative Stage Data Collection System** http://www.cancerstaging.org/cstage/

Revised –2014

2014 Optional TNM

108

AJCC TNM CANCER STAGING SYSTEM

2014-2015 Transition Years Requirement: The AJCC TNM Cancer Staging data itmes may be left blank or may be reported as "Optional" for cancers diagnosed, treated, or otherwise reported to FCDS 1/1/2014-12/31/2015. Only registries with CoC Accreditation can submit the "Optional" TNM fields. AJCC TNM staging requires use of the *AJCC Cancer Staging Manual*, 7th edition for all TNM items.

2016 Requirement: AJCC TNM staging requires use of the *AJCC Cancer Staging Manual*, 7th edition for all cancers diagnosed, treated, or otherwise reported to FCDS beginning 1/1/2016.

The AJCC TNM Cancer Staging System is based on the clinical, operative, and pathologic assessment of the anatomic extent of disease at the time of initial cancer diagnosis and is used to make appropriate treatment decisions, determine prognosis, and measure end results.

Rules for Staging and Definitions of T, N, M (clinical and pathologic) may vary across primary site. You MUST refer to the current *AJCC Cancer Staging Manual* to code AJCC TNM Stage data item.

Use the rules in the current *AJCC Cancer Staging Manual* to assign AJCC T, N, M and Stage Group values. The following general rules apply to AJCCTNM staging for all cancer sites.

- *Clinical Staging* includes any information obtained about the extent of cancer before initiation of definitive treatment (surgery, systemic or radiation therapy, active surveillance, or palliative care) or within four months after the date of diagnosis, whichever is *shorter*, as long as the cancer has not clearly progressed during that time frame.
- *Pathologic Staging* includes any information obtained about the extent of cancer through completion of definitive surgery as part of first course treatment or identified within four months after the date of diagnosis, whichever is *longer*, as long as there is no systemic or radiation therapy initiated or the cancer has not clearly progressed during that time frame.

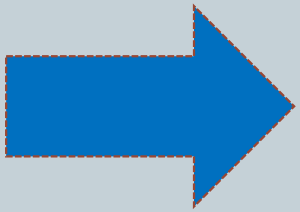
Data Items Included in this Section:

NAACCR Item Number	Item Name
940	Clinical T
950	Clinical N
960	Clinical M
970	Clinical Stage Group
980	Clinical Stage (Prefix/Suffix) Descriptor
990	TNM Clinical – Staged By
880	Pathologic T
890	Pathologic N
900	Pathologic M
910	Pathologic Stage Group
920	Pathologic Stage (Prefix/Suffix) Descriptor
930	TNM Pathologic – Staged By
1060	TNM Edition Number

Coding AJCC TNM Cancer Staging Data Items
The complete coding instructions and site-histology defined criteria for assigning individual T, N, and M elements and the Stage Group (clinical and pathologic) are available in the current version of *AJCC Cancer Staging Manual*. Go to http://www.cancerstaging.org for ordering information.

2014 FCDS DAM – LVI Errata

Replacement Page 106



LYMPH-VASCULAR INVASION **NAACCR ITEM #1182**

Lymph-vascular invasion or LVI indicates the presence or absence of tumor cells in small lymphatic channels (not lymph nodes) or small blood vessels within the primary tumor or in the surrounding tissues of the primary site as noted microscopically by the pathologist. When a neoplasm shows the presence of lymph-vascular invasion, tumor cells have broken free of the primary tumor and now have the ability to float throughout the body. Therefore, lymph-vascular invasion may be used an indicator of prognosis.

Benign, borderline and in-situ neoplasms cannot have lymphatic or vascular invasion by definition. When any invasion is present, the neoplasm is classified as malignant with behavior = 3.

Lymphoid and myeloid neoplasms (neoplasms that originate in the lymphatic system, bone marrow, or in circulating blood) cannot have lymphatic or vascular invasion. Only solid tumors may have LVI.

Lymphatic invasion is not the same as involvement of regional lymph nodes.

Lymph-vascular invasion does not include perineural invasion.

Coding Instructions

1. The primary source of this information is the pathology report or a physician's statement.
2. **Use code 0 when behavior = 0, 1, or 2 (ALL benign, borderline, and in-situ neoplasms)**
3. Use code 0 when the pathology report states that no lymph-vascular invasion was identified.
4. Use code 1 when lymph-vascular is identified anywhere in a primary tumor specimen.
5. **Use code 8 when histology = 9590-9992 (ALL lymphoid and myeloid neoplasms).**
6. Use code 9 if the pathology report indicates that the presence of lymph-vascular invasion could not be determined or when no information is available in the pathology report or medical record.
7. **Use code 9 when no tissue from the primary site was examined (invasive solid tumors only).**

Code	Description
0	Behavior = 0, 1, or 2 (benign, borderline or in-situ neoplasm)
0	Lymph-vascular invasion not present (absent)/not identified
1	LVI Present/Identified
8	Histology = 9590-9992 (lymphoid or myeloid neoplasm)
9	LVI Unknown, Indeterminate, Not Stated, or no tissue from primary site was examined

Corrected Coding Instructions

NCDB Rapid Quality Reporting System

- Participation in RQRS is Voluntary – Commendation-Only Standard 5.2 – Replaces CoC 6-month timing requirement
- FCDS 6-MONTH REPORTING REQUIREMENT - NO CHANGE
- COMPLETE Case Reports (Abstracts) Are Still Required to be sent to FCDS on or before Annual Deadline of June 30
- You may have to report a few cases to FCDS that are still flagged as "incomplete" at the time of FCDS Annual June 30th Reporting Deadline – this may occur when the case must be reported for deadline and the abstract includes all information available at the time of deadline. But, the case must still pass FCDS EDITS.

2014-2015 Education & Training Plan

FCDS Webcast Series and VoIP Audio

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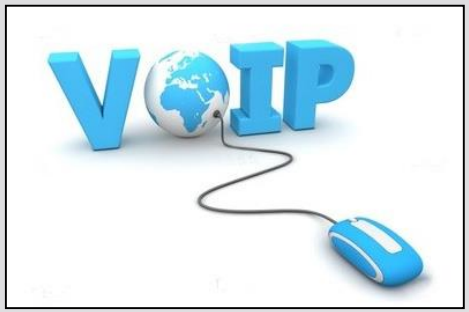
2014-2015 FCDS EDUCATION & TRAINING PLAN
TRAINING TOOLS AND RESOURCES
GO TO MEETING AND USING THE VOIP AUDIO OPTION

FCDS ANNUAL CONFERENCE
ORLANDO, FL
7/24/2014

STEVEN PEACE, CTR



2014-2015 FCDS Webcast Schedule

Date	Time	Presentation Title
8/21/2014	1:00pm – 3:00pm	**2014 Reporting Requirements:** FCDS Annual Meeting Highlights
9/18/2014	1:00pm – 3:00pm	**GYN Neoplasms:** Background, Anatomy, Risk Factors, Signs and Symptoms, MPH Rules, Staging (CSv02.05, SSFs, TNM, SS) and TX
10/16/2014	1:00pm – 3:00pm	**Neuroendocrine Tumors (NET) and GI Stromal Tumors (GIST):** Background, Anatomy, Risk Factors, Signs and Symptoms, MPH Rules, Staging (CSv02.05, SSFs, TNM, SS) and TX
11/20/2014	1:00pm – 3:00pm	**Reportable Skin Cancers:** Background, Anatomy, Risk Factors, Signs and Symptoms, MPH Rules, Staging (CSv02.05, SSFs, TNM, SS) and TX
1/15/2015	1:00pm – 3:00pm	**Genitourinary Neoplasms (Kidney, Bladder, Prostate, Penis):** Background, Anatomy, Risk Factors, Signs and Symptoms, MPH Rules, Staging (CSv02.05, SSFs, TNM, SS) and TX
2/19/2015	1:00pm – 3:00pm	**Lower GI Tract Neoplasms:** Background, Anatomy, Risk Factors, Signs and Symptoms, MPH Rules, Staging (CSv02.05, SSFs, TNM, SS) and TX
FCDS Educational Webcast Series Re-Starts in August 2015 Following the FCDS Annual Meeting		

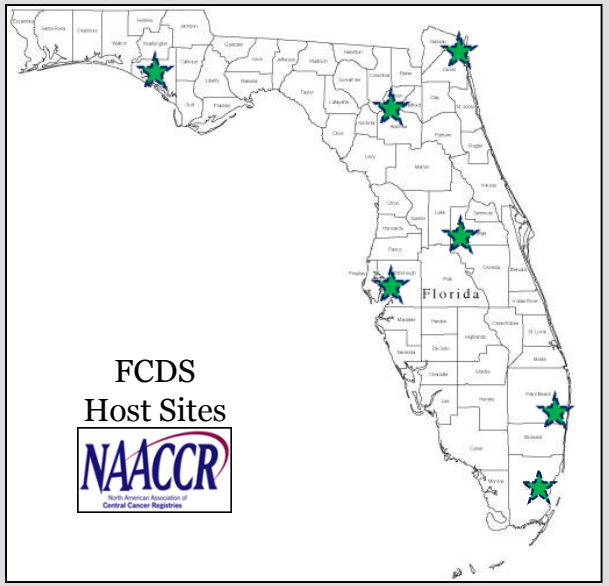
2014-2015 NAACCR Webinar Schedule

Date	Time	Presentation Title
10/2/2014	9:00am - 12:00pm	Directly -Coded Stage : Using the AJCC Cancer Staging Manual and Summary Stage 2000
11/6/2014	9:00am - 12:00pm	Collecting Cancer Data: Hematopoietic and Lymphoid Neoplasms
12/4/2014	9:00am - 12:00pm	Using the Multiple Primary and Histology (MP/H) Coding Rules
1/8/2015	9:00am - 12:00pm	Collecting Cancer Data: Testis
2/5/2015	9:00am - 12:00pm	Collecting Cancer Data: Uterus
3/5/2015	9:00am - 12:00pm	Abstracting and Coding Boot Camp: Cancer Case Scenarios
4/2/2015	9:00am - 12:00pm	Collecting Cancer Data: Stomach & Esophagus
5/7/2015	9:00am - 12:00pm	Collecting Cancer Data: Larynx and Thyroid
6/4/2015	9:00am - 12:00pm	Collecting Cancer Data: Pancreas
7/9/2015	9:00am - 12:00pm	Survivorship Care Plans
8/6/2015	9:00am - 12:00pm	Collecting Cancer Data: Central Nervous System
9/3/2015	9:00am - 12:00pm	Coding Pitfalls

NAACCR Webinar Host Sites

- 7 FCDS-Hosted Sites
- Geographically Dispersed
- Registration Requested
- Encourage Attendance
- Recordings Available
- 3 CEUs per Webinar
- No Cost to Registrar/Host

Baptist Regional Cancer Center	Jacksonville
Boca Raton Community Hospital	Boca Raton
Gulf Coast Medical Center	Panama City
H. Lee Moffitt Cancer Center	Tampa
UF Health Cancer Center Orlando Health	Orlando
Shands University of Florida	Gainesville
FCDS	Miami



NAACCR CTR Prep Webinars

- The NAACCR CTR Exam Preparation & Review Webinar Series offers online instruction with experienced faculty. The course includes eight 2-hour sessions, sample CTR Exam and a follow-up post exam session. All sessions are recorded and available for playback 24/7 via Drop Box.

- Individual Subscription for the Series is $400 – includes “live” sessions

- FCDS picks up the $400 fee for any Florida candidate CTR
  - This is NOT a Beginner Abstracting Course
  - Candidate CTRs must be planning to write the CTR Exam
  - Florida candidate CTRs must view recordings as part of agreement
  - This allows you to watch each session whenever time allows
  - All Course Materials including Sample CTR Exam are included
  - Contact and Feedback from Course Instructors is included
  - Next CTR Exam Prep and Review Series begins in mid-August

“Staging of Cancer”

- Transition Training from CS to Direct-Coded TNM and SS2000
- Teaching All 3 Staging Approaches/Systems in Webcasts
- Reinforce Biomarker and Prognostic Indicator Tests
- Identify Additional Available Resources – Concept (How To) Training
- Identify Additional Available Resources – Practice Cases
- Tap Into National Training Efforts
- QC of TNM and Summary Stage will begin with 2016 dx/admit
- FCDS Text Requirements – Never More Critical Than Now

AJCC
American Joint Committee on Cancer

AJCC TNM Stage - Available Resources

Free TNM 7th Edition Webinar Series Recordings and Other Resources Available on AJCC Cancer Staging Website (http://cancerstaging.org)

Date	Duration	Title	Description
August 21, 2009	60 min	**Debunking Urban Legends in Staging**	This presentation is intended to provide physicians and cancer registrars with highlights of the AJCC staging rules, especially the changes that have taken place in the 7th Edition, which become effective with cases diagnosed January 1, 2010.
January 6, 2010	60 min	**AJCC Seventh Edition Staging Series: Shaping the Future: An Overview Presentation on the 7th Edition AJCC Cancer Staging Manual**	The purpose of this presentation is to highlight the major changes in the 7th edition and review the new and emerging prognostic factors related to cancer staging.
February 1, 2010	60 min	**AJCC Seventh Edition Staging Series: Introducing the Next Generation of Prostate Cancer Staging - Working with The AJCC Cancer Staging Manual, 7th Ed**	The 7th Edition Cancer Staging Manual introduces an important change in cancer staging for the prostate, incorporating the preferred use of the Gleason Score as a prognostic factor in the Anatomic Stage/Prognostic Groups.
February 24, 2010	60 min	**AJCC Seventh Edition Staging Series: The Staging of Colorectal Cancer: What's New in the Seventh Edition of The AJCC Cancer Staging Manual**	The purpose of this presentation is to review the major changes in the 7th edition for colorectal cancer staging and to highlight new and emerging prognostic factors related to colorectal cancer staging.
March 5, 2010	60 min	**AJCC Seventh Edition Staging Series: Implementation of The AJCC Cancer Staging Manual, Seventh Edition Revised Staging System for Breast Cancer**	This presentation seeks to review the major changes in the seventh edition of The AJCC Cancer Staging Manual for breast cancer staging and to highlight new and emerging prognostic factors related to breast cancer.
March 15, 2010	60 min	**AJCC Seventh Edition Staging Series: Staging Head and Neck Cancers - Transitioning to the Seventh Edition of The AJCC Cancer Staging Manual**	This presentation summarizes the criteria used in the new staging schema for head and neck tumors, and outlines the rationale behind the changes.
March 29, 2010	60 min	**AJCC Seventh Edition Staging Series: The New Staging System for Lung Cancer - A Clear View of Prognosis**	The purpose of this presentation is to review the major changes in the 7th Edition for Lung Cancer Staging and to highlight new and emerging prognostic factors related to lung cancer staging.
April 13, 2010	60 min	**AJCC Seventh Edition Staging Series: The AJCC Cancer Staging Manual, 7th Ed Staging for Esophagus and Stomach: A Simplified Road Map for Tumor Location**	The purpose of this presentation is to review the major changes in the Seventh Edition for Esophagus and Stomach Cancer Staging and to highlight new and emerging prognostic factors related to the staging.
August 18, 2010	60 min	**AJCC and FIGO: Unified Staging of Gynecologic Disease Sites**	The purpose of this presentation is to highlight the major changes for all of the Gynecological Sites.
September 16, 2010	60 min	**What's New in GI Staging: Gastrointestinal Stromal Tumors, Neuroendocrine Tumors of the GI Tract, and Endocrine Tumors of the Pancreas**	The purpose of this presentation is to highlight the major changes for Neuroendocrine, Gastrointestinal Stromal and Endocrine Pancreatic Tumors.
November 3, 2010	60 min	**TNM Staging for Kidney and Adrenal Gland**	The purpose of this presentation is to highlight the major changes for Kidney and Adrenal Gland including Ipsilateral adrenal involvement reclassification and the simplification of nodal involvement.
November 10, 2010	60 min	**New Classifications of Appendiceal Tumors and Understanding the Connection Between Appendix and Ovary: A Pathologist View**	The purpose of this presentation is to highlight the major changes for Appendix and Ovary and demonstrate the important connection the sites share.
December 15, 2010	60 min	**Melanoma and Merkel Cell Carcinoma Staging**	The purpose of this presentation is to highlight the major changes for Melanoma and Merkel Cell Carcinoma.
May 8, 2012	40 min	**AJCC and UICC: Tumor Deposits in Colorectal Cancer**	The purpose of this presentation is to highlight the criteria and provide guidance on the new N1c category. The presentation answers frequently asked questions on tumor deposits with a united voice from the AJCC and UICC.

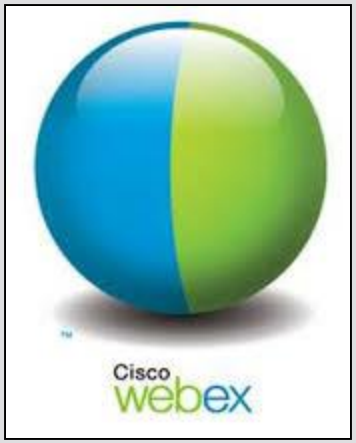
AJCC TNM Stage - Available Resources

Articles and Manuscripts on AJCC TNM Staging System
Cutaneous Melanoma: A Model to Study Cancer Metastasis. Leong SPL, et al. Journal of Surgical Oncology, 103:538-549, 2011.
The prognostic significance of mitotic rate in localized primary cutaneous melanoma: An analysis of patients in the multi-institutional AJCC melanoma staging database. Thompson JF, et al. Journal of Clinical Oncology, Jun 1;29(16):2199-205, 2011
Factors predictive of the status of sentinel and non-sentinel lymph nodes in melanoma from a large, multi-center database. White RL, et al, Annals of Surgical Oncology. 2011 Dec; 18(13);3593-600.
Update of the melanoma staging system: The importance of sentinel node staging and primary tumor mitotic rate. Balch CM, Gershenwald JE, Soong SJ, Thompson JF. Journal of Surgical Oncology. Sept: 104(4): 379-85, 2011.
Initial PET/CT staging for choroidal melanoma: AJCC correlation and second nonocular primaries in 333 patients. Freton A, Chin KJ, Raut R, Tena LB, Kivelä T, Finger PT. European Journal of Ophthalmology. 2012 Mar-Apr; 22(2):236-43.
New N Staging System of Penile Cancer Provides a Better Reflection of Prognosis, Yao Zhu, Ding-Wei Ye, Xu-Dong Yao, Shi-Lin Zhang, Bo Dai and Hai-Liang Zhang
TNM: Our Language of Cancer, Frederick L. Greene, MD, FACS
The Staging of Cancer: A Retrospective and Prospective Appraisal, Frederick L. Greene, MD, et. al.
Comparison of Registrar Collaborative Staging and Physician AJCC Staging Using Date Submitted to the National Cancer Data Base,Phillips, JL, Gress, DM, Journal of Registry Management Spring 2008.
The "y" Symbol: an Important Classification Tool for Neoadjuvant Cancer Treatment, Brierley, JD, Greene, FL, Sobin, LH, Wittekind, C. Cancer 2006; 106:2526-7.
On the Use and Abuse of X in the TNM Classification, Frederick L. Greene, MD, FACS Cancer 2005; 103:647-649.
The AJCC the 7th Edition of the AJCC Cancer Staging Manual and the Future of TNM, Stephen B. Edge, MD and Carolyn C. Compton, MD PhD, Annals of Surgical Oncology 2010
2010 TNM Staging System for Cutaneous Melanoma and Beyond, Jeffrey E. Gershenwald, MD, Seng-jaw Soong, PhD, Charles M. Balch, MD, Annals of Surgical Oncology 2010
7th Edition AJCC Cancer Staging Manual Stomach, Mary Kay Washington, Md PhD, Aannals of Surgical Oncology 2010
Creating and Providing Predictions of Melanoma Outcome, Kenneth K. Tanabe, MD, Sebastian Jara, BSc, and James Michaelson, PhD. Annals of Surgical Oncology 2010
Improvements in the Staging of Cutaneous Squamous Cell Carcinoma in the 7th Edition of the AJCC Cancer Staging Manual, Thomas Lardaro, BSc, Sofia M. Shea, MD, et al. Annals of Surgical Oncology 2010

Resources for Practice Cases

- AJCC You Tube "Staging Moments" – free
- SEER*Educate Website – free
  - More than 500 Cases – 50 cancer sites
- FCDS Webcast Series – free
  - Practice Cases will be included for most webcasts
  - Will reduce some of the content provided
  - Go To Meeting Poll for Interactive Q&A
- NCRA Workbook for the Staging of Cancer - $75
  - Overview of Basic Principles of AJCC TNM Staging System plus Practice Cases
  - 8 Sites - Head & Neck, Colon, Breast, Ovary, Prostate, Testis, Bladder, Lymphoma
- April Fritz "The Cancer Registry CASEbook(s)" - $75 each
  - Volume I - Introduction and 5 Sites - Colon, Breast, Lung, Prostate, Bladder
  - Volume II - Challenging Sites - Head & Neck, Female Genital, CNS, Lymphoma

FCDS Webcast Series with VoIP Audio



Using GoToMeeting to Full Potential

- Delivered to Your Desktop with Live Interactive Meetings
- No More Toll Free Number to Call In if you use VoIP
  - VoIP is easy to use and you are probably already set up to use it
  - Individuals may opt to pay long distance charges instead of VoIP
- Goal is to allow more time for Q&A using polls/surveys
- Also to allow time for Brief Discussion of Practice Cases
- All Webcasts will continue to be available in recorded format

Audio Options

- Use USB Headset and Voice-Over Internet Protocol (VoIP) – free
- Use internal microphone and internal laptop speakers – free
- Use external webcam with built-in microphone and speakers – free
- Use Provided Phone Line – may incur long distance charges

- CAUTION – You Cannot Use Both VoIP and Telephone
- CAUTION – Avoid Setup Problems that cause ECHO during webcast
  - VoIP setup – audio from speakers reaches the microphone
  - Phone setup – audio from a computer feeds into the telephone

- The person causing the echo does not hear the echo!!

- Use headset whenever possible to avoid echo
- Use headset whenever possible to minimize disruption to others
- If you use telephone for audio – be sure to enter the Audio PIN when asked upon entry into the webcast – a notice will appear with the PIN #

Audio Options and Audio Setup Instructions

Listed in order from best quality to poor quality	
USB* headset connected to your computer	Best
Headphones and USB* microphone connected to your computer	
Analog** headset connected to your computer	Good
Headphones and analog microphone** connected to your computer	
External speakers and USB microphone	Fair
External speakers and analog microphone	
Laptop built-in microphone and speakers	Poor
External speakers and USB Webcam microphone	

http://support.citrixonline.com/en_US/gotowebinar/all_files/GTW040003

Using a Headset

- A quality headset separates your computer's microphone from the speakers on your computer and helps you focus.
- Allows you to listen and talk – speaker and microphone
- Eliminates your neighbors from having to listen, too.
- Reduces Background Noise and Eliminates Echo Potential
- Speak Clearly – there may be a few seconds wait time to hear
- Use Chat Window to Avoid Interrupting Speaker
- Know How to Use Your Mute Button
- Types of Headsets
  - Wraparound headset with built-in microphone
  - Webcam with built-in microphone
  - Ear "buds" – listen only
- Price Range - $10-$500

Enhancing Central Cancer Registry Treatment Data using Physician Medical Claims: A Florida Pilot Project

FCDS Annual Meeting

July 24-25, 2014

Caribe Royale Resort

Orlando, Florida

Introduction

- Data collected by central cancer registries is utilized for patient outcomes research
- Requires complete detailed treatment data
- Capturing information from physician offices can improve cancer surveillance without increased burden on physicians

Introduction

- Medical claims from hospitals and Medicare have been used by central registries for case ascertainment and data enhancement
- Use of claims from physician offices offers more complete dataset
- Enables longitudinal tracking
- Updates patient information with each encounter

Medical Claims Crosswalks

- To efficiently gather claims information
  - Need to automate and translate data from medical claims forms
  - Convert data into established standard coding layouts for national cancer reporting

- Crosswalk/derive treatment/procedure codes to cancer registry codes
  - ICD-9-CM – International Classification of Disease , 9th revision
  - CPT – Current Procedural Terminology
  - HCPC – Healthcare Common Procedure Coding System

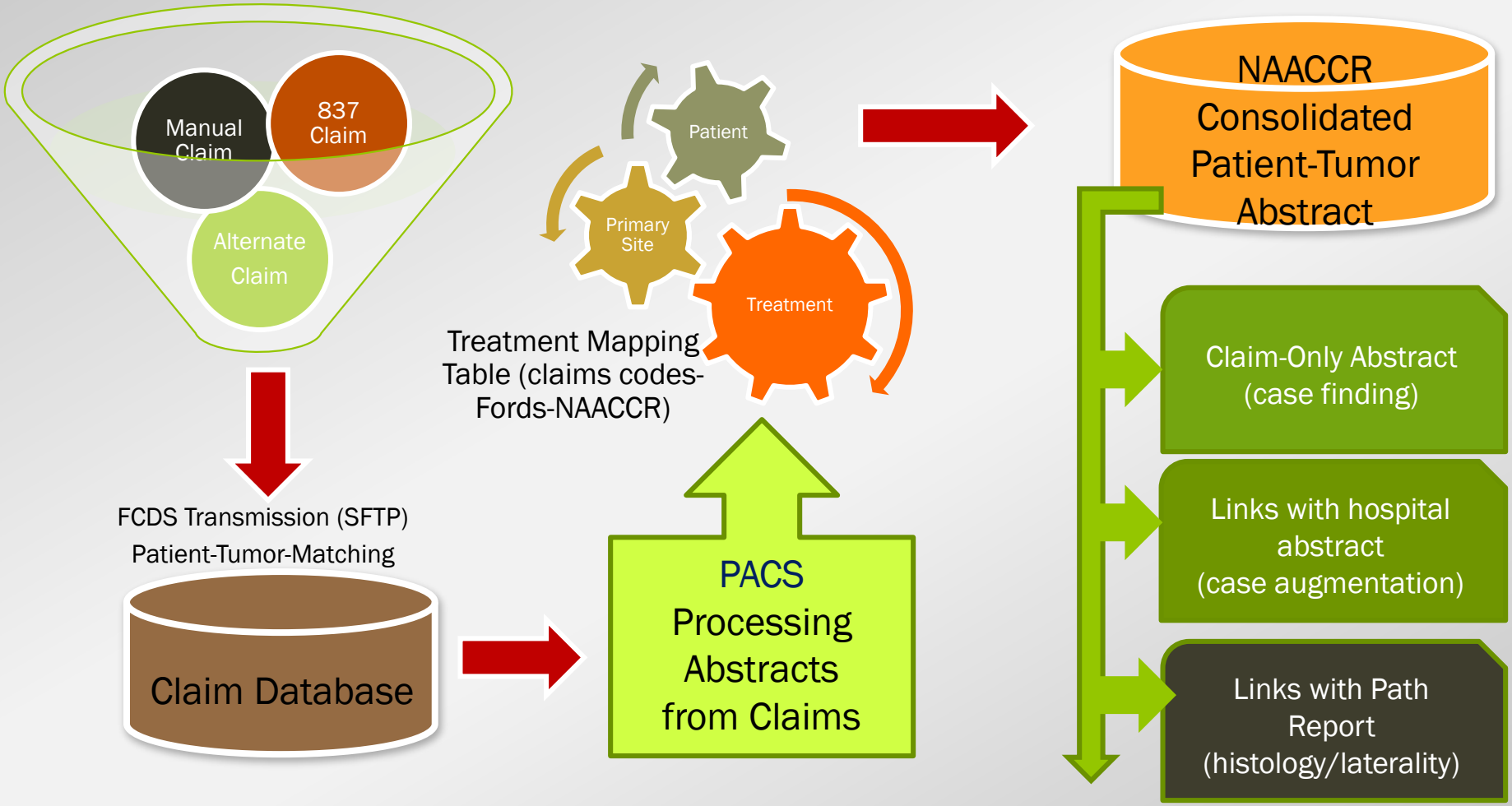
  - Anti-neoplastic agents, RT, Hormones
  - Ancillary therapies to enhance chemo tolerance

APPENDIX C
CPT / HCPCS Procedure Codes List
SAMPLE ONLY - NOT a Complete List of Codes
(Procedures Indicate Patient Encounter was for the Diagnosis and/or Treatment of Neoplasm)

Note: Any CPT/HCPCS code that indicates a patient encounter related to the diagnosis or treatment of any neoplasm that meets the Case Eligibility Criteria described in Section I Part A should be included. A complete CPT/HCPCS code list would include diagnostic and surgical procedure(s) used to establish a diagnosis or to surgically remove primary or metastatic cancer, administration or prescribing of any chemotherapeutic agent(s), immunotherapy agent(s), or biological response modifier(s), administration of radiation therapy of any type (beam radiation, radioactive implants, radioisotopes, brachytherapy, IMRT, gamma knife), blood, bone marrow or stem cell transplant procedure(s), endocrine gland resection for treatment of prostate, breast, or other cancer, and other cancer-directed therapy(s).

Coding System	Code	Brief Description	Detailed Description
CPT	96412	CHEMOTHERAPY, INFUSION METHOD.	CHEMOTHERAPY ADMINISTRATION, INTRAVENOUS; INFUSION TECHNIQUE, ONE TO 8 HOURS, EACH ADDITIONAL HOUR (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
CPT	96414	PROLONGED INFUSION MORE THAN 8 HRS	CHEMOTHERAPY ADMINISTRATION, INTRAVENOUS; INFUSION TECHNIQUE, INITIATION OF PROLONGED INFUSION (MORE THAN 8 HOURS), REQUIRING THE USE OF A PORTABLEOR IMPLANTABLE PUMP
CPT	96420	CHEMOTHERAPY, PUSH TECHNIQUE.	CHEMOTHERAPY ADMINISTRATION, INTRA-ARTERIAL; PUSH TECHNIQUE
CPT	96422	CHEMOTHERAPY, INFUSION METHOD...	CHEMOTHERAPY ADMINISTRATION, INTRA-ARTERIAL; INFUSION TECHNIQUE, UP TO ONE HOUR
CPT	96423	CHEMOTHERAPY, INFUSION METHOD....	CHEMOTHERAPY ADMINISTRATION, INTRA-ARTERIAL; INFUSION TECHNIQUE, ONE TO 8 HOURS, EACH ADDITIONAL HOUR (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
CPT	96440	CHEMO ADM INTO PLEURAL CAVITY/THORACENTESIS	CHEMOTHERAPY ADMINISTRATION INTO PLEURAL CAVITY, REQUIRING AND INCLUDING THORACENTESIS
CPT	96450	CHEMOTHERAPY, INTO CNS	CHEMOTHERAPY ADMINISTRATION, INTO CNS (EG, INTRATHECAL), REQUIRING AND INCLUDING SPINAL PUNCTURE
CPT	96520	PUMP REFILLING, MAINTENANCE	REFILLING AND MAINTENANCE OF PORTABLE PUMP
HCPCS	J1830	Interferon beta-1b / .25 MG	INJECTION INTERFERON BETA-1B, 0.25 MG
HCPCS	J8520	Capecitabine, oral, 150 mg	CAPECITABINE, ORAL, 150 MG
HCPCS	J8521	Capecitabine, oral, 500 mg	CAPECITABINE, ORAL, 500 MG
HCPCS	J8530	Cyclophosphamide oral 25 mg	CYCLOPHOSPHAMIDE; ORAL, 25 MG
HCPCS	J8560	Etoposide oral 50 MG	ETOPOSIDE; ORAL, 50 MG

Claims Processing



Claims Validation Study

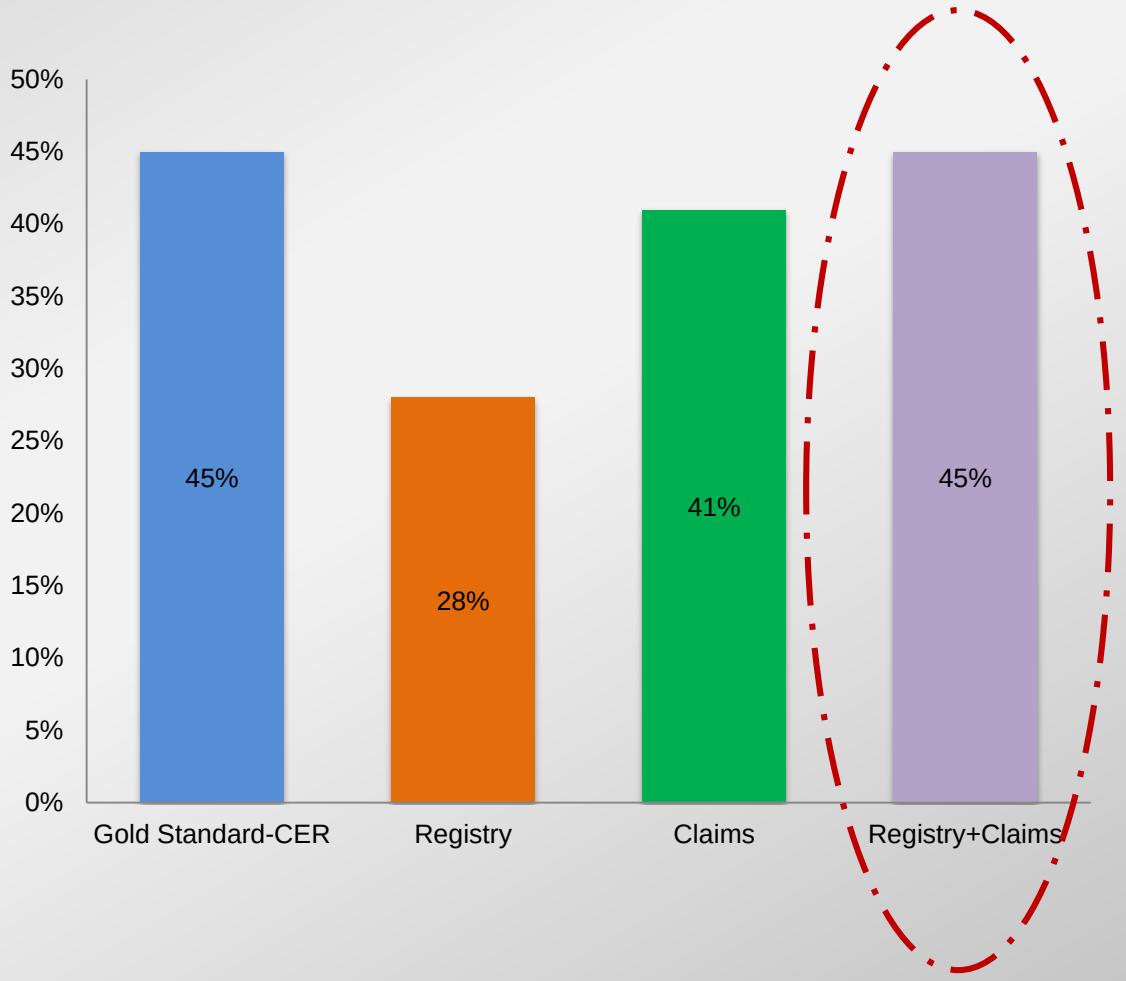
- Objective: To validate the processing of claims and to evaluate enhancement to chemo treatment information

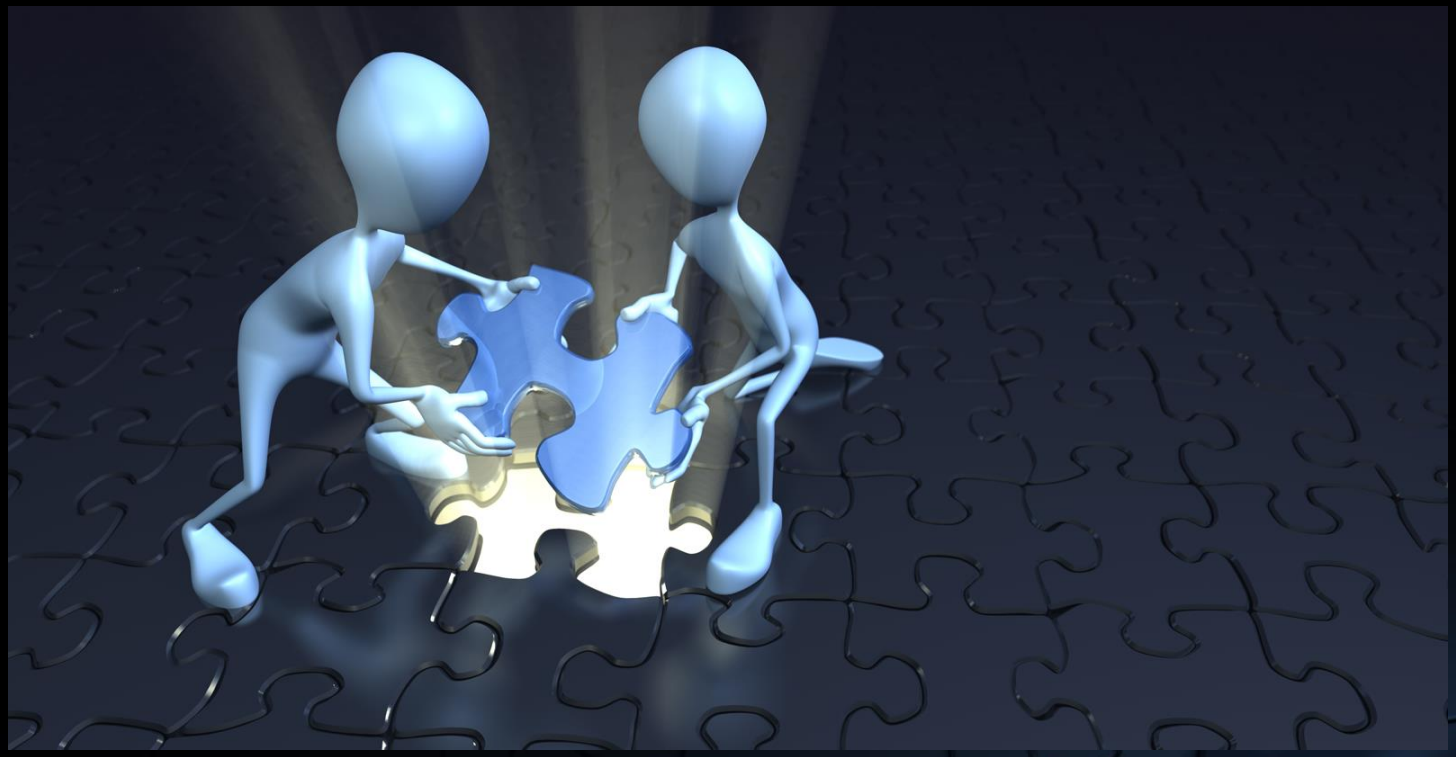
- Background: Florida is one of ten states funded for the Comparative Effectiveness Research project. Part of funding for this project aimed at expansion of physician cancer reporting

Hernandez MN, MacKinnon JA, Penberthy L, Bonner J, Huang YX. Enhancing Central Cancer Registry Treatment Data Using Physician Medical Claims: A Florida Pilot Project. *Journal of Registry Management*. Summer 2014, Vol. 41, No. 2

Percent Chemotherapy Received by Data Source

- Claims captured 41% with chemotherapy, compared to 28% in the registry dataset
- 45% of cases with chemotherapy captured in the gold standard CER data





FCDS IDEA Follow Up System

Gary M. Levin, CTR, BA

FCDS Annual Meeting

July 24th, 2014

At Last Year's Meeting We Presented

Benefits To Your Registry

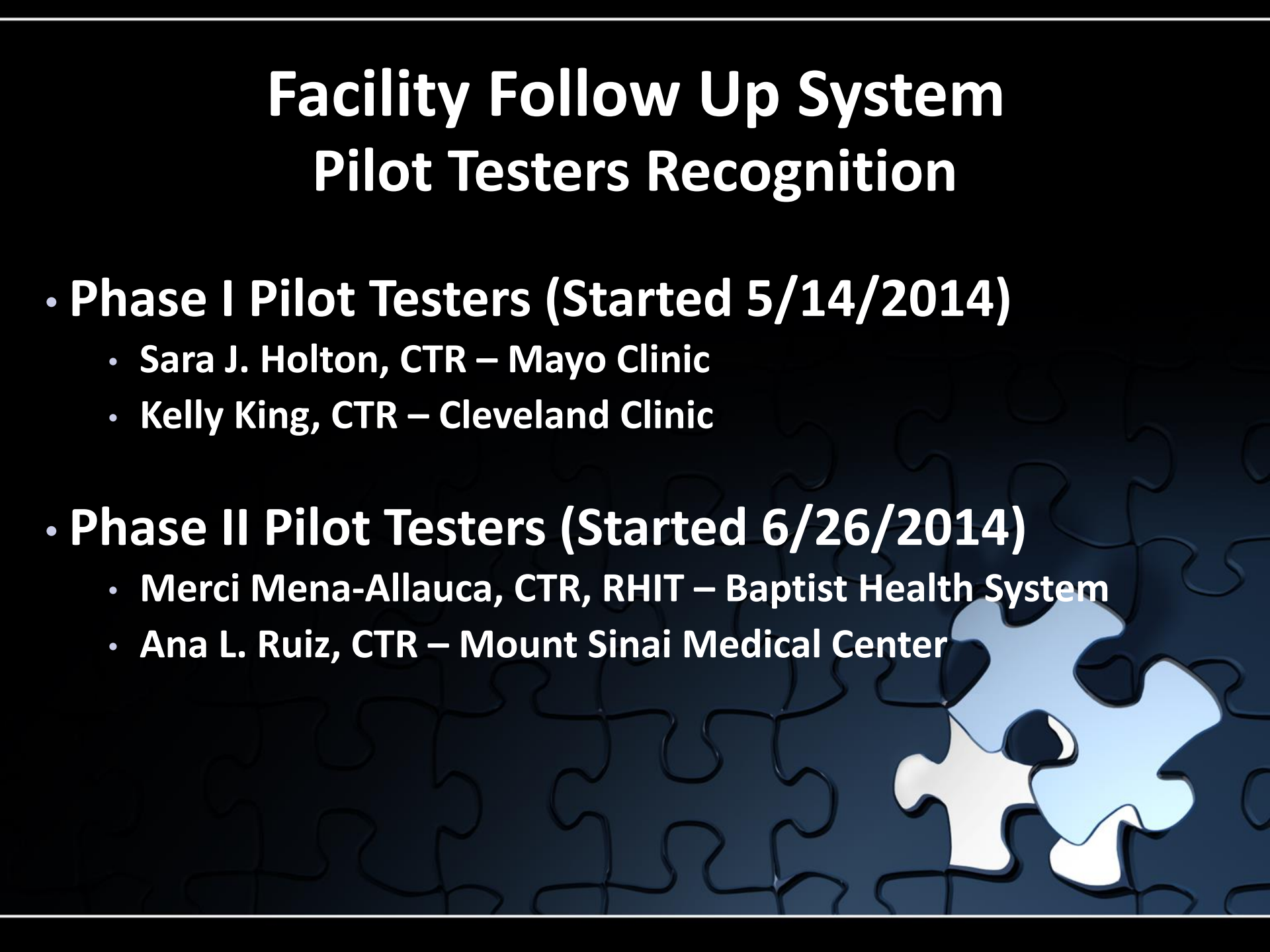
Possible Data Delivery Methodology

- Allow Upload Of List of Cases Needing Follow Up
  - Will Define File Layout
  - Will Define Maximum Number Of Cases Per Upload
  - Will Have Access To Facilities Assigned Via IDEA

- Return Information For Each Requested Case
  - Information Will Include
    - Facility/Accession/Sequence
    - First Course Treatment Information + TBD
  - Return Data In Tab Delimited or Excel File

Facility Follow Up System
Pilot Testers Recognition

- **Phase I Pilot Testers (Started 5/14/2014)**
  - Sara J. Holton, CTR – Mayo Clinic
  - Kelly King, CTR – Cleveland Clinic
- **Phase II Pilot Testers (Started 6/26/2014)**
  - Merci Mena-Allauca, CTR, RHIT – Baptist Health System
  - Ana L. Ruiz, CTR – Mount Sinai Medical Center



Facility Follow Up System
Pilot Testers Recognition

- Tested module to ensure error free
- Analyzed Results
  - Checking Date of Last Contact
  - Comparing Treatment Information
  - Impact on follow back rates
- Shared findings and issues
- Recommended improvements

Facility Follow Up System
Presentations by Pilot Testers

Kelly King, CTR – Cleveland Clinic
Sara J. Holton, CTR – Mayo Clinic

Facility Follow Up System

When Will This Be Available You Ask?

Depending On Time And Budgetary Resources By The ~~End Of 2013~~

During 4th Quarter 2014 (Hopefully by August)

2014 FCDS Data Validation Audit
Diagnosis Year 2012 Cases

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BACKGROUND
AUDIT METHODOLOGY
AUDITOR VALIDATION EXAMPLE
FACILITY RECONCILIATION EXAMPLE

FCDS ANNUAL CONFERENCE
ORLANDO, FL
7/24/2014

STEVEN PEACE, CTR

Data Validation with E-Path Verification

- Audits may include manual/visual review of one or more source documents, data linkages of one or more electronic files from reporting facilities with the central cancer registry database with a cross-walk and/or comparison of output results.

- This audit has 2 components;
  - **First:** a focused review of analytic breast and colon cancer cases diagnosed/treated at the facility with validation (recoding) of data from text only;
  - **Second:** a focused review of e-pathology report(s) from any e-path report source matching hospital registry abstracts with recode of data from pathology report(s).

- Facilities are required to reconcile BOTH data sets for a best code.
- Additional documentation will be required if not available.

Data Validation with E-Path Verification

- The visual editing validation and recoding of key data component of this audit is modeled after the NPCR Visual Editing Audit conducted early in 2013 for 2010 diagnoses and consolidation.

- This method utilizes FCDS standard visual editing/QC Review procedures used to convey review findings targeted to specific cancers (breast and colon) that were also part of the CER Project.

- NOTE: Text Documentation of specific data items has been both a state and national cancer reporting requirement for nearly two decades with requirements and expectations reinforced via QC Review or personal contact with registrars on a routine basis.

Timeline

01/2014	02/2014	03/2014	04/2014	05/2014	06/2014	7/2014	8/2014	9/2014	10/2014
Protocol Development	Protocol Development	Final Protocol							
		Software Development	Software Development	Software Development					
			Identify Audit Team	Train Audit Team	Follow-Up Audit Team				
				Audit	Audit	Audit			
					Reconciliation	Reconciliation	Reconciliation		
							Final Review	Final Review	
									Update FCDS Record
								Preliminary Audit Report	Final Audit Report

2013 Jean Byers Award

FCDS Annual Meeting July 24 & 25

2013 Jean Byers Award

- 2013 award for 2011 data awarded in 2014!
- Criteria for the award:
  - All deadlines met with respect to the 2011 cancer case admissions
    - a. 2011 Annual Caseload Submission Deadline – June 30, 2012
    - b. Consolidated Follow Back Deadline – October 15, 2013
    - c. No more than 5% (or 35 cases, whichever number is greater) of the 2011 cancer case admissions reported to FCDS within 2 months (60 days) following the June 30, 2012 deadline.
    - d. No more than 10% of the 2011 cancer case admissions reported to FCDS within 12 months following the June 30, 2012 reporting deadline.

FCDS Annual Meeting of the Future

Jill A. MacKinnon, PhD, CTR
Epidemiologist and Project Director

2013 FCDS QC Activities Summary

FCDS ANNUAL CONFERENCE
ORLANDO, FL
7/25/2014

STEVEN PEACE, CTR

Submission Summary & QC Review Sample

Description	# Cases	% of Total
Total Cases Submitted to FCDS 1/1/2013-12/31/2013 – All Sources	**197,208**	**100%**
Total Cases – NO CHANGE – Pass ALL Edits – No Visual Review by FC or QC	**187,163**	**95.0%**
Total Cases – FC Visual Review *(FC Review to assess case for possible FORCE)*	**10,045**	**5.0%**
• FORCED *(EDIT Override Confirmed and FORCE was set - NOT an error)*	4,003	2.0%
• CORRECTED *(1 or more corrections made based on text – NOT a FORCE)*	4,519	2.3%
• DELETED *(duplicate case, not a reportable neoplasm, not a new primary)*	1,523	0.7%
Total Cases – Every 25th Case QC Review Sample/Visual Editing • *Sample includes **4% of analytic** hospital, radiation, surgery center cases* • *Sample includes **ALL male breast** and **ALL pediatric** cases* • *Sample **does not include** dermatology or other **physician office cases***	**6,067**	**3.2%**
Total Cases Visually Edited by FCDS in 2013 *(combined FC and/or QC Review)*	**16,112**	**8.2%**

QC Review Sample / Visual Editing - Summary

Description	# Cases	% of Total
Total Cases – Every 25th Case QC Review Sample/Visual Editing	**6,067**	**3.2% of Analytic Cases**
Total Cases – NO CHANGE on QC Review	**3,486**	**57.5% of QC Sample**
Total Cases Sent to Facility with Correction or Inquiry	**2,581**	**42.5% of QC Sample**
Total Cases Sent to Facility with Correction or Inquiry	**2,581**	**42.5% of QC Sample**
• NO CHANGE after Follow-Back to Facility	374	14.5%
• FORCED *(EDIT Override Confirmed - NOT an error)*	46	1.8%
• CORRECTED *(1 or more corrections made – NOT a FORCE)*	2,125	82.3%
• DELETED *(duplicate case, not a reportable neoplasm, not a new primary)*	36	1.4%

New QC Review Summary Report

A new or enhanced QC Completion Analysis Report would benefit FCDS and registrars in the field if we would provide a QC Review Summary Report by Facility and by Abstractor Code that would include the following items or grouped items.

Three Summary Reports

- Summary by Facility
- FCDS State Summary
- Summary by Abstractor Code

Summary Items - General

- # Cases Reviewed with No Change
- # Cases Reviewed with Correction with Breakdown by Type of Correction
- # Cases Reviewed Requiring Force
- # Cases Reviewed and Deleted
- Total QC Review Cases

Summary Items from Correct Cases - Aggregated into 6 Major Groups for all Three Summary Reports

- Patient Demographic
- Tumor Description
- Stage and SSFs
- Treatment
- Text Documentation
- Other – includes FAC/ACC/SEQ and Class of Case

2014 FCDS DQIR (2012 Analytic Cases)

Sample Report

Florida Cancer Data System - Facility Data Quality Indicator Report (DQIR) for 2012

Analytic cases[1] (extracted 3/3/2014)

Data Quality Indicator/Admission Year	Goals	2012 Facility %	2012 Florida Facilities %	2011 Facility %	2011 Florida Facilities %	2010 Facility %	2010 Florida Facilities %	2009 Facility %	2009 Florida Facilities %	2008 Facility %	2008 Florida Facilities %
Demographics											
Total Analytic Cases		1,885	107,567	1,821	111,182	1,865	111,552	2,092	114,918	2,050	113,878
Sex Unknown (9)	< 2%	0.000	0.033	0.000	0.037	0.000	0.021	0.000	0.029	0.049	0.047
Race not U.S., NOS (98)	< 3%	1.751	1.186	2.142	1.064	1.930	1.084	2.294	0.917	2.000	0.839
Race Unknown (99)	< 3%	0.743	0.692	1.483	0.724	2.306	0.844	5.784	1.235	4.878	1.128
Ethnicity Unknown (9)	< 1%	0.849	0.654	0.659	0.971	0.751	0.967	1.004	0.800	0.439	0.969
Birth Year Unknown	< 2%	0.000	0.001	0.000	0.004	0.000	0.002	0.096	0.002	0.049	0.002
Birth Month Unknown	< 2%	0.000	0.002	0.000	0.004	0.000	0.003	0.096	0.002	0.049	0.002
Birth Day Unknown	< 2%	0.000	0.003	0.000	0.004	0.000	0.003	0.096	0.002	0.049	0.002
Birthplace US NOS/Unknown (998,999)		75.915	75.347	70.566	75.995	66.810	75.152	72.945	73.028	76.683	73.155
Primary Payor Unknown (99)	< 3%	0.371	0.971	0.604	1.083	1.126	1.401	1.338	1.167	1.512	1.447
Marital Status Unknown (9)		1.114	2.112	1.043	2.095	1.501	2.503	2.342	2.338	2.585	1.963
Missing/Impossible SSN*[2]	< 3%	2.050	2.343	2.310	1.944	2.009	1.787	2.075	1.754	2.869	1.870
Ungeocodables (Certainty 9)[2]	< 2%	0.000	0.162	0.056	0.430	0.056	0.126	0.000	0.123	0.050	0.115
PO Boxes (Certainty 5)[2]	0%	0.000	0.208	0.958	1.652	1.395	2.076	1.038	2.432	1.057	2.247
Tumor Characteristics											
Diagnostic Confirmation											
Not Microscopically Confirmed (5-8)	< 2%	5.464	0.401	7.249	0.462	8.472	0.502	7.839	0.392	7.512	0.330
DX Method Unknown (9)	< 2%	0.053	0.172	0.055	0.179	0.000	0.100	0.048	0.046	0.000	0.032
Topography											
Other/Ill-Defined Sites (C76x)	< 1%	0.000	0.016	0.000	0.020	0.000	0.030	0.191	0.036	0.049	0.045
Unknown Primary Site (C809)	< 5%	1.804	1.847	1.483	1.962	1.287	1.954	1.386	1.989	1.317	1.898
Morphology Non-specific (8000-8005)	< 5%	3.607	2.010	2.306	1.941	2.735	1.992	1.816	2.121	1.268	1.989
Grade Unknown (excludes C80.9)		39.204	36.274	40.802	33.958	40.804	34.729	40.822	34.351	40.293	34.497
Derived/Summary Stage-2000 Unknown (9)	< 5%	5.570	5.763	4.393	6.144	4.343	6.212	6.358	6.778	6.585	7.029

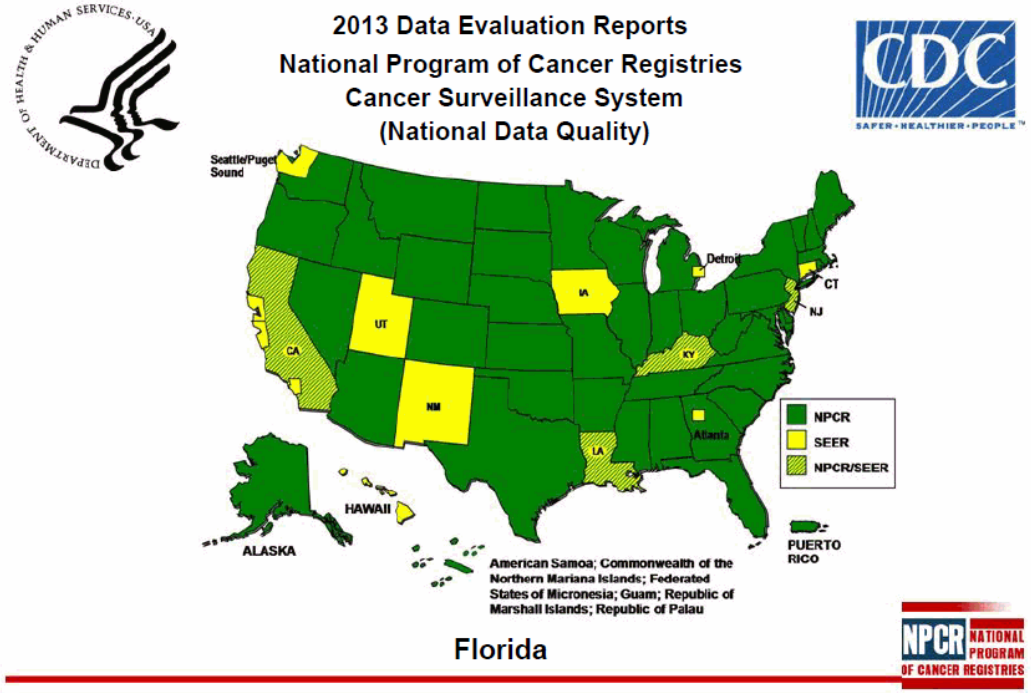
* 999999999, 123456789, 111111111, 222222222, 333333333, 444444444, 555555555, 666666666, 777777777, 888888888, 000000000, 773000000, 987654321

[1] Analytic according to FCDS (class of case: 0 - 22 or 34 - 42)

[2] Percentages based on analytic cases of Florida residents at time of DX only.

*modified 3/3/14

2013 Call for Data – NPCR DER Summary



2013 Call for Data – NPCR DER Summary

National Program of Cancer Registries - Cancer Surveillance System

SSR2 - Submission Summary Report - 2013

Florida

Table 1: Submission Summary

Diagnosis Year	Record Status					
	Records Received	Non-reportable Records	Reportable Records	Invasive Records*	In Situ Records	Benign Brain Records
2010	112037	0	112037	102166	6540	3331
2009	117564	0	117564	106773	7249	3542
2008	119027	0	119027	108297	7345	3385
2007	116930	0	116930	106427	7313	3190
2006	114304	0	114304	104404	6606	3294
<= 2005 **	1147891	0	1147891	1085770	55807	6314
Prior to NPCR Referance Year	0	0	0	0	0	
Total	1727753	0	1727753	1613836	90860	23057

* Invasive records include in situ bladder.

** Includes all submitted records from the NPCR reference year through 2005.

Submission Date: November 29, 2011

NAACCR Record Version: 122

NPCR Reference Year: 1995

Years Submitted: 1995-2011

2013 Call for Data – NPCR DER Summary

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FCDS % Lower than NPCR Median %

Spanish/Hispanic Origin [190] Unknown
Birthplace Country [254] Unknown
DX Date [390] Month Blank
Topography [400] Other/Ill defined sites (C76.0 - C76.8)
DX Confirmation [490] (Excludes DCO) Not Microscopically Confirmed (5-8)
DX Confirmation [490] (Excludes DCO) Unknown and Blank
Laterality [410] (paired organs only) Unknown and Blank
RX Summ Surg Prim Site [1290] Blank and Unknown
RX Scope Reg LN Sur [1292] Blank and Unknown
Reason for No Surgery [1340] Blank and Unknown
RX Summ Radiation [1360] Blank and Unknown
RX Summ Chemo [1390] Blank and Unknown
RX Summ Hormone [1400] Blank and Unknown
RX Summ BRM [1410] Blank and Unknown
RX Summ Other [1420] Blank and Unknown
Rad Regional RX Modality [1570] NOS
Rad Regional RX Modality [1570] Blank and Unknown
RX Summ Transplnt/Endocr [3250] Blank and Unknown
Over-Ride Site/Type [2030] Overused
Date Last Contact [1750] (Decedents only) Year Invalid
Cause of Death [1910] (Decedents only) Death Cert Available No COD
Cause of Death [1910] (Decedents only) Death Certificate Not Available

2013 Call for Data – NPCR DER Summary

FCDS % Higher than NPCR Median %

Birthplace Country [254] NOS
Sequence Number Central [380] Two or More (01-35)
Topography [400] Unknown Primary Site (C80.9)
Morphology [420] Non-specific Neoplasms (8000-8005)
Grade [440] (Excludes DCO) Unknown and Blank
Laterality [410] (paired organs only) Only 1 side and Side NOS
CS Extension [2810] Unknown
CS Lymph Nodes [2830] Unknown
CS Mets at DX [2850] Unknown
Derived Summary Stage 2000 [3020] Unknown/Unstaged
RX Summ Surg Prim Site [1290] Surgery NOS
RX Summ Surg Oth Reg/Dis [1294] Blank and Unknown
RX Summ Surg/Rad Seq [1380] Blank and Unknown
RX Summ Systemic/Sur Seq [1639] Blank and Unknown
Over-Ride Age/Site/Morph [1990] Overused
Over-Ride SeqNo/DxConf [2000] Overused
Over-Ride Site/Lat/SeqNo [2010] Overused
Over-Ride Histology [2040] Morphology Type and Behavior
Over-Ride Site/Lat/Morph [2074] Overused
Census Tr Cert 2000 [365] Unknown
Follow-up Source [1790] Blank

Florida Cancer Data System

2014 Grade Coding Instructions ICD-O-3 Updates

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IMPLEMENTATION TIMELINE(S)
2014 FCDS DAM APPENDIX HANDOUTS

FCDS ANNUAL CONFERENCE
ORLANDO, FL
7/25/2014

STEVEN PEACE, CTR

Florida HEALTH

Outline

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Grade Coding Instructions 2014+

Instructions for Coding Grade for 2014+

GRADE, DIFFERENTIATION OR CELL INDICATOR
Item Length: 1
NAACCR Item #: 440
NAACCR Name: Grade
Grade, Differentiation for solid tumors (Codes 1, 2, 3, 4, 9) and Cell Indicator for Lymphoid Neoplasms (Codes 5, 6, 7, 8, 9)
Note: These instructions pertain to the data item Grade, Differentiation or Cell Indicator.

These are coding instructions for **cases diagnosed 1/1/2014** and forward.

Hematopoietic and Lymphoid Neoplasms

Cell Indicator (Codes 5, 6, 7, 8, 9)

Cell Indicator (Codes 5, 6, 7, 8) describes the lineage or phenotype of the cell. Codes 5, 6, 7, and 8 are used only for hematopoietic and lymphoid neoplasms. Code 9 indicates cell type not determined, not stated, or not applicable.

Coding Grade for Hematopoietic and Lymphoid Neoplasms

1. Determine the histology based on the current Hematopoietic and Lymphoid Neoplasm Manual [http://seer.cancer.gov/tools/heme/Hematopoietic_Instructions_and_Rules/].
2. Determine the Cell Indicator by applying the "Grade of Tumor Rules" within the current Hematopoietic and Lymphoid Neoplasm Manual [http://seer.cancer.gov/tools/heme/Hematopoietic_Instructions_and_Rules/] to code the grade.

Grade codes for hematopoietic and lymphoid neoplasms

Terminology	Grade Code
T-cell; T-precursor	5
B-Cell; Pre-B; B-precursor	6
Null cell; Non T-non B	7
NK cell (natural killer cell)	8
Grade unknown, not stated, or not applicable	9

Solid tumors

Grade, Differentiation (Codes 1, 2, 3, 4, 9)

Pathologic examination determines the grade, or degree of differentiation, of the tumor. For these cancers, the grade is a measurement of how closely the tumor cells resemble the parent tissue (organ of origin). Well-differentiated tumor cells closely resemble the tissue from the organ of origin. Poorly differentiated and undifferentiated tumor cells are disorganized and abnormal looking; they bear little

North American Association of Central Cancer Registries, Inc.

GUIDELINES FOR ICD-O-3 UPDATE IMPLEMENTATION

Effective January 1, 2014

Prepared by the

NAACCR ICD-O-3 Update Implementation Work Group

December 1, 2013

Introduction to Coding Grade for 2014+

To: The Cancer Registry Community

From: CoC-SEER-NPCR Technical Working Group

Date: 21 November 2013

Subject: Grade coding instructions to be implemented for cases diagnosed 1 January 2014+

The coding of grade (**GRADE, DIFFERENTIATION OR CELL INDICATOR [NAACCR Item #: 440]**) has become complicated over time by the introduction of specialized site-specific grading systems. In addition, the coding instructions listed in CoC's FORDS Manual and SEER's Coding Manual differed. Therefore, a small group has been meeting to see if a consensus on grade could be reached among CoC, SEER, and NPCR. The consensus decision was to draft a set of instructions that were simpler, the same among all 3 groups, and in the end, were different from CoC's or SEER's previous instructions. Separate documentation will be produced later to outline these differences.

The 'Instructions for Coding Grade' can be found at http://seer.cancer.gov/tools/grade/ and are to be implemented for cases diagnosed 1 January 2014 and forward for CoC, SEER, and NPCR. CoC and SEER will incorporate these instructions into their respective coding manuals for 2014. CoC, SEER, and NPCR will notify their respective constituents of their general coding instructions for 2014 including grade.

No codes have been added or deleted. Vendors will not be required to make any changes to software. However, vendors may be able to implement some of the grading instructions electronically to aid cancer registrars in coding the grade field.

Educational materials/presentations will be developed. Short articles/announcements are being developed to highlight some of the changes.

The impact of these new instructions on the analyses of grade trends over time may be substantial for some sites especially prostate. It was difficult to balance changing rules with a desire to keep grade trends intact. For prostate, however, earlier changes based on 'current at the time' AJCC/UICC rules had already wreaked havoc on trying to analyze prostate grade trends.

Many thanks to those who reviewed the instructions. Your comments and questions were very helpful.

The members of the CoC-SEER-NPCR Technical Working Group who drafted this document were Margaret Adamo (NCI-SEER), Mary Lewis (CDC-NPCR), Jerri Linn Phillips (CoC), Joan Phillips (CDC-NPCR), Lynn Ries (NCI contractor), Jennifer Ruhl (NCI-SEER), and Shannon Vann (NAACCR).

- The coding of grade has become complicated over time with the introduction of specialized site-specific grading systems and changes to coding instructions for some cancer sites.
- Coding instructions in ICD-O-3, the CoC FORDS Manual and the SEER Coding Manual differ - confusing.
- The Consensus Technical Work Group drafted a new set of instructions for 2014 forward that were simpler and the same for CoC, SEER, and NPCR.
- These consensus instructions differ from all previous instructions.
- Site-Specific Grade will continue for some cancer sites similar to SSF grades.

Introduction to Coding Grade for 2014+

- New Instructions Found @ http://seer.cancer.gov/tools/grade
- CoC, NPCR, SEER and FCDS will implement for all cases 2014>
- FCDS has included full set of new instructions in 2014 FCDS DAM
- No New Codes Added and No Codes Deleted
- Some grade values may be derived from SSF grade fields
- Prostate Grade and Gleason Cross-Walk to Grade is Significant

New Instruction Highlights

DO NOT GO BACK TO OLD CASES TO CHANGE OR CORRECT

- Code highest invasive tumor grade – even if just a focus
- Do not code grade from metastatic site or recurrent tumor – primary site only
- Do not code grade from tissue post chemo/xrt/brm/horm – tx may alter grade
  - includes post neoadjuvant surgical specimen – do not code post neoadj tx

- Instructions allow coding grade for non-invasive tumors – most are 2-grade
  - 2 grade system = **code 2** (**low grade**)
  - 2 grade system = **code 4** (**high grade**)

- **BUT** – if both in-situ and invasive –code the grade of the invasive tumor only!

- Gleason Conversion now same as what appears in AJCC 7th edition
  - Caution: Gleason 5, 6, 7 has changed over the years – use table
  - Gleason 10 is not = 4 (undifferentiated) – use table

Coding Grade for Solid Tumors - General

97

- Code grade of primary tumor only
- Code the highest grade recorded – even if it is only a focus
- Do not code grade based on metastatic or recurrent tissue sample
- Do not code grade based on tissue sample obtained after start of any TX
  - NOTE: This is particularly important for cases with surgery following neoadjuvant therapy

- C80.9 – Unknown Primary – Grade Must = 9
- C76.0-C76.8 – Other and Ill-Defined Sites – Grade Must = 9
- Body System, NOS Codes – Grade Must = 9 (no primary site)

- Non-Invasive/In-Situ Neoplasm – path may state grade – not same as invasive grade – BUT, can be coded – Do NOT code grade of dysplasia

- Invasive and Non-Invasive – code grade of invasive component ONLY!

Coding Grade - Prostate

Analysis of Prostate Grade Prior to 2014
Based Solely on the Grade Field
Is NOT Recommended – WHY?

Description	Grade Code	AJCC 7th	SEER 2003-2013	AJCC 6th	SEER < 2003
Gleason Score					
2	1	G1	G1	G1	G1
3	1	G1	G1	G1	G1
4	1	G1	G1	G1	G1
5	1	G1	G2	G2	G2
6	1	G1	G2	G2	G2
7	2	G2	G3	G3	G2
8	3	G3	G3	G3	G3
9	3	G3	G3	G3	G3
10	3	G3	G3	G3	G3

Coding Grade - Prostate

99

Use highest Gleason score from biopsy/TURP/prostatectomy

Use a known value over an unknown value.

Exclude results from tests performed after neoadjuvant therapy.

Gleason Grade Conversion Table

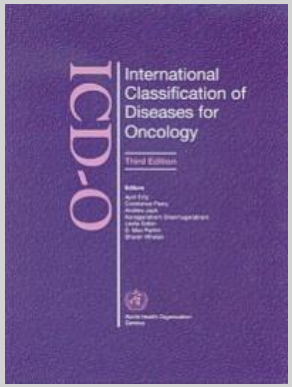
Code	Gleason's Score	Terminology	Histologic Grade
1	2, 3, 4, 5, 6	Well Differentiated	I
2	7	Moderately Differentiated	II
3	8, 9, 10	Poorly Differentiated	III

CAUTION: Gleason 5, 6, 7 have changed over the years

Gleason 10 is never Grade = 4

Introduction to ICD-O-3 Updates

- History of ICD-O
  - 1976 – ICD-O
  - 1990 – ICD-O-2
  - 2000 – ICD-O-3
    - 2001 Errata
    - 2003 Errata
    - 2011 Updates
    - ICD-O-3.1 On-Line - IARC
  - Languages: Chinese, Czech, English, Finnish, Flemish/Dutch, French German, Japanese, Korean, Portuguese, Spanish, Romanian, Turkish



North American Association of Central Cancer Registries, Inc.

GUIDELINES FOR ICD-O-3 UPDATE IMPLEMENTATION
Effective January 1, 2014

Prepared by the

NAACCR ICD-O-3 Update Implementation Work Group

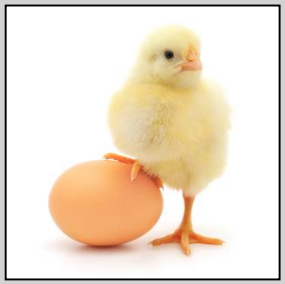
December 1, 2013

Introduction to ICD-O-3 Updates

101

- What drives the timing of ICD-O-3 Updates?
- Why has U.S. delayed implementing the 2011 updates?
- What do the 2011 updates include?
- What do the updates NOT include?
- What if we encounter a “new histology” before implementation?
- How do you use the interim cross-walk to ICD-O-3?
- When will the next updates be published?
- When will the next updates be implemented in the U.S.?

World Health Organization



What is Changing for 2015?

102

TABLE 2. ICD-O-3 CHANGES EFFECTIVE FOR JANUARY 1, 2015

ICD-O-3 change	New code in ICD-O-3	Description	Comment	Use this code in 2015
New term and code	8158/1	Endocrine tumor, functioning, NOS	Not reportable	
New related term	8158/1	ACTH-producing tumor	Not reportable	
New term and code	8163/3	Pancreatobiliary-type carcinoma (C24.1)	DO NOT use new code	8255/3
New synonym	8163/3	Adenocarcinoma, pancreatobiliary-type (C24.1)	DO NOT use new code	8255/3
New term	8213/3	Serrated adenocarcinoma		8213/3*
New code and term	8265/3	Micropapillary carcinoma, NOS (C18._, C19.9, C20.9)	DO NOT use new code	8507/3*
New code and term	8480/1	Low grade appendiceal mucinous neoplasm (C18.1)	Not reportable	
New term and code	8552/3	Mixed acinar ductal carcinoma	DO NOT use new code	8523/3
New term and code	8975/1	Calcifying nested epithelial stromal tumor (C22.0)	Not reportable	
New term and code	9395/3	Papillary tumor of the pineal region	DO NOT use new code	9361/3*
New term and code	9425/3	Pilomyxoid astrocytoma	DO NOT use new code	9421/3
New term and code	9431/1	Angiocentric glioma	DO NOT use new code	9380/1*
New term and code	9432/1	Pituicytoma	DO NOT use new code	9380/1*
New term and code	9509/1	Papillary glioneuronal tumor	DO NOT use new code	9505/1
New related term	9509/1	Rosette-forming glioneuronal tumor	DO NOT use new code	9505/1
New term and code	9741/1	Indolent systemic mastocytosis	Not reportable	

** ICD-O-3 rule F applies (code the behavior stated by the pathologist). If necessary, over-ride any advisory messages.*

Interim Cross-Walk

4 REPORTABILITY AND RECODE CHANGES EFFECTIVE IN 2015

Make the following reportability change.
Behavior code change
- ☐ Delete code and term, 8240/1, Carcinoid tumor, NOS, of appendix (C18.1).
- ☐ Code carcinoid tumor, NOS, of appendix to 8240/3. (Change made in Canada in 2012).

Recode the following conditions as shown.
- ☐ Recode all cases of enteroglucagonoma, NOS, as 8152/1. *Enteroglucagonoma is now a related term for glucagonoma.*
- ☐ Then delete code 8157/1 Enteroglucagonoma, NOS.
- ☐ Recode all cases of enteroglucagonoma, malignant as 8152/3. *Enteroglucagonoma, malignant is now a related term for glucagonoma, malignant.*
- ☐ Then delete code 8157/3 Enteroglucagonoma, malignant.

NOTE: It is important to understand that cancer registry reportability rules based on behavior code still apply. With the exception of primary intracranial and central nervous system benign and borderline tumors, the addition of a /0 or /1 coded term to ICD-O-3 does not imply that it is now reportable.

Why Can't We Just Start Using the New ICD-O-3 Codes in 2015?

Why Delay? -- The Impact of ICD-O-3 Updates

1. Changes to Legislation Required in Some States
2. Volume II Reportable Case Matrix (high grade dysplasia for GI cancers)
3. Casefinding List Review (ICD-9-CM diagnosis codes for new histologies)
4. SEER Site/Type Table Update
5. MPH Rules Solid Tumors
6. MPH Rules Hematopoietic/Lymphoid Neoplasms
7. Standard EDITS and State-Specific EDITS
8. AJCC/TNM – Histology Inclusion Tables and Histology-Driven Chapters
9. Collaborative Stage Data Collection – Histology Inclusion Tables
10. Collaborative Stage Data Collection – any special SSFs included/excluded
11. FORDS/SEER/State Coding Manual Updates
12. CoC Site-Specific Surgery Codes – Histology-Driven "Sites"
13. Automated/Manual Tumor Consolidation Histology Pairs Tables
14. SEER Incidence Site Recode ICD-O-3 –Histology-Driven Recodes
15. SEER Lymphoma Subtype Recodes – Histology-Driven Recodes
16. International Classification of Childhood Cancer (ICCC) Recodes
17. Histology Code Conversion(s) if any are required
18. Software-related: Site/Histo grouping updates as required where available for ad-hoc reports
19. Software-related: Updates to scoped lookups (based on site/histo)
20. Revisions: Does that include codes being added, deleted, converted?
21. Registry Plus Online Help resource

What do you do in the interim for coding?

- Call FCDS if you have a question
- Use the ICD-O-3 Cross-Walk for new-to-old codes
- Do not try to enter new ICD-O-3 codes until implemented
- Do not try to force the stated histology into a code that doesn't apply

- Consider adding a local-use data item to store new codes until guidance on implementation provides instruction about how to code and if you need to go back to identify older cases that can be recoded after implementation

- If pathologist terminology is specific but there is not a specific ICD-O-3 code (whether it is in the 2011 Update or NOT), you must code to a less specific ICD-O-3 code even if it is NOS code.

- Be consistent with your coding – you and your staff

- Clearly Document new terminology used by pathologist in the pathology text area for future reference – this allows you to find the case for possible recode in future once rules have been established, codes approved, etc.

FCDS Florida Cancer Data System

2014 Updates to the Hematopoietic and Lymphoid Neoplasm Coding Manual, Heme/Lymph MPH Rules and Database

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NEW RULES AND INSTRUCTIONS
NEW LOOK FOR DATABASE
HOW TO USE

FCDS ANNUAL CONFERENCE
ORLANDO, FL
7/25/2014

STEVEN PEACE, CTR

Florida HEALTH

New Look and New Instructions

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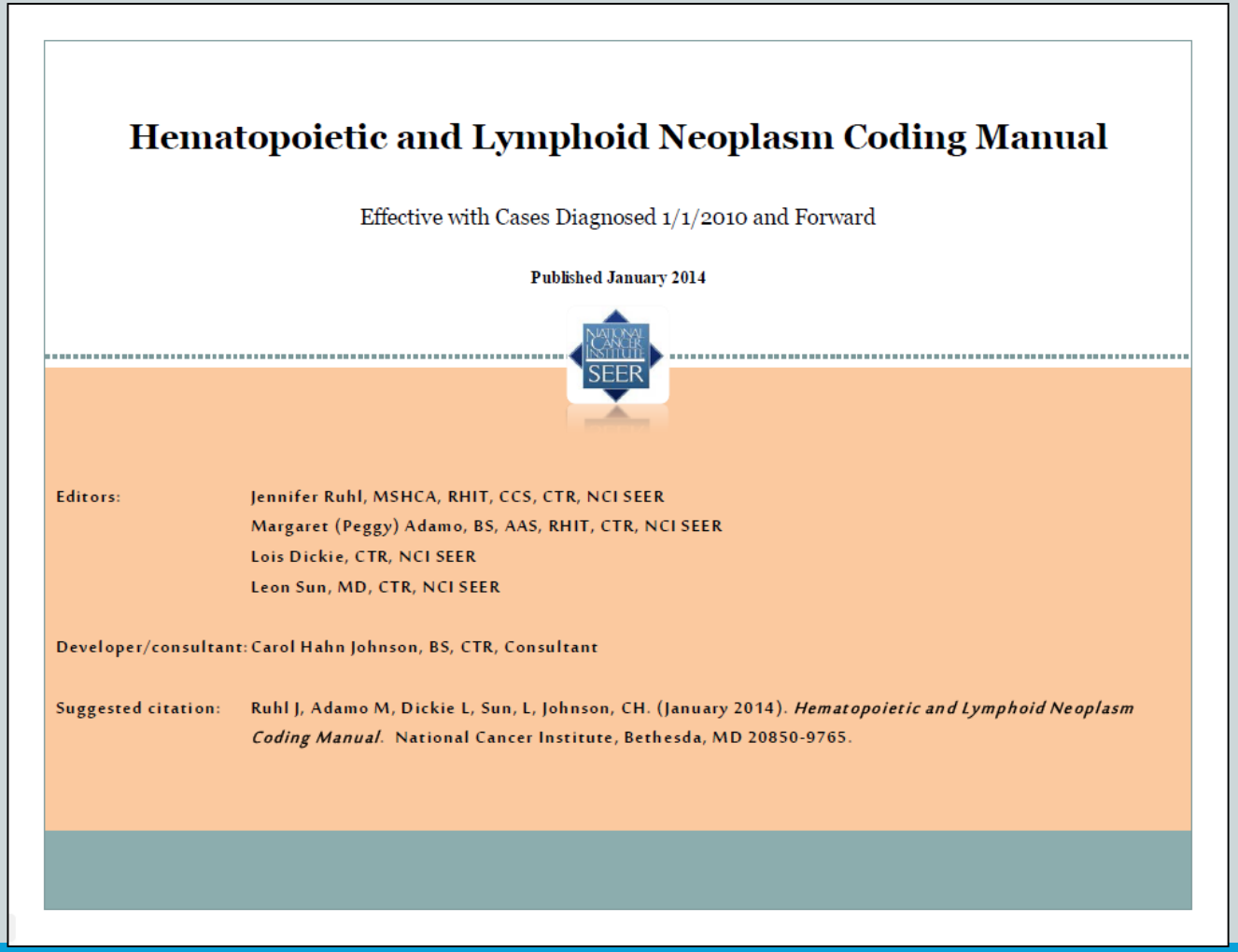

Hematopoietic and Lymphoid Neoplasm Coding Manual

Effective with Cases Diagnosed 1/1/2010 and Forward

Published January 2014

Editors: Jennifer Ruhl, MSHCA, RHIT, CCS, CTR, NCI SEER
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Developer/consultant: Carol Hahn Johnson, BS, CTR, Consultant

Suggested citation: Ruhl J, Adamo M, Dickie L, Sun, L, Johnson, CH. (January 2014). *Hematopoietic and Lymphoid Neoplasm Coding Manual*. National Cancer Institute, Bethesda, MD 20850-9765.

Where to Locate the Manual and Database

Web-based Version of the Database

The Heme DB provided in a web-based format has several benefits over the software version:

- Updates are automatic: users do not have to install anything to access the latest revisions.
- Allows access from any computer or device with an Internet connection.
- Eliminates problems for users who do not have permission to install software on their work computers.

Information from the 2010 and 2012 databases has been consolidated into one database and all information for cases diagnosed from 2010 and forward is contained in this one database. There are also entries for some obsolete terms that were in effect for cases diagnosed 2001–2009. These entries are clearly marked as Obsolete.

Hematopoietic and Lymphoid Neoplasm Database and Coding Manual – For cases diagnosed January 1, 2010 and later.

Stand-alone Version of the Database

The stand-alone version of the database also contains the information from the 2010 and 2012 databases consolidated into one database. The web-based version of the Heme DB is the preferred method to access the current data. If you need the stand-alone version because of limited Internet access, it is still available for now, but may be phased out in the future. Note that the information in the stand-alone version of the database may not be as current as the web-based version. A new feature will soon be implemented to update the Heme data in the stand-alone version automatically whenever you have an Internet connection. An e-mail will be sent out when this new feature is available.

Download the Hematopoietic Database Software Version 2.3.1 (released January 21, 2014)

Major Changes

- 2014 Updates are effective for all cases 1/1/2010 >
- Review of cases abstracted using older version(s) is not required;
- However, for those who choose to review cases already abstracted using an older version – Please refer to soon-to-be-published change documents that will be available on SEER Website in the near future.
- Revised manual effective for cases 1/1/2010 forward
  - There will no longer be a different "Version" based on Dx Year
  - "Published Date" will be used as reference instead of "Version"
    - *Published January 2014*
  - 2010 and 2012 Versions of Database and Manual no longer available
  - The option to switch between 2010 and 2012 versions was removed

Major Changes

- OBSOLETE CODES ARE INVALID for All Cases 1/1/2010 >
- All ICD-O [obs] and (OBS) codes are obsolete as of 1/1/2010
  - EDITS have not completely caught up with new[obs] rules
- Search and Re-Direct for OBS codes are now date driven
- Instruction for abstracting or creating “DCO, path-only and minimal information” cases was removed from the database
- Working on how to “fix” cases already coded using OBS codes

Hematopoietic Database Changes

Users Guide for
NCI's Online Hematopoietic and Lymphoid Database

Table of Contents

What's New in the Hematopoietic and Lymphoid Database 1
Home Page 2
Searching the Database 3
Multiple Primaries Calculator 4
Using the ICD Code Lists 5
Viewing the Information for a Specific Disease 6
Viewing the Information for an Obsolete Disease 9

Home Page

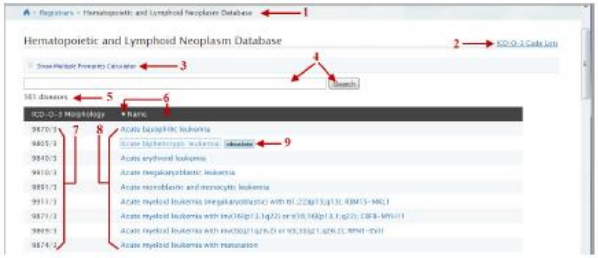

Figure 1 – Hematopoietic and Lymphoid Database Home Page

When the **Hematopoietic and Lymphoid Database** opens the search field is blank, all of the entries in the database appear under the **ICD-O-3 and Morphology** and **Name** columns. When the user highlights a disease, the Disease Information page opens.

1. The breadcrumbs appear at the top of each page of the **Hematopoietic and Lymphoid Database**, telling you where you are on the web site.
2. The **ICD-O-3 Code Lists**, link **ICD-O-3 Code Lists** page. From that page you can select the ICD-O Code List you want to display. (See the section Using ICD Code Lists for more information.)
3. To open the **Multiple Primaries Calculator**, click on the link on the upper left side of the screen. The calculator compares ICD codes, as long as the latest diagnosis year of one of the codes is 2010 or later, to determine whether they represent the same primary or a new primary.
4. The database search field and **Search** button are above the **ICD-O-3 and Morphology** and **Name** title bar (#6). (See the section **Searching the Database** for more information.)
5. The number of the diseases in the database appears above the title bar for the **ICD-O-3 and Morphology** and **Name**. When a search has been run, this number becomes the number of results for that search.
6. The title bar for the **ICD-O-3 and Morphology** and **Name**. The diseases can be sorted by ICD-O-3 code or name in descending order (down arrow) or ascending (up arrow) order by clicking on the title by which you want to search. The arrow toggles to point either up or down by clicking again.
7. The **ICD-O-3 and Morphology** column holds the ICD-O-3 and morphology codes for each disease on the list.
8. The names of each disease appear in the **Name** column.
9. Indication that a disease has been declared obsolete. (See *Viewing the Information for an Obsolete Disease*.)

Hematopoietic Database Changes

Searching the Database

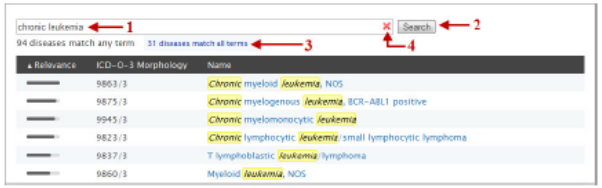

Figure 2 – Search Screen

1. Enter terms for the search in the Search field.
2. Click the **Search** button to run an "and" search. An "and" search treats multiple terms as if there is an "and" between each. So every term that appears in the search string must also appear in every result.
3. Click on the ***N* diseases match any term** link (***N*** stands for the number of matching diseases). The "or" search results will appear and the link will change to ***N* diseases match all terms** which will take the user back to the "and" search results. An "or" search treats multiple terms as if there is an "or" between each search term. In the example above, either the word "chronic" or the word "leukemia" must appear in every result.
4. Click on the red **X** to reset the search to blank. The Results will include all database entries.

The Hematopoietic and Lymphoid Database search function follows these rules:

- Search terms are not case-sensitive so you can enter them in any case.
- To search for exact terms in a precise order, use quotation marks (e.g., "term1 term2").
- All search terms are highlighted in the **Results** column and the **Disease Information** column.
- The search is weighted and the default is to sort the results based on **Relevance** by weight, but the column headers also allow the user to sort the results by relevance, name, or ICD-O-3 code, either ascending or descending, simply by clicking on the column header.

Viewing the Information for a Specific Disease

Each disease now has its own page and URL, which makes it possible to bookmark any disease information pages that you use regularly.

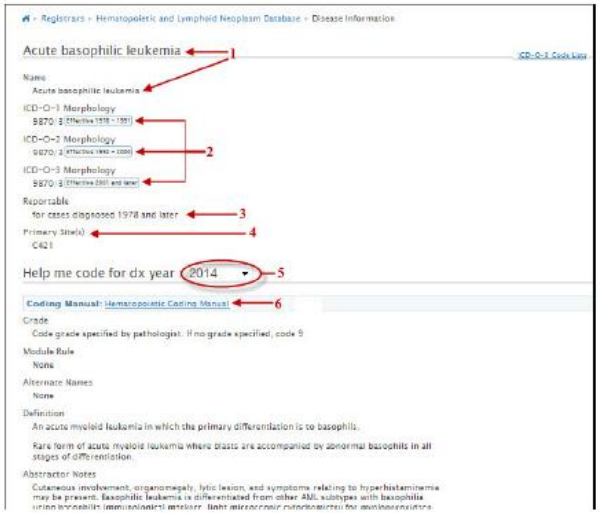

Figure 6 – Disease Information Page

1. **Name** of the disease on this Disease Information Page.
2. Codes and effective date ranges for all of the ICD-O morphologies (when available).
3. The years the disease was reportable.
4. Primary site code.
5. Diagnosis year dropdown menu for coding the disease. (See Figure 7.)
6. Link to the **Coding Manual** for the year of the diagnosis.

Hematopoietic Database Changes

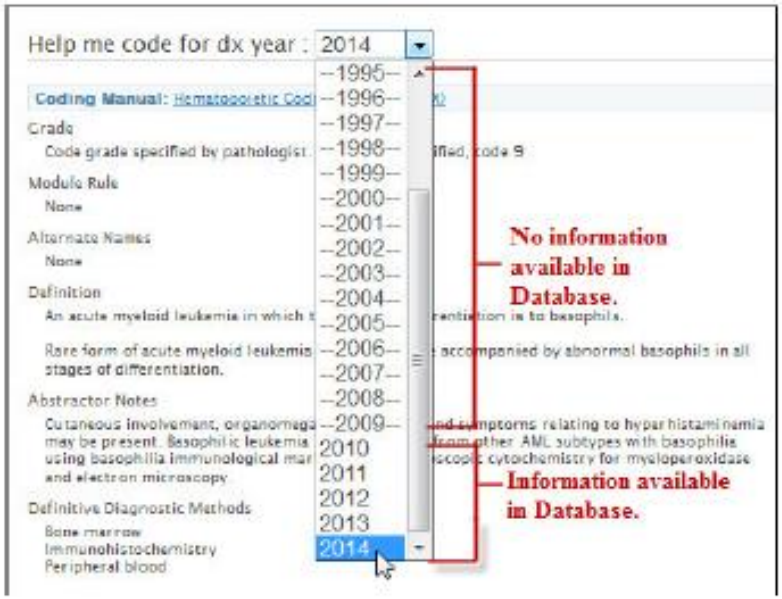

Figure 7 – Year of Diagnosis Dropdown Menu

The dropdown menu for selecting the year for diagnosis may include years where there is no information available in the database, other than the information above the diagnosis year dropdown menu. A double hyphen appearing before and after a year (e.g. --1995--) indicates that information such as description and abstractor notes for that year of diagnosis for that disease is not currently available in the database.

FCDS Florida Cancer Data System

Surgery Coding Refresher and Review of Instructions for Coding Scope Reg LN Surg

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PROBLEM SITE-SPECIFIC SURGERY CODES
CLARIFICATIONS FOR CODING
SCOPE OF REGIONAL LYMPH NODE SURGERY

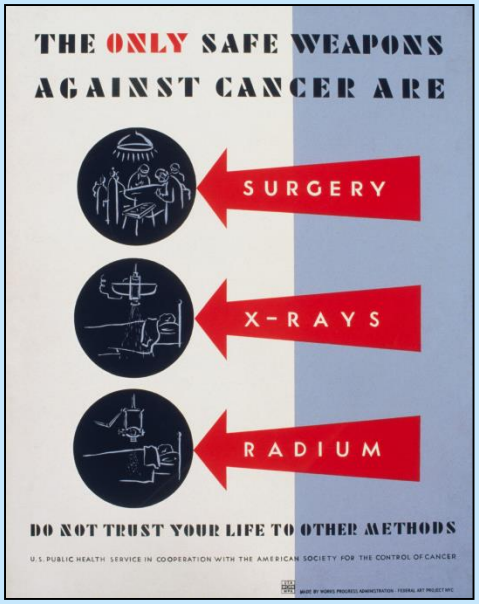
FCDS ANNUAL CONFERENCE
ORLANDO, FL
7/25/2014

STEVEN PEACE, CTR

Florida HEALTH

Surgery Coding Refresher - Outline

- First Course of Treatment
- What is Surgical Treatment
- Coding Multiple Surgery Fields
- Problematic Site-Specific Surgery Codes
  - Colon
  - Breast
  - Lymphoma
  - Ovary vs. Female Peritoneum



- Coding Scope of Regional Lymph Node Surgery
  - Sentinel Node(s) Biopsy or Excision
  - Regional Lymph Node Dissection
  - Sentinel Node(s) + Regional Lymph Node Dissection
  - Resection of Distant Lymph Node(s)

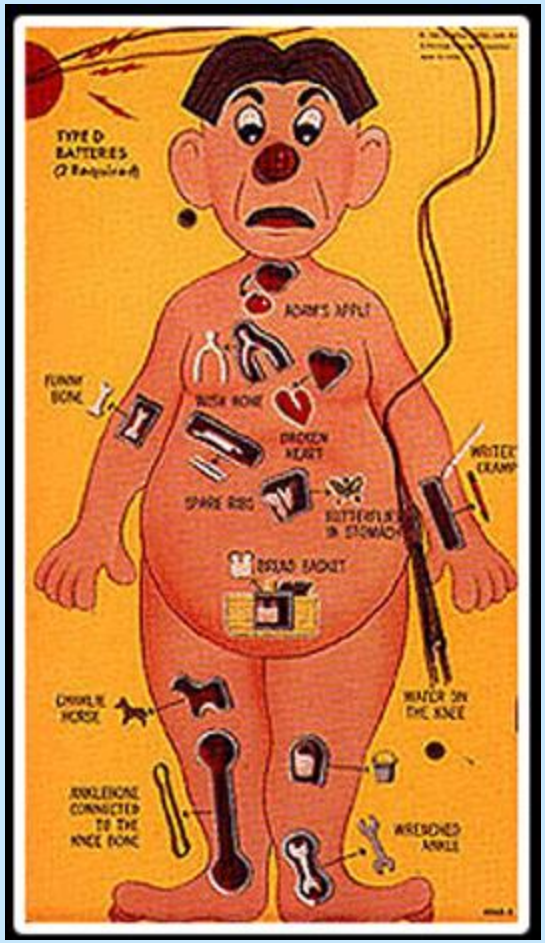
Source: WPA Poster US Public Health Service and American Society for the Control of Cancer 1941

Principles of Surgery

- Establish a diagnosis
- Remove primary tumor
- Evaluate regional extent of disease
- Surgical management of metastatic disease

- Appropriateness of surgery for type of neoplasm
- Appropriateness of surgery and clinical stage at Dx
- Appropriateness of surgery given patient factors
- Appropriateness of surgery given tumor factors

- Weighing the treatment options
- Informed Consent and Patient Choice
- Conservative versus radical surgical approach
- Reconstruction as part of first course of treatment



Coding Multiple Surgery Fields

CoC FORDS Surgery Fields
Date of First Surgical Procedure
RX Date – Surgery Flag
~~Date Most Definitive Surg - Prim Site~~
~~RX Date – Most Definitive Surg Flag~~
Surg Proc - Primary Site
~~Surg Proc - Primary Site – This Facility~~
~~Approach – Surg Prim Site This Fac.~~
~~Surgical Margins – Primary Site~~
Scope Reg LN Surg
~~Scope Reg LN Surg – This Facility~~
Surg Proc – Other Site
~~Surg Proc – Other Site – This Facility~~
~~Date Surg Discharge~~
~~RX Date Surg Discharge Flag~~
Reason for No Surgery of Primary Site
Radiation/Surgery Sequence
Systemic/Surgery Sequence

Central Registry Surgery Fields
Date of First Surgical Procedure
RX Date – Surgery Flag
RX Summ – Surg Prim Site
Reason for No Surgery of Primary Site
RX Summ – Scope Reg LN Surgery
RX Summ – Surgery OtherReg/Distant Site
RX Summ – Radiation/Surgery Sequence
RX Summ – Systemic/Surgery Sequence

Coding Multiple Surgery Fields

When multiple first course surgical procedures are included under the same surgery item, the most extensive surgery is usually the last surgery performed.

The code represents the cumulative effect of the separate surgical procedures.

- Surg Prim Site – the most extensive surgical procedure of the primary site (includes local tumor destruction, surgical excision or resection of the primary site, resection plus reconstruction of the primary site, and surgical resection of the primary site plus any surrounding tissues or organs removed in continuity with the primary site – en bloc resection)

- Scope of Regional LN Surgery – biopsy, aspiration or removal of sentinel lymph node(s) and/or surgical excision/resection of other regional lymph nodes that drain the primary site – may include 1 or more procedures – the LN "removal" may be for diagnostic, staging and/or treatment of disease.

- Surgery of Other Sites – surgical removal of distant lymph node(s) and/or regional and/or distant tissue or organs beyond primary site or regional LN

Surgery of Primary Site - Colon

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COLON

C18.0–C18.9

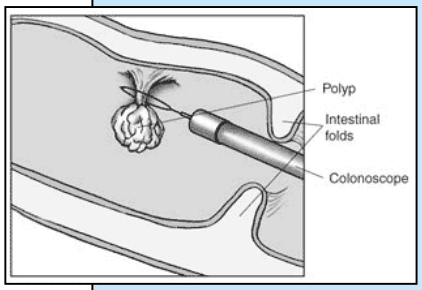
(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Code removal/surgical ablation of single or multiple liver metastases under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294).

Codes

00 None; no surgery of primary site; autopsy ONLY

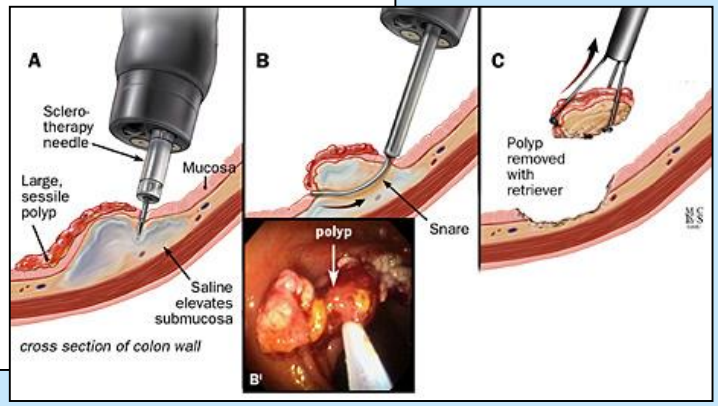
10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser



No specimen sent to pathology from surgical events 10–14.

20 Local tumor excision, NOS
- 27 Excisional biopsy
- 26 Polypectomy, NOS
- 28 Polypectomy-endoscopic
- 29 Polypectomy-surgical excision

Any combination of 20 or 26–29 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision



Surgery of Primary Site - Colon

119

30 Partial colectomy, segmental resection
32 Plus resection of contiguous organ; example: small bowel, bladder

40 Subtotal colectomy/hemicolectomy (total right or left colon and a portion of transverse colon)
41 Plus resection of contiguous organ; example: small bowel, bladder

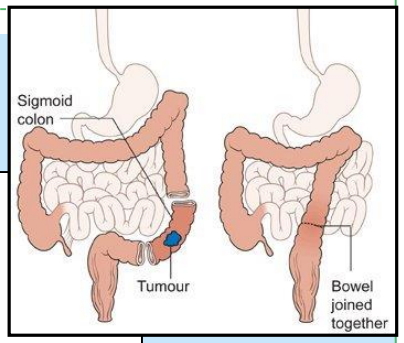
50 Total colectomy (removal of colon from cecum to the rectosigmoid junction; may include a por
the rectum)
51 Plus resection of contiguous organ; example: small bowel, bladder

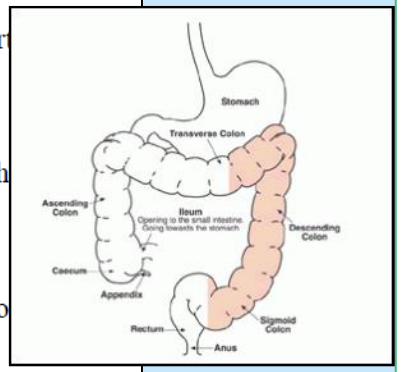
60 Total proctocolectomy (removal of colon from cecum to the rectosigmoid junction, including th
entire rectum)
61 Plus resection of contiguous organ; example: small bowel, bladder

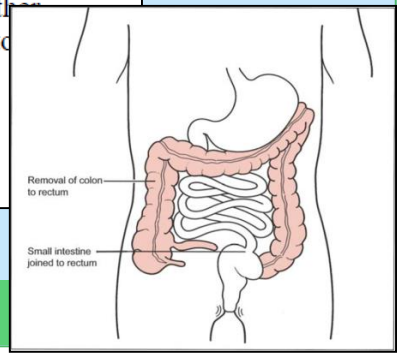
70 Colectomy or coloproctotectomy with resection of contiguous organ(s), NOS (where there is no
enough information to code 32, 41, 51, or 61)

Code 70 includes: Any colectomy (partial, hemicolectomy, or total) WITH a resection of any other organs in continuity with the primary site. Other organs may be partially or totally removed. Oth
organs may include, but are not limited to, oophorectomy, partial proctectomy, rectal mucosecto
or pelvic exenteration.

80 Colectomy, NOS







Surgery of Primary Site - Breast

120

BREAST

C50.0–C50.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9

Codes

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction, NOS

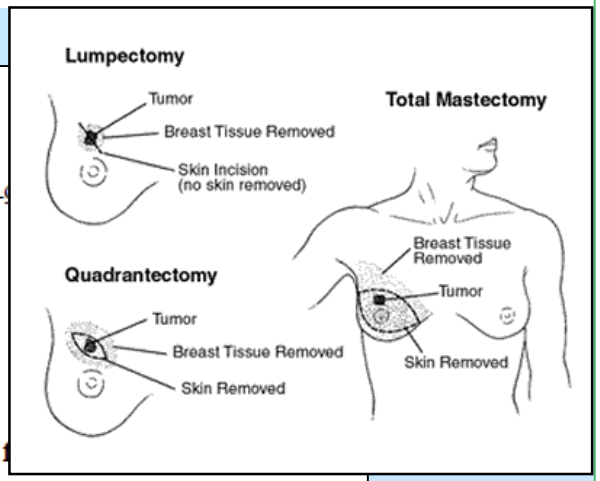
No specimen was sent to pathology for surgical events coded 19 (principally f to January 1, 2003).

20 Partial mastectomy, NOS; less than total mastectomy, NOS
- 21 Partial mastectomy WITH nipple resection
- 22 Lumpectomy or excisional biopsy
- 23 Reexcision of the biopsy site for gross or microscopic residual disease
- 24 Segmental mastectomy (including wedge resection, quadrantectomy, tylectomy)

Procedures coded 20–24 remove the gross primary tumor and some of the breast tissue (breast-conserving or preserving). There may be microscopic residual tumor.

30 Subcutaneous mastectomy

A subcutaneous mastectomy, also called a nipple sparing mastectomy, is the removal of breast tissue without the nipple and areolar complex or overlying skin. It is performed to facilitate immediate breast reconstruction. Cases coded 30 may be considered to have undergone breast reconstruction.



Surgery of Primary Site - Breast

121

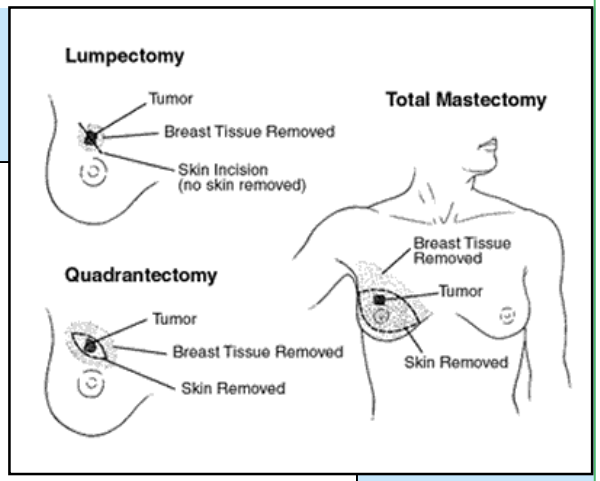
40 Total (simple) mastectomy
- 41 WITHOUT removal of uninvolved contralateral breast
  - 43 With reconstruction NOS
    - 44 Tissue
    - 45 Implant
    - 46 Combined (Tissue and Implant)
- 42 WITH removal of uninvolved contralateral breast
  - 47 With reconstruction NOS
    - 48 Tissue
    - 49 Implant
    - 75 Combined (Tissue and Implant)

A total (simple) mastectomy removes all breast tissue, the nipple, and areolar complex. An axillary dissection is not done, but sentinel lymph nodes may be removed.

For single primaries only, code removal of the involved contralateral breast under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294) and/or *Surgical Procedure/Other Site at This Facility* (NAACCR Item #674).

If the contralateral breast reveals a second primary, each breast is abstracted separately. The surgical procedure is coded 41 for the first primary. The surgical code for the contralateral breast is coded to the procedure performed on that site.

Reconstruction that is planned as part of first course treatment is coded 43-49 or 75, whether it is done at the time of mastectomy or later.



Surgery of Primary Site - Lymphoma

122

Most Common Error:
When a lymph node is biopsied or removed only to diagnose or to stage a lymphoma – to assess the patient status and confirm the lymphoma - do not code the lymph node removal as surgical treatment for lymphoma – this is a biopsy only to confirm the presence or absence of disease.

LYMPH NODES

C77.0–C77.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction or excision, NOS

Unknown whether a specimen was sent to pathology for surgical events coded to 19 (principally for cases diagnosed prior to January 1, 2003).

15 Local tumor destruction, NOS

No specimen sent to pathology from surgical event 15.

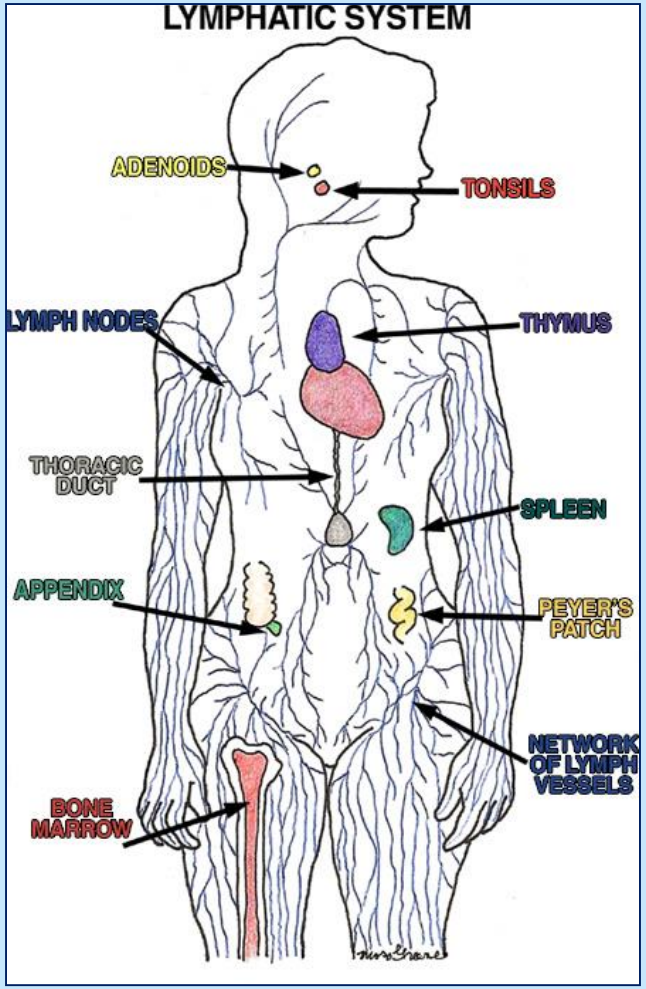
25 Local tumor excision, NOS
Less than a full chain, includes an excisional biopsy of a single lymph node.

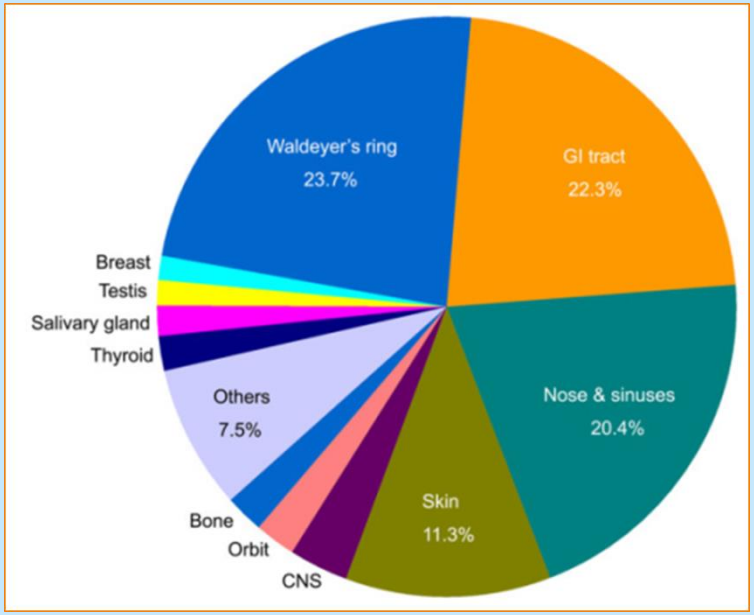
30 Lymph node dissection, NOS
31 One chain
32 Two or more chains

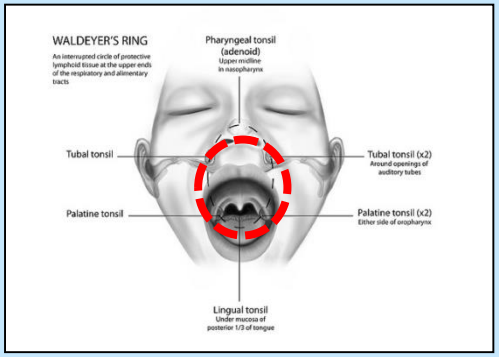
40 Lymph node dissection, NOS PLUS splenectomy
41 One chain
42 Two or more chains

50 Lymph node dissection, NOS and partial/total removal of adjacent organ(s)
51 One chain
52 Two or more chains

Surgery of Primary Site - Extranodal Lymphoma







http://commonsensehealth.com

http://nlm.nih.gov // http://cancer.gov

Surgery of Primary Site - Ovary

124

OVARY
C56.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

SURGERY OF PRIMARY SITE

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY

17 Local tumor destruction, NOS
No specimen sent to pathology from surgical event 17.

25 **Total removal** of tumor or (single) **ovary**, NOS
- 26 Resection of ovary (wedge, subtotal, or partial) ONLY, NOS; unknown if hysterectomy done
- 27 WITHOUT hysterectomy
- 28 WITH hysterectomy

Specimen sent to pathology from surgical events 25.28.

35 Unilateral (salpingo-) oophorectomy; unknown if hysterectomy done
- 36 WITHOUT hysterectomy
- 37 WITH hysterectomy

[*NOTE:* Use code 37 for current unilateral (salpingo-) oophorectomy with previous history of hysterectomy]

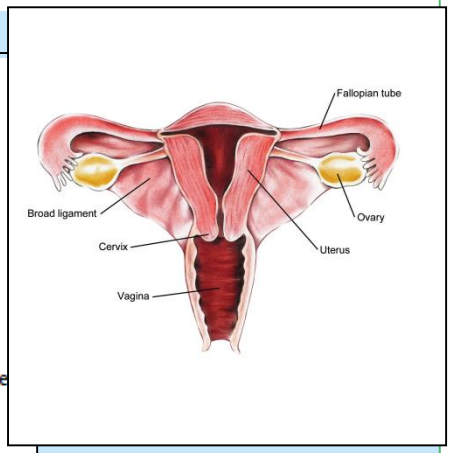
50 Bilateral (salpingo-) oophorectomy; unknown if hysterectomy done
- 51 WITHOUT hysterectomy
- 52 WITH hysterectomy

[*NOTE:* Use code 52 for current bilateral (salpingo-) oophorectomy with previous history of hysterectomy]

55 Unilateral or bilateral (salpingo-) **oophorectomy** WITH **OMENTECTOMY**, NOS; partial or total; **unknown if hysterectomy** done
- 56 WITHOUT hysterectomy
- 57 WITH hysterectomy

60 Debulking; cytoreductive surgery, NOS
- 61 WITH colon (including appendix) and/or small intestine resection (not incidental)
- 62 WITH partial resection of urinary tract (not incidental)
- 63 Combination of 61 and 62

Debulking is a partial or total removal of the tumor mass and can involve the removal of multiple organ sites. It may include removal of ovaries and/or the uterus (a hysterectomy). The pathology report may or may not identify ovarian tissue. A debulking is usually followed by another treatment modality such as chemotherapy.



Surgery of Primary Site – Female Peritoneum

125

ALL OTHER SITES

C14.2-C14.8, C17.0-C17.9, C23.9, C24.0-C24.9, C26.0-C26.9, C30.0-C30.1, C31.0-C31.9, C33.9,C38.0-C38.8, C39.0-C39.9, C48.0-C48.8, C51.0-C51.9, C52.9, C57.0-C57.9, C58.9, C60.0-C60.9, C63.0-C63.9, C68.0-C68.9, C69.0-C69.9, C74.0-C74.9, C75.0-C75.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

SURGERY OF PRIMARY SITE

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from surgical events 10.14

20 **Local tumor excision**, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any **combination** of **20** or **26-27** WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

Specimen sent to pathology from surgical events 20–27.

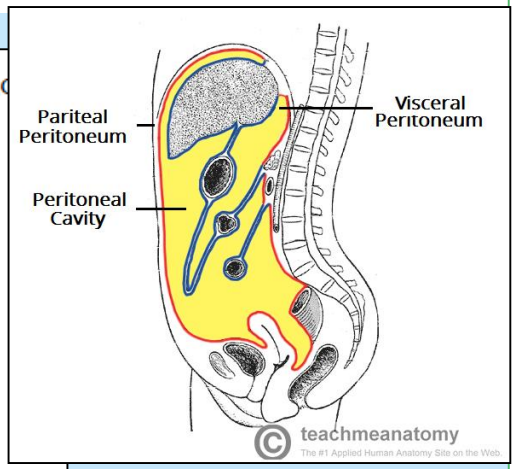
30 Simple/partial surgical removal of primary site

40 **Total surgical removal** of primary site; enucleation

41 Total enucleation (for eye surgery only)

50 Surgery stated to be. "**debulking**"

60 Radical surgery
Partial or total removal of the primary site WITH a resection in continuity (partial or total removal) with other organs.



Coding Scope of Regional Lymph Node Surgery

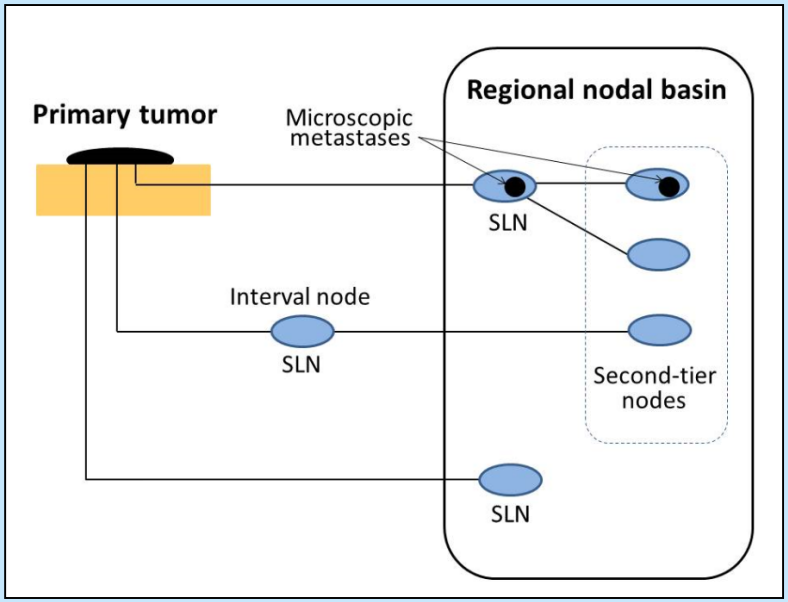
- Sentinel lymph node biopsy increasingly valuable tool for treatment planning
- Easy method to identify early lymph node metastasis at 1st node(s) station
- Clinically early stage cancers benefit from sentinel lymph node biopsy
- Clarification document published on 3/9/2012, BUT…
- Investigators still raising concerns regarding validity of coding of this data item
  - Significant under-reporting of sentinel lymph node biopsies
  - Significant incorrect coding of Scope of Regional LN Surgery
  - Registrars still not following the instructions from 3/9/2012
  - SLNBx are most often performed for breast and skin cancers
- Confusion continues for registrars on how to correctly code item
- Vendors may be incorrectly mapping multiple LN surgical procedures when software allows every procedure to be coded separately >> algorithm = derived

Coding Scope of Regional Lymph Node Surgery

- Scope of Regional Lymph Node Surgery is defined as; "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.
  - Collected for each surgical event even if surgery of primary site not performed
  - Record any surgical procedures which aspirate, biopsy or remove regional lymph nodes in an effort to diagnose and/or stage the patient's disease
  - Combinations of both SLNBx (FNA or excisional) plus regional lymph node dissection occur when sentinel lymph node biopsy shows evidence of neoplasm
  - Codes 0-7 are hierarchical. If only 1 procedure can be recorded, code the procedure that is numerically higher.
  - Review the operative report to confirm whether an aspiration or excision of regional lymph nodes was performed plus or minus additional node dissection
  - Sometimes SLNBx is attempted but no nodes map and/or none removed – when this happens, the patient normally moves on to a full node dissection – code the sentinel node biopsy as having been performed PLUS the node dissection.
  - When 5 or more nodes are examined by pathologist – probably node dissection and not a sentinel node biopsy – the sentinel node biopsy usually is 1 or 2 nodes only
  - Do NOT USE the items #LN+ and #LNexamined as means to determine the code

Sentinel Lymph Node(s) - Biopsy

- Sentinel Lymph Node(s) are;
  - ✓ First node(s) to receive lymphatic drainage from the primary tumor
  - ✓ First node(s) to which tumor will metastasize – bx with FNA or excise
  - ✓ When sentinel node(s) negative for tumor (FNA or excision) then other nodes in the primary site regional nodal basin also likely to be negative
  - ✓ Reduces unnecessary surgery and complications from surgery removing all nodes from the nodal basin



Regional Lymph Node Dissection

- Current standards of care for melanoma and breast indicate patients with 1 or more positive sentinel lymph node(s) should undergo full regional node dissection.
- Many studies comparing SLNBx to full nodal bed dissection conclude SLNBx prevents unnecessary short and/or long term complications and comorbidities in patients with negative nodes
- SLNBx Methodology and Surgical Practice Guidelines continue to evolve – particularly when micrometastasis is identified – is the presence (or absence) of micrometastasis significant or not?
- Do you include nodes with micrometastasis as positive lymph node(s)?

Risks and Side Effects of Node Dissection

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- SLNBx is not recommended for clinically positive nodes or when the primary tumor is large and/or ulcerated or if disseminated disease
- Node dissection costs more than SLNBx or FNA of lymph node in terms of procedure, where procedure can be performed, follow-up, other risk
- Risk post-operative range of motion limitations in lymph drainage area
- Risk of lymphedema is higher with a node dissection
- Risk of numbness of skin in lymph drainage area
- Scarring is more extensive with node dissection
- Risk of infection higher with node dissection
- Risk increases with obesity

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Recurring Issues and Problem Areas for Florida Registrars

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NUMEROUS DISCUSSION TOPICS
SEE DETAILED LIST

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7/25/2014

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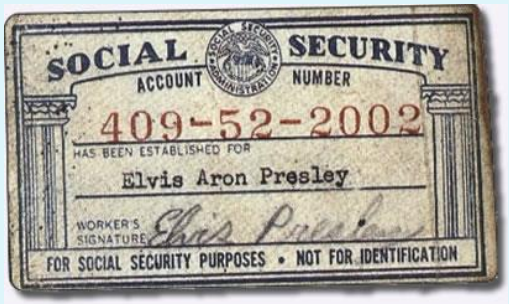
Please Use Current Desk References

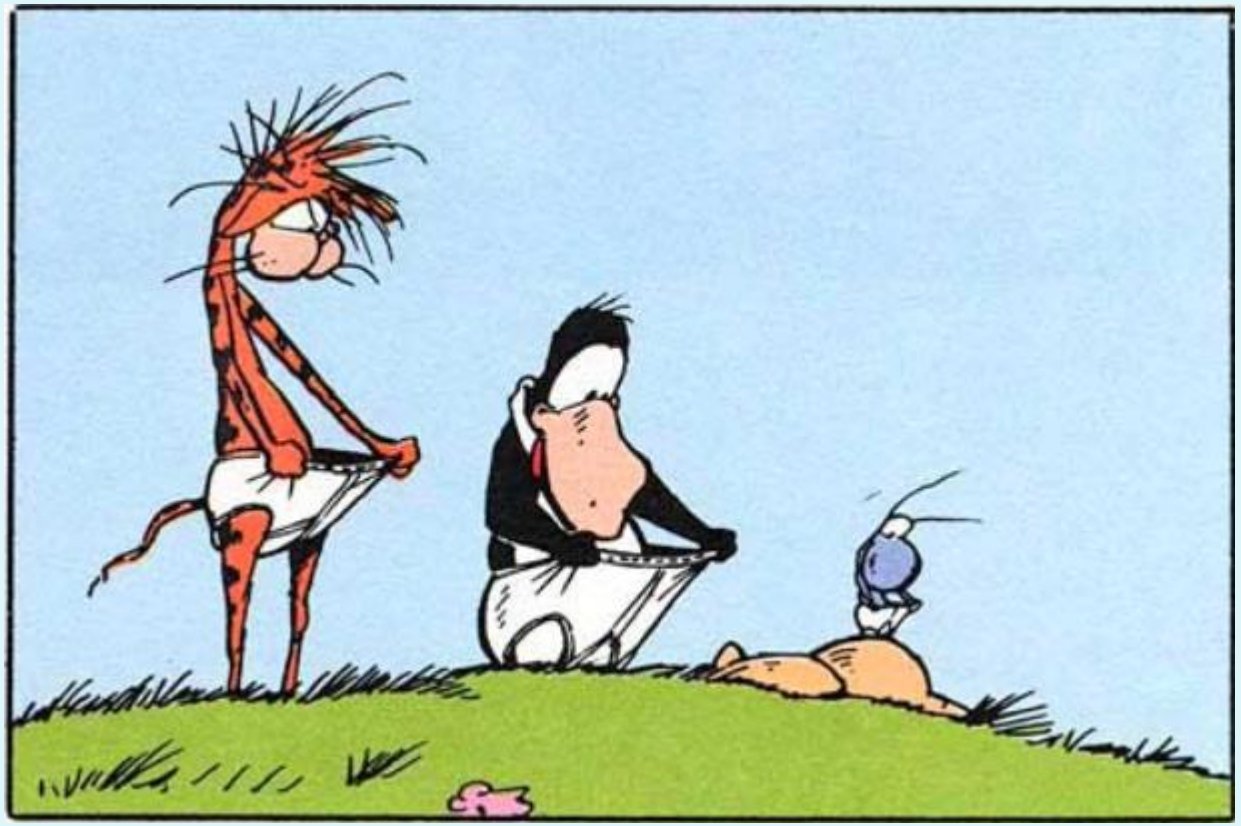
- 2014 FCDS DAM plus LVI Errata
- ICD-O-3 plus 3 errata and the 2011 updates
- Do not use ICD-O-3 to code heme/lymph
- SEER*Rx
  - On-Line Version – BEST
  - Desktop Version – version 2.2.0
- 2007 MPH Rules for Solid Tumors
  - 2012 Updated Version
- 2014 Hematopoietic and Lymphoid Neoplasm
  - 2014 Manual – Reportability Criteria and MPH Rules
  - 2014 Database – Neoplastic Details and Abstractor Notes
  - On-Line Version – BEST
  - Desktop Version – version 2.3.1
- Collaborative Stage Data Collection System v02.05
- AJCC TNM Manual, 7th ed.
- CoC FORDS – not updated for 2014
- SEER 2014 Coding and Staging Manual
- NCCN Guidelines – current year version

Social Security Number (SSN)



- Why is Social Security Number so important?
- Why isn't SSN with patient registration anymore?
- Are you sure we still get SSN – it isn't showing up in my software
  - AHCA requires SSN also – it is the only patient identifier besides DOB provided
  - EMR may prevent SSN from automatically populating into the registry software
  - Problems with cross-walks and updates when auto-populating demographics
- How do I gain access to the SSN in the EMR? Billing Systems
- What about SSN EDITS? Can they be overridden?
- When should I use 999999999? Can I enter just the last 4-digits?

PLEASE VALIDATE "SEX" OF PATIENT



Make time to ponder the little things in life.

Lymph Vascular Invasion

LYMPH-VASCULAR INVASION **NAACCR ITEM #1182**

Lymph-vascular invasion or LVI indicates the presence or absence of tumor cells in small lymphatic channels (not lymph nodes) or small blood vessels within the primary tumor or in the surrounding tissues of the primary site as noted microscopically by the pathologist. When a neoplasm shows the presence of lymph-vascular invasion, tumor cells have broken free of the primary tumor and now have the ability to float throughout the body. Therefore, lymph-vascular invasion may be used an indicator of prognosis.

Benign, borderline and in-situ neoplasms cannot have lymphatic or vascular invasion by definition. When any invasion is present, the neoplasm is classified as malignant with behavior = 3.

Lymphoid and myeloid neoplasms (neoplasms that originate in the lymphatic system, bone marrow, or in circulating blood) cannot have lymphatic or vascular invasion. Only solid tumors may have LVI.

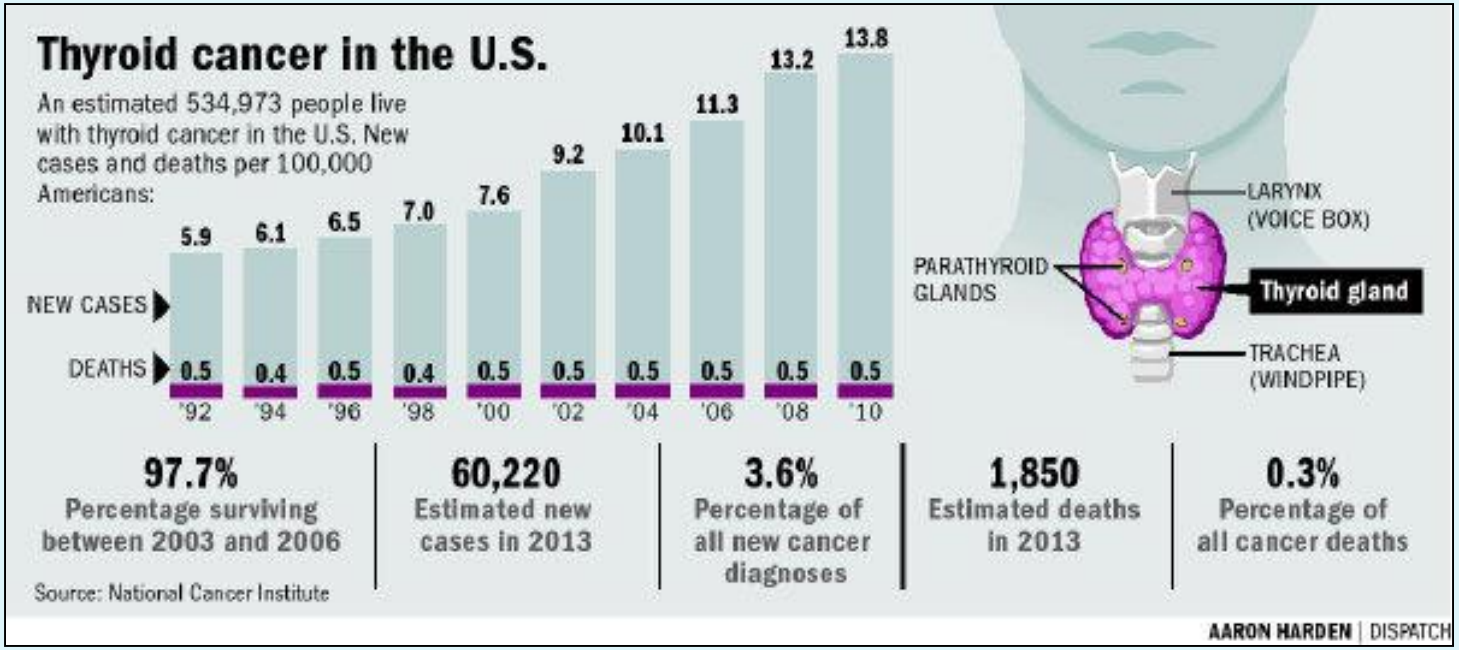
Lymphatic invasion is not the same as involvement of regional lymph nodes.

Lymph-vascular invasion does not include perineural invasion.

Coding Instructions

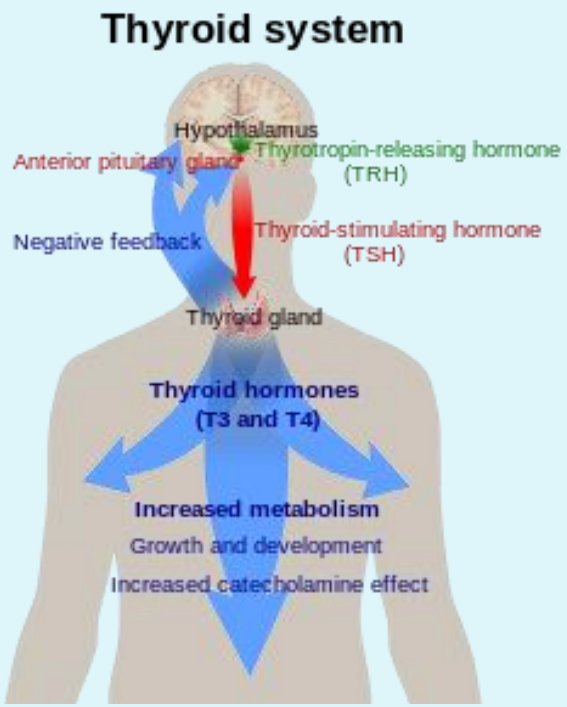
1. The primary source of this information is the pathology report or a physician's statement.
2. **Use code 0 when behavior = 0, 1, or 2 (ALL benign, borderline, and in-situ neoplasms)**
3. Use code 0 when the pathology report states that no lymph-vascular invasion was identified.
4. Use code 1 when lymph-vascular is identified anywhere in a primary tumor specimen.
5. **Use code 8 when histology = 9590-9992 (ALL lymphoid and myeloid neoplasms).**
6. Use code 9 if the pathology report indicates that the presence of lymph-vascular invasion could not be determined or when no information is available in the pathology report or medical record.
7. **Use code 9 when no tissue from the primary site was examined (invasive solid tumors only).**

Thyroid Cancer: I-131 and Hormone Therapy



High Frequency/Low Mortality	Low Frequency/High Mortality
Papillary (Adeno)carcinoma = 8260/3	Medullary Carcinoma
Follicular (Adeno)carcinoma = 8330/3	Anaplastic Carcinoma
Papillary-Follicular Adenocarcinoma = 8340/3	

Thyroid Cancer: I-131 and Hormone Therapy



PRINCIPLES OF THYROID STIMULATING HORMONE (TSH) SUPPRESSION

- Because TSH is a trophic hormone that can stimulate the growth of cells derived from thyroid follicular epithelium, the use of levothyroxine to maintain low TSH levels is considered optimal in treatment of patients with papillary, follicular, or Hürthle cell carcinoma. However, data are lacking to permit precise specification of the appropriate serum levels of TSH.
  - In general, patients with known residual carcinoma or at high risk for recurrence should have TSH levels maintained below 0.1 mU/L, whereas disease-free patients at low risk for recurrence should have TSH levels maintained either slightly below or slightly above the lower limit of the reference range.
  - For low-risk patients with biochemical evidence but no structural evidence of disease (eg, Tg positive, but imaging negative), maintain TSH levels at 0.1 - 0.5 mU/L.
  - Patients who remain disease free for several years can probably have their TSH levels maintained within the reference range.
- Given the potential toxicities associated with TSH-suppressive doses of levothyroxine--- including cardiac tachyarrhythmias (especially in the elderly) and bone demineralization (particularly in post-menopausal women) as well as frank symptoms of thyrotoxicosis---the risk and benefit of TSH-suppressive therapy must be balanced for each individual patient.
- Patients whose TSH levels are chronically suppressed should be counseled to ensure adequate daily intake of calcium (1200 mg/day) and vitamin D (1000 units/day).

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Recent Developments in Cancer Diagnosis and Treatment

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Outline

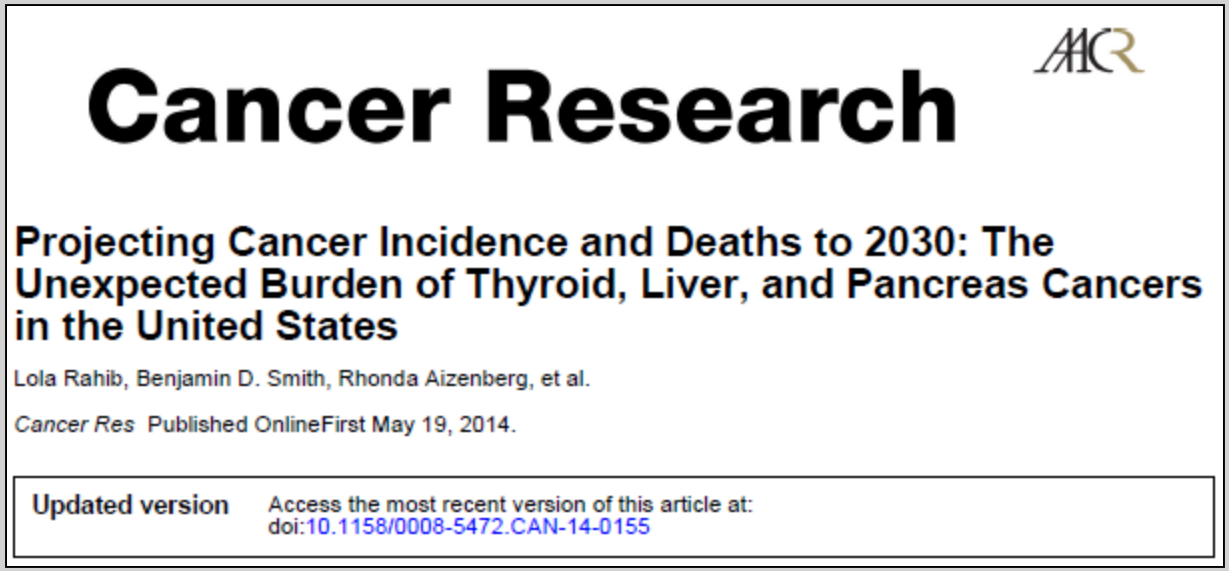
- Introduction
- Trends in Cancer Incidence and Mortality
- Current Trends in Cancer Screening
- The Over-Diagnosis and Over-Treatment of “Cancer”
- Canadian National Breast Screening Study – 25 Year Follow-up
- Surgeon General’s Report on Smoking and Health – 50 Years
- The State of Cancer Care in America – 2014
- This and That
- Wrap Up

Trends in Cancer Incidence and Mortality

- Early-detection via screening identifies early cancers (non-invasive, minimally invasive, in-situ) amenable to treatment.
- Early-treatment should focus on prevention and lifestyle with focus on smoking cessation, weight control, and active lifestyle.
- The 2 biggest risk factors for all cancers: Smoking & Obesity
- Obesity is related to diet AND exercise and causes diabetes
- Obesity-related diabetes is linked to increases in occurrence of cancers of the esophagus, thyroid, pancreas, gallbladder, kidney, colon, female breast (post-menopausal) and endometrium.

Source: Cancer Research, American Association for Cancer Research

Trends in Cancer Incidence and Mortality



Cancer Research

AACR

Projecting Cancer Incidence and Deaths to 2030: The Unexpected Burden of Thyroid, Liver, and Pancreas Cancers in the United States

Lola Rahib, Benjamin D. Smith, Rhonda Aizenberg, et al.

Cancer Res Published OnlineFirst May 19, 2014.

Updated version	Access the most recent version of this article at: doi:10.1158/0008-5472.CAN-14-0155

Demographic Changes in U.S. Population – age, race, income, insurance
Trends in Smoking, HPV Infection, Obesity, Nutrition, Diabetes, Physical Activity
Trends in Cancer Screening and Prevention
Trends in Cancer Diagnosis and Treatment

Source: Cancer Research, American Association for Cancer Research

Over-Diagnosis / Over-Treatment of "Cancer"

- Estimates suggest that 25%-30% of individuals classified as "cancer survivors" never needed any treatment for their cancer.
  - 20% of image-detected lung cancers
  - 25% of mammography-detected breast cancers
  - 40% of ultrasound-detected thyroid cancers
  - 60% of PSA-detected prostate cancers
- Early non-invasive cancers are not malignant by definition and cannot spread or metastasize if treated with surgical resection.
- Patients may develop new cancers, but non-invasive cancers will not "recur" in surgically treated site – optimal care – prevention
- Non-invasive cancers often grouped with and treated as if they were invasive cancers – tied to reimbursement / patient choice

Source: 2014 Cancer Facts & Figures and Dr. Otis Brawley

Over-Diagnosis / Over-Treatment of "Cancer"

- Once diagnosed – patients' and their families hear the word "cancer" they naturally want to eradicate any trace of cancer in themselves or their family member. So, they agree to or even insist on cancer treatment that may do more harm than good to the patient/cancer.

- Should all screen-detected neoplasms deemed non-invasive be classified, treated, and followed as though they were malignant?

- What is the cost associated with over-treatment?
- What are the risks associated with over-treatment?

- What should screening and treatment recommendations include?
- What else can be done by patient's and health care providers?

Source: 2014 Cancer Facts & Figures and Dr. Otis Brawley

Surgeon General Report on Smoking & Health

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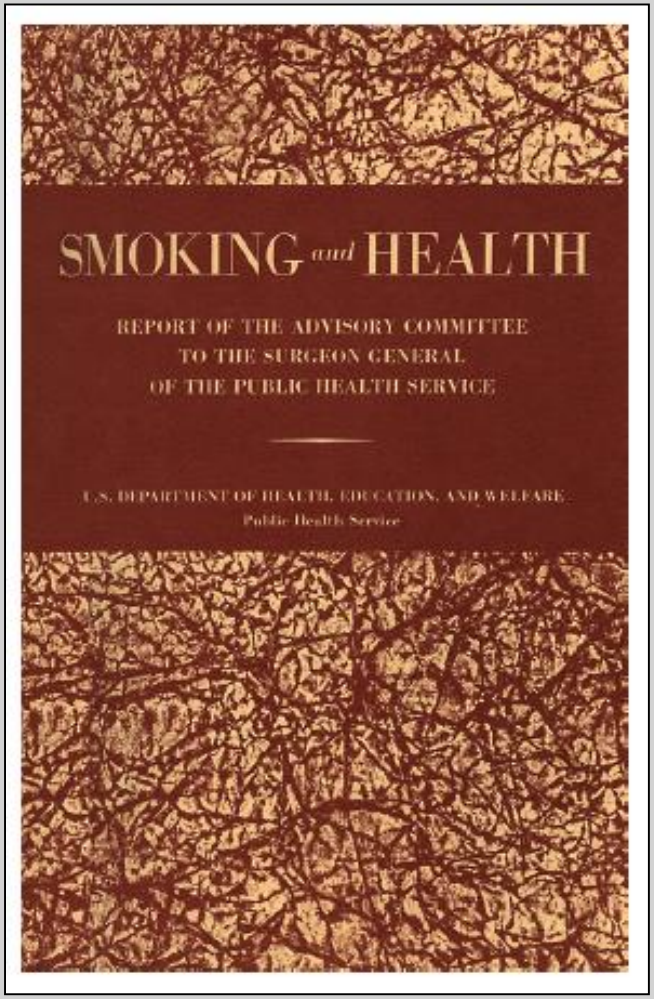

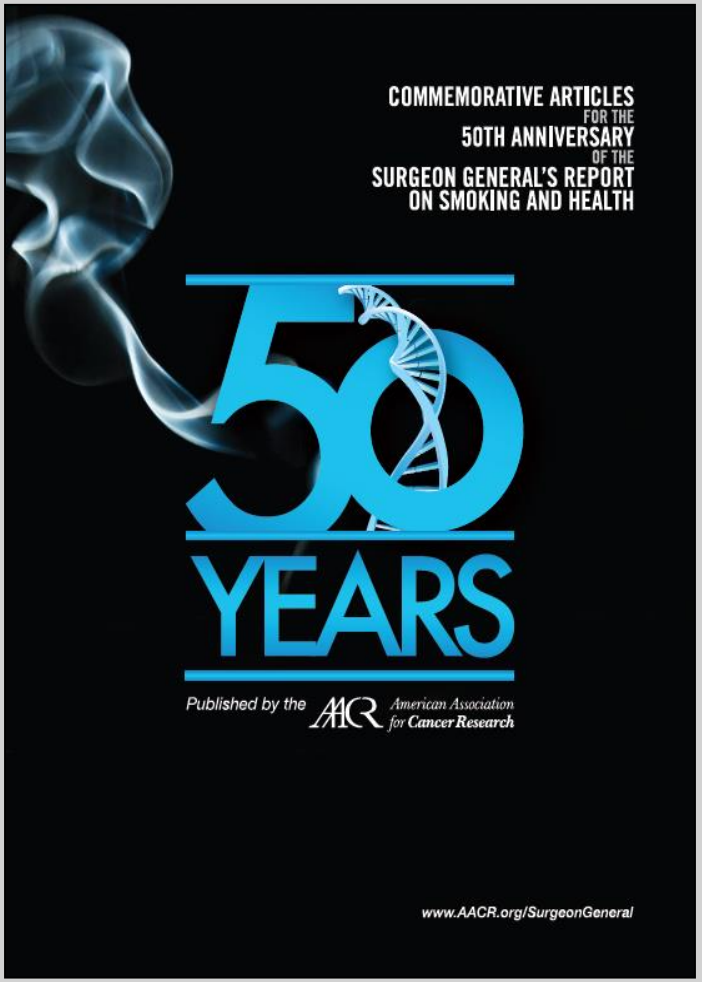

Source: American Association for Cancer Research – AACR.org/Surgeon General

The State of Cancer Care in America – 2014

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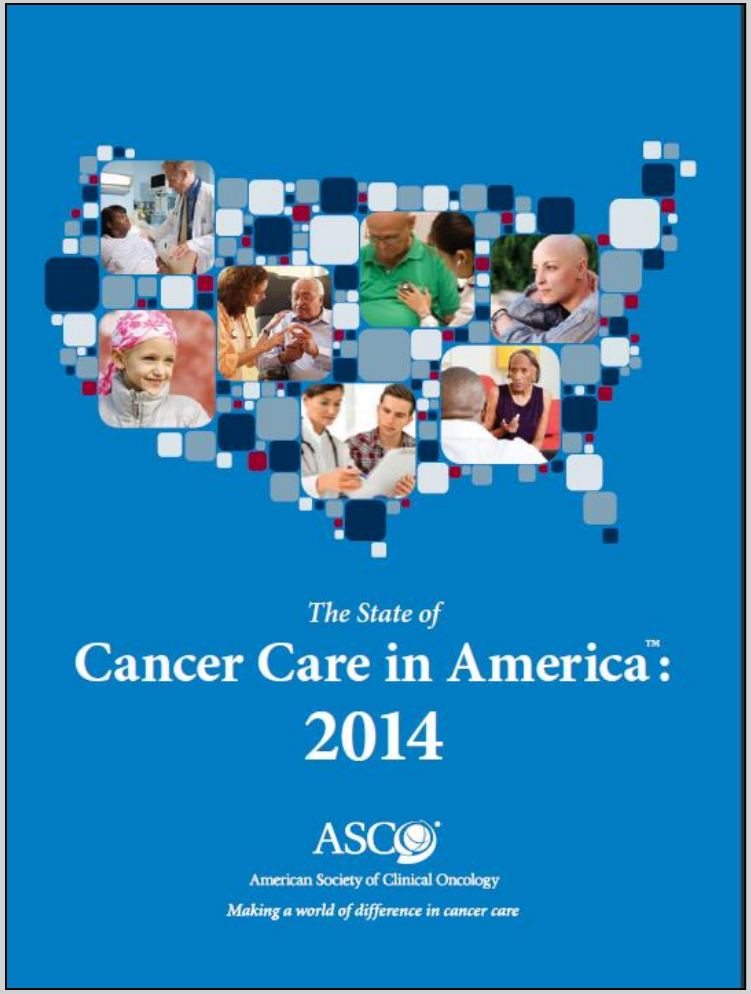

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Source: American Society of Clinical Oncology – ASCO.org

This and That: FDA New Drugs Approved

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Generic Name	Brand Name	Approved Use	Precision or Targeted Therapy?[7]	Oral or Injection
Sorafenib	NEXAVAR	Differentiated thyroid carcinoma	N	Oral
Crizotinib	Xalkori	Non-small cell lung cancer, anaplastic lymphoma kinase (ALK)-positive	Y	Oral
Ibrutinib	IMBRUVICA	Mantle cell lymphoma	Y	Oral
Obinutuzumab	GAZYVA	Chronic lymphocytic leukemia	Y	Injection
Pertuzumab injection	PERJETA	HER2-positive breast cancer	Y	Injection
Paclitaxel protein-bound particles (albumin-bound)	Abraxane for injectable suspension	Adenocarcinoma of the pancreas	N	Injection
Afatinib	Gilotrif tablets	Non-small cell lung cancer, with epidermal growth factor receptor (EGFR) mutations	Y	Oral
Denosumab	Xgeva injection	Giant cell tumor of bone	N	Injection
lenalidomide capsules	REVLIMID	Mantle cell lymphoma	N	Oral
Trametinib	MEKINIST tablet	Melanoma with BRAF V600E or V600K mutation	Y	Oral
Dabrafenib	TAFINLAR capsule	Melanoma with BRAF V600E mutation	Y	Oral
Radium Ra 223 dichloride	Xofigo Injectio	Prostate cancer	N	Injection
Erlotinib	Tarceva	Non-small cell lung cancer with EGFR exon 19 deletions or exon 21 (L858R) substitution mutations	Y	Oral
Ado-trastuzumab emtansine	KADCYLA for injection	HER2-positive, metastatic breast cancer	Y	Injection
Pomalidomide	POMALYST capsules	Multiple myeloma	N	Oral
Doxorubicin hydrochloride liposome injection	Generic version of DOXIL Injection	Ovarian cancer	N	Injection
Doxorubicin hydrochloride liposome injection	Generic version of DOXIL Injection	AIDS-related Kaposi's sarcoma	N	Injection
Bevacizumab	Avastin	Colorectal cancer	N	Injection

2014 FCDS Annual Conference – Recordings & Handouts

http://fcds.med.miami.edu/inc/educationtraining.shtml

Day 1

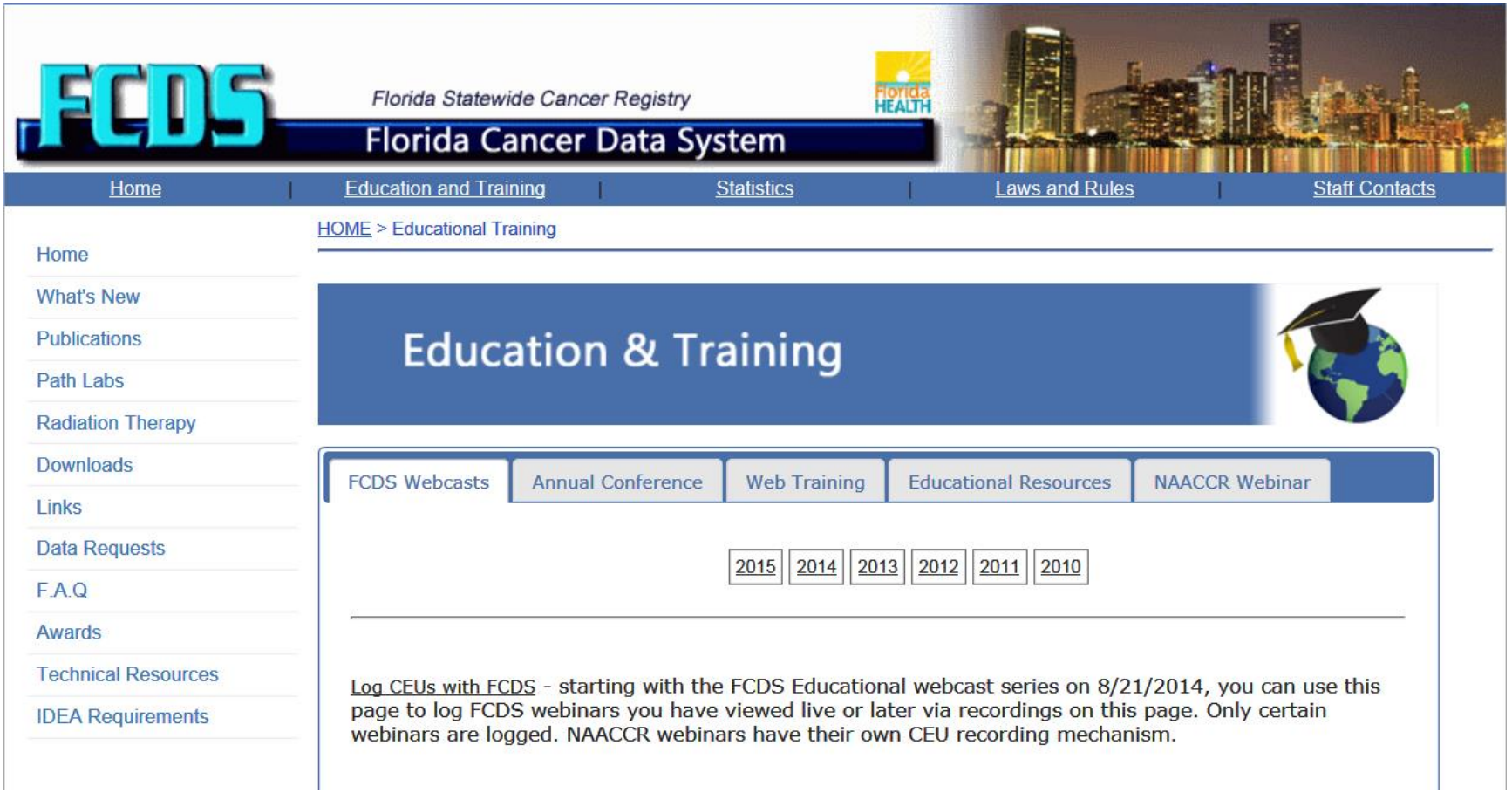
- All the Slides/Handouts/PDFs from the Annual Meeting in one zip file
- Agenda
- Welcome to the FCDS Annual Meeting
- FCDS Updates - State of the State, Dr. Jill MacKinnon, Slides, Recording
- Cancer Data Uses and Dissemination, Joseph Lowry, MPH, Slides, Recording
- Individual and Neighborhood-Level Predictors of Mortality in Florida Colorectal Cancer Patients, Dr. David Lee, Slides, Recording
- Patterns of Care - Initial Assessment of Adherence to Evidence-Based Cancer Treatment Guidelines - Colon, Dr. Monique Hernandez and Judy Bonner, MSN, CTR, Slides, Recording
- SART Data Linkage, Brad Wohler, Slides, Recording
- Highlights from the NAACCR 2014 Annual Conference, Dr. Jill MacKinnon, Slides, Recording
- Update on Meaningful Use Stage II and CDA Validation, Dr. Monique Hernandez, Slides, Recording
- Data Acquisition Update, Mike Thiry, Slides, Recording
- Transition from CSv2 to Direct-Coded TNM and Summary Stage, Dr. Jill MacKinnon, Recording only, no slides with this session
- 2014 Reporting Requirements - 2014 FCDS DAM Highlights, Steve Peace, Slides, Recording
- 2014-2015 FCDS Education and Training Plan, Steve Peace, Slides, Recording
- Physician Claims and Treatment Data Validation Study, Dr. Monique Hernandez, Slides, Recording
- Introducing the FCDS IDEA Follow-Up System, Gary Levin, Kelly King, CTR, Cleveland Clinic, Sara Holton, CTR, Mayo Clinic, Slides, Slides (Sara Holton), Recording
- 2014 FCDS Data Validation Audit - 2012 Dx, Steve Peace, Slides, Recording
- Jean Byers Award Presentation, Mike Thiry, Slides, Recording
- The FCDS Annual Meeting of the Future and Round Table Discussion, Dr. Jill MacKinnon, Slides, Recording

Day 2

- 2013 FCDS QC Activities Summary, Steve Peace, Slides, Recording
- 2014 Grade Coding Instructions and ICD-O-3 Updates, Steve Peace, Slides, Recording
- 2014 Hematopoietic Rules and Data Base Updates, Steve Peace, Slides, Recording
- Coding Instructions for Surgery Fields Including Scope Reg LN, Steve Peace, Slides, Recording
- Recurring Issues and Problem Areas for Florida Registrars, Steve Peace, Slides, Recording
- Recent Developments in Cancer Diagnosis and Treatment, Steve Peace, Slides, Recording

Handouts

- Cancer Surveillance Community TimelineAs of June 9, 2014
- Collaborative Stage Data Collection System Coding instructions
- Installation Instructions Collaborative Stage Coding Instructions v02.05
- Free TNM 7th Edition Webinar Series Recordings and Other Resources
- FCDS Data Quality Indicator Report
- Guidelines for ICD-O-3 update implementation Effective January 1, 2014
- Users Guide for NCI's Online Hematopoietic and Lymphoid Database
- Instructions for Coding Grade for 2014+
- FCDS DAM LVI Errata
- Scope of Regional Lymph Node Surgery: A review of Data Validity, Revised Coding Directives, and Agency Transition Plans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- (●) 08/21/2014, 2014 Reporting Requirements: FCDS Annual Meeting Highlights, 2 CEUs
- ( ) 09/18/2014, GYN Neoplasms, 2 CEUs
- ( ) 10/16/2014, Neuroendocrine Tumors (NET) and GI Stromal Tumors (GIST), 2 CEUs
- ( ) 11/20/2014, Reportable Skin Cancers, 2 CEUs
- ( ) 01/15/2015, Genitourinary Neoplasms (Kidney, Bladder, Prostate), 2 CEUs
- ( ) 02/19/2015, Lower GI Tract Neoplasms, 2 CEUs

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Wrap Up