Florida Statewide Cancer Registry
Florida Cancer Data System

2021-2022 FCDS Educational Webcast Series

A Grand Tour of the 2021 FCDS Data Acquisition Manual:
Where to Find What You Need
or
'Florida Abstracting 101'

Steven Peace, CTR
10/21/2021

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CDC & Florida DOH Attribution

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

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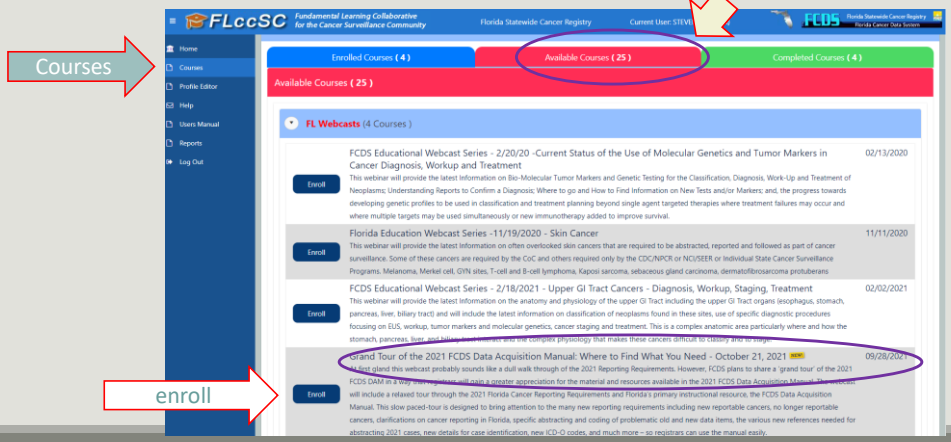
FLccSC and CEU Certificate

Go to Courses – then Available Courses then Enroll

This webinar is a 2-hour CEU 'freebie'. But, you must register for the course in FLccSC to get your CEU Certificate and be awarded the CEUs – 2 Category A CEUs. Thank you. Steve



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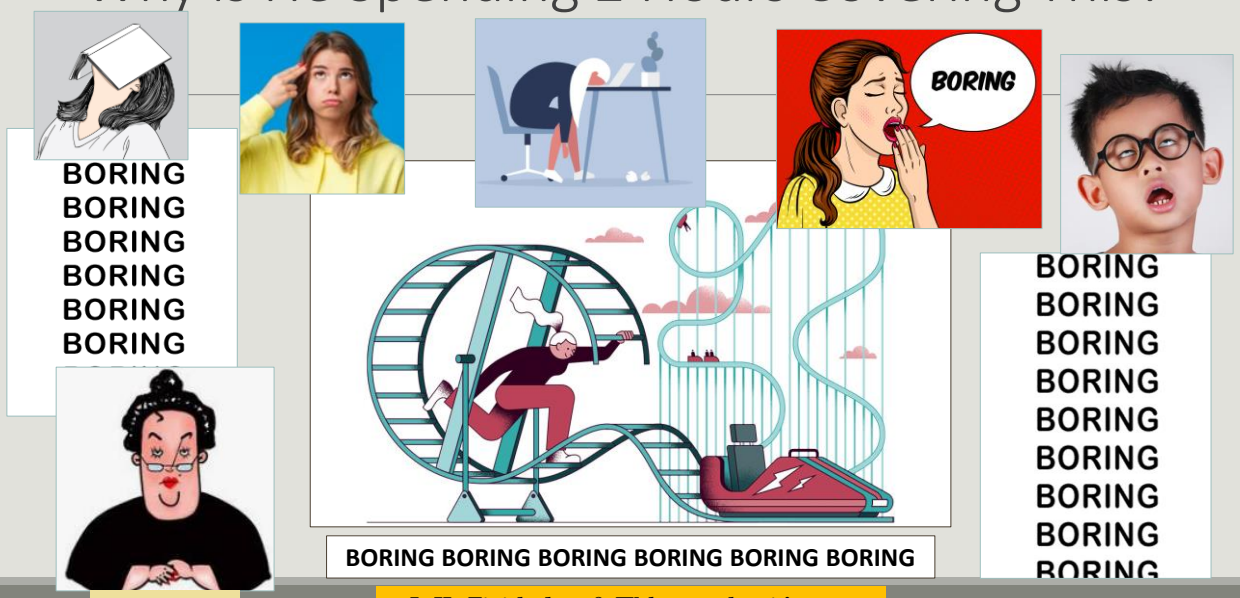
Why is He Spending 2 Hours Covering This?



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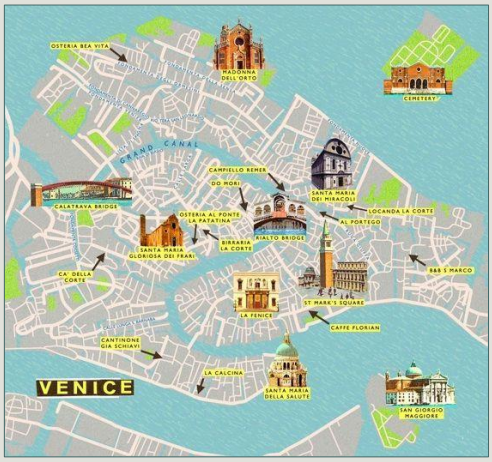
Outline – it's a map!

- Introduction to the 2021 FCDS DAM
- Confidentiality/Patient & Facility Privacy/HIPAA Exemption
- Florida State Law/DOH Regulations/National Legislation
- Section I – Guidelines for Cancer Reporting
- Section II – General Abstracting Instructions (by Section)
  - Registry Information
  - Patient Demographics
  - Tumor Information
  - Cancer Staging
  - Site Specific Data Items
  - Treatment Information
- Appendix A – S (Highlight - Appendix C, F, G, H, L, O, Q, R, S)
- Questions



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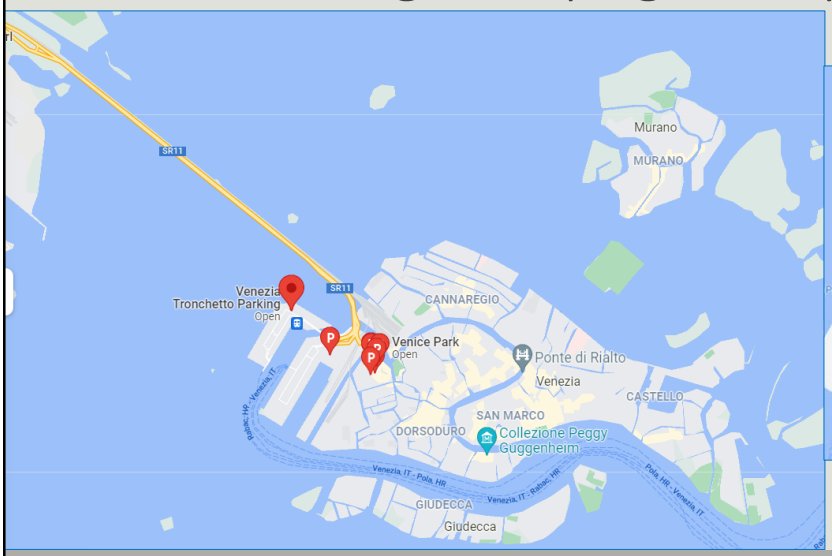
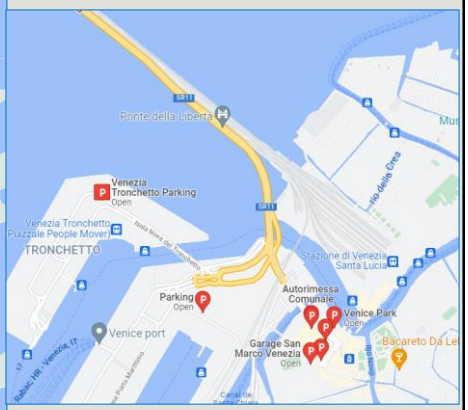
Google Maps go Everywhere





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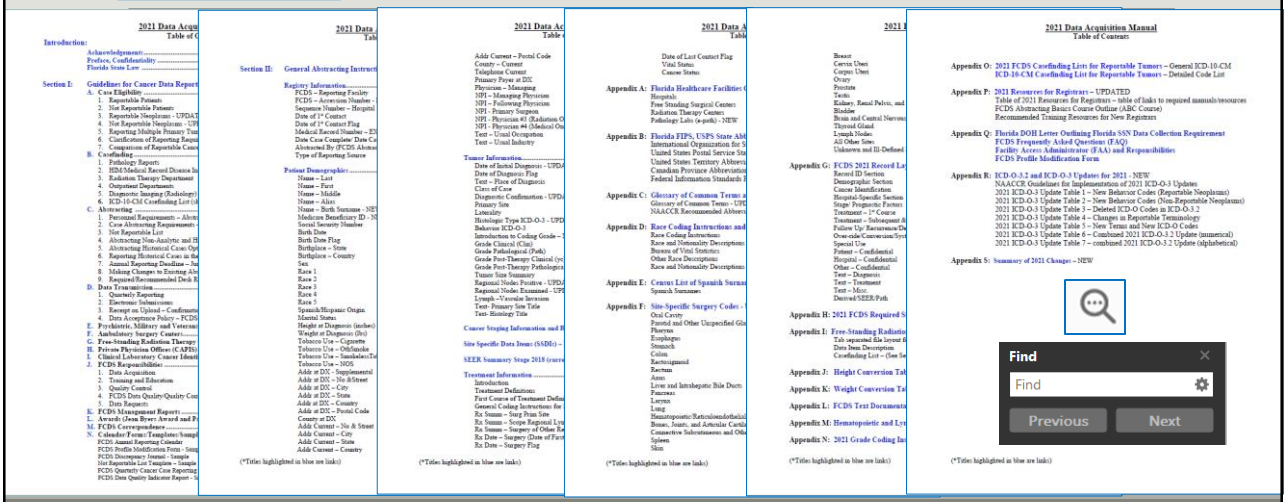
Outline – it's a map! Table of Contents



Use the Table of Contents or The Adobe Find Feature in the View Menu to Navigate to a Topic of Interest

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Introduction to the 2021 FCDS DAM

- DOH Contracts with University of Miami School of Medicine/Sylvester Comprehensive Cancer Center for FCDS Operations - 1978
- **Every Florida Healthcare Facility has an FCDS Start Date of 1/1/1981 (**or the Date the Facility Opened after 1981)
- **Florida Statute** – PUBLIC HEALTH – Title XXIX – Chapter: 381, 385.202, 395, 405, 408.07
- **Florida Administrative Code** – Chapter 64D-3 – Rules: 64D-3.003, 3.006, 3.029, 3.031, 3.034
- **Public Law 107-260** – National Program of Cancer Registries (NPCR) – FCDS joins NPCR in 1995
- **Confidentiality Protection** – Florida Statute 381 - "Information submitted in reports required by this section is confidential, exempt from the provisions of s.119.07 (1), and is to be made public only when necessary to public health. A report so submitted is not a violation of the confidential relationship between practitioner and patient."
- **HIPAA Exemption** – HIPAA Privacy Rule – 45 CFR 164.512(b) – Disclosures for Public Health Activities - The HIPAA Privacy Rule recognizes the legitimate need for public health authorities and others responsible for ensuring public health and safety to have access to protected health information to carry out their public health mission. The Rule also recognizes that public health reports made by covered entities are an important means of identifying threats to the health and safety of the public at large, as well as individuals. Accordingly, the Rule permits covered entities to disclose protected health information without authorization for specified public health purposes. Covered entities are required reasonably to limit the protected health information disclosed for public health purposes to the minimum amount necessary to accomplish the public health purpose. Examples of a public health authority include State Health Departments and the Centers for Disease Control and Prevention
- **Immunity from Liability** - No institution or individual complying with Florida statutes 385.202, 405.01, 381.0031, and Florida State Administrative Code(may not have latest update) Rules 64D-3.004 and 64D3.034 shall be civilly or criminally liable for divulging information or providing materials to the statewide registry as required by the law.

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Who Reports Abstracts, Encounter Information, Vital Records or Other Data to FCDS?

Type of Reporting Source	Jul-21
Hospital	230
Radiation Treatment Center	119
Surgery Center	502
Pathology Lab (CLIA) e-path	1453
Private/Group Physicians	
Hematology/Oncology	592
Hematology	38
Oncology	206
Urology	548
Dermatology	1153
Other Specialty Physician	1947
TOTAL PRIMARY SOURCES	**6788**

Other Key Sources of Data

AHCA In-Patient Discharge Data
AHCA Ambulatory Care Encounter Data
Vital Records Data
Other State Registry on Florida Cancer Cases
E-Pathology Cases
E-Claims Data

TOTAL RECORDS PROCESSED ANNUALLY = 6 million

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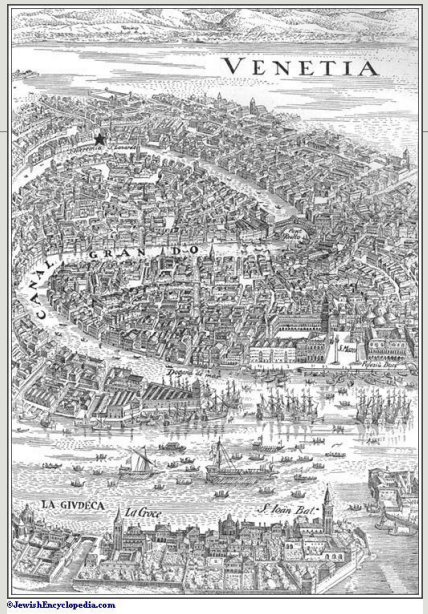
Grand Canal



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Section I – Guidelines for Cancer Reporting

If your facility participates in the diagnosis, staging, treatment, or continuing care of a patient during the first course of treatment, progression of disease or disease recurrence the case must be reported to FCDS.

- If any diagnostic, staging, or other evaluative studies are conducted at your facility (diagnostic imaging, re-biopsy, sentinel node biopsy, surgical resection or other staging or treatment, etc.) your facility must report the case regardless of the Class of Case.
- **NO TREATMENT" is a different treatment decision than "Active Surveillance or "Watchful Waiting"**
  - Patients whose "First Course of Therapy" is "Active Surveillance" or "Watchful Waiting" Active Surveillance cases are usually low grade, slow growing, early stage neoplasms that may not require intervention at this time.
  - 'No Treatment' cases are usually patients with advanced or untreatable disease or when the patient has other comorbid factors that prohibit cancer treatment of any kind.
- **"Consult-Only" and "Second Opinion"** cases MAY be an exception to reporting depending upon what took place at the facility to confirm a diagnosis or establish or confirm the validity of a proposed treatment plan.
- Anytime a new test is ordered by your facility – your facility becomes part of the patient care for this cancer and the case is no longer a consult only, regardless the class of case assigned – and regardless of how the CoC asks you to assign the Class of Case.
  - **Exception 1:** Patients undergoing planned first course or later course long-term hormonal treatment for breast or prostate cancer that continue to demonstrate no active neoplasm should not be reported.
  - **Exception 2:** Patients seen in an ambulatory care setting for "port-a-cath" placement only where no chemotherapeutic or anti-neoplastic agent(s) is injected into the port do not need to be reported.
    - Some Florida healthcare facilities including Commission on Cancer/American College of Surgeons accredited cancer programs may wish to track 'port-a-cath' placement visits voluntarily as part of monitoring the full continuum of patient care available and monitored under the care of the facility for completeness.
  - Emergency Room with Mention of Cancer – No Other Information – cannot code what you do not know – not enough info to abstract

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Case Eligibility Reportable Patients

Reportable Patients Include:

A. all patients with an active, malignant neoplasm (in-situ or invasive), whether being treated or not (includes "active surveillance" cases) – with limited exceptions such as CIN III and PIN III,
B. all patients with an active, benign or borderline brain or central nervous system (CNS) tumor, diagnosed on or after 01/01/2004, whether being treated or not (includes active surveillance)
C. Note: Patients with 'chronic' neoplastic diseases such as chronic leukemia, myelodysplastic syndromes and myeloproliferative diseases, or other lymphoid/myeloid neoplasms designated as 'chronic' disease always have some level of active disease and must be reported. They may described as being in a 'clinical remission'. However, the chronic nature of their disease makes them always reportable, regardless of clinical status. These are never totally disease free cancers.
D. all patients undergoing prophylactic, neoadjuvant, or adjuvant therapy for malignancy,
E. all patients undergoing 'active surveillance' or 'watch and wait' approach to therapy,
F. patients seen as in-patient, out-patient, or in-clinic are reportable,
G. all patients diagnosed at autopsy,
H. all patients with only a clinically diagnosis (imaging, physical exam, physician statement of diagnosis)
I. all historical cases that meet FCDS reportable guidelines.

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Case Eligibility
Not Reportable Patients

Not Reportable Patients Include:

A. patients in remission (NED) and not receiving prophylactic or adjuvant therapy,

B. patients seen only in consultation to provide a second opinion to confirm a diagnosis or a treatment plan (no additional testing can be performed at your facility or the case is reportable),

C. patients first seen at the reporting facility prior to January 1, 1981 (July 1, 1997 for free-standing centers) and returning after that date for treatment of the same primary malignant neoplasm,

D. patients who receive transient care to avoid interrupting a course of therapy started elsewhere.

E. patients with specific types of cancer that are not reportable – do not abstract

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Case Eligibility
Reportable Neoplasms

- **FCDS Requires all neoplasms with behavior of /2 (in-situ) or /3 (malignant) be reported to FCDS** with minor exclusions including; CIN III and PIN III or CIS of cervix or prostate.
  - AIN III (anus or anal canal only), LCIS, PeIN III, VAIN III, VIN III, PanIN III,
  - Glandular Intraepithelial Neoplasia Grade III of Esophagus – only
  - Glandular Intraepithelial Neoplasia Grade III (high grade dysplasia) only when the pathologists states 'in-situ' adenocarcinoma
  - In Utero Diagnosis and Treatment
  - Early or Evolving Melanoma, in-situ and invasive
  - ALL Gastro-Intestinal Stromal Tumors (GIST)
  - Most Thymoma Neoplasms
  - Specific Neoplasms of Skin – Kaposi Sarcoma, Malignant Melanoma, Merkel Cell Carcinoma, Mycosis Fungoides, Sebaceous Adenocarcinoma, Sweat Gland Adenocarcinoma, Eyelid and Lip Cancers
  - More Specific Neoplasms of Skin – BCC/SCC of Genital Skin Sites (labia, vagina, scrotum, clitoris, penis, prepuce, vulva)
- **Clarification of /2 and /3 Pancreatic Neoplasms – October 2021 FCDS Memo Clarification**

  IPMN Path Description must include at least one of the clarifying descriptive terms below;
  - IPMN, with high grade dysplasia
  - IPMN, non-invasive
  - IPMN, in-situ
  - IPMN, associated with invasive carcinoma
  - IPMN, invasive

8453/2	Preferred	Intraductal papillary mucinous neoplasm with high grade dysplasia	(C25._)
8453/2	Related	Intraductal papillary mucinous carcinoma, non-invasive	(C25._)
8453/3	Preferred	Intraductal papillary mucinous neoplasm with an associated invasive carcinoma	(C25._)
8453/3	Related	Intraductal papillary mucinous carcinoma, invasive	(C25._)

- **All benign, borderline, malignant tumors of the Brain, Central Nervous System, Cranial Nerves, Intracranial Glands, Meninges and (/3) Peripheral Nerve Tumors.**
- **Specific Neoplasms Reportable – sphenoid wing meningioma, glomus jugular tumor, carotid body tumor – pilocytic juvenile astrocytoma 9421/3 not 9421/1**

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Case Eligibility Reporting Neoplasms

NEW REPORTABLE NEOPLASMS OR RECLASSIFIED TUMORS INCLUDE:

a. Early or evolving melanoma, in situ and invasive – now reportable neoplasms
b. ALL Gastro-Intestinal Stromal Tumors (GIST) – now classified 'malignant'
c. Thymoma Neoplasms – many are now classified 'malignant'
   - Below are the Required Thymoma Codes and Terms
   - Exceptions include specific thymomas still classified as benign or borderline tumors and are therefore not reportable. Exceptions include: microscopic thymoma, thymoma benign, micronodular thymoma with lymphoid stroma and ectopic hamartomatous thymomas.

ICDO3.2	Histology	Behavior	Level	Term	Code reference	obs
8580/3	8580	3	Preferred	Thymoma, NOS	(C37.9)	
8580/3	8580	3	Related	Intrapulmonary thymoma	(C34._)	
8580/3	8580	3	Related	Sclerosing thymoma	(C34._)	
8580/3	8580	3	Related	Metaplastic thymoma	(C37.9)	
8581/3	8581	3	Preferred	Thymoma, type A	(C37.9)	
8581/3	8581	3	Synonym	Thymoma, medullary	(C37.9)	[obs]
8581/3	8581	3	Synonym	Thymoma, spindle cell	(C37.9)	[obs]
8582/3	8582	3	Preferred	Thymoma, type AB	(C37.9)	
8582/3	8582	3	Synonym	Thymoma, mixed type	(C37.9)	
8583/3	8583	3	Preferred	Thymoma, type B1	(C37.9)	
8583/3	8583	3	Synonym	Thymoma, lymphocyte-rich	(C37.9)	[obs]
8583/3	8583	3	Synonym	Thymoma, lymphocytic	(C37.9)	[obs]
8583/3	8583	3	Synonym	Thymoma, organoid	(C37.9)	[obs]
8583/3	8583	3	Synonym	Thymoma, predominantly cortical	(C37.9)	[obs]
8584/3	8584	3	Preferred	Thymoma, type B2	(C37.9)	
8584/3	8584	3	Synonym	Thymoma, cortical	(C37.9)	[obs]
8585/3	8585	3	Preferred	Thymoma, type B3	(C37.9)	
8585/3	8585	3	Synonym	Thymoma, atypical	(C37.9)	[obs]
8585/3	8585	3	Synonym	Thymoma, epithelial	(C37.9)	[obs]

PLEASE REFERENCE APPENDIX R – Tables 1-5 for New Reportable Histology Codes, Retired Codes, New/Changes to Behavior and Reportability of Neoplasms.

From ICD-O-3.2 Table – WHO/IACR.

8580/0	Preferred	Microscopic thymoma
8580/0	Related	Thymoma, benign
8580/1	Preferred	Micronodular thymoma with lymphoid stroma
8580/3	Preferred	Thymoma, NOS
8580/3	Related	Intrapulmonary thymoma
8580/3	Related	Sclerosing thymoma
8580/3	Related	Metaplastic thymoma
8581/3	Preferred	Thymoma, type A
8581/3	Synonym	Thymoma, medullary
8581/3	Synonym	Thymoma, spindle cell
8582/3	Preferred	Thymoma, type AB
8582/3	Synonym	Thymoma, mixed type
8583/3	Preferred	Thymoma, type B1
8583/3	Synonym	Thymoma, lymphocyte-rich
8583/3	Synonym	Thymoma, lymphocytic
8583/3	Synonym	Thymoma, organoid
8583/3	Synonym	Thymoma, predominantly cortical
8584/3	Preferred	Thymoma, type B2
8584/3	Synonym	Thymoma, cortical
8585/3	Preferred	Thymoma, type B3
8585/3	Synonym	Thymoma, atypical
8585/3	Synonym	Thymoma, epithelial
8585/3	Synonym	Well differentiated thymic carcinoma
8586/3	Preferred	Thymic carcinoma, NOS
8586/3	Synonym	Thymoma, type C

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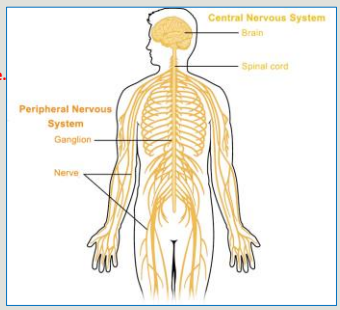
Case Eligibility Reporting Neoplasms

Reportable Tumors:

- **Benign/Borderline/Malignant Primary Tumors of Brain & CNS and Intracranial Glands**
  - **Meninges, Brain, Spinal Cord, Cranial Nerves and Other Pars of CNS – plus the Intracranial Glands**
  - **ICD-O Topography Codes: C71.0-C72.9, C75.1, C75.2, C75.3**
- **Primary Malignant Tumors of Peripheral Nerves, Ganglion and Tumors of the Autonomic Nervous System (C47.*)**
  - **ICD-O Topography Codes: C47.0-C47.9**



WHO revised the histology/behavior for a number of these neoplasms in 2016 and in 2021 – changing from not reportable to reportable.

- WHO published the 4th edition of Classification of Tumors of the Central Nervous System in 2007.
- WHO published a Revised the Fourth Edition in 2016. A lot of changes to behavior codes and classifications in this revision.
- WHO also published the 5th edition of Classification of H&N Tumors in 2021 that included updates to the H&N Paraganglioma.
- WHO published the 5th edition of Classification of Tumors of the Central Nervous System in 2021.

Registrars must use the following 2 sources to ensure they are using the correct histology/behavior for newly reportable neoplasms.

- ICD-O-3.2 Histology Code List from WHO/IACR – the official version from the WHO website – it is a free download
- NAACCR ICD-O-3.2 HISTOLOGY CODE AND BEHAVIOR UPDATE for 2021
  - Includes histology/behavior code changes for paragangliomas and Brain/CNS codes

The 'newly re-classified as malignant tumors' of autonomic nervous system are still 'under the radar' for many registrars, especially:

- Carotid body paraganglioma
- Laryngeal paraganglioma
- Middle ear paraganglioma
- Paraganglioma, NOS
- Vagal paraganglioma
- Paraganglioma, NOS

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Case Eligibility
Not Reportable Neoplasms

- Non-invasive follicular thyroid neoplasm with papillary features (NIFTP) is not reportable.
- BCC/SCC of non-genital skin sites are not reportable – skin with histology code 8000-8110
- AIN III of Perianal Skin is not reportable.
- Dermatofibrosarcoma Protuberans is not reportable.
- Low Grade Appendiceal Mucinous Neoplasm (LAMN) is not reportable (8480/1 in the 2018 ICD-O-3.2 Table) – change in 2022 -/2
- Pancreas - IPMN - Histology Code 8453 with Behavior Code /0

  SEER Clarification - Intraductal Papillary Mucinous Neoplasm of the Pancreas or IPMN, NOS is NOT REPORTABLE unless there is additional descriptive terminology included on the pathology report. If the additional descriptive terminology noted below is not included – the tumor is a benign condition (N/R).

  - The IPMN Path Description must include at least one of the clarifying descriptive terms below;
    - IPMN, with high grade dysplasia
    - IPMN, non-invasive
    - IPMN, in-situ
    - IPMN, associated with invasive carcinoma
    - IPMN, invasive

8453/2	Preferred	Intraductal papillary mucinous neoplasm with high grade dysplasia	(C25._)
8453/2	Related	Intraductal papillary mucinous carcinoma, non-invasive	(C25._)
8453/3	Preferred	Intraductal papillary mucinous neoplasm with an associated invasive carcinoma	(C25._)
8453/3	Related	Intraductal papillary mucinous carcinoma, invasive	(C25._)

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Venetian Boats – Diane Cardaci

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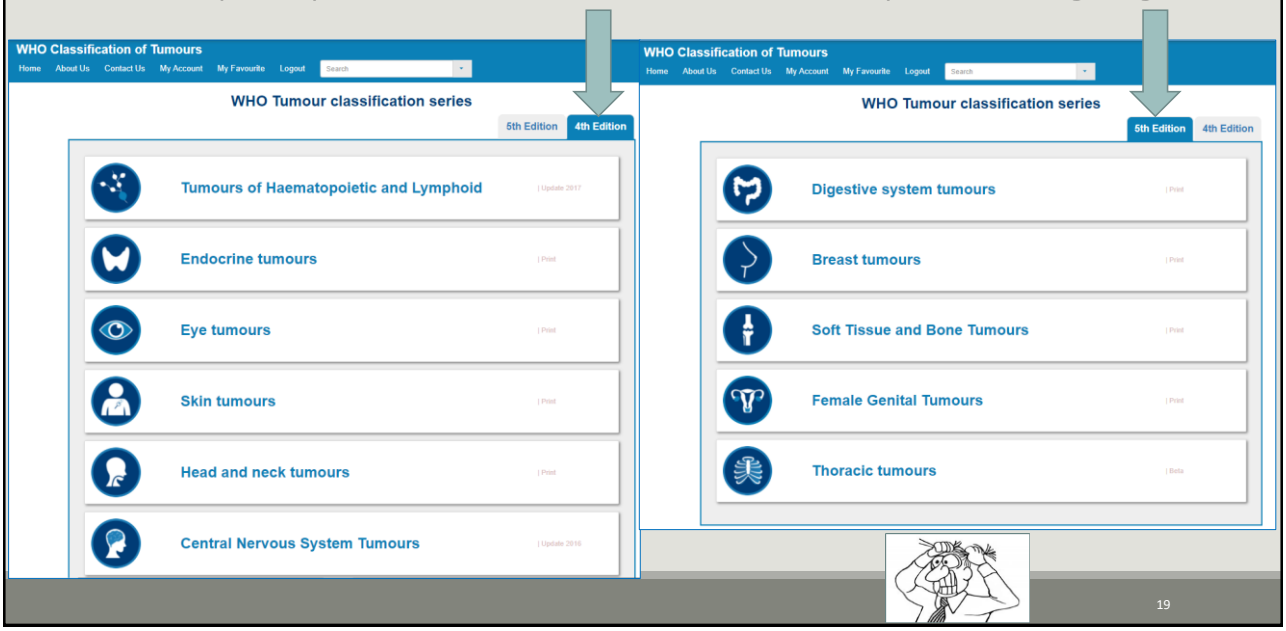
Why Reportable Cancers List Keeps Changing



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Why Reportable Cancers List Keeps Changing

ICD-O-3.2 Table Does Not Include ANY New Tumor Classifications or ANY New/Changed Histology/Behavior Codes AFTER 2018

International Agency for Research on Cancer
World Health Organization

ICD-O- Third Edition, Second Revision Morphology

ICDO3.2	Level	Term	Code reference	obs
8441/2	Preferred	Serous intraepithelial carcinoma		
8441/2	Related	Serous tubal intraepithelial carcinoma (STIC)	(C57.0)	
8441/2	Related	Serous endometrial intraepithelial carcinoma	(C54.1)	
8441/3	Preferred	Serous carcinoma, NOS		
8441/3	Synonym	Serous cystadenocarcinoma, NOS		
8441/3	Synonym	Serous adenocarcinoma, NOS	(C56.9)	
8441/3	Synonym	Serous papillary adenocarcinoma, NOS	(C56.9)	
8441/3	Synonym	Papillary serous cystadenocarcinoma	(C56.9)	
8441/3	Synonym	Papillary serous adenocarcinoma	(C56.9)	
8441/3	Synonym	Serous surface papillary carcinoma	(C56.9)	
8442/1	Preferred	Serous borderline tumor, NOS	(C56.9)	
8442/1	Synonym	Serous tumor, atypical proliferative	(C56.9)	
8442/1	Synonym	Serous cystadenoma, borderline malignancy	(C56.9)	
8442/1	Synonym	Serous tumor, NOS, of low malignant potential	(C56.9)	
8442/1	Synonym	Serous papillary cystic tumor of borderline malignancy	(C56.9)	
8442/1	Synonym	Atypical proliferative papillary serous tumor	(C56.9)	
8442/1	Synonym	Papillary serous cystadenoma, borderline malignancy	(C56.9)	
8442/1	Synonym	Papillary serous tumor of low malignant potential	(C56.9)	
8442/1	Synonym	Serous surface papillary tumor of borderline malignancy	(C56.9)	
8443/0	Preferred	Clear cell cystadenoma	(C56.9)	
8450/0	Preferred	Papillary cystadenoma, NOS	(C56.9)	
8450/0	Related	Papillary cystadenofibroma		
8450/3	Preferred	Papillary cystadenocarcinoma, NOS	(C56.9)	[obs]
8450/3	Synonym	Papillocystic adenocarcinoma		[obs]

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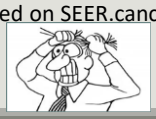
Why Reportable Cancers List Keeps Changing

The following fourth editions were released after the 2018 ICD-O-3 update:

WHO Classification of Tumors of Endocrine Organs (2017)
WHO Classification of Tumors of Hematopoietic and Lymphoid Tissues (2017)
WHO Classification of Tumors of the Eye (2018)
WHO Classification of Tumors of Skin (2018)

Where can the 2021 ICD-O-3 update tables be found?

These documents will be posted to the NAACCR web site and in the FCDS DAM - 2021 Data Changes page. Blast emails from the standard setting organizations will also include the link to the updated tables. The documents can then be saved to your desktop or printed. A link to the tables will also be posted on SEER.cancer.gov (https://seer.cancer.gov/registrars/index.html)



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Why Reportable Cancers List Keeps Changing

2021 ICD-O-3.2 UPDATE
TABLES 1-5

Table 1: New behavior codes (Reportable neoplasms)
WHO has changed behavior codes for the following terms which result in previously non-reportable neoplasms becoming reportable for cases diagnosed 1/1/2021 forward. DO NOT report cases diagnosed prior to 1/1/2021.

Action	ICD-O Code	Term/Site	Comments
New behavior	8077/2	Squamous intraepithelial neoplasia, grade II	Change from /0 **Excludes cervix** Refer to standard setter and/or guidelines for further reportabil
New behavior	8150/3	Pancreatic endocrine tumor, NOS (C25.4) Islet cell adenoma (C25.4) Islet cell adenomatosis (C25.4) Nesidioblastoma (C25.4) Islet cell tumor, NOS (C25.4)	Change from /1 Change from /0 Change from /0 Change from /0 Change from /1
New behavior	8151/3	Insulinoma, NOS (C25.4) Beta cell adenoma (C25.4)	Change from /0 Change from /0
New behavior	8158/3	ACTH-producing tumor Endocrine tumor, functioning, NOS	Change from /1
New behavior code and term	8380/2	Endometrioid intraepithelial neoplasia (C54.1)	
New behavior code	8408/3	Aggressive digital papillary adenoma (C44. _)	Change from behavior /1
New behavior/term	8452/3	Solid pseudopapillary neoplasm of pancreas	Change from /1
New behavior code and term	8620/3	Granulosa cell tumor, adult type (C56.9)	Reportable for cases diagnosed forward
New behavior/term	8690/3	**Middle ear paraganglioma (C30.1, C755.5))** Glomus jugulare tumor, NOS (C75.5) Jugular paraganglioma C75.5) Jugulotympanic paraganglioma (C75.5)	Change from /1
New behavior code	8691/3	**Aortic body tumor (C75.5)** Aortic body paraganglioma (75.5) Aorticopulmonary paraganglioma (C75.5)	Change form /1
New behavior/term	8692/3	**Carotid body paraganglioma (C75.4)** Carotid body tumor (75.4)	Change from /1
New behavior code	8693/3	**Extra-adrenal paraganglioma, NOS** Nonchromaffin paraganglioma, NOS Chemodectoma Composite paraganglioma Laryngeal paraganglioma Vagal paraganglioma	Change from /1
New behavior	8700/3	**Pheochromocytoma, NOS (74.1)** Adrenal medullary paraganglioma (74.1) Chromaffin paraganglioma (C74.1) Chromaffin tumor Chromaffinoma Composite pheochromocytoma (C74.1) Pheochromoblastoma C74.1)	Change from /0
New behavior code	8936/3	Gastrointestinal autonomic nerve tumor GANT Gastrointestinal pacemaker cell tumor	Change from /1
New behavior/term	9505/0	Multinodular and vascolating neuronal tumor (MVNT) (C71.2)	
New behavior/term	9766/3	Lymphomatoid granulomatosis, grade 3	

New Reportable Cancers
Change in Behavior to /2 or /3

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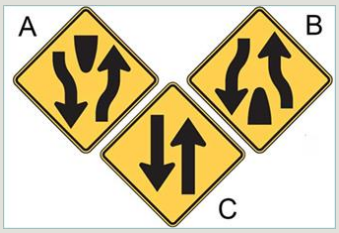
Why Reportable Cancers List Keeps Changing

New Not Reportable Cancers
Change in Behavior from /2 or /3 to /1 or /0

Table 2: New behavior codes (Non-reportable neoplasms)
WHO has changed behavior codes for the following terms which result in reportable neoplasms becoming non-reportable beginning with cases diagnosed 1/1/2021. Continue reporting these cases when diagnosed prior to 1/1/2021.

Action	ICD-O Code	Term/Site	Comments
New behavior	8832/1	Dermatofibrosarcoma protuberans, NOS (C44. _) Dermatofibrosarcoma, NOS (C44. _)	Change from /3
New behavior	8833/1	Pigmented dermatofibrosarcoma protuberans (C44. _) Bednar tumor (C44. _)	Change from /3
New behavior code (*for specific sites only*)	9080/1	Immature teratoma of the lung (C34. _) Immature teratoma of thymus (C37.9) Immature teratoma of thyroid (C73.9)	Change from behavior /3 for the histology/site combination will make these terms non-reportable
New behavior code	9709/1	Primary cutaneous CD4-positive small/medium T-cell lymphoma (C44. _)	Change from /3
New behavior code	9718/1	Primary cutaneous CD30+ T cell lymphoproliferative disorder (C44. _) Lymphoid papulosis (C44. _)	Change for /3
New behavior/term	9725/1	Hydroa vacciniforme-like lymphoproliferative disorder	Change from /3.
New behavior code	9751/1	Langerhans cell histiocytosis, NOS Langerhans cell histiocytosis, monostotic Langerhans cell histiocytosis, polystotic	Change from /3
New behavior	9971/1	Polymorphic Post Transplant Lymphoproliferative Disorder (PTLD)	Change from /3
New behavior & term	8335/1	Follicular tumor of uncertain malignant potential (C73.0) Preferred term Follicular carcinoma, encapsulated (C73.9)	Change from /3



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NAACCR Annotated Histology Code List

https://www.naaccr.org/icdo3/

Value	strHistologyB	Preferred	label
8337	3	TRUE	Poorly differentiated thyroid carcinoma (C73.9) [2021+]
8337	3	FALSE	Carcinoma, insular (C73.9)
8337	3	FALSE	Carcinoma, thyroid, poorly differentiated (C73.9) [2021+]
8337	3	FALSE	Insular carcinoma (C73.9)
8342	3	TRUE	Papillary carcinoma, oncocytic variant (C73.9) [2021+]
8342	3	FALSE	Carcinoma, papillary, oncocytic variant (C73.9) [2021+]
8342	3	FALSE	Carcinoma, papillary, oxyphilic cell (C73.9)
8342	3	FALSE	Oncocytic variant papillary carcinoma (C73.9) [2021+]
8342	3	FALSE	Oxyphilic cell papillary carcinoma (C73.9)
8342	3	FALSE	Papillary carcinoma, oxyphilic cell (C73.9)
8921	3	TRUE	Ectomesenchymoma
8921	3	FALSE	Differentiation, rhabdomyosarcoma with ganglionic
8921	3	FALSE	Ganglionic differentiation, rhabdomyosarcoma with
8921	3	FALSE	Rhabdomyosarcoma with ganglionic differentiation
9364	3	TRUE	Ewing sarcoma (C40._, C41._) [2021+. FOR PRE-2021 USE 9260/3]
9364	3	FALSE	Ewing tumor (C40._, C41._) [2021+. FOR PRE-2021 USE 9260/3]
9364	3	FALSE	Neuroectodermal tumor, NOS
9364	3	FALSE	Neuroectodermal tumor, peripheral
9364	3	FALSE	Neuroectodermal tumor, peripheral primitive, NOS
9364	3	FALSE	Peripheral neuroectodermal tumor
9364	3	FALSE	Peripheral primitive neuroectodermal tumor, NOS
9364	3	FALSE	PPNET
9364	3	FALSE	Primitive neuroectodermal tumor, peripheral, NOS
9364	3	FALSE	Sarcoma, Ewing (C40._, C41._) [2021+. FOR PRE-2021 USE 9260/3]
9364	3	FALSE	Tumor, Ewing (C40._, C41._) [2021+. FOR PRE-2021 USE 9260/3]
9364	3	FALSE	Tumor, neuroectodermal, NOS
9364	3	FALSE	Tumor, neuroectodermal, peripheral

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Rialto Bridge – Theodore Decker

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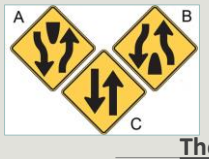

More Changes Coming in 2022

The following fifth editions were released after the 2021 ICD-O-3.2 update:

WHO Classification of Tumors of the Breast (2018)
WHO Classification of Tumors of Digestive System (2018)
WHO Classification of Tumors of the Female Reproductive Organs (2019)
WHO Classification of Tumors of Soft Tissue and Bone (2019)

GASTROINTESTINAL HIGH GRADE DYSPLASIA: UNDERSTADING REPORTABILITY

While the WHO "Blue Books" reflect current thinking and current terminology among pathologists and specialists, population-based cancer registries may not share the same principles in terms of reportability rules. NAACCR is taking a close look at these ambiguous terms and the potential challenges in implementing them as reportable neoplasms in the United States. Most of the problematic terms include the words "high grade neoplasia" or "high grade dysplasia" or "severe dysplasia" in digestive system sites, primarily colorectal. The implications of accepting these terms as reportable are being carefully studied as they may affect not only reporting legislation, but also workload in case ascertainment (casefinding), abstracting, follow-up (as applicable) and incidence reporting. The ICD-O-3 Work Group will continue working with NAACCR work groups, committees, and the College of American Pathologists (CAP) (among others) to make recommendations on the adoption of various dysplasia terminologies for future inclusion in cancer registries. It is important to note, the 2022 ICD-O update tables includes only three specific high grade dysplasia terms which are reportable for specific sites (stomach and small intestines) beginning 1/1/2022.

Where can the 2022 ICD-O-3 update tables be found?

These documents will be posted to the NAACCR web site and in the FCDS DAM - 2022 Data Changes page. Blast emails from the standard setting organizations will also include the link to the updated tables. The documents can then be saved to your desktop or printed. A link to the tables will also be posted on SEER.cancer.gov (https://seer.cancer.gov/registrars/index.html

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2019 Clarification for Mammography Use of Breast Imaging BI-RADS Category 4 or 5:

- RADS Classification is the American College of Radiology and Data Systems Assessment or RADS Classification
- Breast Imaging (BI) includes 2D/3D Mammography, MRI or other imaging technique.
- BI-RADS Category 4 (suspicious for cancer) or BI-RADS Category 5 (positive for cancer)
- A positive/suspicious mammogram **ALONE** should **NEVER** be **USED** as the date of diagnosis.
- A positive/suspicious mammogram date should be **USED** as the date of diagnosis **ONLY WHEN** the patient goes on to subsequently have a **positive biopsy and/or resection** that **confirms that the suspicious abnormality is a malignancy**.
- BI-RADS is not the only American College of Radiology and Data Systems Assessment (RADS) classification system.
- Newer Radiology and Data Systems Assessment (RADS) classification systems include but not limited to;
  - C-RADS – CT Colonography
  - LI-RADS – Liver Imaging
  - Lung-RADS – lung imaging
  - NI-RADS – Head and Neck Imaging
  - O-RADS – Ovarian/Adnexal Imaging
  - PI-RADS – prostate imaging
  - TI-RADS – Thyroid Imaging

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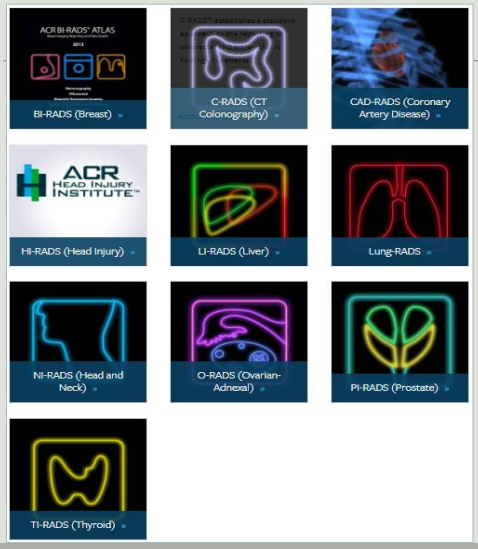
ACR – RADS

RADS Classification is the American College of Radiology and Data Systems Assessment or RADS Classification



BI-RADS CATEGORIES

- **BI-RADS 0 (incomplete):** Recommend additional imaging -- mammogram or targeted ultrasound
- **BI-RADS 1 (negative):** Routine breast MR screening if cumulative lifetime risk ≥ 20%
- **BI-RADS 2 (benign):** Routine breast MR screening if cumulative lifetime risk ≥ 20%
- **BI-RADS 3 (probably benign):** Short-interval (6-month) follow-up
- **BI-RADS 4 (suspicious):** Tissue diagnosis
- **BI-RADS 5 (highly suggestive of malignancy):** Tissue diagnosis
- **BI-RADS 6 (known biopsy-proven malignancy):** Surgical excision when clinically appropriate

	Pathologic Condition	Score or Category	Score Assignment	Modalities
BI-RADS	Breast cancer	0–6 (4A-C)	Patient based	Mammography, MRI, US
C-RADS	Colon cancer	Colonic findings (C0–4); extracolonic findings (E0-4)	Lesion based	CT colonography
CAD-RADS	Coronary artery disease	0–5, N	Patient based	CT angiography
LI-RADS	Liver cancer (HCC)	1–5, TIV, NC, M, TR	CT, MR, CEUS: lesion based; US: patient based	CT, MRI, CEUS, US
Lung-RADS	Lung cancer (screening)	0–4 (4A, B, X), S, C	Patient based	Low-dose CT
NI-RADS	Head and neck cancers (diagnostic system)	0–4 (2A, B)	Patient based	PET, CT, MRI
O-RADS	Ovarian-adnexal masses	NA	NA	US
PI-RADS	Prostate cancer	1–5	Lesion based	Multiparametric MRI
TI-RADS	Thyroid cancer (incidental lesions)	1–5	Lesion based	US

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2021 FCDS DAM
Section I, p.9 / Section II, p.90

d) **2019 Clarification for Mammography Use of Breast Imaging BIRADS Category 4 or 5: Breast Imaging includes 2D/3D Mammography, MRI or other imaging technique with a diagnosis of BIRADS Category 4 (suspicious for cancer) or BIRADS Category 5 (positive for cancer).**

A positive/suspicious mammogram alone should never be used to code the date of diagnosis.

A positive/suspicious mammogram date should be used as the date of diagnosis ONLY when the patient goes on to subsequently have a positive biopsy and/or resection that confirms the suspicious abnormality is in fact a malignancy.

BI-RADS is not the only American College of Radiology and Data Systems Assessment (RADS) classification system. You may also begin to see multiple other new diagnostic imaging standards for evaluation of findings and image results classification including but not limited to;

- C-RADS – CT Colonography
- LI-RADS – Liver Imaging
- Lung-RADS – lung imaging
- NI-Rads – Head and Neck Imaging
- O-Rads – Ovarian/Adnexal Imaging
- PI-RADS – prostate imaging
- TI-RADS – Thyroid Imaging

5. **2019 Clarification for Use of Breast Imaging Dates:** Breast Imaging includes 2D/3D Mammography, MRI or other imaging technique with a diagnosis of BIRADS Category 4 (suspicious for cancer) or BIRADS Category 5 (positive for cancer). This is an "exception" to Instruction 4.
   a. A positive/suspicious mammogram alone should never be used to code the date of diagnosis.
   b. A positive/suspicious mammogram date should be used as the date of diagnosis ONLY when the patient goes on to subsequently have a positive biopsy and/or resection that confirms the suspicious abnormality is in fact a malignancy.

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Grand Canal Print - 1742

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Ambiguous versus Definitive Terminology

When 'definitive terminology' is used in a report, the reviewing physician or radiologist or pathologist is confident that a cancer is present or a stated diagnosis or extent of disease for staging is not in question.

The physician already has high confidence that the 'definitive term' is what s/he says it is.

They do not have to repeat themselves and say that they are 'suspicious' about the presence or absence of disease – they are already confident it is what they say it is in the report. (diagnosis, staging, histology, etc)

Registrars should always apply 'definitive terminology' over 'ambiguous terminology.'

Reports do not have to restate 'suspicious for cancer'when a definitive assessment or terminology is used.

When a physician uses definitive terminology, they are stating that a mass, tumor, neoplasm or a specified histology is what they say it is unless or until it is otherwise proven not to be what they say it is based on some other test or if a subsequent test clarifies a more specific diagnosis.

USE THE AMBIGUOUS TERMINOLOGY INSTRUCTIONS ONLY WHEN THERE IS NO DEFINITIVE TERM USED.

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Casefinding: All Sources to Identify All Cases

Casefinding is the method used to identify new cancer cases, inpatient or outpatient. All facilities are responsible for complete casefinding for all patients seen at your facility regardless of type of service. **YOU are responsible for full casefinding - all sources.**

Do not rely on Medical Records Casefinding or AHCA/Mortality (Consolidated Follow-Back) as the sole source of Casefinding for any Facility. Single Source Casefinding Results in Missed Cases Every Year. We find thousands of missed cases from pathology every year.

ACTIVE Casefinding. Do not wait 2 years when Consolidated Follow-Back Identifies Missed Cases. When you wait for the Consolidated Follow-Back Audit – any missed cases are already two years LATE. It is important that the following multiple sources in the hospital be searched to keep missed reportable cases to a minimum. The sources outlined below should be adapted to each individual facility:

1. **Pathology & Tumor Specimen Reports** (biopsy specimens, surgical specimens, bone marrow biopsy, needle biopsy, cytology, addenda/updates to final diagnosis, outside expert consultation reports, genetic profiles from biopsied or resected neoplasms, autopsy reports, any other specialized studies on tissue or tumor cells performed at your facility – including tumor markers as available)
2. **HIM/Medical Record Disease Indices or Unified Billing System Report – All Services – APPENDIX O - FCDS List of ICD-10-CM Codes**
3. **Radiation Therapy** Department (patient logs and/or billing reports)
4. **Infusion or Treatment Center** (patient logs and/or billing reports)
5. **Outpatient Departments** (cancer clinics, chemo clinics, infusion centers, day surgery,
   - emergency room, radiation oncology, etc.)
6. **Diagnostic Imaging** (Radiology) Department (MRI, CT, PET, x-ray, mammogram, etc.)
7. **Any Specialty Services Related to Cancer – Screening, Diagnosis, Workup, Treatment**

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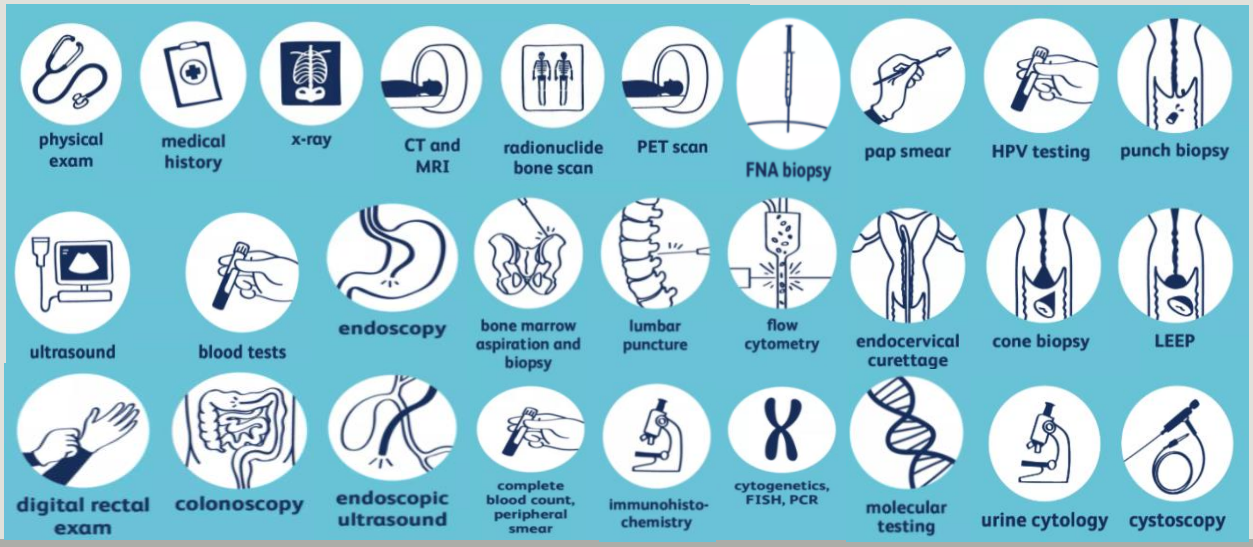
Casefinding: All Sources to Identify All Cases



Images from Very Well Health

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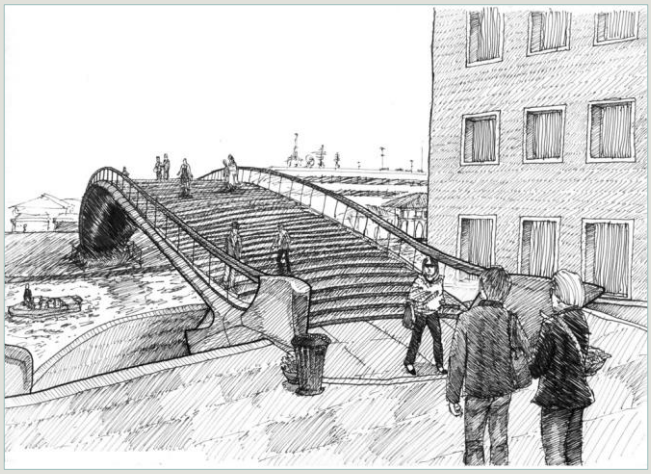
Ponte della Costituzione
Santiago Calatrava Bridge



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What is an Abstract?

A Cancer Registry Abstract is an organized summary of information taken from a patient's medical record(s) for a tumor diagnosed and/or treated by a healthcare provider. The abstract includes data (text and codes) describing specific patient demographics, patient characteristics and medical history, cancer diagnostic and imaging studies, tumor classification by cancer site, histologic type, grade of tumor or other specific characteristics that may 'classify' the neoplasm, cancer-specific tumor markers, specific gene studies, genetic profiles or tumor assays, cancer staging (extent of the cancer), planned treatment, treatment delivered, and cancer follow-up.

AN ABSTRACT IS (usually) NOT A SET OF CODES OR SHORTHAND OF ONE PATIENT ENCOUNTER.

EVERY ABSTRACT MUST TELL A STORY IN THE TEXT DOCUMENTATION – INCLUDE A HISTORY, PHYSICAL, IMAGING, LAB TESTS, TUMOR MARKERS, SURGICAL PROCEDURES, OPERATIVE FINDINGS, PATHOLOGICAL FINDINGS, TUMOR ANALYTICS INCLUDING GENETIC PROFILES, CANCER STAGING INFORMATION IN DETAIL (NOT JUST TNM), AND ANY-ALL TREATMENTS GIVEN.

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Abstracting Requirements Analytic Cases

Analytic Cases (Class of Case 00-22) are the crux of the NCDB – a clinical research database with voluntary reporting that includes about 70-80% of hospitals in the United States – not 100% population-based statewide reporting. This is a key difference in NCDB versus NPCR/SEER DBs.

Analytic Cases are cancers diagnosed and/or having administered any of the first course of treatment at your facility. Any facility covered under your Joint Commission accreditation would be covered as reportable to FCDS as 'analytic cases'.

FCDS also requires reporting of some 'non-analytic cases' – next slide

FCDS uses the term 'state-analytic' as a more inclusive term than CoC 'analytic'

Analytic Cases are used in research and are important to understand how your facility performs on newly diagnosed cancers and adherence to new treatment regimens, 5-year survival, etc.

Analytic cases Class of Case 10-22 are included in treatment and survival analysis.

Analytic cases Class of Case 00 are included as state-reportable and data are 'consolidated'

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Abstracting Requirements
Non-Analytic Cases

FCDS does require the collection and reporting of ALL cases that meet the FCDS reporting requirements (active disease), regardless of Class of Case. Report the most complete history available.

State Cancer Reporting Laws in ALL States plus the CDC NPCR and NCI SEER require that ALL cases within a defined geographic region (state of Florida) be identified and reported for 100% of the United States. This is the definition of 'population-based reporting' and the crux of cancer incidence rates and cancer mortality rates…without all cases of cancer, the geographic area has 'holes' in it.

While Hospital Analytic Cases are the crux of the NCDB and form a foundation for central registry data, they are not the only part of the central registry foundation. Non-analytic cases are equally important, particularly when the patient has any evidence of their cancer, due to recurrence of cancer, or progression of cancer after initial therapy. These are still active cancers & Reportable

Advanced, Recurrent and Progressive Cancers (Analytic and Non-Analytic) require a greater level care, advanced diagnostic and treatment resources, clinical trial access with multiple options for advanced disease, and repeat visits for continuity of care and eventually end of life care. These patients are more expensive to treat than patients with a new diagnosis, workup and initial course of therapy.

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Abstracting Requirements
Historical Cases – Multiple Primaries

FCDS requires the collection and reporting of some historical NED cancers…even without evidence of active disease…But, ONLY when the patient has evidence that a different cancer is new, active, or undergoing treatment.

If a patient has had at least one primary reportable neoplasm that is currently active or under treatment, all other primary reportable neoplasms the patient has ever had (active or inactive), regardless of the date of diagnosis, must be reported. Each case of cancer must be abstracted and reported separately.

Historical Cancers with NO current evidence of active disease can be reported in the 'Historical Grid'

Historical Cancers with evidence of active disease are reported as a complete abstract – not 'Historical Grid'

It is important for researchers to know the number and types of any and all cancers each patient has had during his/her lifetime in order to effectively research and evaluate cancer incidence.

Patients diagnosed with any cancer during their lifetime are many times more likely to develop new cancers.

The abstractor should complete these abstracts with as much information as is available in the medical record.

THIS PROVIDES FCDS WITH A CHRONOLOGY OF ALL CANCERS THE PATIENT HAS EVER HAD

AND WHICH CANCER(S) ARE ACTIVE AT THIS TIME.

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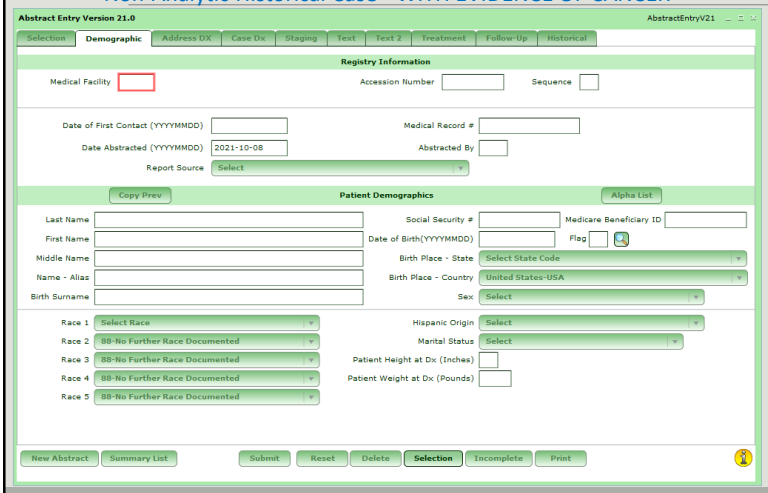
Abstracting Requirements
Historical Cases – Multiple Primaries

Non-Analytic Historical Case - WITH EVIDENCE OF CANCER



Historical Case - NO EVIDENCE OF CANCER

C	Historical #1: Sequence Number
C	Historical #1: DX Date
C	Historical #1: Primary Site
C	Historical #1: Morphology
C	Historical #1: Behavior
C	Historical #1: Laterality
C	Historical #1: Dx State *Abbreviation*
C	Historical #1: Dx County *FIPS*
C	Historical #1: CS SSF25 Discriminator
C	Historical #1: Schema Discriminator 1
C	Historical #1: Schema Discriminator 2
C	Historical #1: Schema Discriminator 3
C	Historical #2: Sequence Number
C	Historical #2: DX Date
C	Historical #2: Primary Site
C	Historical #2: Morphology
C	Historical #2: Behavior
C	Historical #2: Laterality
C	Historical #2: Dx State *Abbreviation*
C	Historical #2: Dx County *FIPS*
C	Historical #2: CS SSF25 Discriminator
C	Historical #2: Schema Discriminator 1
C	Historical #2: Schema Discriminator 2
C	Historical #2: Schema Discriminator 3

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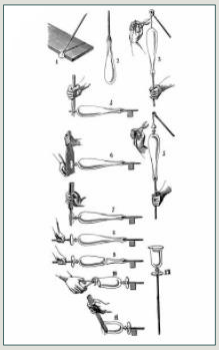
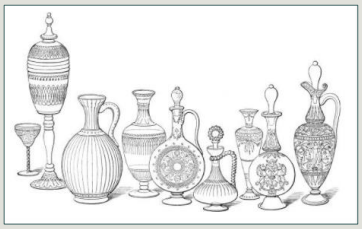
Side Trip to Islands of Murano – Glass Blowers





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FCDS Requirements

Trained personnel must perform abstracting. It is highly recommended that each student enter the course with a strong understanding of human anatomy and medical terminology.

Appendix P of this Manual provides recommended resources for new registrars with both an Abstracting Basics Course Outline and Recommended Training Resources for New Registrars. Please refer to these outside sources for new abstractor training. FCDS used to provide an Abstracting Basics Course through our Learning Management System. However, due to the rapidly changing cancer registry environment for coding and staging of cancers; FCDS has been unable to keep this course current due to annual changes to requirements and standards. FCDS recommends outside training resources to provide basic training for abstractors, specifically the SEER Training Website and SEER*Educate Website with additional training from other sources.

FCDS provides continuing education via FLccSC https://fcds.med.miami.edu/inc/flccsc.shtml.

Additionally, every registrar/abstractor planning to work in the State of Florida is required to obtain an individual FCDS Abstractor Code. This code is assigned by FCDS to persons who successfully pass the FCDS Abstractor Code On-Line Examination, regardless of certification by NCRA as a CTR,

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FCDS Abstractor Code Test - Annual

Every registrar/abstractor planning to work in the State of Florida is required to obtain an individual FCDS Abstractor Code. This code is assigned by FCDS to persons who successfully pass the FCDS Abstractor Code On-Line Examination, regardless of certification by NCRA as a CTR, experience in the registry industry, or other factors. As of January 1, 2013 any individual planning to acquire a New FCDS Abstractor Code or planning to renew an Existing FCDS Abstractor Code must take and pass the FCDS Abstractor Code Exam.

This is a Basic Knowledge and Abstracting Skills Set Evaluation. It tests if the abstractor can use required manuals

Exams are short (20 multiple choice or T/F questions) with a variable mix of content questions.

FCDS will not accept any cases from individuals without an Active/Current FCDS Abstractor Code.

Questions are updated annually to ensure the current standards are familiar to the tester. Questions are selected at random from a pool of more than 350 questions covering 7 major topic areas. No two exams will be alike.

The FCDS Abstractor Code Requirement has been FCDS Policy for many years and applies to every cancer registrar working in the state of Florida (CTR or non-CTR, Florida resident, local or out-of-state contractor, interim service provider, or other registry staff - regardless of number of years' experience or certification). This is a minimum standards evaluation that places all Florida Abstractors at the same testing level regardless of certification status.

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Management Reports

- Admissions by Facility Report
- Facility Timeliness Report
- FCDS Follow-Up Report in FCDS IDEA
- QC Review Report/QC Facility Analysis
- AHCA Follow-Back of Missed Cases (Casefinding Audit).
- Florida Bureau of Vital Statistics Follow-Back of Missed Cases (Casefinding Audit)
- Annual FCDS Data Quality Audit Review Reports
- Quarterly Activity Status Report - Completeness, Accuracy and Timeliness
- FCDS Data Quality Indicator Report (DQIR)

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Madonna Dell'Orto - Cannaregio

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FCDS Annual Deadlines Calendar

FCDS 2021-2022 Reporting Years
Calendar and FCDS Recurring Deadlines
Dates Subject To Change

Patient Encounter for Cancer	Case Should Be Reported
ALL 2020 CASES DUE 6/30/2021	ALL 2020 CASES DUE 6/30/2021
START REPORT OF 2021 CASES – 7/1/2021	START REPORT OF 2021 CASES – 7/1/2021
January 2021	July 2021
February 2021	August 2021
March 2021	September 2021
April 2021	October 2021
May 2021	November 2021
June 2021	December 2021
July 2021	January 2022
August 2021	February 2022
September 2021	March 2022
October 2021	April 2022
November 2021	May 2022
December 2021	June 2022
ALL 2021 CASES DUE 6/30/2022	ALL 2021 CASES DUE 6/30/2022

RECURRING DEADLINES		
Monthly	FC Review/Inquiry	Cases with FC Review Inquiry or correction(s) must be reviewed and responded to monthly
Monthly	QC Review/Inquiry	Cases with QC Review Inquiry or correction(s) must be reviewed and responded to monthly
June 30	Annual Reporting Deadline	All cases from previous calendar year must be reported to FCDS on or before June 30th each year
October 15	Consolidated Follow-Back Deadline	All unmatched cases from the combined AHCA and Vital Records Death Match must be resolved 7/15-10/15 each year
Varies	FAPTP Follow-Back Deadline	All unmatched cases from FAPTP must be resolved each year

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Annual Certificate of Completeness

Technical Resources

The Florida Cancer Data System has numerous technical resources available to assist the facility based abstractor, vendor and physician office with data submission editing and statistical analysis. Some resources were developed by FCDS personnel, some by other national agencies and individuals. Please download the files/documentation as necessary.

Certification of Completeness:

In order for FCDS to have a better assessment of hospital completeness, we have implemented a Certification of Completeness that will require each reporting facility to certify that they have completed their current data year reporting. The system will record the date of completion for reference and can provide a reflection of historical performance relative to on-time reporting. Demo recording

Each facility is required to certify their completeness by logging into the IDEA system, choosing Admissions Report /Certify Completeness under the Reports/Inquiry tab and following the steps to certify completeness.

We will be sending out reminders about the Certification of Completeness requirement as we get closer to our annual reporting deadline. As always, we thank you for your support.

If you have any questions, please feel free to call or email me.

Thank you,

Megsys C. Herna, BA, CTR
Manager, Data Acquisition and Record Consolidation
Florida Cancer Data System
University of Miami Miller School of Medicine
P.O. BOX 016960 (D4-11)
Miami, FL 33101
Office: (305) 243-2625
Fax: (305) 243-4871
mherna@med.miami.edu

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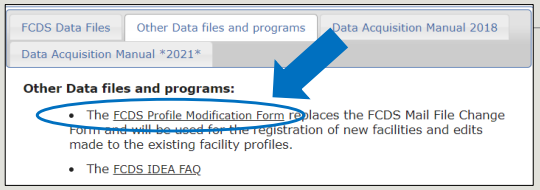
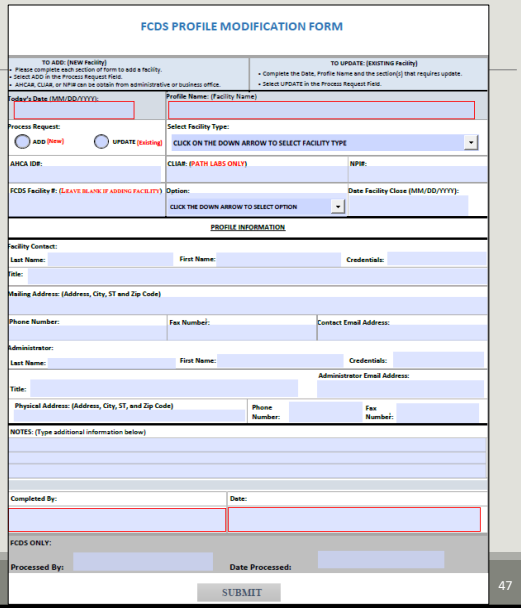
FCDS Profile Modification Form





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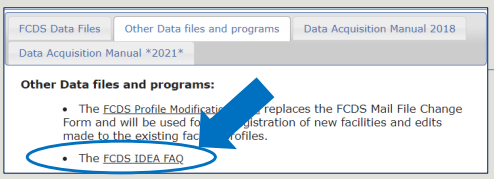
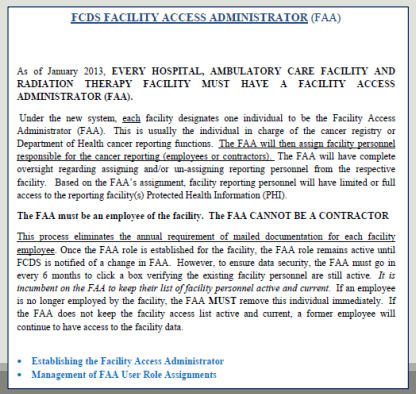
FAA Role and FCDS IDEA User Accounts



Instructions in Appendix Q - FAQs



FCDS FACILITY ACCESS ADMINISTRATOR (FAA)

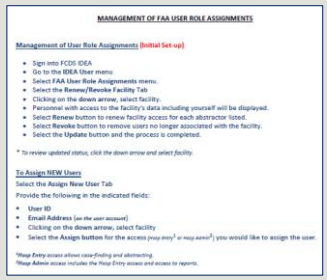
As of January 2013, **EVERY HOSPITAL, AMBULATORY CARE FACILITY AND RADIATION THERAPY FACILITY MUST HAVE A FACILITY ACCESS ADMINISTRATOR (FAA).**

Under the new system, each facility designates one individual to be the Facility Access Administrator (FAA). This is usually the individual in charge of the cancer registry or Department of Health cancer reporting functions. The FAA will then assign facility personnel responsible for the cancer reporting (employees or contractors). The FAA will have complete oversight regarding assigning and/or un-assigning reporting personnel from the respective facility. Based on the FAA's assignment, facility reporting personnel will have limited or full access to the reporting facility(s) Protected Health Information (PHI).

The FAA must be an employee of the facility. The FAA CANNOT BE A CONTRACTOR

This process eliminates the annual requirement of mailed documentation for each facility employee. Once the FAA role is established for the facility, the FAA role remains active until FCDS is notified of a change in FAA. However, to ensure data security, the FAA must go in every 6 months to click a box verifying the existing facility personnel are still active. *It is incumbent on the FAA to keep their list of facility personnel active and current.* If an employee is no longer employed by the facility, the FAA **MUST** remove this individual immediately. If the FAA does not keep the facility access list active and current, a former employee will continue to have access to the facility data.

- Establishing the Facility Access Administrator
- Management of FAA User Role Assignments



MANAGEMENT OF FAA USER ROLE ASSIGNMENTS

Management of User Role Assignments (Initial Set-up)

- Sign into FCDS IDEA
- Go to the **IDEA User** menu
- Select **FAA User Role Assignments** menu.
- Select the **Renew/Revoke Facility Tab**
- Clicking on the **down arrow**, select facility.
- Personnel with access to the facility's data including yourself will be displayed.
- Select **Renew** button to renew facility access for each abstractor listed.
- Select **Revoke** button to remove users no longer associated with the facility.
- Select the **Update** button and the process is completed.

* *To review updated status, click the down arrow and select facility.*

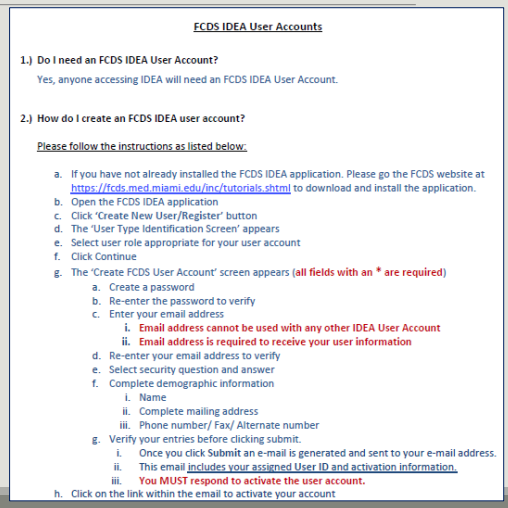
To Assign NEW Users

Select the Assign New User Tab

Provide the following in the indicated fields:

- User ID
- Email Address (*on the user account*)
- Clicking on the **down arrow**, select facility
- Select the **Assign button** for the access (*Keap Entry*[1] or *Keap Admin*[2]) you would like to assign the user.

[1]*Keap Entry access allows case-finding and abstracting.*
[2]*Keap Admin access includes the Keap Entry access and access to reports.*



FCDS IDEA User Accounts

1.) Do I need an FCDS IDEA User Account?

Yes, anyone accessing IDEA will need an FCDS IDEA User Account.

2.) How do I create an FCDS IDEA user account?

Please follow the instructions as listed below:

a. If you have not already installed the FCDS IDEA application. Please go the FCDS website at https://fcds.med.miami.edu/inc/tutorials.shtml to download and install the application.
b. Open the FCDS IDEA application
c. Click 'Create New User/Register' button
d. The 'User Type Identification Screen' appears
e. Select user role appropriate for your user account
f. Click Continue
g. The 'Create FCDS User Account' screen appears (**all fields with an * are required**)
   a. Create a password
   b. Re-enter the password to verify
   c. Enter your email address
      i. **Email address cannot be used with any other IDEA User Account**
      ii. **Email address is required to receive your user information**
   d. Re-enter your email address to verify
   e. Select security question and answer
   f. Complete demographic information
      i. Name
      ii. Complete mailing address
      iii. Phone number/ Fax/ Alternate number
   g. Verify your entries before clicking submit.
      i. Once you click **Submit** an e-mail is generated and sent to your e-mail address.
      ii. This email includes your assigned User ID and activation information.
      iii. **You MUST respond to activate the user account.**
h. Click on the link within the email to activate your account

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A View of Saint Mark's Square – Carlo Grubacs

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Section II - Composition

- General Abstracting Instructions
- Registry Information
- Patient Demographics
- Tumor Information
- Cancer Staging – Requirements by Year
- Site Specific Data Items – Required for 2021 Cases
- Treatment Information
- Text Required
- Follow-Up Information

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General Abstracting Instructions

SECTION II: GENERAL ABSTRACTING INSTRUCTIONS

It is the responsibility of every abstractor working in the state of Florida (including contract abstractors) to know the full content of the latest *FCDS Data Acquisition Manual (FCDS DAM)* and to update it upon receipt of any change from FCDS. Should you need training in cancer registry data collection, please visit the FLccSC Learning Management System and consider taking the FCDS Abstracting Basics Course to gain a better understanding of the skills and training required to meet FCDS abstracting requirements and the national standards used when abstracting and coding cancer cases. Note: This course is being updated.

This manual is intended to explain in detail each data item required for Florida Cancer Data System (FCDS) case reporting. It should be used as the primary information resource for any data item that must be coded and documented in accordance with Florida cancer reporting rules and statutes. Descriptions are only intended to provide sufficient detail to achieve consensus in submitting the required data. In no way does this manual imply any restriction on the type or degree of detail information collected, classified or studied within any healthcare facility-based cancer registry. Special Use Fields are available as needed.

Basic Rules:

1) Always refer to the most current version of the *FCDS Data Acquisition Manual* when completing an abstract. The CoC STORE Manual may provide slightly different instructions for coding or abstracting of data items. However, the STORE Manual, the NAACCR Volume II Data Dictionary and the SEER Coding and Staging Manual should essentially be comparable in content, rules, instructions, and examples provided to ensure consistent coding across programs.

2) Always submit a separate abstract for each reportable primary neoplasm identified.

3) Text is required to adequately justify ALL coded values and to document supplemental information such as patient sex and family history of malignancy. Data items MUST be well documented in text field(s); specifically, Place of Diagnosis, Physical Exam, the Reason Why the Patient Came to Your Facility, Patient Sex, Imaging Studies including X-rays and Scans with Dates in Chronological Order, Diagnostic Endoscopy and Other Diagnostic Tools, Surgical Procedures and Operative Findings, Laboratory Tests and Pathology Reports (including: Dates of Specimen Collection, Primary Site, Histology, Behavior and Grade), Genetic Testing Results, Cancer Staging Information and Coding Rationale, and Site Specific Data Items as Required.

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Registry Information

REGISTRY INFORMATION

The Registry Information section of the abstract includes the data items that identify the reporting facility, the case, the date of first contact or admission, the abstractor and the date abstracted.

Data Items Included In This Section

NAACCR Item Number	Item Name
540	Reporting Facility
550	Accession Number – Hospital
560	Sequence Number – Hospital
580	Date of First Contact
581	Date of First Contact Flag
2300	Medical Record Number – EXPANDED TO 15 CHARACTERS
2090	Date Case Completed/Date Abstracted
570	Abstracted By (FCDS Abstractor Code)
2152	CoC Accredited Flag
500	Type of Reporting Source

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PATIENT DEMOGRAPHICS

The Patient Demographics section of the abstract includes the set of data items used to describe personal information about an individual patient. When grouped, these data can be used to study how cancer rates differ by geographic location, as well as what groups are at a higher risk of certain types of cancer. Much of the information in this section is confidential in nature and can be used to identify individual patients. Care must be taken at all times to assure patient confidentiality when reporting cases.

Data Items Included in this section:

NAACCR Item Number	Item Name
2230	Name – Last
2240	Name – First
2250	Name – Middle
2280	Name – Alias
2232	Name – Birth Surname – NEW DATA ITEM
2315	Medicare Beneficiary ID – NEW DATA ITEM
2320	Social Security Number
240	Date of Birth
241	Date of Birth Flag
252	Birthplace State
254	Birthplace Country
220	Sex
160	Race 1
161	Race 2
162	Race 3
163	Race 4
164	Race 5
190	Spanish/Hispanic Origin
150	Marital Status
9960	Height at Diagnosis (inches)
9961	Weight at Diagnosis (lbs.)
9965	Tobacco Use – Cigarette
9966	Tobacco Use – OthSmoke
9967	Tobacco Use - NOS
9968	Tobacco Use – NOS
2335	Addr at DX - Supplemental
2330	Addr at DX – No &Street
70	Addr at DX – City
80	Addr at DX – State
102	Addr at DX – Country
100	Addr at DX – Postal Code
90	County at DX
2350	Addr Current – No & Street
1810	Addr Current – City

Patient Demographics

Code	Label	Code	Label
01	White	20	Micronesian, NOS
02	Black	21	Chamorro/Chamoru
03	American Indian, Aleutia, Alaskan Native or Eskimo (includes all indigenous populations of the Western hemisphere)	22	Guamanian, NOS
04	Chinese	25	Polynesian, NOS
05	Japanese	26	Tahitian
06	Filipino	27	Samoan
07	Hawaiian	28	Tongan
08	Korean	30	Melanesian, NOS
		31	Fiji Islanders
10	Vietnamese	32	New Guinean
11	Laotian	96	Other Asian, including Asian, NOS and Oriental, NOS
12	Hmong	97	Pacific Islander, NOS
13	Kampuchean	98	Other
14	Thai	99	Unknown
15	Asian Indian or Pakistani, NOS		
16	Asian Indian		
17	Pakistani		

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

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Piazza San Marco – Saint Mark's Square Patriarchal Cathedral Basilica

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Piazza San Marco – Saint Mark's Square Patriarchal Cathedral Basilica

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Tumor Information

TUMOR INFORMATION

The Tumor Information section includes the set of data items used to describe the cancer or tumor being reported. It includes when and where the cancer was first diagnosed, the anatomic location and type of cancer, staging and other descriptive information used to characterize the cancer at the time of diagnosis.

Data Items Included in This Chapter

NAACCR Item Number	Item Name
390	Date of Diagnosis - REVISED
391	Date of Diagnosis Flag
2690	Text – Place of Diagnosis
610	Class of Case
490	Diagnostic Confirmation
400	Primary Site
2580	Text- Primary Site Title
410	Laterality
522	Histologic Type ICD-O-3
2590	Text- Histology Title
523	Behavior ICD-O-3
3843	Grade Clinical
3844	Grade Pathological
1068	Grade Post Therapy Clin (yc) – NEW DATE ITEM
3845	Grade Post Therapy Path (yp)
756	Tumor Size Summary
820	Regional Lymph Nodes Positive
830	Regional Lymph Nodes Examined
1182	Lymph-Vascular Invasion

Reference: 2021 SEER Coding and Staging Manual – Appendix C: Site Specific Coding Modules
https://seer.cancer.gov/tools/codingmanuals/index.html

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Date of Diagnosis

FCDS Requirement for Unknown Date of Diagnosis for all cases

FCDS has long recognized that medical record history and physical exams often include mention of a 'history of cancer' but provide little if any information regarding when or where the diagnosis or initial treatment occurred. This is why for many years FCDS has allowed registrars to enter blanks, 9's, or use the Date of Admission as a proxy for the Date of Initial Diagnosis when no information was available in the medical record. This generally applied to non-analytic cases seen at your facility with current evidence of cancer and historical-only cases with no evidence of cancer reported to FCDS in the historical grid when a new cancer has been diagnosed (multiple primaries diagnosed over patient's lifetime).

FCDS requires every case that you abstract (analytic, non-analytic and historical grid cases) to include at a minimum a valid year of diagnosis. The FCDS EDITS Metafile will reinforce this new requirement.

Note: All Treatment (surgery, radiation, chemo, etc.) will also require a valid date consistent with the Date of Diagnosis so the edits can validate the treatment is indeed within the parameters of first course of therapy.

Without a valid year of diagnosis, FCDS EDITS cannot determine which set of diagnosis year specific standards to apply. This has led to complicated Florida-only rules for EDITS to point to which standards the EDITS must apply when trying to stage and grade cases (and the site-specific data items), and based on the Date of First Contact. Date of First Contact has proven not to be a very good proxy for Date of Diagnosis.

Below is a revised set of instructions and guidelines for estimating the Date of Diagnosis when no information or limited information is available in a medical record. See Instructions 22 & 23 below.

Estimating the Date of Diagnosis When No Information is Available in the Medical Record

Registrars must use every resource available at the reporting facility to determine the best date of diagnosis. In the absence of an exact date of initial diagnosis, you must estimate at least the year of diagnosis using your best approximation from the information available in the record. Documentation that the exact date of diagnosis was not available in the medical record must be included in a text field. When an exact date of diagnosis is identified after a case has been completed, contact FCDS.

Do not use the Date of Admission as the proxy for the Date of Diagnosis.

Often, the History and Physical or a Consultation Report will provide clues to aid in estimating a date of diagnosis. Key words and phrases such as recently, a few months ago, or in the distant past can provide hints to when a patient was diagnosed without providing an exact year or date. However, registrars can use these key words and phrases to guide them when determining an estimated date of diagnosis. Some medical record histories provide no clues to when the patient was diagnosed with cancer. These can be the most difficult cases to estimate the date of diagnosis. Guidelines for estimating dates are provided below bearing in mind that the clues in the record should be used first and will always override the guidelines. These are guidelines. No specific rules are available.

The date of initial diagnosis is the earliest date this primary reportable neoplasm is recognized by a medical practitioner. It may be diagnosed clinically, by imaging or microscopically. The date is the FIRST DATE, regardless of whether the diagnosis was made at the reporting facility or elsewhere.

The initial diagnosis date may be from a clinical diagnosis or other acceptable diagnostic method; for example, when a radiologist reviews a CT Scan or chest x-ray and the diagnosis is lung cancer or suspicious for lung cancer. When a diagnosis is confirmed at a later date on biopsy/resection, the (clinical or other acceptable testing) date of diagnosis remains the date of the initial diagnosis.

Date of Diagnosis Coding Instructions:

1. NEVER LEAVE THE DATE OF DIAGNOSIS BLANK.
2. NEVER ENTER 99/99/9999 FOR DATE OF DIAGNOSIS.
3. Use the first date of diagnosis whether clinically or histologically established or when an acceptable laboratory or genetic test is allowed to be used as a confirmation of a cancer diagnosis.
4. When diagnostic imaging or other test confirms a diagnosis (including when the diagnosis uses one of the "Ambiguous Terms" defined in Section I), the date of diagnosis is the date of the first diagnosis from positive imaging, allowable confirmatory diagnostic testing, or biopsy/resection.
5. **2019 Clarification for Use of Breast Imaging Dates:** Breast Imaging includes 2D/3D Mammography, MRI or other imaging technique with a diagnosis of BIRADS Category 4 (suspicious for cancer) or BIRADS Category 5 (positive for cancer). This is an "exception" to Instruction 4.
   a. A positive/suspicious mammogram alone should never be used to code the date of diagnosis.
   b. A positive/suspicious mammogram date should be used as the date of diagnosis ONLY when the patient goes on to subsequently have a positive biopsy and/or resection that confirms the suspicious abnormality is in fact a malignancy.
6. If the physician states that in retrospect the patient had cancer at an earlier date, use the earlier date as the date of diagnosis. When this occurs and the Date of Diagnosis is confirmed as earlier than previously reported, the registrar should contact FCDS to update the Date of Diagnosis.
7. Refer to the list of "Ambiguous Terms" in Section I for language that represents a diagnosis of cancer. This list should be used for both clinical and pathological first confirmation of cancer.
8. The date of diagnosis based on a pathology report should be the date the specimen was taken, not the date the pathology report was read or created. Imaging often identifies a neoplasm prior to biopsy.

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Histology and Behavior

ICD-O-3.2 Table Does Not Include ANY New Tumor Classifications or ANY New/Changed Histology/Behavior Codes AFTER 2018

International Agency for Research on Cancer
World Health Organization

ICD-O- Third Edition, Second Revision Morphology

ICDO3.2	Level	Term	Code reference	obs
8441/2	Preferred	Serous intraepithelial carcinoma		
8441/2	Related	Serous tubal intraepithelial carcinoma (STIC)	(C57.0)	
8441/2	Related	Serous endometrial intraepithelial carcinoma	(C54.1)	
8441/3	Preferred	Serous carcinoma, NOS		
8441/3	Synonym	Serous cystadenocarcinoma, NOS		
8441/3	Synonym	Serous adenocarcinoma, NOS	(C56.9)	
8441/3	Synonym	Serous papillary adenocarcinoma, NOS	(C56.9)	
8441/3	Synonym	Papillary serous cystadenocarcinoma	(C56.9)	
8441/3	Synonym	Papillary serous adenocarcinoma	(C56.9)	
8441/3	Synonym	Serous surface papillary carcinoma	(C56.9)	
8442/1	Preferred	Serous borderline tumor, NOS	(C56.9)	
8442/1	Synonym	Serous tumor, atypical proliferative	(C56.9)	
8442/1	Synonym	Serous cystadenoma, borderline malignancy	(C56.9)	
8442/1	Synonym	Serous tumor, NOS, of low malignant potential	(C56.9)	
8442/1	Synonym	Serous papillary cystic tumor of borderline malignancy	(C56.9)	
8442/1	Synonym	Atypical proliferative papillary serous tumor	(C56.9)	
8442/1	Synonym	Papillary serous cystadenoma, borderline malignancy	(C56.9)	
8442/1	Synonym	Papillary serous tumor of low malignant potential	(C56.9)	
8442/1	Synonym	Serous surface papillary tumor of borderline malignancy	(C56.9)	
8443/0	Preferred	Clear cell cystadenoma	(C56.9)	
8450/0	Preferred	Papillary cystadenoma, NOS	(C56.9)	
8450/0	Related	Papillary cystadenofibroma		
8450/3	Preferred	Papillary cystadenocarcinoma, NOS	(C56.9)	[obs]
8450/3	Synonym	Papillocystic adenocarcinoma		[obs]

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Grade Codes – c, p, yc, yp
Grade Coding Manual - next webcast

Schema ID	Schema ID Name (EOD Schema Name)	AJCC Chap.	AJCC Chapter Name	SS Chapter	Grade Table
00358	Trachea				
00360	Lung				
00370	Pleural Mesothelion				
00378	Respiratory Other				
00381	Bone Appendicular Skeleton				
00382	Bone Spine				
00383	Bone Pelvis				
00400	Soft Tissue Head an Neck				
00410	Soft Tissue Trunk an Extremities				
00421	Soft Tissue Abdomen and Thoracic (excluding Heart, Mediastinum, Pleura)	42	Soft tissue sarcoma of the Abdomen and Thoracic Visceral Organs	Soft Tissue	
00422	Heart, Mediastinum and Pleura	42	Soft tissue sarcoma of the Abdomen and Thoracic Visceral Organs	Heart, Mediastinum, and Pleura	Grade 09
00430	GIST	43	Gastrointestinal Stromal Tumors	GIST	Grade 11
00440	Retroperitoneum	44	Soft tissue sarcoma of the Retroperitoneum	Retroperitoneum	Grade 10
00450	Soft Tissue Usual Histologies/Sites	45	Soft tissue sarcoma of Unusual Sites and Histologies	Soft Tissue	Grade 09
00458	Kaposi Sarcoma	45	Soft tissue sarcoma of Unusual Sites and Histologies	Kaposi Sarcoma	Grade 09
00460	Merkel Cell Skin	46	Merkel Cell Carcinoma	Merkel Cell Skin	Grade 98
00470	Melanoma Skin	47	Melanoma of the Skin	Melanoma Skin	Grade 98
00478	Skin Other	N/A	N/A	Skin (except Eyelid)	Grade 99
00480	Breast	48	Breast	Breast	Grade 12

Grade Coding Instructions and Tables

Effective with Cases Diagnosed 1/1/2018 and Forward

Published January 2021

Version 2.01

Grade Coding Instructions and Tables

Effective with Cases Diagnosed 1/1/2018 and Forward

Published August 2021

Version 2.1

AJCC Chap.	AJCC Chapter Name	SS Chapter	Grade Table
72	Brain and Spinal Cord	Brain	Grade 24
72	Brain and Spinal Cord	CNS Other	Grade 24
72	Brain and Spinal Cord	Intracranial Gland	Grade 24
73	Thyroid-Differentiated and Anaplastic Carcinoma	Thyroid (including Medullary)	Grade 98
74	Thyroid-Medullary	Thyroid (including Medullary)	Grade 98
75	Parathyroid	Parathyroid	Grade 25
76	Adrenal Cortical Carcinoma	Adrenal Gland (including NET)	Grade 26
77	Adrenal-Neuroendocrine Tumors	Adrenal Gland (including NET)	Grade 98
N/A	N/A	Endocrine Other	Grade 99
	Hodgkin and Non-		Grade 88

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

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Site Specific Data Items for 2021

FCDS Requires the Following SSDIs for Cases Diagnosed/Treated 2018 and Forward

Core/Derived	Item #	Item Name	Length	Start Date
D	3800	Schema ID	5	2018
C	3816	Brain Molecular Markers	2	2018
C	3817	Breslow Tumor Thickness	4	2018
C	3827	Estrogen Receptor Summary	1	2018
C	3835	Fibrosis Score	1	2018
C	3838	Gleason Patterns Clinical	2	2021
C	3839	Gleason Patterns Pathological	2	2021
C	3840	Gleason Score Clinical	2	2021
C	3841	Gleason Score Pathological	2	2021
C	3842	Gleason Tertiary Pattern	2	2021
C	3843	Grade Clinical	1	2018
C	3844	Grade Pathological	1	2018
C	1068	Grade Post Therapy Clin (yc)	2	2021
C	3845	Grade Post Therapy Path (yp)	1	2018
C	3855	HER2 Overall Summary (breast, esophagus & stomach were added starting 1/1/2021)	1	2018 2021
C	3890	Microsatellite Instability (MSI)	1	2018
C	3915	Progesterone Receptor Summary	1	2018
C	3920	PSA (Prostatic Specific Antigen) Lab Value	5	2018
C	3932	LDH Pretreatment Lab Value	7	2018

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Staging Requirements by Date of DX

CANCER STAGING INFORMATION AND REQUIREMENTS BY DATE OF DIAGNOSIS

FCDS Cancer Staging Requirements follow the NPCR Stage Requirements by Year

State and National cancer staging requirements have changed over time. The focus of State and National cancer programs is monitoring cancer incidence over time. In order to support standardization and consistency in reporting stage of cancer at time of diagnosis, state and national cancer surveillance programs have often utilized a "summary staging" approach with stable anatomic staging criteria that includes both clinical data from imaging reports and medical procedures combined with pathological data gleaned from surgical resection of the primary tumor and regional lymph nodes. This is known as SEER Summary Stage. SEER Summary Stage has gone through 2 revisions since it was instituted back in the mid 1970s. The latest edition is Summary Stage 2018 or SS2018. Summary Stage is required for all cases since 1981.

Continuity of staging requirements is essential for longitudinal cancer studies, but our programs recognize that changes in anatomic staging criteria have and continue to be modified over time. Furthermore, biomolecular and genetic tests to help qualify stage subgroups are being used more frequently with tests offering greater details for staging than ever before. In order to begin capturing these new tumor markers and other cancer-specific testing or prognostic-related laboratory tests, the United States created the Collaborative Stage Data Collection System including Site-Specific Factors to house these cancer-specific tests results and other clinical care and research oriented data items to expand 'staging'.

The Collaborative Stage Data Collection System was implemented for cases diagnosed 1/1/2004-12/31/2015 and provided algorithmic solutions to deriving standardized stage groupings based in multiple cancer staging systems including SS1977, SS2000, AJCC TNM 6th ed and AJCC TNM 7th ed.

The combined system of staging parameters was decommissioned and replaced by the originating staging systems being directly coded for SS2000 and AJCC TNM 7th ed. in 2016 and again updated in 2018 to provide updated anatomic and prognostic staging data items to meet current and future research needs.

SUMMARY STAGE 2018 (SS2018): Direct-Assignment of SEER Summlary Stage using the SEER Summary Stage 2018 Manual is required for all cases diagnosed and reported to FCDS 1/1/2018 forward.

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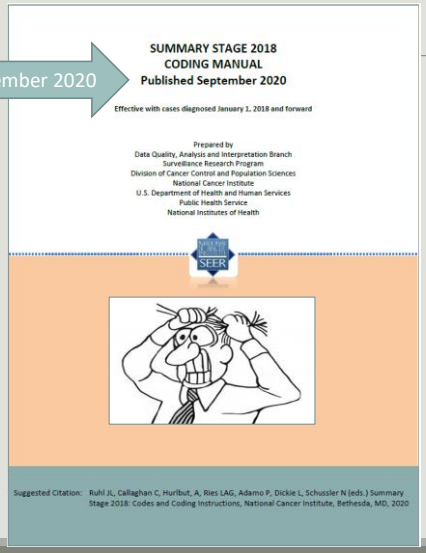
SEER Summary Stage 2021/2022 – Required All Cases

September 2020



2022

September 2021

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San Giorgio Maggiore Monastery

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Treatment Information

- The Treatment Information section includes the set of data items used to describe how the cancer or tumor was treated. FCDS only collects the "First Course of Treatment." This concept is described and reinforced throughout the chapter. Treatment must be fully documented whether given at your facility or any other facility or per history. This provides FCDS with a more complete picture of the patient's entire cancer treatment experience from the time of first diagnosis through recurrence/progression until death.
- Planned First Course of Therapy Guidelines
- No Treatment
- Active Surveillance
- Maintenance Therapy
- Palliative Care Therapy
- Tumor Ablation versus Use of Agent for Embolization
- Neoadjuvant (Pre-Surgical) Therapy versus Adjuvant (Post-Surgical) Therapy
- Post-Treatment Surgery/Chemo/Radiation as Part of Planned First Course of Therapy
- All Therapy Delivered as Planned…In the Absence of Disease Progression or Recurrence.
- FCDS will Override Florida Edit when First Course of Therapy Extends Beyond 240/365 Days

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Treatment Information

QUESTION: How to handle submitting cases with treatment falling outside the 6-12 month window. We have an increasing number of rectal cases falling into this category based on a new treatment protocol, where patients receive neoadjuvant treatment, surgery, then potentially adjuvant treatment. As a result, the patient may not complete their first course of treatment until 8 months or later from the date of original diagnosis.

ANSWER: FCDS wants the entire planned first course of treatment to be included – even if you have to hold the case…as long as the treatment is part of the original treatment plan as First Course of Therapy… AND … as long as there has been no evidence of disease progression or recurrence during the extended first course treatment window. If there is any change to the treatment, the changed treatment is not part of the initial planned first course. First Course of Therapy ENDS anytime the cancer has progression or recurrence, regardless of whether or not the treatment was part of the initial First Course of Therapy Plan.

This is particularly important in 2020 and 2021 and probably later due to Covid-19.

It is also of particular importance as newer protocols now do extend beyond traditional 1st Course of Therapy Guidelines and Guidelines for Reporting Cases within 6 Months of Dx/Tx.

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Site-Specific Surgery
CoC/SEER Working on Updates

GENERAL CODING INSTRUCTIONS SITE-SPECIFIC SURGERY

1. Refer to **Appendix F** for site-specific surgery codes. Updated from the 2021 STORE Manual.
2. Once it is determined that cancer-directed surgery was performed, use the best information in the operative/pathology reports to determine the operative procedure. Do not depend on the name of the procedure since it may be incomplete.
3. If the operative report is unclear regarding what was excised or if there is a discrepancy between the operative and pathology reports, use the pathology report, unless there is a reason to doubt its accuracy.
4. If a surgical procedure removes the remaining portion of an organ, which had been partially resected previously for any condition, code as total removal of the organ.
5. A date field is also included to document the first date of any surgery performed.
6. If there is no indication anywhere in the patient's medical record that surgery was either planned or performed enter Surgery Rx Summary as 00 – No Surgical Procedure.
7. There is no need to code any non-cancer-directed surgery performed (i.e., the patient had only a biopsy, exploratory or bypass surgery without resection of the primary or metastatic tumor).
8. If multiple primaries are excised at the same time, code the appropriate surgery for each site.

COLON
C18.0–C18.9
(Except for 9727, 9732, 9741-9742, 9749, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9968, 9975-9993)

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

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 portion of 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 the entire rectum)

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DO NOT USE CODE '99' FOR TREATMENT

For 2021 and Forward Cases – STOP USING CODE 9 or 99 IN ANY TREATMENT FIELDS – USE '00'

EDIT - FL3032

Over Use of 9's in Treatment Fields

RX Summ - Surg Primary Site

RX Summ – Scope Reg LN Surg (exceptions)

RX Summ – Surg Oth Reg/Dis

Phase I Treatment Modality

Rad – Regional RX Modality

Reason for No Radiation

RX Summ – BRM

RX Summ – Chemo

RX Summ – Hormone

RX Summ – Transplpnt/Endocr

2021 NPCR Completeness Audit
Follow-Back Cases with Treatment = 9's

- FCDS has been asked to Follow-Back (to You) a Large Sample of Cases Because Registrars Coded 9 or 99 for Treatment.
- Abstractor should use Treatment Code 'Recommended' if Treatment was Recommended…or '00' if no information.
- '99' looks like Treatment was done – but, you aren't sure.
- Code what TX you do know was given or performed at your facility (or any other facility) - Part of First Course of Therapy.
- Do not code 'unknown' (9 or 99) when 'you' think treatment should have been done or might have been done – use '00'.
- It makes the case look like treatment is incomplete and needs further attention or follow-back to get rest of the TX.

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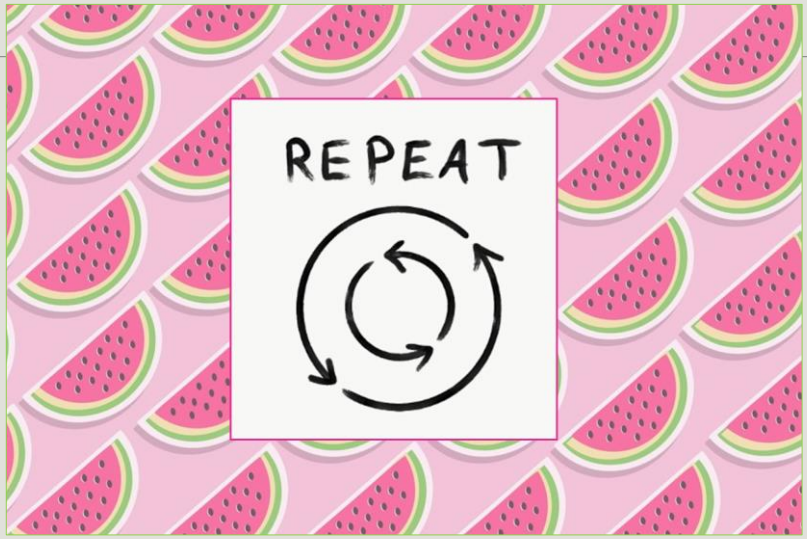
Text Required



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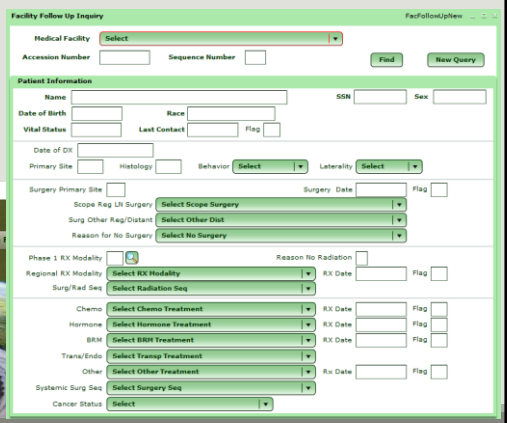
Follow-Up Information & IDEA Follow-Up Inquiry

FOLLOW UP

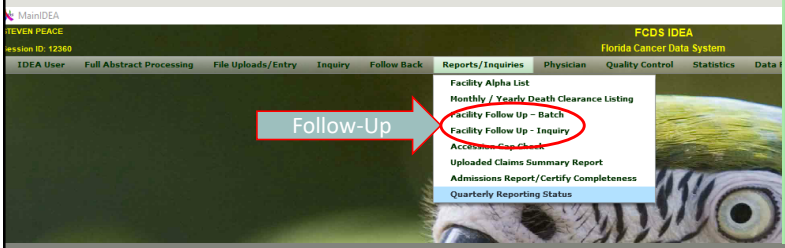
The Follow Up section includes the set of data items used by the FCDS to monitor a facility's last contact with the patient at the time that the abstract was completed. FCDS does not require the collection of most of the data items pertaining to follow up. The FCDS required follow up data items are limited in scope; they mainly assist in performing limited survival analyses.

Data Items Included In This Section

NAACCR Item Number	Item Name
1750	Date of Last Contact
1751	Date of Last Contact Flag
1760	Vital Status
1770	Cancer Status



Don't Forget About the FCDS IDEA Follow-Up Inquiry Report



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Grand Canal – Francesco Guardi

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Appendix A – Appendix S

- Appendix A – Florida Healthcare Facilities Reporting to FCDS
- Appendix B – Florida FIPS, USPS State Abbreviations, ISO Country Codes
- Appendix C – Glossary of Common Terms and Standard Abbreviations
- Appendix D – Race Coding Instructions and Race and Nationality Descriptions
- Appendix E – Census List of Spanish Surnames
- Appendix F – Site Specific Surgery Codes
- Appendix G – FCDS 2021 Record Layout – Core Required Data Items/Derived Data Items
- Appendix H – FCDS Required Site Specific Data Items 2021 – 2021 SSDIs
- Appendix I – Free-Standing Radiation Therapy Centers Case identification Program

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Appendix A – Appendix S

- Appendix J – Height Conversion Tables – Converting Feet to Inches
- Appendix K – Weight Conversion Tables – Converting Kilograms to Pounds
- Appendix L – FCDS Text Documentation Requirements
- Appendix M – Hematopoietic and Lymphoid Neoplasms
- Appendix N – 2021 Grade Coding Instructions and Tables
- Appendix O – 2021 FCDS Casefinding List – General/Detailed ICD-10-CM
- Appendix P – 2021 FCDS Resources for Registrars
- Appendix Q – Florida DOH Letter – SSN is Required by Florida Law/FAQ/FAA/Profile Modification
- Appendix R – ICD-O-3.2 Updates for 2021
- Appendix S – Summary of 2021 Changes

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Appendix C – Glossary & Abbreviations

Glossary

Abbreviations

APPENDIX C

GLOSSARY OF COMMON TERMS

SEER ALSO MAINTAINS A GLOSSARY FOR REGISTRARS
https://seer.cancer.gov/seertools/glossary/

NAACCR RECOMMENDED ABBREVIATIONS FOR ABSTRACTORS
NAACCR Recommended Abbreviations consist of almost 500 terms with recommended abbreviations.
The lists are a copy of NAACCR Volume II Data Standards and Data Dictionary – Appendix G

ABBREVIATION/SYMBOL ORDERED BY TERM/WORD
TERM/WORD ORDERED BY ABBREVIATION/SYMBOL
CONTEXT SENSITIVE ABBREVIATIONS

Abbreviations often are used by cancer abstractors to shorten the written narratives entered into text fields. However, abbreviations can generate confusion, because abbreviations may vary among different institutions and even between different specialties within the same institution. To be useful, an abbreviation must be clearly understood by any individual who encounters it. Consequently, the use of abbreviations is a useful abstracting practice only if universally recognized abbreviations are used.

These lists are to be used as a primary reference by the cancer abstractor, to help abstract necessary information into a limited number of text fields for storage and transmission of cancer information. Terms included in the lists are limited to those that are commonly utilized when abstracting cancer information.

When abstracting into text fields, the use of abbreviations should be limited to those that appear on these lists whenever practical. Listings are not exhaustive, but the most commonly used terms were included.

Please note that although abbreviations are presented in uppercase, either upper- or lowercase may be utilized when entering abbreviations within abstraction software.

The listings were compiled from abbreviation lists from SEER Book 3, the NAACCR Pathology Committee, the Veterans Administration, Dr. Jay Piccirillo's comorbid conditions training materials, the Florida Cancer Data System, and the California Cancer Registry.

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Appendix D & E – Race & Ethnicity

Race and Ethnicity can be difficult to identify as they are not routinely captured during patient intake, anymore. FCDS and ALL U.S. Cancer Surveillance Programs Rely on Accurate Race & Ethnicity Coding to create Comparative Cancer Rates by Race Groups and by Race/Ethnicity Groups. These are Standard Healthcare Metric Categories for State & Federal Programs.

Race & Ethnicity Coding Instructions are Based on the Race & Nationality Descriptions and Ethnicity Groups from the Year 2000 United States Census and Bureau of Vital Statistics. NPCR and SEER are Required by Law to Capture These Data.

FCDS and other states Match Patient Data to U.S. Tribal Roles through the Indian Health Service, annually to get good data on Native American Populations who participate in the Indian Health Service.

Self-Identified Persons of Multiple Races and Individuals from Multiple Ethnic Groups complicate this coding even further.

APPENDIX D

RACE CODING INSTRUCTIONS

AND

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

RACE AND NATIONALITY DESCRIPTIONS
ALPHABETIC INDEX

APPENDIX E
CENSUS LIST OF SPANISH SURNAMES

ABAD	ABELLEIRA	ABREO	ACETY	AFANADOR
ABADIA	ABELLERA	ABREU	ACEUEDO	AFRE
ABADIANO	ABENDANO	ABREUS	ACEVDO	AGADO
ABADIAS	ABERASTURI	ABREUT	ACEVEDA	AGALA
ABADILLA	ABERASTURIA	ABREV	ACEVEDO	AGANZA
ABADIN	ABERGEL	ABREW	ACEVES	AGAPITO
ABAIGAR	ABESADA	ABREYO	ACEVEZ	AGEITOS
ABAJO	ABETE	ABRICA	ACEVIDO	AGIRRE
ABALLE	ABEYTA	ABRIGO	ACHA	AGON
ABALO	ABEYTIA	ABRIL	ACHEZ	AGOSTO
ABALOS	ABIEGA	ABRIOL	ACHON	AGRA
ABAONZA	ABILA	ABUIN	ACIDO	AGRAIT

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Appendix F: Site-Specific Surgery Codes

GENERAL CODING INSTRUCTIONS SITE-SPECIFIC SURGERY

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

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60 Total proctocolectomy (removal of colon from cecum to the rectosigmoid junction, including the entire rectum)

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Appendix G – 2021 FCDS Record Layout

Section	Data Opt	Item #	FCDS / NAACCR Item Name	Length	Year Start-E	NEW for 20
Demographic	C	70	Addr at DX--City	50	2001	
Demographic	C	80	Addr at DX--State	2	2010	
Demographic	C	90	County at DX Reported	3	2010	
Demographic	C	100	Addr at DX--Postal Code	9	2001	
Demographic	C	102	Addr at DX--Country	3	2013	
Demographic	C	160	Race 1	2	1981	
Demographic	C	161	Race 2	2	2001	
Demographic	C	190	Spanish/Hispanic Origin	1	1981	
Demographic	C	220	Sex	1	1981	
Demographic	C	240	Date of Birth	8	1981	
Cancer Identification	C	390	Date of Diagnosis	8	1981	
Cancer Identification	C	400	Primary Site	4	1981	
Cancer Identification	C	410	Laterality	1	1995	
Cancer Identification	C	490	Diagnostic Confirmation	1	1981	
Cancer Identification	C	500	Type of Reporting Source	1	1995	
Cancer Identification	C	522	Histologic Type ICD-O-3	4	2001	
Cancer Identification	C	523	Behavior Code ICD-O-3	1	2001	
Hospital-Specific	C	540	Reporting Facility	10	2010	
Hospital-Specific	C	550	Accession Number--Hosp	9	2010	
Hospital-Specific	C	560	Sequence Number--Hospital	2	1981	
Hospital-Specific	C	570	Abstracted By	3	1981	
Hospital-Specific	C	580	Date of 1st Contact	8	1981	
Hospital-Specific	C	581	Date of 1st Contact Flag	2	2010	
Hospital-Specific	C	610	Class of Case	2	1995	
Hospital-Specific	C	630	Primary Payer at DX	2	2003	
Stage/Prognostic Factors	C	756	Tumor Size Summary	3	2016	
Stage/Prognostic Factors	C	764	Directly Assigned SS2018	1	2018	
Stage/Prognostic Factors	C	820	Regional Nodes Positive	2	1995	
Stage/Prognostic Factors	C	830	Regional Nodes Examined	2	1995	
Stage/Prognostic Factors	C	1068	Grade Post Therapy Clin (yc)	2	2021	Yes
Stage/Prognostic Factors	C	1182	Lymph-vascular Invasion	1	2010	
Treatment-1st Course	C	1200	RX Date Surgery	8	1995	
Treatment-1st Course	C	1201	RX Date Surgery Flag	2	2010	
Treatment-1st Course	C	1210	RX Date Radiation	8	1995	
Treatment-1st Course	C	1211	RX Date Radiation Flag	2	2010	
Treatment-1st Course	C	1220	RX Date Chemo	8	1995	

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Appendix H – Required SSDIs

FCDS Requires the Following SSDIs for Cases Diagnosed/Treated 2018 and Forward

Core/Derived	Item #	Item Name	Length	Start Date
D	3800	Schema ID	5	2018
C	3816	Brain Molecular Markers	2	2018
C	3817	Breslow Tumor Thickness	4	2018
C	3827	Estrogen Receptor Summary	1	2018
C	3835	Fibrosis Score	1	2018
C	3838	Gleason Patterns Clinical	2	2021
C	3839	Gleason Patterns Pathological	2	2021
C	3840	Gleason Score Clinical	2	2021
C	3841	Gleason Score Pathological	2	2021
C	3842	Gleason Tertiary Pattern	2	2021
C	3843	Grade Clinical	1	2018
C	3844	Grade Pathological	1	2018
C	1068	Grade Post Therapy Clin (yc)	2	2021
C	3845	Grade Post Therapy Path (yp)	1	2018
C	3855	HER2 Overall Summary (breast, esophagus, stomach)	1	2018 2021
C	3890	Microsatellite Instability (MSI)	1	2018
C	3915	Progesterone Receptor Summary	1	2018
C	3920	PSA (Prostatic Specific Antigen) Lab Value	5	2018
C	3932	LDH Pretreatment Lab Value	7	2018

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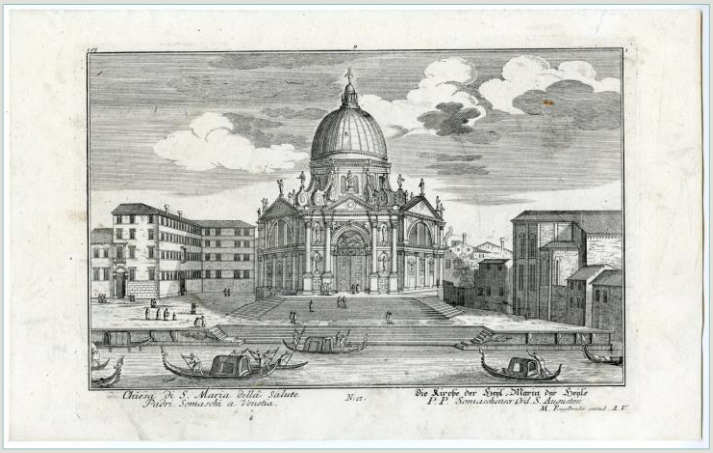
Grand Canal – Santa Maria Della Salute
Martin Engelbracht – circa 1740



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Appendix J & K – Height/Weight Conversions

Appendix J
Height Conversion Table
Feet (ft), Inches (in) / Centimeters (cm)

Feet/Inches	Total Inches	Centimeters	Feet/Inches	Total Inches	Centimeters	Feet/Inches	Total Inches	Centimeters
1' 6"	18"	46	3' 3"	39"	99	5'	60"	152
1' 7"	19"	48	3' 4"	40"	102	5' 1"	61"	155
1' 8"	20"	51	3' 5"	41"	104	5' 2"	62"	157
1' 9"	21"	53	3' 6"	42"	107	5' 3"	63"	160
1' 10"	22"	56	3' 7"	43"	109	5' 4"	64"	163
1' 11"	23"	58	3' 8"	44"	112	5' 5"	65"	165
2'	24"	61	3' 9"	45"	114	5' 6"	66"	168
2' 1"	25"	64	3' 10"	46"	117	5' 7"	67"	170
2' 2"	26"	66	3' 11"	47"	119	5' 8"	68"	173
2' 3"	27"	69	4'	48"	122	5' 9"	69"	175
2' 4"	28"	71	4' 1"	49"	124	5' 10"	70"	178
2' 5"	29"	74	4' 2"	50"	127	5' 11"	71"	180
2' 6"	30"	76	4' 3"	51"	130	6'	72"	183
2' 7"	31"	79	4' 4"	52"	132	6' 1"	73"	185
2' 8"	32"	81	4' 5"	53"	135	6' 2"	74"	188
2' 9"	33"	84	4' 6"	54"	137	6' 3"	75"	191
2' 10"	34"	86	4' 7"	55"	140	6' 4"	76"	193

Appendix K
Weight Conversion Table = Pounds (lb) / Kilograms (kg)

Pounds	Kilograms	Pounds	Kilograms	Pounds	Kilograms	Pounds	Kilograms
2	1	95	43	187	85	280	127
4	2	97	44	190	86	282	128
7	3	99	45	192	87	284	129
9	4	101	46	194	88	287	130
11	5	104	47	196	89	289	131
13	6	106	48	198	90	291	132
15	7	108	49	201	91	293	133
18	8	110	50	203	92	295	134
20	9	112	51	205	93	298	135
22	10	115	52	207	94	300	136
24	11	117	53	209	95	302	137
26	12	119	54	212	96	304	138
29	13	121	55	214	97	306	139
31	14	123	56	216	98	309	140
33	15	126	57	218	99	311	141
35	16	128	58	220	100	313	142
37	17	130	59	223	101	315	143
40	18	132	60	225	102	317	144
42	19	134	61	227	103	320	145
44	20	137	62	229	104	322	146

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Appendix L – TEXT DOCUMENTATION

Appendix L

FCDS TEXT DOCUMENTATION REQUIREMENTS – REVISED FOR 2021

ALL REGISTRARS MUST FULLY DOCUMENT ALL CASES REGARDLESS OF CLASS OF CASE OR INFORMATION AVAILABLE IN THE MEDICAL RECORD

WHEN INFORMATION IS NOT AVAILABLE OR DATES ESTIMATED, PLEASE DOCUMENT THAT THE INFORMATION IS MISSING AND DATES ARE ESTIMATED SO WE DO NOT HAVE TO ASK YOU WHY THEY ARE MISSING.

ADDITIONAL REFERENCES FOR DOCUMENTATION:

NCRA Informational Abstracts
NCRA has published a series of Informational Abstracts
FREE FOR DOWNLOAD
Providing cancer-site specific guidelines for text to be included in Abstracts

Additional

ADDITIONAL REFERENCES FOR DOCUMENTATION:

NCRA Informational Abstracts
NCRA has published a series of Informational Abstracts
FREE FOR DOWNLOAD
Providing cancer-site specific guidelines for text to be included in Abstracts

The National Cancer Registrars Association (NCRA) is also a source for tools and resources for registrars. NCRA's Education Committee created a series of "informational abstracts" for common cancers and a presentation entitled Using the Informational Abstracts in Your Registry that shows registrars how to use the informational abstracts as an abstracting resources. These are available as a set of cancer site-specific abstracts provide an outline to follow when determining what text to include.

The NCRA Informational Abstracts can be found at http://www.cancerregistryeducation.org/rr and include;
(Updated 11.2019)

- Benign Brain
- Bladder
- Breast
- Cervix
- Colon
- Endometrial
- Kidney
- Larynx
- Lung
- Lymphoma
- Malignant Brain
- Melanoma
- Ovarian
- Pancreas
- Prostate
- Renal Pelvis
- Testis

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Appendix O – ICD-10-CM DX Code Lists

ICD-10-CM CASEFINDING LIST FOR REPORTABLE TUMORS – *Oct 1, 2020 and later encounters*

The following ICD-10-CM list is to be used to identify potentially reportable tumors. Some ICD-10-CM codes contain conditions that are not reportable. These records should be reviewed and assessed individually to verify whether or not they are reportable to FCDS. ICD-10-CM implementation is expected nationwide October 1, 2020 for all hospitals.

ICD-10-CM	Description
C00._ - C43._	Malignant neoplasms
C4A._	Merkel cell carcinoma
C44.13__	Sebaceous Cell Carcinoma of Skin of Eyelid (upper, lower, left, right)
C45._ - C96._	Malignant neoplasms
C49.A_	GI stromal tumor
C7A._	Malignant carcinoid tumors
C84.A_	Cutaneous T-cell lymphoma
C84.Z_	Other mature T/NK-cell lymphoma
C91.A_	Mature B-cell leukemia Burkitt-type
C91.Z_	Other lymphoid leukemia
C92.A_	Acute myeloid leukemia with multi-lineage dysplasia
C92.Z_	Other myeloid leukemia
C93.Z_	Other monocytic leukemia
C96.2_	Malignant mast cell neoplasms
C96.A_	Histiocytic sarcoma
C96.Z_	Other specified malignant neoplasm of lymphoid, hematopoietic and related tissue
D00._ - D09._	Carcinoma in situ (**exclude: skin, cervix and prostate– D04._, D06._ and D07.5**)
D32._	Benign neoplasm of meninges (cerebral, spinal and unspecified)
D33._	Benign neoplasm of brain and other parts of central nervous system
D35.2, D35.4	Benign neoplasm of pituitary gland, craniopharyngeal duct and pineal gland
D42._, D43._	Neoplasm of uncertain or unknown behavior of meninges, brain, CNS
D44.3-D44.5	Neoplasm of uncertain behavior of pituitary gland, craniopharyngeal duct and pineal gland
D45	Polycythemia vera (9950/3)
D46.0-D46.9, D46.A-D46.Z	Myelodysplastic syndromes (9980, 9982, 9983, 9985, 9986, 9989, 9991, 9992)
D47.1, D47.3, D47.4, D47.9	Myeloproliferative diseases (9931, 9740, 9741, 9742, 9960, 9961, 9962, 9963, 9965, 9966, 9967, 9970, 9971, 9975, 9987)
D47.Z, D47.Z1, D47.Z9	Post-transplant lymphoproliferative disorder (PTLD)
D49.6, D49.7	Neoplasm of unspecified behavior of brain, endocrine glands and other CNS
D72.110-D72.119	Hypereosinophilic Syndrome [HES] – idiopathic, lymphocytic, other, unspecified

Note: Pilocytic/juvenile astrocytoma (M-9421) is reported with the behavior coded /3 (9421/3 not 9421/1).

2021 ICD-10-CM Casefinding List for FCDS Reporting

REPORTABLE	ICD-10-CM	FULL_DESCRIPTION
Y	C49.3	Malignant neoplasm of connective and soft tissue of thorax
Y	C49.4	Malignant neoplasm of connective and soft tissue of abdomen
Y	C49.5	Malignant neoplasm of connective and soft tissue of pelvis
Y	C49.6	Malignant neoplasm of connective and soft tissue of trunk, unspecified
Y	C49.8	Malignant neoplasm of overlapping sites of connective and soft tissue
Y	C49.9	Malignant neoplasm of connective and soft tissue, unspecified
Y	C49.A	Gastrointestinal stromal tumor
Y	C49.A0	Gastrointestinal stromal tumor, unspecified site
Y	C49.A1	Gastrointestinal stromal tumor of esophagus
Y	C49.A2	Gastrointestinal stromal tumor of stomach
Y	C49.A3	Gastrointestinal stromal tumor of small intestine
Y	C49.A4	Gastrointestinal stromal tumor of large intestine
Y	C49.A5	Gastrointestinal stromal tumor of rectum
Y	C49.A9	Gastrointestinal stromal tumor of other sites
Y	C4A	Merkel cell carcinoma
Y	C4A.0	Merkel cell carcinoma of lip
Y	C4A.1	Merkel cell carcinoma of eyelid, including canthus
Y	C4A.10	Merkel cell carcinoma of unspecified eyelid, including canthus
Y	C4A.11	Merkel cell carcinoma of right eyelid, including canthus
Y	C4A.111	Merkel cell carcinoma of right upper eyelid, including canthus
Y	C4A.112	Merkel cell carcinoma of right lower eyelid, including canthus
Y	C4A.12	Merkel cell carcinoma of left eyelid, including canthus
Y	C4A.121	Merkel cell carcinoma of left upper eyelid, including canthus
Y	C4A.122	Merkel cell carcinoma of left lower eyelid, including canthus
Y	C4A.2	Merkel cell carcinoma of ear and external auricular canal
Y	C4A.20	Merkel cell carcinoma of unspecified ear and external auricular canal
Y	C4A.21	Merkel cell carcinoma of right ear and external auricular canal
Y	C4A.22	Merkel cell carcinoma of left ear and external auricular canal
Y	C4A.3	Merkel cell carcinoma of other and unspecified parts of face
Y	C4A.30	Merkel cell carcinoma of unspecified part of face
Y	C4A.31	Merkel cell carcinoma of nose
Y	C4A.39	Merkel cell carcinoma of other parts of face

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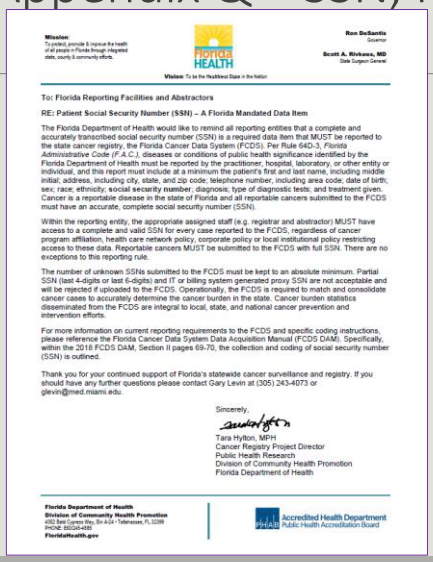
Appendix Q – SSN, FAQs & Misc. Instructions



Mission: To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.

Ron DeSantis, Governor

Scott A. Rivkees, MD, State Surgeon General

Vision: To be the Healthiest State in the Nation

To: Florida Reporting Facilities and Abstractors

RE: Patient Social Security Number (SSN) – A Florida Mandated Data Item

The Florida Department of Health would like to remind all reporting entities that a complete and accurately transcribed social security number (SSN) is a required data item that MUST be reported to the state cancer registry, the Florida Cancer Data System (FCDS). Per Rule 64D-3, *Florida Administrative Code (F.A.C.)*, diseases or conditions of public health significance identified by the Florida Department of Health must be reported by the practitioner, hospital, laboratory, or other entity or individual, and this report must include at a minimum the patient's first and last name, including middle initial; address, including city, state, and zip code; telephone number, including area code; date of birth; sex; race; ethnicity; social security number; diagnosis; type of diagnostic tests; and treatment given. Cancer is a reportable disease in the state of Florida and all reportable cancers submitted to the FCDS must have an accurate, complete social security number (SSN).

Within the reporting entity, the appropriate assigned staff (e.g. registrar and abstractor) MUST have access to a complete and valid SSN for every case reported to the FCDS, regardless of cancer program affiliation, health care network policy, corporate policy or local institutional policy restricting access to these data. Reportable cancers MUST be submitted to the FCDS with full SSN. There are no exceptions to this reporting rule.

The number of unknown SSNs submitted to the FCDS must be kept to an absolute minimum. Partial SSN (last 4-digits or last 6-digits) and IT or billing system generated proxy SSN are not acceptable and will be rejected if uploaded to the FCDS. Operationally, the FCDS is required to match and consolidate cancer cases to accurately determine the cancer burden in the state. Cancer burden statistics disseminated from the FCDS are integral to local, state, and national cancer prevention and intervention efforts.

For more information on current reporting requirements to the FCDS and specific coding instructions, please reference the Florida Cancer Data System Data Acquisition Manual (FCDS DAM). Specifically, within the 2018 FCDS DAM, Section II pages 69-70, the collection and coding of social security number (SSN) is outlined.

Thank you for your continued support of Florida's statewide cancer surveillance and registry. If you should have any further questions please contact Gary Levin at (305) 243-4073 or glevin@med.miami.edu.

Sincerely,

Tara Hylton, MPH
Cancer Registry Project Director
Public Health Research
Division of Community Health Promotion
Florida Department of Health

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4052 Bald Cypress Way, Bin A-04 • Tallahassee, FL 32399
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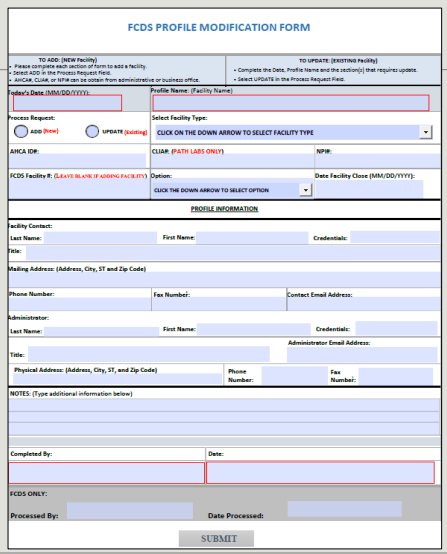
FloridaHealth.gov

Accredited Health Department
Public Health Accreditation Board



FCDS PROFILE MODIFICATION FORM

TO ADD: (NEW Facility)
- Please complete each section of form to add a facility.
- Select ADD in the Process Request Field.
- AHCA#, CLIA#, or NPI# can be obtain from administrative or business office.

TO UPDATE: (EXISTING Facility)
- Complete the Date, Profile Name and the section(s) that requires update.
- Select UPDATE in the Process Request Field.

Today's Date (MM/DD/YYYY):
Profile Name: (Facility Name)
Process Request: ADD (New) UPDATE (Existing)
Select Facility Type: CLICK ON THE DOWN ARROW TO SELECT FACILITY TYPE
AHCA ID#:
CLIA#: (PATH LABS ONLY)
NPI#:
FCDS Facility #: (LEAVE BLANK IF ADDING FACILITY)
Option: CLICK THE DOWN ARROW TO SELECT OPTION
Date Facility Close (MM/DD/YYYY):

PROFILE INFORMATION

Facility Contact:
Last Name: First Name: Credentials:
Title:
Mailing Address: (Address, City, ST and Zip Code)
Phone Number: Fax Number: Contact Email Address:
Administrator:
Last Name: First Name: Credentials:
Administrator Email Address:
Title:
Physical Address: (Address, City, ST, and Zip Code) Phone Number: Fax Number:
NOTES: (Type additional information below)
Completed By: Date:
FCDS ONLY:
Processed By: Date Processed:
SUBMIT

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Piazza San Marco – Saint Mark's Square

Appendix R - ICD-O-3.2 Updates for 2021

ICD-O-3 Coding Materials

- **Reporting Guidelines**
- Casefinding Lists
- 2021 SEER Coding Manual +
- Hematopoietic Project +
- ICD-O-3 Coding Materials
- 2018 Solid Tumor Rules +

ICD-O-3 Guidelines

The revised 2021 Guidelines for ICD-O-3.2 Histology Code and Behavior Update for cases diagnosed 1/1/202 now available on the NAACCR website. The update includes links to tables listing new codes and other change in two formats: PDF and Excel. Also available are the 2021 ICD-O-3.2 Update Guidelines.

The NAACCR ICD-O-3 Implementation Work Group highly recommends all users read the guidelines whi important coding information related to the 2021 update.

ICD-O-3 SEER Site/Histology Validation Lists

Appendix R

FCDS ADOPTED ICD-O-3.2 in 2018
NAACCR ADOPTED ICD-O-3.2 in 2020

Included in this Appendix are the Histology Code Updates for 2021.

The WHO is the organization responsible for the structure, format, coding rules and guidelines as well as the anatomical topography (primary site), histology, and behavior codes as published in the *International Classification of Diseases for Oncology*.

The printed ICD-O-3 purple book is very much out of date. However, the Introduction and Basic Instructions as well as all Topography Codes are Still Valid and Can Be Used.

However, you should not use the ICD-O-3 purple book for coding Histology.

Please use the ICD-O-3.2 Master Histology List and the Solid Tumor Rules (current edition) and the Hematopoietic Database from SEER (online interactive) to correctly assign histology and behavior codes for all cancers – do not rely on the codes in the printed ICD-O-3 Manual.

Guidelines for ICD-O-3.2 Update Implementation NAACCR, Inc

North American Association of Central Registries, Inc

GUIDELINES FOR ICD-O-3.2 HISTOLOGY CODE AND BEHAVIOR UPDATE IMPLEMENTATION
Effective January 1, 2021

Prepared by:

NAACCR ICD-O-3 Update Implementation Work Group

OPEN TABLES FILE

2021 ICD-O-3 Update to be used jointly with ICD-O-3.2, Solid Tumor Rules, and Hematopoietic and Lymphoid Neoplasm Database

December 1, 2020

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Appendix R - ICD-O-3.2 Updates for 2021

Guidelines for ICD-O-3.2 Update Implementation *NAACCR, Inc*

TABLE OF CONTENTS

3.1 TABLE 1: BEHAVIOR CODE CHANGES- NON-REPORTABLE TO REPORTABLE
Table 1 lists 16 terms and codes that have changed behavior from non-reportable to reportable beginning with cases diagnosed on or after January 1, 2021.

3.2 TABLE 2: BEHAVIOR CODE CHANGES- REPORTABLE TO NON-REPORTABLE
Table 2 lists nine terms and codes that have changed behavior from reportable to non-reportable beginning with cases diagnosed on or after January 1, 2021.

3.3 TABLE 3: DELETED CODES- HISTOLOGY TERMS MOVED TO OTHER ICD-O CODES
Table 3 lists ten terms and codes that have been deleted from one ICD-O code and moved to another code effective with cases diagnosed on or after January 1, 2021.

3.4 TABLE 4: CHANGE IN REPORTABLE TERMINOLOGY
Table 4 lists revised preferred terminology for 13 neoplasms in ICD-O-3.2. These neoplasms no longer require "malignant" to be included in the diagnostic term in order to report the case as malignant (/3).

3.5 TABLE 5: NEW ICD-O CODES AND TERMINOLOGY
Table 5 lists 12 new terms and ICD-O codes effective for cases diagnosed on or after January 1, 2021.

3.6 TABLE 6: COMBINED 2021 ICD-O-3.2 UPDATE (NUMERICAL ORDER)
Table 6 combines Tables 1 through 5 into a single list in numerical order by ICD-O code.

3.7 TABLE 7: COMBINED 2021 ICD-O-3.2 UPDATE (ALPHA ORDER)
Table 7 combines Tables 1 through 5 into a single list in alpha order by histology term.

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Appendix R - ICD-O-3.2 Updates for 2021

Table 1: New behavior codes (Reportable neoplasms)
WHO has changed behavior codes for the following terms which result in previously non-reportable neoplasms becoming reportable for cases diagnosed 1/1/2021 forward. DO NOT report cases diagnosed prior to 1/1/2021.

Action	ICD-O Code	Term/Site	Comments
New behavior	8077/2	Squamous intraepithelial neoplasia, grade II	Change from /0 **Excludes cervix** Refer to standard setter and/or state guidelines for further reportability guidelines
New behavior	8150/3	Pancreatic endocrine tumor, NOS (C25.4)	Change from /1
New behavior	8151/3		
New behavior	8158/3		
New behavior code and term	8380/2		
New behavior code	8408/3		
New behavior/term	8452/3		
New behavior code and term	8620/3		
New behavior/term	8690/3		
New behavior code	8691/3		

Table 2: New behavior codes (Non-reportable neoplasms)
WHO has changed behavior codes for the following terms which result in reportable neoplasms becoming non-reportable when diagnosed 1/1/2021. Continue reporting these cases when diagnosed prior to 1/1/2021.

Action	ICD-O Code	Term/Site	Comments
New behavior	8832/1	Dermatofibrosarcoma protuberans, NOS (C44. _) Dermatofibrosarcoma, NOS (C44. _)	Change from /3
New behavior	8833/1	Pigmented dermatofibrosarcoma protuberans (C44. _) Bednar tumor (C44. _)	Change from /3
New behavior code ***(for specific sites only)***	9080/1	Immature teratoma of the lung (C34. _) Immature teratoma of thymus (C37.9) Immature teratoma of thyroid (C73.9)	Change from b combination
New behavior code	9709/1		
New behavior code	9718/1		
New behavior/term	9725/1		
New behavior code	9751/1		
New behavior	9971/1		
New behavior & term	8335/1		

Table 3: Deleted ICD-O codes in ICD-O-3.2
In ICD-O-3.2, several ICD-O codes have been removed and the histologies moved to other codes. The instructions for cases diagnosed prior to 1/1/2021 and 1/1/2021 forward. This table lists only *reportable*

ICD-O-3/3.1 Code/behavior	Term(s)	ICD-O-3. (1/1/20
8471/3	Papillary mucinous cystadenocarcinoma (C56.9) Papillary pseudomucinous cystadenocarcinoma (C56.9)	8470/3
9150/3	Hemangiopericytoma, malignant	8815/3
9260/3	Ewing sarcoma	9364/3
9670/3	Malignant lymphoma, small B lymphocytic, NOS *(see also M-9823/3)* Malignant lymphoma, lymphocytic, diffuse, NOS	9823/3

Table 4: Changes in reportable terminology
(*) WHO has revised preferred terminology for these neoplasms and no longer requires "malignant" to be used in the term in order to code behavior of /3

Action	ICD-O Code	Term/Site	Comments
New term	8151/3	Insulinoma	(*)
New term	8152/3	Glucagonoma	(*)
New term	8153/3	Gastrinoma	(*)
New term	8155/3	VIPoma	(*)
New term	8156/3	Somatostatinoma	(*)
New term	8580/3	Thymoma, NOS (C37.9)	(*)
New term			
New term			
New term			
New term			
New Pref term			
New term			

Table 5: New Terms and ICD-O codes

Action	ICD-O Code	Term/Site	Comment
New code/term	8273/3	Pituitary blastoma Embryoma	
New code/term	9749/3	Erdheim-Chester Disease	
New code/term	9766/3	Lymphomatoid granulomatosis, grade 3	
New code/term	9819/3	B-lymphocytic leukemia/lymphoma, BCR-ABL1-like	
New code/term	9877/3	Acute myeloid leukemia with mutated NPM1	
New code/term	9878/3	Acute myeloid leukemia with biallelic mutations of CEBPA	
New code/term	9879/3	Acute myeloid leukemia with mutated RUNX1	
New code/term	9912/3	Acute myeloid leukemia with BCR-ABL1	
New code/term	9968/3	Myeloid/lymphoid neoplasms with PCM1-JAK2	
New code/term	9993/3	Myelodysplastic syndrome with ring sideroblasts and multilineage dysplasia	
New code/term	9715/3	Anaplastic large cell lymphoma ALK-negative Breast implant-associated anaplastic large cell lymphoma	
New code/term	8349/1	Non-invasive follicular thyroid neoplasm with papillary-like nuclear features (NIFTP) C73.9) Non-invasive FTP (C73.9)	**This term was previously coded to 8343/2. The new code and behavior will make this non-reportable**

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Appendix S – Summary of Changes

APPENDIX S – Summary of Changes 2021

The 2021 FCDS DAM includes clarifications to old instructions, expansion of instructions, new instructions, new data items, new terminology, new reportable cancers, no longer reportable cancers, a new records layout, new requirements for SSDIs, New Codes for existing data items, and many more changes to the 2021 FCDS DAM. We encourage users to review the entire FCDS DAM to ensure they have captured the latest updates and revisions including Appendix P – Resources for Registrars. This is only a Summary of Changes and does not include every single revision in the manual – only major change points. Thank You.

- MOST CHANGES APPEAR IN RED TYPE, BLUE TYPE, OR HIGHLIGHTED SECTIONS – and described here
- Section I has many changes and clarifications – FCDS suggests every registrar read Section I carefully for changes.
- Section I has expanded Section explaining the Requirement for Reporting Non-Analytic Cases and Importance of These Cases
- Section I now has multiple statements describing that FCDS does not at this time allow or receive Update or Modify Records and cannot just update your abstracts when you make a change in your database. FCDS only receives the case from you once.
- Section I has an updated Comparison Table of Reportable Cancers – comparing CoC, SEER, and NPCR/FCDS Requirements.
- Section II has individual data item additions, revisions, updates, new codes, and some updated instructions.
- Section II has expanded the Date of Diagnosis and Definitive Terminology Sections to clarify frequently asked questions about using imaging dates as the Initial Date of DX, Mammography BIRADS and other xyz-RADS Classifications in imaging and how to use, and the need to prioritize Positive Terminology over Ambiguous Terminology on Imaging and how to know the difference.
- Appendix A has been updated to reflect the status of Florida Reporting Facilities in 2021.
- Appendix G has the Complete FCDS 2021 Record Layout including All New Data Items and All Core Data Items
- Appendix H has the Complete FCDS 2021 SSDI Requirements List
- Appendix O has both the abbreviated and the extended versions of the 2021 Casefinding List for Florida
- Appendix P has 2021 Resources for Registrars including all required manuals and references to abstract and code cases.
- Appendix P also has information about the FCDS Abstracting Basics Course Outline and Recommended Training Resources
- Appendix R has all the information about 2021 Updates to ICD-O-3 and How to Use Them

- All Treatment Items – FCDS will no longer allow the Treatment Codes to = 9 or 99. Enter 0 or 00 rather than 9 or 99 if unknown.

- Exceptions to Allow Coding of 9 in Scope of Regional Lymph Node Surgery or 98 in Surgery of Primary Site is for leukemia, lymphoma, brain tumors, myelodysplastic syndromes and myeloproliferative diseases – plus the unknown and ill-defined sites that require specific codes in these fields.
- Scope of Regional Lymph Node Surgery = 9
  - Primary Site: C420, C421, C423, C424, C700-C709, C710-C729, C751-C753, C761,-C768, C809
  - Lymphoma (M-9590-9726, 9728-9732, 9734-9740, 9750-9762, 9811-9831, 9940, 9948, 9971) with Lymph Node Primary Site C77.0-C77.9)
  - Unknown or Ill-defined Primary Site (C76.0-C76.8, C80.9)
  - Hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease (9727, 9733, 9741, 9742, 9764, 9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9993)

- FCDS no longer accepts an unknown Date of Diagnosis – the date must be estimated if unknown – see the Instructions under Date of Initial Diagnosis for handling unknown or partial dates in these cases. This includes Historical Grid Cases – no unknown.

- ITEM # 830 – Regional Lymph Nodes Examined
- ITEM # 820 Regional Lymph Nodes Positive
- ITEM # 1292 Scope of Regional Node Surgery

The above 3 Regional Lymph Node Items have been modified to recognize that FNA or core biopsy of a regional lymph node should not be coded as a regional lymph node removed, nor should it be counted as 'treatment' in the various Treatment EDITS as surgery.

Therefore, when the Scope of Regional Lymph Node Surgery is coded = 1 (FNA, core biopsy), this is no longer considered surgery in the Treatment Status Field or Sequence of Surgery to XRT or Systemic Therapy Fields. And, the Regional Lymph Nodes Examined should = 95 for all of these cases. However, the Regional Lymph Nodes Positive may be coded as either 00 or 95 depending on the result. Code 95 when the result of the FNA/Core Biopsy is positive. Code 00 when the result of the FNA/Core Biopsy is negative.

NEW Histological Terms and New Histological Terms – Appendix R

ICD-O Code	Term/site
8273/3	Pituitary blastoma/ Embryoma
9749/3	Erdheim-Chester Disease
9766/3	Lymphomatoid granulomatosis, grade 3
9819/3	B-lymphocytic leukemia/lymphoma, BCR-ABL1-like
9877/3	Acute myeloid leukemia with mutated NPM1
9878/3	Acute myeloid leukemia with biallelic mutations of CEBPA
9879/3	Acute myeloid leukemia with mutated RUNX1
9912/3	Acute myeloid leukemia with BCR-ABL1
9968/3	Myeloid/lymphoid neoplasms with PCM1-JAK2
9993/3	Myelodysplastic syndrome with ring sideroblasts and multilineage dysplasia
9715/3	Anaplastic large cell lymphoma ALK-negative Breast implant-associated anaplastic large cell lymphoma

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Questions

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