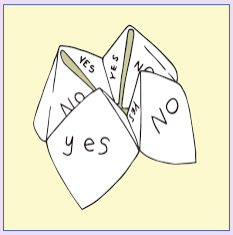
Common Registrar Technical Questions and Clarifications from Visual Editing

1

2022-2023 FCDS EDUCATIONAL WEBCAST SERIES

5/18/2023

STEVEN PEACE, CTR



1

CDC & Florida DOH Attribution

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"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."

FCDS would also like to acknowledge the Florida Department of Health for its support of the Florida Cancer Data System, including the development, printing and distribution of materials for the 2022 Virtual FCDS Annual Conference and the 2022-2023 FCDS Webcast Series under state contract COHAW. The findings and conclusions in this series are those of the author(s) and do not necessarily represent the official position of the Florida Department of Health.

2

FLccSC LMS – CEU Quiz – FCDS IDEA

3

FLccSC
Fundamental Learning Collaborative for the Cancer Surveillance Community

NO CEU QUIZ FOR THIS WEBCAST

NCRA CEU# is 2022-161

2 CEUs AWARDED
2 CAT A CEUs

Login to FLccSC to Print Your Certificate

3

Outline

4

- An Introduction to FCDS
- National Uniform Data Standards
- Why New Instructions and Software Version Every Year?
- Reportable Patients/Reportable Cancers
- Identifying Cases (Casefinding & Re-Casefinding)
- Required Data Items, Data Item Definitions, Code Definitions
- Please Explain Rationale and Differences in Cancer Staging Systems
- Please Explain Rationale for Multiple Primary/Histology Code Rules
- Where to Go for Questions – How to Use the Answers
- This and That for $1000 – Real Q&A Time – Actual Questions
- How Are We Expected To Keep Up With Everything – Every Year ???

4

So Many Questions – So Little Time

5

- Everybody has questions about Cancer Registries
  - Who has to report cases and under what authority?
  - Questions about Privacy, Confidentiality and HIPAA
  - Questions about how to find cases (casefinding)
  - Questions about reportable cancer criteria
  - Questions about reportable patient criteria
  - Questions about interpreting words and phrases
  - Questions about data items and code definitions
  - Questions about software – uploads, downloads, reports
  - Questions about data quality, edits and audits
  - Questions about education and training
  - Questions about becoming a CTR or Cancer Registrar
  - Questions about FCDS Abstractor Code Test Requirements
  - Questions about using Manuals, References, Resources, Websites
  - Questions about where to go when you have questions about cases….
  - And of course that one question – **HOW DO YOU KEEP UP WITH EVERYTHING?**

5

An Introduction to FCDS – FCDS 101

6

- FCDS is an 'Incidence-Only' Population-Based Central Cancer Registry
- FCDS receives MILLIONS of records from THOUSANDS of Sources
- FCDS matches, merges and consolidates records into individual cancers
- BUT - FCDS only receives ONE copy of your facility's abstract – ONE –
- FCDS expects a lot from Florida Abstractors – Data Quality not Quantity
- FCDS only requires a subset of the data items that CoC/NCDB requires
- You need to know what CoC Requires and what FCDS Requires
- You do not need to abstract data items not required – we see this a lot
- Registrars code whatever is on the screen – ~~don't code excess data items~~
- We will discuss more when we talk about data items required

6

Laws and Privacy and Confidentiality

7

Title XXIX - Chapter 381 - Public Health: General Provisions
381.0031 Report of diseases of public health significance to department.
Title XXIX - Chapter 385 - Chronic Diseases
385.202 Statewide cancer registry
Title XXIX - Chapter 405 - Medical Information Available for Research
405.01 Release of medical information to certain study groups; exemption from liability
405.02 Limitation on publication of released information
405.03 Confidentiality
Title XXIX - Chapter 408 - Health Care Administration
408.07 Definitions

Rule 64D-3.003 Notification by Laboratories
Rule 64D-3.006 Reports, Medical Facilities and Freestanding Radiation Therapy Centers
Rule 64D-3.031 Notification by Laboratories
Rule 64D-3.034 Cancer Reporting

PUBLIC LAW 107-260-Oct 29, 2002 116 STAT.1743 - National Program of Cancer Registries

HIPAA Privacy Rule [45 CFR 164.512(b)] - DISCLOSURES FOR PUBLIC HEALTH ACTIVITIES

OCR HIPAA Privacy
December 3, 2002
Revised April 3, 2003

DISCLOSURES FOR PUBLIC HEALTH ACTIVITIES
[45 CFR 164.512(b)]

Background
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.

How the Rule Works
General Public Health Activities. The Privacy Rule permits covered entities to disclose protected health information, without authorization, to public health authorities who are legally authorized to receive such reports for the purpose of preventing or controlling disease, injury, or disability. This would include, for example, the reporting of a disease or injury; reporting vital events, such as births or deaths; and conducting public health surveillance, investigations, or interventions. See 45 CFR 164.512(b)(1)(i). Also, covered entities may, at the direction of a public health authority, disclose protected health information to a foreign government agency that is acting in collaboration with a public health authority. See 45 CFR 164.512(b)(1)(i). Covered entities who are also a public health authority may use, as well as disclose, protected health information for these public health purposes. See 45 CFR 164.512(b)(2).

A "public health authority" is an agency or authority of the United States government, a State, a territory, a political subdivision of a State or territory, or Indian tribe that is responsible for public health matters as part of its official mandate, as well as a person or entity acting under a grant of authority from, or under a contract with, a public health agency. See 45 CFR 164.501. Examples of a public health authority include State and local health departments, the Food and Drug Administration (FDA), the Centers for Disease Control and Prevention, and the Occupational Safety and Health Administration (OSHA).

Generally, 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

7

FCDS Receives Only ONE Copy of Each Abstract

8

- **FCDS *normally* only receives ONE copy of your abstract – ever.**
- Whenever you make a correction on your abstract – FCDS does NOT get an updated copy of your abstract – even if you mark it to resend.
- FCDS only gets the correction/update/additional text information from the Message System within FCDS IDEA for a case – one-at-a-time
- Then FCDS Staff Manually enter the corrections or changes
- Please don't forget this and assume FCDS gets automatic updates
- FCDS misses a lot of information and changes from you – especially from registrars who work on contract from other states – because many other states DO ALLOW Correction/Update Abstracts to be sent to them.
- **FCDS does not get ANY electronic correction/update/changes!!!**

8

Active Cancers and Historical Cancers

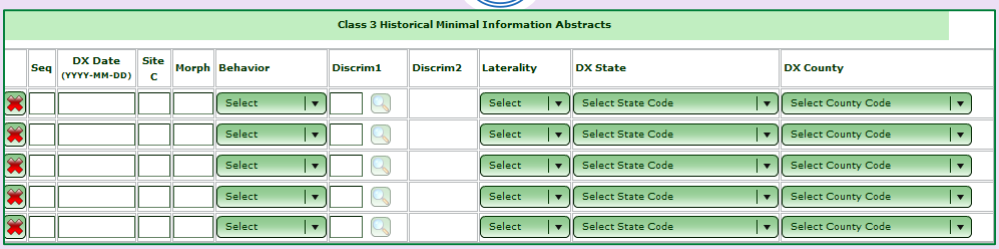
9

- Unique to Florida – FCDS keeps track of ALL cancers in a lifetime
- You Must Report All Historical Cancers if You Report Any Cancer
- Then you have to ask 'Do I complete a Full Abstract or Historical Grid?'
- It depends on whether or not the patient has evidence of that cancer.
- If all Cancers are Free of Disease and None Receiving Treatment – N/R
- If any Cancer has Evidence of Disease or is Receiving Treatment
  - Report ALL Cancers - Active Cancer, Under Treatment, and Not Active Cancer
  - Report the Inactive Cancers (No Evidence of Disease) in the Historical Grid
  - Report ANY Active Cancer or Cancer Receiving Treatment in a Full Abstract
  - Some Cancers are Deemed Not Reportable – see the FCDS DAM and change annually
- Annual Updates to Reportable Cancers come from WHO and SEER
- Casefinding Lists are Updated Annually when WHO Updates ICD Codes

9

Historical Cancers – No Evidence of this Cancer

10



1. Sequence Number
2. Diagnosis Date
3. Primary Site (ICD-O-3)
4. Histology (ICD-O-3)
5. Behavior (ICD-O-3)
6. Laterality
7. State of Residence at Diagnosis (State Abbreviation)
8. County of Residence at Diagnosis (FIPS County Code)
9. Schema Discriminator 1
10. Schema Discriminator 2

If you forget to include Historical Cancers in the grid on the first complete abstract you send to FCDS, FCDS will delete the 1st abstract and ask you to complete the Historical Case in 'the grid' and resubmit both cases again. Otherwise, FCDS has no information to 'build' a 'dummy' historical case into the cancer sequence chronology to complete it with other(s).

10

Historical Cancers – WITH Evidence of This Cancer

11

Some Historical Cancers REQUIRE YOU COMPLETE A FULL ABSTRACT

- The Cancer was Never Treated
- Patient is Undergoing Active Treatment for This Cancer (exceptions)
- Patient has Persistent Active Disease at the Conclusion of 1st Course Treatment
- Recurrence of This Historical Cancer – Must Have Been Treated & Disease Free
- *Recurrence: Use Solid Tumor Rules to Rule Out a New Primary*
- Disease Progression – Different than Disease Recurrence
- Patient was Never Free of Cancer

11

Other Things FCDS Does A Little Differently

12

- An explanation including years of change is described in the FCDS DAM under a section entitled, "CANCER STAGING INFORMATION AND REQUIREMENTS BY DATE OF DIAGNOSIS" for more reading on staging.
- NO AJCC TNM Required for Any Sites or Any Years – it has proven unreliable and inconsistent for Florida
- But, we do ask you to code Collaborative Stage for DX Years 2004-2015 and Summary Stage is Required for all other years – you can just use the latest version as there are not significant changes from edition-to-edition.
- SSFs and SSDIs will change depending on the year of diagnosis
- FCDS is Highly Automated more so than probably every other state in the country.
- FCDS Audits Facilities More Frequently than most other state registries - casefinding & reabstracting/recoding
- DEADLINES with Consequences when you are late – legal/license, data are excluded from state/national totals

12

FCDS Abstractor Code Test – A Skills Test

13

- As of January 1, 2013 FCDS Requires EVERYBODY to take a test every year.
- We used to review copies of 25 abstracts before we assigned a code – for years.
- FCDS is the ONLY State with an FCDS Abstractor Code Test Requirement – not a CTR Requirement but an FCDS Code Requirement – we have for decades.
- 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 Test, regardless of certification by NCRA as a CTR, experience in the registry industry, or other factors.
- Annual re-testing is required to ensure all abstractors retain current level understanding of cancer registry reporting requirements, abstracting and coding standards and procedures.

13

FCDS Abstractor Code Test – A Skills Test

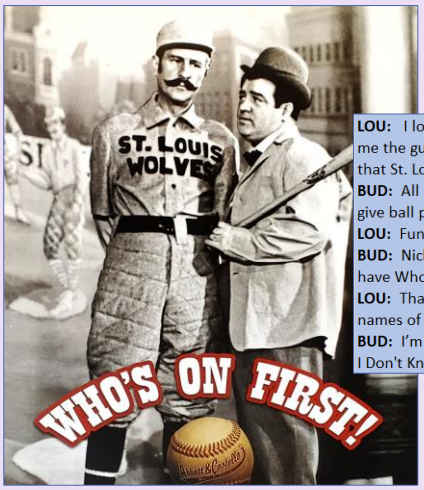
14

- 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).
- FCDS will not accept any cases from individuals without an Active/Current FCDS Abstractor Code.
- Exams are short (20 MP or T/F questions) with a mix of content questions.
- Questions are updated annually to ensure 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.

14

Who's on First?

15



LOU: I love baseball. When we get to St. Louis, will you tell me the guys' names on the team so when I go to see them in that St. Louis ballpark I'll be able to know those fellows?
BUD: All right. But you know, strange as it may seem, they give ball players nowadays very peculiar names.
LOU: Funny names?
BUD: Nicknames, pet names. Now, on the St. Louis team we have Who's on first, What's on second, I Don't Know is on third...
LOU: That's what I want to find out; I want you to tell me the names of the fellows on the St. Louis team.
BUD: I'm telling you: Who's on first, What's on second, I I Don't Know is on third.

15

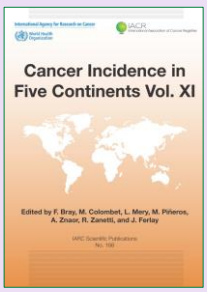
National & International - Uniform Data Standards

16

- Who Makes Up All These Crazy Rules and Instructions?
  - **Collaboration** under the NAACCR Uniform Data Standards Work Group
    - NCI SEER - national
    - CDC NPCR - national
    - State Cancer Registries
    - Statistics Canada/Canadian Council of Cancer Registries/Public Health Agency of Canada
    - ACoS/CoC/AJCC – set hospital rules and instructions only

Annual Report to the Nation on the Status of Cancer
NCI SEER/CDC NPCR/American Cancer Society

- Who else Contributes to Rules and Instructions
  - WHO/UICC/IACR
  - College of American Pathologists
  - American Cancer Society
  - Central Brain Tumor Registry of the United States
  - National Cancer Registrars Association
  - Institutional Liaisons - various



16

Required Data Items by Program
Data Item Definitions, Code Definitions

17

Who Sets the Requirements – Do we have to follow all requirements?

CHAPTER VIII:

REQUIRED STATUS TABLE (ITEM # ORDER)

The following table presents Version 23 of the NAACCR required status summarizing the requirements and recommendations for collection of each item by standard-setting groups. Differences from Version 22 are marked "Revised" or "New" in the "Note" column of the table and are highlighted in the body of the table. Text of previous versions is revealed by hovering over a highlighted cell.

NPCR Refers to requirements and recommendations of the NPCR regarding data items that are to be collected or computed by NPCR central cancer registries. The NPCR transmit column was removed with Version 11.2. Transmit instructions are provided annually by NPCR. Note: Patient identifying data items collected are not transmitted to CDC.

CoC Refers to requirements of CoC. CoC-accredited cancer program registries are required to collect the indicated items in the "Collect" column. Facilities should refer to the CoC *STORE* manual for further clarification of required fields. *The CoC Transmit column has been removed with Version 21.* Note: Patient identifying data items collected are not transmitted to the NCDB. The Transmit column has been removed with Version 21.

SEER Refers to requirements of NCI's SEER Program. Central registries are required to collect the indicated items in the "Collect" column. Facilities and central registries should refer to the *SEER Program Code Manual* for further clarification of required fields. The SEER Transmit column has been removed with Version 21.

CCCR Refers to requirements of CCCR for cases submitted to the Canadian Cancer Registry. Provincial/Territorial registries should refer to the *Canadian Cancer Registry Data Provider Documentation* for further clarification of fields. Items indicated in the "Collect" column are required to be collected at the registry level and reported to the Canadian Cancer Registry. CCCR requirements have been added to the Required Status Table with Version 11.2. The Transmit column has been removed with Version 21.

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Required Data Items by Program
Data Item Definitions, Code Definitions

18

Who Sets the Requirements – Do we have to follow all requirements?

Item #	Item Name	NPCR Collect	CoC Collect	SEER Collect	CCCR Collect	Source of Standard	Note
522	Behavior Code ICD-O-3	R	R	R	R	SEER,CoC	
530	EDP MDE Link Date	RS	.	.	.	NPCR	
531	EDP MDE Link	RS	.	.	.	NPCR	
540	Reporting Facility	R	R	R	.	CoC	
545	NPI--Reporting Facility	R*	R	R*	.	CMS	
550	Accession Number--Hosp	.	R	R	.	CoC	
560	Sequence Number--Hospital	.	R	R	.	CoC	
570	Abstracted By	.	R	R	.	CoC	
580	Date of 1st Contact	R*	R	.	.	CoC	Revised
590	Date of Inpt Adm	.	.	.	.	NAACCR	
600	Date of Inpt Disch	.	.	.	.	NAACCR	
605	Inpatient Status	.	.	.	.	NAACCR	
610	Class of Case	R	R	R	.	CoC	Revised
630	Primary Payer at DX	R*	R	R	.	CoC	
668	RX Hosp--Surg App 2010	.	R	.	.	CoC	
670	RX Hosp--Surg Prim Site 93-2022	.	R	RH	.	CoC	Revised
671	RX Hosp--Surg Prim Site 2023	.	R	R	.	CoC	New
672	RX Hosp--Scope Reg LN Sur	.	R	R	.	CoC	
674	RX Hosp--Surg Oth Reg/Dis	.	R	R	.	CoC	
676	RX Hosp--Reg LN Removed	.	RH	.	.	CoC	
682	Date Regional Lymph Node Dissection	.	R	RC	.	NAACCR	
690	RX Hosp--Radiation	.	.	RH	.	SEER	
700	RX Hosp--Chemo	.	R	R	.	CoC	
710	RX Hosp--Hormone	.	R	R	.	CoC	

Item #	Item Name	NPCR Collect	CoC Collect	SEER Collect	CCCR Collect	Source of Standard	Note
720	RX Hosp--BRM	.	R	R	.	CoC	
730	RX Hosp--Other	.	R	R	.	CoC	
740	RX Hosp--DX/Stg Proc	.	R	.	.	CoC	
746	RX Hosp--Surg Site 98-02	.	RH	RH	.	CoC	
747	RX Hosp--Scope Reg 98-02	.	RH	RH	.	CoC	
748	RX Hosp--Surg Oth 98-02	.	RH	RH	.	CoC	
752	Tumor Size Clinical	.	.	R	R*	SEER	
754	Tumor Size Pathologic	.	.	R	R*	SEER	
756	Tumor Size Summary	R	R	S	.	NPCR,CoC	
758	SEER Summary Stage 2000	RH	RH	RH	.	SEER	
760	SEER Summary Stage 1977	RH	RH	.	.	SEER	
762	Derived Summary Stage 2018	.	.	D	.	SEER	
764	Summary Stage 2018	R	.	R*	.	SEER	
772	EOD Primary Tumor	.	.	R	.	SEER	
774	EOD Regional Nodes	.	.	R	.	SEER	
776	EOD Mets	.	.	R	.	SEER	
780	EOD--Tumor Size	.	RH	RH	.	SEER,CoC	
785	Derived EOD 2018 T	.	.	D	.	SEER	
790	EOD--Extension	.	.	RH	.	SEER	
795	Derived EOD 2018 M	.	.	D	.	SEER	
800	EOD--Extension Prost Path	.	.	RH	.	SEER	
810	EOD--Lymph Node Involv	.	.	RH	.	SEER	
815	Derived EOD 2018 N	.	.	D	.	SEER	
818	Derived EOD 2018 Stage Group	.	.	D	.	SEER	
820	Regional Nodes Positive	R	R	R	R*	SEER,CoC	

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FCDS Requirements are mostly NPCR Requirements

Section	Data Opt	Item #	FCDS / NAACCR Item Name	Length	Year Start-End	NEW for 2023
Stage/Prognostic Factors		3914	Progesterone Receptor Percent Positive or Range	3		
Stage/Prognostic Factors	C	3915	Progesterone Receptor Summary	1	2018	
Stage/Prognostic Factors		3916	Progesterone Receptor Total Allred Score	2		
Stage/Prognostic Factors		3917	Primary Sclerosing Cholangitis	1		
Stage/Prognostic Factors		3918	Profound Immune Suppression	1		
Stage/Prognostic Factors		3919	Prostate Pathological Extension	3		
Stage/Prognostic Factors	C	3920	PSA (Prostatic Specific Antigen) Lab Value	5	2018	
Stage/Prognostic Factors		3921	Residual Tumor Volume Post Cytoreduction	2		
Stage/Prognostic Factors		3922	Response to Neoadjuvant Therapy	1		
Stage/Prognostic Factors		3923	S Category Clinical	1		
Stage/Prognostic Factors		3924	S Category Pathological	1		
Stage/Prognostic Factors		3925	Sarcomatoid Features	3		
Stage/Prognostic Factors	C	3926	Schema Discriminator 1	1	2018	
Stage/Prognostic Factors	C	3927	Schema Discriminator 2	1	2018	
Stage/Prognostic Factors	C	3928	Schema Discriminator 3	1	2018	
Stage/Prognostic Factors		3929	Separate Tumor Nodules	1		
Stage/Prognostic Factors		3930	Serum Albumin Pretreatment Level	1		
Stage/Prognostic Factors		3931	Serum Beta-2 Microglobulin Pretreatment Level	1		
Stage/Prognostic Factors	C	3932	LDH Pretreatment Lab Value	7	2018	
Stage/Prognostic Factors		3933	Thrombocytopenia	1		
Stage/Prognostic Factors		3934	Tumor Deposits	2		
Stage/Prognostic Factors		3935	Tumor Growth Pattern	1		
Stage/Prognostic Factors		3936	Ulceration	1		
Stage/Prognostic Factors		3937	Visceral and Parietal Pleural Invasion	1		
Stage/Prognostic Factors	C	3956	p16 (cervix, oropharynx, anus)	1	2022	2023

Section	Data Opt	Item #	FCDS / NAACCR Item Name	Length	Year Start-End	NEW for 2023
Stage/Prognostic Factors	C	3960	Histologic Subtype (appendix)	1	2023	2023
State/Requestor Items	C	9500	Historical #1: Sequence Number	2	2007	
State/Requestor Items	C	9501	Historical #1: DX Date	8	2007	
State/Requestor Items	C	9502	Historical #1: Primary Site	4	2007	
State/Requestor Items	C	9503	Historical #1: Morphology	4	2007	
State/Requestor Items	C	9504	Historical #1: Behavior	1	2007	
State/Requestor Items	C	9505	Historical #1: Laterality	1	2007	
State/Requestor Items	C	9506	Historical #1: Dx State *Abbreviation*	2	2007	
State/Requestor Items	C	9507	Historical #1: Dx County *FIPS*	3	2007	
State/Requestor Items	C	9508	Historical #1: CS SSF25 Discriminator	3	2010-2017	
State/Requestor Items	C	9509	Historical #1: Schema Discriminator 1	1	2018	
State/Requestor Items	C	9510	Historical #1: Schema Discriminator 2	1	2018	
State/Requestor Items	C	9511	Historical #1: Schema Discriminator 3	1	2018	
State/Requestor Items	C	9512	Historical #2: Sequence Number	2	2007	
State/Requestor Items	C	9513	Historical #2: DX Date	8	2007	
State/Requestor Items	C	9514	Historical #2: Primary Site	4	2007	
State/Requestor Items	C	9515	Historical #2: Morphology	4	2007	
State/Requestor Items	C	9516	Historical #2: Behavior	1	2007	
State/Requestor Items	C	9517	Historical #2: Laterality	1	2007	
State/Requestor Items	C	9518	Historical #2: Dx State *Abbreviation*	2	2007	
State/Requestor Items	C	9519	Historical #2: Dx County *FIPS*	3	2007	
State/Requestor Items	C	9520	Historical #2: CS SSF25 Discriminator	3	2010-2017	
State/Requestor Items	C	9521	Historical #2: Schema Discriminator 1	1	2018	
State/Requestor Items	C	9522	Historical #2: Schema Discriminator 2	1	2018	
State/Requestor Items	C	9523	Historical #2: Schema Discriminator 3	1	2018	
State/Requestor Items	C	9524	Historical #3: Sequence Number	2	2007	
State/Requestor Items	C	9525	Historical #3: DX Date	8	2007	

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Required Data Items
Data Item Definitions, Code Definitions

20

- While Data Item Requirements may differ from program-to-program…
- Data Item Definitions & Code Definitions should have little if any differences
- FCDS does have some minor variations on the 'years required' for some items
- BUT, FCDS should have very little variation from the Source of Standard
- This again is the reason for having NAACCR and Uniform Data Standards (UDS)
- FCDS has tried to provide more descriptive information and has incorporated some of both STORE and SEER Program Code Manuals plus NAACCR Vol II data definitions into our FCDS version of the same…
- We give you as much information as we can. The items all have the same meaning.

20

Why New Instructions and Software Version Every Year?

21

- NAACCR UDS WG approves new data items all year long
- They are assembled in late summary and become part of Volume II
- Then the state/national cancer programs must decide:
  - Which New Data Items do WE want to Require?
  - Which Years of Diagnosis do WE want to Require the Item?
  - Which Retired Data Items Does Anybody Still Support – do we keep or retire them?
  - Which Data Items can WE Completely Retire?
- Changes in the Data Transmission Protocols – flat file to html to xml
- New Features for Software / New Analytic Software to Add / Updates
- Each Vendor has their own timeline and clients demands to customize
- Each state has their own timeline and clients demands to customize
- FCDS writes our own FCDS State Software – FCDS does not use NPCR/SEER

21

Change Management – Cost of Taking Shortcuts

22

22

Reportable Patients/Reportable Cancers

23

- The most often asked questions – Is this cancer/patient reportable?
- Asks 2 questions – is the case reportable AND how to code Class of Case.
- A RUMOR: Class of Case *might* be going back to a 1-digit code soon.
- But FIRST let's talk about determining patient and cancer reportability.
- It is not as easy as it looks in Section IA of the FCDS DAM…25 pages.

- These rather simplistic subsection titles have become complicated/dense.

23

Reportable Patients/Reportable Cancers

24

Case Eligibility begins in Section 1 on Page 1 of every FCDS DAM every year

CASE ELIGIBILITY

Florida facilities are legislatively mandated to report any case of cancer meeting the Florida "cancer" definition, regardless of facility or network affiliation or Class of Case. FCDS requires complete abstracting of additional select neoplasms that the Commission on Cancer/American College of Surgeons does not require such as benign and borderline brain and central nervous system tumors and certain reproductive site cancers.

The 2023 Updates to National Standards incorporate several new histologic types, subtypes, and changes to tumor behavior making some cancers new to our state reportable list due to reclassification by WHO as "malignancy" or other reportable cancer criteria.

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. Please review all standard cancer diagnosis codes and procedures codes.

Revised 2023

24

Reportable Patients/Reportable Cancers

25

But the detail and all of the bulleted exceptions have grown over the years

1. Reportable Patients

All patients first seen at the reporting facility on or after January 1, 1981 (July 1, 1997 for free-standing/ambulatory surgery centers and freestanding radiation therapy centers), whether as an inpatient, outpatient or in an ambulatory care setting, who meet one or more of the below criteria must be reported to FCDS. Any patient with a coded diagnosis of cancer but not reported may be included in Casefinding Audits for review to ensure the case is truly not reportable. This may require a second complete review of the chart.

Revised 2023

SECTION I: GUIDELINES FOR CANCER DATA REPORTING

3

IMPORTANT NOTE: The start date for your registry for the state of Florida is 1/1/1981 or the day your facility opened. It is not the same start date that the Commission on Cancer assigns your facility. All reporting began in 1981. FCDS has cancer cases from your facility going back to 1981. If you submit a new cancer for a person already registered by your facility with FCDS, you must use the same Accession Number assigned to that person before your CoC Start Date. The older Accession Numbers can be found in the Alphabetical Listing Report of ALL Cases Every Reported to FCDS by your Facility. This 'alpha list' runs interactively and is the most up-to-date listing of all cases ever reported by your facility. It can be run in Accession Number Order or in Alphabetical Order in IDEA.

Reportable Patients

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 (see Reportable Tumors)
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 and never treated)
c) all patients undergoing prophylactic, neoadjuvant, or adjuvant therapy for malignancy,
d) all patients undergoing 'active surveillance' or 'watch and wait' approach to therapy,
e) patients seen as in-patient, out-patient, or in-clinic are reportable,
f) all patients diagnosed at autopsy,
g) all historical cases that meet FCDS reportable guidelines.

Note: Patients with 'chronic' neoplastic conditions 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. Treatment for these neoplasms may achieve a state of 'clinical remission'. However, these conditions cannot be cured without aggressive therapy including high-dose chemotherapy plus bone marrow transplant or stem cell transplant. The chronic nature of their disease makes these cases always reportable, regardless of clinical status.

2. Not Reportable Patients

a) patients in complete remission with no evidence of cancer (NED) – see Note regarding chronic neoplasms
b) patients with no evidence of cancer and not receiving prophylactic or adjuvant therapy,
c) 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),
d) 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,
e) patients who receive transient care to avoid interrupting a course of therapy started elsewhere.

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Reportable Patients/Reportable Cancers

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And the Reportable Neoplasms Section is Now HUGE and DETAILED….

3. Reportable Neoplasms

Determination of whether or not a given primary neoplasm is reportable is made by reference to the histology and behavior codes of the *International Classification of Diseases for Oncology*, 3rd ed. including approved updates and errata published by WHO and approved by NAACCR for ICD-O-3.

FCDS Requires that 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 carcinoma in-situ of the cervix or prostate.

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Additionally, FCDS requires reporting of all benign, borderline, and malignant tumors of the Brain, Central Nervous System, Cranial Nerves, Intracranial Glands, Meninges and Peripheral Nerve Tumors.

Please see NAACCR Version 23: Table of Comparison of Reportable Cancers: CoC, SEER, and NPCR found at the end of FCDS DAM Section I for clarification of cancers required to be reported to NPCR and FCDS. This table can also be found in **NAACCR Standards Volume III, Version 23 – Data Standards and Data Dictionary, Chapter 3 – Standards for Tumor Inclusion and Reportability** at https://www.naaccr.org/data-standards-data-dictionary/. Additional resources for clarification of FCDS reportable neoplasms include the (current) Solid Tumor Manual and the (current) SEER Hematopoietic Database.

FCDS adopted ICD-O-3.2 in 2018. This includes all of the 4th edition 'Blue Books" published as a series entitled; IACR/WHO Classification of Neoplasms. Currently, the WHO is publishing electronic 5th edition WHO Classification of Neoplasms for all neoplasms described. Use the ICD-O-3.2 Tables from IACR/WHO in addition to the (current) Solid Tumor Manual and (current) SEER Hematopoietic Database to determine whether a neoplasm is reportable to FCDS and the current correct ICD-O-3.2 histology and behavior code.

IACR/WHO began publishing 5th edition Classification of Neoplasm volumes in 2020. The 5th edition WHO Classification Series incorporates new histology codes, new behavior codes, and other changes that may change the reportability of some neoplasms over time. **Appendix R of this Manual includes the 2023 Updates to the IARC/WHO Classification of Neoplasms.**

The 2023 ICD-O-3.2 Update Guidelines includes comprehensive tables listing all changes to ICD-O-3.2 including new ICD-O codes, terminology and reportability changes effective for cases diagnosed 1/1/2023 forward. The 2023 update represents changes identified in recently published 5th Ed WHO Classification of Tumors books. Included in these guidelines are instructions for using the tables together with ICD-O-3.2.

The update includes important information on reportable versus non-reportable high-grade dysplasia in specified gastrointestinal sites.

The following WHO Classification of Tumor, 5th editions were released after the 2022 ICD-O-3.2 update:

- WHO Classification of Tumors of the Breast (2019)
- WHO Classification of Tumors of Digestive System (2019)
- WHO Classification of Tumors of the Female Genital Tumors (2019)
- WHO Classification of Tumors of Soft Tissue and Bone (2020)
- WHO Classification of Thoracic Tumors (2020))
- WHO Classification of Central Nervous System Tumors (2021)
- WHO Classification of Urinary and Male Genital Tumors (2022) – pending review

- The IARC/WHO ICD-O Committee has published two versions of additions, changes and revisions to the ICD-O-3 since the original publication (ICD-O-3.1 and ICD-O-3.2)
- The IARC/WHO Version of ICD-O-3.2 (Histology & Behavior Codes) is accessible from IARC/WHO @ http://www.iacr.com.fr/index.php?option=com_content&view=category&layout=blog&id=100&Itemid=577. This links to the January 25, 2021 edition of the ICD-O-3.2…but, it is not 100% current.
- The 2023-compliant NAACCR Annotated Histology List including Preferred Histology Terms, Synonyms, and Changes is available from the NAACCR Website at https://www.naaccr.org/icdo3
- The NAACCR Annotated Histology List does not include the Topography or Primary Site Codes.
- The 2023-specific ICD-O-3.2 Coding Guidelines and Implementation Documents including changes to Histology & Behavior Codes are available in Appendix R of this manual.
- Complete 2023 ICD-O-3.2 Coding Guidelines and Implementation Documents are also available from NAACCR at https://www.naaccr.org/icdo3/.
- Registrars MUST use the current version of the Solid Tumors Rules to supplement the ICD-O-3.2 Tables for all solid tumors diagnosed 2018 and later. https://seer.cancer.gov/tools/solidtumor/
- Registrars MUST use the current online version of the Rules for Hematopoietic and Lymphoid Neoplasms and the Hematopoietic Database to identify and code any myeloid or lymphoid neoplasm https://seer.cancer.gov/seertools/hemelymph/ An instructional manual is located under 'downloads'.

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Reportable Patients/Reportable Cancers

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And the Reportable Neoplasms Section is Now HUGE and DETAILED….

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Reportable Patients/Reportable Cancers

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SECTION I: GUIDELINES FOR CANCE

a) **In Situ and Invasive Cancers** - FCDS includes all primary n
Therefore, any cancer with an ICD-O behavior code of /2 (in
(except carcinoma in situ of the cervix, carcinoma in situ of t
with benign or borderline behavior are discussed elsewhere in
behavior code of /0 or /1 is determined to be in-situ or invasiv
malignant fashion), or by a pathologist, the case is reportable.

i. **Anal Intraepithelial Neoplasia (AIN III)** is reportal
casefinding activities. This non-invasive neoplasm of
the same as SCC of perianal skin (C44.5). It is impor
and skin of anus neoplasms. Neoplasms of the skin o
if they extend into the anal canal. **AIN III** of the peri

ii. **Penile Intraepithelial Neoplasia Grade III (PeIN I**
included in casefinding activities.

iii. **Vulvar Intraepithelial Neoplasia Grade III (VIN I**
included in casefinding activities.

iv. **Vaginal Intraepithelial Neoplasia Grade III (VAI**
included in casefinding activities.

v. **Lobular Intraepithelial Neoplasia Grade III (LIN**

vi. The CoC does not require Lobular Carcinoma In-Situ
However, LCIS is reportable to FCDS and to all c

vii. **(Pancreatic Intraepithelial Neoplasia (PanIN III)**
should be included in casefinding activities.

2021/2022/2023 REPORTABLE NEOPLASMS OR RE
Please check individual year ICD-O-3 Update Guideline

2021 New Reportable Neoplasms/Reclassified Tumors

a. Early or evolving melanoma, in situ and invasive – no
b. ALL Gastro-Intestinal Stromal Tumors (GIST) – now
c. Thymoma Neoplasms – most now classified 'malignar
d. Pheochromocytoma and Medullary Paraganglioma of

2022 New Reportable Neoplasms/Reclassified Tumors

a. LAMN – low grade appendiceal mucinous neoplasm (C18
b. HAMN – high grade appendiceal mucinous neoplasm (HA
c. Serrated dysplasia, high grade (C160-C166, C168-C169, C
d. Adenomatous polyp, high grade dysplasia (C160-C166, C
e. Intestinal-type adenoma, high grade (C160-C166, C168-C
f. Chondrosarcoma, grade 1
g. 9 New Histology Codes with Associated New Histology T
   - 8455/3 - Intraductal oncocytic papillary neoplasm with C254, C257-C259)
   - 8483/3 - Adenocarcinoma, HPV-associated C530-C53
   - 8484/3 - Adenocarcinoma, HPV-independent, NOS C
   - 8859/3 - Myxoid pleomorphic liposarcoma
   - 8976/3 - Gastroblastoma (C16.0 – C16.9)
   - 9111/3 - Mesonephric-like adenocarcinoma
   - 9366/3 - Round cell sarcoma with EWSR1-non-ETS fu
   - 9367/3 - CIC-rearranged sarcoma
   - 9368/3 - Sarcoma with BCOR genetic alterations

2022 New Codes & New Terms – Do not Use for Cases Diagnosed 1

ICD-O	Term
8033/3	Carcinoma with sarcomatoid component
8044/3	Small cell carcinoma, large cell variant (C56.9)
8085/3	Squamous cell carcinoma, HPV-associated
8086/3	Squamous cell carcinoma, HPV-independent

2023 New Reportable Neoplasms/Reclassified Tumors

- **IMPORTANT FOR CASES Diagnosed 2023 FORWARD:** Beginning 1/1/2023, all cases diagnosed with pilocytic astrocytoma/juvenile pilocytic astrocytoma and related terminology are to be reported with behavior /1. They will no longer be collected with malignant behavior (/3).
- Code 9421/3 will be valid for diagnoses of high-grade astrocytoma with piloid features (HFAP).
- Coding instructions are in the remarks section for 9421/1 and 9421/3 in the 2023 ICD-O Update
- 2023 ICD-O Updates include:
  - 5 new ICD-O histology codes/terms
  - 1 histology changed behavior and is reportable
  - 41 new preferred or related terms

New terminology may be used by your local pathologist to describe malignant or in situ neoplasms (i.e. well differentiated neuroendocrine neoplasm). When this occurs, the neoplasm is reportable to FCDS.

PLEASE REFERENCE APPENDIX R for the Complete Set of Changes for 2023 New Reportable Histology Codes, Retired Codes, New/Changes to Behavior and Reportability of Neoplasms.

ICD-O	New Codes and Terms
8272/3	Pituitary adenoma/pituitary neuroendocrine tumor (PitNET) (C75.1)
8693/3	Cauda equina neuroendocrine tumor (cranial and paraspinal nerves)
9385/3	Diffuse hemispheric glioma, H3 G34-mutant
9385/3	Diffuse midline glioma, H3 K27-altered

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ICD-O	New Codes and Terms
9385/3	Diffuse pediatric-type glioma, H3-wildtype and IDH-wildtype
9385/3	Infant-type hemispheric glioma
9391/3	Posterior fossa ependymoma, NOS
9391/3	Spinal ependymoma, NOS (C72.0)
9391/3	Supratentorial ependymoma, NOS
9396/3	Posterior fossa group A (PFA) ependymoma
9396/3	Posterior fossa group B (PFB) ependymoma
9396/3	Spinal ependymoma, MYCN-amplified (C72.0)
9396/3	Supratentorial ependymoma, YAP1 fusion-positive

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Reportable Patients/Reportable Cancers

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(IPMN/IOPN/ITPN/CPEN) seen on endosc
clinically malignant due to metastasis. *Note*
if they had malignancy. So, treatment is not
Please take care when reviewing these cases

The IPMN Path Description must include
- IPMN, with high grade dysplasia
- IPMN, non-invasive
- IPMN, in-situ
- IPMN, associated with invasive ca
- IPMN, invasive

Reportable	ICD-O-3	Description
Yes	8150/3	Cystic Pancreatic En
Yes	8163/2	Papillary neoplasm, neoplasia
Yes	8163/3	Pancreatobiliary-type
Yes	8240/3	Neuroendocrine Tun
Yes	8246/3	Neuroendocrine Car
Yes	8249/3	Neuroendocrine Tun
Yes	8440/3	Cystadenocarcinoma
Yes	8452/3	Solid Pseudo-Papilla
Yes	8453/2	Intraductal Papillary high grade dysplasia
Yes	8453/2	Intraductal Papillary invasive
Yes	8453/3	Intraductal Papillary invasive carcinoma
Yes	8453/3	Intraductal Papillary
Yes	8470/2	Mucinous Cystic Ne dysplasia
Yes	8470/2	Non-invasive Mucin high-grade dysplasia
Yes	8470/2	Mucinous Cystadeno
Yes	8470/3	Mucinous Cystadeno
Yes	8470/3	Mucinous Cystic Ne carcinoma
Yes	8471/3	Papillary Mucinous
Yes	8500/3	Infiltrating Duct Car
Yes	8503/2	Intraductal Oncocyti

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i) **Benign and Borderline Cancers** - **Benign** and **borderline** primary **intracranial** and **central nervous system (CNS) tumors** with a **behavior code of /0 or /1 in ICD-O-3** are report

Benign/Borderline Cancers diagnosed and/or treated before 1/1/2004 are r

FCDS requires reporting of all benign, borderline, and malignant tumors of the System, Cranial Nerves, Intracranial Glands, Meninges and Peripheral Nerve T

CDC published a reference manual in 2004 entitled, "Data Collection of Prima Tumors." The manual is available free of charge in PDF format on the CDC N http://www.cdc.gov/ncpr/pdf/btr/brainTumorguide.pdf. This document and ICD references when determining case reportability for primary brain and CNS tum

SEER has also published new 2021 requirements for abstracting benign/border Please be sure to reference the current Solid Tumor Rules chapter for Non-M a complete listing of new required brain and central nervous system neoplasms

- **Sphenoid Wing Meningioma is a Reportable Neoplasm beginning with**
- **Glomus Jugulare Tumors, Paraganglioma and Carotid Body Tumors with 1/1/2019 diagnoses for primary sites C75.4 and C75.5. Malignant Sites (C47.9) are reportable for pre-2019 diagnoses – see Solid Tumor**
- **Pilocytic Astrocytoma/Juvenile Pilocytic Astrocytoma – CHANGES T**

  From 1976 to 2000, WHO assigned code 9421/3 to pilocytic astrocytom with the release of ICD-O-3 in 2001, WHO changed the behavior for t making it non-reportable. 9421/3 was removed from ICD-O-3, howeve organizations in North America opted to continue collecting these tum The practice did not change once benign/borderline CNS tumors becam The exception being pilocytic astrocytoma/optic glioma of the optic ner 9421/1 effective 2018 and forward.

  The 5th Ed Central Nervous System Tumors reinstated code 9421/3 fo neoplasm: High-grade astrocytoma with piloid features (HGAP).

- **IMPORTANT FOR CASES Diagnosed 2023 FORWARD: Beginning 1 diagnosed with pilocytic astrocytoma/juvenile pilocytic astrocytoma a to be reported with behavior /1. They will no longer be collected with ICD-O code 9421/3 will be valid for the diagnosis of high-grade astroc or HGAP only. Coding instructions are included in the remarks section the 2023 ICD-O Update Tables 1 and 2.**

4. Not Reportable Neoplasms

a) **Primary skin tumors (C44. _) with histology codes 8000-8110**

Skin Cancers - Basal cell carcinoma and squamous cell carcinoma of non-genital skin sites are common malignancies. These tumors are not to be reported to FCDS, regardless of stage. All other malignant tumors of the skin must be reported including but not limited to malignant melanoma, Merkel cell carcinoma, lymphoma of skin, and other non-squamous and non-basal cell skin cancers. Only the following malignant neoplasms of the skin (C44.0-C44.9) are not reportable:

M 8000 – M 8005	Neoplasm, malignant, NOS of the skin
M 8010 – M 8046	Epithelial carcinoma, NOS of the skin
M 8050 – M 8084	Papillary and squamous cell neoplasm of the skin
M 8090 – M 8110	Basal cell carcinoma of the skin

b) **AIN III (8077/2) of the Perianal Skin (C44.5) is not reportable.**

c) **AIN III of anus or anal canal (C21.0- C21.1) is reportable to FCDS.**

d) **BIRADS Category 4 and BIRADS Category 5 Diagnosis without biopsy is not reportable.**

e) **Using the Date of Mammography as Date of Initial Cancer Diagnosis for Imaging BIRADS Category 4 or 5 with positive biopsy:**

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)

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Reportable Patients/Reportable Cancers

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The term "pre-invasive cervical neoplasia" refers to carcinoma *in situ* of the cervix and conditions viewed as equivalent to it or on a continuum with it. Diagnostic terminology for pre-invasive cervical neoplasia has changed significantly over time, from the four-tiered system of dysplasia and carcinoma *in situ*, to the three-tiered system of CIN, to the two-tiered Bethesda System, with high- and low-grade squamous intraepithelial lesions (SIL). In the past, cancer registries generally considered carcinoma *in situ* of the cervix reportable, but they differed in which of these other terms they considered synonymous with carcinoma *in situ* and hence reportable. Consequently, data were not comparable over time or across registries.

NAACCR convened a multidisciplinary working group in April 1993 to review the problem and make recommendations for its membership. The recommendation was that "population-based registries discontinue routine collection of data on pre-invasive cervical neoplasia unless there is strong local need and interest, and sufficient resources are available to collect all [high-grade squamous intraepithelial lesions] and its equivalent terms."[30] NAACCR and NPCR adopted this recommendation at that time. SEER and CoC adopted it effective for cases diagnosed January 1, 1996, forward. CCCR adopted it effective for cases diagnosed June 1, 2007.

Ambiguous Terminology

In most circumstances, the diagnosis of cancer, as recorded in the patient's medical record, is clearly synonymous with reportable cancer. However, in those situations where the physician is not certain of the diagnosis, the associated terminology in the medical record reflects that uncertainty and is ambiguous. CoC, NPCR, SEER and CCCR are in agreement in regard to the list of terms that are diagnostic of cancer and the list of terms not diagnostic of cancer. These terms are shown in Table 2.

Table 2. NAACCR Version 22: Comparison of Reportable Cancers: CoC, SEER, NPCR and CCCR.

	CoC	SEER	NPCR	CCCR
Reportable Diagnoses	1. Behavior code of 2 or 3 in ICD-O-3; or, for 2010 and later diagnoses, behavior code 3 according to the *WHO Classification of Tumours of Haematopoietic and Lymphoid*	1. Behavior code of 2 or 3 in ICD-O-3.2 plus the ICD-O-3.2 updates posted on the NAACCR website or, for 2010 and later diagnoses, behavior code 3 according to the WHO Classification of Tumours of Haematopoietic and	1. Behavior code 2 or 3 in ICD-O-3.2; behavior code 3 in WHO Classification of Tumours of Haematopoietic and Lymphoid Tissues (2008)[30] (2010+); behavior code 2 or 3 in WHO Classification of	1. Behavior code of 2 or 3 in ICD-O-3; or, for 2010 and later diagnoses, behavior code 3 according to the *WHO Classification of Tumours of Haematopoietic and*

	CoC	SEER	NPCR	CCCR
	Tissues (2008)[30]. 2. Non-malignant (behavior codes 0 and 1) primary intracranial and central nervous system tumors, including juvenile astrocytoma (M9421/3)* for primary sites as defined in Table 3. 3. Carcinoid, NOS of the appendix C181 (as of 1/1/2015).	Lymphoid Tissues (2008)[30]. 2. Non-malignant (behavior codes 0 and 1) primary intracranial and central nervous system tumors, including juvenile astrocytoma (M9421/3)* for primary sites as defined in Table 3. 3. As of 01/01/2021, early or evolving melanoma in situ, or any other early or evolving melanoma, is reportable. 4. Carcinoid, NOS of the appendix C181 (as of 1/1/2015). 5. All GIST are reportable as of 01/01/2021 except for those specifically stated to be benign. The behavior code for GIST is /3 in ICD-O-3.2. 6. Nearly all thymomas are reportable as of 01/01/2021. The behavior code is /3 in ICD-O-3.2. The exceptions are microscopic thymoma or thymoma benign (8580/0), micronodular thymoma with lymphoid stroma (8580/1), and ectopic hamartomatous thymoma (8587/0). 7. Lobular neoplasia grade III (LN III)/lobular intraepithelial neoplasia	Tumours 5th Ed. (2022+) (Refer to instructions provided by NPCR for detailed information.) 2. Primary intracranial and central nervous system tumors behavior code 0 or 1, including juvenile astrocytoma (M9421/3)* for primary sites defined in Table 3 (2004+). 3. Early or evolving melanoma in situ, or any other early or evolving melanoma (2021+). 4. Carcinoid, NOS of the appendix C181, behavior changed to 3 effective 2015 (2015+). 5. GIST tumors, all histologies changed to behavior 3 in ICD-O-3.2 (2021+). 6. Thymomas, most behaviors changed to 3 in ICD-O-3.2. (2021+) See exceptions listed below. 7. Lobular neoplasia grade III (LN III)/lobular intraepithelial neoplasia grade III (LIN III) breast C500-C509 (/2016+). 8. Pancreatic intraepithelial neoplasia (PanIN III) (2016+).	*Lymphoid Tissues* (2008)[30]. 2. Non-malignant (behavior codes 0 and 1) primary intracranial and central nervous system tumors (ICD-O-3 topography codes C70-C72) (1/1/1992). 3 Non-malignant (behavior codes 0 and 1) primary endocrine glands and related structures (ICD-O-3 Topography codes C75.1-C75.3) (1/1/2007). 4. Non- malignant Borderline (behavior code 1) (all topographies in ICD-O-3) (1/1/1992 to 12/31/2020). Non- malignant Borderline (behavior code of 1) for these histology/ topography ICD-O-3 codes (9761/3, 9765/1, 9970/1) and (8442/1, 8472/1 with C56.9 only). (01/01/2021- forward) 5. Carcinoid, NOS of the appendix C181 (as of 1/1/2012). 6. Non-invasive follicular thyroid neoplasm with papillary-like nuclear

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REMINDER: Check the Sex – No Sex Changes in FL

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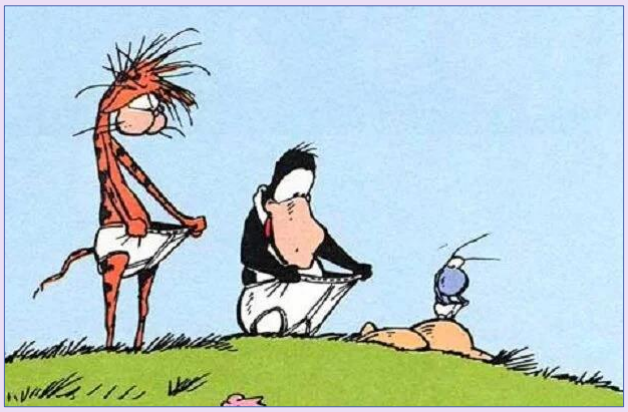

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Assigning Class of Case

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- Also one of most asked questions – what is the Class of Case?
- Started Out as 1-digit Field – it was easy to understand
- 2010 Class of Case was Expanded and Redefined in a 2-digit Field
- It was supposed to make things more clear – it created a nightmare
- Class of Case is going back to a 1-digit code in 2024.

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Assigning Class of Case

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- 0 – Diagnosed Only
- 1 – Diagnosed and Treated
- 2 – Treated Only
- 3 – Not Analytic (may be required by your state registry)
  - See instructions in state manual for legislative reporting requirements in your state
- 4 – (Maybe) a Subset of Not Analytic
- FCDS Requirements for Reporting Will NOT Change – only Class of Case
- FCDS collects Type of Reporting Source that describes source of reports

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Assigning Class of Case

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- Question.. common scenario in FL. The snowbirds DX in FL, then go up north for treatment, we transfer records to Hospital XXX Up North… No further info available. Does Class of Case still have to be a 10, even though we referred to a specific hospital and we know they are coming back? Doesn't it make more sense to code 00 – dx only?
- Answer.. I tell them to make Class of Case = 00 DX Only…even if the FL hospital sets up a treatment plan and knows where pt got TX – all the FL hospital did was a DX.
- CoC created a bunch of coding instructions about whether or not you know a patient went elsewhere for treatment after your facility made a DX making this so confusing.
- And then Registrars were afraid that only 1 facility could be the DX hospital when multiple facilities can be involved in the DX and Workup and each could take credit for diagnosis – and even for treatment.
- FCDS stayed with the original definitions for Class of Case for simplicity & consistency
- Hopefully, when/if the CoC actually does revert back to 1-digit codes – it will be straightforward again – DX Only (0), DX/TX (1), TX Only (2), or Non-Analytic (3)

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Diagnostic Confirmation

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- Never Use a '9' – not even for historical cancers – YOU can figure out if they had a biopsy or a resection or a CT Scan for DX – that makes it a '1' or '7' not '9'
- Most will be a '1' histology – biopsy, bone marrow, blood, lymph, tumor resection, biopsy or resection of metastasis, etc.
- **Use a '5' Code Only for a urine electrophoresis** for Bence Jones Protein for Plasma Cell Myeloma – **'5' is INVALID** for every other case you abstract
- Only use a '3' for lymphoid or myeloid neoplasms that have documented immunophenotype test, flow cytometry, PCR testing, FISH, gene panel or other genetic testing.
  - These tests are used to 'confirm the diagnosis, clarify the type of neoplasm (histologic type or subtype), or identify a target drug or specific biological, molecular or immunotherapy (BRM)'
- Use '7' when only IMAGING is done to diagnose cancer – CT, MRI, PET, etc.
- FNA is not a '2' – FNA is a '1' and is just like a bone marrow biopsy

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Identifying Cases (Casefinding & Re-Casefinding)

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ICD-10-CM Casefinding List, 2023
Based on the International Classification of Diseases, ICD-10-CM Tabular List of Diseases and Injuries, FY 2023

COMPREHENSIVE ICD-10-CM Casefinding Code List for Reportable Tumors (EFFECTIVE DATES: 10/1/2022-9/30/2023) Please refer to your standard setter(s) for specific reporting requirements before using the Casefinding List	
ICD-10-CM Code	**Explanation of Code**
C00.-- C43.-, C4A.-, C45.-- C48.-, C49.-- C96.-	Malignant neoplasms (excluding category C44 and C49.A), stated or presumed to be primary (of specified site) and certain specified histologies
C44.00, C44.09	Unspecified/other malignant neoplasm of skin of lip
C44.10-, C44.19-	Unspecified/other malignant neoplasm of skin of eyelid
C44.13-	Sebaceous cell carcinoma of skin of eyelid, including canthus
C44.20-, C44.29-	Unspecified/other malignant neoplasm skin of ear and external auricular canal
C44.30-, C44.39-	Unspecified/other malignant neoplasm of skin of other/unspecified parts of face
C44.40, C44.49	Unspecified/other malignant neoplasm of skin of scalp & neck
C44.50-, C44.59-	Unspecified/other malignant neoplasm of skin of trunk
C44.60-, C44.69-	Unspecified/other malignant neoplasm of skin of upper limb, incl. shoulder
C44.70-, C44.79-	Unspecified/other malignant neoplasm of skin of lower limb, including hip
C44.80, C44.89	Unspecified/other malignant neoplasm of skin of overlapping sites of skin
C44.90, C44.99	Unspecified/other malignant neoplasm of skin of unspecified sites of skin
C49.A-	Gastrointestinal Stromal Tumors
D00.-- D05.-, D07.-- D09	In-situ neoplasms *Note 1: Excludes carcinoma in situ tumors of the cervix (D06._)* *Note 2: Excludes prostatic intraepithelial neoplasia (PIN III) (8148/2) of the prostate. Other prostate in situ histologies are reportable* *Note 3: For D04 (carcinoma in situ of skin), excludes basal and squamous cell in situ lesions*
D18.02	Hemangioma of intracranial structures and any site
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

ICD-10-CM Casefinding List, 2023
Based on the International Classification of Diseases, ICD-10-CM Tabular List of Diseases and Injuries, FY 2023

NOTE: Cases with the codes in the Supplemental list below should be screened as registry time allows. Experience in the SEER registries has shown that using the supplemental lists increases casefinding for benign brain and CNS, hematopoietic neoplasms, other reportable diseases and treatment related information

- *The codes included in this supplemental have been changed. During a major review, many of the codes previously included were found to not be necessary and were removed*
  - *All codes previously included can be found in the ICD-10-CM Casefinding List, 2022*

SUPPLEMENTAL LIST (PART I) ICD-10-CM (EFFECTIVE DATES: 10/1/2022-9/30/2023) Please refer to your standard setter(s) for specific reporting requirements before using the Casefinding List	
ICD-10-CM Code	**Explanation of Code**
D06.-	Carcinoma in situ of the cervix
D13.7	Benign neoplasm of endocrine pancreas *Note: Effective 1/1/2021: Review this code to look for the following which were previously a benign tumor of the pancreas, but is now malignant per ICD-O-3.2* • Islet cell adenoma • Nesidioblastoma • Islet cell adenomatosis • Insulinoma • Beta cell adenoma
D21.4	Benign neoplasm of connective and other soft tissue of abdomen *Note: Effective 1/1/2021: Review this code to look for the following which were previously a benign tumor of the pancreas, but is now malignant per ICD-O-3.2* Gastrointestinal stromal tumor, NOS/GIST, NOS/Gastrointestinal autonomic nerve tumor/GANT/Gastrointestinal pacemaker cell tumor (8936/1, now 8936/3)
D23.9	Other benign neoplasm of skin Benign carcinoid tumors of other sites

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Identifying Cases (Casefinding & Re-Casefinding)

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SECTION I: GUIDELINES FOR CANCER DATA REPORTING

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ICD-10-CM CASEFINDING LIST FOR REPORTABLE TUMORS – *Oct 1, 2022 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, 2022 for all hospitals. A complete listing of ALL Required ICD-10-CM Code is in Appendix O of this manual.

ICD-10-CM Code	Description
C00.0 – C43.9	Malignant neoplasms
C44.13.1 – C44.13.92	Sebaceous Cell Carcinoma of Skin of Eyelid, Including Canthus
C45.0 – C96.9	Malignant neoplasms
C4A.0 – C4A.9	Merkel cell carcinoma
C49.A0 – C49.A9	GI stromal tumor
C7A.0 – C7A.8	Malignant carcinoid tumors
C84.A0 – C84.A9	Cutaneous T-cell lymphoma
C84.Z0 – C84.Z9	Other Mature T/NK-cell lymphoma
C91.A0 – C91.A2	Mature B-cell leukemia Burkitt-type
C91.Z0 – C91.Z2	Other lymphoid leukemia
C92.A0 – C92.A2	Acute myeloid leukemia with multi-lineage dysplasia
C92.Z0 – C92.Z2	Other myeloid leukemia
C93.Z0 – C93.Z2	Other monocytic leukemia
C96.A	Histiocytic sarcoma
C96.Z	Other specified malignant neoplasm of lymphoid, hematopoietic and related tissue
D00.0 – D09.9	Carcinoma in situ (exclude: skin, cervix, prostate– D04._, D06._ and D07.5)
D18.2	Hemangioma of intracranial structures
D32.0 – D32.9	Benign neoplasm of meninges (cerebral, spinal and unspecified)
D33.0 – D33.9	Benign neoplasm of brain and other parts of central nervous system
D35.00-D35.02	Benign neoplasm of adrenal gland - pheochromocytoma, medullary paraganglioma, chromaffin paraganglioma, chromaffin tumor, chromaffinoma
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	Myelodysplastic syndromes (9980, 9982, 9983, 9985, 9986, 9989, 9991, 9992)
D46.A – D46.Z	Other myelodysplastic syndromes
D47.02, D47.1-D47.9	Myeloproliferative diseases (9931, 9740, 9741, 9742, 9960, 9961, 9962, 9963, 9965, 9966, 9967, 9970, 9971, 9975, 9987)
D47.Z – D47.Z9	Post-transplant lymphoproliferative disorder (PTLD)
D49.6, D49.7	Neoplasm of unspecified behavior of brain, endocrine glands and other CNS
D72.110 – D72.1119	Hypereosinophilic Syndrome
R90.0	Intracranial space-occupying lesion found on diagnostic imaging of CNS

Note: Pilocytic astrocytoma are coded 9421/1 when diagnosed 1/1/2023 or later.
Pilocytic astrocytoma are coded 9421/3 when diagnosed prior to 1/1/2023.

- **Pathology – FNA, biopsy, blood, bone marrow, core biopsy, molecular genetic testing, immunophenotype, flow cytometry, DNA microarray, FISH, NGS gene panel, etc.**
- **Medical Record/Billing - Disease Index**
- **In-Patient Services**
- **Ambulatory Care Services**
- **Autopsy**
- **Cancer Clinics**
- **Cancer Treatment Centers**
- **Diagnostic Imaging – Imaging-Only Cases**

If you find a case that is not your responsibility to report, Ask yourself if these cases are being reported by somebody else or do you just ignore it and let it pass or contact FCDS?

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Identifying Cases (Casefinding & Re-Casefinding)

Appendix O – Detailed ICD-10-CM CaseFinding List – 10/1/2021 forward
See Section I for Details on Required Reportable Neoplasms

CODE	NAME
C84.15	Sezary disease, lymph nodes of inguinal region and lower limb
C84.16	Sezary disease, intrapelvic lymph nodes
C84.17	Sezary disease, spleen
C84.18	Sezary disease, lymph nodes of multiple sites
C84.19	Sezary disease, extranodal and solid organ sites
C84.4	Peripheral T-cell lymphoma, not classified
C84.40	Peripheral T-cell lymphoma, not classified, unspecified site
C84.41	Peripheral T-cell lymphoma, not classified, lymph nodes of head, face, and neck
C84.42	Peripheral T-cell lymphoma, not classified, intrathoracic lymph nodes
C84.43	Peripheral T-cell lymphoma, not classified, intra-abdominal lymph nodes
C84.44	Peripheral T-cell lymphoma, not classified, lymph nodes of axilla and upper limb
C84.45	Peripheral T-cell lymphoma, not classified, lymph nodes of inguinal region and lower limb
C84.46	Peripheral T-cell lymphoma, not classified, intrapelvic lymph nodes
C84.47	Peripheral T-cell lymphoma, not classified, spleen
C84.48	Peripheral T-cell lymphoma, not classified, lymph nodes of multiple sites
C84.49	Peripheral T-cell lymphoma, not classified, extranodal and solid organ sites
C84.6	Anaplastic large cell lymphoma, ALK-positive
C84.60	Anaplastic large cell lymphoma, ALK-positive, unspecified site
C84.61	Anaplastic large cell lymphoma, ALK-positive, lymph nodes of head, face, and neck
C84.62	Anaplastic large cell lymphoma, ALK-positive, intrathoracic lymph nodes
C84.63	Anaplastic large cell lymphoma, ALK-positive, intra-abdominal lymph nodes
C84.64	Anaplastic large cell lymphoma, ALK-positive, lymph nodes of axilla and upper limb
C84.65	Anaplastic large cell lymphoma, ALK-positive, lymph nodes of inguinal region and lower limb
C84.66	Anaplastic large cell lymphoma, ALK-positive, intrapelvic lymph nodes
C84.67	Anaplastic large cell lymphoma, ALK-positive, spleen
C84.68	Anaplastic large cell lymphoma, ALK-positive, lymph nodes of multiple sites
C84.69	Anaplastic large cell lymphoma, ALK-positive, extranodal and solid organ sites
C84.7	Anaplastic large cell lymphoma, ALK-negative
C84.70	Anaplastic large cell lymphoma, ALK-negative, unspecified site
C84.71	Anaplastic large cell lymphoma, ALK-negative, lymph nodes of head, face, and neck
C84.72	Anaplastic large cell lymphoma, ALK-negative, intrathoracic lymph nodes
C84.73	Anaplastic large cell lymphoma, ALK-negative, intra-abdominal lymph nodes
C84.74	Anaplastic large cell lymphoma, ALK-negative, lymph nodes of axilla and upper limb
C84.75	Anaplastic large cell lymphoma, ALK-negative, lymph nodes of inguinal region and lower limb
C84.76	Anaplastic large cell lymphoma, ALK-negative, intrapelvic lymph nodes
C84.77	Anaplastic large cell lymphoma, ALK-negative, spleen
C84.78	Anaplastic large cell lymphoma, ALK-negative, lymph nodes of multiple sites
C84.79	Anaplastic large cell lymphoma, ALK-negative, extranodal and solid organ sites
C84.9	Mature T/NK-cell lymphomas, unspecified
C84.90	Mature T/NK-cell lymphomas, unspecified, unspecified site
C84.91	Mature T/NK-cell lymphomas, unspecified, lymph nodes of head, face, and neck
C84.92	Mature T/NK-cell lymphomas, unspecified, intrathoracic lymph nodes
C84.93	Mature T/NK-cell lymphomas, unspecified, intra-abdominal lymph nodes
C84.94	Mature T/NK-cell lymphomas, unspecified, lymph nodes of axilla and upper limb

Appendix O – Detailed ICD-10-CM CaseFinding List – 10/1/2021 forward
See Section I for Details on Required Reportable Neoplasms

CODE	NAME
C84.95	Mature T/NK-cell lymphomas, unspecified, lymph nodes of inguinal region and lower limb
C84.96	Mature T/NK-cell lymphomas, unspecified, intrapelvic lymph nodes
C84.97	Mature T/NK-cell lymphomas, unspecified, spleen
C84.98	Mature T/NK-cell lymphomas, unspecified, lymph nodes of multiple sites
C84.99	Mature T/NK-cell lymphomas, unspecified, extranodal and solid organ sites
C84.A	Cutaneous T-cell lymphoma, unspecified
C84.A0	Cutaneous T-cell lymphoma, unspecified, unspecified site
C84.A1	Cutaneous T-cell lymphoma, unspecified lymph nodes of head, face, and neck
C84.A2	Cutaneous T-cell lymphoma, unspecified, intrathoracic lymph nodes
C84.A3	Cutaneous T-cell lymphoma, unspecified, intra-abdominal lymph nodes
C84.A4	Cutaneous T-cell lymphoma, unspecified, lymph nodes of axilla and upper limb
C84.A5	Cutaneous T-cell lymphoma, unspecified, lymph nodes of inguinal region and lower limb
C84.A6	Cutaneous T-cell lymphoma, unspecified, intrapelvic lymph nodes
C84.A7	Cutaneous T-cell lymphoma, unspecified, spleen
C84.A8	Cutaneous T-cell lymphoma, unspecified, lymph nodes of multiple sites
C84.A9	Cutaneous T-cell lymphoma, unspecified, extranodal and solid organ sites
C84.Z	Other mature T/NK-cell lymphomas
C84.Z0	Other mature T/NK-cell lymphomas, unspecified site
C84.Z1	Other mature T/NK-cell lymphomas, lymph nodes of head, face, and neck
C84.Z2	Other mature T/NK-cell lymphomas, intrathoracic lymph nodes
C84.Z3	Other mature T/NK-cell lymphomas, intra-abdominal lymph nodes
C84.Z4	Other mature T/NK-cell lymphomas, lymph nodes of axilla and upper limb
C84.Z5	Other mature T/NK-cell lymphomas, lymph nodes of inguinal region and lower limb
C84.Z6	Other mature T/NK-cell lymphomas, intrapelvic lymph nodes
C84.Z7	Other mature T/NK-cell lymphomas, spleen
C84.Z8	Other mature T/NK-cell lymphomas, lymph nodes of multiple sites
C84.Z9	Other mature T/NK-cell lymphomas, extranodal and solid organ sites
C85	OTHER SPECIFIED AND UNSPECIFIED TYPES OF NON- HODGKIN LYMPHOMA
C85.1	B-cell lymphoma, unspecified
C85.10	Unspecified B-cell lymphoma, unspecified site
C85.11	Unspecified B-cell lymphoma, lymph nodes of head, face, and neck
C85.12	Unspecified B-cell lymphoma, intrathoracic lymph nodes
C85.13	Unspecified B-cell lymphoma, intra-abdominal lymph nodes
C85.14	Unspecified B-cell lymphoma, lymph nodes of axilla and upper limb
C85.15	Unspecified B-cell lymphoma, lymph nodes of inguinal region and lower limb
C85.16	Unspecified B-cell lymphoma, intrapelvic lymph nodes
C85.17	Unspecified B-cell lymphoma, spleen
C85.18	Unspecified B-cell lymphoma, lymph nodes of multiple sites
C85.19	Unspecified B-cell lymphoma, extranodal and solid organ sites
C85.2	Mediastinal (thymic) large B-cell lymphoma
C85.20	Mediastinal (thymic) large B-cell lymphoma, unspecified site
C85.21	Mediastinal (thymic) large B-cell lymphoma, lymph nodes of head, face, and neck
C85.22	Mediastinal (thymic) large B-cell lymphoma, intrathoracic lymph nodes
C85.23	Mediastinal (thymic) large B-cell lymphoma, intra-abdominal lymph nodes

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Audit Re-Casefinding

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- ✓ Requirements Focus is on 'who diagnoses cancers' and 'who treats cancers'
- ✓ AHCA – 100% Audit Every Year of ALL Hospitals and ALL Surgery Centers
  - ✓ AHCA In-Patient – All Cancer Codes from FCDS Casefinding List
  - ✓ AHCA Ambulatory – All Cancer Codes from FCDS Casefinding List
- ✓ Radiation Centers – 1995 Florida passed a law that allows the radiation centers to get away with a lot of 'not reporting' rather than 'active reporting'
  - ✓ XRT Centers must report all 'never reported to FCDS cases' and use a reverse casefinding system that FCDS creates – unless affiliated with a CoC Accredited Cancer Program where the program picks up full abstracts
- ✓ Physician Office Claims – hematology, hematology/oncology, oncology, urology
- ✓ Physician Office Abstract – dermatology (mostly melanoma) mini-abstracts
- ✓ Other Outside Sources – have different reporting calendars

NOTE: FCDS does not have the means to conduct 100% e-path re-casefinding – that does not mean that you get a pass and do not need to conduct path casefinding

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Staging Systems

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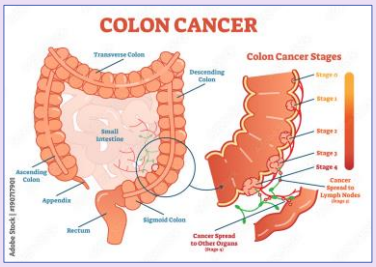
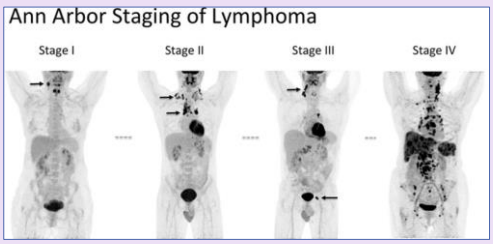


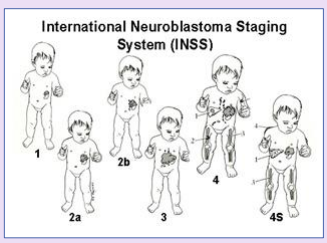
Rai stage		
Rai 0	Lymphocytosis	Low risk
Rai I	Lymphocytosis + lymphadenopathy	
Rai II	Lymphocytosis + splenomegaly and/or liver enlargement	
Rai III	Lymphocytosis + Hb < 11.0g/dL	
Rai IV	Lymphocytosis + platelets < 100 x10⁹/L	High risk
Binet stage		
Binet A	Hb > 10g/dL, platelets > 100 x10⁹/L and < 2 lymph node areas involved (*)	Low risk
Binet B	Hb > 10g/dL, platelets > 100 x10⁹/L and ≥ 3 lymph node areas involved (*)	
Binet C	Hb < 10g/dL or platelets < 100 x10⁹/L	High risk

(*)**Lymph node areas:** 1. Head and neck (uni- or bilateral), 2. Axillar (uni- or bilateral), 3. Inguinal (uni- or bilateral), 4. Splenomegaly, 5. Hepatomegaly

FIGO Uterus

Stage	Description
I	Tumor confined to the uterus
IA	<50% invasion of the myometrium
IB	≥50% invasion of the myometrium
II	Tumor invades the cervical stroma but does not extend beyond the uterus
III	Local or regional spread of tumor
IIIA	Serosal or adnexal invasion
IIIB	Vaginal or parametrial involvement
IIIC	Metastasis to pelvic or paraaortic lymph nodes
IIIC1	Pelvic lymph node involvement
IIIC2	Paraaortic lymph node involvement (with or without pelvic nodes)
IV	Extension to the pelvic wall, lower one-third of the vagina, or hydronephrosis or nonfunctioning kidney
IVA	Invasion of bladder or bowel mucosa
IVB	Distant metastases, including abdominal, or involvement of inguinal lymph nodes





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Rationale and Differences in Cancer Staging Systems

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.The most current version of Summary Stage 2018 is version 3 – found on SEER website.

2018 Site-Specific Data Items (SSDI): An "SSDI'" is a site-specific data item. "Site" in this instance is based on the primary site, the histologic type or histology of the tumor, the AJCC Chapter, Summary Stage Chapter and the EOD Schema. SSDIs were preceded by Collaborative Stage Data Collection System Site-Specific Factors or SSFs, which were first introduced in 2004 with CSv1, and went through major revisions in 2010 with Collaborative Stage v2 (CSv2). The CS SSFs were discontinued as of 12/31/2017. FCDS only requires a limited number of SSDI's be reported. See the table further in this section for details. The Site-Specific Data Items is currently in version 3 – found on the NAACCR Website.

SEER*RSA (Registrar Staging Assistant) Website is a Tremendous Resource to assist Registrars in understanding, coding, testing and learning about Cancer Staging, Staging Schema Criteria, Site Specific Data Items, SEER Extent of Disease Coding (EOD), Collaborative Stage Data Collection System and the Collaborative Stage Site Specific Factors. This is a wonderful resource highly recommended by FCDS to assist registrars in understanding how to associate staging criteria and codes to specific cancer types, histologic types, staging and grading schema, and site-specific requirements.

SEER*RSA - GO TO: https://seer.cancer.gov/tools/staging/rsa.html

HISTORICAL STAGING SYSTEMS REFERENCE BY DIAGNOSIS YEAR

SEER SUMMARY STAGE 1977: Direct-Assignment of SEER Summary Stage using the SEER Summary Stage 1977 Manual was required for all cases abstracted and reported to FCDS before 1/1/2000.

SEER SUMMARY STAGE 2000: Direct-Assignment of SEER Summary Stage using the SEER Summary Stage 2000 Manual is required for all cases abstracted and reported to FCDS before 1/1/2018

SEER SUMMARY STAGE 2018: Direct Assignment of SEER Summary Stage using the SEER Summary Stage 2018 Manual (most current version September 2020) is required for all cases abstracted and reported to FCDS on or after 1/1/2018. There have been multiple versions of SS2018 published.

AJCC TNM CANCER STAGING - FCDS does not require AJCC TNM for any cases. Registrars may decide to include AJCC TNM staging in their section of the abstract used to document Staging Information to help support the Summary Stage assignment. However, text documentation for Summary Staging is also required.

COLLABORATIVE STAGE DATA COLLECTION SYSTEM (CSv2): Direct-Assignment of Core CS Data Items was required for all cases diagnosed 1/1/2004 and 12/31/2015 and seen at the facility for continuation of initial course of treatment or with evidence of recurrence or progression of cancer not previously reported to FCDS. This includes "non-analytic" cases with evidence of cancer. Some cases may still require the abstractor to use Collaborative Stage – please use the on-screen help to assign.

NOTE: Minimal Historical Cases (historical cancers with no evidence of the historical cancer – but having a new primary cancer diagnosis or undergiong treatment for a different primary cancer) are not required to have the Core CS Data Items coded. However, the minimal historical case will be required to have a SEER Summary Stage 2000 assigned and entered in the "historical grid" that is sent to FCDS.

Required Core CS Data Items (Cancers diagnosed 1/1/20014 thru 12/31/2015)

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

CS SITE-SPECIFIC FACTORS: CS Site-Specific Factors 1-25 were required for all cancers with an exception made for Minimal Historical Cases.

2018 Site-Specific Data Items (SSDI): An "SSDI'" is a site-specific data item. "Site" in this instance is based on the primary site, the histologic type or histology of the tumor, the AJCC Chapter, Summary Stage Chapter and the EOD Schema. SSDIs were preceded by Collaborative Stage Data Collection System Site-Specific Factors or SSFs, which were first introduced in 2004 with CSv1, and went through major revisions in 2010 with Collaborative Stage v2 (CSv2). The CS SSFs were discontinued as of 12/31/2017.

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Rationale and Differences in Cancer Staging Systems

Item #	Item Name	NPCR Collect	CoC Collect	SEER Collect	CCCR Collect	Source of Standard	Note
720	RX Hosp--BRM	.	R	R	.	CoC	
730	RX Hosp--Other	.	R	R	.	CoC	
740	RX Hosp--DX/Stg Proc	.	R	.	.	CoC	
746	RX Hosp--Surg Site 98-02	.	RH	RH	.	CoC	
747	RX Hosp--Scope Reg 98-02	.	RH	RH	.	CoC	
748	RX Hosp--Surg Oth 98-02	.	RH	RH	.	CoC	
752	Tumor Size Clinical	.	.	R	R*	SEER	
754	Tumor Size Pathologic	.	.	R	R*	SEER	
756	Tumor Size Summary	R	R	S	.	NPCR/CoC	
758	SEER Summary Stage 2000	RH	RH	RH	.	SEER	
760	SEER Summary Stage 1977	RH	RH	.	.	SEER	
762	Derived Summary Stage 2018	.	.	D	.	SEER	
764	Summary Stage 2018	R	.	R*	.	SEER	
772	EOD Primary Tumor	.	.	R	.	SEER	
774	EOD Regional Nodes	.	.	R	.	SEER	
776	EOD Mets	.	.	R	.	SEER	
780	EOD--Tumor Size	.	RH	RH	.	SEER/CoC	
785	Derived EOD 2018 T	.	.	D	.	SEER	
790	EOD--Extension	.	.	RH	.	SEER	
795	Derived EOD 2018 M	.	.	D	.	SEER	
800	EOD--Extension Prost Path	.	.	RH	.	SEER	
810	EOD--Lymph Node Involv.	.	.	RH	.	SEER	
815	Derived EOD 2018 N	.	.	D	.	SEER	
816	Derived EOD 2018 Stage Group	.	.	D	.	SEER	
820	Regional Nodes Positive	R	R	R	R*	SEER/CoC	

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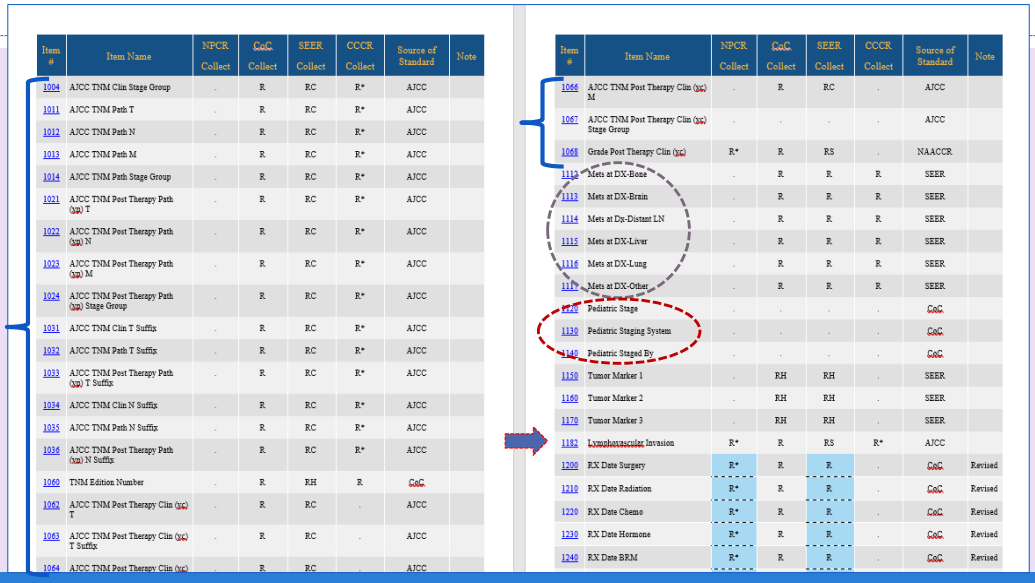
Item #	Item Name	NPCR Collect	CoC Collect	SEER Collect	CCCR Collect	Source of Standard	Note
830	Regional Nodes Examined	R	R	R	R*	SEER/CoC	
831	Date of Sentinel Lymph Node Biopsy	.	RS	R*	.	CoC	
834	Sentinel Lymph Nodes Examined	.	RS	RS	.	CoC	Revised
835	Sentinel Lymph Nodes Positive	.	RS	RS	.	CoC	
840	EOD--Old 13 Digit	.	.	RH	.	SEER	
850	EOD--Old 2 Digit	.	.	RH	.	SEER	
860	EOD--Old 4 Digit	.	.	RH	.	SEER	
870	Coding System for EOD	.	.	RH	.	SEER	
880	TNM Path T	.	RH	RH	.	AJCC	
890	TNM Path N	.	RH	RH	.	AJCC	
900	TNM Path M	.	RH	RH	.	AJCC	
910	TNM Path Stage Group	.	RH	RH*	.	AJCC	
920	TNM Path Descriptor	.	RH	RH	.	CoC	
930	TNM Path Staged By	.	RH	RH	.	CoC	
940	TNM Clin T	.	RH	RH	.	AJCC	
950	TNM Clin N	.	RH	RH	.	AJCC	
960	TNM Clin M	.	RH	RH	.	AJCC	
970	TNM Clin Stage Group	.	RH	RH*	.	AJCC	
980	TNM Clin Descriptor	.	RH	RH	.	CoC	
990	TNM Clin Staged By	.	RH	RH	.	CoC	
995	AJCC ID	D	D	D	R*	NAACCR	Revised
1001	AJCC TNM Clin T	.	R	RC	R*	AJCC	
1002	AJCC TNM Clin N	.	R	RC	R*	AJCC	
1003	AJCC TNM Clin M	.	R	RC	R*	AJCC	

42

Rationale and Differences in Cancer Staging Systems



Item #	Item Name	NPCR Collect	CoC Collect	SEER Collect	CCCR Collect	Source of Standard	Note
1004	AJCC TNM Clin Stage Group	.	R	RC	R*	AJCC	
1011	AJCC TNM Path T	.	R	RC	R*	AJCC	
1012	AJCC TNM Path N	.	R	RC	R*	AJCC	
1013	AJCC TNM Path M	.	R	RC	R*	AJCC	
1014	AJCC TNM Path Stage Group	.	R	RC	R*	AJCC	
1021	AJCC TNM Post Therapy Path (yp) T	.	R	RC	R*	AJCC	
1022	AJCC TNM Post Therapy Path (yp) N	.	R	RC	R*	AJCC	
1023	AJCC TNM Post Therapy Path (yp) M	.	R	RC	R*	AJCC	
1024	AJCC TNM Post Therapy Path (yp) Stage Group	.	R	RC	R*	AJCC	
1031	AJCC TNM Clin T Suffix	.	R	RC	R*	AJCC	
1032	AJCC TNM Path T Suffix	.	R	RC	R*	AJCC	
1033	AJCC TNM Post Therapy Path (yp) T Suffix	.	R	RC	R*	AJCC	
1034	AJCC TNM Clin N Suffix	.	R	RC	R*	AJCC	
1035	AJCC TNM Path N Suffix	.	R	RC	R*	AJCC	
1036	AJCC TNM Post Therapy Path (yn) N Suffix	.	R	RC	R*	AJCC	
1060	TNM Edition Number	.	R	RH	R	CoC	
1062	AJCC TNM Post Therapy Clin (yc) T	.	R	RC	.	AJCC	
1063	AJCC TNM Post Therapy Clin (yc) T Suffix	.	R	RC	.	AJCC	
1064	AJCC TNM Post Therapy Clin (yc)	.	R	RC	.	AJCC	

Item #	Item Name	NPCR Collect	CoC Collect	SEER Collect	CCCR Collect	Source of Standard	Note
1066	AJCC TNM Post Therapy Clin (yc) M	.	R	RC	.	AJCC	
1067	AJCC TNM Post Therapy Clin (yc) Stage Group	.	.	.	.	AJCC	
1068	Grade Post Therapy Clin (yc)	R*	R	RS	.	NAACCR	
1112	Mets at DX-Bone	.	R	R	R	SEER	
1113	Mets at DX-Brain	.	R	R	R	SEER	
1114	Mets at Dx-Distant LN	.	R	R	R	SEER	
1115	Mets at DX-Liver	.	R	R	R	SEER	
1116	Mets at DX-Lung	.	R	R	R	SEER	
1117	Mets at DX-Other	.	R	R	R	SEER	
1120	Pediatric Stage	.	.	.	.	CoC	
1130	Pediatric Staging System	.	.	.	.	CoC	
1140	Pediatric Staged By	.	.	.	.	CoC	
1150	Tumor Marker 1	.	RH	RH	.	SEER	
1160	Tumor Marker 2	.	RH	RH	.	SEER	
1170	Tumor Marker 3	.	RH	RH	.	SEER	
1182	Lymphovascular Invasion	R*	R	RS	R*	AJCC	
1200	RX Date Surgery	R*	R	R	.	CoC	Revised
1210	RX Date Radiation	R*	R	R	.	CoC	Revised
1220	RX Date Chemo	R*	R	R	.	CoC	Revised
1230	RX Date Hormone	R*	R	R	.	CoC	Revised
1240	RX Date BRM	R*	R	R	.	CoC	Revised

43

Rationale for Multiple Primary/Histology Code Rules

44

- Purpose of Registry is to CONSISTENTLY Count Tumors/Patients
- We began to see more patients with multiple tumors (breast, melanoma)
- Registrars had lots of trouble with combination histology codes
- WHO kept revising classifications and adding histology codes
- WHO began to count all 'urothelial' sites as one single site
- Terminology started changing and was confusing
- Odd histologies started showing up in unusual anatomic locations
- Count of Tumors for Staging was Different than Count of Tumors for Rates
- Old Rules were not logical and could not even be mapped into flowchart
- New Rules were to become easy to use and flow logically for everybody

44

WHO keeps publishing new WHO Classifications

45

Table borrowed from the Texas Cancer Registry 'Texas Cancer Reporting News" - Elizabeth Harvey, BS, CTR

Solid Tumor Rules (2023 Update) Aligns with STR for all sites General Instructions	Solid Tumor Rules 2021 Cutaneous Melanoma Rules Update General Instructions	Solid Tumor Rules 2018 Update General Instructions	Multiple Primary and Histology Rules 2007 General Instructions 2007
dx date 2023	dx date 2021-2022	dx date 2018-2022	
Breast Colon Head & Neck Lung Kidney Malignant CNS Non-Malignant CNS Urinary		Breast Colon Head & Neck Lung Kidney Malignant CNS Non-Malignant CNS Urinary	
Cutaneous Melanoma	Cutaneous Melanoma		Cutaneous Melanoma dx date 2007-2020
Other Sites			Other Sites dx date 2007-2022

45

WHO keeps Publishing new WHO Classifications

46

The WHO Classification of Tumor 4th and 5th editions were released after ICD-O 3 was published

- WHO Classification of Tumors of the Central Nervous System, 4th ed, vol 1 (2007)
- WHO Classification of Tumors of the Hematopoietic and Lymphoid Tissues, 4th ed, vol 2 (2008)
- WHO Classification of Tumors of the Digestive System, 4th ed, vol 3 (2010)
- WHO Classification of Tumors of the Breast, 4th ed, vol 4 (2012)
- WHO Classification of Tumors of Soft Tissue and Bone, 4th ed, vol 5 (2013)
- WHO Classification of Tumors of Female Reproductive Organs, 4th ed, vol 6 (2014)
- WHO Classification of Tumors of the Lung, Pleura, Thymus, and Heart, 4th ed, vol 7 (2015)
- WHO Classification of Tumors of Central Nervous System, Revised 4th ed, vol 1 (2016)
- WHO Classification of Tumors of Urinary System and Male Genital Organs, 4th ed, vol 8 (2016)
- WHO Classification of Hematopoietic and Lymphoid Tissues, Revised 4th ed, vol 2 (2017)
- WHO Classification of Tumors of Endocrine Organs, 4th ed, vol 10 (2017)
- WHO Classification of Head & Neck Tumors, 4th ed, vol 9 (2017)
- WHO Classification of Tumors of the Eye, 4th ed, vol 12 (2018)
- WHO Classification of Skin Tumors, 4th ed, vol 11 (2018)

- WHO Classification of Tumors of Digestive System, 5th ed, vol 1 (2019)
- WHO Classification of Tumors of the Female Genital Tumors, 5th ed, vol 4 (2019)
- WHO Classification of Tumors of Soft Tissue and Bone, 5th ed, vol 3 (2020)
- WHO Classification of Thoracic Tumors, 5th ed, vol 5 (2020)
- WHO Classification of Central Nervous System Tumors, 5th ed, Vol 6 (2021)
- WHO Classification of Urinary and Male Genital Tumors, 5th ed, Vol 8 (2022)

46

When an 'Unknown Primary' is NOT C80.9

47

Use the table below to assign primary site when the only information available is the histologic type of tumor and the patient has metastatic disease without an identifiable primary site. The primary site is presumed to be the NOS or "not otherwise specified" primary site code when the histology is known but for which no primary can be found. Do not code these cases to C80.9.

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

47

IMPOSSIBLE Site/Histology Combinations

48

Some histologic types are more appropriately coded to a site representing the tissue in which such tumors arise rather than the ill-defined region of the body, which contains multiple tissues. The table below shows for some histologic types the specific sites that cannot be used – these truly are C80.9 Unknown Primary as they represent metastatic disease.

SITE	HISTOLOGY
C480-C488 Retroperitoneum and peritoneum	8720-8790 Melanomas
C300 Nasal Cavity C301 Middle ear C310-C319 Accessory sinuses	9250-9342 Osteosarcoma (Giant cell Ewing's odontogenic)
C381-C388 Pleura and mediastinum	8010-8245 8247-8671 8940-8941 8720-8790 Melanomas
C470-C479 Peripheral nerves C490-C499 Connective tissue	8010-8671 Carcinomas 8940-8941 8720-8790 Melanomas
C700-C709 Meninges C710-C719 Brain C720-C729 Other central nervous system	8010-8671 Carcinomas 8940-8941
C400-C419 Bone	8010-8060 Carcinoma (except squamous cell) 8075-8671 8940-8941 8720-8790 Melanomas
C760-C768 Ill-defined Sites	8720-8790 Melanoma 8800-8811 Sarcoma except myeloid sarcoma 8813-8830 Fibromatous neoplasms 8840-8921 Fibrosarcoma 8990-8991 mesenchymoma 8940-8941 Mixed tumor, salivary gland type 9120-9170 Blood vessel tumor lymphatic vessel tumor 9240-9252 Mesenchymal chondrosarcoma, and giant cell tumors 9540-9560 Nerve Sheath tumor 9580-9582 Granular cell tumor and alveolar soft part sarcoma

48

One Primary or Two? Histology Code?

49

49

Difficult or Confusing MP Rules

50

- Each of us has our own STM Chapter that gives us grief…at least one.
  - Urinary System
  - Head and Neck
  - Breast
  - Lung
- But most of the STM Chapters are pretty straightforward
  - Kidney
  - Colon, Rectosigmoid and Rectum
  - Malignant CNS and Peripheral Nerves
  - Non-Malignant CNS and Peripheral Nerves
  - Cutaneous Melanoma
  - Other Sites

50

Difficult or Confusing MP Rules - Urinary

51

- Urinary System – big changes came when WHO recognized the urinary system organs as a 'single organ' and treated urothelial cancers of the sites that have a urothelium lining as single tumors – period…1 tumor.
- Urothelium includes both renal pelvis of kidney (right & left), both ureters (right & left), the bladder, and the upper section of urethra (including prostatic urethra)
- The American Urological Association, AJCC, and urologists objected as they want each site coded and staged and abstracted separately. But we had to change.
- The Solid Tumor Rules created a workable solution for urothelial cancers
- In the United States more than 90% of bladder tumors are urothelial
- Report only 1 in-situ in any site UNTIL there is 1 invasive cancer
- Then most of the tumors that follow are treated as 'recurrences'
- Today, we do not include urothelial subtypes or histology combinations

51

Difficult or Confusing MP Rules - Urinary

52

Rule M7 Abstract a **single primary**[i] when the patient has multiple occurrences of /2 urothelial carcinoma in the **bladder**. Tumors may be any combination of:

- In situ urothelial carcinoma **8120/2 AND/OR**
- Papillary urothelial carcinoma noninvasive **8130/2** (does **not** include micropapillary subtype)

Note 1: Timing is irrelevant. Tumors may be synchronous or non-synchronous.
Note 2: Abstract only one /2 urothelial bladder primary per the patient's lifetime.
Note 3: There are no /2 subtypes for urothelial carcinoma with the exception of papillary urothelial carcinoma.

Rule M10 Abstract **multiple primaries**[ii] when the patient has a subsequent tumor after being **clinically disease-free** for **greater than three years** after the original diagnosis or last recurrence.
Note 1: This rule **does not apply** when both/all tumors are urothelial carcinoma of the bladder (all subtypes/variants of 8120 except for 8131).
Note 2: **Clinically** disease-free means that there was **no evidence** of recurrence on follow-up.

- Scans are NED
- Urine cytology is NED
- Scopes are NED

Rule M11 Abstract a **single primary**[i] when there are **urothelial carcinomas** in multiple urinary organs.
Note 1: This rule is **ONLY** for urothelial carcinoma **8120** and all subtypes/variants of urothelial carcinoma. This rule does not apply to any other carcinomas or sarcomas.
Note 2: Behavior is irrelevant.
Note 3: This rule applies to multifocal/multicentric carcinoma which involves two or more of the following urinary sites:

- Renal pelvis
- Ureter
- Bladder
- Urethra

52

Difficult or Confusing MP Rules – H&N

53

- Recent Additions of 2 bone sites and 1 autonomic nervous system site
- New Instructions for HPV positive/negative and p16 testing
- There are LOTS of anatomic sites and subsites in the head & neck
- Identifying the primary site can be difficult and makes determining 1 versus more than 1 primary hard when described as a different anatomy
- The Physical Oral Exam is more important than imaging or surgery when identifying the primary site in many cases – use the oral exam from physical or the oral exam as noted in the operative report for best site.
- Large tumors overlap adjacent anatomic sites often – use overlapping
- C76.0 is a new addition to 'unknown primary' with neck nodes + ONLY.
- LOTS of Histologic Types and Subtypes can be found in the Head & Neck Anatomy
  - Squamous cell, adeno, neuroblastoma, lymphoma, mucoepidermoid, melanoma, NET, PNET, sarcoma

53

Difficult or Confusing MP Rules – H&N

54

Table Number	Table Title
Table 1	Tumors of Nasal Cavity **C300** Paranasal Sinuses **C310-C313, C318, C319**
Table 2	Tumors of Nasopharynx **C110, C111 (posterior wall of nasopharynx only), C112, C113, C118, C119**
Table 3	Pyriform Sinus **C129** Tumors of Hypopharynx **C130-C132, C138, C139** Larynx **C320-C323, C328, C329** Trachea **C339** and Parapharyngeal Space **C139**
Table 4	Tumors of Oral Cavity and mobile tongue **C020-C023, C028, C029, C030, C031, C039, C040, C041, C048, C049, C050-C052, C058, C059, C060-C062, C068, C069**
Table 5	Tumors of Oropharynx **C100-C104, C108 C109** Base of Tongue **C019, Lingual Tonsil C024**, Tonsils **C090, C091, C098, C099** Adenoids/pharyngeal tonsil only **C111**
Table 6	Tumors of Salivary Glands **C079, C080, C081, C088, C089**
Table 7	Tumors of Odontogenic and Maxillofacial Bone (Mandible **C411**, Maxilla **C410**)
Table 8	Tumors of Ear **C301**
Table 9	Paraganglioma of Carotid Body, Extra-adrenal, Larynx, Middle Ear, Vagal Nerve **C479, C754, C755**
Table 10	Paired Sites

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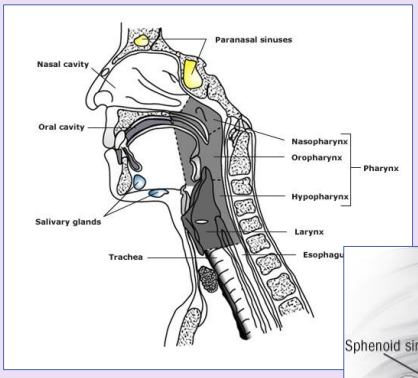
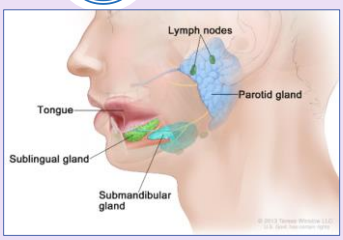
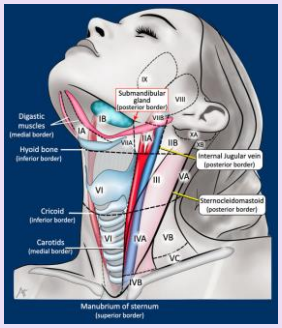
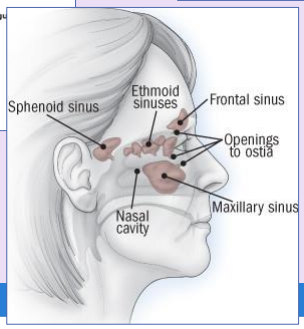
Difficult or Confusing Histology Rules – H&N

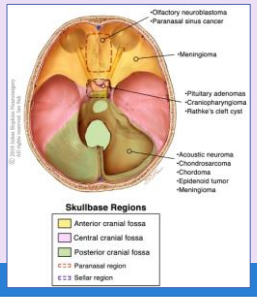
55











55

Difficult or Confusing Histology Rules – H&N

56

- So many histologic types/subtypes from tissue in the H&N
  - Squamous Cell Carcinoma and Subtypes (with or without HPV/p16)
  - Mucoepidermoid Carcinoma – oral cavity
  - Lymphoma – multiple subtypes
  - Salivary gland and Sinus Tumors – adenoid cystic carcinoma
  - Autonomic Nervous System – Paraganglioma
    - Carotid Body
    - Extra-Adrenal
    - Larynx
    - Middle Ear Vagal Nerve
  - Neuroendocrine Carcinoma & Subtypes
  - Neuroblastoma, Olfactory
  - Malignant Melanoma of Oral Mucosa
  - Bone Sarcoma and PNET/Ewing Sarcoma

Histological Types	Frequency	Percent
Squamous Cell Carcinoma	138	57.5
Papillary Carcinoma	26	10.8
Non Hodgkin Lymphoma	21	8.8
Basal Cell Carcinoma	15	6.2
Adenocarcinoma	13	5.4
Other Lymphomas	6	2.5
Hodgkin Lymphoma	4	1.7
Follicular Carcinoma	3	1.2
Melanoma	3	1.2
Acinic Cell Carcinoma	2	0.8
Mucoepidermoid Carcinoma	2	0.8
Small Round Cell Tumor	2	0.8
Anaplastic Carcinoma	1	0.4
Lieomyosarcoma	1	0.4
Chondrosarcoma	1	0.4
Myoepithelial Carcinoma	1	0.4
Transitional Cell Carcinoma	1	0.4
Total	240	100

56

Difficult or Confusing MP Rules - Breast

57

- Primary Tumor Location – mammogram or history or physical exam
- One Primary or Two Primaries?
  - No Invasive Tumor – Non-Invasive/In-Situ Only
  - Invasive and In-Situ Tumor in Same Breast
  - Ductal Carcinoma & Lobular Carcinoma (both in-situ/both invasive – mixed behavior)
  - Ductal Carcinoma with Lobular Features is Coded 8522 – this is a CAP Rule in STM
  - Multiple tumors in the same breast
  - One tumor in each breast
  - Multiple histologies in the same tumor
  - Different histologies in multiple tumors in same breast
  - Tumor with mixed/combination histology
  - Recurrence of Same Primary or New Primary in Same Breast
  - Disease-Free Interval – 5 years

57

Difficult or Confusing Histology Rules - Breast

58

- Using the Subtypes/Variants Table
- Using the Combination Codes Table
- Always Check the Behavior – invasive cancer always top selection
- Whatever Happened to Inflammatory Carcinoma? It is coded in stage not histo
- Carcinoma, NST – LOTS of Synonyms – all are ductal carcinoma, NOS
- No Subtypes or Features – except ductal with lobular features per CAP
- Metaplastic Carcinoma – 8575 (sarcomatoid, squamous, osseous)
- Mucinous Carcinoma – 8480 – colloid carcinoma
- Paget Disease – 8540 – in-situ or invasive – associated with a primary tumor?
- Papillary Carcinoma of Breast – 8503
- Subtypes of Papillary Carcinoma – 8507, 8504, 8509
- Sarcoma of Breast (intermediate/high grade) & Phyllodes Tumor (low grade)
- Small Cell Neuroendocrine Carcinoma of Breast

58

Difficult or Confusing Histology Rules – 2 Tables

59

Using Combination Histology Tables

Required Histology Terms	Histology Combination Term and Code
DCIS/duct carcinoma/carcinoma NST **8500** **AND** LCIS/lobular carcinoma **8520 or 8519** ***Note 1:*** Histologies may be a mix of in situ and invasive ***Note 2:*** 8522 is used when: • Duct and lobular carcinoma are present in a single tumor **OR** • Duct is present in at least one tumor and lobular present in a least one tumor in the same breast **OR** • One tumor is mixed duct and lobular; the other tumor in the same breast is either duct or lobular **OR** • All tumors in the same breast are mixed duct and lobular ***Example:*** One tumor with invasive duct carcinoma in LOQ RT breast; second tumor with invasive lobular carcinoma in UOQ RT breast ***Note 3:*** **Do not** use 8522 when the diagnosis is carcinoma NST/duct carcinoma with lobular **differentiation.** See Histology Rules for instructions on **coding differentiation**.	DCIS and in situ lobular carcinoma **8522/2** Note: The lobular includes pleomorphic lobular carcinoma in situ **8519/2** Invasive carcinoma NST/duct carcinoma and invasive lobular carcinoma **8522/3** ***Note 1:*** CAP uses the term Invasive carcinoma with ductal and lobular features ("mixed type carcinoma") to indicate both duct and lobular are present. ***Note 2:*** This is an exception to the instruction that features are not coded. ***Note 3:*** Carcinoma NST includes all subtypes of carcinoma NST ***Note 4:*** Lobular carcinoma includes invasive pleomorphic lobular carcinoma **Additional combinations of duct and lobular coded 8522/3**: • Intraductal and lobular carcinoma (includes invasive pleomorphic lobular carcinoma) • Infiltrating duct and lobular carcinoma in situ (LCIS) • Infiltrating duct and pleomorphic lobular carcinoma in situ • Infiltrating lobular carcinoma and ductal carcinoma in situ (DCIS) Infiltrating pleomorphic lobular carcinoma and ductal carcinoma in situ (DCIS)

59

Difficult or Confusing Histology Rules

60

Using Specific Histology vs Synonym vs Subtype/Variant Table

Specific and NOS/NST Terms and Code	Synonyms	Subtypes/Variants
Acinic cell carcinoma 8550	Acinar adenocarcinoma Acinar carcinoma	
Adenoid cystic carcinoma (ACC) 8200	ACC Adenocystic basal cell carcinoma Carcinoma adenoides cysticum Cylindromatous carcinoma	
Adenomyoepithelioma with carcinoma 8983	AME Malignant AME	
Apocrine carcinoma 8401 *Note:* This is a diagnosis that is **EXACTLY** apocrine **carcinoma**, **not** a carcinoma **NST** with apocrine **features**, **differentiation**, or **type.**		
Carcinoma NST 8500 *Note:* Cribriform carcinoma may consist of up to 50% tubular formations. The term cribriform/tubular carcinoma is coded as cribriform carcinoma.	Carcinoma, NOS Carcinoma of no special type (ductal/NST) Carcinoma/carcinoma NST with chorionocarcinomatous features Carcinoma/carcinoma NST with cribriform features Carcinoma/carcinoma NST with melanotic features Carcinoma/carcinoma NST with neuroendocrine features Carcinoma/carcinoma NST with signet ring cell differentiation DCIS **8500/2** DCIS of high nuclear grade 8500/2	Carcinoma with osteoclastic-like stromal giant cells **8035** Cribriform carcinoma/Ductal carcinoma, cribriform type **8201/3**; Cribriform carcinoma in situ **8201/2** Pleomorphic carcinoma **8022/3** Ductal carcinoma in situ, solid type/intraductal carcinoma, solid type **8230/2** Solid carcinoma/solid adenocarcinoma **8230/3**

Specific and NOS/NST Terms and Code	Synonyms	Subtypes/Variants
Note 1: This is a diagnosis that is **EXACTLY** "mucinous carcinoma," "mucinous duct carcinoma," "mucinous DCIS" OR "greater than 90% mucinous." **See** Histology Rules *Note 2:* Mucinous duct carcinoma is listed on the CAP protocol. It is not recognized by WHO or IARC. Mucinous carcinoma is not a subtype/variant of Carcinoma NST/duct carcinoma.	Mucoid carcinoma	
Mucoepidermoid carcinoma 8430		
Oncocytic carcinoma 8290		
Paget disease of the nipple with no underlying tumor 8540		
Papillary carcinoma 8503	Intraductal papillary carcinoma **8503/2*** Intraductal papillary carcinoma with DCIS **8503/2*** Intraductal papilloma with ductal carcinoma in situ **8503/2** Invasive ductal papillary carcinoma **8503/3** Invasive papillary carcinoma **8503/3** Papillary carcinoma of breast, NOS **8503/3** Papillary carcinoma non-invasive **8503/2*** Papillary ductal carcinoma in situ **8503/2***	Encapsulated papillary carcinoma, NOS/non-infiltrating/intracystic **8504/2** with invasion **8504/3** with invasive carcinoma, NST/invasive duct carcinoma **8504/3** Micropapillary carcinoma **8507*** Tall cell carcinoma with reverse polarity **8509/3** Solid papillary carcinoma in situ **8509/2*** with invasion **8509/3***

60

Difficult or Confusing MP Rules – Lung

61

Rule M5 Abstract **multiple primaries**[ii] when there is **at least one** tumor that is **small cell** carcinoma **8041** or any small cell subtypes/variants and another tumor that is **non-small cell** carcinoma **8046** or any non-small cell carcinoma subtypes/variants.

Note 1: Small cell carcinoma and non-small cell carcinoma are
- See Table 3 in Equivalent Terms and Definitions f subtypes/variants
- With the exception of small cell/neuroendocrine ca Equivalent Terms and Definitions are **non-small c**

Note 2: It is **irrelevant** whether the tumors are in the **ipsilater**

Rule M6 Abstract **multiple primaries**[ii] when separate/non-contiguo Column 3, Table 3 in the Equivalent Terms and Definitio

Note 1: The tumors may be subtypes/variants of the **same** or di
- **Same NOS:** Colloid adenocarcinoma 8480/3 and l NOS 8140/3 but are distinctly different histologies
- **Different NOS:** Keratinizing squamous cell carcin Lepidic adenocarcinoma 8250/3 is a subtype of ade Abstract multiple primaries.

Note 2: The tumors may be different **behaviors**: Acinar adeno subtypes of adenocarcinoma NOS 8140/3 but are distin

Rule M7 Abstract a **single primary**[i] when synchronous, separate/no in Table 3 in the Equivalent Terms and Definitions.

Note 1: Tumors must be **in the same lung.**

Note 2: The same row means the tumors are:
- The same histology (same four-digit ICD-O code) **OR**
- One is the preferred term (column 1) and the other is a synonym for the preferred term (column 2) **OR**
- A NOS (column 1/column 2) and the other is a subtype/variant of that NOS (column 3)

Rule M9 Abstract a **single primary**[i] when there are **simultaneous multiple** tumors:
- In **both** lungs (multiple in right and multiple in left) **OR**
- In the **same** lung **OR**
- **Single** tumor in one lung; **multiple** tumors in **contralateral** lung

Note 1: Tumors may be combinations of:
- In situ and invasive **OR**
- NOS and subtype/variant (See Table 3 in the Equivalent Terms and Definitions)
- Cancer NOS **8000** or carcinoma NOS **8010** and any other histology

Note 2: Examples of NOS and subtypes/variants include:
- Adenocarcinoma **8140** and a subtype/variant of adenocarcinoma
- Squamous cell carcinoma **8070** and a subtype/variant of squamous cell carcinoma
- NSCLC **8046** and a subtype/variant of NSCLC
- Carcinoma NOS **8010** and adenocarcinoma

Note 3: Code multiple primaries only when there is proof that one of the tumors is a different histology. Proof is any one of the following:
- Pathology from a biopsy
- Attending, oncologist, or
  - **Unequivocal** means t "ambiguous terms" li

Note 4: When there are multiple tumo patient based on that single b

Rule M11 Abstract **multiple primaries**[ii] when there is a **single** tumor in **each lung** (one tumor in the right lung and one tumor in the left lung).

Note 1: The only **exception** is when there is **proof** that one tumor is **metastatic**. Proof is any one of the following:
- Tissue from both tumors is compared and the pathologic diagnoses definitively says one tumor is metastatic
- Attending physician, oncologist, or pulmonologist state unequivocally that the tumor in the contralateral lung is metastatic
  - Unequivocal means that no words such as "probably possibly, most likely, etc." are used in the statement. Terms which are on the "ambiguous terms" list make the statement equivocal (cannot be used to prove metastases)

Note 2: Lung **metastases usually** present as multiple tumors/masses. A single tumor in each lung is unlikely to be a single primary (e.g. metastatic to the contralateral lung).

Note 3: The term "**bilateral**" is **not** a synonym for a **single primary**. It is simply a statement that there are tumors in both lungs.

Note 4: This rule is based on **long-term epidemiologic studies** of multiple primaries. The specialty medical experts (SME) and the CoC site physician teams reviewed and approved these rules. Many of the CoC site team physicians were also authors, co-authors, or editors of the AJCC Staging Manual.

Note 5: Lymph node involvement is recorded in staging criteria.

Note 6: Tumors do **not** need to be diagnosed at the same time (do not need to be simultaneous or synchronous).

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Difficult or Confusing Histology Rules – Lung

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Specific or NOS Histology Term and Code	Synonym of Specific or NOS	Subtype/variant of NOS and Code
Adenocarcinoma 8140 **Note 1:** Mucinous adenocarcinoma for lung only is coded as follows: • **8253/3*** when o Behavior unknown/not documented (use staging form to determine behavior when available) o Invasive • **8257/3*** when o Microinvasive o Minimally invasive • **8253/2*** when o Preinvasive o In situ **Note 2:** Non-mucinous adenocarcinoma for lung only is coded as follows: • **8256/3*** when o Microinvasive o Minimally invasive • **8250/2*** when o Preinvasive o In situ	Adenocarcinoma NOS Adenocarcinoma in situ **8140/2** Adenocarcinoma invasive **8140/3** Adenocarcinoma, non-mucinous, NOS Invasive non-mucinous adenocarcinoma **8140/3** Minimally invasive adenocarcinoma **8140/3**	Acinar adenocarcinoma/adenocarcinoma, acinar predominant **(for lung only) 8551*** Adenoid cystic/adenocystic carcinoma **8200** Colloid adenocarcinoma **8480** Enteric adenocarcinoma/pulmonary intestinal-type adenocarcinoma **8144** Fetal adenocarcinoma **8333** Lepidic adenocarcinoma/adenocarcinoma, lepidic predominant **8250/3*** Mucinous carcinoma/adenocarcinoma **(for lung only)** in situ **8253/2***; invasive **8253/3*** minimally invasive **8257/3*** microinvasive **8257/3*** preinvasive **8253/2*** Micropapillary adenocarcinoma/adenocarcinoma, micropapillary predominant **8265** Mixed invasive mucinous and non-mucinous adenocarcinoma **8254*** Non-mucinous adenocarcinoma **(for lung only)** in situ **8250/2*** microinvasive **8256/3*** minimally invasive **8256/3*** preinvasive **8250/2*** Papillary adenocarcinoma/adenocarcinoma, papillary predominant **8260** Solid adenocarcinoma/adenocarcinoma, solid predominant **8230**
Adenosquamous carcinoma 8560		

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Finding Answers to Questions

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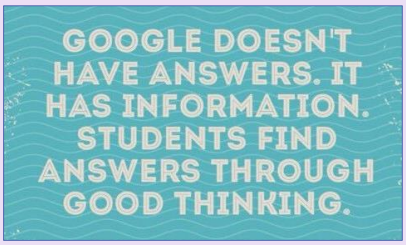

"Eeny Meeny Miny Moe"

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Where to Go for Questions – How to Use the Answers

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- PDF Manuals and Instructions – Required and Recommended
- Website Resources – SINQ, Ask a SEER Registrar, CAnswer Forum
- CALL FCDS – Field Coordinators or QC Manager
- FCDS DAM – Required Desktop Resources – Updated Annually
- FCDS DAM – Resources for Registrars – Updated Annually
- NCI Webpages – PDQ – General Cancer and Treatment Information
- American Cancer Society – Cancer A-Z
- NCCN Treatment Guidelines - FREE
- Your Vendor Representative or Help Desk
- Call FCDS for Technical Help

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Where to Go for Questions – How to Use the Answers

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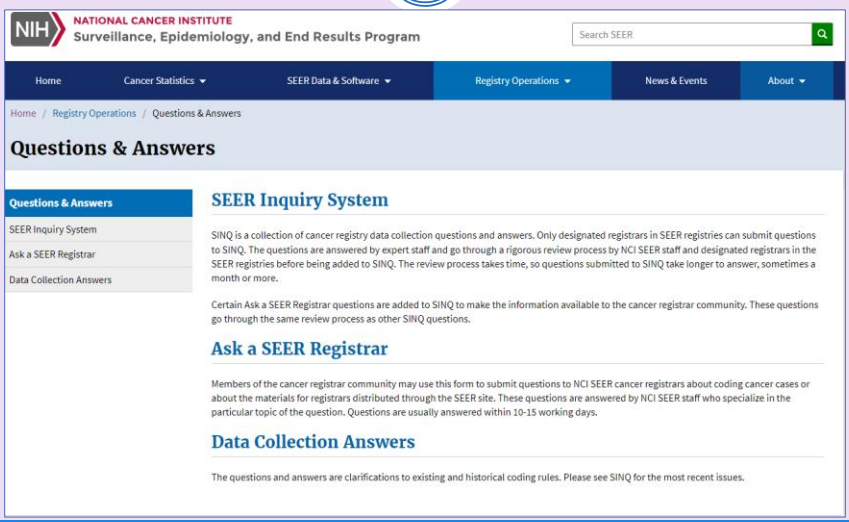

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Where to Go for Questions – How to Use the Answers

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This and That for $1000 – Actual Questions

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- HPV and p16 protein – What sites? What years? Same or Different?
- 8085 for HPV 'mediated', HPV positive, p16 positive – since 2021
- FCDS will Override the site/type edit if it is not on the 'official' list of valid sites for code 8085 – oral cavity, anus, vulva, cervix, sinus, vagina
- C310-C313, C318, C319, C510-C512, C518, C529, C519, C530-C531, C538-C539
- But this list is still missing primary sites where we find HPV and p16+ squamous cell carcinoma – code it as you see it and FCDS will override edit
- p16 has always been a surrogate HPV test – but it is not a perfect surrogate and does not find all HPV-positive cancers. p16 tests for a specific protein overexpressed in persons that have high-risk HPV. It is an IHC test used as a surrogate marker of 'transcriptionally active high-risk HPV infection'

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This and That for $1000 – Actual Questions

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- High-risk HPV types: HPV 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 66, 68.
- Two of these, HPV16 and HPV18, are responsible for most HPV-related cancers
- We see HPV/p16 in tissue from many other sites other than tongue and oropharynx and cervix…we see it in anus, rectum, skin of face, nostrils, tonsils, cheek mucosa, lip, perianal skin, scrotum and even the lung – you get the picture – and the ones in the H&N are the same HPV as the genital sites.
- Edits don't like 8085/8086 in sites except the ones that SEER and CoC agreed upon…but there is a caveat…the central registries can override this edit
- Most locally advanced oropharyngeal cancers (p16/HPV-positive or p16/HPV-negative) are treated with chemoradiation.
- Problem with p16 surrogate is that p16 can also be positive for melanoma, esophageal cancer, glioma, pancreas, NSCLC Lung and other cancers…

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This and That for $1000 – Actual Questions

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- Can help me make sense of how to code paragangliomas?
- Paraganglioma Distribution: 85% are abdominal, 12% mediastinal, only 3% are H&N
- Paraganglioma is a neuroendocrine tumor that grow from chromaffin cells – these cells are all over the place in the body but tend to bundle in a few specific locations. The cells help regulate blood pressure, blood sugar, heart rate.
- So the bundles, many of which are in the head & neck, communicate quickly with the CNS and organs to change blood pressure quickly and work with fight/flight responses (this is what neuroendocrine tumors and nerve bundles do – shortcuts to speed communications between organs or organ systems where they 'live' and the CNS to make for rapid response to certain stimuli).
- Sometimes they are called extra-adrenal pheochromocytoma)…and they are pretty rare. They tend to bundle around the carotid artery (carotid body), outside the adrenal glands (pheochromocytoma), and the vagus nerve and around the larynx/chest. Most are benign. Up to 25% are malignant – only 10% of pheochromocytomas are malignant. They all (I think) secrete catecholamine.
- Unlike some other tumors that we name by the organ in which they arise…paraganglioma are to be coded to the C47.* series because they involve peripheral nerves and autonomic nervous system codes most of us are not too familiar with. But they are tumors of the nervous system, not the blood or circulation system or adrenal gland. That is why they get coded C47.*.

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This and That for $1000 – Actual Questions

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Specific or NOS Term and Code	ICD-O Code DX prior to 1/1/2021 *Must be stated to be malignant*	ICD-O Code DX 1/1/2021 forward *"Malignant" no longer required to assign /3*	Synonyms (Per ICD-O-3.2)
Carotid body paraganglioma (C75.4)	8692/3	8692/3	Carotid body tumor
Extra-Adrenal paraganglioma, NOS	8693/3	8693/3	Nonchromaffin paraganglioma, NOS Chemodectoma Composite paraganglioma
Laryngeal paraganglioma	8690/3	8693/3	
Middle ear paraganglioma (C75.5)	8690/3	8690/3	Glomus jugulare tumor Jugulotympanic paraganglioma
Paraganglioma, NOS	8680/3	8680/3	
Vagal paraganglioma *Note:* Vagal paraganglioma has the same histology code as laryngeal paraganglioma. Extra-adrenal, laryngeal and vagal are in separate rows to emphasize primary site.	8690/3	8693/3	

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This and That for $1000…

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- This is probably the most common question I get asked over and over and over and over and over and over and over again !!! Why can't the CoC and SEER get this straightened out? ASK THE ACR – PLEASE.
- I have been a Registrar for 42 years – PLEASE - GIVE US A GOOD and CURRENT ANSWER.
- **What about Bi-RADS4 and Bi-RADS5?** Can we use the results? Can we use the dates? What if there is a biopsy? What if it is 3 months before the patient comes back? What if it is 6 months?
- We *almost* had an answer IN PRINT in the 2023 STORE Manual – until the CoC realized they answered it. So, CoC actually went back in February 2023 and TOOK IT OUT for goodness sake. It is not clarified in CAnswer or SINQ or Ask a SEER Registrar - or any manual in or out of print –
- DETERMINED TO BE RIGHT REGISTRARS ARE STILL CIRCULATING AN ANSWER THAT NOBODY CAN FIND IN PRINT that is from the era of film mammography that you print onto film not 2D or 3D or other digital mammography or MRI of breast or any other digital imaging techniques with great detail.
- I have been requesting this in writing from CoC and SEER for DECADES through NAACCR and in person

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This and That for $1000 – Actual Questions

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2023 Bi-RADS4 and Bi-RADS5 Clarifications FCDS/CoC/SEER

- The original question we asked in the 1980s when we should have started collecting mammogram date is, 'how much time lapsed between the date of the suspicious imaging and a biopsy' – then a separate question – 'how much time lapsed between the mammogram and a surgical resection of the breast'.
- We often forget the original question and ask 2 other related but separate questions. One question is about 'reportability'. The other questions are about Date of Diagnosis and Diagnostic Confirmation
  - If you only have a BIRADS4 or BIRADS5 from screening without a biopsy – the case is not reportable as imaging, only diagnosis – no other information.
  - If BIRADS4 or BIRADS5 imaging is followed by + biopsy – the Date of Dx is the date of imaging – Diagnostic Confirmation is still = 1 (histology – because of the bx)
- There was always supposed to be this difference because we did not collect mammography date and should have since the 1980s.

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This and That for $1000 – Actual Questions

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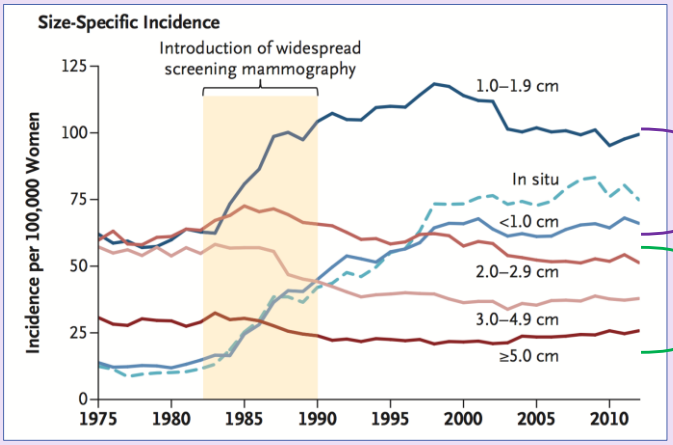

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This and That for $1000 – Actual Questions

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2023 FCDS Data Acquisition Manual (and back to 2018 & FCDS Memos)

d) **BIRADS Category 4 and BIRADS Category 5 Diagnosis without biopsy is not reportable.**

e) **Using the Date of Mammography as Date of Initial Cancer Diagnosis for Imaging BIRADS Category 4 or 5 with positive biopsy:**

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)

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SECTION I: GUIDELINES FOR CANCER DATA REPORTING

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classification system. You may see other RADS Diagnostic Imaging Standards referenced in the evaluation of diagnostic imaging 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

Do not use the newer RADS standards as a date of diagnosis until/unless SEER publishes this in manuals.

- Mammography used to be considered inferior to other imaging techniques – it is not any longer
- 1990s along came digital imaging – 2D, 3D digital mammography, MRI, combined imaging and the advanced technology to identify a tumor as small as 1mm
- Why was the mammogram the only imaging study that we were not allowed to use as the date of first diagnosis with or without a biopsy? We report other solid tumors with less information from imaging.
- It is just like any other imaging diagnosis prior to biopsy – the imaging diagnosis is suspicious or confirmation of cancer if BIRADS4 or BIRADS5…we use it for what it says it is. But not imaging alone.
- We still do not allow a case to be reported with only a BIRADS4 or BIRADS5 imaging report – even though we would if there were liver mets on an ultrasound - there must be a subsequent biopsy of that site to confirm the suspicious or definite tumor is neoplastic

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This and That for $1000 – Actual Questions

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Mammo and Ultrasound with BI-RADS scores - Confirmed with Biopsy - CAnswer Forum (facs.org)

2 months after CoC published the clarification – they removed it and republished STORE without it.

So the March 2023 version of the 2023 STORE Manual no longer has this clarification in writing.

STORE 2023 *STORE 2023 Summary of Changes*

STORE 2023 Page Number	Section or NAACCR Data Item Number	Data Item Name	Changes/Comments/Clarifications
42	2023 Source References	Case Eligibility	The 2023 Source Reference Document is located on the NAACCR website available at https://www.naaccr.org/implementation-guidelines/
44	Overview of Coding Principles	Case Eligibility	Updated reportability on juvenile pilocytic astrocytoma 9421/1. Added: Effective January 1, 2023, low grade appendiceal mucinous neoplasms (LAMN) (8480) are reportable. LAMN is a distinctive histologic subtype of mucinous appendiceal neoplasm and can be in-situ or invasive. Please reference the AJCC Appendix Protocol Version 9 for further information.
45	Overview of Coding Principles	Case Eligibility	Added: PI Rads, BI Rads, LI Rads alone are not reportable for CoC. PI Rads, BI Rads, LI Rads confirmed with biopsy or physician statement are reportable to CoC. Date of diagnosis is the date PI Rads, BI Rads, LI Rads imaging. The biopsy makes it reportable to CoC however the date of diagnosis is the date of the imaging.

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This and That for $1000 – Actual Questions

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2022 SEER Program Coding and Staging Manual

A group of representatives from NAACCR, CoC, SEER and others are meeting with ACR on this RADs issue.

4. The first diagnosis of cancer may be **clinical** (i.e., based on clinical findings or physician's documentation)

   Note: Do **not** change the date of diagnosis when a clinical diagnosis is subsequently confirmed by positive histology or cytology.

   Example 1: On May 15, 2023, physician states that patient has lung cancer based on clinical findings. The patient has a positive biopsy of the lung in June 3, 2023. The date of diagnosis remains May 15, 2023.

   Example 2: Radiologist reports Liver Imaging Reporting and Data System (LI-RADS) Category 5 on imaging. Later biopsy confirms hepatocellular carcinoma (HCC). Record date of diagnosis as date of LI-RADS imaging.

   Note: Appendix E in the 2023 SEER Program Manual lists which PI-RADS, BI-RADS, and LI-RADS are reportable versus non-reportable. If reportable, use the date of the imaging procedure as the date of diagnosis when this is the earliest date and there is no information to dispute the imaging findings.

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This and That for $1000 - Lymphoma - Biopsy or Surgery?

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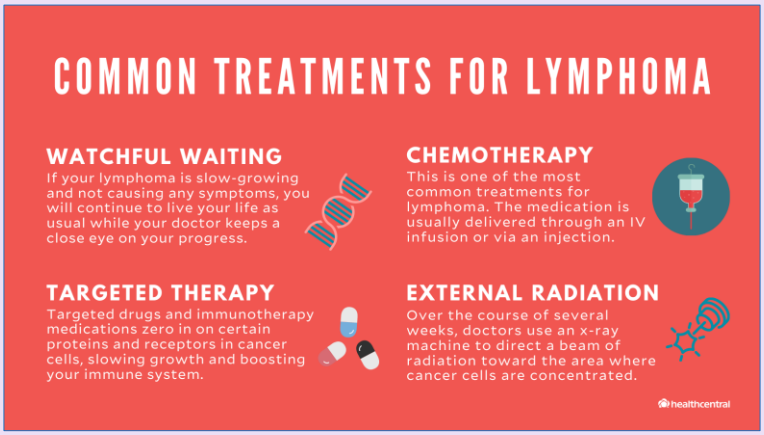

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This and That for $1000 - Lymphoma - Biopsy or Surgery?

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LYMPH NODES
C77.0–C77.9

Codes

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction or excision, NOS

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

15 Local tumor destruction, NOS

No specimen sent to pathology from surgical event 15.

25 Local tumor excision, NOS

~~**Less than a full chain, includes an excisional biopsy of a single lymph node.**~~

ASK YOURSELF: Is this procedure a cancer treatment or only a biopsy to make a diagnosis? A single lymph node is always just for diagnosis.

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1350	2	2235-2236	00–07, 09	All Years	09/06, 09/08, 01/12, 01/15

Description

Identifies the positive surgical procedure(s) performed to diagnose and/or stage disease.

Rationale

This data item is used to track the use of surgical pr… …ources that are not considered treatment.

Coding Instructions

- Record the type of procedure performed as … …nitial diagnosis and workup, whether this is done at your institution or another f…
- Only record positive procedures. For benign … …e reportable tumors, report the biopsies positive for those conditions. For malignant t… …report procedures if they were positive for malignancy.
- If both an … …biopsy of the primary site and an incisional biopsy of a … …site are done, use code 02 (Incisional biopsy of primary site).
- If a lymph node is biopsied or removed to diagnose or stage lymphoma, and that node is NOT the only node involved with lymphoma, use code 02. If there is only a single lymph node involved with lymphoma, use the data item Surgical Procedure of Primary Site [1290] to code these procedures.
- Do not code surgical procedures which aspirate, biopsy, or remove regional lymph nodes in effort to diagnose lymphoma disease in this data item. Use the data item Scope of Regional Lymph Node Surgery [1292] to code these procedures. Do not record the date of surgical procedures which aspirate, biopsy, or remove regional lymph nodes in the data item Date of Surgical Diagnostic and Staging Procedure [1280]. See instructions for Scope of Regional Lymph Node Surgery [1292].

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COMPLETE TEXT DOCUMENTATION IS A MUST

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How To Keep Up With Everything – Every Year

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How To Keep Up With Everything – Every Year

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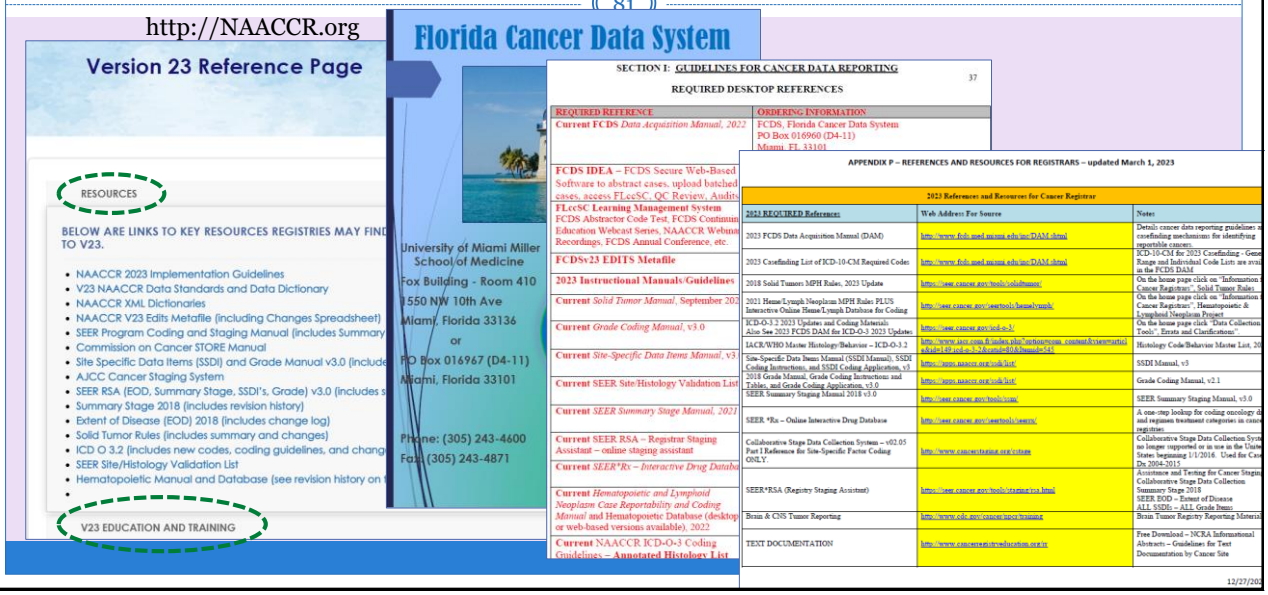

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Questions

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~ FIN ~

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