FCDS MONTHLY MEMO
NOVEMBER 2001

FCDS CONGRATULATES
74 Outstanding Cancer Registries
AWARDED
The 2001 Jean Byers Award for Excellence In Cancer Registration !!

A complete listing of the 2001 Jean Byers Memorial Award recipients appeared in the volume III issue of the FCDS Register. Again, congratulations to ALL of this year's award recipients.

JEAN BYERS MEMORIAL AWARD FOR EXCELLENCE IN CANCER REGISTRATION

The Jean Byers Memorial Award for Excellence in Cancer Registration honors Florida cancer registries exhibiting outstanding leadership and dedication to the field of cancer registration by examining measurable quality control indicators.

The following quality control indicators were carefully evaluated leading up to this year's choice for recipients of the 2001 Jean Byers Memorial Award for Excellence in Cancer Registration.

- ◊ Timeliness - All deadlines must have been met for the time period July 1, 2000 - June 30, 2001 including:
  - ✓ 1998 Death Certificate Notification - Deadline - July 17, 2000
  - ✓ 1999 Death Certificate Notification - Deadline - April 16, 2001
  - ✓ 2000 Annual Caseload Submission - Deadline - June 30, 2001
  - ✓ No more than 5% (or 35 cases whichever is greater) of the 2000 cancer case admissions reported to FCDS within 2 months following the June 30, 2001 deadline (Late Reporting of 2000 cancer case admissions).
- ◊ Completeness -
  - ✓ All cases reported to FCDS
  - ✓ No more than 10% of the 1999 cancer case admissions are reported to FCDS during the 12 months following the June 30, 2000 reporting deadline.

  (Note: Completeness is evaluated for two distinct time periods. The first time period is the sixty days following the FCDS Annual Deadline. Cases received during this time period are considered delinquent and contribute to the first completeness criteria. The second time period is the twelve months following the FCDS Annual Deadline. Missed cases found during the annual Death Certificate Notification and AHCA Case Identification Audits are considered delinquent and contribute to the second completeness criteria.)
- ◊ Affidavit of Completeness – Deadline – August 15, 2001
- ◊ Jean Byers Award Application – Deadline – August 15, 2001

Jean Byers (continued)

Regarding the nearly fifty (that's 50 !!!) facilities that met all but one of the eligibility criteria…

Each year FCDS gets phone calls, letters and e-mails from registrars and administrators making inquiry as to why their facility did not receive a Jean Byers Award. Often the reason is that only one of the criteria was not met. Usually the criterion not met was either that the facility never submitted a Jean Byers Award Application Form or that the facility never submitted an Affidavit of Completeness Form. Registrars must work with facility administrators to receive this award. It doesn't matter if you are a full-time registrar in an ACoS-approved cancer program or if you are a contractor working three weeks out of the year at a small facility seeing 100 cancer patients a year. It is up to both the registrar and the administration to make both eligibility and application a priority. FCDS salutes all registrars in our state. Thank you all for a job well done!

FCDS EDUCATIONAL TELECONFERENCE SERIES

FCDS hosted our 6th phone-in teleconference of the year on Thursday, November 14, 2001 from 2-3PM. This was the final telephone conference for the year 2001. Conferences will resume in January with the topic "Multiple Primary Cancers – How do you know?" The January conference will also include instruction for coding multiple histologies found in a single tumor. The date of the conference will be announced sometime next month.

The objective of the 6th telephone conference was to provide registrars, abstractors and contractors with a review of difficult to understand data items and to provide a review of all of the new FCDS Edits. This conference built from the previous teleconference which focused on cancer registry references including instruction on the format and structure of the 2001 FCDS Data Acquisition Manual. If you missed either conference, the power-point slide presentations are still available on the FCDS Website.

A fifteen minute Question & Answer Session followed the scheduled telephone conference during which the following questions were addressed:

Q. "Reason no cancer surgery" has been a confusing item and there is no explanation of how to code a lymphoma biopsy followed by chemotherapy or how to code reason no surgery when only a bronchoscopy was done and you don't know what future treatment will be done.
A. First you must refer to the surgery code definitions for each primary site. If you don't have any surgery coded under Surgery of Primary Site, Scope Regional Lymph Node Surgery or Surgery of Other Regional or Distant Sites then you have to code a value between 1 and 9 in the Reason No Surgery data item.

For leukemias Reason No Surgery should be coded as a 1 because surgery is contraindicated for these cases. In the case where only a bronchoscopy was performed, the Reason No Surgery code is 9.

Q. How do you code melanoma depth of invasion in the tumor size field?

A. The Tumor Size field should indicate the Breslow Depth of Invasion coded in millimeters for melanoma of the skin. Unfortunately, the data item does not adequately leave room for coding depth of invasion less than one millimeter (which includes most melanoma cases).
For example: If the lesion had a Breslow depth of invasion of 0.375mm, the three-digit tumor size field is inadequate for coding less than one millimeter. You should code this data item as 001.
Note: FCDS has made a recommendation to both the COC/ACOS and NAACCR Uniform Data Standards Committee for a new field to be added to code Breslow depth of invasion for melanoma

as it is not actually a tumor size and should not be coded in the tumor size field. The response from both COC and NAACCR is that in 2003 this data item will have a qualifier as a part of the Collaborative Stage Dataset. This qualifier will identify whether actual tumor size is coded in this data item or if it is depth of invasion or some other qualifier. The Collaborative Stage task force is very much aware of this situation and is making plans to clarify and update the codeset and dataset in 2003.

Q. FCDS IDEA - when I am finished entering a case, how do I log off?
A. You can click the FCDS logo at the top of the screen and it will take you back to the sign off page. Then select the sign off button and enter.

COMMENT FROM CALLER: "Thanks for the FCDS IDEA it has been excellent. The edits online are great and the support from Mark and everyone else has also been great. Thank you."
A. I appreciate your call. Folks are now getting 0% edits failures when using the FCDS IDEA single case entry program. We appreciate your comment. Also, soon there will be an Internet module for Physician office online case identification and entry and there will be a teleconference presentation to explain how this is to be used. We will also soon have a Pathology Laboratory online data entry for case identification similar to the old FoxPro application we had with the old FCDS software Version 3.1…except nicer.

Q. How do you code treatment summaries including how do you choose which is the most definitive surgery performed during the first course of therapy even when the patient has multiple surgeries of both the primary site and lymph nodes and other sites? Or excision of the primary site followed by a sentinel node biopsy then a node dissection?
A. The answer to this can depend on how your software handles the choice and it may not be up to you to select this. Your software vendor may do the selection for you. But we can tell you how to determine which surgery is the most definitive surgery and how you should code these particular situations. Again, first of all you need to consult your Site-Specific Surgery Coding section of the FCDS DAM or ROADS. Once you are in the right section of the surgery code set, you follow the rules for that site. In the example where you have multiple surgeries of the primary site, you need to select the most extensive Surgery of Primary Site code in the code set for that primary. If you also have either a sentinel node or a node dissection, you need to select the most extensive Scope of Regional Lymph Nodes code in the code set. You select the Number of Regional Lymph Nodes Examined/Removed IN THE SURGERY DATA ITEMS from the singlemost extensive lymph node removal (one procedure only is coded for this surgery item). This is different from the data item Regional Lymph Nodes Examined IN THE STAGING or EXTENT OF DISEASE data section of the abstract. The Regional Lymph Nodes Examined in the staging data section of the abstract requires that you add together all of the regional lymph nodes removed for all surgeries of regional lymph nodes. Sometimes these values are both the same for both data items and sometimes they are not. Be careful to distinguish that one is included for staging and is included in the staging area of your abstract. The other is included for surgical treatment and is included in the treatment area of your abstract.

QUALITY CONTROL - Every 25th Record Sampling Report

The QC staff will be mailing the **Every 25th Record Sampling Report** from the latest reporting quarter during the next month or so. This report provides you with a visual review of at least every 25th record that FCDS receives from every facility. The report contains all the data items and the data reviewed and stored by FCDS. A copy of each of the cases reviewed will be mailed to you. FCDS asks that you review each case report and provide us with feedback on any comments or questions noted on any of the reports. The next issue of the FCDS REGISTER includes a detailed explanation of how FCDS examines each case during the quarterly review of every 25th case. Look for the QC Corner in the next FCDS Register.

Annual FCDS QC Site Visits

FCDS will be performing **On-Site Quality Control Audits** in 56 randomly selected Florida hospitals during the next few months. The on-site QC Audits will include Pathology Casefinding and Reabstracting Audits of 1999 and 2000 admissions data. The audits should be completed by April 2002.

2001 FCDS DAM CLARIFICATIONS

NOTE: Additional errata for the 2001 FCDS Data Acquisition Manual will be distributed to everyone in December 2001. Please take the time to review each change carefully. Please also let us know if there are any further corrections or clarifications needed. Below are some important updates that we felt needed to be shared with everyone right away.

A recent NAACCR Uniform Data Standards Committee Conference Call provided much needed clarifications for how to code **Scope of Regional Lymph Node Surgery** for numerous types of cancers. April Fritz provided us with some **Clarification for Coding Grade for Lymphoma** cases. Approved cancer program should visit the ACoS website for Surgery Code Clarification Replacement Errata Pagese from 8/00.
http://www.facs.org/dept/cancer/index.html

Scope of Regional Lymph Node Surgery must equal '9' - for all of the following cases:

C70.0 - C70.9, C71.0 - C71.9, C72.0 - C72.9 - Primary Sites including meninges, brain, spinal cord, cranial nerves and other parts of the central nervous system

C77.0 - C77.9 - Primary Site of lymph node with the following morphology codes - **9590 through 9596, 9650 through 9719, 9727 through 9729**

C76.0 - C76.8, C80.9 - Unknown Primary or Primaries of Ill-defined Sites

C42.0, C42.1, C42.3, C42.4 - Hematopoietic, reticuloendothelial, immunoproliferative or myeloproliferative diseases including the following morphologies - **9720, 9722, 9723, 9731 through 9734, 9740 through 9742, 9750 through 9758, 9760 through 9769, 9800 through 9941, 9945, 9946, 9948, 9950 through 9989.**

Assigning 6th Digit Codes for Differentiation and/or Immunophenotype for Lymphoma

In general for both lymphoma and leukemia, phenotype takes precedence over grade. The specifics for coding grade for coding differentiation and for 6th digit coding of immuno-phenotype are included in the ICD-O-3 Errata under Items 6 and 7.

(Assigning 6th Digit Codes … continued)
Per the ICD-O-3 Errata, the guidelines for assigning 6th digit codes are as follows:

6. **Using a grade designation to assign 6th digit differentiation** – In some instances, the term "grade" does not imply differentiation and should not be used to code the 6th digit of the morphology code. For example, in describing some diseases, pathologists use the term "grade" as a synonym for "type" or "category." Registrars, on the other hand,

recognize the term "grade" as an indicator of cell differentiation that is coded in the 6th digit of the ICD-O morphology code. It is important to recognize when the term "grade" refers to category and when it refers to biologic activity. For example, the grades of nodular sclerosing Hodgkin lymphoma and follicular lymphoma are actually types or categories of these diseases. The 6th digit should NOT be coded as grade 1, 2 or 3 for these cases. However, a poorly-differentiated lymphocytic lymphoma or a B-cell or T-cell lymphoma should be coded in the 6th digit of the morphology code. Other terms described as high grade or low grade as part of the diagnostic term may be used to code the 6th digit of the morphology code.

7. **Assigning 6th digit immunophenotype** – Sixth digit codes for T-cell, B-cell, and NK-cell phenotyping of lymphomas and leukemias should be based on the diagnosis as specifically stated in the pathology report. Sixth digit phenotype codes should not be used when T- or B- cell is implied from the boldface header in the morphology numeric list. In other words, if no T- or B- cell designation is provided in the pathology or laboratory report, do NOT code the T- or B- cell designation based on the boldface header in the ICD-O-3. For example, a diffuse large B-cell lymlphoma would be coded to 9680/36; a diffuse centroblastic lymphoma would be coded to 9680/39. When cases are analyzed, they can be grouped by cell line as stated ion the category headings in the lymphoma and leukemia sections of the morphology numeric list.

CODING QUESTIONS SEER Response & Inquiry

Question: Breast cancer diagnosed 2001. Pathology report: Poorly diff ductal carcinoma which shares features of lymphoepithelial carcinoma. What histology code should be assigned?
Answer: Code to lymphoepithelial (8082) because the term "features" is a term that indicates the majority of the tumor.

Question: Pathology reports describe the tumor as a "focus" but also gives a size, should size of tumor be recorded as 001 (focus) or the actual size?
Answer: Record the actual tumor size. The rule that says to code a focus or foci of tumor as 001 was developed for use when no tumor size is given.

Question: Tumor sizes recorded on x-ray, CT scan and MRI may differ. Is there a hierarchy for using information from clinical tests (scans, radiography) to determine clinical tumor size?
Answer: There is no hierarchy for multiple scans and/or radiography. Use the largest tumor size recorded.

Question: In cases where the tumor has both invasive and in-situ components, the pathologists usually do not report a size for invasive portion. In most cases, the invasive portion is described as a percentage of the tumor mass. What should be recorded as tumor size when the pathology report does not specify dimensions for the invasive component?
Answer: If size of invasion is not given, and the total tumor size is < 1 cm, you can use code 009. In general if a tumor is described as <1 cm, code as 009. If the total tumor size is < 2 cm, you can use code 019. In general if a tumor is described as <2 cm, code as 019. If the tumor mass is > 2 cm, code size as 999 as stated in the EOD manual, "If only one size is given for a mixed in situ and invasive tumor, code size as 999, unknown.

CODING QUESTIONS SEER Response & Inquiry

Question: What rules should be used to code tumor size and histology when the cancer arises in a polyp. A polyp is described as sessile (both by the surgeon and the pathologist). Final histology dx is: Rectal sessile polyp: Invasive mod. diff. adenocarcinoma. Should the histology be coded as adenocarcinoma, NOS (8140/32) or as adenocarcinoma arising in a polyp (8210/32)?

Answer: Code adenocarcinoma arising in a polyp (8210/32). The structure in which this adenocarcinoma is arising is a polyp. If you do not know the size of the tumor (only the size of the polyp), code size as 999. The histology code does not affect the coding of tumor size.

Question: Lymph node biopsy positive for melanoma, primary site not identified. There is no tumor size because the primary site has not been identified. Should the size be 000 because no primary was found or 999 for unknown?

Answer: Code 000 No mass, no tumor found

Question: For lung cancers, the size given in an x-ray and the size given in a scan often differ. What are the rules for coding size of tumor when the chest x-ray and chest scan show different sizes for a lung tumor? How should tumor size be coded for the following lung cancer?
2/11/91 CXR: 3.5 cm RUL lung lesion
2/12/91 CT: 2.0 cm RUL lung lesion
Is a CT more accurate than chest radiographic exam, or should the larger size be selected?

Answer: Code the larger size; tumor size is 3.5 cm in this case.

Question: If the patient has inflammatory carcinoma of the breast, is the tumor size coded as 998 even though we have a tumor size?

Answer: Code 998 for size for inflammatory breast carcinoma.
These cases have a worse prognosis because of the dermal lymphatic invasion. Half of the inflammatory breast carcinomas will have no palpable mass.

Question: Can you give a general size for polyps that are called "diminutive," small," or "large?"

Answer: Diminutive <= 5 mm, Small 5.01 to 10 mm, Large >10 MM

Question: If tumor size is stated as "at least 2 cm", what code? This seems to be different from >2cm, which could be anything. Stating "at least" seems to indicate that if the tumor is larger than 2 cm, it is difficult to ascertain for whatever reason. So should we accept 2 cm as the best info we have, or default to 999 because of the lack of specificity?

Answer: Code the size as 020 (2 cm), using the rule "code what you know."
Excisional biopsy is done prior to admission and the tumor size is unknown. Pt is admitted for a mastectomy and the residual tumor size is 5 mm. Is tumor size coded 999 or 005? Code as unknown, 999. The majority of the tumor would have been removed during excisional biopsy and it is possible that the tumor could have been quite large.

HIPAA and the Cancer Registry

The North American Association of Central Cancer Registries (NAACCR) has developed materials to assist both central cancer registries and cancer reporting facilities in assuring compliance with HIPAA regulations. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) became law April 14, 2001. NAACCR evaluated the effects of HIPAA on the cancer surveillance community. The NAACCR legal counsel letter was presented to NCI and CDC for review and approval. Representatives from NCRA had expressed that there is a lot of concern regarding HIPAA in the hospitals from the registrars who report and gather the data. Questions regarding how this new HIPPA law impacts cancer reporting have arisen with regard to cancer registry compliance. For further information please visit the NAACCR website at
http://www.naaccr.org/Training/index.html

HIPAA and the Cancer Registry

The NAACCR documents including Frequently Asked Questions Regarding HIPAA and Cancer Registries, an academic interpretation of the HIPAA legislation as it relates to the reporting of cancer, a letter from NAACCR legal counsel and a sample letter that central registries can send to hospitals that explains, in brief, the impact of HIPAA on cancer reporting can be found in the NAACCR website. You can access these documents directly by typing in the following:

http://www.naaccr.org/toc.html for search and type HIPAA
http://www.naaccr.org/Training/files/FAQsRegardingHIPAAandCancerRegistries.pdf
http://www.naaccr.org/Training/files/NAACCRLettertoCentralCancerRegistriesreHIPAA.pdf
http://www.naaccr.org/Training/files/ModelLetterforCentralCancerRegistriestosendtoReportingFacilities.pdf

EDUCATION & TRAINING

In September 2000, SEER introduced a new training and education component that is currently being developed within the existing SEER website. When the component is completed it will contain 12 individual training modules, each covering a particular area of cancer registration. If you have any questions or comments about this site, please direct them to Steven Roffers, PA, CTR at Emory University at sroffer@sph.emory.edu. At this time visit the SEER training module by going to SEER.cancer.gov, and clicking the training icon. The following is available:

SEER TRAINING MODULES

- ICD-O-3 Satellite Training Video
- SEER Summary Stage 2000
- ICD-O-3 Training module
- Cancer Registration

INFORMATIONAL MODULES

- ICD-0-3 Satellite Training Video
- Summary Stage 2000 Manual

Principles of Oncology for Cancer Registry Professionals, December 3-7, 2001

Presented by The SEER Program of the National Cancer Institute. Bolger Center for Leadership Development Potomac, Maryland. Registration fee: $650.00 and the registration fee are reduced for participants who stay at the conference center.

Principles of Oncology is an intensive five-day training program in cancer registry operations and procedures emphasizing accurate data collection. The training program includes extensive
site-specific, hands-on case abstracting and coding sessions using both full medical records and abstracts that demonstrate the many situations registrars may face. The National Cancer Registrars Association (NCRA) and the North American Association of Central Cancer

Registries (NAACCR) endorse this program. NAACCR also serves as the fiscal agent for this program.

Principles of Oncology for Cancer Registry Professionals, December 3-7, 2001

The program provides approximately 35 hours of classroom and individualized instruction on basic registry concepts, such as abstracting, staging (summary, TNM and EOD), and ICD-O coding, as well as use of resources available to registrars. Attendees will have the benefit of lectures as well as a variety of practical exercises. Three volumes of training materials prepared especially for this program will be provided to registrants, as well as NCRA=s Workbook for Staging of Cancer, second edition.

Download the **Principles of Oncology** announcement and registration information by clicking on the following links for the , or version.

Commission on Cancer/American College of Surgeons, Chicago, March 8-9, 2002

The Commission on Cancer/American College of Surgeons will conduct a 2-day workshop in the Wyndham Hotel Chicago that will focus on: Survey Savvy, **NCDB Benchmark Reports,** ROADS 2003; Changes in TNM. For more information and details, contact Pat Tary at tary@facs.org. Headquarters of the American College of Surgeons, 633 N. Saint Clair Street, 28th floor, Chicago, Illinois 60611, 312/273-0300 Place: The Wyndham Hotel Chicago, 633 N. Saint Clair Street, Chicago, IL 60611. Registration Fee: $350

Principles and Practice of Cancer Registration, Surveillance, and Control, March 11-15, 2002, November 4-8, 2002

A staff of recognized experts in cancer registration, surveillance, and control teaches this intensive and comprehensive training program. The instructors are accomplished adult trainers and are internationally recognized as leaders in their fields. The following is a brief outline of the program content: Cancer Burdens in Defined Populations, What Data Are We Trying to Collect? And How?, Neoplasms and Cancer, Reportable Lists and Casefinding, Abstracting Pertinent Cancer Information, Medical Record Information and Data Collection, ICD-O-2 Coding Exercises and Case Scenarios, Cancer Staging: Summary Stage; TNM Stage; SEER EOD and others, Cancer Registry Operations and Procedures, Data Item Definitions and Codes, Cancer Registry Follow-Up, American College of Surgeons

Commission on Cancer Operations and Standards and Commission on Cancer Approvals Program, Cancer Abstracting and Coding; Using Case Scenarios and Actual Medical Records, Central Registry Operations; Visual Editing; Death Certificate Clearance; and Case Consolidation, Basic Statistics, Data Analysis, Data Presentation, Report Writing and Essential Quality Control Techniques, Resources Available to the Cancer Registrar. Location: Emory University in Atlanta, Georgia. Complete details are available on the training program web site at or contact Steven Roffers, PA, CTR at (404) 727-4535.

THE FOLLOWING COLLEGES AND UNIVERSITIES OFFER CERTIFICATE PROGRAMS IN CANCER REGISTRY

Burlington County College

Van Nguyen, RHIA, Academic Program Director Health Information Technology
Cancer Registry Program, County Route 530, Pemberton, NJ 08068, (609)894-9311, Ext. 7339 College web site:

College Ahuntsic

Manuela Das Neves, CHRA(c), CTR, Royal Victoria Hospital, 687 Pine Ave. W.,Rm. E3 40, Montreal, Quebec, Canada H3A 1A1, 514/842-1231 Ext. 4230

Lehman College

Miriam Cooney, MPS, RRA, Director Cancer Registry Program, Office of Continuing Education250 Bedford Park Boulevard West, Bronx, NY 10468-1589, (718)960-8825, FAX: 516/593-7266

Molloy College

Cheryl M. Frank, CTR, Program Coordinator, Division of Continuing Education, 1000 Hempstead Ave. P. O. Box 5002, Rockville, Centre, NY 11571-5002, (516)678-5000 Ext. 6206, Molloy College Web Site www.molloy.edu

Northeastern University

Annalee Collins, RRA, Director of HIA, 360 Huntington Ave., 266 Ryder Hall, Boston, MA 02115. (617)373-2525, a.collins@nunet.neu.edu

Orange County Community College, Institute for Business, Industry and Government (IBIG)

Joan Howard, IBIG Coordinator, 115 South Street, Middletown, NY, 10940, 845/341-4380, Fax 845/341-4921, email: ibig@sunyorange.edu

St. Petersburg Junior College

Valerie Polansky, M.Ed., Interim Program Director, Health Information Management Program P.O. Box 13489, St. Petersburg, FL 33733, email: picarda@spjc.eduwebsite: www.spjc.edu

Santa Barbara City College

Cancer Information Management (CIM) Online Program, Sue Watkins, RHIA, CTR, Program Coordinator, 721 Cliff Drive, Santa Barbara, California 93109-2394, Information: watkins@sbcc.net, CIM Program Information: http://www.sbcc.net/academic/hit/index.htmlSanta Barbara City College (SBCC) Online Web Site:http://online.sbcc.net

THE FOLLOWING UNIVERSITY OFFERS AN INTEGRATED HEALTH INFORMATION MANAGEMENT AND CANCER REGISTRY PROGRAM

University of Pittsburgh

Pat Grofic, School of Health and Rehabilitation Sciences, Department of Health Information Management, 6051 Forbes Tower, Pittsburgh, PA 15260, 412/647-1190, FAX: 412/647-1199, University of Pittsburgh Web Site,

Western Suffolk BOCES

Debra Tenenbaum, Principal of Career and Technical, Education, 17 Westminster Ave., Dix Hills, NY 11746, 631/667-6000 ext. 320, FAX: 631/667-1519, email: , Register Online:

DEADLINES

HOSPITALS

Hospitals should now be reporting June 2001 cases
Reminder: All Hospitals are expected to be 50% complete for 2001 Reporting by December 31, 2001

AMBULATORY CANCER CARE REPORTING PROGRAM (ACCRP)
The Deadline for All 1999 Patient Encounters was September 30, 2001

FCDS wishes everyone a safe and happy holiday season.