The Florida Cancer Data System

MonthlyMemo

Monthly Journal of Updates and Information

MARCH/ APRIL 2011

What's New:

The following information is currently available on the FCDS website.

DERMATOLOGY CANCER REPORTING DATA ACQUISITION MANUAL
(Revised 4/15/2011)

FCDS/NAACCR EDITS METAFILE - COMPATIBLE WITH NAACCR 12D VERSION - 5/3/2011, METAFILE CHANGES.

FCDS/NAACCR WEBINAR SERIES
Collecting Cancer Data: Prostate, 5/05/2011
BEING HELD AT 6 FLORIDA FACILITIES AND requires registration

FCDS REGISTER,

VOL. 50

FCDS 2011 Annual Conference

The 2011 Florida Cancer Data System Annual Conference is being held July 28-29, 2011 at the Renaissance Tampa International Plaza Hotel. The FCRA Annual conference is at the same hotel and precedes the FCDS conference.

TOPICS:

- NPCR CER and AHRQ Projects and Data Requirements
- 2011 Changes to FCDS Data Collection
- Collaborative Stage Data Collection System Version 02.03.02
- FCDS Quality Control - Feedback on Data Quality
- CSv2 Educational Workshop

REGISTRATION ONLINE:
https://fcds.med.miami.edu/scripts/register.pl

REGISTRATION FEE: $50.00

You may visit the hotel reservation link available on the FCDS registration page (click or copy and paste link listed) or call 1-800-644-2685 and reference the group code "**CERCERA**" to get the group rate of **$129.00**.

*****Deadline for group rate reservations 7/4/2011.*****

For more information you may contact:
Bleu Thompson
bthompson@med.miami.edu
305-243-2635

The Florida Cancer Data System (FCDS) is Florida's statewide, population-based cancer registry and has been collecting incidence data since 1981.

Job Opportunities with the Florida Cancer Data System

- *Florida Central Cancer Registry Specialists*
- *Senior Regulatory Analyst/ Quality Control Coordinator*

FLORIDA CENTRAL CANCER REGISTRY SPECIALIST

The University of Miami, Miller School of Medicine has two opportunities available for a Central Cancer Registry Specialist located on our Medical Campus in Miami, Florida. This individual will be responsible to be the primary point of contact between the Florida Cancer Data System (FCDS), Florida's statewide population based cancer registry, and our reporting sources (hospitals, physician offices, radiation treatment centers and surgery centers). Primary duties include the processing, review and correction of submitted cancer abstracts by the reporting sources, developing relationships with each assigned facility and being the primary contact for questions and issues.

Position requirements are:

1. A minimum of two years experience in a cancer registry;
2. NCRA certification as a Certified Tumor Registrar (CTR) or CTR eligible with cancer abstracting.

Send resumes to mthiry@med.miami.edu or call 305-243-2639 for more information.

SR. REGULATORY ANALYST/QUALITY CONTROL COORDINATOR

FCDS, Florida's population-based state-wide cancer registry, has an exciting job opportunity for an experienced CTR as a Senior Regulatory Analyst/Quality Control Coordinator. The QC Coordinator will work directly with the Manager of Data Quality and Education and Training and the FCDS Data Quality Team. The FCDS Data Quality Team is involved in the overall planning and delivery of various data quality studies across the state of Florida (reporting completeness, abstracting completeness, and coding accuracy) as well as ad hoc data quality and quality improvement activities that combine to make-up the FCDS

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Quality Control Plan. The FCDS Data Quality Team is also actively involved in the development and delivery of high quality education and training programs geared toward both new and experience cancer registrars. This is a challenging and rewarding position for a highly motivated CTR. FCDS is a busy hub of activity that includes cancer reporting from many types of report sources.

Routine responsibilities include: the Quality Control of abstracted/coded data to ensure that all cases received by FCDS are accurate and reliable and that data meet or exceed national data quality standards; re-casefinding and re-abstracting field audits and audit reconciliation activities; response to technical inquiries from in-the-field registrars, and serving as a subject matter expert to both hospital registry staff and the staff at the central registry. Experience with electronic data capture, e-path, and other electronic health records including EMRs is also highly desirable.

Qualified individuals should have a bachelor's degree and at least three years relevant work experience in a cancer registry as a CTR. Applicants must demonstrate a working knowledge of ICD-O-3, ICD-9-CM, ICD-10 including ICD-10-CM/PCS, and HCPCS/CPT coding. Understanding of national cancer case abstraction and cancer registry coding standards and related best practices is a requirement. Experience in epidemiological and/or clinical research studies is a plus.

The University of Miami, Miller School of Medicine is proud to offer those who lead with us competitive salaries, medical; and dental benefits, tuition remission, vacation, university paid holidays and much, much more. The University of Miami is an Equal Opportunity/Affirmative Action Employer. Please send cover letter and resume/CV to Steven Peace at speace@med.miami.edu.

FCDS IS NOT ACCEPTING ANY 2011 CASES.

Please hold any abstracted 2011 cases until you hear from FCDS that we are prepared to receive the 2011 cases.

A few of you have already tried to slip one or two cases in – we will delete them.

Thank you.

~ FCDS QC Team

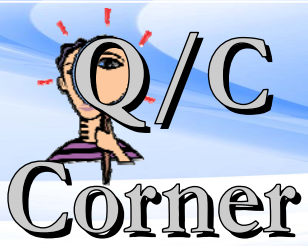
NEW! NCRA Program Recognition Application

A new easier-to-use form for Program Recognition requests is now available! Download at http://www.ncra-usa.org/CErequest

Designed to simplify the application process, some of new features are:

- Application can be submitted completely electronically – complete the Excel file, attach any additional documents and then email it to NCRA (ce@ncra-usa.org).
- CV's for your speakers are no longer required. Simply complete the Faculty Data Form page.
- Learning objectives are required for all segments of your program (brochures are no longer accepted in lieu of objectives).
- On the last page of your application, find answers to the most frequently asked questions.

Past versions of the application will no longer be accepted. We look forward to this transition and welcome your feedback. If you have additional questions, please contact NCRA at amundis@ncra-usa.org.



New FCDS EDITS Metafile and New FCDS Edits

FCDS recently posted the latest FCDS EDITS Metafile on the Downloads page of the FCDS website http://fcds.med.miami.edu/inc/downloads.shtml#datafilesandprograms. This latest metafile incorporates all of the Florida-relevant NAACCR 12D metafile changes as well as a few Florida-specific edits. Please be sure you and/or your vendor are using the most current version of the FCDS metafile. Highlights from the newest metafile are provided below.

We expect this to be the final metafile to go with the NAACCR 12 record layout. NAACCR 12.1 requirements and edits will be announced soon.

FCDS is also testing some of the new national "clinical Check Edits" that look for complete treatment data and check that treatment is consistent with the patient's stage of disease at diagnosis and other factors. These edit checks are an outgrowth of the increased focus on clinical care and whether or not patients are receiving treatment consistent with clinical care guidelines and other published standards.

FCDS is also encouraging the CoC, AJCC, and SEER to work more closely to ensure that new abstracting, coding and data standards are updated and synchronized with existing standards prior to any major implementation to ensure that coding rules such as surgery codes are aligned with new multiple primary or histology coding rules as well as being aligned with new Collaborative Stage Data Collection schema.

New Race Edit: When you submit a case with multiple race codes (not 99 or 88), there is now an edit to make sure that if Race 01 is included in the multiple races, it must appear in the last race field of multiple races, before you enter 88 into the remaining fields. *Note: 98 (Other Race) is a valid race field and should be treated the same as Race Codes 01, 02, etc. in the following examples.*

Example One: The patient is of one race - Japanese. The correct coding/order for Race1-Race5 should be: Race1=05, Race2 = 88, Race3 = 88, Race4 = 88, Race5 = 88

Example Two: The patient is of mixed race including Native American, Black, and White. The correct coding/order for Race1-Race5 should be: Race1 = 03, Race2 = 02, Race3 = 01, Race4 = 88, Race5= 88

Example Three: The patient is of mixed race unknown which races. The correct coding/order for Race1-Race5 should be: Race1 = 99, Race2 = 99, Race3 = 99, Race4 = 99, Race5 = 99

Example Four: The patient is of unknown race. The correct coding/order for Race1-Race5 should be: Race1 = 99, Race2 = 99, Race3 = 99, Race4 = 99, Race5 = 99

New Plasma Cell Neoplasms Edit: This new edit will no longer allow you to code solitary

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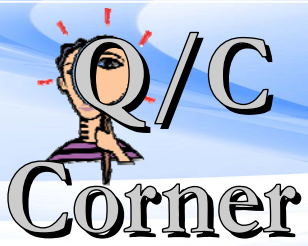

New FCDS EDITS Metafile and New FCDS Edits

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plasmacytoma (9731/3) to any site other than bone. Plasmacytoma can occur in sites other than bone and there is a specific code (9734/3 – extramedullary plasmacytoma) for these neoplasms. The term "extramedullary" indicates the plasmacytoma is in an anatomic site other than bone.

The new edit checks if Histologic Type ICD-O-3 = 9731 (solitary plasmacytoma of bone) and Behavior ICD-O-3 = 3 (malignant), then Primary Site must = C400-C419 (bone)—**this is for all dx years and is not override-able (cannot be Forced).**

Updated Heme/Lymph Grade/Differentiation Edits: The Grade/Differentiation Edits are updated to ensure that the standard single-digit Grade field is coded consistent with the new Heme/Lymph Grade Coding Rules. The easiest to read tables can be found in the Matrix Version of the Rules and are included below. Please be sure that you are coding grade in accordance with the new rules.

The following histologies Grade MUST be coded to 9: Cell type not determined
9740/3, 9741/3, 9742/3, 9751/3, 9755/3, 9757/3, 9758/3, 9759/3, 9801/3, 9805/3, 9806/3, 9807/3, 9808/3, 9809/3, 9875/3, 9876/3, 9945/3, 9946/3, 9950/3, 9961/3, 9962/3, 9963/3, 9964/3, 9975/3, 9980/3, 9982/3, 9982/3, 9983/3, 9985/3, 9986/3, 9989/3, 9991/3, 9992/3

The following histologies Grade MUST be coded to 5: T-Cell

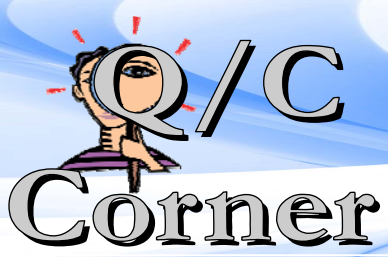
9700/3, 9701/3, 9702/3, 9705/3, 9708/3, 9709/3, 9716/3, 9717/3, 9718/3, 9724/3, 9725/3, 9726/3, 9827/3, 9831/3, 9834/3, 9837/3, 9714/3

The following histologies Grade MUST be coded to 6: B-cell

9596/3, 9597/3, 9670/3, 9671/3, 9673/3, 9678/3, 9679/3, 9680/3, 9684/3, 9687/3, 9688/3, 9689/3, 9690/3, 9691/3, 9695/3, 9698/3, 9699/3, 9712/3, 9728/3, 9731/3, 9732/3, 9734/3, 9737/3, 9738/3, 9762/3, 9811/3, 9812/3, 9813/3, 9814/3, 9815/3, 9816/3, 9817/3, 9818/3, 9823/3, 9833/3

The following histologies Grade MUST be coded to 8: NK (natural killer)

9719/3, 9948/3



Understanding the Heme/Lymph MPH Rules for Myeloproliferative Diseases

Chronic Myeloproliferative Disease (9960/3) is the least specific diagnostic description of the myeloproliferative disorders. Myeloproliferative Disorders include polycythemia vera, chronic myeloproliferative disease, myelofibrosis, essential thrombocythemia, and other disorders. When a diagnosis of chronic myeloproliferative disease is followed by or made in reference to a more specific myeloproliferative disorder – this is a single primary of myeloid origin and the registrar should code the histology to the more specific histology (i.e. primary myelofibrosis, polycythemia vera, etc.

Rule M6 describes this situation and should be used along with the Hematopoietic Database Multiple Primary Calculator to confirm this is a single primary.

Rule M6 Abstract as a single primary when a more specific histology is diagnosed after an NOS when the Hematopoietic DB Multiple Primaries Calculator confirms that the NOS and the more specific histology are the same primary.

Note 1: There are no time restrictions on these diagnoses; the interval between the NOS and the more specific histology does not affect this rule stating that the two neoplasms are a single primary.

Note 2: The Hematopoietic DB will identify these histologies as a single primary.

Rule PH39 instructs the registrar to code the more specific histology and affirms the circumstance of same primary.

Rule PH39 Code the specific histology when the diagnosis is

- **One non-specific (NOS) histology AND**
- **One specific histology AND**
- **The Hematopoietic DB multiple primaries calculator documents the specific histology and NOS are the same primary**

QUESTIONS? AND ANSWERS.

RADIATION TREATMENT CODE

Question:

How would a registrar find information to code a patient who has received Zevalin. In the SEER*Rx Zevalin is listed as a radiation treatment and the subcategory is radiolabled monoclonal antibody. This was administered via injection. Unable to locate an answer in FORDS or the CAnswer Forum.

Answer:

Zevalin should be coded as radio-isotope as it uses monoclonal antibody CD20 as delivery of Indium-111 or Yt-trium-90 radio-isotopes .

IS ESSENTIAL THROMBOCYTOSIS REPORTABLE?

Question:

If essential thrombocytosis is on the coding sheet of the medical record, does it mean that the physician agreed and it is reportable?

Answer:

Please refer to the SEER Heme DBv1.6.1 the primary Heme/Lymph Q&A reference.

Essential thrombocytosis is reportable and it is equivalent to essential thrombocythemia with histology code 9962/3. Essential thrombocythemia is a clonal myeloproliferative neoplasm. It is a rare chronic blood disorder characterized by elevated platelet count. Sustained thrombocytosis in blood and increased numbers of large, mature megakaryocytes in bone marrow; clinically episodes of thrombosis and/or hemorrhage.

SEER MPH QUESTION

Question:

I have a question regarding Hematopoietic case/ SEER Inquiry Question.
96953 LT Groin LN
96803 Spleen

4/21/10 Lt Inguinal LN BX - Follicular Lymphoma Grade 1 / 96953
5/17/10 Bone Marrow BX (-) Negative
5/21/10 Splenic FNA - Diffuse Large B-Cell Lymphoma/ 96803

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QUESTIONS? AND ANSWERS.

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The biopsies are from 2 different anatomic locations and not within 21 days PH16 indicates code to DLBCL in the same Lymph node, tissue or organ. I am uncertain if I code this as 2 primaries or 1 primary with Topography of C77.9 & Histology code 96803- DLBCL

Per MD suspicion of transformed Lymphoma in Spleen DLBCL possibly arising from underlying Grade 1 Follicular Lymphoma.

Answer:

The Hematopoietic MP Rules and MP Calculator can be misleading when DLBCL (diffuse large B-cell lymphoma) is diagnosed along with or prior to the diagnosis of follicular lymphoma. Rule PH16 makes it clear that this is a single primary – but if you use the MP Calculator alone the answer is New Primary. Use both Rule M3 and Rule PH16 in this case. SEER plans to clarify this specific clinical condition and diagnostic conundrum in subsequent release/update of the Heme MPH Rules.

M3

Abstract as a single primary when **two or more types of non-Hodgkin lymphoma** are present in the same anatomic location(s), such as one lymph node, one organ, or one tissue.*

PH16

Code the primary site to the **site of origin** (lymph node region(s), tissue, or organ) and code the histology diffuse large B-cell lymphoma (DLBCL) (9680/3) when **DLBCL** (9680/3) and **follicular lymphoma** (9690/3) are present **in the same lymph node**(s), **tissue**, or **organ**

Note 1: *The original pathology may identify only DLBCL although both DLBCL and follicular lymphoma are present. The DLBCL is much more aggressive than the follicular lymphoma and often masks the follicular lymphoma during the initial work-up. Because it is more aggressive, the DLBCL will respond more rapidly to treatment so the post-treatment biopsies may show a combination of DLBCL and follicular lymphoma or the post-treatment biopsy may be positive for only follicular lymphoma. The follicular lymphoma was present from the beginning but was hidden. Do not change the histology; it should remain 9680/3.*

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CODING CS EXT = 100 FOR INTRAMUCOSAL NEOPLASM OF COLON, ESOPHAGUS - CLARIFICATION

Question:

What is the rule for coding CS extension and behavior on intramucosal tumors of the esophagus and colon?

This is staged a Tis with AJCC staging, however with collaborative stage, CS Ext code 100 is used for intramucosal, NOS. I understand using code 100 with a behavior 3 if intramucosal is the only information I have, but if the pathologist makes it a point to state no invasion identified, can we code this using extension code 000?

Answer:

You should not code intra-mucosal tumor spread to any histology with behavior = 3 when pathologist states in situ. These should be classified as "in situ" whenever the pathologists makes such a statement.

There is still mixed opinion as to true nature of "invasion" when the term "intra-mucosal spread" is used to describe these tumors – this is exactly why there is the division in the CS Ext code addressing this situation. When Summary Stage was created intra-mucosal spread was always counted as invasive neoplasm because of the association with "spread" of tumor. Now, it is more often treated as in situ behavior since we know better that these tumors travel along the surface of the mucosa without invading into the mucosa (unless so stated).

Follow your pathologist's guidance as to how s/he determines behavior AND be sure to document this in accordance with facility guidelines and/or current practice.

Unfortunately, the CS Ext code "100" when used for Colon and Esophagus indicates "invasive tumor confined to mucosa, NOS (including intra-mucosal, NOS". The two codes map to very different T category with one mapping to in situ (Colon) and the other to minimal invasion (esophagus). This may have to do with anatomy of the wall of esophagus versus colon, not sure.

For esophagus intra-mucosal (CS Ext = 100) maps to T1a invasive tumor. For colon intra-mucosal (CS Ext = 100) maps to Tis (in situ not invasive). This was done intentionally so registrars would not confuse the issue with how pathologists might phrase invasion versus intra-mucosal spread and the difference between what should be identical staging criteria (in my humble opinion).

Again, check with your pathologist regarding what is meant by intra-mucosal spread when used for Esophagus and Colon – don't just ask about one and not the other. And, follow the pathologist guideline when abstracting cases – just document, document!!

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QUESTIONS? AND ANSWERS.

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RECTOSIGMOID COLON CASE AND CS LYMPH NODES

Question: (Pt. 1 of 2)

I have abstracted a Rectosigmoid Adenocarcinoma and the patient had positive Pericolonic Lymph Nodes. I code the CS Lymph Nodes to 200 - Rectosigmoid, Colic, NOS.

When my abstract was QC'd, they indicated that Pericolonic wasn't on the list for Code 200 and that I should have used Code 300 for Regional Lymph Nodes, NOS. Aren't Pericolic and Pericolonic Lymph nodes the same thing?

Answer: (Pt. 1 of 2)

I agree this should be 100 not 300. Please write back to the QC Team that pericolonic/pericolic are synonyms for the same lymph nodes and that you confirmed with me.

Question: (Pt. 2 of 2)

You mean Code 110-Rectosigmoid - Paracolic/Pericolic ?

Answer: (Pt. 2 of 2)

NO – I actually do mean 200 not 110 since 110 is a valid value only for CSv02.03 and is invalid for CSv02.02 which is the version we are currently using. 110 will come up with error when it gets to FCDS.

CS EXTENSION LUNG AND INVASION OF/THROUGH PLEURA CODING

Question:

I am abstracting a lung case.

The path report says: "tumor extends to, but does not microscopically involve the pleural resection margin.

The CS extension code 410 says "extension to, but not into pleura.

410 maps to T2nos, ut T2 in AJCC says that it invades visceral pleura, which I don't have.

Is there a typ-0 or erratta for this?

Answer:

The CS Extension code 410 is your best choice. That said, 410 is not a direct mapping to T2nos – it also takes into account SSF 1 and 2 as to where the T gets mapped. This tumor does in fact invade the visceral pleural but not through the visceral pleura – this is code 410. If you do not code SSF2 then this will map to T2nos and that is in fact where you would want it to go…not to invasion of parietal pleural…but it does invade visceral pleura – just not through it.

Florida Cancer Data System

Cancer Reporting Completeness Report

TOTAL NUMBER OF CASES IN THE FCDS MASTERFILE AS OF MARCH 31, 2011

Total number of *New Cases* added to the FCDS Master file in March, 2011: 14,003

The figures shown below reflect initial patient encounters (admissions) for cancer by year.

Admission Year	Hospital	Radiation	Ambi/Surg	Physician Office	Derm Path	DCO	Total Cases	New Cases
2010	78,764	1,119	95	498	0	**Pending**	80,476	12,833
2009	167,866	3.930	142	3,441	0	**Pending**	175,379	1,095
2008	172,282	8,683	2,823	5,140	3	2,948	191,906	75

		Actual	Expected
% Complete for:	2010	49%	75%
	2009	100%	100%
	2008	100%	100%

Expected % based on 165,000 reported cases/year

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