

The Florida Cancer Data System's Memo

JANUARY 2018

Congratulations To Florida's Newest CTRs

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WHAT'S NEW:

The following information
is currently available on the
FCDS website.

**FLORIDA ANNUAL
CANCER REPORT:
INCIDENCE AND
MORTALITY - 2014**

**FCDS/NAACCR
EDIT's Metafile**
16E Metafile,
posted on
8/22/2017.

**FCDS/NAACCR
WEBINAR SERIES:**
NAACCR 2017-2018
Cancer Registry and
Surveillance Webinar
series - Stomach and
Esophagus, 02/01/18,
being held at 7 Florida
facilities and
[requires registration.](#)



**Florida Statewide
Cancer Registry**



Quality Control

REMINDER - Name and Sex

FCDS has noticed an uptick in the number of abstracts where last name and first name are not being entered correctly and sex for patients with unusual first names is not documented in the text of the abstract so we do not know if the patient really is male or female. Correct entry of the patient's name (first, last, and middle) and correct coding and documentation of the patient's sex is needed for both analytic and non-analytic cases.



Sex should be documented in the H&P section of every single abstract along with the reason why the patient came into your facility.

Regarding entering the patient's name correctly; **DO NOT** include the middle initial or middle name in the first name field. This makes it more difficult to match up multiple abstracts and other linked records for patients seen at multiple facilities. FCDS receives records from multiple reporting sources and the name (first, last and middle), date of birth, sex and SSN fields are all critical for efficient and correct patient matching and record linkage.

Please refer to the current FCDS DAM for specific coding instructions for last name, first name, middle name, alias and maiden name.

Please refer to the current FCDS DAM for specific coding instructions for Sex - critical codes for intersex patients and intersex documentation included.

FCDS Continues To Identify Excessive Incorrect Assignment Of Primary Site

FCDS continues to identify excessive incorrect assignment of primary site code C70.9 (meninges, NOS) for many of the reported meningioma cases.

Cranial Meningioma (C70.0) Too Often Miscoded to Primary Site C70.9

FCDS continues to identify far too many meningioma cases with incorrect coding of primary site.

C70.9 should never be used when abstracting and reporting these “brain tumors”.

There are only 3 primary site codes available in ICD-O-3 to code meningioma; C70.0 (cranial meninges), C70.1 (spinal meninges) and C70.9 (meninges, NOS). The vast majority of meningiomas (90%) occur in the cranial meninges and are referred to as “brain tumors”. **Do Not Use C70.9.**

Cranial Meningioma includes meningioma of the sphenoid wing, cavernous sinus, foramen magnum, tentorium, posterior fossa and other intra-cranial sites and should always be coded to primary site C70.0 (not C70.9).

Spinal Meningioma (meningioma of spinal cord, spinal column, or spinal space) is quite rare and should always be assigned primary site code C70.1.

FCDS will be introducing a new edit in 2018 to eliminate this common error.

Treatment Status



FCDS has noticed a huge uptick in abstracts where Treatment Status is being coded = 1 (Treatment Given) when the patient did not receive any treatment of any kind, was not qualified as a “watch and wait” candidate, or was discharged directly to hospice with advanced disease.

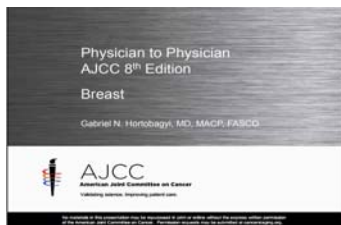
Registrars know that Treatment is not given for every case of cancer. Benign tumors often are not treated. Sometimes patient’s refuse treatment. And, some patients’ are simply observed over time to see if their cancer behaves poorly and treatment is later initiated after failing a “watch and wait” period. These patients have early and very limited disease not advanced disease - or they are not “watch and wait” or “active surveillance”.

A patient qualifies for Active Surveillance when they have a benign brain tumor such as meningioma or when they have very early stage insitu or malignant disease. Watch and Wait (Active Surveillance) is not a treatment option for advanced disease. It

is intended to be used to identify patients whose tumor is not life-threatening and for whom treatment is not given until or unless they have disease progression and then treatment begins.

So, we don’t not know if registrars entering code 1 without thinking about it or possibly vendors are auto-coding cases as having received treatment. It is also possible that registrars are confusing Treatment Status with Class of Case. A treatment plan is not treatment. The plan to not treat is not 0 treatment. And, when a patient is sent to hospice due to advanced disease - this is not treatment. Treatment is either given or not given.

Please take care when entering this data item. It appears we are over-staging treatment given on far too many cases.



American Joint Committee on Cancer (AJCC) Cancer Staging Manual - Updated Breast Chapter for Eighth Edition

The decision to delay implementation of the American Joint Committee on Cancer (AJCC) Cancer Staging Manual, Eighth Edition to January 1, 2018 has provided the AJCC with an opportunity to take a careful look at the way it has traditionally communicated cancer staging. Since the manual was published last fall, the AJCC has worked with the surveillance community, the pathology community, and clinical decision support software developers to take a more critical look at the content and make improvements and clarifications that will help everyone who uses this information including the registrar, clinician, and the software developer.

As part of this effort, the AJCC decided to validate and update the Eighth Edition breast cancer staging system using an additional year's worth of data from the National Cancer Database (NCDB). The AJCC Breast Expert Panel has recommended providing two breast cancer Prognostic Stage tables based on further analysis of the NCDB data.

The Clinical Prognostic Stage Group will be used to assign stage for all patients based on history, physical examination, imaging studies, and relevant biopsies. The Pathological Prognostic Stage Group will be used to assign stage for patients who have surgical resection as the initial treatment of their cancer before any systemic or radiation therapy. The Breast Expert Panel also recommended clinical, pathological, and post-therapy data elements that cancer registries should record.

As science continues to evolve, the AJCC is committed to validating and incorporating important updates and communicating them transparently. We understand the burden that these changes place on those who purchased the first printing of the manual. To this end, the entire breast cancer chapter of the manual will be publicly available through the AJCC website on November 10th, 2017 and replacement pages for all updates and corrections made to the entire manual will be available in December 2017. Future printings of the staging manual will include the updated breast chapter as well as other minor updates and corrections issued to date.

Please visit cancerstaging.org for education and regular updates to the Eighth Edition

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“Surgery of Other Regional or Distant Sites”

FCDS continues to see far too many cases abstracted with “Surgery of Other Regional or Distant Sites” incorrectly coded when the surgical procedure performed has absolutely nothing to do with removing cancerous tissue or surgical treatment to remove or resect a regional or distant metastasis.

Registrars are over-coding this data item designed to capture surgical cancer treatment of metastasis, when the surgery being coded has nothing to do with the patient’s cancer or cancer treatment plan. When you code this item - it tags the procedure as surgical treatment for the patient’s cancer.

The Data Item “Surgery of Other Regional or Distant Sites” serves a special purpose in the *Treatment Dataset*. This field was designed to capture “surgical treatment” of a metastasis or in rare instances “surgical staging” beyond the primary site - not just “other surgery”.

The Definition for Surgery of Other Regional or Distant Sites; **“records the surgical removal of distant lymph nodes or other tissue(s) or organ(s) removed beyond the primary site” to “document the extent of surgical treatment used in evaluating the extent of metastatic involvement.”**

This means that the resection **must** have been performed to evaluate the extent of disease (stage) **and** must be based on suspected metastatic involvement of a non-nodal regional site (rare) or a distant metastatic site (possible but not used for debulking procedures); **and** that the surgery performed on the patient was not limited to surgery of the primary site with regional involvement or surgical evaluation of regional lymph nodes.

When you code this data item - it ‘counts’ as surgical treatment for the patient’s cancer. If the procedure does not remove cancerous tissue or is not performed to rule out metastatic disease (i.e. for staging) - do not code it. It must be performed to remove metastatic disease or suspected disease.

The following are NOT to be Coded as “Surgery of Other Regional or Distant Sites”:

- Debulking procedures
- Diverting procedures
- Exploratory surgery
- Surgery for reconstruction
- Other Surgery not related to the patient’s cancer diagnosis
- En bloc resection that includes the primary site plus adjacent tissue and/or organ(s)
- Nephrectomy that includes adrenal gland - the adrenal gland is removed as part of the Surgery of Pri-

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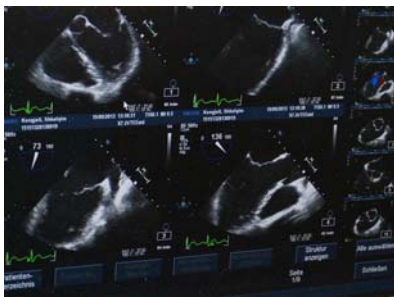
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mary Site procedure - even it positive for involvement - just because the adrenal gland is removed with the kidney does not make this a surgery of other regional or distant site.

- Head and Neck surgery with unknown Head and Neck primary - do not code primary site to C80.9.
- Incidental removal of non-primary organ(s)/tissue during a surgical procedure to remove the primary tumor and/or regional nodes

Below are some instances when you DO Code Surgery of Other Regional or Distant Sites.

- When surgery is performed TO TREAT tumors of unknown or ill-defined primary sites or TO TREAT hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease. (*it is rare to surgically treat an unknown primary or the lymphoid/myeloid neoplasms.*)
- Surgical removal of metastasis (removal of brain, liver, lung metastasis) - not just a biopsy but a resection
- Surgical removal of metastasis with unknown primary (removal of brain, liver, lung metastasis) - not just a biopsy but a resection



In-Situ Pancreatic Cancers Diagnosed Only by Imaging or Direct Visualization

We wanted to remind everybody once again that it is now possible to diagnose in-situ pancreatic cancers based only on imaging, esophagogastroduodenoscopy (EGD), endoscopic ultrasound (EUS) or direct visualization during an endoscopy. This was clarified in our FCDS DAM for 2016 and was included in previous FCDS Memos. Please do not delete these cases...they are important.

This is ONLY for pancreatic tumors...not breast or colon or lung. And, only for diagnosis 1/1/2016 or later.

We still have FCs and QCs sending these cases back telling registrars they are not reportable or that you cannot have in-situ behavior /2 without biopsy - you can and these must be FORCED. And, the FORCE is to override 2 edit failures (site/type and confirmation of in-situ behavior).

Please refer to Section I, p.4&5 of the 2016 FCDS DAM for more information. This has been verified by SEER for 2016 and later reporting. We expect to provide an updated table and instructions in the 2018 DAM.

Clarification for Reporting /2 and /3 Pancreatic Neoplasms - The classification and reporting of tumors of the pancreas can be confusing in part due to the latest terminology associated with tumors arising in the pancreas, and complicated by the mixed nature of benign, borderline, in-situ and invasive neoplasms and various histologic subtypes associated with pancreatic neoplasms. In 2010 the World Health Organization (WHO) published the latest WHO Classification of Tumors of the Pancreas. ALL in-situ and invasive (malignant) neoplasms of the pancreas are reportable to FCDS. However, some reportable neoplasms are associated with terminology registrars may not immediately recognize as reportable malignancy.

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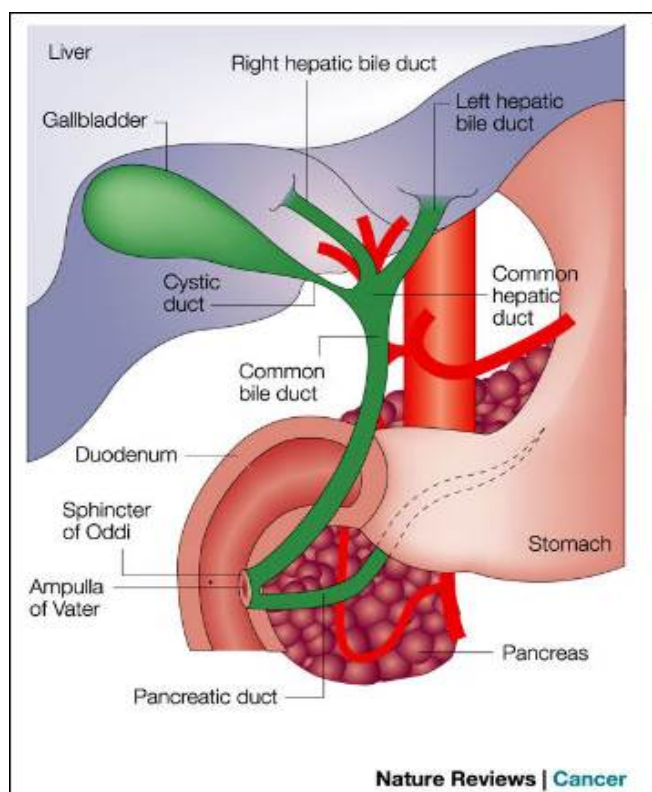
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Reportable	ICD-O-3	Description
Yes	****/2	All Histologies with Behavior Code of /2 (in-situ)
Yes	****/3	All Histologies with Behavior Code of /3 (invasive)
Yes	8440/3	Cystadenocarcinoma of the pancreas
Yes	8150/3	Cystic Pancreatic Endocrine Neoplasm (CPEN)
Yes	8500/3	Infiltrating Duct Carcinoma of the pancreas
Yes	8503/2	Intraductal Oncocytic Papillary Neoplasm (IOPN) of the pancreas
Yes	8453/2	Intraductal Papillary Mucinous Neoplasms (IPMN) of the pancreas
Yes	8453/3	Intraductal Papillary Mucinous Neoplasm (IPMN) with invasive carcinoma
Yes	8503/2	Intraductal Tubule-Papillary Neoplasm (ITPN) of the pancreas
Yes	8503/3	Intraductal Tubule-Papillary Neoplasm (ITPN) with invasive carcinoma
Yes	8470/2	Mucinous Cystic Neoplasm (MCN) of the pancreas with high-grade dysplasia
Yes	8470/2	Non-invasive Mucinous Cystic Neoplasm (MCN) of the pancreas with high-grade dysplasia
Yes	8470/2	Mucinous Cystadenocarcinoma, non-invasive (MCN)
Yes	8470/3	Mucinous Cystadenocarcinoma of the pancreas
Yes	8470/3	Mucinous Cystic Neoplasm (MCN) of the pancreas with invasive carcinoma
Yes	8246/3	Neuroendocrine Carcinoma of the pancreas
Yes	8240/3	Neuroendocrine Tumor, Grade 1 (NET GR1) of the pancreas
Yes	8249/3	Neuroendocrine Tumor, Grade 2 (NET GR2) of the pancreas
Yes	8471/3	Papillary Mucinous Cystadenocarcinoma of the pancreas
Yes	8452/3	Solid Pseudo-Papillary Neoplasm (SPN) of the pancreas
Yes	8552/3*	Mixed acinar-ductal carcinoma
Yes	8163/2*	Papillary neoplasm, pancreatobiliary-type, with high grade intraepithelial neoplasia
Yes	8163/3*	Pancreatobiliary-type carcinoma
No	n/a	Histologies with Behavior Code of /0 (benign)
No	n/a	Histologies with Behavior Code of /1 (borderline)
No	n/a	Serous cystadenomas, solid and cystic papillary (Hamoudi) tumors, lympho-epithelial cysts and simple cysts are all benign and not reportable
* New histology codes not yet implemented in the U.S. are still reportable – use histology 8500 or 8140		
References: 2010 WHO Classification of Tumours of the Pancreas; Pathologe. 2011 Nov;32 Suppl 2:332-6. doi: 10.1007/s00292-011-1515-2; Ann Surg. 2004 May; 239(5): 651–659), 2011 ICD-O-3 Updates, 2015 SEER Program Coding and Staging Manual, and NCI SEER Ask A SEER Registrar.		

(Continued on page 8)

Pancreatobiliary IPMN/ICPN/IPBN

“Intracholecystic papillary-tubular neoplasms (ICPN) are rare precursor lesions of gallbladder cancer. They are considered homologous to intra-papillary mucinous neoplasms (IPMN) of the pancreas and intrabiliary papillary neoplasms of the common bile duct (IPBN). Their definition as a single category derives from their common clinicopathological, immunophenotypic and molecular characteristics, better prognosis, and homology to other papillary neoplasms of the pancreatobiliary track. In contrast with the commoner flat-type precursor gallbladder cancer lesions, they follow a more indolent clinical course and probably different genetic pathways to carcinogenesis. They are largely uninvestigated with only a handful of studies providing biological and clinical information.” World J Surg Oncol. 2016; 14: 202. Published online 2016 Aug 2. doi: 10.1186/s12957-016-0962-x.



These neoplasms are all reportable as non-invasive (in-situ) cancer of the biliary system. ICPN and IPBN are essentially the same type of cancer as IPMN of the pancreas. Use the same histology code as IPMN. These neoplasms are confirmed by visualization or endoscopic ultrasound (EUS) and may never get a biopsy. So, the diagnostic confirmation may = 6 or 7 (direct visualization during endoscopy or ultrasound imaging during endoscopy).

We understand this goes against the long-held rule that all in-situ cancers must be biopsied to verify no invasion. But, EUS has come a long way and there are now international criteria for diagnosis and staging of these neoplasms. The entire biliary system has potential for these neoplasms - gallbladder, bile ducts, pancreas, intrahepatic bile ducts - but, not the liver itself - just the ducts - it is “intraductal” carcinoma. And since these biliary system tumors are “in-situ” without biopsy - we have to FORCE them unless they happen to get a biopsy during the endoscopic procedure.

NAACCR 2017-2018 Webinar Series

The Florida Cancer Data System is happy to announce that for another year we will be presenting the NAACCR Cancer Registry and Surveillance Webinar. Seven Florida facilities will host the 2017-2018 webinar series. Be sure to mark your calendars for each of these timely and informative NAACCR webinars.

- Boca Raton Regional Hospital (Boca Raton)
- Moffitt Cancer Center (Tampa)
- M.D. Anderson Cancer Center Orlando (Orlando)
- Shands University of Florida (Gainesville)
- Gulf Coast Medical Center (Panama City)
- Baptist Regional Cancer Center (Jacksonville)
- Florida Cancer Data System (Miami)

Special thanks to the hosting facilities for their participation and support. For a complete description of the webinars, click here: https://fcds.med.miami.edu/scripts/naacccr_webinar.pl All webinars start at 9am.

Please go to the FCDS website to register online for your location of choice. Registration link is: https://fcds.med.miami.edu/scripts/naacccr_webinar.pl. A separate registration will be required for each webinar. The number of participants allowed to be registered for each webinar will be dependent on space availability. For more information, please contact Steve Peace at 305-243-4601 or speace@med.miami.edu.

DATE	TOPIC
*10/5/17	Collecting Cancer Data: Prostate
*11/2/17	Collecting Cancer Data: Larynx
*12/7/17	Collecting Cancer Data: Uterus
*1/4/18	Collecting Cancer Data: GIST and Soft Tissue Sarcomas
2/1/18	Collecting Cancer Data: Stomach and Esophagus
3/1/18	Abstracting and Coding Boot Camp: Cancer Case Scenarios
4/5/18	Collecting Cancer Data: Pancreas
5/3/18	Directly Coded Stage
6/7/18	Collecting Cancer Data: Thyroid and Adrenal Gland
7/12/18	Hospital Cancer Registry Operations - Topic TBD
8/2/18	Multiple Primary and Histology Rules
9/6/18	Coding Pitfalls

*All NAACCR Webinars presented are available on the FCDS website, on the Downloads page:
<http://fcds.med.miami.edu/inc/educationtraining.shtml>

NAACCR CANCER REGISTRY AND SURVEILLANCE WEBINAR SERIES

Seven Florida facilities will host the 2016-2017 webinar series, registration is required



[REGISTER FOR THE
NEXT WEBINAR](#)

FCDS is the host site for Miami, FL with space for 10 participants.

CEU information for the 2017 FCDS Annual Conference:

CEU Hours: 9.5
(3.75 Hrs Category A)

NCRA Recognition Number: 2017-088

CEU information for the 2016 FCDS Annual Conference:

CE Hours: 8.25

NCRA Recognition Number: 2016-056



CEU Tracking

FCDS will no longer keep track of CEUs using the “Log CEUs with FCDS”. We have gone back to the certificate way of tracking CEUs because so many registrars rely on certificates to track their CEUs and registrars seemed to have a difficult time understanding how to get their CEU list from the FCDS website. So, attendance at FCDS Educational Webcast Series held 8/21/2014 - 8/21/2017 can be logged into the FCDS CEU Tracking System the old way. Only webcasts held during this 3-year period will use the old system. Beginning on 10/19/2017 ONLY Registered FLccSC Users will be given access to the CEU Quiz to earn continuing education hours. FLccSC Users can download and print attendance certificate after they take and pass the quiz. Florida attendees must have a Florida FLccSC account & pass the CEU Quiz to get CEUs. South Carolina attendees must have a South Carolina FLccSC account & pass the CEU Quiz to get CEUs. Non-FLccSC Users (Out-of-State Attendees) are invited to attend the live webcasts or view recorded sessions but will not receive CEUs for attendance. NAACCR webinars have their own CEU recording mechanism.

Log CEUs with FCDS: https://fcds.med.miami.edu/scripts/log_CEUs_with_fcds.pl

Save the Dates: 8th Edition Cancer Staging Webinars for Registrars

The AJCC has announced upcoming live webinars covering topics from the AJCC Staging Manual Eighth Edition for registrars. All webinars will be held from 1-2 pm CT. Make sure to mark your calendars. Additional information and registration links coming soon. Earn FREE Category A CE credits for the live or recorded webinars. Visit the AJCC website for updates. Save the Dates.

Registration link: <https://cancerstaging.org/CSE/Registrar/Pages/8thEditionWebinars.aspx>

Webinar Topic	Date	Time
Introduction & Descriptors	Thursday, December 7, 2017	1 pm – 2 pm CST
Minor Rule Changes	Thursday, February 15, 2018	1 pm – 2 pm CST
Major Rule Changes	Tuesday, March 20, 2018	1 pm – 2 pm CDT
CAnswer Forum & Staging Questions	Tuesday, April 17, 2018	1 pm – 2 pm CDT
Head and Neck Staging	Wednesday, July 25, 2018	1 pm – 2 pm CDT
Breast Staging	Thursday, September 6, 2018	1 pm – 2 pm CDT



2017-2018 FCDS Educational Webcast Series

FCDS is pleased to announce the 2017-2018 FCDS Webcast Series schedule and topics. FCDS will focus the series on preparing Florida Registrars for the 2018 Revisions to Standards including; 2018 MPH Rules, 2018 ICD-O-3 Updates, Summary Stage 2018, AJCC TNM 8th edition, and the new Site Specific Data Items (SSDI).

Date	Time Schedule 3 rd Thursday	Presentation Title
*8/17/2017	1:00pm – 3:00pm	Convention Brief: 2017 FCDS Annual Meeting Highlights
*10/19/2017	1:00pm – 3:00pm	Lymphoid & Myeloid Neoplasms: 2016 Revision of the WHO Classification & You
*11/16/2017	1:00pm – 3:00pm	Lung Cancer: FCDS Audit Findings, Anatomy, Staging Using the AJCC 8th ed., SSF Req'd to Stage
*12/14/2017	1:00pm – 3:00pm	Biomolecular and Genetic Tumor Profiles: Classification and Characteristics of Disease, Required SSFs, CAP Biomarker Checklists, and Targeting Treatment
To be rescheduled		2018 MPH Rules: MPH Rule Updates for Solid Tumors and Introduction to the Solid Tumors Database+
To be rescheduled		AJCC Cancer Staging Manual 8th ed. and Summary Stage 2018+

- + The FCDS webcast, 2018 MPH Rules: MPH Rule Updates for Solid Tumors and Introduction to the Solid Tumors Database will be rescheduled to later in the year. The 2018 Updates to the MPH Rules, Manual and Database(s) have not been finalized or released so FCDS cannot present on this topic.
- + The FCDS webcast, “2018 Updates to Cancer Staging” will be rescheduled to later in the year. The 2018 Updates to Cancer Staging (Summary Stage 2018 Manual, Site Specific Data Items Manual, and AJCC Cancer Staging Manual 8th ed.) have not been finalized for implementation so FCDS cannot present on this topic.
- + Webcasts available on the FCDS website, on the Downloads page: <http://fcds.med.miami.edu/inc/teleconferences.shtml>

*There is no fee and each 2-hour webcast will be recorded and available on the FCDS website, <http://fcds.med.miami.edu/inc/teleconferences.shtml>.

Webcast materials are also available on the FCDS website.

Blood Cancer Conference

FLORIDA 2018

A Free Educational Conference for Patients, Caregivers and Healthcare Professionals



Fort Lauderdale Marriott Harbor
Beach Resort & Spa
3030 Holiday Drive
Fort Lauderdale, FL, 33316

FLBCC@lls.org
954.744.5310

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fighting blood cancers

For questions , please contact:

The Patient Access team | FL.BCC@lls.org | 954.744.5310

A free educational event for:

- **Survivors**
- **Caregivers**
- **Healthcare Professionals***

**This is not a continuing education (CE) program.*

NCRA Applauds Decision to Establish a Special SOC Code for Medical Registrars

New Code Will Vastly Improve Data Accuracy on Cancer Registrar Workforce and Salary Trends

Alexandria, VA, December 8, 2017—The National Cancer Registrars Association (NCRA) applauds the Bureau of Labor Statistics' (BLS) decision yesterday to establish a distinct, detailed occupation code of "Health Information Technologists and Medical Registrars" in the Standard Occupational Classification (SOC) system. The new detailed occupation code reflects the increase use of data to improve medical treatment and care and the critical role cancer registrars play in collecting that data. The new code will also ensure that the statistics on the cancer registry workforce will be more accurate, providing a clearer understanding of the current and future workforce needs; correct salary information will help recruit and retain qualified individuals; and skill-appropriate personnel will be hired to fill cancer registrar positions at both the central and hospital levels.

Historically, cancer registrars have been grouped under a detailed occupation code entitled "Medical Records and Health Information Technicians." The federal definition of this occupation did not accurately describe the complex roles and responsibilities of cancer registrars or other medical registrars. In fact, the definition best described the work of medical coders.

NCRA recognized that this misclassification was impacting national workforce planning—a key purpose of data collected by the BLS. It was also impacting how facilities classified cancer registry positions, leading to recruitment and retention challenges at central and hospital registries and below-market salaries. To address the problem, NCRA embarked on an initiative to establish a distinct detailed occupation code to ensure cancer registrars and other medical registrars were classed appropriately. After a 13-year effort, success was achieved. In the 2020 Census, cancer registrars will

choose a more accurate SOC classification—one that recognizes the distinct skills and responsibilities of the medical registry and health informatics professions. According to NCRA President Barbara Dearmon, BS, CTR, "NCRA is grateful that the BLS has acknowledged the important work of cancer registrars and agreed that there is a national-level role in workforce planning for our and other medical registry occupations."

The new SOC classification for Cancer Registrars is 29-9021: Health Information Technologists and Medical Registrars. The definition is:

"Apply knowledge of healthcare and information systems to assist in the design, development, and continued modification and analysis of computerized healthcare systems. Abstract, collect, and analyze treatment and follow-up information of patients. May educate staff and assist in problem solving to promote the implementation of the healthcare information system. May design, develop, test, and implement databases with complete history, diagnosis, treatment, and health status to help monitor diseases."

Illustrative examples: Cancer Registrar, Health Informatics Specialist, Health Information Analyst

To learn more about NCRA's efforts to establish a new SOC classification, go to www.ncra-usa.org/Advocacy/Current-Priorities. Additional information on the 2018 Standard Occupational Classification System can be found at: www.bls.gov/soc/2018/major_groups.htm.

Florida Cancer Data System

Cancer Reporting Completeness Report



TOTAL NUMBER OF CASES IN THE FCDS MASTERFILE AS OF DECEMBER 31, 2017

Total number of *New Cases* added to the FCDS Master file in December, 2017: **21,767**

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

ADMISSION YEAR	HOSPITAL	RADIATION	AMBI/ SURG	DERMATOLOGY	PHYSICIANS CLAIMS	DCO	TOTAL CASES	NEW CASES
2017	69,217	253	46	8,710	192	Pending	78,418	14,912
2016	190,384	3,089	125	11,443	6,404	Pending	211,445	6,093
2015	197,572	8,808	1,907	12,279	14,483	2,033	237,082	762
						<u>Actual</u>	<u>Expected</u>	
% Complete for:			2017	41%		50%		
			2016	100%		100%		
			2015	100%		100%		

**Expected % based on 190,000 reported cases per year*

The Florida Cancer Data System (FCDS) is Florida's statewide, population-based cancer registry and has been collecting incidence data since 1981 when it was contracted by the State of Florida Department of Health in 1978 to design and implement the registry. The University of Miami Miller School of Medicine has been maintaining FCDS (<http://fcds.med.miami.edu>) since that time.

The FCDS is wholly supported by the State of Florida Department of Health, the National Program of Cancer Registries (NPCR) of the Centers for Disease Control and Prevention (CDC) and the Sylvester Comprehensive Cancer Center at the University of Miami Miller School of Medicine.

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Missed an FCDS Webcast or NAACCR Webinar?

Did you know that FCDS Webcasts and NAACCR Webinars can be viewed after-the-fact? FCDS Webcasts and NAACCR Webinars are recorded and posted on the FCDS Website (Education Tab). The FCDS Webcast recordings are available free of charge and can be viewed anytime/anywhere by anybody. However, starting in October 2017 the CEU award mechanism is restricted to approved FLccSC Users. Access to the NAACCR recordings is still password protected.

Recordings of FCDS Webcasts held 2014-2017 can be accessed from the FCDS Website. There are no CEU Quizzes for sessions held 10/2014-9/2017. However, your attendance must be manually logged into the FCDS CEU Tracking System for you to get credit for attending these recorded sessions.

Recordings of FCDS Webcasts held 10/2017 or later can be viewed either from the FCDS Website or in FLccSC, Florida's new Learning Management System. However, Registrars must have an active FLccSC Account and must take and pass the CEU Quiz to get any CEUs and to obtain a certificate of attendance.

NAACCR Webinars have their own CEU award mechanism whether viewed live or via a recorded session. Again, access to the NAACCR recordings is password protected. Only Florida registrars with Active/Current FCDS Abstractor Codes can access NAACCR Webinars per FCDS/NAACCR agreement.

Please contact FCDS for more information on viewing recorded webinars, or to obtain the password to view individual NAACCR Webcast Recordings.