

The Florida Cancer Data System's Memo

JULY 2019



NEW DEADLINE FOR REPORTING 2018 CASES

The Florida Department of Health's Florida Cancer Data System (FCDS) has established a new deadline for reporting all reportable cancers diagnosed and/or treated in Florida during calendar year 2018. **The new deadline for reporting 2018 cancer cases is March 31, 2020.**

Reporting for 2018 cases is over 9 months behind schedule. The reasons for these delays are attributed to finalizing national data standards, multiple revisions to data layouts due to issues discovered, and making 2018-compliant vendor software available to registrars that will meet all of the new standards.

The FCDS has started to receive cases from a few facilities as they receive 2018 compliant software. Some vendors still do not have working field versions that are 2018 compliant as the national standards have changed as recently as this month.

The FCDS has been in regular contact with all cancer registry software vendors and has been informed that the remaining vendor updates are imminent. Some will still have minor issues – but, for the most part all vendors should have 2018-compliant software before the end of April.

In addition to the 9+ month abstracting delay, we recognize that there are impacts to each facility(s) productivity as abstractors learn how to apply new rules, adapt to new software, and learn to deal with the new abstracting complexities required at the

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WHAT'S NEW:

The following information is currently available on the FCDS website.

**WEIGHT-RELATED
CANCERS IN FLORIDA
1992-2013 MONOGRAPHS**

**FCDS RESEARCH
JOURNAL PUBLICATIONS
REPORT**

**FCDS/NAACCR
EDIT's Metafile
V18 Metafile,
posted on 05/7/2019.**

**FCDS/NAACCR
WEBINAR SERIES:
NAACCR 2018-2019
Cancer Registry and
Surveillance Webinar Series -
Collecting Cancer Data: Colon
on 8/01/19, being held at 7
Florida facilities and
[requires registration.](#)**

FCDS Florida Cancer Data System
**Florida Statewide Cancer
Registry**



Florida Cancer Data System Deadlines, Updates, & Reminders

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national level and by the Commission on Cancer and the National Cancer Database.

It is vitally important that each abstractor take the necessary time to learn the new rules and to submit quality abstracts to the FCDS. We cannot afford to rush through the abstracting process and create a less than quality product. We do not want to fill the FCDS database with 'unknown' values or 'not available' information, when it is really a time-availability and data quality issue.

Additionally, as cases are abstracted it's important to report early and often in order to make sure the V18 format is meeting all requirements so as not to overwhelm yours' or the FCDS' staff with edits and quality assurance reviews. **In other words, please submit smaller batches more often.**

With this in mind, the FCDS is factoring this need for additional time to account for these delays, at least for this reporting year, to our deadline timeline in order to provide the necessary time for facilities to produce a quality product.

The FCDS deadline for abstracting and reporting all 2018 cases (ANY Class of Case and including all inpatient and ambulatory patient encounters 1/1/2018-12/31/2018) will be March 31, 2020.

The FCDS will be monitoring facility's submissions and will make a decision about future extensions to the deadline once we get a better understanding for how facilities are dealing with all of the new com-

plexities. If it is determined this deadline cannot be met, please submit or e-mail a written plan to your field coordinator regarding when 2018 cases will be completed.

The FCDS has been notified that there will be no changes to reporting for the 2019 reporting year which will allow everyone to flow right into 2019 reporting once 2018 reporting is complete. We are hopeful that this will help facilities catch up.

If you have any questions, please do not hesitate to contact us. As stated earlier, it is vitally important for everyone to take the necessary time to learn the new requirements and to provide quality abstracts to the state.

These delays and changes in rules and standards has caused significant operations issues both for you and the FCDS. Remember we are all in this boat together and together we will work to navigate these uncharted waters. **Together we will get through this.**

Thank you for your support and patience, and continuing to submit complete, accurate, and timely data to the FCDS. It is greatly appreciated.



DCO SSDI

DCO SSDI

On May 16, 2019, Social Security Death Index (SSDI) URL has been changed to
<https://www.npcrcss.cdc.gov/ssdi>
from <https://ssdi.npcrcss.org>



Florida Cancer Data System Deadlines, Updates, & Reminders

Retirement Announcement Mike Thiry



Mike Thiry is retiring on August 31st, 2019. Mike has been the Manager for Data Acquisition since March 2009. Mike was not your typical registry hire having a strong background in managing large projects with staff size exceeding 150 members. Mike quickly became acquainted with the needs of the cancer registry and was able to transition his skill set to cancer data collection. Mike has been a key contributor to the success at the FCDS. He was able to work

with the FCDS team to make processes more efficient and to add new ones where they were needed based on reporting requirements. Mike has endured, with the rest of us, the hurricane of 2010 changes and has participated actively working towards dealing with the tsunami of 2018 ones.

Mike will be missed both personally and professionally. Let's all wish him the best of luck as he enters the next chapter of his life.



Florida Cancer Data System Deadlines, Updates, & Reminders

Mission:

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

**Ron DeSantis**

Governor

Scott A. Rivkees, MD

State Surgeon General

Vision: To be the **Healthiest State** in the Nation**To: Florida Reporting Facilities and Abstractors****RE: Patient Social Security Number (SSN) – A Florida Mandated Data Item**

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

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

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

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

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

Sincerely,

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



Florida Cancer Data System Deadlines, Updates, & Reminders

Unknown Date of Diagnosis - No Longer Valid

DATE OF INITIAL DIAGNOSIS

NAACCR ITEM #390

Records the date of initial diagnosis by a physician for the tumor reported.

An error is issued when the Date of First Contact precedes the Date of Diagnosis by more than thirty days.

Positive tumor markers alone are not diagnostic of cancer. Use the date of clinical, histologic, or positive cytological confirmation as the date of diagnosis – never the date of positive tumor marker.

FCDS Requirement for Unknown Date of Diagnosis beginning 8/1/2019 for ALL cases. FCDS will be posting a new FCDS EDITS Metafile v16D on or around 8/5/2019. This is when the new requirement will be enforced.

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

Beginning 8/1/2019, FCDS will require every case that you abstract (analytic, non-analytic and historical grid cases) to include at a minimum a valid year of diagnosis. This is new to Florida. **The FCDS EDITS Metafile will reinforce these new requirements beginning 8/1/2019.**

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

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

Below is a revised set of instructions and guidelines for estimating the Date of Diagnosis when no information or limited information is available in a medical record. See Instructions 22 and 23 below. A 2019 revision to BIRADS was made in Instruction 5 regarding the interpretation and use of mammography dates for date of dx.

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Unknown Date of Diagnosis - No Longer Valid

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

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

DO NOT USE DATE OF ADMISSION TO YOUR FACILITY AS A PROXY FOR THE DATE OF DIAGNOSIS

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

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

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

Date of Diagnosis Coding Instructions:

1. NEVER LEAVE THE DATE OF DIAGNOSIS BLANK.
2. NEVER ENTER 99/99/9999 FOR DATE OF DIAGNOSIS.
3. Use the first date of diagnosis whether clinically or histologically established or when an acceptable laboratory or genetic test is allowed to be used as a confirmation of a cancer diagnosis.
4. When diagnostic imaging or other test confirms a diagnosis (including when the diagnosis uses one of the “Ambiguous Terms” defined in Section I), the date of diagnosis is the date of the first diagnosis from positive imaging, allowable confirmatory diagnostic testing, or biopsy/resection.

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Unknown Date of Diagnosis - No Longer Valid

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5. **2019 Clarification for Use of Breast Imaging Dates:** Breast Imaging includes 2D/3D Mammography, MRI or other imaging technique with a diagnosis of BIRADS Category 4 (suspicious for cancer) or BIRADS Category 5 (positive for cancer). These are a “conditional exception” to Instruction 4. **A positive/suspicious mammogram alone should never be used to code the date of diagnosis.** 5. **A positive/suspicious mammogram date should be used as the date of diagnosis ONLY when the patient goes on to subsequently have a positive biopsy and/or resection that confirms the suspicious abnormality is in fact a malignancy.**
6. If the physician states that in retrospect the patient had cancer at an earlier date, use the earlier date as the date of diagnosis. When this occurs and the Date of Diagnosis is confirmed as earlier than previously reported, the registrar should contact FCDS to update the Date of Diagnosis.
7. Refer to the list of “Ambiguous Terms” in Section I for language that represents a diagnosis of cancer. This list should be used for both clinical and pathological first confirmation of cancer.
8. The date of diagnosis based on a pathology report should be the date the specimen was taken, not the date the pathology report was read or created.
9. The date of death is the date of diagnosis for a *Class of Case* 38 (diagnosed at autopsy) - NAACCR Item #610. However, if the patient is suspected of having cancer prior to death/autopsy and the autopsy simply confirms the presence of malignancy, the date of the first diagnosis for the suspected malignancy should be used. These patients were not actually diagnosed at autopsy, but rather the suspected cancer was confirmed at the time of death when the autopsy was performed.
10. For patients diagnosed prior to the date of first contact with the reporting facility, record the date of diagnosis as given in the medical record. This can usually be found in the patient history or in a resection, laboratory, or consultation report.
11. Suspicious Cytology should never be used as a basis for diagnosis when ‘suspicious’ or other ambiguous terms are used. Ambiguous cytology is not diagnostic of cancer. Any suspicious cytology must be confirmed by biopsy, resection or a statement by the physician that the patient has cancer. Cytology is the examination of cells rather than tissue. This would include sputum smears, bronchial brushings, bronchial washings, prostatic secretions, breast secretions, gastric fluids, spinal fluid, peritoneal fluid, urinary sediment, and cervical and vaginal smears. This does not include FNA. Use the date of clinical, histologic, or positive cytologic confirmation as the date of diagnosis.
12. Positive tumor markers alone are usually not diagnostic of cancer. There are rare exceptions that may use a combination of clinical and laboratory tests to confirm a diagnosis. For example, the combination of a positive digital rectal exam or DRE plus an elevated PSA for prostate cancer can be used as a clinical diagnosis of prostate cancer. These are rare exceptions. In most cases, you will still use the date of imaging, histologic, or positive cytologic confirmation as the date of diagnosis.
13. If a date is not recorded and if the patient was seen at the reporting facility within one month of the diagno-

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sis then the date of first contact may be used as the date of diagnosis.

14. If a date is not recorded and if the date of the first cancer-directed therapy or treatment is known then the date of the first cancer-directed therapy or treatment may be used as the date of diagnosis.
15. Treatment dates may not be coded to unknown.
16. When a diagnosis of cancer is made during the patient's long-term stay for another condition, adjust the date of first contact as outlined under Date of First Contact.
17. If the only information is "Spring of," "Middle of the year," "Fall," approximate these as April, July, and October, respectively. For "Winter of," it is important to determine whether the beginning of the year or the end of the year is meant before approximating the month.
18. If the only information is "recently," the date of diagnosis should be estimated as one month prior to month and year of admission. You may estimate the day as the 15th of the month.
19. If the only information is "several months ago," the date of diagnosis should be estimated as three months prior to the month and year of admission. You may estimate the day as the 15th of the month.
20. Use the actual date of diagnosis for an in utero diagnosis (For cases diagnosed before January 1, 2009, assign the date of birth).
21. In the absence of a definitive diagnosis date for patient undergoing first course therapy at the reporting facility the date of first cancer-directed therapy may be recorded as the date of diagnosis.
22. **If the year of diagnosis cannot be identified, the year of diagnosis MUST be approximated based on information from the H&P. Only the month and day of diagnosis can be left blank/coded "unknown".**
23. If a registrar wants to estimate month and day – they can decide whichever dates best suit the case.

24. FINAL RESORT FOR ESTIMATING DATE OF DIAGNOSIS WHEN NO INFORMATION OR HINTS FOUND:

- a. Always take into account the chronology of previous diagnosis of cancer and adjust the below recommendations to take the age of the patient and the chronology of diagnoses into account.
- b. FCDS Cancer Site-Specific Estimates when no information available except 'history of xyz cancer'. The below estimates are suggestions for a date of diagnosis of last resort and must take the chronology of the other cancers, initial course of therapy, and other factors into account.
- c. FCDS Cancer Site-Specific Estimates are loosely based on the Multiple Primary Rules, estimated time to recurrence or progression, expected lifespan, and/or FCDS Experience applying the Multiple Primary Rules over many years and as available. These estimates are far from perfect and must always be used with caution taking into account all other factors available in the patient's age and medical history.
 - i. Head and Neck Sites – at least 3 years prior to admission

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- ii. Colon/Rectosigmoid/Rectum Sites – at least 5 years prior to admission
- iii. Lung – at least 3 years prior to admission
- iv. Kidney – at least 5 years prior to admission
- v. Cutaneous Melanoma – at least 1 year prior to admission
- vi. Breast – at least 5 years prior to admission
- vii. GYN Sites – at least 5 years prior to admission
- viii. Urinary Sites – at least 3 years prior to admission
- ix. Prostate – at least 5 years prior to admission
- x. Malignant Lymphoma – at least 3 years prior to admission
- xi. Chronic Leukemia – at least 5 years prior to admission
- xii. Myeloproliferative/Myelodysplastic Neoplasms – at least 5 years prior to admission AND diagnosed after 2001 which is the year these cancers became reportable to FCDS
- xiii. Benign Brain Tumors – at least 5 years prior to admission AND diagnosed after 2004 which is the year these cancers became reportable to FCDS.
- xiv. Malignant Brain Tumors – at least 1 year prior to admission
- xv. Other Sites – at least 5 years prior to admission

Date of Initial Diagnosis – Estimating a Best Date of Diagnosis	
Spring	Use April (04) for the month
Summer	Use July (07) for the month
Fall/Autumn	Use October (10) for the month
Winter	Determine if this means the beginning or the end of the year. Use December (12) or January (01) for the month as determined.
Early in Year	Use January (01) for the month
Middle of Year	Use July (07) for the month
Late in Year	Use December (12) for the month
Recently	Use the year and month of admission and leave the day blank. If patient was admitted during the first week of a month, use the previous month.
Several Months Ago	If the patient was not previously treated or if first course treatment started elsewhere was continued at the reporting facility, assume the case was first diagnosed three months before admission with day unknown (blank).
A Couple of Years	Code to two years earlier
A Few Years	Code to three years earlier



CDC/NPCR Registry of Distinction And NAACCR Gold Certification

We are very proud and happy to announce that the Florida Cancer Data System has been recognized nationally by the Center for Disease Control and Prevention's National Program of Cancer Registries as a "2018 Registry of Distinction". We are one of only twenty two states to achieve this designation.

Due to the high quality of our data, Florida received the "U.S. Cancer Statistics Registry for Surveillance" designation which represents Florida's inclusion in the CDC/NCI SEER USCS national dataset.

Additionally, the Florida Cancer Data System has been recognized nationally at the highest level of certification, NAACCR GOLD, for the 17th consecutive year. We officially received the certification on June 12th in Vancouver, BC at the NAACCR Annual Conference.

This does not happen by accident. This is a team effort between the FCDS, University of Miami, DOH and all of our reporters around the state. FCDS would like to personally thank each of you for all your hard work and dedication to what we do. Through all your efforts, you have made and continue to make Florida one of the top registries in the country.

You all are truly incredible. Thank you!!





QUESTIONS? ANSWERS. and CLARIFICATION

THYMOMA, MALIGNANT

Question:

A thymoma diagnosed 02/12/18 and according to FCDS DAM as of 01/01/18 these are to be reported as thymoma, malignant.

ICD-O-3 histology/behavior as 8580/3.

Getting this edit:

- Edit Name: Histology ICDO3, Behavior ICDO3 (FCDS)
- Edit Message: 0189: If Histol ICDO3 = 8580, Behavior [3] is usually 0 or 1.
- Edit #0189: If Histology ICDO3 = Behavior ICDO3 8580/ is usually benign or borderline.

Please let me know what is going on with this? Has the edit been updated.

Answer:

This is an override-able edit. Just document the histology and submit the case with behavior = 3. Apparently, after a lot of discussion about making all of the thymoma cases malignant beginning in 2018 – this never actually was approved by the ICD-O-3 work group of NAACCR – but, we have been telling registrars to code them all as malignant starting in 2018 – so, that is what we are staying with. Below is the WHO Table and they are all /3. We will set the override at FCDS.

Thymoma	
Type A thymoma, including <i>atypical variant</i>	8581/3*
Type AB thymoma	8582/3*
Type B1 thymoma	8583/3*
Type B2 thymoma	8584/3*
Type B3 thymoma	8585/3*
Micronodular thymoma with lymphoid stroma	8580/1*
Metaplastic thymoma	8580/3
Other rare thymomas	
Microscopic thymoma	8580/0
Sclerosing thymoma	8580/3
Lipofibroadenoma	9010/0*

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QUESTIONS? ANSWERS. and CLARIFICATION

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LUNG MICROINVASIVE/LEPIDIC

Question:

1/18/18 WEDGE RESECTION LEFT LOWER LOBE LUNG-MICROINVASIVE 1.3CM TUMOR, LEFT LOWER LOBE, GRADE 1, WD, ADENOCARCINOMA WITH PREDOMINANTLY LEPIDIC PATTERN, pT1mIN0 by path

Is there a combo code for microinvasive with adenocarcinoma predominantly lepidic pattern? I used code 82503 for predominantly lepidic

Was not clear if the new microinvasive code was only for mucinous adenocarcinomas of the lung.

Answer:

Histologically you are looking at a grade 1 adenocarcinoma with predominant lepidic pattern – code 8250/3 grade 1.

If you were to use the code 8256/3 (minimally invasive non-mucinous adenocarcinoma) you would lose the lepidic predominant component – but, the code technically would still be correct. But, you really do want to capture the predominant lepidic pattern more than just non-mucinous which would be more of an NOS term.

LUMPECTOMY SURGICAL CODE 22 VS. 23 2017 CASE

Question:

I have a lumpectomy case where the operative report states lumpectomy, the path report has re-excision of multiple margins during lumpectomy procedure. What is the appropriate code to use for this case and why?

Answer:

Either is just fine since both code 22 and 23 are in the 20-29 series indicating they are some type of partial mastectomy but less than a total mastectomy. My opinion is that the sub codes under one rubric are all similar enough that any of the codes are supported even if you cannot distinguish – any of them will work – even 20 for NOS. I don't worry about difference between 22 and 23. The 'most correct' answer is 23.

RECONCILIATION LIST

Question:

I am trying to submit an AHCA Disposition 07 with what I think is a valid FAC/ACC/SEQ but my hospital database shows this case was transmitted to FCDS, already. What do I do in this case?

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QUESTIONS? ANSWERS. and CLARIFICATION

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Answer:

We do not have this full explanation in the FCDS DAM partly because it is long and can be a bit confusing – but, also because it helps us to encourage direct communication between our reporting facilities and our central registry staff Field Coordinators when questions arise.

Let me start off by telling you that the data we get from AHCA is very limited. Hospitals send AHCA their Diagnosis, Procedures, and Financial Data from patient billing (not medical records) and sometimes the registrar does not have access to all of the billing information when they abstract the case (particularly SSN) – but the SSN is sent to AHCA. FCDS does not use any of the AHCA financial data per our agreement with AHCA.

AHCA does not provide a patient name – not even initials – no name at all. We do get a SSN from AHCA – but, sometimes the registrar does not have access to the SSN when they abstract the case so they enter 999s in the SSN field – so, the SSN does not match between AHCA and FCDS. We do get a Date of Birth and Sex – which may not match with what was abstracted but may be updated. So, the matching process has its limitations.

We usually do pretty well matching cases between AHCA and FCDS with just the 3 variables that AHCA sends to us – SSN, DOB and Sex. But, trying to match cases using only these 3 variables limits our ability to accurately match *all* cases between AHCA and FCDS. Some registrars have no access to SSN when abstracting – but, the billing department does get the SSN and does send SSN to AHCA – then the SSNs don't match up and we have to try to match cases using only a DOB and Sex. Obviously, this limits our capabilities to match cases using just DOB and Sex. The registrars access to a valid SSN affects some facilities more than others...some facilities have very low matching results and some have very high matching results.

We also have limitations with matching FAC/ACC/SEQ as there are times when FCDS finds that the case submitted more recently with a 'new' FAC/ACC/SEQ had been previously reported to FCDS with a different FAC/ACC/SEQ that may/not be in the facility database for various reasons.

The original (old) abstract ACC# may go back as far as 1981 which is our state reference date – and the state reference date is frequently not the same as the hospital reference date – so, you might not have the old abstract in your database – but, FCDS does have the old accession number – and we update the accession number to the old number – never to the new number – to stay consistent with a policy that once a case is sent to FCDS – we keep the old accession number and only update the sequence number when we get a new primary cancer. This causes confusion when hospitals change their reference date with CoC – but, the reference date with FCDS stays 1981 and we have the old abstracts under an old ACC#.

When a 'no match' occurs it indicates that FCDS either never received the case or when FCDS processed the abstract we did not find that it did not match the AHCA data or did not meet reporting criteria from documentation in the abstract – and you need to review the abstract and figure out why a case didn't match or if FCDS might have

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QUESTIONS? ANSWERS. and CLARIFICATION

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deleted it or changed ACC# to the old ACC# and only updated the FCDS SEQ #.

Cases may have been submitted and later deleted at FCDS. These may require that you fix the documentation and/or coding and resubmit the case...or we have the old or a different ACC# and the FAC/ACC/SEQ does not match – sometimes this is just the sequence number, sometimes the whole accession number changes for some reason...or it is possible the case had been sent previously under a different accession number and did not match. And, sometimes the facility submits more than one abstract for the same case and we delete one ACC and keep another. This should always be communicated back to the facility as to which case FCDS retains with instruction for the hospital to delete the other duplicate case.

So, AHCA unmatched cases can get kicked back for various reasons. And, they need research to figure out what happened and might need to be ‘cleared’ with the help of a phone call to Edith to see why it was not accepted or never got sent to FCDS but were marked as sent in your database.

The FCDS Field Coordinator should work with you to clear questionable cases and can help you figure out why we didn’t get a case or identify whether or not the abstract was deleted for some reason or that we never even got it – but, it is still marked in your system as ‘sent’.

Long answer but several moving parts – hope this helps you understand the process and matching and follow-back and how it can seem ‘glitchy’ at times...but, it is imperfect and always will be since AHCA does not have patient names to help the matching and because we have various reasons why the FAC/ACC/SEQ may not match up due to old ACC numbers prior to your reference date versus FCDS reference date and Duplicated cases with different accession numbers get sent to FCDS and we deleted one but forgot to tell you what we did or the facility did not follow-thru to delete the case and causes a discrepant match between our two databases (yours and FCDS’).

HEMATOPOIETIC CASES

Question:

I remember a rule that we should report all hematopoietic and lymphomas, even if they are “in remission” or “ned”. Is that correct thinking?

Answer:

Your statement is a bit too broad and general as the ‘rule’ does not apply to ALL lymphoid and myeloid neoplasms – only the chronic ones. Some chronic lymphoid/myeloid neoplasms cannot just be identified by their name – but, they are definitely chronic conditions and always reportable.

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QUESTIONS? ANSWERS. and CLARIFICATION

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So, we have chronic conditions in both areas. They may go into a clinical remission but are never totally disease free. They may ‘smolder’ and not change much over time...or, they may ‘recur’ or ‘transform’ into another chronic neoplasm condition or even transform into an acute leukemia. Most of the ‘chronic’ neoplasms are myeloid not lymphoid neoplasms. The primary chronic lymphoid neoplasm is chronic lymphocytic leukemia.

Examples: Chronic lymphoma - CLL – 9823/3 (which is a chronic leukemic phase of lymphoma). Chronic myeloid conditions that fall into several categories including the myeloproliferative neoplasms (MPN) like polycythemia vera, essential thrombocythemia or primary myelofibrosis - PLUS the myelodysplastic syndrome neoplasms (MDS) - PLUS the neoplasms that are classified as unclassified or ‘mixed’ MPN/MDS like 9975/3 (myelodysplastic/myeloproliferative neoplasm, unclassifiable - PLUS the chronic myeloid leukemia’s 9863/3, 9875/3, 9876/3, 9945/3 and 9946/3.

There are a few additional chronic leukemias that are classified under the myeloproliferative neoplasms like 9964/3 (chronic neutrophilic leukemia) and 9964/3 (chronic eosinophilic leukemia, NOS) – but these can be identified more easily because they include the word ‘chronic’. Also, some of the plasma cell neoplasms are treated as ‘chronic’ conditions – but, many solitary plasma cell neoplasms may actually be ‘cured’ and are NED.

There are tables in Appendix B of the Hematopoietic and Lymphoid Neoplasms Coding Manual published in 2018 and include below for reference. These include Tables B1-B5 plus a few conditions listed as ‘chronic’ in other Tables in Appendix B – but, Tables B1-B5 are the easiest to reference. But, they do not include the chronic lymphocytic leukemia code as these are lymphoid neoplasms not myeloid...and appear with the lymphomas.

(Continued on page 16)



QUESTIONS? ANSWERS. and CLARIFICATION

Table B1: Myeloproliferative Neoplasms

WHO Preferred Term	ICD-O
Chronic eosinophilic leukemia, NOS	9964/3
Chronic myelogenous leukemia, <i>BCR-ABL1</i> -positive	9875/3
Chronic neutrophilic leukemia	9963/3
Essential thrombocythemia	9962/3
Myeloproliferative neoplasm, unclassifiable	9975/3
Polycythemia vera	9950/3
Primary myelofibrosis	9961/3

Table B2: Mastocytosis

WHO Preferred Term	ICD-O
Aggressive systemic mastocytosis	9741/3
Cutaneous mastocytosis	9740/1
Indolent systemic mastocytosis	9741/1
Mast cell leukemia	9742/3
Mast cell sarcoma	9740/3
Systemic mastocytosis with an associated hematological neoplasm	9741/3

Table B3: Myeloid/Lymphoid Neoplasms with eosinophils and gene rearrangement

WHO Preferred Term	ICD-O
Myeloid/lymphoid neoplasms with <i>FGFR1</i> rearrangement	9967/3
Myeloid/lymphoid neoplasms with <i>PDGFRA</i> rearrangement	9965/3
Myeloid/lymphoid neoplasms with <i>PDGFRB</i> rearrangement	9966/3

Table B4: Myelodysplastic/Myeloproliferative Neoplasms

WHO Preferred Term	ICD-O
Atypical chronic myeloid leukemia, <i>BCR-ABL1</i> -negative	9876/3
Chronic myelomonocytic leukemia	9945/3
Juvenile myelomonocytic leukemia	9946/3
Myelodysplastic/myeloproliferative neoplasm, unclassifiable	9975/3
Myelodysplastic/myeloproliferative neoplasm with ring sideroblasts and thrombocytosis	9982/3

Table B5: Myelodysplastic Syndromes

WHO Preferred Term	ICD-O
Myelodysplastic syndrome with isolated del(5q)	9986/3
Myelodysplastic syndrome, unclassifiable	9989/3
Myelodysplastic syndrome with single lineage dysplasia	9980/3
- Refractory neutropenia	9991/3
- Refractory thrombocythemia	9992/3
Myelodysplastic syndrome with excess blasts	9983/3
Myelodysplastic/myeloproliferative neoplasm with ring sideroblasts and single lineage dysplasia	9982/3
Myelodysplastic syndrome with multilineage dysplasia	9985/3
Refractory cytopenia of childhood	9985/3

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QUESTIONS? ANSWERS. and CLARIFICATION

DESMOID TUMOR

Question:

Are all Desmoid tumors benign? I am looking at a case with abdominal desmoid tumor 2013 with multiple chemo, Gleevec, Doxorubicin, Sorafenib. Now has desmoid tumor adjacent to Lt Kidney and additional tumors in abdomen, not surgical resection for any of these tumors, back on Doxorubicin.

There is no histology code for Desmoid Tumor, so I am assuming not malignant, but want to make certain.

Answer:

Desmoid tumors are almost always benign/borderline fibrous tumors. But, they have a /1 (borderline) behavior in the ICD-O-3 Histology Codes. They are often called 'fibromatosis'. But, they can occasionally become quite aggressive and are then classified and treated as malignant neoplasms. They can even metastasize to other parts of the body...and can be fatal. Desmoid tumors arise from the musculoskeletal connective tissue (tendons, ligaments, muscle or bone) and most often appear in the connective tissue of the arms, legs, or head & neck region. They can also be found in the colon and abdomen in patients with Gardner's Syndrome or familial adenomatous polyposis (FAP), a genetically inherited type of colon cancer. And, they are also associated with pregnancy as they are

found to grow in women with excess levels of estrogen during pregnancy. They are known to recur locally with some frequency – but, the 'recurrences' are still benign/borderline malignant in most cases. Because, they are most often benign/borderline tumors, they are usually not reportable. This is true unless/until they become aggressive/malignant or metastasize to other parts of the body...and are then life-threatening and reportable neoplasms. In these rare cases of malignant transformation you change the histology/behavior from 8821/1 to 8821/3 using the ICD-O-3 Matrix Principle & you should abstract and report the case as a malignant tumor.

DIFFUSE INTRINSIC PONTINE GLIOMAS (DIPG)

Question:

We have had a community cancer concern regarding Diffuse Intrinsic Pontine Glioma (DIPG) for several years from a father who lost a child to this awful brain cancer. In 2017, there was no histology code, they were all categorized within malignant gliomas, NOS (9380/3). I decided to check the 2018 errata for ICD-O, and I see Diffuse Midline glioma, H3 K27M-mutant. (9385/3). Do you know if this is it? DIPG?

Answer:

The ICD-10-CM code for these is C71.7 – The code is for brain stem malignant neoplasms - but, it is not specific to DIPG. So, that is no help.

These neoplasms are confined to the pons of the brain which links the medulla to the thalamus. This is all brainstem in a general sense (C71.7). But, coding of the primary site could possibly be an issue

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QUESTIONS? ANSWERS. and CLARIFICATION

(Continued from page 17)

if the registrar assigned a primary site code of; brain, NOS (C71.9), overlapping brain (C71.8) or thalamus (C71.0).. But, it should be coded to C71.7 in all cases.

Usually found in kids – but, adults can have this tumor with the same mutation.

My concern for histology for old cases would be use of glioma, NOS or glioblastoma multiforme since these are high-grade gliomas.

My concern for the histology for new cases would be in the absence of the ‘H3 K27M-mutant’ annotation or the use of the term “diffuse midline glioma’ instead of ‘diffuse intrinsic pontine glioma’. That said, most of these cases would be seen at a Children’s hospital.

If the staff at any children’s hospital is aware of the new histology code (9385/3) for C71.7 (pons or brainstem) there should be good data capture. Otherwise, they may need additional reviews to make sure all of these tumors are correctly coded as C71.7 with histology 9385/3 and term ‘diffuse intrinsic pontine glioma’ in the medical record.

But, to answer your question – yes, we do have a new code and yes, we need to be sure that registrars working with pediatric records know this.

CODING MALIGNANT FIBROUS HISTIOCYTOMA (MFH) AND ANGIOSARCOMA - PRIMARY SITE AND TNM STAGING

Question:

I have a bx spindle cell of scalp but it won’t allow me to stage it. I looked it up, it looks like it can be done but it won’t stage. The surgical path states FAVOR MALIGNANT FIBROUS HISTIOCYTOMA. I have tried coding the primary site to C44.4 and C49.0 and the histology to spindle cell sarcoma and MFH. But, I am not sure if this is correct and I cannot assign TNM to the case with any of the site/histology combinations. Can you please clarify.

Answer:

This is a sarcoma (malignant fibrous histiocytoma) of the soft tissue of the scalp – not skin of scalp and not spindle cell carcinoma – it is sarcoma. This is considered “Other Soft Tissue Sarcoma of Head & Neck – and there is not a chapter in AJCC TNM 7th or 8th edition for this site/histo combination. Chapter 40 has specific criteria for AJCC TNM Staging and this histology is not to be included in staging. Code the primary site to C49.0 with histology 8830/3. The only stage you can assign is SS2018 – unless your facility voluntarily collects EOD (not a Florida requirement).

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QUESTIONS? ANSWERS. and CLARIFICATION

(Continued from page 18)

Primary Site	Histology	AJCC ID	Description
C000-C148, C150, C153, C158, C300-C329, C470, C490, C722, C724-C725, C739, C750-C755, C758-C759	8711, 8800-8802, 8810-8811, 8815, 8825, 8832-8833, 8840, 8850, 8852, 8854, 8858, 8890, 8901, 8912, 9040-9041, 9043, 9133, 9136, 9180, 9251, 9364, 9540, 9542, 9561, 9580	40	Soft Tissue Sarcoma of the Head and Neck
C470, C490	8000-8700, 8720-8790, 9700-9701	XX	Other Soft Tissue Sarcoma of the Head and Neck
C000-C148, C150, C153, C158, C300-C329, C470, C490	8710, 8712-8714, 8803, 8812-8814, 8820-8824, 8826-8831, 8834-8836, 8841-8842, 8851, 8853, 8855-8857, 8860-8881, 8891-8898, 8900, 8902-8905, 8921, 8932-8934, 8950-8973, 8975, 8981, 8983-8990, 9000-9016, 9030, 9042, 9045-9110, 9121-9132, 9135, 9137, 9141-9175, 9181-9230, 9240-9250, 9252-9363, 9365-9539, 9541, 9550-9560, 9562-9571, 9582	XX	Other Soft Tissue Sarcoma of the Head and Neck

NAACCRv16 No Longer Accepted in IDEA

FCDS will no longer accept cases in the NAACCRv16 format on 8/1/2019.

Only NAACCRv18 formatted cases will be accepted 8/1/2019 and later.

FCDS made special allowances to continue allowing the submission of cases diagnosed/treated before 1/1/2018 in NAACCRv16 format for an additional 12 months after the June 30 Annual Deadline (6/30/2018 for all 2017 cases) to allow registrars to get caught up with these old cases and to allow them to access FCDS while they waited for v18 compliant software. This allowed these cases to be submitted up to 2 years after deadline.

The old cases are just trickling in now. So, we have decided there is no longer a reason to keep v16 uploads available.

- Everybody should have fully function v18 software by now...and should be sending cases to FCDS on a regular basis.
- All cases submitted 8/1/2019 and later must be submitted in NAACCRv18 and must pass all of the latest FCDS EDITS.
- FCDS will be closely monitoring the 2018 AHCA/Mortality and Other Follow-Back to keep track of any missed 2018 cases.
- The FCDS Deadline for Reporting ALL 2018 cases is 3/31/2020.

Thank you for your compliance

New ICD-10-CM Codes for 2019 Casefinding - AHCA and Mortality

ICD-10-CM New Diagnosis Codes Added for Reportable Tumors – Oct 1, 2018 and later encounters

Please add these NEW ICD-10-CM Diagnosis Codes to your Annual Casefinding List. The new codes are effective for 10/1/2018 and later patient encounters. The International Classification of Disease is the international “standard diagnostic tool for epidemiology, health management and clinical purposes” and is used worldwide to codify Diseases and Related Health Problems to bill for services, cause of death coding, and research.

The United States version of ICD-10 Clinical Modification or ICD-10-CM is used by healthcare providers across the U.S. to codify diseases including cancer and is updated every year. New codes are added effective October 1st for the following year. FCDS also uses these codes for Casefinding Audits such as AHCA and Mortality during our annual follow-back procedures to identify cases of cancer missed or otherwise not reported to FCDS.

SEER recommends additional codes for Casefinding including a small number of codes that FCDS does not require PLUS a long list of Supplemental Codes that the SEER Program recommends be added to the required cancer diagnosis codes for conditions that may indicate a patient has cancer.

The complete list of cancer diagnosis codes that SEER publishes (<https://seer.cancer.gov/tools/casefinding/>) includes codes for “unspecified malignant neoplasms of the skin” that FCDS does not require. These codes rarely result in new/missed reportable-to-FCDS skin cancers. FCDS does not require you to casefind any of the codes not listed in the FCDS DAM or included in this list of new (additional) codes for Florida Reporting.

NOTE: Most reportable skin cancers have their own specific series of ICD-10-CM codes outside the C44.* (skin cancer) rubric unless otherwise specified. For example; Malignant Melanoma of the skin falls under the rubric of C43.* and D03.* not C44.*. Merkel Cell Carcinoma of the skin falls under the rubric of C4A.* not C44.*. Kaposi sarcoma falls under the rubric of C46.* not C44.*. and Lymphoma of the skin falls under the rubrics of C84.* and C84.A* for cutaneous lymphoma and mycosis fungoides. Basal and Squamous cell carcinoma of the skin is coded under C44.* and are not reportable to FCDS.

For a complete list of ICD-10-CM Required by FCDS Codes for Casefinding please reference Section I of the FCDS DAM (short list) and Appendix O (detailed list). FCDS will be publishing a 2019 Update to the FCDS DAM that will include all required ICD-10-CM Codes for Casefinding. In the meantime, please add the codes to your casefinding list for 2019 reporting.

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EDUCATION AND TRAINING

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General Category	Type	ICD-10-CM Code Specific	ICD-10-CM Code Definition
Malignant neoplasm	Reportable	C43.111	Malignant melanoma of right upper eyelid, including canthus
Malignant neoplasm	Reportable	C43.112	Malignant melanoma of right lower eyelid, including canthus
Malignant neoplasm	Reportable	C43.121	Malignant melanoma of left upper eyelid, including canthus
Malignant neoplasm	Reportable	C43.122	Malignant melanoma of left lower eyelid, including canthus
Sebaceous cell carcinoma of skin	Reportable	C44.13	Sebaceous cell carcinoma of skin of eyelid, including canthus
Sebaceous cell carcinoma of skin	Reportable	C44.131	Sebaceous cell carcinoma of skin of unspecified eyelid, including canthus
Sebaceous cell carcinoma of skin	Reportable	C44.132	Sebaceous cell carcinoma of skin of right eyelid, including canthus
Sebaceous cell carcinoma of skin	Reportable	C44.1321	Sebaceous cell carcinoma of skin of right upper eyelid, including canthus
Sebaceous cell carcinoma of skin	Reportable	C44.1322	Sebaceous cell carcinoma of skin of right lower eyelid, including canthus
Sebaceous cell carcinoma of skin	Reportable	C44.139	Sebaceous cell carcinoma of skin of left eyelid, including canthus
Sebaceous cell carcinoma of skin	Reportable	C44.1391	Sebaceous cell carcinoma of skin of left upper eyelid, including canthus
Sebaceous cell carcinoma of skin	Reportable	C44.1392	Sebaceous cell carcinoma of skin of left lower eyelid, including canthus
Malignant neoplasm	Reportable	C4A.111	Merkel cell carcinoma of right upper eyelid, including canthus
Malignant neoplasm	Reportable	C4A.112	Merkel cell carcinoma of right lower eyelid, including canthus
Malignant neoplasm	Reportable	C4A.121	Merkel cell carcinoma of left upper eyelid, including canthus
Malignant neoplasm	Reportable	C4A.122	Merkel cell carcinoma of left lower eyelid, including canthus
In-situ neoplasm	Reportable	D03.111	Melanoma in situ of right upper eyelid, including canthus
In-situ neoplasm	Reportable	D03.112	Melanoma in situ of right lower eyelid, including canthus
In-situ neoplasm	Reportable	D03.121	Melanoma in situ of left upper eyelid, including canthus
In-situ neoplasm	Reportable	D03.122	Melanoma in situ of left lower eyelid, including canthus

EDUCATION AND TRAINING

NAACCR 2018-2019 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 2018-2019 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
*10/4/18	Collecting Cancer Data: Lung
*11/1/18	Collecting Cancer Data: Pharynx
*12/6/18	Collecting Cancer Data: Breast
*1/10/19	Collecting Cancer Data: Testis
*2/7/19	Solid Tumor Rules
*3/7/19	Abstracting and Coding Boot Camp: Cancer Case Scenarios
*4/4/19	Collecting Cancer Data: Hematopoietic and Lymphoid Neoplasms
*5/2/19	Collecting Cancer Data: Neuroendocrine Tumors
*6/6/19	Collecting Cancer Data: Ovary
*7/11/19	Hospital Cancer Registry Operations - Topic TBD
8/1/19	Collecting Cancer Data: Colon
9/5/19	Coding Pitfalls

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

Seven Florida facilities will host the 2018-2019 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 2018
FCDS Annual
Conference:**

CE Hours: 8.25
5.5 Hrs Category A

NCRA Recognition
Number: 2018-143

**CEU information
for the 2017
FCDS Annual
Conference:**

CE Hours: 9.5
3.75 Hrs Category A

NCRA Recognition
Number: 2017-088

NAACCR CTR Exam Preparation & Review Webinar

NAACCR CTR Exam Preparation & Review Webinar Syllabus (1/8/2019-2/26/2019)

Note: This series is offered in Preparation for the October 2019 CTR Exam Window (10/11/2019-11/2/2019)

In keeping with FCDS' long-standing commitment to provide Florida registrars with opportunity for early and continuing education and our collaboration with FCRA to "Grow CTRs in Florida", FCDS is pleased to announce a special NAACCR Webinar Series offered to Florida Candidate CTRs who plan to sit for the CTR Exam during the **10/11/2019-11/02/2019 CTR Exam Testing Window**. Please note that the 2019 CTR Examination will be based on the 2018 U.S. Standards for cancer registries.

The NAACCR CTR Exam Preparation and Review Webinar Series is being offered free of charge to Florida Candidate CTRs via special arrangement with NAACCR. Florida registrants may not be able to attend the "live" sessions - depending upon total number of registrations.

You will have full access to next-day recordings of all eight 2-hour webinar sessions to view at your leisure. You will also have full access to all course materials including presentations, handouts, quizzes, practice exercises, and more. Moreover, you will have full access to the course instructors for Q&A.

The series was updated to follow the 2019 CTR Exam content described in the 2019 CTR Examination Candidate Handbook available on the NCRA Website. The course includes a practice test and a post-test follow-up session to discuss how well you tested. The complete syllabus is below.

A special registration portal is available on the FCDS NAACCR Webinar Registration Site. All FCDS-sponsored participants must register on the FCDS website - first. Following registration with FCDS you will need to set up a MyNAACCR Account on the NAACCR website. This and email will be the mechanism for webinar communications.

If you try to register for this course directly through NAACCR you will be required to pay the \$195/subscription fee for the "live" course. FCDS-sponsored participants must register directly through FCDS using the FCDS registration portal and the link provided below. Again, FCDS will cover the cost for the course using the recorded sessions.

NOTE ONE: This is a CTR Exam Preparation Course. It is not an Introduction to Cancer Registry. Sessions are presented by experienced CTR instructors and include lectures, Q&A sessions, study materials, on-line discussions, interactive quizzes, and a timed CTR Exam practice test.

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NOTE TWO: This is not a starter or basics abstractor course. It is a review course for registrars who plan to write the CTR Examination. Please do not register for this series if you do not plan to sit for the CTR Examination. This frees up registration for actual candidate CTRs. Thank you.

Please contact Steven Peace, CTR at FCDS for more information on the course.

Please do not contact NAACCR directly to register.

Register at: https://fcds.med.miami.edu/scripts/register_naaccr_ctr_readiness.pl

DATE	TIME	TOPIC
*8/27/2019	1:30PM-3:30PM	Session 1: Introduction to the Exam Format; Registry Operations and Management; Central Registry Activities
*8/29/2019	1:30PM-3:30PM	Session 2: Data Collection: Casefinding,,Abstracting, Coding;
09/03/2019	1:30PM-3:30PM	Session 3: Data Collection: ICD-O-3 Coding; 2018 Solid Tumor Rules Hematopoietic and Lymphoid Neoplasm Coding
09/10/2019	1:30PM-3:30PM	Session 4: Data Collection: 2018 STORE Manual Anatomy & Physiology
09/17/2019	1:30PM-3:30PM	Session 5: Data Quality Assurance; Cancer Program Standards: Ensuring Patient-Centered Care
09/24/2019	1:30PM-3:30PM	Session 6: Analysis and Data Usage Follow Up, Survivorship & Outcomes
10/01/2019	1:30PM-3:30PM	Session 7: Data Collection: Staging AJCC 8 th Edition (3 rd Printing) & Summary Stage 2018
10/08/2019	1:30PM-3:30PM	Session 8: Timed Test; Overview; Test Taking Tips; Q&A

Florida Cancer Data System

Cancer Reporting Completeness Report



TOTAL NUMBER OF CASES IN THE FCDS MASTERFILE AS OF JUNE 30, 2019

Total number of *New Cases* added to the FCDS Master file in June 2019: **14,465**

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
2018	37,161	269	136	12,096	167	Pending	49,829	10,755
2017	204,960	7,700	211	12,462	19,848	Pending	245,181	3,542
2016	207,176	8,537	1,967	12,926	28,986	2,021	261,613	168
						<u>Actual</u>	<u>Expected</u>	
% Complete for:			2018	26%		100%		
			2017	100%		100%		
			2016	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 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.



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