Please Remember to Investigate All Cases and to Document and Code All Required Data Items

FCDS continues to see an increase in the use of defaults (9's or 'not available') among registrars in many of our registries for data items that registrars may have been misinformed as being 'unimportant' or 'not required' in order to save time during the catch-up of abstracting backlogs.

This includes required data items for both 'analytic' and 'non-analytic' cases. Many hospital 'non-analytic' cases are still 'analytic' for the state of Florida. This is why we require these cases be reported and why we continue to remind registrars and managers that all cases and all data items are important. They would not be required if they did not have value for researchers, administrators, students and other data users in our state.

FCDS requires the collection and reporting of ALL cases and ALL data items that meet the FCDS reporting requirements, regardless of Class of Case.

Every data item in the FCDS Required data set must be investigated and reported. Abstractors and Contractors MUST take the time to look for, code and document all required data items– even items you may think are a waste of time (smoking history, height/weight, SS2018, SSDIs, etc.)

FCDS is responsible for administering a high quality database that includes all required data items. And, we check facility 'analytic' and 'non-analytic' cases for overuse of defaults, unknown values, 9's and not available values as well as text documentation. Many facility 'non-analytic' cases are actually 'analytic' to the state…so, every data item for every case is important…please don't forget this in lieu of increased productivity.

(Continued on page 2)

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 EDITs Metafile
V18 Metafile,
posted on 10/25/2019.

FCDS/NAACCR WEBINAR SERIES:
NAACCR 2019-2020 Cancer Registry and Surveillance Webinar Series - Bladder and Kidney 2019 on 11/07/19, 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

(Continued from page 1)

Additionally, we continue to see overuse of NOS codes for primary site, histology and other incorrectly coded data items because folks are not using their manuals or trying to abstract quantity over quality. FCDS knows registrars are trying to catch up. But, please don't sacrifice data quality for productivity just to complete a specified number of abstracts in any given day. High quality data is the goal for any and all reported cancers.

You are responsible for providing complete high quality abstracts to FCDS and you must investigate, look for, code and document all data items that are required in the FCDS data set. And, your managers need to support the state requirements for abstracting and reporting cases to FCDS.

FCDS cannot meet our data quality goals when abstractors, registrars or managers do not provide FCDS with as complete and the highest quality data and documentation available in your medical records systems. Please continue to take pride in the work you do – productivity will follow.

SS2018 Manual

FCDS no longer collects AJCC TNM or SEER EOD. Therefore, SS2018 is the primary staging system used in our state registries, nationwide. Please take the time to use the SS2018 Manual to correctly assign SS2018 (SS2000 for older cases). We are finding many cases routinely coded to '9' unknown when it is clear the abstractor has staging information documented; but did not bother to look up the stage in the SS2018 Manual…or they just guessed the Summary Stage without looking it up in the manual. Please take care when assigning stage using SS2018 – and remember that benign/borderline brain tumors are always SS2018 = 8 (not 9).

Florida Cancer Data System Deadlines, Updates, & Reminders

National Cancer Registrars Association NCRA News

Help Field Test 12 New SSDIs!

The NAACCR Mid-Level Tactical Group (MLTG), which includes representatives from CoC, NAACCR, NCRA, NPCR, and SEER/IMS, now requires that field testing be done for proposed new data items, or major changes, before implementation in the registry field. This process will help standard setters evaluate the feasibility of collecting new data items and clarify codes and coding instructions before implementation. The MLTG strongly encourages participation in this effort, which will facilitate better communication with the registrars in the field and provide critical information to the groups working on these data items.

There are 12 new SSDIs being proposed for implementation in 2021.The field testing will provide information for clarification of codes and coding instructions; needed revisions and/or modifications; how often the information is available; and feasibility of implementing the new SSDIs.

The field testing will take place from 8 a.m. ET, November 1, 2019 to 12:00 a.m. ET, December 15, 2019. Participants must have access to the SEER reliability studies site during this period. Registration for Field Testing opened on October 15, 2019. Note that since the objectives of this field testing are to determine how well the new data items are understood, individual results will remain confidential and not released. Results will be de-identified before analysis. Questions? E-mail **Jennifer Ruhl** , Co-chair of the SSDI Work Group.

Florida Cancer Data System Deadlines, Updates, & Reminders

Status of October 2019

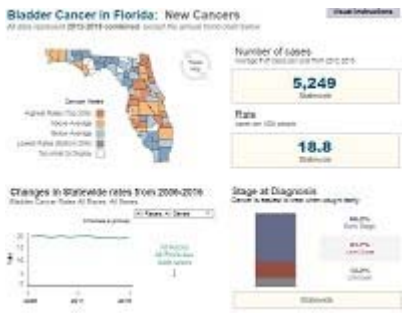
In mid-October, the FCDS launched a new data dashboard on the statistics page of the website. The purpose of this dashboard is to make statistics on the most commonly diagnosed cancers in Florida more accessible and understandable to the public. In addition to the data, the tool gives users the ability to hover over datapoints with their mouse and get more information. Informative details on each cancer are also shown in the 'Did you know?' section.

What statistics are included in the dashboard? A snapshot of statewide and county statistics are available for select new cancers, cancer deaths and stage of disease. Also included are statewide cancer trend data available dating back to 2006, which users can filter based on sex and race/ethnicity. An interactive map feature allows users to identify specific county data, and compare those rates to the rest of the state.

The display and visualization of data are important for deriving meaningful information from statistics. Often, interactive data tools in public health can require previous knowledge of the disease, the statistics utilized to track outcomes, as well as the specific terminology used to describe results. It became clear that while the FCDS already provides a platform for interactive rates and maps, there was a need for a more simplified and user-friendly version. It is our hope that this option enables greater use and understanding of the cancer data by the general public.

We at FCDS are proud to be nationally recognized for the completeness and quality of our data, which requires enormous effort to collect. It is extremely important that this information be available, accessible, AND understandable to *everyone* in the state.

Please share the dashboard with your colleagues and other stakeholders who can find this information useful.



https://fcds.med.miami.edu/inc/statistics_data_viz.shtml

QUESTIONS? ANSWERS. and CLARIFICATION

Clinical Grade

Question:
If the patient has a biopsy and then has resection of primary site – then clinical grade = biopsy grade and pathologic grade = resection of primary site grade?

If the clinical (biopsy) grade is higher than the pathological (resection) grade, we are to use the higher clinical grade in both grade fields?

Answer:
Clinical Grade and Pathological Grade – I am seeing lots of people who misunderstand the manual or don't bother to use the instructions because they never downloaded it and only use their software pull down menu and then guess the rules.

If the patient has a biopsy before resection of primary site or a biopsy without a resection of the primary site -- then clinical grade = biopsy grade (first grade identified)

If the patient has no biopsy but does have a resection of the primary then clinical grade = pathologic grade (first grade identified)

If the patient has biopsy and then has resection of primary site – then clinical grade = biopsy grade and pathologic grade = resection of primary site grade

Biopsy or resection of a metastatic site still can never be used as the specimen for coding grade – only code the grade of the primary site

Interesting Edit

Question:
Patient had an incidental meningioma noted on CT during workup for their GBM (glioblastoma multiforme). CTR had no further info on the meningioma, the GBM was resected, so the abstractor put the meningioma in the historical grid in the GBM full abstract. Follow-Up on the patient provided additional information on the menin-

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giom. Can we still put the meningioma in the historical grid or do we have to report a separate abstract for the glioblastoma and one for the meningioma?

Answer:
The later information provided clearly shows the meningioma was never treated, is still present, and has enlarge in 2018. Therefore, you must abstract a complete abstract for both the GBM and the Meningioma. Most meningiomas are not treated. They undergo active surveillance until/unless symptoms become problematic then they are resected. Therefore, history of meningioma should rarely be placed in the historical grid unless the patient has had surgery to remove it. For example, the additional information for this case included; "CT Head showing 4.3cm mass posterior left corona radiata likely reflecting hypercellular neoplasm, small meningioma 9mm along superior falyx cerebri. MRI Brain shows 4cm mass left trigonal/peri-trigonal region likely represents metastasis, crosses midline; 8mm mass left para falcine likely calcified meningioma. CT Abdomen/Pelvis with Chest showing no evidence of metastastis. CT Brain shows left cerebral mass with hemorrhage since prior exam and overall increase in size to 6cm." This clearly indicates the meningioma was never treated, is very active and growing and needs to be abstracted and reported as a full case. Historical Grid Cases MUST have NO EVIDENCE OF CANCER or they require a complete abstract.

Hematopoietic and Lymphoid Neoplasm Coding Manual, 2018

Question:
When the Primary Site is Multiple Lymph Nodes for a Lymphoma; Is the primary site coded C77.8 or C77.9?

Answer:
Primary Site should be coded C77.8 when multiple nodal chains/regions are involved (Stage II, III or IV). This is Rule PH21 in the Hematopoietic and Lymphoid Neoplasm Coding Manual last published in 2018 (attached). Not multiple lymph nodes but multiple nodal regions. C77.9 when primary lymph node but not sure which nodes involved…this is Rule PH22 in the Hematopoietic and Lymphoid Neoplasm Coding Manual – often usually the C77.9 cases are non-analytic or the site is coded per history from a physician – there are other circumstances for coding C77.9 also defined.

SEER changed the primary site rule to now allows us to code C80.9 instead of C77.9 for lymphoma, NOS – not to presume the lymphoma is primary of lymph nodes because more than 25% of lymphoma cases are actually extra nodal primary site…and the related edits have not yet caught up with this change…There is a rule PH27 for coding primary site C809 – this is very often confused with Rule PH21 when people don't use the manual.

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There are other problems that arise when coding C809 as well…so, it's really important to get these lymphoma primary sites coded correctly…and to not use C80.9 unless allowed.

Rule PH21 Code the **primary site** to lymph nodes of multiple regions (C778) when multiple lymph node regions, as defined by ICD-O, are involved and it is **not possible to identify the lymph node region where the lymphoma or one of the other neoplasms originated.**

Note 1: See Rule PH24 when there is also **organ** involvement.

Note 2: Do **not** simply code the site of a biopsy; use the information available from scans to determine the correct primary site. See Primary Site Coding Instructions for more information on coding primary site for lymphoma.

Note 3: See Appendix C for help identifying lymph node names, chains, regions, and codes.

Example 1: Cervical (C770) and intra-thoracic (C771) lymph nodes involved with B-cell lymphoma. No indication of site of origin. Code the primary site to lymph nodes of multiple regions (C778).

Example 2: Biopsy of an axillary lymph node (C773) confirmed lymphoma. CT scans showed involvement of the axillary lymph nodes (C773) and the pelvic lymph nodes (C775). No additional involvement was identified during the work-up and no indication of site of origin. Code the primary site to lymph nodes of multiple regions (C778).

Example 3: Documentation at diagnosis includes mediastinal lymphadenopathy, unilateral left sided pleural effusion, questionable left lung nodular abnormality, splenomegaly, thrombocytopenia, and nodes present above and below the diaphragm, pleural fluid involvement. Pericardial soft tissue abnormality. Code the primary site to lymph nodes of multiple regions (C778).

Rule PH22 Code the **primary site** to **lymph nodes, NOS** (C779) when the neoplasm presents in:

- An organ and lymph nodes that are **not** regional (distant lymph nodes only, no regional lymph node involvement) for that organ and the origin of the lymphoma cannot be determined even after consulting the physician **OR**
- Multiple organs and the regional nodes for all involved organs **OR**
  - **Note:** Does not include distant involvement (e.g., bone marrow involvement)
- Multiple organs and some combination of regional and distant nodes for the involved organs **OR**
- Lymph node(s) and involved organ(s) and no primary site/particular lymph node region is identified
  - **Note:** Use for history only or path only cases
- Lymph node(s) and no primary site/particular lymph node region is identified
  - **Note:** Use when no other information is available

Note 1: See Rule PH24 for involvement of an organ and its regional lymph nodes

Note 2: **Do not use this rule for extraosseous plasmacytomas (9734/3) or Langerhans cell histiocytosis (9751/3)**

Note 3: Lymphoma can spread from organs to regional lymph nodes, but does not spread from the organ directly to distant lymph nodes.

Note 4: See Appendix C for help identifying lymph node names, chains, regions, and codes.

Note 5: Lymphoma only: Use this rule when there is no available information concerning where the lymphoma originated, such as historical cases.

Example 1: The patient has positive mediastinal lymph nodes (C771) and cervical lymph nodes (C770) and involvement of the stomach (C169). No further information is available. Code to lymph node, NOS (C779).

Example 2: Lymphoma is found in both lymph nodes and bone marrow. The pathology report is not available to help determine the primary site and no further information can be obtained. Code to lymph nodes, NOS (C779).

Example 3: he patient has involvement of two extranodal sites and regional lymph nodes for only one of those sites. If the site of origin cannot be determined, code the primary site to lymph nodes, NOS (C779).

Example 4: The patient has a history of Stage II lymphoma. No other information is available. Code to lymph nodes, NOS (C779).

What are these new drugs?

Question:
Can you tell me what they are as far as chemo or BRM or hormone?

Asparis---chemo.

Gamifant---BRM.

Lutathera---hormone.

Answer:
Asparlas (not Asparis) is a cytotoxic chemo (it directly kills cancer cells) for acute lymphoblastic leukemia – B cell type (ALL) in kids and young adults to be used in combination regimen with other drugs like vincristine and cytarabine - not by itself. It is related to the drug L-asparaginase – it is a new generation version of this old drug that has been used for decades to treat ALL.

Gamifant is a type of interferon blocking antibody – so, yes – it is a BRM

Lutathera is a radionuclide therapy that uses 'dotatate' to target the attached Lu-177 radioisotope to a peptide receptor on the surface of NET tumor cells – for treatment of GI tract NETs including pancreas. This is actually a radiation therapy delivery system using the NET cell surface somatostatin/peptide receptor as the target and dotatate as the binding mechanism to attach the drug with attached Lu-177 radioactive isotope placing it directly on the NET cell surface target. The Lu-177 radioactive isotope as the actual treatment. It will likely be coded under radiation therapy – but might also need to be coded under BRM. PS – it only costs about $50K per dose…

Which code is correct?

Question:
Malig CNS Solid Tumor Rules in the Table has IDH-Wild Type as 9440/3 But in the row beside that it states IDH Mutant 9445/3. (what is the difference here, between Wild type and Mutation--Wild Type is the type of Mutation--correct?).

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QUESTIONS? ANSWERS. and CLARIFICATION

(Continued from page 8)

Answer:

Before we had the ability to do gene testing, we knew only that we could use the size and shape and arrangements of brain tumor cells to assign a WHO Grade which was associated with varying prognosis based on the WHO Grade of the neoplasm. IDH mutant positive/negative is a new and additional way to classify these neoplasms in addition to WHO Grade. It is also a potential new target for delivering drugs or radiation directly to GBM tumor cells either with or without the mutation. IDH gene mutation (positive/negative) is a better predictor of survival than WHO Grade.

"Wild-type" classifications of a gene indicates that the tumor cells do not have the specific gene mutation (IDH in this case). So, IDH wild type GBM are tumors that do not have the IDH Mutation.

GBM tumors with the IDH mutation are associated with the patient having a weaker natural immune response to the glioma which in turn reduces the aggressiveness of the GBM so patients live longer when they have the mutation. These patients can live 5-10 years with GBM.

GBM with unmutated IDH prompts a stronger natural immune response that actually increases the tumors aggressiveness and negatively impacts survival. These GBM tumors carry a much poorer prognosis with median survival of only about 18 months.

So, looking for this testing of IDH for GBM is really important to classify these tumors – huge differences in survival and different treatment plan.

They also hope that IDH can be a target for development of new drugs directed at the GBM cells to get them to convert to IDH mutant.

Question:

The non-analytic cases, how does this help a state for incidence? I'm thinking of patients who come to visit (happens a lot here), they end up in the hospital for whatever reason and someone mentions active cancer. You know all the treatment happened elsewhere….how does that help the state of FL? Seems like what we can give you is really junk, estimated dates and very general treatment codes. They didn't live in FL when they were diagnosed or treated. And when someone ends up in the hospital for something other than cancer, that mention of cancer is sometimes so minor to the actual reason for admission that all you get his history of prostate cancer….physicians are not delving into that prostate cancer because it is not relevant.

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QUESTIONS? ANSWERS. and CLARIFICATION

(Continued from page 9)

Answer:
The reason we have to support reporting analytic cases is multi-factorial…but, the primary reason is that it is because it is written into ours and other states' laws this way…and we have to abide by the legislation…diagnosed, treated, undergoing treatment, recurrence, progression, and death are all covered by the law. We also do data sharing with all other states in the country – so, this could be f/u for another state. Also, it helps hospitals know what kinds of patients they continue to see in patient care mix as many cancer care centers are secondary and tertiary care centers not primary care centers and the cost of treating advanced, recurring or progressive cancers are more than primary care…so, it ties into state financial picture for cancer care in the state. It is not only physicians who use our data for research. We also have state financial planners, facility planners, etc. All of these components go into the complete continuum of cancer care…so, these really are important cases in the big picture…not for the CoC which is focuses on current state of cancer care…but, the continuum of care.

Y90 Embolization

Question:
How are we to code Y90 liver embolization?

Do we code it to Radioisotopes NOS, or Interstitial Brachytherapy?

Answer:
Y90 can be used in different ways…But, usually it is used for tumor embolization may or may not be interstitial. Sometimes this is coded interstitial therapy and sometimes it is not – it depends on how the Y90 is placed and what the intent of placement may be…do they leave radiation source behind or do they use the radiation source to collapse the artery only. Embolization often will follow tumor ablation with RFA or other technique to treat the tumor and then cut off the blood/nourishment/oxygen source after the tumor has been ablated. Two terms that often get confused.

I probably confused things a bit further when I grouped all of the radioactive isotopes under 'systemic' when some are 'localized brachytherapy''.

The FCDS DAM p.118 describes embolization intent and agents including RFA – which is what Y90 is most often used for…and Ablation…

Most often Y90 is coded as targeted or localized brachytherapy and the modality is the radioisotope Y90.

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Y90 is introduced into an artery that feeds directly into the primary tumor – and it collapses the artery blocking any blood flow to the tumor – sometimes the beads trap radiation implanted behind the collapsed artery so the radiation keeps working along with the lack of blood flow to the tumor. Sometimes radiation is used only to collapse the artery instead of coils, alcohol, chemo or other 'plugs'.

Similar to tumor artery embolization with chemo drugs – they may push drugs into the organ then cut off the artery (both with chemo or perhaps with chemo and then alcohol to collapse the artery). And, it is important to keep ablation and embolization separate.

It is radiation embolization of tumor – usually these are liver tumors or kidney tumors that get embolization. I think I listed it with the other radioisotopes in my annual meeting slides – but, these are actually a different type of radiation delivery system with the intent to place radiation behind an ablated tumor and cut off the blood supply to the primary tumor (or sometimes mets for palliation).

The Y90 is the radioactive source (modality).

The embolization is the mechanism of delivery – brachytherapy via radioactive glass beads inserted thru a catheter to the primary tumor.

We are also now getting the very first FDA Approved delivery system for radiation at a cellular level with a new drug approved last year. Lutathera is a radionuclide therapy that uses 'dotatate' to target the attached Lu-177 radioisotope to a peptide receptor on the surface of NET tumor cells – for treatment of GI tract NETs including pancreas. This is actually a radiation therapy delivery system using the NET cell surface somatostatin/peptide receptor as the target and dotatate as the binding mechanism to attach the drug with attached Lu-177 radioactive isotope placing it directly on the NET cell surface target. The Lu-177 radioactive isotope as the actual treatment. It will likely be coded under radiation therapy - but might also need to be coded under BRM. PS – it only costs about $50K per dose…

Histology Code

Question:
What is the Correct Histology Code for NSCLC of the Lung?

Answer:
The Solid Tumor Manual instruct you to use code 8046/3 when NSCLC is documented as the final diagnosis by the pathologist…and code 8046/3 is still a valid code in ICD-O-3.2 (the proxy ICD-O-4 histology tables).

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It is NOT OBSOLETE – per WHO/IARC and SEER. AJCC does not provide instructions for coding ICD-O – they have no say in this matter - unless there is an agreement set up with SEER for ICD-O coding and we have it documented in manual/instructions by SEER – not AJCC.

AJCC is the standards holder for AJCC TNM Staging Instructions only – SEER and AJCC work together – but, this issue is still 'unresolved' between the two organizations. AJCC excludes 8046/3 from staging tables for lung cancers and that is their prerogative. BUT, SEER includes 8046/3 as a valid histology code for classification of the neoplasm and it is very clear in both the ICD-O-3.2 tables and the Solid Tumor Rules that the use of 8046/3 should continue until resolved. They are out of synch, yes…but, SEER holds the standards for ICD-O coding and has been the standards setting organization for ICD-O since the 1970s. Even CAP does not overrule WHO/IARC/SEER work on rules and instructions for ICD-O coding.

So, until WHO/IARC/SEER and AJCC agree on one or the other…the WHO/IARC/SEER instructions for use of 8046/3 will hold for the United States. It will be up to AJCC to 'fix' their tables to allow 8046/3 to be staged in the United States. This is the way our national standards work. We can only be asked to follow one set of requirements/guidelines/instructions that are set by the holder of the standard in the U.S. To manage multiple instructions from multiple 'experts' is impossible. We stick to the instructions set by the standards holder – not ancillary parties.

8046 is not an obsolete histology code. Hundreds of pathologists still use the terminology and the WHO/IARC Tables still include code 8046/3 and not listed as 'obs'. Furthermore, NSCLC is used to describe tumors in numerous other anatomic sites such as GYN, prostate, and GI Tract.

The only way we can ensure that registrars look for the clarification that genetic testing provides to determine if NSCLC can be further refined as a diagnosis to adenocarcinoma, squamous cell carcinoma, or large cell carcinoma is to keep using it and craft an edit to ensure registrars look for the genetic testing in the medical record. Otherwise, we just replace 8046/3 with 8010/3 and we gain nothing from the advances of genetic testing or target therapy. This is a big deal for folks with lung cancer – it may mean treatment or no treatment or that xyz treatment will or won't work on their tumor. This is why SEER has included the instruction that genetic testing for further classification of a tumor overrules light microscopy diagnosis.

Most Importantly - SEER has included the continued use of 8046/3 for many reasons – this histologic term is used in up to 50% of lung cancers as well as cancers of many other anatomic locations. It has meaning beyond 8010/3. Furthermore, SEER is the United States standards holder for ICD-O. AJCC cannot instruct registrars how to code ICD-O histology, behavior, grade.

NAACCR Cancer Registry and Surveillance Webinar Series Registration

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 2019-2020 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/naaccr_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/naaccr_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
*10/3/19	Breast 2019
11/7/19	Bladder and Kidney 2019
12/5/19	Base of Tongue 2019
1/09/20	Prostate 2020
2/6/20	SSDIs an In-Depth Look
3/5/20	Abstracting and Coding Boot Camp 2020
4/2/20	Melanoma 2020
5/7/20	Central Nervous System 2020
6/11/20	Esophagus 2020
7/9/20	Navigating the 2020 Survey Application Record (SAR)
8/6/20	Corpus Uteri 2020
9/3/20	Coding Pitsfalls 2020

NAACCR CANCER REGISTRY AND SURVEILLANCE WEBINAR SERIES

Seven Florida facilities will host the 2019-2020 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 2019 FCDS Annual Conference:

CE Hours: 9.5
4.75 Hrs Category A

NCRA Recognition Number: Pending

CEU information for the 2018 FCDS Annual Conference:

CE Hours: 8.25
5.5 Hrs Category A

NCRA Recognition Number: 2018-143

2019-2020 FCDS Webcast Series Schedule

FCDS is pleased to announce the 2019-2020 FCDS Webcast Series schedule and topics.

Date	Time Schedule 3rd Thursday	Presentation Title
11/21/2019	1:00pm – 3:00pm	**Imaging and Radiation Updates**: When to Use an Imaging Date as Date of Diagnosis, Use of Ambiguous Terminology to Establish a Diagnosis, How to Best Estimate a Diagnosis Date with Limited Information, Review of New Imaging Tests & Radiation Therapy Terms.
12/19/2019	1:00pm – 3:00pm	**FCDS Physician Claims Reporting**: Data Sources, Maintain the DX/ Procedure Codes for Cancer, Crosswalk Updates, System Functions, and TX Follow-Up Reports for You to Use
1/16/2020	1:00pm – 3:00pm	**FLccSC Updates and Live Demonstration** of Where to Access Key Registry References, Manuals, Coding Tables, Cancer Learning Resources for New Registrar Training and Continuing Education. Includes demonstrations of educational websites including FLccSC
2/20/2020	1:00pm – 3:00pm	**Genetics and Cancer**: Latest Information on Bio-Molecular Markers and Genetic Testing for the Classification and Treatment of Neoplasms – Understanding Reports to Confirm a Diagnosis

+ 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.

Florida Cancer Data System
Cancer Reporting Completeness Report

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

Total number of *New Cases* added to the FCDS Master file in September 2019: **8,362**

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
2019	151	0	0	5,101	0	**Pending**	5,252	**142**
2018	87,605	842	169	12,308	261	**Pending**	101,185	**6,858**
2017	208,831	8,822	625	13,165	21,532	**Pending**	252,975	**1,362**

		Actual	Expected
% Complete for:	**2019**	**3%**	**25%**
	2018	53%	100%
	2017	100%	100%

Expected % based on 190,000 reported cases per year

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.

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.

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FCDS
PO Box 016960 (D4-11)
Miami, FL 33101

Phone: 305-243-4600
800-906-3034
Fax: 305-243-4871

http://fcds.med.miami.edu