CANCER REPORTING IN CALIFORNIA: ABSTRACTING AND CODING PROCEDURES FOR HOSPITALS
California Cancer Reporting System Standards, Volume I

Changes and Clarifications –10th[th] Edition
November 2010

SECTION/CHANGE

I.1.6   Reporting
Added a link to a printable guide for the specific date when mandatory reporting began in each region. Clarified the two methods of reporting cancer cases to the CCR and provided a link to a printable guide outlining the CCR's reporting requirements by Class of Case.

I.1.6.4   Entering Dates
Added instructions for the change to interoperable date format and advised registries to consult their software vendor for specific data entry instructions.

I.1.6.5   Date Format Changes
Added instructions for the change to interoperable date format and advised registries to consult their software vendor for specific data entry instructions. Added a link to a printable guide outlining the allowable values for each date field. The CCR requires that date flag fields be completed on submission.

I.1.6.6   Coding Resources
Updated all resources and links.

I.1.6.7   CCR Reportability Guide
Added a link to a printable Reportability Guide with information on specific histologies and sites for tumors that are reportable or not reportable to the CCR.

I.1.8.1   Autopsy Only Cases
Changed Class of Case for Autopsy Only to Class 38.

II.1.3.6   Lymphatic and Hematopoietic Diseases – Subsequent Diagnoses
Added a reference to the 2010 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual and Hematopoietic Database.

II.1.7 Pathology Only, Tumor Board Only, and Consultation Only Cases

Added if the reporting hospital is confirming a diagnosis made elsewhere, rendering a second opinion, or recommending treatment to be delivered and managed elsewhere, an abstract is not required, although the regional registry must be notified by submitting the patient's pathology report or submitting a completed Confidential Morbidity Report (CMR) form.

II.1.8 Newly Reportable Hematopoietic Diseases (NRHD)

Added a reference to the 2010 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual and Hematopoietic Database.

II.1.9.8 CS Staging – Benign/Borderline Brain and CNS Tumors

Added a reference to Collaborative Stage Data Collection System Coding Instructions (CSv2).

II.1.10 Borderline Ovarian Tumors

Added clarification that borderline ovarian tumors will continue to be reported for cases diagnosed January 1, 2010 and forward. Updated the guidelines provided to include CSv2 data items. Informed registrars that active follow-up will no longer be required for any borderline ovarian cases diagnosed since January 1, 2001. Provided clarification that borderline ovarian cases will only be visually edited for failed electronic edits.

III.1.2.1.1 Last Name
III.2.1.2 First Name
III.2.1.3 Middle Name
III.2.1.4 Maiden Name
III.2.1.5 Alias Last Name
III.2.1.6 Alias First Name
III.2.1.9 Mother's First Name

Changed number of allowable characters to 40.

III.2.2 Medical Record Number

Noted that format changed to allow alphanumeric Medical Records numbers.

III.2.5.2 Number and Street at DX

Changed number of allowable characters to 60.

III.2.5.3 City at Dx

Changed number of allowable characters to 50

III.2.5.6 County at DX

Added the word "Required" to designate the county codes that must be provided to the CCR for reportable cases.

III.2.5.7   City at DX, USPS - Obsolete in 2010
Noted that this data item became obsolete in 2010.

III.2.9.1   Race 1-5
Added codes 15, 16, and 17 for Asian Indian and Pakistani races that replace code 09.

III.2.9.2   Spanish/Hispanic Origin
Added SEER caution not to presume ethnicity for Portuguese, Brazilians and Filipinos but to assign code 7 if the name is on the Spanish Surname list and code 1 if not.

III.2.10   Date of Birth
Added a reference to Section I.1.6.4 and Section I.1.6.5 for Coding and Entering Dates. Advised registries to consult their software vendor for specific data entry instructions.

III.2.10.1   Date of Birth Flag
Added data items to be used to explain why there is no appropriate value in the corresponding date field. Noted that depending on the registry software being used, these changes may be transparent to the registrar. The CCR requires that date flag fields be completed on submission.

III.2.14   Patient, No Research Contact Flag
Added VA cases to those cases that should not be contacted for research studies, enter code 4.

III.3.1   Date of First Contact
III.3.2   Date of Inpatient Admission and Inpatient Discharge
III.3.3   Date of Diagnosis
III.3.3.1   Coding Dates
Added a reference to Section I.1.6.4 and Section I.1.6.5 for Coding and Entering Dates. Advised registries to consult their software vendor for specific data entry instructions.

III.3.1.1   Date of 1st Contact
III.3.2.1   Date of Inpt Adm Flag
III.3.2.2   Date of Inpt Disch Flag
III.3.3.4   Date of Diagnosis Flag
Added data items to be used to explain why there is no appropriate value in the corresponding date field.   Noted that depending on the registry software being used, these changes may be transparent to the registrar. The CCR requires that date flag fields be completed on submission.

III.3.3.2 Vague Dates
Added instructions for coding vague dates relating to diagnosis or an admission. Use whatever information is available to calculate the year, code the year of admission when there is no basis for estimation, or use the date treatment was started if the patient receives a first course of treatment before a definitive diagnosis.

III.3.5 Class of Case
Please refer directly to this section as the code structure for this data item has undergone major revision in 2010.

III.3.6 Type of Reporting Source
Updated Class of Case categories to 40 and 41.

III.3.9 Payment Source (Primary and Secondary) and Payment Source Text
Note to record the primary payer from the information available at diagnosis and if unknown, record the information available during the initial treatment period.

III.3.12.1 Physician License Numbers
Clarified that the license number for an osteopath requires a leading O (alpha character) to be added.

III.3.12.2 Entering Physician NPI Codes
Changed the designation of attending physician to managing physician. Added a reference to instructions for coding the follow-up physician.

IV.1 Diagnostic Procedures Performed
Changed autopsy only class of case to 38.

IV.1.1 General Instructions
Added note that text fields have been expanded to 1000 characters, however, only pertinent text should be entered. Text must support coded data items and must be entered in a clear and concise manner.

IV.1.1.2 Tumor Size
IV.1.1.3 Extension
Added a reference to Collaborative Stage Data Collection System Coding Instructions (CSv2).

IV.1.5 Laboratory Tests
Laboratory tests and tumor markers recorded in CSv2 site specific factor fields must be documented in the laboratory text field by using the actual name of the test. Do not use "SSF 1-25" to identify the test. Documentation includes date, test type, value, and interpretation (elevated, borderline or normal).

IV.2 Diagnostic Confirmation
Added Code 3 – Positive immunophenotyping and/or positive genetic studies, adopted for use effective with 2010 diagnoses and to be used only for hematopoietic and lymphoid neoplasms 9590/3-9992/3.

IV.3   DXRX Report Identifier Data Items-Obsolete in 2010
IV.3.1   DXRX Report Facility ID (1-5) - Obsolete in 2010
IV.3.2   DXRX Report Number (1-5) - Obsolete in 2010
IV.3.3   DXRX Report Date (1-5) - Obsolete in 2010
IV.3.4   DXRX Report Type (1-5) - Obsolete in 2010
Added note that the data item became obsolete in 2010

IV.3.5   Text – Staging
Updated from DxRx data item designation to Path for consistency with data items IV.4.1 – IV.4.4.

IV.4.1   Path Reporting Facility ID 1-5
Added a data item that identifies the pathology facility that produced the report. This item is required by the CCR.

IV.4.2   Path Report Numbers 1-5
Added a data item for a unique sequential number assigned by a laboratory to the corresponding pathology report for the case. This item is required by the CCR.

IV.4.3   Path Date Spec Collect 1-5
Added a data item to collect the date and time of the specimen collection for the cancer being reported, not the date read or date the report was typed. This item is required by the CCR.

IV.4.4   Path Report Type 1-5
Added a data item that describes the type of report transmitted to the cancer registry and may need to be classified at the central cancer registry. This data item accommodates information for only one path report. If additional path reports are prepared, enter the path report type(s) in Path Report Type 2 through Path Report Type 5. This data item is required by the CCR.

V.1.4   Special Conditions
Added reference to the 2010 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual and the Hematopoietic Database.

V.1.7.2 Date of Conclusive Diagnosis
V.1.7.4 Date of Multiple Diagnosis
Added a reference to Section I.1.6.4 and Section I.1.6.5 for Coding and Entering Dates and advised registries to consult their software vendor for specific data entry instructions.

V.1.7.2.1 Date Conclusive DX Flag
V.1.7.4.1 Date of Multiple Tumors Flag
Added data items to be used to explain why there is no appropriate value in the
corresponding date field. Noted that depending on the registry software being used,
these changes may be transparent to the registrar. The CCR requires that date flag
fields be completed on submission.

V.2.1 (Coding) Laterality
Added code 5 for Paired site, midline tumor.

V.2.2 Principal Paired Sites
Added code 5 for Paired site, midline tumor and codes C70.0, C71.0, C71.1, C71.2,
C71.3, C71.4, C72.2, C72.3, C72.4, and C72.5 to the list of applicable sites.

V.3.3.1 Sources for Determining Histology
V.3.3.2 Basic Rule
V.3.3.3 Variations in Terminology
V.3.3.6 Leukemia and Lymphoma Codes
Added a reference to the 2010 Hematopoietic and Lymphoid Neoplasm Case
Reportability and Coding Manual and the Hematopoietic Database.

V.3.5 Grade and Differentiation
Added instructions for coding grade when patient receives neoadjuvant therapy.

V.3.5.6 Gleason's Score
Added a note that Gleason's grading system is coded in a site-specific factor for the
applicable CS schema.

V.3.5.7 Lymphomas and Leukemias
Added a reference to the 2010 Hematopoietic and Lymphoid Neoplasm Case
Reportability and Coding Manual and Hematopoietic Database.

V.3.5.8 Bloom-Richardson Grade for Breast Cancer
Added a note that the Bloom-Richardson grading system is coded in a site-specific
factor for the applicable CS schema.

V.3.5.9 Grading Astrocytomas
Added a note that the WHO grading system is coded in a site-specific factor for the
applicable CS schema.

V.3.5.10 Fuhrman's Grade for Renal Cell Carcinoma
Added a note that Furhman's grading system is coded in a site-specific factor for the
applicable CS schema.

V.3.5.11 Grade Path System
This new data item records whether a two, three or four grade system was used in the pathology report to describe the grade. It is used in conjunction with Grade Path Value. This data item is required by the CCR.   Code this item from the same tissue as that used to code Grade/Differentiation.   Do not report grading systems such as Bloom-Richardson for breast primaries, Fuhrman for kidney, Gleason for prostate, or WHO grade. Those grading systems are coded in a site-specific factor for the applicable CS schema.

V.3.5.12 Grade Path Value
This new data item records the numeric grade reported in the pathology report. It does not replace Grade/Differentiation. This data item is required by the CCR. Do not report grading systems such as Bloom-Richardson for breast primaries, Fuhrman for kidney, Gleason for prostate, or WHO grade. Those grading systems are coded in a site-specific factor for the applicable CS schema.

V.4.2 CS Site-Specific Factors (7-25)
CS Site-Specific Factor items (7-25) have been added to code additional site-specific information needed to derive TNM or AJCC stage, or to code prognostic factors that have an effect on stage or survival.   This data item belongs to the Collaborative Stage (CS) Data Collection System and is based on the AJCC Cancer Staging Manual, 6th and 7th editions. Additional educational information is available in Part 1- Section 2: Lab Tests, Tumor Markers and Site-Specific Factor Notes. CCR required site-specific Factors are available in Appendix Y.

For CS SSF data items not required by the CCR, enter code 988. For CS SSF data items required by the CCR with an unknown value, enter code 999.

V.4.2.1 CS Mets at DX – Bone

Added a new data item CS Mets at DX - Bone to identify the presence of distant metastatic involvement of bone at time of diagnosis. This data item is required by the CCR.

V.4.2.2 CS Mets at DX – Brain

Added a new data item CS Mets at DX - Brain to identify the presence of distant involvement of brain at time of diagnosis.   This data item is required by the CCR.

V.4.2.3 CS Mets at DX – Liver
Added a new data item CS Mets at DX – Liver to identify the presence of discontinuous or distant metastatic involvement of the liver at time of diagnosis. This data item is required by the CCR.

V.4.2.4 CS Mets at DX – Lung

Added a new data item CS Mets at DX – Lung to identify the presence of distant metastatic involvement of the lung at time of diagnosis. This data item is required by the CCR.

V.5.9.1 Staging Rules for Inaccessible Sites

Added a reference to Collaborative Staging Data Collection System Coding Instructions manual for coding instructions.

V.5.13 Special Rule for Lymph Nodes

Added reference to Collaborative Stage Data Collection System Coding Instructions and specific information for counting regional lymph nodes.

V.5.14 Lymph-vascular Invasion

Added a new data item, Lymph-vascular Invasion, to identify the presence or absence of tumor cells in lymphatic channels (not lymph nodes) or blood vessels with the primary tumor as noted microscopically by the pathologist. Lymph-vascular invasion is an indicator of prognosis. The CCR requires that this data item be collected for primary sites penis and testis only.

V.6 Tumor Markers
V.6.1 – V.6.3 Tumor Marker 1 - 3
V.6.4 Tumor Marker California-1

Added a clarification that this data item has been replaced by CS breast schema site-specific factors 8-14. Referred registrars to Collaborative Stage Data Collection System Coding Instructions – Site Specific Factor Fields (Part 1, Section 2).

V.7.6 TNM Coder (Clinical, Pathological, and Other)

Record the responsible person for performing the TNM staging on the case. Code 4 now includes Cancer Committee Chair, Cancer Liaison Physician, and Registry Physician Advisor. Code 6 now includes the Cancer Registrar and any physician identified in codes 1 – 4.

V.7.7 TNM Edition

Added code 07 to designate the seventh edition.

VI.1 First Course of Treatment: General Instructions

Added a new data item, RX-Treatment Status, to summarize the status of all treatment modalities. This data item is a summary of whether treatment was given, including an option that identifies active surveillance or watchful waiting.

Note that a referral to an oncologist is considered a recommendation. Registry personnel should follow-up on these cases to determine whether chemotherapy was administered or not, and code accordingly. Prior to January 1, 2010, referral did not equal a recommendation.

VI.1.1   Special Situations
Added definitions of treatments (first course) for leukemia and hematopoietic diseases. Referred registrars to 2010 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual and the Hematopoietic Database.

VI.1.2   Treatment Definitions
Added definitions for active surveillance, disease recurrence, treatment failure, and watchful waiting.

VI.1.3.1   First Course of Treatment – Codes
Added definitions for chemoembolization, radioembolization, and tumor embolization.

VI.1.3.2   First Course of Treatment - Dates
Added instructions for the change to interoperable date format. Advised registries to consult their software vendor for specific data entry instructions. Added a link to a printable guide outlining the allowable values for each date flag field.

VI.1.3.5   No First Course of Treatment
Added data item, RX-Treatment Status, to summarize the status of all treatment modalities. This data item is a summary of whether treatment was given, including an option that identifies active surveillance or watchful waiting.

Note that a referral to an oncology specialist is considered a recommendation. Registry personnel should follow up on these cases to determine whether treatment was administered or not, and code accordingly. Prior to January 1, 2010, referral does not equal a recommendation.

VI.1.3.6   First Course of Treatment – Unknown
Note that a referral to a specialist is considered a recommendation. Registry personnel should follow up on these cases to determine whether treatment was administered or not, and code accordingly. Prior to January 1, 2010, referral did not equal a recommendation.

VI.2.1   Surgery of the Primary Site
Note that a referral to a specialist is considered a recommendation. Registry personnel should follow-up on these cases to determine whether treatment was administered or not and code accordingly. Note: Prior to January 1, 2010, referral did not equal a recommendation.

VI.2.2   Scope of Regional Lymph Node Surgery

Added a reference to Section V.5.13 for counting regional lymph nodes. Added to code 9 additional applicable CNS sites.

VI.2.5   Date of Surgery
VI.2.11   Date of Diagnostic or Staging Surgical Procedures
Added a reference to Section I.1.6.4 and Section I.1.6.5 for Coding and Entering Dates. Advised registries to consult their software vendor for specific data entry instructions.

VI.2.5.1   Date of Surgery Flag
VI.2.11.1   Date of Diagnostic or Staging Surgical Procedures Flag
Added data items to be used to explain why there is no appropriate value in the corresponding date field. Noted that depending on the registry software being used, these changes may be transparent to the registrar. The CCR requires that date flag fields be completed on submission.

VI.2.14   Systemic Therapy With Surgery Sequence
Added to code 0 the following: Unknown if surgery and/or systemic therapy given.

VI.3.1.2   Radioactive Implants
Added instructions to code I-125 treatment for prostate cancer to brachytherapy (code 2) and LDR treatment modality (code 53).

VI.3.3   Radiation - Regional RX Modality
Added a note that a referral to a radiation oncologist is considered a recommendation. Follow-up on these cases is required to determine whether radiation was administered or not, and code accordingly. Prior to January 1, 2010, referral did not equal a recommendation.

VI.3.4   Radiation - Boost RX Modality
Added a note that a referral to a radiation oncologist is considered a recommendation. Follow-up on these cases is required to determine whether radiation was administered or not, and code accordingly. Prior to January 1, 2010, referral did not equal a recommendation.

VI.3.5   Date of Radiation Therapy
VI.4.3   Date of Chemotherpy
VI.5.5   Date of Hormone Therapy
VI.6.3   Date of Immunotherapy (BRM)
VI.7.2   Date of Transplant/Endocr
VI.8.2   Date of Other Therapy
Added a reference to Section I.1.6.4 and Section I.1.6.5 for Coding and Entering Dates. Advised registries to consult their software vendor for specific data entry instructions.

VI.3.5.1 Date Radiation Therapy Flag
VI.4.3.1 Date of Chemotherapy Flag
VI.5.5.1 RX Date – Hormone Flag
VI.6.3.1 RX Date – BRM Flag
VI.7.2.1 RX Date – Transplant/Endocr Flag
VI.8.2.1 RX Date – Other Flag
Added data items to be used to explain why there is no appropriate value in the corresponding date field. Noted that depending on the registry software being used, these changes may be transparent to the registrar. The CCR requires that date flag fields be completed on submission.

VI.4.2 Chemotherapy Codes
Added a note that a referral to a medical oncologist is considered a recommendation and that follow-up on these cases is required to determine whether chemotherapy was administered or not.   Prior to January 1, 2010, a referral did not equal a recommendation.

VI.5.4 Hormone Therapy Codes
Added a note that a referral to a medical oncologist is considered a recommendation and that follow-up on these cases is required to determine whether hormone therapy was administered or not. Prior to January 1, 2010, a referral did not equal a recommendation.

VI.6.2 Immunotherapy Codes
Added a note that a referral to a medical oncologist is considered a recommendation and that follow-up on these cases is required to determine whether immunotherapy was administered or not. Prior to January 1, 2010, a referral did not equal a recommendation.

VI.7 First Course of Treatment – Transplant/Endocrine Procedures
Added instructions for coding total body irradiation.

VI.7.1 Transplant/Endocrine Codes
Added a note that a referral to a specialist for hematologic transplant or endocrine procedures is considered a recommendation.   Follow-up on these cases is required to determine whether a procedure was performed or not, and code accordingly. Prior to January 1, 2010, referral did not equal a recommendation.

VI.8 First Course of Treatment - Other Therapy
Note added to clarify that cancer vaccines are still in the experimental phase. Currently, clinical trials use cancer vaccines for brain, breast, colon, kidney, lung, melanoma, and ovary.

VI.8.1 Other Therapy Codes

Added a note that a referral to a specialist is considered a recommendation. Follow-up on these cases is required to determine whether treatment was administered or not, and code accordingly. Prior to January 1, 2010, referral did not equal a recommendation.

VI.9 RX Summary – Treatment Status

This new data item is used to summarize the status for all treatment modalities. It is used in conjunction with Date of Initial RX and/or Date of 1st Course RX-CoC and each modality of treatment with their respective date field to document whether treatment was given or not given, whether it is unknown if treatment was given, or whether treatment was given on an unknown date. Active surveillance (watchful waiting) is also documented. This data item is required by the CCR.

VII.1 Follow-Up Information

Added a note that follow-up is still required for the following tumors now categorized in Class of Case 34 or 36:

- Benign and borderline CNS tumors diagnosed between January 1, 2001 and December 31, 2003 (before the national benign and borderline CNS tumor reporting requirement was implemented).
- VIN III
- VAIN III
- AIN III

Also added a note that borderline ovarian tumors, diagnosed January 1, 2001 and forward, no longer require follow-up.

VII.2.2 Date of Last Contact

Added a reference to Section I.1.6.4 and Section I.1.6.5 for Coding and Entering Dates. Advised registries to consult their software vendor for specific data entry instructions.

VII.2.2.1 Date of Last Contact Flag

Added data items to be used to explain why there is no appropriate value in the corresponding date field. Noted that depending on the registry software being used, these changes may be transparent to the registrar. The CCR requires that date flag fields be completed on submission.

VII.2.10 Follow-Up Physician

Added a clarification to enter code 99999999 if there is no Follow-Up Physician or

if the Follow-Up Physician is unknown.

VII.3.2   Contact #
VII.3.3   Contacts #2 through #6
Changed number of allowable characters for name, street/post office box, city and supplemental field.

Part VIII – No changes

IX.1.2   Corrections
List updated with new data items.

APPENDICES

Appendix A: Histology Codes for Lymphomas and Leukemias
Added reference to the 2010 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual and Hematopoietic Database.

Appendix B: Postal Abbreviations
Added a note that the CCR has adopted official USPS abbreviations for coding of States and Possessions, Street Suffixes, and Secondary Unit Designations and included a reference to the USPS website.

Appendix M1, M2: Approved Abbreviations
Expanded list from 84 to 400+.

Appendix O: Spanish Surnames
Reformatted the list and added search functions.

Appendix-Q2: Site-specific Surgery Codes – all non hematopoietic
Note that all non hematopoietic sites include an updated exception list. Note for many sites there has been a change to the "Specimen sent to pathology from surgical events XX-XX".

**Appendix Q-2:
Hematopoietic/reticuloendothelial/immunoproliferative/myeloproliferative**
Change in the inclusion list to the following: C42.0, C42.1, C42.3, C42.4 for all histologies or M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992 for all sites.

Appendix Q-2: Bladder
Added clarification for codes 60-64, 71, 72 and 73.

Appendix Q-2: Brain

Added codes 21 and 22.   Notes added to code 10 and codes 30-55.

Appendix Y: Site specific Factors
Added a searchable table of required site-specific factors by schema.