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

Changes and Clarifications – 8thth Edition
Revised May 2008

SECTION	CHANGE
I.1.3	**State Cancer Reporting Requirements** Added the reportability of borderline and benign CNS tumors, borderline ovarian tumors and Newly Reportable Hematopoietic Diseases (NRHD).
I.1.6	**Reporting** Clarification to the 4th bullet: Patients who are receiving long term therapy (such as hormone therapy) with a history of cancer but with no current evidence of cancer. Do not report cases with only a history of cancer. The patient must be receiving long term therapy AND have a history of cancer to be reportable via notification to the CCR.
I.2	**CNExT** This section was software specific and deleted in 2008.
II.1.1	**Criterion for Reportability** Added reportability criteria for benign and borderline brain and CNS tumors.
II.1.3.1	**Single Primaries**
II.1.3.2	**Multiple Primaries**
II.1.3.3	**Paired Sites**
II.1.3.4	**Breast Ductal and Lobular Carcinomas**
II.1.3.5	**Intraductal Carcinoma and Paget Disease** Added: For cases and tumors diagnosed January 1, 2007 forward, apply the SEER Multiple Primary and Histology Coding Rules.
II.1.4	**Skin Carcinomas** Corrected the ranges of non-reportable histology codes for skin carcinomas (site codes C44.0-C44.9): 8000-*8005* Neoplasm, malignant, NOS, of the skin 8010-*8046* Epithelial carcinomas of the skin 8050-*8084* Papillary and squamous cell carcinomas of the skin

SECTION	CHANGE
II.1.7	**Pathology Only, Tumor Board Only, and Consultation Only Cases** Clarification: 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 although the regional registry ***must*** be notified of the case using one or both of the following methods: • Submit the patient's pathology report • Submit a completed Confidential Morbidity Report (CMR) form
II.1.9.1	**Reportability** Added: Note: Benign Schwannomas (9560/0) of the cranial nerves only are reportable to the CCR. Benign Schwannomas occurring in the spinal cord, peripheral nerves or peripheral nerve root are not reportable to the CCR.
II.1.9.6	**Tumor Grade** Clarification: Always assign code 9 for non-malignant *brain and CNS* tumors.
II.1.10	**Borderline Ovarian Tumors** Added: Beginning with the implementation of Collaborative Staging, Version 01.04.00, and for borderline ovarian cases diagnosed on or after January 1, 2008, code CS Extension to 99. (See Ovary Schema, CS Extension, Note 8, Collaborative Staging Manual, Version 01.04.00).
II.2	**Abstracting: Preliminary Procedures** Removed references to software functionality. Added: The first four digits of the accession number usually represents the year first seen for the patient (see Section II.2.1). The last five digits usually represent the approximate chronological order of the abstracts prepared for that year.
II.2.2	**CNExT Generated Accession Numbers** This section was software specific and deleted in 2008.
II.2.3	**Accession Number** Editorial changes only with removal of references to software functionality.
II.2.4	**Sequence Number** Clarification: Effective with cases diagnosed 1/1/2003 forward, *reportable* borderline ovarian tumors, benign and uncertain behavior CNS tumors and cases that are reportable by agreement *must* be sequenced using numeric codes (60-87).

SECTION	CHANGE
II.2.4.2	**Updating – Sequence Number** Clarification: the sequence number must be updated if it was originally coded as 00 or 60, designating a single tumor.
III.1.2	**Suspense Flag**
III.1.3	**Year First Seen, Accession Number, and Sequence Number**
III.1.5	**CNExT Automatic Entries** These sections were software specific and deleted in 2008.
III.2.1.2	**First Name** Added: If the patient's first name is not a common male or female name or it is ambiguous with regard to gender, include a statement in the Remarks field confirming the patient's gender.
III.2.5.6	**Data Entry, County** Change: Enter code *998* if the county of residence is not known or if it is a state and is other than California and its name is known.
III.2.5.7	**Address Dx City, USPS (new)** This data item identifies the city in which the patient resides at the time the reportable tumor is diagnosed. Currently, the data item, City at Diagnosis, allows for up to 20 characters. The data item, Address Dx City, USPS, using the USPS file listing, allows for up to 28 characters. No data entry is required, as it is a generated field.
III.2.7	**Sex** Added: If the patient's first name is not a common male or female name or it is ambiguous with regard to gender, include a statement in the Remarks field confirming the patient's gender.
III.2.8	**Religion** Added: Code 94 Scientology
III.2.9.2	**Spanish/Hispanic Origin** Added: If race is not known (Race code 99), use code 9, Unknown Whether Spanish or Not, *unless the patient's last name appears on the Spanish surname list, then use code 7, Spanish surname only.*
III.2.11	**Age at Diagnosis** Section re-worded. References to specific software functionality were removed.

SECTION	CHANGE
III.3.12.1	**License Numbers** For osteopaths, enter the entire eight-character code including a leading O (alpha character). *For handling a nine-character number, drop the first zero after O2 for osteopaths.* Changed the example of a physician license number with less than 8 characters.
IV.1.1.2	**Size**
IV.1.1.3	**Extension**
IV.1.1.4	**Lymph Nodes** Added: For cases diagnosed January 1, 2004 and forward, apply the Collaborative Staging rules for documenting tumor size, extension and lymph node involvement.
IV.1.5	**Laboratory Tests** Added: Document the date, *test type*, value and interpretation (elevated, borderline or normal) of any pertinent tumor markers or lab tests in the lab text field.
IV.1.7	**Pathology** Added: Beginning in 2008 and forward, record the text for each pathology report type (see the DxRx Report Type listing, IV_3_4 DxRx Report Type 1-5) in the Path Text field. If additional space is necessary, continue the text documentation in the Text – Staging field. Each DxRx report must be identified in the text field as R1 - R5 with R1 referencing DxRx Report 1, R2 referencing Report 2, etc. If additional text space is needed, continue the pathology text in the Staging Text field. If there is a pathology report, all the DxRx fields must be completed. If the medical record only includes "hearsay" information or the physician only refers to a report finding, but there is no report in the medical record, do not complete the DxRx fields, but include the information in the text field. Enter the facility ID number, dates, report types, and pathology numbers in the DxRx Reports (1-5) fields.
IV.1.7.1	**Pathology Report Number – Biopsy/FNA** This data item became obsolete with the implementation of DxRx Report Number, January 1, 2008.
IV.1.7.2	**Pathology Report Number - Surgery** This data item became obsolete with the implementation of DxRx Report Number, January 1, 2008.

SECTION	CHANGE
IV.3	**DxRx Report Identifier Data Items (New)**

In order for the CCR's central data base system (Eureka) to integrate pathology report processing with new case abstract processing, the system needs a way to easily match abstracts to path reports. Five sets of path report identifier data items have been added to the CCR's required data set to allow the documentation of up to five pathology reports that were used as reference reports. These new items include "DxRx" in their names because they are intended to allow documentation of diagnostic and treatment reports. Initially, they will be used to document the types of pathology reports used in abstracting that are listed under DxRx Report Type.

For any existing cases in the database, the fields: DxRx Report Number (1-5) and the DxRx Report Type (1-5) will be filled with data converted from the following fields: Pathology Report Number Biopsy/FNA and Pathology Report Number Surgery. The fields Pathology Report Number Biopsy/FNA and Pathology Report Number Surgery become obsolete with the implementation of the DxRx Report Identifier fields.

Additional report types that include report numbers, dates, and facility may be added later as they become available. These data items are required by the CCR, effective January 1, 2008. If there is no report, leave the field blank.

IV.3.1 **DxRx Report Facility ID (1-5) (New)**

Identifies the facility that produced the reference report, using the CCR reporting source number. Allows for the documentation of up to five facility ID numbers that were used as reference reports. This data item is required by the CCR, effective January 1, 2008. Leave this field blank if there is no report.

IV.3.2 **DxRx Report Number (1-5) (New)**

Enter the filler order number/lab accession number associated with the pathology report specimen or other report type's number uniquely identifying the report for that facility. For cases diagnosed prior to 1/1/2008 and any existing cases in the database, this field will be filled with data converted from the following fields:
Pathology Report Number Biopsy/FNA and Pathology Report Number Surgery. This is a 20 character field that accommodates the documentation of up to five filler order number/lab accession numbers. This data item is required by the CCR, effective January 1, 2008. Leave this field blank if there is no report.

SECTION	CHANGE
IV.3.3	**DxRx Report Date (1-5) (New)** Identifies the date the specimen associated with a pathology report was collected from the patient, or the most distinguishing report date for other document types. This 8-character field accommodates the documentation of up to five dates. This data item is required by the CCR, effective January 1, 2008. Leave this field blank if there is no report.
IV.3.4	**DxRx Report Type (1-5) (New)** Identifies the type of report entered as a reference report in the other DxRx fields of the set. This 2-character field allows for the documentation of up to five report types that were used as reference reports. If a biopsy, surgical resection or bone marrow biopsy report also includes results of report types 05-10, code to biopsy, surgical resection or bone marrow biopsy. Use codes 05-10 only if that is the single item result in the report, not as part of the biopsy or resection specimen. For cases diagnosed prior to 1/1/2008 and any existing cases in the database, DxRx Report Type (1-5) will be filled with data converted from the following fields: Pathology Report Number Biopsy/FNA and Pathology Report Number Surgery. This data item is required by the CCR, effective January 1, 2008. Leave this field blank if there is no report. **Codes:** 01 Biopsy 02 Surgical resection 03 Bone marrow biopsy 04 Autopsy 05 Cytology 06 Flow Cytometry/Immunophenotype 07 Tumor Marker (p53, CD's Ki, CEA, HER2-neu) 08 Cytogenetics 09 Immunohistochemical stains 10 Molecular studies 88 Other, NOS

SECTION	CHANGE
IV.3.5	**Text Staging (New)** This text field can be used to document additional staging and diagnostic workup information. Text information that supports the DxRx Reports data items (1-5) should be listed here, identifying each report by using the R1- R5 designation. Each DxRx report must be identified in the text field as R1 - R5 with R1 referencing DxRx Report 1, R2 referencing Report 2, etc. As a reminder, record the text for each pathology report type (see the DxRx Report Type listing, IV_3_4 DxRx Report Type 1-5) in the Path Text field. If additional space is necessary, continue the text documentation in the Text - Staging field. Each DxRx Report must be identified in the text field as R1 - R5 with R1 referencing DxRx Report 1, R2 referencing Report 2, etc. Registrars may include the date into the text field if they wish, but do not compromise the integrity of the text content, due to lack of adequate text space. This text field was available in the past, but not transmitted to the CCR.
V.3.1	**ICD-O** Cases diagnosed prior to January 1, 2001, *must* be coded using the International Classification of Diseases for Oncology, Second Edition, 1990 (ICD-O-2).
V.3.3	**Histologic Type**
V.3.3.1	**Sources for Determining Histology**
V.3.3.2	**Basic Rule**
V.3.3.3	**Variations in Terminology**
V.3.3.5	**Metastatic Site**
V.3.3.6	**Lymphoma Codes**
V.3.3.7	**Special Cases** Added: For cases or tumors diagnosed after January 1, 2007, apply the SEER Multiple Primary and Histology Coding Rules to determine histology.
V.3.4	**Behavior** Clarification: Beginning with cases diagnosed 1/1/2001 forward, brain and CNS tumors with behavior code /0 (benign) or /1 (uncertain whether benign or malignant) are reportable to the CCR.
V.4.1	**Extent of Disease** Added: Extent of Disease (EOD) Coding applies to cases diagnosed prior to January 1, 2004. Collaborative Staging replaced EOD staging with cases diagnosed January 1, 2004 and forward.

SECTION	CHANGE
V.4.2	**Collaborative Staging** Added: The CCR requires the CS Evaluation fields with cases diagnosed 1/1/2008 forward. New codes were implemented: colorectal CS SSF 2 (replacing obsolete code 888), stomach CS SSF 1 (replacing obsolete code 888); breast CS Lymph Nodes, (codes 28 and 50 be obsolete).
V.5	**Stage at Diagnosis** Added: Beginning with cases diagnosed January 1, 2004 and forward, the CCR requires the collection of Collaborative Staging (CS) data items necessary to derive AJCC T, N, M, Stage Group, Summary Stage 1977, and Summary Stage 2000.
V.5.3	**Ambiguous Terms** Clarification: Physicians sometimes use ambiguous terms to indicate the involvement of tissue or an organ by a tumor. Refer to the *Collaborative Staging Manual*, for a list of ambiguous terms.
V.5.9.1	**Inaccessible Sites** Added: For cases diagnosed January 1, 2004 and forward, apply the Collaborative Staging rules for inaccessible sites.
V.5.9.3	**Multicentric Tumors** Clarification: Refer to the Collaborative Staging Manual for rules about satellite lesions (with reference to staging).
V.5.13	**Special Rules for Lymph Nodes** Added: For lung primaries, if at mediastinoscopy or x-ray, the description states mass/adenopathy/enlargement of any of the lymph nodes listed under *Note 2 of the CS Lymph Nodes instructions in the CS Manual*, assume those lymph nodes are involved.
V.6	**Tumor Markers**
V.6.1	**Tumor Marker 1**
V.6.2	**Tumor Marker 2**
V.6.3	**Tumor Marker 3** Added: Document type of test performed. Added: Do not use code 1 for testicular cancers (for Tumor Markers 1-3)
V.6.4	**Tumor Marker California -1** Added: Document the type of test performed.

SECTION	CHANGE
V.7	**AJCC Staging and Other ACoS Items** Added: Beginning with cases diagnosed January 1, 2004 and forward, the CCR requires the collection of Collaborative Staging (CS) data items necessary to derive AJCC T, N, M, and Stage Group. Effective with cases diagnosed January 1, 2008 forward; physician-assigned pathologic AJCC staging will no longer be required to be collected by ACoS approved facilities.
V.7.1	**The TNM System**
V.7.4	**TNM Staging Elements (Clinical and Pathological)**
V.7.5	**AJCC Stage Group (Clinical and Pathological)** Added: Beginning with cases diagnosed January 1, 2004 and forward, the CCR requires the collection of Collaborative Staging (CS) data items necessary to derive AJCC T, N, M, and Stage Group.
VI.1.2	**Definitions** Added under Antineoplastic Drugs: For cases diagnosed 1/1/2005 forward, registrars must use SEER*Rx, for coding systemic treatment (i.e. chemotherapy, hormone therapy, and immunotherapy). SEER*Rx is the downloadable, interactive antineoplastic drug database that replaces SEER Self-Instructional Manual Book 8, Antineoplastic Drugs. The software can be downloaded from the SEER*Rx Web Site.
VI.1	**First Course of Treatment: General Instructions**
VI.1.3.5	**No Treatment**
VI.1.3.6	**Unknown if Treated**
VI.2.1	**Surgery of the Primary Site**
VI.3.3	**Radiation – Regional Rx Modality**
VI.3.4	**Radiation – Boost Rx Modality**
VI.4.2	**Chemotherapy Codes**
VI.5.4	**Hormone Therapy Codes**
VI.6.2	**Immunotherapy Codes**
VI.7.1	**Transplant/Endocrine Codes**
VI.8.1	**Other Therapy Codes** Added: If the only information available is that the patient was referred to a surgeon, medical oncologist or radiation oncologist, with no confirmation that treatment was administered, code no treatment given. Reminder: Referral does not equal a recommendation.

SECTION	CHANGE
VI.2.2	**Scope of Regional Lymph Node Surgery** Added: Primaries of the brain and central nervous system to the definition of code 9. Added pituitary gland to the sites using code 9.
VI.2.3	**Number of Regional Lymph Nodes Examined** Added pituitary gland to the list of sites coded to 99.
VI.2.6	**Treatment Hospital Number** Added: Use NPI facility number, if available.
VI.3	**First Course of Treatment: Radiation Therapy**
VI.3.8	**Location of Radiation Treatment (New Required Data Item)** Added: For cases diagnosed 1/1/2008 forward, the data item, Radiation Location Treatment is required by the CCR. This data item identifies the location of the facility in which radiation treatment was administered during first course of treatment.
VII.1	**Follow-Up Information** Added: The CCR also requires follow-up on all benign and borderline CNS tumors as well as borderline ovarian tumors from ACoS approved facilities.
VII.2.6.2	**Last Type of Patient Follow-Up** Added: Code 48 - Research Study Follow-Up
VII.2.7	**Last Follow-Up Hospital**
VII.2.9	**Next Follow-Up Hospital** Added: Enter the ten-digit code (beginning with 4 leading zeros), *NPI number if available* or name of the hospital…..
VII.2.11	**Alternate Medical Record Number** Clarification: The item is not required, and is not *transmitted to the CCR.*
VII.2.14	**Follow-Up Remarks** This section was software specific and deleted in 2008. The information entered here was not transmitted to the CCR.
VII.3.1	**Follow-Up Resources** This section was software specific and deleted in 2008.
VII.3.3	**Contacts #2 through #6** Clarification: *If available in the abstracting software*, enter the names, addresses, and phone numbers of up to six people designated as contacts for the case.

SECTION	CHANGE
VIII.1	**Remarks *and Final Diagnosis*** Changed the section title by adding "and Final Diagnosis" and added the following: *Record the date of the notation and the final diagnosis, including stage if given.* If there is no final diagnosis in the medical record, please state FDX: NR; *do not leave this field blank.*
VIII.1.2 **VIII.1.3**	**Confidential Remarks** **More Remarks** Note: This section is software specific and will be removed after 2008.
VIII.3	**Extra Hospital Information** Clarification: The information is not sent to the *CCR.*
IX.1.2	**Corrections** Added the new data items generating a correction record for 2008.
IX.2.2	**Accuracy** This section was revised to reflect current practices.
Appendix B	**Postal Abbreviations for States and Territories of the United States** Added codes for United States Military Personnel Serving Abroad: AA American Territories-US Military abroad AE Europe-US Military abroad AP Pacific-US Military abroad
Appendix E	**Rules for Determining Residency of Military Personnel Assigned to Ships and Crews of Merchant Vessels** Added: Note: Also see Appendix B - Postal Code Abbreviations, for military personnel serving abroad.
Appendix F	**California Hospital Code Numbers** Updated the lists of California Hospital Codes by facility code or facility name to Version 1.8.0.8, dated May 14, 2008.
Appendix G	**Religions** Added code 94 - Scientology

SECTION	CHANGE
Appendix J	**Patient Information Sheet** Added reportable borderline and benign CNS tumors, borderline ovarian tumors and Newly Reportable Hematopoietic Diseases (NRHD).
Appendix L	**Codes for California Counties** The FIPS codes have been added to Appendix L as a cross-reference to the California County Codes.
Appendix S	**DSQC Memos** Added the 2007 DSQC Memos.
Appendix T	**Over-ride Flags and Edits** Added edit: Seq Num-Hosp, Primary Site, Morphology - ED2514 - Override, Hosp Seq/Site
Appendix U	**Table of Data Items and Their Required Status** Added the 2008 data items.