

**CANCER REPORTING IN CALIFORNIA:  
STANDARDS FOR AUTOMATED REPORTING**

**CALIFORNIA CANCER REPORTING  
SYSTEM STANDARDS for 2013**

**VOLUME II**

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## PART I INTRODUCTION

The reporting of cancer is mandatory under provisions of California's Health and Safety Code.

Hospitals and other reporting facilities are required to report cancer information to the California Cancer Registry using computer reporting systems that meet State standards. This manual, *Cancer Reporting in California: Standards for Automated Reporting, California Cancer Reporting System Standards, Volume II (CCR Volume II)* is intended for hospitals and other reporting facilities or vendors wishing to update their own automated reporting systems or create new reporting systems that comply with State requirements.

The intended audience for this document is system analysts and software developers. It describes the format in which collected data must be reported.

Detailed instructions for collecting and coding data can be found in *Cancer Reporting in California: Data Standards and Data Dictionary, California Cancer Reporting System Standards, Volume I*.

Documentation for computer edits can be found in *Cancer Reporting in California: Data Standards for Regional Registries and California Cancer Registry, California Cancer Reporting System Standards, Volume III*.

### Section I.1 Summary of Changes for 2013

Changes for 2013 are identified by with **dark red** font color.

Corrections to the changes are identified by a **dark green** font color.

In response to requests from users of this document, the exchange records ([Appendices A, B, C, & D](#)) are now posted in an Excel (PDF) spreadsheet.

On CCRCAL.ORG, this volume and its related appendix will be listed as follows:

**VOLUME II**

**2013**

California Cancer Reporting Standards: Volume II-2013 (dated dd/mm/yy)

Volume II Appendices: California Cancer Reporting Standards: (dated dd/mm/yy)

Appendices A, B, C, & D identify each data item with a unique CCR Identifier. This identifier will never change and can be used to uniquely identify a data item to a database system, if such an identifier is needed in your database system.

See Appendix A for the following updates:

- Add seven new address fields:
  - Addr at DX--Country, 3 characters, CCR Identifier E1768
  - Addr Current—Country, 3 characters, CCR Identifier E1769
  - Birthplace—Country, 3 characters, CCR Identifier E1770
  - Birthplace—State, 3 characters, CCR Identifier E1771
  - Followup Contact—Country, 3 characters, CCR Identifier E1772

- Place of Death—Country, 3 characters, CCR Identifier E1773
- Place of Death—State, 3 characters, CCR Identifier E1774
- Retire two address fields:
  - Birthplace, 3 characters, CCR Identifier E1035. Replaced by Birthplace—Country and Birthplace—State
  - Place of Death, 3 characters, CCR Identifier E1537. Replaced by Place of Death—Country and Place of Death—State.
- Retire two temporary data items:
  - Occ Code—Census (4-dig) (CCR Identifier E1766)
  - Ind Code—Census (4-dig) (CCR Identifier E1767)
- Add two new Occupation and Industry Code fields:
  - CensusIndCode2010, 4 characters, CCR Identifier E1773
  - CensusOccCode2010, 4 characters, CCR Identifier E1774
- Add one new Census field:
  - CensusTrPovertyIndictr, 1 character, CCR Identifier E1775
- Added ten new codes for Comorbidities/Complications specifically to capture that information in ICD-CM-10 when available:
  - Secondary Diagnosis 1, 7 characters, CCR Identifier E1778
  - Secondary Diagnosis 2, 7 characters, CCR Identifier E1779
  - Secondary Diagnosis 3, 7 characters, CCR Identifier E1780
  - Secondary Diagnosis 4, 7 characters, CCR Identifier E1781
  - Secondary Diagnosis 5, 7 characters, CCR Identifier E1782
  - Secondary Diagnosis 6, 7 characters, CCR Identifier E1783
  - Secondary Diagnosis 7, 7 characters, CCR Identifier E1784
  - Secondary Diagnosis 8, 7 characters, CCR Identifier E1785
  - Secondary Diagnosis 9, 7 characters, CCR Identifier E1786
  - Secondary Diagnosis 10, 7 characters, CCR Identifier E1787
- NAACCR Record Version [130] (CCR Identifier E1003) has been revised from 122 to 130 to reflect NAACCR version 13.0.
- For GIS Coordinate Quality (CCR Identifier E1046),
  - “Supplied by CCR” column was blank (no requirement).
  - “Supplied by CCR” column is now specified as “geocoding”.
- Coding Proc has been updated from 29 to 30. (CCR Identifier E1576)
- The field Mult Tumors Reported as on Primary (CCR Identifier E1076) is now **optional**.
- The field Multiplicity Counter (CCR Identifier E1079) is now **optional**.
- The field Date of Multiple Tumors (CCR Identifier E1077) is now **optional**.
- The field Date of Multiple Tumors Flag (CCR Identifier E1078) is now **optional**.
- The field Date of Conclusive DX (CCR Identifier E1074) is now **optional**.
- The field Date of Conclusive DX Flag (CCR Identifier E1075) is now **optional**.
- The field Ambiguous Terminology (CCR Identifier E1073) is now **optional**.
- The field CER\_Hieght (CCR Identifier E1263) is now **conditional**.
- The field CER\_Weight (CCR Identifier E1264) is now **conditional**.
- The field TobaccoUseCigarette (CCR Identifier E1277) is now **conditional**.
- TobaccoUseOtherSmoke (CCR Identifier E1278) is now **conditional**.
- TobaccoUseSmokeless (CCR Identifier E1279) is now **conditional**.
- TobaccoUseNOS (CCR Identifier E1280) is now **conditional**.

- SourceComorbidity (CCR Identifier E1281) is now **conditional**.
- For NAACCR v13 the CER data items, located in positions 5133 – 5564, should no longer be transmitted to the central registry, nor should corrections be sent for those data items either.

See Appendix B for the following update:

- NAACCR Record Version [130] has been revised from 122 to 130 to reflect NAACCR version 13.0.

See Appendix C for the following updates:

- Version has been updated to "N".
- Place of Death, CCR Identifier E1537 at position 283 has been replaced by Place of Death – State, CCR Identifier E1772.
- Place of Death – Country, CCR Identifier E1771, has been added at position 793.
- Addr Current – Country, CCR Identifier E1767, has been added at position 796.
- Followup Contact – County, CCR Identifier E1770, has been added at position 799.
- Reserved section at the end of the file has been shortened to 2 characters.
- Place of Death--State (CCR Identifier E1772) has been shortened to 2 characters.
- A blank space has been added at position 285 to compensate for the shortened Place of Death–State field.

Additional Instructions:

The California Cancer Registry requires the use of Collaborative Staging for all cases. For this reason the use of Over-ride CS 20, CCR Identifier E1508, is not allowed and the value should always be transmitted as blank. All edits for Collaborative Staging will be enforced and all edits associated with Collaborative Staging must be cleared before transmission to the CCR.

## **PART II DATA TRANSMISSION STANDARDS**

### **Section II.1 Summary**

Communication between a reporting facility and the California Cancer Registry (CCR) can be of two forms: some types of records are transmitted from the reporting facility to the CCR, and other types of records are transmitted from the CCR to the reporting facility.

There are four record types that must be transmitted from the reporting facility to the central registry. They are: New Case records, Correction records, Follow-Up Only records, and Deletion records. All four of these record types are described in Section II.3. A reporting facility cancer registry is required to submit all four types of records, following the procedures described below, to be in compliance with the California Cancer Reporting System Standards, Volume II.

There is one type of record that is sent from the central registry to the reporting facility. This is Shared Follow-Up, described in Section II.4. Acceptance of that record by the reporting facility is optional (although we strongly recommend it).

Cases should NOT be transmitted to the CCR using a format that is earlier than the year that the case is reportable. For example, 2010 cases, as defined by the CCR casefinding rules, cannot be submitted in the format required in 2009.

## Section II.2 Explanatory Notes

Reporting requirements vary by item and record type and are listed in the "CCR Required from Reporting Facility" column in the Appendices. Each record type is described in a table, which must be consulted to determine whether or not a particular item is required. The following key explains the terms used in the "CCR Required from Reporting Facility" column.

### Key to Symbols

no	Not required. It is optional for the facility to submit this data item value to the central registry.
yes	Required. The facility must submit this data item value to the central registry.
yes*	Required if available. If the information can be obtained, the facility must submit it to the central registry. If not available or not applicable, may be left blank.
conditional	Required on selected cases dependent on one or more conditions being true, such as the case's diagnosis date being before or after a certain date.
yes, gen by facility	Required, but the facility's registry software must generate the data item value based on a standard algorithm, rather than a user manually entering the data item value.

Items that are facility-generated are described in more detail, including allowable values in Cancer Reporting in California, Data Standards for Regional Registries and California Cancer Registry (California Cancer Reporting System Standards, Volume III).

## Section II.3 Transmission between Hospitals and Regions

### II.3.1 Selection of Cases

Only cases which are reportable under California Cancer Registry (CCR) requirements are to be included in transmissions to the CCR. A reporting facility may elect to abstract certain benign conditions or skin cancers to meet local interest or ACoS requirements; however, these cases are not to be transmitted to the CCR.

Transmit all cases with a 2 or 3 (in situ or malignant) in Histology - Behavior, EXCEPT the following histologies occurring in the skin (site codes C44.0 -C44.9):

8000-8005 Neoplasms, malignant, NOS of the skin

8010-8046 Epithelial carcinomas of the skin

8050-8084 Papillary and squamous cell carcinomas of the skin

8090-8110 Basal cell carcinomas of the skin

In addition, for cases diagnosed after 1995, do not transmit any in situ (Histology - Behavior of 2) of the cervix (site codes C53.0 - C53.9). Beginning with cases diagnosed January 1, 2001, benign (behavior code 0) and uncertain behavior (behavior code 1) intracranial and central nervous system tumors are reportable. In addition, borderline ovarian tumors (behavior code 1) in ICD-O-3 are reportable.

**II.3.2 New Case Record**

For every abstract of a reportable case that is completed at the reporting facility, a New Case Record must be sent to the CCR. Timing considerations for reporting are discussed in Standards, Volume I, Section IX.1.1.

The format for the New Case record is specified in Appendix A. (Key to symbols is in Section II.2.)

**II.3.3 Update (Correction) Record**

An Update (Correction) record must be sent to the CCR every time a data item designated as "yes" in the column entitled "Update" is changed at the facility.

The following special items are used in the record layout for corrections:

Changed Data Item Number	The changed data item number is the updated/corrected data item's CCR Identifier.
Changed Item New Value	This field holds the new contents of the changed item. The data should be left-justified in a field of 1000 characters. The field may be blank if blanks are an allowable value for the item being changed.
Correction Comments	This is a 200-Character field (4 lines of 50 characters). It should contain a comment indicating the reasons for the changes. It should be left-justified beginning with the first of the 4 lines.
Old Item Value	This field holds the original contents of the changed item.

If a change is made solely because of information furnished by the CCR or one of the CCR's regional registries, the Update (Correction) Comments field should contain only an "R" or "REGION" (all upper case).

If the same field is changed more than once in a series of Update (Correction) records, the last correction on the transaction file is the one that prevails.

The Update (Correction) record may be used to change any field. When a change is being made to any of the data items listed in the identifier fields, the old values should appear in the identifier fields of the Update (Correction) record, with the new values in the Changed Item Value field.

**Whenever a correction to a date field is transmitted, the corresponding date flag must *always* be transmitted as well, regardless as to whether the date change precipitates a change to the date flag. And Vice-versa.**

### **II.3.3A Update (Correction) Record Layout**

See Appendix B for the record layout for Update (Correction) records.

### **II.3.4 Follow-Up Only Shared Follow-Up Record**

#### II.3.4.1 Follow-Up Only

A Follow-Up Only record must be sent to the CCR whenever the reporting facility changes data in any of the fields on the following list:

#### **Item Name**

- Date of Last Patient Contact or
- Death
- Vital Status
- Tumor Status
- Date of Last Tumor Status

Although only these items should trigger a Follow-Up Only record, all data items in the record are to be sent.

PLEASE NOTE: Whenever these items change due to the receipt of shared follow-up from the CCR, DO NOT SEND a Follow-Up record.

#### II.3.4.2 Shared Follow-Up

Reporting facilities which agree in advance may be able to receive shared follow-up. Whenever the CCR receives follow-up on a reporting facility's patient (and, possibly, that patient's tumor) from a different source (another reporting facility, State death tapes, DMV, etc.), the CCR may make available to the reporting facility the most current follow-up data available on that patient and tumor. The fields Follow-Up Hospital (Last) and Follow-Up - Last Type (Patient) and Follow-Up - Last Type (Tumor) in the Shared Follow-Up record will indicate the sources of the follow-up information being provided. The record format for Shared Follow-Up is the same as the record format for reporting facilities reporting follow-up to the CCR.

### **II.3.4A Follow-Up Only and Shared Follow-Up Record Layout**

See Appendix C for the record layout for Follow-Up Only and Shared Follow-Up records. (Key to symbols is in Section II.2.)

### **II.3.5 Deletion Record**

Whenever a reporting facility decides to delete from its database a case that has previously been reported to the CCR, a Deletion record must be transmitted to the CCR, EXCEPT when the reporting facility is deleting a duplicate.

The following special item is used in the record layout for this record type:

Text - Transaction Remarks - This is a 150-character field (3 lines of 50). It must contain a comment indicating the reason for deleting the record.

If a deletion is made because the CCR's regional registry instructed the reporting facility to do so, the Text-Transaction Remarks field should contain only an "R" or "REGION" (all upper case).



### II.3.5A Deletion Record Layout

See Appendix D for layout of deletion records. (Key to symbols is in Section II.2.)

## Section II.4 Data Transmittal Format

### Transmitted Data Files

All electronic files must be encrypted and password protected. File names must conform to the following schema:

- A three-letter abbreviation assigned by the CCR regional registry to the hospital (the case file suffix).
- Plus the four-digit year (YYYY) showing the year the file was created.
- Plus the three-digit day of the year (001 through 366) showing the day the file was created.
- Plus a single letter (A-Z) showing the sequence within one day the file was created. (Different file types can have the same sequence letter.)
- Plus a standard suffix according to the record type (see below).

For example, the first file of new cases created on February 1 at hospital abbreviated STJ would be named STJ2013032A.XAA and the second file of new cases created that day would be STJ2013032B.XAA.

The following files may be included, in any order.

Record Type	File Suffix	Record Length
New Case	.XAA	22824 plus CR/LF
Correction	.XCO	2585 plus CR/LF
Follow-Up and Shared Follow-Up	.XFU	804 plus CR/LF
Shared Follow-Up	.XSH	804 plus CR/LF
Deletion	.XDL	368 plus CR/LF

## Section II.5 Rules for Computer-Generated Data Items Required by California

Please refer to California Cancer Reporting System Standards, Volume III, for specifications for generating the data items referred to in Section II.5.1.2-4.II.5.1 Data Items.

To determine which items to generate in facility software, refer to the *CCR Required from Reporting Facility Software* column in Appendices A, B, C, or D.

## Appendix A: New Case Record, NAACCR Version 12.2

Data Item Name	CCR Identifier	NAACCR Identifier	Col Start	Col End	Length	CCR Required from Reporting Facility Software	Supplied by CCR	Correction Record Required
NPI--Reporting Facility	E1080	545	691	700	10	yes*		yes*
Reporting Facility	E1081	540	701	710	10	yes		yes
NPI--Archive FIN	E1082	3105	711	720	10	no		no
Archive FIN	E1083	3100	721	730	10	no		no
Accession Number--Hosp	E1084	550	731	739	9	yes		yes

### II.5.2 End of Record

Must be a period (.).

### II.5.3 Record Type

This is a one-character field used to identify the type of record being processed. The hospital computer system must supply the appropriate code letter at the time that the file is created. The appropriate code for each record type is listed below:

New Case	A
Correction	U
Follow-Up Only	F
Deletion	D

The code for the record type generated by the central registry is:

Shared Follow-Up	S
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### II.5.4 (NAACCR or Central Registry Record Version)

This field must contain the version code that identifies which revision of a record layout was used to create a record for the recipient. Once your software system has been modified to transmit records using the latest record layouts in this volume, all records transmitted must include the latest record version code(s), shown parenthetically after the record version data item name in each record layout.

## Section II.6 Rules to Computer Generate Data Items for Standard Setting Organizations

The California Cancer Registry is required to submit data to standard-setting organizations. There are a number of data items that are generated for these submissions. These organizations include the North American Association of Central Cancer Registries (NAACCR), NCI's Surveillance, Epidemiology and End Results Program (SEER) and the Center for Disease Control and Prevention's National Program of Cancer Registries (NPCR). Please refer to California Cancer Reporting System Standards, Volume III, for specifications for the data items listed below.

### II. 6. 1 Data Items

- Census Tract Coding System 1970/80/90
- COC Coding Sys - Current

- COC Coding Sys - Original
- Coding System for EOD
- Computer-Derived Ethnicity (formerly Spanish Surname)
- Computer-Derived Ethnicity Source
- ~~First Course Calc. Method~~
- ICD Revision Number
- Industry (Census)
- Industry Source
- Follow-Up Source- Central (Mapped from Last Type of Follow-Up (Patient))
- Morph Coding Sys - Current
- Morph Coding Sys - Original
- Occup/Ind Coding System
- Occupation (Census)
- Occupation Source
- Race Coding Sys - Current
- Race Coding Sys - Original
- Registry ID
- Registry Type
- RX Coding System - Current
- SEER Coding Sys - Current
- SEER Coding Sys - Original
- Site Coding Sys - Current
- Site Coding Sys - Original

## **Part III Quality Control Standards**

### **Section III.1 Summary**

One method used by the regional registry for insuring data quality is to pass submitted records through computer edits to assess whether coding rules have been properly followed. Two types of computer edits will be applied to submitted data: item edits and interfield edits. These edits are described in Cancer Reporting in California: Standards for Regional Registries and the California Cancer Reporting System Standards, Volume III. See Section III.4 in this manual for the acceptance standards.

### **Section III.2 Item Edits**

Most individual items will be checked for valid codes or other types of allowable values. Valid values for specific items can be found in California Cancer Reporting System Standards, Volume III. This document is available on the CCR website at [www.ccrca.org](http://www.ccrca.org).

### **Section III.3 Interfield Edits**

An interfield edit compares the contents of two or more fields for consistency. Only the New Case record will be edited. Other types of records will be checked for consistency with the previously sent New Case record, as it would be modified by this newer information. A large number of interfield edits will be applied to any data records submitted. Interfield edits are documented in California Cancer Reporting System Standards, Volume III.

## **Section III.4 Acceptance Procedure**

### **III.4.1 Acceptance Standards for Software**

Hospitals (and other reporting sources) wishing to develop their own systems for automated reporting to the regional registry, or vendors wishing to market software which meets California Cancer Registry requirements, are required to demonstrate that they have procedures in place to assure the accuracy of the data being collected. In order for another method of automated reporting to be accepted for reporting to the California Cancer Registry and its regional registries, the hospital or vendor must demonstrate the following:

1. Data must conform to the specifications described in this document.
2. Software must allow all valid values in data item fields.
3. All records must pass the item edits (California Cancer Reporting System Standards, Volume III).
4. All records must pass the interfield edits (California Cancer Reporting System Standards, Volume III).
5. A percentage of incoming records must contain data in required fields, but may be left blank if the information is not available. This percentage will vary by item. Data items are indicated by yes\* on the record layouts.

A hospital or vendor must demonstrate its ability to meet these standards before its system is accepted and it will be expected to continue to meet these standards. Each time a hospital or vendor changes the registry software (i.e., changes the version) it must again demonstrate its ability to meet these standards.

### **III.4.2 Test Submission**

In order for the California Cancer Registry to determine whether a hospital or vendor meets the above requirements, the hospital or vendor must submit test records of each type for approximately 50 cases, covering one-month, three-months, or six-months; whichever time period is closest to 50 cases. A test file cannot contain only easy cases, but must contain a sample that is representative of the normal caseload. After the submission is evaluated by the California Cancer Registry, the reporting facility or vendor will receive notification of problems detected and what changes, if any, need to be made before the reporting facility's or vendor's software can be accepted for automated reporting.

When Volume II requirements change in such a way that vendor software must be revised, then the vendor must submit additional test files to demonstrate that they meet the new requirements.

## **Appendices A, B, C, & D (Exchange Records)**

[Exchange records. Appendices A, B, C, & D, are presented in spreadsheet format. Click here to open the appendices.](#)