2015 DATA CHANGES

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Welcome to the 2015 Data Changes Overview.

OVERVIEW

- 2015 Data Changes
  - New Data Items
  - Revised Data Items
  - ICD-0-3
    - Reportability Change
    - New ICDO Terms and Codes
  - SEER Reportability Clarifications
  - CCR Updates
  - General Info-Reminders

NEW DATA ITEMS FOR 2015

- No *New* Data Fields for hospitals

- There are no **new** fields/data items for 2015
- Several new survival data items apply only to central registries which will not be reviewed in this presentation.

2015 REVISED DATA ITEMS

PATIENT SEX

- Code range expanded - 2 Codes Added:
  - Code 5: Transsexual, natal male
  - Code 6: Transsexual, natal female

1 Revised Code:

- Code 4-Transsexual, NOS (formally Transsexual)

- Codes document natal sex (sex at birth) for Transsexual patients (when known over unknown).
- IMPORTANT: TEXT documentation *required* to support codes!

There are 2 additional codes for patient sex…
Code 5 Transsexual, natal male, and
Code 6 Transsexual, natal female.

These codes were necessary to allow for identification of persons who are transsexual (transgender), and to document an individuals gender at birth (even though that person may now be living as the opposite gender).

The former Code 4 has been revised to "Transsexual NOS", previously it was simply TRANSEXUAL.

It is very important that registrars **document in TEXT patient sex for ALL cases**, and when you have a patient who is transsexual.

COUNTRY CODES

- 5 Codes Revised

Country Name	OLD Code	NEW Code
Czechoslovakia	XCG	CSK
Yugoslavia	XYG	YUG
Above replace historic-use-only ("X") codes with ISO country codes		

Country Name	OLD Code	Corrected Code
Brunei	BND	BRN
Slovakia	SWK	SVK
Vanuatu	VLT	VUT

- 1 New Code for 2015:

New Country Code 2015	Code
Saint Martin (French Part)	MAF

- See Appendix's D.1 & D.2 in Volume 1

The allowable values for the country data items have been modified. Previously Yugoslavia and Czechoslovakia were only used as historic codes, and only for Birthplace– Country. This restriction caused complications; therefore a decision was made to allow these codes to be used for ANY of the country data items, and to replace the historic-use-only ('X') codes with the ISO codes.

The ISO is the International Organization for Standardization who defines codes for countries and independent territories.

The codes for Brunei, Slovakia and Vanuatu have been revised/corrected to be in line with the ISO codes And …..

There is one NEW country code this year for the French part of Saint Martin, which is MAF.

See appendix D.1 & D.2 in Volume 1 for complete listing of codes

CLASS OF CASE

New Coding Instruction #1:

- RE: Physicians with admitting privileges:
  - "Physicians who are not employed by the hospital but are under contract with it *or* *have routine admitting privileges there, are described in codes 10-12 and 41 as physicians with admitting privileges.* Treatment provided in the office of a physician with admitting privileges is provided "elsewhere". That is because care given at the physician's office is not within the hospital's realm of responsibility"

FORDS Manual, page 113
CCR Volume I Updated

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A NEW BULLET WAS ADDED to the coding instructions for Class of Case. **The new wording essentially replaces the term "staff physician" with a more descriptive clarifying narrative.** This additionally clarifies that treatment provided in the office of a physician with admitting privileges is considered "treatment elsewhere" which will affect class of case code assignments. The term "staff physician" was not being interpreted consistently by registrars and facilities, and this description will hopefully make the distinction more clear and help assigning class of case.

CLASS OF CASE

- **Revised Definition: Modified wording for codes 10,11,12, and 41**

Code 10:

Initial diagnosis is at the reporting facility or *in an office of a physician with admitting privileges* AND part or all of first course treatment or a decision not to treat was done at the reporting facility.

Code 11:

Initial diagnosis **is** *in an office of a physician with admitting privileges* AND part of first course treatment was done at the reporting hospital.

FORDS pg 113
CCR Volume I Updated

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Modified wording for Class of Case codes 10, 11, 12, and 41.

For all Class of Case codes 10, 11, 12 and 41, the wording has been changed; Staff physician has been removed and replaced with **"in an office of a physician with admitting privileges".**

CLASS OF CASE

- **Revised Definition: Modified wording for codes 10,11,12, and 41**

Code 12:

Initial diagnosis is *in an office of a physician with admitting privileges* AND all first course treatment or a decision not to treat was done at the reporting facility.

Code 41:

Diagnosis and all first course treatment is given in two or more different *offices of a physician with admitting privileges.*

FORDS pg 113
CCR Volume I Updated

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Class of Case descriptions with revised wording

CLASS OF CASE

New Coding Instruction #2:

- RE: Purchase of Physician Practice by a Hospital
  - If the hospital purchases a physician practice, it will be necessary to determine whether the practice is now legally considered part of the hospital, (their activity is coded as the hospital's) or not.
  - If the practice is not legally part of the hospital, it will be necessary to determine whether the physicians involved have routine admitting privileges or not [to your hospital], as with any other physician.
  - **Must determine to assign correct class of case code.**

FORDS pg 113
CCR Volume I Updated

Bullet updated to clarify the purchase of a physician's office and how to determine its relationship with the hospital. This determination is important because it will affect the class of case assigned.

This clarification is especially timely since in CA we have recently seen several hospital systems expand their patient care services with purchase of radiation facilities, medical groups, surgery centers, and other types of diagnostic centers. What the registrar/facility will need to clarify is if any of these "entities" are considered legally part of the hospital----usually that means any services provided there, even if not physically located within the walls of the hospital, are BILLED and CODED as being provided by the reporting hospital.

OR, if the purchase of a medical group or ROC center by the parent organization who also owns the hospital, however, services at these locations are still billed separately from the reporting hospital, in which case this MAY mean it is not legally part of the reporting hospital, but rather part of the parent organization.

Either scenario will change the class of case assignment. So if your facility or parent organization has made such purchases, you need to clarify with your organization the legal specifics.

CLASS OF CASE

Coding Instruction Update

"IN-TRANSIT" CARE"

CODE 31:

- **"In-transit"care**: Care of a patient who is temporarily away from the patient's usual practitioner for continuity of care. If these cases are abstracted, they are ***Class of Case 31***
- Monitoring of oral medication started elsewhere *Class of Case 3*1.

Reporting Requirement Change

- **NOTE: CCR requires *Class of Case 31* to be reported via an abstract - CMR reporting is no longer acceptable**

In Transit care Class of Case Code 31: Use with patients visiting area who receive treatment in order to maintain their continuity of care. This applies to oral medications as well.

NOTE: Reporting requirement change for California; Class of Case 31 cases must be reported via an abstract- CMR reporting is no longer acceptable.

2015

REPORTABILITY CHANGE & ICD-O-3 UPDATES

REPORTABILITY CHANGE
CARCINOID OF APPENDIX

- **Carcinoid tumor of the appendix (C18.1)**
  - **Case is reportable- Must code as behavior 3**
  - Code histology to *8240/3*
  - Effective for cases dx 1/1/2015
- **Code *8240/1* Carcinoid tumor, NOS of appendix (C181.1)** *obsolete in 2015*

Effective for cases 1/1/2015 we have a NEW reportability requirement for Carcinoid tumors, NOS of the appendix. These tumors are reportable and considered "malignant".

Code histology to 8240, behavior 3

Note code 8240/1- Carcinoid tumor, of the appendix becomes obsolete is 2015

ICD-O-3 / CODE *CHANGE*
Two PANCREATIC tumors

Same Term – Code Change		
Pancreas	Old Code Pre-2015	Code Change 2015 forward
Enteroglucagonoma, NOS (uncertain behavior)	8157/1	8152/1 Can use in 2015
Enteroglucagonoma, Malignant	8157/3	8152/3 Can use in 2015
Code 8157 is obsolete effective in 2015		
NOTE: Reportability rules based on behavior still apply; the addition of /0 or /1 to ICD-0 term does NOT imply it is now reportable (exception is primary intracranial and CNS benign/borderline reportable tumors)		

Two Pancreatic tumors have a new histology code, but the terms have not changed.

Enteroglucagonoma, NOS of uncertain behavior as well as Enteroglucagonoma, malignant should be coded to 8152/1 and 8152/3 respectively.

Note: Code 8157 becomes obsolete in 2015

Note: Reportability rules based on behavior code still apply. With the exception of primary intracranial and central nervous system tumors, the addition of behavior code 0 and code 1 (benign or borderline) to a histology code does NOT imply that is now reportable.

ICD-O-3 UPDATES
HISTOLOGY TERMS & CODES

- New Codes and/or Terms added to ICD-O-3
  - **7 new terms (6 new codes) are reportable malignant(/3) tumors**
  - **4 new terms (3 new codes) for reportable borderline (/1) tumors of the central nervous system.**
  - **4 new terms not reportable**

Important Note: **Many of the new codes cannot be used for 2015 diagnoses**

- **Not included in Collaborative Stage Algorithm's**
- **If used, CS schema cannot be determined nor stage derived**

ICD-O has been updated and there are now 15 new ICD-O-3 codes of relevance for data collection.

HOWEVER, for diagnosis year 2015 many of these new ICD-0-3 codes cannot be used. Since we will still be collecting CS stage data, these new codes are not included in the CS Scheme, therefore if any of these codes were used, registry software would not be able to determine the correct schema to code, nor run the CS algorithms.

We will review these codes and terms in the upcoming slides.

ICD-O-3
NEW HISTOLOGY TERMS & CODES

**New Term and Codes - Reportable*
"Malignant tumors"**

New Term	New Code*	Use this Code for 2015**
Pancreatobiliary type carcinoma (C24.1) • New synonym: Adenocarcinoma pancreatobiliary type (C24.1)	**8163/3**	8255/3
Micropapillary carcinoma NOS (C18._, C19.9, C20.9)	**8265/3**	8507/3 (change behavior)
Mixed acinar ductal carcinoma	**8552/3**	8523/3

*Do not use the new ICD-O-3 codes for diagnosis year 2015

** ICD-O-3 rule F applies (code behavior stated by pathologist). If necessary, over-ride any advisory messages.

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NEW Terms and Codes

- **Pancreatobiliary type carcinoma**
- Synonym is adenocarcinoma, pancreatobiliary type
  - ***New code is 8163/3.***
  - However, for cases diagnosed in 2015 if you see these terms in the medical record, **you are to Use code 8255/3** (Adenocarcinoma with mixed subtypes)

- **Micropapillary carcinoma** NOS (C18._, C19.9, C20.9)
  - ***New code is 8265/3***
  - **In 2015 use code 8507/3** (Intraductal micropapillary ca & substitute behavior of /3 to 8507)

- **Mixed acinar ductal carcinoma**
  - ***New code 8552/3***
  - **In 2015 use code 8523/3** (Infiltrating duct mixed with other types of ca- no need to change behavior)

ICD-O-3
NEW HISTOLOGY TERMS & CODES

**New Term and Codes - Reportable*
"Malignant tumors"**

New Term	New Code*	Use this Code for 2015**
Serrated adenocarcinoma	**8213/3**	8213/3 (change behavior)
Papillary tumor of the pineal region	**9395/3**	9361/3 (change behavior)
Pilomyxoid astrocytoma	**9425/3**	9421/3 (change behavior)

*Do not use the new ICD-O-3 codes for diagnosis year 2015

**ICD-O-3 rule F applies(code behavior stated by pathologist). If necessary, overide any advisory messages.

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New terms and Codes

- **Serrated Adenocarcinoma**
  - ***New code 8213/3***
  - **In 2015 use code 8213/3** (Serrated adenoma 8213/1: note you change the behavior to a 3).
  -

Then we have two malignant CNS tumors

- **Papillary tumor of pineal region**
  - ***New code 9395/3.***
  - **In 2015 use code 9361/3** (pineocytoma 9361/1: note you change the behavior to a 3).

- **Pilomyxoid astrocytoma**
  - ***New code 9424/3***
  - In 2015 Use code 9421/3 (pilocytic astrocytoma 9421/1: note you change the behavior to a 3).

ICD-O-3
NEW HISTOLOGY TERMS & CODES

**New Term and Codes - Reportable*
"Borderline CNS Tumors"**

New Term	New Code*	Use this Code for 2015**
Angiocentric glioma	**9431/1**	9380/1 (change behavior)
Pituicytoma	**9432/1**	
Papillary glioneuronal tumor • New related term: o Rosette-forming glioneuronal tumor	**9509/1**	9505/1

*Do not use the new ICD-O-3 codes for diagnosis year 2015

**ICD-O-3 rule F applies(code behavior stated by pathologist). If necessary, overide any advisory messages.

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These are all Borderline **CNS** tumors :

New term

- **Angiocentric glioma**
  - ***New code 9431/1***
  - **In 2015 use 9380/1** (glioma, malignant 9380/3 Note; change the behavior to a 1 instead of 3).

- **Pituicytoma**
  - ***New code 9432/1***
  - **In 2015 use code 9380/1**- follow same rule as above, changing behavior from 3 to 1.

- **Papillary Glioneuronal tumor**
- Synonym/related term: Rosette-forming glioneuronal tumor
  - ***New code 9509/1***
  - **In 2015 use code 9505/1** (Ganglioglioma, NOS; no change in behavior needed)

ICD-0-3
NEW HISTOLOGY TERMS & CODES

New Term and Codes "Not Reportable"	
New Term(s)	New Code or behavior variant
Endocrine tumor, functioning, NOS • New related term o ACTH-producing tumor	8158/1 new
Calcifying nested epithelial stromal tumor	8975/1 new
Low grade appendiceal mucinous neoplasm (C18.1)	8480/1 (new behavior variant)
Indolent systemic mastocytosis	9741/1 (new behavior variant)

The following are **new terms** however these conditions are **not reportable.**

- **Endocrine tumor, functioning, NOS**
  - Related term **ACTH producing tumor**.
  - ***New Code 8158/1***

  Sometimes found in the pituitary gland where they increase the production of adrenal gland hormone Adrenocorticotropic hormone (ACTH). Can also be found in the bronchus or lung.

- **Low grade appendiceal mucinous neoplasm**
  - ***New code 8975/1***-

  Can be found at surgery for appendicitis

- **Calcifying nested epithelial stromal tumors**
  - ***Code 8480/1***(new behavior variant of existing code)

  Often found in the liver or intrahepatic bile ducts.

- **Indolent systemic mastocytosis**
  - ***Code 9741/1*** (new behavior variant of existing code)

  Proliferation of mast cells in the body; can be noted in cutaneous skin lesions, bone marrow, or other body tissues.

ICD-0-3
NEW HISTOLOGY TERMS & CODES

For a list of New ICD-0-3 codes & terms see:

- **2015 ICD-O-3 Coding Crosswalk**
  - Volume I, V.3 , Attachment A

To view a comprehensive list of the previously described new ICDO terms and codes, refer to the crosswalk table located in **Volume 1, V.3, Attachment A**

2015

SEER

REPORTABILITY CLARIFICATIONS

SEER REPORTABILITY CLARIFICATIONS

Site	New Reportable Term	Histology	Effective
Pancreas (C25.0-C25.9)	Neuroendocrine Tumor when clinical dx is insulinoma	8240/3 or 8151/3	1/1/2015+
Pancreas (C25.0-C25.9)	Cystic pancreatic endocrine neoplasm (CPEN)	8150/3	1/1/2015+
Pancreas (C25.0-C25.9)	Cystic pancreatic endocrine neoplasm specified as neuroendocrine tumor, Grade 1	8240/3	1/1/2015+
Pancreas (C25.0-C25.9)	Cystic pancreatic endocrine neoplasm specified as neuroendocrine tumor, Grade 2	8249/3	1/1/2015+
Pancreas (C25.0-C25.9)	Solid pseudopapillary neoplasm of pancreas	8452/3	1/1/2015+
Pancreas (C25.0-C25.9)	Non-invasive mucinous cystic neoplasm (MCN) of pancreas with **high grade dysplasia** *NOTE: Term "high-grade dysplasia" replaces term mucinous cystadenocarcinoma, non-invasive*	8470/3	1/1/2015+

These are newly reportable terms, per the SEER reportability guidelines. Note these all apply to the pancreas.

These new terms are the preferred pathologic terminology to describe these histologic types, but you will note they include the word "neoplasm"; HOWEVER, these terms ARE reportable tumors.

SEER REPORTABILITY CLARIFICATIONS

Site	Reportable Term	Histology
TESTES (C62.0-C62.9)	**"Mature teratoma" of testes in an adult** *is malignant and reportable* • Adult defined as post puberty • Pubescence can take place over a number of years • **Do not report if unknown whether patient is pre or post pubescence.** • Do not rely solely on age to indicate pre or post puberty status - review physical history, etc.	9080/3

As a reminder, the following histologies are NOT reportable:
- Mature teratoma of the ovary - BENIGN condition, therefore, NOT reportable
- Mature teratoma of the testes diagnosed prior to puberty is NOT reportable
- Venous angiomas are NOT reportable wherever they arise
  - **The combination of 9122/0** (venous hemangioma) **and C490* is NOT reportable.**
  - NOTE: This is a venous abnormality, previously referred to as venous angiomas and currently referred to as developmental venous anomalies (DVA)

***C490** (Connective, subcutaneous and other soft tissues of head, face, and neck. Includes adipose tissue, aponeuroses, artery, blood vessel, bursa, connective tissue, fascia, fatty tissue, fibrous tissue, ligament, lymphatic, muscle, skeletal muscle, subcutaneous tissue, synovia, tendon, tendon sheath, vein, vessel

Mature teratoma of the testes in an adult is malignant and reportable.
- An adult is described as someone who is post puberty
- Mature teratoma in a child pre puberty is not reportable.

You cannot rely on a statement of patient age to determine if someone is pre or post puberty. Careful review of the medical record is required to clarify if the patient is "pre" or "post" puberty.

- As a reminder, teratoma of the ovary is a benign condition, therefore NOT reportable.
- Mature teratoma diagnosed prior to puberty is not reportable
- Venous angiomas are not reportable wherever they arise.

2015 CCR UPDATES

ADDRESS AT DX-"HOMELESS"

New Coding Instructions:

- **If patient is homeless or transient with no usual residence:**
  - Enter Street, City and Zip as Unknown
  - Code county at residence to county where hospital is located
  - Code state to California
  - Document patient is "Homeless" or "Transient" in TEXT remarks field
- **Coding otherwise would be incorrect in CA**
  - **Important from a research perspective**
  - **To code otherwise would skew cluster investigations.**

If the patient is homeless or transient the CCR directs the following for recording address at diagnosis.

- ✓ ***Enter street, city and zip code as unknown***
- ✓ ***Code county of residence to county where hospital is located and***
- ✓ ***Code the state to California.***
- ✓ ***Document the patient is "Homeless" or "Transient" in Remarks field.***

NOTE: Coding address information for homeless/transient patients in this manner is important from a research perspective. Attempting to code otherwise would be incorrect in California and would skew cluster investigations.

DATE OF BIRTH AGE 100 YEARS+

- DOB - patient age is 100 years or older
- **Registrars *must* document the patient's age in the Text Remarks field**

- If the patient is 100 years old or older based on date of birth, DO NOT FORGET TO DOCUMENT IN TEXT CONFIRMING THE PATIENT'S AGE IS 100(+).
- Text documentation in this manner is **required.**

TREATMENT DATA COLLECTION REQUIREMENTS 2015

California Cancer Registry

Requires:

- Treatment dates
- Treatment Date flags

AND

- **All other treatment data fields for all modalities (Surgery, Chemo, Radiation, Hormone, etc.)**

- Treatment Associated Dates & Date flags as well as ALL other treatment data fields for all modalities ARE REQUIRED TO BE COMPLETED/COLLECTED.

NEW VISUALLY EDITED ITEMS 2015

Treatment field	Feedback Only	Discrepancy Counted
Surgical Procedures 1-3 • RX Date Surgery • RX Date Surgery Flag • Surgery Prim 1-3 • Scope LN Proc 1-3 • Surg Other Proc 1-3	7/1/2015 to 12/31/2015 Not counted in accuracy rate	Surgery & Radiation Will be counted as a set/single discrepancy after six months 1/01/2016 forward
Radiation • RX Date Radiation • RX Date Radiation Flag • Rad Reg RX Modality • Rad Boost RX Modality • Radiation Summary • Radiation Sequence • Location of Radiation • Reason No Radiation		

In addition to the current list of visually edited data items…… in 2015 all the treatment fields have been added.

- Note feedback only will be provided for six months from 7/1/2015 through Dec 31 2015 for treatment data.
- Treatment dates and treatment modalities are especially important moving forward with TNM staging to establish And verify those cases with neoadjuvant therapy.
- RX Date flags are auto generated by some registry software so if you don't know what a date flag is, your software is likely auto-populating them. So no worries. But for those who do manually enter date flags, note that these are on the list of VE item.

NEW VISUALLY EDITED ITEMS

Treatment field	Feedback Only	Discrepancy Counted
Chemotherapy • RX Date Chemo • RX Date Chemo Flag • Chemotherapy Summary • Chemotherapy At This Hosp	7/1/2015 to 12/31/2015 Not counted in Accuracy Rate	Chemotherapy Hormone Therapy Immunotherapy/BRM Each counted as a set/single discrepancy after six months 1/01/2016 forward
Hormone Therapy • RX Date Hormone • RX Date Hormone Flag • Hormone Summary • Hormone At This Hosp		
Immunotherapy • RX Date Immunotherapy • RX Date Flag Immuno • Immunotherapy Summary • Immunotherapy At This Hosp		

- Note that each treatment category and all its data elements are considered a "set". Any number of discrepancies within the category set only counts as 1 (one) discrepancy
- Note feedback only on treatment data will be provided for six months from 7/1/2015 through Dec 31 2015.

NEW VISUALLY EDITED ITEMS

Treatment field	Feedback Only	Discrepancy Counted
Transplant & Endocrine Therapy • RX Date Transplant/endo • RX Date Flat • Transplant/Endo Summary • Transplant/Endo At This Hosp	**7/1/2015** **to** **12/31/2015** Not Counted in Accuracy Rate	Transplant & Endocrine Therapy Other Therapy Counted as a **set/single** discrepancy after six months 1/01/2016 forward
Other Treatment • RX Date Other • RX Date Flag • Other Therapy Summary • Other Therapy At This Hosp		

- Note that each treatment category and all its data elements are considered a "set". Any number of discrepancies within the category set only counts as 1 (one) discrepancy
- Note feedback only on treatment data will be provided for six months from 7/1/2015 through Dec 31 2015.

NEW VISUALLY EDITED ITEMS

Cancer Staging	Feed Back Only 7/1/2015 - 6/30/2016
SUMMARY STAGE	Not counted in accuracy rate for cases diagnosed **7/1/2015 - 6/30/2016**
• Directly coded **SEER Summary Stage 2000**	
AJCC TNM STAGE	NOTE: **ONE YEAR PERIOD OF FEEDBACK!**
• Directly assigned **TNM fields a-c below**	
a. T,N,M Clinical & Stage Group	For a complete list of all VE items in 2015 see the CCR website
b. T,N,M Pathologic & Stage Group	
c. TNM Edition Number	

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For the new VE data items for directly coded Summary Stage and AJCC TNM Stage, feedback **will be provided for ONE FULL YEAR** prior to discrepancies being counted.

7/1/2015 through 6/30/2016.

For a complete list of visually edited data items please go to the California Cancer Registry website >Registrar Resources > Visually Edited Data Items > Visually Edited Data items for 2015 Data Changes.

2015 GENERAL INFO

REMINDERS:
- STAGING TRANSITION TIMELINE
- "HEME" DATABASE UPDATE

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STAGING TRANSITION TIMELINE

Stage System	2014 Diagnosis	2015 Diagnosis	2016 Diagnosis
CS Stage	• CS Staging required (V02.05)	• CS Staging required	• CS no longer required • **Stay tuned-Some yet TBD prognostic factors may still be collected.**
Summary Stage	• Derived	• Directly Coded Summary Stage **required from all facilities**	
TNM	• Directly coded cTNM & pTNM required "as available"	• Directly Coded cTNM & pTNM **required from CoC facilities** • "As available" from other facilities	• Directly coded cTNM & pTNM **required from all facilities**

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Please review the staging timeline so you are clear on when your facility will be required to report directly coded TNM and Summary Stage.

Note that while CS is no longer required in 2016, some prognostic factors which are required for staging and currently captured in CS site specific factors will likely still need to be collected in some fashion. Which prognostic factors and the data fields used for collection are yet to be determined. As soon as the standard setters make their decisions we will provide an update.

HEMATOPOIETIC AND LYMPHOID NEOPLASM CODING MANUAL & DATABASE CHANGES

- **Update Released 1/14/15**
  - Consolidates 2010 & 2012 "HEME" Databases/Manuals into one
  - Earlier versions (2010 and 2012) no longer available
- **Use for cases diagnosed 1/1/2010 forward**
- "Heme" database rules take precedence over ICD-0-3 rules for coding hematopoietic and lymphoid neoplasms

Reminder: The Hematopoietic and Lymphoid Neoplasm Coding Manual & Data base underwent consolidation as well as update and revisions, and was re-released in 1/14/15.

For coding hematologic and lymphoid neoplasm the "Heme" database and manual rules regarding histology, tumor grade and MPH rules take precedence over ICD-0-3 rules.

HEMATOPOIETIC AND LYMPHOID NEOPLASM CODING MANUAL & DATABASE CHANGES

- 24 Obsolete Hematopoietic Histologies
  - Obsolete histologies results in necessary data conversions
  - Conversions done at central registry level
  - Applied to 3 data items:
    - **Histology, Primary site, and Grade**
    - Results in CS schema change for some cases and other CS data fields changes
- Conversions apply to malignant (/3) histologies 9590-9992 for cases dx 1/1/2010 forward

The "Heme" database conversion resulted in 24 obsolete histologies which required(s) data conversion for some histologies/primary sites.

3 steps to conversion
Step 1: Obsolete histologies converted to the current histologies
Step 2: Grade assigned to current histologies
Step 3: Primary site assigned to current histologies

Data conversions done at central cancer registry level

HEMATOPOIETIC AND LYMPHOID NEOPLASM CODING MANUAL & DATABASE CHANGES

After Data Conversion:

- **Manual review required for some Histologies/Sites**
  - Review required for *all registries*
  - Number of cases needing review will be minimal
- **Many registries will not have any cases to review**
  - Check with your software vendor
  - May have new filter/report to identify your cases

The "Heme" data conversion results in a need to manually review some cases which are unable to be converted automatically. The number cases needing review will be minimal. Less than 500 cases nationally meet the criteria.

Check with your software vendor to see if your 2015 data changes version will contain a report you can run to identify any cases which may need a manual review.

HEMATOPOIETIC AND LYMPHOID NEOPLASM CODING MANUAL & DATABASE CHANGES

"Heme" Database and Manual

2 versions available:

- Web-based version – always current
  - **Can access from any computer**
  - **Option for users without permission to install software on their work computers.**
- Downloadable Hematopoietic Database Software Version -"Stand-Alone"
  - **Auto updates with newly published data when you connect to the internet.**

Registrars can choose to access the "Heme' database and manual using the web version or a stand-alone version. The stand-alone version can be downloaded to your desktop but will auto update any time your computer is connected to the internet. This feature can be useful if you have times you need to work offline for any reason.

HEMATOPOIETIC AND LYMPHOID NEOPLASM CODING MANUAL & DATABASE CHANGES

- Some Highlights:
  - **New** First Course of Treatment Section
    - Provides information on coding treatment
  - **New** GLOSSARY Feature
    - Terms underlined in hematopoietic descriptions can be clicked to see definition
  - Rule clarifications and revisions
    - A complete list of changes are available on the SEER website

http://seer.cancer.gov/tools/heme/update.html

Some highlights in the updated "Heme" database include:

- A new first course treatment section which provides info on coding treatment.
- New Glossary feature

Example:Plasmacytoma
A type of cancer that begins in the plasma cells (white blood cells that produce antibodies). A plasmacytoma may turn into multiple myeloma. Clonal proliferation of plasma cells cytologically and immunophenotypically identical to those of plasma cell myeloma but manifesting as localized osseous growth.

For a complete list of revisions and updates to the "Heme" database please see the SEER website.

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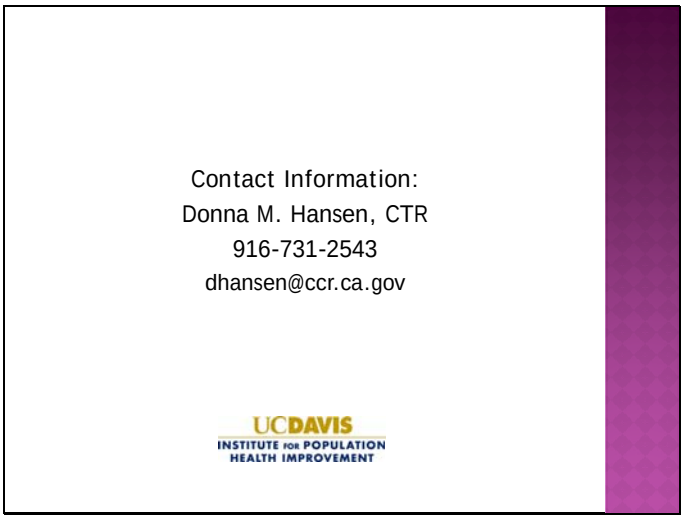
- Kyle Ziegler, CTR

Thank you to Cheryl Moody, Mary Brant and Kyle Ziegler for contributions to this presentation.



- For questions please see contact information at left.

- See the CCR website for a narrated recorded version of this presentation if desired.