NAACCR
2007 Implementation Guidelines and Recommendations

(For NAACCR Standards Volume II, Data Standards and Data Dictionary, Version 11.1,

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NAACCR 2007 IMPLEMENTATION WORK GROUP

Andrew Stewart, M.A., Co-Chair
American College of Surgeons
Telephone: (312) 202-5285
Fax: (312) 202-5009
*E-mail: astewart@fa*cs.org

Frances Ross, CTR Co-Chair
Kentucky Cancer Registry
Telephone: (859) 219-0773
Fax: (859) 219-0557
E-mail: fer@kcr.uky.edu

Lori A. Havener, CTR
NAACCR, Inc.
Telephone: (217) 698-0800 ext. 5
Fax: (217) 698-0188
E-mail lhavener@naaccr.org

Peggy Adamo, RHIT, CTR
National Cancer Institute
SEER, DCCPS, Cancer Statistics Branch
Telephone: (301) 435-4971
Fax: (301) 496-9949
*E-mail:*c s . o r

1 INTRODUCTION

The North American Association of Central Cancer Registries, Inc. (NAACCR) 2007 Implementation Work Group has been working with the American College of Surgeons' (ACoS) Commission on Cancer (CoC), National Cancer Institute's (NCI) Surveillance Epidemiology and End Results (SEER) Program, Centers for Disease Control and Prevention (CDC) National Program of Cancer Registries (NPCR), National Cancer Registrars Association (NCRA), Canadian Council of Cancer Registries (CCCR), central cancer registries, and cancer registry software vendors to develop an implementation plan for Version 11.1 standards. NAACCR Standards for Cancer Registries Volume II, Version 11.1, *Data Standards and Data Dictionary,*

New Data Items for 2007 Implementation	
NAACCR Item Name	**NAACCR Item #**
NPI--Registry ID	45
NPI--Reporting Facility	545
NPI--Archive FIN	3105
NPI--Physician--Primary Surg	2485
NPI--Physician--Managing	2465
NPI--Physician--Follow Up	2475
NPI--Physician 3	2495
NPI--Physician 4	2505
NPI--Inst Referred From	2415
NPI--Inst Referred To	2425
NPI--Following Registry	2445

3.2 Other New Data Items

The following five data items (in Standards Volume II, Version 11.1) will be implemented for cases diagnosed on or after January 1, 2007. Leave bl

Ambiguous Terminology:
Change from code1 to code 2 when, more than 2 months after the initial ambiguous diagnosis, a conclusive diagnosis was made by any diagnostic method including clinical diagnosis, cytology,

5 EDITS

The NACR111 (version 11.1) metafile includes edits on all of the new and modified data items as specified in Standards Volume II, Version 11.1. The edits and edit sets are consistent with the reporting requirements as specified in this document by CoC, NPCR, and SEER.

To download the new metafile from the NAACCR Web site (www.naaccr.org), click on Registration Standards, NAACCR Data Standards for Cancer Registries, and Standard Data Edits. Then select Version 11.1 Metafile under Current Metafiles.

As additional changes are made to the metafile, NAACCR Listserv messages will be sent to the cancer registry community.

It should also be noted that a new version of the CDC EDITS software will be available in the late fall of 2006. The EDITS software provides the tools that are used to develop and maintain the various metafiles of edits and edit sets (NAACCR, NCDB, NPCR, SEER, and state-specific). The EDITS tools have been changed as follows:

- Both GenEDITS and GenEDITS Lite, the current software programs for running selected sets of edits against data and generating edit error reports, will be replaced by GenEDITS Plus. GenEDITS Plus is faster, more efficient, and easier to use. In addition, it can handle very large edit sets and it provides additional report options and flexibility.
- EditWriter, the EDITS tool used for developing the edit metafiles, has been converted from its MS DOS version (EditWriter, Version 2) to a Windows version (EditWriter, Version 3). EditWriter can be used to write edits, create edit sets, and produce reports of the edits and edit sets included in a metafile.
- Software providers should be aware that there is also a new version of the EDITS Application Program Interface (API), sometimes called the EDITS Engine, available in Dynamic Link Library (.DLL) form. It has been upgraded for increas

6.1 CoC Reporting Requirements for 2007

Beginning with cases diagnosed on or after January 1, 2007, CoC will implement the data collection and submission requirements as published in the NAACCR Standards Volume II, Version 11.1, Chapter VIII, Required Status Table updated in this document dthis document dthis docullection and

> NPI is not classified as protected health information (PHI), and as such the NPI can be transmitted between parties that have entered into a business associate agreement and where transmission of limited data sets (those that do not include PHI) occurs."

The CoC will prefer that approved program cancer registries use the items NPI-Physician 3 [2495] and NPI-Physician 4 [2505] to indicate the physicians who performed the most definitive radiation therapy and systemic therapy, respectively. If registries choose to identify another physician, the facility will need to develop and implement definitions for analysis.

Install the software update from your provider when it becomes available. Once it has been installed, use it for coding CS input for all future cases, whether they were diagnosed in 2007 or earlier. You may now code CS for new Other Lip and Ethmoid Sinus cases using the new manual.

Once the software update is installed, follow your provider's instructions for updating the cases described

NPCR Requirements for New Data Items Standards Volume II, Version 11.1			
NAACCR Item Name	**NAACCR Item #**	**NPCR Collect**	**NPCR Transmit**
Ambiguous Terminology Dx	442	.	.
Date of Conclusive DX	443	.	.
Mult Tum Rpt as one Prim	444	.	.
Date of Multiple Tumors	445	.	.
Multiplicity Counter	446	.	.
NPI--Reporting Facility	545	R*	.
NPI--Registry ID	45	.	.
Primary Payer at Dx	630	R*	R*
. = no recommendations; R = required; R* = required when available			

6.2.1 NPCR Multiple Primary and Histology Rules Reporting Requirements

Beginning with cases diagnosed on or after January 1, 2007, the NPCR will require full adoption of the Multiple Primary and Histology (MP/H) coding rules, as documented by the SEER program. These requirements ***do not*** include the coding and reporting of the data items related to the Multiple Primary and Histology rules (See Section 6.2).

6.2.2 NPCR NPI Reporting Requirements

The NPCR Program requires the collection but not transmission of the National Provider Identifier – Reporting Facility as codes become available (See Section 6.2).

6.2.3 NPCR Reporting Requirements Primary Payer at Diagnosis

The NPCR Program requires that the Primary Payer at Diagnosis be collected and transmitted when available (See Section 6.2).

6.2.4 NPCR Reporting Requirements for CS Release 01.03.00

The NPCR Program recommendations and requirements, as listed in the Collaborative Stage announcement for version 01.03.00 include the following:

- NPCR recommends that the new CS version be implemented as soon as possible.
- Beginning with cases diagnosed on January 1, 2007, all cases must be coded using CS version 01.03.00.
- Prior to the January 2007 NPCR-CSS data submission, registries must download, replace, and re-run CS version 01.03.00 to correct derived Collaborative Staging.
- Prior to the January 2008 NPCR-CSS data submission, the review and any necessary recoding of cases diagnosed 2004 through 2006 must be completed.

The CS Record Log of Changes posted on http://cancerstaging.org/cstage/index.html gives detailed information on the changes made between CS version 01.02.00 and CS version 01.03.00.

6.2.5 NPCR Reporting Requirements for New Data Items

The data items associated with the Multiple Primary and Histology rules [444-446] are not required to be collected or submitted to NPCR-CSS.

The data items, Ambiguous Terminology DX [442] and Date of Conclusive DX [443], are not required to be collected or submitted to NPCR-CSS.

6.2.6 NPCR Recommendations for Education and Training

The NPCR Program requires that the central cancer registry has a designated education/training coordinator who is a CTR to provide training to the central cancer registry staff and reporting sources to ensure high-quality data.

The NPCR Program recommends that the designated education/training coordinator in each state participate in the NPCR Education and Training Series (NETS). The purpose of this training series is to build the educational capacity in the central registries, resulting in a solid infrastructure to provide education and day-to-day support of the data collectors.

The NPCR Program requires that the central cancer registry implement and deliver training for the new Multiple Primary and Histology (MP/H) rules that are effective with a 2007 date of diagnosis. This training will be provided for the data collectors as well as the central cancer registry staff, and should be delivered by the trainer who participated in the formal sessions given by SEER.

The NPCR Program recommends that the central cancer registries participate in the online Web conferences called Breeze sessions. These are offered by SEER to provide a basic understanding of the Multiple Primary and Histology (MP/H) Coding rules, how they were created, and how they work; to

Changes to SEER Reporting Requirements for 2007 Standards Volume II, Version 11.1			
NAACCR Item Name	**NAACCR Item #**	**SEER Collect**	**SEER Transmit**
NPI--Registry ID	45	R*	.
NHIA Derived Hisp Origin	191	D	R
Computed Ethnicity	200	D	R
GIS Coordinate Quality	366	S	.
Ambiguous Terminology	442	R	R
Date of Conclusive DX	443	R	R
Mult Tum Rpt as One Prim	444	R	R
Date of Multiple Tumors	445	R	R
Multiplicity Counter	446	R	R
Casefinding Source	501	R	R
NPI--Reporting Facility	545	R*	.
Primary Payer at DX	630	R	R
SEER Summary Stage 2000	759		S
RX Summ--Systemic/Sur Seq	1639	R	R
Addr at DX--Supplementl	2335	R	.
DC State File Number	2380	R*	.
NPI--Following Registry	2445	R*	.
NPI--Physician--Follow Up	2475	R*	.
RX Date--Systemic	3230	S	.
. = no recommendations; R = required; R* = required when available; S = Supplementary/Recommended			

6.3.1 SEER Multiple Primary and Histology Rules: Reporting Requirements

The SEER Program is requiring the adoption of the 2007 Multiple Primary and Histology rules for tumors diagnosed on or after January 1, 2007:

- The 2007 Multiple Primary rules replace all previous multiple primary rules except those for benign brain/CNS and hematopoietic neoplasms.
- The rules are effective for cases diagnosed on or after January 1, 2007. Do not use these rules to abstract cases diagnosed prior to January 1, 2007.
- If there is a previously diagnosed primary before January 1, 2007, do not change the previous primary based on the new rules but use the new multiple primary rules for any new tumor diagnosed after January 1, 2007, to determine if it is an additional primary.

Note: Use the SEER Program Coding and Staging Manual 2007 to determine the reportability of a cancer diagnosis; use the 2007 Multiple Primary and Histology rules to determine the number of primaries to be abstracted.

6.3.2 SEER NPI Reporting Requirements

The SEER Program encourages the central registries to adopt the NPI when it becomes available. Because there will be legacy data from facilities that have closed or physicians who have died, the local physician and facility codes will have to be maintained in those instances where there is not an NPI number. The status codes in the requirements table were changed from R to R*.

6.3.3 SEER Reporting Requirements for CS Release 01.03.00

Recommendations from the National Cancer Institute–Surveillance, Epidemiology and End Results Program (NCI-SEER), as listed in the release announcement, include the following:

- SEER recommends that participating central cancer registries work closely with their hospital registries to avoid duplication of effort in implementing CS version 01.03.00.
- SEER also recommends that the new CS version be implemented as soon as possible.
- Beginning with cases diagnosed on or after January 1, 2007, all cases must be coded using CS version 01.03.00. CS version 01.03.00 will be incorporated into the SEER Program Coding and

http://www.seer.cancer.gov/tools/mph_speakers.html

Additional training is being provided using technology that integrates slide presentations with live oral delivery. These are interactive sessions with audien

- If there is a biopsy previous to January 1, 2007, and the surgery occurs after the new rules (January 1, 2007), code based on the rules for the diagnosis date year (i.e., 2006).

6.4.2 CCCR NPI Reporting Requirements

NPI reporting requirements do not apply in Canada.

6.4.3 CCCR Reporting Requirements for CS Release 01.03.00

Recommendations from the Canadian Council of Cancer Registries (CCCR) (Statistics Canada–Canadian Cancer Registry [CCR]), as listed in the September 8, 2006, release announcement, are:

- Statistics Canada (STC) recommends that PTCRs implement the new CS version as soon as possible.
- Cases diagnosed on or after January 1, 2007, should be coded using CS version 01.03.00.
- The review and conversion or recoding of 2004-2006 cases should be completed before the CCR annual data submission to Statistics Canada.
- STC will run the data using the most current version of the CS algorithm. The results will be provided to the PTCRs upon request.

6.4.4 CCCR Reporting Requirements for New Data Items

The data items associated with the Multiple Primary and Histology rules [444-446] are not required to be collected or submitted to the CCCR.

The data items, Ambiguous Terminology DX [442] and Date of Conclusive DX [443], are not required to be collected or submitted to the CCCR.

6.4.5 CCCR Recommendations for Education and Training

The CCCR Committee on Data and Quality Management (DQMC) and its Education subcommittee will determine the education and training needs of the PTCRs on matters relating to professional education and designation within the PTCRs and/or the CCR and propose methods to meet those needs.

MP/H Training

The CCCR supports the recommendation to adopt the new Multiple Primary and Histology (MP/H) rules that are effective with a 2007 date of diagnosis. The CCCR has appointed a national training coordinator and two additional master trainers for MP/H, and has asked these individuals to coordinate in conjunction with the DQMC any immediate and ongoing training requirements for this implementation. All work of this group must ensure congruence with the materials and directions provided by the SEER Multiple/Primary Histology Task Force. CCCR is supportive of the national trainers and encourages PTCRs to attend training sessions. The primary training activity in Canada took place during the September 2006 national Canadian Cancer Registry Professionals Workshop (CCRPW). Training materials from the CCRPW have been provided to the PTCRs for in-house followup and review. The 2007 CCRPW may provide a forum for additional MP/H training. The PTCRs have been informed of additional training opportunities (e.g., SEER Breeze sessions; NAACCR Webinars) scheduled to take place throughout the fall of 2006 and winter/spring of 2007. A national workgroup has been developed with representation from PTCRs and STC to assess additional MP/H implementation-related issues.

6.5 Summary for Central Cancer Registries

Cases diagnosed on or after January 1, 2007, must be collected and reported in accordance with the standards and definitions of the NAACCR Standards Volume II, Version 11.1, record layout. Central cancer registry systems that have not implemented the Version 11.1 layout should develop a plan to accommodate files submitted by reporting facilities in the Version 11.1 layout. Central cancer registries should specify a date by which they will be able to accept records in the Version 11.1 layout and a date

after which they will no longer accept earlier record versions. Large backlogs of records should be avoided, both at the level of the reporting facility (records abstracted, but not submitted at the request of the central cancer registry) as well as at the level of the central cancer registry (records received and put into a suspense file to be processed at a later date).

Because all of the standard setters have adopted the new Multiple Primary and Histology coding rules effective with cancers diagnosed on or after January 1, 2007, central cancer registries must make the necessary changes to implement these as well. This includes making changes to manuals, training materials, and other documentation, as well as changes in automated and manual procedures for record consolidation. To describe cancer incidence consistently across different registries and different populations, the determination of the number of primary malignancies also must be consistent from hospital-based registries to population-based registries as well as from one central registry to another. The new multiple primary coding rules are of particular importance to central cancer registries as they process many reports from multiple facilities over an extended period of time, and they must effectively incorporate these new rules into long-established record consolidation processes.

Central registry software should be updated to use the dll/function library for CS Version 01.03.00 as soon as it becomes available. Once it has been installed, follow the providers instructions for updating the cases described in the table in Section 6.1.3.2. Any cases previously collaborative staged with a primary site of Other Lip or Ethmoid Sinus should be reviewed and manually recoded.

Central registries should distribute information on how to obtain the updated CS Manual to all reporting facilities. This information should clearly state that all changes to the manual are effective immediately and should be implemented as soon as possible. Other Lip and Ethmoid Sinus tumors may be recoded once the facility's reporting software has been updated to CS Version 01.03.00. Central registries should specify if they want reporting facilities to submit a changed record for these sites.

The CS algorithm should be re-run on all CS-coded cases, regardless of diagnosis date, when the review and recode process is complete. The CS Version 01.03.00 algorithm must be applied to all cases submitted in previous CS Versions.

6.5.1 New Data Items

Central cancer registries should carefully review the new data items in Version 11.1 and identify those data items that will be collected and/or stored in their registry, paying particular attention to those data items required by the various standard-setting organizations.

The 2007 diagnosis year will be considered a transition year regarding the collection of NPIs. NPIs may not be assigned to all reporting facilities and physicians during this time period. Both CoC and SEER require the collection of the NPI items as they become available. It should be noted that NPCR requires the collection of only one of the new NPI items [NPI- -Reporting Facility]. Central registries should continue to collect any NPI equivalent variables during this time period.

Also note, SEER and CoC require the collection of the three new items associated with the new Multiple Primary and Histology coding rules as well as the two new items regarding ambi4.68 5.7l8(e)1.4(.)-5.4(,e ne0)-1.7(e)Tj ite

also included in Appendix C.

NAACCR Standards Volume II, Version 11.1 Data Items With Revised Codes or Code Definition			
NAACCR Item Name	**NAACCR Item #**	**NAACCR Item Name**	**NAACCR Item #**

New Data Items for 2007 Implementation	
NAACCR Item Name	**NAACCR Item #**
NPI--Registry ID	45
NPI--Reporting Facility	545
NPI--Archive FIN	3105
NPI--Physician--Primary Surg	2485
NPI--Physician--Managing	2465
NPI--Physician--Follow Up	2475
NPI--Physician 3	2495
NPI--Physician 4	2505
NPI--Inst Referred From	2415
NPI--Inst Referred To	2425
NPI--Following Registry	2445

The following new multiple primary data items should be a valid code or blank for cases diagnosed prior to January 1, 2007:

New Data Items for 2007 Implementation	
NAACCR Item Name	**NAACCR Item #**
Ambiguous Terminology	442
Date of Conclusive DX	443
Mult Tum Rpt as One Prim	444
Date of Multiple Tumors	445
Multiplicity Counter	446

- Incorporate the new version of CS 01.03.00
  - Replace documentation including changes to Part I and/or Part II of the CS coding manual (available online or printed as replacement pages);
  - Replace the computer algorithm;
  - Review and recode certain codes – report or log to identify those cases to be reviewed and were recoded as applicable;
  - Update the lookups, if applicable;
  - Re-run the algorithm on previously entered CS elements to re-derive the CS fields, regardless of diagnosis date;
  - After implementation of a new CS algorithm, all CS cases should be run through the new CS dll and the CS Version Latest [2936] updated to the new version.
- Note: Prior to the January 2007 NPCR-CSS data submission, registries must download, replace, and re-run CS version 01.03.00 to correct derived Collaborative Staging.
  - Prior to the January 2008 NPCR-CSS data submission, the review and any necessary recoding of cases diagnosed 2004 through 2006 must be completed.
- The new Multiple Primary and Histology coding rules will be implemented for all data collection in the United States for cases diagnosed on or after January 1, 2007.
- The rules are site specific for the following eight site groups:
  - Head and neck
  - Colon
  - Lung
  - Melanoma of skin [C44.0-C44.9 with Histology 8720-8780]
  - Breast
  -

6.6.4 Technical Support, Education and Training

Software vendors will be expected to support their software changes and provide training on the software upgrades, which include reference to the source for information on year 2007 changes. Education and training for Version 11.1 and the new multiple primary rules as well as associated data items should be referred to the appropriate standard-setting organization.

6.6.5 Communication With Central Cancer Registries and Hospital Registries

Because of the minor changes involved in the implementation of the Version 11.1 layout, software vendors should not encounter undue problems with the transition.

Software vendors should take into consideration the central cancer registry requirements when it comes to central cancer registries' implementation of NAACCR Version 11.1 reporting; for example, state-specific metafiles, whether any data items still required by the state have been retired from the NAACCR record.

6.7 Summary for Hospital Cancer Registrars and Reporting Facilities

Implementation of NAACCR Version 11.1 reporting is required for cases diagnosed as of January 1, 2007.

6.7.1 Prioritize Case Abstracting

Registrars should prioritize their abstracting. Ideally, abstracting of cases diagnosed prior to January h 11 Tw10sesl4al012

7 APPENDIX A: CHAPTER VIII, REQUIRED STATUS TABLE (ITEM # ORDER)

Item	Item Name	NPCR		COC		SEER		Exchange Elements		Source of Standard	Note
		Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp → Central	Central → Central		
340	Tobacco History	.	.	.	.	.	.	.	.	Varies	

Item	Item Name	NPCR		COC		SEER		Exchange Elements		Source of Standard	Note
		Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp → Central	Central → Central		
570	Abstracted By	.	.	R	R	R	.	.	.	COC	
580	Date of 1st Contact	R	.	R	R	.	.	T	.	COC	
590	Date of Inpatient Adm	.	.	.	.	.	.	.	.	NAACCR	
600	Date of Inpatient Disch	.	.	.	.	.	.	.	.	NAACCR	
610	Class of Case	R	.	R	R	RC	.	T	.	COC	
615	Reserved 26	.	.	.	.	.	.	.	.		
620	Year First Seen This CA										Retired
630	Primary Payer at DX	R*	R*	R	R	R	R	.	.	COC	Revised
635	Reserved 27	.	.	.	.	.	.	.	.		Retired
640	Inpatient/Outpt Status										Retired
650	Presentation at CA Conf										Retired
660	Date of CA Conference										Retired
670	RX Hosp -- Surg Prim Site	.	.	R	R	R	.	T*	.	COC	
672	RX Hosp -- Scope Reg LN Sur	.	.	R	R	R	.	T*	.	COC	
674	RX Hosp -- Surg Oth Reg/Dis	.	.	R	R	R	.	T*	.	COC	
676	RX Hosp -- Reg LN Removed	.	.	.	RH	.	.	T*	.	COC	
680	Reserved 03	.	.	.	.	.	.	.	.		
690	RX Hosp -- Radiation	.	.	.	.	RH	.	TH*	.	SEER/COC	Revised
700	RX Hosp -- Chemo	.	.	R	R	R	.	T*	.	COC	
710	RX Hosp -- Hormone	.	.	R	R	R	.	T*	.	COC	
720	RX Hosp -- BRM	.	.	R	R	R	.	T*	.	COC	
730	RX Hosp -- Other	.	.	R	R	R	.	T*	.	COC	
740	RX Hosp -- DX/Stg Proc	.	.	R	R	.	.	.	.	COC	
741	Reserved 28	.	.	.	.	.	.	.	.		
742	RX Hosp -- Screen/BX Proc1										Retired
743	RX Hosp -- Screen/BX Proc2										Retired
744	RX Hosp -- Screen/BX Proc3										Retired
745	RX Hosp -- Screen/BX Proc4										Retired
746	RX Hosp -- Surg Site 98-02	.	.	.	RH	RH	.	TH*	.	COC	
747	RX Hosp -- Scope Reg 98-02	.	.	.	RH	RH	.	TH*	.	COC	
									.	COC	
									.		

Item	Item Name	NPCR		COC		SEER		Exchange Elements		Source of Standard	Note
		Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp → Central	Central → Central		
1250	RX Date--Other	.	.	R	R	S	.	T*	T*	COC	
1260	Date of Initial RX--SEER	R#	R#	.	.	R	R	T*	T*	SEER	

Item	Item Name	NPCR		COC		SEER		Exchange Elements		Source of Standard	Note
		Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp → Central	Central → Central		
1714	Subsq RX 4th Course Horm	.	.	.	.	.	.	.	.	COC	
1715	Subsq RX 4th Course BRM	.	.	.	.	.	.	.	.	COC	
1716	Subsq RX 4th Course Oth	.	.	.	.	.	.	.	.	COC	

Item	Item Name	NPCR		COC		SEER		Exchange Elements		Source of Standard	Note
		Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp → Central	Central → Central		
1890	Recurrence Type --1st--Oth										Retired

Item	Item Name	NPCR		COC		SEER		Exchange Elements		Source of Standard	Note
		Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp → Central	Central → Central		
2112	Date Case Report Loaded	R	.	.	.	.	.	.	.	NPCR	
2113	Date Tumor Record Availbl	R	.	.	.	.	.	.	.	NPCR	
2114	Future Use Timeliness 1										Retired
2115	Future Use Timeliness 2										Retired
2116	ICD-O-3 Conversion Flag	R	R	R	R	R	R	T	T	SEER/COC	
2120	SEER Coding Sys --Current	.	.	.	.	.	R	T*	T*	NAACCR	
2130	SEER Coding Sys --Original	.	.	.	.	.	R	T*	T*	NAACCR	
2140	COC Coding Sys --Current	.	.	R	R	.	.	T*	T*	COC	

NPCR	COC	SEER	

Item	Item Name	NPCR		COC		SEER		Exchange Elements		Source of Standard	Note
		Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp → Central	Central → Central		
2840	CS Reg Node Eval	.	.	R	R	.	.	T*	T*	AJCC	

8 APPENDIX B: EDUCATION AND TRAINING OPPORTUNITIES

Sponsor

Sponsor	Multiple Primary/ Histology Coding Rules	Collaborative Staging
NCRA	Pre-NCRA Conference 2007 – 1-Day Workshop http://ncra-usa.org/ Las Vegas, NV 4/21/07	
NCRA	NCRA 2007 Annual Conference – 1-Day Workshop http://ncra-usa.org/ Las Vegas, NV 4/22/07	
NCRA	Multiple Primary/ Histology Coding Rules Workshop http://ncra-usa.org/ Orlando, FL - 12/7/06 and 12/8/06 Pittsburgh, PA – 3/22/07 and 3/23/07	
NPCR	NETS – See section 6.2.6	NETS – see section 6.2.6

9 APPENDIX C: REVISED DATA ITEMS IN THE DATA STANDARDS AND DATA DICTIONARY, VOLUME II, VERSION 11.1

Appendix C includes errata and revisions to the data

Description

USPS abbreviation for the state, territory, commonwealth, U.S. possession, or CanadaPost abbreviation for the Canadian province/territory in which the patient resides at the time the reportable tumor is diagnosed. If the patient has multiple primaries, the state of residence may be different for each tumor.

Codes (in addition to the U.S. and Canadian postal service abbreviations)

CD Resident of Canada, NOS (province/territory unknown)
US Resident of United States, NOS (state/commonwealth/territory/possession unknown)
XX Resident of country other than the United States (including its territories, commonwealths, or possessions) or Canada, and country is known
YY Resident of country other than the United States (including its territories, commonwealths, or possessions) or Canada, and country is unknown
ZZ Residence unknown

Description

USPS abbreviation for the state, territory, commonwealth, U.S. possession, or Canada Post abbreviation for the Canadian province/territory of the patient's current usual residence. If the patient has multiple tumors, the current state of residence should be the same for all tumors.

Rationale

"Current address" can be used to measure the regional "cancer burden" (cost, medical care needs), especially in major retirement regions. Sometimes central registries carry out follow-up by contacting the patients via letter or telephone calls to ascertain vital status. The most current reported address and telephone number are needed. This information also is useful for conducting interview studies.

Codes (in addition to the U.S. and Canadian postal service abbreviations)

CD Resident of Canada, NOS (province/territory unknown)
US Resident of United States, NOS (state/commonwealth/territory/possession unknown)
XX Resident of country other than the United States (including its territories, commonwealths, or possessions) or Canada, and country is known
YY Resident of country other than the United States (including its territories, commonwealths, or possessions) or Canada, and country is unknown
ZZ Residence unknown

CODING SYSTEM FOR EOD **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Coding System for Extent of Disease (SEER)	870	1	SEER	562-562

Description

Indicates the type of SEER EOD code applied to the tumor. Should be used whenever EOD coding is applied.

Rationale

Used in data editing and analysis.

Codes

0 2-Digit Nonspecific Extent of Disease (1973-82)
1 2-Digit Site-Specific Extent of Disease (1973-82)
2 13-Digit (expanded) Site-Specific Extent of Disease (1973-1982)
3 4-Digit Extent of Disease (1983-87)
4 10-Digit Extent of Disease, 1988 (1988-2003)
blank Cases diagnosed 2004+; or the item is not collected

DATE OF INITIAL RX--SEER **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Date Therapy Initiated (SEER) Date Started (SEER)	1260	8	SEER	835-842

Description

Date of initiation of the first course therapy for the tumor being reported, using the SEER definition of first course. See also Date of 1st Crs RX--COC [1270]. See Chapter V, Unresolved Issues, for further discussion of the difference between SEER and COC items. See page 87 for date format.

Codes (in addition to valid dates)

00000000 No therapy
99999999 Unknown date/Unknown if therapy was administered

Clarification of NPCR Required Status

Central registries funded by NPCR are required to collect either Date of Initial RX--SEER [1260] or Date of 1st Crs RX--COC [1270].

FIN CODING SYSTEM **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	35	1	NAACCR	11-11

Description

The FIN Coding System is a generated code that identifies the coding system used by individual facilities (hospital, clinics, or other providers). This field identifies the coding system used by facilities in the following seven fields of the NAACCR layout:

Registry ID [40] (when Registry Type [30] = 3)
Reporting Facility [540]
Institution Referred From [2410]
Institution Referred To [2420]
Last Follow-Up Hospital [2430] (this data item was retired in Version 11)
Following Registry [2440]
Archive FIN [3100]

Within a single NAACCR record, all of these fields listed above must be coded using the same FIN coding system.

NPI, a unique identification number for health care providers, is scheduled for 2007 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). When a facility starts to use the NPI codes, they should be transmitted in the NPI-specific data items, not in a FIN data item.

Rationale

FIN and NPI codes should not be stored in the same Coding System field, as they are reported in distinctly different fields within the NAACCR layout.

Codes

1 COC 7-digit codes (assigned by COC until the end of 2000)
2 COC FIN 10-digit codes (assigned 2001+)
9 Unknown

Note: Code 3, NPI 8-digit code, has been deleted. Code 4, 15-digit code, has been deleted.

Description
USPS abbreviation for the state (including U.S. territories, commonwealths, or possessions), or Canada Post abbreviation for the Canadian province/territory of the follow-up contact's current usual residence. If the patient has multiple tumors, the follow-up contact state should be the same for all tumors.

Rationale
Sometimes registries carry out follow-up by contacting the patient and other contacts by a letter or phone call to ascertain their vital status. When a patient's current address is unknown or the patient is for some reason not to be contacted (e.g., patient is a minor child), the most current name, address, and phone number of another contact such as a relative or neighbor are needed. This information may also be useful for conducting epidemiological or research studies.

Codes (in addition to USPS and Canadian Postal Service abbreviations)

CD	Resident of Canada, NOS (province/territory unknown)
US	Resident of United States, NOS (state/commonwealth/territory/possession unknown)
XX	Resident of country other than the United States (including its territories, commonwealths, or possessions) or Canada, and country is known
YY	Resident of country other than the United States (including its territories, commonwealths, or possessions) or Canada, and country is unknown
ZZ	Residence unknown

Description
This item indicates the coding system in which the Comorbidities and Complications (secondary diagnoses) codes are provided.

Rationale
The COC currently requires the collection and reporting of up to 10 ICD-9-CM codes describing secondary diagnoses for patients hospitalized for cancer treatment. Currently the use of ICD-10-CM is not mandatory in U.S. hospitals, though it may become so in the future. In the event this occurs, cancer registries tha.odberCl.453 TD0.srTw[(saddress is)-3.8(ldya.)(od).47

NAACCR RECORD VERSION

Description
This item applies only to record types I, C, A, and M. Code the NAACCR record version used to create the record.

Note: The correction record (U) has its own record version data item.

Codes

1	1992-1994 Version 2 and Version 3
4	1995 Version 4.0
5	1996 and 1997 Version 5.0 or Version 5.1
6	1998 Version 6
7	1999 Version 7
8	2000 Version 8
9	2001 and 2002 Version 9 and 9.1
A	2003, 2004, and 2005 Version 10, 10.1, and 10.2
B	2006 and 2007 Version 11 and 11.1
Blank	September 1989 Version

Note: Code 4 was assigned to the 1995 Version to synchronize the document version and the layout version numbers. Layout document Versions 2 and 3 are coded as 1.

OVER-RIDE HISTOLOGY **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Histology/Behavior Inter-field Review (Field Item Edit Morph) (SEER #2)	2040	1	SEER	1129-1129

Description

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

Diagnostic Confirmation, Behavior ICDO2 (SEER IF31)
Diagnostic Confirmation, Behavior ICDO3 (SEER IF31)
Morph (1973-91) ICD-O-1 (SEER MORPH)
Morphology--Type/Behavior ICDO2 (SEER MORPH)
Morphology--Type/Behavior ICDO3 (SEER MORPH)

Rationale

Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flags as Used in the EDITS Software Package

Edits of the type Diagnostic Confirmation, Behavior, differ in the use of ICD-O-2 or ICD-O-3 and check that, for *in situ* cases (Behavior = 2), Diagnostic Confirmation specifies microscopic confirmation (1, 2, or 4).

The distinction between *in situ* and invasive is very important to a registry, as prognosis is so different. Since the determination that a neoplasm has not invaded surrounding tissues, i.e., *in situ*, is made microscopically, cases coded *in situ* in behavior should have a microscopic confirmation code. However, very rarely, a physician will designate a case noninvasive or *in situ* without microscopic evidence.

1. If an edit of the type, Diagnostic Confirmation, Behavior, gives an error message or warning, check that Behavior and Diagnostic Confirmation have been coded correctly. Check carefully for any cytologic or histologic evidence that may have been missed in coding.

Edits of the type, Morphology--Type/Behavior, perform the following check:

1. Codes listed in ICD-O-2 or ICD-O-3 with behavior codes of only 0 or 1 are considered valid, since the behavior matrix of ICD-O-2 and ICD-O-3 allows for the elevation of the behavior of such histologies when the tumor is *in situ* or malignant. This edit forces review of these rare cases to verify that they are indeed *in situ* or malignant.
2. The following histologies are generally not accepted as *in situ*: ICD-O-2 histologies 8000-8004, 8020, 8021, 8331, 8332, 8800-9054, 9062, 9082, 9083, 9110-9491, 9501-9989, ICD-O-3 histologies 8000-8005, 8020, 8021, 8331, 8332, 8800-9055, 9062, 9082, 9083, 9110-9493, 9501-9989. This edit forces review of these cases.

3. If a Morphology-Type/Behavior edit produces an error or warning message and the case is one in which the 4-digit morphology code is one that appears in ICD-O-2 or ICD-O-3 only with behavior codes of 0 or 1, or the case is one in which the 4-digit morphology code is not generally accepted with a behavior code of 2, verify the coding of morphology and that the behavior should be coded malignant or *in situ*. The registrar may need to consult a pathologist or medical advisor in problem cases.

Exceptions:
If year of Date of Diagnosis > 2000, then a behavior code of 1 is valid for the following ICD-O-2 histologies and no over-ride flag is needed: 8931, 9393, 9538, 9950, 9960-9962, 9980-9984, and 9989. Similarly, the following ICD-O-3 histologies are valid with a behavior code of 1: 8442, 8451, 8462, 8472, and 8473.

If year of Date of Diagnosis > 2003, the following ICD-O-3 benign histologies will pass without review: 8146, 8271, 8861, 8897, 9121, 9122, 9131, 9161, 9350, 9351, 9352, 9360, 9361, 9383, 9384, 9394, 9412, 9413, 9444, 9492, 9493, 9506, 9531, 9532, 9533, 9534, 9537, 9541, 9550, 9562, and 9570.

3. Code 1, 2, or 3 as indicated if review of all items in the error or warning message confirms that all are correct.

Codes

1 Reviewed: The behavior code of the histology is designated as "benign" or "uncertain" in

Description
Records the total number of regional lymph nodes that were removed and examined by the pathologist.

REGIONAL NODES POSITIVE **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Number of Positive Regional Lymph Nodes (SEER) Pathologic Review of Regional Lymph Nodes (SEER) Regional Lymph Nodes Positive	820	2	SEER/COC	539-540

Description

Records the exact number of regional nodes examined by the pathologist and found to contain metastases. Beginning with tumors diagnosed on or after January 1, 2004, this item is a component of the Collaborative Stage system. Tumors diagnosed from 1988 through 2003, this item is part of the 10-digit EOD [779], detailed site-specific codes for anatomic EOD.

Rationale

This data item is necessary for pathologic staging, and it serves as a quality measure for pathology reports and the extent of the surgical evaluation and treatment of the patient.

Codes

00 All nodes examined are negative
01-89 1-89 nodes are positive (Code exact number of nodes positive)
90 90 or more nodes are positive
95 Positive aspiration of lymph node(s) was performed
97 Positive nodes are documented, but the number is unspecified
98 No nodes were examined
99 It is unknown whether nodes are positive; not applicable; not stated in patient record

Note: See Chapter V, Unresolved Issues, for a discussion of coding differences between COC and SEER.

RURALURBAN CONTINUUM 2003 **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Beale Code RuralUrban Continuum 2000	3310	2	NAACCR	229-230

Description

The "RuralUrban Continuum 2003" code, often referred to as the "Beale Code," is generated programmatically using Addr at DX--State [80] and County at DX [90]. It contains the Rural-Urban Continuum code as provided by OMB.

The code is a 10-point continuum (00-09) measuring urban-rural status. Abstractors do not enter these codes.

The code has been expanded to 2 digits to accommodate areas that are not included in Rural Urban Continuum code table, such as Canadian provinces/territories and U.S. territories. These areas will be coded with a value of 98. Records for nonresidents of the state of reporting institution (County at DX = 998) will also be coded 98. If Addr at DX--State is XX, YY, or ZZ, the Rural Urban Continuum 2003 code will be coded as 99. If County at DX equals 999, the Rural Urban Continuum 2003 code will be coded as 99.

RuralUrban Continuum 2003 codes are provided for each county by OMB and consist of a 1-character rural-urban status, which is very useful for incidence data analysis.

Rationale

RuralUrban Continuum 2003 codes are provided for each county by OMB and consist of a 1-character rural-urban status, which is very useful for incidence data analysis.

Codes

Metropolitan Counties (00-03)

00 Central counties of metropolitan areas of 1 million population or more
01 Fringe counties of metropolitan areas of 1 million population or more
02 Counties in metropolitan areas of 250,000-1,000,000 population
03 Counties in metropolitan areas of less than 250,000 population

Nonmetropolitan Counties (04-09)

04 Urban population of 20,000 or more, adjacent to a metropolitan area
05 Urban population of 20,000 or more, not adjacent to a metropolitan area
06 Urban population of 2,500-19,999, adjacent to a metropolitan area
07 Urban population of 2,500-19,999, not adjacent to a metropolitan area
08 Completely rural (no places with a population of 2,500 or more) adjacent to a metropolitan area
09 Completely rural (no places with a population of 2,500 or more) not adjacent to a metropolitan area
98 Program run, but: (1) area is not included in Rural-Urban Continuum code table, or (2) record is for resident outside of state of reporting institution

99 Unknown
Blank Program not run; record not coded

RX SUMM--RADIATION **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Radiation (SEER/COC) Radiation Therapy (pre-96 COC)	1360	1	SEER	873-873

Description

Codes for the type of radiation therapy performed as part of the first course of treatment.

Note: Radiation to brain and central nervous system for leukemia and lung cases is coded as radiation in this field.

Codes

0 None
1 Beam radiation
2 Radioactive implants
3 Radioisotopes
4 Combination of 1 with 2 or 3
5 Radiation, NOS—method or source not specified
6 Currently allowable for historic cases only; see note below
7 Patient or patient's guardian refused*
8 Radiation recommended, unknown if administered*
9 Unknown if radiation administered

* *Note:* For COC, codes 7 and 8 were used for tumors diagnosed before 1996, but should have been converted to 0 in this field and to the appropriate code in the new field Reason for No Radiation [1430]. The COC standards for hospitals do not allow use of codes 7 and 8 in 1996 and later. SEER continues to use codes 7 and 8 for all years. See Chapter V, Unresolved Issues, for further discussion

Note: In the SEER program, a code 2 for other radiation was used between 1973 and 1987. When the radiation codes were expanded to add codes '2' radioactive implants and '3' radioisotopes, all cases with a code '2' and diagnosed in 1973-1987 were converted to a code '6' radiation other than beam radiation.

Description
This shows the SEER coding system best describing the majority of SEER items as they are in the record (after conversion).

Codes
0 No SEER coding
1 Pre-1988 SEER Coding Manuals
2 May 1988 SEER Coding Manual
3 January 1989 SEER Coding Manual
4 January 1992 SEER Coding Manual
5 January 1998 SEER Coding Manual
6 January 2003 SEER Coding Manual
7 January 2004 SEER Coding Manual
8 January 2007 SEER Coding Manual

Description
This shows the SEER coding system best describing the way the majority of SEER items in the record were originally coded.

Codes
0 No SEER coding
1 Pre-1988 SEER Coding Manuals
2 May 1988 SEER Coding Manual
3 January 1989 SEER Coding Manual
4 January 1992 SEER Coding Manual

Description
Code indicates the sequence of all reportable neoplasms over the lifetime of the person. This data item differs from Sequence Number--Hospital [560], because the definitions of reportable neoplasms often vary between a hospital and a central registry. Each

Rationale

The purpose of sequencing based on the patient's lifetime is to truly identify the 00s, the people who only had one malignant primary in their lifetimes for survival analysis. If a central registry sequences by just what is reported to them, then it will be unclear whether 00 means the person only had one malignant primary in his lifetime or the person had one malignant primary since the central registry started collecting data. The Federally required reportable list has changed throughout the years, so the registry must use the appropriate reportable list for the year of diagnosis. The central registry reference date will not affect Sequence Number-Central.

Codes

In Situ/Malignant as Federally Required based on Diagnosis Year

00 One primary in the patient's lifetime
01 First of two or more primaries
02 Second of two or more primaries
..
..
59 Fifty-ninth or higher of fifty-nine or more primaries
99 Unspecified or unknown sequence number of federally required *in situ* or malignant tumors. Sequence number 99 can be used if there is a malignant tumor and its sequence number is unknown. If there is known to be more than one malignant tumor, then the tumors must be sequenced.

Non-malignant Tumor as Federally Required based on Diagnosis Year or State/Province Defined

60 One non-malignant tumor or central registry-defined neoplasm
61 First of two or more non-malignant tumor or central registry-defined neoplasms
62 Second of two or more non-malignant tumor or central registry-defined neoplasms
..
88 Unspecified or unknown sequence number for non-malignant tumor or central registry-defined neoplasms. (Sequence number 88 can be used if there is a non-malignant tumor and its sequence number is unknown. If tber isR- 4 -1.15Yomown sequ32g8aient'sn-malignant tumoe or m

Skin SCC/BCC	60 – 87
PIN III	60 – 87
Cervix CIS/CIN III, Diagnosis Year 2003+	60 – 87
Unspecified Non-malignant Tumor or Central Registry-Defined Sequence Number	88
Cervix CIS/CIN III, Diagnosis Year 1996-2002	98

*Juvenile astrocytomas should be reported as 9421/3.

Note: See the section on Sequence Number—Central in *The SEER Program Code Manual.*

Note: Conversion Guidance: The sequence numbers for neoplasms whose histologies were associated with behavior codes that changed from *in situ*/malignant to benign/borderline or vice versa during the conversion from ICD-O-2 to ICD-O-3 should not be re-sequenced.

Description
Code indicates the sequence of all malignant and non-malignant neoplasms over the lifetime of the patient. This item differs from the Sequence Number--Central [380] because the definitions of reportable neoplasms often vary between a hospital and a central registry. Each neoplasm is assigned a different number. Sequence Number 00 indicates that the person has only one malignant neoplasm in his lifetime (regardless of hospital registry reference date). Sequence Number 01 indicates the first of two or more malignant neoplasms, while 02 indicates the second of two or more malignant neoplasms, and so on. Because the time period of Sequence Number is a person's lifetime, reportable neoplasms not included in the hospital registry are also allotted a sequence number. For example, a registry may contain a single record for a patient with a sequence number of 02 because the first reportable neoplasm occurred before the hospital registry's reference date. Similarly, Sequence Number 60 indicates the patient has only one non-malignant neoplasm, and Sequence Number 61 represents the first of multiple non-malignant neoplasms.

Reporting Requirements: COC, State/Province, and the Hospital Cancer Committee

Codes

In situ and Malignant Tumors:

00 One malignant primary only in the patient's lifetime
01 First of two or more malignant primaries
02 Second of two or more malignant primaries
..
.. (Actual number of this malignant primary)
..
59 Fifty-ninth or higher of fifty-nine or more primaries
99 Unspecified sequence number of a primary malignant tumor or unknown (When a patient has multiple tumors with unspecified/unknown sequence numbers, code 99 should only be used once.)

Nonmalignant Tumors:

60 Only one non-malignant tumor in the patient's lifetime
61 First of two or more non-malignant tumors
62 Second of two or more non-malignant tumors
..
88 Unspecified number of non-malignant tumors (When a patient has multiple unspecified neoplasms in this category, code 88 should only be used once.)

The table below shows which sequence number series to use by type of neoplasm

Neoplasm	**SeqNum-Hospital**
***In situ* and Malignant**	**(code range)**
One *in situ* (behavior code = 2) or malignant (behavior code = 3) primary tumor only in the patient's lifetime	00
First of multiple *in situ* or malignant primary tumors in the patient's lifetime	01
Actual sequence of two or more *in situ* or malignant primary tumors	02 – 59
Unspecified malignant sequence number or unknown	99
Non-Malignant	
One benign (behavior code = 0) or borderline (behavior code = 1) primary tumor only in the patient's lifetime	60
First of two or more benign or borderline primary tumors in the patient's lifetime	61
Actual sequence of two or more non-malignant primary tumors	62 – 87
Unspecified non-malignant sequence number or unknown	88

*Juvenile astrocytomas should be reported as 9421/3

Note: See the section on Sequence Number in the COC (FORDS) Manual.