Michigan Cancer Surveillance Program
April 2014 Update

MCSP REPORTABLE CONDITIONS: AIN, CIN, HSIL/HGSIL, VAIN, VIN ~

Please note! The following conditions are considered reportable by the MCSP and MUST be reported ***regardless of facility type.*** For more information on Reportable Conditions, refer to the MCSP Cancer Program Manual at http://michigan.gov/mdch/0,4612,7-132-2945_5221-16586--,00.html.

Reportable Conditions				
ICD-10-CM Code	***ICD-9-CM Code***	***Primary Site***	***Histology Code***	***Topography Code***
D01.3	230.5	AIN III (anal intraepithelial neoplasia – histologically confirmed) NOTE: "Severe dysplasia ALONE **is** reportable." A diagnosis of "High grade dysplasia" ONLY is **not** reportable.	8077/2	C21.1
D06.9	233.1	CIN III (cervical intraepithelial neoplasia - histologically confirmed) with or without carcinoma in situ (CIS) NOTE: "Severe dysplasia" ALONE **is** reportable. A diagnosis of "High grade dysplasia" ONLY is **not** reportable.	8077/2	C53.0 - C53.9
D06.9	233.1	HSIL/HGSIL (high-grade squamous intraepithelial lesion - histologically confirmed) with or without carcinoma in situ (CIS); with or without CIN III; with or without severe dysplasia. NOTE: A diagnosis of "High grade dysplasia" ONLY is **not** reportable.	8077/2	C53.0 -C53.9
D07.2	233.31	VAIN III (vaginal intraepithelial neoplasia) with or without carcinoma in situ (CIS) NOTE: "Severe dysplasia" ALONE **is** reportable. A diagnosis of "High grade dysplasia" ONLY is **not** reportable.		
D07.2	233.31	VAIN III (vaginal intraepithelial neoplasia) with or without carcinoma in situ (CIS) NOTE: "Severe dysplasia" ALONE **is** reportable. A diagnosis of "High grade dysplasia" ONLY is **not** reportable.	8077/2	C52.0 - C52.9
D07.1	233.32	VIN III (vulvar intraepithelial neoplasia - histologically confirmed) with or without carcinoma in situ (CIS). NOTE: "Severe dysplasia" ALONE **is** reportable. A diagnosis of "High grade dysplasia" ONLY is **not** reportable.	8077/2	C51.0 - C51.9

Examples: ***Reportable***

- CIN 2 **and** 3 IS reportable
- CIN 2 **&** 3 IS reportable
- CIN 2 + 3 IS reportable

Not Reportable

- CIN 2-3 is NOT reportable
- CIN 2/3 is NOT reportable

Coding Histology

Use histology code 8077/2 for diagnoses of HGSIL, CIN III, VIN III, VAIN III or AIN III (Multiple Primary and Histology Coding Rules – Rule H21).

Number of Reportable Conditions

To determine the ***number*** of reportable conditions for AIN, CIN, HSIL/HGSIL, VAIN and VIN, refer to the Multiple Primary and Histology Coding Rules manual.

General Instructions

A. General Information

7. Do not use a physician's statement to decide whether the patient has a recurrence of a previous cancer or a new primary. Use the multiple primary rules as written unless a pathologist compares the present tumor to the "original" tumor and states that this tumor is a recurrence of cancer from the previous primary.

Other Sites Multiple Primary Rules

Other Sites Multiple Primary Rules - Rule M10: Tumors diagnosed **more than one (1) year** apart are multiple primaries.

Collaborative Stage (CS) version 02.05 ~

CSv2 version 02.05 must be used to code all cases diagnosed on or after January 1, 2014. Once version 02.05 is implemented in a registry, this version should be used to code all newly abstracted cases diagnosed from 2004 and forward.

Use CSv2 02.04 to code all cases diagnosed 2004 through diagnosis year 2013 ***OR*** until CS v02.05 is implemented for abstraction of 2014 cases.

For more information, go to http://www.cancerstaging.org/cstage/Pages/default.aspx

Instructions for Coding Grade 2014 ~

Don't forget! A new set of instructions have been created for coding of grade (Grade, Differentiation or Cell Indicator) and are to be implemented with cases diagnosed January 1, 2014 and forward. The 'Instructions for Coding Grade' can be found at http://seer.cancer.gov/tools/grade.

Laterality Coding Instructions (NAACCR Item #410) ~

If the primary site being reported is NOT defined as a paired site laterality MUST be coded as '0 – not a paired site.' For more information, refer to the section on Laterality in the MCSP Cancer Program Manual at http://michigan.gov/mdch/0,4612,7-132-2945_5221-16586--,00.html.

Sequence Number ~

The reporting of **Sequence Number** is a REQUIRED data item for facilities defined by the MCSP as a 'Hospital with a Registry' or 'Hospital without a Registry.' The **Sequence Number** indicates the sequence of malignant and nonmalignant neoplasms over the lifetime of the patient.

Codes 00-59 and 99 indicate neoplasms of malignant (*in situ or invasive*) behavior (*behavior* code equals '2 – in situ' or '3 – invasive').

- Use code 00 if the patient has a single malignant primary.
- If the patient develops a subsequent reportable invasive or in situ primary tumor, change the sequence number for the first tumor from code 00 to 01 and number the new subsequent primary tumor sequentially.
- If the patient has two or more invasive or in situ neoplasms diagnosed at the same time, assign the lowest sequence number to the diagnosis with the worst prognosis. If no difference in prognosis, the decision on which to assign first is arbitrary.
- If information about the sequence of reportable malignant tumors is unknown, use code 00.

Codes 60-88 indicate neoplasms of non-malignant behavior (*behavior* code equals '0 – benign' or '1 – borderline').

- Use code 60 only if the patient has a single non-malignant reportable benign/borderline primary tumor.
- If the patient develops a subsequent reportable benign/borderline primary tumor, change the code for the first tumor from 60 to 61 and assign codes to subsequent non-malignant primaries sequentially.
- If information about the sequence of reportable benign/borderline tumors is unknown, use code 60.

Any tumor in the patient's past which is reportable or reportable by agreement at the time the current tumor is diagnosed must be taken into account when sequencing subsequently accessioned tumors. *Note:* Do not reassign sequence numbers if one of those tumors becomes non-reportable later.

For more information, refer to the MCSP Cancer Program Manual at http://michigan.gov/mdch/0,4612,7-132-2945_5221-16586--,00.html.

2014 MCSP Educational Workshops ~

There are a few slots still open for attendance at the 2014 MCSP Educational Workshops. For more information on dates and topics of workshops, please refer to the MCSP webpage at http://michigan.gov/mdch/0,1607,7-132-2945_5221-16586--,00.html.

Cancer Register Training Resources ~

Links to SEER Cancer Registrar Training are available on the SEER training webpage at http://seer.cancer.gov/training/.

MCSP Reporting Facility Contact Information Form ~

The MCSP has not received updated facility contact information from all reporting facilities yet. If your facility has not completed a copy of this form within the past year or if the contact information has changed, please complete a copy of the form and submit to the MCSP. Having current contact information enables the MCSP to conduct proper follow-back on cancer data and correspondence. A copy of the form is available at http://michigan.gov/mdch/0,1607,7-132-2945_5221-16586--,00.html.

MCSP Submission of Data ~

Please note the submission of data reminders listed below!

- All cases diagnosed in 2012 MUST be submitted to the MCSP by ***May 31, 2014***.
- Diagnosis year 2013 cases MUST be submitted to the MCSP by ***July 31, 2014***.

  Exception: Due to the delay of Abstract Plus v13.0, which is required to abstract diagnosis year 2013 cases, the deadline date for submission of data for 2013 cases is ***August 31, 2014***.

- Diagnosis year 2014 cases from January through March are required to be submitted by September 31, 2014. *(Regardless of submission due dates, please submit data on a monthly basis to the MCSP.)*

  ***Exception*:** Abstract Plus users will not be able to abstract diagnosis year 2014 cases until after 2013 cases are submitted to the MCSP. Detailed instructions on how to upgrade to NAACCR v14.0, which is required for diagnosis year 2014, will be provided at a later date.

NOTE: If your registry is in the SEER area (Wayne, Oakland or Macomb County) and you have questions regarding submission of data, please contact your SEER-State Coordinator, Jeanne Whitlock at 313.578.4219 or whitlock@med.wayne.edu.

Michigan Abstract Plus Users Update ~

We apologize for the delay and appreciate your patience during the customization process of Abstract Plus. This version is needed to process NAACCR version 13.0 records ***effective for cases diagnosed prior to 2014*** will be released by the MCSP in MCSP within the next few weeks. If you have any questions regarding Abstract Plus, please contact Terry McTaggart at 517.335.9624 or McTaggartT1@michigan.gov.

Coding Questions ~

Questions and answers for common coding issues have been provided below. If you have a coding issue that you would like addressed in the next issue of the MCSP Update, please submit the question to field representative, Jetty Alverson at alversong@michigan.gov

Breast

Question: For breast primaries, the SEER manual states "Code the subsite with the invasive tumor when the pathology report identifies invasive tumor in one subsite and in situ tumor in a different subsite or subsites." The FORDS manual does not include this instruction.

Answer: Code the subsite of the invasive tumor. (Note: This specific instruction from the SEER manual will also be added to the MP/H manual.)

Reference Source: Data Collection Answers from the CoC, NPCR, SEER Technical Workgroup. Updated February 20, 2013. See Questions by Category: Reportability. *Taken from the SEER website at http://seer.cancer.gov/registrars/data-collection.html* on April1, 2014. *Web 01 Apr. 2014.*

Question: Does the number of nodes removed affect whether you would code a simple mastectomy or a modified radical mastectomy? For example, if the patient had only a sentinel node biopsy, would the surgical procedure of the primary site be coded as a simple mastectomy or a modified radical mastectomy?

Answer: Code a simple mastectomy when sentinel nodes are the ONLY nodes removed. For all other procedures that remove lymph nodes code the surgical procedure of the primary site as a modified radical mastectomy. Note: There is no specific number of nodes removed that equals a lymph node dissection.

Reference Source: Data Collection Answers from the CoC, NPCR, SEER Technical Workgroup. Updated February 20, 2013. See Questions by Category: Description of This Neoplasm *at* *http://seer.cancer.gov/registrars/data-collection.html* on April1, 2014.

Kaposi Sarcoma

Question: How do you code the primary site of a Kaposi sarcoma if it arises simultaneously in the skin and another site or the primary site is not identified?

Answer: Code to Skin, NOS (C44.9).

Reference Sources: MCSP Cancer Program Manual (Primary Anatomical Site) or FORDS (Case Eligibility and Overview of Coding Principles).

Laterality

Question: Can laterality codes '1, 2, 3, 4, 5 or 9' be coded for sites that are not defined as a paired organ?

Answer: The MCSP did not adopt the 2010 FORDS, CoC use of coding of laterality for non-paired organs. For submission of data to the MCSP, follow the MCSP cancer reporting requirements (regardless of facility type). If the primary site of the tumor being reported is not a paired organ code laterality to '0 – not a paired site.'

Reference Source: MCSP Cancer Program Manual (Laterality).

Reportability

Question: Is bladder urothelial neoplasms of low malignant potential reportable to the MCSP?
Answer: No, these are not reportable. They are pre-malignant growths in the upper urinary tract (renal pelvis, ureters, urinary bladder, part of urethra).

Reference source: MCSP Cancer Program Manual – Reportable Conditions.

Electronic Cancer Case Reporting Now Available for Stage 2 Meaningful Use ~

Eligible professionals entering into Stage 2 Meaningful Use in 2014 will have the opportunity to meet both the Stage 2 cancer reporting objective and the Michigan Department of Community Health's (MDCH) cancer reporting mandate. Public Act 82 of 1984 requires physicians, dentists, clinics, hospitals and laboratories that diagnose or treat patients with reportable conditions to submit cancer case information to the Michigan Cancer Surveillance Program.

Providers in non-hospital settings using certified EHR technology now have the option to submit cancer case information electronically, avoiding duplicate data entry and improving the timeliness and completeness of cancer case information reported to the Michigan Cancer Surveillance Program. **Note that this does not replace the current reporting by hospitals and other health facilities/laboratories.**

Eligible professionals interested in reporting cancer case information to meet the Stage 2 Meaningful Use objective should contact Laura Rappleye, laura.rappleye@altarum.org for further instructions. For further information on the cancer case reporting mandate, contact Jetty Alverson at (517) 335-8855 or alversong@michigan.gov.

In May of 2014, eligible professionals will also be able to select the Stage 2 Meaningful Use objective of reporting to a specialized registry. Electronic birth defect reporting will be available in support of meeting the specialized registry menu item. As soon as this capability is in place, MDCH will announce the option or you can follow our progress under Public Health Reporting on www.michiganhealthit.org.

MCSP Staff ~

If you have any questions regarding cancer reporting, or would like more information about workshops, please feel free to give one of us a call.

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Michigan Cancer Surveillance Program
July 2014 Update

Labeling of Electronic Submission Files ~

Electronic submission of data files (excluding registries in the SEER area – Wayne, Oakland or Macomb County) submitted to the Michigan central cancer registry **must be labeled according to the guidelines as provided in the MCSP Cancer Program Manual**.

Once the export file has been created, label the file as MI (Michigan) followed by your 5-digit facility number, then add the date stamp (YYYYMMDD) which is the date the file was created. For example, facility 98765 created an export file on April 28, 2014. The file will be named MI9876520140428, plus the extension assigned by their software. The extension for Metriq is either .xva (new case) or .xvm (updated case) and will automatically be assigned. The extension assigned by Abstract Plus is always .txt.

If you are sending more than one file at a time, please make sure that EACH file is numbered appropriately by adding -1, -2, -3, etc. to the file name. For example, the same facility could have two or more files MI9876520140428-1of2.xva and MI9876520140428-2of2.xva.

Even if you use the FTP site and save your file under your specific folder, you MUST accurately label your file according the MCSP Cancer Program Manual guidelines. ***Any files that are not accurately labeled will be rejected by the MCSP***.

Don't forget! Facilities submitting cases electronically are required to submit in the most recent version of the data exchange format and code structure as specified by NAACCR. Monthly submission of data is also preferred. For example, cases abstracted in June should be submitted to the MCSP on July 1.

For more information on Labeling of Electronic Submission Files and/or Submission of Data, please refer MCSP Cancer Program Manual at http://michigan.gov/mdch/0,1607,7-132-2945_5221-16586--,00.html.

Electronic Pathology Reporting System ~

Many cancer registrars have some knowledge of what an electronic pathology reporting system is, but others do not. There are several factors for those who don't know: maybe you are new to the cancer registry; work in a smaller facility, too busy for anything else but abstracting; or maybe you're just not in the loop or want to be in the loop. Below is some background information to familiarize you a little more with the process.

- The electronic reporting system is commonly referred to as **e-Path**. What is **e-Path**? It is a computerized selection of cancer-related pathology reports pulled from all pathology reports. ***E-Path*** is an electronic cancer data delivery system that completely automates the case finding and reporting process. How does this work? ***E-Path*** uses *algorithms* (used for calculation, data processing and automated reasoning) to achieve very high sensitivities and specificities in cancer case finding and is more accurate and consistent than human interpretation. In practice, cancer registries can expect an increase in incident cancer reporting by as much as 20%.
- There are algorithm engines that support the interpretation of anatomic pathology reports and diagnostic imaging reports of central nervous system. Processing anatomic pathology reports

finds all histologically confirmed tumors. Processing imaging reports finds neoplasms of the central nervous system that are not commonly biopsied and often under reported.

- Data standards (***Health Level 7 or HL7*** refers to a set of international standards for transfer of clinical and administrative data between hospital information systems) are used to facilitate transmission of critical pathology data from pathology labs to cancer registries. It is estimated that 95% of all cancer cases are microscopically confirmed in a pathology report.
- There are many benefits for the cancer register such as cancer pathology within hours of diagnosis, all pathology reports in a standardized format, a desktop pathology report viewer, an automated ICD-O-3 coding assistant, and automated data exports to the registry system.

E-Path is here to stay with electronic pathology reporting for a cancer registry. ***E-Path*** has been implemented in about every state and many SEER registries. For more information, please refer to the reference sources provided below.

- AIM (Artificial Intelligence in Medicine, INC.) – e-path
  - http://www.oranjonline.com/documents/ePath%20Solutions%202%20%282%29.pdf

- Cancer Registry of Greater California – Electronic Pathology Reporting System
  - http://crgc-cancer.org/e-path/

- Center for Disease Control and Prevention (CDC) – NPCR-AERRO ePath Reporting Activities
  - http://www.cdc.gov/cancer/npcr/informatics/aerro/activities/epath.htm

Abstract Plus: Searchable List of Possible Values for Histologic Type ICD-O-3 ~

Please note! When using the searchable list function within Abstract Plus, HGSIL/HSIL is not included in the possible values for histologic type ICD-O-3. If the final diagnosis is HGSIL/HSIL, code the histology as 8077/2.

For more information, please refer to the MCSP Cancer Program Manual and/or the 'Reportable versus Non-Reportable Conditions for CIN, HSIL, VIN, VAIN, AIN document, which are located at http://www.michigan.gov/mdch/0,1607,7-132-2945_5221-16586--,00.html

SEER - Collaborative Stage Transition ~

The SEER 2014 Training Assessment for TNM Staging will open July 7, 2014!

Why is the study important and why should you participate? TNM Staging is important as it provides a baseline to evaluate the effectiveness of training materials that are developed and to collect data to evaluate the impact of TNM staging on incidence trends over time. This study provides information on training needs as we move to TNM Staging. In addition, free CEUs will be awarded for review and assignment of TNM Stage for 10 cases with an option to complete an additional 10 cases.

Who is invited to participate and how do you sign up for the study? All registrars in the US and Canada are invited to participate. To sign up for the study, go to https://reliability.seer.cancer.gov/user/login/?next=/.

NOTE: You will need to create a new account to get started. To create an account on SEER*Reliability, go to https://reliability.seer.cancer.gov/user/register_user/

Industry and Occupation ~

It has come to the attention of the MCSP that some registrars are still including non-descriptive terms when recording Usual Occupation and/or Usual Industry. Descriptive terms such as such as "longest," "current," "previously," "prior history unknown, now working at," "last 5 years," "retired," "not applicable (N/A)," "disabled," etc. when recording Usual Occupation and Usual Industry.

Accurately recording the usual (longest-held) occupation and industry of workers can reveal the national cancer burden by industry and occupation. Such information can also be used to help discover jobs that may have a high risk for cancer or other diseases and for which prevention efforts can be concentrated (or targeted). The coding instructions for recording Industry and Occupation are provided below.

Patient's Usual Occupation Prior to Retirement

Enter the usual occupation of the patient. "Usual Occupation" is the kind of work the patient did during most of his/her working life before retirement, e.g., claim adjuster, farm hand, coal miner, janitor, retail store manager, research chemist, civil engineer, college professor, teacher, registered nurse, etc.

Enter "student" if the patient was a student at the time of diagnosis and was never regularly employed.

This data item applies only to patients who are 14 years of age or older at the time of diagnosis.

If the Usual Occupation is not available or is unknown, record the patient's current or most recent occupation, or any available occupation.

Examples

Inadequate: "teacher"
Adequate: "preschool teacher," "high school teacher"

Inadequate: "laborer"
Adequate: "residential bricklayer"

Inadequate: "worked in a warehouse," "worked in a shipping department"
Adequate: "warehouse forklift operator"

Do **NOT** include descriptive terms with the Usual Occupation such as "longest," "current," "last 10 years," "not applicable (N/A)," "disabled," etc.

Do **NOT** use "retired." If the patient has retired from his or her usual occupation, the "usual occupation and business/industry" of the patient must be specified.

If the patient was never employed enter "never employed."

If the usual occupation of the patient is unknown, enter "unknown."

If the patient was a homemaker at the time of diagnosis, but had worked outside the household during his or her working life, enter that occupation.

If the patient was a homemaker during most of his or her working life, and never worked outside the household, enter "homemaker."

Examples If patient worked only at home, record occupation and industry as:

Occupation: “homemaker”
Industry: “own home”

If patient worked at someone else’s home for pay, then record:
Occupation: “housekeeper” (or “nurse,” “babysitter,” etc.)
Industry: “private home”

“Self-employed” by itself is incomplete. The kind of work must be determined. The entry for business/industry should include both the proper business/industry and the entry “self-employed.”

Do **NOT** leave this data item blank.

Patient’s Usual Industry Prior to Retirement
Record the primary type of activity carried on by the business/industry at the location where the patient was employed for the most number of years before diagnosis of this tumor. Enter the kind of business or industry to which the occupation in Item 15a was related, such as insurance, automobile, government, school, church, etc. Be sure to distinguish among “manufacturing,” “wholesale,” “retail,” and “service” components of an industry that performs more than one of these components.

Examples Inadequate: “automobile industry”
Adequate: “automobile manufacturing”

Inadequate: “manufacturing”
Adequate: “automobile manufacturing”

Inadequate: “fire department”
Adequate: “city fire department”

Do **NOT** include descriptive terms with the Usual Industry such as “longest,” “current,” “last 10 years,” “not applicable (N/A),” “disabled,” etc.

Do **NOT** record “retired.”

If the primary activity of the industry is unknown, record the name of the company (with city or town) in which the patient worked the most number of years before diagnosis.

If the patient was never employed, enter “never employed.”

If this information is unknown, enter “unknown.”

Do **NOT** leave this data item blank.

NOTE: For more information, refer to the A Cancer Registrar’s Guide to Collecting Industry and Occupation to assist with coding this data item. The guide can be downloaded at http://www.cdc.gov/niosh/docs/2011-173/ and has been provided by CDC.

NAACCR – Registries Certified in 2014 for 2011 Incidence Data ~

In 1997, the North American Association for Central Cancer Registries (NAACCR) instituted a program that annually reviewed member registries for their ability to produce complete, accurate, and timely data. Each year, members of the Data Evaluation and Certification Committee (DECC) evaluate cancer incidence data for the most recent data year, based on pre-determined registry certification criteria established by the DECC. Following an evaluation by members of the Registry Certification

Subcommittee (a subcommittee of DECC), registry staff receive a report that contains the results of the registry certification evaluation for the most recent data year.

There are two primary reasons for evaluating central cancer registry incidence data. First is to recognize population-based cancer registries that have achieved excellence in the areas of completeness of case ascertainment, data quality, and timeliness. Second is to provide confidential feedback, which individual registries can use to identify current and future resource and training needs.

The Michigan Cancer Surveillance Program is pleased to announce that it received GOLD certification from NAACCR for its 2011 incidence data. A big THANK YOU goes out to everyone for submitting timely data, which makes it possible for the MCSP to achieve the highest recognition. We could not have accomplished this without you! Your efforts on submitting complete, accurate and quality data on a timely basis are sincerely appreciated by the MCSP staff!

Michigan Department of Community Health (MDCH) – Cancer Statistics ~

Did you know that you can generate customized maps and tables on the most readily available cancer data on the MDCH website? To view cancer statistics, go to http://www.michigan.gov/mdch/0,4612,7-132-2944_5323---,00.html and click on the magnifying glass next to Community Cancer Incidence and Mortality.

To view data, you can select from one of the regions to view cancer statistics for your community. The statistics can then be viewed from any of Michigan's 83 counties or 45 local health departments. In Michigan, local health departments are composed of one or more counties except for the local health department for the City of Detroit. Scroll down through the list that appears and click on the desired choice. Alternately, you may type the first letter of the community in order to move closer to it in the list. For example, to select Tuscola County, press the down arrow in the County list and press "T".

Data Requests

To request statistical data that are not available from this web site, please contact Georgia Spivak at 517.335.8702 or SpivakG@Michigan.gov. Written requests should be sent to:

Georgia Spivak
Division for Vital Records & Health Statistics
Michigan Department of Community Health
201 Townsend
P.O. Box 30691
Lansing, MI 48909

Web Site

If you have questions, problems or comments about this web site, please contact Glenn Radford at 517.335.9075 or Radfordg@Michigan.gov.

Revised Version of the MCSP Cancer Program Manual ~

A revised version of the Cancer Program Manual has been uploaded to the web page at http://www.michigan.gov/mdch/0,1607,7-132-2945_5221-16586--,00.html.

Since only a few pages have changed, you can download the file and print the following pages to update your existing printed copy. (Set printer for two-sided printing.)

Pages 1-4 (New cover and revision number)
Pages 27-68 (Additional copy added to page 27 with subsequent reflow of text through page 68)
Pages 117-118 (correction of typo on page 118)
Pages 203-204 (New revision number)

MCSP Submission of Data ~

Please note the submission of data reminders listed below!

- All cases diagnosed in 2012 were due to the MCSP by ***May 31, 2014***.

- Diagnosis year 2013 cases MUST be submitted to the MCSP by ***July 31, 2014***.

  Exception: Due to the delay of Abstract Plus v13.0, which is required to abstract diagnosis year 2013 cases, the deadline date for 2013 cases is ***August 15, 2014***.

- Diagnosis year 2014 cases from January through March are required to be submitted by September 31, 2014. *(Regardless of submission due dates, please submit data on a monthly basis to the MCSP.)*

  ***Exception*:** Abstract Plus users will not be able to abstract diagnosis year 2014 cases until after 2013 cases are submitted to the MCSP. Detailed instructions on how to upgrade to NAACCR v14.0, which is required for diagnosis year 2014, will be provided at a later date.

Facilities non-compliant with the Michigan cancer reporting requirements will be addressed and corrective action taken if necessary.

NOTE: If your registry is in the SEER area (Wayne, Oakland or Macomb County) and you have questions regarding submission of data, please contact your SEER-State Coordinator, Jeanne Whitlock at 313.578.4219 or whitlock@med.wayne.edu.

MCSP Staff ~

If you have any questions regarding cancer reporting, or would like more information about workshops, please feel free to give one of us a call.

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October 2014 Update

MCSP Educational Cancer Registry Workshop ~

MCSP staff would like to thank all who participated in the full day workshop held in Lansing on September 12. We hope that attendees found the presentations interesting and useful. We'd especially like to thank Debra Duquette and Sarah Mange from the Department of Community Health for their presentation on cancer genomics. We have reviewed your feedback forms and urge you to forward other comments and suggestions so we can improve the content and format of future workshops.

New Staff Member at the Michigan Cancer Surveillance Program ~

In September 2014, Stacey Coltrain joined the Michigan Cancer Surveillance Program staff as a Cancer Registry Operations Technician at the Department of Community Health in the Division of Vital Records and Health Statistics. Stacey is a graduate of Baker College, with an Associate Degree in Health Information Technology. She holds the credential of Registered Health Information Technician (RHIT).

MCSP Submission of Data ~

Please note the submission of data reminders listed below:

- Diagnosis year 2013 and earlier cases were due to the MCSP by ***September 30, 2014***.
- Diagnosis year 2014 cases from January through March are required to be submitted by September 30, 2014. *(Regardless of submission due dates, please submit data on a monthly basis to the MCSP.)*

  ***Exception*:** Abstract Plus users will not be able to abstract diagnosis year 2014 cases until after 2013 cases are submitted to the MCSP. Detailed instructions on how to upgrade to NAACCR version customized for Michigan, which is required for diagnosis year 2014, will be provided at a later date.

Facilities found to be non-compliant with the Michigan cancer reporting requirements will be addressed and corrective action taken if necessary.

NOTE: If your registry is in the SEER area (Wayne, Oakland or Macomb County) and you have questions regarding submission of data, please contact your SEER-State Coordinator, Jeanne Whitlock at 313.578.4219 or whitlock@med.wayne.edu.

Labeling of Electronic Submission Files ~

Electronic submission of data files (excluding registries in the SEER area – Wayne, Oakland or Macomb County) that are submitted to the Michigan central cancer registry MUST be labeled according to the guidelines as provided in the MCSP Cancer Program Manual.

Summary of guidelines

Once the export file has been created, label the file as MI (Michigan) followed by your 5-digit facility number, then add the date stamp (YYYYMMDD) which is the date the file was created. For example, facility 98765 created an export file on April 28, 2014. The file will be named MI9876520140428, plus the extension assigned by their software. The extension for Metriq is either .xva (new case) or .xvm (updated case) and will automatically be assigned. The extension assigned by Abstract Plus is always .txt.

If you are sending more than one file at a time, please make sure that EACH file is numbered appropriately by adding -1, -2, -3, etc. to the file name. For example, the same facility could have two or more files and would be labeled MI9876520140428-1of2.xva, MI9876520140428-2of2.xva, etc.

Even if you use the FTP site and save your file under your specific folder, you MUST accurately label your file according the MCSP Cancer Program Manual guidelines. ***Any files that are not accurately labeled will be rejected by the MCSP***.

Don't forget! Facilities submitting cases electronically are required to submit in the most recent version of the data exchange format and code structure as specified by NAACCR. Monthly submission of data is also preferred. For example, cases abstracted in June should be submitted to the MCSP on July 1.

For more information, please refer to "*Labeling Your Electronic Submission File*" on page 27 of the current MCSP Cancer Program Manual.

Coding of CIN III Cases ~

For these cases, histology is based on a pathology report text description that includes at least one of the following terms: "cervical intraepithelial neoplasia grade III (CIN III)," "HGSIL," "HSIL," or "severe dysplasia." Histology for any of these cervical neoplasia conditions is coded as 8077 with or without the term "carcinoma in situ."

Example: If the final diagnosis on the pathology report is "high grade squamous intraepithelial neoplasia (HGSIL)," code histology as 8077.
Do NOT code the histology in this instance as 8070.

For more information on these conditions, please refer to "Reportable Conditions for AIN III, CIN III, HSIL/HGSIL, VAIN III, VIN III" in the current MCSP Cancer Reporting Manual.

For Cervical Intraepithelial Neoplasia, Grade III, code Local Tumor Excision, Excisional Biopsy, Dilation and Curettage, Copy Biopsy with gross excision of lesion, LEEP and/or combinations of surgical procedures as defined in FORDS: Appendix B: Site-Specific Surgery Codes as first course of treatment. (*Note:* For invasive cancers, dilation and curettage is coded as an incision biopsy code 02 under the data item Surgical Diagnostic and Staging Procedure (NAACCR Item # 1350).

For non-invasive cancers, code Dilation and Curettage for in situ ONLY as code 25.

Example: If the first course of treatment for a non-invasive cancer is documented as LEEP, code the RX-Summ-Surgery Primary Site as 28.

Code an excision biopsy, even when documented as incisional, when:

- All disease is removed (margins free) OR
- All gross disease is removed and there is only microscopic residual at the margin
- Do NOT code an excision biopsy when there is macroscopic residual disease

The following is a guideline of appropriate coding values for CS and Treatment Fields for CIN III:

- CS Extension: 010 (Cervical intraepithelial neoplasia (CIN) Grade III)
  - Note: Only use CS Extension code 000 when histology is:
    - In situ, intraepithelial, noninvasive, pre-invasive: Cancer in situ WITH endocervical gland involvement
    - Histology not coded as 8077
- CS Size/Ext Eval: 3 (If surgical procedure is considered as first course of treatment for CIN III, code CS Size/Ext Eval as pathologic. For example, a LEEP procedure is considered as first course of treatment for CIN III)
  - If no surgical procedure was performed, assign appropriate CS Size/Ext Eval code
- Nodes: 000 (if cell behavior is 2 – in situ, follow the CS general rules and code nodes as negative)
- CS Lymph Nodes Eval: 0 (if assessment is other than clinical, use appropriate code)
- Regional Nodes Positive: 98 (if no nodes were examined)
- Regional Nodes Examined: 00 (if no nodes were examined)
- CS Mets @ Dx: 00
- CS Mets @ Dx Bone: 0
- CS Mets @ Dx Brain: 0
- CS Mets @ Dx Liver: 0
- CS Mets @ Dx Lung: 0
- CS Mets Eval: 0
- CS Site-Specific Factor: 987
  - Carcinoma in situ (intraepithelial, noninvasive, pre-invasive), Cervical intraepithelial neoplasia (CIN) Grade III
- Date First Course Treatment CoC: If surgical procedure was performed for first course of treatment, record the date in this field. If no surgical procedure was performed and/or information not known, select the appropriate value in the Date First Course Treatment CoC Flag field.
- Rx Summary Treatment Status: If surgical treatment performed, enter code '1 – treatment performed. If no treatment given, select appropriate value.
- Rx Date Surgery: Record date of surgical procedure when procedure is considered as first course of treatment for CIN III
- Rx Date Definitive Surgery: FirstRxDateCoC and RXDateDefSurg should be coded to the same date for surgical procedure (CIN III cases)
- Reason No Surgery: If surgical treatment was performed, use code 0
- Rx Summary Surgery Primary Site: If surgical treatment is considered as first course of treatment, record the site-specific surgery code. For more information on site specific surgery codes, refer to FORDS: Appendix B: Site-Specific Surgery Codes
- Reason No Radiation: 1
- Rx Summary Surg/Rad Sequence: 0

- Radiation Regional Rx Modality: 00
- RxDateSystmcFlag: 11
- RxSumTransEndo: 00
- RxDateChem Flag: 11
- RxSumChemo: 00
- RxDateHormFlag: 11
- RxSumHorm: 00
- RxSumSysSurgSeq: 0
- RxDateBRMFlag: 11
- RxSumBRM: 00
- RxDateOthFlag: 11
- RxSumOth: 0

Industry and Occupation ~

It has come to the attention of MCSP that some registrars are still including non-descriptive terms when recording Usual Occupation and/or Usual Industry. Descriptive terms such as such as "longest," "current," "previously," "prior history unknown, now working at," "last 5 years," "retired," "not applicable (N/A)," "disabled," etc. should be avoided when recording Usual Occupation and Usual Industry.

Accurately recording the usual (longest-held) occupation and industry of workers can reveal the national cancer burden by industry and occupation. Such information can also be used to help discover jobs that may have a high risk for cancer or other diseases and for which prevention efforts can be concentrated (or targeted). The coding instructions for recording Industry and Occupation are provided below.

Patient's Usual Occupation Prior to Retirement

Enter the usual occupation of the patient. "Usual Occupation" is the kind of work the patient did during most of his/her working life before retirement, e.g., claim adjuster, farm hand, coal miner, janitor, retail store manager, research chemist, civil engineer, college professor, teacher, registered nurse, etc.

Enter "student" if the patient was a student at the time of diagnosis and was never regularly employed.

This data item applies only to patients who are 14 years of age or older at the time of diagnosis.

If the Usual Occupation is not available or is unknown, record the patient's current or most recent occupation, or any available occupation.

Examples	Inadequate: "teacher"	Adequate: "preschool teacher," "high school teacher"
	Inadequate: "laborer"	Adequate: "residential bricklayer"
	Inadequate: "worked in a warehouse"	Adequate: "warehouse forklift operator"

Do NOT include descriptive terms with the Usual Occupation such as "longest," "current," "last 10 years," "not applicable (N/A)," "disabled," etc.

Do NOT use "retired." If the patient has retired from his or her usual occupation, the "usual occupation and business/industry" of the patient must be specified.

If the patient was never employed enter "never employed." If the usual occupation of the patient is unknown, enter "unknown."

If the patient was a homemaker at the time of diagnosis, but had worked outside the household during his or her working life, enter that occupation.

If the patient was a homemaker during most of his or her working life, and never worked outside the household, enter "homemaker."

Examples If patient worked only at home, record occupation and industry as:
Occupation: "homemaker"
Industry: "own home"
If patient worked at someone else's home for pay, then record:
Occupation: "housekeeper" (or "nurse," "babysitter," etc.)
Industry: "private home"

"Self-employed" by itself is incomplete. The kind of work must be determined. The entry for business/industry should include both the proper business/industry and the entry "self-employed."

Do NOT leave this data item blank.

Patient's Usual Industry Prior to Retirement
Record the primary type of activity carried on by the business/industry at the location where the patient was employed for the most number of years before diagnosis of this tumor. Enter the kind of business or industry to which the occupation in Item 15a was related, such as insurance, automobile, government, school, church, etc. Be sure to distinguish among "manufacturing," "wholesale," "retail," and "service" components of an industry that performs more than one of these components.

Examples		
	Inadequate: "automobile industry"	Adequate: "automobile manufacturing"
	Inadequate: "manufacturing"	Adequate: "automobile manufacturing"
	Inadequate: "fire department"	Adequate: "city fire department"

Do NOT include descriptive terms with the Usual Industry such as "longest," "current," "last 10 years," "not applicable (N/A)," "disabled," etc. Do NOT record "retired."

If the primary activity of the industry is unknown, record the name of the company (with city or town) in which the patient worked the most number of years before diagnosis.

If the patient was never employed, enter "never employed." If this information is unknown, enter "unknown." Do NOT leave this data item blank.

NOTE: For more information, refer to the A Cancer Registrar's Guide to Collecting Industry and Occupation to assist with coding this data item. The guide can be downloaded at http://www.cdc.gov/niosh/docs/2011-173/ and has been provided by CDC.

Blank CS Data Fields ~

MCSP has found that the following CS data fields are often submitted as blank fields:

- CS Lymph Nodes
- CS Lymph Nodes Eval
- CS Mets at DX
- CS Mets at DX – Bone, Brain, Liver, Lung
- CS Mets Eval

Abstracts must be submitted with appropriate case data or default values for ALL CS items. Please review MCSP Reporting Requirements by Item & Facility Type found on the MCSP web page. For more information on Collaborative Stage (CS) go to http://www.cancerstaging.org/cstage/Pages/default.aspx.

Text Fields Are Required for All Reporting Entities ~

Many facilities are not documenting supporting text to the level that is required by the state. As text documentation is an essential component of a complete electronic abstract and is utilized for quality control and special studies, text is needed to justify coded values and to document supplemental information not transmitted within the coded values.

Text documentation is **not just recommended**, **but is a required** component of the abstract, which justifies the codes selected AND allows for documentation of information that is not coded.

Since the purpose of text is to provide the opportunity for checking coded values, the text fields MUST contain a description of the disease process entered by the abstractor from review of the medical record and NOT from the generated electronically coded values.

Text fields CANNOT contain control characters (Note: Copying and pasting of text documentation from the electronic medical record and/or hospital record system might contain control characters. Issues with control characters are not identified during submission of data and instead during the central cancer registry case consolidation process.

When documenting supporting text, be as specific as possible. For example, in the Surgery Text Field record the date and the complete name of the surgical procedure. If multiple surgical procedures are performed, record the date and name of each surgical procedure.

The rationale behind supporting text documentation is that anyone should be able to print the free text and re-abstract the case **solely from the supporting text fields.**

If there is no information for a particular text field, do NOT leave the data item blank. Record "N/A," "None" or "Unknown" in the appropriate text field. This documentation confirms that information was searched for but no information exists.

Only NAACCR approved abbreviations should be utilized. Recommended abbreviations for Abstractors are included in Appendix G of the NAACCR Volume II Data Standards and Data Dictionary.

For more information on Text Documentation, refer to:
NAACCR Standards for Cancer Registries, Data Standards and Data Dictionary (Volume II) at http://www.naaccr.org/StandardsandRegistryOperations/VolumeII.aspx.

MCSP - Reporting Facility Contact Information Form~

We still need your help in updating facility contact information. If you have not completed and submitted a copy of new MCSP *Reporting Facility Contact Information Form*, or if there has been a change in personnel at your facility since a form was last submitted, it is important that you submit an updated form to ensure continued correspondence from the MCSP to the appropriate individuals at your facility. The contact information form is available on the MCSP web page.

Michigan Cancer Surveillance Program Web Page ~

To download this or previous issues of the MCSP Updates, Cancer Report Form, Cancer Program Manual, and other current Michigan cancer reporting documents, visit the MCSP web page at http://michigan.gov/mdch/0,4612,7-132-2945_5221-16586--,00.html.

MCSP Staff ~

If you have any questions regarding cancer reporting, or would like more information about workshops, please feel free to give one of us a call.

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