MCSP
MICHIGAN
CANCER SURVEILLANCE PROGRAM

Cancer Program Manual

For cases diagnosed in 2018 and later

DCH-0916 Rev. 2/25/2019

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Michigan Department of Health and Human Services
Division for Vital Records and Health Statistics
By Authority of Act 82, P.A. 1984

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DCH-0916 Rev. 2/11/2019

Michigan Department of Health and Human Services
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CANCER PROGRAM MANUAL

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Data Services Provided To Facilities

A variety of services are available to Michigan facilities providing cancer patient information to the Michigan Cancer Surveillance Program. These services are made available to support the research and planning efforts that facility staff determine are necessary and are particularly intended to aid in hospital cancer registry management and associated activities.

The key services available include:

- Hospital Specific Data or Listings
- Ad Hoc Statistical Data
- Death Searches - Death Certificates
- Death Indexes
- Microfiche - from 1985 - 1995 (135mm)
- Data Files - from 1996 to current
- Death Notices when Reported Patients Die (includes deaths in Michigan and for many other states.)

For more information on these special services contact:

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Introduction

The Michigan Department of Health and Human Services (MDHHS) is mandated by Act 82 of 1984, effective July 1, 1984, to establish a cancer registry for the State of Michigan. This statute states "the department shall establish a registry to record cases of cancer and other specified tumorous and precancerous diseases that occur in the state, and to record information concerning these cases as the department considers necessary and appropriate in order to conduct epidemiologic surveys of cancer and cancer-related diseases in the state."

Reports of diagnosed cancers are required of a facility diagnosing and/or treating a cancer patient. all hospitals, clinical laboratories, physician offices, dentists and clinic directors who have knowledge of a case of cancer shall report the case to the MDHHS.

Reporting of diagnosed cancers statewide is effective for those cases diagnosed on or after January 1, 1985. This manual is intended to provide those responsible for reporting with specific instructions on the proper and complete reporting of cancer diagnoses.

In October 1, 2004, the Michigan Cancer Surveillance Program (MCSP) implemented the collection of benign/ borderline intracranial and Central Nervous System (CNS) tumors as a new requirement.

Contact Registry Staff

If you need assistance, please contact the MCSP staff below:

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Research use of statewide registry or hospital planning data
Cancer reporting requirements or submission of data
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History of the Michigan Central Cancer Registry

The history of cancer reporting in Michigan dates back to 1947 when an administrative rule was enacted to require the reporting of cancer cases. This rule was never effectively enforced until 1978, when a governor's task force was empaneled to examine the need for cancer reporting in Michigan. The recommendations from this panel prompted the department in 1980, to initiate a pilot program. By 1984, 52 hospitals were reporting cancer cases on a voluntary basis, which resulted in approximately 6,000 cases being reported each year. As the pilot project progressed, legislation to require state wide reporting was developed. On April 17, 1984, a bill to mandate state wide reporting was signed into law.

A panel was assembled to develop and design the rules for reporting incidence of cancer to the state wide central cancer registry. In 1984, the “Task Force on Administrative Rules to Implement Act 82” began meeting. The task force consisted of professional groups throughout the state who in some way dealt with cancer patients or cancer data systems. In addition, public health officials involved in health programs concerned with cancer control, and individuals involved with epidemiological cancer research, were also assigned to the task force.

The objective of the task force was to “provide advice to the department on a set of administrative rules as required by the authorizing legislation.” This panel made recommendations on data items to be collected, methods of reporting, quality control issues, confidentiality, as well as rules for reporting facilities. These cancer reporting rules were developed and outlined in the original 1984 Cancer Reporting Manual, which was approved by the original task force. On January 1, 1985, the rules for reporting cancer cases went into effect.

MCSP began tabulating cancer incidence reports on January 1, 1985. By the end of 2016, the state central cancer registry contained 2.2 million reports with 1.7 million individual cancer cases. Currently the central registry processes approximately 59,000 new reports yearly. These cases represent approximately 165 reporting facilities, which include hospitals, physician offices and laboratories.

The Detroit Metropolitan Cancer Surveillance System operates a Surveillance Epidemiology End Results (SEER) registry which reports for all hospitals and majority of the laboratories within Oakland, Macomb, and Wayne counties. The SEER registry represents approximately 60 hospitals and laboratories in these three counties.

Facilities are able to report cancer cases to the state central cancer registry either manually on the cancer report form or electronically through the State’s free online abstracting feature in Web Plus. Hospital registries are becoming more sophisticated in their collection and transferal methods since the state cancer registry began in 1985. As of November 2016, approximately 95 percent of the cases from hospitals and regional registries are involved in an automated reporting system. Automated facilities send their data through Web Plus, which is a web-based application that collects cancer data securely over the public Internet.

State cancer data has been compiled and analyzed annually since 1985. These yearly reports are produced using the submitted data and are made available on the Michigan Department of Health and Human Services - Cancer Statistics web site. As new annual reports are prepared, updated data for prior years is developed and released to ensure that the most complete information is made available. Processing time for a report from diagnosis to manual statistics is approximately two years.

Purpose

A state wide population based cancer registry is the only means whereby state wide incidence data for cancers by type and by area of residence can be developed. Timely information on cancer cases is employed as a basis for cancer surveillance, as a tool for initial evaluation of cancer incidence within regions of particular interest, and as a source of baseline incidence data. The registry is of value in examining the frequency of cancer by demographic characteristics such as age, race and sex and is of significant value to researchers in epidemiological case control studies. This data is also helpful in the areas of planning health education and addressing public health concerns.

Confidentiality

Cancer incidence reports and data files on cancer cases which are received by the department are afforded confidential handling as required by Act 82 of 1984, being section 2631 of Act 368 of 1978 as amended, and by administrative rule. The release of data in identifiable form is specifically prohibited, except as outlined in Rule Four. Under the rules, release of this data or reports is permitted to the individual patient or to the patient's legal representative. Information may be provided to a researcher conducting approved research, following specific protocol based upon the nature of the research. Release is permitted to a cancer registry from another state with regard to residents of that state so long as the state agrees to restrict the use of the information to statistical tabulations. Further protection of the data is afforded by sections 2632 and 2633 of Act 368 of 1978 which designates that the reports or information thereon are inadmissible as evidence in a court and which establishes a shield from liability for furnishing the information. In addition, the privacy regulations enacted in conjunction with the Health Insurance Portability and Accountability Act (HIPAA) has a specific exemption to permit disclosing identifiable patient data to the official public health agency of a state.

Revised Reporting Requirements

In 2011, changes to the information being reported for cancer cases was initiated. These new reporting standards are designed to ensure that the registry in Michigan conforms as closely to central incidence registries operated in other states. The new data set collected conforms to the items recommended for collection by the North American Association of Central Cancer Registries (NAACCR) and are nearly the same as the recommendations by the National Program for Cancer Registries (NPCR).

The decision to change the reporting requirements was precipitated by two important developments. The first was the release of standards for the operation of a central registry which were produced by NAACCR in 2011. Concurrent with the release of these new standards were recommendations on standard items for collection released by NPCR within the Centers for Disease Control (CDC). The information being collected in Michigan did not conform to these two new sets of standards. It was apparent that the long term usefulness of the state central cancer registry hinged upon careful review of the new standards and the development of specific recommendations for implementation in Michigan.

The initial structure for cancer reporting used in Michigan was developed in consultation with an "ad hoc task force" with members representing key organizations of cancer care and cancer research in Michigan. This group provided counsel on a number of important matters that needed to be addressed when the registry was first established. These issues included determining who was responsible for reporting, the
manner the information was to be reported, timeliness requirements, and finally the specific items to be reported. The advice of this group proved to be an important key to the success of the state wide

cancer registry. This same approach was adopted with regard to re-evaluating the basic operational principles for the Michigan registry in light of the recommendations of NAACCR and NPCR.

The standards set forth by the Commission on Cancer (CoC) were also taken under advisement. A strategy for required data sets takes place in a tiered priority which conforms to the requirements of the CoC. Those facilities approved by the CoC, are required to submit more detailed information, which includes further information on staging and treatment. Those facilities with CoC approved cancer registries are perceived to have the ability of their staff to supply the central registry with this further information. A table has been developed to distinguish the reporting requirements for approved facilities, non-approved facilities and laboratories.

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Act No. 82 of 1984 Establishing the Central Cancer Registry

Act No. 82
Public Acts of 1984
Approved by the Governor
April 17, 1984

Filed with the Secretary of State
April 19, 1984

STATE OF MICHIGAN
82ND LEGISLATURE
REGULAR SESSION OF 1984

Introduced by Reps. Spaniola, Hertel, Barns, Dutko, Porreca, Sitz, Maynard and DeMars

ENROLLED HOUSE BILL No. 4090

AN ACT to amend Act No. 368 of the Public Acts of 1978, entitled "An act to protect and promote the public health; to codify, revise, consolidate, classify, and add to the laws relating to public health; to provide for the prevention and control of diseases and disabilities; to provide for the classification, administration, regulation, financing, and maintenance of personal, environmental, and other health services and activities; to create or continue, and prescribe the powers and duties of, departments, boards, commissions, councils, committees, task forces, and other agencies; to prescribe the powers and duties for governmental entities and officials; to regulate occupations, facilities, and agencies affecting the public health; to promote the efficient and economical delivery of health care services, to provide for the appropriate utilization of health care facilities and services, and to provide for the closure of hospitals or consolidation of hospitals or services; to provide for the collection and use of data and information; to provide for the transfer of property; to provide the certain immunity from liability; to provide for penalties and remedies; and to repeal certain acts and parts of acts," as amended, being sections 333.1101 to 333.25211 of the Michigan Compiled Laws, by adding section 2619.

The People of the State of Michigan enact:

Section 1. Act No. 368 of the Public Acts of 1978, as amended, being sections 333.1101 to 333.25211 of the Michigan Compiled Laws, is amended by adding section 2619 to read as follows:

Sec. 2619. (1) The department shall establish a registry to record cases of cancer and other specified tumorous and precancerous diseases that occur in the state, and to record information concerning these cases as the department considers necessary and appropriate in order to conduct epidemiologic surveys of cancer and cancer-related diseases in the state.
(2) Each diagnosed case of cancer and other specified tumorous and precancerous diseases shall be reported to the department pursuant to subsection (4), or reported to a cancer reporting registry if the cancer reporting registry meets standards established pursuant to subsection (4) to ensure that accuracy and completeness of the reported information. A person or facility required to report a diagnosis pursuant to subsection (4) may elect to report the diagnosis to the state through an existing cancer registry only if the registry meets minimum reporting standards established by the department.
(3) The department shall maintain comprehensive records of all reports submitted pursuant to this section. These report shall be subject to the same requirements of confidentiality as provided in section 2631 for data or records concerning medical research projects.
(4) The director shall promulgate rules which provide for all of the following:
(a) A list of tumorous and precancerous disease other than cancer to be reported pursuant to subsection (2).
(b) The quality and manner in which the cases and other information described in subsection (1) are reported to the department.
(c) The terms and conditions under which records disclosing the name and medical condition of a specific individual and kept pursuant to this section are released by the department.

(5) This section does not compel an individual to submit to medical or department examination or supervision.
(6) The department may contract for the collection and analysis of, and research related to, the epidemiologic data required under this section.
(7) Within 2 years after the effective date of this section, the department shall begin evaluating the reports collected pursuant to subsection (2). The department shall publish and make available to the public reports summarizing the information collected. The first summary report shall be published not later than 180 days after the end of the first 2 full calendar years after the effective date of this section. Subsequent annual summary reports shall be made on a full calendar year basis and published not later than 180 days after the end of each calendar year.
(8) Reporting pursuant to subsection (2) shall begin the next calendar year after the effective date of this section.
(9) This section shall take effect July 1, 1984.

This act is ordered to take immediate effect.

William A. Ryan

Clerk of the House of Representatives

William C. Kandler

Secretary of the Senate

Approved

Governor

Administrative Rules on Cancer Reporting

Department of Health and Human Services
Office of the State Registrar

Filed with the Secretary of State on April 16, 1985. These rules take effect 15 days after filing with the Secretary of State.

(By authority conferred on the department of public health by section 2619 of Act No. 368 of the Public Acts of 1978, as amended, being 333.2619 of the Michigan Compiled Laws.)

R 325.9050, R 325.9051, and R 325.9052 are amended; and R 325.9057 is rescinded (Eff. May 27, 2016).

R 325.9050 Registry

Rule 9050. (1) The department shall establish a registry to record cases of cancer and other specified tumorous and precancerous diseases that occur in the state. The registry shall include information concerning these cases as the department considers necessary and appropriate to conduct epidemiologic surveys of cancer and cancer-related diseases in the state.
(2) Each diagnosed case of cancer and other specified tumorous and precancerous diseases shall be reported to the department pursuant to subrule (4) of this rule, or reported to a cancer reporting registry if the cancer reporting registry meets standards established pursuant to subrule (4) of this rule by a reporting entity as defined in R 325.9051 to ensure the accuracy and completeness of the reported information. A reporting entity required to report a diagnosis pursuant to subrule (4) of this rule may elect to report the diagnosis to the state through an existing cancer registry only if the registry meets minimum reporting standards established by the department.
(3) The department shall maintain comprehensive records of all reports submitted pursuant to this rule. These reports shall be subject to the same requirements of confidentiality as provided in section 2631 of the public health code, 1978 PA 368, MCL 333.2619 for data or records concerning medical research projects.
(4) The director shall provide for all of the following:
(a) A list of tumorous and precancerous disease other than cancer to be reported pursuant to subrule (2) of this rule.
(b) The quality and manner in which the cases and other information described in subrule (1) of this rule are reported to the department.
(c) The terms and conditions under which records disclosing the name and medical condition of a specific individual and kept pursuant to this rule are released by the department.
(5) This rule does not require an individual to submit to medical or department examination or supervision.
(6) The department may contract for the collection and analysis of, and research related to, the epidemiologic data required by this rule.
(7) Within 2 years after the effective date of these rules, the department shall begin evaluating the reports collected pursuant to subrule (2) of this rule. The department shall publish and make available to the public reports summarizing the information collected.
(8) Reporting pursuant to subrule (2) of this rule shall begin the next calendar year after the effective date of this rule.

History: 2004 MR 14, Eff. July 23, 2004; 2016 MR 14, Eff. March 27, 2016

R 325.9051 Definitions

Rule 9051. As used in these rules:
(a) "Primary brain-related tumor" means a primary tumor, whether malignant or benign, of the brain, meninges, spinal cord, cauda equina, a cranial nerve or nerves, or any part of the central nervous system or of the pituitary gland, pineal gland, or craniopharyngeal gland.
(b)"Cancer" means all diagnoses with a behavior code of 2 (carcinoma in situ) or 3 (malignant primary site) which is listed in publication found in department policy and made available to the public including carcinomas of skin of the vagina, prepuce, clitoris, vulva, labia, penis, and scrotum but excluding basal, epithelial, papillary, and squamous cell carcinomas of the skin.
(c) "Department" means the department of health and human services.
(d) “Reporting entity or reporting entities” means an individual, facility, or other entity described in these rules as required to report patient information with a diagnosed cancer or other reportable condition to the state cancer registry. A reporting entity includes the following:
(i) Physician as defined in sections 17001 and 17501 of the public health code, 1978 PA 368, MCL 333.17001 and 333.17501.
(ii) Dentist as defined in in section 16601 of the public health code, 1978 PA 368, MCL 333.16601.
(iii) Hospital as defined in section 20106 of the public health code, 368 PA 1978 of the public health code, MCL 333.20106.
(iv) Clinic defined as an outpatient facility that provides advice, counseling, diagnosis, treatment, surgery, care, or services relating to the preservation or maintenance of health.
(v) Clinical laboratory as defined in section 20104 of the public health code, 1978 PA 368, MCL 333.20104.

History: 1985 MR 4, Eff. May 2, 1985; 2004 MR 14, Eff. July 23, 2004; 2016 MR 14, Eff. March 27, 2016

R 325.9052 Reportable Diagnoses

Rule 9052. (1) Cancer diagnoses, diagnoses of benign brain-related tumors, and any tumorous and precancerous diseases otherwise required to be reported by state or federal law shall be reported to the department in a manner consistent with these rules and procedures issued by the department.
(2) Diagnoses shall be reported by all reporting entities.
(3) A reporting entity may elect to report cases through a hospital or regional cancer registry that meets the rules set by the department.
(4) Reports shall be submitted within 180 days of a diagnosis on a form prescribed or approved by the department, except for reports forwarded on electronic media.
(5) Reports submitted on electronic media shall meet data quality, format, and timeliness standards prescribed by the department.

History: 1985 MR 4, Eff. May 2, 1985; 2004 MR 14, Eff. July 23, 2004; 2016 MR 14, Eff. March 27, 2016

R 325.9053 Quality Assurance

Rule 3. (1) For the purpose of assuring the quality of submitted data, each reporting entity shall allow the department to inspect such parts of a patient's medical records as are necessary to verify the accuracy of submitted data.
(2) A reporting entity which meets the standards of quality and completeness set by the department shall be subject to inspection not more than once every 2 years for the purpose of assessing the quality and completeness of reporting from the entity.

(3) A reporting entity shall, upon request of the department, supply missing information, if known, or clarify information submitted to the department.
(4) Upon mutual agreement between a reporting entity and the department, the reporting entity may elect to submit copies of medical records instead of inspection. Each copy of a medical record or part thereof submitted to the department pursuant to this rule shall be used only for verification of corresponding reported data, shall not be recopied by the department, and shall be kept in a locked file cabinet when not being used. Such copies shall be destroyed promptly following verification of the corresponding reported data or, if the reported data appears to be inaccurate, following clarification or correction of the reported data.
(5) Both of the following provisions shall be complied with to preserve the confidentiality of each patient's medical records:
(a) Each reporting entity shall provide to the department, for inspection only, all of the following records and reports:
(i) Reports of tissue analyses which have been performed for the purpose of determining the presence or absence of malignant disease.
(ii) Reports of radiological examinations performed for the purpose of determining the presence or absence of malignant disease.
(iii) Reports of diagnoses of malignant disease and notations of the reasons for such diagnoses, including both the primary clinician's reports and consultation reports.
(iv) Those parts of medical records which contain the specific information required to be reported.
(b) A reporting entity shall not be required by this rule to allow inspection of any part of any patient's medical record other than those parts listed in subrule (3) of this rule. A reporting entity may allow the inspection of medical records from which parts, other than those specified, have been deleted, masked, crossed out, or otherwise rendered illegible.

History: 1985 MR 4, Eff. May 2, 1985.

R 325.9054 Confidentiality of Reports

Rule 4. (1) The department shall maintain the confidentiality of all reports of cancer submitted to the department and shall not release such reports, or any information which, because of name, identifying number, mark, or description, can be readily associated with a particular individual, except in accordance with subrules (2), (3), (4), and (5) of this rule. The department shall not release any information that would indicate whether or not the name of a particular person is listed in the cancer registry, except in accordance with subrules (2), (3), (4), and (5) of this rule.
(2) A report of cancer submitted to the department concerning a particular individual, and any other information maintained in the cancer reporting system which, because of name, identifying number, mark, or description, can be readily associated with a particular individual, shall be released as follows:
(a) To the particular individual upon compliance with both of the following provisions:
(i) Receipt of a written request which is signed by the particular individual and which is witnessed or notarized as required by subrule (3) of this rule.
(ii) Presentation by the particular individual of suitable identification as required by subrule (4) of this rule.
(b) If the particular individual is a minor, to a parent of the particular individual upon compliance with all of the following provisions:
(i) Receipt of a written request which is signed by the parent and which is witnessed or notarized as required by subrule (3) of this rule.
(ii) Receipt of a certified copy of the birth certificate of the particular individual.
(iii) Presentation by the parent of suitable identification as required by subrule (4) of this rule.
(c) If the particular individual has a court-appointed guardian or if the particular individual is deceased, to the court-appointed guardian or to the executor or administrator of the particular individual's estate upon compliance with all the following provisions:

(i) Receipt of a written request which is signed by the court-appointed guardian, executor, or administrator and which is witnessed or notarized as required by subrule (3) of this rule.
(ii) Receipt of a certified copy of the order or decree which appoints the guardian, executor, or administrator.
(iii) Presentation by the guardian, executor, or administrator of suitable identification as required by subrule (4) of this rule.
(d) To an attorney or other person designated by the particular individual upon compliance with both of the following provisions:
(i) Receipt of a written request which is signed by the particular individual, which is witnessed or notarized as required by subrule (3) of this rule, and which requests release of the information to the attorney or other person.
(ii) Presentation by the attorney or other person of suitable identification as required by subrule (4) of this rule.
(e) To an attorney or other person designated by the court-appointed guardian of the particular individual or designated by the executor or administrator of the estate of the particular individual upon compliance with all of the following provisions:
(i) Receipt of a written request which is signed by the court-appointed guardian, executor, or administrator, which is witnessed or notarized as required by subrule (3) of this rule, and which requests release of the information to the attorney or other person.
(ii) Receipt of a certified copy of the order or decree which appoints the guardian, executor, or administrator.
(iii) Presentation by the attorney or other person of suitable identification as required by subrule (4) of this rule.
(f) If the particular individual is a minor, to an attorney or other person designated by the parent of the particular individual upon compliance with all of the following provisions:
(i) Receipt of a written request which is signed by the parent, which is witnessed or notarized as required by subrule (3) of this rule, and which requests release of the information to the attorney or other person.
(ii) Receipt of a certified copy of the birth certificate of the particular individual.
(iii) Presentation by the attorney or other person of suitable identification as required by subrule (4) of this rule.
(3) Every written request for the release of information submitted pursuant to subrule (2) of this rule shall be signed by the person making the written request. Such signature shall comply with either of the following provisions:
(a) Be witnessed by an employee of the department who has been designated to witness such requests and to whom the person making the request presents suitable identification as required by subrule (4) of this rule.
(b) Be notarized by a notary public or magistrate.
(4) Any person who is required by subrule (2) or (3) of this rule to present suitable identification shall present an identification document, such as a driver's license, or other document which contains both a picture of the person and the signature or mark of the person.
(5) The director of the department may, pursuant to R 325.9055, release information from the cancer reporting system to an authorized representative of a study or research project reviewed by the scientific advisory panel and approved by the director. The department shall not release any part of a patient's medical record obtained pursuant to R 325.9053.

History: 1985 MR 4, Eff. May 2, 1985. 5

R 325.9055 Scientific Advisory Panel; Release of Information for Research

Rule 5. (1) The director of the department shall appoint a scientific advisory panel of not less than 3 scientists to review research proposals whereby a release of information maintained by the department which identifies an individual reported to have a diagnosis of cancer is required.
(2) All research proposals which require the release of information that identifies individuals with reported diagnoses of cancer shall be reviewed by the scientific advisory panel.
(3) The panel shall, in writing, advise the director concerning the merits of the study.
(4) The release of information for research which identifies individuals with reported diagnoses of cancer shall be subject to the terms and conditions set by the department. Such study or research project shall not publish the name of any individual who is or was the subject of a report of cancer submitted to the department, and such study or research project shall not release any identifying number, mark, or description which can be readily associated with an individual who is or was the subject of a report of cancer submitted to the department.
(5) A reporting entity shall, upon notification that the director has approved a research project, provide to the department or a researcher named by the director the name of the primary physician responsible for the medical care of persons selected for the research study as indicated in the reporting entity's records.

History: 1985 MR 4, Eff. May 2, 1985.

R 325.9056 Exchange of Records

Rule 6. The department, by agreement, may transmit transcripts or copies of reports of cancer diagnoses to state or national cancer registries when the reports relate to residents of other states or countries. The agreement shall require that the transcripts or records be used for statistical purposes only as specified in the agreement and that the identity of a person subject to the report shall not be released.

History: 1985 MR 4, Eff. May 2, 1985.

R 325.9057 Rescinded

Rule 7. The publication entitled “International Classifications of Diseases for Oncology,” 1976, specified in R 325.9051 is adopted by reference in these rules. Copies of the adopted matter may be obtained from the World Health Organization Publications Center, U.S.A., 49 Sheridan Avenue, Albany, NY 12210, or from the Department of Public Health, Box 30035, 3500 N. Martin Luther King, Jr. Blvd., Lansing, Michigan 48909. At the time of adoption of these rules the cost per copy is $10.00.

History: 1985 MR 4, Eff. May 2, 1985; 2016 MR 14, Eff. March 27, 2016.

R 325.971 Reporting of Cancer

Rule 1. (1) On and after May 1, 1947, every physician, dentists, hospital superintendent, and clinic director who has knowledge of a case of cancer shall, within 10 days, report the same to the Michigan department of health on a form provided by said department. The report shall contain the name and address of the patient and either the name and address of the physician, or of the dentist, or of the hospital superintendent and hospital, or of the clinic director and clinic, and such other data as may be required.
(2) All such reports and records of the Michigan department of health pertaining to cancer are hereby declared to be confidential.

History: 1944 ACS 10. p. 16: 1954 AC. P. 2317.

Editor’s note: This rule appears in the Michigan Administrative code of 1954 as R 325.975.

Reporting Responsibilities

Responsibilities of Michigan Hospitals and Laboratories

- Know the MCSP reporting requirements and attend the educational workshops when rules change or deemed necessary by the quality assurance field representative.

- Select an abstract reporting option; whether on paper or electronic and establish a schedule for regular reporting. Notify the MCSP of any changes in the method of reporting.

- Perform all casefinding activities to ensure completeness of reporting.

- Regardless of submission format (paper forms or electronic file), all reportable cases MUST be submitted to the MCSP within six months or 180 days from the initial date of diagnosis. Refer to the table below to determine when abstracts are to be submitted based upon the date of diagnosis.

- Electronic data submissions are required on a monthly basis and are to be received by MCSP on or before the first working day of each month.

  Example:
  Patient diagnosed January 15, 2018.
  Case is due to the MCSP by July 2018.

  Abstract Submission Schedule for Diagnosed Cases

Month of Diagnosis…	Submit Abstract No Later Than…
January	July
February	August
March	September
April	October
May	November
June	December
July	January
August	February
September	March
October	April
November	May
December	June

- Inform the MCSP of ALL facility or contact person changes (e.g., mailing address, contact name, phone, email) using the “Reporting Facility Contact Information Form” on the MCSP web page.

- Facilities will be involved in periodic quality control visits by a quality improvement field representative from the MCSP. These reporting facilities will be requested to do the following:
  - Provide access to all health records as requested for quality review
  - Submit master disease index and pathology reports as requested for complete casefinding
  - Provide adequate work space for field representative
  - Provide access to pathology, radiation, chemotherapy, and other treatment indices for complete casefinding
  - Be available for consultation during quality control reviews and summation

- Maintain some type of accession log or master file of submissions which will serve as a quick reference of all cases sent to the MCSP. This may be as simple as keeping copies of the cancer report forms or maintaining a reporting log which includes name, primary site, date of diagnosis, and date case was submitted to the state.

- Have access to online or printed versions of all manuals need to complete the required data items on the cancer report form or abstracting a case using Web Plus. A list of reference links to these materials can be found at the back of this manual.

Responsibilities of the Michigan Cancer Surveillance Program (MCSP)

- Provide all reporting facilities the current cancer report form and/or software for reporting.

- Provide educational workshops and instructions to locate online reference materials.

- Perform all computer data entry of manually submitted reports and process patient data updates.

- Conduct procedures to un-duplicate the cancer patient file.

- Edit the file following NAACCR and NPCR standards.

- Clarify and resolve issues relative to data quality that are encountered during the editing process.

- Provide specific reports to verify data submission as requested by the reporting facility.

- Post an annual Cancer Incidence and Mortality statistical report on the MDHHS/Cancer Statistics web page.

Preparation of the Cancer Report Form (Abstract)

The Michigan Department of Health and Human Services (MDHHS) is mandated by Act 82 of 1984, effective July 1, 1984 to establish a cancer registry for the state of Michigan. This statute states "the department staff shall establish a registry to record cases of cancer and other specified tumorous and precancerous diseases that occur in the state, and to record information concerning these cases as the department considers necessary and appropriate in order to conduct epidemiologic surveys of cancer and cancer-related disease in the state."

Reports of diagnosed cancers are required of a facility diagnosing and/or treating a cancer patient. All hospitals, clinical laboratories, physician offices, dentists and clinic directors who have knowledge of a case of cancer shall report the case to the Michigan Cancer Surveillance Program (MCSP).

Reporting of diagnosed cancers statewide is effective for those cases diagnosed on or after January 1, 1985. The MCSP Cancer Program Manual is intended to provide those responsible for reporting with specific instructions on the proper and complete reporting of cancer diagnoses. See sections of Introduction, Reporting Facility Terminology, Casefinding Procedures, and any other sections applicable to ensure proper and complete reporting of cancer diagnoses. The MCSP Cancer Program Manual and other departmental documents are available on the MCSP web page.

Reporting Requirements for Physicians and Dentists

As part of the requirements for meeting Meaningful Use (MU) in the Medicare and Medicaid EHR Incentive Programs, Eligible Professionals (Eps) will need to electronically submit certain forms of public health data to registrars within the MDHHS.

Eligible health professionals enrolled in the Medicare and Medicaid EHR incentive program may elect to report case information to the MCSP to satisfy the MCSP cancer reporting requirements. In order to select cancer reporting as a Specialized Registry Measure, eligible professionals must meet the following criteria:

- **Diagnose or Treat Cancer**
  In Michigan, all in situ and malignant conditions are reportable, with the exception of basal and squamous cell skin cancers in non-genital skin. Benign tumors of the brain and central nervous system are also reportable. For more information, see the "Reportable Conditions" section of this manual.

- **Capacity to Submit Cancer Case Reports in Standard Format**
  A national standard has been developed for certified electronic health record technology (CEHRT) to generate electronic cancer case reports. Not all CEHRTs have the capability to generate cancer cases reports using the national standard. Verification that the CEHRT has the capability is a requirement before proceeding with cancer reporting. The MCSP has developed a supplemental implementation guide CEHRT vendors should review before setting up cancer reporting for Michigan providers: Michigan Ambulatory Cancer Reporting Guide

  Eligible professionals who meet the criteria for selecting cancer reporting as the Specialized Registry Measure must complete a registration to submit cancer reports within 60 days of the start of the meaningful use reporting period Registration is completed through the Michigan Health System Testing Repository (HSTR)

  Instructions for completing the registration: Michigan Ambulatory Cancer Reporting Guide

Once the registration is complete, an e-mail will be sent with instructions on next steps to comply with meaningful use active engagement requirements.

View and Download the 5 Step Cancer Reporting Meaningful Use Process

Manual Submission

Manual submission is only available to physician offices without a certified electronic health record (EHR) with less than 50 reportable conditions (cases) per year.

Cases submitted manually must use the current revision of the MCSP Cancer Report Form, which is available in PDF format and can be downloaded and/or printed from the MCSP web page.

Electronic Cancer Case Submission

Physicians without a certified Electronic Health Record (EHR) with more than 50 reportable conditions (cases) per year must submit data electronically to the MCSP using the registry's Web Plus online abstracting application that collects cancer data securely over the public internet. Potential Web Plus users must complete a user request form.

Manual or Electronic Cancer Case submission of data does require a unique Michigan Facility Number, which is assigned by the MCSP.

To establish a Web Plus account and/or to obtain a Michigan Facility Number, please contact Amy Marquardt at Marquardta@michigan.gov .

General Reporting Instructions for All Reporting Types (Hospitals, Clinics, Labs, Physicians and Dentists)

Whenever a cancer case is diagnosed or first treated within a hospital or laboratory, an abstract of the case must be prepared and forwarded to the MCSP. The abstract MUST be sent within 180 days or six months from the initial date of diagnosis or initial treatment.

The instructions contained in this MCSP Program Manual are intended to outline what information is needed and to provide specific guidance for completing the form, and meeting state reporting requirements. Should the instructions need clarification, or if special problems exist that make reporting as outlined difficult, do not hesitate to contact MCSP to discuss the matter.

Specific instructions for identifying cases, determining primary site, assigning histology and stage are discussed in detail in sections to follow.

Upon reaching a diagnosis of an in situ or invasive cancer or providing treatment for a patient diagnosed elsewhere, a hospital or laboratory is to report the case via a paper or electronic abstract. In addition, any tumor diagnosed October 1, 2004 or later with a behavior code of "0" or "1" for the following site codes must be reported: meninges (C70.0 – C70.9); brain (C71.0 – C71.9); spinal cord, cranial nerves, and other parts of the central nervous system (C72.0 – C72.9); pituitary gland (C75.1); craniopharyngeal duct (C75.2); and pineal gland (C75.3).

The abstract must be in a format provided or approved by MCSP and submitted within 180 days or six months from the initial date of diagnosis.

- Each primary cancer diagnosed or treated within a hospital or laboratory must be reported to the MCSP on a separate cancer abstract.
- The diagnosis and/or treatment of a patient for a primary tumor that was previously reported by the facility need not be reported a second time.
- However, revisions and corrections to previously submitted information are important and should be reported to MCSP. (See "Submitting Updates (Corrections)" later in this section for instructions on how to report revisions or corrections to previously submitted abstracts.)
- New primary tumors diagnosed in previously reported patients are reportable.

As abstracts are received by the department, they will be reviewed, queried, electronically recorded and edited. In the course of assembling the data into a registry, duplicate reports of primary tumor diagnoses will be identified and tagged. The resulting file can therefore be used to develop accurate incidence information. There will be no active follow-up on the status or treatment of reported cases. MCSP maintains an incidence-based central registry – follow-up is limited to quality control issues or specific research projects.

The use of acceptable casefinding and record abstracting procedures are essential to complete reporting. The basic elements of reporting include sound casefinding techniques, correct identification of reportable cases, as well as the proper preparation and prompt submission of completed cancer reports.

Because the state maintains an incidence registry only, the information required for the state cancer report is limited compared to what is collected by a typical hospital cancer registry. Reporting of annual follow-up information on the status of a case is not necessary. However, a change in basic items of information that identify and describe the patient or that relate to the reportable conditions with which the patient has been diagnosed must be submitted as a case report update. In addition, information regarding the types of therapy provided as the first course of therapy is also required. The instructions which follow are organized alphabetically by NAACCR data item name.

Because the majority of quality-related problems are associated with a set of essential data items, these items are routinely queried for clarification during internal quality control reviews.

Quality-related issues for certain data fields

Data Field	Typical Quality-Related Issues
Patient's First Name	• Blank • Inconsistent • Unknown • Illegible
Patient's Last Name	• Blank • Unknown • Illegible
Complete Address	• Blank • Illegible • Inconsistent
Sex	• Blank • Inconsistent with name or site

Data Field	Typical Quality-Related Issues
Date of Birth	• Blank • Inconsistent with site, report date, or date of diagnosis
Social Security Number	• Blank
Primary Site	• Blank • Inconsistent with histology
Laterality	• A paired organ is reported for the primary site, but laterality is blank
Histology	• Blank • Inconsistent with the primary site • Indicates the condition may not be reportable
Stage	• Blank • Inconsistent with histology • Invalid values based on specific staging system
Method of Diagnosis	• Blank • Inconsistent, e.g., in situ diagnosis not based upon a microscopic method of diagnosis
First Course of Treatment	• Blank, but the report is from a hospital with a treatment center

If the reporting facility is unable to provide information for a required data item, the next step is to query the attending physician. For independent laboratories that do not have access to requested patient demographic information, adding the name and office address of the doctor to the abstract report is extremely helpful. Contact information about the physician should be added to the cancer report form for any case with missing information. Be sure to supply the doctor's full name and complete mailing address.

Manual Submission

The cancer report (abstract) form may be typed or completed by hand. The four-page "MCSP Cancer Report Form" is available in PDF format and can be downloaded and printed from the MCSP website.

Fully completed forms must be submitted within 180 days or six months from the initial date of diagnosis. Manual submission is limited to 50 or less cases per year. Facilities with caseloads greater than 50 cases per year need written permission from MCSP to submit paper abstracts.

An abstract report for each separate primary tumor is required. A second report is NOT required if a patient is diagnosed with a recurrence that is confirmed to NOT be a second primary.

If mailed via United States Postal Service, send completed cancer report forms to:

MDHHS
Cancer Surveillance Section, 2nd Floor
Attention: Elaine Snyder
P.O. Box 30691
Lansing, MI 48909

If shipped via commercial courier such as FedEx or UPS, send completed cancer report forms to:

MDHHS
Cancer Surveillance Section, 2nd Floor

Attention: Elaine Snyder
333 S. Grand Ave., 2nd Floor
Lansing, MI 48933

Electronic Submission

Facilities submitting cases electronically must submit their data in the NAACCR format version specified by MCSP. In order to avoid data submission backlogs, facilities are requested to submit completed abstracts on a monthly basis.

Labeling Your Electronic Submission File

Once the export file has been created, enter a file name that begins with MI (Michigan) followed by your 5-digit Michigan Facility Number, then add the date stamp (YYYYMMDD) which is the date the file was created. For example, facility 98765 creates an export file on April 28, 2018. The file will be named MI9876520180428, plus the extension assigned by their software. The extension for Metriq is either **.xva** (new case) or **.xvm** (updated case) and will be assigned automatically.

If you are sending more than one file at a time, please make sure that each file is numbered appropriately by adding -1ofX, -2ofX, -3ofX, etc. to the end of the file name. For example, facility 98765 could have two files:

MI9876520180428-1of2.xva
and
MI9876520180428-2of2.xva

It is important that you accurately label your file for security reasons − if a file is not accurately labeled, it cannot be loaded into the MCSP registry. **MCSP no longer accepts submissions that are incorrectly labelled.**

Submission of Data Using Web Plus

Electronic submission of data must be submitted through Web Plus.

Web Plus is a web-based application that collects cancer data securely over the public internet. Web Plus supports three main functions: online abstracting, file upload and download, and follow-back efforts. Web Plus' online abstracting capability is ideal for reporting from physicians' offices and other low-volume reporting sources, while the file upload feature can be used for electronic submission of data to MCSP by reporting sources.

All records are saved in a database at the central cancer registry, and cases entered by one facility or office are not visible to other facilities. Data are validated by the CDC EDITS engine running on a Web server. Users, display types, and edit configurations are managed by the hosting central registry. Web Plus is hosted on a secure Web server that has a digital certificate installed; the communication between the client and the server is encrypted with Secure Sockets Layer (SSL) technology.

1. Go to MCSP Web Plus Login page.
2. Enter your User ID and Password that was provided by MCSP.
3. Enter PIN based on your assigned Web Plus PIN Matrix
4. Select Upload File link
5. Select New Upload tab
6. Load file
   A. Select the NAACCR version of the flat file. If the version is not listed, you will need to use the NORTHCON application to convert the file to one of the listed versions. The Non-

NAACCR option is only for uploading reports. Abstract files uploaded via the Non-NAACCR method will **NOT** be counted.

B. Click the Browse button and select the file to be uploaded.
C. Click the Upload button

7. Once all records have been uploaded to the system, an edit report will open up as a pop-up window. (Make sure your browser is set to allow pop-up windows.)
8. If there are errors, you should print the edit report to aid in making corrections.
9. Make the corrections to your patient record.
10. Regenerate the submission file.
11. Delete the previous erroneous submission file from Web Plus.
12. Re-submit the new, clean, submission file.

Note: Any file containing edit errors will not be processed by MCSP.

For detailed instructions on how to access Web Plus and upload data files, refer to the *Web Plus Login and File Upload Instructions* document on the MCSP web page.

Web Plus User Account Request Form
To establish a Web Plus user account, complete and submit a copy of the *MCSP Web Plus User Account Request Form* from the MCSP web page. Instructions are provided on the form. User instructions will be provided to the Local Administrator once the Web Plus account has been established.

For detailed instructions on how to access Web Plus and upload data files, refer to the *Web Plus Login and File Upload Instructions* document on the MCSP web page.

If you have any questions regarding Web Plus and/or completion of the MCSP Web Plus User Account Request Form, please contact Amy Marquardt at 517-335-9058 or Marquardta@michigan.gov .

Electronic Software
The software programs used by facilities in Michigan that are approved by the American College of Surgeons (ACoS) include *Metriq* and *OncoLog*.

Facilities with 100 or more yearly cases must submit electronic abstract data generated by abstracting software such as *Metriq* or *OncoLog*. Non-registry hospitals, clinics, and laboratories may use the cancer case abstraction function of Web Plus for electronic submission of case reports..

Web Plus is a web-based application that collects cancer data securely over the public internet. Web Plus supports three main functions: online abstracting, file upload and download, and follow-back efforts. Web Plus online abstracting capability is ideal for reporting from physicians' offices and other low-volume reporting sources, while the file upload feature can be used for electronic submission of data to MCSP by reporting sources.

All records are saved in a database at the central cancer registry, and cases entered by one facility or office are not visible to other facilities. Data are validated by the CDC EDITS engine running on a Web server. Users, display types, and edit configurations are managed by the hosting central registry. Web Plus is hosted on a secure Web server that has a digital certificate installed; the communication between the client and the server is encrypted with Secure Sockets Layer (SSL) technology.

To establish a Web Plus user account, complete and submit a copy of the MCSP Web Plus User Account Request Form from the MCSP web page. Instructions are provided on the form. User

instructions will be provided to the Local Administrator once the Web Plus account has been set up by MCSP.

If you have any questions regarding Web Plus and/or completion of the MCSP Web Plus User Account Request Form, please contact Amy Marquardt at 517-335-9058 or Marquardta@michigan.gov . For individual training in the abstracting function of Web Plus, please contact Jetty Alverson at 517-335-8855 or AlversonG@michigan.gov.

Submitting Updates (Corrections)

Beginning January 1, 2016 MCSP requires submission of a **case report update** when changes are made to certain data items for a reported primary.

A correction to the previously submitted report MUST be forwarded when one of the following conditions occurs:

- A cancer case has been reported but is later determined to be not reportable
- Information to resolve an unknown variable has been obtained
- Information for a particular variable of a previously submitted case was later determined to be submitted incorrectly
- A change has been made to one of the reportable fields on the following table since the last data submission:

New or Altered Values for These Data Fields Require an Update Submission for Diagnoses prior to 2018

Field Name	Field Name (continued)	Field Name (continued)
Behavior Code ICD-O-3	Race codes 1-5	RX Date Systemic
CS Site Specific Factors 1-25	Rad – Regional RX Modality	RX Summary for BRM
Date of 1st Course RX CoC	Reason for No Radiation	RX Summary for Chemo
Date of Birth	Reason for No Surgery	RX Summary for Surgery – Primary Site
Date of Diagnosis	Regional Nodes Examined	RX Summary for Transplant/Endocrin
Diagnostic Confirmation	Regional Nodes Positive	RX Summary of Treatment Status
Grade	RX Date BRM	SEER Summary Stage 2000
Histological Type ICD-O-3	RX Date Chemo	Sex
Laterality	RX Date Hormone	Social Security Number
Name – First	RX Date Most Definitive Surgery	Spanish/Hispanic Origin
Name – Last	RX Date Other	AJCC TNM Clinical Stage Group
Name – Middle	RX Date Radiation	AJCC TNM Pathologic Stage Group
Primary Site	RX Date Surgery	Tumor Size Summary

New or Altered Values for These Data Fields Require an Update Submission for Diagnoses in 2018 and later

Field Name	Field Name (continued)	Field Name (continued)
AJCC TNM Clin Stage Group	Name--Middle	RX Date Systemic
AJCC TNM Path Stage Group	Primary Site	RX Summ--BRM
All Site Specific Data Items (SSDIs)	Race codes 1-5	RX Summ--Chemo
Behavior Code ICD-O-3	Rad--Regional RX Modality	RX Summ--Hormone
Date 1st Crs RX CoC	Reason for No Radiation	RX Summ--Other
Date of Birth	Reason for No Surgery	RX Summ--Radiation
Date of Diagnosis	Regional Nodes Examined	RX Summ--Surg Prim Site
Diagnostic Confirmation	Regional Nodes Positive	RX Summ--Transplnt/Endocr
EOD--Mets	RX Date BRM	RX Summ--Treatment Status
EOD--Primary Tumor	RX Date Chemo	Sex
EOD--Regional Nodes	RX Date Hormone	Social Security Number
Histologic Type ICD-O-3	RX Date Mst Defn Srg	Spanish/Hispanic Origin
Laterality	RX Date Other	Summary Stage 2018
Name--First	RX Date Radiation	Tumor Size Summary
Name--Last	RX Date Surgery	

Manual Updates (Corrections) Submission
Note: Manual updates are allowed for changes to abstracts originally submitted in paper format only. Changes made to electronic abstract files must be submitted per "Electronic Updates" instructions below.

1. Make a photocopy the cancer abstract report form that was originally submitted.
2. Draw a line through the INCORRECT information.
3. Pencil in and HIGHLIGHT the corrected information.
4. Check UPDATE in the upper right hand corner.
5. Mail corrected cancer report forms via United States Postal Service to:
   MDHHS
   Cancer Surveillance Section, 2nd Floor
   Attention: Elaine Snyder
   P.O. Box 30691
   Lansing, MI 48909

Electronic Updates (Corrections) Submission
Proprietary abstracting software designates updated abstracts as "M" files because the file suffix for these documents is ."xv**m**" rather than ."xv**a**" (new case). "M" files are uploaded to MCSP via Web Plus. For detailed instructions on how to access Web Plus and upload data files, refer to the Web Plus Login and File Upload Instructions document on the MCSP web page.

Text Documentation

Note: Text documentation is required regardless of facility type. An abstract submitted with codes that lack supporting text data will be rejected in its entirety.

Text documentation is an essential component of a complete abstract and is heavily utilized for quality control and special studies. Text is required to justify coded values and to document supplemental

information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The purpose of text information is to provide the opportunity to review and check coded values. To accomplish this, important information that documents the disease process should be entered manually from the medical record. Another registrar should be able to completely and accurately re-abstract the case relying solely on the furnished text data. This text must not be electronically generated from the coded values, as doing so would invalidate this re-abstracting quality check.

Do not leave text fields blank. If there is no information to record in the text field, type “NR” (Not Reported) or “No Info”, By doing so, you confirm that information was sought, but none could be found; otherwise it will be assumed that the information is actually missing if the field is left blank..

Examples:

Physical Examination (PE)
2018/02/15: 49 year old white, non-Hispanic male presenting w/enlarged prostate. Retired farmer.

Lab Tests
02/15/2018: PSA elevated 4.6 ng/ml. 2018/04/20: ER/PR positive or (+), HER2 negative or (-)

Pathology
11/12/2018 colon polyp, 1.2 x 1.0 x 0.8cm. Adenocarcinoma contained within polyp showing invasion of submucosa. Stalk: no evidence of adenocarcinoma or dysplasia. 2017/07/04 mastectomy of breast for R upper outer quadrant mass; 1.0 x 1.3 x 0.9cm. Ductal carcinoma, infiltrating, Grade III. Margins clear; 1/12/18: lymph nodes negative for cancer; no metastasis noted; Positive histology; ERA negative.

For guidance on the collection of supporting text, refer to NAACCR Chapter X: Data Dictionary for instructions on how to record data in text fields. (Data field names used in the MCSP Cancer Program Manual match those in the NAACCR Data Dictionary.)

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Required Level of Follow-Back Effort by Item and Facility Type

Registry Types

Not all facilities are required to meet the same level of follow-back effort to ascertain and record data. Data reporting requirements are determined by data item and facility type.

Specific reporting requirements for hospitals with a registry, hospitals without a registry, and independent laboratories are summarized in the table below. The need to report an item has been assigned to the levels of required, reportable, and not required. These requirements are patterned after the American College of Surgeons (ACoS) levels for inclusion of information within a hospital registry. **The practical definitions of these levels of reportability are best termed as levels of effort associated with collecting and providing the information.**

- **Hospital with a Registry** - an entity that has an approved cancer program by the American College of Surgeons (ACoS) or is working towards ACoS approval or is a regional registry that houses data for surrounding facilities.
- **Hospital without a Registry** - geared towards smaller entities that do not have an approved cancer program or have limited resources to diagnosis and treat cancer patients.
- **Independent Laboratories** - a separate laboratory from a hospital that reads specimens for either a hospital or physician's office.
- **Cancer Reporting and Meaningful Use** - Eligible physicians and dentists enrolled in the Medicare and Medicaid Incentive Program and the Merit-based Incentive Payment System (MIPS) may elect to report cancer case information to the MCSP, and thereby fulfilling the Public Health Objective Specialized Registry Measure. Hospitals are not eligible at this time to select cancer reporting as a specialized registry measure and should continue to report in accordance with the MCSP guidelines.

Follow-back Level	Description
[REQ] Required	The facility must collect and report the information with data collection efforts including review of the patient's hospital charts, outpatient records or other available records, as well as making inquiries with other facilities or the physician on record as is necessary to obtain the information. **NOTE: For instructions on how to code missing information, refer to the applicable coding manual for that data item.**
[REP] Reportable	The facility MUST report the information if it can be located within the patient's chart, outpatient records or other available records, but need not make inquiries of other facilities or physician's offices. For example, if AJCC Stage is documented in the medical record, it must be reported. **NOTE: A "Reportable" designation does not mean that the field may be left blank. An appropriate default value must be reported for all Reportable items.**
[N/R] Not Required/Non-Reportable	Item considered generally not available to the facility and/or not considered as reliably available. Information may be reported if available to the facility. **Note: An "N/R" designation does not mean that the field may be left blank. An appropriate default value must be reported for N/R items.**

If there is no information available, and inquiries have been made, do not leave the item blank (unless specifically noted in the individualized data item instructions, e.g. Name--Alias.) Instead, record the appropriate NOS or default code.

Examples:

Data item: Primary Site
All facilities are required to report appropriate primary site ICD-O-3 code for the tumor

Data item: Name--Alias
Facilities may enter appropriate information if available or leave field blank if unknown/not applicable.

Data item: Grade (Clinical, Pathological or Post Therapy)
Hospitals with registries are required to do necessary follow-back to report correct value for this item. Hospitals without registries and laboratories are to enter the correct grade if it is available, but these facilities are not required to do follow-back to determine the tumor grade. If the value is unknown, they may record the appropriate default or NOS value for this item. In all cases, a value must be entered regardless of facility type or level of follow-back effort – this field must not be left blank.

Table: Follow-Back Requirements by Data Item and Facility Type (Data Item List)

Table Notations:

- [2] (superscript 2) Reporting required by Metropolitan Detroit Cancer Surveillance System (MDCSS) only.
- AUTO - Data is auto-populated by software at facility or central registry. Other NAACCR data items may not appear on this list if values are auto-generated for electronic reporting of cases.

NAACCR Item Name	NAACCR Item	Hospital with Registry	Hospital without Registry	Independent Lab	MCSP Paper Report Form Item
Abstracted By	570	REQ	REQ	REQ	100
Accession Number--Hosp	550	REQ	N/R	N/R	21
Addr at DX--City	70	REQ	REQ	REQ	5b
Addr at DX--Country	102	REQ	REQ	REQ	5g
Addr at DX--No & Street	2330	REQ	REQ	REQ	5a
Addr at DX--Postal Code	100	REQ	REQ	REQ	5e
Addr at DX--State	80	REQ	REQ	REQ	5d
Addr at DX--Supplementl (May be left blank)	2335	REP	REP	REP	5c
Addr Current--City	1810	REQ	REQ	REQ	6
Addr Current--Country	1832	REQ	REQ	REQ	6
Addr Current--No & Street	2350	REQ	REQ	REQ	6
Addr Current--Postal Code	1830	REQ	REQ	REQ	6
Addr Current--State	1820	REQ	REQ	REQ	6
Addr Current--Supplementl (May be left blank)	2355	REP	REP	REP	6
Adenoid Cystic Basaloid Pattern	3803	REP	REP	N/R	
Adenopathy	3804	REP	REP	N/R	
AFP Post-Orchiectomy Lab Value	3805	REP	REP	N/R	
AFP Post-Orchiectomy Range	3806	REP	REP	N/R	
AFP Pre-Orchiectomy Lab Value	3807	REP	REP	N/R	
AFP Pre-Orchiectomy Range	3808	REP	REP	N/R	
AFP Pretreatment Interpretation	3809	REP	REP	N/R	

NAACCR Item Name	NAACCR Item	Hospital with Registry	Hospital without Registry	Independent Lab	MCSP Paper Report Form Item
AFP Pretreatment Lab Value	3810	REP	REP	N/R	
Age at Diagnosis	230	AUTO	AUTO	AUTO	
AJCC ID (2018 cases and later)	995	REQ	REP	N/R	
AJCC TNM Clin M 8th Edition applies to cases diagnosed in 2018 and forward	1003	REQ	REP	N/R	
AJCC TNM Clin N 8th Edition applies to cases diagnosed in 2018 and forward	1002	REQ	REP	N/R	
AJCC TNM Clin N Suffix 8th Edition applies to cases diagnosed in 2018 and forward	1034	REQ	REP	N/R	
AJCC TNM Clin Stage Group 8th Edition applies to cases diagnosed in 2018 and forward	1004	REQ	REP	N/R	
AJCC TNM Clin T 8th Edition applies to cases diagnosed in 2018 and forward	1001	REQ	REP	N/R	
AJCC TNM Clin T Suffix 8th Edition applies to cases diagnosed in 2018 and forward	1031	REQ	REP	N/R	
AJCC TNM Path M 8th Edition applies to cases diagnosed in 2018 and forward	1013	REQ	REP	N/R	
AJCC TNM Path N 8th Edition applies to cases diagnosed in 2018 and forward	1012	REQ	REP	N/R	
AJCC TNM Path N Suffix 8th Edition applies to cases diagnosed in 2018 and forward	1035	REQ	REP	N/R	
AJCC TNM Path Stage Group 8th Edition applies to cases diagnosed in 2018 and forward	1014	REQ	REP	N/R	
AJCC TNM Path T 8th Edition applies to cases diagnosed in 2018 and forward	1011	REQ	REP	N/R	
AJCC TNM Path T Suffix 8th Edition applies to cases diagnosed in 2018 and forward	1032	REQ	REP	N/R	
AJCC TNM Post Therapy M	1023	REQ	REP	N/R	
AJCC TNM Post Therapy N	1022	REQ	REP	N/R	
AJCC TNM Post Therapy N Suffix	1036	REQ	REP	N/R	
AJCC TNM Post Therapy Stage Group	1024	REQ	REP	N/R	
AJCC TNM Post Therapy T	1021	REQ	REP	N/R	
AJCC TNM Post Therapy T Suffix	1033	REQ	REP	N/R	
Alcohol Use (State-specific item 9521)	NA	REP	REP	REP	17

NAACCR Item Name	NAACCR Item	Hospital with Registry	Hospital without Registry	Independent Lab	MCSP Paper Report Form Item
Anemia	3811	REP	REP	N/R	
B symptoms	3812	REP	REP	N/R	
Behavior Code ICD-O-3	523	REQ	REQ	REQ	33b
Bilirubin Pretreatment Total Lab Value	3813	REP	REP	N/R	
Bilirubin Pretreatment Unit of Measure	3814	REP	REP	N/R	
Birthplace--Country	254	REP	REP	N/R	8b
Birthplace--State	252	REP	REP	N/R	8a
Bone Invasion	3815	REP	REP	REP	
Brain Molecular Markers	3816	REP	REP	N/R	
Breslow Tumor Thickness	3817	REP	REP	REP	
CA-125 Pretreatment Interpretation	3818	REP	REP	N/R	
Casefinding Source	501	REQ	REQ	REQ	23
Cause of Death	1910	REP	REP	N/R	103
CEA Pretreatment Interpretation	3819	REP	REP	N/R	
CEA Pretreatment Lab Value	3820	REP	REP	N/R	
Census Tr Poverty Indictr	145	REP	REP	REP	
Chromosome 19q: Loss of Heterozygosity (LOH)	3802	REP	REP	N/R	
Chromosome 1p: Loss of Heterozygosity (LOH)	3801	REP	REP	N/R	
Chromosome 3 Status	3821	REP	REP	N/R	
Chromosome 8q Status	3822	REP	REP	N/R	
Circumferential Resection Margin (CRM)	3823	REP	REP	REP	
Class of Case	610	REQ	REQ	REQ	26
CoC Accredited Flag	2152	REQ	N/R	N/R	
Comorbid/Complication 1 (ICD-9-CM codes only)	3110	REP	REP	N/R	14a
Comorbid/Complication 10 (ICD-9-CM codes only)	3164	REP	REP	N/R	14a
Comorbid/Complication 2 (ICD-9-CM codes only)	3120	REP	REP	N/R	14a
Comorbid/Complication 3 (ICD-9-CM codes only)	3130	REP	REP	N/R	14a
Comorbid/Complication 4 (ICD-9-CM codes only)	3140	REP	REP	N/R	14a
Comorbid/Complication 5 (ICD-9-CM codes only)	3150	REP	REP	N/R	14a
Comorbid/Complication 6 (ICD-9-CM codes only)	3160	REP	REP	N/R	14a
Comorbid/Complication 7 (ICD-9-CM codes only)	3161	REP	REP	N/R	14a
Comorbid/Complication 8 (ICD-9-CM codes only)	3162	REP	REP	N/R	14a

NAACCR Item Name	NAACCR Item	Hospital with Registry	Hospital without Registry	Independent Lab	MCSP Paper Report Form Item
Comorbid/Complication 9 (ICD-9-CM codes only)	3163	REP	REP	N/R	14a
County at DX	90	REQ	REQ	REQ	5f
County--Current	1840	REQ	REQ	REQ	6
Creatinine Pretreatment Lab Value	3824	REP	REP	N/R	
Creatinine Pretreatment Unit of Measure	3825	REP	REP	N/R	
CS Extension (DX year 2004 - 2015 only)	2810	REQ	REQ	N/R	
CS Lymph Nodes (DX year 2004 - 2015 only)	2830	REQ	REQ	N/R	
CS Lymph Nodes Eval (DX year 2004 - 2015 only)	2840	REQ	REQ	N/R	
CS Mets at Diagnosis (DX year 2004 - 2015 only)	2850	REQ	REQ	N/R	
CS Mets at DX - Bone (DX year 2004 - 2015 only)	2851	REQ	REQ	N/R	
CS Mets at DX - Brain (DX year 2004 - 2015 only)	2852	REQ	REQ	N/R	
CS Mets at DX - Liver (DX year 2004 - 2015 only)	2853	REQ	REQ	N/R	
CS Mets at DX - Lung (DX year 2004 - 2015 only)	2854	REQ	REQ	N/R	
CS Mets Eval (DX year 2004 - 2015 only)	2860	REQ	REQ	N/R	
CS Site-Specific Factor 1 (DX year 2004 - 2017 only)	2880	REP	REP	N/R	
CS Site-Specific Factor 10 (DX year 2004 - 2017 only)	2864	REP	REP	N/R	
CS Site-Specific Factor 11 (DX year 2004 - 2017 only)	2865	REP	REP	N/R	
CS Site-Specific Factor 12 (DX year 2004 - 2017 only)	2866	REP	REP	N/R	
CS Site-Specific Factor 13 (DX year 2004 - 2017 only)	2867	REP	REP	N/R	
CS Site-Specific Factor 14 (DX year 2004 - 2017 only)	2868	REP	REP	N/R	
CS Site-Specific Factor 15 (DX year 2004 - 2017 only)	2869	REP	REP	N/R	
CS Site-Specific Factor 16 (DX year 2004 - 2017 only)	2870	REP	REP	N/R	
CS Site-Specific Factor 17 (DX year 2004 - 2017 only)	2871	REP	REP	N/R	
CS Site-Specific Factor 18 (DX year 2004 - 2017 only)	2872	REP	REP	N/R	
CS Site-Specific Factor 19 (DX year 2004 - 2017 only)	2873	REP	REP	N/R	
CS Site-Specific Factor 2 (DX year 2004 - 2017 only)	2890	REP	REP	N/R	

NAACCR Item Name	NAACCR Item	Hospital with Registry	Hospital without Registry	Independent Lab	MCSP Paper Report Form Item
CS Site-Specific Factor 20 (DX year 2004 - 2017 only)	2874	REP	REP	N/R	
CS Site-Specific Factor 21 (DX year 2004 - 2017 only)	2875	REP	REP	N/R	
CS Site-Specific Factor 22 (DX year 2004 - 2017 only)	2876	REP	REP	N/R	
CS Site-Specific Factor 23 (DX year 2004 - 2017 only)	2877	REP	REP	N/R	
CS Site-Specific Factor 24 (DX year 2004 - 2017 only)	2878	REP	REP	N/R	
CS Site-Specific Factor 25 (DX year 2004 - 2017 only)	2879	REP	REP	N/R	
CS Site-Specific Factor 3 (DX year 2004 - 2017 only)	2900	REP	REP	N/R	
CS Site-Specific Factor 4 (DX year 2004 - 2017 only)	2910	REP	REP	N/R	
CS Site-Specific Factor 5 (DX year 2004 - 2017 only)	2920	REP	REP	N/R	
CS Site-Specific Factor 6 (DX year 2004 - 2017 only)	2930	REP	REP	N/R	
CS Site-Specific Factor 7 (DX year 2004 - 2017 only)	2861	REP	REP	N/R	
CS Site-Specific Factor 8 (DX year 2004 - 2017 only)	2862	REP	REP	N/R	
CS Site-Specific Factor 9 (DX year 2004 - 2017 only)	2863	REP	REP	N/R	
CS Tumor Size (DX year 2004 - 2015 only)	2800	REQ	REQ	N/R	
CS Tumor Size/Ext Eval (DX year 2004 - 2015 only)	2820	REQ	REQ	N/R	
CS Version Input Current	2937	AUTO	AUTO	AUTO	
CS Version Input Original	2935	AUTO	AUTO	AUTO	
Date 1st Crs RX CoC	1270	REQ	REP	N/R	74a
Date 1st Crs RX CoC Flag	1271	REQ	REP	N/R	74b
Date Case Completed	2090	REQ	REQ	REQ	105
Date Case Report Exported	2110	REQ	REQ	REQ	
Date Initial RX SEER	1260	REQ[2]	REP[2]	REP[2]	
Date Initial RX SEER Flag	1261	REQ[2]	REP[2]	REP[2]	
Date of 1st Contact	580	REQ	REP	REP	29
Date of 1st Contact Flag	581	REQ	REP	REP	
Date of Birth	240	REQ	REQ	REQ	7
Date of Death (Required on paper reporting form only)	1750	REP	REP	N/R	102
Date of Diagnosis	390	REQ	REQ	REQ	30
Date of Last Contact	1750	REP	REP	N/R	94a
Date of Last Contact Flag	1751	REP	REP	N/R	94b
Date of Sentinel Lymph Node Biopsy	832	REQ	REP	REP	

NAACCR Item Name	NAACCR Item	Hospital with Registry	Hospital without Registry	Independent Lab	MCSP Paper Report Form Item
Date of Sentinel Lymph Node Biopsy Flag	833	REQ	REP	REP	
Date Regional Lymph Node Dissection	682	REQ	REP	REP	
Date Regional Lymph Node Dissection Flag	683	REQ	REP	REP	
DC State File Number	2380	REP	REP	REP	
Derived EOD 2018 M (2018 cases and later)	795	REQ[2]	REQ[2]	REP[2]	49
Derived EOD 2018 N (2018 cases and later)	815	REQ[2]	REQ[2]	REP[2]	49
Derived EOD 2018 Stage Group (2018 cases and later)	818	REQ[2]	REQ[2]	REP[2]	49
Derived EOD 2018 T (2018 cases and later)	785	REQ[2]	REQ[2]	REP[2]	49
Diagnostic Confirmation	490	REQ	REQ	REQ	36
EOD--Mets	776	REQ[2]	REQ[2]	REP[2]	49
EOD--Primary Tumor	772	REQ[2]	REQ[2]	REP[2]	49
EOD--Regional Nodes	774	REQ[2]	REQ[2]	REP[2]	49
Esophagus and EGJ Tumor Epicenter	3829	REP	REP	N/R	
Estrogen Receptor Percent Positive or Range	3826	REP	REP	REP	
Estrogen Receptor Summary	3827	REP	REP	REP	
Estrogen Receptor Total Allred Score	3828	REP	REP	N/R	
Extranodal Extension Clin (non-Head and Neck)	3830	REP	REP	N/R	
Extranodal Extension Head and Neck Clinical	3831	REP	REP	N/R	
Extranodal Extension Head and Neck Pathological	3832	REP	REP	N/R	
Extranodal Extension Path (Non-Head and Neck)	3833	REP	REP	N/R	
Extravascular Matrix Patterns	3834	REP	REP	N/R	
Family History of Cancer (State-specific item 9520)	NA	REP	REP	REP	16a-c
Fibrosis Score	3835	REP	REP	N/R	
FIGO Stage	3836	REP	REP	REP	
Follow-Up Source	1790	REP	REP	REP	
Follow-Up Source Central	1791	REP	REP	REP	
Gestational Trophoblastic Prognostic Scoring Index	3837	REP	REP	N/R	
Gleason Patterns Clinical	3838	REP	REP	REP	
Gleason Patterns Pathological	3839	REP	REP	N/R	
Gleason Score Clinical	3840	REP	REP	REP	
Gleason Score Pathological	3841	REP	REP	N/R	
Gleason Tertiary Pattern	3842	REP	REP	N/R	

NAACCR Item Name	NAACCR Item	Hospital with Registry	Hospital without Registry	Independent Lab	MCSP Paper Report Form Item
Grade (Cases prior to 2018 only)	440	REQ	REP	REP	34
Grade Clinical (2018 cases and later)	3843	REQ	REP	REP	34
Grade Pathological (2018 cases and later)	3844	REQ	REP	REP	
Grade Post Therapy (2018 cases and later)	3845	REQ	REP	N/R	
hCG Post-orchiectomy Lab Value	3846	REP	REP	N/R	
hCG Post-orchiectomy Range	3847	REP	REP	N/R	
hCG Pre-orchiectomy Lab Value	3848	REP	REP	N/R	
hCG Pre-orchiectomy Range	3849	REP	REP	N/R	
HER2 IHC Summary	3850	REP	REP	N/R	
HER2 ISH Dual Probe Copy Number	3851	REP	REP	N/R	
HER2 ISH Dual Probe Ratio	3852	REP	REP	N/R	
HER2 ISH Single Probe Copy Number	3853	REP	REP	N/R	
HER2 ISH Summary	3854	REP	REP	N/R	
HER2 Overall Summary	3855	REP	REP	N/R	
Heritable Trait	3856	REP	REP	N/R	
High Risk Cytogenetics	3857	REP	REP	N/R	
High Risk Histologic Features	3858	REP	REP	N/R	
Histologic Type ICD-O-3	522	REQ	REQ	REQ	33a
HIV Status	3859	REP	REP	N/R	
ICD Revision Number	1920	REQ	REQ	REP	
International Normalized Ratio Prothrombin Time	3860	REP	REP	N/R	
Invasion Beyond Capsule	3864	REP	REP	REP	
Ipsilateral Adrenal Gland Involvement	3861	REP	REP	N/R	
JAK2	3862	REP	REP	N/R	
Ki-67	3863	REP	REP	REP	
KIT Gene Immunohistochemistry	3865	REP	REP	REP	
KRAS	3866	REP	REP	REP	
Laboratory Report Number (State-specific item 9507)	NA	REP	REP	REQ	20
Laterality	410	REQ	REQ	REQ	32
Latitude	2352	REP	REP	REP	
LDH Post-Orchiectomy Range	3867	REP	REP	N/R	
LDH Pre-Orchiectomy Range	3868	REP	REP	N/R	
LDH Pretreatment Lab Value	3932	REP	REP	N/R	
LDH Pretreatment Level	3869	REP	REP	N/R	
LDH Upper Limits of Normal	3870	REP	REP	N/R	
LN Assessment Method Femoral-Inguinal	3871	REP	REP	N/R	
LN Assessment Method Para-aortic	3872	REP	REP	N/R	

NAACCR Item Name	NAACCR Item	Hospital with Registry	Hospital without Registry	Independent Lab	MCSP Paper Report Form Item
LN Assessment Method Pelvic	3873	REP	REP	N/R	
LN Distant Assessment Method	3874	REP	REP	N/R	
LN Distant: Mediastinal, Scalene	3875	REP	REP	N/R	
LN Head and Neck Levels I-III	3876	REP	REP	N/R	
LN Head and Neck Levels IV-V	3877	REP	REP	N/R	
LN Head and Neck Levels VI-VII	3878	REP	REP	N/R	
LN Head and Neck Other	3879	REP	REP	N/R	
LN Isolated Tumor Cells (ITC)	3880	REP	REP	REP	
LN Laterality	3881	REP	REP	REP	
LN Positive Axillary Level I-II	3882	REP	REP	REP	
LN Size	3883	REP	REP	REP	
LN Status Femoral-Inguinal, Para-aortic, Pelvic	3884	REP	REP	N/R	
Longitude	2354	REP	REP	REP	
Lymphocytosis	3885	REP	REP	REP	
Lymph-vascular Invasion	1182	REP	REP	REP	35
Major Vein Involvement	3886	REP	REP	N/R	
Marital Status at DX	150	REP	REP	REP	12
Measured Basal Diameter	3887	REP	REP	REP	
Measured Thickness	3888	REP	REP	REP	
Medical Record Number	2300	REQ	REQ	N/R	19
Methylation of O6-Methylguanine-Methyltransferase	3889	REP	REP	REP	
Mets at DX-Bone (2016 cases and forward)	1112	REP	REP	N/R	42
Mets at DX-Brain (2016 cases and forward)	1113	REP	REP	N/R	43
Mets at DX-Distant LN (2016 cases and forward)	1114	REP	REP	N/R	44
Mets at DX-Liver (2016 cases and forward)	1115	REP	REP	N/R	45
Mets at DX-Lung (2016 cases and forward)	1116	REP	REP	N/R	46
Mets at DX-Other (2016 cases and forward)	1117	REP	REP	N/R	47
Michigan Facility Number (State-specific item 9508)	NA	REQ	REQ	REQ	25
Microsatellite Instability (MSI)	3890	REP	REP	REP	
Microvascular Density	3891	REP	REP	REP	
Mitotic Count Uveal Melanoma	3892	REP	REP	REP	
Mitotic Rate Melanoma	3893	REP	REP	REP	
Multigene Signature Method	3894	REP	REP	N/R	
Multigene Signature Results	3895	REP	REP	N/R	
Name--Alias (May be left blank)	2280	REP	REP	REP	3
Name--First	2240	REQ	REQ	REQ	1b
Name--Last	2230	REQ	REQ	REQ	1a
Name--Maiden (May be left blank)	2390	REP	REP	N/R	2

NAACCR Item Name	NAACCR Item	Hospital with Registry	Hospital without Registry	Independent Lab	MCSP Paper Report Form Item
Name--Middle (May be left blank)	2250	REP	REP	REP	1c
NCCN International Prognostic Index (IPI)	3896	REP	REP	N/R	
NPCR Derived AJCC 8 TNM Clin Stg Grp	3645	REQ	REP	N/R	
NPCR Derived AJCC 8 TNM Path Stg Grp	3646	REQ	REP	N/R	
NPCR Derived AJCC 8 TNM Post Therapy Stg Grp	3647	REP	REP	N/R	
NPCR Derived Clin Stg Grp	3650	REQ	REP	N/R	
NPCR Derived Path Stg Grp	3655	REQ	REP	N/R	
NPCR Specific Field	3720	REQ	REP	N/R	
NPI--Reporting Facility	545	REQ	REP	REP	
Number of Cores Examined	3897	REP	REP	REP	
Number of Cores Positive	3898	REP	REP	REP	
Number of Examined Para-Aortic Nodes	3899	REP	REP	N/R	
Number of Examined Pelvic Nodes	3900	REP	REP	N/R	
Number of Phases of Rad Treatment to this Volume	1532	REP	REP	N/R	
Number of Positive Para-Aortic Nodes	3901	REP	REP	N/R	
Number of Positive Pelvic Nodes	3902	REP	REP	N/R	
Oncotype Dx Recurrence Score-DCIS	3903	REP	REP	REP	
Oncotype Dx Recurrence Score-Invasive	3904	REP	REP	REP	
Oncotype Dx Risk Level-DCIS	3905	REP	REP	REP	
Oncotype Dx Risk Level-Invasive	3906	REP	REP	REP	
Organomegaly	3907	REP	REP	N/R	
Percent Necrosis Post Neoadjuvant	3908	REP	REP	N/R	
Perineural Invasion	3909	REP	REP	REP	
Peripheral Blood Involvement	3910	REP	REP	REP	
Peritoneal Cytology	3911	REP	REP	REP	
Phase I Dose per Fraction	1501	REP	REP	N/R	
Phase I Number of Fractions	1503	REP	REP	N/R	
Phase I Radiation External Beam Planning Tech	1502	REP	REP	N/R	
Phase I Radiation Primary Treatment Volume	1504	REP	REP	N/R	
Phase I Radiation to Draining Lymph Nodes	1505	REP	REP	N/R	
Phase I Radiation Treatment Modality	1506	REQ	REP	N/R	
Phase I Total Dose	1507	REP	REP	N/R	
Phase II Dose per Fraction	1511	REP	REP	N/R	

NAACCR Item Name	NAACCR Item	Hospital with Registry	Hospital without Registry	Independent Lab	MCSP Paper Report Form Item
Phase II Number of Fractions	1513	REP	REP	N/R	
Phase II Radiation External Beam Planning Tech	1512	REP	REP	N/R	
Phase II Radiation Primary Treatment Volume	1514	REP	REP	N/R	
Phase II Radiation to Draining Lymph Nodes	1515	REP	REP	N/R	
Phase II Radiation Treatment Modality	1516	REP	REP	N/R	
Phase II Total Dose	1517	REP	REP	N/R	
Phase III Dose per Fraction	1521	REP	REP	N/R	
Phase III Number of Fractions	1523	REP	REP	N/R	
Phase III Radiation External Beam Planning Tech	1522	REP	REP	N/R	
Phase III Radiation Primary Treatment Volume	1524	REP	REP	N/R	
Phase III Radiation to Draining Lymph Nodes	1525	REP	REP	N/R	
Phase III Radiation Treatment Modality	1526	REP	REP	N/R	
Phase III Total Dose	1527	REP	REP	N/R	
Place of Death--Country	1944	REP	REP	N/R	104b
Place of Death--State	1942	REQ	REQ	N/R	104a
Pleural Effusion	3913	REP	REP	REP	
Primary Payer at DX	630	REP	REP	REP	13
Primary Sclerosing Cholangitis	3917	REP	REP	REP	
Primary Site	400	REQ	REQ	REQ	31
Profound Immune Suppression	3918	REP	REP	N/R	
Progesterone Receptor Percent Positive or Range	3914	REP	REP	REP	
Progesterone Receptor Summary	3915	REP	REP	REP	
Progesterone Receptor Total Allred Score	3916	REP	REP	REP	
Prostate Pathological Extension	3919	REP	REP	N/R	
PSA (Prostatic Specific Antigen) Lab Value	3920	REP	REP	REP	
Race 1	160	REQ	REQ	REQ	11
Race 2	161	REQ	REQ	REQ	11
Race 3	162	REQ	REQ	REQ	11
Race 4	163	REQ	REQ	REQ	11
Race 5	164	REQ	REQ	REQ	11
Radiation Treatment Discontinued Early	1531	REP	REP	N/R	
Rad--Regional RX Modality	1570	REQ	REP	N/R	84
Reason for No Radiation	1430	REQ	REP	N/R	83
Reason for No Surgery	1340	REQ	REP	N/R	76
Regional Nodes Examined	830	REQ	REQ	N/R	41
Regional Nodes Positive	820	REQ	REQ	N/R	40

NAACCR Item Name	NAACCR Item	Hospital with Registry	Hospital without Registry	Independent Lab	MCSP Paper Report Form Item
Reporting Facility	540	REQ	REQ	REQ	24a
Residual Tumor Volume Post Cytoreduction	3921	REP	REP	N/R	
Response to Neoadjuvant Therapy	3922	REP	REP	N/R	
RQRS NCDB Submission Flag	2155	REQ	N/R	N/R	
RX Coding System--Current	1460	REQ	REP	N/R	
RX Date BRM	1240	REQ	REP	N/R	90a
RX Date BRM Flag	1241	REQ	REP	N/R	90b
RX Date Chemo	1220	REQ	REP	N/R	85a
RX Date Chemo Flag	1221	REQ	REP	N/R	85b
RX Date Hormone	1230	REQ	REP	N/R	88a
RX Date Hormone Flag	1231	REQ	REP	N/R	88b
RX Date Mst Defn Srg	3170	REQ	REP	N/R	77c
RX Date Mst Defn Srg Flag	3171	REQ	REP	N/R	77d
RX Date Other	1250	REQ	REP	N/R	92a
RX Date Other Flag	1251	REQ	REP	N/R	92b
RX Date Radiation	1210	REQ	REP	N/R	82a
RX Date Radiation Flag	1211	REQ	REP	N/R	82b
RX Date Surgery	1200	REQ	REP	N/R	77a
RX Date Surgery Flag	1201	REQ	REP	N/R	77b
RX Date Systemic	3230	REQ	REP	N/R	
RX Date Systemic Flag	3231	REQ	REP	N/R	
RX Summ--BRM	1410	REQ	REP	N/R	91
RX Summ--Chemo	1390	REQ	REP	N/R	86
RX Summ--Hormone	1400	REQ	REP	N/R	89
RX Summ--Other	1420	REQ	REQ	REQ	93
RX Summ--Radiation	1360	REQ	REP	N/R	
RX Summ--Scope Reg NL Sur	1292	REQ	REP	N/R	80
RX Summ--Surg Oth Reg/Dis	1294	REQ	REP	N/R	79
RX Summ--Surg Prim Site (Code the most definitive surgical procedure of primary site)	1290	REQ	REP	REP	78
RX Summ--Surg/Rad Seq	1380	REQ	REP	N/R	81
RX Summ--Systemic/Sur Seq	1639	REQ	REQ	REQ	75
RX Summ--Transplnt/Endocr	3250	REQ	REP	N/R	87
RX Summ--Treatment Status	1285	REQ	REP	N/R	73
RX Text--BRM	2660	REQ	REP	N/R	98
RX Text--Chemo	2640	REQ	REP	N/R	98
RX Text--Hormone	2650	REQ	REP	N/R	98
RX Text--Other	2670	REP	REP	N/R	98
RX Text--Radiation (Beam)	2620	REQ	REP	N/R	99
RX Text--Radiation Other	2630	REP	REP	N/R	99
RX Text--Surgery	2610	REQ	REP	REP	78
S Category Clinical	3923	REP	REP	REP	
S Category Pathological	3924	REP	REP	REP	
Sarcomatoid Features	3925	REP	REP	REP	

NAACCR Item Name	NAACCR Item	Hospital with Registry	Hospital without Registry	Independent Lab	MCSP Paper Report Form Item
Schema Discriminator 1	3926	REQ	REP	REP	
Schema Discriminator 2	3927	REQ	REP	REP	
Schema Discriminator 3	3928	REP	REP	REP	
Schema ID	3800	REQ	REQ	N/R	
Secondary Diagnosis 1 (ICD-10-CM codes only)	3780	REP	REP	N/R	14b
Secondary Diagnosis 10 (ICD-10-CM codes only)	3798	REP	REP	N/R	14b
Secondary Diagnosis 2 (ICD-10-CM codes only)	3782	REP	REP	N/R	14b
Secondary Diagnosis 3 (ICD-10-CM codes only)	3784	REP	REP	N/R	14b
Secondary Diagnosis 4 (ICD-10-CM codes only)	3786	REP	REP	N/R	14b
Secondary Diagnosis 5 (ICD-10-CM codes only)	3788	REP	REP	N/R	14b
Secondary Diagnosis 6 (ICD-10-CM codes only)	3790	REP	REP	N/R	14b
Secondary Diagnosis 7 (ICD-10-CM codes only)	3792	REP	REP	N/R	14b
Secondary Diagnosis 8 (ICD-10-CM codes only)	3794	REP	REP	N/R	14b
Secondary Diagnosis 9 (ICD-10-CM codes only)	3796	REP	REP	N/R	14b
SEER Cause Specific COD	1914	REP[2]	REP[2]	REP[2]	
SEER Other COD	1915	REP[2]	REP[2]	REP[2]	
SEER Summary Staging 2000 (Directly coded. Applies to cases diagnosed prior to 2018 only)	759	REQ	REP	REP	
Sentinel Lymph Nodes Examined	834	REQ	REP	REP	
Sentinel Lymph Nodes Positive	835	REQ	REP	REP	
Separate Tumor Nodules	3929	REP	REP	REP	
Sequence Number--Hospital	560	REQ	REP	REP	21
Serum Albumin Pretreatment Level	3930	REP	REP	N/R	
Serum Beta-2 Microglobulin Pretreatment Level	3931	REP	REP	N/R	
Sex	220	REQ	REQ	REQ	9
Social Security Number	2320	REQ	REQ	REQ	4
Spanish/Hispanic Origin	190	REP	REP	REP	10
Summary Stage 2018 - Directly assigned (2018 cases and later)	764	REQ	REP	REP	37
Text--DX Proc--Lab Tests	2550	REP	REP	N/R	95
Text--DX Proc--OP	2560	REP	REP	N/R	78
Text--DX Proc--Path	2570	REP	REP	N/R	33a
Text--DX Proc--PE	2520	REP	REP	REP	95
Text--DX Proc--Scopes	2540	REP	REP	REP	97
Text--DX Proc--X-ray/Scan	2530	REP	REP	N/R	96

NAACCR Item Name	NAACCR Item	Hospital with Registry	Hospital without Registry	Independent Lab	MCSP Paper Report Form Item
Text--Histology Title	2590	REP	REP	REP	33a
Text--Place of Diagnosis	2690	REP	REP	N/R	24b
Text--Primary Site Title	2580	REP	REP	REP	31
Text--Remarks	2680	REP	REP	N/R	99
Text--Staging	2600	REP	REP	REP	97
Text--Usual Industry	320	REP	REP	REP	15b
Text--Usual Occupation	310	REP	REP	REP	15a
Thrombocytopenia	3933	REP	REP	N/R	
TNM Clin Descriptor (7th ed., cases 1/1/2010 – 12/31/2017)	980	REQ	REP	N/R	38
TNM Clin M (7th ed., cases diagnosed 1/1/2010 – 12/31/2017)	960	REQ	REP	N/R	38
TNM Clin N (7th ed., cases 1/1/2010 – 12/31/2017)	950	REQ	REP	N/R	38
TNM Clin Stage Group (7th ed., cases 1/1/2010 – 12/31/2017)	970	REQ	REP	N/R	38
TNM Clin T (7th ed., cases 1/1/2010 – 12/31/2017)	940	REQ	REP	N/R	38
TNM Edition Number	1060	REQ	REP	N/R	
TNM Path Descriptor (7th ed., cases 1/1/2010 – 12/31/2017)	920	REQ	REP	N/R	38
TNM Path M (7th ed., cases 1/1/2010 – 12/31/2017)	900	REQ	REP	N/R	38
TNM Path N (7th ed., cases 1/1/2010 – 12/31/2017)	890	REQ	REP	N/R	38
TNM Path Stage Group (7th ed., cases 1/1/2010 – 12/31/2017)	910	REQ	REP	N/R	38
TNM Path T (7th ed., cases 1/1/2010 – 12/31/2017)	880	REQ	REP	N/R	38
Tobacco Use (State-specific item 9522)	NA	REP	REP	REP	18
Total Dose	1533	REP	REP	N/R	
Tumor Deposits	3934	REP	REP	REP	
Tumor Growth Pattern	3935	REP	REP	REP	
Tumor Size Clinical (2016 cases and forward)	752	REP	REP	REP	39
Tumor Size Pathologic (2016 cases and forward)	754	REP	REP	REP	39
Tumor Size Summary (2016 cases and forward)	756	REQ	REQ	REQ	N/A
Type of Reporting Source	500	REQ	REQ	REQ	22
Ulceration	3936	REP	REP	REP	
Visceral and Parietal Pleural Invasion	3937	REP	REP	REP	
Vital Status	1760	REP	REP	REP	101

General Coding Instructions for First Course of Treatment Data Items

The first course of treatment includes all methods of treatment recorded in the treatment plan and administered to the patient before disease progression or recurrence. “Active surveillance” is a form of planned treatment for some patients; its use is coded in the RX SUMM--TREATMENT STATUS item. “No therapy” is a treatment option that occurs if the patient refuses treatment, the family or guardian refuses treatment, the patient dies before treatment starts, or the physician recommends no treatment be given. If the patient refuses all treatment, code “patient refused” (code 7 or 87) for all treatment modalities.

DO NOT leave treatment items blank. If a particular treatment (or any type of treatment) was not administered, enter the “Unknown” value for that item.

Treatment Coding Guidelines and References

The National Cancer Institute provides a website that describes typical treatment modalities for a wide variety of cancer types. Additionally, as a component of its Clinical Practice Guidelines in Oncology project, the National Comprehensive Cancer Network (NCCN) posts NCCN Guidelines for Treatment of Cancer by Site.

Consult the STORE manual for general information on treatment modalities as well as specific instructions for properly coding cancer treatments including surgical procedures, radiation, and systemic therapies. Appendix B of this manual contains all surgery codes organized by primary site.

Treatment Plan

A treatment plan describes the type(s) of therapies intended to modify, control, remove, or destroy proliferating cancer cells. The documentation confirming a treatment plan may be found in several different sources; for example, medical or clinic records, consultation reports, and outpatient records.

- All therapies specified in the physician(s) treatment plan are a part of the first course of treatment if they are actually administered to the patient.
- A discharge plan must be part of the patient’s record in a Joint Commission-accredited hospital and may contain part or all of the treatment plan.
- An established protocol or accepted management guidelines for the disease can be considered a treatment plan in the absence of other written documentation.
- If there is no treatment plan, established protocol, or management guidelines, and consultation with a physician advisor is not possible, use the principle: “initial treatment must begin within four months of the date of initial diagnosis.”

Time Periods for First Course of Treatment

If first course treatment was provided, the Date of First Course of Treatment is the earliest of Date of First Surgical Procedure, Date Radiation Started, Date Systemic Therapy Started, or Date Other Treatment Started.

- If no treatment is given, record the date of the decision not to treat, the date of patient refusal, or the date the patient expired if the patient died before treatment could be given.
- If active surveillance (“watchful waiting”) was selected, record the date of that decision.

- Additional data items further define the parameters for specific treatments and treatment modalities, as described in the following sections.

- RX SUMM--TREATMENT STATUS summarizes whether the patient received any first course treatment, no treatment, or is being managed by active surveillance.

All Malignancies except Leukemias
The first course of treatment includes all therapy planned and administered by the physician(s) during the first diagnosis of cancer. Planned treatment may include multiple modes of therapy and may encompass intervals of a year or more. Any therapy administered after the discontinuation of first course treatment is subsequent treatment.

Leukemias
The first course of treatment includes all therapies planned and administered by the physician(s) during the first diagnosis of leukemia. Record all remission-inducing or remission-maintaining therapy as the first course of treatment. Treatment regimens may include multiple modes of therapy. The administration of these therapies can span a year or more. A patient may relapse after achieving a first remission. All therapy administered after the relapse is secondary or subsequent treatment.

Instructions for Completing All MCSP Reportable Data Items

In describing the proper reporting of cancer patient information, frequent reference is made to standard-setting organizations and source materials. Links to these references can be found within the data item descriptions below as well as at the back of this manual. Reference sources are abbreviated within the instructions as follows:

Reference Abbreviations

Code	Reference Source
SEER	Surveillance, Epidemiology and End Results
CoC	Commission on Cancer within the American College of Surgeons
ACoS	American College of Surgeons
STORE	STandards for Oncology Registry Entry manual produced by the CoC
NAACCR	North American Association of Central Cancer Registries
AJCC	American Joint Committee on Cancer
ICD-O-3	International Classification of Diseases for Oncology, 3rd Ed., World Health Organization (WHO)
CS	Collaborative Stage Data Collection System Manual
NPCR	National Program of Cancer Registries
SSDI	Identifies fields that are Site Specific Data Items. These items apply only to selected primary sites, histologies, and years of diagnosis.

Data field names used in the MCSP Cancer Program Manual match those used in the NAACCR Data Dictionary and are presented in alphabetic order. For those using paper reporting forms, refer to the MCSP 2016 Report Form Item column of the Data Items chart. The paper form field number that corresponds to the NAACCR item is shown in this column.

Regardless of facility type of reporting entity, only approved abbreviations may be used when entering information into data fields. For approved abbreviations, see NAACCR Data Standards & Data Dictionary, Appendix G

Item: ABSTRACTED BY

NAACCR Item 570
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: ACCESSION NUMBER--HOSP

NAACCR Item 550
The **Accession Number** is **required only for hospitals with a registry**, (i.e., approved by CoC with an approved cancer program) in which case, the number would be assigned as the patient is enrolled into the system.

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: ADDR AT DX--CITY

NAACCR Item 70

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: ADDR AT DX--COUNTRY

NAACCR Item 102
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

For ISO alpha-3 Country Codes, refer to Appendix B of the SEER Program Code Manual.

Item: ADDR AT DX--NO & STREET

NAACCR Item 2330
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: ADDR AT DX--POSTAL CODE

NAACCR Item 100
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: ADDR AT DX--STATE

NAACCR Item 80
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

For a complete list of state, territory, commonwealth, U.S. possession, or Canadian province or territory codes, refer to Appendix B of the SEER Program Code Manual.

Item: ADDR AT DX--SUPPLEMENTL

NAACCR Item 2335
This data item may be left blank if not applicable or unknown.

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: ADDR CURRENT--CITY

NAACCR Item 1810
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: ADDR CURRENT--COUNTRY

NAACCR Item 1832
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

For ISO alpha-3 Country Codes, refer to Appendix B of the SEER Program Code Manual.

Item: ADDR CURRENT--NO & STREET

NAACCR Item 2350
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: ADDR CURRENT--POSTAL CODE

NAACCR Item 1830
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: ADDR CURRENT--STATE

NAACCR Item 1820
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

For a complete list of state, territory, commonwealth, U.S. possession, or Canadian province or territory codes, refer to Appendix B of the SEER Program Code Manual.

Item: ADDR CURRENT--SUPPLEMENTL

NAACCR Item 2355
This data item may be left blank if not applicable or unknown.

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: ADENOID CYSTIC BASALOID PATTERN (SSDI)

NAACCR Item 3803
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: ADENOPATHY (SSDI)

NAACCR Item 3804
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: AFP POST-ORCHIECTOMY LAB VALUE (SSDI)

NAACCR Item 3805
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: AFP POST-ORCHIECTOMY RANGE (SSDI)

NAACCR Item 3806

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: AFP PRE-ORCHIECTOMY LAB VALUE (SSDI)

NAACCR Item 3807
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: AFP PRE-ORCHIECTOMY RANGE (SSDI)

NAACCR Item 3808
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: AFP PRETREATMENT INTERPRETATION (SSDI)

NAACCR Item 3809
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: AFP PRETREATMENT LAB VALUE (SSDI)

NAACCR Item 3810
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: AGE AT DIAGNOSIS

NAACCR Item 230
For description, rationale, and coding instructions for this data item, refer to NCI SEER and CoC STandards for Oncology Registry Entry (STORE) Manual

Item: AJCC ID

NAACCR Item 995
The values for this data item are based on the chapters of the AJCC manual and will be derived primarily from the site/histology fields and other data items as required. IDs are assigned to cases for which AJCC staging is applicable. When staging is not applicable, code 'XX' is used. Refer to American Joint Committee on Cancer (AJCC) web site.

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: AJCC TNM CLIN M

NAACCR Item 1003
CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to American Joint Committee on Cancer (AJCC) web site.

MCSP has defined some facilities as a “Hospitals without registry”. These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: AJCC TNM CLIN N

NAACCR Item 1002
CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to American Joint Committee on Cancer (AJCC) web site.

MCSP has defined some facilities as a “Hospitals without registry”. These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: AJCC TNM CLIN N SUFFIX

NAACCR Item 1034
CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to American Joint Committee on Cancer (AJCC) web site.

MCSP has defined some facilities as a “Hospitals without registry”. These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: AJCC TNM CLIN STAGE GROUP

NAACCR Item 1004
CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to American Joint Committee on Cancer (AJCC) web site.

MCSP has defined some facilities as a “Hospitals without registry”. These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: AJCC TNM CLIN T

NAACCR Item 1001
CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to American Joint Committee on Cancer (AJCC) web site.

MCSP has defined some facilities as a “Hospitals without registry”. These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: AJCC TNM CLIN T SUFFIX

NAACCR Item 1031
CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to American Joint Committee on Cancer (AJCC) web site.

MCSP has defined some facilities as a “Hospitals without registry”. These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: AJCC TNM PATH M

NAACCR Item 1013
CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to American Joint Committee on Cancer (AJCC) web site.

MCSP has defined some facilities as a “Hospitals without registry”. These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: AJCC TNM PATH N

NAACCR Item 1012
CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to American Joint Committee on Cancer (AJCC) web site.

MCSP has defined some facilities as a “Hospitals without registry”. These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: AJCC TNM PATH N SUFFIX

NAACCR Item 1035
CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to American Joint Committee on Cancer (AJCC) web site.

MCSP has defined some facilities as a “Hospitals without registry”. These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: AJCC TNM PATH STAGE GROUP

NAACCR Item 1014
CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to American Joint Committee on Cancer (AJCC) web site.

MCSP has defined some facilities as a “Hospitals without registry”. These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: AJCC TNM PATH T

NAACCR Item 1011
CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to American Joint Committee on Cancer (AJCC) web site.

MCSP has defined some facilities as a “Hospitals without registry”. These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: AJCC TNM PATH T SUFFIX

NAACCR Item 1032
CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to American Joint Committee on Cancer (AJCC) web site.

MCSP has defined some facilities as a “Hospitals without registry”. These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: AJCC TNM POST THERAPY M

NAACCR Item 1023
CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to American Joint Committee on Cancer (AJCC) web site.

MCSP has defined some facilities as a “Hospitals without registry”. These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: AJCC TNM POST THERAPY N

NAACCR Item 1022
CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to American Joint Committee on Cancer (AJCC) web site.

MCSP has defined some facilities as a “Hospitals without registry”. These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: AJCC TNM POST THERAPY N SUFFIX

NAACCR Item 1036
CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to American Joint Committee on Cancer (AJCC) web site.

MCSP has defined some facilities as a “Hospitals without registry”. These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: AJCC TNM POST THERAPY STAGE GROUP

NAACCR Item 1024
CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to American Joint Committee on Cancer (AJCC) web site.

MCSP has defined some facilities as a “Hospitals without registry”. These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: AJCC TNM POST THERAPY T

NAACCR Item 1021

CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to American Joint Committee on Cancer (AJCC) web site.

MCSP has defined some facilities as a “Hospitals without registry”. These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: AJCC TNM POST THERAPY T SUFFIX

NAACCR Item 1033
CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to American Joint Committee on Cancer (AJCC) web site.

MCSP has defined some facilities as a “Hospitals without registry”. These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: ALCOHOL USE

State-Specific Item 9521
This is a Michigan-specific data item. Abstracts submitted with incorrect format or missing values will be rejected by MCSP.

Paper form submission:

Paper Form Item 17: Mark appropriate value: current use, prior use, never used or unknown.

Do not leave this data item blank. If unknown, enter “9” or “Unknown.”
Supporting text documentation for selected data value must be entered in Paper Form Field 95: TEXT - PHYSICAL EXAM even when value is “9” or “Unknown.”

Electronic submission:

This is a Michigan-specific data item. Starting with data submitted in NAACCR version 13, facilities that submit electronic abstract data to MCSP must coordinate with their software vendors to ensure that this data value is recorded in NAACCR record layout. Abstracts submitted with incorrect format or missing values will be rejected by MCSP.

Do not leave this data item blank. If unknown, enter “9.”

Alcohol History Data Values

Code	Current	Prior	Never
1	Yes	Blank	Blank
2	Blank	Yes	Blank
3	Blank	Blank	Yes
9	Blank (Unknown)	Blank (Unknown)	Blank (Unknown)

Item: ANEMIA (SSDI)

NAACCR Item 3811

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: B SYMPTOMS (SSDI)

NAACCR Item 3812
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: BEHAVIOR CODE ICD-O-3

NAACCR Item 523
You must obtain and use these required reference and coding resources:

- 2018 Solid Tumor Rules
- International Classification of Diseases for Oncology, Third Edition (ICD-O-3) coding book. This book can be purchased through any book store or ordered from online sources. Electronic CSV database files or print copies of the classifications are available from the World Health Organization. Additionally, the ICD-O-3 Implementation Task Force has approved new codes, changes in behavior codes, and new terms associated with current codes. See ICD-O-3 Implementation Guidelines.
- Hematopoietic and Lymphoid Neoplasm Database and the Hematopoietic and Lymphoid Neoplasm Coding Manual to assist with coding these primaries. These references apply only to cases diagnosed January 1, 2010 and forward.

The Hematopoietic and Lymphoid Neoplasm Database and the Hematopoietic and Lymphoid Neoplasm Coding Manual apply to only those **non-solid tumor cases diagnosed January 1, 2010 and forward.** The ICD-O-3 coding book is obsolete for coding non-solid tumors after this date. You must use the Hematopoietic and Lymphoid Neoplasm Database and Coding Manual to assign the histology code.

Record the behavior of the tumor being reported. The fifth digit of the morphology code is the behavior code. The behavior code is used by pathologists to describe whether tissue samples are benign (0), borderline (1), in situ (2), or invasive (3).

Code 3 if any invasion is present, no matter how limited. If the specimen is from a metastatic site, code the histology of the metastatic site and code 3 for behavior code for the behavior of the tumor being reported.

EXCEPTION 1: Juvenile astrocytoma, listed as 9421/1 in ICD-O-3, is REQUIRED and should be recorded as 9421/3 in the registry.

Nonmalignant primary intracranial and central nervous system tumors diagnosed on or after January 1, 2004, with an ICD-O-3 behavior code of 0 or 1 are required for the following sites: meninges (C70._), brain (C71._), spinal cord, cranial nerves, and other parts of central nervous system (C72._), pituitary gland (C75.1), craniopharyngeal duct (C75.2) and pineal gland (C75.3).

Grade Codes, Grade Labels and Grade Definitions

Code	Label	Definition
0	Benign	• Benign
1	Borderline	• Uncertain whether benign or malignant • Borderline malignancy • Low malignant potential • Uncertain malignant potential
2	In situ and/or carcinoma in situ	• Adenocarcinoma in an adenomatous polyp with no invasion of stalk • Clark level 1 for melanoma (limited to epithelium) • Comedocarcinoma, non-infiltrating (C50._)
2	Synonymous with in situ	• Confined to epithelieum • Hutchinson melanotic freckle, NOS (C44._) • Intracystic, non-infiltrating • Intraductal • Intraepidermal, NOS • Intraepithelial, NOS • Involvement up to, but not including the basement membrane • Lentigo maligna (C44._) • Lobular neoplasia (C50._) • Lobular, non-infiltrating (C50._) • Non-infiltrating • No stromal involvement • Papillary, non-infiltrating or intraductal • Precancerous melanosis (C44._) • Queyrat erythroplasia (C60._)
3	Invasive	• Invasive or micro-invasive

For description, rationale, and coding instructions for this data item, refer to NCI SEER and CoC STandards for Oncology Registry Entry (STORE) Manual

Item: BILIRUBIN PRETREATMENT TOTAL LAB VALUE

NAACCR Item 3813
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: BILIRUBIN PRETREATMENT UNIT OF MEASURE

NAACCR Item 3814
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: BIRTHPLACE--COUNTRY

NAACCR Item 254
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

For ISO alpha-3 Country Codes, refer to Appendix B of the SEER Program Code Manual.

Item: BIRTHPLACE--STATE

NAACCR Item 252
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

For a complete list of state, territory, commonwealth, U.S. possession, or Canadian province or territory codes, refer to Appendix B of the SEER Program Code Manual.

Item: BONE INVASION (SSDI)

NAACCR Item 3815
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: BRAIN MOLECULAR MARKERS (SSDI)

NAACCR Item 3816
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: BRESLOW TUMOR THICKNESS (SSDI)

NAACCR Item 3817
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: CA-125 PRETREATMENT INTERPRETATION (SSDI)

NAACCR Item 3818
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: CASEFINDING SOURCE

NAACCR Items 501
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Do not leave this item blank if case was diagnosed in 2006 or later. Leave field blank if the case was diagnosed prior to 2006.

Item: CAUSE OF DEATH

NAACCR Items 1910
For description, rationale, and coding instructions for this data item, refer to NCI SEER

Item: CEA PRETREATMENT INTERPRETATION (SSDI)

NAACCR Item 3819
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: CEA PRETREATMENT LAB VALUE (SSDI)

NAACCR Item 3820
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: CENSUS TR POVERTY INDICTR

NAACCR Item 145
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: CHROMOSOME 19q: LOSS OF HETEROZYGOSITY (LOH) (SSDI)

NAACCR Item 3802
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: CHROMOSOME 1p: LOSS OF HETEROZYGOSITY (LOH) (SSDI)

NAACCR Item 3801
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: CHROMOSOME 3 STATUS (SSDI)

NAACCR Item 3821
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: CHROMOSOME 8q STATUS (SSDI)

NAACCR Item 3822
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: CIRCUMFERENTIAL RESECTION MARGIN (CRM)

NAACCR Item 3823
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: CLASS OF CASE

NAACCR Items 610
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: CoC ACCREDITED FLAG

NAACCR Item 2152
For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR)

Item: COMORBID/COMPLICATION (1-10)

NAACCR Items 3110-3164
For cases using ICD-9-CM codes only. ICD-9-CM coding allowed prior to 10/1/2015 only.

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

NOTE: DO NOT record ICD-10-CM codes in the COMORBID/COMPLICATION (1-10) fields.

Item: COUNTY AT DX (REPORTED)

NAACCR Item 90
For description, rationale, and coding instructions for this data item, refer to NCI SEER

For a complete listing of county names and FIPS codes, refer to NAACCR Appendix A: FIPS Codes for Counties and Equivalent Entities.

Item: COUNTY--CURRENT

NAACCR Item 1840
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

For a complete listing of county names and FIPS codes, refer to NAACCR Appendix A: FIPS Codes for Counties and Equivalent Entities.

Item: CREATININE PRETREATMENT LAB VALUE (SSDI)

NAACCR Item 3824
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: CREATININE PRETREATMENT UNIT OF MEASURE (SSDI)

NAACCR Item 3825
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: CS EXTENSION

NAACCR Item 2810
This data item applies to cases diagnosed 1/1/2004 through 12/31/2015 only.

For information on this data item, refer to AJCC CS Collaborative Stage Data Collection System

Item: CS LYMPH NODES

NAACCR Item 2830
This data item applies to cases diagnosed 1/1/2004 through 12/31/2015 only.

For information on this data item, refer to AJCC CS Collaborative Stage Data Collection System

Item: CS LYMPH NODES EVAL

NAACCR Item 2840
This data item applies to cases diagnosed 1/1/2004 through 12/31/2015 only.

For information on this data item, refer to AJCC CS Collaborative Stage Data Collection System

Item: CS METS AT DIAGNOSIS

NAACCR Item 2850
This data item applies to cases diagnosed 1/1/2004 through 12/31/2015 only.

For information on this data item, refer to AJCC CS Collaborative Stage Data Collection System

Item: CS METS AT DX - BONE

NAACCR Item 2851
This data item applies to cases diagnosed 1/1/2004 through 12/31/2015 only.

For information on this data item, refer to AJCC CS Collaborative Stage Data Collection System

Item: CS METS AT DX - BRAIN

NAACCR Item 2852
This data item applies to cases diagnosed 1/1/2004 through 12/31/2015 only.

For information on this data item, refer to AJCC CS Collaborative Stage Data Collection System

Item: CS METS AT DX - LIVER

NAACCR Item 2853
This data item applies to cases diagnosed 1/1/2004 through 12/31/2015 only.

For information on this data item, refer to AJCC CS Collaborative Stage Data Collection System

Item: CS METS AT DX - LUNG

NAACCR Item 2854
This data item applies to cases diagnosed 1/1/2004 through 12/31/2015 only.

For information on this data item, refer to AJCC CS Collaborative Stage Data Collection System

Item: CS METS EVAL

NAACCR Item 2860
This data item applies to cases diagnosed 1/1/2004 through 12/31/2015 only.

For information on this data item, refer to AJCC CS Collaborative Stage Data Collection System

Item: CS SITE-SPECIFIC FACTORS (1-25)

NAACCR Items 2861-2880, 2890, 2900, 2910, 2920, 2930.
This data item applies to cases diagnosed 1/1/2004 through 12/31/2017.

The parameter and allowable values for each Site-Specific Factor are determined by anatomic site.
For information on this data item, refer to AJCC CS Collaborative Stage Data Collection System

Item: CS TUMOR SIZE

NAACCR Item 2800
This data item applies to cases diagnosed 1/1/2004 through 12/31/2015 only.

For information on this data item, refer to AJCC CS Collaborative Stage Data Collection System

Item: CS TUMOR SIZE/EXT EVAL

NAACCR Item 2820
This data item applies to cases diagnosed 1/1/2004 through 12/31/2015 only.

For information on this data item, refer to AJCC CS Collaborative Stage Data Collection System

Item: CS VERSION INPUT CURRENT

NAACCR Item 2937
Data item auto-populated by registry software

Item: CS VERSION INPUT ORIGINAL

NAACCR Item 2935
Data item auto-populated by registry software

Item: DATE 1ST CRS RX COC

NAACCR Item 1270
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

An allowable value must be in this Date field or its corresponding Flag field. Both fields cannot be blank.

Item: DATE 1ST CRS RX COC FLAG

NAACCR Item 1271
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

An allowable value must be in this Flag field or its corresponding Date field. Both fields cannot be blank.

Item: DATE CASE COMPLETED

NAACCR Item 2090
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: DATE CASE REPORT EXPORTED

NAACCR Item 2110
For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR)

Item: DATE INITIAL RX SEER

NAACCR Item 1260
Reporting required by Metropolitan Detroit Cancer System (MDCSS) only.

For description, rationale, and coding instructions for this data item, refer to NCI SEER

Item: DATE INITIAL RX SEER FLAG

NAACCR Item 1261
Reporting required by Metropolitan Detroit Cancer System (MDCSS) only.

For description, rationale, and coding instructions for this data item, refer to NCI SEER

Item: DATE OF 1ST CONTACT

NAACCR Item 580
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

An allowable value must be in this Date field or its corresponding Flag field. Both fields cannot be blank.

Item: DATE OF 1ST CONTACT FLAG

NAACCR Item 581
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

An allowable value must be in this Flag field or its corresponding Date field. Both fields cannot be blank.

Item: DATE OF BIRTH

NAACCR Item 240
Enter the date of birth of the patient using **YYYYMMDD** format (for example 19580912). Be sure to omit slashes or hyphens between date components.

If age at diagnosis and year of diagnosis are known, but year of birth is unknown, then year of birth should be calculated and so coded.

For in utero diagnosis and treatment, record the actual date of birth. It will follow one or both dates for these events.

Estimate date of birth when information is not available. It is better to estimate than to leave birthdate unknown.

Do not leave this data item blank.

For description, rationale, and coding instructions for this data item, refer to NCI SEER and CoC STandards for Oncology Registry Entry (STORE) Manual

Item: DATE OF DEATH

NAACCR Item 1750
Applies to paper reporting form only. See instructions for DATE OF LAST CONTACT

Item: DATE OF DIAGNOSIS

NAACCR Item 390
Enter the year, month and day (**YYYYMMDD**) for the date of diagnosis, for example 19580912. Be sure to omit slashes or hyphens between date components.

Date of initial diagnosis by a recognized medical practitioner for the tumor being reported whether clinically or microscopically confirmed.

If the diagnosis was determined by pathological examination, **use the date the specimen was collected** (date of biopsy or surgery), **not the date the specimen was received or read** by the pathologist or the date the report was dictated, transcribed or printed.

If the physician states that in retrospect the patient had cancer at an earlier date, then use the earlier date as the date of diagnosis. These physician statements must be documented in abstract text.

Though the original diagnosis may be a clinical diagnosis that is later confirmed through pathological examination or other procedures, the clinical diagnosis date should be reported.

Example:

> A patient underwent a mammogram on August 25, 2016. The radiologist read the report as suspicious for cancer, recommending biopsy. The patient does not get a biopsy until February 4, 2017 which reveals an infiltrating ductal adenocarcinoma.
> **Record the date of diagnosis as August 25, 2016.**

Ambiguous terminology must be taken into consideration when determining the initial date of diagnosis.

Refer to the Ambiguous Terminology section for a list of specific terms and further instructions.

If the year is unknown, estimate the diagnosis year based upon documentation in the medical record and how long the patient has had the diagnosis.

If an approximation is not possible, use the date first confirmed, first treated, or in the case of death, the date of death, whichever is earliest.

If a patient is diagnosed elsewhere before entering the reporting facility and the date of diagnosis is unknown, record the date the patient was first seen at the reporting hospital.

Use the date therapy was started as the date of diagnosis if the patient receives cancer directed treatment before a definitive diagnosis.

The date of death is the date of diagnosis for cases diagnosed at autopsy.

If information is limited to a description, use the following guidelines.

Examples:

Spring of 2016
Code date of diagnosis as April 15, 2016

Middle of 2016
Code date of diagnosis as July 15, 2016

Fall of 2016
Code date of diagnosis as October 15, 2016

Winter of 2016
Code date of diagnosis as December 15, 2016 or January 15, 2017 (further investigation may need to be done to determine the year of diagnosis.)

Do not leave this data item blank. As of 2010, month and day may be left blank if unknown.

For description, rationale, and coding instructions for this data item, refer to NCI SEER and CoC STandards for Oncology Registry Entry (STORE) Manual

Item: DATE OF LAST CONTACT

NAACCR Item 1750
An allowable value must be in this Flag field or its corresponding Date field. Both fields cannot be blank.

For description, rationale, and coding instructions for this data item, refer to NCI SEER and CoC STandards for Oncology Registry Entry (STORE) Manual

Item: DATE OF LAST CONTACT FLAG

NAACCR Item 1751
This flag explains why there is no appropriate value in the corresponding date field.

An allowable value must be in this Flag field or its corresponding Date field. Both fields cannot be blank.

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: DATE OF SENTINEL LYMPH NODE BIOPSY

NAACCR Item 832
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: DATE REGIONAL LYMPH NODE DISSECTION

NAACCR Item 682
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: DATE REGIONAL LYMPH NODE DISSECTION FLAG

NAACCR Item 683
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: DATE SENTINEL LYMPH NODE BIOPSY

NAACCR Item 832
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: DATE SENTINEL LYMPH NODE BIOPSY FLAG

NAACCR Item 833
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: DC STATE FILE NUMBER

NAACCR Item 2380
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: DERIVED EOD 2018 M

NAACCR Item 795
Reporting required by Metropolitan Detroit Cancer System (MDCSS) only.

For description, rationale, and coding instructions for this data item, refer to NCI SEER

Item: DERIVED EOD 2018 N

NAACCR Item 815
Reporting required by Metropolitan Detroit Cancer System (MDCSS) only.

For description, rationale, and coding instructions for this data item, refer to NCI SEER

Item: DERIVED EOD 2018 STAGE GROUP

NAACCR Item 818
Reporting required by Metropolitan Detroit Cancer System (MDCSS) only.

For description, rationale, and coding instructions for this data item, refer to NCI SEER

Item: DERIVED EOD 2018 T

NAACCR Item 785
Reporting required by Metropolitan Detroit Cancer System (MDCSS) only.

For description, rationale, and coding instructions for this data item, refer to NCI SEER

Item: DIAGNOSTIC CONFIRMATION

NAACCR Item 490
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: EOD--METS

NAACCR Item 776
Reporting required by Metropolitan Detroit Cancer System (MDCSS) only.

For description, rationale, and coding instructions for this data item, refer to NCI SEER

Item: EOD--PRIMARY TUMOR

NAACCR Item 772
Reporting required by Metropolitan Detroit Cancer System (MDCSS) only.

For description, rationale, and coding instructions for this data item, refer to NCI SEER

Item: EOD--REGIONAL NODES

NAACCR Item 774
Reporting required by Metropolitan Detroit Cancer System (MDCSS) only.

For description, rationale, and coding instructions for this data item, refer to NCI SEER

Item: ESOPHAGUS AND EGJ TUMOR EPICENTER (SSDI)

NAACCR Item 3829
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: ESTROGEN RECEPTOR PERCENT POSITIVE OR RANGE (SSDI)

NAACCR Item 3826
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: ESTROGEN RECEPTOR SUMMARY (SSDI)

NAACCR Item 3827
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: ESTROGEN RECEPTOR TOTAL ALLRED SCORE (SSDI)

NAACCR Item 3828
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: EXTRANODAL EXTENSION CLIN (NON-HEAD AND NECK) (SSDI)

NAACCR Item 3830
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: EXTRANODAL EXTENSION HEAD AND NECK CLINICAL (SSDI)

NAACCR Item 3831
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: EXTRANODAL EXTENSION HEAD AND NECK PATHOLOGICAL (SSDI)

NAACCR Item 3832
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: EXTRANODAL EXTENSION PATH (NON-HEAD AND NECK) (SSDI)

NAACCR Item 3833
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: EXTRAVASCULAR MATRIX PATTERNS (SSDI)

NAACCR Item 3834
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: FAMILY HISTORY OF CANCER

State-specific Item 9520
This item records whether or not the patient has a family history of cancer.

This is a Michigan-specific data item. Abstracts submitted with incorrect format or missing values will be rejected by MCSP.

Explanation of terminology:

> “Immediate (first degree) Family Member”: Mother, Father, Brother, Sister, Son, Daughter.
>
> “Non-Immediate (second degree) Family Member”: Aunt, Uncle, Niece, Nephew, Cousin, Half-brother, and Half-sister.
>
> An immediate relative, or first degree family member, is any blood-relative who is one meiosis away from a particular individual in a family (i.e., parent, sibling, and offspring). A half-brother, half-sister, would be considered as a non-immediate family member, or second-degree family member.
>
> There will be cases in which a cancer patient has both a first degree blood-relative and a second degree relative with a history of cancer. If the patient and a relative share a common primary site, code this data item with respect to the relative with the same primary site, regardless of degree of

relationship. If the patient and all relatives have tumors involving non-similar primary sites, code this item with respect to the cancer history of the first degree blood-relative.

Example 1:

Patient is diagnosed with breast cancer. Father has history of colon cancer; maternal aunt has history of breast cancer.
Provided she is a blood-relative, refer to the aunt's cancer history since she shares the same primary site.

Example 2:

Patient is diagnosed with breast cancer. Father has history of colon cancer; a maternal uncle has history of prostate cancer.
Since no relative shares the patient's primary site, refer to the father's cancer history since he is the immediate (first degree) family member.

Supporting text documentation for patient and family history of cancer must be recorded in TEXT--DX PROC--PE field even when value is "9" or "Unknown."

Example 1:

Family Medical History negative [or FMH (-)] Personal Medical History negative [or PMH (-)]

Example 2:

FMH (-) PMH (+) STAGE 1 DUCTAL CA, RT BREAST 1999, TX'D WITH LUMPECTOMY

Example 3:

FMH UNK, PMH (-)

Paper form submission:

Item 16a. <u>Family History of Cancer</u>

Enter whether or not the patient has a family history of cancer.

Item 16b. If yes, Immediate Family Member

Enter whether or not the patient is an immediate family member.

Item 16c. If yes, Same Anatomical Site

Enter whether or not the individual has the same type of cancer as the patient. "Same Cancer" means the same organ site or, in the case of a sarcoma, leukemia and lymphomas, the same cancer type.

Do not leave items 16a, 16b, or 16c blank. If unknown, enter "9" or "Unknown."
Supporting text documentation for selected data value must be entered in **Paper Form Field 95: TEXT - PHYSICAL EXAM** even when value is "9" or "Unknown."

Electronic submission:

This is a Michigan-specific data item. Starting with data submitted in NAACCR version 13, facilities that submit electronic abstract data to MCSP must coordinate with their software vendors to ensure

that data value is recorded in NAACCR record layout. Abstracts submitted with incorrect format or missing values will be rejected by MCSP.

Family History of Cancer Data Values

Code	Family History	Immediate Family Member	Same Site
0	No	No	No
1	Yes	Yes	Yes
2	Yes	Yes	No
3	Yes	No	Yes
4	Yes	No	No
5	Yes	Yes	Blank
6	Yes	Blank	Yes
7	Yes	Blank	No
8	Yes	Blank	Blank
A	Yes	No	Blank
9	Blank (Unknown)	Blank (Unknown)	Blank (Unknown)

Do not leave this data item blank. If unknown, enter "9."

Item: FIBROSIS SCORE (SSDI)

NAACCR Item 3835
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: FIGO STAGE (SSDI)

NAACCR Item 3836
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: FOLLOW-UP SOURCE

NAACCR Item 1790
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: FOLLOW-UP SOURCE CENTRAL

NAACCR Item 1791
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: GESTATIONAL TROPHOBLASTIC PROGNOSTIC SCORING INDEX (SSDI)

NAACCR Item 3837
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: GLEASON PATTERNS CLINICAL (SSDI)

NAACCR Item 3838
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: GLEASON PATTERNS PATHOLOGICAL (SSDI)

NAACCR Item 3839
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: GLEASON SCORE CLINICAL (SSDI)

NAACCR Item 3840
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: GLEASON SCORE PATHOLOGICAL (SSDI)

NAACCR Item 3841
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: GLEASON TERTIARY PATTERN (SSDI)

NAACCR Item 3842
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: GRADE

NAACCR Item 440
Applies to cases diagnosed prior to 2018 only.

Refer to SEER Instructions for Coding Grade for 2014+ for complete instructions to determine grade, differentiation or cell indicator for tumors diagnosed prior to 2018.

Refer to the Hematopoietic and Lymphoid Neoplasm Database and the Hematopoietic and Lymphoid Neoplasm Coding Manual to assist with coding these primaries. These references apply only to cases diagnosed between and including January 1, 2010 and December 31, 2017.

Item: GRADE CLINICAL (SSDI)

NAACCR Item 3843
Applies to cases diagnosed in 2018 and later only. For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: GRADE PATHOLOGICAL (SSDI)

NAACCR Item 3844

Applies to cases diagnosed in 2018 and later only. For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: GRADE POST THERAPY (SSDI)

NAACCR Item 3845
Applies to cases diagnosed in 2018 and later only. For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: hCG POST-ORCHIECTOMY LAB VALUE (SSDI)

NAACCR Item 3846
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: hCG POST-ORCHIECTOMY RANGE (SSDI)

NAACCR Item 3847
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: hCG PRE-ORCHIECTOMY LAB VALUE (SSDI)

NAACCR Item 3848
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: hCG PRE-ORCHIECTOMY RANGE (SSDI)

NAACCR Item 3849
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: HER2 IHC SUMMARY (SSDI)

NAACCR Item 3850
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: HER2 ISH DUAL PROBE COPY NUMBER (SSDI)

NAACCR Item 3851
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: HER2 ISH DUAL PROBE RATIO (SSDI)

NAACCR Item 3852
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: HER2 ISH SINGLE PROBE COPY NUMBER (SSDI)

NAACCR Item 3853
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: HER2 ISH SUMMARY (SSDI)

NAACCR Item 3854
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: HER2 OVERALL SUMMARY (SSDI)

NAACCR Item 3855
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: HERITABLE TRAIT (SSDI)

NAACCR Item 3856
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: HIGH RISK CYTOGENETICS (SSDI)

NAACCR Item 3857
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: HIGH RISK HISTOLOGIC FEATURES (SSDI)

NAACCR Item 3858
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: HISTOLOGIC TYPE ICD-O-3

NAACCR Item 522
For description, rationale, and coding instructions for this data item, refer to NCI SEER and CoC STandards for Oncology Registry Entry (STORE) Manual

The ICD-O-3 Implementation Task Force has approved new codes, changes in behavior codes, and new terms associated with current codes. These changes reflect updates to the WHO Classifications for Tumors (Blue Books). The new codes, new terms, and change to behavior codes for all cases diagnosed 1/1/18 and later. The new codes, new terms, and codes with changes to behavior are listed in the .pdf table and in the excel table. The two tables are identical in the ICD-O-3 Implementation Guidelines.

Important reminder: Please check the 2018 ICD-O-3 Update Table first to determine if the histology is listed. If the histology is not included in the update, then review ICD-O-3 and/or Hematopoietic and Lymphoid Database and/or Solid Tumor Rules (MP/H).

Item: HIV STATUS (SSDI)

NAACCR Item 3859
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: ICD REVISION NUMBER

NAACCR Item 1920
For description, rationale, and coding instructions for this data item, refer to NCI SEER

Item: INTERNATIONAL NORMALIZED RATIO PROTHROMBIN TIME (SSDI)

NAACCR Item 3860
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: INVASION BEYOND CAPSULE (SSDI)

NAACCR Item 3864
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: IPSILATERAL ADRENAL GLAND INVOLVEMENT (SSDI)

NAACCR Item 3861
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: JAK2 (SSDI)

NAACCR Item 3862
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: Ki-67 (SSDI)

NAACCR Item 3863
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: KIT GENE IMMUNOHISTOCHEMISTRY (SSDI)

NAACCR Item 3865
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: KRAS (SSDI)

NAACCR Item 3866
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: LABORATORY REPORT NUMBER

State-specific Item 9507
If a case has been assigned a laboratory record number or pathology report specimen number, enter that number. This number can be alphanumeric. If more than one laboratory record number has been assigned to the case, enter the number which most closely corresponds with the initial diagnosis of the primary tumor being reported.

If no laboratory number exists, enter “none.”

Item: LATERALITY

NAACCR Item 410
Laterality (paired organs) refers to a specific side of the body or lobe of an organ. In the case of paired or bilateral organs, it is important to indicate whether the primary site of the tumor is the right organ, the left organ, or bilateral involvement. Laterality refers to the primary site only; do not code the laterality of the metastatic site(s).

NOTE: Laterality reporting rules vary depending upon standard-setter. MCSP and other central cancer registries have not adopted the revision to laterality rules found in FORDS (STORE). MCSP reporting requirements for laterality follow current SEER Program Coding and Staging Manual 2018.

Note: Table 11 on Page 27 of the June 2018 Solid Tumor Rules manual states that sites C090 and C091 are paired organs. According to Ask SEER CTR, this is incorrect and will be changed in a future update. Paired organs are correctly listed in the SEER Program Coding and Staging Manual 2018.

Do not leave this data item blank. If the primary site is reported as “unknown primary site,” code the laterality to “0 - not a paired site.”

If the primary site being reported is not defined as a paired site, laterality must be coded as “0 – not a paired site” **regardless of facility type.**

Laterality Codes and Description

Code	Pairing Description
0	Not a paired site
1	Right: origin of primary
2	Left: origin of primary
3	Only one side involved, right or left origin unspecified
4	Bilateral involvement at time of diagnosis, lateral origin unknown for a single primary; or both ovaries involved simultaneously, single histology; bilateral retinoblastomas; bilateral Wilms tumors
5*	Paired site: midline tumor. Code 5 - Midline is an allowable value for the following sites only: C700, C710-C714, C722-C725, C443, and C445.
9	Paired site, but no information concerning laterality

* “Midline” in this context refers to the point where the “right” and “left” sides of paired organs come into direct contact and a tumor forms at that point. Most paired sites cannot develop midline tumors.

Use code “3 - One side only, NOS” if the laterality is not known but the tumor is confined to a single side of a paired organ.

Example:

The pathology report states that the “patient has a 2 cm carcinoma in the upper pole of the kidney.”
Code laterality as “3 - One side only, NOS” because laterality is not specified but the tumor is not present on both sides of a paired site.

Admitting history states that the patient has a positive, sputum cytology but is being treated with radiation for painful bony metastases.
Code laterality as “9 - Unknown,” because there is no information concerning laterality in the implied diagnosis of lung cancer and the case is metastatic.

Patient has a melanoma of skin just above the umbilicus.
Code laterality as “5 - Midline.”

The skin of the lip, scalp and neck is not considered a paired organ, laterality for these subcategories is coded as “0 - Not a paired site.”

If reporting the primary site of the skin as “skin, NOS (C44.9)” the laterality is coded as “0 - Not a paired site.”

NOTE: The prostate and thyroid are made up of lobes, which are represented by left and right - Do not code as a paired organ.

NOTE: The description of right colon and left colon does not apply to laterality, but to the exact location (sub-site) of the tumor origin in the colon. Code right colon to ascending colon (C18.2) and the left colon to descending colon (C18.6). Do not code as a paired organ.

The chart below lists sites for which laterality codes must be recorded: Laterality must be recorded for the following paired organs as 1-5 or 9.

Paired Organs Requiring Laterality Codes

Primary Site Description	Topography Code
Parotid gland	C079
Submandibular gland	C080
Sublingual gland	C081
Tonsil, overlapping lesion	C098
Tonsil, NOS (faucial tonsil, palatine tonsil)	C099
Nasal cavity (excluding nasal cartilage and nasal septum - code 0)	C300
Middle ear	C301
Maxillary sinus	C310
Frontal sinus	C312
Main bronchus (excluding carina - code 0)	C340
Lung	C341 – C349
Pleura	C384
Long bones of upper limb, scapula and associated joints	C400

Primary Site Description	Topography Code
Short bones of upper limb and associated joints	C401
Long bones of lower limb and associated joints	C402
Short bones of lower limb and associated joints	C403
Rib and clavicle (excluding sternum - code 0)	C413
Pelvic bones (excluding sacrum, coccyx and symphysis pubis - code “0’)	C414
Skin of eyelid	C441
Skin of external ear	C442
*Skin of other unspecified parts of face	C443
*Skin of trunk	C445
Skin of upper limb and shoulder	C446
Skin of lower limb and hip	C447
Peripheral nerves and autonomic nervous system of upper limb and shoulder	C471
Peripheral nerves and autonomic nervous system of lower limb and hip	C472
Connective, subcutaneous and other soft tissue of upper limb and shoulder	C491
Connective, subcutaneous, and other soft tissue of lower limb and hip	C492
Breast	C500 - C509
Ovary	C569
Fallopian tube	C570
Testis	C620 – C629
Epididymis	C630
Spermatic cord	C631
Kidney, NOS	C649
Renal pelvis	C659
Ureter	C669
Eye and lacrimal gland	C690 – C699
*Cerebral meninges, NOS (excluding diagnoses prior to 2004)	C700
*Cerebrum (excluding diagnoses prior to 2004)	C710
Frontal lobe (excluding diagnoses prior to 2004)	C711
Temporal lobe (excluding diagnoses prior to 2004)	C712
Parietal lobe (excluding diagnoses prior to 2004)	C713
*Occipital lobe (excluding diagnoses prior to 2004)	C714
*Olfactory nerve (excluding diagnoses prior to 2004)	C722
*Optic nerve (excluding diagnoses prior to 2004)	C723
*Acoustic nerve (excluding diagnoses prior to 2004)	C724
*Cranial Nerve, NOS (excluding diagnoses prior to 2004)	C725
Adrenal gland	C740 – C749
Carotid body	C754

*Site includes code 5 - midline tumor

Item: LATITUDE

NAACCR Item 2352
Paired with Longitude [2354], this represents the point location of the individual’s residence on the earth’s surface. It is typically determined by matching an address to a reference file or by identifying the residence using satellite imagery. This item is coded at the central registry, not by the reporting facility.

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: LDH POST-ORCHIECTOMY RANGE (SSDI)

NAACCR Item 3867
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: LDH PRE-ORCHIECTOMY RANGE (SSDI)

NAACCR Item 3868
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: LDH PRETREATMENT LAB VALUE (SSDI)

NAACCR Item 3932
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: LDH PRETREATMENT LEVEL (SSDI)

NAACCR Item 3869
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: LDH UPPER LIMITS OF NORMAL (SSDI)

NAACCR Item 3870
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: LN ASSESSMENT METHOD FEMORAL-INGUINAL (SSDI)

NAACCR Item 3871
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: LN ASSESSMENT METHOD PARA-AORTIC (SSDI)

NAACCR Item 3872
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: LN ASSESSMENT METHOD PELVIC (SSDI)

NAACCR Item 3873
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: LN DISTANT ASSESSMENT METHOD (SSDI)

NAACCR Item 3874
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: LN DISTANT: MEDIASTINAL, SCALENE (SSDI)

NAACCR Item 3875
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: LN HEAD AND NECK LEVELS I-III (SSDI)

NAACCR Item 3876
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: LN HEAD AND NECK LEVELS IV-V (SSDI)

NAACCR Item 3877
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: LN HEAD AND NECK LEVELS VI-VII (SSDI)

NAACCR Item 3878
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: LN HEAD AND NECK OTHER (SSDI)

NAACCR Item 3879
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: LN ISOLATED TUMOR CELLS (ITC) (SSDI)

NAACCR Item 3880
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: LN LATERALITY (SSDI)

NAACCR Item 3881
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: LN POSITIVE AXILLARY LEVEL I-II (SSDI)

NAACCR Item 3882
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: LN SIZE (SSDI)

NAACCR Item 3883

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: LN STATUS FEMORAL-INGUINAL, PARA-AORTIC, PELVIC (SSDI)

NAACCR Item 3884
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: LONGITUDE

NAACCR Item 2354
Paired with Latitude [2352], this represents the point location of the individual's residence on the earth's surface. It is typically determined by matching an address to a reference file or by identifying the residence using satellite imagery. This item is coded at the central registry, not by the reporting facility.

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: LYMPHOCYTOSIS (SSDI)

NAACCR Item 3885
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: LYMPH-VASCULAR INVASION

NAACCR Item 1182
For description, rationale, and coding instructions for this data item, refer to AJCC

Item: MAJOR VEIN INVOLVEMENT (SSDI)

NAACCR Item 3886
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: MARITAL STATUS AT DX

NAACCR Item 150
For description, rationale, and coding instructions for this data item, refer to NCI SEER

Item: MEASURED BASAL DIAMETER (SSDI)

NAACCR Item 3887
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: MEASURED THICKNESS (SSDI)

NAACCR Item 3888
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: MEDICAL RECORD NUMBER

NAACCR Item 2300
Records medical record number used by the facility to identify the patient. The CoC STORE manual instructs registrars to record numbers assigned by the facility's Health Information Management (HIM) Department only, not department-specific numbers.

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: METHYLATION OF O6-METHYLGUANINE-METHYLTRANSFERASE (SSDI)

NAACCR Item 3889
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: METS AT DX-BONE

NAACCR Item 1112
This data item applies to cases diagnosed 1/1/2016 and forward only.

For description, rationale, and coding instructions for this data item, refer to NCI SEER

Item: METS AT DX-BRAIN

NAACCR Item 1113
This data item applies to cases diagnosed 1/1/2016 and forward only.

For description, rationale, and coding instructions for this data item, refer to NCI SEER

Item: METS AT DX-DISTANT LN

NAACCR Item 1114
This data item applies to cases diagnosed 1/1/2016 and forward only.

For description, rationale, and coding instructions for this data item, refer to NCI SEER

Item: METS AT DX-LIVER

NAACCR Item 1115
This data item applies to cases diagnosed 1/1/2016 and forward only.

For description, rationale, and coding instructions for this data item, refer to NCI SEER

Item: METS AT DX-LUNG

NAACCR Item 1116
This data item applies to cases diagnosed 1/1/2016 and forward only.

For description, rationale, and coding instructions for this data item, refer to NCI SEER

Item: METS AT DX-OTHER

NAACCR Item 1117
This data item applies to cases diagnosed 1/1/2016 and forward only.

For description, rationale, and coding instructions for this data item, refer to NCI SEER

Item: MICHIGAN FACILITY NUMBER

State-specific Item 9508
Enter the 5-digit Michigan Facility Number that has been assigned to your institution by the Michigan Cancer Surveillance Program. Note: This number may have a leading zero, e.g., 01234.

If you do not know your Michigan Facility Number, contact your field representative or contact Amy Marquardt or Jetty Alverson.

Do not leave this data item blank.

Item: MICROSATELLITE INSTABILITY (MSI) (SSDI)

NAACCR Item 3890
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: MICROVASCULAR DENSITY (SSDI)

NAACCR Item 3891
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: MITOTIC COUNT UVEAL MELANOMA (SSDI)

NAACCR Item 3892
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: MITOTIC RATE MELANOMA (SSDI)

NAACCR Item 3893
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: MULTIGENE SIGNATURE METHOD (SSDI)

NAACCR Item 3894
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: MULTIGENE SIGNATURE RESULTS (SSDI)

NAACCR Item 3895

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: NAME--ALIAS

NAACCR Item 2280
This data item may be left blank if not applicable or unknown.

Enter the alternate name or "AKA" (also known as) used by the patient. Note that maiden name is entered in Maiden Name field.

Item: NAME--FIRST

NAACCR Item 2240
Type the legal First Name of the patient. Truncate if more than 40 letters long, but do not abbreviate, e.g., do not use "Robt" for "Robert." Blank spaces or hyphens between multiple-word names are allowed. Do not use other punctuation such as apostrophes. Do not use nicknames in this field; nicknames should be used in Alias Name field only.

If the patient's first name is not available, type Unknown.

This field may be updated if the last name changes. For information on how to submit corrections, refer to Submitting Updates (Corrections) in the MCSP Cancer Reporting Manual.

Do not leave this data item blank.

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: NAME--LAST

NAACCR Item 2230
Type the legal Last Name of the patient. Truncate name if more than 40 letters long. Blank spaces or hyphens between multiple-word names are allowed. Do not use other punctuation such as apostrophes. Include JR (junior) or SR (senior) with the last name when applicable.

If the last name is not available, type Unknown.

This field may be updated if the last name changes. For information on how to submit corrections, refer to Submitting Updates (Corrections) in the MCSP Cancer Reporting Manual.

Do not leave this data item blank.

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: NAME--MAIDEN

NAACCR Item 2390
This data item may be left blank if not applicable or unknown.

Enter the Maiden Name of female patients who are or have been married. Do not abbreviate. Blank spaces or hyphens between multiple-word names are allowed. Do not use other punctuation such as apostrophes. Leave this item blank for any of the following: a) if it is not appropriate for the patient being reported; b) maiden name is not available in the records; or c) if maiden name is not a reportable data item per facility's cancer reporting rules.

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: NAME--MIDDLE

NAACCR Item 2250
This data item may be left blank if not applicable or unknown.

Type the legal Middle Name or Middle Initial of the patient. If only an initial is available for the middle name, enter the initial. Blank spaces or hyphens between multiple-word names are allowed. Do not use other punctuation such as apostrophes. If no middle name or initial, leave field blank.

This field may be updated if the last name changes. For information on how to submit corrections, refer to Submitting Updates (Corrections) in the MCSP Cancer Reporting Manual.

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: NCCN INTERNATIONAL PROGNOSTIC INDEX (IPI) (SSDI)

NAACCR Item 3896
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: NPCR DERIVED AJCC 8 TNM CLIN STG GRP

NAACCR Item 3645
For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR)

Item: NPCR DERIVED AJCC 8 TNM PATH STG GRP

NAACCR Item 3646
For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR)

Item: NPCR DERIVED AJCC 8 TNM POST THERAPY STG GRP

NAACCR Item 3647
For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR)

Item: NPCR DERIVED CLIN STG GRP

NAACCR Item 3650

For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR)

Item: NPCR DERIVED PATH STG GRP

NAACCR Item 3655
For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR)

Item: NPCR SPECIFIC FIELD

NAACCR Item 3720
For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR)

Item: NPI--REPORTING FACILITY

NAACCR Item 545
NPI, a unique identification number for US health care providers, was scheduled for 2007-2008 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For billing purposes, large practices and large group providers were required to use NPI codes by May 2007; small health plans were required to use NPI codes by May 2008.

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: NUMBER OF CORES EXAMINED (SSDI)

NAACCR Item 3897
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: NUMBER OF CORES POSITIVE (SSDI)

NAACCR Item 3898
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: NUMBER OF EXAMINED PARA-AORTIC NODES (SSDI)

NAACCR Item 3899
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: NUMBER OF EXAMINED PELVIC NODES (SSDI)

NAACCR Item 3900
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: NUMBER OF PHASES OF RAD TREATMENT TO THIS VOLUME

NAACCR Item 1532
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: NUMBER OF POSITIVE PARA-AORTIC NODES (SSDI)

NAACCR Item
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: NUMBER OF POSITIVE PELVIC NODES (SSDI)

NAACCR Item 3902
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: ONCOTYPE DX RECURRENCE SCORE-DCIS (SSDI)

NAACCR Item 3903
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: ONCOTYPE DX RECURRENCE SCORE-INVASIVE (SSDI)

NAACCR Item 3904
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: ONCOTYPE DX RISK LEVEL-DCIS (SSDI)

NAACCR Item 3905
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: ONCOTYPE DX RISK LEVEL-INVASIVE (SSDI)

NAACCR Item 3906
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: ORGANOMEGALY (SSDI)

NAACCR Item 3907
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: PERCENT NECROSIS POST NEOADJUVANT (SSDI)

NAACCR Item 3908
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: PERINEURAL INVASION (SSDI)

NAACCR Item 3909
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: PERIPHERAL BLOOD INVOLVEMENT (SSDI)

NAACCR Item 3910
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: PERITONEAL CYTOLOGY (SSDI)

NAACCR Item 3911
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: PHASE I DOSE PER FRACTION

NAACCR Item 1501
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: PHASE I NUMBER OF FRACTIONS

NAACCR Item 1503
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: PHASE I RADIATION EXTERNAL BEAM PLANNING TECH

NAACCR Item 1502
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: PHASE I RADIATION PRIMARY TREATMENT VOLUME

NAACCR Item 1504
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: PHASE I RADIATION TO DRAINING LYMPH NODES

NAACCR Item 1505
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: PHASE I RADIATION TREATMENT MODALITY

NAACCR Item 1506

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: PHASE I TOTAL DOSE

NAACCR Item 1507
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: PHASE II DOSE PER FRACTION

NAACCR Item 1511
Blanks allowed if no Phase II radiation treatment administered.

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: PHASE II NUMBER OF FRACTIONS

NAACCR Item 1513
Blanks allowed if no Phase II radiation treatment administered.

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: PHASE II RADIATION EXTERNAL BEAM PLANNING TECH

NAACCR Item 1512
Blanks allowed if no Phase II radiation treatment administered.

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: PHASE II RADIATION PRIMARY TREATMENT VOLUME

NAACCR Item 1514
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: PHASE II RADIATION TO DRAINING LYMPH NODES

NAACCR Item 1515
Blanks allowed if no Phase II radiation treatment administered.

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: PHASE II RADIATION TREATMENT MODALITY

NAACCR Item 1516
Blanks allowed if no Phase II radiation treatment administered.

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: PHASE II TOTAL DOSE

NAACCR Item 1517
Blanks allowed if no Phase II radiation treatment administered.

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: PHASE III DOSE PER FRACTION

NAACCR Item 1521
Blanks allowed if no Phase III radiation treatment administered.

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: PHASE III NUMBER OF FRACTIONS

NAACCR Item 1523
Blanks allowed if no Phase III radiation treatment administered.

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: PHASE III RADIATION EXTERNAL BEAM PLANNING TECH

NAACCR Item 1522
Blanks allowed if no Phase III radiation treatment administered.

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: PHASE III RADIATION PRIMARY TREATMENT VOLUME

NAACCR Item 1524
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: PHASE III RADIATION TO DRAINING LYMPH NODES

NAACCR Item 1525
Blanks allowed if no Phase III radiation treatment administered.

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: PHASE III RADIATION TREATMENT MODALITY

NAACCR Item 1526

Blanks allowed if no Phase III radiation treatment administered.

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: PHASE III TOTAL DOSE

NAACCR Item 1527
Blanks allowed if no Phase III radiation treatment administered.

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: PLACE OF DEATH--COUNTRY

NAACCR Item 1944
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

For ISO alpha-3 Country Codes, refer to Appendix B of the SEER Program Code Manual.

Item: PLACE OF DEATH--STATE

NAACCR Item 1942
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

For a complete list of state, territory, commonwealth, U.S. possession, or Canadian province or territory codes, refer to Appendix B of the SEER Program Code Manual.

Item: PLEURAL EFFUSION (SSDI)

NAACCR Item 3913
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: PRIMARY PAYER AT DX

NAACCR Item 630
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: PRIMARY SCLEROSING CHOLAGITIS (SSDI)

NAACCR Item 3917
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: PRIMARY SITE

NAACCR Item 400

For description, rationale, and coding instructions for this data item, refer to NCI SEER and CoC STandards for Oncology Registry Entry (STORE) Manual

Item: PROFOUND IMMUNE SUPPRESSION (SSDI)

NAACCR Item 3918
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: PROGESTERONE RECEPTOR PERCENT POSITIVE OR RANGE (SSDI)

NAACCR Item 3914
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: PROGESTERONE RECEPTOR SUMMARY (SSDI)

NAACCR Item 3915
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: PROGESTERONE RECEPTOR TOTAL ALLRED SCORE (SSDI)

NAACCR Item 1316
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: PROSTATE PATHOLOGICAL EXTENSION (SSDI)

NAACCR Item 3919
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: PSA (PROSTATIC SPECIFIC ANTIGEN) LAB VALUE (SSDI)

NAACCR Item 3920
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: RACE (1-5)

NAACCR Item 160-164
Enter the patient's race according to the documentation in the medical record.

NOTE: ALL tumors for the same patient should have the same race code(s).

If multi-racial, enter each race according to the documentation in the patient's chart, for a total of five races.

In general, race should be reported as American Indian, white, black, etc.

White includes Mexican, Puerto Rican, Cuban, and all other Caucasians.

If Asian, enter the national origin as Chinese, Vietnamese, Japanese, Hmong, etc.

Race is a required data item for all facilities regardless of the facility type. If the patient's race is not available in the medical record, it may be necessary to contact the physician's office.

Examples:

If the patient is multiracial -
Code all races using Race 1 through Race 5. Code any subsequent unused Race fields as 88 (no further race documented.)

If the person is multiracial and one of the races is white -
Code the other race(s) first with white in the next race field.

If the person is multiracial and one of the races is Hawaiian -
Code Hawaiian as Race 1, followed by the other race(s).

If Race 1 is coded 99 (unknown) -
Then Race 2 through Race 5 must all be coded 99.

Do not leave this data item blank. If race is not documented, then follow-back is required.
Record race description in TEXT--DX PROC--PE field. If unknown, and if follow-back has been conducted, record as such in this field so it is clear that follow-back has been attempted.

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: RADIATION TREATMENT DISCONTINUED EARLY

NAACCR Item 1531
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: RAD--REGIONAL RX MODALITY

NAACCR Item 1570
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: REASON FOR NO RADIATION

NAACCR Item 1430.
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: REASON FOR NO SURGERY

NAACCR Item 1340
For description, rationale, and coding instructions for this data item, refer to NCI SEER and CoC STandards for Oncology Registry Entry (STORE) Manual

Item: REGIONAL NODES EXAMINED

NAACCR Item 830
For description, rationale, and coding instructions for this data item, refer to NCI SEER and CoC STandards for Oncology Registry Entry (STORE) Manual

Item: REGIONAL NODES POSITIVE

NAACCR Item 820
For description, rationale, and coding instructions for this data item, refer to NCI SEER and CoC STandards for Oncology Registry Entry (STORE) Manual

Item: REPORTING FACILITY

NAACCR Item 540
The Reporting Facility ten-digit identification number or FIN is used to identify a reporting facility in the central registry database and is useful for monitoring data submission, ensuring the accuracy of data and identifying areas for special studies. A compilation of valid FINs can be found here: American College of Surgeons Facility Identification Number (FIN) List

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: RESIDUAL TUMOR VOLUME POST CYTOREDUCTION (SSDI)

NAACCR Item 3921
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: RESPONSE TO NEOADJUVANT THERAPY (SSDI)

NAACCR Item 3922
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: RQRS NCDB SUBMISSION FLAG

NAACCR Item 2155
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: RX CODING SYSTEM--CURRENT

NAACCR Item 1460
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: RX DATE BRM

NAACCR Item 1240
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

An allowable value must be in this Date field or its corresponding Flag field. Both fields cannot be blank.

Item: RX DATE BRM FLAG

NAACCR Item 1241
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

An allowable value must be in this Flag field or its corresponding Date field. Both fields cannot be blank.

Item: RX DATE CHEMO

NAACCR Item 1220
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

An allowable value must be in this Date field or its corresponding Flag field. Both fields cannot be blank.

Item: RX DATE CHEMO FLAG

NAACCR Item 1221
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

An allowable value must be in this Flag field or its corresponding Date field. Both fields cannot be blank.

Item: RX DATE HORMONE

NAACCR Item 1230
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

An allowable value must be in this Date field or its corresponding Flag field. Both fields cannot be blank.

Item: RX DATE HORMONE FLAG

NAACCR Item 1231
This flag explains why there is no appropriate value in the corresponding date field.

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

An allowable value must be in this Flag field or its corresponding Date field. Both fields cannot be blank.

Item: RX DATE MST DEFN SRG

NAACCR Item 3170
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

An allowable value must be in this Date field or its corresponding Flag field. Both fields cannot be blank.

Item: RX DATE MST DEFN SRG FLAG

NAACCR Item 3171
This flag explains why there is no appropriate value in the corresponding date field.

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

An allowable value must be in this Flag field or its corresponding Date field. Both fields cannot be blank.

Item: RX DATE OTHER

NAACCR Item 1250
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

An allowable value must be in this Date field or its corresponding Flag field. Both fields cannot be blank.

Item: RX DATE OTHER FLAG

NAACCR Item 1251
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

An allowable value must be in this Flag field or its corresponding Date field. Both fields cannot be blank.

Item: RX DATE RADIATION

NAACCR Item 1210
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

An allowable value must be in this Date field or its corresponding Flag field. Both fields cannot be blank.

Item: RX DATE RADIATION FLAG

NAACCR Item 1211
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

An allowable value must be in this Flag field or its corresponding Date field. Both fields cannot be blank.

Item: RX DATE SURGERY

NAACCR Item 1200
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

An allowable value must be in this Date field or its corresponding Flag field. Both fields cannot be blank.

Item: RX DATE SURGERY FLAG

NAACCR Item 1201

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

An allowable value must be in this Flag field or its corresponding Date field. Both fields cannot be blank.

Item: RX DATE SYSTEMIC

NAACCR Item 3230
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

An allowable value must be in this Date field or its corresponding Flag field. Both fields cannot be blank.

Item: RX DATE SYSTEMIC FLAG

NAACCR Item 3230
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

An allowable value must be in this Flag field or its corresponding Date field. Both fields cannot be blank.

Item: RX SUMM--BRM

NAACCR Item 1410
For description, rationale, and coding instructions for this data item, refer to NCI SEER and CoC STandards for Oncology Registry Entry (STORE) Manual

Item: RX SUMM--CHEMO

NAACCR Item 1390
For description, rationale, and coding instructions for this data item, refer to NCI SEER and CoC STandards for Oncology Registry Entry (STORE) Manual

Item: RX SUMM--HORMONE

NAACCR Item 1400
For description, rationale, and coding instructions for this data item, refer to NCI SEER and CoC STandards for Oncology Registry Entry (STORE) Manual

Item: RX SUMM--OTHER

NAACCR Item 1420
For description, rationale, and coding instructions for this data item, refer to NCI SEER and CoC STandards for Oncology Registry Entry (STORE) Manual

Item: RX SUMM--RADIATION

NAACCR Item 1360
For description, rationale, and coding instructions for this data item, refer to NCI SEER

Item: RX SUMM--SCOPE REG NL SUR

NAACCR Item 1292
For description, rationale, and coding instructions for this data item, refer to NCI SEER and CoC STandards for Oncology Registry Entry (STORE) Manual

Item: RX SUMM--SURG OTH REG/DIS

NAACCR Item 1294
For description, rationale, and coding instructions for this data item, refer to NCI SEER and CoC STandards for Oncology Registry Entry (STORE) Manual

Item: RX SUMM--SURG PRIM SITE

NAACCR Item 1290
Code the most definitive surgical procedure of primary site.

For description, rationale, and coding instructions for this data item, refer to NCI SEER and CoC STandards for Oncology Registry Entry (STORE) Manual

Item: RX SUMM--SURG/RAD SEQ

NAACCR Item 1380
For description, rationale, and coding instructions for this data item, refer to NCI SEER and CoC STandards for Oncology Registry Entry (STORE) Manual

Item: RX SUMM--SYSTEMIC/SUR SEQ

NAACCR Item 1639
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: RX SUMM--TRANSPLNT/ENDOCR

NAACCR Item 3250
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: RX SUMM--TREATMENT STATUS

NAACCR Item 1285
For description, rationale, and coding instructions for this data item, refer to NCI SEER and CoC STandards for Oncology Registry Entry (STORE) Manual

IMPORTANT NOTICE:
Text documentation is required regardless of facility type. An abstract submitted with codes that lack supporting text data will be rejected in its entirety.

General Instructions for Text Field Entries ("RX TEXT--" and "TEXT--" data items)

- Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies.

- Text is needed to justify coded values and to document supplemental information not transmitted within coded values.
- High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.
- The text field MUST contain a description that has been entered by the abstractor independently from the code(s).
- If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values.
- Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values.
- When the supporting text information is printed for review, one should be able to re-abstract the case without obtaining additional medical records and have the same codes as the original abstract.
- For additional information on text documentation rationale, consult NAACCR Data Standards & Data Dictionary

Do not leave text data items blank. If there is no information to record in the text field, type "NR" (Not Reported) or "No Info" to indicate that there is no information, otherwise it will be assumed that the information is actually missing.

Only use standard abbreviations in text fields. For a list of recommended abbreviations, refer to NAACCR Data Dictionary Appendix G: Recommended Abbreviations for Abstractors.

Item: RX TEXT--BRM

NAACCR Items 2660
Text area for manual documentation of information regarding the treatment of the tumor being reported with biological response modifiers or immunotherapy.

Required for Text:

- When Treatment was given, e.g., at this facility; at another facility
- Type of BRM agent, e.g., Interferon, BCG
- BRM procedures, e.g., bone marrow transplant, stem cell transplant
- Other treatment information, e.g., treatment cycle incomplete; unknown if BRM was given

Do not leave this data item blank. If there is no information to record in the text field, type "NR" (Not Reported) or "No Info" to indicate that there is no information, otherwise it will be assumed that the information is actually missing.

For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR)

Item: RX TEXT--CHEMO

NAACCR Items 2640
Text area for information regarding chemotherapy treatment of the reported tumor.

Required for Text:

- Date when chemotherapy began
- Where treatment was given, e.g., name of agent(s) or protocol

- Other treatment information, e.g., treatment cycle incomplete, unknown if chemotherapy was given

Do not leave this data item blank. If there is no information to record in the text field, type "NR" (Not Reported) or "No Info" to indicate that there is no information, otherwise it will be assumed that the information is actually missing.

For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR)

Item: RX TEXT--HORMONE

NAACCR Items 2650
Text area for information about hormonal treatment

Required for Text:

- Date treatment was started
- Where treatment was given, e.g., at this facility, at another facility
- Type of hormone or antihormone, e.g., Tamoxifen
- Type of endocrine surgery or radiation, e.g., 3-D conformal
- Other treatment information, e.g., treatment cycle incomplete; unknown if hormones were given.

Do not leave this data item blank. If there is no information to record in the text field, type "NR" (Not Reported) or "No Info" to indicate that there is no information, otherwise it will be assumed that the information is actually missing.

For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR)

Item: RX TEXT--OTHER

NAACCR Items 2670
Text area for manual documentation of information regarding the treatment of the tumor being reported with treatment that cannot be defined as surgery, radiation, or systemic therapy. This includes experimental treatments (when the mechanism of action for a drug is unknown), and blinded clinical trials. If the mechanism of action for the experimental drug is known, code to the appropriate treatment field.

Required for Text:

- Date treatment was started
- Where treatment was given, e.g., at this facility, at another facility
- Type of other treatment, e.g., blinded clinical trial, hyperthermia
- Other treatment information, e.g., treatment cycle incomplete; unknown if other treatment was given.

Do not leave this data item blank. If there is no information to record in the text field, type "NR" (Not Reported) or "No Info" to indicate that there is no information, otherwise it will be assumed that the information is actually missing.

For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR)

Item: RX TEXT--RADIATION (BEAM)

NAACCR Items 2620
Text area for manual documentation of information regarding treatment of the tumor being reported with beam radiation.

Required for Text:

- Date radiation treatment began
- Where treatment was given, e.g., at this facility, at another facility
- Type(s) of beam radiation, e.g., Orthovoltage, Cobalt 60, MV X-rays, Electrons, Mixed modalities
- Other treatment information, e.g., patient discontinued after 5 treatments; unknown if radiation was given

Do not leave this data item blank. If there is no information to record in the text field, type "NR" (Not Reported) or "No Info" to indicate that there is no information, otherwise it will be assumed that the information is actually missing.

For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR)

Item: RX TEXT--RADIATION OTHER

NAACCR Items 2630
Text area for manual documentation of information regarding treatment of the tumor being reported with radiation other than beam radiation. This includes brachytherapy and systemic radiation therapy.

Required for Text:

- Date treatment was started
- Where treatment was given, e.g., at this facility, at another facility
- Type(s) of non-beam radiation, e.g., High Dose rate brachytherapy, seed implant, Radioisotopes (I-131)
- Other treatment information, e.g., unknown if radiation was given

Do not leave this data item blank. If there is no information to record in the text field, type "NR" (Not Reported) or "No Info" to indicate that there is no information, otherwise it will be assumed that the information is actually missing.

For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR)

Item: RX TEXT--SURGERY

NAACCR Items 2610
Text area for information describing all surgical procedures performed as part of treatment.

Required for Text:

- Date of each procedure.
- Type(s) of surgical procedure(s), including excisional biopsies and surgery to other and distant sites.

- Lymph nodes removed.
- Regional tissues removed.
- Metastatic sites.
- Facility where each procedure was performed.
- Record positive and negative findings. Record positive findings first.
- Other treatment information, e.g., planned procedure aborted; unknown if surgery performed.

Do not leave this data item blank. If there is no information to record in the text field, type "NR" (Not Reported) or "No Info" to indicate that there is no information, otherwise it will be assumed that the information is actually missing.

For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR)

Item: S CATEGORY CLINICAL (SSDI)

NAACCR Item 3923
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: S CATEGORY PATHOLOGICAL (SSDI)

NAACCR Item 3924
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: SARCOMATOID FEATURES (SSDI)

NAACCR Item 3925
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: SCHEMA DISCRIMINATOR 1 (SSDI)

NAACCR Item 3926
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: SCHEMA DISCRIMINATOR 2 (SSDI)

NAACCR Item 3927
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: SCHEMA DISCRIMINATOR 3 (SSDI)

NAACCR Item 3928
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: SCHEMA ID

NAACCR Item 3800
See NAACCR website for complete Cancer Schema List. This site generates all required Site Specific Data Items (SSDI) by schema.

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: SECONDARY DIAGNOSIS (1-10)

NAACCR Items 3780-3798
For cases using ICD-10-CM codes only. ICD-10-CM coding required beginning 10/1/2015.

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: SEER CAUSE SPECIFIC COD

NAACCR Item 1914
Reporting required by Metropolitan Detroit Cancer System (MDCSS) only.

For description, rationale, and coding instructions for this data item, refer to NCI SEER

Item: SEER OTHER COD

NAACCR Item 1915
Reporting required by Metropolitan Detroit Cancer System (MDCSS) only.

For description, rationale, and coding instructions for this data item, refer to NCI SEER

Item: SEER SUMMARY STAGE 2000 (Directly Assigned/Coded)

NAACCR Items 759
Must be directly assigned/coded. Applies to cases diagnosed prior to 2018 only. MCSP will always require directly assigned/coded SEER Summary Stage to be reported from all facilities regardless of type.

For description, rationale, and coding instructions for this data item, refer to NCI SEER

Item: SENTINEL LYMPH NODES EXAMINED

NAACCR Item 834
This data item is required for CoC-accredited facilities as of cases diagnosed 01/01/2018 and later.
This data item is required for breast and melanoma cases only.

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: SENTINEL LYMPH NODES POSITIVE

NAACCR Item 835

This data item is required for CoC-accredited facilities as of cases diagnosed 01/01/2018 and later.
This data item is required for breast and melanoma cases only.

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: SEPARATE TUMOR NODULES (SSDI)

NAACCR Item 3929
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: SEQUENCE NUMBER--HOSPITAL

NAACCR Item 560
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Important: Michigan requires reporting of non-invasive (pre-cancerous) intraepithelial neoplasia grade III tumors of the cervix (CIN III), vulva (VIN III), vagina (VAIN III), and anus (AIN III). Sequence numbers 00-59 must be used for these tumors -- do not use sequence number “99” or the 60-87 sequence range which is reserved for benign/borderline CNS tumors.

Item: SERUM ALBUMIN PRETREATMENT LEVEL (SSDI)

NAACCR Item 3930
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: SERUM BETA-2 MICROGLOBULIN PRETREATMENT LEVEL (SSDI)

NAACCR Item 3931
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: SEX

NAACCR Item 220
Note: The word “hermaphrodite” formerly classified under code 3 is outdated. Beginning with cases diagnosed in 2016, the definition has been updated to code “3 - Other (intersex, disorders of sexual development/DSD).”

For description, rationale, and coding instructions for this data item, refer to NCI SEER and CoC STandards for Oncology Registry Entry (STORE) Manual

NOTE: The same sex code should appear in each abstract for a patient with multiple tumors.

Do not leave this data item blank.

Item: SOCIAL SECURITY NUMBER

NAACCR Item 2320

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: SPANISH/HISPANIC ORIGIN

NAACCR Item 190
For description, rationale, and coding instructions for this data item, refer to NCI SEER and CoC STandards for Oncology Registry Entry (STORE) Manual

Item: SUMMARY STAGE 2018 (Directly Assigned)

NAACCR Item 764
Must be directly assigned/coded. Applies to cases diagnosed in 2018 and later. MCSP will always require directly assigned/coded SEER Summary Stage to be reported from all facilities regardless of type.

For description, rationale, and coding instructions for this data item, refer to NCI SEER

IMPORTANT NOTICE:
Text documentation is required regardless of facility type. An abstract submitted with codes that lack supporting text data will be rejected in its entirety.

General Instructions for Text Field Entries ("RX TEXT--" and "TEXT--" data items)

- Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies.
- Text is needed to justify coded values and to document supplemental information not transmitted within coded values.
- High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.
- The text field MUST contain a description that has been entered by the abstractor independently from the code(s).
- If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values.
- Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values.
- When the supporting text information is printed for review, one should be able to re-abstract the case without obtaining additional medical records and have the same codes as the original abstract.
- For additional information on text documentation rationale, consult NAACCR Data Standards & Data Dictionary

Do not leave text data items blank. If there is no information to record in the text field, type "NR" (Not Reported) or "No Info" to indicate that there is no information, otherwise it will be assumed that the information is actually missing.

Only use standard abbreviations in text fields. For a list of recommended abbreviations, refer to NAACCR Data Dictionary Appendix G: Recommended Abbreviations for Abstractors.

Item: TEXT--DX PROC--LAB TESTS

NAACCR Item 2550
For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR)

Item: TEXT--DX PROC--OP

NAACCR Item 2560
For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR)

Item: TEXT--DX PROC--PATH

NAACCR Item 2570
For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR)

Item: TEXT--DX PROC--PE

NAACCR Item 2520
For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR)

Item: TEXT--DX PROC--SCOPES

NAACCR Item 2540
For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR)

Item: TEXT--DX PROC--X-RAY/SCAN

NAACCR Item 2530
For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR)

Item: TEXT--HISTOLOGY TITLE

NAACCR Item 2590
For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR)

Item: TEXT--PLACE OF DIAGNOSIS

NAACCR Item 2690
For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR)

Item: TEXT--PRIMARY SITE TITLE

NAACCR Item 2580
For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR)

Item: TEXT--REMARKS

NAACCR Item 2680
For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR)

Item: TEXT--STAGING

NAACCR Item 2600
For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR)

Item: TEXT--USUAL INDUSTRY

NAACCR Item 320
For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR)

Item: TEXT--USUAL OCCUPATION

NAACCR Item 310
For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR)

Item: THROMBOCYTOPENIA (SSDI)

NAACCR Item 3933
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: TNM CLIN DESCRIPTOR

NAACCR Item 980
CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

MCSP has defined some facilities as a “Hospitals without registry”. These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: TNM CLIN M

NAACCR Item 960
CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to AJCC

MCSP has defined some facilities as a “Hospitals without registry”. These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: TNM CLIN N

NAACCR Item 950
CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to AJCC

MCSP has defined some facilities as a “Hospitals without registry”. These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: TNM CLIN STAGE GROUP

NAACCR Item 970
CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to AJCC

MCSP has defined some facilities as a “Hospitals without registry”. These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: TNM CLIN T

NAACCR Item 940
CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to AJCC

MCSP has defined some facilities as a “Hospitals without registry”. These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: TNM EDITION NUMBER

NAACCR Item 1060
CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

MCSP has defined some facilities as a “Hospitals without registry”. These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: TNM PATH DESCRIPTOR

NAACCR Item 920
CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

MCSP has defined some facilities as a “Hospitals without registry”. These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: TNM PATH M

NAACCR Item 900
CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to AJCC

MCSP has defined some facilities as a “Hospitals without registry”. These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: TNM PATH N

NAACCR Item 890
CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to AJCC

MCSP has defined some facilities as a “Hospitals without registry”. These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: TNM PATH STAGE GROUP

NAACCR Item 910
CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to AJCC

MCSP has defined some facilities as a “Hospitals without registry”. These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: TNM PATH T

NAACCR Item 880
CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to AJCC

MCSP has defined some facilities as a “Hospitals without registry”. These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: TOBACCO USE

State-specific Item 9522
Records whether or not the patient has a history of tobacco use (cigarettes, pipe, cigars, snuff, chew).

If the patient quit smoking one year or less from the initial date of diagnosis, indicate “current use.”

This is a MCSP-required data item. Abstracts submitted with incorrect format or missing values will be rejected by MCSP.

Paper form submission:

Paper Form Item 18: Mark appropriate value: current use, prior use, never used or unknown.

Do not leave this data item blank. If unknown, enter “9” or “Unknown.”
Supporting text documentation for selected data value must be entered in Paper Form Field 95: TEXT - PHYSICAL EXAM even when value is “9” or “Unknown.”

Electronic submission:

Enter whether or not the patient has a history of tobacco use (cigarettes, pipe, cigars, snuff, or chew.)

This is a Michigan-specific data item. Starting with data submitted in NAACCR version 13, facilities that submit electronic abstract data to MCSP must coordinate with their software vendors to ensure that this data value is recorded in NAACCR record layout. Abstracts submitted with incorrect format or missing values will be rejected by MCSP.

Do not leave this data item blank. If unknown, enter "9."
Supporting text documentation for selected data value must be entered in TEXT--DX PROC--PE field even when value is "9."

Tobacco History Data Values

Code	Current	Prior	Never
1	Yes	Blank	Blank
2	Blank	Yes	Blank
3	Blank	Blank	Yes
9	Blank (Unknown)	Blank (Unknown)	Blank (Unknown)

Item: TOTAL DOSE

NAACCR Item 1533
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: TUMOR DEPOSITS (SSDI)

NAACCR Item 3934
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: TUMOR GROWTH PATTERN (SSDI)

NAACCR Item 3935
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: TUMOR SIZE CLINICAL

NAACCR Item 752
This data item applies to cases diagnosed 1/1/2016 and forward only.

For description, rationale, and coding instructions for this data item, refer to NCI SEER

Item: TUMOR SIZE PATHOLOGIC

NAACCR Item 754
This data item applies to cases diagnosed 1/1/2016 and forward only.

For description, rationale, and coding instructions for this data item, refer to NCI SEER

Item: TUMOR SIZE SUMMARY

NAACCR Item 756
This data item applies to cases diagnosed 1/1/2016 and forward only.
This refers to size measured on the surgical resection specimen, when surgery is administered as the first definitive treatment, i.e., no pre-surgical treatment administered. If neoadjuvant therapy is followed by surgery, do not record the size from the pathologic specimen. Code the largest size of tumor prior to neoadjuvant treatment; if unknown code size as 999.

For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR) and CoC STandards for Oncology Registry Entry (STORE) Manual

Item: TYPE OF REPORTING SOURCE

NAACCR Item 500
For description, rationale, and coding instructions for this data item, refer to NCI SEER

Item: ULCERATION (SSDI)

NAACCR Item 3936
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: VISCERAL AND PARIETAL PLEURAL INVASION (SSDI)

NAACCR Item 3937
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: VITAL STATUS

NAACCR Item 1760
For description, rationale, and coding instructions for this data item, refer to NCI SEER and CoC STandards for Oncology Registry Entry (STORE) Manual

Item: VITAL STATUS RECODE

NAACCR Item 1762
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

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Follow-Up Work on Reported Cases

Contact with the reporting entity concerning an individual cancer report or a specific patient will occur under four separate circumstances. As is consistent with Administrative Rules; the cooperation of facility personnel in these four areas is essential. Should problems or concerns arise, please feel free to contact the office.

1. As cancer reports are received and processed, each will be reviewed for completeness, legibility and consistency. Contact with the reporting entity will occur to resolve identified problems in these areas as reports are initially processed and later as final processing occurs. Contacts will generally be by e-mail (with no patient identifiers) or phone. Prompt attention to such issues by the personnel responsible for completing these reports is important for smooth processing.

2. In assessing the quality of the cancer reports received from across the state, the office will contact hospitals, laboratories or registries for access to or copies of pertinent records. This is necessary in order to evaluate the quality and completeness of the information received from individual reporting entities. Problems that are identified during such reviews will be addressed as necessary to maintain or improve data quality and usefulness.

3. Contact may also occur to conduct approved epidemiological research projects. When a research study is approved by the Director of the Michigan Department of Health and Human Services, study subjects will be drawn from the state registry. Hospitals, laboratories and registries will be contacted concerning each case reported by them to ascertain the physician treating the patient. Through this process, physicians can then be contacted and patient consent obtained.

4. Unlinked Death Survey is part of the department's passive casefinding system. The Michigan Cancer Surveillance Program is required to conduct death clearance at least once a year. Through the death follow back study we add cases yearly which helps to create a more complete state cancer registry.

   Death clearance match of deaths from the official mortality file from the state, territorial, or provincial vital records office (mortality file) are linked to the registry database to identify records that match and those that do NOT match. (Note: For each patient match, the registry record is updated with death and other relevant data from the mortality file.)

   For records in the mortality file with a cancer diagnosis that did not match a central cancer registry record, the MCSP investigates to identify potentially missed incidence cases. If follow-back information is obtained, the case may be added as a missed incidence report. If no information is obtained other than the death certificate, the case is entered into the Michigan central cancer registry database as a DCO (Death Clearance Only).

   When follow-back is required, the MCSP contacts the certifying physician who signed the Certificate of Death. If no information is obtained from the physician on the cancer-related death, the MCSP conducts follow-back based upon county of death.

   If an Unlinked Death Survey is forwarded to a facility, the cancer-related death information could not be obtained from follow-back with the certifying physician, which may include follow-back of a health care provider more closely connected with the diagnosis and /or treatment of the patient.

Unlinked Death Survey Instructions

Please note! The Diagnosis Reported on the MDHHS Survey of Unlinked Cancer Deaths is **ICD-10-CM Cause of Death Code** and is NOT an ICD-O-3 topography code.

1. If a cancer case report for the cancer case death cause was abstracted by the facility, attach a copy of the abstract to the Unlinked Death Survey and return in self-addressed envelope.

2. If a cancer case report for cancer case death cause was not abstracted by the facility, review the patient's medical record(s) to determine if information regarding the patient's diagnosis and/or first course of treatment can be identified.

3. If information regarding the patient's diagnosis and/or first course of treatment can be obtained from review of the patient's medical record(s), please complete the Unlinked Death Survey and return in self-addressed envelope.

   a. Note: If the cancer-related death (cancer diagnosis) was identified as a missed report for the facility, in addition to completing the Unlinked Death Survey, please abstract the case and submit with next file submission.

4. If you are unable to provide the requested information but can provide information on a health care provider more closely connected with the patient's diagnosis and/or first course of treatment, please complete Section 3 (Referral Information) and return Unlinked Death Survey in the self-addressed envelope.

5. If you are unable to provide any information on the patient's cancer related death (or other significant condition of a cancer diagnosis contributing to death but not resulting in the underlying cause), please record **"no information"** on the Unlinked Death Survey and return in the provided self-addressed envelope.

Reportable Conditions

The first step in any casefinding effort is to outline what is reportable. The administrative rules on cancer reporting provide the definition of a reportable cancer. ALL cases satisfying this definition are reportable. The residence of the patient is NOT a factor.

Cases diagnosed on or after **January 1, 1985 to date** MUST be reported to the Michigan Cancer Surveillance Program **within 180 days or six months from the date of initial diagnosis**.

"Cancer" means all diagnoses with a behavior code of "2" (carcinoma in situ) or "3" (malignant primary site) as listed in the most recently amended International Classification of Diseases for Oncology, EXCLUDING basal, epithelial, papillary and squamous cell carcinomas of the skin, but **including** carcinomas of the skin prepuce, clitoris, vulva, labia, penis and scrotum.

Carcinoma in situ of the cervix (CIS) and intraepithelial neoplasia grade III (8077/2) of the cervix (CIN III), vulva (VIN III), vagina (VAIN III), and anus (AIN III) are all reportable conditions.

Juvenile astrocytoma listed as 9421/**1** in ICD-O-3 are required and should be recorded as 9421/**3**, thereby making it a reportable condition.

Once a tumor has been identified, it is assigned a six digit morphology code (e.g. 8522/34) from the International Classification of Diseases for Oncology, Third Edition (ICD-O-3) coding book. The first four digits record the cell type or histology. The fifth digit, after the slash or solidus (/), is the behavior code and the sixth digit is the tumor grade. ALL tumors assigned a fifth digit behavior code of “2” or “3” in the ICD-O-3 are reportable.

ICD-O-3 Fifth Digit Behavior Codes for Neoplasms

Behavior Code	Definition	Reportable	Non-Reportable
/0	Benign EXCEPTION: Brain and CNS		**X**
/1	Uncertain whether benign or malignant • Borderline malignancy • Low malignant potential • Uncertain malignant potential EXCEPTION: Brain and CNS		**X**
/2	Carcinoma In Situ • Intraepithelial • Non-infiltrating • Noninvasive	**X**	
/3	Malignant, primary site	**X**	
/6*	Malignant, metastatic site • Malignant, secondary site		**X**
/9*	Malignant, uncertain whether primary or metastatic site * Not used by cancer registries.		**X**

NOTE*:* Screening of diagnostic codes for behavior codes “6 - malignant, metastatic site,” and “9 - malignant, uncertain whether primary or metastatic site” is necessary for casefinding. If this is the

first diagnosis of this cancer and even though it is the metastatic site, it is still a reportable condition. The first time a diagnosis of cancer is made with an "unknown primary" it should be reported as such. If the primary site is determined after further study and it was originally reported as an unknown primary, a correction MUST be reported. The behavior code of "6" is only allowed to be used by central registries. When reporting an unknown primary site, a behavior code "3 - malignant" must be used.

Benign/Borderline Intracranial and CNS Tumors

Non-malignant primary intracranial and central nervous system tumors diagnosed on or after **October 1, 2004** with an ICD-O-3 behavior code of "0" or "1" are required for the following sites:

- Meninges (C70.0 – C70.9)
- Brain (C71.0 – C71.9)
- Spinal cord, cranial nerves, and other parts of the central nervous system (C72.0 – C72.9)
- Pituitary gland (C75.1)
- Craniopharyngeal duct (C75.2)
- Pineal gland (C75.3)

Those facilities approved by the American College of Surgeons (ACoS) began collecting non-malignant primary intracranial and central nervous system tumors on January 1, 2004.

For benign/borderline intracranial and central nervous system tumors, the terms "tumor" and "neoplasm" are considered clinically diagnostic for the purpose of case reporting, in addition to the terms generally applicable to malignant tumors.

Diagnoses using the terms "hypodense mass" or "cystic neoplasm" are NOT reportable.

If the final **pathologic** (tissue sample) diagnosis is "CNS neoplasm" or "mass," there MUST be an ICD-O-3 code for the mass or neoplasm. If there is not an ICD-O-3 code, the case is NOT reportable.

If only a clinical diagnosis of "CNS tumor" or "neoplasm" is available, then the case is reportable with the histology is coded as M-8000/1 (Neoplasm, NOS, uncertain whether benign or malignant.)

General Rules

- No timing rules for CNS neoplasms
- Laterality not used to determine multiple primaries
- Multiple cerebral meningiomas are a single primary

Laterality for CNS sites

While laterality is not considered in determining multiple CNS primaries, laterality is assigned to certain CNS sites. Per Michigan central registry rules (which follow SEER rules), the following CNS sites defined as paired for cases diagnosed 1/1/2004 and after:

- Cerebral meninges C70.0
- Cerebrum C71.0
- Frontal lobe C71.1
- Temporal lobe C71.2
- Parietal lobe C71.3
- Occipital lobe C71.4
- Olfactory nerve C72.2
- Optic nerve C72.3
- Acoustic nerve 72.4
- Cranial nerve, NOS C72.5

- Assign laterality as “0” for all other CNS sites

Reportable Pre-Invasive Cervical (C53) Conditions

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

Examples:

5/4/18 - Final diagnosis on the pathology report is “CIN III” or if described only as “severe dysplasia”
Code histology as 8077.

3/15/19 - Final diagnosis on the pathology report is “high grade squamous intraepithelial neoplasia (HSIL).”
Code histology as 8077. Do not code the histology as 8070 in this instance.

For pre-invasive cervical lesions, cases identified by only a PAP smear **are not** eligible for inclusion. The diagnosis must be confirmed by some other method, which could include a clinical diagnosis (physician’s statement) or positive tissue biopsy.

For Cervical Intraepithelial Neoplasia, Grade III, code Local Tumor Excision, Excisional Biopsy, Dilation and Curettage, Cone 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:

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 conditions are considered reportable and MUST be reported to the Michigan Cancer Surveillance Program by all providers **regardless of facility type.**

Instructions for Coding Histology and Histology Terminology for Pre-invasive (Non-invasive) Lesions

Do not use a physician’s statement to decide whether the patient has a recurrence of a previous cancer or a new primary unless a pathologist compares the present tumor to the “original” tumor and specifically states that the new tumor is a recurrence of cancer from the previous primary. Refer to the Multiple Primary & Histology Coding Rules Manual to determine single vs. multiple tumors.

Assigning Sequence Numbers

These pre-invasive lesions must be coded in sequence range 00-59. **Do not use the 60-88 non-malignant sequence range or sequence 98 for these lesions** as these cases are required by the MCSP (not reportable by agreement.)

Included Histologies
Use histology code 8077/2 for diagnoses of HSIL or HGSIL with CIN or CIS as determined by diagnosis year (Solid Tumor Rules – Rule H21). **All 8077 lesions are to have a coded Grade/Differentiation value of 9.**

Lesions with ICD-O-3 histology codes 8010, 8050, 8052, 8070, 8071, 8072, 8076, 8077, and 8140 are eligible for inclusion. Lesions with histology code 8560 and behavior code 2 may also be eligible if it is determined that behavior code 2 is appropriate – the pathology report should specifically indicate "in situ" behavior [since histology 8560 (adenosquamous carcinoma) is normally an invasive cancer.] An entry should be made in pathology text field to the effect that "eligibility is confirmed for this 8560 case."

Number of Reportable Conditions
All types of squamous histologies (8010, 8050, 8052, 8070, 8071, 8072, 8076, and 8077) are considered to be the same for determining inclusion eligibility when reviewing multiple reports for the same patient. If a patient has more than one lesion with these squamous histologies **within a 12-month period,** only the lesion with earliest diagnosis date (or one lesion, if the lesions have the same diagnosis date) is eligible for inclusion.

Histology codes 8140 (adenocarcinoma in situ) and 8560 (adenosquamous carcinoma) with behavior code 2 are considered to be the same for determining inclusion eligibility when reviewing multiple reports for the same patient. If a patient has more than one lesion with either of these histologies **within a 12-month period,** only the lesion with earliest diagnosis date (or one lesion, if the lesions have the same diagnosis date) is eligible for inclusion.

A subsequent lesion is eligible for inclusion **only if its histology is different** from the first eligible lesion. If a lesion is described as having both squamous cell carcinoma in situ **and** adenocarcinoma in situ, then it should be entered as two separate abstracts, one with each histology code.

If a patient is diagnosed with another pre-invasive lesion with the same histology **after** the 12-month period following the first eligible lesion, the subsequent lesion is eligible for inclusion.

If a patient has **both** an in situ and invasive diagnosis **on the same date,** or if the invasive diagnosis follows a previously included in situ diagnosis **within 60 days,** the in situ diagnosis is no longer considered to be eligible and should be removed from the database. However, the date of diagnosis should remain the date the in situ tumor was diagnosed.

If a patient has an invasive tumor diagnosed **more than 60 days after** the in situ tumor was diagnosed, then the invasive tumor is reported as a second primary tumor.

If a patient is diagnosed with a pre-invasive (in situ) lesion **within a 12-month period after** having been diagnosed with an invasive lesion, the pre-invasive lesion is not considered to be eligible for inclusion.

If separate tumors are diagnosed on the same date with differing histologies (adenocarcinoma, CIN III), a separate abstract is to be created for each tumor per the terminology used in the pathology description.

For pre-invasive cervical lesions, cases identified by only a PAP smear **ARE NOT** eligible for inclusion. The diagnosis must be confirmed by some other method, which could include a clinical diagnosis (physician's statement) or positive tissue biopsy.

The MCSP has provided the following Case Definitions for Pre-Invasive Cervical Lesions (C53):

FOR CASES DIAGNOSED PRIOR TO 2019

The reporting requirements for pre-invasive cervical lesions diagnosed through 2018 have been revised due to CDC NPCR granting funding of MCSP collection of pre-invasive cervical lesions.

The case definitions for pre-invasive cervical lesions (C53) for newly abstract cases diagnosed ***prior* to 2019** are as follows:

Eligible Cases
The determination of whether a case is reportable to MCSP is based on the information included in the pathology report, particularly in the section describing the final diagnosis.
Cases identified by only a cytology report are not eligible for inclusion.
Below is a summary of the inclusion criteria for determination of an eligible case (also see **Exhibit 1 & Exhibit 2**).

- Synonyms for in situ carcinoma may include: CIN grade III, confined to epithelium, intraepidermal, intraepithelial, involvement up to but not including the basement membrane, noninfiltrating, noninvasive, no stromal involvement, papillary noninfiltrating.

    - Other synonyms for pre-invasive cervical lesions may include: HSIL, HGSIL (high grade squamous intraepithelial neoplasia). However, for cases diagnosed ***prior to 2019***, a diagnosis of **HSIL/HGSIL alone** (i.e. without terminology of AIS, CIS, CIN3, or severe dysplasia alone) need to be clearly identifiable upon submission of the case report to MCSP. Record the histologically confirmed diagnosis in its entirety, exactly as it appears in the final diagnosis of the pathology report in the Path-Text Field. If multiple terms are used, include all of them.

- All cases diagnosed as "CIN III", "CIS", or "AIS" are eligible. If a pathologist does not use the CIN terminology and only provides an assessment using the dysplasia scale, then cases listed as "severe dysplasia" alone are eligible.

- For any case that comes in with a histology code other than those listed, the pathology report should be carefully reviewed to make sure that it is not an invasive lesion (path report should specifically indicate "in situ" behavior) and that the histology has been coded accurately.

- Review the histologically confirmed diagnosis in its entirety to determine if any reportable conditions exist based on all reported terminology and staining results included in the pathology report. If necessary, check with lab to locate immunostaining information in patient record.

Exhibit 1 – Eligibility/Inclusion Criteria

Site (ICD-O-3)	C53.0 (endocervix) C53.1 (exocervix) C53.8 (overlapping lesions of cervix uteri) C53.9 (cervix uteri)
Behavior	2 (in situ or non-invasive)

Histology	8010/2 Carcinoma in situ, NOS 8050/2 Papillary carcinoma in situ 8052/2 Papillary squamous cell carcinoma, non-invasive 8070/2 Squamous cell carcinoma in situ, NOS 8071/2 Squamous cell carcinoma, keratinizing, NOS, in situ 8072/2 Squamous cell carcinoma, large cell, non-keratinizing, in situ 8076/2 Squamous cell carcinoma in situ with question(able) stromal invasion 8077/2 Squamous intraepithelial neoplasia grade III 8140/2 Adenocarcinoma in situ
Pathologic Classification	CIN III, CIS, AIS ***or*** **"Severe dysplasia"** alone is reportable **only** in cases in which the pathologist does not use the CIN terminology and only provides an assessment using the dysplasia scale terminology "severe dysplasia."

Exhibit 2 – MCSP Reportable Pre-Invasive Cervical (C53) Conditions

Reportable Conditions				
ICD-10-CM Code	**ICD-9-CM Code**	**Diagnostic Description**	**Histology Code**	**Topography Code**
D06. __	233.1	CIN III (cervical intraepithelial neoplasia - histologically confirmed) **with or without** carcinoma in situ (CIS) is reportable. *"Severe dysplasia" alone is reportable **only** in cases in which the pathologist does not use the CIN terminology and only provides an assessment using the dysplasia scale terminology "severe dysplasia."*	8077/2	C53.0 - C53.9
D06. __	233.1	HSIL/HGSIL (high-grade squamous intraepithelial lesion - histologically confirmed) **with or without** carcinoma in situ (CIS)or **with or without** CIN III is reportable. *"High grade dysplasia" **alone is <u>not</u> reportable***	8077/2	C53.0 - C53.9

Examples:

Reportable CIN combination terms

- "CIN 2 **and** 3" is reportable
- "CIN 2 **&** 3" is reportable
- "CIN 2 **+** 3" is reportable
- "Severe dysplasia" alone is reportable only in cases in which the pathologist does not use the CIN terminology and only provides an assessment using the dysplasia scale terminology "severe dysplasia."

Not Reportable

- **"**CIN 2**-**3" alone is **<u>not</u>** reportable
- "CIN 2**/**3" alone is **<u>not</u>** reportable
- "Moderate <u>to</u> severe dysplasia" alone is **<u>not</u>** reportable
- "High grade dysplasia" alone is **<u>not</u>** reportable

Note: A case is reportable when at least one reportable condition is mentioned in the path report, regardless of whether additional non-reportable conditions are also mentioned.

Examples:

- Pathology report gives the following diagnosis: CIN 2/3 (CIN III).
  *Although CIN 2/3 alone is not reportable, CIN III **is reportable**. Therefore, this case should be reported to MCSP. Make sure the full diagnosis is reported, including all terminology and all staining information, type of test (i.e. p16) and the results in the Path-Text Field.*

- Pathology report gives the following diagnosis: CIN 2 (HSIL/HGSIL).
  *Although CIN 2 alone is not reportable, HSIL (HGSIL) **is reportable**. Therefore, this case should be reported to MCSP. Make sure the full diagnosis is reported, including all terminology and all staining information, type of test (i.e. p16) and the results in the Path-Text Field.*

- Pathology report gives the following diagnosis: CIN 2/3 (Severe dysplasia).
  *Although the term "severe dysplasia" is included in the diagnosis, CIN terminology is also included. Severe dysplasia is only reported when no reportable CIN terminology is used. Since a CIN term is present that is not reportable, CIN 2/3, this case **is not** reportable.*

Case Finding

- Case finding sources will include pathology laboratories—private, reference, and hospital.
- Case finding is to be performed by manual review of pathology reports or an electronic search using CIN related key words or phrases, ICD-9 CM codes or ICD-10-CM codes.
- The appropriate ICD-9-CM code is 233.1 (CIN III/CIS/Severe Dysplasia).
- The appropriate ICD-10-CM code is D06. __ (CIN III/CIS/Severe Dysplasia).
- **Exhibit 3** provides a list of eligible SNOMED codes.

Exhibit 3 - Eligible SNOMED codes for cases diagnosed ***prior to 2019***.

Histology	SNOMED Concept ID	SNOMED Legacy Code
Adenocarcinoma in situ	51642000	M-81402
Squamous cell carcinoma in situ	59529006	M-80702
Squamous Intraepithelial Neoplasia Grade III	20365006	M-80772

Submission of Pre-Invasive Cervical Cancer Case Reports

1. All reportable pre-invasive cervical lesions (C53) are required to be submitted to the MCSP regardless of facility type ***within 180 days (6 months) from the date of initial diagnosis***.
2. A complete case report is required.
3. Electronic submission files through Web Plus must be free of edit errors.
4. TEXT is a required data item.
5. Record the histologically confirmed diagnosis in its entirety, exactly as it appears in the final diagnosis of the pathology report. If multiple terms are used, include all of them.

   Examples:
   - "High grade squamous intraepithelial lesion (severe dysplasia/CIN III)"
   - "HGSIL (severe dysplasia/squamous cell carcinoma in situ)"
   - "Endocervical adenocarcinoma in situ (AIS).
   - "CIN2/3 (CIN3)
   - "Moderate to severe dysplasia (CIN3)"

Record all pertinent data regarding staining information in the Path-Text Field (for MCSP processing of these types of case reports). For example: If p16 and/or Ki-67, ProEx C IHC (Immunohistochemistry) staining is performed, record the type of the test (i.e. p16, Ki-67, ProEx C) and the results (i.e. positive, negative). For these pre-invasive cervical cases, please enter all staining information in the Path Text Field rather than the Lab Field due to how these cases are reviewed and processed at the central registry.

The MCSP has provided the following Case Definitions for Pre-Invasive Cervical Lesions (C53):

FOR CASES DIAGNOSED IN 2019 AND FORWARD

Reporting requirements for pre-invasive cervical lesions diagnosed in 2019 and later are currently under review by CDC. MCSP will notify you when those requirements are finalized and posted.

Reportable AIN III, VAIN III, VIN III Conditions

Included Histologies
Use histology code 8077/2 for diagnoses of VIN III, VAIN III, or AIN III (Solid Tumor Rules – Rule H21). **All 8077 lesions are to have a coded Grade/Differentiation value of 9.**

Lesions with ICD-O-3 histology codes 8010, 8050, 8052, 8070, 8071, 8072, 8076, 8077, and 8140 are eligible for inclusion. Lesions with histology code 8560 and behavior code 2 may also be eligible if it is determined that behavior code 2 is appropriate – the pathology report should specifically indicate "in situ" behavior [since histology 8560 (adenosquamous carcinoma) is normally an invasive cancer.] An entry should be made in pathology text field to the effect that "eligibility is confirmed for this 8560 case."

Number of Reportable Conditions
All types of squamous histologies (8010, 8050, 8052, 8070, 8071, 8072, 8076, and 8077) are considered to be the same for determining inclusion eligibility when reviewing multiple reports for the same patient. If a patient has more than one lesion with these squamous histologies **within a 12-month period,** only the lesion with earliest diagnosis date (or one lesion, if the lesions have the same diagnosis date) is eligible for inclusion.

Histology codes 8140 (adenocarcinoma in situ) and 8560 (adenosquamous carcinoma) with behavior code 2 are considered to be the same for determining inclusion eligibility when reviewing multiple reports for the same patient. If a patient has more than one lesion with either of these histologies **within a 12-month period,** only the lesion with earliest diagnosis date (or one lesion, if the lesions have the same diagnosis date) is eligible for inclusion.

A subsequent lesion is eligible for inclusion **only if its histology is different** from the first eligible lesion. If a lesion is described as having both squamous cell carcinoma in situ **and** adenocarcinoma in situ, then it should be entered as two separate abstracts, one with each histology code.

If a patient is diagnosed with another pre-invasive lesion with the same histology **after** the 12-month period following the first eligible lesion, the subsequent lesion is eligible for inclusion.

If a patient has **both** an in situ and invasive diagnosis **on the same date,** or if the invasive diagnosis follows a previously included in situ diagnosis **within 60 days,** the in situ diagnosis is no longer considered to be eligible and should be removed from the database. However, the date of diagnosis should remain the date the in situ tumor was diagnosed.

If a patient has an invasive tumor diagnosed **more than 60 days after** the in situ tumor was diagnosed, then the invasive tumor is reported as a second primary tumor.

If a patient is diagnosed with a pre-invasive (in situ) lesion **within a 12-month period after** having been diagnosed with an invasive lesion, the pre-invasive lesion is not considered to be eligible for inclusion.

If separate tumors are diagnosed on the same date with differing histologies (adenocarcinoma, AIN-III), a separate abstract is to be created for each tumor per the terminology used in the pathology description.

The diagnosis must be confirmed by a positive tissue biopsy or a clinical diagnosis (physician's statement).

ICD-10-CM Code	Primary Site	Histology Code	Topography Code
D01.3	• AIN III (anal intraepithelial neoplasia - histologically confirmed) • "Severe dysplasia" of anus ***alone is reportable*** • "High grade dysplasia" of anus ***alone is not reportable*** • Note: High grade dysplasia is reportable only with documentation of physican statement of in-situ disease	8077/2	C21.1
D07.2	• VAIN III (vaginal intraepithelial neoplasia) with or without carcinoma in situ (CIS) • "Severe dysplasia" of vagina ***alone is reportable*** • "High grade dysplasia" of vagina ***alone is not reportable***	8077/2	C52.0-C52.9
D07.1	• VIN III (vulvar intraepithelial neoplasia - histologically confirmed) with or without carcinoma in situ (CIS) • "Severe dysplasia" of vulva ***alone is reportable*** • "High grade dysplasia" of vulva ***alone is not reportable***	8077/2	C51.0-C51.9

Non-Reportable AIN I/III, CIN I/II, LSIL, VAIN I/II, VIN I/II, PIN I/II/III Conditions

ICD-10-CM Code	Primary Site	Histology Code	Topography Code
K62.82	AIN I (anal intraepithelial neoplasia) with or without mild dysplasia	8077/0	C21.1

ICD-10-CM Code	Primary Site	Histology Code	Topography Code
K62.82	AIN II (anal intraepithelial neoplasia) with or without moderate dysplasia	8077/0	C21.1
N87.0	CIN I (cervical intraepithelial neoplasia) with or without mild dysplasia	8077/0	C53.0 - C53.9
N87.1	CIN II (cervical intraepithelial neoplasia) with or without moderate dysplasia	8077/0	C53.0 - C53.9
N89.3	LSIL (low-grade squamous intraepithelial lesion) with or without mild dysplasia	8077/0	C53.0 - C53.9
N89.3	VAIN I (vaginal intraepithelial neoplasia) with or without mild dysplasia	8077/0	C52.9
N89.3	VAIN II (vaginal intraepithelial neoplasia) with or without moderate dysplasia	8077/0	C52.9
N90.0	VIN I (vulvar intraepithelial neoplasia) with or without mild dysplasia	8077/0	C51.0 - C51.9
N90.1	VIN II (vulvar intraepithelial neoplasia) with or without moderate dysplasia	8077/0	C51.0 - C51.9
N42.3	PIN I (prostatic intraepithelial neoplasia)	8077/0	C61.9
N42.3	PIN II (prostatic intraepithelial neoplasia)	8077/0	C61.9
D07.5	PIN III (prostatic intraepithelial neoplasia)	8077/0	C61.9

Reportable Vs. Non-Reportable Conditions of the Skin

The Michigan Cancer Surveillance Program has exclusions to the collection of skin malignancies based upon the primary site and histology.

If the following histologies arise in the skin (C44.0 - C44.9) they are NOT reportable regardless of the stage at the initial time of diagnosis.

- Malignant Neoplasm (Carcinoma), NOS of the skin 8000 - 8004
- Epithelial Neoplasms (Carcinoma), NOS of the skin 8010 - 8045
- Papillary and Squamous Cell Neoplasm (Carcinoma) of the skin 8050 - 8082
- Basal Cell Neoplasm (Carcinoma) of the skin 8090 - 8110

EXCEPTION: The above histologies must be reported if the primary site is skin of the male and female genital sites. See “Reportable vs. Non-Reportable Conditions of the Skin” table below.

ALL other histologies of the skin ARE REPORTABLE, e.g.: melanoma, Kaposi sarcoma, mycosis fungoides, cutaneous lymphomas, Merkel cell carcinoma, etc.

Reportable vs. Non-Reportable Conditions of the Skin

ICD-10-CM Code	Primary Site	Topography Code	Reportable	Non-Reportable
C52	Skin of vagina	C52.9	X	
C51.2	Skin of labia majora	C51.0, C51.1	X	
C51.1	Skin of labia minora	C51.1	X	
C51.2	Skin of clitoris	C51.2	X	
C51.9	Skin of vulva, NOS	C51.9	X	
C57.8	Skin, overlapping lesion	C51.9	X	
C60.0	Skin of prepuce	C60.0	X	
C60.9	Skin of penis, NOS	C60.9	X	
C63.2	Skin of scrotum	C63.2	X	
C44.00 C44.01 C44.02 C44.09	***Skin of lip (see note below)**	C44.0		X
C44.101 C44.111 C44.121 C44.191	Skin of eyelid/other unspecified parts of the face	C44.2		X
C44.201 C44.211 C44.221 C44.291	Skin of external ear/auditory canal	C44.2		X
C44.300 C44.301 C44.309 C44.310 C44.311 C44.319 C44.320 C44.321 C44.329 C44.390 C44.391 C44.399	Skin of other & unspecified parts of the face	C44.3		X
C44.40 C44.41 C44.42 C44.49	Skin of scalp and neck	C44.4		X
C44.509 C44.519 C44.529 C44.599	Skin of anus & skin of trunk (except scrotum)	C44.5		X
C44.601 C44.611 C44.621 C44.691	Skin of upper limb and shoulder	C44.6		X

ICD-10-CM Code	Primary Site	Topography Code	Reportable	Non-Reportable
C44.701 C44.711 C44.721 C44.791	Skin of lower limb and hip	C44.7		X
C44.80 C44.81 C44.82 C44.89	Skin, overlapping lesion	C44.8		X
C44.90 C44.91 C44.92 C44.99	Skin, NOS	C44.9		X

Note: *Skin of the lip:

- The codes for the mucoepidermoid portions of the lip are C00.0 - C00.9. These include the inner mucosal surface of the lip, the vermilion surface of the lip (the area where lipstick is applied and the vermilion border of the lip). Report these C00 cases.
- C44.0 is the code for the SKIN of the upper lip between the vermilion border and the nose and SKIN of the lower lip between the vermilion border and the chin. DO NOT report these C44 cases.

Cancer Case Reportability Scenarios

The following scenarios and definitions are to assist with determining whether or not the patient has a reportable condition.

Reportable Case Scenarios

1. If a lesion is originally assigned a behavior code of “0 - benign” or “1 - uncertain” and is later assigned a behavior code of “2 - in situ” or “3 - malignant” by the pathologist, the case is reportable.

2. If a lesion is originally assigned a behavior code of “0 - benign” or “1 - uncertain” and is later assigned a behavior code of “2 - in situ” or “3 - malignant” by the managing physician, the case is reportable.

3. If a specimen is sent to your facility from a staff physician’s office and read by your pathologist (e.g., pap smear, stereotactic needle biopsy for a breast mass, or excisional biopsy for a suspicious skin lesion) the case is to be reported.

4. An incidental finding of a malignancy at the time of an autopsy, with no suspicion of cancer prior to death, MUST be reported.

5. All malignant histologically confirmed specimens identified by your facility, e.g., tissue specimens from biopsy, frozen section, surgery, autopsy, or dilation and curettage (D&C); bone marrow biopsy, bone marrow aspiration; hematologic confirmation of leukemia (peripheral blood smear); loop electrocautery excision procedure (LEEP), are reportable.

6. All malignant cytological confirmed specimens identified by your facility, e.g.,, breast secretion, bronchial brushing, bronchial washings, cervical smear (pap smear), fine needle aspirate (FNA), gastric fluid, peritoneal fluid, pleural fluid, prostatic secretions, spinal fluid, sputum smears, tracheal washings, urinary sediment, vaginal smears, are reportable.

7. Patient is diagnosed in a staff physician's office and treated at your facility.

8. Patient is diagnosed at your facility and treated elsewhere, whether by referral or by choice.

9. Patient is diagnosed at your facility and receives all or part of his/her treatment at your facility.

10. Patient is diagnosed at your facility and refuses therapy.

11. Patient is diagnosed at your facility and the family/guardian refuses therapy.

12. Patient is diagnosed at your facility and is untreatable due to age, advanced disease or other medical conditions.

13. Patient is diagnosed at your facility and specific therapy was recommended but not received at your facility or unknown if administered.

14. Patient was diagnosed elsewhere, but received all or part of his/her treatment at your facility.

15. Patient is diagnosed at your facility but unknown if therapy was recommended or administered.

16. Patient was diagnosed by death certificate only.

17. Patient receives all or part of the first course of therapy for a malignancy, regardless of where they were first diagnosed.

18. Patient is a non-resident of Michigan and is receiving treatment at your facility.

19. Patient is a Michigan resident diagnosed out of state but receiving treatment at your facility.

20. Patient is a Michigan resident diagnosed and treated out of state, e.g., The patient is diagnosed and treated in Wisconsin for breast cancer, but is admitted to the cardiac care unit at your facility. You recognize that the patient has breast cancer and is receiving their first course of treatment in Wisconsin. The patient is a Michigan resident, therefore the case is reportable.

Non-Reportable Case Scenarios

1. Precancerous or benign conditions (except benign or borderline intracranial CNS tumors).

2. Patients seen only in consultation to establish or confirm a diagnosis of cancer or treatment plan when the patient was first seen in a known Michigan facility.

3. Patient is diagnosed with a recurrence or progression of a previously diagnosed malignancy. Note: Consult Solid Tumor Rules effective 1/1/2018 under General Instructions/Timing Rule on usage of the term "recurrence."

4. The patient's malignancy was originally diagnosed prior to January 1, 1985.

5. Patient receives a radiographic exam (MRI, X-ray, CT) which reveals an ill-defined “mass.” If the patient does NOT return to your facility for diagnostic confirmation or treatment of cancer, the case is not reportable. For example: an outpatient CT scan of the pelvis reads, probable carcinoma of the right kidney. The patient did not return to your facility for diagnostic confirmation or treatment; therefore the case is not reportable.

   NOTE: In order for a “radiographic diagnosis” to be reportable, the patient’s primary care physician MUST state in the medical record that the patient has cancer and treatment has been decided upon. Keep in mind, that refusal of treatment and the decision not to treat is still classified as treatment and the case is to be reported.

6. Patient visits your facility for blood work (lab only) and is NOT admitted for treatment, e.g., blood drawn to monitor anemia for patients receiving chemotherapy elsewhere; blood drawn to monitor PSA levels for prostate cancer.

7. Patient has an active malignancy but is admitted to your facility for an unrelated medical condition and does not receive first course of treatment for their cancer.

8. Patient is admitted to your facility with an active malignancy and receives supportive or palliative care, e.g., gastrostomy tubes for enteral nutrition, if previously reported or diagnosed/treated through another Michigan hospital.

9. Patients with a history of cancer who are clinically free of disease.

10. Patients admitted for terminal supportive care, including home care services, if previously reported or diagnosed/treated through another Michigan hospital.

11. Patients admitted to a designated hospice, if previously reported or diagnosed/treated through another Michigan hospital.

12. Patient’s specimen slides are sent to your pathologist for a second opinion.

13. Patients with skin cancer that does NOT meet the histology and site requirements listed previously.

Facility Specific Case Scenario

Your facility may receive specimens from a separate facility that are read by your pathologist due to the facility not having a pathologist or a laboratory. Once the specimen is read, the final report and specimen(s) are sent back to the original facility. You may or may not be responsible for reporting the ones that are malignancies. A verbal or written contract between the two facilities must exist that designates which facility will be responsible for reporting these cases to the Michigan Cancer Surveillance Program. If an agreement does NOT exist, BOTH facilities are expected to report each case.

Ambiguous Terminology

As part of the registry case-finding activities, ALL pathology reports should be reviewed to confirm whether a case is required. If the terminology is ambiguous, use the following guidelines to determine whether a particular case should be included. Words or phrases that appear to be synonyms of these terms **do not** constitute a diagnosis. For example, "likely" alone does not constitute a diagnosis.

Ambiguous terms may originate from any source document, such as pathology report, radiology report, or from a clinical report.

NOTE: The ambiguous terms in this section are used to determine diagnostic reportability to MCSP. The following list is NOT used to determine multiple tumors or AJCC TNM Staging.

- Consult the Solid Tumors Rules manual and appropriate AJCC TNM Staging Manual for allowable terminology.

- See "Ambiguous terminology for hematopoietic and lymphoid neoplasm" heading on next page for information concerning non-solid tumors.

Ambiguous terms that **constitute a diagnosis:**

- Apparent(ly)
- Appears
- Comparable with
- Compatible with
- Consistent with
- Favors
- Malignant appearing
- Most likely
- *Neoplasm (only applies to sites C70.0 - C72.9 and C75.1 - C75.3 diagnosed 2004 and later)
- Presumed
- Probable
- Suspect(ed)
- Suspicious (for)
- *Tumor (only applies to sites C70.0 - C72.9 and C75.1 - C75.3 diagnosed 2004 and later)
- Typical of

Note: * these terms apply to nonmalignant primary intracranial and central nervous system tumors only

EXCEPTION: If a cytology is identified only with an ambiguous term, **do not** interpret it as a diagnosis of cancer.

- Abstract the case only if a positive biopsy or a physician's clinical impression of cancer supports the cytology findings.

Examples:

The inpatient discharge summary documents a chest X ray consistent with carcinoma of the right upper lobe. The patient refused further work-up or treatment.
"Consistent with carcinoma" is indicative of cancer.

The mammogram report states "suspicious for malignancy."
"Suspicious for malignancy" is indicative of cancer.

Ambiguous terms that **do not constitute a diagnosis without additional information:**

- Cannot be ruled out
- Equivocal
- Possible
- Potentially malignant
- Questionable
- Rule out
- Suggests
- Worrisome

Examples of non-diagnostic terms:

The inpatient discharge summary documents a chest x-ray consistent with neoplasm of the right upper lobe. The patient refused further work-up or treatment.
"Consistent with neoplasm" is not indicative of cancer. While "consistent with" can indicate involvement, "neoplasm" without specification of malignancy is not considered diagnostic except for non-malignant primary intracranial and central nervous system tumors.

Final diagnosis is reported as possible carcinoma of the breast.
"Possible" is not a diagnostic term for cancer.

Genetic findings in the absence of pathologic or clinical evidence of reportable disease are indicative of **risk only** and **do not** constitute a diagnosis.

Ambiguous terminology for hematopoietic and lymphoid neoplasm
Apply the following terminology to non-solid tumor cases diagnosed in 2010 and later. Report the case when the diagnosis of a hematopoietic or lymphoid neoplasm is preceded by one of the following ambiguous terms. For additional information, refer to the Hematopoietic & Lymphoid Neoplasm Coding Manual.

- Apparent(ly)
- Appears
- Comparable with
- Compatible with
- Consistent with
- Favor(s)
- Malignant appearing
- Most likely
- Presumed
- Probable
- Suspect(ed)
- Suspicious (for)
- Typical (of)

Note 1: Use these terms when screening all reports other than cytology and tumor markers.

Note 2: Report cases that use only the words on the list or an equivalent word such as "favored" rather than "favor(s)". Do not substitute synonyms such as "supposed" for "presumed" or "equal" for "comparable with." Do not substitute "likely" for "most likely." See SEER coding manual - Reportability section.

Note 3: Accept the reportable term and report the case when one part of the medical record uses a reportable ambiguous term such as “apparently” and another section of the medical record(s) uses a term that is not on the reportable list.

Note 4: Follow back is recommended for diagnoses based on ambiguous terminology to see if the diagnosis has been confirmed or proven to be incorrect (see note 5).

Note 5: Do not report the case when biopsy or physician’s statement confirms a non-reportable condition or proves the ambiguous diagnosis is wrong.

Example: CT scan shows enlarged lymph nodes suspicious for lymphoma. Subsequent biopsies of the lymph nodes thought to be involved with a neoplasm are negative for malignancy. The pathology is more reliable than the scan; the negative biopsy proves that the ambiguous diagnosis was wrong. Do not report the case.

Note 6: Do not report cases diagnosed only by ambiguous cytology (cytology diagnosis preceded by ambiguous term).

Example: Parotid ultrasound guided FNA: consistent with non-Hodgkin’s lymphoma. This case was diagnosed based on cytology/fine needle aspiration (FNA) preceded by ambiguous terminology (consistent with). Do not report this case based on ambiguous cytology.

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Casefinding Procedures

Casefinding is a systematic process used to identify all cases eligible to be included in the central cancer registry. Cases include those patients that were diagnosed and/or treated with a reportable condition in your facility.

One source for casefinding is not enough to identify all cancer cases diagnosed or treated at your facility and multiple sources must be used to obtain a complete description of each patient's course of cancer care.

At a minimum facilities need to conduct reviews of MDI and pathology reports (benign and malignant) to determine all reportable conditions as well as investigating other sources listed below as applicable based on facility type.

Each facility should have written procedures and instructions for carrying out complete casefinding. This will ensure that casefinding is performed on a regular basis and allow personnel to know the status of casefinding at all times. A written log or tracking system should be in place to monitor all casefinding sources. Casefinding sources may be monitored daily, weekly, monthly or quarterly.

Having a system for recognizing reportable conditions is essential to complete reporting. A process which will identify all cancer cases that are diagnosed or treated within a facility must be devised. All pertinent medical records which may contain information on any case of diagnosed cancer must be reviewed, whether that diagnosis is clinical or histological. The hospital where a diagnosis is reached or a patient is treated must endeavor to report all cases regardless of the patient's status. This includes outpatients and patients diagnosed elsewhere when the place of diagnosis is unknown or is outside the state. An independent laboratory must similarly ascertain needed information upon determining that a reportable condition exists. It is important to report all patients, including patients who do not live in Michigan.

Patients who were diagnosed elsewhere and newly admitted to your facility for further treatment, are to be reported provided the first diagnosis occurred after the start date of the state registry on January 1, 1985. This may result in multiple reports on one patient, but it will enable the MCSP to have the most comprehensive data on each case and serves as a quality control mechanism.

Cancer registries should first examine the sources used to identify malignant CNS tumors and expand the procedures to include non-malignant CNS tumors.

Since surgery is often the treatment for CNS tumors of all behaviors, pathology reports are an excellent casefinding source. Inpatient and outpatient surgery logs should also be reviewed. Many patients with CNS tumors of all behaviors are treated with adjuvant radiation therapy and review of radiation oncology appointment logs is a way to identify these cases.

Gamma/cyber knife is becoming a common treatment for non-malignant CNS tumors. If the hospital has a gamma/cyber knife center, review logs and schedules as part of casefinding. Hormone therapy and immunotherapy are medical treatments given for both non-malignant and malignant CNS tumors.

Reports are necessary for outpatients who are diagnosed as having cancer based upon a laboratory diagnosis of submitted specimens as well as those cases where outpatient surgery is the only means of diagnosis. Outpatients initially treated for cancer who were not diagnosed within a facility should also be reported if receiving outpatient radiotherapy or chemotherapy.

A report is not required when initially treating a patient diagnosed elsewhere if it is known that the patient was first diagnosed and treated in some other Michigan hospital, and you have the name of the diagnosing hospital in the medical record. Patients that have been diagnosed out of state e.g. Mayo Clinic or in an unknown facility, who come to your facility for treatment must be reported. This requirement includes the reporting of "historic" cases that otherwise meet the definition of a reportable case.

In many facilities, these functions and/or record systems are coordinated which can greatly simplify the process of casefinding. What is important, is that all sources of information pertinent to case identification must be reviewed. The development of a coordinated screening of these various files is essential to assuring complete reporting.

A second report is not necessary upon confirmation or re-diagnosis of a specific primary tumor or the metastasis therefrom, if that specific primary is known to have been reported earlier. Send a second report only if the information first reported on the patient requires correction or can be reported more completely than previously known.

It is very important to report all cases regardless of state residency. Data on all cancer cases is of value in several ways. In particular, Michigan currently has resident data exchange agreements with several states concerning cancer cases diagnosed and/or treated within our respective borders. Michigan sends reports of nonresident patients to their state of residency and these states reciprocate by sending MCSP records of MI residents diagnosed or treated for cancer in their state.

When in doubt about submitting a cancer case to the Michigan Cancer Surveillance Program (MCSP), ask these three questions:

1. Does the patient have a diagnosis of cancer that is reportable?
2. Is it a new reportable condition?
3. Was the case diagnosed since the start date of the central registry January 1, 1985?

If the answer is yes to these questions and the case has not yet been submitted by your hospital, report the case.

If you have questions about a particular case, submit the case with an attached note of explanation or call the state registry.

A record of those cases submitted to the central state registry must be maintained. It is recommended for those facilities that submit manually, to make a copy of the completed cancer report form, submit the original form to the state central cancer registry and file the copy alphabetically by last name combining all diagnosis years. For those facilities that submit electronically, a list of cases submitted to the state central cancer registry can easily be generated via the software.

The MCSP recommends retaining copies of the cancer report forms or submission log for a period of three full years. Legislation indicates that an audit may be conducted "not more than once every two years for the purpose of assessing the quality and completeness of cancer reporting." During the audit process, the MDI and submission logs are reviewed. As a result, maintaining these records for a period of three years, will be useful during the audit process.

If a submission log is maintained, it should contain at a minimum, the following items: patient's full name, medical record number, social security number, date of birth, date of diagnosis, primary site, laterality and summary stage. The submission log is not necessarily the best mechanism for keeping

track of those cases submitted to the MCSP, but those facilities that wish to maintain a log are free to do so.

Examples and definitions of sources for casefinding are as follows:

Pathology Reports

Review all pathology reports from the pathology department for reportable conditions on a weekly, monthly or quarterly basis.

If the final pathologic diagnosis is “CNS neoplasm” or “mass,” there must be an ICD-O-3 code for the mass or neoplasm. If there is not an ICD-O-3 code, the case is not reportable.

If the only diagnosis available is “CNS tumor” or “neoplasm” the case is reportable and the histology is coded as M-8000/1 (Neoplasm, NOS, uncertain whether benign or malignant.)

This includes specimens sent to your facility from physician’s offices to be read by the hospital pathologist.

Cytology Reports

Review all cytology reports from the pathology department for reportable conditions on a weekly, monthly or quarterly basis.

This includes pap smears, or specimens sent to your facility from a physician’s offices to be read by the hospital pathologist.

Bone Marrow Reports

Review all bone marrow reports from the pathology department for reportable conditions on a weekly, monthly or quarterly basis.

Autopsy Reports

Review all autopsy reports from the pathology department at least twice a year. Review all diagnoses recorded, not just the cause of death, as occult or unexpected malignancies can be found on autopsy reports. If your facility does not perform autopsies, these reports may be located in the health information department.

Medical Oncology Logs (Chemotherapy)

Chemotherapy is administered either as an inpatient, outpatient, in a free-standing facility or a physician’s office. Develop a system for identifying patients who receive chemotherapy at any facility affiliated with the reporting institution. Review the list of patients on a monthly or quarterly basis. e.g., billing, summary sheet, appointment book, treatment record.

Radiation Oncology Logs

Radiation therapy is administered either as an inpatient, outpatient or in a free-standing facility. Develop a system for identifying patients who receive radiation therapy at any facility affiliated with the reporting institution. Review the list of patients on a monthly or quarterly basis. e.g., billing, summary sheet, appointment book, treatment record.

Radiology

Review CT scans of the head, MRI's of the head and any additional scans of the head to identify reportable benign conditions of the brain and/or central nervous system. Review the reports from radiology on a monthly or quarterly basis.

For benign/borderline intracranial and central nervous system tumors, the terms "tumor" and "neoplasm" are considered diagnostic for the purpose of case reporting, in addition to the terms generally applicable to malignant tumors.

Diagnoses like "hypodense mass" or "cystic neoplasm" are NOT reportable even for CNS sites.

Master Disease Index (MDI)

Generate a MDI on a monthly or quarterly basis by discharge date which is based upon the diagnosis year.

Use the applicable ICD-CM codes from casefinding list to generate the MDI.

Select those patients seen at your facility as an inpatient and/or as an outpatient for surgery, endoscopy, chemotherapy, radiation therapy, etc. **Exclude laboratory visits. Include radiology visits only for benign/borderline brain/CNS tumors.**

List the principle code, primary code and secondary codes to include up to six diagnostic codes that have been assigned.

The MDI should include the following items: last name, first name, middle initial, date of birth, social security number, medical record number, laboratory number (if applicable), admit date, discharge date, patient type, the six ICD-CM codes and ICD-CM code descriptions that have been assigned.

Once the MDI has been generated, it must be compared with the log (or copies) of previously submitted cases. Sort the MDI alphabetically by last name. This will make it easier when comparing the MDI to previously submitted cases.

If the name from the MDI appears on the log of previously submitted cases, determine whether this is a new primary, recurrence or progression of disease from the original primary. (Refer to the Multiple Primary and Histology Coding Rules for clarification.)

- A separate report must be submitted for each new primary.
- Additional reports for recurrence or progression of disease should not be included.

If the name from the MDI does not appear on the log of previously submitted cases, determine whether this a new case, missed case or non-reportable condition.

- A separate report must be submitted for a new or missed case.
- If a non-reportable condition exists, document on the MDI next to the patient's name the condition that was determined to be non-reportable. This will be helpful when reviewing future MDI's.

Examples:

John Doe

NR SCC skin (non-reportable squamous cell carcinoma)
James Doe
NR recurrent bladder cancer

Based upon your facility's needs, it may be beneficial to maintain a separate log of those cases determined to be non-reportable. This can easily be achieved by completing the demographic information only on the cancer report form and documenting the non-reportable condition in the primary anatomical site field.

The MCSP recommends retaining the MDI log for a period of **three full years**. Legislation indicates that an audit may be conducted "not more than once every two years for the purpose of assessing the quality and completeness of cancer reporting." During the audit process, the MDI and submission logs are reviewed. As a result, maintaining these records for a period of three years, will be useful during the audit.

The tables that follow illustrate the applicable ICD-CM codes that should be used to generate the Master Disease Index (MDI).

ICD-9-CM Casefinding List Effective Through September 30, 2015 Only

ICD-9-CM Casefinding List Effective Through September 30, 2015 Only

ICD-9-CM Code	Explanation of Code
140.0 – 172.9, 174.0 – 208.9	Malignant neoplasms: stated or presumed to be primary (of specified sites and certain specified histologies)
209.0 – 209.29	Neuroendocrine tumors
209.30	Malignant poorly differentiated neuroendocrine tumors; Other malignant neuroendocrine tumors Reportable inclusion terms: • High grade neuroendocrine carcinoma, any site • Malignant poorly differentiated neuroendocrine tumor, NOS, any site
209.31 – 209.36	Merkel cell carcinoma **NOTE**: Effective date 10/1/09
209.70 – 209.74	Secondary neuroendocrine tumors **NOTE:** Effective Date 10/1/09 Reportable inclusion terms: • Secondary carcinoid tumors **NOTE:** ALL neuroendocrine or carcinoid tumors specified as secondary are malignant.
209.75	Secondary Merkel cell carcinoma Reportable inclusion terms: • Merkel cell carcinoma nodal presentation • Merkel cell carcinoma visceral metastatic presentation • Secondary Merkel cell carcinoma, any site **NOTE:** ALL neuroendocrine or carcinoid tumors specified as secondary are malignant.
209.79	Secondary neuroendocrine tumors of other sites **NOTE:** ALL neuroendocrine or carcinoid tumors specified as secondary are malignant.
225.0 – 225.9	Benign neoplasm of brain and other parts of nervous system

ICD-9-CM Code	Explanation of Code
227.3	Benign neoplasm of pituitary gland and craniopharyngeal duct (pouch) Reportable inclusion terms: • Benign neoplasm of Craniobuccal pouch, Hypophysis, Rathke's pouch or Sella turcica
227.4	Benign neoplasm of pineal gland (pineal body)
227.9	Benign neoplasm of unspecified endocrine gland
228.02	Hemangioma; of intracranial structures Reportable inclusion terms: • Angioma, NOS • Cavernous nevus • Glomus tumor **NOTE:** Venous angioma of the brain/CNS is not reportable. Venous angioma is a malformation (developmental venous anomaly), not a tumor.
228.1	Lymphangioma, any site **NOTE:** Includes only lymphangioma of the brain, other parts of nervous system and endocrine gland.
230.0 – 234.9	Carcinoma in situ Reportable inclusion terms: • Cervical Intraepithelial neoplasia, Grade III • Erythroplasia, Queyrat's • AIN III, CIN III, VAIN III, VIN III
237.0 – 237.1	Neoplasm of uncertain behavior [borderline] of Endocrine glands and Nervous system: Pituitary gland, Craniopharyngeal duct and Pineal gland
237.5, 237.6, 237.9	Neoplasm of uncertain behavior [borderline] of Endocrine glands and Nervous system: Brain and Spinal cord, Meninges, Endocrine glands and Other and unspecified parts of nervous system
238.4	Polycythemia vera (9950/3): Excludes: • Familial polycythemia (D75.0) • Secondary polycythemia (D75.1)
238.6	Plasma cells
238.7	Other Lymphatic and Hematopoietic tissues **NOTE:** This code was expanded in 10/2006. It is now a subcategory and is no longer valid for coding purposes; however, it should be included in extract programs for quality control purposes.
238.71 – 238.77, 238.79	Other Lymphatic and Hematopoietic tissues: Essential thrombocythemia, Myelodysplastic syndromes, Lymphoproliferative disorders, and Other lymphatic and hematopoietic tissues

ICD-9-CM Code	Explanation of Code
239.6, 239.7	Neoplasms of unspecified nature; Brain, Endocrine glands and Other parts of Nervous system **NOTE:** Category D49 classifies by site neoplasms of unspecified morphology and behavior. The term “mass,” unless otherwise stated, is not to be regarded as a neoplastic growth. Includes: • ‘growth, NOS’ • ‘neoplasm, NOS’ • ‘new growth, NOS’ • ‘tumor, NOS’ • ‘neoplasm of uncertain behavior” (D37-D44, D48) Excludes: • Neoplasm of unspecified behavior of cerebral meninges (D49.7) • Neoplasm of unspecified behavior of cranial nerves (D49.7) • Neoplasm of unspecified behavior of peripheral, sympathetic, and parasympathetic nerves and ganglia (D49.2)
273.2	Other paraproteinemias (Cryoglobulinemia) Reportable inclusion terms: • Franklin’s disease (heavy chain) (9762/3) • Heavy chain disease (9762/3) • Mu-chain disease (9762/3)
273.3	Macroglobulinemia (Waldenstrom’s macroglobulinemia)
277.89	Other specified disorders of metabolism Reportable inclusion terms: • Hand-Schuller-Christian disease • Histiocytosis (acute) (chronic) • Histiocytosis X (chronic) [OBS] • Langerhans-cell histiocytosis, NOS (diagnosed 2010 and later)
285.0	Sideroblastic anemia Reportable inclusion terms: • Acquired idiopathic sideroblastic anemia • Pure sideroblastic anemia • Refractory anemia with hemochromatosis • Refractory anemia with sideroblasts • Refractory anemia with ringed sideroblasts (RARS) • Sideroblastic anemia
288.3	Eosinophilia **NOTE**: This code is for eosinophilia, which is not reportable. Do not abstract unless diagnosis is: • Chronic eosinophilic leukemia (CEL) • Chronic eosinophilic leukemia (and the hyperosinophilic • syndrome) • Hypereosinophilic (idiopathic) syndrome (HES)
288.4	Hemophagocytic syndromes (Histiocytic syndromes)
289.6	Familial polycythemia (synonym for polycythemia vera)
795.04	Papanicolaou smear of cervix with high grade squamous intraepithelial lesion (HGSIL)
795.06	Papanicolaou smear of cervix with cytologic evidence of malignancy

ICD-9-CM Code	Explanation of Code
795.14	Papanicolaou smear of vagina with high grade squamous intraepithelial lesion (HGSIL)
795.16	Papanicolaou smear of vagina with cytologic evidence of malignancy
795.74	Papanicolaou smear of anus with high grade squamous intraepithelial lesion (HGSIL)
796.76	Papanicolaou smear of anus with cytologic evidence of malignancy

NOTE: Pilocytic/juvenile astrocytoma M-9421 moved from behavior /3 (malignant) to /1 (borderline malignancy) in ICD-O-3. However, SEER registries will continue to report these cases and code behavior as /3 (malignant).

ICD-10-CM Casefinding List Effective October 1, 2015 and Later.

ICD-10-CM Casefinding List Effective October 1, 2015 and Later

ICD-10-CM Code	Explanation of Code
C00.0 – C43.9, C45.0 – C96.6, C96.9, C96.A, C96.Z	Malignant neoplasms: stated or presumed to be primary (of specified sites and certain specified histologies)
C4A._	Merkel cell carcinoma **NOTE:** Effective date 10/1/09
C75.0	Familial polycythemia (synonym for polycythemia vera)
C7A.00 – C7A.098	Neuroendocrine tumors
C7A.1, C7A.8	Malignant poorly differentiated neuroendocrine tumors; Other malignant neuroendocrine tumors Reportable inclusion terms: • High grade neuroendocrine carcinoma, any site • Malignant poorly differentiated neuroendocrine tumor, NOS, any site
C7B.00 – C7B.04, C7B.09	Secondary neuroendocrine tumors **NOTE:** Effective Date 10/1/09 Reportable inclusion terms: • Secondary carcinoid tumors **NOTE:** ALL neuroendocrine or carcinoid tumors specified as secondary are malignant.
C7B.1	Secondary Merkel cell carcinoma Reportable inclusion terms: • Merkel cell carcinoma nodal presentation • Merkel cell carcinoma visceral metastatic presentation • Secondary Merkel cell carcinoma, any site **NOTE:** ALL neuroendocrine or carcinoid tumors specified as secondary are malignant.
C7B.8	Secondary neuroendocrine tumors of other sites **NOTE:** ALL neuroendocrine or carcinoid tumors specified as secondary are malignant.
C88.0	Macroglobulinemia (Waldenstrom's macroglobulinemia)

ICD-10-CM Code	Explanation of Code
C96.5, C96.6	Other specified disorders of metabolism Reportable inclusion terms: • Hand-Schuller-Christian disease • Histiocytosis (acute) (chronic) • Histiocytosis X (chronic) [OBS] • Langerhans-cell histiocytosis, NOS (diagnosed 2010 and later)
D00.00 – D03.9, D05.00 – D09.9	Carcinoma in situ Reportable inclusion terms: • Cervical Intraepithelial neoplasia, Grade III • Erythroplasia, Queryrat's • AIN III, CIN III, VAIN III, VIN III
D18.1	Lymphangioma, any site **NOTE:** Includes only lymphangioma of the brain, other parts of nervous system and endocrine gland.
D18.02	Hemangioma; of intracranial structures Reportable inclusion terms: • Angioma, NOS • Cavernous nevus • Glomus tumor **NOTE:** Venous angioma of the brain/CNS is not reportable. Venous angioma is a malformation (developmental venous anomaly), not a tumor.
C71.0 – C72.9	Malignant neoplasm of brain and other parts of nervous system
C75.1	Malignant neoplasm of pituitary gland and craniopharyngeal duct (pouch) Reportable inclusion terms: • Malignant neoplasm of Craniobuccal pouch, Hypophysis, Rathke's pouch or Sella turcica
C75.3	Malignant neoplasm of pineal gland (pineal body)
C75.9	Malignant neoplasm of unspecified endocrine gland
D42.0, D42.1, D42.9, D43.2, D43.3, D43.4, D43.9	Neoplasm of uncertain behavior [borderline] of Endocrine glands and Nervous system: Brain and Spinal cord, Meninges, Endocrine glands and Other and unspecified parts of nervous system
D44.3 – D44.5	Neoplasm of uncertain behavior [borderline] of Endocrine glands and Nervous system: Pituitary gland, Craniopharyngeal duct and Pineal gland
D45	Polycythemia vera (9950/3): Excludes: • Familial polycythemia (D75.0) • Secondary polycythemia (D75.1)
D46.0 – D46.2, D46.20 – D46.22, D46.A, D46.B, D46.C, D47.3, D46.9, D47.1, D47.Z1, D47.7, D47.9, D47.Z9	Other Lymphatic and Hematopoietic tissues: Essential thrombocythemia, Myelodysplastic syndromes, Lymphoproliferative disorders, and Other lymphatic and hematopoietic tissues
D47.Z9	Plasma cells

ICD-10-CM Code	Explanation of Code
D49.6, D49.7	Neoplasms of unspecified nature; Brain, Endocrine glands and Other parts of Nervous system **NOTE:** Category D49 classifies by site neoplasms of unspecified morphology and behavior. The term “mass,” unless otherwise stated, is not to be regarded as a neoplastic growth. Includes: • ‘growth, NOS’ • ‘neoplasm, NOS’ • ‘new growth, NOS’ • ‘tumor, NOS’ • ‘neoplasm of uncertain behavior” (D37-D44, D48) Excludes: • Neoplasm of unspecified behavior of cerebral meninges (D49.7) • Neoplasm of unspecified behavior of cranial nerves (D49.7) • Neoplasm of unspecified behavior of peripheral, sympathetic, and parasympathetic nerves and ganglia (D49.2)
D64.0 – D64.3	Sideroblastic anemia Reportable inclusion terms: • Acquired idiopathic sideroblastic anemia • Pure sideroblastic anemia • Refractory anemia with hemochromatosis • Refractory anemia with sideroblasts • Refractory anemia with ringed sideroblasts (RARS) • Sideroblastic anemia
D72.1	Eosinophilia **NOTE:** This code is for eosinophilia, which is not reportable. **Do not** abstract unless diagnosis is: • Chronic eosinophilic leukemia (CEL) • Chronic eosinophilic leukemia (and the hyperosinophilic • syndrome) • Hypereosinophilic (idiopathic) syndrome (HES)
D76.1 – D76.3	Hemophagocytic syndromes (Histiocytic syndromes)
D89.1	Other paraproteinemias (Cryoglobulinemia) Reportable inclusion terms: • Franklin’s disease (heavy chain) (9762/3) • Heavy chain disease (9762/3) • Mu-chain disease (9762/3)
R87.613	Papanicolaou smear of cervix with high grade squamous intraepithelial lesion (HGSIL)
R87.614	Papanicolaou smear of cervix with cytologic evidence of malignancy
R87.623	Papanicolaou smear of vagina with high grade squamous intraepithelial lesion (HGSIL)
R87.624	Papanicolaou smear of vagina with cytologic evidence of malignancy
R85.613	Papanicolaou smear of anus with high grade squamous intraepithelial lesion (HGSIL)
R85.614	Papanicolaou smear of anus with cytologic evidence of malignancy

NOTE: Pilocytic/juvenile astrocytoma M-9421 moved from behavior /3 (malignant) to /1 (borderline malignancy) in ICD-O-3. However, SEER registries will continue to report these cases and code behavior as /3 (malignant).

Select those patients seen at your facility as an inpatient and/or as an outpatient for surgery, endoscopy, chemotherapy, radiation therapy, etc. **Exclude all laboratory visits. Include radiology visits for benign/borderline intracranial and CNS tumors only:**

- Endoscopy short stay
- Inpatient admission
- Outpatient surgery, short stay
- Outpatient surgery
- Outpatient care unit
- Outpatient endoscopy
- Outpatient administration of chemotherapy
- Outpatient administration of radiation therapy

Benign/Borderline Intracranial and CNS Tumors Casefinding List

Due to a change in the federal law affected by passage of Public Law 107-260, which requires the collection of case information for benign brain and CNS tumors, revisions to the administrative rules that govern Michigan cancer reporting have been made. Reporting of benign brain and CNS related tumors is now required. This new requirement is effective with cases diagnosed on October 1, 2004 forward.

Non-malignant primary intracranial and central nervous system tumors diagnosed on or after October 1, 2004 with an ICD-O-3 behavior code of “0” or “1” are required for the following sites:

- Meninges (C70.0 – C70.9)
- Brain (C71.0 – C71.9)
- Spinal cord, cranial nerves, and other parts of the central nervous system (C72.0 – C72.9)
- Pituitary gland (C75.1)
- Craniopharyngeal duct (C75.2)
- Pineal gland (C75.3).

Juvenile astrocytomas should continue to be reported as 9421/3.

Select those patients seen at your facility as an inpatient and/or as an outpatient for surgery, endoscopy, chemotherapy, radiation therapy, etc. **Exclude all laboratory visits. Include radiology visits for benign/borderline intracranial and CNS tumors only:**

- Endoscopy short stay
- Inpatient admission
- Outpatient surgery, short stay
- Outpatient surgery
- Outpatient care unit
- Outpatient endoscopy
- Outpatient administration of chemotherapy
- Outpatient administration of radiation therapy

Casefinding List for Benign/Borderline Intracranial and Central Nervous System (CNS) Tumors

ICD-9-CM Code	ICD-10-CM Code	ICD-O-3 Code and Description
225.2	D32.0	C70.0 Cerebral meninges
225.4	D32.1	C70.1 Spinal meninges

ICD-9-CM Code	ICD-10-CM Code	ICD-O-3 Code and Description
237.6	D42.0, D42.1, D42.9	C70.9 Meninges, NOS
225.0	D33.0, D43.0	Brain - Supratentorial: • C71.0 Cerebrum (Supratentorial, NOS) • C71.1 Frontal lobe • C71.2 Temporal lobe • C71.3 Parietal lobe • C71.4 Occipital lobe • C71.5 Ventricle ○ Includes: ▪ Ventricle, NOS ▪ Cerebral ▪ Lateral ▪ Third ○ Excludes: Fourth ventricle
225.0, 237.5	D33.1, D43.1	Brain - Infratentorial: • C71.6 Cerebellum, NOS • C71.7 Brain stem • C71.7 Fourth ventricle
225.0, 237.5	D33.1 – D33.9, D43.2	C71.8 Overlapping lesion of brain
225.0, 237.5	D33.2, D43.2	C71.9 Brain, NOS
225.3, 237.5	D33.4, D43.4	C72.0 Spinal cord C72.1 Cauda equina
225.1	D33.3, D43.3	Nerves - Olfactory, optic, acoustic, NOS: • C72.2 Olfactory nerve • C72.3 Optic nerve • C72.4 Acoustic nerve • C72.5 Cranial nerve, NOS
225.8, 225.9, 237.9	D33.7, D33.9, D43.8, D43.9	C72.8 Overlapping lesion of brain and CNS C72.9 Central nervous system, NOS: • Other specified sites of nervous system • Nervous system, part unspecified
227.3, 237.0	D35.2, D44.3	C75.1 Pituitary gland
227.3, 237.0	D35.3, D44.4	C75.2 Craniopharyngeal duct
227.4, 237.1	D35.4, D44.5	C75.3 Pineal gland

Components of Good Reporting

Quality control field projects carried out within Michigan have been designed to measure the completeness and accuracy of the cancer data as well as timeliness of reporting. The results indicated the following quality control problems that need to be addressed if a facility is to satisfy the obligation to report all cancer cases. These issues are identified separately with recommendations that would help avoid reporting problems. The topics are discussed below and are divided into those that affect casefinding and those that affect the accuracy of reports.

Casefinding Problems

- **Completeness** Reporting responsibility placed solely in the pathology department results in cases being missed that are diagnosed through other means. This especially pertains to cases involving the primary sites of the trachea, bronchus, pancreas, brain or lung, chronic leukemia and lymphoma. In hospitals with no tumor registry there needs to be an established procedure that ensures all cases are reported. These procedures must **include every department in the hospital which deals with cancer patients**. A procedure for reporting should be in place within all departments involved in either diagnosing or treating cancer patients. One approach is to develop a communication system between each department, and the group coordinating reporting, by placing one person in charge of reporting across all departments. Training staff within each area to follow coordinated procedures will eliminate missing cases. This should be covered within the written procedures on reporting in place within each facility.

- **Registries in Transition** Hospital cancer registries changing from manual reporting to a software system, or updating to a new software system, tend to have more missing cases. The registry staff while learning the new software system abstracts into the hospital registry while continuing to report manually this can be confusing and can result in cases that need to be sent to the state registry being overlooked. During a transition stage **a procedure needs to be developed which will ensure all cases are properly reported**. One approach is to maintain a log of reported cases, or some type of recording system, to allow comparison between the cases in the hospital registry and those cases sent to the central registry. The log needs to be updated and checked on a monthly basis through this transition period.

- **Class of Case** All approved hospital registries classify cases as analytical or non-analytical. Sometimes registries mistakenly send only the analytical cases. Completeness of reporting is improved by registries being sure they are sending **all cancer patient data regardless of class of case**. Though this may result in duplication, it is the best way to ensure that all cases are reported to the state and none are skipped due to confusion on a patient's status. The MCSP accepts all cases regardless of their class of case status.

- **Reporting Outpatient Cases** Outpatient cases can be overlooked by reporting facilities due to a lack of communication and lack of a reliable reporting system within the facility. It is important to establish a referral procedure that will identify and prompt the reporting of **all outpatient cancer cases which are diagnosed or treated in your facility, clinics operated by your facility or through an affiliated laboratory**. Reporting personnel should set up a reporting system with personnel having access to outpatient records relative to outpatient treatment and outpatient diagnosis. It is important to include diagnostic work for specimens submitted to the laboratory in this process. Outpatient cancer case information can be reported independently, or preferably, routed to the personnel responsible for all cancer case reporting. This should be done on a regular basis, i.e., weekly or daily depending upon the size of the hospital, to insure timeliness of reporting and to avoid backlogs.

- **Reporting Michigan Residents Diagnosed Out of State** Michigan residents diagnosed out of state but receiving treatment in a Michigan hospital can mistakenly not be reported. If a patient has been diagnosed out of state it is important to report the case in all instances. (Michigan does have an exchange agreement with some states to exchange data concerning cancer cases of Michigan residents, **but not** with all states.) These cases MUST be reported regardless of the state of diagnosis. Report all cases treated in your facility that were diagnosed outside Michigan or in an unknown facility.

- **Reporting Non-residents** Out of state residents are reportable. Non-resident cases cannot be skipped due to a presumption that only resident cases are necessary. ALL cancer cases are required to be reported regardless of residency. Report all cases regardless of the patient's address or state of residency.

- **Referrals to Another Facility** Cases can be missed if there is a lack of communication between facilities. Especially in instances where a patient was diagnosed at one facility and then referred to a second facility for treatment and each facility assumed that the other had reported the case. The end result was often that neither had reported this case. In a situation where hospitals are referring patients, it is recommended that the diagnosing facility and the hospital initially treating the patient **both** report the case. This recommendation applies to clinically diagnosed cases, in particular.

Determining Multiple Primary Tumors

For both solid tumors and hematopoietic/lymphoid neoplasms, there are specific rules to be followed when determining a new or subsequent primary. You must review the rules for each case to determine if a new primary exists.

Solid Tumor Rules

The Solid Tumor Rules guide and standardize the process of determining the number of primaries. The histology rules contain detailed histology coding instructions.

Refer to the 2018 Solid Tumor Rules for all cases diagnosed 1/1/2018 and later.

Note: Multiple Primary & Histology Rules for previous diagnosis years can be found in NCI SEER Historical Staging and Coding Manuals.

Hematopoietic & Lymphoid Neoplasms Manual and Database

The Hematopoietic & Lymphoid Neoplasms manual and the corresponding database are to be used for coding cases diagnosed January 1, 2010 and forward. **The changes made do not require registrars to recode old cases.**

ICD-O-3 SEER Site/Histology Validation List

Specific histologies arise in specific tissue types. Refer to the SEER site/histology validation list to determine valid primary site and histology combinations for cases diagnosed **on or after** January 1, 2001.

The Site/Histology Validation List can be downloaded by visiting the SEER website.

Most comparisons can be made to the three-digit histology code but a four-digit histology comparison is required whenever an "!" appears to the left of the three-digit histology name.

To use the SEER site/histology validation list:

1. Locate the three-digit topography code in ICD-O-3, for the primary site in question.
2. Locate the five-digit morphology code in ICD-O-3, for the primary site in question.
3. Locate the three-digit topography code in the SEER site/histology validation list in the left hand column, in numeric order by topography code.
4. Locate the five-digit morphology code in the SEER site/histology validation list in the right hand column, in numeric order by morphology code.
5. If the five-digit morphology code is listed in the right hand column, the site/histologic type is valid.
6. If the five-digit morphology code is NOT listed in the right hand column, the site/histologic type is NOT valid.
7. Confirm with your pathologist and/or managing physician if the site/histology is valid and code appropriately.

NOTE: If the primary site/histology is valid according to the pathologist and/or managing physician, document this in the text to justify the selected codes. As the purpose of text information is to provide the opportunity for documenting and checking coded values, information documenting the disease process should be entered from the medical record and should NOT be generated electronically from coded values.

Diagnostic Confirmation

Descriptions of procedures performed to determine the method of diagnosis are listed below. A low number takes precedence over all higher numbers regardless of the type of procedure performed.

Positive Histology

Use code 1 for the following methods of diagnoses.

- Bone Marrow Biopsy - examination of a piece of bone marrow by puncture or trephine (removing a circular disc of bone) for possible diagnosis of leukemia or multiple myeloma
- Curettage - removal of growths or other material by scraping with a curette (D&C)
- Excisional Biopsy - the removal of a growth in its entirety and having a therapeutic as well as diagnostic purpose
- Frozen Section - a thin slice of tissue cut from a frozen specimen, often used for rapid microscopic diagnosis
- Hematologic examination - microscopic examination of the cells of the blood or blood-forming tissues (especially bone marrow) for possible diagnosis of leukemia or multiple myeloma
- Incisional Biopsy - incomplete removal of a growth for the purpose of diagnostic study
- Punch Biopsy - biopsy of material obtained from the body tissue by a punch technique
- Surface Biopsy - scraping of cells from surface epithelium, especially from the cervix, for microscopic examination
- Surgical Biopsy - removal of tissue from the body by surgical excision for examination

Endoscopic Procedures

Use code 1 (histology) if a “piece of tissue” is taken and examined under a microscope.

Use code 2 (cytology) if “fluid” is taken and examined under a microscope.

Use code 6 (visualization) if no tissue or fluid is taken and a diagnosis of cancer is made.

Examples:

A patient undergoes a bronchoscopy with a bronchial washing.
Code the method of diagnosis as: 2 - cytology

A patient undergoes a colonoscopy with a biopsy of a mass.
Code the method of diagnosis as: 1 - histology

Endoscopy Terminology

Procedure	Refers to examination of…
Bronchoscopy	Bronchi
Colonoscopy	Colon and rectum by means of an elongated flexible fiberscope
Colposcopy	Tissue of the cervix and vagina by use of a magnifying lens inserted into the vagina
Culdoscopy	Female pelvic viscera by means of an endoscope introduced through the posterior vaginal wall into that part of the pelvic cavity known as the rectovaginal pouch or cul de sac
Cystoscopy	Interior of the urinary bladder by means of a cystoscope
Esophagoscopy	Interior of the esophagus
Gastroscopy -	Interior of the stomach
Laryngoscopy	Larynx
Laparoscopy	Intra-abdominal structures by means of an illuminated tubular instrument inserted through a small incision in the abdominal wall
Mediastinoscopy	Mediastinum by means of a tubular instrument permitting direct inspection of the area between the lungs
Nasopharyngoscopy	Nasopharynx, pharynx, and the pharyngeal end of the auditory tube by lighted telescopic endoscope
Ophthalmoscopy	Interior of the eye with an instrument containing a perforated mirror and lens
Otoscopy	Internal ear
Panendoscopy	Urinary bladder via wide angle viewing
Peritoneoscopy	Peritoneal cavity by an instrument inserted through the abdominal wall
Proctoscopy	Rectum
Sigmoidoscopy	Colon up to sigmoid flexure
Thoracoscopy	Pleural cavity by means of an endoscope which is inserted into the cavity through an intercostal space

Positive Cytology

Use code 2 for the following methods of diagnoses.

- Aspiration Biopsy - biopsy of material obtained by suction through a needle attached to a syringe
- Brushings - the procedure of brushing the lining of an organ for the purpose of obtaining cells
- Fine Needle Aspiration (FNA) - a hollow needle used for withdrawing fluid from a cavity
- Paracentesis - surgical puncture of a cavity, such as the abdominal cavity, for aspiration of fluid
- Punctures - inserting a hollow needle into a cavity or organ for the purpose of removal of some portion of the contents
- Scraping - the procedure of scraping the lining of a structure with an instrument for the purpose of obtaining cells
- Swab - using a swab or similar device to obtain fluid and secretions which then can be used to make a smear
- Thoracentesis - surgical puncture for aspiration of fluid from the chest
- Washings - the removal of fluid from a hollow organ or structure for the purpose of collecting cells

Visualization

Use code 6 for the following method of diagnosis.

- Exploratory surgery - surgery is performed to determine whether or not a cancerous condition exists and the degree to which the cancer may have affected other organs and structures within the observed area; no biopsies are taken

Radiographic Examination

Use code 7 for the following methods of diagnoses.

Radiographic examination refers to a negative image on photographic film made by exposure to x-rays or gamma rays that have passed through matter or tissue.

1. Angiography - radiographic study of the vascular system
    a. Cerebral Angiogram - x-ray of the vessels of the brain
    b. Cardiac Angiogram - x-ray showing the functions of the heart and large blood vessels
    c. Lymphangiogram - x-ray study of the vessels of the lymphatic system
    d. Arteriography - x-ray examination of arteries
    e. Venography - x-ray examination of veins

2. Bronchography - radiographic study of the bronchi of the lung
    a. Bronchogram - x-ray of the bronchial system

3. Cholecystography - radiologic study of the function of the gallbladder and bile ducts after an opaque medium has been introduced either orally or intravenously
    a. Cholangiogram - x-ray of extrahepatic ducts
    b. Cholecystogram - x-ray of the gallbladder

4. Computerized (Axial) Tomography (CT) - examination of body tissue; directs a thin, concentrated beam of radiation through a cross-section of the body to detectors; the technique involves recording of “slices” of the body with an x-ray scanner

5. Hysterosalpingography - radiography of the uterus and fallopian tubes after the injection of radiopaque material

6. Infusion Nephrotomography - radiographic visualization of the kidney by tomography after intravenous introduction of contrast medium

7. Intraoperative Imaging - an imaging procedure such as x-ray, CT scan, ultrasound, or mammogram that is performed during an operative procedure, e.g., to direct a biopsy or to verify the position of a prosthesis

8. KUB (Kidneys, Ureter, Bladder) - a frontal film of the abdomen taken in the supine position

9. Laminography - x-ray of a selected layer of the body; usually performed on joints and eye orbits

10. Lower GI series or Barium Enema - x-ray studies, following rectal injection of barium, of the large bowel; air and barium are used as contrast materials

11. Mammogram - several x-ray views are taken of one or both breasts and the radiographs are examined for the presence of a lesion, mass or calcification

12. Magnetic Resonance Imaging (MRI) - based on magnetization of the various biological tissues; does not use any ionizing radiation (such as x-rays) and is capable of direct imaging in any plane without reformatting

13. Myelography - radiologic study of the spinal cord

14. Positron Emission tomography (PET) - is a unique noninvasive technique that produces three-dimensional images within inside the human body. Compounds like glucose, oxygen, and carbon, which are found naturally in body chemistry, are labeled with signal-emitting tracers and injected into the body. All cells use this tracer, and cells with increased metabolism use more glucose. Because cancer cells are highly metabolic and use more glucose than normal cells, they are easily seen on a PET scan.

15. Radioisotopes - substance administered to patients in order to diagnose disease in which the radioisotopes gather in the infected area emitting gamma rays from within the body which enable the physician to visualize internal abnormalities

16. Salpingography - radiologic study of the uterus and fallopian tubes

17. Sialography - radiologic study of the salivary ducts

18. Thermography - technique for detecting cancer by differentiating regions of hot and cold in the body; the surface temperature is photographically recorded

19. Tomography - a special x-ray technique to show in detail images of structures lying in a predetermined plane of tissue while blurring or eliminating detail in images of structures in other planes; usually performed on the kidneys

20. Upper GI series or Barium Swallow - x-ray studies, following ingestion of barium, of the pharynx, esophagus, stomach, and duodenum

21. Urography - radiologic study of the urinary tract
    a. Urogram - x-ray of the kidney and ureter with emphasis on the pelvis of the kidney by intravenous injection of a contrast medium
    b. Cystogram - x-ray of the urinary bladder by filling the bladder by catheterization with a contrast medium
    c. IVP (intravenous pyelography) - a succession of x-ray films of the urinary tract following the injection into a vein of an iodine-containing substance which is collected by the kidneys, passing into the ureters and subsequently the bladder, allowing the study of urinary tract function
    d. Retrograde Urography - examination of the ureter and renal collecting structures by means of instillation of contrast material through a ureteral catheter passed through a cystoscope into the bladder and ureter

22. Ultrasound - high-frequency sound waves; waves can be bounced off of tissues using special devices. The echoes are then converted into a picture called a sonogram. Ultrasound imaging, referred to as ultrasonography, allows physicians and patients to get an inside view of soft tissues and body cavities, without using invasive techniques.

Cancer Staging

SEER Summary Stage

Responsible organization: NCI SEER

- Designed to reflect changes in the AJCC 8th Edition.
- **Must be directly assigned/coded**. MCSP will always require directly assigned/coded SEER Summary Stage to be reported from all facilities regardless of type.
    - Directly assigned/coded SEER Summary Stage 2000 required for all cases diagnosed prior to 2018.
    - Directly assigned/coded SEER Summary Stage 2018 required for all cases diagnosed in 2018 and later.

Refer to the NCI SEER web site for more information.

AJCC TNM Staging

Eighth Edition
Directly assigned 8th Edition TNM Stage values are **Required** by the Michigan Cancer Surveillance Program from CoC facilities beginning with cases diagnosed January 1, 2018. Additionally, directly assigned AJCC TNM Stage, 8th edition is **Reportable** (recorded) by non-CoC facilities if staging assignment is recorded in the patient's medical record. Note that registrars for non-CoC facilities are NOT required to conduct follow-back to identify stage. However, appropriate default values must be entered. See "Description of Follow-back Levels" for reporting requirements.

Seventh Edition
AJCC TNM Stage, 7th Edition is a **Required** data item for CoC facilities. For non-CoC facilities, AJCC TNM Stage, 7th Edition is a **Reportable** data item, beginning with cases diagnosed 1/1/2016 through 12/31/2017. See "Description of Follow-back Levels" for reporting requirements.

For more information, refer to the AJCC Cancer Staging Manual. For AJCC TNM Stage training, refer to the Registrar education section on the AJCC web site.

Physicians are responsible for documenting physician-assigned clinical and pathologic stage in the patient medical record. Hospital registrars are responsible for recording the physician-assigned stage in the registry database.

Collaborative Staging (For cases diagnosed prior to 2018 only)

All CS data items required for cases diagnosed 2004 – 2015. Site Specific Factor (SSF) data items only are required for cases diagnosed 2016 – 2017.

For Schema-specific data requirements, refer to Collaborative Stage Data Collection System.

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Quality Control

Quality control measures are essential to establish accuracy, completeness and consistency of reporting within the registry. Internal quality control relates to the process that is established to check for errors and discrepancies as reports come into the registry from the reporting facilities. External quality control is a method that checks for errors and discrepancies at the reporting facility.

NOTE: Some of the edit checks are prompts to review unusual data such as a prostate gland cancer in a man less than 45 years of age. If it is something rare, please review it with your pathologist.

Internal Quality Control

Proper Completion

As the reports are received, they are reviewed for consistency and completeness. Whenever a case is incomplete or inconsistent relative to an essential data item or items the department will query the reporting facility to clarify the case. A copy of the report in question is sent to the reporting facility with a request to clarify or complete the essential data item or items. However, it is customary to make a telephone call rather send out a letter requesting clarification.

Commonplace Essential Data Deficiencies

Data Field	Deficiency
Patient's first name	If blank or inconsistent, unknown or illegible
Patient's last name	If blank or unknown or illegible
Complete address	If blank, illegible or inconsistent
Sex	If blank or inconsistent with name or site
Date of Birth	If blank or inconsistent with site, report date, or date of diagnosis
Social Security Number	If blank
Primary site	If blank or inconsistent with histology
Laterality	If blank and a paired organ is reported for the primary site
Histology	If blank, if inconsistent with the primary site or it indicates the condition may not be reportable
Stage	If inconsistent with histology, blank, or, for TNM values, not consistent with the AJCC staging system
Method of diagnosis	If blank or inconsistent as in an in situ diagnosis not based upon a microscopic method of diagnosis
Non-diagnostic method	If method of diagnosis is reported as cytology and the case is in-situ, VIN III or CIN III, or a Pap smear, the case will be queried, to determine if a histological confirmation was obtained
Treatment	If blank and if the report is from a hospital with a cancer treatment center

If the reporting facility cannot supply the needed data items requested, the next step is to query the attending physician. For such cases, the complete name and office address of the physician are requested from the reporting facility.

For independent laboratories that do not have access to necessary patient demographic information to complete the report, adding the name and office address of the doctor to the report is extremely helpful. This reference information on the physician should be added to the **bottom** of the cancer report form for any case with missing information. Be sure to supply the doctor's full name and complete mailing address.

Manual checks of new reports Routine checking of incoming reports identifies problems early in the processing. Letters are prepared to survey the hospital, laboratory or doctor to obtain information or clarification on identified problems. The situations that will result in a letter of inquiry include when:

- important information on the patient is missing
- the diagnosis is vague or not clearly a malignancy
- the diagnosis is an in situ lesion based upon a cytological diagnosis
- diagnostic information is missing
- logical inconsistencies are evident, such as date of birth that is the same as the date of the report, cancer sites that disagree with the patient's sex or sites and histologies that are not compatible

If reporting a case that will likely generate a query, such as a CIN III pap smear or a patient with an unknown residence, record the physician's name and address in the lower margin of the report. This information will allow the MCSP staff to contact the doctor directly.

Computer edit checks A series of edit checks are employed to scan incoming data. Many of these checks are basic screens of the data to insure all codes are valid. Other edits are more complex. These include the standard edit checks for sex and site, site and histology, histology and stage and other edits patterned after those employed at the National Cancer Institute and as recommended by NAACCR. Problems identified by these edits may result in additional inquiries concerning a cancer report.

External Quality Control

A quality control field representative will visit each contributing facility to conduct a review of the quality of the cancer reporting at that facility. The field representative will help the facility identify and solve problems associated with casefinding, timeliness, abstracting, reporting, etc. Facility staff responsible for submitting reports are encouraged to contact their quality control field representative with questions about cancer reports.

Facility Audit Procedure

The reporting of cancer cases by Michigan licensed hospitals and laboratories are required by Act No. 82 of 1984. Administrative Rule 325.9053 provides the Michigan Cancer Surveillance Program (MCSP) with the authority to conduct quality assurance reviews within each reporting entity to ensure consistency and completeness of the statewide cancer incidence registry.

MCSP quality improvement field representatives (CTRs) are to conduct periodic facility quality review as applicable. These reporting facilities may be requested to conduct the following:

- provide access to all health records as requested for quality review in the format and timeframe as specified and/or agreed upon between the facility and the MCSP
- submit master disease index and/or pathology reports
- provide adequate work space for field representative if quality review is on site at facility
- provide access to all pertinent reports/records, which may include pathology, radiation, chemotherapy, laboratory, radiology and other treatment indices
- if quality review is conducted via remote access to the facilities electronic health record (EHR) system, all applicable paperwork and access to the facilities EHR system must be established and available during the timeframe as specified by MCSP
- be available for consultation during quality control reviews and summation

Selecting Cases for Audit

A percentage of all accepted cases are re-abstracted to assess the accuracy of abstracting and interpretation of data definitions. These cases are selected and re-abstracted without reference to the original abstract. Discrepancies between abstract and re-abstract are discussed by the original abstractor and the field representative. The re-abstracting study is a tool by which the abstractor and the MCSP staff can identify areas of inconsistency and improve the overall reliability of the registry database.

1. The diagnosis year for audit should be the last complete year the department has closed out or the last complete diagnosis year submitted by that facility. A combination of no more than two diagnosis years will be used when the minimum number of cases is not obtainable.

2. Generate a report from CRS Plus by diagnosis year(s), using class of case codes (refer to the NAACCR Data Standards Dictionary). This report will be used in Step #3 and should contain the following information.

    a. State file number
    b. Name of patient
    c. Street address
    d. City
    e. State
    f. Zip
    g. Marital status
    h. Social security number
    i. County of residence
    j. Date of birth
    k. Sex
    l. Race
    m. Hispanic origin
    n. Accession number/sequence number
    o. Class of case
    p. Primary site
    q. Laterality
    r. Histology
    s. Cell behavior
    t. Tumor grade
    u. Date of diagnosis
    v. Method of diagnosis
    w. SEER summary stage
    x. Tumor size
    y. AJCC Edition
    z. AJCC Staging (clinical and\or pathological)
    aa. Date first therapy initiated
    bb. Reason no surgery
    cc. Date of surgery
    dd. Surgery code
    ee. Date of radiation therapy
    ff. Radiation therapy code
    gg. Date of chemotherapy
    hh. Chemotherapy code

ii. Date of hormone therapy
jj. Hormone therapy code
kk. Date of BRM therapy
ll. BRM therapy code

3. Determine the number of cases to audit using the following methodology.

   a. If the number of reportable cases for a specific diagnosis year is 1-400, a **minimum** of forty cases must be selected for review.

   b. If the facility has thirty-six cases for the specific year being audited, it is NOT necessary to add an additional year to reach the minimum of forty cases.

   c. If the facility has less than thirty-six cases for the specific year being audited, combine two years of complete data to reach forty cases. Additional cases should be selected succeeding the current audit year. If the combination of TWO years does not meet the minimum of forty cases, do NOT add additional years.

   d. If the number of reportable cases for a specific diagnosis year is 401-799, select ten percent (10%) of the cases for review.

   e. If the number of cases for a specific diagnosis year is greater than 800, a **maximum of eighty** cases will be selected for review.

4. For facilities with less than 400 cases, a minimum of forty cases from a select group of primary anatomical sites will be audited at each facility. If the minimum number of cases selected for each assigned primary anatomical site is NOT reached, select additional cases from the facilities top five reported sites or other sites such as esophagus, larynx, pancreas, testis, pharynx, etc. Discretion should be used when selecting additional primary anatomical sites to include a diverse number of sites. Audits are determined annually based on review of registry data.

5. For facilities with over 401 cases, select ten percent (10%) up to a maximum of eighty cases. Select the cases for each assigned primary anatomical site as outlined above for the minimum forty cases. Use discretion when selecting additional primary anatomical sites to include a diverse number of sites. If there is not a variety of primary sites, review the baseline of forty cases above and choose additional cases up to the ten percent (10%) or a maximum of eighty.

6. Those facilities that have not submitted cases for the specified audit year, a review of their MDI must take place and there will be no records to audit. The results of the MDI will determine if the facility should have reported cases. This will also determine how far back the department should abstract any backlog.

7. For those facilities that do not report their own cases, a review of their MDI must take place and there will be no records to audit. The records at the reporting facility will be reviewed for accuracy.

Master Disease Index Review

1. A Master Disease Index (MDI) from the facility for the same diagnosis year as the audit year will be Requested. The ICD-9-CM/ICD-10-CM codes identified in Sources for Casefinding are used by the facility to generate the master disease index.

2. Patients seen at the facility as an inpatient and/or as an outpatient must be selected. If possible, the facility will eliminate any duplicates that may appear in the listing. If a patient is seen with active or previously diagnosed cancer and is admitted for an unrelated medical condition, exclude these patients from the main listing.

3. The MDI will be submitted the MCSP in an Excel file with the following information:

    a. patients full name (alphabetical order by last name)
    b. date of birth
    c. social security number
    d. ICD-9-CM/ICD-10-CM diagnostic code
    e. admit date
    f. discharge date

4. Upon receipt of the file, it will be electronically compared to the cancer registry for complete casefinding.

5. A list identifying the cases that did NOT appear in the registry will be generated. This list will be sent back to the facility for verification of non-reportable conditions.

Pathology Review

In addition to the MDI comparison, a total of 120 pathology reports for the specific diagnosis year being audited is required for additional case ascertainment. The pathology reports must be separated into reportable and non-reportable conditions, with the reportable conditions compared to the central cancer registry.

Data Items Reviewed During the Audit		
Name of Patient	Medical Record Number	SEER Summary Stage
Street Address, City, Zip	Primary Site	Tumor Size
County	Paired Organ	AJCC – TNM Values
Social Security Number	Clinical/Histological Diagnosis	AJCC – Stage Group
Date of Birth	Cell Behavior	Date Therapy Began
Sex	Tumor Grade	Reason No Surgery
Race	Date of Diagnosis	Surgery Dates and Codes
Hispanic Origin	Method of Diagnosis	First Course of Treatment

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Recommended Abbreviations for Abstractors

The use of abbreviations in cancer abstraction is becoming more commonplace as the demands on abstractors increase. Abbreviations often are used by cancer abstractors to shorten the written narratives entered into text fields to facilitate the electronic storage and transmission of the information. However, abbreviations can generate confusion, because abbreviations may vary among different institutions and even between different specialties within the same institution. To be useful, an abbreviation must be clearly understood by any individual who encounters it. Consequently, the use of abbreviations is a useful abstracting practice only if universally recognized and understood abbreviations are used.

The NAACCR Recommended Abbreviations Listings were developed for utilization by cancer report abstractors and the agencies to which they submit their data. These lists were compiled to reduce some of the confusion that can result from the use of common and not-so-common abbreviations when abstracting reports of cancer from the medical record. Although the lists may shed some light on abbreviations used in the medical record, please note that these lists are intended to be used as a primary reference by the cancer abstractor, to help abstract necessary information into a limited number of text fields for storage and transmission of cancer information.

Never abbreviate the names of facilities; spell them out fully:

- Correct: University of Michigan
- Incorrect: UoM

For a list of recommended abbreviations for abstractors, refer to NAACCR Data Standards & Data Dictionary, Appendix G

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References Links for Registrars, Abstractors and Other Cancer Reporters

U.S. State, Territory, Commonwealth, U.S. Possession, and Canadian Province or Territory Codes

Two-character State or Province/Territory codes are required for certain data items. A complete listing of these codes can be found at the reference below.

Reference Appendix B: SEER Program Coding and Staging Manual 2018

Alphabetic Listing of Country Codes (ISO-3 Alpha Codes)

Three-character ISO Country codes are required for certain data items. A complete listing of these codes can be found at the reference below.

Reference Appendix B: SEER Program Coding and Staging Manual 2018

FIPS Codes for Counties and Equivalent Entities

Three digit FIPS codes are required for certain data items. A complete listing of these codes can be found at the reference below.

Reference Appendix A: NAACCR Data Standards & Data Dictionary

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Manuals and Reporting Guides

Michigan Cancer Surveillance Program

MCSP Cancer Reporting Manual

AJCC

AJCC Cancer Staging
AJCC 8th Edition will be used beginning with cases diagnosed 1/1/2018. Refer to the AJCC web site for more information on the AJCC Staging System, how to purchase the AJCC Cancer Staging Manual 8th edition, a review of staging rules, and errata to the 8th edition, AJCC news, education and training.

Collaborative Stage Data Collection System
Schema and site specific factors for cases diagnosed prior to 2018)

NCI SEER

Solid Tumor Rules (for cases diagnosed in 2018 and later)
Multiple Primary and Histology Coding Rules (for cases diagnosed prior to 2018)

SEER Program Coding and Staging Manual 2018 (for cases diagnosed in 2018 and later)

SEER Summary Stage 2018 (for cases diagnosed in 2018 and later)
SEER Summary Staging 2000 (for cases diagnosed prior to 2018)

SEER EOD 2018 (for cases diagnosed in 2018 and later)
All CoC facilities are required to submit EOD data. Further, all facilities (regardless of type) that submit data to the Metropolitan Detroit Cancer Surveillance System (also known as Karmanos Cancer Institute) are required to submit EOD data. All other facilities are encouraged to report EOD data when collected.

Hematopoietic and Lymphoid Neoplasm Database and the Hematopoietic and Lymphoid Neoplasm Coding Manual

SEER*Rx - Interactive Antineoplastic Drugs Database

ICD-O-3 SEER Primary Site/Histology Validation List

Commission on Cancer (CoC)

2018 STORE Manual
Use this manual for current cases. In most instances, it also should be used for historic cases being abstracted currently; exceptions are noted in the text.

NAACCR

NAACCR Site Specific Data Items (SSDI) / Grade
The NAACCR Site Specific Data (SSDI) / Grade page includes schema specific codes and coding instructions, a .pdf of the SSDI Manual, and a .pdf of the Grade Manual.

Data Standards & Data Dictionary, Volume II
The Data Standards and Data Dictionary provides detailed specifications and codes for each data item in the NAACCR data exchange record layout.

ICD-O-3 Histology Coding

International Classification of Diseases for Oncology, 3rd Edition (ICD-O-3) – This book can be purchased through any book store or ordered from online sources. Electronic CSV database files or print copies of the classifications are available from the World Health Organization.

ICD-O-3 errata and clarifications

ICD-O-3 Histology Revisions
The ICD-O-3 Implementation Task Force has approved new codes, changes in behavior codes, and new terms associated with current codes. These changes reflect updates to the WHO Classifications for Tumors (Blue Books). The new codes, new terms, and change to behavior codes for all cases diagnosed 1/1/18 and later.

Registrar Education and Training

AJCC Registrar Education

CAnswer Forum
An interactive bulletin board to ask questions, search topics, and connect with activities. It is designed as an open forum for networking and discussion.

Michigan Cancer Registrars Association (MICRA) Educational Resources

NAACCR Annual Conference and Training
Find events, webinars and educational resources offered by NAACCR and its partners.

National Cancer Registrars Association (NCRA)
The Center for Cancer Registry Education is designed to provide easy access to high-quality educational programming to support both seasoned professionals and those new to the field.

SEER*Educate
This comprehensive training platform is tailored specifically for cancer registry professionals to improve technical skills through applied testing on the latest coding guidelines and concepts.

SEER Training
SEER's Training Website was developed to provide web-based training modules for cancer registration and surveillance.

Cancer Organizations

American Cancer Society

American College of Surgeons (ACoS)

American Joint Commission on Cancer (AJCC)

Cancer Registrar's Guide to Collecting Industry and Occupation

Centers for Disease Control and Prevention (CDC)

College of American Pathologists (CAP)

Commission on Cancer (CoC)

International Classification of Diseases (ICD-9, ICD-10)

International Classification of Diseases for Oncology, 3rd Edition (ICD-O-3)

Michigan Cancer Registrar's Association

National Cancer Institute (NCI)

National Cancer Registrars Association (NCRA)

National Program of Cancer Registries (NPCR)

North American Association of Central Cancer Registries (NAACCR)

Surveillance, Epidemiology, and End Results Program (SEER)

World Health Organization (WHO) (ICD-O-3 Reference Manual)

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