October 2015 Update

MCSP Edit Set~

A new edit set for electronic submission of data to the MCSP is now available. The edit set is available on the MDCH File Transfer (FTP) site at https://sso.mdch.state.mi.us/. The edit set file is labeled as 'NAACCR_v15.rmf.'

Installation of the new MCSP edit set is **required** for proprietary cancer registry software users AND Abstract Plus version 15.0. Electronic data submissions that do not meet the MCSP requirements for reporting, which include the MCSP edit set will be rejected.

If you have any questions regarding the implementation of the new MCSP edit set, please contact Jetty Alverson at Alversong@michigan.gov or (517) 335-8855. If you do not have an FTP account, need password reset and/or assistance with installation of the edit set, please contact David Westover at WestoverD1@michigan.gov or (517) 335-9624.

Data Submission Format~

Data submission format: Facilities submitting cases electronically are required to submit in the most recent version of the data exchange format and code structure as specified by NAACCR. Currently, the MCSP is ONLY accepting data submissions in NAACCR format version 15.0 and include the most current MCSP edit set. Electronic submission of files must follow the MCSP reporting requirements for labeling of file name.

For more information on the MCSP requirements for labeling of electronic submission files and/or submission of data, please refer to the MCSP Cancer Program Manual at http://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_5221-16586--,00.html.

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

MCSP Reporting Requirements~

Submission of data to the MCSP **must** follow the MCSP reporting requirements as defined in the MCSP Cancer Program Manual. It is important to note that the MCSP reporting requirements do differ from those of the Commission on Cancer (for approved cancer programs by the American College of Surgeons). Please review the information provided below, as well as, the MCSP

Cancer Program Manual to ensure that the facility meets the MCSP requirements for submission of data to the central cancer registry.

Facility Reporting Responsibilities

- Know the MCSP reporting requirements as provided in the MCSP Cancer Program Manual. Please note that changes to reporting requirements do occur on a yearly basis and/or as applicable.

- 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 and/or facility contact information.

- If the facility uses proprietary cancer abstracting software, it is the responsibility of the facility to ensure that the software is compliant with the MCSP reporting requirements, including most recent edit set.

- Perform ALL casefinding activities (as applicable based upon facility type) to ensure completeness of reporting.

Note: For more information on reporting responsibilities, refer to the MCSP Cancer Program Manual.

Social Security Number

The social security number (SSN) is a **required data item regardless of facility type**. If the SSN is not documented or unavailable in the patient's medical record(s), out-patient records, or other facility specific records, follow-back with the physician(s) on record is required.

If the SSN is unknown after ALL applicable facility follow-back is conducted, record the SSN as unknown (999999999). If the SSN is coded as unknown (9's), supporting text documentation of facility follow-back is required in the applicable text field.

Race

Race is a required data item regardless of facility type. If the patient's race is not available/not documented, facility follow-back with the physician(s) on record. If facility follow-back is required and the patient's race cannot be obtained, record the race as unknown (99) in race fields 1-5, AND record supporting documentation on follow-back in the applicable text field.

Coding Instructions:

- Record the patient's race according to the documentation in the patient's medical record(s) and/or facility records.
- All tumors for the same patient must have the same race code.

- If multi-racial, enter each race according to the documentation in the patient's records, 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.

Note: For electronic submission, please refer to the MCSP Cancer Program Manual for additional information on coding race fields 1-5.

Laterality

Laterality 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 right, left, or bilateral involvement. Laterality refers to the primary site ONLY; do NOT code the laterality of metastatic site(s). 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.

Codes are as follows:

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 *
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. For example, skin of the trunk can have a midline tumor, but the breasts cannot.

Laterality for sites defined as a paired organ MUST be recorded as 1, 2, 3, 4, 5, or 9.

For a complete list of allowable laterality codes by primary site code and description, download "MCSP Laterality Codes by Primary Site" on the MCSP website (http://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_5221-16586--,00.html). Additional information on coding instructions is provided in the MCSP Cancer Program Manual.

Treatment Fields

In order to properly code patient treatment, it is necessary to think about treatment data as sets of fields in which all of the data values must coincide regarding how (or whether) a modality was administered. All the fields required to code radiation treatment are listed in the tables below.

The value in each of these fields records a certain aspect of the modality and it is important that one value doesn't contradict another in the set. Non-agreement of codes can lead to edit errors.

For example, if the patient does not receive radiation, then only the following values are allowed in the radiation treatment fields:

Tx Data Field	Value	Explanation of Value
RxDateRad		(Blank)
RxDateRadFlag	11	RX Modality not given; autopsy only
RxSumRad	**0**	**None**
RadRegModal	00	No radiation treatment
ReasonNoRad	1*	Radiation therapy not administered; not planned 1st course

*Other values are allowed to explain why radiation was not administered

If it is unknown whether or not radiation treatment was administered, then only the following values are allowed in the radiation treatment fields:

Tx Data Field	Value	Explanation of Value
RxDateRad		(Blank)
RxDateRadFlag	10	Unknown if RX modality performed/administered
RxSumRad	**9**	**Unknown**
RadRegModal	99	Unknown; unknown if RT given
ReasonNoRad	9	Unknown if RT recommended or performed; DC-only/autopsy

Below are other major treatment data sets. There must be agreement between all values recorded within each set.

Surgery	Chemotherapy	Hormone Therapy	BRM Therapy
RxDateSurg	RxDateChemo	RxDateHorm	RxDateBRM
RxDateSurgFlag	RxDateChemoFlag	RxDateHormFlag	RxDateBRMFlag
RxDateMostDefSurg	RxSumChemo	RxSumHorm	RxSumBRM
RxDateDefSurgFlag			
RxSumSurgSite			
ReasonNoSurg			

Patient Address at DX Fields and Current Address Fields

There are two sets of data fields to capture patient address information – a set for the patient's residence at time of diagnosis and another set for the patient's current usual residence. Complete data for both address sets is required for all submitted abstracts. The data recorded in these sets may be different or identical depending on patient circumstances.

NAACCR description of Address at DX information: The number and street address or the rural mailing address of the **patient's residence at the time the reportable tumor was diagnosed**. If the patient has multiple tumors, address at diagnosis may be different for each tumor. Additional address information such as facility, nursing home, or name of apartment complex should be entered in Addr At DX—Supplemental. Do not update this item if patient moves after diagnosis.

NAACCR description of Current Address information: The number and street address or the rural mailing address of the **patient's current usual residence. This can be used to generate a follow-up inquiry**, and must correspond to other fields in the current address. If the patient has multiple tumors, the current address should be the same. Additional address information such as facility, nursing home, or name of apartment complex should be entered in item Addr Current--Supplemental.

The table below lists required data fields for each set.

Address at DX	**Current Address**
Number and Street	Number and Street
Supplemental Number and Street	Supplemental Number and Street
City	City
State	State
Zip Code	Zip Code
County Code	County Code
Country Code	Country Code

If data values for Address at DX and Current Address are the same, some registry software provides a shortcut to duplicate the field data. For example, Abstract Plus allows the user to copy **all** Address at DX field data into the corresponding Current Address fields by placing the cursor in the "Addr Current-No Street" field and then pressing the F5 key.

Recording Breast Case ER/PR/HER2 Receptor Assay Results

The following CS Site-Specific Factor fields capture receptor assay data:

Site-Specific Factor 1	Estrogen Receptor (ER) Assay
Site-Specific Factor 2	Progesterone Receptor (PR) Assay
Site-Specific Factor 8	HER2: Immunohistochemistry (IHC) Lab Value
Site-Specific Factor 9	HER2: Immunohistochemistry (IHC) Test Interpretation
Site-Specific Factor 10	HER2: Fluorescence In Situ Hybridization (FISH) Lab Value
Site-Specific Factor 11	HER2: Fluorescence In Situ Hybridization (FISH) Test Interpretation
Site-Specific Factor 12	HER2: Chromogenic In Situ Hybridization (CISH) Lab Value
Site-Specific Factor 13	HER2: Chromogenic In Situ Hybridization (CISH) Test Interpretation
Site-Specific Factor 14	HER2: Result of Other or Unknown Test
Site-Specific Factor 15	HER2: Summary Result of Test
Site-Specific Factor 16	Combinations of ER, PR, and HER2 Results

See notes and instructions for each SSF field at https://cancerstaging.org/cstage/schema/Pages/version0205.aspx

To stay clear of potential edit errors, avoid discrepancies when recording values in all SSF fields that are associated with receptor assay data.

Example: Assay test results are as follows:
ER – Positive
PR – Positive
HER2 (IHC) – (2+) Equivocal
FISH – (Ratio 1.2) Negative

The field values should be recorded as follows:

Site-Specific Factor	Value	Interpretation
SSF 1	010	Positive/elevated
SSF 2	010	Positive/elevated
SSF 8	002	Score 2+
SSF 9	030	Borderline; equivocal; indeterminate; undetermined
SSF 10	120	Ratio of 1.2
SSF 11	020	Negative/normal
SSF 12	998	Test not done
SSF 13	998	Test not done
SSF 14	998	Test not done
SSF 15	020	Negative/normal; within normal limits; not amplified
SSF 16	110	ER Negative, PR Negative, HER2 Negative*

* In this example, value for FISH is recorded in the combined results because the HER2 assay results were equivocal.

Supporting Text Documentation

Remember that your text field documentation must include enough information so that an abstract can be completed based upon a text review only. Text is required to support coded values such as:

- Race
- Age
- History of cancer
- Sequence number (when the patient has multiple reportable conditions)
- Method of diagnosis
- Pathology/cytology report (final diagnosis including addendum and applicable comments)
- Primary Site
- Histology
- Tumor Grade
- Stage (extent of disease)
- Surgical procedure/work-up
- Treatment work-up
- First course of treatment including date, type of type (i.e. chemo agents), and start date. If the decision is made not to treat the tumor, then the reason for non-treatment must be noted, e.g., Not recommended due to other health issues. Keep in mind that Active Surveillance can be considered as first course of treatment.

The MCSP will begin conducting quality assurance audits on text documentation. Facilities non-compliant with the Michigan cancer reporting requirements, which include completeness, accuracy and timeliness of data submission, will be addressed and corrective action taken if necessary.

ICD-O-3 Implementation and Reportability~

CDC is following the NAACCR Guidelines for ICD-O-3 Update Implementation (published Dec. 2013). At this time, it has not been determined whether the new reportable histology codes originally intended for implementation with 2015 diagnoses will become effective for 2016 diagnoses. More information will be provided in the NAACCR 2016 Implementation Guide, as well as in the revised MCSP Cancer Program Manual for 2016.

Reportable Conditions for CIN III, HGSIL/HGSIL~

To ensure that ONLY eligible CIN cases are submitted to the MCSP, please review the guidelines for reportability as provided in the MCSP Cancer Program Manual. See 'Reportable Conditions for AIN III, CIN III, HSIL/HGSIL, VAIN II, VIN III.' If the case is identified as a reportable condition, please record the final diagnosis as provided in the pathology report in the pathology text field. Any pertinent information such as date of diagnosis, type of procedure and other applicable information must be recorded in the appropriate text field.

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)," "HGSIL," "HSIL," or "severe dysplasia." Histology for any of these cervical neoplasia conditions is coded as 8077 with or without the term "carcinoma in situ."

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

For 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 biopsy pathology.

Examples of Reportable versus Non-Reportable diagnoses based upon histological confirmation are provided below. Additional information on coding of data items for reportable CIN III cases is included in the MCSP Cancer Program Manual.

Examples

Reportable
"CIN 2 and 3" is reportable
"CIN 2 & 3" is reportable
"CIN 2 + 3" is reportable
"Moderate and severe dysplasia" is reportable

Not Reportable
"CIN 2-3" is NOT reportable
"CIN 2/3" is NOT reportable
"Moderate to severe dysplasia" is NOT reportable

Web Plus~

What is Web Plus? It is a Web-based application that collects cancer data securely over the public Internet. It is ideal for use by central cancer registries for all electronic reporting needs. Web Plus supports three main functions: online abstracting, file upload and download, and follow-back efforts. Web Plus online abstracting capacity is ideal for reporting from physician offices and other low-volume reporting sources, while the file upload feature can be used for electronic submission of data from all other reporting sources to the central cancer registry.

The follow-back features in Web Plus enables the central cancer registry to upload partially filled abstracts generated from death certificate and pathology lab files, and to notify the appropriate facility via e-mail to log in and update the abstracts.

All records are saved in a database at the hosting central cancer registry, and cases entered by one facility or offices 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 at 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.

The MCSP is currently in the process of implementing Web Plus for electronic submission of data. Once the Web-based application server is up and running, information on the revision for electronic submission of data will be provided. Please watch for upcoming correspondence and webinar schedule to assist facilities with the revisions for electronic submission of data.

MCSP Staff ~

Please feel free to contact one of us if you have any questions regarding cancer reporting or if you would like more information about upcoming training/workshop opportunities.

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MCSP Cancer Program Manual and Resource References ~

The MCSP Cancer Program Manual and resource reference documents can be obtained from the MCSP webpage at http://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_5221-16586--,00.html.

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