



OCCR NewsFlash



Oklahoma Central Cancer Registry

Spring Issue

In Memory of our Friend and Co-worker, Amanda E. Moran

It is with great sadness that the staff of the OCCR shares the passing of one of our own, Amanda E. Moran.

Having graduated with a Bachelor's of Science in Health Information Management from East Central University in Ada, Amanda had experience as a cancer registrar, CTR, and a HIPAA Privacy /Security Officer in a hospital setting when she came to join OCCR in November of



1978-2014

2010. She was passionate about her work in the registry field and truly enjoyed her job. Amanda was a valued member of our team and will be greatly missed.

In memory of her passion and commitment to the cancer registry field, the staff of the Chronic Disease Service will be donating money to sponsor students to attend the OCRA Fall Workshop in September.

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This issue is dedicated in memory of Amanda. The pictures and quotes seen throughout are little things that brought joy to her workday (and ours).



Minute Details but Vital Information

by Christina Panicker, MBA, CTR

This article has been included in response to the number of coding errors seen lately. Please keep these in mind for future abstracting.

Properly coding the lymph nodes in breast cancer primaries is very important. One should note whether lymph nodes were clinically or pathologically evaluated. When abstracting CS Lymph Nodes, pay close attention to the difference between 000 and 050. The code 000 is used for lymph nodes that are clinically staged, while

050 is used for lymph nodes that have been pathologically staged and found to be negative.

Also needing special attention are patient demographics. Their accuracy is critical to the integrity of the data. Please provide any pertinent information regarding demographic items such as birthdate, race, ethnicity, social security number and place of birth. One critical example is *gender*. Sometimes this field is completed

incorrectly based on patient name. As simple as it sounds, it's a mistake that happens.

Your attention to such details can help to reduce time spent correcting this type of error.



Re-Abstraction Audits

by Marva Dement, BBA, BS, CTR

The OCCR's Quality Assurance Specialist, Marva Dement and the Compliance Specialist, Delores Greene, are hitting the road and heading to a facility near you! We began auditing facilities for case quality in January 2014.

Variables that will be included in the audit are:

- * Demographic information
- * Pathology data
- * Treatment information

The items included in re-abstraction are items that the OCCR is also audited on once every five years by the Centers for Disease Control and Prevention – National Program of Cancer Registries. The purpose of these audits is to confirm high quality abstraction and identify any potential training needs.

The facilities selected for re-abstraction will receive a list of cases at least 30 days prior to the audit. The facility will need

to either have the actual record available to the OCCR staff or allow electronic access. The OCCR staff will require the pathology reports, dictated reports, (H & P, Discharge Summary, Consultative Reports, etc.) and radiation therapy logs for review. The facility registry staff will not be required to be present during the audit unless required by their facility.

RMCDs Corner

by Paula Marshall, BBA, CTR

All RMCDs facilities are required to run the Conversion of Collaborative Stage 02.04 to 02.05 prior to abstracting cases diagnosed January 01, 2014, and forward. After converting to CS 02.05 all

newly abstracted cases must be coded using the CS 02.05 coding instructions.

Abstracting of all 2013 diagnosed cases must be completed before the CS 02.05 conversion is ran. If you have already submitted 2014 cases or are starting to abstract 2014 cases, please contact me ASAP so that I can help you with the conversion of your RMCDs system.

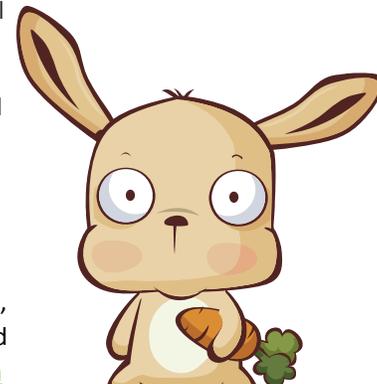
Please note that 2014 diagnosed cases submitted to the state will not be processed until the OCCR has converted the main database. Also, when you upload a NAACCR ver 14 file via Web Plus, you will need to select non-naaccr file upload. Please contact me if you have any questions.



Update on Collaborative Stage Transition

by Delores Greene, CTR

Beginning with cases diagnosed January 1, 2016, and after, the standard-setters in the U.S. will require AJCC TNM and Summary Stage coding to be recorded in the cancer registry abstract. NCRA is a member of the CS Transition Group, along with the AJCC, CDC/NPCR, CoC, NAACCR, NCI-SEER, and Statistics Canada/Canadian Council of Cancer Registries. The group was formed as an information-sharing and planning forum. It will provide a collaborative opportunity to identify the issues involved in the transition and to share the tasks involved in developing best practices for both the overall cancer surveillance community and the individual agencies/organizations in addressing this change.



To help keep everyone better informed, the CS Transition Group (NCRA, AJCC, CDC/NPCR, CoC, NAACCR, NCI-SEER and Statistics Canada/Canadian Council of Cancer Registries) has developed the "Collaborative Stage Transition Newsletter." The first copy is available at http://www.ncra-usa.org/files/public/CS_TransitionNewsletter_March2014.pdf. The newsletter will address the process and ongoing efforts to coordinate and effectively transition from Collaborative Staging v2 system to use of the AJCC TNM staging standard with related biomarkers and prognostic factors.

Members of the CS Transition Group recognize that the transition away from CS is a major change and are committed to working with stakeholders to develop appropriate implementation plans and processes. This is a work in progress and there are many questions that have yet to be fully addressed. As answers become available, NCRA will share updates and provide opportunities for members to identify issues and concerns.

This quote was a favorite displayed on a plaque at Amanda's desk.

*Lord, please keep your arm
around my shoulder and
Your hand over
my mouth!*



Excellent Educational Opportunity Coming Soon

by Leslie Dill

Historically, OCRA has presented a Fall Workshop each year. This year, OCRA is partnering with the Missouri, Kansas and Arkansas Cancer Registry Associations to hold a regional education meeting instead. Make plans now to attend the Missouri, Oklahoma, Kansas & Arkansas (M.O.K.A) Regional Meeting to be held September 24 – 26, 2014. This will be a 2 ½ day meeting (ending around noon on Friday) and will be held at the Hilton Branson Convention Center at 200 E. Main St. in Branson, Missouri. Renowned International speaker, April Fritz, RHIT, CTR, is only one of several speakers scheduled to speak at the meeting. You won't want to miss it! Additional details will be posted on the Education page of the [OCRA website](#) and in upcoming newsletters.



ICD-O-3 Update Implementation by Paula Marshall, BBA, CTR

The ICD-O-3 Implementation Update Work Group, with April Fritz as chair, began meeting in 2012, to determine how and when NAACCR member registries should implement the ICD-O-3 Update terms and codes for cases diagnosed on or after January 1, 2014. The Work Group forwarded their implementation recommendations to the Cancer Registration Steering Committee (CRSC) Change Management Board (CMB) in June 2013. The CMB reviewed the recommendations and accepted them with implementation dates effective January 1, 2014.

The CMB has approved 36 new terms to be added to existing codes in ICD-O-3 for use in the United States and Canada beginning with cases diagnosed on or after January 1, 2014. Of these terms, 21 are malignant (/3) terms, and one is a new borderline (/1) tumor of the central nervous system. All of these are reportable. The remaining 14 are benign (/0) or uncertain malignancy (/1) and are not reportable conditions. Table 1 displays the terms approved for use with 2014 diagnoses and forward.

It is important to remember that cancer registry reportability rules based on behavior code still apply. With the exception of primary intracranial and central nervous system benign and borderline tumors, the addition of a /0 or /1 coded term to ICD-O-3 does not imply that it is now reportable.

For 2015, 16 new codes and terms were proposed for addition to ICD-O-3. Of these, 7 are reportable malignant (/3) tumors and 4 are reportable borderline (/1) tumors of the central nervous system. Also proposed for 2015 is a behavior and reportability change for carcinoid of the appendix. The OCCR will keep you updated as per the implementation of the new codes and terms for 2015 or they can be accessed at the NAACCR website www.naacccr.org.

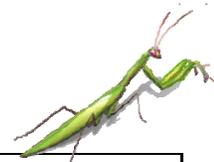


Guidelines for ICD-O-3 Update Implementation

TABLE 1 ICD-O-3 CHANGES EFFECTIVE JANUARY 1, 2014

Use the following new terms, synonyms, and related terms for existing ICD-O-3 codes. Bold indicates a preferred term. **TABLE 1 is continued on page 5.**

New preferred term	8150/0 Pancreatic endocrine tumor, benign (C25._)
Move former preferred term to synonym	8150/0 Islet cell adenoma (C25._)
New related term	8150/0 Pancreatic microadenoma (C25._)
New preferred term	8150/1 Pancreatic endocrine tumor, NOS (C25._)
Move former preferred term to synonym	8150/1 Islet cell tumor, NOS (C25._)
New preferred term	8150/3 Pancreatic endocrine tumor, malignant (C25._)
Move former preferred term to synonym	8150/3 Islet cell carcinoma (C25._)
New related term	8150/3 Pancreatic endocrine tumor, nonfunctioning (C25._)
New related term	8152/1 L-cell tumor
New related term	8152/1 Glucagon-like peptide-producing tumor (C25._)
New related term	8152/1 Pancreatic peptide and pancreatic peptide-like peptide within terminal tyrosine amide producing tumor
New synonym for related term	8152/1 PP/PYY producing tumor



New preferred term	8154/3 Mixed pancreatic endocrine and exocrine tumor, malignant (C25._)
New related term	8154/3 Mixed endocrine and exocrine adenocarcinoma (C25._)
New synonym for related term	8154/3 Mixed islet cell and exocrine adenocarcinoma (C25._)
New related term	8154/3 Mixed acinar-endocrine-ductal carcinoma
New related term	8201/3 Cribriform comedo-type carcinoma (C18._, C19.9, C20.9)
New synonym	8201/3 Adenocarcinoma, cribriform comedo-type, (C18._, C19.9, C20.9)
New synonym to primary term	8213/0 Traditional serrated adenoma
New related term	8213/0 Sessile serrated adenoma
New related term	8213/0 Sessile serrated polyp
New related term	8213/0 Traditional sessile serrated adenoma
New related term	8240/3 Neuroendocrine tumor, grade 1
New related term	8240/3 Neuroendocrine carcinoma, low grade
New related term	8240/3 Neuroendocrine carcinoma, well-differentiated
New preferred term	8244/3 Mixed adenoneuroendocrine carcinoma
Move former preferred term to synonym	8244/3 Composite carcinoid
New synonym	8244/3 Combined/mixed carcinoid and adenocarcinoma
New synonym	8244/3 MANEC
New synonym	8249/3 Neuroendocrine tumor, grade 2
New related term	8249/3 Neuroendocrine carcinoma, moderately differentiated
New synonym	8263/0 Tubulo-papillary adenoma
New related term	8290/0 Spindle cell oncocytoma (C75.1)
New related term	8490/3 Poorly cohesive carcinoma
New related term	8811/0 Plexiform fibromyxoma
New related term	8970/3 Hepatoblastoma, epithelioid (C22.0)
New related term	8970/3 Hepatoblastoma, mixed epithelial-mesenchymal (C22.0)
New related term	9471/3 Medulloblastoma with extensive nodularity
New related term	9474/3 Anaplastic medulloblastoma
New related term	9506/1 Extraventricular neurocytoma

NAACCR 2014 Webinar Schedule May-September

by Leslie Dill



Is it just me, or is this year flying by very quickly? One reason for feeling that way is because there are only five webinars left of the NAACCR 2014 series.

- 5/1/2014 Collecting Cancer Data: Colon and Rectum
- 6/5/2014 Collecting Cancer Data: Liver
- 7/10/2014 Topics in Survival Data
- 8/7/2014 Collecting Cancer Data: Lung
- 9/11/2014 Coding Pitfalls

Presented at Oklahoma City's OU Medical Center, Samis Education Center, next to Children's Hospital, 120 Children's Ave., Basement Level B-Conference Room C. The Tulsa location will be at the Mary K. Chapman Health Plaza at St. John Medical Center, 1819 E. 19th St., Tulsa. This is scheduled in the Newman Room at the end of the lobby area.

To register email DeloresG@health.ok.gov or LeslieD@health.ok.gov.

ER (Estrogen Receptor) – Estrogen receptors are a group of proteins found inside cells. They are receptors that are activated by contact with the estrogen hormone. When these receptors are found in cancer cells, estrogen can bind to them and cause the cancer cells to grow.

PR (Progesterone Receptor) – Progesterone receptors are a group of proteins found inside cells. When these proteins are found in cancer cells, they can be activated by the hormone progesterone which can cause them to grow.

Her2 (Human epidermal growth factor receptor 2) – Her2 is a protein involved in normal cell growth. When these proteins are found in cancer cells, they can cause the cancer cells to grow.

Biomarker testing plays a very important role in the evaluation of breast cancer. Biomarkers can be prognostic, predictive, or both. The expression of ER and PR hormone receptors is a weak prognostic but strong predictive biomarker. For example, if evaluation of a breast tumor shows ER and/or PR expression, doctors can safely predict that the patient will benefit from endocrine (hormone) therapy. Research studies have shown that even cancers with low numbers of hormone receptors may respond to hormonal therapy. Most testing labs use a special staining process that makes the hormone receptors show up in a sample of breast cancer tissue called an immunohistochemical staining assay, or ImmunoHistoChemistry (IHC). The specific tests are called ERA and PRA.

ERA (Estrogen Receptor Assay) – PRA (Progesterone Receptor Assay) – these tests show a percentage of how many cells out of 100 stain positive for the hormone receptor. The results will be a percentage number between 0% (none have receptors) and 100% (all have receptors).

It is important to know that different labs have different cutoff points for calling the cancer either “hormone-receptor-positive” or “hormone-receptor-negative”. Some labs consider anything 1% or above to be positive, while other labs consider results between 1%-10% to be negative. The rules state to use the physician’s interpretation over the lab report (see coding tips below).

Another type of biomarker testing used is Her2 testing. The overexpression of Her2 is both a prognostic and predictive biomarker. Her2 expression is associated with a higher risk of recurrence (prognostic) because Her2 positive breast cancers tend to grow faster and are more likely to spread and come back. Her2 expression is also used to plan treatment (predictive) because cancers that are HER2 positive indicate that the patient will benefit from chemotherapies, but NOT endocrine-based therapies. The most common HER2 tests that we see on a regular basis are the **Her2 IHC** (also called Her2/neu) and **Her2 FISH** tests.



IHC test (ImmunoHistoChemistry) – this test measures the amount of Her2 protein in the cancer cell. The results can be 0 (negative), 1+ (also negative), 2+ (borderline/ equivocal) or 3+ (positive – Her2 protein overexpression).

If the Her2 IHC test comes back with a borderline/equivocal result, a more precise test will be performed. There are 3 different types, but the most common we see is called **Her2 FISH**.

FISH test (Fluorescence In Situ Hybridization) – this test looks for too many copies of the Her2 gene in the cancer cells. The results of the FISH test can be positive (Her2 gene amplification) or negative (no Her2 gene amplification).

Continued on page 8

Timeliness in Reporting by Delores Greene, CTR

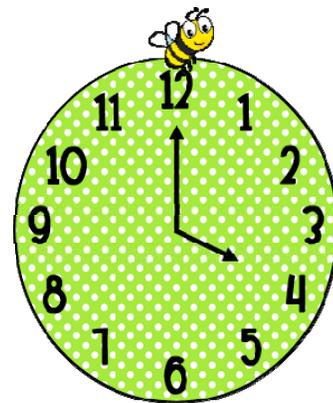
Oklahoma Central Cancer Registry (OCCR) requires all cancer cases be reported within 180 days of first contact for the patient's cancer. This is mandated by Federal and State Laws.

As we enter the month of April 2014, facilities should be and are required to be 75% (January-September) complete in submitting 2013 cases. All 2013 cases are due to OCCR by June 30, 2014. If you expect a delay in reporting all your 2013 cancer cases by June 30, 2014, please contact Delores Greene as soon as possible at deloresg@health.ok.gov or 405-271-9444 extension 57103.

In addition as of this date, all 2012 cases were due June 30, 2013. Any 2012 cases not submitted are considered past due and the facility is non-compliant. It is vital that all 2012 admission year cancer cases are completed and submitted immediately to avoid the issuance of a non-compliance letter.

As part of the CDC's National Program for Central Registries, OCCR must achieve 90% of cases to be included within 12 months of the close of the diagnosis year for case completeness. OCCR target goal is 95% or greater for case completeness.

If your facilities case load is 100 or greater, cases should be reported monthly. Facilities who report less than 100 cases, report monthly or quarterly. See table below.



Oklahoma Central Cancer Registry (OCCR) Timeliness Schedule			
Reporting Schedule			
Annual Caseload	Reporting Period	Cases Diagnosed	Date Cases Due to OCCR
>100	Monthly	January 2013 February 2013 March 2013 April 2013 May 2013 June 2013 July 2013 August 2013 September 2013 October 2013 November 2013 December 2013	July 31, 2013 August 31, 2013 September 30, 2013 October 31, 2013 November 30, 2013 December 31, 2013 January 31, 2014 February 28, 2014 March 31, 2014 April 30, 2014 May 31, 2014 June 30, 2014
<100	Monthly or Quarterly	Same as above Jan/Feb/Mar 2013 Apr/May/Jun 2013 Jul/Aug/Sept 2013 Oct/Nov/Dec 2013	Same as above September 30, 2013 December 31, 2013 March 31, 2014 June 30, 2014

"Tell me and I forget. Teach me and I remember. Involve me and I learn." Benjamin Franklin

CODING TIPS:

- Always code the value and interpretation of each test from the **same specimen**.
- When there is more than one ER/PR/Her2 test performed, record the test with highest value.
- If there are positive and negative ER/PR/Her2 values, record the positive.
- You can use the ER results from a biopsy and PR results from mastectomy.
- Code the lab value and interpretation from the same test (same specimen).
- Do NOT code from Multigene Signatures tests (i.e. Oncotype)



IMPORTANT: Definitions of “positive” and “negative” interpretations for the test vary from one lab to another. Each may have a different range for normal values. Look for the interpretation of the test by patient’s clinician or the facility pathology as first priority. In the absence of the local doctor’s interpretation, look on the actual lab report for that particular lab’s reference values and use that information to assign the appropriate interpretation code. If neither a physician interpretation nor a lab reference range can be found, do not attempt to interpret the results; code as 999 unknown.



NCRA will celebrate its 40th anniversary at this year’s annual education conference in Nashville, TN. This year’s theme is “Working in Harmony to Deliver Excellence.” In keeping with that theme, the conference will be held May 15-18, 2014, at the Gaylord Opryland Resort and Convention Center. Registration is still open. Visit their website at www.ncra-usa.org for more information and registration.



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Cancer Awareness Calendar by Judy Hanna, HT(ASCP)

April = National Oral, Head & Neck Cancer Awareness Month
May = National Melanoma/Skin Cancer Detection & Prevention Month
May = Brain Tumor Awareness & National Neurofibromatosis Month
June = Cancer Immunotherapy Awareness Month
September = National Ovarian Cancer Month
September = Gynecologic Cancer Awareness Month
September = Leukemia and Lymphoma Awareness Month
September = Thyroid Cancer Awareness Month
October 2014 = National Breast Cancer Awareness Month
November 2014 = Lung Cancer Awareness Month
November 2014 = Pancreatic Cancer Awareness Month



National Cancer Survivors Day
Sunday, June 1, 2014

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