

## CDC-NPCR Requirements for 2013

By Paula Marshall, BBA, CTR

Beginning with cases diagnosed on or after January 1, 2013, the OCCR will follow the new record layout and data collection requirements as set by our funding source, CDC-NPCR.

Seven new data items were added as part of an initiative to standardize the use of International Standards Organization (ISO) 3-character county codes and USPS 2-character state abbreviations. Effective for 2013, CDC-NPCR has added requirements for four of the seven data items listed below:

- \*Birthplace Country
- \*Birthplace State
- \*Place of Death State
- \*Place of Death Country

The OCCR will continue to collect the required data items as specified for cases diagnosed in 2012 as well as the four newly required items for 2013.



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## Oklahoma Has Three New CTRs

By Leslie Dill

Spring of 2013 is off to a spectacular start in Oklahoma! Of the hundreds that took the NCRA Certified Tumor Registrar Exam, 3 were Oklahomans that passed with flying colors. At Hillcrest Medical Center, Miss Danillie Clark dedicated 4 ½ years of her lunch hours and spare time to studying for the CTR Exam. Danillie has an Associate's Degree in medical assisting, education and liberal arts. She began her medical career in a North Carolina doctor's office in 2006, worked for the Red Cross for 4 years, and then became the supervisor at Saint Francis Breast Center. Having made a decision to follow the cancer registry path, Danillie left Saint Francis for a cancer registry position at Hillcrest Medical Center where she is presently employed.



Amy Finn, A.S., CTRS, CTR

Oklahoma's second new CTR, Amy Finn, has been in the medical field for 24 years, starting at St. John Medical Center as a transcriptionist. Amy has an Associate's Degree in Health Information Management/Coding & Reimbursement and is also a Certified Trauma Registry Specialist (CTRS).



Danillie Clark, A.S., CTR

Last, but certainly not least, Glenda Mayfield has joined the ranks as a CTR. A native of Muskogee, OK, Glenda earned her Bachelor's Degree in Business Management from the University of Phoenix. She has worked in the healthcare field for 19 years, beginning her career at Muskogee Regional Medical Center as an Admission Registrar and a Cancer Registrar. Currently she is a Cancer Registrar for the Jack C. Montgomery VA Medical Center in Muskogee.

When asked to share with others preparing to take the CTR exam, Danillie said, "The NAACCR CTR Exam Prep Webinars were helpful. I used them like a study guide, but I also use the NCRA study guide book. April Fritz's staging manual workbooks were a good resource. The webinar series had good exercises, and the recommended readings were especially good. Now that it is available on the NetLink, it makes it so convenient. You can access the recordings and handouts as much as you like. My advice to future test takers is to read the questions twice and start preparing early."



Glenda Mayfield, BS, CTR

OCCR congratulates Danillie, Amy and Glenda on this outstanding accomplishment!



## Re-abstractation of 2011 Cases

By Marva Dement, BBA, BS, CTR

In the coming months, the OCCR's Quality Assurance Specialist, Marva Dement, and the Compliance Specialist, Delores Greene, will be hitting the road and coming to a facility near you! We will begin auditing facilities by re-abstracting some of your 2011 cases. This would be a great time to finish your 2011 abstracting and check your disease index for any possible missed cases.

Variables included in the audit will be:

\*Demographic information (date of birth, race and sex)

\*Pathology data (primary site, laterality, histology, behavior code, grade, date of diagnosis, collaborative staging information and derived Summary Stage 2000)

\*Treatment information (date of first course of treatment, surgery of primary site, regional lymph node surgery, surgery of other regional/distant sites, radiation therapy, chemotherapy, hormonal therapy, biological response modifier therapy, transplant/endocrine therapy and other therapy)

The facilities selected for re-abstractation will receive a list of cases at least 30 days prior to the audit. In addition, the facility will need to either have the actual record available to the OCCR staff or allow electronic access. The OCCR staff will need the disease index of the year being audited, pathology reports, non-gynecological cytology reports 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.

Volunteers should call (405) 271-4072, x 57119 or e-mail [marvad@health.ok.gov](mailto:marvad@health.ok.gov).

# RMCDs Corner

## Edit Tips for RMCDs Users

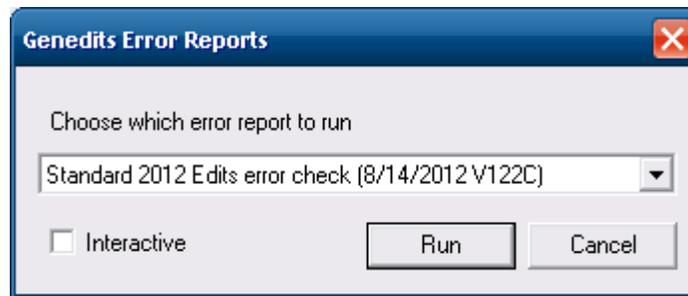
By Data Manager Paula Marshall, BBA, CTR

Our Web Plus application has been upgraded to NAACCR v12.2 format and now runs the Central: Vs 12.2 – Incoming Abstracts edit set when the file is uploaded. Before the upgrade, files were not run through the state specific edit set due to the difference in the file format and Web Plus version. In the past, we had designated some CS SSF fields as not required/not collected, but the standard setters agreed that beginning with 2010 data, the SSF fields should not be allowed to be left blank. Therefore, you should code an uncollected SSF to 988 or other code indicating "not collected" if 988 is not a valid code for a schema. In the updated version of Web Plus, the new state specific edits will run accordingly and you will not be allowed to leave any SSF fields blank.

In order to run the state back-up once in RMCDs and have all edits cleared before the file is uploaded via Web Plus, please follow these steps to run the appropriate edit set:

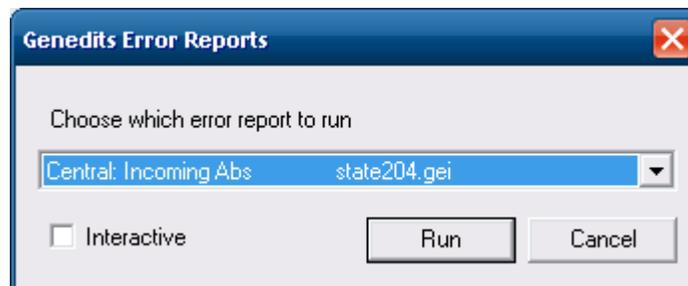
When the abstract is complete, you will need to run the case through edits. While the abstract is open.....

1. Click on the tab labeled Errors.
2. Select the option CDC and the window seen below will open.



Notice that the default is Standard 2012 Edits error check (8/14/2012 V122C) BUT you will select a different error report to run.

3. Click on the black drop down arrow and select as shown below:
4. Choose Central: Incoming Abs state204.gei.



This is the same edit set that the uploaded files run through in Web Plus. If you clear edits in RMCDs system you should not have any edits when the file is uploaded.

Please contact me with any questions or if you need assistance. [PaulaM@health.ok.gov](mailto:PaulaM@health.ok.gov) or (405)271-9444, ext 57121.

# Making Mets Make Sense

By Amanda E. Moran, RHIA, CTR

Metastasis (mets) is any tumor spread to a part of the body away from the primary tumor. There are two types of mets. First, let's consider mets found during the work-up of the original primary tumor. These mets are included in the CS data and on the treatment page. They can be found with:

- Information gathered through the completion of surgery(ies) in the first course of treatment;
- Any information available within **four** months of the date of diagnosis in the absence of disease progression (mets known to have developed after the diagnosis was established should be excluded); OR
- Whichever is **longer**.

Next, there are mets found any time after the treatment plan for the patient's primary tumor has been established. These mets are **NOT** included in the CS data or on the treatment page. However, the date on which the mets are diagnosed is listed on the Outcomes Page as the "Recurrence Date." For these mets, any diagnosing or treatment information should be included at the back of the abstract in one of the large, blank data fields.

## Seer-Rx Update: January 2013 Release

By Delores Greene, CTR

A comprehensive review of chemotherapeutic drugs currently found in SEER\*RX has been completed, and in keeping with the FDA, the following drugs listed in the table below have changed categories from Chemotherapy to BRM/Immunotherapy. *This change is for cases with a diagnosis date January 1, 2013 forward.* For cases diagnosed prior to January 1, 2013, continue coding these six drugs as chemotherapy. Coding instructions related to this change have been added to the remarks field for the applicable drugs.

<http://seer.cancer.gov/tools/seerrx/revisions.html>

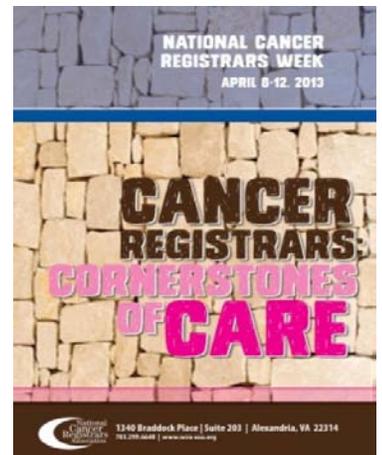
Drug Name(s)	Previous Category	New Category	Effective Date
Alemtuzumab/Campath	Chemotherapy	BRM/Immunotherapy	1/1/2013
Bevacizumab/Avastin	Chemotherapy	BRM/Immunotherapy	1/1/2013
Rituximab	Chemotherapy	BRM/Immunotherapy	1/1/2013
Trastuzumab/Herceptin	Chemotherapy	BRM/Immunotherapy	1/1/2013
Pertuzumab/Perjeta	Chemotherapy	BRM/Immunotherapy	1/1/2013
Cetuximab/Erbix	Chemotherapy	BRM/Immunotherapy	1/1/2013

## National Cancer Registrars Week, April 8-12th

By Christina Panicker, BS, MBA, CTR

The National Cancer Registrars Association has proclaimed April 8-12, 2013, as National Cancer Registrars Week. The extensive work that cancer registrars perform is necessary for treatment research and improvement in cancer patient survival. Quality information on cancer diagnosis and treatment is vital in enabling research to progress and finding a cure.

The OCCR thanks you for the outstanding work that you do and wishes you a Happy NCRW!



# Questions & Answers

## SEER Website "Data Collection Answers"

By Delores Greene, CTR



Are schwannomas reportable?	Reportability depends on the primary site. When they originate in the intracranial (intradural) or intraspinal space they are reportable.
Are Stage I GIST tumors reportable? In the past, tumor size and mitotic rate were used to determine if malignant, not stage.	GIST's are reportable based on the pathologist's designation of tumor behavior, just as with all sites.
What site code should be used for angiosarcoma of breast?	Code the primary site to breast (C50_). Although angiosarcoma actually originates in the lining of the blood vessels, an angiosarcoma originating in the breast has a poorer prognosis than many other breast tumors.
How are dates recorded when cancer is diagnosed in utero or prior to birth?	Instructions were changed for cases diagnosed 2009 forward. Record the actual diagnosis and treatment dates even when the dates are prior to date of birth.
When are the carcinoids of the appendix reportable?	1. When the regional lymph node or nodes are positive for malignant metastatic carcinoid 2. When there are discontinuous malignant metastasis from the appendix carcinoid Note: The metastases may be found at the same time as the primary carcinoid of the appendix or may occur years later.
Do you use the date of a suspicious cytology as the date of diagnosis?	No, do not use the date of suspicious cytology as the date of diagnosis.
How do you code the diagnostic confirmation for hematopoietic and lymphoid neoplasms when immunophenotyping, genetics, etc. confirms the diagnosis?	Code 3 is used for hematopoietic and lymphoid cases when three conditions are met:  1. Genetic testing and/or immunophenotyping are described in the Hematopoietic database "Definitive Diagnostic Methods" field; AND 2. Genetic testing and/or immunophenotyping were done; AND 3. The genetic testing and/or immunophenotyping were positive (proved the type of neoplasm being coded).

# Coding Instructions

## Did You Know?

By Jessica Taylor

Code an **excisional 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

**Note:** Do *not* code an excisional biopsy when there is *macroscopic* residual disease.

**Example:** Patient has an incisional biopsy of a suspicious skin lesion on the right arm. Pathologic examination of the specimen revealed an invasive melanoma but with clear margins. You would not code this as a dx/staging procedure. Since the whole tumor was removed at the time of the biopsy, this would be considered as a treatment procedure and would be coded as an excisional biopsy.

\*See the SEER Program Coding and Staging Manual 2012, Section VI, Surgery of Primary Site for more details.

# Type of Reporting Source/Facility

By Amanda E. Moran, RHIA, CTR

A commonly overlooked field in the abstract is the "Type of Reporting Source/Facility" field. This field is important because it tells us the type of reporting source/facility that provided the best information used when abstracting the case. Please be sure to use one of the following codes to describe your facility or the facility from which you obtained your information.

Code	Description
1	Hospital inpatient; Managed health plans with comprehensive, unified medical records (new code definition effective with diagnosis on or after 1/1/2006)
2	Radiation Treatment Centers or Medical Oncology Centers (hospital-affiliated or independent) (effective with diagnosis on or after 1/1/2006)
3	Laboratory Only (hospital-affiliated or independent)
4	Physician's Office/Private Medical Practitioner (LMD)
5	Nursing/Convalescent Home/Hospice
6	Autopsy Only
7	Death Certificate Only
8	Other hospital outpatient units/surgery centers (effective with diagnosis on or after 1/1/2006)

In the past 30 years,  
more than 7,000  
individuals have  
earned the Certified  
Tumor Registrar (CTR)  
credential.

# New Specifications for the 2014 CTR Exam

By Delores Greene, CTR

In 2012, Professional Examination Service was hired by the National Cancer Registrars Association (NCRA) Council on Certification to conduct a Job Analysis of cancer registry professionals. The Job Analysis is a scientific research study that sought to outline the knowledge, skills, and abilities that define a profession and distinguishes it from others. The results of this study were used to validate the content of the credentialing exam and to ensure it accurately reflects changes in our profession. The Job Analysis was performed under the guidance of a six-member Steering Committee comprised of members of NCRA volunteer leadership and representatives of key stakeholder groups. The Steering Committee appointed a ten-member Task Force to further assist with analyses.

The 2012 Job Analysis identified essential job tasks of cancer registry professionals across a range of registry roles and settings and outlined the knowledge bases needed to accurately perform those required tasks. As a result of these findings, a set of recommendations that the Council on Certification will implement beginning with the 2014 exam, including updating the exam content outline and weighting, plus reducing the number of exam questions (see chart below).

After reviewing the results, the Steering Committee and Task Force developed a recommended set of updated test specifications for the CTR Examination. The proposed new specifications allocate specific percentages of test questions across six domains of practice. The specifications include the job tasks and knowledge bases that received survey ratings high enough that were judged to have met a reasonable threshold for inclusion.

	2007 to 2013 CTR Exam	2014 CTR Exam
Number of Questions	250	225
Number of Questions Closed-Book Portion	200	180
Number of Questions Open-Book Portion	50	45  (open book questions focused on coding and staging)
Exam Content and Weighting	Domains of Practice <ul style="list-style-type: none"> <li>• Registry Organization &amp; Operations (25%)</li> <li>• Data Management &amp; Analysis (20%)</li> <li>• Concepts of Abstracting, Coding &amp; Follow up (35%)</li> <li>• Application of Coding &amp; Staging (20%)</li> </ul>	Domains of Practice <ul style="list-style-type: none"> <li>• Data Collection (53-57%)               <ul style="list-style-type: none"> <li>○ Case Finding</li> <li>○ Abstracting</li> <li>○ Follow-up, Survivorship &amp; Outcomes</li> </ul> </li> <li>• Data Quality Assurance (10%)</li> <li>• Analysis and Data usage (10-14%)</li> <li>• Operations &amp; Management (8%)</li> <li>• Cancer Committee and Conference (10%)</li> <li>• Activities Unique to Centralized Registries (5%)</li> </ul>



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Oklahoma State  
Department of Health

# Coding Stumpers

Case Scenarios Submitted by CTR's

## Case Scenario 1

A 12-year old boy with brain lesion undergoes surgery, 5/24/2012 near total resection. Final pathology shows the diagnosis of Ependyoblastoma. He begins chemotherapy on 6/3/2012 for his aggressive tumor. In the mean time, the slides were sent for review at an out of state children's hospital. Consultation showed the diagnosis to be a grade 2 ependymoma. Because of the change in diagnosis, and a much less aggressive tumor, the treatment plan was changed. Chemotherapy is stopped and he receives adjuvant radiation, beginning on 7/20/2012, with no other therapy.

### Question:

Should the registrar record the chemotherapy that was administered? Why or why not? If there's a reference please share.

### Answer received from April Fritz:

Yes, you should code the chemotherapy because it meets the definition of cancer-directed treatment. It destroys cancer cells. It may not be the best treatment for the revised diagnosis but it was an attempt to kill cancer cells. This case will be an outlier when you analyze cases, so document, document, document.

### AND from Louanne Currence:

Chemotherapy was planned for the diagnosis at the time. There is no way of knowing if it had any effect on the tumor. You would not want to analyze this chart **as if there was no chemotherapy** because patient's prognosis may have changed BECAUSE of the chemotherapy.

## Case Scenario 2

Esophageal endoscopy with biopsy: 2 cm squamous cell carcinoma in the proximal third of the esophagus with proximal edge of tumor 22 cm from the incisors: 4 cm squamous cell carcinoma in middle esophagus with distal edge of tumor 30 cm from the incisors. Endoscopic ultrasound (EUS): Lesion in proximal esophagus invades surrounding adventitia: second tumor identified in middle esophagus is localized in the esophagus.

Two questions were asked:

1. What would you code SSF4 (Distance to Proximal Edge of Tumor from Incisors)? **AND**
2. What would you code SSF5 (Distance to Distal Edge of Tumor from Incisors)?

### Answer received from Shannon Vann:

In the case scenario, there are 2 tumors of the esophagus determined to be a single primary. So, which tumor do you use to code SSF4 and SSF5? There is no priority given in the coding instructions. The most invasive tumor was coded in the CS Extension so it is best to use the same tumor to code SSF4 and SSF5. The most invasive tumor was the one in the proximal esophagus that was 2 cm in size and the proximal edge of the tumor was 22 cm from the incisors. There is no statement of the distal edge of the tumor. The statement of distal edge of tumor was from the tumor in the middle esophagus, which is less invasive. You would calculate the measurement to the distal edge of the tumor by adding the distance from the proximal tumor edge (22 cm) and the size of the tumor (2 cm). The calculated distance of the tumor in the proximal third of the esophagus is 24 cm so code 024 is assigned to SSF5.

To share your coding stumpers email [deloresg@health.ok.gov](mailto:deloresg@health.ok.gov).



## Compliance

*By Delores Greene, CTR*

All 2012 Cases are due to OCCR by June 30, 2013. If your 2012 cases will not be completed by this time, please contact Delores at [deloresg@health.ok.gov](mailto:deloresg@health.ok.gov) or (405) 271-9444 extension 57103 to discuss the situation.

## Reporting Phlebotomy, Blood-Thinners / Anti-Clotting Medications and Transfusions as Treatment

*By Delores Greene, CTR*

Do not collect blood transfusions (whole blood, platelets, stem cell transplants, etc.) as treatment. Blood transfusions are used widely to treat anemia and it is not possible to collect this procedure in a meaningful way. Note: This is new for cases diagnosed on or after 1/1/2012.

Collect phlebotomy for polycythemia vera ONLY. Note this is an addition to the 2010 instructions.

Collect blood-thinners and/or anti-clotting agents for:

9740/3 Mast cell sarcoma  
9741/3 Systemic mastocytosis  
9742/3 Mast cell leukemia  
9875/3 Chronic myelogenous leukemia BCR/ABL 1 positive  
9950/3 Polycythemia vera  
9961/3 Primary myelofibrosis  
9962/3 Essential thrombocythemia  
9963/3 Chronic neutrophilic leukemia  
9975/3 Myelodysplastic/myeloproliferative neoplasm, unclassifiable

Note: This information was added in the 2012 Hematopoietic manual. It is not listed in the 2010 Hematopoietic manual, but it can be applied to cases diagnosed 2010 and forward.

Taken from Version 2.2 (February 2013), page 15, Hematopoietic Coding Manual.

## Upcoming NAACCR Webinars

**May 2, 2013** Collecting Cancer Data: Bladder and Renal Pelvis

**June 6, 2013** Collecting Cancer Data: Kidney

**July 11, 2013** Topics in Geographic Information Systems

**August 1, 2013** Cancer Registry Quality Control

**September 5, 2013** Coding Pitfalls

OCCR continues to purchase the NAACCR Webinar Series for registrars of Oklahoma Reporting facilities and presents them in two convenient locations.

Tulsa: St John Medical Center, Mary K. Chapman Health Plaza, 1819 E. 19<sup>th</sup> St, in the Newman Room at the end of the lobby area

Oklahoma City: The Children's Hospital, Samis Education Center. The webinar is hosted by OU Medical Center.

To register, please contact Delores Greene at [deloresg@health.ok.gov](mailto:deloresg@health.ok.gov).



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