

OCCR NEWSFLASH



Gold Certification

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By Leslie Dill

The North American Association of Central Cancer Registries (NAACCR) and the Centers for Disease Control and Prevention (CDC) National Program of Cancer Registries (NPCR) have awarded Oklahoma its highest Gold Standard Award for data quality, timeliness and completeness. This is exciting news for all of us because our high quality data is not possible without all of you! With budget cuts and staff shortages in many facilities across the

state, submitting high quality data can be a real challenge. We at the OCCR would like to thank those of you who partner with us to achieve this high standard. We appreciate your dedication and commitment as we work together to eliminate cancer in Oklahoma.



NAACCR Registry Certification on Quality, Completeness & Timeliness of 2008 Data					
Registry Element	Gold Standard	Silver Standard	Actual Measure	Measurement Error Allowed	Standard Achieved
Completeness of case ascertainment	95%	90%	95.40%	1.00%	Gold
Completeness of information recorded					
*Missing/unknown "age at diagnosis"	< = 2%	< = 3%	0.0%	-0.4%	Gold
*Missing/unknown "sex"	< = 2%	< = 3%	0.0%	-0.4%	Gold
*Missing/unknown "race"	< = 3%	< = 5%	1.9%	-0.4%	Gold
*Missing/unknown "State & county"	< = 2%	< = 3%	0.0%	-0.4%	Gold
Death certificate only cases	< = 3%	< = 5%	2.50%	-0.4%	Gold
Duplicate primary cases	< =1 per 1000	< =2 per 1000	< =0.3 per 1000	-0.4 per 1000	Gold
Passing EDITS	100%	97%	100.00%	Not applicable	Gold
Timeliness	Data submitted within 23 months of close of accession year				Gold
Certification Status					Gold

OK2Share



OK2SHARE

By Anne Pate, MPH, PhD

The OCCR would like to share that we are now posting preliminary data on the OK2Share website. We have 2009 and 2010 diagnosis years available, and the data will be updated regularly. If you have any data requests or individuals who want access to more up-to-date data, please feel free to point them to the website: www.health.ok.gov/ok2share. Please keep in mind that these years of data are preliminary and are subject to change.

If you have any questions, or if you have a data request that OK2Share doesn't have enough information to answer, please contact the OCCR Epidemiologist, Anne Pate, at 405-271-9444, ext 57111 or email AnneB@health.ok.gov.

CONGRATULATIONS, Anne!

By Judy Hanna, HT(ASCP)

Please join OCCR in congratulating Anne Pate, Epidemiologist for OCCR. Anne has just completed the PhD program at the University of Oklahoma. After several years of hard work, commitment and dedication, Anne presented and defended her dissertation to her committee on July 28, 2011. It is official—she is Anne Pate, MPH, PhD. We are extremely proud of her for this accomplishment. Way to go, Dr. Pate!



Anne Pate, MPH, PhD

New OCCR Staff



By Leslie Dill

OCCR would like to introduce the newest member of our staff, Christina Panicker. Born and raised in the Yukon, OK, area, Christina is a graduate of Southern Nazarene University. She has a bachelor's degree in Biology and Chemistry and is currently finishing up her MBA in healthcare.

Christina brings with her experience from both the hospital and laboratory settings. Previous employers include OU Medical Center and Diagnostic Laboratory of Oklahoma.

OCCR welcomes Christina and is excited to have her as a member of our team!



Christina Panicker

Death Clearance 2009/2010

By Paula Marshall, BBA, CTR

As part of the quality control procedures to ensure complete and quality data, the Oklahoma Central Cancer Registry (OCCR) sends queries to physicians and/or facilities for patients with a diagnosis of cancer on their death certificate that appear to potentially be missing from the OCCR database. Patients identified during the OCCR linkage known as Death Match program are selected according to the following criteria: a death certificate stated they had a diagnosis of cancer; they died in 2009 or 2010; and/or they were admitted to and/or died at your facility. Therefore, OCCR has mailed Death Clearance letters requesting your assistance.

Because these patients appear to have not been reported to the OCCR, we are requesting copies of medical records, espe-

cially those areas that document the date and diagnosis of cancer such as History and Physical, Discharge Summary, Radiology, Pathology, etc. If you currently report to the OCCR, you may abstract the case via your current reporting system and it is important for you to notify us that you are responding to the request in this manner. Also, you may respond by calling (405) 271-4072 and speaking to an OCCR consultant or by making written notes on your attached list of patients and mailing it back in the business reply envelope provided for your convenience.

In the event you did not treat the patients on your list, please provide the referring physician who indicated a diagnosis of cancer or the method by which you became aware of the patient's diagnosis of cancer.

If you have no records on the patients on your attached list and you were only the physician of record at the time of death, please provide information on how you became aware of the patient's diagnosis of and/or treatment for cancer.

All responses should be received in the OCCR office no later than August 31, 2011. If you have any questions, or if you anticipate difficulty meeting the above deadline, you may contact us at 405-271-4072.

Thank you in advance for assisting the OCCR in the collection of timely, accurate and complete cancer data which will be utilized to improve the health of Oklahoma residents.



Cancer reporting is required by both federal and state law (PL 102-515 and 63-1-551.1). It is also considered a public health report under HIPAA (C.F.R. 164-501, C.F.R. 164.512).

OCRA Fall Conference

By Leslie Dill

Don't forget! The Oklahoma Cancer Registrars Association (OCRA) Fall Conference is right around the corner, September 29 & 30, 2011. The conference will be held at Rose State College in Midwest City, OK. For more details

go to: www.ocra-ok.org/education.asp.



SEER*Rx

SEER*Rx is a helpful tool used for coding oncology drugs and categorizing regimen treatments. This is a FREE program provided by Surveillance Epidemiology and End Results (SEER). To download, go to:

<http://www.seer.cancer.gov/tools/seerrx/>

NAACCR Webinars

By Delores Greene, CTR



The last NAACCR Webinar in the 2010-2011 Season will be held on Thursday, September 1, 2011, 8-11a.m. at Deaconess Hospital in Oklahoma City and at St. John Medical Center in Tulsa. The topic will be "Coding Pitfalls."

OCCR has already purchased the 2011-2012 NAACCR Webinars Series which will begin in October 2011 and end in September 2012. The webinars will be held at Deaconess Hospital October-December 2011. OU Medical Center will host for the remainder of the series.

St. John Medical Center will host in Tulsa through the entire series. The webinars are from 8-11a.m. and are scheduled for the first Thursday of each month. Each participant will receive 3 hours of continuing education from the National Cancer Registrars Association.

October 6, 2011	Collecting Cancer: Larynx Including Mucosal Melanoma of Larynx
November 3, 2011	Collecting Cancer Data: Ovary
December 1, 2011	Collecting Cancer Data: Thyroid and Adrenal Gland
January 5, 2012	Collecting Cancer Data: Pancreas
February 2, 2012	Collecting Cancer Data: Hematopoietic
March 1, 2012	Abstracting and Coding Boot Camp: Cancer Case Scenarios
April 5, 2012	Collecting Cancer Data: Lower Digestive System
May 3, 2012	Collecting Cancer Data: Lung
June 7, 2012	Using and Interpreting Data Quality Indicators
August 2, 2012	Collecting Cancer Data: Melanoma of Skin
September 6, 2012	Coding Pitfalls

A helpful link to verify patient date of death is <http://ssdi.rootsweb.ancestry.com>. Searches can be done using first/last name or social security number.

Coming Soon...

By Delores Greene, CTR



Exciting news! NAACCR has given permission for OCCR to place recorded webinars on a secure website. The details are currently being worked out, but the plan is to have this available no later than November 2011. To participate, each user will be assigned a user name and a password to access the recorded webinars. Once this is available you will be able to view from work or home at a time that is best for you. This will allow for greater participation and access for those who could not attend in Oklahoma City or Tulsa. OCCR will continue the live webinars at Deaconess Hospital/OU Medical Center in Oklahoma City and St. John in Tulsa for those who wish to participate in the live productions of the webinars.

CSv2.03 Known Issues from FAQs: Update from NAACCR

By Delores Greene, CTR

As you know starting with our 2011 cases we will be utilizing CSv203. This manual can be accessed at <http://www.cancerstaging.org/cstage/manuals/coding0203.html>. This issue was last updated on June 12, 2011. The next release will be sometime in the fall. In the meantime, the CS Team has developed a known issue document that can be useful when coding in CSv2.03. This document contains important information for a few schemas and fields where there is a known issue with CSv2.03 which will be resolved in the upcoming release. The CS Team created this document so you would be aware of the issues you may be encountering with these few fields in CSv2.03 and they will be resolved in SCV2.04.

Schema Name	CS Fields(s)	Description
Part 1		Use Lymph-Vascular Invasion code 8 only for Hematopoietic and Lymphoid disorders. Use code 9 for non-Hematopoietic and Lymphoid disorders where there is no microscopic examination of a primary tissue specimen. See CS Manual, Part1, Section1, page 83 for CSv0203. This use of code 9 is a change from the definition in CSv0202, but a conversion from code 8 to code 9 for appropriate cases is NOT automatically applied in the upgrade to CSv0203. If you wish to do your own conversion, search for 2010+ diagnosis cases with Lymph-Vascular Invasion code 8 and all histology codes less than 9590/3, and change 8 to 9. 06/30/11
Colon, Rectum	CS Extension	We will modify the notes in v0204 to clarify that code "050" may be used when there are tumor deposits without lymph node metastasis in T1, T2 T3 and T4 cases. Previously, the v0203 instructions state that you could only use this code for T1and T2 cases. 06/03/2011
Colon, Rectum	CS SSF2, Extra Table	Code 030 is not relevant for SSF2 and we will be making it obsolete in the next version. This is because tumor deposits are identified histologically and SSF2 is used to code the clinical assessment of regional lymph nodes. We are not supposed to include information from surgical observation or lymph node biopsies in this SSF. Cases that were abstracted with this code will need to be reviewed and corrected 6/3/2001.
Corpus Carcinoma, Corpus Sarcoma	Schema Page	For corpus uterine/uterus NOS primaries, histology codes 8950 and 8951 should have been included in the Corpus Carcinoma schema. This will be fixed in CSv0204. Do NOT
Kidney Parenchyma	CS SSF 3	For Kidney Parenchyma SSF3, code 998 for "No histologic examination to determine ipsilateral adrenal gland involvement", will be added. In the meantime, code 999 should be used for cases without histologic examination that determines ipsilateral adrenal gland involvement. 0/10/2011
Lung	CS Extension, Extra Table	A tumor involving the carina, regardless of size, should be a T4, per AJCC. If you code 250, for confined to carina, you will derive based on tumor size. "Confined to carina" will be moved to a T4 (in a future version.) For now, the best code to use is code 700, which includes the description extension to carina and will derive a T4. In your abstract you can note this situation. The confusion arises since Summary Stage focuses strictly on how big or how many structures are involved, making a tumor strictly in the carina a localized tumor. Whereas AJCC assign stage based on treatment guidelines and prognosis (survival). We know that a tumor in the carina, even if it is small and strictly confined to the carina, will be unresectable and will have poor outcomes, since the tumor can easily spread to both lungs due to the location (tumor can spread from the carina down BOTH mainstem bronchus into both lungs) it has a very poor prognosis (survival). 06/30/2011
Testis	CS SSF 8, CS SSF 14	The measurements in SSFs 8 & 14 were incorrectly entered as ng/ml and will be updated to mIU/ml in v0204. 06/03/2011.

Questions and Answers

By Delores Greene, CTR



Question:

When the final path report reads: Mixed Germ Cell Tumor composed of 70% Embryonal Carcinoma, 20% Yolk Sac Tumor and 10% Teratoma. Table 2 in the MPH instructs us to code 9081 Teratocarcinoma when you have Embryonal Carcinoma and Teratoma. Code 9085 Mixed Germ Cell when you have a Yolk Sac Tumor and Teratoma, but nothing for all three histologies. How would you code the histology?

Answer:

If the pathologist states the final diagnosis is Mixed Germ Cell then this is what you would code regardless of what percentage the mixed components are. You would code to Mixed Germ Cell 9085.

Question:

How would you code the histology for a diagnosis of squamous carcinoma and large cell undifferentiated neuroendocrine carcinoma of the lung?

Answer:

For cases diagnosed 2007 or after, apply rule H7 and code the numerically higher ICD-O3 code, 8070/3 (squamous cell carcinoma). See Chart 1 on page 35 MPH Manual, the histology tree in lung equivalent terms. Large cell neuroendocrine carcinoma is histology code 8013/3. The other histology is squamous cell carcinoma, 8070/3 which is numerically higher.

Question:

How do you determine the correct subsite of the colon when there is conflicting information in different reports? The path report for a hemicolectomy says, "specimen left colon" and the microscopic also says, "designated left colon," but the operative report states, "splenic flexure tumor." The text in the operative report says, "mobilizing the splenic flexure mass difficult" and the surgeon goes on to describe how he resected the colon. The discharge summary says, "carcinoma of the splenic flexure."

Answer:

Use the information from the operative report to code the primary site in this case. It is more accurate. In the operative report the surgeon states the splenic flexure. The operative report is usually a better source since the pathologist can only reiterate the location as it was reported to him/her.

Clarification within the Surgery Codes for Bladder submitted by Dulce Bramblett, CTR

Prior to 2010, radical cystoprostatectomies were coded to the 60-64 range. However with the 2010 cases forward, if the prostate is removed at the time of radical cystectomy, surgical code 71 would be used. If the prostate is not removed, then surgical codes 60-64 would be used.

Jerri Linn Phillips said this change had been missed and will be added to the updates in the next edition of Appendix C. Look for a single sentence reference in the 2010 preface, page XV of VORDS; Revised for 2011.

Coding 101

By Amanda E. Moran

1st Course of Treatment Do's and Don'ts

Deciding on the date to use for a patient's first course of treatment can sometimes be tricky. According to FORD's (Section 2, Appendix B Coding Instructions), "Record the date on which treatment (surgery, radiation, systemic or other therapy) of the patient began at any facility." Notice the list of treatments that are acceptable does not include the date of a positive biopsy, even if the biopsy was what diagnosed the patient's cancer. A biopsy is considered to be treatment if the biopsy removes the entire tumor and has negative margins. In that case, you would code the procedure as an excisional biopsy which is a surgery code.

If a physician decides not to treat a patient or a patient's family or guardian declines all treatment, FORD's (Section 2, page 211 Coding Instructions) instructs that, "the date of first course of treatment is the date the decision not to treat was made."

Different Grade/Differentiation Rules

The grade/differentiation of a tumor reflects how much the tumor cells differ from the cells of the normal tissue from which the tumor originated. According to FORD's (Section 1: pages 11-12 and Section 2: pages 112-113), "Well differentiated (Grade 1) is the most like normal tissue and undifferentiated (Grade 4) is the least like normal tissue." Determining a tumor's grade/differentiation is vital because this information is used to evaluate each specific cancer patient, develop the patient's individual treatment strategy and predict the patient's prognosis.

A key instruction for ICD-O-3 coding is to code to the highest grade listed on the patient's pathology report. This rule is true, but you must be sure to look at the pathologic specimen's site location first. FORD's tells us to, "Code the grade or differentiation from the pathologic examination of the primary tumor, not from a metastatic site." If the primary tumor is not pathologically examined, the histology from the metastatic site is used, but the grade is coded to a 9 for unknown.

When a path report shows two grades for a specimen (i.e. well-moderately differentiated adenocarcinoma), FORD's instructs us to, "Code to the highest grade." Therefore, this example would be coded 8140/3 with a grade of 2 for the moderately-differentiated histology. This rule is also used when a path report states, "Moderately differentiated squamous cell carcinoma with poorly differentiated areas." This would be coded 8070/3 with a grade of 3. {Rule G on page 30-31 of the ICD-O book}



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Oklahoma Registrars Receive Proclamation from Gov. Fallin for National Cancer Registrars Week



Fourth Row, left to right: Chrissy Marsh, Barbara Murray, Sue Anderson, Laurie Harder, Darlene Scott. Third row, left to right: Sharon Abrams, Amanda Moran, Beth Watwood, Anna McIntosh, Darla Dennis. Second row, left to right: Paula Marshall, Charlotte Murphy, Stacey Hibbets, Denise Baker, Delores Greene. Front row, left to right: Marie Sanders, Shelly Ware, Susan Nagelhout, Governor Mary Fallin, Abby Williams, Leslie Dill, Carolyne Dale.