District of Columbia Central Cancer Registry (DCCR)
Hospital Cancer Data Reporting Manual

DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

District of Columbia Department of Health
Director: Ayanna Bennett, MD, MSPH, FAAP
2201 Shannon Place SE, 5th floor.
Washington, DC 20020

Table of Contents

7

District of Columbia Central Cancer Registry Staff/Contacts

Alfreda Woods, BS, CHES, ODS-C
Cancer Registry Program Manager
Community Health Administration
DC Health
2201 Shannon Place SE, 5th floor.
Alfreda.woods@dc.gov

Claudine Samanic, PhD
Epidemiologist
Community Health Administration
DC Health
2201 Shannon Place SE, 5th floor.
claudine.samanic@dc.gov

Maria Leuchert, MHA, RHIT, ODS-C
Quality Assurance Coordinator
Community Health Administration
DC Health
2201 Shannon Place SE, 5th floor.
maria.leuchert@dc.gov

Ian Quan
Geographer, Data Analyst
Community Health Administration
DC Health
2201 Shannon Place SE, 5th floor.
ian.quan@dc.gov

Malorie Thomas, BS, ODS-C
Education Training Coordinator
Community Health Administration
DC Health
2201 Shannon Place SE, 5th floor.
malorie.thomas@dc.gov

District of Columbia Cancer Registry (DCCR) Regulations

The District of Columbia Cancer Registry (DCCR) is a population-based incidence data system maintained by the DC Department of Health (DOH). All new cases of reportable cancer, benign brain and central nervous system tumors diagnosed and/or treated in the District according to the District of Columbia Cancer Reporting Regulations (Appendix A). DCCR's reference date is 1/1/1996.

- In 1951, Public Law 83 (65 Stat.124), the US Senate and the House of Representatives enacted requiring "reporting cancer and all malignant neoplasms to the Director of Public Health of the District of Columbia".

- In 1971, initial enabling legislation provided for the establishment of cancer registries. That legislation initiated the Surveillance Epidemiology and End Results (SEER) Program under the National Cancer Institute (NCI). Due to the small case counts from SEER registries and inability to obtain data for their constituents, states began initiating cancer registries in their jurisdictions. funding has been provided from the Centers for Disease Control (CDC) National Program of Cancer Registries (NPCR) under Public Law 102-515 entitled "Cancer Registries Amendment Act" of 1992.

- In 1985, The second Act was entitled the "Preventive Health Services Amendment Act of 1985 (D.C. Law 6-83). The purpose of this Act was to broaden and update preventive health requirements, (and to) strengthen confidentiality and penalty provisions.

- In 1990, Preventive Health Services Amendment Act of 1990, (D.C. Law 8-157) provided permission for the Commissioner of Public Health "to exchange identifying cancer information to a registry maintained by a state in order to foster effective cancer research, prevention, and control effects".

- Public Law 102-515 entitled "Cancer Registries Amendment Act" of 1992, provided funding for central cancer registries from the Centers for Disease Control (CDC) National Program of Cancer Registries (NPCR)

- In 1995, (42 DCR 6379) provided specific details of the rules for monitoring and reporting the occurrence of cancer under these laws published in the DC Register. These rules would amend the final rules by: (1) clarifying reporting requirements for persons who diagnose and treat cancer: (2) expanding the categories of persons subject to the reporting requirement; (3) revising the definition of the term "cancer".

- In 1998, Chapter 2 (Communicable and Reportable Diseases) of Subtitle 22-B (Public Health and Medicine) Section 215.1 of the DCMR was amended to include "each health care provider and health care facility shall report benign tumors of the brain and central nervous system and all malignant cancers".

- In 1998, Section 215.4 was amended to include Each report required by Subsection 215.1 "shall be submitted electronically by a secured form of transmission approved by the North American Association of Central Cancer Registries (NAACCR) to the DC Central Cancer Registry within the Department".

- In 1999, the final proposed rulemaking (46 DCR 6840) that was similar to that previously reported was published in the D.C. Register. The rules became effective May 2000.

DCCR has data exchange agreements with 26 states and territories including bordering states of Maryland, Virginia, Pennsylvania, Delaware, and West Virginia. DCCR receives data on all District residents with reportable cancer diagnosis or treatment. DCCR receives funding from the Centers for Disease Control and Prevention (CDC) National Program of Cancer Registries (NPCR) and District of Columbia local funds.

The data is received in abstract form electronically from hospitals that have on-site or contract registrars. DCCR will obtain data from facilities that have an annual analytic caseload of less than 100 cases. The information is valuable in determining risk factors, environmental impacts, ethnic and social variation as well as effectiveness of state control programs.

DCCR Mission Statement

The mission of the District of Columbia Cancer Registry (DCCR) is to promote a reduction in the cancer rates of District residents through:

(1) effective cancer surveillance and epidemiologic evaluations,

(2) the formulation and presentation of sound epidemiologic data for the promotion of effective public education and awareness programs regarding early detection and preventive health measures,

(3) the provision of analytic cancer data for implementing targeted cancer screening initiatives in the at-risk, under-insured segments of the District, and (4) conduct epidemiologic research for understanding the etiology and, spatial and temporal trends of cancer among District residents. The efficiency of the DCCR depends on data that is timely, complete, and accurately reported.

Penalties

Penalties for violation of this regulation (§ 218) (Appendix A) includes:

- Any person who willfully does not comply with the reporting requirements set forth in §215 or the access to records required in §216 shall be **guilty of a misdemeanor and upon conviction, subject to a fine not to exceed one thousand dollars ($1,000).**
- Any person who willfully violates the confidentiality provisions set forth in § 217 shall be **guilty of a misdemeanor and upon conviction, subject to a fine not to exceed five thousand dollars ($5,000), imprisonment for not more than ninety (90) days, or both.**

DCCR Non-Compliance Protocol

- DCCR staff notification of nonreceipt of data submission file to facility within 3 days after due date. Notification could also include noncompliance for quality and completeness. (See Compliance, Timeliness, and Data Quality Section)
- DCCR will submit a reminder email regarding the submission status.
- If submission is not received within 3 days, a **noncompliance letter** will be sent to hospital administration.
- DCCR will provide recommendations for improvement for noncompliant criteria.

Purpose

This manual provides instructions for reporting cancer cases to District of Columbia Cancer Registry (DCCR) and an overview of the District of Columbia cancer reporting regulations for all abstractors and reporting facilities.

Acknowledgements

We wish to acknowledge the cancer registrars that work diligently to provide data to DCCR and continue to work towards data quality and completeness that will provide an overview of cancer in the District of Columbia

Sources used in preparation of this manual:

SEER Program Coding and Staging Manual
https://seer.cancer.gov/tools/codingmanuals/

SEER Solid Tumor Rules
https://seer.cancer.gov/tools/solidtumor/

SEER Hematopoietic and Lymphoid Neoplasm Database and Coding Manual
http://www.seer.cancer.gov/seertools/hemelymph/

SSDI Manual
https://apps.naaccr.org/ssdi/list/

Grade Coding Instructions and Tables
https://apps.naaccr.org/ssdi/list/

Standards for Oncology Registry Entry (STORE)
https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/cocmanuals/

International Classification of Diseases for Oncology Third Edition (ICD-O-3)
https://apps.who.int/iris/bitstream/handle/10665/96612/9789241548496_eng.pdf?sequence=1&isAllowed=y

https://www.naaccr.org/icdo3/

NAACCR Data Standards and Data Dictionary
https://apps.naaccr.org/data-dictionary/

National Program for Cancer Registries (NPCR)

CDC's National Program of Cancer Registries (NPCR) works to measure progress in preventing and treating cancer, a leading cause of death in the United States.

NPCR requires central cancer registries to:

- Report cancer incidence trends by geographic area and provide cancer data in support of cancer control programs.
- Collect and report cancer incidence, burden, and stage data that can direct targeted interventions and be used to evaluate the success of cancer prevention and screening programs.
- Identify disparities by age, gender, race/ethnicity and geographic areas in cancer incidence, stage at diagnosis and mortality.
- Create and maintain registry policies and recommend state policies supportive of research uses of cancer registry data.
- Collect incidence data on all patients diagnosed and/or receiving first course of treatment in the registry's state, regardless of residency.
- Have legislation mandating the reporting of cancer cases by all facilities diagnosing and/or treating cancer.
- Provide training for central cancer registry staff, hospital registry and non-hospital reporting facility staff.
- Collect information on cancer cases in a standard data format.
- Produce pre-calculated data tables in an electronic data file or report within 12 months of the end of the diagnostic year (90% complete).
- Produce pre-calculated data tables in an electronic data file or a report, within 24 months of the end of the diagnostic year (95% complete).
- Conduct case finding and re-abstracting audits to determine the completeness and quality of all cancer cases being submitted to the registry.

Reporting Facilities

All health care providers in the District are required to report cancer diagnosis/treatment in their patient population to the Department of Health, DC Cancer Registry. This includes all facilities providing diagnostic evaluations and/or treatment for cancer patients such as hospitals, outpatient surgical facilities, laboratories, radiation therapy, medical oncology facilities, physician offices, hospices, nursing homes, and medical examiner offices.

The DCCR:

- Collects data that are compliant with required NPCR/NAACCR data elements.
- Meets standard requirements designated by NPCR and NAACCR for incidence reporting.
- Assists in determining data quality; and
- Provide useful information, feedback, and assistance to submitting facilities.

Data is submitted annually to NPCR and NAACCR for registry certification and publication in *Cancer in North America (CINA), United States Cancer Statistics (USCS): Cancer Incidence and Mortality Data*. Central cancer registries that submit data which meet established criteria of timeliness, accuracy, and completeness are recognized annually as Silver or Gold Certified Registries and Registries of Distinction award.

The District of Columbia has eight hospitals, including Veteran's Administration and Kaiser Permanente (free-standing clinics) that collect cancer data for District residents. Of those eight hospitals, five are American College of Surgeons/Commission on Cancer (ACoS/CoC) accredited facilities. One facility (United Medical Center) does not have a cancer registry which requires data collection to be performed by central registry staff or out-sourced contractors. (The Veteran Administration is currently not reporting to DCCR.)

DCCR Reporting Hospitals with ACoS/CoC Accreditation and Ward

Ward	Hospitals
1	**Howard University Hospital - HUH** Community Cancer Program - CCP
2	**Medstar Georgetown University Hospital - MGUH** NCI Designated Comprehensive Cancer Center Program (NCIP) **George Washington University Hospital - GWUH** Academic Comprehensive Cancer Program (ACAD)
3	**Sibley Memorial Hospital - SMH** Non-ACoS/COC Accredited Hospital
4	**None**
5	**Medstar Washington Hospital Center - MWHC** Academic Comprehensive Cancer Program (ACAD) **Washington DC VA Medical Center** VA Affairs Cancer Program **Childrens National Medical Center - CNMC** Non-ACoS/COC Accredited Hospital **Providence Hospital – Closed Dec 28, 2018**
6	**Kaiser Permanente of Mid-Atlantic States - MAPMG** Comprehensive Community Cancer Program (CCCP)
7	**None**
8	**United Medical Center - UMC** Non-ACoS/COC Accredited Hospital **Ceder Hill Regional Medical Center** **Tentatively opening December 2024**

Confidentiality

The DC Central Cancer Registry is mandated to collect cancer incidence data, and as such, must act as custodian of these data. This is to ensure these records are held in trust, and that the privacy of individual patients, reporting facilities and physicians is protected. Confidentiality of the data is protected under code of DC Municipal Regulation Chapter Three § 7-302e, protection of public health CDCR 22-217 - confidentiality. (Appendix A)

"The Department shall use information from reports submitted pursuant to these rules for statistical and public health purposes only". No person shall disclose or re-disclose identifying information included in a cancer report submitted pursuant unless:

- Disclosure of information is essential to safeguard the physical health of others.
- The person who is the subject of the identifying information gives his or her prior, written permission.
- The person with whom the identifying information is shared as a state cancer registry that provides assurances that the confidentiality of the identifying information will be preserved.
- A court finds, upon clear and convincing evidence and after granting the person who is the subject of the identifying information an opportunity to contest the disclosure, that disclosure is essential to safeguard the physical health of others.

Note: Protected health information will not be released for the purpose of clinical trial studies. Cancer Researchers must collaborate with the facilities in which the patient population will be included in the clinical trial.

A signed confidentiality agreement is required for anyone, including DCCR staff, requesting access to or review of confidential registry data and is required to follow confidentiality procedures as stated in the DC Cancer Registry Policy and Procedure Manual. This also includes secure electronic access, fire resistant, locked file cabinets for confidential data, procedures for handling requests for data and policies for handling breaches of confidentiality. A data destruction agreement is required of all researchers to ensure that any cancer registry data utilized in research or publications will be destroyed at the conclusion of their investigation.

Health Insurance Portability and Accountability (HIPAA) Act of 1996

According to HIPAA Privacy Rules and the VHA Policy, DCCR staff may collect or receive individually identifiable health information as a Public Health Authority for the purpose of preventing or controlling cancer, and to conduct public health surveillance, public health investigations, and public health interventions. The minimum necessary information required for cancer reporting will be requested.

The Health Insurance Portability and Accountability Act (HIPAA) allows for the reporting of identifiable cancer data to public health entities, which applies to central cancer registries. Under HIPAA written informed consent from each cancer patient reported to public health entities or a Business Associate Agreement is not required; rather, hospitals must simply document that reporting has occurred. Because DCCR falls under the definition of a public health authority, HIPAA allows your facility to continue reporting cancer incidence data in compliance with the current district statutes.
The Privacy Rule protects all "individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information "protected health information (PHI).
Anyone who knowingly obtains or discloses individually identifiable health information in violation of the Privacy Rule may face a criminal penalty of up to $50,000 and up to one-year imprisonment. The criminal penalties increase to $100,000 and up to five years imprisonment if the wrongful conduct involves false pretenses, and to $250,000 and up to 10 years imprisonment if the wrongful conduct involves the intent to sell, transfer, or use identifiable health information for commercial advantage, personal gain, or malicious harm.

The Health Insurance Portability and Accountability Act of 1996 established standards to protect individuals' medical records and other personal information and applies to health plans, health care clearinghouses and those health care providers that conduct certain health care transactions electronically.

The rules require appropriate safeguards to protect privacy of personal health information and set limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives patients' rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.

DCCR is a "public health authority" as defined by the HIPAA [see 45 CFR § 164.512(a), (b), and (d) and §160.203(c)] authorize disclosure without patient consent in several circumstances, including the following:
"Disclosure is permitted to a public health authority by law to access information to prevent/control disease, injury, disability, e.g., disease reporting, vial statistics reporting, public health investigations, public health interventions and partner notifications". See 45 CFR §164.512(b). (Appendix A)

Data Transmission Security

Data Submissions

All hospital data submissions to DCCR should be in the current NAACCR format and submitted through DCCR's secure FTP server.

Note: Protected Health Information (PHI) and other confidential data MUST NOT be included in an unsecured text, e-mail, or attachment to DCCR.

DCCR Secure File Transfer Protocol Server (SFTP)

Reporting hospitals must utilize the DCCR SFTP secure server to transmit data to DCCR and have dedicated staff that are responsible for transmitting and receiving data submission. Other types of data that must be transmitted through SFTP server includes but is not limited to: Follow back files for death clearance, data resolution reports (special studies review) and follow-up requests from reporting hospitals.

E-Marc Plus

E-Marc plus is a CDC sponsored software that allows pathology reports and information from physician clinics to be submitted electronically and securely to DCCR.

Hard Copy Submissions

DCCR receives hard copy pathology reports from other small labs without electronic capabilities. These reports are electronically scanned into a pathology folder by facility. A response email from DCCR staff is provided to verify receipt of the cases.

Data Requests

Data is requested by cancer researchers, students, hospital registrars, physicians and community organizations for cancer outcome analysis, grant requests and development of cancer control plans, including preventive screenings. All data provided by DCCR will be de-identified and transmitted through a secure FTP server.

Data Destruction

Anyone requesting data must sign an agreement to destroy the initial data upon completion of research project, research, including linkages or confirmed receipt of linked data results. There must not be any individually identifiable information, dataset copies, or parts, thereof, retained when the files are destroyed. Each requestor is required to submit an assurance statement of destruction that the data has been destroyed, (including the date of destruction and the method used to destroy data, such as file shredder, evidence eliminator, burn, shred or returning of data to DCCR), to the Program Manager of the DC Cancer Registry.

DCCR Reporting Requirements/Eligibility

The role of the District of Columbia Cancer Registry (DCCR) is to gather information from hospitals and other sources to monitor incidence of cancer in the District, to develop and evaluate prevention and control through epidemiological research.

Facilities are required to report all malignant, specific in-situ cancers and reportable benign brain and central nervous system tumors to the District of Columbia Cancer Registry (DCCR) utilizing the most current version of the data collection requirements. (Links to these manuals are listed in Appendix H)

Basic Rules for Reporting/Data Submissions

- All hospital-based registries are **required** by the District of Columbia statute to abstract inpatient and outpatient cancer cases within six (6) months after date of initial diagnosis/first contact.

- All reportable cancer cases diagnosed and/or treated in your facility on or after January 1, 1996, **must** be abstracted and reported to DCCR. This includes non-analytic cases, Class of Case 30-33, 38 (dx at autopsy only) and 43 (pathology consults). (See Appendix A & Appendix F)

- Facilities **must** submit cancer cases on a bi-monthly basis (on the 15th of even months), Feb, Apr, Jun, Aug, Oct, Dec. Facilities not reporting within the required timeline will receive a non-compliance letter and may be subject to penalties. (See Submission Schedule - Appendix G)

- All reporting hospitals must utilize the most current DC Metafile to identify any errors prior to submitting data to the DC Cancer Registry. All files must be 100% error-free prior to submission to DCCR. Submission files include analytics, non-analytic, resubmission, and modification cases.

- All reporting facilities **must** utilize internal quality assurance processes prior to submission to ensure data quality.

- Bi-monthly submission files **must** include:
    - Analytic case file (New cases)
    - Non-analytic case file (Cases with history of cancer, progression/recurrence at your facility)
    - Modification/follow-up file (Previously submitted cases with changes or revisions)

- All required data items **must** be collected and reported to DCCR using the rules and guidelines by the National Program of Cancer Registries (NPCR), North American Association of Central Cancer Registries (NAACCR) and Commission on Cancer (CoC).

- All reporting facilities are **required** to utilize the following documents:

  DCCR Text Requirements document. (See Appendix E)

  NAACCR Recommended Abbreviations for Abstractors (See Appendix C)

  SEER Race and Nationality Descriptions (See SEER Program and Staging Manual, Appendix D): https://seer.cancer.gov/manuals/2024/SPCSM_2024_Appendix_D.pdf

  SEER Country and State Codes (See SEER Program and Staging Manual, Appendix B): https://seer.cancer.gov/manuals/2024/SPCSM_2024_Appendix_B.pdf

Non-Compliance

Facilities will have a maximum of five (5) business days to correct all errors and re-submit files to DCCR.

Case Eligibility/Reportability

DCCR requires complete abstracting of cancer cases that some programs including the Commission on Cancer/American College of Surgeons may not require. District facilities are required to report analytic cases (Class of Case 00-22) and non-analytic cases (Class of Case 30-99) of cancer defined by DCCR.

Reportable

- ***All Malignancies*** with Behavior Code of 2 (in-situ) or 3 (malignant) in the 2018 International Classification of Diseases for Oncology, Third Edition (ICD-O-3) **ARE REPORTABLE** to DCCR.

- ***CIS and CIN III of Cervix*** - Carcinoma in Situ of the Cervix (CIS) and Intraepithelial Neoplasia Grade III (8077/2) of the Cervix (CIN III) **ARE REPORTABLE** to DCCR - **Class of Case 34**.

- ***Benign Brain & CNS Tumors*** - Non-malignant primary intracranial and central nervous system (CNS) tumors diagnosed on or after January 1, 2004, **ARE REPORTABLE** to DCCR regardless of behavior (This includes benign, malignant, and borderline tumors) with the following ICD-O topography codes:

    - Meninges (C70.0 - C70.9)
    - Brain (C71.0 - C71.9)
    - Spinal Cord, cranial nerves, and other parts of CNS (C72.0 – C72.9)
    - Pituitary gland, craniopharyngeal duct and pineal glands, (C75.1 – C75.9)

    Note: Benign and borderline CNS cases diagnosed prior to 2004 ARE NOT REPORTABLE

    Note: Benign and borderline tumors of the cranial bones (C410) ARE NOT REPORTABLE

- ***Malignant Primary Skin Cancers of the Genitals*** (C51, C60, C63) **ARE REPORTABLE** to DCCR.

- ***All Other Skin Histologies*** - Like Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Cutaneous Lymphoma etc. **ARE REPORTABLE** to DCCR.

Non-Reportable

- ***Malignant Skin Cancers*** - **Exception**: Malignant primary skin cancers with a topography code (C44._) with **histology codes 8000 – 8110 ARE NOT REPORTABLE** to DCCR.

- ***PIN III, VIN III, VAIN III, AIN III*** - Exception 1: Prostate (PIN III), vulva (VIN III), vagina (VAIN III), and anus (AIN III) **ARE NOT REPORTABLE** to DCCR.

Reportable vs Non-Reportable Skin Cancers:

Reportable Cancers of the Skin					
ICD-10 Code	**Primary Site**	**Topography Code**	**Reportable**	**Non-Reportable**	**Histologies**
C51.0	Skin of Labia Majora	C51.0 – C51.1	X		8000 – 8110
C51.2	Skin of Clitoris	C51.2	X		8000 – 8110
C51.9	Skin of Vulva	C51.9	X		8000 – 8110
C60.0	Skin of Prepuce	C60.0	X		8000 – 8110
C60.9	Skin of Penis	C60.9	X		8000 – 8110
C63.2	Skin of Scrotum	C63.2	X		8000 – 8110
Non-Reportable Cancers of the Skin					
C44.0	Skin of Lip	C44.0		X	8000 – 8110
C44.1	Skin of Eyelid	C44.1		X	8000 – 8110
C44.2	Skin of External Ear	C44.2		X	8000 – 8110
C44.3	Skin of Other Unspecified Parts of Face	C44.3		X	8000 – 8110
C44.4	Skin of Scalp and Neck	C44.4		X	8000 – 8110
C44.5	Skin of Trunk	C44.5		X	8000 – 8110
C44.6	Skin of Upper Limb	C44.6		X	8000 – 8110
C44.7	Skin of Lower Limb	C44.7		X	8000 – 8110
C44.8	Skin of Overlapping Lesion	C44.8		X	8000 – 8110
C44.9	Skin, NOS	C44.9		X	8000 – 8110

Ambiguous Terminology for Determining Reportability

Reportable cases are usually based on unequivocal statements made by recognized medical practitioners that the patient has a reportable diagnosis. However, physicians sometimes use vague or ambiguous terms to describe a tumor when its behavior is uncertain. In these instances, where pathology or cytology findings cannot definitively confirm a cancer diagnosis or when imaging studies show inconclusive results, physicians often state the diagnosis in ambiguous terms. Reportability of such a diagnosis depends on the verbiage used.

As part of the registry casefinding activities, all diagnostic 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 that Constitute a Reportable Diagnosis	
Apparent(ly)	**Most likely (must have both words)**
Appears	**Presumed**
Comparable with	**Probable**
Compatible with	**Suspect(ed)**
Consistent with	**Suspicious (for)**
Favors	**Typical of**
Malignant appearing	
Additional Terms that Constitute a Reportable Diagnosis for Nonmalignant Primary Intracranial and Central Nervous System Tumors Only*	
Neoplasm	**Tumor**
* Beginning with diagnosis year 2004 and only for C70.0-C72.9 and C75.1-C75.3	

Note 1: Do not substitute synonyms such as 'supposed' for 'presumed,' or 'equal' for 'comparable.' Do not substitute 'likely' for 'most likely.' Use only the exact words on the list or their conjugate forms, for example, "favored" is allowed as a substitute for "favor".

Note 2: If a cytology report uses only an ambiguous term for the diagnosis, do not interpret it as a diagnosis of cancer. Do not report ambiguous cytology *unless* a physician makes a statement of malignancy, the patient receives cancer-directed therapy or tissue diagnosis confirms ambiguous cytology. Under these circumstances, cytology may be used as the date of diagnosis.

Note 3: The ambiguous terms list is applicable to hematopoietic and lymphoid neoplasms for determining reportability only. The use of ambiguous terms for assigning and reporting histology is covered in the Hematopoietic and Lymphoid Neoplasms Coding Manual.
https://seer.cancer.gov/tools/heme/Hematopoietic_Instructions_and_Rules.pdf

Examples Using Ambiguous Terms

Do report – Mammogram report states breast mass is **suspicious** for malignancy. Suspicious for malignancy is reportable ambiguous terminology. Please note, BI-RADS terms are not considered diagnostic on their own. For example, BI-RADS 5, highly suggestive of malignancy, does not constitute a diagnosis.

Do report – Discharge summary final diagnosis states **probable** primary lung malignancy. Probable primary lung malignancy is reportable ambiguous terminology.

Do not report – An outpatient CT scan of the chest documents a right lower lobe lung nodule, **possible** malignancy. The patient has no other encounters with your facility. Possible is not a reportable ambiguous term.

Do not report – **Cytology** from bronchial washings, final diagnosis: **Suspicious** for malignancy. Suspicious is an ambiguous reportable term, but cytology is the exception (see above: Note 2).

Ambiguous Terms that DO NOT Constitute a Reportable Diagnosis	
Cannot be ruled out	**Questionable**
Equivocal	**Rule out**
Possible	**Suggests**
Potentially malignant	**Worrisome**

Differential Diagnosis

A **differential** diagnosis is made when a physician does not have enough information to assign a **definitive** diagnosis. Only report cases with a differential diagnosis if all possible disease processes mentioned are reportable.

Do report – CT exam of the chest shows a nodule in the left lower lung. The radiologist report has a differential diagnosis of **suspicion** for lung cancer vs **metastatic** lung lesion. Both are reportable terms.

Diagnosis – Pathologic vs Clinical

A pathological diagnosis is made by examining body tissues (histology) or fluids (cytology) under a microscope to identify the presence of malignant cells. A clinical diagnosis is made by a physician after a physical exam, reviewing signs and symptoms, lab reports and/or imaging tests. Most of the time a clinical diagnosis will be followed by a pathological diagnosis. Both methods of diagnosis are reportable with one exception. If a clinical diagnosis is made and is then proven to be benign by pathology, it becomes non-reportable.

Examples of Clinically Diagnosed Reportable Cases

In the absence of a histologic or cytologic confirmation of a reportable diagnosis, accession the case based on the **clinical diagnosis** (when a recognized medical practitioner states the patient has a reportable diagnosis). A clinical diagnosis may be recorded in the final diagnosis, in a clinic note, on an x-ray report, or in other parts of the medical record.

Note: A pathology report takes precedence over a clinical diagnosis. If the patient has a biopsy or fine-needle aspiration that disproves the clinical diagnosis, the case is not reportable.

Clinical Diagnosis Only - A "clinical diagnosis only" is a diagnosis based solely on clinical judgment; diagnostic procedures were not performed or did not confirm the diagnosis.

Note: Patients diagnosed clinically ARE REPORTABLE to DCCR. Please refer to the "Ambiguous Terminology" to help determine reportability.

Consult-Only- Private Outpatient Specimens (POP) (Path Only) – Consultation provided by your facility to establish or confirm a cancer diagnosis or for treatment planning ARE REPORTABLE to DCCR. (Class Case 30). Document as "consult-only cases".

Examples of Reportable Consult-Only Cases

- An outpatient CT scan of the thorax is performed at your facility. The findings are "suspicious for malignancy in right lung." The clinical impression is confirmed at your facility and the patient is referred to their managing physician.

- A patient comes to your facility for consultation. The managing physician works up the patient and develops a treatment plan. The patient either does not return to your facility or refuses treatment.

Terminal Care – Patients admitted to your facility with active cancer for the purpose of receiving supportive care, palliative care, pain management and/or hospice care **ARE REPORTABLE** to DCCR.

Autopsy Only Cases - Final autopsy reports containing reportable diagnoses or incidental findings of cancer **ARE REPORTABLE** to DCCR. This includes incidental findings of cancer at autopsy where there was no suspicion of cancer before death. Please review autopsy details to include all information regarding the cancer, including, but not limited to tumor site, tumor extension, size, lymph node involvement, distant metastasis, etc.,

Patients Treated at Your Facility - The DCCR requires patients receiving treatment, cancer-directed or non-cancer-directed (palliative), to be reported provided they have not been previously reported by your facility.

- **Cancer-Directed Treatment (Curative)** – Any treatment that is given to modify, control, remove or destroy primary or metastatic cancer tissue. This type of treatment is meant to remove a tumor or minimize the size of tumor or delay the spread of disease.

- **Non-Cancer-Directed Treatment (Palliative)** – Any treatment that is intended to prolong the patient's life, alleviate pain, make the patient comfortable, or prepare the patient for cancer directed therapy. They do not destroy, control the tumor, or delay the spread of disease. Non-cancer-directed procedures include diagnostic tests and supportive care (debulking) which is designed to relieve symptoms and minimize the effects of the disease.

Note: Always document the treatment information in the appropriate text fields with the word "palliative" included.

Manuals Used for Determining Reportability

SEER Multiple Primary and Histology Rules (Used for diagnosis years 1/1/2007 – 12/31/2017)
Rules have been devised to aid cancer reporters in identifying whether a recurrence of a previously reported cancer is considered a new primary and must be reported as such, or whether a newly diagnosed cancer is in fact, multiple primaries based on location and histology, with the need to report more than one primary. The guidelines used for this process (diagnosis years 1/1/2007 – 12/31/2017) are the 2007 SEER Multiple Primary and Histology Coding Rules.
https://seer.cancer.gov/tools/mphrules/

SEER Solid Tumor Rules (Used for Diagnosis years 1/1/2018 +)
The SEER Solid Tumor Rules were initially released in 2018 and are like the 2007 Multiple Primary and Histology Coding Rules. Follow the guidelines as described in the General Instructions and in the Site–Specific Modules of the Solid Tumor Rules when determining multiple primaries for the listed sites. Cutaneous Melanoma (skin melanoma) was added beginning with diagnosis year 2021.
https://seer.cancer.gov/tools/codingmanuals/index.html

SEER Hematopoietic and Lymphoid Neoplasms
Follow the guidelines as described in the Hematopoietic and Lymphoid Neoplasm Coding Manual and Database when determining multiple primaries and histology.
https://seer.cancer.gov/tools/heme/Hematopoietic_Instructions_and_Rules.pdf

Casefinding

Casefinding is a system for identifying every patient (inpatient or outpatient) who is diagnosed and/or treated with a reportable condition. The reporter for each facility is responsible for identifying all reportable conditions. Methods of casefinding include review of disease index, pathology reports, radiology reports and treatment records (surgery, chemotherapy, radiation). Other sources can include hospital discharge summaries and/or insurance Claims.

Medical Record Disease Index

The disease index is a comprehensive listing of all patients—inpatient or outpatient, who are discharged with an ICD-10-CM cancer diagnosis code. The disease index should be obtained after medical records are completed and coded and must be based on year of admission. The report should include the following information: patient first and last names, medical record number, date of birth, social security number, discharge date, all primary and secondary ICD-10-CM codes, and the type of encounter. Since many cancer patients have multiple encounters at a facility, the report should be sorted by medical record number. This will ensure all visits for each patient are grouped together. The facility reporter is responsible for reviewing each patient on the disease index to identify reportable cases.

SEER Casefinding List

The following list is to be used by appropriate staff to create the disease index. It includes the required reportable neoplasms and ICD-10-CM codes. An Excel spreadsheet and a PDF file with the current codes can be downloaded at: https://seer.cancer.gov/tools/casefinding/. If IT staff are available at your facility, enlist their help in creating the disease index report.

- How to use the Case Finding Code List for Reportable Tumors

In the first column, first row "C00.- - C43.- "means all codes that begin at C00.- and end at C43.- are included as reportable. For example, C00.9 is not specifically stated but it falls in that range as does C43.9. On the second row we find "C44.0, C44.9." There are no dashes, therefore these are the only two codes that apply. They are not ranges.

Pathology Reports

All pathology reports, both positive and negative, must be reviewed by the facility reporter to ensure that all reportable cases are identified. Included in the pathology review are histology reports, cytology reports, bone marrow reports, hematology reports and autopsy reports.

Treatment Logs

Either electronic or physical logs of patients receiving treatment (radiation therapy, systemic therapy, surgery, interventional radiology, and interventional gastroenterology) should be reviewed to ensure that all reportable cases are identified. Reviewing treatment logs is required for free standing treatment facilities and ambulatory surgery centers.

Analytic Case Reporting

Cases diagnosed and/or administered any of the first course of treatment at the accessioning facility after the registry's reference date are analytic (*Class of Case* 00-22). A network clinic or outpatient center belonging to the facility is part of the facility. The CoC is aligned with the Joint Commission accreditation status for your hospital/facility. Any services or facility covered under your Joint Commission accreditation would then be covered under your CoC accreditation and you would be responsible for reporting the associated data that is reportable as defined in the STORE.

- **Analytic cases *Class of Case* 10-22** are included in treatment and survival analysis.
- **Analytic cases *Class of Case* 00** are not required to be staged or followed, regardless of the year of diagnosis. *Class of Case* 00 is reserved for patients who are originally diagnosed by the reporting facility and receive all their treatment elsewhere or a decision not to treat is made elsewhere. If the patient receives no treatment, either because the patient refuses recommended treatment or a decision is made not to treat, the *Class of Case* is 14. If there is no information about whether or where the patient was treated, the *Class of Case* is *10*.

Analytic Cases Reportable to DCCR

Class of case marked in yellow highlights are reportable to DCCR.

Initial diagnosis at reporting facility or in a staff physician's office	
00	Initial diagnosis at the reporting facility AND all treatment or a decision not to treat was done elsewhere
10	Initial diagnosis at the reporting facility or in an office of a physician with admitting privileges AND part or all of first course treatment or a decision not to treat was at the reporting facility, NOS
11	Initial diagnosis in an office of a physician with admitting privileges AND part of first course treatment was done at the reporting facility
12	Initial diagnosis in an office of a physician with admitting privileges AND all first course treatment or a decision not to treat was done at the reporting facility
13	Initial diagnosis at the reporting facility AND part of first course treatment was done at the reporting facility; part of first course treatment was done elsewhere
14	Initial diagnosis at the reporting facility AND all first course treatment or a decision not to treat was done at the reporting facility
Initial diagnosis elsewhere	
20	Initial diagnosis elsewhere AND all or part of first course treatment was done at the reporting facility, NOS
21	Initial diagnosis elsewhere AND part of first course treatment was done at the reporting facility; part of first course treatment was done elsewhere.
22	Initial diagnosis elsewhere AND all first course treatment or a decision not to treat was done at the reporting facility

Note: For complete class of case list, see STORE manual: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/cocmanuals/

Non-Analytic Case Reporting

Nonanalytic cases (Class of Case 30-99) are not usually included in routine treatment or survival statistics. DCCR requires all facilities to abstract and submit the following class of case. Cases must pass electronic edit check before submission to DCCR.

30

- Class of Case 30-33
- Class of Case 34 (CIN III/CIS Cervix)
- Class of Case 38 (dx established by autopsy only)
- Class of Case 43 (pathology/lab consult only)

Instruction for collection of non-analytic cases:

- This includes pathology consultations, patients that are admitted to the facility for other medical conditions but have an active cancer diagnosis or history of cancer. DCCR is aware that relevant information for this cancer may not be available at the time of abstraction, in which case the data fields will be recorded as unknown.
- Patients that are diagnosed and/or treated in your inpatient or outpatient departments, emergency room, ambulatory care center, or other units included under your hospital license must be reported.
- If information is missing or workup was not done, or a required data item is not available, please use N/A, unknown or none. Blanks are not acceptable values. Estimate date of DX if unknown – document estimation in text.
- Address at diagnosis: If the address at time of original diagnosis is unknown, record it as "unknown" in corresponding data fields.

Example: A patient is treated at your facility for hypertension. The patient has a history of colon cancer. The patient does NOT receive any treatment for their colon cancer and there is no documentation of progression or recurrence of disease. This case must be reported with appropriate documentation that details the reason for the visit and the history of colon cancer.

Note: Use abbreviated abstract format for non-analytic cases (See Appendix F).

Non-Analytic Cases Reportable to DCCR

Class of case marked in yellow highlights are reportable to DCCR.

Patient appears in person at reporting facility	
30	Initial diagnosis and all first course treatment elsewhere AND reporting facility participated in diagnostic workup (for example, consult only, treatment plan only, staging workup after initial diagnosis elsewhere)
31	Initial diagnosis and all first course treatment elsewhere AND reporting facility provided in-transit care; or hospital provided care that facilitated treatment elsewhere (for example, stent placement)
32	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease recurrence or persistence (active disease)
33	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease history only (disease not active)
34	Type of case not required by CoC to be accessioned (for example, a benign colon tumor) AND initial diagnosis AND part or all of first course treatment by reporting facility
35	Case diagnosed before the program's Reference Date AND initial diagnosis AND all or part of first course treatment by reporting facility
Code	**Label**
36	Type of case not required by CoC to be accessioned (for example, a benign colon tumor) AND initial diagnosis elsewhere AND all or part of first course treatment by reporting facility
37	Case diagnosed before the program's Reference Date AND initial diagnosis elsewhere AND all or part of first course treatment by facility
38	Initial diagnosis established by autopsy at the reporting facility, cancer not suspected prior to death
Patient does not appear in person at reporting facility	
40	Diagnosis AND all first course treatment given at the same staff physician's office
41	Diagnosis and all first course treatment given in two or more different offices of physicians with admitting privileges
42	Nonstaff physician or non-CoC accredited clinic or other facility, not part of reporting facility, accessioned by reporting facility for diagnosis and/or treatment by that entity (for example, hospital abstracts cases from an independent radiation facility)
43	Pathology or other lab specimens only
49	Death certificate only
99	Nonanalytic case of unknown relationship to facility (not for use by CoC accredited cancer programs for analytic cases).

Note: For complete class of case list, see STORE manual: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/cocmanuals/

DCCR Coding and Staging Rules by Manual & Diagnosis Year

Staging		
Manual	**Effective Years**	**Use for Diagnosis Years**
AJCC Cancer Staging Manual 7th Ed.	2010-2017	2010-2017
AJCC Cancer Staging Manual 8th Ed.	2018-	2018-
AJCC Cancer Staging Manual 9th Ed. Chapter: Cervix Uteri	2021-	2021-
AJCC Cancer Staging Manual 9th Ed. Chapter: Anus	2023-	2023-
AJCC Cancer Staging Manual 9th Ed. Chapter: Brain/Spinal Cord	2023-	2023-
AJCC Cancer Staging Manual 9th Ed. Chapter: Appendix	2023-	2023-
AJCC Cancer Staging Manual 9th Ed. Chapter: Vulva	2024-	2024-
AJCC Cancer Staging Manual 9th Ed. Chapter: Neuroendocrine Tumors of Appendix	2024-	2024-
SEER Summary Staging Guide	1977-2000	1997-2000
SEER Summary Stage 2000	2001-2003, 2016-2017	2001-2003, 2016-2017
SEER Summary Stage 2018	2018-	2018
Data Collection		
Registry Operations and Data Standards (ROADS)	1996-2002	1997-2002
Facility Oncology Registry Data Standards (FORDS)	2003-2017	2003-2017
Historical Standards for Oncology Registry Entry Manuals (STORE)	2018-2022	2018-2022
Standards for Oncology Registry Entry (STORE)	2023-	2023-
SEER Program Code Manual	1988-2004	1997-2004
SEER Historical Program Staging & Coding Manual	2004-2022	2004-2022
SEER Program Coding & Staging Manual	2024-	2024-
Grade		
Instructions for Coding Grade 2014	2014-2017	2014-2017
NAACCR Grade Coding Manual	2018-	2018-
Primary Site and Histology		
International Classification of Diseases for Oncology	1976-2000	1997-2000
ICD-O Third Ed. 1st Revision	2001-2017 2018+ (Primary site only)	2001-2017 2018+ (Primary site only)
ICD-O 3 Coding Updates (Histology only)	(3.1) 2018-2020 (3.2) 2021-	(3.1) 2018-2020 (3.2) 2021-
ICD-O 3 Hematopoietic Primaries Table	2001-2009	2001-2009
SEER Hematopoietic & Lymphoid Neoplasm & Manual	2010-	2010-
SEER Multiple Primary & Histology Coding Rules	2007-2017	2007-2017

SEER Solid Tumor Rules	2018+ (2024 Update)	2018+ (2024 Update)
Treatment		
SEER Self Instructional Manual, Book 8	1993-2004	1997-2004
SEER RX Interactive Antineoplastic Drug Database	2005-	2005-
STORE CTR Guide to Coding Radiation (Appendix R)	2019-	2019-

33

(See Appendix H)

Data Quality Assurance

DCCR is a National Program for Cancer Registries (NPCR) sponsored registry and is required to perform quality assurance audits on data from reporting facilities. The NPCR standard for Data Quality Assurance states: The central cancer registry has an overall program of quality assurance that is defined in the registry operations manual. The quality assurance program includes, but is not limited to:

- A designated Certified Oncology Data Specialist (ODS-C) is responsible for the quality assurance program.
- Quality assurance activities should be conducted by qualified, experienced, and certified oncology data specialists (ODS-C) or ODS-eligible staff.
- Data consolidation procedures are performed according to the central cancer registry protocol and nationally accepted abstracting and coding standards.
- At least once every five years, a combination of case-finding and re-abstracting audits are conducted from a sample of source documents for each hospital-based reporting facility and may include external audits by CDC or SEER **(DCCR is not a SEER registry).**
- Routine audit of a sample of consolidated cases are performed by the central cancer registry.
- Feedback is provided to reporting sources on data quality and completeness.

Quality control activities are conducted by DCCR Quality Assurance staff annually as required by the National Program for Cancer Registries (NPCR). The purpose of these audits is to ensure data in the central registry are complete, accurate and timely.

To remain compliant with NPCR standards, DCCR performs visual audits on each facility's data submission file. (See Submission Criteria). Cases are randomly sampled and reviewed for errors. A summary report is submitted to the facility with the results, resources for review and DCCR recommendations. A report card is established, and grades are assigned on a point scale for each facility submission. At the end of the submission period, points are totaled, and an average grade is assigned. Only facilities receiving an overall grade of "A" will receive the cancer registry spotlight award. Facilities that did not achieve an overall grade of an "A" may be recognized for improvement in specific data quality areas.

A summary of the audit is provided to the facility's cancer registry supervisor, manager and/or director, cancer committee chair and hospital administrator. Follow-up meetings are scheduled to discuss the results of the summary, if applicable.

DCCR Audit Types

Case Ascertainment Audits

Case ascertainment audits (also known as Casefinding Audits) are performed by reviewing inpatient and outpatient disease indices, pathology reports and other pertinent case finding documents such as: oncology clinic and surgery sign in logs, pathology reports and medical records disease indices for a specified diagnosis year. The documents are reviewed to determine if all reportable cancers have been collected and submitted to DCCR. Cases that are identified as not being in the DCCR database will be sent to the hospital registrar for reconciliation. Reconciliation must be completed within 14 days of receipt of identified missed cases. Reporting facilities must provide a summary detailing the reasons for missed cases. If cases are required to be reported, the hospital registrar must submit electronically to DCCR within the required timeframe.

Re-Abstracting Audits or Quality Assurance

Quality assurance or re-abstracting audits consists of reviewing specific fields identified during case consolidation that have consistent abstracting discrepancies, including but not limited to; primary site, histology, staging, text, use of the Solid Tumor Rules, FKA Multiple Primary Rules (MPH), etc. The DCCR will create a list that includes 10% of analytic cases from the reporting facility (Class Case 10-22) for a specific diagnosis year and provide a list of critical data items that will be reviewed to the hospital. The DCCR staff will re-abstract the hospital facility's data and compare it with the original data (un-consolidated abstract) that was submitted from the reporting facility to ensure that standard coding rules have been utilized during the abstracting process.

A summary of the percentage of cases that have errors within the abstracts will be sent to the facilities for staff training. The appropriate resources for the errors identified will be provided in a summary report to the reporting facilities to ensure that the errors identified will not continue.

Death Clearance

DCCR staff performs additional checks of reporting completeness through the death clearance process. Each year the DCCR electronically matches existing incidence cases in the cancer master file against the DOH Vital Statistics death certificate records, Social Security Death Index (SSDI) and National Death Index (NDI) to update cases in the registry database with current death dates. If an exact match is found, specific data items are automatically updated within the patient's record, which includes patient's country of birth, last date of contact, vital status, and cause of death. Patients with a diagnosis of cancer on their death certificate that have expired at a reporting facility and not in the DCCR cancer database, will be submitted to the facility for reconciliation. Each facility is required to designate registry personnel that can assist with any follow back questions from DCCR for patients identified during the death clearance process. Facilities are required to submit abstracts for all cases

that were either clinically or pathologically diagnosed at their facility or refused treatment and had an admission regardless of whether treatment was or was not received.

Death Clearance Process

All death files provided to DCCR (DC Health Vital Records death certificate, Social Security Death Index file (SSDI) and the National Death Index (NDI) are processed through the DCCR database to ensure that all cases are updated accurately. To ensure that all death cases are captured, the Death Clearance process is performed in the following order:

1. **DC Health Vital Records Death Tape:** This process captures all death occurrences in the District regardless of the patient's residence at time of death. This is the step where cases are sent back to facilities for reconciliation.

2. **Social Security Death Index (SSDI):** This process captures all deaths of persons that paid into social security or received social security. Persons not contributing to Social Security will not be included on this list.

3. **National Death Index**: This process captures any cases within DCCR that may have expired in other states. The file generated for this process will include all deaths that have an unknown cause of death listed and patients that are documented as alive in the database. Linkage with this database concludes the death clearance process.

The following reports are generated for each death file:

- **Exact Match Cases** – These are cases that match exacting from the DC Vital records death tape, Social Security Death Index and National Death Index using criteria such as, patient name, social security number and date of birth. Specific data items are automatically updated in these cases: Date last contact, cause of death, date of death, state of death, autopsy performed, death certificate number, place of death, death source, i.e., state vital records.

- **Possible Match Cases** – These are cases that have a discrepancy with one of the variables, patient name's, date of birth or social security number. These cases are manually reviewed by DCCR staff to determine if the deceased patient is the same as the patient within the DCCR database by reviewing other variables and resources such, as address at diagnosis or current address and reviewing the information in Lexis Nexis. If a match is determined, DCCR staff will update all appropriate variables for each case.

- **Non-Match Cases** – These are cases with a cancer cause of death that did not match with any cases within the DCCR database. Non-matched cases from the DC vital records death tape are sent back to the facilities for reconciliation. Non-matched cases from the social security death index (SSDI) file and the National Death Index (NDI) file do not require any follow back.

Compliance, Timeliness and Data Quality Assurance

To ensure timely and complete cancer cases, each healthcare provider and healthcare facility is required by DC Municipal Regulation (Rule: 22-B215) to report all malignant cancers and benign brain or central nervous system tumors within six (6) months of diagnosis or first date of contact to DCCR. Failure to report cancer cases in compliance with DC Municipal Regulation Rule: 22-B128.2, "Any person who willfully does not comply with the reporting requirements set forth in § 215 or the access to records as required in § 216 shall be guilty of a misdemeanor, and upon conviction, subject to a fine not to exceed one thousand dollars ($ 1,000). (Appendix A)

Hospital Bi-monthly Submission Requirements

Hospitals are required to submit their data every other month during even months (Feb, Apr, Jun, Aug, Oct, and Dec) no later than the 15th of each month.

Example: Cases submitted in February 2019 should include **all 2018 cases through June 2018** and **75%** of **July 2018** cases, date of first contact must be greater than or equal to July 2018 to comply. Also, a separate follow-up (modification) file must be submitted electronically with the 2018 Data. (See submission schedule - Appendix G)

Use of DCCR Metafile

All hospitals are required to process data files using the most current DC metafile prior to submission to DCCR to ensure that data is error-free. Data files that are **not** 100% free of errors will be returned to the facilities for correction and resubmission. Hospitals will have five (5) business days to correct errors and re-send files to DCCR. The DC metafile will be updated to include the most recent edits from the NAACCR metafile.

Data Submission Review Report

To reduce the likelihood of inaccurate data, each reporting facility **must** perform data quality reviews prior to submission of data. A summary of the internal reviews performed must be provided with each data submission. The summary must include the number of cases reviewed, data items reviewed, corrected and percentage of accuracy.

DCCR Abstracting Responsibilities

DCCR staff will be responsible for abstracting cases for any healthcare facility with a caseload of 100 or less. Healthcare facilities with more than 100 cases will be required to collect and submit electronic cancer data with their hospital registry staff or contract personnel.

Re-Submission File

To ensure complete case ascertainment, each reporting hospital is **required** to re-submit the most recent completed year of data to the DC Cancer Registry by **January 31st of each year**. **For Example:** For 2023 NPCR data submission, **all** cases for diagnosis year 2021 must be re-submitted. ***(File should be named: 2021_resubmission_ABC Hospital).***

Data Quality Report Card

Each facility will be provided with a registry status summary report and report card for each submission. At the end of the year, facility submissions will be calculated to provide an overall score for their annual submissions. At the end of each submission year, facilities with an overall score of an "A" will receive a Cancer Registry Spotlight Award.

The submission criteria include:

- ✓ 100% electronic edit error free data for each data submission.
- ✓ All eligible cancer cases received within 6 months of First Date of Contact/Diagnosis
- ✓ No duplicate or suspense cases within submission file
- ✓ Data submissions include 75% of cases submitted for the abstracting month.
- ✓ Data must pass a 96% accuracy threshold for visual case review.
- ✓ DCCR text requirements are utilized.

Cancer Registry Spotlight Awards

Starting with the review of 2019 diagnoses, the DC Cancer Registry will be recognizing reporting hospitals with a Cancer Registry Spotlight Award. This award will be given to the hospital(s) that has met the data submission criteria and achieved an overall grade of "A" for annual submissions. Points will be assigned for each submission, determined by the number of criteria that are met for the submission file. For each criterion that is met, reporting hospitals will receive a "1" and if the criterion is not met, a "0" will be assigned. There is a total of six (6) points assigned for each submission. At the end of the calendar, all points will be totaled and assigned a grade. That grade will be used to determine the status of the award recipients. Only facilities receiving an overall annual grade of an "A" will be recognized at the annual DCCR educational conference. The notice of the award will be sent to the Cancer Registry Manager, Cancer Registry Director, Hospital CEO and Cancer Committee Chair, if Commission on Cancer Accredited and published in the quarterly DCCR newsletter.

Cancer Registry Training

Cancer registry education is essential for cancer registrars to perform their daily activities. DCCR will provide virtual educational opportunities for all cancer registrars within the District of Columbia and surrounding area. DCCR has mandated that all DC cancer registry staff attend educational opportunities including but not limited to training sponsored by NAACCR, NPCR, SEER, and DCCR.

All training is available on DCCR's educational web-based platform for oncology data specialists (ODS) named Fundamental Learning Collaborative for the Cancer Surveillance Community – FLccSC (pronounced Flossy):

- DCCR Annual Educational Conference available on DCCR's Fundamental Learning Collaborative for the Cancer Surveillance Community (FLccSC – pronounced: Flossy). (Appendix B)
- Monthly NAACCR Webinars available on DCCR's Fundamental Learning Collaborative for the Cancer Surveillance Community (FLccSC – pronounced: Flossy). (Appendix B)
- Quarterly Cancer Registry Roundtables available on DCCR's Fundamental Learning Collaborative for the Cancer Surveillance Community (FLccSC – pronounced: Flossy). (Appendix B)

Note: NPCR does not require DCCR to provide AJCC TNM Staging 8th or 9th Edition to hospital registrars. All AJCC training must be obtained from American College of Surgeons and Commission on Cancer ACoS/CoC.

FLccSC - Fundamental Learning Collaborative for the Cancer Surveillance Community

- DCCR/FLccSC (Pronounced "Flossy") is a state specific, web-based, educational portal for cancer registry professionals.
- Courses and webinars are designed and offered for oncology data specialists (ODS) and students of all experience/skill levels.
- The platform provides access to monthly NAACCR webinars, DCCR Annual Educational Conferences, and NPCR presentations.

DCCR FLccSC Access Link

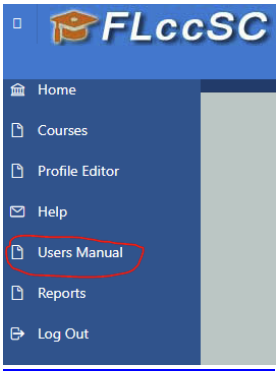
https://dcs.fcdslms.med.miami.edu/

Trouble Shooting Tips

- Use a different browser (Edge, Explorer, Google etc.)
- Try connecting without using a VPN connection.

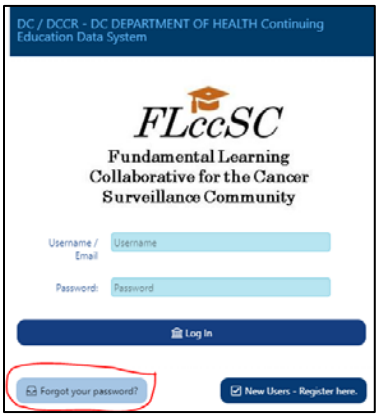
Student User Manual

https://dcs.fcdslms.med.miami.edu/



Assistance with Password or Username

Click "Forgot your password?" button on the log-on screen, add your username email (this is the email you used to sign up for FLCCSC), and follow the emailed password reset instructions.
https://dcs.fcdslms.med.miami.edu



For any FLccSC related assistance or questions: Email, call, or text:
Malorie Thomas, BS, ODS-C
Education Training Coordinator | malorie.thomas@dc.gov | Work cell: 202-578-5623

Case Ascertainment Techniques

The District of Columbia Cancer Registry (DCCR) is charged with maintaining a high-quality database of usable, timely, complete, and accurate cancer data for every reportable case of cancer in the District. These guidelines have been established to achieve and maintain this objective. The goal of the reporting facility is to identify and register all reportable cases for the citizens in the District of Columbia.

Definition of Casefinding (case ascertainment): Process of identifying all reportable cases through review of source documents and case listings. Casefinding covers a range of cases that need to be assessed to determine whether they are reportable.

Note: A case ascertainment list is not the same as a reportable list.

- Casefinding lists are intended for searching a variety of cases so as not to miss any reportable cases.
- Reportable list includes all diagnoses that are to be reported and clarifies the types of diagnoses that are not reportable.

Sources that can be utilized by hospitals for case ascertainment are:

- Pathology reports – review all surgical, cytology, hematology, gynecologic, cytogenetic and autopsy reports. Also review reference studies applicable to cancer diagnosis, such as immunohistochemistry, fluorescence in situ hybridization, flow cytometry, and other tests as they become available. Review the hospital and nonhospital pathology reports.

- Health Information Management (HIM) Reports - Disease indices and daily discharges. The indices must include both inpatient and outpatient admissions and must be based on year of admission. It must be sorted alphabetically by last name and include the following: last name, first name, medical record number, admission/discharge date, date of birth, social security number, all primary and secondary ICD-9 or ICD-10 diagnosis codes and admission type.

- Radiation Oncology Reports – Radiation oncology log, if not included in disease indices and/or treatment summaries.

- Medical Oncology Reports – Oncology therapy log, if not included in disease indices and/or treatment summaries.

- Surgery Report – Surgery log

- Diagnostic Radiology Reports – Nuclear Medicine log/reports and radiology scan log/reports, i.e., PET CT, MRI, Endoscopic US (EUS), etc.

Note: It is important to form an alliance with staff from the above-mentioned departments to establish and develop a systemic method to routinely receive necessary information from them. All reporting facilities, regardless of affiliation, MUST adhere to the guidelines for cancer data reporting.

A link to the current and previous case ascertainment lists are available on the SEER website: https://seer.cancer.gov/tools/casefinding/**.** ICD-10-CM codes will be used for cases diagnosed on or after January 1, 2016. This list is updated annually to add new codes as applicable.

Helpful hints for case ascertainment process:

- Review the disease index for reportable cancer **ICD-9-CM / ICD-10-CM** codes to ensure the facility has reported all its reportable cases to the DCCR.
- Compare the cases with the patients in your facility database. This process can help in capturing any missing treatment, follow up information, recurrence status or possible new primary.
- If a previously reported patient is found to have a subsequent primary, assign the new primary to the patient's existing accession number. The sequence number should be assigned to reflect the new primary.
- If an automated case ascertainment method (for example: the hospital's mainframe extracts possible reportable cases and places these into cancer registry software suspense file), a manual disease index should be run at the end of the reporting year. **Ensure that the ICD-9-CM / ICD-10-CM codes used are the most current for the reporting year.** This disease index is then checked against the cancer registry database to ensure that all cases were either reported or clearly documented as non-reportable.

Data Linkages

DCCR performs multiple linkages with data from several sources. Some of these sources include the following:

DC Vital Records – DC death certificates consists of all persons that was expired in the District regardless of state of residence. Death certificates are linked to the cancer registry database to update cases with specific data items, such as date of death, cause of death and state of death. The linkage provides information for staff at hospital registries review for follow-back. Death clearance only cases are identified through this process.

Social Security Death Index (SSDI) – DCCR links with SSDI files provided by NPCR to update cases in the cancer registry. The information found on cases is acquired from individuals who received Social Security benefits only. This process identifies possible cases that can be compared with the cancer registry database to determine matches. No follow-back is required for this process.

National Death Index (NDI) – DCCR links with NDI to capture any deaths no identified in the previous linkages (DC Vital Records & SSDI). NDI links deaths from anyone that has expired in the United States regardless of receiving government benefits, i.e., Social Security payments. Possible matches are reviewed after linkage and confirmed matches are updated in the cancer registry database. There is no follow-back for this process.

Hospital Follow-up – Reporting hospitals may request follow-up information from DCCR. Each hospital must submit a formal request and patient file to DCCR to perform the linkage. To ensure accuracy, the file must contain the following items:

- Patient's Full Name - if available
- Social Security Number
- Date of Birth
- Gender
- Current Address
- Date of First Contact
- Date Last Contact
- Vital Status

Cancer Research Linkages – DCCR participates in cancer research locally and nationally. To perform a linkage with DCCR, requestors must complete and submit a data request form and submit an IRB application to DOH IRB. Upon approval, requestors must submit a file with information to be linked. Any information from DCCR is de-identified to protect patient confidentiality.

Data Requests

Data is requested by cancer researchers, students, hospital registrars, physicians and community organizations for cancer outcome analysis, grant requests and development of cancer control plans, including preventive screenings.

All requestors must complete a data request form that will be reviewed by the Cancer Registry Advisory Board and approved by the Cancer Registry Program Manager. It can be found on the DC Health website, https://dchealth.dc.gov/service/cancer-registry-0 and submitted to the cancer registry email, DOH.CancerRegistry@dc.gov.

Any requests that include confidential patient information must have a current and approved DOH IRB that contains the specific data items needed to complete their research. DCCR strongly recommends that any requestor of data provide a copy of the completed project, to maintain a sufficient record of cancer data utilization. Any data used from the DCCR should be properly quoted within the completed projects. If case counts are below the required number of cases, the data will not be shared with the requestor due to susceptibility of patient identification.

Data Requests are provided in three levels:

- **Level 1 Data** – Reports of aggregate data stratified by non-confidential data fields (i.e., aggregated incidence and mortality rates by race, sex, etc.). **No IRB required.**
- **Level 2 Data** - Files containing individual, record-level data with no personal identifiers. The file will not contain name, street address, phone number, social security number, date of birth, any reporting facility or physicians involved in the patient's care, or any other information that could potentially be used to identify individual patients. (For cancer research activities, I.e., publications, manuscripts). **IRB Required.**
- **Level 3 Data** - For purposes of record linkage (but not direct patient contact) the requestor must submit to DCCR a file containing individual record level data with personal identifiers to be used for the linkage. **IRB Required.**

For level 2 and 3 data requests, a DC DOH IRB must be completed in conjunction with the cancer registry data request. Upon approval of the IRB, DCCR will provide requested data to the requestor. The information for the IRB protocol can be found at https://dchealth.dc.gov/service/institutional-review-board-public-health.

Note: These rules do not apply to standard hospital linkages, such as follow-up.

Required Data Variables for Patient Abstracts

The DCCR is required by DC regulations and the National Program for Cancer Registries (NPCR) to capture the following data variables for each cancer patient diagnosed in the District of Columbia. DCCR encourages facilities to review all staging manual thoroughly for data items. The resource for each variable is listed.

Registry/Accession Number - NAACCR Item 550

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Note: DCCR uses the registry accession number to refer to patient records that may have to be reviewed for resolution by the reporting hospital.

Sequence Number Hospital Override - NAACCR Item 560

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Note: Sequence numbers will be reassigned at the central registry level to ensure accurate sequencing of cancer cases from multiple facilities.

Reporting Hospital/Facility Number - NAACCR Item 540

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Last Name - NAACCR Item 2230

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/
SEER Program & Staging Manual https://seer.cancer.gov/tools/codingmanuals/

Note: Document in *Text Remarks – Other Pertinent Information*: Last name Unknown

First Name - NAACCR Item 2240

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/
SEER Program & Staging Manual https://seer.cancer.gov/tools/codingmanuals/

Note: Document in *Text Remarks – Other Pertinent Information*: First name Unknown

Middle Name – Middle Initial - NAACCR Item 2250

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Maiden Name - NAACCR Item 2390

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Alias Name - NAACCR Item 2280

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Note: This item is no longer supported by CoC but is required for collection by DCCR.

Patient Address (Number and Street) at Diagnosis - NAACCR Item 2330

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Note 1: All reporting facilities are required to provide information for this field regardless of class of case. For DC cases, please pay close attention to "quadrants". Addresses in the District of Columbia should ALWAYS include a quadrant.

Note 2: Only update based on improved information on the residential address at time of diagnosis.

Note 3: Only use the post office box or the rural mailing address when the physical address is not available.

Note 4: Post office box addresses do not provide accurate geographical information for analyzing cancer incidence. Every effort should be made to obtain complete valid address information.

Patient Address at DX – Supplemental - NAACCR Item 2335

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Note: For DC addresses, record apartment numbers in this data field.

City/Town at Diagnosis (City or Town) - NAACCR Item 70

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Note: Every effort should be made to record the patient's address from resources available in your facility. If the patient's address is not available, do not leave it blank. The address data fields for these cases should be recorded Unknown in the street address, Unknown in the city, ZZ in the state, 99999 in the zip code and 999 in the FIPS data field. Do not record the reporting facility's city, state, zip and FIPS for unknown addresses.

State at DX-State - NAACCR Item 80

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Postal Code at Diagnosis (Zip Code) - NAACCR Item 100

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Address at Diagnosis - Country - NAACCR Item 102

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

County at Diagnosis Reported - NAACCR Item 90

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Date of Birth - NAACCR Item 240

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Social Security Number - NAACCR Item 2320

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Birthplace- State - NAACCR Item 252

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Birthplace – Country - NAACCR Item 254

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Tobacco History

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Note: This field has been retired by NAACCR/CoC but is required for collection for DCCR.

Alcohol History

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Note: This field has been retired by NAACCR/CoC but is required for collection for DCCR.

Family History

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Note 1: Document social and family history information in the Physical Examination – text field.

Note 2: Do not leave this field blank.

Note 3: This field has been retired by NAACCR/CoC but is required for collection for DCCR.

Age at Diagnosis - NAACCR Item 230

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Note: Age of diagnosis is calculated when date of diagnosis and birth date is recorded in the patient abstract.

Race 1 - NAACCR Item 160

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/
SEER Program & Staging Manual https://seer.cancer.gov/tools/codingmanuals/

Race 2 – Race 5 - NAACCR Item 161, 162, 163, 164

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/
SEER Program & Staging Manual https://seer.cancer.gov/tools/codingmanuals/

Spanish Origin – All sources - NAACCR Item 190

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/
SEER Program & Staging Manual https://seer.cancer.gov/tools/codingmanuals/

Sex (Gender) - NAACCR Item 220

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Primary Payer at Diagnosis - NAACCR Item 630

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Medical Record Number - NAACCR Item 2300

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Date of First Contact - NAACCR Item 580

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Class of Case - NAACCR Item 610

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Note 1: All reporting facilities must report non-analytic cases (30-33, 38, 43) DCCR, regardless of ACoS approval status.

Note 2: Non-analytic cases, classes 49 and 99 are to be used solely by the central cancer registry.

Type of Reporting Source - NAACCR Item 500

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/
SEER Program & Staging Manual https://seer.cancer.gov/tools/codingmanuals/

Casefinding Source - NAACCR Item 501

Refer to the NAACCR data dictionary, Chapter X, for casefinding source codes:
https://www.naaccr.org/data-standards-data-dictionary/

Co-Morbidities & Complications 1-10 - NAACCR Items 3110, 3120, 3130, 3140, 3150, 3160-3164

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Secondary Diagnosis 1- 10 - NAACCR items 3780, 3782, 3784, 3786, 3788, 3790, 3792, 3794, 3796, 3798

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Required Data Variables for Cancer Identification

The DCCR is required by DC regulations and the National Program for Cancer Registries (NPCR) to capture the following data variables for each cancer patient diagnosed in the District of Columbia. DCCR encourages facilities to review all staging manual thoroughly for data items. The resource for each variable is listed.

Primary Site - NAACCR Item 400

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Histology - NAACCR Item 522

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/. Record the histology using the ICD-0-3 (https://seer.cancer.gov/icd-o-3) codes in the Numeric Lists/Morphology section (ICD-O-3, pp. 69-104) and in the Alphabetic Index (ICD-O-3, pp. 105-218). Use the current SEER Solid Tumor Rules https://seer.cancer.gov/tools/solidtumor/ when coding the histology for all reportable solid tumors. These rules are effective for cases diagnosed January 1, 2007, or later. Do not use these rules to abstract cases diagnosed prior to January 1, 2007. For lymphoma, leukemia, and other hematopoietic tumors, follow the instructions in *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual* and the *Hematopoietic and Lymphoid Database (Hematopoietic DB)*. https://seer.cancer.gov/tools/heme/Hematopoietic_Instructions_and_Rules.pdf

Note: do not use these rules to determine case reportability, tumor grade or behavior.

Behavior Code - NAACCR Item 523

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/
SEER Program & Staging Manual https://seer.cancer.gov/tools/codingmanuals/

Grade Clinical - NAACCR Item 3843

Find description, rationale, and coding instructions here:
SEER Program & Staging Manual https://seer.cancer.gov/tools/codingmanuals/. Refer to the most recent version of the **Grade Coding Instructions and Tables** for additional site-specific instructions.
https://www.naaccr.org/SSDI/Grade-Manual.pdf

Grade Pathological - NAACCR Item 3844

SEER Program & Staging Manual https://seer.cancer.gov/tools/codingmanuals/
Refer to the most recent version of the **Grade Coding Instructions and Tables** for additional site-specific instructions. https://www.naaccr.org/SSDI/Grade-Manual.pdf

Grade Post Therapy - NAACCR Item 3845

Find description, rationale, and coding instructions here:
SEER Program & Staging Manual https://seer.cancer.gov/tools/codingmanuals/
Refer to the most recent version of the Grade Coding Instructions and Tables for additional site-specific instructions. https://www.naaccr.org/SSDI/Grade-Manual.pdf

Laterality - NAACCR Item 410

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Date of Initial Diagnosis - NAACCR Item 390

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Diagnostic Confirmation - NAACCR Item 490

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Lymph Vascular Invasion - NAACCR Data Item 1182

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Required Data Variables for Stage of Disease at Diagnosis

The DCCR is required by DC regulations and the National Program for Cancer Registries (NPCR) to capture the following data variables for each cancer patient diagnosed in the District of Columbia. DCCR encourages facilities to review all staging manual thoroughly for data items. The resource for each variable is listed.

Date of Surgical Diagnostic and Staging Procedure - NAACCR Item 1280

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Surgical Diagnostic and Staging Procedure - NAACCR Item 1350

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

TNM Staging

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Summary Stage 2018 - NAACCR Item 764

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Note: Code "5" for "Regional, NOS" can no longer be coded.

Site-Specific Data Items (SSDI)

In 2018, Collaborative Stage (CS) Site-Specific Factors (SSF's) were discontinued, and Site-Specific Data Items (SSDIs) will be used for collection of site-specific information. SSDI's will have unique names and NAACCR data item numbers and can be applied to as many sites as needed. Unlike SSF's, field length is not limited to 3 digits, decimals are allowed, and different coding conventions are used to record actual values, percentages, and ranges.

A "SSDI'" is a site-specific data item. "Site" in this instance is based on the primary site, the AJCC chapter, Summary Stage chapter and the EOD schema. SSDIs were preceded by CS SSFs, which were first introduced in 2004 with CSv1, and went through major revisions in 2010 with **Collaborative Stage v2 (CSv2)**. CS SSFs were discontinued as of 12/31/2017.

SSDIs have their own data item name and number and can be collected for as many sites/chapters/schemas as needed.

Each Site-Specific Data Item (SSDI) applies only to selected schemas. SSDI fields should be blank for schemas where they do not apply.

Refer to the SSDI Manual to assign appropriate site-specific data items:
www.naaccr.org/wp-content/uploads/2023/10/Site-Specific-Data-Item-SSDI-Manual_printed.pdf

Regional Lymph Nodes Examined - NAACCR Item 830

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Regional Lymph Nodes Positive - NAACCR Item 820

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Tumor Size Summary - NAACCR Item 756

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Mets at Diagnosis – Bone - NAACCR Item 1112

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Mets at Diagnosis – Brain - NAACCR Item 1113

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Mets at Diagnosis – Distant Lymph Nodes - NAACCR Item 1114

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Mets at Diagnosis – Liver - NAACCR Item 1115

Find description, rationale, and coding instructions here:

STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Mets at Diagnosis – Lung - NAACCR Item 1116

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Mets at Diagnosis – Other - NAACCR Item 1117

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Brain Molecular Markers - NAACCR Item 3816

Refer to the SSDI Manual to assign appropriate site-specific data items:
www.naaccr.org/wp-content/uploads/2023/10/Site-Specific-Data-Item-SSDI-Manual_printed.pdf
Refer to the AJCC Manual to assign appropriate data items: https://www.facs.org/quality-programs/cancer-programs/american-joint-committee-on-cancer/cancer-staging-systems/cancer-staging-system-products/

Note: Each Site-Specific Data Item (SSDI) applies only to selected primary sites, histologies, and years of diagnosis. Depending on applicability and standard-setter requirements, SSDIs may be left blank.

Breslow Tumor Thickness - NAACCR Item 3817

Refer to the SSDI Manual to assign appropriate site-specific data items:
www.naaccr.org/wp-content/uploads/2023/10/Site-Specific-Data-Item-SSDI-Manual_printed.pdf
Refer to the AJCC Manual to assign appropriate data items: https://www.facs.org/quality-programs/cancer-programs/american-joint-committee-on-cancer/cancer-staging-systems/cancer-staging-system-products/

Note 1: Physician statement of Breslow Tumor Thickness can be used to code this data item when no other information is available, or the available information is ambiguous.

Note 2: Code Breslow tumor thickness, not size. Record actual measurement in tenths of millimeters from the pathology report. Measurement given in hundredths of millimeters should be rounded to the nearest tenth.

Examples:
0.4 mm – 0.4
1.0 mm- 1.0
2.5 mm – 2.5
2.56 mm- 2.6
11 mm – 11.0
12.35 mm – 12.4 mm

Note 3: Code the greatest measured thickness from any procedure performed on the lesion, whether it is described as a biopsy or an excision. For *example*, if a punch biopsy with a thickness of 1.5 mm is followed by a re-excision with a thickness of residual tumor of 0.2 mm, code 1.5.

Note 4: Do not add measurements together from different procedures (even in the rare circumstance that the pathologist adds the measurements from two specimens).

Note 5: If the pathologist describes the thickness as "at least," use the appropriate A code. An exact measurement takes precedence over A codes. If the pathologist states "greater than" instead of "at least", code to XX.9, unless it is greater than 9.9 mm (Code AX.0)

Examples:
Pathologist states the thickness is "at least 2.0 mm." Code A2.0
Pathologist states the thickness is "greater than 4 mm." Code XX.9
Each Site-Specific Data Item (SSDI) applies only to selected primary sites, histologies, and years of diagnosis. Depending on applicability and standard-setter requirements, SSDIs may be left blank.

Estrogen Receptor Summary - NAACCR Item 3827

Refer to the SSDI Manual to assign appropriate site-specific data items:
www.naaccr.org/wp-content/uploads/2023/10/Site-Specific-Data-Item-SSDI-Manual_printed.pdf
Refer to the AJCC Manual to assign appropriate data items: https://www.facs.org/quality-programs/cancer-programs/american-joint-committee-on-cancer/cancer-staging-systems/cancer-staging-system-products/

Note 1: Physician statement of ER (Estrogen Receptor) Summary status can be used to code this data item when no other information is available.

Note 2: The result of the ER test performed on the primary breast tissue is to be recorded in this data item.

Note 3: Results from nodal or metastatic tissue may be used ONLY when there is no evidence of primary tumor.

Note 4: In cases where ER is reported on more than one breast tumor specimen, record the highest value. If any sample is positive, record as positive. *Exception*: If ER is positive on an in-situ specimen and ER is negative on all tested invasive specimens, code ER as negative (code 0).

Each Site-Specific Data Item (SSDI) applies only to selected primary sites, histologies, and years of diagnosis. Depending on applicability and standard-setter requirements, SSDIs may be left blank.

Progesterone Receptor Summary - NAACCR Item 3915

Refer to the SSDI Manual to assign appropriate site-specific data items:

www.naaccr.org/wp-content/uploads/2023/10/Site-Specific-Data-Item-SSDI-Manual_printed.pdf
Refer to the AJCC Manual to assign appropriate data items: https://www.facs.org/quality-programs/cancer-programs/american-joint-committee-on-cancer/cancer-staging-systems/cancer-staging-system-products/

Note 1: Physician statement of ER (Estrogen Receptor) Summary status can be used to code this data item when no other information is available.

Note 2: The result of the ER test performed on the primary breast tissue is to be recorded in this data item.

Note 3: Results from nodal or metastatic tissue may be used ONLY when there is no evidence of in situ or invasive carcinoma in the primary tumor.

Note 4: In cases where there are invasive and in situ components in the primary tumor and ER is done on both, ignore the in-situ results. If ER is positive on an in-situ component and ER is negative on all tested invasive components in the primary tumor, code ER as negative (code 0). If in situ and invasive components are present and ER only done on the in-situ component in the primary tumor, code unknown (code 9).

Note 5: In cases where there is a single tumor with multiple biopsies and/or surgical resection with different ER results. Use the highest (positive versus negative).

Note 6: In cases where there are multiple tumors with different ER results, code the results from the largest tumor size (determined either clinically or pathologically) when multiple tumors are present. Do not use specimen size to determine the largest tumor size.

Note 7: If neoadjuvant therapy is given, record the assay from tumor specimens prior to neoadjuvant therapy. If neoadjuvant therapy is given and there are no ER results from pre-treatment specimens, report the findings from post-treatment specimens.

Note 8: If the patient is ER positive and node negative, a multigene test such as Oncotype Dx may be performed, in which case another ER test will be performed. Do not record the results of that test in this field. Record only the results of the test which made the patient eligible to be given the multigene test.

HER2 Overall Summary - NAACCR Item 3855

Refer to the SSDI Manual to assign appropriate site-specific data items:
www.naaccr.org/wp-content/uploads/2023/10/Site-Specific-Data-Item-SSDI-Manual_printed.pdf
Refer to the AJCC Manual to assign appropriate data items: https://www.facs.org/quality-programs/cancer-programs/american-joint-committee-on-cancer/cancer-staging-systems/cancer-staging-system-products/

Note 1: Physician statement of HER2 Overall Summary can be used to code this data item when no other information is available.

Note 2: The result of the HER2 test performed on the primary breast tissue is to be recorded in this data item.

Note 3: Results from nodal or metastatic tissue may be used ONLY when there is no evidence of primary tumor.

Note 4: In cases where HER2 is reported on more than one breast tumor specimen, record the highest value. If any sample is positive, record as positive. *Exception*: If HER2 is positive on an in-situ specimen and HER2 is negative on all tested invasive specimens, code HER2 as negative (code 0).

Note 5: If neoadjuvant therapy is given, record the assay from tumor specimens prior to neoadjuvant therapy. If neoadjuvant therapy is given and there are no HER2 results from pre-treatment specimens, report the findings from post-treatment specimens.

Note 6: If the patient is HER2 positive and node negative, a multigene test such as Oncotype Dx may be performed, in which case another HER2 test will be performed. Do not record the results of that test in this field. Record only the results of the test which made the patient eligible to be given the multigene test.

Each Site-Specific Data Item (SSDI) applies only to selected primary sites, histologies, and years of diagnosis. Depending on applicability and standard-setter requirements, SSDIs may be left blank.

Fibrosis Score - NAACCR Item 3835

Refer to the SSDI Manual to assign appropriate site-specific data items:
www.naaccr.org/wp-content/uploads/2023/10/Site-Specific-Data-Item-SSDI-Manual_printed.pdf
Refer to the AJCC Manual to assign appropriate data items: https://www.facs.org/quality-programs/cancer-programs/american-joint-committee-on-cancer/cancer-staging-systems/cancer-staging-system-products/

Note 1: Physician statement of fibrosis score can be used to code this data item when no other information is available. However, code 7 when the physician statement of fibrosis score is not based on histologic examination of the liver.

Note 2: FIB-4 is NOT a pathological fibrosis score of 4. It is a scoring method using the patient's age and relevant lab values to calculate a score. The medical record may show something like "FIB-4 = 3.52." Do not code FIB-4 values in this data item.

Note 3: AJCC classifies Ishak fibrosis scores 0-4 (none to moderate fibrosis) as F0, and Ishak fibrosis scores 5-6 (cirrhosis/severe fibrosis) as F1. This is not the same as METAVIR score F0 or F1.

Note 4: Record the results based on information collected during the initial work-up. If multiple biopsies are taken and have conflicting scores, use the results from the biopsy closest to the start of treatment. Information collected after the start of treatment may not be used to code this data item.

Note 5: Code the absence (code 0) or presence (code 1) of fibrosis as documented in the pathology report.

Note 6: If no score is mentioned, descriptive terms may be used to assign codes 0 and 1 – see specific terms in the table below.

Note 7: If a fibrosis score is stated but the scoring system is not recorded, consult with the physician. If no further information is available, code 9.

Each Site-Specific Data Item (SSDI) applies only to selected primary sites, histologies, and years of diagnosis. Depending on applicability and standard-setter requirements, SSDIs may be left blank.

HIV Status - NAACCR Item 3855

Refer to the SSDI Manual to assign appropriate site-specific data items:
www.naaccr.org/wp-content/uploads/2023/10/Site-Specific-Data-Item-SSDI-Manual_printed.pdf
Refer to the AJCC Manual to assign appropriate data items: https://www.facs.org/quality-programs/cancer-programs/american-joint-committee-on-cancer/cancer-staging-systems/cancer-staging-system-products/

Note 1: Physician statement of HIV status can be used to code this data item when no other information is available.

Note 2: Acquired Immune Deficiency Syndrome (AIDS) lymphomas are a late manifestation of Human Immunodeficiency Virus (HIV) infection and have unique clinical and pathological features that differ from lymphomas in the general population. They have a preponderance for extra nodal involvement, with the central nervous system being the most common site.

Note 3: HIV includes types I and II. Older terminology includes Human T Lymphotropic Virus -3 (HTLV-3) and Lymphadenopathy Associated Virus (LAV).

Note 4: Code 9 if there is no mention of HIV/AIDS in the medical record. Do not assume that the patient is HIV negative.

Each Site-Specific Data Item (SSDI) applies only to selected primary sites, histologies, and years of diagnosis. Depending on applicability and standard-setter requirements, SSDIs may be left blank.

Microsatellite Instability (MSI) - NAACCR Item 3890

Refer to the SSDI Manual to assign appropriate site-specific data items:
www.naaccr.org/wp-content/uploads/2023/10/Site-Specific-Data-Item-SSDI-Manual_printed.pdf
Refer to the AJCC Manual to assign appropriate data items: https://www.facs.org/quality-programs/cancer-programs/american-joint-committee-on-cancer/cancer-staging-systems/cancer-staging-system-products/

Note 1: Physician statement of MSI can be used to code this data item when no other information is available.

Note 2: The microsatellite instability (MSI) test is a genetic test performed on tumor tissue to look for differences in length of certain non-functioning sections of DNA. The differences are caused by problems with the genes that encode proteins that normally repair certain types of DNA damage. A high proportion of colon cancers arising in patients with hereditary nonpolyposis colorectal cancer (HNPCC) (also known as Lynch syndrome) have high MSI and a smaller percentage of colon cancers not associated with Lynch syndrome have high MSI. Patients with colon cancers with high MSI may be further tested to determine if they have HNPCC. In addition, MSI is a useful prognostic marker in that patients with high MSI colon cancers have better response to surgery and survival.

Note 3: Testing for MSI may be done by immunology or genetic testing. Only genetic testing results will specify whether the MSI is low or high.

- Some laboratories only test for MSI via an immunologic test for Mismatch Repair (MMR) Protein
- Results from immunology will only provide you with positive or negative results and will not specify whether the MSI is low or high.
- Results of Mismatch Repair (MMR) may be recorded in this data item - see codes 0 and 2.
- MMR proficient (pMMR or MMR-P) should be coded as a 0.

Note 4: If both tests are done and one or both are positive, code 2.

Note 5: If all tests done are negative, code 0.

Each Site-Specific Data Item (SSDI) applies only to selected primary sites, histologies, and years of diagnosis. Depending on applicability and standard-setter requirements, SSDIs may be left blank.

PSA (Prostatic Specific Antigen) Lab Value - NAACCR Item 3920

Refer to the SSDI Manual to assign appropriate site-specific data items: www.naaccr.org/wp-content/uploads/2023/10/Site-Specific-Data-Item-SSDI-Manual_printed.pdf
Refer to the AJCC Manual to assign appropriate data items: https://www.facs.org/quality-programs/cancer-programs/american-joint-committee-on-cancer/cancer-staging-systems/cancer-staging-system-products/

***Note 1*: Serum PSA is not the same as free PSA or precursor PSA—do not record values from either of these tests in this field.**

Note 2*: *This is a change from CSv2, where the instructions stated to code the highest PSA value within 3 months prior to diagnostic biopsy.

Note 3: Physician statement of prostatic specific antigen (PSA) pre-diagnosis can be used to code this data item when no other information is available.

Note 4: PSA is a prognostic factor required for AJCC staging. It affects the stage group in most cases.

Note 5: Record to the nearest tenth in nanograms/milliliter (ng/ml) the last pre-diagnosis PSA lab value prior to diagnostic biopsy of prostate and treatment. The lab value may be recorded in the lab report, history and physical, or clinical statement in the pathology report, etc.

A lab value expressed in micrograms per liter (ug/L) is equivalent to the same value expressed in nanograms per milliliter (ng/ml). Record 0.1 when the lab results are stated as less than 0.1 ng/ml with no exact value.

***Examples*:**
PSA of 7.2. Code 7.2
PSA of 10. Code 10.0
PSA of 8.56. Code 8.6
PSA of 110.35. Code 110.4

Note 6: A discrepancy between the PSA documented in the lab report and the PSA documented by the clinician may arise due to the clinician's adjusting the PSA value. Certain medications for benign prostatic hypertrophy (BPH) decrease the PSA. If there is documentation by a clinician within the medical record of an adjusted PSA value, record the adjusted value. The registrar does not adjust the PSA value based on BPH medication use. If there is no documentation by a clinician within the medical record of an adjusted PSA value, record the PSA value provided. The fact that an adjusted PSA value is being recorded should be documented in the Dx Proc – Lab Tests text field (NAACCR Item # 2550).

Each Site-Specific Data Item (SSDI) applies only to selected primary sites, histologies, and years of diagnosis. Depending on applicability and standard-setter requirements, SSDIs may be left blank.

Schema Discriminator 1 Urethra/Prostatic Urethra - NAACCR Item 3926

Refer to the SSDI Manual to assign appropriate site-specific data items:
www.naaccr.org/wp-content/uploads/2023/10/Site-Specific-Data-Item-SSDI-Manual_printed.pdf
Refer to the AJCC Manual to assign appropriate data items: https://www.facs.org/quality-programs/cancer-programs/american-joint-committee-on-cancer/cancer-staging-systems/cancer-staging-system-products/

Schema Discriminator 2 - NAACCR Item 3927

Refer to the SSDI Manual to assign appropriate site-specific data items:
www.naaccr.org/wp-content/uploads/2023/10/Site-Specific-Data-Item-SSDI-Manual_printed.pdf

Note: The information recorded in Schema Discriminator differs for each anatomic site. See the SSDI manual for the most current version of the site-specific codes and coding structures.

LDH Pretreatment Lab Value - NAACCR Item 3932

Refer to the SSDI Manual to assign appropriate site-specific data items:
www.naaccr.org/wp-content/uploads/2023/10/Site-Specific-Data-Item-SSDI-Manual_printed.pdf
Refer to the AJCC Manual to assign appropriate data items: https://www.facs.org/quality-programs/cancer-programs/american-joint-committee-on-cancer/cancer-staging-systems/cancer-staging-system-products/

Note 1: Physician statement of LDH (Lactate Dehydrogenase) Pretreatment Lab Value can be used to code this data item when no other information is available.

Required Data Variables for First Course Cancer Treatment

Cancer Directed Treatment

Record all cancer-directed therapy information available whether administered at the reporting hospital or at another facility. If the patient receives part of the first course of therapy at the reporting hospital and is transferred to another facility to continue treatment, also record the treatment given at the other hospital if it is known. Documenting all treatments in the given RX Summ fields provides a complete "picture" of the patient's cancer experience and is meaningful in calculating survival statistics and assessing treatment success. Subsequent courses of treatment should only be mentioned in text fields.

Date of First Course of Treatment - NAACCR Data Item 1270

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Date of First Surgical Procedure - NAACCR Item 1200

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Required Data Variables for Surgery

Date of Most Definitive Surgical Resection of Primary Site - NAACCR Item 3170

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Rx Date – Surgery Flag - NAACCR Item 1201

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Rx Date Mst Defn Srg Flag - NAACCR Item 3171

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Surgical Procedure of Primary Site - NAACCR Item 1290

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Scope of Regional Lymph Node Surgery - NAACCR Item 1292

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Surgical Procedure/Other Site - NAACCR Item 1294

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Reason No Surgery of Primary Site - NAACCR Item 1340

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Required Data Variables for Radiation

Date Radiation Started - NAACCR Item 1210

Find description, rationale, and coding instructions here:

STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Phase I Radiation Treatment Modality - NAACCR Item 1506

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Note: Do not confuse a radioiodine scan with treatment. Only treatment is recorded in this item.

Radiation/Surgery Sequence - NAACCR Item 1380

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Required Data Variables for Systemic Therapy

Date Chemotherapy Started - NAACCR Item 1220

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Rx Date-Chemo Flag - NAACCR Item 1221

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Chemotherapy - NAACCR Item 1390

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/. Refer to the ***SEER*Rx Interactive Drug Database*** *https://seer.cancer.gov/tools/seerrx/* for a list of chemotherapeutic agents.

Date Hormone Therapy Started - NAACCR Item 1230

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

RX Date-Hormone Flag - NAACCR Item 1231

Find description, rationale, and coding instructions here:

STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Hormone Therapy (Hormone/Steroid Therapy) - NAACCR Item 1400

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/. Refer to the ***SEER*Rx Interactive Drug Database*** *https://seer.cancer.gov/tools/seerrx/* for a list of hormonal agents.

Date Immunotherapy Started - NAACCR Item 1240

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Rx Date-BRM Flag - NAACCR Item 1241

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Immunotherapy - NAACCR Item 1410

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/. Refer to the **SEER*Rx Interactive Drug Database** https://seer.cancer.gov/tools/seerrx/ for immunotherapeutic agents.

Hematologic Transplant and Endocrine Procedures - NAACCR Item 3250

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Systemic/Surgery Sequence - NAACCR Item 1639

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Date Other Treatment Started - NAACCR Item 1250

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Rx Other-Other Flag - NAACCR Item 1251

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Other Treatment - NAACCR Item 1420

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Required Data Variables for Outcome

Date of First Recurrence - NAACCR Item 1860

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Recurrence Date – 1st Flag - NAACCR Item 1861

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Type of First Recurrence - NAACCR Item 1880

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Cancer Status - NAACCR Item 1770

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Date of Last Contact or Death - NAACCR Item 1750

Find description, rationale, and coding instructions here:

STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Date of Last Contact Flag - NAACCR Item 1751

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Vital status - NAACCR Item 1760

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Follow-Up Source - NAACCR Item 1790

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Required Data Variables for Case Administration

Facility identification number (FIN) (NAACCR Item #540) (STORE pg. 402)

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Note: A complete list of FINs is available on the American College of Surgeons Web site at https://www.facs.org/quality-programs/cancer/accredited/info/fin

NPI-Reporting Facility - NAACCR Item 545

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/. The facility's NPI can be obtained from the billing or accounting department or searched at https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do.

Override TNM Stage - NAACCR Item 1992

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Override TNM TIS - NAACCR Item 1993

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Override Site/TNM-Stage Group - NAACCR Item 1989

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Override Age/Site/Morph - NAACCR Item 1990

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Override SeqNo/DxConf - NAACCR Item 2000

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Override Site/Lat/SeqNo - NAACCR Item 2010

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Override Surg/Dx Conf - NAACCR Item 2020

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Override Site/Type - NAACCR Item 2030

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Override Histology - NAACCR Item 2040

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Note: The *Morphology-Type/Behavior* edits are complex and perform several additional types of checks. No other aspects of their checks are subject to override.

Override Report Source - NAACCR Item 2050

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Override Ill-Define Site - NAACCR Item 2060

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Override Leuk, Lymphoma - NAACCR Item 2070

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Override Site/Behavior - NAACCR Item 2071

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Override Site/Lat/Morph - NAACCR Item 2074

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Override Name/Sex - NAACCR Item 2078

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Site Coding System–Current - NAACCR Item 450

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Morphology Coding System–Current - NAACCR Item 470

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

ICD-O-3 Conversion Flag - NAACCR Item 2116

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

CoC Accredited Flag - NAACCR Item 2152

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Rx Coding System–Current - NAACCR Item 1460

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Institution Referred From - NAACCR Item 2410

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Institution Referred To - NAACCR Item 2420

Find description, rationale, and coding instructions here:
STORE: https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/

Changing Information on an Abstract

It is possible to revise a case that has been submitted to DCCR, when additional information is available on the patient's chart that would change specific data items, including the primary site and histology. The information originally collected on the abstract should be changed or modified under the following circumstances:

1. To correct coding or abstracting errors (for example, errors found during quality control activities).

2. When clarifications or rule changes retroactively affect data item code. Example: SEER adds codes to a data item and asks the registries to review a set of cases and update using the new codes.

3. When better information is available later:

   Example 1: Consults from specialty labs, pathology report addendums/comments or other information that has been added to the chart. Reports done during the diagnostic workup and placed on the chart after the registrar abstracted the information may contain valuable

information. Whenever these later reports give better information about the histology, grade of tumor, primary site, etc., change the codes to reflect the better information.

Example 2: The primary site was recorded as unknown at the time of diagnosis. Later, the physician determines a specific primary site. Change the primary site from unknown to the specific site identified by the physician. Be sure to make any necessary changes in the relevant data fields within the abstract and document the new information in the appropriate text fields.

Example 3: The original diagnosis was in situ. Metastases are diagnosed later, within the required timeframe and before the first course treatment begins. Change the behavior code for the original diagnosis from in situ to invasive if no new primary has been diagnosed in the interim. Please follow the rules of the 2018 STORE Manual to determine how to document the information.

Example 4: Patient seen in Hospital A. The pathologic diagnosis was negative for malignancy. Patient goes to Hospital B and the slides from Hospital A are re-read. The diagnosis at Hospital B is reportable. Hospital B sends their slide report back to Hospital A. Hospital A reports the case based on the info from Hospital B and enters supporting documentation in the text field.

Example 5: When the date of diagnosis is confirmed in retrospect to be earlier than the original date abstracted.

Example 6: Patient has surgery for a benign argentaffin carcinoid (8240/1) of the sigmoid colon in May 2015. In January 2016 the patient is admitted with widespread metastasis consistent with malignant argentaffin carcinoid. The registrar abstracts the malignant argentaffin carcinoid as a 2016 diagnosis. Two months later, the pathologist reviews the slides from the May 2015 surgery and concludes that the carcinoid diagnosed in 2015 was malignant. Change the date of diagnosis to May 2015 and histology to 8241 and the behavior code to malignant (/3).

Note: Be sure to make any necessary changes in the relevant data fields within the abstract. Document the new information in the appropriate text fields using the DCCR text requirements document.

Note: Contact the DCCR staff regarding appropriate procedure to follow when there is updated information on an abstract already submitted. *Do not resubmit the abstract*. This can result in duplicate records and require manual resolution.

Appendix A

Federal Legislation

106 STAT. 3373 Public Law 102-515 - 102d Congress October 24, 1992
https://www.congress.gov/bill/102nd-congress/senate-bill/3312/text/cps

DC Municipal Regulations for Cancer Reporting

https://www.dcregs.dc.gov/Common/DCMR/RuleList.aspx?ChapterNum=22-B2

Health Insurance Portability and Accountability Act (HIPAA)

https://www.hhs.gov/hipaa/index.html

HIPAA resources for Cancer Registrars
https://www.naaccr.org/hippa/

Frequently Asked Questions and Answers About the HIPAA Privacy Rule Regarding Hospital-based Cancer Registry Operations
https://www.naaccr.org/wp-content/uploads/2019/05/HIPAA-LETTER-5-30-2019.docx

Appendix B

FLccSC - Fundamental Learning Collaborative for the Cancer Surveillance Community

- DCCR/FLccSC (Pronounced "Flossy") is a state specific, web-based, educational portal for cancer registry professionals.
- Courses and webinars are designed and offered for oncology data specialists (ODS) and students of all experience/skill levels.
- The platform provides access to monthly NAACCR webinars, DCCR Annual Educational Conferences, and NPCR presentations.

DCCR FLccSC Access Link

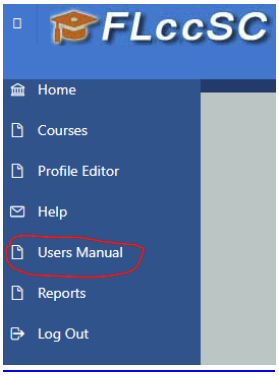
https://dcs.fcdslms.med.miami.edu/

Trouble Shooting Tips

- Use a different browser (Edge, Explorer, Google etc.)
- Try connecting without using a VPN connection.

Student User Manual

https://dcs.fcdslms.med.miami.edu/



Assistance with Password or Username

Click “Forgot your password?” button on the log-on screen, add your username email (this is the email you used to sign up for FLCCSC), and follow the emailed password reset instructions.
https://dcs.fcdslms.med.miami.edu

For any FLccSC related assistance or questions: Email, call, or text:
Malorie Thomas, BS, ODS-C
Education Training Coordinator | malorie.thomas@dc.gov | Work cell: 202-578-5623

Appendix C

NAACCR Recommended Abbreviations for Abstractors

Follow Link: https://apps.naaccr.org/data-dictionary/data-dictionary/version=24/chapter-view/abbreviations-and-acronyms/recommended-abbreviations-for-abstractors/

SEER/NCI Dictionary of Cancer Terms

Follow Link: https://www.cancer.gov/publications/dictionaries/cancer-terms/

SEER/NCI Glossary for Registrars

Follow Link: https://seer.cancer.gov/seertools/glossary/

Common Cancer Registry Acronyms

ACoS - American College of Surgeons
ACS - American Cancer Society
AJCC - American Joint Committee on Cancer
CDC - Centers for Disease Control and Prevention
CoC - Commission on Cancer (of the American College of Surgeons)
CCR - Central Cancer Registry
CTR - Certified Tumor Registrar (Oncology Data Specialist - ODS as of 1/1/2024)
DCCR - District of Columbia Cancer Registry
DOH - Department of Health
DVR - Division of Vital Records
EDITS - Exchangeable-edits, Data–dictionary, and Information Translation Standard
EOD - Extent of Disease
HIPAA - Health Insurance Probability and Accountability Act
ICD-O-3 - International Classification of Diseases for Oncology
JC - Joint Commission (previously JCAHO Joint Commission on Accreditation of Healthcare Organizations)
NAACCR - North American Association of Central Cancer Registries
NCDB - National Cancer Data Base
NCI - National Cancer Institute
NCRA - National Cancer Registrars Association

NIH - National Institutes of Health

NPCR - National Program of Cancer Registries, CDC

ODS-C - Certified Oncology Data Specialist (formerly known as Certified Tumor Registrar - CTR)

SEER - Surveillance, Epidemiology, and End Results a Program of NCI

SS - Summary Stage

STORE - Standards for Oncology Registry Entry

TNM - Tumor, Nodes, Metastasis (staging system of AJCC and UICC)

WHO - World Health Organization

Terms Common to Cancer Reporting

Abstract – A review of detailed medical records, summarized in an organized reportable form for each incident of malignancy.

Cancer/Cancerous – A collection of diseases in which body cells multiply without stopping. Most cancer can form masses called tumors and spread into surrounding tissues. The cells can also travel throughout the body via blood vessels and the lymphatic system where additional tumors can develop. Leukemias, cancers of the bone marrow and blood, generally do not form tumors. Another term for cancer is malignancy.

Clinic – Any licensed medical facility serving persons on an outpatient basis, which provides a diagnosis and/or treatment of cancerous and precancerous conditions.

Cytology – The study of cells under microscope to aid in diagnosing diseases and conditions.

Diagnostic Services – Any service that identifies the nature of an illness including cancerous diseases or precancerous diseases by examination including, but not limited to, imaging, laboratory testing.

Facility – A general term used for any licensed or certified medical establishment that provides patient care on an inpatient or outpatient basis including diagnostic services and/or treatment of cancerous and precancerous conditions.

Hematopoiesis & Hematopoietic System – Relating to the production of blood (blood cells, plasma etc.) and the organs and tissues, primarily the bone marrow, spleen, tonsils, and lymph nodes involved in the production of blood.

Histology – The microscopic study of biologic tissue. Histology in cancer reporting includes, but is not limited to, morphology, grade, and behavior.

Hospital – A licensed healthcare institution equipped and staffed for the purpose of diagnosing and treating patients with cancer, including medical and surgical care on an inpatient or outpatient basis.

Hospital Identifier – A unique code assigned by the DCCR to each reporting facility in the District for identification of cancer cases reported from each facility.

In Situ – A group of abnormal cells that remain where they first formed within the body. These abnormal cells may become invasive and spread into nearby tissue.

Laboratory – A facility providing a wide range of procedures that aid physicians in carrying out the diagnosis, treatment, and management of cancer. This includes, but is not limited to, histopathology (examination of tissue), cytopathology (examination of fluids), and hematology (examination and characterization of blood) related to both cancerous and precancerous conditions.
Lymphoid – Relating to the lymphatic system including lymph, lymph nodes, bone marrow, and other lymphatic tissue that produces lymphocytes (a type of white blood cells).

Pathologist – A physician certified by the American Board of Pathology and licensed by the state to carry out pathologic examination of bodily tissues. This includes the diagnosis of cancerous and precancerous conditions.

Physician – Any person authorized to practice medicine in the District of Columbia. (A Doctor of Medicine; Doctor of Osteopathy; Doctor of Dental Surgery or of Dental Medicine; Doctor of Podiatric Medicine; or Doctor of Optometry who is legally authorized to practice medicine, osteopathy, dental surgery, dental medicine, podiatric medicine, or optometry by the State in which he performs such function and who is acting within the scope of his license when he performs such functions.)

Precancerous Condition – A disease process exhibiting abnormal cells with an increased risk of developing into cancer.

Registry – A computerized system for collecting and compiling cancer data in a standard format, with the functional ability to merge data from various sources and perform correlations among a variety of data elements. Summary reports and statistical analysis reports can be generated from registry data.

Solid Tumor – A tumor that develops in body tissue other than lymphoid tissue, bone marrow or blood. Examples include bone, skin, and organs.

Stage of Disease – Stage defines the extent of a patient's malignancy and can change throughout the disease process. This includes disease limited to localized tissue, invasion from the original tumor into surrounding tissue, invasion of regional lymph nodes (usually lymph nodes in the typical draining pathway of the primary site of disease) and distant spread (distant metastasis) including distant tissue and distant lymph nodes.

TNM – The three components of tumor staging: T – tumor, N – nodes (regional lymph nodes), and M –

metastasis.

Treatment Services – The delivery of therapeutic services for cancerous disease or precancerous conditions, performed in a medical facility.

Tumor/Tumorous – A circumscribed, non–inflammatory growth arising from existing tissue but growing independently of the normal rate or structural development of such tissue and serving no physiological function. Tumors may or may not be malignant.
Additional cancer related definitions can be found on the NCI website and the SEER Glossary for Registrars.

Appendix D

2024 New Data Items and Changes/Updates

Applicable for cases diagnosed January 1, 2024, and forward, NAACCR version 24.
https://www.naaccr.org/wp-content/uploads/2023/10/2024-Implementation-Guidelines_20231020.pdf

2023 New Data Items and Changes/Updates

Applicable for cases diagnosed January 1, 2023, and forward, NAACCR version 23.
https://www.naaccr.org/wp-content/uploads/2023/01/2023-Implementation-Guidelines_20230126.pdf

Information listed in this document pertains exclusively to DCCR reporting requirements from the CDC NPCR. ACoS CoC accredited hospitals have additional updates and changes beyond the scope of this document. Please refer to the NAACCR implementation guidelines for updates and changes from all standard setters or contact the ACoS for CoC accredited hospitals.

Other Data Collection Updates

https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/cocmanuals/

Comorbidities and Complications

Comorbidity and complication codes record the patient's pre-existing medical conditions, factors influencing health status, and/or complications during the patients' hospital stay for cancer treatment. The ICD-9-CM-based *Comorbidities and Complications 1-10* [3110-3164] or *ICD Revision Comorbid* [3165] data items are no longer required to be used for this data item. As of cases diagnosed January 1, 2018, and later, only ICD- 10-CM codes will be accepted to document secondary diagnoses. **The ICD-10-CM code-based data items of *Secondary Diagnosis 1- 10* [3780-3798] will continue to be required.**

Note: If you are a CoC-accredited program, documentation and submission of secondary diagnosis information is required.

Revisions to Staging Requirements

Staging Data Items No Longer Required for Cases Diagnosed in 2018 and Later (Required for Cases Diagnosed 2017 and earlier)

To accommodate the implementation of the AJCC 8th Edition Staging System, collection of SSDIs and SEER Summary Stage 2018, the following data items are no longer required for cases diagnosed January 1, 2018, and later:

TNM Path T, N, and M [880, 890, 900]

- *TNM Path Stage Group* [910]
- *TNM Path Descriptor* [920]
- *TNM Path Staged By* [930]

TNM Clin T, N, and M [940, 950, 960]

- *TNM Clin Stage Group* [970]
- *TNM Clin Descriptor* [980]
- *TNM Clin Staged By* [990]

CS Site-Specific Factors [2861-2880, 2890-2930]

- *CS Version Input Original, Derived, Input Current* [2935-2937]
- *Summary Stage 2000* [759]

Specific Staging Data Items that are required to be collected:

- *Tumor Size Summary* [756] (Required 2016+)
- *Regional Nodes Positive* [820] (Required 2004+)
- *Regional Nodes Examined* [830] (Required 2004+)
- *Mets at Diagnosis – Bone, Brain, Distant LN, Liver, Lung, Other* [1112-1117] (Required 2016+)
- *Lymph Vascular Invasion* [1182] (Required 2010+)

Newly required AJCC 8th Edition Staging Data Items (Required for cases diagnosed 2018+):

Required 8th Edition AJCC Stage T, N, M Data Items (may be blank as appropriate)

- *AJCC TNM Clin T, N, M* [1001-1003]
- *AJCC TNM Path T, N, M* [1011-1013]
- *AJCC TNM Post Therapy T, N, M* [1021-1023]

Required 8th Edition AJCC Stage Groups:

- *AJCC TNM Clin Stage Group* [1004] **AND**
- *AJCC TNM Path Stage Group* [1014] **OR** *AJCC TNM Post Therapy Stage Group* [1024]

Newly required when appropriate for the tumor being abstracted:

- *AJCC TNM Clin T Suffix* [1031]
- *AJCC TNM Path T Suffix* [1032]
- *AJCC TNM Post Therapy T Suffix* [1033]
- *AJCC TNM Clin N Suffix* [1034]
- *AJCC TNM Path N Suffix* [1035]
- *AJCC TNM Post Therapy N Suffix* [1036]

Other Newly Required Stage Associated Data Items

- *Summary Stage 2018* [764]
- *Clinical, Pathological and Post Therapy Grade* [3843-3845]
- Site-Specific Data Items: Please refer to the CoC data item requirements listed in the Data Standards and Data Dictionary, Chapter VIII Required Status Table for the CoC's required status of the new/revised SSDIs for cases diagnosed 1/1/2018 and later.

Implementation of New Sentinel and Regional Node Data Items

Because sentinel lymph node biopsies have been generally under-reported and the timing and results of sentinel lymph node biopsy procedures are used in multiple CoC Quality of Care Measures, the CoC developed six new data items for collection of more specific information on sentinel and regional nodes.

- *Date of Regional Lymph Node Dissection* [682]
- *Date Regional Lymph Node Dissection Flag* [683]
- *Date of Sentinel Lymph Node Biopsy (for breast and melanoma only)* [832]
- *Date of Sentinel Lymph Node Biopsy Flag (for breast and melanoma only)* [833]
- *Sentinel Lymph Nodes Examined (for breast and melanoma only)* [834]
- *Sentinel Lymph Nodes Positive (for breast and melanoma only)* [835]

Revisions to Radiation Treatment Requirements

Radiation Treatment Data Items No Longer Required

The following data items are no longer required as of 2018. They have been replaced by new 2018 radiation data items. Values in the existing v16 data items below will be converted to the new data items upon conversion to v18-compliant software.

- *Regional Dose: cGy* [1510]
- *Number of Treatments to this Volume* [1520]
- *Radiation Treatment Volume* [1540]
- *Regional Treatment Modality* [1570]
- *Boost Treatment Modality* [3200]
- *Boost Radiation Dose cGy [3210]*

Specific Radiation Treatment Data Items with Continuing Requirement

- *Reason for No Radiation* [1430] (Required 2003+)
- *Date Radiation Started* [1210] (Required All Years)
- *Date Radiation Ended* [3220] (Required 2003+)
- *Location of Radiation Treatment* [1550] (Required 2003+)
- *RX Date–Radiation Flag* [1211] (Required 2010+)
- *RX Date–Rad Ended Flag* [3211] (Required 2010+)

Appendix E

DCCR Text Requirements

DC HEALTH GOVERNMENT OF THE DISTRICT OF COLUMBIA

DCCR DISTRICT OF COLUMBIA CANCER REGISTRY

DCCR Text Field Requirements

Text documentation is an essential component of an abstract and is heavily utilized in quality control, to validate data at time of NPCR Audits and special studies. Also, it is used to assure that the data meets the standards of ACoS, NAACCR, NCDB, SEER, and NPCR. Adequate text is a data quality indicator and major part of Quality Control.

The main purpose of text fields in the abstract is to justify coded values and to document supplemental information not transmitted within coded values. Text is an essential component of a complete electronic report and is heavily utilized for quality control and special studies at the central cancer registry. DCCR relies solely on the text documentation provided from reporting facilities due to no access to patient EMR. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central cancer registry.

Text documentation "Dos" and "Don'ts" are listed below:

- Use ***NAACCR-approved*** abbreviations. (See NAACCR Recommended Abbreviations for Abstractors, Appendix G). **DO NOT USE** non-standard or stylistic shorthand.
- Text **should not** be generated electronically from coded values, but manually entered from the medical record/EMR.
- Do not include **irrelevant** information. Document only information pertinent to patient's cancer diagnosis/treatment. For treatment, include beginning and ending dates, if applicable.
- Do **not** include information that the registry is **not authorized to collect.** This includes additional information that has not been approved for collection by DCCR.
- Do not leave text fields blank. If information is not available, record "Not available", "Unknown", "Not documented in patient record", etc.
- ***DO NOT REPEAT INFORMATION*** from section to section.
- **Date(s)** should be included in **all** text fields and listed in chronological order. Estimated dates should be documented as **3/15/2018 (est.)**
- **Location** – Include facility/physician/other location where the event occurred for Tests, studies, treatments, etc. **Do not abbreviate out-of-area facility names.**
- **Description** – Include the description of the events (test/study/treatment/other). Positive and negative results should be recorded.

Note: Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks (**) or other symbols (>>), to indicate the connection with preceding text.

Source: NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Chapter X: Data Dictionary
DCCR Text Field Requirements – Revised 2/28/2023.

1

DC | HEALTH GOVERNMENT OF THE DISTRICT OF COLUMBIA

DCCR DISTRICT OF COLUMBIA CANCER REGISTRY

Text Data Item Name NAACCR Item# Field Length	Text Documentation Source and Item Description *DCCR Required Text Documentation* Example:
Text - Physical Exam H&P NAACCR Item #2520 Field Length = 1000	Text area for manual documentation from the history and physical examination about the history of the current tumor and the clinical description of the tumor. *Date of visit, facility, age, sex race/ethnicity, type and duration of symptoms, reasons for admission, where patient resided at diagnosis, if not diagnosed your facility, and patient's previous history of reportable cancers, family history of cancer, personal medical history, and social history (i.e. previous tobacco or alcohol abuse)* **Example:** 12/01/2018 (ABC HOSPITAL) 82 Y/O AAF PRESENTS TO ER W/ ALTERED MENTAL STATUS & LT BREAST NIPPLE DISCHARGE W/ INFLAMMATION PEAU D'ORANGE. PT ADMITTED FOR FURTHER W/U. FMH MOTHER & SISTER BREAST CA. PMH RT BREAST CA DX IN 1993 HTN DIABETES. SMH PREV TOB & ETOH ABUSE.
Text - X-rays/Scans NAACCR Item #2530 Field Length = 1000	Enter text information from diagnostic imaging reports, including X-rays, CT, MRI, PET scan, Bone Scan, and Ultrasound that provide information about staging. *Date, facility where procedure was performed, type of scan, relevant findings (primary site, size of tumor, location of tumor, nodes, metastatic sites), clinical assessment with qualifying terms used to identify cancer, positive/ negative results (if nothing is found on scans, state negative)* **Example:** 06/11/2018 (ANYWHERE BREAST CTR) BILAT BREAST US LT BREAST 3.5 CM MASS AT 9 O'CLOCK SUSP FOR MALIG. RT BREAST NEG.
Text - Scopes NAACCR Item #2540 Field Length = 1000	Text area for manual documentation from endoscopic examinations that provide information for staging and treatment *Date of procedure, facility where procedure was performed, type of procedure, detail findings (primary site, extension and/or spread of tumor) clinical assessment, positive and negative results.* ***Example:*** 04/12/2018 (ANYWHERE ENDOSCOPY CTR) EGD GASTRIC MUCOSA W/ EVIDENCE OF 6.8 CM LRG TUMOR IN STOMACH ANTRUM OCCUPYING HALF OF STOMACH. NUMEROUS SATELLITE TUMORS SEEN ON OPPOSTIE WALL OF STOMACH. ESOPHAGUS & DUODENUM NEG.

Source: NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Chapter X: Data Dictionary
DCCR Text Field Requirements – Revised 2/28/2023.

DC | HEALTH GOVERNMENT OF THE DISTRICT OF COLUMBIA

DCCR DISTRICT OF COLUMBIA CANCER REGISTRY

Text Data Item Name NAACCR Item# Field Length	Text Documentation Source and Item Description *DCCR Required Text Documentation* Example:
Text - Lab Test NAACCR Item #2550 Field Length = 1000	Text area for manual documentation of information from laboratory examinations other than cytology or histopathology. *Date(s) of Test(s), facility where test was performed, type of test(s) and test results (value and assessment).* **Example:** 01/19/2018 (FAR AWAY HOSP) ER+, PR+, HER2 NEG BY IHC METHOD. 07/20/2018 (DR PRINCE CHARMING OFFICE) PSA 5.3 (ELEVATED). 03/08/2018 (WYSTERIA LANE ONCOLOGY GROUP) AFP 1194.9 NG/ML (ELEVATED)
Text - Operative Report NAACCR Item #2560 Field Length = 1000	Text area for manual documentation of all surgical procedures that provide information for staging. This text should be entered manually from the EMR not generated electronically. Prioritize entered information in the order in which they occurred. *Date of procedure, facility where procedure was performed, type of surgical procedure, detailed surgical findings (Could include but not limited to: location of tumor, size, other organ involvement, lymph node removed, type of lymph node dissection, documentation of residual tumor, and evidence of invasion of surrounding areas). Include reason surgery aborted (inoperable), i.e. tumor attached to aorta or other major organ that could cause death or further damage.* **Example:** 06/24/2018 (METROPOLIS HOSP) RT COLON RESECTION EXT DISEASE IN PELVIS (CARCINOMATOSIS) RESECTION ABORTED DUE TO NUMEROUS MESENTERIC IMPLANTS.
Text - Pathology NAACCR Item #2570 Field Length = 1000	Enter text information from cytology and histopathology reports. *Date of specimen/resection or biopsy, facility where specimen examined, pathology accession number (not applicable for outside pathology reports if unknown), type of specimen, final diagnosis, comments, addendum/additional comments, supplemental information, histology, behavior, size of tumor, tumor extension, lymph nodes (removed/ biopsied), margins, some special histology studies, Lymph vascular invasion.* **Example:** 02/05/2018 (NEVERLAND MED CTR) - S11-9999 - RECTUM ADNENOCA MOD DIFF TUMOR SIZE 2.5 CM EXT TO PERICOLIC FAT. 1 OF 22 PERIRECTAL LNS POS. MARGINS NEG. LYMPHOVASCULAR INV IDENITIFIED
Text - Primary Site NAACCR Item #2580 Field Length = 100	Enter information regarding the primary site (including sub-site) and laterality of the tumor being reported. **Example:** RT BREAST UOQ @ 10 O'CLOCK (C50.4)

Source: NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Chapter X: Data Dictionary
DCCR Text Field Requirements – Revised 2/28/2023.

3

DC | HEALTH GOVERNMENT OF THE DISTRICT OF COLUMBIA
DCCR DISTRICT OF COLUMBIA CANCER REGISTRY

Text Data Item Name NAACCR Item# Field Length	Text Documentation Source and Item Description *DCCR Required Text Documentation* Example:
Text - Histology NAACCR Item #2590 Field Length = 100	Enter information regarding the histological type, behavior, and grade (differentiation) of the tumor being reported. **Example:** INFILT LOBULAR CA W/ TUBULAR & APOCRINE FEAT. POOR DIFF
Text - Staging NAACCR Item #2600 Field Length = 1000	Additional text area for staging information not already in other text fields. Include specific information on Tumor Size, Extension of Primary Tumor, Metastatic Sites, etc. Information documenting the disease process should be entered manually from the medical record. *Date, facility, organs involved by direct extension, tumor size, margin status, sites of distant metastasis, special consideration for staging, overall stage, etc.* **Example:** 01/17/2018 (TAKE CARE HOSP) (breast) PT2A (tumor size 2.5 cm) PN1A (axillary LN) CM1 (DISTANT LUNG METS) PER DR GOODNIGHT.
Text - Surgery NAACCR Item #2610 Field Length = 1000	Text area for information describing all surgical procedures performed as part of treatment. *Date surgery performed, facility where surgery was performed, and type of procedure(s), LN resection/dissection/SLN bx. Biopsy of metastatic sites, regional tissues removed.* **Example:** 01/02/2018- (DR SPIRIT OFFICE) PROSTATE BX. 01-17-2018 (CHAMPION HOSP) ROBOTIC ASST RAD PROSTATECTOMY.
Text - Radiation (Beam) NAACCR Item #2620 Field Length = 1000	Enter information regarding the treatment of the tumor being reported with radiation. *Treatment Plan (if no treatment given), date of treatment initiated/completed, facility where treatment was administered, type of radiation (Orthovoltage, Cobalt 60, MV X-rays, Electrons, Mixed modalities), dose (if known), and treatment site.* **Example:** 04/06/2018 – 03/15/2018- (TAKECARE HOSP) LT BREAST 6MV 4500 CGY 20 FX W/BOOST 1200 CGY, 12 MeV, 5 FX, 12 DAYS. PT EXPIRED BEFORE COMPLETION OF TX OR TX D/C DUE TO INTOLERANCE.
Text - Radiation (Other) NAACCR Item #2630 Field Length = 1000	Enter information regarding the treatment of the tumor being reported with non-radiation beam treatment. *Treatment Plan w/date (if no treatment given), date of treatment initiated and completed, facility where treatment was administered, type of radiation (High Dose rate brachytherapy, seed implant, Radioisotopes (I-131), dose (if known), and treatment site.* **Example:** 05/06/2018 (TAKE CARE HOSP) PROSTATE SEED IMPLANT RADIOTOPES (I-131).

Source: NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Chapter X: Data Dictionary
DCCR Text Field Requirements – Revised 2/28/2023.

4

DC HEALTH GOVERNMENT OF THE DISTRICT OF COLUMBIA

DCCR DISTRICT OF COLUMBIA CANCER REGISTRY

Text Data Item Name NAACCR Item# Field Length	Text Documentation Source and Item Description *DCCR Required Text Documentation* Example:
Text - Chemo NAACCR Item #2640 Field Length = 1000	Enter information regarding the chemotherapy treatment for the reported tumor. *Date treatment initiated, facility/ physician office where administered/ prescribed, name of agent(s), protocol, dose/cycle (if known), treatment plan if known* **Example:** 01/13/2018 - (DR RUBBLE) 6 CYCLES R-CHOP, 14 STANDARD DOSE AT 2 WK INTERVALS. PT EXPIRED (2/15/18) PRIOR TO COMPLETION OF CHEMO.
Text - Hormone NAACCR Item #2650 Field Length = 1000	Enter information regarding the treatment of the tumor being reported with hormone. *Date treatment initiated, facility/physician office where administered/prescribed, name of hormone/anti-hormone agent or procedure, dose, (if known), Treatment plan* **Example:** 01/14/2018 (DR JETSON) TAMOXIFEN (DOSE/ DURATION NOT STATED). 09/16/2018 (PLUTO MEMORIAL) BILAT ORCHIECTOMY.
Text - BRM NAACCR Item #2660 Field Length = 1000	Enter information regarding the treatment of the tumor being reported with biological response modifiers or immunotherapy. *Date treatment initiated, facility/ physician office where administered/prescribed, name of BRM or immunotherapy agent or procedure, dose (if known), treatment plan.* **Example:** 02/14/2018 (BEDROCK HEATLH SYSTEM) INTERFERON OR BCG (DOSE/DURATION NOT DOCUMENTED). 4/28/18 (MICKEY MOUSE HOSPITAL) ANALOGOUS BONE MARROW TRANSPLANT.
Text - Other NAACCR Item #2670 Field Length = 1000	Enter information regarding treatment that cannot be defined as surgery, radiation, or systemic therapy. *Date treatment planned/ initiated, name of other therapy, agent or procedure, dose (if known), facility where performed* **Example:** 01/31/2018 (SPACELY MEDICAL CTR) BLINDED CLINICAL TRIAL HYPERTHERMIA.
Text - Remarks NAACCR Item #2680 Field Length = 1000	Document information not provided in any other text field or overflow from text fields. Document personal history of carcinogenic exposure (arsenic, drinking water, uranium, asbestos). **Example:** 40 Y/O H/O WORKING IN SHIP BUILDING & CONSTRUCTION W/ LOTS OF ASBESTOS EXPOSURE.
Text - Usual Occupation NAACCR Item #310 Field Length = 1000	Enter information about the patient's usual occupation or occupation in which patient had worked the longest. Enter **Unknown** when no information is available. **DO NOT** enter **RETIRED, UNEMPLOYED,** and or **DISABLED.** **Example:** ADMINISTRATIVE ASSISTANT, HOUSEWIFE, MECHANIC, REGISTERED NURSE. SCHOOL AGED PATIENTS' OCCUPATION SHOULD BE RECORDED AS "STUDENT".

Source: NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Chapter X: Data Dictionary
DCCR Text Field Requirements – Revised 2/28/2023.

5

DC HEALTH GOVERNMENT OF THE DISTRICT OF COLUMBIA

DCCR DISTRICT OF COLUMBIA CANCER REGISTRY

Text Data Item Name NAACCR Item# Field Length	Text Documentation Source and Item Description *DCCR Required Text Documentation* Example:
Text - Usual Industry NAACCR Item #320 Field Length = 1000	Record the primary type of activity the business/industry at the location where the patient was employed for the greatest number of years before diagnosis of tumor, if documented. If The information for the industry should be based upon the information in the occupation text. If no information is available for the industry for the reported occupation, record "unknown". **Examples:** NASSAU COUNTY BOARD OF EDUCATION, DOMESTIC, DEPT OF TRANSPORTATION. STUDENT AS OCCUPATION, INDUSTRY SHOULD BE CODED AS "HIGH SCHOOL" OR "COLLEGE".
Text - Place of Diagnosis NAACCR Item #2690 Field Length = 60	Text area for manual documentation of the facility, physician office, city, state or county where the diagnosis was made. Enter the complete name of the facility, do not use initials. For out-of-state residents and facilities, include the city/state where the medical facility is located. **Example:** DR JIM GOODFELLOW @ ENDOSCOPY CENTER BETHESDA, MD.
Text - Address at Diagnosis NAACCR Item #2330 Field Length = 60	Record number and street address of the patient's residence at the time the reportable tumor was diagnosed. Do not add spaces or dots between quadrants. Do not abbreviate street names. Do not record apartment numbers in this data field. **DCCR requires all apartment numbers to be recorded in supplemental address text for geocoding purposes.** **Example:** 23 HUMBLE RD **NE**, 440 EINSTEIN CT **SW**
Text - Address at Diagnosis - Supplemental NAACCR Item #2335 Field Length = 60	Provides the ability to store additional address information such as the name of a place or facility (for example a nursing home, apartment complex, jail or PO Box residential or other mailing address) at the time of diagnosis. **DCCR requires all apartment numbers to be recorded in supplemental address text for geocoding purposes.** **Example:** APT # 232, NURSING HOME NAME, APARTMENT COMPLEX NAME, PO BOX

Source: NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Chapter X: Data Dictionary DCCR Text Field Requirements – Revised 2/28/2023.

6

Appendix F

DCCR Non-Analytic Required Fields for Abbreviated Abstracts

DC HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA
Community Health Administration

DCCR DISTRICT OF COLUMBIA CANCER REGISTRY

89

List of DCCR Data Elements Required for Non-Analytic Abbreviated Abstracts for DC Reporting Facilities

(Please complete full abstract if 1st course Tx information is available.)

NAACCR	Item Name	Status	Comments
10	Record Type	Required	Defaulted Field
40	Registry ID	Required	Do not leave blank
50	NAACCR Record Version	Required	Defaulted Field
2330	Addr at DX--No & Street	Required	Review EMR & physician notes
70	Addr at DX--City	Required	Review EMR & physician notes
80	Addr at DX--State	Required	Review EMR & physician notes
90	County at DX	Required	Review EMR & physician notes
100	Addr at DX--Postal Code	Required	Review EMR & physician notes
160	Race 1	Required	See Rules for coding
161	Race 2	Required	Defaulted Field
162	Race 3	Required	Defaulted Field
163	Race 4	Required	Defaulted Field
164	Race 5	Required	Defaulted Field
190	Spanish/Hispanic Origin	Required	See Rules for Coding
220	Sex	Required	See coding options for sex
230	Age at Diagnosis	Required	Do not leave blank
240	Date of Birth	Required	Do not leave blank
252	Birthplace--State	Required	Code ZZ for unknown state
254	Birthplace--Country	Required	Code ZZU for unknown country
390	Date of Diagnosis	Required	See Rules for Coding
400	Primary Site	Required	Do not leave blank

899 North Capitol Street NE, 2nd Fl, Washington, DC 20002 | P 202-535-2180 | F 202-535-2180 | dchealth.dc.gov

DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA
Community Health Administration

DCCR DISTRICT OF COLUMBIA CANCER REGISTRY

List of DCCR Data Elements Required for Non-Analytic Abbreviated Abstracts for DC Reporting Facilities

(Please complete full abstract if 1st course Tx information is available.)

Item #	Item Name	Status	Comments
410	Laterality	Required if applicable	Do not leave blank
3843	Grade Clinical	Required if applicable	Defaulted Field
3844	Grade Pathological	Required if applicable	Defaulted Field
1068	Grade Post Clin (YC)	Required if applicable	Leave blank if not applicable
3845	Grade Post Path (YP)	Required if applicable	Leave blank if not applicable
490	Diagnostic Confirmation	Required	Do not leave blank
500	Type of Reporting Source	Required	Document facility type, i.e. Hosp
501	Casefinding Source	Required	Document source type, i.e. Path
522	Histologic Type ICD-O-3	Required	Do not leave blank
523	Behavior Code ICD-O-3	Required	Do not leave blank
540	Reporting Facility	Required	Do not leave blank
550	Accession Number--Hosp	Required	Do not leave blank
560	Sequence Number--Hospital	Required	Do not leave blank
580	Date of 1st Contact	Required	Do not leave blank
610	Class of Case	Required	Do not leave blank
630	Primary Payer at DX	Required	If unavailable, code "99"
756	Tumor Size Summary	Required, if applicable	Code "999" if unknown
764	Summary Stage 2018	Required	Do not leave blank
820	Regional Nodes Positive	Required	Use "98" no nodes positive
830	Regional Nodes Examined	Required	Use "00" no nodes examined
1182	Lymphovascular Invasion	Required, if applicable	Code according to primary site
1200	RX Date Surgery	Required, if applicable	May be left blank

899 North Capitol Street NE, 2nd Fl, Washington, DC 20002 | P 202-535-2180 | F 202-535-2180 | dchealth.dc.gov

DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA
Community Health Administration

DCCR DISTRICT OF COLUMBIA CANCER REGISTRY

List of DCCR Data Elements Required for Non-Analytic Abbreviated Abstracts for DC Reporting Facilities

(Please complete full abstract if 1st course Tx information is available.)

Item#	Item Name	Status	Comments
1210	RX Date Radiation	Required, if applicable	May be left blank
3170	Rx Date Mst Defn Srg	Required, if applicable	May be left blank
1220	RX Date Chemo	Required, if applicable	May be left blank
1230	RX Date Hormone	Required, if applicable	May be left blank
1240	RX Date BRM	Required, if applicable	May be left blank
1250	RX Date Other	Required, if applicable	May be left blank
1270	Date 1st Crs RX CoC	Required, if applicable	May be left blank
1280	RX DATE DX/STG PROC	Required, if applicable	May be left blank
1285	RX Summ--Treatment Status	Required, if applicable	May be left blank
1290	RX Summ--Surg Prim Site	Required, if applicable	May be left blank
1292	RX Summ--Scope Reg LN Sur	Required, if applicable	May be left blank
1294	RX Summ--Surg Oth Reg/Dis	Required, if applicable	May be left blank
1340	Reason for No Surgery	Required, if applicable	Code only if info available
1350	Summ-Dx/STG Proc	Required, if applicable	Code only if info available
1380	RX Summ--Surg/Rad Seq	Required, if applicable	Code only if info available
1390	RX Summ--Chemo	Required, if applicable	Code only if info available
1400	RX Summ--Hormone	Required, if applicable	Code only if info available
1410	RX Summ--BRM	Required, if applicable	Code only if info available

899 North Capitol Street NE, 2nd Fl, Washington, DC 20002 | P 202-535-2180 | F 202-535-2180 | dchealth.dc.gov

DC HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA
Community Health Administration

DCCR DISTRICT OF COLUMBIA CANCER REGISTRY

List of DCCR Data Elements Required for Non-Analytic Abbreviated Abstracts for DC Reporting Facilities

(Please complete full abstract if 1st course Tx information is available.)

Item #	Item Name	Status	Comments
1420	RX Summ--Other	Required, if applicable	Code only if info available
1430	Reason for No Rad	Required, if applicable	Code only if info available
1460	RX Coding System--Current	Required	Default Field
3230	RX Date Systemic	Required, if applicable	May be left blank
3250	RX Summ--Transplnt/Endocr	Required, if applicable	Default Field
3270	RX Summ--Palliative Proc	Required, if applicable	Default Field
1639	RX Summ--Systemic/Sur Seq	Required, if applicable	Record zero if no adj Tx given
1750	Date of Last Contact	Required	Indicate date of last contact with patient
1760	Vital Status	Required	Do not leave blank
2230	Name Last	Required	Do not leave blank
2240	Name First	Required	Do not leave blank
2300	MRN	Required	Do not leave blank
2320	SSN	Required	Do not leave blank
2460	Physician--Managing	Required	If known document managing physician
2520	Text--DX Proc--PE	Required, if provided	Document pertinent physical exam findings

899 North Capitol Street NE, 2nd Fl, Washington, DC 20002 | P 202-535-2180 | F 202-535-2180 | dchealth.dc.gov

DC HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA
Community Health Administration

DCCR DISTRICT OF COLUMBIA CANCER REGISTRY

List of DCCR Data Elements Required for Non-Analytic Abbreviated Abstracts for DC Reporting Facilities

(Please complete full abstract if 1st course Tx information is available.)

Item #	Item Name	Status	Comments
2530	Text--DX Proc--X-ray/Scan	Required, if provided	Document date, Procedure, findings of x-ray/scans
2540	Text--DX Proc--Scopes	Required, if provided	Document date, Procedure, findings of scopes
2550	Text--DX Proc--Lab Tests	Required, if provided	Document date lab, Procedure, findings
2560	Text--DX Proc--Op	Required, if provided	Document date Operative, Procedure, findings
2570	Text--DX Proc--Path	Required, if provided	Document date, Path findings, dx procedure.
2580	Text--Primary Site Title	Required, if provided	Document primary site of cancer dx
2590	Text--Histology Title	Required, if provided	Document histology on Path report
2600	Text--Staging	Required, if provided	Document Stage if known
2610	RX Text--Surgery	Required, if provided	Document date surgical, Procedure, findings
2620	RX Text--Radiation (Beam)	Required, if provided	Document date, Radiation modality, dose
2630	RX Text--Radiation Other	Required, if provided	Document date, Radiation modality, dose
2640	RX Text--Chemo	Required, if provided	Document date, Chemo regimen, dose, cycle
2650	RX Text--Hormone	Required, if provided	Document date, hormone regimen, dose, cycle
2660	RX Text--BRM	Required, if provided	Document date, regimen, cycle
2670	RX Text--Other	Required, if provided	Document all other pertinent findings
2680	Text--Remarks	Required, if provided	Document all other pertinent findings
2690	Text--Place of Diagnosis	Required, if provided	Document place of diagnosis

899 North Capitol Street NE, 2nd Fl, Washington, DC 20002 | P 202-535-2180 | F 202-535-2180 | dchealth.dc.gov

DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA
Community Health Administration

DCCR DISTRICT OF COLUMBIA CANCER REGISTRY

DCCR Non-Analytic Case Reporting Requirement by Class of Case

DCCR **requires** the reporting of Class of Case: 30-33, 34 (CIN III/CIS Cervix), 38 (dx established by autopsy only) and 43 (pathology consult only)

Code	Label
Patient appears in person at reporting facility	
30	Initial diagnosis and all first course treatment elsewhere AND reporting facility participated in diagnostic workup (for example, consult only, treatment plan only, staging workup after initial diagnosis elsewhere)
31	Initial diagnosis and all first course treatment elsewhere AND reporting facility provided in transit care; or hospital provided care that facilitated treatment elsewhere (for example, stent placement)
32	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease recurrence or persistence (active disease)
33	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease history only (disease not active)
34	Type of case not required by CoC to be accessioned (for example, a benign colon tumor) AND initial diagnosis AND part or all of first course treatment by reporting facility **(CIN III/CIS CERVIX)**
38	Initial diagnosis established by **AUTOPSY** at the reporting facility, cancer not suspected prior to death
Patient does not appear in person at reporting facility	
43	**PATHOLOGY** or other lab specimens **ONLY**

899 North Capitol Street NE, 2nd Fl, Washington, DC 20002 | P 202-535-2180 | F 202-535-2180 | dchealth.dc.gov

Appendix G

Bi-Monthly Submission Schedule

DCCR Submission Table

DCCR Bi-Monthly Cancer Data Submission Requirements.

On the 15th day of even months (Feb, Apr, Jun, Aug, Oct, Dec).

If the 15th falls on a Saturday or Sunday, submission is due the following Monday.

Months of Submission (Months to submit data to DCCR)	Months to be Submitted (Cases diagnosed in these months for specified years)
February	June & July
April	August & September
June	October & November
August	December & January
October	February & March
December	April & May

Example:

December 15th, 2022, data submission includes cases diagnosed through April 2022 (100% of April 2022 cases) and May (75% of May 2022 cases).

Appendix H

Coding and Staging Rules by Manual & Diagnosis Year

Staging		
Manual	**Effective Years**	**Use for Diagnosis Years**
AJCC Cancer Staging Manual 7th Ed.	2010-2017	2010-2017
AJCC Cancer Staging Manual 8th Ed.	2018-	2018-
AJCC Cancer Staging Manual 9th Ed. Chapter: Cervix Uteri	2021-	2021-
AJCC Cancer Staging Manual 9th Ed. Chapter: Anus	2023-	2023-
AJCC Cancer Staging Manual 9th Ed. Chapter: Brain/Spinal Cord	2023-	2023-
AJCC Cancer Staging Manual 9th Ed. Chapter: Appendix	2023-	2023-
AJCC Cancer Staging Manual 9th Ed. Chapter: Vulva	2024-	2024-
AJCC Cancer Staging Manual 9th Ed. Chapter: Neuroendocrine Tumors of Appendix	2024-	2024-
SEER Summary Staging Guide	1977-2000	1997-2000
SEER Summary Stage 2000	2001-2003, 2016-2017	2001-2003, 2016-2017
SEER Summary Stage 2018	2018-	2018
Data Collection		
Registry Operations and Data Standards (ROADS)	1996-2002	1997-2002
Facility Oncology Registry Data Standards (FORDS)	2003-2017	2003-2017
Historical Standards for Oncology Registry Entry Manuals (STORE)	2018-2022	2018-2022
Standards for Oncology Registry Entry (STORE)	2023-	2023-
SEER Program Code Manual	1988-2004	1997-2004
SEER Historical Program Staging & Coding Manual	2004-2022	2004-2022
SEER Program Coding & Staging Manual	2024-	2024-
Grade		
Instructions for Coding Grade 2014	2014-2017	2014-2017
NAACCR Grade Coding Manual	2018-	2018-
Primary Site and Histology		
International Classification of Diseases for Oncology	1976-2000	1997-2000
ICD-O Third Ed. 1st Revision	2001-2017 2018+ (Primary site only)	2001-2017 2018+ (Primary site only)
ICD-O 3 Coding Updates (Histology only)	(3.1) 2018-2020 (3.2) 2021-	(3.1) 2018-2020 (3.2) 2021-
ICD-O 3 Hematopoietic Primaries Table	2001-2009	2001-2009

SEER Hematopoietic & Lymphoid Neoplasm & Manual	2010-	2010-
SEER Multiple Primary & Histology Coding Rules	2007-2017	2007-2017
SEER Solid Tumor Rules	2018+ (2024 Update)	2018+ (2024 Update)
Treatment		
SEER Self Instructional Manual, Book 8	1993-2004	1997-2004
SEER RX Interactive Antineoplastic Drug Database	2005-	2005-
STORE CTR Guide to Coding Radiation (Appendix R)	2019-	2019-