Maine Cancer Registry (MCR)
Data Collection Manual for Hospitals – 2011 (Partial)

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Preface 2011

This document is intended to provide Maine cancer registrars and reporters a single document containing updated information for 2011. It is not a complete data collection manual. For additional information regarding Maine Cancer Registry reporting requirements, including confidentiality, casefinding guidelines and reportable diagnoses, refer to the ***Maine Cancer Registry Data Collection Manual for Hospitals, Fourth Edition*** – Sections One and Two and the appendices.

In this document:

- ***Maine Cancer Registry ICD-9-CM Casefinding Code Lists for Reportable Tumors - 2011***. MCR's lists include the same codes as those posted on the SEER website. There are no new reportable diagnoses for 2011, but a few new codes to review have been added to both the Comprehensive (Core) list and to Supplementary List 2. In addition, some codes have been moved from Comprehensive to Supplementary List 2. The changes are summarized after the casefinding lists.

- ***Special note about Commission on Cancer (CoC) Class of Case:*** Included in this document are guidelines for determining reportability by Class of Case.

- ***Maine Cancer Registry Required Data Items - 2011***. Of note, all of the new data items that MCR is requiring for 2011 are already required by the Commission on Cancer (CoC):

  - **Grade Path Value**
  - **Grade Path System**
  - **Lymph-vascular Invasion (**if needed to derive stage**)**
  - **Rad--Boost RX Modality**
  - **RX Date--Systemic**
  - **RX Date--Most Defin Surg**
  - **NPI--Physician--Managing (**when available**)**
  - **Follow-up Source**

  For the most part, MCR requires **CS Site-Specific Factors** only when the information collected in those fields is required to derive stage - either SEER Summary 2000 (SS2000) or AJCC 6th and/or 7th edition. For the breakdown, see the table following **MCR Required Data Items – 2011**.

- ***Instructions for coding the data items that are required by MCR but not by the CoC***. Only one of those data items (**Date of Diagnosis Flag)** has been revised for 2011, and the revision was just a clarification in the description of the data item. MCR did add a note asking that you reference the applicable MP/H rule in the text fields for **Primary Site Title** and **Histology Title**. This information will be very helpful for MCR's data team, and documenting the applicable MP/H rule is a good QA practice for your own internal use.

Coding instructions for all other required data items can be found in ***FORDS 2011***.

FORDS 2011 is a free download on the CoC website, http://www.facs.org/cancer/coc/fordsmanual.html.

Supplementary references are necessary for coding Collaborative Stage, Multiple Primaries and Histologies, Hematopoietic Tumors, and Systemic Agents.

Other reference materials, tools and manuals registrars will need to abstract 2011 cases:

- ✓ **Collaborative Stage Version 02.03** - For information and free downloads go to http://cancerstaging.org/cstage/manuals/index.html.

- ✓ **The 2007 Multiple Primary and Histology Coding Rules** (revised 11/05/10) - For information and free downloads go to http://www.seer.cancer.gov/tools/mphrules/download.html OR http://www.afritz.org/freetools/index.htm. Note: The 11/05/10 revisions are all for data items that are not required by MCR.

- ✓ **The ICD-O-3 SEER Site/Histology Validation List** (update 12/04/09) - For a free download and Errata go to http://www.seer.cancer.gov/icd-o-3/index.html.

- ✓ **SEER*Rx version 1.5.0** (released 09/27/2010) - For information and a free download go to http://www.seer.cancer.gov/tools/seerrx/index.html.

- ✓ **The Hematopoietic Database and Imbedded 2010 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual Version 1.6.2** (released 01/04/11) - For information and a free download go to http://www.seer.cancer.gov/tools/heme/.

  Use the instructions and rules within the Hematopoietic and Lymphoid Neoplams manual first. The Hematopoietic DB is used when the rules specifically instruct the abstractor to refer to the DB or when the abstractor has used all of the rules in the manual. Additional information and educational presentations are also available on the SEER website above.

Still under construction (hopefully available later this spring or summer):

- ✓ **MCR Edits for Hospitals** (NAACCR V12 metafile) – Please use your registry software's "**Extended Edits**" until Maine Cancer Registry's edit set is available.

- ✓ Implementation of CDC's **Web Plus,** a web-based application for data submissions

Remember, you MUST NOT complete and submit an abstract for a case that was diagnosed in 2011 until your registry software has been updated to accommodate CS Version 02.03! Also, please let us know that your software has been upgraded the first time you send a submission after your upgrade.

SECTION ONE

Introduction

MAINE CANCER REGISTRY ICD-9-CM CASEFINDING CODE LISTS FOR REPORTABLE TUMORS

(EFFECTIVE DATE 01/01/2011)

Some ranges are expressed with only 1 decimal place (e.g. 237.0-237.9) while some codes within that range may have two decimal places (e.g. 237.71 and 237.72). All codes in the range are included.

MCR Comprehensive ICD-9-CM Casefinding Code List for Reportable Tumors (Effective Date: 1/1/2011)	
ICD-9-CM Code^	**Explanation of Code**
140.0 – 208.92	Malignant Neoplasms
209.00 – 209.29	Neuroendocrine tumors
209.30	Malignant poorly differentiated neuroendocrine carcinoma, any site *Reportable inclusion terms:* *High grade neuroendocrine carcinoma, any site* *Malignant poorly differentiated neuroendocrine tumor NOS*
209.31 – 209.36	Merkel cell carcinoma (new code effective 10/01/2009)
209.70 – 209.79	Secondary neuroendocrine tumors *Reportable inclusion terms:* *Secondary carcinoid tumors* *Note: All neuroendocrine or carcinoid tumors specified as secondary are malignant*
225.0 – 225.9	Benign neoplasm of brain and spinal cord neoplasm
227.3	Benign neoplasm of pituitary gland and craniopharyngeal duct (pouch) *Reportable inclusion terms:* *Benign neoplasm of craniobuccal pouch, hypophysis, Rathke's pouch or sella turcica*
227.4	Benign neoplasm of pineal gland
228.02	Hemangioma; of intracranial structures *Reportable inclusion terms:* *Angioma NOS, Cavernous nevus, Glomus tumor, Hemangioma (benign)*
228.1	Lymphangioma, any site *Note: This code includes Lymphangiomas of Brain, Other parts of nervous system and endocrine glands, which are reportable.*
230.0 – 234.9	Carcinoma in situ
236.0	Endometrial stroma, low grade (8931/1) *Reportable inclusion terms:* *Stromal endometriosis (8931/3 per ICD-O-3)* *Stromal myosis (endolymphatic) (8931/3 per ICD-O-3)* *Stromatosis, endometrial (8931/3 per ICD-O-3)*
237.0 – 237.1	Neoplasm of uncertain behavior [borderline] of pituitary gland, craniopharyngeal duct and pineal gland
237.5 – 237.6	Neoplasm of uncertain behavior [borderline] of brain, spinal cord and meninges
237.72	Neurofibromatosis, type 2 [acoustic neurofibromatosis] *Note: Acoustic neuromas growing along the acoustic nerve.* See "supplementary" list for Neurofibromatosis, unspecified (237.70) and Neurofibromatosis, type 1 (237.71)
237.9	Neoplasm of other and unspecified parts of nervous system (cranial nerves)
238.4	Polycythemia vera (9950/3)
238.6	Neoplasm of uncertain behavior of other and unspecified sites and tissues, Plasma cells

MCR Comprehensive ICD-9-CM Casefinding Code List for Reportable Tumors (Effective Date: 1/1/2011)	
ICD-9-CM Code^	**Explanation of Code**
	(Plasmacytoma, extramedullary, 9734/3) *Reportable inclusion terms:* *Plasmacytoma NOS (9731/3)* *Solitary myeloma (9731/3)*
238.7	Other lymphatic and hematopoietic tissues *Note: This code was expanded 10/2006. It is now a subcategory and is no longer valid for use for coding purposes. It should be included in extract programs for quality control purposes.)*
238.71	Essential thrombocythemia (9962/3) *Reportable inclusion terms:* *Essential hemorrhagic thrombocythemia* *Idiopathic (hemorrhagic) thrombocythemia*
238.72	Low grade myelodysplastic syndrome lesions (includes 9980/3, 9982/3, 9983/3, 9985/3) *Reportable inclusion terms:* *Refractory anemia (RA) (9980/3)* *Refractory anemia with excess blasts-1 (RAEB-1) (9983/3)* *Refractory anemia with ringed sideroblasts (RARS) (9982/3)* *Refractory cytopenia with multilineage dysplasia (RCMD) (9985/3)* *Refractory cytopenia with multilineage dysplasia and ringed sideroblasts (RCMD-RS) (9985/3)*
238.73	High grade myelodysplastic syndrome lesions (includes 9983/3) *Reportable inclusion terms:* *Refractory anemia with excess blasts-2 (RAEB-2)*
238.74	Myelodysplastic syndrome with 5q deletion (9986/3) *Reportable inclusion terms:* *5q minus syndrome NOS*
238.75	Myelodysplastic syndrome, unspecified (9985/3, 9987/3)
238.76	Myelofibrosis with myeloid metaplasia (9961/3) *Reportable inclusion terms:* *Agnogenic myeloid metaplasia* *Idiopathic myelofibrosis (chronic)* *Myelosclerosis with myeloid metaplasia*
238.77	Post transplant lymphoproliferative disorder (9987/3)
238.79	Other lymphatic and hematopoietic tissues (includes 9960/3, 9961/3, 9970/1, 9931/3) *Reportable inclusion terms:* *Lymphoproliferative disease (chronic) NOS (9970/1)* *Megakaryocytic myelosclerosis (9961/3)* *Myeloproliferative disease (chronic) NOS (9960/3)* *Panmyelosis (acute) (9931/3)*
239.6	Neoplasms of unspecified nature, brain
239.7	Neoplasms of unspecified nature; endocrine glands and other parts of nervous system
273.2	Other paraproteinemias *Reportable inclusion terms:* *Franklin's disease (heavy chain) (9762/3)* *Heavy chain disease (9762/3)* *Mu-chain disease (9762/3)*

MCR Comprehensive ICD-9-CM Casefinding Code List for Reportable Tumors (Effective Date: 1/1/2011)	
ICD-9-CM Code^	**Explanation of Code**
273.3	Macroglobulinemia *Reportable inclusion terms:* *Waldenström's macroglobulinemia (9761/3)* *Waldenström's (macroglobulinemia) syndrome*
277.89	Other specified disorders of metabolism Hand-Schuller-Christian disease Histiocytosis (acute) (chronic) Histiocytosis (chronic)
288.4	Hemophagocytic syndrome (9751/3, 9754/3) *Reportable inclusion terms:* *Histiocytic syndromes*
289.6	Familial polycythemia *Note: This is a synonym for polycythemia vera*
795.06	Papanicolaou smear of cervix with cytologic evidence of malignancy
795.16	Papanicolaou smear of vagina with cytologic evidence of malignancy
796.76	Papanicolaou smear of anus with cytologic evidence of malignancy
V10.0 – V10.89	Personal history of malignancy *Note: Screen for recurrences, subsequent primaries, and/or subsequent treatment*
V10.90	Personal history of unspecified malignant neoplasm *Note: Screen for recurrences, subsequent primaries, and/or subsequent treatment*
V10.91	Personal history of malignant neuroendocrine tumor, carcinoid tumor, Merkel cell carcinoma *Note: Screen for recurrences, subsequent primaries, and/or subsequent treatment*
V12.41	Personal history of benign neoplasm of the brain

The following codes are not reportable per se, but they should alert registrars to look for the first malignant neoplasm associated with these codes.

MCR Supplementary List #1-ICD-9-CM Codes that Should Be Followed by or Associated with a Neoplasm Code^	
ICD-9-CM Code^	**Explanation of Code**
258.02 – 258.03	Multiple endocrine neoplasia (MEN) type IIA and IIB (rare familial cancer syndrome) *Note: Use additional codes to identify any malignancies and other conditions associated with the syndrome*
285.22	Anemia in neoplastic disease *Note: Assign also a code for the neoplasm causing the anemia* *Excludes: anemia due to antineoplastic chemotherapy, new code 285.3*
289.83	Myelofibrosis (NOS) (9961/3) *Note: Not every case of myelofibrosis is associated with a malignancy. Review terms included in ICD-O-3 to determine if case is reportable. See ICD-9-CM*
338.3	Neoplasm related pain (acute, chronic); Cancer associated pain; Pain due to malignancy (primary/secondary); Tumor associated pain
511.81	Malignant pleural effusion *Note : Code first malignant neoplasm if known. If the primary site is not known, code 199.0, disseminated carcinomatosis, or code 199.1, malignancy NOS, should be assigned*
789.51	Malignant ascites *Note : Code first malignant neoplasm if known. If the primary site is not known, code 199.0, disseminated carcinomatosis, or code 199.1, malignancy NOS, should be assigned*

NOTE: Cases with these codes should be screened as registry time allows. These are neoplasm-related secondary conditions for which there should also be a primary diagnosis of a reportable neoplasm. Experience in the SEER registries has shown that using the supplementary list increases casefinding for benign brain and CNS, hematopoietic, and other reportable neoplasms.

MCR Supplementary List #2-ICD-9-CM Code List to Screen for Cancer Cases Not Identified by Other Codes (Effective Date: 1/1/2011)^	
ICD-9-CM Code^	**Explanation of Code**
042	Acquired Immunodeficiency Syndrome (AIDS) *Note: This is not a malignancy. Medical coders are instructed to add codes for AIDS-associated malignancies. Screen 042 for history of cancers that might not be coded.*
079.4	Human papillomavirus
079.50 – 079.59	Retrovirus (HTLV, types I, II and 2)
209.40-209.69	Benign carcinoid tumors
210.0 – 229.9	Benign neoplasms (except for 225.0-225.9, 227.3, 227.4, 228.02, and 228.1, which are listed in the Reportable list) *Note: Screen for incorrectly coded malignancies or reportable by agreement tumors.*
235.0 – 236.7, 236.90 – 236.99	Neoplasms of uncertain behavior (except for 236.0, which is listed in the Reportable list) *Note: Screen for incorrectly coded malignancies or reportable by agreement tumors*
237.2 – 237.4	Neoplasm of uncertain behavior of adrenal gland, paraganglia and other and unspecified endocrine glands *Note: Screen for incorrectly coded malignancies or reportable by agreement tumors*

MCR Supplementary List #2-ICD-9-CM Code List to Screen for Cancer Cases Not Identified by Other Codes (Effective Date: 1/1/2011)^	
ICD-9-CM Code^	**Explanation of Code**
237.70 – 237.71	Neurofibromatosis, unspecified and Type 1 *Note: An inherited condition with developmental changes in the nervous system, muscles, bones and skin; multiple soft tumors (neurofibromas) distributed over the whole body. (See "must report" for Neurofibromatosis, type 2, 237.72)*
237.73	Schwannomatosis *Note: Effective date 10/1/2010. Screen for incorrectly coded malignancies or reportable by agreement tumors*
237.79	Other neurofibromatosis *Note: Effective date 10/1/2010 Screen for incorrectly coded malignancies or reportable by agreement tumors*
238.0 – 239.9	Neoplasms of uncertain behavior (except for 238.4, 238.6, 238.71-238.79, 239.6, 239.7, which are listed in the Reportable list) *Note: Screen for incorrectly coded malignancies or reportable by agreement tumors*
253.6	Syndrome of inappropriate secretion of antidiuretic hormone *Note: Part of the paraneoplastic syndrome. See note of explanation in the "notes" section.*
259.2	Carcinoid Syndrome
259.8	Other specified endocrine disorders
273.0	Polyclonal hypergammaglobulinemia (Waldenstrom) *Note: Review for miscodes*
273.1	Monoclonal gammopathy of undetermined significance (9765/1) *Note: Screen for incorrectly coded Waldenstrom macroglobulinemia or progression*
273.8	Other disorders of plasma protein metabolism
273.9	Unspecified disorder of plasma protein metabolism *Note: Screen for incorrectly coded Waldenstrom's macroglobulinemia*
275.42	Hypercalcemia *Note: Part of the paraneoplastic syndrome. See note of explanation in the "notes" section.*
277.88	Tumor lysis syndrome/Tumor lysis syndrome following antineoplastic drug therapy
279.00	Hypogammaglobulinemia *Note: Predisposed to lymphoma or stomach cancer*
279.02 – 279.06	Selective IgM immunodeficiency *Note: Associated with lymphoproliferative disorders*
279.10	Immunodeficiency with predominant T-cell defect, NOS
279.12	Wiskott-Aldrich Syndrome
279.13	Nezelof's Syndrome
279.2 – 279.9	Combined immunity deficiency – Unspecified disorder of immune mechanism
284.81	Red cell aplasia (acquired, adult, with thymoma)
284.89	Other specified aplastic anemias due to drugs (chemotherapy or immunotherapy), infection, radiation
284.9	Aplastic anemia, unspecified *Note: Review for miscodes*
285.0	Sideroblastic anemia
285.3	Antineoplastic chemotherapy induced anemia (Anemia due to antineoplastic chemotherapy)

MCR Supplementary List #2-ICD-9-CM Code List to Screen for Cancer Cases Not Identified by Other Codes (Effective Date: 1/1/2011)^	
ICD-9-CM Code^	**Explanation of Code**
288.03	Drug induced neutropenia
288.3	Eosinophilia *Note: This is the code for eosinophilia (9964/3). Not every case of eosinophilia is associated with a malignancy. Diagnosis must be "Hypereosonophilic syndrome" to be reportable*.
289.89	Other specified diseases of blood and blood-forming organs *Note: Review for miscodes*
289.9	Other specified diseases of blood and blood-forming organs
323.81	Encephalomyelitis; specified cause NEC *Note: Part of the paraneoplastic syndrome. See note of explanation in the "notes" section.*
379.59	Opsoclonia *Note: Part of the paraneoplastic syndrome. See note of explanation in the "notes" section.*
528.01	Mucositis due to antineoplastic therapy
630	Hydatidiform Mole (9100/0) *Note: This is a benign tumor that can become malignant. If malignant, it should be reported as Choriocarcinoma (9100/3) and will have a malignancy code in the 140-209 range.*
686.01	Pyoderma gangrenosum *Note: Part of the paraneoplastic syndrome. See note of explanation in the "notes" section.*
695.89	Sweet's syndrome *Note: Part of the paraneoplastic syndrome. See note of explanation in the "notes" section.*
701.2	Acanthosis nigricans *Note: Part of the paraneoplastic syndrome. See note of explanation in the "notes" section.*
710.3	Dermatomyositis *Note: Part of the paraneoplastic syndrome. See note of explanation in the "notes" section.*
710.4	Polymyositis *Note: Part of the paraneoplastic syndrome. See note of explanation in the "notes" section.*
733.10 – 733.16	Pathologic fracture *Note: pathologic fractures can be due to bone structure weakening by pathological processess (e.g. osteopororis, neoplasms and osteomalacial)*
758.0	Down's Syndrome *Note: Screen for myeloid leukemia associated with Down's Syndrome (9898/3)*
785.6	Enlargement of lymph nodes *Note: Screen for large B-cell lymphoma arising in HHV8-associated multicentric Castleman disease (9738/3)*
790.93	Elevated prostate specific antigen [PSA]
795.8_	Abnormal tumor markers; Elevated tumor associated antigens [TAA]; Elevated tumor specific antigens [TSA]; *Excludes: Elevated prostate specific antigen [PSA] (790.93)*
795.81	Elevated carcinoembryonic antigen [CEA]

MCR Supplementary List #2-ICD-9-CM Code List to Screen for Cancer Cases Not Identified by Other Codes (Effective Date: 1/1/2011)^	
ICD-9-CM Code^	**Explanation of Code**
795.82	Elevated cancer antigen 125 [CA 125]
795.89	Other abnormal tumor markers
999.31	Infection due to central venous catheter (porta-cath)
999.81	Extravasation of vesicant chemotherapy
E879.2	Adverse effect of radiation therapy
E930.7	Adverse effect of antineoplastic therapy
E933.1	Adverse effect of immunosuppressive drugs
V07.31, V07.39	Other prophylactic chemotherapy
V07.8	Other specified prophylactic measure
V12.72	Colonic polyps (history of)
V15.3	Irradiation: previous exposure to therapeutic or ionizing radiation
V42.81	Organ or tissue replaced by transplant, Bone marrow transplant
V42.82	Transplant; Peripheral stem cells
V51.0	Encounter for breast reconstruction following mastectomy
V52.4	Breast prosthesis and implant
V54.2_	Aftercare for healing pathologic fracture
V58.0	Encounter for radiation therapy
V58.1	Encounter for antineoplastic chemotherapy and immunotherapy *Note: This code was discontinued as of 10/2006 but should be included in extract programs for quality control purposes*
V58.11	Encounter for antineoplastic chemotherapy
V58.12	Encounter for antineoplastic immunotherapy
V58.42	Aftercare following surgery for neoplasm
V58.9	Unspecified aftercare
V66.1	Convalescence following radiotherapy
V66.2	Convalescence following chemotherapy
V66.7	Encounter for palliative care
V67.01	Follow-up vaginal pap smear Vaginal pap smear, status-post hysterectomy for malignant condition
V67.1	Radiation therapy follow up
V67.2	Chemotherapy follow up
V71.1	Observation for suspected malignant neoplasm
V76.0 – V76.9	Special screening for malignant neoplasm
V78.0 – V78.9	Special screening for disorders of blood and blood-forming organs
V82.71	Screening for genetic disease carrier status
V82.79	Other genetic screening
V82.89	Genetic screening for other specified conditions
V82.9	Genetic screening for unspecified condition
V84.01 – V84.09	Genetic susceptibility to malignant neoplasm

MCR Supplementary List #2-ICD-9-CM Code List to Screen for Cancer Cases Not Identified by Other Codes (Effective Date: 1/1/2011)^	
ICD-9-CM Code^	**Explanation of Code**
V84.81	Genetic susceptibility to multiple endocrine neoplasia [MEN]
V86.0	Estrogen receptor positive status [ER+]
V86.1	Estrogen receptor negative status [ER-]
V87.41	Personal history of antineoplastic chemotherapy

NOTES:

- Prostatic Intraepithelial Neoplasia (PIN III) M-8148/2 is not required for diagnoses made **01/01/2001** and after.
- CIN III and Carcinoma in situ of the cervix is not required for diagnoses made **01/01/2004** and after.
- Pilocytic/juvenile astrocytoma M-9421 moved from behavior /3 (malignant) to /1 (borderline malignancy) in ICD-O-3; however, cancer registries will CONTINUE to report these cases and code behavior a /3 (malignant).
- Borderline cystadenomas M-8442, 8451, 8462, 8472, 8473, of the ovaries moved from behavior /3 (malignant) to /1 (borderline malignancy) in ICD-O-3. Cancer registries are not required to collect these cases for diagnoses made 1/1/2001 and after; however, cases diagnosed prior to 1/1/2001 should still be abstracted and reported.
- Codes 253.6, 686.01, 695.89, 701.2, 710.3 and 710.4 are part of the paraneoplastic syndrome. "Paraneoplastic syndrome isn't cancer. It's a disease or symptom that is the consequence of cancer but is not due to the local presence of cancer cells. A paraneoplastic syndrome may be the first sign of cancer."

^ *International Classification of Diseases, Ninth Revision, Clinical Modification, 2011.*

Changes from 2010 Casefinding Lists
Codes Added to Comprehensive List
277.89
288.4
289.6
Codes that moved from Comprehensive List to Supplementary List 2
227.9
237.2 - 237.4; 237.70 - 237.71; 237.73; 237.79
239.81 - 239.89
288.3
Codes Added to Supplementary List 2
236.7; 236.90-236.99
273.8
289.9
733.10-733.16
758.0
V58.9
V66.7
V67.01

Special Note about Commission on Cancer (CoC) Class of Case:

When deciding whether or not you need to report a case to MCR, consider this: Population based cancer registries (like MCR) need to collect information about all cancers that are diagnosed and treated in their catchment area (the state of Maine). We also have data-exchange agreements with other states.

On the other hand, the focus of the Commission on Cancer and hospitals participating in the CoC Approvals Program is assessing quality of care for patients diagnosed and treated in CoC-Approved hospitals. For that reason, the CoC may not require a case that your state cancer registry needs to collect.

Use the table below as a guide when deciding if a case is reportable to MCR, based on the CoC's expanded Class of Case codes. If you are unsure about a case, you can check with us.

Class of Case	Should this case be reported to MCR
00 – 22*	Yes – Analytic (Incidence) Cases
30 – 32*	Yes- to ensure that the case is not missed (You can check with us to see if the case has been reported)
33*	No
34*	Yes if the case is reportable to MCR. Please refer to the ***Maine Cancer Registry Data Collection Manual for Hospitals 4th Edition***, page 8 **Reportable Diagnoses.** Example: VIN III, VAIN III and AIN III are not reportable to the CoC, but they are reportable to MCR.
35*	Yes – if the case was diagnosed on or after 01/01/1995, the Reference Date for MCR
36*	Yes if the case is reportable to MCR. Please refer to the ***Maine Cancer Registry Data Collection Manual for Hospitals 4th Edition***, page 8 **Reportable Diagnoses.** Example: VIN III, VAIN III and AIN III are not reportable to the CoC, but they are reportable to MCR.
37*	Yes – if the case was diagnosed on or after 01/01/1995, the Reference Date for MCR
38*	Yes
40 – 42*	No
43*	Yes – minimal information is better than no information
49*	No
99*	No (unlikely code)

***** See ***FORDS 2011*** for Class of Case Code Definitions

SECTION THREE

Coding Instructions

Maine Cancer Registry Required Data Items - 2011

The following is the list of data items that are required to be reported to the Maine Cancer Registry. It is arranged in the general order that information is abstracted into the registry software used by most hospitals in Maine. The list includes NAACCR item number, NAACCR item name and the diagnosis year(s) for which each data item is reportable to MCR. Data items that are required by Maine Cancer Registry but not by the Commission on Cancer (CoC) are checked in the last column. The ***FORDS*** manual does not include coding instructions for data items that are not required by the CoC.

Data items that are newly required in 2010 and 2011 are in **bolded blue font**.

MCR Required Data Items for Hospitals, as of 01/01/2011

NAACCR Item #	NAACCR Item Name	Diagnosis Year Required	Not Required by CoC	Page
PATIENT DEMOGRAPHICS				
550	Accession Number--Hospital	2005+		
2230	Name--Last	All		
2240	Name--First	All		
2250	Name--Middle	All		
2390	Name--Maiden	All	X	23
2280	Name--Alias	2005 +	X	24
2320	Social Security Number	All		
2300	Medical Record Number	2005 +		
2350	Addr Current--No & Street	All		
2355	Addr Current--Supplementl	2005 +		
1810	Addr Current--City	All		
1820	Addr Current--State	All		
1830	Addr Current--Postal	All		
1840	County--Current	2005 +	X	25
PATIENT STATUS				
240	Birth Date	All		
250	Birthplace	2001 +		
1750	Date of Last Contact	2001 +		
1940	Place of Death	2005 +	X	26
1760	Vital Status	2001 +		
1920	ICD Revision Number	2005 +	X	27
1910	Cause of Death	2001 +	X	28
220	Sex	All		

NAACCR Item #	NAACCR Item Name	Diagnosis Year Required	Not Required by CoC	Not Required Page
190	Spanish/Hispanic Origin	All		
160	Race 1	All		
161	Race 2	2001 +		
162	Race 3	2001 +		
163	Race 4	2001 +		
164	Race 5	2001 +		
PRIMARY (CANCER IDENTIFICATION)				
400	Primary Site	All		
560	Sequence Number--Hospital	All		
522	Histologic Type ICD-O-3	2001 +		
523	Behavior Code ICD-O-3	2001 +		
440	Grade	All		
441	Grade Path Value	2011		
449	Grade Path System	2011		
410	Laterality	All		
490	Diagnostic Confirmation	All		
500	Type of Reporting Source	2004 +	X	29
610	Class of Case	2004 +		
580	Date of 1st Contact	All		
390	Date of Diagnosis	All		
1080	Date of 1st Positive BX	2005 - 2009	RETIRED	
630	Primary Payer at DX	2004 +		
STAGING				
2879	CS Site-Specific Factor 25 (Site Specific)*	2010		
2800	CS Tumor Size	2004 +		
2810	CS Extension	2004 +		
2820	CS Tumor Size/Ext Eval	2004 +		
820	Regional Nodes Positive	2001 +		
830	Regional Nodes Examined	2001 +		
2830	CS Lymph Nodes	2004 +		
2840	CS Reg Nodes Eval	2004 +		
2850	CS Mets at DX	2004 +		
2860	CS Mets Eval	2004 +		
2851	CS Mets at DX-Bone	2010		
2852	CS Mets at DX-Brain	2010		
2853	CS Mets at DX-Liver	2010		

NAACCR Item #	NAACCR Item Name	Diagnosis Year Required	Not Required by CoC	Page
2854	CS Mets at DX-Lung	2010		
2880	CS Site-Specific Factor 1 (Site Specific)*	2004 +		
2890	CS Site-Specific Factor 2 (Site Specific)*	2004 +		
2900	CS Site-Specific Factor 3 (Site Specific)*	2004 +		
2910	CS Site-Specific Factor 4 (Site Specific)*	2004 +		
2920	CS Site-Specific Factor 5 (Site Specific)*	2004 +		
2930	CS Site-Specific Factor 6 (Site Specific)*	2004 +		
2861	CS Site-Specific Factor 7 (Site Specific)*	2010		
2862	CS Site-Specific Factor 8 (Site Specific)*	2010		
2863	CS Site-Specific Factor 9 (Site Specific)*	2010		
2864	CS Site-Specific Factor 10 (Site Specific)*	2010		
2865	CS Site-Specific Factor 11 (Site Specific)*	2010		
2866	CS Site-Specific Factor 12 (Site Specific)*	2010		
2867	CS Site-Specific Factor 13 (Site Specific)*	2010		
2868	CS Site-Specific Factor 14 (Site Specific)*	2010		
2869	CS Site-Specific Factor 15 (Site Specific)*	2010		
2870	CS Site-Specific Factor 16 (Site Specific)*	2010		
2871	CS Site-Specific Factor 17 (Site Specific)*	2010		
1182	Lymph-Vascular Invasion (Site Specific)*	2011		
1090	Site of Distant Met 1	2005 - 2009	Retired	
1100	Site of Distant Met 2	2005 - 2009	Retired	
1110	Site of Distant Met 3	2005 - 2009	Retired	
	TREATMENT			
1280	RX Date--DX/Stg Proc	All		
1350	RX Summ--DX/Stg Proc	2005		
1200	RX Date--Surgery	All		
1290	RX Summ--Surg Prim Site	All		
1292	RX Summ--Scope Reg LN Sur	2001 +		
1294	RX Summ--Surg Oth Reg/Dis	2001 +		
1210	RX Date--Radiation	All		
1570	Rad--Regional RX Modality	All		
3200	Rad--Boost RX Modality	2011		
1220	RX Date--Chemo	All		
1390	RX Summ--Chemo	All		
1230	RX Date--Hormone	All		
1400	RX Summ--Hormone	All		

NAACCR Item #	NAACCR Item Name	Diagnosis Year Required	Not Required by CoC	Page
1240	RX Date--BRM	All		
1410	RX Summ--BRM	All		
None	Date Hematalogic Transplant/Endocrine Procedure	2005+	X	31
3250	RX Summ--Transplnt/Endocr	2005 +		
1250	RX Date--Other	All		
1420	RX Summ--Other	All		
	FIRST COURSE			
1340	Reason for no Surgery	All		
1639	RX Summ--Systemic Surg Seq	2006+		
1380	RX Summ--Surg/Rad Seq	All		
1430	Reason for no Radiation	All		
1285	RX Summ--Treatment Status	2010		
1270	Date of 1st Crs RX--COC	All		
3230	RX Date--Systemic	2011		
3170	RX Date--Most Defin Surg	2011		
	GENERAL (PHYSICIANS)			
2460	Physician--Managing	All	X	32
2465	NPI—Physician--Managing	2011 (If available)		
None	Physician--Referring	All	X	33
1790	Follow-Up Source	2011		
	NOTEPAD (TEXT FIELDS)			
2520	Text--Dx Proc--PE	All	X	35
2530	Text--DX Proc--X-ray/scan	All	X	36
2540	Text--DX Proc--Scopes	All	X	37
2550	Text--DX Proc--Lab Tests	All	X	38
2560	Text--DX Proc--Op	All	X	39
2570	Text--DX Proc--Path	All	X	40
2580	Text--Primary Site Title	All	X	41
2590	Text--Histology Title	All	X	42
2600	Text--Staging	All	X	43
2610	RX Text--Surgery	All	X	44
2620	RX Text--Radiation (Beam)	2005 +	X	45
2630	RX Text--Radiation Other	2005 +	X	46
2640	RX Text--Chemo	2005 +	X	47
2650	RX Text--Hormone	2005 +	X	48

NAACCR Item #	NAACCR Item Name	Diagnosis Year Required	Not Required by CoC	Page
2660	RX Text--BRM	2005 +	X	49
2670	RX Text--Other	2005 +	X	50
2680	RX Text--Remarks	2005+	X	51
310	Text--Usual Occupation	All	X	52
320	Text--Usual Industry	All	X	53
2690	Text--Place of Diagnosis	2005+	X	54
CASE STATUS (TUMOR DEMOGRAPHICS)				
2335	Addr at DX--Supplementl	2005 +		
2330	Addr at DX--No & Street	All		
70	Addr at DX--City	All		
80	Addr at DX--State	All		
90	County at DX	All		
100	Addr at DX--Postal Code	All		
CASE ADMIISTRATION				
540	Reporting Facility	All		
545	NPI--Reporting Facility	2007+		
450	Site Coding Sys--Current	All		
470	Morp Coding Sys--Current	All		
NAACCR Item #	**NAACCR Item Name**	**Diagnosis Year Required**	**Not Required by CoC**	**Page**
1460	RX Coding System--Current	All		
2116	ICD-O-3 Conversion Flag	2007+	X	55
2935	CS Version Input Original	2004+		
2936	CS Version Derived	2004+		
2937	CS Version Input Current	2010		
1500	First Course Calc Method	All	X	56
DATE FLAGS				
241	Date of Birth Flag	2010		
391	Date of Diagnosis Flag	2010	X	57
581	Date of 1st Contact Flag	2010		
1201	RX Date--Surgery Flag	2010		
1211	RX Date--Radiation Flag	2010		
1221	RX Date--Chemo Flag	2010		
1231	RX Date--Hormone Flag	2010		
1241	RX Date--BRM Flag	2010		
1251	RX Date--Other Flag	2010		

NAACCR Item #	NAACCR Item Name	Diagnosis Year Required	Not Required by CoC	Page
1271	Date of 1st Crs RX Flag	2010		
1281	RX Date--DX/Stg Proc Flag	2010		
1751	Date of Last Contact Flag	2010		
3171	RX Date Mst Defin Srg Flag	2010		
3231	Rx Date Systemic Flag	2010		
	OVERRIDE FLAGS			
1986	Over-ride HospSeq/DxConf	2010		
1990	Over-ride Age/Site/Morph	2010		
2020	Over-ride Surg/DxConf	2010		
2030	Over-ride Site/Type	2010		
2040	Over-ride Histology	2010		
2070	Over-ride Leuk, Lymphoma	2010		
2071	Over-ride Site/Behavior	2010		
2074	Over-ride Site/Lat/Morph	2010		

* Maine Cancer Registry requires the data items Lymph-vascular Invasion and CS Site Specific Factors 1-25 for selected sites only. See Table below:

Required by MCR by Site/schema (in alphabetical order)			
	Needed to Derive Stage (AJCC and/or SEER Summary 2000)		Not Needed to Derive Stage
Lymph-vascular Invasion	Testis, Penis		
CS SSF 1	Buccal Mucosa Conjunctiva Epiglottis Anterior Esophagus EsophagusGEJunction Floor of Mouth Gum Lower Gum Other Gum Upper HeartMediastinum Hypopharynx Larynx Glottic Larynx Other Larynx Subglottic Larynx Supraglottic Lip Lower Lip Other Lip Upper Lung Melanoma Conjunctiva Melanoma Skin Mouth Other Mycosis Fungoides Nasal Cavity Nasopharynx NET Stomach Oropharynx Palate Hard Palate Soft Parotid Gland Peritoneum Pharyngeal Tonsil Pleura Prostate Retinoblastoma		Brain Breast CNS Other Intracranial Gland

Required by MCR by Site/schema (in alphabetical order)			
	Needed to Derive Stage (AJCC and/or SEER Summary 2000)		Not Needed to Derive Stage
	Retroperitoneum Salivary Gland Other Sinus Ethmoid Sinus Maxillary Soft Tissue Stomach Submandibular Gland Tongue Anterior Tongue Base		
CS SSF 2	Appendix Bladder Carcinoid Appendix Colon Corpus Adenosarcoma Corpus Carcinoma Corpus Sarcoma Lymphoma Lymphoma Occular Adnexa Melanoma Choroid Melanoma Ciliary Body Melanoma Conjunctiva Melanoma Skin NET Colon NET Rectum Rectum Small Intestine		Breast
CS SSF 3	Breast Melanoma Choroid Melanoma Ciliary Body Melanoma Skin Merkel Cell Penis Merkel Cell Scrotum Merkel Cell Skin Merkel Cell Vulva Prostate		
CS SSF 4	Breast Melanoma Choroid Melanoma Ciliary Body Melanoma Iris		

Required by MCR by Site/schema (in alphabetical order)			
	Needed to Derive Stage (AJCC and/or SEER Summary 2000)		Not Needed to Derive Stage
	Melanoma Skin Testis		
CS SSF 5	Breast GIST Peritoneum Testis		
CS SSF 6	GIST Esophagus GIST Small Intestine GIST Stomach Skin Eyelid		
CS SSF 7	Melanoma Skin Testis		
CS SSF 8	Prostate		Breast
CS SSF 9	Testis		Breast
CS SSF 10	Bile Ducts Intrahepatic GIST Peritoneum Prostate Testis		Breast
CS SSF 11	Appendix GIST Appendix GIST Colon GIST Rectum Merkel Cell Vulva Vulva		Breast
CS SSF 12	Skin		Breast
CS SSF 13	Testis		Breast
CS SSF 14			Breast
CS SSF 15	Testis		Breast
CS SSF 16	Skin Testis		Breast
CS SSF 17	Penis		
CS SSF 18			
CS SSF 19			
CS SSF 20			
CS SSF 21			
CS SSF 22			
CS SSF 23			
CS SSF 24			

Required by MCR by Site/schema (in alphabetical order)			
	Needed to Derive Stage (AJCC and/or SEER Summary 2000)		Not Needed to Derive Stage
CS SSF 25 (Schema Discriminator)			Bile Ducts Distal Bile Ducts Perihilar Cystic Duct EsophagusGEJunction Lacrimal Gland Lacrimal Sac Melanoma Ciliary Body Melanoma Iris Nasopharynx Peritoneum Peritoneum Female Gen Pharyngeal Tonsil Stomach

How to Use MCR Coding Instructions

Except where otherwise noted, Maine Cancer Registry uses *FORDS* coding instructions, with the permission of the Commission on Cancer (CoC). This section includes instructions for coding data items that are required by MCR but not by the CoC.

Each data item is listed in a box like the one below:

(1) NAACCR ITEM NAME **(2) [ALTERNATE NAME]**	(3) Item Length: (4) NAACCR Item # (5) Source of Standard: (6) Dx Yr Req by MCR:

(1) NAACCR ITEM NAME: The name assigned to this data item by NAACCR*

(2) ALTERNATE NAME: Another name for this data item; (i.e., another descriptive name for this data field such as one assigned by a FORDS or a software vendor)

(3) Item Length: The number of characters allowed for this data item in the NAACCR format

(4) NAACCR Item #: The number assigned by NAACCR for this data item

(5) Source of Standard: The Standard Setter(s) responsible for this data item:
AJCC = American Joint Committee on Cancer Staging
CoC = Commission on Cancer of the American College of Surgeons
NAACCR = North American Association of Central Cancer Registries
NPCR = National Program for Cancer Registries of the CDC
SEER = Surveillance Epidemiology & End Results Program of the NCI
MCR = Maine Cancer Registry

(6) Dx Yr Req by MCR: The diagnosis year(s) for which this data item is required by the MCR
N/R = not required

Underneath the box is a brief ***Description*** and **Instructions for Coding** for each data item. In addition, the pertinent pages in *FORDS Revised for 2004* and/or any other applicable resource(s) are referenced.

Coding instructions, special notes and examples added by or specific to the MCR appear in shaded boxes.

** The North American Association of Central Cancer Registries, Inc. (NAACCR, Inc.), is a professional organization that develops and promotes uniform data standards for cancer registration*

NAME – MAIDEN	Item Length: 40 NAACCR Item #2390 Source of Standard: CoC (Revised 01/2010) Dx Yr Reg by MCR: All

Description: *Identifies the maiden name of female patients who have been married.*

Instructions for Coding (See current version of *NAACCR Volume II, Data Standards and Data Dictionary*)

- Record the maiden name of a female patient who is or has been married, if available.
- Truncate the name if more than 40 letters long. Blanks, spaces and hyphens are allowed. Do not use other punctuation, such as periods and apostrophes.
- Leave blank if the female patient does not have a maiden name or the information is unavailable. Only legitimate surnames are allowable. Any variation of "unknown" or "not applicable" is not allowable.

For complex names that include a period, replace the period with a space.

Example: St. Amand should be recorded as St Amand.

Note: *As January 1, 2003, this data item is no longer supported by the CoC.*

NAME – ALIAS **[ALIAS (COC)]**	Item Length: 40 NAACCR Item #2280 Source of Standard: CoC (Revised 01/2010) Dx Yr Reg by MCR: 2005+

Description: *Records an alternate name or "AKA" (also known as) used by the patient if known. Note that maiden name is recorded in item #2390.*

***Instructions for Coding (See current version of NAACCR Volume II, Data Standards and Data Dictionary*)**

- If the patient uses an alias for a first name only, record the last name followed by a blank space and the first name alias.
- If the patient uses only a last name alias, record the last name alias followed by a blank space and the actual first name.
- If the patient uses an alias for the first and last name, record last name alias followed by a blank space and the first name alias.
- If the patient has no known alias, leave the field blank.

Note: *As January 1, 2003, this data item is no longer supported by the CoC.*

COUNTY
CURRENT

Item Length: 3
NAACCR Item # 1840
Source of Standard: NAACCR
Dx Yr Req by MCR: 2005+

Description: *Identifies the county of the patient's current (last known) residence.*

Instructions for Coding (See current version of *NAACCR Volume II, Data Standards and Data Dictionary*)

- For Maine residents, use the codes issued by the Federal Information Processing Standards (FIPS) publication, *Counties and Equivalent Entities of the United States, Its Possessions, and Associated Areas* (See table below).

See Appendix C for a listing of Maine cities and towns with corresponding county and zip codes.

- Codes in addition to FIPS and geocodes:
  - 998: Patient is a resident outside of Maine.
  - 999: Patient is a resident of Maine, but county is unknown.
- If the patient is a non-U.S. resident and XX is coded in *Current State of Residence* (NAACCR Item #1820), then code the patient's country of residence in this field.
  - For country codes, see Appendix D in this manual.
- If the patient has multiple tumors, the current county of residence should be the same for all tumors.

Code	County Name	Code	County Name
001	Androscoggin	017	Oxford
003	Aroostook	019	Pennobscot
005	Cumberland	021	Piscataquis
007	Franklin	023	Sagadahoc
009	Hancock	025	Somerset
011	Kennebec	027	Waldo
013	Knox	029	Washington
015	Lincoln	031	York
998	Patient is a resident outside of Maine	999	Patient is a resident of Maine, but county is unknown

Note: *As of January 1, 2003, this data item is no longer supported by the CoC.*

PLACE OF DEATH

Item Length: 3
NAACCR Item #1940
Source of Standard: NPCR
Dx Yr Req by MCR: 2005+

Description: *Records the state or country where the patient died and where certificate of death is filed.*

Instructions for Coding (See current version of *NAACCR Volume II, Data Standards and Data Dictionary)*

- Use the SEER Geocodes for "Place of Death." These codes include states of the United States as well as foreign countries.
    - For SEER Geocodes, see Appendix D in this manual.
- Use the most specific code.

Codes in addition to geocodes

Code	Definition
997	Not applicable, patient alive
999	Place of death unknown

ICD REVISION NUMBER	Item Length: 1 NAACCR Item #1920 Source of Standard: SEER (Revised 01/2010) Dx Yr Reg by MCR: 2005+

Description: *Indicator for the coding scheme used to code the cause of death.*

Instructions for Coding (See current version of the *SEER Program Coding and Staging Manual)*

- Indicate the ICD revision used to code the underlying cause of death.

Code	Definition
0	Patient alive at last contact
1	ICD-10
9	ICD-9

- If the patient has multiple primaries, the ICD Code Revision used for cause of death must be identical on each record.

Note: ICD-10 was implemented for coding causes of death on death certificates in the United States effective January 1, 1999. For deaths occurring on or after that date the **ICD Revision Number** should be coded as 1 (ICD-10) even when one of the special codes for cancer registries (7777 or 7797) is entered in the **Cause of Death** filed.

CAUSE OF DEATH (UNDERLYING CAUSE OF DEATH [SEER])	Item Length: 4 NAACCR Item #1910 Source of Standard: SEER (Revised 01/2010) Dx Yr Req by MCR: 2001+

Description: *Official cause of death as coded from the death certificate in valid ICD-O-9 or ICD-O-10 codes.*

Instructions for Coding **(See current version of the *SEER Program Coding and Staging Manual)***

- Record the cause of death listed on the death certificate. Use the underlying cause of death (ICD code) identified by the state health department.
- If the patient has multiple primaries, the underlying cause of death must be identical on each record.
- Special codes in addition to ICD-O-9 and ICD-O-10 codes:

Code	Definition
0000	Patient alive at last contact
7777	State death certificate not available
7797	State death certificate/listing available but underlying cause of death is not coded.

A specific **Cause of Death** should be entered only if you have access to the coded underlying cause of death from the death certificate; do not code cause of death from any other source, such as a discharge summary or an oncology chart.

If the patient is deceased, and you do not have access to the coded underlying case of death as listed on the death certificate, enter the code 7777.

Note: *As of January 1, 2003, this data item is no longer supported by CoC.*

TYPE OF REPORTING SOURCE	Item Length: 1 NAACCR Item #500 Source of Standard: SEER (Revised 01/10) Dx Yr Reg by MCR: 2004+

Description: *Code identifying source documents used to abstract the tumor being reported. This may not be the source of the original case finding; rather, it is the source that provided the best information.*

Instructions for Coding (See current version of the *SEER Program Coding and Staging Manual)*

- Coding is hierarchical. When multiple source documents are used to abstract a case, use the following priority order to assign a code for Type of Reporting Source: Priority order of codes 1, 2, 8, 4, 3, 5, 6, 7.

Definitions

Managed health plan: HMO or other health plan (e.g. Kaiser, Veterans Administration, military facilities) in which all diagnostic and treatment information is maintained centrally (in a unit record) and is available to the abstractor.

Physician office: Examinations, tests and limited surgical procedures may be performed in a physician office. If called a surgery center, but cannot perform surgical procedures under general anesthesia, code as a physician office.

Serial record: The office or facility stores information separately for each patient encounter.

Surgery center: Surgery centers are equipped and staffed to perform surgical procedures under general anesthesia. Patient does not stay overnight.

Unit record: The office or facility stores information for all of a patient's encounters in one record with one record number.

Note: *Beginning with cases diagnosed 01/01/2006, the definitions for this field have been expanded. Codes 2 and 8 were added to identify outpatient sources that were previously grouped under code 1. The source facilities included in the previous code 1 (hospital inpatient and outpatient) are split between codes 1, 2, and 8.*

Type of Reporting Source Code Definitions

Code	Label	Source Documents	Priority

1	Hospital inpatient; Managed health plans with comprehensive, unified medical records **(new code definition effective with diagnosis on or after 1/1/2006)**	• Hospital inpatient
		• Offices/facilities with unit record
		  • HMO physician office or group
		  • HMO affiliated free-standing laboratory, surgery, radiation or oncology clinic
		
		Includes outpatient services of HMOs and large multi-specialty physician group practices with unit record.
			1

2	Radiation Treatment Centers or Medical Oncology Centers (hospital-affiliated or independent) **(effective with diagnosis on or after 1/1/2006)**	• Facilities with serial record (not a unit record)
		  • Radiation treatment centers
		  • Medical oncology centers (hospital affiliated or independent)
		
		There were no source documents from code 1.
			2

3	Laboratory Only (hospital affiliated or independent)	• Laboratory with serial record (not a unit record) There were no source documents from codes 1, 2, 8, or 4.	5
4	Physician's Office/Private Medical Practitioner (LMD)	• Physician's office that is NOT an HMO or large multi-specialty physician group practice. There were no source documents from codes 1, 2 or 8.	4
5	Nursing/Convalescent Home/Hospice	• Nursing or convalescent home or a hospice. There were no source documents from codes 1, 2, 8, 4, or 3.	6
6	Autopsy Only	• Autopsy The cancer was first diagnosed on autopsy. There are no source documents from codes 1, 2, 8, 4, 3, or 5.	7
7	Death Certificate Only	• Death certificate Death certificate is the only source of information; follow-back activities did not identify source documents from codes 1, 2, 8, 4, 3, 5 or 6. If another source document is subsequently identified, the Type of Reporting Source code must be changed to the appropriate code in the range of 1, 2, 8, 4, 3 or 6.	8
8	Other hospital outpatient units/surgery centers **(effective with diagnosis on or after 1/1/2006)**	• Other hospital outpatient units/surgery centers. Includes, but not limited to, outpatient surgery and nuclear medicine services. There are no source documents from codes 1 or 2.	3

DATE OF HEMATOLOGIC TRANSPLANT/ ENDOCRINE PROCEDURE

Item Length: 2
NAACCR Item N/A
Source of Standard: MCR
Dx Yr Req by MCR: All

***Description*:** *Records the date of initiation of hematopoietic transplant or endocrine procedure that is part of the first course of treatment.*

Instructions for Coding

- Record the first or earliest date on which a hematopoietic transplant or endocrine procedure was performed by any facility.

- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for ***Date of Hematopoietic Transplant/Endocrine Procedure*** is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of ***Date of Hematopoietic Transplant/Endocrine Procedure*** transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable.

Date of Hematologic Transplant/Endocrine Procedure is not an official NAACCR data item; however, a date must be entered in order to enter ***Rx Summ--Transplant/Endocrine*** codes (NAACCR Item #3250) in the registry software that most Maine hospitals use.

PHYSICIAN – MANAGING (PREVIOUSLY ATTENDING)	Item Length: 6 NAACCR Item #2460 Source of Standard: NAACCR (Revised 01/2010) Dx Yr Reg by MCR: All

Description: Code for the physician/clinician who is responsible for the overall management of the patient during diagnosis and/or treatment for this cancer.

Instructions for Coding (See current version of *NAACCR Volume II, Data Standards and Data Dictionary*)

- Record the identification code for the physician/clinician responsible for the management of the patient during diagnosis and/or treatment of this cancer.
- Do not change or update this field even if the patient subsequently receives care from another physician/clinician.

For medical doctors and doctors of osteopathy use the 5-digit Maine license number, omitting the "M" or the "O" and leading 0 (zero) if applicable. For physician assistants and nurse practitioners, retain the PA and R respectively.

If registry software has a data field for license number in the physician database, enter the Maine license number in the above format in that field as well.

Example1: If Dr Smith's Maine license number is M009999, then use the code 09999 for his ID number and enter 09999 in the license number field.

Example2: If Family Nurse Practitioner Jane Doe's license number is R009999, then use the code R9999 for her ID number and enter R9999 in the license number field.

License numbers for Maine clinicians may be found on the following websites:

- For medical doctors and physician assistants, go to the Maine Board of Licensure in Medicine website @ www.docboard.org/me/df/mesearch.htm
- For doctors of osteopathy, go to the Maine Board of Osteopathic Licensure website @ www.docboard.org/me-osteo/df/index.htm
- For nurse practitioners, go to the Maine State Board of Nursing website @ https://portal.maine.gov/nlv/bnxdev.license_search.main_page

Note: *As of January 1, 2003, this data item is no longer supported by the CoC.*

PHYSICIAN – REFERRING	Item Length: 6 NAACCR Item #N/A Source of Standard: MCR (Revised 01/2010) Dx Yr Reg by MCR: All

Description: *Code for the referring physician/clinician. Often this is the Primary Care Provider (PCP).*

Instructions for Coding: (Maine Cancer Registry defined data item)

- Record the identification code for the referring physician/clinician. This is often the patient's primary care provider (PCP).

For medical doctors and doctors of osteopathy use the 5-digit Maine license number, omitting the "M" or the "O" and leading 0 (zero) if applicable. For physician assistants and nurse practitioners, retain the PA and R respectively.

If registry software has a data field for license number in the physician database, enter the Maine license number in the above format in that field as well.

> ***Example1:*** If Dr Smith's Maine license number is M009999, then use the code 09999 for his ID number and enter 09999 in the license number field.
>
> ***Example2:*** If Family Nurse Practitioner Jane Doe's license number is R009999, then use the code R9999 for her ID number and enter R9999 in the license number field.

License numbers for Maine clinicians may be found on the following websites:

- For medical doctors and physician assistants, go to the Maine Board of Licensure in Medicine website @ www.docboard.org/me/df/mesearch.htm
- For doctors of osteopathy, go to the Maine Board of Osteopathic Licensure website @ www.docboard.org/me-osteo/df/index.htm
- For nurse practitioners, go to the Maine State Board of Nursing website @ https://portal.maine.gov/nlv/bnxdev.license_search.main_page

Text Fields

Text documentation is an essential component of a complete electronic abstract and is utilized extensively for quality control at MCR. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High quality text documentation facilitates consolidation of information from multiple reporting sources and the resolution of both intra- and inter-record edits. All text fields are required when the information is available and/or applicable.

If the patient is age 14 or older there must be something entered in the Text--Usual Industry and Text--Usual Occupation fields. The associated edits are:

- Age at Diagnosis, Text--Usual Industry (NAACCR)
- Age at Diagnosis, Text--Usual Occupation (NAACCR)

There must be text documentation for primary site and histology. The associated edits are:

- Text--Primary Site Title (NAACCR)
- Text--Histology Title (NAACCR)

If the cancer was microscopically confirmed there must be something entered in the Text--Dx Proc--Path field. The associated edit is:

- Text--Dx Proc--Path, Diagnostic Confirm (NAACCR)

If treatment is coded there must be something entered in the corresponding text field. The associated edits are:

- Rx Date--Surgery, Rx Text--Surgery (NAACCR)
- Rx Summ--BRM, Text--BRM (NAACCR)
- Rx Summ--Chemo, Text--Chemo (NAACCR)
- Rx Summ--Hormone, Text--Hormone (NAACCR)
- Rx Summ--Other, Text--Other (NAACCR)
- Rx Summ--Radiation, Text--Radiation (NAACCR)

General Guidelines

- ✓ Use text fields to justify coded data items in the abstract. After manual entry of a text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the record.

- ✓ Do not report non-cancer related information such as psychiatric status or social issues to the MCR. If you need to record these for your institution, check with your software provider for your confidential text field.

- ✓ DO NOT REPORT HIV/AIDS STATUS to the MCR, even if related to cancer.

- ✓ Do not send messages to the MCR in text fields (such as "please confirm stage"); these fields are not routinely 100 % reviewed. If you want something checked by MCR staff, send a note along with the data submission or call the MCR staff person assigned to your hospital for assistance.

TEXT--DX PROC--PE	Item Length: 1000 NAACCR Item #2520 Source of Standard: NPCR (Revised 01/2010) Dx Yr Req by MCR: All

Description: *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.*

Instructions for Coding (See current version of *NAACCR Volume II, Data Standards and Data Dictionary)*

- The text field must contain a description that has been entered by the abstractor independently from the code(s). Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values. After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes. The text should justify the code(s) and not vice versa.
- Text automatically generated from coded data is not acceptable.
- Record relevant positive and negative clinical findings.
- NAACCR-approved abbreviations should be utilized. See Appendix E in this manual.
- Additional comments can be continued in empty fields including "Remarks".
- Do not include irrelevant information.

Suggestions for text: Include disease related findings on physical exam and/or presenting symptoms; information regarding estimated date of diagnosis and method of diagnosis.

If the Date of Diagnosis is based on clinical findings or a clinician's statement, be sure to document the method and date of diagnosis (see Ambiguous Terminology in Section Two).

***Example*: Date of Dx per Dr. Jones statement in 01/15/10 H&P "probably carcinoma."**

- **Do not include information that MCR is not authorized to collect. (i.e., AIDS or HIV status)**

TEXT--DX PROC--XRAY/SCAN	Item Length: 1000 NAACCR Item #2530 Source of Standard: NPCR (Revised 01/2010) Dx Yr Req by MCR: All

Description: *Text area for manual documentation from all x-rays, scans and/or other imaging examinations that provide information about staging.*

Instructions for Coding (See current version of *NAACCR Volume II, Data Standards and Data Dictionary)*

- The text field must contain a description that has been entered by the abstractor independently from the code(s). Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values. After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes. The text should justify the code(s) and not vice versa.
- Text automatically generated from coded data is not acceptable.
- Record relevant positive and negative finding on radiographic or other imaging studies.
- NAACCR-approved abbreviations should be utilized. See Appendix E in this manual.
- Additional comments can be continued in empty fields including "Remarks".
- Do not include irrelevant information.

Suggestions for text: Include disease related findings on imaging examinations, including x-rays, mammograms, ultrasounds, CT scans, MRIs, PET scans, etc. Include the date the study was performed.

If the Date of Diagnosis is based on findings on an imaging examination, be sure that the terminology in the imaging report and the text documentation in this data item support a reportable diagnosis (see Ambiguous Terminology in Section Two).

- **Do not include information that MCR is not authorized to collect. (i.e., AIDS or HIV status)**

TEXT--DX PROC--SCOPES	Item Length: 1000 NAACCR Item #2540 Source of Standard: NPCR (Revised 01/2010) Dx Yr Reg by MCR: All

Description: *Text area for manual documentation from endoscopic examinations that provide information about staging and treatment.*

Instructions for Coding (See current version of *NAACCR Volume II, Data Standards and Data Dictionary)*

- The text field must contain a description that has been entered by the abstractor independently from the code(s). Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values. After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes. The text should justify the code(s) and not vice versa.
- Text automatically generated from coded data is not acceptable.
- Record relevant positive and negative endoscopic findings.
- NAACCR-approved abbreviations should be utilized. See Appendix E in this manual.
- Additional comments can be continued in empty fields including "Remarks".
- Do not include irrelevant information.

Suggestions for text: Include disease related findings on endoscopic examinations including colonoscopy, esophagogastroduodenoscopy (EGD), laryngoscopy, bronchoscopy, endoscopic retrograde cholangiopancreatography (ERCP), etc. Include the date the study was performed.

If the Date of Diagnosis is based on endoscopic findings, be sure that the terminology in the endoscopic/operative report and the text documentation in this data item support a reportable diagnosis (see Ambiguous Terminology in Section Two).

- **Do not include information that MCR is not authorized to collect. (i.e., AIDS or HIV status)**

TEXT--DX PROC--LAB TESTS	Item Length: 1000 NAACCR Item #2550 Source of Standard: NPCR (Revised 01/2010) Dx Yr Reg by MCR: All

Description: *Text area for manual documentation from laboratory examinations other than cytology or histopathology.*

Instructions for Coding (See current version of *NAACCR Volume II, Data Standards and Data Dictionary)*

- The text field must contain a description that has been entered by the abstractor independently from the code(s). Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values. After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes. The text should justify the code(s) and not vice versa.
- Text automatically generated from coded data is not acceptable.
- Record relevant positive and negative laboratory findings.
- NAACCR-approved abbreviations should be utilized (See Appendix E in this manual).
- Additional comments can be continued in empty fields including "Remarks".
- Do not include irrelevant information.

Suggestions for text: Include disease related findings on clinical laboratory tests including, but limited to, tumor markers, serum and urine electrophoresis, special studies, etc.

- **Colorectal Cancer: Carcinoembryonic Antigen (CEA)**
- **Breast Cancer:Estrogen Receptor Assay (ERA); Progesterone Receptor Assay (PRA); Her/2-neu**
- **Ovarian Cancer: Carbohydrate Antigen (CA-125)**
- **Prostate Cancer: Prostatic Specific Antigen (PSA)**
- **Testicular Cancer: Human Chorionic Gonadotropin (hCG); Alpha Fetaprotein (AFP); Lactate Dehydrogenase (LDH)**

- **Do not include information that the MCR is not authorized to collect. (i.e., AIDS or HIV status)**

TEXT--DX PROC--OP	Item Length: 1000 NAACCR Item #2560 Source of Standard: NPCR (Revised 01/2010) Dx Yr Reg by MCR: All

Description: *Text area for manual documentation of all surgical procedures/findings that provide information for staging.*

Instructions for Coding (See current version of *NAACCR Volume II, Data Standards and Data Dictionary)*

- The text field must contain a description that has been entered by the abstractor independently from the code(s). Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values. After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes. The text should justify the code(s) and not vice versa.
- Text automatically generated from coded data is not acceptable.
- Record relevant positive and negative surgical findings.
- NAACCR-approved abbreviations should be utilized. See Appendix E in this manual.
- Additional comments can be continued in empty fields including "Remarks".
- Do not include irrelevant information.

Suggestions for text: Include dates and descriptions of biopsies and other surgical procedures from which staging information was derived. Record disease related findings on operative notes that will not be recorded elsewhere in text fields, such as local/regional spread, residual tumor and nodal assessment.

If the Date of Diagnosis is based on operative findings, be sure that the terminology in the operative report and the text documentation in this data item support a reportable diagnosis (see Ambiguous Terminology in Section Two).

- **Do not include information that MCR is not authorized to collect. (i.e., AIDS or HIV status)**

TEXT--DX PROC--PATH	Item Length: 1000 NAACCR Item #2570 Source of Standard: NPCR (Revised 01/2010) Dx Yr Reg by MCR: All

Description: *Text area for manual documentation of information from cytology and histopathology reports.*

Instructions for Coding (See current version of *NAACCR Volume II, Data Standards and Data Dictionary)*

- The text field must contain a description that has been entered by the abstractor independently from the code(s). Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values. After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes. The text should justify the code(s) and not vice versa.
- Text automatically generated from coded data is not acceptable.
- Record relevant positive and negative pathologic findings.
- NAACCR-approved abbreviations should be utilized. See Appendix E in this manual.
- Additional comments can be continued in empty fields including "Remarks".
- Do not include irrelevant information.

Suggestions for text: Include dates and types of procedures; types of tissue specimens; pathology accession numbers; tumor type and grade (include modifying adjectives such as predominantly, with features of, with foci of, etc); gross tumor size; extent of tumor spread; status of surgical margins; number of lymph nodes involved and examined; any relevant additional comments from the pathologist.

Example 1 : 06/15/10 L Upper Lobectomy/Mediastinal LN Dissection (S10-9999999) 4.5cm nonsmall cell carcinoma with squamous differentiation invades visceral pleura ; margins clear; 0/10 mediastinal lymph nodes.

Example 2: 6/15/10 Lumpectomy L Breast (S10-888888) 1.5cm infiltrating ductal carcinoma cribriform type; margins clear

- **Do not include information that MCR is not authorized to collect. (i.e., AIDS or HIV status)**

TEXT--PRIMARY SITE TITLE	Item Length: 100 NAACCR Item #2580 Source of Standard: NPCR (Revised 01/2011) Dx Yr Reg by MCR: All

Description: *Text area for manual documentation of information regarding the primary site and laterality of the tumor.*

Instructions for Coding (See current version of *NAACCR Volume II, Data Standards and Data Dictionary)*

- The text field must contain a description that has been entered by the abstractor independently from the code(s). Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values. After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes. The text should justify the code(s) and not vice versa.

- Text automatically generated from coded data is not acceptable.

- NAACCR-approved abbreviations should be utilized. See Appendix E in this manual.

Suggestions for text: Include the most specific information available on the location of the primary site of the tumor, including subsite, also state available information on tumor laterality for pair sites.

Example 1: Right Breast UOQ
Example 2: Lung LUL

- **If it was necessary to apply the Multiple Primary and Histology Coding (MP/H) Rules because multiple tumors were present, please document the MP/H rule that determined the number of abstracts that you created.**
- **Do not include information that MCR is not authorized to collect. (i.e., AIDS or HIV status)**

TEXT--HISTOLOGY TITLE	Item Length: 100 NAACCR Item #2590 Source of Standard: NPCR (Revised 01/2011) Dx Yr Reg by MCR: All

Description: *Text area for manual documentation of information regarding the histologic type (morphology), behavior, and grade (differentiation) of the tumor being reported.*

Instructions for Coding (See current version of *NAACCR Volume II, Data Standards and Data Dictionary)*

- The text field must contain a description that has been entered by the abstractor independently from the code(s). Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values. After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes. The text should justify the code(s) and not vice versa.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized. See Appendix E in this manual.
- Do not include irrelevant information.

Suggestions for text: Include information on histologic type (morphology) and behavior, as well as, information on differentiation/grade from scoring systems such as Gleason's Score, Bloom-Richardson Grade, etc. See Data Item #440 Grade/differentiation for grading terminology conversion tables.

Example 1: Mod Diff Adenoca in a Tubulovillous Adenoma
Exampe 2: Adenocarcinoma Gleason 3+4=7
Example 3: Papillary Urothelial Ca Grade II of III

- **Please document the applicable Multiple Primary and Histology Coding (MP/H) Rule**
- **Do not include information that MCR is not authorized to collect. (i.e., AIDS or HIV status)**

TEXT--STAGING	Item Length: 1000 NAACCR Item #2600 Source of Standard: NPCR (Revised 01/2010) Dx Yr Reg by MCR: All

Description: *Additional text area for manual documentation of staging information.*

Instructions for Coding (See current version of *NAACCR Volume II, Data Standards and Data Dictionary)*

- The text field must contain a description that has been entered by the abstractor independently from the code(s). Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values. After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes. The text should justify the code(s) and not vice versa.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized. See Appendix E in this manual.
- Additional comments can be continued in empty fields including "Remarks".
- Do not include irrelevant information.

Suggestions for text: Provide a narrative description to justify the coded staging values for this tumor. Include tumor size and/or extension (T status); presence or absence of nodal involvement (N status); presence or absence of distant metastasis (M status) including the distant sites involved. Do not simply repeat the coded TNM values, SEER Summary Stage values or Collaborative Stage codes.

Remember: Describe the extent of disease whether or not AJCC staging is applicable or will be derived. Every tumor is eligible for SEER Summary Staging even if it is not eligible for AJCC (TNM) staging.

- **Do not include information that MCR is not authorized to collect. (i.e., AIDS or HIV status)**

RX TEXT--SURGERY	Item Length: 1000 NAACCR Item #2610 Source of Standard: NPCR (Revised 01/2010) Dx Yr Reg by MCR: All

Description: *Text area for manual documentation of information regarding all surgical procedures performed as part of treatment.*

Instructions for Coding (See current version of *NAACCR Volume II, Data Standards and Data Dictionary)*

- The text field must contain a description that has been entered by the abstractor independently from the code(s). Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values. After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes. The text should justify the code(s) and not vice versa.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized. See Appendix E in this manual.
- Additional comments can be continued in empty fields including "Remarks".
- Do not include irrelevant information.

Suggestions for text: Include date and description/type of each surgical procedure; the facility where each procedure was performed; the name of the physician who performed each procedure. If multiple procedures were performed, all procedures should be documented.

Example 1: 6/15/05 Colonoscopy w/ Biopsy @ Hospital Name (Physician)
7/15/05 Sigmoid Resection @ hospital name (Physician)

Example 2: 6/15/05 Stereotactic Biopsy Left Breast @ Hospital Name (Physician)

7/15/05 Lumpectomy L Breast w/ SLN and Axillary Dissection @ Hospital Name (Physician)

If surgical treatment was considered standard of care for the case you are abstracting, but surgery was not performed, document in this field the reason that it was not performed, if known.

- **Do not include information that MCR is not authorized to collect. (i.e., AIDS or HIV status)**

RX TEXT--RADIATION (BEAM)	Item Length: 1000 NAACCR Item #2620 Source of Standard: NPCR (Revised 01/2010) Dx Yr Reg by MCR: 2005+

Description: *Text area for manual documentation of information regarding treatment of the tumor being reported with beam radiation*

Instructions for Coding (See current version of *NAACCR Volume II, Data Standards and Data Dictionary)*

- The text field must contain a description that has been entered by the abstractor independently from the code(s). Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values. After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes. The text should justify the code(s) and not vice versa.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized. See Appendix E in this manual.
- Additional comments can be continued in empty fields including "Remarks".
- Do not include irrelevant information.

Suggestions for text: Include dates when radiation treatment started and ended; site(s) irradiated; tumor dose(s); type(s) of beam radiation (e.g., Orthovoltage, Cobalt 60, MV x-rays, Electrons, Mixed modalities); facility where treatment was given.

If external beam radiation was considered standard of care for the case you are abstracting, but beam radiation was not administered, document in this field the reason that it was not administered, if known.

- **Do not include information that MCR is not authorized to collect. (i.e., AIDS or HIV status)**

RX TEXT--RADIATION (OTHER)	Item Length: 1000 NAACCR Item #2630 Source of Standard: NPCR (Revised 01/2010) Dx Yr Reg by MCR: 2005+

Description: *Text area for manual documentation of information regarding treatment of tumor being reported with radiation other than beam radiation. This includes brachytherapy and systemic radiation therapy.*

Instructions for Coding (See current version of *NAACCR Volume II, Data Standards and Data Dictionary)*

- The text field must contain a description that has been entered by the abstractor independently from the code(s). Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values. After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes. The text should justify the code(s) and not vice versa.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized. See Appendix E in this manual.
- Additional comments can be continued in empty fields including "Remarks".
- Do not include irrelevant information.

Suggestions for text: Include date treatment was started; site(s) irradiated; type(s) of non-beam radiation (e.g., high dose rate brachytherapy, seed implant, radioisotopes such as I-131); facility where treatment was given.

If other radiation, such as brachytherapy or radioisotopes, was considered standard of care for the case you are abstracting, but other radiation was not administered, document in this field the reason that it was not administered, if known.

- **Do not include information that MCR is not authorized to collect. (i.e., AIDS or HIV status)**

RX TEXT--CHEMO	Item Length: 1000 NAACCR Item #2640 Source of Standard: NPCR (Revised 01/2010) Dx Yr Reg by MCR: 2005+

Description: *Text area for manual documentation of information regarding chemotherapy treatment of the reported tumor.*

Instructions for Coding (See current version of *NAACCR Volume II, Data Standards and Data Dictionary)*

- The text field must contain a description that has been entered by the abstractor independently from the code(s). Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values. After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes. The text should justify the code(s) and not vice versa.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized. See Appendix E in this manual.
- Additional comments can be continued in empty fields including "Remarks".
- Do not include irrelevant information.

Refer to *SEER*Rx*, an interactive antineoplastic drugs database for coding oncology drugs and regimens.

Suggestions for text: Include date when chemotherapy was started; type of chemotherapy (e.g., name of agent(s) or protocol); facility where treatment was given.

If chemotherapy was considered standard of care for the case you are abstracting, but chemotherapy was not administered, document in this field the reason that it was not administered, if known.

- **Do not include information that MCR is not authorized to collect. (i.e., AIDS or HIV status)**

RX TEXT--HORMONE	Item Length: 1000 NAACCR Item #2650 Source of Standard: NPCR (Revised 01/2010) Dx Yr Reg by MCR: 2005+

Description: *Text area for manual documentation of information about hormonal cancer-directed treatment.*

Instructions for Coding (See current version of *NAACCR Volume II, Data Standards and Data Dictionary)*

- The text field must contain a description that has been entered by the abstractor independently from the code(s). Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values. After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes. The text should justify the code(s) and not vice versa.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized. See Appendix E in this manual.
- Additional comments can be continued in empty fields including "Remarks".
- Do not include irrelevant information.

Refer to *SEER*Rx*, an interactive antineoplastic drugs database for coding oncology drugs and regimens.

Suggestions for text: Include date treatment was started; type of hormone or antihormone (e.g., Tamoxifen); type of endocrine surgery/radiation treatment (e.g., bilateral orchiectomy); and the facility where treatment was given.

Note: **Until 2003 endocrine surgeries and radiation treatments that were performed for hormonal manipulation were coded as "*Hormone Therapy*". With *FORDS*, these therapies were reclassified as "*Hematologic Transplant and /or Endocrine Procedures*". There is no text field for "*Hematologic Transplant and /or Endocrine Procedures*" so continue to document endocrine procedures in the "*Hormone*" text field until the new text field is added to the data set.**

If hormone therapy was considered standard of care for the case you are abstracting, but hormone therapy was not administered, document in this field the reason that it was not administered, if known.

- **Do not include information that MCR is not authorized to collect. (i.e., AIDS or HIV status)**

RX TEXT--BRM [IMMUNOTHERAPY]	Item Length: 1000 NAACCR Item #2660 Source of Standard: NPCR (Revised 01/2010) Dx Yr Reg by MCR: 2005+

Description: *Text area for manual documentation of information regarding the treatment of the tumor being reported with biological response modifiers or immunotherapy.*

Instructions for Coding (See current version of *NAACCR Volume II, Data Standards and Data Dictionary)*

- The text field must contain a description that has been entered by the abstractor independently from the code(s). Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values. After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes. The text should justify the code(s) and not vice versa.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized. See Appendix E in this manual.
- Additional comments can be continued in empty fields including "Remarks".
- Do not include irrelevant information.

Refer to *SEER*Rx*, an interactive antineoplastic drugs database for coding oncology drugs and regimens.

Suggestions for text: Include date treatment was started; type of BRM agent (e.g., Interferon, BCG); BRM procedures (e.g., bone marrow transplant, stem cell harvest and infusion); and the facility where treatment was given.

Note: **Until 2003 bone marrow transplants and stem cell harvest & infusions were coded as "*Biological Response Modifiers*". With *FORDS*, these therapies were reclassified as "*Hematologic Transplant and /or Endocrine Procedures*".**
There is no text field for "*Hematologic Transplant and /or Endocrine Procedures*" so continue to document bone marrow transplants and stem cell harvest/infusions in the "*BRM*" text field until the new text field is added to the data set.

If immunotherapy (BRM) was considered standard of care for the case you are abstracting, but immunotherapy was not performed, document in this field the reason that it was not administered, if known.

- **Do not include information that MCR is not authorized to collect. (i.e., AIDS or HIV status)**

RX TEXT--OTHER	Item Length: 1000 NAACCR Item #2670 Source of Standard: NPCR (Revised 01/2010) Dx Yr Reg by MCR: 2005+

Description: *Text area for manual documentation of information regarding the treatment of the tumor being reported with treatment that cannot be defined as surgery, radiation, or systemic therapy. This includes experimental treatments (when the mechanism of action for a drug is unknown), and blinded clinical trials. If the mechanism of action for the experimental drug is known, code to the appropriate treatment field.*

Instructions for Coding (See current version of *NAACCR Volume II, Data Standards and Data Dictionary)*

- The text field must contain a description that has been entered by the abstractor independently from the code(s). Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values. After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes. The text should justify the code(s) and not vice versa.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized. See Appendix E in this manual.
- Additional comments can be continued in empty fields including "Remarks".
- Do not include irrelevant information.

Refer to *SEER*Rx*, an interactive antineoplastic drugs database for coding oncology drugs and regimens.

Suggestions for text: Include the date treatment was started; type of other treatment (e.g., blinded clinical trial, hyperthemia); facility where the treatment was given.

- **Do not include information that MCR is not authorized to collect. (i.e., AIDS or HIV status)**

TEXT--REMARKS	Item Length: 1000 NAACCR Item #2680 Source of Standard: NPCR (Revised 01/2010) Dx Yr Reg by MCR: 2005+

Description: *Text area for manual documentation of information that is given only in coded form elsewhere or for which the abstract provides no other place. Overflow data from other text fields can also be placed here. Problematic coding issues can also be discussed in this section.*

Instructions for Coding (See current version of *NAACCR Volume II, Data Standards and Data Dictionary)*

- The text field must contain a description that has been entered by the abstractor independently from the code(s). Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values. After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes. The text should justify the code(s) and not vice versa.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized. See Appendix E in this manual.
- Additional comments can be continued in empty fields including "Remarks".
- Do not include irrelevant information.

Suggestions for text: Include information on cancer history if a person was previously diagnosed with another reportable tumor; information regarding synchronous tumors; justification of over-ride flags; any relevant information not documented in another text field.

Use this field to summarize as much as possible about nonanalytic/recurrent cases, including the reason the person was seen and/or treated at your facility. Document anything you know about the initial diagnosis and treatment, including where the diagnosis was made and/or the treatment was given.

- **Do not include information that MCR is not authorized to collect. (i.e., AIDS or HIV status)**

TEXT--USUAL OCCUPATION [LONGEST OCCUPATION]	Item Length: 100 NAACCR Item #310 Source of Standard: NPCR (Revised 01/2010) Dx Yr Req by MCR: All

Description: *Text area for information about the patient's usual or longest occupation, also known as usual type of job or work.*

Instructions for Coding (See current version of *NAACCR Volume II, Data Standards and Data Dictionary)*

- Record the patient's usual occupation (i.e., the kind of work performed during most of the patient's working life before diagnosis of this tumor). Do not record "retired". If usual occupation is not available or is unknown, record the patient's current or most recent occupation, or any available occupation.

- If the patient was a homemaker and also worked outside the home during most of his/her adult life, record the usual occupation outside the home; if the patient was a homemaker and did not work outside the home for most of his/her adult life, record "homemaker."

- If the patient was not a student or homemaker and never worked, record "never worked" as the usual occupation.

- If no information is available, record "unknown."

- This data item is collected only for patients who are age 14 or older at the time of diagnosis

TEXT--USUAL INDUSTRY **[LONGEST INDUSTRY]**	Item Length: 100 NAACCR Item #320 Source of Standard: NPCR (Revised 01/2010) Dx Yr Req by MCR: All

Description: *Text area for information about the patient's usual or longest industry, also known as usual kind of business/industry.*

Instructions for Coding (See current version of *NAACCR Volume II, Data Standards and Data Dictionary)*

- Record the primary type of activity carried out by the business/industry at the location where the patient was employed for the most number of years before diagnosis of this tumor. Be sure to distinguish among "manufacturing," "wholesale," "retail" and service components of any industry that performs more than one of these components.

- The information should be based upon the information about occupation; therefore, if current or most recent occupation rather than usual occupation was recorded, record the patient's current or most recent business/industry.

- If the patient was a homemaker and did not work outside the home for most of his/her adult life, record "own home" as usual industry.

- If the patient was not a student or homemaker and had never worked outside the home record "never worked" as the usual industry.

- If no information is available regarding the industry in which the reported occupation was carried out, record "unknown."

- This data item is collected only for patients who are age 14 or older at the time of diagnosis.

TEXT--PLACE OF DIAGNOSIS	Item Length: 60 NAACCR Item #2690 Source of Standard: NPCR (Revised: 01/2010) Dx Yr Reg by MCR: 2005+

Description: *Text area for manual documentation of the facility, physician office, city, state or county where the diagnosis was made.*

Instructions for Coding (See current version of *NAACCR Volume II, Data Standards and Data Dictionary)*

- The text field must contain a description that has been entered by the abstractor independently from the code(s). Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values. After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes. The text should justify the code(s) and not vice versa.

- Additional comments can be continued in empty fields including "Remarks".

- Do not include irrelevant information.

Suggestions for text: Include the complete name of the hospital or physician office where the diagnosis occurred. For out-of-state residents and facilities, include the city and state where the medical facility is located.

- **Do not include information that MCR is not authorized to collect. (i.e., AIDS or HIV status)**

ICD-O-3 CONVERSION FLAG	Item Length: 1 NAACCR Item #2116 Source of Standard: SEER/CoC (Revised 01/2010) Dx Yr Reg by MCR: 2007+

Description: *Code specifying how the conversion of site and morphology codes from ICD-O-2 to ICD-O-3 was accomplished.*

Instructions for Coding: (See current version of the *SEER Program Coding and Staging Manual)*

- Codes 0 and 1 are auto-coded by the software provider.

- Code 3 is manually entered following review of the automated morphology conversion from ICD-0-2 to ICD-O-3.

Code	Description
0	Morphology (Morph – Type & Behavior ICD-O-3) originally coded in ICD-O-3
1	Morphology (Morph – Type & Behavior ICD-O-3) converted from (Morph – Type & Behavior ICD-O-2) without review.
3	Morphology (Morph – Type & Behavior ICD-O-3) converted from (Morph – Type & Behavior ICD-O-2) with review.
Blank	Not converted (clarification for cases diagnosed as of January 1, 2007; cases coded in prior ICD-O version and not converted to ICD-O-3.

This flag defaults to Code 0 when cases diagnosed on or after January 1, 2001 are abstracted.

Use Code 3 when abstracting cases diagnosed prior to 2001. Histology must be coded in both ICD-O-2 and ICD-O-3 for cases diagnosed prior to 2001.

FIRST COURSE CALC METHOD	Item Length: 1 NAACCR Item #1500 Source of Standard: NAACCR Dx Yr Req by MCR: All

Description: *Code indicating the time interval for defining first cource of therapy.*

The NAACCR record layout provides two data items that indicate the date of the start of first course treatment. ***Date of 1st Crs RX--CoC*** *as defined by the CoC and* ***Date of Initial RX--SEER*** *as defined by SEER. The difference between the two is that CoC defines the date the physician decides not to treat the patient as the date of initial treatment, while SEER considers such a decision to be no treatment and the date is recorded as zeros.*

Instructions for Coding: (See current version of *NAACCR Volume II, Data Standards and Data Dictionary*)

- System default value must be set to 1.

Maine Cancer Registry utilizes the Commission on Cancer (CoC) definitions for Date of First Course Treatment. System default value must be set to 1.

Code	Description
1	CoC definitions
2	SEER definitions
9	Other, unknown

DATE OF DIAGNOSIS FLAG	Item Length: 2 NAACCR Item #391 Source of Standard: NAACCR (Revised 01/2011) Dx Yr Reg by MCR: 2010

Description: This flag explains why no appropriate value is in the field, Date of Diagnosis [NAACCR Item #390]. This data item was first available effective January 2010.

Before NAACCR Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Instructions for Coding: (See current version of *NAACCR Volume II, Data Standards and Data Dictionary*)

Code	Description
Blank	Leave this item blank if a valid full or partial date is provided in item *Date of Diagnosis* [NAACCR Item #390].
12	A proper value is applicable but not known. (e.g., date of diagnosis is unknown - 9999/99/99)

Estimate the date of diagnosis if at all possible; however, if it is not possible to estimate the year of diagnosis, code 12 must be entered in this field.

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date of First Diagnosis* (NAACCR Item #390) and *Date of Diagnosis Flag* (NAACCR Item #391). ***In the table below, the lowercase letter "b" is used to represent each blank space.***

Description	**Traditional Date of Diagnosis** **Date entered in MMDDCCYY sequence; unknown portions represented by 99 or 9999**	**Interoperative Date of Diagnosis** **Date entered in CCYYMMDD sequence, leaving unknown portions blank (spaces); omit the date if the date is completely unknown.**	**Date of Diagnosis Flag**
Full date known	MMDDCCYY (example: 02182010)	CCYYMMDD (example: 20100218)	bb
Month and year known	MM99CCYY (example: 02992010)	CCYYMMbb (example: 201002bb)	bb
Year only known	9999CCYY (example: 99992010)	CCYYbbbb (example: 2010bbbb)	bb
Unknown date	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	12