Welcome to the 2015 Data Changes Overview.

- **2015 Data Changes**
  - New Data Items
  - Revised Data Items
  - ICD-0-3
    - Reportability Change
  - New ICDO Terms and Codes
  - SEER Reportability Clarifications
  - CCR Updates
  - General Info-Reminders

- **NEW DATA ITEMS FOR 2015**
  - No New Data Fields for hospitals

- There are no new fields/data items for 2015
- Several new survival data items apply only to central registries which will not be reviewed in this presentation.
There are 2 additional codes for patient sex...
Code 5 Transsexual, natal male, and
Code 6 Transsexual, natal female.

These codes were necessary to allow for identification of persons
who are transsexual (transgender), and to document an individuals
gender at birth (even though that person may now be living as the
opposite gender).

The former Code 4 has been revised to “Transsexual NOS”,
previously it was simply TRANSEXUAL.

It is very important that registrars document in TEXT patient sex for
ALL cases, and when you have a patient who is transsexual.

The allowable values for the country data items have been
modified. Previously Yugoslavia and Czechoslovakia were only used
as historic codes, and only for Birthplace—Country. This restriction
caused complications; therefore a decision was made to allow these
codes to be used for ANY of the country data items, and to replace
the historic-use-only (‘X’) codes with the ISO codes.

The ISO is the International Organization for Standardization who
defines codes for countries and independent territories.

The codes for Brunei, Slovakia and Vanuatu have been
revised/corrected to be in line with the ISO codes And .....
A NEW BULLET WAS ADDED to the coding instructions for Class of Case. The new wording essentially replaces the term “staff physician” with a more descriptive clarifying narrative. This additionally clarifies that treatment provided in the office of a physician with admitting privileges is considered “treatment elsewhere” which will affect class of case code assignments. The term “staff physician” was not being interpreted consistently by registrars and facilities, and this description will hopefully make the distinction more clear and help assigning class of case.

Modified wording for Class of Case codes 10, 11, 12, and 41.

For all Class of Case codes 10, 11, 12 and 41, the wording has been changed; Staff physician has been removed and replaced with “in an office of a physician with admitting privileges”.

Class of Case descriptions with revised wording
**New Coding Instruction #2:**

- **RE: Purchase of Physician Practice by a Hospital**
  - If the hospital purchases a physician practice, it will be necessary to determine whether the practice is now legally considered part of the hospital, (their activity is coded as the hospital's) or not.
  - If the practice is not legally part of the hospital, it will be necessary to determine whether the physicians involved have routine admitting privileges or not [to your hospital], as with any other physician.
  - Must determine to assign correct class of case code.

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**Coding Instruction Update**

**“IN-TRANSIT” CARE**

**CODE 31:**

- “In-transit” care: Care of a patient who is temporarily away from the patient’s usual practitioner for continuity of care. If these cases are abstracted, they are **Class of Case 31**
- Monitoring of oral medication started elsewhere **Class of Case 31**

**Reporting Requirement Change**

- NOTE: CCR requires **Class of Case 31** to be reported via an abstract - CMR reporting is no longer acceptable

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**REPORTABILITY CHANGE & ICD-10-PCS UPDATES**
Carcinoid tumor of the appendix (C18.1)

- Case is reportable- Must code as behavior 3
- Code histology to 8240/3
- Effective for cases dx 1/1/2015
- Code 8240/1 Carcinoid tumor, NOS of appendix (C181.1) obsolete in 2015

Effective for cases 1/1/2015 we have a NEW reportability requirement for Carcinoid tumors, NOS of the appendix. These tumors are reportable and considered “malignant”.

Code histology to 8240, behavior 3

Note code 8240/1- Carcinoid tumor, NOS of the appendix becomes obsolete is 2015

Two Pancreatic tumors

Same Term - Code Change

<table>
<thead>
<tr>
<th>Condition</th>
<th>Old Code Pre-2015</th>
<th>Code Change 2015 forward</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enteroglucagonoma, NOS (uncertain behavior)</td>
<td>8157/1</td>
<td>8152/1 Can use in 2015</td>
</tr>
<tr>
<td>Enteroglucagonoma, Malignant</td>
<td>8157/3</td>
<td>8152/3 Can use in 2015</td>
</tr>
</tbody>
</table>

Code 8157 is obsolete effective in 2015

NOTE: Reportability rules based on behavior still apply; the addition of /0 or /1 to ICD-0 term does NOT imply it is new reportable (exception is primary intracranial and CNS benign/borderline reportable tumors)

Two Pancreatic tumors have a new histology code, but the terms have not changed.

Enteroglucagonoma, NOS of uncertain behavior as well as Enteroglucagonoma, malignant should be coded to 8152/1 and 8152/3 respectively.

Note: Code 8157 becomes obsolete in 2015

Note: Reportability rules based on behavior code still apply. With the exception of primary intracranial and central nervous system tumors, the addition of behavior code 0 and code 1 (benign or borderline) to a histology code does NOT imply that is now reportable.

ICD-O has been updated and there are now 15 new ICD-O-3 codes of relevance for data collection.

HOWEVER, for diagnosis year 2015 many of these new ICD-O-3 codes cannot be used. Since we will still be collecting CS stage data, these new codes are not included in the CS Scheme, therefore if any of these codes were used, registry software would not be able to determine the correct schema to code, nor run the CS algorithms.

We will review these codes and terms in the upcoming slides.
**NEW Terms and Codes**

- **Pancreatobiliary type carcinoma**
  - Synonym is adenocarcinoma, pancreatobiliary type
    - New code is 8163/3.
    - However, for cases diagnosed in 2015 if you see these terms in the medical record, you are to Use code 8255/3 (Adenocarcinoma with mixed subtypes).

- **Micropapillary carcinoma** NOS (C18. _, C19.9, C20.9)
  - New code is 8265/3
  - In 2015 use code 8507/3 (Intraductal micropapillary ca & substitute behavior of /3 to 8507)

- **Mixed acinar ductal carcinoma**
  - New code 8552/3
  - In 2015 use code 8523/3 (Infiltrating duct mixed with other types of ca- no need to change behavior)

**NEW TERMS AND CODES**

**Serrated Adenocarcinoma**
- New code 8213/3
- In 2015 use code 8213/3 (Serrated adenoma 8213/1: note you change the behavior to a 3).

Then we have two malignant CNS tumors

- **Papillary tumor of pineal region**
  - New code 9361/3.
  - In 2015 use code 9361/3 (pineocytoma 9361/1: note you change the behavior to a 3).

- **Pilomyxoid astrocytoma**
  - New code 9421/3
  - In 2015 Use code 9421/3 (pilocytic astrocytoma 9421/1: note you change the behavior to a 3).

These are all Borderline CNS tumors:

- **Angiocentric glioma**
  - New code 9431/1
  - In 2015 use 9380/1 (glioma, malignant 9380/3 Note; change the behavior to a 1 instead of 3).

- **Pituicytoma**
  - New code 9432/1
  - In 2015 use code 9432/1 (Serratoctoma 9432/1 note you change the behavior to a 3).

- **Papillary Glioneuronal tumor**
  - Synonym/related term: Rosette-forming glioneuronal tumor
  - New code 9509/1
  - In 2015 use code 9505/1 (Ganglioglioma, NOS; no change in behavior needed)
The following are new terms however these conditions are not reportable.

- **Endocrine tumor, functioning, NOS**
  - Related term ACTH producing tumor.
  - **New Code 8158/1**
    Sometimes found in the pituitary gland where they increase the production of adrenal gland hormone Adrenocorticotrophic hormone (ACTH). Can also be found in the bronchus or lung.

- **Low grade appendiceal mucinous neoplasm**
  - **New code 8975/1**
    Can be found at surgery for appendicitis

  - **Calcifying nested epithelial stromal tumors**
    - **Code 8480/1** (new behavior variant of existing code)
      Often found in the liver or intrahepatic bile ducts.

  - **Indolent systemic mastocytosis**
    - **Code 9741/1** (new behavior variant of existing code)
      Proliferation of mast cells in the body; can be noted in cutaneous skin lesions, bone marrow, or other body tissues.

For a list of New ICD-0-3 codes & terms see:

- **2015 ICD-O-3 Coding Crosswalk**
  - Volume I, V.3, Attachment A

To view a comprehensive list of the previously described new ICDO terms and codes, refer to the crosswalk table located in **Volume 1, V.3, Attachment A**
These are newly reportable terms, per the SEER reportability guidelines. Note these all apply to the pancreas.

These new terms are the preferred pathologic terminology to describe these histologic types, but you will note they include the word "neoplasm"; HOWEVER, these terms ARE reportable tumors.

Mature teratoma of the testes in an adult is malignant and reportable.

- An adult is described as someone who is post puberty
- Mature teratoma in a child pre puberty is not reportable.

You cannot rely on a statement of patient age to determine if someone is pre or post puberty. Careful review of the medical record is required to clarify if the patient is “pre” or “post” puberty.

- As a reminder, teratoma of the ovary is a benign condition, therefore NOT reportable.
- Mature teratoma diagnosed prior to puberty is not reportable
- Venous angiomas are not reportable wherever they arise.
If the patient is homeless or transient the CCR directs the following for recording address at diagnosis:

- **Enter street, city and zip code as unknown**
- **Code county of residence to county where hospital is located and**
- **Code the state to California.**
- **Document the patient is “Homeless” or “Transient” in TEXT remarks field.**

**NOTE:** Coding address information for homeless/transient patients in this manner is important from a research perspective. Attempting to code otherwise would be incorrect in California and would skew cluster investigations.

- If the patient is 100 years old or older based on date of birth, **DO NOT FORGET TO DOCUMENT IN TEXT CONFIRMING THE PATIENT’S AGE IS 100(+)**.

- Text documentation in this manner is **required.**

- **Treatment Associated Dates & Date flags as well as ALL other treatment data fields for all modalities ARE REQUIRED TO BE COMPLETED/COLLECTED.**
In addition to the current list of visually edited data items, in 2015 all the treatment fields have been added.

- Note feedback only will be provided for six months from 7/1/2015 through Dec 31 2015 for treatment data.

- Treatment dates and treatment modalities are especially important moving forward with TNM staging to establish and verify those cases with neoadjuvant therapy.

- RX Date flags are auto generated by some registry software so if you don’t know what a date flag is, your software is likely auto-populating them. So no worries. But for those who do manually enter date flags, note that these are on the list of VE item.

- Note that each treatment category and all its data elements are considered a “set”. Any number of discrepancies within the category set only counts as 1 (one) discrepancy.

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- Note feedback only on treatment data will be provided for six months from 7/1/2015 through Dec 31 2015.
For the new VE data items for directly coded Summary Stage and AJCC TNM Stage, feedback will be provided for ONE FULL YEAR prior to discrepancies being counted.

7/1/2015 through 6/30/2016.

For a complete list of visually edited data items please go to the California Cancer Registry website >Registrar Resources > Visually Edited Data Items > Visually Edited Data items for 2015 Data Changes.

Please review the staging timeline so you are clear on when your facility will be required to report directly coded TNM and Summary Stage.

Note that while CS is no longer required in 2016, some prognostic factors which are required for staging and currently captured in CS site specific factors will likely still need to be collected in some fashion. Which prognostic factors and the data fields used for collection are yet to be determined. As soon as the standard setters make their decisions we will provide an update.
**Hematopoietic and Lymphoid Neoplasm Coding Manual & Database Changes**

- **Update Released 1/14/15**
  - Consolidates 2010 & 2012 “HEME” Databases/Manuals into one
  - Earlier versions (2010 and 2012) no longer available
- **Use for cases diagnosed 1/1/2010 forward**
  - “Heme” database rules take precedence over ICD-0-3 rules for coding hematopoietic and lymphoid neoplasms

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**Reminder:** The Hematopoietic and Lymphoid Neoplasm Coding Manual & Database underwent consolidation as well as update and revisions, and was re-released in 1/14/15.

For coding hematologic and lymphoid neoplasm the “Heme” database and manual rules regarding histology, tumor grade and MPH rules take precedence over ICD-0-3 rules.

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**Hematopoietic and Lymphoid Neoplasm Coding Manual & Database Changes**

- **24 Obsolete Hematopoietic Histologies**
  - Obsolete histologies results in necessary data conversions
  - Conversions done at central registry level
  - Applied to 3 data items:
    - Histology, Primary site, and Grade
    - Results in CS schema change for some cases and other CS data fields changes
  - Conversions apply to malignant (/3) histologies 9590-9992 for cases dx 1/1/2010 forward

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The “Heme” database conversion resulted in 24 obsolete histologies which required(s) data conversion for some histologies/primary sites.

3 steps to conversion
Step 1: Obsolete histologies converted to the current histologies
Step 2: Grade assigned to current histologies
Step 3: Primary site assigned to current histologies

Data conversions done at central cancer registry level

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**Hematopoietic and Lymphoid Neoplasm Coding Manual & Database Changes**

After Data Conversion:

- Manual review required for some Histologies/Sites
  - Review required for all registries
  - Number of cases needing review will be minimal
- Many registries will not have any cases to review
  - Check with your software vendor
  - May have new filter/report to identify your cases

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The “Heme” data conversion results in a need to manually review some cases which are unable to be converted automatically. The number cases needing review will be minimal. Less than 500 cases nationally meet the criteria.

Check with your software vendor to see if your 2015 data changes version will contain a report you can run to identify any cases which may need a manual review.
Registrars can choose to access the “Heme’ database and manual using the web version or a stand-alone version. The stand-alone version can be downloaded to your desktop but will auto update any time your computer is connected to the internet. This feature can be useful if you have times you need to work offline for any reason.

Some highlights in the updated “Heme” database include:
- A new first course treatment section which provides info on coding treatment.
- New Glossary feature

Example: Plasmacytoma
A type of cancer that begins in the plasma cells (white blood cells that produce antibodies). A plasmacytoma may turn into multiple myeloma. Clonal proliferation of plasma cells cytologically and immunophenotypically identical to those of plasma cell myeloma but manifesting as localized osseous growth.

For a complete list of revisions and updates to the “Heme” database please see the SEER website.

Thank you to Cheryl Moody, Mary Brant and Kyle Ziegler for contributions to this presentation.
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- For questions please see contact information at left.

- See the CCR website for a narrated recorded version of this presentation if desired.