NAACCR
2007 Implementation Guidelines and Recommendations

(For NAACCR Standards Volume II, Data Standards and Data Dictionary, Version 11.1, effective with cases diagnosed on or after January 1, 2007)

December 20, 2006

North American Association of
Central Cancer Registries, Inc.

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1 INTRODUCTION

The North American Association of Central Cancer Registries, Inc. (NAACCR) 2007 Implementation Work Group has been working with the American College of Surgeons' (ACoS) Commission on Cancer (CoC), National Cancer Institute's (NCI) Surveillance Epidemiology and End Results (SEER) Program, Centers for Disease Control and Prevention (CDC) National Program of Cancer Registries (NPCR), National Cancer Registrars Association (NCRA), Canadian Council of Cancer Registries (CCCR), central cancer registries, and cancer registry software vendors to develop an implementation plan for Version 11.1 standards. NAACCR Standards for Cancer Registries Volume II, Version 11.1, *Data Standards and Data Dictionary,* was developed in response to requested revisions from a broad set of constituents. Data transmission standards should be consistently maintained among all hospital and central cancer registries and should be implemented in a planned and timely manner. The introduction of a new set of standards has potential consequences, and implementation must be evaluated by each national program, central cancer registry, software vendor, and reporting facility during the planning process. Delays in implementation may result in inconsistent data collection.

Revisions to data collection and data system design require close attention to transition to NAACCR Version 11.1 in an efficient and timely manner. NAACCR Record Layout Version 11.1 and the data collection and file maintenance issues must be addressed by hospital and central cancer registries in addition to software vendors who support these registries.

2 MULTIPLE PRIMARY AND HISTOLOGY CODING RULES

The 2007 Multiple Primary and Histology coding rules will be implemented for all data collection in the United States and partial data collection in Canada for cases diagnosed on or after January 1, 2007. The new rules are located on the SEER Web site at
http://www.seer.cancer.gov/tools/mphrules/download.html

The new multiple primary rules are still based on the number of tumors, anatomic site, histology, and date of diagnosis of cancer. The major changes are that the new rules are site specific and the time between primary tumors is no longer defined as 2 months.

There are site specific Multiple Primary and Histology coding rules for the following eight site groups, excluding leukemia and lymphoma (M9590-9989) and Kaposi sarcoma (M9140):

- Head and neck [C00.0-C14.8, C30.0-C32.9]
- Colon [C18.0-C18.9]
- Lung [C34.0-C34.9]
- Melanoma of skin [C44.0-C44.9 with Histology 8720-8780]
- Breast [C50.0-C50.9]
- Kidney [C64.9]
- Renal pelvis, ureter and bladder [C65.9, C66.9, C67.0-C67.9, C68.0-C68.9]
- Malignant brain and CNS [C70.0, C70.1, C70.9, C71.0-C71.9, C72.0-72.5, C72.8, C72.9, C75.1-C75.3]

A ninth set of rules covers all other sites (except benign and borderline brain and CNS tumors and hematopoietic malignancies) for solid malignancies. Solid tumors of unknown primary site should also be coded using the *Other Sites* histology coding rules. Benign and borderline brain and CNS tumors, along with hematopoietic malignancies, are not covered in the 2007 multiple primary and histology coding rules. The pre-existing multiple primary and histology coding rules should be used for benign and

borderline brain and CNS tumors and for reportable hematopoietic diseases until new versions are developed.

The 2007 rules will be implemented by SEER, CoC, NPCR, and CCCR for cases diagnosed on or after January 1, 2007.

The 2007 rules should be used to determine the number of primaries and to code histology for tumors diagnosed on or after January 1, 2007 (including non-analytic cases). Estimate the date of diagnosis for cases with an unknown date of diagnosis.

The 2007 rules replace the SEER site grouping table (page 9 of the *2004 SEER Program Manual*).

Apply the 2007 multiple primary rules to the tumor(s) diagnosed on or after January 1, 2007, for cases with tumors diagnosed before and after January 1, 2007.

> *Example 1:* Duct carcinoma of the right breast diagnosed in July 2006. In February 2007, duct carcinoma of the right breast is diagnosed in a separate tumor. Apply the 2007 rules to the tumor diagnosed in 2007. According to the 2007 rules, the 2007 tumor is not a new primary.
>
> *Example 2:* Duct carcinoma of the right breast diagnosed in July 2006. In February 2007, duct carcinoma of the left breast is diagnosed. Apply the 2007 rules to the 2007 diagnosis. According to the 2007 rules, the 2007 diagnosis is a new primary.

Do not apply the 2007 rules to cases diagnosed prior to January 1, 2007. In addition, do not use the 2007 rules to recode cases diagnosed prior to January 1, 2007.

3 NEW DATA ITEMS

The following table includes data items that are new to the NAACCR Data Standards and Data Dictionary, Volume II, Version 11.1, or are being implemented for the first time with reportable diagnoses occurring on or after January 1, 2007. See Section 6 for ***all*** changes in reporting requirements listed by each of the standard setters, including changes in the Requirement Status to existing data items as well as the new data items being implemented.

New Data Items for 2007 Implementation	
NAACCR Item Name	**NAACCR Item #**
NPI--Registry ID	45
NPI--Reporting Facility	545
NPI--Archive FIN	3105
NPI--Physician--Primary Surg	2485
NPI--Physician--Managing	2465
NPI--Physician--Follow Up	2475
NPI--Physician 3	2495
NPI--Physician 4	2505
NPI--Inst Referred From	2415
NPI--Inst Referred To	2425
NPI--Following Registry	2445
Ambiguous Terminology	442
Date of Conclusive DX	443
Mult Tum Rpt as One Prim	444
Date of Multiple Tumors	445
Multiplicity Counter	446

3.1 National Provider Identifier

The National Provider Identifier (NPI) is a unique identification number for health care providers. It is scheduled for 2007 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Health care providers have started the process of obtaining NPI codes, and hospitals have until May 2007 to meet the HIPAA deadline. NPI numbers are being distributed by CMS to all health care providers in the United States. CMS has mandated use of the assigned NPI in all administrative and financial transactions between "large" health plans and CMS starting in May 2007. For billing purposes, these providers will be required to use NPI codes by May 2007, but indications are that some health care facilities will start using these codes in advance of this deadline. If a facility starts to use the NPI codes, that information should be available from the provider's billing department.

Central cancer registries will not be assigned an NPI. NPI numbers are assigned to health care providers who meet the definition of a "covered entity", and this only includes individuals and entities licensed to provide health care. NPIs are not being issued to physicians who have opted out of government programs; entities that bill or are paid for health care services furnished by other health care providers; or clearing houses, vendors, administrative, and billing services (*Federal Register* [Friday, January 23, 2004]).

Cancer registries should be able to record the NPI for their hospital or individual physicians with January 1, 2007, diagnoses. It is necessary, however, to be aware that NPIs may not have been assigned to all eligible parties by January 1, 2007. Therefore, data collection agencies should be flexible regarding the timing of the reporting requirements for these items. During the period of transition (minimally through the end of 2008), it is strongly recommended that reporting entities be requested to submit both their historic identifier (if one was assigned) and their NPI, regardless of the year of diagnosis. No standard setter, software provider, or state should require submission of an NPI for any case diagnosed prior to 2007 for any entity other than the entity or individual doing the reporting. Historic facilities or physicians may no longer be in business or licensed and, therefore, may not have an NPI assigned. Thus, tracing the NPI for prior case references may be unduly onerous. Submission of any NPI for cases diagnosed prior to 2007 should not be construed as an error, though the receiving registry may choose to ignore that

information. Some software systems retain some of this information in a patient-specific record within a relational database, which cannot easily be blocked from submission based on diagnosis date.

The NPI is a 10 byte numeric data-item. The issue of field length differences between the current physician fields length of 8 versus 10 byte NPI has been addressed with the addition of NPI fields to the NAACCR record layout for cases diagnosed on or after January 1, 2007.

Cancer registries should communicate their needs for collecting the various NPI numbers to their registry software provider. Implementation of the NPI into individual data collection/reporting software may vary, and cancer registries should become aware of how the NPI will be implemented in their specific software.

Because it is anticipated that the adoption and collection of NPI will vary by facility, provider, and data collection/reporting software, it is important that the software's data-entry functions accept a blank field as a valid entry value.

Of importance is the check digit algorithm that is useful to validate individual NPI numbers. The NPI consists of 9 numeric digits followed by one numeric check digit. The NPI will not have embedded intelligence. The NPI format and check digit calculation will be compatible with the card issuer identifier on a standard health identification card. The card standard was developed by the National Committee for Information Technology Standards (NCITS), which is accredited by the American National Standards Institute. NPIs will be issued initially with the first digit equal to 1 or 2. NPIs with the first digit equal to 1 are assigned to individual health care providers (i.e., physicians); hospitals or other entities that provide health care services will be assigned the first digit of NPI equal to 2. These digits will not be used as the first digits for other card issuer identifiers. NPI numbers will be generated using a scattering algorithm that has the capability to use all possible numeric combinations beginning with 1 or 2. Each NPI generated will be unique, without requiring database access for verification.

The NPI check digit can be used to validate an individual NPI number. The NPI is calculated using the Luhn formula for computing the modulus 10 "double-add-double" check digit. This algorithm is recognized as an ISO standard and is the specified check digit algorithm to be used for the card issuer identifier on a standard health identification card. Below is an example of the check digit calculation of an NPI. Assume that the 9-position identifier part of the NPI is 123456789. Using the Luhn formula on the identifier portion, the check digit is calculated as follows:

NPI without check digit:
123456789

Step 1: Double the value of alternate digits, beginning with the rightmost digit.
2 6 10 14 18

Step 2: Add constant 24, to account for the 80840 prefix that would be present on a card issuer identifier, plus the individual digits of products of doubling, plus unaffected digits.
24 + 2 + 2 + 6 + 4 + 1 + 0 + 6 + 1 + 4 + 8 + 1 + 8 = 67

Step 3: Subtract from the next higher number ending in zero.
70 – 67 = 3
Check digit = 3
NPI with check digit = 1234567893

3.2 Other New Data Items

The following five data items (in Standards Volume II, Version 11.1) will be implemented for cases diagnosed on or after January 1, 2007. Leave blank for cases diagnosed prior to January 1, 2007.

Ambiguous Terminology DX [442]
Date of Conclusive DX [443]
Mult Tum Rpt as One Prim [444]
Date of Multiple Tumors [445]
Multiplicity Counter [446]

Note: The following data item has been withdrawn, will not be implemented, and is not required by any of the standard setting organizations; however, it has not been retired from the NAACCR layout.

Number of Tumors/Hist [447]

The instructions for completing the new data items are located on the SEER Web site: http://www.seer.cancer.gov/tools/mphrules/download.html.

Three data items are associated with the 2007 Multiple Primary and Histology coding rules. They include:

- Multiplicity Counter [446]
- Date of Multiple Tumors [445]
- Mult Tum Rpt as One Prim [444]

Two data items capture information about cases accessioned based on ambiguous terminology:

- Ambiguous Terminology [442]
- Date of Conclusive DX [443]

Original information in these five data items should be changed when new information becomes available. For example:

Multiplicity Counter:
Change from code 01 to code 02 when a second tumor is determined to be the same primary as the first tumor. [There are certain site/histology groupings for which this code is not applicable, such as leukemia, lymphoma, immunoproliferative diseases, and unknown primaries. These cancers are coded 88 in this field.]

Date of Multiple Tumors:
Change from zeros (00000000) to the date that the second tumor was diagnosed when the second tumor is determined to be the same primary as the first tumor and both are abstracted as a single primary.

Mult Tum Rpt as One Prim:
For cases diagnosed on or after January 1, 2007, change from 00 to another code when subsequent tumor(s) are determined to be the same primary as the first tumor and are abstracted as a single primary.

Ambiguous Terminology:
Change from code1 to code 2 when, more than 2 months after the initial ambiguous diagnosis, a conclusive diagnosis was made by any diagnostic method including clinical diagnosis, cytology, pathology, autopsy, etc.

Date of Conclusive DX:
Change from the original code of 00000000 to the date that the malignancy was described clearly and definitely.

4 COLLABORATIVE STAGING RELEASE 01.03.00

4.1 General Procedures for Collaborative Staging Updates

As a result of inquiries and issues identified by the cancer registry community, the Collaborative Staging (CS) system is revised and updated periodically. Releases have been CS Version 01.01.00 in August 2004, Version 01.02.00 in April 2005, and Version 01.03.00 in September 2006. When a new version is released, the implementation should be as rapid as possible. Changes to CS may take many forms: (1) coding changes; (2) clarifications; (3) changes to the CS mapping; and/or (4) changes to the computer program. Information on CS and any updates can be found on: http://www.cancerstaging.org/cstage/index.html. This Web site also contains information on when new releases occur and provides the steps necessary to implement the new release. The steps to implement a new version may include the following:

(1) Replace documentation including changes to Part I and/or Part II of the CS coding manual (available online or printed as replacement pages);
(2) Replace the computer algorithm;
(3) Review and recode certain cases;
(4) Re-run the algorithm on previously entered CS elements to re-derive the CS fields.

Standard setters may differ in how or when the implementation of a new version should proceed. As CS updates become available, each of the standard setters is invited to post its CS implementation procedures on the CS Web site or publicize its requirements. [Note: Standard setter requirements for implementing Version 01.03.00 are presented in Section 6.]

The CoC, NPCR, SEER, and CCCR encourage the adoption of any new CS release in a timely manner. Registries will be notified of any conversion/review that the changes in the CS algorithm necessitate. After implementation of a new CS algorithm, all CS cases should be run through the new CS algorithm and the data item, CS Version Latest [2936], should be updated to the new version.

4.2 Collaborative Staging Release 01.03.00

Release 01.03.00 contains changes that affect most of the schemas and some derived fields. Many of the changes are in response to issues identified in the multi-agency coding reliability study that was conducted in the spring of 2006. According to the release announcement of September 8, 2006, "The CS Task Force has resolved issues and enhanced the documentation to improve the quality of data collection, and considers all revisions necessary. . . . It is recommended that vendors deliver these updates to their clients as soon as possible." A document entitled "Vendor Actions," available from the above-cited Web address, provides detailed recommendations for vendors from the CS Task Force, including actions that should be taken as soon as possible, optional actions, and actions that should be taken before any calls-for-data that involve stage.

5 EDITS

The NACR111 (version 11.1) metafile includes edits on all of the new and modified data items as specified in Standards Volume II, Version 11.1. The edits and edit sets are consistent with the reporting requirements as specified in this document by CoC, NPCR, and SEER.

To download the new metafile from the NAACCR Web site (www.naaccr.org), click on Registration Standards, NAACCR Data Standards for Cancer Registries, and Standard Data Edits. Then select Version 11.1 Metafile under Current Metafiles.

As additional changes are made to the metafile, NAACCR Listserv messages will be sent to the cancer registry community.

It should also be noted that a new version of the CDC EDITS software will be available in the late fall of 2006. The EDITS software provides the tools that are used to develop and maintain the various metafiles of edits and edit sets (NAACCR, NCDB, NPCR, SEER, and state-specific). The EDITS tools have been changed as follows:

- Both GenEDITS and GenEDITS Lite, the current software programs for running selected sets of edits against data and generating edit error reports, will be replaced by GenEDITS Plus. GenEDITS Plus is faster, more efficient, and easier to use. In addition, it can handle very large edit sets and it provides additional report options and flexibility.
- EditWriter, the EDITS tool used for developing the edit metafiles, has been converted from its MS DOS version (EditWriter, Version 2) to a Windows version (EditWriter, Version 3). EditWriter can be used to write edits, create edit sets, and produce reports of the edits and edit sets included in a metafile.
- Software providers should be aware that there is also a new version of the EDITS Application Program Interface (API), sometimes called the EDITS Engine, available in Dynamic Link Library (.DLL) form. It has been upgraded for increased reliability and processing speed and, unlike the older version, it can process very large edit sets. It is backward-compatible and can seamlessly be moved into any Windows-based platform. The source code is also available for compiling to non-Windows platforms.

Additional information on the new CDC EDITS software is available in the Tools section at http://www.cdc.gov/cancer/npcr. A training manual will be available with the software, and additional support will be provided by CDC.

NAACCR will begin using EditWriter 3.0 with the version 11.1A metafile. A metafile created by (or converted to) EditWriter 3.0 is not backward-compatible (i.e., will not work with EditWriter 2.0 or GenEDITS), and any subsequent changes to the metafile will have to be made using EditWriter 3.0.

6 CHANGES IN REPORTING REQUIREMENTS FOR 2007

Refer to NAACCR Standards for Cancer Registries Volume II, Version 11.1, *Data Standards and Data Dictionary*, Chapter VIII, Required Status Table for specific information regarding standard-setter data reporting requirements. Where necessary, refer to individual program or central cancer registry requirements for additional information. A copy of the Required Status Table is included in this document as Appendix A.

6.1 CoC Reporting Requirements for 2007

Beginning with cases diagnosed on or after January 1, 2007, CoC will implement the data collection and submission requirements as published in the NAACCR Standards Volume II, Version 11.1, Chapter VIII, Required Status Table updated in this document (see Appendix A).

Changes to CoC Reporting Requirements for 2007 Standards Volume II, Version 11.1			
NAACCR Item Name	**NAACCR Item #**	**COC Collect**	**COC Transmit**
Ambiguous Terminology	442	R	R
Date of Conclusive DX	443	R	R
Mult Tum Rpt as One Prim	444	R	R
Date of Multiple Tumors	445	R	R
Multiplicity Counter	446	R	R
NPI--Registry ID	45	.	.
NPI--Reporting Facility	545	R*	R*
NPI--Archive FIN	3105	R*	R*
NPI--Physician--Primary Surg	2485	R*	R*
NPI--Physician--Follow Up	2475	R*	R*
NPI--Physician 3	2495	R*	R*
NPI--Physician 4	2505	R*	R*
NPI--Inst Referred From	2415	R*	.
NPI--Inst Referred To	2425	R*	.
NPI--Following Registry	2445	.	.
. = no recommendations; R = required; R* = required when available			

6.1.1 CoC Multiple Primary and Histology Rules: Reporting Requirements

Beginning with cases diagnosed on or after January 1, 2007, the CoC will require full adoption of the Multiple Primary and Histology (MP/H) coding rules, as documented by the SEER program. These requirements include the coding and reporting of the data items listed in the table, Changes to CoC Reporting Requirements for 2007 (see Section 6.1 above).

- The MP/H items should be blank for all cases diagnosed before January 1, 2007.

6.1.2 CoC NPI Reporting Requirements

Because NPIs are a billing requirement of CMS due to be implemented by May 2007, it may be that NPIs will continue to be assigned to existing facilities and providers until that time. The following guidelines are provided for CoC-approved programs regarding the collection and transmission of NPI:

- The NPI items may be blank for cases diagnosed before January 1, 2007.
- The CoC will require that NPIs be recorded as available for cases diagnosed during 2007, and require that these items be recorded for all cases diagnosed January 1, 2008, and later.
- If, during this 2007 phase-in period an NPI is not available, a blank value may be transmitted.
- CoC-approved programs will not be required to "back-code" NPI items for cases diagnosed in 2007 once a provider number becomes available and known to the registry.
- Transmission of an NPI to the National Cancer Data Base (NCDB) will be required and is permitted under the terms of the American College of Surgeons Business Associate Agreement, signed by each CoC-approved program. According to the *Federal Register* (Friday, January 23, 2004) in its final ruling on the Standard Unique Health Identifier for Health Care Providers, "The

NPI is not classified as protected health information (PHI), and as such the NPI can be transmitted between parties that have entered into a business associate agreement and where transmission of limited data sets (those that do not include PHI) occurs."

The CoC will prefer that approved program cancer registries use the items NPI-Physician 3 [2495] and NPI-Physician 4 [2505] to indicate the physicians who performed the most definitive radiation therapy and systemic therapy, respectively. If registries choose to identify another physician, the facility will need to develop and implement definitions for analysis.

During the period of transition (minimally through the end of 2008), it is strongly recommended that CoC-approved programs submit both their CoC assigned facility ID Number (FIN) and their NPI, regardless of the year of diagnosis. However, the CoC will not require submission of an NPI for any case diagnosed prior to 2007. Historic facilities or physicians may no longer be in business or licensed and therefore may not have an NPI assigned, and tracing the NPI for prior case references may be unduly onerous. Submission of any NPI for cases diagnosed prior to 2007 will not be construed as an error.

6.1.3 CoC Reporting Requirements for CS Release 01.03.00

CoC recommendations and requirements, as listed in the Collaborative Staging announcement for version 01.03.00, include the following:

- The Commission on Cancer encourages expeditious implementation of the new CS version 01.03.00 and use of the updated CS Guidelines, which clarify many issues that have been raised about coding.
- All CS-coded "Ethmoid Sinus" and select CS-coded "Other Lip" cases must be reviewed and recoded, regardless of the diagnosis date. Specific instructions are included in the document "CoC Specifications for Approved Programs and Software Providers."
- Cases submitted or resubmitted during the upcoming NCDB Call for Data may be coded either in version 01.02.00 or version 01.03.00.
- All updates and recoded cases must be completed by the time of the NCDB Call for Data submission that begins in fall 2007.

CoC has issued more detailed specifications in a document entitled, "CS Release 01.03.00: CoC Review and Recode Specifications for Approved Programs and the Software Providers that Serve Them," which is available on the Web site http://www.cancerstaging.org/cstage/index.html.

6.1.3.1 Software Providers

Incorporate the new CS dll for Release 01.03.00, associated CS documentation, and the NACR110C or NACR111 metafile (which includes edits associated with that release) into registry software, and distribute it to facility registries as soon as practicable.

Provide a mechanism whereby registrars can identify cases required by CoC to be reviewed and recoded, as described below.

6.1.3.2 Registrars

The updated CS manual can be downloaded from http://www.cancerstaging.org/cstage/index.html. You can begin using this manual immediately without waiting for the new software for all cases *except* Other Lip and Ethmoid Sinus. For those two schemas, see the paragraphs that follow. Changes were made to nearly every schema, ranging from clarifications in instructions, to minor modifications in table and code definitions, to a few changes in the histologies for which Derived AJCC values are computed.

Install the software update from your provider when it becomes available. Once it has been installed, use it for coding CS input for all future cases, whether they were diagnosed in 2007 or earlier. You may now code CS for new Other Lip and Ethmoid Sinus cases using the new manual.

Once the software update is installed, follow your provider's instructions for updating the cases described in the table below. There are two schema affected, Other Lip and Ethmoid Sinus. Both are very rare sites, and some facilities will not have any cases to recode. The cases that need to be reviewed and recoded are those with a site and histology matching those identified in the first column of the table, and the CS input field values equal to those in the second column. The third column specifies what coding is needed.

Re-run the CS algorithm on all CS-coded cases, regardless of diagnosis date, when you have completed the review and recode process. Your software will generate the derived values using the revised program and will identify all re-run cases with the "CS Version Latest" set to the up-to-date code.

NCDB will accept CS codes associated with CS Version Latest of either 01.02.00 (implemented summer 2005) or 01.03.00 (the new revision) for the Call for Data beginning October 2, 2006, including resubmissions made through June 1, 2007. Always re-run the CS algorithm on all existing CS-coded cases after updating your CS program, before using or transmitting your data, to prevent derived data errors.

Schema Requiring Review and Recode of CS-Coded Cases		
Site and Histology	**CS Input Field Values**	**Action Recommended, Comments**
Other Lip C002, C005, C008-C009 ICD-O-3 histology is **not** = 9140, 9590-9699 or 9702-9989	CS Lymph Nodes = 12	Manual review and recode to 10 or 12, depending on specific nodes involved.
Ethmoid Sinus C311 ICD-O-3 histology is **not** = 9140, 9590-9699 or 9702-9989	All CS-coded	Because some codes and several coding instructions affecting this very rare cancer site have been modified, all CS-coded ethmoid sinus cases need manual review and recoding.

6.1.4 CoC Recommendations for Education and Training

The SEER program organized a Train-the-Trainers session in August 2006, to help implement the new multiple primary and histology rules. A list of qualified trainers is available on the SEER Web site: http://www.seer.cancer.gov/tools/mph_speakers.html. Additional training by SEER is being provided using technology that integrates slide presentations with live oral delivery. These are interactive sessions with audience participation that include sessions on the new multiple primary and histology rules and will be recorded and posted on the SEER Web site for future viewing. Transcripts of oral presentations will be available on the Web site as well (http://www.seer.cancer.gov/registrars/).

6.2 NPCR Reporting Requirements for 2007

Beginning with cases diagnosed on or after January 1, 2007, NPCR will implement the data collection and submission requirements as published in the NAACCR Standards Volume II ,Version 11.1, Chapter VIII, Required Status Table updated in this document (see Appendix A).

NPCR Requirements for New Data Items Standards Volume II, Version 11.1			
NAACCR Item Name	**NAACCR Item #**	**NPCR Collect**	**NPCR Transmit**
Ambiguous Terminology Dx	442	.	.
Date of Conclusive DX	443	.	.
Mult Tum Rpt as one Prim	444	.	.
Date of Multiple Tumors	445	.	.
Multiplicity Counter	446	.	.
NPI--Reporting Facility	545	R*	.
NPI--Registry ID	45	.	.
Primary Payer at Dx	630	R*	R*
. = no recommendations; R = required; R* = required when available			

6.2.1 NPCR Multiple Primary and Histology Rules Reporting Requirements

Beginning with cases diagnosed on or after January 1, 2007, the NPCR will require full adoption of the Multiple Primary and Histology (MP/H) coding rules, as documented by the SEER program. These requirements ***do not*** include the coding and reporting of the data items related to the Multiple Primary and Histology rules (See Section 6.2).

6.2.2 NPCR NPI Reporting Requirements

The NPCR Program requires the collection but not transmission of the National Provider Identifier – Reporting Facility as codes become available (See Section 6.2).

6.2.3 NPCR Reporting Requirements Primary Payer at Diagnosis

The NPCR Program requires that the Primary Payer at Diagnosis be collected and transmitted when available (See Section 6.2).

6.2.4 NPCR Reporting Requirements for CS Release 01.03.00

The NPCR Program recommendations and requirements, as listed in the Collaborative Stage announcement for version 01.03.00 include the following:

- NPCR recommends that the new CS version be implemented as soon as possible.
- Beginning with cases diagnosed on January 1, 2007, all cases must be coded using CS version 01.03.00.
- Prior to the January 2007 NPCR-CSS data submission, registries must download, replace, and re-run CS version 01.03.00 to correct derived Collaborative Staging.
- Prior to the January 2008 NPCR-CSS data submission, the review and any necessary recoding of cases diagnosed 2004 through 2006 must be completed.

The CS Record Log of Changes posted on http://cancerstaging.org/cstage/index.html gives detailed information on the changes made between CS version 01.02.00 and CS version 01.03.00.

6.2.5 NPCR Reporting Requirements for New Data Items

The data items associated with the Multiple Primary and Histology rules [444-446] are not required to be collected or submitted to NPCR-CSS.

The data items, Ambiguous Terminology DX [442] and Date of Conclusive DX [443], are not required to be collected or submitted to NPCR-CSS.

6.2.6 NPCR Recommendations for Education and Training

The NPCR Program requires that the central cancer registry has a designated education/training coordinator who is a CTR to provide training to the central cancer registry staff and reporting sources to ensure high-quality data.

The NPCR Program recommends that the designated education/training coordinator in each state participate in the NPCR Education and Training Series (NETS). The purpose of this training series is to build the educational capacity in the central registries, resulting in a solid infrastructure to provide education and day-to-day support of the data collectors.

The NPCR Program requires that the central cancer registry implement and deliver training for the new Multiple Primary and Histology (MP/H) rules that are effective with a 2007 date of diagnosis. This training will be provided for the data collectors as well as the central cancer registry staff, and should be delivered by the trainer who participated in the formal sessions given by SEER.

The NPCR Program recommends that the central cancer registries participate in the online Web conferences called Breeze sessions. These are offered by SEER to provide a basic understanding of the Multiple Primary and Histology (MP/H) Coding rules, how they were created, and how they work; to address why new rules were needed based on problems with the current rules; to explain how to use the rules, priority order for use of documents, and ambiguous terms for coding histology.

6.3 SEER Reporting Requirements for 2007

For cases diagnosed from on or after January 1, 2007, the SEER rules are contained in the SEER Program Coding and Staging Manual 2007. Note that several data items that SEER collects have been changed. Refer to the list of changes in Section 6.5.2 and the appropriate appendix as well as the SEER Program Coding and Staging Manual 2007.

Beginning with cases diagnosed on or after January 1, 2007, SEER will implement the data collection and submission requirements as published in the NAACCR Standards Volume II, Version 11.1, Chapter VIII, Required Status Table as updated in this document (see Appendix A).

Changes to SEER Reporting Requirements for 2007 Standards Volume II, Version 11.1			
NAACCR Item Name	**NAACCR Item #**	**SEER Collect**	**SEER Transmit**
NPI--Registry ID	45	R*	.
NHIA Derived Hisp Origin	191	D	R
Computed Ethnicity	200	D	R
GIS Coordinate Quality	366	S	.
Ambiguous Terminology	442	R	R
Date of Conclusive DX	443	R	R
Mult Tum Rpt as One Prim	444	R	R
Date of Multiple Tumors	445	R	R
Multiplicity Counter	446	R	R
Casefinding Source	501	R	R
NPI--Reporting Facility	545	R*	.
Primary Payer at DX	630	R	R
SEER Summary Stage 2000	759		S
RX Summ--Systemic/Sur Seq	1639	R	R
Addr at DX--Supplementl	2335	R	.
DC State File Number	2380	R*	.
NPI--Following Registry	2445	R*	.
NPI--Physician--Follow Up	2475	R*	.
RX Date--Systemic	3230	S	.
. = no recommendations; R = required; R* = required when available; S = Supplementary/Recommended			

6.3.1 SEER Multiple Primary and Histology Rules: Reporting Requirements

The SEER Program is requiring the adoption of the 2007 Multiple Primary and Histology rules for tumors diagnosed on or after January 1, 2007:

- The 2007 Multiple Primary rules replace all previous multiple primary rules except those for benign brain/CNS and hematopoietic neoplasms.
- The rules are effective for cases diagnosed on or after January 1, 2007. Do not use these rules to abstract cases diagnosed prior to January 1, 2007.
- If there is a previously diagnosed primary before January 1, 2007, do not change the previous primary based on the new rules but use the new multiple primary rules for any new tumor diagnosed after January 1, 2007, to determine if it is an additional primary.

Note: Use the SEER Program Coding and Staging Manual 2007 to determine the reportability of a cancer diagnosis; use the 2007 Multiple Primary and Histology rules to determine the number of primaries to be abstracted.

6.3.2 SEER NPI Reporting Requirements

The SEER Program encourages the central registries to adopt the NPI when it becomes available. Because there will be legacy data from facilities that have closed or physicians who have died, the local physician and facility codes will have to be maintained in those instances where there is not an NPI number. The status codes in the requirements table were changed from R to R*.

6.3.3 SEER Reporting Requirements for CS Release 01.03.00

Recommendations from the National Cancer Institute–Surveillance, Epidemiology and End Results Program (NCI-SEER), as listed in the release announcement, include the following:

- SEER recommends that participating central cancer registries work closely with their hospital registries to avoid duplication of effort in implementing CS version 01.03.00.
- SEER also recommends that the new CS version be implemented as soon as possible.
- Beginning with cases diagnosed on or after January 1, 2007, all cases must be coded using CS version 01.03.00. CS version 01.03.00 will be incorporated into the SEER Program Coding and Staging Manual 2007.
- The review and recoding of earlier cases must be completed before the November 2007 data submission. Information about which cases require review and recoding for the November 2007 data submission will be posted at a later date. Very few cases will need review.

The CS Record Log of Changes posted on http://cancerstaging.org/cstage/index.html gives detailed information on the changes made between CS version 01.02.00 and CS version 01.03.00.

6.3.4 SEER Reporting Requirements for New Data Items

The SEER Program is requiring the following data items for cases diagnosed on or after January 1, 2007:

Ambiguous Terminology DX [442]
Date of Conclusive DX [443]
Mult Tum Rpt as One Prim [444]
Date of Multiple Tumors [445]
Multiplicity Counter [446]
Casefinding Source [501]
Primary Payer at Dx [630]
RX Summ−Systemic/Sur Seq [1639]

Due to the significant and increasing importance of HER/2 measurements in breast cancer diagnostic procedures and treatment, SEER is initiating efforts towards including HER/2 as a required SEER data element in the future. To accomplish this, SEER is requesting that all SEER registries collect HER/2 Status for all breast cancer cases during the 2007 diagnosis year

6.3.5 SEER Changes to Reporting Status of Other Data Items

Because NHIA Derived Hisp Origin [191] and Computed Ethnicity [200] are not items that are collected but rather they are derived, their status for data collection was changed from R to D. GIS Coordinate Quality [366] and RX Date--Systemic [3230] were added to the list of items that are recommended for collection but are not transmitted to SEER. DC State File Number [2380] should be collected if available but not transmitted to SEER. SEER Summary Stage 2000 [759] should not have an "S" in the SEER collect field as previously published. For Address at DX--Supplementl [2335], the "R" should have been under Collect and not under Transmit.

6.3.6 SEER Recommendations for Education and Training

To ensure high-quality training for new cancer coding rules and procedures, the SEER program conducts a program known as "Train the Trainers." Graduates of the Train-the-Trainers program are then qualified to train others, frequently as part of state or chapter cancer registry meetings. The most recent Train-the-Trainers session occurred in August 2006, to help implement the new multiple primary and histology rules. The SEER program also monitors the feedback of the trainers to improve successive training/education sessions. A list of qualified trainers is available on the SEER Web site:

http://www.seer.cancer.gov/tools/mph_speakers.html

Additional training is being provided using technology that integrates slide presentations with live oral delivery. These are interactive sessions with audience participation. Most recently, the SEER program began sessions on the new multiple primary and histology rules. These sessions are recorded and will be posted on the SEER Web site for future viewing. A transcript of the oral presentation will be available on the Web site as well (http://www.seer.cancer.gov/registrars/).

For many topics in cancer data collection and quality assurance, the SEER Web site contains Web-based training modules. The current selection of topics may be viewed at http://training.seer.cancer.gov/.

At each SEER cancer registry site, SEER funds one position solely for data quality control. This person is responsible for all quality-related issues at the registry and also functions as a SEER auditor for other SEER registries. The auditors are rotated to other SEER registries on a bi-annual basis to conduct cancer data audits. The auditors conduct an audit on a different SEER registry each time, so that there are minimal biases introduced into the audit process.

Abstractors and coders in each SEER registry are required to participate in SEER reliability studies every other year. The reliability studies are educational tools and also measure consistency of data collection across the SEER registries. Education and training needs are identified through the reliability studies and these needs are addressed in future workshops.

SEER conducts annual abstractor and coder workshops for registry staff. The workshops target education and training needs identified during SEER audits and reliability studies. The workshops also focus on recent changes, such as Collaborative Staging and the 2007 multiple primary and histology coding rules.

See Appendix B for a table listing the various educational opportunities available on the new Multiple Primary and Histology coding rules and Collaborative Staging.

6.4 CCCR Reporting Requirements for 2007

Cases diagnosed on or after January 1, 2007, will be submitted to the Canadian Cancer Registry (CCR) during the CCR Annual Call for Data while referencing the CCR Input Record Layout of the CCR System Guide.

6.4.1 CCCR Multiple Primary and Histology Rules: Reporting Requirements

- Beginning with cases diagnosed on or after January 1, 2007, the CCCR recommends that the Provincial/Territorial Cancer Registries (PTCRs) adopt the Multiple Primary and Histology coding rules as developed and documented by the SEER program. It is understood that not all PTCRs are in a position to move to full adoption on January 1, 2007. CCCR will monitor the progression of full adoption of these rules by all PTCRs to identify a full compliance date.

- The new data items associated with the Multiple Primary and Histology rules [444-446] are not required to be collected or submitted to the CCR.
- The 2007 Multiple Primary/Histology rules replace all previous multiple primary/histology guidelines documented in the CCR System Guide.
- The rules are effective for cases diagnosed on or after January 1, 2007. Do not use these rules to register cases diagnosed prior to January 1, 2007.
- If there is a previously diagnosed primary before January 1, 2007, do not change the previous primary based on the new rules but use the new multiple primary rules for any new tumor diagnosed after January 1, 2007, to determine if it is an additional primary.

- If there is a biopsy previous to January 1, 2007, and the surgery occurs after the new rules (January 1, 2007), code based on the rules for the diagnosis date year (i.e., 2006).

6.4.2 CCCR NPI Reporting Requirements

NPI reporting requirements do not apply in Canada.

6.4.3 CCCR Reporting Requirements for CS Release 01.03.00

Recommendations from the Canadian Council of Cancer Registries (CCCR) (Statistics Canada–Canadian Cancer Registry [CCR]), as listed in the September 8, 2006, release announcement, are:

- Statistics Canada (STC) recommends that PTCRs implement the new CS version as soon as possible.
- Cases diagnosed on or after January 1, 2007, should be coded using CS version 01.03.00.
- The review and conversion or recoding of 2004-2006 cases should be completed before the CCR annual data submission to Statistics Canada.
- STC will run the data using the most current version of the CS algorithm. The results will be provided to the PTCRs upon request.

6.4.4 CCCR Reporting Requirements for New Data Items

The data items associated with the Multiple Primary and Histology rules [444-446] are not required to be collected or submitted to the CCCR.

The data items, Ambiguous Terminology DX [442] and Date of Conclusive DX [443], are not required to be collected or submitted to the CCCR.

6.4.5 CCCR Recommendations for Education and Training

The CCCR Committee on Data and Quality Management (DQMC) and its Education subcommittee will determine the education and training needs of the PTCRs on matters relating to professional education and designation within the PTCRs and/or the CCR and propose methods to meet those needs.

MP/H Training

The CCCR supports the recommendation to adopt the new Multiple Primary and Histology (MP/H) rules that are effective with a 2007 date of diagnosis. The CCCR has appointed a national training coordinator and two additional master trainers for MP/H, and has asked these individuals to coordinate in conjunction with the DQMC any immediate and ongoing training requirements for this implementation. All work of this group must ensure congruence with the materials and directions provided by the SEER Multiple/Primary Histology Task Force. CCCR is supportive of the national trainers and encourages PTCRs to attend training sessions. The primary training activity in Canada took place during the September 2006 national Canadian Cancer Registry Professionals Workshop (CCRPW). Training materials from the CCRPW have been provided to the PTCRs for in-house followup and review. The 2007 CCRPW may provide a forum for additional MP/H training. The PTCRs have been informed of additional training opportunities (e.g., SEER Breeze sessions; NAACCR Webinars) scheduled to take place throughout the fall of 2006 and winter/spring of 2007. A national workgroup has been developed with representation from PTCRs and STC to assess additional MP/H implementation-related issues.

6.5 Summary for Central Cancer Registries

Cases diagnosed on or after January 1, 2007, must be collected and reported in accordance with the standards and definitions of the NAACCR Standards Volume II, Version 11.1, record layout. Central cancer registry systems that have not implemented the Version 11.1 layout should develop a plan to accommodate files submitted by reporting facilities in the Version 11.1 layout. Central cancer registries should specify a date by which they will be able to accept records in the Version 11.1 layout and a date

after which they will no longer accept earlier record versions. Large backlogs of records should be avoided, both at the level of the reporting facility (records abstracted, but not submitted at the request of the central cancer registry) as well as at the level of the central cancer registry (records received and put into a suspense file to be processed at a later date).

Because all of the standard setters have adopted the new Multiple Primary and Histology coding rules effective with cancers diagnosed on or after January 1, 2007, central cancer registries must make the necessary changes to implement these as well. This includes making changes to manuals, training materials, and other documentation, as well as changes in automated and manual procedures for record consolidation. To describe cancer incidence consistently across different registries and different populations, the determination of the number of primary malignancies also must be consistent from hospital-based registries to population-based registries as well as from one central registry to another. The new multiple primary coding rules are of particular importance to central cancer registries as they process many reports from multiple facilities over an extended period of time, and they must effectively incorporate these new rules into long-established record consolidation processes.

Central registry software should be updated to use the dll/function library for CS Version 01.03.00 as soon as it becomes available. Once it has been installed, follow the providers instructions for updating the cases described in the table in Section 6.1.3.2. Any cases previously collaborative staged with a primary site of Other Lip or Ethmoid Sinus should be reviewed and manually recoded.

Central registries should distribute information on how to obtain the updated CS Manual to all reporting facilities. This information should clearly state that all changes to the manual are effective immediately and should be implemented as soon as possible. Other Lip and Ethmoid Sinus tumors may be recoded once the facility's reporting software has been updated to CS Version 01.03.00. Central registries should specify if they want reporting facilities to submit a changed record for these sites.

The CS algorithm should be re-run on all CS-coded cases, regardless of diagnosis date, when the review and recode process is complete. The CS Version 01.03.00 algorithm must be applied to all cases submitted in previous CS Versions.

6.5.1 New Data Items

Central cancer registries should carefully review the new data items in Version 11.1 and identify those data items that will be collected and/or stored in their registry, paying particular attention to those data items required by the various standard-setting organizations.

The 2007 diagnosis year will be considered a transition year regarding the collection of NPIs. NPIs may not be assigned to all reporting facilities and physicians during this time period. Both CoC and SEER require the collection of the NPI items as they become available. It should be noted that NPCR requires the collection of only one of the new NPI items [NPI- -Reporting Facility]. Central registries should continue to collect any NPI equivalent variables during this time period.

Also note, SEER and CoC require the collection of the three new items associated with the new Multiple Primary and Histology coding rules as well as the two new items regarding ambiguous terminology. NPCR and CCCR have no reporting requirements for these items.

6.5.2 Revised Items

Multiple data items have revisions to the data dictionary description, the data dictionary rationale, or the data descriptor note. Central cancer registries should review all revisions (see NAACCR Standards Volume II, Data Standards and Data Dictionary, Version 11.1, Appendix F) to update reporting manuals and documentation. The following table identifies data items with code revisions and these data items are

also included in Appendix C.

NAACCR Standards Volume II, Version 11.1 Data Items With Revised Codes or Code Definition			
NAACCR Item Name	**NAACCR Item #**	**NAACCR Item Name**	**NAACCR Item #**
FIN Coding System	35	Addr-Current State	1820
NAACCR Record Version	50	Follow-up Contact-State	1844
Addr at DX-State	80	Over-ride Histology	2040
Sequence Number-Central	380	ICD-O-3 Conversion Flag	2116
Sequence Number-Hospital	560	SEER Coding Sys-Current	2120
Regional Nodes Positive	820	SEER Coding Sys-Original	2130
Regional Nodes Examined	830	Military Record No Suffix	2310
Coding System for EOD	870	ICD Revision Comorbid	3165
Date of Initial RX-SEER	1260	Rural/Urban Continuum 2003	3310
RX Summ-Radiation	1360		

6.5.3 Central Registry-Specific Fields and Retired Items

Central cancer registries should clearly delineate any non-standard or central registry-specific data items that they will be collecting, and should generate detailed abstracting instructions for each item. This information must be circulated to software vendors/developers and reporting facilities. Data items required for collection/reporting by the central cancer registry, and not part of Version 11.1, should be collected/reported in the State/Requestor Items [2220].

Central cancer registries should not reuse column spaces of retired items for state-specific items nor should they continue to collect the retired items in these column spaces. If the central cancer registry chooses to collect information on retired data items, the information should be collected as State/Requestor Items [2220].

6.5.4 Central Registry Edits

The central cancer registry should review the EDITS metafile for Version 11.1 (NACR111 can be downloaded from www.naaccr.org) to determine which edits should be implemented (see Section 5).

Central cancer registries should note that edits in the NACR111 metafile may need to be revised to accommodate central cancer registry-specific reporting requirements, and that special edits may need to be developed to be applied to central registry-specific data items (e.g., edits for retired data items that are moved to the state-requestor section). Implementation, testing, and distribution of central registry-specific EDITS metafiles to reporting facilities and vendors should be considered as central cancer registries develop their Version 11.1 implementation plans. Central cancer registries that generate and distribute their own metafiles should have a plan to keep them updated.

6.5.5 Conversion Consideration

There are no conversion requirements necessary for the implementation of the 2007 changes in these guidelines.

6.5.6 Software Implementation Plan

Central cancer registries that receive submissions from facilities that use commercial software to generate their files should pay close attention to the release dates of these products and coordinate their overall central cancer registry Version 11.1 implementation plan accordingly. To ensure transmission in the appropriate record layout version, every data submission should be reviewed before being merged into the

central cancer registry database. There are multiple methods that can be used to test a data submission including the application of the edits metafile; line review in LIST or UltraEdit (http://www.idmcomp.com); and the use of a software package that allows selection of specific variables and the development of individual edits that check for specific variables (for example, date of diagnosis) or variable combinations.

A reporting facility's first transmission in Version 11.1 should be tested as thoroughly as possible for layout and code problems before further Version 11.1 records are accepted from that facility. Some registries may find it useful to require a "test batch" from each software vendor or facility.

6.5.7 Communication With Reporting Facilities and Software Vendors

Central cancer registries will need to distribute their implementation plan and timeline to reporting facilities and software vendors as soon as possible. Changes to the implementation plan or the timeline should be forwarded immediately to all affected parties (no later than 3 months prior to expected implementation). Reporting facilities that are not CoC-approved cancer programs may be less aware of upcoming changes and may need more transition time.

Central cancer registries should ensure that abstractors at reporting facilities have been exposed to pertinent Multiple Primary and Histology coding rules, and state-specific training opportunities prior to 2007 implementation.

6.5.8 Education and Training

Central cancer registries should attend education and training workshops provided by national programs. See Appendix B for education and training opportunities for the new multiple primary rules.

6.6 Summary for Software Developers and Vendors

6.6.1 Identify Software Changes

New data items and changes to codes/descriptions will modify the software's data dictionary applicable to NAACCR Version 11.1. Specifications supporting the upgrade are unique to each software vendor; one factor is based on whether the registry software is a hospital registry system or a central registry product. The instruction to development staff should address the following:

The following new National Provider Identifier (NPI) data items should be a valid code (refer to the check digit algorithm for validation checking in Section 3.1) or blank for cases diagnosed prior to January 1, 2007:

New Data Items for 2007 Implementation	
NAACCR Item Name	**NAACCR Item #**
NPI--Registry ID	45
NPI--Reporting Facility	545
NPI--Archive FIN	3105
NPI--Physician--Primary Surg	2485
NPI--Physician--Managing	2465
NPI--Physician--Follow Up	2475
NPI--Physician 3	2495
NPI--Physician 4	2505
NPI--Inst Referred From	2415
NPI--Inst Referred To	2425
NPI--Following Registry	2445

The following new multiple primary data items should be a valid code or blank for cases diagnosed prior to January 1, 2007:

New Data Items for 2007 Implementation	
NAACCR Item Name	**NAACCR Item #**
Ambiguous Terminology	442
Date of Conclusive DX	443
Mult Tum Rpt as One Prim	444
Date of Multiple Tumors	445
Multiplicity Counter	446

- Incorporate the new version of CS 01.03.00
  - Replace documentation including changes to Part I and/or Part II of the CS coding manual (available online or printed as replacement pages);
  - Replace the computer algorithm;
  - Review and recode certain codes – report or log to identify those cases to be reviewed and were recoded as applicable;
  - Update the lookups, if applicable;
  - Re-run the algorithm on previously entered CS elements to re-derive the CS fields, regardless of diagnosis date;
  - After implementation of a new CS algorithm, all CS cases should be run through the new CS dll and the CS Version Latest [2936] updated to the new version.
- Note: Prior to the January 2007 NPCR-CSS data submission, registries must download, replace, and re-run CS version 01.03.00 to correct derived Collaborative Staging.
  - Prior to the January 2008 NPCR-CSS data submission, the review and any necessary recoding of cases diagnosed 2004 through 2006 must be completed.
- The new Multiple Primary and Histology coding rules will be implemented for all data collection in the United States for cases diagnosed on or after January 1, 2007.
- The rules are site specific for the following eight site groups:
  - Head and neck
  - Colon
  - Lung
  - Melanoma of skin [C44.0-C44.9 with Histology 8720-8780]
  - Breast
  - Kidney

- Renal pelvis, ureter and bladder
- Malignant brain and CNS.

A ninth set of rules covers Other Sites (except benign and borderline brain, and CNS tumors and hematopoietic malignancies). All of the 2007 rules are for solid malignancies. Use the Other Sites histology coding rules for solid tumors, including tumors of unknown primary site. Use the pre-existing multiple primary rules for benign and borderline brain, and CNS tumors and for reportable hematopoietic diseases.

- Visit the SEER Web site to locate the Multiple Primary and Histology coding rules Manual (http://seer.cancer.gov/tools/mphrules/download.html).
- →Apply revisions to existing data items (See NAACCR Standards Volume II, Version 11.1, Appendix F.
- Add/modify lookups (pick lists) of codes/descriptions for existing fields.
- Determine that appropriate code values are recorded and stored, as well as validated within the system.
- Make updates to online Help system identifying new/revised data items.
- Incorporate EDITS metafiles (NACR111), including modified state-specific metafiles.
- New version of the EDITS Application Program Interface (API), sometimes called the EDITS Engine, available in Dynamic Link Library (.DLL) form. It has been upgraded for increased reliability and processing speed and, unlike the older version, it can process very large edit sets. It is backward-compatible and can seamlessly be moved into any Windows based platform. The source code is also available for compiling to non-Windows platforms.
- Reports: Add new data items to abstracts, other canned reports, and to ad-hoc report writing.
- State reporting programs: Add option for Version 11.1 layout with option intact for reporting in Version 11 (generic and state-specific versions).
- Determine state-specific level as to handling of retired data items to be moved to state/requestor section.
- Incorporate changes necessitated by posted updates to CS DLL (see section 4).

Along with an upgrade to software, vendors will also have to provide applicable user documentation to support the changes to the software for NAACCR Version 11.1. This includes an online Help system and training/tutorial guides.

6.6.2 Conversion Consideration

Implementation of Version 11.1 does not require any data item conversions to satisfy CoC reporting requirements.

6.6.3 Programming, Testing, and Implementation

Software vendors should provide programming instructions to support the necessary changes for NAACCR Version 11.1, as well as testing (if time allowed, beta site testing) and implementation of the items listed earlier.

Software vendors need to revise/develop, test, distribute, and install software prior to implementation dates set by standard-setting organizations and central cancer registries. Central cancer registries may require test files to be submitted prior to approval in reporting in the Version 11.1 format. Any changes to this timeline should be immediately reported to all involved parties.

If there are delays to the standards or errata that have not been identified, the software vendor programs will be at risk of delay.

6.6.4 Technical Support, Education and Training

Software vendors will be expected to support their software changes and provide training on the software upgrades, which include reference to the source for information on year 2007 changes. Education and training for Version 11.1 and the new multiple primary rules as well as associated data items should be referred to the appropriate standard-setting organization.

6.6.5 Communication With Central Cancer Registries and Hospital Registries

Because of the minor changes involved in the implementation of the Version 11.1 layout, software vendors should not encounter undue problems with the transition.

Software vendors should take into consideration the central cancer registry requirements when it comes to central cancer registries' implementation of NAACCR Version 11.1 reporting; for example, state-specific metafiles, whether any data items still required by the state have been retired from the NAACCR record.

6.7 Summary for Hospital Cancer Registrars and Reporting Facilities

Implementation of NAACCR Version 11.1 reporting is required for cases diagnosed as of January 1, 2007.

6.7.1 Prioritize Case Abstracting

Registrars should prioritize their abstracting. Ideally, abstracting of cases diagnosed prior to January 1, 2007, should be completed before software vendors convert registry data and/or begin to use NAACCR Version 11.1 reporting upgrades.

6.7.2 Communication With Central Cancer Registries and Software Vendors

Hospital registries should be in contact with their software vendor to determine when the necessary software upgrade may be delivered, and then make a tentative schedule within the facility to have someone available for the upgrade installation.

Registries that have an interest in being involved in implementation of changes early should consider being a beta test site. This will allow them to receive software and software vendor support early in the process.

6.7.3 Conversion Consideration

There are no conversion requirements necessary for the implementation of the 2007 changes in these guidelines.

6.7.4 Education and Training

Registrars and abstractors should attend education training provided by regional, state, or national programs. See Appendix B for education and training opportunities for the new multiple primary rules.

7 APPENDIX A: CHAPTER VIII, REQUIRED STATUS TABLE (ITEM # ORDER)

The following table presents Version 11.1 of the NAACCR required status summarizing the requirements and recommendations for collection of each item by standard-setting groups. Differences from Version 11 are marked "Revised," "New," or "Retired" in the "Note" column of the table.

NPCR Refers to requirements and recommendations of the NPCR regarding data items that should be collected or computed by NPCR state registries. Note: Personal identifying data items collected are not transmitted to CDC.

CoC Refers to requirements of CoC. Facilities should refer to the CoC *FORDS Manual* for further clarification of required fields.

SEER Refers to requirements of NCI's SEER Program. Facilities and central registries should refer to the *SEER Program Code Manual* for further clarification of required fields.

Exchange Elements for Hospital to Central and Central to Central
The target audience for this set of requirements is comprised of the various designers of registry software, at the hospital, central registry, and national levels. In the Exchange Elements columns, data items marked are either required by key national organizations for cancer reporting or are of special importance in the unambiguous communication of reports and the proper linking of records. A clear distinction is made between items required for facilities reporting to central registries (labeled Hosp → Central), and those items that central registries should use when sending cases to other central registries (labeled Central → Central). "T" is used when the data are vital to a complete exchange record. If a data item is unknown, it should have the proper code for unknown assigned. It is not specified how registries should handle records that have empty T fields. "T*" means the vendor should convey the data if they are available for any of the cases; otherwise, they can leave the field empty. The receiving end (central registry) may, of course, ignore these items if they so choose. "TH" means only certain cases diagnosed before 2004 may require these fields. Some central registries have additional required data fields. For these, vendors should contact the central registry directly.

Codes for Recommendations: R = Required. RH = Historically collected and currently transmitted. RC = Collected by SEER from CoC-approved hospitals. RS = Required, site specific. S = Supplementary/recommended. D = Derived. · = No recommendations. * = When available. # = Central registries may code available data using either the SEER or COC data item and associated rules. ^ = These text requirements may be met with one or several text block fields. T = data are vital to complete exchange record. TH – cases diagnosed before 2004, transmit data if available in exchange record. T* - transmit data if available for any case in exchange record.

Item	Item Name	NPCR		COC		SEER		Exchange Elements		Source of Standard	Note
		Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp→ Central	Central→ Central		
10	Record Type	.	R	.	R	.	R	T	T	NAACCR	
20	Patient ID Number	R	R	.	.	R	R	.	T	Reporting Registry	
21	Patient System ID-Hosp	.	.	.	.	.	.	T	.	NAACCR	
30	Registry Type	.	.	.	.	.	.	.	T	NAACCR	
35	FIN Coding System	.	.	.	.	.	.	.	.	NAACCR	
37	Reserved 00	.	.	.	.	.	.	.	.		
40	Registry ID	.	R	.	.	R	R	T	T	NAACCR	
45	NPI--Registry ID	.	.	.	.	R*	.	.	.	NAACCR	New
50	NAACCR Record Version	.	R	.	R	.	.	T	T	NAACCR	
60	Tumor Record Number	.	.	.	.	S	S	T	T	NAACCR	
70	Addr at DX--City	R	.	R	R	R	.	T	T	COC	
80	Addr at DX--State	R	R	R	R	R	.	T	T	COC	
90	County at DX	R	R	R	R	R	R	T	T	FIPS/SEER	
100	Addr at DX--Postal Code	R	R	R	R	R	.	T	T	COC	
110	Census Tract 1970/80/90	RH*	RH*	.	.	RH	RH	.	T*	SEER	
120	Census Cod Sys 1970/80/90	RH*	RH*	.	.	RH	RH	.	T*	SEER	
130	Census Tract 2000	R	R	.	.	R	R	.	T*	NAACCR	
140	Census Tract Cod Sys--Alt										Retired
150	Marital Status at DX	.	.	.	.	R	R	.	.	SEER	
160	Race 1	R	R	R	R	R	R	T	T	SEER/COC	
161	Race 2	R	R	R	R	R	R	T	T	SEER/COC	
162	Race 3	R	R	R	R	R	R	T	T	SEER/COC	
163	Race 4	R	R	R	R	R	R	T	T	SEER/COC	
164	Race 5	R	R	R	R	R	R	T	T	SEER/COC	
170	Race Coding Sys--Current	.	.	R	R	.	.	T	T	NAACCR	
180	Race Coding Sys--Original	.	.	R	R	.	.	T	T	NAACCR	
190	Spanish/Hispanic Origin	R	R	R	R	R	R	T	T	SEER/COC	
191	NHIA Derived Hisp Origin	D	R	.	.	D	R	.	.	NAACCR	Revised
192	IHS Link	R*	R*	.	.	.	R	.	.	NPCR	
200	Computed Ethnicity	R	R	.	.	D	R	.	.	SEER	Revised
210	Computed Ethnicity Source	R	R	.	.	R	R	.	.	SEER	
220	Sex	R	R	R	R	R	R	T	T	SEER/COC	
230	Age at Diagnosis	R	R	R	R	R	R	.	.	SEER/COC	
240	Birth Date	R	R	R	R	R	R	T	T	SEER/COC	
250	Birthplace	R*	R*	R	R	R	R	T*	T	SEER/COC	
260	Religion	.	.	.	.	.	.	.	.	Varies	
270	Occupation Code--Census	R*	R*	.	.	.	.	.	.	Census/NPCR	
280	Industry Code−Census	R*	R*	.	.	.	.	.	.	Census/NPCR	
290	Occupation Source	R*	R*	.	.	.	.	.	.	NPCR	
300	Industry Source	R*	R*	.	.	.	.	.	.	NPCR	
310	Text--Usual Occupation	R*	.	.	.	.	.	T*	T*	NPCR	
320	Text--Usual Industry	R*	.	.	.	.	.	T*	T*	NPCR	
330	Occup/Ind Coding System	R*	R*	.	.	.	.	.	.	NPCR	

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Item	Item Name	NPCR		COC		SEER		Exchange Elements		Source of Standard	Note
		Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp→ Central	Central→ Central		
340	Tobacco History	.	.	.	.	.	.	.	.	Varies	
350	Alcohol History	.	.	.	.	.	.	.	.	Varies	
360	Family History of Cancer	.	.	.	.	.	.	.	.	Varies	
362	Census Tract Block Group	.	.	.	.	.	.	.	.	Census	
364	Census Tr Cert 1970/80/90	RH*	RH*	.	.	RH	RH	.	.	SEER	
365	Census Tr Certainty 2000	R	R	.	.	R	R	.	.	NAACCR	
366	GIS Coordinate Quality	R*	R*	.	.	S	.	.	.	NAACCR	Revised
370	Reserved 01	.	.	.	.	.	.	.	.		
380	Sequence Number--Central	R	R	.	.	R	R	.	T	SEER	
390	Date of Diagnosis	R	R	R	R	R	R	T	T	SEER/COC	
400	Primary Site	R	R	R	R	R	R	T	T	SEER/COC	
410	Laterality	R	R	R	R	R	R	T	T	SEER/COC	
419	Morph --Type&Behav ICD-O-2										
420	Histology (92-00) ICD-O-2	RH	RH	RH.	RH	RH	RH	TH	TH	SEER/COC	
430	Behavior (92-00) ICD-O-2	RH	RH	RH	RH	RH	RH	TH	TH	SEER/COC	
440	Grade	R	R	R	R	R	R	T	T	SEER/COC	
442	Ambiguous Terminology DX	.	.	R	R	R	R	.	.	SEER	Revised
443	Date of Conclusive DX	.	.	R	R	R	R	.	.	SEER	Revised
444	Mult Tum Rpt as One Prim	.	.	R	R	R	R	.	.	SEER	Revised
445	Date of Multiple Tumors	.	.	R	R	R	R	.	.	SEER	Revised
446	Multiplicity Counter	.	.	R	R	R	R	.	.	SEER	Revised
447	Number of Tumors/Hist	.	.	.	.	.	.	.	.	NAACCR	
450	Site Coding Sys--Current	R	R	R	R	.	.	T	T	NAACCR	
460	Site Coding Sys--Original	.	.	R	R	.	.	T	T	NAACCR	
470	Morph Coding Sys --Current	R	R	R	R	.	.	T	T	NAACCR	
480	Morph Coding Sys --Originl	.	.	R	R	.	.	T	T	NAACCR	
490	Diagnostic Confirmation	R	R	R	R	R	R	T	T	SEER/COC	
500	Type of Reporting Source	R	R	.	.	R	R	T	T	SEER	
501	Casefinding Source	.	.	.	.	R	R	T*	T*	NAACCR	Revised
510	Screening Date	.	.	.	.	.	.	.	.	NAACCR	
520	Screening Result	.	.	.	.	.	.	.	.	NAACCR	
521	Morph --Type&Behav ICD-O-3										
522	Histologic Type ICD-O-3	R	R	R	R	R	R	T	T	SEER/COC	
523	Behavior Code ICD-O-3	R	R	R	R	R	R	T	T	SEER/COC	
530	Reserved 02	.	.	.	.	.	.	.	.		
535	Reserved 25	.	.	.	.	.	.	.	.		Retired
538	Reporting Hospital FAN										Retired
540	Reporting Facility	R	.	R	R	R	.	T	.	COC	
545	NPI --Reporting Facility	R*	.	R*	R*	R*	.	.	.	NAACCR	New
550	Accession Number--Hosp	.	.	R	R	R	.	T*	.	COC	
560	Sequence Number--Hospital	.	.	R	R	R	.	T	.	COC	

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Item	Item Name	NPCR		COC		SEER		Exchange Elements		Source of Standard	Note
		Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp→ Central	Central→ Central		
570	Abstracted By	.	.	R	R	R	.	.	.	COC	
580	Date of 1st Contact	R	.	R	R	.	.	T	.	COC	
590	Date of Inpatient Adm	.	.	.	.	.	.	.	.	NAACCR	
600	Date of Inpatient Disch	.	.	.	.	.	.	.	.	NAACCR	
610	Class of Case	R	.	R	R	RC	.	T	.	COC	
615	Reserved 26	.	.	.	.	.	.	.	.		
620	Year First Seen This CA										Retired
630	Primary Payer at DX	R*	R*	R	R	R	R	.	.	COC	Revised
635	Reserved 27	.	.	.	.	.	.	.	.		Retired
640	Inpatient/Outpt Status										Retired
650	Presentation at CA Conf										Retired
660	Date of CA Conference										Retired
670	RX Hosp -- Surg Prim Site	.	.	R	R	R	.	T*	.	COC	
672	RX Hosp -- Scope Reg LN Sur	.	.	R	R	R	.	T*	.	COC	
674	RX Hosp -- Surg Oth Reg/Dis	.	.	R	R	R	.	T*	.	COC	
676	RX Hosp -- Reg LN Removed	.	.	.	RH	.	.	T*	.	COC	
680	Reserved 03	.	.	.	.	.	.	.	.		
690	RX Hosp -- Radiation	.	.	.	.	RH	.	TH*	.	SEER/COC	Revised
700	RX Hosp -- Chemo	.	.	R	R	R	.	T*	.	COC	
710	RX Hosp -- Hormone	.	.	R	R	R	.	T*	.	COC	
720	RX Hosp -- BRM	.	.	R	R	R	.	T*	.	COC	
730	RX Hosp -- Other	.	.	R	R	R	.	T*	.	COC	
740	RX Hosp -- DX/Stg Proc	.	.	R	R	.	.	.	.	COC	
741	Reserved 28	.	.	.	.	.	.	.	.		
742	RX Hosp -- Screen/BX Proc1										Retired
743	RX Hosp -- Screen/BX Proc2										Retired
744	RX Hosp -- Screen/BX Proc3										Retired
745	RX Hosp -- Screen/BX Proc4										Retired
746	RX Hosp -- Surg Site 98-02	.	.	.	RH	RH	.	TH*	.	COC	
747	RX Hosp -- Scope Reg 98-02	.	.	.	RH	RH	.	TH*	.	COC	
748	RX Hosp -- Surg Oth 98-02	.	.	.	RH	RH	.	TH*	.	COC	
750	Reserved 04	.	.	.	.	.	.	.	.		
759	SEER Summary Stage 2000	RH	RH	RH	RH		S	TH*	TH*	SEER	Revised
760	SEER Summary Stage 1977	RH	RH	RH	RH	.	S	TH*	TH*	SEER	
765	Reserved 29	.	.	.	.	.	.	.	.		
770	Loc/Reg/Distant Stage										Retired
779	Extent of Disease 10-Dig										
780	EOD--Tumor Size	.	.	RH	RH	RH	RH	TH*	TH*	SEER/COC	
790	EOD--Extension	.	.	.	.	RH	RH	TH*	TH*	SEER	
800	EOD--Extension Prost Path	.	.	.	.	RH	RH	TH*	TH*	SEER	
810	EOD--Lymph Node Involv	.	.	.	.	RH	RH	TH*	TH*	SEER	
820	Regional Nodes Positive	.	.	R	R	R	R	T*	T*	SEER/COC	
830	Regional Nodes Examined	.	.	R	R	R	R	T*	T*	SEER/COC	

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Item	Item Name	NPCR		COC		SEER		Exchange Elements		Source of Standard	Note
		Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp→ Central	Central→ Central		
840	EOD--Old 13 Digit	.	.	.	.	RH	RH	.	.	SEER	
850	EOD--Old 2 Digit	.	.	.	.	RH	RH	.	.	SEER	
860	EOD--Old 4 Digit	.	.	.	.	RH	RH	.	.	SEER	
870	Coding System for EOD	.	.	.	.	RH	RH	.	TH*	SEER	
880	TNM Path T	.	.	R	R	.	.	T*	T*	AJCC	
890	TNM Path N	.	.	R	R	.	.	T*	T*	AJCC	
900	TNM Path M	.	.	R	R	.	.	T*	T*	AJCC	
910	TNM Path Stage Group	.	.	R	R	.	.	T*	T*	AJCC	
920	TNM Path Descriptor	.	.	R	R	.	.	T*	T*	COC	
930	TNM Path Staged By	.	.	R	R	.	.	T*	T*	COC	
940	TNM Clin T	.	.	R	R	.	.	T*	T*	AJCC	
950	TNM Clin N	.	.	R	R	.	.	T*	T*	AJCC	
960	TNM Clin M	.	.	R	R	.	.	T*	T*	AJCC	
970	TNM Clin Stage Group	.	.	R	R	.	.	T*	T*	AJCC	
980	TNM Clin Descriptor	.	.	R	R	.	.	T*	T*	COC	
990	TNM Clin Staged By	.	.	R	R	.	.	T*	T*	COC	
995	Reserved 30	.	.	.	.	.	.	.	.		
1000	TNM Other T										Retired
1010	TNM Other N										Retired
1020	TNM Other M										Retired
1030	TNM Other Stage Group										Retired
1040	TNM Other Staged By										Retired
1050	TNM Other Descriptor										Retired
1060	TNM Edition Number	.	.	R	R	.	.	T*	T*	COC	
1065	Reserved 31	.	.	.	.	.	.	.	.		
1070	Other Staging System										Retired
1080	Date of 1st Positive BX	.	.	.	.	.	.	.	.	NAACCR	
1090	Site of Distant Met 1	.	.	.	RH	.	.	.	.	COC	
1100	Site of Distant Met 2	.	.	.	RH	.	.	.	.	COC	
1110	Site of Distant Met 3	.	.	.	RH	.	.	.	.	COC	
1120	Pediatric Stage	.	.	.	.	.	.	.	.	COC	
1130	Pediatric Staging System	.	.	.	.	.	.	.	.	COC	
1140	Pediatric Staged By	.	.	.	.	.	.	.	.	COC	
1150	Tumor Marker 1	.	.	.	RH	RH	RH	TH*	TH*	SEER	
1160	Tumor Marker 2	.	.	.	RH	RH	RH	TH*	TH*	SEER	
1170	Tumor Marker 3	.	.	.	RH	RH	RH	TH*	TH*	SEER	
1180	Reserved 05	.	.	.	.	.	.	.	.		
1190	Reserved 06	.	.	.	.	.	.	.	.		
1200	RX Date--Surgery	.	.	R	R	S	.	T*	T*	COC	
1210	RX Date--Radiation	.	.	R	R	S	.	T*	T*	COC	
1220	RX Date--Chemo	.	.	.	.	.	.	TH*	TH*	NAACCR	
1230	RX Date--Hormone	.	.	.	.	.	.	TH*	TH*	NAACCR	
1240	RX Date--BRM	.	.	.	.	S	.	TH*	TH*	NAACCR	

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		Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp→ Central	Central→ Central		
1250	RX Date--Other	.	.	R	R	S	.	T*	T*	COC	
1260	Date of Initial RX--SEER	R#	R#	.	.	R	R	T*	T*	SEER	
1270	Date of 1st Crs RXcCOC	R#	R#	R	R	.	.	T*	T*	COC	
1280	RX Date--DX/Stg Proc	.	.	R	R	.	.	.	.	COC	
1290	RX Summ--Surg Prim Site	R	R	R	R	R	R	T	T*	SEER/COC	
1292	RX Summ--Scope Reg LN Sur	R	R	R	R	R	R	T	T*	SEER/COC	
1294	RX Summ--Surg Oth Reg/Dis	R	R	R	R	R	R	T	T*	SEER/COC	
1296	RX Summ--Reg LN Examined	.	.	.	RH	RH	RH	TH*	TH*	SEER/COC	Revised
1300	Reserved 07	.	.	.	.	.	.	.	.		
1310	RX Summ--Surgical Approch	.	.	.	RH	.	.	.	.	COC	
1320	RX Summ--Surgical Margins	.	.	R	R	.	.	.	.	COC	
1330	RX Summ--Reconstruct 1st	.	.	.	.	RH	RH	.	.	SEER	
1340	Reason for No Surgery	R	R	R	R	R	R	T	T*	SEER/COC	
1350	RX Summ--DX/Stg Proc	.	.	R	R	.	.	.	.	COC	
1355	Reserved 22	.	.	.	.	.	.	.	.		
1360	RX Summ--Radiation	.	.	.	.	R	R	TH*	TH*	SEER	Revised
1370	RX Summ--Rad to CNS	.	.	.	.	R	R	.	.	SEER/COC	
1380	RX Summ--Surg/Rad Seq	R	R	R	R	R	R	T	T*	SEER/COC	
1390	RX Summ--Chemo	R	R	R	R	R	R	T*	T*	SEER/COC	
1400	RX Summ--Hormone	R	R	R	R	R	R	T*	T*	SEER/COC	
1410	RX Summ--BRM	R	R	R	R	R	R	T*	T*	SEER/COC	
1420	RX Summ--Other	R	R	R	R	R	R	T*	T*	SEER/COC	
1430	Reason for No Radiation	.	.	R	R	.	.	.	.	COC	
1435	Reserved 32	.	.	.	.	.	.	.	.		
1440	Reason for No Chemo										Retired
1450	Reason for No Hormone										Retired
1460	RX Coding System--Current	R	R	R	R	.	RH	T*	T*	NAACCR	
1465	Reserved 33	.	.	.	.	.	.	.	.		
1470	Protocol Eligibility Stat										Retired
1480	Protocol Participation										Retired
1490	Referral to Support Serv										Retired
1500	First Course Calc Method	.	.	.	.	.	.	.	.	NAACCR	
1510	Rad--Regional Dose: CGY	.	.	R	R	.	.	T	.	COC	
1520	Rad--No of Treatment Vol	.	.	R	R	.	.	T	.	COC	
1530	Rad--Elapsed RX Days										Retired
1535	Reserved 34	.	.	.	.	.	.	.	.		
1540	Rad--Treatment Volume	.	.	R	R	.	.	T	.	COC	
1550	Rad--Location of RX	.	.	R	R	.	.	T	.	COC	
1555	Reserved 35	.	.	.	.	.	.	.	.		
1560	Rad--Intent of Treatment										Retired
1570	Rad--Regional RX Modality	R	R	R	R	RC	.	T	T*	COC	
1580	Rad--RX Completion Status										Retired
1590	Rad--Local Control Status										Retired

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Item	Item Name	NPCR		COC		SEER		Exchange Elements		Source of Standard	Note
		Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp→ Central	Central→ Central		
1600	Chemotherapy Field 1										Retired
1610	Chemotherapy Field 2										Retired
1620	Chemotherapy Field 3										Retired
1630	Chemotherapy Field 4										Retired
1635	Reserved 23	.	.	.	.	.	.	.	.		
1639	RX Summ--Systemic/Sur Seq	R	R	R	R	R	R	T	T	COC	Revised
1640	RX Summ--Surgery Type	.	.	.	.	RH	RH	TH*	TH*	SEER	
1641	Reserved 36	.	.	.	.	.	.	.	.		
1642	RX Summ--Screen/BX Proc1										Retired
1643	RX Summ--Screen/BX Proc2										Retired
1644	RX Summ--Screen/BX Proc3										Retired
1645	RX Summ--Screen/BX Proc4										Retired
1646	RX Summ--Surg Site 98-02	.	.	RH	RH	RH	RH	TH*	TH*	SEER/COC	
1647	RX Summ--Scope Reg 98-02	.	.	RH	RH	RH	RH	TH*	TH*	SEER/COC	
1648	RX Summ--Surg Oth 98-02	.	.	RH	RH	RH	RH	TH*	TH*	SEER/COC	
1650	Reserved 08	.	.	.	.	.	.	.	.		
1660	Subsq RX 2nd Course Date	.	.	.	.	.	.	.	.	COC	
1670	Subsq RX 2nd Course Codes										
1671	Subsq RX 2nd Course Surg	.	.	.	.	.	.	.	.	COC	
1672	Subsq RX 2nd Course Rad	.	.	.	.	.	.	.	.	COC	
1673	Subsq RX 2nd Course Chemo	.	.	.	.	.	.	.	.	COC	
1674	Subsq RX 2nd Course Horm	.	.	.	.	.	.	.	.	COC	
1675	Subsq RX 2nd Course BRM	.	.	.	.	.	.	.	.	COC	
1676	Subsq RX 2nd Course Oth	.	.	.	.	.	.	.	.	COC	
1677	Subsq RX 2nd --Scope LN SU	.	.	.	.	.	.	.	.	COC	
1678	Subsq RX 2nd --Surg Oth	.	.	.	.	.	.	.	.	COC	
1679	Subsq RX 2nd --Reg LN Rem	.	.	.	.	.	.	.	.	COC	
1680	Subsq RX 3rd Course Date	.	.	.	.	.	.	.	.	COC	
1690	Subsq RX 3rd Course Codes										
1691	Subsq RX 3rd Course Surg	.	.	.	.	.	.	.	.	COC	
1692	Subsq RX 3rd Course Rad	.	.	.	.	.	.	.	.	COC	
1693	Subsq RX 3rd Course Chemo	.	.	.	.	.	.	.	.	COC	
1694	Subsq RX 3rd Course Horm	.	.	.	.	.	.	.	.	COC	
1695	Subsq RX 3rd Course BRM	.	.	.	.	.	.	.	.	COC	
1696	Subsq RX 3rd Course Oth	.	.	.	.	.	.	.	.	COC	
1697	Subsq RX 3rd--Scope LN Su	.	.	.	.	.	.	.	.	COC	
1698	Subsq RX 3rd--Surg Oth	.	.	.	.	.	.	.	.	COC	
1699	Subsq RX 3rd--Reg LN Rem	.	.	.	.	.	.	.	.	COC	
1700	Subsq RX 4th Course Date	.	.	.	.	.	.	.	.	COC	
1710	Subsq RX 4th Course Codes										
1711	Subsq RX 4th Course Surg	.	.	.	.	.	.	.	.	COC	
1712	Subsq RX 4th Course Rad	.	.	.	.	.	.	.	.	COC	
1713	Subsq RX 4th Course Chemo	.	.	.	.	.	.	.	.	COC	

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Item	Item Name	NPCR		COC		SEER		Exchange Elements		Source of Standard	Note
		Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp→ Central	Central→ Central		
1714	Subsq RX 4th Course Horm	.	.	.	.	.	.	.	.	COC	
1715	Subsq RX 4th Course BRM	.	.	.	.	.	.	.	.	COC	
1716	Subsq RX 4th Course Oth	.	.	.	.	.	.	.	.	COC	
1717	Subsq RX 4th--Scope LN Su	.	.	.	.	.	.	.	.	COC	
1718	Subsq RX 4th--Surg Oth	.	.	.	.	.	.	.	.	COC	
1719	Subsq RX 4th--Reg LN Rem	.	.	.	.	.	.	.	.	COC	
1720	Subsq RX 5th Course Date										Retired
1725	Reserved 37	.	.	.	.	.	.	.	.		
1726	Reserved 38	.	.	.	.	.	.	.	.		
1730	Subsq RX 5th Course Codes										Retired
1731	Subsq RX 5th Course Surg										Retired
1732	Subsq RX 5th Course Rad										Retired
1733	Subsq RX 5th Course Chemo										Retired
1734	Subsq RX 5th Course Horm										Retired
1735	Subsq RX 5th Course BRM										Retired
1736	Subsq RX 5th Course Oth										Retired
1737	Subsq RX 5th--Scope LN Su										Retired
1738	Subsq RX 5th--Surg Oth										Retired
1739	Subsq RX 5th--Reg LN Rem										Retired
1740	Reserved 09	.	.	.	.	.	.	.	.		
1741	Subsq RX--Reconstruct Del	.	.	.	.	.	.	.	.	COC	
1750	Date of Last Contact	R	R	R	R	R	R	T	T	SEER/COC	
1760	Vital Status	R	R	R	R	R	R	T	T	SEER/COC	
1770	Cancer Status	.	.	R	R	.	.	.	.	COC	
1780	Quality of Survival	.	.	.	.	.	.	.	.	COC	
1790	Follow-Up Source	.	.	R	R	.	.	T*	.	COC	
1791	Follow-up Source Central	R	R	.	.	.	.	.	T*	NAACCR	
1800	Next Follow-Up Source	.	.	R	.	.	.	.	.	COC	
1810	Addr Current --City	.	.	R	.	R	.	T*	.	COC	
1820	Addr Current --State	.	.	R	.	R	.	T*	.	COC	
1830	Addr Current --Postal Code	.	.	R	.	R	.	T*	.	COC	
1835	Reserved 10	.	.	.	.	.	.	.	.		
1840	County--Current	.	.	.	.	.	.	.	.	NAACCR	
1842	Follow-Up Contact--City	.	.	.	.	R	.	T*	.	SEER	
1844	Follow-Up Contact--State	.	.	.	.	R	.	T*	.	SEER	
1846	Follow-Up Contact--Postal	.	.	.	.	R	.	T*	.	SEER	
1850	Unusual Follow-Up Method	.	.	.	.	.	.	.	.	COC	
1860	Recurrence Date--1st	.	.	R	R	RC	.	T*	.	COC	
1870	Recurrence Distant Sites										Retired
1871	Recurrence Distant Site 1	.	.	.	.	.	.	.	.	NAACCR	
1872	Recurrence Distant Site 2	.	.	.	.	.	.	.	.	NAACCR	
1873	Recurrence Distant Site 3	.	.	.	.	.	.	.	.	NAACCR	
1880	Recurrence Type --1st	.	.	R	R	RC	.	T*	.	COC	

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		Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp→ Central	Central→ Central		
1890	Recurrence Type --1st--Oth										Retired
1895	Reserved 39	.	.	.	.	.	.	.	.		
1900	Reserved 11	.	.	.	.	.	.	.	.		
1910	Cause of Death	R	R	.	.	R	R	.	T	SEER	
1920	ICD Revision Number	R	R	.	.	R	R	.	T	SEER	
1930	Autopsy	.	.	.	.	.	.	.	.	NAACCR	
1940	Place of Death	R	.	.	.	.	.	T*	T*	NPCR	
1950	Reserved 12	.	.	.	.	.	.	.	.		Retired
1960	Site (73-91) ICD-O-1	.	.	.	.	RH	RH	.	.	SEER	
1970	Morph (73-91) ICD-O-1										
1971	Histology (73-91) ICD-O-1	.	.	.	.	RH	RH	.	.	SEER	
1972	Behavior (73-91) ICD-O-1	.	.	.	.	RH	RH	.	.	SEER	
1973	Grade (73-91) ICD-O-1	.	.	.	.	RH	RH	.	.	SEER	
1980	ICD-O-2 Conversion Flag	.	.	R	R	R	R	T*	T*	SEER	
1981	Over-ride SS/NodesPos	.	.	.	.	.	.	T*	T*	NAACCR	
1982	Over-ride SS/TNM-N	.	.	.	.	.	.	T*	T*	NAACCR	
1983	Over-ride SS/TNM-M	.	.	.	.	.	.	T*	T*	NAACCR	
1984	Over-ride SS/DisMet1	.	.	.	.	.	.	T*	T*	NAACCR	
1985	Over-ride Acsn/Class/Seq	.	.	R	R	.	.	T*	T*	COC	
1986	Over-ride HospSeq/DxConf	.	.	R	R	.	.	T*	T*	COC	
1987	Over-ride COC-Site/Type	.	.	R	R	.	.	T*	T*	COC	
1988	Over-ride HospSeq/Site	.	.	R	R	.	.	T*	T*	COC	
1989	Over-ride Site/TNM-StgGrp	.	.	R	R	.	.	T*	T*	COC	
1990	Over-ride Age/Site/Morph	R	R	R	R	R	R	T*	T*	SEER	
2000	Over-ride SeqNo/DxConf	R	R	.	.	R	R	T*	T*	SEER	
2010	Over-ride Site/Lat/SeqNo	R	R	.	.	R	R	T*	T*	SEER	
2020	Over-ride Surg/DxConf	R	R	R	R	R	R	T*	T*	SEER	
2030	Over-ride Site/Type	R	R	R	R	R	R	T*	T*	SEER	
2040	Over-ride Histology	R	R	R	R	R	R	T*	T*	SEER	
2050	Over-ride Report Source	R	R	.	.	R	R	T*	T*	SEER	
2060	Over-ride Ill-define Site	R	R	.	.	R	R	T*	T*	SEER	
2070	Over-ride Leuk, Lymphoma	R	R	R	R	R	R	T*	T*	SEER	
2071	Over-ride Site/Behavior	R	R	R	R	R	R	T*	T*	SEER	
2072	Over-ride Site/EOD/DX Dt	.	.	.	.	R	R	T*	T*	SEER	
2073	Over-ride Site/Lat/EOD	.	.	.	.	R	R	T*	T*	SEER	
2074	Over-ride Site/Lat/Morph	R	R	R	R	R	R	T*	T*	SEER	
2080	Reserved 13										Retired
2081	CRC CHECKSUM	.	.	.	.	S	S	.	.	NAACCR	
2082	Reserved 24	.	.	.	.	.	.	.	.		
2090	Date Case Completed	.	.	.	.	.	.	.	.	NAACCR	
2100	Date Case Last Changed	.	.	.	.	.	.	.	.	NAACCR	
2110	Date Case Report Exported	R	.	.	R	.	.	T	.	NPCR	
2111	Date Case Report Received	R	.	.	.	.	.	.	.	NPCR	

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		Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp→ Central	Central→ Central		
2112	Date Case Report Loaded	R	.	.	.	.	.	.	.	NPCR	
2113	Date Tumor Record Availbl	R	.	.	.	.	.	.	.	NPCR	
2114	Future Use Timeliness 1										Retired
2115	Future Use Timeliness 2										Retired
2116	ICD-O-3 Conversion Flag	R	R	R	R	R	R	T	T	SEER/COC	
2120	SEER Coding Sys --Current	.	.	.	.	.	R	T*	T*	NAACCR	
2130	SEER Coding Sys --Original	.	.	.	.	.	R	T*	T*	NAACCR	
2140	COC Coding Sys --Current	.	.	R	R	.	.	T*	T*	COC	
2150	COC Coding Sys --Original	.	.	R	R	.	.	T*	T*	COC	
2160	Subsq Report for Primary										Retired
2161	Reserved 20										Retired
2170	Vendor Name	.	.	.	R	.	.	T	T	NAACCR	
2180	SEER Type of Follow-Up	.	.	.	.	R	R	.	.	SEER	
2190	SEER Record Number	.	.	.	.	.	R	.	.	SEER	
2200	Diagnostic Proc 73-87	.	.	.	.	RH	RH	.	.	SEER	
2210	Reserved 14										Retired
2220	State/Requestor Items	.	.	.	.	.	.	.	.	Varies	
2230	Name--Last	R	.	R	.	R	.	T	T	NAACCR	
2240	Name--First	R	.	R	.	R	.	T	T	NAACCR	
2250	Name--Middle	R	.	R	.	R	.	T*	T*	COC	
2260	Name--Prefix	.	.	.	.	.	.	.	.	SEER	
2270	Name--Suffix	.	.	.	.	R	.	T*	T*	SEER	
2280	Name--Alias	R	.	.	.	R	.	T*	T*	SEER	
2290	Name--Spouse/Parent	.	.	.	.	.	.	.	.	NAACCR	
2300	Medical Record Number	R	.	R	.	R	.	T	.	COC	
2310	Military Record No Suffix	.	.	R	.	.	.	.	.	COC	
2320	Social Security Number	R	.	R	.	R	.	T	T	COC	
2330	Addr at DX --No & Street	R	.	R	.	R	.	T	T	COC	
2335	Addr at DX --Supplementl	R	.	R	.	R	.	T*	T*	COC	Revised
2350	Addr Current --No & Street	.	.	R	.	R	.	T*	T*	COC	
2352	Latitude	R*	R*	.	.	S	.	.	.	NAACCR	
2354	Longitude	R*	R*	.	.	S	.	.	.	NAACCR	
2355	Addr Current --Supplementl	.	.	R	.	R	.	T*	.	COC	
2360	Telephone	.	.	R	.	R	.	T*	T*	COC	
2370	DC State										Retired
2371	Reserved 21										Retired
2380	DC State File Number	R	.	.	.	R*	.	.	T*	State	Revised
2390	Name--Maiden	R	.	.	.	R	.	T*	T*	SEER	
2392	Follow-Up Contact--No&St	.	.	.	.	R	.	.	.	SEER	
2393	Follow-Up Contact--Suppl	.	.	.	.	R	.	.	.	SEER	
2394	Follow-Up Contact--Name	.	.	.	.	R	.	.	.	SEER	
2400	Reserved 16										Retired
2410	Institution Referred From	.	.	R	.	.	.	T*	.	COC	

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		Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp→ Central	Central→ Central		
2415	NPI--Inst Referred From	.	.	R*	.	.	.	.	.	NAACCR	New
2420	Institution Referred To	.	.	R	.	.	.	T*	.	COC	
2425	NPI--Inst Referred To	.	.	R*	.	.	.	.	.	NAACCR	New
2430	Last Follow-Up Hospital										Retired
2435	Reserved 40	.	.	.	.	.	.	.	.		
2440	Following Registry	.	.	R	.	R	.	.	.	COC	
2445	NPI --Following Registry	.	.	.	.	R*	.	.	.	NAACCR	New
2450	Reserved 17										Retired
2460	Physician--Managing	.	.	.	.	.	.	.	.	NAACCR	
2465	NPI --Physician--Managing	.	.	.	.	.	.	.	.	NAACCR	New
2470	Physician--Follow-Up	.	.	R	.	R	.	T*	T*	COC	
2475	NPI--Physician--Follow-Up	.	.	R*	R*	R*	.	.	.	NAACCR	New
2480	Physician--Primary Surg	.	.	R	.	.	.	.	.	COC	
2485	NPI --Physician--Primary Surg	.	.	R*	R*	.	.	.	.	NAACCR	New
2490	Physician 3	.	.	R	.	.	.	.	.	COC	
2495	NPI--Physician 3	.	.	R*	R*	.	.	.	.	NAACCR	New
2500	Physician 4	.	.	R	.	.	.	.	.	COC	
2505	NPI--Physician 4	.	.	R*	R*	.	.	.	.	NAACCR	New
2520	Text--DX Proc--PE	R^	.	.	.	R	.	T*	T*	NPCR	
2530	Text--DX Proc--X-ray/Scan	R^	.	.	.	R	.	T*	T*	NPCR	
2540	Text--DX Proc--Scopes	R^	.	.	.	R	.	T*	T*	NPCR	
2550	Text--DX Proc--Lab Tests	R^	.	.	.	R	.	T*	T*	NPCR	
2560	Text--DX Proc--Op	R^	.	.	.	R	.	T*	T*	NPCR	
2570	Text--DX Proc--Path	R^	.	.	.	R	.	T*	T*	NPCR	
2580	Text--Primary Site Title	R^	.	.	.	R	.	T*	T*	NPCR	
2590	Text--Histology Title	R^	.	.	.	R	.	T*	T*	NPCR	
2600	Text--Staging	R^	.	.	.	R	.	T*	T*	NPCR	
2610	RX Text--Surgery	R^	.	.	.	R	.	T*	T*	NPCR	
2620	RX Text--Radiation (Beam)	R^	.	.	.	R	.	T*	T*	NPCR	
2630	RX Text--Radiation Other	R^	.	.	.	R	.	T*	T*	NPCR	
2640	RX Text--Chemo	R^	.	.	.	R	.	T*	T*	NPCR	
2650	RX Text--Hormone	R^	.	.	.	R	.	T*	T*	NPCR	
2660	RX Text--BRM	R^	.	.	.	R	.	T*	T*	NPCR	
2670	RX Text--Other	R^	.	.	.	R	.	T*	T*	NPCR	
2680	Text--Remarks	.	.	.	.	R	.	T*	T*	NPCR	
2690	Text--Place of Diagnosis	.	.	.	.	.	.	.	.	NPCR	
2700	Reserved 19	.	.	.	.	.	.	.	.		
2800	CS Tumor Size	.	.	R	R	R	R	T	T	AJCC	
2810	CS Extension	R	.	R	R	R	R	T	T	AJCC	
2820	CS Tumor Size/Ext Eval	.	.	R	R	.	.	T*	T*	AJCC	
2830	CS Lymph Nodes	R	.	R	R	R	R	T	T	AJCC	

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		Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp→ Central	Central→ Central		
2840	CS Reg Node Eval	.	.	R	R	.	.	T*	T*	AJCC	
2850	CS Mets at DX	R	.	R	R	R	R	T	T	AJCC	
2860	CS Mets Eval	.	.	R	R	.	.	T*	T*	AJCC	
2880	CS Site-Specific Factor 1	RS	.	R	R	R	R	T	T	AJCC	
2890	CS Site-Specific Factor 2	.	.	R	R	R	R	T	T	AJCC	
2900	CS Site-Specific Factor 3	RS	.	R	R	R	R	T	T	AJCC	
2910	CS Site-Specific Factor 4	.	.	R	R	R	R	T	T	AJCC	
2920	CS Site-Specific Factor 5	.	.	R	R	R	R	T	T	AJCC	
2930	CS Site-Specific Factor 6	.	.	R	R	R	R	T	T	AJCC	
2935	CS Version 1st	R	.	R	R	R	R	.	.	AJCC	
2936	CS Version Latest	R	.	R	R	R	R	.	.	AJCC	
2940	Derived AJCC T	.	.	D	D	D	D	T*	T*	AJCC	
2950	Derived AJCC T Descriptor	.	.	D	D	.	.	T*	T*	AJCC	
2960	Derived AJCC N	.	.	D	D	D	D	T*	T*	AJCC	
2970	Derived AJCC N Descriptor	.	.	D	D	.	.	T*	T*	AJCC	
2980	Derived AJCC M	.	.	D	D	D	D	T*	T*	AJCC	
2990	Derived AJCC M Descriptor	.	.	D	D	.	.	T*	T*	AJCC	
3000	Derived AJCC Stage Group	.	.	D	D	D	D	T*	T*	AJCC	
3010	Derived SS1977	.	.	D	D	D	D	T*	T*	AJCC	
3020	Derived SS2000	D	R	D	D	D	D	T*	T*	AJCC	
3030	Derived AJCC --Flag	.	.	R	R	D	D	T*	T*	AJCC	
3040	Derived SS1977 --Flag	.	.	R	R	D	D	T*	T*	AJCC	
3050	Derived SS2000 --Flag	D	R	R	R	D	D	T*	T*	AJCC	
3100	Archive FIN	.	.	R	R	.	.	.	.	COC	
3105	NPI--Archive FIN	.	.	R*	R*	.	.	.	.	NAACCR	New
3110	Comorbid/Complication 1	.	.	R	R	.	.	T*	.	COC	
3120	Comorbid/Complication 2	.	.	R	R	.	.	T*	.	COC	
3130	Comorbid/Complication 3	.	.	R	R	.	.	T*	.	COC	
3140	Comorbid/Complication 4	.	.	R	R	.	.	T*	.	COC	
3150	Comorbid/Complication 5	.	.	R	R	.	.	T*	.	COC	
3160	Comorbid/Complication 6	.	.	R	R	.	.	T*	.	COC	
3161	Comorbid/Complication 7	.	.	R	R	.	.	T*	.	COC	
3162	Comorbid/Complication 8	.	.	R	R	.	.	T*	.	COC	
3163	Comorbid/Complication 9	.	.	R	R	.	.	T*	.	COC	
3164	Comorbid/Complication 10	.	.	R	R	.	.	T*	.	COC	
3165	ICD Revision Comorbid	.	.	R	R	.	.	T*	.	COC	
3170	RX Date--Most Defin Surg	.	.	R	R	.	.	T*	.	COC	
3180	RX Date--Surgical Disch	.	.	R	R	.	.	.	.	COC	
3190	Readm Same Hosp 30 Days	.	.	R	R	.	.	.	.	COC	
3200	Rad--Boost RX Modality	.	.	R	R	RC	.	T*	T*	COC	
3210	Rad--Boost Dose cGy	.	.	R	R	.	.	.	.	COC	
3220	RX Date--Radiation Ended	.	.	R	R	.	.	.	.	COC	
3230	RX Date--Systemic	.	.	R	R	S	.	T*	T*	COC	Revised

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		Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp→ Central	Central→ Central		
3250	RX Summ--Transplnt/Endocr	R	R	R	R	R	R	T*	T*	COC	
3260	Pain Assessment										Retired
3270	RX Summ --Palliative Proc	.	.	R	R	.	.	T*	.	COC	
3280	RX Hosp --Palliative Proc	.	.	R	R	.	.	T*	.	COC	
3300	RuralUrban Continuum 1993	D	.	.	.	.	.	.	.	NAACCR	
3310	RuralUrban Continuum 2003	D	.	.	.	.	.	.	.	NAACCR	

Codes for Recommendations: R = Required. RH = Historically collected and currently transmitted. RC = Collected by SEER from CoC-approved hospitals. RS = Required, site specific. S = Supplementary/recommended. D = Derived. • = No recommendations. * = When available. # = Central registries may code available data using either the SEER or COC data item and associated rules. ^ = These text requirements may be met with one or several text block fields. T = data are vital to complete exchange record. TH – cases diagnosed before 2004, transmit data if available in exchange record. T* - transmit data if available for any case in exchange record.

8 APPENDIX B: EDUCATION AND TRAINING OPPORTUNITIES

Sponsor	Multiple Primary/ Histology Coding Rules	Collaborative Staging
NAACCR	MP/H coding rules will be covered in both the Hospital and Central Registry Webinar Series. See the NAACCR Web site for more details at http://www.naaccr.org/. Recorded versions are available for purchase.	Collaborative Staging coding rules will be covered in both the Hospital and Central Registry Webinar Series. See the NAACCR Web site for more details at http://www.naaccr.org/. Recorded versions are available for purchase.
NAACCR	NAACCR 2007 Annual Meeting Post Conference Workshop http://www.naaccr.org/ Detroit, MI 6/8/07	
SEER	A series of 21 live online training sessions. Recorded Sessions will be available on the SEER Web site http://www.seer.cancer.gov/	
SEER	SEER Abstractor/Coding Workshop http://www.seer.cancer.gov/ Las Vegas, NV 4/25/07-4/26/07	
SEER	SEER Web-based training module will be added to the SEER training Web site in early 2007. http://training.seer.cancer.gov/	SEER Web-based training module "Intro to Collaborative Stage" is available on the SEER training Web site. http://training.seer.cancer.gov/
SEER	A series of local training sessions across the United States and Canada conducted by a cadre of speakers. Training sessions began in the fall of 2006 and will continue into 2007. A list of speakers is available on the SEER Web site. http://www.seer.cancer.gov/tools/mph_speakers.html	
CoC/ AJCC		Collaborative Stage presentations will be provided on following sites: Colorectal, Breast, Prostate and Lung cancers. These will be offered through the Online Education Center. http://www.facs.org/cancer/
STC	Canadian Cancer Registry Professionals Workshop (CCRPW) 2-day annual workshop. September 2006 agenda: MP/H General Instructions, Format, Rules and Practicum: Lung, Colon, Breast, Other Sites.	
PHAC / STC		Collaborative Stage training includes: General Principles, Overview of CS with a focus on specific anatomical sites (2006 schedule lung, colon, breast, prostate / 2007 schedule H&N). Onsite facilitated format with exercises and discussion.

Sponsor	Multiple Primary/ Histology Coding Rules	Collaborative Staging
NCRA	Pre-NCRA Conference 2007 – 1-Day Workshop http://ncra-usa.org/ Las Vegas, NV 4/21/07	
NCRA	NCRA 2007 Annual Conference – 1-Day Workshop http://ncra-usa.org/ Las Vegas, NV 4/22/07	
NCRA	Multiple Primary/ Histology Coding Rules Workshop http://ncra-usa.org/ Orlando, FL - 12/7/06 and 12/8/06 Pittsburgh, PA – 3/22/07 and 3/23/07	
NPCR	NETS – See section 6.2.6	NETS – see section 6.2.6

9 APPENDIX C: REVISED DATA ITEMS IN THE DATA STANDARDS AND DATA DICTIONARY, VOLUME II, VERSION 11.1

Appendix C includes errata and revisions to the data items in Standards for Cancer Registries Volume II, *Data Standards and Data Dictionary*, Eleventh Edition, Record Layout Version 11.1 (Effective January 1, 2007). Excerpts from Volume II, Version 11.1 revealing the errata for each data item are provided below. Track Changes were used to reveal the changes made to each data item. The Volume II, Version 11.1 Access database (Revised September 2006) has been updated with these changes and is posted to the NAACCR Web site standards page.

ADDR AT DX--STATE **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
State (pre-96 COC) State at Diagnosis (COC)	80	2	COC	72-73

Description

USPS abbreviation for the state, territory, commonwealth, U.S. possession, or CanadaPost abbreviation for the Canadian province/territory in which the patient resides at the time the reportable tumor is diagnosed. If the patient has multiple primaries, the state of residence may be different for each tumor.

Codes (in addition to the U.S. and Canadian postal service abbreviations)

CD Resident of Canada, NOS (province/territory unknown)
US Resident of United States, NOS (state/commonwealth/territory/possession unknown)
XX Resident of country other than the United States (including its territories, commonwealths, or possessions) or Canada, and country is known
YY Resident of country other than the United States (including its territories, commonwealths, or possessions) or Canada, and country is unknown
ZZ Residence unknown

ADDR CURRENT—STATE **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
State--Current (COC)	1820	2	COC	1327-1328

Description

USPS abbreviation for the state, territory, commonwealth, U.S. possession, or Canada Post abbreviation for the Canadian province/territory of the patient's current usual residence. If the patient has multiple tumors, the current state of residence should be the same for all tumors.

Rationale

"Current address" can be used to measure the regional "cancer burden" (cost, medical care needs), especially in major retirement regions. Sometimes central registries carry out follow-up by contacting the patients via letter or telephone calls to ascertain vital status. The most current reported address and telephone number are needed. This information also is useful for conducting interview studies.

Codes (in addition to the U.S. and Canadian postal service abbreviations)

CD Resident of Canada, NOS (province/territory unknown)
US Resident of United States, NOS (state/commonwealth/territory/possession unknown)
XX Resident of country other than the United States (including its territories, commonwealths, or possessions) or Canada, and country is known
YY Resident of country other than the United States (including its territories, commonwealths, or possessions) or Canada, and country is unknown
ZZ Residence unknown

Note: Prior to Version 5, Follow-Up Contact fields may have been used for patient current address in the NAACCR record layout.

CODING SYSTEM FOR EOD **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Coding System for Extent of Disease (SEER)	870	1	SEER	562-562

Description

Indicates the type of SEER EOD code applied to the tumor. Should be used whenever EOD coding is applied.

Rationale

Used in data editing and analysis.

Codes

0 2-Digit Nonspecific Extent of Disease (1973-82)
1 2-Digit Site-Specific Extent of Disease (1973-82)
2 13-Digit (expanded) Site-Specific Extent of Disease (1973-1982)
3 4-Digit Extent of Disease (1983-87)
4 10-Digit Extent of Disease, 1988 (1988-2003)
blank Cases diagnosed 2004+; or the item is not collected

DATE OF INITIAL RX--SEER **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Date Therapy Initiated (SEER) Date Started (SEER)	1260	8	SEER	835-842

Description

Date of initiation of the first course therapy for the tumor being reported, using the SEER definition of first course. See also Date of 1st Crs RX--COC [1270]. See Chapter V, Unresolved Issues, for further discussion of the difference between SEER and COC items. See page 87 for date format.

Codes (in addition to valid dates)

00000000 No therapy
99999999 Unknown date/Unknown if therapy was administered

Clarification of NPCR Required Status

Central registries funded by NPCR are required to collect either Date of Initial RX--SEER [1260] or Date of 1st Crs RX--COC [1270].

FIN CODING SYSTEM **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	35	1	NAACCR	11-11

Description

The FIN Coding System is a generated code that identifies the coding system used by individual facilities (hospital, clinics, or other providers). This field identifies the coding system used by facilities in the following seven fields of the NAACCR layout:

Registry ID [40] (when Registry Type [30] = 3)
Reporting Facility [540]
Institution Referred From [2410]
Institution Referred To [2420]
Last Follow-Up Hospital [2430] (this data item was retired in Version 11)
Following Registry [2440]
Archive FIN [3100]

Within a single NAACCR record, all of these fields listed above must be coded using the same FIN coding system.

NPI, a unique identification number for health care providers, is scheduled for 2007 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). When a facility starts to use the NPI codes, they should be transmitted in the NPI-specific data items, not in a FIN data item.

Rationale

FIN and NPI codes should not be stored in the same Coding System field, as they are reported in distinctly different fields within the NAACCR layout.

Codes

1 COC 7-digit codes (assigned by COC until the end of 2000)
2 COC FIN 10-digit codes (assigned 2001+)
9 Unknown

Note: Code 3, NPI 8-digit code, has been deleted. Code 4, 15-digit code, has been deleted.

FOLLOW-UP CONTACT--STATE **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	1844	2	SEER	1377-1378

Description

USPS abbreviation for the state (including U.S. territories, commonwealths, or possessions), or Canada Post abbreviation for the Canadian province/territory of the follow-up contact's current usual residence. If the patient has multiple tumors, the follow-up contact state should be the same for all tumors.

Rationale

Sometimes registries carry out follow-up by contacting the patient and other contacts by a letter or phone call to ascertain their vital status. When a patient's current address is unknown or the patient is for some reason not to be contacted (e.g., patient is a minor child), the most current name, address, and phone number of another contact such as a relative or neighbor are needed. This information may also be useful for conducting epidemiological or research studies.

Codes (in addition to USPS and Canadian Postal Service abbreviations)

CD Resident of Canada, NOS (province/territory unknown)
US Resident of United States, NOS (state/commonwealth/territory/possession unknown)
XX Resident of country other than the United States (including its territories, commonwealths, or possessions) or Canada, and country is known
YY Resident of country other than the United States (including its territories, commonwealths, or possessions) or Canada, and country is unknown
ZZ Residence unknown

ICD REVISION COMORBID **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
ICD Revision Comorbidities	3165	1	COC	737-737

Description

This item indicates the coding system in which the Comorbidities and Complications (secondary diagnoses) codes are provided.

Rationale

The COC currently requires the collection and reporting of up to 10 ICD-9-CM codes describing secondary diagnoses for patients hospitalized for cancer treatment. Currently the use of ICD-10-CM is not mandatory in U.S. hospitals, though it may become so in the future. In the event this occurs, cancer registries that maintain or collect this information will need to differentiate between ICD-9-CM and ICD-10-CM code use. The code values and definitions for this item would be expanded as necessary. Allowable codes reported in the Comorbidity and Complications items in FORDS would be re-assessed at the same time.

Codes

0 No comorbidities or complications recorded in patient's record
1 ICD-10-CM
9 ICD-9-CM
Blank Comorbidities and Complications not collected

ICD-O-3 CONVERSION FLAG **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	2116	1	SEER/COC	1243-1243

Description

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

Codes

0 Morphology (Morph--Type&Behav ICD-O-3 [521]) originally coded in ICD-O-3
1 Morphology (Morph--Type&Behav ICD-O-3 [521]) converted from (Morph--Type&Behav ICD-O-2 [419]) without review
3 Morphology (Morph--Type&Behav ICD-O-3 [521]) converted from (Morph--Type&Behav ICD-O-2 [419]) with review
Blank Not converted: Cases originally coded in a previous/subsequent ICD-O version and not converted to ICD-0-3. (Conversion from blank to 0 is recommended but not required for cases diagnosed prior to 2007.)

MILITARY RECORD NO SUFFIX **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Military Medical Record Number Suffix (COC)	2310	2	COC	2097-2098

Description

Patient identifier used by military hospitals to record relationship of the patient to the sponsor.

Codes

01-19 Child
20 Sponsor
30-39 Spouse
40-44 Mother
45-49 Father
50-54 Mother-in-law
55-59 Father-in-law
60-69 Other eligible dependents
98 Civilian emergency (Air Force/Navy)
99 Not classified elsewhere/stillborn
Blank Not a military facility

NAACCR RECORD VERSION

Alternate Name	Item #	Length	Source of Standard	Column #
	50	1	NAACCR	19-19

Description
This item applies only to record types I, C, A, and M. Code the NAACCR record version used to create the record.

Note: The correction record (U) has its own record version data item.

Codes
1 1992-1994 Version 2 and Version 3
4 1995 Version 4.0
5 1996 and 1997 Version 5.0 or Version 5.1
6 1998 Version 6
7 1999 Version 7
8 2000 Version 8
9 2001 and 2002 Version 9 and 9.1
A 2003, 2004, and 2005 Version 10, 10.1, and 10.2
B 2006 and 2007 Version 11 and 11.1
Blank September 1989 Version

Note: Code 4 was assigned to the 1995 Version to synchronize the document version and the layout version numbers. Layout document Versions 2 and 3 are coded as 1.

OVER-RIDE HISTOLOGY **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Histology/Behavior Inter-field Review (Field Item Edit Morph) (SEER #2)	2040	1	SEER	1129-1129

Description

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

Diagnostic Confirmation, Behavior ICDO2 (SEER IF31)
Diagnostic Confirmation, Behavior ICDO3 (SEER IF31)
Morph (1973-91) ICD-O-1 (SEER MORPH)
Morphology--Type/Behavior ICDO2 (SEER MORPH)
Morphology--Type/Behavior ICDO3 (SEER MORPH)

Rationale

Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flags as Used in the EDITS Software Package

Edits of the type Diagnostic Confirmation, Behavior, differ in the use of ICD-O-2 or ICD-O-3 and check that, for *in situ* cases (Behavior = 2), Diagnostic Confirmation specifies microscopic confirmation (1, 2, or 4).

The distinction between *in situ* and invasive is very important to a registry, as prognosis is so different. Since the determination that a neoplasm has not invaded surrounding tissues, i.e., *in situ*, is made microscopically, cases coded *in situ* in behavior should have a microscopic confirmation code. However, very rarely, a physician will designate a case noninvasive or *in situ* without microscopic evidence.

1. If an edit of the type, Diagnostic Confirmation, Behavior, gives an error message or warning, check that Behavior and Diagnostic Confirmation have been coded correctly. Check carefully for any cytologic or histologic evidence that may have been missed in coding.

Edits of the type, Morphology--Type/Behavior, perform the following check:

1. Codes listed in ICD-O-2 or ICD-O-3 with behavior codes of only 0 or 1 are considered valid, since the behavior matrix of ICD-O-2 and ICD-O-3 allows for the elevation of the behavior of such histologies when the tumor is *in situ* or malignant. This edit forces review of these rare cases to verify that they are indeed *in situ* or malignant.
2. The following histologies are generally not accepted as *in situ*: ICD-O-2 histologies 8000-8004, 8020, 8021, 8331, 8332, 8800-9054, 9062, 9082, 9083, 9110-9491, 9501-9989, ICD-O-3 histologies 8000-8005, 8020, 8021, 8331, 8332, 8800-9055, 9062, 9082, 9083, 9110-9493, 9501-9989. This edit forces review of these cases.

3. If a Morphology-Type/Behavior edit produces an error or warning message and the case is one in which the 4-digit morphology code is one that appears in ICD-O-2 or ICD-O-3 only with behavior codes of 0 or 1, or the case is one in which the 4-digit morphology code is not generally accepted with a behavior code of 2, verify the coding of morphology and that the behavior should be coded malignant or *in situ*. The registrar may need to consult a pathologist or medical advisor in problem cases.

Exceptions:
If year of Date of Diagnosis > 2000, then a behavior code of 1 is valid for the following ICD-O-2 histologies and no over-ride flag is needed: 8931, 9393, 9538, 9950, 9960-9962, 9980-9984, and 9989. Similarly, the following ICD-O-3 histologies are valid with a behavior code of 1: 8442, 8451, 8462, 8472, and 8473.

If year of Date of Diagnosis > 2003, the following ICD-O-3 benign histologies will pass without review: 8146, 8271, 8861, 8897, 9121, 9122, 9131, 9161, 9350, 9351, 9352, 9360, 9361, 9383, 9384, 9394, 9412, 9413, 9444, 9492, 9493, 9506, 9531, 9532, 9533, 9534, 9537, 9541, 9550, 9562, and 9570.

4. Grade 5-8 with histologies not in the range of 9590-9948 is impossible.

5. Some terms in ICD-O-2 and ICD-O-3 carry an implied statement of grade. These histologies must be reported with the correct grade as stated below. An error of this type cannot be over-ridden.

ICD-O-2
8020/34 Carcinoma, undifferentiated
8021/34 Carcinoma, anaplastic
8331/31 Follicular adenocarcinoma, well differentiated
8851/31 Liposarcoma, well differentiated
9062/34 Seminoma, anaplastic
9082/34 Malignant teratoma, undifferentiated
9083/32 Malignant teratoma, intermediate type
9401/34 Astrocytoma, anaplastic
9451/34 Oligodendroglioma, anaplastic
9511/31 Retinoblastoma, differentiated
9512/34 Retinoblastoma, undifferentiated

ICD-O-3
8020/34 Carcinoma, undifferentiated
8021/34 Carcinoma, anaplastic
8331/31 Follicular adenocarcinoma, well differentiated
9082/34 Malignant teratoma, undifferentiated
9083/32 Malignant teratoma, intermediate type
9401/34 Astrocytoma, anaplastic
9451/34 Oligodendroglioma, anaplastic
9511/31 Retinoblastoma, differentiated
9512/34 Retinoblastoma, undifferentiated

Instructions for Coding
1. Leave blank if the program does not generate an error message for the edits of the types, Diagnostic Confirmation, Behav Code or Morphology--Type/Behavior.
2. Leave blank and correct any errors for the case if an item is discovered to be incorrect.

3. Code 1, 2, or 3 as indicated if review of all items in the error or warning message confirms that all are correct.

Codes

1	Reviewed: The behavior code of the histology is designated as "benign" or "uncertain" in ICD-O-2 or ICD-O-3, and the pathologist states the primary to be "*in situ*" or "malignant" Reviewed: The behavior code of the histology is generally not *"in situ*."
2	Reviewed: The behavior code is "*in situ*," but the case is not microscopically confirmed (flag for a "Diagnostic Confirmation, Behavior" edit)
3	Reviewed: Conditions 1 and 2 above both apply
Blank	Not reviewed or reviewed and corrected

REGIONAL NODES EXAMINED **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Number of Regional Lymph Nodes Examined (SEER) Pathologic Review of Regional Lymph Nodes (SEER) Regional Lymph Nodes Examined	830	2	SEER/COC	541-542

Description

Records the total number of regional lymph nodes that were removed and examined by the pathologist. Beginning with tumors diagnosed on or after January 1, 2004, this item is a component of the Collaborative Stage system. Tumors diagnosed from 1988 through 2003, this item is a part of the 10-digit EOD [779], detailed site-specific codes for anatomic EOD.

Rationale

This data item serves as a quality measure of the pathologic and surgical evaluation and treatment of the patient.

Codes

00	No nodes were examined
01-89	1-89 nodes were examined (code the exact number of regional lymph nodes examined)
90	90 or more nodes were examined
95	No regional nodes were removed, but aspiration of regional nodes was performed
96	Regional lymph node removal was documented as a sampling, and the number of nodes is unknown/not stated
97	Regional lymph node removal was documented as a dissection, and the number of nodes is unknown/not stated
98	Regional lymph nodes were surgically removed, but the number of lymph nodes is unknown/not stated and not documented as a sampling or dissection; nodes were examined, but the number is unknown
99	It is unknown whether nodes were examined; not applicable or negative; not stated in patient record

Note: See Chapter V, Unresolved Issues, for a discussion of coding differences between COC and SEER.

REGIONAL NODES POSITIVE **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Number of Positive Regional Lymph Nodes (SEER) Pathologic Review of Regional Lymph Nodes (SEER) Regional Lymph Nodes Positive	820	2	SEER/COC	539-540

Description

Records the exact number of regional nodes examined by the pathologist and found to contain metastases. Beginning with tumors diagnosed on or after January 1, 2004, this item is a component of the Collaborative Stage system. Tumors diagnosed from 1988 through 2003, this item is part of the 10-digit EOD [779], detailed site-specific codes for anatomic EOD.

Rationale

This data item is necessary for pathologic staging, and it serves as a quality measure for pathology reports and the extent of the surgical evaluation and treatment of the patient.

Codes

00 All nodes examined are negative
01-89 1-89 nodes are positive (Code exact number of nodes positive)
90 90 or more nodes are positive
95 Positive aspiration of lymph node(s) was performed
97 Positive nodes are documented, but the number is unspecified
98 No nodes were examined
99 It is unknown whether nodes are positive; not applicable; not stated in patient record

Note: See Chapter V, Unresolved Issues, for a discussion of coding differences between COC and SEER.

RURALURBAN CONTINUUM 2003 **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Beale Code RuralUrban Continuum 2000	3310	2	NAACCR	229-230

Description

The "RuralUrban Continuum 2003" code, often referred to as the "Beale Code," is generated programmatically using Addr at DX--State [80] and County at DX [90]. It contains the Rural-Urban Continuum code as provided by OMB.

The code is a 10-point continuum (00-09) measuring urban-rural status. Abstractors do not enter these codes.

The code has been expanded to 2 digits to accommodate areas that are not included in Rural Urban Continuum code table, such as Canadian provinces/territories and U.S. territories. These areas will be coded with a value of 98. Records for nonresidents of the state of reporting institution (County at DX = 998) will also be coded 98. If Addr at DX--State is XX, YY, or ZZ, the Rural Urban Continuum 2003 code will be coded as 99. If County at DX equals 999, the Rural Urban Continuum 2003 code will be coded as 99.

RuralUrban Continuum 2003 codes are provided for each county by OMB and consist of a 1-character rural-urban status, which is very useful for incidence data analysis.

Rationale

RuralUrban Continuum 2003 codes are provided for each county by OMB and consist of a 1-character rural-urban status, which is very useful for incidence data analysis.

Codes

Metropolitan Counties (00-03)

00 Central counties of metropolitan areas of 1 million population or more
01 Fringe counties of metropolitan areas of 1 million population or more
02 Counties in metropolitan areas of 250,000-1,000,000 population
03 Counties in metropolitan areas of less than 250,000 population

Nonmetropolitan Counties (04-09)

04 Urban population of 20,000 or more, adjacent to a metropolitan area
05 Urban population of 20,000 or more, not adjacent to a metropolitan area
06 Urban population of 2,500-19,999, adjacent to a metropolitan area
07 Urban population of 2,500-19,999, not adjacent to a metropolitan area
08 Completely rural (no places with a population of 2,500 or more) adjacent to a metropolitan area
09 Completely rural (no places with a population of 2,500 or more) not adjacent to a metropolitan area
98 Program run, but: (1) area is not included in Rural-Urban Continuum code table, or (2) record is for resident outside of state of reporting institution

99 Unknown
Blank Program not run; record not coded

RX SUMM--RADIATION **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Radiation (SEER/COC) Radiation Therapy (pre-96 COC)	1360	1	SEER	873-873

Description

Codes for the type of radiation therapy performed as part of the first course of treatment.

Note: Radiation to brain and central nervous system for leukemia and lung cases is coded as radiation in this field.

Codes

0 None
1 Beam radiation
2 Radioactive implants
3 Radioisotopes
4 Combination of 1 with 2 or 3
5 Radiation, NOS—method or source not specified
6 Currently allowable for historic cases only; see note below
7 Patient or patient's guardian refused*
8 Radiation recommended, unknown if administered*
9 Unknown if radiation administered

** Note:* For COC, codes 7 and 8 were used for tumors diagnosed before 1996, but should have been converted to 0 in this field and to the appropriate code in the new field Reason for No Radiation [1430]. The COC standards for hospitals do not allow use of codes 7 and 8 in 1996 and later. SEER continues to use codes 7 and 8 for all years. See Chapter V, Unresolved Issues, for further discussion

Note: In the SEER program, a code 2 for other radiation was used between 1973 and 1987. When the radiation codes were expanded to add codes '2' radioactive implants and '3' radioisotopes, all cases with a code '2' and diagnosed in 1973-1987 were converted to a code '6' radiation other than beam radiation.

SEER CODING SYS--CURRENT **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	2120	1	NAACCR	1198-1198

Description

This shows the SEER coding system best describing the majority of SEER items as they are in the record (after conversion).

Codes

0 No SEER coding
1 Pre-1988 SEER Coding Manuals
2 May 1988 SEER Coding Manual
3 January 1989 SEER Coding Manual
4 January 1992 SEER Coding Manual
5 January 1998 SEER Coding Manual
6 January 2003 SEER Coding Manual
7 January 2004 SEER Coding Manual
8 January 2007 SEER Coding Manual

SEER CODING SYS--ORIGINAL **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	2130	1	NAACCR	1199-1199

Description

This shows the SEER coding system best describing the way the majority of SEER items in the record were originally coded.

Codes

0 No SEER coding
1 Pre-1988 SEER Coding Manuals
2 May 1988 SEER Coding Manual
3 January 1989 SEER Coding Manual
4 January 1992 SEER Coding Manual
5 January 1998 SEER Coding Manual
6 January 2003 SEER Coding Manual
7 January 2004 SEER Coding Manual
8 January 2007 SEER Coding Manual

SEQUENCE NUMBER--CENTRAL **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Sequence Number (pre-96 SEER)	380	2	SEER	281-282

Description
Code indicates the sequence of all reportable neoplasms over the lifetime of the person. This data item differs from Sequence Number--Hospital [560], because the definitions of reportable neoplasms often vary between a hospital and a central registry. Each neoplasm is assigned a different number. Sequence Number 00 indicates that the person has had only one *in situ* or one malignant neoplasm as defined by the Federal reportable list (regardless of central registry reference date). Sequence Number 01 indicates the first of two or more reportable neoplasms, while 02 indicates the second of two or more reportable neoplasms, and so on. Because the time period of Sequence Number is a person's lifetime, reportable neoplasms not included in the central registry (those that occur outside the registry catchment area or before the reference date) also are allotted a sequence number. For example, a registry may contain a single record for a patient with a sequence number of 02 because the first reportable neoplasm preceded the central registry's reference date.

Reporting Requirements: Federally Required and State/Province Defined
The Federal or SEER/NPCR standard defining which neoplasms are reportable is described in Chapter III, Standards for Tumor Inclusion and Reportability. It is assumed that this shared standard is the "minimum" definition of reportability. Individual central cancer registries may define additional neoplasms as reportable.

Numeric codes in the 00-35 range indicate the sequence of neoplasms of *in situ* or malignant behavior (2 or 3) at the time of diagnosis, which SEER/NPCR standards require to be reported. Codes 60 to 87 indicate the sequence of non-malignant tumors (as defined in Chapter III) and any other neoplasms that the central registry has defined as reportable. Neoplasms required by SEER/NPCR with an *in situ* or malignant behavior at the time of diagnosis are sequenced completely independently of this higher numbered category. Sequence Number-Hospital does not affect Sequence Number-Central. The two notational systems are independent, but central registries should take Sequence Number-Hospital [560] into account when coding Sequence Number Central.

Timing Rule
The sequence number may change over the lifetime of the patient. If an individual previously diagnosed with a single reportable malignant neoplasm is subsequently diagnosed with a second reportable malignant neoplasm, the sequence code for the first neoplasm changes from 00 to 01. A central registry might also discover that an individual with one or more known neoplasms had an earlier reportable neoplasm that had been unknown to the registry. Typically, a re-evaluation of all related sequence numbers is required whenever an additional neoplasm is identified.

If two or more reportable neoplasms are diagnosed at the same time, the lowest sequence number is to be assigned to the diagnosis with the worst prognosis. If no difference in prognosis is evident, the decision is arbitrary.

If a registry collects any central registry-defined neoplasms, the codes 60-87 should be used. The codes 60-87 also should be used for non-malignant tumor diagnosed on or after January 1, 2004. Timing rules for sequencing these neoplasms are the same as timing rules for sequencing of required *in situ* or invasive neoplasms.

Rationale
The purpose of sequencing based on the patient's lifetime is to truly identify the 00s, the people who only had one malignant primary in their lifetimes for survival analysis. If a central registry sequences by just what is reported to them, then it will be unclear whether 00 means the person only had one malignant primary in his lifetime or the person had one malignant primary since the central registry started collecting data. The Federally required reportable list has changed throughout the years, so the registry must use the appropriate reportable list for the year of diagnosis. The central registry reference date will not affect Sequence Number-Central.

Codes
In Situ/Malignant as Federally Required based on Diagnosis Year
00 One primary in the patient's lifetime
01 First of two or more primaries
02 Second of two or more primaries
..
..
59 Fifty-ninth or higher of fifty-nine or more primaries
99 Unspecified or unknown sequence number of federally required *in situ* or malignant tumors. Sequence number 99 can be used if there is a malignant tumor and its sequence number is unknown. If there is known to be more than one malignant tumor, then the tumors must be sequenced.

Non-malignant Tumor as Federally Required based on Diagnosis Year or State/Province Defined
60 One non-malignant tumor or central registry-defined neoplasm
61 First of two or more non-malignant tumor or central registry-defined neoplasms
62 Second of two or more non-malignant tumor or central registry-defined neoplasms
..
88 Unspecified or unknown sequence number for non-malignant tumor or central registry-defined neoplasms. (Sequence number 88 can be used if there is a non-malignant tumor and its sequence number is unknown. If there is known to be more than one non-malignant tumor, then the tumors must be sequenced.)
98 Cervix carcinoma *in situ* (CIS)/CIN III, Diagnosis Years 1996-2002.

The table below shows which sequence number series to use by type of neoplasm

Neoplasm	**SeqNum-Central**
***In Situ*/Malignant as Federally Required Based on Diagnosis Year**	**(Numeric Series)**
In Situ (behavior code = 2) (Cervix CIS/CIN III, Diagnosis Year before 1996) (includes VIN III, VAIN III, AIN III)	00 – 59
Malignant (behavior code = 3)	00 – 59
Juvenile Astrocytoma, Diagnosis Year 2001+ (*)	00 – 59
Invasive following *In Situ*−New primary as defined by COC	00 – 59
Invasive following *In Situ*−New primary as defined by SEER	00 – 59
Unspecified Federally Required Sequence Number or Unknown	99
Non-malignant Tumor as Federally Required based on Diagnosis Year or State/Province Registry-Defined	
Examples:	
Non-malignant Tumor/Benign Brain	60 – 87
Borderline Ovarian, Diagnosis Year 2001+	60 – 87
Other Borderline/Benign	60 – 87

Skin SCC/BCC	60 – 87
PIN III	60 – 87
Cervix CIS/CIN III, Diagnosis Year 2003+	60 – 87
Unspecified Non-malignant Tumor or Central Registry-Defined Sequence Number	88
Cervix CIS/CIN III, Diagnosis Year 1996-2002	98

*Juvenile astrocytomas should be reported as 9421/3.

Note: See the section on Sequence Number—Central in *The SEER Program Code Manual*.

Note: Conversion Guidance: The sequence numbers for neoplasms whose histologies were associated with behavior codes that changed from *in situ*/malignant to benign/borderline or vice versa during the conversion from ICD-O-2 to ICD-O-3 should not be re-sequenced.

SEQUENCE NUMBER--HOSPITAL **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Sequence Number (COC)	560	2	COC	411-412

Description
Code indicates the sequence of all malignant and non-malignant neoplasms over the lifetime of the patient. This item differs from the Sequence Number--Central [380] because the definitions of reportable neoplasms often vary between a hospital and a central registry. Each neoplasm is assigned a different number. Sequence Number 00 indicates that the person has only one malignant neoplasm in his lifetime (regardless of hospital registry reference date). Sequence Number 01 indicates the first of two or more malignant neoplasms, while 02 indicates the second of two or more malignant neoplasms, and so on. Because the time period of Sequence Number is a person's lifetime, reportable neoplasms not included in the hospital registry are also allotted a sequence number. For example, a registry may contain a single record for a patient with a sequence number of 02 because the first reportable neoplasm occurred before the hospital registry's reference date. Similarly, Sequence Number 60 indicates the patient has only one non-malignant neoplasm, and Sequence Number 61 represents the first of multiple non-malignant neoplasms.

Reporting Requirements: COC, State/Province, and the Hospital Cancer Committee
The COC standard defining which neoplasms are reportable is described in Chapter III, Standards for Case Inclusion and Reportability; it is assumed that this standard is the "minimum" definition of reportability. In addition to the COC-required reportable neoplasms, hospital cancer registries have to meet the reporting requirements of the central cancer registry and the hospital cancer committee. These neoplasms often are called "reportable by agreement" in COC publications. Any tumor in the patient's past that is reportable or reportable-by-agreement must be taken into account when sequencing subsequently accessioned tumors. Sequence numbers should be reassigned if the facility subsequently learns of an unaccessioned tumor that affects sequencing. Sequence Number-Central [380] does not affect Sequence Number-Hospital. The two notational systems are independent.

Timing Rule
If two or more malignant tumors are diagnosed at the same time, the lowest sequence number will be assigned to the diagnosis with the worst prognosis. Likewise, if two or more non-malignant tumors are diagnosed at the same time, the lowest sequence number is assigned to the diagnosis with the worse prognosis. If no difference in prognosis is evident, the decision is arbitrary.

Codes

In situ and Malignant Tumors:

00 One malignant primary only in the patient's lifetime
01 First of two or more malignant primaries
02 Second of two or more malignant primaries
..
.. (Actual number of this malignant primary)
..
59 Fifty-ninth or higher of fifty-nine or more primaries
99 Unspecified sequence number of a primary malignant tumor or unknown (When a patient has multiple tumors with unspecified/unknown sequence numbers, code 99 should only be used once.)

Nonmalignant Tumors:

60 Only one non-malignant tumor in the patient's lifetime
61 First of two or more non-malignant tumors
62 Second of two or more non-malignant tumors
..
88 Unspecified number of non-malignant tumors (When a patient has multiple unspecified neoplasms in this category, code 88 should only be used once.)

The table below shows which sequence number series to use by type of neoplasm

Neoplasm	**SeqNum-Hospital**
***In situ* and Malignant**	**(code range)**
One *in situ* (behavior code = 2) or malignant (behavior code = 3) primary tumor only in the patient's lifetime	00
First of multiple *in situ* or malignant primary tumors in the patient's lifetime	01
Actual sequence of two or more *in situ* or malignant primary tumors	02 – 59
Unspecified malignant sequence number or unknown	99
Non-Malignant	
One benign (behavior code = 0) or borderline (behavior code = 1) primary tumor only in the patient's lifetime	60
First of two or more benign or borderline primary tumors in the patient's lifetime	61
Actual sequence of two or more non-malignant primary tumors	62 – 87
Unspecified non-malignant sequence number or unknown	88

*Juvenile astrocytomas should be reported as 9421/3

Note: See the section on Sequence Number in the COC (FORDS) Manual.