CANCER REPORTING IN CALIFORNIA:
STANDARDS FOR AUTOMATED REPORTING

CALIFORNIA CANCER REPORTING
SYSTEM STANDARDS for 2016

VOLUME II

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PART I INTRODUCTION

The reporting of cancer is mandatory under provisions of California's Health and Safety Code.

Hospitals and other reporting facilities are required to report cancer information to the California Cancer Registry using computer reporting systems that meet State standards. This manual, *Cancer Reporting in California: Standards for Automated Reporting, California Cancer Reporting System Standards for 2016, Volume II (CCR Volume II)* is intended for hospitals and other reporting facilities or vendors wishing to update their own automated reporting systems or create new reporting systems that comply with State requirements.

The intended audience for this document is system analysts and software developers. It describes the format in which collected data must be reported.

Detailed instructions for collecting and coding data can be found in *Cancer Reporting in California: California Cancer Reporting System Standards, Volume I: Abstracting and Coding Procedures for Hospitals*.

Documentation for computer edits can be found in *Cancer Reporting in California: Data Standards for Regional Registries and California Cancer Registry, California Cancer Reporting System Standards, Volume III*.

Section I.1 Summary of Changes for 2016

Changes for 2016 are identified by with dark red font color.

Corrections to the changes are identified by a dark green (corrected 02/2016), purple (corrected 03/2016), and blue (corrected 4/2016) font color.

In response to requests from users of this document, the exchange records (Appendices A, B, C, & D) are now posted in an Excel (PDF) spreadsheet.

On CCRCAL.ORG, this volume and its related appendix will be listed as follows:

VOLUME II
  2016
California Cancer Reporting Standards: Volume II-2016 (dated dd/mm/yy)
      Volume II Appendices: California Cancer Reporting Standards: (dated dd/mm/yy)

Appendices A, B, C, & D identify each data item with a unique CCR Identifier. This identifier will never change and can be used to uniquely identify a data item to a database system, if such an identifier is needed in your database system.

See Appendix A for the following updates:

- NAACCR Record Version [160] (CCR Identifier E1003) has been revised from 150 to 160 to reflect NAACCR version 16.0.
- Census Ind Code 2010 CDC (CCR Identifier #E1775) name has been revised from Census Ind Code 2010 to Census Ind Code 2010 CDC.

- Census Occ Code 2010 CDC (CCR Identifier #E1776) name has been revised from Census Occ Code 2010 to Census Occ Code 2010 CDC.

- The following are new geocoding data fields:
  - County at DX Geocode1990 (CCR Identifier #E1795)
  - County at DX Geocode2000 (CCR Identifier #E1796)
  - County at DX Geocode2010 (CCR Identifier #E1797)
  - County at DX Geocode2020 (CCR Identifier #E1798)
- Reserved 02 (No CCR Identifier) length is now 50, with start positon of 478 and end position 527.
- Reserved 04 (No CCR Identifier) length is now 30, with start position 804 and end position 833.
- TNM Path Staged By (CCR Identifier E1151) length is now 2, with start position 834 and end positon 835. Also now required for DX Year 2016 and forward.
- TNM Clin Staged By (CCR Identifier E1157) length is now 2, with start position 836 and end position 837. Also now required for DX Year 2016 and forward.
- The following are new data fields required for DX Year 2016 and forward:
  - Mets at DX-Bone (CCR Identifier #E1808)
  - Mets at DX-Brain (CCR Identifier #E1809)
  - Mets at DX-Distant LN (CCR Identifier #E1810)
  - Mets at DX-Liver (CCR Identifier #E1811)
  - Mets at DX-Lung (CCR Identifier #E1812)
  - Mets at DX-Other (CCR Identifier #E1813)
  - TNM Size Clinical (CCR Identifier #E1800)
  - TNM Size Pathologic (CCR Identifier #E1801)
  - TNM Size Summary (CCR Identifier #E1802)
- RuralUrban Continuum 2013 (CCR Identifier #E1799) is a new data fields generated for extract.
- The following are new data fields generated in the Eureka database only:
  - Derived SEER Path Stg Grp (CCR Identifier #E1814)
  - Derived SEER Clin Stg Grp (CCR Identifier #E1815)
  - Derived SEER Cmb Stg Grp (CCR Identifier #E1816)
  - Derived SEER Combined T (CCR Identifier #E1817)
  - Derived SEER Combined N (CCR Identifier #E1818)
  - Derived SEER Combined M (CCR Identifier #E1819)
  - Derived SEER Cmb T Src (CCR Identifier #E1820)
  - Derived SEER Cmb N Src (CCR Identifier #E1821)
  - Derived SEER Cmb M Src (CCR Identifier #E1822)
  - NPCR Derived Clin Stg Grp (CCR Identifier #E1823)
  - NPCR Derived Path Stg Grp (CCR Identifier #E1824)
- The following are new non-required fields:
  - SEER Primary Tumor (CCR Identifier #E1805)
  - SEER Regional Nodes (CCR Identifier #E1806)
  - SEER Mets (CCR Identifier #E1807)
  - Derived SS2017 (CCR Identifier #E1803)

- o Directly Assigned SS2017 (CCR Identifier #E1804)
- The following TNM fields are now required for DX Year 2016 and forward:
  - o TNM Edition Number (CCR Identifier #E1145)
  - o TNM Path T (CCR Identifier #E1146)
  - o TNM Path N (CCR Identifier #E1147)
  - o TNM Path M (CCR Identifier #E1148)
  - o TNM Path Stage Group (CCR Identifier #E1149)
  - o TNM Path Descriptor (CCR Identifier #E1150)
  - o TNM Clin T (CCR Identifier #E1152)
  - o TNM Clin N (CCR Identifier #E1153)
  - o TNM Clin M (CCR Identifier #E1154)
  - o TNM Clin Stage Group (CCR Identifier #E1155)
  - o TNM Clin Descriptor (CCR Identifier #E1156)
- The following are new reserve data fields:
  - o Reserved 19 (No CCR Identifier)
  - o Reserved 20 (No CCR Identifier)
- Lymph-vascular Invasion (CCR Identifier #E1164) is now required for testis and penis cases for DX Year 2010 and forward. Required when available for other sites.
- The following CS fields are now required for DX Year 2004 to 2015:
  - o CS Tumor Size (CCR Identifier #E1165)
  - o CS Extension (CCR Identifier #E1166)
  - o CS Tumor Size/Ext Eval (CCR Identifier #E1167)
  - o CS Lymph Nodes (CCR Identifier #E1168)
  - o CS Lymph Nodes Eval (CCR Identifier #E1169)
  - o CS Mets at DX (CCR Identifier #E1170)
  - o CS Mets Eval (CCR Identifier #E1171)
  - o CS Mets at DX-Bone (CCR Identifier #E1172)
  - o CS Mets at DX-Brain (CCR Identifier #E1173)
  - o CS Mets at DX-Liver (CCR Identifier #E1174)
  - o CS Mets at DX-Lung (CCR Identifier #E1175)
- The following CS Site-Specific Factor fields are now required, site specific:
  - o CS Site-Specific Factor 1 (CCR Identifier #E1176)
  - o CS Site-Specific Factor 2 (CCR Identifier #E1177)
  - o CS Site-Specific Factor 3 (CCR Identifier #E1178)
  - o CS Site-Specific Factor 4 (CCR Identifier #E1179)
  - o CS Site-Specific Factor 5 (CCR Identifier #E1180)
  - o CS Site-Specific Factor 6 (CCR Identifier #E1181)
  - o CS Site-Specific Factor 7 (CCR Identifier #E1182)
  - o CS Site-Specific Factor 8 (CCR Identifier #E1183)
  - o CS Site-Specific Factor 9 (CCR Identifier #E1184)
  - o CS Site-Specific Factor 10 (CCR Identifier #E1185)
  - o CS Site-Specific Factor 11 (CCR Identifier #E1186)
  - o CS Site-Specific Factor 12 (CCR Identifier #E1187)
  - o CS Site-Specific Factor 13 (CCR Identifier #E1188)
  - o CS Site-Specific Factor 14 (CCR Identifier #E1189)
  - o CS Site-Specific Factor 15 (CCR Identifier #E1190)
  - o CS Site-Specific Factor 16 (CCR Identifier #E1191)

- o CS Site-Specific Factor 17 (CCR Identifier #E1192)
- o CS Site-Specific Factor 18 (CCR Identifier #E1193)
- o CS Site-Specific Factor 19 (CCR Identifier #E1194)
- o CS Site-Specific Factor 20 (CCR Identifier #E1195)
- o CS Site-Specific Factor 21 (CCR Identifier #E1196)
- o CS Site-Specific Factor 22 (CCR Identifier #E1197)
- o CS Site-Specific Factor 23 (CCR Identifier #E1198)
- o CS Site-Specific Factor 24 (CCR Identifier #E1199)
- o CS Site-Specific Factor 25 (CCR Identifier #E1200)
- The following derived fields are now required for DX Year 2004 to 2015:
  - o Derived AJCC-6 T (CCR Identifier #E1212)
  - o Derived AJCC-6 T Descript (CCR Identifier #E1213)
  - o Derived AJCC-6 N (CCR Identifier #E1214)
  - o Derived AJCC-6 N Descript (CCR Identifier #E1215)
  - o Derived AJCC-6 M (CCR Identifier #E1216)
  - o Derived AJCC-6 M Descript (CCR Identifier #E1217)
  - o Derived AJCC-6 Stage Group (CCR Identifier #E1218)
  - o Derived AJCC-7 T (CCR Identifier #E1219)
  - o Derived AJCC-7 T Descript (CCR Identifier #E1220)
  - o Derived AJCC-7 N (CCR Identifier #E1221)
  - o Derived AJCC-7 N Descript (CCR Identifier #E1222)
  - o Derived AJCC-7 M (CCR Identifier #E1223)
  - o Derived AJCC-7 M Descript (CCR Identifier #E1224)
  - o Derived AJCC-7 Stage Group (CCR Identifier #E1225)
  - o Derived SS1977 (CCR Identifier E#1237)
  - o Derived SS2000 (CCR Identifier #E1238)
  - o Derived AJCC--Flag (CCR Identifier #E1240)
  - o Derived SS1977--Flag (CCR Identifier #E1241)
  - o Derived SS2000--Flag (CCR Identifier #E1242)
  - o CS Version Derived (CCR Identifier #E1245)
- The following fields are now required when available:
  - o RX Summ-Surgical Margins (CCR Identifier #E1336)
  - o Over-ride SS/Nodes Pos (CCR Identifier #E1444)
  - o Over-ride SS/TNM-N (CCR Identifier #E1445)
  - o Over-ride SS/TNM-M (CCR Identifier #E1446)
- Coding Proc (CCR Identifier #E1576) has been updated from 32 to 33.
- Follow-up Flag (CCR Identifier #E1825) is a new non-required field.
- Medical Record Number (CCR Identifier #E1744) name has been revised from Medical Record Number [Len 12] to Medical Record Number.

See Appendix B for the following updates:

- Record Type (CCR Identifier #E1000) has been revised from U for Update/Corrections to M for Modified Records. Modified Record layout replaces the Update/Corrections and Follow-Up layouts. It is the same length (22824 characters) and contains the same fields in the same locations as the New Case Record, record type A.
- Follow-up Flag (CCR Identifier #E1825) is a new vendor generated data field.

- The Correction Record Required column title updated to Update Triggers Modified Record.
- The following are changes between the requirements in the Update Triggers Modified and Correction Record Required columns:
    - The following new fields do not trigger a Modified Record when updated:
        - County at DX Geocode1990 (CCR Identifier #E1795)
        - County at DX Geocode2000 (CCR Identifier #E1796)
        - County at DX Geocode2010 (CCR Identifier #E1797)
        - County at DX Geocode2020 (CCR Identifier #E1798)
        - RuralUrban Continuum 2013 (CCR Identifier #E1799)
        - Derived SEER Path Stg Grp (CCR Identifier #E1814)
        - Derived SEER Clin Stg Grp (CCR Identifier #E1815)
        - Derived SEER Cmb Stg Grp (CCR Identifier #E1816)
        - Derived SEER Combined T (CCR Identifier #E1817)
        - Derived SEER Combined N (CCR Identifier #E1818)
        - Derived SEER Combined M (CCR Identifier #E1819)
        - Derived SEER Cmb T Src (CCR Identifier #E1820)
        - Derived SEER Cmb N Src (CCR Identifier #E1821)
        - Derived SEER Cmb M Src (CCR Identifier #E1822)
        - SEER Primary Tumor (CCR Identifier #E1805)
        - SEER Regional Nodes (CCR Identifier #E1806)
        - SEER Mets (CCR Identifier #E1807)
        - Derived SS2017 (CCR Identifier #E1803)
        - Directly Assigned SS2017 (CCR Identifier #E1804)
        - NPCR Derived Clin Stg Grp (CCR Identifier #E1823)
        - NPCR Derived Path Stg Grp (CCR Identifier #E1824)
    - The following new fields trigger a Modified Record when updated:
        - Mets at DX-Bone (CCR Identifier #E1808)
        - Mets at DX-Brain (CCR Identifier #E1809)
        - Mets at DX-Distant LN (CCR Identifier #E1810)
        - Mets at DX-Liver (CCR Identifier #E1811)
        - Mets at DX-Lung (CCR Identifier #E1812)
        - Mets at DX-Other (CCR Identifier #E1813)
        - TNM Size Clinical (CCR Identifier #E1800)
        - TNM Size Pathologic (CCR Identifier #E1801)
        - TNM Size Summary (CCR Identifier #E1802)
    - The following fields no longer trigger a Modified Record when updated:
        - RX Date Systemic (CCR Identifier #E1318)
        - RX Date Systemic Flag (CCR Identifier #E1319)
    - The following fields now trigger a Modified Record when updated:
        - Place of Death--State (CCR Identifier #E1773)
        - Place of Death--Country (CCR Identifier #E1774)
        - Ambiguous Terminology (CCR Identifier #E1073)
        - Date Conclusive DX (CCR Identifier #E1074)
        - Date Conclusive DX Flag (#E1075)
        - Mult Tum Rpt as One Prim (CCR Identifier #E1076)
        - Date of Mult Tumors (CCR Identifier #E1077)

- Date of Mult Tumors Flag (CCR Identifier #E1078)
- Multiplicity Counter (CCR Identifier #E1079)
- NPI--Reporting Facility (CCR Identifier #E1080)
- RX Summ--Surgical Margins (CCR Identifier #E1336)
- Over-ride SS/NodesPos (CCR Identifier #E1444)
- Over-ride SS/TNM-N (CCR Identifier #E1445)
- Over-ride SS/TNM-M (CCR Identifier #E1446)
- Date Case Last Changed (CCR Identifier #E1483)
- Date of Last Contact (CCR Identifier #E1516)
- Date of Last Contact Flag (CCR Identifier #E1517)
- Vital Status (CCR Identifier #E1518)
- Cancer Status (CCR Identifier #E1519)
- Addr Current--City (CCR Identifier #E1523)
- Addr Current--State (CCR Identifier #E1524)
- Addr Current--Postal Code (CCR Identifier #E1525)
- Follow-Up Contact--City (CCR Identifier #E1531)
- Follow-Up Contact--State (CCR Identifier #E1532)
- Follow-Up Contact--Postal (CCR Identifier #E1533)
- Follow-Up Last Type (Patient) (CCR Identifier #E1580)
- Follow-Up Next Type (CCR Identifier #E1581)
- Date Cancer Status (CCR Identifier #E1582)
- Date Cancer Status Flag (CCR Identifier #E1583)
- Follow-Up Last Type (Tumor) (CCR Identifier #E1584)
- Follow-Up Hospital Last (CCR Identifier #E1628)
- Addr Current--No & Street (CCR Identifier #E1650)
- Addr Current--Supplementl (CCR Identifier #E1651)
- Telephone (CCR Identifier #E1652)
- Follow-Up Contact--Name (CCR Identifier #E1654)
- Follow-Up Contact--No & St (CCR Identifier #E1655)
- Follow-Up Contact--Suppl (CCR Identifier #E1656)
- Physician--Follow-Up (CCR Identifier #E1668)
- Contact Name (CCR Identifier #E1740)

See Appendix C for the following updates:

- Record Type (CCR Identifier #E1000) has been revised from F/S for Follow-up and Shared Follow-up to S only. Modified Record layout in Appendix B replaces the Update/Corrections and Follow-Up layouts.
- Medical Record Number (CCR Identifier #E1744) name has been revised from Medical Record Number [Len 12] to Medical Record Number.

See Appendix D for the following updates:

- Medical Record Number (CCR Identifier #E1744) name has been revised from Medical Record Number [Len 12] to Medical Record Number.

Additional Instructions:

The California Cancer Registry requires the use of Collaborative Staging for all cases with DX Year 2004 to 2015. For this reason the use of Over-ride CS 20, CCR Identifier E1508, is not allowed and the value should always be transmitted as blank. All edits for Collaborative Staging will be enforced and all edits associated with Collaborative Staging must be cleared before transmission to the CCR.

PART II DATA TRANSMISSION STANDARDS

Section II.1 Summary

Communication between a reporting facility and the California Cancer Registry (CCR) can be of two forms: some types of records are transmitted from the reporting facility to the CCR, and other types of records are transmitted from the CCR to the reporting facility.

Currently, there are three record types that must be transmitted from the reporting facility to the central registry. They are: New Case Records, Modified Records, and Deletion Records. All of these record types are described in Section II.3. A reporting facility cancer registry is required to submit all three types of records, following the procedures described below, to be in compliance with the California Cancer Reporting System Standards, Volume II.

There is one type of record that is sent from the central registry to the reporting facility. This is Shared Follow-Up, described in Section II.4. Acceptance of that record by the reporting facility is optional (although we strongly recommend it).

Cases should NOT be transmitted to the CCR using a format that is earlier than the year that the case is reportable. For example, 2010 cases, as defined by the CCR casefinding rules, cannot be submitted in the format required in 2009.

Section II.2 Explanatory Notes

Reporting requirements vary by item and record type and are listed in the "CCR Required from Reporting Facility" column in the Appendices. Each record type is described in a table, which must be consulted to determine whether or not a particular item is required. The following key explains the terms used in the "CCR Required from Reporting Facility" column.

Key to Symbols

no	Not required. It is optional for the facility to submit this data item value to the central registry.
yes	Required. The facility must submit this data item value to the central registry.
yes*	Required if available. If the information can be obtained, the facility must submit it to the central registry. If not available or not applicable, may be left blank.
conditional	Required on selected cases dependent on one or more conditions being true, such as the case's diagnosis date being before or after a certain date.
yes, gen by facility	Required, but the facility's registry software must generate the

	data item value based on a standard algorithm, rather than a user manually entering the data item value.

Items that are facility-generated are described in more detail, including allowable values in Cancer Reporting in California, Data Standards for Regional Registries and California Cancer Registry (California Cancer Reporting System Standards, Volume III).

Section II.3 Transmission between Hospitals and Regions

II.3.1 Selection of Cases

Only cases which are reportable under California Cancer Registry (CCR) requirements are to be included in transmissions to the CCR. A reporting facility may elect to abstract certain benign conditions or skin cancers to meet local interest or ACoS requirements; however, these cases are not to be transmitted to the CCR.

Transmit all cases with a 2 or 3 (in situ or malignant) in Histology - Behavior, EXCEPT the following histologies occurring in the skin (site codes C44.0 -C44.9):

8000-8005 Neoplasms, malignant, NOS of the skin

8010-8046 Epithelial carcinomas of the skin

8050-8084 Papillary and squamous cell carcinomas of the skin

8090-8110 Basal cell carcinomas of the skin

In addition, for cases diagnosed after 1995, do not transmit any in situ (Histology - Behavior of 2) of the cervix (site codes C53.0 - C53.9). Beginning with cases diagnosed January 1, 2001, benign (behavior code 0) and uncertain behavior (behavior code 1) intracranial and central nervous system tumors are reportable. Borderline ovarian tumors (behavior code 1) in ICD-O-3 are no longer reportable, effective with cases diagnosed January 1, 2016 and forward.

II.3.2 New Case Record

For every abstract of a reportable case that is completed at the reporting facility, a New Case Record must be sent to the CCR. Timing considerations for reporting are discussed in Standards, Volume I, Section IX.1.1.

The format for the New Case record is specified in Appendix A. (Key to symbols is in Section II.2.)

II.3.3 Modified Record

The CCR now requires facilities to use the Modified Record instead of the former Update/Correction and Follow-Up Records to transmit data modifications for abstracts already submitted as New Case Records. The Modified Record, record type M, has the same length (22824 characters) and contains the same fields in the same locations as the New Case Record, record type A. The field Follow-up Flag is the only field that has a different requirement status between the two record types. The flag documents if the Modified Record contains updates to fields identified to contain follow-up information. Vendors will be responsible for generating this field using the following guidelines:

- Generate a flag of 1 in the field Follow-up Flag when an update has been made to any of the following fields:
  - Date of Last Contact
  - Date of Last Contact Flag
  - Vital Status
  - Date Cancer Status
  - Date Cancer Status Flag
  - Cancer Status
  - Follow-Up Hospital Last
  - Follow-Up Last Type (Patient)
  - Follow-Up Last Type (Tumor)
  - Follow-Up Registry - Next
  - Follow-Up Next Type
  - Physician--Follow-Up
  - Cause of Death
  - Place of Death - State
  - ~~Date Case Last Changed~~
  - DC State File Number
  - Contact Name
  - Addr Current--No & Street
  - Addr Current--Supplementl
  - Addr Current--City
  - Addr Current--State
  - Addr Current--Postal Code
  - Telephone
  - Pat No Contact
  - Follow-Up Contact--Name
  - Follow-Up Contact--No&St
  - Follow-Up Contact--Suppl
  - Follow-Up Contact--City
  - Follow-Up Contact--State
  - Follow-Up Contact--Postal
  - Place of Death - Country
  - Addr Current – Country
  - Followup Contact - Country

Unlike the former Update/Correction record, the Modified Record is designed to allow facilities to submit the current version of an abstract, providing the cumulative updates to all of the fields since the original new case was submitted, rather than sending a separate record for each data item change. The Modified Record can only be used once the reporting facility's registry system has been converted to use the latest NAACCR record version and CCR coding procedure standards.

A Modified Record will be sent to the CCR following a monthly (30 day) timeline and will be triggered by the following:

- The reporting facility changes a data item value with an Update Triggers Modified Record specification of yes in Appendix B: Modified Record Layout.

Although only the above criteria will trigger a Modified Record, all data items in the Modified Record will be sent to the CCR. A Modified Record will only be generated by vendor software after an updated field triggered the record as outlined above and 30 days have followed since the initial trigger. This will allow for multiple changes to be sent in the same Modified Record. A record's first 30-day waiting period starts with the first update after the original new case transmit, and then restarts each time the case is transmitted, as a retransmitted new case or as a modified record, on the day the next post-transmit update is made. Vendors will be responsible for tracking this timeline within the software. Hospital registrars will have these Modified Records generated and included in their monthly transmissions to the CCR as appropriate. It is important to note that the timeline should not be altered due to a scheduled monthly transmit to the CCR. If 30 days have not passed since the initial trigger, then the Modified Record should not be transmitted.

There should not be any additional work effort placed on the Hospital registrars in regards to generation of these records. The field Date Case Last Changed will continue to be updated by the software during the 30 days to accurately reflect the date the abstract was last updated.

Modified Records will now be rejected from the Eureka database software if they are unable to pass edits, see Section III.1 for further details and requirements.

PLEASE NOTE: Whenever items change due to the receipt of shared follow-up from the CCR, DO NOT TRIGGER a Modified Record.

II.3.3A Modified Record Layout

See Appendix B for the record layout for Modified records.

II.3.4 Shared Follow-Up Record

II.3.4.1 Shared Follow-Up

Reporting facilities which agree in advance may be able to receive shared follow-up. Whenever the CCR receives follow-up on a reporting facility's patient (and, possibly, that patient's tumor) from a different source (another reporting facility, State death tapes, DMV, etc.), the CCR may make available to the reporting facility the most current follow-up data available on that patient and tumor. The fields Follow-Up Hospital (Last) and Follow-Up - Last Type (Patient) and Follow-Up - Last Type (Tumor) in the Shared Follow-Up record will indicate the type of reporting source that supplied the latest follow-up information being provided.

II.3.4A Shared Follow-Up Record Layout

See Appendix C for the record layout for Shared Follow-Up records. (Key to symbols is in Section II.2.)

II.3.5 Deletion Record

Whenever a reporting facility decides to delete from its database a case that has previously been reported to the CCR, a Deletion record must be transmitted to the CCR, EXCEPT when the reporting facility is deleting a duplicate.

The following special item is used in the record layout for this record type:

Text - Transaction Remarks - This is a 150-character field (3 lines of 50). It must contain a comment indicating the reason for deleting the record.

If a deletion is made because the CCR's regional registry instructed the reporting facility to do so, the Text-Transaction Remarks field should contain only an "R" or "REGION" (all upper case).

II.3.5A Deletion Record Layout

See Appendix D for layout of deletion records. (Key to symbols is in Section II.2.)

Section II.4 Data Transmittal Format

Transmitted Data Files

All electronic files must be encrypted and password protected. File names must conform to the following schema:

- A three-letter abbreviation assigned by the CCR regional registry to the hospital (the case file suffix).
- Plus the four-digit year (YYYY) showing the year the file was created.
- Plus the three-digit day of the year (001 through 366) showing the day the file was created.
- Plus a single letter (A–Z) showing the sequence within one day the file was created. (Different file types can have the same sequence letter.)
- Plus a standard suffix according to the record type (see below).

For example, the first file of new cases created on February 1 at hospital abbreviated STJ would be named STJ2015032A.XAA and the second file of new cases created that day would be STJ2015032B.XAA.

The following files may be included, in any order.

Record Type	File Suffix	Record Length	
New Case	.XAA	22824	plus CR/LF
Modified Record	.XMO	22824	plus CR/LF
Shared Follow-Up	.XSH	804	plus CR/LF
Deletion	.XDL	368	plus CR/LF

Section II.5 Rules for Computer-Generated Data Items Required by California

Please refer to California Cancer Reporting System Standards, Volume III, for specifications for generating the data items referred to in Section II.5.1.2-4.II.5.1 Data Items.

To determine which items to generate in facility software, refer to the *CCR Required from Reporting Facility Software* column in Appendices A, B, C, or D.

Appendix A: New Case Record, NAACCR Version 12.2

Data Item Name	CCR Identifier	NAACCR Identifier	Col Start	Col End	Length	CCR Required from Reporting Facility Software	Supplied by CCR	Correction Record Required
NPI--Reporting Facility	E1080	545	691	700	10	yes*		yes*
Reporting Facility	E1081	540	701	710	10	yes		yes
NPI--Archive FIN	E1082	3105	711	720	10	no		no
Archive FIN	E1083	3100	721	730	10	no		no
Accession Number--Hosp	E1084	550	731	739	9	yes		yes

II.5.2 End of Record

Must be a period (.).

II.5.3 Record Type

This is a one-character field used to identify the type of record being processed. The hospital computer system must supply the appropriate code letter at the time that the file is created. The appropriate code for each record type is listed below:

New Case	A
Modified Record	M
Deletion	D

The code for the record type generated by the central registry is:

Shared Follow-Up	S

II.5.4 NAACCR or Central Registry Record Version

This field must contain the version code that identifies which revision of a record layout was used to create a record for the recipient. Once your software system has been modified to transmit records using the latest record layouts in this volume, all records transmitted must include the latest record version code(s), shown parenthetically after the record version data item name in each record layout.

Section II.6 Rules to Computer Generate Data Items for Standard Setting Organizations

The California Cancer Registry is required to submit data to standard-setting organizations. There are a number of data items that are generated for these submissions. These organizations include the North American Association of Central Cancer Registries (NAACCR), NCI's Surveillance, Epidemiology and End Results Program (SEER) and the Center for Disease Control and Prevention's National Program of Cancer Registries (NPCR). Please refer to California Cancer Reporting System Standards, Volume III, for specifications for the data items listed below.

II.6.1 Data Items

- Census Tract Coding System 1970/80/90
- COC Coding Sys - Current
- COC Coding Sys - Original
- Coding System for EOD
- Computer-Derived Ethnicity (formerly Spanish Surname)

- Computer-Derived Ethnicity Source
- ICD Revision Number
- Industry Source
- Follow-Up Source- Central (Mapped from Last Type of Follow-Up (Patient))
- Morph Coding Sys - Current
- Morph Coding Sys – Original
- Occupation Source
- Race Coding Sys - Current
- Race Coding Sys - Original
- RX Coding System - Current
- SEER Coding Sys - Current
- SEER Coding Sys – Original
- SEER Type of Follow-Up
- SEER Record Number
- Site Coding Sys - Current
- Site Coding Sys – Original
- Census Tr Poverty Indictr
- Surv-Date Active Followup
- Surv-Flag Active Followup
- Surv-Mos Active Followup
- Surv-Date Presumed Alive
- Surv-Flag Presumed Alive
- Surv-Mos Presumed Alive
- Surv-Date DX Recode
- Derived SEER Path Stg Grp
- Derived SEER Clin Stg Grp
- Derived SEER Cmb Stg Grp
- Derived SEER Combined T
- Derived SEER Combined N
- Derived SEER Combined M
- Derived SEER Cmb T Src
- Derived SEER Cmb N Src
- Derived SEER Cmb M Src
- NPCR Derived Clin Stg Grp
- NPCR Derived Path Stg Grp

Part III Quality Control Standards

Section III.1 Edits

One method used by the regional registry for insuring data quality is to pass submitted records through computer edits to assess whether coding rules have been properly followed. Two types of computer edits will be applied to New Case Records and Modified Records when they are received: allowable value edits and interfield edits. Allowable Value edits check individual data items for valid codes or other types of allowable values. Interfield edits compare the contents of two or more fields for consistency. These edits are described in Cancer Reporting in California: Standards for Regional Registries and the California Cancer Reporting

System Standards, Volume III. This document is available on the CCR website. See Section III.4 in this manual for the acceptance standards.

CCR edits must be run and any edit errors corrected before the creation of a New Case Record or Modified Record submission file. Modified Records will be rejected by the CCR's Eureka database software if they are unable to pass the CCR edits, and the facility will be required to fix the necessary data items prior to the next scheduled monthly transmit. Please see Section II.3.3 for further requirements for the Modified Record.

Section III.2 Acceptance Procedure

III.2.1 Acceptance Standards for Software

Hospitals (and other reporting sources) wishing to develop their own systems for automated reporting to the regional registry, or vendors wishing to market software which meets California Cancer Registry requirements, are required to demonstrate that they have procedures in place to assure the accuracy of the data being collected. In order for another method of automated reporting to be accepted for reporting to the California Cancer Registry and its regional registries, the hospital or vendor must demonstrate the following:

1. Data must conform to the specifications described in this document.

2. Software must allow all valid values in data item fields.

3. All records must pass the allowable value edits (California Cancer Reporting System Standards, Volume III).

4. All records must pass the interfield edits (California Cancer Reporting System Standards, Volume III).

5. ~~A percentage of incoming records must contain data in required fields, but may be left blank if the information is not available. This percentage will vary by item. Data items are indicated by yes* on the record layouts.~~

A hospital or vendor must demonstrate its ability to meet these standards before its system is accepted and it will be expected to continue to meet these standards. Each time a hospital or vendor changes the registry software (i.e., changes the version) it must again demonstrate its ability to meet these standards.

III.2.2 Test Submission

In order for the California Cancer Registry to determine whether a hospital or vendor meets the above requirements, the hospital or vendor must submit test records of each type for approximately 50 cases, covering one-month, three-months, or six-months; whichever time period is closest to 50 cases. A test file cannot contain only easy cases, but must contain a sample that is representative of the normal caseload. After the submission is evaluated by the California Cancer Registry, the reporting facility or vendor will receive notification of problems detected and what changes, if any, need to be made before the reporting facility's or vendor's software can be accepted for automated reporting.

When Volume II requirements change in such a way that vendor software must be revised, then the vendor must submit additional test files to demonstrate that they meet the new requirements.

Appendices A, B, C, & D (Exchange Records)

[Exchange records. Appendices A, B, C, & D, are presented in spreadsheet format. Click here to open the appendices.](#)