GENERAL CHANGES

Select Pages

✓ Formatting and general typo updates.
✓ Confirmed page breaks.
✓ Updated Table of Contents.

SECTION CHANGES

Preface

✓ Changed region name from “Cancer Surveillance Program” to “The Los Angeles County Cancer Surveillance Program”.

II.1 CCR Reportability Guide

✓ Added Coding Instruction:
  o If a case has a reportable histology for 2018 forward and was diagnosed with that histology prior to 2018:
    ▪ Do not go back and report for 2017 because the histology was not reportable then. Report the date of diagnosis when case first became reportable in 2018.
✓ Removed the following note under Site Specific Terms Indicating In-situ Behavior heading: INTRAEPITHELIAL NEOPLASIA Note: (8077/2 and 8148/2) MUST be documented exactly as stated here. Grade III MUST be included in the diagnosis for these to be reportable. No variation in terms allowed.

III.3.3 Date of Diagnosis

✓ Updated Coding Instruction:
  o Forth bullet and sub-bullets - For non-analytic cases where there is no information about the date or at least year of diagnosis, the instruction has been modified to read:
    ▪ Use the date of admission /1st contact year as the date of diagnosis and apply the applicable coding instructions.

III.3.5 Class of Case

✓ Updated Codes table, Class 00 - To avoid confusion the example was moved from under the notes listed to above them.

IV.2 Diagnostic Confirmation

✓ Coding Instructions, second bullet - Reworded the instruction to be in alignment with standard setters.

V.3.3.1 In-Situ Coding
✓ Removed the following note under Site Specific Terms Indicating In-situ Behavior heading - INTRAEPITHELIAL NEOPLASIA Note: (8077/2 and 8148/2) MUST be documented exactly as stated here. Grade III MUST be included in the diagnosis for these to be reportable. No variation in terms allowed.

V.5.1 Tumor Size Clinical - NEW
✓ Coding Instructions, third bullet - Added second sub-bullet and note.
  o Record the size from an incisional biopsy. Use the clinical guideline for TNM to determine if the biopsy was done during the clinical timeframe. Use the source that gives you the best size and take the largest size.
  NOTE: An incisional biopsy that removed the whole tumor is actually an excisional biopsy. Record tumor size from an excisional biopsy in Tumor Size – Pathologic.

V.8 Terms Indicating In-situ for Staging
✓ Removed the following note under Site Specific Terms Indicating In-situ Behavior heading: INTRAEPITHELIAL NEOPLASIA Note: (8077/2 and 8148/2) MUST be documented exactly as stated here. Grade III MUST be included in the diagnosis for these to be reportable. No variation in terms allowed.

V.11.1.3 EOD - Mets - NEW
✓ Added Coding Instruction:
  o Eleventh bullet - Not all possible metastatic sites are listed in each of the schemas. If there is confirmed metastasis that is not listed, assign the highest code as described below:
    ▪ Code 70 is used for all mets (except distant lymph nodes only), for schemas that have only codes 10 (distant lymph nodes) and 70 (all other mets).
    ▪ For schemas where there are additional codes:
      • Use the highest code before code 70, when mets are present that are not specified in any of the other codes.
      • Code 70 in these cases should only be used when the only information is “distant metastasis, NOS,” and there is no documentation regarding the specific metastases.

V.12 SSDI General Information - NEW
✓ Added Coding Instruction:
  o First bullet - SSDIs are to be collected during the initial diagnosis, workup and first course treatment.
  o Sixth bullet - SSDIs follow the standard definitions of rounding.
    ▪ All SSDIs that have lab values, percentages or measurements are set up to record in the 10ths (one digit after the decimal point).
    ▪ If a lab value, percentage or measurement is recorded in 100ths (two digits after the decimal point), then the last digit must be rounded.
    ▪ The general rounding rules are:
      • If digit is 0-4, round down
      • If digit is 5-9, round up
      • Currently, the only SSDIs that have exceptions to the general rounding rules are:
        o HER2 ISH Single Probe Copy Number
        o HER2 ISH Dual Probe Copy Number
        o HER2 ISH Dual Probe Ratio
  o Seventh bullet - Unless instructions for a specific laboratory test state otherwise, record only test results obtained.
    ▪ Before any cancer-directed treatment is given (neoadjuvant therapy or surgical), AND
    ▪ No earlier than approximately three months before diagnosis AND
    ▪ If multiple lab tests are available, record the highest value
VI.2.5.3 Sentinel Lymph Nodes Examined
✓ Codes table - Removed code 90 – 90 or more nodes examined. This was a duplication and was not in any of our standard setter manuals.

VI.3.3.3 Radiation Treatment Modality - Phases I-3
✓ Added Coding Instruction:
  o Last bullet - Coding instructions for radiation modality based on the type of heavy equipment used for therapy, are located in the CoC’s CTR Guide to Coding Radiation Therapy Treatment, Appendix B - Coding Modality for the Heavy Equipment of Modern Radiation Therapy.

IX.1.3 Deletions
✓ Bullet one , added sub-bullet - Deletions cannot be submitted for a case to be re-abstracted under a new reporting facility if the case was previously abstracted under another reporting source.
✓ Bullet three, added sub-bullet - Mass deletions must be approved by the regional or central registry in advance.

Appendix G: Codes for Casefinding
✓ Updated screening list for 2019-2020 ICD-10-CM Codes for casefinding tables.

Appendix J: Spanish Surnames
✓ Changed format of appendix to comply with Americans with Disabilities Act (ADA).