
CANCER REPORTING IN CALIFORNIA:
ABSTRACTING AND CODING PROCEDURES
California Cancer Reporting System Standards, Volume I

Changes and Clarifications –17th Edition
April 28, 2017

Updates to Volume I

SECTION CHANGES

I.1.6 Reporting

- ✓ Added list of cases that are not reportable:
 - Hospice only.
 - Patients receiving long term therapy with a history of cancer, but no current evidence of cancer.
 - Patients receiving transient care.
 - Cancer Conference (Tumor Board) presentation only.
 - Catheter placement for cancer therapy only.
 - Consult Only (See Pathology and Consultation Only Cases for exceptions)
- ✓ All references to Confidential Morbidity Reporting (CMR) were either removed or revised to state “other approved notification mechanism”.
- ✓ Minor grammar and formatting changes.

I.1.6.1 Definition of Cancer

- ✓ Updated section to include any other healthcare practitioner diagnosing or providing treatment for cancer patients.
- ✓ Added example: Physician Assistant (PA) or Nurse Practitioner (NP)
- ✓ Minor grammar and formatting changes.

I.1.6.2 Abstracting Cancer Data

- ✓ Added bullets to clarify items on abstract that do not require supporting text.
- ✓ Minor grammar and formatting changes.

I.1.6.5 Coding Resources

- ✓ AJCC (American Joint Committee on Cancer). 8th ed., added to the table.
- ✓ Updated release dates of the Abstracting and Coding References.
- ✓ Added the California Cancer Registry – Registrar Education and Training link to the helpful references section.

I.1.6.5.1 Historical Coding and Staging Manual Requirements for CCR - *NEW PAGE*

- ✓ New page added to compile a list of coding and staging manuals required by the CCR since their reference date of January 1, 1988.

II.1 CCR Reportability Guide

- ✓ Revised Benign Brain Reportability: Standard setter difference to clarify the CCR reportability requirement for benign schwannoma's were included in the benign brain tumor reportability for 2001 forward. SEER and CDS registries began requiring their reporting requirement for benign brain tumors (including schwannoma's) in 2004.

II.2.2 Skin Reportability

- ✓ Revised and reordered codes by site code in first bullet "Genitalia" under title "Reportable" table.
- ✓ Added the following sites previously omitted from this page. Note: These sites were included in II.1 CCR Reportability Guide.
 - labium (C51.0)
 - vulva (C51.9)
 - vagina (C52.9)
 - prepuce (C60.0)
- ✓ Minor grammar and formatting changes.

II.2.4 Pathology, Tumor Board, and Consultation Only Cases

- ✓ Renamed page, removing "Tumor Board."
- ✓ Moved "Tumor Board" to the not reportable list in I.1.6 Reporting page.
- ✓ All references to Confidential Morbidity Reporting (CMR) were either removed or revised to state "other approved notification mechanism".
- ✓ Minor grammar and formatting changes.

III.2.1 Name

- ✓ Removed instruction: Use uppercase letters only (Volume III, allowable values, permit mixed case).
- ✓ Added instruction: Avoid using only uppercase/capitals.
- ✓ Changed Examples for "Saint" from all capital letters to mixed case). Updated instruction
- ✓ Minor grammar and formatting changes.

III.2.1.1 Entering Names

- ✓ Under "Last Name", updated bullet 3 to include mixed case for "Unknown" Last Name entry.
- ✓ Under "Alias Last Name", removed instruction to not leave a blank space between words. (Volume III, allowable values, permit spaces).
- ✓ Under "First Name", updated bullet 4 to include mixed case for "Unknown" First Name entry.

III.2.9.2 Spanish/Hispanic Origin

- ✓ Updated Code 0, bullet 2 to clarify:
 - If a patient has a Spanish surname and is not of Hispanic origin, a statement indicating the patient is not Hispanic "is required".
 - Updated that text supporting the scenario above, can be included in either the physical exam or remarks text field. Previous instruction only included "Remarks text".

III.2.10 Date of Birth

- ✓ Updated instruction to explain that text supporting the patient's age can be entered in the physical exam or remarks text field.
- ✓ Changed bullet to sub-bullet indicating text documentation for patient's over 100 should be entered in the remarks text field.

III.2.11 Age at Diagnosis

- ✓ Updated instruction to explain that text supporting the patient's age can be entered in the physical exam or remarks text field.
- ✓ Changed bullet to sub-bullet indicating text documentation for patient's over 100 should be entered in the remarks text field.

III.3.5 Class of Case

- ✓ Removed "Stent Placement" as an example from Class 31.
- ✓ All references to Confidential Morbidity Reporting (CMR) were either removed or revised to state "other approved notification mechanism".
- ✓ Minor grammar and formatting changes.

III.3.8 Casefinding Source

- ✓ All references to Confidential Morbidity Reporting (CMR) were either removed or revised to state "other approved notification mechanism".

TEXT FIELDS:

IV.1 Text - Diagnostic Procedures Performed

IV.1.1 Text - Physical Examination

IV.1.2 Text - X-Ray/Scans

IV.1.3 Text - Scopes

IV.1.4 Text - Laboratory Tests

IV.1.5 Text - Operative Findings

IV.1.6 Text - Pathology Findings

IV.1.7 Text - Staging

VIII.1 Text - Remarks

- ✓ These guidelines for the text fields listed above have been added as suggested by the Educational Training Coordinators Workgroup.
- ✓ Additional revisions and added content specific to each text field may also be listed further down in this document.
- ✓ General additions/revisions, for all text fields listed above:
 - Use phrases not complete sentences. Separate phrases using either periods (.) or semi-colons (;).
 - Avoid using only uppercase/capitals in text documentation.
 - Do not leave text fields blank. Record "None", NR, or NA when information is missing from the medical record or there is not pertinent information.
 - Use standard medical abbreviations when possible. See Appendices [M.1](#) and [M.2](#) for common acceptable abbreviations.
 - Record both the information and the source of the information.
 - Added bullets to clarify items on abstract that do not require supporting text.
 - Use either a slash (/) or hyphen (-) to separate month, day, and year.
 - Minor grammar and formatting changes.

IV.1 Text - Diagnostic Procedures Performed

- ✓ See list under “**TEXT FIELDS**” above.

IV.1.1 Text - Physical Examination

- ✓ Record the date of the patient's physical examination.
- ✓ Record both the information and the source of the information
 - **Example:** Race (white per face sheet)
- ✓ The following demographics may be entered in either the physical exam or remarks text fields:
 - Age
 - Include text verification when the patient is 100 years or older.
 - Race
 - Include text verification for the race of patient when coded as "Other" or if there is conflicting race information. See Race and Ethnicity.
 - Hispanic Origin
 - Sex

IV.1.2 Text - X-Ray/Scans

- ✓ See list under “**TEXT FIELDS**” above.

IV.1.3 Text – Scopes

- ✓ See list under “**TEXT FIELDS**” above.

IV.1.4 Text - Laboratory Tests

- ✓ See list under “**TEXT FIELDS**” above.

IV.1.5 Text - Operative Findings

- ✓ See list under “**TEXT FIELDS**” above.
- ✓ Added “Residual tumor size” to the list of important information to include.

IV.1.6 Text - Pathology Findings

- ✓ See list under “**TEXT FIELDS**” above.
- ✓ Added bullet instructing to record margin status.
- ✓ Added bullet for clarification on use of path text field for pathology staging only.
 - Sub-bullet with link added for instruction on non-path staging.

IV.1.7 Text - Staging

- ✓ See list under “**TEXT FIELDS**” above.
- ✓ Added bullet for clarification on use of staging text field for staging done by any other physician besides the pathologist.
 - Sub-bullet added instructing registrar to enter the type of physician who is staging the case (i.e. Managing MD, Radiation Oncologist, Registrar and MD, etc.).
 - Sub-bullet with link added for instruction on pathology staging.

IV.1.7 Text - Staging

- ✓ See list under “**TEXT FIELDS**” above.
- ✓ Updated description to explain that this text field collects diagnostic information not already entered in other text fields.
- ✓ Added bullet to reinforce **not** to repeat information from other text fields.

V.3 ICD-O Morphology – Histology, Behavior, and Differentiation

- ✓ Added note extending use of ICD-O-3 Histology Code Crosswalk through 2017.
- ✓ Updated Attachment A, extending the date through 2017.
- ✓ Revised description of grade to match that documented in V.3.6 Grade and Differentiation.

V.4.1.1 Tumor Size Clinical

- ✓ Added clarifying extension to sub-bullet under bullet 3, stating:
 - Code the largest size in the record, regardless of the imaging technique, when there is a difference in reported tumor size among imaging and radiographic reports, unless the physician specifies the imaging that is most accurate.
- ✓ Updated typo in codes table, from 998 to 988

V.4.1.2 Tumor Size Pathologic

- ✓ Updated typo in codes table, from 998 to 988
- ✓ Updated misspelled word.

V.4.1.3 Tumor Size Summary

- ✓ Updated typo in codes table, from 998 to 988
- ✓ Minor grammar and formatting changes.

V.4.2 Mets at Diagnosis – Bone, Brain, Distant Lymph Nodes, Liver, Lung, and Other

- ✓ Revised this page to be introduction page for generalized coding instructions for all Mets at Diagnosis fields.
- ✓ Separated the following Mets at Diagnosis field pages into their own site specific pages:
 - Mets at Diagnosis - Bone **V.4.2.1**
 - Mets at Diagnosis - Brain **V.4.2.2**
 - Mets at Diagnosis - Liver **V.4.2.3**
 - Mets at Diagnosis - Lung **V.4.2.4**
 - Mets at Diagnosis - Distant Lymph Nodes **V.4.2.5**
 - Mets at Diagnosis - Other **V.4.2.6**
- ✓ Clarified to code this field for Lymphomas of all sites for the histologies (9590-9699, 9702-9727, 9735, 9737-9738, 9811-9818, 9823, 8927, and 9737).

V.4.2.1 Mets at Diagnosis - Bone - **NEW PAGE**

- ✓ Created page specific for Mets at Diagnosis - Bone coding instructions.

V.4.2.2 Mets at Diagnosis - Brain - **NEW PAGE**

- ✓ Created page specific for Mets at Diagnosis - Brain coding instructions.

V.4.2.3 Mets at Diagnosis - Liver - **NEW PAGE**

- ✓ Created page specific for Mets at Diagnosis - Liver coding instructions.

V.4.2.4 Mets at Diagnosis - Lung - *NEW PAGE*

- ✓ Created page specific for Mets at Diagnosis - Lung coding instructions.

V.4.2.5 Mets at Diagnosis – Distant Lymph Node(s) - *NEW PAGE*

- ✓ Created page specific for Mets at Diagnosis – Distant Lymph Node(s) coding instructions.

V.4.2.6 Mets at Diagnosis - Other - *NEW PAGE*

- ✓ Created page specific for Mets at Diagnosis - Other coding instructions.
- ✓ Added Code 2: Generalized metastasis such as carcinomatosis. Note, this was approved by all standard setters for 2016 implementation. However, it was inadvertently left out, per NAACCR.

V.4.3 Lymph-Vascular Invasion

- ✓ Updated section to include additional instructions in order to aid registrars in coding this field.

V.6.1 TNM Staging Classifications

- ✓ Minor grammar and formatting changes.

VIII.1 Text – Remarks

- ✓ See list under “*TEXT FIELDS*” above.
- ✓ Added height, weight, and smoking information to demographics bullet.
- ✓ Added instructions for additional supplemental information, which cannot be coded numerically but may be useful to clarify special circumstances or situations.

IX.2.2 Accuracy - Quality Control

- ✓ Minor grammar and formatting changes.

CHANGES to APPENDICES

Appendix K: Codes for Casefinding

- ✓ Removed the following code and description from the Codes for Casefinding ICD-10-CM List. SEER has removed it from their list as well.
 - D18.1 – Lymphangioma, any site;
Note: Includes Lymphangiomas of Brain, Other parts of nervous system and endocrine glands, which are reportable

Appendix F: California Reporting Facility Codes

- ✓ Updated California Cancer Reporting Facility Codes Lists.

Appendix Q-2: FORDS Surgery Codes

- ✓ RECTUM:
 - Removed duplicate of “Curette and fulguration” from code 30 as it is coded to 28