

REMINDERS FOR REPORTING CASES DIAGNOSED 2007

New Rules

Use the new Multiple Primary and Histology (MPH) Coding Rules for all cases diagnosed January 1, 2007 and later. The only exceptions are hematopoietic primaries (lymphoma and leukemia) of any site and the reportable benign or borderline intracranial or CNS tumors. The new MPH rules apply to both single and multiple tumors. The multiple primary rules guide and standardize the process of determining the number of primaries. The histology rules contain detailed histology coding instructions and include sections for both single tumors and multiple tumors abstracted as a single primary. These rules replace all previously published rules for cases diagnosed in 2007 and beyond. Do not use these rules to abstract cases diagnosed prior to January 1, 2007.

The rules are available on the SEER Web site at http://www.seer.cancer.gov/tools/mphrules/mphrules_manual_01012007.pdf. A hard copy of the MPH rules (with 3-ring binder and dividers) may be purchased from the National Cancer Registrars Association at <http://www.ncra-usa.org/store/#pubs8>.

If you missed the MPH training offered at the State or want additional information, free training for the rules is available in recorded and transcript formats on the SEER Web site at <http://seer.cancer.gov/tools/mphrules/training.html>.

New Item

NPI-Reporting Facility is a new item required by NPCR for 2007 diagnoses when the NPI (National Provider Identifier) numbers become available. NPI is a unique identification number for health care providers scheduled for 2007-2008 implementation by the Centers for Medicare & Medicaid Services as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The *NPI-Reporting Facility* item should be automatically coded by the software provider. The item description is provided on attached page 37A for your State coding manual. At the time of this news brief, the numbers are to be available September 4, 2007 at http://www.cms.hhs.gov/NationalProvIdentStand/06a_DataDissemination.asp.

New Codes

For the *State at Diagnosis* item, there are new codes for Canada, NOS and United States, NOS. These codes are provided on the attached replacement page 50 for your State coding manual.

New Definitions

In Collaborative Staging Version 01.03.00, "core biopsy" was added to the definitions for code 95 in the items *Regional Nodes Positive* and *Regional Nodes Examined*. These changes are reflected on the attached replacement pages 115 and 117 for your State coding manual.

Changes in the ICD-9-CM Casefinding List

Recent ICD-9-CM coding changes for health information (medical record) diagnoses require revision of the list of codes that must be screened for reportable tumors. The changes became effective for healthcare encounters and discharges October 1, 2006 and after. The revised list is provided on the attached replacement pages 279 and 280 for your State coding manual.

NPI-REPORTING FACILITY

Item Length: 10
Data Type: Numeric
ACoS: Required*¹
State Registry: Required*²

*¹For cases diagnosed 01/01/2008 or later.

*²For cases diagnosed 01/01/2007 or later, when available.

Description

This is a required 10-character field that identifies the facility submitting the data in the record. NPI (National Provider Identifier) is a unique identification number for health care providers implemented by the Centers for Medicare & Medicaid Services as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Rationale

Each facility's NPI is unique. The number is essential to National Cancer Database (NCDB) for monitoring data submissions, ensuring the accuracy of data, and for identifying areas for special studies.

Instructions

- a. *NPI-Reporting Facility* is automatically coded by the software provider.
- b. NPI should be recorded as available for cases diagnosed during 2007, and is required to be recorded for all cases diagnosed January 1, 2008.
- c. NPI may be blank for cases diagnosed on or before December 31, 2006.

12. STATE AT DIAGNOSIS

Item Length: 2
Data Type: Alphabetic
ACoS: Required
State Registry: Required

Description

This is a required 2-character field for the patient's usual state of residence at the time of diagnosis. See "General Guidelines for Recording Patient Address at Diagnosis" for detailed residency rules.

Rationale

The address is a part of the patient's demographic data and has multiple uses. It indicates referral patterns and allows for the analysis of cancer clusters or environmental studies.

Instructions

- a. Record the standard U.S. Postal Service 2-letter abbreviation for the state, territory, commonwealth, U.S. possession, or Canadian province/territory in which the patient resides at the time of diagnosis. The 2-letter codes appear on the following page.
- b. If the patient has multiple tumors, the state of residence may be different for each primary.
- c. Do not update this data item if the patient's state of residence changes.

Special Codes

CD Resident of Canada, NOS (province/territory unknown)

US Resident of United States, NOS (state/commonwealth/territory/possession unknown)

XX Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada, and the country is known. Code the country of residence in *County at Diagnosis*.

YY Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and the country is unknown

ZZ Residence unknown

39. REGIONAL NODES POSITIVE

Item Length: 2
 Data Type: Numeric
 Right Justified, Zero Fill
 ACoS: Required
 State Registry: Required

Description

This is a required 2-character field to record the number of regional lymph nodes the pathologist examined and described as metastatic, or positive for malignancy. For numbers less than 10, enter a leading zero. Beginning with cases diagnosed on or after January 1, 2004, this item is a component of the Collaborative Staging System (CS).

Codes

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

Example: The pathology report reads 11 out of 17 nodes examined were found to contain metastatic squamous cell carcinoma. Record 11 in the *Regional Nodes Positive* field.

Instructions

- a. Record the total number of regional lymph nodes removed as part of the first course of treatment, examined by the pathologist, and reported to contain cancer. The number of regional lymph nodes positive is cumulative from all procedures that removed lymph nodes through the completion of surgeries in the first course of treatment.
 - Do not record positive *distant* lymph nodes removed as part of the first course of treatment.
 - Do not code positive regional lymph nodes removed to establish recurrence or progression of disease.
 - Do not code nodes assessed by clinical examination only and stated to be positive.
- b. Record the number positive regardless of whether the patient received preoperative treatment.
- c. Use code 90 when 90 or more nodes are positive.
- d. Use code 95 when the cytology or histology from a lymph node aspiration is positive for malignant cells.
- e. Use code 97 for any combination of positive aspirated, biopsied, sampled, dissected lymph nodes if the number of involved nodes cannot be determined on the basis of cytology or histology.
- f. Use code 98 when no nodes were removed for examination or if a lymph node drainage area was removed, but no lymph nodes were found.
- g. Use code 99 when it is unknown whether lymph nodes were examined.
- h. Use code 99 for the following primary sites and histologies:
 - Placenta (C58.9)
 - Brain and cerebral meninges (C70.0, C71.0-C71.9)
 - Other parts of central nervous system (C70.1, C70.9, C72.0-C72.5, C72.8-C72.9)
 - Hodgkin and non-Hodgkin lymphoma (9590-9729) **except** 9700/3 and 9701/3

40. REGIONAL NODES EXAMINED

Item Length: 2
 Data Type: Numeric
 Right Justified, Zero Fill
 ACoS: Required
 State Registry: Required

Description

This is a required 2-character field to record the total number of regional lymph nodes that were examined by a pathologist. For numbers less than 10, enter a leading zero. Removal of regional lymph nodes and removal of the primary tumor may be performed in the same or in separate operative episodes. Beginning with cases diagnosed on or after January 1, 2004, this item is a component of the Collaborative Staging System (CS).

Codes

- 00 No regional lymph nodes were examined.
- 01-89 1-89 regional lymph node(s) were examined. Code the exact number of regional lymph nodes examined.
- 90 Ninety or more regional lymph nodes were examined.
- 95 No regional lymph node(s) were removed but aspiration or core biopsy of regional lymph node(s) was performed.
- 96 Regional lymph node removal was documented as a sampling and the number of lymph nodes is unknown/not stated.
- 97 Regional lymph node removal was documented as a dissection and the number of lymph nodes is unknown/not stated.
- 98 Regional lymph nodes were surgically removed but the number of lymph nodes unknown/not stated and not documented as 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 the patient record.

Notes:

- For cases diagnosed through 1997, see page 145 in the June 1998 State manual.
- When this field is left blank in the RMCDS program, the system defaults to code zeros (00).

Instructions

- a. Record the total number of regional lymph nodes removed as part of the first course of treatment and examined by the pathologist. The number of regional lymph nodes examined is cumulative from all procedures that removed lymph nodes through the completion of surgeries in the first course of treatment.
 - Do not record *distant* lymph nodes removed as part of the first course of treatment.
 - Do not code regional lymph nodes removed to establish recurrence or progression of disease.
 - Do not code nodes assessed by clinical examination. The statement, "the neck was negative for nodes," should be interpreted (coded) as "no nodes examined."
- b. Record the number examined regardless of whether the patient received preoperative treatment.
- c. Use code 00 when no nodes are removed for examination or if a lymph node drainage area was removed, but no lymph nodes were found. (Use code 98 for the *Regional Lymph Nodes Positive* field when no nodes are examined.)
- d. Use code 95 when a lymph node aspiration was performed, but no nodes were removed.
- e. Use code 96 if a lymph node biopsy was performed and the number of nodes is not known. Code the number of nodes removed, if known.
- f. Use code 98 if lymph nodes are aspirated and other lymph nodes are removed.

APPENDIX C

ICD-9-CM CODE SCREENING LISTS FOR CASEFINDING

Certain *International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)* codes used by health information management (medical record) departments identify reportable neoplasms. Most reportable cases fall within the ranges of codes 140 to 208 and 230 to 234. A few additional codes outside those ranges also identify reportable neoplasms.

The following lists are intended to assist in casefinding activities that are performed in casefinding sources that use *ICD-9-CM* codes to codify the diagnoses.

Casefinding List for Reportable Tumors

ICD-9-CM Codes Diagnoses (in preferred ICD-O-3 terminology)

140.0 - 208.9	Malignant neoplasms
225.0 - 225.9	Benign neoplasm of brain and spinal cord neoplasm
227.3 - 227.4	Benign neoplasm of pituitary gland, pineal body, and other intracranial endocrine-related structures
230.0 - 234.9	Carcinoma in situ
237.0 - 237.9	Neoplasms of uncertain behavior (borderline) of endocrine glands and nervous system
238.4	Polycythemia vera (9950/3)
238.6	Solitary plasmacytoma (9731/3)
238.6	Extramedullary plasmacytoma (9734/3)
238.71	Essential thrombocythemia (9962/3)
238.72	Low grade myelodysplastic syndrome lesions (includes 9980/3, 9982/3, 9985/3)
238.73	High grade myelodysplastic syndrome lesions (includes 9983/3)
238.74	Myelodysplastic syndrome with 5q deletion (9986/3)
238.75	Myelodysplastic syndrome, unspecified (9985/3)
238.76	Myelofibrosis with myeloid metaplasia (9961/3)
238.79	Other lymphatic and hematopoietic tissues (includes 9960/3, 9961/3, 9970/1, 9931/3)
273.2	Gamma heavy chain disease (9762/3); Franklin disease (9762/3)
273.3	Waldenstrom macroglobulinemia (9761/3)
288.3	Hypereosinophilic syndrome (9964/3)
289.83	Myelofibrosis, NOS (9961/3)
795.06	Papanicolaou smear of cervix with cytologic evidence of malignancy (<i>without histologic confirmation</i>) (<i>positive Pap smear</i>)
V10.0 - V10.9	Personal history of malignancy (<i>review these for recurrences, subsequent primaries, and/or subsequent treatment</i>)
V58.0	Encounter or admission for radiotherapy
V58.11	Encounter for antineoplastic chemotherapy
V58.12	Encounter for antineoplastic immunotherapy

Procedures

92.21-92.29	Therapeutic radiology and nuclear medicine
99.25	Injection or infusion of cancer chemotherapeutic substance

Supplementary ICD-9-CM Codes to Screen for Cancer Cases Not Identified by Other Codes

Note: Cases with these codes should be screened only as registry time allows. These are neoplasm-related secondary conditions for which there should also be a primary diagnosis of a reportable neoplasm.

042	AIDS (review cases for AIDS-related malignancies)
210.0 - 229.9	Benign neoplasms (<i>screen for incorrectly coded malignancies or reportable-by-agreement tumors</i>)
235.0 - 236.9	Neoplasms of uncertain behavior (<i>screen for reportable-by-agreement tumors</i>)
238.0 - 238.9	Neoplasms of uncertain behavior (<i>screen for reportable-by-agreement tumors</i>)
239.0 - 239.9	Neoplasms of unspecified behavior (<i>screen for incorrectly coded malignancies or reportable-by-agreement tumors</i>)
273.9	Unspecified disorder of plasma protein metabolism (<i>screen for potential 273.3 miscodes</i>)
338.3	Neoplasm related pain (acute) (chronic) (<i>new code</i>) Cancer associated pain Pain due to malignancy (primary) (secondary) Tumor associated pain
528.01	Mucositis due to antineoplastic therapy (<i>new code</i>)
790.93	Elevated prostate specific antigen (PSA)
795.8	Abnormal tumor markers (<i>new sub-category</i>) Elevated tumor associated antigens (TAA) Elevated tumor specific antigens (TSA) Excludes: elevated prostate specific antigen (PSA) (790.93)
795.81	Elevated carcinoembryonic antigen (CEA) (<i>new code</i>)
795.82	Elevated cancer antigen 125 (CA 125) (<i>new code</i>)
795.89	Other abnormal tumor markers (<i>new code</i>)
E879.2	Adverse effect of radiation therapy
E930.7	Adverse effect of antineoplastic therapy
E933.1	Adverse effect of immunosuppressive drugs
V07.3	Other prophylactic chemotherapy (<i>screen carefully for miscoded malignancies</i>)
V07.8	Other specified prophylactic measure
V66.1	Convalescence following radiotherapy
V66.2	Convalescence following chemotherapy
V67.1	Radiation therapy follow-up
V67.2	Chemotherapy follow-up
V76.0 - V76.9	Special screening for malignant neoplasm
V86.0	Estrogen receptor positive status (ER+) (<i>new code</i>)
V86.1	Estrogen receptor negative status (ER-) (<i>new code</i>)