March 2010

Montana Central Tumor Registry Newsletter

Hematopoietic & Lymphoid Neoplasm Project

New reportability instructions and data collection rules for hematopoietic and lymphoid neoplasms go into effect for cases **diagnosed** beginning January 1, 2010. These instructions and rules were developed by the Hematopoietic Working Group. Two tools have been developed for use beginning with 2010 cases:

- The Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual is embedded in the Hematopoietic database (Hematopoietic DB). This manual contains reportability instructions and rules for determining the number of primaries, the primary site and histology and the cell lineage or phenotype. Use the instructions and rules within the manual first. The Hematopoietic DB is used when the rules specifically instruct the abstractor to refer to the DB or when the registrar has used all of the rules in the manual.

- The Hematopoietic Database is an electronic tool developed to assist in screening for reportable cases and determining reportability requirements. The database contains abstracting and coding information for all hematopoietic and lymphoid neoplasms (9590/3-9992/3).

Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Rules Online Training should be reviewed prior to using either the manual or the Hematopoietic DB. Thirteen educational presentations on the Hematopoietic and Lymphoid Neoplasm Project are now available on the SEER website http://seer.cancer.gov/tools/heme/index.html. NCRA has approved these presentations for continuing education units. CEU certificates are available upon successful completion of the quiz associated with each presentation. From this website you can also download the Hematopoietic Database version 1.2 with the embedded manual.

Source: Surveillance Epidemiology and End Results

Cancer Surveillance & Epidemiology Program Staff

Carol Ballew, PhD
Program Manager
(406) 444-6988
cballew@mt.gov

Debbi Lemons, RHIA, CTR
Coordinator, Montana Central Tumor Registry
(406) 444-6786
dlemons@mt.gov

Diane Dean, MS, CTR
Data Control Specialist
(406) 444-6710
ddean@mt.gov

Paige Johnson, BS, CTR
Data Control Specialist
(406) 444-6709
paigejohnson@mt.gov

Janae Grotbo
Financial Specialist
(406) 444-2618
jgrotbo@mt.gov

FAX: (406) 444-6557

www.cancer.mt.gov

Meet the Registrar

Mary Hybner

Greetings from the cold and icy HiLine! When Paige asked me to participate in the spotlight column, my first reaction was that I'm definitely not in the same category as all you cancer registry professionals, but perhaps what I lack in formal registry education, I possibly make up in longevity.

My childhood was spent in Anaconda with college at Carroll, graduating in 1978 with a degree in Medical Record Administration. My first professional job was in Havre at Northern Montana Hospital. I didn't have much exposure to "tumor registry" until I worked in Medical Records at the University of Chicago Hospital in 1980-81. At that time they had three registrars for their 1700 bed facility. I moved back to Montana in 1981, married a farmer in Rudyard and started working part time at Liberty County Hospital in Chester. We started our registry in 1983 and I have been abstracting ever since. In those early years, we averaged about 10 cases per year, but with our population getting older, we now average about 20 a year, with a record volume of 28 in 2004.

Cancer registry is only one of the hats I wear at Liberty Medical Center, and it is difficult to keep up with cancer treatments, pharmaceuticals and abstracting rules. I try to attend state meetings when time and budgets allow and I always learn a great deal. I do appreciate you real Cancer Registrars, and your patience with us part-time registrars.

In my free time, I try to keep up with my wonderful husband, Terry, and our four amazing children; Mark (an attorney in New Jersey,) David (a computer programmer in Maryland,) Colleen (a student at U of M) and Brian (a high school junior.) I also enjoy reading and trying new wines. Those experts who suggest daily red wine to prevent illness are my heroes.

Release of Collaborative Stage Version 2

In January 2010, the Collaborative Stage Version 2 Work Group released the Collaborative Stage version 2.00.01 (CSv2) implementation guide and the General Rules (Part I, Section I), available at http://cancerstaging.org/cstage/manuals/index.html. The staging system has been renamed the Collaborative Stage Data Collection System. This new version incorporates significant changes to collaborative staging that are effective for cases diagnosed on or after January 1, 2010, and are based on the American Joint Committee on Cancer's Cancer Staging Manual, 7th Edition. Cases diagnosed in 2010 must be coded using the revised version, therefore, it will be necessary for cancer registries to install software updates before abstracting 2010 diagnoses. If abstracting of 2010 cases begins before the software is updated, registrars will have to review those cases after the update to code the new items and ensure that converted items have specific codes assigned. Cases diagnosed prior to 2010 may be coded using the new layout, but it is not necessary to code the new 2010 data items. To ensure correct conversion and derivation of CS data, all records in the registry database with staging information diagnosed from 1/1/2004 through the date of implementation must be processed through the CSv2 conversion algorithm. AJCC 6 stage and SS1977 and SS2000 will be re-derived on all cases where sufficient information is available.

Continued on Page 3.

Release of CSV2 continued

Users can expect fewer conversion problems with edited data. Once CSv2 is installed, it will be the only CS version used for all cases diagnosed from the year 2004 to the present, regardless of diagnosis year. The CSv2 algorithm for AJCC 6 and 7 will be applied to cases as described below:

- AJCC 7th edition mapping algorithm will be applied only to cases diagnosed from January 1, 2010 and forward.
- Cases diagnosed before January 1, 2010 can be coded using CSv2, but the mapping algorithm will only calculate AJCC 6th edition for these cases. **The MCTR recommends completing your 2009 cases prior to updating software and starting 2010 cases.**
- New site specific factors can be coded for pre-2010 cases.
- For data converted from CSv1 to CSv2, SSFs 1-25 may be left blank.

To date the CSv2 teams are still resolving some outstanding issues, which is why Part I Section II and Part II of the CSV2 manual are not yet available. Read the Implementation Guide and Part I General Coding Rules as well as Part II Site Specific Schema Coding Instructions (when available) before you begin abstracting your 2010 cases to ensure you are up-to-date on the new coding rules.

The Commission on Cancer's Inquiry and Response System, http://web.facs.org/coc/default.htm, is a good resource if you have questions regarding any of the cancer abstracting rules.

Source: American Joint Committee on Cancer

Certificate of Excellence Recipients

The following hospitals and Dermatology offices received a certificate for the 2009 Fourth Quarter, acknowledging their timeliness in reporting. Ninety percent of their cases were reported within 12 months.

Hospital	City
Northern MT Hospital	Havre
Billings Clinic	Billings
St Vincent's Hospital	Billings
Rosebud Health Care Center	Forsyth
Frances Mahon Deaconess Hospital	Glasgow
Sletten Cancer Institute	Great Falls
Big Horn Co Memorial Hospital	Hardin
St Patricks Hospital	Missoula
Great Falls Clinic	Great Falls
Yellowstone Path Institute	Billings
Helena Dermatology	Helena
Dermatology Provider Office of Great Falls	Great Falls
Dermatology Associates of Kalispell	Kalispell
Advanced Dermatology of Butte	Butte
Tallman Dermatology	Billings
Associated Dermatology of Helena	Helena

Upcoming Events

- **National Cancer Registrars Week**. April 12-16, 2010, this week was established as an annual celebration of the **amazing work** of Cancer Registry professionals.

- **National Cancer Registrars Association 36th Annual Educational Conference**. April 20-23, 2010 in Palm Springs, CA. NCRA offers the Danielle Chufar Scholarship, a scholarship committed to funding expenses associated with travel; lodging and registration for this conference. www.ncra-usa.org/ .

- **MT Cancer Registrars Association Spring Workshop**. Join us May 20-21, 2010 at St Patrick's Hospital in Missoula, MT. April Fritz will be our guest speaker on Thursday, May 20. Look for the MCRA Annual Meeting Brochures and Registration Materials, they should reach your mailbox in the upcoming months. Hope to see you there!

Q & A

Question: Concerning melanoma, are shave biopsies and punch biopsies considered diagnostic staging procedures or surgical procedures? Which treatment code do we select when a shave biopsy or punch biopsy is done and the pathology report does not mention the completeness of margins? Do we assume the biopsy done was an incisional biopsy because margins are not mentioned? If a shave/punch biopsy is done and is then followed by a re-excision or wide excision, how do we code the procedures?

Answer: The skin biopsy of any technique (shave, punch, incisional, etc), which shows gross residual margins visible by eye is coded in Surgical Diagnostic and Staging Procedure, (code 02 for diagnostic biopsy of primary site). The biopsy with positive margins invisible by eye, but visible as involved by the tumor under microscope is coded as a surgical procedure-excisional biopsy, codes 20 or 27. If margins are positive macro- or microscopically, the re-excision is required for treatment. The re-excision is coded as 30-33 (depends on technique of previous biopsy) if the margins are clean microscopically, and the distance from the tumor to the margins is less than or equal to 1 cm or unknown. If the margins are clean microscopically, and the distance from the tumor to the margins is greater than 1 cm, code the re-excision to 45-47. (Inquiry # 45521 Revised by AD 01/27/2010; Fords Appendix B pg 268)

Question: A malignant melanoma was removed with close or transected margins on a punch or shave biopsy. It was followed by a re-excision that showed no residual. Is the punch or shave biopsy coded as a diagnostic procedure and the re-excision coded as the only treatment or is the shave/punch biopsy coded as part of the surgical treatment?

Answer: If the shave/punch biopsy removed all gross tumor (only microscopic margins), then it would be coded as a surgery (code 20 or 27) and the re-excision will be coded 30-32 or 45-47 depending on size of margins. (Inquiry # 21668; Fords page 135, Revised 2009)

Source: ACOS COC Inquiry & Response Team http://web.facs.org/coc/default.htm