SECTION THREE – CODING INSTRUCTIONS

Required Data Items

It is important to code cases according the manuals and reference materials that are applicable to the year of diagnosis. Please refer to Appendix G: *Reference Materials for Hospitals* and Appendix H: *Effective Dates for Registry Standards*.

The following is a list of the required data items to be reported to the Maine Cancer Registry. The list is arranged according to the order that information is usually abstracted into registry software. The list includes the NAACCR item number, NAACCR item name, the diagnosis year(s) for which each data item is reportable to the MCR, and the page where the specific coding instructions can be found in this section. Section Three also includes data items that are not required by MCR, but may be related or are required by most registry software systems. **Bold items are newly required items for cases diagnosed in 2007.**

MCR Required Data Items for Hospitals, as of 1/1/07

PATIENT IDENTIFICATION/DEMOGRAPHIC INFORMATION			
NAACCR Item #	**NAACCR Item Name**	**Diagnosis Year Required**	**Page Number**
550	Accession Number – Hospital	2005+	30
2230	Name--Last	All	31
2240	Name--First	All	32
2250	Name--Middle	All	33
2390	Name--Maiden	All	34
2280	Name – Alias	2005 +	35
2320	Social Security Number	All	36
2300	Medical Record Number	2005 +	37
2350	Addr Current - No & Street	All	38
2355	Addr Current – Supplementl	2005 +	39
1810	Addr Current - City	All	40
1820	Addr Current - State	All	41
1830	Addr Current - Postal	All	43
1840	County – Current	2005 +	44
240	Birth Date	All	45
250	Birthplace	2001 +	46
220	Sex	All	47
160	Race 1	All	48
161	Race 2	2001 +	52
162	Race 3	2001 +	53
163	Race 4	2001 +	54
164	Race 5	2001 +	55
190	Spanish/Hispanic Origin	All	56

CANCER IDENTIFICATION			
NAACCR Item #	**NAACCR Item Name**	**Diagnosis Year Required**	**Page Number**
400	Primary Site	All	57
560	Sequence Number – Hospital	All	58
410	Laterality	All	59
522	Histologic Type ICD-O-3	2001 +	60
523	Behavior Code ICD-O-3	2001 +	65
420	Histology ICD-O-2	1992-2000	67
430	Behavior ICD-O-2	1992-2000	68
440	Grade	All	69
490	Diagnostic Conformation	All	72
500	Type of Reporting Source	2004 +	73
610	Class of Case	2004 +	74
580	Date of 1st Contact (previously Date of Adm)	All	75
390	Date of Diagnosis	All	76
1080	Date of 1st Positive BX	2005 +	77
630	Primary Payer at DX	2004 +	78
STAGING AND EXTENT OF DISEASE INFORMATION			
NAACCR Item #	**NAACCR Item Name**	**Diagnosis Year Required**	**Page Number**
2800	CS Tumor Size	2004 +	80
2810	CS Extension	2004 +	83
2820	CS Tumor Size/Ext Eval	2004 +	85
830	Regional Nodes Examined	2001 +	87
820	Regional Nodes Positive	2001 +	88
2830	CS Lymph Nodes	2004 +	89
2840	CS Reg Nodes Eval	2004 +	92
2850	CS Mets at DX	2004 +	94
2860	CS Mets Eval	2004 +	96
2880	CS Site-Specific Factor 1	2004 +	98
2890	CS Site-Specific Factor 2	2004 +	99
2900	CS Site-Specific Factor 3	2004 +	100
2910	CS Site-Specific Factor 4	2004 +	101
2920	CS Site-Specific Factor 5	2004 +	102
2930	CS Site-Specific Factor 6	2004 +	103
760	SEER Summary Stage 1977	Prior to 2001	105
759	SEER Summary Stage 2000	2001-2003	106
1060	TNM Edition Number	Prior to 2004	108
880	TNM Path T	Prior to 2004	109
890	TNM Path N	Prior to 2004	110
900	TNM Path M	Prior to 2004	111
910	TNM Path Stage Group	Prior to 2004	112

920	TNM Path Descriptor	Prior to 2004	113
940	TNM Clin T	Prior to 2004	114
950	TNM Clin N	Prior to 2004	115
960	TNM Clin M	Prior to 2004	116
970	TNM Clin Stage Group	Prior to 2004	117
980	TNM Clin Descriptor	Prior to 2004	118
1090	Site of Distant Met 1	2005 +	119
1100	Site of Distant Met 2	2005 +	119
1110	Site of Distant Met 3	2005 +	119
FIRST COURSE OF TREATMENT/THERAPY			
NAACCR Item #	**NAACCR Item Name**	**Diagnosis Year Required**	**Page Number**
1280	RX Date -- DX/Stg Proc (noncancer-directed surgery)	All	120
1350	RX Summ – DX/Stg Proc (if done)	2005 +	121
1270	Date of 1st Crs RX--COC (if done)	All	123
1200	RX Date -- Surgery (if done)	All	124
1290	RX Summ--Surg Prim Site (if done)	All	125
1292	RX Summ--Scope Reg LN Sur (if done)	2001 +	126
1294	RX Summ--Surg Oth Reg/Dis (if done)	2001 +	128
1646	RX Summ - Surg Site (if done)	Prior to 2003	129
1647	RX Summ - Scope Reg (if done)	Prior to 2003	130
1296	RX Summ--Reg LN Examined (if done)	Prior to 2003	131
1648	RX Summ - Surg Oth (if done)	Prior to 2003	132
1380	RX Summ - Surg/Rad Seq (if done)	All	133
1639	RX Summ – Systemic Surg Seq (if done)	2006+	133A
1340	Reason for no Surgery	All	134
1430	Reason for no Radiation	All	135
1220	RX Date--Chemo (if done)	All	136
1390	RX Summ - Chemo (if done)	All	137
1230	RX Date--Hormone (if done)	All	138
1400	RX Summ - Hormone (if done)	All	139
1240	RX Date--BRM (if done)	All	140
1410	RX Summ - BRM (if done)	All	141
None	Date Hematalogic Transplant/Endocrine Procedure	2005+	142
3250	RX Summ – Transplnt/Endocr	2005 +	143
1250	RX Date -- Other (if done)	All	144
1420	RX Summ - Other (if done)	All	145
1210	RX Date -- Radiation (if done)	All	146
1570	Rad - Regional RX Modality (if done)	All	151
DIAGNOSIS MISCELLANEOUS DATA/PATIENT STATUS			
NAACCR Item #	**NAACCR Item Name**	**Diagnosis Year Required**	**Page Number**
2460	Physician - Managing (previously Attending)	All	158
None	Physician - Referring	All	159
1750	Date of Last Contact	2001 +	161

1760	Vital Status	2001 +	162
1910	Cause of Death (if available)	2001 +	163
1920	ICD Revision Number	2005 +	164
1940	Place of Death	2005 +	165
2330	Addr at DX--No & Street	All	166
2335	Addr at DX - Supplementl	2005 +	167
70	Addr at DX--City	All	168
80	Addr at DX--State	All	169
100	Addr at DX--Postal Code	All	171
90	County at DX	All	172
DIAGNOSIS CASE ADMIISTRATION			
NAACCR Item #	**NAACCR Item Name**	**Diagnosis Year Required**	**Page Number**
540	Reporting Hospital	2005 +	173
545	**NPI – Reporting Facility**	**2007+**	**173A**
1460	RX Coding System--Current (if done)	All	174
2935	CS Version 1st	2004 +	175
2936	CS Version Latest	2004 +	176
1980	**ICD-O-2 Conversion Flag**	**2007+**	**176A**
2116	**ICD-O-3 Conversion Flag**	**2007+**	**176B**
TEXT FIELDS			
NAACCR Item #	**NAACCR Item Name**	**Diagnosis Year Required**	**Page Number**
2520	Text--Dx Proc--PE	All	179
2530	Text--DX Proc--X-ray/scan	All	180
2540	Text--DX Proc--Scopes	All	181
2550	Text--DX Proc--Lab Tests	All	182
2560	Text--DX Proc--Op	All	183
2570	Text--DX Proc--Path	All	184
2580	Text--Primary Site Title	All	185
2590	Text--Histology Title	All	186
2600	Text--Staging	All	187
2610	RX Text--Surgery	All	188
2620	RX Text – Radiation (Beam)	2005 +	189
2630	RX Text – Radiation Other	2005 +	190
2640	RX Text – Chemo	2005 +	191
2650	RX Text – Hormone	2005 +	192
2660	RX Text - BRM	2005 +	193
2670	RX Text - Other	2005 +	194
2680	RX Text – Remarks	2005+	195
310	Text--Usual Occupation (if available)	All	196
320	Text--Usual Industry (if available)	All	197
2690	Place of Diagnosis	2005+	198

ADDRESS – STATE CURRENT	Item Length: 2 NAACCR Item #1820 Source of Standard: CoC (Revised 01/07) Dx Yr Req by MCR: All

Description: *Identifies the patient's current state of residence.*

Instructions for Coding (See *FORDS Revised for 2007* p. 52)

- Record the U.S. Postal Service abbreviation for the state, territory, commonwealth, U.S. possession, or Canadian province/territory of the patient's current usual residence. See the following page for common abbreviations.

- Codes in addition to the U.S. and Canadian Postal Services abbreviations

  - CD Resident of Canada, NOS (province/territory unknown)
  - US Resident of United States, NOS (state/commonwealth/territory/possession unknown)
  - YY Resident of a country other than the United States (including its territories, commonwealths or possessions) or Canada and the country is unknown
  - ZZ Residence unknown

- If the patient has multiple tumors, the current state of residence should be the same for all tumors.

- Update this data item if the patient's state of residence changes.

- Do not change this item when the patient dies.

SEQUENCE NUMBER – HOSPITAL	Item Length: 2 NAACCR Item #560 Source of Standard: CoC (Revised 01/07) Dx Yr Req by MCR: All

Description: *Indicates the sequence of malignant and non-malignant neoplasms over the lifetime of the patient.*

Instructions for Coding (See *FORDS Revised for 2007* pp. 34-35)

- Codes 00-59 and 99 indicate neoplasms of in situ behavior, including VIN III, VAIN III and AIN III (Behavior equals 2), or malignant behavior (Behavior equals 3).
- Codes 60-88 indicate neoplasms of non-malignant behavior (Behavior equals 0 or 1).
- Code 00 only if the patient has a single malignant or in situ primary. If the patient develops a subsequent malignant or in situ primary tumor, change the code for the first tumor from 00 to 01, and number subsequent tumors sequentially.
- Code 60 only if the patient has a single non-malignant primary. If the patient develops a subsequent nonmalignant primary, change the code for the first tumor from 60 to 61, and assign codes to subsequent non-malignant primaries sequentially.
- If two or more malignant or in situ neoplasms are diagnosed at the same time, assign the lowest sequence number to the diagnosis with the worst prognosis. If no difference in prognosis is evident, the decision is arbitrary.
- If two or more non-malignant neoplasms are diagnosed at the same time, assign the lowest sequence number to the diagnosis with the worst prognosis. If no difference in prognosis is evident, the decision is arbitrary.
- Any tumor in the patient's past which is reportable or reportable-by-agreement must be taken into account when sequencing subsequently accessioned tumors.

Malignant or In Situ

Code	Definition
00	One malignant or in situ primary in the patient's lifetime
01	First of two or more independent malignant or in situ primaries
02	Second of two or more independent malignant or in situ primaries
…	(Actual sequence of this malignant or in situ primary)
59	Fifty-ninth or higher of fifty-nine or more malignant or in situ primaries
99	Unspecified malignant or in situ sequence number or unknown

Non-malignant

Code	Definition
60	Only one non-malignant primary
61	First of two or more independent non-malignant primaries
62	Second of two or more independent non-malignant primaries
…	(Consecutive number of non-malignant primaries)
87	Twenty-seventh of twenty-seven independent non-malignant primaries
88	Unspecified number of neoplasms in this category

Sites for Which Laterality Codes Must Be Recorded

ICD-O-3 Code	Site or Subsite
C079	Parotid gland
C080	Submandibular gland
C081	Sublingual gland
C090	Tonsillar fossa
C091	Tonsillar pillar
C098	Overlapping lesion of tonsil
C099	Tonsil, NOS
C300	Nasal cavity (excluding nasal cartilage, nasal septum)
C301	Middle ear
C310	Maxillary sinus
C312	Frontal sinus
C340	Main bronchus (excluding carina)
C341-C349	Lung
C384	Pleura
C400	Long bones of upper limb, scapula, and associated joints
C401	Short bones of upper limb and associated joints
C402	Long bones of lower limb and associated joints
C403	Short bones of lower limb and associated joints
C413	Rib, clavicle (excluding sternum)
C414	Pelvic bones (excluding sacrum, coccyx, symphysis pubis)
C441	Skin of the eyelid
C442	Skin of the external ear
C443	Skin of other and unspecific parts of the face (if midline, assign code 9)
C445	Skin of the trunk (if midline, assign code 9)
C446	Skin of upper limb and shoulder
C447	Skin of the lower limb and hip
C471	Peripheral nerves and autonomic nervous system of upper limb and shoulder
C472	Peripheral nerves and autonomic nervous system of the lower limb and hip
C491	Connective, subcutaneous, and other soft tissues of upper limb and shoulder
C492	Connective, subcutaneous, and other soft tissues of the lower limb and hip
C500-C509	Breast
C569	Ovary
C570	Fallopian tube
C620-C629	Testis
C630	Epididymis
C631	Spermatic cord
C649	Kidney, NOS
C659	Renal pelvis
C669	Ureter

ICD-O-3 Code	Site or Subsite
C690-C699	Eye and adnexa
C700	Cerebral meninges, NOS (Effective with cases diagnosed 1/1/2004)
C710	Cerebrum (Effective with cases diagnosed 1/1/2004)
C711	Frontal lobe (Effective with cases diagnosed 1/1/2004)
C712	Temporal lobe (Effective with cases diagnosed 1/1/2004)
C713	Parietal lobe (Effective with cases diagnosed 1/1/2004)
C714	Occipital lobe (Effective with cases diagnosed 1/1/2004)
C722	Olfactory nerve (Effective with cases diagnosed 1/1/2004)
C723	Optic nerve (Effective with cases diagnosed 1/1/2004)
C724	Acoustic nerve (Effective with cases diagnosed 1/1/2004)
C725	Cranial nerve, NOS (Effective with cases diagnosed 1/1/2004)
C740-C749	Adrenal gland
C754	Carotid body

Note: A laterality code of 1-4 or 9 **must** be assigned for the above sites except as noted. If the site is not listed on the table, assign code 0 for laterality.

HISTOLOGIC TYPE (ICD-O-3)	Item Length: 4 NAACCR Item #522 Source of Standard: SEER/CoC (Revised 01/07) Dx Yr Req by MCR: 2001+

Description: *Identifies the microscopic anatomy of cells. The data item Histologic Type describes the microscopic composition of cells and/or tissue for a specific primary. The International Classification of Diseases for Oncology, Third Edition (ICD-O-3) is the standard reference for coding the histology for tumors diagnosed in 2001 and later.*

General Instructions for Coding (See *FORDS Revised for 2007* p. 93)

- Record histology using the ICD-O-3 codes in the Numeric Lists/Morphology section (ICD-O-3, pp. 69–104) and in the Alphabetic Index (ICD-O-3, pp. 105–218).
- ICD-O-3 identifies the morphology codes with an "M" preceding the code number. Do not record the "M."
- Follow the coding rules outlined on pages 20 through 40 of ICD-O-3.
- Use the ***2007 Multiple Primary and Histology Coding Rules Manual*** when coding the histology for all reportable solid malignant tumors diagnosed on or after January 1, 2007. Do not use the 2007 MP/H rules for cases diagnosed before 2007.

  Note: Benign and borderline brain and CNS tumors along with hematopoietic malignancies are not covered in the 2007 MP/H rules. Use the existing multiple primary and coding rules for benign and borderline brain and CNS tumors and for hematopoietic malignancies.

- **Use the rules and definitions below (from *SEER Program Coding and Staging Manual 2004* pp. 84-88) for solid malignant tumors diagnosed prior to 2007.**
  - **Synonyms and Equivalent Terms:** Mixed, combined, and complex are usually used as synonyms when describing histology.
  - **Definitions**
    - **Cancer,** NOS (8000) and **carcinoma,** NOS (8010) are not interchangeable. If the physician says that the patient has carcinoma, then code carcinoma, NOS (8010).
    - **Carcinoma**, NOS (8010) and **adenocarcinoma**, NOS (8140) are interchangeable (see ICD-O-3)
    - **Complex (mixed, combined) histology:** The pathologist uses **multiple histologic terms** to describe a tumor. The histologic terms are frequently connected by the word "and" (for example ductal and lobular carcinoma).

* **Different histology**: The first three digits of the ICD-O-3 histology code are different.

* **Different subtypes:** The NOS cell types often have multiple subtypes; for example, scirrhous adenocarcinoma (8143), adenocarcinoma, intestinal type (8144), and linitis plastica (8141) are subtypes of Adenocarcinoma, NOS (8140).

* **Mixed/combined histology:** Different cell types in one tumor; terms used interchangeably. In most cases, the terms mixed and combined are used as synonyms; however the term mixed may designate a specific tumor.

* **Not Otherwise Specified (NOS):** "Not Otherwise Specified."

* **Same histology:** The first three digits of the ICD-O-3 histology code are identical.

Detailed Coding Instructions for Solid Malignant Tumors Diagnosed Prior to 2007

Refer to "Single vs. Multiple Primaries" in Section Two of this manual to determine the number of primaries. Use all of the information for a single primary to code the histology.

1. If there is no tumor specimen, code the histology described by the medical practitioner.

   Example 1: The patient has a CT scan of the brain with a final diagnosis of glioblastoma multiforme (9440). The patient refuses all further workup or treatment. Code the histology to glioblastoma multiforme (9440).

   Example 2**:** If a physician says that the patient has carcinoma, code carcinoma, NOS (8010).

2. Review all pathology reports. Use the histology stated in the **final diagnosis** from the pathology report. Use the pathology from the procedure that resected the majority of the primary tumor. If a more specific histologic type is definitively described in the microscopic portion of the pathology report or the comment, code the more specific diagnosis.

   Example**:** If the final diagnosis is "Not Otherwise Specified" (carcinoma, NOS; melanoma, NOS; sarcoma, NOS; lymphoma, NOS; or malignant tumor, NOS), then code the histology from the microscopic description or comment if it identifies a more specific histologic type (higher ICD-O-3 code) such as adenocarcinoma, amelanotic melanoma, spindle cell sarcoma.

3. The WHO Classification, REAL system, Rappaport, or Working Formulation may classify lymphomas. The WHO Classification is preferred. See page 13 in the ICD-O-3 for a discussion of hematologic malignancies.

4. Cases reported to the central registry cannot have a metastatic (/6) behavior code. If the only pathology specimen is from a metastatic site, code the appropriate histology code and the malignant behavior code /3. The primary site and its metastatic site(s) have the same basic histology.

Histology Coding Rules for Single Tumor (diagnosed prior to 2007)

The rules are in hierarchical order. Rule 1 has the highest priority.
Use the rules in priority order.

Use the first rule that applies to the case. (Do not apply any additional rules.)

1. Code the histology if only one type is mentioned in the pathology report.

2. Code the **invasive histology** when both invasive and in situ tumor are present.

Example: Pathology report reads infiltrating ductal carcinoma and cribriform ductal carcinoma in situ. Code the invasive histology 8500/3.

Exception: If the histology of the invasive component is an 'NOS' term (e.g., carcinoma, adenocarcinoma, melanoma, sarcoma), then code the histology of the specific term associated with the in situ component and an invasive behavior code.

3. Use a **mixed** histology code if one exists.

Examples of mixed codes: (This is not a complete list, these are examples only)

8490	Mixed tumor, NOS
9085	Mixed germ cell tumor
8855	Mixed liposarcoma
8990	Mixed mesenchymal sarcoma
8951	Mixed mesodermal tumor
8950	Mixed Mullerian tumor
9362	Mixed pineal tumor
8940	Mixed salivary gland tumor, NOS
9081	Teratocarcinoma, mixed embryonal carcinoma and teratoma

4. Use a **combination** histology code if one exists.

Examples of combination codes: (This is not a complete list; these are examples only)

8255	Renal cell carcinoma, mixed clear cell and chromophobe types
8523	Infiltrating duct carcinoma mixed with other types of carcinoma
8524	Infiltrating lobular carcinoma mixed with other types of carcinoma
8560	Adenosquamous carcinoma
8045	Combined small cell carcinoma, combined small cell-large cell

5. Code the **more specific term** when one of the terms is 'NOS' and the other is a more specific description of the same histology.

Example 1: Pathology report reads poorly differentiated carcinoma, probably squamous in origin. Code the histology as squamous cell carcinoma rather than the non-specific term "carcinoma."

Example 2: The pathology report from a nephrectomy reads renal cell carcinoma (8312) (renal cell identifies the affected organ system rather than the histologic cell type) in one portion of the report and clear cell carcinoma (8310) (a histologic cell type) in another section of the report. Code clear cell carcinoma (8310); renal cell carcinoma (8312) refers to the renal system rather than the cell type, so renal cell is the less specific code.

6. Code the **majority** of tumor.

   a. Based on the pathology report description of the tumor.

   b. Based on the use of majority terms. See majority terms on the following page.

Terms that mean the majority of tumor	**Terms that do not mean the majority of tumor**
Predominantly	With foci of
With features of	Focus of/focal
Major	Areas of
Type[1]	Elements of
With …. Differentiation[1]	Component
Pattern (Only if written in College of American Pathologists [CAP] Protocol)	
Architecture (Only if written in College of American Pathologists [CAP] Protocol)	

7. Code the **numerically higher** ICD-O-3 code. This is the rule with the lowest priority and should be used infrequently.

Histology Coding Rules for Multiple Tumors with Different Behaviors in the Same Organ Reported as a Single Primary (diagnosed prior to 2007)

1. Code the histology of the invasive tumor when one lesion is in situ (/2) and the other is invasive (/3).

Example: At mastectomy for removal of a 2 cm invasive ductal carcinoma, an additional 5 cm area of intraductal carcinoma was noted. Code histology and behavior as invasive ductal carcinoma (8500/3).

Histology Coding Rules for Multiple Tumors in Same Organ Reported as a Single Primary (diagnosed prior to 2007)

1. Code the histology when multiple tumors have the same histology.

2. Code the histology to adenocarcinoma (8140/_; in situ or invasive) when there is an adenocarcinoma and an adenocarcinoma in a polyp (8210/_, 8261/_, 8263/) in the same segment of the colon or rectum.

3. Code the histology to carcinoma (8010/_; in situ or invasive) when there is a carcinoma and a carcinoma in a polyp (8210/_) in the same segment of the colon or rectum.

4. Use a **combination** code for the following:

   a. Bladder: Papillary and urothelial (transitional cell) carcinoma (8130)

   b. Breast: Paget Disease and duct carcinoma (8541)

   c. Breast: Duct carcinoma and lobular carcinoma (8522)

   d. Thyroid: Follicular and papillary carcinoma (8340)

5. Code the more specific term when one of the terms is 'NOS' and the other is a more specific description of the same histology.

6. Code all other multiple tumors with different histologies as multiple primaries.

- **How to determine same vs. different histologies for benign and borderline primary intracranial and CNS tumors (C70.0-C72.9, C75.1-C75.3) (Based on histologic groupings for all diagnosis years)**

When there are **multiple tumors**, use the following table to determine if the tumors are the same histology or different histologies.

Histologic groupings to determine same histology for non-malignant brain tumors

Histologic Group	**ICD-O-3 Code**
Choroid plexus neoplasm	9390/0, 9390/1
Ependymoma	9383, 9394, 9444
Neuronal and neuronal-glial neoplasm	9384, 9412, 9413, 9442, 9505, 9506
Neurofibroma	9540/0, 9540/1, 9541, 9550, 9560
Neurinomatosis	9560
Neurothekeoma	9562
Neuroma	9570
Perineurioma, NOS	9571

Instructions for Using Histologic Group Table

1. Both histologies are listed in the table:

   a. Histologies that are in the same grouping or row in the table are the same histology.

      Note: Histologies that are in the same grouping are a progression, differentiation or subtype of a single histologic category.

   b. Histologies listed in different groupings in the table are different histologies.

2. One or both of the histologies is not listed in the table:

   a. If the ICD-O-3 codes for both histologies have the identical first three digits, the histologies are the same.

   b. If the first three digits of the ICD-O-3 histology code are different, the histology types are different.

- **Coding Lymphatic and Hematopoietic Malignancies (for all diagnosis years)**

  - Leukemia/Lymphoma (Chronic Lymphocytic Leukemia [CLL] and Small Lymphocytic Lymphoma [SLL])

    Code the diagnosis of chronic lymphocytic leukemia (9823/3) and/or small lymphocytic lymphoma (9670/3) to SLL if there are positive lymph nodes or deposits of lymphoma/leukemia in organs or in other tissue. Code the histology to CLL if there are no physical manifestations of the disease other than a positive blood study or positive bone marrow.

  - Use the SEER table "**Definitions of Single Versus Subsequent Primaries of Lymphatic and Hematopoietic Diseases**" to determine same versus subsequent primary for lymphatic and hematopoietic malignancies (see **Appendix I** in this manual).

TYPE OF REPORTING SOURCE	Item Length: 1 NAACCR Item #500 Source of Standard: SEER (Revised 01/07) Dx Yr Req by MCR: 2004+

Description: *Code identifying source documents used to abstract the tumor being reported. This may not be the source of the original case finding; rather, it is the source that provided the best information. (For example, if a case is identified through a pathology laboratory report review and all source documents used to abstract the case are from the physician's office, code this item 4).*

Instructions for Coding (See *SEER Program Coding and Staging Manual 2004* pp. 31-32a)

- Coding is hierarchical. When multiple source documents are used to abstract a case, use the following priority order to assign a code for Type of Reporting Source: Priority order of codes 1, 2, 8, 4, 3, 5, 6, 7.

Definitions

Managed health plan: HMO or other health plan (e.g. Kaiser, Veterans Administration, military facilities) in which all diagnostic and treatment information is maintained centrally (in a unit record) and is available to the abstractor.

Physician office: Examinations, tests and limited surgical procedures may be performed in a physician office. If called a surgery center, but cannot perform surgical procedures under general anesthesia, code as a physician office.

Serial record: The office or facility stores information separately for each patient encounter.

Surgery center: Surgery centers are equipped and staffed to perform surgical procedures under general anesthesia. Patient does not stay overnight.

Unit record: The office or facility stores information for all of a patient's encounters in one record with one record number.

Note: Beginning with cases diagnosed 01/01/2006, the definitions for this field have been expanded. Codes 2 and 8 were added to identify outpatient sources that were previously grouped under code 1. Laboratory reports now have priority over nursing home reports. The source facilities included in the previous code 1 (hospital inpatient and outpatient) are split between codes 1, 2, and 8.

Code Definitions

Code	Label	Source Documents	Priority

1	Hospital inpatient; Managed health plans with comprehensive, unified medical records **(new code definition effective with diagnosis on or after 1/1/2006)**	• Hospital inpatient
		• Offices/facilities with unit record
		  • HMO physician office or group
		  • HMO affiliated free-standing laboratory, surgery, radiation or oncology clinic
		
		Includes outpatient services of HMOs and large multi-specialty physician group practices with unit record.
			1

2	Radiation Treatment Centers or Medical Oncology Centers (hospital-affiliated or independent) **(effective with diagnosis on or after 1/1/2006)**	• Facilities with serial record (not a unit record)
		  • Radiation treatment centers
		  • Medical oncology centers (hospital affiliated or independent)
		
		There were no source documents from code 1.
			2

3	Laboratory Only (hospital affiliated or independent)	• Laboratory with serial record (not a unit record) There were no source documents from codes 1, 2, 8, or 4.	5
4	Physician's Office/Private Medical Practitioner (LMD)	• Physician's office that is NOT an HMO orlarge multi-specialty physician group practice. There were no source documents from codes 1, 2 or 8. 5	4
5	Nursing/Convalescent Home/Hospice	• Nursing or convalescent home or a hospice. There were no source documents from codes 1, 2, 8, 4, or 3. 6	6
6	Autopsy Only	• Autopsy The cancer was first diagnosed on autopsy. There are no source documents from codes 1, 2, 8, 4, 3, or 5.2, 8, 4, 3, or 5.	7
7	Death Certificate Only	• Death certificate Death certificate is the only source of information; follow-back activities did not identify source documents from codes 1, 2, 8, 4, 3, 5 or 6. If another source document is subsequently identified, the Type of Reporting Source code must be changed to the appropriate code in the range of 1, 2, 8, 4, 3 or 6.	8
8	Other hospital outpatient units/surgery centers **(effective with diagnosis on or after 1/1/2006)**	• Other hospital outpatient units/surgery centers. Includes, but not limited to, outpatient surgery and nuclear medicine services. There are no source documents from codes 1 or 2.	3

REGIONAL LYMPH NODES EXAMINED	Item Length: 2 NAACCR Item #830 Source of Standard: SEER/CoC (Revised 01/07) Dx Yr Req by MCR: 2001+

Description: *Records the total number of regional lymph nodes that were removed and examined by the pathologist. Beginning with cases diagnosed on or after January 1, 2004, this item is a component of the Collaborative Staging System (CS).*

Instructions for Coding (See *CS Manual* p. I-46 and *FORDS Revised for 2007* pp. 102-102A)

- Only record information about regional lymph nodes in this data item. Involved distant lymph nodes should be coded in *CS Mets at Dx* (NAACCR Item #2850).
- This data item is based on pathology information only. If no lymph nodes were removed for examination, or if a lymph node drainage area was removed, but no lymph nodes were found, code 00.
- Record the total number of regional lymph nodes removed 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.
  - Code 98 if lymph nodes are aspirated and other lymph nodes are removed.
  - This data item is to be recorded regardless of whether the patient received preoperative treatment.
- If a lymph node biopsy was performed, code the number of nodes removed, if known. If the number of nodes removed by biopsy is not known, code 96.
- Code 99 for the following primary sites and histologies:

  Placenta
  Brain and Cerebral Meninges
  Other Parts of Central Nervous System
  Hodgkin and non-Hodgkin Lymphoma **except** 9700/3 and 9701/3
  Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms
  Unknown and Ill-Defined Primary Sites

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

REGIONAL LYMPH NODES POSITIVE	Item Length: 2 NAACCR Item #820 Source of Standard: SEER/CoC (Revised 01/07) Dx Yr Req by MCR: 2001+

Description: *Records the exact number of regional lymph nodes examined by the pathologist and found to contain metastases. Beginning with cases diagnosed on or after January 1, 2004, this item is a component of the Collaborative Staging System (CS).*

Instructions for Coding (See *CS Manual* p. I-45 and *FORDS Revised for 2007* p. 103)

- Only record information about regional lymph nodes in this item. Involved distant lymph nodes should be coded in *CS Mets at Dx* (NAACCR Item #2850).
- This item is based on pathology information only. If no lymph nodes were removed for examination, or if a lymph node drainage area was removed, but no lymph nodes were found, code 98.
- Record the total number of regional lymph nodes removed and found to be positive by pathologic examination.
    - 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.
    - This item is recorded regardless of whether the patient received preoperative treatment.
- Any combination of positive aspirated, biopsied, sampled or dissected lymph nodes is coded 97 if the number of involved nodes cannot be determined on the basis of cytology or histology.
- Code 99 for the following primary sites and histologies:

  Placenta
  Brain and Cerebral Meninges
  Other Parts of Central Nervous System
  Hodgkin and non-Hodgkin Lymphoma **except** 9700/3 and 9701/3)
  Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms
  Unknown and Ill-Defined Primary Sites

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

ADDRESS – STATE AT DIAGNOSIS	Item Length: 2 NAACCR Item #80 Source of Standard: CoC (Revised 01/07) Dx Yr Req by MCR: All

Description: *Identifies the patient's state of residence at the time of diagnosis.*

Instructions for Coding (See *FORDS Revised for 2007* p. 45)

- Record the U.S. Postal Service abbreviation for the state, territory, commonwealth, U.S. possession, or Canadian province/territory in which the patient resides at the time the tumor is diagnosed and treated. See following page for common abbreviations.

- Codes in addition to the U.S. and Canadian Postal Services abbreviations

  - CD Resident of Canada, NOS (province/territory unknown)
  - US Resident of United States, NOS (state/commonwealth/territory/possession unknown)
  - YY Resident of a country other than the United States (including its territories, commonwealths or possessions) or Canada and the country is unknown
  - ZZ Residence unknown

- If the patient has multiple tumors, the state of residence may be different for subsequent primaries

- Do not update this data item if the patient's state of residence changes.

NPI – REPORTING FACILITY	Item Length: 10 NAACCR Item #545 Source of Standard: NAACCR Dx Yr Req by MCR: 2007+ (as available)

Description: *The NPI (National Provider Identifier) identifies the facility submitting the data in the record.*

NPI, a unique identification number for health care providers, is scheduled for 2007-2008 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Instructions for Coding (See *FORDS Revised for 2007 p 208A)*

- *NPI-Reporting Facility* is automatically coded by the software provider.
- The first digit of the NPI for a facility is 2.
- NPI should be recorded as available for cases diagnosed during 2007, and is required to be recorded for all cases diagnosed January 1, 2008, and later.
- NPI may be blank for cases diagnosed on or before December 31, 2006.

Code	Definitions
(fill spaces)	10-digit NPI number for the facility (first digit=2)
(leave blank)	NPI for facility is unknown or not available.

ICD-O-2 CONVERSION FLAG

Item Length: 1
NAACCR Item #1980
Source of Standard: SEER/CoC
Dx Yr Req by MCR: 2007+

Description: *Code specifying whether or how site and morphology codes were converted to ICD-O-2.*

Instructions for Coding: (See *FORDS Revised for 2007 p232*)

- Codes 0, 1 and 2 are autocoded for existing records by the software provider.

- Code 3 and 4 are manually entered following review of the automated morphology conversion from ICD-0-3 to ICD-O-2.

The ICD-O-2 conversion flag is not applicable for cases diagnosed on or after January 1, 2001. Do not code this field for cases diagnosed on or after January 1, 2001.

Use Code 0 when abstracting cases diagnosed prior to 2001. Histology must be coded in both ICD-O-2 and ICD-O-3 for cases diagnosed prior to 2001.

Code	Description
0	Primary site and morphology originally coded in ICD-O-2.
1	Primary site and morphology converted without review.
2	Primary site and morphology converted with review; morphology machine-converted without review.
3	Primary site machine-converted without review; morphology converted with review.
4	Primary site and morphology converted with review.
5	Morphology converted from ICD-O-3 without review.
6	Morphology converted from ICD-O-3 with review.

ICD-O-3 CONVERSION FLAG

Item Length: 1
NAACCR Item #2116
Source of Standard: SEER/CoC
Dx Yr Req by MCR: 2007+

Description: *Code specifying how the conversion of site and morphology codes from ICD-O-2 to ICD-O-3 was accomplished.*

Instructions for Coding: (See *FORDS Revised for 2007 p. 233*)

- Codes 0 and 1 are autocoded by the software provider.

- Code 3 is manually entered following review of the automated morphology conversion from ICD-0-2 to ICD-O-3.

This flag defaults to Code 0 when abstracting cases diagnosed on or after January 1, 2001.

Use Code 3 when abstracting cases diagnosed prior to 2001. Histology must be coded in both ICD-O-2 and ICD-O-3 for cases diagnosed prior to 2001.

Code	Description
0	Morphology (Morph – Type & Behavior ICD-O-3) originally coded in ICD-O-3
1	Morphology (Morph – Type & Behavior ICD-O-3) converted from (Morph – Type & Behavior ICD-O-2) without review.
3	Morphology (Morph – Type & Behavior ICD-O-3) converted from (Morph – Type & Behavior ICD-O-2) with review.