Cancer Reporting in California
System Standards

VOLUME III

Data Standards for Regional Registries and California Cancer Registry

NAACCR Record Layout Version 18.0
Eureka Version 16.2 and Coding Procedure 34

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Revision 9.4

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DATA FIELDS

Abstracted By

IDENTIFIERS

CCR ID	NAACCR ID
E1086	570

DESCRIPTION

Abstractor's initials which identify the person who completed the abstract on this admission.

LEVELS

Admissions

LENGTH

3

ALLOWABLE VALUES

Alpha-numeric, left justified and uppercase
XXX = Unknown

SOURCE

If blank, enter XXX. Upshift (but do not record upshift in Audit Log).

UPDATE

Manual

CONSOLIDATED DATA EXTRACT

No

HISTORICAL CHANGES

2010	2010 Data Changes: CCR name (Abstractor) changed to NAACCR name.

Accession Number--Hosp

IDENTIFIERS

CCR ID	NAACCR ID
E1084	550

OWNER

CoC

DESCRIPTION

Provides a unique identifier for the patient consisting of the year in which the patient was first seen at the reporting facility and the consecutive order in which the patient was abstracted.

LEVELS

Admissions

LENGTH

9

ALLOWABLE VALUES

Numeric

SOURCE

Upload with no conversion.

UPDATE

Manual or Automatic Correction (See Appendix 26)

CONSOLIDATED DATA EXTRACT

Yes, with each facility record (or earliest admission while sending one admission per tumor).

HISTORICAL CHANGES

01/1999	This field was lengthened from 6 to 9 digits. The values were converted to include the century as the first two digits (19), then the existing two-digit year from the beginning of the original number, then a 0, and finally the last four digits of the original number.
2010	Data Item Changes: CCR name (Accession_No) changed to NAACCR name.
05/2016	Per NAACCR v16, updated description to match NAACCR, including replacement of the term “hospital” with “facility” to accommodate EHR reporting.

ACOS Approved

IDENTIFIERS

CCR ID	NAACCR ID
E1608	None: State Requestor

OWNER

CCR

DESCRIPTION

This data item has been replaced by CoC Accredited Flag [NAACCR #2152]. This page has been retained for historical purposes only and this data item should not be populated in any cases under the NAACCR v18 or later coding standards.

Flag which indicates whether or not the reporting facility has an ACoS-approved cancer program.

LEVELS

Admissions

LENGTH

1

ALLOWABLE VALUES

1	Cancer Program Approved
2	Cancer Program Not Approved
Blank	Cases diagnosed or transmitted prior to 1999

SOURCE

1. If Date of Diagnosis is 2018 and later, then blank out the field.
2. If Coding Proc is less than 34, then execute the same conversion from use case Perform Eureka 2018 One-Time Data Conversions and Table Populations – UC, step ~~16~~ 23.

UPDATE

Manual

CONSOLIDATED DATA EXTRACT

Yes, from admission with the earliest date of first admission.

HISTORICAL CHANGES

01/01/99	New field added to the data set; initial value set to blank.
01/2019	Per NAACCR v18, this data item has been replaced by CoC Accredited Flag [NAACCR #2152]. Revisions to Source Logic to run One-Time Data Conversions as necessary.
03/2020	Revised Source Logic – Step 2 for Coding Proc 34, changed UC step from 16 to 23

Addr at DX--City

IDENTIFIERS

CCR ID	NAACCR ID
E1009	70

DESCRIPTION

City name of patient's residence at diagnosis.

LEVELS

Tumors, Admissions

LENGTH

50

ALLOWABLE VALUES

Any alpha, possibly with embedded and trailing blanks.
Entire field not equal to blanks.
Enter UNKNOWN, if city of residence is unknown.

SOURCE

Left justify and upshift (but do not record change in Audit Log).

UPDATE

Tumor Level
    New Case Consolidation
        If Admission level Addr at DX--City < > UNKNOWN
        If Tumor level Addr at DX--City = UNKNOWN,
            Update
        else, if not=
            List for review
    Manual Change
Admission Level
    Manual Change only

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

10/10/07	Changed length to 28 per a software vendor's request to allow full spelling of city names with greater than 20 characters from getting truncated. Handling this item like Medical Record No until NAACCR increases the length of this field. A different item name (Addr_DX_City USPS) will be in the transmit format in Volume II (and keep the standard one in its spot) and it will be truncated in the standard NAACCR spot when we have to submit cases to SEER, NPCR, other states. Eureka Screens: Display the 28-character Addr_DX_City only.
2010	2010 Data Changes: CCR name (Addr_DX_City) changed to NAACCR name. Length changed from 28 to 50. Updated SOURCE logic by replacing a software vendor's item numbers with data item names.

Addr at DX--Country

IDENTIFIERS

CCR ID	NAACCR ID
E1768	102

OWNER

NAACCR

DESCRIPTION

Country code for the address of the patient's residence at the time the reportable tumor is diagnosed. If the patient has multiple tumors, the country of residence may be different for each tumor. This data item became part of the NAACCR transmission record effective with Volume II, Version 13 in order to include country and state for each geographic item and to use interoperable codes. It supplements the item Addr at Dx--State [NAACCR #80].

LEVELS

Tumors, Admissions

LENGTH

3

ALLOWABLE VALUES

See Volume I, Appendix C.1

SOURCE

1. Left-justify and upshift (but don't record these changes in the audit log).
2. If Coding Procedure is 30 or 31, then

If Addr at DX--Country =	Then convert Addr at DX--Country to
XCZ	CSK
XYG	YUG
BND	BRN
SWK	SVK
VLT	VUT

3. If coding procedure is less than 30 or Addr at DX--Country is blank

    If County at DX = 060 - 750 or 998 - 999 and the code exists in Appendix 32 Country/Country/State Crosswalk, then

        Generate the value for Address at DX--Country using County at DX and Appendix 32 Country/Country/State Crosswalk

    Else

        If Addr_DX_State is a valid state code in Appendix 31 State/Country Crosswalk, then

            Generate the value for Address at DX--Country using Addr at DX--State and Appendix 31 State/Country Crosswalk

    Else

            Generate ZZU (unknown)

UPDATE

Tumor Level

New Case Consolidation

If both of the following conditions are true:

- The admission's Addr at DX--Country is neither ZZU nor ZZX
- The tumor's Addr at DX--Country is ZZU or ZZX

Then update the tumor's Addr at DX--Country with the admission's Addr at DX--Country code.

Otherwise,

If the admission's Addr at DX--Country is not the same as the tumor's Addr at DX--Country

Then list for review

Manual Change

Admission Level

Manual Change or Correction

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

05/2013	New data item for 2013. Added IF 996, 997 Added ER 1114
03/2015	Per NAACCR v15, the historic codes XYG, XCZ, BND, SWK, and VLT converted to active ISO codes; updated SOURCE logic to include the conversions upon upload.

Addr at DX--No & Street

IDENTIFIERS

CCR ID	NAACCR ID
E1648	2330

DESCRIPTION

House number and street name of patient's residence at diagnosis.

LEVELS

Tumors, Admissions

LENGTH

60

ALLOWABLE VALUES

Item may not be blank. Must be alphanumeric, left-justified, and blank-filled.
Mixed case is allowed. Embedded spaces are allowed. Special characters are limited to periods, slashes, hyphens, and pound signs.

CCR Specific notes:

A space should be between house number and street name.
UNKNOWN if address is not known.

SOURCE

Left-justify and upshift (but do not record change in Audit Log).

UPDATE

TUMOR LEVEL

NEW CASE CONSOLIDATION

If AD_ Addr at DX--No & Street does not = UNKNOWN AND TU_ Addr at DX--No & Street = UNKNOWN
Then Update
Else List for review

Manual Change

ADMISSION LEVEL

Manual Change Only

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/26/03	Length of field changed from 25 to 40 characters.
11/2008	Changed Allowable values to require an alpha character. This change will prevent an address being entered that is only numerical.
2010	2010 Data Changes: CCR name (Addr_DX_Street) changed to NAACCR name. Length changed from 40 to 60. Changed Allowable values edit to NAACCR edit standard so no longer allow commas.

Addr at DX--Postal Code

IDENTIFIERS

CCR ID	NAACCR ID
E1011	100

DESCRIPTION

ZIP code of patient's residence at diagnosis. May be entered for any country.

LEVELS

Tumors, Admissions

LENGTH

9

ALLOWABLE VALUES

Nine-digit US ZIP code; 9's if US or Canadian resident, unknown zip; if first 5 <> 9's and last 4 unknown, then last 4 blank; 8's if unknown outside USA and Canada.
If the code is known, regardless of the country that it is in, the postal code should be entered here. Alpha characters allowed.

888888888	Resident of country other than the US (including its possessions, etc.) or Canada and postal code unknown.
999999999	Resident of the US (including its possessions, etc.) or Canada and postal code unknown.

SOURCE

If both of the following conditions are true:

- the first 5 characters are NOT 99999
- the last 4 characters are 9999

then reset the last 4 characters to blank.
If both of the following conditions are true:

- the first 5 characters are 99999
- the last 4 characters are NOT 9999

then reset the last 4 characters to 9999.

UPDATE

Tumor Level

New Case Consolidation
If Admission level Addr at DX--Postal Code = 9s do nothing,
Else
If Tumor level Addr at DX--Postal Code = 9s (and Admission level Addr at DX--Postal Code does not =9s)
move Admission level Addr at DX--Postal Code to Tumor level Addr at DX--Postal Code
Else,
If Admission level Addr at DX--Postal Code (first 5) = Tumor level Addr at DX--Postal Code (first 5)
If (Tumor level Addr at DX--Postal Code (last 4) = blank or 9's and Admission level Addr at DX--Postal Code (last 4) does not = blank or 9's),
move Admission level Addr at DX--Postal Code to Tumor level Addr at DX--Postal Code
Else,

If Tumor level Addr at DX--Postal Code (last 4) does not = blank or 9s and Admission level Addr at DX--Postal Code (last 4) = blank or 9s

do nothing

Else,

If either are within the range 900000000 to 966999999

list for review.

Manual Change

If first five characters of Addr at DX--Postal Code = 99999,

then automatically set last 4 characters to 9999.

Admission Level

Manual Change

If first five characters of Addr at DX--Postal Code = 99999,

then automatically set last 4 characters to 9999.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

1/19/05	Added alpha characters to Allowable Values for foreign postal codes. Clarified definitions for 9's and 8's.
12/30/08	Removed C/N number from Source. C/N numbers are located in Volume II, Appendix "A".
2010	2010 Data Changes: CCR name (Addr_DX_Zip) changed to NAACCR name.

Addr at DX--State

IDENTIFIERS

CCR ID	NAACCR ID
E1010	80

OWNER

CoC

DESCRIPTION

State or Canadian province of patient's residence at diagnosis.

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

AK-WY	US States/Territories
AA-AP	United States Military Personnel Serving Abroad
AB-YT	Canadian Provinces/Territories
CD	Canada, NOS
US	Resident of United States, NOS
XX	Not U.S., U.S. Territory, not Canada, and country is known
YY	Not U.S., U.S. Territory, North American Islands, not Canada, and country is unknown
ZZ	Residence is unknown

See Volume I, Appendix B for all Postal Abbreviations for states/territories.

SOURCE

1. Left-justify and upshift (but don't record these changes in the audit log).
2. If Coding_Proc is less than 23, then:
   - If Addr at DX--State is XX Then convert Addr at DX--State to ZZ.
   - If all of the following conditions are true:
     - Addr at DX--State is YY
     - County at DX is NOT 999
     Then convert Addr at DX--State to XX.
3. If Coding_Proc is less than 24, then:
   - If all of the following conditions are true:
     - County at DX is 220 (Canada NOS)
     - Addr at DX--State is ZZ
     Then convert Addr at DX--State to CD.
   - If all of the following conditions are true:
     - County at DX is 000
     - Addr at DX--State is ZZ
     Then convert Addr at DX--State to US.

UPDATE

See Addr Current--City

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

11/14/02	Changed US territories range in Interfield edit to 139 (Palau=139) Now matches the NAACCR edit. Changed range in AB-YT range to 227 (Canadian province Nunavut=227).
03/26/03	Conversion table added to Source and Census_Tract_80 removed from Interfield edit 3).
03/03/04	Removed conversion instructions from SOURCE for Version 9 records. See Use Case 22.
01/19/05	Changed Allowable Values to match NAACCR/CoC codes. Database will be converted and needs to be converted before edit update. Conversion spec added to Source. Update logic changed to update ZZ (was XX). Edits #307 updated with new values and other edit checks deleted. New edit error #728 given to Addr_DX_State & County_DX edit. OLD values: XX Unknown or USA or Canada, where state or province unknown, or U.S. Territory, NOS YY Not USA and not Canada
04/27/05	Added 999 to IF 728 for ZZ.
07/07/06	Changed Addr DX State requirement (for YY & XX, IF #307) of 8's only for Addr DX Zip to match the Volume One standard (updated to only restrict 9's).
08/15/06	Added CD and US to Allowable Values and changed definition for ZZ. Conversion will need to be done on database (If County_DX= 220 (Canada NOS) and Addr_DX_State=ZZ, then convert Addr_DX_State to CD. If County_DX=000 and Addr_DX_State=ZZ, then convert Addr_DX_State to US.
2010	Data Item Changes: CCR name (Addr DX State) changed to NAACCR name. Revised Update logic based on new date criteria.
05/2013	Added IF 1049, 1050
07/2014	Clarified allowable values and included reference to Volume I, Appendix B.

Addr at DX--Supplementl

IDENTIFIERS

CCR ID	NAACCR ID
E649	2335

DESCRIPTION

This data item allows the storage of additional address information such as the name of a place or facility (i.e., a nursing home, or name of an apartment complex).

LEVELS

Tumors, Admissions

LENGTH

60

ALLOWABLE VALUES

Item may be blank. Must be alphanumeric, left-justified, and blank-filled.
Mixed case is allowed. Embedded spaces are allowed. Special characters are limited to periods, slashes, hyphens, and pound signs.

SOURCE

Left-justify and upshift (but do not record change in Audit Log).

UPDATE

Tumor Level

New Case Consolidation

If AD_Addr at DX -- Supplementl not = BLANK
If TU_Addr at DX -- Supplementl = BLANK,
Update,
else,
If not equal,
List for review.
Manual Change

Admission Level

Manual Change Only

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/26/03	New data item in the 2003 data item set.
2010	2010 Data Changes: CCR name (Addr_DX_Street_Suppl) changed to NAACCR name. Length changed from 40 to 60. Changed Allowable values edit to NAACCR edit standard so no longer allow commas.

Addr Current--City

IDENTIFIERS

CCR ID	NAACCR ID
E1523	1810

DESCRIPTION

City name of patient's current address or address where patient can be contacted.

LEVELS

Patients, Admissions

LENGTH

50

ALLOWABLE VALUES

Any alpha, possibly with embedded and trailing blanks.
Entire field blanks
UNKNOWN if city of residence is not known.

SOURCE

If Address Current No & Street, Addr Current--City, or Addr Current-State are blank, then convert Addr at DX-- City value into Addr Current--City.
Otherwise, left-justify (but don't record in Audit Log) and load the transmitted value.

UPDATE

Patient Active Follow-up Fields Update Logic

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

2010	2010 Data Changes: CCR name (Contact_City) changed to match NAACCR name. Length changed from 20 to 50. Revised Update logic based on new date criteria.
05/2013	Added Addr Current--Country to the Update logic.

Addr Current--Country

IDENTIFIERS

CCR ID	NAACCR ID
E1769	1832

OWNER

NAACCR

DESCRIPTION

Country code for the address of patient's current usual residence. If the patient has multiple tumors, the current country of residence should be the same for all tumors. This data item became part of the NAACCR transmission record effective with Volume II, Version 13 in order to include country and state for each geographic item and to use interoperable codes. It supplements the item Addr Current--State [NAACCR #1820].

LEVELS

Patients, Admissions

LENGTH

3

ALLOWABLE VALUES

See Volume I, Appendix C.1

SOURCE

1. Left-justify and upshift (but don't record these changes in the audit log).
2. If Coding Procedure is 30 or 31, then

If Addr Current--Country =	Then convert Addr Current--Country to
XCZ	CSK
XYG	YUG
BND	BRN
SWK	SVK
VLT	VUT

3. If coding procedure is less than 30, then
   If Addr Current-State can be found in Appendix 31 State/Country Crosswalk, then

Generate Address Current--Country using Current--State's associated CountryISO code from the Appendix

Else

Generate ZZU (unknown)

UPDATE

Patient Active Follow-up Fields Update Logic

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

05/2013	New data item for 2013. • Added IF 998, 1000 • Added ER 1115

03/2015	Per NAACCR v15, the historic codes XYG, XCZ, BND, SWK, and VLT converted to active ISO codes; updated SOURCE logic to include the conversions upon upload.

Addr Current--No & Street

IDENTIFIERS

CCR ID	NAACCR ID
E1648	2330

DESCRIPTION

House number and street name of patient's current address, or address where patient can be contacted.

LEVELS

Patients, Admissions

LENGTH

60

ALLOWABLE VALUES

- Item may not be blank.
- Must be alphanumeric, left-justified, and blank-filled.
- Mixed case is allowed.
- Embedded spaces are allowed.
- Special characters are limited to periods, slashes, hyphens, and pound signs.

CCR Specific notes:

If Address Current-- No & Street, Addr Current--City, or Addr Current--State are blank, then convert Addr at DX--No & Street value into Address Current No & Street. Otherwise, left-justify (but don't record in Audit Log just for this type of change) and load the transmitted value.

SOURCE

Left-justify and upshift (but do not record change in Audit Log).

UPDATE

Patient Active Follow-up Fields Update Logic

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/26/03	Length of field changed from 25 to 40 characters.
2010	2010 Data Changes: Length changed from 40 to 60. CCR name (Contact Street) changed to NAACCR name. Update logic revised. Changed Allowable values edit to NAACCR edit standard so no longer allow commas.
02/2020	Added back to Volume III

Addr Current--Postal Code

IDENTIFIERS

CCR ID	NAACCR ID
E1525	1830

RASP NAME

CONZIP

DESCRIPTION

ZIP code of patient's current address or address where patient can be contacted.

LEVELS

Patients
Admissions

LENGTH

9

ALLOWABLE VALUES

Nine-digit US ZIP code; 9's if US or Canadian resident, unknown zip; if first 5 <> 9's and last 4 unknown, then last 4 blank; 8's if unknown outside USA and Canada.
If the code is known, regardless of the country that it is in, the postal code should be entered here.

888888888	Resident of country other than the US (including its possessions, etc.) or Canada and postal code unknown.
999999999	Resident of the US (including its possessions, etc.) or Canada and postal code unknown.

Item may not be blank.
Must be alphanumeric, left-justified, and blank-filled.
Mixed case is allowed.
Embedded spaces are not allowed.
Special characters are not allowed.

SOURCE

1. If Addr Current--No & Street, Addr Current--City, or Addr Current--State are blank, convert Addr at DX--Postal Code value into Addr Current-Postal Code.
2. If both of the following conditions are true:
   - the first 5 characters are NOT 99999
   - the last 4 characters are 9999

   Then reset the last 4 characters to blank.
3. If both of the following conditions are true:
   - the first 5 characters are 99999
   - the last 4 characters are NOT 9999

   Then reset the last 4 characters to 9999.

UPDATE

Patient Active Follow-up Fields Update Logic

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

2010	2010 Data Changes: CCR name (Contact Zip) changed to NAACCR name. Other data item names changed in Source and Update. An allowable value edit was added (#1102) so data item is edited like Addr at DX-Postal Code and matches NAACCR edit (Allowable values was "any" prior to this change). Revised Update logic based on new date criteria.

Addr Current--State

IDENTIFIERS

CCR ID	NAACCR ID
E1524	1820

OWNER

CoC

DESCRIPTION

State of patient's current address or address where patient can be contacted.

LEVELS

Patients, Admissions

LENGTH

2

ALLOWABLE VALUES

AK-WY	US States/Territories
AA-AP	United States Military Personnel Serving Abroad
AB-YT	Canadian Provinces/Territories
CD	Canada, NOS
US	Resident of United States, NOS
XX	Not U.S., U.S. Territory, not Canada, and country is known
YY	Not U.S., U.S. Territory, North American Islands, not Canada, and country is unknown
ZZ	Residence is unknown

See Volume I, Appendix B for all Postal Abbreviations for states/territories.

SOURCE

If Addr Current--No & Street, Addr Current--City, or Addr Current-State are blank,
Then:

Convert Addr at DX--State value into Addr Current-State
Left-justify and upshift (but don't record these changes in the audit log)

If Coding_Proc is less than 23, then:

If Addr at DX--State is XX, then convert Addr at DX--State to ZZ.
If all of the following conditions are true:

- Addr at DX--State is YY
- County at DX is NOT 999

Then convert Addr at DX--State to XX.

If Coding Proc is less than 24, then:

If all of the following conditions are true:

- County at DX is 220 (Canada NOS)
- Addr at DX--State is ZZ

Then convert Addr at DX--State to CD.
If all of the following conditions are true:

- County at DX is 000
- Addr at DX--State is ZZ

Then convert Addr at DX--State to US.

Otherwise, left-justify and upshift (but don't record these changes in the audit log).

UPDATE

Patient Active Follow-up Fields Update Logic

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

03/26/03	Added conversion table for Canadian provinces to Source. Update logic rewritten.
03/03/04	Removed conversion instructions from SOURCE for Version 9 records. See Use Case 22.
01/19/05	Added ZZ to Allowable Values and updated definitions of XX and YY to match the CoC/NAACCR definitions. Conversion spec added to Source. Database will be converted.
03/07/05	Corrected Source field conversion spec to Contact_State (was Addr_DX_State).
08/15/06	Added CD and US to Allowable Values and changed definition for ZZ.
2010	2010 Data Changes: CCR name (Contact State) changed to NAACCR name. Other name changes made in Update and Source.
07/2014	Clarified allowable values and included reference to Volume I, Appendix B.

Addr Current--Supplemental

IDENTIFIERS

CCR ID	NAACCR ID
E1651	2355

DESCRIPTION

Additional address information that is current or where the patient can be contacted. This data item allows the storage of additional address information such as the name of a place or facility (i.e., a nursing home, or the name of an apartment complex).

LEVELS

Patients, Admissions

LENGTH

60

ALLOWABLE VALUES

Item may be blank. Must be alphanumeric, left-justified, and blank-filled. Mixed case is allowed. Embedded spaces are allowed. Special characters are limited to periods, slashes, hyphens, and pound signs.

SOURCE

If Addr Current--No & Street, Addr Current--City, or Addr Current--City is blank, then convert Addr at DX--Supplementl (C/N # F03460) value into Addr Current--Supplementl.
Otherwise, left-justify (but don't record in Audit Log just for this type of change) and load the transmitted value.

UPDATE

Patient Active Follow-up Fields Update Logic

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/26/03	New data item for 2003 data set.
3/03/04	Changed the Allowable Values to "Any" and removed edit Err #227.
2010	2010 Data Changes: CCR name (Contact_Street_Suppl) changed to NAACCR name. Length changed from 40 to 60. Revised Update logic based on new date criteria. Added Allowable values edit (#1105).

Adenoid Cystic Basaloid Pattern

IDENTIFIERS

CCR ID	NAACCR ID
E1916	3803

OWNER

NAACCR

DESCRIPTION

Adenoid Cystic Basaloid Pattern, the presence of a basaloid pattern on pathological examination, is a prognostic factor for adenoid cystic carcinoma of the lacrimal gland.

LEVELS

Admissions, Tumors

LENGTH

5

ALLOWABLE VALUES

0.0-100.0	0.0 to 100.0 percent basaloid pattern
XXX.5	Basaloid pattern present, percentage not stated
XXX.8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code XXX.8 will result in an edit error.)
XXX.9	Not documented in medical record Adenoid Cystic Basaloid Pattern not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

If Date of Diagnosis is 2018 and greater:

1. If all of the following conditions are true:
   - Schema ID is 00690
   - Type of Reporting Source is not 7
   - Adenoid Cystic Basaloid Pattern is blank or XXX.8

   Then convert Adenoid Cystic Basaloid Pattern to XXX.9
2. If all of the following conditions are true:
   - One of the following is true:
     - Schema ID is not 00690

       OR
     - Type of Reporting Source is 7
   - Adenoid Cystic Basaloid Pattern is not blank

   Then convert Adenoid Cystic Basaloid Pattern to blank

Otherwise,

Blank out field

UPDATE

TUMOR LEVEL

NEW CASE CONSOLIDATION

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00690
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00690
- One of the following conditions is true
- Admission's value is not blank, XXX.9
- Tumor's value is blank or XXX.9

  OR
- Admission's value is XXX.9
- Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.
Otherwise,
If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

ADMISSION

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Adenopathy

IDENTIFIERS

CCR ID	NAACCR ID
E1917	3804

OWNER

NAACCR

DESCRIPTION

Adenopathy is defined as the presence of lymph nodes greater than 1.5 cm on physical examination (PE) and is part of the staging criteria for Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma (CLL/SLL).

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	Adenopathy not identified/not present No lymph nodes >1.5 cm
1	Adenopathy present Presence of lymph nodes >1.5 cm
9	Not documented in medical record Adenopathy not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
   A. If all of the following conditions are true:
      - Schema ID is 00795
      - Type of Reporting Source is not 7
      - Adenopathy is blank

      Then convert Adenopathy to 9
   B. If all of the following conditions are true:
      - One of the following is true:
        - Schema ID is not 00795

          OR
        - Type of Reporting Source is 7
      - Adenopathy is not blank

      Then convert Adenopathy to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00795
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00795

One of the following conditions is true

- Admission's value is not blank, 9
- Tumor's value is blank, 9

OR

- Admission's value is 9
- Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.
Otherwise,
If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Admission ID

IDENTIFIERS*

CCR ID	NAACCR ID
None	None

* Admission ID is not in the exchange record (Volume II, Appendix A) and does not have a CCR IF nor a NAACCR ID.

DESCRIPTION

Replace

LEVELS

Replace or None

LENGTH

Replace or None

ALLOWABLE VALUES

1-99999999

SOURCE

Generated automatically when admission record was migrated or when a new admission record is created.

UPDATE

None

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

03/03/04	Added to Volume III

AFP Post-Orchiectomy Lab Value

IDENTIFIERS

CCR ID	NAACCR ID
E1918	3805

OWNER

NAACCR

DESCRIPTION

AFP (Alpha Fetoprotein) Post-Orchiectomy Lab Value refers to the lowest AFP value measured post-orchiectomy. AFP is a serum tumor marker that is often elevated in patients with nonseminomatous germ cell tumors of the testis. The Post-Orchiectomy lab value is used to monitor response to therapy.

LEVELS

Admissions, Tumors

LENGTH

7

ALLOWABLE VALUES

0.0	0.0 nanograms/milliliter (ng/mL)
0.1-99999.9	0.1–99,999.9 ng/mL
XXXXX.1	100,000 ng/mL or greater
XXXXX.7	Test ordered, results not in chart
XXXXX.8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code XXXXX.8 may result in an edit error.) Not documented in medical record
XXXXX.9	No orchiectomy performed AFP (Alpha Fetoprotein) Post-Orchiectomy Lab Value not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00590
        - Type of Reporting Source is not 7
        - COC Accredited Flag is 1
        - AFP Post-Orchiectomy Lab Value is blank or XXXXX.8

        Then convert AFP Post-Orchiectomy Lab Value to XXXXX.9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00590

OR
- Type of Reporting Source is 7

- AFP Post-Orchiectomy Lab Value is not blank

Then convert AFP Post-Orchiectomy Lab Value to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00590
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00590

One of the following conditions is true

- Admission's value is not blank, XXXXX.8, or XXXXX.9
- Tumor's value is blank , XXXXX.8, or XXXXX.9

OR

- Admission's value is XXXXX.9
- Tumor's value is blank or XXXXX.8

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

AFP Post-Orchiectomy Range

IDENTIFIERS

CCR ID	NAACCR ID
E1919	3806

OWNER

NAACCR

DESCRIPTION

AFP (Alpha Fetoprotein) Post-Orchiectomy Range identifies the range category of the lowest AFP value measured post-orchiectomy. AFP is a serum tumor marker that is often elevated in patients with nonseminomatous germ cell tumors of the testis. The Post-Orchiectomy lab value is used to monitor response to therapy.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	Within normal limits
1	Above normal and less than 1,000 nanograms/milliliter (ng/mL)
2	1,000 -10,000 ng/mL
3	Greater than 10,000 ng/mL
4	Post-Orchiectomy alpha fetoprotein (AFP) stated to be elevated
7	Test ordered, results not in chart
8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code 8 may result in an edit error.)
9	Not documented in medical record No orchiectomy performed AFP (Alpha Fetoprotein) Post-Orchiectomy Range not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00590
        - Type of Reporting Source is not 7
        - COC Accredited Flag is 1
        - AFP Post-Orchiectomy Range is blank or 8

        Then convert AFP Post-Orchiectomy Range to 9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00590

OR
- Type of Reporting Source is 7

- AFP Post-Orchiectomy Range is not blank

Then convert AFP Post-Orchiectomy Range to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00590
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00590

One of the following conditions is true

- Admission's value is not blank, 8, 9
- Tumor's value is blank, 8, or 9

OR

- Admission's value is 9
- Tumor's value is blank or 8

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

AFP Pre-Orchiectomy Lab Value

IDENTIFIERS

CCR ID	NAACCR ID
E1920	3807

OWNER

NAACCR

DESCRIPTION

AFP (Alpha Fetoprotein) Pre-Orchiectomy Lab Value refers to the AFP value measured prior to treatment. AFP is a tumor marker that is often elevated in patients with nonseminomatous germ cell tumors of the testis.

LEVELS

Admissions, Tumors

LENGTH

7

ALLOWABLE VALUES

0.0	0.0 nanograms/milliliter (ng/mL)
0.1-99999.9	0.1–99,999.9 ng/mL
XXXXX.1	100,000 ng/mL or greater
XXXXX.7	Test ordered, results not in chart
XXXXX.8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code XXXXX.8 may result in an edit error.) Not documented in medical record
XXXXX.9	AFP (Alpha Fetoprotein) Pre-Orchiectomy Lab Value not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00590
        - Type of Reporting Source is not 7
        - COC Accredited Flag is 1
        - AFP Pre-Orchiectomy Lab Value is blank or XXXXX.8

        Then convert AFP Pre-Orchiectomy Lab Value to XXXXX.9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00590

            OR

- Type of Reporting Source is 7
- AFP Pre-Orchiectomy Lab Value is not blank

Then convert AFP Pre-Orchiectomy Lab Value to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00590
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00590

One of the following conditions is true

- Admission's value is not blank, XXXXX.8, or XXXXX.9
- Tumor's value is blank , XXXXX.8, or XXXXX.9

OR

- Admission's value is XXXXX.9
- Tumor's value is blank or XXXXX.8

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

AFP Pre-Orchiectomy Range

IDENTIFIERS

CCR ID	NAACCR ID
E1921	3808

OWNER

NAACCR

DESCRIPTION

AFP (Alpha Fetoprotein) Pre-Orchiectomy Range identifies the range category of the highest AFP value measured prior to treatment. AFP is a serum tumor marker that is often elevated in patients with nonseminomatous germ cell tumors of the testis.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	Within normal limits
1	Above normal and less than 1,000 nanograms/milliliter (ng/mL)
2	1,000 -10,000 ng/mL
3	Greater than 10,000 ng/mL
4	Pre-Orchiectomy alpha fetoprotein (AFP) stated to be elevated
7	Test ordered, results not in chart
8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code 8 may result in an edit error.) Not documented in medical record
9	AFP (Alpha Fetoprotein) Pre-Orchiectomy Range not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00590
        - Type of Reporting Source is not 7
        - COC Accredited Flag is 1
        - AFP Pre-Orchiectomy Range is blank or 8

        Then convert AFP Pre-Orchiectomy Range to 9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00590

OR
- Type of Reporting Source is 7

- AFP Pre-Orchiectomy Range is not blank

Then convert AFP Pre-Orchiectomy Range to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00590
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00590

One of the following conditions is true

- Admission's value is not blank, 8, 9
- Tumor's value is blank, 8, 9

OR

- Admission's value is 9
- Tumor's value is blank or 8

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

AFP Pretreatment Interpretation

IDENTIFIERS

CCR ID	NAACCR ID
E1922	3809

OWNER

NAACCR

DESCRIPTION

AFP (Alpha Fetoprotein) Pretreatment Interpretation, a nonspecific serum protein that generally is elevated in the setting of hepatocellular carcinoma (HCC), is a prognostic factor for liver cancer.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	Negative/normal; within normal limits
1	Positive/elevated
2	Borderline; undetermined if positive or negative
7	Test ordered, results not in chart
8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code 8 will result in an edit error.)
9	Not documented in medical record AFP pretreatment interpretation not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

3. If Date of Diagnosis is less than 2018, then blank out field
4. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00220
        - Type of Reporting Source is not 7
        - COC Accredited Flag is 1
        - AFP Pretreatment Interpretation is blank or 8

        Then convert AFP Pretreatment Interpretation to 9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00220

              OR
            - Type of Reporting Source is 7
        - AFP Pretreatment Interpretation is not blank

        Then convert AFP Pretreatment Interpretation to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00220
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00220

One of the following conditions is true

- Admission's value is not blank, 8, 9
- Tumor's value is blank, 8, or 9

OR

- Admission's value is 9
- Tumor's value is blank or 8

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

AFP Pretreatment Lab Value

IDENTIFIERS

CCR ID	NAACCR ID
E1923	3810

OWNER

NAACCR

DESCRIPTION

AFP (Alpha Fetoprotein) Pretreatment Lab Value is a nonspecific serum protein that generally is elevated in the setting of hepatocellular carcinoma (HCC). This data item pertains to the pre-treatment lab value.

LEVELS

Admissions, Tumors

LENGTH

6

ALLOWABLE VALUES

0.0	0.0 nanograms/milliliter (ng/ml); not detected
0.1 – 9999.9	0.1-9999.9 ng/ml (Exact value to nearest tenth of ng/ml)
XXXX.1	10,000.0 ng/ml or greater
XXXX.7	Test ordered, results not in chart
XXXX.8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code XXXX.8 will result in an edit error.)
XXXX.9	Not documented in medical record AFP (Alpha Fetoprotein) Pretreatment Lab Value not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00220
        - Type of Reporting Source is not 7
        - COC Accredited Flag is 1
        - AFP Pretreatment Lab Value is blank or XXXX.8

        Then convert AFP Pretreatment Lab Value to XXXX.9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00220

              OR
            - Type of Reporting Source is 7
        - AFP Pretreatment Lab Value is not blank

Then convert AFP Pretreatment Lab Value to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00220
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00220

One of the following conditions is true

- Admission's value is not blank, XXXX.8, XXXX.9
- Tumor's value is blank , XXXX.8, or XXXX.9

OR

- Admission's value is XXXX.9
- Tumor's value is blank or XXXX.8

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Age at Diagnosis

IDENTIFIERS

CCR ID	NAACCR ID
E1032	230

DESCRIPTION

Age at Diagnosis is the system-generated age of the patient at diagnosis (in number of years) determined by calculating the difference between Date of Birth and Date of Diagnosis. Since Date of Birth is captured at the patient level and Date of Diagnosis is captured at the tumor level, different ages may be generated for each of a patient's tumors.

LEVELS

Tumors

LENGTH

3

ALLOWABLE VALUES

000	Less than 1 year old; diagnosed in utero
001	1 year old, but less than 2 years
002 … 120	2 to 120 years old (show actual age in completed years) Note: Right justify and zero fill. Thus, age 2 is 002. Age 15 is 015 and so forth.
999	Unknown age at diagnosis
	Note: Right justify and zero fill codes.

SOURCE

Computer generate from Date of Birth and Date of Diagnosis (see Also, see CS Version Derived.

UPDATE

Recalculate when either Date of Birth or Date of Diagnosis is changed.

CONSOLIDATED DATA EXTRACT

Yes, generate upon extract if appropriate for the recipient according to the specification in Appendix #6

HISTORICAL CHANGES

7/2001	Changed interfield edits involving HIST-TYPE and HIST-BEHAVIOR to reference HIST-TYPE-3 and HIST-BEHAVIOR-3 and changed histology type ranges checked to match SEER Edit IF15 for ICDO-3.
11/2002	Interfield edit 3) had a typo so changed 348 to 384. Interfield edit 4) range changed from 340 to 339 (now matches SEER IF15).
03/2003	In the CCR central system (EUREKA), this field is generated when necessary and is not stored in the database. The Allowable values edit (#48) was removed.
08/2006	Description updated with Volume Two text. Updated Extract information.
2010	2010 Data Changes: CCR names (Birth Date; Date DX) changed to match NAACCR names. Changed Allowable Values to match NAACCRv12. Added diagnosed in utero to allowable value 000.
8/2011	IF #367, 368 and 369 added for 2011 as part of the CER project.

AGE-GROUP

IDENTIFIERS*

CCR ID	NAACCR ID
None	None

* Age-Group is not in the exchange record (Volume II, Appendix A) and does not have a CCR ID nor a NAACCR ID.

DESCRIPTION

Age group where AGE-DX falls for statistical reports.
In the CCR central system (EUREKA), this field is generated when necessary and is not stored in the database. The Allowable values edit and Interfield edit was removed.

LEVELS

Tumors

LENGTH

2

ALLOWABLE VALUES

Replace or None or use table for lists

01	0-4 years
02	5-9 years
03	10-14 years
04	15-19 years
05	20-24 years
06	25-29 years
07	30-34 years

08	35-39 years
09	40-44 years
10	45-49 years
11	50-54 years
12	55-59 years
13	60-64 years
14	65-69 years

15	70-74 years
16	75-79 years
17	80-84 years
18	85-89 years
99	Unknown age

SOURCE

Computer generate from AGE-DX.

UPDATE

Regenerate if AGE-DX changes

CONSOLIDATED DATA EXTRACT

Yes, optional

HISTORICAL CHANGES

3/26/03	In the CCR central system (EUREKA), this field is generated when necessary and is not stored in the database. The Allowable values edit and Interfield edit was removed.

AJCC ID

IDENTIFIERS

CCR ID	NAACCR ID
E1852	995

OWNER

NAACCR

DESCRIPTION

The values for this data item are based on the chapters of the AJCC manual and will be derived primarily from the site/histology fields and other data items as required. IDs are assigned to cases for which AJCC staging is applicable. When staging is not applicable, code 'XX' is used.

LEVEL

Tumors, Admissions

LENGTH

4

ALLOWABLE VALUES

See NAACCR SSDI Manual

SOURCE

See UC 02.21 Perform SEER EOD Staging Algorithm – UC for specifications to re-run algorithm.

UPDATE

See UC 02.21 Perform SEER EOD Staging Algorithm – UC for specifications to re-run algorithm.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

AJCC TNM Clin M

IDENTIFIERS

CCR ID	NAACCR ID
E1855	1003

OWNER

AJCC

DESCRIPTION

Detailed site-specific codes for the clinical metastases (M) as defined by the current AJCC edition.

LEVEL

Admission

LENGTH

15

ALLOWABLE VALUES

Codes in addition to those published in the ***AJCC Cancer Staging Manual***:

88	Not applicable, no code assigned for this case in the current ***AJCC Cancer Staging Manual***
Blank	Information not available to code this item. Date of Diagnosis pre-2018

Note: See the AJCC Cancer Staging Manual, 8th edition for site-specific categories for the TNM elements and stage groups. See the CURRENT STORE manual for specifications for codes and data entry rules.

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater, then upload with no conversion.

UPDATE

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

AJCC TNM Clin N

IDENTIFIERS

CCR ID	NAACCR ID
E1854	1002

OWNER

AJCC

DESCRIPTION

Detailed site-specific codes for the clinical nodes (N) as defined by the current AJCC edition.

LEVEL

Admission

LENGTH

15

ALLOWABLE VALUES

Codes in addition to those published in the ***AJCC Cancer Staging Manual***:

88	Not applicable, no code assigned for this case in the current ***AJCC Cancer Staging Manual***
Blank	Information not available to code this item. Date of Diagnosis pre-2018

Note: See the AJCC Cancer Staging Manual, 8th edition for site-specific categories for the TNM elements and stage groups. See the CURRENT STORE manual for specifications for codes and data entry rules.

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater, then upload with no conversion.

UPDATE

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

AJCC TNM Clin N Suffix

IDENTIFIERS

CCR ID	NAACCR ID
E1868	1034

OWNER

AJCC

DESCRIPTION

Detailed site-specific codes for the clinical N category suffix as defined by AJCC.

LEVEL

Admission

LENGTH

4

ALLOWABLE VALUES

Per AJCC Cancer Staging Manual:

(sn)	Sentinel node procedure with or without FNA or core needle biopsy
(f)	FNA or core needle biopsy only
Blank	No suffix needed or appropriate; not recorded Date of Diagnosis pre-2018

Note: Refer to the current AJCC Cancer Staging Manual for staging rules.

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater, then upload with no conversion.

UPDATE

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

AJCC TNM Clin Stage Group

IDENTIFIERS

CCR ID	NAACCR ID
E1856	1004

OWNER

AJCC

DESCRIPTION

Detailed site-specific codes for the clinical stage group as defined by the current AJCC edition.

LEVEL

Admission

LENGTH

15

ALLOWABLE VALUES

Codes in addition to those published in the ***AJCC Cancer Staging Manual***:

88	Not applicable, no code assigned for this case in the current ***AJCC Cancer Staging Manual***
99	Unknown, not staged
Blank	Date of Diagnosis pre-2018

Note: See the AJCC Cancer Staging Manual, 8th edition for site-specific categories for the TNM elements and stage groups. See the CURRENT STORE manual for specifications for codes and data entry rules.

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater, then upload with no conversion.

UPDATE

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

AJCC TNM Clin T

IDENTIFIERS

CCR ID	NAACCR ID
E1853	1001

OWNER

AJCC

DESCRIPTION

Detailed site-specific codes for the clinical tumor (T) as defined by the current AJCC edition.

LEVEL

Admission

LENGTH

15

ALLOWABLE VALUES

Codes in addition to those published in the ***AJCC Cancer Staging Manual***:

88	Not applicable, no code assigned for this case in the current ***AJCC Cancer Staging Manual***
Blank	Information not available to code this item. Date of Diagnosis pre-2018

Note: See the AJCC Cancer Staging Manual, 8th edition for site-specific categories for the TNM elements and stage groups. See the CURRENT STORE manual for specifications for codes and data entry rules.

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater, then upload with no conversion.

UPDATE

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

AJCC TNM Clin T Suffix

IDENTIFIERS

CCR ID	NAACCR ID
E1865	1031

OWNER

AJCC

DESCRIPTION

Detailed site-specific codes for the clinical T category suffix as defined by AJCC.

LEVEL

Admission

LENGTH

4

ALLOWABLE VALUES

Per AJCC Cancer Staging Manual:

(m)	Multiple synchronous tumors OR For thyroid differentiated and anaplastic only, Multifocal tumor
(s)	For thyroid differentiated and anaplastic only, Solitary tumor
Blank	No information available; not recorded Date of Diagnosis pre-2018

Note: Refer to the current AJCC Cancer Staging Manual for staging rules.

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater, then upload with no conversion.

UPDATE

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

AJCC TNM Path M

IDENTIFIERS

CCR ID	NAACCR ID
E1859	1013

OWNER

AJCC

DESCRIPTION

Detailed site-specific codes for the pathologic metastases (M) as defined by the current AJCC edition.

LEVEL

Admission

LENGTH

15

ALLOWABLE VALUES

Codes in addition to those published in the ***AJCC Cancer Staging Manual***:

88	Not applicable, no code assigned for this case in the current ***AJCC Cancer Staging Manual***
Blank	Information not available to code this item. Date of Diagnosis pre-2018

Note: See the AJCC Cancer Staging Manual, 8th edition for site-specific categories for the TNM elements and stage groups. See the CURRENT STORE manual for specifications for codes and data entry rules.

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater, then upload with no conversion.

UPDATE

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

AJCC TNM Path N

IDENTIFIERS

CCR ID	NAACCR ID
E1858	1012

OWNER

AJCC

DESCRIPTION

Detailed site-specific codes for the pathologic nodes (N) as defined by the current AJCC edition.

LEVEL

Admission

LENGTH

15

ALLOWABLE VALUES

Codes in addition to those published in the ***AJCC Cancer Staging Manual***:

88	Not applicable, no code assigned for this case in the current ***AJCC Cancer Staging Manual***
Blank	Information not available to code this item. Date of Diagnosis pre-2018

Note: See the AJCC Cancer Staging Manual, 8th edition for site-specific categories for the TNM elements and stage groups. See the CURRENT STORE manual for specifications for codes and data entry rules.

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater, then upload with no conversion.

UPDATE

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

AJCC TNM Path N Suffix

IDENTIFIERS

CCR ID	NAACCR ID
E1869	1035

OWNER

AJCC

DESCRIPTION

Detailed site-specific codes for the pathological N category suffix as defined by AJCC.

LEVEL

Admission

LENGTH

4

ALLOWABLE VALUES

Per AJCC Cancer Staging Manual:

(sn)	Sentinel node procedure without resection of nodal basin
(f)	FNA or core needle biopsy without resection of nodal basin
Blank	No suffix needed or appropriate; not recorded Date of Diagnosis pre-2018

Note: Refer to the current AJCC Cancer Staging Manual for staging rules.

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater, then upload with no conversion.

UPDATE

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

AJCC TNM path Stage Group

IDENTIFIERS

CCR ID	NAACCR ID
E1860	1014

OWNER

AJCC

DESCRIPTION

Detailed site-specific codes for the pathologic stage group as defined by the current AJCC edition.

LEVEL

Admission

LENGTH

15

ALLOWABLE VALUES

Codes in addition to those published in the ***AJCC Cancer Staging Manual***:

88	Not applicable, no code assigned for this case in the current ***AJCC Cancer Staging Manual***
99	Unknown, not staged
Blank	Date of Diagnosis pre-2018

Note: See the AJCC Cancer Staging Manual, 8th edition for site-specific categories for the TNM elements and stage groups. See the CURRENT STORE manual for specifications for codes and data entry rules.

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater, then upload with no conversion.

UPDATE

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

AJCC TNM Path T

IDENTIFIERS

CCR ID	NAACCR ID
E1857	1011

OWNER

AJCC

DESCRIPTION

Detailed site-specific codes for the pathologic tumor (T) as defined by the current AJCC edition.

LEVEL

Admission

LENGTH

15

ALLOWABLE VALUES

Codes in addition to those published in the ***AJCC Cancer Staging Manual***:

88	Not applicable, no code assigned for this case in the current ***AJCC Cancer Staging Manual***
Blank	Information not available to code this item. Date of Diagnosis pre-2018

Note: See the AJCC Cancer Staging Manual, 8th edition for site-specific categories for the TNM elements and stage groups. See the CURRENT STORE manual for specifications for codes and data entry rules.

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater, then upload with no conversion.

UPDATE

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

AJCC TNM path T Suffix

IDENTIFIERS

CCR ID	NAACCR ID
E1866	1032

OWNER

AJCC

DESCRIPTION

Detailed site-specific codes for the pathological T category suffix as defined by AJCC.

LEVEL

Admission

LENGTH

4

ALLOWABLE VALUES

Per AJCC Cancer Staging Manual:

(m)	Multiple synchronous tumors OR For thyroid differentiated and anaplastic only, Multifocal tumor
(s)	For thyroid differentiated and anaplastic only, Solitary tumor
Blank	No information available; not recorded Date of Diagnosis pre-2018

Note: Refer to the current AJCC Cancer Staging Manual for staging rules.

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater, then upload with no conversion.

UPDATE

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

AJCC TNM Post Therapy M

IDENTIFIERS

CCR ID	NAACCR ID
E1863	1023

OWNER

AJCC

DESCRIPTION

Detailed site-specific codes for the post-neoadjuvant therapy category metastases (M) as defined by the current AJCC edition.

LEVEL

Admission

LENGTH

15

ALLOWABLE VALUES

Codes in addition to those published in the ***AJCC Cancer Staging Manual***:

88	Not applicable, no code assigned for this case in the current ***AJCC Cancer Staging Manual***
Blank	Information not available to code this item. Date of Diagnosis pre-2018

Note: See the AJCC Cancer Staging Manual, 8th edition for site-specific categories for the TNM elements and stage groups. See the CURRENT STORE manual for specifications for codes and data entry rules.

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater, then upload with no conversion.

UPDATE

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

AJCC TNM Post Therapy N

IDENTIFIERS

CCR ID	NAACCR ID
E1862	1022

OWNER

AJCC

DESCRIPTION

Detailed site-specific codes for the post-neoadjuvant therapy nodes (N) as defined by the current AJCC edition.

LEVEL

Admission

LENGTH

15

ALLOWABLE VALUES

Codes in addition to those published in the ***AJCC Cancer Staging Manual***:

88	Not applicable, no code assigned for this case in the current ***AJCC Cancer Staging Manual***
Blank	Information not available to code this item. Date of Diagnosis pre-2018

Note: See the AJCC Cancer Staging Manual, 8th edition for site-specific categories for the TNM elements and stage groups. See the CURRENT STORE manual for specifications for codes and data entry rules.

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater, then upload with no conversion.

UPDATE

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

AJCC TNM Post Therapy N Suffix

IDENTIFIERS

CCR ID	NAACCR ID
E1870	1036

OWNER

AJCC

DESCRIPTION

Detailed site-specific codes for the post-neoadjuvant therapy N category suffix as defined by AJCC.

LEVEL

Admission

LENGTH

4

ALLOWABLE VALUES

Per AJCC Cancer Staging Manual:

(sn)	Sentinel node procedure without resection of nodal basin
(f)	FNA or core needle biopsy without resection of nodal basin
Blank	No suffix needed or appropriate; not recorded Date of Diagnosis pre-2018

Note: Refer to the current AJCC Cancer Staging Manual for staging rules.

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater, then upload with no conversion.

UPDATE

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

AJCC TNM Post Therapy Stage Group

IDENTIFIERS

CCR ID	NAACCR ID
E1864	1024

OWNER

AJCC

DESCRIPTION

Detailed site-specific codes for the post-neoadjuvant therapy stage group as defined by the current AJCC edition.

LEVEL

Admission

LENGTH

15

ALLOWABLE VALUES

Codes in addition to those published in the ***AJCC Cancer Staging Manual***:

88	Not applicable, no code assigned for this case in the current ***AJCC Cancer Staging Manual***
99	Unknown, not staged
Blank	Date of Diagnosis pre-2018

Note: See the AJCC Cancer Staging Manual, 8th edition for site-specific categories for the TNM elements and stage groups. See the CURRENT STORE manual for specifications for codes and data entry rules.

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater, then upload with no conversion.

UPDATE

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

AJCC TNM Post Therapy T

IDENTIFIERS

CCR ID	NAACCR ID
E1861	1021

OWNER

AJCC

DESCRIPTION

Detailed site-specific codes for the post-neoadjuvant therapy tumor (T) as defined by the current AJCC edition.

LEVEL

Admission

LENGTH

15

ALLOWABLE VALUES

Codes in addition to those published in the ***AJCC Cancer Staging Manual***:

88	Not applicable, no code assigned for this case in the current ***AJCC Cancer Staging Manual***
Blank	Information not available to code this item. Date of Diagnosis pre-2018

Note: See the AJCC Cancer Staging Manual, 8th edition for site-specific categories for the TNM elements and stage groups. See the CURRENT STORE manual for specifications for codes and data entry rules.

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater, then upload with no conversion.

UPDATE

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

AJCC TNM Post Therapy T Suffix

IDENTIFIERS

CCR ID	NAACCR ID
E1867	1033

OWNER

AJCC

DESCRIPTION

Detailed site-specific codes for the post-neoadjuvant therapy T category suffix as defined by AJCC.

LEVEL

Admission

LENGTH

4

ALLOWABLE VALUES

Per AJCC Cancer Staging Manual:

(m)	Multiple synchronous tumors OR For thyroid differentiated and anaplastic only, Multifocal tumor
(s)	For thyroid differentiated and anaplastic only, Solitary tumor
Blank	No information available; not recorded Date of Diagnosis pre-2018

Note: Refer to the current AJCC Cancer Staging Manual for staging rules.

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater, then upload with no conversion.

UPDATE

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Ambiguous Terminology DX

IDENTIFIERS

CCR ID	NAACCR ID
E1073	442

NAACCR NAME

Ambiguous Terminology DX (#442)

RASP NAME

None

DESCRIPTION

Identifies cases for which an ambiguous term is the most definitive word or phrase used to establish a cancer diagnosis. This field is allowed to be blank because the item is not required for all years of diagnosis.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

	(refer to SEER.cancer.gov/tools/mphrules for additional instructions)
0	Conclusive term
1	Ambiguous term only
2	Ambiguous term followed by conclusive term
9	Unknown term
Blank	Date of Diagnosis is before January 1, 2007. Or, data not collected for Year DX 2013 or later.

SOURCE

Upload with no conversion.

UPDATE

TUMOR LEVEL

NEW CASE CONSOLIDATION

If the admission and tumor's Ambiguous Terminology DX values are not the same, then list for review.

Manual Change

ADMISSION LEVEL

Manual Change

Correction/Update Record Applied

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

8/15/06	New data item for 2007.
2010	2010 Data Changes: Update logic rewritten to list for review (was manual).

Anemia

IDENTIFIERS

CCR ID	NAACCR ID
E1924	3811

OWNER

NAACCR

DESCRIPTION

Anemia is defined by a deficiency of red blood cells or of hemoglobin in the blood. In staging of Chronic Lymphocytic Leukemia/Small Lymphocytic Leukemia (CLL/SLL), anemia is defined as Hgb less than 11.0 g/dL.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	Anemia not present Hgb >=11.0 g/dL
1	Anemia present Hgb <11.0 g/dL
6	Lab value unknown, physician states patient is anemic
7	Test ordered, results not in chart
9	Not documented in medical record Anemia not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00795
        - Type of Reporting Source is not 7
        - Anemia is blank

        Then convert Anemia to 9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00795

              OR
            - Type of Reporting Source is 7
        - Anemia is not blank

        Then convert Anemia to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00795
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 007953

One of the following conditions is true

- Admission's value is not blank, 9
- Tumor's value is blank, 9

OR

- Admission's value is 9
- Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

B Symptoms

IDENTIFIERS

CCR ID	NAACCR ID
E1925	3812

OWNER

NAACCR

DESCRIPTION

B symptoms refer to systemic symptoms of fever, night sweats, and weight loss which can be associated with both Hodgkin lymphoma and some non-Hodgkin lymphomas. The presence of B symptoms is a prognostic factor for some lymphomas.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	No B symptoms (asymptomatic) Classified as "A" by physician when asymptomatic
1	Any B symptom(s) Night sweats (drenching) Unexplained fever (above 38 degrees C) Unexplained weight loss (generally greater than 10% of body weight in the six months before admission) B symptoms, NOS Classified as "B" by physician when symptomatic
8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code 8 will result in an edit error.)
9	Not documented in medical record B symptoms not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
   A. If all of the following conditions are true:
      - Schema ID is 00790 or 00795
      - Type of Reporting Source is not 7
      - B Symptoms is blank or 8

      Then convert B Symptoms to 9
   B. If all of the following conditions are true:
      - One of the following is true:
        - Schema ID is numeric and is not 00790, 00795

        OR

- Type of Reporting Source is 7

- B Symptoms is not blank

Then convert B Symptoms to blank

C. Then convert B Symptoms to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00790 or 00795
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00790, 00795

One of the following conditions is true

- Admission's value is not blank, 9
- Tumor's value is blank, 9

OR

- Admission's value is 9
- Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.
02/2020	Source Logic update

Batch

IDENTIFIERS*

CCR ID	NAACCR ID
None	None

* BATCH is not in the exchange record (Volume II, Appendix A) and does not have identifiers.

DESCRIPTION

In the CCR central system (EUREKA), this data item is retained for historical purposes only.
Previously, it identified a group of abstracts as belonging to a particular batch for visual editing purposes in the CANDIS system.

LEVELS

Admissions

LENGTH

6

ALLOWABLE VALUES

Any numeric

SOURCE

UPDATE

N/A

CONSOLIDATED EXTRACT

None

HISTORICAL CHANGES

3/03	In the CCR central system (EUREKA), this data item is retained for historical purposes only. The Source and Update requirements were removed.

BCR-ABL Cytogenetic Date

Full Name: **Breakpoint Cluster Region (BCR)-Acetylbritannilactone (ABL) Cytogen Date**

IDENTIFIERS

CCR ID	NAACCR ID
E1266	9901

DESCRIPTION

This data item has been retired. This page has been retained for historical purposes only and this data item should not be populated in any cases diagnosed 2013 or later or coded under the NAACCR v13 or later coding standards.
Records the date of the cytogenetic analysis for BCR-ABL at the time of initial diagnosis.

LEVELS

Tumors, Admissions

LENGTH

8

ALLOWABLE VALUES

A valid, complete date in YYYYMMDD format
A valid year & month (YYYYMM) followed by two blanks (unknown day)
A valid year (YYYY) followed by four blanks (unknown month and day)
Eight blanks (no known or partially known date)

Notes:
A valid day requires a valid month and valid year.
A valid month requires a valid year.

SOURCE

None

UPDATE

None

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

3/14/11	This item added for 2011 as part of the CER project.
05/2013	Retired at the conclusion of data collection for the CER project

BCR-ABL Cytogen Date Flag

Full Name: **Breakpoint Cluster Region (BCR)-Acetylbritannilactone (ABL) Cytogen Date Flag**

IDENTIFIERS

CCR ID	NAACCR ID
E1267	9902

DESCRIPTION

This data item has been retired. This page has been retained for historical purposes only and this data item should not be populated in any cases diagnosed 2013 or later or coded under the NAACCR v13 or later coding standards.
This flag explains why there is not a valid date in the BCR-ABL Cytogenetic Date data item.

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if BCR-ABL Cytogenetic test done)
11	No proper value is applicable in this context (e.g., no BCR-ABL Cytogenetic test done, not applicable)
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., BCR-ABL Cytogenetic test done but date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (e.g., BCR-ABL Cytogenetic test ordered, but had not been administered at the time of the most recent follow-up).
blank	A valid date value is provided in item CR-ABL Cytogenetic Date or the date was not expected to have been transmitted. A blank is allowed for cases Diagnosed prior to 2011 Diagnose date 2011 and not a Region 3 resident Region 3 resident and sites other than Breast, Colorectal, and CML

SOURCE

None

UPDATE

None

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

2011 Data Item Changes, CER Project	Added for CER requirements.
05/2013	Retired at the conclusion of data collection for the CER project

BCR-ABL Cytogenetic

Full Name: **Breakpoint Cluster Region (BCR)-Acetylbritannilactone (ABL)**

IDENTIFIERS

CCR ID	NAACCR ID
E1265	9900

DESCRIPTION

This data item has been retired. This page has been retained for historical purposes only and this data item should not be populated in any cases diagnosed 2013 or later or coded under the NAACCR v13 or later coding standards.
Record the results of the cytogenetic analysis for BCR-ABL at the time of initial diagnosis.

LEVELS

Tumors, Admissions

LENGTH

3

ALLOWABLE VALUES

000	Negative result OR Not applicable (e.g., information not collected for this case) OR Test not done (e.g., test not ordered and was not performed) OR Unknown information (e.g., not documented in source record) OR Test ordered (e.g., results not in source records)
010	Positive
Blank	A blank is allowed for cases • Diagnosed prior to 2011 • Diagnose date 2011 and not a Region 3 resident • Region 3 resident and sites other than Breast, Colorectal, and CML

SOURCE

None

UPDATE

None

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

3/14/2011	This item added for 2011 as part of the CER project.
05/2013	Retired at the conclusion of data collection for the CER project

BCR-ABL FISH Date

Full Name: **Breakpoint Cluster Region (BCR)-Acetylbritannilactone (ABL) Fluorescence in Situ Hybridization and Interpretation (FISH) Date**

IDENTIFIERS

CCR ID	NAACCR ID
E1269	9904

DESCRIPTION

This data item has been retired. This page has been retained for historical purposes only and this data item should not be populated in any cases diagnosed 2013 or later or coded under the NAACCR v13 or later coding standards.

Record the date of only the Fluorescence in Situ Hybridization for BCR-ABL at the time of initial diagnosis.

LEVELS

Tumors, Admissions

LENGTH

8

ALLOWABLE VALUES

A valid, complete date in YYYYMMDD format

A valid year & month (YYYYMM) followed by two blanks (unknown day)

A valid year (YYYY) followed by four blanks (unknown month and day)

Eight blanks (no known or partially known date)

Notes:

A valid day requires a valid month and valid year.

A valid month requires a valid year.

SOURCE

N/A

UPDATE

N/A

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

2011 Data Item Changes, CER Project	Added for CER requirements.
05/2013	Retired at the conclusion of data collection for the CER project

BCR-ABL FISH

Full Name: **Breakpoint Cluster Region (BCR)-Acetylbritannilactone (ABL) Fluorescence in Situ Hybridization and Interpretation (FISH)**

IDENTIFIERS

CCR ID	NAACCR ID
E1268	9903

DESCRIPTION

This data item has been retired. This page has been retained for historical purposes only and this data item should not be populated in any cases diagnosed 2013 or later or coded under the NAACCR v13 or later coding standards.
Record the results of the Fluorescence in Situ Hybridization for BCR-ABL at the time of initial diagnosis.

LEVELS

Tumors, Admissions

LENGTH

3

ALLOWABLE VALUES

000	Negative result OR Not applicable (e.g., information not collected for this case) OR Test not done (e.g., test not ordered and was not performed) OR Unknown information (e.g., not documented in source record) OR Test ordered (e.g., results not in source records)
010	Positive
Blank	A blank is allowed for cases • Diagnosed prior to 2011 • Diagnose date 2011 and not a Region 3 resident • Region 3 resident and sites other than Breast, Colorectal, and CML

SOURCE

N/A

UPDATE

N/A

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

2011 Data Item Changes, CER Project	Added for CER requirements.
05/2013	Retired at the conclusion of data collection for the CER project

BCR-ABL FISH Date Flag

Full Name: **Breakpoint Cluster Region (BCR)-Acetylbritannilactone (ABL) Fluorescence in Situ Hybridization and Interpretation (FISH) Date Flag**

IDENTIFIERS

CCR ID	NAACCR ID
E1270	9905

DESCRIPTION

This data item has been retired. This page has been retained for historical purposes only and this data item should not be populated in any cases diagnosed 2013 or later or coded under the NAACCR v13 or later coding standards.

This flag explains why there is not a valid date in the BCR-ABL FISH Date data item.

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if any or unknown if BCR-ABL FISH test done)
11	No proper value is applicable in this context (e.g., no chemotherapy agent administered)
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., chemotherapy administered but date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (e.g., chemotherapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow up).
blank	A valid date value is provided in item Chemo 1 Start Date [9821]. A blank is allowed for cases • Diagnosed prior to 2011 • Diagnose date 2011 and not a Region 3 resident • Region 3 resident and sites other than Breast, Colorectal, and CML

SOURCE

N/A

UPDATE

N/A

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

2011	Data Changes: Added for CER requirements.
05/2013	Retired at the conclusion of data collection for the CER project

BCR-ABL RT-PCR Qual Date

Full Name: **Breakpoint Cluster Region (BCR)-Acetylbritannilactone (ABL) Reverse Transcription Polymerase Chain Reaction (RT-PCR) Qual Date**

IDENTIFIERS

CCR ID	NAACCR ID
E1272	9907

DESCRIPTION

This data item has been retired. This page has been retained for historical purposes only and this data item should not be populated in any cases diagnosed 2013 or later or coded under the NAACCR v13 or later coding standards.

Records the date of the *qualitative* Reverse Transcriptase Polymerase Chain Reaction RT-PCR for BCR-ABL at the time of initial diagnosis.

LEVELS

Tumors, Admissions

LENGTH

8

ALLOWABLE VALUES

A valid, complete date in YYYYMMDD format
A valid year & month (YYYYMM) followed by two blanks (unknown day)
A valid year (YYYY) followed by four blanks (unknown month and day)
Eight blanks (no known or partially known date)

Notes:

A valid day requires a valid month and valid year.
A valid month requires a valid year.

SOURCE

N/A

UPDATE

N/A

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

2011 Data Item Changes, CER Project	Added for CER requirements.
05/2013	Retired at the conclusion of data collection for the CER project

BCR-ABL RT-PCR Qual

Full Name: **Breakpoint Cluster Region (BCR)-Acetylbritannilactone (ABL) Reverse Transcription Polymerase Chain Reaction (RT-PCR) Qual**

IDENTIFIERS

CCR ID	NAACCR ID
E1271	9906

DESCRIPTION

This data item has been retired. This page has been retained for historical purposes only and this data item should not be populated in any cases diagnosed 2013 or later or coded under the NAACCR v13 or later coding standards.

Records the results of the *qualitative* Reverse Transcriptase Polymerase Chain Reaction RT-PCR for BCR-ABL at the time of initial diagnosis.

LEVELS

Tumors, Admissions

LENGTH

3

ALLOWABLE VALUES

000	Negative result OR Not applicable (e.g., information not collected for this case) OR Test not done (e.g., test not ordered and was not performed) OR Unknown information (e.g., not documented in source record) OR Test ordered (e.g., results not in source records)
010	Positive
Blank	A blank is allowed for cases • Diagnosed prior to 2011 • Diagnose date 2011 and not a Region 3 resident • Region 3 resident and sites other than Breast, Colorectal, and CML

SOURCE

N/A

UPDATE

N/A

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

2011 Data Item Changes, CER Project	Added for CER requirements.
05/2013	Retired at the conclusion of data collection for the CER project

BCR-ABL RT-PCR Qual DtFlg

Full Name: **Breakpoint Cluster Region (BCR)-Acetylbritannilactone (ABL) Reverse Transcription Polymerase Chain Reaction (RT-PCR) Qual Date Flag**

IDENTIFIERS

CCR ID	NAACCR ID
E1273	9908

DESCRIPTION

This data item has been retired. This page has been retained for historical purposes only and this data item should not be populated in any cases diagnosed 2013 or later or coded under the NAACCR v13 or later coding standards.

This flag explains why there is not a valid date in the BCR-ABL RT-PCR Qual Date data item.

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if any chemotherapy agent administered)
11	No proper value is applicable in this context (e.g., no chemotherapy agent administered)
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., chemotherapy administered but date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (e.g., chemotherapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow up).
blank	A valid date value is provided in item Chemo 1 Start Date [9821]. A blank is allowed for cases • Diagnosed prior to 2011 • Diagnose date 2011 and not a Region 3 resident • Region 3 resident and sites other than Breast, Colorectal, and CML

SOURCE

N/A

UPDATE

N/A

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

2011 Data Item Changes, CER Project	Added for CER requirements.
05/2013	Retired at the conclusion of data collection for the CER project

BCR-ABL RT-PCR Quan DtFlg

Full Name: **Breakpoint Cluster Region (BCR)-Acetylbritannilactone (ABL) Reverse Transcription Polymerase Chain Reaction (RT-PCR) Qual Quan Date Flag**

IDENTIFIERS

CCR ID	NAACCR ID
E1276	9911

DESCRIPTION

This data item has been retired. This page has been retained for historical purposes only and this data item should not be populated in any cases diagnosed 2013 or later or coded under the NAACCR v13 or later coding standards.

This flag explains why there is not a valid date in the BCR-ABL RT-PCR Quan Date data item.

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if any chemotherapy agent administered)
11	No proper value is applicable in this context (e.g., no chemotherapy agent administered)
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., chemotherapy administered but date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (e.g., chemotherapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow up).
blank	A valid date value is provided in item Chemo 1 Start Date [9821]. A blank is allowed for cases Diagnosed prior to 2011 Diagnose date 2011 and not a Region 3 resident Region 3 resident and sites other than Breast, Colorectal, and CML

SOURCE

N/A

UPDATE

N/A

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

2011 Data Item Changes, CER Project	Added for CER requirements.
05/2013	Retired at the conclusion of data collection for the CER project

BCR-ABL RT-PCR Quant

Full Name: **Breakpoint Cluster Region (BCR)-Acetylbritannilactone (ABL) Reverse Transcription Polymerase Chain Reaction (RT-PCR) Qual Quant**

IDENTIFIERS

CCR ID	NAACCR ID
E1274	9909

DESCRIPTION

This data item has been retired. This page has been retained for historical purposes only and this data item should not be populated in any cases diagnosed 2013 or later or coded under the NAACCR v13 or later coding standards.

Records results of the quantitative Reverse Transcriptase Polymerase Chain Reaction RT-PCR for BCR-ABL at time of initial diagnosis.

LEVELS

Tumors, Admissions

LENGTH

3

ALLOWABLE VALUES

000	Negative result OR Not applicable (e.g., information not collected for this case) OR Test not done (e.g., test not ordered and was not performed) OR Unknown information (e.g., not documented in source record) OR Test ordered (e.g., results not in source records)
001-998	Ratio of 0.001 to 0.998 (enter exact ratio)
999	Ratio greater than or equal to 0.999
blank	A blank is allowed for cases • Diagnosed prior to 2011 • Diagnose date 2011 and not a Region 3 resident • Region 3 resident and sites other than Breast, Colorectal, and CML

SOURCE

N/A

UPDATE

N/A

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

2011 Data Item Changes, CER Project	Added for CER requirements.
05/2013	Retired at the conclusion of data collection for the CER project

BCR-ABL RT-PCR Quant Date

Full Name: **Breakpoint Cluster Region (BCR)-Acetylbritannilactone (ABL) Reverse Transcription Polymerase Chain Reaction (RT-PCR) Qual Quant Date**

IDENTIFIERS

CCR ID	NAACCR ID
E1275	9910

DESCRIPTION

This data item has been retired. This page has been retained for historical purposes only and this data item should not be populated in any cases diagnosed 2013 or later or coded under the NAACCR v13 or later coding standards.
Record date of quantitative Reverse Transcriptase Polymerase Chain Reaction RT-PCR for BCR-ABL at time of initial diagnosis.

LEVELS

Tumors, Admissions

LENGTH

8

ALLOWABLE VALUES

A valid, complete date in YYYYMMDD format
A valid year & month (YYYYMM) followed by two blanks (unknown day)
A valid year (YYYY) followed by four blanks (unknown month and day)
Eight blanks (no known or partially known date)
Note*s:*
A valid month requires a valid year.

SOURCE

N/A

UPDATE

N/A

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

2011 Data Item Changes, CER Project	Added for CER requirements.
05/2013	Retired at the conclusion of data collection for the CER project

Behavior (92-00) ICD-O-2

IDENTIFIERS

CCR ID	NAACCR ID
E1059	430

DESCRIPTION

Fifth digit of the ICD-O Morphology code which designates the malignancy or behavior of this tumor. This data item was required by all standard-setting organizations for tumors diagnosed from January 1, 1992, through December 31, 2000, and recommended for tumors diagnosed before 1992.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

2	In situ
3	Malignant (invasive)
blank	ICDO-3 case, diagnosed in 2001 or later

Note:
Behavior (92-00) ICD-O-2 = 1 no longer allowed.

SOURCE

Upload with no conversion.

UPDATE

Tumor level

New Case Consolidation

If the admission and tumor's Behavior (92-00) ICD-O-2 values are not the same, then list for review.

Manual Change – See Behavior Code ICD-O-3

Admission Level

Manual Change – See Behavior Code ICD-O-3

Correction/Update Record Applied – See Behavior Code ICD-O-3

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

1/1999	Changed EOD-related interfield edits to be DATE-DX conditional.
5/01	Renamed from HIST-BEHAVIOR to HIST-BEHAVIOR-2; Modified Edit 2) to pertain only to Region 1/8.
7/01	Changed type to alphanumeric (X); added blank as an allowable value for ICDO-3 cases; removed EOD comparison edits that duplicate new ICDO-3 versions in purpose and edit 327 because it includes and override field check and it is described on the SITE page (the SEER edit allows the override).
2010	Data Item Changes: CCR name (Hist_Behavior_2) changed to match NAACCR name. Update logic rewritten to list for review (was manual).
2/2011	Removed IF306, 335 and 336 to match metafile.

Behavior Code ICD-O-3

IDENTIFIERS

CCR ID	NAACCR ID
E1062	523

OWNER

SEER/CoC

DESCRIPTION

Fifth digit of the ICD-O Morphology code which designates the malignancy or behavior of this tumor.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

0	Benign
1	Uncertain/Borderline
2	In situ
3	Malignant

SOURCE

If both of the following conditions are true:

Any of the following conditions are true:

Date of Diagnosis year is blank

Date of Diagnosis is 9999

Date of Diagnosis year is 0000-2000

Any of the following conditions are true:

Histologic Type ICD-O-3 is NOT 8000-9999

Behavior Code ICD-O-3 is NOT 0-3

Then perform the procedure described in Appendix 29 - Histology ICDO-3 Conversion Specifications and load the resulting Histologic Type ICD-O-3 value.

Otherwise, just load the transmitted value with no conversion. Also, see CS Version Derived.

UPDATE

Tumor Level

New Case Consolidation

If the admission's Behavior Code ICD-O-3 is not the same as the tumor's Behavior Code ICD-O-3, then list for review.

Manual Change to Histology (92-00) ICD-O-2 or Behavior (92-00) ICD-O-2

If Date of DX year <2001 and Histology (92-00) ICD-O-2 or Behavior (92-00) ICD-O-2 were changed, then perform the procedure described in Appendix 29 – Histology ICDO-3 Conversion Specifications and auto-update with the resulting>Behavior Code ICD-O-3 value.

Manual Change

Admission Level

Manual Change to Histology (92-00) ICD-O-2 or Behavior (92-00) ICD-O-2

If Date of Diagnosis year < 2001 and Histology (92-00) ICD-O-2 or Behavior (92-00) ICD-O-2 were changed, then perform the procedure described in Appendix 29 – Histology ICDO-3 Conversion Specifications and auto-update with the resulting Behavior Code ICD-O-3

Manual Change or Correction Applied

CONSOLIDATED DATA EXTRACT

Yes

HISTOICAL CHANGES

05/2001	New field added to collect ICD-O-3 behavior. Modified Edit 2) to pertain only to Region 1/8.
07/2001	Changed type to alphanumeric; allow 0 and 1 as allowable values; reworked edits to cover ICDO-2 and ICDO-3; removed ill-defined site/behavior edit because edit 327 on SITE page covers it; added edits to make sure behaviors 0 and 1 are used for the appropriate SITEs; changed new edit numbers since some of the old ones could be used here.
11/2002	Removed the histology range 8523-8524 from Interfield edit 1) to match the SEER MORPH_3 edit and allow behavior code 2.
03/2003	Removed specific Region 1/8 and Region 9 edit logic from Interfield edits 1) and 3).
03/2004	Added IF #517).
01/2005	Removed IF#517 per NAACCR's removal of this edit. Removed IF #443 to handle cases that were entered as /3 in ICD-0-2 and converted to borderline/1 in ICD-0-3.
02/2009	Added IF #829.
2010	Data Item Changes: CCR name (Hist_Behavior_3) changed to NAACCR name. CCR names and date checks changed in Source and Update. Added IF #383, 473, 474, 475, 476, 477, 482-483, 491, 534, 720, 721, 732, 748, 749, 750, 767, 779, 781, 789, 790, 793, 794, 797, 823, 824, 825, 826, 827, 843, 849, 876, 882, 874, 878, 880, 884, 958, 959, 960, 961, 962, 963, 964, 967, 909.
2011	Data Item Changes: Removed IF440 and 441 to match the deletion in the metafile. 05/2013
05/2013	Added IF 1005, 1006, 1007, 1008, 1009, 1010, 1011, 1012, 1013, 1014, 1015, 1016, 1017, 1018, 1019, 1020, 1021, 1022, 1023, 1024, 1025, 1026, 1027, 1028, 1029, 1030, 1031, 1032, 1033, 1034, 1035, 1036, 1037, 1038, 1039, 1040, 1041, 1042, 1051, 1052, 1053, 1054, 1055, 1056, 1057, 1058, 1059, 1060, 1061, 1062, 1063, 1065, 1066, 1067, 1069, 1070

Bill Flag

IDENTIFIERS*

CCR ID	NAACCR ID
None	None

* This item is not in the exchange record (Volume II, Appendix A) and does not have CCR or NAACCR identifiers.

NAACCR NAME

None

RASP NAME

None

DESCRIPTION

As a new case from a contract hospital is added, this flag is set to designate "to be billed". It is reset after the billing program is run. This item is not in the exchange record (Volume II, Appendix A).

LEVELS

Admissions

LENGTH

1

ALLOWABLE VALUES

0, 1-9

SOURCE

Computer generate based on information in Reporting Facility and Date of First Contact.

0	Not a Contract Hospital or Already Billed
1-9	To Be Billed (codes can be used to designate fee schedule as determined by regional registry)

UPDATE

Computer generate based on information in C/N #F01683 and C/N #F00024.

CONSOLIDATED DATA EXTRACT

No

HISTORICAL CHANGES

3/03	In the CCR central system (EUREKA), type became alpha-numeric (X) and the Allowable values edit (#026) was removed.

Bilirubin Pretreatment Total Lab Value

IDENTIFIERS

CCR ID	NAACCR ID
E1926	3813

OWNER

NAACCR

DESCRIPTION

Bilirubin Pretreatment Total Lab Value records the bilirubin value prior to treatment. Bilirubin level is an indicator of how effectively the liver excretes bile and is required to calculate the Model for End-Stage Liver Disease (MELD) score used to assign priority for liver transplant.

LEVELS

Admissions, Tumors

LENGTH

5

ALLOWABLE VALUES

0.0	0.0 milligram/deciliter (mg/dL) 0.0 micromole/liter (umol/L)
0.1 – 999.9	0.1-999.9 milligram/deciliter (mg/dL) 0.1-999.9 micromole/liter (umol/L)
XXX.1	1000 milligram/deciliter (mg/dL) or greater 1000 micromole/liter (umol/L) or greater
XXX.7	Test ordered, results not in chart
XXX.8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code XXX.8 will result in an edit error.)
XXX.9	Not documented in medical record Bilirubin Pretreatment Total Lab Value not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00220
        - Type of Reporting Source is not 7
        - COC Accredited Flag is 1
        - Bilirubin Pretreatment Total Lab Value is blank or XXX.8
          Then convert Bilirubin Pretreatment Total Lab Value to XXX.9

    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00220

OR

- Type of Reporting Source is 7

- Bilirubin Pretreatment Total Lab Value is not blank

Then convert Bilirubin Pretreatment Total Lab Value to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00220
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00220

One of the following conditions is true

- Admission's value is not blank, XXX.8, or XXX.9
- Tumor's value is blank , XXX.8, or XXX.9

OR

- Admission's value is XXX.9
- Tumor's value is blank or XXX.8

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Bilirubin Pretreatment Unit of Measure

IDENTIFIERS

CCR ID	NAACCR ID
E1927	3814

OWNER

NAACCR

DESCRIPTION

Bilirubin Pretreatment Unit of Measure identifies the unit of measure for the bilirubin value measured prior to treatment. Bilirubin is commonly measured in units of Milligrams/deciliter (mg/dL) in the United States and Micromoles/liter (umol/L) in Canada and Europe.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

1	Milligrams per deciliter (mg/dL)
2	Micromoles/liter (umol/L)
7	Test ordered, results not in chart
8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code 8 will result in an edit error.)
9	Not documented in medical record Bilirubin unit of measure not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
   A. If all of the following conditions are true:
      - Schema ID is 00220
      - Type of Reporting Source is not 7
      - COC Accredited Flag is 1
      - Bilirubin Pretreatment Unit of Measure is blank or 8

      Then convert Bilirubin Pretreatment Unit of Measure to 9
   B. If all of the following conditions are true:
      - One of the following is true:
        - Schema ID is not 00220

          OR
        - Type of Reporting Source is 7
      - Bilirubin Pretreatment Unit of Measure is not blank

      Then convert Bilirubin Pretreatment Unit of Measure to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00220
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00220

One of the following conditions is true

- Admission's value is not blank, 8, 9
- Tumor's value is blank, 8, or 9

OR

- Admission's value is 9
- Tumor's value is blank or 8

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Birthplace

IDENTIFIERS

CCR ID	NAACCR ID
E1035	250

DESCRIPTION

This data item has been retired and replaced by data items Birthplace--State [252] and Birthplace--Country [254]. This page has been retained for historical purposes only and this data item should not be populated in any cases diagnosed 2013 or later or coded under the NAACCR v13 or later coding standards.
State or country of the patient's birth.

LEVELS

Patients, Admissions

LENGTH

3

ALLOWABLE VALUES

000-999 (The entire range is not used; see Appendix D of Volume I.)

SOURCE

Since this data item has been retired this source logic should no longer be performed.
If the value is completely blank, then convert 999.
If the value includes a non-blank, non-numeric character, then convert 999.
Otherwise, just load the transmitted value, but right-justify and zero fill.

UPDATE

Since this data item has been retired this update logic should no longer be performed.
Patient Level

New Case Consolidation

If Admission level Birthplace <> 999 and Patient level Birthplace = 999, move Admission level Birthplace to Patient level Birthplace.

If Admission level Birthplace = 001-099 and Patient level Birthplace = 000, move Admission level Birthplace to Patient level Birthplace.

Manual Change

If Birthplace changes, through consolidation or manual change, then NHIA_Derived_Hisp_Origin must be regenerated.

Admission Level

Manual Change Only

List for Review

Admission level Birthplace (000-998) <> Patient level Birthplace (000-998) but excluding Admission level Birthplace = 001-099 and Patient level Birthplace = 000.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

1/05	Update Logic added for NHIA_Derived_Hisp_Origin regeneration.
2010	Data Item Changes: CCR name (Birth Place) changed to match NAACCR name.

2013 Data Changes	• This data item has been retired and replaced by Birthplace--State[252] and Birthplace--Country[254] • Removed IF655 and IF663.

Birthplace--Country

IDENTIFIERS

CCR ID	NAACCR ID
E1771	254

OWNER

NAACCR

DESCRIPTION

Code for the country in which the patient was born. If the patient has multiple tumors, all records should contain the same code. This data item became part of the NAACCR transmission record effective with Volume II, Version 13 in order to include country and state for each geographic item and to use interoperable codes. It supplements the item Birthplace--State [NAACCR #252]. These two data items are intended to replace the use of Birthplace [NAACCR #250].

LEVELS

Patients, Admissions

LENGTH

3

ALLOWABLE VALUES

See Volume I, Appendix D.1

SOURCE

1. Left-justify and upshift (but don't record these changes in the audit log).
2. If Coding Procedure is 30 or 31, then

If Birthplace--Country =	Then convert Birthplace--Country to
XCZ	CSK
XYG	YUG
BND	BRN
SWK	SVK
VLT	VUT

3. If coding procedure is less than 30 and Birthplace--Country is blank, then
   If Birthplace [250] is 000-999 and can be found in Appendix 32 Country/Country/State Crosswalk, then
   Generate Birthplace--Country using the crosswalk table in Appendix 32 Country/Country/State Crosswalk, and Birthplace [250]
   Else
   Generate ZZU (unknown)
   Else
   Load without conversion

UPDATE

Patient level
Consolidation

If Admission level Birthplace--Country is not ZZU or ZZX and
If Patient level Birthplace--Country is ZZU or ZZX and
If a match can be found in Appendix 31 State/Country Crosswalk for the Patient level Birthplace--State and the Admission level Birthplace--Country then
Update
Else
List for review

Manual change
If there is a change to Birthplace--State, attempt to regenerate Birthplace--Country using the crosswalk table in Appendix 31 State/Country Crosswalk and Birthplace--State.

Admission level

Manual change
If there is a change to Birthplace--State, attempt to regenerate Birthplace--Country using the crosswalk table in Appendix 31 State/Country Crosswalk and Birthplace--State.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

05/2013	New data item for 2013. Added IF 1002, 1003 Added ER 1130
03/2015	Per NAACCR v15, the historic codes XYG, XCZ, BND, SWK, and VLT converted to active ISO codes; updated SOURCE logic to include the conversions upon upload.
04/2017	Revised Source Logic

Birthplace--State

IDENTIFIERS

CCR ID	NAACCR ID
E1770	252

OWNER

NAACCR

DESCRIPTION

USPS abbreviation for the state, commonwealth, U.S. possession; or Canada Post abbreviation for the Canadian province/territory in which the patient was born. If the patient has multiple primaries, the state of birth is the same for each tumor. This data item became part of the NAACCR transmission record effective with Volume II, Version 13 in order to include country and state for each geographic item and to use interoperable codes. It supplements the item BIRTHPLACE--COUNTRY [254]. These two data items are intended to replace the item BIRTHPLACE [250].

LEVELS

Patients, Admissions

LENGTH

2

ALLOWABLE VALUES

AK-WY	US States/Territories
AA-AP	United States Military Personnel Serving Abroad
AB-YT	Canadian Provinces/Territories
MM-YN	Historic Custom Codes (States/Provinces)
CD	Canada, NOS
US	Resident of United States, NOS
XX	Not U.S., U.S. Territory, not Canada, and country is known
YY	Not U.S., U.S. Territory, North American Islands, not Canada, and country is unknown
ZZ	Residence is unknown

See Volume I, Appendix B for all Postal Abbreviations for states/territories

SOURCE

1. Left-justify and upshift (but don't record these changes in the audit log).
2. If Coding_Proc is less than 30 and Birthplace--State is blank, then:

    If Birthplace [250] is 000-999 and can be found in Appendix 32 Country/Country/State Crosswalk, then

        Generate Birthplace--State using the crosswalk table in Appendix 32 Country/Country/State Crosswalk and Birthplace [250]

    Else

        Generate ZZ (unknown)

    Else

        Load without conversion

UPDATE

Patient Level

Consolidation

If Admission level Birthplace--State is not YY or ZZ and
If Patient level Birthplace--State is YY or ZZ then
Update
Else
List for review

Manual change

Admission Level

Manual change

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

05/2013	New data item for 2013 Added IF 1003, 1004 Added ER 1116
07/2014	Clarified allowable values and corrected Volume I reference from Appendix D to Appendix B.
04/2017	Revised Source Logic.

Bone Invasion

IDENTIFIERS

CCR ID	NAACCR ID
E1928	3815

OWNER

NAACCR

DESCRIPTION

Bone invasion, the presence or absence of bone invasion based on imaging, is a prognostic factor for soft tissue sarcomas.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	Bone invasion not present/not identified on imaging
1	Bone invasion present/identified on imaging
8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code 8 may result in an edit error.)
9	Not documented in medical record Bone invasion not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

3. If Date of Diagnosis is less than 2018, then blank out field
4. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00400, 00410, 00421, 00422, 00440, 00450
        - Type of Reporting Source is not 7
        - Bone Invasion is blank or 8

        Then convert Bone Invasion to 9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00400, 00410, 00421, 00422, 00440, 0045

            OR
            - Type of Reporting Source is 7
        - Bone Invasion is not blank

        Then convert Bone Invasion to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00400, 00410, 00421, 00422, 00440, 0045
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00400, 00410, 00421, 00422, 00440, 0045

One of the following conditions is true

- Admission's value is not blank, 9
- Tumor's value is blank, 9

  OR

  - Admission's value is 9
  - Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.
Otherwise,
If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Brain Molecular Markers

IDENTIFIERS

CCR ID	NAACCR ID
E1929	3816

OWNER

NAACCR

DESCRIPTION

Multiple brain molecular markers have become standard pathology components necessary for diagnosis. This data item captures clinically important brain cancer subtypes identified by molecular markers that are not distinguishable by ICD-O-3 codes.

LEVELS

Admissions, Tumors

LENGTH

2

ALLOWABLE VALUES

01	Diffuse astrocytoma, IDH-mutant (9400/3)
02	Diffuse astrocytoma, IDH-wild type (9400/3)
03	Anaplastic astrocytoma, IDH-mutant (9401/3)
04	Anaplastic astrocytoma, IDH-wild type (9401/3)
05	Glioblastoma, IDH-wild type (9440/3)
06	Oligodendroglioma, IDH-mutant and 1 p/19q co-deleted (9450/3)
07	Anaplastic oligodendroglioma, IDH-mutant and 1 p/19q co-deleted (9451/3)
08	Medulloblastoma, SHH-activated and TP53-wildtype (9471/3)
09	Embryonal tumor with multilayered rosettes, C19MC-altered (9478/3)
85	Not applicable: Histology not 9400/3, 9401/3, 9440/3, 9450/3, 9451/3, 9471/3, 9478/3
86	Benign or borderline tumor
87	Test ordered, results not in chart
88	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code 88 will result in an edit error.)
99	Not documented in patient record No microscopic confirmation Brain molecular markers not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    a. If all of the following conditions are true:
        - Schema ID is 00721, 00722
        - Type of Reporting Source is not 7
        - Brain Molecular Markers is blank or 88

Then convert Brain Molecular Markers to 99

b. If all of the following conditions are true:
   - One of the following is true:
     - Schema ID is not 00721, 00722
       OR
     - Type of Reporting Source is 7
   - Brain Molecular Markers is not blank

   Then convert Brain Molecular Markers to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00721, 00722
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00721, 00722

One of the following conditions is true

- Admission's value is not blank, 99
- Tumor's value is blank, 99

  OR
  - Admission's value is 99
  - Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.
02/2020	Description Update

Breslow Tumor Thickness

IDENTIFIERS

CCR ID	NAACCR ID
E1930	3817

OWNER

NAACCR

DESCRIPTION

Breslow Tumor Thickness, the measurement of the thickness of a melanoma as defined by Dr. Alexander Breslow, is a prognostic factor for Melanoma of the Skin.

LEVELS

Admissions, Tumors

LENGTH

4

ALLOWABLE VALUES

0.0	No mass/tumor found
0.1	Greater than 0.0 and less than or equal to 0.1
0.2-99.9	0.2 - 99.9 millimeters
XX.1	100 millimeters or larger
A0.1-A9.9	Stated as "at least" some measured value of 0.1 to 9.9
AX.0	Stated as greater than 9.9 mm
XX.8	Not applicable: Information not collected for this schema (If this item is required by your standard setter, use of code XX.8 will result in an edit error)
XX.9	Not documented in medical record Microinvasion; microscopic focus or foci only and no depth given Cannot be determined by pathologist In situ melanoma Breslow Tumor Thickness not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00470
        - Type of Reporting Source is not 7
        - Behavior ICD-O-3 = 2
        - Breslow Tumor Thickness is not XX.9

        Then convert Breslow Tumor Thickness to XX.9
    B. If all of the following conditions are true:
        - Schema ID is 00470
        - Type of Reporting Source is not 7

- Behavior ICD-O-3 not 2
- Breslow Tumor Thickness is blank or XX.8

Then convert Breslow Tumor Thickness to XX.9

C. If all of the following conditions are true:

- One of the following is true:
  - Schema ID is not 00470

  OR
  - Type of Reporting Source is 7
- Breslow Tumor Thickness is not blank

Then convert Breslow Tumor Thickness to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00470
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00470

One of the following conditions is true

- Admission's value is not blank, XX.9
- Tumor's value is blank, XX.9

  OR
  - Admission's value is XX.9
  - Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

BRM 1-2 NSC Number

IDENTIFIERS

Data Item	CCR	NAACCR
BRM 1 NSC Number	E1511	9871
BRM 2 NSC Number	E1512	9872

DESCRIPTION

This data item has been retired. This page has been retained for historical purposes only and this data item should not be populated in any cases diagnosed 2013 or later or coded under the NAACCR v13 or later coding standards.
NSC number for a BRM agent administered as all or part of the first course of treatment at any facility.

LEVELS

Tumors, Admissions

LENGTH

6

ALLOWABLE VALUES

000000	BRM therapy was not planned to be administered OR no additional BRM therapy agents were planned
######	NSC code (enter the actual code)
777777	Bone marrow transplant, stem cell harvests, or surgical and/or radiation endocrine therapy
999998	BRM therapy was planned, but the agent NSC code is unknown; the code "999998" is a temporary code that registries should use while they contact ICF Macro to obtain a permanent code to enter for agents that do not have SEER*Rx-assigned NSC codes.
999999	Unknown if BRM therapy was planned
Blank	A blank is allowed for cases • Diagnosed prior to 2011 • Diagnose date 2011 and not a Region 3 resident • Region 3 resident and sites other than Breast, Colorectal, and CML

SOURCE

N/A

UPDATE

N/A

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

2011 Data Item Changes, CER Project	Added for CER requirements.
05/2013	Retired at the conclusion of data collection for the CER project

CA-125 Pretreatment Interpretation

IDENTIFIERS

CCR ID	NAACCR ID
E1931	3818

OWNER

NAACCR

DESCRIPTION

Carbohydrate Antigen 125 (CA-125) is a tumor marker that is useful for following the response to therapy in patients with ovarian cancer, who may have elevated levels of this marker.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	Negative/normal; within normal limits
1	Positive/elevated
2	Stated as borderline; undetermined whether positive or negative
7	Test ordered, results not in chart
8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code 8 will result in an edit error)
9	Not documented in medical record CA-125 not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00551, 00552, 00553
        - Type of Reporting Source is not 7
        - CA-125 Pretreatment Interpretation is blank or 8

        Then convert Percent Necrosis Post Neoadjuvant to 9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00551, 00552, 00553

            OR
            - Type of Reporting Source is 7
        - CA-125 Pretreatment Interpretation is not blank

        Then convert CA-125 Pretreatment Interpretation to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00551, 00552, 00553
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00551, 00552, 00553

One of the following conditions is true

- Admission's value is not blank, 9
- Tumor's value is blank, 9

OR

- Admission's value is 9
- Tumor's value is blank or 8

Then automatically update the Tumor's value with the Admission's value.
Otherwise,
If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Cancer Status

IDENTIFIERS

CCR ID	NAACCR ID
E1519	1770

DESCRIPTION

Status of this tumor at time of last tumor follow-up.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

1	Free of this tumor
2	Not free of this tumor
9	Tumor status unknown

SOURCE

If the transmitted value is numeric, then just load it with no conversion. Otherwise, convert it to 9.

UPDATE

Tumor Active Follow-up Fields Update Logic

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

2010:	Data Item Changes: CCR name (Tum_Status) changed to NAACCR name. Revised *Update* logic based on new date criteria.

Casefinding Source

IDENTIFIERS

CCR ID	NAACCR ID
E1072	501

DESCRIPTION

Source of casefinding, i.e. method used to first identify the case by this reporting source.

LEVELS

Admissions

LENGTH

2

ALLOWABLE VALUES

Case first identified in a cancer-reporting facility:

10	Reporting Hospital, NOS
20	Pathology Department Review
21	Daily Discharge Review
22	Disease Index Review
23	Radiation Therapy Department/Center
24	Laboratory Reports
25	Outpatient Chemotherapy
26	Diagnostic Imaging/Radiology
27	Tumor Board
28	Hospital Rehabilitation Service or Clinic
29	Other Hospital Source, including Clinic, NOS or OPD, NOS

Case first identified by source other than a cancer reporting facility:

30	Physician-initiated case
40	Consultation-only or Pathology-only report
50	Private Pathology Laboratory Report
60	Nursing-Home-Initiated case
70	Coroner's-Office Records Review
75	Managed Care Organization (MCO) or Insurance Records
80	Death Certificate Follow-back
85	Out-of-state Case Sharing
90	Other Non-Reporting Hospital Source
95	Quality Control Review
99	Unknown

SOURCE

If Other_Reg_ID loaded is alphabetic or 98, then automatically generate 85. Otherwise upload with no conversion.

UPDATE

Manual Update or Correction/Update Record Applied

CONSOLIDATED DATA EXTRACT

Yes, earliest admission date.

HISTORICAL CHANGES

1/1/99	Code 85 added to allowable values; auto coding for code 85 from OTHER-REG-ID added to source section.
7/27/05	New data item for NAACCR so updated name & number. Data item will be moved from column 1591-1592 to 322-323 in the NAACCR Record Layout. Changed CCR name (Was Case_Find) to NAACCR name.
2/01/06	Added code 75 to Allowable Values. The CCR was originally going to delay this code addition until 2007, but it must be added for 2006 to meet NPCR requirements. Code 75 will be restricted for use by the regional registries only, although we anticipate this code will be rarely used in California.
2010	2010 Data Changes: Changed Update logic (was List for review).

Cause of Death

IDENTIFIERS

CCR ID	NAACCR ID
E1534	1910

DESCRIPTION

Underlying cause of death on the death certificate, as assigned and coded by the Department of Health Services on the electronic death certificate master file.

LEVELS

Patients, Admission

LENGTH

4

ALLOWABLE VALUES

0000	Patient not dead
7777	Death certificate not (yet) available
7797	Death certificate was available but cause of death not coded
Other	Cause of death as coded by DHS except, if the 4th digit is X, hyphen (-), or blank, a 9 is substituted
See CCR Edit IFCOD for additions to ICD-A 9th Rev. codes 0420, 0421, 0422, 0429, 0430, 0431, 0432, 0433, 0439, 0440, 0449 and 7958.	

Notes:

1969-78 deaths = ICD-A 8th Rev.
1979-98 deaths = ICD-A 9th Rev.
1999 deaths forward = ICD10

SOURCE

Computer generate a code (0000 if AD_Vital_Status = 1 and 7777 if AD_Vital_Status = 0) until the official cause of death code is provided by the CCR, except accept a non-zero Cause of Death when Hosp_No = 0000000801, 0000000802, 0000000803, 0000000804, 0000999996 or when Other Reg ID <> blank.
Upshift, but do not write the upshift change to Audit Log.

UPDATE

Patient Active Follow-up Fields Update Logic

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/00	Changed from numeric to alphanumeric field. Will begin receiving ICD10 Cause_Death codes with 1999 deaths.
3/03	Extended year range in allowable value note in coding 1979-92 deaths to 1979-98 deaths. Added 4 leading zeroes in hospital numbers listed in Source. Update logic added for Active & Passive Follow-up. Removed List for Review.
7/06	Updated reference in IF 377.
10/07	Changed definition of 7797 in Allowable Values to match NAACCR (was noted for Region 8 cases only).

2010	Data Changes: CCR name (Cause_Death) changed to NAACCR name. Update logic rewritten.

CEA Pretreatment Interpretation

IDENTIFIERS

CCR ID	NAACCR ID
E1932	3819

OWNER

NAACCR

DESCRIPTION

CEA (Carcinoembryonic Antigen) Pretreatment Interpretation refers to the interpretation of the CEA value prior to treatment. CEA is a glycoprotein that is produced by adenocarcinomas from all sites as well as many squamous cell carcinomas of the lung and other sites. CEA may be measured in blood, plasma or serum. CEA is a prognostic marker for adenocarcinomas of the appendix, colon and rectum and is used to monitor response to treatment.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	CEA negative/normal; within normal limits
1	CEA positive/elevated
2	Borderline
3	Undetermined if positive or negative (normal values not available) AND no MD interpretation
7	Test ordered, results not in chart
8	Not applicable: Information not collected for this case (If this data item is required by your standard setter, use of code 8 will result in an edit error.)
9	Not documented in medical record CEA (Carcinoembryonic Antigen) Pretreatment Interpretation not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

3. If Date of Diagnosis is less than 2018, then blank out field
4. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00190 or 00200
        - Type of Reporting Source is not 7
        - CEA Pretreatment Interpretation is blank or 8

        Then convert CEA Pretreatment Interpretation to 9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00190 or 00200

OR

- Type of Reporting Source is 7

- CEA Pretreatment Interpretation is not blank

Then convert CEA Pretreatment Interpretation to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00190 or 00200
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00190 or 00200

One of the following conditions is true

- Admission's value is not blank, 8, or 9
- Tumor's value is blank , 8, or 9

OR

- Admission's value is 9
- Tumor's value is blank or 8

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

CEA Pretreatment Lab Value

IDENTIFIERS

CCR ID	NAACCR ID
E1933	3820

OWNER

NAACCR

DESCRIPTION

CEA (Carcinoembryonic Antigen) Pretreatment Lab Value records the CEA value prior to treatment. CEA is a nonspecific tumor marker that has prognostic significance for colon and rectum cancer.

LEVELS

Admissions, Tumors

LENGTH

6

ALLOWABLE VALUES

0.0	0.0 nanograms/milliliter (ng/m) exactly
0.1 – 9999.9	0.1-9999.9 ng/ml (Exact value to nearest tenth in ng/ml)
XXXX.1	10,000 ng/ml or great rumor necrosis present, percent not stated
XXXX.7	Test ordered, results not in chart
XXXX.8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code XXXX.8 may result in an edit error.)
XXXX.9	Not documented in medical record CEA (Carcinoembryonic Antigen) Pretreatment Lab Value not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00190 or 00200
        - Type of Reporting Source is not 7
        - CEA Pretreatment Lab Value is blank or XXXX.8

        Then convert CEA Pretreatment Lab Value to XXXX.9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00190 or 00200

            OR
            - Type of Reporting Source is 7
        - CEA Pretreatment Lab Value is not blank

Then convert CEA Pretreatment Lab Value to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00190 or 00200
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00190 or 00200

One of the following conditions is true

- Admission's value is not blank, XXXX.8, or XXXX.9
- Tumor's value is blank , XXXX.8, or XXXX.9

OR

- Admission's value is XXXX.9
- Tumor's value is blank or XXXX.8

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Census Block 90

IDENTIFIERS

CCR-ID	NAACCR ID
e1570	None. State Requestor

DESCRIPTION

Block Groups (BG's) are defined within the Census Tract. They are a set of blocks sharing the same first digit within a Census Tract. For example, BG 3 within a particular Census Tract would include any blocks numbered between 301 and 399.

LEVELS

Tumors

LENGTH

1

ALLOWABLE VALUES

Any numeric or blank (not tracted).

SOURCE

Set to blank

UPDATE

Whenever Census Tract 1970/80/90 is changed, Census_Block_90 must be changed accordingly.
If Census Tract 1970/80/90 is untracted then Census_Block_90 must be blank.
If Census Tract 1970/80/90 is tracted and a Census_Block_90 tracted code is available (whether through geocoding, linking a tumor with a tracted address, or manual entry of a Census_Block_90 value) the available Census_Block_90 code should be used.
However, if Census Tract 1970/80/90 is tracted but Census_Block_90 is not available Census_Block_90 should be set to blank.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

	None

Census Block 2000

IDENTIFIERS

CCR ID	NAACCR ID
E1616	None. State Requestor

DESCRIPTION

A census block is the smallest geographical unit used by the U.S. Census Bureau. The first number of the census block indicates which block group the block is in.

LEVELS

Tumors

LENGTH

4

ALLOWABLE VALUES

Numeric or blank

SOURCE

Set to blank

UPDATE

Whenever Census Tract 2000 is changed, Census Block 2000 must be changed accordingly.

- If Census Tract 2000 is untracted then Census Block 2000 must be blank.
- If Census Tract 2000 is tracted and a Census Block 2000 tracted code is available (whether through geocoding, linking a tumor with a tracted address, or manual entry of a Census Block 2000 value) the available Census Block 2000 code should be used.
- However, if Census Tract 2000 is tracted but Census Block 2000 is not available Census Block 2000 should be set to blank.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/15/00	New data item added for Year 2000 census.
5/15/01	Data item expanded from one to four digits to specify complete block.
2010	2010 Data Item Changes: CCR name (Census Block 00) changed to be consistent with NAACCR naming conventions.
3/14/11	Changed Allowable Values to Numeric or blank per Holly Hodges and Winny Roshala email. Also updated description section.

Census Block 2010

IDENTIFIERS

CCR ID	NAACCR ID
E1763	None. State Requestor

DESCRIPTION

Census Block 2010 captures the value of both the 2010 Census Block and the 2010 Census Group. A census block is the smallest geographical unit used by the U.S. Census Bureau. A block group is a set of blocks sharing the same first digit of the four-digit block within a Census Tract. For example, block group 3 within a particular Census Tract would include any blocks numbered between 301 and 399. The first digit of this variable identifies the 2010 Census Block Group. The 3 digits of this variable, taken as whole, identify the 2010 Census Block.

Eureka stores Census Block 2010 in the database and can parse Block Group from Block, if needed. This number is supplied by Geocoding. Volume II, Appendix A does not require it from vendor software.

LEVELS

Tumors

LENGTH

4

ALLOWABLE VALUES

Numeric or blank

SOURCE

Set to blank

UPDATE

Whenever Census Tract 2010 is changed, Census Block 2010 must be changed accordingly.

- If Census Tract 2010 is untracted ('999993' or '999996') then Census Block 2010 must be blank.
- If Census Tract 2010 is tracted and a Census Block 2010 tracted code is available (whether through geocoding, linking a tumor with a tracted address, or manual entry of a Census Block 2010 value) the available Census Block 2010 code should be used.
- However, if Census Tract 2010 is tracted but Census Block 2010 is not available, Census Block 2010 should be set to blank

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/14/2011	This item added for 2011 data changes.
3/1/12	Description updated and code range added to Update logic for untracted definition in first bullet.

Census Block Group 2020

IDENTIFIERS

CCR ID	NAACCR ID
E1840	361

DESCRIPTION

Census Block Group 2020 captures the value of both the 2020 Census Block and the 2020 Census Group. A census block is the smallest geographical unit used by the U.S. Census Bureau. A block group is a set of blocks sharing the same first digit of the four-digit block within a Census Tract. For example, block group 3 within a particular Census Tract would include any blocks numbered between 301 and 399. The first digit of this variable identifies the 2020 Census Block Group. The 3 digits of this variable, taken as whole, identify the 2020 Census Block Group.
Eureka stores Census Block Group 2020 in the database and can parse Block Group from Block, if needed. This number is supplied by Geocoding. Volume II, Appendix A does not require it from vendor software.

LEVELS

Tumors

LENGTH

4

ALLOWABLE VALUES

Numeric or blank

SOURCE

Set to blank

UPDATE

Whenever Census Tract 2020 is changed, Census Block Group 2020 must be changed accordingly.

- If Census Tract 2020 is untracted ('999993' or '999996') then Census Block Group 2020 must be blank.
- If Census Tract 2020 is tracted and a Census Block Group 2020 tracted code is available (whether through geocoding or linking a tumor with a tracted address) the available Census Block Group 2020 code should be used.
- However, if Census Tract 2020 is tracted but Census Block Group 2020 is not available, Census Block Group 2020 should be set to blank

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new geocode data field implemented.

Census Cod Sys 1970/80/90

IDENTIFIERS

CCR ID	NAACCR ID
E1015	120

DESCRIPTION

Identified the set of Census Bureau census tract definitions (boundaries) that were used to code the census tract in Census Tract 1970/80/90 for a specific record.

LEVELS

Tumors

LENGTH

1

ALLOWABLE VALUES

Replace or None or use table for lists

0	Not Tracted
1	1970 Census Tract Definitions
2	1980 Census Tract Definitions
3	1990 Census Tract Definitions
Blank	Census Tract 1970/80/90 not coded

SOURCE

See Extract

UPDATE

None

CONSOLIDATED DATA EXTRACT

Generate 3 (1990 Census Tract Definitions) on extract.

HISTORICAL CHANGES

8/15/06	Generated item in Volume II added to Volume III with 2007 data changes.

Census Ind Code 2010 CDC

IDENTIFIERS

CCR ID	NAACCR ID
E1775	272

OWNER

Census/NPCR

DESCRIPTION

Code for the patient's usual industry, using U.S. Census Bureau codes (see note below) according to coding procedures recommended for death certificates. This data item applies only to patients who are age 14 years or older at the time of diagnosis. Usual industry refers to the type of activity at the patient's place of work for most of his or her working life.
Note: Occupation/industry coding should NOT be performed by reporting facilities. This is a central cancer registry data item. Specially trained and qualified personnel should perform coding.

LEVELS

Tumors

LENGTH

4

ALLOWABLE VALUES

Census codes for industry are routinely updated to include new or more detailed codes. The 4-digit 2010 Census industry codes are the most recent codes for industry and are recommended for tumors diagnosed on or after January 1, 2013. The Census industry codes for 2010 may be used for earlier diagnosis years. See the U.S. Census Bureau websites at: https://www.census.gov/topics/employment/industry-occupation/guidance/indexes.html and https://www.census.gov/programs-surveys/acs/data.html

2010 NIOSH Codes for Non-Paid Worker Titles:

9880	Retired
9890	Housewife, homemaker, volunteers, student, child or infant, patient, disabled, inmate, or individual who did not work
9990	Blank text, unknown, don't know, not applicable, refused, or information is inadequate to select a code
Blank	Coding of Census Ind Code 2010 CDC not attempted

SOURCE

N/A

UPDATE

Tumor Level
- New Case Consolidation
  - If Text--Usual Industry changes, reset Census Ind Code 2010 CDC to [blank]
- Manual Change to Text--Usual Industry
  - If Text--Usual Industry changes, reset Census Ind Code 2010 CDC to [blank]
- Manual Change

Admission Level
- Manual Change to Text--Usual Industry

If Text--Usual Industry changes, reset Census Ind Code 2010 CDC to [blank]

Manual Change

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

05/2013	New data item for 2013
05/2016	Per NAACCR v16, data item name revised from "Census Ind Code 2010" to "Census Ind Code 2010 CDC."
03/2020	Allowable Values Added

Census Occ Code 2010 CDC

IDENTIFIERS

CCR ID	NAACCR ID
E1776	282

OWNER

Census/NPCR

DESCRIPTION

Code for the patient's usual occupation, using U.S. Census Bureau codes (see note below) according to coding procedures recommended for death certificates.22 This data item applies only to patients who are age 14 years or older at the time of diagnosis. Usual occupation is defined as type of job the patient was engaged in for most of his or her working life. Note: Occupation/industry coding should NOT be performed by reporting facilities. This is a central registry data item. Specially trained and qualified personnel should perform coding.

LEVELS

Tumors

LENGTH

4

ALLOWABLE VALUES

Codes for occupation are routinely updated to include new or more detailed codes. The 4-digit 2010 occupation codes from the U.S. Census Bureau and NIOSH are the most recent codes for occupation. When assigning occupation codes, central registries should use the most recent code set available. The occupation codes for 2010 may be used for earlier diagnosis years. Cases already coded with older occupation codes do not have to be recoded to the 2010 codes.

Valid codes for occupation include the U.S. Census codes and the NIOSH non-paid worker codes (listed below). CDC has combined these two sets of codes into a PHIN-VADS value set located here: http://phinvads.cdc.gov/vads/ViewValueSet.action?id=1445D71C-F37F-4504-8B6C-BA48C5A3F4CA

2010 NIOSH Occupation Codes for Non-Paid Worker Titles:

9010	Housewife, homemaker
9020	Volunteers
9050	Student
9060	Retired
9100	Child or infant, patient, disabled, inmate, or individual who did not work
9900	Blank text, unknown, don't know, not applicable, refused or information is inadequate to select a code
Blank	Coding of Census Occ Code 2010 CDC not attempted

SOURCE

N/A

UPDATE

Tumor Level

New Case Consolidation

If Text--Usual Occupation changes, reset Census Occ Code 2010 CDC to [blank]

Manual Change to Text--Usual Occupation

If Text--Usual Occupation changes, reset Census Occ Code 2010 CDC to [blank]

Manual Change

Admission Level

Manual Change to Text--Usual Occupation

If Text--Usual Occupation changes, reset Census Occ Code 2010 CDC to [blank]

Manual Change

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

05/2013	New data item for 2013
05/2016	Per NAACCR v16, data item name revised from "Census Occ Code 2010" to "Census Occ Code 2010 CDC."
03/2020	Allowable Values Added

Census Occ/Ind 70-00

IDENTIFIERS

CCR ID	NAACCR ID
E1042	330

DESCRIPTION

Code that identifies coding system used for occupation and industry. This is a central cancer registry data item (i.e., codes should be applied by a central or regional registry rather than collected from reporting facilities).

LEVELS

Tumors

LENGTH

1

ALLOWABLE VALUES

Replace or None or use table for lists

1	1970 Census
2	1980 Census
3	1990 Census
4	2000 Census
5	2010 Census
7	Other coding system
9	Unknown coding sysem
Blank	Not collected

SOURCE

N/A

UPDATE

None

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

2012	2012 Data Changes: Added code 5 for 2010 Census.
05/2013	Name changed from Occup/Ind Coding System to Census Occ/Ind Sys 70-00.
03/2020	Added back to Volume III

Census Place 00

IDENTIFIERS

CCR ID	NAACCR ID
E1617	None: State Requestor

OWNER

CCR

DESCRIPTION

Five digit code from the 2000 Census for Census Designated Place.

LEVELS

Tumors

LENGTH

5

ALLOWABLE VALUES

Any numeric or blank (not tracted)

SOURCE

Set to blank.

UPDATE

Whenever Census Tract 2000 is changed, Census_Place_2000 must be changed accordingly.
If Census Tract 2000 is untracted then Census Place 2000 must be blank.
If Census Tract 2000 is tracted and a Census Place 2000 tracted code is available (whether through geocoding, linking a tumor with a tracted address, or manual entry of a Census Place 2000 value) the available Census Place 2000 code should be used.
However, if Census Tract 2000 is tracted but Census Place 2000 is not available Census Place 2000 should be set to blank.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

05/2001	New data item added to CCR dataset
07/2001	Changed interfield edit number from 449 to 442.
2010	Data Changes: CCR name (Census Place 00) changed to be consistent with NAACCR naming conventions.
03/2020	Added back to Volume III

Census Source 00

IDENTIFIERS

CCR ID	NAACCR ID
E1610	None: State Requestor

OWNER

CCR

DESCRIPTION

Field which tracks how and where Year 2000 (Census_Tract_2000 and Census_Block_2000) was performed.

LEVELS

Tumors

LENGTH

2

ALLOWABLE VALUES

Two-digit field with codes as follows:

First digit (how geocoding performed)

1	Batch computerized geocoding (automatic, non-interactive)
2	Interactive computerized geocoding (done with a software program, but individual makes decision)
3	Manual (using source other than computer software program such as maps, contacting local planning departments, etc.)
4	Hard Geocode. (This address represents an institution (prison, veteran's home, etc.) that may be reported with many variations of the same address but should always be geocoded to the same location. Eureka recognizes these addresses and automatically sets the geocode values.)
9	Year 2000 geocodes not assigned

Second digit (where performed)

1	GDT
2	Teale
3	CCR
4	Region
5	USC Spatial Sciences
6	Market Maps
7	NAACCR Geocoder
8	Non-specified
9	Year 2010 geocodes not assigned

SOURCE

Set to blank.

UPDATE

Whenever Census Tract 2000 is changed Census Source 2000 must be changed accordingly:

1. If Census Tract 2000 is 999996 or 999997 (waiting for geocoding),
   Then Census Source 2000 must be set to 99.
2. If Census Tract 2000 cannot be tracted (999993 or 999998-999999),
   Then Census Source 2000 must be 99.
3. If Census Tract 2000 is tracted using batch geocoding by the current vendor,
   Then change Census Source 2000 to 1 in the first digit and the associated vendor code in the second digit.
4. If Census Tract 2000 is tracted using interactive (console) geocoding the current vendor,
   Then change Census Source 2000 to 2 in the first digit and the associated vendor code in the second digit.
5. If Census Tract 2000 is tracted using manual (console) geocoding by the current vendor,
   Then change Census Source 2000 to 1 in the first digit and the associated vendor code in the second digit.
6. If Census-Tract 2000 is tracted manually by region/central registry staff,
   Then change Census Source 2000 to 34.

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

03/2000	New data item added for Year 2000 census.
07/2000	Updated but reason not specified.
2010	2010 Data Changes: CCR name change for consistency in naming (was Census Source 00).
2011	Date approximate. Second Digit updated to include 5, USC Spatial Sciences as an allowable value.
03/2012	Add value 4 to first digit values to match the Eureka changes taking place with 10.2 release. Consolidation logic updated.
07/2012	Added codes 6, 7, and 8 to allowable values for the Second Digit.
03/2020	Added back to Volume III

Census Source 2010

IDENTIFIERS

CCR ID	NAACCR ID
E1762	None: State Requestor

OWNER

CCR

DESCRIPTION

Tracks how and where geocoding was performed for the variables Census Tract 2010 and Census Block 2010.

LEVELS

Tumors

LENGTH

2

ALLOWABLE VALUES

Two-digit field with codes as follows:

First digit (how geocoding performed)

1	Batch computerized geocoding (automatic, non-interactive)
2	Interactive computerized geocoding (done with a software program, but individual makes decision)
3	Manual (using source other than computer software program such as maps, contacting local planning departments, etc.)
4	Hard Geocode. (This address represents an institution (prison, veteran's home, etc.) that may be reported with many variations of the same address but should always be geocoded to the same location. Eureka recognizes these addresses and automatically sets the geocode values.)
9	Year 2010 geocodes not assigned

Second digit (where performed)

1	GDT
2	Teale
3	CCR
4	Region
5	USC Spatial Sciences
6	Market Maps
7	NAACCR Geocoder
8	Non-specified
9	Year 2010 geocodes not assigned

SOURCE

Geocoding upload program and manual coding by the region.

UPDATE

Whenever Census Tract 2010 is changed Census Source 2010 must be changed accordingly:

If Census Tract 2010 is 999993, 999994, or 999996,

then Census Source 2010 must be set to 99.

If Census-Tract 2010 cannot be tracted (999999)
then Census Source 2010 must be 99.
If Census Tract 2010 is tracted manually by current commercial geocoding vendor,
then change Census Source 2010 to 3 in the first digit and the associated vendor code in the second digit.
If Census-Tract 2010 is tracted manually by region/central registry staff,
then change Census Source 2010 to 34.

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

03/04/2011	New data item added for 2011 data changes.
03/01/2012	Revised update specification to reflect the actual process per Eureka and geocoding advisor.
07/20/2012	Added codes 6, 7, and 8 to allowable values for the Second Digit.
07/2014	Clarified description.

Census Tract 1970/80/90

IDENTIFIERS

CCR-ID	NAACCR ID
E1013	110

DESCRIPTION

Census tract of usual residence when this tumor was first diagnosed, using 1990 census tract boundaries. Refer to the GIS Guide for CCR and Regional Registries for more detailed information.

LEVELS

Tumors

LENGTH

6

ALLOWABLE VALUES

Refer to the codes provided by the private vendor (currently Tele Atlas/GDT) that is contracted to do geocoding or the codes returned by the CCR-approved publicly available geocoding website (currently American FactFinder)." Enter 0's for any leading or trailing blanks.
The following (not tracted or not tractable) codes are also used:

999993	Unknown street address or unknown city, but state is California
999994	PO Boxes for California residents only
999995	Neither manual nor machine tracting has been successful
999996	Not yet submitted for tracting
999997	Submitted for tracting once - unsuccessfully
999998	California case - not machine tractable
999999	Non-California resident or unknown residence

SOURCE

Computer generate:

999999	If AD_Addr at DX--State <> CA, else
999993	If Addr at DX--No and Street = UNKNOWN or Addr at DX--City =UNKNOWN, else
999994	If Addr at DX--No and Street begins PO BOX, else
999996	If none of the above

UPDATE

As census tracts are determined via the geocoding process, add the census tract codes to the database, either manually or by computer.
Reset Census Tract 90 to 999993, 999994, 999996 or 999999 (see Source), if TU Addr at DX--No and Street, TU_Addr at DX--City, TU_Addr at DX--State, TU_Addr at DX--Postal Code, or TU_County at DX is changed. (Don't reset if only TU_County at DX was changed as a result of geocoding.)
Allow user to specify that the code should not be reset while manually changing one or more of the preceding fields.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

1/05	Allowable Values edit should be 27 (was 41).

7/05	Updated Allowable Values information with current vendor information.
7/06	Removed reference to Appendix 7 (deleted) in Description. Other reference added.
2010	2010 Data Changes: CCR name (Census Tract 90) changed to NAACCR name.

Census Tract 2000

IDENTIFIERS

CCR ID	NAACCR ID
E1017	130

DESCRIPTION

Census tract of address when this tumor was first diagnosed, using the boundaries defined by the U.S. Census Bureau for the Year 2000 Census.
Census tract codes allow central registries to calculate incidence rates for geographical areas having population estimates. This field allows a central registry to add Year 2000 Census tracts to tumors diagnosed in previous years, without losing the codes in data item 110.
Census tract codes are provided by a vendor that is under contract with the CCR to geocode patient addresses. If an address and its assigned census tract goes to IPAQ after being returned from the geocoding vendor, the census tract can be changed by an authorized user. The authorized user should first check with the CCR-approved publicly available address locator, American FactFinder.

LEVELS

Tumors

LENGTH

6

ALLOWABLE VALUES

Census tract codes have a 4-digit basic number and may have a 2-digit suffix. For example: Census tract 0145.05 is coded as 014505.

000100 – 999992	Census Tract Codes
999993	Unknown City and Unknown ZIP, County and State Known, Street may be known or unknown
999994	PO Boxes for California residents only
999996	Not yet submitted for tracting
999997	Submitted for tracting once unsuccessfully
999998	California case - not machine tractable
999999	Non-Calif. resident or unknown residence

SOURCE

No Census Tract 2000 variable at admission. Variable created at tumor level.
Computer generate:

999999	If State at DX not CA (includes UNKNOWN)
999993	If City at DX = UNKNOWN and ZIP at DX = UNKNOWN and County at DX has valid value and State at DX = CA and Addr at DX (No & Street) has valid value including 'UNKNOWN'.
999994	If Addr at DX (No & Street) begins with PO BOX
999996	If none of the above

UPDATE

1. As census tracts are determined via the geocoding process add to the database, either manually or by computer.
2. Reset Census Tract 2000 to 999993, 999994, 999996 or 999999 (see Source), if TU Addr at DX--No & Street, TU Addr at DX--City, TU Addr at DX--State, TU Addr at DX--Postal Code, or TU County at DX is changed. (Don't reset if only TU_County at DX was changed as a result of geocoding). Allow user to specify that the code should not be reset while manually changing one or more of the preceding fields.
3. If tumors are being relinked and the addresses are identical but one case is tracted and the other is not, the tracted census values should be used.
4. If geocoded values from geocoding vendor are being linked with tumor and the census tract 2000 certainty value returned from the vendor is '9' (census tract not assigned, geocoding attempted), the system will update, upon being linked, a census tract value of '999996' to '999997' or census tract value of '999997' to '999998'.
5. When the variable is created at the tumor level and an address receives a value of '999993', it is not sent for geocoding at the vendor. It will be reviewed so as to get better address information that may allow it to be geocoded.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/00	New data item added for Year 2000 census
7/05	Updated Allowable Values information with current vendor information.
7/06	Removed reference to Appendix 7 (deleted) in Description. Other reference added.
2010	Data Changes: CCR name (Census Tract 00) changed to NAACCR name.
3/1/12	Change to definition of value '999993' to match the new coding in Eureka 10.2. Eliminate value of '999995'. Changes in 'Description' and 'Update' sections to better match the process and Census Tract 2010.
05/2013	Added IF 1049

Census Tract 2010

IDENTIFIERS

CCR ID	NAACCR ID
E1049	135

DESCRIPTION

Census tract of usual residence when this tumor was first diagnosed, using 2010 census tract boundaries used by the U.S. Census Bureau for the Year 2010 Census.
Census tract codes allow central registries to calculate incidence rates for geographical areas having population estimates. This field allows a central registry to add Year 2010 Census tracts to tumors diagnosed in previous years, without losing the codes in data items 110, 130, and 125.
See also:

Census Tract 1970-80-90
Census Tract 2000
Census Tract 2020

Census tract codes are provided by a vendor that is under contract with the CCR to geocode patient addresses. If an address and its assigned census tract goes to IPAQ after being returned from the geocoding vendor, the census tract can be changed by an authorized user. The authorized user should first check with the CCR-approved publicly available address locator, American FactFinder.

LEVELS

Tumors

LENGTH

6

ALLOWABLE VALUES

Blank
000000
000100-999999
Codes
Census tract codes have a 4-digit basic number and may have a 2-digit suffix. For example: Census tract 0145-05 is coded as 014505.

000100-999992	Census Tract Codes
999993	Unknown City and Unknown ZIP, County and State Known, Street may be known or unknown
999994	PO Boxes for California residents only
999996	Not yet submitted for tracting
999997	Submitted for tracting once unsuccessfully
999998	California case – not machine tractable
999999	Not a California residence (includes UNKNOWN state)

SOURCE

No Census Tract 2010 variable at admission. Variable created at tumor level.
Computer generated values when created:

999999	If State at DX not CA (includes UNKNOWN)
999993	If City at DX = UNKNOWN and ZIP at DX = UNKNOWN and County at DX has valid value and State at DX = CA and Addr at DX (No & Street) has valid value including 'UNKNOWN'.
999994	If Addr at DX (No & Street) begins with PO BOX
999996	If none of the above

UPDATE

1. As census tracts are determined via the geocoding process, add to the database either manually or by computer.
2. Reset Census Tract 2010 to 999993, 999994, 999996 or 999999 (see Source), if TU_Addr at DX--No & Street, TU_Addr at DX--City, TU_Addr at DX--State, TU_Addr at DX--Postal Code, or TU_County at DX is changed. (Don't reset if only TU_County at DX was changed as a result of geocoding). Allow user to specify that the code should not be reset while manually changing one or more of the preceding fields
3. If tumors are being relinked and the addresses are identical, but one case is tracted and the other is not, the tracted census values should be used.
4. If geocoded values from geocoding vendor are being linked with tumor and the census tract 2010 certainty value returned from the vendor is '9' (census tract not assigned, geocoding attempted), the system will update, upon being linked, a census tract value of '999996' to '999997' or census tract value of '999997' to '999998'.
5. When the variable is created at the tumor level and an address receives a value of '999993', it is not sent for geocoding at the vendor. It will be reviewed to get better address information that may allow it to be geocoded.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

2011	Data changes per NAACCR 12v1.
3/1/12	Changed definition for value '999993'. Removed value of '999995'.
05/2013	Added IF 1050

Census Tract 2020

IDENTIFIERS

CCR ID	NAACCR ID
E1831	125

DESCRIPTION

Census tract of usual residence when this tumor was first diagnosed, using 2020 census tract boundaries used by the U.S. Census Bureau for the Year 2020 Census.
Census tract codes allow central registries to calculate incidence rates for geographical areas having population estimates. This field allows a central registry to add Year 2020 Census tracts to tumors diagnosed in previous years, without losing the codes in data items 110, 130, and135.
See also:

Census Tract 1970-80-90
Census Tract 2000
Census Tract 2010

Census tract codes are provided by a vendor that is under contract with the CCR to geocode patient addresses. If an address and its assigned census tract goes to IPAQ after being returned from the geocoding vendor, the census tract can be changed by an authorized user. The authorized user should first check with the CCR-approved publicly available address locator, American FactFinder.

LEVELS

Tumors

LENGTH

6

ALLOWABLE VALUES

Blank
000000
000100-999999
Codes
Census tract codes have a 4-digit basic number and may have a 2-digit suffix. For example: Census tract 0145-05 is coded as 014505.

000100-999992	Census Tract Codes
999993	Unknown City and Unknown ZIP, County and State Known, Street may be known or unknown
999994	PO Boxes for California residents only
999996	Not yet submitted for tracting
999997	Submitted for tracting once unsuccessfully
999998	California case – not machine tractable
999999	Not a California residence (includes UNKNOWN state)

SOURCE

No Census Tract 2020 variable at admission. Variable created at tumor level.
Computer generated values when created:

999999	If State at DX not CA (includes UNKNOWN)
999993	If City at DX = UNKNOWN and ZIP at DX = UNKNOWN and County at DX has valid value and State at DX = CA and Addr at DX (No & Street) has valid value including 'UNKNOWN'.
999994	If Addr at DX (No & Street) begins with PO BOX
999996	If none of the above

UPDATE

1. As census tracts are determined via the geocoding process, add to the database either manually or by computer.
2. Reset Census Tract 2020 to 999993, 999994, 999996 or 999999 (see Source), if TU_Addr at DX--No & Street, TU_Addr at DX--City, TU_Addr at DX--State, TU_Addr at DX--Postal Code, or TU_County at DX is changed. (Don't reset if only TU_County at DX was changed as a result of geocoding). Allow user to specify that the code should not be reset while manually changing one or more of the preceding fields
3. If tumors are being relinked and the addresses are identical but one case is tracted and the other is not, the tracted census values should be used.
4. If geocoded values from geocoding vendor are being linked with tumor and the census tract 2020 certainty value returned from the vendor is '9' (census tract not assigned, geocoding attempted), the system will update, upon being linked, a census tract value of '999996' to '999997' or census tract value of '999997' to '999998'.
5. When the variable is created at the tumor level and an address receives a value of '999993', it is not sent for geocoding at the vendor. It will be reviewed so as to get better address information that may allow it to be geocoded.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new geocode data field implemented.

Census Tr Cert 1970/80/90

IDENTIFIERS

CCR-ID	NAACCR ID
E1016	364

DESCRIPTION

Flag which indicates the basis of assignment of the census tract.
Note: Codes 1-5 and 9 are usually assigned by a geocoding vendor, while code 6 is usually assigned through a special effort by the central registry.

LEVELS

Tumors

LENGTH

1

ALLOWABLE VALUES

1	Census tract based on complete and valid street address of residence
2	Census tract based on residence zip + 4
3	Census tract based on residence zip + 2
4	Census tract based on residence zip only
5	Census tract based on zip of post office box
6	Census tract/BNA based on residence city where city has only one census tract, or based on residence ZIP code where ZIP code has only one census tract
9	Not assigned, geocoding attempted
Blank	Not assigned, geocoding not attempted

SOURCE

Set to blank for new cases.

CONSOLIDATION LOGIC

Whenever Census Tract 1970/80/90 is changed, Census Tr Cert 1970/80/90 must be changed accordingly:

1	If Census Tract 1970/80/90 is 999996 or 999997 (waiting for geocoding), then Census Tr Cert 1970/80/90 must be set to blank.
2	If Census Tract 1970/80/90 cannot be tracted (999993-999995 or 999998-999999) then Census Tr Cert 1970/80/90 must be 9.
3	If Census Tract 1970/80/90 is tracted and a Census Tr Cert 1970/80/90 code is available (whether through geocoding, linking a tumor with a tracted address, or manual entry of a Census Tr Cert 1970/80/90 value) the available Census Tr Cert 1970/80/90 code should be used.
4	If Census Tract 1970/80/90 is tracted, but Census Tr Certainty 1970/80/90 is not available, Census Tract 1970/80/90 should be set to 999996 and Census Tr Certainty 1970/80/90 should be set to blank

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

1/1/99	New field added to the data set; Initial values generated using the above UPDATE rules.

3/15/00	Name changed from CENSUS-CERTAINTY to Census_Cert_90 because of Year 2000 census.
7/27/05	New Allowable Value code 6 added to Err #205 for 2006 data changes.
2010	CCR name (Census Cert 90) changed to match NAACCR name. Added IF352.
3/14/2011	2011 Data Changes: Updated definition of Code 9 (was Unable to assign census tract based on available information) and blank (Applicable (e.g., census tracting not yet attempted) per NAACCR 12.1.
9/26/2011	Consolidation logic number 4 was modified. Was: *Census Tract 1970/80/90 is tracted, but Census Tr Cert 1970/80/90 is not available, Census Tr Cert 1970/80/90 should be set to 1.*

Census Tr Certainty 2000

IDENTIFIERS

CCR-ID	NAACCR ID
E1019	365

DESCRIPTION

Flag which indicates the basis of assignment of the census tract.
Note: Codes 1-5 and 9 are usually assigned by a geocoding vendor, while code 6 is usually assigned through a special effort by the central registry.

LEVELS

Replace or None

LENGTH

1

ALLOWABLE VALUES

1	Census tract based on complete and valid street address of residence
2	Census tract based on residence zip + 4
3	Census tract based on residence zip + 2
4	Census tract based on residence zip only
5	Census tract based on zip of post office box
6	Census tract/BNA based on residence city where city has only one census Tract, or based on residence ZIP code where ZIP code has only one census tract.
9	Not Assigned, geocoding attempted
Blank	Not Assigned, geocoding not attempted

SOURCE

Set to blank for new cases.

UPDATE

Whenever Census_Tract_2000 is changed, Census Tr Certainty 2000 must be changed accordingly:

1. If Census_Tract_2000 is 999996 or 999997 (waiting for geocoding), then Census Tr Certainty 2000 must be set to blank.
2. If Census_Tract_2000 cannot be tracted (999993-999995 or 999998-999999) then Census Tr Certainty 2000 must be 9.
3. If Census_Tract_2000 is tracted and a Census Tr Certainty 2000 code is available (whether through geocoding, linking a tumor with a tracted address, or manual entry of a Census Tr Certainty 2000 value) the available Census Tr Certainty 2000 code should be used.
4. If Census Tract 2000 is tracted, but Census Tr Certainty 2000 is not available, Census Tract 2000 should be set to 999996 and Census Tr Certainty 2000 should be set to blank

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/15/00	New field added to the data set; Initial values generated using the above UPDATE rules.
7/27/05	New Allowable Value code 6 added to Err #214 for 2006 data changes.

7/07/06	Some PO Box addresses associated with an institution with a valid street address will be geocoded as that street address and receive a certainty value of 1 (as of Eureka Version 5.3-July 2006 release).
2010	2010 Date Changes: CCR name (Census Cert 00) changed to NAACCR name. Added IF352.
3/14/2011	2011 Data Changes: Updated definition of Code 9 (was Unable to assign census tract based on available information) and blank (Applicable (e.g., census tracting not yet attempted) per NAACCR 12.1.
9/26/2011	Consolidation logic number 4 was modified. Was: *Census Tract 2000 is tracted, but Census Tr Certainty 2000 is not available, Census Tr Certainty 2000 should be set to 1.*

Census Tr Certainty 2010

IDENTIFIERS

CCR-ID	NAACCR ID
E1051	367

DESCRIPTION

Code indicates the basis of assignment of the Census Tract 2010.

LEVELS

Tumors

LENGTH

1

ALLOWABLE VALUES

1	Census tract based on complete and valid street address of residence
2	Census tract based on residence ZIP + 4
3	Census tract based on residence ZIP + 2
4	Census tract based on residence ZIP code only
5	Census tract based on ZIP code of P.O. Box
6	Census tract/BNA based on residence city where city has only one census tract, or based on residence ZIP code where ZIP code has only one census tract
9	Not assigned, geocoding attempted
Blank	Not assigned, geocoding not attempted

SOURCE

Set to blank for new cases.

CONSOLIDATION

Whenever Census Tract 2010 is changed Census Tr Certainty 2010 must be changed accordingly:

1. If Census Tract 2010 is 999996 (waiting for geocoding) or 999993 (unknown city and unknown ZIP) or 999994 or 999999, then Census Tr Certainty 2010 must be set to blank.
2. If the address at diagnosis has been sent for tracting once and the geocoder could only locate the address at the county centroid, the Census Tract 2010 will be populated with 9999997 and Census Tract Certainty will be 9.
3. If the address at diagnosis has been sent for tracting twice and the geocoder could only locate the address at the county centroid on the 2nd attempt, Census Tract 2010 will be 999998 and Census Tract Certainty will be 9.
4. If Census Tract 2010 is tracted and a Census Tr Certainty 2010 code is available (whether through geocoding, linking a tumor with a tracted address, or manual entry of a Census Tr Certainty 2010 value) the available Census Tr Certainty 2010 code should be used.
5. If Census Tract 2010 is tracted, but Census Tr Certainty 2010 is not available, Census Tract 2010 should be set to 999996 and Census Tr Certainty should be set to blank.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/14/2011	This item added for 2011 data changes.

9/26/2011	Consolidation logic number 4 was modified. Was: Census Tract 2010 is tracted, but Census Tr Certainty 2010 is not available, Census Tr Certainty 2010 should be set to 1.
3/1/12	Consolidation logic modified for how Eureka processes geocoding processes.

Census Tr Certainty 2020

IDENTIFIERS

CCR-ID	NAACCR ID
E1841	369

DESCRIPTION

Code indicates the basis of assignment of the Census Tract 2020.

LEVELS

Tumors

LENGTH

1

ALLOWABLE VALUES

1	Census tract based on complete and valid street address of residence
2	Census tract based on residence ZIP + 4
3	Census tract based on residence ZIP + 2
4	Census tract based on residence ZIP code only
5	Census tract based on ZIP code of P.O. Box
6	Census tract/BNA based on residence city where city has only one census tract, or based on residence ZIP code where ZIP code has only one census tract
9	Not assigned, geocoding attempted
Blank	Not assigned, geocoding not attempted

SOURCE

Set to blank for new cases.

CONSOLIDATION

Whenever Census Tract 2010 is changed Census Tr Certainty 2020 must be changed accordingly:

1. If Census Tract 2020 is 999996 (waiting for geocoding) or 999993 (unknown city and unknown ZIP) or 999994 or 999999, then Census Tr Certainty 2020 must be set to blank.
2. If the address at diagnosis has been sent for tracting once and the geocoder could only locate the address at the county centroid, the Census Tract 2020 will be populated with 9999997 and Census Tract Certainty will be 9.
3. If the address at diagnosis has been sent for tracting twice and the geocoder could only locate the address at the county centroid on the 2nd attempt, Census Tract 2020 will be 999998 and Census Tract Certainty will be 9.
4. If Census Tract 2020 is tracted and a Census Tr Certainty 2020 code is available (whether through geocoding, linking a tumor with a tracted address, or manual entry of a Census Tr Certainty 2020 value) the available Census Tr Certainty 2020 code should be used.
5. If Census Tract 2020 is tracted, but Census Tr Certainty 2020 is not available, Census Tract 2020 should be set to 999996 and Census Tr Certainty should be set to blank.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new geocode data field implemented.

Census Tr Poverty Indictr

IDENTIFIERS

CCR ID	NAACCR ID
E1777	145

OWNER

NAACCR

DESCRIPTION

Assigns a code for neighborhood poverty level based on the census tract of diagnosis address. Cases diagnosed between 1995 and 2004 are assigned a code based on the 2000 U.S. Census, the last decennial census for which poverty level was collected. Cases diagnosed since 2005 are assigned a code based on the American Community Survey (ACS). Codes may be automatically assigned by running the Poverty and Census Tract Linkage Program available through the Data Analysis Tools section of the NAACCR website.

LEVELS

Tumors

LENGTH

1

ALLOWABLE VALUES

Census Tr Poverty Indictr must be 1-4, 9 or blank.

SOURCE

See Extract

UPDATE

None

CONSOLIDATED DATA EXTRACT

No

HISTORICAL CHANGES

05/2013	New data item for 2013
02/2014	Included list of Allowable Values.
03/2015	Clarified this field is generated on extract.

Chemo 1-6 End Date

IDENTIFIERS

Data Item	CCR	NAACCR
Chemo 1 End Date	E1119	9841
Chemo 2 End Date	E1130	9842
Chemo 3 End Date	E1291	9843
Chemo 4 End Date	E1302	9844
Chemo 5 End Date	E1374	9845
Chemo 6 End Date	E1385	9846

DESCRIPTION

These data items have been retired. This page has been retained for historical purposes only and these data items should not be populated in any cases diagnosed 2013 or later or coded under the NAACCR v13 or later coding standards.
Records the date for the last day of the last cycle that the patient received chemotherapy as all or part of the first course of treatment at any facility.

LEVELS

Tumors, Admissions

LENGTH

8

ALLOWABLE VALUES

A valid, complete date in YYYYMMDD format
Blanks allowed

SOURCE

N/A

UPDATE

N/A

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

2011	Data Item Changes: Added for CER Project
05/2013	Retired at the conclusion of data collection for the CER project

Chemo 1-6 End Date Flag

This topic in Volume III records all six of the Chemo End Date Flags as they are nearly identical.

IDENTIFIERS

Item	CCR-ID	NAACCR-ID
Chemo 1 End Date Flag	E1120	9851
Chemo 2 End Date Flag	E1131	9852
Chemo 3 End Date Flag	E1292	9853
Chemo 4 End Date Flag	E1303	9854
Chemo 5 End Date Flag	E1375	9855
Chemo 6 End Date Flag	E1386	9856

DESCRIPTION

These data items have been retired. This page has been retained for historical purposes only and these data items should not be populated in any cases diagnosed 2013 or later or coded under the NAACCR v13 or later coding standards.

This flag explains why there is not a valid date in Chemo 1-6 End Date Flag.

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if any chemotherapy agent administered
11	No proper value is applicable in this context (e.g., no chemotherapy agent administered)
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., chemotherapy administered but date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (e.g., chemotherapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow up).
blank	A valid date value is provided in item Chemo 1 Start Date [9821]. A blank is allowed for cases other than Breast, Colorectal, and CML even when there is no valid date in item Chemo 1 Start Date [9821]. Also a blank is allowed for cases • Diagnosed prior to 2011 • Diagnose date 2011 and not a Region 3 resident • Region 3 resident and sites other than Breast, Colorectal, and CML

SOURCE

N/A

UPDATE

N/A

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

2011 Data Item Changes, CER Project	Added for CER requirements.
05/2013	Retired at the conclusion of data collection for the CER project

Chemo 1-6 NSC Number

IDENTIFIERS

Data Item	CCR	NAACCR
Chemo 1 NSC Number	E1110	9751
Chemo 2 NSC Number	E1121	9752
Chemo 3 NSC Number	E1282	9753
Chemo 4 NSC Number	E1293	9754
Chemo 5 NSC Number	E1365	9755
Chemo 6 NSC Number	E1376	9756

DESCRIPTION

These data items have been retired. This page has been retained for historical purposes only and these data items should not be populated in any cases diagnosed 2013 or later or coded under the NAACCR v13 or later coding standards.

NSC number* for the chemotherapy agent administered as all or part of the first course of treatment at any facility.

* The term "NSC" [number] refers to (part of) the acronym of the Cancer Chemotherapy National Service Center (CCNSC)). The NSC number is a National Service Center assigned number from the National Cancer Institute (NCI). This number is assigned to a drug during its investigational phase prior to the adoption of a United States Adopted Name. A full list of NSC codes is maintained in SEER*Rx.

LEVELS

Tumors, Admissions

LENGTH

6

ALLOWABLE VALUES

6-digits	NSC Code
000000	Chemotherapy was not planned to be administered OR no additional chemotherapy agents were planned.
999998	Chemotherapy was planned and/or administered, but the agent NSC code is unknown; the code "999998" is a temporary code that registries should use while they contact ICF Macro to obtain a permanent code to enter for agents that do not have SEER*Rx-assigned NSC codes.
999999	Unknown if chemotherapy planned.
Blank	Blank is allowable for any case not subject to CER reporting. A blank is allowed for cases • Diagnosed prior to 2011 • Diagnose date 2011 and not a Region 3 resident • Region 3 resident and sites other than Breast, Colorectal, and CML

SOURCE

N/A

UPDATE

N/A

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

2011	Data Item Changes: Added for CER Project.
05/2013	Retired at the conclusion of data collection for the CER project

Chemo 1-6 Num Doses Planned

IDENTIFIERS

Data Item	CCR	NAACCR
Chemo 1 Num Doses Planned	E1111	9761
Chemo 2 Num Doses Planned	E1122	9762
Chemo 3 Num Doses Planned	E1283	9763
Chemo 4 Num Doses Planned	E1294	9764
Chemo 5 Num Doses Planned	E1366	9765
Chemo 6 Num Doses Planned	E1377	9766

DESCRIPTION

These data items have been retired. This page has been retained for historical purposes only and these data items should not be populated in any cases diagnosed 2013 or later or coded under the NAACCR v13 or later coding standards.
The total number of chemotherapy doses planned to be delivered to the patient as all or part of the first course of treatment at any facility.

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

00	Chemotherapy was not planned OR no additional chemotherapy agents were planned
01-96	Actual number of chemotherapy doses planned
97	97 or more chemotherapy doses planned
98	Chemo was planned and/or administered, but number doses is unknown
99	Unknown if chemotherapy planned
Blank	Blank is allowable for any case not subject to CER reporting

SOURCE

N/A

UPDATE

N/A

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

2011	Data Item Changes: Added for CER Project
05/2013	Retired at the conclusion of data collection for the CER project

Chemo 1-6 Num Doses Received

IDENTIFIERS

Data Item	CCR	NAACCR
Chemo 1 Num Doses Received	E1114	9791
Chemo 2 Num Doses Received	E1125	9792
Chemo 3 Num Doses Received	E1286	9793
Chemo 4 Num Doses Received	E1297	9794
Chemo 5 Num Doses Received	E1369	9795
Chemo 6 Num Doses Received	E1380	9796

DESCRIPTION

These data items have been retired. This page has been retained for historical purposes only and these data items should not be populated in any cases diagnosed 2013 or later or coded under the NAACCR v13 or later coding standards.

Records the total number of chemotherapy doses delivered to the patient as all or part of the first course of treatment at any facility.

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

00	Chemotherapy was not received OR no additional chemotherapy agents were received
01-96	Actual number of chemotherapy doses received
97	97 or more chemotherapy doses received
98	Chemotherapy was received, but the number of doses is unknown
99	Unknown if chemotherapy received
Blank	Blank is allowable for any case not subject to CER reporting. Diagnosed prior to 2011 Diagnose date 2011 and not a Region 3 resident Region 3 resident and sites other than Breast, Colorectal, and CML

SOURCE

N/A

UPDATE

N/A

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

2011	Data Items: Added for CER Project
05/2013	Retired at the conclusion of data collection for the CER project

Chemo 1-6 Planned Dose

IDENTIFIERS

Data Item	CCR	NAACCR
Chemo 1 Planned Dose	ER007	9771
Chemo 2 Planned Dose	ER268	9772
Chemo 3 Planned Dose	ER261	9773
Chemo 4 Planned Dose	ER262	9774
Chemo 5 Planned Dose	ER262	9775
Chemo 6 Planned Dose	ER264	9776

DESCRIPTION

These data items have been retired. This page has been retained for historical purposes only and these data items should not be populated in any cases diagnosed 2013 or later or coded under the NAACCR v13 or later coding standards.

For the first chemotherapy agent, this item records the planned total dose to be delivered to the patient as all or part of the first course of treatment at any facility (note that this is the total dosage, not the total *number* of doses.)

LEVELS

Tumors, Admissions

LENGTH

6

ALLOWABLE VALUES

6-digit number or blank.

000000	Chemotherapy was not planned OR no additional chemotherapy agents were planned
999998	Chemotherapy was planned and/or administered, but the dose planned is unknown
999999	Unknown if chemotherapy planned.
Blank	Unknown if chemotherapy planned or not required for this primary site/histology

SOURCE

N/A

UPDATE

N/A

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

2011	Data Changes: Added for CER Project.
05/2013	Retired at the conclusion of data collection for the CER project

Chemo 1-6 Planned Dose Unit

IDENTIFIERS

Data Item	CCR	NAACCR
Chemo 1 Planned Dose Unit	E1113	9781
Chemo 2 Planned Dose Unit	E1124	9782
Chemo 3 Planned Dose Unit	E1285	9783
Chemo 4 Planned Dose Unit	E1296	9784
Chemo 5 Planned Dose Unit	E1368	9785
Chemo 6 Planned Dose Unit	E1382	9786

DESCRIPTION

These data items have been retired. This page has been retained for historical purposes only and these data items should not be populated in any cases diagnosed 2013 or later or coded under the NAACCR v13 or later coding standards.
Records the overall total chemotherapy dose planned.

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

00	Chemo was not planned OR no additional chemotherapy agents were planned
01	Mg
02	Grams
07	Other (please specify in chemo text field)
98	Chemo was planned and/or administered, but the dose planned is unknown
99	Unknown if chemo planned
Blank	Blank is allowable for any case not subject to CER reporting. A blank is allowed for cases Diagnosed prior to 2011 Diagnose date 2011 and not a Region 3 resident Region 3 resident and sites other than Breast, Colorectal, and CML

SOURCE

N/A

UPDATE

N/A

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

2011	Data Change: Added for CER Project
05/2013	Retired at the conclusion of data collection for the CER project

Chemo 1-6 Received Dose

IDENTIFIERS

Data Item	CCR	NAACCR
Chemo 1 Received Dose	E1115	9801
Chemo 2 Received Dose	E1126	9802
Chemo 3 Received Dose	E1287	9803
Chemo 4 Received Dose	E1298	9804
Chemo 5 Received Dose	E1370	9805
Chemo 6 Received Dose	E1381	9806

DESCRIPTION

These data items have been retired. This page has been retained for historical purposes only and these data items should not be populated in any cases diagnosed 2013 or later or coded under the NAACCR v13 or later coding standards.

Records the total dose actually delivered to the patient as all or part of the first course of treatment at any facility. Note that this is the total dosage received, not the total *number* of doses.)

LEVELS

Tumors, Admissions

LENGTH

6

ALLOWABLE VALUES

000000, 000001 – 999997, 999998, 999999 or blank

######	Chemotherapy dose received (Six digits. Zero fill from the left, as required.)
000000	Chemotherapy was not received OR no additional chemo agents were received
999998	Chemotherapy was received, but the dose Received is unknown
999999	Unknown if chemotherapy received
Blank	Blank is allowable for any case not subject to CER reporting. A blank is allowed for cases • Diagnosed prior to 2011 • Diagnose date 2011 and not a Region 3 resident • Region 3 resident and sites other than Breast, Colorectal, and CML

SOURCE

N/A

UPDATE

N/A

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

2011	Data Changes: Added for CER Project.
05/2013	Retired at the conclusion of data collection for the CER project

Chemo 1-6 Received Dose Unit

IDENTIFIERS

Data Item	CCR	NAACCR
Chemo 1 Received Dose Unit	E1116	9811
Chemo 2 Received Dose Unit	E1127	9812
Chemo 3 Received Dose Unit	E1288	9813
Chemo 4 Received Dose Unit	E1299	9814
Chemo 5 Received Dose Unit	E1271	9815
Chemo 6 Received Dose Unit	E1382	9816

DESCRIPTION

These data items have been retired. This page has been retained for historical purposes only and these data items should not be populated in any cases diagnosed 2013 or later or coded under the NAACCR v13 or later coding standards.
Records the overall total chemotherapy dose received, including the units.

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

00	Chemo was not received or no additional chemotherapy agents were received
01	Mg
02	Grams
07	Other (please specify in chemo text field, item # XX)
98	Chemo was received, but the dose received is unknown
99	Unknown if chemo received
Blank	Blank is allowable for any case not subject to CER reporting. A blank is allowed for cases • Diagnosed prior to 2011 • Diagnose date 2011 and not a Region 3 resident • Region 3 resident and sites other than Breast, Colorectal, and CML

SOURCE

N/A

UPDATE

N/A

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

2011	Data Changes: Added for CER Project
05/2013	Retired at the conclusion of data collection for the CER project

Chemo 1-6 Start Date

IDENTIFIERS

Data Item	CCR	NAACCR
Chemo 1 Start Date	E1117	9821
Chemo 2 Start Date	E1128	9822
Chemo 3 Start Date	E1289	9823
Chemo 4 Start Date	E1300	9824
Chemo 5 Start Date	E1372	9825
Chemo 6 Start Date	E1383	9826

DESCRIPTION

These data items have been retired. This page has been retained for historical purposes only and these data items should not be populated in any cases diagnosed 2013 or later or coded under the NAACCR v13 or later coding standards.
Records the date for the first day of the first cycle that the patient started chemotherapy as all or part of the first course of treatment at any facility.

LEVELS

Tumors, Admissions

LENGTH

8

ALLOWABLE VALUES

A valid, complete date in CCYYMMDD format
Blanks allowed

SOURCE

N/A

UPDATE

N/A

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

2011	Data Changes: Added for CER Project
05/2013	Retired at the conclusion of data collection for the CER project

Chemo 1-6 Start Date Flag

IDENTIFIERS

Data Item	CCR	NAACCR
Chemo 1 Start Date Flag	E1118	9831
Chemo 2 Start Date Flag	E1129	9832
Chemo 3 Start Date Flag	E1290	9833
Chemo 4 Start Date Flag	E1301	9834
Chemo 5 Start Date Flag	E1373	9835
Chemo 6 Start Date Flag	E1384	9836

DESCRIPTION

These data items have been retired. This page has been retained for historical purposes only and these data items should not be populated in any cases diagnosed 2013 or later or coded under the NAACCR v13 or later coding standards. This flag explains why there is not a valid date in Chemo 1-6 Start Date.

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if any chemotherapy agent administered)
11	No proper value is applicable in this context (e.g., no chemotherapy agent administered)
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., chemotherapy administered but date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (e.g., chemotherapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow up).
blank	A valid date value is provided in item Chemo 1 Start Date [9821]. A blank is allowed for cases • Diagnosed prior to 2011 • Diagnose date 2011 and not a Region 3 resident • Region 3 resident and sites other than Breast, Colorectal, and CML

SOURCE

N/A

UPDATE

N/A

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

2011	Data Changes: Added for CER Project
05/2013	Retired at the conclusion of data collection for the CER project

Chemo Completion Status

IDENTIFIERS

CCR ID	NAACCR ID
E1387	9859

DESCRIPTION

This data item has been retired. This page has been retained for historical purposes only and this data item should not be populated in any cases diagnosed 2013 or later or coded under the NAACCR v13 or later coding standards.
Codes the completion status of chemotherapy for the first course of treatment.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

0	No chemo treatment
1	Treatment completed as planned
2	Chemo not completed as planned, patient health/complications
3	Chemo not completed as planned, patient expired
4	Chemo not completed as planned, patient/family choice
5	Chemo not completed as planned, cytopenia
6	Chemo not completed as planned, other reason
7	Chemo treatment extends beyond the end of data collection for this project
8	Chemotherapy administered, unknown if completed
9	Unknown if Chemo therapy given
Blank	Blank is allowable for any case not subject to CER reporting A blank is allowed for cases • Diagnosed prior to 2011 • Diagnose date 2011 and not a Region 3 resident • Region 3 resident and sites other than Breast, Colorectal, and CML

SOURCE

N/A

UPDATE

N/A

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

2011	Data Changes: Added for CER Project
05/2013	Retired at the conclusion of data collection for the CER project

Chromosome 3 Status

IDENTIFIERS

CCR ID	NAACCR ID
E1934	3821

OWNER

NAACCR

DESCRIPTION

Chromosome 3 Status refers to the partial or total loss of Chromosome 3, which is a prognostic factor for uveal melanoma.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	No loss of chromosome 3
1	Partial loss of chromosome 3
2	Complete loss of chromosome 3
3	Loss of chromosome 3, NOS
7	Test ordered, results not in chart
8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code 8 may result in an edit error.)
9	Not documented in medical record Chromosome 3 status not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00671, 00672
        - Type of Reporting Source is not 7
        - COC Accredited Flag is 1
        - Chromosome 3 Status is blank or 8

        Then convert Chromosome 3 Status to 9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00671, 00672

              OR
            - Type of Reporting Source is 7
        - Chromosome 3 Status is not blank

Then convert Chromosome 3 Status to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00671, 00672
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00671, 00672

One of the following conditions is true

- Admission's value is not blank, 8, 9
- Tumor's value is blank , 8, 9

OR

- Admission's value is 9
- Tumor's value is blank or 8

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Chromosome 8q Status

IDENTIFIERS

CCR ID	NAACCR ID
E1935	3822

OWNER

NAACCR

DESCRIPTION

Chromosome 8q Status refers to gain in Chromosome 8q, which is a prognostic factor for uveal melanoma.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	No gain in chromosome 8q
1	Gain in chromosome 8q
7	Test ordered, results not in chart
8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code 8 may result in an edit error.)
9	Not documented in medical record Chromosome 8q status not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00671, 00672
        - Type of Reporting Source is not 7
        - COC Accredited Flag is 1
        - Chromosome 8q Status is blank or 8

        Then convert Chromosome 8q Status to 9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00671, 00672

            OR
            - Type of Reporting Source is 7
        - Chromosome 8q Status is not blank

        Then convert Chromosome 8q Status to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00671, 00672
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00671, 00672

One of the following conditions is true

- Admission's value is not blank, 8, 9
- Tumor's value is blank , 8, 9

OR

- Admission's value is 9
- Tumor's value is blank or 8

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Chromosome 19Q: Loss of Heterozygosity (LOH)

IDENTIFIERS

CCR ID	NAACCR ID
E1915	3802

OWNER

NAACCR

DESCRIPTION

Chromosome 19q: Loss of Heterozygosity (LOH) refers to the loss of genetic material normally found on the long arm of one of the patient's two copies of chromosome 19. Codeletion of Chromosome 1p and 19q is a diagnostic, prognostic and predictive marker for gliomas and is strongly associated with the oligodendroglioma phenotype.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	Chromosome 19q deletion/LOH not identified/not present
1	Chromosome 19q deletion/LOH identified/present
6	Benign or borderline tumor
7	Test ordered, results not in chart
8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code 8 will result in an edit error.)
9	Not documented in patient record Cannot be determined by the pathologist Chromosome 19q deletion/LOH not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00721 or 00722
        - Type of Reporting Source is not 7
        - Chromosome 19q: Loss of Heterozygosity (LOH) is blank or 8

        Then convert Chromosome 19q: Loss of Heterozygosity (LOH) to 9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00721, 00722

              OR
            - Type of Reporting Source is 7
        - Chromosome 19q: Loss of Heterozygosity (LOH) is not blank

Then convert Chromosome 19q: Loss of Heterozygosity (LOH) to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00721 or 00722
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00721 or 00722

One of the following conditions is true

- Admission's value is not blank or 9
- Tumor's value is blank or 9

OR

- Admission's value is 9
- Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Chromosome 1p: Loss of Heterozygosity (LOH)

IDENTIFIERS

CCR ID	NAACCR ID
E1914	3801

OWNER

NAACCR

DESCRIPTION

Chromosome 1p: Loss of Heterozygosity (LOH) refers to the loss of genetic material normally found on the short arm of one of the patient's two copies of chromosome 1. Codeletion of Chromosome 1p and 19q is a diagnostic, prognostic and predictive marker for gliomas and is strongly associated with the oligodendroglioma phenotype.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	Chromosome 1p deletion/LOH not identified/not present
1	Chromosome 1p deletion/LOH identified/present
6	Benign or borderline tumor
7	Test ordered, results not in chart
8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code 8 will result in an edit error.)
9	Not documented in patient record Cannot be determined by the pathologist Chromosome 1p deletion/LOH not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00721 or 00722
        - Type of Reporting Source is not 7
        - Chromosome 1p: Loss of Heterozygosity (LOH) is blank or 8

        Then convert Chromosome 1p: Loss of Heterozygosity (LOH) to 9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00721, 00722

            OR
            - Type of Reporting Source is 7
        - Chromosome 1p: Loss of Heterozygosity (LOH) is not blank

Then convert Chromosome 1p: Loss of Heterozygosity (LOH) to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00721 or 00722
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00721 or 00722

One of the following conditions is true

- Admission's value is not blank or 9
- Tumor's value is blank or 9

OR

- Admission's value is 9
- Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Circumferential Resection Margin (CRM)

IDENTIFIERS

CCR ID	NAACCR ID
E1936	3823

OWNER

NAACCR

DESCRIPTION

Circumferential or Radial Resection Margin, the distance in millimeters between the leading edge of the tumor and the surgically dissected margin as recorded on the pathology report, is a prognostic indicator for colon and rectal cancer. This may also be referred to as the Radial Resection Margin or surgical clearance.

LEVELS

Admissions, Tumors

LENGTH

4

ALLOWABLE VALUES

0.0	Circumferential resection margin (CRM) positive Margin IS involved with tumor Described as "less than 1 millimeter (mm)"
0.1 – 99.9	Distance of tumor from margin: 0.1- 99.9 millimeters (mm) (Exact size to nearest tenth of millimeter)
XX.0	100 mm or greater
XX.1	Margins clear, distance from tumor not stated Circumferential or radial resection margin negative, NOS No residual tumor identified on specimen
XX.2	Margins cannot be assessed
XX.3	Described as "at least" 1 mm
XX.4	Described as "at least" 2 mm
XX.5	Described as "at least" 3 mm
XX.6	Described as "greater than" 3 mm
XX.7	No resection of primary site Surgical procedure did not remove enough tissue to measure the circumferential or radial resection margin (Examples include: polypectomy only, endoscopic mucosal resection (EMR), excisional biopsy only, transanal disk excision)
XX.8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code XX.8 may result in an edit error.)
XX.9	Not documented in medical record Circumferential or radial resection margin not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
   A. If all of the following conditions are true:
      - Schema ID is 00200
      - Type of Reporting Source is not 7
      - Circumferential Resection Margin (CRM) is blank or XX.8

      Then convert Circumferential Resection Margin (CRM) to XX.9
   B. If all of the following conditions are true:
      - One of the following is true:
        - Schema ID is not 00200

          OR
        - Type of Reporting Source is 7
      - Circumferential Resection Margin (CRM) is not blank

      Then convert Circumferential Resection Margin (CRM) to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00200
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00200

One of the following conditions is true

- Admission's value is not blank, XX.8, or XX.9
- Tumor's value is blank , XX.8, or XX.9

  OR
  - Admission's value is XX.9
  - Tumor's value is blank or XX.8

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

City Code

IDENTIFIERS

CCR ID	NAACCR ID
None	None

OWNER

CCR

DESCRIPTION

Regional registry's option to assign a code to the city of usual residence at the time this tumor was first diagnosed.

LEVELS

Tumors

LENGTH

4

ALLOWABLE VALUES

0000-9998	City/town code as assigned by registry.
9999	Unknown or not coded.

SOURCE

Computer generate 9999; add city code manually or by matching with computer-generated geocode tape.

UPDATE

List for review if City Code <> 9999 and Addr DX City is changed.

CONSOLIDATED DATA EXTRACT

No

HISTORICAL CHANGES

03/2020	Added back to Volume III

Class of Case

IDENTIFIERS

CCR ID	NAACCR ID
E1094	610

OWNER

CoC

DESCRIPTION

Class of Case divides cases into two groups. Analytic cases (codes 00-22) are those that are required by CoC to be abstracted because of the program's primary responsibility in managing the cancer. Analytic cases are grouped according to the location of diagnosis and treatment. Treatment and outcome reports may be limited to analytic cases. Nonanalytic cases (codes 30-49 and 99) may be abstracted by the facility to meet central registry requirements or because of a request by the facility's cancer program. Nonanalytic cases are grouped according to the reason a patient who received care at the facility is nonanalytic, or the reason a patient who never received care at the facility may have been abstracted.
Class of Case reflects the facility's role in managing the cancer, whether the cancer is required to be reported by CoC, and whether the case was diagnosed after the program's Reference Date.

LEVELS

Admissions

LENGTH

2

ALLOWABLE VALUES

Initial Diagnosis Reporting Facility	
00*	Initial diagnosis at the reporting facility AND all treatment or a decision not to treat was done ELSEWHERE
10*	Initial diagnosis at the reporting facility or in a staff physician's office AND PART OR ALL of first course treatment or a decision not to treat was at the reporting facility, NOS
11	Initial diagnosis in staff physician's office AND PART of first course treatment was done at the reporting facility
12	Initial diagnosis in staff physician's office AND ALL first course treatment or a decision not to treat was done at the reporting facility
13*	Initial diagnosis AND PART of first course treatment was done at the reporting facility
14*	Initial diagnosis at the reporting facility AND ALL first course treatment or a decision not to treat was done at the reporting facility
INITIAL DIAGNOSIS ELSEWHERE, FACILITY INVOLVED IN FIRST COURSE TREATMENT	
20*	Initial diagnosis elsewhere AND PART OR ALL of first course treatment was done at the reporting facility, NOS
21*	Initial diagnosis elsewhere AND PART of treatment was done at the reporting facility
22*	Initial diagnosis elsewhere AND ALL first course treatment was done at the reporting facility

PATIENT APPEARS IN PERSON AT REPORTING FACILITY; BOTH INITIAL DIAGNOSIS AND TREATMENT ELSEWHERE	
30*	Initial diagnosis and all first course treatment elsewhere AND reporting facility participated in DIAGNOSTIC WORKUP (for example, consult only, staging workup after initial diagnosis elsewhere)
31*	Initial diagnosis and all first course treatment elsewhere AND reporting facility provided IN-TRANSIT care
32*	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease RECURRENCE OR PERSISTENCE
33*	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease HISTORY ONLY
34	Type of case not required by CoC to be accessioned (for example, a benign colon tumor) AND initial diagnosis AND part or all of first course treatment by reporting facility
35	Case diagnosed before program's Reference Date AND initial diagnosis AND PART OR ALL of first course treatment by reporting facility
36	Type of case not required by CoC to be accessioned (for example, a benign colon tumor) AND initial diagnosis elsewhere AND part of all of first course treatment by reporting facility
37	Case diagnosed before program's Reference Date AND initial diagnosis elsewhere AND all or part of first course treatment by facility
38*	Initial diagnosis established by AUTOPSY at the reporting facility, cancer not suspected prior to death
PATIENT DOES NOT APPEAR IN PERSON AT REPORTING FACILITY	
40	Diagnosis AND all first course treatment given at the same staff physician's office
41	Diagnosis and all first course treatment given in two or more different staff physician offices
42	Non-staff physician or non-CoC approved clinic or other facility, not part of reporting facility, accessioned by reporting facility for diagnosis and/or treatment by that entity (for example, hospital abstracts cases from an independent radiation facility
43*	PATHOLOGY or other lab specimens ONLY
49*	DEATH CERTIFICATE ONLY
UNKNOWN RELATIONSHIP TO REPORTING FACILITY	
99*	Nonanalytic case of unknown relationship to facility (not for use by CoC accredited cancer programs for analytic cases.); UNKNOWN

*Indicates Class of Case codes appropriate for abstracting cases from non-hospital sources such as physician offices, ambulatory surgery centers, freestanding pathology laboratories, radiation therapy centers. When applied to these types of facilities, the non-hospital source is the reporting facility. The codes are applied the same way as if the case were reported from a hospital.

By using Class of Case codes in this manner for non-hospital sources, the central cancer registry is able to retain information reflecting the facility's role in managing the cancer consistent with the way it is reported from hospitals. Using Class of Case in conjunction with Type of Reporting Source [500] which identifies the source documents used to abstract the cancer being reported, the central cancer registry has two distinct types of information to use in making consolidation decisions.

SOURCE

If the record version is NAACCR version 12 (120 in original new case) or later, then load class of case without conversion. Otherwise, convert class of case in the same manner as specified in the Eureka Process Specification: 2010 Data Conversions document.

UPDATE

Manual Update or Correction/Update Record Applied

CONSOLIDATED DATA EXTRACT

Yes; record with the earliest admission date for this tumor.

HISTORICAL CHANGES

<table>
<tr><td>12/04/02</td><td>Removed IR #809.</td></tr>
<tr><td>03/26/03</td><td>Codes 7 and 8 added to allowable values. Change definition of code 9. Changed IF #608 to Class_Of_Case=8 (DC Only was 9) and removed Date_DX condition. Added Transp_Endo_Hosp to IF#450. Added 4 leading zeros to hospital numbers. Pre-CP21 cases converted to Class_Of_Case 8 if Report_Source=7.</td></tr>
<tr><td>03/03/04</td><td>Updated treatment codes in IF #369 and rewrote logic in “not equal” terminology. Removed Rad_Hosp in IF #368. Removed IF #406, 407 & 408 which referred to the Procedure fields. Removed conversion instructions from SOURCE for Version 9 records. See Use Case 22.</td></tr>
<tr><td>06/11/04</td><td>Removed IF#608 as it is duplicated in Err#612 under Report_Source</td></tr>
<tr><td>02/01/06</td><td>Removed IF #652 & 606 for cases where a “no treatment” decision is made at another facility and the Class 0 facility records this.</td></tr>
<tr><td>2010</td><td>Data Changes: Length changed from 1 to 2. New codes. Changed Update logic (was Manual). Source information updated. Conversion of old codes is required. Added IF612. Removed IF 652 (Class of Case, Date of Initial RX--SEER) and 772 (CS Items, Class of Case).
Pre-2010 Allowable Values:
0 DX Only Here
1 DX & RX Here
2 RX Here
3 DX & RX Elsewhere
4 DX &/or RX prior to hospital reference date
5 DX at Autopsy
6 Staff Physician
7 Pathology Report Only
8 Death Certificate Only (central registries only)
9 Unknown
See Eureka Process Specification: 2010 Data Conversions for most current conversion specs. As of 6/23/10 here is a copy for convenience:
4.1. Class_Of_Case
4.1.1. First, convert according to this table:
<table>
<tr><th>From</th><th>To</th></tr>
<tr><td>0</td><td>00</td></tr>
<tr><td>1</td><td>10</td></tr>
</table>
</td></tr>
</table>

	<table><tr><td>2</td><td>20</td></tr><tr><td>3</td><td>32</td></tr><tr><td>4</td><td>37</td></tr><tr><td>5</td><td>38</td></tr><tr><td>6</td><td>40</td></tr><tr><td>7</td><td>43</td></tr><tr><td>8</td><td>49</td></tr><tr><td>9</td><td>99</td></tr></table> 4.1.2. If any of the following conditions are true (condition values are all in already-converted, related tblAdmission_Master entries): Site = C440-C449 AND Hist_Type_2 or Hist_type_3 = 8000-8110 Site = C530-C539 AND Hist_Behavior_2 or Hist_Behavior_3 = 2 Site = C619 AND Hist_Type_2 or Hist_type_3 = 8148 Hist_Type_2 or Hist_type_3 = 8077 (Site is NOT C700-C729, and not C751-C753) AND (Hist_Behavior_2 or Hist_Behavior_3 = 0) Hist_Behavior_2 or Hist_Behavior_3 = 1 and NEITHER of the following conditions are true: Site is C569 AND Hist_Type_2 or Hist_Type_3 = 8442, 8451, 8462, 8472, or 8473) Site is C700-C729 or C751-C753) (DateOfDiagnosisFlag = 12 or Year_DX =0001-2000) AND (Site = C700-C729 or C751-C753 AND Hist_Behavior_2 or Hist_Behavior_3 = 0 or 1) (DateOfDiagnosisFlag = 12 or Year_DX = 0001-2000) AND Site = C569 AND Hist_Behavior_2 or Hist_Behavior_3 = 1 AND Hist_Type_2 or Hist_type_3 = 8442, 8451, 8462, 8472, or 8473 Then convert any of these values found again: <table><tr><td>From</td><td>To</td></tr><tr><td>00</td><td>34</td></tr><tr><td>10</td><td>34</td></tr><tr><td>20</td><td>36</td></tr></table>
03/14/11	Added some additional information relating to the asterisk in the table. IF 318 (Class of Case, County at DX, Date Added, Institution Referred From) and #607 (Class Case 2/3, Date of 1st Contact, Date of Diagnosis) made obsolete.
07/2015	Clarified Class of Case code descriptions to match NAACCR.

CoC Accredited Flag

IDENTIFIERS

CCR ID	NAACCR ID
E1906	2152

OWNER

CCR

DESCRIPTION

CoC Accredited Flag is assigned at the point and time of data abstraction to label an abstract being prepared for an analytic cancer case at a facility accredited by the Commission on Cancer (CoC). The flag may be assigned manually or can be defaulted by the registry's software.

LEVELS

Admissions

LENGTH

1

ALLOWABLE VALUES

0	Abstract prepared at a facility WITHOUT CoC accreditation of its cancer program
1	ANALYTIC abstract prepared at facility WITH CoC accreditation of its cancer program (Includes Class of Case codes 10-22)
2	NON-ANALYTIC abstract prepared at facility WITH CoC accreditation of its cancer program (Includes Class of Case codes 30-43 and 99, plus code 00 which CoC considers analytic but does not require to be staged)
Blank	Not applicable; DCO

SOURCE

If Coding Proc is less than 34 (2018 data changes), then convert from ACOS APPROVED according to use case Perform Eureka 2018 One-Time Data Conversions and Table Populations – UC, step 23.
Otherwise,

1. If all of the following conditions are true:
    a. Class of Case is 10-14, 20-22
    b. CoC Accredited Flag is not Blank, 0 or 1
    Then convert COC Accredited Flag to 1
2. If all of the following conditions are true:
    a. Class of Case is 00, 30-38, 40-43, 99
    b. COC Accredited Flag is not Blank, 0 or 2
    Then convert COC Accredited Flag to 2
3. If all of the following conditions are true:
    a. Class of Case is 49
    b. COC Accredited Flag is not blank
    Then convert COC Accredited Flag to blank
4. Otherwise, convert COC Accredited Flag to 0

UPDATE

Tumor Level

New Case Consolidation

Use the following hierarchy to determine the best value to populate at the consolidated level: 1, 2, 0, blank.

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes, from admission with the earliest date of first admission.

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented. Replaces ACOS Approved Flag [CCR #E1608].
01/2019	Revised Source Logic 1B and 2B to include Blank and 0
03/2019	Added Source Logic for Coding Proc 34 and Revised Update Logic to include code 0
08/2019	New edit added to v18c metafile (N2811) does not allow COC Accredited Flag to be blank for Date Dx 2018 forward except for Class of Case 49 (Reporting Source 7)
03/2020	Added "4. Otherwise, convert COC Accredited Flag to 0" to source Logic

CoC Coding Sys--Current

IDENTIFIERS

CCR ID	NAACCR ID
E1470	2140

DESCRIPTION

Code the ACoS CoC coding system currently used in the record. CoC codes may be converted from an earlier version.

LEVELS

Tumors

LENGTH

2

ALLOWABLE VALUES

00	No CoC coding system used
01	Pre-1988 (Cancer Program Manual Supplement)
02	1988 Data Acquisition Manual
03	1989 Data Acquisition Manual Revisions
04	1990 Data Acquisition Manual Revisions
05	1994 Data Acquisition Manual (Interim/Revised)
06	ROADS (effective with cases diagnosed 1996-1997)
07	ROADS and 1998 Supplement (effective with cases diagnosed 1998-2002)
08	FORDS2003/2004 effective with cases diagnosed 2003 and forward)
99	Unknown coding system

SOURCE

See Extract.

UPDATE

None

CONSOLIDATED DATA EXTRACT

Generate 08 (effective with cases diagnosed 2003 and forward) on extract.

HISTORICAL CHANGES

8/06	Generated item in Volume II added to Volume III with 2007 data changes.
2010	2010 Data Changes: Removed date specific info in Code 08.

CoC Coding Sys--Original

IDENTIFIERS

CCR ID	NAACCR ID
E1475	2150

DESCRIPTION

Code for the ACoS CoC coding system originally used to code the record.

LEVELS

Tumors

LENGTH

2

ALLOWABLE VALUES

Replace or None or use table for lists

00	No CoC coding system used
01	Pre-1988 (Cancer Program Manual Supplement)
02	1988 Data Acquisition Manual
03	1989 Data Acquisition Manual Revisions
04	1990 Data Acquisition Manual Revisions
05	1994 Data Acquisition Manual (Interim/Revised)
06	ROADS (effective with cases diagnosed 1996-1997)
07	ROADS and 1998 Supplement (effective with cases diagnosed 1998-2002)
08	FORDS 2003/2004 (effective with cases diagnosed 2003 and forward)
99	Original CoC coding system is not known

SOURCE

See Extract.

UPDATE

None

CONSOLIDATED DATA EXTRACT

Generate on extract:
If Date of Diagnosis < 1992, then generate 03 (1989 Data Acquisition Manual revisions)
Else
If Date of Diagnosis > 1991 and < 1994, then generate 04 (1990 Data Acquisition Manual revisions)
Else
If Date of Diagnosis > 1994 and < 1996, then generate 05 (1994 Data Acquisition Manual, Interim/Revised)
Else
If Date of Diagnosis > 1995 and < 1998, then generate 06 (ROADS and 1998 Supplement)
Else
If Date of Diagnosis > 1998 and < 2002, then generate 07 (1998 ROADS),
Otherwise,
Generate 08 (FORDS 2003+).

HISTORICAL CHANGES

8/06	Added for 2007 data changes.

2010	Data Changes: Removed date specific info in Code 08 and updated Date DX name to Date of Diagnosis.
2011	Data Changes: Changed wording of code 99 per NAACCR 12.1

Coding Proc

IDENTIFIERS

CCR ID	NAACCR ID
E1576	None: State Requestor

OWNER

CCR

DESCRIPTION

Designates the set of rules used to code this case. If a case is updated or deleted, then the coding procedure in effect at the time the update or deletion was made must be transmitted in the associated ~~correction,~~ ~~active follow-up~~ modified or deletion record (rather than transmitting the original coding procedure in effect when the case was abstracted).

LEVELS

Admissions

LENGTH

2

ALLOWABLE VALUES

03-09	Coded prior to May 1978 (Region 8 only)
10	Coded May 1978 - Dec. 1983 (Region 8 only)
11	Coded Jan. 1984 - Apr. 1988
12	Coded May 1988 and later
13	Coded June 1, 1991 and later (phased in C/N 1.34 - distribution dates varied)
14	DX January 1, 1992 and later and DX earlier that came in after C/N conversion (Spring thru Fall 92)
15	Coded during or after Summer 1993
16	Coded beginning in 1996
17	Coded beginning in 1997
18	Coded beginning in 1998
19	Coded beginning in 2000
20	Coded beginning in 2001
21	Coded beginning in 2003
22	Coded beginning in 2004
23	Coded beginning in 2005
24	Coding rules implemented with 2006 data changes
25	Coding rules implemented with 2007 data changes
26	Coding rules implemented with 2008 data changes
27	Coding rules implemented with 2010 data changes
28	Coding rules implemented with 2011 data changes
29	Coding rules implemented with 2012 data changes
30	Coding rules implemented with 2013 data changes
31	Coding rules implemented with 2014 data changes

32	Coding rules implemented with 2015 data changes
33	Coding rules implemented with 2016 data changes (No data changes for 2017 – code remained 33)
34	Coding rules implemented with 2018 data changes
99	Default value for blanks/non-numeric values

SOURCE

If the value is completely blank, then convert 99.
If the value includes a non-blank, non-numeric character, then convert 99.
Otherwise, just load the transmitted value. Right-justify and zero fill, but do not record change in Audit Log just for that reason.
Incoming values may not be less than 33.

UPDATE

None
When an on-line correction of AD-Coding_Proc is made, remind the user to check the following items for necessary changes.

Checklist for CP11 to12

Item	Action
RACE = 98	Possibly recode to 08-13
SPANISH-ORIGIN = 6	Possibly recode to 1-5
COUNTY-DX = 998	Recode to 110-725
HIST-TYPE = any (also HIST-BEHAVIOR and HIST_GRADE)	Recode using ICD-O 1988 Field Trial version as necessary
REASON-NO-SURG = 6	Possibly recode to 1-2, 7
SURG-PRIM-SUM = any	Recode to 1989 site-specific scheme.
RAD-SUM = 5-6	Recode to 1-4
SURG-HOSP = any	Recode to 1989 site-specific scheme
RAD-HOSP = 6	Recode to 2-3

Checklist for CP12 to13

Item	**Action**
RACE = 98	Possibly recode to 20 to 32 or 97 or 96.

Checklist for CP13 to14

This is the conversion from ICDO-1 to ICDO-2. Most sites converted directly. The following requires manual review:

Item	**Action**
191.5	C 71.5, C71.7

Checklist for CP14 to 15

Item	**Action**
RACE = 96 or 98	Possibly recode to 14.
~~RAD-HOSP~~	

Checklist for CP15 to 16

None

Checklist for CP16 to 17

None

Checklist for CP17 to 18

Item	Action
RADCNS-HOSP	Discontinued. Data integrated into Rad_Hosp field.
RADCNS-SUM	Discontinued. Data integrated into Rad_Sum field.
SURG-SUM	Data item split into 3 separate items. (SURG-PRIM-SUM, SCOPE-LN-SUM, and SURG-OTHER-SUM). New codes converted from 1996 codes. See ACoS conversion specs document. Old values kept on database.
SURG-HOSP	For cases prior to 1/1/98, codes converted from 1996 to 1998 code. Old codes kept on database. Converted codes moved into SURG-PRIM-PROC(1), SCOPE-LN-PROC (1), SURG OTHER-PROC (1).
RELIGION	New codes added. See Religion and Appendix 19.
SITE-ICDO1	Discontinued.
Hist_ICDO1	Discontinued.
ICDO2-CONV-FLAG	Discontinued.

Checklist for CP18 to 19

None

Checklist for CP19 to 20

This is the conversion from ICD-O-2 to ICD-O-3. Most histologies converted directly. There are some that required manual review. The conversion program will flag these cases.
Benign and uncertain behavior brain and CNS tumors became reportable. Programs need to be modified to allow these tumors with behavior codes of /0 and /1 to be collected.
Ovarian tumors that changed behavior in ICD-O-3 from /3 to /1 remain reportable to the CCR. Programs need to be modified to allow for their collection.

CONSOLIDATED DATA EXTRACT

Yes; highest code number on any Admissions record pertaining to this tumor.

HISTORICAL CHANGES

7/01	Added 20 to allowable values for 2001 data changes.
3/03	Added 21 to allowable values for 2003 data changes. For all the 2003 data item changes for this coding procedure, review the Summary of Changes document in Appendix 25.
3/04	Added 22 to Allowable Values for 2004 data changes. For all the 2004 data item changes for this coding procedure, review the Summary of Changes document in Appendix 25.
1/05	Added 23 to Allowable Values for 2005 data changes. 2005 data item changes are listed in the Summary of Changes document in Appendix 25.

2/06	Added 24 to Allowable Values for 2006 data changes.
8/06	Added 25 to Allowable Values for 2007 data changes. FYI: Coding procedure will now be in the record format for follow-up, corrections and deletion records. This was not done per IT.
6/07	This was not implemented by Eureka until this mid-year release. Added 99 to Allowable Values to follow source code logic (this arose in the processing of NC cases).
10/07	Added 26 to Allowable Values for 2008 data changes. Description changed to specify that the coding procedure in effect at the time an update or deletion was made must be transmitted in the associated correction, active follow-up, or deletion record (rather than transmitting the original coding procedure in effect when the case was abstracted).
2010	Added 27 to Allowable Values for 2010 Data Changes.
2011	Data Changes: Added 28 to Allowable Values for 2011 Data Changes.
2012	Data Changes: Added 29 to Allowable Values for 2011 Data Changes.
2013	Added 30 to Allowable Values for 2013 Data Changes.
04/2014	Added 31 to Allowable Values for 2014 Data Changes.
03/2015	Added 32 to Allowable Values for 2015
03/2016	Added 33 to Allowable Values for 2016 and 2017
02/2019	Added 34 to Allowable Values for 2018 Revised Description: removed 'correction and active follow-up' and replaced with 'modified'

Coding System for EOD

IDENTIFIERS

CCR ID	NAACCR ID	RASP Name
E1144	870	None

DESCRIPTION

Indicates the type of SEER EOD code applied to the tumor. Should be used whenever EOD coding is applied.

LEVELS

Tumors

LENGTH

1

ALLOWABLE VALUES

0	2-Digit Nonspecific Extent of Disease (1973-1982)
1	2-Digit Site-Specific Extent of Disease (1973-1982)
2	13-Digit (expanded) Site-Specific Extent of Disease (1973-1982)
3	4-Digit Extent of Disease (1983-87)
4	10-Digit Extent of Disease 1988 (1988-2003)
Blank	Cases diagnosed 2004+ (CS staging); pre-1973, or unknown dx year (9's)

SOURCE

If Date of Diagnosis year = 0001-1972, 2004-9998, or blank, then generate blank.
If Date of Diagnosis year = 1988-2003, then generate 4.
If Date of Diagnosis year = 1983-1987, then generate 3.

UPDATE

If Date of Diagnosis year changes, regenerate according to SOURCE specifications. Manual changes allowed for 1973-1982 diagnoses.

CCR DATA EXTRACT

Yes, see Source.

HISTORICAL CHANGES

8/27/03	Removed the Allowable values edit (#81).
8/15/06	Generated item in Volume II added to Volume III with 2007 data changes.
3/01/07	Changed name to match NAACCR name (was EOD_Scheme) and added NAACCR name, number, Allowable values and updated Source and Update to reflect what Eureka generates. Old Allowable Values Labels: 0=EOD_2 (non-specific) Region 8 incident cases only 1=EOD_2 (site-specific) Region 8 incident cases only 2=EOD_13 (13-digit) Region 8 incident cases only 3=EOD_4 (4-digit) Region 8 incident cases only 4=1988 and forward for Regions 1 and 8 1988 Breast cancer (SEER Site Recode = 26000) for all regions 1992 forward for Region 9

	1994 forward for all regions 9=EOD not coded
2010	2010 Data Changes: Changed Update logic to check year. Rewrote Source for date format changes.

Comorbid/Complication 1

IDENTIFIERS

CCR ID	NAACCR ID
E1253	3110

OWNER

CoC

DESCRIPTION

Records the patient's pre-existing medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer using ICD-9-CM codes. These are secondary diagnoses.

LEVELS

Tumors, Admissions

LENGTH

5

ALLOWABLE VALUES

00000	No comorbid conditions or complications documented.
00100-13980, 24000-99990	Comorbid conditions: Omit the decimal point between the third and fourth characters.
E8700-E8799, E9300-E9499	Complications: Omit the decimal point between the fourth and fifth characters.
V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, V5041-V5049	Factors affecting health status: Omit the decimal point between the fourth and fifth characters.
Blank	

SOURCE

Comorbid Fields Source Logic

UPDATE

Comorbid Fields Update Logic

CONSOLIDATED DATA EXTRACT

Yes, from the record with the most definitive surgical procedure for this tumor.

HISTORICAL CHANGES

03/03/04	New data item for 2004.
01/19/05	Corrected V codes.
05/11/11	Data Item Changes: Essentially a new edit. It was previously listed as an allowable value edit (ER240). Now, per NAACCR v12.1 it is an interfield edit (IF551) and cross edits ICD Revision Comorbid and Comorbid/Complication 1.
2012	Data Item Changes: Added ICD-10-CM code to description.
2013	Data Item Changes:

	• No longer allow ICD-10-CM codes to be used in this field, although all historical values will be retained. • Added IF697
04/2014	Clarifications to Description and Allowable Values. Added IF1121. Revisions to Source and Update Logic. Added to the Tumor Level.
07/2014	ICD-10-CM codes were only allowed in cases diagnosed in 2012, or those cases coded under the NAACCR v12.1 or 12.2 coding standards. Beginning with the NAACCR v13 coding standards, only ICD-9-CM codes were only allowed in this field. Historically, no ICD-10-CM codes had been entered into Eureka database. Allowable Values revised to accurately reflect this.

Comorbid/Complication 2

IDENTIFIERS

CCR ID	NAACCR ID
E1254	3120

OWNER

CoC

DESCRIPTION

Records the patient's pre-existing medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer using ICD-9-CM codes. These are secondary diagnoses.

LEVELS

Tumors, Admissions

LENGTH

5

ALLOWABLE VALUES

00100-13980, 24000-99990	Comorbid conditions: Omit the decimal point between the third and fourth characters.
E8700-E8799, E9300-E9499	Complications: Omit the decimal point between the fourth and fifth characters.
V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, V5041-V5049	Factors affecting health status: Omit the decimal point between the fourth and fifth characters.
Blank	Fewer than two comorbid conditions or complications documented.

SOURCE

Comorbid Fields Source Logic

UPDATE

Comorbid Fields Update Logic

CONSOLIDATED DATA EXTRACT

Yes, from the record with the most definitive surgical procedure for this tumor.

HISTORICAL CHANGES

03/03/04	New data item for 2004.
01/19/05	Added blank as an allowable value. Corrected V codes.
2011	Data Item Changes: Essentially a new edit. It was previously listed as an allowable value edit (ER241). Now, per NAACCR v12.1 it is an interfield edit (IF552) and cross edits ICD Revision Comorbid and Comorbid/Complication 2.
2012	Data Item Changes: Added ICD-10-CM code to description.
2013	Data Item Changes:

	• No longer allow ICD-10-CM codes to be used in this field, although all historical values will be retained. • Added IF698
04/2014	Clarifications to Description and Allowable Values. Added IF1121 and retired IF698. Revisions to Source and Update Logic. Added to the Tumor Level.
07/2014	ICD-10-CM codes were only allowed in cases diagnosed in 2012, or those cases coded under the NAACCR v12.1 or 12.2 coding standards. Beginning with the NAACCR v13 coding standards, only ICD-9-CM codes were only allowed in this field. Historically, no ICD-10-CM codes had been entered into Eureka database. Allowable Values revised to accurately reflect this.

Comorbid/Complication 3

IDENTIFIERS

CCR ID	NAACCR ID
E1255	3130

OWNER

CoC

DESCRIPTION

Records the patient's pre-existing medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer using ICD-9-CM codes. These are secondary diagnoses.

LEVELS

Tumors, Admissions

LENGTH

5

ALLOWABLE VALUES

00100-13980, 24000-99990	Comorbid conditions: Omit the decimal point between the third and fourth characters.
E8700-E8799, E9300-E9499	Complications: Omit the decimal point between the fourth and fifth characters.
V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, V5041-V5049	Factors affecting health status: Omit the decimal point between the fourth and fifth characters.
Blank	Fewer than two comorbid conditions or complications documented.

SOURCE

Comorbid Fields Source Logic

UPDATE

Comorbid Fields Update Logic

CONSOLIDATED DATA EXTRACT

Yes, from the record with the most definitive surgical procedure for this tumor.

HISTORICAL CHANGES

03/03/04	New data item for 2004.
01/19/05	Added blank as an allowable value. Corrected V codes.
2011	Data Item Changes: Essentially a new edit. It was previously listed as an allowable value edit (ER242). Now, per NAACCR v12.1 it is an interfield edit (IF553) and cross edits ICD Revision Comorbid and Comorbid/Complication 3.
2012	Data Item Changes: Added ICD-10-CM code to description.
2013	Data Item Changes:

	• No longer allow ICD-10-CM codes to be used in this field, although all historical values will be retained.
04/2014	Clarifications to Description and Allowable Values. Added IF1121. Revisions to Source and Update Logic. Added to the Tumor Level.
07/2014	ICD-10-CM codes were only allowed in cases diagnosed in 2012, or those cases coded under the NAACCR v12.1 or 12.2 coding standards. Beginning with the NAACCR v13 coding standards, only ICD-9-CM codes were only allowed in this field. Historically, no ICD-10-CM codes had been entered into Eureka database. Allowable Values revised to accurately reflect this.

Comorbid/Complication 4

IDENTIFIERS

CCR ID	NAACCR ID
E1256	3140

OWNER

CoC

DESCRIPTION

Records the patient's pre-existing medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer using ICD-9-CM codes. These are secondary diagnoses.

LEVELS

Tumors, Admissions

LENGTH

5

ALLOWABLE VALUES

00100-13980, 24000-99990	Comorbid conditions: Omit the decimal point between the third and fourth characters.
E8700-E8799, E9300-E9499	Complications: Omit the decimal point between the fourth and fifth characters.
V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, V5041-V5049	Factors affecting health status: Omit the decimal point between the fourth and fifth characters.
Blank	Fewer than two comorbid conditions or complications documented.

SOURCE

Comorbid Fields Source Logic

UPDATE

Comorbid Fields Update Logic

CONSOLIDATED DATA EXTRACT

Yes, from the record with the most definitive surgical procedure for this tumor.

HISTORICAL CHANGES

03/03/04	New data item for 2004.
01/19/05	Added blank as an allowable value. Corrected V codes.
2011	Data Item Changes: Essentially a new edit. It was previously listed as an allowable value edit (ER243). Now, per NAACCR v12.1 it is an interfield edit (IF554) and cross edits ICD Revision Comorbid and Comorbid/Complication 4.
2012	Data Item Changes: Added ICD-10-CM code to description.
2013	Data Item Changes:

	• No longer allow ICD-10-CM codes to be used in this field, although all historical values will be retained.
04/2014	Clarifications to Description and Allowable Values. Added IF1121. Revisions to Source and Update Logic. Added to the Tumor Level.
07/2014	ICD-10-CM codes were only allowed in cases diagnosed in 2012, or those cases coded under the NAACCR v12.1 or 12.2 coding standards. Beginning with the NAACCR v13 coding standards, only ICD-9-CM codes were only allowed in this field. Historically, no ICD-10-CM codes had been entered into Eureka database. Allowable Values revised to accurately reflect this.

Comorbid/Complication 5

IDENTIFIERS

CCR ID	NAACCR ID
E1257	3150

OWNER

CoC

DESCRIPTION

Records the patient's pre-existing medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer using ICD-9-CM codes. These are secondary diagnoses.

LEVELS

Tumors, Admissions

LENGTH

5

ALLOWABLE VALUES

00100-13980, 24000-99990	Comorbid conditions: Omit the decimal point between the third and fourth characters.
E8700-E8799, E9300-E9499	Complications: Omit the decimal point between the fourth and fifth characters.
V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, V5041-V5049	Factors affecting health status: Omit the decimal point between the fourth and fifth characters.
Blank	Fewer than two comorbid conditions or complications documented.

SOURCE

Comorbid Fields Source Logic

UPDATE

Comorbid Fields Update Logic

CONSOLIDATED DATA EXTRACT

Yes, from the record with the most definitive surgical procedure for this tumor.

HISTORICAL CHANGES

03/03/04	New data item for 2004.
01/19/05	Added blank as an allowable value. Corrected V codes.
2011	Data Item Changes: Essentially a new edit. It was previously listed as an allowable value edit (ER244). Now, per NAACCR v12.1 it is an interfield edit (IF555) and cross edits ICD Revision Comorbid and Comorbid/Complication 5.
2012	Data Item Changes: Added ICD-10-CM code to description.
2013	Data Item Changes:

	• No longer allow ICD-10-CM codes to be used in this field, although all historical values will be retained.
04/2014	Clarifications to Description and Allowable Values. Added IF1121. Revisions to Source and Update Logic. Added to the Tumor Level.
07/2014	ICD-10-CM codes were only allowed in cases diagnosed in 2012, or those cases coded under the NAACCR v12.1 or 12.2 coding standards. Beginning with the NAACCR v13 coding standards, only ICD-9-CM codes were only allowed in this field. Historically, no ICD-10-CM codes had been entered into Eureka database. Allowable Values revised to accurately reflect this.

Comorbid/Complication 6

IDENTIFIERS

CCR ID	NAACCR ID
E1258	3160

OWNER

CoC

DESCRIPTION

Records the patient's pre-existing medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer using ICD-9-CM codes. These are secondary diagnoses.

LEVELS

Tumors, Admissions

LENGTH

5

ALLOWABLE VALUES

00100-13980, 24000-99990	Comorbid conditions: Omit the decimal point between the third and fourth characters.
E8700-E8799, E9300-E9499	Complications: Omit the decimal point between the fourth and fifth characters.
V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, V5041-V5049	Factors affecting health status: Omit the decimal point between the fourth and fifth characters.
Blank	Fewer than two comorbid conditions or complications documented.

SOURCE

Comorbid Fields Source Logic

UPDATE

Comorbid Fields Update Logic

CONSOLIDATED DATA EXTRACT

Yes, from the record with the most definitive surgical procedure for this tumor.

HISTORICAL CHANGES

03/03/04	New data item for 2004.
01/19/05	Added blank as an allowable value. Corrected V codes.
2011	Data Item Changes: Essentially a new edit. It was previously listed as an allowable value edit (ER245). Now, per NAACCR v12.1 it is an interfield edit (IF556) and cross edits ICD Revision Comorbid and Comorbid/Complication 6.
2012	Data Item Changes: Added ICD-10-CM code to description.
2013	Data Item Changes:

	• No longer allow ICD-10-CM codes to be used in this field, although all historical values will be retained.
04/2014	Clarifications to Description and Allowable Values. Added IF1121. Revisions to Source and Update Logic. Added to the Tumor Level.
07/2014	ICD-10-CM codes were only allowed in cases diagnosed in 2012, or those cases coded under the NAACCR v12.1 or 12.2 coding standards. Beginning with the NAACCR v13 coding standards, only ICD-9-CM codes were only allowed in this field. Historically, no ICD-10-CM codes had been entered into Eureka database. Allowable Values revised to accurately reflect this.

Comorbid/Complication 7-10

IDENTIFIERS

CCR NAME	CCR ID	NAACCR ID
Comorbid Complication 7	E1259	3161
Comorbid Complication 8	E1260	3162
Comorbid Complication 9	E1261	3163
Comorbid Complication 10	E1262	3164

OWNER

CoC

DESCRIPTION

Records the patient's pre-existing medical conditions, factors influencing health status, and/or complications for the treatment of this cancer using ICD-9-CM codes. All are considered secondary diagnoses.

LEVELS

Tumors, Admissions

LENGTH

5

ALLOWABLE VALUES

00100-13980, 24000-99990	Comorbid conditions: Omit the decimal point between the third and fourth characters.
E8700-E8799, E9300-E9499	Complications: Omit the decimal point between the fourth and fifth characters.
V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, V5041-V5049	Factors affecting health status: Omit the decimal point between the fourth and fifth characters.
Blank	Fewer than two comorbid conditions or complications documented.

SOURCE

Comorbid Fields Source Logic

UPDATE

Comorbid Fields Update Logic

CONSOLIDATED DATA EXTRACT

Yes, from the record with the most definitive surgical procedure for this tumor.

HISTORICAL CHANGES

03/03/04	New data item for 2004.
01/19/05	Added blank as an allowable value. Corrected V codes.
2011	Data Item Changes: Essentially a new edit. It was previously listed as an allowable value edit (ER278, 279, 280, and 281). Now, per NAACCR v12.1 it is an interfield edit (IF557, 558, 559, and 560) and cross edits ICD Revision Comorbid and Comorbid/Complication 7-10.

2012	Data Item Changes: Added ICD-10-CM code to description.
2013	Data Item Changes: • No longer allow ICD-10-CM codes to be used in this field, although all historical values will be retained.
04/2014	Clarifications to Description and Allowable Values. Added IF1121. Revisions to Source and Update Logic. Added to the Tumor Level.
07/2014	ICD-10-CM codes were only allowed in cases diagnosed in 2012, or those cases coded under the NAACCR v12.1 or 12.2 coding standards. Beginning with the NAACCR v13 coding standards, only ICD-9-CM codes were only allowed in this field. Historically, no ICD-10-CM codes had been entered into Eureka database. Allowable Values revised to accurately reflect this.
05/2016	Per NAACCR v16, updated description to match NAACCR with the removal of the term "hospital" to accommodate EHR reporting.

Computed Ethnicity

IDENTIFIERS

CCR ID	NAACCR ID
E1029	200

DESCRIPTION

This code is used to denote those persons with Spanish surname as recognized by the computer from tables of Spanish names. It conforms to the codes used by NAACCR for Computed Ethnicity.

LEVELS

Patients

LENGTH

1

ALLOWABLE VALUES

0	No match was run
1	Non-Hispanic last name and Non-Hispanic Maiden Name
2	Non-Hispanic last name didn't check Maiden Name (or male)
3	Non-Hispanic last name, missing Maiden Name
4	Hispanic last name, Non-Hispanic Maiden Name
5	Hispanic last name, didn't check Maiden Name (or male)
6	Hispanic last name, missing Maiden Name
7	Hispanic Maiden name (females only) regardless of Surname
Blank	For SEER, blanks are required for all cases diagnosed before 1994 and blanks are not allowed for any case diagnosed 1994 and after. Other registries may have computed this item for earlier years.

SOURCE

Computer generate:
Move 0 to Computed Ethnicity.
If Not Male (Sex <> 1)
    If there is no Name--Maiden
        Move 3 to Computed Ethnicity
    Else
        If Name--Maiden1 is Spanish
            Move 7 to Computed Ethnicity
        Else
            Move 1 to Computed Ethnicity
Else (Male Sex = 1)
    Move 2 to Computed Ethnicity.
If Computed Ethnicity = 7
    Stop.
Else
    If Name--Last1 is Spanish
If Computed Ethnicity = 3

Move 6 to Computed Ethnicity

Else

If Computed Ethnicity = 1

Move 4 to Computed Ethnicity

Else (Hispanic male)

Move 5 to Computed Ethnicity

If Name is hyphenated and the hyphenated name is not found on the Spanish Surname table, look for each portion of the name on the Spanish Surname table.

UPDATE

Update with appropriate values using Spanish surname table (see Appendix O of Volume I).
Note: If Computed Ethnicity changes, you may need to update RACE-RECODE-CAL.

CONSOLIDATED DATA EXTRACT

Generate the code depending on the value in the Computed Ethnicity field.

- If 9, generate 0: No match yet done
- If 0, generate 2: Non-Hispanic Last Name, no check on Maiden Name
- If 6, generate 5: Hispanic Last Name, no check on Maiden Name
- For cases diagnosed prior to 1993 submit blank.

HISTORICAL CHANGES

11/2002	Generated when necessary and not stored in the database. The allowable values edit was removed.
08/2006	Changed name to NAACCR name (was Spanish_Surname). Added Extract information from Volume II.
03/2020	Added back to Volume III

Computed Ethnicity Source

IDENTIFIERS

CCR ID	NAACCR ID
E1030	210

DESCRIPTION

Code identifying the method used to determine ethnicity as recorded in Computed Ethnicity (200).

LEVELS

Tumors

LENGTH

1

ALLOWABLE VALUES

0	No match was run, for 1994 and later tumors
1	Census Bureau list of Spanish surnames, NOS
2	1980 Census Bureau list of Spanish surnames
3	1990 Census Bureau list of Spanish surnames
4	GUESS Program
5	Combination list including South Florida names
6	Combination of Census and other locally generated list
7	Combination of Census and GUESS, with or without other lists
8	Other type of match
9	Unknown type of match
Blank	1993 and earlier tumors, no match was run
NOTE:	For SEER, blanks are required for all cases diagnosed before 1994 and blanks are not allowed for any case diagnosed 1994 and after. Other registries may have computed this item for earlier years.

SOURCE

See Extract.

UPDATE

None

CONSOLIDATED DATA EXTRACT

Generate 6 (1990 Census plus local)

HISTORICAL CHANGES

8/15/06	Generated item in Volume II added to Volume III with 2007 data changes.

Contact Name

IDENTIFIERS

CCR ID	NAACCR ID
E1740	None

DESCRIPTION

Patient's name as it should appear on a letter (include prefixes - e.g., Mr., Mrs., Sister and suffixes - e.g., Esq., Jr., M.D.) or contact's name (e.g., parent's name if patient is a minor).

LEVELS

Patients, Admissions

LENGTH

30

ALLOWABLE VALUES

Any. Should be alpha, possibly with punctuation marks and embedded blanks; entire field may be blank.

SOURCE

Upload with no conversion.

UPDATE

Patient Active Follow-up Fields Update Logic

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

2010	2010 Data Changes: Update logic rewritten to include new date operability rules.

County at DX Reported

IDENTIFIERS

CCR-ID	NAACCR-ID
E1012	90

DESCRIPTION

Code for the county of the patient's residence at the time the tumor was diagnosed. For U.S. residents, standard codes are those of the FIPS publication "Counties and Equivalent Entities of the United States, Its Possessions, and Associated Areas." If the patient has multiple tumors, the county codes may be different for each tumor.

Detailed standards have not been set for Canadian provinces/territories. Use code 998 for Canadian residents.

Note: SEER does not use code 998. CoC uses country geocodes for nonresidents of the United States (see Appendix B) and 998 for residents of other states.

LEVELS

Tumors, Admissions

LENGTH

3

ALLOWABLE VALUES

001-058	California counties in alphabetical order. (See Volume I) (Alameda....Yuba)
000	California, county unknown or other USA state
100-725	Non-USA (see Appendix D of Volume I) (COUNTRY-CODES)
998	Non-USA (other than Canada and Mexico), specific country code not yet assigned
999	Unknown country of residence when this tumor was first diagnosed

SOURCE

If the value is completely blank, then convert 999.

If the value contains a non-blank, non-numeric character, then convert 999.

Otherwise, just load the transmitted value, but right-justify and zero fill (but do not record change in Audit Log just for this formatting).

UPDATE

Tumor Level

New Case Consolidation

If Admission level County at DX is not 999 or 998,

If Tumor level County at DX is 999 or 998, then update.

If not equal, then list for review.

Geocoding Upload

Convert from FIPS county code and list for review if converted code is different than existing County at DX

Manual Change

Admission Level

Manual Change Only

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

10/07	Stopped using city/county look-up table and now use USPS tables.
2011	Data Changes: CCR name changed (County DX) to match NAACCR name.
2/24/2011	Removed IF306, 318, 334, 336, 437, 440 and 441.
05/2013	Added IF 1049, 1050
07/2015	Updated description to match NAACCR.
01/2019	Per NAACCR v18, data item name revised from County at DX to County at DX Reported.

County at DX Geocode 1970/80/90

IDENTIFIERS

CCR ID	NAACCR ID
E1795	94

OWNER

NAACCR

DESCRIPTION

Code for the county of the patient's residence at the time the tumor was diagnosed is a derived (geocoded) variable based on Census Boundary files from 1990 Decennial Census. This code should be used for county and county-based (such as CHSDA) rates and analysis for all cases diagnosed prior to 2000. Recording a county at diagnosis that reflects the relevant date (decade) and relies on geocoded data will improve the accuracy of county and census tract assignments and of links with geographic data (i.e., population, poverty category, urban/rural designation).

LEVELS

Tumors

LENGTH

3

ALLOWABLE VALUES

001-997	County at diagnosis. Valid FIPS code.
998	Outside state/county code unknown. Known town, city, state, or country of residence but county code not known AND a resident outside of the state of reporting institution (must meet all criteria).
999	County unknown. The county of the patient is unknown, or the patient is not a United States resident. County is not documented in the patient's medical record.
Blank	Not tracted.

Note: For U.S. residents, historically, standard codes are those of the FIPS publication "Counties and Equivalent Entities of the United States, Its Possessions, and Associated Areas." These FIPS codes (FIPS 6-4) have been replaced by INCITS standard codes, however, there is no impact on this variable as the codes align with the system the Census used for each decennial census and will automatically be accounted for during geocoding.

SOURCE

No County at DX Geocode1990 at admission. Variable created at tumor. Set to blank for new cases.

UPDATE

Whenever Census Tract 1970/80/90 is changed, County at DX Geocode1990 must be changed accordingly:

- If Census Tract 1970/80/90 is '999996' or '999997' (waiting for geocoding) then County at DX Geocode1990 must be blank.
- If Census Tract 1970/80/90 cannot be tracted (999993-999995 or 999998-999999) then County at DX Geocode1990 must be 999.

- If Census Tract 1970/80/90 is tracted and a County at DX Geocode1990 is available (whether through geocoding or linking a tumor with a tracted address) the available County at DX Geocode1990 code should be used.
- However, if Census Tract 1970/80/90 is tracted but County at DX Geocode1990 is not available, County at DX Geocode1990 should be set to blank.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

05/2016	Per NAACCR v16, new geocode data field implemented.
01/2019	Per NAACCR v18, data item name revised from County at DX Geocode1990 to County at DX Geocode 1970/80/90.

County at DX Geocode2000

IDENTIFIERS

CCR ID	NAACCR ID
E1796	95

OWNER

NAACCR

DESCRIPTION

Code for the county of the patient's residence at the time the tumor was diagnosed is a derived (geocoded) variable based on Census Boundary files from 2000 Decennial Census. This code should be used for county and county-based (such as CHSDA) rates and analysis for all cases diagnosed prior to 2000-2009. Recording a county at diagnosis that reflects the relevant date (decade) and relies on geocoded data will improve the accuracy of county and census tract assignments and of links with geographic data (i.e., population, poverty category, urban/rural designation).

LEVELS

Tumors

LENGTH

3

ALLOWABLE VALUES

001-997	County at diagnosis. Valid FIPS code.
998	Outside state/county code unknown. Known town, city, state, or country of residence but county code not known AND a resident outside of the state of reporting institution (must meet all criteria).
999	County unknown. The county of the patient is unknown, or the patient is not a United States resident. County is not documented in the patient's medical record.
Blank	Not tracted.

Note: For U.S. residents, historically, standard codes are those of the FIPS publication "Counties and Equivalent Entities of the United States, Its Possessions, and Associated Areas." These FIPS codes (FIPS 6-4) have been replaced by INCITS standard codes, however, there is no impact on this variable as the codes align with the system the Census used for each decennial census and will automatically be accounted for during geocoding.

SOURCE

No County at DX Geocode2000 at admission. Variable created at tumor. Set to blank for new cases.

UPDATE

Whenever Census Tract 2000 is changed, County at DX Geocode2000 must be changed accordingly:

- If Census Tract 2000 is '999996' or '999997' (waiting for geocoding) then County at DX Geocode2000 must be blank.
- If Census Tract 2000 cannot be tracted (999993-999994 or 999998-999999) then County at DX Geocode2000 must be 999.

- If Census Tract 2000 is tracted and a County at DX Geocode2000 is available (whether through geocoding or linking a tumor with a tracted address) the available County at DX Geocode2000 code should be used.
- However, if Census Tract 2000 is tracted but County at DX Geocode2000 is not available, County at DX Geocode2000 should be set to blank.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

05/2016	Per NAACCR v16, new geocode data field implemented.

County at DX Geocode2010

IDENTIFIERS

CCR ID	NAACCR ID
E1797	96

OWNER

NAACCR

DESCRIPTION

Code for the county of the patient's residence at the time the tumor was diagnosed is a derived (geocoded) variable based on Census Boundary files from 2010 Decennial Census. This code should be used for county and county-based (such as CHSDA) rates and analysis for all cases diagnosed prior to 2010-2019. Recording a county at diagnosis that reflects the relevant date (decade) and relies on geocoded data will improve the accuracy of county and census tract assignments and of links with geographic data (i.e., population, poverty category, urban/rural designation).

LEVELS

Tumors

LENGTH

3

ALLOWABLE VALUES

001-997	County at diagnosis. Valid FIPS code.
998	Outside state/county code unknown. Known town, city, state, or country of residence but county code not known AND a resident outside of the state of reporting institution (must meet all criteria).
999	County unknown. The county of the patient is unknown, or the patient is not a United States resident. County is not documented in the patient's medical record.
Blank	Not tracted.

Note: For U.S. residents, historically, standard codes are those of the FIPS publication "Counties and Equivalent Entities of the United States, Its Possessions, and Associated Areas." These FIPS codes (FIPS 6-4) have been replaced by INCITS standard codes, however, there is no impact on this variable as the codes align with the system the Census used for each decennial census and will automatically be accounted for during geocoding.

SOURCE

No County at DX Geocode2010 at admission. Variable created at tumor. Set to blank for new cases.

UPDATE

Whenever Census Tract 2010 is changed, County at DX Geocode2010 must be changed accordingly:

- If Census Tract 2010 is '999996' or '999997' (waiting for geocoding) then County at DX Geocode2010 must be blank.
- If Census Tract 2010 cannot be tracted (999993-999994 or 999998-999999) then County at DX Geocode2010 must be 999.

- If Census Tract 2010 is tracted and a County at DX Geocode2010 is available (whether through geocoding or linking a tumor with a tracted address) the available County at DX Geocode2010 code should be used.
- However, if Census Tract 2010 is tracted but County at DX Geocode2010 is not available, County at DX Geocode2010 should be set to blank.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

05/2016	Per NAACCR v16, new geocode data field implemented.

County at DX Geocode2020

IDENTIFIERS

CCR ID	NAACCR ID
E1798	97

OWNER

NAACCR

DESCRIPTION

Code for the county of the patient's residence at the time the tumor was diagnosed is a derived (geocoded) variable based on Census Boundary files from 2020 Decennial Census. This code should be used for county and county-based (such as CHSDA) rates and analysis for all cases diagnosed prior to 2020-2029. Recording a county at diagnosis that reflects the relevant date (decade) and relies on geocoded data will improve the accuracy of county and census tract assignments and of links with geographic data (i.e., population, poverty category, urban/rural designation).

LEVELS

Tumors

LENGTH

3

ALLOWABLE VALUES

001-997	County at diagnosis. Valid FIPS code.
998	Outside state/county code unknown. Known town, city, state, or country of residence but county code not known AND a resident outside of the state of reporting institution (must meet all criteria).
999	County unknown. The county of the patient is unknown, or the patient is not a United States resident. County is not documented in the patient's medical record.
Blank	Not tracted.

Note: For U.S. residents, historically, standard codes are those of the FIPS publication "Counties and Equivalent Entities of the United States, Its Possessions, and Associated Areas." These FIPS codes (FIPS 6-4) have been replaced by INCITS standard codes, however, there is no impact on this variable as the codes align with the system the Census used for each decennial census and will automatically be accounted for during geocoding.

SOURCE

No County at DX Geocode2020 at admission. Variable created at tumor. Set to blank for new cases.

UPDATE

Whenever Census Tract 2020 is changed, County at DX Geocode2020 must be changed accordingly:

- If Census Tract 2020 is '999996' or '999997' (waiting for geocoding) then County at DX Geocode2020 must be blank.
- If Census Tract 2020 cannot be tracted (999993-999994 or 999998-999999) then County at DX Geocode2020 must be 999.

- If Census Tract 2020 is tracted and a County at DX Geocode2020 is available (whether through geocoding or linking a tumor with a tracted address) the available County at DX Geocode2020 code should be used.
- However, if Census Tract 2020 is tracted but County at DX Geocode2020 is not available, County at DX Geocode2020 should be set to blank.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

05/2016	Per NAACCR v16, new field implemented in record layout only. Field is a placeholder for 2020 Data Changes and is not implemented in Eureka.

Creatinine Pretreatment Lab Value

IDENTIFIERS

CCR ID	NAACCR ID
E1937	3824

OWNER

NAACCR

DESCRIPTION

Creatinine Pretreatment Lab Value, an indicator of kidney function is required to calculate the Model for End-Stage Liver Disease (MELD) score, which is used to assign priority for liver transplant.

LEVELS

Admissions, Tumors

LENGTH

4

ALLOWABLE VALUES

0.0	0.0 milligram/deciliter (mg/dl) 0.0 micromole/liter (umol/L)
0.1 – 99.9	0.1-99.9 milligram/deciliter (mg/dl) 0.1-99.9 micromole/liter (umol/L) (Exact value to nearest tenth of mg/dl or umol/L)
XX.1	100 mg/dl or greater 100 umol/L or greater
XX.7	Test ordered, results not in chart
XX.8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code XX.8 will result in an edit error.)
XX.9	Not documented in medical record Creatinine Pretreatment Lab Value not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00220
        - Type of Reporting Source is not 7
        - COC Accredited Flag is 1
        - Creatinine Pretreatment Lab Value is blank or XX.8

        Then convert Creatinine Pretreatment Lab Value to XX.9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00220

            OR

- Type of Reporting Source is 7
- Creatinine Pretreatment Lab Value is not blank

Then convert Creatinine Pretreatment Lab Value to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00220
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00220

One of the following conditions is true

- Admission's value is not blank, XX.8, XX.9
- Tumor's value is blank , XX.8, or XX.9

OR

- Admission's value is XX.9
- Tumor's value is blank or XX.8

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Creatinine Pretreatment Unit of Measure

IDENTIFIERS

CCR ID	NAACCR ID
E1938	3825

OWNER

NAACCR

DESCRIPTION

Creatinine Pretreatment Unit of Measure identifies the unit of measure for the creatinine value measured in blood or serum prior to treatment. Creatinine is commonly measured in units of Milligrams/deciliter (mg/dl) in the United States and Micromoles/liter (umol/L) in Canada and Europe.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

1	Milligrams/deciliter (mg/dl)
2	Micromoles/liter (umol/L)
7	Test ordered, results not in chart
8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code 8 will result in an edit error.)
9	Not documented in medical record Creatinine unit of measure not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
   - A. If all of the following conditions are true:
     - Schema ID is 00220
     - Type of Reporting Source is not 7
     - COC Accredited Flag is 1
     - Creatinine Pretreatment Unit of Measure is blank or 8

     Then convert Creatinine Pretreatment Unit of Measure to 9
   - B. If all of the following conditions are true:
     - One of the following is true:
       - Schema ID is not 00220

         OR
       - Type of Reporting Source is 7
     - Creatinine Pretreatment Unit of Measure is not blank

     Then convert Creatinine Pretreatment Unit of Measure to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00220
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00220

One of the following conditions is true

- Admission's value is not blank, 8, 9
- Tumor's value is blank, 8, or 9

OR

- Admission's value is 9
- Tumor's value is blank or 8

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

CS Extension

IDENTIFIERS

CCR ID	NAACCR ID
E1166	2810

OWNER

AJCC

DESCRIPTION

This data item identifies contiguous growth (extension) of the primary tumor within the organ of origin or its direct extension into neighboring organs. Tumor extension at diagnosis is a prognostic indicator used by Collaborative Staging to derive some TNM-T codes and some SEER Summary Stage codes.
For cases diagnosed prior to 2010: this was a 2-character field in CS version 1 which was converted to a 3-character field in CS version 2. Most 2-character codes were converted by adding a zero as the third character. For example, code 05 was usually converted to 050, 10 to 100, 11 to 110, etc. Special codes such as 88 and 99 were usually converted to 888 and 999, respectively.

LEVELS

Tumors, Admissions

LENGTH

3

ALLOWABLE VALUES

000-999	Site specific
Blank	Year of Diagnosis is before 2004 or after 2015

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org) for rules and site-specific codes and coding structures.

SOURCE

See CS Version Derived

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Any of these conditions are true:
  - the admission's Date of Diagnosis year is 2004-2015
  - the tumor's Date of Diagnosis year is 2004-2015
  - the tumor's Date of Diagnosis year is blank AND the admission's Date of 1st Contact year is 2004-2015
  - the admission's Date of Diagnosis year is blank AND the admission's Date of 1st Contact year is 2004-2015
- the admission's CS value is NOT blank
- the admission and tumor's CS values are different

then list for review

Manual Change

Admission Level

Manual Change or Correction Applied

CONSOLIDATED DATA EXTRACT

Yes, extract from tumor.

HISTORICAL CHANGES

03/03/04	New data item for 2004
01/19/05	Added 13) IF #718 to validate the CS Extension by primary site & histology. Added #731. Renumbered IF #472 to 15.
07/13/05	Added histo code 9734 (extramedullary plasmacytoma) to Err# 731 so CS_Ext 10 allowable for this histology. Added Err #733 and renumbered edit errors to group histology exclusion edits together. Updated #480 and #481 with CS_Ext values. Removed Urethra out of main #479 site grouping edit since CS_Ext codes are different. Added 11 and 13 to match the CS edits. Added Obsolete table reference to Err #718. Added upload conversion spec note to Source.
02/01/06	Added Update logic that covers Date_DX unknown. Added logic to IF's 2)-20) that apply at the admission level only for Date_DX unknown. For CS Version 01.02.00 these CS Ext codes became obsolete: Prostate (61.9) = 31, 33 & 34 and Renal Pelvis (65.9, 66.9) = 62.
2010	2010 Data Changes: Length changed from 2 to 3. Added IF #837, 843, 877, 878, & 977.
07/27/11	IF 380 and 381 were created to comply with NAACCR 12.1.A
05/2013	Added IF1005, 1006, 1007, 1008, 1009, 1010, 1011, 1012, 1013, 1014, 1015, 1026, 1051, 1054, 1058, 1059, 1061.
05/2016	Per NAACCR v16, CS Extension is no longer required for DX Year 2016 and forward. Updated description and codes to match NAACCR. Update logic revised to follow new year requirements.

CS Lymph Nodes

IDENTIFIERS

CCR ID	NAACCR ID
E1168	2830

OWNER

AJCC

DESCRIPTION

This data item identifies the regional lymph nodes involved with cancer at the time of diagnosis.

LEVELS

Tumors, Admissions

LENGTH

3

ALLOWABLE VALUES

000-999	Site specific
Blank	Year of Diagnosis is before 2004 or after 2015

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org) for rules and site-specific codes and coding structures.

SOURCE

See CS Version Derived

UPDATE

See CS Extension

CONSOLIDATED DATA EXTRACT

Yes, extract from tumor

HISTORICAL CHANGES

03/03/04	New data item for 2004.
01/19/05	Removed 88 from CS_LN value in IF 485. Removed 05 from CS_LN value in #486. Removed IF 487. Added IF #535 under 3) Added 4) Err #719 to validate the CS Lymph Nodes by primary site & histology. Renumbered IF #484 to 5).
07/13/05	Added Obsolete table reference to Err #719. Added upload conversion note to Source.
02/01/06	Added Update logic that covers Date_DX unknown. Added logic to IF's (1-4) that apply at the admission level only for Date_DX unknown. For CS Version 01.02.00 these CS LN codes became obsolete: Thyroid (73.9) = 11, 20, 21, 30 & 31.
11/08/06	For CS Version 01.03 CS_Exten.dbf updated to allow CS Extension codes of 62, 63 and 64 for Ethmoid Sinus schema and 67 for Liver schema.
2010	Data Item Changes: CCR name (CS LN) changed to NAACCR name. Length changed from 2 to 3. Allowable values changed from "00-99" to "000-999". Added IF824, IF849, IF877, IF878, IF880, and IF978. Revised Update logic based on date criteria. Source updated. All CS fields will be converted to CSv2; (see https://cancerstaging.org/cstage/coding/Documents/csv1tocsv2conversionspecs.pdf): CS Lymph Nodes will convert 1. Convert 88 to 888

	2. Convert 99 to 999 3. Add trailing zero to all other numeric values (e.g., 23 becomes 230)
05/2013	Added IF 1016, 1017, 1018, 1019, 1020, 1021, 1022, 1027, 1028, 1033, 1052, 1053, 1057, 1066.
05/2016	Per NAACCR v16, CS Lymph Nodes is no longer required for DX Year 2016 and forward. Updated description and codes to match NAACCR. Update logic revised to follow new year requirements.

CS Lymph Nodes Eval

IDENTIFIERS

CCR ID	NAACCR ID
E1169	2840

OWNER

AJCC

DESCRIPTION

Records how the code for CS Lymph Nodes [NAACCR #2830] was determined, based on the diagnostic methods employed. This data item is used by Collaborative Staging to describe whether the staging basis for the TNM-N code is clinical or pathological and to record applicable prefix and suffix descriptors used with TNM staging.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

0-3, 5, 6, 8, 9	Site specific
Blank	Year of Diagnosis is before 2004 or after 2015

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org) for rules and site-specific codes and coding structures.

SOURCE

See CS Version Derived

UPDATE

See CS Extension

CONSOLIDATED DATA EXTRACT

Yes, extract from tumor

HISTORICAL CHANGES

03/03/04	Not a required data item for 2004 but is sent in from CoC facilities and will only be edited to validate the Allowable values.
02/01/06	Added Update logic that covers Date_DX unknown.
10/10/07	This is a reportable date item starting with 2008 cases per SEER. Added IF #779.
02/2009	Added IF #824.
2010	Data Item Changes: NAACCR changed data item name to CS Lymph Nodes Eval (was CS Reg Node Eval). Revised Update logic based on date criteria. All CS fields will be converted to CSv2; CS Lymph Nodes Eval will have the existing value copied; (see https://cancerstaging.org/cstage/coding/Documents/csv1tocsv2conversionspecs.pdf). Added IF #877, 878 & 979.

05/2013	Added IF 1016, 1017, 1018, 1019, 1020, 1021, 1022, 1052, 1053.
05/2016	Per NAACCR v16, CS Lymph Nodes Eval is no longer required for DX Year 2016 forward. Updated description and codes to match NAACCR. Update logic revised to follow new year requirements.

CS Mets at DX

IDENTIFIERS

CCR ID	NAACCR ID
E1170	2850

OWNER

AJCC

DESCRIPTION

This data item identifies the distant site(s) of metastatic involvement at time of diagnosis.

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

00-99	Site specific
Blank	Year of Diagnosis is before 2004 or after 2015

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org) for rules and site-specific codes and coding structures.

SOURCE

See CS Version Derived

UPDATE

See CS Extension

CONSOLIDATED DATA EXTRACT

Yes, extract from tumor

HISTORICAL CHANGES

03/2004	New data item for 2004.
01/2005	Added IF #720 to validate the CS Mets at DX by site & histology. Renumbered IF #489 to 3).
07/2005	Added Obsolete table reference to Err #720. Added upload conversion spec to Source.
02/2006	Added Update logic that covers Date_DX unknown. Added logic to IF's 1)-2) that apply at the admission level only for Date_DX unknown. For CS Version 01.02.00 these CS Mets DX codes became obsolete: Thyroid (73.9) = 10, 11 & 50.
02/2009	Added IF 823.
2010	Data Item Changes: CR name (CS Mets DX) changed to NAACCR name. Revised Update logic based on date criteria. Source updated. All CS fields will be converted to CSv2; CS Tumor Size will have the existing value copied; (see https://cancerstaging.org/cstage/coding/Documents/csv1tocsv2conversionspecs.pdf). Added IF #846, 848, 850, 851, 852, 875, 877, 878, 885 & 980.
05/2013	Added IF 1023, 1029, 1035, 1038, 1062.
05/2016	Per NAACCR v16, CS Mets at DX is no longer required for DX Year 2016 and forward. Updated description and codes to match NAACCR. Update logic revised to follow new year requirements.

CS Mets at Dx-Bone

IDENTIFIERS

CCR ID	NAACCR ID
E1172	2851

OWNER

AJCC

DESCRIPTION

This data item identifies the presence of distant metastatic involvement of bone at time of diagnosis. The presence of metastatic bone disease at diagnosis is an independent prognostic indicator, and it is used by Collaborative Staging to derive TNM-M codes and SEER Summary Stage codes for some sites.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

0, 1, 8, 9	Site specific
Blank	Year of Diagnosis is before 2010 or after 2015

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org) for rules and site-specific codes and coding structures.

SOURCE

See CS Version Derived

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Any of these conditions are true:
  - the admission's Date of Diagnosis year is 2010-2015
  - the tumor's Date of Diagnosis year is 2010-2015
  - the tumor's Date of Diagnosis year is blank AND the admission's Date of 1st Contact year is 2010-2015
  - the admission's Date of Diagnosis year is blank AND the admission's Date of 1st Contact year is 2010-2015
- the admission's CS value is NOT blank
- the admission and tumor's CS values are different

Then list for review

Manual Change

Admission Level

Manual Change or Correction Applied

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

2010	New data item for 2010. CSv1 to CSv2 Conversion Specs documentation states to leave these blank (see https://cancerstaging.org/cstage/coding/Documents/csv1tocsv2conversionspecs.pdf). Added IF #846, 848, 850, and 878. Updated the description section.
05/2016	Per NAACCR v16, CS Mets at DX-Bone is no longer required for DX Year 2016 and forward. Updated description and codes to match NAACCR. Update logic revised to follow new year requirements.

CS Mets at Dx-Brain

IDENTIFIERS

CCR ID	NAACCR ID
E1173	2852

OWNER

AJCC

DESCRIPTION

The presence of metastatic brain disease at diagnosis is an independent prognostic indicator, and it is used by Collaborative Staging to derive TNM-M codes and SEER Summary Stage codes for some sites. Effective for cases diagnosed 2010+.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

0, 1, 8, 9	Site specific
Blank	Year of Diagnosis is before 2010 or after 2015

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org) for rules and site-specific codes and coding structures.
Note: This includes only the brain, not spinal cord or other parts of the central nervous system.

SOURCE

See CS Version Derived

UPDATE

See CS Mets at DX--Bone

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

2010	New data item for 2010. CSv1 to CSv2 Conversion Specs documentation states to leave these blank (see https://cancerstaging.org/cstage/coding/Documents/csv1tocsv2conversionspecs.pdf). Added IF #846, 848, 850, and 878. Updated the description section.
05/2016	Per NAACCR v16, CS Mets at DX-Brain is no longer required for DX Year 2016 and forward. Updated description and codes to match NAACCR. Update logic revised to follow new year requirements.

CS Mets at Dx-Liver

IDENTIFIERS

CCR ID	NAACCR ID
E1174	2853

OWNER

AJCC

DESCRIPTION

Identifies the presence of distant metastatic involvement of the liver at time of diagnosis. The presence of metastatic liver disease at diagnosis is an independent prognostic indicator, and it is used by Collaborative Staging to derive TNM-M codes and SEER Summary Stage codes for some sites.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

0, 1, 8, 9	Site specific
Blank	Year of Diagnosis is before 2010 or after 2015

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org) for rules and site-specific codes and coding structures.

SOURCE

See CS Version Derived

UPDATE

See CS Mets at DX--Bone

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

2010	New data item for 2010. CSv1 to CSv2 Conversion Specs documentation states to leave these blank (see https://cancerstaging.org/cstage/coding/Documents/csv1tocsv2conversionspecs.pdf). Added IF #846, 848, 850, and 878. Updated the description section.
05/2016	Per NAACCR v16, CS Mets at DX-Liver is no longer required for DX Year 2016 and forward. Updated description and codes to match NAACCR. Update logic revised to follow new year requirements.

CS Mets at Dx-Lung

IDENTIFIERS

CCR ID	NAACCR ID
E1175	2854

OWNER

AJCC

DESCRIPTION

Identifies the presence of distant metastatic involvement of the lung at time of diagnosis. The presence of metastatic lung disease at diagnosis is an independent prognostic indicator, and it is used by Collaborative Staging to derive TNM-M codes and SEER Summary Stage codes for some sites.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

0, 1, 8, 9	Site specific
Blank	Year of Diagnosis is before 2010 or after 2015

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org) for rules and site-specific codes and coding structures.

SOURCE

See CS Version Derived

UPDATE

See CS Mets at DX--Bone

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

2010	New data item for 2010. CSv1 to CSv2 Conversion Specs documentation states to leave these blank (see https://cancerstaging.org/cstage/coding/Documents/csv1tocsv2conversionspecs.pdf). Added IF #846, 848, and 885.
05/2016	Per NAACCR v16, CS Mets at DX-Lung is no longer required for DX Year 2016 and forward. Updated description and codes to match NAACCR. Update logic revised to follow new year requirements.

CS Mets Eval

IDENTIFIERS

CCR ID	NAACCR ID
E1171	2860

OWNER

AJCC

DESCRIPTION

This data item records how the code for CS Mets at DX [NAACCR #2850] was determined based on the diagnostic methods employed. This data item is used by Collaborative Staging to describe whether the staging basis for the TNM-M code is clinical or pathological and to record applicable prefix and suffix descriptors used with TNM staging.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

0, 1, 6, 8, 9	Site specific
Blank	Year of Diagnosis is before 2010 or after 2015

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org) for rules and site-specific codes and coding structures.

SOURCE

See CS Version Derived

UPDATE

See CS Extension

CONSOLIDATED DATA EXTRACT

No

HISTORICAL CHANGES

03/03/04	Not a required data item for 2004 but is sent in from CoC facilities and will only be edited to validate the Allowable values.
02/01/06	Added Update logic that covers Date_DX unknown.
10/10/07	This is a reportable date item starting with 2008 cases per SEER. Added IF 778.
2010	2010 Data Changes: Revised Update logic based on date criteria. All CS fields will be converted to CSv2; CS Tumor Size will have the existing value copied (see https://cancerstaging.org/cstage/coding/Documents/csv1tocsv2conversionspecs.pdf). Added IF 769, 778, 877, 878 & 981.
05/2016	Per NAACCR v16, CS Mets Eval is no longer required for DX Year 2016 and forward. Updated description and codes to match NAACCR. Update logic revised to follow new year requirements.

CS Schema Name

IDENTIFIERS

CCR ID	NAACCR ID
E1786	N/A

DESCRIPTION

The name of the Schema as described by AJCC used to collect Collaborative Staging input fields and calculate derived stage for a cancer incidence as defined by Primary Site, Histology Type 3 and the schema discriminator (CSSiteSpecificFactor25)

LEVELS

Tumors, Admissions

LENGTH

50

ALLOWABLE VALUES

See the AJCC Collaborative Staging website for allowable values: http://www.cancerstaging.org
Blank is allowed for cases diagnosed prior to 2004.

SOURCE

Generate on upload/creation of admissions and tumors

UPDATE

Tumor Level

Manual Change to any of the input fields:

Primary Site
Histologic Type ICD-O-3
CS Site-Specific Factor 25

Admission Level

Manual Change to any of the input fields (see Tumor Level Update)

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

05/2013 Data Changes	Now generating and storing in the database.

CS Site-Specific Factor 1

IDENTIFIERS

CCR ID	NAACCR ID
E1176	2880

OWNER

AJCC

DESCRIPTION

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival. Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

LEVELS

Tumors, Admissions

LENGTH

3

ALLOWABLE VALUES

000-999	Site specific
Blank	Year of Diagnosis is before 2004, after 2017, or unknown

The information recorded in CS Site-Specific Factor 1 differs for each anatomic site. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), for rules and site-specific codes and coding structures.

SOURCE

See CS Version Derived

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Any of these conditions are true:
  - the admission's Date of Diagnosis year is 2004-2017
  - the tumor's Date of Diagnosis year is 2004-2017
  - ~~the tumor's Date of Diagnosis year is blank AND the admission's Date of 1st Contact year is 2004-9998~~
  - ~~the admission's Date of Diagnosis year is blank AND the admission's Date of 1st Contact year is 2004-9998~~
- the admission's CS value is NOT blank
- the admission and tumor's CS values are different

Then list for review

Manual Change

Admission Level

Manual Change or Correction Applied

CONSOLIDATED DATA EXTRACT

Yes, extract from tumor.

HISTORICAL CHANGES

03/03/04	New data item for 2004.
01/19/05	Added 3) Err #722 to validate the CS Site Specific Factor 1 by site & histology. Renumbered IF #490 to 4).
07/13/05	Added Obsolete table reference to Err #722. Added upload conversion spec to Source.
02/01/06	Added Update logic that covers Date_DX unknown. Added logic to IF's 1)-3) that apply at the admission level only for Date_DX unknown. For CS Version 01.02.00 these CS Site Spec F1 codes became obsolete: Melanoma (8720-8790) & Conjunctiva (69.0) = 990, Melanoma (8720-8790) & Choroid (69.3) = 990, and Melanoma (8720-8790) & Iris & Ciliary Body (69.4) = 990.
2010	2010 Data Item Changes: CCR name (CS Site Spec F1) changed to NAACCR name. Revised Update logic based on date criteria. Source updated. All CS fields will be converted to CSv2; CS Site-Specific Factor 1 will have the existing value copied (see https://cancerstaging.org/cstage/coding/Documents/csv1tocsv2conversionspecs.pdf). Added IF #847, 872, 877, 952 & 982.
07/27/11	IF 384, 387, 388, 390, 391, 393, 395, 396 and 399 were created to comply with NAACCR 12.1.A. Information for these new edits arrived in late July 2011.
05/2013	Added IF 1006, 1008, 1024, 1051, 1054, 1055, 1056.
05/2016	Per NAACCR v16, CS Site-Specific Factor 1 continues to be required site specifically. Updated description and codes to match NAACCR. Update logic revised for other CS fields due to new date requirements; however CS Site-Specific Factor logic remains the same.
01/2019	Per NAACCR v18, CS Staging is no longer being collected 2018 and forward and unknown Years of DX. Allowable Values, Update, and Source logic revised.

CS Site-Specific Factor 2

IDENTIFIERS

CCR ID	NAACCR ID
E1177	2890

OWNER

AJCC

DESCRIPTION

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival. Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

LEVELS

Tumors, Admissions

LENGTH

3

ALLOWABLE VALUES

000-999	Site specific
Blank	Year of Diagnosis is before 2004, after 2017, or unknown

The information recorded in CS Site-Specific Factor 2 differs for each anatomic site. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), for rules and site-specific codes and coding structures.

SOURCE

See CS Version Derived

UPDATE

See CS Site-Specific Factor 1

CONSOLIDATED DATA EXTRACT

Yes, extract from tumor.

HISTORICAL CHANGES

03/03/04	New data item for 2004.
01/19/05	Added 2 Err #723 to validate the CS Site Specific Factor 2 by site & histology. Renumbered IF #492 to IF#493.
07/13/05	Added Obsolete table reference to Err #72. Added upload conversion spec to Source.
02/01/06	Added Update logic that covers Date_DX unknown. Added logic to IF's 1)-2) that apply at the admission level only for Date_DX unknown.
2010	Data Item Changes: CCR name (CS Site Spec F2) changed to NAACCR name. Revised Update logic based on date criteria. All CS fields will be converted to CSv2; CS Site-Specific Factor 2 will have the existing value copied (see https://cancerstaging.org/cstage/coding/Documents/csv1tocsv2conversionsp

	ecs.pdf). Note that the values may change when the spreadsheet conversions are applied. Added IF #874, 877, 953 and 983.
05/11/11	2011 Data Item Changes: Added IF 537 per NAACCR 12.1.
07/27/11	IF 413, 414, 415, 416, 417 and 418 were created to comply with NAACCR 12.1.A. Information for this new edit arrived in late July 2011.
05/2013	Added IF 1009, 1010, 1011, 1012, 1026, 1027, 1028, 1029, 1030, 1031, 1032, 1055, 1059, 1060.
05/2016	Per NAACCR v16, CS Site-Specific Factor 2 continues to be required site specifically. Updated description and codes to match NAACCR. Update logic revised for other CS fields due to new date requirements; however CS Site-Specific Factor logic remains the same.
01/2019	Per NAACCR v18, CS Staging is no longer being collected 2018 and forward and unknown Years of DX. Allowable Values, Update, and Source logic revised.

CS Site-Specific Factor 3

IDENTIFIERS

CCR ID	NAACCR ID
E1178	2900

OWNER

AJCC

DESCRIPTION

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival. Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

LEVELS

Tumors, Admissions

LENGTH

3

ALLOWABLE VALUES

000-999	Site specific
Blank	Year of Diagnosis is before 2004, after 2017, or unknown

The information recorded in CS Site-Specific Factor 3 differs for each anatomic site. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), for rules and site-specific codes and coding structures.

SOURCE

See CS Version Derived

UPDATE

See CS Site-Specific Factor 1

CONSOLIDATED DATA EXTRACT

Yes, extract from tumor.

HISTORICAL CHANGES

03/03/04	New data item for 2004.
01/19/05	Updated IF #494 to include values of 096 & 098 in CS_Site_Spec_F3. Added 3). Err #724 to validate the CS Site Specific Factor 3 by site & histology. Renumbered IF #493 to 4).
07/13/05	Added Obsolete table reference to Err #724. Added upload conversion spec to Source.
02/01/06	Edit IF #494 will be skipped for Report Source=6 (autopsy only) cases. Added Update logic that covers Date_DX unknown. Added logic to IF's (1-3) that apply at the admission level only for Date_DX unknown. For CS Version 01.02.00 these CS Site Spec F3 codes became obsolete: Prostate (61.9) = 031, 033, & 034.
2009	Added If #825 (SEER IF 214).

2010	2010 Data Item Changes: CCR name (CS Site Spec F3) changed to NAACCR name. Revised Update logic based on date criteria. Source updated. All CS fields will be converted to CSv2; CS Site-Specific Factor 3 will have the existing value copied (see https://cancerstaging.org/cstage/coding/Documents/csv1tocsv2conversionspecs.pdf). Note that the values may change when the spreadsheet conversions are applied. Added IF #849, 876, 877, 878, 954 & 984.
05/11/11	2011 Data Item Changes: Added IF 506, 535 and 537 per NAACCR 12.1. Removed #849 which no longer edits SSF3.
05/2013	Added IF 1013, 1014, 1016, 1017, 1018, 1019, 1020, 1031, 1033, 1034, 1052, 1061, 1062.
05/2016	Per NAACCR v16, CS Site-Specific Factor 3 continues to be required site specifically. Updated description and codes to match NAACCR. Update logic revised for other CS fields due to new date requirements; however CS Site-Specific Factor logic remains the same.
01/2019	Per NAACCR v18, CS Staging is no longer being collected 2018 and forward and unknown Years of DX. Allowable Values, Update, and Source logic revised.

CS Site-Specific Factor 4

IDENTIFIERS

CCR ID	NAACCR ID
E1179	2910

OWNER

AJCC

DESCRIPTION

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival. Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

LEVELS

Tumors, Admissions

LENGTH

3

ALLOWABLE VALUES

000-999	Site specific
Blank	Year of Diagnosis is before 2004, after 2017, or unknown

The information recorded in CS Site-Specific Factor 4 differs for each anatomic site. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), for rules and site-specific codes and coding structures.

SOURCE

See CS Version Derived

UPDATE

See CS Site-Specific Factor 1

CONSOLIDATED DATA EXTRACT

Yes, extract from tumor.

HISTORICAL CHANGES

03/03/04	New data item for 2004.
06/11/04	Added IF 3) to edit the reverse of 2) (Err #496).
01/19/05	Added 3) Err #725 to validate the CS Site Specific Factor 4 by site & histology. Renumbered IF #495 to 5).
07/13/05	Added Obsolete table reference to Err #725. Added upload conversion spec to Source.
02/01/06	Added Update logic that covers Date_DX unknown. Added logic to IF's (1-4) that apply at the admission level only for Date_DX unknown. For CS Version 01.02.00 these CS Site Spec F4 codes became obsolete: Prostate (61.9) = 000, 010, 020, 030, 080 & 999.
02/2009	Added If #825 (SEER IF 214).
2010	2010 Data Item Changes: CCR name (CS Site Spec F4) changed to NAACCR name. Added IF 849, 877, 880, 985. Removed IF #486 and 535 (now Obsolete).

	Revised Update logic based on date criteria. Source updated. All CS fields will be converted to CSv2; CS Site-Specific Factor 4 will have the existing value copied (see https://cancerstaging.org/cstage/coding/Documents/csv1tocsv2conversionspecs.pdf). Note that the values may change when the spreadsheet conversions are applied.
07/27/11	IF 424 was created to comply with NAACCR 12.1.A. Information for this new edit arrived in late July 2011.
05/2013	Added IF 1023, 1035, 1036, 1063.
05/2016	Per NAACCR v16, CS Site-Specific Factor 4 continues to be required site specifically. Updated description and codes to match NAACCR. Update logic revised for other CS fields due to new date requirements; however CS Site-Specific Factor logic remains the same.
01/2019	Per NAACCR v18, CS Staging is no longer being collected 2018 and forward and unknown Years of DX. Allowable Values, Update, and Source logic revised.

CS Site-Specific Factor 5

IDENTIFIERS

CCR ID	NAACCR ID
E1180	2920

OWNER

AJCC

DESCRIPTION

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival. Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

LEVELS

Tumors, Admissions

LENGTH

3

ALLOWABLE VALUES

000-999	Site specific
Blank	Year of Diagnosis is before 2004, after 2017, or unknown

The information recorded in CS Site-Specific Factor 5 differs for each anatomic site. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), for rules and site-specific codes and coding structures.

SOURCE

See CS Version Derived

UPDATE

See CS Site-Specific Factor 1

CONSOLIDATED DATA EXTRACT

Yes, extract from tumor.

HISTORICAL CHANGES

03/03/04	New data item for 2004.
01/19/05	Added 2) Err #726 to validate the CS Site Specific Factor 5 by site & histology. Renumbered IF #497 to 4).
07/13/05	Added Obsolete table reference to Err #722. Added upload conversion spec to Source.
02/01/06	Added Update logic that covers Date_DX unknown. Added logic to IF's 1)-3) that apply at the admission level only for Date_DX unknown.
2010	2010 Data Item Changes: CCR name (CS Site Spec F5) changed to NAACCR name. Revised Update logic based on date criteria. All CS fields will be converted to CSv2; CS Site-Specific Factor 5 will have the existing value copied (see https://cancerstaging.org/cstage/coding/Documents/csv1tocsv2conversionspec

	s.pdf). Note that the values may change when the spreadsheet conversions are applied. Added IF 849 (replaces 486, 488 & 535), 877, 882 & 986.
05/11/11	2011 Data Item Changes: IF #732 (CS SSF 5, SSF 6, Grade, Prostate Schema) deleted per NAACCR 12.1.
07/27/11	IF 424 was created to comply with NAACCR 12.1.A. Information for this new edit arrived in late July 2011.
05/2013	Added IF 1036, 1037.
05/2016	Per NAACCR v16, CS Site-Specific Factor 5 continues to be required site specifically. Updated description and codes to match NAACCR. Update logic revised for other CS fields due to new date requirements; however CS Site-Specific Factor logic remains the same.
01/2019	Per NAACCR v18, CS Staging is no longer being collected 2018 and forward and unknown Years of DX. Allowable Values, Update, and Source logic revised.

CS Site-Specific Factor 6

IDENTIFIERS

CCR ID	NAACCR ID
E1181	2930

OWNER

AJCC

DESCRIPTION

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival. Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

LEVELS

Tumors, Admissions

LENGTH

3

ALLOWABLE VALUES

000-999	Site specific
Blank	Year of Diagnosis is before 2004, after 2017, or unknown

The information recorded in CS Site-Specific Factor 6 differs for each anatomic site. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), for rules and site-specific codes and coding structures.

SOURCE

See CS Version Derived

UPDATE

See CS Site-Specific Factor 1

CONSOLIDATED DATA EXTRACT

Yes, extract from tumor.

HISTORICAL CHANGES

03/2004	New data item for 2004.
01/2005	Added IF #727 to validate the CS Site Specific Factor 6 by site & histology. Renumbered IF #498.
07/2005	Added Obsolete table reference to Err #722. Added upload conversion spec to Source.
02/2006	Added Update logic that covers Date_DX unknown. Added logic to IF's 1)-2) that apply at the admission level only for Date_DX unknown.
12/2006	Added IF #748.
01/2009	Added IF #826.
2010	2010 Data Item Changes: CCR name (CS Site Spec F6) changed to NAACCR name. Revised Update logic based on date criteria. All CS fields will be converted to CSv2; CS Site-Specific Factor 6 will have the existing value copied (see

	https://cancerstaging.org/cstage/coding/Documents/csv1tocsv2conversionspecs.pdf). Note that the values may change when the spreadsheet conversions are applied. Added IF #727, 877, 884, 987.
2011	2011 Data Item Changes: IF #732 (CS SSF 5, SSF 6, Grade, Prostate Schema) deleted per NAACCR 12.1.
05/2013	Added IF 1038, 1039, 1065.
05/2016	Per NAACCR v16, CS Site-Specific Factor 6 continues to be required site specifically. Updated description and codes to match NAACCR. Update logic revised for other CS fields due to new date requirements; however CS Site-Specific Factor logic remains the same.
01/2019	Per NAACCR v18, CS Staging is no longer being collected 2018 and forward and unknown Years of DX. Allowable Values, Update, and Source logic revised.

CS Site-Specific Factor 7

IDENTIFIERS

CCR ID	NAACCR ID
E1182	2861

OWNER

AJCC

DESCRIPTION

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival. Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

LEVELS

Tumors, Admissions

LENGTH

3

ALLOWABLE VALUES

000-999	Site specific
Blank	Year of Diagnosis is before 2004, after 2017, or unknown

The information recorded in CS Site-Specific Factor 7 differs for each anatomic site. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), for rules and site-specific codes and coding structures.

SOURCE

See CS Version Derived

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Any of these conditions are true:
  - the admission's Date of Diagnosis year is 2010-9998
  - the tumor's Date of Diagnosis year is 2010-9998
  - the tumor's Date of Diagnosis year is blank AND the admission's Date of 1st Contact year is 2010-9998
  - the admission's Date of Diagnosis year is blank AND the admission's Date of 1st Contact year is 2010-9998
- the admission's CS value is NOT blank
- the admission and tumor's CS values are different

Then list for review

Manual Change

Admission Level

Manual Change or Correction Applied

CONSOLIDATED DATA EXTRACT

Yes, extract from tumor.

HISTORICAL CHANGES

2010	New data item for 2010 data changes.
05/2013	Added IF 1037, 1039, 1040, 1041.
05/2016	Per NAACCR v16, CS Site-Specific Factor 7 continues to be required site specifically. Updated description and codes to match NAACCR. Update logic revised for other CS fields due to new date requirements; however CS Site-Specific Factor logic remains the same.
01/2019	Per NAACCR v18, CS Staging is no longer being collected 2018 and forward and unknown Years of DX. Allowable Values, Update, and Source logic revised.

CS Site-Specific Factor 8

IDENTIFIERS

CCR ID	NAACCR ID
E1183	2862

OWNER

AJCC

DESCRIPTION

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival. Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

LEVELS

Tumors, Admissions

LENGTH

3

ALLOWABLE VALUES

000-999	Site specific
Blank	Year of Diagnosis is before 2004, after 2017, or unknown

The information recorded in CS Site-Specific Factor 8 differs for each anatomic site. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), for rules and site-specific codes and coding structures.

SOURCE

See CS Version Derived.

UPDATE

See CS Site-Specific Factor 7

CONSOLIDATED DATA EXTRACT

Yes, extract from tumor.

HISTORICAL CHANGES

2010	New data item for 2010 data changes.
07/2011	IF 426, 427, 428 and 443 were created to comply with NAACCR 12.1.A. Information for this new edit arrived in late July 2011.
05/2013	Added IF 1040, 1041, 1066.
05/2016	Per NAACCR v16, CS Site-Specific Factor 8 continues to be required site specifically. Updated description and codes to match NAACCR. Update logic revised for other CS fields due to new date requirements; however CS Site-Specific Factor logic remains the same.
01/2019	Per NAACCR v18, CS Staging is no longer being collected 2018 and forward and unknown Years of DX. Allowable Values, Update, and Source logic revised.

CS Site-Specific Factor 9

IDENTIFIERS

CCR ID	NAACCR ID
E1184	2863

OWNER

AJCC

DESCRIPTION

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival. Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

LEVELS

Tumors, Admissions

LENGTH

3

ALLOWABLE VALUES

000-999	Site specific
Blank	Year of Diagnosis is before 2004, after 2017, or unknown

The information recorded in CS Site-Specific Factor 9 differs for each anatomic site. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), for rules and site-specific codes and coding structures.

SOURCE

See CS Version Derived

UPDATE

See CS Site-Specific Factor 7

CONSOLIDATED DATA EXTRACT

Yes, extract from tumor.

HISTORICAL CHANGES

2010	New data item for 2010 data changes.
2011	2011 Data Changes: IF 540 added to NAACCR v12.1 metafile and IF 960 revised.
07/27/2011	IF 412, 426, 427 and 444 were created to comply with NAACCR 12.1.A. Information for this new edit arrived in late July 2011.
05/2013	Added IF 1042, 1067.
05/2016	Per NAACCR v16, CS Site-Specific Factor 9 continues to be required site specifically. Updated description and codes to match NAACCR. Update logic revised for other CS fields due to new date requirements; however CS Site-Specific Factor logic remains the same.
01/2019	Per NAACCR v18, CS Staging is no longer being collected 2018 and forward and unknown Years of DX. Allowable Values, Update, and Source logic revised.
03/2020	Change link in updated logic from CS Site-Specific Factor 8 to CS Site-Specific Factor 7.

CS Site-Specific Factor 10

IDENTIFIERS

CCR ID	NAACCR ID
E1185	2864

OWNER

AJCC

DESCRIPTION

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival. Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

LEVELS

Tumors, Admissions

LENGTH

3

ALLOWABLE VALUES

000-999	Site specific
Blank	Year of Diagnosis is before 2004, after 2017, or unknown

The information recorded in CS Site-Specific Factor 10 differs for each anatomic site. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), for rules and site-specific codes and coding structures.

SOURCE

See CS Version Derived

UPDATE

See CS Site-Specific Factor 7

CONSOLIDATED DATA EXTRACT

Yes, extract from tumor.

HISTORICAL CHANGES

2010	New data item for 2010 data changes.
07/2011	IF 400 and 401 were created to comply with NAACCR 12.1.A. Information for this new edit arrived in late July 2011.
05/2013	Added IF 1042.
05/2016	Per NAACCR v16, CS Site-Specific Factor 10 continues to be required site specifically. Update logic revised for other CS fields due to new date requirements; however CS Site-Specific Factor logic remains the same.
01/2019	Per NAACCR v18, CS Staging is no longer being collected 2018 and forward and unknown Years of DX. Allowable Values, Update, and Source logic revised.

CS Site-Specific Factor 11

IDENTIFIERS

CCR ID	NAACCR ID
E1186	2865

OWNER

AJCC

DESCRIPTION

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival. Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

LEVELS

Tumors, Admissions

LENGTH

3

ALLOWABLE VALUES

000-999	Site specific
Blank	Year of Diagnosis is before 2004, after 2017, or unknown

The information recorded in CS Site-Specific Factor 11 differs for each anatomic site. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), for rules and site-specific codes and coding structures.

SOURCE

See CS Version Derived

UPDATE

See CS Site-Specific Factor 7

CONSOLIDATED DATA EXTRACT

Yes, extract from tumor.

HISTORICAL CHANGES

2010	New data item for 2010 data changes.
07/2011	IF 400, 401, 406, 407 and 408 were created to comply with NAACCR 12.1.A. Information for this new edit arrived in late July 2011.
05/2013	Added IF 1057.
05/2016	Per NAACCR v16, CS Site-Specific Factor 11 continues to be required site specifically. Update logic revised for other CS fields due to new date requirements; however CS Site-Specific Factor logic remains the same.
01/2019	Per NAACCR v18, CS Staging is no longer being collected 2018 and forward and unknown Years of DX. Allowable Values, Update, and Source logic revised.

CS Site-Specific Factor 12

IDENTIFIERS

CCR ID	NAACCR ID
E1187	2866

OWNER

AJCC

DESCRIPTION

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival. Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

LEVELS

Tumors, Admissions

LENGTH

3

ALLOWABLE VALUES

000-999	Site specific
Blank	Year of Diagnosis is before 2004, after 2017, or unknown

The information recorded in CS Site-Specific Factor 12 differs for each anatomic site. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), for rules and site-specific codes and coding structures.

SOURCE

See CS Version Derived

UPDATE

See CS Site-Specific Factor 7

CONSOLIDATED DATA EXTRACT

Yes, extract from tumor.

HISTORICAL CHANGES

2010	New data item for 2010 data changes.
07/2011	IF 409 and 410 were created to comply with NAACCR 12.1.A. Information for this new edit arrived in late July 2011.
05/2013	Added IF 1025 and 1040.
05/2016	Per NAACCR v16, CS Site-Specific Factor 12 continues to be required site specifically. Update logic revised for other CS fields due to new date requirements; however CS Site-Specific Factor logic remains the same.
01/2019	Per NAACCR v18, CS Staging is no longer being collected 2018 and forward and unknown Years of DX. Allowable Values, Update, and Source logic revised.

CS Site-Specific Factor 13

IDENTIFIERS

CCR ID	NAACCR ID
E1188	2867

OWNER

AJCC

DESCRIPTION

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival. Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

LEVELS

Tumors, Admissions

LENGTH

3

ALLOWABLE VALUES

000-999	Site specific
Blank	Year of Diagnosis is before 2004, after 2017, or unknown

The information recorded in CS Site-Specific Factor 13 differs for each anatomic site. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), for rules and site-specific codes and coding structures.

SOURCE

See CS Version Derived

UPDATE

See CS Site-Specific Factor 7

CONSOLIDATED DATA EXTRACT

Yes, extract from tumor.

HISTORICAL CHANGES

2010	New data item for 2010 data changes.
05/2013	Added IF 1025, 1040 and 1058.
05/2016	Per NAACCR v16, CS Site-Specific Factor 13 continues to be required site specifically. Update logic revised for other CS fields due to new date requirements; however CS Site-Specific Factor logic remains the same.
01/2019	Per NAACCR v18, CS Staging is no longer being collected 2018 and forward and unknown Years of DX. Allowable Values, Update, and Source logic revised.

CS Site-Specific Factor 14

IDENTIFIERS

CCR ID	NAACCR ID
E1189	2868

OWNER

AJCC

DESCRIPTION

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival. Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

LEVELS

Tumors, Admissions

LENGTH

3

ALLOWABLE VALUES

000-999	Site specific
Blank	Year of Diagnosis is before 2004, after 2017, or unknown

The information recorded in CS Site-Specific Factor 14 differs for each anatomic site. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), for rules and site-specific codes and coding structures.

SOURCE

See CS Version Derived

UPDATE

See CS Site-Specific Factor 7

CONSOLIDATED DATA EXTRACT

Yes, extract from tumor.

HISTORICAL CHANGES

2010	New data item for 2010 data changes.
07/2011	IF 411 was created to comply with NAACCR 12.1.A. Information for this new edit arrived in late July 2011.
05/2016	Per NAACCR v16, CS Site-Specific Factor 14 continues to be required site specifically. Update logic revised for other CS fields due to new date requirements; however CS Site-Specific Factor logic remains the same.
01/2019	Per NAACCR v18, CS Staging is no longer being collected 2018 and forward and unknown Years of DX. Allowable Values, Update, and Source logic revised.

CS Site-Specific Factor 15

IDENTIFIERS

CCR ID	NAACCR ID
E1190	2869

OWNER

AJCC

DESCRIPTION

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival. Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

LEVELS

Tumors, Admissions

LENGTH

3

ALLOWABLE VALUES

000-999	Site specific
Blank	Year of Diagnosis is before 2004, after 2017, or unknown

The information recorded in CS Site-Specific Factor 15 differs for each anatomic site. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), for rules and site-specific codes and coding structures.

SOURCE

See CS Version Derived

UPDATE

See CS Site-Specific Factor 7

CONSOLIDATED DATA EXTRACT

Yes, extract from tumor.

HISTORICAL CHANGES

2010	New data item for 2010 data changes.
2011	Data Item Changes: IF507 and 545 added to NAACCR v12.1 metafile.
2011	IF412 created to comply with NAACCR 12.1.A. Information for this edit arrived in late July 2011.
05/2013	Added IF 1055.
05/2016	Per NAACCR v16, CS Site-Specific Factor 15 continues to be required site specifically. Update logic revised for other CS fields due to new date requirements; however CS Site-Specific Factor logic remains the same.
01/2019	Per NAACCR v18, CS Staging is no longer being collected 2018 and forward and unknown Years of DX. Allowable Values, Update, and Source logic revised.

CS Site-Specific Factor 16

IDENTIFIERS

CCR ID	NAACCR ID
E1191	2870

OWNER

AJCC

DESCRIPTION

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival. Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

LEVELS

Tumors, Admissions

LENGTH

3

ALLOWABLE VALUES

000-999	Site specific
Blank	Year of Diagnosis is before 2004, after 2017, or unknown

The information recorded in CS Site-Specific Factor 16 differs for each anatomic site. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), for rules and site-specific codes and coding structures.

SOURCE

See CS Version Derived

UPDATE

See CS Site-Specific Factor 7

CONSOLIDATED DATA EXTRACT

Yes, extract from tumor.

HISTORICAL CHANGES

2010	New data item for 2010 data changes.
05/2013	Added IF 1055.
05/2016	Per NAACCR v16, CS Site-Specific Factor 16 continues to be required site specifically. Update logic revised for other CS fields due to new date requirements; however CS Site-Specific Factor logic remains the same.
01/2019	Per NAACCR v18, CS Staging is no longer being collected 2018 and forward and unknown Years of DX. Allowable Values, Update, and Source logic revised.

CS Site-Specific Factor 17

IDENTIFIERS

CCR ID	NAACCR ID
E1192	2871

OWNER

AJCC

DESCRIPTION

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival. Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

LEVELS

Tumors, Admissions

LENGTH

3

ALLOWABLE VALUES

000-999	Site specific
Blank	Year of Diagnosis is before 2004, after 2017, or unknown

The information recorded in CS Site-Specific Factor 17 differs for each anatomic site. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), for rules and site-specific codes and coding structures.

SOURCE

See CS Version Derived

UPDATE

See CS Site-Specific Factor 7

CONSOLIDATED DATA EXTRACT

Yes, extract from tumor.

HISTORICAL CHANGES

2010	New data item added for 2010 data changes. Added IF 863 and 877.
05/11	2011 Data Item Changes: Added IF 516 per NAACCR 12.1.
05/2013	Added IF 1022.
05/2016	Per NAACCR v16, CS Site-Specific Factor 17 continues to be required site specifically. Update logic revised for other CS fields due to new date requirements; however CS Site-Specific Factor logic remains the same.
11/2108	Per NAACCR v18, CS Staging is no longer being collected 2018 and forward and unknown Years of DX. Allowable Values, Update, and Source logic revised.

CS Site-Specific Factor 18

IDENTIFIERS

CCR ID	NAACCR ID
E1193	2872

OWNER

AJCC

DESCRIPTION

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival. Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

LEVELS

Tumors, Admissions

LENGTH

3

ALLOWABLE VALUES

000-999	Site specific
Blank	Year of Diagnosis is before 2004, after 2017, or unknown

The information recorded in CS Site-Specific Factor 18 differs for each anatomic site. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), for rules and site-specific codes and coding structures.

SOURCE

See CS Version Derived

UPDATE

See CS Site-Specific Factor 7

CONSOLIDATED DATA EXTRACT

Yes, extract from tumor.

HISTORICAL CHANGES

2010	New data item added for 2010 data changes.
05/2016	Per NAACCR v16, CS Site-Specific Factor 18 continues to be required site specifically. Update logic revised for other CS fields due to new date requirements; however CS Site-Specific Factor logic remains the same.
11/208	Per NAACCR v18, CS Staging is no longer being collected 2018 and forward and unknown Years of DX. Allowable Values, Update, and Source logic revised.

CS Site-Specific Factor 19

IDENTIFIERS

CCR ID	NAACCR ID
E1194	2873

OWNER

AJCC

DESCRIPTION

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival. Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

LEVELS

Tumors, Admissions

LENGTH

3

ALLOWABLE VALUES

000-999	Site specific
Blank	Year of Diagnosis is before 2004, after 2017, or unknown

The information recorded in CS Site-Specific Factor 19 differs for each anatomic site. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), for rules and site-specific codes and coding structures.

SOURCE

See CS Version Derived

UPDATE

See CS Site-Specific Factor 7

CONSOLIDATED DATA EXTRACT

Yes, extract from tumor.

HISTORICAL CHANGES

2010	New data item added for 2010 data changes. Added IF 865 and 877.
05/2016	Per NAACCR v16, CS Site-Specific Factor 19 continues to be required site specifically. Update logic revised for other CS fields due to new date requirements; however CS Site-Specific Factor logic remains the same.
01/2019	Per NAACCR v18, CS Staging is no longer being collected 2018 and forward and unknown Years of DX. Allowable Values, Update, and Source logic revised.

CS Site-Specific Factor 20

IDENTIFIERS

CCR ID	NAACCR ID
E1195	2874

OWNER

AJCC

DESCRIPTION

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival. Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

LEVELS

Tumors, Admissions

LENGTH

3

ALLOWABLE VALUES

000-999	Site specific
Blank	Year of Diagnosis is before 2004, after 2017, or unknown

The information recorded in CS Site-Specific Factor 20 differs for each anatomic site. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), for rules and site-specific codes and coding structures.

SOURCE

See CS Version Derived

UPDATE

See CS Site-Specific Factor 7

CONSOLIDATED DATA EXTRACT

Yes, extract from tumor.

HISTORICAL CHANGES

2010	New data item added for 2010 data changes. Added IF 851, 866 and 877.
05/2016	Per NAACCR v16, CS Site-Specific Factor 20 continues to be required site specifically. Update logic revised for other CS fields due to new date requirements; however CS Site-Specific Factor logic remains the same.
01/2019	Per NAACCR v18, CS Staging is no longer being collected 2018 and forward and unknown Years of DX. Allowable Values, Update, and Source logic revised.

CS Site-Specific Factor 21

IDENTIFIERS

CCR ID	NAACCR ID
E1196	2875

OWNER

AJCC

DESCRIPTION

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival. Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

LEVELS

Tumors, Admissions

LENGTH

3

ALLOWABLE VALUES

000-999	Site specific
Blank	Year of Diagnosis is before 2004, after 2017, or unknown

The information recorded in CS Site-Specific Factor 21 differs for each anatomic site. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), for rules and site-specific codes and coding structures.

SOURCE

See CS Version Derived

UPDATE

See CS Site-Specific Factor 7

CONSOLIDATED DATA EXTRACT

Yes, extract from tumor.

HISTORICAL CHANGES

2010	New data item added for 2010 data changes. Added IF 867 and 877.
07/2011	IF 419 was created to comply with NAACCR 12.1.A. Information for this new edit arrived in late July 2011.
05/2016	Per NAACCR v16, CS Site-Specific Factor 21 continues to be required site specifically. Update logic revised for other CS fields due to new date requirements; however CS Site-Specific Factor logic remains the same.
01/2019	Per NAACCR v18, CS Staging is no longer being collected 2018 and forward and unknown Years of DX. Allowable Values, Update, and Source logic revised.

CS Site-Specific Factor 22

IDENTIFIERS

CCR ID	NAACCR ID
E1197	2876

OWNER

AJCC

DESCRIPTION

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival. Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

LEVELS

Tumors, Admissions

LENGTH

3

ALLOWABLE VALUES

000-999	Site specific
Blank	Year of Diagnosis is before 2004, after 2017, or unknown

The information recorded in CS Site-Specific Factor 22 differs for each anatomic site. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), for rules and site-specific codes and coding structures.

SOURCE

See CS Version Derived

UPDATE

See CS Site-Specific Factor 7

CONSOLIDATED DATA EXTRACT

Yes, extract from tumor.

HISTORICAL CHANGES

2010	New data item added for 2010 data changes.
07/27/11	IF 421 and 422 were created to comply with NAACCR 12.1.A.
05/2016	Per NAACCR v16, CS Site-Specific Factor 22 continues to be required site specifically. Update logic revised for other CS fields due to new date requirements; however CS Site-Specific Factor logic remains the same.
01/2019	Per NAACCR v18, CS Staging is no longer being collected 2018 and forward and unknown Years of DX. Allowable Values, Update, and Source logic revised.

CS Site-Specific Factor 23

IDENTIFIERS

CCR ID	NAACCR ID
E1198	2877

OWNER

AJCC

DESCRIPTION

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival. Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

LEVELS

Tumors, Admissions

LENGTH

3

ALLOWABLE VALUES

000-999	Site specific
Blank	Year of Diagnosis is before 2004, after 2017, or unknown

The information recorded in CS Site-Specific Factor 23 differs for each anatomic site. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), for rules and site-specific codes and coding structures.

SOURCE

See CS Version Derived

UPDATE

See CS Site-Specific Factor 7

CONSOLIDATED DATA EXTRACT

Yes, extract from tumor.

HISTORICAL CHANGES

2010	New data item added for 2010 data changes. Added IF 869, 877 and 974.
05/2016	Per NAACCR v16, CS Site-Specific Factor 23 continues to be required site specifically. Update logic revised for other CS fields due to new date requirements; however CS Site-Specific Factor logic remains the same.
01/2019	Per NAACCR v18, CS Staging is no longer being collected 2018 and forward and unknown Years of DX. Allowable Values, Update, and Source logic revised.

CS Site-Specific Factor 24

IDENTIFIERS

CCR ID	NAACCR ID
E1199	2878

OWNER

AJCC

DESCRIPTION

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival. Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

LEVELS

Tumors, Admissions

LENGTH

3

ALLOWABLE VALUES

000-999	Site specific
Blank	Year of Diagnosis is before 2004, after 2017, or unknown

The information recorded in CS Site-Specific Factor 24 differs for each anatomic site. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), for rules and site-specific codes and coding structures.

SOURCE

See CS Version Derived

UPDATE

See CS Site-Specific Factor 7

CONSOLIDATED DATA EXTRACT

Yes, extract from tumor.

HISTORICAL CHANGES

2010	New data item added for 2010 data changes. Added IF 843, 870 and 877.
05/2016	Per NAACCR v16, CS Site-Specific Factor 24 continues to be required site specifically. Update logic revised for other CS fields due to new date requirements; however CS Site-Specific Factor logic remains the same.
01/2019	Per NAACCR v18, CS Staging is no longer being collected 2018 and forward and unknown Years of DX. Allowable Values, Update, and Source logic revised.

CS Site-Specific Factor 25

IDENTIFIERS

CCR ID	NAACCR ID
E1200	2879

OWNER

AJCC

DESCRIPTION

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival. Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

LEVELS

Tumors, Admissions

LENGTH

3

ALLOWABLE VALUES

000-999	Site specific
Blank	Year of Diagnosis is before 2004, after 2017, or unknown

The information recorded in CS Site-Specific Factor 25 differs for each anatomic site. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), for rules and site-specific codes and coding structures.

SOURCE

See CS Version Derived

UPDATE

See CS Site-Specific Factor 7

CONSOLIDATED DATA EXTRACT

Yes, extract from tumor.

HISTORICAL CHANGES

2010	New data item added for 2010 data changes.
05/2013	Added IF1005, 1006, 1007, 1008, 1009, 1010, 1011, 1012, 1013, 1014, 1015, 1016, 1017, 1018, 1019, 1020, 1021, 1022, 1023, 1024, 1025, 1026, 1027, 1028, 1029, 1030, 1031, 1032, 1033, 1034, 1035, 1036, 1037, 1038, 1039, 1040, 1041, 1042, 1051, 1052, 1053, 1054, 1055, 1056, 1057, 1058, 1059, 1060, 1062, 1063, 1065, 1066, 1067, 1068, 1070
05/2016	Per NAACCR v16, CS Site-Specific Factor 25 continues to be required site specifically. Update logic revised for other CS fields due to new date requirements; however CS Site-Specific Factor logic remains the same.
01/2019	Per NAACCR v18, CS Staging is no longer being collected 2018 and forward and unknown Years of DX. Allowable Values, Update, and Source logic revised.

CS Tumor Size

IDENTIFIERS

CCR ID	NAACCR ID
E1165	2800

OWNER

AJCC

DESCRIPTION

This data item is based on and replaces Tum_Size. Records the largest dimension or diameter of the primary tumor in millimeters. Tumor size at diagnosis is an independent prognostic indicator for many tumors and it is used by Collaborative Staging to derive some TNM-T codes.

LEVELS

Tumors, Admissions

LENGTH

3

ALLOWABLE VALUES

000-999	Site specific
Blank	Year of Diagnosis is before 2004 or after 2015

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), for rules and site-specific codes and coding structures.

SOURCE

See CS Version Derived

UPDATE

See CS Extension

CONSOLIDATED DATA EXTRACT

Yes, extract from tumor.

HISTORICAL CHANGES

03/2004	New data item for 2004.
01/2005	Added IF #721 5) and renumbered IF #499 to 6).
07/2005	Removed site codes 695, 698, and 699 from IF #501 and added to the vice versa (CS_SFF1 check) edit per CS update. Renumbered edit errors to group histology exclusion edits together. Added edit check to unknown primaries under IF #721. Added upload conversion spec note to Source.
02/2006	Correction per NAACCR11 on IF #721 for histology range (was 9702-9899) to 9702-9989. Added Update logic that covers Date_DX unknown. Added logic to IF's 2)-7) that apply at the admission level only for Date_DX unknown.
04/2009	Added IF #826.
2010	2010 Data Item Changes: CCR name (CS_Tum_Size) to NAACCR name. Revised Update logic based on date criteria. Source updated. All CS fields will be converted to CSv2; CS Tumor Size will have the existing value copied (see http://www.cancerstaging.org/cstage/software/csv1tocsv2conversionspecs.pdf). Added IF #837, 877 & 878.

05/2013	Added IF 1015
05/2016	Per NAACCR v16, CS Tumor Size is no longer required for DX Year 2016 and forward. Updated description and codes to match NAACCR. Update logic revised to follow new year requirements.

CS Tumor Size/Ext Eval

IDENTIFIERS

CCR ID	NAACCR ID
E1167	2820

OWNER

AJCC

DESCRIPTION

This data item records how the codes for CS Tumor Size and CS Extension were determined based on the diagnostic methods employed. This item is used by Collaborative Staging to describe whether the staging basis for the TNM-T code is clinical or pathological and to record applicable prefix and suffix descriptors used with TNM staging.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

0-6, 8, 9	Site specific
Blank	Year of Diagnosis is before 2004 or after 2015

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), for rules and site-specific codes and coding structures.

SOURCE

See CS Version Derived

UPDATE

See CS Extension

CONSOLIDATED DATA EXTRACT

No

HISTORICAL CHANGES

03/03/04	Not a required data item for 2004 but is sent in from CoC facilities and will only be edited to validate the Allowable values.
02/01/06	Added Update logic that covers Date_DX unknown.
10/10/07	This is a reportable data item starting with 2008 cases per SEER. Added IF #780.
01/2009	Added IF #827.
2010	2010 Data Item Changes: CCR name (CS_TS_Ext_Eval) changed to NAACCR name. All CS fields will be converted to CSv2; CS Tumor Size/Ext Eval will have the existing value copied (see http://www.cancerstaging.org/cstage/software/csv1tocsv2conversionspecs.pdf). Added IF #877, 878 & 990.
05/2013	Added IF1005, 1006, 1009
05/2016	Per NAACCR v16, CS Tumor Size/Ext Eval is no longer required for DX Year 2016 and forward. Updated description and codes to match NAACCR. Update logic revised to follow new year requirements.

CS Version Derived

IDENTIFIERS

CCR ID	NAACCR ID
E1245	2936

OWNER

AJCC

DESCRIPTION

This item indicates the version number of CS used most recently to derive the CS output fields. This data item is recorded the first time the CS output fields are derived and should be updated each time the CS Derived items are re-computed. The CS version number is returned as part of the output of the CS algorithm. The returned value from the program should be automatically stored as CS Version Derived. This item should not be updated manually.
The first two digits represent the major version number; the second two digits represent minor version changes; and, the last two digits represent even less significant changes, such as corrections of typographical errors that do not affect coding or derivation results (e.g., 010100)
Important: This edit only runs when a case is uploaded.

LEVELS

Tumors, Admissions

LENGTH

6

ALLOWABLE VALUES

A six-digit number or a blank is allowed.
Blank = Date of diagnosis is before January 1, 2004 or after December 31, 2017
As of 2014 data items changes, the first four digits must be 0205.
This item should not be blank if the CS Derived items contains values.
This item should be blank if the CS Derived items are empty or the CS algorithm has not been applied.

SOURCE

1. If the input case's Date of Diagnosis year is 0001 – 2003, 2018-9998, or blank then ignore any submitted CS values, DO NOT CREATE A SET OF ASSOCIATED CS VALUES FOR THE ADMISSION and stop here.
2. Perform CS Version Input Original, Date of Birth, Date of Diagnosis, Histologic Type ICD-O-3, Behavior Code ICD-O-3, Grade, Lymph Vascular Invasion, and Primary Site uploads/conversions.
3. If all of the following conditions are true:
    - Date of Diagnosis is year is 2004 – 2015
        - ~~Date of Diagnosis is blank and Date of 1st Contact is 2004-2015~~
    - Input case's CS Version Derived does NOT contain the same version number as the latest CS Algorithm version installed in the central system

    Then:
        - Perform all specified CS input field (CS Extension, CS Lymph Nodes, CS Lymph Nodes Eval, CS Mets DX, CS Mets Eval, CS Site-Specific Factor 1-25, CS Tumor Size, and CS Tumor Size/Ext Eval, CS Version Input Current) conversions for the versions

that came after the new case's version in version order, including creation of review records for values requiring manual conversion.

- Upload the converted/unconverted CS input values.
- If all of the following conditions are true:
  a. Automatic conversions have changed one or more input field values listed under UPDATE New Case Consolidation
  b. No manual conversions are required
  c. Conditions are such that Visual Editing is going to be bypassed

Then calculate Age at Diagnosis according to Appendix 6 and then perform the CS Algorithm as described in use case 2.12 – Perform Collaborative Staging Algorithm – UC automatically to regenerate and upload all the CS derived field values for the admission. Otherwise, upload the new case's derived fields without conversion.

4. If Date of Diagnosis is 2016-2107
   - ~~Date of Diagnosis is blank and Date of 1st Contact is 2016-9998~~

   Then:
   - If a value is present in one of the fields below, then blank it out:
     - CS Extension
     - CS Lymph Nodes
     - CS Mets at DX
     - CS Tumor Size
     - CS Tumor Size/Ext Eval
     - CS Lymph Nodes Eval
     - CS Mets Eval
     - CS Mets at DX-Bone
     - CS Mets at DX-Brain
     - CS Mets at DX-Liver
     - CS Mets at DX-Lung
     - Derived AJCC-Flag
     - Derived SS1977-Flag
     - Derived SS2000-Flag
     - Derived AJCC-6 M
     - Derived AJCC-6 N
     - Derived AJCC-6 Stage Group
     - Derived AJCC-6 T
     - Derived SS1977
     - Derived SS2000
     - Derived AJCC-7 M
     - Derived AJCC-7 N
     - DerivedAJCC-7 T
     - Derived AJCC-7 Stage Grp
     - Derived AJCC-6 T Descript
     - Derived AJCC-6 N Descript
     - Derived AJCC-6 M Descript
     - Derived AJCC-7 T Descript
     - Derived AJCC-7 N Descript
     - Derived AJCC-7 M Descript

        - CS Version Derived
    - Perform the specified CS input field (CS Site-Specific Factor 1-25 and CS Version Input Current) conversions for the versions that came after the new case's version in version order, including creation of review records for values requiring manual conversion.
    - Upload the converted/unconverted CS input values and calculate Age at Diagnosis according to Appendix 6.
    - Set CS Version Input Current to 020550 if it is not already.
    - Set CS Version Original to 020550 if it is not already.
5. Note all CS input and derived field changes in the Audit Log (not in the global audit log as the one-time specifications require).

UPDATE

Tumor Level

New Case Consolidation or Manual Change to CS Input Fields

1. If ALL of the following conditions are true:

- Date of Diagnosis year is NOT being changed from:
    - 0001-2003 to 2004-2015
    - 2016-2017 to 2004-2015
    - 2004-2015 to 0001-2003
    - 2004-2015 to 2016-2017
- A manual change or automatic change is made to at least one collaborative staging input field:
    - Date of Birth*
    - Primary Site
    - Histologic Type ICD-O-3, Behavior Code ICD-O-3, Grade
    - Date of Diagnosis
    - Regional Nodes Positive, Regional Nodes Examined
    - CS Tumor Size
    - CS Extension
    - CS Lymph Nodes
    - CS Mets at DX
    - CS Tumor Size/Ext Eval, CS Lymph Nodes Eval, CS Mets Eval
    - CS Site-Specific Factor 1 – 25 or
    - Lymph-Vascular Invasion
- Date of Diagnosis year is 2004-2015

Then automatically calculate Age at Diagnosis according to Appendix 6, perform the Collaborative Staging algorithm (use case ***2.12 – Perform Collaborative Staging Algorithm - UC***) to regenerate all the derived fields, and update the corresponding stored and displayed values:

- Derived AJCC--Flag
- Derived AJCC-6 M
- Derived AJCC-6 M Descript
- Derived AJCC-6 N
- Derived AJCC-6 N Descript
- Derived AJCC-6 Stage Grp
- Derived AJCC-6 T
- Derived AJCC-6 T Descript
- Derived AJCC-7 M

- Derived AJCC-7 M Descript
- Derived AJCC-7 N
- Derived AJCC-7 N Descript
- Derived AJCC-7 Stage Grp
- Derived AJCC-7 T
- Derived AJCC-7 T Descript
- Derived SS1977
- Derived SS1977--Flag
- Derived SS2000
- Derived SS2000--Flag
- CS Version Derived.

2. If the Date of Diagnosis year is changed from 0001-2003 to 2004-2015
   Then CREATE a set of related tumor CS values by:
   - Setting CS Version Input Original and CS Version Input Current to the current CS Algorithm version deployed in the central system,
   - Calculating Age at Diagnosis according to appendix 6,
   - Capturing the rest of the now required CS input values entered,
   - Performing the Collaborative Staging algorithm (use case ***2.12 – Perform Collaborative Staging Algorithm - UC***) to generate all the derived fields, including CS Version Derived.
3. If the Date of Diagnosis year is changed from 2004-2015 to 0001-2003, 2018 – 9998, or blank
   Then blank out the entire set of related CS values for this tumor.
4. If the Date of Diagnosis year is changed from 2004-2015 to 2016-2017
   Then blank out the CS values for this tumor for the following fields:
   - CS Extension
   - CS Lymph Nodes
   - CS Mets at DX
   - CS Tumor Size
   - CS Tumor Size/Ext Eval
   - CS Lymph Nodes Eval
   - CS Mets Eval
   - CS Mets at DX-Bone
   - CS Mets at DX-Brain
   - CS Mets at DX-Liver
   - CS Mets at DX-Lung
   - Derived AJCC-Flag
   - Derived SS1977-Flag
   - Derived SS2000-Flag
   - Derived AJCC-6 M
   - Derived AJCC-6 N
   - Derived AJCC-6 Stage Group
   - Derived AJCC-6 T
   - Derived SS1977
   - Derived SS2000
   - Derived AJCC-7 M
   - Derived AJCC-7 N
   - DerivedAJCC-7 T

- Derived AJCC-7 Stage Grp
- Derived AJCC-6 T Descript
- Derived AJCC-6 N Descript
- Derived AJCC-6 M Descript
- Derived AJCC-7 T Descript
- Derived AJCC-7 N Descript
- Derived AJCC-7 M Descript
- CS Version Derived

And set both CS Version Input Current and CS Version Original to 020550.

Admission Level

Manual Change to CS Input Fields or Correction Applied to CS Input Fields

1. If ALL of the following conditions are true:
    - Date of Diagnosis year is NOT being changed from 0001-2003 or 2016-2017 to 2004-2015 or from 2004-2015 to 0001-2003 or 2016-2017
    - A manual change or automatic change is made to at least one collaborative staging input field:
        - Date of Birth*
        - Primary Site
        - Histologic Type ICD-O-3, Behavior Code ICD-O-3, Grade
        - Date of Diagnosis
        - Regional Nodes Positive, Regional Nodes Examined
        - CS Tumor Size
        - CS Extension
        - CS Lymph Nodes
        - CS Mets at DX
        - CS Tumor Size/Ext Eval, CS Lymph Nodes Eval, CS Mets Eval
        - CS Site-Specific Factor 1 – 25
        - Lymph-Vascular Invasion
    - Date of Diagnosis year is 2004-2015

Then automatically calculate Age at Diagnosis according to Appendix 6, perform the Collaborative Staging algorithm (use case ***2.12 – Perform Collaborative Staging Algorithm - UC***) to regenerate all the derived fields, and update the corresponding stored and displayed values:

- Derived AJCC--Flag
- Derived AJCC-6 M
- Derived AJCC-6 M Descript
- Derived AJCC-6 N
- Derived AJCC-6 N Descript
- Derived AJCC-6 Stage Grp
- Derived AJCC-6 T
- Derived AJCC-6 T Descript
- Derived AJCC-7 M
- Derived AJCC-7 M Descript
- Derived AJCC-7 N
- Derived AJCC-7 N Descript
- Derived AJCC-7 Stage Grp
- Derived AJCC-7 T

- Derived AJCC-7 T Descript
- Derived SS1977
- Derived SS1977--Flag
- Derived SS2000
- Derived SS2000--Flag
- CS Version Derived

2. If the Date of Diagnosis year is changed from 0001-2003 or 2016-2017 to 2004-2015
   Then CREATE a set of related admission CS values by:
   - Setting CS Version Input Original and CS Version Input Current to the current CS Algorithm version deployed in the central system
   - Calculating Age at Diagnosis according to appendix 6
   - Capturing the rest of the now required CS input values entered
   - Performing the Collaborative Staging algorithm (use case ***2.12 – Perform Collaborative Staging Algorithm - UC***) to generate all the derived fields, including CS Version Derived
3. If the Date of Diagnosis year is changed from 2004-2015 to 0001-2003, 2018 – 9998, or blank
   Then blank out the entire set of related CS values for this admission.
4. If the Date of Diagnosis year is changed from 2004-2015 to 2016-2017
   Then blank out the CS values for this tumor for the following fields:
   - CS Extension
   - CS Lymph Nodes
   - CS Mets at DX
   - CS Tumor Size
   - CS Tumor Size/Ext Eval
   - CS Lymph Nodes Eval
   - CS Mets Eval
   - CS Mets at DX-Bone
   - CS Mets at DX-Brain
   - CS Mets at DX-Liver
   - CS Mets at DX-Lung
   - Derived AJCC-Flag
   - Derived SS1977-Flag
   - Derived SS2000-Flag
   - Derived AJCC-6 M
   - Derived AJCC-6 N
   - Derived AJCC-6 Stage Group
   - Derived AJCC-6 T
   - Derived SS1977
   - Derived SS2000
   - Derived AJCC-7 M
   - Derived AJCC-7 N
   - DerivedAJCC-7 T
   - Derived AJCC-7 Stage Grp
   - Derived AJCC-6 T Descript
   - Derived AJCC-6 N Descript
   - Derived AJCC-6 M Descript

- Derived AJCC-7 T Descript
- Derived AJCC-7 N Descript
- Derived AJCC-7 M Descript
- CS Version Derived

And set both CS Version Input Current and CS Version Original to 020550.

* A change in Date of Birth or Date of Diagnosis will required that a new Age at Diagnosis value be generated as input for the CS algorithm too. A change to Date of Birth at the Patient Level will cause the CS algorithm to be performed for all tumors with Date of Diagnosis 2004-2015.

CONSOLIDATED DATA EXTRACT

Yes, extract from tumor.

HISTORICAL CHANGES

03/03/04	New data Item for 2004.
07/13/05	Added allowable values edit (Err #277) to only run when a case is uploaded.
01/08/07	Added 0103 to Allowable Values.
11/26/07	Added 0104 to Allowable Values.
2010	Added 0200 to Allowable Values. NAACCR changed name of field to CS Version Derived (was CS Version Latest). Revised Update logic based on new date criteria and new CS fields. All CS fields will be converted to CSv2; CS Version Derived will be left blank (see http://www.cancerstaging.org/cstage/software).
05/11/11	2011 Data Item Changes: Per NAACCR 12.1: Changed the specification from version 02 to the new version 0203.
07/27/11	Revised Source and Update logic.
04/23/12	In the last IF statement, changed the term Admission to the term Tumor.
04/2014	Per NAACCR v14, allowable values updated to correspond to the CSV0205 requirements.
05/2016	Per NAACCR v16, CS Version Derived is no longer required for DX Year 2016 and forward. Update and Source logic revised to follow new year requirements for all CS fields.
12/20/2016	Clarified SOURCE and UPDATE logic and DX Year requirements.
11/2108	Per NAACCR v18, CS Staging is no longer being collected 2018 and forward and unknown Years of DX. Update and Source logic revised.

CS Version Input Current

IDENTIFIERS

CCR ID	NAACCR ID
E1243	2937

DESCRIPTION

This item indicates the number of the version after CS input fields have been updated or recoded. This data item is recorded the first time the CS input fields are entered and should be updated each time the CS input fields are modified. Effective for cases diagnosed 2010+. For cases originally coded under CSv1, upon conversion from CSv1 to CSv2, CS Version Input Current will be set to 020000, a special version number to reflect its conversion status.

LEVEL

Tumors, Admissions

LENGTH

6

ALLOWABLE VALUES

000000-999999

Must be a six-digit number or blank.

Digits 1 and 2	Major version number
Digits 3 and 4	Minor version changes
Digits 5 and 6	Less significant changes (such as typographical errors that do not affect coding or derivation of results).

Codes

See the most current version of the Collaborative Stage Data Collection System Manual and Coding Instructions (http://www.cancerstaging.org/cstage/coding/pages/version-02.05.aspx), 13 for rules and site-specific codes and coding

STRUCTURES.

SOURCE

See CS Version Derived.

UPDATE

Tumor Level

New Case Consolidation or Manual Change

1. If the tumor's Date of Diagnosis year is 2004-2017, and one or more of these selected CS Input fields are manually or automatically updated through case consolidation:
    - CS Tumor Size
    - CS Extension
    - CS Tumor Size/Ext Eval
    - CS Lymph Nodes
    - CS Lymph Nodes Eval
    - CS Mets at DX
    - CS Mets Eval

- CS Site-Specific Factor 1 – 25
- Regional Nodes Positive
- Regional Nodes Examined

Then run the CS Get Version function supplied with the current installed CS software and update CS Version Input Current with the returned version number.

2. If any of the following conditions are true:
   - Date of Diagnosis year is 0001-2003
   - Date of Diagnosis is 2018 - 9998
   - Date of Diagnosis year is blank ~~AND all the CS input fields are blank~~
   - ~~Date of Diagnosis year is blank AND Date of 1st Contact year is 0001-2003 (admission level only)~~

   Then set CS Version Input Current to blank

Admission Level

Manual Change or Correction Applied

1. If the admission's Date of Diagnosis year is 2004-2017~~ or Date of Diagnosis is blank and Date of 1st Contact year is 2004-9998~~, and one or more of the selected CS Input fields listed in the tumor update section are manually updated or automatically updated through an applied correction,

   Then run the CS Get Version function supplied with the current installed CS software and update CS Version Input Current with the returned version number.
2. If any of the following conditions are true:
   - Date of Diagnosis year is 0001-2003
   - Date of Diagnosis is 2018 - 9998
   - Date of Diagnosis year is blank ~~AND all the CS input fields are blank~~
   - ~~Date of Diagnosis year is blank AND Date of 1st Contact year is 0001-2003 (admission level only)~~

   Then set CS Version Input Current to blank

CONSOLIDATED DATA EXTRACT

Yes, extract from tumor.

HISTORICAL CHANGES

2010	2010 Data Changes: New data item added.
3/14/11	Added Update logic to handle cases that have a date of diagnosis change to a pre-2004 dx and CS values are blanked out. CS Version Input Current was being retained (users cannot update this field) and this was causing edit errors.
01/2019	Per NAACCR v18, CS Staging is no longer being collected 2018 and forward and unknown Years of DX. Allowable Values, Update, and Source logic revised.

CS Version Input Original

IDENTIFIERS

CCR ID	NAACCR ID
E1244	2935

OWNER

CS

DESCRIPTION

Indicates the version number used to initially code CS input fields. CS Version Original is a software-generated field and should be populated at the time the CS fields are first coded. The first two digits represent the major version number; the second two digits represent minor version changes; and, the last two digits represent even less significant changes, such as corrections of typographical errors that do not affect coding or derivation of results (e.g., 010100).

LEVELS

Tumors, Admissions

LENGTH

6

ALLOWABLE VALUES

000000-999999

Must be a six-digit number or blank.

If not blank, the full six-digit number must be one of the following numbers:

020550 or higher
020440
020302
020200
020100
020001
010401
010400
010300
010200
010100
010005
010004
010003
010002
010000
000937

SOURCE

Upload with no conversion.

UPDATE

Tumor and Admission Level

If any of the following conditions are true:

Date of Diagnosis year is 0001-2003

Date of Diagnosis is 2018 – 9998

Date of Diagnosis is blank

~~Date of Diagnosis year is blank AND all the CS input fields are blank~~

~~Date of Diagnosis year is blank AND Date of 1st Contact year is 0001-2003 (admission level only)~~

Then set CS Version Input Original to blank

CONSOLIDATED DATA EXTRACT

Yes, extract from tumor

HISTORICAL CHANGES

<table>
<tr><td>03/03/04</td><td>New data item for 2004.</td></tr>
<tr><td>01/19/05</td><td>Adding time table for tracking CS Version number
<table>
<tr><th>CS_Version_Input Original</th><th>Released</th><th>Implemented in vendor software</th><th>Implemented in Eureka</th></tr>
<tr><td>01.00.00</td><td>01/2004</td><td>05/2004</td><td>Not in Eureka</td></tr>
<tr><td>01.01.00</td><td>08/2004</td><td>10/2004</td><td>09/2004</td></tr>
<tr><td>01.02.00</td><td>05/2005</td><td>07/29/2005</td><td>08/2005 (Ver 4.3)</td></tr>
<tr><td>01.03.00</td><td>09/2006</td><td>12/2006</td><td>01/2006</td></tr>
<tr><td>01.04.00</td><td>10/2007</td><td>01/2008</td><td>2/11/2008</td></tr>
<tr><td>01.04.01</td><td>03/2008</td><td>04/2008</td><td>5/12/2008</td></tr>
<tr><td>02.00.00</td><td>2010</td><td>2010</td><td>2010</td></tr>
</table></td></tr>
<tr><td>04/27/05</td><td>Updated table.</td></tr>
<tr><td>07/13/05</td><td>Added Allowable values edit (Err #276) to only run when a case is uploaded.</td></tr>
<tr><td>02/01/06</td><td>Updated table.</td></tr>
<tr><td>01/08/07</td><td>Added 0103 to Allowable Values and updated table.</td></tr>
<tr><td>11/26/07</td><td>Added 0104 to Allowable Values and updated table.</td></tr>
<tr><td>02/20/08</td><td>Added 010401 to table.</td></tr>
<tr><td>2010</td><td>2010 Data Changes: Added 0200 to Allowable values and to Tracking table. NAACCR changed name from CS Version 1st to CS Version Input Original. Added IF #825, 877, 878, 890, 958, 959, 960, 961, 962, 963, 964, 967, 977, 978, 983, 984, 985, 986, 987, 988.</td></tr>
<tr><td>03/14/11</td><td>Added Update logic (was "None") to handle cases that have a date of diagnosis change to a pre-2004 dx and CS values are blanked out. CS Version Input Original was being retained (users cannot update this field) and this was causing edit errors. Changed allowable values text to CS edit (was: If not blank, the first four digits must be 0100, 0101, 0102, 0103, 0104, or 0200.)</td></tr>
<tr><td>04/23/2012</td><td>Allowable Values Section: Removed "Edit only runs when a case is uploaded."</td></tr>
<tr><td>04/2014</td><td>Per NAACCR v14, list of allowable codes updated.</td></tr>
<tr><td>01/2019</td><td>Per NAACCR v18, CS Staging is no longer being collected 2018 and forward and unknown Years of DX. Allowable Values, Update, and Source logic revised.</td></tr>
</table>

Date Added

IDENTIFIERS

CCR ID	NAACCR ID
None	None

This is a state requestor item and appears in Eureka only. Therefore, it is not in the exchange record and does not have either a CCR ID or a NAACCR ID.

DESCRIPTION

On the Tumors file, it is the date this tumor was added to the regional registry's Main database. On the Admissions file, it is the date that this case report was added to the Main database. In both cases the date must be no earlier than the date that the registry determined that the case report was ready for transmittal to the CCR (all visual editing and inconsistencies resolved). The difference between DATE-ADDED and Date_Case_Load will allow analysis of time spent in processing at the registry. (This date may be on other files than those specified, but is not required on those other files.)

LEVELS

Tumors, Admissions

LENGTH

8

ALLOWABLE VALUES

A valid, complete date in YYYYMMDD, after the registry began and no later than current date. (Computer generated date)

General Date Editing Rules:

Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD). Month and day must have leading zeros for values 01...09.

The following date format is allowed:

CCYYMMDD Century+Year, Month and Day are provided.

Dates are checked first to ensure they conform to one of these formats, then for errors in the components. Checking stops on the first non-valid situation.

Range checking:

Lowest allowed value: January 1, 1850 (or in D1 format: 18500101)

Highest allowed value: current system date

The month is checked to ensure it falls within range 01...12.

The day is checked to ensure it falls within range for that specific month. Accommodation is made for leap years.

SOURCE

Historical data item representing the date a tumor or admission was created, captured from previous systems in original Eureka migration; not uploaded for new cases.

UPDATE

None

CONSOLIDATED DATA EXTRACT

Yes, from Tumors File

HISTORICAL CHANGES

11/02	In the CCR central system (EUREKA), this data item is kept for historical purposes only. If needed for new cases processed after migration, this field can be generated from the audit log. The Allowable values edit (#1) was removed.
2010	2010 Data Changes: Revised Allowable Values and Source information to match NAACCRv12 date scheme.
7/8/2011	General Date Editing Rules and Range Checking updated for additional clarity. However, the intent of the date rules remains the same as the 2010 update.

Date Cancer Status

IDENTIFIERS

CCR ID	NAACCR ID
E1582	None: State Requestor

DESCRIPTION

This data item has been replaced by Date of Last Cancer (tumor) Status [NAACCR #1772]. This page has been retained for historical purposes only and this data item should not be populated in any cases under the NAACCR v18 or later coding standards.

The date of last contact with the patient where there was specific information about the tumor being reported on by Cancer Status.

LEVELS

Tumors, Admissions

LENGTH

8

ALLOWABLE VALUES

A valid date containing, at the minimum, CCYY.

GENERAL DATE AND EDITING RULES

Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD). Month and day must have leading zeros for values 01...09.

The following date formats are allowed:

CCYYMMDD Century+Year, Month and Day are provided.
CCYYMM__ Century+Year and Month. Day consists of two blank spaces.
CCYY____ Century+Year. Month and Day consist of four blank spaces.

Dates are checked first to ensure they conform to one of these formats, then for errors in the components. Checking stops on the first non-valid situation.

Range checking:

Lowest allowed value: January 1, 1850 (or in D1 format: 18500101)
Highest allowed value: current system date
When month is known, it is checked to ensure it falls within range 01...12.
When month and day are known, day is checked to ensure it falls within range for that specific month. Accommodation is made for leap years.

SOURCE

1. If Date of Diagnosis is 2018 and later, then blank out the field.
2. If Coding Proc is less than 34, then execute the same conversion from use case Perform Eureka 2018 One-Time Data Conversions and Table Populations – UC, step ~~17~~ 24.

UPDATE

Tumor Active Follow-up Fields Update Logic

CCR DATA EXTRACT

Yes

HISTORICAL CHANGES

2/01/07	Added update logic (and rewrote to simplify) to take current Date_Tum_Status when both Tum_Status are 9.

2/20/08	Clarified Source logic that blanks and 0s are not allowable values.
2010	2010 Data Item Changes: CCR name (Date Tumor Status) changed to match NAACCR naming convention for Cancer Status. Revised Allowable Values, Source and Update logic information to match NAACCRv12 date scheme. Added IF #840.
7/8/2011	General Date Editing Rules and Range Checking updated for additional clarity. However, the intent of the date rules remains the same as the 2010 update.
01/2019	Per NAACCR v18, this data item has been replaced by Date of Last Cancer (tumor) Status Flag [NAACCR #1772]. Revisions to Source Logic to run One-Time Data Conversions as necessary.
03/2019	Revised Source Logic, Step 2 for Coding Proc 34, changed UC step from 17 to 24

Date Cancer Status Flag

IDENTIFIERS

CCR ID	NAACCR ID
E1583	None

DESCRIPTION

This data item has been replaced by Date of Last Cancer (tumor) Status Flag [NAACCR #1773]. This page has been retained for historical purposes only and this data item should not be populated in any cases under the NAACCR v18 or later coding standards

Explains why there is no appropriate value in the corresponding date field, Date Cancer Status.

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

10-20, spaces

12	A proper value is applicable but not known (e.g., date of cancer status is unknown)
Blank	A valid date value is provided in item Date Cancer Status Flag or the date was not expected to have been transmitted.

SOURCE

1. If Date of Diagnosis is 2018 and later, then blank out the field.
2. If Coding Proc is less than 34, then execute the same conversion from use case Perform Eureka 2018 One-Time Data Conversions and Table Populations – UC, step ~~18~~ 25.

UPDATE

Tumor Active Follow-up Fields Update Logic

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

2010	Added as a state requestor item for 2010 data changes. This field is unique to the CCR because NAACCR does not have a date field for Cancer Status.
01/2019	Per NAACCR v18, this data item has been replaced by Date of Last Cancer (tumor) Status Flag [NAACCR #1773]. Revisions to Source Logic to run One-Time Data Conversions as necessary.
03/2019	Revised Source Logic – Step 2 for Coding Proc 34, changed UC step from 18 to 25

Date Case Completed

IDENTIFIERS

CCR ID	NAACCR ID
E1481	2090

DESCRIPTION

Date this abstract was first completed by this abstractor. Used to monitor abstracting progress.

LEVELS

Admissions

LENGTH

8

ALLOWABLE VALUES

A valid, complete date in YYYYMMDD.

General Date Editing Rules:

Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD). Month and day must have leading zeros for values 01...09.

The following date format is allowed:

CCYYMMDD Century+Year, Month and Day are provided.

Dates are checked first to ensure they conform to one of these formats, then for errors in the components. Checking stops on the first non-valid situation.

Range checking:

Lowest allowed value: January 1, 1850 (or in D1 format: 18500101)

Highest allowed value: current system date

The month is checked to ensure it falls within range 01...12.

The day is checked to ensure it falls within range for that specific month. Accommodation is made for leap years.

SOURCE

If the record version is NAACCR version 12 (120 in original new case) or later, then upload the date with no conversion.

Otherwise, if the record version is earlier than 12, then perform the following conversions in this order:

1. Right-justify and zero-fill the date to 8 digits.
2. Convert MMDDYYYY to YYYYMMDD.

DO NOT record any changes made in the audit log.

UPDATE

None: auto-generated when case was originally completed

CONSOLIDATED DATA EXTRACT

Yes, record with the earliest admission date for this tumor.

HISTORICAL CHANGES

8/06	Name updated to NAACCR name (was Date_Completed).
2010	Data Changes: Revised Allowable Values and Source information to match NAACCRv12 date scheme. Update logic corrected to reflect auto generation (was manual).

7/8/2011	General Date Editing Rules and Range Checking updated for additional clarity. However, the intent of the date rules remains the same as the 2010 update

Date Case Initiated

IDENTIFIERS

CCR ID	NAACCR ID
E1480	2085

DESCRIPTION

This is the date that the hospital registrar began the process of case identification and abstraction at the hospital registry. This field is used by the hospital to identify the data a case was first added to the hospital database. It represents the date that casefinding or initial data entry was done, not the date the case was completed. It should not change once it has been generated.

LEVELS

Admissions

LENGTH

8

ALLOWABLE VALUES

A valid, complete date in YYYYMMDD.

General Date Editing Rules:

Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD). Month and day must have leading zeros for values 01...09.

The following date format is allowed:

CCYYMMDD Century+Year, Month and Day are provided.

Dates are checked first to ensure they conform to one of these formats, then for errors in the components. Checking stops on the first non-valid situation.

Range checking:

Lowest allowed value: January 1, 1850 (or in D1 format: 18500101)

Highest allowed value: current system date

The month is checked to ensure it falls within range 01...12.

The day is checked to ensure it falls within range for that specific month. Accommodation is made for leap years.

SOURCE

If the record version is NAACCR version 12 (120 in original new case) or later, then upload the date with no conversion.

Otherwise, if the record version is earlier than 12, then perform the following conversions in this order:

1. Right-justify and zero-fill the date to 8 digits.
2. Convert MMDDYYYY to YYYYMMDD.

Do not record changes in the audit log.

UPDATE

None: auto-generated when case was originally started.

CONSOLIDATED DATA EXTRACT

Yes, record with earliest admission date for this tumor.

HISTORICAL CHANGES

3/03/04	Added Err# 259 to the Allowable Values edit.

1/19/05	Zeros are added to the Allowable Values.
2010	2010 Data Changes: This is a new field from NAACCR starting with 2010 and NAACCR v12. However, it actually replaces California Requestor Item Date First Enter. Updated Allowable Values and Source with new date format spec. Update logic corrected to reflect auto generation (was manual).
7/8/2011	General Date Editing Rules and Range Checking updated for additional clarity. However, the intent of the date rules remains the same as the 2010 update.

Date Case Last Changed

IDENTIFIERS

CCR ID	NAACCR ID
E1483	2100

DESCRIPTION

Date that the case was last changed by the hospital before being sent to the regional registry. This generated field is to be used by the hospital to reflect when a record was last changed. It is required on Correction records.

LEVELS

Admissions

LENGTH

8

ALLOWABLE VALUES

A valid, complete date in YYYYMMDD.

General Date Editing Rules:

Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD). Month and day must have leading zeros for values 01...09.

The following date format is allowed:

CCYYMMDD Century+Year, Month and Day are provided.

Dates are checked first to ensure they conform to one of these formats, then for errors in the components. Checking stops on the first non-valid situation.

Range checking:

Lowest allowed value: January 1, 1850 (or in D1 format: 18500101)

Highest allowed value: current system date

The month is checked to ensure it falls within range 01...12.

The day is checked to ensure it falls within range for that specific month. Accommodation is made for leap years.

SOURCE

If the record version is NAACCR version 12 (120 in original new case) or later, then upload the date with no conversion.

Otherwise, if the record version is earlier than 12, then perform the following conversions in this order:

1. Right-justify and zero-fill the date to 8 digits.
2. Convert MMDDYYYY to YYYYMMDD.

Do not record any changes made in the audit log.

UPDATE

Manual update, Correction applied (date correction was made at facility), Active Follow-up applied (date follow-up-related change was made at facility)

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

8/15/2006	Name changed to NAACCR name (was Date_Chng_Hosp). Description updated with Volume II information.

2010	2010 Data Changes: Revised Allowable Values and Source information to match NAACCRv12 date scheme. Update logic clarified.
7/8/2011	General Date Editing Rules and Range Checking updated for additional clarity. However, the intent of the date rules remains the same as the 2010 update.

Date Case Report Exported

IDENTIFIERS

CCR ID	NAACCR ID
E1484	2110

DESCRIPTION

Date that the case was written to an external transmit file (not necessarily the date the file was sent). Re-transmits should update this date.

LEVELS

Admissions

LENGTH

8

ALLOWABLE VALUES

A valid, complete date in YYYYMMDD.

General Date Editing Rules:

Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD). Month and day must have leading zeros for values 01...09.

The following date format is allowed:

CCYYMMDD Century+Year, Month and Day are provided.

Dates are checked first to ensure they conform to one of these formats, then for errors in the components. Checking stops on the first non-valid situation.

Range checking:

Lowest allowed value: January 1, 1850 (or in D1 format: 18500101)

Highest allowed value: current system date

The month is checked to ensure it falls within range 01...12.

The day is checked to ensure it falls within range for that specific month. Accommodation is made for leap years.

SOURCE

If the record version is NAACCR version 12 (120 in original new case) or later, then upload the date with no conversion.

Otherwise, if the record version is earlier than 12, then perform the following conversions in this order:

1. Right-justify and zero-fill the date to 8 digits.
2. Convert MMDDYYYY to YYYYMMDD.

Do not record changes in the audit log.

UPDATE

None: auto-generated when case was originally transmitted

CONSOLIDATED DATA EXTRACT

Yes, record with the earliest admission date for this tumor.

HISTORICAL CHANGES

8/15/06	Name updated to NAACCR name (was Date_Transmit). Description text updated from Volume II.

2010	2010 Data Changes: Revised Allowable Values and Source information to match NAACCRv12 date scheme. Update logic corrected to reflect auto generation (was manual).
7/8/2011	General Date Editing Rules and Range Checking updated for additional clarity. However, the intent of the date rules remains the same as the 2010 update.

Date Case Report Loaded

IDENTIFIERS

CCR ID	NAACCR ID
E1486	2112

DESCRIPTION

The date that this case report was loaded into the regional registry database for initiation of quality control activities.

LEVELS

Admissions

LENGTH

8

ALLOWABLE VALUES

A valid, complete date in YYYYMMDD.

General Date Editing Rules:

Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD). Month and day must have leading zeros for values 01...09.

The following date format is allowed:

CCYYMMDD Century+Year, Month and Day are provided.

Dates are checked first to ensure they conform to one of these formats, then for errors in the components. Checking stops on the first non-valid situation.

Range checking:

Lowest allowed value: January 1, 1850 (or in D1 format: 18500101)

Highest allowed value: current system date

The month is checked to ensure it falls within range 01...12.

The day is checked to ensure it falls within range for that specific month. Accommodation is made for leap years.

SOURCE

Automatically generate current date when case is loaded (same as Transmission Log's transmission date) but don't record as a data conversion in the audit log.

UPDATE

None

CONSOLIDATED DATA EXTRACT

Yes; record with the earliest admission date for this tumor.

HISTORICAL CHANGES

12/02	Added logic to Interfield edit that allows for when year is equal to Date_Case_Load and month and day dates are unknown or when month and year are equal to Date_Case_Load and day is unknown.
3/04	Removed Interfield edits #300, 301, 302 & 600 and the Allowable values edit (#152).
7/05	Removed Interfield edit text to correctly reflect the removal of these edits from 3/3/04.

2010	2010 Data Changes: CCR name (Date_Case_Load) changed to NAACCR name. Revised Allowable Values to use the date format of CCYYMMDD and the new interoperability date functions and rules.
7/8/2011	General Date Editing Rules and Range Checking updated for additional clarity. However, the intent of the date rules remains the same as the 2010 update.

Date Case Report Received

IDENTIFIERS

CCR ID	NAACCR ID
	2111

DESCRIPTION

The date and time that the electronic abstract is received by the regional cancer registry from the reporting facility.

LEVELS

Admissions

LENGTH

8

ALLOWABLE VALUES

A valid, complete date in YYYYMMDD.

General Date Editing Rules:

Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD). Month and day must have leading zeros for values 01...09.

The following date format is allowed:

CCYYMMDD Century+Year, Month and Day are provided.

Dates are checked first to ensure they conform to one of these formats, then for errors in the components. Checking stops on the first non-valid situation.

Range Checking:

Lowest allowed value: January 1, 1850 (or in D1 format: 18500101)

Highest allowed value: current system date

The month is checked to ensure it falls within range 01...12.

The day is checked to ensure it falls within range for that specific month. Accommodation is made for leap years.

SOURCE

If the admission was loaded into Eureka using regular file upload, then the Date Case Report Received is the date that was entered as the Date Received in the transmission log (this is the date that the user is asked to enter when uploading the file).

If the admission was migrated to Eureka, the Date Case Report Received is taken from the Date_Case_Rec value in the Admission Historical table, if it exists.

If the admission was created from a NER source document (during the NER Upload process) then the Date Case Report Received is initially set to null.

From Eureka version 4.4, if the admission is created using the New Case Entry page, then the Date Case Report Received will be the date and time that the admission is entered into Eureka.

In all other cases (e.g. the admission was migrated but there is no Date_Case_Rec value in the Admission Historical table, or the admission was created using the New Case Entry page prior to Eureka version 4.4), then Date Case Report Received is null.

UPDATE

None

CONSOLIDATED DATA EXTRACT

Yes, record with the earliest admission date for this tumor.

HISTORICAL CHANGES

1/98	New data item added. Defaulted to 99999999 in existing cases.
1/99	Name changed to NAACCR name (was Date_Case_Rec). Source documentation replaced with Eureka specific information. Value now stored at the admission level.
2/06	Name changed to NAACCR name (was Date_Case_Rec). Source documentation replaced with Eureka specific information. Value now stored at the admission level.
2010	2010 Data Changes: Revised Allowable Values and Source information to match NAACCRv12 date scheme.
7/8/2011	General Date Editing Rules and Range Checking updated for additional clarity. However, the intent of the date rules remains the same as the 2010 update.

Date Conclusive DX

IDENTIFIERS

CCR ID	NAACCR ID
E1074	443

DESCRIPTION

Documents the date when a conclusive cancer diagnosis (definite statement of malignancy) is made following an initial diagnosis that was based only on ambiguous terminology. The date of the conclusive diagnosis must be greater than two months following the initial (ambiguous terminology only) diagnosis.

LEVELS

Tumors, Admissions

LENGTH

8

ALLOWABLE VALUES

A valid, complete date in YYYYMMDD.

General Date Editing Rules:

Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD). Month and day must have leading zeros for values 01...09.

The following date format is allowed:

CCYYMMDD Century+Year, Month and Day are provided.

Dates are checked first to ensure they conform to one of these formats, then for errors in the components. Checking stops on the first non-valid situation.

Range Checking:

Lowest allowed value: January 1, 1850 (or in D1 format: 18500101)

Highest allowed value: current system date

The month is checked to ensure it falls within range 01...12.

The day is checked to ensure it falls within range for that specific month. Accommodation is made for leap years.

SOURCE

If the record version is NAACCR version 12 (120 in original new case) or later, then upload the date and its associated flag value with no conversion.

Otherwise, if the record version is earlier than 12, then perform the following conversions in this order:

1. Right-justify and zero-fill the date to 8 digits.
2. Convert MMDDYYYY to YYYYMMDD.
3. Convert Date Conclusive DX and Date Conclusive DX Flag in the same manner as described in the Eureka Process Specification: 2010 Data Conversions document.

If steps 1 and 2 are the only changes made to the date, then DO NOT record them in the audit log.

UPDATE

Tumor Level

New Case Consolidation

If the admission and tumor's Date Conclusive DX or Date Conclusive DX Flag values are different, then

List both dates and both flags for review

Manual Update*, **

Admission Level

Manual Update or Correction Applied to date or associated date flag*, **

*If a full or partial date is entered in the date field, then automatically change the associated flag to blank; if a numeric associated flag code is selected/entered, then automatically change the date to blank

If the date is changed, it is now later* than Date of Last Contact, and Vital Status is alive (1), then automatically update Date of Last Contact with the new date and reset Date of Last Contact Flag to blank (this update applies to the patient's Date of Last Contact and Vital Status for a Tumor Level change and to the patient and admission's Date of Last Contact and Vital Status for an Admission level change).

*** With year, month, and/or day potentially blank, a completely known date could appear to be later because it is a larger number than a partial later date. Thus, to test for the latest date among known full or partial dates, use these tests in this order:

- If one of the known dates' years is later than (greater than) the other date's year being compared or if it is the only known year/date, then that date is the latest known date
- If multiple known dates have the same latest year, but only one of them has a latest known month, then that is the latest known date
- If multiple known dates have the same latest year & month, but only one of them has a latest known day, then that is the latest known date

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

	None

Date Conclusive DX Flag

IDENTIFIERS

CCR ID	NAACCR ID
E1075	443

DESCRIPTION

This flag explains why there is no appropriate value in the corresponding date field, Date of Conclusive DX. This data item was added to NAACCR Version 12 (effective January 2010).

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

10	No information whatsoever can be inferred from this exceptional value. (e.g., unknown if the diagnosis was initially based on ambiguous terminology).
11	No proper value is applicable in this context. (e.g., not applicable, initial diagnosis made by unambiguous terminology [Code 0 in data item Ambiguous Terminology DX]).
12	A proper value is applicable but not known (e.g., the initial ambiguous diagnosis was followed by a conclusive term, but the date of the conclusive term is unknown).
15	Information is not available at this time, but it is expected that it will be available later (e.g., accessioned based on ambiguous terminology only [Code 1 in data item Ambiguous Terminology DX].
Blank	A valid date value is provided in item Date of Conclusive DX or the date was not expected to have been transmitted.

SOURCE

If the record version is version 12 or later, then upload with no conversion.
If the record version is earlier than 12, then follow the conversion specs - Eureka Process Specification: 2010 Data Conversions.

UPDATE

See Date of Conclusive DX

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

2010	New data item added for 2010 data changes. IF #896 added
03/2020	Added back to Volume III

Date First Sent

IDENTIFIERS

CCR ID	NAACCR ID
E1548	None

DESCRIPTION

Date this tumor was first sent to CCR.

LEVELS

Tumors

LENGTH

8

ALLOWABLE VALUES

A valid, complete date in YYYYMMDD.
General Date Editing Rules:

Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD). Month and day must have leading zeros for values 01...09.

The following date format is allowed:

CCYYMMDD Century+Year, Month and Day are provided.

Dates are checked first to ensure they conform to one of these formats, then for errors in the components. Checking stops on the first non-valid situation.

Range Checking:

Lowest allowed value: January 1, 1850 (or in D1 format: 18500101)

Highest allowed value: current system date

The month is checked to ensure it falls within range 01...12.

The day is checked to ensure it falls within range for that specific month. Accommodation is made for leap years.

SOURCE

Historical data item captured in original Eureka migration; not uploaded for new cases.

UPDATE

None

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

11/2002	In the CCR central system (EUREKA), this data item is no longer generated, but migrated dates are kept for historical purposes. The Allowable values edit (#4) was removed as were instructions for Source and Update
2010	2010 Data Changes: Revised Allowable Values to match NAACCRv12 date scheme.
07/2011	General Date Editing Rules and Range Checking updated for additional clarity. However, the intent of the date rules remain the same as the 2010 update.
03/2020	Added back to Volume III

Date Initial RX SEER

IDENTIFIERS

CCR ID	NAACCR ID
E1304	1260

DESCRIPTION

Date first course of definitive treatment started for this tumor.

LEVELS

Tumors, Admissions

LENGTH

8

ALLOWABLE VALUES

A valid, complete date in YYYYMMDD.

General Date Editing Rules:

Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD). Month and day must have leading zeros for values 01...09.

The following date format is allowed:

CCYYMMDD Century+Year, Month and Day are provided.

Dates are checked first to ensure they conform to one of these formats, then for errors in the components. Checking stops on the first non-valid situation.

Range Checking:

Lowest allowed value: January 1, 1850 (or in D1 format: 18500101)

Highest allowed value: current system date

The month is checked to ensure it falls within range 01...12.

The day is checked to ensure it falls within range for that specific month. Accommodation is made for leap years.

SOURCE

After all the input dates and flags have been loaded or converted and loaded (depending on the record version), perform steps 1 – 4 in the UPDATE section, Tumor Level, New Case Consolidation to generate this date and its associated date flag, rather than loading vendor values which may or may not be generated in the same way.

UPDATE

Tumor Level

New Case Consolidation

(Perform after all other treatment field and Type of Reporting Source consolidations)

If the tumor's RX Date Surgery, RX Date Surgery Flag, RX Date Mst Defn Surg, RX Date Mst Defn Srg Flag, RX Date Radiation, RX Date Radiation Flag, RX Date Chemo, RX Date Chemo Flag, RX Date Hormone, RX Date Hormone Flag, RX Date BRM, RX Date BRM Flag, RX Date--Transplnt Endocr, RX Date--Transplnt Endocr Flag, RX Date Other, RX Date Other Flag, or Type of Reporting Source are changed, then compare them to generate Date of Initial RX--SEER and Date of Initial RX Flag values according to these consolidation rules, executed in order and stopped when one of the numbered conditions is true:

1. If the tumor's Type of Reporting Source is 7 (DC only), then set Date Initial RX SEER to blank and Date Initial RX SEER Flag to 10.

2. If the tumor's Type of Reporting Source is 6 (Autopsy only), then set Date Initial RX SEER to blank and Date Initial RX SEER Flag to 11.
3. If all input dates are blank, then set Date Initial RX SEER to blank and consolidate Date Initial RX SEER Flag by comparing all the individual input date flags and determine the best value according to this hierarchy: 12, 15, 10, 11, blank. If Date Initial RX SEER Flag is now 15, convert it again to 10.
4. Otherwise, set Date Initial RX SEER Flag to blank and compare all fully known or partially known dates and set Date Initial RX SEER to the earliest of these known dates, taking into account that partial dates can have blank months and/or days.*

Manual change to RX Date Surgery, RX Date Surgery Flag, RX Date Mst Defn Surg, RX Date Mst Defn Srg Flag, RX Date Radiation, RX Date Radiation Flag, RX Date Chemo, RX Date Chemo Flag, RX Date Hormone, RX Date Hormone Flag, RX Date BRM, RX Date BRM Flag, RX--Date Transplnt Endocr, RX--Date Transplnt Endocr Flag, RX Date Other, RX Date Other Flag, or Type of Reporting Source:

Regenerate according to above New Case Consolidation rules.

Admission Level

Manual change or Correction Applied to RX Date Surgery, RX Date Surgery Flag, RX Date Mst Defn Surg, RX Date Mst Defn Srg Flag, RX Date Radiation, RX Date Radiation Flag, RX Date Chemo, RX Date Chemo Flag, RX Date Hormone, RX Date Hormone Flag, RX Date BRM, RX Date BRM Flag, RX Date--Transplnt Endocr, RX Date--Transplnt Endocr Flag, RX Date Other, RX Date Other Flag, or Type of Reporting Source:

Regenerate according to above New Case Consolidation rules.

* With year, month, and/or day potentially blank, a date with a partial but later date could appear to be earlier because it is a smaller number than a full earlier date. Thus, to test for the earliest among known dates, use these tests in this order:

- If one of the known dates' years is earlier than (less than) the rest of the known dates' years or if it is the only known year/date, then that date is the earliest known date
- If multiple known dates have the same earliest year, but only one of them has an earliest known month, then that is the earliest known date
- If multiple known dates have the same earliest year & month, but only one of them has an earliest known day, then that is the earliest known date
- Otherwise, if two or more of the dates are the same earliest full or partial date, then that date is the earliest date

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

	None

Date Initial RX SEER Flag

IDENTIFIERS

CCR ID	NAACCR ID
E1035	1261

DESCRIPTION

The Date of Initial RX Flag codes indicates why there is no appropriate value in the corresponding date field, Date Initial RX SEER.

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if therapy was administered)
11	No proper value is applicable in this context (e.g., therapy was not administered)
12	A proper value is applicable but not known (e.g., therapy was administered and date is unknown)
Blank	A valid date value is provided in item Date of Initial RX--SEER, or the date was not expected to have been transmitted.

SOURCE

If the record version is version 12 or later, then upload with no conversion.
If the record version is earlier than 12, then follow the conversion specs - Eureka Process Specification: 2010 Data Conversions.

UPDATE

See Date Initial RX SEER

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

2010	New data item added for 2010 data changes.
05/2013	Name changed from Date of Initial RX Flag to Date Initial RX SEER Flag
03/2020	Added back to Volume III

Date Last Sent

IDENTIFIERS

CCR ID	NAACCR ID
E1549	None

DESCRIPTION

Date this tumor was last sent to CCR.

LEVELS

Tumors

LENGTH

8

ALLOWABLE VALUES

A valid, complete date in YYYYMMDD.

General Date Editing Rules:

Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD). Month and day must have leading zeros for values 01...09.

The following date format is allowed:

CCYYMMDD Century+Year, Month and Day are provided.

Dates are checked first to ensure they conform to one of these formats, then for errors in the components. Checking stops on the first non-valid situation.

Range Checking:

Lowest allowed value: January 1, 1850 (or in D1 format: 18500101)

Highest allowed value: current system date

The month is checked to ensure it falls within range 01...12.

The day is checked to ensure it falls within range for that specific month. Accommodation is made for leap years.

SOURCE

Historical data item captured in original Eureka migration; not uploaded for new cases.

UPDATE

Historical data item captured in original Eureka migration; not uploaded for new cases.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

11/2002	In the CCR central system (EUREKA), this data item is no longer generated, but migrated dates are kept for historical purposes. The Allowable values edit (#5) was removed as were instructions for Source and Update.
2010	2010 Data Changes: Revised Allowable Values information to match NAACCRv12 date scheme. Update logic changed from "none" to clarify the process.
7/8/2011	General Date Editing Rules and Range Checking updated for additional clarity. However, the intent of the date rules remains the same as the 2010 update.

Date of 1st Contact

IDENTIFIERS

CCR ID	NAACCR ID
E1087	580

DESCRIPTION

Date patient was first seen at this hospital for evaluation and/or treatment of this tumor. This date is independent of whether the patient was an inpatient or an outpatient.

LEVELS

Admission

LENGTH

8

ALLOWABLE VALUES

A VALID, COMPLETE DATE IN YYYYMMDD.
GENERAL DATE EDITING RULES:

DATE FIELDS ARE RECORDED IN THE D1 DATE FORMAT OF YEAR, MONTH, DAY (CCYYMMDD). MONTH AND DAY MUST HAVE LEADING ZEROS FOR VALUES 01...09.

THE FOLLOWING DATE FORMAT IS ALLOWED:

CCYYMMDD Century+Year, Month and Day are provided.

DATES ARE CHECKED FIRST TO ENSURE THEY CONFORM TO ONE OF THESE FORMATS, THEN FOR ERRORS IN THE COMPONENTS. CHECKING STOPS ON THE FIRST NON-VALID SITUATION.

RANGE CHECKING:

LOWEST ALLOWED VALUE: JANUARY 1, 1850 (OR IN D1 FORMAT: 18500101)

HIGHEST ALLOWED VALUE: CURRENT SYSTEM DATE

THE MONTH IS CHECKED TO ENSURE IT FALLS WITHIN RANGE 01...12.

THE DAY IS CHECKED TO ENSURE IT FALLS WITHIN RANGE FOR THAT SPECIFIC MONTH. ACCOMMODATION IS MADE FOR LEAP YEARS.

SOURCE

If the record version is NAACCR version 12 (120 in original new case) or later, then upload the date and its associated flag value with no conversion.
Otherwise, if the record version is earlier than 12, then perform the following conversions in this order:

1. Right-justify and zero-fill the date to 8 digits.
2. Convert MMDDYYYY to YYYYMMDD.
3. Convert Date of 1st Contact and Date of 1st Contact Flag in the same manner as described in the Eureka Process

Specification: 2010 Data Conversions document.
If steps 1 and 2 are the only changes made to the date, then DO NOT record them in the audit log.
When month and day are known, day is checked to ensure it falls within range for that specific month. Accommodation is made for leap years.

UPDATE

Manual Update or Correction Applied to date or associated date flag*, **
*If a full or partial date is entered in the date field, then automatically change the associated flag to blank; If a numeric associated flag code is selected/entered, then automatically change the date to blank

If the date is changed, it is now later* than Date of Last Contact, and Vital Status is alive(1), then automatically update Date of Last Contact with the new date and reset Date of Last Contact Flag to blank (this update applies to the patient and admission's Date of Last Contact and Vital Status).

*** With year, month, and/or day potentially blank, a completely known date could appear to be later because it is a larger number than a partial later date. Thus, to test for the latest date among known full or partial dates, use these tests in this order:

- If one of the known dates' years is later than (greater than) the other date's year being compared or if it is the only known year/date, then that date is the latest known date
- If multiple known dates have the same latest year, but only one of them has a latest known month, then that is the latest known date
- If multiple known dates have the same latest year & month, but only one of them has a latest known day, then that is the latest known date

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

2010	New data item added for 2010 data changes.
02/2020	Added back to Volume III

Date of 1st Contact Flag

IDENTIFIERS

CCR ID	NAACCR ID
E1088	581

DESCRIPTION

Explains why there is no appropriate value in the corresponding date field, Date of 1st Contact

LEVELS

Admissions

LENGTH

2

ALLOWABLE VALUES

12	A proper value is applicable but not known (e.g., date of 1st contact is unknown)
Blank	A valid date value is provided in item Date of 1st Contact or the date was not expected to have been transmitted

SOURCE

If the record version is version 12 or later, then upload with no conversion.
If the record version is earlier than 12, then follow the conversion specs - Eureka Process Specification: 2010 Data Conversions.

UPDATE

See Date of 1st Contact field

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

2010	New data item added for 2010 data changes.

Date of Birth

IDENTIFIERS

CCR ID	NAACCR ID
E1033	240

DESCRIPTION

Birth date (CCYYMMDD) of the patient. Used to supplement patient identification for linkage, determine age at diagnosis, and to carry out cohort analyses.

LEVELS

Patients, Admissions

LENGTH

8

ALLOWABLE VALUES

A valid, complete date in YYYYMMDD.

General Date Editing Rules:

Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD). Month and day must have leading zeros for values 01...09.

The following date format is allowed:

CCYYMMDD Century+Year, Month and Day are provided.

Dates are checked first to ensure they conform to one of these formats, then for errors in the components. Checking stops on the first non-valid situation.

Range Checking:

Lowest allowed value: January 1, 1850 (or in D1 format: 18500101)

Highest allowed value: current system date

The month is checked to ensure it falls within range 01...12.

The day is checked to ensure it falls within range for that specific month. Accommodation is made for leap years.

SOURCE

If the record version is NAACCR version 12 (120 in original new case) or later, then upload the date and its associated flag value with no conversion.

Otherwise, if the record version is earlier than 12, then perform the following conversions in this order:

1. Right-justify and zero-fill the date to 8 digits.
2. Convert MMDDYYYY to YYYYMMDD.
3. Convert Date of Birth and Date of Birth Flag in the same manner as described in the Eureka Process Specification: 2010 Data Conversions document.

If steps 1 and 2 are the only changes made to the date, then DO NOT record them in the audit log.

Also, see CS Version Derived.

UPDATE

Patient Level

New Case Consolidation

If either of the following conditions are true:

- The Admission's Date of Birth contains a full or partial date and the Patient's Date of Birth is blank

- Any part of the patient's Date of Birth is blank, that same part of the admission's Date of Birth is entered, and other entered parts are equal

Then automatically update the patient's Date of Birth and Date of Birth Flag values with the admission's corresponding values

Manual Change*, **

Admission Level

Manual Change or Correction Applied to date or associated date flag*, **

*If a full or partial date is entered in the date field, then automatically change the associated flag to blank; if a numeric associated flag code is selected/entered, then automatically change the date to blank

If the date is changed, it is now later* than Date of Last Contact, and Vital Status is alive (1), then automatically update Date of Last Contact with the new date and reset Date of Last Contact Flag to blank (this update applies to the patient's Date of Last Contact and Vital Status for a patient Level change and to the patient and admission's Date of Last Contact and Vital Status for an Admission level change).

*** With year, month, and/or day potentially blank, a completely known date could appear to be later because it is a larger number than a partial later date. Thus, to test for the latest date among known full or partial dates, use these tests in this order:

1. If one of the known dates' years is later than (greater than) the other date's year being compared or if it is the only known year/date, then that date is the latest known date
2. If multiple known dates have the same latest year, but only one of them has a latest known month, then that is the latest known date
3. If multiple known dates have the same latest year & month, but only one of them has a latest known day, then that is the latest known date

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

1/1/99	Century 20 added to allowable values.

Date of Birth Flag

IDENTIFIERS

CCR ID	NAACCR ID
E1034	241

DESCRIPTION

This flag explains why there is no appropriate value in the corresponding date field, Date of Birth.

LEVELS

Patients, Tumors

LENGTH

2

ALLOWABLE VALUES

12	Use code 12 when date of birth is unknown.
Blank	A valid date value is provided in item Date of Birth or the date was not expected to have been transmitted.

SOURCE

If the record version is version 12 or later, then upload with no conversion.
If the record version is earlier than 12, then follow the conversion specs - Eureka Process Specification: 2010 Data Conversions.

UPDATE

See Date of Birth

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

2010	New data item added for 2010 data changes.
03/2020	Added back to Volume III

Date of Diagnosis

IDENTIFIERS

CCR ID	NAACCR ID
E1053	390

OWNER

SEER/CoC

DESCRIPTION

Date when this tumor was first diagnosed.
For Type of Reporting Source = 6 (Autopsy case) and Type of Reporting Source = 7 (DC Only case), date of death is entered for date of diagnosis as well as for dates of admission, discharge and follow-up.

LEVELLS

Tumors, Admissions

LENGTH

8

ALLOWABLE VALUES

A valid, complete date in YYYYMMDD.
General Date Editing Rules:

Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD). Month and day must have leading zeros for values 01-09.
The following date format is allowed:

CCYYMMDD Century+Year, Month and Day are provided.

Dates are checked first to ensure they conform to one of these formats, then for errors in the components. Checking stops on the first non-valid situation.

Range Checking:

Lowest allowed value: January 1, 1850 (or in D1 format: 18500101)
Highest allowed value: current system date
The month is checked to ensure it falls within range 01-12.
The day is checked to ensure it falls within range for that specific month. Accommodation is made for leap years.

SOURCE

If the record version is NAACCR version 12 (120 in original new case) or later, then upload the date and its associated flag value with no conversion.
Otherwise, if the record version is earlier than 12, then perform the following conversions in this order:

1. Right-justify and zero-fill the date to 8 digits.
2. Convert MMDDYYYY to YYYYMMDD.
3. Convert Date of Diagnosis and Date of Diagnosis Flag in the same manner as described in the Eureka Process Specification: 2010 Data Conversions document.

If steps 1 and 2 are the only changes made to the date, then DO NOT record them in the audit log.
Also see CS Version Derived.

UPDATE

Tumor Level

New Case Consolidation

If the admission and tumor Date of Diagnosis or Date of Diagnosis Flag values are different, then list both sets of values for review.

Manual Update*, **

Admission Level

Manual Update or Correction Applied to date or associated date flag*, **

*If a full or partial date is entered in the date field, then automatically change the associated flag to blank; if a numeric associated flag code is selected/entered, then automatically change the date to blank

If the date is changed, it is now later* than Date of Last Contact, and Vital Status is alive (1), then automatically update Date of Last

Contact with the new date and reset Date of Last Contact Flag to blank (this update applies to the patient's Date of Last Contact and Vital Status for a tumor Level change and to the patient and admission's Date of Last Contact and Vital Status for an Admission level change).

*** With year, month, and/or day potentially blank, a completely known date could appear to be later because it is a larger number than a partial later date. Thus, to test for the latest date among known full or partial dates, use these tests in this order:

- If one of the known dates' years is later than (greater than) the other date's year being compared or if it is the only known year/date, then that date is the latest known date
- If multiple known dates have the same latest year, but only one of them has a latest known month, then that is the latest known date
- If multiple known dates have the same latest year & month, but only one of them has a latest known day, then that is the latest known date

CONSOLIDATED DATA EXTRACT

Yes

HISTORICLA CHANGES

01/1999	Interfield edit 325 YEAR-DX check changed to look for 9999 instead of 99.
07/2001	Changed HIST-TYPE reference to HIST-TYPE-3 reference.
01/2005	Added Update logic.
2010	CCR name (Date DX) changed to match NAACCR name. Revised Allowable Values, Source and Update logic information to match NAACCRv12 date scheme. Added IF #613, 784, 785, 786, 825, 877, 878, 887, 888, 893, 897, 910, 911, 912, 913, 916. 959, 960, 961, 963, 964, 967, 977, 978, 983, 984, 985, 986, 987, and 988.
03/02/2011	Removed IF306, 334, 437, 910, 911, 912, 913, 914, 916 to match deletions in the metafile.
07/08/2011	General Date Editing Rules and Range Checking updated for additional clarity. However, the intent of the date rules remains the same as the 2010 update.
05/2013	Added IF996, 998, 1002, 1004, 1005, 1006, 1007, 1008, 1011, 1012, 1013, 1014, 1015, 1016, 1017, 1018, 1019, 1020, 1021, 1022, 1023, 1043, 1047, 1051, 1052, 1068, 1072, 1073.

Date of Diagnosis Flag

IDENTIFIERS

CCR ID	NAACCR ID
E1054	391

DESCRIPTION

This flag explains why there is no appropriate value in the corresponding date field, Date of Diagnosis. This data item was added to NAACCR Version 12 (effective January 2010) as a part of the 2010 data changes. Prior to version 12 (through 2009 diagnosis), date fields included codes which provided information other than dates. As part of an initiative to standardize date fields to interoperable dates, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

12
A proper value is applicable but not known. (e.g., date of diagnosis is unknown).
Blank
A valid date value is provided in item Date of Diagnosis or the date was not expected to have been transmitted.

SOURCE

If the record version is version 12 or later, then upload with no conversion.
If the record version is earlier than 12, then follow the conversion specs - Eureka Process Specification: 2010 Data Conversions.

UPDATE

See Date of Diagnosis

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

2010	New data item for 2010 data changes.

Date of Inpt Adm

IDENTIFIERS

CCR ID	NAACCR ID
E1089	590

DESCRIPTION

Date of the inpatient admission to the facility for the most definitive surgery. If no surgery, use the inpatient admission date for other cancer-directed therapy. If no cancer directed therapy, use date of inpatient admission for diagnostic work up.

LEVELS

Admissions

LENGTH

8

ALLOWABLE VALUES

A valid, complete date in YYYYMMDD.

General Date Editing Rules:

Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD). Month and day must have leading zeros for values 01...09.

The following date format is allowed:

CCYYMMDD Century+Year, Month and Day are provided.

Dates are checked first to ensure they conform to one of these formats, then for errors in the components. Checking stops on the first non-valid situation.

Range Checking:

Lowest allowed value: January 1, 1850 (or in D1 format: 18500101)

Highest allowed value: current system date

The month is checked to ensure it falls within range 01...12.

The day is checked to ensure it falls within range for that specific month. Accommodation is made for leap years.

SOURCE

If the record version is NAACCR version 12 (120 in original new case) or later, then upload the date and its associated flag value with no conversion.

Otherwise, if the record version is earlier than 12, then perform the following conversions in this order:

1. Right-justify and zero-fill the date to 8 digits.
2. Convert MMDDYYYY to YYYYMMDD.
3. Convert Date of Inpt Adm and Date of Inpt Adm Flag in the same manner as described in the Eureka Process

Specification: 2010 Data Conversions document.

If steps 1 and 2 are the only changes made to the date, then DO NOT record them in the audit log.

UPDATE

Manual Update or Correction Applied to date or associated date flag*, **

*If a full or partial date is entered in the date field, then automatically change the associated flag to blank; if a numeric associated flag code is selected/entered, then automatically change the date to blank

If the date is changed, it is now later* than Date of Last Contact, and Vital Status is alive(1), then automatically update Date of Last Contact with the new date and reset Date of Last Contact Flag to blank (this update applies to the patient and admission's Date of Last Contact and Vital Status).
*** With year, month, and/or day potentially blank, a completely known date could appear to be later because it is a larger number than a partial later date. Thus, to test for the latest date among known full or partial dates, use these tests in this order:

- If one of the known dates' years is later than (greater than) the other date's year being compared or if it is the only known year/date, then that date is the latest known date
- If multiple known dates have the same latest year, but only one of them has a latest known month, then that is the latest known date
- If multiple known dates have the same latest year & month, but only one of them has a latest known day, then that is the latest known date

CONSOLIDATED DATA EXTRACT

Yes, record with the earliest inpatient admission date for this tumor.

HISTORICAL CHANGES

3/97	This new field was added to the data set to collect the admission date on inpatients. It corresponds to the revised DATE-DISCHARGE field
2010	CCR name (Date Inpat Admis) changed to NAACCR name. Revised Allowable Values, Source and Update logic information to match NAACCRv12 date scheme. Added IF# 404, 904
7/8/2011	General Date Editing Rules and Range Checking updated for additional clarity. However, the intent of the date rules remains the same as the 2010 update.
05/2013	Name changed from Date of Inpatient Adm to Date of Inpt Adm

Date of Inpt Adm Flag

IDENTIFIERS

CCR ID	NAACCR ID
E1090	591

DESCRIPTION

Explains why there is no appropriate value in the corresponding date field, Date of Inpatient Adm.

LEVELS

Admissions

LENGTH

2

ALLOWABLE VALUES

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if patient was an inpatient).
11	No proper value is applicable in this context (e.g., patient was never an inpatient at the reporting facility).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., the patient was an inpatient but the date is unknown).
Blank	A valid date value is provided in item Date of Inpatient Admission or the date was not expected to have been transmitted.

SOURCE

If the record version is version 12 or later, then upload with no conversion.
If the record version is earlier than 12, then follow the conversion specs - Eureka Process Specification: 2010 Data Conversions.

UPDATE

See Date of Inpatient Adm

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

2010	New data item added for 2010 data changes.

Date of Inpt Disch

IDENTIFIERS

CCR ID	NAACCR ID
E1091	600

DESCRIPTION

Date of the inpatient discharge for the most definitive surgery, other cancer-directed therapy, or diagnostic evaluation. This date corresponds with the Date of Inpatient Admission field.

LEVELS

Admissions

LENGTH

8

ALLOWABLE VALUES

A valid, complete date in YYYYMMDD.

General Date Editing Rules:

Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD). Month and day must have leading zeros for values 01...09.

The following date format is allowed:

CCYYMMDD Century+Year, Month and Day are provided.

Dates are checked first to ensure they conform to one of these formats, then for errors in the components. Checking stops on the first non-valid situation.

Range Checking:

Lowest allowed value: January 1, 1850 (or in D1 format: 18500101)

Highest allowed value: current system date

The month is checked to ensure it falls within range 01...12.

The day is checked to ensure it falls within range for that specific month. Accommodation is made for leap years.

SOURCE

If the record version is NAACCR version 12 (120 in original new case) or later, then upload the date and its associated flag value with no conversion.

Otherwise, if the record version is earlier than 12, then perform the following conversions in this order:

1. Right-justify and zero-fill the date to 8 digits.
2. Convert MMDDYYYY to YYYYMMDD.
3. Convert Date of Inpt Disch and Date of Inpt Disch Flag in the same manner as described in the Eureka Process Specification: 2010 Data Conversions document.

If steps 1 and 2 are the only changes made to the date, then DO NOT record them in the audit log.

UPDATE

Manual Update or Correction Applied to date or associated date flag*, **

*If a full or partial date is entered in the date field, then automatically change the associated flag to blank; if a numeric associated flag code is selected/entered, then automatically change the date to blank

If the date is changed, it is now later* than Date of Last Contact, and Vital Status is alive(1), then automatically update Date of Last Contact with the new date and reset Date of Last Contact Flag to blank (this update applies to the patient and admission's Date of Last Contact and Vital Status).

*** With year, month, and/or day potentially blank, a completely known date could appear to be later because it is a larger number than a partial later date. Thus, to test for the latest date among known full or partial dates, use these tests in this order:

- If one of the known dates' years is later than (greater than) the other date's year being compared or if it is the only known year/date, then that date is the latest known date
- If multiple known dates have the same latest year, but only one of them has a latest known month, then that is the latest known date
- If multiple known dates have the same latest year & month, but only one of them has a latest known day, then that is the latest known date

CONSOLIDATED DATA EXTRACT

Yes, record with earliest inpatient admission date for this tumor.

HISTORICAL CHANGES

3/97	Prior to 3/17/97, this date field captured the date of discharge for both inpatients and outpatients. It will now only capture the date for inpatient discharge. Historical cases will be converted to 0's (zeroes) for TYPE-ADM=2, 3, 4, and 7.
1/05	Revised Update logic.
2010	Data Changes: CCR name (Date Discharge) changed to NAACCR name. Revised Allowable Values, Source and Update information to match NAACCRv12 date scheme. Added IF #905.
7/8/2011	General Date Editing Rules and Range Checking updated for additional clarity. However, the intent of the date rules remains the same as the 2010 update.
05/2013	Name changed from Date of Inpatient Disch to Date of Inpt Disch

Date of Inpt Disch Flag

IDENTIFIERS

CCR ID	NAACCR ID
E1092	601

DESCRIPTION

Explains why there is no appropriate value in the corresponding date field, Date of Inpatient Disch

LEVELS

Admissions

LENGTH

2

ALLOWABLE VALUES

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if patient was an inpatient).
11	No proper value is applicable in this context (e.g., patient was never an inpatient at the reporting facility).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., the patient was an inpatient but the date is unknown).
Blank	A valid date value is provided in item Date of Inpatient Disch or the date was not expected to have been transmitted.

SOURCE

If the record version is version 12 or later, then upload with no conversion.
If the record version is earlier than 12, then follow the conversion specs - Eureka Process Specification: 2010 Data Conversions.

UPDATE

See Date of Inpatient Disch

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

2010	New data item added for 2010 data changes

Date of Last Cancer (Tumor) Status

IDENTIFIERS

CCR ID	NAACCR ID
E1896	1772

OWNER

COC

DESCRIPTION

This data item documents the date of last cancer (tumor status) of the patient's malignant or non-malignant tumor. Record in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable.

LEVELS

Tumors, Admissions

LENGTH

8

ALLOWABLE VALUES

A valid date containing, at the minimum, CCYY.

General Date Editing Rules

Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD). Month and day must have leading zeros for values 01...09.

The following date formats are allowed:

CCYYMMDD Century+Year, Month and Day are provided.

CCYYMM__ Century+Year and Month. Day consists of two blank spaces.

CCYY____ Century+Year. Month and Day consist of four blank spaces.

Dates are checked first to ensure they conform to one of these formats, then for errors in the components. Checking stops on the first non-valid situation.

Range checking:

Lowest allowed value: January 1, 1850 (or in D1 format: 18500101)

Highest allowed value: current system date

When month is known, it is checked to ensure it falls within range 01...12.

When month and day are known, day is checked to ensure it falls within range for that specific month. Accommodation is made for leap years.

SOURCE

1. If Coding Proc is less than 34 (2018 data changes), then convert directly from DATE CANCER STATUS according to use case Perform Eureka 2018 One-Time Data Conversions and Table Populations – UC, step 24.
2. If any parts of the date (YYYY, MM, or DD) are 00, 0000, 88, 8888, 99, or 9999, then convert them to blank (no value).
3. If the date is now completely blank, then set the associated date flag to 12 (unknown); otherwise, set the date flag to blank.

UPDATE

Tumor Active Follow-up Fields Update Logic

CCR DATA EXTRACT

Yes

HISTORICAL CHANGES

11/2018	Per NAACCR v18, new data field implemented. Replaces Date Cancer Status [CCR #E1582].
01/2019	Revised Source Logic, Removed the following: • Right justify and zero fill the date to 8 digits • Convert MMDDYYYY to YYYYMMDD
03/2019	Revised Source Logic - added Step 1 for Coding Proc 34

Date of Last Cancer (Tumor) Status Flag

IDENTIFIERS

CCR ID	NAACCR ID
E1897	1773

OWNER

COC

DESCRIPTION

This flag explains why there is no appropriate value in the corresponding date field, Date of Last Cancer (tumor) Status [NAACCR #1772].

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

10-20, spaces

12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, the Date of Last Cancer (tumor) Status is unknown).
Blank	A valid date value is provided in item Date of Last Cancer (tumor) Status [NAACCR #1772].

SOURCE

1. If Coding Proc is less than 34 (2018 data changes), then convert directly from DATE CANCER STATUS FLAG according to use case Perform Eureka 2018 One-Time Data Conversions and Table Populations – UC, step 25.
2. If Date of Last Cancer (tumor) Status is not blank a Date of Last Cancer (tumor) Status Flag is not blank, then blank out field.
3. If Date of Last Cancer (tumor) Status is blank a Date of Last Cancer (tumor) Status Flag is blank, then set flag to 12.

UPDATE

Tumor Active Follow-up Fields Update Logic

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

11/2018	Per NAACCR v18, new data field implemented. Replaces Date Cancer Status Flag [CCR #E1583].
03/2019	Revised Source Logic – Added Step 1 for Coding Proc 34

Date of Last Contact

IDENTIFIERS

CCR ID	NAACCR ID
E1516	1750

DESCRIPTION

Date of last known information about this patient, or date of death if patient deceased

LEVELS

Patients, Admissions

LENGTH

8

ALLOWABLE VALUES

Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD). Month and day must have leading zeros for values 01...09.

The following date formats are allowed:

CCYYMMDD Century+Year, Month and Day are provided.

CCYYMM__ Century+Year and Month. Day consists of two blank spaces.

CCYY____ Century+Year. Month and Day consist of four blank spaces.

Dates are checked first to ensure they conform to one of these formats, then for errors in the components. Checking stops on the first non-valid situation.

Range Checking

Lowest allowed value: January 1, 1850 (or in D1 format: 18500101).

Highest allowed value: current system date.

When month is known, it is checked to ensure it falls within range 01...12.

When month and day are known, day is checked to ensure it falls within range for that specific month. Accommodation is made for leap years.

SOURCE

If the record version is version 12 or later, then upload with no conversion.

If the record version is earlier than 12, then perform the following conversions in this order:

1. If any parts of the date (YYYY, MM, or DD) are 00, 0000, 88, 8888, 99, or 9999, then convert them to blank (no value).
2. If the date is now completely blank, then set the associated date flag to 12 (unknown); otherwise, set the date flag to blank.

UPDATE

Patient Active Follow-up Fields Update Logic

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

2010	2010 Data changes: CCR name (Date_Last_Pat_FU) changed to NAACCR name. Revised Allowable Values, Source and Update logic information to match NAACCRv12 date scheme. Added IF 605, 624, 626, 841.

07/08/2011	General Date Editing Rules and Range Checking updated for additional clarity. However, the intent of the date rules remains the same as the 2010 update.
01/2019	Revised Source logic – removed the following: • Right-justify and zero-fill the date to 8 digits. • Convert MMDDYYYY to YYYYMMDD. • If steps 1 and 2 are the only changes made, then don't record them in the audit log.

Date of Last Contact Flag

IDENTIFIERS

CCR ID	NAACCR ID
E1517	1751

DESCRIPTION

This flag explains why there is no appropriate value in the corresponding date field, Date of Last Contact [1750].
This data item was added to NAACCR Version 12 (effective January 2010).

LEVELS

Patients, Admissions

LENGTH

2

ALLOWABLE VALUES

12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., date of last contact is unknown)
Blank	A valid date value is provided in item Date of Last Contact or the date was not expected to have been transmitted

SOURCE

If the record version is version 12 or later, then upload with no conversion.
If the record version is earlier than 12, then follow the conversion specs - Eureka Process Specification: 2010 Data Conversions.

UPDATE

Patient Active Follow-up Fields Update Logic

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

2010	New data item added for 2010 data changes.

Date of Mult Tumors

IDENTIFIERS

CCR ID	NAACCR ID
E1077	445

DESCRIPTION

This data item is used to identify the month, day and year the patient is diagnosed with multiple or subsequent reportable tumor(s) reported as a single primary using the SEER multiple tumor rules.

LEVELS

Tumors, Admissions

LENGTH

8

ALLOWABLE VALUES

A valid, complete date in YYYYMMDD.

General Date Editing Rules:

Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD). Month and day must have leading zeros for values 01...09.

The following date format is allowed:

CCYYMMDD Century+Year, Month and Day are provided.

Dates are checked first to ensure they conform to one of these formats, then for errors in the components. Checking stops on the first non-valid situation.

Range Checking:

Lowest allowed value: January 1, 1850 (or in D1 format: 18500101)

Highest allowed value: current system date

The month is checked to ensure it falls within range 01...12.

The day is checked to ensure it falls within range for that specific month. Accommodation is made for leap years.

SOURCE

If the record version is version 12 or later, then upload with no conversion.

If the record version is earlier than 12, then perform the following conversions in this order:

1. Right-justify and zero-fill the date to 8 digits.
2. Convert MMDDYYYY to YYYYMMDD.
3. If any parts of the date (year, month, and/or day) are 00, 0000, 88, 8888, 99, or 9999, then convert them to blank (no value).

When formatting is the only change to a date, do not record it in the audit log.

UPDATE

Tumor Level

New Case Consolidation

If the admission and tumor's Date of Mult Tumors or Date of Mult Tumors Flag values are different, then list both dates and both flags for review

Manual Update*, **

Admission Level

Manual Update or Correction applied to date or its associated date flag*, **

*If a full or partial date is entered in the date field, then automatically change the associated flag to blank; if a numeric associated flag code is selected/entered, then automatically change the date to blank
If the date is changed, it is now later* than Date of Last Contact, and Vital Status is alive (1), then automatically update Date of Last Contact with the new date and reset Date of Last Contact Flag to blank (this update applies to the patient's Date of Last Contact and Vital Status for a Tumor Level change and to the patient and admission's Date of Last Contact and Vital Status for an Admission level change).
*** With year, month, and/or day potentially blank, a completely known date could appear to be later because it is a larger number than a partial later date. Thus, to test for the latest date among known full or partial dates, use these tests in this order:

- If one of the known dates' years is later than (greater than) the other date's year being compared or if it is the only known year/date, then that date is the latest known date
- If multiple known dates have the same latest year, but only one of them has a latest known month, then that is the latest known date
- If multiple known dates have the same latest year & month, but only one of them has a latest known day, then that is the latest known date

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

8/15/06	New data item for 2007.
2/20/08	Changed Update spec to List for Review (was Manual) so discrepancies are reflected in Conflict table. Added IF #784.
2/2009	Added IF #830.
2010	2010 Data Changes: Revised Allowable Values and Source information to match NAACCRv12 date scheme. Revised Allowable Values, Source and Update logic information to match NAACCRv12 date scheme. Added IF #906.
7/8/2011	General Date Editing Rules and Range Checking updated for additional clarity. However, the intent of the date rules remains the same as the 2010 update.
05/2013	Name changed from Date of Multiple Tumors to Date of Mult Tumors

Date of Mult Tumors Flag

IDENTIFIERS

CCR ID	NAACCR ID
E1078	439

OWNER

NAACCR

DESCRIPTION

This flag explains why there is no appropriate value in the corresponding date field, Date of Mult Tumors.

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

11	No proper value is applicable in this context (e.g., information on multiple tumors not collected/not applicable for this site).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g. patient was diagnosed with multiple tumors and the date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (e.g., single tumor).
Blank	A valid date value is provided in item Date Multiple Tumors or information not collected for this diagnosis date - year of Date of Diagnosis is prior to 2007 or 2013 and later.

SOURCE

If the record version is version 12 or later, then upload with no conversion.
If the record version is earlier than 12, then follow the conversion specs - Eureka Process Specification: 2010 Data Conversions.

UPDATE

See Date of Mult Tumors

CCR DATA EXTRACT

Yes

HISTORICAL CHANGES

2010	New data item added for 2010 data changes. IF #742, 784, 830, and 906 added.
03/2015	Clarified that blank is also allowed for year of Date of Diagnosis prior to 2007 or 2013 and later.

Date of Sentinel Lymph Nodes Biopsy

IDENTIFIERS

CCR ID	NAACCR ID
E1848	832

OWNER

NAACCR

DESCRIPTION

Records the date of the sentinel lymph node(s) biopsy procedure. This data item is required for breast and melanoma cases only.

LEVELS

Tumors, Admissions

LENGTH

8

ALLOWABLE VALUES

A valid, complete or partial date in YYYYMMDD. May be blank.

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater
   AND Schema ID is NOT 00470 (melanoma) or 00480 (breast), THEN blank out field
3. If Date of Diagnosis is 2018 and greater
   AND Schema ID IS 00470 (melanoma) or 00480 (breast), THEN upload with no conversion.

UPDATE

TUMOR LEVEL

NEW CASE CONSOLIDATION

If the admission and tumor Date of Sentinel Lymph Node Biopsy or Date of Sentinel Lymph Node Biopsy Flag values are different, then list both sets of values for review.

MANUAL UPDATE*, **

ADMISSION LEVEL

MANUAL UPDATE*, **

**If a full or partial date is entered in the date field, then automatically change the associated flag to blank; if a numeric associated flag code is selected/entered, then automatically change the date to blank*

If the date is changed, it is now later than Date of Last Contact, and Vital Status is alive (1), then automatically update Date of Last Contact with the new date and reset Date of Last Contact Flag to blank (this update applies to the patient's Date of Last Contact and Vital Status for a tumor Level change and to the patient and admission's Date of Last Contact and Vital Status for an Admission level change).*

**** With year, month, and/or day potentially blank, a completely known date could appear to be later because it is a larger number than a partial later date. Thus, to test for the latest date among known full or partial dates, use these tests in this order:*

1. *If one of the known dates' years is later than (greater than) the other date's year being compared or if it is the only known year/date, then that date is the latest known date*
2. *If multiple known dates have the same latest year, but only one of them has a latest known month, then that is the latest known date*

3. *If multiple known dates have the same latest year & month, but only one of them has a latest known day, then that is the latest known date*

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data item implemented.
11/2019	SOURCE Logic revised

Date of Sentinel Lymph Node Biopsy Flag

IDENTIFIERS

CCR ID	NAACCR ID
E1849	833

DESCRIPTION

This flag explains why there is no appropriate value in the corresponding date data item, Date of Sentinel Lymph Node Biopsy [832]. This data item is required for breast and melanoma cases only.

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any sentinel lymph node biopsy was performed)
11	No proper value is applicable in this context (for example, no sentinel lymph node biopsy performed; autopsy only cases)
12	A proper value is applicable but not known. This event occurred, but the date is unknown (for example, sentinel lymph node biopsy performed but date is unknown)
Blank	A valid date value is provided in item Date of Sentinel Lymph Node Biopsy [NAACCR #832]. Case was diagnosed pre-2018.

SOURCE

1. If Date of Diagnosis is less than 2018, THEN blank out field.
2. If Date of Diagnosis is 2018 and greater
   AND Schema ID is NOT 00470 (melanoma) or 00480 (breast), THEN blank out field.
3. If Date of Diagnosis is 2018 and greater
   AND Schema ID IS 00470 (melanoma) or 00480 (breast)
   AND Date of Sentinel Lymph Node Biopsy is blank
   AND Type of Reporting Source is NOT 7 (Death Certificate)
   AND Date of Sentinel Lymph Node Biopsy Flag is NOT 11, then convert to 11
4. Otherwise, upload with no conversion.

UPDATE

See Date Sentinel Lymph Node Biopsy [NAACCR #832]

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data item implemented.
11/2019	SOURCE Logic revised
04/2020	Added death certificate case exception in Source Logic

Date Ready for Research

IDENTIFIERS

CCR ID	NAACCR ID
None	None

This data item is not in the exchange record (Volume II, Appendix A). Therefore, it does not have either a CCR ID or a NAACCR ID.

DESCRIPTION

Date and time that visual editing and linkage/consolidation were completed by the central registry.

LEVELS

Patients, Tumors, Admissions

LENGTH

Date/time

ALLOWABLE VALUES

A valid, complete date in YYYYMMDD.

General Date Editing Rules:

Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD). Month and day must have leading zeros for values 01...09.

The following date format is allowed:

CCYYMMDD Century+Year, Month and Day are provided.

Dates are checked first to ensure they conform to one of these formats, then for errors in the components. Checking stops on the first non-valid situation.

Range Checking:

Lowest allowed value: January 1, 1850 (or in D1 format: 18500101)

Highest allowed value: current system date

The month is checked to ensure it falls within range 01...12.

The day is checked to ensure it falls within range for that specific month. Accommodation is made for leap years.

SOURCE

Generated in Eureka.

Date ready for research (tumor level):

- If the tumor is created from an admission during admission linkage resolution, and consolidation is not required, then Date Ready for Research is the date and time of the linkage.
- If the tumor is created from an admission during admission linkage resolution, and consolidation is required, then Date Ready for Research is the date and time that consolidation of the admission was completed.
- If the tumor was created during migration, then Date Ready for Research is null.
- If the tumor was created from a NER source document (during the NER Upload process) then the Date Ready for Research is null.
- In all other cases (e.g. the tumor has not yet completed consolidation), the Date Ready for Research will be null.

Date ready for research (patient level):

- Same as tumor level, but for patients.

Date ready for research (admission level):

- If the admission is linked to a patient and tumor for the first time and consolidation with the patient and tumor is not required, then Date Ready for Research is the date and time of the linkage.
- If the admission is linked to a patient and tumor for the first time and consolidation is required, then Date Ready for Research is the date and time that the consolidation is completed.
- If the admission was created during migration, then Date Ready for Research is null.
- If the admission was created from a NER source document (during the NER Upload process) then the Date Ready for Research is null.
- In all other cases (e.g. the admission is deleted prior to linkage, the admission has not yet been linked, or consolidation is not yet complete), the Date Ready for Research will be null.

UPDATE

See Source

CONSOLIDATED DATA EXTRACT

No

HISTORICAL CHANGES

2/01/06	Data item created and value generated as described in Source on 10/03/05.
2010	Revised Allowable Values and Source information to match NAACCRv12 date scheme. Unknown values of 1/1/9999 were converted to null.
7/8/2011	General Date Editing Rules and Range Checking updated for additional clarity. However, the intent of the date rules remains the same as the 2010 update.

Date Rec Avail

IDENTIFIERS

CCR ID	NAACCR ID
None	None

This data item is not in the exchange record (Volume II, Appendix A). Therefore, it does not have either a CCR ID or a NAACCR ID.

DESCRIPTION

Date the demographic and cancer identification information on a single primary cancer/reportable neoplasm, compiled from one or more source records, from one or more facilities, was available in the regional cancer registry databases before the advent of the central, statewide, database, Eureka. Migrated dates are maintained for historical purposes.

LEVELS

Tumors

LENGTH

8

ALLOWABLE VALUES

A valid, complete date in YYYYMMDD.

SOURCE

Historical data item captured in original Eureka migration; not uploaded for new cases.

UPDATE

None

CCR DATA EXTRACT

Yes

HISTORICAL CHANGES

11/02	In the CCR central system (EUREKA), this data item is no longer generated, but migrated dates are kept for historical purposes. For tumors processed first in the central system, this date can be derived from the Audit Log. The allowable values edit was removed and SOURCE was changed. To N/A.
2010	Data Changes: Revised Allowable Values to match NAACCRv12 date scheme.
7/8/11	General Date Editing Rules and Range Checking updated for additional clarity. However, the intent of the date rules remains the same as the 2010 update.

Date Regional Lymph Node Dissection

IDENTIFIERS

CCR ID	NAACCR ID
E1842	682

OWNER

NAACCR

DESCRIPTION

Records the date non-sentinel regional node dissection was performed.

LEVELS

Tumors, Admissions

LENGTH

8

ALLOWABLE VALUES

A valid, complete or partial date in YYYYMMDD. May be blank.

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater, then upload with no conversion.

UPDATE

Tumor Level

New Case Consolidation

If the admission and tumor Date Regional Lymph Node Dissection or Date Regional Lymph Node Dissection Flag values are different, then list both sets of values for review.

Manual Update*, **

Admission Level

Manual Update*, **

*If a full or partial date is entered in the date field, then automatically change the associated flag to blank; if a numeric associated flag code is selected/entered, then automatically change the date to blank

If the date is changed, it is now later* than Date of Last Contact, and Vital Status is alive (1), then automatically update Date of Last

Contact with the new date and reset Date of Last Contact Flag to blank (this update applies to the patient's Date of Last Contact and Vital Status for a tumor Level change and to the patient and admission's Date of Last Contact and Vital Status for an Admission level change).

*** With year, month, and/or day potentially blank, a completely known date could appear to be later because it is a larger number than a partial later date. Thus, to test for the latest date among known full or partial dates, use these tests in this order:

- If one of the known dates' years is later than (greater than) the other date's year being compared or if it is the only known year/date, then that date is the latest known date
- If multiple known dates have the same latest year, but only one of them has a latest known month, then that is the latest known date
- If multiple known dates have the same latest year & month, but only one of them has a latest known day, then that is the latest known date

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data item implemented.

Date Regional Lymph Node Dissection Flag

IDENTIFIERS

CCR ID	NAACCR ID
E1843	683

DESCRIPTION

This flag explains why there is no appropriate value in the corresponding date data item, Date of Regional Lymph Node Dissection [NAACCR #682].

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any regional lymph node dissection was performed)
11	No proper value is applicable in this context (for example, no regional lymph node dissection was performed; autopsy only cases)
12	A proper value is applicable but not known. This event occurred, but the date is unknown (for example, regional lymph node dissection was performed but date is unknown)
Blank	A valid date value is provided in item Date of Regional Lymph Node Dissection [NAACCR #682]. Case was diagnosed pre-2018.

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field.
2. If Date of Diagnosis is 2018 and greater, then upload with no conversion.

UPDATE

See Date Regional Lymph Node Dissection [NAACCR #682]

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

2010	Per NAACCR v18, new data item implemented.

Date Surg Prim First

IDENTIFIERS

CCR ID	NAACCR ID
E1625	None. State Requestor

DESCRIPTION

The date of the first/earliest surgery performed on the primary site during first course of treatment.

LEVELS

Tumor

LENGTH

8

ALLOWABLE VALUES

A valid, complete date in YYYYMMDD.

SOURCE

See Update. (F03673 assigned for edit purposes).

UPDATE

Generate from all related admissions' surgical procedure dates according to Business Rules Requirements: Surgery Consolidation Rules document. The business rules may require manual review.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

1/08/07	New data item per CCR research group request. An Allowable Values edit was added because visual editors can change the data item value on the consolidation screen.
2010	2010 Data Changes. Revised Allowable Values to match NAACCRv12 date scheme. Added IF #873.

Date Surg Prim First Flag

IDENTIFIERS

CCR ID	NAACCR ID
E1626	None. State Requestor

DESCRIPTION

The Date Surg Prim First Flag explains why there is no corresponding date in the related field, Date Surg Prim First.
From January 1, 2010 forward, this field accommodates non-date information that had previously been transmitted in date fields.
Until December 31, 2009, date fields included codes which provided information other than dates.

LEVELS

Tumor

LENGTH

2

ALLOWABLE VALUES

10	Unknown if surgery performed (*Date Surg Prim First* is unknown and surgery code is nines)
11	No surgery performed in this procedure
12	Surgery was performed to the primary site but it is unknown when; or it is impossible to tell which of multiple surgical procedures for the primary site was performed first
Blank	A valid date value is provided in Date Surg Prim First, or the date and flag have not been generated/entered yet.

SOURCE

See Date Surg Prim First

UPDATE

See Date Surg Prim First

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

2010	New data item added for 2010 data changes. This field is unique to the CCR because NAACCR does not have a Date Surg Prim First/Surg Prim First field.

Date Surg Proc 1-3

Data Item	CCR ID	NAACCR ID
Date Surg Proc 1	E1591	None. State Requestor
Date Surg Proc 2	E1596	None. State Requestor
Date Surg Proc 3	E1601	None. State Requestor

DESCRIPTION

Date each surgical procedure was performed. Data items displayed but not visually edited in central system in CP 22.

LEVELS

Admissions

LENGTH

3 * 8

ALLOWABLE VALUES

Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD). Month and day must have leading zeros for values 01...09.

General Date Editing Rules:

Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD). Month and day must have leading zeros for values 01...09.

The following date format is allowed:

CCYYMMDD Century+Year, Month and Day are provided.

Dates are checked first to ensure they conform to one of these formats, then for errors in the components. Checking stops on the first non-valid situation.

Range Checking:

Lowest allowed value: January 1, 1850 (or in D1 format: 18500101).

Highest allowed value: current system date.

The month is checked to ensure it falls within range 01...12.

The day is checked to ensure it falls within range for that specific month. Accommodation is made for leap years.

SOURCE

If the record version is version 12 or later, then upload with no conversion.

If the record version is earlier than 12, then perform the following conversions in this order:

1. Right-justify and zero-fill the date to 8 digits.
2. Convert MMDDYYYY to YYYYMMDD.
3. Convert Date Surg Proc 1 - 3 and Date Surg Proc 1 - 3 Flag in the same manner as described in the Eureka Process Specification: 2010 Data Conversions document.

If steps 1 and 2 are the only changes made to the date, then DO NOT record them in the audit log.

UPDATE

Manual Update or Correction applied to a date or its associated date flag *, **

*If a full or partial date is entered in the date field, then automatically change the associated flag to blank; if a numeric associated flag code is selected/entered, then automatically change the date to blank

If the date is changed, it is now later* than Date of Last Contact, and Vital Status is alive(1), then automatically update Date of Last Contact with the new date and reset Date of Last Contact Flag to blank (this update applies to the patient and admission's Date of Last Contact and Vital Status). In addition, if

one or more of these dates is changed, the corresponding admission automatic updates and consolidation procedures upon manual update to Date Surg Proc1-3 required for RX Date--Surgery, RX Date--Most Defin Surg, Hosp_Surg_Prim_Sum, Surg_Prim_First, Date_Surg_Prim_First, and Hosp_Surg_Prim_First must be performed.

*** With year, month, and/or day potentially blank, a completely known date could appear to be later because it is a larger number than a partial later date. Thus, to test for the latest date among known full or partial dates, use these tests in this order:

- If one of the known dates' years is later than (greater than) the other date's year being compared or if it is the only known year/date, then that date is the latest known date
- If multiple known dates have the same latest year, but only one of them has a latest known month, then that is the latest known date
- If multiple known dates have the same latest year & month, but only one of them has a latest known day, then that is the latest known date

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

1/1/98	DATE-SURG-PROC (1) initialized to 99999999 for 1998 data changes.
3/26/03	Updated the C/N #s in Source to the correct numbers. Allowable Values changed for DC Only cases to code 9's instead of 0's. Added logic to Interfield edit 4) for DC Only cases.
3/03/04	Removed IF 1-4) and Admission Update logic that pertains to Proc 1-3.
1/08/07	Added Update text.
2010	2010 Data Item Changes: Updated Allowable Values, Source and Update logic to match NAACCRv12 date changes.
7/8/2011	General Date Editing Rules and Range Checking updated for additional clarity. However, the intent of the date rules remains the same as the 2010 update.

Date Surg Proc 1 Flag

IDENTIFIERS

CCR ID	NAACCR ID
E1592	None. State Requestor

DESCRIPTION

The Date of Surg Proc 1 Flag explains why there is no corresponding date in the related field, Date of Surg Proc-1.
From January 1, 2010 forward, this field accommodates non-date information that had previously been transmitted in date fields.
Until December 31, 2009, date fields included codes which provided information other than dates.

LEVELS

Admissions

LENGTH

2

ALLOWABLE VALUES

10	Unknown if surgery performed (*Date of Surgical Procedure 1* is unknown and surgery code is nines)
11	No surgery performed in this procedure
12	Surgery performed (not 0, 00, 98, 9, or 99) but *Date of Surgical Procedure 1* is unknown
Blank	A valid date value is provided in item *Date of Surgical Procedure 1*, or the date was not expected to have been transmitted.

SOURCE

If the record version is version 12 or later, then upload with no conversion.
If the record version is earlier than 12, then follow the conversion specs - Eureka Process Specification: 2010 Data Conversions.

UPDATE

See Date Surg Proc 1-3

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

2010	New data item added for 2010 data changes.

Date Surg Proc 2 Flag

IDENTIFIERS

CCR ID	NAACCR ID
E1597	None. State Requestor

DESCRIPTION

The Date of Surg Proc 2 Flag explains why there is no corresponding date in the related field, Date of Surg Proc-2.
From January 1, 2010 forward, this field accommodates non-date information that had previously been transmitted in date fields.
Until December 31, 2009, date fields included codes which provided information other than dates.

LEVELS

Admissions

LENGTH

2

ALLOWABLE VALUES

10	Unknown if surgery performed (*Date of Surgical Procedure 2* is unknown and surgery code is nines)
11	No surgery performed in this procedure
12	Surgery performed (not 0, 00, 98, 9, or 99) but *Date of Surgical Procedure 2* is unknown
Blank	A valid date value is provided in item *Date of Surgical Procedure 2*, or the date was not expected to have been transmitted.

SOURCE

If the record version is version 12 or later, then upload with no conversion.
If the record version is earlier than 12, then follow the conversion specs - Eureka Process Specification: 2010 Data Conversions.

UPDATE

See Date Surg Proc 1-3

CCR DATA EXTRACT

Yes

HISTORICAL CHANGES

2010	New data item added for 2010 data changes.

Date Surg Proc 3 Flag

IDENTIFIERS

CCR ID	NAACCR ID
E1602	None. State Requestor

DESCRIPTION

The Date of Surg Proc 3 Flag explains why there is no corresponding date in the related field, Date of Surg Proc-3.
From January 1, 2010 forward, this field accommodates non-date information that had previously been transmitted in date fields.
Until December 31, 2009, date fields included codes which provided information other than dates.

LEVELS

Admissions

LENGTH

2

ALLOWABLE VALUES

10	Unknown if surgery performed (Date Surg Proc 3 is unknown and surgery code is nines)
11	No surgery performed in this procedure
12	Surgery performed (codes not 0, 00, 98, 9, or 99) but Date Surg Proc 3 is unknown
Blank	A valid date value is provided in item Date Surg Proc 3, or the date was not expected to have been transmitted.

SOURCE

If the record version is version 12 or later, then upload with no conversion.
If the record version is earlier than 12, then follow the conversion specs - Eureka Process Specification: 2010 Data Conversions.

UPDATE

See Date Surg Proc 1-3

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

2010	New data item added for 2010 data changes.

Date Updated

IDENTIFIERS

CCR ID	NAACCR ID
None	None. Eureka Data Item

This date is written internally to Eureka. Therefore, it is not in the Exchange record (Volume II, Appendix A and does not have a CCR-ID nor a NAACCR ID.

DESCRIPTION

Date and time that tumor/patient/admission were last changed.

LEVELS

Patients, Tumors, Admissions

LENGTH

8

ALLOWABLE VALUES

A valid, complete date in YYYYMMDD.

UPDATE

Automatically update when a data item is changed so that the date of the most recent change is on the file.

CONSOLIDATED DATA EXTRACT

No

HISTORICAL CHANGES

2/06	Data item created and value generated from latest date in the tumor/patient/admission detail audit log on 10/03/05.
2010	2010 Data Item Changes: Revised Allowable Values and Source information to match NAACCRv12 date scheme.
2011	Length changed from Date/time to Length 8.
7/8/11	General Date Editing Rules and Range Checking updated for additional clarity. However, the intent of the date rules remains the same as the 2010 update.

Date VE

IDENTIFIERS

CCR ID	NAACCR ID
E1611	None. State Requestor.

DESCRIPTION

Date visual editing was performed by the regional registries

LEVELS

Admissions

LENGTH

8

ALLOWABLE VALUES

A valid, complete date in YYYYMMDD.

General Date Editing Rules:

Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD). Month and day must have leading zeros for values 01...09.

The following date format is allowed:

CCYYMMDD Century+Year, Month and Day are provided.

Dates are checked first to ensure they conform to one of these formats, then for errors in the components. Checking stops on the first non-valid situation.

Range Checking:

Lowest allowed value: January 1, 1850 (or in D1 format: 18500101)

Highest allowed value: current system date

The month is checked to ensure it falls within range 01...12.

The day is checked to ensure it falls within range for that specific month. Accommodation is made for leap years.

SOURCE

New Case Upload: Generate initial value of blank, but do not record as data conversion in Audit Log.
Visual Editing: If blank, automatically default this date to today's date upon display.

UPDATE

Manual

CONSOLIDATED DATA EXTRACT

Yes, earliest non-zero date or blank if no admissions have a date.

HISTORICAL CHANGES

3/00	New data item added for visual editing standards.
2010	2010 Data Item Changes: Revised Allowable Values to match NAACCRv12 date scheme.
7/8/2011	General Date Editing Rules and Range Checking updated for additional clarity. However, the intent of the date rules remains the same as the 2010 update.

Date VE Reported

IDENTIFIERS

CCR ID	NAACCR ID
E1612	None

DESCRIPTION

Date visual editing feedback was provided to hospital registrars by regional registries.

LEVELS

Admissions

LENGTH

8

ALLOWABLE VALUES

A valid, complete date in YYYYMMDD.

General Date Editing Rules:

Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD). Month and day must have leading zeros for values 01...09.

The following date format is allowed:

CCYYMMDD Century+Year, Month and Day are provided.

Dates are checked first to ensure they conform to one of these formats, then for errors in the components. Checking stops on the first non-valid situation.

Range Checking:

Lowest allowed value: January 1, 1850 (or in D1 format: 18500101)

Highest allowed value: current system date

The month is checked to ensure it falls within range 01...12.

The day is checked to ensure it falls within range for that specific month. Accommodation is made for leap years.

SOURCE

Generate initial value of blank, but do not record as data conversion in Audit Log.

UPDATE

Automatic update by Visual Editing Discrepancies Report Program.

CONSOLIDATED DATA EXTRACT

Yes, earliest non-zero date or blank if no admissions have a date.

HISTORICAL CHANGES

3/00	New data item added for visual editing standards.
2010	2010 Data Item Changes: Revised Allowable Values and Source information to match NAACCRv12 date scheme.
7/8/2011	General Date Editing Rules and Range Checking updated for additional clarity. However, the intent of the date rules remains the same as the 2010 update.

Date VE Resolved

IDENTIFIERS

CCR ID	NAACCR ID
E1613	None. State Requestor

DESCRIPTION

Date that disputed visual editing discrepancy is resolved.

LEVELS

Admissions

LENGTH

8

ALLOWABLE VALUES

A valid, complete date in YYYYMMDD.

General Date Editing Rules:

Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD). Month and day must have leading zeros for values 01...09.

The following date format is allowed:

CCYYMMDD Century+Year, Month and Day are provided.

Dates are checked first to ensure they conform to one of these formats, then for errors in the components. Checking stops on the first non-valid situation.

Range Checking:

Lowest allowed value: January 1, 1850 (or in D1 format: 18500101)

Highest allowed value: current system date

The month is checked to ensure it falls within range 01...12.

The day is checked to ensure it falls within range for that specific month. Accommodation is made for leap years.

SOURCE

Generate initial value of blank, but do not record as data conversion in Audit Log.

UPDATE

Manual

CONSOLIDATED DATA EXTRACT

No

HISTORICAL CHANGES

3/00	New data item added for visual editing standards.
2010	2010 Data Item Changes: Revised Allowable Values and Source information to match NAACCRv12 date scheme.
7/8/2011	General Date Editing Rules and Range Checking updated for additional clarity. However, the intent of the date rules remains the same as the 2010 update.

DC Birth Place

IDENTIFIERS

CCR ID	NAACCR ID
E1587	None. State Requestor.

DESCRIPTION

State or country of the patient's birth as stated on the death certificate.

LEVELS

Patients

LENGTH

3

ALLOWABLE VALUES

Any

SOURCE

Blank when patient created.

UPDATE

Manual change or automatic upload from death clearance passive follow-up documents only.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/17/97	This new field was added in order to capture birthplace as recorded on vital statistics records in a separate field.
12/2008	Field length changed to 3 for 2009 data changes.

DC Fathers Surname

IDENTIFIERS

CCR ID	NAACCR ID
E1728	None. State Requestor

DESCRIPTION

Father's surname as stated on the death certificate.

LEVELS

Patients

LENGTH

40

ALLOWABLE VALUES

Any

SOURCE

Not entered upon patient creation.

UPDATE

Manual change or automatic upload from death clearance passive follow-up documents only.
If DC Father's Surname changes, then NHIA Derived Hisp Origin must be regenerated.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

1/19/05	This new field was added in order to capture father's surname as recorded on vital statistics records in a separate field.
2010	2010 Data Item Changes: Length changed from 15 to 40.

DC Race

IDENTIFIERS

CCR ID	NAACCR ID
E1574	None. State Requestor.

DESCRIPTION

Race/ethnicity of the patient as stated on the death certificate.

LEVELS

Patients

LENGTH

2

ALLOWABLE VALUES

Any

SOURCE

Blank when patient created

UPDATE

Manual change or automatic upload from death clearance passive follow-up documents only.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/17/97	This new field was added in order to capture race as recorded on vital statistics records in a separate field.

DC Spanish Origin

IDENTIFIERS

CCR ID	NAACCR ID
E1575	None. State Requestor.

DESCRIPTION

This field is used to denote those persons of Spanish origin as stated on the death certificate. Persons of Spanish origin may be of any race.

LEVELS

Patients

LENGTH

1

ALLOWABLE VALUES

Any

SOURCE

Blank when patient created.

UPDATE

Manual change or automatic upload from death clearance passive follow-up documents only.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

	None

DC SSN

IDENTIFIERS

CCR ID	NAACCR ID
E1742	None. State Requestor.

DESCRIPTION

Patient's social security number as stated on the death certificate.

LEVELS

Patients

LENGTH

9

ALLOWABLE VALUES

Any

SOURCE

Blank when patient is created.

UPDATE

Manual change or automatic upload from death clearance passive follow-up documents only.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/17/97	This new field was added in order to capture Social Security Number as recorded on vital statistics records in a separate field.

DC State File Number

IDENTIFIERS

CCR ID	NAACCR ID
E1168	2830

DESCRIPTION

Unique State File Number assigned to the death certificate by the state specified in Death_File_No_St (Death File Number State).

LEVELS

Patients, Admissions

LENGTH

6

ALLOWABLE VALUES

000000	=	Patient is not dead
999999	=	DC SF# not known
Other	=	State File No.

SOURCE

If Other_Reg_ID is not blank or Reporting Facility is 0000000801, 0000000802, 0000000803, 0000000804, or 0000999996, and the transmitted DC State File Number value is not blank, then load the transmitted value without conversion (except right-justify and zero-fill).
Otherwise,
If Vital_Status = 1, then Convert 000000 into DC State File Number
Else Convert 999999 into DC State File Number

UPDATE

Patient Active Follow-up Fields Update Logic

CONSOLIDATED DATA EXTRACT

Yes

INTERFIELD EDITS

HISTORICAL CHANGES

5/01	Description modified due to the addition of DEATH-FILE-NO-ST.
1/07	Added IF #753 to edit the incorrect numbers that were being assigned or added during linkage and to reflect Vital Statistics information that California death file numbers would not be assigned above the annual mortality rate which is below.
2010	Data Item Changes: CCR name (Death_File_No) changed to match NAACCR name.

Death File No St

IDENTIFIERS

CCR ID	NAACCR ID
E1615	None: State Requestor

OWNER

CCR

DESCRIPTION

Postal Code for the state that issued the death certificate (DC) referenced by number in the DC State File Number field.

LEVELS

Patients, Admissions

LENGTH

2

ALLOWABLE VALUES

AK-WY	US States/Territories
AA-AP	United States Military Personnel Serving Abroad
AB-YT	Canadian Provinces/Territories
CD	Canada, NOS
US	Resident of United States, NOS
XX	Not U.S., U.S. Territory, not Canada, and country is known
YY	Not U.S., U.S. Territory, North American Islands, not Canada, and country is unknown
ZZ	Residence is unknown
Blank	

See Volume I, Appendix B for all Postal Abbreviations for states/territories.

SOURCE

If Other_Reg_ID is not blank or Reporting Facility is 0000000801, 0000000802, 0000000803, 0000000804, or 0000999996, and the transmitted DC State File Number value is not blank, then load the transmitted value without conversion. Upshift.
Otherwise, if Death_File_No_S is not blank, convert it to blank (space).

UPDATE

Patient Active Follow-up Fields Update Logic

CONSOLIDATED DATA EXTRACT

Yes, from the record with the most definitive surgical procedure for this tumor.

HISTORICAL CHANGES

05/2001	This new field was added in order to capture the postal code for the state that issued the death certificate.
11/2002	Added update logic and removed Err#220 under allowable values.
07/2014	Clarified allowable values and included reference to Volume I, Appendix B.

Deleted Flag

IDENTIFIERS

CCR ID	NAACCR ID
None	None. Eureka internal use.

This item is not in the exchange record (Volume II, Appendix A) and therefore does not have a CCR ID nor a NAACCR ID.

DESCRIPTION

Flag value that tells the central system and its users when a patient or tumor has been logically deleted or merged (patients and tumors cannot be physically deleted from central system).

LEVELS

Patients, Tumors

LENGTH

1

ALLOWABLE VALUES

NULL	Active (not deleted)
1	Deleted (manually or automatically)
2	Merged (manually or automatically)
3	Deleted in an unlink operation (cannot be restored or retrieved)
4 - 5	Original post-migration clean-up deletions made by Eureka staff
6 - 7	Original post-migration clean-up deletions made specifically for region 1/8 by Eureka staff
8	Potential duplicate admission deletions made by Eureka staff

SOURCE

Computer generate code 0

UPDATE

Automatically set to 1 or 2 by central system when a system user deletes or merges a patient or tumor.

CONSOLIDATED DATA EXTRACT

No

HISTORICAL CHANGES

	None

Derived AJCC Flag

IDENTIFIERS

CCR ID	NAACCR ID
E1240	3030

OWNER

AJCC

DESCRIPTION

Flag to indicate whether AJCC stage was coded directly or was derived from CS or EOD codes.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

1	AJCC Sixth Edition derived from Collaborative Staging Manual and Coding <Instructions, Version 1.0>
2	AJCC Sixth Edition derived from EOD (Prior to 2004)
Blank	Not derived and Date of Diagnosis is before January 1, 2004.

SOURCE

Upload with no conversion.

UPDATE

See CS Version Derived

CONSOLIDATED DATA EXTRACT

Yes, extract from tumor.

HISTORICAL CHANGES

03/03/04	New data item for 2004.
2010	Revised Update logic based on new date criteria and new CS fields.
05/2016	Per NAACCR v16, Update logic revised to follow new year requirements for all CS fields.

Derived AJCC-6 M

IDENTIFIERS

CCR ID	NAACCR ID
E1216	2980

OWNER

AJCC

DESCRIPTION

This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the AJCC Cancer Staging Manual, 6th and 7th editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus descriptors and AJCC stage for 6th and 7th editions. This field contains the numeric representation for AJCC 6th edition "M" and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the "storage" code and its associated label is referred to as the "display" code. Explanations of the "storage" codes and their corresponding "display" codes can be found in the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org). The display code should be used for display on the screen and in reports.

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

Must be a valid two-digit Storage Code for Derived AJCC-6 M. May be blank.
The following Storage Codes are valid:
00, 10-13, 19, 88, 99
The following table shows the allowable values for the generated Collaborative Stage data items.

- Storage Code - value to be stored in the field of a NAACCR record for sixth edition of TNM. The Storage Codes are designed for analysis.
- Display String - label that should be displayed on the screen or in a report.

Storage Code	Display String	Comments
00	M0	M0
10	M1	M1
11	M1a	M1a
12	M1b	M1b
13	M1c	M1c
19	M1NOS	M1 NOS
88	Not applicable	Not applicable
99	MX	MX
	ERROR	Processing error (no storage code needed)
	NONE	None (internal use only, no storage code needed)

For more information, see the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), for rules and site-specific codes and coding structures.)

SOURCE

See CS Version Derived

UPDATE

See CS Version Derived

CONSOLIDATED DATA EXTRACT

Yes, extract from tumor.

HISTORICAL CHANGES

3/04	New data item for 2004.
2010	Data Changes: NAACCR name change (was Derived AJCC M). Revised Update logic based on new date criteria and new CS fields.
05/2016	Per NAACCR v16, Update and Source logic revised to follow new year requirements for all CS fields.
03/2020	Update table description and definition for blank value based on description in CS 02/05 Coding Instructions

Derived AJCC-6 M Descript

IDENTIFIERS

CCR ID	NAACCR ID
E1217	2990

OWNER

AJCC

DESCRIPTION

This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the AJCC Cancer Staging Manual, 6th and 7th editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus descriptors and AJCC stage for 6th and 7th editions. This field contains the numeric representation for AJCC 6th edition "M Descriptor" and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the "storage" code and its associated label is referred to as the "display" code. Explanations of the "storage" codes and their corresponding "display" codes can be found in the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org). The display code should be used for display on the screen and in reports.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

c	Clinical stage
p	Pathologic stage
a	Autopsy stage
y	Pathologic examination of metastatic tissue performed after presurgical systemic treatment and extension based on pathologic evidence
N	Not applicable (derived from Collaborative Stage fields)
Blank	Date of Diagnosis is before January 1, 2004.

SOURCE

Upload with no conversion.

UPDATE

See CS Version Derived

CONSOLIDATED DATA EXTRACT

Yes, extract from tumor.

HISTORICAL CHANGES

03/03/04	Not a required data item for 2004 but is sent in from CoC facilities.
2010	Data Change: NAACCR name change (was Derived AJCC M). Revised Update logic based on new date criteria and new CS fields.
05/2016	Per NAACCR v16, Update logic revised to follow new year requirements for all CS fields.

Derived AJCC-6 N

IDENTIFIERS

CCR ID	NAACCR ID
E1214	2960

OWNER

AJCC

DESCRIPTION

This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the AJCC Cancer Staging Manual, 6th and 7th editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus descriptors and AJCC stage for 6th and 7th editions. This field contains the numeric representation for AJCC 6th edition "N" and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the "storage" code and its associated label is referred to as the "display" code. Explanations of the "storage" codes and their corresponding "display" codes can be found in the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org). The display code should be used for display on the screen and in reports.

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

Must be a valid two-digit Storage Code for Derived AJCC-6 N. May be blank.
The following Storage Codes are valid:
00-04, 10-13, 18-23, 29-33, 39, 88, 99
The following table shows the allowable values for the generated Collaborative Stage data items.

- Storage Code - value to be stored in the field of a NAACCR record for sixth edition of TNM. The Storage Codes are designed for analysis.
- Display String - label that should be displayed on the screen or in a report.

Storage Code	Display String	Comments
00	N0	N0
01	N0(i-)	N0 (i-)
02	N0(i+)	N0 (i+)
03	N0(mol-)	N0 (mol-)
04	N0(mol+)	N0 (mol+)
10	N1	N1
19	N1NOS	N1 NOS
11	N1a	N1a
12	N1b	N1b
13	N1c	N1c
18	N1mi	N1mi
20	N2	N2

29	N2NOS	N2 NOS
21	N2a	N2a
22	N2b	N2b
23	N2c	N2c
30	N3	N3
39	N3NOS	N3 NOS
31	N3a	N3a
32	N3b	N3b
33	N3c	N3c
88	Not applicable	Not applicable
99	NX	NX
	ERROR	Processing error (no storage code needed)
	NONE	None (internal use only, no storage code needed)

For more information, see the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), for rules and site-specific codes and coding structures.)

SOURCE

Upload with no conversion.

UPDATE

See CS Version Derived

CONSOLIDATED DATA EXTRACT

Yes, extract from tumor.

HISTORICAL CHANGES

3/04	New data item for 2004.
2010	2010 Data Item Changes: NAACCR name change (was Derived AJCC N). Revised Update logic based on new date criteria and new CS fields. Per NAACCR 12: Code 09 was deleted from the list of allowable values.
05/2016	Per NAACCR v16, Update and Source logic revised to follow new year requirements for all CS fields.
03/2020	Update table description and definition for blank value based on description in CS 02/05 Coding Instructions

Derived AJCC-6 N Descript

IDENTIFIERS

CCR ID	NAACCR ID
E1215	2970

OWNER

AJCC

DESCRIPTION

This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the AJCC Cancer Staging Manual, 6th and 7th editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus descriptors and AJCC stage for 6th and 7th editions. This field contains the numeric representation for AJCC 6th edition "N Descriptor" and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the "storage" code and its associated label is referred to as the "display" code. Explanations of the "storage" codes and their corresponding "display" codes can be found in the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org). The display code should be used for display on the screen and in reports.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

c	Clinical stage
p	Pathologic stage
a	Autopsy stage
y	Lymph nodes removed for examination after presurgical systemic treatment or radiation and lymph nodes evaluation based on pathologic evidence.
N	Not applicable (derived from Collaborative Stage fields).
Blank	Date of Diagnosis is before January 1, 2004.

SOURCE

See CS Version Derived

UPDATE

See CS Version Derived

CONSOLIDATED DATA EXTRACT

Yes, extract from tumor

HISTORICAL CHANGES

3/03/04	Not a required data item for 2004 but is sent in from CoC.
2010	Data Changes: NAACCR name change (was Derived AJCC N Desc). Revised Update logic based on new date criteria and new CS fields.
05/2016	Per NAACCR v16, Update and Source logic revised to follow new year requirements for all CS fields.

Derived AJCC-6 Stage Grp

IDENTIFIERS

CCR ID	NAACCR ID
E1218	3000

OWNER

AJCC

DESCRIPTION

This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the AJCC Cancer Staging Manual, 6th and 7th editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus descriptors and AJCC stage for 6th and 7th editions. This field contains the numeric representation for the AJCC 6th edition "Stage Group" and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the "storage" code and its associated label is referred to as the "display" code. Explanations of the "storage" codes and their corresponding "display" codes can be found in the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org). The display code should be used for display on the screen and in reports.

LEVELS

Tumors, admissions

LENGTH

2

ALLOWABLE VALUES

Must be a valid two-digit Storage Code for Derived AJCC-6 Stage Group. May be blank.
The following Storage Codes are valid:
00-02, 10-24, 30-43, 50-63, 70-74, 88, 90, 99
The following table shows the allowable values for the generated Collaborative Stage data items.

- Storage Code - value to be stored in the field of a NAACCR record for sixth edition of TNM. The Storage Codes are designed for analysis.
- Display String - label that should be displayed on the screen or in a report.

Storage Code	Display String	Comments
00	0	Stage 0
01	0a	Stage 0a
02	0is	Stage 0is
10	I	Stage I
11	INOS	Stage I NOS
12	IA	Stage IA
13	IA1	Stage IA1
14	IA2	Stage IA2
15	IB	Stage IB
16	IB1	Stage IB1
17	IB2	Stage IB2

18	IC	Stage IC
19	IS	Stage IS
23	ISA	Stage ISA (lymphoma only)
24	ISB	Stage ISB (lymphoma only)
20	IEA	Stage IEA (lymphoma only)
21	IEB	Stage IEB (lymphoma only)
22	IE	Stage IE (lymphoma only)
30	II	Stage II
31	IINOS	Stage II NOS
32	IIA	Stage IIA
33	IIB	Stage IIB
34	IIC	Stage IIC
35	IIEA	Stage IIEA (lymphoma only)
36	IIEB	Stage IIEB (lymphoma only)
37	IIE	Stage IIE (lymphoma only)
38	IISA	Stage IISA (lymphoma only)
39	IISB	Stage IISB (lymphoma only)
40	IIS	Stage IIS (lymphoma only)
41	IIESA	Stage IIESA (lymphoma only)
42	IIESB	Stage IIESB (lymphoma only)
43	IIES	Stage IIES (lymphoma only)
50	III	Stage III
51	IIINOS	Stage III NOS
52	IIIA	Stage IIIA
53	IIIB	Stage IIIB
54	IIIC	Stage IIIC
55	IIIEA	Stage IIIAB (lymphoma only)
56	IIIEB	Stage IIIEB (lymphoma only)
57	IIIE	Stage IIIE (lymphoma only)
58	IIISA	Stage IIISA (lymphoma only)
59	IIISB	Stage IIISB (lymphoma only)
60	IIIS	Stage IIIS (lymphoma only)
61	IIIESA	Stage IIIESA (lymphoma only)
62	IIIESB	Stage IIIESB (lymphoma only)
63	IIIES	Stage IIIES (lymphoma only)
70	IV	Stage IV
71	IVNOS	Stage IV NOS
72	IVA	Stage IVA
73	IVB	Stage IVB
74	IVC	Stage IVC
88	NA	Not applicable
90	OCCULT	Stage Occult

99	UNK	Stage Unknown
	ERROR	Processing error (no storage code needed)
	NONE	None (internal use only, no storage code needed)

For more information, see the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), for rules and site-specific codes and coding structures.

SOURCE

Upload with no conversion.

UPDATE

See CS Version Derived.

CONSOLIDATED DATA EXTRA

Yes, extract from tumor.

HISTORICAL CHANGES

3/04	New date item for 2004
2010	Data Changes: NAACCR name change (was AJCC Stg Grp). Revised Update logic based on new date criteria and new CS fields.
05/2016	Per NAACCR v16, Update and Source logic revised to follow new year requirements for all CS fields.
03/2020	Update table description and definition for blank value based on description in CS 02/05 Coding Instructions

Derived AJCC-6 T

IDENTIFIERS

CCR ID	NAACCR ID
E1212	2940

OWNER

AJCC

DESCRIPTION

This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the AJCC Cancer Staging Manual, 6th and 7th editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus descriptors and AJCC stage for 6th and 7th editions. This field contains the numeric representation for the AJCC 6th edition "T" and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the "storage" code and its associated label is referred to as the "display" code. Explanations of the "storage" codes and their corresponding "display" codes can be found in the most current version of the Collaborative Stage Data Collection System (https://cancerstaging.org/cstage/Pages/default.aspx).[13] The display code should be used for display on the screen and in reports.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

Must be a valid two-digit Storage Code for Derived AJCC-6 T. May be blank.
The following Storage Codes are valid:
00, 01, 05-07, 10-23, 29-33, 39-44, 49, 80, 81, 88, 99
The following table shows the allowable values for the generated Collaborative Stage data items.

- Storage Code - value to be stored in the field of a NAACCR record for sixth edition of TNM. The Storage Codes are designed for analysis.
- Display String - label that should be displayed on the screen or in a report.

Storage Code	Display String	Comments and Notes
99	TX	TX
00	T0	T0
01	Ta	Ta
05	Tis	Tis
06	Tispu	Tispu (Urethra only)
07	Tispd	Tispd (Urethra only)
10	T1	T1
11	T1mi	T1mi
19	T1NOS	T1 NOS
12	T1a	T1a
13	T1a1	T1a1

14	T1a2	T1a2
80	T1aNOS	T1a NOS
15	T1b	T1b
16	T1b1	T1b1
17	T1b2	T1b2
81	T1bNOS	T1b NOS
18	T1c	T1c
20	T2	T2
29	T2NOS	T2 NOS
21	T2a	T2a
22	T2b	T2b
23	T2c	T2c
30	T3	T3
39	T3NOS	T3 NOS
31	T3a	T3a
32	T3b	T3b
33	T3c	T3c
40	T4	T4
49	T4NOS	T4 NOS
41	T4a	T4a
42	T4b	T4b
43	T4c	T4c
44	T4d	T4d
88	NA	Not applicable
	ERROR	Processing error (no storage code needed)
	NONE	None (internal use only, no storage code needed)

For more information, see the most current version of the Collaborative Stage Data Collection System, for rules and site-specific codes and coding structures.

SOURCE

Upload with no conversion.

UPDATE

See CS Version Derived.

CONSOLIDATED DATA EXTRACT

Yes, extract from tumor.

INTERFIELD EDITS

None

HISTORICAL CHANGES

03/2004	New data item for 2004.
2010	Data Item Changes: NAACCR name change (was Derived AJCC T). Revised Update logic based on new date criteria and new CS fields. Per NAACCR 12: Codes 80 and 81 were added to the list of allowable values.
02/2020	Description Update
03/2020	Allowable values table update based on CS 02/05 Coding Instructions

Derived AJCC-6 T Descript

IDENTIFIERS

CCR ID	NAACCR ID
E1213	2950

DESCRIPTION

This is the AJCC6 "T Descriptor" component that is derived from CS coded fields, using the CS algorithm.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

c	Clinical stage
p	Pathologic stage
a	Autopsy stage
y	Surgical resection performed after presurgical systemic treatment or radiation; tumor size/extension based on pathologic evidence
N	Not applicable (Derived from Collaborative Stage fields)
Blank	Date of Diagnosis is before January 1, 2004.

SOURCE

Upload with no conversion.

UPDATE

See CS Version Derived

CONSOLIDATED DATA EXTRACT

Yes, extract from tumor

HISTORICAL CHANGES

03/2004	Not a required data item for 2004 but is sent in from CoC facilities.
2010	Data Changes: CCR name (Derived AJCC T Desc) changed to NAACCR name and NAACCR name change (was Derived AJCC T Descriptor). Revised Update logic based on new date criteria and new CS fields.
03/2020	Added back to Volume III

Derived AJCC-7 M

IDENTIFIERS

CCR ID	NAACCR ID
E1223	3420

DESCRIPTION

Contains the numeric representation for the AJCC 7th edition "M" and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the storage code and its associated label is referred to as the display code. The display code should be used for display on the screen and in reports.

LEVELS

Tumors, Admissions

LENGTH

3

ALLOWABLE VALUES

Must be a valid three-digit Storage Code for Derived AJCC-7 M. May be blank.
Codes

- Derived as part of the Collaborative Staging System.
- Fields must not be modified manually.
- Fields should not be transmitted as blank, if the associated CS input items contain value.
- Fields should be transmitted blank, if the associated CS input items are empty or the CS algorithm has not been applied.

The following Storage Codes are valid:
000, 010, 100, 110, 120, 130, 140, 150, 199, 888, 999
The following table shows the allowable values for the generated Collaborative Stage data items.

- Storage Code - value to be stored in the field of a NAACCR record for seventh edition of TNM. The Storage Codes are designed for analysis.
- Display String - label that should be displayed on the screen or in a report.

Storage Code	Display String	Comments
999	MX	MX
000	M0	M0
010	M0 (i+)	M0 (i+)
100	M1	M1
110	M1a	M1a
120	M1b	M1b
130	M1c	M1c
140	M1d	M1d
150	M1e	M1e
199	M1NOS	M1NOS
888	NA	Not applicable
	ERROR	Processing error (no storage code needed)
	NONE	None (internal use only, no storage code needed)

For more information, see the most current version of theCollaborative Stage Data Collection System (http://cancerstaging.org/cstage/manuals.html), for rules and site-specific codes and coding structures.

SOURCE

Upload with no conversion.

UPDATE

See CS Version Derived

CONSOLIDATED DATA EXTRACT

Yes, extract from tumor

HISTORICAL CHANGES

2010	New data item added for 2010 data changes.
03/2020	Added back to Volume III and updated table description and definition for blank value based on description in CS 02/05 Coding Instructions

Derived AJCC-7 M Descript

IDENTIFIERS

CCR ID	NAACCR ID
E1224	3422

OWNER

AJCC

DESCRIPTION

Contains the numeric representation for the AJCC 7th edition "M Descriptor" and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the *storage* code and its associated label is referred to as the *display* code. The display code should be used for display on the screen and in reports.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

c, p, a, y, N, blank

Codes

Derived as part of the Collaborative Staging System.

Fields must not be modified manually.

Fields should not be transmitted as blank, if the associated CS input items contain value.

Fields should be transmitted blank, if the associated CS input items are empty or the CS algorithm has not been applied.

SOURCE

Upload with no conversion

UPDATE

See CS Version Derived

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

2010	New data item added for 2010 data changes.
05/2016	Per NAACCR v16, Update logic revised to follow new year requirements for all CS fields.

Derived AJCC-7 N

IDENTIFIERS

CCR ID	NAACCR ID
E1221	3410

OWNER

AJCC

DESCRIPTION

Contains the numeric representation for the AJCC 7th edition "N Descriptor" and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the *storage* code and its associated label is referred to as the *display* code. The display code should be used for display on the screen and in reports.

LEVELS

Tumors, Admissions

LENGTH

3

ALLOWABLE VALUES

Must be a valid three-digit Storage Code for Derived AJCC-7 N. May be blank.
The following Storage Codes are valid:
000, 010, 020, 030, 040, 100, 110, 120, 130, 180, 199, 200, 210, 220, 230, 299,300, 310, 320, 330, 399, 400, 888, 999
Codes

- Derived as part of the Collaborative Staging System.
- Fields must not be modified manually.
- Fields should not be transmitted as blank, if the associated CS input items contain value.
- Fields should be transmitted blank, if the associated CS input items are empty or the CS algorithm has not been applied.

The following table shows the allowable values for the generated Collaborative Stage data items.

- Storage Code - value to be stored in the field of a NAACCR record for seventh edition of TNM. The Storage Codes are designed for analysis.
- Display String - label that should be displayed on the screen or in a report.

Storage Code	Display String	Comments
999	NX	NX
000	N0	N0
010	N0(i-)	N0(i-)
020	N0(i+)	N0(i+)
030	N0(mol-)	N0(mol-)
040	N0(mol+)	N0(mol+)
100	N1	N1
199	N1NOS	N1 NOS
110	N1a	N1a
120	N1b	N1b
130	N1c	N1c
180	N1mi	N1mi

200	N2	N2
299	N2NOS	N2 NOS
210	N2a	N2a
220	N2b	N2b
230	N2c	N2c
300	N3	N3
399	N3NOS	N3 NOS
310	N3a	N3a
320	N3b	N3b
330	N3c	N3c
400	N4	N4
888	NA	Not applicable
	ERROR	Processing error (no storage code needed)
	NONE	None (internal use only, no storage code needed)

For more information, see the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), for rules and site-specific codes and coding structures.)

SOURCE

See CS Version Derived

UPDATE

See CS Version Derived

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

2010	New data item added for 2010 data changes.
05/2016	Per NAACCR v16, Update logic revised to follow new year requirements for all CS fields.
03/2020	Allowable values table update based on CS 02/05 Coding Instructions

Derived AJCC-7 N Descript

IDENTIFIERS

CCR ID	NAACCR ID
E1222	3412

OWNER

AJCC

DESCRIPTION

Contains the numeric representation for the AJCC 7th edition "M" and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the *storage* code and its associated label is referred to as the *display* code. The display code should be used for display on the screen and in reports.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

Must be a valid value for Derived AJCC-7 N Descriptor (c, p, a, y, n). May be blank.
Codes

- Derived as part of the Collaborative Staging System.
- Fields must not be modified manually.
- Fields should not be transmitted as blank, if the associated CS input items contain value.
- Fields should be transmitted blank, if the associated CS input items are empty or the CS algorithm has not been applied.

SOURCE

Upload with no conversion

UPDATE

See CS Version Derived

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/31/10	New data item added for 2010 data changes.
05/2016	Per NAACCR v16, Update logic revised to follow new year requirements for all CS fields.

Derived AJCC-7 Stage Grp

IDENTIFIERS

CCR ID	NAACCR ID
E1225	3430

OWNER

AJCC

DESCRIPTION

Contains the numeric representation for the AJCC 7th edition "Stage Group" and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the *storage* code and its associated label is referred to as the *display* code. The display code should be used for display on the screen and in reports.

LEVELS

Tumors, Admissions

LENGTH

3

ALLOWABLE VALUES

Must be a valid three-digit Storage Code for Derived AJCC-7 Stage Group. May be blank.
The following Storage Codes are valid:
000, 010, 020, 100, 110, 120, 121, 130, 140, 150, 151, 160, 170, 180, 190, 200, 210, 220, 230, 240, 300, 310, 320, 321, 322, 323, 330, 340, 350, 360, 370, 380, 390, 400, 410, 420, 430, 500, 510, 520, 530, 540, 541, 542, 550, 560, 570, 580, 590, 600, 610, 620, 630, 700, 710, 720, 721, 722, 730, 740, 888, 900, 999
Codes

- Derived as part of the Collaborative Staging System.
- Fields must not be modified manually.
- Fields should not be transmitted as blank, if the associated CS input items contain value.
- Fields should be transmitted blank, if the associated CS input items are empty or the CS algorithm has not been applied.

The following table shows the allowable values for the generated Collaborative Stage data items.

- Storage Code - value to be stored in the field of a NAACCR record for seventh edition of TNM. The Storage Codes are designed for analysis.
- Display String - label that should be displayed on the screen or in a report.

Storage Code	Display String	Comments
000	0	Stage 0
010	0a	Stage 0a
020	0is	Stage 0is
100	I	Stage I
110	INOS	Stage I NOS
120	IA	Stage IA
121	IANOS	Stage IA NOS
130	IA1	Stage IA1
140	IA2	Stage IA2
150	IB	Stage IB

151	IBNOS	Stage IB NOS
160	IB1	Stage IB1
170	IB2	Stage IB2
180	IC	Stage IC
190	IS	Stage IS
230	ISA	Stage ISA (lymphoma only)
240	ISB	Stage ISB (lymphoma only)
200	IEA	Stage IEA (lymphoma only)
210	IEB	Stage IEB (lymphoma only)
220	IE	Stage IE (lymphoma only)
300	II	Stage II
310	IINOS	Stage II NOS
320	IIA	Stage IIA
321	IIANOS	Stage IIA NOS
322	IIA1	Stage IIA1
323	IIA2	Stage IIA2
330	IIB	Stage IIB
340	IIC	Stage IIC
350	IIEA	Stage IIEA (lymphoma only)
360	IIEB	Stage IIEB (lymphoma only)
370	IIE	Stage IIE (lymphoma only)
380	IISA	Stage IISA (lymphoma only)
390	IISB	Stage IISB (lymphoma only)
400	IIS	Stage IIS (lymphoma only)
410	IIESA	Stage IIESA (lymphoma only)
420	IIESB	Stage IIESB (lymphoma only)
430	IIES	Stage IIES (lymphoma only)
500	III	Stage III
510	IIINOS	Stage III NOS
520	IIIA	Stage IIIA
530	IIIB	Stage IIIB
540	IIIC	Stage IIIC
541	IIIC1	Stage IIIC1
542	IIIC2	Stage IIIC2
550	IIIEA	Stage IIIAB (lymphoma only)
560	IIIEB	Stage IIIEB (lymphoma only)
570	IIIE	Stage IIIE (lymphoma only)
580	IIISA	Stage IIISA (lymphoma only)
590	IIISB	Stage IIISB (lymphoma only)
600	IIIS	Stage IIIS (lymphoma only)
610	IIIESA	Stage IIIESA (lymphoma only)
620	IIIESB	Stage IIIESB (lymphoma only)
630	IIIES	Stage IIIES (lymphoma only)

700	IV	Stage IV
710	IVNOS	Stage IV NOS
720	IVA	Stage IVA
721	IVA1	Stage IVA1
722	IVA2	Stage IVA2
730	IVB	Stage IVB
740	IVC	Stage IVC
888	NA	Not applicable
900	OCCULT	Stage Occult
999	UNK	Stage Unknown
	ERROR	Processing error (no storage code needed)
	NONE	None (internal use only, no storage code needed)

For more information, see the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), for rules and site-specific codes and coding structures.

SOURCE

See CS Version Derived

UPDATE

See CS Version Derived

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

2010	New data item added for 2010 data changes.
05/2016	Per NAACCR v16, Update and Source logic revised to follow new year requirements for all CS fields.
03/2020	Blank values update based on description in CS 02/05 Coding Instructions

Derived AJCC-7 T

IDENTIFIERS

CCR ID	NAACCR ID
E1219	3400

OWNER

AJCC

DESCRIPTION

Contains the numeric representation for the AJCC 7th edition "T" and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the *storage* code and its associated label is referred to as the *display* code. The display code should be used for display on the screen and in reports. Effective for cases diagnosed 2010+.

LEVELS

Tumors, Admissions

LENGTH

3

ALLOWABLE VALUES

Must be a valid three-digit Storage Code for Derived AJCC-7 T. May be blank.
The following Storage Codes are valid:
999, 000, 010, 050, 060, 070, 100, 110, 199, 191, 192, 120, 121, 122, 130, 140, 800, 150, 151, 152, 160, 170, 810, 180, 181, 200, 201, 202, 299, 210, 211, 212, 213, 220, 230, 240, 300, 301, 302, 399, 310, 320, 330, 340, 400, 499, 491, 492, 410, 411, 412, 420, 421, 422, 430, 440, 450, 888
Codes:

- Derived as part of the Collaborative Staging System.
- Fields must not be modified manually.
- Fields should not be transmitted as blank, if the associated CS input items contain value.
- Fields should be transmitted blank, if the associated CS input items are empty or the CS algorithm has not been applied.

The following table shows the allowable values for the generated Collaborative Stage data items.

- Storage Code - value to be stored in the field of a NAACCR record for seventh edition of TNM. The Storage Codes are designed for analysis.
- Display String - label that should be displayed on the screen or in a report.

Storage Code	Display String	Comments and Notes
999	TX	TX
000	T0	T0
010	Ta	Ta
050	Tis	Tis
060	Tispu	Tispu (Urethra only)
070	Tispd	Tispd (Urethra only)
100	T1	T1
110	T1mi	T1mi
199	T1NOS	T1 NOS

191	T1NOS(s)	T1 NOS(s) (Thyroid only)
192	T1NOS(m)	T1 NOS(m) (Thyroid only)
120	T1a	T1a
121	T1a(s)	T1a(s) (Thyroid only)
122	T1a(m)	T1a(m) (Thyroid only)
130	T1a1	T1a1
140	T1a2	T1a2
800	T1aNOS	T1a NOS
150	T1b	T1b
151	T1b(s)	T1b(s) (Thyroid only)
152	T1b(m)	T1b(m) (Thyroid only)
160	T1b1	T1b1
170	T1b2	T1b2
810	T1bNOS	T1b NOS
180	T1c	T1c
181	T1d	T1d
200	T2	T2
201	T2(s)	T2(s) (Thyroid only)
202	T2(m)	T2(m) (Thyroid only)
299	T2NOS	T2 NOS
210	T2a	T2a
211	T2a1	T2a1
212	T2a2	T2a2
213	T2aNOS	T2a NOS
220	T2b	T2b
230	T2c	T2c
240	T2d	T2d
300	T3	T3
301	T3(s)	T3(s) (Thyroid only)
302	T3(m)	T3(m) (Thyroid only)
399	T3NOS	T3 NOS
310	T3a	T3a
320	T3b	T3b
330	T3c	T3c
340	T3d	T3d
400	T4	T4
499	T4NOS	T4 NOS
491	T4NOS(s)	T4 NOS(s) (Thyroid only)
492	T4NOS(m)	T4 NOS(m) (Thyroid only)
410	T4a	T4a
411	T4a(s)	T4a(s) (Thyroid only)
412	T4a(m)	T4a(m) (Thyroid only
420	T4b	T4b
421	T4b(s)	T4b(s) (Thyroid only)
422	T4b(m)	T4b(m) (Thyroid only)

430	T4c	T4c
440	T4d	T4d
450	T4e	T4e
888	NA	Not applicable
	ERROR	Processing error (no storage code needed)
	NONE	None (internal use only, no storage code needed)

For more information, see the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), for rules and site-specific codes and coding structures.

SOURCE

See CS Version Derived

UPDATE

See CS Version Derived

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

2010	New data item added for 2010 data changes.
05/2016	Per NAACCR v16, Update and Source logic revised to follow new year requirements for all CS fields.
03/2020	Allowable values table update based on CS 02/05 Coding Instructions

Derived AJCC-7 T Descript

IDENTIFIERS

CCR ID	NAACCR ID
E1220	3402

OWNER

AJCC

DESCRIPTION

Contains the numeric representation for the AJCC 7th edition "T" and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the *storage* code and its associated label is referred to as the *display* code. The display code should be used for display on the screen and in reports.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

c, p, a, y, n, blank

Codes

- Derived as part of the Collaborative Staging System.
- Fields must not be modified manually.
- Fields should not be transmitted as blank, if the associated CS input items contain value.
- Fields should be transmitted blank, if the associated CS input items are empty or the CS algorithm has not been applied.

SOURCE

Upload with no conversion

UPDATE

See CS Version Derived

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

2010	New data item added for 2010 data changes.
05/2016	Per NAACCR v16, Update logic revised to follow new year requirements for all CS fields.

Derived EOD 2018 M

IDENTIFIERS

CCR ID	NAACCR ID
E1845	795

OWNER

SEER

DESCRIPTION

This item stores the derived EOD 2018 M value derived from coded fields using the EOD algorithm. Effective for cases diagnosed 1/1/2018+.

LEVELS

Tumors

LENGTH

15

ALLOWABLE VALUES

See the most current version of EOD (https://staging.seer.cancer.gov/) for rules and site-specific codes and coding structures.

SOURCE

No Derived EOD 2018 M at admission. Variable created at tumor.

UPDATE

See UC 02.21 Perform SEER EOD Staging Algorithm – UC for specifications to re-run algorithm.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented. Field will be generated at Tumor level using SEER EOD API.

Derived EOD 2018 N

IDENTIFIERS

CCR ID	NAACCR ID
E1846	815

OWNER

SEER

DESCRIPTION

This item stores the derived EOD 2018 N value derived from coded fields using the EOD algorithm. Effective for cases diagnosed 1/1/2018+.

LEVELS

Tumors

LENGTH

15

ALLOWABLE VALUES

See the most current version of EOD (https://staging.seer.cancer.gov/) for rules and site-specific codes and coding structures.

SOURCE

No Derived EOD 2018 N at admission. Variable created at tumor.

UPDATE

See UC 02.21 Perform SEER EOD Staging Algorithm – UC for specifications to re-run algorithm.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented. Field will be generated at Tumor level using SEER EOD API.

Derived EOD 2018 Stage Group

IDENTIFIERS

CCR ID	NAACCR ID
E1847	818

OWNER

SEER

DESCRIPTION

Derived EOD 2018 Stage Group is derived using the EOD data collection system (EOD Primary Tumor [772], EOD Regional Nodes [774] and EOD Mets [776]) algorithm. Other data items may be included in the derivation process. Effective for cases diagnosed 1/1/2018+.

LEVELS

Tumors

LENGTH

15

ALLOWABLE VALUES

See the most current version of EOD (https://staging.seer.cancer.gov/) for rules and site-specific codes and coding structures.

SOURCE

No Derived EOD 2018 Stage Group at admission. Variable created at tumor.

UPDATE

See UC 02.21 Perform SEER EOD Staging Algorithm – UC for specifications to re-run algorithm.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented. Field will be generated at Tumor level using SEER EOD API.

Derived EOD 2018 T

IDENTIFIERS

CCR ID	NAACCR ID
E1844	785

OWNER

SEER

DESCRIPTION

This item stores the derived EOD 2018 T value derived from coded fields using the EOD algorithm. Effective for cases diagnosed 1/1/2018+.

LEVELS

Tumors

LENGTH

15

ALLOWABLE VALUES

See the most current version of EOD (https://staging.seer.cancer.gov/) for rules and site-specific codes and coding structures.

SOURCE

No Derived EOD 2018 T at admission. Variable created at tumor.

UPDATE

See UC 02.21 Perform SEER EOD Staging Algorithm – UC for specifications to re-run algorithm.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented. Field will be generated at Tumor level using SEER EOD API.

Derived SEER Clin Stg Grp

IDENTIFIERS

CCR ID	NAACCR ID
E1815	3610

OWNER

SEER

DESCRIPTION

This item is used to store the results of the derived algorithmic calculation of Derived SEER Clinical Stage Group.

LEVELS

Tumors

LENGTH

5

ALLOWABLE VALUES

0	Stage 0
0A	Stage 0A
0IS	Stage 0is
1	Stage I
1A	Stage IA
1A1	Stage IA1
1A2	Stage IA2
1B	Stage IB
1B1	Stage IB1
1C	Stage 1C
1S	Stage IS
2	Stage II
2A	Stage IIA
2A1	Stage IIA1
2A2	Stage IIA2
2B	Stage IIB
2C	Stage IIC
3	Stage III
3A	Stage IIIA
3B	Stage IIIB
3C	Stage IIIC
3C1	Stage IIIC1
3C2	Stage IIIC2
4	Stage IV
4A	Stage IVA
4A1	Stage IVA1
4A2	Stage IVA2

4B	Stage IVB
4C	Stage IVC
OC	Occult
88	Not applicable
99	Unknown
Blank	Algorithm has not been run

Refer to most recent version of AJCC Cancer Staging Manual and FORDS manual.

SOURCE

No Derived SEER Clin Stg Grp at admission. Variable created at tumor.

UPDATE

See UC 02.19 Perform SEER Staging Algorithm – UC for specifications to re-run algorithm.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

05/2016	Per NAACCR v16, new data field implemented. Field will be generated at Tumor level using SEER API.

Derived SEER Cmb M Src

IDENTIFIERS

CCR ID	NAACCR ID
E1822	3626

OWNER

SEER

DESCRIPTION

This item is used to store the results of the source information selected for the derived algorithmic calculation of Derived SEER Combined M [NAACCR #3620].

LEVELS

Tumors

LENGTH

1

ALLOWABLE VALUES

1	Clinical
2	Pathologic
3	Clinical and pathologic used
9	Unknown

SOURCE

No Derived SEER Cmb M Src at admission. Variable created at tumor.

UPDATE

See UC 02.19 Perform SEER Staging Algorithm – UC for specifications to re-run algorithm.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

05/2016	Per NAACCR v16, new data field implemented. Field will be generated at Tumor level using SEER API.

Derived SEER Cmb Stg Grp

IDENTIFIERS

CCR ID	NAACCR ID
E1816	3614

OWNER

SEER

DESCRIPTION

This item is used to store the results of the derived algorithmic calculation of Derived SEER Cmb Stg Grp.

LEVELS

Tumors

LENGTH

5

ALLOWABLE VALUES

0A	Stage 0A
0IS	Stage 0is
1	Stage I
1A	Stage IA
1A1	Stage IA1
1A2	Stage IA2
1B	Stage IB
1B1	Stage IB1
1B2	Stage IB2
1C	Stage 1C
1S	Stage IS
2	Stage II
2A	Stage IIA
2A1	Stage IIA1
2A2	Stage IIA2
2B	Stage IIB
2C	Stage IIC
3	Stage III
3A	Stage IIIA
3B	Stage IIIB
3C	Stage IIIC
3C1	Stage IIIC1
3C2	Stage IIIC2
4	Stage IV
4A	Stage IVA
4A1	Stage IVA1
4A2	Stage IVA2
4B	Stage IVB

4C	Stage IVC
OC	Occult
88	Not applicable
99	Unknown
Blank	Algorithm has not been run

Refer to most recent version of AJCC Cancer Staging Manual and FORDS manual.

SOURCE

No Derived SEER Cmb Stg Grp at admission. Variable created at tumor.

UPDATE

See UC 02.19 Perform SEER Staging Algorithm – UC for specifications to re-run algorithm.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

05/2016	Per NAACCR v16, new data field implemented. Field will be generated at Tumor level using SEER API.

Derived SEER Cmb T Src

IDENTIFIERS

CCR ID	NAACCR ID
E1820	3622

OWNER

SEER

DESCRIPTION

This item is used to store the results of the source information selected for the derived algorithmic calculation of Derived SEER Combined T [NAACCR #3616].

LEVELS

Tumors

LENGTH

1

ALLOWABLE VALUES

1	Clinical
2	Pathologic
3	Clinical and pathologic used
9	Unknown

SOURCE

No Derived SEER Cmb T Src at admission. Variable created at tumor.

UPDATE

See UC 02.19 Perform SEER Staging Algorithm – UC for specifications to re-run algorithm.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

05/2016	Per NAACCR v16, new data field implemented. Field will be generated at Tumor level using SEER API.

Derived SEER Combined M

IDENTIFIERS

CCR ID	NAACCR ID
E1819	3620

OWNER

SEER

DESCRIPTION

This item is used to store the results of the source information selected for the derived algorithmic calculation of Combined T, N, and M.

LEVELS

Tumors

LENGTH

5

ALLOWABLE VALUES

88	Not applicable
Blank	Not derived

Refer to most recent version of AJCC Cancer Staging Manual and FORDS manual.

SOURCE

No Derived SEER Combined M at admission. Variable created at tumor.

UPDATE

See UC 02.19 Perform SEER Staging Algorithm – UC for specifications to re-run algorithm.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

05/2016	Per NAACCR v16, new data field implemented. Field will be generated at Tumor level using SEER API.

Derived SEER Combined N

IDENTIFIERS

CCR ID	NAACCR ID
E1818	3618

OWNER

SEER

DESCRIPTION

This item is used to store the results of the source information selected for the derived algorithmic calculation of Combined T, N, and M.

LEVELS

Tumors

LENGTH

5

ALLOWABLE VALUES

88	Not applicable
Blank	Not derived

Refer to most recent version of AJCC Cancer Staging Manual and FORDS manual.

SOURCE

No Derived SEER Combined N at admission. Variable created at tumor.

UPDATE

See UC 02.19 Perform SEER Staging Algorithm – UC for specifications to re-run algorithm.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

05/2016	Per NAACCR v16, new data field implemented. Field will be generated at Tumor level using SEER API.

Derived SEER Cmb N Src

IDENTIFIERS

CCR ID	NAACCR ID
E1821	3624

OWNER

SEER

DESCRIPTION

This item is used to store the results of the source information selected for the derived algorithmic calculation of Derived SEER Combined N [NAACCR #3618].

LEVELS

Tumors

LENGTH

1

ALLOWABLE VALUES

1	Clinical
2	Pathologic
3	Clinical and pathologic used
9	Unknown

SOURCE

No Derived SEER Combined N Src at admission. Variable created at tumor.

UPDATE

See UC 02.19 Perform SEER Staging Algorithm – UC for specifications to re-run algorithm.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

05/2016	Per NAACCR v16, new data field implemented. Field will be generated at Tumor level using SEER API.

Derived SEER Combined T

IDENTIFIERS

CCR ID	NAACCR ID
E1817	3616

OWNER

SEER

DESCRIPTION

This item is used to store the results of the source information selected for the derived algorithmic calculation of Combined T.

LEVELS

Tumors

LENGTH

5

ALLOWABLE VALUES

88	Not applicable
Blank	Not derived

Refer to most recent version of AJCC Cancer Staging Manual and FORDS manual.

SOURCE

No Derived SEER Combined T at admission. Variable created at tumor.

UPDATE

See UC 02.19 Perform SEER Staging Algorithm – UC for specifications to re-run algorithm.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

05/2016	Per NAACCR v16, new data field implemented. Field will be generated at Tumor level using SEER API.

Derived SEER Path Stg Grp

IDENTIFIERS

CCR ID	NAACCR ID
E1814	3605

OWNER

SEER

DESCRIPTION

This item is used to store the results of the derived algorithmic calculation of Derived SEER Pathologic Stage Group.

LEVELS

Tumors

LENGTH

5

ALLOWABLE VALUES

0	Stage 0
0A	Stage 0A
0IS	Stage 0is
1	Stage I
1A	Stage IA
1A1	Stage IA1
1A2	Stage IA2
1B	Stage IB
1B1	Stage IB1
1B2	Stage 1B2
1C	Stage 1C
1S	Stage IS
2	Stage II
2A	Stage IIA
2A1	Stage IIA1
2A2	Stage IIA2
2B	Stage IIB
2C	Stage IIC
3	Stage III
3A	Stage IIIA
3B	Stage IIIB
3C	Stage IIIC
3C1	Stage IIIC1
3C2	Stage IIIC2
4	Stage IV
4A	Stage IVA
4A1	Stage IVA1

4A2	Stage IVA2
4B	Stage IVB
4C	Stage IVC
OC	Occult
88	Not applicable
99	Unknown
Blank	Algorithm has not been run

Refer to most recent version of AJCC Cancer Staging Manual and FORDS manual.

SOURCE

No Derived SEER Path Stg Grp at admission. Variable created at tumor.

UPDATE

See UC 02.19 Perform SEER Staging Algorithm – UC for specifications to re-run algorithm.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

05/2016	Per NAACCR v16, new data field implemented. Field will be generated at Tumor level using SEER API.

Derived SS1977

IDENTIFIERS

CCR ID	NAACCR ID
E1237	3010

OWNER

AJCC

DESCRIPTION

This data item is the derived "SEER Summary Stage 1977" from the CS algorithm (or EOD codes) effective with 2004 diagnosis.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

Must be a valid one-digit Storage Code for Derived SS1977. May be blank.
The following Storage Codes are valid:
0-5, 7-9
This table shows the corresponding Display String for each Storage Code:

Storage Code	Display String	Comments
0	IS	In situ
1	L	Localized
2	RE	Regional, direct extension
3	RN	Regional, lymph nodes
4	RE+RN	Regional, extension and nodes
5	RNOS	Regional, NOS
7	D	Distant
8	NA	Not applicable
9	U	Unknown/Unstaged (Derived from Collaborative Stage fields)
Blank = Date of Diagnosis is before January 1, 2004.		

For more information, see the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), for rules and site-specific codes and coding structures.)

SOURCE

Upload with no conversion.

UPDATE

See CS Version Derived

CONSOLIDATED DATA EXTRACT

Yes, extract from tumor.

HISTORICAL CHANGES

3/04	New data item for 2004

2010	2010 Data Changes: Update logic revised.
05/2016	Per NAACCR v16, Update logic revised to follow new year requirements for all CS fields.

Derived SS1977--Flag

IDENTIFIERS

CCR ID	NAACCR ID
E1241	3040

OWNER

AJCC

DESCRIPTION

Flag to indicate whether SEER Summary Stage 1977 was coded directly or was derived from CS or EOD codes.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

1	SS1977 derived from Collaborative Staging Manual and Coding Instructions, Version 1.0
2	SS1977 derived from EOD (prior to 2004
Blank	Not derived and Date of Diagnosis is before January 1, 2004.

SOURCE

Upload with no conversion.

UPDATE

See CS Version Derived

CONSOLIDATED DATA EXTRACT

Yes, extract from tumor.

HISTORICAL CHANGES

3/04	New data item for 2004
2010	2010 Data Changes: Update logic revised.
05/2016	Per NAACCR v16, Update logic revised to follow new year requirements for all CS fields.

Derived SS2000

IDENTIFIERS

CCR ID	NAACCR ID
E1238	3020

OWNER

AJCC

DESCRIPTION

This data item is the derived "SEER Summary Stage 2000" from the CS algorithm (or EOD codes) effective with 2004 diagnosis.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

Must be a valid one-digit Storage Code for Derived SS2000. May be blank.
The following Storage Codes are valid:
0-5, 7-9
This table shows the corresponding Display String for each Storage Code:

Storage Code	Display String	Comments
0	IS	In situ
1	L	Localized
2	RE	Regional, direct extension
3	RN	Regional, lymph nodes
4	RE+RN	Regional, extension and nodes
5	RNOS	Regional, NOS
7	D	Distant
8	NA	Not applicable
9	U	Unknown/Unstaged (Derived from Collaborative Stage fields)
Blank = Date of Diagnosis is before January 1, 2004.		

For more information, see the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), for rules and site-specific codes and coding structures.)

SOURCE

Upload with no conversion.

UPDATE

See CS Version Derived.

CONSOLIDATED DATA EXTRACT

Yes, extract from tumor.

HISTORICAL CHANGES

03/03/04	New data item for 2004.
2010	2010 Data Changes: Update logic revised.
05/2016	Per NAACCR v16, Update logic revised to follow new year requirements for all CS fields.

Derived SS2000--Flag

IDENTIFIERS

CCR ID	NAACCR ID
E1242	3050

OWNER

AJCC

DESCRIPTION

Flag to indicate whether SEER Summary Stage 2000 was coded directly or was derived from CS or EOD codes.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

1	SS2000 derived from Collaborative Staging Manual and Coding Instructions, Version 1.0
2	SS2000 derived from EOD (prior to 2004)
Blank	Not derived and Date of Diagnosis is before January 1, 2004.

SOURCE

Upload with no conversion.

UPDATE

See CS Version Derived

CCR DATA EXTRACT

Yes, extract from tumor.

HISTORICAL CHANGES

3/04	New data item for 2004.
2010	Data Changes: Update logic revised.
05/2016	Per NAACCR v16, Update logic revised to follow new year requirements for all CS fields.

Derived Summary Stage 2018

IDENTIFIERS

CCR ID	NAACCR ID
E1803	762

OWNER

SEER

DESCRIPTION

Derived Summary Stage 2018 is derived using the EOD data collection system (EOD Primary Tumor [772], EOD Regional Nodes [774] and EOD Mets [776]) algorithm. Other data items may be included in the derivation process. Effective for cases diagnosed 1/1/2018+.

LEVELS

Tumors

LENGTH

1

ALLOWABLE VALUES

Storage code	Display String	Comments
	ERROR	Processing error (no storage code needed)
	NONE	None (internal use only, no storage code needed)
0	IS	In situ
1	L	Localized
2	RE	Regional, direct extension only
3	RN	Regional, regional lymph nodes only
4	RE+RN	Regional, direct extension and regional lymph nodes
5	RNOS	Distant
7	D	Benign, borderline
8	NA	Unknown if extension or mets (unstaged, unknown, or unspecified) DCO
9	U	

SOURCE

No Derived Summary Stage 2018 at admission. Variable created at tumor.

UPDATE

See UC 02.21 Perform SEER EOD Staging Algorithm – UC for specifications to re-run algorithm.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented. Field will be generated at Tumor level using SEER EOD API.
03/2020	Allowable values table update

Diagnostic Confirmation

IDENTIFIERS

CCR-ID	NAACCR ID
E1070	490

DESCRIPTION

This item indicates whether at any time during the patient's medical history there was microscopic confirmation of this cancer.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

1	Positive histology
2	Positive cytology
3	Positive histology PLUS – positive immunophenotyping AND/OR positive genetic studies (Used only for hematopoietic and lymphoid neoplasms 95903-99923)
4	Positive microscopic confirmation, method not specified (Used only for hematopoietic and lymphoid neoplasms M-9590/3-9992/3)
5	Positive lab test or marker study
6	Direct visualization without microscopic confirmation
7	Radiography and/or other imaging techniques without microscopic confirmation
8	Clinical diagnosis only (other than 5, 6, or 7)
9	Unknown whether or not microscopically confirmed; death certificate only

Note: Code 3 (used only for hematopoietic and lymphoid neoplasms 9590/3-9992/3) was adopted for use effective with 2010 diagnoses.

SOURCE

If the transmitted value is numeric, then just load it with no conversion. Otherwise, convert it to 9.

UPDATE

Tumor

New Case Consolidation

If TU_Diagnostic Confirmation <> AD_Diagnostic Confirmation, then list for review.

Manual Change

Admission

Manual Change

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/2004	Removed automatic Update logic and changed to manual due to regional requests.
2010	Data Changes: Added code 3 to Allowable values. CCR name (DX Conf) changed to match NAACCR name. Added IF #874.

3/14/2011	Added Revised codes. 2/24/11: Removed IF 306 and 441 to match deletion in the metafile.

Discovered by Screening

IDENTIFIERS

CCR-ID	NAACCR ID
E1618	None. State Requestor

DESCRIPTION

Used to track which cancer cases were first diagnosed via screening programs. If this information is not available, the field may be left blank (defaults to 9). Stored in EUREKA. Transmit from DoD fields.

LEVELS

Admissions

LENGTH

1

ALLOWABLE VALUES

1	No (discovered by some other method such as symptomatic patient)
2	Routine screening exam (e.g., routine screening mammogram in asymptomatic patient)
3	State-sponsored screening program
4	Nationally-sponsored screening program
5	Other type of screening (e.g., American Cancer Society screening project)
8	Screening, NOS
9	Unknown if via screening (default)
Blank = Cases diagnosed prior to January 1, 2006.	

SOURCE

If blank and Date of Diagnosis year is 2006 or later, then convert to 9.

UPDATE

If blank and Date of Diagnosis year is 2006 or later, then convert to 9.

CONSOLIDATED DATA EXTRACT

No

HISTORICAL CHANGES

7/05	New data item for 2006 (storage only-Column #6053). Transmitted from DoD fields.

DOC ID

IDENTIFIERS

CCR-ID	NAACCR ID
E1586	None. State Requestor

DESCRIPTION

A control number assigned by the regional registry to uniquely identify and track a single case report through the entire system.

LEVELS

Admissions

LENGTH

10

ALLOWABLE VALUES

Numeric, where, on most records:

Pos.		
1-2	=	Doc. Type (15,19, or 20)
3-4	=	Processing Year (varies by region)
5-7	=	Day of Year (001-366)
8-10	=	Serial Number (000-999)
Regional 8 cases may also have codes 00, 04-06 or 10-14 in Pos. 1-2 and any numeric code in Pos. 3-10.		
Records that are not Doc. Type 15, 19, or 20 or that are Date_First_Admis less than 86 are not edited for DOC-ID.		
Are not re-used.		

SOURCE

Upload with no conversion.

UPDATE

None

CONSOLIDATED DATA EXTRACT

No

HISTORICAL CHANGES

1/99	Added century 20 as an allowable value for digits 1-2.
3/03	Historical data item for central Eureka system, so no longer generated on new admissions

DX Proc

IDENTIFIERS

CCR ID	NAACCR ID
None	None: Region 8 Only

This item is in the database for Region 8 use, but is not collected and is not in the exchange record (Volume II, Appendix A).

DESCRIPTION

Pathological examinations performed on SEER (Region 8) cases of selected sites/histologies diagnosed in 1975-87.

LEVELS

Tumors

LENGTH

1

ALLOWABLE VALUES

Codes 0 - 9, +, -, &, or blank.

SOURCE

Manual entry was discontinued in 1988

UPDATE

Manual

CONSOLIDATED DATA EXTRACT

No

HISTORICAL CHANGES

	None

Editor ID

IDENTIFIERS

CCR ID	NAACCR ID
None	None

Not in the exchange record (Volume II, Appendix A)

DESCRIPTION

Identification of the person who (visually) edited this abstract.

LEVELS

Admissions

LENGTH

3

ALLOWABLE VALUES

Alphanumeric code assigned by regional registry to each editor.

SOURCE

Computer generate blank (empty).

UPDATE

Manual entry as records are edited or as batches are assigned.

CONSOLIDATED DATA EXTRACT

No

HISTORICAL CHANGES

	None

EOD--Extension

IDENTIFIERS

CCR ID	NAACCR ID
E1136	790

DESCRIPTION

Two-digit extension code represents the growth of the primary tumor within the organ of origin, its extension into neighboring organs, or its metastasis to distant structures. This field is only coded for cases diagnosed prior to January 1, 2004.

LEVELS

Admissions, Tumors

LENGTH

2

ALLOWABLE VALUES

00, 01, 03, 05, 06, 10, 11, 12, 13, 14, 15, 16, 17, 18, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 40, 41, 42, 43, 44, 45, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 60, 61, 62, 63, 64, 65, 66, 67, 68, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 85, 87, 90, 99

Blank - not abstracted; or for cases diagnosed after January 1, 2004.

SOURCE

Upload with no conversion.

UPDATE

Tumor Level

New Case Consolidation

If the admission's value <> the tumor's value, then

If All of the following conditions are true:

Any of the following conditions are true:

The tumor's responsible region = 9 and its Date of Diagnosis year = 0000-1991

The tumor's responsible region = 8 and its Date of Diagnosis year = 0000-1987

The tumor's responsible region <> 8 & 9 and its Date of Diagnosis year = 0000-1993 or blank

The admission's value <> blank

The tumor's value = blank

Then automatically update the tumor's value with the admission's value

Otherwise, list for review.

Manual Update

Admission Level

Manual Update

Correction/Update Applied

CONSOLIDATED DATA EXTRACT

Yes, extract from tumor

HISTORICAL CHANGES

1/99	Added Codes 03 and 06 to allowable values; replaced item edit with DX interfield edit check; adjusted other interfield edits to check Date_DX too.

7/01	Added code 57 as allowable, and changed edits involving histology fields for ICDO-3, and changed edits involving the summary stage fields to accommodate SUM-STAGE-77 and SUM-STAGE-00.
11/02	Added code 18 to allowable values (breast EOD code).
3/03	Removed the Region 1/8 and 9 specific portions of the Interfield edit in 2c)
3/04	Updated Description and IF to apply to cases diagnosed prior to 2004. Added Interfield edit 3) to limit EOD to cases diagnosed prior to 2004. Updated CCR Data Extract.
2010	Data Changes: CCR name (Extension) changed to NAACCR name. Rewrote Update logic to reflect new date rules since unknown dates can no longer be used in update logic.

EOD--Extension Prost Path

IDENTIFIERS

CCR ID	NAACCR ID
E1137	800

DESCRIPTION

Two-digit code for prostate cancers only (and used only after prostatectomy within 4 months of diagnoses) to code the extension of the tumor. This field is only coded for cases diagnosed prior to January 1, 2004.

LEVELS

Admissions, Tumors

LENGTH

2

ALLOWABLE VALUES

00, 20, 21, 22, 23, 30, 31, 32, 33, 34, 40, 41, 42, 43, 44, 45, 48, 49, 50, 51, 52, 53, 60, 61, 70, 85, 90, 98
99 - Prostate case without prostatectomy within 4 months
Blank= Not abstracted
Non-prostate case
Prostate lymphoma case
Cases diagnosed after Jan 1, 2004.

SOURCE

If all of the following conditions are true:
Either of the following conditions are true:
Date of Diagnosis year is 1995-2003
Date of Diagnosis is blank and EOD--Prost Path is NOT blank
Primary Site is Prostate (C619)
Histologic Type ICD-O-3 is NOT 9590-9699 and NOT 9702-9729,
Then
If the Type of Reporting Source is death clearance (7), then convert EOD--Extension Prost Path to 90.
If all of the following conditions are true:
Type of Reporting Source is NOT death clearance (not 7)
RX Summ--Surg Prim Site is NOT prostatectomy (not 30, 40, 50, 70, or 80)
Then convert EOD--Extension Prost Path to 99.
If both of the following conditions are true:
Type of Reporting Source is NOT death clearance (not 7)
RX Summ--Surg Prim Site is prostatectomy (30, 40, 50, 70, or 80)
Then upload EOD--Extension Prost Path with no conversion.
Otherwise, if NOT blank, then convert EOD--Extension Prost Path to blank.

UPDATE

Tumor Level
New Case Consolidation
If the admission's value <>the tumor's value, then
If All of the following conditions are true:

- the tumor's Date of Diagnosis year = 1995-2003 or blank

- the admission's value <>blank
- the tumor's value = blank

Then automatically update the tumor's value with the admission's value

Otherwise, list for review.

Manual Update

Admission Level

Manual Update

Correction/Update Applied

CONSOLIDATED DATA EXTRACT

Yes, extract from tumor

HISTORICAL CHANGES

1/99	Replaced item edit with DATE-DX interfield edit check; adjusted other applicable interfield edits to check DATE-DX too.
3/99	Added code 48 as an allowable value.
3/00	Added codes 33 and 34 as allowable values.
3/03	Changed Allowable values to allow blanks for non-prostate cases (now matches NAACCR and SEER specifications). If Site is not C619, convert Extension_Path to blank; changed allowable values, Source and Interfield edit 1) a) to accommodate this new data standard.
3/04	Updated Description and IF to apply to cases diagnosed prior to 2004. Updated CCR Data Extract. Removed 99 from IF 1 b) and c).
1/05	Updated Source to allow DCO values of 90. Data conversion added to 2004 conversions in use case for both tumors and admissions. If (Date_DX > 19949999 and < 20040101) and (Site=C619) and (Report_Source=7) and (Extension_Path is NOT 90), then update Extension_Path to 90.
10/07	Changed Update logic to put blanks in prostate lymphoma cases.
2010	Data Changes: CCR name (Extension_Path) to NAACCR name. Rewrote Source and Update logic to reflect new date rules since unknown dates can no longer be used in update logic. Added IF#644.
11/8/11	Removed reference to interfield edit IF664. The edit does not refer to this data item.

EOD--Lymph Node Involv

IDENTIFIERS

CCR ID	NAACCR ID
E1138	810

DESCRIPTION

Lymph Node involvement

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	No nodes involved
8	Varies by site
9	Unknown whether nodes involved
Blank	Not abstracted; or for cases diagnosed after January 1, 2004.

SOURCE

Upload with no conversion.

UPDATE

See EOD--Extension

CONSOLIDATED DATA EXTRACT

Yes, extract from tumor

HISTORICAL CHANGES

1/99	Replaced item edit with DATE-DX interfield edit check; adjusted other applicable interfield edits to check DATE-DX too.
7/01	Added reference to HIST-BEHAVIOR-3 under interfield edits.
3/03	Removed Region 1/8 and Region 9 specific logic from Interfield edit.
3/04	Updated CCR Data Extract to only include Tumor Files. Updated IF to only edit case diagnosed prior to 2004. Added Interfield edit 3) to limit EOD to cases diagnosed prior to 2004.
2010	Data Changes: CCR name (Nodes Involved) changed to match NAACCR name. Rewrote Update logic to reflect new date rules since unknown dates can no longer be used in update logic.

EOD--Old 2 Digit

IDENTIFIERS

CCR ID	NAACCR ID
E1142	850

DESCRIPTION

Either a two-digit site-specific code (ERG EOD) or a two-digit non-specific code (use EOD_Scheme to differentiate) for SEER (Region 8) cases of selected sites/histologies diagnosed in 1973-82.

LEVELS

Tumors

LENGTH

2

ALLOWABLE VALUES

Valid codes (combinations of 0-9, -, and &) vary by Site, HIST_TYPE, and Date_DX year.
See the SEER Program Code Manual, revised August 1, 1985).
Blank on 1983+ diagnoses and on 1973-82 SEER cases with EOD_13 coded.
May be blank on any non-SEER case.

SOURCE

Manual entry on 1973-82 SEER (Region 8) cases.

UPDATE

None

CONSOLIDATED DATA EXTRACT

No

HISTORICAL CHANGES

	None

EOD--Old 4 Digit

IDENTIFIERS

CCR ID	NAACCR ID
E1143	860

NAACCR NAME

EOD--Old 4 Digit (#860) (Region 8 only)

RASP NAME

DESCRIPTION

A four-digit site-specific description of extent of disease on 1983-87 diagnoses in terms of tumor size, extension and lymph node involvement.

LEVELS

Tumors

LENGTH

4

ALLOWABLE VALUES

Valid codes (combinations of 0-9) vary by Site and Hist_Type on 1983-87 diagnosis.
(See the SEER Program Code Manual, revised August 1, 1985).
May be blank or partially blank on any non-SEER case - i.e., a case may have the tumor size coded in the first two positions and the second two positions blank.

SOURCE

Manual only.

UPDATE

Manual entry on 1983-87 SEER (Region 8) cases.

CONSOLIDATED DATA EXTRACT

No

HISTORICAL CHANGES

EOD--Old 13 Digit

IDENTIFIERS

CCR ID	NAACCR ID
E1141	840

DESCRIPTION

A 13-digit site-specific description of extent of disease for SEER (Region 8) cases of selected sites/histologies diagnosed in 1975-82. (Note: Start date varies by site.)

LEVELS

Tumors

LENGTH

13

ALLOWABLE VALUES

Valid codes (combinations of 0-9, -, and &) vary by Site, Hist_Type, Date_DX year and Report_Source not checked.

(See the SEER Program Code Manual, revised August 1, 1985).

Blank on 1983+ diagnoses and on 1973-82 SEER cases with EOD_2 coded.

May be blank on any non-SEER case.

SOURCE

Manual entry on 1975-82 SEER (Region 8) cases.

UPDATE

None

CONSOLIDATED DATA EXTRACT

No

INTERFIELD EDITS

None (Region 8 uses SEER edits.)

HISTORICAL CHANGES

	None

EOD Mets

IDENTIFIERS

CCR ID	NAACCR ID
E1807	776

DESCRIPTION

EOD Mets is part of the EOD 2018 data collection system and is used to classify the distant site(s) of metastatic involvement at time of diagnosis. See also EOD Primary Tumor [772] and EOD Regional Nodes [774]. Effective for cases diagnosed 1/1/2018+.

LEVELS

Admissions, Tumors

LENGTH

2

ALLOWABLE VALUES

00	None No distant metastasis Unknown if distant metastasis
	SCHEMA-SPECIFIC CODES WHERE NEEDED
88	N/A: Information not collected for this schema Use for these sites only: HemeRetic, Ill Defined Other (includes unknown primary site), Kaposi Sarcoma, Lymphoma, Lymphoma-CLL/SLL, Myeloma Plasma Cell Disorder
99	Death certificate only (DCO)
Blank	Date of Diagnosis pre-2018

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater, then:
    - Left justify and zero fill values less than two digits
    - Convert blanks or non-numeric values to 00

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Tumor's Date of Diagnosis year is 2018 – 9998
- Admission's value is not blank
- Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

EOD Primary Tumor

IDENTIFIERS

CCR ID	NAACCR ID
E1805	772

DESCRIPTION

EOD Primary Tumor is part of the EOD 2018 data collection system and is used to classify contiguous growth (extension) of the primary tumor within the organ of origin or its direct extension into neighboring organs. See also EOD Regional Nodes [NAACCR #774] and EOD Mets [NAACCR #776]. Effective for cases diagnosed 1/1/2018 and forward.

LEVELS

Admissions, Tumors

LENGTH

3

ALLOWABLE VALUES

000	In situ, intraepithelial, noninvasive
	SCHEMA-SPECIFIC CODES WHERE NEEDED
800	No evidence of primary tumor
999	Unknown; primary tumor not stated; Primary tumor cannot be assessed; Not documented in patient record; Death certificate only (DCO)
Blank	Date of Diagnosis pre-2018

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater, then:
    - Left justify and zero fill values less than three digits
    - Convert blanks or non-numeric values to 999

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Tumor's Date of Diagnosis year is 2018 – 9998

One of the following conditions is true

- Admission's value is not blank or 999
- Tumor's value is blank or 999

OR

- Admission's value is 999
- Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

EOD Regional Nodes

IDENTIFIERS

CCR ID	NAACCR ID
E1806	774

DESCRIPTION

EOD Regional Nodes is part of the EOD 2018 data collection system and is used to classify the regional lymph nodes involved with cancer at the time of diagnosis. See also EOD Primary Tumor [772] and EOD Mets [776]. Effective for cases diagnosed 1/1/2018+.

LEVELS

Admissions, Tumors

LENGTH

3

ALLOWABLE VALUES

000	None
	SCHEMA-SPECIFIC CODES WHERE NEEDED
800	Regional lymph node(s), NOS Lymph node(s), NO
888	Not applicable: CNS, hematopoietic
999	Unknown
Blank	Date of Diagnosis pre-2018

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater, then:
    - Left justify and zero fill values less than three digits
    - Convert blanks or non-numeric values to 999

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Tumor's Date of Diagnosis year is 2018 – 9998

One of the following conditions is true

- Admission's value is not blank or 999
- Tumor's value is blank or 999

OR

- Admission's value is 999
- Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

EOD Tumor Size

IDENTIFIERS

CCR ID	NAACCR ID
E1135	780

DESCRIPTION

Size of Tumor. Millimeter equivalent by physicians to describe the size of a tumor. This field is only coded for cases diagnosed prior to January 1, 2004.

LEVELS

Admissions, Tumors

LENGTH

3

ALLOWABLE VALUES

All numeric values including 0 are allowed.
Blank - Not abstracted; for cases diagnosed after January 1, 2004.

SOURCE

Upload with no conversion.

UPDATE

See EOD--Extension

CONSOLIDATED DATA EXTRACT

Yes, extract from tumor.

HISTORICAL CHANGES

1/99	Replaced item edit with updated interfield edit (conditional on Date_DX).
3/03	Removed the Region 1/8 and 9 specific portions of the IF #603.
3/04	Updated Description and IF to apply to cases in the time period EOD was required. Added Interfield edit 2 to limit EOD to cases diagnosed prior to 2004.
2010	Data Changes: CCR name (Tum Size) changed to match NAACCR name. Rewrote Update logic to reflect new date rules since unknown dates can no longer be used in update logic.

Erythro Growth Fact Sta (CER)

IDENTIFIERS

CCR-ID	NAACCR-ID
E1514	9881

DESCRIPTION

This data item has been retired. This page has been retained for historical purposes only and this data item should not be populated in any cases diagnosed 2013 or later or coded under the NAACCR v13 or later coding standards.
Code the use of Erythrocyte-Growth Factors/Cytokines agents during the twelve months after diagnosis.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

0	No Erythrocyte-Growth Factors/Cytokines treatment given
1	Erythrocyte-Growth Factors/Cytokines treatment was given
7	Erythrocyte-Growth Factors/Cytokines treatment prescribed – patient, patient's family member, or patient's guardian refused
8	Erythrocyte-Growth Factors/Cytokines treatment prescribed, unknown if administered
9	Unknown if Erythrocyte-Growth Factors/Cytokines therapy given
Blank	A blank is allowed for cases • Diagnosed prior to 2011 • Diagnose date 2011 and not a Region 3 resident • Region 3 resident and sites other than Breast, Colorectal, and CML

SOURCE

No longer uploaded

UPDATE

None

CONSOLIDATED DATA EXTRACT

N/A

INTERFIELD EDITS

IF704 Erythro Growth Factor, Date of DX, Site, Hist (CER)

HISTORICAL CHANGES

2011	New data item added for CER requirements.
05/2013	Retired at the conclusion of data collection for the CER project

Esophagus and EGJ Tumor Epicenter

IDENTIFIERS

CCR ID	NAACCR ID
E1942	3829

OWNER

NAACCR

DESCRIPTION

Esophagus and Esophagogastric Junction (EGJ), Squamous Cell (including adenosquamous), Tumor Location refers to the position of the epicenter of the tumor in the esophagus.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	U: Upper (Cervical/Proximal esophagus to lower border of azygos vein)
1	M: Middle (Lower border of azygos vein to lower border of inferior pulmonary vein)
2	L: Lower (Lower border of inferior pulmonary vein to stomach, including gastroesophageal junction) X: Esophagus, NOS
9	Specific location of epicenter not documented in medical record Specific location of epicenter not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00161
        - Type of Reporting Source is not 7
        - Esophagus and EGJ Tumor Epicenter is blank

        Then convert Esophagus and EGJ Tumor Epicenter to 9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00161

              OR
            - Type of Reporting Source is 7
        - Esophagus and EGJ Tumor Epicenter is not blank

        Then convert Esophagus and EGJ Tumor Epicenter to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00161
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00161

One of the following conditions is true

- Admission's value is not blank, 9
- Tumor's value is blank or 9

OR

- Admission's value is 9
- Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Estrogen Receptor Percent Positive or Range

IDENTIFIERS

CCR ID	NAACCR ID
E1939	3826

OWNER

NAACCR

DESCRIPTION

Estrogen Receptor, Percent Positive Range is the percent of cells staining estrogen receptor positive by IHC.

LEVELS

Admissions, Tumors

LENGTH

3

ALLOWABLE VALUES

000	ER negative, or stated as less than 1%
001-100	1-100 percent
R10	Stated as 1-10%
R20	Stated as 11-20%
R30	Stated as 21-30%
R40	Stated as 31-40%
R50	Stated as 31-40%
R60	Stated as 51-60%
R70	Stated as 61-70%
R80	Stated as 71-80%
R90	Stated as 81-90%
R99	Stated as 91-100%
XX8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code XX8 will result in an edit error.)
XX9	Not documented in medical record Estrogen Receptor, Percent Positive Range not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00480
        - Type of Reporting Source is not 7
        - COC Accredited Flag is 1

- Estrogen Receptor Percent Positive or Range is blank or XX8
  Then convert Estrogen Receptor Percent Positive or Range to XX9

B. If all of the following conditions are true:
   - One of the following is true:
     - Schema ID is not 00480
       OR
     - Type of Reporting Source is 7
   - Estrogen Receptor Percent Positive or Range is not blank
     Then convert Estrogen Receptor Percent Positive or Range to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00480
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00480

One of the following conditions is true

- Admission's value is not blank, XX8, or XX9
- Tumor's value is blank, XX8, or XX9
  OR
  - Admission's value is XX9
  - Tumor's value is blank or XX8

Then automatically update the Tumor's value with the Admission's value.
Otherwise,
If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Estrogen Receptor Summary

IDENTIFIERS

CCR ID	NAACCR ID
E1940	3827

OWNER

NAACCR

DESCRIPTION

ER (Estrogen Receptor) Summary is a summary of results of the estrogen receptor (ER) assay.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	ER negative
1	ER positive
7	Test ordered, results not in chart
9	Not documented in medical record Cannot be determined (indeterminate) ER (Estrogen Receptor) Summary status not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00480
        - Type of Reporting Source is not 7
        - Estrogen Receptor Summary is blank

        Then convert Estrogen Receptor Summary to 9
    B. If all of the following conditions are true:
        - One of the following conditions is true:
            - Schema ID is not 00480

            OR
            - Type of Reporting Source is 7
        - Estrogen Receptor Summary is not blank

        Then convert Estrogen Receptor Summary to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998

- Admission's Schema ID is 00480
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00480

One of the following conditions is true

- Admission's value is not blank or 9
- Tumor's value is blank or 9

OR

- Admission's value is 9
- Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.
Otherwise,
If Admission's value is not the same as the Tumor's value
Then list for review
Manual Update
Admission
Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Estrogen Receptor Total Allred Score

IDENTIFIERS

CCR ID	NAACCR ID
E1941	3828

OWNER

NAACCR

DESCRIPTION

Estrogen Receptor, Total Allred Score is based on the percentage of cells that stain positive by IHC for estrogen receptor (ER) and the intensity of that staining.

LEVELS

Admissions, Tumors

LENGTH

2

ALLOWABLE VALUES

00	Total ER Allred score of 0
01	Total ER Allred score of 1
02	Total ER Allred score of 2
03	Total ER Allred score of 3
04	Total ER Allred score of 4
05	Total ER Allred score of 5
06	Total ER Allred score of 6
07	Total ER Allred score of 7
08	Total ER Allred score of 8
X8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code X8 will result in an edit error.)
X9	Not documented in medical record Estrogen Receptor, Total Allred Score not assessed, or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
   A. If all of the following conditions are true:
      - Schema ID is 00480
      - Type of Reporting Source is not 7
      - COC Accredited Flag is 1
      - Estrogen Receptor Total Allred Score is blank or X8

      Then convert Estrogen Receptor Total Allred Score to X9
   B. If all of the following conditions are true:

- One of the following is true
  - Schema ID is not 00480
    OR
  - Type of Reporting Source is 7
- Estrogen Receptor Total Allred Score is not blank
  Then convert Estrogen Receptor Total Allred Score to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00480
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00480

One of the following conditions is true

- Admission's value is not blank, X8, or X9
- Tumor's value is blank, X8, or X9
  OR
  - Admission's value is X9
  - Tumor's value is blank or X8

Then automatically update the Tumor's value with the Admission's value.
Otherwise,
If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.
02/2020	Description Update

Extranodal Extension Clin (Non-Head and Neck)

IDENTIFIERS

CCR ID	NAACCR ID
E1943	3830

OWNER

NAACCR

DESCRIPTION

Extranodal Extension (ENE) Clinical is defined as "the extension of a nodal metastasis through the lymph node capsule into adjacent tissue" during the diagnostic workup. This data item defines clinical ENE for sites other than Head and Neck.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	Regional lymph nodes involved, ENE not present/not identified during diagnostic workup
1	Regional lymph nodes involved, ENE present/identified during diagnostic workup, based on physical exam and/or imaging
2	Regional lymph nodes involved, ENE present/identified during diagnostic workup, based on microscopic confirmation
7	No lymph node involvement during diagnostic workup (cN0)
8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code 8 may result in an edit error)
9	Not documented in medical record Clinical ENE not assessed or unknown if assessed during diagnostic workup Clinical assessment of lymph nodes not done, or unknown if done
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00460, 00570
        - Type of Reporting Source is not 7
        - COC Accredited Flag is 1
        - Extranodal Extension Clin (non-Head and Neck) is blank or 8

        Then convert Extranodal Extension Clin (non-Head and Neck) to 9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00460, 00570

            OR

- Type of Reporting Source is 7

- Extranodal Extension Clin (non-Head and Neck) is not blank

Then convert Extranodal Extension Clin (non-Head and Neck) to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00460, 00570
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00460, 00570

One of the following conditions is true

- Admission's value is not blank, 8, 9
- Tumor's value is blank, 8, or 9

OR

- Admission's value is 9
- Tumor's value is blank or 8

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Extranodal Extension Head and Neck Clinical

IDENTIFIERS

CCR ID	NAACCR ID
E1934	3831

OWNER

NAACCR

DESCRIPTION

Extranodal extension (ENE) is defined as "the extension of a nodal metastasis through the lymph node capsule into adjacent tissue" and is a prognostic factor for most head and neck tumors. This data item pertains to clinical staging extension.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	Regional lymph nodes involved, ENE not present/not identified during diagnostic workup
1	Regional lymph nodes involved, ENE present/identified during diagnostic workup, based on physical exam WITH or WITHOUT imaging
2	Regional lymph nodes involved, ENE present/identified during diagnostic workup, based on microscopic confirmation
7	No lymph node involvement during diagnostic workup (cN0)
8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code 8 may result in an edit error)
9	Not documented in medical record ENE not assessed during diagnostic workup, or unknown if assessed Clinical assessment of lymph nodes not done, or unknown if done
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00060, 00071, 00072, 00073, 00074, 00075, 00076, 00077, 00080, 00090, 00100, 00111, 00112, 00121, 00122, 00130, 00131, 00132, 00133, 00140
        - Type of Reporting Source is not 7
        - COC Accredited Flag is 1
        - Extranodal Extension Head and Neck Clinical is blank or 8

        Then convert Extranodal Extension Head and Neck Clinical to 9
    B. If all of the following conditions are true:
        - One of the following is true:

- Schema ID is not 00060, 00071, 00072, 00073, 00074, 00075, 00076, 00077, 00080, 00090, 00100, 00111, 00112, 00121, 00122, 00130, 00131, 00132, 00133, 00140
  OR
- Type of Reporting Source is 7

- Extranodal Extension Head and Neck Clinical is not blank
  Then convert Extranodal Extension Head and Neck Clinical to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00060, 00071, 00072, 00073, 00074, 00075, 00076, 00077, 00080, 00090, 00100, 00111, 00112, 00121, 00122, 00130, 00131, 00132, 00133, 00140
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00060, 00071, 00072, 00073, 00074, 00075, 00076, 00077, 00080, 00090, 00100, 00111, 00112, 00121, 00122, 00130, 00131, 00132, 00133, 00140

One of the following conditions is true

- Admission's value is not blank, 8, or 9
- Tumor's value is blank , 8, or 9
  OR
  - Admission's value is 9
  - Tumor's value is blank or 8

Then automatically update the Tumor's value with the Admission's value.
Otherwise,
If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Extranodal Extension Head and Neck Pathological

IDENTIFIERS

CCR ID	NAACCR ID
E1945	3832

OWNER

NAACCR

DESCRIPTION

Extranodal extension (ENE) is defined as "the extension of a nodal metastasis through the lymph node capsule into adjacent tissue" and is a prognostic factor for most head and neck tumors. This data item pertains to pathological staging extension.

LEVELS

Admissions, Tumors

LENGTH

3

ALLOWABLE VALUES

0.0	Lymph nodes positive for cancer but ENE not identified or negative
0.1-9.9	ENE 0.1 to 9.9 mm
X.1	ENE 10 mm or greater
X.2	ENE microscopic, size unknown Stated as ENE (mi)
X.3	ENE major, size unknown Stated as ENE (ma)
X.4	ENE present, microscopic or major unknown, size unknown
X.7	Surgically resected regional lymph nodes negative for cancer (pN0)
X.8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code X.8 may result in an edit error)
X.9	Not documented in medical record No surgical resection of regional lymph nodes ENE not assessed pathologically, or unknown if assessed Pathological assessment of lymph nodes not done, or unknown if done
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00060, 00071, 00072, 00073, 00074, 00075, 00076, 00077, 00080, 00090, 00100, 00111, 00112, 00121, 00122, 00130, 00131, 00132, 00133, 00140
        - Type of Reporting Source is not 7
        - Extranodal Extension Head and Neck Pathological is blank or X.8

Then convert Extranodal Extension Head and Neck Pathological to X.9

B. If all of the following conditions are true:
- One of the following is true:
  - Schema ID is not 00060, 00071, 00072, 00073, 00074, 00075, 00076, 00077, 00080, 00090, 00100, 00111, 00112, 00121, 00122, 00130, 00131, 00132, 00133, 00140
    OR
  - Type of Reporting Source is 7
- Extranodal Extension Head and Neck Pathological is not blank

  Then convert Extranodal Extension Head and Neck Pathological to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:
- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00060, 00071, 00072, 00073, 00074, 00075, 00076, 00077, 00080, 00090, 00100, 00111, 00112, 00121, 00122, 00130, 00131, 00132, 00133, 00140
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00060, 00071, 00072, 00073, 00074, 00075, 00076, 00077, 00080, 00090, 00100, 00111, 00112, 00121, 00122, 00130, 00131, 00132, 00133, 00140

One of the following conditions is true
- Admission's value is not blank, X.9
- Tumor's value is blank or X.9

  OR
  - Admission's value is X.9
  - Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Extranodal Extension Path (Non-Head and Neck)

IDENTIFIERS

CCR ID	NAACCR ID
E1946	3833

OWNER

NAACCR

DESCRIPTION

Extranodal Extension Pathological is defined as "the extension of a nodal metastasis through the lymph node capsule into adjacent tissue" identified as part of the surgical resection. This data item defines pathological ENE for sites other than Head and Neck.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	Regional lymph nodes involved, ENE not present/not identified from surgical resection
1	Regional lymph nodes involved, ENE present/identified from surgical resection
7	No lymph node involvement from surgical resection (pN0)
8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code 8 may result in an edit error)
9	Not documented in medical record No surgical resection of regional lymph nodes Cannot be determined Pathological assessment of lymph nodes not done, or unknown if done Extranodal Extension Pathological not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00460, 00570
        - Type of Reporting Source is not 7
        - COC Accredited Flag is 1
        - Extranodal Extension Path (non-Head and Neck) is blank or 8

        Then convert Extranodal Extension Path (non-Head and Neck) to 9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00460, 00570

OR

- Type of Reporting Source is 7

- Extranodal Extension Path (non-Head and Neck) is not blank

Then convert Extranodal Extension Path (non-Head and Neck) to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00460, 00570
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00460, 00570

One of the following conditions is true

- Admission's value is not blank, 8, 9
- Tumor's value is blank, 8, or 9

OR

- Admission's value is 9
- Tumor's value is blank or 8

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Extravascular Matrix Patterns

IDENTIFIERS

CCR ID	NAACCR ID
E1947	3834

OWNER

NAACCR

DESCRIPTION

Extravascular Matrix Patterns, the presence of loops and networks in extracellular matrix patterns, is a prognostic factor for uveal melanoma.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	Extravascular matrix pattern not present/not identified
1	Extravascular matrix pattern present/identified
8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code 8 may result in an edit error.)
9	Not documented in medical record Extravascular Matrix Pattern not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00671, 00672
        - Type of Reporting Source is not 7
        - COC Accredited Flag is 1
        - Extravascular Matrix Patterns is blank or 8

        Then convert Extravascular Matrix Patterns to 9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00671, 00672

              OR
            - Type of Reporting Source is 7
        - Extravascular Matrix Patterns is not blank

        Then convert Extravascular Matrix Patterns to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00671, 00672
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00671, 00672

One of the following conditions is true

- Admission's value is not blank, 8, 9
- Tumor's value is blank, 8, or 9

OR

- Admission's value is 9
- Tumor's value is blank or 8

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Fibrosis Score

IDENTIFIERS

CCR ID	NAACCR ID
E1948	3835

OWNER

NAACCR

DESCRIPTION

Fibrosis Score, the degree of fibrosis of the liver based on pathological examination, is a prognostic factor for liver cancer.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	Ishak fibrosis score 0-4 No to moderate fibrosis METAVIR score F0-F3 Batt-Ludwig score 0-3
1	Ishak fibrosis score 5-6 Advanced/severe fibrosis METAVIR score F4 Batt-Ludwig score 4 Developing cirrhosis Incomplete cirrhosis Transition to cirrhosis Cirrhosis, probable or definite Cirrhosis, NOS
7	Clinical statement of advanced/severe fibrosis or cirrhosis, AND Not histologically confirmed or unknown if histologically confirmed
8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code 8 will result in an edit error.)
9	Not documented in medical record Stated in medical record that patient does not have advanced cirrhosis/advanced fibrosis, not histologically confirmed or unknown if histologically confirmed Fibrosis score stated but cannot be assigned to codes 0 or 1 Fibrosis score stated but scoring system not recorded Fibrosis Score not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
   A. If all of the following conditions are true:
      - Schema ID is 00220 or 00230
      - Type of Reporting Source is not 7
      - Fibrosis Score is blank or 8

      Then convert Fibrosis Score to 9
   B. If all of the following conditions are true:
      - One of the following is true:
        - Schema ID is not 00220, 00230

          OR
        - Type of Reporting Source is 7
      - Fibrosis Score is not blank

      Then convert Fibrosis Score to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00220, 00230
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00220, 00230

One of the following conditions is true

- Admission's value is not blank, 9
- Tumor's value is blank, 9

  OR
  - Admission's value is 9
  - Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

FIGO Stage

IDENTIFIERS

CCR ID	NAACCR ID
E1949	3836

OWNER

NAACCR

DESCRIPTION

Fédération Internationale de Gynécologie et d'Obstétrique (FIGO) is a staging system for female reproductive cancers.

LEVELS

Admissions, Tumors

LENGTH

2

ALLOWABLE VALUES

01	FIGO Stage I
02	FIGO Stage IA
03	FIGO Stage IA1
04	FIGO Stage IA2
05	FIGO Stage IB
06	FIGO Stage IB1
07	FIGO Stage IB2
08	FIGO Stage IC
09	FIGO Stage IC1
10	FIGO Stage IC2
11	FIGO Stage IC3
20	FIGO Stage II
21	FIGO Stage IIA
22	FIGO Stage IIA1
23	FIGO Stage IIA2
24	FIGO Stage IIB
30	FIGO Stage III
31	FIGO Stage IIIA
32	FIGO Stage IIIA1
33	FIGO Stage IIIAi
34	FIGO Stage IIIAii
35	FIGO Stage IIIA2
36	FIGO Stage IIIB
37	FIGO Stage IIIC
38	FIGO Stage IIIC1
39	FIGO Stage III2
40	FIGO Stage IV

41	FIGO Stage IVA
42	FIGO Stage IVB
97	Not applicable: Carcinoma in situ (intraepithelial, noninvasive, preinvasive)
98	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code 98 will result in an edit error.)
99	Not documented in medical record FIGO stage unknown, not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
   A. If all of the following conditions are true:
      - Schema ID is 00500, 00510, 00520, 00530, 00541, 00542, 00551, 00552, 00553, or 00560
      - Type of Reporting Source is not 7
      - FIGO Stage is blank or 98

      Then convert FIGO Stage to 99
   B. If all of the following conditions are true:
      - One of the following is true:
        - Schema ID is not 00500, 00510, 00520, 00530, 00541, 00542, 00551, 00552, 00553, 00560

          OR
        - Type of Reporting Source is 7
      - FIGO Stage is not blank

      Then convert FIGO Stage to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00500, 00510, 00520, 00530, 00541, 00542, 00551, 00552, 00553, 00560
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00500, 00510, 00520, 00530, 00541, 00542, 00551, 00552, 00553, 00560
- One of the following conditions is true
  - ((Admission's value is not blank or 99) and (Tumor's value is blank or 99))

    OR
  - (Admission's value is 99 and Tumor's value is blank)

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

First Course Calc Method

IDENTIFIERS

CCR-ID	NAACCR-ID
E1351	1500

DESCRIPTION

This data item was retired in the 2013 data item changes. This page is retained for historical purposes only. Do not generate this field for any cases diagnosed 2013 or later, or coded under the NAACCR v13 coding standards.
Code indicating the source of the standard for defining the first course of therapy.

LEVELS

Tumors

LENGTH

1

ALLOWABLE VALUES

1	CoC definitions
2	SEER definitions
9	Other, unknown

SOURCE

See Extract.

UPDATE

None

CONSOLIDATED DATA EXTRACT

Do not generate this field after the 2013 data changes are implemented.
~~Generate 2 (defined from treatment start date (SEER).~~

HISTORICAL CHANGES

8/06	Generated item in Volume II added to Volume III with 2007 data changes.
2013 Data changes	This data items have been retired.

Follow-Up Contact--City

IDENTIFIERS

CCR-ID	NAACCR-ID
E1531	1842

DESCRIPTION

The name of the city to be used to generate a follow-up inquiry to a contact other than the patient

LEVELS

Patients, Admissions

LENGTH

50

ALLOWABLE VALUES

Any.
Leave blank if not needed.

SOURCE

Left-justify (but don't record in Audit Log) and load the transmitted value.

UPDATE

Patient Active Follow-up Fields Update Logic

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/03	Added C/N # in Source field.
1/09	Removed C/N # in Source field.
2010	Data Changes: CCR name (FU_Con_City_Oth) changed to NAACCR name. Length changed from 20 to 50. Revised Update logic based on new date criteria.
05/2013	Added Follow-Up Contact--Country to the Update logic.

Follow-Up Contact--Country

IDENTIFIERS

CCR ID	NAACCR ID
E1772	1847

OWNER

NAACCR

DESCRIPTION

Country code for the address of follow-up contact's current usual residence. If the patient has multiple tumors, the country of follow-up contact residence should be the same for all tumors. This data item became part of the NAACCR transmission record effective with Volume II, Version 13 in order to include country and state for each geographic item and to use interoperable codes. It supplements the item Follow-up Contact--State [NAACCR #1844].

LEVELS

Patients, Admissions

LENGTH

3

ALLOWABLE VALUES

See Volume I, Appendix D.1

SOURCE

1. Left-justify and upshift (but don't record these changes in the audit log).
2. If Coding Procedure is 30 or 31, then

If Follow-up Contact--Country =	Then convert Follow-up Contact--Country to
XCZ	CSK
XYG	YUG
BND	BRN
SWK	SVK
VLT	VUT

If coding procedure is less than 30, then

If Follow-up Contact--State can be found in Appendix 31 State/Country Crosswalk, then

Generate Follow-up Contact--Country using Follow-up Contact--State's associated CountryISO code from the Appendix

Else

Generate ZZU (unknown) if blank

Else

Load without conversion

UPDATE

Patient Active Follow-up Fields Update Logic

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

05/2013	New data item for 2013. • Added IF 1043 • Added ER 1117
03/2015	Per NAACCR v15, the historic codes XYG, XCZ, BND, SWK, and VLT converted to active ISO codes; updated SOURCE logic to include the conversions upon upload.

Follow-Up Contact--Name

IDENTIFIERS

CCR ID	NAACCR ID
E1654	2394

DESCRIPTION

Name that is used to generate a follow-up inquiry to contact other than the patient. Must correspond to the follow-up contact address - other fields.

LEVELS

Patient
Admission

LENGTH

60

ALLOWABLE VALUES

Any alphanumeric or blank.

SOURCE

Load the transmitted value.
Left justify, but don't record the left justification in the audit log.

UPDATE

Patient Active Follow-up Fields Update Logic

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/26/03	Added C/N # to Source field.
2010	Data Changes: Length changed from 30 to 60. CCR name (FU_Contact_Other) changed to NAACCR name. Revised Update logic based on new date criteria.

Follow-Up Contact--No & St

IDENTIFIERS

CCR-ID	NAACCR-ID
E1655	2392

DESCRIPTION

The number and street address or rural mailing address to be used to generate a follow-up inquiry to a contact other than the patient. Must correspond to other fields in follow-up contact address - other.

LEVELS

Patients, Admissions

LENGTH

60

ALLOWABLE VALUES

Any alpha, numeric, spaces, and 5 special characters. (/ # - , .); Left-justified with a space between house number and street name. UNKNOWN if address is not known.

SOURCE

Left-justify (but don't record in Audit Log) and load the transmitted value.

UPDATE

Patient Active Follow-up Fields Update Logic

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/03	Added C/N # in Source field. Length changed from 25 to 40.
2010	Data Changes: CCR name (FU_Con_Addr_Oth) change to NAACCR name. Length changed from 40 to 60. Revised Update logic based on new date criteria.

Follow-Up Contact--Postal

IDENTIFIERS

CCR-ID	NAACCR-ID
E1533	1846

DESCRIPTION

Zip code for the address to be used for the follow-up contact other than the patient.

LEVELS

Patients, Admissions

LENGTH

9

ALLOWABLE VALUES

Any

SOURCE

If last 4 characters = 9999 and first 5 characters not 9's, set last 4 characters to blank. If first 5 characters is 99999 and last 4 characters is not 9999, move 9999 to last 4 characters

UPDATE

Patient Active Follow-up Fields Update Logic

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/03	Added C/N # to Source field.
2010	Data Changes: CCR name FU_Con_Zip_Oth) changed to NAACCR name. Revised Update logic based on new date criteria.

Follow-Up Contact--State

IDENTIFIERS

CCR ID	NAACCR ID
E1532	1844

OWNER

SEER

DESCRIPTION

US Postal Service abbreviation for the state (including U.S. Territories, commonwealths, or possessions) or Canadian province in which the follow-up contact other than the patient resides.

LEVELS

Patients, Admissions

LENGTH

2

ALLOWABLE VALUES

AK-WY	US States/Territories
AA-AP	United States Military Personnel Serving Abroad
AB-YT	Canadian Provinces/Territories
CD	Canada, NOS
US	Resident of United States, NOS
XX	Not U.S., U.S. Territory, not Canada, and country is known
YY	Not U.S., U.S. Territory, North American Islands, not Canada, and country is unknown
ZZ	Residence is unknown
Blank	

See Volume I, Appendix B for all Postal Abbreviations for states/territories.

SOURCE

Left-justify and Upshift (but don't record these changes in the Audit Log).

UPDATE

Patient Active Follow-up Fields Update Logic

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

03/26/03	Added C/N # and conversion table for Canadian provinces to Source field. Update logic rewritten.
03/03/04	Removed conversion instructions from SOURCE for Version 9 records. See Use Case 22.
03/07/05	Added ZZ to Allowable Values and updated definitions of XX and YY to match the CoC/NAACCR definitions. Conversion spec added to Source. Database will be converted.
08/15/06	Added CD and US to Allowable Values and changed definition for ZZ.

2010	Data Item Changes: CCR name (FU_Con_State_Oth) changed to NAACCR name. Revised Update logic based on new date criteria.
07/2014	Clarified allowable values and included reference to Volume I, Appendix B.

Follow-Up Contact--Suppl

IDENTIFIERS

CCR-ID	NAACCR-ID
E1656	2393

DESCRIPTION

This data item allows the storage of additional address information such as the name of a place or facility (i.e., a nursing home, or the name of an apartment complex). To be used to generate a follow-up inquiry to a contact other than the patient. Must correspond to other fields in follow-up contact address - other.

LEVELS

Patients, Admissions

LENGTH

60

ALLOWABLE VALUES

Any
Leave blank if not needed.

SOURCE

Left-justify (but don't record in Audit Log) and load the transmitted value.

UPDATE

Patient Active Follow-up Fields Update Logic

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/26/03	New data item in 2003 data set.
3/03/04	Changed the Allowable Values to "Any" and removed edit Err #231.
2010	2010 Data Changes: CCR name (FU_Con_Addr_Oth_Supp) changed to NAACCR name. Length changed from 40 to 60. Revised Update logic based on new date criteria.

Follow-Up Eligible

IDENTIFIERS

CCR ID	NAACCR ID
None	None: Generated in Eureka

OWNER

CCR

DESCRIPTION

Indicates the follow-up activity on an incidence case. In Eureka, this field is generated when necessary and is not stored in the database. This item is not in Volume II, Appendix A, the Exchange Record.

LEVELS

Tumors

LENGTH

2

ALLOWABLE VALUES

1	Not in follow-up - autopsy and DC cases
2	Case that is (or was) in follow-up
3	Not in follow-up - cervix in situ cases
4	SEER case not in follow-up until Feb. 1983 (Region 8 only)
9	Non-incidence case

SOURCE

Computer generate:
If Incidence Code = 0, move 9
else
If Type of Reporting Source = 6 or 7, move 1
else
If (Primary Site= 530-539 and Behavior Code ICD-O-3 = 2), move 3
else move 2.

UPDATE

Regenerate if Incidence Code, Type of Reporting Source, Primary Site or Behavior Code ICD-O-3 is changed.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

07/2001	Renamed HIST-BEHAVIOR to HIST-BEHAVIOR-3.
01/2002	In the central system (EUREKA), this field is generated when necessary and is not stored in the database. The Allowable values edit was removed. Interfield edit 375 under REPORT-SOURCE was also removed.
2011	CCR name changed from "FU Eligible" to "Follow-Up Eligible".

Follow-Up Flag

IDENTIFIERS

CCR ID	NAACCR ID
E1825	None: State Required

OWNER

CCR

DESCRIPTION

The field Follow-up Flag is the only field that has a different requirement status between the New Case Record and Modified Record. The flag documents if the Modified Record contains updates to fields identified to contain follow-up information.

Vendors will be responsible for generating this field using the following guidelines:

- Generate a flag of 1 in the field Follow-up Flag when an update has been made to any of the following fields:
    - Date of Last Contact
    - Date of Last Contact Flag
    - Vital Status
    - Date Cancer Status
    - Date Cancer Status Flag
    - Cancer Status
    - Follow-Up Hospital Last
    - Follow-Up Last Type (Patient)
    - Follow-Up Last Type (Tumor)
    - Follow-Up Registry - Next
    - Follow-Up Next Type
    - Physician--Follow-Up
    - Cause of Death
    - Place of Death - State
    - Date Case Last Changed
    - DC State File Number
    - Contact Name
    - Addr Current--No & Street
    - Addr Current--Supplemental
    - Addr Current--City
    - Addr Current--State
    - Addr Current--Postal Code
    - Telephone
    - Pat No Contact
    - Follow-Up Contact--Name
    - Follow-Up Contact--No&St
    - Follow-Up Contact--Suppl
    - Follow-Up Contact--City
    - Follow-Up Contact--State
    - Follow-Up Contact--Postal
    - Place of Death - Country

- Addr Current – Country
- Follow-up Contact - Country

LEVELS

N/A

LENGTH

1

ALLOWABLE VALUES

1	Follow-up information included in Modified Record
Blank	Follow-up information included in Modified Record

SOURCE

N/A

UPDATE

N/A

CONSOLIDATED DATA EXTRACT

No

HISTORICAL CHANGES

05/2016	Per NAACCR v16, field implemented that is generated by vendors on Modified Record.

Follow-Up Hospital Last

IDENTIFIERS

CCR-ID	NAACCR-ID
E1628	None: State Requestor

DESCRIPTION

Code number of the hospital that reported the latest follow up information on this patient or tumor.

LEVELS

Patients, Tumors, Admissions

LENGTH

10

ALLOWABLE VALUES

Valid hospital code numbers, see CA Hosp Codes or 9's if unknown.

0000000001	=	Information from CCR
0000000101-0000000110	=	Obtained by Regional Registry 01-10, respectively.

SOURCE

If the transmitted value is numeric, then load it with no conversion.
Otherwise, convert it to 0000999999.
Also see CS Version Derived.

UPDATE

Patient Active Follow-up Fields Update Logic
Tumor Active Follow-up Fields Update Logic

CONSOLIDATED DATA EXTRACT

No

HISTORICAL CHANGES

1/1/99	Changed SOURCE section to reflect change to 15-digits in transmission formats.
3/26/03	Length, Source and Allowable values changes due to field length change from 15 to 10 characters.
3/03/04	Removed conversion instructions from SOURCE for Version 9 records. See Use Case 22. Updated C/N# to F01687.
6/11/04	Updated C/N# to F01686.
7/27/05	Removed the Allowable Values reference (Volume One Appendix F) & reference is now to the current California hospitals labels file on the CCR website.
2010	Data Changes: Retired by NAACCR (#2430) but retained as a California Requestor item. Revised Update logic based on new date criteria.
2011	Data Changes: Name changed from "FU Hosp Last" to "Follow-Up Hospital Last".

Follow-Up Last Type Patient

IDENTIFIERS

CCR ID	NAACCR ID
E1580	None: State Requestor

DESCRIPTION

Source of last follow-up information, whether that follow-up was specifically looking for patient or tumor information.

LEVELS

Patients, Admissions

LENGTH

2

ALLOWABLE VALUES

Hospital

00	Admission Being Reported
01	Readmission to Reporting Hospital
02	Follow-up Report from Physician
03	Follow-up Report from Patient
04	Follow-up Report from Relative
05	Obituary
06	Follow-up Report from Social Security Administration or Medicare
07	Follow-up Report from Hospice
08	Follow-up Report from Other Hospital
09	Other Source
11	Telephone call to any source
12	Special Studies
13	Equifax
14	ARS (AIDS Registry System)
15	Computer Match with Discharge Data
16	SSDI Match

Regional Registry

20	Letter to a Physician
21	Computer match with Department of Motor Vehicles
22	Computer match with Medicare or Medicaid file
23	Computer match with HMO file
24	Computer match with voter registration file
25	National Death Index
26	Computer match with State Death Tape
27	Social Security, Death Master file
29	Computer match, Other or NOS
30	Other Source
31	Telephone call to any source
32	Special Studies

33	Equifax
34	ARS (AIDS Registry System)
35	Computer Match with Discharge Data
36	Obituary
37	Computer-Match using Address Service
38	TRW Credit
39	Regional Registry Follow-up Listing

Central Registry

40	Letter to a Physician
41	Telephone call to any source
48	Research Study Follow Up
49	Birth StatMaster Linkage
50	CMS (Center for Medicare and Medicaid Services)
51	Department of Motor Vehicles
52	CMS-SEER
53	HMO file
54	CalVoter Registration
55	National Death Index
56	State Death Tape-Death Clearance (StatMaster)
57	Medi-Cal Eligibility
58	Social Security - Deaths
59	Computer match, Other or NOS
60	Other Source
61	Social Security - SSN
62	Special Studies
63	Master Files
64	Accurint
65	Hospital Discharge Data-OSHPD
66	National Change of Address (NCOA)
67	Social Security Administration - Epidemiological Vital Status
68	Property Tax Linkage
69	State Death Tape-Death Clearance (Incremental)
70	Death Clearance LA County

Hospital Supplemental

73	Computer match with HMO file
76	Computer match with State Death Tape

Regional Registry (Additional Codes)

80	Social Security Administration - Epidemiological Vital Status
81	Property Tax Linkage
82	Probe360
83	SSDI Internet
84	E-Path
85	Path Labs
86	Patient

87	Relative

Unknown Source

99	Source Unknown

SOURCE

If the value is completely blank, then convert 99.
If the value contains a non-blank, non-numeric character, then convert 99.
Otherwise, just load the transmitted value, but right-justify and zero fill.

UPDATE

Patient Active Follow-up Fields Update Logic

CONSOLIDATED DATA EXTRACT

For NPCR Extract on cases dx prior to 2006.

HISTORICAL CHANGES

1/99	Added codes 62 and 65 as allowable values; changed transmit to CCR section to Yes.
5/01	Added codes 57, 58 and 66.
11/02	Changed label for code 52. Added codes 27, 36 and 58 to the Interfield edit. Editorial change-took the wording "computer match" out of Central Registry codes where applicable.
3/03	Added code 69 to Allowable Values to differentiate between the State Death Tape incremental and the State Death Tape StatMaster (56). Added codes 82-87 based on Active Follow-Up Task Force recommendations. Added 69 and 83 to the Interfield edit.
1/05	Added codes 63 and 64.
10/06	Added to Allowable Values.
1/07	Added code 16 to Allowable Values to capture SSDI death matches.
10/07	Added code 70 for LA County and code 48 for Research Study Follow Up (per Region 1/8 request to reflect the upload follow-up information provided to them from research studies conducted by researchers in their region). Changed label for 52 to CMS-SEER per Research unit (was CMRI).
2010	Data Changes: Rewrote Update logic to reflect new date rules since unknown dates can no longer be used in update logic.
2011	Data Changes: Data Item Name changed from FU Last Type Pat to Follow-Up Last Type Patient

Follow-Up Last Type Tumor

IDENTIFIERS

CCR ID	NAACCR ID
E1584	None. State Requestor

DESCRIPTION

Source of last tumor follow-up information which gave a specific tumor status.

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

HOSPITAL

00	Admission Being Reported
01	Readmission to Reporting Hospital
02	Follow-up Report from Physician
03	Follow-up Report from Patient
04	Follow-up Report from Relative
05	Obituary
07	Follow-up Report from Hospice
08	Follow-up Report from Other Hospital
09	Other Source
11	Telephone call to any source
12	Special Studies
14	ARS (AIDS Registry System)
15	Computer Match with Discharge Data

REGIONAL REGISTRY

20	Letter to a Physician
22	Medicare or Medicaid file
23	HMO file
25	National Death Index
26	State Death Tape
29	Computer match, Other or NOS
30	Other Source
31	Telephone call to any source
32	Special Studies
34	ARS (AIDS Registry System)
35	Discharge Data
36	Obituary

CENTRAL REGISTRY

40	Letter to a Physician
41	Telephone call to any source

52	Medicare or Medicaid file
53	HMO file
55	National Death Index
56	State Death Tape
59	Computer match, Other or NOS
60	Other Source

HOSPITAL, SUPPLEMENTAL

73	HMO file
76	State Death Tape

REGIONAL REGISRTY (ADDITIONAL CODES)

85	Path Labs

UNKNOWN SOURCE

99	Source Unknown

SOURCE

If the value is completely blank, then convert 99.
If the value contains a non-blank, non-numeric character, then convert 99.
Otherwise, just load the transmitted value, but right-justify and zero fill

UPDATE

Tumor Active Follow-up Fields Update Logic

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

0/1999	Changed transmit to CCR section to Yes.
2010	Data Changes: Revised Update logic based on new date criteria.
10/2015	Added code of 85: Path Labs. This addition is part of the new case building functionality in Eureka.

Follow-Up Next Type

IDENTIFIERS

CCR ID	NAACCR ID
E1584	None. State Requestor

DESCRIPTION

Method to be used the next time the patient is due for follow-up as reported by the hospital with the most recent follow-up date (date entered in Date of Last Contact).

LEVELS

Patients, Admissions

LENGTH

1

ALLOWABLE VALUES

0	Hospital chart
1	Letter to physician
2	Letter to designated contact
3	Phone patient or designated contact
4	Contact another hospital
5	Other
6	Send follow-up letter to the patient
7	Not to be followed - patient presumed lost
8	Not to be followed - foreign resident
9	Not to be followed - other reasons
Blank	Indeterminate or patient dead.

SOURCE

If the transmitted value is numeric, then just load it with no conversion. Otherwise, convert it to blank.

UPDATE

Patient Active Follow-up Fields Update Logic

CONSOLIDATED DATA EXTRACT

No

HISTORICAL CHANGES

2010	Data Changes: In Update area, data item name for Date of Last Pat FU changed to Date of Last Contact.
2011	Changed name from FU Next Type to Follow-Up Next Type.

Gestational Trophoblastic Prognostic Scoring Index

IDENTIFIERS

CCR ID	NAACCR ID
E1950	3837

OWNER

NAACCR

DESCRIPTION

Gestational Trophoblastic Prognostic Scoring Index, a score based on the FIGO-modified World Health Organization (WHO) Prognostic Scoring Index, is used to stratify women with gestational trophoblastic neoplasia in addition to the anatomical stage group. The risk score is appended to the anatomic stage.

LEVELS

Admissions, Tumors

LENGTH

2

ALLOWABLE VALUES

00-25	Risk factor score
X9	Not documented in medical record Prognostic scoring index not assessed, or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
   A. If all of the following conditions are true:
      - Schema ID is 00560
      - Type of Reporting Source is not 7
      - Gestational Trophoblastic Prognostic Scoring Index is blank

      Then convert Gestational Trophoblastic Prognostic Scoring Index to X9
   B. If all of the following conditions are true:
      - One of the following is true:
        - Schema ID is not 00560

          OR
        - Type of Reporting Source is 7
      - Gestational Trophoblastic Prognostic Scoring Index is not blank

      Then convert Gestational Trophoblastic Prognostic Scoring Index to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00560

- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00560

One of the following conditions is true

- Admission's value is not blank, X9
- Tumor's value is blank, X9

OR

- Admission's value is X9
- Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

GIS Coordinate Quality

IDENTIFIERS

CCR ID	NAACCR ID
E1046	366

DESCRIPTION

Code indicating the basis of assignment of latitude and longitude coordinates for an individual record from an address.
This data item is helpful in identifying cases that were assigned coordinates based on incomplete information, post office boxes, or rural routes.
Most of the time, this information is provided by geocoding software. Alternatively, a central registry staff member manually assigns the code. Codes are hierarchical, with lower numbers having priority.

LEVELS

Tumors

LENGTH

2

ALLOWABLE VALUES

00	Coordinates derived from local government-maintained address points, which are based on property parcel locations, not interpolation over a street segment's address range
01	Coordinates assigned by Global Positioning System (GPS)
02	Coordinates are match of house number and street, and based on property parcel location
03	Coordinates are match of house number and street, interpolated over the matching street segment's address range
04	Coordinates are street intersections
05	Coordinates are at mid-point of street segment (missing or invalid building number)
06	Coordinates are address ZIP code+4 centroid
07	Coordinates are address ZIP code+2 centroid
08	Coordinates were obtained manually by looking up a location on a paper or electronic map
09	Coordinates are address 5-digit ZIP code centroid
10	Coordinates are point ZIP code of Post Office Box or Rural Route
11	Coordinates are centroid of address city (when address ZIP code is unknown or invalid, and there are multiple ZIP codes for the city)
12	Coordinates are centroid of county
98	Latitude and longitude are assigned, but coordinate quality is unknown
99	Latitude and longitude are not assigned, but geocoding was attempted; unable to assign coordinates based on available information
Blank	Blank GIS Coordinate Quality not coded

SOURCE

None

UPDATE

Whenever Latitude and/or Longitude is changed, GIS Coordinate Quality must be changed accordingly:

1. If Latitude or Longitude is blank, then GIS Coordinate Quality must be set to blank.
2. If Latitude and Longitude are tracted, then GIS Coordinate Quality must have a value of 00-98.

CONSOLIDATED DATA EXTRACT

None

HISTORICAL CHANGES

2012	Data Changes: New data item added to V3 for 2012, NAACCR Version 12.2.

Gleason Patterns Clinical

IDENTIFIERS

CCR ID	NAACCR ID
E1951	3838

OWNER

NAACCR

DESCRIPTION

Prostate cancers are graded using Gleason score or pattern. This data item represents the Gleason primary and secondary patterns from needle core biopsy or TURP.

LEVELS

Admissions, Tumors

LENGTH

2

ALLOWABLE VALUES

11	Primary pattern 1, secondary pattern 1
12	Primary pattern 1, secondary pattern 2
13	Primary pattern 1, secondary pattern 3
14	Primary pattern 1, secondary pattern 4
15	Primary pattern 1, secondary pattern 5
19	Primary pattern 1, secondary pattern unknown
21	Primary pattern 2, secondary pattern 1
22	Primary pattern 2, secondary pattern 2
23	Primary pattern 2, secondary pattern 3
24	Primary pattern 2, secondary pattern 4
25	Primary pattern 2, secondary pattern 5
29	Primary pattern 2, secondary pattern unknown
31	Primary pattern 3, secondary pattern 1
32	Primary pattern 3, secondary pattern 2
33	Primary pattern 3, secondary pattern 3
34	Primary pattern 3, secondary pattern 4
35	Primary pattern 3, secondary pattern 5
39	Primary pattern 3, secondary pattern unknown
41	Primary pattern 4, secondary pattern 1
42	Primary pattern 4, secondary pattern 2
43	Primary pattern 4, secondary pattern 3
44	Primary pattern 4, secondary pattern 4
45	Primary pattern 4, secondary pattern 5
49	Primary pattern 4, secondary pattern unknown
51	Primary pattern 5, secondary pattern 1
52	Primary pattern 5, secondary pattern 2
53	Primary pattern 5, secondary pattern 3

54	Primary pattern 5, secondary pattern 4
55	Primary pattern 5, secondary pattern 5
59	Primary pattern 5, secondary pattern unknown
X6	Primary pattern unknown, secondary pattern unknown
X7	No needle core biopsy/TURP performed
X8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code X8 may result in an edit error.)
X9	Not documented in medical record Gleason Patterns Clinical not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
   A. If all of the following conditions are true:
      - Schema ID is 00580
      - Type of Reporting Source is not 7
      - Gleason Patterns Clinical is blank or X8

      Then convert Gleason Patterns Clinical to X9
   B. If all of the following conditions are true:
      - One of the following is true:
        - Schema ID is not 00580

        OR
        - Type of Reporting Source is 7
      - Gleason Patterns Clinical is not blank

      Then convert Gleason Patterns Clinical to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00580
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00580

One of the following conditions is true

- Admission's value is not blank, X9
- Tumor's value is blank, X9

  OR
  - Admission's value is X9
  - Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.
Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Gleason Patterns Pathological

IDENTIFIERS

CCR ID	NAACCR ID
E1952	3839

OWNER

NAACCR

DESCRIPTION

Prostate cancers are graded using Gleason score or pattern. This data item represents the Gleason primary and secondary patterns from prostatectomy or autopsy.

LEVELS

Admissions, Tumors

LENGTH

2

ALLOWABLE VALUES

11	Primary pattern 1, secondary pattern 1
12	Primary pattern 1, secondary pattern 2
13	Primary pattern 1, secondary pattern 3
14	Primary pattern 1, secondary pattern 4
15	Primary pattern 1, secondary pattern 5
19	Primary pattern 1, secondary pattern unknown
21	Primary pattern 2, secondary pattern 1
22	Primary pattern 2, secondary pattern 2
23	Primary pattern 2, secondary pattern 3
24	Primary pattern 2, secondary pattern 4
25	Primary pattern 2, secondary pattern 5
29	Primary pattern 2, secondary pattern unknown
31	Primary pattern 3, secondary pattern 1
32	Primary pattern 3, secondary pattern 2
33	Primary pattern 3, secondary pattern 3
34	Primary pattern 3, secondary pattern 4
35	Primary pattern 3, secondary pattern 5
39	Primary pattern 3, secondary pattern unknown
41	Primary pattern 4, secondary pattern 1
42	Primary pattern 4, secondary pattern 2
43	Primary pattern 4, secondary pattern 3
44	Primary pattern 4, secondary pattern 4
45	Primary pattern 4, secondary pattern 5
49	Primary pattern 4, secondary pattern unknown
51	Primary pattern 5, secondary pattern 1
52	Primary pattern 5, secondary pattern 2
53	Primary pattern 5, secondary pattern 3

54	Primary pattern 5, secondary pattern 4
55	Primary pattern 5, secondary pattern 5
59	Primary pattern 5, secondary pattern unknown
X6	Primary pattern unknown, secondary pattern unknown
X7	No prostatectomy/autopsy performed
X8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code X8 may result in an edit error.)
X9	Not documented in medical record Gleason Patterns Pathological not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
   A. If all of the following conditions are true:
      - Schema ID is 00580
      - Type of Reporting Source is not 7
      - Gleason Patterns Pathological is blank or X8

      Then convert Gleason Patterns Pathological to X9
   B. If all of the following conditions are true:
      - One of the following is true:
        - Schema ID is not 00580

        OR
        - Type of Reporting Source is 7
      - Gleason Patterns Pathological is not blank

      Then convert Gleason Patterns Pathological to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00580
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00580

One of the following conditions is true

- Admission's value is not blank, X9
- Tumor's value is blank, X9

  OR
  - Admission's value is X9
  - Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.
Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Gleason Score Clinical

IDENTIFIERS

CCR ID	NAACCR ID
E1953	3840

OWNER

NAACCR

DESCRIPTION

This data item records the Gleason score based on adding the values for primary and secondary patterns in Needle Core Biopsy or TURP.

LEVELS

Admissions, Tumors

LENGTH

2

ALLOWABLE VALUES

02	Gleason score 2
03	Gleason score 3
04	Gleason score 4
05	Gleason score 5
06	Gleason score 6
07	Gleason score 7
08	Gleason score 8
09	Gleason score 9
10	Gleason score 10
X7	No needle core biopsy/TURP performed
X8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code X8 may result in an edit error.)
X9	Not documented in medical record Gleason Score Clinical not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00580
        - Type of Reporting Source is not 7
        - COC Accredited Flag is 1
        - Gleason Score Clinical is blank or X8

        Then convert Gleason Score Clinical to X9

B. If all of the following conditions are true:
- One of the following is true:
  - Schema ID is not 00580
    OR
  - Type of Reporting Source is 7
- Gleason Score Clinical is not blank

Then convert Gleason Score Clinical to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:
- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00580
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00580

One of the following conditions is true
- Admission's value is not blank, X8, X9
- Tumor's value is blank, X8, X9

  OR
  - Admission's value is X9
  - Tumor's value is blank or X8

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Gleason Score Pathological

IDENTIFIERS

CCR ID	NAACCR ID
E1954	3841

OWNER

NAACCR

DESCRIPTION

This data item records the Gleason score based on adding the values for primary and secondary patterns from prostatectomy or autopsy.

LEVELS

Admissions, Tumors

LENGTH

2

ALLOWABLE VALUES

02	Gleason score 2
03	Gleason score 3
04	Gleason score 4
05	Gleason score 5
06	Gleason score 6
07	Gleason score 7
08	Gleason score 8
09	Gleason score 9
10	Gleason score 10
X7	No prostatectomy done
X8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code X8 may result in an edit error.)
X9	Not documented in medical record Gleason Score Pathological not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00580
        - Type of Reporting Source is not 7
        - COC Accredited Flag is 1
        - Gleason Score Clinical is blank or X8

        Then convert Gleason Score Pathological to X9

B. If all of the following conditions are true:
- One of the following is true:
  - Schema ID is not 00580
    OR
  - Type of Reporting Source is 7
- Gleason Score Pathological is not blank

Then convert Gleason Score Pathological to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:
- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00580
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00580

One of the following conditions is true
- Admission's value is not blank, X8, X9
- Tumor's value is blank, X8, X9
  OR
  - Admission's value is X9
  - Tumor's value is blank or X8

Then automatically update the Tumor's value with the Admission's value.
Otherwise,
If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Gleason Tertiary Pattern

IDENTIFIERS

CCR ID	NAACCR ID
E1955	3842

OWNER

NAACCR

DESCRIPTION

Prostate cancers are graded using Gleason score or pattern. This data item represents the tertiary pattern value from prostatectomy or autopsy.

LEVELS

Admissions, Tumors

LENGTH

2

ALLOWABLE VALUES

10	Tertiary pattern 1
20	Tertiary pattern 2
30	Tertiary pattern 3
40	Tertiary pattern 4
50	Tertiary pattern 5
X7	No prostatectomy/autopsy performed
X8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code X8 may result in an edit error.)
X9	Not documented in medical record Gleason Tertiary Pattern not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
   - A. If all of the following conditions are true:
     - Schema ID is 00580
     - Type of Reporting Source is not 7
     - COC Accredited Flag is 1
     - Gleason Tertiary Pattern is blank or X8

     Then convert Gleason Tertiary Pattern to X9
   - B. If all of the following conditions are true:
     - One of the following is true:
       - Schema ID is not 00580

         OR
       - Type of Reporting Source is 7

- Gleason Tertiary Pattern is not blank
  Then convert Gleason Tertiary Pattern to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00580
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00580

One of the following conditions is true

- Admission's value is not blank, X8, X9
- Tumor's value is blank, X8, X9
  OR
  - Admission's value is X9
  - Tumor's value is blank or X8

Then automatically update the Tumor's value with the Admission's value.
Otherwise,
If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Grade

IDENTIFIERS

CCR ID	NAACCR ID
E1063	440

OWNER

SEER/CoC

DESCRIPTION

Sixth digit of ICD-O, which designates the grade or differentiation of this tumor.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

1	Grade I or (well) differentiated
2	Grade II or moderately (well) differentiated
3	Grade III or poorly differentiated
4	Grade IV or undifferentiated/anaplastic
5	T-cell
6	B-cell
7	Null-cell
8	NK (Natural killer cell)
9	Grade and differentiation not stated
Blank	2018 and forward Date of Diagnosis

SOURCE

1. If Date of Diagnosis is 2018 and later, then blank out the field and stop here.
2. If Coding Procedure is less than 32
    A. Execute the same conversions from use case **Perform Eureka 2015 One-Time Data Conversions and Table Populations – UC**, step 10, for the new admission, including creation of manual review records if necessary.
    B. Execute the following conversion if the following are true:
        - Site is C619
        - Histologic Type ICD-O-3 is 8000-9136, 9141-9582, or 9700-9701
        - Behavior Code ICD-O-3 is not equal to 1 or 2

    Then check for the following conditions:
        - CS Site-Specific Factor 8 is 002-006:
            - And CS Site-Specific Factor 10 is 002-006, 998, or 999, then:
                - If Grade is not equal to 1, then set to 1

            And stop here.
            - Or if CS Site-Specific Factor 10 is 007, then:
                - If Grade is not equal to 2, then set to 2

            And stop here.
            - Or if CS Site-Specific Factor 10 is 008-010, then:

- If Grade is not equal to 3, then set to 3

And stop here.

- CS Site-Specific Factor 8 is 007:
  - And CS Site-Specific Factor 10 is 002-007, 998, or 999, then:
    - If Grade is not equal to 2, then set to 2

And stop here.

  - Or CS Site-Specific Factor 10 is 008-010, then:
    - If Grade is not equal to 3, then set to 3

And stop here.

- CS Site-Specific Factor 8 is 008-010:
  - And CS Site-Specific Factor 10 is 002-010, 998, or 999, then:
    - If Grade is not equal to 3, then set to 3

And stop here.

- CS Site-Specific Factor 8 is 998 or 999
  - And CS Site-Specific Factor 10 is 002-006, then:
    - If Grade is not equal to 1, then set to 1

And stop here.

  - Or CS Site-Specific Factor 10 is 007, then:
    - If Grade is not equal to 2, then set to 2

And stop here.

  - Or CS Site-Specific Factor 10 is 008-010, then:
    - If Grade is not equal to = 3, then set to 3

And stop here.

C. Execute the same type of procedure as described for the admission in use case 29.06 - Perform CS Recalculations after 2015 Data Changes Conversions - UC to attempt to generate a schema and recalculate CS if any of the input values were changed in the previous step. Create a review record if the schema generation or recalculation fail.

3. If the transmitted value is numeric, then just load it with no conversion.
4. Otherwise, convert it to 9.

Also see CS Version Derived

UPDATE

Tumor Level

New Case Consolidation for Date of Diagnosis less than 2018

If Admission level Grade = 5-8 and Tumor level Grade = 1-4, move Admission level Grade to Tumor level Grade.

If Admission level Grade = 1-8 and Tumor level Grade = 9, move AD to TU.

Else if Admission level Grade <> Tumor level Grade, list for review.

Manual Change

Admission Level

Manual Change Only

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

03/1997	Code 8 - NK (Natural killer cell) added to data set. Can be used for cases diagnosed 1/1/95 and forward.

07/2001	Interfield edit #333 changed to check DATE-DX and HIST-TYPE-2 and added edit #438 to check HIST-TYPE-3. Specified HIST-TYPE-3 in correction logic.
2010	Data Item Changes: CCR name (Hist_Grade) changed to NAACCR name. Added IF844.
05/11/11	Data Item Changes: IF #732 (CS SSF 5, SSF 6, Grade, Prostate Schema) deleted per NAACCR 12.1.
07/27/11	IF 367, 368 and 369 added for CER project. IF 380 and 381 were created to comply with NAACCR 12.1.A.
2015	Updated SOURCE logic to include 2015 conversions when Coding Procedure is less than 32. Note: Not implemented in Eureka yet.
01/2019	Per NAACCR v18, added step 1 in SOURCE LOGIC to blank out field when Year DX is 2018 and greater.

Grade Clinical

IDENTIFIERS

CCR ID	NAACCR ID
E1956	3843

OWNER

NAACCR

DESCRIPTION

This data item records the grade of a solid primary tumor before any treatment (surgical resection or initiation of any treatment including neoadjuvant).
For cases diagnosed January 1, 2018, and later, this data item, along with Grade Pathological and Grade Post-Neoadjuvant, replaces NAACCR Data Item Grade [NAACCR #440] as well as SSF's for cancer sites with alternative grading systems (e.g., breast [Bloom-Richardson], prostate [Gleason]).

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

Refer to the most recent version of the SSDI Manual for additional site-specific instructions.

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field.
2. If Date of Diagnosis is greater than 2018 convert blanks using Schema ID:
    A. 00060, 00080, 00090, 00100, 00111, 00112, 00119, 00121, 00128, 00130, 00131, 00132, 00133, 00140, 00150, 00161, 00169, 00170, 00180, 00190, 00200, 00210, 00220, 00230, 00241, 00242, 00250, 00260, 00270, 00278, 00280, 00288, 00290, 00301, 00302, 00310, 00320, 00330, 00340, 00350, 00358, 00360, 00370, 00378, 00381, 00382, 00383, 00410, 00421, 00422, 00430, 00440, 00450, 00458, 00460, 00470, 00478, 00480, 00500, 00510, 00520, 00530, 00541, 00542, 00551, 00552, 00553, 00559, 00560, 00570, 00580, 00590, 00598, 00600, 00610, 00620, 00631, 00633, 00638, 00640, 00650, 00660, 00671, 00672, 00680, 00690, 00698, 00700, 00710, 00718, 00721, 00722, 00723, 00730, 00740, 00750, 00760, 00770, 00778, 99999
        Convert to 9
    B. 00790, 00795, 00811, 00812, 00821, 00822, 00830
        Convert to 8

UPDATE

Tumor Level
    New Case Consolidation
        If all of these conditions are true:
        - Admission's Date of Diagnosis year is 2018 – 9998
        - Tumor's Date of Diagnosis year is 2018 – 9998
        - Admission's value is not blank
        - Tumor's value is blank

        Then automatically update the Tumor's value with the Admission's value.
        Otherwise,

If Admission's value is not the same as the Tumor's value
Then list for review
Manual Update
Admission
Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data item implemented.

Grade Path System

IDENTIFIERS

CCR ID	NAACCR ID
E1065	449

OWNER

CoC

DESCRIPTION

Indicates whether or two, three, or four grade system is used.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

2	Recorded as Grade II or 2
3	Recorded as Grade III or 3
4	Recorded as Grade IV or 4
Blank	No 2, 3, or 4 grade system available; unknown; not collected (Cases collected prior to NAACCR Version 12.)

SOURCE

Upload with no conversion.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

2010	New data item added for 2010 data changes. CSv1 to CSv2 Conversion Specs documentation states to leave these blank (see https://cancerstaging.org/cstage/software/Pages/Version-02.05.aspx). Added IF844.
04/2014	Per NAACCR v14, added "not collected" to the label for Grade Path System code of blank.

Grade Path Value

IDENTIFIERS

CCR ID	NAACCR ID
E1064	441

OWNER

CoC

DESCRIPTION

Describes the actual grade according to the grading system in Grade Path System. This data item records grade specified in Grade--Path System. It does not replace Grade.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

1	Recorded as Grade I or 1
2	Recorded as Grade II or 2
3	Recorded as Grade III or 3
4	Recorded as Grade IV or 4
Blank	No 2, 3, or 4 System Grade available; unknown; not collected (Cases collected prior to NAACCR Version 12.)

SOURCE

Upload with no conversion

UPDATE

See Grade Path System

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

2010	New data item added for 2010 data changes. CSv1 to CSv2 Conversion Specs documentation states to leave these blank (see https://cancerstaging.org/cstage/software/Pages/Version-02.05.aspx). Added IF844.
04/2014	Per NAACCR v14, added "not collected" to the label for Grade Path Value of blank.

Grade Pathological

IDENTIFIERS

CCR ID	NAACCR ID
E1957	3844

OWNER

NAACCR

DESCRIPTION

This data item records the grade of a solid primary tumor that has been resected and for which no neoadjuvant therapy was administered. If AJCC staging is being assigned, the tumor must have met the surgical resection requirements in the AJCC manual. This may include the grade from the clinical workup. Record the highest grade documented from any microscopic specimen of the primary site whether from the clinical workup or the surgical resection.

For cases diagnosed January 1, 2018, and later, this data item, along with Grade Clinical and Grade Post-Neoadjuvant, replaces NAACCR Data Item Grade [NAACCR #440] as well as SSF's for cancer sites with alternative grading systems (e.g., breast [Bloom-Richardson], prostate [Gleason]).

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

Refer to the most recent version of the SSDI Manual for additional site-specific instructions.

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field.
2. If Date of Diagnosis is greater than 2018 convert blanks using Schema ID:
   A. 00060, 00080, 00090, 00100, 00111, 00112, 00119, 00121, 00128, 00130, 00131, 00132, 00133, 00140, 00150, 00161, 00169, 00170, 00180, 00190, 00200, 00210, 00220, 00230, 00241, 00242, 00250, 00260, 00270, 00278, 00280, 00288, 00290, 00301, 00302, 00310, 00320, 00330, 00340, 00350, 00358, 00360, 00370, 00378, 00381, 00382, 00383, 00410, 00421, 00422, 00430, 00440, 00450, 00458, 00460, 00470, 00478, 00480, 00500, 00510, 00520, 00530, 00541, 00542, 00551, 00552, 00553, 00559, 00560, 00570, 00580, 00590, 00598, 00600, 00610, 00620, 00631, 00633, 00638, 00640, 00650, 00660, 00671, 00672, 00680, 00690, 00698, 00700, 00710, 00718, 00721, 00722, 00723, 00730, 00740, 00750, 00760, 00770, 00778, 99999
      Convert to 9
   B. 00790, 00795, 00811, 00812, 00821, 00822, 00830
      Convert to 8

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Tumor's Date of Diagnosis year is 2018 – 9998
- Admission's value is not blank

- Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.
Otherwise,
If Admission's value is not the same as the Tumor's value
Then list for review
Manual Update
Admission
Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data item implemented.

Grade Post Therapy

IDENTIFIERS

CCR ID	NAACCR ID
E1958	3845

OWNER

NAACCR

DESCRIPTION

This data item records the grade of a solid primary tumor that has been resected and for which no neoadjuvant therapy was administered. If AJCC staging is being assigned, the tumor must have met the surgical resection requirements in the AJCC manual. This may include the grade from the clinical workup. Record the highest grade documented from any microscopic specimen of the primary site whether from the clinical workup or the surgical resection.

For cases diagnosed January 1, 2018, and later, this data item, along with Grade Clinical and Grade Post-Neoadjuvant, replaces NAACCR Data Item Grade [NAACCR #440] as well as SSF's for cancer sites with alternative grading systems (e.g., breast [Bloom-Richardson], prostate [Gleason]).

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

Refer to the most recent version of the SSDI Manual for additional site-specific instructions.

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field.
2. If Date of Diagnosis is greater than 2018 then upload with no conversions.

UPDATE

TUMOR LEVEL

NEW CASE CONSOLIDATION

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Tumor's Date of Diagnosis year is 2018 – 9998
- Admission's value is not blank
- Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

ADMISSION

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data item implemented.

Granulocyte CSF Status

IDENTIFIERS

CCR ID	NAACCR ID
E1513	9880

DESCRIPTION

This data item has been retired. This page has been retained for historical purposes only and this data item should not be populated in any cases diagnosed 2013 or later or coded under the NAACCR v13 or later coding standards.
Codes Granulocyte-Growth Factors/Cytokines (G-CSF) agents used during the twelve months after diagnosis.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

0	No G-CSF treatment given
1	G-CSF treatment was given
7	G-CSF treatment prescribed – patient, patient's family member, or patient's guardian refused
8	G-CSF treatment prescribed, unknown if administered
9	Unknown if G-CSF therapy given
Blank	A blank is allowed for cases • Diagnosed prior to 2011 • Diagnose date 2011 and not a Region 3 resident • Region 3 resident and sites other than Breast, Colorectal, and CML

SOURCE

No longer uploaded

UPDATE

None

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

2011 Data Item Changes, CER Project	Added for CER requirements.
05/2013	Retired at the conclusion of data collection for the CER project

HCG Post-Orchiectomy Lab Value

IDENTIFIERS

CCR ID	NAACCR ID
E1959	3846

OWNER

NAACCR

DESCRIPTION

hCG (Human Chorionic Gonadotropin) Post-orchiectomy Lab Value refers to the lowest hCG value measured post-orchiectomy. hCG is a serum tumor marker that is often elevated in patients with nonseminomatous germ cell tumors of the testis. The Post-Orchiectomy lab value is used to monitor response to therapy.

LEVELS

Admissions, Tumors

LENGTH

5

ALLOWABLE VALUES

0.0	0.0 milli-International Units/milliliter (mIU/mL)
0.1-99999.9	0.1–99,999.9 mIU/mL
XXXXX.1	100,000 mIU/mL or greater
XXXXX.7	Test ordered, results not in chart
XXXXX.8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code XXXXX.8 may result in an edit error.)
XXXXX.9	Not documented in medical record No orchiectomy performed hCG (Human Chorionic Gonadotropin) Post-orchiectomy Lab Value not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00590
        - Type of Reporting Source is not 7
        - COC Accredited Flag is 1
        - hCG Post-Orchiectomy Lab Value is blank or XXXXX.8

        Then convert hCG Post-Orchiectomy Lab Value to XXXXX.9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00590

OR

- Type of Reporting Source is 7

- hCG Post-Orchiectomy Lab Value is not blank

Then convert hCG Post-Orchiectomy Lab Value to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00590
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00590

One of the following conditions is true

- Admission's value is not blank, XXXXX.8, or XXXXX.9
- Tumor's value is blank , XXXXX.8, or XXXXX.9

OR

- Admission's value is XXXXX.9
- Tumor's value is blank or XXXXX.8

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

HCG Pre-Orchiectomy Lab Value

IDENTIFIERS

CCR ID	NAACCR ID
E1961	3848

OWNER

NAACCR

DESCRIPTION

hCG (Human Chorionic Gonadotropin) Pre-orchiectomy Lab Value refers to the hCG value measured prior to treatment. hCG is a serum tumor marker that is often elevated in patients with nonseminomatous germ cell tumors of the testis.

LEVELS

Admissions, Tumors

LENGTH

7

ALLOWABLE VALUES

0.0	0.0 milli-International Units/milliliter (mIU/mL)
0.1-99999.9	0.1–99,999.9 mIU/mL
XXXXX.1	100,000 mIU/mL or greater
XXXXX.7	Test ordered, results not in chart
XXXXX.8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code XXXXX.8 may result in an edit error.)
XXXXX.9	Not documented in medical record hCG (Human Chorionic Gonadotropin) Pre-orchiectomy Lab Value not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
   A. If all of the following conditions are true:
      - Schema ID is 00590
      - Type of Reporting Source is not 7
      - COC Accredited Flag is 1
      - hCG Pre-Orchiectomy Lab Value is blank or XXXXX.8

      Then convert hCG Pre-Orchiectomy Lab Value to XXXXX.9
   B. If all of the following conditions are true:
      - One of the following is true:
        - Schema ID is not 00590

          OR
        - Type of Reporting Source is 7

- hCG Pre-Orchiectomy Lab Value is not blank
  Then convert hCG Pre-Orchiectomy Lab Value to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00590
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00590

One of the following conditions is true

- Admission's value is not blank, XXXXX.8, or XXXXX.9
- Tumor's value is blank , XXXXX.8, or XXXXX.9

  OR

  - Admission's value is XXXXX.9
  - Tumor's value is blank or XXXXX.8

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

HCG Pre-Orchiectomy Range

IDENTIFIERS

CCR ID	NAACCR ID
E1962	3849

OWNER

NAACCR

DESCRIPTION

Human Chorionic Gonadotropin (hCG) Pre-orchiectomy Range identifies the range category of the highest hCG value measured prior to treatment. hCG is a serum tumor marker that is often elevated in patients with nonseminomatous germ cell tumors of the testis.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	Within normal limits
1	Above normal and less than 5,000 milli-International Units/milliliter (mIU/mL)
2	5,000 - 50,000 mIU/mL
3	Greater than 50,000 mIU/mL
4	Pre-orchiectomy human chorionic gonadotropin (hCG) stated to be elevated
7	Test ordered, results not in chart
8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code 8 may result in an edit error.)
9	Not documented in medical record hCG pre-orchiectomy range not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
   - A. If all of the following conditions are true:
     - Schema ID is 00590
     - Type of Reporting Source is not 7
     - hCG Pre-Orchiectomy Range is blank or 8

     Then convert hCG Pre-Orchiectomy Range to 9
   - B. If all of the following conditions are true:
     - One of the following is true:
       - Schema ID is not 00590

         OR
       - Type of Reporting Source is 7

- hCG Pre-Orchiectomy Range is not blank
  Then convert hCG Pre-Orchiectomy Range to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00590
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00590

One of the following conditions is true

- Admission's value is not blank, 9
- Tumor's value is blank, 9

  OR

  - Admission's value is 9
  - Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.
Otherwise,
If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Height

IDENTIFIERS

CCR ID	NAACCR ID
E1263	9960

OWNER

NPCR

DESCRIPTION

The height of the patient on or near the time of diagnosis.

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

Height (in inches) must be a 2-digit number in the range of 00-99 or blank.
Blanks are not allowed for cases diagnosed 2011 and forward.
Code the height in inches (two digits).
Code 98 for height of 98 inches or greater.
Code 99 for unknown height.

SOURCE

If the value is completely blank, then convert 99; if the value includes a non-blank, non-numeric character, then convert 99; otherwise, just load the transmitted value, but right-justify and zero fill.

UPDATE

Tumor Level

New Case Consolidation

If Tumor.Value is blank and Admission.Value is not blank, then copy Admission.Value to Tumor.Value.

If Tumor.Value is not blank and Admission.Value is blank, then do nothing.

If Tumor.Value is equal to Admission.Value, then do nothing.

If Tumor.Value is not blank and Admission.Value is not blank, and Tumor.Value does not equal Admission.Value, then list for review.

Manual Change Admission Level

Manual Change

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

2011 Data Item Changes, CER Project	Added for CER requirements.
05/2013	This data item is now required by NPCR for Date of Diagnosis 2013 and forward. We are still required to submit the values as part of the CER dataset.

12/2013	Allowable values revised per NPCR. Required for Date of Diagnosis 2011 and forward for all Regions. Global fix performed to change blanks to 99 for Date of Diagnosis 2011 forward.

HER2 IHC Summary

IDENTIFIERS

CCR ID	NAACCR ID
E1963	3850

OWNER

NAACCR

DESCRIPTION

HER2 IHC Summary is the summary score for HER2 testing by IHC.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	Negative (Score 0)
1	Negative (Score 1+)
2	Equivocal (Score 2+) Stated as equivocal
3	Positive (Score 3+) Stated as positive
4	Stated as negative, but score not stated
7	Test ordered, results not in chart
8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code 8 will result in an edit error.)
9	Not documented in medical record Cannot be determined (indeterminate) HER2 IHC Summary not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00480
        - Type of Reporting Source is not 7
        - HER2 IHC Summary is blank or 8

        Then convert HER2 IHC Summary to 9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00480

              OR
            - Type of Reporting Source is 7

- HER2 IHC Summary is not blank

  Then convert HER2 IHC Summary to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00480
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00480

One of the following conditions is true

- Admission's value is not blank or 9
- Tumor's value is blank or 9

  OR

  - Admission's value is 9
  - Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

HER2 ISH Dual Probe Copy Number

IDENTIFIERS

CCR ID	NAACCR ID
E1964	3851

OWNER

NAACCR

DESCRIPTION

HER2 in situ hybridization (ISH) Dual Probe Copy Number is the HER2 copy number based on a dual probe test.

LEVELS

Admissions, Tumors

LENGTH

4

ALLOWABLE VALUES

0.0-99.9	Reported HER2 copy number of 0.0-99.9
XX.1	Reported HER2 copy number of 100 or greater
XX.7	Test ordered, results not in chart
XX.8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code XX.8 will result in an edit error.)
XX.9	Not documented in medical record Cannot be determined (indeterminate) HER2 ISH Dual Probe Copy Number not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Type of Reporting Source is not 7
        - Schema ID is 00480
        - HER2 ISH Dual Probe Copy Number is blank or XX.8

        Then convert HER2 ISH Dual Probe Copy Number to XX.9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00480

              OR
            - Type of Reporting Source is 7
        - HER2 ISH Dual Probe Copy Number is not blank

        Then convert HER2 ISH Dual Probe Copy Number to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00480
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00480

One of the following conditions is true

- Admission's value is not blank or XX.9
- Tumor's value is blank or XX.9

OR

- Admission's value is XX.9
- Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

HER2 ISH Dual Probe Ratio

IDENTIFIERS

CCR ID	NAACCR ID
E1965	3852

DESCRIPTION

HER2 in situ hybridization (ISH) Dual Probe Ratio is the summary score for HER2 testing using a dual probe. The test will report results for both HER2 and CEP17, the latter used as a control. The HER2/CEP17 ratio is reported.

LEVELS

Admissions, Tumors

LENGTH

4

ALLOWABLE VALUES

0.0-99.9	Ratio of 0.0 to 99.9
XX.2	Less than 2.0
XX.3	Greater than or equal to 2.0
XX.7	Test ordered, results not in chart
XX.8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code XX.8 will result in an edit error.)
XX.9	Not documented in medical record Results cannot be determined (indeterminate) HER2 ISH Dual Probe Ratio not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00480
        - Type of Reporting Source is not 7
        - HER2 ISH Dual Probe Ratio is blank or XX.8

        Then convert HER2 ISH Dual Probe Ratio to XX.9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00480

              OR
            - Type of Reporting Source is 7
        - HER2 ISH Dual Probe Ratio is not blank

        Then convert HER2 ISH Dual Probe Ratio to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00480
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00480

One of the following conditions is true

- Admission's value is not blank or XX.9
- Tumor's value is blank or XX.9

OR

- Admission's value is XX.9
- Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

HER2 ISH Single Probe Copy Number

IDENTIFIERS

CCR ID	NAACCR ID
E1966	3853

OWNER

NAACCR

DESCRIPTION

HER2 in situ hybridization (ISH) Single Probe Copy Number is the HER2 copy number based on a single probe test.

LEVELS

Admissions, Tumors

LENGTH

4

ALLOWABLE VALUES

0.0-99.9	Reported HER2 copy number of 0.0-99.9
XX.1	Reported HER2 copy number of 100 or greater
XX.7	Test ordered, results not in chart
XX.8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code XX.8 will result in an edit error.)
XX.9	Not documented in medical record Cannot be determined (indeterminate) HER2 ISH Single Probe Copy Number not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00480
        - Type of Reporting Source is not 7
        - HER2 ISH Single Probe Copy Number is blank or XX.8

        Then convert HER2 ISH Single Probe Copy Number to XX.9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00480

              OR
            - Type of Reporting Source is 7
        - HER2 ISH Single Probe Copy Number is not blank

        Then convert HER2 ISH Single Probe Copy Number to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00480
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00480

One of the following conditions is true

- Admission's value is not blank or XX.9
- Tumor's value is blank or XX.9

OR

- Admission's value is XX.9
- Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

HER2 ISH Summary

IDENTIFIERS

CCR ID	NAACCR ID
E1967	3854

OWNER

NAACCR

DESCRIPTION

HER2 in situ hybridization (ISH) Summary is the summary score for results of testing for ERBB2 gene copy number by any ISH method. An immunohistochemistry (IHC) test identifies the protein expressed by the gene (ERBB2), and an ISH test identifies the number of copies of the gene (ERBB2) itself.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	Negative [not amplified]
2	Equivocal
3	Positive [amplified]
7	Test ordered, results not in chart
8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code 8 will result in an edit error.)
9	Not documented in medical record Cannot be determined (indeterminate) HER2 Overall Summary status not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00480
        - Type of Reporting Source is not 7
        - HER2 ISH Summary is blank or 8

        Then convert HER2 ISH Summary to 9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00480

              OR
            - Type of Reporting Source is 7
        - HER2 ISH Summary is not blank

        Then convert HER2 ISH Summary to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00480
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00480

One of the following conditions is true

- Admission's value is not blank or 9
- Tumor's value is blank or 9

OR

- Admission's value is 9
- Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

HER2 Overall Summary

IDENTIFIERS

CCR ID	NAACCR ID
E1968	3855

OWNER

NAACCR

DESCRIPTION

HER2 Overall Summary is a summary of results from HER2 testing.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	HER2 negative; equivocal
1	HER2 positive
7	Test ordered, results not in chart
9	Not documented in medical record Cannot be determined (indeterminate) HER2 Overall Summary status not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
   - A. If all of the following conditions are true:
     - Schema ID is 00480
     - Type of Reporting Source is not 7
     - HER2 Overall Summary is blank

     Then convert HER2 Overall Summary to 9
   - B. If all of the following conditions are true:
     - One of the following is true:
       - Schema ID is not 00480

         OR
       - Type of Reporting Source is 7
     - HER2 Overall Summary is not blank

     Then convert HER2 Overall Summary to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998

- Admission's Schema ID is 00480
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00480

One of the following conditions is true

- Admission's value is not blank or 9
- Tumor's value is blank or 9

OR

- Admission's value is 9
- Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.
Otherwise,
If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Heritable Trait

IDENTIFIERS

CCR ID	NAACCR ID
E1969	3856

OWNER

NAACCR

DESCRIPTION

1 Heritable trait pertains to evidence that a tumor is associated with a heritable mutation. In retinoblastoma, the heritable trait is a germline mutation in the RB1 gene, which is associated with bilateral disease, family history of retinoblastoma, presence of concomitant CNS midline embryonic tumor (commonly in pineal region), or retinoblastoma with an intracranial primitive neuroectodermal tumor (i.e., trilateral retinoblastoma). Children with any of these features may be assigned the H1 status without molecular testing. High quality molecular testing for RB1 mutation is required to determine the presence or absence of RB1 mutation for children without clinical features of a heritable mutation.
Heritable trait is required for prognostic stage grouping in AJCC 8th edition, Chapter 68 Retinoblastoma. It is a new data item for cases diagnosed 1/1/2018+.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	H0: Normal RB1 alleles No clinical evidence of mutation
1	H1: RB1 gene mutation OR Clinical evidence of mutation
7	Test ordered, results not in chart
9	HX: Not documented in medical record Test not done, or unknown if done Insufficient evidence of a constitutional RB1 gene mutation
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00680
        - Type of Reporting Source is not 7
        - Heritable Trait is blank

        Then convert Heritable Trait to 9
    B. If all of the following conditions are true:
        - One of the following is true:

- Schema ID is not 00680
  OR
- Type of Reporting Source is 7

- Heritable Trait is not blank

Then convert Heritable Trait to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00680
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00680

One of the following conditions is true

- Admission's value is not blank, 9
- Tumor's value is blank, 9
  OR
  - Admission's value is 9
  - Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.
Otherwise,
If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

High Risk Cytogenetics

IDENTIFIERS

CCR ID	NAACCR ID
E1970	3857

OWNER

NAACCR

DESCRIPTION

High Risk Cytogenetics is defined as one or more of t(4;14), t(1416), or del 17p identified from FISH test results and is part of the staging criteria for plasma cell myeloma.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	High-risk cytogenetics not identified/not present
1	High-risk cytogenetics present
7	Test ordered, results not in chart
9	Not documented in medical record High Risk Cytogenetics not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00821
        - Type of Reporting Source is not 7
        - Schema Discriminator 1 = 0
        - High Risk Cytogenetics is blank

        Then convert High Risk Cytogenetics to 9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00821

              OR
            - Schema ID is 00821
            - Schema Discriminator is 1 or 9

              OR
            - Type of Reporting Source is 7
        - High Risk Cytogenetics is not blank

        Then convert High Risk Cytogenetics to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00821
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00821

One of the following conditions is true

- Admission's value is not blank, 9
- Tumor's value is 9

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

High Risk Histologic Features

IDENTIFIERS

CCR ID	NAACCR ID
E1971	3858

OWNER

NAACCR

DESCRIPTION

High Risk Histologic Features are defined in AJCC 8 Chapter 15 to include the terms "poor differentiation, desmoplasia, sarcomatoid differentiation, undifferentiated." High risk histologic features are a prognostic factor for cutaneous squamous cell carcinomas of the head and neck.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	No high-risk histologic features
1	Desmoplasia
2	Poor differentiation (grade 3)
3	Sarcomatoid differentiation
4	Undifferentiated (grade 4)
5	Multiple high-risk histologic features
6	Histologic features, NOS (type of high-risk histologic feature not specified)
8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code 8 may result in an edit error)
9	Not documented in medical record High risk histologic features not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00150
        - Type of Reporting Source is not 7
        - High Risk Histologic Features is blank or 8

        Then convert High Risk Histologic Features to 9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00150

            OR

- Type of Reporting Source is 7
- High Risk Histologic Features is not blank

Then convert High Risk Histologic Features to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00150
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00150

One of the following conditions is true

- Admission's value is not blank, 9
- Tumor's value is blank, 9

OR

- Admission's value is 9
- Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Histology (92-00) ICD-O-2

IDENTIFIERS

CCR ID	NAACCR-ID
E1058	420

DESCRIPTION

First four digits of the morphology code in ICDO-2, - 1990.

LEVELS

Tumors, Admissions

LENGTH

4

ALLOWABLE VALUES

8000-9989	Entire range is not used; see Appendix #9-ID
Blank	ICDO-3 case, diagnosed in 2001 or later.

SOURCE

Upload with no conversion.

UPDATE

Tumor

New Case Consolidation

If the admission's Histology (92-00) ICD-O-2 code is not the same as the tumor's Histology (92-00) ICD-O-2 code, then list for review

Manual Change (see Histologic Type ICD-O-3)

Admission

Manual Change or Correction applied (see Histologic Type ICD-O-3)

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

1/98	New ICDO-2 histology codes added for leukemia.
1/99	Changed EOD-related interfield edit 656 to be conditional on DATE-DX.
5/01	Modified Edit 2) to pertain to Region 1/8 only.
7/01	Changed to alphanumeric type (X); added Blank as an allowable value for cases initially coded in ICDO-3; removed edits that merely reference histology fields since the same edits now exist for ICDO-3 and provide the same functionality.
11/02	Added IF #447.
3/03	Vendor software # in Source changed to F02501.
2010	Data Changes: CCR name (Hist_Type_2) changed to NAACCR name. Update logic rewritten.
2/24/11	Removed IF 334 to match deletion in the metafile.

Histologic Type ICD-O-3

IDENTIFIERS

CCR ID	NAACCR ID
E1061	522

OWNER

SEER/CoC

DESCRIPTION

First four digits of the morphology code in ICD-O-3, 2000.

LEVELS

Tumors, Admissions

LENGTH

4

ALLOWABLE VALUES

8000-9992 (entire range is not used)

SOURCE

If Coding Procedure is less than 32, then

1. Execute the same conversions from use case ***Perform Eureka 2015 One-Time Data Conversions and Table Populations – UC***, step 10, for the new admission, including creation of manual review records if necessary
2. Execute the same type of procedure as described for the admission in use case ***29.06 - Perform CS Recalculations after 2015 Data Changes Conversions - UC*** to attempt to generate a schema and recalculate CS if any of the input values were changed in the previous step. Create a review record if the schema generation or recalculation fail.

Also see Behavior Code ICD-O-3

UPDATE

Tumor Level

New Case Consolidation

If the admission's Histologic Type ICD-O-3 code is not the same as the tumor's Histologic Type ICD-O-3 code, then List for Review

Manual Change to Histology (92-00) ICD-O-2 or Behavior (92-00) ICD-O-2

If all of the following conditions are true:

Date of Diagnosis year is earlier* than 2001, and

Histology (92-00) ICD-O-2 and/or Behavior (92-00) ICD-O-2 were changed

Then perform the procedure described in Appendix 29 - Histology ICDO-3 Conversion Specifications and auto-update with the resulting Histologic Type ICD-O-3 value.

Manual Change

Admission Level

Manual Change or Correction Applied to Histology (92-00) ICD-O-2 or Behavior (92-00) ICD-O-2

Same as requirement for Tumor Level

Manual Change or Correction Applied

* With year, month, and/or day potentially blank, a date with a partial but later date could appear to be earlier because it is a smaller number than a full earlier date. Thus, to test for the earliest among known (partial or full) dates, use these tests in this order:

- If one of the known dates' years is earlier than (less than) the other known date's year or if it is the only known year/date, then that date is the earliest known date
- If multiple known dates have the same earliest year, but only one of them has an earliest known month, then that is the earliest known date
- If multiple known dates have the same earliest year & month, but only one of them has an earliest known day, then that is the earliest known date

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

05/2001	New field added to collect ICD-O-3 histology.
07/2001	Changed type to alphanumeric (X); changed edit 2) to check DATE-DX, added edit 3), changed interfield and interrecord edits to handle ICDO-3.
03/2003	Removed Region 1/8 and Region 9 specific logic in Interfield edit 6). C/N # under Source changed to F02502.
07/2005	Updated Err#656 to match SEER edit IF130 histology ranges & to exclude mycosis fungoides.
2010	CCR name (Hist_Type_3) changed to NAACCR name. Allowable values range is changed from 9989 to 9992. Added IF #789, 825, 838, 871, 878, 958, 959, 960, 961, 962, 963, 964, 967, 977, 978, 983, 985, 986, 987, and 988.
2011	Removed IF437 to match the deletion in the metafile. Added IF 380, 38.
05/2013	Added IF 1005, 1006, 1007, 1008, 1009, 1010, 1011, 1012, 1013, 1014, 1015, 1016, 1017, 1018, 1019, 1020, 1021, 1022, 1023, 1024, 1025, 1026, 1027, 1028, 1029, 1030, 1031, 1032, 1033, 1034, 1035, 1036, 1037, 1038, 1039, 1040, 1041, 1042, 1047, 1051, 1052, 1053, 1054, 1055, 1056, 1057, 1058, 1059, 1060, 1061, 1062, 1063, 1065, 1066, 1067, 1068, 1069, 1070.
03/2015	Changed source section to perform 2015 heme conversions and recalculate CS upon upload as necessary if coding procedure is less than 32.

HIV Status

IDENTIFIERS

CCR ID	NAACCR ID
E1972	3859

OWNER

NAACCR

DESCRIPTION

HIV status refers to infection with the Human Immunodeficiency Virus which causes Acquired Immune Deficiency Syndrome (AIDS). AIDS is associated with increased risk of developing some lymphomas.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	Not associated with Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome(AIDS) HIV negative
1	Associated with HIV/AIDS HIV positive
7	Test ordered, results not in chart
8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code 8 will result in an edit error.)
9	Not documented in medical record HIV status not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
   A. If all of the following conditions are true:
      - Schema ID is 00790 or 00795
      - Type of Reporting Source is not 7
      - HIV Status is blank or 8

      Then convert HIV Status to 9
   B. If all of the following conditions are true:
      - One of the following is true:
        - Schema ID is numeric and not 00790, 00795

          OR
        - Type of Reporting Source is 7
      - HIV Status is not blank

      Then convert HIV Status to blank
   C. Otherwise, upload the abstracted value.

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00790 or 00795
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00790 or 00795

One of the following conditions is true

- Admission's value is not blank, 9
- Tumor's value is blank, 9

  OR

  - Admission's value is 9
  - Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.
Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.
02/2020	Source Logic Update

Hormone 1-2 NSC Number

IDENTIFIERS

Data Item	CCR	NAACCR
Hormone 1 NSC Number	E1509	9861
Hormone 2 NSC Number	E1510	9862

DESCRIPTION

These data items have been retired. This page has been retained for historical purposes only and these data items should not be populated in any cases diagnosed 2013 or later or coded under the NAACCR v13 or later coding standards.
NSC number for the first hormonal agent administered as all or part of the first course of treatment at any facility.

LEVELS

Tumors, Admissions

LENGTH

6

ALLOWABLE VALUES

000000	NSC code (enter the actual code)
######	Hormonal therapy was not planned to be administered or no additional hormonal therapy agents were planned
999998	Hormone therapy was planned, but the agent NSC code is unknown; the code "999998" is a temporary code that registries should use while they contact ICF Macro to obtain a permanent code to enter for agents that do not have SEER*Rx-assigned NSC codes
999999	Unknown if hormonal therapy was planned
Blank	A blank is allowed for cases • Diagnosed prior to 2011 • Diagnose date 2011 and not a Region 3 resident • Region 3 resident and sites other than Breast, Colorectal, and CML

SOURCE

No longer uploaded

UPDATE

None

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

2011 Data Item Changes, CER Project	Added for CER requirements.
05/2013	Retired at the conclusion of data collection for the CER project

Hosp Pat No

IDENTIFIERS

CCR ID	NAACCR ID
E1743	None. State Requestor

DESCRIPTION

This number uniquely identifies a patient at the hospital level, whether from a single hospital or a cluster of hospitals. All hospital registries must assign a unique and unchanging hospital Patient number for each patient. This number must be separate from the accession number, and the patient number should be identical for all tumors for that patient. (In the case of multiple tumors, this patient number should be reported for each case.) This number should never be changed or reused, even if the original patient to whom the number is assigned is subsequently deleted. Registry systems that service a cluster of hospitals must use a common Hospital Patient number that is unique within that cluster of hospitals as well as within each participating hospital.

LEVELS

Admissions

LENGTH

12

ALLOWABLE VALUES

Alpha and/or numeric only. 9s if unknown

SOURCE

If necessary (if the field does not contain 12 digits), right-justify and zero-fill; set to all 9's if blank.
Note: Eureka is not using the standard NAACCR Patient System ID--Hosp 8-character field for this because of the length.
Hosp Pat No (CCR-ID E1743), which is a 12-character field, exists only so that Eureka can access the field Hosp Pat No and paste its value into the edit buffer in the metafile.

UPDATE

Manual

CONSOLIDATED DATA EXTRACT

Yes, from the hospital performing the most extensive cancer-directed surgery. If no cancer-directed surgery was performed, then consider Class_Of_Case using the following hierarchy: 1, 2, 0, 3, or higher.

HISTORICAL CHANGES

2/01/06	Updated Source text to clarify where this value originates.

Hosp Surg Prim First

IDENTIFIERS

CCR ID	NAACCR ID
E1622	None: State Requestor

OWNER

CCR

DESCRIPTION

Unique ten-digit number assigned by CCR to hospital or other facility that performed the first/earliest surgery.

LEVELS

Tumor

LENGTH

10

ALLOWABLE VALUES

Valid hospital code numbers see CA Hosp Codes, except that the following codes are not allowed in this field:

0000000000, 0000999993, 0000999997, 0000999998 and 0000999999.

In addition, these special codes are referred to in many other places in this document and are defined here for ease of reference.

0000000801	DC ONLY
0000000802	CORONER
0000000803	MD
0000000804	CONV. HOSPITAL
0000999990	HOSPICE
0000999991	HOME HEALTH
0000999992	SKILLED NURSING FACILITY
0000999993	STAFF PHYSICIAN
0000999994	UNSPEC NONCAL HOSP
0000999995	NON-HOSPITAL NOS
0000999996	PHYSICIAN ONLY
0000999997	UNSPEC BAY AREA H
0000999998	UNSPEC CALIF HOSP
0000999999	UNKNOWN HOSP

Blank = no surgery was performed.

SOURCE

See update

UPDATE

Generate from all related admissions' surgical procedures according to Business Rules Requirements: Surgery Consolidation Rules document. The business rules may require manual review.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

08/2006	New data item per CCR research group request. An Allowable Values edit was added because visual editors can change the data item value on the consolidation screen.
01/2007	Changed name from Hosp First Surg to Hosp Surg Prim First.

Hosp Surg Prim Sum

IDENTIFIERS

CCR ID	NAACCR ID
E1623	None: State Requestor

OWNER

CCR

DESCRIPTION

Unique ten-digit number assigned by CCR to hospital or other facility that performed the most definitive surgery.

LEVELS

Tumor

LENGTH

10

ALLOWABLE VALUES

Valid hospital code numbers see CA Hosp Codes, except that the following codes are not allowed in this field:

0000000000, 0000999993, 0000999997, 0000999998 and 0000999999.

In addition, these special codes are referred to in many other places in this document and are defined here for ease of reference.

0000000801	DC ONLY
0000000802	CORONER
0000000803	MD
0000000804	CONV. HOSPITAL
0000999990	HOSPICE
0000999991	HOME HEALTH
0000999992	SKILLED NURSING FACILITY
0000999993	STAFF PHYSICIAN
0000999994	UNSPEC NONCAL HOSP
0000999995	NON-HOSPITAL NOS
0000999996	PHYSICIAN ONLY
0000999997	UNSPEC BAY AREA H
0000999998	UNSPEC CALIF HOSP
0000999999	UNKNOWN HOSP
Blank = no surgery was performed.	

SOURCE

See update

UPDATE

Generate from all related admissions' surgical procedures according to Business Rules Requirements: Surgery Consolidation Rules document. The business rules may require manual review.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

08/15/06	New data item per CCR research group request. An Allowable Values edit was added because visual editors can change the data item value on the consolidation screen.
01/08/07	Changed name from Hosp Def Surg to Hosp Surg Prim Sum.

Hospital Tumor Number CCR

IDENTIFIERS

CCR ID	NAACCR ID
E1571	None. State Requestor

DESCRIPTION

Sequential number assigned to each tumor entered into a hospital database for the patient. This number should never change, even if other tumor records are added or deleted for the same patient. It will be used by the regional registry to identify corrections, deletions, or follow-up to that particular tumor record and it will be supplied to the hospital by the regional registry in the New Case Reply and Shared Follow-up records for hospital use in apply these records.

LEVELS

Admissions

LENGTH

2

ALLOWABLE VALUES

01-99

SOURCE

Upload with no conversion.

UPDATE

Manual

CONSOLIDATED DATA EXTRACT

Yes, with each hospital record (or earliest admission while sending one admission per tumor).

HISTORICAL CHANGES

	None

ICD Revision Comorbid

IDENTIFIERS

CCR ID	NAACCR ID
E1252	3165

OWNER

CoC

DESCRIPTION

This item indicates the coding system in which the Comorbidities and Complications (secondary diagnoses) codes are provided.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

ICD-10-CM codes are only allowed in cases diagnosed in 2011 or 2012, or those cases coded under the NAACCR v12.1 or 12.2 coding standards. Beginning with the NAACCR v13 coding standards, only ICD-9-CM codes are allowed in Comorbidity/Complication fields. ICD-10-CM codes will be entered in the Secondary Diagnosis fields for cases diagnosed in 2013 and later or coded under the NAACCR v13 coding standards and the code of 1 in this field will no longer be allowed.

0	No secondary diagnosis reported
1	ICD-10-CM
9	ICD-9-CM
Blank	Comorbidities and Complications not coded

SOURCE

Comorbid Fields Source Logic

UPDATE

Comorbid Fields Update Logic

CONSOLIDATED DATA EXTRACT

No

HISTORICAL CHANGES

07/27/05	2006 Data Item (stored only).
02/01/06	Added Source logic. Converted to 9 for historical cases where Comorbid/Complication 1-6 coded.
07/07/06	Added 0 as an Allowable Value to match the Volume One/FORDS standard.
2010	Added IF551 to IF560 edits.
2013 data changes	The code of 1 is no longer allowed in this field for cases diagnosed in 2013 or coded under the NAACCR v13 coding standards.
04/2014	Added to the Tumor Level. Revisions to Source and Update Logic.

ICD Revision Number

IDENTIFIERS

CCR ID	NAACCR ID
E1535	1920

DESCRIPTION

Indicator for the coding scheme used to code the cause of death.

LEVELS

Patients

LENGTH

1

ALLOWABLE VALUES

0	Patient alive at last follow-up
1	ICD-10 (1999+ deaths)
7	ICD-7
8	ICDA-8
9	ICD-9

SOURCE

See Extract.

UPDATE

None

CONSOLIDATED DATA EXTRACT

If Vital Status = 1, then generate 0 (patient alive at last follow-up);
Otherwise, generate 9 (ICD-9) or generate 1 (ICD-10) for 1999 deaths.

HISTORICAL CHANGES

8/15/06	Generated item in Volume II added to Volume III with 2007 data changes.

ICD-O-3 Conversion Flag

IDENTIFIERS

CCR ID	NAACCR ID
E1488	2116

DESCRIPTION

Flag to indicate how the conversion was done from ICD-O-2 to ICD-O-3.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

0	Morphology originally coded in ICD-O-3
1	Morphology converted without review
3	Morphology converted with review (Definition clarified per Lynn Ries 8/07: Code 3 should also be used for cases that are dx prior to 2001 and are directly coded (not machine converted) into the ICDO-3 field. Abstractors might want to do this on older cases because the software provider does not machine convert these.)

SOURCE

If Date of Diagnosis < 20010101 or = blank and Histologic Type ICD-O-3 < 8000 or > 9999 or Behavior Code ICD-O-3 is not 0-3,

Then perform the procedure described in Appendix 29 - Histology ICDO-3 Conversion Specifications and load the resulting ICD-O-3 Conversion Flag value.

Otherwise, just load the transmitted value with no conversion.

UPDATE

Tumor Level

New Case Consolidation

If the admission's ICD-O-3 Conversion Flag code is not the same as the tumor's ICD-O-3 Conversion Flag code, Then List for Review

Manual Change to Histology (92-00) ICD-O-2 or Behavior (92-00) ICD-O-2

If all of the following conditions are true:

Date of Diagnosis year is earlier* than 2001

Histology (92-00) ICD-O-2 or Behavior (92-00) ICD-O-2 were changed

Then perform the procedure described in Appendix 29 - Histologic Type ICD-O-3 Conversion Specifications and auto-update with the resulting ICD-O-3 Conversion Flag value.

Manual Change to Histologic Type ICD-O-3 or Behavior Code ICD-O-3

If Date of Diagnosis year is earlier* than 2001

Then perform the procedure described in Appendix 29 - Histologic Type ICD-O-3 Conversion Specifications in memory only (don't apply converted values) to determine the proper converted Histologic Type ICD-O-3 and Behavior Code ICD-O-3

If the manually changed values match the proper converted values

Then automatically update ICD-O-3 Conversion Flag to 1

Otherwise, automatically update ICD-O-3 Conversion Flag to 3

If Date of Diagnosis year is 2001 or later** than 2001

Then automatically update ICD-O-3 Conversion Flag to 0.

Manual Change

Admission Level

Manual Change to Histology (92-00) ICD-O-2 or Behavior (92-00) ICD-O-2

Same as requirement for Tumor Level

Manual Change to Histologic Type ICD-O-3 or Behavior Code ICD-O-3

Same as requirement for Tumor Level

Manual Change

* With year, month, and/or day potentially blank, a date with a partial but later date could appear to be earlier because it is a smaller number than a full earlier date. Thus, to test for the earliest among known (partial or full) dates, use these tests in this order:

- If one of the known dates' years is earlier than (less than) the other known date's year or if it is the only known year/date, then that date is the earliest known date
- If multiple known dates have the same earliest year, but only one of them has an earliest known month, then that is the earliest known date
- If multiple known dates have the same earliest year & month, but only one of them has an earliest known day, then that is the earliest known date

** With year, month, and/or day potentially blank, a completely known date could appear to be later because it is a larger number than a partial later date. Thus, to test for the latest date among known full or partial dates, use these tests in this order:

- If one of the known dates' years is later than (greater than) the other date's year being compared or if it is the only known year/date, then that date is the latest known date
- If multiple known dates have the same latest year, but only one of them has a latest known month, then that is the latest known date
- If multiple known dates have the same latest year & month, but only one of them has a latest known day, then that is the latest known date

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

5/15/01	New data item added to the dataset.
10/16/06	Changed Update logic so when ICD0-3 is manually updated, the conversion flag lists for review. Prior to this update logic, update was a 0 first and did not consider date dx (was " Update based on hierarchy 0, 3, 1"). Added definition to Allowable values Code 3 as cases were coming in with the flag set to 0 (for cases dx prior to 2001 where the ICDO2 and ICDO3 codes were used, a software vendor had the flag defaulted to 0 and ICDO2 and ICDO3 codes were being entered) and were bumping into SEER IF 86 and 87. 0 Conversion of database was done to change these to 3.
2010	2010 Data Changes: CCR name (ICDO3 Conv Flag) changed to NAACCR name. Update logic rewritten. Source logic rewritten to account for blanks instead of unknown date dx (was or >= 99990000).

IHS Link

Indian Health Service Linkage

IDENTIFIERS

CCR ID	NAACCR ID
E1045	192

DESCRIPTION

This variable captures the results of the linkage of the registry database with the Indian Health Service patient registration database.

LEVELS

Patients

LENGTH

1

ALLOWABLE VALUES

0	Record sent for linkage, no IHS match.
1	Record sent for linkage, IHS match.
Blank	Record not sent for linkage or linkage result pending.

SOURCE

See description

UPDATE

None

CCR DATA EXTRACT

Yes

HISTORICAL CHANGES

7/05	This is a 2006 Data Item. Required by SEER & NPCR.

Incidence Code

IDENTIFIERS

CCR ID	NAACCR ID
None	None

This data item is not in the exchange record, Volume II, Appendix A; therefore CCR ID or NAACCR ID are not assigned.

DESCRIPTION

Designates whether or not this tumor is an incidence case for this region. (SEER cases are incident cases for Region 8 if diagnosed after 1972 and for Regions 1 and 9 if diagnosed after 1991).

LEVELS

Tumor

LENGTH

1

ALLOWABLE VALUES

0	No
1	Yes
2	Incident case for Region 1 for California reporting, but not incident for SEER reporting.

SOURCE

Computer generate code 1 if all of the following conditions are true:	
1)	Date of Diagnosis year < 2001 and Hist_Behavior_2 = 2 or 3) or Date of Diagnosis year >= 2001 and < 9999 and (Hist_Behavior_3 = 2 or 3) or (Hist_Behavior_3 = 0 and Site=700-709, 710-719, 720-729,or 751-753) or (Hist_Behavior_3= 1 and Primary Site=569, 700-709, 710-719, 720-729, 751- 753)).
2)	Primary Site = 000-424, 470 809 or(Primary Site = 440-449 and Hist_Type_3 <> 8000-8005 ,8010-8046 , 8050-8084 , 8090-8110)
3)	>Date of Diagnosis year >= Reference Date (varies by region, see “Generating Code 1” below), and >Date of Diagnosis year < 9999,
4)	style="font-family: Verdana;">County at DX (varies by region, see “Generating Code 1” below).

If all of the above conditions have been met and if Region is 8 and style="margin-top: 6px; margin-bottom: 6px;">County at DX = 027, 035, 043, or 044 then if style="margin-top: 6px; margin-bottom: 6px; font-style: normal; font-size: 11pt;">Date of Diagnosis year > 1987 and < 1992 generate code 2 else if style="margin-top: 6px; margin-bottom: 6px; font-style: normal; font-size: 11pt;">Date of Diagnosis year < 88 Generate code 0. Enter code 0 on all other records

UPDATE

None

CONSOLIDATED DATA EXTRACT

No

GENERATING CODE 1(Incidence case) FOR EACH REGION
Region 01 **

Reference Date = January 1, 1988, and County at DX = 027, 035, 043, 044
Region 02 Reference Date = January 1, 1987, and County at DX = 010, 015, 016, 020, 022, 024, 050, 054, 055
Region 03 Reference Date = January 1, 1987, and County at DX = 002, 003, 005, 009, 029 031, 034, 039, 046, 048, 051, 057, 058
Region 04 Reference Date = January 1, 1988, and County at DX = 040, 042, 056
Region 05 Reference Date = January 1, 1988, and County at DX = 014, 026, 033, 036
Region 06 Reference Date = January 1, 1988, and County at DX = 004, 006, 008, 011, 012, 017, 018, 023, 025, 028, 032, 045, 047, 049, 052, 053
Region 07 ** Reference Date = January 1, 1988, and County at DX = 013, 037
Region 08 Reference Date = January 1973, and County at DX = 001, 007, 021, 038, 041
Region 09 Reference Date = January 1, 1972, and County at DX = 019
Region 10 ** Reference Date = January 1, 1984, and County at DX = 030

HISTORICAL CHANGES

5/01	ICDO-3 changes
7/01	Removed source section item 5) and rewrote item 1) to look for new brain and ovary combinations in source section. Changed histology type ranges in source section item 2) for ICD0-3.
11/02	In Eureka, this field will be generated when necessary and not stored in the database. The allowable values edit (#17) was removed.

Industry 80

IDENTIFIERS

CCR ID	NAACCR ID
E1568	None. State Requestor

DESCRIPTION

This data item is no longer being collected. Identifies the kind of industry or business associated with the longest held occupation at time of diagnosis. The coding scheme is that used by the Census Bureau in 1980.

LEVELS

Tumors, Admissions

LENGTH

4

ALLOWABLE VALUES

010 - 961 with a trailing 0 (entire range is not used; see Appendix 14).
Codes 932, 942, 951, and 961 are NIOSH's additions.
9900 Not reported
9999 Code not yet assigned

SOURCE

If Industry 80 is numeric and Other Reg ID is not blank, then right-justify and zero-fill and load transmitted value
Else
Convert to 9999

UPDATE

Tumor Level
- New Case Consolidation
  - If Text--Usual Industry changes, reset Industry 80 to 9999
- Manual Change to Text--Usual Industry
  - If Text--Usual Industry changes, reset Industry 80 to 9999
- Manual Change

Admission Level
- Manual Change to Text--Usual Industry
  - If Text--Usual Industry changes, reset Industry 80 to 9999
- Manual Change

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

04/2014	Updated to reflect that this data item is no longer being collected.

Industry 90

IDENTIFIERS

CCR ID	NAACCR ID
E1569	None. State Requestor

DESCRIPTION

This data item is no longer being collected. The code which identifies the kind of industry or business associated with the longest held occupation at time of diagnosis. The coding scheme is that used by the Census Bureau in 1990.

LEVELS

Tumors, Admissions

LENGTH

4

ALLOWABLE VALUES

010 - 970 with a trailing 0 (entire range is not used; see Appendix 14).
Codes 932, 942, 951, and 961 are NIOSH's additions.
9900 Not reported
9999 Code not yet assigned

SOURCE

If Industry 90 is numeric and Other Reg ID is not blank,
    Then Right-justify and zero-fill and load transmitted value
Else
    Convert to 9999

UPDATE

Tumor Level
    New Case Consolidation
        If Text--Usual Industry changes, reset Industry 90 to 9999
    Manual Change to Text--Usual Industry
        If Text--Usual Industry changes, reset Industry 90 to 9999
    Manual Change
Admission Level
    Manual Change to Text--Usual Industry
        If Text--Usual Industry changes, reset Industry 90 to 9999
    Manual Change

CONSOLIDATED DATA EXTRACT

For NPCR submission, extract first 3 characters of this data item and send in for NAACCR Industry Code--Census (#280) (column #138-140)

HISTORICAL CHANGES

8/15/06	Updated extract information from Volume II.
5/2012	Revised Update section. Was referring to "Industry Text". Now, properly refers to Text--Usual Industry.
04/2014	Updated to reflect that this data item is no longer being collected.

Industry Source

IDENTIFIERS

CCR ID	NAACCR ID
E1039	300

DESCRIPTION

Code that best describes the source of industry information provided on this patient. This is a central cancer registry data item (i.e., codes should be applied by the central registry rather than collected from reporting facilities).

LEVELS

Tumors

LENGTH

1

ALLOWABLE VALUES

0	Unknown industry/no industry available
1	Reporting facility records
2	Death certificate
3	Interview
7	Other source
8	Not applicable, patient less than 14 years of age at diagnosis
9	Unknown source
Blank	Not collected

SOURCE

See Consolidated Data Extract.

UPDATE

None

CONSOLIDATED DATA EXTRACT

Generate 1 (See ALLOWABLE VALUES: 1 Reporting facility records)

HISTORICAL CHANGES

8/15/06	Generated item in Volume II added to Volume III with 2007 data changes.

Institution Referred From

IDENTIFIERS

CCR ID	NAACCR ID
E1662	2410

DESCRIPTION

Identifies the facility that referred the patient to the reporting facility.

LEVELS

Admissions

LENGTH

10

ALLOWABLE VALUES

For valid hospital code numbers see the Registrar's Resource page on http://www.ccrcal.org.
0000000803, 0000999993, or 0000999996 = Diagnosed but not hospitalized prior to this admission.
0000000000 = Not diagnosed prior to this admission (including DC Only cases).

SOURCE

If the record version is A or later, then if the transmitted value is numeric, then just load it with no conversion.
Otherwise, convert it to 0000000000.

UPDATE

Manual

CONSOLIDATED DATA EXTRACT

Yes; record with the earliest admission date for this tumor; 10 digits, right-justified, zero-filled.

HISTORICAL CHANGES

1/1/99	Source and transmit to CCR sections change to process 15-digit numbers.
3/26/03	Source and CCR Data Extract changes due to field length change from 15 to 10 characters.
3/03/04	Removed conversion instructions from SOURCE for Version 9 records. See Use Case 22.
7/27/05	Removed the Allowable Values reference (Volume One Appendix F) & reference is now to the current California hospital labels file on the CCR website
2010	2010 Data Changes: CCR name (Hosp Ref From) changed to NAACCR name. Added IF #611.

Institution Referred To

IDENTIFIERS

CCR ID	NAACCR ID
E1664	2420

DESCRIPTION

Ten-digit code of the facility to which patient was referred for diagnostic workup or cancer treatment.

LEVELS

Admissions

LENGTH

10

ALLOWABLE VALUES

Valid Hospital Code Numbers see CA Hosp Codes.
0000000000 = Not referred to another institution (including DC Only cases)

SOURCE

If the record version is A or later, then if the transmitted value is numeric, then just load it with no conversion.
Otherwise, convert it to 0000000000.

UPDATE

Manual

CONSOLIDATED DATA EXTRACT

Yes; record with the earliest admission date for this tumor; 10 digits, right-justified, zero-filled.

HISTORICAL CHANGES

1/1/99	Source and transmit to CCR sections change to process 15-digit numbers.
3/26/03	Source and transmit to CCR changes due to field length change from 15 to 10 characters.
3/03/04	Removed conversion instructions from SOURCE for Version 9 records. See Use Case 22.
7/27/05	Removed the Allowable Values reference (Volume One Appendix F) & reference is now to the current California hospital labels file on the CCR website.
2010	2010 Data Changes: CCR name (Hosp Ref To) changed to NAACCR name.
05/2016	Per NAACCR v16, updated description to match NAACCR, including replacement of the term “hospital” with “facility” to accommodate EHR reporting.

International Normalized Ratio Prothrombin Time

IDENTIFIERS

CCR ID	NAACCR ID
E1973	3860

OWNER

NAACCR

DESCRIPTION

International Normalized Ratio for Prothrombin Time (INR), an indicator of the liver's ability to make clotting factors, is required to calculate the Model for End-Stage Liver Disease (MELD) score, which is used to assign priority for liver transplant.

LEVELS

Admissions, Tumors

LENGTH

3

ALLOWABLE VALUES

0.0	0.0
0.1	0.1 or less
0.2-9.9	0.2 - 9.9 (Exact ratio to nearest tenth)
X.1	10 or greater
X.7	Test ordered, results not in chart
X.8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code X.8 may result in an edit error.)
X.9	Not documented in medical record INR (International Normalized Ratio for Prothrombin Time) not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00220
        - Type of Reporting Source is not 7
        - COC Accredited Flag is 1
        - International Normalized Ratio Prothrombin Time is blank or X.8

        Then convert International Normalized Ratio Prothrombin Time to X.9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00220

OR

- Type of Reporting Source is 7

- International Normalized Ratio Prothrombin Time is not blank

Then convert P International Normalized Ratio Prothrombin Time to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00220
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00220

One of the following conditions is true

- Admission's value is not blank, X.8, X.9
- Tumor's value is blank, X.8, or X.9

OR

- Admission's value is X.9
- Tumor's value is blank or X.8

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Invasion Beyond Capsule

IDENTIFIERS

CCR ID	NAACCR ID
E1977	3864

OWNER

NAACCR

DESCRIPTION

Invasion beyond capsule pertains to the pathologically confirmed invasion of the tumor beyond the fibrous capsule in which the kidney is enclosed.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	Invasion beyond capsule not identified
1	Perinephric (beyond renal capsule) fat or tissue
2	Renal sinus
3	Gerota's fascia
4	Any combination of codes 1-3
5	Invasion beyond capsule, NOS
8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code 8 may result in an edit error.)
9	Not documented in medical record Invasion beyond capsule not assessed or unknown if assessed No surgical resection of primary site is performed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00600
        - Type of Reporting Source is not 7
        - Invasion Beyond Capsule is blank or 8

        Then convert Invasion Beyond Capsule to 9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00600

              OR
            - Type of Reporting Source is 7
        - Invasion Beyond Capsule is not blank

Then convert Invasion Beyond Capsule to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00600
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00600

One of the following conditions is true

- Admission's value is not blank, 9
- Tumor's value is blank, 9

OR

- Admission's value is 9
- Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Ipsilateral Adrenal Gland Involvement

IDENTIFIERS

CCR ID	NAACCR ID
E1974	3861

OWNER

NAACCR

DESCRIPTION

Ipsilateral adrenal gland involvement pertains to direct extension of the tumor into the ipsilateral adrenal gland (continuous) or ipsilateral adrenal gland involvement by a separate nodule (noncontiguous).

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	Ipsilateral adrenal gland involvement not present/not identified
1	Adrenal gland involvement by direct involvement (contiguous involvement)
2	Adrenal gland involvement by separate nodule (noncontiguous involvement)
3	Combination of code 1-2
4	Ipsilateral adrenal gland involvement, unknown if direct involvement or separate nodule
8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code 8 may result in an edit error.)
9	Not documented in medical record Ipsilateral adrenal gland not resected Ipsilateral adrenal gland involvement not assessed or unknown if assessed No surgical resection of primary site is performed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00600
        - Type of Reporting Source is not 7
        - Ipsilateral Adrenal Gland Involvement is blank or 8

        Then convert Ipsilateral Adrenal Gland Involvement to 9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00600

              OR
            - Type of Reporting Source is 7

- Ipsilateral Adrenal Gland Involvement is not blank
  Then convert Ipsilateral Adrenal Gland Involvement to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00600
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00600

One of the following conditions is true

- Admission's value is not blank, 9
- Tumor's value is blank or 9

  OR

  - Admission's value is 9
  - Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.
Otherwise,
If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

JAK2

IDENTIFIERS

CCR ID	NAACCR ID
E1975	3862

OWNER

NAACCR

DESCRIPTION

Janus Kinase 2 (JAK2, JAK 2) is a gene mutation that increases susceptibility to several myeloproliferative neoplasms (MPNs). Testing for the JAK2 mutation is done on whole blood. Nearly all people with polycythemia vera, and about half of those with primary myelofibrosis and essential thrombocythemia, have the mutation. JAK2 analysis continues to increase in use for hematopoietic neoplasms.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	JAK2 result stated as negative
1	JAK2 positive for mutation V617F WITH or WITHOUT other mutations
2	JAK2 positive for exon 12 mutation
3	JAK2 positive for other specified mutation
4	JAK2 positive for more than one mutation other than V617F
5	JAK2 positive NOS Specific mutation(s) not stated
7	Test ordered, results not in chart
8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code 8 will result in an edit error.)
9	Not documented in medical record JAK2 not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00830
        - Type of Reporting Source is not 7
        - JAK2 is blank or 8

        Then convert JAK2 to 9
    B. If all of the following conditions are true:
        - One of the following is true:

- Schema ID is not 00380
  OR
- Type of Reporting Source is 7

- JAK2 is not blank

Then convert JAK2 to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00380
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00380

One of the following conditions is true

- Admission's value is not blank, 9
- Tumor's value is blank or 9
  OR
  - Admission's value is 9
  - Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.
Otherwise,
If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.
02/2020	Description Update

Ki-67

IDENTIFIERS

CCR ID	NAACCR ID
E1976	3863

OWNER

NAACCR

DESCRIPTION

Ki-67 (MIB-1) is a marker of cell proliferation. A high value indicates a tumor that is proliferating more rapidly.

LEVELS

Admissions, Tumors

LENGTH

5

ALLOWABLE VALUES

0.0-100.0	0.0 to 100.0 percent positive: enter percent positive
XXX.7	Test done, actual percentage not stated
XXX.8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code XXX.8 will result in an edit error.)
XXX.9	Not documented in medical record Ki-67 (MIB-1) not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00480
        - Type of Reporting Source is not 7
        - COC Accredited Flag is 1
        - Ki-67 is blank or XXX.8

        Then convert Ki-67 to XXX.9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00480

              OR
            - Type or Reporting Source is 7
        - Ki-67 is not blank

        Then convert Ki-67 to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00480
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00480

One of the following conditions is true

- Admission's value is not blank, XXX.8, or XXX.9
- Tumor's value is blank, XXX.8, or XXX.9

OR

- Admission's value is XXX.9
- Tumor's value is blank or XXX.8

Then automatically update the Tumor's value with the Admission's value.
Otherwise,
If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

KIT Gene Immunohistochemistry

IDENTIFIERS

CCR ID	NAACCR ID
E1978	3865

OWNER

NAACCR

DESCRIPTION

KIT Gene Immunohistochemistry (IHC) is the expression of the KIT gene in tumor tissue specimens based on immunohistochemical (IHC) stains. A positive test is a diagnostic and predictive marker for GIST tumors.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	KIT negative/normal; within normal limits
1	KIT positive
7	Test ordered, results not in chart
8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code 8 may result in an edit error.)
9	Not documented in medical record Cannot be determined by pathologist KIT not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00430
        - Type of Reporting Source is not 7
        - COC Accredited Flag is 1
        - KIT Gene Immunohistochemistry is blank or 8

        Then convert KIT Gene Immunohistochemistry to 9

    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00430

              OR
            - Type of Reporting Source is 7
        - KIT Gene Immunohistochemistry is not blank

        Then convert KIT Gene Immunohistochemistry to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00430
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00430

One of the following conditions is true

- Admission's value is not blank, 8, 9
- Tumor's value is blank , 8, or 9

OR

- Admission's value is 9
- Tumor's value is blank or 8

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

KRAS

IDENTIFIERS

CCR ID	NAACCR ID
E1949	3866

OWNER

NAACCR

DESCRIPTION

KRAS is an important signaling intermediate in the growth receptor pathway which controls cell proliferation and survival. KRAS is a protein with production controlled by the K-ras gene. When the K-ras gene is activated through mutation during colorectal carcinogenesis, production of KRAS continuously stimulates cell proliferation and prevents cell deaths. Activating mutations in KRAS are an adverse prognostic factor for colorectal carcinoma and predict a poor response to monoclonal anti-EGFR antibody therapy in advanced colorectal carcinoma.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	Normal (wild type) Negative for mutations
1	Abnormal (mutated) in codon(s) 12, 13 and/or 61
2	Abnormal (mutated) in codon 146 only
3	Abnormal (mutated), but not in codon(s) 12, 13, 61, or 146
4	Abnormal (mutated), NOS, codon(s) not specified
7	Test ordered, results not in chart
8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code 8 may result in an edit error.)
9	Not documented in medical record KRAS not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00200
        - Type of Reporting Source is not 7
        - KRAS is blank or 8

        Then convert KRAS to 9
    B. If all of the following conditions are true:

- One of the following is true:
  - Schema ID is not 00200
    OR
  - Type of Reporting Source is 7
- KRAS is not blank
  Then convert KRAS to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00200
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00200

One of the following conditions is true

- Admission's value is not blank or 9
- Tumor's value is blank or 9
  OR
  - Admission's value is 9
  - Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.
Otherwise,
If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Laterality

IDENTIFIERS

CCR ID	NAACCR ID
E1056	410

DESCRIPTION

For some specific primary sites, the side of the body in which this tumor originated (see Calif. Cancer Reporting System Standards, Vol. I, V.2.3).

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

0	Not a paired site
1	Right
2	Left
3	Unilateral, NOS
4	Bilateral involvement at time of diagnosis, lateral origin unknown for a single primary; or both ovaries involved simultaneously, single histology; bilateral retinoblastomas; bilateral Wilms tumors
5	Paired site: midline tumor
9	Paired site, but no information concerning laterality

SOURCE

If the transmitted value is numeric, then just load it with no conversion.
Otherwise, convert it to 9.

UPDATE

Tumor Level

New Case Consolidation

If AD_Laterality <> TU_Laterality and Admission Class of Case=00-22 then,

AD Laterality =	TU Laterality =	TU Laterality becomes
Paired site*:		
1 or 2	3	1 or 2
1,2,3,4, 5	9	1,2,3,4, 5
9	1,2,3,4, 5	1,2,3,4,5

Otherwise, list for review.

If TU_Site is an unpaired site and TU_Laterality is not 0, then automatically set TU_Laterality to 0.

*Paired sites are referenced under Site.

Manual Change

Admission Level

Manual Change Only

CONSOLIDATED DATA EXTRACT

Yes

Due to differences between SEER and the CCR (SEER wants 5 coded only for cases dx 2010 or later), for cases dx prior to 2010 convert the 5 to 9.

HISTORICAL CHANGES

2/01/06	Removed Update logic that conflicted with IF #326 which now requires a laterality code of 0 for non-paired sites. Conversion of database performed.
2/2009	Added IF #823.
2010	2010 Data Changes: Added 5 to Allowable values. Code 9 no longer records midline tumor information and is used only when there is no laterality information for a paired site. Code 5 may be used to record a midline tumor of a paired site for any year of diagnosis, but review or recoding of historic cases is not required. For analysis using data with diagnoses before January 1, 2010, code 5 should be grouped with code 9. Revised Update logic to consider analytic class of case before performing update and removed the update that would take a laterality 4 over a 1 or 2 so these cases will be manually reviewed.
5/11/11	2011 Data changes: Added extract note for converting 5 to 9 for pre-2010 cases. Added new interfield edits IF9154 and IF966.

Latitude

IDENTIFIERS

CCR ID	NAACCR ID
E1657	2352

DESCRIPTION

The distance, north or south of the equator, measured in degrees along a meridian as provided by the geocoding vendor for the patient's address at time of diagnosis. Paired with Longitude, this represents the point location of the individual's residence on the earth's surface.

LEVELS

Tumors

LENGTH

10

ALLOWABLE VALUES

Any numeric or decimal or blank (not tracted).

SOURCE

Set to blank.

UPDATE

Whenever Census Tract 2010 is changed, LATITUDE must be changed accordingly.
If Census Tract 2010 is untracted then LATITUDE must be blank.
If Census Tract 2010 is tracted and a LATITUDE tracted code is available, (whether through 1) geocoding, 2) linking a tumor with a tracted address, or 3) manual entry of a LATITUDE value) the available LATITUDE code should be used.
However, if Census Tract 2010 is tracted but LATITUDE is not available LATITUDE should be set to blank.
Beginning with the collection of 2010 Census data (Eureka release 10.2), LATITUDE is only stored if the CENSUS TRACT CERTAINTY 2010 values is 1 or 2.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

5/15/01	Started receiving data.
3/1/12	With release of Eureka 10.2, geocoding moves to the 2010 census boundaries. Longitude reflects the location of the 2010 geocodes for Census Tract Certainty values of 1 and 2. Updated description.

LDH post-Orchiectomy Range

IDENTIFIERS

CCR ID	NAACCR ID
E1980	3867

OWNER

NAACCR

DESCRIPTION

LDH (Lactate Dehydrogenase) Post-Orchiectomy Range identifies the range category of the lowest LDH value measured post-orchiectomy. LDH is a nonspecific marker for testicular cancer that is elevated in some germ cell tumors. The Post-Orchiectomy lab value is used to monitor response to therapy.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	Within normal limits
1	Less than 1.5 x N (Less than 1.5 times the upper limit of normal for LDH)
2	1.5 to 10 x N (Between 1.5 and 10 times the upper limit of normal for LDH)
3	Greater than 10 x N (Greater than 10 times the upper limit of normal for LDH)
4	Post-Orchiectomy lactate dehydrogenase (LDH) range stated to be elevated
7	Test ordered, results not in chart
8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code 8 may result in an edit error.)
9	Not documented in medical record No orchiectomy performed LDH (Lactate Dehydrogenase) Post-Orchiectomy Range not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00590
        - Type of Reporting Source is not 7
        - LDH Post-Orchiectomy Range is blank or 8

        Then convert LDH Post-Orchiectomy Range to 9
    B. If all of the following conditions are true:
        - One of the following is true:

- Schema ID is not 00590
  OR
- Type of Reporting Source is 7

- LDH Post-Orchiectomy Range is not blank

Then convert LDH Post-Orchiectomy Range to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00590
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00590

One of the following conditions is true

- Admission's value is not blank, 9
- Tumor's value is blank, 9
  OR
  - Admission's value is 9
  - Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

LDH Pre-Orchiectomy Range

IDENTIFIERS

CCR ID	NAACCR ID
E1981	3868

OWNER

NAACCR

DESCRIPTION

Lactate Dehydrogenase (LDH) Range identifies the range category of the highest LDH value measured prior to treatment. LDH is a nonspecific marker for testicular cancer that is elevated in some germ cell tumors. This data item refers to the Pre-Orchiectomy range.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	Within normal limits
1	Less than 1.5 x N (Less than 1.5 times the upper limit of normal for LDH)
2	1.5 to 10 x N (Between 1.5 and 10 times the upper limit of normal for LDH)
3	Greater than 10 x N (Greater than 10 times the upper limit of normal for LDH)
4	Pre-Orchiectomy lactate dehydrogenase (LDH) range stated to be elevated
7	Test ordered, results not in chart
8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code 8 may result in an edit error.)
9	Not documented in medical record LDH (Lactate Dehydrogenase) Pre-Orchiectomy Range not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

3. If Date of Diagnosis is less than 2018, then blank out field
4. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00590
        - Type of Reporting Source is not 7
        - LDH Pre-Orchiectomy Range is blank or 8

        Then convert LDH Pre-Orchiectomy Range to 9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00590

OR

- Type of Reporting Source is 7

- LDH Pre-Orchiectomy Range is not blank

Then convert LDH Pre-Orchiectomy Range to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00590
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00590

One of the following conditions is true

- Admission's value is not blank, 9
- Tumor's value is blank, 9

OR

- Admission's value is 9
- Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

LDH Pretreatment Level

IDENTIFIERS

CCR ID	NAACCR ID
E1982	3869

OWNER

NAACCR

DESCRIPTION

LDH (Lactate Dehydrogenase) is an enzyme involved in conversion of sugars to energy and present in most cells in the body. Elevated pretreatment LDH is an adverse prognostic factor for plasma cell myeloma and melanoma of the skin.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	Normal LDH level Low, below normal
1	Above normal LDH level; High
7	Test ordered, results not in chart
9	Not documented in medical record LDH (Lactate Dehydrogenase) Pretreatment Level not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is 00470
              OR
            - Schema ID is 00821
            - Schema Discriminator = 0
        - Type of Reporting Source is not 7
        - LDH Pretreatment Level is blank

        Then convert LDH Pretreatment Level to 9

    A. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00470, 00821
              OR
            - Schema ID is 00821
            - Schema Discriminator = 1 or 9

OR

- Type of Reporting Source is 7

- LDH Pretreatment Level is not blank

Then convert LDH Pretreatment Level to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00470
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00470

One of the following conditions is true

- Admission's value is not blank, 9
- Tumor's value is 9

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

LDH Pretreatment Lab value

IDENTIFIERS

CCR ID	NAACCR ID
E2044	3932

OWNER

NAACCR

DESCRIPTION

LDH (Lactate Dehydrogenase) Pretreatment Lab Value, measured in serum, is a predictor of treatment response, progression-free survival and overall survival for patients with Stage IV melanoma of the skin.

LEVELS

Admissions, Tumors

LENGTH

7

ALLOWABLE VALUES

0.0	0.0 (U/L)
0.1-99999.9	0.1–99,999.9 U/L
XXXXX.1	100,000 U/L or greater
XXXXX.7	Test ordered, results not in chart
XXXXX.8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code XXXXX.8 will result in an edit error.)
XXXXX.9	Not documented in medical record LDH (Lactate Dehydrogenase) Pretreatment Lab Value not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00470
        - Type of Reporting Source is not 7
        - LDH Pretreatment Lab Value is blank or XXXXX.8

        Then convert LDH Pretreatment Lab Value to XXXXX.9

    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00470

              OR
            - Type of Reporting Source is 7
        - LDH Pretreatment Lab Value is not blank

        Then convert LDH Pretreatment Lab Value to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00470
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00470

One of the following conditions is true

- Admission's value is not blank, XXXXX.9
- Tumor's value is blank, XXXXX.9

OR

- Admission's value is XXXXX.9
- Tumor's value is blank or XXXXX.8

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

LDH Upper Limits of Normal

IDENTIFIERS

CCR ID	NAACCR ID
E1983	3870

OWNER

NAACCR

DESCRIPTION

LDH (Lactate Dehydrogenase), an enzyme involved in converting sugars to energy in the body, is elevated in some malignancies. LDH level is a prognostic factor for patients with Stage IV melanoma. This data Item refers to the Upper Limit of Normal in the laboratory test used to interpret the Serum LDH result.

LEVELS

Admissions, Tumors

LENGTH

3

ALLOWABLE VALUES

001-999	001 - 999 upper limit of normal (Exact upper limit of normal)
XX8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code XX8 may result in an edit error.)
XX9	Not documented in medical record LDH Upper Limit not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00470
        - Type of Reporting Source is not 7
        - COC Accredited Flag is 1
        - LDH Upper Limits of Normal is blank or XX8

        Then convert LDH Upper Limits of Normal to XX9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00470

            OR
            - Type of Reporting Source is 7
        - LDH Upper Limits of Normal is not blank

        Then convert LDH Upper Limits of Normal to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00470
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00470

One of the following conditions is true

- Admission's value is not blank, XX8, or XX9
- Tumor's value is blank , XX8, or XX9

OR

- Admission's value is XX9
- Tumor's value is blank or XX8

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

LN Assessment Method Femoral-Inguinal

IDENTIFIERS

CCR ID	NAACCR ID
E1984	3871

OWNER

NAACCR

DESCRIPTION

This data item describes the method used to assess involvement of femoral-inguinal lymph nodes associated with certain female genital cancers.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	Radiography, imaging (Ultrasound (US), computed tomography scan (CT), magnetic resonance imaging (MRI), positron emission tomography scan (PET)) Physical exam only
1	Incisional biopsy; fine needle aspiration (FNA)
2	Lymphadenectomy Excisional biopsy or resection with microscopic confirmation
7	Regional lymph node(s) assessed, unknown assessment method
8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code 8 will result in an edit error.)
9	Not documented in medical record Regional lymph nodes not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00500, 00510, 00520
        - Type of Reporting Source is not 7
        - COC Accredited Flag is 1
        - LN Assessment Method Femoral-Inguinal is blank or 8

        Then convert LN Assessment Method Femoral-Inguinal to 9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00500, 00510, 00520

            OR

- Type of Reporting Source is 7

- LN Assessment Method Femoral-Inguinal is not blank

Then convert LN Assessment Method Pelvic to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00500, 00510, 00520
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00500, 00510, 00520

One of the following conditions is true

- Admission's value is not blank, 8, or 9
- Tumor's value is blank, 8, or 9

OR

- Admission's value is 9
- Tumor's value is blank or 8

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

LN Assessment Method Para-Aortic

IDENTIFIERS

CCR ID	NAACCR ID
E1985	3872

OWNER

NAACCR

DESCRIPTION

This data item describes the method used to assess involvement of para-aortic lymph nodes associated with certain female genital cancers.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	Radiography, imaging (Ultrasound (US), computed tomography scan (CT), magnetic resonance imaging (MRI), positron emission tomography scan (PET)) Physical exam only
1	Incisional biopsy; fine needle aspiration (FNA)
2	Lymphadenectomy Excisional biopsy or resection with microscopic confirmation
7	Regional lymph node(s) assessed, unknown assessment method
8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code 8 will result in an edit error.)
9	Not documented in medical record Regional lymph nodes not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00500, 00510, 00520
        - Type of Reporting Source is not 7
        - COC Accredited Flag is 1
        - LN Assessment Method Para-Aortic is blank or 8

        Then convert LN Assessment Method Para-Aortic to 9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00500, 00510, 00520

            OR

- Type of Reporting Source is 7
- LN Assessment Method Para-Aortic is not blank

Then convert LN Assessment Method Para-Aortic to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00500, 00510, 00520
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00500, 00510, 00520

One of the following conditions is true

- Admission's value is not blank, 8, or 9
- Tumor's value is blank, 8, or 9

OR

- Admission's value is 9
- Tumor's value is blank or 8

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

LN Assessment Method Pelvic

IDENTIFIERS

CCR ID	NAACCR ID
E1986	3873

OWNER

NAACCR

DESCRIPTION

This data item describes the method used to assess involvement of pelvic lymph nodes associated with certain female genital cancers.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	Ultrasound (US), computed tomography scan (CT), magnetic resonance imaging (MRI), positron emission tomography scan (PET)) Physical exam only
1	Incisional biopsy; fine needle aspiration (FNA)
2	Lymphadenectomy Excisional biopsy or resection with microscopic confirmation
7	Regional lymph node(s) assessed, unknown assessment method
8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code 8 will result in an edit error.)
9	Not documented in medical record Regional lymph nodes not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

3. If Date of Diagnosis is less than 2018, then blank out field
4. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00500, 00510, 00520
        - Type of Reporting Source is not 7
        - COC Accredited Flag is 1
        - LN Assessment Method Pelvic is blank or 8

        Then convert LN Assessment Method Pelvic to 9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00500, 00510, 00520

            OR

- Type of Reporting Source is 7
- LN Assessment Method Pelvic is not blank

Then convert LN Assessment Method Pelvic to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00500, 00510, 00520
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00500, 00510, 00520

One of the following conditions is true

- Admission's value is not blank, 8, or 9
- Tumor's value is blank, 8, or 9

OR

- Admission's value is 9
- Tumor's value is blank or 8

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

LN Distant Assessment Method

IDENTIFIERS

CCR ID	NAACCR ID
E1987	3874

OWNER

NAACCR

DESCRIPTION

This data item describes the method used to assess involvement of Distant (mediastinal, scalene) nodes associated with certain female genital cancers.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	Radiography, imaging (Ultrasound (US), computed tomography scan (CT), magnetic resonance imaging (MRI), positron emission tomography scan (PET)) Physical exam only
1	Incisional biopsy; fine needle aspiration (FNA)
2	Lymphadenectomy Excisional biopsy or resection with microscopic confirmation
7	Distant lymph node(s) assessed, unknown assessment method
8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code 8 will result in an edit error.)
9	Not documented in medical record Distant lymph nodes not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00510, 00520
        - Type of Reporting Source is not 7
        - COC Accredited Flag is 1
        - LN Distant Assessment Method is blank or 8

        Then convert LN Distant Assessment Method to 9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00510, 00520

            OR

- Type of Reporting Source is 7
- LN Distant Assessment Method is not blank

Then convert LN Distant Assessment Method to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00510, 00520
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00510, 00520

One of the following conditions is true

- Admission's value is not blank, 8, or 9
- Tumor's value is blank, 8, or 9

OR

- Admission's value is 9
- Tumor's value is blank or 8

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

LN Distant, Mediastinal, Scalene

IDENTIFIERS

CCR ID	NAACCR ID
E1988	3875

OWNER

NAACCR

DESCRIPTION

This data item describes the status of Distant (mediastinal, scalene) nodes associated with certain female genital cancers.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	Negative mediastinal and scalene lymph nodes
1	Positive mediastinal lymph nodes
2	Positive scalene lymph nodes
3	Positive mediastinal and scalene lymph nodes
8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code 8 will result in an edit error.)
9	Not documented in medical record Mediastinal and scalene lymph nodes not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

3. If Date of Diagnosis is less than 2018, then blank out field
4. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00510, 00520
        - Type of Reporting Source is not 7
        - COC Accredited Flag is 1
        - LN Distant: Mediastinal, Scalene is blank or 8

        Then convert LN Distant: Mediastinal, Scalene to 9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00510, 00520

            OR
            - Type of Reporting Source is 7
        - LN Distant: Mediastinal, Scalene is not blank

        Then convert LN Distant: Mediastinal, Scalene to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00510, 00520
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00510, 00520

One of the following conditions is true

- Admission's value is not blank, 8, or 9
- Tumor's value is blank, 8, or 9

OR

- Admission's value is 9
- Tumor's value is blank or 8

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

LN Head and Neck Levels I-III

IDENTIFIERS

CCR ID	NAACCR ID
E1989	3876

OWNER

NAACCR

DESCRIPTION

Lymph Nodes for Head and Neck, Levels I-III records the involvement of Levels I-III lymph nodes.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	No involvement in Levels I, II, or III lymph nodes
1	Level I lymph node(s) involved
2	Level II lymph node(s) involved
3	Level III lymph node(s) involved
4	Levels I and II lymph nodes involved
5	Levels I and III lymph nodes involved
6	Levels II and III lymph nodes involved
7	Levels I, II and III lymph nodes involved
8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code 8 will result in an edit error)
9	Not documented in medical record Positive nodes, but level of positive node(s) unknown Lymph node levels I-III not assessed, or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00060 or 00140
        - Type of Reporting Source is not 7
        - LN Head and Neck Levels I-III is blank or 8

        Then convert LN Head and Neck Levels I-III to 9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00060, 00140

              OR
            - Type of Reporting Source is 7

- LN Head and Neck Levels I-III is not blank
  Then convert LN Head and Neck Levels I-III to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00060 or 00140
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00060 or 00140

One of the following conditions is true

- Admission's value is not blank, 9
- Tumor's value is blank, 9

  OR

  - Admission's value is 9
  - Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.
Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

LN Head and Neck Levels IV-V

IDENTIFIERS

CCR ID	NAACCR ID
E1990	3877

OWNER

NAACCR

DESCRIPTION

Lymph Nodes for Head and Neck, Levels IV-V records the involvement of Levels IV-V lymph nodes.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	No involvement in Levels IV or V lymph nodes
1	Level IV lymph node(s) involved
2	Level V lymph node(s) involved
3	Levels IV and V lymph node(s) involved
8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code 8 will result in an edit error)
9	Not documented in medical record Positive nodes, but level of positive node(s) unknown Lymph node levels IV-V not assessed, or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00060 or 00140
        - Type of Reporting Source is not 7
        - LN Head and Neck Levels IV-V is blank or 8

        Then convert LN Head and Neck Levels IV-V to 9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00060, 00140

              OR
            - Type of Reporting Source is 7
        - LN Head and Neck Levels IV-V is not blank

        Then convert LN Head and Neck Levels IV-V to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00060 or 00140
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00060 or 00140

One of the following conditions is true

- Admission's value is not blank, 9
- Tumor's value is blank, 9

OR

- Admission's value is 9
- Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

LN Head and Neck Levels VI-VII

IDENTIFIERS

CCR ID	NAACCR ID
E1991	3878

OWNER

NAACCR

DESCRIPTION

Lymph Nodes for Head and Neck, Levels VI-VII records the involvement of Levels VI-VII lymph nodes.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	No involvement in Levels VI to VII lymph nodes
1	Level VI lymph node(s) involved
2	Level VII lymph node(s) involved
3	Levels VI and VII lymph node(s) involved
8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code 8 will result in an edit error)
9	Not documented in medical record Positive nodes, but level of positive node(s) unknown Lymph node levels VI-VII not assessed, or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00060 or 00140
        - Type of Reporting Source is not 7
        - LN Head and Neck Levels VI-VII is blank or 8

        Then convert LN Head and Neck Levels VI-VII to 9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00060, 00140

            OR
            - Type of Reporting Source is 7
        - LN Head and Neck Levels VI-VII is not blank

        Then convert LN Head and Neck Levels VI-VII to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00060 or 00140
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00060 or 00140

One of the following conditions is true

- Admission's value is not blank, 9
- Tumor's value is blank, 9

OR

- Admission's value is 9
- Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

LN Head and Neck Other

IDENTIFIERS

CCR ID	NAACCR ID
E1992	3879

OWNER

NAACCR

DESCRIPTION

Lymph Nodes for Head and Neck, Other records the involvement of lymph nodes other than Levels I-III, IV-V, and VI-VII.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	No involvement in other head and neck lymph node regions
1	Buccinator (facial) lymph node(s) involved
2	Parapharyngeal lymph node(s) involved
3	Periparotid and intraparotid lymph node(s) involved
4	Preauricular lymph node(s) involved
5	Retropharyngeal lymph node(s) involved
6	Suboccipital/retroauricular lymph node(s) involved
7	Any combination of codes 1-6
8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code 8 will result in an edit error)
9	Not documented in medical record Positive nodes, but level of positive node(s) unknown Other Head and Neck lymph nodes not assessed, or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00060 or 00140
        - Type of Reporting Source is not 7
        - LN Head and Neck Other is blank or 8

        Then convert LN Head and Neck Other to 9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00060, 00140

            OR

- Type of Reporting Source is 7
- LN Head and Neck Other is not blank

Then convert LN Head and Neck Other to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00060 or 00140
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00060 or 00140

One of the following conditions is true

- Admission's value is not blank, 9
- Tumor's value is blank, 9

OR

- Admission's value is 9
- Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

LN Isolated Tumor Cells (ITC)

IDENTIFIERS

CCR ID	NAACCR ID
E1993	3880

OWNER

NAACCR

DESCRIPTION

Lymph Nodes Isolated Tumor Cells (ITC), the presence of isolated tumor cells in regional lymph node(s) that may be detected by hematoxylin and eosin or by immunohistochemical staining, is a potential prognostic factor for Merkel Cell Carcinoma.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	Regional lymph nodes negative for ITCs
1	Regional lymph nodes positive for ITCs (Tumor cell clusters not greater than 0.2 millimeter (mm))
8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code 8 may result in an edit error.)
9	Not documented in medical record ITCs not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00460
        - Type of Reporting Source is not 7
        - LN Isolated Tumor Cells (ITC) is blank or 8

        Then convert LN Isolated Tumor Cells (ITC) to 9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00460

              OR
            - Type of Reporting Source is 7
        - LN Isolated Tumor Cells (ITC) is not blank

        Then convert LN Isolated Tumor Cells (ITC) to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00460
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00460

One of the following conditions is true

- Admission's value is not blank, 9
- Tumor's value is blank, 9

OR

- Admission's value is 9
- Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

LN Laterality

IDENTIFIERS

CCR ID	NAACCR ID
E1994	3881

OWNER

NAACCR

DESCRIPTION

This data item describes whether positive regional lymph nodes are unilateral or bilateral.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	No regional lymph node involvement
1	Unilateral - all positive regional nodes with same laterality OR only one regional node positive
2	Bilateral - positive bilateral regional lymph nodes
3	Laterality unknown - positive regional lymph nodes with unknown laterality
8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code 8 may result in an edit error.)
9	Not documented in medical record Lymph node laterality not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
   A. If all of the following conditions are true:
      - Schema ID is 00500
      - Type of Reporting Source is not 7
      - LN Laterality is blank or 8

      Then convert LN Laterality to 9
   B. If all of the following conditions are true:
      - One of the following is true:
        - Schema ID is not 00500

          OR
        - Type of Reporting Source is 7
      - LN Laterality is not blank

      Then convert LN Laterality to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00500
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00500

One of the following conditions is true

- Admission's value is not blank, 9
- Tumor's value is blank, 9

OR

- Admission's value is 9
- Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.
Otherwise,
If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

LN Positive Axillary Level I-II

IDENTIFIERS

CCR ID	NAACCR ID
E1995	3882

OWNER

NAACCR

DESCRIPTION

This data item pertains to the number of positive ipsilateral level I and II axillary lymph nodes and intramammary lymph nodes based on pathological information.

LEVELS

Admissions, Tumors

LENGTH

2

ALLOWABLE VALUES

00	All ipsilateral axillary nodes examined negative
01-99	1 - 99 nodes positive (Exact number of nodes positive)
X1	100 or more nodes positive
X5	Positive nodes, number unspecified
X6	Positive aspiration or needle core biopsy of lymph node(s)
X8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code X8 will result in an edit error.)
X9	Not documented in medical record Level I-II axillary nodes not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00480
        - Type of Reporting Source is not 7
        - LN Positive Axillary Level I-II is blank or X8

        Then convert LN Positive Axillary Level I-II to X9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00480

              OR
            - Type of Reporting Source is 7
        - LN Positive Axillary Level I-II is not blank

        Then convert LN Positive Axillary Level I-II to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00480
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00480

One of the following conditions is true

- Admission's value is not blank or X9
- Tumor's value is blank or X9

OR

- Admission's value is X9
- Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

LN Size

IDENTIFIERS

CCR ID	NAACCR ID
E1996	3883

OWNER

NAACCR

DESCRIPTION

Lymph Nodes Size records diameter of the involved regional lymph node(s) with the largest diameter of any involved regional lymph node(s). Pathological measurement takes precedence over a clinical measurement for the same node.

LEVELS

Admissions, Tumors

LENGTH

4

ALLOWABLE VALUES

0.0	No involved regional nodes
0.1 – 99.9	0.1–99.9 millimeters (mm) (Exact size of lymph node to nearest tenth of a mm)
XX.1	100 millimeters (mm) or greater
XX.2	Microscopic focus or foci only and no size of focus given
XX.3	Described as "less than 1 centimeter (cm)"
XX.4	Described as "at least" 2 cm
XX.5	Described as "at least" 3 cm
XX.6	Described as "at least" 4 cm
XX.7	Described as greater than 5 cm
XX.8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code XX.8 will result in an edit error)
XX.9	Not documented in medical record Regional lymph node(s) involved, size not stated Lymph Nodes Size not assessed, or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00060, 00071, 00072, 00073, 00074, 00075, 00076, 00077, 00080, 00090, 00100, 00111, 00112, 00121, 00122, 00130, 00131, 00132, 00133, 00140, 00150
        - Type of Reporting Source is not 7

- LN Size is blank or XX.8
  Then convert LN Size to XX.9

B. If all of the following conditions are true:
- One of the following is true:
  - Schema ID is not 00060, 00071, 00072, 00073, 00074, 00075, 00076, 00077, 00080, 00090, 00100, 00111, 00112, 00121, 00122, 00130, 00131, 00132, 00133, 00140, 00150
    OR
  - Type of Reporting Source is 7
- LN Size is not blank
  Then convert LN Size to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:
- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00060, 00071, 00072, 00073, 00074, 00075, 00076, 00077, 00080, 00090, 00100, 00111, 00112, 00121, 00122, 00130, 00131, 00132, 00133, 00140, 00150
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00060, 00071, 00072, 00073, 00074, 00075, 00076, 00077, 00080, 00090, 00100, 00111, 00112, 00121, 00122, 00130, 00131, 00132, 00133, 00140, 00150

One of the following conditions is true
- Admission's value is not blank, XX.9
- Tumor's value is blank or XX.9
  OR
  - Admission's value is XX.9
  - Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.
Otherwise,
If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.
02/2020	Description Update

LN Status Femoral-Inguinal, Para-Aortic, Pelvic

IDENTIFIERS

CCR ID	NAACCR ID
E1997	3884

OWNER

NAACCR

DESCRIPTION

This data item describes the status of femoral-inguinal, para-aortic and pelvic lymph nodes associated with certain female genital cancers.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	Negative femoral-inguinal, para-aortic and pelvic lymph nodes
1	Positive femoral-inguinal lymph nodes
2	Positive para-aortic lymph nodes
3	Positive pelvic lymph nodes
4	Positive femoral-inguinal and para-aortic lymph nodes
5	Positive femoral-inguinal and pelvic lymph nodes
6	Positive para-aortic and pelvic lymph nodes
7	Positive para-aortic, pelvic, and femoral-inguinal lymph nodes
8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code 8 may result in an edit error.)
9	Not documented in medical record Femoral-Inguinal, Para-aortic and Pelvic lymph nodes not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00500, 00510, 00520
        - Type of Reporting Source is not 7
        - LN Status Femoral-Inguinal, Para-Aortic, Pelvic is blank or 8

        Then convert LN Status Femoral-Inguinal, Para-Aortic, Pelvic to 9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00500, 00510, 00520

OR

- Type of Reporting Source is 7

- LN Status Femoral-Inguinal, Para-Aortic, Pelvic is not blank

Then convert LN Status Femoral-Inguinal, Para-Aortic, Pelvic to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00500, 00510, 00520
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00500, 00510, 00520

One of the following conditions is true

- Admission's value is not blank, 9
- Tumor's value is blank, 9

OR

- Admission's value is 9
- Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.
02/2020	Description Update

Longitude

IDENTIFIERS

CCR ID	NAACCR ID
E1658	2354

DESCRIPTION

The distance, east or west of the Prime Meridian at Greenwich, England, measured in degrees along a meridian as provided by the geocoding vendor for the patient's address at time of diagnosis. Paired with Latitude, Longitude represents the point location of the individual's residence on the earth's surface.

LEVELS

Tumors

LENGTH

11

ALLOWABLE VALUES

Any numeric or decimal or blank (not tracted). May be preceded by a negative sign (-).

SOURCE

Set to blank

UPDATE

Whenever Census Tract 2010 is changed, Longitude must be changed accordingly.
If Census Tract 2010 is untracted then Longitude must be blank.
If Census Tract 2010 is tracted and a Longitude tracted code is available, (whether through 1) geocoding, 2) linking a tumor with a tracted address, or 3) manual entry of a Longitude value) the available Longitude code should be used.
However, if Census Tract 2010 is tracted but Longitude is not available Longitude should be set to blank.
Beginning with the collection of 2010 Census data (Eureka release 10.2), LONGITUDE is only stored if the CENSUS TRACT CERTAINTY 2010 values is 1 or 2.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

5/15/01	Started receiving data.
3/1/12	With release of Eureka 10.2, geocoding moves to the 2010 census boundaries. Longitude reflects the location of the 2010 geocodes for Census Tract Certainty values of 1 and 2. Updated description.

Lymphocytosis

IDENTIFIERS

CCR ID	NAACCR ID
E1998	3885

OWNER

NAACCR

DESCRIPTION

Lymphocytosis is defined by an excess of lymphocytes in the blood. In staging of Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma (CLL/SLL), lymphocytosis is defined as an absolute lymphocyte count (ALC) greater than 5,000 cells/µL.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	Lymphocytosis not present Absolute lymphocyte count = 5,000 cells/ µL
1	Lymphocytosis present Absolute lymphocyte count > 5,000 cells/µL
6	Lab value unknown, physician states lymphocytosis is present
7	Test ordered, results not in chart
9	Not documented in medical record Lymphocytosis not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00795
        - Type of Reporting Source is not 7
        - Lymphocytosis is blank

        Then convert Lymphocytosis to 9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00795

            OR
            - Type of Reporting Source is 7
        - Lymphocytosis is not blank

        Then convert Lymphocytosis to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00795
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00795

One of the following conditions is true

- Admission's value is not blank, 9
- Tumor's value is blank, 9

OR

- Admission's value is 9
- Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Lymphovascular Invasion

IDENTIFIERS

CCR ID	NAACCR ID
E1164	1182

OWNER

AJCC

DESCRIPTION

Indicates whether lymph-vascular invasion (LVI) is identified in the pathology report. This data item will record the information as stated in the record. Presence or absence of cancer cells in the lymphatic ducts or blood vessels is useful for prognosis.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

0	Lymph-vascular Invasion stated as not present
1	Lymph-vascular Invasion Present/Identified
8	Not Applicable
9	Unknown/Indeterminate/not mentioned in path report
Blank	Date of Diagnosis prior to 2010

SOURCE

See CS Version Derived

UPDATE

Tumor Level

New Case Consolidation

If All of the following conditions are true:

Any of these conditions is true:

The admission's Date of Diagnosis year is 2010-9998

The tumor's Date of Diagnosis year is 2010-9998

The admission's Date of Diagnosis year is blank AND the admission's Date of 1st Contact year is 2010-9998

The admission's Lymph-Vascular Invasion is NOT blank

The admission's Lymph-Vascular Invasion value is not the same as the tumor's Lymph-Vascular Invasion

Then list for review

Manual Update

Admission Level

Manual update

Correction/Update Applied

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

2010	New data item added for 2010 data changes. CSv1 to CSv2 Conversion Specs documentation states to leave these blank (see http://www.cancerstaging.org/cstage/software). Added IF #747 and 878.
05/2013	Added IF 1070
05/2016	Revised code descriptions to match NAACCR.
11/2108	Per NAACCR v18, data item name revised from Lymph-vascular Invasion to Lymphovascular Invasion.

Major Vein Involvement

IDENTIFIERS

CCR ID	NAACCR ID
E1999	3886

OWNER

NAACCR

DESCRIPTION

Major vein involvement pertains to the invasion of the kidney tumor into major veins.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	Major vein involvement not present/not identified
1	Renal vein or its segmental branches
2	Inferior vena cava (IVC)
3	Major vein invasion, NOS
4	Any combination of codes 1-3
8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code 8 may result in an edit error.)
9	Not documented in medical record Vein involvement not assessed or unknown if assessed No surgical resection of primary site is performed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00600
        - Type of Reporting Source is not 7
        - Major Vein Involvement is blank or 8

        Then convert Major Vein Involvement to 9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00600

              OR
            - Type of Reporting Source is 7
        - Major Vein Involvement is not blank

        Then convert Major Vein Involvement to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00600
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00600

One of the following conditions is true

- Admission's value is not blank, 9
- Tumor's value is blank, 9

OR

- Admission's value is 9
- Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Marital Status at DX

IDENTIFIERS

CCR ID	NAACCR ID
E1020	150

DESCRIPTION

Marital status when the patient was first diagnosed with this tumor.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

1	Single, never married
2	Married
3	Separated
4	Divorced
5	Widowed
6	Unmarried or Domestic Partner (same sex or opposite sex, registered or unregistered other than common law marriage.)
9	Unknown

SOURCE

If the transmitted value is numeric, then just load it with no conversion. Otherwise convert it to 9.

UPDATE

Tumor Level

New Case Consolidation

If AD_Marital_Status at DX <> 9, TU_Marital_Status at DX = 9, and AD_Class_of_Case = 00-22 or 34,
Move AD_ Marital_Status at DX to TU_ Marital_Status at DX.

If AD_ Marital_Status at DX6 , TU_ Marital_Status at DX = 1, and AD_Class_of_Ca= 00-22 or 34,
Move AD_ Marital_Status at DX to TU_ Marital_Status at DX.

Manual Change

Admission Level

Manual Change Only

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/31/10	2010 Data Changes: CCR name (Marital Status) changed to NAACCR name.
3/14/2011	2011 Data Changes: Added Code 6 for domestic partners.

Measured Basal Diameter

IDENTIFIERS

CCR ID	NAACCR ID
E2000	3887

OWNER

NAACCR

DESCRIPTION

Measured Basal Diameter, the largest basal diameter of a uveal melanoma, is a prognostic indicator for this tumor.

LEVELS

Admissions, Tumors

LENGTH

4

ALLOWABLE VALUES

0.0	No mass/tumor found
0.1 – 99.9	0.1–99.9 millimeters (mm) (Exact measurement to nearest tenth of mm)
XX.0	100 millimeters (mm) or larger
XX.1	Described as "less than 3 mm"
XX.2	Described as “at least” 3 mm
XX.3	Described as “at least” 6 mm
XX.4	Described as “at least” 9 mm
XX.5	Described as “at least” 12 mm
XX.6	Described as “at least” 15 mm
XX.8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code XX.8 may result in an edit error.)
XX.9	Not documented in medical record Cannot be determined by pathologist Measured Basal Diameter not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00671, 00672
        - Type of Reporting Source is not 7
        - Measured Basal Diameter is blank or XX.8

        Then convert Measured Basal Diameter to XX.9
    B. If all of the following conditions are true:

- One of the following is true:
  - Schema ID is not 00671, 00672
    OR
  - Type of Reporting Source is 7
- Measured Basal Diameter is not blank
  Then convert Measured Basal Diameter to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00671, 00672
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00671, 00672

One of the following conditions is true

- Admission's value is not blank, XX.9
- Tumor's value is blank, XX.9
  OR
  - Admission's value is XX.9
  - Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.
Otherwise,
If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Measured Thickness

IDENTIFIERS

CCR ID	NAACCR ID
E2001	3888

OWNER

NAACCR

DESCRIPTION

Measured Thickness, or height, of a uveal melanoma, is a prognostic indicator for this tumor.

LEVELS

Admissions, Tumors

LENGTH

4

ALLOWABLE VALUES

0.0	No mass/tumor found
0.1 – 99.9	0.1–99.9 millimeters (mm) (Exact measurement to nearest tenth of mm)
XX.0	100 millimeters (mm) or larger
XX.1	Described as "less than 3 mm"
XX.2	Described as “at least” 3 mm
XX.3	Described as “at least” 6 mm
XX.4	Described as “at least” 9 mm
XX.5	Described as “at least” 12 mm
XX.6	Described as “at least” 15 mm
XX.8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code XX.8 may result in an edit error.)
XX.9	Not documented in medical record Cannot be determined Measured Thickness not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00660, 00671, 00672
        - Type of Reporting Source is not 7
        - Measured Thickness is blank or XX.8

        Then convert Measured Thickness to XX.9
    B. If all of the following conditions are true:
        - One of the following is true:

- Schema ID is not 00660, 00671, 00672
  OR
- Type of Reporting Source is 7

- Measured Thickness is not blank

Then convert Measured Thickness to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00660, 00671, 00672
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00660, 00671, 00672

One of the following conditions is true

- Admission's value is not blank, XX.9
- Tumor's value is blank, XX.9
  OR
  - Admission's value is XX.9
  - Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.
Otherwise,
If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Medical Record Number-CCR

IDENTIFIERS

CCR ID	NAACCR ID
E1744	None. State Requestor

There is no NAACCR name or number for this data item. It is a CCR (State) required data item.

DESCRIPTION

Medical record number assigned to the patient/admission by the reporting hospital. Note that some hospitals use the patient's Social Security Number.

LEVELS

Admissions

LENGTH

12

ALLOWABLE VALUES

Any combination of alpha and numeric, right-justified. No embedded blanks or special characters. May be blank.

SOURCE

Right justify.

UPDATE

Admission Level

Correction applied

Correction Record value equals Admission value, then do not apply

Correction Record value is not equal to Admission value, then apply

Manual Change

CCR DATA EXTRACT

Yes, record with the earliest admission date for this tumor.

HISTORICAL CHANGES

6/11/04	Updated C/N # to F01049 per C/N unit.
2010	2010 Data Item Changes. CCR name (Med_Rec_No) to match NAACCR name.
2015	Revised Admission level UPDATE logic for Correction Records: • Correction Record value equals Admission value, then do not apply • Correction Record value is not equal to Admission value, then apply

Medicare Beneficiary Identifier

IDENTIFIERS

CCR ID	NAACCR ID
E1908	2315

DESCRIPTION

Congress passed the Medicare Access and CHIP Reauthorization ACT to remove Social Security Number (SSN) from Medicare ID card and replace the existing Medicare Health Insurance Claim Numbers with a Medicare Beneficiary Identifier (MBI). The MBI will be a randomly generated identifier that will not include an SSN or any personal identifiable information.

LEVELS

Patients, Admissions

LENGTH

11

ALLOWABLE VALUES

Blank	Not Available, Non-Medicare Patient, Not Applicable, or Unknown

Note: The Medicare Beneficiary Identifier (MBI) is randomly generated and has 11 characters, consisting of numbers and letters, entered without dashes. The MBI format: https://www.cms.gov/Medicare/New-Medicare-Card/Understanding-the-MBI-with-Format.pdf

SOURCE

If Medicate Beneficiary Identifier is > 0, then load transmitted value.

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's value is not blank
- Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Methylation of O6-Methylguanine-Methyltransferase

IDENTIFIERS

CCR ID	NAACCR ID
E2002	3889

OWNER

NAACCR

DESCRIPTION

O6-Methylguanine-Methyltransferase (MGMT) is an enzyme in cells that repairs DNA. Methylation of the MGMT gene reduces production of MGMT enzyme and the ability of tumor cells to repair damage caused by chemotherapy. Methylation of MGMT is a prognostic and predictive factor for high grade gliomas.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	MGMT methylation absent/not present, unmethylated MGMT
1	MGMT methylation present, low level Hypomethylated Partial methylated
2	MGMT methylation present, high level Hypermethylated
3	MGMT Methylation present, level unspecified
6	Benign or borderline tumor
7	Test ordered, results not in chart
8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code 8 will result in an edit error.)
9	Not documented in patient record Cannot be determined by the pathologist MGMT not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00721 or 00722
        - Type of Reporting Source is not 7
        - Methylation of O6-Methylguanine-Methyltransferase is blank or 8

        Then convert Methylation of O6-Methylguanine-Methyltransferase to 9
    B. If all of the following conditions are true:
        - One of the following is true:

- Schema ID is not 00721, 00722
  OR
- Type of Reporting Source is 7

- Methylation of O6-Methylguanine-Methyltransferase is not blank
  Then convert Methylation of O6-Methylguanine-Methyltransferase to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00721 or 00722
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00721 or 00722

One of the following conditions is true

- Admission's value is not blank or 9
- Tumor's value is blank or 9
  OR
  - Admission's value is 9
  - Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.
Otherwise,
If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Mets at DX-Bone

IDENTIFIERS

CCR ID	NAACCR ID
E1808	1112

OWNER

SEER

DESCRIPTION

This field identifies whether bone is an involved metastatic site. The six Mets at Dx-Metastatic Sites fields provide information on specific metastatic sites for data analysis.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	None; no bone metastases
1	Yes; distant bone metastases
8	Not applicable
9	Unknown whether bone is an involved metastatic site. Not documented in patient record.

SOURCE

1. If Date of Diagnosis is less than 2016, then blank out field
2. If Date of Diagnosis is 2016 and greater, then convert non-blank, non-numeric value to 9

UPDATE

Tumor

New Case Consolidation

If all of these conditions are true:

- Any of these conditions are true:
  - Admission's Date of Diagnosis year is 2016-9998
  - Tumor's Date of Diagnosis year is 2016-9998
  - Tumor's Date of Diagnosis year is blank AND the admission's Date of 1st Contact year is 2016-9998
  - Admission's Date of Diagnosis year is blank AND the admission's Date of 1st Contact year is 2016-9998
- Admission's value is NOT blank
- Admission and tumor's values are different

Then list for review.

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

08/2016	Per NAACCR v16, new data field implemented.

Mets at DX-Brain

IDENTIFIERS

CCR ID	NAACCR ID
E1809	1113

OWNER

SEER

DESCRIPTION

This field identifies whether brain is an involved metastatic site. The six Mets at Dx-Metastatic Sites fields provide information on specific metastatic sites for data analysis.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	None; no brain metastases
1	Yes; distant brain metastases
8	Not applicable
9	Unknown whether brain is an involved metastatic site. Not documented in patient record.

SOURCE

1. If Date of Diagnosis is less than 2016, then blank out field
2. If Date of Diagnosis is 2016 and greater, then convert non-blank, non-numeric value to 9

UPDATE

Tumor

New Case Consolidation

If all of these conditions are true:

- Any of these conditions are true:
  - Admission's Date of Diagnosis year is 2016-9998
  - Tumor's Date of Diagnosis year is 2016-9998
  - Tumor's Date of Diagnosis year is blank AND the admission's Date of 1st Contact year is 2016-9998
  - Admission's Date of Diagnosis year is blank AND the admission's Date of 1st Contact year is 2016-9998
- Admission's value is NOT blank
- Admission and tumor's values are different

Then list for review.

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

08/2016	Per NAACCR v16, new data field implemented.

Mets at DX-Distant LN

IDENTIFIERS

CCR ID	NAACCR ID
E1810	1114

OWNER

SEER

DESCRIPTION

This field identifies whether distant lymph node(s) are an involved metastatic site. The six Mets at DX-Metastatic Sites fields provide information on specific metastatic sites for data analysis.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	None; no lymph node metastases
1	Yes; distant lymph node metastases
8	Not applicable
9	Unknown whether distant lymph node(s) are involved metastatic site. Not documented in patient record.

SOURCE

1. If Date of Diagnosis is less than 2016, then blank out field
2. If Date of Diagnosis is 2016 and greater, then convert non-blank, non-numeric value to 9

UPDATE

Tumor

New Case Consolidation

If all of these conditions are true:

- Any of these conditions are true:
  - Admission's Date of Diagnosis year is 2016-9998
  - Tumor's Date of Diagnosis year is 2016-9998
  - Tumor's Date of Diagnosis year is blank AND the admission's Date of 1st Contact year is 2016-9998
  - Admission's Date of Diagnosis year is blank AND the admission's Date of 1st Contact year is 2016-9998
- Admission's value is NOT blank
- Admission and tumor's values are different

Then list for review.

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

08/2016	Per NAACCR v16, new data field implemented.

Mets at DX-Liver

IDENTIFIERS

CCR ID	NAACCR ID
E1811	1115

OWNER

SEER

DESCRIPTION

This field identifies whether liver is an involved metastatic site. The six Mets at Dx-Metastatic Sites fields provide information on specific metastatic sites for data analysis.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	None; no liver metastases
1	Yes; distant liver metastases
8	Not applicable
9	Unknown whether liver is involved metastatic site. Not documented in patient record.

SOURCE

1. If Date of Diagnosis is less than 2016, then blank out field
2. If Date of Diagnosis is 2016 and greater, then convert non-blank, non-numeric value to 9

UPDATE

Tumor

New Case Consolidation

If all of these conditions are true:

- Any of these conditions are true:
  - Admission's Date of Diagnosis year is 2016-9998
  - Tumor's Date of Diagnosis year is 2016-9998
  - Tumor's Date of Diagnosis year is blank AND the admission's Date of 1st Contact year is 2016-9998
  - Admission's Date of Diagnosis year is blank AND the admission's Date of 1st Contact year is 2016-9998
- Admission's value is NOT blank
- Admission and tumor's values are different

Then list for review.

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

08/2016	Per NAACCR v16, new data field implemented.

Mets at DX-Lung

IDENTIFIERS

CCR ID	NAACCR ID
E1812	1116

OWNER

SEER

DESCRIPTION

This field identifies whether lung is an involved metastatic site. The six Mets at Dx-Metastatic Sites fields provide information on specific metastatic sites for data analysis.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	None; no lung metastases
1	Yes; distant lung metastases
8	Not applicable
9	Unknown whether lung is involved metastatic site. Not documented in patient record.

SOURCE

1. If Date of Diagnosis is less than 2016, then blank out field
2. If Date of Diagnosis is 2016 and greater, then convert non-blank value to 9

UPDATE

Tumor

New Case Consolidation

If all of these conditions are true:

- Any of these conditions are true:
  - Admission's Date of Diagnosis year is 2016-9998
  - Tumor's Date of Diagnosis year is 2016-9998
  - Tumor's Date of Diagnosis year is blank AND the admission's Date of 1st Contact year is 2016-9998
  - Admission's Date of Diagnosis year is blank AND the admission's Date of 1st Contact year is 2016-9998
- Admission's value is NOT blank
- Admission and tumor's values are different

Then list for review.

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

05/2016	Per NAACCR v16, new data field implemented.

Mets at DX-Other

IDENTIFIERS

CCR ID	NAACCR ID
E1813	1117

OWNER

SEER

DESCRIPTION

This field identifies whether other metastatic involvement, other than bone, brain, liver, lung or distant lymph nodes exists. Some examples include but are not limited to the adrenal gland, bone marrow, pleura, peritoneum and skin. The six Mets at Dx-Metastatic Sites fields provide information on specific metastatic sites for data analysis.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	None; no other metastases
1	Yes; distant metastases in known site(s) other than bone, brain, liver, lung, or distant lymph nodes
8	Not applicable
9	Unknown whether any other metastatic site. Not documented in patient record.

SOURCE

1. If Date of Diagnosis is less than 2016, then blank out field
2. If Date of Diagnosis is 2016 and greater, then convert non-blank, non-numeric value to 9

UPDATE

Tumor

New Case Consolidation

If all of these conditions are true:

- Any of these conditions are true:
  - Admission's Date of Diagnosis year is 2016-9998
  - Tumor's Date of Diagnosis year is 2016-9998
  - Tumor's Date of Diagnosis year is blank AND the admission's Date of 1st Contact year is 2016-9998
  - Admission's Date of Diagnosis year is blank AND the admission's Date of 1st Contact year is 2016-9998
- Admission's value is NOT blank
- Admission and tumor's values are different

Then list for review.

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

08/2016	Per NAACCR v16, new data field implemented.

Microsatellite Instability (MSI)

IDENTIFIERS

CCR ID	NAACCR ID
E2003	3890

OWNER

NAACCR

DESCRIPTION

Microsatellite Instability (MSI) is a form of genetic instability manifested by changes in the length of repeated single- to six-nucleotide sequences (known as DNA microsatellite sequences). High MSI, found in about 15% of colorectal carcinomas, is an adverse prognostic factor for colorectal carcinomas and predicts poor response to 5-FU chemotherapy (although the addition of oxaliplatin in FOLFOX regimens negates the adverse effects [page 266 AJCC manual]). High MSI is a hallmark of hereditary nonpolyposis colorectal carcinoma, also known as Lynch syndrome.

LEVELS

Admissions, Tumors

LENGTH

ALLOWABLE VALUES

0	Microsatellite instability (MSI) stable; microsatellite stable (MSS); negative, NOS AND/OR Mismatch repair (MMR) intact, no loss of nuclear expression of MMR proteins
1	MSI unstable low (MSI-L)
2	MSI unstable high (MSI-H) AND/OR MMR-D (loss of nuclear expression of one or more MMR proteins, MMR protein deficient)
8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code 8 may result in an edit error.)
9	Not documented in medical record MSI-indeterminate Microsatellite instability not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00200
        - Type of Reporting Source is not 7
        - Microsatellite Instability (MSI) is blank or 8

        Then convert Microsatellite Instability (MSI) to 9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00200

OR

- Type of Reporting Source is 7

- Microsatellite Instability (MSI) is not blank

Then convert Microsatellite Instability (MSI) to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00200
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00200

One of the following conditions is true

- Admission's value is not blank or 9
- Tumor's value is blank or 9

OR

- Admission's value is 9
- Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Microvascular Density

IDENTIFIERS

CCR ID	NAACCR ID
E2004	3891

OWNER

NAACCR

DESCRIPTION

Microvascular Density (MVD), a quantitative measure of tumor vascularity, is a prognostic factor for uveal melanoma.

LEVELS

Admissions, Tumors

LENGTH

2

ALLOWABLE VALUES

00	No vessels involved
01-99	01-99 vessels per 0.3 square millimeter (mm2)
X1	Greater than or equal to 100 vessels per 0.3 square millimeter (mm2)
X2	Lowest quartile for laboratory
X3	Second quartile for laboratory
X4	Third quartile for laboratory
X5	Highest quartile for laboratory
X7	Test ordered, results not in chart
X8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code 8 may result in an edit error.)
X9	Not documented in medical record Microvascular Density (MVD) not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00671, 00672
        - Type of Reporting Source is not 7
        - COC Accredited Flag is 1
        - Microvascular Density is blank or X8

        Then convert Microvascular Density to X9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00671, 00672

            OR

- Type of Reporting Source is 7
- Microvascular Density is not blank

Then convert Microvascular Density to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00671, 00672
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00671, 00672

One of the following conditions is true

- Admission's value is not blank, X8, X9
- Tumor's value is blank, X8, or X9

OR

- Admission's value is X9
- Tumor's value is blank or X8

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Mitotic Count Uveal Melanoma

IDENTIFIERS

CCR ID	NAACCR ID
E2006	3892

OWNER

NAACCR

DESCRIPTION

Mitotic Count Uveal Melanoma, the number of mitoses per 40 high-power fields (HPF) based on pathological evaluation, is a prognostic factor for uveal melanoma.

LEVELS

Admissions, Tumors

LENGTH

4

ALLOWABLE VALUES

0.0	0 mitoses per 40 high-power fields (HPF) Mitoses absent, no mitoses present, no mitotic activity
0.1 – 99.9	0.1-99.9 mitosis per 40 HPF
XX.1	100 or more mitoses per 40 HPF
XX.2	Stated as low mitotic count or rate with no specific number
XX.3	Stated as high mitotic count or rate with no specific number
XX.4	Mitotic count described with denominator other than 40 HPF
XX.7	Test ordered, results not in chart
XX.8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code XX.8 may result in an edit error.)
XX.9	Not documented in medical record Mitotic Count Uveal Melanoma not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00671, 00672
        - Type of Reporting Source is not 7
        - COC Accredited Flag is 1
        - Mitotic Count Uveal Melanoma is blank or XX.8

        Then convert Mitotic Count Uveal Melanoma to XX.9
    B. If all of the following conditions are true:
        - One of the following is true:

- Schema ID is not 00671, 00672
  OR
- Type of Reporting Source is 7

- Mitotic Count Uveal Melanoma is not blank

Then convert Mitotic Count Uveal Melanoma to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00671, 00672
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00671, 00672

One of the following conditions is true

- Admission's value is not blank, XX.8, or XX.9
- Tumor's value is blank , XX.8, or XX.9
  OR
  - Admission's value is XX.9
  - Tumor's value is blank or XX.8

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Mitotic Rate Melanoma

IDENTIFIERS

CCR ID	NAACCR ID
E2006	3893

OWNER

NAACCR

DESCRIPTION

Mitotic Rate Melanoma, the number of mitoses per square millimeter based on pathological evaluation, is a prognostic factor for melanoma of the skin.

LEVELS

Admissions, Tumors

LENGTH

2

ALLOWABLE VALUES

00	0 mitoses per square millimeter (mm) Mitoses absent No mitoses present
01-99	1 - 99 mitoses/square mm (Exact measurement in mitoses/square mm)
X1	100 mitoses/square mm or more
X2	Stated as "less than 1 mitosis/square mm" Stated as "nonmitogenic"
X3	Stated as "at least 1 mitosis/square mm" Stated as "mitogenic"
X4	Mitotic rate described with denominator other than square millimeter (mm)
X7	Test ordered, results not in chart
X8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code X8 may result in an edit error.)
X9	Not documented in medical record Mitotic Rate Melanoma not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00470
        - Type of Reporting Source is not 7
        - Mitotic Rate Melanoma is blank or X8

        Then convert Mitotic Rate Melanoma to X9

B. If all of the following conditions are true:
- One of the following is true:
  - Schema ID is not 00470
    OR
  - Type of Reporting Source is 7
- Mitotic Rate Melanoma is not blank

Then convert Mitotic Rate Melanoma to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:
- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00470
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00470

One of the following conditions is true
- Admission's value is not blank, X9
- Tumor's value is blank, X9

OR
- Admission's value is X9
- Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Morph Coding Sys--Current

IDENTIFIERS

CCR ID	NAACCR ID
E1068	470

DESCRIPTION

Code that best describes how morphology is currently coded. If converted, this field shows the system it is converted to.

LEVELS

Tumors

LENGTH

1

ALLOWABLE VALUES

1	ICD-O, First Edition
2	ICD-O, 1986 Field Trial
3	ICD-O, 1988 Field Trial
4	ICD-O, Second Edition
5	ICD-O, Second Edition, plus REAL lymphoma codes effective 1/1/95
6	ICD-O, Second Edition, plus FAB codes effective 1/1/98
7	ICD-O, Third Edition
8	ICD-O, Third Edition, plus 2008 WHO hematopoietic/lymphoid new terms effective 1/1/2010
9	Other

SOURCE

See Extract.

UPDATE

None

CONSOLIDATED DATA EXTRACT

Generate 7 (ICDO Third Edition (2000).

HISTORICAL CHANGES

8/15/06	Generated item in Volume II added to Volume III with 2007 data changes.
2010	2010 Data Changes: Added code 8 to Allowable values.

Morph Coding Sys--Originl

IDENTIFIERS

CCR ID	NAACCR ID
E1069	480

DESCRIPTION

Code that best describes how morphology was originally coded. If later converted, this field shows the original codes used.

LEVELS

Tumors

LENGTH

1

ALLOWABLE VALUES

1	ICD-O, First Edition
2	ICD-O, 1986 Field Trial
3	ICD-O, 1988 Field Trial
4	ICD-O, Second Edition
5	ICD-O, Second Edition, plus REAL lymphoma codes, effective 1/1/95
6	ICD-O, Second Edition, plus FAB codes, effective 1/1/98
7	ICD-O, Third Edition
8	ICD-O, Third Edition, plus 2008 WHO hematopoietic/lymphoid new terms, effective 1/1/2010
9	Other

SOURCE

See Consolidated Data Extract.

UPDATE

None

CONSOLIDATED DATA EXTRACT

If Date of Diagnosis < 1992, then generate 3 (ICDO 1988 Field Trial);
Else
if Date of Diagnosis is > 1991 and < 2001, then generate 4 (ICDO Second Edition (1990));
otherwise,
Generate 7 (ICDO Third Edition (2000)).

HISTORICAL CHANGES

8/06	Generated item in Volume II added to Volume III with 2007 data changes.
2010	Data Changes: Added code 8 to Allowable values.

Mult Tum Rpt As One Prim

IDENTIFIERS

CCR ID	NAACCR ID
E1076	444

OWNER

SEER

DESCRIPTION

Identifies cases with multiple tumors that are abstracted and reported as a single primary using the SEER, multiple primary rules. Multiple tumors may individually exhibit in situ, invasive, or any combination of in situ and invasive behaviors. Multiple intracranial and central nervous system tumors may individually exhibit benign, borderline, malignant, or any combination of these behaviors. Multiple tumors found in the same organ or in a single primary site may occur at the time of initial diagnosis or within one year of the initial diagnosis.

LEVELS

Admissions, Tumors

LENGTH

2

ALLOWABLE VALUES

00	Single tumor
10	At least two benign tumors in same organ/primary site (Intracranial & CNS sites only)
11	At least two borderline tumors in the same organ/primary site (Intracranial & CNS sites only)
12	Benign and borderline tumors in the same organ/primary site (Intracranial & CNS sites only)
20	At least two in situ tumors in the same organ/primary site
30	One or more in situ & one or more invasive tumors in the same organ/primary site
31	One or more in situ/invasive adenocarcinoma in a polyp & one or more frank adenocarcinoma in one segment of colon
32	Familial polyposis with one or more in situ/invasive carcinoma
40	At least two invasive tumors in the same organ (Includes one or more invasive tumor with histology "NOS" & one or more separate invasive tumor with a more specific histology)
80	Multiple tumors present in the same organ/primary site, unknown if in situ or invasive
88	Information on multiple tumors not collected/not applicable for this site
99	Unknown
Blank	Information not collected for this diagnosis date - Year of Date of Diagnosis is prior to 2007 or 2013 and later.

SOURCE

N/A

UPDATE

List for Review

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

08/15/06	New data item for 2007.
02/20/08	Changed Update spec to List for Review (was Manual) so discrepancies are reflected in Conflict table. Added IF #785.
02/2009	Added IF #828, 829 and 830.
03/2015	Clarified that blank is also allowed when year of Date of Diagnosis is prior to 2007 or 2013 and later.

Multigene Signature Method

IDENTIFIERS

CCR ID	NAACCR ID
E2007	3894

OWNER

NAACCR

DESCRIPTION

Multigene signatures or classifiers are assays of a panel of genes from a tumor specimen, intended to provide a quantitative assessment of the likelihood of response to chemotherapy and to evaluate prognosis or the likelihood of future metastasis. This data item identifies the multigene signature method used. Oncotype Dx is coded elsewhere.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

1	Mammaprint
2	PAM50 (Prosigna)
3	Breast Cancer Index
4	EndoPredict
5	Test performed, type of test unknown
6	Multiple tests, any tests in codes 1-4
7	Test ordered, results not in chart
8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code 8 will result in an edit error.)
9	Not documented in medical record Multigene Signature Method not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00480
        - Type of Reporting Source is not 7
        - Multigene Signature Method is blank or 8

        Then convert Multigene Signature Method to 9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00480

            OR

- Type of Reporting Source is 7
- Multigene Signature Method is not blank
  Then convert Multigene Signature Method to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00480
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00480

One of the following conditions is true

- Admission's value is not blank or 9
- Tumor's value is blank or 9
  OR
  - Admission's value is 9
  - Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.
Otherwise,
If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Multigene Signature Results

IDENTIFIERS

CCR ID	NAACCR ID
E2008	3895

OWNER

NAACCR

DESCRIPTION

Multigene signatures or classifiers are assays of a panel of genes from a tumor specimen, intended to provide a quantitative assessment of the likelihood of response to chemotherapy and to evaluate prognosis or the likelihood of future metastasis. This data item identified the multigene signature result. Oncotype Dx is coded elsewhere.

LEVELS

Admissions, Tumors

LENGTH

2

ALLOWABLE VALUES

00-99	Enter actual recurrence score Note: Depending on the test, the range of values may be different
X1	Score 100
X2	Low risk
X3	Moderate [intermediate] risk
X4	High risk
X7	Test ordered, results not in chart
X8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code X8 will result in an edit error.)
X9	Not documented in medical record Multigene Signature Results not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00480
        - Type of Reporting Source is not 7
        - Multigene Signature Results is blank or X8

        Then convert Multigene Signature Results to X9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00480

            OR

- Type of Reporting Source is 7
- Multigene Signature Results is not blank

Then convert Multigene Signature Results to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00480
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00480

One of the following conditions is true

- Admission's value is not blank or X9
- Tumor's value is blank or X9

OR

- Admission's value is X9
- Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Multiplicity Counter

IDENTIFIERS

CCR ID	NAACCR ID
E1079	446

OWNER

SEER

DESCRIPTION

This data item is used to count the number of individual reportable tumors (multiplicity) that are present at the time of diagnosis or the number of reportable tumors that occur within one year of the original diagnosis reported as a single primary using the SEER, IARC, or Canadian Cancer Registry multiple primary rules.

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

00	No primary tumor identified.
01	One tumor only
02	Two tumors present bilateral ovaries involved with cystic carcinoma.
03	Three tumors present
04-87	Respective number of tumors present
88	Information on multiple tumors not collected/not applicable for this site
89	Multicentric, multifocal, number unknown.
99	Unknown if multiple tumors; not documented.
Blank	Information not collected for this diagnosis date - Year of Date of Diagnosis is prior to 2007 or 2013 and later.

SOURCE

Upload with no conversion.

UPDATE

List for Review

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

8/15/06:	New data item for 2007.
2/20/08:	Changed Update spec to List for Review (was Manual) so discrepancies are reflected in Conflict table. Added IF #786 and 787.
11/2008:	Removed IF #787 (Multiplicity Counter, Thyroid Schema) due to removal from NAACCR metafile.
2/2009:	Added IF #828.
3/14/2011:	For 2011 data changes, added codes 00 and 89 and modified text for codes 02 and 99.

03/2015	Clarified that blank is allowed when year of Date of Diagnosis is prior to 2007 or 2013 and later.

NAACCR Record Version

IDENTIFIERS

CCR ID	NAACCR ID
E1003	50

OWNER

NAACCR

DESCRIPTION

This field denotes the version of any transmit record format, regardless of the record type or whether the record is being moved between the region and central or region and hospital.

LEVELS

Various transmit files

LENGTH

3

ALLOWABLE VALUES

Any alphanumeric character that is specified for a particular record type in either Volume 2 or Volume 3. For new case transmission files, this field corresponds to the NAACCR record version.

Codes

120 2010 Version 12
121 2011 Version 12.1
122 2012 Version 12.2
130 2013 Version 13
140 2014 Version 14
150 2015 Version 15
160 2016 Version 16
180 2018 Version 18

Before 2010, this was a 1-character field with the following codes.

1	1992-1994 Version 2 and Version 3
4	1995 Version 4.0
5	1996 and 1997 Version 5.0 or Version 5.1
6	1998 Version 6
7	1999 Version 7
8	2000 Version 8
9	2001 and 2002 Version 9 and 9.1
A	2003, 2004 and 2005 Version 10, 10.1 and 10.2
B	2006, 2007, and 2008 Version 11, 11.1, 11.2 and 11.3
Blank	September 1989 Version

SOURCE

Either generate the appropriate value on creation of a record to be transmitted or receive it from the transmitting agency.

UPDATE

None

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/26/03:	Added NAACCR record version explanation to the Allowable values area. Name change to Version (was REC-VERSION.
7/27/05:	Changed CCR name (Version) to the NAACCR name. Updated Allowable Values.
2010	Data Changes: Length increased to 3 (was 1) and 120 added to Allowable Values and B modified.
2011	Data Changes: Added code 121 to identify Version 12.1.
2012	Data Changes: Added code 122 to identify Version 12.2.
04/2014	Per NAACCR v14, added code 140 to identify 2014 Version 14.
03/2015	Per NAACCR v15, added code 150 to identify 2015 Version 15.
03/2016	Per NAACCR v16, added code 160 to identify 2016 Version 16.
01/2019	Per NAACCR v18, added code 180 to identify 2018 Version 18.

Name Alias 1-5

Item Name	Alternate Name	CCR-ID	NAACCR-ID
Name Alias 1	AKANAME1	E1730	None. State Requestor
Name Alias 2	AKANAME2	E1732	None. State Requestor
Name Alias 3	AKANAME3	E1733	None. State Requestor
Name Alias 4	AKANAME4	E1736	None. State Requestor
Name Alias 5	AKANAME5	E1738	None. State Requestor

DESCRIPTION

This is another name that the person may be known as; extracted by the CCR when there are multiple Name--Alias Last, Name--Alias First, or Name--Maiden.

LEVELS

N/A

LENGTH

40

ALLOWABLE VALUES

May be blank. If entered, must be alpha, left-justified, and blank-filled. Mixed case, embedded spaces, hyphens, and apostrophes are also allowed. No other special characters are allowed.

SOURCE

N/A

UPDATE

N/A

CONSOLIDATED DATA EXTRACT

Yes.
Send Name-Maiden in Name-Maiden field of the record. (If there is a hyphenated Name--Maiden, that value should be selected for transmittal instead of either of its component parts).
Send the first Name Alias Last and Name Alias First in the specifically designated fields.
Send additional aliases (first ones found with either a code 1 or 2 in the Name Alias Flag field) in ALIAS fields, filling the first fields first until there either are no more Alias values to send, or there is no more space in the transmittal record.
Send Mother_Fir_Name in its designated field.

HISTORICAL CHANGES

3/03	This field does not exist in the CCR central system (EUREKA), so the levels, source, and update requirements were removed. But it does exist in the new case record format in Volume II and the region to central format in Volume III, Appendix 15. The Allowable values edit and the Interrecord edits were removed here. The Interfield edits were relocated to other pages. AKAFNAME and AKALNAME moved to their own data item pages.
2010	Data Changes: CCR name (Alias-Name) changed for consistency in naming.
2/7/11	Allowable values text changed to match other Alias name specs.

Name Alias-Flag 1-5

IDENTIFIERS

Name	Alternative Name	CCR ID	NAACCR ID
Name Alias-Flag 1	AKAFLAG1	E1731	None. State Requestor
Name Alias-Flag 2	AKAFLAG2	E1733	None. State Requestor
Name Alias-Flag 3	AKAFLAG3	E1735	None. State Requestor
Name Alias-Flag 4	AKAFLAG4	E1737	None. State Requestor
Name Alias-Flag 5	AKAFLAG5	E1739	None. State Requestor

DESCRIPTION

Code indicates whether the Alias name represents an Alias for the patient's first name or last name or is a maiden name, or a portion of either last name, alias name, or maiden name in data extracted for the CCR.

LEVELS

N/A

LENGTH

1

ALLOWABLE VALUES

1	Alias for first name
2	Alias for last name or a portion thereof
3	Alias value is Name--Maiden or a portion thereof
4	Mother's first name

SOURCE

N/A

UPDATE

N/A

CONSOLIDATED DATA EXTRACT

Yes, generate from Name--Alias First, Name--Alias Last, Name--Maiden if more than one of each type exist.

HISTORICAL CHANGES

3/26/03	This field no longer exists in the CCR central system (EUREKA), so the levels, source and update requirements were removed. But it does exist in the new case record format in Volume II and the region to central format in Volume III, Appendix 15. The Allowable value edit (#032), Update logic and Interrecord edits were removed.
2010	Data Changes: Name change for consistency in naming (was Alias-Flag)(is Alias Flag 1-5)

Name--Alias First

IDENTIFIERS

CCR ID	NAACCR ID
E1741	None. State Requestor

DESCRIPTION

This is another first name that the person may be known as

LEVELS

Patients, Admissions

LENGTH

40

ALLOWABLE VALUES

May be blank. If entered, must be alpha, left-justified, and blank-filled. Mixed case, embedded spaces, hyphens, and apostrophes are also allowed. No other special characters are allowed.

SOURCE

If transmitted name includes two names separated by a hyphen, then create an alias first name for each separate name, unless they already exist as alias first names or the first name.
Otherwise, just upload the transmitted alias first name value.
Auto-generate NYSIIS name for each name. Upshift. Don't record change in Audit Log unless additional alias first names are created.

UPDATE

Patient Level

New Case Consolidation

If the incoming Admission's Name--First or any of its Name--Alias First are not the same as the Patient's Name--First and current Name--Alias First, then add them as additional Patient Name--Alias First.

Manual Change to Name--First

Automatically add original Name--First as an additional Name--Alias First

Manual Addition or Change

Admission Level

Manual Change to Name--First

Automatically add original Name--First as an additional Name--Alias First

Manual Addition or Change

CONSOLIDATED DATA EXTRACT

Yes, in alias first name field and generic alias fields if there is more than one.

HISTORICAL CHANGES

3/26/03	Date Page Added
3/31/10	2010 Data Changes: Name change for consistency in naming (was Alias First Name). Length changed from 15 to 40.
2/7/2011	Allowable values text changed to match Err #033 specification.

Name--Alias Last

IDENTIFIERS

CCR ID	NAACCR ID
E1642	2280

DESCRIPTION

This is another last name that the person may be known as.

LEVELS

Patients, Admissions

LENGTH

40

SOURCE

If transmitted name includes two names separated by a hyphen, then create a Name--Alias (Last) for each separate name, unless they already exist as Name--Aliases, Name--Maidens, or Name--Last.
Otherwise, just upload the transmitted alias last name value.
Auto-generate NYSIIS name for each name.
Upshift.
Don't record change in Audit Log unless additional alias last names are recreated.

UPDATE

PATIENT LEVEL

NEW CASE CONSOLIDATION

If the incoming Admission's Last_Name or any of its Name--Alias Last are not the same as the Patient's Name--Last and current Name--Aliases and Names--Maiden, then

- Add them as additional Patient Name--Aliases
- Manual Change to Name--Last or Name--Maiden
- Automatically add original name as an additional Name--Alias (Last)

MANUAL ADDITION OR CHANGE

If Name--Alias (Last) changes, through consolidation or manual change, then

NHIA_Derived_Hisp_Origin must be regenerated

ADMISSION LEVEL

- Manual Change to Name--Last or Name--Maiden
- Automatically add original name as an additional Name--Alias (Last)
- Manual Addition or Change

CONSOLIDATED DATA EXTRACT

Yes, in alias last name field and generic alias fields if there is more than one.

HISTORICAL CHANGES

3/03	This data item page was added. Data item used to be in Alias_Name page
1/05	Added Update logic for NHIA_Derived_Hisp_Origin regeneration.
2010	Data Changes: Length changed from 15 to 40. Numerous names changed in the Update Section to match NAACCR names. CCR name (Alias Last Name) changed to match NAACCR for consistency in naming. CCR added Last to the NAACCR name for clarity.
2/7/11	Allowable values text changed to match Err #033 specification.

Name--First

IDENTIFIERS

CCR ID	NAACCR ID
E1638	2240

OWNER

CoC

DESCRIPTION

Patient's first name

LEVELS

Patients, Admissions

LENGTH

40

ALLOWABLE VALUES

May not be blank.
Enter NFN, if no first name.
Enter UNKNOWN, if unknown first name.
Must be alpha, left-justified, and blank-filled. Mixed case, embedded spaces, hyphens, and apostrophes are also allowed. No other special characters are allowed.

SOURCE

If transmitted name includes two names separated by a hyphen, then create an alias first name for each separate name, unless they already exist as alias first names.
Otherwise, just upload the transmitted first name value.
Auto-generate NYSIIS name for each name.
Upshift. Don’t record change in Audit Log unless additional alias first names are created

UPDATE

Manual

CONSOLIDATED DATA EXTRACT

Yes

LIST FOR REVIEW

AD_Name First <>PA_Name First

HISTORICAL CHANGES

08/03	Added text to Source that explains how to handle a hyphened name
2010	2010 Data Item Changes: Length changed from 14to 40. CCR name (First_Name) changed to NAACCR name
03/14/11	2011 Data Changes: Changed to NPCR edit per Note: As of the NAACCR v12.1 metafile, the NAACCR edit of the same name has been deleted. We are using the NPCR edit because we don't allow blanks (the COC edit allows blanks). This edit now allows hyphens.
04/2014	In allowable values, corrected NLN to NFN and added UNKNOWN.

Name--Last

IDENTIFIERS

CCR ID	NAACCR ID
E1637	2230

OWNER

CoC

DESCRIPTION

Patient's last name.

LEVELS

Patients, Admissions

LENGTH

40

ALLOWABLE VALUES

May not be blank.
Enter NLN, if no last name.
Enter UNKNOWN, if unknown last name.
Must be alpha, left-justified, and blank-filled. Mixed case, embedded spaces, hyphens, and apostrophes are also allowed. No other special characters are allowed.
Historical note in V3: no SR or JR allowed.

SOURCE

Upshift; if transmitted Name--Last includes two names separated by a hyphen, then create an Alias_Name Last for each separate name, unless they already exist as Name Alias--Last or Name--Maiden.
Otherwise, just upload the transmitted Name--Last value.
Auto-generate NYSIIS name (See Appendix 5) for each name added (don't record in Audit Log unless Alias_Last_Names are created

UPDATE

Manual
If "Name--Last" changes, then NHIA_Derived_Hisp_Origin must be regenerated.

CONSOLIDATED DATA EXTRACT

Yes

LIST FOR REVIEW

AD_Name--Last <> PA_Name--Last

HISTORICAL CHANGES

08/03	Added NLN to Allowable values for cases with no last name. Added text to Source that explains how to process a hyphened name.
01/05	Added Update logic to handle NHIA_Derived_Hisp_Origin regeneration.
2010	Data Changes: Length changed to 40 (was 25). CCR name (Last_Name) changed to NAACCR name.
03/2011	Data Changes: Allowable values definition changed to COC edit definitions per NAACCR 12.1 notes.
04/2014	Added UNKNOWN to allowable values.

Name--Maiden

IDENTIFIERS

CCR ID	NAACCR ID
E1643	2390

DESCRIPTION

This is the maiden name (unmarried name) of the patient when the patient has a different Name Last

LEVELS

Patients, Admissions

LENGTH

40

ALLOWABLE VALUES

Name--Maiden may be blank. If entered, must be alpha, left-justified, and blank-filled.
Mixed case, embedded spaces, hyphens, and apostrophes are also allowed. No other special characters are allowed.

SOURCE

Upshift;
If transmitted Name--Maiden includes two names separated by a hyphen, then create a Name--Maiden for each separate name, unless they already exist as Name--Alias, Name--Last, or Name--Maiden. Otherwise, just upload the transmitted Name--Maiden value. Auto-generate NYSIIS name for each name added (don't record in Audit Log unless additional Name--Maiden are created).

UPDATE

Manual
If Name--Maiden changes, then NHIA_Derived_Hisp_Origin must be regenerated.

CONSOLIDATED DATA EXTRACT

Yes (in its own field)

LIST FOR REVIEW

If AD_Name--Maiden<> PA_Name--Maiden

HISTORICAL CHANGES

1/05	Update logic added for NHIA_Derived_Hisp_Origin regeneration.
2010	Data Changes: Length changed from 15 to 40. CCR name (Maiden Last) changed to NAACCR name.
3/14/11	Updated Allowable Values to match SEER edit. Note: This edit is not supported by the COC as of 1/1/2003; however, SEER has agreed to support this data item and edit.

Name--Middle

IDENTIFIERS

CCR ID	NAACCR ID
E1369	2250

DESCRIPTION

Patient's middle name.

LEVELS

Patients, Admissions

LENGTH

40

ALLOWABLE VALUES

Name--Middle may be blank.
If entered, must be alpha, left-justified, and blank-filled. Mixed case, embedded spaces, hyphens, and apostrophes are also allowed. No other special characters are allowed.

SOURCE

Upshift, left justify.

UPDATE

If any of the following conditions are true:

- Admission Name--Middle is blank
- Admission Name--Middle = Patient Name--Middle
- Admission Name--Middle is 1 character long and that character matches the first character of Patient Name--Middle
- Admission Name--Middle is a nick name associated with the Patient Name-Middle

  - **Then do nothing**

Else If any of the following conditions are true:

- Admission Name--Middle is NOT blank and Patient Name--Middle is blank
- Admission Name--Middle is 2 or more characters and Patient Name--Middle is just the first character of Admission Name--Middle
- Patient Name--Middle is a nick-name associated with the Admission Name--Middle (if we don't want to take name over associated nick-name, then we could just add a bullet to the previous "if" statement to do nothing in this situation too)

  - **Then update Patient Name--Middle with Admission Name--Middle and stop here.**

Else If Admission Name--Middle ≠ Patient Name--Middle

  - **Then list for review.**

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

2010	Data Changes: Length changed from 14 to 40. CCR name (Middle Name) changed to NAACCR name.
03/2011	Data Changes: As of the NAACCR v12.1 metafile, the NAACCR edit of the same name has been deleted. Registries are expected to follow the COC standard in that embedded spaces are allowed. The allowable values edit now allows hyphens

02/2020	Update Logic change

Name--Mother First

IDENTIFIERS

CCR ID	NAACCR ID
E1729	None. State Requestor

DESCRIPTION

Enter the mother's first name in this field for all patients.

LEVELS

Patients, Admissions

LENGTH

40

ALLOWABLE VALUES

Name--Mother First may be blank.
If entered, must be alpha, left-justified, and blank-filled. Mixed case, embedded spaces, hyphens, and apostrophes are also allowed. No other special characters are allowed.

SOURCE

Upshift

UPDATE

Manual

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

2010	Data Changes: Length changed from 14 to 40. CCR name (Mother Fir Name) changed to NAACCR name.
2011	Data Changes: Allowable values edit updated to match Name--First changes that accept hyphens now.

Name--Suffix

IDENTIFIERS

CCR ID	NAACCR ID
E1641	2270

DESCRIPTION

A generational title that would follow a name in a letter. It helps to distinguish between patients with the same name. Contains no punctuation.

LEVELS

Patients, Admissions

LENGTH

3

ALLOWABLE VALUES

Alpha or blank.

SOURCE

Upshift

UPDATE

If AD Name--Suffix = (PA Name--Suffix or blank) do nothing.
If AD Name--Suffix <> blank and PA Name--Suffix = blank, move AD Name--Suffix to PA Name--Suffix.
If none of the above, list for review.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

	None

NBCCEDP Linkage Date

IDENTIFIERS

CCR-ID	NAACCR-ID
E1636	9981

DESCRIPTION

The BCCEDP link date indicates the date where a linkage between the central registry DMS and the BCCEDP database occurred.

LEVELS

Tumors

LENGTH

8

ALLOWABLE VALUES

A complete date (CCYYMMDD) or a blank.

SOURCE

Upload with no conversions.

UPDATE

None

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

3/14/11	This item added for 2011 as part of the CER project.

NBCCEDP Linkage Results

Full Name: **Breast and Cervical Cancer Early Detection Program (BCCEDP Linkage Results)**

IDENTIFIERS

Data Item	CCR	NAACCR
NBCCEDP Linkage Results	E1635	9980

DESCRIPTION

The purpose of this variable is to enhance the completeness and quality of the central registry database by expanding the linkage with the state Breast and Cervical Cancer Early Detection Program (BCCEDP) data system and to capture and maintain the resulting information.
The information to be captured and maintained includes a BCCEDP link variable and BCCEDP link date.
The NBCCEDP MDE Link variable will identify breast or cervical cancer cases in the registry database that matched the same patient and tumor in the NBCCEDP data set.

LEVELS

Tumors

LENGTH

1

ALLOWABLE VALUES

0	No match for this cancer with BCCEP data
1	Match for this cancer with BCCEP data
blank	Match unknown: Record not sent for linkage

SOURCE

Upload with no conversion.

UPDATE

None

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

2011 Data Item Changes, CER Project	Added for CER requirements.

NCCN International Prognostic Index (IPI)

IDENTIFIERS

CCR ID	NAACCR ID
E2009	3896

OWNER

NAACCR

DESCRIPTION

The NCCN International Prognostic Index (IPI) (previously only "IPI") is used to define risk groups for specific lymphomas using a 0-5 score range, based on age, stage, number of extranodal sites of involvement, patient's performance status and pretreatment LDH level.

LEVELS

Admissions, Tumors

LENGTH

2

ALLOWABLE VALUES

00-08	0-8 points
X1	Stated as low risk (0-1 point)
X2	Stated as low intermediate risk (2-3 points)
X3	Stated as intermediate risk (4-5 points)
X4	Stated as high risk (6-8 points)
X8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code X8 will result in an edit error.)
X9	Not documented in medical record NCCN International Prognostic Index (IPI) not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
   - A. If all of the following conditions are true:
     - Schema ID is 00790, 00795
     - Type of Reporting Source is not 7bsymp
     - NCCN International Prognostic Index (IPI) is blank or X8

     Then convert NCCN International Prognostic Index (IPI) to X9
   - B. If all of the following conditions are true:
     - One of the following is true:
       - Schema ID is numeric and is not 00790, 00795

         OR
       - Type of Reporting Source is 7
     - NCCN International Prognostic Index (IPI) is not blank

     Then convert NCCN International Prognostic Index (IPI) to blank
   - C. Otherwise, upload the abstracted value.

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00790, 00795
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00790, 00795

One of the following conditions is true

- Admission's value is not blank, X9
- Tumor's value is blank, X9

OR

- Admission's value is X9
- Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.
02/2020	Source Logic Update

NHIA Derived Hisp Origin

IDENTIFIERS

CCR ID	NAACCR ID
E1043	191

DESCRIPTION

The NAACCR Hispanic Identification Algorithm (NHIA) uses a combination of NAACCR variables to directly or indirectly classify cases as Hispanic for analytic purposes. The algorithm uses the following NAACCR standard variables:

- IHS Link [192]
- Spanish/Hispanic Origin [190]
- Name-Last [2230]
- Name-Maiden [2390]
- Birthplace [250]
- Race 1 [160]
- Sex [220].

The CCR will be generating this value by examining the primary last name, all alias last names, all maiden names, and all DC father's surnames.

LEVELS

Patients

LENGTH

1

ALLOWABLE VALUES

0	Non-Hispanic
1	Mexican, by birthplace or other specific identifier
2	Puerto Rican, by birthplace or other specific identifier
3	Cuban, by birthplace or other specific identifier
4	South or Central American (except Brazil), by birthplace or other specific identifier
5	Other specified Spanish/Hispanic origin (includes European; excludes Dominican Republic), by birthplace or other specific identifier
6	Spanish, NOS; Hispanic, NOS; Latino, NOS
7	NHIA surname match only
8	Dominican Republic
Blank	Algorithm has not been run

SOURCE

Generated according to Use Case 34 – Generate NHIA_Derived_Hisp_Origin (based on NAACCR Approach to Hispanic Identification – NHIA Packet 5 at http://www.naaccr.org/

UPDATE

Regenerate if either IHS Link, Spanish Origin, Name--Last, Name--Maiden, Birthplace, Race 1, Sex, DC Fathers Surname or Name Alias (Last) changes.

CONSOLIDATED DATA EXTRACT

Yes

INTERFIELD EDITS

None

HISTORICAL CHANGES

1/05	Added data item to Eureka for more efficiency. Previously was generated for tape submissions.
12/08	IHS Link added to algorithm for 2009 data changes to reflect NHIA Version 2.1 minor changes. Cases coded as Hispanic NOS (value 6) may now be coded to a more specific Hispanic group based on birthplace. Previously, this was only true of cases coded as 0, 7 or 9. The IHS link variable (NAACCR #192) is required for the algorithm, and cases where IHS=1 are excluded from NHIA. This is because American Indians/Alaska Natives are excluded from NHIA by rule.
2010	Data Changes: Updated Source documentation.
10/12/2011	Removed obsolete link to "Version 2.2 https://www.naaccr.org/wp-content/uploads/2016/11/NHIA_v2_2_1_09122011.pdf

NPCR Derived Clin Stg Grp

IDENTIFIERS

CCR ID	NAACCR ID
E1822	3650

OWNER

NPCR

DESCRIPTION

This item is needed to store the results of NPCR's derived algorithmic calculation of clinical stage group based on AJCC T, N, and M and relevant biomarkers and prognostic factors. At this time the algorithm derives AJCC 7th ed. Stage group only; however, updates to future AJCC editions are anticipated. The purpose of the derived stage fields is to segregate the data values for AJCC clinical and pathological stage groups derived from the NPCR algorithm from the values directly entered from the medical record or by the registrar.

LEVELS

Tumors

LENGTH

4

ALLOWABLE VALUES

88	Not applicable
99	Unknown
Blank	Not staged

Refer to most recent version of FORDS for additional coding instructions.

SOURCE

No NPCR Derived Clin Stg Grp at admission. Variable created at tumor.

UPDATE

See UC 02.20 Perform NPCR Staging Algorithm – UC for specifications to re-run algorithm.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

05/2016	Per NAACCR v16, new data field implemented. Field will be generated at Tumor level using NPCR API.

NPCR Derived Path Stg Grp

IDENTIFIERS

CCR ID	NAACCR ID
E1823	3655

OWNER

NPCR

DESCRIPTION

This item is used to store the results of NPCR's derived algorithmic calculation of pathological stage group based on AJCC T, N, and M and relevant biomarkers and prognostic factors. At this time the algorithm derives AJCC 7th ed. Stage group only; however, updates to future AJCC editions is anticipated. The purpose of the derived stage fields is to segregate the data values for AJCC clinical and pathological stage groups derived from the NPCR algorithm from the values directly entered from the medical record or by the registrar.

LEVELS

Tumors

LENGTH

4

ALLOWABLE VALUES

88	Not applicable
99	Unknown
Blank	Not staged

Refer to most recent version of FORDS for additional coding instructions.

SOURCE

No NPCR Derived Path Stg Grp at admission. Variable created at tumor.

UPDATE

See UC 02.20 Perform NPCR Staging Algorithm – UC for specifications to re-run algorithm.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

05/2016	Per NAACCR v16, new data field implemented. Field will be generated at Tumor level using NPCR API.

NPI--Inst Referred From

IDENTIFIERS

CCR ID	NAACCR ID
E1661	2415

DESCRIPTION

The NPI (National Provider Identifier) code that identifies the facility that referred the patient to the reporting facility.

LEVELS

Admissions

LENGTH

10

ALLOWABLE VALUES

Either valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit) or all blanks are allowed.
Allowable values include 0000000000 and 9999999999.

SOURCE

N/A

UPDATE

Manual

CONSOLIDATED DATA EXTRACT

Yes; record with the earliest admission date for this tumor.

HISTORICAL CHANGES

8/06	New data item for 2007
2010	Data Changes: Improved wording of allowable values. Removed invalid link to NPI which was http://new.cms.hhs.gov/nationalProvIdentStand/Downloads/NPIcheckdigit.pdf

NPI--Inst Referred To

IDENTIFIERS

CCR ID	NAACCR ID
E1663	2425

DESCRIPTION

The NPI (National Provider Identifier) code that identifies the facility to which the patient was referred for further care after discharge from the reporting facility.

LEVELS

Admissions

LENGTH

10

ALLOWABLE VALUES

Either valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit) or all blanks are allowed.
Allowable values include 0000000000 and 9999999999.

SOURCE

N/A

UPDATE

Manual

CONSOLIDATED DATA EXTRACT

Yes; record with the earliest admission date for this tumor.

HISTORICAL CHANGES

8/06	New data item for 2007.
2010	Data Changes: Improved wording of allowable values. Removed invalid link to NPI which was http://new.cms.hhs.gov/nationalProvIdentStand/Downloads/NPIcheckdigit.pdf

NPI--Physician 3

IDENTIFIERS

CCR-ID	NAACCR-ID
E1671	2495

DESCRIPTION

The NPI (National Provider Identifier) code for another physician involved in the care of the patient.

LEVELS

Admissions

LENGTH

10

ALLOWABLE VALUES

Either valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit) or all blanks are allowed.

SOURCE

N/A

UPDATE

Manual

CONSOLIDATED DATA EXTRACT

Yes; record with the earliest admission date for this tumor.

HISTORICAL CHANGES

8/06	New data item for 2007.
2010	Data Changes: Improved wording of allowable values. Removed invalid link to NPI which was http://new.cms.hhs.gov/nationalProvIdentStand/Downloads/NPIcheckdigit.pdf

NPI--Physician 4

IDENTIFIERS

CCR ID	NAACCR ID
E1673	2505

DESCRIPTION

The NPI (National Provider Identifier) code for another physician involved in the care of the patient

LEVELS

Admissions

LENGTH & TYPE

10 N

ALLOWABLE VALUES

Either valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit) or all blanks are allowed.

SOURCE

N/A

UPDATE

Manual

CONSOLIDATED DATA EXTRACT

Yes; record with the earliest admission date for this tumor.

HISTORICAL CHANGES

8/06	New data item for 2007.
2010	Data Changes: Improved wording of allowable values. Removed invalid link to NPI which was http://new.cms.hhs.gov/nationalProvIdentStand/Downloads/NPIcheckdigit.pdf

NPI--Physician--Follow-Up

IDENTIFIERS

CCR ID	NAACCR ID
E1667	2475

DESCRIPTION

The NPI (National Provider Identifier) code for the physician currently responsible for the patient's medical care.

LEVELS

Patients and Admissions

LENGTH

10

ALLOWABLE VALUES

Either valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit) or all blanks are allowed.

SOURCE

N/A

UPDATE

Manual

CONSOLIDATED DATA EXTRACT

Yes, from patient's file.

HISTORICAL CHANGES

8/06	New data item for 2007.
2010	Data Changes: Improved wording of allowable values. Removed invalid link to NPI which was https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/

NPI--Physician--Managing

IDENTIFIERS

CCR ID	NAACCR ID
E1665	2465

DESCRIPTION

The NPI (National Provider Identifier) code that identifies the physician who is responsible for the overall management of the patient during diagnosis and/or treatment for this cancer.

LEVELS

Admissions

LENGTH

10

ALLOWABLE VALUES

Either valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit) or all blanks are allowed.

SOURCE

N/A

UPDATE

Manual

CONSOLIDATED DATA EXTRACT

Yes; record with the earliest admission date for this tumor.

HISTORICAL CHANGES

8/06	New data item for 2007.
2010	Data Changes: Improved wording of allowable values. Removed invalid link to NPI which was https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/

NPI--Physician Other 1

IDENTIFIERS

CCR ID	NAACCR ID
E1630	None. State Requestor

DESCRIPTION

The NPI (National Provider Identifier) code of the physicians other than attending and following physicians.

LEVELS

Admissions

LENGTH

10

ALLOWABLE VALUES

Either valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit) or all blanks are allowed.

SOURCE

N/A

UPDATE

Manual

CONSOLIDATED DATA EXTRACT

Yes; record with the earliest admission date for this tumor.

HISTORICAL CHANGES

8/06	New data item for 2007
2010	Data Changes: Improved wording of allowable values. Removed invalid link to NPI which was https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/

NPI--Physician Other 2

IDENTIFIERS

CCR ID	NAACCR ID
E1663	None. State Requestor

DESCRIPTION

The NPI (National Provider Identifier) code of the physicians other than attending and following physicians.

LEVELS

Admissions

LENGTH

10

ALLOWABLE VALUES

Either valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit) or all blanks are allowed.

SOURCE

N/A

UPDATE

Manual

CONSOLIDATED DATA EXTRACT

Yes; record with the earliest admission date for this tumor.

HISTORICAL CHANGES

8/06	New data item for 2007
2010	Data Changes: Improved wording of allowable values. Removed invalid link to NPI which was https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/

NPI--Physician--Primary Surg

IDENTIFIERS

CCR ID	NAACCR ID
E1669	2485

DESCRIPTION

The NPI (National Provider Identifier) code for physician who performed the most definitive surgical procedure.

LEVELS

Admissions

LENGTH

10

ALLOWABLE VALUES

Either valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit) or all blanks are allowed.

SOURCE

N/A

UPDATE

Manual

CONSOLIDATED DATA EXTRACT

Yes; record with the earliest admission date for this tumor.

HISTORICAL CHANGES

8/06	New data item for 2007.
2010	Data Changes: Improved wording of allowable values. Removed invalid link to NPI which was https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/

NPI--Registry ID

IDENTIFIERS

CCR ID	NAACCR ID
E1004	45

DESCRIPTION

The NPI (National Provider Identifier) code that represents the data transmission source. This item stores the NPI of the facility registry that transmits the record.

LEVELS

Admissions

LENGTH

10

ALLOWABLE VALUES

Either valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit) or all blanks are allowed.

SOURCE

N/A

UPDATE

Manual

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

8/06	New data item for 2007.
2010	Data Changes: Improved wording of allowable values. Removed invalid link to NPI which was https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/

NPI--Reporting Facility

IDENTIFIERS

CCR ID	NAACCR ID
E1080	545

DESCRIPTION

The NPI (National Provider Identifier) code for the facility submitting the data in the record.

LEVELS

Admissions

LENGTH

10

ALLOWABLE VALUES

Either valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit) or all blanks are allowed.

SOURCE

N/A

UPDATE

Manual

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

8/06	New data item for 2007.
2010	Data Changes: Improved wording of allowable values. Removed invalid link to NPI which was https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/

Num Abs Assoc

CCR ID	NAACCR ID
None	None: Generated

DESCRIPTION

This is a Eureka-generated field which counts the number of reports (abstracts) which are associated with a case.

LEVELS

Regional Submission (StateExtract) File only

LENGTH

2

ALLOWABLE VALUES

Any number between 01 and 99.

SOURCE

N/A

UPDATE

None

CONSOLIDATED DATA EXTRACT

Yes, generate.

INTERFIELD EDITS

None

HISTORICAL CHANGES

	None

Number of Cores Examined

IDENTIFIERS

CCR ID	NAACCR ID
E2010	3897

OWNER

NAACCR

DESCRIPTION

Percent Necrosis Post Neoadjuvant is a prognostic factor for bone sarcomas.

LEVELS

Admissions, Tumors

LENGTH

2

ALLOWABLE VALUES

01-99	1 - 99 cores examined (Exact number of cores examined)
X1	100 or more cores examined
X6	Biopsy cores examined, number unknown
X7	No needle core biopsy performed
X8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code X8 may result in an edit error.)
X9	Not documented in medical record Number of cores examined not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00580
        - Type of Reporting Source is not 7
        - Number of Cores Examined is blank or X8

        Then convert Number of Cores Examined to X9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00580

              OR
            - Type of Reporting Source is 7
        - Number of Cores Examined is not blank

        Then convert Number of Cores Examined to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00580
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00580

One of the following conditions is true

- Admission's value is not blank, X9
- Tumor's value is blank, X9

OR

- Admission's value is X9
- Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Number of Cores Positive

IDENTIFIERS

CCR ID	NAACCR ID
E2011	3898

OWNER

NAACCR

DESCRIPTION

This data item represents the number of positive cores documented in the pathology report from needle biopsy of the prostate gland.

LEVELS

Admissions, Tumors

LENGTH

2

ALLOWABLE VALUES

00	All examined cores negative
01-99	1 - 99 cores positive (Exact number of cores positive)
X1	100 or more cores positive
X6	Biopsy cores positive, number unknown
X7	No needle core biopsy performed
X8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code X8 may result in an edit error.)
X9	Not documented in medical record Number of Cores Positive not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

3. If Date of Diagnosis is less than 2018, then blank out field
4. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00580
        - Type of Reporting Source is not 7
        - Number of Cores Positive is blank or X8

        Then convert Number of Cores Positive to X9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00580

              OR
            - Type of Reporting Source is 7
        - Number of Cores Positive is not blank

Then convert Number of Cores Positive to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00580
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00580

One of the following conditions is true

- Admission's value is not blank, X9
- Tumor's value is blank, X9

OR

- Admission's value is X9
- Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Number of Examined Para-Aortic Nodes

IDENTIFIERS

CCR ID	NAACCR ID
E2012	3899

OWNER

NAACCR

DESCRIPTION

Number of examined para-aortic nodes is the number of nodes examined based on para-aortic nodal dissection.

LEVELS

Admissions, Tumors

LENGTH

2

ALLOWABLE VALUES

00	No para-aortic nodes examined
01-99	1 - 99 para-aortic nodes examined (Exact number of para-aortic lymph nodes examined)
X1	100 or more para-aortic nodes examined
X2	Para-aortic nodes examined, number unknown
X6	No para-aortic lymph nodes removed, but aspiration or core biopsy of para-aortic node(s) only
X8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code X8 will result in an edit error.)
X9	Not documented in medical record Cannot be determined, indeterminate if positive para-aortic nodes present Para-aortic lymph nodes not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00530, 00541, or 00542
        - Type of Reporting Source is not 7
        - COC Accredited Flag is 1
        - Number of Positive Para-Aortic Nodes is blank or X8

        Then convert Number of Positive Para-Aortic Nodes to X9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00530, 00541, 00542

            OR
            - Type of Reporting Source is 7

- Number of Positive Para-Aortic Nodes is not blank

  Then convert Number of Positive Para-Aortic Nodes to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00530, 00541, or 00542
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00530, 00541, or 00542

One of the following conditions is true

- Admission's value is not blank, X8, or X9
- Tumor's value is blank , X8, or X9

  OR

  - Admission's value is X9
  - Tumor's value is blank or X8

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Number of Examined Pelvic Nodes

IDENTIFIERS

CCR ID	NAACCR ID
E2013	3900

OWNER

NAACCR

DESCRIPTION

Number of examined pelvic nodes is the number of nodes examined based on pelvic nodal dissection.

LEVELS

Admissions, Tumors

LENGTH

2

ALLOWABLE VALUES

00	No pelvic lymph nodes examined
01-99	1 - 99 pelvic lymph nodes examined (Exact number of pelvic lymph nodes examined)
X1	100 or more pelvic nodes examined
X2	Positive pelvic nodes examined, number unknown
X6	No pelvic lymph nodes removed, but aspiration or core biopsy of pelvic node(s) only
X8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code X8 will result in an edit error.)
X9	Not documented in medical record Cannot be determined, indeterminate if positive pelvic nodes present Pelvic lymph nodes not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00530, 00541, or 00542
        - Type of Reporting Source is not 7
        - COC Accredited Flag is 1
        - Number of Examined Pelvic Nodes is blank or X8

        Then convert Number of Examined Pelvic Nodes to X9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00530, 00541, 00542

            OR

- Type of Reporting Source is 7
- Number of Examined Pelvic Nodes is not blank

Then convert Number of Examined Pelvic Nodes to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00530, 00541, or 00542
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00530, 00541, or 00542

One of the following conditions is true

- Admission's value is not blank, X8, or X9
- Tumor's value is blank , X8, or X9

OR

- Admission's value is X9
- Tumor's value is blank or X8

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Number of Phases of Rad Treatment to This Volume

IDENTIFIERS

CCR ID	NAACCR ID
E1893	1532

OWNER

COC

DESCRIPTION

Identifies the total number of phases administered to the patient during the first course of treatment. A "phase" consists of one or more consecutive treatments delivered to the same anatomic volume with no change in the treatment technique. Although the majority of courses of radiation therapy are completed in one or two phases (historically, the "regional" and "boost" treatments) there are occasions in which three or more phases are used, most typically with head and neck malignancies.

LEVELS

Admissions, Tumors

LENGTH

2

ALLOWABLE VALUES

00	No radiation treatment
01	1 phase
02	2 phases
03	3 phases
04	4 phases
99	Unknown number of phases; Unknown if radiation therapy administered

SOURCE

Right justify and zero fill any values less than 2 digits, but not blank

UPDATE

TUMOR LEVEL

NEW CASE CONSOLIDATION

If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

ADMISSION

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Number of Positive Para-Aortic Nodes

IDENTIFIERS

CCR ID	NAACCR ID
E2014	3901

OWNER

NAACCR

DESCRIPTION

Number of Positive Para-Aortic Nodes is the number of positive nodes based on para-aortic nodal dissection.

LEVELS

Admissions, Tumors

LENGTH

2

ALLOWABLE VALUES

00	All para-aortic lymph nodes examined negative
01-99	1-99 para-aortic lymph nodes positive (Exact number of nodes positive)
X1	100 or more para-aortic nodes positive
X2	Positive para-aortic nodes identified, number unknown
X6	Positive aspiration or core biopsy of para-aortic lymph node(s)
X8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code X8 will result in an edit error.)
X9	Not documented in medical record Cannot be determined, indeterminate if positive para-aortic nodes present Para-aortic lymph nodes not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00530, 00541, or 00542
        - Type of Reporting Source is not 7
        - COC Accredited Flag is 1
        - Number of Positive Para-Aortic Nodes is blank or X8

        Then convert Number of Positive Para-Aortic Nodes to X9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00530, 00541, 00542

              OR
            - Type of Reporting Source is 7

- Number of Positive Para-Aortic Nodes is not blank
  Then convert Number of Positive Para-Aortic Nodes to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00530, 00541, or 00542
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00530, 00541, or 00542

One of the following conditions is true

- Admission's value is not blank, X8, or X9
- Tumor's value is blank , X8, or X9
  OR
  - Admission's value is X9
  - Tumor's value is blank or X8

Then automatically update the Tumor's value with the Admission's value.
Otherwise,
If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Number of Positive Pelvic Nodes

IDENTIFIERS

CCR ID	NAACCR ID
E2015	3902

OWNER

NAACCR

DESCRIPTION

Number of Positive Pelvic Nodes is the number of positive nodes based on pelvic nodal dissection.

LEVELS

Admissions, Tumors

LENGTH

2

ALLOWABLE VALUES

00	All pelvic nodes examined negative
01-99	1-99 pelvic nodes positive (Exact number of nodes positive)
X1	100 or more pelvic nodes positive
X2	Positive pelvic nodes identified, number unknown
X6	Positive aspiration or core biopsy of pelvic lymph node(s)
X8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code X8 will result in an edit error.)
X9	Not documented in medical record Cannot be determined, indeterminate if positive pelvic nodes present Pelvic lymph nodes not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

3. If Date of Diagnosis is less than 2018, then blank out field
4. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00530, 00541, or 00542
        - Type of Reporting Source is not 7
        - COC Accredited Flag is 1
        - Number of Positive Pelvic Nodes is blank or X8

        Then convert Number of Positive Pelvic Nodes to X9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00530, 00541, 00542

              OR
            - Type of Reporting Source is 7
        - Number of Positive Pelvic Nodes is not blank

Then convert Number of Positive Pelvic Nodes to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00530, 00541, or 00542
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00530, 00541, or 00542

One of the following conditions is true

- Admission's value is not blank, X8, or X9
- Tumor's value is blank , X8, or X9

OR

- Admission's value is X9
- Tumor's value is blank or X8

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

NYSSIS Name

IDENTIFIERS

CCR ID	NAACCR ID
None	None: Eureka Generated

DESCRIPTION

New York State Identification and Intelligence System (NYSIIS) is a phonetic code of patient's last name for use in matching records with similar names in order to identify all records on file for a given patient. Their system has been modified by the CCR to change some matches and to extend the code from 6 characters to 8 characters. (See Attachment #5.)

LEVELS

Patients, Aliases

LENGTH

8

ALLOWABLE VALUES

Any combination of alphas, possibly with trailing blanks.

SOURCE

Computer generate using Last_Name, ALIAS-NAME or Maiden_Name as appropriate (see Appendix #5).

UPDATE

Regenerate when Last_Name, Maiden_Name or ALIAS-NAME is changed manually

CONSOLIDATED DATA EXTRACT

No

HISTORICAL CHANGES

	None

Occupation 80

IDENTIFIERS

CCR ID	NAACCR ID
E1566	None. State Requestor

DESCRIPTION

This data item is no longer being collected. The code for the patient's longest-held occupation at the time of diagnosis. The coding scheme is that used by the Census Bureau in 1980.

LEVELS

Tumors, Admissions

LENGTH

4

ALLOWABLE VALUES

003-917 with a trailing 0 (entire range is not used; see Appendix 14.)
Codes 905 and 913_917 are NIOSH's additions.
9990 Not reported
9999 Code not yet assigned

SOURCE

If Occupation 80 is numeric and Other Reg ID is not blank, then right-justify and zero-fill and load transmitted value
Else
Convert to 9999

UPDATE

Tumor Level
- New Case Consolidation
  - If Text--Usual Occupation changes, reset Occupation 80 to 9999
- Manual Change to Text--Usual Occupation
  - If Text--Usual Occupation changes, reset Occupation 80 to 9999
- Manual Change

Admission Level
- Manual Change to Text--Usual Occupation
  - If Text--Usual Occupation changes, reset Occupation 80 to 9999
- Manual Change

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

10/24/11	Fixed incorrect Data Items Names. Occupation_Text is now Text--Usual Occupation Other_Reg_ID is now Other Reg ID. Occupation_80 is now Occupation 80
04/2014	Updated to reflect that this data item is no longer being collected.

Occupation 90

IDENTIFIERS

CCR ID	NAACCR ID
E1567	None. State Requestor

Not to be confused with Occupation Code--Census NAACCR Item [270] which is not required by California.

DESCRIPTION

This data item is no longer being collected. The code for the patient's longest-held occupation at the time of diagnosis. The coding scheme is that used by the Census Bureau in 1990.

LEVELS

Tumors, Admissions

LENGTH

4

ALLOWABLE VALUES

003-917 with a trailing 0 (entire range is not used; see Appendix 14.)
Codes 905 and 913-917 are NIOSH's additions.
9990 Not reported
9999 Code not yet assigned

SOURCE

If Occupation 90 is numeric and Other Reg ID is not blank, then right-justify and zero-fill and load transmitted value
Else
Convert to 9999

UPDATE

Tumor Level
- New Case Consolidation
  - If Text--Usual Occupation changes, reset Occupation 90 to 9999
- Manual Change to Text--Usual Occupation
  - If Text--Usual Occupation changes, reset Occupation 90 to 9999
- Manual Change

Admission Level
- Manual Change to Text--Usual Occupation
  - If Text--Usual Occupation changes, reset Occupation 90 to 9999
- Manual Change

CONSOLIDATED DATA EXTRACT

For NPCR submission, extract first 3 characters of this data item and send in for NAACCR Occupation Code--Census (#270).

HISTORICAL CHANGES

8/06	Updated extract information from Volume II
10/24/11	Fixed incorrect Data Items Names. Occupation_Text is now Text--Usual Occupation

	Other_Reg_ID is now Other Reg ID. Occupation 90 is now Occupation 90.
04/2014	Updated to reflect that this data item is no longer being collected.

Occupation Source

IDENTIFIERS

CCR ID	NAACCR ID
E1038	290

DESCRIPTION

Code that best describes the source of occupation information provided on this patient. This is a central cancer registry data item and should be applied by the central registry.

LEVELS

Tumors

LENGTH

1

ALLOWABLE VALUES

0	Unknown occupation/no occupation available
1	Reporting facility records
2	Death certificate
3	Interview
7	Other source
8	Not applicable, patient less than 14 years of age at diagnosis
9	Unknown source
Blank	Not collected

SOURCE

See Extract.

UPDATE

None

CONSOLIDATED DATA EXTRACT

Generate 1 (See ALLOWABLE VALUES: 1 Reporting facility record

HISTORICAL CHANGES

8/15/06	Generated item in Volume II added to Volume III with 2007 data changes.

Oncotype DX Recurrence Score-DCIS

IDENTIFIERS

CCR ID	NAACCR ID
E2016	3903

OWNER

NAACCR

DESCRIPTION

Oncotype Dx Recurrence Score-DCIS is a numeric score of a genomic test to predict the risk of local recurrence of breast cancer based on the assessment of 12 genes.

LEVELS

Admissions, Tumors

LENGTH

3

ALLOWABLE VALUES

0-100	Enter actual recurrence score between 0 and 100
XX6	Not applicable: invasive case
XX7	Test ordered, results not in chart
XX8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code XX8 will result in an edit error.)
XX9	Not documented in medical record Oncotype Dx Recurrence Score-DCIS not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater perform the following:
   A. If all of the following conditions are true:
      - Schema ID is 00480
      - Type of Reporting Source is not 7
      - COC Accredited Flag is 1
      - Behavior Code ICD-O-3 is 3
      - Oncotype Dx Recurrence Score-DCIS is not XX6

      Then convert Oncotype Dx Recurrence Score-DCI to XX6
   B. If all of the following conditions are true:
      - Schema ID is 00480
      - COC Accredited Flag is 1
      - Type of Reporting Source is not 7
      - Behavior Code ICD-O-3 is 2
      - Oncotype Dx Recurrence Score-DCIS is XX6, XX8, or blank

      Then convert Oncotype Dx Recurrence Score-DCI to XX9
   C. If all of the following conditions are true:

- One of the following is true:
  - Schema ID is not 00480
    OR
  - Type of Reporting Source is 7
- Oncotype Dx Recurrence Score-DCIS is not blank

Then convert Oncotype Dx Recurrence Score-DCIS to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00480
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00480

One of the following conditions is true

- Admission's value is not blank, XX8, or XX9
- Tumor's value is blank, XX8, or XX9
  OR
  - Admission's value is XX9
  - Tumor's value is blank or XX8

Then automatically update the Tumor's value with the Admission's value.
Otherwise,
If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Oncotype DX Recurrence Score-Invasive

IDENTIFIERS

CCR ID	NAACCR ID
E2017	3904

OWNER

NAACCR

DESCRIPTION

Oncotype Dx Recurrence Score-Invasive is a numeric score of a genomic test to predict the likelihood of distant recurrence of invasive breast cancer based on the assessment of 21 genes.

LEVELS

Admissions, Tumors

LENGTH

3

ALLOWABLE VALUES

0-100	Enter actual recurrence score between 0 and 100
XX4	Stated as less than 11
XX5	Stated as equal to or greater than 11
XX6	Not applicable: in situ case
XX7	Test ordered, results not in chart
XX9	Not documented in medical record Oncotype Dx Recurrence Score-Invasive not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater perform the following:
   - A. If all of the following conditions are true:
     - Schema ID is 00480
     - Type of Reporting Source is not 7
     - Behavior Code ICD-O-3 is 3
     - Oncotype Dx Recurrence Score-Invasive is XX6 or blank

     Then convert Oncotype Dx Recurrence Score-Invasive to XX9
   - B. If all of the following conditions are true:
     - Schema ID is 00480
     - Type of Reporting Source is not 7
     - Behavior Code ICD-O-3 is 2
     - Oncotype Dx Recurrence Score-Invasive is not XX6

     Then convert Oncotype Dx Recurrence Score-Invasive to XX6
   - C. If all of the following conditions are true:
     - One of the following is true:
       - Schema ID is not 00480

OR

- Type of Reporting Source is 7

- Oncotype Dx Recurrence Score-Invasive is not blank

Then convert Oncotype Dx Recurrence Score-Invasive to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00480
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00480

One of the following conditions is true

- Admission's value is not blank, XX8, or XX9
- Tumor's value is blank, XX8, or XX9

OR

- Admission's value is XX9
- Tumor's value is blank or XX8

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Oncotype DX Risk Level-DCIS

IDENTIFIERS

CCR ID	NAACCR ID
E2018	3905

OWNER

NAACCR

DESCRIPTION

Oncotype Dx Risk Level-DCIS stratifies Oncotype Dx recurrence scores into low, intermediate, and high risk of local recurrence.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	Low risk (recurrence score 0-38)
1	Intermediate risk (recurrence score 39-54)
2	High risk (recurrence score greater than or equal to 55)
6	Not applicable: invasive case
7	Test ordered, results not in chart
8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code 8 will result in an edit error.)
9	Not documented in medical record Oncotype Dx Risk Level-DCIS not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
   A. If all of the following conditions are true:
      - Schema ID is 00480
      - Type of Reporting Source is not 7
      - COC Accredited Flag is 1
      - Behavior Code ICD-O-3 is 3
      - Oncotype Dx Risk Level-DCIS is not 6

      Then convert Oncotype Dx Risk Level-DCIS to 6
   B. If all of the following conditions are true:
      - Schema ID is 00480
      - Type of Reporting Source is not 7
      - COC Accredited Flag is 1
      - Behavior Code ICD-O-3 is 2
      - Oncotype Dx Risk Level-DCIS is 6, 8, or blank

Then convert Oncotype Dx Risk Level-DCIS to 9

C. If all of the following conditions are true:
- One of the following is true:
  - Schema ID is not 00480
    OR
  - Type of Reporting Source is 7
- Oncotype Dx Risk Level-DCIS is not blank

Then convert Oncotype Dx Risk Level-DCIS to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:
- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00480
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00480

One of the following conditions is true
- Admission's value is not blank, 8, or 9
- Tumor's value is blank, 8, or 9
  OR
  - Admission's value is 9
  - Tumor's value is blank or 8

Then automatically update the Tumor's value with the Admission's value.
Otherwise,
If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Oncotype DX Risk Level-Invasive

IDENTIFIERS

CCR ID	NAACCR ID
E2019	3906

OWNER

NAACCR

DESCRIPTION

Oncotype Dx Risk Level-Invasive stratifies Oncotype Dx recurrence scores into low, intermediate, and high risk of distant recurrence.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	Low risk (recurrence score 0-17)
1	Intermediate risk (recurrence score 18-30)
2	High risk (recurrence score greater than or equal to 31)
6	Not applicable: DCIS case
7	Test ordered, results not in chart
8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code 8 will result in an edit error.)
9	Not documented in medical record Oncotype Dx Risk Level-Invasive not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00480
        - COC Accredited Flag is 1
        - Behavior Code ICD-O-3 is 3
        - Oncotype Dx Risk Level-Invasive is 6 or 8

        Then convert Oncotype Dx Risk Level-Invasive to 9

    B. If all of the following conditions are true:
        - Schema ID is 00480
        - COC Accredited Flag is 1
        - Behavior Code ICD-O-3 is 2
        - Oncotype Dx Risk Level-Invasive is not 6

        Then convert Oncotype Dx Risk Level-Invasive to 6

C. If all of the following conditions are true:
- Schema ID is not 00480
- Oncotype Dx Risk Level-Invasive is not blank

Then convert Oncotype Dx Risk Level-Invasive to blank

UPDATE

TUMOR LEVEL

NEW CASE CONSOLIDATION

If all of these conditions are true:
- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00480
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00480
- And One of the following conditions is true
  - Admission's value is not blank, 8, or 9
  - Tumor's value is blank, 8, or 9

OR
- Admission's value is 9
- Tumor's value is blank or 8

Then automatically update the Tumor's value with the Admission's value.
Otherwise,
If Admission's value is not the same as the Tumor's value
Then list for review

MANUAL UPDATE

ADMISSION

MANUAL UPDATE

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.
03/2020	In source and update logic removed XX in front of defined values

Organomegaly

IDENTIFIERS

CCR ID	NAACCR ID
E2020	3907

OWNER

NAACCR

DESCRIPTION

Organomegaly is defined as presence of enlarged liver and/or spleen on physical examination and is part of the staging criteria for Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma (CLL/SLL).

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	Organomegaly of liver and/or spleen not present
1	Organomegaly of liver and/or spleen present
9	Not documented in medical record Organomegaly not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
   A. If all of the following conditions are true:
      - Schema ID is 00795
      - Type of Reporting Source is not 7
      - Organomegaly is blank

      Then convert Organomegaly to 9
   B. If all of the following conditions are true:
      - One of the following is true:
        - Schema ID is not 00795

          OR
        - Type of Reporting Source is 7
      - Organomegaly is not blank

      Then convert Organomegaly to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00795

- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00795

One of the following conditions is true

- Admission's value is not blank, 9
- Tumor's value is blank, 9

OR

- Admission's value is 9
- Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.
Otherwise,
If Admission's value is not the same as the Tumor's value
Then list for review
Manual Update
Admission
Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Other Reg ID

CCR ID	NAACCR ID
E1542	None. State Requestor

DESCRIPTION

A non-blank value, on case-shared cases only, is the Region ID of the region where a case was diagnosed or treated when the patient did not live within that region. A blank value indicates that the case report came in from a local reporting facility.

LEVELS

Admissions

LENGTH

2

ALLOWABLE VALUES

01-10	Regional registry (see REG-ID
98	CCR (from an unspecified out-of-state source
Blank	No report from an outside source
AK-WY	AK-WY State which sent out of state case sharing (Postal abbreviation for states and territories - See California Cancer Reporting Standards, Vol. I, Appendix B)

SOURCE

If Registry ID is one of the standard NAACCR registry IDs (NAACCR Volume II-Appendix B: Regid.DBF) for state registries other than registries in this state*, then convert the corresponding state abbreviations into Other Reg ID:

Registry ID	State
0000009100	AK
0000009101	AK
0000009180	AK
0000007100	AK
0000008700	AZ
0000008300	CO
0000003500	FL
0000009900	HI
0000008100	ID
0000006100	IL
0000007300	LA
0000007301	LA
0000007302	LA
0000007303	LA
0000007304	LA
0000007305	LA
0000007306	LA
0000007307	LA
0000007308	LA
00000073092	LA

00000073010	LA
0000004100	MI
0000004101	MI
0000005200	MN
0000006300	MO
0000003900	MS
0000005600	MT
0000002500	NC
0000008500	VV
0000001100	NY
0000009500	OR
0000009580	OR
0000007700	TX
0000008400	UT
0000009300	WA
0000009301	WA
0000009302	WA
0000009380	WA
0000005100	WI
0000008200	WY

Otherwise, load blank.

*currently limited to state registries with which California has a case sharing agreement.

UPDATE

Manual entry or case-sharing data provided by CCR or by another regional registry. Retain the first non-blank entry.

CONSOLIDATED DATA EXTRACT

Yes, earliest admission date

HISTORICAL CHANGES

1/99	Changed SOURCE specifications to generate value from NAACCR-REG-ID
3/03	Removed the 5 leading zeros in the Source examples as the NAACCR_Reg_ID codes field length has been changed to 10 digits.
2/06	Updated Source information.

Other Reg Pat No

IDENTIFIERS

CCR ID	NAACCR ID
E1543	None.State Requestor

DESCRIPTION

Patient number assigned by another regional registry.

LEVELS

Admissions

LENGTH

8

ALLOWABLE VALUES

Any numeric or blank; 9's mean unknown.*

SOURCE

If Registry ID is one of the standard NAACCR registry IDs for state registries (NAACCR Volume II-Appendix B: Regid.DBF) other than registries in this state, and Patient ID Number (E1007) is not blank, then load Patient ID Number (E1007).
If Registry ID is one of the standard NAACCR registry IDs for state registries other than registries in this state, and Patient ID Number (E0117) is blank, then load 99999999.
If Registry ID is NOT one of the standard NAACCR registry IDs for state registries other than registries in this state, then load blank.

UPDATE

Manual entry or case sharing data provided by CCR or by another regional registry. Retain the entry sent with the Other Reg ID.

CONSOLIDATED DATA EXTRACT

Yes, earliest admission date.

HISTORICAL CHANGES

2/06	Update Source section

Other Reg Tum No

IDENTIFIERS

CCR ID	NAACCR ID
E1544	None, State Requestor

DESCRIPTION

A patient's tumor number assigned by another regional registry.

LEVELS

Admissions

LENGTH

2

ALLOWABLE VALUES

01-99 or blank

SOURCE

If Registry ID is one of the standard NAACCR registry IDs for state registries other than registries in this state, and Tumor Record Number is not blank, then load Tumor Record Number (E1006).
If Registry ID is one of the standard NAACCR registry IDs for state registries other than registries in this state, and Tumor Record Number is blank, then load 99.
If Registry ID is NOT one of the standard NAACCR registry IDs for state registries other than registries in this state, then load blank.

UPDATE

Manual entry or case-sharing data provided by CCR or by another regional registry. Retain the entry that came with the value in Other Reg Pat No

CONSOLIDATED DATA EXTRACT

Yes, earliest admission date.

HISTORICAL CHANGES

2/06	Updated Source section.
2010	Data Changes: Added IF304

Over-Ride Admis DX

IDENTIFIERS

CCR ID	NAACCR ID
E1561	None, State Requestor

DESCRIPTION

Date DX & Date of Admission discrepancy.

LEVELS

Admission

LENGTH

1

ALLOWABLE VALUES

1	Reviewed
Blank	Not reviewed or reviewed and corrected
Before CP26, Eureka defined 0 as not reviewed.	

SOURCE

Load each individual override flag value as a separate element value.

UPDATE

Manual Change or Correction Applied

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/04	Updated table format and corrected level information.
10/07	Override flags separated out on individual pages. Converted database so CR allowable values match NAACCR standards (CCR value for not reviewed = blank, NAACCR value for not reviewed=0).
11/08	Added IF 798 to prevent Over-ride flag misuse.
2010	Data Changes: Although this data item is not a NAACCR item, the CCR data item name (OR AdmisDX) was changed to match the NAACCR naming standard for over-ride fields. Update logic rewritten.

Over-Ride Age/Site/Morph

IDENTIFIERS

CCR ID	NAACCR ID
E1452	1990

DESCRIPTION

Unusual occurrence of Primary Site and/or Histologic Type ICD-O-3 for a given Age-DX. This over-ride is used with the following edits:

- Age, Primary Site, Morphology ICDO3 (SEER IF15)
- Age, Primary Site, Morph ICDO3--Adult (SEER)

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

1	Reviewed and confirmed that age/site/histology combination is correct as reported
2	Reviewed and confirmed that case was diagnosed in utero
3	Reviewed and confirmed that conditions 1 and 2 both apply
Blank	Not reviewed or reviewed and corrected

Prior to CP26, Eureka defined 0 as not reviewed.

SOURCE

Load each individual override flag value as a separate element value.

UPDATE

Tumor Level

New Case Consolidation

If the admission's over-ride flag is 1 and the tumor's over-ride flag is blank, then automatically update the tumor's over-ride flag with the admission's corresponding over-ride flag.

Manual Change

Admission Level

Manual Change or Correction Applied

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/04	Updated table format and corrected level information.
10/07	Override flags separated out on individual pages. Converted database so CCR allowable values match NAACCR standards (CCR value for not reviewed = blank, NAACCR value for not reviewed=0).
11/08	Added IF 798 to prevent Over-ride flag misuse.
2010	Data Item Changes: CCR name (OR Age Site) changed to match NAACCR name. Added codes 2 and 3 to Allowable Values because this flag is used with IF604 and in utero was a new requirement in 2009. Rewrote update logic.

Over-Ride CS 1-20

IDENTIFIERS

Data Item	CCR-ID	NAACCR ID
Over-ride CS 1	E1489	3750
Over-ride CS 2	E1490	3751
Over-ride CS 3	E1491	3752
Over-ride CS 4	E1492	3753
Over-ride CS 5	E1493	3754
Over-ride CS 6	E1494	3755
Over-ride CS 7	E1495	3756
Over-ride CS 8	E1496	3757
Over-ride CS 9	E1497	3758
Over-ride CS 10	E1498	3759
Over-ride CS 11	E1499	3760
Over-ride CS 12	E1500	3761
Over-ride CS 13	E1501	3762
Over-ride CS 14	E1502	3763
Over-ride CS 15	E1503	3764
Over-ride CS 16	E1504	3765
Over-ride CS 17	E1505	3766
Over-ride CS 18	E1506	3767
Over-ride CS 19	E1507	3768
Over-ride CS 20	E1508	3769

OWNER

AJCC

DESCRIPTION

Indicates that the unusual combination of codes in different fields have been reviewed and are correct. Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags are used to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

SOURCE

Upload with no conversion.

UPDATE

Manual.

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

2011	Data Item added for 2011.

Over-Ride Histology

IDENTIFIERS

CCR ID	NAACCR ID
E1457	2040

DESCRIPTION

Histologic Type ICD-O-3 code is one that ICDO3 classifies as benign or uncertain behavior. This over-ride is used with SEER IF31 and SEER MORPH.

LEVELS

Tumors, Admissions
LENGTH
1

ALLOWABLE VALUES

1	Reviewed, histology edit caused the override
2	Reviewed, SEER IF31
3	Reviewed and confirmed that conditions 1 and 2 both apply
Blank	Not reviewed or reviewed and corrected

Before CP26, Eureka defined 0 as not reviewed.

SOURCE

N/A

UPDATE

Tumor Level

New Case Consolidation

If the admission's over-ride flag is 1 and the tumor's over-ride flag is blank, then automatically update the tumor's over-ride flag with the admission's corresponding over-ride flag.

Manual Change

Admission Level

Manual Change or Correction Applied

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

7/01	Changed HIST-TYPE references to HIST-TYPE-3 references.
3/03	Over-ride flag name OR-QUEST-MULT changed to OR_Site_Lat_SeqNo to match the NAACCR/SEER name. Changed to table format.
3/04	Updated table format and corrected level information.
10/07	Override flags separated out on individual pages. Converted database so CCR allowable values match NAACCR standards (CCR value for not reviewed = blank, NAACCR value for not reviewed=0).
11/08	Added IF 798 to prevent Over-ride flag misuse.
2010	Data Changes: Changed CCR name (OR Hist Behavior) changed to match NAACCR name. Rewrote Update logic.

Over-Ride HospSeq/Site

IDENTIFIERS

CCR ID	NAACCR ID
E1450	1988

DESCRIPTION

Override flag that forces review of multiple primary cancers when one of the primaries is coded to a site/morphology combination that could indicate a metastatic site rather than a primary site. This over-ride is used with Seq Num--Hosp Primary Site, Morph ICD03 (CoC).

LEVELS

Admission

LENGTH

1

ALLOWABLE VALUES

1	Reviewed
Blank	Not reviewed or reviewed and corrected

Before CP26, Eureka defined 0 as not reviewed.

SOURCE

Load each individual override flag value as a separate element value.

UPDATE

Manual Change or Correction Applied

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

10/07	New over-ride flag added for 2008. Expanded edit to include all ranges in COC edit and moved edit to this Override flag (was mixed in with Multi-ILDEF over-ride flag). Added this full edit based on the North Carolina project.
11/08	Added IF 798 to prevent Over-ride flag misuse.
2010	Data Changes: CCR name (OR_HospSeq/Site) changed to NAACCR name. Hematopoietic end range code was changed from 9989 to 9992. Update logic rewritten.

Over-Ride Ill-Define Site

IDENTIFIERS

CCR ID	NAACCR ID
E1459	2060

DESCRIPTION

Multiple primaries involving ill-defined sites. This over-ride is used with SEER IF22.
If Sequence Number-Central indicates the person has had more than one primary, then any case with one of the following site/histology combinations requires review:

- C760-C768 (ill-defined sites) or C809 (unknown primary) and ICD-O-2 or ICD-O-3 histology <9590. Look for evidence that the unknown or ill-defined primary is a secondary site from one of the patient's other cancers. For example, a clinical discharge diagnosis of "abdominal carcinomatosis" may be attributable to the patient's primary ovarian cystadenocarcinoma already in the registry, and should not be entered as a second primary.
- C770-C779 (lymph nodes) and ICD-O-2 histology not in the range 9590-9717 or ICD-O-3 histology not in the range 9590-9729; or C420-C424 and ICD-O-2 histology not in the range 9590-9941 or ICD-O-3 histology not in the range 9590-9989. That combination is most likely a metastatic lesion. Check whether the lesion could be a manifestation of one of the patient's other cancers.
- Any site and ICD-O-2 histology in the range 9720-9723, 9740-9741, or ICD-O-3 histology in the range 9740-9758. Verify that these diagnoses are coded correctly and are indeed separate primaries from the others.

If it turns out that the suspect tumor is a manifestation of one of the patient's other cancers, delete the metastatic or secondary case, re-sequence remaining cases, and correct the coding on the original case as necessary.

LEVELS

Admission, Tumor

LENGTH

1

ALLOWABLE VALUES

1	Reviewed
Blank	Not reviewed or reviewed and corrected

Before CP26, Eureka defined 0 as not reviewed.

SOURCE

Load each individual override flag value as a separate element value.

UPDATE

Tumor Level

New Case Consolidation

If the admission's over-ride flag is 1 and the tumor's over-ride flag is blank, then automatically update the tumor's over-ride flag with the admission's corresponding over-ride flag

Manual Change

Admission Level

Manual Change or Correction Applied

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

7/01	Changed HIST-TYPE references to HIST-TYPE-3 references.
3/04	Updated table format and corrected level information.
10/07	Override flags separated out on individual pages. Converted database so CCR allowable values match NAACCR standards (CCR value for not reviewed = blank, NAACCR value for not reviewed=0). Moved IF #361 to OR_HospSeq/Site.
11/08	Added IF 798 to prevent Over-ride flag misuse.
2011	Data Changes: CCR name (OR Multi ILDEF) changed to match NAACCR name. Rewrote Update logic.

Over-Ride Leuk, Lymphoma

IDENTIFIERS

CCR ID	NAACCR ID
E1460	2070

DESCRIPTION

Lymphoma or leukemia with Diagnosis Confirmation = 6 (direct observe) or 8 (clinical, other). This over-ride is used with SEER IF48.

- Since lymphoma and leukemia are almost exclusively microscopic diagnoses, this edit forces review of any cases of lymphoma that have diagnostic confirmation of direct visualization or clinical, and any leukemia with a diagnostic confirmation of direct visualization.
- If histology = 9590-9717 for ICD-O-2 or 9590-9729 for ICD-O-3 (lymphoma) then Diagnostic Confirmation cannot be 6 (direct visualization) or 8 (clinical).
- If histology = 9720-9941 for ICD-O-2 or 9731-9948 for ICD-O-3 (leukemia and other) then Diagnostic Confirmation cannot be 6 (direct visualization).

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

Before CP26, Eureka defined 0 as not reviewed.

SOURCE

Load each individual override flag value as a separate element value.

UPDATE

Tumor Level

New Case Consolidation

If the admission's over-ride flag is 1 and the tumor's over-ride flag is blank, then automatically update the over-ride flag with the admission's corresponding over-ride flag

Manual Change

Admission Level

Manual Change or Correction Applied

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

6/01	Changed HIST-TYPE references to HIST-TYPE-3 references.
3/04	Updated table format and corrected level information.
10/07	Override flags separated out on individual pages. Converted database so CCR allowable values match NAACCR standards (CCR value for not reviewed = blank, NAACCR value for not reviewed=0).
11/208	Added IF #798 to prevent Over-ride flag misuse.

2010	Data Changes: CCR name (OR Lymph Leuk) changed to NAACCR name. Rewrote Update logic.

Over-Ride Name Sex

IDENTIFIERS

CCR ID	NAACCR ID
E1560	None. State Requestor

DESCRIPTION

This data item has been replaced by Over-ride Name/Sex [NAACCR #2078]. This page has been retained for historical purposes only and this data item should not be populated in any cases under the NAACCR v18 or later coding standards.

Unusual first names for males & females.

LEVELS

Admission, Patient

LENGTH

1

ALLOWABLE VALUES

1	Reviewed
Blank	Not reviewed or reviewed and corrected

Before CP26, Eureka defined 0 as not reviewed (conversion database done).

SOURCE

1. If Date of Diagnosis is 2018 and later, then blank out the field.
2. If Coding Proc is less than 34, then execute the same conversion from use case Perform Eureka 2018 One-Time Data Conversions and Table Populations – UC, step ~~20~~ 27.

UPDATE

Patient Level

New Case Consolidation

If the admission's over-ride flag is 1 and the patient's over-ride flag is blank, then automatically update the patient's over-ride flag with the admission's corresponding over-ride flag

Manual Change

Admission Level

Manual Change or Correction Applied

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/04	Updated table format and corrected level information.
10/07	Override flags separated out on individual pages. Converted database so CCR allowable values match NAACCR standards (CCR value for not reviewed = blank, NAACCR value for not reviewed=0).
11/08	Added IF 798 to prevent Over-ride flag misuse.
2010	Data Changes: Rewrote Update logic to reflect patient level status. Changed OR to Over-ride in message names. Update logic rewritten.

01/2019	Per NAACCR v18, this data item has been replaced by Over-ride Name/Sex [NAACCR #2078]. Revisions to Source Logic to run One-Time Data Conversions as necessary.
03/2019	Revised Source Logic – Step 2 for Coding Proc 34, changed UC step from 20 to 27

Over-Ride Name/Sex

IDENTIFIERS

CCR ID	NAACCR ID
E1905	2078

OWNER

NAACCR

DESCRIPTION

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.
This over-ride is used with the following edit in the NAACCR Metafile of the EDITS software: Sex, Name-First, Date of Birth (NAACCR)

LEVELS

Admission, Patient

LENGTH

1

ALLOWABLE VALUES

1	Reviewed
Blank	Not reviewed or reviewed and corrected

SOURCE

1. Load each individual override flag value as a separate element value
1. If Coding Proc is less than 34, then execute the same conversion from use case Perform Eureka 2018 One-Time Data Conversions and Table Populations – UC, step 27.

UPDATE

Patient Level

New Case Consolidation

If the admission's over-ride flag is 1 and the patient's over-ride flag is blank, then automatically update the patient's over-ride flag with the admission's corresponding over-ride flag

Manual Change

Admission Level

Manual Change or Correction Applied

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented. Replaces Over-ride Name Sex [CCR # E1560].
03/2019	Revised Source Logic – Added Step 2 for Coding Proc 34

Over-Ride Race BPL

IDENTIFIERS

CCR ID	NAACCR ID
E1562	None. State Requestor

DESCRIPTION

Race/Spanish/Birthplace conflict.

LEVELS

Admission, Patient

LENGTH

1

ALLOWABLE VALUES

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

Before Coding Procedure 26, Eureka defined 0 as not reviewed.

SOURCE

Load each individual override flag value as a separate element value.

UPDATE

Patient Level

New Case Consolidation

If the admission's over-ride flag is 1 and the patient's over-ride flag is blank, then automatically update the patient's over-ride flag with the admission's corresponding over-ride flag

Manual Change

Admission Level

Manual Change or Correction Applied

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/04	Updated table format and corrected level information.
10/07	Override flags separated out on individual pages. Converted database so CCR allowable values match NAACCR standards (CCR value for not reviewed = blank, NAACCR value for not reviewed=0).
11/08	Added 251 (Guatemala) and 252 (Belize) to IF #655. Added IF 798 to prevent Over-ride flag misuse.
2010	Data Changes: Although this data item is not a NAACCR item, the CCR data item name (OR Race BPL) was changed to match the NAACCR naming standard for over-ride fields. Rewrote Update logic to reflect patient level status.

Over-Ride Report Source

IDENTIFIERS

CCR ID	NAACCR ID
E1458	2050

DESCRIPTION

DC Only cases with multiple primaries (other than lymphoma & leukemia).

LEVELS

Admission, Tumor

LENGTH

1

ALLOWABLE VALUES

1	Reviewed
Blank	Not reviewed or reviewed and corrected

Before CP26, Eureka defined 0 as not reviewed.

SOURCE

Load each individual override flag value as a separate element value.

UPDATE

Tumor Level

New Case Consolidation

If the admission's over-ride flag is 1 and the tumor's over-ride flag is blank, then automatically update the

tumor's over-ride flag with the admission's corresponding over-ride flag

Manual Change

Admission Level

Manual Change or Correction Applied

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/04	Updated table format and corrected level information
10/07	Override flags separated out on individual pages. Converted database so CCR allowable values match NAACCR standards (CCR value for not reviewed = blank, NAACCR value for not reviewed=0)
11/08	Added IF 798 to prevent Over-ride flag misuse.
2010	Data Item Changes: CCR name (OR DC Seq) changed to NAACCR name. Rewrote Update logic.

Over-Ride SeqNo/DxConf

IDENTIFIERS

CCR ID	NAACCR ID
E1453	2000

OWNER

SEER

DESCRIPTION

Multiple primaries where at least one tumor was not microscopically confirmed.

LEVELS

Tumor

LENGTH

1

ALLOWABLE VALUES

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

Before CP26, Eureka defined 0 as not reviewed.

SOURCE

Load each individual override flag value as a separate element value.

UPDATE

Tumor Level

New Case Consolidation

If the admission's over-ride flag is 1 and the tumor's over-ride flag is blank, then automatically update the tumor's over-ride flag with the admission's corresponding over-ride flag

Manual Change

Admission Level

Manual Change or Correction Applied

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

03/2004	Updated table format and corrected level information.
10/2007	Removed IF 373 which should apply to Seq No Hosp. Override flags separated out on individual pages. Converted database so CCR allowable values match NAACCR standards (CCR value for not reviewed = blank, NAACCR value for not reviewed=0).
11/2008	Added IF 798 to prevent Over-ride flag misuse.
2010	Data Item Changes: CCR name (OR Seq DX Conf changed to NAACCR name. Rewrote Update logic
2015	Removed Over-ride SeqNo/DxConf from Admission level. Flag is used for Sequence Number--Central at the Tumor level only. Note: Not implemented in Eureka yet.

Over-Ride Site/Lat/EOD

IDENTIFIERS

CCR ID	NAACCR ID
E1463	2073

DESCRIPTION

Site/Laterality/EOD conflict. This over-ride is used with SEER IF41.
Edits of the type Site, Laterality, EOD apply to paired organs and identifies EOD specified as *in situ*, localized or regional by direct extension if laterality is coded as "bilateral, site unknown," or "laterality unknown."

LEVELS

Admission, Tumor

LENGTH

1

ALLOWABLE VALUES

1	Reviewed (and both site and histology are correct
Blank	Not reviewed or reviewed and corrected

Before CP26, Eureka defined 0 as not reviewed.

SOURCE

Load each individual override flag value as a separate element value.

UPDATE

Tumor Level

New Case Consolidation

If the admission's over-ride flag is 1 and the tumor's over-ride flag is blank, then automatically update the tumor's over-ride flag with the admission's corresponding over-ride flag

Manual Change

Admission Level

Manual Change or Correction Applied

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

7/01	Changed HIST-TYPE references to HIST-TYPE-3 references.
3/04	Updated table format and corrected level information.
10/07	Override flags separated out on individual pages. Converted database so CCR allowable values match NAACCR standards (CCR value for not reviewed = blank, NAACCR value for not reviewed=0).
11/08	Added IF 798 to prevent Over-ride flag misuse.
2010	Data Item: CCR name (OR Site Lat EOD) changed to NAACCR name. Rewrote Update logic.

Over-Ride Site/Lat/Morph

IDENTIFIERS

CCR ID	NAACCR ID
E1464	2074

DESCRIPTION

This over-ride is used with SEER IF42.

1. If the Site is a paired organ and ICD-O-2 or ICD-O-3 behavior is *in situ* (2), then laterality must be 1, 2, or 3.
2. If diagnosis year less than 1988 and ICD-O-2 or ICD-O-3 histology >=9590, no further editing is performed.
3. If diagnosis year greater than 1987 and ICD-O-2 or ICD-O-3 histology =9140, 9700, 9701, 9590-9980, no further editing is performed.

The intent of this edit is to force review of *in situ* cases for which laterality is coded 4 (bilateral) or 9 (unknown laterality) as to origin.

1. In rare instances when the tumor is truly midline (9) or the rare combination is otherwise confirmed correct, enter a code 1 for Override Site/Lat/Morph.

LEVELS

Admission, Tumor

LENGTH

1

ALLOWABLE VALUES

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

Before CP26, Eureka defined 0 as not reviewed.

SOURCE

Load each individual override flag value as a separate element value.

UPDATE

Tumor Level

New Case Consolidation

If the admission's over-ride flag is 1 and the tumor's over-ride flag is blank, then automatically update the tumor's over-ride flag with the admission's corresponding over-ride flag

Manual Change

Admission Level

Manual Change or Correction Applied

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

7/01	Changed HIST-TYPE references to HIST-TYPE-3 references.
3/04	Updated table format and corrected level information.

10/07	Override flags separated out on individual pages. Converted database so CCR allowable values match NAACCR standards (CCR value for not reviewed = blank, NAACCR value for not reviewed=0).
11/08	Added IF 798 to prevent Over-ride flag misuse.
2010	Data Changes: CCR name (OR Site Lat Hist) changed to NAACCR name. Rewrote Update logic.

Over-Ride Site/Lat/SeqNo

IDENTIFIERS

CCR ID	NAACCR ID
E1454	2010

DESCRIPTION

This over-ride is used with the following Interrecord Edit from the SEER Program: Verify Same Primary Not Reported Twice for a Person (SEER IR09). This applies to paired organs and does not allow two cases with the same primary site group, laterality and three-digit histology code. This edit verifies that the same primary is not reported twice for a person.
Instructions for Coding:

- Leave blank if the program does not generate an error message for the edit Verify Same Primary Not Reported twice for a Person (SEER IR09).
- Code 1 if the case has been reviewed and it has been verified that the patient had multiple primaries of the same histology (3 digit) in the same primary site group.

LEVELS

Admission, Tumor

LENGTH

1

ALLOWABLE VALUES

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

Before CP26, Eureka defined 0 as not reviewed.

SOURCE

Load each individual override flag value as a separate element value.

UPDATE

Tumor Level

New Case Consolidation

If the admission's over-ride flag is 1 and the tumor's over-ride flag is blank, then automatically update the tumor's over-ride flag with the admission's corresponding over-ride flag

Manual Change

Admission Level

Manual Change or Correction Applied

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

7/01	Changed HIST-TYPE references to HIST-TYPE-3 references.
3/04	Updated table format and corrected level information.
10/07	Override flags separated out on individual pages. Converted database so CCR allowable values match NAACCR standards (CCR value for not reviewed = blank, NAACCR value for not reviewed=0).
11/08	Added IF 798 to prevent Over-ride flag misuse.

2010	Data Changes: CCR name (OR Site Lat SeqNo) changed to NAACCR name. Rewrote Update logic.

Over-Ride Site/Behavior

IDENTIFIERS

CCR ID	NAACCR ID
E1461	2071

DESCRIPTION

Site/Behavior conflict.

LEVELS

Admission, Tumor

LENGTH

1

ALLOWABLE VALUES

1	Reviewed (and both site and histology are correct)
Blank	Not reviewed or reviewed and corrected

Before CP26, Eureka defined 0 as not reviewed.

SOURCE

Load each individual override flag value as a separate element value.

UPDATE

Tumor Level

New Case Consolidation

If the admission's over-ride flag is 1 and the tumor's over-ride flag is blank, then automatically update the tumor's over-ride flag with the admission's corresponding over-ride flag

Manual Change

Admission Level

Manual Change or Correction Applied

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

7/01	Changed HIST-TYPE references to HIST-TYPE-3 references.
10/04	Updated table format and corrected level information.
10/07	Override flags separated out on individual pages. Converted database so CCR allowable values match NAACCR standards (CCR value of 0 = blank). Old Values: Code 0 (not reviewed) or code 1 (reviewed) in each of the 19 positions.
11/08	Added IF 798 to prevent Over-ride flag misuse.
2010	Data Changes: CCR name (OR Site Behavior) changed to NAACCR name. Rewrote Update logic.

Over-Ride Site/EOD/DX Dt

IDENTIFIERS

CCR ID	NAACCR ID
E1462	2072

DESCRIPTION

Site/CS Ext/CS Mets DX conflict

LEVELS

Admission, Tumor

LENGTH

1

ALLOWABLE VALUES

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

Before CP26, Eureka defined 0 as not reviewed.

SOURCE

Load each individual override flag value as a separate element value.

UPDATE

Tumor Level

New Case Consolidation

If the admission's over-ride flag is 1 and the tumor's over-ride flag is blank, then automatically update the tumor's over-ride flag with the admission's corresponding over-ride flag

Manual Change

Admission Level

Manual Change or Correction Applied

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

7/01	Changed HIST-TYPE references to HIST-TYPE-3 references.
3/04	Updated table format and corrected level information.
1/07	Added SEER edit (SEER IF176).
10/07	Override flags separated out on individual pages. Converted database so CCR allowable values match NAACCR standards (CCR value for not reviewed = blank, NAACCR value for not reviewed=0).
11/08	Added IF 798 to prevent Over-ride flag misuse.
2010	Data Item Changes: CCR name (OR Site EOD DX DT) changed to NAACCR name. Rewrote Update logic.

Over-Ride Site Stage

IDENTIFIERS

CCR ID	NAACCR ID
E1564	None: State Requestor

DESCRIPTION

Site/Stage conflict.

LEVELS

Admission, Tumor

LENGTH

1

ALLOWABLE VALUES

1	Reviewed and both site and histology are correct
Blank	Not reviewed or reviewed and corrected

Before CP26, Eureka defined 0 as not reviewed.

SOURCE

Load each individual override flag value as a separate element value

UPDATE

Tumor Level

New Case Consolidation

If the admission's over-ride flag is 1 and the tumor's over-ride flag is blank, then automatically update the tumor's over-ride flag with the admission's corresponding over-ride flag

Manual Change

Admission Level

Manual Change or Correction Applied

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

7/01	Changed HIST-TYPE references to HIST-TYPE-3 references.
3/04	Updated table format and corrected level information.
10/07	Override flags separated out on individual pages. Converted database so CCR allowable values match NAACCR standards (CCR value of 0 = blank). Old Values: Code 0 (not reviewed) or code 1 (reviewed) in each of the 19 positions.
11/08	Added IF 798 to prevent Over-ride flag misuse.
2010	Data Changes: Although this data item is not a NAACCR item, the CCR data item name (OR Site Stage) was changed to match the NAACCR naming standard for over-ride fields. Rewrote update logic.

Over-Ride Site/TNM-STGGRP

IDENTIFIERS

CCR ID	NAACCR ID
E1451	1989

OWNER

CoC

DESCRIPTION

Since pediatric cancers whose sites and histologies have an AJCC scheme may be coded according to a pediatric scheme instead, Override Site/TNM-Stage Group is used to indicate pediatric cases not coded according to the AJCC manual. Pediatric Stage groups should not be recorded in the TNM Clin Stage Group or TNM Path Stage Group items. When neither clinical nor pathologic AJCC staging is used for pediatric cases, code all AJCC items 88. When any components of either is used to stage a pediatric case, follow the instructions for coding AJCC items and leave Override Site/TNM-Stage Group blank.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

1	Reviewed and confirmed as reported.
Blank	Not reviewed or reviewed and corrected

SOURCE

Load each individual override flag value as a separate element value.

UPDATE

Tumor Level

New Case Consolidation

If the admission's over-ride flag is 1 and the tumor's over-ride flag is blank, then automatically update the tumor's over-ride flag with the admission's corresponding over-ride flag

Manual Change

Admission Level

Manual Change or Correction Applied

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

03/2015	Implemented new data field to support transition to TNM staging.

Over-Ride Site/Type

IDENTIFIERS

CCR ID	NAACCR ID
E1456	2030

DESCRIPTION

Indicates that the unusual combination of codes in different fields have been reviewed and are correct. Unusual Site/Histologic Type ICD-O-3 combination. This override is used with SEER IF25. Multiple versions of edits of the type Primary site, Morphology-Type check for "usual" combinations of site and ICD-O-2 or ICD-O-3 histology. The SEER version of the edit is more restrictive than the CoC edit, and thus uses a different over-ride flag. The CoC version of the edit will accept Over-ride CoC Site/Type or Over-ride Site/Type as equivalent.

1. The Primary Site/Histology validation list (available on the SEER web site) contains those histologies commonly found in the specified primary site. Histologies that occur only rarely or never are not included. These edits require review of all combinations not listed.
2. Since basal and squamous cell carcinomas of non-genital skin sites are not reportable to SEER, these site/histology combinations do not appear on the SEER validation list. For the CoC version of the edit, if Primary Site is in the range C440-C449 (skin), and ICD-O-2 histology is in the range 8000-8004 (neoplasms, malignant NOS), 8010-8045 (epithelial carcinomas), 8050-8082 (papillary and squamous cell carcinomas), or 8090-8110 (basal cell carcinomas), or ICD-O-3 histology is in the range 8000-8005 (neoplasms, malignant, NOS), 8010-8046 (epithelial carcinomas), 8050-8084 (papillary and squamous cell carcinomas), or 8090-8110 (basal cell carcinomas), no further editing is done. No over-ride is necessary for these cases in the CoC version of the edit.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

Before CP26, Eureka defined 0 as not reviewed.

SOURCE

Load each individual override flag value as a separate element value.

UPDATE

Tumor Level

New Case Consolidation

If the admission's over-ride flag is 1 and the tumor's over-ride flag is blank, then automatically update the tumor's over-ride flag with the admissions corresponding over-ride flag

Manual Change

Admission Level

Manual Change or Correction Applied

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

7/01	Changed HIST-TYPE references to HIST-TYPE-3 references.
3/03	Over-ride flag name OR-QUEST-MULT changed to OR_Site_Lat_SeqNo to match the NAACCR/SEER name. Changed to table format.
3/04	Updated table format and corrected level information.
10/07	Override flags separated out on individual pages. Converted database so CCR allowable values match NAACCR standards (CCR value for not reviewed = blank, NAACCR value for not reviewed=0).
11/08	Added IF 798 to prevent Over-ride flag misuse.
2010	2010 Changes: CCR name OR Site/Type) changed to NAACCR name. Rewrote update logic. IF 446 made obsolete and is now operating as IF #917. This specification is now the same as Primary Site, Morphology-Type, Beh ICDO3(SEER IF25). NAACCR's historical notes for this edit are summarized here for clarity: Modifications: NAACCR v11.2:11/07 - Replaces old version Primary Site, Morphology-Type ICDO3 (SEER IF25). - Updated to now edit site/histology/behavior instead of just site/histology. - Updated to allow meningiomas (9530 - 9539) only for meninges sites (C70_). Please note that it allows meningiomas outside of the meninges if the case is reviewed and the over-ride flag is set. NAACCR v11.3A 10/08 - Histology 8461/3 is now valid for sites C480-C482, C488 - Histology 8144/3 is no longer valid for C15, C17, C18, C19, C20, and C21 - Histology 9582/0 is now valid for C751 NAACCR v12 - Correction: added C209 8143/3 to table of valid site/hist/behavior combinations. It had mistakenly been removed from NAACCR v11.3A. NAACCR v12 - Correction: added C209 8143/3 to table of valid site/hist/behavior combinations. It had mistakenly been removed from NAACCR v11.3A. NAACCR v12D - Modified: if year of diagnosis is 2010 or higher AND Histologic Type ICD-O-3 = 9731 (solitary plasmacytoma of bone) AND Behavior ICD-O-3 = 3 (malignant), then Primary Site must = C400-C419 (bone). 2011 Data Changes: Per NAACCR V12.1, SEER edit modified so logic allows solitary plasmacytoma of bone (9731/3) only for bone (C400-C41) if year of diagnosis is 2010+, was removed from this edit. A separate edit was created: Primary Site, Morphology, Date of DX (Eureka IF 550).

Over-Ride Spanish BPL

IDENTIFIERS

CCR ID	NAACCR ID
E1563	None. State Requestor

DESCRIPTION

Spanish/Birth Place conflict.

LEVELS

Admission, Patient

LENGTH

1

ALLOWABLE VALUES

1	Reviewed
Blank	Not reviewed or reviewed and corrected

Before CP26, Eureka defined 0 as not reviewed (conversion database done).

SOURCE

Load each individual override flag value as a separate element value.

UPDATE

Patient Level

New Case Consolidation

If the admission's over-ride flag is 1 and the patient's over-ride flag is blank, then automatically update the patient's over-ride flag with the admission's corresponding over-ride flag.

Manual Change

Admission Level

Manual Change or Correction Applied

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/04	Updated table format and corrected level information.
10/07	Override flags separated out on individual pages. Converted database so CCR allowable values match NAACCR standards (CCR value for not reviewed = blank, NAACCR value for not reviewed=0).
11/08	Added 251 (Guatemala) and 252 (Belize) to IF #663. Added IF 798 to prevent Over-ride flag misuse.
2010	Data Changes: Although this data item is not a NAACCR item, the CCR data item name was changed to match the NAACCR naming standard for over-ride fields. Rewrote Update logic to reflect patient level status.

Over-Ride SS/NodesPos

IDENTIFIERS

CCR ID	NAACCR ID
E1444	1981

OWNER

NAACCR

DESCRIPTION

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

- Summary Stage 1977, Regional Nodes Pos (NAACCR)
- Summary Stage 2000, Regional Nodes Pos (NAACCR)

The edit Summary Stage 1977, Regional Nodes Pos (NAACCR) checks SEER Summary Stage 1977 against Regional Nodes Positive and generates an error or warning if there is an incompatibility between the two data items. The edit Summary Stage 2000, Regional Nodes Pos (NAACCR) checks SEER Summary Stage 2000 against Regional Nodes Positive and generates an error or warning if there is an incompatibility between the two data items.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

SOURCE

Load each individual override flag value as a separate element value.

UPDATE

Tumor Level

New Case Consolidation

If the admission's over-ride flag is 1 and the tumor's over-ride flag is blank, then automatically update the tumor's over-ride flag with the admission's corresponding over-ride flag

Manual Change

Admission Level

Manual Change or Correction Applied

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

05/2016	Implemented new data field to support transition to directly coded AJCC TNM and SEER Summary Stage.

Over-ride SS/TNM-M

IDENTIFIERS

CCR ID	NAACCR ID
E1446	1983

OWNER

NAACCR

DESCRIPTION

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

- Summary Stage 1977, TNM-N (NAACCR)
- Summary Stage 2000, TNM-N (NAACCR)

The edit Summary Stage 1977, TNM-M (NAACCR) checks the SEER Summary Stage 1977 against the TNM-M and generates a warning if the SEER Summary Stage 1977 is 'distant' and the TNM-M is '0'. (TNM-M is derived from TNM Path M and TNM Clin M, with TNM Path M having precedence.) It also checks if the SEER Summary Stage 1977 is not 'distant' and the TNM-M is greater than or equal to '1' and generates an error or a warning. The edit Summary Stage 2000, TNM-M (NAACCR) checks the SEER Summary Stage 2000 against the TNM-M and generates a warning if the SEER Summary Stage 2000 is 'distant' and the TNM-M is '0'. It also checks if the SEER Summary Stage 2000 is not 'distant' and the TNM-M is greater than or equal to '1' and generates an error or a warning.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

SOURCE

Load each individual override flag value as a separate element value.

UPDATE

Admission Level

Manual Change or Correction Applied

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

05/2016	Implemented new data field to support transition to directly coded AJCC TNM and SEER Summary Stage.

Over-Ride SS/TNM-N

IDENTIFIERS

CCR ID	NAACCR ID
E1445	1982

OWNER

NAACCR

DESCRIPTION

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

- Summary Stage 1977, TNM-N (NAACCR)
- Summary Stage 2000, TNM-N (NAACCR)

The edit Summary Stage 1977, TNM-N (NAACCR) checks SEER Summary Stage 1977 against the TNM-N and generates an error if the SEER Summary Stage 1977 indicates regional nodal involvement and the TNM-N does not. (TNM-N is derived from TNM Path N and TNM Clin N, with TNM Path N having precedence.) It also generates an error if the SEER Summary Stage 1977 is 'in situ' or 'localized' and the TNM-N is greater than or equal to '1'. The edit Summary Stage 2000, TNM-N (NAACCR) checks SEER Summary Stage 2000 against the TNM-N and generates an error if the SEER Summary Stage 2000 indicates regional nodal involvement and the TNM-N does not. It also generates an error if the SEER Summary Stage 2000 is 'in situ' or 'localized' and the TNM-N is greater than or equal to '1'.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

SOURCE

Load each individual override flag value as a separate element value.

UPDATE

Admission Level

Manual Change or Correction Applied

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

05/2016	Implemented new data field to support transition to directly coded AJCC TNM and SEER Summary Stage.

Over-Ride Surg/DxConf

IDENTIFIERS

CCR ID	NAACCR ID
E1455	2020

OWNER

SEER

DESCRIPTION

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

- RX Summ--Surg Prim Site, Diag Conf (SEER IF76)
- RX Summ--Surg Site 98-02, Diag Conf (SEER IF106)
- RX Summ--Surgery Type, Diag Conf (SEER IF46)

Edits of the type RX Summ--Surg Prim Site, Diag Conf check that cases with a primary site surgical procedure coded 20-90 are histologically confirmed. If the patient had a surgical procedure, most likely there was a microscopic examination of the cancer. Verify the surgery and diagnostic confirmation codes, and correct any errors. Sometimes there are valid reasons why no microscopic confirmation is achieved with the surgery; for example, the tissue removed may be inadequate for evaluation.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

SOURCE

Load each individual override flag value as a separate element value.

UPDATE

Tumor Level

New Case Consolidation

If the admission's over-ride flag is 1 and the tumor's over-ride flag is blank, then automatically update the tumor's over-ride flag with the admissions corresponding over-ride flag

Manual Change

Admission Level

Manual Change or Correction Applied

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

03/2004	Updated table format and corrected level information.
10/2007	Override flags separated out on individual pages. Converted database so CCR allowable values match NAACCR standards (CCR value for not reviewed = blank, NAACCR value for not reviewed=0).
11/2008	Added IF 798 to prevent Over-ride flag misuse.

2010	Data Item Changes: CCR name (OR Surg DX Conf) changed to NAACCR name. Updated name of IF #319 to match SEER edit name. Added IF# 403 and 460. Update logic rewritten.

Over-Ride TNM stage

IDENTIFIERS

CCR ID	NAACCR ID
E1901	1992

OWNER

NAACCR

DESCRIPTION

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.
This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

- Primary Site, TNM Clin Stage Valid A- Ed 7 (CoC)
- Primary Site, TNM Clin Stage Valid B- Ed 7 (CoC)
- Primary Site, TNM Path Stage Valid A- Ed 7 (CoC)
- Primary Site, TNM Path Stage Valid B- Ed 7 (CoC)

These edits check T, N, and M combinations against stage group. Adding this over-ride allows the edit to pass when combinations of T, N, and M are entered that are not included in the stage tables used with the edits.

LEVELS

Admission

LENGTH

1

ALLOWABLE VALUES

1	Reviewed
Blank	Not reviewed or reviewed and corrected

SOURCE

Load each individual override flag value as a separate element value.

UPDATE

Admission Level

Manual Change or Modified Record Applied

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Over-Ride TNM TIS

IDENTIFIERS

CCR ID	NAACCR ID
E1903	1993

OWNER

NAACCR

DESCRIPTION

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.
This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

- TNM Clin T, N, M, In Situ (CoC)
- TNM Path T, N, M, In Situ (CoC)

If the patient has a T value indicating in situ/ noninvasive, this edit verifies that the N, M, and stage group reflect in situ/noninvasive disease. However, there are certain circumstances where AJCC does allow a T value indicating in situ/noninvasive and N, M, and/or stage group that indicates invasive disease. An over-ride is required to accommodate these situations.

LEVELS

Admission

LENGTH

1

ALLOWABLE VALUES

1	Reviewed
Blank	Not reviewed or reviewed and corrected

SOURCE

Load each individual override flag value as a separate element value.

UPDATE

Manual Change or Modified Record Applied

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Path Date Spec Collect 1-5

THIS TOPIC COVERS THE FOLLOWING DATA ITEMS:

Data Item	CCR-ID	NAACCR ID
Path Date Spec Collect 1	E1667	7320
Path Date Spec Collect 2	E1683	7321
Path Date Spec Collect 3	E1689	7322
Path Date Spec Collect 4	E1695	7323
Path Date Spec Collect 5	E1701	7324

DESCRIPTION

Records the date and time of the specimen collection for the cancer being reported, not the date read or date the report was typed.

PRE-2010 CCR DEFINITION:

Date the specimen associated with a path report was collected from the patient, or the most distinguished report date for other document types.

LEVELS

Admissions

LENGTH

5 x 14 fields

ALLOWABLE VALUES

A valid, complete date and time in YYYYMMDDhhmmss format.
A valid, complete date (YYYYMMDD) followed by six spaces.
A valid year & month (YYYYMM) followed by eight spaces (unknown day and unknown time).
A valid year (YYYY) followed by ten spaces (unknown month, day, and time).
Blank (no known or partially known date segments or time).

SOURCE

(For each of the five fields)
If the new case's record version is NAACCR version 12.0 or later, then load the value as is.
If the new case record version is an earlier version than 12.0, then perform the following data conversions upon upload in this order:

1. Right justify and zero-fill the date to 8 digits.
2. Convert MMDDYYYY to YYYYMMDD.

Do not record these types of reformatting changes it in the audit log.

UPDATE

Manual Change or Correction Applied

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

10/10/07	New data items added to help identify path reports used in abstracting, to facilitate automatic new case abstract/pathology report matching at the regional/central registry, and to expand the space available in the path text field. Starting in 2008, visual editors

	will be reviewing path reports alongside the submitted cases, so it is important to identify all the reports used by the abstractor.
2010	2010 Data Changes: CCR names (DxRx Report Date1-5) changed to NAACCR names because this is now a NAACCR required field. Description updated and length changed from 8 to 14. Allowable Values and Source sections changed to allow for a 14-character date rather than the previous 8-character date. Consolidated Data Extract changed to yes.

Path Report Number 1-5

THIS TOPIC COVERS THE FOLLOWING DATA ITEMS:

Data Item	CCR-ID	NAACCR ID
Path Report Number 1	E1676	7090
Path Report Number 2	E1682	7091
Path Report Number 3	E1688	7092
Path Report Number 4	E1694	7093
Path Report Number 5	E1700	7094

DESCRIPTION

Describes unique sequential number assigned by a laboratory to the corresponding path report for this case.
Pre-2010 CCR Definition: Filler order number/lab accession number associated with pathology report specimen or other report type's report number uniquely identifying the report for that facility. For cases diagnosed prior to 1/1/2008, this field will be filled with data converted form the following fields: Pathology Report Number Biopsy/FNA and Pathology Report Number Surgery.

LEVELS

Admissions

LENGTH

20 x 5 fields

ALLOWABLE VALUES

All characters are allowed.
Embedded spaces are allowed.
Must be left-justified.
May be blank.

SOURCE

Left-justify and upload but don't record any conversions in case history (this is simple reformatting, so significant characters remain unchanged).

UPDATE

Manual Change or Correction Applied

HISTORICAL CHANGES

10/07	New data items added to help identify path reports used in abstracting, to facilitate automatic new case abstract/pathology report matching at the regional/central registry, and to expand the space available in the path text field. Starting in 2008, visual editors will be reviewing path reports alongside the submitted cases, so it is important to identify all the reports used by the abstractor. Did not add allowable values errors. Convert Path_Report_No_B and Path_Report_No_S: Default/initialize all Path Report fields to blank. If Pathology Report Number Biopsy/FNA was entered, then Convert Pathology Report Number Biopsy/FNA into Path Report Number 1 If Type of Reporting Source is 6 (autopsy), then convert Path Report Type 1 to 01 (autopsy) Else (Otherwise), convert Path Report Type 1 to 01 (biopsy).

	If Pathology Report Number Biopsy/FNA was blank and Pathology Report Number – Surgery was entered, then Convert Pathology Report Number – Surgery into Path Report Number 1 If Type of Reporting Source is 6 (autopsy), then convert Path Report Type 1 to 04 (autopsy), Else (Otherwise), convert Path Report Type 1 to 02 (surgical resection). If Pathology Report Number Biopsy/FNA was entered and Pathology Report Number – Surgery was entered, then Convert Pathology Report Number – Surgery into Path Report Number 2 If Type of Reporting Source is 6 (autopsy), then convert Path Report Type 2 to 04 (autopsy), Else (Otherwise), convert Path Report Type 2 to 02 (surgical resection). Strip/Remove all special characters (non-alphabetic and non-numeric characters such as hyphens, periods, or slashes) AND spaces from Path Report Number 1 and Path Report Number 2.
2010	Data Changes: 010 Data Item Changes: CCR names changed from DxRx Report Number 1-5 to Path Report Number 1-5 to accommodate NAACCRR adoption of CCR RxDx fields. Consolidated Data Extract changed to Yes.
2011	Data Changes: Clarified Source text.
11/7/11	Changed Specification: All characters are allowed. Embedded spaces are allowed. Must be left-justified blank filled. May be blank.
11/28/11	Updated the Source section based on DSQC and Business Analyst discussions. Removed requirement for the system to strip embedded spaces and special characters.

Path Report Type 1-5

THIS TOPIC COVERS THE FOLLOWING DATA ITEMS:

Data Item	CCR-ID	NAACCR ID
Path Report Type 1	E1678	7480
Path Report Type 2	E1684	7481
Path Report Type 3	E1690	7482
Path Report Type 4	E1696	7483
Path Report Type 5	E1702	7484

DESCRIPTION

This field reflects the type of report transmitted to the cancer registry. This data item accommodates information for only one path report. If additional path reports were prepared, enter the path report type(s) in Path Report Type 4 through Path Report Type 5 [7433-7484]. Information in this data item should refer to the path report described in NAACCR data items #7012, 7102, 7092, and 7192.

LEVELS

Admissions

LENGTH

2 x 5 fields

ALLOWABLE VALUES

01	Pathology
02	Cytology
03	Gyn Cytology
04	Bone Marrow (biopsy/aspirate)
05	Autopsy
06	Clinical Laboratory Blood Work, NOS
07	Tumor Marker (p53, CD's Ki, CEA, HER2-neu, etc.)
08	Cytogenetics
09	Immunohistochemical stains
10	Molecular studies
11	Flow Cytometry, Immunophenotype
98	Other
99	Unknown
NOTE: Additional codes will be added as other sources become available.	
Blank is allowed if there is no report or if the case was diagnosed prior to 01/01/08	

SOURCE

Perform this procedure for each of the five fields in the order listed:

1. If a single digit is entered, right-justify and zero-fill to fix single-digit codes.
2. If value is now 00, null, or not numeric, then convert to blank (empty string).
3. If the corresponding Path Report Number value is now entered (not null and not empty string) and the Path Report Type is now an empty string, then change the type code to 99 (unknown).
4. If the new case's record version is earlier than NAACCR 12.0 (120), then perform the following conversions:

If Path Report Type (1-5_	Then Convert
02	01
03	04
04	05
05	02
06	11
88	98

UPDATE

Manual Change or Correction Applied

CONSOLIDATEDDATA EXTRACT

Yes

HISTORICAL CHANGES

<table>
<tr><td>10/10/07</td><td>New data items added to help identify path reports used in abstracting, to facilitate automatic new case abstract/pathology report matching at the regional/central registry, and to expand the space available in the path text field. Starting in 2008, visual editors will be reviewing path reports alongside the submitted cases, so it is important to identify all the reports used by the abstractor.</td></tr>
<tr><td>2010</td><td>2010 Changes: Name changed because former California item DxRx Report Type 1-5 is now required by NAACCR with the name of Path Report Type 1-5. Consolidated Data Extract changed to Yes. Allowable Values changed to NAACCR values and conversion of CCR data base to NAACCR values.
CONVERSION TABLE
<table>
<tr><th>Codes:</th><th>Pre-2010 CCR Values:</th><th>NAACCR 2010 VALUES</th></tr>
<tr><td>01</td><td>Biopsy</td><td>01 Pathology</td></tr>
<tr><td>02</td><td>Surgical resection</td><td>01 Pathology</td></tr>
<tr><td>03</td><td>Bone marrow biopsy</td><td>04 Bone Marrow (biopsy/aspirate)</td></tr>
<tr><td>04</td><td>Autopsy</td><td>05 Autopsy</td></tr>
<tr><td>05</td><td>Cytology</td><td>02 Cytology</td></tr>
<tr><td>06</td><td>Flow Cytometry/Immunophenotype</td><td>11 Flow Cytometry, Immunophenotype</td></tr>
<tr><td>07</td><td>Tumor Marker (p53, CD's Ki, CEA, HER2-neu)</td><td>07 Tumor Marker (p53, CD's Ki, CEA, Her2/Neu, etc.)</td></tr>
<tr><td>08</td><td>Cytogenetics</td><td>08 Cytogenetics</td></tr>
<tr><td>09</td><td>Immunohistochemical stains</td><td>09 Immunohistochemical Stains</td></tr>
<tr><td>10</td><td>Molecular studies</td><td>10 Molecular Studies</td></tr>
</table></td></tr>
</table>

		88	Other NOS	98 Other
		NOTE: Highlighted rows are values that have the same numerical value post conversion.		

Path Reporting Fac ID 1-5

Former CCR name was DxRx Report Facility ID 1-5

THIS TOPIC COVERS THE FOLLOWING DATA ITEMS:

Data Item	CCR-ID	NAACCR ID
Path Reporting Fac ID 1	E1675	7010
Path Reporting Fac ID 2	E1681	7011
Path Reporting Fac ID 3	E1687	7012
Path Reporting Fac ID 4	E1693	7013
Path Reporting Fac ID 5	E1714	7014

DESCRIPTION

Path Reporting Fac ID 1 describes the identifying code (for example, a CLIA number) that uniquely identifies the pathology facility sending the first report of the case. Pre-2010 CCR definition: The CCR Reporting source number that identifies the facility that produced the report. Note: Eventually, this may become the NPI number for the facility, but for now we will use the CCR reporting source numbers.

LEVELS

Admissions

LENGTH

25 x 5 fields

ALLOWABLE VALUES

For valid hospital code numbers see CA_Hosp_Codes on the CCRCAL page.
Blank is allowed if there is no report or if the case was diagnosed prior to 01/01/08.

SOURCE

Left-justify, but keep leading 0's for each field upon upload.

UPDATE

Manual Change or Correction Applied

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

10/10/07	New data items added to help identify path reports used in abstracting, to facilitate automatic new case abstract/pathology report matching at the regional/central registry, and to expand the space available in the path text field. Starting in 2008, visual editors will be reviewing path reports alongside the submitted cases, so it is important to identify all the reports used by the abstractor. Interfield edits #762-766 added.
2010	2010 Data Changes: CCR names changed from DxRx Report Facility ID 1-5 to Path Reporting Facility 1-5 because the former California item is now a new NAACCR item. Consolidated Data Extract changed to Yes. Length changed from 10 to 25.

Patient ID Number

IDENTIFIERS

CCR ID	NAACCR ID
E1007	20

DESCRIPTION

Unique number automatically assigned by the CCR (Eureka system) to identify each patient.

LEVELS

Patients, Tumors, Admissions

LENGTH

8

ALLOWABLE VALUES

1-99999999

SOURCE

Generated automatically when patient record was migrated or when a new patient record is created.

UPDATE

Patient ID Number may be updated automatically at the tumor level and admission level if two patients are merged or if an admission is unlinked and relinked. No update is possible at the patient level.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/03	Field name changed from CENTRAL-PAT-NO to Patient_ID. Updated Description, type, Allowable values (Err #11 deleted), Source and Update to reflect how Eureka handles this data item. This number is assigned to any new patient in the CCR central system (Eureka).
3/04	Clarified Update section.
8/06	Name updated to NAACCR Name (was Patient_ID).

Patient No Contact

In the metafile, this is also known as "Patient No Contact Flag"

IDENTIFIERS

CCR ID	NAACCR ID
E1573	None. State Requestor

DESCRIPTION

Flag which indicates that patient does not want to be recruited for research purposes, ever.

LEVELS

Patients, Admissions

LENGTH

1

ALLOWABLE VALUES

0	No Flag
1	Hospital First Notified
2	Region First Notified
3	CCR First Notified
4	Out of State Case, Not for Research
5	VA Case

SOURCE

If converted Other Reg ID value is alphabetic or 98, then load 4.
Otherwise, just load the transmitted value.

UPDATE

Patient Active Follow-up Fields Update Logic

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/97	New field added to the data set.
1/99	Added the word “First” to each allowable value description.
3/03	Added code 4 to Allowable Values for Out of State cases. Updated Source to load Out of State cases.
2010	Data Changes: Clarified Update logic and changed a 2nd "If" statement to "and" and changed the word "update" to an exact instruction.
2011	Data Changes: Code 5 added to Allowable values for VA Cases. Update logic revised to include code 5 as the overriding value. Conversion of VA Cases with code 4 should be converted to 5.

Pay Source 2

IDENTIFIERS

CCR ID	NAACCR ID
E1614	None. State Requestor

DESCRIPTION

Secondary source of payment to the hospital.

LEVELS

Admissions

LENGTH

2

ALLOWABLE VALUES

See Primary Payer at DX for codes.
EXCEPTION: Blank definition =Allowable for any diagnosis year

SOURCE

If the new case record version is B or later, then simply load from Pay Source 2.
If the new case record version is prior to A (8 or 9), then convert as described in Use Case 2003 --- Perform 2003 Data Conversions.
If the new case record version is A or earlier, then convert as described in Use Case 2006 – Perform 2006 Data Conversions.

UPDATE

Manual or Automatic Correction (See Appendix 26)

CONSOLIDATED DATA EXTRACT

Yes, from the hospital performing the most extensive cancer-directed surgery. If no cancer-directed surgery was performed, then consider Class_Of_Case using the following hierarchy: ~~1, 2, 0, 3,~~ 10-14, 20-22, 00, 30 or higher.

HISTORICAL CHANGES

3/00	Data item to be transmitted to the regions and CCR.
3/03	Source information reference added to conversion table in Pay_Source_1.
3/04	Removed conversion instructions from SOURCE for Version 9 records. See Use Case 22. Updated C/N# in Source.
1/05	Added Blank to Allowable Value definitions.
7/05	Conversion per Pay_Source_1 note.
2/06	See Pay_Source_1 note. Added Source information.
05/2013	Pay_Source_1 name updated to Primary Payer at DX
03/2019	Revised Class of Case codes to 2 digits in Consolidated Data Extract

Payment Source Text

IDENTIFIERS

CCR ID	NAACCR ID
E1577	None. State Requestor

DESCRIPTION

This is the text describing the Payment Source (Primary) code.

LEVELS

Admissions

LENGTH

40

ALLOWABLE VALUES

Any

SOURCE

Upload with no conversion.

UPDATE

Manual or Automatic Correction (See Appendix 26)

CONSOLIDATED DATA EXTRACT

Yes, from the hospital performing the most extensive cancer-directed surgery. If no cancer-directed surgery was performed, then consider Class_Of_Case using the following hierarchy: 1, 2, 0, 3, or higher.

HISTORICAL CHANGES

11/8/11	Minor name change to match Volume II. Pay Source Text is now Payment Source Text.

Pediatric Stage

IDENTIFIERS

CCR ID	NAACCR ID
E11158	1120

DESCRIPTION

The pediatric stage as specified in the pediatric staging system selected.

LEVELS

Admissions

LENGTH

2

ALLOWABLE VALUES

1	Second character may be blank, A, or B
2	Second character may be blank, A, B, or C
3	Second character may be blank, A, B, C, D, or E
4	Second character may be blank, A, B, or S
5	
A	
B	
C	
D	
DS	
88	Not applicable (not a pediatric case)
99	Unstaged, Unknown (for pediatric cases)
Blank	For case not abstracted or not a pediatric case prior to 1996

Upload with no conversion.

UPDATE

Manual or Automatic Correction (See Appendix 26)

CONSOLIDATED DATA EXTRACT

Yes. To choose the correct values, consider Pediatric Stage, Ped Staged By, and Pediatric Staging System together as a group. Start with most recent (i.e., latest admission date) analytic admission (Class of case <> 3) and work back until an admission is found with all non-blank values. However, if there is no qualifying analytic admission, send the values from the most recent non-blank, non-analytic admission.

HISTORICAL CHANGES

3/03	Removed Interfield edit
2010	Data Item Changes: CCR name (Ped-Stage) changed to match NAACCR name.

Pediatric Staged By

IDENTIFIERS

CCR ID	NAACCR ID
E1160	1140

DESCRIPTION

This field identifies the person who documented the pediatric staging.

LEVELS

Admissions

LENGTH

1

ALLOWABLE VALUES

For pediatric cases:

0	Not staged
1	Managing physician
2	Pathologist
3	Other physician
4	Any combination of 1, 2, or 3
5	Registrar
6	Any combination of 5 with 1, 2, or 3
7	Other
8	Staged, individual not specified
9	Unknown

If staged for non-pediatric cases:
Blank for CP21 and forward cases

SOURCE

N/A

UPDATE

Manual or Automatic Correction (See Appendix 26)

CONSOLIDATED DATA EXTRACT

Yes; see Pediatric Stage.

HISTORICAL CHANGES

3/00	Interfield edit -If AGE-DX >= 20 Pediatric Staged By = 0 else (Err #670) was removed.
8/03	Added blank to the Allowable values and changed to alphanumeric type.
2010	Data Item Changes: CCR name (Ped_State_Coder) changed to match NAACCR name.

Pediatric Staging System

IDENTIFIERS

CCR ID	NAACCR ID
E1159	1130

OWNER

CoC

DESCRIPTION

This field identifies the type of staging system used for the pediatric staging.

LEVELS

Admissions

LENGTH

2

ALLOWABLE VALUES

00	None
01	American Joint Committee on Cancer (AJCC)
02	Ann Arbor
03	Children's Cancer Group (CCG)
04	Evans
05	General Summary
06	Intergroup Ewings
07	Intergroup Hepatoblastoma
08	Intergroup Rhabdomyosarcoma
09	International System
10	Murphy
11	National Cancer Institute (Pediatric oncology)
12	National Wilm's Tumor Study
13	Pediatric Oncology Group (POG)
14	Reese-Ellsworth
15	SEER Extent of Disease
16	Children's Oncology Group (COG)
88	Not applicable (not pediatric case)
97	Other
99	Unknown

For Non-Pediatric Cases:

00	None, Diagnosed before 1996
88	Not applicable (not pediatric case)
Blank	For CP21 and forward cases

SOURCE

If Pediatric Staging System = 00, 88, 99, or blank,

If Date of Diagnosis > 1995 and < 2150,

Calculate Age_DX using Birth_Date and Date of Diagnosis

If Age_DX < 20,

Load 99

Else Load 88

Else Load 00

Else Right-justify, zero-fill, and load the transmitted Pediatric Staging System value

UPDATE

Manual or Automatic Correction (See Appendix 26)

CONSOLIDATED DATA EXTRACT

Yes; see Pediatric Stage

HISTORICAL CHANGES

03/2003	Added code 16 to allowable values. Deleted interfiled edit as the CoC no longer requires this data item. This data item remains a part of the CCR data set.
08/2003	Added blank to the Allowable values and changed to alphanumeric type.
2010	Data Item Changes: CCR name (Ped Stage Sys) changed to NAACCR name. Updated date logic in Source section.
11/09/2011	Corrected old date notation left over from 1009 and before. Was: If Date of Diagnosis > 1995 and < 9998 Is now: If Date of Diagnosis > 1995 and < 2150,
07/2015	Corrected listed allowable values to include code 16.

Percent Necrosis Post Neoadjuvant

IDENTIFIERS

CCR ID	NAACCR ID
E2021	3908

OWNER

NAACCR

DESCRIPTION

Percent Necrosis Post Neoadjuvant is a prognostic factor for bone sarcomas.

LEVELS

Admissions, Tumors

LENGTH

5

ALLOWABLE VALUES

0.0	Tumor necrosis not identified/not present
0.1 – 100.0	0.1–100.0 percent tumor necrosis (Percentage of tumor necrosis to nearest tenth of a percent)
XXX.2	Tumor necrosis present, percent not stated
XXX.8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code XXX.8 will result in an edit error.)
XXX.9	Not documented in medical record No histologic examined of primary site No neoadjuvant therapy No surgical resection of primary site is performed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00381, 00382, or 00383
        - Type of Reporting Source is not 7
        - COC Accredited Flag is 1
        - Percent Necrosis Post Neoadjuvant is blank or XXX.8

        Then convert Percent Necrosis Post Neoadjuvant to XXX.9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00381, 00382, 00383

            OR
            - Type of Reporting Source is 7
        - Percent Necrosis Post Neoadjuvant is not blank

Then convert Percent Necrosis Post Neoadjuvant to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00381, 00382, or 00383
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00381, 00382, or 00383

One of the following conditions is true

- Admission's value is not blank, XXX.8, or XXX.9
- Tumor's value is blank , XXX.8, or XXX.9

OR

- Admission's value is XXX.9
- Tumor's value is blank or XXX.8

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Perineural Invasion

IDENTIFIERS

CCR ID	NAACCR ID
E2022	3909

OWNER

NAACCR

DESCRIPTION

Perineural Invasion, within or adjacent to the primary tumor, is a negative prognostic factor for cutaneous squamous cell carcinomas of the head and neck and carcinomas of the colon and rectum, eyelid and lacrimal gland.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	Perineural invasion not identified/not present
1	Perineural invasion identified/present
8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code 8 may result in an edit error.)
9	Not documented in medical record Pathology report does not mention perineural invasion Cannot be determined by the pathologist Perineural invasion not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00150, 00200, 00640, or 00690
        - Type of Reporting Source is not 7
        - Perineural Invasion is blank or 8

        Then convert Perineural Invasion to 9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00150, 00200, 00640, 00690

            OR
            - Type of Reporting Source is 7
        - Perineural Invasion is not blank

        Then convert Perineural Invasion to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00150, 00200, 00640, or 00690
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00150, 00200, 00640, or 00690

One of the following conditions is true

- Admission's value is not blank or 9
- Tumor's value is blank or 9

OR

- Admission's value is 9
- Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Peripheral Blood Involvement

IDENTIFIERS

CCR ID	NAACCR ID
E2023	3910

OWNER

NAACCR

DESCRIPTION

Peripheral blood involvement, summarized in "B category", refers to the percentage of peripheral blood lymphocytes that are atypical (Sezary) cells and whether they are "Clone negative" or "Clone positive".

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	Absence of significant blood involvement 5% or less of peripheral blood lymphocytes are atypical (Sezary) cells Clone unknown Stated as B0
1	Absence of significant blood involvement 5% or less of peripheral blood lymphocytes are atypical (Sezary) cells Clone negative Stated as B0a
2	Absence of significant blood involvement: 5% or less of peripheral blood lymphocytes are atypical (Sezary) cells Clone positive Stated as B0b
3	Low blood tumor burden More than 5% of peripheral blood lymphocytes are atypical (Sezary) cells but does not meet the criteria of B2 Clone unknown Stated as B1
4	Low blood tumor burden More than 5% of peripheral blood lymphocytes are atypical (Sezary) cells but does not meet the criteria of B2 Clone negative Stated as B1a
5	Low blood tumor burden More than 5% of peripheral blood lymphocytes are atypical (Sezary) cells but does not meet the criteria of B2 Clone positive Stated as B1b
6	High blood tumor burden

	Greater than or equal to 1000 Sezary cells per microliter (uL) Clone positive Stated as B2
7	Test ordered, results not in chart
9	Not documented in medical record Peripheral Blood Involvement not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
   A. If all of the following conditions are true:
      - Schema ID is 00811
      - Type of Reporting Source is not 7
      - Peripheral Blood Involvement is blank

      Then convert Percent Necrosis Post Neoadjuvant to 9
   B. If all of the following conditions are true:
      - One of the following is true:
        - Schema ID is not 00811

        OR
        - Type of Reporting Source is 7
      - Peripheral Blood Involvement is not blank

      Then convert Peripheral Blood Involvement to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00811
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00811

One of the following conditions is true

- Admission's value is not blank, 9
- Tumor's value is blank, 9

  OR
  - Admission's value is 9
  - Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.
Otherwise,
If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Peritoneal Cytology

IDENTIFIERS

CCR ID	NAACCR ID
E2024	3911

OWNER

NAACCR

DESCRIPTION

Peritoneal cytology pertains to the results of cytologic examination for malignant cells performed on fluid that is obtained from the peritoneal cavity.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	Peritoneal cytology/washing negative for malignancy
1	Peritoneal cytology/washing atypical and/or suspicious
2	Peritoneal cytology/washing malignant (positive for malignancy)
3	Unsatisfactory/nondiagnostic
7	Test ordered, results not in chart
8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code 8 will result in an edit error.)
9	Not documented in medical record Peritoneal cytology not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00530, 00541, or 00542
        - Type of Reporting Source is not 7
        - Peritoneal Cytology is blank or 8

        Then convert Peritoneal Cytology to 9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00530, 00541, 00542

            OR
            - Type of Reporting Source is 7
        - Peritoneal Cytology is not blank

        Then convert Peritoneal Cytology to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00530, 00541, or 00542
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00530, 00541, or 00542

One of the following conditions is true

- Admission's value is not blank, 9
- Tumor's value is blank or 9

OR

- Admission's value is 9
- Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Phase I Dose Per Fraction

IDENTIFIERS

CCR ID	NAACCR ID
E1871	1501

OWNER

COC

DESCRIPTION

Records the dose per fraction (treatment session) delivered to the patient in the first phase of radiation during the first course of treatment. The unit of measure is centiGray (cGy).

LEVELS

Admissions, Tumors

LENGTH

5

ALLOWABLE VALUES

00000	Radiation therapy was not administered
00001-99997	Record the actual Phase I dose delivered in cGy
99998	Not applicable, brachytherapy or radioisotopes administered to the patient
99999	Regional radiation therapy was administered but dose is unknown, it is unknown whether radiation therapy was administered. Death Certificate only

SOURCE

Right justify and zero fill any values less than 5 digits, but not blank

UPDATE

TUMOR LEVEL

NEW CASE CONSOLIDATION

If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

ADMISSION

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Phase I Number of Fractions

IDENTIFIERS

CCR ID	NAACCR ID
E1873	1503

OWNER

COC

DESCRIPTION

Records the dose per fraction (treatment session) delivered to the patient in the first phase of radiation during the first course of treatment. The unit of measure is centiGray (cGy).

LEVELS

Admissions, Tumors

LENGTH

3

ALLOWABLE VALUES

000	Radiation therapy was not administered to the patient
001-998	Number of fractions administered to the patient during the first phase of radiation therapy
999	Phase I Radiation therapy was administered, but the number of fractions is unknown; It is unknown whether radiation therapy was administered

SOURCE

Right justify and zero fill any values less than 3 digits, but not blank

UPDATE

TUMOR LEVEL

NEW CASE CONSOLIDATION

If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

ADMISSION

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Phase I Radiation External Beam Planning Tech

IDENTIFIERS

CCR ID	NAACCR ID
E1872	1502

OWNER

COC

DESCRIPTION

Identifies the external beam radiation planning technique used to administer the first phase of radiation treatment during the first course of treatment.

LEVELS

Admissions, Tumors

LENGTH

2

ALLOWABLE VALUES

00	No radiation treatment
01	External beam, NOS
02	Low energy x-ray/photon therapy
03	2-D therapy
04	Conformal or 3-D conformal therapy
05	Intensity modulated therapy
06	Stereotactic radiotherapy or radiosurgery, NOS
07	Stereotactic radiotherapy or radiosurgery, robotic
08	Stereotactic radiotherapy or radiosurgery, Gamma Knife®
09	CT-guided online adaptive therapy
10	MR-guided online adaptive therapy
88	Not Applicable
98	Other, NOS
99	Unknown

SOURCE

1. If not blank, then right-justify and zero-fill any values less than 2 digits.
2. If Coding Proc is less than 34 (2018 data changes), then convert from RAD--REGIONAL RX MODALITY according to use case Perform Eureka 2018 One-Time Data Conversions and Table Populations – UC, step 22 (first table).

UPDATE

TUMOR LEVEL

NEW CASE CONSOLIDATION

If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

ADMISSION

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented
03/2019	Revised Source Logic – Added Step 2 for Coding Proc 34

Phase I Radiation Primary Treatment Volume

IDENTIFIERS

CCR ID	NAACCR ID
E1874	1504

OWNER

COC

DESCRIPTION

Identifies the primary treatment volume or primary anatomic target treated during the first phase of radiation therapy during the first course of treatment.

LEVELS

Admissions, Tumors

LENGTH

2

ALLOWABLE VALUES

00	No radiation treatment
01	Neck lymph node regions
02	Thoracic lymph node regions
03	Neck and thoracic lymph node regions
04	Breast/ Chest wall lymph node regions
05	Abdominal lymph nodes
06	Abdominal lymph nodes
07	Abdominal lymph nodes
09	Abdominal lymph nodes
10	Abdominal lymph nodes
11	Pituitary
12	Brain
13	Brain (Limited)
14	Spinal cord
20	Nasopharynx
21	Oral Cavity
22	Oropharynx
23	Larynx (glottis) or hypopharynx
24	Sinuses/Nasal tract
25	Parotid or other salivary glands
26	Thyroid
29	Head and neck (NOS)
30	Lung or bronchus
31	Mesothelium
32	Thymus
39	Chest/lung (NOS)
40	Breast - whole
41	Breast - partial
42	Chest wall
50	Esophagus
51	Stomach
52	Small bowel
53	Colon
54	Rectum
55	Anus
56	Liver
57	Biliary tree or gallbladder
58	Pancreas or hepatopancreatic ampulla
59	Abdomen (NOS)
60	Bladder - whole
61	Bladder - partial
62	Kidney
63	Ureter
64	Prostate - whole
65	Prostate - partial
66	Urethra
67	Urethra
68	Urethra
70	Ovaries or fallopian tubes
71	Uterus or Cervix
72	Vagina
73	Vulva
80	Skull
81	Spine/vertebral bodies
82	Shoulder
83	Ribs

84	Hip
85	Pelvic bones
86	Pelvis (NOS, non-visceral)
88	Extremity bone, NOS
90	Skin
91	Soft tissue
92	Hemibody
93	Whole body
94	Mantle, mini-mantle (obsolete after 2017)
95	Lower extended field (obsolete after 2017)
96	Inverted Y (obsolete after 2017)
97	Invalid historical FORDS value
98	Other
99	Unknown

SOURCE

Right justify and zero fill any values less than 2 digits, but not blank

UPDATE

TUMOR LEVEL

NEW CASE CONSOLIDATION

If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

ADMISSION

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Phase I Radiation to Draining Lymph Nodes

IDENTIFIERS

CCR ID	NAACCR ID
E1875	1505

OWNER

COC

DESCRIPTION

Identifies the draining lymph nodes treated (if any) during the first phase of radiation therapy delivered to the patient during the first course of treatment.

LEVELS

Admissions, Tumors

LENGTH

2

ALLOWABLE VALUES

00	No radiation treatment
01	Neck lymph node regions
02	Thoracic lymph node regions
03	Neck and thoracic lymph node regions
04	Breast/Chest wall lymph node regions
05	Abdominal lymph nodes
06	Pelvic lymph nodes
07	Abdominal and pelvic lymph nodes
08	Lymph node region, NOS
88	Not applicable; Phase I Radiation Primary Treatment Volume is lymph nodes
99	Unknown if any radiation treatment to draining lymph nodes; Unknown if radiation treatment administered

SOURCE

Right justify and zero fill any values less than 2 digits, but not blank

UPDATE

TUMOR LEVEL

NEW CASE CONSOLIDATION

If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

ADMISSION

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Phase I Radiation Treatment Modality

IDENTIFIERS

CCR ID	NAACCR ID
E1876	1506

OWNER

COC

DESCRIPTION

Identifies the radiation modality administered during the first phase of radiation treatment delivered during the first course of treatment.

LEVELS

Admissions, Tumors

LENGTH

2

ALLOWABLE VALUES

00	No radiation treatment
01	External beam, NOS
02	External beam, photons
03	External beam, protons
04	External beam, electrons
05	External beam, neutrons
06	External beam, carbon ions
07	Brachytherapy, NOS
08	Brachytherapy, intracavitary, LDR
09	Brachytherapy, intracavitary, HDR
10	Brachytherapy, Interstitial, LDR
11	Brachytherapy, Interstitial, HDR
12	Brachytherapy, electronic
13	Radioisotopes, NOS
14	Radioisotopes, Radium-232
15	Radioisotopes, Strontium-89
16	Radioisotopes, Strontium-90
99	Treatment radiation modality unknown; Unknown if radiation treatment administered

SOURCE

1. If not blank, then right-justify and zero-fill any values less than 2 digits.
2. If Coding Proc is less than 34 (2018 data changes), then convert from RAD--REGIONAL RX MODALITY according to use case Perform Eureka 2018 One-Time Data Conversions and Table Populations – UC, step 22 (first table).

UPDATE

TUMOR LEVEL

NEW CASE CONSOLIDATION

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

ADMISSION

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented
03/2019	Revised Source Logic – Added Step 2 for Coding Proc 34

Phase I Total Dose

IDENTIFIERS

CCR ID	NAACCR ID
E1877	1507

OWNER

COC

DESCRIPTION

Identifies the total radiation dose delivered to the patient in the first phase of radiation treatment during the first course of treatment. The unit of measure is centiGray (cGy).

LEVELS

Admissions, Tumors

LENGTH

6

ALLOWABLE VALUES

000000		No th
000001-999997		Reco
999998		Not a
999999		Radia radia

SOURCE

Right justify and zero fill any values less than 6 digits, but not blank

UPDATE

TUMOR LEVEL

NEW CASE CONSOLIDATION

If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

ADMISSION

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Phase II Dose Per Fraction

IDENTIFIERS

CCR ID	NAACCR ID
E1878	1511

OWNER

COC

DESCRIPTION

Records the dose per fraction (treatment session) delivered to the patient in the second phase of radiation during the first course of treatment. The unit of measure is centiGray (cGy).

LEVELS

Admissions, Tumors

LENGTH

5

ALLOWABLE VALUES

00000	Radiation therapy was not administered
00001-99997	Record the actual Phase I dose delivered in cGy
99998	Not applicable, brachytherapy or radioisotopes administered to the patient
99999	Phase II (Boost) radiation therapy was administered but dose is unknown, it is unknown whether Phase II radiation therapy was administered. Death Certificate only

SOURCE

Right justify and zero fill any values less than 5 digits, but not blank

UPDATE

TUMOR LEVEL

NEW CASE CONSOLIDATION

If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

ADMISSION

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Phase II number of Fractions

IDENTIFIERS

CCR ID	NAACCR ID
E1880	1513

OWNER

COC

DESCRIPTION

Records the total number of fractions (treatment sessions) administered to the patient in the second phase of radiation during the first course of treatment.

LEVELS

Admissions, Tumors

LENGTH

3

ALLOWABLE VALUES

000	Radiation therapy was not administered to the patient
001-998	Number of fractions administered to the patient during the second phase of radiation therapy
999	Phase II Radiation therapy was administered, but the number of fractions is unknown; It is unknown whether radiation therapy was administered

SOURCE

Right justify and zero fill any values less than 3 digits, but not blank

UPDATE

TUMOR LEVEL

NEW CASE CONSOLIDATION

If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

ADMISSION

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Phase II Radiation External Beam Planning Tech

IDENTIFIERS

CCR ID	NAACCR ID
E1879	1512

OWNER

COC

DESCRIPTION

Identifies the external beam radiation planning technique used to administer the second phase of radiation treatment during the first course of treatment.

LEVELS

Admissions, Tumors

LENGTH

2

ALLOWABLE VALUES

00	No radiation treatment
01	External beam, NOS
02	Low energy x-ray/photon therapy
03	2-D therapy
04	Conformal or 3-D conformal therapy
05	Intensity modulated therapy
06	Stereotactic radiotherapy or radiosurgery, NOS
07	Stereotactic radiotherapy or radiosurgery, robotic
08	Stereotactic radiotherapy or radiosurgery, Gamma Knife®
09	CT-guided online adaptive therapy
10	MR-guided online adaptive therapy
88	Not Applicable
98	Other, NOS
99	Unknown

SOURCE

1. If not blank, then right-justify and zero-fill any values less than 2 digits.
2. If Coding Proc is less than 34 (2018 data changes), then convert from RAD--BOOST RX MODALITY according to use case Perform Eureka 2018 One-Time Data Conversions and Table Populations – UC, step 22 (second table).

UPDATE

TUMOR LEVEL

NEW CASE CONSOLIDATION

If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

ADMISSION

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.
03/2019	Revised Source Logic – Added Step 2 for Coding Proc 34

Phase II Radiation tp Draining Lymph Nodes

IDENTIFIERS

CCR ID	NAACCR ID
E1882	1515

OWNER

COC

DESCRIPTION

Identifies the draining lymph nodes treated (if any) during the second phase of radiation therapy delivered to the patient during the first course of treatment.

LEVELS

Admissions, Tumors

LENGTH

2

ALLOWABLE VALUES

00	No radiation treatment to draining lymph nodes
01	Neck lymph node regions
02	Thoracic lymph node regions
03	Neck and thoracic lymph node regions
04	Breast/Chest wall lymph node regions
05	Abdominal lymph nodes
06	Pelvic lymph nodes
07	Abdominal and pelvic lymph nodes
08	Lymph node region, NOS
88	Not Applicable; Phase II Radiation Primary Treatment Volume is lymph nodes
99	Unknown if any radiation treatment to draining lymph nodes; Unknown if radiation treatment administered

SOURCE

Right justify and zero fill any values less than 2 digits, but not blank

UPDATE

TUMOR LEVEL

NEW CASE CONSOLIDATION

If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

ADMISSION

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Phase II Radiation Primary Treatment Volume

IDENTIFIERS

CCR ID	NAACCR ID
E1881	1514

OWNER

COC

DESCRIPTION

Identifies the primary treatment volume or primary anatomic target treated during the second phase of radiation therapy during the first course of treatment.

LEVELS

Admissions, Tumors

LENGTH

2

ALLOWABLE VALUES

00	No phase II radiation treatment
01	Neck lymph node regions
02	Thoracic lymph node regions
03	Neck and thoracic lymph node regions
04	Breast/ Chest wall lymph node regions
05	Abdominal lymph nodes
06	Abdominal lymph nodes
07	Abdominal lymph nodes
09	Abdominal lymph nodes
10	Abdominal lymph nodes
11	Pituitary
12	Brain
13	Brain (Limited)
14	Spinal cord
20	Nasopharynx
21	Oral Cavity
22	Oropharynx
23	Larynx (glottis) or hypopharynx
24	Sinuses/Nasal tract
25	Parotid or other salivary glands
26	Thyroid
29	Head and neck (NOS)
30	Lung or bronchus
31	Mesothelium
32	Thymus
39	Chest/lung (NOS)
40	Breast - whole
41	Breast - partial
42	Chest wall
50	Esophagus
51	Stomach
52	Small bowel
53	Colon
54	Rectum
55	Anus
56	Liver
57	Biliary tree or gallbladder
58	Pancreas or hepatopancreatic ampulla
59	Abdomen (NOS)
60	Bladder - whole
61	Bladder - partial
62	Kidney
63	Ureter
64	Prostate - whole
65	Prostate - partial
66	Urethra
67	Urethra
68	Urethra
70	Ovaries or fallopian tubes
71	Uterus or Cervix
72	Vagina
73	Vulva
80	Skull
81	Spine/vertebral bodies
82	Shoulder
83	Ribs

84	Hip
85	Pelvic bones
86	Pelvis (NOS, non-visceral)
88	Extremity bone, NOS
90	Skin
91	Soft tissue
92	Hemibody
93	Whole body
94	Mantle, mini-mantle (obsolete after 2017)
95	Lower extended field (obsolete after 2017)
96	Inverted Y (obsolete after 2017)
97	Invalid historical FORDS value
98	Other
99	Unknown

SOURCE

Right justify and zero fill any values less than 2 digits, but not blank

UPDATE

TUMOR LEVEL

NEW CASE CONSOLIDATION

If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

ADMISSION

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Phase II Radiation Treatment Modality

IDENTIFIERS

CCR ID	NAACCR ID
E1883	1516

OWNER

COC

DESCRIPTION

Identifies the radiation modality administered during the second phase of radiation treatment delivered during the first course of treatment.

LEVELS

Admissions, Tumors

LENGTH

2

ALLOWABLE VALUES

00	No radiation treatment
01	External beam, NOS
02	External beam, photons
03	External beam, protons
04	External beam, electrons
05	External beam, neutrons
06	External beam, carbon ions
07	Brachytherapy, NOS
08	Brachytherapy, intracavitary, LDR
09	Brachytherapy, intracavitary, HDR
10	Brachytherapy, Interstitial, LDR
11	Brachytherapy, Interstitial, HDR
12	Brachytherapy, electronic
13	Radioisotopes, NOS
14	Radioisotopes, Radium-232
15	Radioisotopes, Strontium-89
16	Radioisotopes, Strontium-90
99	Treatment radiation modality unknown; Unknown if radiation treatment administered

SOURCE

1. If not blank, then right-justify and zero-fill any values less than 2 digits.
2. If Coding Proc is less than 34 (2018 data changes), then convert from RAD--BOOST RX MODALITY according to use case Perform Eureka 2018 One-Time Data Conversions and Table Populations – UC, step 22 (second table).

UPDATE

TUMOR LEVEL

NEW CASE CONSOLIDATION

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

ADMISSION

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.
03/2019	Revised Source Logic: Added Step 2 for Coding Proc 34

Phase II Total Dose

IDENTIFIERS

CCR ID	NAACCR ID
E1884	1517

OWNER

COC

DESCRIPTION

Identifies the total radiation dose administered in the second phase of radiation treatment delivered to the patient during the first course of treatment. The unit of measure is centiGray (cGy).

LEVELS

Admissions, Tumors

LENGTH

6

ALLOWABLE VALUES

000000	No therapy administered
000001-999997	Record the actual total dose delivered in cGy
999998	Not applicable, radioisotopes administered to the patient
999999	Radiation therapy was administered, but the dose is unknown; it is unknown whether radiation therapy was administered

SOURCE

Right justify and zero fill any values less than 6 digits, but not blank

UPDATE

TUMOR LEVEL

NEW CASE CONSOLIDATION

If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

ADMISSION

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Phase III Dose Per Fraction

IDENTIFIERS

CCR ID	NAACCR ID
E1885	1521

OWNER

COC

DESCRIPTION

Records the dose per fraction (treatment session) delivered to the patient in the third phase of radiation during the first course of treatment. The unit of measure is centiGray (cGy).

LEVELS

Admissions, Tumors

LENGTH

5

ALLOWABLE VALUES

00000	No radiation treatment
00001-99997	Record the actual Phase III dose delivered in cGy
99998	Not applicable, radioisotopes administered to the patient
99999	Phase III radiation therapy was administered but dose is unknown, it is unknown whether Phase III radiation therapy was administered. Death Certificate only

SOURCE

Right justify and zero fill any values less than 5 digits, but not blank

UPDATE

TUMOR LEVEL

NEW CASE CONSOLIDATION

If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

ADMISSION

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Phase III Number of Fractions

IDENTIFIERS

CCR ID	NAACCR ID
E1887	1523

OWNER

COC

DESCRIPTION

Records the total number of fractions (treatment sessions) delivered to the patient in the third phase of radiation during the first course of treatment.

LEVELS

Admissions, Tumors

LENGTH

3

ALLOWABLE VALUES

000	No radiation treatment
001-998	Number of fractions administered to the patient during the third phase of radiation therapy
999	Phase III Radiation therapy was administered, but the number of fractions is unknown; It is unknown whether radiation therapy was administered

SOURCE

Right justify and zero fill any values less than 3 digits, but not blank

UPDATE

TUMOR LEVEL

NEW CASE CONSOLIDATION

If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

ADMISSION

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Phase III Radiation External Beam Planning Tech

IDENTIFIERS

CCR ID	NAACCR ID
E1886	1522

OWNER

COC

DESCRIPTION

Identifies the external beam radiation planning technique used to administer the third phase of radiation treatment during the first course of treatment.

LEVELS

Admissions, Tumors

LENGTH

2

ALLOWABLE VALUES

00	No radiation treatment
01	External beam, NOS
02	Low energy x-ray/photon therapy
03	2-D therapy
04	Conformal or 3-D conformal therapy
05	Intensity modulated therapy
06	Stereotactic radiotherapy or radiosurgery, NOS
07	Stereotactic radiotherapy or radiosurgery, robotic
08	Stereotactic radiotherapy or radiosurgery, Gamma Knife®
09	CT-guided online adaptive therapy
10	MR-guided online adaptive therapy
88	Not Applicable
98	Other, NOS
99	Unknown

SOURCE

Right justify and zero fill any values less than 2 digits, but not blank

UPDATE

TUMOR LEVEL

NEW CASE CONSOLIDATION

If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

ADMISSION

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Phase III Radiation to Draining Lymph Nodes

IDENTIFIERS

CCR ID	NAACCR ID
E1889	1525

OWNER

COC

DESCRIPTION

Identifies the draining lymph nodes treated (if any) during the third phase of radiation therapy delivered to the patient during the first course of treatment.

LEVELS

Admissions, Tumors

LENGTH

2

ALLOWABLE VALUES

00	No radiation treatment
01	Neck lymph node regions
02	Thoracic lymph node regions
03	Neck and thoracic lymph node regions
04	Breast/Chest wall lymph node regions
05	Abdominal lymph nodes
06	Pelvic lymph nodes
07	Abdominal and pelvic lymph nodes
08	Lymph node region, NOS
88	Not Applicable; Phase III Radiation Primary Treatment Volume is lymph nodes
99	Unknown if any radiation treatment to draining lymph nodes; Unknown if radiation treatment administered

SOURCE

Right justify and zero fill any values less than 2 digits, but not blank

UPDATE

TUMOR LEVEL

NEW CASE CONSOLIDATION

If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

ADMISSION

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Phase III Radiation Primary Treatment Volume

IDENTIFIERS

CCR ID	NAACCR ID
E1888	1524

OWNER

COC

DESCRIPTION

Identifies the primary treatment volume or primary anatomic target treated during the third phase of radiation therapy during the first course of treatment.

LEVELS

Admissions, Tumors

LENGTH

2

ALLOWABLE VALUES

00	No phase III radiation treatment
01	Neck lymph node regions
02	Thoracic lymph node regions
03	Neck and thoracic lymph node regions
04	Breast/ Chest wall lymph node regions
05	Abdominal lymph nodes
06	Abdominal lymph nodes
07	Abdominal lymph nodes
09	Abdominal lymph nodes
10	Abdominal lymph nodes
11	Pituitary
12	Brain
13	Brain (Limited)
14	Spinal cord
20	Nasopharynx
21	Oral Cavity
22	Oropharynx
23	Larynx (glottis) or hypopharynx
24	Sinuses/Nasal tract
25	Parotid or other salivary glands
26	Thyroid
29	Head and neck (NOS)
30	Lung or bronchus
31	Mesothelium
32	Thymus
39	Chest/lung (NOS)
40	Breast - whole
41	Breast - partial
42	Chest wall
50	Esophagus
51	Stomach
52	Small bowel
53	Colon
54	Rectum
55	Anus
56	Liver
57	Biliary tree or gallbladder
58	Pancreas or hepatopancreatic ampulla
59	Abdomen (NOS)
60	Bladder - whole
61	Bladder - partial
62	Kidney
63	Ureter
64	Prostate - whole
65	Prostate - partial
66	Urethra
67	Urethra
68	Urethra
70	Ovaries or fallopian tubes
71	Uterus or Cervix
72	Vagina
73	Vulva
80	Skull
81	Spine/vertebral bodies
82	Shoulder
83	Ribs

84	Hip
85	Pelvic bones
86	Pelvis (NOS, non-visceral)
88	Extremity bone, NOS
90	Skin
91	Soft tissue
92	Hemibody
93	Whole body
94	Mantle, mini-mantle (obsolete after 2017)
95	Lower extended field (obsolete after 2017)
96	Inverted Y (obsolete after 2017)
97	Invalid historical FORDS value
98	Other
99	Unknown

SOURCE

Right justify and zero fill any values less than 2 digits, but not blank

UPDATE

TUMOR LEVEL

NEW CASE CONSOLIDATION

If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

ADMISSION

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Phase III Radiation Treatment Modality

IDENTIFIERS

CCR ID	NAACCR ID
E1890	1526

OWNER

COC

DESCRIPTION

Radiation modality reflects whether a treatment was external beam, brachytherapy, a radioisotope as well as their major subtypes, or a combination of modalities. This data item should be used to indicate the radiation modality administered during the third phase of radiation.

LEVELS

Admissions, Tumors

LENGTH

2

ALLOWABLE VALUES

00	No radiation treatment
01	External beam, NOS
02	External beam, photons
03	External beam, protons
04	External beam, electrons
05	External beam, neutrons
06	External beam, carbon ions
07	Brachytherapy, NOS
08	Brachytherapy, intracavitary, LDR
09	Brachytherapy, intracavitary, HDR
10	Brachytherapy, Interstitial, LDR
11	Brachytherapy, Interstitial, HDR
12	Brachytherapy, electronic
13	Radioisotopes, NOS
14	Radioisotopes, Radium-232
15	Radioisotopes, Strontium-89
16	Radioisotopes, Strontium-90
99	Treatment radiation modality unknown; Unknown if radiation treatment administered

SOURCE

Right justify and zero fill any values less than 2 digits, but not blank

UPDATE

TUMOR LEVEL

NEW CASE CONSOLIDATION

If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

ADMISSION

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Phase III Total Dose

IDENTIFIERS

CCR ID	NAACCR ID
E1891	1527

OWNER

COC

DESCRIPTION

Identifies the total radiation dose delivered during the third phase of radiation treatment delivered to the patient during the first course of treatment. The unit of measure is centiGray (cGy).

LEVELS

Admissions, Tumors

LENGTH

6

ALLOWABLE VALUES

000000	No radiation treatment
000001-999997	Record the actual total dose delivered in cGy
999998	Not applicable, radioisotopes administered to the patient
999999	Radiation therapy was administered, but the dose is unknown; it is unknown whether radiation therapy was administered

SOURCE

Right justify and zero fill any values less than 6 digits, but not blank

UPDATE

TUMOR LEVEL

NEW CASE CONSOLIDATION

If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

ADMISSION

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Physician 3

IDENTIFIERS

CCR ID	NAACCR ID
E1672	2490

DESCRIPTION

California license number of the radiation oncologist. Out-of-state physicians' license numbers may be entered here with the first character being an X.

LEVELS

Admissions

LENGTH

8

ALLOWABLE VALUES

First position must be alpha, all others must be numeric except when first character is O, third or fourth character may be alpha.
If first character is X the rest of the characters may be any alpha or numeric character.
Exceptions to the alpha first position rule are:

00000000 No radiation therapy or radiation therapy consult performed
99999999 Unknown physician/license number not assigned
Blank if no information.

SOURCE

Upshift; if transmitted value is X9999999, convert it to 99999999.
If transmitted value is 88888888, then convert to blank.

UPDATE

Manual

CONSOLIDATED DATA EXTRACT

Yes, record with the earliest admission date for this tumor.

HISTORICAL CHANGES

3/26/03	Allowable value for unknown changed from X9999999 to 99999999. Converted X9999999 Phys_Rad_ONC fields to 99999999 (pre-Coding Procedure 21). 88888888 and 00000000 added to Allowable values.
7/27/05	Deleted code 88888888 from Allowable Values Err #149 per CoC standards.
2/01/06	Converted 8's to blank. Updated Source information to handle 8's.
7/2008	Modified Allowable values for osteopaths to allow alphanumeric character in third or fourth position.
2010	Data Changes: CCR name (Phys_Rad_ONC) changed to NAACCR name.

Physician 4

IDENTIFIERS

CCR ID	NAACCR ID
E1674	2500

DESCRIPTION

California license number of the medical oncologist. Out-of-state physicians' license numbers may be entered here with the first character being an X.

LEVELS

Admissions

LENGTH

8

ALLOWABLE VALUES

First position must be alpha, all others must be numeric except when first character is O, third or fourth character may be alpha.
If first character is X the rest of the characters may be any alpha or numeric character.
Exceptions to the alpha first position rule are:

00000000 No radiation therapy or radiation therapy consult performed
99999999 Unknown physician/license number not assigned
Blank if no information.

SOURCE

Upshift; if transmitted value is X9999999, convert it to 99999999.
If transmitted value is 88888888, then convert to blank.

UPDATE

Manual

CONSOLIDATED DATA EXTRACT

Yes, record with the earliest admission date for this tumor.

HISTORICAL CHANGES

03/26/03	Allowable value for unknown changed from X9999999 to 99999999. Converted X9999999 Phys_Rad_ONC fields to 99999999 (pre-Coding Procedure 21). 88888888 and 00000000 added to Allowable values.
07/27/05	Deleted code 88888888 from Allowable Values Err #149 per CoC standards.
02/01/06	Converted 8's to blank. Updated Source information to handle 8's.
07/2008	Modified Allowable values for osteopaths to allow alphanumeric character in third or fourth position.
2010	Data Changes: CCR name (Phys_Rad_ONC) changed to NAACCR name.
02/2014	Corrected description to reflect field is used for medical oncologists.

Physician--Follow-up

IDENTIFIERS

CCR ID	NAACCR ID
E1668	2470

DESCRIPTION

California license of the physician who will be seeing the patient after discharge from the hospital and who could be contacted for follow-up information.
Out-of-state physicians' license numbers may be entered here with the first character being an X.
Hospital-specific codes may be used for out-of-state physicians.

LEVELS

Patient, Admission

LENGTH

8

ALLOWABLE VALUES

First position must be alpha, all others must be numeric except when first character is O, third or fourth character may be alpha.
If first character is X the rest of the characters may be any alpha or numeric character.
Use 99999999 if unknown.
Blank if no information.

SOURCE

Upshift; if transmitted value is X9999999, convert it to 99999999.

UPDATE

Patient Level

New Case Consolidation

If the admission's Physician--Follow Up is NOT blank and either:

1. the patient's Physician--Follow Up is blank or 99999999
   or
2. the admission's Date of Last Contact is later* than the patient's Date of Last Contact or the two dates are the same,

Then automatically update the patient's Physician--Follow-Up with the admission's Physician--Follow-Up license number.

Manual Change

Admission

Manual Change Only

* With year, month, and/or day potentially blank, a completely known date could appear to be later because it is a larger number than a partial later date. Thus, to test for the latest date among known full or partial dates, use these tests in this order:

- If one of the known dates' years is later than (greater than) the other date's year being compared or if it is the only known year/date, then that date is the latest known date
- If multiple known dates have the same latest year, but only one of them has a latest known month, then that is the latest known date

- If multiple known dates have the same latest year & month, but only one of them has a latest known day, then that is the latest known date

CONSOLIDATED DATA EXTRACT

Yes, from Patient's file.

HISTORICAL CHANGES

03/2003	Allowable value for unknown changed from X9999999 to 99999999. Converted X9999999 Phys_FU fields to 99999999 (pre-Coding Procedure 21). Added unknown value to Update 1) so a known Phys_FU will over-ride an unknown.
03/2007	Software vendor item # corrected.
06/2007	Software vendor item # corrected.
07/2008	Modified Allowable values for osteopaths to allow alphanumeric character in third or fourth position.
2010	Data Changes: CCR name (Phys_FU) changed to NAACCR name. Rewrote update logic.
02/2020	Added back to Volume III

Physician--Managing

IDENTIFIERS

CCR ID	NAACCR ID
E1666	2460

DESCRIPTION

California license number of the attending (managing) physician at time of this admission for this tumor. Out-of-state physicians' license numbers may be entered here with the first character being an X.

LEVELS

Admissions

LENGTH

8

ALLOWABLE VALUES

First position must be alpha, all others must be numeric except when first character is O, third or fourth character may be alpha; if first character is X the rest of the characters may be any alpha or numeric character.
Cannot be blank.
Use 99999999 if unknown.

SOURCE

Upshift; if transmitted value is X9999999, convert it to 99999999.

UPDATE

Manual

CONSOLIDATED DATA EXTRACT

Yes, from record with earliest admission date for this tumor.

HISTORICAL CHANGES

1/1/99	Converted blank PHYS-ATTENDING fields to X9999999; changed allowable values to require a value other than blank.
3/26/03	Allowable value for unknown changed from X9999999 to 99999999. Converted X9999999 Phys_Attending fields to 99999999 (pre-Coding Procedure 21).
7/2008	Modified Allowable values for osteopaths to allow alphanumeric character in third or fourth position.
2010	Data Changes: CCR name (Phys_Attending) changed to NAACCR name.

Physician Other (1-2)

IDENTIFIERS

	CCR ID	NAACCR ID
Physician Other 1	E1630	None. State Requestor
Physician Other 2	E1633	None. State Requestor

DESCRIPTION

California license numbers of the physicians other than attending and following physicians. Out-of-state physicians' license numbers may be entered here with the first character being an X.

LEVELS

Admissions

LENGTH

8*2

ALLOWABLE VALUES

First position must be alpha, all others must be numeric except when first character is O, third or fourth character may be alpha; if first character is X the rest of the characters may be any alpha or numeric character.

Exceptions to the alpha first position rule are:

00000000 No other consult was performed

99999999 Unknown physician/license number not assigned

Blank if no information.

SOURCE

These physicians may be any physician. Upshift; if transmitted value is X9999999, convert it to 99999999.

UPDATE

Manual

CONSOLIDATED DATA EXTRACT

Yes, record with the earliest admission date for this tumor.

HISTORICAL CHANGES

3/26/03	Removed note in Source that put an X in the first character field was 9s.
8/27/03	Added unknown value of 99999999 to Allowable values. Added 00000000 to Allowable values.
7/2008	Modified Allowable values for osteopaths to allow alphanumeric character in third or fourth position.
2/9/2011	Name changed from Phys Other 1-2 to Physician Other1-2.

Physician--Primary Surg

IDENTIFIERS

CCR ID	NAACCR ID
E1670	2480

DESCRIPTION

California license number of the surgeon. Out-of-state physicians' license numbers may be entered here with the first character being an X.

LEVELS

Admissions

LENGTH

8

ALLOWABLE VALUES

First position must be alpha, all others must be numeric except when first character is O, third or fourth character may be alpha; if first character is X the rest of the characters may be any alpha or numeric character.

Exceptions to the alpha first position rule are:

00000000 No surgery and no surgical consultation performed
88888888 Non-surgeon performed procedure
99999999 Unknown physician/license number not assigned
Blank if no information.

SOURCE

Upshift; if transmitted value is X9999999, convert it to 99999999.

UPDATE

First position must be alpha, all others must be numeric except when first character is O, third or fourth character may be alpha; if first character is X the rest of the characters may be any alpha or numeric character.

Exceptions to the alpha first position rule are:

00000000 No surgery and no surgical consultation performed
88888888 Non-surgeon performed procedure
99999999 Unknown physician/license number not assigned
Blank if no information.

CONSOLIDATED DATA EXTRACT

Yes, from the record with the most definitive surgical procedure for this tumor.

HISTORICAL CHANGES

1/1999	Changed transmit to CCR specifications to send data from the admission with the most definitive surgical procedure. Allowable value for unknown changed from X9999999 to 99999999. Converted X9999999 Phys_Surg fields to 99999999 (pre-Coding Procedure 21). 88888888 and 00000000 added to Allowable values.
7/2008	Modified Allowable values for osteopaths to allow alphanumeric character in third or fourth position.
2010	Data Changes: CCR name (Phys_Surg) changed to NAACCR name.

Physician--Referring

IDENTIFIERS

CCR ID	NAACCR ID
E1578	None. State Requestor

DESCRIPTION

California license number of the referring physician. Out-of-state physicians' license numbers may be entered here with the first character being an X.

LEVELS

Admissions

LENGTH

8

ALLOWABLE VALUES

First position must be alpha, all others must be numeric except when first character is O, third or fourth character may be alpha; if first character is X the rest of the characters may be any alpha or numeric character.

Exceptions to the alpha first position rule are:

00000000 No referral

99999999 Unknown physician/license number not assigned

Blank if no information.

SOURCE

Upshift; if transmitted value is X9999999, convert it to 99999999.

UPDATE

Manual

CONSOLIDATED DATA EXTRACT

Yes, record with the earliest admission date for this tumor.

HISTORICAL CHANGES

Unknown	Removed note in Source that put an X in the first character field was 9s.
8/27/03	Added unknown value of 99999999 to Allowable values.
3/03/04	Added 00000000 to Allowable values.
7/2008	Modified Allowable values for osteopaths to allow alphanumeric character in third or fourth position.
2010	Data Changes: CCR name (Phys_Ref) changed to be consistent with NAACCR naming for physicians.

Place of Death

IDENTIFIERS

CCR ID	NAACCR ID
E1537	1940

DESCRIPTION

This data item has been retired and replaced by data items Place of Death--State [1942] and Place of Death--Country [1944]. This page has been retained for historical purposes only and this data item should not be populated in any cases diagnosed 2013 or later or coded under the NAACCR v13 or later coding standards. State or country where the patient died.

LEVELS

Patients, Admissions

LENGTH

3

ALLOWABLE VALUES

000-996, and 998, 999 = State or country of death (see Appendix D of Volume I)
997 = Patient is not dead

SOURCE

If 997 and AD_Vital_Status = 0, then enter 999
If the value includes a non-numeric character and Vital_Status = 0, then convert 999
If the value is blank or non-numeric and Vital_Status = 1, then convert 997
Otherwise, just load the transmitted value (if value is non-blank, then right-justify and zero-fill too).

UPDATE

Patient Level

New Case Consolidation

If updated PA-Vital_Status = 0, and PA_Place_Of_Death = 999 or 997 and AD_Place_Of_Death <> (999 or 997),

move AD_Place_Of_Death to PA_Place_Of_Death,

or

PA_Place_Of_Death = 997 and AD_Place_Of_Death = 999 or 997,

enter 999 in PA_Place_Of_Death.

Manual Change

Admission Level

Manual Change Only

CONSOLIDATED DATA EXTRACT

Yes

LIST FOR REVIEW

AD_Place_of_Death (000-996, 998,) <> PA_Place_Of_Death (000-996, 998).

HISTORICAL CHANGES

3/26/03	Code for "Not applicable, patient alive" changed from blank to 997 so the CCR is now in alignment with NAACCR. This affected the Allowable values, Update logic, Interfield Edits 1) and 2) and List for Review.

3/3/04	Updated Source text to convert blank, Vital_Status=1 cases to 997.
2013 Data Changes	This data item has been retired and replaced by Place of Death--State[1942] and Place of Death--Country[1944]

Place of Death--Country

IDENTIFIERS

CCR ID	NAACCR ID
E1774	1944

OWNER

NAACCR

DESCRIPTION

Code for the country in which the patient died and where certificate of death is filed. If the patient has multiple tumors, all records should contain the same code. This data item became part of the NAACCR transmission record effective with Volume II, Version 13 in order to include country and state for each geographic item and to use interoperable codes. It supplements the item Place of Death--State [NAACCR #1942]. It replaces the use of Place of Death [NAACCR #1940].

LEVELS

Patients, Admissions

LENGTH

3

ALLOWABLE VALUES

See Volume I, Appendix D.1 or Appendix D.2
Leave blank if patient is not dead

SOURCE

1. Left-justify and upshift (but don't record these changes in the audit log).
2. If Vital Status is 1, and Place of Death--Country is not blank, then set to blank.
3. If Vital Status is 0, then proceed with following conversions:
    a. If Coding Procedure is 30 or 31, then

If Place of Death--Country =	Then convert Place of Death--Country to
XCZ	CSK
XYG	YUG
BND	BRN
SWK	SVK
VLT	VUT

If Coding_Proc is less than 30 and Place of Death--Country is blank, then, then

If Place of Death [1940] is 000-999 and can be found in Appendix 32 Country/Country/State Crosswalk, then

Generate Place of Death--Country using the crosswalk table in Appendix 32 Country/Country/State Crosswalk and Place of Death [1940]

Else

Generate ZZU (unknown)

Else

Load without conversion

UPDATE

Patient Active Follow-up Fields Update Logic

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

05/2013	New data item changes for 2013: • Added IF 1045, 1072 • Added ER 1118
02/2014	Clarified allowable values.
03/2015	Per NAACCR v15, the historic codes XYG, XCZ, BND, SWK, and VLT converted to active ISO codes; updated SOURCE logic to include the conversions upon upload.
04/2017	Revised Source logic to take into account Vital Status to prevent conversions when Vital Status is equal to 1.

Place of Death--State

IDENTIFIERS

CCR ID	NAACCR ID
E1773	1942

OWNER

NAACCR

DESCRIPTION

State or Province where the patient died and where certificate of death is filed. It supplements the item Place of Death--Country [NAACCR #1944]. It replaces the use of Place of Death [NAACCR #1940].

LEVELS

Patients, Admissions

LENGTH

2

ALLOWABLE VALUES

AK-WY	US States/Territories
AA-AP	United States Military Personnel Serving Abroad
AB-YT	Canadian Provinces/Territories
MM-YN	Historical Custom Codes (States/Provinces)
CD	Canada, NOS
US	Resident of United States, NOS
XX	Not U.S., U.S. Territory, not Canada, and country is known
YY	Not U.S., U.S. Territory, North American Islands, not Canada, and country is unknown
ZZ	Residence is unknown
Blank	Patient is alive

See Volume I, Appendix B for all Postal Abbreviations for states/territories.

SOURCE

1. Left-justify and upshift (but don't record these changes in the audit log).
2. If Vital Status is 1, and Place of Death--State is not blank, then set to blank
3. Vital Status is 0, then proceed with following conversion:
    a. If Coding_Proc is less than 30 and Place of Death--State is blank, then
        If Place of Death [1940] is 000-999 and can be found in Appendix 32 Country/Country/State Crosswalk, then
            Generate Place of Death--State using the crosswalk table in Appendix 32 Country/Country/State Crosswalk and Place of Death [250]
        Else
            Generate ZZU (unknown)
        Else
        Load without conversion

UPDATE

Patient Active Follow-up Fields Update Logic

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

05/2003	New data item for 2013 Added IF 1046, 1073 Added ER 1119
02/2014	Clarified description and allowable values.
07/2014	Clarified allowable values and corrected Volume I reference from Appendix D to Appendix B.
2015	Revised Admission level UPDATE logic for Correction Records: • Correction Record value equals Admission value, then do not apply • Correction Record value equals ZZ and Admission Value does not equal ZZ, then do not apply

Pleural Effusion

IDENTIFIER

CCR ID	NAACCR ID
E2025	3913

OWNER

NAACCR

DESCRIPTION

Pleural effusion is the accumulation of fluid between the parietal pleura (the pleura covering the chest wall and diaphragm) and the visceral pleura (the pleura covering the lungs).

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	Pleural effusion not identified/not present
1	Pleural effusion present, non-malignant (negative)
2	Pleural effusion present, malignant (positive)
3	Pleural effusion, atypical/atypical mesothelial cells
4	Pleural effusion, NOS
8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code 8 will result in an edit error.)
9	Not documented in medical record Pleural Effusion not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00370
        - Type of Reporting Source is not 7
        - Pleural Effusion is blank or 8

        Then convert Pleural Effusion to 9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00370

            OR
            - Type of Reporting Source is 7
        - Pleural Effusion is not blank

        Then convert Pleural Effusion to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00370
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00370

One of the following conditions is true

- Admission's value is not blank, 9
- Tumor's value is blank, 9

OR

- Admission's value is 9
- Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Primary Payer at DX

IDENTIFIERS

CCR ID	NAACCR ID
E1095	630

DESCRIPTION

Primary payer/insurance carrier at the time of initial diagnosis and/or treatment at the reporting facility.

LEVELS

Admissions

LENGTH

2

ALLOWABLE VALUES

01	Not insured
02	Not insured, self-pay
10	Insurance NOS
20	Private Insurance: Managed Care, HMO, or PPO
21	Private Insurance: Fee-for-Service
28	HMO
29	PPO
31	Medicaid
35	Medicaid - Administered through a Managed Care plan
60	Medicare/Medicare, NOS
61	Medicare with supplement, NOS
62	Medicare - Administered through a Managed Care plan
63	Medicare with private supplement
64	Medicare with Medicaid eligibility
65	TRICARE
66	Military
67	Veterans Affairs
68	Indian/Public Health Service
89	County funded, NOS
99	Unknown
Blank	Blank allowed when Date of diagnosis < 1996

SOURCE

If the new case record version is B or later, then simply load from Primary Payer at DX.
If the new case record version is prior to A (8 or 9), then convert as described in Use Case 2003 --- Perform 2003 Data Conversions.
If the new case record version is A or earlier, then convert as described in Use Case 2006 – Perform 2006 Data Conversions. You can view a copy of the table in Pay_Source_1, Historical Changes.

UPDATE

Manual or Automatic Correction (See Appendix 26)

CONSOLIDATED DATA EXTRACT

Yes, from the hospital performing the most extensive cancer-directed surgery.
If no cancer-directed surgery was performed,
Then consider Class of Case using the following hierarchy: 1, 2, 0, 3, or higher.

HISTORICAL CHANGES

03/26/03	C/N # changed from F00160 to F03534. Allowable values changed in Coding Procedure 21. Source conversion chart added. Codes now match CoC codes except for code 50 (County funded, NOS) which changed to code 60. Convert all cases. Refer to, NAACCR 2003 Implementation Work Group: Guidelines and Recommendations (NAACCR website: http//www.naaccr.org). See a version of V3 from before 3/03 to view older codes.
03/03/04	CCR added codes 28 & 29 to Allowable Values (these will be converted to 20 on extraction). Removed conversion instructions from SOURCE for Version 9 records. See Use Case 22.
01/19/05	Added Blank to Allowable Values definitions.
07/27/05	Added codes 62 and 63 to Allowable Values for 2006 data changes. New CCR code for County Funded is now 89. Other codes were renumbered; thus a conversion will be required for the following codes listed in Table Old Codes (Below)
02/01/06	Removed code 36 & added code 21 to Allowable Values for 2006 data changes. Added Source information for conversion logic.
2010	Data Changes: CCR name (Pay Source 1) changed to NAACCR name.
12/07/11	To match 2010 date strategy and the current inter-field edit, changed Allowable Value = Blank as follows: If Date of Diagnosis <1996 or > 9999 to If Date of Diagnosis < 1996 (eliminated the > 9999 requirement to match the edit.
03/2015	Corrected code descriptions to match NAACCR. Codes 28, 29, and 89 are CA specific.
05/2016	Per NAACCR v16, updated description to match NAACCR, including replacement of the term "hospital" with "facility" to accommodate EHR reporting.

TABLE: OLD CODES

Pre-2006 Code	2006 Code
36 Medicaid with Medicare supplement	64 Medicare with Medicaid eligibility
50 Medicare	60 Medicare/Medicare, NOS
51 Medicare with supplement	61 Medicare with supplement, NOS
52 Medicare with Medicaid supplement	64 Medicare with Medicaid eligibility
53 Tricare	65 Tricare
54 Military	66 Military
55 Veterans Affairs	67 Veterans Affairs
56 Indian/Public Health Services	68 Indian/Public Health Services
60 County Funded, NOS	89 County Funded, NOS

Primary Sclerosing Cholangitis

IDENTIFIERS

CCR ID	NAACCR ID
E2029	3917

OWNER

NAACCR

DESCRIPTION

Primary sclerosing cholangitis denotes a chronic autoimmune inflammation of the bile ducts that leads to scar formation and narrowing of the ducts over time. It is a prognostic factor for intrahepatic bile duct cancer.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	PSC not identified/not present
1	PSC present
8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code 8 may result in an edit error.)
9	Not documented in medical record PSC not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00230 or 00250
        - Type of Reporting Source is not 7
        - COC Accredited Flag is 1
        - Primary Sclerosing Cholangitis is blank or 8

        Then convert Primary Sclerosing Cholangitis to 9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00230, 00250

            OR
            - Type of Reporting Source is 7
        - Primary Sclerosing Cholangitis is not blank

        Then convert Primary Sclerosing Cholangitis to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00230, 00250
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00230, 00250

One of the following conditions is true

- Admission's value is not blank, 8, or 9
- Tumor's value is blank , 8, or 9

OR

- Admission's value is 9
- Tumor's value is blank or 8

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Primary Site

IDENTIFIERS

CCR ID	NAACCR ID
E1055	400

DESCRIPTION

Location where this tumor originated in as much detail as is known and for which a code is provided in ICD-O-3.

LEVELS

Tumor, Admission

LENGTH

4

ALLOWABLE VALUES

C000-C809 (Entire range is not used; see ICD-O, Third Edition, 2000)

SOURCE

Upshift.
Also See CS Version Derived.

UPDATE

Manual

CONSOLIDATED DATA EXTRACT

Yes.

HISTORICAL CHANGES

1/1/1999	Changed SITE/HIST-TYPE/OVERRIDE-FLAG edit 378 to require 1 in OVERRIDE-FLAG 1 for SITE = C770-C779 and HIST-TYPE = 9715 and for SITE = C079, C422 or C446 and HIST-TYPE = 9710; changed EOD-related interfield edits to be conditional on DATE-DX;\added interfield edits for new override flags 15 - 17.
5/15/2001	Modified edits IF #388 and IF #363 that pertain to Region 1/8 only.
7/6/2001	Many changes to the edit specs that include histology and summary stage to insure that the proper fields are checked for the proper dx year (if applicable).
11/14/2002	Removed Region 1/8 specific edit IF #388 and rewrote IF #363 to take out Region 1/8 specific logic. SUM-STAGE check was redundant for setting override flag. Also, SUM-STAGE is not a required CCR item.
3/26/2003	Changed IR #804 to reflect the Over-ride flag name change of OR-QUEST-MULT to OR_Site_Lat_SeqNo. Added Appendix reference notes to Interfield edits 9), 10), 11) and 12).
10/8/2003	Sites C000-009, C199, C209, C210-218 with histology 8090-8096 were removed from IF #328 and #445 as 'impossible' combinations to match the SEER edit update.
3/3/2004	Added IF # 532 to not allow a left laterality (code 2) with a middle lobe lung primary. Added IF 2 e) to cover 2004 brain laterality requirements. Updated IF 8 a) to only edit cases diagnosed from 1994-2003. Removed site code 490-499 from IF 6a) c & f and 6b) c & f to reflect site/histology combinations no longer considered impossible per SEER.
6/11/2004	Removed IF #532 because redundant with IF #326.

1/19/2005	Added date check to IF 432.
7/13/2005	Added 9140 histology exclusion to Err# 657 to match SEER IF130. Update to Err#445 as C38.1-C38.8 and 8246 are no longer an impossible site/histology combination.
2/1/2006	Added logic to Err#326 to only allow 0 for non-paired sites for cases diagnosed 2004 forward. This now matches the Volume One standard and the NAACCR edit.
12/8/2006	Added IF #776 and 777 to match SEER IF 176 & 177.
Feb 2009	Added IF #829.
2010	Data Changes: CCR name (Site) changed to NAACCR name. Added IF#312, 313, 361, 473, 475, 476, 477, 485, 534, 641, 642, 738, 749, 750, 767, 771, 778, 779, 781, 784, 785, 786, 789, 790, 793, 794, 797, 823, 824, 826, 827, 843, 846, 848, 849, 874, 876, 878, 880, 882, 884, 887, 907, 914, 915, 916, 917, 952, 958, 959, 960, 961, 962, 963, 964, 967, 968, 977, 978, 983, 984, 985, 986, 987, 988.
2011	Data Changes: Added IF #380, 381, 414, 415, 416
05/2013	Added IF 1005, 1006, 1007, 1008, 1009, 1010, 1011, 1012, 1013, 1014, 1015, 1016, 1017, 1018, 1019, 1020, 1021, 1022, 1023, 1024, 1025, 1026, 1027, 1028, 1029, 1030, 1031, 1032, 1033, 1034, 1035, 1036, 1037, 1038, 1039, 1040, 1041, 1042
02/2020	Added back to Volume III

Profound Immune Suppression

IDENTIFIERS

CCR ID	NAACCR ID
E2030	3918

OWNER

NAACCR

DESCRIPTION

Profound Immune Suppression, suppressed immune status that may be associated with HIV/AIDs, solid organ transplant, chronic lymphocytic leukemia, non-Hodgkin lymphoma, multiple conditions or other conditions, increases the risk of developing Merkel Cell Carcinoma and is an adverse prognostic factor.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	No immune suppression condition(s) identified/not present
1	Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Syndrome (AIDS)
2	Solid organ transplant recipient
3	Chronic lymphocytic leukemia
4	Non-Hodgkin lymphoma
5	Multiple immune suppression conditions
6	Profound immune suppression present
8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code 8 may result in an edit error.)
9	Not documented in medical record Profound immune suppression not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00460
        - Type of Reporting Source is not 7
        - Profound Immune Suppression is blank or 8

        Then convert Profound Immune Suppression to 9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00460

            OR
            - Type of Reporting Source is 7

- Profound Immune Suppression is not blank
  Then convert Profound Immune Suppression to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00460
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00460

One of the following conditions is true

- Admission's value is not blank, 9
- Tumor's value is blank, 9

  OR

  - Admission's value is 9
  - Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.
Otherwise,
If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Progesterone Receptor Percent Positive or Range

IDENTIFIERS

CCR ID	NAACCR ID
E2026	3914

OWNER

NAACCR

DESCRIPTION

Progesterone Receptor, Percent Positive or Range is the percent of cells staining progesterone receptor positive measured by IHC.

LEVELS

Admissions, Tumors

LENGTH

3

ALLOWABLE VALUES

000	PR negative, or stated as less than 1%
001-100	1-100 percent
R10	Stated as 1-10%
R20	Stated as 11-20%
R30	Stated as 21-30%
R40	Stated as 31-40%
R50	Stated as 41-50%
R60	Stated as 51-60%
R70	Stated as 61-70%
R80	Stated as 71-80%
R90	Stated as 81-90%
R99	Stated as 91-100%
XX6	PR results cannot be determined (indeterminate)
XX7	Test done, results not in chart
XX8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code XX8 will result in an edit error.)
XX9	Not documented in medical record PR (Progesterone Receptor) Percent Positive or Range not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00480
        - Type of Reporting Source is not 7
        - COC Accredited Flag is 1

- Progesterone Receptor Percent Positive or Range is XX8 or blank
  Then convert Progesterone Receptor Percent Positive or Range to XX9

B. If all of the following conditions are true:
   - One of the following is true:
     - Schema ID is not 00480
       OR
     - Type of Reporting Source is 7
   - Progesterone Receptor Percent Positive or Range is not blank
     Then convert Progesterone Receptor Percent Positive or Range to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00480
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00480

One of the following conditions is true

- Admission's value is not blank, XX8, or XX9
- Tumor's value is blank, XX8, or XX9
  OR
  - Admission's value is XX9
  - Tumor's value is blank or XX8

Then automatically update the Tumor's value with the Admission's value.
Otherwise,
If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.
05/2020	Two more values (XX6 and XX7) added to allowable values table.

Progesterone Receptor Total Allred Score

IDENTIFIERS

CCR ID	NAACCR ID
E2028	3916

OWNER

NAACCR

DESCRIPTION

Progesterone Receptor, Total Allred Score is based on the percentage of cells that stain by IHC for progesterone receptor (PR) and the intensity of that staining.

LEVELS

Admissions, Tumors

LENGTH

2

ALLOWABLE VALUES

00	Total PR Allred score of 0
01	Total PR Allred score of 1
02	Total PR Allred score of 2
03	Total PR Allred score of 3
04	Total PR Allred score of 4
05	Total PR Allred score of 5
06	Total PR Allred score of 6
07	Total PR Allred score of 7
08	Total PR Allred score of 8
X8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code X8 will result in an edit error.)
X9	Not documented in medical record PR (Progesterone Receptor) Total Allred Score not assessed, or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00480
        - Type of Reporting Source is not 7
        - COC Accredited Flag is 1
        - Progesterone Receptor Total Allred Score is X8 or blank

        Then convert Progesterone Receptor Percent Positive or Range to X9

    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00480

OR

- Type of Reporting Source is 7

- Progesterone Receptor Total Allred Score is not blank

Then convert Progesterone Receptor Total Allred Score to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00480
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00480

One of the following conditions is true

- Admission's value is not blank, X8, or X9
- Tumor's value is blank, X8, or X9

OR

- Admission's value is X9
- Tumor's value is blank or X8

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Progesterone Receptor Summary

IDENTIFIERS

CCR ID	NAACCR ID
E2027	3915

OWNER

NAACCR

DESCRIPTION

PR (Progesterone Receptor) Summary is a summary of results from the progesterone receptor (PR) assay.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	PR negative
1	PR positive
7	Test ordered, results not in chart
9	Not documented in medical record Cannot be determined (indeterminate) PR (Progesterone Receptor) Summary status not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
   A. If all of the following conditions are true:
      - Schema ID is 00480
      - Type of Reporting Source is not 7
      - Progesterone Receptor Summary is blank

      Then convert Progesterone Receptor Summary to 9
   B. If all of the following conditions are true:
      - One of the following is true:
        - Schema ID is not 00480

          OR
        - Type of Reporting Source is 7
      - Progesterone Receptor Summary is not blank

      Then convert Progesterone Receptor Summary to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998

- Admission's Schema ID is 00480
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00480

One of the following conditions is true

- Admission's value is not blank or 9
- Tumor's value is blank or 9

OR

- Admission's value is 9
- Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.
Otherwise,
If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Prostate Pathological Extension

IDENTIFIERS

CCR ID	NAACCR ID
E2031	3919

OWNER

NAACCR

DESCRIPTION

Pathological extension is used to assign pT category for prostate cancer based on radical prostatectomy specimens.

LEVELS

Admissions, Tumors

LENGTH

3

ALLOWABLE VALUES

See the most current version of EOD (Prostate) (https://staging.seer.cancer.gov/) for rules and site-specific codes and coding structures.

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
   A. If all of the following conditions are true:
      - Schema ID is 00580
      - Type of Reporting Source is not 7
      - Prostate Pathological Extension is blank

      Then convert Prostate Pathological Extension to 999
   B. If all of the following conditions are true:
      - One of the following is true:
        - Schema ID is not 00580

          OR
        - Type of Reporting Source is 7
      - Prostate Pathological Extension is not blank

      Then convert Prostate Pathological Extension to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00580
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00580

One of the following conditions is true

- Admission's value is not blank, 999

- Tumor's value is blank, 999

OR

- Admission's value is 999
- Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.
Otherwise,
If Admission's value is not the same as the Tumor's value
Then list for review
Manual Update
Admission
Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Protocol Participation

IDENTIFIERS

CCR ID	NAACCR ID
E1634	1480

DESCRIPTION

Code indicating agency or group that established the protocol in which the patient is participating.

LEVELS

Admissions

LENGTH

2

ALLOWABLE VALUES

00	Not Applicable
	National Protocols
01	NSABP
02	GOG
03	RTOG
04	SWOG
05	ECOG
06	POG
07	CCG
08	CALGB
09	NCI
10	ACS
11	National Protocol, NOS

12	ACOS-OG
13	VA (Veterans Administration)
14	COG (Children's Oncology Group)
15	CTSU (Clinical Trials Support Unit)
16-50	National Trials
51-79	Locally Defined
80	Pharmaceutical
81-84	Locally Defined
85	In-House Trial
86-88	Locally Defined
89	Other
90-98	Locally Defined
99	Unknown

SOURCE

If transmitted value is blank, convert it to 00; otherwise, right-justify, zero-fill, and load new value.

UPDATE

Manual or Automatic Correction (See Appendix 26)

CONSOLIDATED DATA EXTRACT

Yes, take from earliest admission.

HISTORICAL CHANGES

5/15/01	New field added to capture protocol information.
11/14/02	Added logic to "Transmit to CCR".
3/26/03	Added codes 13, 14 and 15 to allowable values. Range for National Trials changed from 13-50 to 16-50.

Race 1

IDENTIFIERS

CCR ID	NAACCR ID
E1021	160

OWNER

SEER/CoC

DESCRIPTION

Race/ethnicity of the patient.

LEVELS

Patients, Admissions

LENGTH

2

ALLOWABLE VALUES

01	White
02	Black
03	American Indian, Aleutian, or Eskimo
04	Chinese
05	Japanese
06	Filipino
07	Hawaiian
08	Korean
09*	(Asian Indian, Pakistani) was retired effective with NAACCR Version 12. See codes 15-17.
10	Vietnamese
11	Laotian
12	Hmong
13	Kampuchean (Cambodian)
14	Thai
15	Asian Indian or Pakistani, NOS (code 09 prior to Version 12)
16	Asian Indian
17	Pakistani

20	Micronesian, NOS
21	Chamorro/Chamoru
22	Guamanian, NOS
25	Polynesian, NOS
26	Tahitian
27	Samoan
28	Tongan
30	Melanesian, NOS
31	Fiji Islander
32	New Guinean
90	Other South Asian, Bangladeshi, Bhutanese, Nepalese, Sikkimese, Sri Lankan
96	Other Asian, including Burmese, Indonesian, Asian, NOS, and Oriental, NOS
97	Pacific Islander, NOS
98	Other
99	Unknown

SOURCE

Race Fields Source Logic

UPDATE

Race Fields Update Logic

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

03/26/03	Added Interfield edit 2) to match the Volume One standard (code 99 is to be used for coding the second through fifth race field if the first race field is unknown).

03/03/04	Added Aleutian & Eskimo to label code 03 to make it consistent with Volume One. Changed Update logic in 5a) to list for review. Codes for 09 labels: Bangladeshi, Bhutanese, Nepalese, Sikkimese and Sri Lankan changed to 90. Database will be converted based on birthplace for cases diagnosed prior Jan 1, 2004. See Jan 1, 2004 Conversion Table below.
01/19/05	Added IF 3) and 4) (Err #729 & 730) to edit race data. Added 8 to IF #655 for 2005 data change. Rewrote Update logic for 5) and added 6) and added logic to update race codes to 88. Added Update logic for NHIA_Derived_Hisp_Origin regeneration.
04/27/05	Removed Update logic 4c) and rewrote 4b)
12/26/07	Added Update logic that updates Race2_5 codes to 99 if Race_1 value changes to 99.
2010	Data Changes: Added codes 15 (Asian Indian or Pakistani, NOS), 16 (Asian Indian), and 17 (Pakistani) to Allowable values and removed code 09 (Asian Indian, Pakistani). Changed Update logic in 4) to 08-17. All "09" values need to be converted to 15-17. Manual review will need to be done prior to any automatic conversion to select cases that can be recoded to 16 and 17. Then, the remaining code 09 cases can be converted to 15.
04/2014	Revisions to Source and Update Logic.

Jan 1, 2004 Conversion Table

If Race code =	And Birthplace =	Then Race =
09	643	90
09	645	90
09	647	90

Race 2

IDENTIFIERS

CCR ID	NAACCR ID
E1022	161

OWNER

SEER/CoC

DESCRIPTION

Race/ethnicity of the patient.

LEVELS

Patients, Admissions

LENGTH

2

ALLOWABLE VALUES

01	White
02	Black
03	American Indian, Aleutian, or Eskimo
04	Chinese
05	Japanese
06	Filipino
07	Hawaiian
08	Korean
09*	(Asian Indian, Pakistani) was retired effective with NAACCR Version 12. See codes 15-17.
10	Vietnamese
11	Laotian
12	Hmong
13	Kampuchean (Cambodian)
14	Thai
15	Asian Indian or Pakistani, NOS (code 09 prior to Version 12)
16	Asian Indian
17	Pakistani

20	Micronesian, NOS
21	Chamorro/Chamoru
22	Guamanian, NOS
25	Polynesian, NOS
26	Tahitian
27	Samoan
28	Tongan
30	Melanesian, NOS
31	Fiji Islander
32	New Guinean
88	No further race documented
90	Other South Asian, Bangladeshi, Bhutanese, Nepalese, Sikkimese, Sri Lankan
96	Other Asian, including Burmese, Indonesian, Asian, NOS, and Oriental, NOS
97	Pacific Islander, NOS
98	Other
99	Unknown

SOURCE

Race Fields Source Logic

UPDATE

Race Fields Update Logic

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

03/15/00	New data item added due to Year 2000 census. Cases diagnosed prior to 1/1/2000 will be coded to 88.
03/26/03	Added to Update 5a) so update to 88 when race code updated. Added Interfield edit reference.
03/03/04	Added Aleutian & Eskimo to label code 03 to make it consistent with Volume One. Changed Update logic in 5a) to list for review. Codes for 09 labels: Bangladeshi, Bhutanese, Nepalese, Sikkimese and Sri Lankan changed to 90. Database will be converted based on birthplace for cases diagnosed prior Jan 1, 2004. See Jan 1, 2004 Conversion Table below.
01/19/05	Added IF 3) and 4) (Err #729 & 730) to edit race data. Added 8 to IF #655 for 2005 data change. Rewrote Update logic for 5) and added 6) and added logic to update race codes to 88. Added Update logic for NHIA_Derived_Hisp_Origin regeneration.
2010	Data Changes: Added codes 15 (Asian Indian or Pakistani, NOS), 16 (Asian Indian), and 17 (Pakistani) to Allowable values and removed code 09 (Asian Indian, Pakistani). Changed Update logic in 4) to 08-17. All "09" values need to be converted to 15-17. Manual review will need to be done prior to any automatic conversion to select cases that can be recoded to 16 and 17. Then, the remaining code 09 cases can be converted to 15.
04/2014	Revisions to Source and Update Logic.

Jan 1, 2004 Conversion Table

If Race code =	And Birthplace =	Then Race =
09	643	90
09	645	90
09	647	90

Race 3

IDENTIFIERS

CCR ID	NAACCR ID
E1023	162

OWNER

SEER/CoC

DESCRIPTION

Race/ethnicity of the patient.

LEVELS

Patients, Admissions

LENGTH

2

ALLOWABLE VALUES

01	White
02	Black
03	American Indian, Aleutian, or Eskimo
04	Chinese
05	Japanese
06	Filipino
07	Hawaiian
08	Korean
09*	(Asian Indian, Pakistani) was retired effective with NAACCR Version 12. See codes 15-17.
10	Vietnamese
11	Laotian
12	Hmong
13	Kampuchean (Cambodian)
14	Thai
15	Asian Indian or Pakistani, NOS (code 09 prior to Version 12)
16	Asian Indian
17	Pakistani

20	Micronesian, NOS
21	Chamorro/Chamoru
22	Guamanian, NOS
25	Polynesian, NOS
26	Tahitian
27	Samoan
28	Tongan
30	Melanesian, NOS
31	Fiji Islander
32	New Guinean
88	No further race documented
90	Other South Asian, Bangladeshi, Bhutanese, Nepalese, Sikkimese, Sri Lankan
96	Other Asian, including Burmese, Indonesian, Asian, NOS, and Oriental, NOS
97	Pacific Islander, NOS
98	Other
99	Unknown

SOURCE

Race Fields Source Logic

UPDATE

Race Fields Update Logic

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

03/15/00	New data item added due to Year 2000 census. Cases diagnosed prior to 1/1/2000 will be coded to 88.
03/26/03	Added to Update 5a) so update to 88 when race code updated. Added Interfield edit reference.
03/03/04	Added Aleutian & Eskimo to label code 03 to make it consistent with Volume One. Changed Update logic in 5a) to list for review. Codes for 09 labels: Bangladeshi, Bhutanese, Nepalese, Sikkimese and Sri Lankan changed to 90. Database will be converted based on birthplace for cases diagnosed prior Jan 1, 2004. See Jan 1, 2004 Conversion Table below.
01/19/05	Added IF 3) and 4) (Err #729 & 730) to edit race data. Added 8 to IF #655 for 2005 data change. Rewrote Update logic for 5) and added 6) and added logic to update race codes to 88. Added Update logic for NHIA_Derived_Hisp_Origin regeneration.
2010	Data Changes: Added codes 15 (Asian Indian or Pakistani, NOS), 16 (Asian Indian), and 17 (Pakistani) to Allowable values and removed code 09 (Asian Indian, Pakistani). Changed Update logic in 4) to 08-17. All "09" values need to be converted to 15-17. Manual review will need to be done prior to any automatic conversion to select cases that can be recoded to 16 and 17. Then, the remaining code 09 cases can be converted to 15.
04/2014	Revisions to Source and Update Logic.

Jan 1, 2004 Conversion Table

If Race code =	And Birthplace =	Then Race =
09	643	90
09	645	90
09	647	90

Race 4

IDENTIFIERS

CCR ID	NAACCR ID
E1024	163

OWNER

SEER/CoC

DESCRIPTION

Race/ethnicity of the patient.

LEVELS

Patients, Admissions

LENGTH

2

ALLOWABLE VALUES

01	White
02	Black
03	American Indian, Aleutian, or Eskimo
04	Chinese
05	Japanese
06	Filipino
07	Hawaiian
08	Korean
09*	(Asian Indian, Pakistani) was retired effective with NAACCR Version 12. See codes 15-17.
10	Vietnamese
11	Laotian
12	Hmong
13	Kampuchean (Cambodian)
14	Thai
15	Asian Indian or Pakistani, NOS (code 09 prior to Version 12)
16	Asian Indian
17	Pakistani
20	Micronesian, NOS
21	Chamorro/Chamoru
22	Guamanian, NOS
25	Polynesian, NOS
26	Tahitian
27	Samoan
28	Tongan
30	Melanesian, NOS
31	Fiji Islander
32	New Guinean
88	No further race documented
90	Other South Asian, Bangladeshi, Bhutanese, Nepalese, Sikkimese, Sri Lankan
96	Other Asian, including Burmese, Indonesian, Asian, NOS, and Oriental, NOS
97	Pacific Islander, NOS
98	Other
99	Unknown

SOURCE

Race Fields Source Logic

UPDATE

Race Fields Update Logic

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

03/15/00	New data item added due to Year 2000 census. Cases diagnosed prior to 1/1/2000 will be coded to 88.
03/26/03	Added to Update 5a) so update to 88 when race code updated. Added Interfield edit reference.
03/03/04	Added Aleutian & Eskimo to label code 03 to make it consistent with Volume One. Changed Update logic in 5a) to list for review. Codes for 09 labels: Bangladeshi, Bhutanese, Nepalese, Sikkimese and Sri Lankan changed to 90. Database will be converted based on birthplace for cases diagnosed prior Jan 1, 2004. See Jan 1, 2004 Conversion Table below.
01/19/05	Added IF 3) and 4) (Err #729 & 730) to edit race data. Added 8 to IF #655 for 2005 data change. Rewrote Update logic for 5) and added 6) and added logic to update race codes to 88. Added Update logic for NHIA_Derived_Hisp_Origin regeneration.
2010	Data Changes: Added codes 15 (Asian Indian or Pakistani, NOS), 16 (Asian Indian), and 17 (Pakistani) to Allowable values and removed code 09 (Asian Indian, Pakistani). Changed Update logic in 4) to 08-17. All "09" values need to be converted to 15-17. Manual review will need to be done prior to any automatic conversion to select cases that can be recoded to 16 and 17. Then, the remaining code 09 cases can be converted to 15.
04/2014	Revisions to Source and Update Logic.

Jan 1, 2004 Conversion Table

If Race code =	And Birthplace =	Then Race =
09	643	90
09	645	90
09	647	90

Race 5

IDENTIFIERS

CCR ID	NAACCR ID
E1025	164

OWNER

SEER/CoC

DESCRIPTION

Race/ethnicity of the patient.

LEVELS

Patients, Admissions

LENGTH

2

ALLOWABLE VALUES

01	White
02	Black
03	American Indian, Aleutian, or Eskimo
04	Chinese
05	Japanese
06	Filipino
07	Hawaiian
08	Korean
09*	(Asian Indian, Pakistani) was retired effective with NAACCR Version 12. See codes 15-17.
10	Vietnamese
11	Laotian
12	Hmong
13	Kampuchean (Cambodian)
14	Thai
15	Asian Indian or Pakistani, NOS (code 09 prior to Version 12)
16	Asian Indian
17	Pakistani

20	Micronesian, NOS
21	Chamorro/Chamoru
22	Guamanian, NOS
25	Polynesian, NOS
26	Tahitian
27	Samoan
28	Tongan
30	Melanesian, NOS
31	Fiji Islander
32	New Guinean
88	No further race documented
90	Other South Asian, Bangladeshi, Bhutanese, Nepalese, Sikkimese, Sri Lankan
96	Other Asian, including Burmese, Indonesian, Asian, NOS, and Oriental, NOS
97	Pacific Islander, NOS
98	Other
99	Unknown

SOURCE

Race Fields Source Logic

UPDATE

Race Fields Update Logic

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

03/15/00	New data item added due to Year 2000 census. Cases diagnosed prior to 1/1/2000 will be coded to 88.
03/26/03	Added to Update 5a) so update to 88 when race code updated. Added Interfield edit reference.
03/03/04	Added Aleutian & Eskimo to label code 03 to make it consistent with Volume One. Changed Update logic in 5a) to list for review. Codes for 09 labels: Bangladeshi, Bhutanese, Nepalese, Sikkimese and Sri Lankan changed to 90. Database will be converted based on birthplace for cases diagnosed prior Jan 1, 2004. See Jan 1, 2004 Conversion Table below.
01/19/05	Added IF 3) and 4) (Err #729 & 730) to edit race data. Added 8 to IF #655 for 2005 data change. Rewrote Update logic for 5) and added 6) and added logic to update race codes to 88. Added Update logic for NHIA_Derived_Hisp_Origin regeneration.
2010	Data Changes: Added codes 15 (Asian Indian or Pakistani, NOS), 16 (Asian Indian), and 17 (Pakistani) to Allowable values and removed code 09 (Asian Indian, Pakistani). Changed Update logic in 4) to 08-17. All "09" values need to be converted to 15-17. Manual review will need to be done prior to any automatic conversion to select cases that can be recoded to 16 and 17. Then, the remaining code 09 cases can be converted to 15.
04/2014	Revisions to Source and Update Logic.

Jan 1, 2004 Conversion Table

If Race code =	And Birthplace =	Then Race =
09	643	90
09	645	90
09	647	90

Race Coding Sys--Current

CCR ID	NAACCR ID
E1026	170

DESCRIPTION

Code describes how race currently is coded. If the data have been converted, this field shows the system to which it has been converted.

LEVELS

Patients

LENGTH

1

ALLOWABLE VALUES

1	4-value coding: 1 = White, 2 = Black, 3 = Other, 9 = Unknown
2	SEER < 1988 (1-digit)
3	1988-1990 SEER & CoC (2-digit)
4	1991-1993 SEER & CoC (added codes 20-97, additional Asian and Pacific Islander codes)
5	1994-1999 SEER & CoC (added code 14, Thai)
6	2000+ SEER & CoC (added code 88 for Race 2, 3, 4, and 5)
7	2010+ SEER & CoC (added codes 15, 16 and 17; removed 09)
9	Other

SOURCE

See Extract.

UPDATE

None

CONSOLIDATED DATA EXTRACT

Generate code 7.

HISTORICAL CHANGES

8/15/06	Generated item in Volume II added to Volume III with 2007 data changes.
2010	Data Changes: Code 7 added to Allowable values.
3/2/11	Corrected the Consolidated Data Extract from "Generate 6.?? changed to 7?" to "Generate code 7".

Race Coding Sys--Original

CCR ID	NAACCR ID
E1027	180

DESCRIPTION

Code that best describes how race originally was coded. If the data have been converted, this field identifies the coding system originally used to code the case.

LEVELS

Patients

LENGTH

1

ALLOWABLE VALUES

1	4-value coding: 1 = White, 2 = Black, 3 = Other, 9 = Unknown
2	SEER < 1988 (1-digit)
3	1988-1990 SEER & CoC (2-digit)
4	1991-1993 SEER & CoC (added codes 20-97, additional Asian and Pacific Islander codes)
5	1994-1999 SEER & CoC (added code 14, Thai)
6	2000+ SEER & CoC (added code 88 for Race 2, 3, 4, and 5)
7	2010+ SEER & CoC (added codes 15, 16 and 17; removed 09)
9	Other

SOURCE

See Extract.

UPDATE

None

CONSOLIDATED DATA EXTRACT

Generate:
If Date of Diagnosis < 1988, then generate 2 (SEER < 1988 (1-digit))
Else
if Date of Diagnosis > 1987 and < 1991, then generate 3 (1988+ SEER & CoC (2-digit))
Else
if Date of Diagnosis > 1990 and < 1994, then generate 4 (1991_SEER & CoC (added codes 20-97, additional Asian and Pacific Islander codes)
Else
if Date of Diagnosis > 1993, then generate 5 (1994+ SEER & CoC (added code 14, Thai)),
Else
if Date of Diagnosis > 1999, then generate 6 (2000+ SEER & CoC)
Else
if Date of Diagnosis > 2009, then generate 7 (2010+ SEER & CoC)

HISTORICAL CHANGES

8/15/06	Generated item in Volume II added to Volume III with 2007 data changes.
2010	Data Changes: Code 7 added to Allowable values.

Race--NAPIIA (Derived API)

IDENTIFIERS

CCR ID	NAACCR ID
E1044	193

DESCRIPTION

NAPIIA stands for NAACCR Asian and Pacific Islander Identification Algorithm. Race--NAPIIA recodes some single-race cases with a Race 1 [160] code of 96 to a more specific Asian race category, based on an algorithm that makes use of the birthplace and name fields (first, last, and maiden names). For single-race cases with Race 1 other than 96, it returns Race 1. Multiple-race cases (those with information in Race 2 through Race 5, [161-164]) are handled variously; refer to the technical documentation for specifics:
In Version 1.1 of the algorithm, birth place can be used to indirectly assign a specific race to one of eight Asian race groups (Chinese, Japanese, Vietnamese, Korean, Asian Indian, Filipino, Thai, and Cambodian), and names can be used to indirectly assign a specific race to one of seven Asian groups (Chinese, Japanese, Vietnamese, Korean, Asian Indian, Filipino, and Hmong). Subsequent versions of NAPIIA may incorporate Pacific Islanders and may potentially incorporate name list for Thai, Cambodian, and Laotians.
The CCR will be generating this value by examining the primary last name, all alias last names, all maiden names, and DC fathers' surnames.

LEVELS

Patients

LENGTH

2

ALLOWABLE VALUES

01	White
02	Black
03	American Indian, Aleutian, or Eskimo (includes all indigenous populations of the Western hemisphere)
04	Chinese
05	Japanese
06	Filipino
07	Hawaiian
08	Korean
*	Code 09 (Asian Indian, Pakistani) was retired effective with NAACCR Version 12. See codes 15-17.
10	Vietnamese
11	Laotian
12	Hmong
13	Kampuchean
14	Thai
15	Asian Indian or Pakistani, NOS (code 09 prior to Version 12)
16	Asian Indian
17	Pakistani
20	Micronesian, NOS

21	Chamorro/Chamoru
22	Guamanian, NOS
25	Polynesian, NOS
26	Tahitian
27	Samoan
28	Tongan
30	Melanesian, NOS
31	Fiji Islander
32	New Guinean
96	Other Asian, including Asian, NOS and Oriental, NOS
97	Pacific Islander, NOS
98	Other
99	Unknown
Blank	Algorithm has not been run
Note: *Codes 20-97 were adopted for use effective with 1991 diagnoses. Code 14 was adopted for use effective with 1994 diagnoses.*	

SOURCE

Generated according to NAPIAA documentation located on the NAACCR website. (Note, the URL for this remote site (remote to CCR) can be changed without notice. To view this document, follow links provided on http://www.naaccr.org. Or, search for NAPIAA using a search engine.

UPDATE

Regenerate if either Last Name, Maiden Name, Birth Place, Race 1-5, Sex, DC Fathers Surname or Alias Last Name changes.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

12/2008	New data item for 2009.
2010	Data Changes: Codes 15 (Asian Indian or Pakistani, NOS), 16 (Asian Indian), and 17 (Pakistani) have been added; code 09 (Asian Indian, Pakistani) was retired effective with Version 12. NAACCR Version 12 changed data item name to Race--NAPIIA (derived API) from Race--NAPIIA.
12/8/11	The NAPIAA link can be and has been changed without warning. It is virtually impossible to maintain links to the websites of other organizations. Therefore, SOURCE section no longer contains the exact URL for NAPIAA, but rather tells the reader how to go about locating NAPIAA documentation.

Race Rcode Calc*

IDENTIFIERS

CCR ID	NAACCR ID
E1765	None

*Calculated in Eureka. Not listed in Appendices A, B, C, or D)

DESCRIPTION

Race and ethnicity grouping of Race 1, Spanish-Hispanic Origin, SPANISH-SURNAME, and Birthplace for statistical reporting using available population_based denominators.

LEVELS

Patients

LENGTH

1

ALLOWABLE VALUES

1	Non-Hispanic White
2	Non-Hispanic Black
3	Hispanic
4	Asian-Pacific Islander
5	Non-Hispanic American Indian
9	Other/Unknown

SOURCE

Computer generate as follows:

If Spanish-Hispanic Origin = 1-6, or 8 and Birthplace is NOT 341 or 445 (Portugal or Brazil) then move 3 into RACE-RECODE-CAL

Else

If (Race 1 = 04 - 97)
OR
(Race 1 = 98 AND Date of Diagnosis year <= 1990 in all tumors))
OR
(Last Name = CAO, DINH, DO, DOAN, DUONG, HUYNH, NGUYEN, VU, VUONG, TRAN, TRINH, TRUONG, HER, KUE, KHANG, HANG, MOUA, THAO, THOR, THOW, VANG, VUE, or XIONG)

Then move 4 into RACE-RECODE-CAL

Else

If Spanish Surname = 5 - 7 and Birthplace is NOT 341 or 445 (Portugal or Brazil), then move 3 into RACE-RECODE-CAL

Else

If Race_1 =	Then RACE-RECODE-CAL =
01	1
02	2
03	5

Else

If none of the above conditions are true, then set RACE-RECODE-CAL to 9.

UPDATE

Regenerate if either Race 1, Birthplace, Name--Last, Name--Maiden, Spanish-Hispanic Origin, Date of Diagnosis year, or SPANISH SURNAME changes.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

1/1/98	Computer generation algorithm changed, so value was recalculated in all patients.
1/1/99	Computer generation algorithm changed, so value was recalculated in all patients.
3/26/03	In the CCR central system (EUREKA), this field is generated when necessary and is not stored in the database. The Allowable values edit (#54) was removed.
1/19/05	Added code 8 to Source algorithm 1).

Rad Boost RX Modality

CCR ID	NAACCR ID
E1357	3200

DESCRIPTION

Identifies the volume or anatomic target of the most clinically significant regional radiation therapy delivered to the patient during the first course of treatment. See also Rad--Regional RX Modality.
This field is no longer required in v18 software and forward per NAACCR. Data will not be deleted out, but no longer running source or consolidation logic.

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

00	None, diagnosed at autopsy
20	External Beam NOS
21	Orthovoltage
22	Cobalt-60, Cesium-137
23	Photons (2-5 MV)
24	Photons (6-10 MV)
25	Photons (11-19 MV)
26	Photons (>19 MV)
27	Photons (mixed energies)
28	Electrons
29	Photons and electrons mixed
30	Neutrons with or without photons/electrons
31	IMRT
32	Conformal or 3-D therapy
40	Protons
41	Stereotactic radiosurgery NOS
42	Linac radiosurgery
43	Gamma Knife
50	Brachytherapy NOS
51	Brachytherapy, Intracavitary, LDR
52	Brachytherapy, Intracavitary, HDR
53	Brachytherapy, Interstitial, LDR
54	Brachytherapy, Interstitial, HDR
55	Radium
60	Radioisotopes NOS
61	Strontium-89
62	Strontium-90
98	Other NOS (Radiation therapy administered, but the treatment modality is not specified or is unknown)

99	Unknown, Death certificate only
Blank	Cases diagnosed prior to 1/01/2003

SOURCE

If the new case record version is A or later and diagnosed between 2003 – 2017, then load and right-justify and zero-fill.

UPDATE

Tumor Level

New Case Consolidation

If both of the following conditions are true:

- the admission and tumor's Rad Boost RX Modality codes are different
- any of the combinations listed in the following table are found:

Admission level value =	Tumor level value =
20- 62	00, 98, 99, blank
21- 40	20
31 or 32	21 - 30
42- 43	41
51- 55	50
61- 62	60
98	00, 99, blank
00	99 or blank
99	blank

Then automatically update the tumor's Rad Boost RX Modality code with the admission's corresponding code.

Otherwise, if both of the following conditions are true:

- the admission and tumor's Rad Boost RX Modality codes are different
- Any combination listed in the following table are found:

Admission level value =	Tumor level value =
20, 41, 50 or 60	20, 41, 50 or 60
21 – 40, 42 – 43, 51 – 55 or 61 – 62	21 – 40, 42 – 43, 51 – 55 or 61 – 62
42 – 43, 51 – 55, 61 – 62	20
21 – 40, 51 – 55, 61 – 62	41
21 – 40, 42 – 43, 61 – 62	50
21 – 40, 42 – 43, 51 – 55	60
41	21 - 40, 51 – 55, 61 – 62
50	21 – 40, 42 – 43, 61 – 62
60	21 – 40, 42 – 43, 51 – 55

Then list for review

Manual Change - May require regeneration of RX Summ--Radiation

Admission Level

Manual Change or Correction Applied - May require regeneration of RX Summ--Radiation

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/26/03:	New data item requirement for cases diagnosed January 1, 2003 and forward. Fill with 00s for cases diagnosed prior to January 1, 2003.
8/27/03:	Removed codes 80 & 85 from Allowable values.
3/03/04:	Added autopsy cases text to code 00 for clarity. Removed conversion instructions from SOURCE for Version 9 records. See Use Case 22.
11/26/07:	Added blank as an Allowable Value on the data item page and added to Update logic.
2/7/11:	Update logic revised.
8/22/11	Revised SOURCE logic. Eliminated C/N #F03454 from the SOURCE logic and replaced it with the data item name as follows: Then load from Rad Boost RX Modality, right-justify, and zero-fill.
01/2019	Per NAACCR v18, this field is no longer required in v18 software and forward per NAACCR. Data will not be deleted out, but no longer running source or consolidation logic.
03/2019	Revised Source Logic: Added: and diagnosed between 2003 - 2017

Rad--Location of RX

IDENTIFIERS

CCR ID	NAACCR ID
E1355	1550

DESCRIPTION

Identifies the location of the facility where radiation treatment was administered during first course of treatment.

LEVELS

Admissions

LENGTH

1

ALLOWABLE VALUES

0	No radiation treatment
1	All radiation treatment at this facility
2	Regional treatment at this facility, boost elsewhere
3	Boost radiation at this facility, regional elsewhere
4	All radiation treatment elsewhere
8	Other, NOS
9	Unknown
Blank	Cases dx prior to 2008.

SOURCE

Upload with no conversion.

UPDATE

Manual update or Correction Applied

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

10/10/07	Added for the 2008 data changes per a request from Business Rules Project to further enhance the automated class of case rules. Currently, the only mechanism for verifying that radiation was given at the reporting hospital is through review of text. If these were coded fields, correctly distinguishing between Class 0, 1, 2 and/or 3 could be accomplished automatically rather than requiring review of text.

Rad--Regional RX Modality

IDENTIFIERS

CCR ID	NAACCR ID
E1356	1570

DESCRIPTION

Records the dominant modality of radiation therapy used to deliver the most clinically significant regional dose to the primary volume of interest during the first course of treatment.
Radiation treatment is frequently delivered in two or more phases which can be summarized as "regional" and "boost" treatments. To evaluate patterns of radiation oncology care, it is necessary to know which radiation resources were employed in the delivery of therapy. For outcomes analysis, the modalities used for each of these phases can be very important.

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

00	None, diagnosed at autopsy
20	External Beam NOS
21	Orthovoltage
22	Cobalt-60, Cesium-137
23	Photons (2-5 MV)
24	Photons (6-10 MV)
25	Photons (11-19 MV)
26	Photons (>19 MV)
27	Photons (mixed energies)
28	Electrons
29	Photons and electrons mixed
30	Neutrons with or without photons/electrons
31	IMRT
32	Conformal or 3-D therapy
40	Protons
41	Stereotactic radiosurgery NOS
42	Linac radiosurgery
43	Gamma Knife
50	Brachytherapy NOS
51	Brachytherapy, Intracavitary, LDR
52	Brachytherapy, Intracavitary, HDR
53	Brachytherapy, Interstitial, LDR
54	Brachytherapy, Interstitial, HDR
55	Radium
60	Radioisotopes NOS
61	Strontium-89

62	Strontium-90
80*	Combination modality, specified*
85*	Combination modality, NOS*
98	Other NOS (Radiation therapy administered, but the treatment modality is not specified or is unknown)
99	Unknown, Death certificate only
Blank	Cases diagnosed prior to 1/01/2003 or after 12/31/2017
*	Codes 80 and 85 describe specific converted descriptions of radiation therapy coded according to Volume II ROADS and DAM rules and should only be used to record regional radiation for tumors diagnosed prior to January 1, 2003.

SOURCE

If the new case record version is A or later and diagnosed between ~~2004~~ 2003 – 2017, then load and right-justify and zero-fill.

UPDATE

Tumor Level

New Case Consolidation

If both of the following conditions are true:

- the admission and tumor's Rad Regional RX Modality codes are different
- any of the combinations listed in the following table are found:

Admission level value =	Tumor level value =
20- 62	00, 98, 99, blank
21- 40	20
31 or 32	21 - 30
42- 43	41
51- 55	50
61- 62	60
98	00, 99, blank
00	99 or blank
99	blank

Then automatically update the tumor's Rad Regional RX Modality code with the admission's corresponding code.

Otherwise, if both of the following conditions are true:

- the admission and tumor's Rad Regional RX Modality codes are different
- Any combination listed in the following table are found:

Admission level value =	Tumor level value =
20, 41, 50 or 60	20, 41, 50 or 60
21 – 40, 42 – 43, 51 – 55 or 61 – 62	21 – 40, 42 – 43, 51 – 55 or 61 –62
42 – 43, 51 – 55, 61 – 62	20
21 – 40, 51 – 55, 61 – 62	41
21 – 40, 42 – 43, 61 – 62	50
21 – 40, 42 – 43, 51 – 55	60
41	21 - 40, 51 – 55, 61 – 62
50	21 – 40, 42 – 43, 61 – 62

60	21 – 40, 42 – 43, 51 – 55
Any value	80 or 85

Then list for review

Manual Change ~~– May require regeneration of RX Summ – Radiation~~

Admission Level

Manual Change or Modified Record Applied ~~Correction Applied – May require regeneration of RX Summ – Radiation~~

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

03/26/03	New data item requirement for cases diagnosed January 1, 2003 and forward. Fill with 00s for cases diagnosed prior to January 1, 2003.
03/03/04	Added two Interfield edits. Added autopsy cases text to code 00 for clarity. Removed conversion instructions from SOURCE for Version 9 records. See Use Case 22.
11/26/07	Added blank as an Allowable Value on the data item page and to Update logic and to IF # 233.
2010	Data Changes: CCR name (Rad_Reg_RX_Mod) changed to NAACCR name. Rewrote Update logic.
02/07/11	Update logic revised.
8/22/11	Revised consolidation logic.
01/2019	Per NAACCR v18, this field is only required for DX Years less than 2018.
03/2019	Revised Source Logic from: diagnosed between 2004 – 2017, to: diagnosed between 2003 - 2017

Radiation Treatment Discontinued Early

IDENTIFIERS

CCR ID	NAACCR ID
E1892	1531

OWNER

COC

DESCRIPTION

This field is used to identify patients/tumors whose radiation treatment course was discontinued earlier than initially planned. That are the patients/tumors received fewer treatment fractions (sessions) than originally intended by the treating physician.

LEVELS

Admissions, Tumors

LENGTH

2

ALLOWABLE VALUES

00	No radiation treatment
01	Radiation treatment completed as prescribed
02	Radiation treatment discontinued early – toxicity
03	Radiation treatment discontinued early - contraindicated due to other patient risk factors (comorbid conditions, advanced age, progression of tumor prior to planned radiation etc.)
04	Radiation treatment discontinued early – patient decision
05	Radiation discontinued early – family decision
06	Radiation discontinued early – patient expired
07	Radiation discontinued early – reason not documented
99	Unknown if radiation treatment discontinued; Unknown whether radiation therapy administered

SOURCE

1. Right justify and zero fill any values less than 2 digits, but not blank

UPDATE

TUMOR LEVEL

NEW CASE CONSOLIDATION

If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

ADMISSION

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Reason for No Surgery

IDENTIFIERS

CCR ID	NAACCR ID
E1338	1340

DESCRIPTION

Reason why the first course of treatment did not include definitive surgery.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

0	Surgery performed
1	None
2	Contraindicated due to patient risk factors
5	Patient died prior to surgery
6	Recommended, not given
7	Refused
8	Recommended, unknown if performed
9	Unknown, diagnosed at autopsy or death certificate only

SOURCE

If new case record version is A or later, then load from C/N# F00118, converting a non-numeric value to 0.

UPDATE

Tumor Level

New Case Consolidation

If all of the following conditions are true

- the admission and tumor's Reason for No Surgery codes are different
- the admission's code is higher than the tumor's code based on a hierarchy of 0, 7, 8, 1, 2, 5, 6, 9

then automatically update the tumor's Reason for No Surgery code with the admission's corresponding code

Manual change to Summ Surg Site 98-02 or RX Summ--Surg Prim Site from surgery not given to surgery given:

If all of the following conditions are true:

- Date of Diagnosis year is 0001-2002
- Summ Surg Site 98-02 was changed from 00 or 99 to 10-90
- Reason for No Surgery is not already 0

Then set the tumor's Reason for No Surgery to 0.

If all of the following conditions are true:

- Date of Diagnosis year is 2003-9998
- RX Summ--Surg Prim Site was changed from 00, 98, or 99 to 10-90
- Reason for No Surgery is not already 0

Then set the tumor's Reason for No Surgery to 0.

Manual change

Admission Level

Manual or automatic update/correction applied to Summ Surg Site 98-02, or RX Summ--Surg Prim Site

Same as requirements as Tumor Level

Manual change or Correction Applied

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

11/14/02	Added logic to IF #351: for cases diagnosed 2000 and later, allow 9's in the SCOPE-LN-SUM field for sites C700-719 and C80.9, histology type (ICD-O-3) 9800-9989, and sites C770-779 where histology type (ICD-O-3) is 9590-9699 or 9702-972.
3/26/03	Added 5 to Allowable values and clarified definitions of codes 2, 6 and 9. Added conversion table to Source. Autopsy only cases were formerly coded to 2 and are now coded to 9. Added code 5 to update hierarchy values. Added surgery 98_02 fields and date criteria to update logic. Added surgery 98_02 fields and date criteria to IF #351 to cover any surgery conversion issues. Changed IF #351 by removing date criteria and loosening up the histology and site specifications to match NAACCR and SEER edits.
8/27/03	Added Err #467 for cases diagnosed 2003 and forward.
10/8/03	Revised Source table to include the conversion of Surg_Prim_Sum = 98 to Reason_No_Surg = 1.
3/3/04	Updated IF #351 to incorporate different reporting source rules. Added IF #521 to match the edit. Conversion table removed from SOURCE for Version 9 records. Refer to Use Case 22.
12/08/06	Update made to logic so it does not conflict with IF #351 (removing Scope_LN_Sum_98_02 & Surg_Other Sum_98_02 from logic).
2010	Data Changes: CCR name (Reason No Surg) changed to NAACCR name. Rewrote update logic.

Reason for No Radiation

IDENTIFIERS

CCR ID	NAACCR ID
E1349	1430

OWNER

CoC

DESCRIPTION

Reason why the first course of treatment did not include radiation.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

0	Radiation was performed
1	Not part of planned first-course treatment. Diagnosed at autopsy.
2	Contraindicated due to other conditions or other patient risk factors.
5	Patient died prior to planned or recommended treatment.
6	Recommended but not performed. No reason documented.
7	Recommended but refused by patient, family member, or guardian. Refusal is documented.
8	Recommended, unknown if given.
9	Unknown if radiation recommended or given. Death certificate only.

SOURCE

1. If new case record version is A or later than 9, then load, converting a non-numeric value to 0.
2. If all of the following conditions are true:
   - Coding Procedure is less than 31
   - Type of Reporting Source is 6
   - Reason for No Radiation <> 1

   Then re-code to Reason for No Radiation to 1.

UPDATE

Tumor Level
New Case Consolidation
If all of the following conditions are true

- the admission and tumor's Reason for No Radiation codes are different
- the admission's code is higher than the tumor's code based on a hierarchy of 0, 7, 8, 1, 2, 5, 6, 9

then automatically update the tumor's Reason for No Radiation code with the admission's corresponding code
Manual Change to Rad Boost RX Modality, Rad--Regional RX Modality, or RX Summ--Radiation
If any of these fields are changed from a radiation not given code to a radiation given code, then set Reason for No Radiation to 0

Data Item	Radiation-Not-Given Codes	Radiation-Given Codes

Rad Boost RX Modality	00, 99, or blank	20-98
Rad--Regional RX Modality	00, 99, or blank	20-98
RX Summ--Radiation	0 or 9	1-6

Manual Change

Admission Level

Manual Change or Correction Applied to Rad Boost RX Modality, Rad--Regional RX Modality, or RX Summ--Radiation

If any of these fields are changed from a radiation-not-given code to a radiation-given code, then set Reason for No Radiation to 0

Manual Change or Correction Applied

CONSOLIDATED DATA EXTRACT

None

HISTORICAL CHANGES

03/26/03	Added code 5 to the allowable values and added code 5 to the UPDATE logic. Conversion table added to Source. Update logic rewritten. Autopsy only cases were formerly coded to 2 and are now coded to 9.
03/03/04	Added code 8 to Source table in third column, second row. Added logic to IF #397 to cover if Reason_No_Rad = 0. Added IF #520 to match the CoC edit. Excluded autopsy only cases from IF 4) and added IF 5) to allow 0 for autopsy only cases. Conversion table removed from SOURCE for Version 9 records. Refer to Use Case 22 for documentation.
2010	Data Changes: CCR name (Reason No Rad) changed to NAACCR name, Reason for No Radiation. Rewrote Update logic.
12/09/11	In the source statement removed the CNExT_ID. Also, removed the terms or later 9 after consulting with Eureka Business Analyst. Was: "If new case record version is A, then load from C/N# F00567, converting a non-numeric value to 0." Is now: "If new case record version is A, then load, converting a non-numeric value to 0."
04/2014	Per NAACCR v14, moved “Diagnosed at autopsy” from code 9 to 1. Updated Source Logic to correct cases with Coding Procedure less than 31. Updated all code descriptions to match NAACCR.

Reason Subsq RX

IDENTIFIERS

CCR ID	NAACCR ID
E1425	9920

DESCRIPTION

This data item has been retired. This page has been retained for historical purposes only and this data item should not be populated in any cases diagnosed 2013 or later or coded under the NAACCR v13 or later coding standards.
Codes the reason for subsequent treatment beyond their first course of therapy.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

0	No subsequent or palliative treatment
1	Subsequent or palliative treatment due to disease progression
2	Subsequent or palliative treatment due to recurrence of disease
4	Subsequent or palliative treatment due to development of medical condition (e.g., heart failure or liver disease develops in patient)
5	Subsequent or palliative treatment due to other reason
9	Unknown if subsequent or palliative therapy given
Blank	A blank is allowed for cases Diagnosed prior to 2011 Diagnose date 2011 and not a Region 3 resident Region 3 resident and sites other than Breast, Colorectal, and CML

SOURCE

No longer uploaded

UPDATE

None

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

2011 Data Item Changes, CER Project	Added for CER requirements.
05/2013	Retired at the conclusion of data collection for the CER project

Record Type

IDENTIFIERS

CCR ID	NAACCR ID
E1000	10

DESCRIPTION

Type of record being transmitted. The hospital computer system must supply the appropriate code letter at the time that the file is created.

LEVELS

Admissions and source documents

LENGTH

1

ALLOWABLE VALUES

A	New Case
U	Correction
D	Deletion
F	Active Follow-up
S	*Shared Follow-up (generated by the central registry)*

NAACCR CODES FOR REFERENCE:

I	Incidence-only record type (non-confidential coded data)--Length = 3339
C	Confidential record type (incidence record plus confidential data)--Length = 5564
DM	Record Modified since previous submission to central registry (identical in format to the "A" record type.

SOURCE

No conversion, just load transmitted value as the document type.

UPDATE

None

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/26/03	Update Allowable values and length type to 3 to reflect how Eureka processes this data item.
8/15/06	Updated data item to match NAACCR length.
2010	Data Changes: Added definitions for NAACCR codes for additional reference.

Reg-Data

IDENTIFIERS

CCR ID	NAACCR ID
E1550 to E1559	None: State Requestor

DESCRIPTION

Data requested of hospitals (etc.) by the regional registry for special study purposes. The regional registry provides the necessary data collection and coding instructions.

LEVELS

Admission

LENGTH

2 X 10

ALLOWABLE VALUES

Any alpha, numeric, blanks or special characters.

SOURCE

Upload with no conversion.

UPDATE

Manual

CONSOLIDATED DATA EXTRACT

None

HISTORICAL CHANGES

	No historical changes recorded.

Reg Pat No

IDENTIFIERS

CCR ID	NAACCR ID
E1545	None. State Requestor

DESCRIPTION

Historical unique patient identification number assigned by regional registry prior to central system.

LEVELS

Patients, Tumors, Admissions

LENGTH

8

ALLOWABLE VALUES

7-digit number + check digit calculated by the Modified IBM 1022 method.

SOURCE

May be entered on the record of a patient previously registered by this hospital in C/N #F00004. Still generated automatically by regions not using the central system directly (see Appendix #4). No number is ever re-used.

UPDATE

None

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/26/03	Updated Description, Source and removed allowable values edit to reflect the changes in this field due to central system processing.

Reg Tum No

IDENTIFIERS

CCR ID	NAACCR ID
E1546	None. State Requestor

DESCRIPTION

Historical independent number assigned by regional registry to each tumor entered into the region's database for a patient. No adjustment is made when a tumor is deleted from the system. May change if Reg_Pat_No is changed via patient relinking, otherwise it does not change at all.

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

01-99

SOURCE

May be entered on the record of a tumor previously registered by this hospital in Reg Tum No; still generated automatically by regions not using the central system directly when a new tumor is created (Date of Diagnosis is not taken into account.); Numbers are never reused.

UPDATE

None

CONSOLIDATED DATA EXTRACT

Yes, extract from tumor record.

HISTORICAL CHANGES

Unknown	Removed allowable value edit ER10.
12/12/11	Replaced reference to F00137 with the data item name: Reg Tum No.

Region ID

IDENTIFIERS

CCR ID	NAACCR ID
E1541	None. State Requestor

DESCRIPTION

Number assigned to the region by CCR.

LEVELS

Admissions

LENGTH

2

ALLOWABLE VALUES

01	Cancer Incidence Registry for Region One (Monterey, San Benito, Santa Clara, and Santa Cruz)
02	Cancer Registry of Central California (Fresno, Kern, Kings, Madera, Mariposa, Merced, Stanislaus, Tulare, and Tuolumne)
03	Cancer Surveillance Program/Sutter Cancer Center (Alpine, Amador, Calaveras, El Dorado, Nevada, Placer, Sacramento, San Joaquin, Sierra, Solano, Sutter, Yolo, and Yuba)
04	Tri-Counties Regional Cancer Registry (San Luis Obispo, Santa Barbara, and Ventura)
05	Desert Sierra Cancer Surveillance Program (Inyo, Mono, Riverside, and San Bernardino)
06	Cancer Registry of Northern California (Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Napa, Plumas, Shasta, Siskiyou, Sonoma, Tehama, and Trinity)
07	San Diego/Imperial Organization for Cancer Control (San Diego and Imperial)
08	Northern California Cancer Center (Alameda, Contra Costa, Marin, San Francisco, and San Mateo)
09	Cancer Surveillance Program of Los Angeles (Los Angeles)
10	Cancer Surveillance Program of Orange County (Orange)
11	Other

SOURCE

Right-justify and zero-fill

UPDATE

None

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/3/04	Updated C/N# to F03356.
8/15/06	Added 11 to Allowable values.

Regional Nodes Examined

IDENTIFIERS

CCR ID	NAACCR ID
E1140	830

DESCRIPTION

Records the total number of regional lymph nodes that were removed and examined by the pathologist. Beginning with tumors diagnosed on or after January 1, 2004, this item is a component of the Collaborative Stage system.

LEVELS

Admissions, Tumors

LENGTH

2

ALLOWABLE VALUES

00	No regional lymph nodes examined
01	One regional lymph node examined
02	Two regional lymph nodes examined
90	Ninety or more regional lymph nodes examined
95	No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96	Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97	Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98	Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99	Unknown; not stated; death certificate only

SOURCE

Upload with no conversion.>
Also see CS Version Derived.Tumor Level

UPDATE

New Case Consolidation

If ALL of the following conditions are true:

the admission's Regional Nodes Positive is NOT blank
the admission's Regional Nodes Examined is NOT blank
the tumor's Regional Nodes Positive is blank
the tumor's Regional Nodes Examined is blank

Then automatically update the tumor's Regional Nodes Positive and Examined with the admission's Regional Nodes Positive and Examined

Otherwise, if the admission's Regional Nodes Positive and Examined <> the tumor's Regional Nodes Positive and Examined, then list for review

Manual Update

Admission Level

Manual Update

Correction/Update Applied

CONSOLIDATED DATA EXTRACT

Yes, extract from tumor.

HISTORICAL CHANGES

3/16/98	Converted codes 90-97 to code 90 due to redefinition of allowable values.
1/1/99	Replaced item edit with DATE-DX interfield edit check; adjusted other applicable interfield edits to check DATE-DX too.
7/6/01	Added HIST-TYPE-3 reference to interfield edits.
3/26/03	Removed Region 1/8 and Region 9 specific logic in IF #700.
3/3/04	Updated CCR Data Extract to only include Tumor Files. Updated IF 700 and added a new logic for Regional Nodes Examined= 95 and Regional Nodes Examined=01-90.
1/8/07	Simplified Update logic to list for review both Nodes Pos and Nodes Exam if values are different.
2010	Data Changes:

Regional Nodes Positive

IDENTIFIERS

CCR ID	NAACCR ID
E1139	820

DESCRIPTION

Number of regional lymph nodes with evidence of involvement.

LEVELS

Admissions, Tumors

LENGTH

2

ALLOWABLE VALUES

00	All nodes examined are negative
01-89	Number positive (code exact number of nodes pos)
90	90 or more nodes positive
95	Positive aspiration of lymph node(s).
97	Positive nodes, but number unknown
98	No Regional Nodes Positive (none removed)
99	Unknown if nodes are positive or negative or unknown if examined or not applicable
Blank	Not abstracted

SOURCE

Upload with no conversion.
Also see CS Version Derived

UPDATE

See Regional Nodes Examined

CONSOLIDATED DATA EXTRACT

Yes, extract from tumor.

HISTORICAL CHANGES

1/1/99	Replaced item edit with DATE-DX interfield edit check; adjusted other applicable interfield edits to check DATE-DX too.
3/15/00	The third edit - IF NODES-POS <> 00 and 98 and 99 then NODES-INVOLVED 0, else (Err #701) - was removed because it was the same as edit 2).
7/6/01	Added reference to HIST-BEHAVIOR-3 and HIST-TYPE-3 under interfield edits.
3/26/03	Removed Region 1/8 and Region 9 specific logic in Interfield edit.
3/3/04	Allowable value changes. Convert database for cases diagnosed prior to 2004.Updated CCR Data Extract to only include Tumor Files. Modified Update logic to include revised codes. See table "Codes for Cases Diagnosed Prior to January 1, 2004" at the bottom of this page.
1/19/05	Added 98 to Update logic in 2nd paragraph.
2/1/06	Added IF #738 to match CS edit.
1/8/07	Simplified Update logic to list for review both Nodes Pos and Regional Nodes Positive if values are different.

2010	Data Changes:
7/27/2011	IF 399, 414 and 415 were created to comply with NAACCR 12.1.A. Information for this new edit arrived in late July 2011.
05/2013	Added IF 1021, 1052, 1053

Code for Cases Diagnosed Prior to January 1, 2004	**Converted Code**
00-90	Copy
91-96	90
97, and Regional Nodes Examined [830] = 95	95
97, and Regional Nodes Examined [830] <> 95	97
98	98
99	99

Registry-ID

IDENTIFIERS

CCR ID	NAACCR ID
E1005	40

DESCRIPTION

NAACCR registry identification number. Computer generate number for California in out-going cases. Convert to Other Reg ID for cases shared from other states.

LEVELS

Admission

LENGTH

10

ALLOWABLE VALUES

0000009700	CA
0000009100	AK
0000009180	AK
0000007100	AR
0000008700	AZ
0000009700	CA
0000008300	CO
0000009900	HI
0000008100	ID
0000006100	IL
0000004100	MI
0000004101	MI
0000006300	MO
0000003900	MS
0000002500	NC
0000008500	NV
0000001100	NY
0000009500	OR
0000009580	OR
0000007700	TX
0000008400	UT
0000009300	WA
0000009301	WA
0000009302	WA
0000009380	WA
0000005100	WI
0000008200	WY
0000000000	Case not reported by a facility

9999999999	Case reported, but facility number is unknown.

Prior to 2008, this field may contain data from reporting facilities.

SOURCE

Load the transmitted value

UPDATE

None

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

1/1/99	New data item added.
3/26/03	Changed Length from 15 to 10 characters and deleted extra digits in Allowable values codes.
3/3/04	Removed conversion instructions from SOURCE for Version 9 records. See Use Case 22. C/N # updated.
1/19/05	C/N # should be F01002 (was F01683).
2/1/06	Name changed to NAACCR name (was NAACCR_Reg_ID)

Registry Type

IDENTIFIERS

CCR ID	NAACCR ID
E1001	30

DESCRIPTION

A computer-generated code that best describes the type of registry generating the record; used when cases are pooled from multiple registries (a hospital-based registry reporting to a state should have a "3" in this field).

LEVEL

Tumor

LENGTH

1

ALLOWABLE VALUES

1	Central registry (population-based)
2	Central registry or hospital consortium (not population-based)
3	Single hospital/freestanding center

SOURCE

See Extract.

UPDATE

None

CONSOLIDATED DATA EXTRACT

Generate 3: For hospital registries and freestanding centers
Generate 1: For regional or central (population-based) registries

HISTORICAL CHANGES

2007	Data Changes: Added to Volume III for 2007 date changes.

Religion

IDENTIFIERS

CCR ID	NAACCR ID
E1627	None. State Requestor

DESCRIPTION

Patient's religion at time of diagnosis.

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

01-94, 98, 99

For definitions, refer to Calif. Cancer Reporting System Standards, Vol. I, Appendix G.

SOURCE

If the value is completely blank, then convert 99; if the value includes a non-blank, non-numeric character, then convert 99; otherwise, just load the transmitted value, but right-justify and zero fill.

UPDATE

1	If AD_Religion = 02-94 and TU_Religion = 01, 98, or 99, move AD_Religion to TU_Religion.
2	If AD_Religion = 07-69 and TU_Religion = 06, move AD_Religion to TU_Religion.
3	If AD_Religion = 29-33 and TU_Religion = 34, move AD_Religion to TU_Religion.
4	If AD_Religion = 72-74 and TU_Religion = 75, move AD_Religion to TU_Religion.
5	If AD_Religion = 76-88 and TU_Religion = 89, move AD_Religion to TU_Religion.
6	If AD_Religion = 90-92 and TU_Religion = 93, move AD_Religion to TU_Religion.

Leave codes 10-98 as originally reported unless a correction is indicated.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

1/1/98	New coding system adopted. See Appendix 19 for 1998 Religion Code Conversion specifications for tumors, suspense abstracts, and corrections.
10/10/07	Added code 94 for Scientology to Allowable Values and Update logic.
09/08	Removed reference to Appendix 19 in Allowable values section. Appendix 19 (Religion Code Conversion Specifications) in Volume III was removed in 2005.
2010	Data Changes: NAACCR Version 12 retired this item, but this is still a CCR required data item (retained as a State Requestor Item--moved from NAACCR #260 to #2220).

Reporting Facility

IDENTIFIERS

CCR ID	NAACCR ID
E1081	540

OWNER

CoC/CCR

DESCRIPTION

Unique ten-digit number assigned by CCR to hospital or other facility reporting this case to regional registry.

LEVELS

Admissions

LENGTH

10

ALLOWABLE VALUES

For hospital code numbers, see CA Hosp Codes on http://www.ccrcal.org.
The following codes are not allowed in this field:
0000000000, 0000999993, 0000999997, 0000999998 and 0000999999.
In addition, the following special codes are defined here for ease of reference.

0000000000	N/A
0000000801	DC ONLY
0000000802	CORONER
0000000803	MD
0000000804	CONV. HOSPITAL
0000999990	HOSPICE
0000999991	HOME HEALTH
0000999992	SKILLED NURSING FACILITY
0000999993	STAFF PHYSICIAN
0000999994	UNSPEC NONCAL HOSP
0000999995	NON-HOSPITAL NOS
0000999996	PHYSICIAN ONLY
0000999997	UNSPEC BAY AREA H
0000999998	UNSPEC CALIF HOSP
0000999999	UNKNOWN HOSP

SOURCE

If the transmitted value is numeric, then just load it with no conversion. Otherwise, convert it to 0000999999

UPDATE

Manual

CONSOLIDATED DATA EXTRACT

Yes; record with the earliest admission date for this tumor; 10 digits, right-justified, zero-filled.

HISTORICAL CHANGES

01/01/99	Source and transmit to CCR sections change to process 15-digit numbers.
11/14/02	Added Interfield edit 3) to identify which region reports a case that has a generic hospital number. This edit (and Err #449) was activated in Eureka.
03/26/03	Length of field changed from 15 to 10 characters.
08/27/04	Removed Interfield edit (Err #649) and extended range in IF #4 (#315).
03/03/04	Removed conversion instructions from SOURCE for Version 9 records. See Use Case 22. Updated Interrecord edit (#808) to exclude DC Only & Coroner cases.
07/25/05	Removed the Allowable Values reference (Volume One Appendix F) & reference is now to the current California hospital labels file on the CCR website. Added 8 to IF #650 and #315.
08/15/06	NAACCR name changed (was Reporting Hospital).
2010	CCR name (Hosp No) changed to NAACCR name.

Residual Tumor Volume Post Cytoreduction

IDENTIFIERS

CCR ID	NAACCR ID
E2033	3921

OWNER

NAACCR

DESCRIPTION

Gross residual tumor after primary cytoreductive surgery is a prognostic factor for ovarian cancer and residual tumor volume after cytoreductive surgery is a prognostic factor for late stage ovarian cancers.

LEVELS

Admissions, Tumors

LENGTH

2

ALLOWABLE VALUES

00	No gross residual tumor nodules
10	Residual tumor nodule(s) 1 centimeter (cm) or less AND neoadjuvant chemotherapy not given or unknown if given
20	Residual tumor nodule(s) 1 cm or less AND neoadjuvant chemotherapy given (before surgery)
30	Residual tumor nodule(s) greater than 1 cm AND neoadjuvant chemotherapy not given or unknown if given
40	Residual tumor nodule(s) greater than 1 cm AND neoadjuvant chemotherapy given (before surgery)
90	Macroscopic residual tumor, size not stated AND neoadjuvant chemotherapy not given or unknown if given
91	Macroscopic residual tumor nodule(s), size not stated AND neoadjuvant chemotherapy given (before surgery)
92	Procedure described as optimal debulking and size of residual tumor nodule(s) not given AND neoadjuvant chemotherapy not given or unknown if given
93	Procedure described as optimal debulking and size of residual tumor nodule(s) not given AND neoadjuvant chemotherapy given (before surgery)
97	No cytoreductive surgery performed
98	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code 98 will result in an edit error.)
99	Not documented in medical record Residual tumor status after cytoreductive surgery not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:

A. If all the following conditions are true:
   - Schema ID is 00551, 00552, or 00553
   - Type of Reporting Source is not 7
   - Residual Tumor Volume Post Cytoreduction is blank or 98

   Then convert Residual Tumor Volume Post Cytoreduction to 97

B. If all the following conditions are true:
   - One of the following is true:
     - Schema ID is not 00551, 00552, or 00553

       OR
     - Type of Reporting Source is 7
   - Residual Tumor Volume Post Cytoreduction is not blank

   Then convert Residual Tumor Volume Post Cytoreduction to blank

UPDATE

TUMOR LEVEL

NEW CASE CONSOLIDATION

If all these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00551, 00552, 00553
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00551, 00552, 00553
- One of the following conditions is true
- Admission's value is not blank or 99
- Tumor's value is blank or 99

  OR
- Admission's value is 99
- Tumor's value is blank

  Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

MANUAL UPDATE

ADMISSION LEVEL

MANUAL UPDATE

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.
03/2019	Schema ID list updated from 00550, 00551, 00552 to 00551, 00552, 00553 and source logic change to default the value to 97 instead of 99

Response to Neoadjuvant Therapy

IDENTIFIERS

CCR ID	NAACCR ID
E2034	3922

OWNER

NAACCR

DESCRIPTION

This data item records the physician's statement of response to neoadjuvant chemotherapy.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	Neoadjuvant therapy not given
1	Stated as complete response (CR)
2	Stated as partial response (PR)
3	Stated as response to treatment, but not noted if complete or partial
4	Stated as no response (NR)
8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code 8 will result in an edit error.)
9	Not documented in medical record Response to neoadjuvant therapy not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00480
        - Type of Reporting Source is not 7
        - COC Accredited Flag is 1
        - Response to Neoadjuvant Therapy is blank or 8

        Then convert Response to Neoadjuvant Therapy to 9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00480

            OR
            - Type of Reporting Source is 7
        - Response to Neoadjuvant Therapy is not blank

        Then convert Response to Neoadjuvant Therapy to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00480
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00480

One of the following conditions is true

- Admission's value is not blank, 8, or 9
- Tumor's value is blank, 8, or 9

OR

- Admission's value is 9
- Tumor's value is blank or 8

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Rural Urban Continuum 2013

IDENTIFIERS

CCR ID	NAACCR ID
E1779	3312

OWNER

NAACCR

DESCRIPTION

The RuralUrban Continuum (2013) codes separate counties into four metropolitan and six non-metropolitan categories, based on the size their populations and form a classification scheme that distinguishes metropolitan counties by size and non-metropolitan counties by degree of urbanization and proximity to metro areas.

These codes can be derived electronically, using patients' state and county at diagnosis, so registrars do not need to provide them. FIPS state and county code mappings to Beale Codes can be obtained in an Excel file at https://www.ers.usda.gov/data-products/rural-urban-continuum-codes.aspx.

The code is a 9-point continuum, transmitted in standard NAACCR record form with a leading 0, (01-09). Abstractors do not enter these codes.

Areas that are not included in the Rural-Urban Continuum code table, such as Canadian provinces/territories and U.S. territories (other than Puerto Rico) will be coded 98. Records for non-residents of the state of the reporting institution (County at DX = 998) also will be coded 98. If Addr at DX–State is XX, YY or ZZ, or if County at DX = 999, the Rural-Urban Continuum will be coded 99.

LEVELS

Tumor

LENGTH

2

ALLOWABLE VALUES

Metropolitan Counties (00-03)	
01	Counties in metro areas of 1 million population or more
02	Counties in metro areas of 250,000 to 1 million population
03	Counties in metro areas of fewer than 250,000 population
Non-metropolitan Counties (04-09)	
04	Urban population of 20,000 or more, adjacent to a metro area
05	Urban population of 20,000 or more, not adjacent to a metro area
06	Urban population of 2,500 to 19,999, adjacent to a metro area
07	Urban population of 2,500 to 19,999, not adjacent to a metro area
08	Completely rural or less than 2,500 urban population, adjacent to a metro area
09	Completely rural or less than 2,500 urban population, not adjacent to a metro area
98	Program run, but: (1) area is not included in Rural-Urban Continuum code table, or (2) record is for resident outside of state of reporting institution
99	Unknown
Blank	Program not run; record not coded

SOURCE

See Extract

UPDATE

None

CONSOLIDATED DATA EXTRACT

No

HISTORICAL CHANGES

05/2016	Per NAACCR v16, new data field implemented. Field will be generated on extract.

RX Coding System--Current

IDENTIFIERS

CCR ID	NAACCR ID
E1350	1460

DESCRIPTION

Code describing how treatment for this tumor now is coded.

LEVEL

Tumor

LENGTH

2

ALLOWABLE VALUES

01	Treatment data coded using 1-digit surgery codes (obsolete)
02	Treatment data coded according to 1983-1992 SEER manuals and 1983-1995 COC manuals
03	Treatment data coded according to 1983-1992 SEER manuals and 1983-1995 COC manuals
04	Treatment data coded according to 1998 ROADS Supplement
05	Treatment data coded according to 1998 SEER Manual
06	Treatment data coded according to FORDS Manual
07	Treatment data coded according to 2010 SEER Manual.
99	Other coding, including partial or nonstandard coding

SOURCE

See extract

UPDATE

None

CONSOLIDATED DATA EXTRACT

Upon extract Generate 05 (Registry Operations and Data Standards (ROADS) Manual)
or (SEER Program Manual 3rd Edition)
or 06 (2003 Facility Oncology Registry Data Standards FORDS)
or SEER Program Code Manual 4th Edition.

HISTORICAL CHANGES

8/15/06	Generated item in Volume II added to Volume III with 2007 data changes.
2010	Data Changes: Added Allowable Value 07.

RX Date BRM

IDENTIFIERS

CCR ID	NAACCR ID
E1324	1240

NAACCR NAME

RX Date BRM (#1240)
RASP NAME
RXDATEI

DESCRIPTION

Date of initiation for immunotherapy (a.k.a. biological response modifier) that is part of the first course of treatment.

LEVELS

Tumors, Admissions

LENGTH

8

ALLOWABLE VALUES

General Date Rules

Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD). Month and day must have leading zeros for values 01...09.

The following date formats are allowed:

CCYYMMDD Century+Year, Month and Day are provided.
CCYYMM__ Century+Year and Month. Day consists of two blank spaces.
CCYY____ Century+Year. Month and Day consist of four blank spaces.

Dates are checked first to ensure they conform to one of these formats, then for errors in the components. Checking stops on the first non-valid situation.

Range Checking:

Lowest allowed value: January 1, 1850 (or in D1 format: 18500101)
Highest allowed value: current system date
When month is known, it is checked to ensure it falls within range 01...12.
When month and day are known, day is checked to ensure it falls within range for that specific month. Accommodation is made for leap years.

SOURCE

General Date Editing Rules and Range Checking updated for additional clarity. However, the intent of the date rules remains the same as the 2010 update.

1. If the record version is NAACCR version 12 (120 in original new case) or later, then upload the date and its associated flag value with no conversion.
2. Right-justify and zero-fill the date to 8 digits.
3. Convert MMDDYYYY to YYYYMMDD.
4. Convert RX Date BRM and RX Date BRM Flag in the same manner as described in the Eureka Process Specification: 2010 Data Conversions document.

When steps 1 and 2 are the only changes made to the date, then DO NOT record them in the audit log.

UPDATE

Tumor Level

New Case Consolidation

If all of the following conditions are true:

- the Admission shows that BRM therapy was given (RX Summ--BRM = 01)
- either of the following conditions are true:
  - the Admission & Tumor RX Summ--BRM codes are the same
  - the Tumor's RX Summ--BRM code shows that no BRM therapy was given
- any of the following conditions are true:
  - the Admission's RX Date BRM contains a full or partial date and the Tumor's RX Date BRM is blank
  - the Admission's RX Date BRM Flag shows that treatment occurred but we don't know when (code 12) and the Tumor's RX Date BRM Flag does NOT show that treatment occurred (codes 10, 11, 15)
  - Any part of the Tumor's RX Date BRM is blank, that same part of the Admission's RX Date BRM is entered, and other entered parts are equal

Then automatically consolidate

- the Admission's RX Date BRM into the Tumor's RX Date BRM**
- the Admission's RX Date BRM Flag into the Tumor's RX Date BRM Flag
- the Admission's RX Summ BRM into the Tumor's RX Summ BRM

Otherwise, if any of the above three BRM therapy summary values differ between the admission and tumor, then

List both sets of summary codes, dates, & flag codes for review

Manual Change*, **

Admission Level

Manual Change or Correction applied to date or its associated date flag *, **

*If a full or partial date is entered in the date field, then automatically change the associated flag to blank; if a numeric associated flag code is selected/entered, then automatically change the date to blank

If the date is changed, it is now later* than Date of Last Contact, and Vital Status is alive (1), then automatically update Date of Last Contact with the new date and reset Date of Last Contact Flag to blank (this update applies to the patient's Date of Last Contact and Vital Status for a Tumor Level change and to the patient and admission's Date of Last Contact and Vital Status for an Admission level change). RX Date Systemic and RX Date Systemic Flag and Date Initial RX SEER and Date Initial RX SEER Flag may also need to be changed (See RX Date Systemic and Date Initial RX SEER UPDATE sections).

*** With year, month, and/or day potentially blank, a completely known date could appear to be later because it is a larger number than a partial later date. Thus, to test for the latest date among known full or partial dates, use these tests in this order:

- If one of the known dates' years is later than (greater than) the other date's year being compared or if it is the only known year/date, then that date is the latest known date
- If multiple known dates have the same latest year, but only one of them has a latest known month, then that is the latest known date
- If multiple known dates have the same latest year & month, but only one of them has a latest known day, then that is the latest known date

CONSOLIDATED DATA EXTRACT HISTORICAL CHANGES

	None

RX Date BRM Flag

IDENTIFIERS

CCR ID	NAACCR ID
E1325	1241

DESCRIPTION

Explains why there is no appropriate value in the corresponding date field, RX Date BRM.

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if immunotherapy administered).
11	No proper value is applicable in this context (e.g., no immunotherapy administered; autopsy only case).
12	A is applicable but not known. This event occurred, but the date is unknown (e.g., immunotherapy administered but date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (e.g., immune therapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow-up).
Blank	A valid date value is provided in item RX Date BRM, or the date was not expected to have been transmitted.

SOURCE

If the record version is version 12 or later, then upload with no conversion.
If the record version is earlier than 12, then follow the conversion specs - Eureka Process Specification: 2010 Data Conversions.

UPDATE

See RX Date BRM

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/31/10	New data item added for 2010 data changes. Added IF #918.
2010	Data Changes: Added IF #502.
05/2013	Name changed from RX Date--BRM Flag to RX Date BRM Flag

RX Date Chemo

IDENTIFIERS

CCR ID	NAACCR ID
E1320	1220

DESCRIPTION

Date of initiation of chemotherapy that is part of the first course of treatment.
See also RX Summ--Chemo [1390].
Formerly RX Date--Chemo.

LEVELS

Tumors, Admissions

LENGTH

8

ALLOWABLE VALUES

GENERAL DATE EDITING RULES:

Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD). Month and day must have leading zeros for values 01...09.
The following date formats are allowed:

CCYYMMDD Century+Year, Month and Day are provided.
CCYYMM__ Century+Year and Month. Day consists of two blank spaces.
CCYY____ Century+Year. Month and Day consist of four blank spaces.

Dates are checked first to ensure they conform to one of these formats, then for errors in the components. Checking stops on the first non-valid situation.
Range Checking:
Lowest allowed value: January 1, 1850 (or in D1 format: 18500101)
Highest allowed value: current system date when month is known, it is checked to ensure it falls within range 01...12.
When month and day are known, day is checked to ensure it falls within range for that specific month. Accommodation is made for leap years.

SOURCE

If the record version is NAACCR version 12 (120 in original new case) or later, then upload the date and its associated flag value with no conversion.
Otherwise, if the record version is earlier than 12, then perform the following conversions in this order:

1. Right-justify and zero-fill the date to 8 digits.
2. Convert MMDDYYYY to YYYYMMDD.
3. Convert RX Date Chemo and RX Date Chemo Flag in the same manner as described in the Eureka Process Specification: 2010 Data Conversions document.

If steps 1 and 2 are the only changes made to the date, then DO NOT record them in the audit log.

UPDATE

Tumor Level
New Case Consolidation
If all of the following conditions are true:
the Admission shows that chemo therapy was given (RX Summ--Chemo = 01-03)

either of the following conditions are true:

the Admission & Tumor RX Summ--Chemo codes are the same

the Tumor's RX Summ--Chemo code shows that no chemotherapy was given

any of the following conditions are true:

the Admission's RX Date Chemo contains a full or partial date and the Tumor's RX Date Chemo is blank

the Admission's RX Date Chemo Flag shows that treatment occurred but we don't know when (code 12) and the Tumor's RX Date Chemo Flag does NOT show that treatment occurred (codes 10, 11, 15)

any part of the Tumor's RX Date Chemo is blank, that same part of the Admission's RX Date Chemo is entered, and other entered parts are equal

Then automatically consolidate

the Admission's RX Date Chemo into the Tumor's RX Date Chemo**

the Admission's RX Date Chemo Flag into the Tumor's RX Date Chemo Flag

the Admission's RX Summ--Chemo into the Tumor's RX Summ--Chemo

Otherwise, if any of the above three chemotherapy summary values differ between the admission and tumor, then list both sets of summary codes, dates, & flag codes for review

Manual Change*, **

Admission Level

Manual Change or Correction applied to date or its associated date flag*, **

*If a full or partial date is entered in the date field, then automatically change the associated flag to blank; if a numeric associated flag code is selected/entered, then automatically change the date to blank

If the date is changed, it is now later* than Date of Last Contact, and Vital Status is alive (1), then automatically update Date of Last Contact with the new date and reset Date of Last Contact Flag to blank (this update applies to the patient's Date of Last Contact and Vital Status for a Tumor Level change and to the patient and admission's Date of Last Contact and Vital Status for an Admission level change). RX Date Systemic and RX Date Systemic Flag and Date Initial RX SEER and Date of Initial RX SEER Flag may also need to be changed (See RX Date Systemic and Date Initial RX SEER UPDATE sections).

*** With year, month, and/or day potentially blank, a completely known date could appear to be later because it is a larger number than a partial later date. Thus, to test for the latest date among known full or partial dates, use these tests in this order:

1. If one of the known dates' years is later than (greater than) the other date's year being compared or if it is the only known year/date, then that date is the latest known date
2. If multiple known dates have the same latest year, but only one of them has a latest known month, then that is the latest known date
3. If multiple known dates have the same latest year & month, but only one of them has a latest known day, then that is the latest known date

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES:

5/15/01	Removed reference to CCR Edit (IFCHEM) in 1) and 2). Modified update 4); added update 5) to address incorrect date being added to database.
7/6/01	Added AAD-@ prefix to CLASS-OF-CASE check in update item 4) and removed item 5) (checking for class 3 and doing nothing) because it was not necessary.

3/26/03	Deleted Interfield edits 1) and 2) because Reason_No_Chemo data item removed. Renumbering of remaining Interfield edits. Interfield edits 3) and 4) updated to reflect the new Chemo_Sum two-digit codes. Allowable Values changed for DC Only cases to code 9's instead of 0's. Added logic to Interfield edit 4) for DC Only cases.
3/03/0	4 Update logic rewritten.
1/19/05	Allowable Values, Source requirements, Update logic, and Interfield Edits changed to handle 8888888 as a valid date.
2010	2010 Data Changes: CCR name (Date Chemo) changed to NAACCR name. Updated Allowable Values and Source sections to match NAACCRv12 date scheme. Modified Update logic to include new date and flag format. Added IF #919.
7/8/2011	General Date Editing Rules and Range Checking updated for additional clarity. However, the intent of the date rules remains the same as the 2010 update.
05/2013	Name changed from RX Date--Chemo to RX Date Chemo Removed IF708 as it no longer uses this field but looks at the associated date flag instead.
02/2020	Description Update

RX Date Chemo Flag

IDENTIFIERS

CCR ID	NAACCR ID
E1321	1221

DESCRIPTION

Explains why there is no appropriate value in the corresponding date field, RX Date Chemo.

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if chemotherapy administered).
11	No proper value is applicable in this context (e.g., no chemotherapy administered; autopsy only case).
12	A value is applicable but not known. This event occurred, but date is unknown (e.g., chemotherapy administered but date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (e.g., chemotherapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow-up).
Blank	A valid date value is provided in item, RX Date-Chemo, or the date was not expected to have been transmitted.

SOURCE

If the record version is version 12 or later, then upload with no conversion.
If the record version is earlier than 12, then follow the conversion specs - Eureka Process Specification: 2010 Data Conversions.

UPDATE

See RX Date Chemo

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

2010	New data item for 2010.
05/2013	Name changed from RX Date--Chemo Flag to RX Date Chemo Flag.

RX Date DX/Stg Proc

IDENTIFIERS

CCR ID	NAACCR ID
E1328	1280

DESCRIPTION

Date of diagnostic or staging procedure.

LEVELS

Tumors, Admissions

LENGTH

8

ALLOWABLE VALUES

General Date Editing Rules:

Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD). Month and day must have leading zeros for values 01...09.

The following date formats are allowed:

CCYYMMDD Century+Year, Month and Day are provided.

CCYYMM__ Century+Year and Month. Day consists of two blank spaces.

CCYY____ Century+Year. Month and Day consist of four blank spaces.

Dates are checked first to ensure they conform to one of these formats, then for errors in the components. Checking stops on the first non-valid situation.

Range Checking:

Lowest allowed value: January 1, 1850 (or in D1 format: 18500101)

Highest allowed value: current system date

When month is known, it is checked to ensure it falls within range 01...12.

When month and day are known, day is checked to ensure it falls within range for that specific month. Accommodation is made for leap years.

SOURCE

If the record version is NAACCR version 12 (120 in original new case) or later, then upload the date and its associated flag value with no conversion.

Otherwise, if the record version is earlier than 12, then perform the following conversions in this order:

1. Right-justify and zero-fill the date to 8 digits.
2. Convert MMDDYYYY to YYYYMMDD.
3. Convert RX Date DX/Stg Proc and RX Date DX/Stg Proc Flag in the same manner as described in the Eureka Process Specification: 2010 Data Conversions document.

If steps 1 and 2 are the only changes made to the date, then DO NOT record them in the audit log.

UPDATE

Tumor Level

New Case Consolidation

If any of the following conditions are true:

- The admission's RX Date DX/Stg Proc date is fully known or partially known and the tumor's RX Date DX/Stg Proc date is blank
- The admission and tumor's RX Date DX/Stg Proc dates are both blank, but the admission's RX Date DX/Stg Proc Flag value is higher according to this hierarchy: 12, 11, 10, blank

- Any part of the Tumor's RX Date DX/Stg Proc date is blank, that same part of the Admission's RX Date DX/Stg Proc date is entered, and other entered parts are equal
- All of the following conditions are true:
- The admission's Class of Case = 10-22,
- the admission and tumor's RX Date DX/Stg Proc dates are both fully known or partially known,
- the admission's RX Date DX/Stg Proc is earlier**** than the tumor's RX Date DX/Stg Proc, and RX Hosp--DX/Stg Proc = 01-07

Then automatically update the tumor's RX Date DX/Stg Proc and RX Date DX/Stg Proc Flag values with the admission's corresponding values
Manual Change*, **
Admission Level
Manual Change or Correction applied to date or its associated date flag*, **
*If a full or partial date is entered in the date field, then automatically change the associated flag to blank; if a numeric associated flag code is selected/entered, then automatically change the date to blank
If the date is changed, it is now later* than Date of Last Contact, and Vital Status is alive(1), then automatically update Date of Last Contact with the new date and reset Date of Last Contact Flag to blank (this update applies to the patient's Date of Last Contact and Vital Status for a Tumor Level change and to the patient and admission's Date of Last Contact and Vital Status for an Admission level change).*** With year, month, and/or day potentially blank, a completely known date could appear to be later because it is a larger number than a partial later date. Thus, to test for the latest date among known full or partial dates, use these tests in this order:

- If one of the known dates' years is later than (greater than) the other date's year being compared or if it is the only known year/date, then that date is the latest known date
- If multiple known dates have the same latest year, but only one of them has a latest known month, then that is the latest known date
- If multiple known dates have the same latest year & month, but only one of them has a latest known day, then that is the latest known date

**** With month and/or day potentially blank, a date with a partial but later date could appear to be earlier because it is a smaller number than a full earlier date. Thus, to test for the earliest among known dates, use these tests in this order:

- If one of the known dates' years is earlier than (less than) the other known date's year or if it is the only known year/date, then that date is the earliest known date
- If multiple known dates have the same earliest year, but only one of them has an earliest known month, then that is the earliest known date
- If multiple known dates have the same earliest year & month, but only one of them has an earliest known day, then that is the earliest known date

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

1/1/99	Added check for partial date not = 00 to update logic step 3.
5/15/01	Name of field changed from DATE-SURG-NCD by Commission on Cancer. Modified UPDATE section, item 4), added item 5) to check for CLASS-OF-CASE = 1 or 2.
7/6/01	Simplified update section, item 4) and removed item 5) because it was not necessary.
3/26/03	Changed data item name from Date_DX_ST_Pall to RX Date--DX/Stg Proc to reflect the removal of palliative treatment from this code. A separate data item has been created for

	palliative treatment dates. The CCR still requires this field but not the fields that pertain to palliative treatment. Allowable Values changed for DC Only cases to code 9's instead of 0's. Added logic to Interfield edit 3) for DC Only cases.
3/03/04	Removed conversion instructions from SOURCE for Version 9 records. See Use Case 22.
1/19/05	Rewrote update logic.
2010	2010 Data Changes: Revised Allowable Values, Source and Update logic information to match NAACCRv12 date scheme. CCR name (Date DX Stg) changed to NAACCR name. Added IF #781 and 920.
7/8/2011	General Date editing rules and range checking updated for additional clarity. However, the intent of the data rules remains the same as the 2010 update.
05/2013	Name changed from RX Date--DX/Stg Proc to RX Date DX/Stg Proc

RX Date DX/Stg Proc Flag

IDENTIFIERS

CCR ID	NAACCR ID
E1329	1281

DESCRIPTION

Explains why there is no appropriate value in the corresponding date field, RX Date DX/Stg Proc.

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

General Date Editing Rules:

Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD). Month and day must have leading zeros for values 01...09.

The following date formats are allowed:

CCYYMMDD Century+Year, Month and Day are provided.

CCYYMM__ Century+Year and Month. Day consists of two blank spaces.

CCYY____ Century+Year. Month and Day consist of four blank spaces.

Dates are checked first to ensure they conform to one of these formats, then for errors in the components. Checking stops on the first non-valid situation.

Range Checking:

Lowest allowed value: January 1, 1850 (or in D1 format: 18500101)

Highest allowed value: current system date

When month is known, it is checked to ensure it falls within range 01...12.

When month and day are known, day is checked to ensure it falls within range for that specific month. Accommodation is made for leap years.

Codes

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if any diagnostic or staging procedure performed).
11	No proper value is applicable in this context (e.g., no diagnostic or staging procedure performed; autopsy only case).

12	Proper value is applicable but not known. This event occurred, but the date is unknown (e.g., diagnostic or staging procedure performed but date is unknown).
Blank	A date value is provided in item RX Date-DX/Stg Proc [NAACCR item #1280], or the date was not expected to have been transmitted.

SOURCE

If the record version is version 12 or later, then upload with no conversion.
If the record version is earlier than 12, then follow the conversion specs - Eureka Process Specification: 2010 Data Conversions.

UPDATE

See RX Date DX/Stg Proc

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

2010	New data item added for 2010 data changes.
05/2013	Name changed from RX Date--DX/Stg Proc Flag to RX Date DX/Stg Proc Flag

RX Date Hormone

IDENTIFIERS

CCR ID	NAACCR ID
E1329	1230

DESCRIPTION

Date hormone therapy started.

LEVELS

Tumors, Admissions

LENGTH

8

ALLOWABLE VALUES

General Date Editing Rules:
Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD). Month and day must have leading zeros for values 01...09.
The following date formats are allowed:
CCYYMMDD Century+Year, Month and Day are provided.
CCYYMM__ Century+Year and Month. Day consists of two blank spaces.
CCYY____ Century+Year. Month and Day consist of four blank spaces.
Dates are checked first to ensure they conform to one of these formats, then for errors in the components. Checking stops on the first non-valid situation.
Range Checking:
Lowest allowed value: January 1, 1850 (or in D1 format: 18500101)
Highest allowed value: current system date
When month is known, it is checked to ensure it falls within range 01...12.
When month and day are known, day is checked to ensure it falls within range for that specific month. Accommodation is made for leap years.

SOURCE

If the record version is NAACCR version 12 (120 in original new case) or later, then upload the date and its associated flag value with no conversion.
Otherwise, if the record version is earlier than 12, then perform the following conversions in this order:
1. Right-justify and zero-fill the date to 8 digits.
2. Convert MMDDYYYY to YYYYMMDD.
3. Convert RX Date Hormone and RX Date Hormone Flag in the same manner as described in the Eureka Process Specification: 2010 Data Conversions document.

If steps 1 and 2 are the only changes made to the date, then DO NOT record them in the audit log.

UPDATE

Tumor Level
New Case Consolidation
If all the following conditions are true:
- the Admission shows that Hormone therapy was given (RX Summ--Hormone = 01)
- either of the following conditions are true:
  - the Admission & Tumor RX Summ--Hormone codes are the same

- the Tumor's RX Summ--Hormone code shows that no Hormone therapy was given
- any of the following conditions are true:
  - the Admission's RX Date Hormone contains a full or partial date and the Tumor's RX Date Hormone is blank
  - the Admission's RX Date Hormone Flag shows that treatment occurred but we don't know when (code 12) and the Tumor's RX Date Hormone Flag does NOT show that treatment occurred (codes 10, 11, 15)
  - Any part of the Tumor's RX Date Hormone is blank, that same part of the Admission's RX Date Hormone is entered, and other entered parts are equal

Then automatically consolidate

- the Admission's RX Date Hormone into the Tumor's RX Date Hormone**
- the Admission's RX Date Hormone Flag into the Tumor's RX Date Hormone Flag
- the Admission's RX Summ--Hormone into the Tumor's RX Summ Hormone

Otherwise, if any of the above three Hormone therapy summary values differ between the admission and tumor, then

List both sets of summary codes, dates, & flag codes for review

Manual Change*, **

Admission Level

Manual Change or Correction applied to date or its associated date flag *, **

*If a full or partial date is entered in the date field, then automatically change the associated flag to blank; if a numeric associated flag code is selected/entered, then automatically change the date to blank

If the date is changed, it is now later* than Date of Last Contact, and Vital Status is alive (1), then automatically update Date of Last Contact with the new date and reset Date of Last Contact Flag to blank (this update applies to the patient's Date of Last Contact and Vital Status for a Tumor Level change and to the patient and admission's Date of Last Contact and Vital Status for an Admission level change). RX Date Systemic and RX Date Systemic Flag and Date Initial RX SEER and Date of Initial RX Flag may also need to be changed (See RX Date Systemic and Date Initial RX SEER UPDATE sections).

*** With year, month, and/or day potentially blank, a completely known date could appear to be later because it is a larger number than a partial later date. Thus, to test for the latest date among known full or partial dates, use these tests in this order:

- If one of the known dates' years is later than (greater than) the other date's year being compared or if it is the only known year/date, then that date is the latest known date
- If multiple known dates have the same latest year, but only one of them has a latest known month, then that is the latest known date
- If multiple known dates have the same latest year & month, but only one of them has a latest known day, then that is the latest known date

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

5/15/01	Reference to CCR Edit (IF___) in 1) and 2) removed. Modified update 4); added update 5) to address incorrect date being added to the database.
7/6/01	Added "AD-". prefix to CLASS-OF-CASE check in update item 4) and removed item 5) (checking for class 3 and doing nothing) because it was not necessary.
3/26/03	Deleted Interfield edits 1) and 2) because Reason_No_Horm data item removed. Renumbering of remaining Interfield edits. Interfield edits 3) and 4) updated to

	reflect the new Horm_Sum two-digit codes. Allowable Values changed for DC Only cases to code 9's instead of 0's. Added logic to Interfield edit 4) for DC Only cases.
3/03/04	Update logic rewritten.
1/19/05	Allowable Values, Source requirements, Update logic, and Interfield Edits changed to handle 88888888 as a valid date.
2010	2010 Data Item Changes: CCR name (Date_Horm) changed to NAACCR name. Revised Allowable Values, Source and Update logic information to match NAACCRv12 date scheme.
7/8/11	General Date Editing Rules and Range Checking updated for additional clarity. However, the intent of the date rules remains the same as the 2010 update.
05/2013	Name changed from RX Date--Hormone to RX Date Hormone

RX Date Hormone Flag

IDENTIFIERS

CCR ID	NAACCR ID
E1323	1231

DESCRIPTION

Explains why there is no appropriate value in the corresponding date field, RX Date Hormone.

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if any hormone therapy administered).
11	No proper value is applicable in this context (e.g., no hormone therapy administered; autopsy only cases).
12	A value is applicable but not known. This event occurred, but date is unknown (e.g., hormone therapy administered but date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (e.g., hormone therapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow-up).
Blank	A valid date value is provided in item RX Date-Hormone [1230], or the date was not expected to have been transmitted

SOURCE

If the record version is version 12 or later, then upload with no conversion.
If the record version is earlier than 12, then follow the conversion specs - Eureka Process Specification: 2010 Data Conversions.

UPDATE

See RX Date Hormone

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

2010	New data item added for 2010 data changes.
05/2013	Name changed from RX Date--Hormone Flag to RX Date Hormone Flag

RX Date Mst Defn Srg

IDENTIFIERS

CCR ID	NAACCR ID
E1310	3170

DESCRIPTION

Records the date of the most definitive surgical resection of the primary site performed as the first course of treatment.

LEVELS

Tumors, Admissions

LENGTH

8

ALLOWABLE VALUES

General Date Editing Rules:

Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD). Month and day must have leading zeros for values 01...09.

The following date formats are allowed:

CCYYMMDD Century+Year, Month and Day are provided.

CCYYMM__ Century+Year and Month. Day consists of two blank spaces.

CCYY____ Century+Year. Month and Day consist of four blank spaces.

Dates are checked first to ensure they conform to one of these formats, then for errors in the components. Checking stops on the first non-valid situation.

Range Checking:

Lowest allowed value: January 1, 1850 (or in D1 format: 18500101)

Highest allowed value: current system date

When month is known, it is checked to ensure it falls within range 01...12.

When month and day are known, day is checked to ensure it falls within range for that specific month. Accommodation is made for leap years.

SOURCE

If the record version is NAACCR version 12 (120 in original new case) or later, then upload the date and its associated flag value with no conversion.

Otherwise, if the record version is earlier than 12, then perform the following conversions in this order:

1. Right-justify and zero-fill the date to 8 digits.
2. Convert MMDDYYYY to YYYYMMDD.
3. Convert RX Date Mst Defn Srg and RX Date Mst Defn Srg Flag in the same manner as described in the Eureka Process Specification: 2010 Data Conversions document.

If steps 1 and 2 are the only changes made to the date, then DO NOT record them in the audit log.

UPDATE

TUMOR LEVEL

NEW CASE CONSOLIDATION

(Perform after Primary Site and Type of Reporting Source consolidation)

1. If the tumor's consolidated Type of Reporting Source is 7 (DC Only), then set RX Date Mst Defn Srg to blank and RX Date Mst Defn Srg Flag to 10

2. If the tumor's consolidated Type of Reporting Source is 6 (Autopsy Only), then set RX Date Mst Defn Srg to blank and RX Date Mst Defn Srg Flag to 11
3. If the tumor's consolidated Type of Reporting Source is not 6 or 7 and any of the following conditions are true:
    a. The admission's RX Summ--Surg Prim Site is higher than the tumor's RX Summ--Surg Prim Site according to the consolidation hierarchy for the associated Site code in Appendix 20B
    b. The admission and tumor's RX Summ--Surg Prim Site codes are the same, but the admission's RX Date Mst Defn Srg is a later date than the same date in the tumor, taking any blank parts of the dates into account***
    c. The admission and tumor's RX Summ--Surg Prim Site codes are the same, and the admission and tumor's RX Date Mst Defn Srg values are both blank, but the admission's associated date flag is higher according to this hierarchy: 12, 11, 10, blank

Then update the tumor's RX Date Mst Defn Srg and RX Date Mst Defn Srg Flag with the corresponding admission values

Manual Change, ***

ADMISSION LEVEL

Manual Change or Correction applied to date or its associated date flag, ***
Manual Change or Correction/Update applied to Surg Prim Proc1-3

1. If the admission's Type of Reporting Source is 7 (DC Only), then set RX Date Mst Defn Srg to blank and RX Date Mst Defn Srg Flag to 10
2. If the admission's Type of Reporting Source is 6 (Autopsy Only), then set RX Date Mst Defn Srg to blank and RX Date Mst Defn Srg Flag to 11
3. If the admission's Type of Reporting Source is not 6 or 7 and any of the following conditions are true:
    a. One of the admission's Surg Prim Proc1-3 codes is higher than the other two codes according to the consolidation hierarchy for the associated Site code in Appendix 20B
    b. There is more than one highest Surg Prim Proc1-3 code according to the consolidation hierarchy, but one of the associated Date Surg Proc1-3 dates is a later date than the other procedure dates with the same associated highest code, taking any blank parts of the dates into account***
    c. There is more than one highest Surg Prim Proc1-3 code according to the consolidation hierarchy, and the related Date Surg Proce1-3 dates are both/all blank, but one of the procedures' associated date flag codes is higher according to this hierarchy: 12, 11, 10, blank

Then update the admission's RX Date Mst Defn Srg and RX Date Mst Defn Srg Flag with the singled out surgical procedure's corresponding Date Surg Proc and Date Surg Proc Flag values

REFERENCES

**If a full or partial date is entered in the date field, then automatically change the associated flag to blank; if a numeric associated flag code is selected/entered, then automatically change the date to blank.*

***If the date is changed, it is now later than Date of Last Contact, and Vital Status is alive (1), then automatically update Date of Last Contact with the new date and reset Date of Last Contact Flag to blank (this update applies to the patient's Date of Last Contact and Vital Status for a Tumor Level change and to the patient and admission's Date of Last Contact and Vital Status for an Admission level change). Date Initial RX SEER and Date Initial RX SEER Flag may also need to be changed (See Date Initial RX SEER UPDATE sections).*

**** With year, month, and/or day potentially blank, a completely known date could appear to be later because it is a larger number than a partial later date. Thus, to test for the latest date among known full or partial dates, use these tests in this order:*

1. *If one of the known dates' years is later than (greater than) the other date's year being compared or if it is the only known year/date, then that date is the latest known date.*
2. *If multiple known dates have the same latest year, but only one of them has a latest known month, then that is the latest known date.*
3. *If multiple known dates have the same latest year & month, but only one of them has a latest known day, then that is the latest known date.*

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/26/03	New data item for cases diagnosed beginning January 1, 2003.
8/27/03	Added text to Source, Update in Tumor & Admission level that adds taking a later known date over an earlier known.
3/03/04	Removed Update logic that referred to Proc1-3 fields. Added Update logic that updates Date_Last_Pat_FU. Interfield edit 3) deactivated until global data fix can be programmed.
1/08/07	Reinstated Update logic which updates Date Def Surg when Surg Prim Proc1-3 or Date Surg Proc1-3 is changed.
2009	Update logic modified (strike-out of Date Surg Proc1-3) to update the definitive surgery date ONLY if Definitive Surgery was actually done (per problem found in Wonderdesk #11995).
2010	Data Changes: Revised Allowable Values, Source and Update logic information to match NAACCRv12 date scheme. Changed CCR name (Date_Def_Surg) to NAACCR name. Added IF #922.
7/8/11	General Date Editing Rules and Range Checking updated for additional clarity. However, the intent of the date rules remains the same as the 2010 update.
05/2013	Name changed from RX Date--Most Defin Surg to RX Date Mst Defn Srg

RX Date Mst Defn Srg Flag

IDENTIFIERS

CCR ID	NAACCR ID
E1311	3171

DESCRIPTION

Explains why there is no appropriate value in the corresponding date field, RX Date--Most Defin Surg.

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

10	No information whatsoever can be inferred from this exceptional value (unknown if any surgical procedure of the primary site was performed)
11	No proper value is applicable in this context (no surgical procedure of the primary site was performed; autopsy only case)
12	A value is applicable but not known. Event occurred, but the date is unknown (e.g., surgery to the primary site was administered but date is unknown).
Blank	A valid date value is provided in item RX Date--Most Defin Surg, or the date was not expected to have been transmitted.

SOURCE

If the record version is version 12 or later, then upload with no conversion.
If the record version is earlier than 12, then follow the conversion specs - Eureka Process Specification: 2010 Data Conversions.

UPDATE

See RX Date Mst Defn Srg

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

2010	New data item added for 2010 data changes.

RX Date Other

IDENTIFIERS

CCR ID	NAACCR ID
E1326	1250

DESCRIPTION

Date other therapy started.

LEVELS

Tumors, Admissions

LENGTH

8

ALLOWABLE VALUES

General Date Editing Rules:
Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD). Month and day must have leading zeros for values 01...09.
The following date formats are allowed:
CCYYMMDD Century+Year, Month and Day are provided.
CCYYMM__ Century+Year and Month. Day consists of two blank spaces.
CCYY____ Century+Year. Month and Day consist of four blank spaces.
Dates are checked first to ensure they conform to one of these formats, then for errors in the components. Checking stops on the first non-valid situation.
Range Checking:
Lowest allowed value: January 1, 1850 (or in D1 format: 18500101)
Highest allowed value: current system date
When month is known, it is checked to ensure it falls within range 01...12.
When month and day are known, day is checked to ensure it falls within range for that specific month. Accommodation is made for leap years.

SOURCE

If the record version is NAACCR version 12 (120 in original new case) or later, then upload the date and its associated flag value with no conversion.
Otherwise, if the record version is earlier than 12, then perform the following conversions in this order:

1. Right-justify and zero-fill the date to 8 digits.
2. Convert MMDDYYYY to YYYYMMDD.
3. Convert RX Date Other and RX Date Other Flag in the same manner as described in the Eureka Process Specification: 2010 Data Conversions document.

If steps 1 and 2 are the only changes made to the date, then DO NOT record them in the audit log.

UPDATE

Tumor Level
New Case Consolidation
If all of the following conditions are true:

- the Admission shows that Other therapy was given (RX Summ--Other = 1-3 or 6)
- either of the following conditions are true:
  - the Admission & Tumor RX Summ--Other codes are the same

- the Tumor's RX Summ--Other code shows that no Other therapy was given

- any of the following conditions are true:
- the Admission's RX Date Other contains a full or partial date and the Tumor's RX Date Other is blank
- the Admission's RX Date Other Flag shows that treatment occurred but we don't know when (code 12) and the Tumor's RX Date Other Flag does NOT show that treatment occurred (codes 10, 11, 15)
- Any part* of the Tumor's RX Date Other is blank, that same part of the Admission's RX Date Other is entered, and other entered parts are equal

Then automatically consolidate

- the Admission's RX Date Other into the Tumor's RX Date Other**
- the Admission's RX Date Other Flag into the Tumor's RX Date Other Flag
- the Admission's RX Summ--Other into the Tumor's RX Summ--Other

Otherwise, if any of the above three Other therapy summary values differ between the admission and tumor, then

List both sets of summary codes, dates, & flag codes for review

Manual Change*, **

Admission Level

Manual Change or Correction applied to date or its associated date flag *, **

*If a full or partial date is entered in the date field, then automatically change the associated flag to blank; if a numeric associated flag code is selected/entered, then automatically change the date to blank

If the date is changed, it is now later* than Date of Last Contact, and Vital Status is alive (1), then automatically update Date of Last Contact with the new date and reset Date of Last Contact Flag to blank (this update applies to the patient's Date of Last Contact and Vital Status for a Tumor Level change and to the patient and admission's Date of Last Contact and Vital Status for an Admission level change). RX Date Systemic and RX Date Systemic Flag and Date Initial RX SEER and Date Initial RX Flag may also need to be changed (See RX Date Systemic and Date Initial RX SEER UPDATE sections).

*** With year, month, and/or day potentially blank, a completely known date could appear to be later because it is a larger number than a partial later date. Thus, to test for the latest date among known full or partial dates, use these tests in this order:

- If one of the known dates' years is later than (greater than) the other date's year being compared or if it is the only known year/date, then that date is the latest known date
- If multiple known dates have the same latest year, but only one of them has a latest known month, then that is the latest known date
- If multiple known dates have the same latest year & month, but only one of them has a latest known day, then that is the latest known date

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

	None

RX Date Other Flag

IDENTIFIERS

CCR ID	NAACCR ID
E1327	1251

DESCRIPTION

This flag explains why there is no appropriate value in the corresponding date field, RX Date Other [1250].

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if other therapy administered).
11	No proper value is applicable in this context (e.g., no other treatment administered; autopsy only case).
12	A value is applicable but not known. This event occurred, but the date is unknown (e.g., other therapy administered but date is unknown).
Blank	A valid date value is provided in item RX Date-Other [NAACCR item #1250], or the date was not expected to have been transmitted.

SOURCE

If the record version is version 12 or later, then upload with no conversion.
If the record version is earlier than 12, then follow the conversion specs - Eureka Process Specification: 2010 Data Conversions.

UPDATE

See RX Date Other

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

2010	New data item added for 2010 data changes.
05/2013	Name changed from RX Date--Other Flag to RX Date Other Flag.
03/2020	Added back to Volume III

RX Date Radiation

IDENTIFIERS

CCR ID	NAACCR ID
E1314	1210

DESCRIPTION

Date radiation therapy started (including radiation to central nervous system).

LEVELS

Tumors, Admissions

LENGTH

8

ALLOWABLE VALUES

General Date Editing Rules:
Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD). Month and day must have leading zeros for values 01...09.
The following date formats are allowed:

CCYYMMDD Century+Year, Month and Day are provided.
CCYYMM__ Century+Year and Month. Day consists of two blank spaces.
CCYY____ Century+Year. Month and Day consist of four blank spaces.

Dates are checked first to ensure they conform to one of these formats, then for errors in the components. Checking stops on the first non-valid situation.
Range Checking:

Lowest allowed value: January 1, 1850 (or in D1 format: 18500101)
Highest allowed value: current system date
When month is known, it is checked to ensure it falls within range 01...12.
When month and day are known, day is checked to ensure it falls within range for that specific month. Accommodation is made for leap years.

SOURCE

If the record version is NAACCR version 12 (120 in original new case) or later, then upload the date and its associated flag value with no conversion.
Otherwise, if the record version is earlier than 12, then perform the following conversions in this order:

1. Right-justify and zero-fill the date to 8 digits.
2. Convert MMDDYYYY to YYYYMMDD.
3. Convert Date of Last Contact and Date of Last Contact Flag in the same manner as described in the Eureka Process Specification: 2010 Data Conversions document.

If steps 1 and 2 are the only changes made to the date, then DO NOT record them in the audit log.

UPDATE

Tumor Level

New Case Consolidation

If all of the following conditions are true:

- the Admission shows that Radiation therapy was given (RX Summ--Radiation=1-6 or Rad--Regional RX Modality = 20-98)
- either of the following conditions are true:

- the Admission & Tumor RX Summ--Radiation codes are the same
- the Tumor's RX Summ--Radiation code shows that no Radiation therapy was given

- any of the following conditions are true:
- the Admission's RX Date Radiation contains a full or partial date and the Tumor's RX Date Radiation is blank
- the Admission's RX Date Radiation Flag shows that treatment occurred but we don't know when (code 12) and the Tumor's RX Date Radiation Flag does NOT show that treatment occurred (codes 10, 11, 15)
- Any part* of the Tumor's RX Date Radiation is blank, that same part of the Admission's RX Date Radiation is entered, and Radiation entered parts are equal

Then automatically consolidate

- the Admission's RX Date Radiation into the Tumor's RX Date Radiation**
- the Admission's RX Date Radiation Flag into the Tumor's RX Date Radiation Flag
- the Admission's RX Summ--Radiation into the Tumor's RX Summ--Radiation

Otherwise, if any of the above three Radiation therapy summary values differ between the admission and tumor, then list both sets of summary codes, dates, & flag codes for review

Manual Change*, **

Admission Level

Manual Change or Correction applied to date or its associated date flag*, **

*If a full or partial date is entered in the date field, then automatically change the associated flag to blank; if a numeric associated flag code is selected/entered, then automatically change the date to blank

If the date is changed, it is now later* than Date of Last Contact, and Vital Status is alive (1), then automatically update Date of Last Contact with the new date and reset Date of Last Contact Flag to blank (this update applies to the patient's Date of Last Contact and Vital Status for a Tumor Level change and to the patient and admission's Date of Last Contact and Vital Status for an Admission level change). Date of Initial RX SEER and Date of Initial RX Flag may also need to be changed (See Date Initial RX SEER UPDATE section).

*** With year, month, and/or day potentially blank, a completely known date could appear to be later because it is a larger number than a partial later date. Thus, to test for the latest date among known full or partial dates, use these tests in this order:

- If one of the known dates' years is later than (greater than) the other date's year being compared or if it is the only known year/date, then that date is the latest known date
- If multiple known dates have the same latest year, but only one of them has a latest known month, then that is the latest known date
- If multiple known dates have the same latest year & month, but only one of them has a latest known day, then that is the latest known date

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

	None

RX Date Radiation Flag

IDENTIFIERS

CCR ID	NAACCR ID
E1315	1211

DESCRIPTION

This flag explains why there is no appropriate value in the corresponding date field, RX Date Radiation. This data item was added to NAACCR Version 12 (effective January 2010).

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown whether any radiation therapy
11	No proper value is applicable in this context (e.g., no radiation therapy administered; autopsy only case).
12	A proper value is applicable but not known. This event occurred, but date is unknown (e.g., date radiation administere
15	Information is not available at this time, but it is expected that it will be available later (e.g., radiation therapy
Blank	A valid date value is provided in item RX Date-Radiation [1210], or the date was not expected to have been transmitted

SOURCE

If the record version is version 12 or later, then upload with no conversion.
If the record version is earlier than 12, then follow the conversion specs - Eureka Process Specification: 2010 Data Conversions.

UPDATE

See RX Date Radiation

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

2010	New data item added for 2010 data changes. This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.
05/2013	Name changed from RX Date--Radiation Flag to RX Date Radiation Flag
03/2020	Added back to Volume III

RX Date Surgery

IDENTIFIERS

CCR ID	NAACCR ID
E1308	1200

DESCRIPTION

Date definitive surgery was first performed.

LEVELS

Tumors, Admissions

LENGTH

8

ALLOWABLE VALUES

A valid, complete date in YYYYMMDD, after the registry began and no later than current date. (Computer generated date).

General Date Editing Rules:

- Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD). Month and day must have leading zeros for values 01...09.
- The following date format is allowed:

  CCYYMMDD Century+Year, Month and Day are provided.
- Dates are checked first to ensure they conform to one of these formats, then for errors in the components. Checking stops on the first non-valid situation.

Range checking:

- Lowest allowed value: January 1, 1850 (or in D1 format: 18500101)
- Highest allowed value: current system date
- The month is checked to ensure it falls within range 01...12.
- The day is checked to ensure it falls within range for that specific month. Accommodation is made for leap years.

SOURCE

If the record version is NAACCR version 12 (120 in original new case) or later, then upload the date and its associated flag value with no conversion.

Otherwise, if the record version is earlier than 12, then perform the following conversions in this order:

1. Right-justify and zero-fill the date to 8 digits.
2. Convert MMDDYYYY to YYYYMMDD.
3. Convert Date of Last Contact and Date of Last Contact Flag in the same manner as described in the Eureka Process Specification: 2010 Data Conversions document.

If steps 1 and 2 are the only changes made to the date, then DO NOT record them in the audit log.

UPDATE

TUMOR LEVEL

NEW CASE CONSOLIDATION

If the tumor's consolidated Date of Diagnosis year is 2003 or later, and all the following conditions are true:

- The admission shows surgery was given
- The Admission's RX Summ--Surg Prim Site = 10-90, or
- the Admission's RX Summ--Scope Reg LN Sur = 1-7, or
- the Admission's RX Summ--Surg Oth Reg-Dis = 1-5

- Either of the following conditions are true
- All three of the admission summary surgery codes match the corresponding tumor codes
- None of the corresponding tumor values show that surgery was given
- Any of the following conditions are true:
- The Admission's RX Date Surgery contains a full or partial date and the Tumor's RX Date Surgery is blank
- The Admission's RX Date Surgery Flag shows that surgery was given but we don't know when (code 12) and the Tumor's RX Date Surgery Flag does NOT show that surgery was given (codes 10, 11)
- Any part of the Tumor's RX Date Surgery is blank, that same part of the Admission's RX Date Surgery is entered, and other entered parts are equal
  Then automatically update the five surgery summary tumor values with the corresponding admission values:
  - RX Date Surgery **
  - RX Date Surgery Flag
  - RX Summ--Surg Prim Site
  - RX Summ--Scope Reg LN Sur
  - RX Summ--Surg Oth Reg-Dis

Otherwise, if any of the above five surgery values are different between admission and tumor, then list both sets of values for review.

If the tumor's consolidated Date of Diagnosis year is earlier than 2003, and all of the following conditions are true:

- The admission shows surgery was given
- (The Admission's RX Summ--Surg Site 98-02 = 10-90, or
- The Admission's RX Summ--Scope Reg 98-02 = 1-6, or
- The Admission's RX Summ--Surg Oth 98-02 = 1-8)
- Either of the following conditions are true
- All three of the admission 98-02 summary surgery codes plus RX Summ--Reg LN Examined and RX Summ--Reconstruct 1st match the corresponding tumor values
- None of the three corresponding 98-02 summary surgery tumor codes show that surgery was given
- Any of the following conditions are true:
- The Admission's RX Date Surgery contains a full or partial date and the Tumor's RX Date Surgery is blank
- The Admission's RX Date Surgery Flag shows that surgery was given but we don't know when (code 12) and the Tumor's RX Date Surgery Flag does NOT show that surgery was given (codes 10, 11)
- Any part of the Tumor's RX Date Surgery is blank, that same part of the Admission's RX Date Surgery is entered, and other entered parts are equal
  Then automatically update these surgery summary tumor values with the corresponding admission values:
- RX Date Surgery**
- RX Date Surgery Flag
- RX Summ--Surg Site 98-02
- RX Summ--Scope Reg 98-02
- RX Summ--Surg Oth 98-02
- RX Summ--Reg LN Examined
- RX Summ--Reconstruct 1st

If RX Summ--Surg Site 98-02, RX Summ--Scope Reg 98-02, or RX Summ--Reconstruct 1st were changed, then

- Perform automatic 2003 Surgery to the Primary Site conversion according to Appendix 28-Surgery to the Primary Site Conversion Table for 2003 Data Changes which is based on the 'Surgical Procedure of Primary Site and Surgical Procedure of Primary Site at this Facility' conversion specifications in

Commission on Cancer, Cancer Registry Data Conversion Rules: ROADS 1998-2000-FORDS, FORDS-ROADS 1998-2000, (see CoC website for the most current revision version), and

- Automatically update RX Summ--Surg Prim Site

If either RX Summ--Scope Reg 98-02 or RX Summ--Reg LN Examined were changed, then

- Automatically convert a new RX Summ--Scope Reg LN Sur value according to the conversion table described under RX Summ--Scope Reg LN Sur (UPDATE section)

If RX Summ--Surg Oth 98-02 was changed, then

- Automatically convert a new RX Summ--Surg Oth Reg-Dis value according to the conversion table described under RX Summ--Surg Oth Reg-Dis (UPDATE section)

Otherwise, if any of the seven surgery values listed in step 1 are different between admission and tumor, then

- List both sets of values for review.

MANUAL CHANGE*,**

ADMISSION LEVEL

MANUAL CHANGE OR CORRECTION APPLIED TO DATE OR ITS ASSOCIATED DATE FLAG*, **

MANUAL CHANGE OR CORRECTION/UPDATE APPLIED TO DATE SURG PROC (1-3):

If Date Surg Proc 1, Date Surg Proc 1 Flag, Date Surg Proc 2, Date Surg Proc 2 Flag, Date Surg Proc 3, Date Surg Proce 3 Flag or Type of Reporting Source are changed, then

- Compare them with RX Date Surgery and RX Date Surgery Flag to generate the best RX Date Surgery and RX Date Surgery Flag values using the following rules, executed in order and stopped when one of the numbered conditions is true*,**:

1. If Type of Reporting Source is 7 (DC only), then
   Set RX Date Surgery to blank and RX Date Surgery Flag to 10.
2. If Type of Reporting Source is 6 (Autopsy only), then
   Set RX Date Surgery to blank and RX Date Surgery Flag to 11.
3. If all four dates are blank, then
   Set the best RX Date Surgery Flag value according to this hierarchy: 12, 11, 10, blank.
4. Otherwise, set RX Date Surgery Flag to blank and compare all fully known or partially known surgical procedure dates and RX Date Surgery and set RX Date Surgery to the earliest**** of these known dates.

*If a full or partial date is entered in the date field, then

- Automatically change the associated flag to blank

If a numeric associated flag code is selected/entered, then

- Automatically change the date to blank

If the date is changed, it is now later* than Date of Last Contact, and Vital Status is alive(1), then

- Automatically update Date of Last Contact with the new date and reset Date of Last Contact Flag to blank (this update applies to the patient's Date of Last Contact and Vital Status for a Tumor Level change and to the patient and admission's Date of Last Contact and Vital Status for an Admission level change). Date of Initial RX SEER and Date of Initial RX Flag may also need to be changed (See Date of Initial RX SEER UPDATE section).

*** WITH YEAR, MONTH, AND/OR DAY POTENTIALLY BLANK, A COMPLETELY KNOWN DATE COULD APPEAR TO BE LATER BECAUSE IT IS A LARGER NUMBER THAN A PARTIAL LATER DATE. THUS, TO TEST FOR THE LATEST DATE AMONG KNOWN FULL OR PARTIAL DATES, USE THESE TESTS IN THIS ORDER:

1. If one of the known dates' years is later than (greater than) the other date's year being compared or if it is the only known year/date, then
   That date is the latest known date
2. If multiple known dates have the same latest year, but only one of them has a latest known month, then
   That is the latest known date

3. If multiple known dates have the same latest year & month, but only one of them has a latest known day, then
   That is the latest known date

**** WITH YEAR, MONTH AND/OR DAY POTENTIALLY BLANK, A DATE WITH A PARTIAL BUT LATER DATE COULD APPEAR TO BE EARLIER BECAUSE IT IS A SMALLER NUMBER THAN A FULL EARLIER DATE. THUS, TO TEST FOR THE EARLIEST AMONG KNOWN DATES, USE THESE TESTS IN THIS ORDER:

1. If one of the known dates' years is earlier than (less than) the rest of the known date's year or if it is the only known year/date, then
   That date is the earliest known date
2. If multiple known dates have the same earliest year, but only one of them has an earliest known month, then
   That is the earliest known date
3. If multiple known dates have the same earliest year & month, but only one of them has an earliest known day, then
   That is the earliest known date
4. Otherwise, if two or more of the dates are the same earliest full or partial date, then
   That date is the earliest date

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

05/2001	Modified update 3); added update 4) to address incorrect date being added to the database.
07/2001	Added "AB-" prefix to CLASS-OF-CASE check in update item 3) and removed item 4) (checking for class 3 and doing nothing) because it was not necessary.
03/2003	Added the surgery 98_02 fields to Interfield edits 5) and 6) and removed inter-record edit between tumor and admissions (not performed in central system). Allowable Values changed for DC Only cases to code 9's instead of 0's. Added logic to Interfield edit 2) and 6) for DC Only cases.
03/2004	Removed IF 1) and 2) to relax edit due to edit standard differences between the College and SEER. Removed IF 7) and Admission Update logic that pertains to Proc 1-3.
06/2004	Added 98 to Surg_Prim_Sum values for cases dx > 20029999 for IF #382.
01/2007	Reinstated Update logic which updates Date Surg when Date Surg Proc1-3 is changed.
2010	Data Changes: Revised Allowable Values and Source information to match NAACCRv12 date scheme. CCR name (Date-Surg) changed to NAACCR name. Added IF #925
07/2011	General Date Editing Rules and Range Checking updated for additional clarity. However, the intent of the date rules remain the same as the 2010 update.
05/2013	Name changed from RX Date--Surgery to RX Date Surgery
03/2020	Added back to Volume III

RX Date Surgery Flag

IDENTIFIERS

CCR ID	NAACCR ID
E1309	1201

DESCRIPTION

This flag explains why there is no appropriate value in the corresponding date field, RX Date Surgery [1200].
This data item was added to NAACCR Version 12 (effective January 2010).

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if any surgical procedure was performed).
11	No proper value is applicable in this context (e.g., no surgical procedure was performed; autopsy only case).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., surgery was performed but the date is unknown).
Blank	A valid date value is provided in item Date-Surgery, or the date was not expected to have been transmitted.

SOURCE

If the record version is version 12 or later, then upload with no conversion.
If the record version is earlier than 12, then follow the conversion specs - Eureka Process Specification: 2010 Data Conversions.

UPDATE

See RX Date Surgery

CONSOLIDATED DATA EXTRACT

Yes

LIST FOR REVIEW

Text

HISTORICAL CHANGES

2010	New data item for 2010 data changes.
05/2013	Name changed from RX Date--Surgery Flag to RX Date Surgery Flag

RX Date Systemic

IDENTIFIERS

CCR ID	NAACCR ID
E1318	3230

DESCRIPTION

Records the date of initiation for systemic therapy that is part of first course of treatment. Systemic therapy is considered chemotherapy agents, hormonal agents, biological response modifiers, bone marrow transplants, stem cell harvests, and surgical and/or radiation endocrine therapy

LEVELS

Admissions, Tumors

LENGTH

8

ALLOWABLE VALUES

General Date Editing Rules

Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD). Month and day must have leading zeros for values 01...09.

The following date formats are allowed:

- CCYYMMDD Century+Year, Month and Day are provided.
- CCYYMM__ Century+Year and Month. Day consists of two blank spaces.
- CCYY____ Century+Year. Month and Day consist of four blank spaces.

Dates are checked first to ensure they conform to one of these formats, then for errors in the components. Checking stops on the first non-valid situation.

Range Checking:

- Lowest allowed value: January 1, 1850 (or in D1 format: 18500101)
- Highest allowed value: current system date
- When month is known, it is checked to ensure it falls within range 01...12.
- When month and day are known, day is checked to ensure it falls within range for that specific month. Accommodation is made for leap years.

SOURCE

After all the input dates and flags have been loaded or converted and loaded (depending on the record version), perform steps 1 – 4 in the UPDATE section, Tumor Level, New Case Consolidation to generate this date and its associated date flag, rather than loading vendor values which may or may not be generated in the same way.

UPDATE

TUMOR LEVEL

NEW CASE CONSOLIDATION

(Perform after chemo, hormone, BRM, and Transp Endo consolidations)

If RX Date Chemo, RX Date Chemo Flag, RX Date Hormone, RX Date Hormone Flag, RX Date BRM, RX Date BRM Flag, RX Date--Transplnt Endocr, RX Date--Transplnt Endocr Flag, or Type of Reporting Source are changed, then

- Compare them to generate RX Date Systemic and RX Date Systemic Flag values according to these consolidation rules, executed in order and stopped when one of the numbered conditions is true:

1. If Type of Reporting Source is 7 (DC only), then
   Set RX Date Systemic to blank and RX Date Systemic Flag to 10.
2. If Type of Reporting Source is 6 (Autopsy only), then
   Set RX Date Systemic to blank and RX Date Systemic Flag to 11.
3. If all four dates are blank, then
   Set RX Date Systemic to blank and consolidate RX Date Systemic Flag by comparing all the individual input date flags and determine the best value according to this hierarchy: 12, 15, 10, 11, blank.
4. Otherwise, set RX Date Systemic Flag to blank and compare all fully known or partially known dates and set RX Date Systemic to the earliest* one.
   Manual Change to RX Date Chemo, RX Date Chemo Flag, RX Date Hormone, RX Date Hormone Flag, RX Date BRM, RX Date BRM Flag, RX Date--Transplnt Endocr, RX Date--Transplnt Endocr Flag, or Type of Reporting Source:
   Regenerate according to above New Case Consolidation rules.

ADMISSION LEVEL

Manual change or correction/update applied to RX Date Chemo, RX Date Chemo Flag, RX Date Hormone, RX Date Hormone Flag, RX Date BRM, RX Date BRM Flag, RX Date--Transplnt Endocr, RX Date--Transplnt Endocr Flag, or Type of Reporting Source:
Regenerate according to above New Case Consolidation rules.
* With year, month and/or day potentially blank, a date with a partial but later date could appear to be earlier because it is a smaller number than a full earlier date. Thus, to test for the earliest among known dates, use these tests in this order:

1. If one of the known dates' years is earlier than (less than)
   The rest of the known dates' years or if it is the only known year/date, then that date is the earliest known date
2. If multiple known dates have the same earliest year, but only one of them has an earliest known month, then
   That is the earliest known date
3. If multiple known dates have the same earliest year & month, but only one of them has an earliest known day, then
   That is the earliest known date
4. Otherwise, if two or more of the dates are the same earliest full or partial date, then
   That date is the earliest date

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

03/2003	New data item requirement for cases diagnosed January 1, 2003 forward.
03/2004	Removed conversion instruction from SOURCE for Version 9 records. See Use Case 22.
01/2005	Allowable Values, Source requirements, and Update logic, changed to handle 88888888 as a valid date.
2010	2010 Data Changes: Updated Allowable Values, Source and Update logic for new NAACCR date specs. CCR name (Date_Systemic) to match NAACCR name. Added IF #891, 926.
12/2010	Updated Source and Step 3 in Update logic to reflect flag hierarchy (changed hierarchy of flags--was 12, 11, 15, 10, blank).
07/2011	General Date Editing Rules and Range Checking updated for additional clarity. However, the intent of the date rules remains the same as the 2010 update.
05/2013	Name changed from RX Date--Systemic to RX Date Systemic

RX Date Systemic Flag

IDENTIFIERS

CCR ID	NAACCR ID
E1319	3231

DESCRIPTION

This flag explains why no appropriate value is in the corresponding date field, RX Date--Systemic [3230]. This data item was added to NAACCR Version 12 (effective January 2010). Prior to Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if systemic therapy was administered).
11	No proper value is applicable in this context (e.g., no systemic therapy was administered; autopsy only case).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., systemic therapy administered but date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (e.g., systemic therapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow-up).
Blank	A valid date value is provided in item RX Date--Systemic, or the date was not expected to have been transmitted.

SOURCE

If the record version is version 12 or later, then upload with no conversion.
If the record version is earlier than 12, then follow the conversion specs - Eureka Process Specification: 2010 Data Conversions.

UPDATE

See RX Date Systemic

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

2010	New data item added for 2010 data changes.

RX Date Transp Endo

IDENTIFIERS

CCR ID	NAACCR ID
E1619	None. State Requestor

DESCRIPTION

Date that the Transplant/Endocrine procedure was done.

LEVELS

Tumor
Admission

LENGTH

8

ALLOWABLE VALUES

General Date Editing Rules:
Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD). Month and day must have leading zeros for values 01...09.
The following date formats are allowed:
CCYYMMDD Century+Year, Month and Day are provided.
CCYYMM__ Century+Year and Month. Day consists of two blank spaces.
CCYY____ Century+Year. Month and Day consist of four blank spaces.
Dates are checked first to ensure they conform to one of these formats, then for errors in the components. Checking stops on the first non-valid situation.
Range Checking:
Lowest allowed value: January 1, 1850 (or in D1 format: 18500101)
Highest allowed value: current system date
When month is known, it is checked to ensure it falls within range 01...12.
When month and day are known, day is checked to ensure it falls within range for that specific month. Accommodation is made for leap years.

SOURCE

If the record version is version 12 or later, then upload with no conversion.
If the record version is earlier than 12, then perform the following conversions in this order:

1. Right-justify and zero-fill the date to 8 digits.
2. Convert MMDDYYYY to YYYYMMDD.
3. Convert Date of Last Contact and Date of Last Contact Flag in the same manner as described in the Eureka Process Specification: 2010 Data Conversions document.

If steps 1 and 2 are the only changes made to the date, then DO NOT record them in the audit log.UPDATE Tumor Level
New Case Consolidation:
If all of the following conditions are true:
the Admission shows that transplant/endocrine therapy was given (RX Summ--Transplnt/Endocr = 10, 11, 12, 20, 30, or 40)
either of the following conditions are true:
the Admission & Tumor RX Summ--Transplnt/Endocr codes are the same

the Tumor's RX Summ--Transplnt/Endocr code shows that no transplant/endocrine therapy was given

any of the following conditions are true:

the Admission's RX Date--Transplnt/Endocr contains a full or partial date and the Tumor's RX Date--Transplnt/Endocr is blank

the Admission's RX Date--Transplnt/Endocr Flag shows that treatment occurred but we don't know when (code 12) and the Tumor's RX Date--Transplnt/Endocr Flag does NOT show that treatment occurred (codes 10, 11, 15)

Any part* of the Tumor's RX Date--Transplnt/Endocr is blank, that same part of the Admission's RX Date--Transplnt/Endocr is entered, and other entered parts are equal

Then automatically consolidate

the Admission's RX Date--Transplnt/Endocr into the Tumor's RX Date--Transplnt/Endocr**

the Admission's RX Date--Transplnt/Endocr Flag into the Tumor's RX Date--Transplnt/Endocr Flag

the Admission's RX Summ--Transplnt/Endocr into the Tumor's RX Summ--Transplnt/Endocr

Otherwise, if any of the above three transplant/endocrine therapy summary values differ between the admission and tumor, then

List both sets of summary codes, dates, & flag codes for review

Manual Change*, **

Admission Level

Manual Change or Correction applied to date or its associated date flag*, **

*If a full or partial date is entered in the date field, then automatically change the associated flag to blank; if a numeric associated flag code is selected/entered, then automatically change the date to blank

If the date is changed, it is now later* than Date of Last Contact, and Vital Status is alive (1), then automatically update Date of Last Contact with the new date and reset Date of Last Contact Flag to blank (this update applies to the patient's Date of Last Contact and Vital Status for a Tumor Level change and to the patient and admission's Date of Last Contact and Vital Status for an Admission level change). RX Date--Systemic and RX Date--Systemic Flag and Date of Initial RX--SEER and Date of Initial RX Flag may also need to be changed (See RX Date--Systemic and Date of Initial RX--SEER UPDATE sections).

*** With year, month, and/or day potentially blank, a completely known date could appear to be later because it is a larger number than a partial later date. Thus, to test for the latest date among known full or partial dates, use these tests in this order:

- If one of the known dates' years is later than (greater than) the other date's year being compared or if it is the only known year/date, then that date is the latest known date
- If multiple known dates have the same latest year, but only one of them has a latest known month, then that is the latest known date
- If multiple known dates have the same latest year & month, but only one of them has a latest known day, then that is the latest known date

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/26/03	New data item requirement for cases diagnosed January 1, 2003 forward.

3/03/04	Conversion specifications updated 3) 4) and 5) in Source to remove dates from Date_Horm and Date_Immuno when treatment codes moved to Transp/Endo fields. Removed conversion instructions from SOURCE for Version 9 records. See Use Case 22. Update logic rewritten.
1/19/05	Allowable Values, Source requirements, Update logic, and Interfield Edits changed to handle 8888888 as a valid date.
2010	Data Changes: CCR name (Date Transp Endo) changed to match NAACCR name. Revised Allowable Values, Update and Source information to match NAACCRv12 date scheme. IF #836 added.
7/8/11	General Date Editing Rules and Range Checking updated for additional clarity. However, the intent of the date rules remains the same as the 2010 update.

RX Date Transp Endo Flag

IDENTIFIERS

CCR ID	NAACCR ID
E1620	None. State Requestor

DESCRIPTION

The Date of Transplant/Endocrine Flag explains why there is no corresponding date in the related field, Date of Transplant/Endocrine Procedure.
From January 1, 2010 forward, this field accommodates non-date information that had previously been transmitted in date fields.
Until December 31, 2009, date fields included codes which provided information other than dates.

LEVELS

Tumor
Admission

LENGTH

2

ALLOWABLE VALUES

10	Unknown if *Transplant/Endocrine Procedure* performed (*Date of Transplant/Endocrine Procedure* is unknown and procedure code is 99)
11	Procedure was not performed
12	Procedure was performed (codes 10-40) but *Date of Transplant/Endocrine Procedure* is unknown
15	Procedure is planned (procedure code is 88)
Blank	A valid date value is provided in item *Date of Transplant/Endocrine*, or the date was not expected to have been transmitted

SOURCE

If the record version is version 12 or later, then upload with no conversion.
If the record version is earlier than 12, then follow the conversion specs - Eureka Process Specification: 2010 Data Conversions.

UPDATE

See RX Date--Transplnt Endocr

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

2010	New data item added for 2010 data changes.

RX Hosp--Chemo

IDENTIFIERS

CCR ID	NAACCR ID
E1101	700

DESCRIPTION

Identifies the type of chemotherapy given as first course of treatment for the reportable tumor at the reporting facility. If chemotherapy not given, codes are provided that record the reason.

LEVELS

Admissions

LENGTH

2

ALLOWABLE VALUES

00	None, chemotherapy was not part of the first course of therapy or there was progression of disease prior to administration; Not customary therapy for this cancer. Diagnosed at autopsy.
01	Chemotherapy NOS (Chemotherapy was administered, but type and number of agents is not documented in patient record)
02	Single agent
03	Multiple agents
82	Contraindicated Chemotherapy was not recommended/administered because it was contraindicated due to patient risk factors (comorbid conditions, advanced age) or there was progression of disease prior to planned administration.
85	Patient died (Chemotherapy was not administered because the patient died prior to planned or recommended therapy)
86	Recommended, not given (Chemotherapy was recommended by the patient's physician, but was not administered as part of first course therapy. No reason was stated in the patient record)
87	Refused (Chemotherapy was not administered. It was recommended by the patient's physician, but was refused by the patient, or the patient's family or guardian. The refusal was noted in the patient record)
88	Recommended, unknown if given
99	It is unknown whether chemotherapy was recommended or administered because it is not stated inpatient record. Death certificate-only case

SOURCE

If new case record version is A or later, then load from C/N# F03374 and right-justify and zero-fill the two-digit value.

UPDATE

Manual Change or Correction Applied (change may require update to RX Summ--Chemo)

CONSOLIDATED DATA EXTRACT

Yes; blank until multiple admissions sent to CCR.

HISTORICAL CHANGES

3/26/03	C/N source number has changed from C/N #F00052 to F03374. Definition changed as now Reason No Chemo is included in the codes. Length changed to 2. Allowable values changed. Removed Interfield edit since this edit is already performed in the Chemo_Sum field. Historically (before 2003), this was a 1-character field with the following codes: 0 None 1 Yes, NOS 2 Single agent 3 Multiple agent 9 Unknown (DC only) The cases prior to Coding Procedure 21 will be converted to these new codes. Refer to the Commission on Cancer, Cancer Registry Data Conversion Rules: ROADS 1998-2000--FORDS, FORDS--ROADS 1998-2000, (see CoC website for the most current revision version).
3/3/04	Added autopsy cases text to code 00 for clarity. Removed conversion instructions from SOURCE for Version 9 records. See Use Case 22.
2010	Data Changes: CCR name (Chemo_Hosp) changed to NAACCR name.

RX Hosp--DX/Stg Proc

IDENTIFIERS

CCR ID	NAACCR ID
E1105	740

DESCRIPTION

Diagnostic or staging procedure was performed at this hospital.

LEVELS

Admissions

LENGTH

2

ALLOWABLE VALUES

Generic Definitions

00	No surgery
01-07	Non-definitive surgery only
09	Unknown if surgery performed (DC Only)

Specific Definitions

00	No surgical diagnostic or staging procedure was performed.
01	A biopsy (incisional, needle, or aspiration) was done to a site other than the primary site. No exploratory procedure was done.
02	A biopsy (incisional, needle, or aspiration) was done of the primary site.
03	A surgical exploratory only. The patient was not biopsied or treated during the procedure.
04	A surgical procedure with a bypass was performed, but no biopsy was done.
05	An exploratory procedure was performed, and a biopsy of either the primary site or another site was done.
06	A bypass procedure was performed, and a biopsy of either the primary site or another site was done.
07	A procedure was done, but the type of procedure is unknown.
09	No information about whether a diagnostic or staging procedure was performed.

SOURCE

If new case record version is A or later, then load from C/N # F00421 and right-justify and zero-fill the two-digit value.

UPDATE

Manual Change or Correction Applied (change may require update to RX Summ--DX/Stg Proc)

CONSOLIDATED DATA EXTRACT

Yes, blank until one record per admission is sent.

HISTORICAL CHANGES

5/15/01	Name changed from SURG-HOSP-NCD by Commission on Cancer.
3/26/03	Data item name changed from DX_St_Pall_Hosp to DX_Stg_Hosp to remove the palliative aspect to this field.

3/03/04	Removed conversion instructions from SOURCE for Version 9 records. See Use Case 22.
2010	Data Changes: CCR name (DX Stg Hosp) changed to NAACCR name.

RX Hosp--Hormone

IDENTIFIERS

CCR ID	NAACCR ID
E1102	710

DESCRIPTION

Records whether systemic hormonal agents were given as first course of treatment at this facility, or the reason they were not given.

LEVELS

Admissions

LENGTH

2

ALLOWABLE VALUES

00	None, diagnosed at autopsy
01	Hormones given
82	Contraindicated
85	Patient died
86	Recommended, not given
87	Refused
88	Recommended, unknown if given
99	Unknown, death certificate only (DCO)

SOURCE

If new case record version is A or later, then load from C/N # F03378 and right-justify and zero-fill the two-digit value.

UPDATE

Manual Change or Correction Applied (change may require update to RX Summ--Hormone)

CONSOLIDATED DATA EXTRACT

HISTORICAL CHANGES

	None

RX Hosp--Scope Reg LN Sur

IDENTIFIERS

CCR ID	NAACCR ID
E1079	672

DESCRIPTION

Records the removal, biopsy, or aspiration of regional lymph nodes performed at the reporting facility for diagnosis and/or staging or as a part of the first course of treatment at the reporting facility.

LEVEL

Admission

LENGTH

1 N

ALLOWABLE VALUES

0	No regional lymph nodes removed. No lymph nodes found in the pathologic specimen. Diagnosed at autopsy.
1	Biopsy or aspiration of regional lymph node, NOS.
2	Sentinel lymph node biopsy.
3	Regional lymph node(s) removed and the number of nodes removed is unknown or not stated; the procedure is not specified as sentinel node biopsy. Regional lymph nodes removed, NOS.
4	1 to 3 regional lymph nodes removed.
5	4 or more regional lymph nodes removed.
6	Sentinel node biopsy and code 3, 4, or 5 at same time or timing not stated.
7	Sentinel node biopsy and code 3, 4, or 5 at different times.
9	Unknown or not applicable. It is unknown whether regional lymph node surgery was performed. Death certificate only case; unknown or ill-defined primary site; hematopoietic, reticuloendothelial, immunoproliferative or myeloproliferative disease.

SOURCE

Upload with no conversion.

UPDATE

Manual Change or Correction Applied (change may require update to RX Summ-- Scope Reg LN Sur)

CONSOLIDATED DATA EXTRACT

No

HISTORICAL CHANGES

3/3/4	Data item added to Coding Procedure 22. This data item will need to be populated with values for cases prior to CP 22.
2010	CCR name (Scope LN Hosp) changed to NAACCR name.

RX Hosp--Surg Oth Reg/Dis

IDENTIFIERS

CCR ID	NAACCR ID
E1098	674

OWNER

CoC

DESCRIPTION

Records the surgical removal of distant lymph nodes or other tissue(s)/organ(s) beyond the primary site performed at this facility as a part of first course of treatment.

LEVEL

Admission

LENGTH

1 N

ALLOWABLE VALUES

0	None; no non-primary site resection was performed. Diagnosed at autopsy.
1	Non-primary surgical procedure performed, unknown if whether site is regional or distant.
2	Non-primary surgical procedure to other regional sites.
3	Non-primary surgical procedure to distant lymph node(s).
4	Non-primary surgical procedure to distant site.
5	Any combination of codes 2, 3, or 4.
9	Unknown; it is unknown whether any surgical procedure of a non-primary site was performed. Death Certificate Only

SOURCE

Upload with no conversion.

UPDATE

Manual Change or Correction Applied (change may require update to RX Summ--Surg Oth Reg-Dis)

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/3/4	Data item added to Coding Procedure 22. This data item will need to be populated with values for cases prior to CP 22.
2010	CCR name (Surg Other Shop) changed to NAACCR name.
05/2016	Per NAACCR v16, updated description to match NAACCR, including replacement of the term “hospital” with “facility” to accommodate EHR reporting.

RX Hosp--Surg Prim Site

IDENTIFIERS

CCR ID	NAACCR ID
E1096	670

DESCRIPTION

Describe surgical procedures used to treat the primary site of the reportable tumor. This item records that portion of the first course of treatment given at the reporting facility.

LEVEL

Admission

LENGTH

2

ALLOWABLE VALUES

Surgically treated. (Not all codes apply to every site - see Site interfield edits.) See Appendix 20B

00	None. No surgical procedure of primary site. Diagnosed at autopsy.
10-19	Definitive surgery to the primary site Site-specific codes; tumor destruction; No pathologic specimen produced.
20-80	Site-specific codes. Resection. Path specimen produced.
90	Surgery, NOS; surgical treatment of the primary site was done, but no information on the type of procedure is provided.
98	Site specific codes; special. Special codes for hematopoietic/reticuloendothelial/immunoproliferative/ myeloproliferative disease, ill-defined site, & unknown primaries. Code 98 takes precedence over 00.
99	Unknown. Patient record does not state whether surgical treatment of the primary site was performed, and no information is available. Death certificate-only.

SOURCE

Upload with no conversion.

UPDATE

Manual Change or Correction Applied (change may require update to RX Summ--Surg Prim Site)

CCR DATA EXTRACT

No

HISTORICAL CHANGES

	None

RX Hosp--Transplnt-Endocr

This edit has also been named **RX Hosp Transplnt/Endocr** in this volume. However, Transp Endo Hosp is the name that will be used for 2012.

IDENTIFIERS

CCR ID	NAACCR ID
E1621	None: State Requestor

DESCRIPTION

Identifies systemic therapeutic procedures given as part of first course of treatment at this facility or the reason they were not used. These include bone marrow transplants, stem cell harvests, and surgical and radiation endocrine therapy

LEVEL

Admission

LENGTH

1

ALLOWABLE VALUES

00	None, diagnosed at autopsy
10	Bone marrow transplant NOS
11	Bone marrow transplant autologous
12	Bone marrow transplant allogeneic
20	Stem cell harvest and infusion
30	Endocrine surgery and/or endocrine radiation therapy
40	Code 30 in combo with 10, 11, 12 or 20
82	Contraindicated
85	Patient died
86	Recommended, not given
87	Refused
88	Recommended, unknown if given
99	Unknown, death certificate-only cases

SOURCE

If the new case record version is A or later, then just load C/N #F03564 and right-justify and zero-fill.

UPDATE

Manual (Change may require update to RX Summ--Transplnt/Endocr).

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/26/03	New data item requirement for cases diagnosed January 1, 2003 and forward.
10/8/03	Added conversion table to Source.
3/3/04	Replaced conversion table in Source to fix conversion problems due to this field being converted incorrectly. Removed conversion instructions from SOURCE for Version 9 records. See Use Case 22. Added autopsy cases text to code 00 for clarity.

2010	Data Change: CCR name (Transp_Endo_Hosp) changed to match NAACCR name. Other data item names changed in Update.
1/9/12	CCR name (RX Hosp--Transplnt-Endocr) changed back to (Transp Endo Hosp), the original name. In the normal sequence, V2 provides the correct name of a data item and V3 is modified (later) to match. In this specific case, the process failed. The item was changed in V3, but was not changed in V2. The best solution is to return V3 to the original name, because a V2 change would impact the "already published) V2 and that impacts Eureka and vendor software teams. Thus, the data item is once again named Transp Endo Hosp. However, both names have been retained in the TOC and the TOC in both instances, points to this topic. Just in case someone actually remembers the 2011 mistaken name. Phew. I'm going home.

RX Query-Flag

IDENTIFIERS

This item is not in the exchange record (Volume II Appendices).
It appears to be a relic of the stone ages.

CCR ID	NAACCR ID
None	None

DESCRIPTION

This field is used by the regional registry for indicating the status of queries to physicians and other sources about the status of treatment which appears to be lacking from the treatment program for a specific case.

LEVEL

Tumor

LENGTH

4 N

ALLOWABLE VALUES

Any

SOURCE

Computer generate all zeroes.

UPDATE

Manually

CONSOLIDATED DATA EXTRACT

No

INTERFIELD EDITS

None

HISTORICAL CHANGES

	None

RX Summ--Reg LN Examined

IDENTIFIERS

CCR ID	NAACCR ID
E1344	1296

DESCRIPTION

Number of Regional Lymph Nodes identified in the pathology report during surgical procedure for cases diagnosed prior to January 1, 2003.

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

00	No regional lymph nodes examined
01	One regional lymph node examined
02	Two regional lymph nodes examined
90	Ninety or more regional lymph nodes examined
95	No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed.
96	Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97	Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98	Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99	Unknown; not stated; death certificate only
Blank	Date of Diagnosis is on or after January 1, 2003

SOURCE

Upload with no conversion.

UPDATE

Tumor Level

New Case Consolidation

See RX Date--Surgery, Update, New Case Consolidation requirements.

Manual change--may require change to RX Summ-Scope Reg LN Sur

Admission Level

Manual change or Correction Applied--may require change to RX Summ-Scope Reg LN Sur

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

1/1/98	Transp Endo Hosp New data item. Cases prior to 1/1/98 will have codes generated usingACoS'96-'98 specifications
3/26/03	This data item is no longer required for cases diagnosed January 1, 2003 forward. Information regarding the number of lymph nodes has been incorporated into the Scope_LN_Sum fields. Cases prior to January 1, 2003 will continue to be coded to meet SEER requirements. Removed Interfield edit 1) and Inter-record edits as they related to Surg_LN_EX_Proc. Removed references to Surg_LN_EX_Proc in update logic. Blank is an allowable value. Made Update logic pertain to cases diagnosed prior to January 1, 2003.
8/27/03	Added Interfield Edit (Err #468).
3/3/04	Rewrote Update logic. Corrected Type to X. Cases will be converted to blank for cases diagnosed 2003 and forward.
2010	Data Changes: CCR name (Surg_LN_EX_Sum) changed to NAACCR name.

RX Summ--BRM

IDENTIFIERS

CCR ID	NAACCR ID
E1347	1410

DESCRIPTION

Records immunotherapy given as first course of treatment at this and all other facilities. If it was not given, codes are provided that record the reason.

LEVELS

Admission, Tumor

LENGTH

2

ALLOWABLE VALUES

00	None, diagnosed at autopsy
01	Immunotherapy given
82	Contraindicated
85	Patient died
86	Recommended, not given
87	Refused
88	Recommended, unknown if given
99	Unknown, death certificate only (DCO)

SOURCE

If new case record version is A or later, then load from CCR identifier E1347, right-justify, and zero-fill the two-digit value.

UPDATE

Tumor Level

New Case Consolidation

See RX Date--BRM Update New Case Consolidation requirements.

Manual Change

Admission Level

Manual change or Correction Applied to RX Hosp--BRM

If all of the following conditions are true:

- RX Hosp--BRM is not the same as RX Summ--BRM
- RX Hosp--BRM is higher than RX Summ--BRM based on a hierarchy of 01, 82, 85, 86, 87, 88, 00, 99

Then automatically update RX Summ--BRM with the RX Hosp--BRM code.

Manual Change or Correction Applied

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/36/03	C/N source number changed from F00057 to F03375. Source conversion table added. Definition changed as now reason for no immunotherapy is included in the codes.

	Length changed to 2. Allowable values changed. Historically (before 2003), this was a 1-character field with the following codes: 0 No 1 Biological response modifier 2 Bone marrow transplant - autologous 3 Bone marrow transplant - allogenic 4 Bone marrow transplant, NOS 5 Stem cell transplant 6 Combination of 1 with any 2, 3, 4, or 5 7 Refused 8 Recommended 9 Unknown The database prior to Coding Procedure 21 will be converted to these new codes. Refer to the Commission on Cancer, Cancer Registry Data Conversion Rules: ROADS 1998-2000-FORDS, FORDS-ROADS 1998-2000, (see CoC website for the most current revision version). Changed interfield edits to two-digit codes and removed invalid codes. Rewrote Update logic to be consistent with Chemo_Sum wording.
3/3/04	Added IF 2) to match COC edit. Added autopsy cases text to code 00 for clarity. Changed Update logic see RX Date BRM. Removed conversion instructions from SOURCE for Version 9 records. See Use Case 22.
2010	Data Changes: CCR name (Immuno_Sum) changed to match NAACCR name. Rewrote Update logic.
2011	Added IF472 for CER project.

RX Hosp -- BRM

IDENTIFIERS

CCR ID	NAACCR ID
E1103	720

DESCRIPTION

Records immunotherapy given as first course of treatment at this facility. If it was not given, codes are provided that record the reason.

LEVELS

Admission

LENGTH

2

ALLOWABLE VALUES

00	None, immunotherapy was not part of the planned first-course of therapy; not customary therapy for this cancer. Diagnosed at autopsy
01	Immunotherapy administered as first course therapy.
82	Contraindicated (Immunotherapy was not recommended/administered because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, etc.) or there was progression of disease prior to administration.
85	Patient died (Immunotherapy was not administered because the patient died prior to planned or recommended therapy)
86	Recommended, not given (Immunotherapy was not administered. It was recommended by the patient's physician but was not administered as part of the first-course of therapy. No reason was noted in the patient record.)
87	Refused (Immunotherapy was not administered. It was recommended by the patient's physician but was refused by the patient or the patient's family or guardian. The refusal was noted in the patient record.
88	Immunotherapy was recommended, but it is unknown if it was administered.
99	It is unknown if immunotherapy was recommended or administered because it was not stated in the patient record. Death certificate-only case.

SOURCE

If new case record version is A or later,
Then load from C/N # F03376 and right- justify and zero-fill the two-digit value.

UPDATE

Manual Change or Correction Applied (change may require update to RX Summ--BRM)

CONSOLIDATED DATA EXTRACT

Yes; blank until multiple admissions sent to the CCR.

HISTORICAL CHANGES

03/2003	C/N source number changed from F00056 to F03376. Definition changed as now reason for no immunotherapy is included in the codes. Length changed to 2. Allowable values

	changed. Removed Interfield edit since this edit is already performed in the Immuno_Sum field. Historically (before 2003), this was a 1-character field with the following codes: 0 None 1 Biological response modifier 2 Bone marrow transplant - autologous 3 Bone marrow transplant - allogenic 4 Bone marrow transplant, NOS 5 Stem cell transplant 6 Combination of 1 with any 2, 3, 4, or 5 7 Refused 8 Recommended 9 Unknown (DC Only) The cases prior to Coding Procedure 21 will be converted to these new codes. Refer to the Commission on Cancer, Cancer Registry Data Conversion Rules: ROADS 1998-2000-FORDS, FORDS-ROADS 1998-2000, (see CoC website for the most current revision version).
03/2004	Added autopsy cases text to code 00 for clarity. Removed conversion instructions from SOURCE for Version 9 records. See Use Case 22.
2010	Data Changes: CCR name (Immuno Hosp) changed to match NAACCR name.
03/2020	Added back to Volume III

RX Hosp No Proc 1-3

IDENTIFIERS

CCR ID	NAACCR ID
E1605 E1606 E1607	None: State Requestor

DESCRIPTION

Records immunotherapy given as first course of treatment at this facility. If it was not given, codes are provided that record the reason.

LEVELS

Admission

LENGTH

3*10

ALLOWABLE VALUES

Valid hospital code numbers, see CA Hosp Codes, except that the following codes are not allowed in this field:

0000000000, 0000999993, 0000999997, 0000999998 and 0000999999.

In addition, these special codes are referred to in many other places in this document and are defined here for ease of reference.

0000000801	DC Only
0000000802	Coroner
0000000803	MD
0000000804	Conv Hosp
0000999990	Hospice
0000999991	Home Health
0000999992	Skilled Nursing Facility
0000999993	Staff Physician
0000999994	Unspec Noncal Hosp
0000999995	Non-Hospital Nos
0000999996	Physician Only
0000999997	Unspec Bay Area Hosp
0000999998	Unspec Calif Hosp
0000999999	Unknown Hosp

SOURCE

If the record version is A or later, then just load the transmitted values.

UPDATE

Manual update or Correction Applied. If changed and the admission is linked to a patient/tumor, also perform the Update rules for Hosp Surg Prim Sum, Surg Prim First, Date Surg Prim First, and Hosp Surg Prim First when the admission is reconsolidated.

CONSOLIDATED DATA EXTRACT

Yes. 10 digits per number, right-justified, zero-filled.

HISTORICAL CHANGES

01/1999	Changed source and transmit to CCR sections to process 15-digit numbers.
03/2003	Changed length, allowable values, source and CCR Data extract to process the 10-digit numbers.
03/2004	All edits removed. References to Appendix 2 removed. Removed conversion instructions from SOURCE for Version 9 records. See Use Case 22.
07/2005	Removed the Allowable Values reference (Volume One Appendix F) & reference is now to the current California hospital labels file on the CCR website.
01/2007	Added Update text.
03/2020	Added back to Volume III

RX Hosp -- Other

IDENTIFIERS

CCR ID	NAACCR ID
E1104	730

DESCRIPTION

Other therapy was given at this hospital.

LEVELS

Admission

LENGTH

1

ALLOWABLE VALUES

0	None
1	Other
2	Experimental
3	Double-blind study
6	Unproven methods
7	Refused
9	Unknown

SOURCE

If the transmitted value is numeric, then just load it with no conversion. Otherwise, convert it to 0 (zero).

UPDATE

Manual Change or Correction Applied (change may require update to RX Summ--Other)

CONSOLIDATED DATA EXTRACT

Yes; blank until multiple admissions sent to the CCR.

HISTORICAL CHANGES

2010	Data Changes: CCR name (Other_RX_Hosp) changed to NAACCR name.
03/2020	Added back to Volume III

RX Summ--Chemo

IDENTIFIERS

CCR ID	NAACCR ID
E1345	1390

DESCRIPTION

Identifies the type of chemotherapy given as first course of treatment at this and all other facilities. If chemotherapy not given, codes are provided that record the reason.

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

00	None, diagnosed at autopsy
01	Chemotherapy NOS
02	Single agent
03	Multiple agents
82	Contraindicated
85	Patient died
86	Recommended, not given
87	Refused
88	Recommended, unknown if given
99	Unknown, death certificate-only (DCO)

SOURCE

If new case record version is A or later, then load from C/N# F03373 and right-justify and zero-fill the two-digit value

UPDATE

Transp Endo HospTumor Level

New Case Consolidation

See RX Date--Chemo Update New Case Consolidation requirements.

Manual Change

Admission Level

Manual change or Correction Applied to RX Hosp--Chemo

If all of the following conditions are true:

- RX Hosp--Chemo is not the same as RX Summ--Chemo
- RX Hosp--Chemo is higher than RX Summ--Chemo based on a hierarchy of 03, 02, 01, 82, 85, 86, 87, 88, 00, 99

Then automatically update RX Summ--Chemo with the RX Hosp--Chemo code.

Manual Change or Correction Applied

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/26/03	C/N source number changed from F00053 to F03373. Definition changed as now Reason No Chemo is included in the codes. Length changed to 2. Allowable values changed. Source updated. Historically (before 2003), this was a 1-character field with the following codes: 0 None 1 Yes, NOS 2 Single agent 3 Multiple agent 9 Unknown The cases prior to Coding Procedure 21 will be converted to these new codes. Refer to the Commission on Cancer, Cancer Registry Data Conversion Rules: ROADS 1998-2000-FORDS, FORDS-ROADS 1998-2000, (see CoC website for the most current revision version). Update logic additions made to incorporate 2 digit and new codes and Tumor/ Admission Levels. Changed IF #631 to two-digit codes and added new codes. Removed Interfield edit 2) as Reason No Chemo field is no longer a data item.
8/27/03	Added code 87 to IF #631.
10/8/03	Added code 87 to Chemo_Sum 02 and 03 lines in IF #631.
3/3/04	Added (Err #471) to match CoC edit. Added autopsy cases text to code 00 for clarity. Changed Update logic, see RX Date Chemo. Removed conversion instructions from SOURCE for Version 9 records. See Use Case 22.
2010	Data Changes: CCR name (Chemo Sum) changed to NAACCR name. Rewrote Update logic. Added IF #891.
2011	Data Changes: IF 582 and IF889 added for CER Project.

RX Summ--DX/Stg Proc

IDENTIFIERS

CCR ID	NAACCR ID
E1339	1350

DESCRIPTION

Most extensive type of diagnostic or staging procedure performed during first course of treatment.

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

00	No surgery
01-07	Non-definitive surgery only
09	Unknown if surgery performed

SOURCE

If new case record version is A or later, then load from C/N #F00420 and right-justify and zero-fill the two-digit value.

UPDATE

Tumor Level

New Case Consolidation

If either of the following conditions are true:

- the admission's RX Summ--DX/Stg Proc is higher than the tumor's RX Summ--DX/Stg Proc according to this hierarchy:
  06, 05, 04, 03, 02, 01, 07, 00, 09
- the admission's RX Hosp--DX/Stg Proc is higher than the tumor's RX Summ--DX/Stg Proc according to this hierarchy:
  06, 05, 04, 03, 02, 01, 07, 00, 09

Then automatically update the tumor's RX Summ--DX/Stg Proc with the admission's RX Summ--DX/Stg Proc code.

Manual Change

Admission Level

Manual change or Correction Applied to RX Hosp--DX/Stg Proc

If RX Hosp--DX/Stg Proc is higher than RX Summ--DX/Stg Proc according to this hierarchy:
06, 05, 04, 03, 02, 01, 07, 00, 09,

Then automatically update RX Summ--DX/Stg Proc with the RX Hosp--DX/Stg Proc code.

Manual Change or Correction Applied

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

5/15/01	Name changed from SURG-SUM-NCD by Commission on Cancer.
3/26/03	Name changed from DX_St_Pall_Sum to DX_Stg_Sum. Added Source conversion table.

3/03/04	Removed conversion instructions from SOURCE for Version 9 records. See Use Case 22.
2010	2010 Data Changes: CCR name (DX_Stg_Sum) changed to NAACCR name.
05/2013	Added IF 1030, 1063

RX Summ--Hormone

IDENTIFIERS

CCR ID	NAACCR ID
E1346	1400

DESCRIPTION

Records whether systemic hormonal agents were administered as first-course treatment at any facility, or the reason they were not given. Hormone therapy consists of a group of drugs that may affect the long-term control of a cancer's growth. It is not usually used as a curative measure.

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

00	None, hormone therapy was not part of the planned first course of therapy
01	Hormones therapy administered as first course therapy
82	Hormone therapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age)
85	Hormone therapy was not administered because the patient died prior to planned or recommended therapy
86	Hormone therapy was not administered. It was recommended by the patient's physician, but was not administered as part of first-course therapy. No reason was stated in the patient record
87	Hormone therapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in the patient record
88	Hormone therapy was recommended, but it is unknown if it was administered
99	It is unknown whether a hormonal agent(s) was recommended or administered because it is not stated in the patient record. Death certificate-only cases

SOURCE

If new case record version is A or later, then load from C/N # F03377 and right-justify and zero-fill the two-digit value.

UPDATE

Tumor Level

New Case Consolidation

See RX Date--Hormone Update New Case Consolidation requirements.

Manual Change

Admission Level

Manual change or Correction Applied to RX Hosp--Hormone

If all of the following conditions are true:

- RX Hosp--Hormone is not the same as RX Summ--Hormone
- RX Hosp--Hormone is higher than RX Summ--Hormone based on a hierarchy of 01, 82, 85, 86, 87, 88, 00, 99

Then automatically update RX Summ--Hormone with the RX Hosp--Hormone code.

Manual Change or Correction Applied

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/26/03	C/N source number changed from F00055 to F03377. Definition changed as now reason for no hormone is included in the codes. Length changed to 2. Allowable values changed. Source conversion table added. Historically (before 2003), this was a 1-character field with the following codes: 0 None 1 Hormones 2 Endocrine Surgery (ES) and/or Endocrine Radiation (ER) 3 Hormones + ES and/or ER 9 Unknown The cases prior to Coding Procedure 21 will be converted to these new codes. Refer to the Commission on Cancer, Cancer Registry Data Conversion Rules: ROADS 1998-2000-FORDS, FORDS-ROADS 1998-2000, (see CoC website for the most current revision version). Moved Interfield edit 1) to the Transp_Endo_Sum field. Changed codes to two digits and added new codes to Interfield edit 2). Removed interfield edit 3) as Reason_No_Horm field is no longer a data item. Update logic rewritten.
8/27/03	Added code 87 to IF #632.
3/03/04	Added IF 2) to match COC edit. Changed Update logic, see RX Date Hormone. Added autopsy cases text to code 00 for clarity. Removed conversion instructions from SOURCE for Version 9 records. See Use Case 22.
2010	2010 Data Item Changes: CCR name (Horm Sum) to NAACCR name. Rewrote Update logic. Added IF #891.
8/2011	IF 474 and IF 898 added for 2011 as part of the CER project.
11/2015	Corrected field and code descriptions to match NAACCR.

RX Summ--Other

IDENTIFIERS

CCR ID	NAACCR ID
E1348	1420

DESCRIPTION

First course of treatment included other types of therapy

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

0	None
1	Other
2	Other Experimental
3	Other Double-blind study
6	Other Unproven
7	Refused
8	Recommended
9	Unknown; unknown if administered

SOURCE

If the transmitted value is numeric, then just load it with no conversion. Otherwise, convert it to 0 (zero).

UPDATE

Tumor Level

New Case Consolidation

See RX Date--Other Update New Case Consolidation requirements.

Manual Change

Admission Level

Manual change or Correction Applied to RX Hosp--Other

If all of the following conditions are true:

- RX Hosp--Other is not the same as RX Summ--Other
- RX Hosp--Other is higher than RX Summ--Other based on a hierarchy of 1, 2, 3, 6, 7, 8, 0, 9

Then automatically update RX Summ--Other with the RX Hosp--Other code.

Manual Change or Correction Applied

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/3/04	Changed Update logic, see RX Date--Other.
2010	Data Changes: CCR name (Other RX Sum) changed to NAACCR name. Rewrote Update logic.
11/2015	Updated code descriptions to match NAACCR.

RX Summ--Radiation

IDENTIFIERS

CCR ID	NAACCR ID
E1341	1360

DESCRIPTION

First course of treatment included radiation therapy.
Beginning with 1/1/98 diagnosis year for lung and leukemia cases (Coding Procedure 18 and above), radiation to central nervous system goes here. See conversion for cases prior to 1/1/98 in the Historical Changes section that follows.
Cases diagnosed in v18 software and forward will no longer have this field be generated.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	None, diagnosed at autopsy
1	Beam
2	Implants
3	Isotopes
4	Combination of 1 with 2 or 3
5	Radiation, NOS
6	Implants/Isotopes, NOS (Coding_Proc = 03-11)
9	Unknown
Blank	2018 and forward Date of Diagnosis

SOURCE

1. If the transmitted value is numeric, then just load it with no conversion.
2. If the transmitted value is not numeric and Date of Diagnosis < 20180101, then load 0.
3. If the transmitted value is not blank and Date of Diagnosis is >20171231, then load blank.

UPDATE

Tumor Level

New Case Consolidation

See RX Date--Radiation Update New Case Consolidation requirements.

~~Manual Change to Rad Boost RX Modality or Rad--Regional RX Modality~~

~~If Date of Diagnosis year is 2003-9998, then if Rad Boost RX Modality or Rad--Regional RX Modality is changed, then regenerate RX Summ--Radiation~~

Manual Change (Note: Change may also require Reason for No Radiation change)

Admission

Manual Change or Modified Record Applied to ~~Rad Boost RX Modality or~~ Rad--Regional RX Modality

Same requirements as Tumor Level

Manual Change or Correction Applied

(Note: Change may also require Reason for No Radiation change)

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

<table>
<tr><td>1/1/98</td><td>1/1/98: RAD-CNS-SUM discontinued, so value was integrated with RX Summ-Radiation using the following conversion scheme:
<table>
<tr><th>If RAD-CNS-SUM</th><th>And RX Summ--Radiation =</th><th>Then RX Summ—Radiation =</th></tr>
<tr><td>0</td><td>Any Code</td><td>No Change</td></tr>
<tr><td>1</td><td>0</td><td>1</td></tr>
<tr><td>1</td><td>1</td><td>1</td></tr>
<tr><td>1</td><td>2</td><td>4</td></tr>
<tr><td>1</td><td>3</td><td>4</td></tr>
<tr><td>1</td><td>5</td><td>1</td></tr>
<tr><td>1</td><td>6 (CP3-11)</td><td>4</td></tr>
<tr><td>1</td><td>9</td><td>1*</td></tr>
<tr><td>7</td><td>Any Code</td><td>No Change</td></tr>
<tr><td>8</td><td>Any Code</td><td>No Change</td></tr>
<tr><td>9</td><td>Any Code</td><td>No Change</td></tr>
</table>
* If RAD-SUM changed from 9 to 1, change Reason_No_Rad to 0.</td></tr>
<tr><td>1/1/99</td><td>Added missing line to 1998 conversion specifications.</td></tr>
<tr><td>3/26/03</td><td>Source and Update sections changed to include conversion from Rad_Reg_RX_Mod and Rad_Boost_RX_Mod if Date_DX is greater than or equal to 20030101. Interfield edit IF#630 removed because Rad_Hosp discontinued. Rad_Hosp removed from Update logic.</td></tr>
<tr><td>3/3/04</td><td>Changed Update logic-see Date_Rad. Removed the IF#397 on this page and referred to it on Reason_No_Rad page. Added autopsy cases text to code 0 for clarity. Removed conversion instructions from SOURCE for Version 9 records. See Use Case 22.</td></tr>
<tr><td>2010</td><td>Data Changes: CCR name (Rad_Sum) changed to match NAACCR name. Rewrote Update logic.</td></tr>
<tr><td>01/2019</td><td>Per NAACCR v18, this field is only required for DX Years less than 2018. The field will no longer be generated.</td></tr>
<tr><td>01/2019</td><td>Per NAACCR v18, added Blank to allowable values</td></tr>
<tr><td>01/2019</td><td>The discontinued conversion is below:
<table>
<tr><th>If RAD-CNS-SUM</th><th>And RX Summ--Radiation =</th><th>Then RX Summ—Radiation =</th></tr>
<tr><td rowspan="6">00</td><td>00, 99</td><td>0</td></tr>
<tr><td>20 - 43</td><td>1</td></tr>
<tr><td>50 - 55</td><td>2</td></tr>
<tr><td>60 - 62</td><td>3</td></tr>
<tr><td>80 - 85</td><td>4</td></tr>
<tr><td>98</td><td>5</td></tr>
<tr><td rowspan="2">20-43</td><td>00, 20 - 43, 98, 99</td><td>1</td></tr>
<tr><td>50 - 55, 60 - 62, 80 - 85</td><td>4</td></tr>
<tr><td rowspan="3">50-55</td><td>00, 50 - 55, 60 - 62, 98 - 99</td><td>2</td></tr>
<tr><td>20 - 43, 80 - 85</td><td>4</td></tr>
<tr><td>60 - 62</td><td>3</td></tr>
</table></td></tr>
</table>

		60-62	00, 50 - 55, 60 - 62, 98 - 99 20 - 43, 80 - 85	3 4
		80-85	00 - 99	4
		98	00, 98, 99	5
		98, 99	20 - 43 50 - 55 60 - 62 80 - 85 98	1 2 3 4 5
		99	00 99	0 9

RX Summ--Reconstruct 1st

IDENTIFIERS

CCR ID	NAACCR ID
E1337	1330

DESCRIPTION

Most extensive reconstructive surgery performed during first course of treatment for cases diagnosed prior to January 1, 2003.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

0-9
Blank = Date of Diagnosis is on or after January 1, 2003

SOURCE

Upload with no conversion.

UPDATE

Tumor Level

New Case Consolidation
See RX Date--Surg, Update, New Case Consolidation requirements.
Manual Change-may require change to RX Summ--Surg Prim Site

Admission Level

Manual Change-may require change to RX Summ--Surg Prim Site

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/26/04	This field is no longer required, by the CCR, beginning with cases diagnosed January 1, 2003. The reconstructive surgery codes for cases diagnosed 2003 and forward are now incorporated into the Surg_Prim_Sum field. This field was directly coded for cases diagnosed prior to January 1, 2003, and the field is retained so cases prior to 2003 can continue to be coded in this field. Cases prior to 2003 will have this field converted into the Surg_Prim_Sum field. See Commission on Cancer, Cancer Registry Data Conversion Rules: ROADS 1998-2000-FORDS, FORDS-ROADS 1998-2000, (see CoC website for the most current revision version). Update logic fields that were AD_Surg_Hosp_Recon changed to AD_Surg_Sum_Recon as Surg_Hosp_Recon field is no longer a valid field.
3/3/04	Blank added to Allowable Values for cases diagnosed on or after January 1, 2003 and type changed to X. This should have been added to the 3/26/03 update for cases diagnosed 2003+. Cases will be converted to blank for cases diagnosed 2003 and forward.
2010	Data Changes: CCR name (Surg_sum_Recon) changed to match NAACCR name.

RX Summ--Scope Reg 98-02

IDENTIFIERS

CCR ID	NAACCR ID
E1363	1647

DESCRIPTION

Records surgery removing regional lymph nodes during the first course of treatment for cases diagnosed prior to January 1, 2003.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

0-6, 9, Blank
Blank = Date of Diagnosis is on or after January 1, 2003

SOURCE

Upload with no conversion.

UPDATE

Tumor Level

New Case Consolidation
See Date_Surgery, Update, New Case Consolidation requirements.
Manual Change – may require change to RX Summ-Scope Reg LN Sur

Admission Level

Manual change or Correction Applied--may require change to RX Summ-Scope Reg LN Sur

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

1/1/98	Converted from SURG-SUM using ACoS '96-'98 specifications.
3/26/03	This field was the Scope_LN_Sum field for cases diagnosed prior to 2003. Removed Interfield edits 1) and 2) and the Inter-record edit. There are no procedures connected to this field any longer. Added Blank to allowable values. New Interfield edit added.
3/3/04	Removed conversion instructions from SOURCE for Version 9 records. See Use Case 22. Updated New Case Consolidation logic to refer to Date_Surg. Moved IF 1) (Err #423) from Scope_LN_Sum to this Scope_LN_Sum_98_02 because it checks against Surg_LN_EX_Sum (a pre-2003 field). Zero-filled removed from Source. Cases will be converted to blank for cases diagnosed 2003 and forward.
2010	Data Changes: CCR name (Scope_LN_Sum_98_02) changed to NAACCR name.

RX Summ--Scope Reg LN Sur

IDENTIFIERS

CCR ID	NAACCR ID
E1332	1292

DESCRIPTION

Records surgery removing regional lymph nodes during the first course of treatment for cases diagnosed January 1, 2003 and forward.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

0-7, 9

SOURCE

Zero-fill

UPDATE

TUMOR LEVEL

NEW CASE CONSOLIDATION

See RX Date-Surgery, Update, New Case Consolidation requirements.

Manual Change to RX Summ--Scope Reg 98-02 or RX Summ--Reg LN Examined

If Date of Diagnosis year = 0001-2002, and RX Summ--Scope Reg 98-02 or RX Summ--Reg LN Examined is changed, then automatically convert a new RX Summ--Scope Reg LN Sur value according to the source conversion table found at the bottom of this page.
See Source Conversion Table at the bottom of this page.

Manual Change

ADMISSION LEVEL

Manual Change or Correction Applied to Scope LN Proc 1-3

If one or more of the Scope LN Proc 1-3 codes are changed, compare all three codes and, if necessary, update RX Summ--Scope Reg LN Sur according to this hierarchy: 6, 7, 5, 4, 3, 2, 1, 0, 9.

Manual Change or Correction Applied to RX Hosp--Scope Reg LN Sur

If RX Hosp--Scope Reg LN Sur is changed, compare RX Hosp--Scope Reg LN Sur with RX Summ--Scope Reg LN Sur and, if necessary, update RX Summ--Scope Reg LN Sur according to this hierarchy: 6, 7, 5, 4, 3, 2, 1, 0, 9.

Manual Change or Correction Applied to RX Summ-Scope Reg 98-02 or RX Summ--Reg LN Examined

If Date of Diagnosis year = 0001-2002, and RX Summ--Scope Reg 98-02 or RX Summ--Reg LN Examined is changed, then automatically convert a new RX Summ--Scope Reg LN Sur value according to the conversion table noted above for the same change at the Tumor Level.

Manual Change or Correction Applied

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

1/1/98	Converted from SURG-SUM using ACoS '96-'98 specifications.

3/26/03	Identifier # changed. Code 7 added to Allowable values and to Update logic and Interfield edit 1). Added conversion chart to Update. This field was changed to apply to all site schemes for cases diagnosed January 1, 2003 forward. Information regarding the number of lymph nodes has been incorporated also. A conversion will be required. Prior to this conversion, codes are to be copied and moved to RX Summ-Scope Reg LN Sur_98_02. See Commission on Cancer, Cancer Registry Data Conversion Rules: ROADS 199802000-FORDS, FORDS-ROADS 1998-2000, (see CoC Website for the most current revision version.
3/3/04	Removed Update logic referring to procedures. Updated New Case Consolidation logic to refer to RX Date-Surgery. Added Manual Change Update logic relating to Scope_LN_Hosp. (Removed 2) (Err#682) and moved IF 1 (Err#423) to the RX Summ-Scope Reg LN Sur_98_02 field. Removed conversion instructions from SOURCE for Version 9 records. See Use Case 22.
2/1/06	2/01/06: Added IF #736 to match SEER's edit IF 159.
1/08/07	Reinstated Update logic which updates RX Summ-Scope Reg LN Sur when Scope LN Proc1-3 is changed.
2010	Data Changes: Data Item Changes: CCR name (Scope LN Sum) changed to NAACCR name. Rewrote Update logic.
2011	Data Changes: 2011 Data Changes: Added IF #514, 515, 516 and 517.
2012	Data Changes: Added IF #514, 515, 516 and 517.
727/11	IF 401, 410, 411, 422 and 427 were created to comply with NAACCR 12.1.A. Information for this new edit arrived in late July 2011.
05/2013	Added IF 1034

SOURCE CONVERSION TABLE

If Site/Histology =	**And Scope_LN_ Sum_ 8_02=**	**And Surg_LN_EX_ Sum =**	**Then convert Scope_LN_ Sum to**
Hist_Type_3=9720, 9750, 9760-9764, 9800-9820, 9826, 9831-9897, 9910-9920, 9931-9964, 9980-9989	Any	Any	9
Site C000-C140, C320-C329, C739	0, 1, 9	Any	Copy
		96-98	3
		99, 00	9
		96-99, 00	3
		01-03	4
		04-90	1
		95	9
Site C420-C421, C423-C424	Any	Any	9
Site C440-C449	0, 9	Any	Copy
		Any	2
		01-03	4
		04-90	5
		95	1
		96-99, 00	3
		9	

Site C500-C509	0, 9	Any	Copy
		Any	2
		01-03	4
		04-90	6
		95	1
		96-99	3
		Any	6
		9	
Site C210-C218, C340-C349, C620-C629, C649, C679	0, 9	Any	Copy
		01-03	4
		04-90	5
		95	1
		96-99, 00	3
		9	
Site C700-C729	Any		9
Site C250-C259, C540-C559	0, 9	Any	Copy
		01-03	4
		04-90	5
		95	1
		96-99, 00	3
		9	
Site C770-C779 and Hist_tpe_3-9590-9596, 9650-9719, or 9727-9729	Any	Any	9
Site C760-C765, C767, C768, C809	Any	Any	9
All other sites	0, 9	Any	Copy
		01-03	4
		04-90	5
		95	1
		96-99, 00	3
		9	9

RX Summ--Surg Oth 98-02

IDENTIFIERS

CCR ID	NAACCR ID
E1364	1648

DESCRIPTION

Surgical removal of tissue other than the primary tumor or organ of origin (other regional site(s), distant site(s) or distant LN(s)) for cases diagnosed prior to January 1, 2003.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

0-9 Blank
Blank equal Date of Diagnosis is on or after January 1, 2003.

SOURCE

Upload with no conversion.

UPDATE

Tumor Level

New Case Consolidation
See RX Date--Surgery, Update, New Case Consolidation requirements.
Manual change--may require change to RX Summ--Surg Oth Reg-Dis

Admission Level

Manual change or Correction Applied--may require change to RX Summ--Surg Oth Reg-Dis

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

1/1/98	Converted from SURG-SUM using ACoS '96-'98 specifications.
3/26/03	This field is for cases diagnosed prior to January 1, 2003. Blanks added to Allowable Values. New Interfield edit.
3/3/04	Removed conversion instructions from SOURCE for Version 9 records. See Use Case 22. Rewrote Update logic. Zero-filled removed from Source. Cases will be converted to blank for cases diagnosed 2003 and forward.
2010	Data Changes: CCR name (Surg_Other_Sum_98_02) changed to match NAACCR name. Added IF #356.

RX Summ--Surg Oth Reg/Dis

IDENTIFIERS

CCR ID	NAACCR ID
E1333	1294

DESCRIPTION

Surgical removal of tissue other than the primary tumor or organ of origin (other regional site(s), distant site(s) or distant LN(s)) for cases diagnosed January 1, 2003 and forward.

LEVELS

Tumor
Admission

LENGTH

1

ALLOWABLE VALUES

0 – 5, 9

SOURCE

Zero-fill.
If the new case record version is 9, then convert Surg Oth Reg/Dis according to the conversion table described under the update section below.

UPDATE

Tumor Level

New Case Consolidation
See Date_Surg, Update, New Case Consolidation requirements.
Manual Change to Surg_Other_Sum_98_02
If Date of Diagnosis < 20030101, and Surg_Other_Sum_98_02 is changed, then automatically convert a new Surg Oth Reg/Dis value according to this conversion table:

If Site/Histology =	**And Surg_Other_Sum_98_02=**	**Then convert Surg Oth Reg/Dis to**
Hist_Type_3=9720, 9750, 9760-9764, 9800-9820, 9826, 9831-9897, 9910-9920, 9931-9964, 9980-9989	0, 1, 9	Copy
	2-5	1
	All other values	9
Site C000-C069	0, 1, 9	Copy
	2-4	2
	5	3
	6	4
	7	5
	All other values	9
Site C090-C140	0, 1, 9	Copy
	2-6	2
	7	1
	8	5
	All other values	9

Site C180-C209	0, 1, 9	Copy
	2-5	2
	6	1
	7-8	5
	All other values	9
Site C340-C349	0-2, 9	Copy
	3	2
	4,6	1
	5,7	4
	All other values	9
Site C400-C419, C470-C479, C490-C499	0-2, 9	Copy
	5	3
	6	4
	7	5
	All other values	9
Site C420-C421, C423-C424	0, 1, 9	Copy
	2-5	1
	All other values	9
Site C422, C700-C729, C770-C779	0-2, 9	Copy
	5	3
	6	4
	7	5
	All other values	9
Site C500-C509	0-4, 9	Copy
	5	4
	6	5
	All other values	9
Site C530-C539	0-3, 9	Copy
	4	3
	5	4
	6,7	5
	All other values	9
Site C760-C765, C767-C768, C809	0, 1, 9	Copy
	2-5	1
	All other values	9
All other Sites	0-5, 9	Copy
	All other values	9

Manual Change

Admission Level

Manual Change to Surg_Other_Proc 1-3

If one of the Surg_Other_Proc1-3 codes are changed, then compare all Surg_Other_Proc1-3 codes based on the 5, 4, 3, 2, 1, 0, 9 hierarchy and move the highest code into Surg Oth Reg/Dis. Manual Change to Surg_Other_Hosp

If Surg_Other_Hosp is changed, then compare Surg_Other_Hosp with Surg Oth Reg/Dis based on the 5, 4, 3, 2, 1, 0, 9 hierarchy and move the highest code into Surg Oth Reg/Dis.
Manual Change to Surg_Other_Sum_98_02
If Date of Diagnosis < 20030101, and Surg_Other_Sum_98_02 is changed, then automatically convert a new Surg Oth Reg/Dis value according to the conversion table noted above for the same change at the Tumor Level.
Manual Change

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

1/1/98	Converted from SURG-SUM using ACoS '96-'98 specifications.
3/26/03	C/N # changed to F03496. Updated Allowable values. Added conversion table to Update. Removed codes 8, 7 & 6 from Update logic. Removed Interrecord edit. This field was changed to apply to all site schemes for cases diagnosed January 1, 2003 forward. A conversion will be required for cases diagnosed prior to 2003. Prior to this conversion, codes are to be copied to Surg_Other_Sum_98_02. Refer to the Commission on Cancer, Cancer Registry Data Conversion Rules: ROADS 1998-2000--FORDS, FORDS--ROADS 1998-2000, (see CoC website for the most current revision version).
3/3/04	Added conversion codes for Site C400-C419, C470-C479, C490-C499 in Update table.
1/8/07	Reinstated Update logic which updates Surg Other Sum when Surg Other Proc1-3 is changed.
2010	Data Changes: Name changed from Surg_Other_Sum to Surg Oth Reg/Dis to match NAACCRv12.
7/27/11	If410, 422, and 427 add to comply with NAACCR 12.1.A.
05/2013	Added IF 1030, 1037

RX Summ--Surg Prim Site

IDENTIFIERS

CCR ID	NAACCR ID
E1331	1290

DESCRIPTION

Most extensive type of surgery performed during first course of treatment for cases diagnosed January 1, 2003 and forward.

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

00, 10-38, 40-80, 90, 98, 99

Surgically treated. (Not all codes apply to every site - see Site inter-field edits.) See Appendix 20B.

Codes

00	No surgery, autopsy only
10-90	Definitive surgery to the primary site
98	Special codes for hematopoietic/reticuloendothelial/immunoproliferative/myeloproliferative disease, ill-defined site, & unknown primaries. Code 98 takes precedence over 00.
99	Unknown whether or not definitive surgery was done, death certificate-only

SOURCE

Right-justify and zero-fill.

UPDATE

Tumor Level

New Case Consolidation

See RX Date--Surg, Update, New Case Consolidation requirements.

Manual change to RX Summ--Surg Site 98-02, RX Summ--Scope Reg 98-02, or RX Summ--Reconstruct 1st

If Date of Diagnosis year is 0001-2002,

and RX Summ--Surg Site 98-02, RX Summ--Scope Reg 98-02,

or RX Summ-Reconstruct 1st are changed,

then perform automatic 2003 Surgery to the Primary Site conversion according to Appendix 28 – Surgery to the Primary Site Conversion Table for 2003 Data Changes, which is based on the 'Surgical Procedure of Primary Site and Surgical Procedure of Primary Site at this Facility' conversion specifications in Commission on Cancer, Cancer Registry Data Conversion Rules: ROADS 1998-2000-FORDS, FORDS-ROADS 1998-2000, (see CoC website for the most current revision version) and automatically update RX Summ--Surg Prim Site.

Manual change

Admission Level

Manual change or Correction(s) Applied to Surg Prim Proc 1-3

If one or more of the Surg Prim Proc 1-3 codes is changed, compare all Surg Prim Proc 1-3 codes based on the Appendix 20B rules and move the most definitive code into RX Summ--Surg Prim Site.

Manual change or Correction Applied to RX Hosp--Surg Prim Site

If RX Hosp--Surg Prim Site is changed, compare RX Hosp--Surg Prim Site with RX Summ--Surg Prim Site and replace RX Summ--Surg Prim Site if the RX Hosp--Surg Prim Site value is more definitive according to Appendix 20B.

Manual change or Correction Applied to RX Summ--Surg Site 98-02, RX Summ--Scope Reg 98-02, or RX SummReconstruct 1st

Same as Tumor Level requirement

Manual change or Correction Applied

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

1/1/98	Converted from SURG-SUM using ACoS '96-'98 specifications.
3/26/03	This field is effective beginning with cases diagnosed January 1, 2003. A conversion will be required for cases prior to January 1, 2003. Prior to this conversion, codes are to be copied and moved to Surg_Prim_Sum_98_02. Refer to the Commission on Cancer, Cancer Registry Data Conversion Rules: ROADS 1998-2000-FORDS, FORDS-ROADS 1998-2000, (see CoC website for the most current revision version). C/N Source # changed to F03491. Codes added to Allowable values. Changed Update section to refer to Appendix 20B and Appendix 28. Scope_LN_sum range changed to 7 in Interfield edit 3). Interrecord edit (#681) removed.
3/3/04	Updated range to include breast surgery codes 44 & 49. Removed Update logic and IF 1), 2) and 4) that referred to Procedure fields. Removed the part of IF 4) that looked at non-primary site surgery fields. Removed conversion 5) instructions from SOURCE for Version 9 records. See Use Case 22.
1/8/07	Reinstated Update logic to Admission Level which updates Surg Prim Sum when Surg Prim Proc1-3 is changed.
2/2009	Added IF #827.
2010	Data Changes: Changed CCR name (Surg Prim Sum) to match NAACCR. Added IF #833 to match the COC edit and enforce the coding standard for BCG. Added IF#467, 882, 878, & 884. Rewrote Update logic.
05/2013	Added IF 1024, 1030, 1032, 1040, 1042, 1056, 1060, 1063, 1067

RX Summ--Surg Site 98-02

IDENTIFIERS

CCR ID	NAACCR ID
E1362	1646

DESCRIPTION

Most extensive type of surgery performed during first course of treatment for cases diagnosed prior to January 1, 2003. This field is to be used for retention of ROADS codes prior to the ROADS to FORDS conversion.

LEVELS

2

LENGTH

Tumors, Admissions

ALLOWABLE VALUES

00, 10-38, 40-43, 45, 50-55, 60-65, 70-74, 80-84, 90, 99, Blank
Surgically treated. (Not all codes apply to every site - see Site interfield edits.) See Appendix 20A.
Definitions

00	No surgery
10-90	Definitive surgery to the primary site (the higher the value, the more definitive the surgery)
99	Unknown whether or not definitive surgery was done
Blank	Date of diagnosis is on or after January 1, 2003

SOURCE

Upload with no conversion.

UPDATE

Tumor Level

New Case Consolidation
See RX Date--Surgery, Update, New Case Consolidation requirements
Manual Change-may require change to RX Summ--Surg Prim Sum

Admission Level

Manual Change or Correction Applied-may require change to RX Summ--Surg Prim Sum

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

1/1/98	Converted from SURG-SUM using ACoS '96-'98 specifications.
3/26/03	This field was renamed from Surg_Prim_Sum to Surg_Prim_Sum_98_02 and will only relate to cases diagnosed prior to January 1, 2003. Blanks added to Allowable Values. Added 6) to update logic. Added Interfield edit 2).
3/3/04	Removed conversion instructions from SOURCE for Version 9 records. See Use Case 22. Rewrote Update logic. Zero-filled removed from Source. Cases will be converted to blank for cases diagnosed 2003 and forward.
2010	Data Changes: CCR name (Surg_Prim_Sum_98_02) changed to NAACCR name. Added IF #351 and 356.

RX Summ--Surg/Rad Seq

IDENTIFIERS

CCR ID	NAACCR ID
E1343	1380

DESCRIPTION

A code indicating the sequence of radiation therapy given with surgery (pre-op, post-op, etc.) during first course of treatment.

LEVELS

Tumor
Admission

LENGTH

1

ALLOWABLE VALUES

0	Not applicable
2	Radiation before surgery
3	Radiation after surgery
4	Radiation before and after surgery
5	Intraoperative
6	Intraoperative radiation with other radiation given before and/or after surgery
7	Surgery both before and after radiation.
9	Both given but sequence unknown

SOURCE

If transmitted value is numeric, load transmitted value. Otherwise, convert to 0.

UPDATE

Tumor Level

New Case Consolidation

1. Consolidate RX Summ--Surg/Rad Seq using the following table:

If the admission's RX Summ-Surg/Rad Seq is	**And the tumor's RX Summ-Surg/Rad Seq is**	**Then the tumor's RX Summ-=Surg/Rad Seq becomes**
0	0-9	4
2-6	0,9	6
2	3,4	4
2	5,6	6
4	2,3	4
4	5,6	6
5	2,3,4,6	6
6	0-9	6
9	0	9

9	2-6	Unchanged

2. If all of the following conditions are true:
    the admission's RX Summ--Surg/Rad Seq is 0
    the tumor's RX Summ--Surg/Rad Seq is 0
    Either of the following conditions are true showing the patient had both surgery and radiation
        All of the following conditions are true:
            Any of the following conditions are true:
                the admission's RX Summ--Surg Prim Site is 10-90
                the admission's RX Summ--Scope Reg LN Sur is 1-7
                the admission's RX Summ--Surg Oth Reg-Dis is 1-5
        the tumor's RX Summ-Radiation is 1-6
        All of the following conditions are true:
            Any of the following conditions are true:
                the tumor's RX Summ--Surg Prim Site is 10-90
                the tumor's RX Summ--Scope Reg LN Sur is 1-7
                the tumor's RX Summ--Surg Oth Reg-Dis is 1-5
                the admission's RX Summ-Radiation is 1-6
    Then reset RX Summ--Surg/Rad Seq:
        A. Consolidate RX Date--Surgery and consolidate RX Date--Radiation.
        B. If any of the following conditions are true:
            RX Date--Surgery Flag is 12
            RX Date--Radiation Flag is 12
            all of the following conditions are true:
                RX Date--Surgery year = RX Date--Radiation year
                RX Date--Surgery year is a known year (1800-9998)
                Either month is blank
            all of the following conditions are true:
                RX Date--Surgery year/month = RX Date--Radiation year/month
                RX Date--Surgery year is a known year (1800-9998)
                RX Date--Surgery month is a known month (01-12)
                Either day is blank
            Then reset the tumor's RX Summ--Surg/Rad Seq to 9.
        C. If RX Date--Surgery is later* than RX Date--Radiation
            Then reset the tumor's RX Summ--Surg/Rad Seq to 2.
        D. If RX Date--Surgery is earlier** than RX Date--Radiation
            Then reset the tumor's RX Summ--Surg/Rad Seq to 3.
        E. Then reset the tumor's RX Summ--Surg/Rad Seq to 5
    Manual changes to related fields
        If one or more manual changes are made to the following related fields, and any of these conditions are now true:
            All of the following conditions are true:
                the tumor's RX Summ--Surg Prim Site is 00, 98, or 99
                the tumor's RX Summ--Scope Reg LN Sur is 0 or 9
                the tumor's RX Summ--Surg Oth Reg-Dis is 0 or 9
            RX Summ--Radiation is 0 or 9

Then change RX Summ--Surg/Rad to 0

Manual Change

Admission Level

Manual Change(s) or Correction(s) Applied to related fields

Same requirement as tumor level for manual changes to related fields

Manual Change or Correction Applied

*	With year, month, and/or day potentially blank, a completely known date could appear to be later because it is a larger number than a partial later date. Thus, to test for the latest date among known full or partial dates, use these tests in this order: 1. If one of the known dates' years is later than (greater than) the other date's year being compared or if it is the only known year/date, then that date is the latest known date 2. If multiple known dates have the same latest year, but only one of them has a latest known month, then that is the latest known date 3. If multiple known dates have the same latest year & month, but only one of them has a latest known day, then that is the latest known date

**	With year, month and/or day potentially blank, a date with a partial but later date could appear to be earlier because it is a smaller number than a full earlier date. Thus, to test for the earliest among known dates, use these tests in this order: 1. If one of the known dates' years is earlier than (less than) the other date's year or if it is the only known year/date, then that date is the earliest known date 2. If multiple known dates have the same earliest year, but only one of them has an earliest known month, then that is the earliest known date 3. If multiple known dates have the same earliest year & month, but only one of them has an earliest known day, then that is the earliest known date

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/16/98	Generate new RAD-SEQ if RAD-SUM was changed by RAD-CNS-SUM conversion
3/3/04	Changed Interfield edit 1) and 2) to edit RX Summ--Surg/Rad Seq against the Surgery summary fields instead of Reason_No_Surg.
1/19/05	Rewrote IF #356 to edit RX Summ--Surg/Rad Seq based on diagnosis year and edit against 98-02 surgery fields because of conversion issues.
2/20/08	Added update logic so Rad Seq will automatically update to 0 (no rad given) when surgery codes are coded to no surgery given.
2010	Date Changes: CCR name (Rad-Seq) changed to NAACCR name. Rewrote Update logic.
2012	Date Changes: Added Code 7, Intraoperative radiation with other radiation given before and/or after surgery

RX Summ--Surgical Margins

IDENTIFIERS

CCR ID	NAACCR ID
E1336	1320

OWNER

CoC

DESCRIPTION

Codes describe the final status of surgical margins after resection of the primary tumor. See also RX Summ--Surg Prim Site [NAACCR #1290]. This item serves as a quality measure for pathology reports, is used for staging, and may be a prognostic factor in recurrence. This item is not limited to cases that have been staged. It applies to all cases that have a surgical procedure of the primary site.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	No residual tumor
1	Residual tumor, NOS
2	Microscopic residual tumor
3	Macroscopic residual tumor
7	Margins not evaluable
8	No primary site surgery
9	Unknown or not applicable

SOURCE

1. If value is non-blank, non-numeric character then convert to 9.

UPDATE

Tumor

New Case Consolidation

If all of these conditions are true:

- Any of these conditions are true:
  - Admission's Date of Diagnosis year is 2016-9998
  - Tumor's Date of Diagnosis year is 2016-9998
  - Tumor's Date of Diagnosis year is blank AND the admission's Date of 1st Contact year is 2016-9998
  - Admission's Date of Diagnosis year is blank AND the admission's Date of 1st Contact year is 2016-9998
- Admission's value is NOT blank
- Admission and tumor's values are different

Then list for review.

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

08/2016	Per NAACCR v16, data field implemented in Eureka to meet SEER requirements.

RX Summ--Systemic Sur Seq

IDENTIFIERS

CCR ID	NAACCR ID
E1359	1639

OWNER

CoC

DESCRIPTION

Records the sequencing of systemic therapy (RX Summ-Chemo [NAACCR #1390], RX Summ-Hormone [NAACCR #1400], RX Summ-BRM [NAACCR #1410], and RX Summ-Transplnt/Endocr [NAACCR #3250] and surgical procedures given as part of the first course of treatment. For cases with a 2006+ diagnosis date.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	No systemic therapy and/or surgical procedures; unknown if surgery and/or systemic therapy given
2	Systemic therapy before surgery
3	Systemic therapy after surgery
4	Systemic therapy both before and after surgery
5	Intraoperative systemic therapy
6	Intraoperative systemic therapy with other therapy administered before and/or after surgery
7	Surgery both before and after systemic therapy
9	Sequence unknown, but both surgery and systemic therapy given

SOURCE

Upload with no conversion

UPDATE

Tumor Level

New Case Consolidation

If only one of the admissions and tumor RX Summ--Systemic Sur Seq values is blank

Then list for review.

If neither of the admission and tumor RX Summ--Systemic Sur Seq values is blank, then consolidate RX Summ--Systemic Sur Seq according to the following table:

If the admission's RX Summ--Systemic Sur Seq =	**and the tumor's RX Summ--Systemic Sur Seq =**	**Then the tumor's RX Summ--Systemic Sur Seq becomes**
0	0-9	unchanged
2-7	0,9	Code in Admission Record
2	3,4	4

2	5,6	6
3	2,4	4
3	5,6	6
4	2,3	4
4	5,6	6
5	2-4,6	6
6	0-9	6
9	0	9
9	2-7	unchanged

If all of the following conditions are true:

- The admission's RX Summ--Systemic Sur Seq is 0
- The tumor's RX Summ--Systemic Sur Seq is 0
- Either of the following conditions are true showing the patient had both surgery and systemic therapy:
  - All of the following conditions are true:
    - Any of the following conditions are true:
      - the admission's RX Summ--Surg Prim Site is 10-90
      - the admission's RX Summ--Scope Reg LN Sur is 1-7
      - the admission's RX Summ--Surg Oth Reg-Dis is 1-5
    - Any of the following conditions are true:
      - the tumor's RX Summ--BRM is 01
      - the tumor's RX Summ--Chemo is 01-03
      - the tumor's RX Summ--Hormone is 01
      - the tumor's RX Summ--Transplnt/Endocr is 10, 11, 12, 20, 30, or 40
  - All of the following conditions are true:
    - Any of the following conditions are true:
      - the tumor's RX Summ--Surg Prim Site is 10-90
      - the tumor's RX Summ--Scope Reg LN Sur is 1-7
      - the tumor's RX Summ--Surg Oth Reg-Dis is 1-5
    - Any of the following conditions are true:
      - the admission's RX Summ--BRM is 01
      - the admission's RX Summ--Chemo is 01-03
      - the admission's RX Summ--Hormone is 01
      - the admission's RX Summ--Transplnt/Endocr is 10, 11, 12, 20, 30, or 40

Then reset RX Summ--Surg/Rad Seq:

(1) Consolidate RX Date--Surgery and consolidate RX Date--Systemic.

(2) If any of the following conditions are true:

- RX Date--Surgery Flag is 12
- RX Date--Systemic Flag is 12
- all of the following conditions are true:
  - RX Date--Surgery year = RX Date--Systemic year
  - RX Date--Surgery year is a known year (1800-9998)
  - Either month is blank

- all of the following conditions are true:
    - RX Date--Surgery year/month = RX Date--Systemic year/month
    - RX Date--Surgery year is a known year (1800-9998)
    - RX Date--Surgery month is a known month (01-12)
    - Either day is blank

Then reset the tumor's RX Summ--Systemic Sur Seq to 9.

(3) If RX Date--Surgery is later* than RX Date--Systemic, then reset the tumor's RX Summ--Systemic Sur Seq to 2.

(4) If RX Date--Surgery is earlier** than RX Date--Systemic, then reset the tumor's RX Summ--Systemic Sur Seq to 3.

(5) If RX Date--Surgery is the same as RX Date--Systemic, then reset the tumor's RX Summ--Systemic Sur Seq to 5.

Manual changes to related fields

If one or more manual changes are made to the following related fields, and any of these conditions are now true:

- All of the following conditions are true:
    - the tumor's RX Summ--Surg Prim Site is 00, 98, or 99
    - the tumor's RX Summ--Scope Reg LN Sur is 0 or 9
    - the tumor's RX Summ--Surg Oth Reg-Dis is 0 or 9
- All of the following conditions are true:
    - the tumor's RX Summ--BRM is 00 or 82-99
    - the tumor's RX Summ--Chemo is 00 or 82-99
    - the tumor's RX Summ--Hormone is 00 or 82-99
    - the tumor's RX Summ--Transplnt/Endocr is 00 or 82-99

Then change RX Summ--Systemic Sur Seq to 0

Manual Change

Admission Level

Manual Change(s) or Correction(s) Applied to related fields

Same requirement as tumor level for manual changes to related fields

Manual Change or Correction Applied

* With year, month, and/or day potentially blank, a completely known date could appear to be later because it is a larger number than a partial later date. Thus, to test for the latest date among known full or partial dates, use these tests in this order:

- If one of the known dates' years is later than (greater than) the other date's year being compared or if it is the only known year/date, then that date is the latest known date
- If multiple known dates have the same latest year, but only one of them has a latest known month, then that is the latest known date
- If multiple known dates have the same latest year & month, but only one of them has a latest known day, then that is the latest known date

** With year, month and/or day potentially blank, a date with a partial but later date could appear to be earlier because it is a smaller number than a full earlier date. Thus, to test for the earliest among known dates, use these tests in this order:

- If one of the known dates' years is earlier than (less than) the other date's year or if it is the only known year/date, then that date is the earliest known date
- If multiple known dates have the same earliest year, but only one of them has an earliest known month, then that is the earliest known date

- If multiple known dates have the same earliest year & month, but only one of them has an earliest known day, then that is the earliest known date

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

7/05	2006 Data item required by CoC & NPCR.
2/06	Updated Consolidation logic to handle cases where one value is blank.
2009	Data Changes: Added 98 to the 2nd paragraph in Update logic (TU level line).
2010	Data Changes: Revised definition of code 0 (added unknown if surgery and/or systemic therapy given). Rewrote Update logic.
2011	IF 419 was created to comply with NAACCR 12.1.A.
2012	Data Change: Added code 7: Surgery both before and after systemic therapy.

RX Summ--Transplnt/Endocr

IDENTIFIERS

CCR ID	NAACCR ID
E1344	3250

DESCRIPTION

Identifies systemic therapeutic procedures given as part of first course of treatment at this facility and all other facilities or the reason they were not used. These include bone marrow transplants, stem cell harvests, and surgical and radiation endocrine therapy.

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

00	None, diagnosed at autopsy
10	Bone marrow transplant NOS
11	Bone marrow transplant autologous
12	Bone marrow transplant allogeneic
20	Stem cell harvest and infusion
30	Endocrine surgery and/or endocrine radiation therapy
40	Code 30 in combo with 10, 11, 12 or 20
82	Contraindicated
85	Patient died
86	Recommended, not given
87	Refused
88	Recommended, unknown if given
99	Unknown, death certificate-only

SOURCE

If the new case record version is A or later, then just load value and right-justify and zero-fill.

UPDATE

Tumor Level

New Case Consolidation

See RX Date--Transplnt/Endocr Update New Case Consolidation requirements

Manual Change

Admission Level

Manual change to RX HOSP--Transplnt/Endocr

If Admission RX HOSP--Transplnt/Endocr is changed and Admission RX HOSP--Transplnt/Endocr <>Admission RX Summ--Transplnt/Endocr, automatically update Admission RX Summ--Transplnt/Endocr if Admission RX HOSP--Transplt/Endocr code is higher based on hierarchy of 40, 11, 12, 10, 20, 30, 82, 85, 86, 87, 88, 00, 99.

Manual change

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/26/03	New data item requirement for cases diagnosed January 1, 2003 and forward.
10/8/03	Added codes to IF 2) (Err #459), if Transp_Endo_Sum = 40. Updated Source table.
3/3/04	Changed Update logic, see RX Date Transp Endo. Added IF 3) (Err #533) to match CoC edit. Added autopsy cases text to code 00 for clarity. Conversion table removed from SOURCE for Version 9 records. Refer to Use Case 22 for documentation.
2010	CCR name (Transp_Endo_Sum) changed to NAACCR name. Other data item names changed in Update. Added IF #891.

RX Summ--Treatment Status

IDENTIFIERS

CCR ID	NAACCR ID
E1330	1285

DESCRIPTION

Summary of the status for all treatment modalities.
Used in conjunction with Date of Initial RX-SEER and/or Date of 1st Crs RX--CoC and each modality of treatment with their respective date field to document whether treatment was given or not given, whether it is unknown if treatment was given, or whether treatment was given on an unknown date
Also indicates active surveillance (watchful waiting). This data item is effective for 2010+ diagnoses.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

0	No treatment given
1	Treatment given.
2	Watchful waiting. Active surveillance
9	Unknown if treatment was given
Blanks	Cases diagnosed prior to 2010.

SOURCE

Upload with no conversion

UPDATE

Tumor Level

New Case Consolidation

If both of the following conditions are true:

- the admission's RX Summ--Treatment Status is 0, 1, or 2
- the tumor's RX Summ--Treatment Status is 9

Then replace the tumor's RX Summ--Treatment Status with the admission's RX Summ--Treatment Status.

Otherwise,

If the admission's RX Summ--Treatment Status is not the same as the tumor's RX Summ--Treatment Status, then list for review.

Manual Update

Admission

Manual Update or Correction Applied

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

2010	New data item added for 2010 data changes. Added IF #991
2012	Data Changes: Added text "Active surveillance" to code 2

S Category Clinical

IDENTIFIERS

CCR ID	NAACCR ID
E2035	3923

OWNER

NAACCR

DESCRIPTION

S Category Clinical combines the results of pre-orchiectomy Alpha Fetoprotein (AFP), Human Chorionic Gonadotropin (hCG) and Lactate Dehydrogenase (LDH) into a summary S value.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	S0: Marker study levels within normal levels
1	S1: At least one of these values is elevated AND LDH less than 1.5 x N* AND hCG (mIU/L) less than 5,000 AND AFP (ng/mL) less than 1,000
2	S2: LDH 1.5 x N* to 10 x N* OR hCG (mIU/L) 5,000 to 50,000 OR AFP (ng/mL) 1,000 to 10,000
3	S3: Only one elevated test is needed LDH greater than 10 x N* OR hcG (mIU/mL) greater than 50,000 OR AFP (ng/mL) greater than 10,000
9	SX: Not documented in medical record S Category Clinical not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00590
        - Type of Reporting Source is not 7
        - S Category Clinical is blank

        Then convert S Category Clinical to 9
    B. If all of the following conditions are true:
        - One of the following is true:

- Schema ID is not 00590
  OR
- Type of Reporting Source is 7

- S Category Clinical is not blank

Then convert S Category Clinical to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00590
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00590

One of the following conditions is true

- Admission's value is not blank, 9
- Tumor's value is blank, 9
  OR
  - Admission's value is 9
  - Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

S Category Pathological

IDENTIFIERS

CCR ID	NAACCR ID
E2036	3924

OWNER

NAACCR

DESCRIPTION

S Category Pathological combines the results of post-orchiectomy Alpha Fetoprotein (AFP), Human Chorionic Gonadotropin (hCG) and Lactate Dehydrogenase (LDH) into a summary S value.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	S0: Marker study levels within normal levels
1	S1: At least one of these values is elevated AND LDH less than 1.5 x N* AND hCG (mIU/L) less than 5,000 AND AFP (ng/mL) less than 1,000
2	S2: LDH 1.5 x N* to 10 x N* OR hCG (mIU/L) 5,000 to 50,000 OR AFP (ng/mL) 1,000 to 10,000
3	S3: Only one elevated test is needed LDH greater than 10 x N* OR hcG (mIU/mL) greater than 50,000 OR AFP (ng/mL) greater than 10,000
9	SX: Not documented in medical record S Category Pathological not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00590
        - Type of Reporting Source is not 7
        - S Category Pathological is blank

        Then convert S Category Pathological to 9
    B. If all of the following conditions are true:
        - One of the following is true:

- Schema ID is not 00590
  OR
- Type of Reporting Source is 7

- S Category Pathological is not blank

Then convert S Category Pathological to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00590
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00590

One of the following conditions is true

- Admission's value is not blank, 9
- Tumor's value is blank, 9
  OR
  - Admission's value is 9
  - Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Sarcomatoid Features

IDENTIFIERS

CCR ID	NAACCR ID
E2037	3925

OWNER

NAACCR

DESCRIPTION

Sarcomatoid features: present or absent and percentage refers to the observation of sheets and fascicles of malignant spindle cells in a kidney tumor which can occur across all histologic subtypes. The percentage of sarcomatoid component has been shown to correlate with cancer-specific mortality.

LEVELS

Admissions, Tumors

LENGTH

3

ALLOWABLE VALUES

000	Sarcomatoid features not present/not identified
000-100	Sarcomatoid features 1-100%
R01	Sarcomatoid features stated as less than 10%
R02	Sarcomatoid features stated as range 10%-30% present
R03	Sarcomatoid features stated as a range 31% to 50% present
R04	Sarcomatoid features stated as a range 51% to 80% present
R05	Sarcomatoid features stated as greater than 80%
XX6	Sarcomatoid features present, percentage unknown
XX7	Not applicable: Not a renal cell carcinoma morphology
XX8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code XX8 may result in an edit error.)
XX9	Not documented in medical record Sarcomatoid features not assessed or unknown if assessed No surgical resection of primary site is performed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

5. If Date of Diagnosis is less than 2018, then blank out field
6. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00600
        - Type of Reporting Source is not 7
        - Percent Sarcomatoid Features is blank or XX8

        Then convert Sarcomatoid Features to XX9
    B. If all of the following conditions are true:

- One of the following is true:
  - Schema ID is not 00600
    OR
  - Type of Reporting Source is 7
- Sarcomatoid Features is not blank
  Then convert Sarcomatoid Features to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00600
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00600

One of the following conditions is true

- Admission's value is not blank, XX9
- Tumor's value is blank, XX9
  OR
  - Admission's value is XX9
  - Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.
Otherwise,
If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Schema Discriminator 1

IDENTIFIERS

CCR ID	NAACCR ID
E2038	3926

OWNER

NAACCR

DESCRIPTION

Captures additional information needed to generate AJCC ID [995] and Schema ID [3800] for some anatomic sites. Discriminators can be based on sub site, histology or other features which affect prognosis.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

See NAACCR SSDI Manual

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field

UPDATE

Tumor Level

New Case Consolidation

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Schema Discriminator 2

IDENTIFIERS

CCR ID	NAACCR ID
E2039	3927

OWNER

NAACCR

DESCRIPTION

Captures additional information needed to generate AJCC ID [995] and Schema ID [3800] for some anatomic sites. Discriminators can be based on sub site, histology or other features which affect prognosis.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

See NAACCR SSDI Manual

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field

UPDATE

Tumor Level

New Case Consolidation

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Schema Discriminator 3

IDENTIFIERS

CCR ID	NAACCR ID
E2040	3928

OWNER

NAACCR

DESCRIPTION

Captures additional information needed to generate AJCC ID [995] and Schema ID [3800] for some anatomic sites. Discriminators can be based on sub site, histology or other features which affect prognosis.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

See NAACCR SSDI Manual

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field

UPDATE

Tumor Level

New Case Consolidation

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Schema ID

IDENTIFIERS

CCR ID	NAACCR ID
E1913	3800

OWNER

NAACCR

DESCRIPTION

The derived values in this data item link Site-Specific Data Items (including grade data items) with the appropriate site/histology grouping and accounts for every combination of primary site and histology. The values for this data item are derived based on primary site, histology, and schema discriminator fields (when required). The derived values link Site-Specific Data Items with the appropriate site/histology grouping.
AJCC ID [995] will not be assigned when a site/histology combination is not eligible for TNM staging.

LEVEL

Tumors, Admissions

LENGTH

5

ALLOWABLE VALUES

See NAACCR SSDI Manual

SOURCE

See UC 02.21 Perform SEER EOD Staging Algorithm – UC for specifications to re-run algorithm.

UPDATE

See UC 02.21 Perform SEER EOD Staging Algorithm – UC for specifications to re-run algorithm.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Scope LN Proc 1-3

IDENTIFIERS

	CCR ID	NAACCR ID
Scope LN Proc 1	E1593	None: State Requestor Item
Scope LN Proc 2	E1598	None: State Requestor Item
Scope LN Proc 3	E1603	None: State Requestor Item

DESCRIPTION

There is no NAACCR name or number for this data item. It is a CCR (State) required data item.

LEVELS

Admission

LENGTH

1

ALLOWABLE VALUES

0-7, 9

SOURCE

If the new case record version is A or later, then load the transmitted values and zero-fill.

UPDATE

Manual Update or Correction Applied
If changed, perform the Update/Admission Level Manual Change rules for RX Summ--Scope Reg LN Sur.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/26/03	C/N numbers updated. Changed Allowable values to include 7. This field was changed to apply to all site schemes for cases diagnosed January 1, 2003 and forward. Cases diagnosed prior to January 1, 2003 will be converted. See Commission on Cancer, Cancer Registry Data Conversion Rules: ROADS 1998-2000-FORDS, FORDS-ROADS 1998-2000, (see CoC website for the most current revision version).
3/3/04	Removed Allowable Values edit (Err #184-186). Removed reference to Appendix 2. Removed conversion instructions from SOURCE for Version 9 records. See Use Case 22.
1/8/07	Added Update text.

Secondary Diagnosis 1-10

CCR NAME	CCR ID	NAACCR ID
Secondary Diagnosis 1	E1778	3780
Secondary Diagnosis 2	E1779	3782
Secondary Diagnosis 3	E1780	3784
Secondary Diagnosis 4	E1781	3786
Secondary Diagnosis 5	E1782	3788
Secondary Diagnosis 6	E1783	3790
Secondary Diagnosis 7	E1784	3792
Secondary Diagnosis 8	E1785	3794
Secondary Diagnosis 9	E1786	3796
Secondary Diagnosis 10	E1787	3798

DESCRIPTION

Records the patient's preexisting medical conditions, factors influencing health status, and/or complications for the treatment of this cancer. Both are considered secondary diagnoses. Preexisting medical conditions, factors influencing health status, and/or complications may affect treatment decisions and influence patient outcomes. Information on comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes. Complications may be related to the quality of care. ICD-10-CM codes are 7 characters long, where each character represents an aspect of the condition or procedure: the 7 characters indicate 'section', 'body system', 'root operation', 'body part', 'approach', 'device', and 'qualifier', respectively (see ICD-10-PCS Reference Manual for additional information).

LEVELS

Tumors, Admissions

LENGTH

7

ALLOWABLE VALUES

ICD-10-CM codes:

- A0000-BZZZZ
- E0000-EZZZZ
- G0000-PZZZZ
- R0000-SZZZZ
- T360X-T50Z9
- Y6200-Y8490
- Z1401-Z2299
- Z2301-Z2493
- Z6810-Z6854
- Z8000-Z8090
- Z8500-Z8603
- Z8611-Z9989

00000 No secondary diagnosis documented.
Blanks allowed

SOURCE

Secondary Diagnosis Fields Source Logic

UPDATE

Secondary Diagnosis Fields Update Logic

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

05/2013	New data items for 2013
05/2016	Per NAACCR v16, updated description with the removal of the term "hospital" to accommodate EHR reporting.
11/2016	New Source and Multi-Document Update Logic implemented.

SEER EOD Derived Version

IDENTIFIERS

CCR ID	NAACCR ID
E2500	None

OWNER

CCR

DESCRIPTION

This item indicates the version of the SEER EOD API used to generate: Derived EOD 2018 T [NAACCR #785], Derived EOD 2018 N [NAACCR #815], Derived EOD 2018 M [NAACCR #795], Derived EOD 2018 Stage Group [NAACCR #818], and Derived Summary Stage 2018 [NAACCR #762].

LEVELS

Admissions, Tumors

LENGTH

50

ALLOWABLE VALUES

See the most current version of EOD (https://staging.seer.cancer.gov/) for rules and site-specific codes and coding structures.

SOURCE

See UC 02.21 Perform SEER EOD Staging Algorithm – UC for specifications to re-run algorithm.

UPDATE

See UC 02.21 Perform SEER EOD Staging Algorithm – UC for specifications to re-run algorithm.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented. Field will be generated at Admission and Tumor level using SEER EOD API.

SEER Coding Sys--Original

IDENTIFIERS

CCR ID	NAACCR ID
E1473	2130

OWNER

SEER

DESCRIPTION

This shows the SEER coding system that describes the way the majority of SEER items were originally coded.

LEVELS

Tumors

LENGTH

1

ALLOWABLE VALUES

Codes

0	No SEER coding
1	Pre-1988 SEER Coding Manuals
2	1988 SEER Coding Manual
3	1989 SEER Coding Manual
4	1992 SEER Coding Manual
5	1998 SEER Coding Manual
6	2003 SEER Coding Manual
7	2004 SEER Coding Manual
8	2007 SEER Coding Manual
9	2007 SEER Coding Manual with 2008 changes
A	2010 SEER Coding Manual
B	2011 SEER Coding Manual
C	2012 SEER Coding Manual
D	2013 SEER Coding Manual
E	2014 SEER Coding Manual
F	2015 SEER Coding Manual
G	2016 SEER Coding Manual

SOURCE

See Extract.

UPDATE

None

CONSOLIDATED DATA EXTRACT

Generate on extract:

1. If Year DX is equal to 1987 or Year Dx is equal to 1988 and Month DX is equal to or less than 04 then SEER Coding Sys--Original = 1.

2. If Year DX is equal to 1988 and Month DX is equal to or greater than 05 then SEER Coding Sys--Original = 2.
3. If Year DX is equal to or greater than 1989 and less than or equal to 1991 then Coding Sys--Original = 3.
4. If Year DX is equal to or greater than 1992 and less than or equal to 1997 then Coding Sys--Original = 4.
5. If Year DX is equal to or greater than 1998 and less than or equal to 2002 then Coding Sys--Original = 5.
6. If Year DX is equal to 2003 then SEER Coding Sys--Original = 6.
7. If Year DX is equal to or greater than 2004 and less than or equal to 2006 then Coding Sys--Original = 7.
8. If Year DX is equal to 2007 then Coding Sys--Original =8.
9. If Year DX is equal to or greater than 2008 and less than or equal to 2009 then Coding Sys--Original = 9.
10. If Year DX is equal to 2010 then Coding Sys--Original = A.
11. If Year DX is equal to 2011 then Coding Sys--Original = B.
12. If Year DX is equal to 2012 then Coding Sys--Original = C.
13. If Year DX is equal to 2013 then Coding Sys--Original = D.
14. If Year DX is equal to 2014 then Coding Sys--Original = E.
15. If Year DX is equal to 2015 then Coding Sys--Original = F.
16. If Year DX is equal to 2016 then Coding Sys--Original = G.

HISTORICAL CHANGES

08/15/06	Generated item in Volume II added to Volume III with 2007 data changes.
01/08/07	Code 8 added to Allowable values and data extract in accordance with SEER's new manual for 2007 because this was not in the NAACCR Volume II Allowable Values.
2010	Data Changes: Added code 9 to Allowable Values. Extract documentation updated.
2011	Data Changes: Per NAACCR v12.1 - Definition of code "9" changed from "2010 SEER Coding Manual" to "January 2008 SEER Coding Manual". - Code "A" (January 2010 SEER Coding Manual) added to list of allowable codes in both description and logic.
02/09/12	Updated Consolidated Data Extract based on Eureka Business Analyst input.
2012	Data Changes: Per NAACCR v12.2 1. Definition of code 9 changed from "9 January 2008 SEER Coding Manual" to "2007 SEER Coding Manual with 2008 changes" 2. Code B (2011 SEER Coding Manual) added to list of allowable codes. 3. Code C (2012 SEER Coding Manual) added to list of allowable codes.
05/2013	Code D (2013 SEER Coding Manual) added to list of allowable codes. Updated the Consolidated Data Extract
04/2014	Code E (2014 SEER Coding Manual) added to list of allowable codes. Updated Consolidated Data Extract.
03/2015	Code F (2015 SEER Coding Manual) added to list of allowable codes. Updated Consolidated Data Extract.

05/2016	Code G (2016 SEER Coding Manual) added to list of allowable codes. Updated Consolidated Data Extract.

SEER Coding Sys--Current

IDENTIFIERS

CCR ID	NAACCR ID
E1472	2120

DESCRIPTION

This shows the SEER coding system that describes the way the majority of SEER items are in the record (after conversion).

LEVELS

Tumor

LENGTH

1

ALLOWABLE VALUES

0	No SEER coding
1	Pre-1988 SEER Coding Manuals
2	1988 SEER Coding Manual
3	1989 SEER Coding Manual
4	1992 SEER Coding Manual
5	1998 SEER Coding Manual
6	2003 SEER Coding Manual
7	2004 SEER Coding Manual
8	2007 SEER Coding Manual
9	2007 SEER Coding Manual with 2008 changes
A	2010 SEER Coding Manual
B	2011 SEER Coding Manual
C	2012 SEER Coding Manual
D	2012 SEER Coding Manual with 2013 changes

SOURCE

Generated item--See Consolidated Data Extract section

UPDATE

None

CONSOLIDATED DATA EXTRACT

Generate on extract:

1. If Year of Diagnosis is 2006 or earlier, then set to 7 (January 2004 SEER Coding Manual).
2. If Year of Diagnosis is 2007, set to 8 (January 2007 SEER Coding Manual).
3. If Year of Diagnosis is 2008 or 2009, set to 9 (January 2008 SEER Coding Manual).
4. If Year of Diagnosis is 2010, set to A (January 2010 SEER Coding Manual).
5. If year of Diagnosis is 2011, set to B (2011 SEER Coding Manual).
6. If year of Diagnosis is 2012, set to C (2012 SEER Coding Manual).
7. If year of Diagnosis is 2013, set to D (2013 SEER Coding Manual).
8. Else SEER Coding Sys--Current = ' '.

HISTORICAL CHANGES

08/2006	Generated item in Volume II added to Volume III with 2007 data changes.
01/2007	Code 8 added to Allowable values and data extract in accordance with SEER's new manual for 2007 because this was not in the NAACCR Volume II Allowable Values.
2010	Data Changes: Added code 9 to Allowable Values. Extract documentation updated.
2011	Data Changes: Per NAACCR v12.1: Definition of code "9" changed from "2010 SEER Coding Manual" to "January 2008 SEER Coding Manual". Code "A" (January 2010 SEER Coding Manual) added to list of allowable codes. Allowable values now are Alpha Numeric. Added SEER edit to verify the extract logic.
2012	Data Changes: Per v12.2: 1. Definition of code 9 changed from "9 January 2008 SEER Coding Manual" to"2007 SEER Coding Manual with 2008 changes" 2. Code B (2011 SEER Coding Manual) added to list of allowable codes. 3. Code C (2012 SEER Coding Manual) added to list of allowable codes.
02/2012	Updated Consolidated Data Extract based on Eureka Business Analyst input.
05/2013	Code D (2013 SEER Coding Maual) added to list of allowable codes.
03/2020	Added back to Volume III

SEER Site-Specific Fact 1

IDENTIFIERS

CCR ID	NAACCR ID
E1246	3700

OWNER

SEER

DESCRIPTION

This data item is reserved for human papilloma virus (HPV)
Status. This data item only applies to the schemas:

- Oropharynx (p16+): C019, C024, C051-C052, C090-C091, C098-C099, C100, C102-C103, C108-C109, C111
- Oropharynx (p16-) and Hypopharynx: C019, C024, C051-C052, C090-C091, C098-C099, C100, C102-C103, C108-C109, C111, C129, C130-C132, C138-C139
- Lip and Oral Cavity: C000-C009, C020-C023, C028-C029, C030-C031, C039, C040-C041, C048-C049, C050, C058-C059, C060-C062, C068-C069

There is evidence that human papilloma virus (HPV) plays a role in the pathogenesis of some cancers. HPV testing may be performed for prognostic purposes; testing may also be performed on metastatic sites to aid in determination of the primary site.

LEVEL

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

0	HPV negative for viral DNA by ISH test
1	HPV positive for viral DNA by ISH test
2	HPV negative for viral DNA by PCR test
3	HPV positive for viral DNA by PCR test
4	HPV negative by ISH E6/E7 RNA test
5	HPV positive by ISH E6/E7 RNA test
6	HPV negative by RT-PCR E6/E7 RNA test
7	HPV positive by RT-PCR E6/E7 RNA test
8	HPV status reported in medical records as positive or negative but test type is unknown
9	Unknown if HPV test detecting viral DNA and or RNA was performed
Blank	Date of Diagnosis pre-2018, or Date of Diagnosis 2018 and greater and Schema ID is NOT listed in step 2 of Source Logic

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater and Schema ID is one of the following:
   - 00071: Lip
   - 00072: Tongue Anterior

- 00073: Gum
- 00074: Floor of Mouth
- 00075: Palate Hard
- 00076: Buccal Mucosa
- 00077: Mouth Other
- 00100: Oropharynx HPV-Mediated (p16+)
- 00111: Oropharynx (p16-)
- 00112: Hypopharynx

Then convert blanks or non-numeric values to 9

3. If Date of Diagnosis is 2018 and greater and Schema ID is NOT listed above,
   Then blank out field

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Tumor's Date of Diagnosis year is 2018 – 9998

One of the following conditions is true

- Admission's value is not blank or 9
- Tumor's value is blank or 9

OR

- Admission's value is 9
- Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.
Otherwise,
If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented
01/2019	Revised Source logic: All Schema IDs NOT listed in step 2 should be blank for this data field

SEER Summary Stage 1977

IDENTIFIERS

CCR ID	NAACCR ID
E1133	760

OWNER

SEER

DESCRIPTION

There are two versions of this field:
Non-Generated: Generalized summary of extent of disease as determined by all evidence obtained from diagnostic and therapeutic procedures performed during the first course of treatment or within four months after the date of diagnosis, whichever is earlier.
Generated: Uses SEER's Summary Stage program to calculate SEER Summary Stage 1977. This program is written in C and the source code can be obtained from SEER.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

0	In Situ
1	Localized
2	Regional, extension only
3	Regional, regional lymph nodes only
4	Regional, direct extension and regional lymph nodes
5	Regional, NOS
7	Distant
8	Not applicable
9	Unstaged

SOURCE

If the transmitted value is numeric, then just load it with no conversion. Otherwise, convert it to 8.

UPDATE

If the tumor's Date of Diagnosis year is 1994-2000, then compare the admission and tumor SEER Summary Stage 1977 values and:

Take 0-7 or 9 over 8
Take 0-7 over 9
Take the highest value of 0-7

If all of the following conditions are true:

The tumor's Date of Diagnosis year is 0001-1993 or blank
The admission's SEER Summary Stage 1977 is 0-7
The tumor's SEER Summary Stage 1977 is 0-7
The admission and tumors' SEER Summary Stage 1977 codes are different

Then list for review

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

05/15/01	Name of field was changed to SUM-STAGE-77 (Summary Stage 1977) due to the addition of the new Summary Stage 2000 field; reference to CCR Edit-IFINSITU deleted; edit 1) changed to include effective date, and "HIST-TYPE 8081" excluded from edit.
07/06/01	Fixed DATE-DX ranges in interfield edits; added Region 1/8 check to interfield edit 2).
03/03/04	Definition for code 8 updated to include "not applicable".
12/2008	Clarified the two methods (generated & non-generated) for Sum Stage 77 values because they can produce different results.
2010	Data Item Changes: CCR names (Sum_Stage_77) changed to NAACCR name. Rewrote Update logic.
2011	Removed IF306, 334, and 336 to match deletion in the metafile.
07/2015	Corrected labels to match NAACCR descriptions.

SEER Summary Stage 2000

IDENTIFIERS

CCR ID	NAACCR ID
E1132	759

OWNER

SEER

DESCRIPTION

There are two versions of this field:
Non-Generated: Code for summary stage at the initial diagnosis or treatment of the reportable tumor.
Generated: Uses SEER's Summary Stage program to calculate SEER Summary Stage 1977. This program is written in C and the source code can be obtained from SEER.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

0	In Situ
1	Localized
2	Regional, direct extension only
3	Regional, regional lymph nodes only
4	Regional, direct extension and regional lymph nodes
5	Regional, NOS
7	Distant
8	Not applicable
9	Unstaged
Blank	2018 and forward Date of Diagnosis

SOURCE

1. If Date of Diagnosis is less than 2018, and the transmitted value is numeric, then load with no conversion. Otherwise, covert it to 8.
2. If Date of Diagnosis is 2018 and greater, then blank out field.

UPDATE

SEER Summary Stage 2000 Update Logic

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

05/15/01	New field added to collect summary stage for cases diagnosed 1/1/01 and later.
07/06/01	Changed interfield edit number from 448 to 441. Fixed DATE-DX range in list for review section.
03/03/04	Definition for code 8 updated to include "not applicable" and benign brain. Updated IF #441 to remove "or 9" as benign brains were coded to 9 in CP 21.

12/2008	Clarified the two methods (generated & non-generated) for Sum Stage 77 values because they can produce different results.
2010	Data Item Changes: CCR names (Sum_Stage_00) changed to NAACCR name. Rewrote Update logic.
2011	Removed IF437, 440, and 441 to match deletion in the metafile.
07/2015	Corrected labels to match NAACCR descriptions.
05/2016	Updated description to match NAACCR Data Dictionary.
11/2016	New Multi-Document Update Logic implemented.
11/2018	Per NAACCR v18, revised Source Logic to handle that field is no longer collected 2018 and forward.
01/2019	Per NAACCR v18, added Blank to allowable values

Sentinel Lymph Nodes Examined

IDENTIFIERS

CCR ID	NAACCR ID
E1850	834

OWNER

COC

DESCRIPTION

Records the total number of lymph nodes sampled during the sentinel node biopsy and examined by the pathologist. This data item is required for ~~CoC accredited facilities as of~~ breast and melanoma skin cases diagnosed 01/01/2018 and later. ~~This data item is required for breast and melanoma cases only.~~

LEVELS

Admissions, Tumors

LENGTH

2

ALLOWABLE VALUES

00	No sentinel nodes were examined
01-90	Sentinel nodes were examined (code the exact number of sentinel lymph nodes examined)
95	No sentinel nodes were removed, but aspiration of sentinel node(s) was performed
98	Sentinel lymph nodes were biopsied, but the number is unknown
99	It is unknown whether sentinel nodes were examined; not stated in patient record
Blank	Date of Diagnosis pre-2018 or Date of Diagnosis 2018 forward and Schema id is NOT 00470 (melanoma) or 00480 (breast)

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater
   AND Schema ID IS NOT 00470 (melanoma) or 00480 (breast), THEN blank out field
3. If Date of Diagnosis is 2018 and greater
   AND Schema ID IS 00470 (melanoma) or 00480 (breast)
   AND Type of Reporting Source is NOT 7 (Death Certificate)
   AND field is blank, 99 or non-numeric, THEN convert to 00
4. Otherwise, left justify and zero fill values less than two digits
   - ~~Convert blanks or non-numeric values to 99~~

UPDATE

TUMOR LEVEL

NEW CASE CONSOLIDATION

If all these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID IS 00470 (melanoma) or 00480 (breast)

- Tumor's Type of Reporting Source is NOT 7 (Death Certificate)

AND One of the following sets of conditions is true

- Admission's value is NOT ~~blank or 99~~ 00
- Tumor's value is blank, 00 or 99

OR

- Admission's value is ~~99~~ 00
- Tumor's value is blank or 99

Then automatically update the Tumor's value with the Admission's value.
Otherwise,
If Admission's value is not the same as the Tumor's value
Then list for review

MANUAL UPDATE

ADMISSION

MANUAL UPDATE

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.
11/2019	SOURCE and UPDATE logic revised
04/2020	SOURCE and UPDATE logic revised – updated with death certificate exceptions and to check admission date of diagnosis in update logic.

Sentinel Lymph Nodes Positive

IDENTIFIERS

CCR ID	NAACCR ID
E1851	835

OWNER

COC

DESCRIPTION

Records the exact number of sentinel lymph nodes biopsied by the pathologist and found to contain metastases. This data item is required for ~~CoC accredited facilities as of~~ breast and melanoma skin cases diagnosed 01/01/2018 and later. ~~This data item is required for breast and melanoma cases only.~~

LEVELS

Admissions, Tumors

LENGTH

2

ALLOWABLE VALUES

00	All sentinel nodes examined are negative
01-90	Sentinel nodes are positive (code exact number of nodes positive)
95	Positive aspiration of sentinel lymph node(s) was performed
97	Positive sentinel nodes are documented, but the number is unspecified; For breast ONLY: SLN and RLND occurred during the same procedure
98	No sentinel nodes were biopsied
99	It is unknown whether sentinel nodes are positive; not applicable; not stated in patient record
Blank	Date of Diagnosis pre-2018 or Date of Diagnosis 2018 forward and Schema ID is NOT 00470 (melanoma) or 00480 (breast)

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater
   AND Schema ID is NOT 00470 (melanoma) or 00480 (breast), THEN blank out field
3. If Date of Diagnosis is 2018 and greater
   AND Schema ID IS 00470 (melanoma) or 00480 (breast)
   AND Type of Reporting Source is NOT 7 (Death Certificate)
   AND field is blank, 99 or non-numeric, then convert to 98
4. Otherwise, left justify and zero fill values less than two digits
   - ~~Convert blanks or non-numeric values to 99~~

UPDATE

TUMOR LEVEL

NEW CASE CONSOLIDATION

If all these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Tumor's Date of Diagnosis year is 2018 – 9998

- Tumor's Schema ID IS 00470 (melanoma) or 00480 (breast)
- Tumor's Type of Reporting Source is NOT 7 (Death Certificate)

AND one of the following sets of conditions is true

- Admission's value is not ~~blank or 99~~ 98
- Tumor's value is blank, 98 or 99

OR

- Admission's value is ~~99~~ 98
- Tumor's value is blank or 99

Then automatically update the Tumor's value with the Admission's value.
Otherwise,
If Admission's value is not the same as the Tumor's value
Then list for review

MANUAL UPDATE

ADMISSION

MANUAL UPDATE

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.
11/2019	SOURCE and UPDATE Logic revised
04/2020	SOURCE and UPDATE logic revised – updated with death certificate exceptions and to check admission date of diagnosis in update logic.

Separate Tumor Nodules

IDENTIFIERS

CCR ID	NAACCR ID
E2041	3929

OWNER

NAACCR

DESCRIPTION

"Separate tumor nodules" refers to what is conceptually a single tumor with intrapulmonary metastasis in the ipsilateral (same) lung. Their presence in the same or different lobes of lung from the primary tumor affects the T and M categories.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	No separate tumor nodules; single tumor only Separate tumor nodules of same histologic type not identified/not present Intrapulmonary metastasis not identified/not present Multiple nodules described as multiple foci of adenocarcinoma in situ or minimally invasive adenocarcinoma
1	Separate tumor nodules of same histologic type in ipsilateral lung, same lobe
2	Separate tumor nodules of same histologic type in ipsilateral lung, different lobe
3	Separate tumor nodules of same histologic type in ipsilateral lung, same AND different lobes
4	Separate tumor nodules of same histologic type in ipsilateral lung, unknown if same or different lobe(s)
7	Multiple nodules or foci of tumor present, not classifiable based on notes 3 and 4
8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code 8 will result in an edit error.)
9	Not documented in medical record Primary tumor is in situ Separate Tumor Nodules not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00360
        - Type of Reporting Source is not 7
        - Behavior Code ICD-O-3 is 2
        - Separate Tumor Nodules is not 0, 9

Then convert Separate Tumor Nodules to 9

B. If all of the following conditions are true:
- Schema ID is 00360
- Type of Reporting Source is not 7
- Behavior Code ICD-O-3 is not 2
- Separate Tumor Nodules is blank or 8

Then convert Separate Tumor Nodules to 9

C. If all of the following conditions are true:
- One of the following is true:
  - Schema ID is not 00360
    OR
  - Type of Reporting Source is 7
- Separate Tumor Nodules is not blank

Then convert Separate Tumor Nodules to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:
- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00360
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00360

One of the following conditions is true
- Admission's value is not blank, 9
- Tumor's value is blank, 9

  OR
  - Admission's value is 9
  - Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.
Otherwise,
If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Sequence Number--Central

IDENTIFIERS

CCR ID	NAACCR ID
E1052	380

OWNER

SEER

DESCRIPTION

Code indicates the sequence of all reportable neoplasms during the patient's lifetime determined by the central registry. This data item differs from Sequence Number Hospital, because the definitions of reportable neoplasms often vary between hospital and a central registry. When two or more tumors are diagnosed simultaneously, the one with the worst prognosis is assigned the lowest sequence number.

LEVELS

Tumor

LENGTH

2

ALLOWABLE VALUES

00	One primary only in the patient's lifetime.
01-59	Actual number of this primary.
99	Unspecified required sequence number or unknown.
State Registry Defined	
60	Only one state registry-defined neoplasm.
61	First of two or more state registry-defined neoplasms.
62	Second of two or more state registry-defined neoplasms.
63-87	Actual number of state registry-defined neoplasms.
88	Unspecified number of state registry-defined neoplasms.

SOURCE

When a new tumor is created, attempt to generate Sequence Number--Central automatically according to NAACCR 2003, Implementation Work Group: Guidelines and Recommendations, as interpreted in UC 02.08.01.01 Consolidate Sequence Number – Central – UC. If system is unable to generate Sequence Number--Central for new the new tumor, system will leave field blank causing an edit error requiring manual resolution.

UPDATE

Tumor Level

Manual Change Only

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

03/26/03	New data item in the 2003 data item set.
03/03/04	Updated Source information to reflect the definition of this field to calculate the tumors for the patient's lifetime.

08/15/06	Updated range of Allowable Values to 59.
10/10/07	Added IF #760.
2010	Data Item Changes: CCR name (Seq_No_Central) changed to NAACCR name.
07/2015	Revised SOURCE logic to reference UC 02.08.01.01 Consolidate Sequence Number – Central instead of Appendix 27. Appendix 27 was duplicate of UC and has been removed from Volume III. UPDATE logic revised to document that Manual Change is needed at Tumor Level.

Sequence Number--Hospital

IDENTIFIERS

CCR ID	NAACCR ID
E1085	560

DESCRIPTION

Chronological order of this tumor among all the reportable tumors diagnosed during the patient's lifetime determined by the reporting facility. When two or more tumors are diagnosed simultaneously, the one with the worst prognosis is assigned the lowest sequence number.LEVELS

LEVEL

Admission

LENGTH

2

ALLOWABLE VALUES

00	One primary only in the patient's lifetime.
01-59	Actual number of this primary.
99	Unspecified required sequence number or unknown.
	State Registry/Cancer Committee Reportable
60	Only one state registry-defined neoplasm.
61	First of two or more state registry-defined neoplasms.
62	Second of two or more state registry-defined neoplasms.
63-87	Actual number of state registry-defined neoplasms.
88	Unspecified number of state registry-defined neoplasms.

SOURCE

Upload with no conversion.

UPDATE

Manual Change or Correction Applied.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

5/15/01	Type of record changed to alphanumeric and allowable values changed to allow characters to accommodate sequencing of benign and uncertain behavior brain and CNS tumors and borderline ovarian tumors.
7/6/01	Changed HIST-TYPE reference to HIST-TYPE-3 and added AA and BB-ZZ to exclusionary condition in IR #803.
11/14/02	IR #802 updated to allow 00 when there are multiple tumors but only if the other sequence numbers are not numeric (alphabetical values for brain tumors).
3/26/03	Data item name changed from Seq_No to Seq_No_Hosp. Changed levels to Admissions only, since Sequence Number--Central is now at tumor level. Changed Allowable Values (number of possible primary tumors changed from 25 to 35). Changed type to numeric codes only. Interfield edit 3) removed. Range in IF #361 and IF #373 changed to reflect the new codes. Removed Interrecord edits and List for Review requirements. Conversion

	from alpha to numeric codes will be necessary for all cases collected prior to Coding Procedure 21. Refer to, NAACCR 2003 Implementation Work Group: Guidelines and Recommendations.
8/15/06	Updated range of Allowable Values to 59.
1/8/07	Changed CCR Data Extract to "no" (was yes).
10/10/07	Added IF #759.
2010	Data Changes: CCR name (Seq No Hosp) changed to NAACCR name. Added IF #324.

Serum Albumin Pretreatment Level

IDENTIFIERS

CCR ID	NAACCR ID
E2042	3930

OWNER

NAACCR

DESCRIPTION

Albumin is the most abundant protein in human blood plasma. Serum albumin pretreatment level is a prognostic factor for plasma cell myeloma.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	Serum albumin <3.5 g/dL
1	Serum albumin =3.5 g/dL
7	Test ordered, results not in chart
9	Not documented in medical record Serum Albumin Pretreatment Level not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00821
        - Schema Discriminator = 0
        - Type of Reporting Source is not 7
        - Serum Albumin Pretreatment Level is blank

        Then convert Serum Albumin Pretreatment Level to 9

    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00821 OR
              Schema ID is 00821
            - Schema Discriminator = 1 or 9 OR
              Type of Reporting Source is 7
        - P Serum Albumin Pretreatment Level is not blank

        Then convert Serum Albumin Pretreatment Level to blank

UPDATE

TUMOR LEVEL

NEW CASE CONSOLIDATION

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00821
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00821
- One of the following conditions is true
- Admission's value is not blank or 9
- Tumor's value is 9

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

ADMISSION

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Serum Beta-2 Microglobulin Pretreatment level

CCR ID	NAACCR ID
E2043	3931

OWNER

NAACCR

DESCRIPTION

Serum Beta-2 Microglobulin is a protein that is found on the surface of many cells and plentiful on the surface of white blood cells. Increased production or destruction of these cells causes Serum β2 (beta-2) Microglobulin level to increase. Elevated Serum β2 (beta-2) Microglobulin level is a prognostic factor for plasma cell myeloma.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	ß2-microglobulin <3.5 mg/L
1	ß2-microglobulin =3.5 mg/L <5.5 mg/L
2	ß2-microglobulin =5.5 mg/L
7	Test ordered, results not in chart
9	Not documented in medical record
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00821
        - Schema Discriminator = 0
        - Type of Reporting Source is not 7
        - Serum Beta-2 Microglobulin Pretreatment Level is blank

        Then convert Serum Beta-2 Microglobulin Pretreatment Level to 9

    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00821 OR
              Schema ID is 00821
            - Schema Discriminator = 1 or 9 OR
              Type of Reporting Source is 7
        - Serum Beta-2 Microglobulin Pretreatment Level is not blank

        Then convert Serum Beta-2 Microglobulin Pretreatment Level to blank

UPDATE

TUMOR LEVEL

NEW CASE CONSOLIDATION

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00821
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00821
- One of the following conditions is true
- Admission's value is not blank, 9
- Tumor's value is 9

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

ADMISSION

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Sex

IDENTIFIERS

CCR ID	NAACCR ID
E1031	220

OWNER

SEER/COC

DESCRIPTION

Sex of the patient.

LEVELS

Patients, Admissions

LENGTH

1

ALLOWABLE VALUES

1	Male
2	Female
3	Other (intersex, disorders of sexual development/DSD). The word hermaphrodite formally classified under this code is an outdated term.
4	Transsexual, NOS
5	Transsexual, natal male
6	Transsexual, natal female
9	Unknown

SOURCE

If the transmitted value is numeric, then just load it with no conversion. Otherwise, convert it to 9.

UPDATE

Patient Level

New Case Consolidation

If AD_Sex <> 9 and PA_Sex = 9, move AD_Sex to PA_Sex else if AD_Sex <> 9 and <> PA_Sex, list for review.

Manual Change

If Sex changes, through consolidation or manual change, then NHIA_Derived_Hisp_Origin must be regenerated.

Admission Level

Manual Change

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/19/05	1/19/05: Update logic added for NHIA_Derived_Hisp_Origin regeneration.
12/2014	Per NAACCR v15, added new codes: 5 (Transsexual, natal male) and 6 (Transsexual, natal female). Revised Code 4 (Transsexual, NOS).

05/2016	Per NAACCR v16, revised code 3 description to reflect that the word hermaphrodite formally classified under this code is an outdated term.

Site Coding Sys--Current

IDENTIFIERS

CCR ID	NAACCR ID
E1066	450

DESCRIPTION

Code that best describes how the primary site currently is coded. If converted, this field shows the system to which it is converted.

LEVELS

Tumors

LENGTH

1

ALLOWABLE VALUES

1	ICD-8 and MOTNAC
2	ICD-9
3	ICD-O, First Edition
4	ICD-O, Second Edition
5	ICD-O, Third Edition
6	ICD-10
9	Other

SOURCE

See Extract.

UPDATE

None

CONSOLIDATED DATA EXTRACT

Generate 5 (ICD-O Third Edition (2000).

HISTORICAL CHANGES

8/15/06	Generated item in Volume II added to Volume III with 2007 data changes.

Site Coding Sys--Original

IDENTIFIERS

CCR ID	NAACCR ID
E1067	460

DESCRIPTION

Code that best describes how the primary site was originally coded. If converted, this field shows the original coding system used.

LEVELS

Tumors

LENGTH

1

ALLOWABLE VALUES

1	ICD-8 and MOTNAC
2	ICD-9
3	ICD-O, First Edition
4	ICD-O, Second Edition
5	ICD-O, Third Edition
6	ICD-10
9	Other

SOURCE

See Extract.

UPDATE

None

CONSOLIDATED DATA EXTRACT

Generate on extract.

HISTORICAL CHANGES

8/15/06	Generated item in Volume II added to Volume III with 2007 data changes.

Site-Recode-SEER

IDENTIFIERS

None: In Eureka, this field is generated when necessary and is not stored in the database.

DESCRIPTION

Site group used for statistical reporting according to SEER's standards. Separates leukemias and lymphomas from site-specific cancers.

LEVELS

Tumor

LENGTH

5

ALLOWABLE VALUES

99999	Unknown
	http://seer.cancer.gov/siterecode

SOURCE

Computer generate using TU_Site and TU_Hist_Type_3 (see Appendix #3).

UPDATE

Regenerate if either TU_Site or TU_Hist_Type_3 change.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

1/1/99	Received new version of subprogram from SEER; regenerated in all tumors.
7/6/01	Changed HIST-TYPE references to HIST-TYPE-3.
3/26/03	In Eureka, this field is generated when necessary and is not stored in the database. Allowable values edit #385 is removed. Appendix now refers to the SEER website. For these values, see the SEER website at http://seer.cancer.gov/siterecode.

Social Security Number

IDENTIFIERS

CCR ID	NAACCR ID
E1647	2320

DESCRIPTION

Social Security Number, which is used for patient identification and linkage.

LEVELS

Patients, Admissions

LENGTH

9

ALLOWABLE VALUES

Any numeric.
The following are not allowed:

- Blanks.
- First three digits cannot = 000 or 666.
- Fourth and fifth digits cannot = 00
- Last four digits cannot = 0000.
- First digit cannot = 9 (except when first digit of 999999999).

SOURCE

If Social Security Number is numeric and > 0, then load transmitted value.
Otherwise, load 999999999

UPDATE

For all documents (passive follow-up, active follow-up, corrections)
If AB-Social Security Number <> 9's and PA-Social Security Number = 9s,
Move AB-Social Security Number to PA-Social Security Number.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

4/27/05	Added NAACCR Allowable Values edit (Err#34) to restrict invalid SSNs.
2010	Data Changes: CCR name (SSN) changed to NAACCR name.
2011	Data Changes: Modified "First Digit" in Allowable Values. SSN is allowed to begin with 8 starting in 2011 as per NAACCR v12.1A.

Source Comorbidity

IDENTIFIERS

CCR ID	NAACCR ID
E1281	9970

OWNER

NPCR

DESCRIPTION

Record the data source from which comorbidities/complications were collected.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

0-5, 9 or blank
Blanks are not allowed for cases diagnosed 2011 and forward.
Codes

0	No comorbid condition or complication identified/Not Applicable
1	Collected from facility face sheet
2	Linkage to facility/hospital discharge data set
3	Linkage to Medicare/Medicaid data set
4	Linkage with another claims data set
5	Linkage through a combination of two or more sources above
9	Other source
Blank	A blank is only allowed for cases diagnosed prior to 2011

SOURCE

Comorbid Fields Source Logic

UPDATE

Comorbid Fields Update Logic

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

2011 Data Item Changes, CER Project	Added for CER requirements.
05/2013	This data item is now required by NPCR for Date of Diagnosis 2013 and forward. We are still required to submit the values as part of the CER dataset.
12/2013	Allowable values revised per NPCR. Required for Date of Diagnosis 2011 and forward for all Regions. Global fix performed to change blanks to 0 or 1 as appropriate for Date of Diagnosis

	2011 forward. Update Logic to be revised with 2014 Data Changes.
04/2014	Revisions to Source and Update Logic. IF 698 retired.

Spanish/Hispanic Origin

IDENTIFIERS

CCR ID	NAACCR ID
E1028	190

DESCRIPTION

This field is used to denote those persons of Spanish origin. Persons of Spanish origin may be of any race. This field is different than computed Spanish surname (SPANISH-SURNAME).

LEVELS

Patients, Admissions

LENGTH

1

ALLOWABLE VALUES

0	Non-Spanish
1	Mexican
2	Puerto Rican
3	Cuban
4	Central or South American (except Brazil)
5	Other Spanish
6	Spanish, NOS
7	Spanish Surname
8	Dominican Republic (effective with diagnosis on or after 1/1/2005)
9	Unknown whether Spanish or not

SOURCE

If the transmitted value is numeric, then just load it with no conversion. Otherwise, convert it to 9.

UPDATE

Select the best according to the following hierarchy:

0-8 is better than 9
0-6 or 8 is better than 7
1-5 or 8 is better than 6
Else if both are 0-6 or 8 and not equal, list for review

If Spanish/Hispanic Origin changes, you may need to update RACE-RECODE-CAL.
If Spanish/Hispanic Origin changes, through consolidation or manual change, then NHIA Derived Hisp Origin must be regenerated.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

1/19/05	Code 8 for Dominican Republic added for cases diagnosed on or after 1/1/2005.
1/1/2005	Cases diagnosed prior to 1/1/2005 will continue to use code 5 for Dominican Republic. Added 8 to Update logic and IF #663. Added Update logic for NHIA_Derived_Hisp_Origin regeneration.

2010	Data Changes: CCR name (Spanish Origin) changed to NAACCR name.

SSN Suffix

IDENTIFIERS

CCR ID	NAACCR ID
E1565	None: State Requestor

DESCRIPTION

Suffix for patient's social security number, used to show the relationship of the patient to the bearer of the SSN entered (e.g. spouse). This only became available with Coding_Proc 13.

LEVELS

Patients
Admissions

LENGTH

2

ALLOWABLE VALUES

Any upper-case alpha character, numeric, ampersand (&), or blank.

SOURCE

Upshift

UPDATE

If PA SSN = AD SSN, then if PA SSN Suffix = blank or 9s and AD SSN Suffix <> blank or 9s, replace
else, if AD SSN Suffix <> blank or 9s, and <> PA SSN Suffix, list for review.

CONSOLIDATED DATA EXTRACT

Yes

INTERFIELD EDITS

None

HISTORICAL CHANGES

	None

Stage Alternate

IDENTIFIERS

CCR ID	NAACCR ID
E1579	None. State Requestor Item

DESCRIPTION

Any other staging system and value that the user wishes to code.

LEVELS

Admission

LENGTH

4

ALLOWABLE VALUES

Any

SOURCE

Upload with no conversion.

UPDATE

Manual

CONSOLIDATED DATA EXTRACT

No

HISTORICAL CHANGES

	None

State at DX Geocode 1970/80/90

IDENTIFIERS

CCR ID	NAACCR ID
E1826	81

DESCRIPTION

Code for the state of the patient's residence at the time the tumor was diagnosed is a derived (geocoded) variable based on Census Boundary files from 1970, 1980, or 1990 Decennial Census.

LEVELS

Tumor

LENGTH

2

ALLOWABLE VALUES

01-95	Valid FIPS code
Blank	Residence unknown, geocoding not performed, geocoding unsuccessful, residence outside US (including its territories, commonwealths, or possessions) residence US, NOS

Note: for u.s. residents, historically, standard codes are those of the fips publication "counties and equivalent entities of the united states, its possessions, and associated areas." these fips codes (fips 6-4) have been replaced by incits standard codes, however, there is no impact on this variable as the codes align with the system the census used for each decennial census and will automatically be accounted for during geocoding.

SOURCE

No State at DX Geocode 1970/80/90 at admission. Variable created at tumor. Set to blank for new cases.

UPDATE

Whenever Census Tract 1970/80/90 is changed, State at DX Geocode 1970/80/90 must be changed accordingly:

- If Census Tract 1970/80/90 is '999996' or '999997' (waiting for geocoding) then State at DX Geocode 1970/80/90 must be blank.
- If Census Tract 1970/80/90 cannot be tracted (999993-999995 or 999998-999999) then State at DX Geocode 1970/80/90 must be 99.
- If Census Tract 1970/80/90 is tracted and a State at DX Geocode 1970/80/90 is available (whether through geocoding or linking a tumor with a tracted address) the available State at DX Geocode 1970/80/90 code should be used.
- However, if Census Tract 1970/80/90 is tracted but State at DX Geocode 1970/80/90 is not available, State at DX Geocode 1970/80/90 should be set to blank.

CONSOLIDATED DATA EXTRACT

No

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new geocode data field implemented.

State at DX Geocode 2000

IDENTIFIERS

CCR ID	NAACCR ID
E1827	82

DESCRIPTION

Code for the state of the patient's residence at the time the tumor was diagnosed is a derived (geocoded) variable based on Census Boundary files from 2000 Decennial Census.

LEVELS

Tumor

LENGTH

2

ALLOWABLE VALUES

01-95	Valid FIPS code
Blank	Residence unknown, geocoding not performed, geocoding unsuccessful, residence outside US (including its territories, commonwealths, or possessions) residence US, NOS

Note: For U.S. Residents, Historically, Standard Codes Are Those Of The Fips Publication "Counties And Equivalent Entities Of The United States, Its Possessions, And Associated Areas." These Fips Codes (Fips 6-4) Have Been Replaced By Incits Standard Codes, However, There Is No Impact On This Variable As The Codes Align With The System The Census Used For Each Decennial Census And Will Automatically Be Accounted For During Geocoding.

SOURCE

No State at DX Geocode 2000 at admission. Variable created at tumor. Set to blank for new cases.

UPDATE

Whenever Census Tract 2000 is changed, State at DX Geocode 2000 must be changed accordingly:

- If Census Tract 2000 is '999996' or '999997' (waiting for geocoding) then State at DX Geocode 2000 must be blank.
- If Census Tract 2000 cannot be tracted (999993-999995 or 999998-999999) then State at DX Geocode 2000 must be 99.
- If Census Tract 2000 is tracted and a State at DX Geocode 2000 is available (whether through geocoding or linking a tumor with a tracted address) the available State at DX Geocode 2000 code should be used.
- However, if Census Tract 2000 is tracted but State at DX Geocode 2000 is not available, State at DX Geocode 2000 should be set to blank.

CONSOLIDATED DATA EXTRACT

No

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new geocode data field implemented.

State at DX Geocode 2010

IDENTIFIERS

CCR ID	NAACCR ID
E1828	83

DESCRIPTION

Code for the state of the patient's residence at the time the tumor was diagnosed is a derived (geocoded) variable based on Census Boundary files from 2010 Decennial Census.

LEVELS

Tumor

LENGTH

2

ALLOWABLE VALUES

01-95	Valid FIPS code
Blank	Residence unknown, geocoding not performed, geocoding unsuccessful, residence outside US (including its territories, commonwealths, or possessions) residence US, NOS

Note: For U.S. Residents, Historically, Standard Codes Are Those Of The Fips Publication "Counties And Equivalent Entities Of The United States, Its Possessions, And Associated Areas." These Fips Codes (Fips 6-4) Have Been Replaced By Incits Standard Codes, However, There Is No Impact On This Variable As The Codes Align With The System The Census Used For Each Decennial Census And Will Automatically Be Accounted For During Geocoding.

SOURCE

No State at DX Geocode 2010 at admission. Variable created at tumor. Set to blank for new cases.

UPDATE

Whenever Census Tract 2010 is changed, State at DX Geocode 2010 must be changed accordingly:

- If Census Tract 2010 is '999996' or '999997' (waiting for geocoding) then State at DX Geocode 2010 must be blank.
- If Census Tract 2010 cannot be tracted (999993-999995 or 999998-999999) then State at DX Geocode 2010 must be 99.
- If Census Tract 2010 is tracted and a State at DX Geocode 2010 is available (whether through geocoding or linking a tumor with a tracted address) the available State at DX Geocode 2010 code should be used.
- However, if Census Tract 2010 is tracted but State at DX Geocode 2010 is not available, State at DX Geocode 2010 should be set to blank.

CONSOLIDATED DATA EXTRACT

No

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new geocode data field implemented.

State at DX Geocode 2020

IDENTIFIERS

CCR ID	NAACCR ID
E1829	84

DESCRIPTION

Code for the state of the patient's residence at the time the tumor was diagnosed is a derived (geocoded) variable based on Census Boundary files from 2020 Decennial Census.

LEVELS

Tumor

LENGTH

2

ALLOWABLE VALUES

01-95	Valid FIPS code
Blank	Residence unknown, geocoding not performed, geocoding unsuccessful, residence outside US (including its territories, commonwealths, or possessions) residence US, NOS

Note: For U.S. Residents, Historically, Standard Codes Are Those Of The Fips Publication "Counties And Equivalent Entities Of The United States, Its Possessions, And Associated Areas." These Fips Codes (Fips 6-4) Have Been Replaced By Incits Standard Codes, However, There Is No Impact On This Variable As The Codes Align With The System The Census Used For Each Decennial Census And Will Automatically Be Accounted For During Geocoding.

SOURCE

No State at DX Geocode 2020 at admission. Variable created at tumor. Set to blank for new cases.

UPDATE

Whenever Census Tract 2020 is changed, State at DX Geocode 2020 must be changed accordingly:

- If Census Tract 2012 is '999996' or '999997' (waiting for geocoding) then State at DX Geocode 2020 must be blank.
- If Census Tract 2020 cannot be tracted (999993-999995 or 999998-999999) then State at DX Geocode 2020 must be 99.
- If Census Tract 2020 is tracted and a State at DX Geocode 2020 is available (whether through geocoding or linking a tumor with a tracted address) the available State at DX Geocode 2020 code should be used.
- However, if Census Tract 2020 is tracted but State at DX Geocode 2020 is not available, State at DX Geocode 2020 should be set to blank.

CONSOLIDATED DATA EXTRACT

No

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new geocode data field implemented.

Study Flag

IDENTIFIERS

CCR ID	NAACCR ID
E1770	None.

DESCRIPTION

Identifies a study in which the patient was included.
This data item is not in the Exchange Record (Volume II). It is internally generated by Eureka.

LEVELS

Patient

LENGTH

4

ALLOWABLE VALUES

0000	Not in any study
8888	Do not contact this patient for study participation.
0001-9999	Number assigned to specific studies by regional registry

Formerly CNET F02497 used for edit purposes. As of 2012 data changes, CCR Identifier E1770 can be used.

SOURCE

Computer generate 0's.

UPDATE

Manual entry of codes as defined by regional registry.

CONSOLIDATED DATA EXTRACT

No

HISTORICAL CHANGES

2/01/06	Added a new item number for Study Flag, to allow editing of this field.
1/27/12	Added a CCR identifier (E1770) to this item to replace the CNET identifier.

Subsq RX 2nd BRM 1-2 NSC

IDENTIFIERS

Data Item	CCR	NAACCR
Subsq RX 2nd BRM 1 NSC	E1433	9951
Subsq RX 2nd BRM 2 NSC	E1434	9952

DESCRIPTION

These data items have been retired. This page has been retained for historical purposes only and these data items should not be populated in any cases diagnosed 2013 or later or coded under the NAACCR v13 or later coding standards.
NSC number for a BRM agent administered as a subsequent course of treatment at any facility.

LEVELS

Tumors, Admissions

LENGTH

6

ALLOWABLE VALUES

000000	BRM therapy was not planned to be administered OR no additional BRM therapy agents were planned
######	NSC code (enter the actual code)
777777	Bone marrow transplant, stem cell harvests, or surgical and/or radiation endocrine therapy
999998	BRM therapy was planned, but the agent NSC code is unknown; the code "999998" is a temporary code that registries should use while they contact ICF Macro to obtain a permanent code to enter for agents that do not have SEER*Rx-assigned NSC codes.
999999	Unknown if BRM therapy was planned
Blank	A blank is allowed for cases Diagnosed prior to 2011 Diagnose date 2011 and not a Region 3 resident Region 3 resident and sites other than Breast, Colorectal, and CML

SOURCE

No longer uploaded

UPDATE

None

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

2011 Data Item Changes, CER Project	Added for CER requirements.
05/2013	Retired at the conclusion of data collection for the CER project

Subsq RX 2nd Chemo 1-6 NSC

IDENTIFIERS

Data Item	CCR	NAACCR
Subsq RX 2nd Chemo 1	E1433	9931
Subsq RX 2nd Chemo 2	E1434	9932
Subsq RX 2nd Chemo 3	E1435	9933
Subsq RX 2nd Chemo 4	E1436	9934
Subsq RX 2nd Chemo 5	E1437	9935
Subsq RX 2nd Chemo 5	E1438	9936

DESCRIPTION

These data items have been retired. This page has been retained for historical purposes only and these data items should not be populated in any cases diagnosed 2013 or later or coded under the NAACCR v13 or later coding standards.

NSC* number for the chemotherapy agent administered as all or part of a subsequent course of treatment.

* The term "NSC" [number] refers to (part of) the acronym of the Cancer Chemotherapy National Service Center (CCNSC)). The NSC number is a National Service Center assigned number from the National Cancer Institute (NCI). This number is assigned to a drug during its investigational phase prior to the adoption of a United States Adopted Name. A full list of NSC codes is maintained in SEER*Rx.

LEVELS

Tumors, Admissions

LENGTH

6

ALLOWABLE VALUES

6 digits	NSC Code
000000	Chemotherapy was not planned to be administered OR no additional chemotherapy agents were planned.
999998	Chemotherapy was planned and/or administered, but the agent NSC code is unknown; the code "999998" is a temporary code that registries should use while they contact ICF Macro to obtain a permanent code to enter for agents that do not have SEER*Rx-assigned NSC codes.
999999	Unknown if chemotherapy planned.
Blank	A blank is allowed for cases Diagnosed prior to 2011 Diagnose date 2011 and not a Region 3 resident Region 3 resident and sites other than Breast, Colorectal, and CML

SOURCE

No longer uploaded

UPDATE

None

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

2011 Data Item Changes, CER Project	Added for CER requirements.
05/2013	Retired at the conclusion of data collection for the CER project

Subsq RX 2nd Course Date

IDENTIFIERS

CCR ID	NAACCR ID
E1388	1660

DESCRIPTION

This data item has been retired. This page has been retained for historical purposes only and this data item should not be populated in any cases diagnosed 2013 or later or coded under the NAACCR v13 or later coding standards.
Date of initiation of subsequent treatment.

LEVELS

Tumors, Admissions

LENGTH

8

ALLOWABLE VALUES

Must be a valid date or blank.

- A valid, complete date in YYYYMMDD format
- A valid year & month (YYYYMM) followed by two blanks (unknown day)
- A valid year (YYYY) followed by four blanks (unknown month and day)
- Eight blanks (no known or partially known date)

Notes:
A valid day requires a valid month and valid year.
A valid month requires a valid year.

SOURCE

No longer uploaded

UPDATE

None

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

2011 Data Item Changes, CER Project	Added for CER requirements.
05/2013	Retired at the conclusion of data collection for the CER project

Subsq RX 2nd DateFlag

IDENTIFIERS

CCR ID	NAACCR ID
E1443	9955

DESCRIPTION

This data item has been retired. This page has been retained for historical purposes only and this data item should not be populated in any cases diagnosed 2013 or later or coded under the NAACCR v13 or later coding standards.

This flag explains why a date is not entered into the Subsq RX 2nd DateFlag field.

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

10	Unknown if any subsequent therapy
11	No subsequent therapy)
12	Subsequent therapy given, but date is unknown)
15	Subsequent therapy ordered, but has not been administered at the time of the most recent follow up)
blank	A valid date value is provided in item Chemo 1 Start Date [9821]. A blank is allowed for cases • Diagnosed prior to 2011 • Diagnose date 2011 and not a Region 3 resident • Region 3 resident and sites other than Breast, Colorectal, and CML

SOURCE

No longer uploaded

UPDATE

None

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

2011 Data Item Changes, CER Project	Added for CER requirements.
05/2013	Retired at the conclusion of data collection for the CER project

Subsq RX 2nd Horm 1-2 NSC

IDENTIFIERS

Data Item	CCR	NAACCR
Subsq RX 2nd Horm 1 NSC	E1439	9941
Subsq RX 2nd Horm 2 NSC	E1440	9942

DESCRIPTION

These data items have been retired. This page has been retained for historical purposes only and these data items should not be populated in any cases diagnosed 2013 or later or coded under the NAACCR v13 or later coding standards.
NSC number for a subsequent course of hormone treatment at any facility.

LEVELS

Tumors, Admissions

LENGTH

6

ALLOWABLE VALUES

000000	NSC code (enter the actual code)
######	Hormonal therapy was not planned to be administered or no additional hormonal therapy agents were planned
999998	Hormone therapy was planned, but the agent NSC code is unknown; the code "999998" is a temporary code that registries should use while they contact ICF Macro to obtain a permanent code to enter for agents that do not have SEER*Rx-assigned NSC codes
999999	Unknown if hormonal therapy was planned
Blank	A blank is allowed for cases • Diagnosed prior to 2011 • Diagnose date 2011 and not a Region 3 resident • Region 3 resident and sites other than Breast, Colorectal, and CML

SOURCE

No longer uploaded

UPDATE

None

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

2011 Data Item Changes, CER Project	Added for CER requirements.
05/2013	Retired at the conclusion of data collection for the CER project

Subsq RX 2nd Crs BRM

IDENTIFIERS

CCR ID	NAACCR ID
E1430	9925

DESCRIPTION

This data item has been retired. This page has been retained for historical purposes only and this data item should not be populated in any cases diagnosed 2013 or later or coded under the NAACCR v13 or later coding standards.
Codes the type of biological response modifier therapy (immunotherapy) given as part of a subsequent course of treatment.

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

00	None OR Not applicable (e.g., not required for this primary site/histology) OR Unknown information
01	Immunotherapy administered as subsequent therapy.
Blank	

SOURCE

No longer uploaded

UPDATE

None

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

2011 Data Item Changes, CER Project	Added for CER requirements.
05/2013	Retired at the conclusion of data collection for the CER project

Subsq RX 2nd Crs Chemo

IDENTIFIERS

CCR ID	NAACCR ID
E1428	9923

DESCRIPTION

This data item has been retired. This page has been retained for historical purposes only and this data item should not be populated in any cases diagnosed 2013 or later or coded under the NAACCR v13 or later coding standards.
Codes the type of chemotherapy given as part of a subsequent course of treatment.

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

00	None OR Not applicable (e.g., not required for this primary site/histology) OR Unknown information
01	Chemotherapy administered as subsequent therapy, but the type and number of agents is not documented in patient record.
02	Single-agent chemotherapy administered as subsequent therapy
03	Multi-agent chemotherapy administered as subsequent therapy.
Blank	

SOURCE

No longer uploaded

UPDATE

None

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

2011 Data Item Changes, CER Project	Added for CER requirements.
05/2013	Retired at the conclusion of data collection for the CER project

Subsq RX 2nd Crs Horm

IDENTIFIERS

CCR ID	NAACCR ID
E1429	9924

DESCRIPTION

This data item has been retired. This page has been retained for historical purposes only and this data item should not be populated in any cases diagnosed 2013 or later or coded under the NAACCR v13 or later coding standards.
Codes the type of hormonal therapy given as part of a subsequent course of treatment.

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

00	None OR Not applicable (e.g., not required for this primary site/histology) OR Unknown information
01	Hormone therapy administered as subsequent therapy.
Blank	

SOURCE

No longer uploaded

UPDATE

None

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

2011 Data Item Changes, CER Project	Added for CER requirements.
05/2013	Retired at the conclusion of data collection for the CER project

Subsq RX 2nd Crs Oth

IDENTIFIERS

CCR ID	NAACCR ID
E1399	9926

DESCRIPTION

This data item has been retired. This page has been retained for historical purposes only and this data item should not be populated in any cases diagnosed 2013 or later or coded under the NAACCR v13 or later coding standards.
Codes for other treatment given as part of a subsequent course of treatment.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

0	None -All subsequent cancer treatment was coded in other treatment fields (surgery, radiation, systemic therapy) OR Not applicable (e.g., not required for this primary site/histology) OR Unknown information.
1	Other -subsequent treatment that cannot be appropriately assigned to specified treatment data items (surgery, radiation, systemic therapy, hematopoietic cases, such as phlebotomy, transfusion, or aspirin).
2	Other-Experimental This code is not defined. It may be used to record participation in institution-based clinical trials.
3	Other-Double Blind A patient is involved in a double-blind clinical trial. Code the treatment actually administered when the double-blind trial code is broken.
6	Other-Unproven Cancer treatments administered by nonmedical personnel.
Blank	

SOURCE

No longer uploaded

UPDATE

None

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

2011 Data Item Changes, CER Project	Added for CER requirements.
05/2013	Retired at the conclusion of data collection for the CER project

Subsq RX 2nd Crs Rad

IDENTIFIERS

CCR ID	NAACCR ID
E1427	9922

DESCRIPTION

This data item has been retired. This page has been retained for historical purposes only and this data item should not be populated in any cases diagnosed 2013 or later or coded under the NAACCR v13 or later coding standards.
Codes the type of radiation given as part of a subsequent course of treatment.

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

00	None OR Not applicable (e.g., not required for this primary site/histology) OR Unknown information
10	Unknown information
20	Regional radiation
30	Distant radiation, NOS OR other radiation, NOS
31	Bone
32	Brain
33	Liver
34	Lung
35	Other distant sites/lymph nodes or more than one distant site
Blank	

SOURCE

No longer uploaded

UPDATE

None

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

2011 Data Item Changes, CER Project	Added for CER requirements.
05/2013	Retired at the conclusion of data collection for the CER project

Subsq RX 2nd Crs Surg

IDENTIFIERS

CCR ID	NAACCR ID
E1425	9921

DESCRIPTION

This data item has been retired. This page has been retained for historical purposes only and this data item should not be populated in any cases diagnosed 2013 or later or coded under the NAACCR v13 or later coding standards.
Codes the type of surgery given as part of a subsequent course of treatment.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

Allowable Values: 00, 20-90, 99 and blanks
Per the NAACCR 12.2 Data Dictionary, 1/1/2011

> Codes for the type of primary site surgery given as part of the second course of treatment. Central registries currently collecting this data item should follow the 1998 ROADS Manual coding instructions. The codes are the same as those for Surgery of Primary Site, 1998 ROADS Manual, pg.187.

SOURCE

No longer uploaded

UPDATE

None

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

2011 Data Item Changes, CER Project	Added for CER requirements.
05/2013	Retired at the conclusion of data collection for the CER project

Subsq RX 2nd Crs Trans End

IDENTIFIERS

CCR ID	NAACCR ID
E1432	9927

DESCRIPTION

This data item has been retired. This page has been retained for historical purposes only and this data item should not be populated in any cases diagnosed 2013 or later or coded under the NAACCR v13 or later coding standards.
Codes the type of transplant/endocrine therapy given as part of a subsequent course of treatment.

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

00, 10, 11, 12, 20, 30, 40 or blank

SOURCE

No longer uploaded

UPDATE

None

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

2011 Data Item Changes, CER Project	Added for CER requirements.
05/2013	Retired at the conclusion of data collection for the CER project

Summary Stage 2018

IDENTIFIERS

CCR ID	NAACCR ID
E1804	764

OWNER

SEER

DESCRIPTION

This item stores the directly assigned Summary Stage 2018. Effective for cases diagnosed 1/1/2018+.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

0	In Situ
1	Localized
2	Regional by direct extension only
3	Regional lymph nodes only
4	Regional by BOTH direct extension AND lymph node involvement
7	Distant site(s)/node(s) involved
8	Benign/borderline Applicable for the following SS2018 chapters; Brain, CNS Other, Intracranial Gland
9	Unknown if extension or metastasis (unstaged, unknown, or unspecified) DCO
Blank	Date of Diagnosis pre-2018

SOURCE

5. date

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Tumor's Date of Diagnosis year is 2018 – 9998

One of the following conditions is true

- Admission's value is not blank or 9
- Tumor's value is blank or 9

OR

- Admission's value is 9
- Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Surg Hosp

Obsolete: For 1998, SURG-HOSP converted to ACoS 1998 coding scheme and moved to SURG_PRIM_PROC (1).
Maintained in Volume III for historical reasons.

IDENTIFIERS

None.

DESCRIPTION

Definitive surgery was performed at this hospital. This field will be used to store unconverted surgery codes for cases prior to coding procedure 18.

LEVELS

Admission

LENGTH

2

ALLOWABLE VALUES

00, 10, 15, 17, 20, 30, 31, 35, 40-41, 45, 50, 51, 52, 55, 60, 70, 80, 90, 99: Surgically treated. (Not all codes apply to every site - see Site interfield edits.)

00	No surgery
10-70	Definitive surgery to the primary site (the higher the value, the more definitive the surgery)
80	Definitive surgery to a metastatic site (not the primary site)
90	Definitive surgery, unknown whether to a primary or metastatic site
99	Unknown whether or not definitive surgery was done

SOURCE

Blank for new loads.

UPDATE

None

CONSOLIDATED DATA EXTRACT

No.

HISTORICAL CHANGES

1/1/98	SURG-HOSP converted to ACoS 1998 coding scheme and moved to SURG_PRIM_PROC (1).

Surg Other Proc 1-3

IDENTIFIERS

	CCR ID	NAACCR ID
Surg Other Proc1	E1594	None
Surg Other Proc2	E1599	None
Surg Other Proc3	E1604	None

DESCRIPTION

Surgical procedures to remove tissue other than the primary tumor or organ of origin (other regional site(s) or distant LN(s)). Displayed but not visually edited in CP 22.

LEVELS

Admission

LENGTH

3

ALLOWABLE VALUES

0-9

SOURCE

If the new case record version is A or later, then load the transmitted values and zero-fill.

UPDATE

Manual Update or Correction Applied
If changed, perform the Update/Admission Level Manual Change rules for RX Summ--Surg Oth Reg-Dis.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/26/03	Source C/N numbers changed.
3/3/04	Removed Allowable Values edit. Removed reference to Appendix 2. Removed conversion instructions from SOURCE for Version 9 records. See Use Case 22.
1/8/07	Added Update text.

Surg Prim First

IDENTIFIERS

CCR ID	NAACCR ID
E1624	None: State Requestor

DESCRIPTION

The first/earliest surgery performed during first course of treatment.

LEVELS

Tumor

LENGTH

2

ALLOWABLE VALUES

00, 10-38, 40-80, 90, 98, 99

Surgically treated. (Not all codes apply to every site - see Site interfield edits.) See Appendix 20B *Identifiers*

00	No surgery, autopsy only
10-90	Definitive surgery to the primary site
98	Special codes for hematopoietic/reticuloendothelial/immunoproliferative/myeloproliferative disease, ill-defined site, & unknown primaries. Code 98 takes precedence over 00.
99	Unknown whether or not definitive surgery was done, death certificate-only

SOURCE

See Update.

UPDATE

Generate from all related admissions' surgical procedures according to Business Rules Requirements: Surgery Consolidation Rules document. The business rules may require manual review.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

8/15/06	New data item per CCR research group request. An Allowable Values edit was added because visual editors can change the data item value on the consolidation screen.

Surg Prim Proc 1-3

IDENTIFIERS

	CCR ID	NAACCR ID
Surg Prim Proc1	E1590	None. State Requestor Item
Surg Prim Proc2	E1595	None. State Requestor Item
Surg Prim Proc3	E1600	None. State Requestor Item

DESCRIPTION

Surgery of Primary Site - Procedure 1-3. This field is used to collect the surgical procedures performed which can be procedures performed at the reporting facility or at another facility. Displayed but not visually edited in CP 22.

LEVELS

Admission

LENGTH

3

ALLOWABLE VALUES

00, 10-38, 40-80, 90, 98, 99
Surgically treated. (Not all codes apply to every site - see Site interfield edits.)
See Appendix 20A & B.

SOURCE

If the new case record version is A or later, then load the transmitted values, right justify and zero-fill.

UPDATE

Manual Update or Correction Applied
If changed: Perform the Update/Admission Level Manual Change rules for RX Date--Most Defin Surg and RX Summ--Surg Prim Site.
Reconsolidation: If the admission is linked to a patient/tumor, also perform the Update rules for Hosp Surg Prim Sum, Surg Prim First, Date Surg Prim First, and Hosp Surg Prim First when the admission is reconsolidated.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/26/03	C/N Source numbers changed. Allowable values changed with new surgery code ranges.
3/3/04	Updated range to include breast surgery codes 44 & 49. Removed Allowable Values edit (Err #200-202). Removed conversion instructions from SOURCE for Version 9 records. See Use Case 22.
1/8/07	Added Update text.
1/27/12	Removed unneeded CNET identifiers from Source section. *Was*: C/N F03488, F03489 and F03490

Surg Sum

Obsolete: In 1998, SURG-SUM was converted to ACoS 1998 coding scheme and moved to SURG-PRIM-SUM.

IDENTIFIERS

CCR ID	NAACCR ID
E1771	None. State Requestor

DESCRIPTION

Most extensive type of surgery performed during first course of treatment. This field stores unconverted surgery codes for cases prior to coding procedure 18.

LEVELS

Tumor

LENGTH

2

ALLOWABLE VALUES

00, 10, 15, 17-20, 30, 31, 35, 40-41, 45, 50, 51, 52, 55, 60, 70, 80, 90, 99
Surgically treated. (Not all codes apply to every site - see Site inter-field edits.)
Definitions

00	No Surgery
10-70	Definitive surgery to the primary site (the higher the value, the more definitive the surgery)
80	Definitive surgery to a metastatic site (not the primary site)
90	Definitive surgery, unknown whether to a primary or metastatic site
99	Unknown whether or not definitive surgery was done

SOURCE

Blank for new loads.

UPDATE

None.

CONSOLIDATED DATA EXTRACT

No.

HISTORICAL CHANGES

1/1/98	SURG-SUM converted to ACoS 1998 coding scheme and moved to SURG-PRIM-SUM.

Surv-Date Active Follow-up

IDENTIFIERS

CCR ID	NAACCR ID
E1788	1782

OWNER

NAACCR

DESCRIPTION

The Surv-Date Active Followup is defined as the earlier of the Date of Last Contact [NAACCR #1782] and a study cutoff date. The study cutoff date is a pre-determined date based on the year of data submission and is set in the survival program used to derive the seven survival variables. If the Date of Last Contact is earlier than the study cutoff date and either the day or month is unknown or not available, the values are inputted by the survival program.

LEVELS

Tumors

LENGTH

8

ALLOWABLE VALUES

A valid date in YYYYMMDD format.

SOURCE

See Extract

UPDATE

None

CONSOLIDATED DATA EXTRACT

No

HISTORICAL CHANGES

03/2015	Per NAACCR v15, new data field implemented. Field will be generated on extract.

Surv-Date DX Recode

IDENTIFIERS

CCR ID	NAACCR ID
E1794	1788

OWNER

NAACCR

DESCRIPTION

The survival date of diagnosis recode is calculated using the month, day, and year of the Date of Diagnosis [NAACCR #390]. If the Date of Diagnosis has complete month and day information, the Surv-Date DX Recode will be the same as the Date of Diagnosis. If the day or month is unknown or not available, the values are imputed into the survival program used to derive the seven survival variables.

LEVELS

Tumors

LENGTH

8

ALLOWABLE VALUES

A valid date in YYYYMMDD format.

SOURCE

See Extract

UPDATE

None

CONSOLIDATED DATA EXTRACT

No

HISTORICAL CHANGES

03/2015	Per NAACCR v15, new data field implemented. Field will be generated on extract.

Surv-Date Presumed Alive

IDENTIFIERS

CCR ID	NAACCR ID
E1791	1785

OWNER

NAACCR

DESCRIPTION

The Surv-Date Presumed Alive is the last date for which completed death ascertainment is available from the registry at the time a file is transmitted. This variable is set in the survival program used to derive the seven survival variables.

LEVELS

Tumors

LENGTH

8

ALLOWABLE VALUES

A valid date in YYYYMMDD format.

SOURCE

See Extract

UPDATE

None

CONSOLIDATED DATA EXTRACT

No

HISTORICAL CHANGES

03/2015	Per NAACCR v15, new data field implemented. Field will be generated on extract.

Surv-Flag Active Followup

IDENTIFIERS

CCR ID	NAACCR ID
E1787	1783

OWNER

NAACCR

DESCRIPTION

This flag is generated by the program that creates Surv-Mos Active Followup [NAACCR #1784] and describes how complete the date information is that was used to calculate survival months. This item is one of seven survival variables designed to facilitate a common approach to survival analysis by NAACCR registries.

LEVELS

Tumors

LENGTH

1

ALLOWABLE VALUES

0	Complete dates are available and there are 0 days of survival
1	Complete dates are available and there are more than 0 days of survival
2	Incomplete dates are available and there could be zero days of follow-up
3	Incomplete dates are available and there cannot be zero days of follow-up
8	Not calculated because a Death Certificate Only or Autopsy Only case
9	Unknown
Blank	Not coded

SOURCE

See Extract

UPDATE

None

CONSOLIDATED DATA EXTRACT

No

HISTORICAL CHANGES

03/2015	Per NAACCR v15, new data field implemented. Field will be generated on extract.

Surv-Flag Presumed Alive

IDENTIFIERS

CCR ID	NAACCR ID
E1790	1786

OWNER

NAACCR

DESCRIPTION

This flag is generated by the survival program that creates Surv-Mos Presumed Alive [NAACCR #1787] and describes how complete the date information is that was used to calculate survival months.

LEVELS

Tumors

LENGTH

1

ALLOWABLE VALUES

0	Complete dates are available and there are 0 days of survival
1	Complete dates are available and there are more than 0 days of survival
2	Incomplete dates are available and there could be zero days of follow-up
3	Incomplete dates are available and there cannot be zero days of follow-up
8	Not calculated because a Death Certificate Only or Autopsy Only case
9	Unknown
Blank	Not coded

SOURCE

See Extract

UPDATE

None

CONSOLIDATED DATA EXTRACT

No

HISTORICAL CHANGES

03/2015	Per NAACCR v15, new data field implemented. Field will be generated on extract.

Surv-Mos Active Followup

IDENTIFIERS

CCR ID	NAACCR ID
E1788	1784

OWNER

NAACCR

DESCRIPTION

The survival interval in months is calculated using the month, day, and year of the Surv-Date DX recode [NAACCR #1788] and the month, day, and year of the Surv-Date Active Followup [NAACCR #1782].

LEVELS

Tumors

LENGTH

4

ALLOWABLE VALUES

A value of 9999 for missing and matches the Surv-Flag Active Followup value of 9 or blank. Leading zeros will be used when needed to left fill the field.

SOURCE

See Extract

UPDATE

None

CONSOLIDATED DATA EXTRACT

No

HISTORICAL CHANGES

03/2015	Per NAACCR v15, new data field implemented. Field will be generated on extract.

Surv-Mos Presumed Alive

IDENTIFIERS

CCR ID	NAACCR ID
E1791	1787

OWNER

NAACCR

DESCRIPTION

The survival interval in months is calculated using the month, day, and year of the Surv-Date DX Recode [NAACCR #1788] and the month, day, and year of the Surv-Date Presumed Alive [NAACCR #1785].

LEVELS

Tumors

LENGTH

4

ALLOWABLE VALUES

A value of 9999 for missing and matches the Surv-Flag Presumed Alive value of 9 or blank. Leading zeros will be used when needed to left fill the field.

SOURCE

See Extract

UPDATE

None

CONSOLIDATED DATA EXTRACT

No

HISTORICAL CHANGES

03/2015	Per NAACCR v15, new data field implemented. Field will be generated on extract.

Survival Time

IDENTIFIERS

CCR ID	NAACCR ID
E1772	None

DESCRIPTION

Number of days patient has survived since their diagnosis.
This item generated when necessary and is not stored in the database.

LEVEL

Tumor

LENGTH

5

ALLOWABLE VALUES

00000 - 47450 (0 - 130 years) (Julian)
99999 Survival time unknown (diagnosis year is unknown)

SOURCE

Computer generate the interval between Date of Diagnosis and Date of Last Patient Follow Up (see Appendix #8).

UPDATE

Recalculate if either Date of Diagnosis or Date of Last Patient Follow Up is changed.

CONSOLIDATED DATA EXTRACT

Optional

HISTORICAL CHANGES

11/14/02	In the CCR central system (EUREKA), this field is generated when necessary and is not stored in the database. The Allowable values edit was removed.
2010	Data Changes: Removed the logic that inserted assumed date parts for unknown month or day from the Allowable Values section. Added link to Appendix 8.

Telephone

IDENTIFIERS

CCR ID	NAACCR ID
E1652	2360

DESCRIPTION

Patient's latest phone number or phone number where patient can be contacted.

LEVELS

Patient
Admission

LENGTH

10

ALLOWABLE VALUES

0000000000	No phone number
9999999999	Unknown phone number
Pos. #1	0, 2-9
Pos. #2-10	Any numeric including 0 (zero)

SOURCE

If the transmitted value is numeric, then just right-justify, zero-fill, and load it with no conversion. Otherwise, convert it to 9999999999.

UPDATE

Patient Active Follow-up Fields Update Logic

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

2010	Data Changes: Changed CCR name (Phone_No) to NAACCR name. Rewrote Update logic.

Telephone Owner

Older name was Phone Owner
This is an obsolete data item maintained in Volume III to describe historic data that has been collected for this field, which may be viewed on some Eureka screens. It is no longer listed in the exchange record, Volume II, Appendix A.

DESCRIPTION

Identifies whose phone number is stored in Phone_No (Currently one of the software vendors only transmits the patient's phone number.)

LEVELS

Patients, Admissions

LENGTH

1

ALLOWABLE VALUES

0	Patient
1	Neighbor
2	Relative
3	Employer
4	Friend
7	Other
8	Do not contact
9	No phone

SOURCE

If loaded Telephone is not blank or 9999999999,
Then load 0
Else load 9

UPDATE

If updated PA_Telephone <> 9's and PA_Telephone = 9, enter 0 in PA_Telephone Owner.
Codes 1-8 are entered manually from information obtained during the follow-up process.

CONSOLIDATE DATA EXTRACT

No

HISTORICAL CHANGES

2010	Date Changes: CCR name (Phone Owner) changed to more closely match the companion data item (Telephone).

Text

THIS TOPIC INCLUDES THE FOLLOWING DATA ITEMS:

Data Item Name	Length	CCR-ID	NAACCR-ID	Old name & Length
Text--DX Proc--PE	1000	E1705	2520	Text_Phys_EX (50*4)
Text--DX Proc--X-ray/Scan	1000	E1706	2530	Text_XRay (50*5)
Text--DX Proc--Scope(s)	1000	E1707	2540	Text_Scopes (50*5)
Text--DX Proc--Text_Lab Test	1000	E1708	2550	Text_Lab (50*5)
Text--Staging	1000	E1713	2600	Text_Staging (50*6)
Text--DX Proc--OP	1000	E1709	2560	Text_OP-Proc (50*5)
Text--DX Proc--Path	1000	E1710	2570	Text_Path (50*5)
Text--Surgery	1000	E1714	2610	Text_Surg_1 (_2 &_3) (50*3)
RX Text--Radiation (Beam)	1000	E1719	2620	Text_Rad-BEAM (50*3)
RX Text--Radiation Other	1000	E1720	2630	Text_Rad-OTHER (50*3)
RX Text--Chemo	1000	E1721	2640	Text--Chemo (50*4)
RX Text--Hormone	1000	E1722	2650	Text_Horm (50*4)
RX Text--BRM	1000	E1723	2660	Text_Immuno (50*2)
RX Text--Other	1000	E1724	2670	Text_Other_RX (50*2)
Text--Remarks	1000	E1725	2680	Text_Remarks (50*5)
Text--Final DX	1000	E1727	None	FINALDX (50*2)
Text--Place of Diagnosis	60	E1726	2690	Place_DX (50*1)
Text--Histology Title	100	E1712	2590	

DESCRIPTION

Free text data items used in abstracting to document diagnostic tests/exams and their results, treatment, general remarks, final diagnosis, and place of diagnosis.

LEVELS

Admissions

LENGTH

See Table in Source

ALLOWABLE VALUES

Any

SOURCE

Upload each text value with no conversion.

Data Item Name	Length	CCR-ID	NAACCR-ID	Old name & Length
Text--Dx Proc--PE	1000	E1705	2520	Text_Phys_EX (50*4)
Text--Dx Proc--X-ray/Scan	1000	E1706	2530	Text_XRay (50*5)
Text--Dx Proc--Scope(s)	1000	E1707	2540	Text_Scopes (50*5)
Text--Dx Proc--Text_Lab Test	1000	E1708	2550	Text_Lab (50*5)

Text_Staging	1000	E1713	2600	Text_Staging (50*6)
Text--Dx Proc--OP	1000	E1709	2560	Text_OP-Proc (50*5)
Text--Dx Proc--Path	1000	E1710	2570	Text_Path (50*5)
Text--Surgery	1000	E1714	2610	Text_Surg_1 (_2 &_3) (50*3)
Rx Text--Radiation (Beam)	1000	E1719	2620	Text_Rad-BEAM (50*3)
RX Text--Radiation Other	1000	E1720	2630	Text_Rad-OTHER (50*3)
Rx--Text--Chemo	1000	E1721	2640	Text--Chemo (50*4)
Rx--Text_Hormone	1000	E1722	2650	Text_Horm (50*4)
Rx Text_BRM	1000	E1723	2660	Text_Immuno (50*2)
Rx--Text Other	1000	E1724	2670	Text_Other_RX (50*2)
Text--Remarks	1000	E1725	2680	Text_Remarks (50*5)
Text_Final_DX	1000	E1727	None	FINALDX (50*2)
Text--Place of Diagnosis	60	E1726	2690	Place_DX (50*1)
Text--Histology Title	100	E1712	2590	

UPDATE

Manual Entry

CONSOLIDATED DATA EXTRACT

No

HISTORICAL CHANGES

3/03	Text fields not created for Text_Transp_Endo, so text will be recorded in Text_Immuno. Record text for Rad_Boost_RX_Mod and Rad_Reg_RX_Mod in the Text_Rad-BEAM and Text_Rad-OTHER.
10/07	Text Staging now being transmitted to CCR by software vendors. Abstractors can now use this field to document additional staging and diagnostic workup information.
2010	Changed all Text names to NAACCR names and changed length to 1000 for all fields except for Place of Diagnosis which increased to 60 (was 50).
10/31/11	Added CCR-ID column to data items listed in tables. Added IF902 to the Interfield Edits. Added Field: Text--Histology Title (CCR-ID E1712) to the table

Text--Histology Title

Was Hist Text

IDENTIFIERS

CCR ID	NAACCR ID
E1712	2590

DESCRIPTION

Text supporting histologic coding.

LEVELS

Admissions

LENGTH

100

ALLOWABLE VALUES

Any

SOURCE

Upload with no conversion.

UPDATE

Manual

CONSOLIDATED DATA EXTRACT

No

INTERFIELD EDITS

None

HISTORICAL CHANGES

1/1/99	Changed transmit to CCR section to "No".
2010	Data Changes: Increased length to 100 (was 40). CCR name (Hist_Text) changed to NAACCR name.

Text--Place of Diagnosis

Was Place DX

IDENTIFIERS

CCR ID	NAACCR ID
E1726	2690

DESCRIPTION

Free text for place of diagnosis.

LEVELS

Admissions

LENGTH

60

ALLOWABLE VALUES

Any

SOURCE

N/A

UPDATE

Manual

CONSOLIDATED EXTRACT

No

HISTORICAL CHANGES

12/7/11	Changed name to NAACCR name. Was: Place DX Is now: Text--Place of Diagnosis

Text--Primary Site Title

Was Site Text

IDENTIFIERS

CCR ID	NAACCR ID
E1711	2580

OWNER

NPCR

DESCRIPTION

Text area for manual documentation of information regarding the primary site and laterality of the tumor being reported.

LEVELS

Admissions

LENGTH

100

ALLOWABLE VALUES

Any

SOURCE

Upload each text value with no conversion.

UPDATE

Manual

CONSOLIDATED DATA EXTRACT

No

HISTORICAL CHANGES

1/1/99	Changed transmit to CCR section to "No" to match Appendix 15.
2010	Data Change: Increased length to 100 (was 40). CCR name (Site_Text) changed to NAACCR name.
05/2016	Updated description and length to correctly match NAACCR and current programming.

Text--Usual Industry

Was Industry Text

IDENTIFIERS

CCR ID	NAACCR ID
E1041	320

DESCRIPTION

Text on industry of the patient's longest-held occupation by the time of diagnosis.

LEVELS

Tumor
Admission

LENGTH

100

ALLOWABLE VALUES

Free text; not required if no information.

SOURCE

Upshift (but don't record change in the Audit Log).

UPDATE

Tumor Level

New Case Consolidation

If AD_Text--Usual Industry = a variation of "RETIRED" and TU_Text--Usual Industry =a variation of "RETIRED"

then move RETIRED to TU_Text--Usual Industry.

If AD_Text--Usual Industry =a variation of "RETIRED" or "DISABLED" and TU_Text--Usual Industry = NR (and variations), UNKNOWN, or blank

then move RETIRED or DISABLED to TU_Text--Usual Industry.

If AD_Text--Usual Industry <> a variation of RETIRED, DISABLED, NR, UNKNOWN, or blank and TU_Text--Usual Industry = a variation of RETIRED, DISABLED, NR, UNKNOWN, or blank

then move AD_Text--Usual Industry to TU_Text--Usual Industry.

If AD_Text--Usual Industry <> a variation of RETIRED, DISABLED, NR, UNKNOWN, or blank and TU_Text--Usual Industry <> a variation of RETIRED, DISABLED, NR, UNKNOWN, or blank and AD_Text--Usual Industry <> TU_AD_Text--Usual Industry,

then list for review.

Manual Change

Admission Level

Manual Change Only

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/03/04	Added "Disabled" to Update logic 2), 3) and 4).

2010	2010 Data Changes: Length changed to 100 (was 40). CCR name (Industry Text) changed to NAACCR name.

Text--Usual Occupation

Was Occupation Text

IDENTIFIERS

CCR ID	NAACCR ID
E1040	310

DESCRIPTION

Text on patient's longest-held occupation by the time of diagnosis.

LEVELS

Tumor
Admission

LENGTH

100

ALLOWABLE VALUES

Free text; not required if no information.

SOURCE

Upshift (but don't record change in Audit Log).

UPDATE

Tumor Level

New Case Consolidation

If AD_Text--Usual Occupation =a variation of "RETIRED" and TU_Text--Usual Occupation = a variation of "RETIRED"

then move RETIRED to TU_Text--Usual Occupation.

If AD_Text--Usual Occupation =a variation of "RETIRED" or "DISABLED" and TU_Text--Usual Occupation = NR (and variations), UNKNOWN, or blank

then move RETIRED or DISABLED to TU_Text--Usual Occupation.

If AD_Text--Usual Occupation <> a variation of RETIRED, DISABLED, NR, UNKNOWN, or blank and TU_Text--Usual Occupation = a variation of RETIRED, DISABLED, NR, UNKNOWN, or blank

then move AD_Text--Usual Occupation to TU_Text--Usual Occupation.

If AD_Text--Usual Occupation <> a variation of RETIRED, DISABLED, NR, UNKNOWN, or blank and TU_Text--Usual Occupation <> a variation of RETIRED, DISABLED, NR, UNKNOWN, or blank and AD_Text--Usual Occupation <> TU_Text--Usual Occupation,

then list for review.

Manual Change

Admission Level

Manual Change Only

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/3/04	Added "Disabled" to Update logic 2), 3) and 4).

2010	Data Changes: Length changed to 100 (was 40). CCR name (Occupation Text) changed to NAACCR name.

Thrombocyte Growth Fact Sta

(Thrombocyte Growth Factor Status)

IDENTIFIERS

CCR ID	NAACCR ID
E1515	9882

DESCRIPTION

This data item has been retired. This page has been retained for historical purposes only and this data item should not be populated in any cases diagnosed 2013 or later or coded under the NAACCR v13 or later coding standards.
Codes the use of Thrombocyte-Growth Factors/Cytokines agents during the twelve months after diagnosis.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

0	No Thrombocyte-Growth Factors/Cytokines treatment given
1	Thrombocyte-Growth Factors/Cytokines treatment was given
7	Thrombocyte-Growth Factors/Cytokines treatment prescribed – patient, patient's family member, or patient's guardian refused
8	Thrombocyte-Growth Factors/Cytokines treatment prescribed, unknown if administered
9	Unknown if Thrombocyte-Growth Factors/Cytokines therapy given
Blank	A blank is allowed for cases Diagnosed prior to 2011 Diagnose date 2011 and not a Region 3 resident Region 3 resident and sites other than Breast, Colorectal, and CML

SOURCE

No longer uploaded

UPDATE

No longer uploaded

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

3/14/11	This added for 2011 as part of the CER project.
05/2013	Retired at the conclusion of data collection for the CER project

Thrombocytopenia

IDENTIFIERS

CCR ID	NAACCR ID
E2045	3933

OWNER

NAACCR

DESCRIPTION

Thrombocytopenia is defined by a deficiency of platelets in the blood. In staging of Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma (CLL/SLL), thrombocytopenia is defined as Platelets (Plt) less than 100,000/µL.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	Thrombocytopenia not present Platelets (Plt) = 100,000/µL
1	Thrombocytopenia present Platelets (Plt) < 100,000/µL
6	Lab value unknown, physician states thrombocytopenia is present
7	Test ordered, results not in chart
9	Not documented in medical record Thrombocytopenia not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00795
        - Type of Reporting Source is not 7
        - Thrombocytopenia is blank

        Then convert Thrombocytopenia to 9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00795

              OR
            - Type of Reporting Source is 7
        - Thrombocytopenia is not blank

        Then convert Thrombocytopenia to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00795
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00795

One of the following conditions is true

- Admission's value is not blank, 9
- Tumor's value is blank, 9

OR

- Admission's value is 9
- Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

TNM Clin Descriptor

IDENTIFIERS

CCR ID	NAACCR ID
E1156	980

OWNER

CoC

DESCRIPTION

Identifies the AJCC clinical stage (prefix/suffix) descriptor of the tumor prior to the start of any therapy. AJCC stage descriptors identify special cases that need separate data analysis. The descriptors are adjuncts to and do not change the stage group.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

0	None
1	E (Extranodal, lymphomas only)
2	S (Spleen, lymphomas only)
3	M (Multiple primary tumors in a single site)
5	E & S (Extranodal and spleen, lymphomas only)
9	Unknown, not stated in patient record
Blank	No information available to code this item

SOURCE

TNM Clin Descriptor, CCR Identifier E1156

UPDATE

TNM Clin Fields Update Logic

CONSOLIDATED DATA EXTRACT

No

HISTORICAL CHANGES

04/2014	Data Item added with 2014 Data Changes.
03/2015	Per NAACCR v15, added field to Tumor level and will be populated in later Eureka release.
05/2016	Implemented automated multi-document consolidation logic.

TNM Clin M

IDENTIFIERS

CCR ID	NAACCR ID
E1154	960

OWNER

AJCC

DESCRIPTION

Identifies the presence or absence of distant metastasis (M) of the tumor known prior to the start of any therapy.

LEVELS

Tumors, Admissions

LENGTH

4

ALLOWABLE VALUES

Codes in addition to those published in the ***AJCC Cancer Staging Manual***:

88	Not applicable, no code assigned for this case in the current ***AJCC Cancer Staging Manual***
Blank	No information at all is available to code this item

Note: See the ***AJCC Cancer Staging Manual***, current edition for site-specific categories for the TNM elements and stage groups. See the ***FORDS*** manual for specifications for codes and data entry rules.

SOURCE

TNM Clin Fields Source Logic

UPDATE

TNM Clin Fields Update Logic

CONSOLIDATED DATA EXTRACT

Yes

To choose the proper values to submit to the State, the fields must be grouped into meaningful clusters, in which all the fields must come from the same report. Therefore, the following groups:

The first T,N,M, and AJCSTAGE, for clinically-based staging

The second T,N,M, and AJCSTAGE, for pathologic-based staging

For each group listed above, start with the most recent (i.e., latest admission date) analytic admission (class of case =10-22, 00) and work back, until an admission is found with all non-blank values in the group (no item in the group is missing). In other words, only send values when they are non-blank for all variables considered in the group. However, if there is no qualifying analytic group send the values from the most recent non-blank, non-analytic admission.

The only exception to the above rule is if no TNM is found by that method, but there is an AJCC Stage, then send in the AJCC Stage from the latest analytic admission.

HISTORICAL CHANGES

2010	Data Changes: CCR name (TNM_M_Code_Clinical) changed to NAACCR name. Length changed from 2 to 4. The following codes were added to Allowable values: 0+, 1D,

	1E. Split TNM Path M out from TNM Clin M which used to be on the same page. Convert 2-character AJCC 6 values to the 4-character values per Eureka Process Specification: 2010 Data Conversions
02/18/11	Per NAACCR v12D: Added code 0I+ to specification based on metafile release dated 2/17/2011.
03/2015	Per NAACCR v15, added to Tumor level and will be populated in later Eureka release. Clarified allowable values. Removed reference to Appendix 26 in how Corrections are applied due to Appendix being outdated.
05/2016	Implemented SOURCE logic to perform 2016 conversions and automated multi-document consolidation logic.

TNM Clin N

IDENTIFIERS

CCR ID	NAACCR ID
E1153	950

OWNER

AJCC

DESCRIPTION

Identifies the absence or presence of regional lymph node (N) metastasis and describes the extent of regional lymph node metastasis of the tumor known prior to the start of any therapy.

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

Codes in addition to those published in the ***AJCC Cancer Staging Manual***:

88	Not applicable, no code assigned for this case in the current ***AJCC Cancer Staging Manual***
Blank	No information at all is available to code this item

Note: See the ***AJCC Cancer Staging Manual***, current edition for site-specific categories for the TNM elements and stage groups. See the ***FORDS*** manual for specifications for codes and data entry rules.

SOURCE

TNM Clin Fields Source Logic

UPDATE

TNM Clin Fields Update Logic

CONSOLIDATED DATA EXTRACT

Yes

To choose the proper values to submit to the State, the fields must be grouped into meaningful clusters, in which all the fields must come from the same report. Therefore, the following groups:

The first T,N,M, and AJCSTAGE, for clinically-based staging

The second T,N,M, and AJCSTAGE, for pathologic-based staging

For each group listed above, start with the most recent (i.e., latest admission date) analytic admission (class of case= 10-22) and work back, until an admission is found with all non-blank values in the group (no item in the group is missing). In other words, only send values when they are non-blank for all variables considered in the group. However, if there is no qualifying analytic group send the values from the most recent non-blank, non-analytic admission.

The only exception to the above rule is if no TNM is found by that method, but there is an AJCC Stage, then send in the AJCC Stage from the latest analytic admission.

HISTORICAL CHANGES

01/19/05	Added codes to Allowable Values.

2010	Data Changes: CCR name (TNM_N_Code_Clinical) changed to NAACCR names. Changed length from 2 to 4. The following codes were added to Allowable values: 0I-, 0I+, 0M-, 0M+, 0A, 0B, 1C, 1M1, 4. Split TNM Path N out from TNM Clin N which used to be on the same page. Convert 2-character AJCC 6 values to the 4-character values per Eureka Process Specification: 2010 Data Conversions.
03/2015	Per NAACCR v15, added to Tumor level and will be populated in later Eureka release. Clarified allowable values. Removed reference to Appendix 26 in how Corrections are applied due to Appendix being outdated.
05/2016	Implemented SOURCE logic to perform 2016 conversions and automated multi-document consolidation logic.

TNM Path Descriptor

IDENTIFIERS

CCR ID	NAACCR ID
E1150	920

OWNER

CoC

DESCRIPTION

Identifies the AJCC pathologic stage (prefix/suffix) descriptor known following the completion of surgical therapy. AJCC stage descriptors identify special cases that need separate data analysis. The descriptors are adjuncts to and do not change the stage group.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

0	None
1	E (Extranodal, lymphomas only)
2	S (Spleen, lymphomas only)
3	M (Multiple primary tumors in a single site)
4	Y (Classification during or after initial multimodality therapy)-pathologic staging only
5	E & S (Extranodal and spleen, lymphomas only)
6	M & Y (Multiple primary tumors and initial multimodality therapy)
9	Unknown, not stated in patient record
Blank	No information available to code this item

SOURCE

TNM Path Fields Source Logic

UPDATE

TNM Path Fields Update Logic

CONSOLIDATED DATA EXTRACT

None

HISTORICAL CHANGES

04/2014	Data Item added with 2014 Data Changes.
03/2015	Per NAACCR v15, added field to Tumor level and will be populated in later Eureka release.
05/2016	Implemented automated multi-document consolidation logic.

TNM Clin Stage Group

IDENTIFIERS

CCR ID	NAACCR ID
E1155	970

OWNER

AJCC

DESCRIPTION

Identifies the anatomic extent of disease based on the T, N, and M elements known prior to the start of any therapy.

LEVELS

Tumors, Admissions

LENGTH

4

ALLOWABLE VALUES

Codes in addition to those published in the ***AJCC Cancer Staging Manual***:

88	Not applicable, no code assigned for this case in the current ***AJCC Cancer Staging Manual***
Blank	Unknown, not staged

Note: See the ***AJCC Cancer Staging Manual,*** current edition for site-specific categories for the TNM elements and stage groups. See the ***FORDS*** manual for specifications for codes and data entry rules.

SOURCE

TNM Clin Fields Source Logic

UPDATE

TNM Clin Fields Update Logic

CONSOLIDATED DATA EXTRACT

None

HISTORICAL CHANGES

03/26/03	Added A and B to allowable values and 1 and 2 in the 2nd character to match CoC.
03/03/04	Added 1C, 1E, 2E, 2S, 3E, 3S, 4E, 4S and OC to Allowable Values table.
2010	Data Changes: CCR name (TNM_Stage Clinical) changed to NAACCR name. Length changed to 4 (was 2). Allowable values added: 0IS, 1A1, 1A2, 1B1, 1B2, 2A1, 2A2, 3C1, 3C2, 4A1, 4A2. Split TNM Path Stage Group out from TNM Clin Stage Group which used to be on the same page. Convert 2-character AJCC 6 values to the 4-character values per Eureka Process Specification: 2010 Data Conversions.
01/11/12	Eliminated CN # from Source *Was*: CN #F01925 *Is Now*: CCR Identifier E1155

03/2015	Per NAACCR v15, added to Tumor level and will be populated in later Eureka release. Clarified allowable values. Removed reference to Appendix 26 in how Corrections are applied due to Appendix being outdated.
05/2016	Implemented automated multi-document consolidation logic.

TNM Clin Staged By

IDENTIFIERS

CCR ID	NAACCR ID
E1157	990

OWNER

CoC

DESCRIPTION

Identifies the person who documented the clinical AJCC staging elements and the Stage Group in the patient's medical record.

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

00	Not Staged
10	Physician, NOS, or physician type not specified in codes 11-15
11	Surgeon
12	Radiation Oncologist
13	Medical Oncologist
14	Pathologist
15	Multiple Physicians; tumor board; etc.
20	Cancer registrar
30	Cancer registrar and physician
40	Nurse, physician assistant, or other non-physician medical staff
50	Staging assigned at another facility
60	Staging by Central Registry
88	Case is not eligible for staging
99	Staged but unknown who assigned stage

SOURCE

1. If Date of Diagnosis is 2018 and greater, then blank out field.
2. If Coding Proc is less than 33, then
    a. Execute the same conversions from use case Perform Eureka 2016 One-Time Data Conversions and Table Populations – UC, step 2, for the new admissions.
3. If the value includes a non-blank, non-numeric character then convert to 99.
4. Left justify and zero-fill any non-blank values less than 2 characters in length.

UPDATE

TNM Clin Fields Update Logic

CONSOLIDATED DATA EXTRACT

Yes, leave blank until reporting multiple records per admission.

HISTORICAL CHANGES

02/01/6	TNM_Coder_Path C/N # changed to F01917 (was incorrect as F02573).
2010	Data Changes: CCR name (TNM_Coder_Clinical) changed to NAACCR name. Split the two fields, TNM Clin Staged By and TNM Path Staged By, which used to be on the same page onto separate pages.
01/11/12	Eliminated CN # from Source Was: CN #F01915 Is Now: CCR Identifier E1157
03/2015	Per NAACCR v15, added to Tumor level and will be populated in later Eureka release. Corrected allowable value descriptions to match CoC and NAACCR. Removed reference to Appendix 26 in how Corrections are applied due to Appendix being outdated.
05/2016	Per NAACCR v16, field converted to length of two. Source logic updated to include 2016 conversion specifications when Coding Proc is less than 33. Implemented automated multi-document consolidation logic.
01/2019	Per NAACCR v18, added step 1 in SOURCE LOGIC to blank out field when Year DX is 2018 and greater.

TNM Clin T

IDENTIFIERS

CCR ID	NAACCR ID
E1152	940

OWNER

AJCC

DESCRIPTION

Evaluates the primary tumor (T) and reflects the tumor size and/or extension of the tumor prior to the start of any therapy.

LEVEL

Tumors, Admissions

LENGTH

4

ALLOWABLE VALUES

Codes in addition to those published in the ***AJCC Cancer Staging Manual***:

88	Not applicable, no code assigned for this case in the current ***AJCC Cancer Staging Manual***
Blank	No information at all is available to code this item

Note: See the ***AJCC Cancer Staging Manual***, current edition for site-specific categories for the TNM elements and stage groups. See the ***FORDS*** manual for specifications for codes and data entry rules.

SOURCE

TNM Clin Fields Source Logic

UPDATE

TNM Clin Fields Update Logic

CONSOLIDATED DATA EXTRACT

Yes

To choose the proper values to submit to the State, the fields must be grouped into meaningful clusters, in which all the fields must come from the same report. Therefore, the following groups:

- the first T,N,M, and AJCSTAGE, for clinically-based staging
- the second T,N,M, and AJCSTAGE, for pathologic-based staging

For each group listed above, start with the most recent (i.e., latest admission date) analytic admission (class of case =10-22) and work back, until an admission is found with all non-blank values in the group (no item in the group is missing). In other words, only send values when they are non-blank for all variables considered in the group. However, if there is no qualifying analytic group send the values from the most recent non-blank, non-analytic admission.

The only exception to the above rule is if no TNM is found by that method, but there is an AJCC Stage, then send in the AJCC Stage from the latest analytic admission.

HISTORICAL CHANGES

03/03/04	Updated C/N# to F02577 (was #F01930).
03/05/07	Changed C/N# back to F01930 (from F02577) per Bert Heuer email 1/27/07.

2010	Data Change: CCR name (TNM_T_Code_Clinical) changed to NAACCR name. Length changed from 2 to 4. The following codes were added to Allowable Values: ISPU, ISPD, 1A1, 1A2, 1B1, 1B2, 1D, 1MI, 2A1, 2A2, 2D, 3D, 4E. Split TNM Path T out from TNM Clin T which used to be on the same page. Convert 2-character AJCC 6 values to the 4-character values per Eureka Process Specification: 2010 Data Conversions.
01/11/12	Eliminated C/N # from Source Section. *Was:* C/N #F01928 *Is now*: CCR Identifier E1152
03/2015	Per NAACCR v15, added to Tumor level and will be populated in later Eureka release. Clarified allowable values. Removed reference to Appendix 26 in how Corrections are applied due to Appendix being outdated.
05/2016	Implemented SOURCE logic to perform 2016 conversions and automated multi-document consolidation logic.

TNM Edition Number

IDENTIFIERS

CCR ID	NAACCR ID
E1145	1060

OWNER

CoC

DESCRIPTION

Identifies the edition of the ***AJCC Cancer Staging Manual*** used to stage the case.

LEVEL

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

00	Not staged (cases that have AJCC staging scheme and staging was not done)
01	1st edition
02	2nd edition (published 1983)
03	3rd edition (published 1988)
04	4th edition (published 1992), recommended for use for cases diagnosed 1993-1997
05	5th edition (published 1997), recommended for use with cases diagnosed 1998-2002
06	6th edition (published 2002), recommended for use with cases diagnosed 2003-2009
07	7th edition (published 2009), recommended for use with cases diagnosed 2010-2017. Eureka Label: 07-SEVENTH EDITION (2010-2017)
08	8th edition (published 2017), recommended for use with cases diagnosed 2018+. Eureka label: 08-EIGHTH EDITION (2018+)
88	Not applicable (cases that do not have an AJCC staging scheme)
99	Unknown Edition

SOURCE

If the new record version is A or later, then just load CCR-ID (E1145) (TNM Edition Number).

UPDATE

TNM Clin Fields Update Logic

CONSOLIDATED DATA EXTRACT

Yes, leave blank until reporting 1 record per admission.

HISTORICAL CHANGES

03/26/03	Conversion table added to Source.
08/27/03	Changed Length and Allowable values to two digit & added 6th edition.
03/03/04	Removed conversion instructions from SOURCE for Version 9 records. See Use Case 22.
01/11/12	Eliminated C/N # from Source Section. *Was:* C/N #F01928 *Is now*: CCR Identifier E1152

03/2015	Per NAACCR v15, added to Tumor level and will be populated in later Eureka release. Removed reference to Appendix 26 in how Corrections are applied due to Appendix being outdated.
01/2019	Per NAACCR v18, added 8th edition to allowable values. Added information to add/update Eureka labels.

TNM Path M

IDENTIFIERS

CCR ID	NAACCR ID
E1148	900

OWNER

AJCC

DESCRIPTION

Identifies the presence or absence of distant metastasis (M) of the tumor known following the completion of surgical therapy.

LEVELS

Tumors, Admissions

LENGTH

4

ALLOWABLE VALUES

Codes in addition to those published in the ***AJCC Cancer Staging Manual***:

88	Not applicable, no code assigned for this case in the current ***AJCC Cancer Staging Manual***
Blank	No information at all is available to code this item

Note: See the ***AJCC Cancer Staging Manual***, current edition for site-specific categories for the TNM elements and stage groups. See the ***FORDS*** manual for specifications for codes and data entry rules.

SOURCE

TNM Path Fields Source Logic

UPDATE

TNM Path Fields Update Logic

CONSOLIDATED DATA EXTRACT

Yes;
To choose the proper values to submit to the State, the fields must be grouped into meaningful clusters, in which all the fields must come from the same report. Therefore, the following groups:

- The first T,N,M, and AJCSTAGE, for clinically-based staging
- The second T,N,M, and AJCSTAGE, for pathologic-based staging

For each group listed above, start with the most recent (i.e., latest admission date) analytic admission (class of case =10-22, 00) and work back, until an admission is found with all non-blank values in the group (no item in the group is missing). In other words, only send values when they are non-blank for all variables considered in the group. However, if there is no qualifying analytic group send the values from the most recent non-blank, non-analytic admission.
The only exception to the above rule is if no TNM is found by that method, but there is an AJCC Stage, then send in the AJCC Stage from the latest analytic admission.

HISTORICAL CHANGES

2010	Data Changes: CCR name (TNM_M_Code_Path) changed to NAACCR name. Length changed from 2 to 4. The following codes were added to Allowable values: 1D, 1E, 1M1.

	Split TNM Path M out from TNM Clin M which used to be on the same page. Convert 2-character AJCC 6 values to the 4-character values per Eureka Process Specification: 2010 Data Conversions: 4.28. Convert TNM_Path M: From 1M to 1M1
01/11/12	Eliminated C/N # from Source Section. *Was:* C/N #F01921 *Is now*: CCR Identifier E1148
03/2015	Per NAACCR v15, added to Tumor level and will be populated in later Eureka release. Clarified allowable values. Removed reference to Appendix 26 in how Corrections are applied due to Appendix being outdated.
05/2016	Implemented SOURCE logic to perform 2016 conversions and automated multi-document consolidation logic.

TNM Path N

IDENTIFIERS

CCR ID	NAACCR ID
E1147	890

OWNER

AJCC

DESCRIPTION

Identifies the absence or presence of regional lymph node (N) metastasis and describes the extent of regional lymph node metastasis of the tumor known following the completion of surgical therapy.

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

Codes in addition to those published in the ***AJCC Cancer Staging Manual***:

88	Not applicable, no code assigned for this case in the current ***AJCC Cancer Staging Manual***
Blank	No information at all is available to code this item

Note: See the ***AJCC Cancer Staging Manual***, current edition for site-specific categories for the TNM elements and stage groups. See the ***FORDS*** manual for specifications for codes and data entry rules.

SOURCE

TNM Path Fields Source Logic

UPDATE

TNM Path Fields Update Logic

CONSOLIDATED DATA EXTRACT

Yes

To choose the proper values to submit to the State, the fields must be grouped into meaningful clusters, in which all the fields must come from the same report. Therefore, the following groups:

- The first T,N,M, and AJCSTAGE, for clinically-based staging
- The second T,N,M, and AJCSTAGE, for pathologic-based staging

For each group listed above, start with the most recent (i.e., latest admission date) analytic admission (class of case = 00, 10-22) and work back, until an admission is found with all non-blank values in the group (no item in the group is missing). In other words, only send values when they are non-blank for all variables considered in the group. However, if there is no qualifying analytic group send the values from the most recent non-blank, non-analytic admission.

The only exception to the above rule is if no TNM is found by that method, but there is an AJCC Stage, then send in the AJCC Stage from the latest analytic admission.

HISTORICAL CHANGES

01/19/05	
2010	Data Changes:

01/11/12	Eliminated C/N # from Source Section. *Was:* C/N #F01924 *Is now*: CCR Identifier E1147
03/2015	Per NAACCR v15, added to Tumor level and will be populated in later Eureka release. Clarified allowable values. Removed reference to Appendix 26 in how Corrections are applied due to Appendix being outdated.
05/2016	Implemented SOURCE logic to perform 2016 conversions and automated multi-document consolidation logic.

TNM Path Stage Group

IDENTIFIERS

CCR ID	NAACCR ID
E1149	910

OWNER

AJCC

DESCRIPTION

Identifies the anatomic extent of disease based on the T, N, and M elements known following the completion of surgical therapy.

LEVELS

Tumors, Admissions

LENGTH

4

ALLOWABLE VALUES

Codes in addition to those published in the ***AJCC Cancer Staging Manual***:

88	Not applicable, no code assigned for this case in the current ***AJCC Cancer Staging Manual***
Blank	Unknown, not staged

Note: See the ***AJCC Cancer Staging Manual***, current edition for site-specific categories for the TNM elements and stage groups. See the ***FORDS*** manual for specifications for codes and data entry rules.

SOURCE

TNM Path Fields Source Logic

UPDATE

TNM Path Fields Update Logic

CONSOLIDATED DATA EXTRACT

Yes

To choose the proper values to submit to the State, the fields must be grouped into meaningful clusters, in which all the fields must come from the same report. Therefore, the following groups:

- The first T,N,M, and AJCSTAGE, for clinically-based staging
- The second T,N,M, and AJCSTAGE, for pathologic-based staging

For each group listed above, start with the most recent (i.e., latest admission date) analytic admission (class of case = 00, 10-22) and work back, until an admission is found with all non-blank values in the group (no item in the group is missing). In other words, only send values when they are non-blank for all variables considered in the group. However, if there is no qualifying analytic group send the values from the most recent non-blank, non-analytic admission.

The only exception to the above rule is if no TNM is found by that method, but there is an AJCC Stage, then send in the AJCC Stage from the latest analytic admission.

HISTORICAL CHANGES

03/26/03	Added A and B to allowable values and 1 and 2 in the 2nd character to match CoC.
03/03/04	Added 1C, 1E, 2E, 2S, 3E, 3S, 4E, 4S and OC to Allowable Values table.

2010	Data Changes: CCR name (TNM_Stage Clinical) changed to NAACCR name. Length changed to 4 (was 2). Allowable values added: 0IS, 1A1, 1A2, 1B1, 1B2, 2A1, 2A2, 3C1, 3C2, 4A1, 4A2. Split TNM Path Stage Group out from TNM Clin Stage Group which used to be on the same page. Convert 2-character AJCC 6 values to the 4-character values per Eureka Process Specification: 2010 Data Conversions.
01/11/12	Eliminated CN # from Source section *Was:* CN/#F01927 *Is Now*: CCR Identifier E1149
03/2015	Per NAACCR v15, added to Tumor level and will be populated in later Eureka release. Clarified allowable values. Removed reference to Appendix 26 in how Corrections are applied due to Appendix being outdated.
05/2016	Implemented automated multi-document consolidation logic.

TNM Path Staged By

IDENTIFIERS

CCR ID	NAACCR ID
E1151	930

OWNER

CoC

DESCRIPTION

Identifies the person who recorded the pathologic AJCC staging elements in the patient's medical record.

LEVELS

Tumors, Admissions

LENGTH

2

ALLOWABLE VALUES

00	Not Staged
10	Physician, NOS, or physician type not specified in codes 11-15
11	Surgeon
12	Radiation Oncologist
13	Medical Oncologist
14	Pathologist
15	Multiple Physicians; tumor board, etc.
20	Cancer registrar
30	Cancer registrar and physician
40	Nurse, physician assistant, or other non-physician medical staff
50	Staging assigned at another facility
60	Staging by Central Registry
88	Case is not eligible for staging
99	Staged but unknown who assigned stage

SOURCE

1. If Date of Diagnosis is 2018 and later, then blank out the field.
2. If Coding Proc is less than 33, then
    a. Execute the same conversions from use case Perform Eureka 2016 One-Time Data Conversions and Table Populations – UC, step 2, for the new admissions.
3. If the value is a non-blank, non-numeric character then convert to 99.
4. Left justify and zero-fill any non-blank values less than 2 characters in length.

UPDATE

TNM Path Fields Update Logic

CONSOLIDATED DATA EXTRACT

Yes, leave blank until reporting multiple records per admission.

HISTORICAL CHANGES

02/01/06	TNM_Coder_Path C/N # changed to F01917 (was incorrect as F02573).
01/11/12	Eliminated CN # from Source *Was*: CN #F01917 *Is Now*: CCR Identifier E1151
03/2015	Per NAACCR v15, added to Tumor level and will be populated in later Eureka release. Corrected allowable value descriptions to match CoC and NAACCR. Removed reference to Appendix 26 in how Corrections are applied due to Appendix being outdated.
05/2016	Per NAACCR v16, field converted to length of two. Source logic updated to include 2016 conversion specifications when Coding Proc is less than 33. Implemented automated multi-document consolidation logic.
01/2019	Per NAACCR v18, added step 1 in SOURCE LOGIC to blank out field when Year DX is 2018 and greater.

TNM Path T

IDENTIFIERS

CCR ID	NAACCR ID
E1146	880

OWNER

AJCC

DESCRIPTION

Evaluates the primary tumor (T) and reflects the tumor size and/or extension of the tumor known following the completion of surgical therapy.

LEVEL

Tumors, Admissions

LENGTH

4

ALLOWABLE VALUES

Codes in addition to those published in the ***AJCC Cancer Staging Manual***:

88	Not applicable, no code assigned for this case in the current ***AJCC Cancer Staging Manual***
Blank	No information at all is available to code this item

Note: See the ***AJCC Cancer Staging Manual***, current edition for site-specific categories for the TNM elements and stage groups. See the ***FORDS*** manual for specifications for codes and data entry rules.

SOURCE

TNM Path Fields Source Logic

UPDATE

TNM Path Fields Update Logic

CONSOLIDATED DATA EXTRACT

Yes

To choose the proper values to submit to the State, the fields must be grouped into meaningful clusters, in which all the fields must come from the same report. Therefore, the following groups:

- the first T,N,M, and AJCSTAGE, for clinically-based staging
- the second T,N,M, and AJCSTAGE, for pathologic-based staging

For each group listed above, start with the most recent (i.e., latest admission date) analytic admission (class of case =10-22) and work back, until an admission is found with all non-blank values in the group (no item in the group is missing). In other words, only send values when they are non-blank for all variables considered in the group. However, if there is no qualifying analytic group send the values from the most recent non-blank, non-analytic admission.

The only exception to the above rule is if no TNM is found by that method, but there is an AJCC Stage, then send in the AJCC Stage from the latest analytic admission.

HISTORICAL CHANGES

03/03/04	Updated C/N# to F02577 (was #F01930).
03/05/07	Changed C/N# back to F01930 (from F02577) per Bert Heuer email 1/27/07

2010	Data Changes: CCR name (TNM_T_Code_Path) changed to NAACCR name. Length changed from 2 to 4. The following codes were added to Allowable Values: ISPU, ISPD, 1A1, 1A2, 1B1, 1B2, 1D, 1MI, 2A1, 2A2, 2D, 3D, 4E. Split TNM Path T out from TNM Clin T which used to be on the same page. Conversion of TNM codes should be done per Use Case for Eureka Version 9.0.
01/11/12	Eliminated C/N # from Source Section. *Was:* C/N #F01930 *Is now*: CCR Identifier E1152
03/2015	Per NAACCR v15, added to Tumor level and will be populated in later Eureka release. Clarified allowable values. Removed reference to Appendix 26 in how Corrections are applied due to Appendix being outdated.
05/2016	Implemented SOURCE logic to perform 2016 conversions and automated multi-document consolidation logic.

Tobacco Use Cigarettes

IDENTIFIERS

CCR ID	NAACCR ID
E1277	9965

OWNER

NPCR

DESCRIPTION

Records patient's past or current use of tobacco.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

0	Never used
1	Current user
2	Former user, quit within one year of the date of diagnosis
3	Former user, quit more than one year prior to the date of diagnosis
4	Former user, unknown when quit
9	Unknown/not stated, no smoking specifics provided
Blank	A blank is only allowed for cases diagnosed prior to 2011

SOURCE

If the value is completely blank, then convert 9; if the value includes a non-blank, non-numeric character, then convert 9; otherwise, just load the transmitted value.

UPDATE

Tumor Level

New Case Consolidation

If Tumor.Value is blank and Admission.Value is not blank, then copy Admission.Value to Tumor.Value.

If Tumor.Value is not blank and Admission.Value is blank, then do nothing.

If Tumor.Value is equal to Admission.Value, then do nothing.

If Tumor.Value is not blank and Admission.Value is not blank, and Tumor.Value does not equal Admission.Value, then list for review.

Manual Change

Admission Level

Manual Change

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

2011 Data Item Changes, CER Project	Added for CER requirements.

05/2013	This data item is now required by NPCR for Date of Diagnosis 2013 and forward. We are still required to submit the values as part of the CER dataset.
12/2013	Allowable values revised per NPCR. Required for Date of Diagnosis 2011 and forward for all Regions. Global fix performed to change blanks to 9 for Date of Diagnosis 2011 forward.

Tobacco Use NOS

IDENTIFIERS

CCR ID	NAACCR ID
E1280	9968

OWNER

NPCR

DESCRIPTION

Records the patient's past or current use of tobacco.

LEVELS

Eureka Transmit Level
Eureka Tumor Level
Eureka Admission Level

LENGTH

1

ALLOWABLE VALUES

0	Never used
1	Current user
2	Former user, quit within one year of the date of diagnosis
3	Former user, quit more than one year prior to the date of diagnosis
4	Former user, unknown when quit
9	Unknown/not stated, no smoking specifics provided
Blank	A blank is only allowed for cases diagnosed prior to 2011

SOURCE

If the value is completely blank, then convert 9; if the value includes a non-blank, non-numeric character, then convert 9; otherwise, just load the transmitted value.

UPDATE

Tumor Level

New Case Consolidation

If Tumor.Value is blank and Admission.Value is not blank, then copy Admission.Value to Tumor.Value.

If Tumor.Value is not blank and Admission.Value is blank, then do nothing.

If Tumor.Value is equal to Admission.Value, then do nothing.

If Tumor.Value is not blank and Admission.Value is not blank, and Tumor.Value does not equal Admission.Value, then list for review.

Manual Change

Admission Level

Manual Change

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

2011 Data Item Changes, CER Project	Added for CER requirements.
05/2013	This data item is now required by NPCR for Date of Diagnosis 2013 and forward. We are still required to submit the values as part of the CER dataset.
12/2013	Allowable values revised per NPCR. Required for Date of Diagnosis 2011 and forward for all Regions. Global fix performed to change blanks to 9 for Date of Diagnosis 2011 forward.

Tobacco Use Other Smoke

IDENTIFIERS

CCR ID	NAACCR ID
E1278	9966

OWNER

NPCR

DESCRIPTION

Records the patient's past or current use of tobacco.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

0	Never used
1	Current user
2	Former user, quit within one year of the date of diagnosis
3	Former user, quit more than one year prior to the date of diagnosis
4	Former user, unknown when quit
9	Unknown/not stated, no smoking specifics provided
Blank	A blank is only allowed for cases diagnosed prior to 2011

SOURCE

If the value is completely blank, then convert 9; if the value includes a non-blank, non-numeric character, then convert 9; otherwise, just load the transmitted value.

UPDATE

Tumor Level

New Case Consolidation

If Tumor.Value is blank and Admission.Value is not blank, then copy Admission.Value to Tumor.Value.

If Tumor.Value is not blank and Admission.Value is blank, then do nothing.

If Tumor.Value is equal to Admission.Value, then do nothing.

If Tumor.Value is not blank and Admission.Value is not blank, and Tumor.Value does not equal Admission.Value, then list for review.

Manual Change

Admission Level

Manual Change

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

2011 Data Item Changes, CER Project	Added for CER requirements.

05/2013	This data item is now required by NPCR for Date of Diagnosis 2013 and forward. We are still required to submit the values as part of the CER dataset.
12/2013	Allowable values revised per NPCR. Required for Date of Diagnosis 2011 and forward for all Regions. Global fix performed to change blanks to 9 for Date of Diagnosis 2011 forward.

Tobacco Use Smokeless

IDENTIFIERS

CCR ID	NAACCR ID
E1279	9967

OWNER

NPCR

DESCRIPTION

Records the patient's past or current use of tobacco.

LEVELS

Tumors, Admissions

LENGTH

1

ALLOWABLE VALUES

0	Never used
1	Current user
2	Former user, quit within one year of the date of diagnosis
3	Former user, quit more than one year prior to the date of diagnosis
4	Former user, unknown when quit
9	Unknown/not stated, no smoking specifics provided
Blank	A blank is only allowed for cases diagnosed prior to 2011

SOURCE

If the value is completely blank, then convert 9; if the value includes a non-blank, non-numeric character, then convert 9; otherwise, just load the transmitted value.

UPDATE

Tumor Level

New Case Consolidation

If Tumor.Value is blank and Admission.Value is not blank, then copy Admission.Value to Tumor.Value.

If Tumor.Value is not blank and Admission.Value is blank, then do nothing.

If Tumor.Value is equal to Admission.Value, then do nothing.

If Tumor.Value is not blank and Admission.Value is not blank, and Tumor.Value does not equal Admission.Value, then list for review.

Manual Change

Admission Level

Manual Change

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

2011 Data Item Changes, CER Project	Added for CER requirements.

05/2013	This data item is now required by NPCR for Date of Diagnosis 2013 and forward. We are still required to submit the values as part of the CER dataset.
12/2013	Allowable values revised per NPCR. Required for Date of Diagnosis 2011 and forward for all Regions. Global fix performed to change blanks to 9 for Date of Diagnosis 2011 forward.

Total Dose

IDENTIFIERS

CCR ID	NAACCR ID
E1894	1533

OWNER

COC

DESCRIPTION

Identifies the total radiation dose administered to the patient across all phases during the first course of treatment. The unit of measure is centiGray (cGy).

To evaluate the patterns of radiation care, it is necessary to capture information describing the prescribed total dose of radiation during the first course of treatment. Outcomes are strongly related to the dose delivered.

LEVELS

Admissions, Tumors

LENGTH

6

ALLOWABLE VALUES

000000	No radiation treatment
000001-999997	Record the actual dose delivered in cGy
999998	Not applicable, radioisotopes administered to the patient
999999	Radiation therapy was administered, but the dose is unknown; it is unknown whether radiation therapy was administered

SOURCE

Right justify and zero fill any values less than 6 digits, but not blank

UPDATE

TUMOR LEVEL

NEW CASE CONSOLIDATION

If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

ADMISSION

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Transmit Vendor Version

IDENTIFIERS

CCR ID	NAACCR ID
E1589	None: State Requestor

DESCRIPTION

Identifies the vendor and software version used to transmit the case. This is to be used for New, Follow-Up, Update/Correction and Deletion records.

LEVEL

Admission

LENGTH

10

ALLOWABLE VALUES

Any (self-assigned by vendor), left-justified

UPDATE

None

CONSOLIDATED DATA EXTRACT

No

HISTORICAL CHANGES

10/10/07	New data item added per regional request. This field will identify which software version was used to create the transmit file so it can be determined whether or not the files/records being uploaded were created with a software version that has fixed one or more particular bugs specific to that vendor.

Tumor Deposits

IDENTIFIERS

CCR ID	NAACCR ID
E2046	3934

OWNER

NAACCR

DESCRIPTION

A tumor deposit is defined as a discrete nodule of cancer in pericolic/perirectal fat or in adjacent mesentery (mesocolic or rectal fat) within the lymph drainage area of the primary carcinoma, without identifiable lymph node tissue or identifiable vascular structure.

LEVELS

Admissions, Tumors

LENGTH

2

ALLOWABLE VALUES

00	No tumor deposits
01-99	01-99 Tumor deposits (Exact number of Tumor Deposits)
X1	100 or more Tumor Deposits
X2	Tumor Deposits identified, number unknown
X8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code X8 may result in an edit error.)
X9	Not documented in medical record Cannot be determined by the pathologist Pathology report does not mention tumor deposits No surgical resection done Tumor Deposits not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00200
        - Type of Reporting Source is not 7
        - Tumor Deposits is blank or X8

        Then convert Tumor Deposits to X9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00200

OR

- Type of Reporting Source is 7

- Tumor Deposits is not blank

Then convert Tumor Deposits to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00200
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00200

One of the following conditions is true

- Admission's value is not blank or X9
- Tumor's value is blank or X9

OR

- Admission's value is X9
- Tumor's value is blank or X8

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Tum Markers 1

IDENTIFIERS

CCR ID	NAACCR ID
E1161	1150

DESCRIPTION

Field to record estrogen receptor for breast, acid phosphatase for prostate and alpha-fetoprotein for testicular cancer, carcinoembryonic antigen (CEA) for colorectal carcinoma, and carbohydrate antigen (CA-125) for ovarian carcinoma. If a hospital is collecting tumor markers on other sites, they may use this field.

LEVELS

Tumor
Admission

LENGTH

1

ALLOWABLE VALUES

0	Test Not Done (includes cases diagnosed at autopsy)
1	Test Done, Results Positive/Elevated
2	Test Done, Results Negative/Normal
3	Borderline
4	Range 1
5	Range 2
6	Range 3
8	Test Ordered, Results Not in Chart
9	Unknown if Test Done or Ordered; No Information (includes death-certificate-only cases).
Blank	Information not available

SOURCE

Tumor Marker 1 (CCR Identifier E1161)
If the transmitted value is numeric, then just load it with no conversion.
Otherwise, convert it to 9.

UPDATE

None at Admissions.
For TU-Tum_Markers, examine all Admissions records for that tumor.
For each marker (considered separately) select from among the values at the Admissions levels in the following order: 1, 2, 3, 8, 0, and 9 (last).
For testis, select values at the Admissions level as follows: 6, 5, 4, 2, 8, 0, and 9.

CONSOLIDATED DATA EXTRACT

Yes, extract from the tumor record.
For SEER EXTRACT:

If Date of Diagnosis < 1990, then generate 9
If Date of Diagnosis =1990-2003 and Primary Site=500-509 and Type of Reporting Source=6 then generate 0

If Date of Diagnosis =1990-2003 and Primary Site=500-509 and Type of Reporting Source=7 then generate 9

If Date of Diagnosis = 1990-2003 and Primary Site=500-509 and Type of Reporting Source <> 6 or 7 then take the tumor level value

If Date of Diagnosis = 1998-2003 and Primary Site=619 or 620-629 and Type of Reporting Source=6 then generate 0

If Date of Diagnosis = 1998-2003 and Primary Site=619 or 620-629 and Type of Reporting Source=7 then generate 9

If Date of Diagnosis = 1990-1997 and Primary Site <> 500-509 then generate 9

If Date of Diagnosis = 1998-2003 and Primary Site=619 or 620-629 and Type of Reporting Source <> 6 or 7 then take tumor level value

If Date of Diagnosis = 1998-2003 and Primary Site <> 500-509 or 619 or 620-629 then generate 9

If Date of Diagnosis > 2003 then generate blank

References: SEER IF65 & 67

HISTORICAL CHANGES

3/15/00	Added 2 tumor markers to Tum_Markers_1 -- CEA and CA-125.
3/4/04	Tumor Markers 1-3 are required by SEER and the CCR for cases diagnosed prior to 2004. For cases diagnosed January 1, 2004 forward, Tumor Markers 1-3 will be collected in the Collaborative Staging Site Specific Factor fields.
3/5/07	Added SEER Extract logic so documentation is recorded and clarified to match SEER edit IF65 & 67 (CCR database contains various values for different sites based on the College's allowance of tumor markers for other sites and diagnosis years. Also, hospitals have used these fields to capture tumor markers.). Added edit IF 756 to enforce the allowable values for testes cases.
2010	Data Changes: CCR name (Tum Markers 1) changed to NAACCR name. Since Tumor Markers are now captured in the CSv2 SSF fields, it is optional for registrars to enter in the data in the old Tumor Marker fields. Vendors can convert any existing Tumor Marker fields to the new CSv2 SSF fields.

Tum Markers 2

IDENTIFIERS

CCR ID	NAACCR ID
E1162	1160

DESCRIPTION

Field to record progesterone receptor for breast, prostatic specific antigen for prostate, and HCG for testis. If a hospital is collecting tumor markers on other sites, they may report in this field.

LEVELS

Tumor
Admission

LENGTH

1

ALLOWABLE VALUES

0	Test Not Done (includes cases diagnosed at autopsy)
1	Test Done, Results Positive/Elevated
2	Test Done, Results Negative/Normal
3	Test Done, Results Borderline or Undetermined Whether Positive or Negative
4	Range 1 < 5,000 mIU/mL
5	Range 2 5,000 - 50,000 mIU/mL
6	Range 3 >50,000 mIU/mL
8	Test Ordered, Results Not in Chart
9	Unknown if Test Done or Ordered; No Information (includes death-certificate-only cases).
For all other sites for which Tumor Marker 2 is not collected:	
	9 is not applicable for cases diagnosed after January 1, 2004.
	For testicular cancer, the valid codes are 0, 2, 4-6, 8, 9.

SOURCE

Tumor Marker 2 (CCR Identifier E1162)
If the transmitted value is numeric, then just load it with no conversion.
Otherwise, convert it to 9.

UPDATE

None at Admissions.
For TU Tum Markers, examine all Admissions records for that tumor.
For each marker (considered separately) select from among the values at the Admissions levels in the following order: 1, 2, 3, 8, 0, and 9 (last).
For testis, select values at the Admissions level as follows: 6, 5, 4, 2, 8, 0, and 9.

CONSOLIDATED DATA EXTRACT

Yes, extract from the tumor record.
For SEER EXTRACT:
If Date of Diagnosis < 1990, then generate 9

If Date of Diagnosis =1990-2003 and Primary Site=500-509 and Type of Reporting Source=6 then generate 0
If Date of Diagnosis =1990-2003 and Primary Site=500-509 and Type of Reporting Source=7 then generate 9
If Date of Diagnosis = 1990-2003 and Primary Site=500-509 and Type of Reporting Source <> 6 or 7 then take the tumor level value
If Date of Diagnosis = 1998-2003 and Primary Site=619 or 620-629 and Type of Reporting Source=6 then generate 0
If Date of Diagnosis = 1998-2003 and Primary Site=619 or 620-629 and Type of Reporting Source=7 then generate 9
If Date of Diagnosis = 1990-1997 and Primary Site <> 500-509 then generate 9
If Date of Diagnosis = 1998-2003 and Primary Site=619 or 620-629 and Type of Reporting Source <> 6 or 7 then take tumor level value
If Date of Diagnosis = 1998-2003 and Primary Site <> 500-509 or 619 or 620-629 then generate 9
If Date of Diagnosis > 2003 then generate blank

References: SEER IF65 & 67

HISTORICAL CHANGES

3/4/04	Tumor Markers 1-3 are required by SEER and the CCR for cases diagnosed prior to 2004. For cases diagnosed January 1, 2004 forward, Tumor Markers 1-3 will be collected in the Collaborative Staging Site Specific Factor fields.
3/5/07	Added SEER Extract logic so documentation is recorded and clarified to match SEER edit 66 & 68 (CCR database contains various values for different sites based on the College's allowance of tumor markers for other sites and diagnosis years. Also, hospitals have used these fields to capture tumor markers.). Added edit IF 757 to enforce the allowable values for testes cases.
2010	Data Changes: CCR name (Tum Markers 2) changed to NAACCR name. Since Tumor Markers are now captured in the CSv2 SSF fields, it is optional for registrars to enter in the data in the old Tumor Marker fields. Vendors can convert any existing Tumor Marker fields to the new CSv2 SSF fields.

Tum Markers 3

IDENTIFIERS

CCR ID	NAACCR ID
E1163	1170

DESCRIPTION

Field to record LDH for testicular cancer.

LEVELS

Tumor
Admission

LENGTH

1

ALLOWABLE VALUES

Where N indicates the upper limit of normal for LDH.	
0	Test Not Done (includes cases diagnosed at autopsy)
1	Test Done, Results Positive/Elevated
2	Test Done, Results Negative/Normal
3	Test Done, Results Borderline or Undetermined Whether Positive or Negative
4	Range 1 < 1.5 * N
5	Range 2 1.5 - 10 * N
6	Range 3 >10 * N
8	Test Ordered, Results Not in Chart
9	Unknown if Test Done or Ordered; No Information (includes death-certificate-only cases).
For all other sites for which Tumor Marker 3 is not collected:	
	9 is not applicable for cases diagnosed after January 1, 2004.
	For testicular cancer, the valid codes are 0, 2, 4-6, 8, 9.

SOURCE

Tumor Marker 2 (CCR Identifier E1163)
If the transmitted value is numeric, then just load it with no conversion.
Otherwise, convert it to 9.

UPDATE

None at Admissions.
For TU Tum Markers, examine all Admissions records for that tumor.
For each marker (considered separately) select from among the values at the Admissions levels in the following order: 1, 2, 3, 8, 0, and 9 (last).
For testis, select values at the Admissions level as follows: 6, 5, 4, 2, 8, 0, and 9.

CONSOLIDATED DATA EXTRACT

Yes; extract from the tumor record.
For SEER EXTRACT:

If Date of Diagnosis < 1998 then generate 9.

If Date of Diagnosis = 1998-2003 and Primary Site = 620-629 and Type of Reporting Source = 6 then generate 0.

If Date of Diagnosis = 1998-2003 and Primary Site = 620-629 and Type of Reporting Source = 7 then generate 9.

If Date of Diagnosis = 1998-2003 and Primary Site = 620-629 and Type of Reporting Source <> 6 or 7 then take the tumor-level value.

If Date of Diagnosis = 1998-2003 and Primary Site <> 620-629 then generate 9.

If Date of Diagnosis > 2003 then generate blank.

References: SEER IF73 & IF74

HISTORICAL CHANGES

3/4/04	Tumor Markers 1-3 are required by SEER and the CCR for cases diagnosed prior to 2004. For cases diagnosed January 1, 2004 forward, Tumor Markers 1-3 will be collected in the Collaborative Staging Site Specific Factor fields.
3/5/07	Added SEER Extract logic so documentation is recorded and clarified to match SEER edit 73 & 74 (CCR database contains various values for different sites based on the COC's allowance of tumor markers for other sites and diagnosis years. Also, hospitals have used these fields to capture tumor markers.).
2010	Data Changes: CCR name (Tum Markers 3) changed to NAACCR name. Since Tumor Markers are now captured in the CSv2 SSF fields, it is optional for registrars to enter in the data in the old Tumor Marker fields. Vendors can convert any existing Tumor Marker fields to the new CSv2 SSF fields.

Tum Marker CA 1

IDENTIFIERS

CCR ID	NAACCR ID
E1609	None: State Requestor

DESCRIPTION

Breast cancer tumor marker for California - 1: Her2/neu (also known as c-erbB2 or ERBB2). In CSv2, this Her-2 Neu data is captured in CSv2 Breast SSF 15 – HER2 Summary Result of Testing.

LEVELS

Tumor
Admission

LENGTH

1

ALLOWABLE VALUES

0	Not done
1	Positive
2	Negative
3	Borderline
8	Order, results not in chart
9	Unknown
Blank	Information not available

SOURCE

If Other Reg ID is 98 or alphabetic and Tum_Marker_CA_1 is not blank, then convert Tum_Marker_CA_1 to blank.
Otherwise, just upload value as is.

UPDATE

None at Admissions.
For TU Tum Markers CA 1), examine all Admissions records for that tumor. Select the best value from the admissions using the following hierarchy:

1, 2, 3, 8, 0, 9, blank.

CONSOLIDATED DATA EXTRACT

Yes, extract from the tumor record.

HISTORICAL CHANGES

1/1/99	New field added to the data set; initialized to 9.
4/2009	Added blank to the allowable values.
2020	Data Changes: Updated Source and Update logic to process blanks. This field need only be entered for pre-2004 cases (although vendors may allow manual entry). For cases entered in CSv2, this data is captured in SSF15. The option of auto-generating the Tumor Marker CA-1 fields from the SSF15 values will allow researchers to find the information in one field.

Tumor Growth Pattern

IDENTIFIERS

CCR ID	NAACCR ID
E2047	3935

OWNER

NAACCR

DESCRIPTION

Tumor Growth Pattern refers to the growth pattern of intrahepatic cholangiocarcinoma.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

1	Mass-forming
2	Periductal infiltrating
3	Mixed mass-forming and periductal infiltrating
8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code 8 may result in an edit error.) Not documented in medical record
9	Pathology report does not mention tumor growth pattern Cannot be determined by the pathologist Tumor growth pattern not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00230
        - Type of Reporting Source is not 7
        - Tumor Growth Pattern is blank or 8

        Then convert Tumor Growth Pattern to 9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00230

            OR
            - Type of Reporting Source is 7
        - Tumor Growth Pattern is not blank

        Then convert Tumor Growth Pattern to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00230
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00230

One of the following conditions is true

- Admission's value is not blank, 9
- Tumor's value is blank or 9

OR

- Admission's value is 9
- Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Tumor ID

IDENTIFIERS

CCR ID	NAACCR ID
None	None

This data item is not in the exchange record (Volume II, Appendices)

DESCRIPTION

Number automatically assigned by the CCR (Eureka system) to uniquely identify each tumor.

LEVELS

Tumor
Admission

LENGTH

8

ALLOWABLE VALUES

1-99999999

SOURCE

Generated automatically when tumor record was migrated or when a new tumor record is created.

UPDATE

Tumor ID may be updated automatically at the admission level if two tumors are merged or if an admission is unlinked and relinked. No update is possible at the tumor level.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

	None

Tumor Record Number

IDENTIFIERS

CCR ID	NAACCR ID
E1006	60

DESCRIPTION

A number assigned by CCR used to uniquely identify a patient's tumor within the patient set. The number should never change even if the tumor sequence is changed or a tumor is deleted.

LEVEL

Tumor

LENGTH

2

ALLOWABLE VALUES

01-99

SOURCE

Generated automatically when tumor record was migrated or when a new tumor record is created in the central system.

UPDATE

None

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

3/26/03	The Allowable values edit (#024) was removed. Description, Length & Type, Allowable values, Source and Update changes made to reflect how EUREKA handles this data item.
8/15/06	Name changed to NAACCR name (was Central_Tum_No).
4/30/12	Removed the association with ER009 Tumor Record Number from V3. This item is not to be edited.

Tumor Size Clinical

IDENTIFIERS

CCR ID	NAACCR ID
E1800	752

OWNER

SEER

DESCRIPTION

This data item records the size of a solid primary tumor before any treatment.

LEVELS

Admissions
Tumors

LENGTH

3

ALLOWABLE VALUES

000	No mass/tumor found
001	1 mm or described as less than 1 mm
002-988	Exact size in millimeters (2 mm to 988 mm)
989	989 millimeters or larger
990	Microscopic focus or foci only and no size of focus is given
998	Alternate descriptions of tumor size for specific sites: Familial/multiple polyposis: Rectosigmoid and rectum (C19.9, C20.9) Colon (C18.0, C18.2-C18.9) **If no size is documented:** Circumferential: Esophagus (C15.0 C15.5, C15.8 C15.9) Diffuse; widespread: 3/4s or more; linitis plastica: Stomach and Esophagus GE Junction (C16.0 C16.6, C16.8 C16.9) Diffuse, entire lung or NOS: Lung and main stem bronchus (C34.0 C34.3, C34.8 C34.9) Diffuse: Breast (C50.0 C50.6, C50.8 C50.9)
999	Unknown; Size not stated; Not documented in patient record; Size of Tumor cannot be assessed; Not applicable

SOURCE

1. If Date of Diagnosis is less than 2016, then blank out field
2. If Date of Diagnosis is 2016 and greater, then:
    a. If value is a non-blank, non-numeric character then convert to 999
    b. Right justify and zero-fill any non-blank values less than 3 characters in length

UPDATE

Tumor

New Case Consolidation

If all of these conditions are true:

- Any of these conditions are true:
  - Admission's Date of Diagnosis year is 2016-9998
  - Tumor's Date of Diagnosis year is 2016-9998
  - Tumor's Date of Diagnosis year is blank AND the admission's Date of 1st Contact year is 2016-9998
  - Admission's Date of Diagnosis year is blank AND the admission's Date of 1st Contact year is 2016-9998
- Admission's value is NOT blank
- Admission and tumor's values are different

Then list for review.

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

08/2016	Per NAACCR v16, new data field implemented.

Tumor Size Pathologic

IDENTIFIERS

CCR ID	NAACCR ID
E1801	754

OWNER

SEER

DESCRIPTION

This data item records the size of a solid primary tumor that has been resected.

LEVELS

Admissions, Tumors

LENGTH

3

ALLOWABLE VALUES

000	No mass/tumor found
001	1 mm or described as less than 1 mm
002-988	Exact size in millimeters (2 mm to 988 mm)
989	989 millimeters or larger
990	Microscopic focus or foci only and no size of focus is given
998	Alternate descriptions of tumor size for specific sites: Familial/multiple polyposis: Rectosigmoid and rectum (C19.9, C20.9) Colon (C18.0, C18.2-C18.9) **If no size is documented:** Circumferential: Esophagus (C15.0 C15.5, C15.8 C15.9) Diffuse; widespread: 3/4s or more; linitis plastica: Stomach and Esophagus GE Junction (C16.0 C16.6, C16.8 C16.9) Diffuse, entire lung or NOS: Lung and main stem bronchus (C34.0 C34.3, C34.8 C34.9) Diffuse: Breast (C50.0 C50.6, C50.8 C50.9)
999	Unknown; Size not stated; Not documented in patient record; Size of Tumor cannot be assessed; Not applicable

SOURCE

1. If Date of Diagnosis is less than 2016, then blank out field
2. If Date of Diagnosis is 2016 and greater, then:
    a. If value is a non-blank, non-numeric character then convert to 999
    b. Right justify and zero-fill any non-blank values less than 3 characters in length

UPDATE

Tumor

New Case Consolidation

If all of these conditions are true:

- Any of these conditions are true:
    - Admission's Date of Diagnosis year is 2016-9998
    - Tumor's Date of Diagnosis year is 2016-9998
    - Tumor's Date of Diagnosis year is blank AND the admission's Date of 1st Contact year is 2016-9998
    - Admission's Date of Diagnosis year is blank AND the admission's Date of 1st Contact year is 2016-9998
- Admission's value is NOT blank
- Admission and tumor's values are different

Then list for review.

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

08/2016	Per NAACCR v16, new data field implemented.

Tumor Size Summary

IDENTIFIERS

CCR ID	NAACCR ID
E1802	756

OWNER

SEER

DESCRIPTION

This data item records the most accurate measurement of a solid primary tumor, usually measured on the surgical resection specimen.

LEVELS

Admissions, Tumors

LENGTH

3

ALLOWABLE VALUES

000	No mass/tumor found
001	1 mm or described as less than 1 mm
002-988	Exact size in millimeters (2 mm to 988 mm)
989	989 millimeters or larger M ,89E
990	Microscopic focus or foci only and no size of focus is given
998	Alternate descriptions of tumor size for specific sites: Familial/multiple polyposis: Rectosigmoid and rectum (C19.9, C20.9) Colon (C18.0, C18.2-C18.9) **If no size is documented:** Circumferential: Esophagus (C15.0 C15.5, C15.8 C15.9) Diffuse; widespread: 3/4s or more; linitis plastica: Stomach and Esophagus GE Junction (C16.0 C16.6, C16.8 C16.9) Diffuse, entire lung or NOS: Lung and main stem bronchus (C34.0 C34.3, C34.8 C34.9) Diffuse: Breast (C50.0 C50.6, C50.8 C50.9)
999	Unknown; Size not stated; Not documented in patient record; Size of Tumor cannot be assessed; Not applicable

SOURCE

1. If Date of Diagnosis is less than 2016, then blank out field
2. If Date of Diagnosis is 2016 and greater, then:
    a. If value is a non-blank, non-numeric character then convert to 999
    b. Right justify and zero-fill any non-blank values less than 3 characters in length

UPDATE

Tumor

New Case Consolidation

If all of these conditions are true:

- Any of these conditions are true:
    - Admission's Date of Diagnosis year is 2016-9998
    - Tumor's Date of Diagnosis year is 2016-9998
    - Tumor's Date of Diagnosis year is blank AND the admission's Date of 1st Contact year is 2016-9998
    - Admission's Date of Diagnosis year is blank AND the admission's Date of 1st Contact year is 2016-9998
- Admission's value is NOT blank
- Admission and tumor's values are different

Then list for review.

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

08/2016	Per NAACCR v16, new data field implemented.

Type Admis

IDENTIFIERS

CCR ID	NAACCR ID
E1572	None. State Requestor

DESCRIPTION

Type of admission to hospital.

LEVELS

Admission

LENGTH

1

ALLOWABLE VALUES

1	Inpatient
2	Out Patient
3	Tumor Board
4	Path
5	Inpatient and Outpatient
6	Inpatient and Tumor Board
7	Outpatient and Tumor Board
8	Inpatient, Outpatient, and Tumor Board
Blank	Not abstracted

SOURCE

Upload with no conversion

UPDATE

Manual

CONSOLIDATED DATA EXTRACT

Yes, record with earliest admission date for this tumor.

HISTORICAL CHANGES

	None

Tumor Record Number Last

Was Central Tum No

IDENTIFIERS

CCR ID	NAACCR ID	RASP Name
None	None	None

This data item is used internally in Eureka and is not in the exchange record (Volume II, Appendix A). It stores the value in Tumor Record Number [NAACCR 60].

DESCRIPTION

Stores the last Tumor Record Number to be assigned so that the linkage program will know the next one to assign.

LEVELS

Patients

LENGTH

2

ALLOWABLE VALUES

01-99

SOURCE

Computer generate 01 when patient is first established (same number as Tumor Record Number)

UPDATE

Whenever a new tumor is added to an existing patient, the value of that Tumor Record Number is moved into this field. As tumors are deleted, this number is not decremented.

CONSOLIDATED DATA EXTRACT

No

HISTORICAL CHANGES

3/26/03	In the CCR central system (EUREKA), this field replaced REG-TUM-NO-LAST.
8/15/06	Central_Tum_No name was changed to Tumor Record Number to be more in line with NAACCR Tumor Record Number [NAACCR 60].

Type of Reporting Source

IDENTIFIERS

CCR ID	NAACCR ID
E1071	500

DESCRIPTION

Best source of information to prepare this case abstract.

LEVELS

Tumor
Admission

LENGTH

1

ALLOWABLE VALUES

1	Hospital inpatient and Clinic
2	Radiation Treatment Centers or medical Oncology Centers for cases DX 2006+
3	Laboratory only
4	Physician's office/private medical practitioner LMD
5	Nursing/convalescent home/hospice
6	Autopsy only
7	Death certificate only
8	Other hospital outpatient units/surgery centers (for cases dx 2006+)

SOURCE

Upload with no conversion.

UPDATE

If Admission Type of Reporting Source = 6 or 7 and Tumor Type of Reporting Source = 6 or 7,
Then list for review.
Otherwise,
If Admission Type of Reporting Source is not the same as Tumor Type of Reporting Source and Admission Type of Reporting Source is a more reliable source of information than Tumor Type of Reporting Source, according to this hierarchy:
1, 2, 8, 4, 3, 5, 6, 7
Then automatically update Tumor Type of Reporting Source with Admission Type of Reporting Source.

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/01/1999	Changed EOD-related interfield edits to be conditional on DATE-DX, blanks no longer allowed because DATE-DX will now be checked; changed DC only REPORT-SOURCE/EXTENSION edit to allow code 90; added additional surgery fields to edit 323.

03/15/2000	First interfield edit changed by adding Code 9 to SURG-SUM-RECON; second interfield edit changed modifying EXTENSION-PATH to include DATE-DX.
07/06/2001	Split interfield edit check of summary stage into two edits; renamed non-cancer directed surgery field references; changed interfield edit 4 for ICDO-3.
11/14/2002	Added logic to Interfield edit 323 under 1: for cases diagnosed 2000 and later, allow 9's in SCOPE-LN-SUM and SURG-LN-EX-SUM for sites C700-719 and C80.9, histology type ICD-O-3 9800-9989, and sites C770-779 where histology type ICD-O-3 is 9590-9699 or 9702-9729.
03/26/2003	Removed Reason_No_Chemo and Reason_No_Horm edits Err #399 and Err #400.
08/27/2003	Removed Interfield edit Err #649.
03/03/2004	Removed code 82 from IF 1 for Chemo_Sum and Horm_Sum (Err #310 and #311). Added edits in IF2 for CS fields (Err #522-531). Changed date check in IF 2 for EOD codes. Err #646 & 647 moved. Changed Class_of_Case = 8 (was 9) under IF 2 (Err #612).
06/11/2004	Added code 98 to Surg_Prim_sum (Edit #323) for Autopsy only cases. (Report_Source = 6 cases).
01/19/2005	Changed date check in IF 2 for EOD codes. Err #646 & 647 moved. Changed Class_of_Case = 8 (was 9) under IF 2 (Err #612).
07/27/2005	Added new codes 2 & 8 to Allowable Values Err #64. Changed Case_Find name to new name Casefinding Source in 2 Err #648. Added new codes 2 & 8 to Err #315. Added 8 to the list for review conditions. Added new edit #734 to allow codes 2 & 8 for cases dx 2006+. Changed Update logic.
02/01/2006	Removed the List for Review section and added Update logic to Update section to only list for review when both the admission and tumor Report_Source = 6 or 7. Added IF #737 to edit RX Summ--Systemic Sur Seq for DCO cases.
07/07/2006	Added code 096 to IF #526 and code 550 to IF #529.
01/08/2007	Added IF #754 to cover MD only and lab only standards for Date_First_Admis and Date_DX.
2010	Data Item Changes: CCR name (Report Source) changed to NAACCR name. Added IF #320, 324, 453, 610, 769, 771, 784, 785, and 786.
2011	Removed IF334 and 437 to match deletion in metafile
05/2013	Added IF 1042

Ulceration

IDENTIFIERS

CCR ID	NAACCR ID
E2048	3936

OWNER

NAACCR

DESCRIPTION

Ulceration, the absence of an intact epidermis overlying the primary melanoma based upon histopathological examination, is a prognostic factor for melanoma of the skin.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	Ulceration not identified/not present
1	Ulceration present
8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code 8 will result in an edit error.)
9	Not documented in medical record Cannot be determined by the pathologist Pathology report does not mention ulceration Ulceration not assessed or unknown if assessed
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00470
        - Type of Reporting Source is not 7
        - Ulceration is blank or 8

        Then convert Ulceration to 9
    B. If all of the following conditions are true:
        - One of the following is true:
            - Schema ID is not 00470

            OR
            - Type of Reporting Source is 7
        - Ulceration is not blank

        Then convert Ulceration to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:

- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00470
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00470

One of the following conditions is true

- Admission's value is not blank, 9
- Tumor's value is blank, 9

OR

- Admission's value is 9
- Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.

Otherwise,

If Admission's value is not the same as the Tumor's value

Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Update Date

IDENTIFIERS

CCR ID	NAACCR ID
E1769	None. State Requestor

DESCRIPTION

Date when a record was added or when any item on a specific file in the region's database was last changed.

LEVELS

Patient
Tumor
Admission
Aliases

LENGTH

8

ALLOWABLE VALUES

Any valid date. (CCYMMDD)

SOURCE

Computer generate current date (date of entry or change)

UPDATE

Generate date when an item is changed so that the date of the most recent change is on the file.

CONSOLIDATED DATA EXTRACT

No

HISTORICAL CHANGES

11/14/02	For historical reasons only, maintained in Eureka.

Update User

IDENTIFIERS

CCR ID	NAACCR ID
E1768	None. State Requestor

DESCRIPTION

Display user ID/program name under which the last change to a record was made.

LEVELS

Patient
Tumor
Admission
Aliases

LENGTH

8

ALLOWABLE VALUES

Security data base is searched to verify USER ID clearance for online program or data access.

SOURCE

Computer generate the USER ID or computer program name that updated the database.

UPDATE

Generate the USER ID or computer program name that updated the database.

CONSOLIDATED DATA EXTRACT

No

HISTORICAL CHANGES

11/14/02	For historical reasons only, maintained in Eureka.

Vendor License Number

IDENTIFIERS

CCR ID	NAACCR ID
E1588	None. State Required

DESCRIPTION

This generated field captures the hospital software vendors' serial or license number. This is not a required field and is not on the screen. It is used to track which vendor is submitting which hospital cases and whether they are using the facility's software license or their own copy of the software.

LEVEL

Admission

LENGTH

10

ALLOWABLE VALUES

Numeric, but treated as a character string.

SOURCE

Upload with no conversion.

UPDATE

None

CONSOLIDATED DATA EXTRACT

No

HISTORICAL CHANGES

10/10/07	Date item added on this date.

Vendor Name

IDENTIFIERS

CCR ID	NAACCR ID
E1476	2170

DESCRIPTION

Designates which software vendor generated this case report and what version of software they were using. Each time a vendor produces a new version of registry software, this value should be changed.

LEVEL

Admission

LENGTH

10

ALLOWABLE VALUES

Code	Description
CNET	VISTA
CN	C/NExT
ELM	ELM
ONCOL	OncoLog
RAMS	UCLA RAMIS
JUCLA	UCLA
ACTUR	ACTUR
ERS	ERS
IMPAC	IMPAC
NEV	NEVADA
OUT OF	Out of Sate
CANDIS	CANDIS
CRIS	Region 10
REG10	Region 10
CATTS	Region 8
REG8	Region 8
ANEW	Region 9
REG9	Region 9
UNKNO	Unknown

SOURCE

Upload with no conversion.

UPDATE

None

CONSOLIDATED DATA EXTRACT

Yes, blank until multiple admissions sent to CCR.

HISTORICAL CHANGES

3/26/03	Deleted Appendix 13 and transferred definitions to Allowable values on data item page. Previous conversions to a 4-digit code have been discontinued, so the field will not contain whatever value was transmitted by the reporting facility.
8/15/06	Name changed to NAACCR name (was Vendor Version).

Visceral and Parietal Pleural Invasion

IDENTIFIERS

CCR ID	NAACCR ID
E2049	3937

OWNER

NAACCR

DESCRIPTION

Visceral and Parietal Pleural Invasion is defined as invasion beyond the elastic layer or to the surface of the visceral pleura.

LEVELS

Admissions, Tumors

LENGTH

1

ALLOWABLE VALUES

0	No evidence of visceral pleural invasion identified Tumor does not completely traverse the elastic layer of the pleura Stated as PL0
1	Invasion of visceral elastic layer Not beyond visceral pleural Stated as PL1
2	Invasion outside surface of the visceral pleura Invasion through outer surface of the visceral pleura Stated as PL2
3	Tumor invades into or through the parietal pleura OR chest wall Stated as PL3
4	Invasion of visceral pleura present, NOS; not stated if PL1 or PL2
6	Tumor extends to pleura, NOS; not stated if visceral or parietal
8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code 8 will result in an edit error.)
9	Not documented in medical record No surgical resection of primary site is performed Visceral Pleural Invasion not assessed or unknown if assessed or cannot be determined
Blank	Date of Diagnosis pre-2018 Non-required Schema ID

SOURCE

1. If Date of Diagnosis is less than 2018, then blank out field
2. If Date of Diagnosis is 2018 and greater:
    A. If all of the following conditions are true:
        - Schema ID is 00360
        - Type of Reporting Source is not 7
        - Visceral and Parietal Pleural Invasion is blank or 8

Then convert Visceral and Parietal Pleural Invasion to 9

B. If all of the following conditions are true:
- One of the following is true:
  - Schema ID is not 00360
    OR
  - Type of Reporting Source is 7
- Visceral and Parietal Pleural Invasion is not blank

Then convert Visceral and Parietal Pleural Invasion to blank

UPDATE

Tumor Level

New Case Consolidation

If all of these conditions are true:
- Admission's Date of Diagnosis year is 2018 – 9998
- Admission's Schema ID is 00360
- Tumor's Date of Diagnosis year is 2018 – 9998
- Tumor's Schema ID is 00360

One of the following conditions is true
- Admission's value is not blank, 9
- Tumor's value is blank, 9

  OR
  - Admission's value is 9
  - Tumor's value is blank

Then automatically update the Tumor's value with the Admission's value.
Otherwise,
If Admission's value is not the same as the Tumor's value
Then list for review

Manual Update

Admission

Manual Update

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

01/2019	Per NAACCR v18, new data field implemented.

Vital Status

IDENTIFIERS

CCR ID	NAACCR ID
E1518	1760

DESCRIPTION

Vital status of the patient at last contact (as of the date entered in Date of Last Contact).

LEVELS

Patient, Admission

LENGTH

1

ALLOWABLE VALUES

0	Dead
1	Alive

SOURCE

If the transmitted value is numeric, then just load it with no conversion. Otherwise, default it to 1.

UPDATE

Patient Active Follow-up Fields Update Logic

CONSOLIDATED DATA EXTRACT

Yes

HISTORICAL CHANGES

11/14/02	Changed Date_Last_Pat_Act to Date_Last_Pat_FU in IF #331. Added "and < 19990000" to IF #331. Added codes 27, 36 and 58 to IF #359.
12/4/02	Added logic to IF #331 to include cause of death validation for cases diagnosed after 1998.
03/26/03	In IF358 where Place_Of_Death = Blank has been changed to 997. All cases need to be converted. Added codes 69 and 83 to IF359.
04/03/06	Deleted "See also Cause_Death, Chemo_Sum, Death_File_No, FU_Last_Type_Pat, Horm_Sum, Immuno_Sum, Place_Of_Death, Reason_No_Rad, Reason_No_Surg, Report_Source, and Transp_Endo_Sum" from INTERFIELD EDITS.
02/20/08	Added IF770 edit from NAACCR 11.2 file effective with 2008 diagnosis year cases.
2010	Data Changes: Changed CCR name for Date Last Pat FU to Date of Last Contact in Update area. Update logic rewritten. Added IF471, 533
05/2013	Added IF 1045, 1046

Weight

IDENTIFIERS

CCR ID	NAACCR ID
E1264	9961

OWNER

NPCR

DESCRIPTION

The weight of the patient on or near the date of diagnosis.

LEVELS

Tumors, Admissions

LENGTH

3

ALLOWABLE VALUES

Weight (in pounds) must be a 3-digit number in the range of 000 to 999 or blank.
Blanks are not allowed for cases diagnosed 2011 and forward.
Codes
Code the weight in pounds (three digits).
For weight less than 100 pounds, use a leading zero. For weight less than 10 pounds, use two leading zeros.
Code 999 for unknown weight.

SOURCE

If the value is completely blank, then convert 999; if the value includes a non-blank, non-numeric character, then convert 999; otherwise, just load the transmitted value, but right-justify and zero fill.

UPDATE

Tumor Level

New Case Consolidation

If Tumor.Value is blank and Admission.Value is not blank, then copy Admission.Value to Tumor.Value.

If Tumor.Value is not blank and Admission.Value is blank, then do nothing.

If Tumor.Value is equal to Admission.Value, then do nothing.

If Tumor.Value is not blank and Admission.Value is not blank, and Tumor.Value does not equal Admission.Value, then list for review.

Manual Change

Admission Level

Manual Change

CONSOLIDATED DATA EXTRACT

N/A

HISTORICAL CHANGES

2011 Data Item Changes, CER Project	Added for CER requirements.

05/2013	This data item is now required by NPCR for Date of Diagnosis 2013 and forward. We are still required to submit the values as part of the CER dataset.
12/2013	Allowable values revised per NPCR. Required for Date of Diagnosis 2011 and forward for all Regions. Global fix performed to change blanks to 999 for Date of Diagnosis 2011 forward.

Year First Seen

IDENTIFIERS

CCR ID	NAACCR ID
E1629	None: State Requestor

DESCRIPTION

Year during which the patient was first seen at this hospital for diagnosis and/or treatment of this primary.

LEVEL

Admission

LENGTH

4

ALLOWABLE VALUES

The allowable range is >1949 to <= current date or blank.
Note: As of 4/15/2011, 9999 remains a valid code for "unknown" because Eureka requires a change to the data type at the database level.

SOURCE

If the transmitted value is numeric, then just load it with no conversion. Otherwise, convert it to blank.

UPDATE

Manual or Correction applied

CONSOLIDATED DATA EXTRACT

No

HISTORICAL CHANGES

1/1/99	Changed allowable values for year 2000.
3/5/07	Added Allowable values edit (Err #002) that wasn't in metafile. NAACCR retired this item with their 2006 data changes.
2010	Data Changes: This was NAACCR Item 620 which was retired for NAACCR v11. CCR retained this item, moved it to the State Requestor area and assigned 2220 in the NAACCR column in Volume II. Changed 9999 to blank in Allowable Values and Source area.
2011	Data Changes: Updated allowable values. They did not reflect that this date item is 4 characters and that blank is allowed.

GLOBAL EDIT RULES

Flag should be re-calculated when appropriate.

Admission Edit Set

If any of the following conditions are true for an admission then run the Admission Edit Set:

- Admission's Year of Date of Diagnosis= 1988-2000 and Behavior (92-00) ICD-O-2 = 2 or 3
- Admission's Year of Date of Diagnosis = 2001-9998
- Admission's Year of Date of Diagnosis = 9999 or blank and its Year of Date of 1st Contact = 1988-9998

Tumor Edit Set

If any of the following conditions are true for a tumor then run the Tumor Edit Set:

- Tumor's Year of Date of Diagnosis = 1988-2000 and Behavior (92-00) ICD-O-2 = 2 or 3
- Tumor's Year of Date of Diagnosis = 2001-9998
- Tumor's Year of Date of Diagnosis = 9999 or blank and at least one of its related admissions has Year of Date of 1st Contact = 1988-9998

Patient Edit Set

If any of the following conditions are true for a tumor then run Patient Edit Set:

- Tumor's Year of Date of Diagnosis = 1988-2000 and Behavior (92-00) ICD-O-2 = 2 or 3
- Tumor's Year of Date of Diagnosis = 2001-9998
- Tumor's Year of Date of Diagnosis = 9999 or blank and at least one of its related admissions has Year of Date of 1st Contact = 1988-9998

Interrecord Edit Set

If any of the following conditions are true for a tumor then run the Interrecord Edit Set:

- Tumor's Year of Date of Diagnosis = 1988-2000 and Behavior (92-00) ICD-O-2 = 2 or 3
- Tumor's Year of Date of Diagnosis = 2001-9998
- Tumor's Year of Date of Diagnosis = 9999 or blank and at least one of its related admissions has Year of Date of 1st Contact = 1988-9998

All tumors that meet the criteria above should be fed into the edits buffer.

Historical Changes

In CANDIS, the Global edit logic was written like this IF (TU-DATE-DX < 19730000) OR ((TU-DATE-DX >= 99990000) AND (TU-DATE-ADDED < 19870000)) OR ((TU-DATE-DX >= 19730000 AND <= 19869999) AND (TU-INCIDENCE-CODE < 1)) Then DO NOT perform edits	
05/2010	Implemented with the Region 9 migration done 5/2010.

09/2014	Bugs fixed to allow programmed rules to function according to documented specifications. Specifications clarified by replacing Eureka element name with NAACCR data item name and separating Interrecord from Patient edit specs.

SOURCE LOGIC

Comorbid Fields Source Logic

FIELDS

Comorbid/Complication 1 [NAACCR #3110]
Comorbid/Complication 2 [NAACCR #3120]
Comorbid/Complication 3 [NAACCR #3130]
Comorbid/Complication 4 [NAACCR #3140]
Comorbid/Complication 5 [NAACCR #3150]
Comorbid/Complication 6 [NAACCR #3160]
Comorbid/Complication 7 [NAACCR #3161]
Comorbid/Complication 8 [NAACCR #3162]
Comorbid/Complication 9 [NAACCR #3163]
Comorbid/Complication 10 [NAACCR #3164]
Source Comorbidity [NAACCR #9970]
ICD Revision Comorbid [NAACCR #3165]

SPECIFICATION

1. Left justify and zero-fill any digit values less than 5 entered in Comorbid/Complication 1 - 10.
2. If Comorbid/Complication 1 - 10 are all blank, then set Comorbid/Complication 1 to 00000.
3. If Comorbid/Complication 1 is 00000 and Comorbid/Complication 2 - 10 are blanks, then check for the following conditions:
    - If Source Comorbidity is not equal to 0, then set to 0.
    - If ICD Revision Comorbid is not equal to 0, then set to 0.

   And stop here.
4. If any (non-blank) Comorbid/Complication codes are duplicated in Comorbid/Complication 1 - 10, then examine the affected fields in field number order and leave the first code alone and set all subsequent duplicate codes to blank.
5. If any Comorbid/Complication values are known codes, but Comorbid/Complication 1 = 00000 or there are one or more blank fields mixed in with known codes after them, then set Comorbid/Complications 1 - 10 in field number order with the remaining distinct known codes (in the order the codes are encountered), leaving the blank fields at the end of the list.
6. If any value (allowable coded value, not 00000 and not blank) is documented in Comorbid/Complication 1 - 10, then set:
    - If Source Comorbidity is not equal to 1, then set to 1.
    - If ICD Revision Comorbid is not equal to 9, then set to 9.

   And stop here.

HISTORICAL CHANGES

04/2014	New Source Logic Implemented.

Race Fields Source Logic

FIELDS

Race 1 [NAACCR #160]
Race 2 [NAACCR #161]
Race 3 [NAACCR #162]
Race 4 [NAACCR #163]
Race 5 [NAACCR #164]

SPECIFICATION

Perform the following steps based on SEER coding rules (with noted exceptions for CA):

1. Right-justify and zero-fill any single digit values entered in Race 1 – Race 5.
2. If none of the race fields have a known race code (01 – 32, 90*, or 96-98), then set all race fields to 99 (unknown) and stop here.
3. If any of the race fields have a known race code (01-32, 90*, or 96-98), then set any values other than the known race code values to 88.
4. If any known race codes are duplicated in Race 1 – Race 5, then examine the race fields in race field number order and leave the first code alone, but reset all subsequent duplicate codes to 88.
5. If any specific known race codes have been entered along with a corresponding non-specific race code, then replace the non-specific race code with 88

specific race code	non-specific race code
04-17, 90*	96
16-17	15
20-32	97
01**-32, 90*, and 96-97	98

6. If necessary, rearrange the remaining race codes in Race 1 – Race 5 so that they match this hierarchical order: 07, 02-97 except 07 & 88 (maintain original order entered for codes in this range), 01**, 98**, 88
*California uses code 90 too (Other South Asian, Bangladeshi, Bhutanese, Nepalese, Sikkimese, and Sri Lankan – changed to 96 for submissions)
**Unlike SEER, California gives code 01 priority over 98 in Steps 5) and 6)

HISTORICAL CHANGES

04/01/14	New Source Logic implemented.
12/2014	Step 5 revised to include code 90 as a specific race code for non-specific race code 96. This will eliminate duplication of code 96 for submissions.

Secondary Diagnosis Fields Source Logic

FIELDS

Secondary Diagnosis 1 [NAACCR #3780]
Secondary Diagnosis 2 [NAACCR #3782]
Secondary Diagnosis 3 [NAACCR #3784]
Secondary Diagnosis 4 [NAACCR #3786]
Secondary Diagnosis 5 [NAACCR #3788]
Secondary Diagnosis 6 [NAACCR #3790]
Secondary Diagnosis 7 [NAACCR #3792]
Secondary Diagnosis 8 [NAACCR #3794]
Secondary Diagnosis 9 [NAACCR #3796]
Secondary Diagnosis 10 [NAACCR #3798]

SPECIFICATION

1. If Secondary Diagnosis 1 - 10 are all blank, then set Secondary Diagnosis 1 to 0000000.
2. If any (non-blank) Secondary Diagnosis codes are duplicated in Secondary Diagnosis 1-10, then examine the affected fields in field number order and leave the first code alone and set all subsequent duplicate codes to blank.
3. If any Secondary Diagnosis values are known codes, but Secondary Diagnosis 1 = 0000000 or there are one or more blank fields mixed in with known codes after them, then set Secondary Diagnosis 1 - 10 in field number order with the remaining distinct known codes (in the order the codes are encountered), leaving the blank fields at the end of the list.

   And stop here.

HISTORICAL CHANGES

11/2016	New Source Logic implemented.

TNM Clin Fields Source Logic

FIELDS

TNM Clin T [NAACCR #940]
TNM Clin N [NAACCR #950]
TNM Clin M [NAACCR #960]
TNM Clin Stage Group [NAACCR #970]

SPECIFICATION

- If a prefix of c or p is not present in the first digit of TNM Clin T, TNM Clin N, TNM Clin M, then execute the same conversions from use case ***Perform Eureka 2016 One-Time Data Conversions and Table Populations – UC***, step 3, for the new admission or modified record.
- Populate blank Path TNM values conversion:

If Year DX = 2016-2017:

- TNM Clin Stage Group = 88
  AND TNM Clin T <> 88
  OR TNM Clin N <> 88
  OR TNM Clin M <> 88
  AND CS Schema Name <> Conjunctiva, Melanoma Conjunctiva, Retinoblastoma, LacrimalGland, Orbit, LymphomaOcularAdnexa
  POPULATE TNM Clin T = 88, TNM Clin N = 88, TNM Clin M = 88
- TNM Clin Stage Group <> 4, 88, 99
  AND TNM Clin T <> blank, cX
  AND TNM Clin N <> blank, cX
  AND TNM Clin M = blank
  AND Behavior ICD-O-3 <> 0, 1
  AND CS Schema Name IN Esophagus, EsophagusGEJunction, Stomach, SmallIntestine, CarcinoidAppendix, Anus, GISTAppendix, GISTColon, GISTEsophagus, GISTPeritoneum, GISTRectum, GISTSmallIntestine, GISTStomach, NETAmpulla, NETColon, NETRectum, NETSmsallIntestine, NETStomach, BileDuctsDistal, AmpullaVater, PancreasHead, PancreasBodyTail, PancreasOther, Lung, Pleura, HeartMediastinum, SoftTissue, Skin, Scrotum, MerkelCellPenis, MerkelCellSkin, MerkelCellScrotum, MerkelCellVulva, MelanomaSkin, Breast, Ovary, PeritoneumFemaleGen, FallopianTube, Penis, Prostate, KidneyParenchyma, KidneyRenalPelvis, Bladder, Urethra, AdrenalGland, SkinEyelid, MelanomaChoroid, MelanomaCiliaryBody, MelanomaIris
  POPULATE TNM Clin M = c0
- TNM Clin Stage Group <> 4B, 88, 99
  AND TNM Clin T <> blank, cX
  AND TNM Clin N <> blank, cX
  AND TNM Clin M = blank
  AND Behavior ICD-O-3 <> 0, 1
  AND CS Schema Name = Liver, Gallbladder, CysticDuct, BileDuctsPerihilar, Vulva, Vagina, Cervix, CorpusAdenosarcoma, CorpusCarcinoma, CorpusSarcoma, MycosisFungoides
  POPULATE TNM Clin M = c0
- TNM Clin Stage Group <> 4C, 88, 99
  AND TNM Clin T <> blank, cX
  AND TNM Clin N <> blank, cX

AND TNM Clin M = blank
AND Behavior ICD-O-3 <> 0, 1
AND CS Schema Name = LipLower, LipUpper, LipOther, TongueAnterior, GumUpper, GumLower, GumOther, FloorMouth, MouthOther, PalateHard, BuccalMucosa, TongueBase, PalateSoft, Oropharynx, Nasopharynx, Hypopharynx, EpiglottisAnterior, LarynxGlottic, LarynxSupraglottic, LarynxSubglottic, LarynxOther, NasalCavity, SinusMaxillary, SinusEthmoid, ParotidGland, SubmandibularGland, SalivaryGlandOther, MelanomaPharynxOther
POPULATE TNM Clin M = c0

- TNM Clin T <> blank, cX
  AND TNM Clin N <> blank, cX
  AND TNM Clin M = blank
  AND Behavior ICD-O-3 <> 0, 1
  AND CS Schema Name = Thyroid
  AND TNM Clin Stage Group <> 2, 3, 88, 99
  AND Birth_Date > 19711231
  OR TNM Clin Stage Group <> 4C, 88, 99
  AND Birth_Date < 19720101
  POPULATE TNM Clin M = c0
- TNM Clin Stage Group <> 4A, 4B, 88, 99
  AND TNM Clin T <> blank, cX
  AND TNM Clin N <> blank, cX
  AND TNM Clin M = blank
  AND Behavior ICD-O-3 <> 0, 1
  AND CS Schema Name = Bone, Colon, Rectum
  POPULATE TNM Clin M = c0
- TNM Clin Stage Group <> 4A, 4B, 4C, 88, 99
  AND TNM Clin T <> blank, cX
  AND TNM Clin N <> blank, cX
  AND TNM Clin M = blank
  AND Hist_Behavior_3 <> 0, 1
  AND CS Schema Name = Appendix
  POPULATE TNM Clin M = c0

- Correct invalid TNM Path Stage Group value conversion:

If Year DX = 2016-2017:

- Site = C421
  AND Histologic Type ICD-O-3 = 9811-9818
  OR Histologic Type ICD-O-3 = 9671
  OR Histologic Type ICD-O-3 = 9673
  OR Histologic Type ICD-O-3 = 9591
  OR Histologic Type ICD-O-3 = 9680
  AND TNM Clinical Stage Group = 88
  POPULATE TNM Clinical Stage Group = 4

HISTORICAL CHANGES

08/2018	Logic Revised to correct TNM API errors for 7th Ed.

TNM Path Fields Source Logic

FIELDS

TNM Path T [NAACCR #880]
TNM Path N [NAACCR #890]
TNM Path M [NAACCR #900]
TNM Path Stage Group [NAACCR #910]

SPECIFICATION

- If a prefix of c or p is not present in the first digit of TNM Path T, TNM Path N, TNM Path M, then execute the same conversions from use case ***Perform Eureka 2016 One-Time Data Conversions and Table Populations – UC***, step 3, for the new admission or modified record.
- Populate blank Path TNM values conversion:

If Year DX = 2016-2017 and TNM Path Descriptor <> 4, 6:

- TNM Path Stage Group = 88
  AND TNM Path T <> 88
  OR TNM Path N <> 88
  OR TNM Path M <> 88
  AND CS Schema Name <> Conjunctiva, MelanomaConjunctiva, Retinoblastoma, LacrimalGland, Orbit, LymphomaOcularAdnexa
  POPULATE TNM Path T = 88, TNM Path N = 88, TNM Path M = 88
- TNM Path Stage Group <> 4, 88, 99
  AND TNM Path T <> blank, pX
  AND TNM Path N <> blank, pX
  AND TNM Path M = blank
  AND Behavior ICD-O-3 <> 0, 1
  AND CS Schema Name = Esophagus, EsophagusGEJunction, Stomach, SmallIntestine, CarcinoidAppendix, Anus, GISTAppendix, GISTColon, GISTEsophagus, GISTPeritoneum, GISTRectum, GISTSmallIntestine, GISTStomach, NETAmpulla, NETColon, NETRectum, NETSmsallIntestine, NETStomach, BileDuctsDistal, AmpullaVater, PancreasHead, PancreasBodyTail, PancreasOther, Lung, Pleura, HeartMediastinum, SoftTissue, Skin, Scrotum, MerkelCellPenis, MerkelCellSkin, MerkelCellScrotum, MerkelCellVulva, MelanomaSkin, Breast, Ovary, PeritoneumFemaleGen, FallopianTube, Penis, Prostate, KidneyParenchyma, KidneyRenalPelvis, Bladder, Urethra, AdrenalGland, SkinEyelid, MelanomaChoroid, MelanomaCiliaryBody, MelanomaIris
  POPULATE TNM Path M = c0
- TNM Path Stage Group = 4
  TNM Path T <> blank, pX
  AND TNM Path N <> blank, pX
  AND TNM Path M = blank
  AND TNM_M_Code_Clinical <> blank
  AND Behavior ICD-O-3 <> 0, 1
  AND CS Schema Name = Esophagus, EsophagusGEJunction, Stomach, SmallIntestine, CarcinoidAppendix, Anus, GISTAppendix, GISTColon, GISTEsophagus, GISTPeritoneum GISTRectum, GISTSmallIntestine, GISTStomach, NETAmpulla, NETColon, NETRectum, NETSmsallIntestine, NETStomach, BileDuctsDistal, AmpullaVater, PancreasHead, PancreasBodyTail, PancreasOther, Lung, Pleura, HeartMediastinum, SoftTissue, Skin,

Scrotum, MerkelCellPenis, MerkelCellSkin, MerkelCellScrotum, MerkelCellVulva, MelanomaSkin, Breast, Ovary, PeritoneumFemaleGen, FallopianTube, Penis, Prostate, KidneyParenchyma, KidneyRenalPelvis, Bladder, Urethra, AdrenalGland, SkinEyelid, MelanomaChoroid, MelanomaCiliaryBody, MelanomaIris
POPULATE TNM Path M with TNM_M_Code_Clin

- TNM Path Stage Group <> 4B, 88, 99
  AND TNM Path T <> blank, pX
  AND TNM Path N <> blank, pX
  AND TNM Path M = blank
  AND Behavior ICD-O-3 <> 0, 1
  AND CS Schema Name = Liver, Gallbladder, CysticDuct, BileDuctsPerihilar, Vulva, Vagina, Cervix, CorpusAdenosarcoma, CorpusCarcinoma, CorpusSarcoma, MycosisFungoides
  POPULATE TNM Path M = c0
- TNM Path Stage Group <> 4C, 88, 99
  AND TNM Path T <> blank, pX
  AND TNM Path N <> blank, pX
  AND TNM Path M = blank
  AND Behavior ICD-O-3 <> 0, 1
  AND CS Schema Name = LipLower, LipUpper, LipOther, TongueAnterior, GumUpper, GumLower, GumOther, FloorMouth, MouthOther, PalateHard, BuccalMucosa, TongueBase, PalateSoft, Oropharynx, Nasopharynx, Hypopharynx, EpiglottisAnterior, LarynxGlottic, LarynxSupraglottic, LarynxSubglottic, LarynxOther, NasalCavity, SinusMaxillary, SinusEthmoid, ParotidGland, SubmandibularGland, SalivaryGlandOther, MelanomaPharynxOther
  POPULATE TNM Path M = c0
- TNM Path T <> blank, pX
  AND TNM Path N <> blank, pX
  AND TNM Path M = blank
  AND Behavior ICD-O-3 <> 0, 1
  AND CS Schema Name = Thyroid
  AND TNM Path Stage Group <> 2, 3, 88, 99
  AND Birth_Date > 19711231
  OR TNM Path Stage Group <> 4C, 88, 99
  AND Birth_Date < 19720101
  POPULATE TNM Path M = c0
- TNM Path T <> blank
  AND TNM Path N <> blank
  AND TNM Path M = blank
  AND TNM_M_Code_Clinical <> blank
  AND Behavior ICD-O-3 <> 0, 1
  AND CS Schema Name = Thyroid
  AND TNM Path Stage Group = 2, 3
  AND Birth_Date > 19711231
  OR TNM Path Stage Group = 4C
  AND Birth_Date < 19720101
  POPULATE TNM Path M with TNM_M_Code_Clin

- TNM Path Stage Group <> 3, 3A, 3B, 3C, 88, 99
  AND TNM Path T <> blank, pX
  AND TNM Path N <> blank, pX
  AND TNM Path M = blank
  AND Behavior ICD-O-3 <> 0, 1
  AND CS Schema Name = Testis
  POPULATE TNM Path M = c0
- TNM Path Stage Group <> 4A, 4B, 88, 99
  AND TNM Path T <> blank, pX
  AND TNM Path N <> blank, pX
  AND TNM Path M =
  AND Behavior ICD-O-3 <> 0, 1
  AND CS Schema Name = Bone, Colon, Rectum
  POPULATE TNM Path M = c0
- TNM Path Stage Group = 4A, 4B
  AND TNM Path T <> blank, pX
  AND TNM Path N <> blank, pX
  AND TNM_M_Code_Clinical <> blank
  AND TNM Path M = blank
  AND Behavior ICD-O-3 <> 0, 1
  AND CS Schema Name = Bone, Colon, Rectum
  POPULATE TNM Path M with TNM_M_Code_Clin
- TNM Path Stage Group <> 4A, 4B, 4C, 88, 99
  AND TNM Path T <> blank, pX
  AND TNM Path N <> blank, pX
  AND TNM Path M = blank
  AND Behavior ICD-O-3 <> 0, 1
  AND CS Schema Name = Appendix
  POPULATE TNM Path M = c0

- Correct invalid Pathologic N value conversion:

If Year DX = 2016-2017, TNM Path Descriptor <> 4, 6, Behavior ICD-O-3 = 3, and TNM Path N = c0:

- Site = C619
  AND Histologic Type ICD-O-3 = 8000-8110
  OR Histologic Type ICD-O-3 = 8140-8576
  OR Histologic Type ICD-O-3 = 8940-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  OR Site = C649
  AND Histologic Type ICD-O-3 = 8000-8576
  OR Histologic Type ICD-O-3 = 8840-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  OR Site = C220
  AND Histologic Type ICD-O-3 = 8170-8175
  AND TNM Path Stage Group = 99
  AND TNM Path T = pX, blank
  AND TNM Path M = c0, blank
  AND Surg_Prim_Sum = 00

POPULATE TNM Path T AND TNM Path N AND TNM Path M = blank

- Site = C619
  AND Histologic Type ICD-O-3 = 8000-8110
  OR Histologic Type ICD-O-3 = 8140-8576
  OR Histologic Type ICD-O-3 = 8940-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  OR Site = C649
  AND Histologic Type ICD-O-3 = 8000-8576
  OR Histologic Type ICD-O-3 = 8840-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  OR Site = C220
  AND Histologic Type ICD-O-3 = 8170-8175
  AND TNM Path Stage Group = 99
  AND TNM Path T = pX, blank
  AND TNM Path M = c0, blank
  AND Surg_Prim_Sum <> 00
  AND Regional Nodes Positive = 98
  POPULATE TNM Path N = pX
- Site = C619
  AND Histologic Type ICD-O-3 = 8000-8110
  OR Histologic Type ICD-O-3 = 8140-8576
  OR Histologic Type ICD-O-3 = 8940-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  OR Site = C649
  AND Histologic Type ICD-O-3 = 8000-8576
  OR Histologic Type ICD-O-3 = 8840-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  OR Site = C220
  AND Histologic Type ICD-O-3 = 8170-8175
  AND TNM Path Stage Group = 99
  AND TNM Path T = pX, blank
  AND TNM Path M = c0, blank
  AND Surg_Prim_Sum <> 00
  AND Regional Nodes Positive = 00
  POPULATE TNM Path N = p0
- Site = C619
  AND Histologic Type ICD-O-3 = 8000-8110
  OR Histologic Type ICD-O-3 = 8140-8576
  OR Histologic Type ICD-O-3 = 8940-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  OR Site = C649
  AND Histologic Type ICD-O-3 = 8000-8576
  OR Histologic Type ICD-O-3 = 8840-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  OR Site = C220
  AND Histologic Type ICD-O-3 = 8170-8175

AND TNM Path Stage Group = 99
AND TNM Path T = pX, blank
AND TNM Path M = c0, blank
AND Surg_Prim_Sum <> 00
AND Regional Nodes Positive = 99
POPULATE TNM Path N = pX

- Site = C619
  AND Histologic Type ICD-O-3 = 8000-8110
  OR Histologic Type ICD-O-3 = 8140-8576
  OR Histologic Type ICD-O-3 = 8940-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  OR Site = C649
  AND Histologic Type ICD-O-3 = 8000-8576
  OR Histologic Type ICD-O-3 = 8840-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  AND TNM Path Stage Group = 99
  AND TNM Path T NOT = pX, blank
  AND Surg_Prim_Sum <> 00
  AND Regional Nodes Positive = 98, 99
  POPULATE TNM Path N = pX
- Site = C619
  AND Histologic Type ICD-O-3 = 8000-8110
  OR Histologic Type ICD-O-3 = 8140-8576
  OR Histologic Type ICD-O-3 = 8940-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  AND TNM Path Stage Group = 99
  AND TNM Path M NOT = c0, blank
  AND Surg_Prim_Sum = 00
  AND Regional Nodes Positive = 98
  POPULATE TNM Path T AND TNM Path N AND TNM Path M = blank
- Site = C619
  AND Histologic Type ICD-O-3 = 8000-8110
  OR Histologic Type ICD-O-3 = 8140-8576
  OR Histologic Type ICD-O-3 = 8940-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  AND TNM Path Stage Group <> 99
  AND Regional Nodes Positive = 98
  AND TNM Path T NOT = pX, blank
  AND TNM Path M = c0, blank
  POPULATE TTNM Path N = pX AND TNM Path Stage Group = 99
- Site = C619
  AND Histologic Type ICD-O-3 = 8000-8110
  OR Histologic Type ICD-O-3 = 8140-8576
  OR Histologic Type ICD-O-3 = 8940-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  OR Site = C649

AND Histologic Type ICD-O-3 = 8000-8576
OR Histologic Type ICD-O-3 = 8840-8950
OR Histologic Type ICD-O-3 = 8980-8981
AND TNM Path Stage Group <> 99
AND Regional Nodes Positive = 98
AND TNM Path T = pX, blank
AND TNM Path M = c0, blank
POPULATE TNM Path T AND TNM Path N AND TNM Path M = blank AND TNM Path Stage Group = 99

- Site = C619
  AND Histologic Type ICD-O-3 = 8000-8110
  OR Histologic Type ICD-O-3 = 8140-8576
  OR Histologic Type ICD-O-3 = 8940-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  AND TNM Path Stage Group <> 99
  AND Regional Nodes Positive = 98
  AND TNM Path T = pX, blank
  AND TNM Path M NOT = c0, blank
  AND Surg_Prim_Sum = 00
  AND Regional Nodes Positive = 98
  AND TNM Path M = p1, p1A, p1B, p1C
  POPULATE TNM Path T AND TNM Path N = blank
- Site = C619
  AND Histologic Type ICD-O-3 = 8000-8110
  OR Histologic Type ICD-O-3 = 8140-8576
  OR Histologic Type ICD-O-3 = 8940-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  AND TNM Path Stage Group <> 99
  AND Regional Nodes Positive = 98
  AND TNM Path T = pX, blank
  AND TNM Path M NOT = c0, blank
  AND Surg_Prim_Sum = 00
  AND Regional Nodes Positive = 98
  AND TNM Path M = c1, c1A, c1B ,c1C
  POPULATE TNM Path T AND TNM Path N AND TNM Path M = blank AND TNM Path Stage Group = 99
- Site = C619
  AND Histologic Type ICD-O-3 = 8000-8110
  OR Histologic Type ICD-O-3 = 8140-8576
  OR Histologic Type ICD-O-3 = 8940-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  OR Site = C649
  AND Histologic Type ICD-O-3 = 8000-8576
  OR Histologic Type ICD-O-3 = 8840-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  AND TNM Path Stage Group <> 99

AND Regional Nodes Positive = 00
AND TNM Path T NOT = pX, blank
AND TNM Path M = c0
POPULATE TNM Path N = p0

- Site = C649
  AND Histologic Type ICD-O-3 = 8000-8576
  OR Histologic Type ICD-O-3 = 8840-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  AND TNM Path Stage Group <> 99
  AND Regional Nodes Positive = 98
  AND Surg_Prim_Sum <> 00
  AND TNM Path T NOT = p3, p3A, p3B, p3C, pX, blank
  AND TNM Path M = c0, blank
  POPULATE TNM Path N = pX AND TNM Path Stage Group = 99
- Site = C649
  AND Histologic Type ICD-O-3 = 8000-8576
  OR Histologic Type ICD-O-3 = 8840-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  AND TNM Path Stage Group <> 99
  AND Regional Nodes Positive = 98
  AND Surg_Prim_Sum <> 00
  AND TNM Path T = p3, p3A, p3B, p3C
  AND TNM Path M = c0, blank
  POPULATE TNM Path N = pX
- Site = C649
  AND Histologic Type ICD-O-3 = 8000-8576
  OR Histologic Type ICD-O-3 = 8840-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  AND TNM Path Stage Group = 4
  AND Regional Nodes Positive = 98
  AND Surg_Prim_Sum = 00
  AND TNM Path M =p1
  POPULATE TNM Path T AND TNM Path N = blank
- Site = C649
  AND Histologic Type ICD-O-3 = 8000-8576
  OR Histologic Type ICD-O-3 = 8840-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  AND TNM Path Stage Group = 4
  AND Regional Nodes Positive = 98
  AND Surg_Prim_Sum = 00
  AND TNM Path M =c1
  POPULATE TNM Path T AND TNM Path N AND TNM Path M = blank AND TNM Path Stage Group = 99
- Site = C649
  AND Histologic Type ICD-O-3 = 8000-8576
  OR Histologic Type ICD-O-3 = 8840-8950

OR Histologic Type ICD-O-3 = 8980-8981
AND TNM Path Stage Group = 4
AND Regional Nodes Positive = 98
AND Surg_Prim_Sum <> 00
AND TNM Path M =p1
POPULATE TNM Path T and TNM Path N = blank

- Site = C649
  AND Histologic Type ICD-O-3 = 8000-8576
  OR Histologic Type ICD-O-3 = 8840-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  AND TNM Path Stage Group = 4
  AND Regional Nodes Positive = 98
  AND Surg_Prim_Sum <> 00
  AND TNM Path M =c1
  POPULATE TNM Path N = pX
- Site = C649
  AND Histologic Type ICD-O-3 = 8000-8576
  OR Histologic Type ICD-O-3 = 8840-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  AND TNM Path Stage Group <> 99
  AND Regional Nodes Positive = 00
  AND TNM Path T NOT = pX, blank
  AND TNM Path M <> c0
  POPULATE TNM Path N = p0
- Site = C739
  AND Histologic Type ICD-O-3 = 8000-8576
  OR Histologic Type ICD-O-3 = 8940-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  AND Regional Nodes Positive = 00
  POPULATE TNM Path N = p0
- Site = C739
  AND Histologic Type ICD-O-3 = 8000-8576
  OR Histologic Type ICD-O-3 = 8940-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  AND Regional Nodes Positive = 98
  AND TNM Path Stage Group = 1, 2
  AND Birth_Date > 19711231
  POPULATE TNM Path N = pX
- Site = C739
  AND Histologic Type ICD-O-3 = 8000-8576
  OR Histologic Type ICD-O-3 = 8940-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  AND Regional Nodes Positive = 98
  AND TNM Path Stage Group NOT = 1, 2
  AND Birth_Date > 19711231
  AND Surg_Prim_Sum <> 00

POPULATE TNM Path N = pX AND TNM Path M = c0

- AND Site = C739
  AND Histologic Type ICD-O-3 = 8000-8576
  OR Histologic Type ICD-O-3 = 8940-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  AND Regional Nodes Positive = 98
  AND TNM Path Stage Group NOT = 1, 2
  AND Birth_Date > 19711231
  AND Surg_Prim_Sum = 00
  POPULATE TNM Path T AND TNM Path N AND TNM Path M = blank AND TNM Path Stage Group = 99
- Site = C739
  AND Histologic Type ICD-O-3 = 8000-8576
  OR Histologic Type ICD-O-3 = 8940-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  AND Regional Nodes Positive = 98
  AND TNM Path Stage Group <> 4C
  AND Birth_Date < 19720101
  AND Surg_Prim_sum <> 00
  AND TNM Path Stage Group <> 99
  POPULATE TNM Path N = pX AND TNM Path Stage Group = 99
- Site = C739
  AND Histologic Type ICD-O-3 = 8000-8576
  OR Histologic Type ICD-O-3 = 8940-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  AND Regional Nodes Positive = 98
  AND TNM Path Stage Group <> 4C
  AND Birth_Date < 19720101
  AND Surg_Prim_sum <> 00
  AND TNM Path Stage Group = 99
  POPULATE TNM Path N = pX AND TNM Path M = c0
- Site = C739
  AND Histologic Type ICD-O-3 = 8000-8576
  OR Histologic Type ICD-O-3 = 8940-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  AND Regional Nodes Positive = 98
  AND TNM Path Stage Group <> 4C
  AND Birth_Date < 19720101
  AND Surg_Prim_sum = 00
  POPULATE TNM Path T AND TNM Path N AND TNM Path M = blank AND TNM Path Stage Group = 99
- Site = C739
  AND Histologic Type ICD-O-3 = 8000-8576
  OR Histologic Type ICD-O-3 = 8940-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  AND Regional Nodes Positive = 98

AND TNM Path Stage Group = 4C
AND TNM Path M = c1
AND Surg_Prim_Sum <> 00
AND Birth_Date < 19720101
POPULATE TNM Path N = p0

- Site = C209, C180, C182, C183, C184, C185, C186, C187, C188, C189, C199
  AND Histologic Type ICD-O-3 = 8000-8152
  OR Histologic Type ICD-O-3 = 8154-8231
  OR Histologic Type ICD-O-3 = 8243-8245
  OR Histologic Type ICD-O-3 = 8250-8576
  OR Histologic Type ICD-O-3 = 8940-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  OR Histologic Type ICD-O-3 = 8247-8248
  AND TNM Path Stage Group = 99
  AND TNM Path T = pX
  AND TNM Path M = c0, blank
  AND Surg_Prim_Sum <> 00
  AND Regional Nodes Positive = 98, 99
  POPULATE TNM Path N = pX
- Site = C209, C180, C182, C183, C184, C185, C186, C187, C188, C189, C199
  AND Histologic Type ICD-O-3 = 8000-8152
  OR Histologic Type ICD-O-3 = 8154-8231
  OR Histologic Type ICD-O-3 = 8243-8245
  OR Histologic Type ICD-O-3 = 8250-8576
  OR Histologic Type ICD-O-3 = 8940-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  OR Histologic Type ICD-O-3 = 8247-8248
  AND TNM Path Stage Group = 99
  AND TNM Path T = pX
  AND TNM Path M = c0, blank
  AND Surg_Prim_Sum <> 00
  AND Regional Nodes Positive = 00
  POPULATE TNM Path N = p0
- Site = C209, C180, C182, C183, C184, C185, C186, C187, C188, C189, C199
  AND Histologic Type ICD-O-3 = 8000-8152
  OR Histologic Type ICD-O-3 = 8154-8231
  OR Histologic Type ICD-O-3 = 8243-8245
  OR Histologic Type ICD-O-3 = 8250-8576
  OR Histologic Type ICD-O-3 = 8940-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  OR Histologic Type ICD-O-3 = 8247-8248
  AND TNM Path Stage Group = 99
  AND TNM Path T <> pX
  AND Surg_Prim_Sum <> 00
  AND Regional Nodes Positive = 00, 97
  POPULATE TNM Path N = p0

- Site = C209, C180, C182, C183, C184, C185, C186, C187, C188, C189, C199
  AND Histologic Type ICD-O-3 = 8000-8152
  OR Histologic Type ICD-O-3 = 8154-8231
  OR Histologic Type ICD-O-3 = 8243-8245
  OR Histologic Type ICD-O-3 = 8250-8576
  OR Histologic Type ICD-O-3 = 8940-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  OR Histologic Type ICD-O-3 = 8247-8248
  AND TNM Path Stage Group = 99
  AND TNM Path T <> pX
  AND Surg_Prim_Sum <> 00
  AND Regional Nodes Positive = 98, 99
  POPULATE TNM Path N = pX
- Site = C209, C180, C182, C183, C184, C185, C186, C187, C188, C189, C199
  AND Histologic Type ICD-O-3 = 8000-8152
  OR Histologic Type ICD-O-3 = 8154-8231
  OR Histologic Type ICD-O-3 = 8243-8245
  OR Histologic Type ICD-O-3 = 8250-8576
  OR Histologic Type ICD-O-3 = 8940-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  OR Histologic Type ICD-O-3 = 8247-8248
  AND TNM Path Stage Group = 99
  AND Surg_Prim_Sum = 00
  AND Regional Nodes Positive = 98
  POPULATE TNM Path T AND TNM Path N AND TNM Path M = blank
- Site = C209, C180, C182, C183, C184, C185, C186, C187, C188, C189, C199
  AND Histologic Type ICD-O-3 = 8000-8152
  OR Histologic Type ICD-O-3 = 8154-8231
  OR Histologic Type ICD-O-3 = 8243-8245
  OR Histologic Type ICD-O-3 = 8250-8576
  OR Histologic Type ICD-O-3 = 8940-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  OR Histologic Type ICD-O-3 = 8247-8248
  AND TNM Path Stage Group = 99
  AND Surg_Prim_Sum = 00
  AND Regional Nodes Positive = 00
  POPULATE TNM Path N = p0
- Site = C209, C180, C182, C183, C184, C185, C186, C187, C188, C189, C199
  AND Histologic Type ICD-O-3 = 8000-8152
  OR Histologic Type ICD-O-3 = 8154-8231
  OR Histologic Type ICD-O-3 = 8243-8245
  OR Histologic Type ICD-O-3 = 8250-8576
  OR Histologic Type ICD-O-3 = 8940-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  OR Histologic Type ICD-O-3 = 8247-8248
  AND TNM Path Stage Group <> 99

AND Surg_Prim_Sum <> 00
AND Regional Nodes Positive = 98, 99
AND TNM Path T <> pIS
AND TNM Path M = c0, blank
POPULATE TNM Path N = pX and TNM Path Stage Group = 99

- Site = C209, C180, C182, C183, C184, C185, C186, C187, C188, C189, C199
  AND Histologic Type ICD-O-3 = 8000-8152
  OR Histologic Type ICD-O-3 = 8154-8231
  OR Histologic Type ICD-O-3 = 8243-8245
  OR Histologic Type ICD-O-3 = 8250-8576
  OR Histologic Type ICD-O-3 = 8940-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  OR Histologic Type ICD-O-3 = 8247-8248
  AND TNM Path Stage Group <> 99
  AND Surg_Prim_Sum <> 00
  AND Regional Nodes Positive = 98, 99
  AND TNM Path T <> pIS
  AND TNM Path M NOT = c0, blank
  POPULATE TNM Path N = pX
- AND Site = C209, C180, C182, C183, C184, C185, C186, C187, C188, C189, C199
  AND Histologic Type ICD-O-3 = 8000-8152
  OR Histologic Type ICD-O-3 = 8154-8231
  OR Histologic Type ICD-O-3 = 8243-8245
  OR Histologic Type ICD-O-3 = 8250-8576
  OR Histologic Type ICD-O-3 = 8940-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  OR Histologic Type ICD-O-3 = 8247-8248
  AND TNM Path Stage Group <> 99
  AND Surg_Prim_Sum <> 00
  AND Regional Nodes Positive = 00
  AND TNM Path T <> pIS
  POPULATE TNM Path N = p0
- Site = C079,C080,C081,C088,C089
  AND Histologic Type ICD-O-3 = 8000-8576
  OR Histologic Type ICD-O-3 = 8154-8231
  OR Histologic Type ICD-O-3 = 8940-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  AND TNM Path M = c0
  AND Surg_Prim_Sum <> 00
  AND Regional Nodes Positive = 98
  POPULATE TNM Path N = pX AND TNM Path Stage Group = 99
- Site = C079,C080,C081,C088,C089
  AND Histologic Type ICD-O-3 = 8000-8576
  OR Histologic Type ICD-O-3 = 8154-8231
  OR Histologic Type ICD-O-3 = 8940-8950
  OR Histologic Type ICD-O-3 = 8980-8981

AND Surg_Prim_Sum = 00
AND Regional Nodes Positive = 98
POPULATE TNM Path T AND TNM Path N AND TNM Path M = blank AND TNM Path Stage Group = 99

- Site = C079,C080,C081,C088,C089
  AND Histologic Type ICD-O-3 = 8000-8576
  OR Histologic Type ICD-O-3 = 8154-8231
  OR Histologic Type ICD-O-3 = 8940-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  AND Surg_Prim_Sum <> 00
  AND Regional Nodes Positive = 00
  POPULATE TNM Path N = p0
- Site = C541,C540,C542,C543,C548,C549,C559
  AND Histologic Type ICD-O-3 = 8000-8576
  OR Histologic Type ICD-O-3 = 8890-8898
  OR Histologic Type ICD-O-3 = 8930-8933
  OR Histologic Type ICD-O-3 = 8940-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  AND TNM Path M = c0
  AND Surg_Prim_Sum <> 00
  AND Regional Nodes Positive = 98, 00
  AND TNM Path Stage Group NOT = 1,1A, 4B
  POPULATE TNM Path N = pX AND TNM Path Stage Group = 99
- Site = C541,C540,C542,C543,C548,C549,C559
  AND Histologic Type ICD-O-3 = 8000-8576
  OR Histologic Type ICD-O-3 = 8890-8898
  OR Histologic Type ICD-O-3 = 8930-8933
  OR Histologic Type ICD-O-3 = 8940-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  AND TNM Path M = c0
  AND Surg_Prim_Sum <> 00
  AND Regional Nodes Positive = 98
  AND TNM Path Stage Group = 1,1A
  POPULATE TNM Path N = blank
- Site = C541,C540,C542,C543,C548,C549,C559
  AND Histologic Type ICD-O-3 = 8000-8576
  OR Histologic Type ICD-O-3 = 8890-8898
  OR Histologic Type ICD-O-3 = 8930-8933
  OR Histologic Type ICD-O-3 = 8940-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  AND TNM Path M <> c0
  AND Surg_Prim_Sum <> 00
  AND Regional Nodes Positive = 98
  AND TNM Path Stage Group = 4B
  POPULATE TNM Path N = pX
- Site = C541,C540,C542,C543,C548,C549,C559

AND Histologic Type ICD-O-3 = 8000-8576
OR Histologic Type ICD-O-3 = 8890-8898
OR Histologic Type ICD-O-3 = 8930-8933
OR Histologic Type ICD-O-3 = 8940-8950
OR Histologic Type ICD-O-3 = 8980-8981
AND Surg_Prim_Sum = 00
AND TNM Path M = p1
AND TNM Path Stage Group = 4B
POPULATE TNM Path T and TNM Path N = blank

- Site = C541,C540,C542,C543,C548,C549,C559
  AND Histologic Type ICD-O-3 = 8000-8576
  OR Histologic Type ICD-O-3 = 8890-8898
  OR Histologic Type ICD-O-3 = 8930-8933
  OR Histologic Type ICD-O-3 = 8940-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  AND Surg_Prim_Sum = 00
  AND TNM Path M = c1
  AND TNM Path Stage Group = 4B
  POPULATE TNM Path T AND TNM Path N AND TNM Path M = blank AND TNM Path Stage Group = 99
- Site = C170,C171,C172,C178,C179
  AND Histologic Type ICD-O-3 = 8000-8152
  OR Histologic Type ICD-O-3 = 8154-8231
  OR Histologic Type ICD-O-3 = 8243-8245
  OR Histologic Type ICD-O-3 = 8250-8576
  OR Histologic Type ICD-O-3 = 8940-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  AND TNM Path M = c1
  AND Surg_Prim_Sum = 00
  AND Regional Nodes Positive = 98
  AND TNM Path Stage Group = 4
  POPULATE TNM Path T AND TNM Path N AND TNM Path M = blank AND TNM Path Stage Group = 99
- Site = C170,C171,C172,C178,C179
  AND Histologic Type ICD-O-3 = 8000-8152
  OR Histologic Type ICD-O-3 = 8154-8231
  OR Histologic Type ICD-O-3 = 8243-8245
  OR Histologic Type ICD-O-3 = 8250-8576
  OR Histologic Type ICD-O-3 = 8940-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  AND TNM Path M = p1
  AND Surg_Prim_Sum = 00
  AND Regional Nodes Positive = 98
  AND TNM Path Stage Group = 4
  POPULATE TNM Path T and TNM Path N = blank
- Site = C170,C171,C172,C178,C179

AND Histologic Type ICD-O-3 = 8000-8152
OR Histologic Type ICD-O-3 = 8154-8231
OR Histologic Type ICD-O-3 = 8243-8245
OR Histologic Type ICD-O-3 = 8250-8576
OR Histologic Type ICD-O-3 = 8940-8950
OR Histologic Type ICD-O-3 = 8980-8981
AND TNM Path M = c0, blank
AND Surg_Prim_Sum NOT = 00
AND Regional Nodes Positive = 98
AND TNM Path Stage Group NOT = 4
POPULATE TNM Path N = pX AND TNM Path Stage Group = 99

- Site = C220
  AND Histologic Type ICD-O-3 = 8170-8175
  AND TNM Path M = c1
  AND Regional Nodes Positive = 98
  AND TNM Path Stage Group = 4B
  POPULATE TNM Path T AND TNM Path N AND TNM Path M = blank AND TNM Path Stage Group = 99
- Site = C220
  AND Histologic Type ICD-O-3 = 8170-8175
  AND TNM Path M = p1
  AND Surg_Prim_Sum = 00
  AND Regional Nodes Positive = 98
  AND TNM Path Stage Group = 4B
  POPULATE TNM Path T and TNM Path N = blank
- Site = C220
  AND Histologic Type ICD-O-3 = 8170-8175
  AND TNM Path M = c0
  AND Surg_Prim_Sum = 00
  AND Regional Nodes Positive = 98
  AND TNM Path Stage Group NOT = 4B, 99
  POPULATE TNM Path T AND TNM Path N AND TNM Path M = blank AND TNM Path Stage Group = 99
- Site = C220
  AND Histologic Type ICD-O-3 = 8170-8175
  AND Surg_Prim_Sum NOT = 00
  AND Regional Nodes Positive = 98
  AND TNM Path Stage Group NOT = 4B, 99
  POPULATE TNM Path N = pX AND TNM Path Stage Group = 99
- Site = C220
  AND Histologic Type ICD-O-3 = 8170-8175
  AND Surg_Prim_Sum NOT = 00
  AND Regional Nodes Positive = 00
  AND TNM Path Stage Group NOT = 4B, 99
  POPULATE TNM Path N = p0
- Site = C569,C481,C482,C488

AND Histologic Type ICD-O-3 = 8000-8576
OR Histologic Type ICD-O-3 = 8930-9110
AND TNM Path Stage Group = 3C
AND Surg_Prim_Sum <> 00
AND Regional Nodes Positive =98
POPULATE TNM Path N = pX

- Site = C569,C481,C482,C488
  AND Histologic Type ICD-O-3 = 8000-8576
  OR Histologic Type ICD-O-3 = 8930-9110
  AND TNM Path Stage Group = 3C
  AND Surg_Prim_Sum <> 00
  AND Regional Nodes Positive =00
  POPULATE TNM Path N = p0
- Site = C569,C481,C482,C488
  AND Histologic Type ICD-O-3 = 8000-8576
  OR Histologic Type ICD-O-3 = 8930-9110
  AND TNM Path Stage Group = 3C
  AND Surg_Prim_Sum = 00
  POPULATE TNM Path T AND TNM Path N AND TNM Path M = blank AND TNM Path Stage Group = 99
- Site = C569,C481,C482,C488
  AND Histologic Type ICD-O-3 = 8000-8576
  OR Histologic Type ICD-O-3 = 8930-9110
  AND TNM Path Stage Group NOT = 3C, 4, 99
  AND Surg_Prim_Sum <> 00
  AND Regional Nodes Positive = 98
  POPULATE TNM Path N = pX AND TNM Path Stage Group = 99
- Site = C569,C481,C482,C488
  AND Histologic Type ICD-O-3 = 8000-8576
  OR Histologic Type ICD-O-3 = 8930-9110
  AND TNM Path Stage Group NOT = 3C, 4, 99
  AND Surg_Prim_Sum <> 00
  AND Regional Nodes Positive = 00
  POPULATE TNM Path N = p0
- Site = C569,C481,C482,C488
  AND Histologic Type ICD-O-3 = 8000-8576
  OR Histologic Type ICD-O-3 = 8930-9110
  AND TNM Path Stage Group = 4
  AND TNM Path M = c1
  AND Surg_Prim_Sum = 00
  POPULATE TNM Path T AND TNM Path N AND TNM Path M = blank AND TNM Path Stage Group = 99
- Site = C569,C481,C482,C488
  AND Histologic Type ICD-O-3 = 8000-8576
  OR Histologic Type ICD-O-3 = 8930-9110
  AND TNM Path Stage Group = 4

AND TNM Path M = p1, c1
AND Surg_Prim_Sum <> 00
POPULATE TNM Path N = pX

- Site = C569,C481,C482,C488
  AND Histologic Type ICD-O-3 = 8000-8576
  OR Histologic Type ICD-O-3 = 8930-9110
  AND TNM Path Stage Group = 4
  AND TNM Path M = p1
  AND Surg_Prim_Sum = 00
  POPULATE TNM Path T and TNM Path N = blank
- Site = C569,C481,C482,C488
  AND Histologic Type ICD-O-3 = 8000-8576
  OR Histologic Type ICD-O-3 = 8930-9110
  AND TNM Path Stage Group = 99
  AND Surg_Prim_Sum = 00
  AND Regional Nodes Positive = 98
  POPULATE TNM Path T AND TNM Path N AND TNM Path M = blank
- Site =C181
  AND Histologic Type ICD-O-3 = 8000-8576
  OR Histologic Type ICD-O-3 = 8940-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  AND TNM Path Stage Group NOT = 4, 4A, 4B, 4C, 99
  AND Regional Nodes Positive = 98
  AND Surg_Prim_Sum <> 00
  POPULATE TNM Path N = pX AND TNM Path Stage Group = 99
- Site =C181
  AND Histologic Type ICD-O-3 = 8000-8576
  OR Histologic Type ICD-O-3 = 8940-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  AND TNM Path Stage Group NOT = 4, 4A, 4B, 4C, 99
  AND Regional Nodes Positive = 00
  AND Surg_Prim_Sum <> 00
  POPULATE TNM Path N = p0
- Site =C181
  AND Histologic Type ICD-O-3 = 8000-8576
  OR Histologic Type ICD-O-3 = 8940-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  AND TNM Path Stage Group = 4, 4A, 4B, 4C
  AND Regional Nodes Positive = 00
  POPULATE TNM Path N = p0
- Site = C300,C310,C311
  AND Histologic Type ICD-O-3 = 8000-8576
  OR Histologic Type ICD-O-3 = 8940-8950
  OR Histologic Type ICD-O-3 = 8980-8981
  AND TNM Path Stage Group NOT = 4C, 99
  AND Regional Nodes Positive = 98

AND Surg_Prim_Sum <> 00
POPULATE TNM Path N = pX AND TNM Path Stage Group = 99

- Site = C440-C449
  OR Site = C510-C519
  OR Site = C600-C609
  OR Site = C632
  AND Histologic Type ICD-O-3 = 9700, 9701
  AND Regional Nodes Positive = 98
  POPULATE TNM Path T AND TNM Path N AND TNM Path M = blank AND TNM Path Stage Group = 99
- Site = C693,C694
  AND Histologic Type ICD-O-3 = 8720-8790
  AND Surg_Prim_Sum = 00
  AND Regional Nodes Positive = 98
  POPULATE TNM Path T AND TNM Path N AND TNM Path M = blank AND TNM Path Stage Group = 99
- Site = C693,C694
  AND Histologic Type ICD-O-3 = 8720-8790
  AND Surg_Prim_Sum <> 00
  AND Regional Nodes Positive = 98
  AND TNM Path Stage Group NOT = 99, 4
  POPULATE TNM Path N = pX AND TNM Path Stage Group = 99
- Site = C693,C694
  AND Histologic Type ICD-O-3 = 8720-8790
  AND Surg_Prim_Sum <> 00
  AND Regional Nodes Positive = 98
  AND TNM Path Stage Group = 99
  POPULATE TNM Path N = pX AND TNM Path Stage Group = 99
- Site = C384
  AND Histologic Type ICD-O-3 = 9050-9053
  AND Surg_Prim_Sum <> 00
  AND Regional Nodes Positive = 98
  AND TNM Path Stage Group NOT = 4, 99
  POPULATE TNM Path N = pX AND TNM Path Stage Group = 99
- Site = C384
  AND Histologic Type ICD-O-3 = 9050-9053
  AND Surg_Prim_Sum = 00
  AND Regional Nodes Positive = 98
  AND TNM Path Stage Group = 99
  POPULATE TNM Path T AND TNM Path N AND TNM Path M = blank
- Site = C740,C749
  AND Histologic Type ICD-O-3 = 8010, 8140, 8370
  AND TNM Path Stage Group NOT = 4, 99
  AND Surg_Prim_Sum <> 00
  AND Regional Nodes Positive = 98
  POPULATE TNM Path N = pX AND TNM Path Stage Group = 99

- Correct invalid TNM Path Stage Group value conversion:

If Year DX = 2016-2017:

- Site = C421

AND Histologic Type ICD-O-3 = 9811-9818
OR Histologic Type ICD-O-3 = 9671
OR Histologic Type ICD-O-3 = 9673
OR Histologic Type ICD-O-3 = 9591
OR Histologic Type ICD-O-3 = 9680
AND TNM Path Stage Group = 88
POPULATE TNM Path Stage Group = 99

HISTORICAL CHANGES

08/2018	Logic Revised to correct TNM API errors for 7th Ed.

UPDATE LOGIC

Comorbid Fields Update Logic

FIELDS

Comorbid/Complication 1 [NAACCR #3110]
Comorbid/Complication 2 [NAACCR #3120]
Comorbid/Complication 3 [NAACCR #3130]
Comorbid/Complication 4 [NAACCR #3140]
Comorbid/Complication 5 [NAACCR #3150]
Comorbid/Complication 6 [NAACCR #3160]
Comorbid/Complication 7 [NAACCR #3161]
Comorbid/Complication 8 [NAACCR #3162]
Comorbid/Complication 9 [NAACCR #3163]
Comorbid/Complication 10 [NAACCR #3164]
Source Comorbidity [NAACCR #9970]
ICD Revision Comorbid [NAACCR #3165]

SPECIFICATION

Tumor Level

Multi-Document Consolidation Process

Relevant Source Documents

- All active (not deleted or merged) admissions linked to the current tumor
- Secondary Diagnosis Document linked to the current tumor

Definitions

- No documented Comorbid/Complications in relevant admissions: Comorbid/Complication 1 is 00000 AND Comorbid/Complication 2 - 10 are blank
- No documented Comorbid Complications in relevant Secondary Diagnosis Document: Comorbid/Complication 1-10 are all blanks.
- Documented Comorbid/Complications: One or more non-blank, non-00000, allowable codes entered.
- Relevant source document hierarchy: An ordered list of selected relevant source documents that provides the means to determine the precedence data from one source document should have over another in consolidation decisions. Here we are using class of case, date of 1st contact if necessary, and then admission ID as a last resort to determine the hierarchy.
- Distinct known codes: No duplicate codes, 00000, or blanks

Triggers

- The set of relevant source documents linked to the tumor changed
- Class of Case, Date of 1st Contact, or one or more Comorbid/Complication fields are changed in a relevant source document
- Special global re-consolidation processes

Process

1. If either of the following conditions is true:
   - All relevant source documents have no documented Comorbid/Complications
   - Relevant admissions have no documented Comorbid/Complications and there is no relevant Secondary Diagnosis Document available

Then set:

- Comorbid/Complication 1 – 10 to not documented
- Source Comorbidity to 0
- ICD Revision Comorbid to 0

And stop here.

2. If both of the following conditions are true:
   - Relevant admissions have no documented Comorbid/Complications
   - Relevant Secondary Diagnosis Document available with documented Comorbid/Complications

   Then set:
   - Comorbid/Complication 1 – 10 fields with distinct known codes from SDX until all fields are filled or distinct known codes are exhausted
   - Source Comorbidity to 2
   - ICD Revision Comorbid to 9

   And stop here.
3. Otherwise, determine the relevant source document hierarchy by selecting only relevant admissions with documented Comorbid/Complications and ignoring relevant Secondary Diagnosis Document:
   - Compare the selected admissions' class of case values. Use the Class of Case hierarchy below to determine an initial relevant source document hierarchy with 00 being highest:
     - 00
     - 10 – 14
     - 34
     - 20 – 22
     - 36
     - 40 – 41
     - 30 – 33
     - 38
     - 35, 37
     - 42 – 49
     - 99
   - If there is more than one selected admission with a class of case in any of the above ranges, then attempt to refine the sub-hierarchies by ordering each range set by Date of 1st Contact (earliest is highest), accounting for missing or partial dates in the comparisons. We can determine whether or not one date is earlier than the other if
     - the two dates have known but different years,
     - the two dates have the same known year but different known months, or
     - the two dates have the same known year & month but different known days

   We can only use this method to set the sub-hierarchy for each class of case range set if the earlier/later determination can be made for all dates in the range set.
   - If there is more than one selected admission in any of the class of case ranges and a sub-hierarchy for a range set could not be determined using Date of 1st Contact, then

set the sub-hierarchy for it using Admission ID (lowest number is highest in the sub-hierarchy).

4. Then set:
    - Comorbid/Complication 1 – 10 fields with distinct known codes from the selected admissions following the relevant source document hierarchy from highest to lowest until all fields are filled or all selected admissions are exhausted
    - Source Comorbidity to 1
    - ICD Revision Comorbid to 9

    And stop here.

Manual Change

Not allowed

Admission Level

Manual Change or Correction Applied to Comorbid/Complication 1 – 10, Source Comorbidity, or ICD Revision Comorbid.

Perform automatic QC procedures described under **SOURCE**

HISTORICAL CHANGES

04/2014	New Multi-Document Update Logic implemented.

Patient Active Follow-up Fields Update Logic

FIELDS

Follow-Up Hospital Last [CCR #1628]
Date of Last Contact [NAACCR #1750]
Date of Last Contact Flag [NAACCR #1751]
Vital Status [NAACCR #1760]
Follow-Up Last Type Patient [CCR #E1580]
Follow-Up Next Type [#E1584]
Physician-Follow-Up [NAACCR #2470]
DC State File Number [NAACCR #2830]
Death File No St [CCR #E1615]
Cause of Death [NAACCR #1910]
Place of Death--State [NAACCR #1942]
Place of Death--Country [NAACCR #1944]
Contact Name [CCR #E1740]
Addr Current--No & Street [NAACCR #2330]
Addr Current--Supplementl [NAACCR #2355]
Addr Current--City [NAACCR #70]
Addr Current--State [NAACCR #80]
Addr Current--Postal Code [NAACCR #1830]
Addr Current--Country [NAACCR #1832]
Telephone [NAACCR#2360]
Pat No Contact [CCR #E1573]
Follow-Up Contact--Name [NAACCR #2394]
Follow-Up Contact--No&St [NAACCR #2392]
Follow-Up Contact--Suppl [NAACCR #2393]
Follow-Up Contact--City [NAACCR #1842]
Follow-Up Contact--State [NAACCR #1844]
Follow-Up Contact--Postal [NAACCR #1846]
Followup Contact--Country [NAACCR #1847]

SPECIFICATION

Patient Level

Multi-Document Consolidation Process

Note: Patient Active Follow-up Fields Logic runs prior to Tumor Active Follow-up Logic

Relevant Source Documents

- The current patient
- All active (non-deleted or merged) admissions linked to the current patient

Definitions

- Non-admission supported relevant patient: any of the patient level active follow-up field values do not match the associated admissions values

Triggers

- The set of relevant source documents linked to the patient changed
- One of the following fields changes in a relevant source document:
  - Follow-Up Hospital Last
  - Date of Last Contact

- Date of Last Contact Flag
- Vital Status
- Follow-Up Last Type Patient
- Follow-Up Next Type
- Physician-Follow-Up
- DC State File Number
- Death File No St
- Cause of Death
- Place of Death--State
- Place of Death--Country
- Physician--Follow Up
- Contact Name
- Addr Current--No & Street
- Addr Current--City
- Addr Current--State
- Addr Current--Postal Code
- Addr Current--Country
- Telephone
- Pat No Contact
- Follow-Up Contact--Name
- Follow-Up Contact--No&St
- Follow-Up Contact--Suppl
- Follow-Up Contact--City
- Follow-Up Contact--State
- Follow-Up Contact--Postal
- Followup Contact--Country
- Date Case Last Changed
- Date of 1st Contact
- Class of Case
- Date of Inpt Disch

- Special global re-consolidation processes

<u>Process</u>

1. If one of the following situations are true:
   - All of the following conditions are true:
     - Relevant admissions have a Vitals Status of 0 or 1
     - Relevant patient has a Vital Status of 0 and Follow-Up Last Type Patient of 56, 69, 55, 58
   - Non-admission supported relevant patient is present with later Date of Last Contact than relevant admissions
2. Then check Pat No Contact field, if relevant patient's Pat No Contact has value of 0 and relevant admissions have value not equal to 0, then set patient's Pat No Contact with non-zero value from Admission with lowest Admission ID.
3. If one of the following situations is true:
   - All of the following conditions are true:
     - Relevant admissions have a Vital Status of 0 or 1

        - Relevant patient has a Vital Status of 0 and Follow-Up Last Type Patient is not 56, 69, 55, or 58
    - All of the following conditions are true:
        - Relevant admissions have a Vital Status of 0 or 1
        - Relevant patient has a Vital Status of 1

Then determine which single relevant admission should be utilized to consolidate all patient level active follow-up fields:

- If there is more than one selected relevant admission in one of the above situations, then attempt to break the tie by using the admissions' Date of Last Contact. Use the hierarchy* below:
    - Relevant admissions have Date of Last Contact later than or equal to patient
    - Relevant admissions have Date of Last Contact earlier than patient
- If the system is unable to determine which single admission has the highest hierarchy using Date of Last Contact, then attempt to break the tie within the results using the admissions' Vital Status information. Use the hierarchy below:
    - Vital Status of 0 and DC State File No not equal to 999999
    - Vital Status of 0 and DC State File No equal to 999999
    - Vital Status of 1
- If the system is unable to determine which single admission has the highest hierarchy using Vital Status information, then attempt to break the tie within the results using the admissions' Date of Last Contact (highest to earliest)*.
- If the system is unable to determine which single admission has the highest hierarchy using Date of Last Contact, then attempt to break the tie within the results using the admission's Date Case Last Changed (highest to earliest)*.
- If the system is unable to determine which single admission has the highest hierarchy using the admissions' Date Case Last Changed, then attempt to break the tie within the results using the admissions' Date of 1st Contact (highest to earliest)*.
- If the system is unable to determine which single admission has the highest hierarchy using the admissions' Date of 1st Contact, then attempt to break the tie within the results using Class of Case. Use the hierarchy below:
    - 20-22
    - 30-32
    - 10-14
    - 00
    - 34
    - 36
    - 40-43
    - 38
    - 33
    - 99
    - 35
    - 47
    - 49

- If the system is unable to determine which single admission has the highest hierarchy using the admissions' Class of Case, then break the final tie within the results using Admission ID (lowest number is highest in the sub-hierarchy).

4. Check Pat No Contact field, if relevant patient's Pat No Contact has value of 0 and relevant admissions have value not equal to 0, then set patient's Pat No Contact with non-zero value from Admission with lowest Admission ID.
5. Set the remaining patient level active follow-up fields with codes that are different than the current consolidated codes from the single admission determined to be the highest in the relevant source document hierarchy and stop here.

Manual Change

Not allowed

* We can determine whether or not one date is earlier than the other if

- The two dates have known but different years,
- The two dates have the same known year but different known months, or
- The two dates have the same known year & month but different known dates

HISTORICAL CHANGES

08/2016	New Multi-Document Update Logic implemented.
05/2018	Removed Date of Inpt Discharge from Vital Status hierarchy and grouped Class of Case into ranges.

Race Fields Update Logic

FIELDS

Race 1 [NAACCR #160]
Race 2 [NAACCR #161]
Race 3 [NAACCR #162]
Race 4 [NAACCR #163]
Race 5 [NAACCR #164]

SPECIFICATION

Patient Level

Multi-Document Consolidation Process

Relevant Source Documents

- The current patient
- All active (not deleted or merged) admissions linked to the current patient
- Passive follow-up with Follow-up Last Type Patient of 56 or 69 linked to the current Patient and has a known passive follow-up race code

Definitions

- Known admission and patient race code(s): 01 – 32, 90*, or 96 – 98
- Known passive follow-up race codes(s):
  - Year of Death 1970-1972: 1-5
  - Year of Death 1973-1977: 1-6
  - Year of Death 1978-1984: 1-4
  - Year of Death 1985-9998: 10, 20, 30, 40-49, 52-59

Triggers

- The set of relevant source documents linked to the patient changes (i.e., new document linked, existing document deleted, etc.)
- One or more race code fields are changed in a relevant source document
- Special global re-consolidation processes

Process

Perform the following steps based on SEER coding rules (with noted exceptions for CA):

1. If relevant patients and admissions have no known race code and there is no relevant passive follow-up record available, then set all the patient's race fields to 99, and stop here.
2. If relevant patients and admissions have no known race codes and one or more relevant passive follow-up documents available, then:
   - Use the following hierarchy to determine which single source document should be consolidated:
     - Follow-up Last Type Patient of 56
     - Follow-up Last Type Patient of 69
   - If there is more than one selected relevant follow-up record with any of the above Follow-up Last Type Patient codes, then attempt to break the tie by using Date Loaded (latest to earliest).
   - Then use Tables A-D to convert the selected relevant passive follow-up race code based on the Date of Last Contact year in the passive follow-up document. Then set Race 1 with converted code and Race 2-5 with 88, and stop here.

Table A: If passive follow-up's year of Date of Last Contact is 1970-1972:

Stat Master Code	Stat Master Description	CCR Code	CCR Description

1	WHITE	01	WHITE
2	BLACK	02	BLACK
3	AMERICAN INDIAN	03	AMERICAN INDIAN, ALEUTIAN, OR ESKIMO
4	CHINESE	04	CHINESE
5	JAPANESE	05	JAPANESE

Table B: If passive follow-up's year of Date of Last Contact is 1973-1977:

Stat Master Code	Stat Master Description	CCR Code	CCR Description
1	WHITE	01	WHITE
2	BLACK	02	BLACK
3	AMERICAN INDIAN	03	AMERICAN INDIAN, ALEUTIAN, OR ESKIMO
4	CHINESE	04	CHINESE
5	JAPANESE	05	JAPANESE
6	FILIPINO	06	FILIPINO

Table C: If passive follow-up's year of Date of Last Contact is 1978-1984:

Stat Master Code	Stat Master Description	CCR Code	CCR Description
1	WHITE	01	WHITE
2	BLACK	02	BLACK
3	AMERICAN INDIAN	03	AMERICAN INDIAN, ALEUTIAN, OR ESKIMO
4	ASIAN	96	OTHER ASIAN, INCLUDING BURMESE, INDONESIAN, ASIAN, NOS AND ORIENTAL, NOS

Table D: If passive follow-up's year of Date of Last Contact is 1985-9998:

Stat Master Code	Stat Master Description	CCR Code	CCR Description
10	WHITE	01	WHITE
20	BLACK	02	BLACK
30	AMERICAN INDIAN	03	AMERICAN INDIAN, ALEUTIAN, OR ESKIMO
40	ASIAN-UNSPECIFIED	96	OTHER ASIAN, INCLUDING BURMESE, INDONESIAN, ASIAN, NOS AND ORIENTAL, NOS

41	ASIAN-SPECIFIED	96	OTHER ASIAN, INCLUDING BURMESE, INDONESIAN, ASIAN, NOS AND ORIENTAL, NOS
42	ASIAN-CHINESE	04	CHINESE
43	ASIAN-JAPANESE	05	JAPANESE
44	ASIAN-KOREAN	08	KOREAN
45	ASIAN-VIETNAMESE	10	VIETNAMESE
46	ASIAN-CAMBODIAN	13	KAMPUCHEAN (CAMBODIAN)
47	ASIAN-THAI	14	THAI
48	ASIAN LAOTIAN	11	LAOTIAN
49	ASIAN-HMONG	12	HMONG
52	INDIAN (EXCLUDES AMERICAN INDIANS, ALEUT, & ESKIMO)	15	ASIAN INDIAN OR PAKISTANI, NOS
53	FILIPINO	06	FILIPINO
54	HAWAIIAN	07	HAWAIIAN
55	GUAMANIAN	22	GUAMANIAN, NOS
56	SAMOAN	27	SAMOAN
57	ESKIMO	03	AMERICAN INDIAN, ALEUTIAN, OR ESKIMO
58	ALEUT	03	AMERICAN INDIAN, ALEUTIAN, OR ESKIMO
59	PACIFIC ISLANDER (EXCLUDES HAWAIIAN, GUAMANIAN, SAMOAN)	97	PACIFIC ISLANDER, NOS

3. Otherwise, starting with the patient and then collecting from all the relevant admissions in Admission ID order (and in race field number order within each document), create a distinct known race codes list (ignore duplicate codes already collected).
4. If the distinct known race codes list contains any of these combinations of specific-codes and non-specific codes, then remove the corresponding non-specific codes from the list.

Specific Race Code	**Non-Specific Race Code**
04-17, 90*	96
16-17	15
20-32	97
01**-32, 90*, and 96-97	98

5. If necessary, reorder the remaining distinct known race codes list according to the following hierarchy: 07, 02-97 except 07 & 88 (maintain original list order set in step 3 for codes in this range), 01**, 98**

6. Set the patient's Race 1 – Race 5 fields to the latest distinct known race codes list (that may have been altered by steps 4 and 5). If there are more than five codes in the list, just use the first five codes in the ordered list. If there are fewer than 5 codes in the ordered list, begin setting the patient's race fields using the ordered list, and then fill the rest of the patient's race fields with 88.
7. If Race 1 was changed, then regenerate NHIA Derived Hisp Origin. If any of the Race 1 – Race 5 codes were changed, then regenerate Race--NAPIIA (derived API).

Manual Change to Race 1 – Race 5

Perform Multi-Document Consolidation Process

Admission Level

Manual Change or Correction Applied to Race 1 – Race 5

Perform automatic QC procedures described under **SOURCE**

Perform Multi-Document Consolidation Process for Patient

*California uses code 90 too (Other South Asian, Bangladeshi, Bhutanese, Nepalese, Sikkimese, and Sri Lankan – changed to 96 for submissions)

**Unlike SEER, California gives code 01 priority over 98 in Steps 4) and 5)

HISTORICAL CHANGES

04/2014	New Multi-Document Update Logic implemented.
12/2014	Step 4 revised to include code 90 as a specific race code for non-specific race code 96. This will eliminate duplication of code 96 for submissions.
10/2015	Revised logic to set patient's race fields with known codes from Passive Follow-up when the admission and patient both have no known codes. This procedure is documented in NAACCR's Death Clearance Manual. NAACCR, SEER, NPCR, and California's epidemiologists are all in agreement.
03/2017	Revised Table D per Stat Master Data Dictionary.

TNM Clin Fields Update Logic

FIELDS

TNM Clin T [NAACCR #940]
TNM Clin N [NAACCR #950]
TNM Clin M [NAACCR #960]
TNM Clin Stage Group [NAACCR #970]
TNM Clin Descriptor [NAACCR #980]
TNM Clin Staged By [NAACCR #990]
TNM Edition Number [NAACCR #1060]

SPECIFICATION

Tumor Level

Multi-Document Consolidation Process

Relevant Source Documents

- All active (not deleted or merged) admissions with a Year of Diagnosis 2017 and earlier linked to the current tumor that also has a Year of Diagnosis 2017 and earlier.

Definitions

- Known TNM Clin fields: does not meet the definitions defined below for unknown TNM Clin Stage Group with criteria met, preferred unknown TNM Clin fields with criteria not met, un-preferred unknown TNM Clin fields with criteria not met, and incorrect unknown TNM Clin fields.
- Unknown TNM Clin Stage Group with criteria met:
  - TNM Clin T: cX or c0
  - TNM Clin N: cX or c0
  - TNM Clin M: c0 or blank
  - TNM Clin Stage Group: 99
- Preferred unknown TNM Clin fields with criteria not met:
  - TNM Clin T: Blank
  - TNM Clin N: Blank
  - TNM Clin M: c0 or blank
  - TNM Clin Stage Group: 99
- Un-preferred unknown TNM Clin fields with criteria not met:
  - TNM Clin T: Blank
  - TNM Clin N: Blank
  - TNM Clin M: c0 or blank
  - TNM Clin Stage Group: Blank
- Incorrect TNM Clin fields:
  - TNM Clin T: cX
  - TNM Clin N: cX
  - TNM Clin M: cX
  - TNM Clin Stage Group: 99 or 88

  OR
  - TNM Clin T: 88
  - TNM Clin N: 88
  - TNM Clin M: 88
  - TNM Clin Stage Group: 88

  AND Schema is not:

- AdnexaUterineOther
- Biliary Other
- Brain
- CNS Other
- Digestive Other
- Endocrine Other
- Eye Other
- Genital Female Other
- Male Genital Other
- Heme Retic
- Ill Defined Other
- Intracranial Gland
- Kaposi Sarcoma
- Lacrimal Sac
- Melanoma Eye Other
- Melanoma Sinus Other
- Middle Ear
- Myeloma Plasma Cell Disorder
- Pharynx Other
- Respirator Other
- Sinus Other
- Trachea
- Urinary Other

Triggers

- The set of relevant source documents linked to the tumor changed
- Year of Diagnosis or one or more TNM Clin fields changed in a relevant source document
- Special global re-consolidation processes

Process

The system follows the hierarchies below to determine which single admission should be utilized to consolidate all TNM Clin fields. Prior to each step, the system will also check to see if all TNM Clin fields match in the admissions. If all TNM Clin fields match, stop here.

1. Compare the admissions' Date of Diagnosis values. If the Date of Diagnosis is greater than 12 months apart, then set TNM Clin T, TNM Clin N, TNM Clin M, TNM Clin Stage Group, TNM Clin Descriptor, TNM Clin Staged By, and TNM Edition fields with all codes that are different from current consolidated codes from the admission associated with the consolidated Date of Diagnosis and stop here.
2. If the system is unable to determine which single admission has the highest hierarchy using Date of Diagnosis values, then attempt to break the tie by using the admissions' TNM fields known and unknown definitions. Use the hierarchy below:
    - Known TNM Clin fields
    - Unknown TNM Clin Stage Group with criteria met
    - Preferred unknown TNM Clin fields with criteria not met
    - Un-preferred unknown TNM Clin fields with criteria not met
    - Incorrect TNM Clin fields

3. If the system is unable to determine which single admission has the highest hierarchy using TNM fields known and unknown definitions, then attempt to break the tie using TNM Clin Stage Group, giving hierarchy to the highest known values. Use the hierarchy below:
    - 4S, 4E
    - 4C
    - 4B
    - 4A2
    - 4A1
    - 4A
    - 4
    - 3S, 3E
    - 3C2
    - 3C1
    - 3C
    - 3B
    - 3A
    - 3
    - 2S, 2E
    - 2C
    - 2B
    - 2A2
    - 2A1
    - 2A
    - 2
    - 1S, 1E
    - 1C
    - B2
    - B1
    - 1B2
    - 1B1
    - 1B
    - A2
    - A1
    - 1A2
    - 1A1
    - 1A
    - 1
    - 0IS
    - 0S
    - 0A
    - 0
    - OC
    - 99
    - Blank
    - 88

4. If the system is unable to determine which single admission has the highest hierarchy using TNM Clin Stage Group values, then attempt to break the tie using TNM Clin T, giving hierarchy to the highest known values. Use the hierarchy below:
    - c4E
    - c4D
    - c4C
    - c4B
    - c4A
    - c4
    - c3D
    - c3C
    - c3B
    - c3A
    - c3
    - c2D
    - c2C
    - c2B
    - c2A2
    - c2A1
    - c2A
    - c2
    - c1D
    - c1C
    - c1B2
    - c1B1
    - c1B
    - c1A2
    - c1A1
    - c1A
    - c1
    - c1MI
    - pISD
    - pISU
    - pIS
    - pA
    - c0
    - cX
    - Blank
    - 88
5. If the system is unable to determine which single admission has the highest hierarchy using TNM Clin T values, then attempt to break the tie using TNM Clin N, giving hierarchy to the highest known values. Use the hierarchy below:
    - c4
    - c3C
    - c3B
    - c3A

- c3
- c2C
- c2B
- c2A
- c2
- c1C
- c1B
- c1A
- c1
- c0B
- c0A
- c0
- cX
- Blank
- 88

6. If the system is unable to determine which single admission has the highest hierarchy using TNM Clin N values, then attempt to break the tie using TNM Clin M, giving hierarchy to the highest known values. Use the hierarchy below:
    - p1E
    - p1D
    - p1C
    - p1B
    - p1A
    - p1
    - c1E
    - c1D
    - c1C
    - c1B
    - c1A
    - c1
    - c0I+
    - c0
    - cX
    - 88
7. If the system is unable to determine which single admission has the highest hierarchy using TNM Clin M values, then attempt to break the tie using the admissions' TNM Clin Staged By. Use the TNM Clin Staged By hierarchy below:
    - If Known TNM Clin fields, use the following hierarchy for TNM Clin Staged By:
        1. 11-15
        2. 30
        3. 10, 20
        4. 40, 50, 60
        5. 99
        6. 88, 00

- If Unknown TNM Clin Stage Group with criteria met, use the following hierarchy for TNM Clin Staged By:
    1. 11-15
    2. 30
    3. 10, 20
    4. 40, 50, 60
    5. 99
    6. 88, 00
- If Preferred Unknown TNM Clin fields with criteria not met, use the following hierarchy for TNM Clin Staged By:
    1. 00
    2. Remaining codes
- If Un-Preferred Unknown TNM Clin fields with criteria not met, use the following hierarchy for TNM Clin Staged By:
    1. 00
    2. Remaining codes
- If Incorrect TNM Clin fields, use the following hierarchy for TNM Clin Staged By:
    1. 00
    2. Remaining codes

8. If the system is unable to determine which single admission has the highest hierarchy using TNM Clin Staged By values, then break the final tie using Admission ID (lowest number is highest in the sub-hierarchy).
9. Then set:
    - TNM Clin T, TNM Clin N, TNM Clin M, TNM Clin Stage Group, TNM Clin Descriptor, TNM Clin Staged By, and TNM Edition fields with all codes that are different from current consolidated codes from the single admission determined to be highest in the relevant source document hierarchy

And stop here.

Manual Change

Not al

TNM Path Fields Update Logic

FIELDS

TNM Path T [NAACCR #880]
TNM Path N [NAACCR #890]
TNM Path M [NAACCR #900]
TNM Path Stage Group [NAACCR #910]
TNM Path Descriptor [NAACCR #920]
TNM Path Staged By [NAACCR #930]

SPECIFICATION

Tumor Level

Multi-Document Consolidation Process

Relevant Source Documents

- All active (not deleted or merged) admissions with a Year of Diagnosis 2017 and earlier linked to the current tumor that also has a Year of Diagnosis 2017 and earlier.

Definitions

- Known TNM Path fields: does not meet the definitions defined below for preferred criteria not met/unknown, un-preferred criteria not met/unknown, and incorrect.
- Preferred criteria not met/unknown TNM Path fields:
  - TNM Path T: Blank
  - TNM Path N: Blank
  - TNM Path M: Blank
  - TNM Path Stage Group: 99
- Un-preferred criteria not met/unknown TNM Path fields:
  - TNM Path T: Blank or pX
  - TNM Path N: Blank or pX
  - TNM Path M: Blank or pX
  - TNM Path Stage Group: blank or 99
- Incorrect TNM Path fields:
  - TNM Path T: pX
  - TNM Path N: pX
  - TNM Path M: pX
  - TNM Path Stage Group: 99 or 88

  OR

  - TNM Path T: 88
  - TNM Path N: 88
  - TNM Path M: 88
  - TNM Path Stage Group: 88

    AND Schema is not:

    - AdnexaUterineOther
    - Biliary Other
    - Brain
    - CNS Other
    - Digestive Other
    - Endocrine Other
    - Eye Other

- Genital Female Other
- Male Genital Other
- Heme Retic
- Ill Defined Other
- Intracranial Gland
- Kaposi Sarcoma
- Lacrimal Sac
- Melanoma Eye Other
- Melanoma Sinus Other
- Middle Ear
- Myeloma Plasma Cell Disorder
- Pharynx Other
- Respirator Other
- Sinus Other
- Trachea
- Urinary Other

Triggers

- The set of relevant source documents linked to the tumor changed
- Year of Diagnosis, one or more TNM Path fields, Class of Case, or RX Summ--Surg Prim Site are changed in a relevant source document
- Special global re-consolidation processes

Process

The system follows the hierarchies below to determine which single admission should be utilized to consolidate all TNM Path fields. Prior to each step, the system will also check to see if all TNM Path fields match in the admissions. If all TNM Path fields match, stop here.

1. Compare the admissions' Date of Diagnosis values. If the Date of Diagnosis is greater than 12 months apart, then set TNM Path T, TNM Path N, TNM Path M, TNM Path Stage Group, TNM Path Descriptor, and TNM Path Staged By with all codes that are different from current consolidated codes from the admission associated with the consolidated Date of Diagnosis.
2. If the system is unable to determine which single admission has the highest hierarchy using Date of Diagnosis values, then attempt to break the tie by using the admissions' TNM fields known and unknown definitions. Use the hierarchy below:
    - Known TNM Path fields
    - Preferred Criteria not met/unknown TNM Path fields
    - Un-Preferred Criteria not met/unknown TNM Path fields
    - Incorrect TNM Path fields
3. If the system is unable to determine which single admission has the highest hierarchy using the known and unknown definitions, then attempt to break the tie using the admissions' TNM Path Descriptor. Use the TNM Path Descriptor hierarchy below:
    - 4
    - All other TNM Path Descriptor codes
4. If the system is unable to determine which single admission has the highest hierarchy using TNM Path Descriptor values, then attempt to break the tie using the

admissions' RX Summ--Surg Prim Site. Use the RX Summ--Surg Prim Site hierarchy below:

- 20-80
- 10-19
- 98
- 90
- 00
- 99

5. If the system is unable to determine which single admission has the highest hierarchy using RX Summ--Surg Prim Site values, then attempt to break the tie using TNM Path Stage Group, giving hierarchy to the highest known values. Use the hierarchy below:
    - 4S, 4E
    - 4C
    - 4B
    - 4A
    - 4
    - 3S, 3E
    - 3C2
    - 3C1
    - 3C
    - 3B
    - 3A
    - 3
    - 2S, 2E
    - 2C
    - 2B
    - 2A2
    - 2A1
    - 2A
    - 2
    - 1S, 1E
    - 1C
    - B2
    - B1
    - 1B2
    - 1B1
    - 1B
    - A2
    - A1
    - 1A2
    - 1A1
    - 1A
    - 1
    - 0IS
    - 0S

- 0A
- 0
- OC
- 99
- Blank
- 88

6. If the system is unable to determine which single admission has the highest hierarchy using TNM Path Stage Group values, then attempt to break the tie using TNM Path T, giving hierarchy to the highest known values. Use the hierarchy below:
    - p4E
    - p4D
    - p4C
    - p4B
    - p4A
    - p4
    - p3D
    - p3C
    - p3B
    - p3A
    - p3
    - p2D
    - p2C
    - p2B
    - p2A2
    - p2A1
    - p2A
    - p2
    - p1D
    - p1C
    - p1B2
    - p1B1
    - p1B
    - p1A2
    - p1A1
    - p1A
    - p1
    - p1mI
    - pISD
    - pISU
    - pIS
    - pA
    - p0
    - pX
    - 88
    - blank

7. If the system is unable to determine which single admission has the highest hierarchy using TNM Path T values, then attempt to break the tie using TNM Path N, giving hierarchy to the highest known values. Use the hierarchy below:
    - p4
    - p3C
    - p3B
    - p3A
    - p3
    - p2C
    - p2B
    - p2A
    - p2
    - p1C
    - p1B
    - p1A
    - p1
    - p0B
    - p0A
    - p1MI
    - p0M+
    - p0M-
    - p0I+
    - p0I-
    - p0
    - c0
    - pX
    - 88
    - blank
8. If the system is unable to determine which single admission has the highest hierarchy using TNM Path N values, then attempt to break the tie using TNM Path M, giving hierarchy to the highest known values. Use the hierarchy below:
    - c1E
    - c1D
    - c1C
    - c1B
    - c1A
    - c1
    - p1E
    - p1D
    - p1C
    - p1B
    - p1A
    - p1
    - c0I+
    - c0
    - 88

- Blank

9. If the system is unable to determine which single admission has the highest hierarchy using TNM Path M values, then attempt to break the tie using the admissions' TNM Path Staged By. Use the TNM Path Staged By hierarchy below:
    - Known TNM Path fields, use the following hierarchy for TNM Clin Staged By:
        1. 11-15
        2. 30
        3. 10, 20
        4. 40, 50, 60
        5. 99
        6. 88, 00
    - Preferred criteria not met/unknown TNM Path fields, use the following hierarchy for TNM Path Staged By:
        1. 00
        2. Remaining codes
    - Un-preferred criteria not met/unknown TNM Path fields, use the following hierarchy for TNM Path Staged By:
        1. 00
        2. Remaining codes
    - Incorrect TNM Path fields, use the following hierarchy for TNM Path Staged By:
        1. 00
        2. Remaining codes
10. If the system is unable to determine which single admission has the highest hierarchy using TNM Path Staged By values, then break the final tie using Admission ID (lowest number is highest in the sub-hierarchy).
11. Then set all TNM Path fields with all codes that are different from current consolidated codes from the single admission determined to be highest in the relevant source document hierarchy and stop here.

Manual Change

Not allowed

HISTORICAL CHANGES

08/2016	New Multi-Document Update Logic implemented.
10/2017	Revisions to logic to match coding rules and allow for automation of all years of TNM.

Tumor Active Follow-up Fields Update Logic

FIELDS

Date of Last Cancer (tumor) Status [NAACCR #1772]
Date of Last Cancer (tumor) Status Flag [NAACCR #1773]
Cancer Status [NAACCR #1770]
Follow-Up Hospital Last [CCR #E1628]
Follow-Up Last Type Tumor [CCR #1584]

HISTORICAL CHANGES

08/2016	New Multi-Document Update Logic implemented.
10/2017	Revisions to logic to match coding rules and allow for automation of all years of TNM.

SPECIFICATION

Tumor Level

Multi-Document Consolidation Process

Note: Tumor Active Follow-up Logic runs after Patient Active Follow-up Fields Update Logic

Relevant Source Documents

- The current tumor
- All active (non-deleted or merged) admissions linked to the current tumor

Definitions

- Non-admission supported relevant tumor: any of the tumor level active follow-up field values do not match the associated admissions values

Triggers

- The set of relevant source documents linked to the tumor changed
- One of the following fields changes in a source document:
  - Date of Last Cancer (tumor) Status
  - Date of Last Cancer (tumor) Status Flag
  - Cancer Status
  - Follow-Up Hospital Last
  - Follow-Up Last Type Tumor
  - Vital Status
  - Date Case Last Changed
  - Date of 1st Contact
  - Class of Case
  - Date of Inpt Disch
- Special global re-consolidation processes

Process

1. If non-admission supported relative tumor is present and meets following criteria:
   - Tumor's Date of Last Cancer (tumor) Status is later than relevant admissions
   - Tumor's Date of Last Cancer (tumor) Status is less than or equal to Patient's Date of Last Contact

   Then stop here.
2. If distinct relative tumor is not present then determine which single relevant admission should be utilized to consolidate all tumor level active follow-up fields:

- If there is more than one selected relevant admission, then attempt to break the tie by using the admissions' Date of Last Cancer (tumor) Status. Use the hierarchy* below:
  - Relevant admissions have:
    1. Date of Last Cancer (tumor) Status later than or equal to tumor's
    2. Date of Last Cancer (tumor) Status less than or equal to Patient's Date of Last Contact
  - Relevant admissions have:
    1. Date of Last Cancer (tumor) Status earlier than tumor's
    2. Date of Last Cancer (tumor) Status less than or equal to Patient's Date of Last Contact
  - Relevant admissions have Date of Last Cancer (tumor) Status later than Patient's Date of Last Contact
- If the system is unable to determine which single admission has the highest hierarchy using Date of Last Cancer (tumor) Status, then attempt to break the tie within the results using the admissions' Vital Status. Use the hierarchy below:
  - Vital Status of 0
  - Vital Status of 1
- If the system is unable to determine which single admission has the highest hierarchy using Vital Status, then attempt to break the tie within the results using the admissions' Date of Last Cancer (tumor) Status (highest to earliest)*.
- If the system is unable to determine which single admission has the highest hierarchy using Date of Last Cancer (tumor) Status, then attempt to break the tie within the results using the admission's Date Case Last Changed (highest to earliest)*.
- If the system is unable to determine which single admission has the highest hierarchy using the admissions' Date Case Last Changed, then attempt to break the tie within the results using the admissions' Date of 1st Contact (highest to earliest)*.
- If the system is unable to determine which single admission has the highest hierarchy using the admissions' Date of 1st Contact, then attempt to break the tie within the results using Class of Case. Use the hierarchy below:
  - 30
  - 31
  - 32
  - 22
  - 21
  - 20
  - 12
  - 13
  - 11
  - 10
  - 14

- 00
- 34
- 36
- 42
- 40
- 41
- 43
- 38
- 33
- 99
- 35
- 37
- 49

- If the system is unable to determine which single admission has the highest hierarchy using the admissions' Class of Case, then break the final tie within the results using Admission ID (lowest number is highest in the sub-hierarchy).

3. Then set tumor level active follow-up fields with codes that are different than the current consolidated codes from the single admission determined to be the highest in the relevant source document hierarchy and stop here.

Manual Change

Not allowed

* We can determine whether or not one date is earlier than the other if

- The two dates have known but different years,
- The two dates have the same known year but different known months, or
- The two dates have the same known year & month but different known dates

HISTORICAL CHANGES

08/2016	New Multi-Document Update Logic implemented.
01/2019	Per NAACCR v18, Date of Last Cancer (tumor) Status [NAACCR #1772] replaces Date Cancer Status [CCR #E1582]. Date of Last Cancer (tumor) Status Flag [NAACCR#1773] replaces Date Cancer Status Flag [CCR #E1583].

Secondary Diagnosis Fields Update Logic

FIELDS

Secondary Diagnosis 1 [NAACCR #3780]
Secondary Diagnosis 2 [NAACCR #3782]
Secondary Diagnosis 3 [NAACCR #3784]
Secondary Diagnosis 4 [NAACCR #3786]
Secondary Diagnosis 5 [NAACCR #3788]
Secondary Diagnosis 6 [NAACCR #3790]
Secondary Diagnosis 7 [NAACCR #3792]
Secondary Diagnosis 8 [NAACCR #3794]
Secondary Diagnosis 9 [NAACCR #3796]
Secondary Diagnosis 10 [NAACCR #3798]

SPECIFICATION

TUMOR LEVEL

MULTI-DOCUMENT CONSOLIDATION PROCESS

RELEVANT SOURCE DOCUMENTS

- All active (not deleted or merged) admissions linked to the current tumor

DEFINITIONS

- No documented Secondary Diagnoses in relevant admissions: Secondary Diagnosis 1 is 0000000 AND Secondary Diagnosis 2 - 10 are blank
- Relevant source document hierarchy: An ordered list of selected relevant source documents that provides the means to determine the precedence data from one source document should have over another in consolidation decisions. Here we are using RX Hosp--Surg Prim Site, RX Hosp--Surg Oth Reg/Dis, Rad-Location, RX Hosp--Chemo, RX Hosp--Hormone, RX Hosp--BRM, RX Hosp--Transplnt-Endocr, RX Hosp--Other, RX Hosp--DX/Stg Proc, and then Admission ID as a last resort to determine the hierarchy.
- Distinct known codes: No duplicate codes, 0000000, or blanks

TRIGGERS

- The set of relevant source documents linked to the tumor changed
- RX Hosp--Surg Prim Site, RX Hosp--Surg Oth/Reg/Dis, Rad-Location, RX Hosp--Chemo, RX Hosp--Hormone, RX Hosp--BRM, RX Hosp--Transplnt-Endocr, RX Hosp--Other, RX Hosp--DX/Stg Proc, or one or more Secondary Diagnosis fields are changed in a relevant source document
- Special global re-consolidation processes

PROCESS

1. If all relevant source documents have no documented Secondary Diagnoses then set Secondary Diagnosis 1 – 10 to not documented and stop here.
2. Otherwise, determine the relevant source document hierarchy by selecting only relevant admissions with documented Secondary Diagnoses:
    - Compare the selected admissions' RX Hosp--Surg Prim Site values. Use the RX Hosp--Surg Prim Site hierarchy below to determine an initial relevant source document hierarchy:
        - Treatment: 10-90
        - No Treatment/Unknown: 00, 98, 99

- If there is more than one selected admission with a RX Hosp--Surg Prim Site in any of the above ranges, then attempt to refine the sub-hierarchies by ordering each range set using RX Hosp-Surg Oth Reg/Dis hierarchy:
    - Treatment: 1-5
    - No Treatment: 0, 9
- If there is more than one selected admission with a RX Hosp-Surg Oth Reg/Dis in any of the above ranges, then attempt to refine the sub-hierarchies by ordering each range set using Radiation and Chemo hierarchy:
    - Treatment
        a. Rad--Location of RX: 1-3
        b. RX Hosp--Chemo: 01-03
    - No Treatment/Unknown
        a. Rad--Location of RX: 0, 4, 8, 9, blank
        b. RX Hosp--Chemo: 00, 82, 85-88, 99
- If there is more than one selected admission with a Radiation and Chemo code in any of the above ranges, then attempt to refine the sub-hierarchies by ordering each range set using Other Therapies hierarchy:
    - Treatment
        a. RX Hosp--Hormone: 01
        b. RX Hosp--BRM: 01
        c. RX Hosp--Transplnt-Endocr: 10-12, 20, 30, 40
        d. RX Hosp--Other: 1-3, 6
    - No Treatment/Unknown
        a. RX Hosp--Hormone: 00, 82, 85-88, 99
        b. RX Hosp--BRM: 00, 82, 85-88, 99
        c. RX Hosp--Transplnt-Endocr: 00, 82, 85-88, 99
        d. RX Hosp--Other: 0, 7-9
- If there is more than one selected admission with an Other Therapies code in any of the above ranges, then attempt to refine the sub-hierarchies by ordering each range set using RX Hosp--DX/Stg Proc hierarchy:
    - Diagnostic Procedure: 01-07
    - None/Unknown: 00, 09
- If there is more than one selected admission in any of the class of case ranges and a sub-hierarchy for a range set could not be determined using treatment fields, then set the sub-hierarchy for it using Admission ID (lowest number is highest in the sub-hierarchy)

3. Then set:
    - Secondary Diagnosis 1 – 10 fields with distinct known codes from the selected admissions following the relevant source document hierarchy from highest to lowest until all fields are filled or all selected admissions are exhausted and stop here.

Manual Change
Not allowed

ADMISSION LEVEL

Manual Change or Modified Record Applied to Secondary Diagnosis 1 – 10
Perform automatic QC procedures described under ***SOURCE***

HISTORICAL CHANGES

11/2016	New Multi-Document Update Logic implemented.

SEER Summary Stage 2000 Update Logic

FIELDS

SEER Summary Stage 2000 [NAACCR #759]

SPECIFICATION

TUMOR LEVEL

MULTI-DOCUMENT CONSOLIDATION PROCESS

RELEVANT SOURCE DOCUMENTS

- All active (non-deleted or merged) admissions

DEFINITIONS

- None

TRIGGERS

- The set of relevant source documents linked to the tumor changed
- Date of Diagnosis, Class of Case, SEER Summary Stage 2000, Behavior ICD-O-3, Histologic Type ICD-O-3, or Primary Site fields are changed in a relevant source document
- Special global re-consolidation processes

PROCESS

The system follows the hierarchies below to determine which single admission should be utilized to consolidate SEER Summary Stage 2000. Prior to each step, the system will also check to see if the field matches in the associated admissions. If all SEER Summary Stage 2000 fields match, then consolidate SEER Summary Stage 2000 when different than the consolidated code, and stop here.

1. Compare the admissions' Date of Diagnosis values. If the Date of Diagnosis is greater than 12 months apart, then set SEER Summary Stage 2000 with the code from the admission associated with the consolidated Date of Diagnosis.
2. If the system is unable to determine which single admission has the highest hierarchy using Class of Case, then attempt to break the tie by the admission's SEER Summary Stage 2000 value and associated Tumor values. Use the hierarchy below:
    - Benign/Borderline
        - Admission's SEER Summary Stage 2000 = 8
        - Tumor's Primary Site = C700, C701, C709, C710-C719, C720-C725, C728-C729
        - Tumor's Behavior ICD-O-3 = 0 or 1
    - Distant
        - Admission's SEER Summary Stage 2000 = 7
        - Tumor's Behavior ICD-O-3 = 3
    - Regional by both direct extension and lymph node involvement
        - Admission's SEER Summary Stage 2000 = 4
        - Tumor's Behavior ICD-O-3 = 3
    - Regional lymph nodes involved only
        - Admission's SEER Summary Stage 2000 = 3
        - Tumor's Behavior ICD-O-3 = 3
    - Regional by direct extension only
        - Admission's SEER Summary Stage 2000 = 2
        - Tumor's Behavior ICD-O-3 = 3
    - Regional, NOS
        - Admission's SEER Summary Stage 2000 = 5

    - Tumor's Behavior ICD-O-3 = 3
  - Localized
    - Admission's SEER Summary Stage 2000 = 1
    - Tumor's Behavior ICD-O-3 = 3
  - In situ
    - Admission's SEER Summary Stage 2000 = 0
    - Tumor's Behavior ICD-O-3 = 2
  - Unknown if extension or metastasis, DCO only
    - Admission's SEER Summary Stage 2000 = 9
    - Tumor's Behavior ICD-O-3 = 3

      OR
    - Admission's SEER Summary Stage 2000 = 9
    - Tumor's Primary Site = C569
    - Tumor's Histologic Type ICD-O-3 = 8443, 8451, 8462, 8472, 8473
    - Tumor's Behavior ICD-O-3 = 1
  - Coded Incorrectly
    - Remaining coding scenarios
3. Compare the admission's Year of Diagnosis, with 2016-2017 being highest:
   - Year of Diagnosis 2016-2017
   - Year of Diagnosis 2015 or 2001-2003
   - Remaining pre-2018 Year of Diagnoses
4. If the system is unable to determine which single admission has the highest hierarchy using the Year of Diagnosis ranges, then attempt to break the tie by using the admissions' Class of Case values. Use the Class of Case hierarchy below:
   - 10-14, 20-22
   - 00
   - 34, 36
   - 40-42
   - 30-32
   - 35, 37
   - 33
   - 99
5. If the system is unable to determine which single admission has the highest hierarchy using admission's SEER Summary Stage 2000 value and associated Tumor values, then break the final tie using Admission ID (lowest number is highest in the sub-hierarchy).
6. Set SEER Summary Stage 2000 with the code from the single admission determined to be the highest in the relevant source document hierarchy, when it differs from the already consolidated value and stop here.

ADMISSION LEVEL

MANUAL CHANGE OR MODIFIED RECORD APPLIED TO SEER SUMMARY STAGE 2000

PERFORM AUTOMATIC QC PROCEDURES DESCRIBED UNDER SOURCE

HISTORICAL CHANGES

11/2016	New Multi-Document Update Logic implemented.
02/2017	Moved previous step 3, admission's SEER Summary Stage 2000 value and associated Tumor values check, to step 1 to account for lack of edits for SEER Summary Stage 2000.

01/2019	Per NAACCR v18, added 2017 end date to logic.

APPENDICES

APPENDIX 1 – COMMON FIRST NAMES

The following lists of common male and female first names are based on a 12% sample of cancer cases diagnosed in 1978-84 among SF-O MSA residents (CCIS--113085), and augmented based on all state of California cases in January 1993.

Female First Names

Ada	Caroline	Elsie	Ina	Leona	Michelle	Sadie
Adeline	Carolyn	Emily	Inez	Lila	Mildred	Sally
Agnes	Catherine	Emma	Irene	Lillian	Minnie	Sandra
Alberta	Cecelia	Erma	Irma	Lillie	Miriam	Sara
Alice	Cecilia	Estelle	Isabel	Linda	Muriel	Sarah
Alicia	Charlotte	Ester	Isabella	Lisa	Myrtle	Sharon
Alma	Cheryl	Esther	Jacqueline	Lois	Nancy	Shelia
Alva	Christina	Ethel	Jane	Lola	Naomi	Shirley
Amelia	Christine	Etta	Janet	Lorene	Nell	Sophia
Amy	Claire	Eugenia	Janice	Loretta	Nellie	Sophie
Ana	Clara	Eula	Jean	Lorraine	Nettie	Stella
Angela	Claudia	Eunice	Jeanette	Louise	Neva	Sue
Angelina	Connie	Eva	Jeanne	Lucille	Nina	Susan
Anita	Constance	Evelyn	Jennie	Lucy	Nora	Suzanne
Ann	Cynthia	Fannie	Jennifer	Luella	Norma	Sybil
Anna	Daisy	Fay	Jessie	Luise	Olga	Sylvia
Anne	Darlene	Faye	Joan	Lupe	Olive	Teresa
Annette	Deborah	Flora	Joann	Luz	Opal	Thelma
Annie	Debra	Florence	Joanne	Lydia	Pamela	Theresa
Antoinette	Delores	Frances	Johanna	Mabel	Patricia	Valerie
Arlene	Denise	Gail	Josephine	Mable	Paula	Veda
Audrey	Diana	Gay	Joyce	Madeline	Pauline	Velma
Barbara	Diane	Genevieve	Juanita	Mae	Pearl	Vera
Beatrice	Dolores	Georgia	Judith	Margaret	Peggy	Verna
Bernice	Donna	Geraldine	Judy	Margarita	Petra	Victoria
Berta	Dora	Gertie	Julia	Marguerite	Phyllis	Viola
Bertha	Doris	Gertrude	Julie	Maria	Rachel	Violet
Bessie	Dorothy	Gladys	June	Marian	Romona	Virginia
Beth	Edith	Gloria	Karen	Marie	Rebecca	Vivian
Bette	Edna	Grace	Katherine	Marilyn	Regina	Wanda
Betty	Eileen	Gwendolyn	Kathleen	Marion	Rena	Wilhelmina
Beulah	Elaine	Harriet	Kathryn	Marjorie	Rita	Wilma
Beverly	Eleanor	Hazel	Kathy	Marsha	Roberta	Winifred
Blanche	Elinor	Helen	Katie	Martha	Rosa	Yolanda
Bonnie	Elizabeth	Helene	Kimberly	Mary	Rosamond	Yvonne
Brenda	Ella	Henrietta	Laura	Mattie	Rose	
Carmen	Ellen	Hilda	Leah	Maureen	Rosemary	
Carol	Elsa	Ida	Lena	Maxine	Ruby	
Carole	Else	Ilona	Lenora	May	Ruth	

Male First Names

Alan	Chauncey	Eugene	Herman	Leo	Oscar	Steve
Albert	Chester	Everett	Homer	Leon	Patrick	Steven
Alex	Christopher	Felix	Howard	Leonard	Paul	Ted
Alexander	Clarence	Floyd	Hugh	Leroy	Pedro	Theodore
Alfred	Claude	Francis	Ira	Leslie	Peter	Thomas
Allen	Clifford	Francisco	Irving	Lester	Philip	Timothy
Alvin	Clyde	Frank	Jack	Lewis	Phillip	Tom
Andrew	Cornelius	Fred	James	Lloyd	Ralph	Tony
Angelo	Curtis	Frederick	Jay	Louis	Ray	Vernon
Anthony	Dale	Fredrick	Jeffrey	Luis	Raymond	Victor
Antonio	Daniel	Gary	Jerome	Manuel	Richard	Vincent
Arnold	David	Gene	Jerry	Mario	Robert	Virgil
Arthur	Dean	George	Jesse	Mark	Roger	Wallace
August	Dennis	Gerald	Jesus	Martin	Roland	Walter
Ben	Don	Gilbert	Joe	Marvin	Ronald	Warren
Benjamin	Donald	Giovanni	John	Matthew	Roy	Wayne
Bernard	Douglas	Glen	Johnny	Maurice	Rudolph	Wesley
Bill	Earl	Glenn	Jose	Max	Russell	Wilbur
Billy	Edgar	Gordon	Joseph	Melvin	Salvadoro	Willard
Brian	Edward	Gregory	Juan	Michael	Salvatore	William
Bruce	Edwin	Hal	Karl	Miguel	Sam	Willie
Bruno	Elbert	Hale	Keith	Milton	Samuel	
Calvin	Elmer	Harold	Kenneth	Morris	Santiago	
Carl	Elwood	Harry	Larry	Nicholas	Sidney	
Carlos	Emanuel	Harvey	Laurence	Nick	Silverio	
Cecil	Eric	Henry	Lawrence	Norman	Stanley	
Charles	Ernest	Herbert	Leland	Oliver	Stephen	

HISTORICAL CHANGES

09/2019	Updated description and added the list of common first name in document instead of a link to separate document.

APPENDIX 4 – CALCULATION OF CHECK DIGIT

Check Digit Calculation by the "Modified IBM 1022" Method

Calculations

1. Starting from the right, number the digits 1-7:
   d7 d6 d5 d4 d3 d2 d1
2. Multiply each digit by the weighting factors 2-8 and add the products:
   N = 8d7 + 7d6 + 6d5 +5d4 + 4d3 + 3d2 + 2d1
3. Divide the results by 11 and keep the remainder:
   REM = N (mod11)
4. Subtract the remainder from 11 and use the result as the check digit if it is 1 through 9. If it is 10, the check digit is 0, and if it is 11, the check digit is 1.

Examples (correct original number)

a)

1	8	3	4	3	4	9
x8	x7	x6	x5	x4	x3	x2
8	56	18	20	12	12	18

the sum N = 144
144/11 = 13 with remainder of 1
11 - 1 = 10
the check digit is 0.

b) 1 8 4 3 3 4 9 (transposition error)
the sum N = 142
142/11 = 12 with remainder of 10
11 - 10 = 1
the check digit is 1 and not 0.

c) 1 8 3 4 9 4 3 (skip transposition)
the sum N = 156
156/11 = 14 with a remainder of 2
11 - 2 = 9
the check digit is 9 and not 0.

d) 1 8 2 4 3 4 9 (mistaken digit)
the sum N = 138
138/11 = 12 with a remainder of 6
11 - 6 = 5
the check digit is 5 and not 0.

HISTORICAL CHANGES

APPENDIX 5 – MODIFIED NYSIIS NAME CODING

Note: Vowel = A, E, I, O, U, or Y

A. Name Manipulation

1. If the first letters of the name are:

MAC	change these letters to	MCC
KN	change these letters to	NN
K	change these letters to	C
PH	change these letters to	FF
PF	change these letters to	FF
SCH	change these letters to	SSS
WR	change these letters to	RR
RH	change these letters to	RR
DG	change these letters to	GG
Y#	change these letters to	A#
Z+	change these letters to	S+
A, E, I, O, U,	change these letters to	A
# non-vowel		
+ vowel		

2. Drop terminal S or Z from all names.
3. If the last letters of the names:

I	change these letters to	Y
EE. IE, YE	change these letters to	Yb
DT, RT, RD	change these letters to	Db
NT or ND	change these letters to	Nb
LE	change these letters to	EL
IX	change these letters to	ICK
EX	change these letters to	ECK
YX	change these letters to	YCK
bJR or bSR	change these letters to	b*
* b = blank		

B. Name Coding

In the following rules, a sequential left to right scan is performed on the letters of the surname. This is described in terms of a program loop.

A pointer is used to indicate the current position.

1. The first letter of the NYSIIS code is the first letter of the manipulated name.
2. Set the pointer to the second letter of the name.
3. Execute only one of the following statements:
   a. If blank, go to step 4.
   b. If the current position is 'E' and if the next letter is 'V', change 'EV' to 'AF'; if the next letter is not 'V', change current position to 'A'.
   c. If the current position is A, I, O or U, change to 'A'.
   d. If the current position is 'Y' and it is not the last letter of the name, change the current position to 'A'.
   e. If the current position is:

Q	change the letter to	G
Z	change the letter to	S
M	change the letter to	N

f. If the current position is 'K' and if the next letter is 'N', change the current position to 'N'; If the next letter is not 'N', change the current position 'C'.

g. If the current position is 'S' and the next letters are 'CH', change to 'SSA' if end of the name or change to 'SSS' if not the end of the name.

h. If the current position is 'S' and the next letter is 'H', change to 'SA' if end of the name or change to 'SS' if not the end of the name.

I. If the current position is 'P' and the next letter is 'H', change 'PH' to 'FF'.

j. If the current position is 'G' and the next letters are 'HT', change 'GHT' to 'TTT'.

k. If the current position is 'D' and the next letter is 'G', change 'DG' to 'GG'.

l. If the current position is 'W' and the next letter is 'R', change 'WR' to 'RR'.

m. If the current position is 'H' and either the preceding or following letter is not a vowel, replace the current position with the preceding letter.

n. If the current position is 'W' and the preceding letter is a vowel, replace the current position with the preceding letter.

o. If none of these rules apply, retain the current position letter value.

4. If the end of the name has been reached, go to step 7.

5. If the current position letter is equal to the last letter placed in the code, set the pointer to the next letter and go to step 3.

6. The next character of the NYSIIS code is the current position letter. Increment the pointer to point to the next letter and go to step 3.

7. If the last letter of the NYSIIS code is 'S', remove it.

8. If the last two letters of the NYSIIS code are 'AY', replace 'AY' with the single letter 'Y'.

9. If the last letter of the NYSIIS code is 'A', remove it.

10. If the first letter of the NYSIIS code is 'A', replace it with the first letter of the original name

APPENDIX 6 – CALCULATION OF AGE AT DIAGNOSIS

Note: Store and display Age at Diagnosis as three digits. For example: 000, 003, 015, 065, or 112. (Refer to Age at Diagnosis., Allowable Values section)

If either of the following conditions is true:

- Date of Birth year is NOT a valid year (1800-2300)
- Date of Diagnosis year is NOT a valid year (1800-2300)

Then set Age at Diagnosis to 999 and stop here.

Otherwise, perform the following steps in the order listed:

1) Subtract Date of Birth year from Date of Diagnosis year to set the initial year-based Age at Diagnosis value (3 digits, right-justified).

2) If all of the following conditions are true:

- Date of Diagnosis month is a valid month (01-12)
- Date of Birth month is a valid month (01-12)
- Date of Diagnosis **month is earlier than** (<) the Date of Birth month

Then subtract 1 from Age at Diagnosis.

3) If all of the following conditions are true:

- Date of Diagnosis month is a valid month (01-12)
- Date of Birth month is a valid month (01-12)
- Date of Diagnosis **month is the same as** the Date of Birth month
- Date of Diagnosis day is a valid day (01-31)
- Date of Birth day is a valid day (01-31)
- Date of Diagnosis **day is earlier than** (<) the Date of Birth day

Then subtract 1 from Age at Diagnosis.

4) If Age at Diagnosis is now > 120, then reset it to 120.

5) If Age at Diagnosis is now < 000, then reset it to 000 (in utero).

HISTORICAL CHANGES

2010	Data Item Changes, page updated to comply with new date formats.

APPENDIX 8 – CALCULATION OF SURVIVAL TIME

If any of the following conditions is true:

- Date of Last Contact is NOT a complete date (18000101-23001231)
- Date of Diagnosis is NOT a complete date (18000101-23001231)
- Date of Last Contact and Date of Diagnosis are complete dates, but Date of Last Contact < Date of Diagnosis

Then set Survival Time to 99999 and stop here.
If Date of Last Contact = Date of Diagnosis,
Then set Survival Time to 00000 and stop here.
Otherwise, convert Date of Last Contact and Date of Diagnosis into three-digit Julian dates (JJJ), taking into account leap years (add 1 more day for leap year dates after February), and perform the following procedure to calculate the number of days the patient has survived since her/his diagnosis:

1. Determine the number of leap years and regular years in between the two years.
2. Compute the number of days in the years in between the two years:
3. (number of leap years * 366) + (number of regular years * 365)

Compute SURVIVAL-TIME:
If Date of Diagnosis CCYY is a leap year
Then SURVIVAL-TIME = 366 - JJJ (Date of Diagnosis)
+ number of days in the years in between the two years
+ JJJ (Date of Last Contact)
Else SURVIVAL-TIME = 365 - JJJ (Date of Diagnosis) I+ number of days in the years

HISTORICAL CHANGES

2010	Updated for 2010 due to date format changes.

APPENDIX 9A – VALID ICD02 HIST-TYPE CODES

8000	8096*	8243	8380	8530	8713*
8001	8100*	8244	8381	8540	8720
8002	8101*	8245	8390	8541	8721
8003	8102*	8246	8400	8542	8722
8004	8110	8247	8401	8543	8723
8010	8120	8248*	8402*	8550	8724*
8011	8121	8250	8403*	8560	8725*
8012	8122	8251	8404*	8561*	8726*
8020	8123	8260	8405*	8562	8727*
8021	8124	8261	8406*	8570	8730
8022	8130	8262	8407*	8571	8740
8030	8140	8263	8408*	8572	8741
8031	8141	8270	8410	8573	8742
8032	8142	8271*	8420	8580	8743
8033	8143	8280	8430	8590*	8744
8034	8144	8281	8440	8600	8745
8040*	8145	8290	8441	8601*	8750*
8041	8146*	8300	8442	8602*	8760*
8042	8147	8310	8450	8610*	8761
8043	8150	8311*	8451	8620	8770
8044	8151	8312	8452*	8621*	8771
8045	8152	8313*	8460	8622*	8772
8050	8153	8314	8461	8623*	8773
8051	8154	8315	8462	8630	8774
8052	8155	8320	8470	8631*	8780
8053*	8160	8321*	8471	8632*	8790*
8060*	8161	8322	8472	8640	8800
8070	8162	8323	8473	8641*	8801
8071	8170	8324*	8480	8650	8802
8072	8171	8330	8481	8660*	8803
8073	8180	8331	8490	8670*	8804
8074	8190	8332	8500	8671*	8810
8075	8191*	8333*	8501	8680	8811
8076	8200	8334*	8502	8681*	8812
8077	8201	8340	8503	8682*	8813
8080	8202*	8350	8504	8683*	8814
8081	8210	8360*	8505*	8690*	8820*
8082	8211	8361*	8506*	8691*	8821*
8090	8220	8370	8510	8692*	8822*
8091	8221	8371*	8511	8693	8823*
8092	8230	8372*	8512	8700	8824*
8093	8231	8373*	8520	8710	8830
8094	8240	8374*	8521	8711*	8832
8095	8241	8375*	8522	8712*	8833

8840	8981	9104*	9262*	9423	9560
8841*	8982*	9110	9270	9424	9561
8850	8990	9120	9271*	9430	9562*
8851	8991	9121*	9272*	9440	9570*
8852	9000	9122*	9273*	9441	9580
8853	9010*	9123*	9274*	9442	9581
8854	9011*	9124	9275*	9443	9590
8855	9012*	9125*	9280*	9450	9591
8856*	9013*	9126*	9281*	9451	9592
8857*	9014*	9130	9282*	9460	9593
8858	9015*	9131*	9290	9470	9594
8860*	9016*	9132*	9300*	9471	9595
8861*	9020	9133	9301*	9472	9650
8870*	9030*	9134*	9302*	9473	9652
8880*	9040	9140	9310	9480	9653
8881*	9041	9141*	9311*	9481	9654
8890	9042	9142*	9312*	9490	9655
8891	9043	9150	9320*	9491*	9657
8892*	9044	9160*	9321*	9500	9658
8893*	9050	9161*	9322*	9501	9659
8894	9051	9170	9330	9502	9660
8895	9052	9171*	9340*	9503	9661
8896	9053	9172*	9350*	9504	9662
8897*	9054*	9173*	9360*	9505*	9663
8900	9055*	9174*	9361*	9506*	9664
8901	9060	9175*	9362	9507*	9665
8902	9061	9180	9363*	9510	9666
8903*	9062	9181	9364	9511	9667
8904*	9063	9182	9370	9512	9670
8910	9064	9183	9380	9520	9671
8920	9070	9184	9381	9521	9672
8930	9071	9185	9382	9522	9673
8931*	9072	9190	9383*	9523	9674
8932*	9073*	9191*	9384*	9530	9675
8933	9080	9200*	9390	9531*	9676
8940	9081	9210*	9391	9532*	9677
8941	9082	9220	9392	9533*	9680
8950	9083	9221	9393*	9534*	9681
8951	9084	9230	9394*	9535*	9682
8960	9085	9231	9400	9536*	9683
8963	9090	9240	9401	9537*	9684
8964	9091*	9241*	9410	9538*	9685
8970	9100	9250	9411	9539	9686
8971	9101	9251	9420	9540	9687
8972	9102	9260	9421	9541*	9688
8980	9103*	9261	9422	9550*	9690

9691	9709	9761	9824	9868	9940
9692	9710	9762	9825	9870	9941
9693	9711	9763	9826	9871	9950*
9694	9712	9764	9827	9872	9960*
9695	9713	9765*	9828	9873	9961*
9696	9714	9766*	9830	9874	9962*
9697	9715	9767*	9840	9880	9970*
9698	9716	9768*	9841	9890	9980*
9700	9717	9800	9842	9891	9981*
9701	9720	9801	9850	9892	9982*
9702	9722	9802	9860	9893	9983*
9703	9723	9803	9861	9894	9984*
9704	9731	9804	9862	9900	9989
9705	9732	9820	9863	9910	
9706	9740	9821	9864	9930	
9707	9741	9822	9866	9931	
9708	9760	9823	9867	9932	

*Denotes benign or borderline tumor behavior designated as malignant by the Pathologist.
**Denotes benign, borderline or uncertain behavior tumors reportable to the CCR effective with cases diagnosed 01/01/2001 forward.

HISTORICAL CHANGES

12/2009	Minor editor changes

APPENDIX 9B – VALID ICD03 HIST-TYPE CODES

8000	8082	8162	8264*	8371*	8473**
8001	8083	8170	8270	8372*	8480
8002	8084	8171	8271**	8373*	8481
8003	8090	8172	8272	8374*	8482
8004	8091	8173	8280	8375*	8490
8005	8092	8174	8281	8380	8500
8010	8093	8175	8290	8381	8501
8011	8094	8180	8300	8382	8502
8012	8095	8190	8310	8383	8503
8013	8096*	8191*	8311*	8384	8504
8014	8097	8200	8312	8390	8505*
8015	8098	8201	8313	8391*	8506*
8020	8100*	8202*	8314	8392*	8507
8021	8101*	8204*	8315	8400	8508
8022	8102	8210	8316	8401	8510
8030	8103*	8211	8317	8402	8512
8031	8110	8212*	8318	8403	8513
8032	8120	8213*	8319	8404*	8514
8033	8121	8214	8320	8405*	8520
8034	8122	8215	8321*	8406*	8521
8035	8123	8220	8322	8407	8522
8040*	8124	8221	8323	8408	8523
8041	8130	8230	8324*	8409	8524
8042	8131	8231	8325*	8410	8525
8043	8140	8240	8330	8413	8530
8044	8141	8241	8331	8420	8540
8045	8142	8242	8332	8430	8541
8046	8143	8243	8333	8440	8542
8050	8144	8244	8334*	8441	8543
8051	8145	8245	8335	8442**	8550
8052	8146*	8246	8336*	8443*	8551
8053*	8147	8247	8337	8444**	8560
8060*	8148	8248*	8340	8450	8561*
8070	8149*	8249	8341	8451**	8562
8071	8150	8250	8342	8452	8570
8072	8151	8251	8343	8453	8571
8073	8152	8252	8344	8454*	8572
8074	8153	8253	8345	8460	8573
8075	8154	8254	8346	8461	8574
8076	8155	8255	8347	8462**	8575
8077	8156	8260	8350	8463**	8576
8078	8157	8261	8360*	8470	8580
8080	8160	8262	8361*	8471	8581
8081	8161	8263	8370	8472**	8582

8583	8722	8830	8932*	9054*	9171*
8584	8723	8831*	8933	9055*	9172*
8585	8725*	8832	8934	9060	9173*
8586	8726*	8833	8935	9061	9174*
8587*	8727*	8834*	8936	9062	9175*
8588	8728	8835*	8940	9063	9180
8589	8730	8836*	8941	9064	9181
8590*	8740	8840	8950	9065	9182
8591*	8741	8841*	8951	9070	9183
8592*	8742	8842*	8959	9071	9184
8593**	8743	8850	8960	9072	9185
8600	8744	8851	8963	9073*	9186
8601*	8745	8852	8964	9080	9187
8602*	8746	8853	8965*	9081	9191*
8610*	8750*	8854	8966*	9082	9192
8620	8760*	8855	8967*	9083	9193
8621**	8761	8856*	8970	9084	9194
8622**	8762*	8857	8971	9085	9195
8623**	8770	8858	8972	9090	9200*
8630	8771	8860*	8973	9091**	9210*
8631	8772	8861*	8974*	9100	9220
8632**	8773	8862*	8980	9101	9221
8633*	8774	8870*	8981	9102	9230
8634	8780	8880*	8982	9103*	9231
8640	8790*	8881*	8983*	9104*	9240
8641*	8800	8890	8990	9105	9241*
8642*	8801	8891	8991	9110	9242
8650	8802	8892*	9000	9120	9243
8660*	8803	8893*	9010*	9121*	9250
8670	8804	8894	9011*	9122*	9251
8671*	8805	8895	9012*	9123*	9252
8680	8806	8896	9013*	9124	9260
8681*	8810	8897*	9014	9125*	9261
8682*	8811	8898*	9015	9130	9262*
8683*	8812	8900	9016*	9131*	9270
8690*	8813	8901	9020	9132*	9271*
8691*	8814	8902	9030*	9133	9272*
8692*	8815	8903*	9040	9135	9273*
8693	8820*	8904*	9041	9136	9274*
8700	8821*	8905*	9042	9140	9275*
8710	8822*	8910	9043	9141*	9280*
8711	8823*	8912	9044	9142*	9281*
8712*	8824*	8920	9050	9150	9282*
8713*	8825*	8921	9051	9160*	9290
8720	8826*	8930	9052	9161*	9300*
8721	8827*	8931	9053	9170	9301*

9302*	9412**	9520	9665	9750	9867
9310	9413**	9521	9667	9751*	9870
9311*	9420	9522	9670	9752*	9871
9312*	9421	9523	9671	9753*	9872
9320*	9423	9530	9673	9754	9873
9321*	9424	9531**	9675	9755	9874
9322*	9430	9532**	9678	9756	9875
9330	9440	9533**	9679	9757	9876
9340*	9441	9534**	9680	9758	9891
9341*	9442	9535**	9684	9760	9895
9342	9444**	9537**	9687	9761	9896
9350*	9450	9538	9689	9762	9897
9351**	9451	9539	9690	9763	9910
9352**	9460	9540	9691	9764	9920
9360**	9470	9541**	9695	9765*	9930
9361*	9471	9550**	9698	9766*	9931
9362	9472	9560	9699	9767*	9940
9363*	9473	9561	9700	9768*	9945
9364	9474	9562**	9701	9769*	9946
9365	9480	9570**	9702	9800	9948
9370	9490	9571	9705	9801	9950
9371	9491**	9580	9708	9805	9960
9372	9492**	9581	9709	9820	9961
9373*	9493**	9582**	9714	9823	9962
9380	9500	9590	9716	9826	9963
9381	9501	9591	9717	9827	9964
9382	9502	9596	9718	9831*	9970*
9383**	9503	9650	9719	9832	9975*
9384**	9504	9651	9727	9833	9980
9390	9505	9652	9728	9834	9982
9391	9506**	9653	9729	9835	9983
9392	9507**	9654	9731	9836	9984
9393	9508	9655	9732	9837	9985
9394**	9510	9659	9733	9840	9986
9400	9511	9661	9734	9860	9987
9401	9512	9662	9740	9861	998
9410	9513	9663	9741	9863	
9411	9514*	9664	9742	9866	

*Denotes benign or borderline tumor behavior designated as malignant by the Pathologist.
**Denotes benign, borderline or uncertain behavior tumors reportable to the CCR effective with cases diagnosed 01/01/2001 forward.

HISTOICAL CHANGES

12/2009	Minor editing changes

APPENDIX 14A – VALID OCCUPATION 80 AND 90 CODES

These codes are only to be used for Occupation 80 and Occupation 90.

EXECUTIVE, ADMINISTRATIVE, AND MANAGERIAL OCCUPATIONS

003 Legislators
004 Chief executives and general administrators, public admin.
005 Administrators and officials, public administration
006 Administrators, protective services
007 Financial managers
008 Personnel and labor relations managers
009 Purchasing managers
013 Managers, marketing, advertising, and public relations
014 Administrators, education and related fields
015 Managers, medicine and health
016 Postmasters and mail superintendents
017 Managers, food serving and lodging establishments
018 Managers, properties and real estate
019 Funeral directors
021 Managers, service organizations, n.e.c.
022 Managers and administrators, n.e.c.
023 Accountants and auditors
024 Underwriters
025 Other financial officers
026 Management analysts
027 Personnel, training, and labor relations specialists
028 Purchasing agents and buyers, farm products
029 Buyers, wholesale and retail trade, except farm products
033 Purchasing agents and buyers, n.e.c.
034 Business and promotion agents
035 Construction inspectors
036 Inspectors and compliance officers, exc. construction
037 Management related occupations, n.e.c.
Professional Specialty Occupations
043 Architects
044 Aerospace engineers
045 Metallurgical and materials engineers
046 Mining engineers
047 Petroleum engineers
048 Chemical engineers
049 Nuclear engineers
053 Civil engineers
054 Agricultural engineers
055 Electrical and electronic engineers
056 Industrial engineers
057 Mechanical engineers

058 Marine engineers and naval architects
059 Engineers, n.e.c.
063 Surveyors and mapping scientists
064 Computer systems analysts and scientists
065 Operations and systems researchers and analysts
066 Actuaries
067 Statisticians
068 Mathematical scientists, n.e.c.
069 Physicists and astronomers
073 Chemists, except biochemists
074 Atmospheric and space scientists
075 Geologists and geodesists
076 Physical scientists, n.e.c.
077 Agricultural and food scientists
078 Biological and life scientists
079 Forestry and conservation scientists
083 Medical scientists
084 Physicians
085 Dentists
086 Veterinarians
087 Optometrists
088 Podiatrists
089 Health diagnosing practitioners, n.e.c.
095 Registered nurses
096 Pharmacists
097 Dietitians
098 Respiratory therapists
099 Occupational therapists
103 Physical therapists
104 Speech therapists
105 Therapists, n.e.c.
106 Physicians' assistants
113 Earth, environmental, and marine science teachers
114 Biological science teachers
115 Chemistry teachers
116 Physics teachers
117 Natural science teachers, n.e.c.
118 Psychology teachers
119 Economics teachers
123 History teachers
124 Political science teachers
125 Sociology teachers
126 Social science teachers, n.e.c.
127 Engineering teachers
128 Mathematical science teachers
129 Computer science teachers

133 Medical science teachers
134 Health specialties teachers
135 Business, commerce, and marketing teachers
136 Agriculture and forestry teachers
137 Art, drama, and music teachers
138 Physical education teachers
139 Education teachers
143 English teachers
144 Foreign language teachers
145 Law teachers
146 Social work teachers
147 Theology teachers
148 Trade and industrial teachers
149 Home economics teachers
153 Teachers, postsecondary, n.e.c.
154 Postsecondary teachers, subject not specified
155 Teachers, prekindergarten and kindergarten
156 Teachers, elementary school
157 Teachers, secondary school
158 Teachers, special education
159 Teachers, n.e.c.
163 Counselors, educational and vocational
164 Librarians
165 Archivists and curators
166 Economists
167 Psychologists
168 Sociologists
169 Social scientists, n.e.c.
173 Urban planners
174 Social workers
175 Recreation workers
176 Clergy
177 Religious workers, n.e.c.
178 Lawyers
179 Judges
183 Authors
184 Technical writers
185 Designers
186 Musicians and composers
187 Actors and directors
188 Painters, sculptors, craft-artists, and artist printmakers
189 Photographers
193 Dancers
194 Artists, performers, and related workers, n.e.c.
195 Editors and reporters
197 Public relations specialists

198 Announcers
199 Athletes

TECHNICIANS AND RELATED SUPPORT OCCUPATIONS

203 Clinical laboratory technologists and technicians
204 Dental hygienists
205 Health record technologists and technicians
206 Radiologic technicians
207 Licensed practical nurses
208 Health technologists and technicians, n.e.c.
213 Electrical and electronic technicians
214 Industrial engineering technicians
215 Mechanical engineering technicians
216 Engineering technicians, n.e.c.
217 Drafting occupations
218 Surveying and mapping technicians
223 Biological technicians
224 Chemical technicians
225 Science technicians, n.e.c.
226 Airplane pilots and navigators
227 Air traffic controllers
228 Broadcast equipment operators
229 Computer programmers
233 Tool programmers, numerical control
234 Legal assistants
235 Technicians, n.e.c.

SALES OCCUPATIONS

243 Supervisors and proprietors, sales occupations
253 Insurance sales occupations
254 Real estate sales occupations
255 Securities and financial services sales occupations
256 Advertising and related sales occupations
257 Sales occupations, other business services
258 Sales engineers
259 Sales representatives, mining, manufacturing, and wholesale
263 Sales workers, motor vehicles and boats
264 Sales workers, apparel
265 Sales workers, shoes
266 Sales workers, furniture and home furnishings
267 Sales workers; radio, television, hi-fi, and appliances
268 Sales workers, hardware and building supplies
269 Sales workers, parts
274 Sales workers, other commodities
275 Sales counter clerks
276 Cashiers
277 Street and door-to-door sales workers

278 News vendors
283 Demonstrators, promoters and models, sales
284 Auctioneers
285 Sales support occupations, n.e.c.

ADMINISTRATIVE SUPPORT OCCUPATIONS, INCLUDING CLERICAL

303 Supervisors, general office
304 Supervisors, computer equipment operators
305 Supervisors, financial records processing
306 Chief communications operators
307 Supervisors; distribution, scheduling, and adjusting clerks
308 Computer operators
309 Peripheral equipment operators
313 Secretaries
314 Stenographers
315 Typists
316 Interviewers
317 Hotel clerks
318 Transportation ticket and reservation agents
319 Receptionists
323 Information clerks, n.e.c.
325 Classified-ad clerks
326 Correspondence clerks
327 Order clerks
328 Personnel clerks, except payroll and timekeeping
329 Library clerks
335 File clerks
336 Records clerks
337 Bookkeepers, accounting, and auditing clerks
338 Payroll and timekeeping clerks
339 Billing clerks
343 Cost and rate clerks
344 Billing, posting, and calculating machine operators
345 Duplicating machine operators
346 Mail preparing and paper handling machine operators
347 Office machine operators, n.e.c.
348 Telephone operators
353 Communications equipment operators, n.e.c.
354 Postal clerks, exc. mail carriers
355 Mail carriers, postal service
356 Mail clerks, exc. postal service
357 Messengers
359 Dispatchers
363 Production coordinators
364 Traffic, shipping, and receiving clerks
365 Stock and inventory clerks

366 Meter readers
368 Weighers, measurers, checkers, and samplers
373 Expediters
374 Material recording, scheduling, and distributing clerks, n.e.c.
375 Insurance adjusters, examiners, and investigators
376 Investigators and adjusters, except insurance
377 Eligibility clerks, social welfare
378 Bill and account collectors
379 General office clerks
383 Bank tellers
384 Proofreaders
385 Data-entry keyers
386 Statistical clerks
387 Teachers' aides
389 Administrative support occupations, n.e.c.

PRIVATE HOUSEHOLD OCCUPATIONS

403 Launderers and ironers
404 Cooks, private household
405 Housekeepers and butlers
406 Child care workers, private household
407 Private household cleaners and servants

PROTECTIVE SERVICE OCCUPATIONS

413 Supervisors, firefighting and fire prevention occupations
414 Supervisors, police and detectives
415 Supervisors, guards
416 Fire inspection and fire prevention occupations
417 Firefighting occupations
418 Police and detectives, public service
423 Sheriffs, bailiffs, and other law enforcement officers
424 Correctional institution officers
425 Crossing guards
426 Guards and police, exc. public service
427 Protective service occupations, n.e.c.

SERVICE OCCUPATIONS, EXCEPT PROTECTIVE AND HOUSEHOLD

433 Supervisors, food preparation and service occupations
434 Bartenders
435 Waiters and waitresses
436 Cooks
438 Food counter, fountain and related occupations
439 Kitchen workers, food preparation
443 Waiters'/waitresses' assistants
444 Miscellaneous food preparation occupations
445 Dental assistants
446 Health aides, except nursing

447 Nursing aides, orderlies, and attendants
448 Supervisors, cleaning and building service workers
449 Maids and housemen
453 Janitors and cleaners
454 Elevator operators
455 Pest control occupations
456 Supervisors, personal service occupations
457 Barbers
458 Hairdressers and cosmetologists
459 Attendants, amusement and recreation facilities
461 Guides
462 Ushers
463 Public transportation attendants
464 Baggage porters and bellhops
465 Welfare service aides
466 Family child care providers
467 Early childhood teachers' assistants
468 Child care workers, n.e.c.
469 Personal service occupations, n.e.c.

FARMING, FORESTRY, AND FISHING OCCUPATIONS

473 Farmers, except horticultural
474 Horticultural specialty farmers
475 Managers, farms, except horticultural
476 Managers, horticultural specialty farms
477 Supervisors, farm workers
479 Farm workers
483 Marine life cultivation workers
484 Nursery workers
485 Supervisors, related agricultural occupations
486 Groundskeepers and gardeners, except farm
487 Animal caretakers, except farm
488 Graders and sorters, agricultural products
489 Inspectors, agricultural products
494 Supervisors, forestry and logging workers
495 Forestry workers, except logging
496 Timber cutting and logging occupations
497 Captains and other officers, fishing vessels
498 Fishers
499 Hunters and trappers

PRECISION PRODUCTION, CRAFT, AND REPAIR OCCUPATIONS

503 Supervisors, mechanics and repairers
505 Automobile mechanics
506 Automobile mechanic apprentices
507 Bus, truck, and stationary engine mechanics
508 Aircraft engine mechanics

509 Small engine repairers
514 Automobile body and related repairers
515 Aircraft mechanics, exc. engine
516 Heavy equipment mechanics
517 Farm equipment mechanics
518 Industrial machinery repairers
519 Machinery maintenance occupations
523 Electronic repairers, communications and industrial equip.
525 Data processing equipment repairers
526 Household appliance and power tool repairers
527 Telephone line installers and repairers
529 Telephone installers and repairers
533 Miscellaneous electrical and electronic equipment repairers
534 Heating, air conditioning, and refrigeration mechanics
535 Camera, watch, and musical instrument repairers
536 Locksmiths and safe repairers
538 Office machine repairers
539 Mechanical controls and valve repairers
543 Elevator installers and repairers
544 Millwrights
547 Specified mechanics and repairers, n.e.c.
549 Not specified mechanics and repairers
553 Supervisors; brick masons, stonemasons, and tile setters
554 Supervisors, carpenters and related workers
555 Supervisors, electricians and power transmission installers
556 Supervisors; painters, paperhangers, and plasterers
557 Supervisors; plumbers, pipefitters, and steamfitters
558 Supervisors, constructing, n. e. c.
563 Brick masons and stonemasons
564 Brick mason and stonemason apprentices
565 Tile setters, hard and soft
566 Carpet installers
567 Carpenters
569 Carpenter apprentices
573 Drywall installers
575 Electricians
576 Electrician apprentices
577 Electrical power installers and repairers
579 Painters, construction and maintenance
583 Paperhangers
584 Plasterers
585 Plumbers, pipefitters, and steamfitters
587 Plumber, pipefitter, and steamfitter apprentices
588 Concrete and terrazzo finishers
589 Glaziers
593 Insulation workers

594 Paving, surfacing, and tamping equipment operators
595 Roofers
596 Sheet metal duct installers
597 Structural metal workers
598 Drillers, earth
599 Construction trades, n.e.c.
613 Supervisors, extractive occupations
614 Drillers, oil well
615 Explosives workers
616 Mining machine operators
617 Mining occupations, n.e.c.
628 Supervisors, production occupations
634 Tool and die makers
635 Tool and die maker apprentices
636 Precision assemblers, metal
637 Machinists
639 Machinist apprentices
643 Boilermakers
644 Precision grinders, fitters, and tool sharpeners
645 Patternmakers and model makers, metal
646 Lay-out workers
647 Precious stones and metals workers (jewelers)
649 Engravers, metal
653 Sheet metal workers
654 Sheet metal worker apprentices
655 Miscellaneous precision metal workers
656 Patternmakers and model makers, wood
657 Cabinet makers and bench carpenters
658 Furniture and wood finishers
659 Miscellaneous precision woodworkers
666 Dressmakers
667 Tailors
668 Upholsterers
669 Shoe repairers
674 Miscellaneous precision apparel and fabric workers
675 Hand molders and shapers, except jewelers
676 Patternmakers, lay-out workers, and cutters
677 Optical goods workers
678 Dental laboratory and medical appliance technicians
679 Bookbinders
683 Electrical and electronic equipment assemblers
684 Miscellaneous precision workers, n.e.c.
686 Butchers and meat cutters
687 Bakers
688 Food batch makers
689 Inspectors, testers, and graders

693 Adjusters and calibrators
694 Water and sewage treatment plant operators
695 Power plant operators
696 Stationary engineers
699 Miscellaneous plant and system operators

MACHINE OPERATORS, ASSEMBLERS, AND INSPECTORS

703 Lathe and turning machine set-up operators
704 Lathe and turning machine operators
705 Milling and planning machine operators
706 Punching and stamping press machine operators
707 Rolling machine operators
708 Drilling and boring machine operators
709 Grinding, abrading, buffing, and polishing machine operators
713 Forging machine operators
714 Numerical control machine operators
715 Miscellaneous metal, plastic, stone, and glass working machine
717 Fabricating machine operators, n.e.c.
719 Molding and casting machine operators
723 Metal plating machine operators
724 Heat treating equipment operators
725 Miscellaneous metal and plastic processing machine operators
726 Wood lathe, routing, and planning machine operators
727 Sawing machine operators
728 Shaping and joining machine operators
729 Nailing and tacking machine operators
733 Miscellaneous woodworking machine operators
734 Printing press operators
735 Photoengravers and lithographers
736 Typesetters and compositors
737 Miscellaneous printing machine operators
738 Winding and twisting machine operators
739 Knitting, looping, taping, and weaving machine operators
743 Textile cutting machine operators
744 Textile sewing machine operators
745 Shoe machine operators
747 Pressing machine operators
748 Laundering and dry-cleaning machine operators
749 Miscellaneous textile machine operators
753 Cementing and gluing machine operators
754 Packaging and filling machine operators
755 Extruding and forming machine operators
756 Mixing and blending machine operators
757 Separating, filtering, and clarifying machine operators
758 Compressing and compacting machine operators
759 Painting and paint spraying machine operators

763 Roasting and baking machine operators, food
764 Washing, cleaning, and pickling machine operators
765 Folding machine operators
766 Furnace, kiln, and oven operators, exc. food
768 Crushing and grinding machine operators
769 Slicing and cutting machine operators
773 Motion picture projectionists
774 Photographic process machine operators
777 Miscellaneous machine operators, n.e.c.
779 Machine operators, not specified
783 Welders and cutters
784 Solderers and brazers
785 Assemblers
786 Hand cutting and trimming occupations
787 Hand molding, casting, and forming occupations
789 Hand painting, coating, and decorating occupations
793 Hand engraving and printing occupations
795 Miscellaneous hand working occupations
796 Production inspectors, checkers, and examiners
797 Production testers
798 Production samplers and weighers
799 Graders and sorters, except agricultural

TRANSPORTATION AND MATERIAL MOVING OCCUPATIONS

803 Supervisors, motor vehicle operators
804 Truck drivers
806 Driver-sales workers
808 Bus drivers
809 Taxicab drivers and chauffeurs
813 Parking lot attendants
814 Motor transportation occupations, n.e.c.
823 Railroad conductors and yardmasters
824 Locomotive operating occupations
825 Railroad brake, signal, and switch operators
826 Rail vehicle operators, n.e.c.
828 Ship captains and mates, except fishing boats
829 Sailors and deckhands
833 Marine engineers
834 Bridge, lock, and lighthouse tenders
843 Supervisors, material moving equipment operators
844 Operating engineers
845 Longshore equipment operators
848 Hoist and winch operators
849 Crane and tower operators
853 Excavating and loading machine operators
855 Grader, dozer, and scraper operators

856 Industrial truck and tractor equipment operators
859 Miscellaneous material moving equipment operators

HANDLERS, EQUIPMENT CLEANERS, HELPERS, AND LABORERS

864 Supervisors; handlers, equipment cleaners, and laborers n.e.c.
865 Helpers, mechanics and repairers
866 Helpers, construction trades
867 Helpers, surveyor
868 Helpers, extractive occupations
869 Construction laborers
874 Production helpers
875 Garbage collectors
876 Stevedores
877 Stock handlers and baggers
878 Machine feeders and offbearers
883 Freight, stock, and material handlers, n.e.c.
885 Garage and service station related occupations
887 Vehicle washers and equipment cleaners
888 Hand packers and packagers
889 Laborers, except construction

MILITARY OCCUPATIONS

903 Commissioned officers and warrant officers
904 Non-commissioned officers and other enlisted personnel
905 Military occupation, rank not specified

MISCELLANEOUS (NOT AN OFFICIAL CATEGORY)

913 Retired
914 Housewife
915 Student
916 Volunteer
917 Never Worked
999 Occupation Not Reported

HISTORICAL UPDATES

05/2013	These codes are only valid for Occupation 80 and Occupation 90

APPENDIX – 14B VALID INDUSTRY 80 AND 90 CODES

These codes are only to be used for Industry 80 and Industry 90

AGRICULTURE, FORESTRY, AND FISHERIES

010 Agricultural production, crops
011 Agricultural production, livestock
012 Veterinary services
020 Landscape and horticultural services
030 Agricultural services, n.e.c.
031 Forestry
032 Fishing, hunting, and trapping

MINING

040 Metal mining
041 Coal mining
042 Oil and gas extraction
050 Nonmetallic mining and quarrying, except fuels

CONSTRUCTION

060 Construction

MANUFACTURING

100 Meat products
101 Dairy products
102 Canned, frozen, and preserved fruits and vegetables
110 Grain mill products
111 Bakery products
112 Sugar and confectionery products
120 Beverage industries
121 Miscellaneous food preparations and kindred products
122 Not specified food industries
130 Tobacco manufactures
132 Knitting Mills
140 Dyeing and finishing textiles, except wool and knit goods
141 Carpets and rugs
142 Yarn, thread, and fabric mills
150 Miscellaneous textile mill products
151 Apparel and accessories, except knit
152 Miscellaneous fabricated textile products
160 Pulp, paper, and paperboard mills
161 Miscellaneous paper and pulp products
162 Paperboard containers and boxes
171 Newspaper publishing and printing
172 Printing, publishing, and allied industries, except newspapers
180 Plastics, synthetics, and resins
181 Drugs
182 Soaps and cosmetics

190 Paints, varnishes, and related products
191 Agricultural chemicals
192 Industrial and miscellaneous chemicals
200 Petroleum refining
201 Miscellaneous petroleum and coal products
210 Tires and inner tubes
211 Other rubber products, and plastics footwear and belting
212 Miscellaneous plastics products
220 Leather tanning and finishing
221 Footwear, except rubber and plastic
222 Leather products, except footwear
230 Logging
231 Sawmills, planning mills, and millwork
232 Wood buildings and mobile homes
241 Miscellaneous wood products
242 Furniture and fixtures
250 Glass and glass products
251 Cement, concrete, gypsum, and plaster products
252 Structural clay products
261 Pottery and related products
262 Miscellaneous nonmetallic mineral and stone products
270 Blast furnaces, steelworks, rolling and finishing mills
271 Iron and steel foundries
272 Primary aluminum industries
280 Other primary metal industries
281 Cutlery, hand tools, and general hardware
282 Fabricated structural metal products
290 Screw machine products
291 Metal forgings and stampings
292 Ordnance
300 Miscellaneous fabricated metal products
301 Not specified metal industries
310 Engines and turbines
311 Farm machinery and equipment
312 Construction and material handling machines
320 Metalworking machinery
321 Office and accounting machines
322 Computers and related equipment
331 Machinery, except electrical, n.e.c.
332 Not specified machinery
340 Household appliances
341 Radio, TV, and communication equipment
342 Electrical machinery, equipment, and supplies, n.e.c.
350 Not specified electrical machinery, equipment, and supplies
351 Motor vehicles and motor vehicle equipment
352 Aircraft and parts

360 Ship and boat building and repairing
361 Railroad locomotives and equipment
362 Guided missiles, space vehicles, and parts
370 Cycles and miscellaneous transportation equipment
371 Scientific and controlling instruments
372 Medical, dental, and optical instruments and supplies
380 Photographic equipment and supplies
381 Watches, clocks, and clockwork operated devices
390 Toys, amusement, and sporting goods
391 Miscellaneous manufacturing industries
392 Not specified manufacturing industries

TRANSPORTATION, COMMUNICATIONS, AND OTHER PUBLIC UTILITIES

400 Railroads
401 Bus service and urban transit
402 Taxicab service
410 Trucking service
411 Warehousing and storage
412 U.S. Postal Service
420 Water transportation
421 Air transportation
422 Pipe lines, except natural gas
432 Services incidental to transportation
440 Radio and television broadcasting and cable
441 Telephone communications
442 Telegraph and miscellaneous communication services
450 Electric light and power
451 Gas and steam supply systems
452 Electric and gas, and other combinations
470 Water supply and irrigation
471 Sanitary services
472 Not specified utilities

WHOLESALE TRADE

500 Motor vehicles and equipment
501 Furniture and home furnishings
502 Lumber and construction materials
510 Professional and commercial equipment and supplies
511 Metals and minerals, except petroleum
512 Electrical goods
521 Hardware, plumbing and heating supplies
530 Machinery, equipment, and supplies
531 Scrap and waste materials
532 Miscellaneous wholesale, durable goods
540 Paper and paper products
541 Drugs, chemicals, and allied products
542 Apparel, fabrics, and notions

550 Groceries and related products
551 Farm products--raw materials
552 Petroleum products
560 Alcoholic beverages
561 Farm supplies
562 Miscellaneous wholesale, nondurable goods
571 Not specified wholesale trade

RETAIL TRADE

580 Lumber and building material retailing
581 Hardware stores
582 Retail nurseries and garden stores
590 Mobile home dealers
591 Department stores
592 Variety stores
600 Miscellaneous general merchandise stores
601 Grocery stores
602 Dairy products stores
610 Retail bakeries
611 Food stores, n.e.c.
612 Motor vehicle dealers
620 Auto and home supply stores
621 Gasoline service stations
622 Miscellaneous vehicle dealers
623 Apparel and accessory stores, except shoe
630 Shoe stores
631 Furniture and home furnishings stores
632 Household appliances stores
633 Radio, TV, and computer stores
640 Music stores
641 Eating and drinking places
642 Drug stores
650 Liquor stores
651 Sporting goods, bicycles, and hobby stores
652 Book and stationery stores
660 Jewelry stores
661 Gift, novelty, and souvenir shop
662 Sewing, needlework, and piece goods stores
663 Catalog and mail order houses
670 Vending machine operators
671 Direct selling establishments
672 Fuel dealers
681 Retail florists
682 Miscellaneous retail stores
691 Not specified retail trade

FINANCE, INSURANCE, AND REAL ESTATE

700 Banking
701 Savings institutions, including credit unions
702 Credit agencies, n.e.c.
710 Security, commodity brokerage, and investment companies
711 Insurance
712 Real estate, including real estate insurance offices

BUSINESS AND REPAIR SERVICES

721 Advertising
722 Services to dwellings and other buildings
731 Personnel supply services
732 Computer and data processing services
740 Detective and protective services
741 Business services, n.e.c.
742 Automotive rental and leasing, without driver
750 Automotive parking and car washes
751 Automotive repair and related services
752 Electrical repair shops
760 Miscellaneous repair services

PERSONAL SERVICES

761 Private households
762 Hotels and motels
770 Lodging places, except hotels and motels
771 Laundry, cleaning, and garment services
772 Beauty shops
780 Barber shops
781 Funeral service and crematories
782 Shoe repair shops
790 Dressmaking shops
791 Miscellaneous personal services

ENTERTAINMENT AND RECREATION SERVICES

800 Theaters and motion pictures
801 Video tape rental
802 Bowling centers
810 Miscellaneous entertainment and recreation services

PROFESSIONAL AND RELATED SERVICES

812 Offices and clinics of physicians
820 Offices and clinics of dentists
821 Offices and clinics of chiropractors
822 Offices and clinics of optometrists
830 Offices and clinics of health practitioners, n.e.c.
831 Hospitals
832 Nursing and personal care facilities
840 Health services, n.e.c.
841 Legal services

842 Elementary and secondary schools
850 Colleges and universities
851 Vocational schools
852 Libraries
860 Educational services, n.e.c.
861 Job training and vocational rehabilitation services
862 Child day care services
863 Family child care homes
870 Residential care facilities, without nursing
871 Social services, n.e.c.
872 Museums, art galleries, and zoos
873 Labor unions
880 Religious organizations
881 Membership organizations, n.e.c.
882 Engineering, architectural, and surveying services
890 Accounting, auditing, and bookkeeping services
891 Research, development, and testing services
892 Management and public relations services
893 Miscellaneous professional and related services

PUBLIC ADMINISTRATION

900 Executive and legislative offices
901 General government, n.e.c.
910 Justice, public order, and safety
921 Public finance, taxation, and monetary policy
922 Administration of human resources programs
930 Administration of environmental quality and housing programs
931 Administration of economic programs
932 National security and international affairs

ACTIVE DUTY MILITARY

940 Army
941 Air Force
942 Navy
950 Marines
951 Coast Guard
952 Armed Forces, branch not specified
960 Military Reserves or National Guard

MISCELLANEOUS (NOT AN OFFICIAL CATEGORY)

961 Doesn't Work
970 Retired
971 Industry Not Reported

HISTORICAL CHANGES

05/2013	These codes are only valid for Industry 80 and Industry 90

APPENDIX 20A – 1998 SURGERY CODES, CONSILDATION RULES< AND SITE EDITS

SURGERY OF PRIMARY SITE: CODES AND CONSOLIDATION RULES

The range of codes 00-89 is hierarchical. If more than one code describes the procedure, use the numerically higher code. Please see the priority of codes.
Priority of Codes:
Priorities for the "Surgery of Primary Site" are in the following Excel spreadsheet which contains tabs for the following tables:

- Priority by Site
- Surgery of Primary Site Edits
- Site Scope of Regional Node Edits
- Scope of Regional Nodes Codes and Consolidation Rules
- Site-Scope of Regional Nodes Edits
- Number of Regional Lymph Nodes Examined Consolidation Rules
- Site-Surgery of Other Regional Site(s), Distant Site(s) Or Distant Lymph Node(s) Edits
- Reconstructive-Restorative Surgery Codes and Consolidation Rules
- Site-Reconstructive-Restorative Surgery Edits

TO VIEW THE TABLES, CLICK HERE TO VIEW AN EXCEL SPREADSHEET, THEN CLICK THE APPROPRIATE TAB AT THE BOTTOM OF THE SPREADSHEET.

HISTORICAL CHANGES

3/2003	Last Update. Reason for update not available.

APPENDIX 20B – SITE/SURGERY OF PRIMARY SITE EDITS

2003 Surgery Codes, Consolidation Rules, and Site Edits
Surgery of Primary Site: Codes and Consolidation Rules
(Cases diagnosed on or after January 1, 2003)
To consolidate a new surgery to the primary site code against the existing summary code, follow this procedure:

1. If the two surgery codes are the same, then do nothing and stop here. Otherwise go on to step 2.
2. Find the applicable site range row in the Site/Surgery Hierarchy Table that follows.
3. If either surgery code is missing from this row, then do nothing and stop here. Otherwise, go on to step 4.
4. Determine the associated column number (within this row) for each surgery code being compared.

If the new surgery code was found in a higher column number than the existing summary code, then replace the summary code with the new code. Otherwise, do nothing and stop here.
Click here to view the Site-Surgery Hierarchy table of 4/26/2011 (lowest to highest and select the SiteSurgeryHeirarchy tab)

SITE/SURGERY OF PRIMARY SITE EDITS

SITE/SURGERY OF PRIMARY SITE EDITS
This edit is skipped if Histologic Type ICD-O-3 is empty.
This edit is skipped if Type of Report Source = 7 (DCO).
The valid RX Summ--Surg Prim Site codes for each Primary Site are specified in Appendix B of the FORDS Manual-2003.
Exceptions are as follows:

For all sites, if Histologic Type ICD-O-3 = 9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9992, then RX Summ--Surg Prim Site must = 98.

If Primary Site = C420, C421, C423, or C424, then RX Summ--Surg Prim Site must = 98, Unknown and ill-defined sites (C760-C768, C809) must also = 98.

Click here to view the Site-Surgery of Primary Site Edits table and select the SiteSurgeryPrimarySiteEdits tab.

HISTORICAL CHANGES

04/26/2011	Page Updated
02/2014	Typos corrected in Eureka's Site/Surgery Hierarchy tables.

APPENDIX 24 PASSIVE FOLLOW-UP INPUT RECORD FORMAT, VERSION 5

Matches 2014 Data Item Conversions and NAACCR v14.

Click to open the Excel Spreadsheet that contains the record format.

At the bottom of the spreadsheet are two tabs.

- **2010 and Forward** contains the current record format.
- **2009 and Before** contains the previous record format.

HISTORICAL CHANGES

12/2008	Specs for 2009 Data Changes--DC Birthplace length changed to 3 (was 2).
03/2009	Updated Start column positioning for data items that follow DC Birthplace. Changed Version to 3.
07/2009	Updated "Document Type Version" allowable value to 3. Code 70 (Death Clearance LA County) added to Follow-up – Last Type (Patient) Allowable values.
02/2010	Updated "Document Type Version" allowable value to 4 to be compatible with 2010 data item changes
05/2013	Updated "Document Type Version" allowable value to 5. Replaced Place of Death with Place of Death State and Place of Death Country. Updated start positions for data items following the new Place of Death fields. Added Address Current Country.
01/2014	Corrected link to Eureka's Passive Follow-up Input Record Layout. No changes to layout related to 2014 Data Item Conversions.

APPENDIX 26 – EUREKA CORRECTIONS APPLY PROCEDURE

In Eureka, corrections for the same admission are linked together and processed together. The system examines all the corrections in the set to see if any of the correction item numbers (software vendor item numbers without the "F" prefix) are NOT on this list of data items that can be automatically corrected:

- F00016 Accession_No
- F00150 Case Find
- F01049 Med_Rec_No
- F00160 Pay_Source_1
- F00293 Pay_Source_2
- F00418 Pay_Source_Text
- F00548 Ped_Stage
- F00417 Ped_Stage_Coder
- F00547 Ped_Stage_Sys
- F00582 Protocol_Part
- F01915 TNM_Coder_Clinical
- F01917 TNM_Coder_Path
- F01918 TNM_Edition
- F01919 TNM_M_Code_Clinical
- F01921 TNM_M_Code_Path
- F01922 TNM_N_Code_Clinical
- F01924 TNM_N_Code_Path
- F01925 TNM_Stage_Clinical
- F01927 TNM_Stage_Path
- F01928 TNM_T_Code_Clinical
- F01930 TNM_T_Code_Pat

If all the correction items are on the above list, then the system performs some special procedures to see if we have one or more TNM corrections that need review. Thus, the system checks to see if there are any TNM Clinical corrections where the admission's TNM Coder Clinical value is in the range 1-4 or TNM Clinical corrections combined with a TNM Coder Clinical correction from 1-4 to 5-8 or 5-8 to 1-4. The system also checks to see if there are any TNM Path corrections where the admission's TNM Coder Path value is in the range 1-4 or TNM Path corrections combined with a TNM Coder Path correction from 1-4 to 5-8 or 5-8 to 1-4. If any of these conditions are true, then we have one or more TNM corrections that need review. The system also tests the potentially updated admission for data quality by executing the system's automatic edits. Finally, the system also compares the corrections in the set to the corresponding existing admission values to see if they are all the same.

Manual Review for all corrections in the set will be necessary if at least one corrected value differs from its corresponding admission value and at least one of the following conditions are true:

1. At least one of the corrections' corrected items is not on the above data item list.
2. There are one or more TNM Clinical corrections where the admission's TNM Coder Clinical value is in the range 1-4 or TNM Clinical corrections combined with a TNM Coder Clinical correction from 1-4 to 5-8 or 5-8 to 1-4.
3. There are one or more TNM Path corrections where the admission's TNM Coder Path value is in the range 1-4 or TNM Path corrections combined with a TNM Coder Path correction from 1-4 to 5-8 or 5-8 to 1-4.
4. Applying one or more of the corrections would cause edit errors to be found by the automatic edits.

If none of these conditions are true, the system automatically updates the admission with all the correction set data values.

HISTORICAL CHANGES

3/2004	Last Updated

APPENDIX 28 – SURGERY OF THE PRIMARY SITE CONVERSION TALBE FOR 2003 DATA CHANGES

CLICK HERE TO VIEW THE PRIMARY SITE CONVERSION TABLE IN EXCEL FORMAT.

NOTES

When Scope_LN_Sum is specified as needed for a particular conversion, and one of the Surg_Prim_Proc1 – 3 is being converted, use the corresponding Scope_LN_Proc1 – 3 value for the conversion instead of Scope_LN_Sum.
Always use Surg_Sum_Recon when specified. Never use Surg_Hosp_Recon for a conversion.
Skin cancer conversions (C440-C449) involving codes 40 and 50 and Surgical Margins have been altered from the CoC specification because we no longer track Surgical Margins. Both codes convert to 45.
Columns 2 and 3 are pre-conversion values.

HISTOICAL CHANGES

APPENDIX 29 – HISTOLOGY ICDO-3 CONVERSION SPECIFICATIONS

Click here to view the Histology ICD0-3 Conversion Specifications Table.

1) If Hist_Type_2 is not 8510, 8832, 8930, or 9731, then skip ahead to step 2). Otherwise, continue with these site-specific updates and then skip ahead to step 4):

```
If Hist_Type_2 = 8510 then
    If Site is thyroid (C739) then
      Change Hist_Type_3 to 8345
    Else
      Change Hist_Type_3 to 8510
    End-If
  End-If
  Change Hist_Behavior_3 to current Hist_Behavior_2 value
End-If.
If Hist_Type_2 = 8832 and Hist_Behavior_2 = 0 then
  If Site is skin (C440-C449) then
    Change Hist_Type_3 to 8832
  Else
    Change Hist_Type_3 to 8831
  End-If
  Change Hist_Behavior_3 to current Hist_Behavior_2 value
End-If.
If Hist_Type_2 = 8832 and Hist_Behavior_2 = 1 then
  If Site is skin (C440-C449) then
    Change Hist_Type_3 to 8832
  Else
    Change Hist_Type_3 to 8834
  End-If
  Change Hist_Behavior_3 to current Hist_Behavior_2 value
End-If.
If Hist_Type_2 = 8832 and Hist_Behavior_2 = 2 or 3 then
  Change Hist_Type_3 to current Hist_Type_2 value
  Change Hist_Behavior_3 to current Hist_Behavior_2 value
End-If.
If Hist_Type_2 = 8930 and Hist_Behavior_2 = 0 then
  If Site is endometrium (C540-C549) then
    Change Hist_Type_3 to 8930
  Else
    If Site is gastrointestinal (C150-C218) or
      Site Is gastrointestinal other (C260-C269) then
      Change Hist_Type_3 to 8936
    Else
      If Site is kidney (C649) then
        Change Hist_Type_3 to 8966
      Else
```

```
            Change Hist_Type_3 to 8935
          End-If
        End-If
      End-If
      Change Hist_Behavior_3 to current Hist_Behavior_2 value
    End-If.
    If Hist_Type_2 = 8930 and Hist_Behavior_2 = 1, 2, or 3 then
      If Site is endometrium (C540-C549) then
        Change Hist_Type_3 to 8930
      Else
        If Site is gastrointestinal (C150-C218) or
          Site is gastrointestinal other (C260-C269) then
          Change Hist_Type_3 to 8936
        Else
          Change Hist_Type_3 to 8935
        End-If
      End-If
      Change Hist_Behavior_3 to current Hist_Behavior_2 value
    End-If.
    If Hist_Type_2 = 9731 then
      If Site is bones (C400-C419) then
        Change Hist_Type_3 to 9731
      Else
        Change Hist_Type_3 to 9734
      End-If
      Change Hist_Behavior_3 to current Hist_Behavior_2 value
    End-If.
```

2) Look up the Hist_Type_2/Hist_Behavior_2 combination in the ICDO2-ICDO3 Conversion Table. If a matching row is found, then convert Hist_Type_3 and Hist_Behavior_3 to the conversion values listed, and go on to step 4). If a matching row is not found, then go on to step 3).
Click here to view the Histology ICD0-3 Conversion Specifications Table.

3) (3, 2, 1, 0), and go on to step 4). Otherwise, if a matching row is not found, then just convert Hist_Type_3 and Hist_Behavior_3 directly from Hist_Type_2 and Hist_Behavior_2 and go on to step 4).
4) Hist_Type_3 had been changed by any of the above procedures, then reset ICDO3_Conv_Flag to 1.

HISTORICAL CHANGES

10/2006	Removed the nested IF changing breast cancer cases to 8513.

APPENDIX 30 – FOLLOW-UP SOURCE CENTRAL EXTRACT TABLE FOR NPCR SUBMISSION

FU_Last_Type_Pat (Eureka Code)	FU_Last_Type_Pat Code Text (Eureka Labels)	Follow-up Source Central Code (NAACCR CODES)	Follow-up Source Central (NAACCR Labels)
HOSPITAL			
0	Admission Being Reported	00	Follow-up not performed for this patient
1	Readmission to Reporting Hospital	30	Hospital in-patient/outpatient
2	Follow-up Report from Physician	49	Physician, NOS
3	Follow-up Report from Patient	50	Patient contact
4	Follow-up Report from Relative	51	Relative contact
5	Obituary	64	Obituary
6	Follow-up Report from Social Security Administration or Medicare	01	Medicare/Medicaid File
7	7 Follow-up Report from Hospice 62 Hospice	62	7 Follow-up Report from Hospice 62 Hospice
8	8 Follow-up Report from Other Hospital 30 Hospital in-patient/outpatient	08	8 Follow-up Report from Other Hospital 30 Hospital in-patient/outpatient
9	Other Source	98	9 Other Source 98 Other, NOS
11	Telephone call to any source	11	11 Telephone call to any source 98 Other, NOS
12	Special Studies	65	12 Special Studies 65 Other research/study related sources
13	Equifax	13	13 Equifax 61 Internet sources
14	ARS (AIDS Registry System)	29	Linkages, NOS
15	Computer Match with Discharge Data	08	Hospital discharge data

16	SSDI Match	07	Social Security Administration Death Master File
REGIONAL REGISTRY			
20	Letter to a Physician	49	Physician, NOS
21	Computer match with Department of Motor Vehicles	03	Department of Motor Vehicle Registration
22	Computer match with Medicare or Medicaid file	01	Medicare/Medicaid File
23	Computer match with HMO file	09	Health Maintenance Organization (HMO) file
24	Computer match with voter registration file	11	Voter registration file
25	National Death Index	04	National Death Index (NDI)
26	Computer match with State Death Tape	05	State Death Tape/Death Certificate File
27	Social Security, Death Master file	07	Social Security Administration Death Master File
29	Computer match, Other or NOS	29	Linkages, NOS
30	Other Source	98	Other, NOS
31	Telephone call to any source	98	Other, NOS
32	Special Studies	65	Other research/study related sources
33	Equifax	61	Internet sources
34	ARS (AIDS Registry System)	29	Linkages, NOS
35	Computer Match with Discharge Data	08	Hospital Discharge data
36	Obituary	64	Obituary
37	Computer Match using Address Service	29	Linkages, NOS
38	TRW Credit	29	Internet sources
39	Regional Registry Follow-up Listing	60	Central or Regional cancer registry
CENTRAL REGISTRY			
40	Letter to a Physician	49	Physician, NOS
41	Telephone call to any source	98	Other, NOS

48	Research Study Follow Up	12	Research/Study Related Linkage
49	Birth StatMaster Linkage	29	Linkages, NOS
50	CMS (Center for Medicare & Medicaid Services)	02	Center for Medicare and Medicaid Services (CMS, formerly HCFA)
51	Department of Motor Vehicles	03	Department of Motor Vehicle Registration
52	CMS-SEER	02	Center for Medicare and Medicaid Services (CMS, formerly HCFA)
53	HMO file	09	Health Maintenance Organization (HMO) file
54	CalVoter Registration	11	Voter registration file
55	National Death Index	04	National Death Index (NDI)
56	State Death Tape-Death Clearance (StatMaster)	05	State Death Tape/Death Certificate File
57	Medi-Cal Eligibility	01	Medicare/Medicaid File
58	Social Security - Deaths	07	Social Security Administration Death Master File
59	Computer match, Other or NOS	29	Linkages, NOS
60	Other Source	98	Other, NOS
61	Social Security - SSN	29	Linkages, NOS
62	Special Studies	65	Other research/study related sources
63	Master Files	29	Linkages, NOS
64	Accurint	29	Linkages, NOS
65	Hospital Discharge Data-OSHPD	08	Hospital Discharge Data
66	National Change of Address (NCOA)	29	Linkages, NOS
67	Social Security Administration - Epidemiological Vital Status	10	Social Security Epidemiological Vital Status Data
68	Property Tax Linkage	29	Linkages, NOS
69	State Death Tape-Death Clearance (Incremental)	05	State Death Tape/Death Certificate File
70	Death Clearance LA County	06	Count/Municipality Death Tape/Death Certificate file

HOSPITAL, SUPPLEMENTAL			
73	Computer match with HMO file	09	Health Maintenance Organization (HMO) file
76	Computer match with State Death Tape	05	State Death Tape/Death Certificate File
REGIONAL REGISTRY (ADDITIONAL CODES)			
80	Social Security Administration - Epidemiological Vital Status	10	Social Security Epidemiological Vital Status Data
81	Property Tax Linkage	29	Linkages, NOS
82	Probe360	29	Linkages, NOS
83	SSDI Internet	61	Internet sources
84	E-Path	31	Casefinding
85	Path Labs	31	Casefinding
86	Patient	50	Patient contact
87	Relative	51	Relative contact
UNKNOWN SOURCE			
99	Source Unknown	99	Unknown source

HISTORICAL CHANGES

2009	Added Code 70

APPENDIX 31 – STATE/COUNTRY CROSSWALK*

See the NAACCR website for the original crosswalk tables.

State or Province	CountryISO
AA	USA
AB	CAN
AE	USA
AK	USA
AL	USA
AP	USA
AR	USA
AS	ASM
AZ	USA
BC	CAN
CA	USA
CD	CAN
CO	USA
CT	USA
DC	USA
DE	USA
FL	USA
FM	FSM
GA	USA
GU	GUM
HI	USA
IA	USA
ID	USA
IL	USA
IN	USA
KS	USA
KY	USA
LA	USA
MA	USA
MB	CAN
MD	USA
ME	USA
MH	MHL
MI	USA
MN	USA
MO	USA
MP	MNP
MS	USA
MT	USA
NB	CAN
NC	USA
ND	USA
NE	USA
NH	USA
NJ	USA
NL	CAN
NM	USA
NS	CAN
NT	CAN
NU	CAN
NV	USA
NY	USA
OH	USA
OK	USA
ON	CAN
OR	USA
PA	USA
PE	CAN
PR	PRI
PW	PLW
QC	CAN
RI	USA
SC	USA
SD	USA
SK	CAN
TN	USA
TX	USA
UM	UMI
US	USA
UT	USA
VA	USA
VI	VIR
VT	USA
WA	USA
WI	USA
WV	USA
WY	USA
XX	ZZX
YN	CAN
YT	CAN
YY	ZZX
ZZ	ZZU

*This data is stored in the database in the StateCountry Crosswalk table. If there is a change to this Appendix the database should be updated and if the table in the database should change this Appendix should be upd

APPENDIX 32 – COUNTRY/COUNTRY/STATE CROSSWALK*

See the NAACCR website for the original crosswalk tables.

Country Numeric	Country ISO	State or Province
000	USA	US
001	USA	NN
002	USA	ME
003	USA	NH
004	USA	VT
005	USA	MA
006	USA	RI
007	USA	CT
008	USA	NJ
010	USA	US
011	USA	NY
014	USA	PA
017	USA	DE
020	USA	US
021	USA	MD
022	USA	DC
023	USA	VA
024	USA	WV
025	USA	NC
026	USA	SC
030	USA	US
031	USA	TN
033	USA	GA
035	USA	FL
037	USA	AL
039	USA	MS
040	USA	US
041	USA	MI
043	USA	OH
045	USA	IN
047	USA	KY
050	USA	US
051	USA	WI
052	USA	MN
053	USA	IA
054	USA	ND
055	USA	SD
056	USA	MT
060	USA	US
061	USA	IL
063	USA	MO
065	USA	KS
067	USA	NE
070	USA	US
071	USA	AR
073	USA	LA
075	USA	OK
077	USA	TX
080	USA	US
081	USA	ID
082	USA	WY
083	USA	CO
084	USA	UT
085	USA	NV
086	USA	NM
087	USA	AZ
090	USA	US
091	USA	AK
093	USA	WA
095	USA	OR
097	USA	CA
099	USA	HI
100	ZZN	YY
101	PRI	PR
102	VIR	VI
109	ZZN	YY
110	PAN	XX
120	ZZP	YY
121	ASM	AS
122	KIR	XX
123	FSM	FM
124	COK	XX
125	TUV	XX
126	GUM	GU
127	UMI	UM
129	MNP	MP
131	MHL	MH
132	UMI	UM
133	JPN	XX
134	JPN	XX

135	UMI	UM
136	TKL	XX
137	UMI	UM
139	PLW	PW
141	ZZP	YY
210	GRL	XX
220	CAN	CD
221	CAN	MM
222	CAN	QC
223	CAN	ON
224	CAN	PP
225	CAN	YN
226	CAN	BC
227	CAN	NU
230	MEX	XX
240	XNI	YY
241	CUB	XX
242	HTI	XX
243	DOM	XX
244	JAM	XX
245	XCB	YY
246	BMU	XX
247	BHS	XX
249	SPM	XX
250	ZZC	YY
251	GTM	XX
252	BLZ	XX
253	HND	XX
254	SLV	XX
255	NIC	XX
256	CRI	XX
257	PAN	XX
260	ZZN	YY
265	ZZU	YY
300	ZZS	YY
311	COL	XX
321	VEN	XX
331	GUY	XX
332	SUR	XX
333	GUF	XX
341	BRA	XX
345	ECU	XX
351	PER	XX
355	BOL	XX

361	CHL	XX
365	ARG	XX
371	PRY	XX
375	URY	XX
380	ZZS	YY
381	FLK	XX
400	GBR	XX
401	XEN	XX
402	WLS	XX
403	SCT	XX
404	NIR	XX
410	IRL	XX
420	XSC	YY
421	ISL	XX
423	NOR	XX
425	DNK	XX
427	SWE	XX
429	FIN	XX
430	XGR	YY
431	DEU	XX
432	NLD	XX
433	BEL	XX
434	LUX	XX
435	CHE	XX
436	AUT	XX
437	LIE	XX
440	ZZE	YY
441	FRA	XX
443	ESP	XX
445	PRT	XX
447	ITA	XX
449	ROU	XX
450	XSL	YY
451	POL	XX
452	CSK	YY
453	YUG	YY
454	BGR	XX
455	RUS	XX
456	XUM	YY
457	BLR	XX
458	EST	XX
459	LVA	XX
461	LTU	XX
463	ZZE	YY

470	ZZE	YY
471	GRC	XX
475	HUN	XX
481	ALB	XX
485	GIB	XX
490	ZZE	YY
491	MLT	XX
495	CYP	XX
499	ZZE	YY
500	ZZF	YY
510	XNF	YY
511	MAR	XX
513	DZA	XX
515	TUN	XX
517	LBY	XX
519	EGY	XX
520	XSD	YY
530	XWF	YY
531	NGA	XX
539	XWF	YY
540	XSF	YY
541	COD	XX
543	AGO	XX
545	XSF	YY
547	ZWE	XX
549	ZMB	XX
551	MWI	XX
553	MOZ	XX
555	MDG	XX
570	XEF	YY
571	TZA	XX
573	UGA	XX
575	KEN	XX
577	RWA	XX
579	BDI	XX
580	XIF	YY
581	SOM	XX
583	DJI	XX
585	XET	YY
600	ZZA	YY
610	ZZA	YY
611	TUR	XX
620	ZZA	YY
621	SYR	XX

623	LBN	XX
625	JOR	XX
627	IRQ	XX
629	XAP	YY
631	XIS	YY
633	XCR	YY
634	XOR	YY
637	IRN	XX
638	AFG	XX
639	PAK	XX
640	MDV	XX
641	IND	XX
643	NPL	XX
645	BGD	XX
647	LKA	XX
649	MMR	XX
650	XSE	YY
651	THA	XX
660	XSE	YY
661	LAO	XX
663	KHM	XX
665	VNM	XX
671	XMS	YY
673	IDN	XX
675	PHL	XX
680	ZZA	YY
681	XCH	YY
682	CHN	XX
683	HKG	XX
684	TWN	XX
685	CHN	XX
686	MAC	XX
691	MNG	XX
693	JPN	XX
695	KOR	XX
711	AUS	XX
715	NZL	XX
720	ZZP	YY
721	XML	YY
723	XMC	YY
725	XPL	YY
750	ATA	XX
997		
998	ZZX	YY

999	ZZU	ZZ

*This data is stored in the database in the CountryCountryState Crosswalk table. If there is a change to this Appendix the database should be updated and if the table in the database should change this Appendix should be updated.

HISTORICAL CHANGES

03/2015	Per NAACCR v15, CountryISO code XCZ changed to CSK and XYG changed to YUG.

APPENDIX 33 – GEOCODING INPUT RECORD LAYOUT, VERSION 6

CLICK TO OPEN THE EXCEL SPREADSHEET THAT CONTAINS THE RECORD FORMAT.

HISTORICAL CHANGES

02/2014	Appendix #33 created for Eureka's Geocoding Input Record Layout.
07/2016	Appendix #33 updated to take into account the three new County at DX Geocode fields.

APPENDIX 34 – SECONDARY DIAGNOSIS DOCUMENT RECORD LAYOUT, VERSION 1

Click to open the Excel Spreadsheet that contains the record format.

HISTORICAL CHANGES

02/2014	Appendix #34 created for Eureka's Secondary Diagnosis Document Record Layout.

HISTORICAL REVISIONS AND DATA ITEM CHANGES

2018 Data Item Changes

Revision 8.0, January 2019

- See Changes for V3, January 2019 for change activity for the 2018 Data Item Changes.

2016 Data Item Changes

Revision 7.1, April 2017

- See Changes for V3, April 2017 (effective 2016) for additional change activity for the 2016 Data Item Changes and activities up until Eureka 15.2 release in March 2017.

Revision 7.0, March 2016

- See Changes for V3 March 2016 for change activity for the 2016 Data Item Changes

2015 Data Item Changes

Revision 6.2, July 2015

- See Changes for V3 July 2015 for additional change activity included up until the Eureka 14.1 release July 2015.

Revision 6.1, March 2015

- See Changes for V3 March 2015 for additional change activity for the 2015 Data Item Changes and Edits

Revision 6.0, February 2015

- See Changes for V3 February 2015 for change activity for the 2015 Data Item Changes

2014 Data Item Changes

Revision 5.2, November 2014

- See Changes for V3 November 2014 for additional change activity included up until Eureka 13.3 release December 2014.

Revision 5.1, August 2014

- See Changes for V3 August 2014 for additional change activity included up until Eureka 13.1 release July 2014

Revision 5.0, February 2014

- See Changes for V3 February 2014 for change activity for the 2014 Data Item Changes

2013 Data Item Changes

Revision 4.1, December 2013

- See Changes for V3 December 2013 for change activity in December 2013

Revision 4.0, 05/2013

- See Changes for V3 05/2013 for change activity for the 2013 Data Item Changes

2012 Data Item Changes

Revision 3.1, February 2013

- See Changes for V3 February 2013 for the revisions made for Eureka 11 implementation

- See Changes for V3 January to May 2012
- See Changes for V3 June to December 2012

2011 Data Item Changes

Changes for V3 January to September 2011
Changes for V3 October through December 2011

2010 Data Item Changes

Changes for V3

2009 Data Item Changes

Changes for V3

2008 Data Item Changes

Changes for V3

2007 Data Item Changes

Changes for V3