SECTION THREE – CODING INSTRUCTIONS

Required Data Items

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

The following is a list of the required data items to be reported to the Maine Cancer Registry. The list is arranged according to the order that information is usually abstracted into registry software. The list includes the NAACCR item number, NAACCR item name, the diagnosis year(s) for which each data item is reportable to the MCR, and the page where the specific coding instructions can be found in this section. Section Three also includes data items that are not required by MCR, but may be related or are required by most registry software systems. **Bold items are newly required items for cases diagnosed in 2006.**

MCR Required Data Items for Hospitals, as of 1/1/06

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

CANCER IDENTIFICATION			
NAACCR Item #	**NAACCR Item Name**	**Diagnosis Year Required**	**Page Number**
400	Primary Site	All	57
560	Sequence Number – Hospital	All	58
410	Laterality	All	59
522	Histologic Type ICD-O-3	2001 +	60
523	Behavior Code ICD-O-3	2001 +	65
420	Histology ICD-O-2	1992-2000	67
430	Behavior ICD-O-2	1992-2000	68
440	Grade	All	69
490	Diagnostic Conformation	All	72
500	Type of Reporting Source	2004 +	73
610	Class of Case	2004 +	74
580	Date of 1st Contact (previously Date of Adm)	All	75
390	Date of Diagnosis	All	76
1080	Date of 1st Positive BX	2005 +	77
630	Primary Payer at DX	2004 +	78, 78A

STAGING AND EXTENT OF DISEASE INFORMATION			
NAACCR Item #	**NAACCR Item Name**	**Diagnosis Year Required**	**Page Number**
2800	CS Tumor Size	2004 +	80
2810	CS Extension	2004 +	83
2820	CS Tumor Size/Ext Eval	2004 +	85
830	Regional Nodes Examined	2001 +	87
820	Regional Nodes Positive	2001 +	88
2830	CS Lymph Nodes	2004 +	89
2840	CS Reg Nodes Eval	2004 +	92
2850	CS Mets at DX	2004 +	94
2860	CS Mets Eval	2004 +	96
2880	CS Site-Specific Factor 1	2004 +	98
2890	CS Site-Specific Factor 2	2004 +	99
2900	CS Site-Specific Factor 3	2004 +	100
2910	CS Site-Specific Factor 4	2004 +	101
2920	CS Site-Specific Factor 5	2004 +	102
2930	CS Site-Specific Factor 6	2004 +	103
760	SEER Summary Stage 1977	Prior to 2001	105
759	SEER Summary Stage 2000	2001-2003	106
1060	TNM Edition Number	Prior to 2004	108
880	TNM Path T	Prior to 2004	109
890	TNM Path N	Prior to 2004	110
900	TNM Path M	Prior to 2004	111
910	TNM Path Stage Group	Prior to 2004	112

920	TNM Path Descriptor	Prior to 2004	113
940	TNM Clin T	Prior to 2004	114
950	TNM Clin N	Prior to 2004	115
960	TNM Clin M	Prior to 2004	116
970	TNM Clin Stage Group	Prior to 2004	117
980	TNM Clin Descriptor	Prior to 2004	118
1090	Site of Distant Met 1	2005 +	119
1100	Site of Distant Met 2	2005 +	119
1110	Site of Distant Met 3	2005 +	119

FIRST COURSE OF TREATMENT/THERAPY

NAACCR Item #	NAACCR Item Name	Diagnosis Year Required	Page Number
1280	RX Date -- DX/Stg Proc (noncancer-directed surgery)	All	120
1350	RX Summ – DX/Stg Proc (if done)	2005 +	121
1270	Date of 1st Crs RX--COC (if done)	All	123
1200	RX Date -- Surgery (if done)	All	124
1290	RX Summ--Surg Prim Site (if done)	All	125
1292	RX Summ--Scope Reg LN Sur (if done)	2001 +	126
1294	RX Summ--Surg Oth Reg/Dis (if done)	2001 +	128
1646	RX Summ - Surg Site (if done)	Prior to 2003	129
1647	RX Summ - Scope Reg (if done)	Prior to 2003	130
1296	RX Summ--Reg LN Examined (if done)	Prior to 2003	131
1648	RX Summ - Surg Oth (if done)	Prior to 2003	132
1380	RX Summ - Surg/Rad Seq (if done)	All	133
1639	**RX Summ – Systemic Surg Seq (if done)**	**2006+**	**133A, B**
1340	Reason for no Surgery	All	134
1430	Reason for no Radiation	All	135
1220	RX Date--Chemo (if done)	All	136
1390	RX Summ - Chemo (if done)	All	137
1230	RX Date--Hormone (if done)	All	138
1400	RX Summ - Hormone (if done)	All	139
1240	RX Date--BRM (if done)	All	140
1410	RX Summ - BRM (if done)	All	141
None	Date Hematalogic Transplant/Endocrine Procedure	2005+	142
3250	RX Summ – Transplnt/Endocr	2005 +	143
1250	RX Date -- Other (if done)	All	144
1420	RX Summ - Other (if done)	All	145
1210	RX Date -- Radiation (if done)	All	146
1570	Rad - Regional RX Modality (if done)	All	151

DIAGNOSIS MISCELLANEOUS DATA/PATIENT STATUS

NAACCR Item #	NAACCR Item Name	Diagnosis Year Required	Page Number
2460	Physician - Managing (previously Attending)	All	158

None	Physician - Referring	All	159
1750	Date of Last Contact	2001 +	161
1760	Vital Status	2001 +	162
1910	Cause of Death (if available)	2001 +	163
1920	ICD Revision Number	2005 +	164
1940	Place of Death	2005 +	165
2330	Addr at DX--No & Street	All	166
2335	Addr at DX - Supplementl	2005 +	167
70	Addr at DX--City	All	168
80	Addr at DX--State	All	169
100	Addr at DX--Postal Code	All	171
90	County at DX	All	172
DIAGNOSIS CASE ADMIISTRATION			
NAACCR Item #	**NAACCR Item Name**	**Diagnosis Year Required**	**Page Number**
540	Reporting Hospital	2005 +	173
1460	RX Coding System--Current (if done)	All	174
2935	CS Version 1st	2004 +	175
2936	CS Version Latest	2004 +	176
TEXT FIELDS			
NAACCR Item #	**NAACCR Item Name**	**Diagnosis Year Required**	**Page Number**
2520	Text--Dx Proc--PE	All	179
2530	Text--DX Proc--X-ray/scan	All	180
2540	Text--DX Proc--Scopes	All	181
2550	Text--DX Proc--Lab Tests	All	182
2560	Text--DX Proc--Op	All	183
2570	Text--DX Proc--Path	All	184
2580	Text--Primary Site Title	All	185
2590	Text--Histology Title	All	186
2600	Text--Staging	All	187
2610	RX Text--Surgery	All	188
2620	RX Text – Radiation (Beam)	2005 +	189
2630	RX Text – Radiation Other	2005 +	190
2640	RX Text – Chemo	2005 +	191
2650	RX Text – Hormone	2005 +	192
2660	RX Text - BRM	2005 +	193
2670	RX Text - Other	2005 +	194
2680	RX Text – Remarks	2005+	195
310	Text--Usual Occupation (if available)	All	196
320	Text--Usual Industry (if available)	All	197
2690	Place of Diagnosis	2005+	198

TYPE OF REPORTING SOURCE	Item Length: 1 NAACCR Item #500 Source of Standard: SEER (Revised 01/06) Dx Yr Req by MCR: 2004+

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

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

- Code in the following priority order: 1, 2, 8, 4, 3, 5, 6, 7. This is a change to reflect the addition of codes 2 and 8 and to prioritize laboratory reports over nursing home reports. The sources facilities included in the previous code 1 (hospital inpatient and outpatient) are split between codes 1, 2 and 8.

Code Definitions

Code	Label	Definition
1	Hospital Inpatient; Managed health plans with comprehensive, unified medical records	One of the source documents used to abstract the case was from a hospital admission as an inpatient.
2	Radiation Treatment Centers or Medical Oncology Centers (hospital affiliated or independent)	One of the source documents used to abstract the case was from a Radiation Treatment Center and/or a Medical Oncology Center
3	Laboratory Only (Hospital or Private)	Source documents from a laboratory were used to abstract the case. There were no source documents from codes 1, 2, 4, 5 or 8.
4	Physician's Office/Private Medical Practitioner (LMD)	Source documents are from a physician's office that is NOT a large multi-specialty physician group practice. There were no source documents from code 1, 2, or 8.
5	Nursing/Convalescent Home/Hospice	The source documents are from a nursing or convalescent home or a hospice. There were no source documents from codes 1, 2, 4 or 8.
6	Autopsy Only	The cancer was first diagnosed on autopsy. There are no source documents from codes 1-5 or 8.
7	Death Certificate Only (Used only by central registry)	Death certificate is the only source of information; followback activities did not identify source documents from codes 1-6 or 8. If another source document is subsequently identified, the Type of Reporting Source code must be changed to the appropriate code in the range of 1-6 and 8.
8	Other hospital outpatient units/surgery centers	One of the source documents used to abstract the case was from a hospital outpatient unit/surgery center not included in code 1.

PRIMARY PAYER AT DX
[PRIMARY PAYER AT DIAGNOSIS (CoC)]

Item Length: 2
NAACCR Item #630
Source of Standard: CoC
(Rev 01/06)
Dx Yr Req by MCR: 2004+

Description: *Identifies the patient's primary payer/insurance carrier at the time of initial diagnosis and/or treatment.*

Instructions for Coding (See *FORDS Revised for 2004* pp. 67-68)

- Record the type of insurance reported on the patient's admission page.
- Codes 21 and 65-68 are to be used for patients diagnosed on or after January 1, 2006.
- If more than one payer or insurance carrier is listed on the patient's admission page record the first.
- If the patient's payer or insurance carrier changes, do not change the initially recorded code.

Code	Label	Definition
01	Not insured	Patient has no insurance and is declared a charity write-off.
02	Not insured, self-pay	Patient has no insurance and is declared responsible for charges.
10	Insurance, NOS	Type of insurance unknown or other than the types listed in codes 20, 21, 31, 35, 60-68.
20	Private Insurance: Managed Care, HMO, or PPO	An organized system of prepaid care for a group of enrollees usually within a defined geographic area. Generally formed as one of the four types: a group model, an independent physician association (IPA), a network, or a staff model. "Gate-keeper model" is another term for describing this type of insurance.
21	Private Insurance: Fee-for-Service	An insurance plan that does not have negotiated fee structure with the participating hospital. Type of insurance plan not coded as 20.
31	Medicaid	State government administered insurance for persons who are uninsured, below the poverty level, or covered under entitlement programs. Medicaid other than those described in codes 35.
35	Medicaid	Patient is enrolled in Medicaid through a Managed Care program (eg. HMO or PPO). The Managed Care plan pays for all incurred costs.
60	Medicare without supplement, Medicare, NOS	Federal government funded insurance for persons who are 62 years of age or older, or are chronically disabled (social security insurance eligible). Not described in codes 61, 62 or 63.
61	Medicare with supplement, NOS	Patient has Medicare and another type of unspecified insurance to pay costs not covered by Medicare.
62	Medicare - Administered through a Managed Care plan	Patient is enrolled in Medicare through a Managed Care plan (eg. HMO or PPO). The Managed Care plan pays for all incurred costs.

Code	Label	Definition
63	Medicare with private supplement	Patient has Medicare and private insurance to pay costs not covered by Medicare.
64	Medicare with Medicaid eligibility	Federal government Medicare insurance with State Medicaid administered supplement.
65	TRICARE	Department of Defense program providing supplementary civilian-sector hospital and medical services beyond a military treatment facility to military dependents, retirees, and their dependents. Formally CHAMPUS (Civilian Health and Medical Program of the Uniformed Services).
66	Military	Military personnel or their dependents who are treated at a military facility.
67	Veterans Affairs	Veterans who are treated in Veterans Affairs facilities.
68	Indian/Public Health Service	Patient who receives care at an Indian Health Service facility or at another facility, and the medical costs are reimbursed by the Indian Health Service. Patient receives care at a Public Health Service facility or a another facility, and medical costs are reimbursed by the Public Health Service.
99	Insurance status unknown	It is unknown from the patient's medical record whether or not the patient is insured.

RX SUMM – SYSTEMIC SURG SEQ **SYSTEMIC/SURGERY SEQUENCE**	Item Length: 1 NAACCR Item #1639 Source of Standard: CoC Dx Yr Req by MCR: 2006+ Added 01//06

Description: *Records the sequencing of systemic therapy and surgical procedures given as part of the first course of treatment.*

Instructions for Coding (See *FORDS Revised for 2004* p. 183A)

- *Systemic/Surgery Sequence* is to be used for patients diagnosed on or after January 1, 2006.
- Code the administration of systemic therapy in sequence with the first surgery performed, described in the item *Date of First Surgical Procedure* (NAACCR Item #1200).
- If none of the following surgical procedures was performed: *Surgical Procedure of Primary Site* (NAACCR Item #1290), *Scope of Regional Lymph Node Surgery* (NAACCR Item #1292), *Surgical Procedure/Other Site* (NAACCR Item #1294), then this item should be coded 0.
- If the patient received both systemic therapy and any one or a combination of the following surgical procedures: *Surgical Procedure of Primary Site* (NAACCR Item #1290), *Scope of Regional Lymph Node Surgery* (NAACCR Item #1292), or *Surgical Procedure/Other Site* (NAACCR Item #1294), then code this item 2-9, as appropriate.

Code	Label	Definition
0	No systemic therapy and/or surgical procedures	No systemic therapy was given; and/or no surgical procedure of primary site; no scope of regional lymph node surgery; no surgery to other regional site(s), distant site(s), or distant lymph node(s); or no reconstructive surgery was performed. Diagnosed at autopsy.
2	Systemic therapy before surgery	Systemic therapy was given before surgical procedure of primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.
3	Systemic therapy after surgery	Systemic therapy was given after surgical procedure of primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.
4	Systemic therapy both before and after surgery	Systemic therapy was given before and after any surgical procedure of primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.
5	Intraoperative systemic therapy	Intraoperative systemic therapy given during surgical procedure of primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
6	Intraoperative systemic therapy with other therapy administered before or after surgery	Intraoperative systemic therapy given during surgical procedure of primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s) with other systemic therapy administered before or after surgical procedure of primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.

Code	Label	Definition
9	Sequence unknown	Administration of systemic therapy and surgical procedure of primary site, scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s) were performed and the sequence of the treatment is not stated in the patient record. It is unknown if systemic therapy was administered and/or it is unknown if surgical procedure of primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s) were performed. Death certificate only.