Maryland Cancer Registry

Reporting Requirements

Updated March 2024

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Purpose

This document outlines the Maryland Cancer Registry's reporting requirements for Maryland abstractors and reporting facilities.

Introduction to the Maryland Cancer Registry (MCR)

State Cancer Registries

State cancer registries are designed to:

- Monitor cancer trends over time
- Determine cancer patterns in various populations
- Guide planning and evaluation of cancer control programs (e.g., determine whether prevention, screening, and treatment efforts are making a difference)
- Help set priorities for allocating health resources
- Advance clinical, epidemiologic, and health services research
- Provide information for a national database of cancer incidence

MCR plays an important role in research to identify causes of cancer. Researchers have used the data to identify cancer patients who could be interviewed about possible exposures they had before being diagnosed with cancer. These responses can then be compared to interview responses of people without cancer to determine whether there were different exposures.

Maryland Cancer Registry

The Maryland Cancer Registry (MCR) collects and processes information on cancer cases in Maryland. In addition, MCR provides data and produces reports on cancer incidence and mortality statewide and other geographic areas in Maryland, by gender, anatomic site (e.g. breast, lung, colon, and prostate) and stage of disease.

- In 1992, the Maryland General Assembly enacted Maryland Health-General Article, §§18-203 and 18-204. These laws required hospitals, radiation therapy centers, and in-state and out-of-state cancer diagnostic laboratories (that provide services to Maryland physicians) to electronically report all cancer cases diagnosed and/or treated in Maryland, beginning on July 1, 1993.

- In 1996, the laws were amended to require freestanding ambulatory care facilities, surgical centers, and physicians to report cancer cases diagnosed and/or treated, beginning on January 1, 1999.

- In 2001, the Maryland General Assembly enacted House bill 626, which requires the reporting of benign brain and central nervous system (CNS) tumors to MCR, effective October 2001. While these will not metastasize beyond the tissue they originated, they are treated aggressively as if they were malignant, which is one of the main reasons those cases are reported.

Through data exchange agreements with 41 other states and territories, including the neighboring states of Delaware, Pennsylvania, Virginia, and West Virginia, plus the District of Columbia, MCR receives information on all Maryland residents with diseases reportable to these jurisdictions. The MCR receives funding from the State of Maryland, the Cigarette Restitution Fund, and the Centers for Disease Control and Prevention (CDC) National Program of Cancer Registries (NPCR) and is composed of a central office and a data management contractor. The MCR central office is located within the Maryland Department of Health located at 201 West Preston Street, Baltimore, MD, 21201, and is part of the Center for Cancer Prevention and Control. It has administrative, technical, analytical, and custodial oversight of MCR data. For more information, please contact the MCR at 410-767-4055.

Reporting Requirements: Frequently Asked Questions

What is the “reference date” of MCR?

The “reference date” of MCR is the date of diagnosis. Any reportable cancer with a date of diagnosis of 1/1/1996, and any non-malignant central nervous system tumors with a date of diagnosis of 10/1/2001 must be reported to the MCR (Health-General §18-204 (b)).

Who must report to the MCR and how? (Health-General §18-204 (b))

- Each **hospital** which has care of a patient with cancer or a central nervous system tumor;
- Each **freestanding laboratory, freestanding ambulatory care facility,** or **therapeutic radiological center** which has care of or has diagnosed cancer or a central nervous system tumor for a non-hospitalized patient;
- Each **general hospice care program** or **assisted living program** which has care of a patient with a diagnosis of cancer or a central nervous system tumor or when contacted through the Maryland Cancer Registry for follow-back activities; and
- Each **physician** who has care of or has diagnosed cancer or a central nervous system tumor for a non-hospitalized patient not otherwise reported
  - A "non-hospitalized patient not otherwise reported" means a patient diagnosed or treated for cancer or a CNS tumor in a physician's office without admission to a hospital or referral to a freestanding ambulatory care facility or freestanding therapeutic radiological center (COMAR 10.14.01.02 B)

The entities in **bold** listed in the bulleted section above shall:

- Submit a cancer report to the Maryland Cancer Registry, on the form that MCR provides or in a computerized file;

- Make available to the Maryland Cancer Registry at the facility the information necessary to compile a cancer report; **or**

- Enter into a formal agreement with a hospital or other facility or agency that agrees to report to the Maryland Cancer Registry to act as the reporting source for a cancer or central nervous system tumor patient who has been referred to or from that facility, or reported to that agency with regard to cancer or central nervous system tumor screening, diagnosis, or treatment;

and shall

- Submit a cancer report in a computerized file* on a quarterly basis to the Maryland Cancer Registry all patients initially diagnosed, treated, or admitted to a facility for cancer or a central nervous system tumor during that calendar quarter.

Note: The MCR will contact reporting sources to obtain additional required information if it is not initially reported to the MCR.

* If a computerized record is not possible, the MCR will work with a reporter to accommodate reporting on *hard copy* forms if the reporter reports only a small number of cases each year (<50 cases per year).

How are these entities defined? (COMAR 10.14.01.02)

A ***hospital*** is a facility licensed by the State pursuant to COMAR 10.07.01.

A ***general hospice care program*** is defined in COMAR 10.07.21.02.

A ***freestanding laboratory*** is a facility, place, establishment, or institution that is licensed by the State to perform a laboratory examination at the request of an authorized health care provider, in connection with the diagnosis of a reportable human cancer or CNS tumor pursuant to COMAR 10.10.03, and:

a) not under the administrative control of a hospital; or

b) under the administrative control of a hospital for a diagnosis of reportable human cancer or CNS tumor of a non-hospitalized patient.

A ***freestanding ambulatory care facility*** is defined in Health-General Article, §19-3B-01, Annotated Code of Maryland.

A ***freestanding therapeutic radiological center*** is a facility, place, establishment, or institution not under the administrative control of a hospital and licensed/registered by the State to provide radiological treatment at the request of an authorized health care provider in connection with a reportable human cancer or a CNS tumor pursuant to COMAR 10.05.03, and.

A ***physician*** is an individual who practices medicine, as stated in Health Occupations Article, §14-101, Annotated Code of Maryland,

A ***non-hospitalized patient not otherwise*** **reported** is a patient diagnosed or treated for cancer or a CNS tumor in a physician's office without admission to a hospital or referral to a freestanding ambulatory care facility or freestanding therapeutic radiological center.

An ***assisted living program*** is defined in COMAR 10.07.14.02B.

What is a cancer report and what information must a report contain? (Health-General §18-204 (a) (2), COMAR 10.14.01.03)

A ***cancer report*** is a one (1)-time abstract of the medical record of a patient diagnosed or treated for cancer or a CNS tumor and contains:

(i) Reasonably obtained patient demographic information, including risk factors;
(ii) Relevant information on the:
    1. Initial histologically precise diagnosis;
    2. Initial treatment;
    3. Extent of the disease by the end of the first hospitalization using a standard nomenclature specified by the Maryland Cancer Registry; and
    4. Extent of the disease within 4 months of diagnosis using a standard nomenclature specified by the Maryland Cancer Registry if the information is available to the reporting facility and the reporting facility has a tumor registry;
(iii) Facility and other provider identification information; and
(iv) Other requirements as considered necessary by the Maryland Cancer Registry.

See Appendix 2 for a list of the fields required for reporting by type of facility/reporter

What Information collected about patients with cancer?

In 1996, when MCR started collecting data, only a minimal amount of information about the patient and tumor was collected. Over the years, as the population ages and knowledge about the disease increases, along with continued research, the volume of cancer cases has increased, and the amount of data collected for each case has expanded. Data can be divided into two major types: information pertaining to the disease process and socio-demographic information about the patient. If a person is diagnosed with more than one type of cancer in his/her lifetime, the same information is collected for each new unique tumor.

Examples of Disease-process information:

- Anatomic site of the tumor, such as breast, lung, or lymph nodes.
- Stage of disease at the time of diagnosis
- Cancer cell type, such as leukemia, melanoma, and osteosarcoma.
- Type of first course treatment rendered to destroy the tumor

Examples of Socio-demographic information:

- Age at diagnosis
- Sex
- Race
- Ethnicity
- Address at diagnosis
- Occupation
- Place of birth

Which cases of cancer, in situ, and benign tumors are reportable to the MCR? Which are excluded? (COMAR 10.14.01.02 and Health- General§18-204 (a)(3))

Report in situ and malignant cases with behavior code 2 or 3 in ICD-O-3.2; behavior code 3 in WHO Classification of Tumors of Hematopoietic and Lymphoid Tissues (2008)39 (2010+); behavior code 2 or 3 in the WHO Classification of Tumors 5th Ed. (2022+). ICD-O-3.2 and WHO Materials can be found on the NAACCR ICD-O-3 Webpage. Exceptions are noted in the Exceptions section below.

- For the Hematopoietic and Lymphoid Neoplasms, the Hematopoietic and Lymphoid Neoplasm Coding Manual and Database should be used to assist in screening and determine reportability requirements.

Reportable Diagnoses

- All malignant and in situ tumors (behavior code of 2 or 3 in ICD-O-3).
- Intraepithelial neoplasia of the following sites (abbreviation and ICD- O-3 codes):
  - vaginal squamous intraepithelial neoplasia (VAIN 8077/2),
  - vulvar squamous intraepithelial neoplasia (VIN 8077/2), and
  - anal squamous intraepithelial neoplasia (AIN III 8077/2),
  - squamous intraepithelial neoplasia, grade III (SIN III 8077/2), except cervix and skin;
- Laryngeal intraepithelial neoplasia, grade III (LIN III 8077/2, C320-C329)
- All non-malignant primary intracranial and central nervous system tumors including juvenile astrocytoma for primary sites including the brain, the cauda equina, a cranial nerve, the craniopharyngeal duct, the meninges, the pineal gland, the pituitary gland, or the spinal cord.
- Neoplasms involving plasma cells (ICD-10-CM code D47.Z9)
- Squamous or basal cell cancers of *genital* skin sites.
- High Grade Dysplasia of the Colon is reportable when the pathologist reports it as a synonym of Adenocarcinoma In-Situ of the Colon. This needs to be documented in the text of the abstract.
- Lobular Carcinoma In-Situ of the Breast is still reportable to the State of Maryland.
- Endometrial Intraepithelial Neoplasia (**EIN)** (ICD-10-CM code N85.02)

Exceptions (Not reportable)

- Squamous or basal cell cancers of *non-genital* skin sites, (except for squamous intraepithelial neoplasia, grade III (SIN III 8077/2).

- Intraepithelial neoplasia of the following sites (abbreviation and ICD- O-3 codes):
  cervical squamous intraepithelial neoplasm (CIN III 8077/2),
  and prostatic glandular intraepithelial neoplasia (PIN
  8148/2)

  Example: Final diagnosis states "Mammogram shows possible carcinoma of the breast." This case is not reportable.

Are there some tumors that may <u>not</u> be reported based on the Class of Case definitions?

MCR does not require facilities to submit Class of Case of 32 and 33.

All reporting facilities except for laboratories and physician offices may not transmit reports with the Class of Case of 40, 41, 42, 43 except where the hospital has an agreement to report cases for physician office or radiation centers.

Laboratories may not transmit reports with the Class of Case of 20, 21, 22, 40, 41, 42. Physician offices may not transmit reports with the Class of Case of 43.
In addition, physician offices may not transmit cancer reports for cases that had been previously reported by any reporter as a Class of Case 00, 10, 11, 12, 13, 14, 20, 21, 22.

The Class of case definitions are those prescribed by the most current version of the Standards for Cancer Registries Volume II: Data Standards and Data Dictionary: North American Association of Central Cancer Registries, Springfield IL at https://www.naaccr.org/data-standards-data- dictionary/.

If in doubt, call an MCR representative for assistance.

Is an out-of-state or out-of-country patient reportable to the MCR?

Yes, a cancer report **<u>must</u>** be submitted to the MCR on an **out-of-state patient if**:

- An out-of-state patient is hospitalized in a Maryland hospital.
- A non-hospitalized, out-of-state patient is treated at an ambulatory care facility in Maryland or at a therapeutic radiological center in Maryland.
- A non-hospitalized, out-of-state patient's specimen is sent to a laboratory located and licensed in Maryland; or
- A non-hospitalized, out-of-state patient is not otherwise reported to the MCR and is treated by a physician licensed in Maryland and practicing in Maryland.

Out-of-Country patients do not need to be reported but can be.

Are cases not histologically confirmed reportable?

A cancer report should be submitted for each reportable primary tumor, independent of whether the tumor was microscopically confirmed, so clinically diagnosed tumors without pathologic or cytological confirmation are reportable. In the process of interpreting the clinical or pathologic diagnosis formulated by a medical practitioner, registrars should use the Ambiguous Terminology rules.

Ambiguous Terminology

In assessing tumor reportability, reporters should use the ***ambiguous terminology*** instructions available in–Standards for Tumor Inclusion and Reportability available at Ambiguous Terminology | NAACCR Data Dictionary

T**he following ambiguous terms are considered diagnostic of cancer and must be reported:**

- apparent(ly)
- appears
- comparable with
- compatible with
- consistent with
- favors
- malignant appearing
- most likely
- presumed
- probable
- suspect(ed)
- suspicious (for)
- typical of

Example: The inpatient discharge summary documents that the patient had a chest X-ray consistent with a carcinoma of the right upper lobe. The patient refused further work-up or treatment.

**Exception: If the cytology is reported as "suspicious" and neither a positive biopsy nor a physician's clinical impression supports the cytology findings, do not consider it as a diagnosis of cancer and do NOT report.*

- **The following ambiguous terms are NOT considered diagnostic of cancer and should NOT be reported** (NAACCR Standards for Cancer Registries, Data Standards and Data Dictionary V23.0, Chapter III: Standards for Tumor Inclusion and Reportability, [COC, SEER, and NPCR agree on these terms])**:**

- apparent(ly)
- cannot be ruled out
-equivocal
-possible
-potentially malignant
- malignant appearing
-questionable
-rule out
-worrisome
-suggests

Are there some tumors that may not be reported based on the Class of Case definitions?

MCR does not require facilities to submit Class of Case of 32 and 33.

All reporting facilities except for laboratories and physician offices may not transmit reports with the Class of Case of 40, 41, 42, 43 except where the hospital has an agreement to report cases for physician office or radiation centers.

Laboratories may not transmit reports with the Class of Case of 20, 21, 22, 40, 41, 42**.**

Physician offices may not transmit reports with the Class of Case of 43.

In addition, physician offices may not transmit cancer reports for cases that had been previously reported by any reporter as a Class of Case 00, 10, 11, 12, 13, 14, 20, 21, 22.

The Class of case definitions are those prescribed by the most current version of the Standards for Cancer Registries Volume II: Data Standards and Data Dictionary: North American Association of Central Cancer Registries, Springfield IL at https://www.naaccr.org/data-standards-data-dictionary/.

If in doubt, call an MCR representative for assistance.

Is an out-of-state or out-of-country patient reportable to the MCR?

Yes, a cancer report **must** be submitted to the MCR on an **out-of-state patient if**:

- An out-of-state patient is hospitalized in a Maryland hospital;
- A non-hospitalized, out-of-state patient is treated at an ambulatory care facility in Maryland or at a therapeutic radiological center in Maryland;
- A non-hospitalized, out-of-state patient's specimen is sent to a laboratory located and licensed in Maryland; or
- A non-hospitalized, out-of-state patient is not otherwise reported to the MCR and is treated by a physician licensed in Maryland and practicing in Maryland.

Out-of-Country patients do not need to be reported but can be.

When is a Maryland resident who is diagnosed or treated out-of-state reportable to the MCR?

A laboratory licensed in Maryland pursuant to COMAR 10.14.01.B.9 but *located outside of Maryland* **must report** to the MCR for all Maryland residents who have a reportable cancer or benign brain or CNS tumor.

A physician licensed in Maryland but *practicing outside of Maryland* **must report** all Maryland residents who are not otherwise reported to the MCR and who are diagnosed and treated exclusively **in his/her Maryland offices**.

A Maryland resident admitted to an out-of-state hospital or treated at an out-of-state facility will be reported to the other state's cancer registry and the MCR will receive the report from the other state if Maryland has an interstate data sharing agreement with them.

Must a physician who gives outpatient chemotherapy to a patient report the case of cancer to the MCR?

A physician **must** report any non-hospitalized case of cancer (or benign brain or CN tumor) not previously reported to the MCR. A physician who provides outpatient chemotherapy to a patient who has been previously reported to the MCR (e.g. by a hospital), is not required to report the case. The physician must have a formal reporting agreement with the hospital cancer registry to report his/her patients to the MCR.

Please note that the MCR will contact a reporting source to obtain additional required information if it is not initially reported to the MCR (e.g., if chemotherapy treatment is not reported to the MCR by a hospital or laboratory, MCR will contact the physician to obtain additional information).

When are reports due to the MCR? (COMAR 10.14.01.04 C.)

MCR monitors the number of cases submitted by each facility and the total number of cases for a given diagnosis year. Completed cases should be submitted to MCR within six months of date of diagnosis, or date of initial contact if diagnosed elsewhere.

Reports should be submitted electronically* via MCR's Web Plus system, a minimum of four (4) times a year (quarterly). If a computerized record is not possible, the MCR will work with a reporter to accommodate reporting on *hard copy* forms if the reporter reports less than 50 cases each year.

Annual Caseload	Schedule
More than 500	Monthly
Less than 500	Monthly or Quarterly

MCR recommends the following example submission schedule to maintain timeliness:

Cases first visited in:	**Reported no later than:**
January 2023	July 2023
February 2023	August 2023
March 2023	September 2023
April 2023	October 2023
May 2023	November 2023
June 2023	December 2023
July 2023	January 2024
August 2023	February 2024
September 2023	March 2024

If you cannot make the deadline for reporting, please contact the assigned MCR representative **before** the end of the quarter.

How does the MCR maintain confidentiality of reports? Can MCR data be released? (COMAR 10.14.01.05)

The Maryland Department of Health regards all tumor data received, processed, and reported to the MCR as confidential, but the law states that information obtained by the MCR is not a medical record. The MCR manages and releases information in accordance with the laws and regulations established for and by the State of Maryland as set forth in the Code of Maryland Regulations 10.14.01, Cancer Registry, and Health-General Articles, §§18-203 and 18-204, and §§4-101—4-103 Annotated Code of Maryland.

The MCR Data Use Manual and Procedures defines how data from the registry are handled and released consistent with Maryland law. The Policy is available at: MCR Data Use and Procedures Manual.

How are MCR reports categorized by the Health Insurance Portability and Accountability Act (HIPAA)?

See Appendix 4 for information on the MCR's surveillance responsibilities and HIPAA. The MCR is a "public health authority," as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and federal regulations [see 45 CFR §164.512(a), (b), and (d) and §160.203(c)] authorize disclosure without patient consent in a number of circumstances, including the following:

> Disclosure is permitted to a public health authority authorized by law to access information to prevent/control disease, injury, disability, e.g., disease reporting, vital statistics reporting, public health surveillance, public health investigations, public health interventions and partner notification. See 45 CFR §164.512(b).

Does the MCR assure compliance with reporting requirements? (18-204 ((b) (2) and COMAR 10.14.01.06))

The MCR reporting laws and regulations permit the MCR to inspect, upon reasonable notice, a representative sample of medical records, pathology reports, and/or radiological records maintained by a reporting facility from which a cancer report should have been previously made at the facility for patients diagnosed, treated, or admitted for cancer or a CNS tumor. The MCR conducts audits of facilities consistent with these provisions, including annual disease index reviews. Disease indices are requested from each facility at the end of the year. All patients submitted within the disease index are matched with the MCR database for each facility to find potential missing cases.

What ICD-10-CM codes should be included in the "disease index" or case finding list? What data elements should be on the list?

When the disease index request is sent out to facilities annually at the end of each year, the email request

includes the Disease Index Instructions, Letter, and Certification as attachments. The disease index instructions include the correct codes that should be included in the disease index/case finding list. Noted within the disease index request email, is also a request for a list of non-reportable class of case 32 and 33's.
Appendix 5 provides specific instructions on how to format and upload a disease index.
Appendix 6 provides the ICD-10-CM codes to be included in the disease index or case finding list.
Appendix 7 provides specific instructions on how to290 format the non-reportable class of case 32/33 list.

Appendix 1: Laws and Regulations

Annotated Code of Maryland
Article - HEALTH - GENERAL
TITLE 18. DISEASE PREVENTION
SUBTITLE 2. REPORTS; PREVENTIVE ACTIONS
PART I. REPORTS ON DISEASES

§ 18-203. Information provided to a cancer control agency in another state

Notwithstanding any other provision of law, the Department may provide patient-identifying information for patients treated in this State for cancer to a cancer control agency in another state if:
(1) The patient is a resident of the other state;
(2) The Department determines that the agency will preserve the confidentiality of the information; and
(3) The other state has the authority to provide equivalent information on Maryland residents to this State.

§ 18-204. Cancer or a central nervous system tumor

(a) Definitions. --

(1) In this section the following words have the meanings indicated.

(2) "Cancer report" means a 1-time abstract of the medical record of a patient diagnosed or treated for cancer or a central nervous system tumor which contains:
(i) Reasonably obtained patient demographic information, including risk factors;
(ii) Relevant information on the:
1. Initial histologically precise diagnosis;
2. Initial treatment;
3. Extent of the disease by the end of the first hospitalization; and
4. Extent of the disease within 2 months of diagnosis if the information is available to the reporting facility and the reporting facility has a tumor registry; and
(iii) Facility and other provider identification information.

(3) (i) "Central nervous system tumor" means, irrespective of histologic type or behavior, a primary tumor in the following sites:
1. The brain;
2. The cauda equina;
3. A cranial nerve;
4. The craniopharyngeal duct;
5. The meninges;
6. The pineal gland;
7. The pituitary gland; or
8. The spinal cord.
(ii) "Central nervous system tumor" includes a primary intracranial tumor.

(4) "Freestanding ambulatory care facility" has the meaning stated in § 19-3B-01 of this article.
(b) Requirements; inspection of records; confidentiality requirements; liability; regulations; annual report. --

(1) Each hospital which has care of a patient with cancer or a central nervous system tumor, each freestanding laboratory, freestanding ambulatory care facility, or therapeutic radiological center which has care of or has diagnosed cancer or a central nervous system tumor for a non-hospitalized patient, and each physician who has care of or has diagnosed cancer or a central nervous system tumor for a non-hospitalized patient not otherwise reported shall:

(i) 1. Submit a cancer report to the Maryland Cancer Registry, on the form that the Maryland Cancer Registry provides or in a computerized file;

2. Make available to the Maryland Cancer Registry, or an agent of the Maryland Cancer Registry, at the facility the information necessary to compile a cancer report; or

3. Enter into an agreement with a hospital or other facility or agency that agrees to report to the Maryland Cancer Registry to act as the reporting source for a cancer or central nervous system tumor patient who has been referred to or from that facility, or reported to that agency with regard to cancer or central nervous system tumor screening, diagnosis, or treatment; and

(ii) Effective July 1, 1993, submit a cancer report in a computerized file on a quarterly basis to the Maryland Cancer Registry, or an agent of the Maryland Cancer Registry, for all patients initially diagnosed, treated, or admitted to a facility for cancer or a central nervous system tumor during that calendar quarter.

(2) To assure compliance with this section, the Maryland Cancer Registry, or an agent of the Maryland Cancer Registry, may inspect upon reasonable notice a representative sample of the medical records of patients diagnosed, treated, or admitted for cancer or a central nervous system tumor at the facility.

(3) (i) Information obtained under this subsection shall be confidential and subject to Title 4, Subtitle 1 of this article.

(ii) This subsection does not apply to a disclosure by the Maryland Cancer Registry to another governmental agency performing its lawful duties pursuant to State or federal law where the Maryland Cancer Registry determines that the agency to whom the information is disclosed will maintain the confidentiality of the disclosure.

(iii) A cancer report is not a medical record under Title 4, Subtitle 3 of this article, but is subject to the confidentiality requirements of Title 4, Subtitle 1 of this article.

(4) Each hospital, freestanding laboratory, freestanding ambulatory care facility, therapeutic radiological center, or physician who in good faith submits a cancer report to the Maryland Cancer Registry is not liable in any cause of action arising from the submission of the report.

(5) The Maryland Cancer Registry, after consultation with the Cancer Registry Advisory Committee, the Maryland Hospital Association, and representatives of freestanding laboratories and therapeutic radiological centers, shall adopt regulations to implement the requirements of this section.

(6) The Maryland Cancer Registry, in accordance with § 2-1246 of the State Government Article, shall submit an annual report to the Governor and General Assembly on the activities of the cancer registry, including utilization of cancer registry data.

HISTORY: 1991, ch. 469, § 3; 1996, ch. 235; 1997, ch. 635, § 9; ch. 636, § 9; 2001, ch. 251; 2009, ch. 60, § 5.

Title 10 DEPARTMENT OF HEALTH
Subtitle 14 CANCER CONTROL
Chapter 01 Cancer Registry

Authority: Health-General Article, §§ 2-104, 18-104, 18-203 and 18-204, Annotated Code of Maryland; 42 U.S.C. §280(e)

.01 Scope.

This chapter establishes a cancer registry within the Department, defines key terms, details the information to be contained in a cancer report, and specifies requirements of reporting facilities, nursing facilities, assisted living programs, and general hospice care programs. In addition, this chapter identifies requestors authorized to receive confidential data, allows a fee to be charged for data reports, and incorporates by reference the Maryland Cancer Registry Data Use Manual and Procedures (July 2016).

.02 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) "Assisted living program" has the meaning stated in COMAR 10.07.14.02B.

(2) "Cancer registry" means a computerized system to register all cases of reportable human cancer or reportable human central nervous system (CNS) tumors of Maryland residents and nonresidents diagnosed or treated in Maryland.

(3) "Cancer report" means a one-time abstract from one or more of the following documents maintained by a reporting facility, nursing facility, assisted living program, or general hospice care program of each new case of reportable human cancer or CNS tumor diagnosed or treated, and any other case of reportable human cancer or CNS tumor initially diagnosed or treated for time periods as designated by the Maryland Cancer Registry:

(a) Medical record;

(b) Pathology report; and

(c) Radiological report.

(4) Case of a Reportable Human CNS Tumor.

(a) "Case of a reportable human CNS tumor" means an identified human tumor, irrespective of histologic type or behavior, occurring as a primary tumor in any of the following sites or sub-sites with International Classification of Diseases for Oncology, Third Edition (ICD-O-3) topography codes C70.0—C72.9 and C75.1—C75.3:

(i) The brain;

(ii) The meninges;

(iii) The spinal cord;

(iv) The cauda equina;

(v) A cranial nerve;

(vi) The pituitary gland;

(vii) The pineal gland; or

(viii) The craniopharyngeal duct.

(b) "Case of a reportable human CNS tumor" includes all benign and uncertain behavior tumors of the CNS (ICD-10-CM Codes D18.02, D32.0—D33.9, D35.2—D35.4, D42.0 – D43.9, D44.3 – D44.5, Q85.00 – Q85.09 and D49.6, and all tumors of the CNS of benign and uncertain behavior with ICD-O-3 codes of "0" or "1"), which includes codes from:

(i) The International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM); and

(ii) The International Classification of Diseases for Oncology, Third Edition (ICD-O-3).

(5) "Case of reportable human cancer" means the identification of a human cancer from the following list, which includes codes from the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) and the International Classification of Diseases for Oncology, Third Edition (ICD-O-3):

(a) All malignant neoplasms with ICD-10-CM Codes C00 – C43.9, C44.00, C44.09, C44.10_, C44.19_, C44.20_, C44.29_, C44.30_, C44.39_, C44.40, C44.49, C44.50_, C44.59_, C44.60_, C44.69_, C44.70_, C44.79_, C44.80, C44.89, C44.90, C44.99, C45._ – C77._, and C80._ - C96._ or ICD-O-3 behavior code of "3", **including** genital skin cancer of the vagina, clitoris, vulva, prepuce, penis, and scrotum and **excluding** other sites of skin cancer with ICD-O-3 topography codes C44.0—C44.9 with one of the following ICD-O-3 histologies (M-XXXX):

(i) M-8000—8005 Neoplasms, malignant, not otherwise specified of skin;

(ii) M-8010—8046 Epithelial carcinomas of skin;

(iii) M-8050—8084 Papillary and squamous cell carcinomas of skin (C44.02, C44.12_, C44.22_, C44.32_, C44.42, C44.52_, C44.62_, C44.72_, C44.82, C44.92); or

(iv) M-8090—8110 Basal cell carcinomas (C44.01, C44.11_, C44.21_, C44.31_, C44.41, C44.51_, C44.61_, C44.71_, C44.81, C44.91);

(b) All malignant neoplasms with the following ICD-10-CM codes where ICD-O-3 behavior is "3" and ICD-O-3 histologies (M-XXXX) are reported (unless otherwise specified):

(i) *If there is evidence of multiple foci, lymph node involvement, or metastasis,* C37—Thymoma (M-8580);

(ii) C7A.020—Malignant carcinoid tumor of the appendix (M-8240);

(iii) C54.1—Endometrial stroma, low grade (M-8931);

(iv) If there is evidence of multiple foci, lymph node involvement, or metastasis, D48.1—Stromal Tumor of the digestive system (GIST 8639);

(v) D48.60—Phyllodes tumor (M-9020);

(vi) D45—Polycythemia (M-9950);

(vii) D47.Z9—Plasmacytoma (M-9731, M-9734);

(viii) D47.3—Essential thrombocythemia (M-9962);

D46.0, D46.1, D46.20, D46.21, D46A, D46B—Low grade myelodysplastic syndrome lesions (M-9980);

D46.22—High grade myelodysplastic syndrome lesions (M-9983); D46.C—Myelodysplastic syndrome with 5q deletion (M-9986); D46.9—Myelodysplastic syndrome, unspecified (M-9975);

D47.1—Myelofibrosis with myeloid metaplasia (primary myelofibrosis) (M-9961);

D47.Z1—post-transplant lymphoproliferative disorder (M-9989)

C94.40, C94.41, C94.42, D47.9, D47.Z9—lympho and myeloproliferative disease (M-9960, M-9970);

(ix) D89.1—Alpha and gamma heavy chain disease (M-9762) or Franklin disease (M-9763); or

(x) C88.0—Waldenstrom macroglobulinemia (M-9761);

(xi) D46.4—Refractory anemia (M-9980); or

(xii) D46.1—Refractory anemia with ringed sideroblasts (M-9982), refractory anemia with excess blasts (M-9983), or refractory anemia with excess blasts in transformation (M-9984);

(c) All cases of carcinoma in situ with ICD-10-CM Codes D00—D09, D47.Z2, D49.511—D49.519, D49.59, D78.31—D78.34, and D89.40—D89.49 or with ICD-O-3 behavior code of "2", **including** genital skin cancers of the vagina, clitoris, vulva, prepuce, penis, and scrotum **and excluding** other skin cancers with ICD-O-3 topography codes C44.0_—C44.9_ with one of the following ICD-O-3 histologies:

(i) M-8000—8005 Neoplasms, malignant, not otherwise specified of skin;

(ii) M-8010—8046 Epithelial carcinomas of skin;

(iii) M-8050—8084 Papillary and squamous cell carcinomas of skin; and

(iv) M-8090—8110 Basal cell carcinomas; or

(d) All cases of intraepithelial neoplasia with ICD-O-3 histology code of M-8077/2:

(i) Including squamous intraepithelial neoplasia of the larynx (LIN), vagina (VAIN), vulva (VIN), and anus (AIN) (ICD-10-CM codes D02.0; D07.2; D70.1; D01.3; and ICD-O-3 topography codes C52, C51, and C21._); and

(ii) Excluding squamous intraepithelial neoplasia of the cervix (CIN III) and glandular intraepithelial neoplasia of the prostate (PIN) (ICD-10-CM codes D06.9_ and D07.5; and ICD-O-3 topography codes C53._ and C61.9).

(6) "Computerized file" means an electronic data file using software approved for use by the Maryland Cancer Registry, containing complete cancer report information transferable to a master electronic database system maintained by the Department.

(7) "Department" means the Department of Health or a designee.

(8) "Freestanding ambulatory care facility" has the meaning stated in Health-General Article, §19-3B-01, Annotated Code of Maryland.

(9) "Freestanding laboratory" means a facility, place, establishment, or institution which performs a laboratory examination for a person, authorized by law to request the examination, in connection with the diagnosis of a reportable human cancer or CNS tumor, and is licensed by the State pursuant to COMAR 10.10.03, and:

(a) Not under the administrative control of a hospital; or

(b) Under the administrative control of a hospital for a diagnosis of reportable human cancer or CNS tumor of a non-hospitalized patient.

(10) “General hospice care program” has the meaning stated in COMAR 10.07.21.02.

(11) "Hospital" means a facility which is licensed by the State pursuant to COMAR 10.07.01.

(11-1) “Maryland Cancer Registry Data Use Manual and Procedures” means the document that describes the Maryland cancer registry procedures for release of cancer data and that outlines the procedures to obtain both non-confidential aggregate data and confidential individual-level data.

(12) "Nursing facility" has the meaning stated in COMAR 10.07.02.01B.

(13) "Physician" means an individual who:

(a) Practices medicine, as defined in Health Occupations Article, §14-101, Annotated Code of Maryland; and

(b) Diagnoses or treats a case of reportable human cancer or a reportable human CNS tumor at a practice located in Maryland.

(14) "Reporting facility" means any of the following:

(a) A hospital, freestanding laboratory, freestanding ambulatory care facility, or therapeutic radiological center; or

(b) A physician who has care of or has diagnosed a case of reportable human cancer

or reportable human CNS tumor for a non-hospitalized patient not otherwise reported.

(15) "Maryland Cancer Registry" means the Maryland Cancer Registry of Health or a designee of the Maryland Cancer Registry.

(16) "Therapeutic radiological center" means a facility or institution:

(a) Performing radiological treatment for a person authorized by law to request the treatment in connection with a reportable human cancer or a reportable human CNS tumor; and

(b) Licensed or registered by the State pursuant to COMAR 10.05.03 and not under the administrative control of a hospital.

.02-1 Incorporation by Reference.

The Maryland Cancer Registry Data Use Manual and Procedures (Maryland Department of Health, July 2016) is incorporated by reference.

.03 Establishment of a Cancer Registry.

There is a cancer registry established within the Department, whose purpose is to collect reportable human cancer data and reportable human CNS tumor data to further the cancer control goals of the State.

.04 Cancer Control Goals of the State.

A. The cancer control goals of the State are to reduce the incidence and mortality of reportable human cancer and reportable human CNS tumors and racial, ethnic, gender, age, and geographic disparities in reportable human cancer and CNS tumor incidence and mortality in Maryland, by:

(1) Advancing the understanding of reportable human cancer and reportable human CNS tumor demographics;

(2) Describing reportable human cancer and reportable human CNS tumor sources, causes, risk factors, preventive measures, diagnostic tests, screening tests, treatment, and survival; and

(3) Evaluating the cost, quality, efficacy, and appropriateness of diagnostic, therapeutic, rehabilitative, and preventive services and programs related to reportable human cancer and reportable human CNS tumors.

B. Research that will further the cancer control goals of the State is research whose protocols have been reviewed by Department staff who have found that the research will:

(1) Advance scientific knowledge or advance knowledge of clinical practice related to cancer;

(2) Have approaches, aims, and methods that will allow the researcher to perform descriptive analyses or test hypotheses;

(3) Have one or more investigators who have training and experience with the approaches and methods; and

(4) Be conducted in a scientific environment likely to contribute to the success of the research.

.05 Content of a Cancer Report.

A cancer report shall contain the following information, using the standard nomenclature contained in the North American Association of Central Cancer Registries' Standards for Cancer Registries, Volume II, Data Standards and Data Dictionary:

A. Reasonably obtained patient demographic information, including risk factors;

B. Information on the industrial or occupational history of an individual with cancer, to the extent such information is available;

C. Relevant information on the:

(1) Initial diagnosis, including the date of the diagnosis;

(2) Initial treatment;

(3) Extent of the disease by the end of the first hospitalization; and

(4) Extent of the disease within 2 months of diagnosis, if the information is available to the reporting facility, nursing facility, assisted living program, or general hospice care program;

D. Facility and other provider identification information; and

E. Other requirements as considered necessary by the Maryland Cancer Registry.

.06 Reporting Requirements.

A. A reporting facility shall submit a:

(1) Cancer report to the Maryland Cancer Registry in a computerized file containing standard information required by the Maryland Cancer Registry;

(2) Computerized file not less than quarterly; and

(3) Completed report of any new individual case of a reportable human cancer or reportable human CNS tumor not later than 6 months after diagnosis or treatment.

B. A nursing facility, an assisted living program, or general hospice care program shall submit a cancer report containing information that is under the control of the facility to the Maryland Cancer Registry if the Maryland Cancer Registry requests a cancer report on a patient who has been a resident of the nursing facility, assisted living program, or general hospice care program.

.07 Confidentiality of Cancer Reports.

A. Information obtained under this chapter is not a medical record under Health-General Article, §4-301, Annotated Code of Maryland, but is subject to the confidentiality requirements of Health-General Article, §§4-101—4-103, Annotated Code of Maryland.

B. The Maryland Cancer Registry may release confidential data to:

(1) An institution or individual researcher for medical, epidemiological, health care, or other cancer-related or CNS tumor-related research approved by the Maryland Cancer Registry and the Department's Institutional Review Board (IRB) in order to further the cancer control goals of the State set forth in Regulation .04 of this chapter;

(2) A reporting facility which:

(a) Routinely submits information on cases of reportable human cancer or reportable human CNS tumors to the cancer registry;

(b) Has been formally accepted as a participant in the cancer registry system; and

(c) Requests data relating to patients reported by the facility;

(3) An out-of-State cancer registry or cancer control agency which requests routine data if the:

(a) Patient is a resident of the other state; and

(b) Other state has authority to provide equivalent information on Maryland residents

to this State;

(4) Each county health officer and the Baltimore City Commissioner of Health; and

(5) Another governmental agency performing its lawful duties pursuant to State or federal law.

C. The Maryland Cancer Registry may release confidential information, subject to:

(1) A determination by the Maryland Cancer Registry that a recipient of the information disclosed will maintain the confidentiality of the disclosed information; and

(2) An agreement signed by the Maryland Cancer Registry and by the recipient of the confidential information that the recipient of the information will maintain the confidentiality of the disclosed information.

D. The Maryland Cancer Registry shall release confidential data to a requestor in response to a written request only, in accordance with Health-General Article, §§4-101 and 4-102, Annotated Code of Maryland.

E. A reporting facility that in good faith submits a cancer report to the Maryland Cancer Registry is not liable for any cause of action arising from the submission of the cancer report to the Maryland Cancer Registry.

F. The use or publication of any statistics, information, or other material that summarizes or refers to confidential records in the aggregate, without disclosing the identity of any person who is the subject of the confidential record is not subject to the provisions of Health-General Article, §4-102, Annotated Code of Maryland.

G. The Maryland Cancer Registry shall release cancer data in accordance with the procedures outlined in the Maryland Cancer Registry Data Use Manual and Procedures (July 2016).

.08 Authority and Requirements of the Maryland Cancer Registry.

A. To assure compliance by a reporting facility, nursing facility, assisted living program, or general hospice care program with Regulation .05 of this chapter, the Maryland Cancer Registry may, upon advance notice, inspect a representative sample of medical records, pathology reports, or radiological reports maintained by the facility of cases of reportable human cancer and reportable human CNS tumors.

B. The Maryland Cancer Registry may charge a reasonable fee to cover the cost of providing data reports to appropriate requestors, as allowed by COMAR 10.01.08.04. All applicable fees shall be paid in full in advance of filling the request.

C. After receiving all necessary information to support a request to release cancer registry data, the Maryland Cancer Registry shall act in a timely manner and decide on the request with one of the following outcomes:

(1) Final approval;

(2) Interim approval, if the request has been accepted with one or more conditions which shall be met before final approval is granted; or

(3) Disapproval.

D. The Maryland Cancer Registry, in accordance with State Government Article, §2-1246, Annotated Code of Maryland, shall submit an annual report to the Governor and General Assembly on the activities of the cancer registry, including use of cancer registry data.

E. Nothing in this chapter is intended to limit or otherwise restrict the Maryland Cancer Registry from obtaining cancer report information on Maryland residents from sources located either inside or outside the State.

10.14.01.9999

Administrative History

Effective date: September 28, 1992 (19:19 Md. R. 1707)
Regulation .01 amended effective April 21, 1997 (24:8 Md. R. 616)
Regulation .02B amended effective April 26, 1993 (20:8 Md. R. 723); April 21, 1997 (24:8 Md. R. 616); June 23, 2003 (30:12 Md. R. 788)
Regulation .04 amended effective April 21, 1997 (24:8 Md. R. 616)
Regulation .04C amended effective June 23, 2003 (30:12 Md. R. 788)
Regulation .05B amended effective June 23, 2003 (30:12 Md. R. 788)
Regulation .06B, D amended effective June 23, 2003 (30:12 Md. R. 788)

Chapter revised effective March 22, 2010 (37:6 Md. R. 478)
Regulation .01 amended effective January 13, 2011 (38:1 Md. R. 11); April 15, 2013 (40:7 Md. R. 611); February 27, 2017 (44:4 Md. R. 253)
Regulation .02B amended effective January 13, 2011 (38:1 Md. R. 11); April 15, 2013 (40:7 Md. R. 611); February 27, 2017 (44:4 Md. R. 253)
Regulation .02-1 adopted effective April 15, 2013 (40:7 Md. R. 611)
Regulation .02-1 amended effective February 27, 2017 (44:4 Md. R. 253)
Regulation .05C amended effective January 13, 2011 (38:1 Md. R. 11)
Regulation .06B amended effective January 13, 2011 (38:1 Md. R. 11)
Regulation .07G adopted effective April 15, 2013 (40:7 Md. R. 611)
Regulation .07G amended effective February 27, 2017 (44:4 Md. R. 253)
Regulation .08A amended effective January 13, 2011 (38:1 Md. R. 11)

Appendix 2: Required Fields and Summary of Changes

The Required Fields by type of Reporter for the State of Maryland:

NAACCR Item #	Required Data Items	Hosp	Rad/MD Office	Amb Sur/ Labs	Standard Setter	Newfor V23
570	Abstracted By	R	R	R	CoC	
550	Accession Number--Hosp	R	R	.	CoC	
70	Addr at DX--City	R	R	R	CoC	
102	Addr at DX--Country	R	R	.	NAACCR	
2330	Addr at DX--No & Street	R	R	R	SEER	
100	Addr at DX--Postal Code	R	R	R	CoC	
80	Addr at DX--State	R	R	R	CoC	
2335	Addr at DX--Supplemental	R*	R*	R	SEER	
1810	Addr Current--City	R	.	.	SEER	
1832	Addr Current--Country	R	.	.	NAACCR	
2350	Addr Current--No & Street	R	R	.	SEER	
1830	Addr Current--Postal Code	R	.	.	SEER	
1820	Addr Current--State	R	.	.	SEER	
2355	Addr Current--supplement	R*	R*	.	SEER	
3803	Adenoid Cystic Basaloid Pattern	RS			NAACCR	
3804	Adenopathy	RS			NAACCR	
3805	AFP Post-Orchiectomy Lab Value	RS			NAACCR	
3806	AFP Post-Orchiectomy Range	RS			NAACCR	
3807	AFPPre-Orchiectomy Lab Value	RS			NAACCR	
3808	AFP Pre-Orchiectomy Range	RS			NAACCR	
3809	AFPPretreatment Interpretation	RS			NAACCR	
3810	AFP Pretreatment Lab Value	RS			NAACCR	
230	Age at Diagnosis	R	R		SEER/CoC	
995	AJCC ID	D			NAACCR	
1003	AJCC TNM Clin M	R			AJCC	
1002	AJCC TNM Clin N	R			AJCC	
1034	AJCC TNM Clin N Suffix	R			AJCC	
1004	AJCC TNM Clin Stage Group	R			AJCC	
1001	AJCC TNM Clin T	R			AJCC	
1031	AJCC TNM Clin T Suffix	R			AJCC	
1013	AJCC TNM Path M	R			AJCC	
1012	AJCC TNM Path N	R			AJCC	
1035	AJCC TNM Path N Suffix	R			AJCC	
1014	AJCC TNM Path Stage Group	R			AJCC	
1011	AJCC TNM Path T	R			AJCC	

NAACCR Item #	Required Data Items	Hosp	Rad/MD Office	Amb Sur/ Labs	Standard Setter	Newfor V23
1032	AJCC TNM Path T Suffix	R			AJCC	
1023	AJCC TNM Post Therapy M	R			AJCC	
1022	AJCC TNM Post Therapy N	R			AJCC	
1036	AJCC TNM Post Therapy N Suffix	R			AJCC	
1024	AJCCTNMPost Therapy Stage Group	R			AJCC	
1021	AJCC TNM Post Therapy T	R			AJCC	
1033	AJCC TNM Post Therapy T Suffix	R			AJCC	
3938	Alk Rearrangement				NAACCR	
442	Ambiguous Terminology DX	RH	RH	.	SEER	
3811	Anemia	RS			NAACCR	
3100	Archive FIN	R	R	.	CoC	
1930	Autopsy	.	.	.	NAACCR	
3812	B symptoms	RS			NAACCR	
430	Behavior (92-00) ICD-O-2	RH	RH	.	SEER/CoC	
523	Behavior Code ICD-O-3	R	R	R	SEER/CoC	
3813	Bilirubin Pretreatment Total Lab Value	RS			NAACCR	
3814	Bilirubin Pretreatment Unit of Measure	RS			NAACCR	
254	Birthplace--Country	R	R	.	NAACCR	
252	Birthplace--State	R	R	.	NAACCR	
3815	Bone Invasion	RS			NAACCR	
3816	Brain Molecular Markers	.			NAACCR	
3817	Breslow Tumor Thickness	RS			NAACCR	
3818	CA-125 Pretreatment Interpretation	RS			NAACCR	
1770	Cancer Status	R	R	.	CoC	
501	Casefinding Source	.	R	R	NAACCR	
1910	Cause of Death	.	.	.	SEER	
3819	CEAPretreatment Interpretation	RS			NAACCR	
3820	CEA Pretreatment Lab Value	RS			NAACCR	
362	Census Block Group 2000	.			Census	
363	Census Block Group 2010	.			Census	
361	Census Block Group 2020	.			Census	
368	Census Block Grp 1970/80/90	.			Census	
120	Census Cod Sys 1970/80/90	.			SEER	

NAACCR Item #	Required Data Items	Hosp	Rad/MD Office	Amb Sur/ Labs	Standard Setter	Newfor V23
280	Census Ind Code 1970-2000	.			Census/ NPCR	
272	Census Ind Code 2010 CDC	.			Census/ NPCR	
270	Census Occ Code 1970-2000	.			Census/ NPCR	
282	Census Occ Code 2010 CDC	.			Census/ NPCR	
330	Census Occ/Ind Sys 70-00	.			NPCR	
364	Census Tr Cert 1970/80/90	.			SEER	
365	Census Tr Certainty 2000	.			NAACCR	
367	Census Tr Certainty 2010	.			NAACCR	
145	Census Tr Poverty Indictr	.			NAACCR	
110	Census Tract 1970/80/90	.			SEER	
130	Census Tract 2000	.			NAACCR	
135	Census Tract 2010	.			NAACCR	
125	Census Tract 2020	.			NAACCR	
369	Census Tract Certainty 2020	.			NAACCR	
3802	Chromosome19q: Loss of Heterozygosity (LOH)	RS			NAACCR	
3801	Chromosome1p: Loss of Heterozygosity (LOH)	RS			NAACCR	
3821	Chromosome 3 Status	RS			NAACCR	
3822	Chromosome 8q Status	RS			NAACCR	
3823	CircumferentialResection Margin (CRM)	RS			NAACCR	
3961	Clinical Margin Width	.			CoC	**New**
610	Class of Case	R	R	R	CoC	
2152	CoC Accredited Flag	.			NPCR	
2140	CoC Coding Sys--Current	R	R	.	CoC	
2150	CoC Coding Sys--Original	R	R	.	CoC	
870	Coding System for EOD	.			SEER	
3110	Comorbid/Complication 1	RH	R	.	CoC	
3164	Comorbid/Complication 10	RH	R	.	CoC	
3120	Comorbid/Complication 2	RH	R	.	CoC	
3130	Comorbid/Complication 3	RH	R	.	CoC	
3140	Comorbid/Complication 4	RH	R	.	CoC	
3150	Comorbid/Complication 5	RH	R	.	CoC	
3160	Comorbid/Complication 6	RH	R	.	CoC	
3161	Comorbid/Complication 7	RH	R	.	CoC	
3162	Comorbid/Complication 8	RH	R	.	CoC	

NAACCR Item #	Required Data Items	Hosp	Rad/MD Office	Amb Sur/ Labs	Standard Setter	Newfor V23
3163	Comorbid/Complication 9	RH	R	.	CoC	
200	Computed Ethnicity	.	.	.	SEER	
210	Computed Ethnicity Source	.	.	.	SEER	
94	County at DX Geocode 1970/80/90	.			NAACCR	
95	County at DX Geocode2000	.			NAACCR	
96	County at DX Geocode2010	.			NAACCR	
97	County at DX Geocode2020	.			NAACCR	
90	County at DX Reported	R	R	.	FIPS/SEER	
1840	County--Current	.			NAACCR	
2081	CRC CHECKSUM	.			NAACCR	
3824	Creatinine Pretreatment Lab Value	RS			NAACCR	
3825	Creatinine Pretreatment Unit of Measure	RS			NAACCR	
2810	CS Extension	RH	RH	RH	AJCC	
2830	CS Lymph Nodes	RH	RH	RH	AJCC	
2840	CS Lymph Nodes Eval	RH	RH	RH	AJCC	
2850	CS Mets at DX	RH	RH	RH	AJCC	
2851	CS Mets at Dx-Bone	RH	RH	RH	AJCC	
2852	CS Mets at Dx-Brain	RH	RH	RH	AJCC	
2853	CS Mets at Dx-Liver	RH	RH	RH	AJCC	
2854	CS Mets at Dx-Lung	RH	RH	RH	AJCC	
2860	CS Mets Eval	RH	RH	RH	AJCC	
2880	CS Site-Specific Factor 1	RH	RH	.	AJCC	
2890	CS Site-Specific Factor 2	RH	RH	.	AJCC	
2900	CS Site-Specific Factor 3	RH	RH	.	AJCC	
2910	CS Site-Specific Factor 4	RH	RH	.	AJCC	
2920	CS Site-Specific Factor 5	RH	RH	.	AJCC	
2930	CS Site-Specific Factor 6	RH	RH	.	AJCC	
2861	CS Site-Specific Factor 7	RH	RH	.	AJCC	
2862	CS Site-Specific Factor 8	RH	RH	.	AJCC	
2863	CS Site-Specific Factor 9	RH	RH	.	AJCC	
2864	CS Site-Specific Factor10	RH	RH	.	AJCC	
2865	CS Site-Specific Factor11	RH	RH	.	AJCC	
2866	CS Site-Specific Factor12	RH	RH	.	AJCC	
2867	CS Site-Specific Factor13	RH	RH	.	AJCC	
2868	CS Site-Specific Factor14	RH	RH	.	AJCC	
2869	CS Site-Specific Factor15	RH	RH	.	AJCC	
2870	CS Site-Specific Factor16	RH	RH	.	AJCC	
2871	CS Site-Specific Factor17	RH	RH	.	AJCC	

NAACCR Item #	Required Data Items	Hosp	Rad/MD Office	Amb Sur/ Labs	Standard Setter	Newfor V23
2872	CS Site-Specific Factor18	RH	RH	.	AJCC	
2873	CS Site-Specific Factor19	RH	RH	.	AJCC	
2874	CS Site-Specific Factor20	RH	RH	.	AJCC	
2875	CS Site-Specific Factor21	RH	RH	.	AJCC	
2876	CS Site-Specific Factor22	RH	RH	.	AJCC	
2877	CS Site-Specific Factor23	RH	RH	.	AJCC	
2878	CS Site-Specific Factor24	RH	RH	.	AJCC	
2879	CS Site-Specific Factor25	RH	RH	.	AJCC	
2800	CS Tumor Size	RH	RH	RH	AJCC	
2820	CS Tumor Size/Ext Eval	RH	RH	RH	AJCC	
2936	CS Version Derived	DH	DH	DH	AJCC	
2937	CS Version Input Current	RH	RH	RH	AJCC	
2935	CS Version Input Original	RH	RH	RH	AJCC	
1270	Date 1st Crs RX CoC	R	R	R	CoC	
1271	Date 1st Crs RX CoC Flag	R	R	R	NAACCR	
2090	Date Case Completed	.	.	.	NAACCR	
2092	Date Case Completed--CoC	D	D	.	CoC	
2085	Date Case Initiated	.	.	.	NAACCR	
2100	Date Case Last Changed	D	D	.	NAACCR	
2110	Date Case Report Exported	R	R	R	NPCR	
2112	Date Case Report Loaded	R	R	R	NPCR	
2111	Date Case Report Received	R	R	R	NPCR	
443	Date Conclusive DX	RH	RH	.	SEER	
1260	Date Initial RX SEER	.	.	.	SEER	
580	Date of 1st Contact	R	R	R	CoC	
240	Date of Birth	R	R	R	SEER/CoC	
1755	Date of Death--Canada	.			CCCR	
390	Date of Diagnosis	R	R	R	SEER/CoC	
590	Date of Inpt Adm	.			NAACCR	
600	Date of Inpt Disch	.			NAACCR	
1772	Date of Last Cancer (tumor) Status	R			CoC	
1750	Date of Last Contact	R			SEER/CoC	
445	Date of Mult Tumors	RH	RH	.	SEER	
832	Date of Sentinel Lymph Node Biopsy	RS			CoC	
682	Date Regional Lymph Node Dissection	R			NAACCR	
2113	Date Tumor Record Availbl	.			NPCR	
2113	Date Tumor Record Availbl	.			NPCR	
2380	DC State File Number	.			State	

NAACCR Item #	Required Data Items	Hosp	Rad/MD Office	Amb Sur/ Labs	Standard Setter	Newfor V23
2980	Derived AJCC-6 M	DH	DH	.	AJCC	
2990	Derived AJCC-6 M Descript	DH	DH	.	AJCC	
2960	Derived AJCC-6 N	DH	DH	.	AJCC	
2970	Derived AJCC-6 N Descript	DH	DH	.	AJCC	
3000	Derived AJCC-6 Stage Grp	DH	DH	.	AJCC	
2940	Derived AJCC-6 T	DH	DH	.	AJCC	
2950	Derived AJCC-6 T Descript	DH	DH	.	AJCC	
3420	Derived AJCC-7 M	DH	DH	.	AJCC	
3422	Derived AJCC-7 M Descript	DH	DH	.	AJCC	
3410	Derived AJCC-7 N	DH	DH	.	AJCC	
3412	Derived AJCC-7 N Descript	DH	DH	.	AJCC	
3430	Derived AJCC-7 Stage Grp	DH	DH	.	AJCC	
3400	Derived AJCC-7 T	DH	DH	.	AJCC	
3402	Derived AJCC-7 T Descript	DH	DH	.	AJCC	
3030	Derived AJCC--Flag	DH	DH	.	AJCC	
795	Derived EOD 2023 M	.			SEER	
815	Derived EOD 2023 N	.			SEER	
818	Derived EOD 2023 Stage Group	.			SEER	
785	Derived EOD 2023 T	.			SEER	
3600	Derived Neoadjuvant Rx Flag	.			AJCC	
3490	Derived PostRx-7 M	.			AJCC	
3482	Derived PostRx-7 N	.			AJCC	
3492	Derived PostRx-7 Stge Grp	.			AJCC	
3480	Derived PostRx-7 T	.			AJCC	
3460	Derived PreRx-7 M	.			AJCC	
3462	Derived PreRx-7 M Descrip	.			AJCC	
3450	Derived PreRx-7 N	.			AJCC	
3452	Derived PreRx-7 N Descrip	.			AJCC	
3470	Derived PreRx-7 Stage Grp	.			AJCC	
3440	Derived PreRx-7 T	.			AJCC	
3442	Derived PreRx-7 T Descrip	.			AJCC	
3955	Derived Rai Stage	.			NAACCR	
3610	Derived SEER Clin Stg Grp	.			SEER	
3626	Derived SEER Cmb M Src	.			SEER	
3624	Derived SEER Cmb N Src	.			SEER	
3614	Derived SEER Cmb Stg Grp	.			SEER	
3622	Derived SEER Cmb T Src	.			SEER	
3620	Derived SEER Combined M	.			SEER	
3618	Derived SEER Combined N	.			SEER	
3616	Derived SEER Combined T	.			SEER	

NAACCR Item #	Required Data Items	Hosp	Rad/MD Office	Amb Sur/ Labs	Standard Setter	Newfor V23
3605	Derived SEER Path Stg Grp	.			SEER	
3010	Derived SS1977	DH	DH	.	AJCC	
3040	Derived SS1977--Flag	DH	DH	.	AJCC	
3020	Derived SS2000	DH	DH	.	AJCC	
3050	Derived SS2000--Flag	DH	DH	.	AJCC	
762	Derived Summary Stage 2023	.	.	.	SEER	
490	Diagnostic Confirmation	R	R	R	SEER/CoC	
2200	Diagnostic Proc 73-87	.			SEER	
3939	EGFR Mutational Analysis	.			NAACCR	
2508	EHR Reporting	.			NAACCR	
776	EOD Mets	.			SEER	
772	EOD Primary Tumor	.			SEER	
3919	EOD Prostate Pathologic Extension	.			SEER	
774	EOD Regional Nodes	.			SEER	
790	EOD--Extension	.			SEER	
800	EOD--Extension Prost Path	.			SEER	
810	EOD--Lymph Node Involv	.			SEER	
840	EOD--Old 13 Digit	.			SEER	
850	EOD--Old 2 Digit	.			SEER	
860	EOD--Old 4 Digit	.			SEER	
780	EOD--Tumor Size	RH			SEER/CoC	
3829	Esophagus and EGJ Tumor Epicenter	RS			NAACCR	
3826	Estrogen Receptor Percent Positive or Range	RS			NAACCR	
3827	Estrogen Receptor Summary	RS			NAACCR	
3828	Estrogen Receptor Total Allred Score	RS			NAACCR	
3830	Extranodal Extension Clin (non-Head and Neck)	RS			NAACCR	
3831	Extranodal Extension Head and Neck Clinical	RS			NAACCR	
3832	Extranodal Extension Head and Neck Pathological	RS			NAACCR	
3833	Extranodal Extension Path (non-Head and Neck)	RS			NAACCR	
3834	Extravascular Matrix Patterns	RS			NAACCR	
3835	Fibrosis Score	RS			NAACCR	
3836	FIGO Stage	RS			NAACCR	
2440	Following Registry	.			CoC	

NAACCR Item #	Required Data Items	Hosp	Rad/MD Office	Amb Sur/ Labs	Standard Setter	Newfor V23
1842	Follow-Up Contact--City	.			SEER	
1847	Follow-Up Contact--Country	.			NAACCR	
2394	Follow-Up Contact--Name	.			SEER	
2392	Follow-Up Contact--No&St	.			SEER	
1846	Follow-Up Contact--Postal	.			SEER	
1844	Follow-Up Contact--State	.			SEER	
2393	Follow-Up Contact--Suppl	.			SEER	
1790	Follow-Up Source	R	.	.	CoC	
1791	Follow-up Source Central	.	.	.	NAACCR	
3837	GestationalTrophoblastic Prognostic Scoring Index	RS			NAACCR	
366	GIS Coordinate Quality	.	.	.	NAACCR	
3838	Gleason Patterns Clinical	RS			NAACCR	
3839	GleasonPatterns Pathological	RS			NAACCR	
3840	Gleason Score Clinical	RS			NAACCR	
3841	Gleason Score Pathological	RS			NAACCR	
3842	Gleason Tertiary Pattern	RS			NAACCR	
440	Grade	RH	RH	RH	SEER/CoC	
1973	Grade (73-91) ICD-O-1	.			SEER	
3843	Grade Clinical	R			NAACCR	
449	Grade Path System	RH	RH	.	AJCC	
441	Grade Path Value	RH	RH	.	AJCC	
3844	Grade Pathological	R			NAACCR	
3845	Grade Post Therapy	R			NAACCR	
3846	hCG Post-Orchiectomy Lab Value	RS			NAACCR	
3847	hCG Post-Orchiectomy Range	RS			NAACCR	
3848	hCG Pre-Orchiectomy Lab Value	RS			NAACCR	
3849	hCG Pre-Orchiectomy Range	RS			NAACCR	
3850	HER2 IHC Summary	RS			NAACCR	
3851	HER2 ISH Dual Probe Copy Number	RS			NAACCR	
3851	HER2 ISH Dual Probe Copy Number	RS			NAACCR	
3852	HER2 ISH Dual Probe Ratio	RS			NAACCR	
3853	HER2 ISH Single Probe Copy Number	RS			NAACCR	
3854	HER2 ISH Summary	RS			NAACCR	

NAACCR Item #	Required Data Items	Hosp	Rad/MD Office	Amb Sur/ Labs	Standard Setter	Newfor V23
3855	HER2 Overall Summary	RS			NAACCR	
3856	Heritable Trait	RS			NAACCR	
3857	High Risk Cytogenetics	RS			NAACCR	
3858	High Risk Histologic Features	RS			NAACCR	
3960	Histologic Subtype	RS			NAACCR	**New**
522	Histologic Type ICD-O-3	R	R	R	SEER/CoC	
1971	Histology (73-91) ICD-O-1	.			SEER	
420	Histology (92-00) ICD-O-2	RH	RH	.	SEER/CoC	
3859	HIV Status	RS			NAACCR	
3165	ICD Revision Comorbid	.			CoC	
1920	ICD Revision Number	.	.	.	SEER	
2116	ICD-O-3 Conversion Flag	.	.	.	SEER/CoC	
192	IHS Link	.	.	.	NPCR	
300	Industry Source	.	.	.	NPCR	
605	Inpatient Status	.			NAACCR	
2410	Institution Referred From	.			CoC	
2420	Institution Referred To	.			CoC	
3860	International Normalized Ratio Prothrombin Time	RS			NAACCR	
3864	Invasion Beyond Capsule	RS			NAACCR	
3861	Ipsilateral Adrenal Gland Involvement	RS			NAACCR	
3862	JAK2	RS			NAACCR	
3863	Ki-67	RS			NAACCR	
3865	KIT Gene Immunohistochemistry	RS			NAACCR	
3866	KRAS	RS			NAACCR	
410	Laterality	R	R	R	SEER/CoC	
2352	Latitude	.	.	.	NAACCR	
3932	LDH Lab Value	RS			NAACCR	
3869	LDH Level	.			NAACCR	
3867	LDH Post-Orchiectomy Range	RS			NAACCR	
3868	LDH Pre-Orchiectomy Range	RS			NAACCR	
3870	LDH Upper Limits of Normal	RS			NAACCR	
3871	LN Assessment Method Femoral-Inguinal	RS			NAACCR	
3872	LN Assessment Method Para-Aortic	RS			NAACCR	
3873	LN Assessment Method Pelvic	RS			NAACCR	

NAACCR Item #	Required Data Items	Hosp	Rad/MD Office	Amb Sur/ Labs	Standard Setter	Newfor V23
3874	LN Distant Assessment Method	RS			NAACCR	
3875	LN Distant: Mediastinal, Scalene	RS			NAACCR	
3876	LN Head and Neck Levels I-III	RS			NAACCR	
3877	LN Head and Neck Levels IV-V	RS			NAACCR	
3878	LN Head and Neck Levels VI-VII	RS			NAACCR	
3879	LN Head and Neck Other	RS			NAACCR	
3880	LN Isolated Tumor Cells (ITC)	RS			NAACCR	
3881	LN Laterality	RS			NAACCR	
3882	LN Positive Axillary Level I-II	RS			NAACCR	
3883	LN Size	RS			NAACCR	
3959	LN Status Femoral-Inguinal	.			SEER	
3884	LN Status Femoral-Inguinal, Para-Aortic, Pelvic	RS			NAACCR	
3958	LN Status Para-Aortic	.	.	.	SEER	
3957	LN Status Pelvic	.	.	.	SEER	
2354	Longitude	.	.	.	NAACCR	
3885	Lymphocytosis	RS			NAACCR	
1182	Lymphovascular Invasion	R	R	R	AJCC	
3950	Macroscopic Evaluation of Mesorectum	.	.	.	CoC	
3886	Major Vein Involvement	RS			NAACCR	
150	Marital Status at DX	.	.	.	SEER	
3887	Measured Basal Diameter	RS			NAACCR	
3888	Measured Thickness	RS			NAACCR	
2300	Medical Record Number	R	R	R	CoC	
2315	MedicareBeneficiary Identifier				NAACCR	
3889	Methylation of O6-Methylguanine-Methyltransferase	RS			NAACCR	
1112	Mets at DX-Bone	R	R	.	SEER	
1113	Mets at DX-Brain	R	R	.	SEER	
1114	Mets at Dx-Distant LN	R	R	.	SEER	
1115	Mets at DX-Liver	R	R	.	SEER	
1116	Mets at DX-Lung	R	R	.	SEER	
1117	Mets at DX-Other	R	R	.	SEER	
3890	Microsatellite Instability (MSI)	RS			NAACCR	

NAACCR Item #	Required Data Items	Hosp	Rad/MD Office	Amb Sur/ Labs	Standard Setter	Newfor V23
3891	Microvascular Density	RS			NAACCR	
2310	Military Record No Suffix	.			CoC	
3892	MitoticCount Uveal Melanoma	RS			NAACCR	
3893	Mitotic Rate Melanoma	RS			NAACCR	
1970	Morph (73-91) ICD-O-1	.				
470	Morph Coding Sys--Current	R	R	R	NAACCR	
480	Morph Coding Sys--Originl	R	R	R	NAACCR	
444	Mult Tum Rpt as One Prim	RH	RH	.	SEER	
3894	Multigene Signature Method	RS			NAACCR	
3895	Multigene Signature Results	RS			NAACCR	
446	Multiplicity Counter	RH	RH	.	SEER	
50	NAACCR Record Version	.	.	.	NAACCR	
2280	Name--Alias	.	.	.	NAACCR	
2232	Name—Birth Surname	R	.	.	NAACCR	
2240	Name--First	R	R	R	CoC	
2230	Name--Last	R	R	R	CoC	
2390	Name--Maiden	.	.	.	NAACCR	
2250	Name--Middle	R	R	R	CoC	
2260	Name--Prefix	.			NAACCR	
2290	Name--Spouse/Parent	.			NAACCR	
2270	Name--Suffix	.			NAACCR	
3896	NCCN International Prognostic Index (IPI)	RS			NAACCR	
1632	Neoadjuvant Therapy	.	.	.	SEER	
1633	Neoadjuvant Therapy	.	.	.	SEER	
1634	Neoadjuvant Therapy	.	.	.	SEER	
1800	Next Follow-Up Source	R	.	.	CoC	
191	NHIA Derived Hisp Origin	.			NAACCR	
1854	No Patient Contact Flag	.	.	.	NAACCR	**NEW**
1856	Reporting Facility Restriction Flag	.	.	.	NAACCR	**NEW**
3645	NPCR Derived AJCC 8 TNM Clin Stg Grp	.			NPCR	
3646	NPCR Derived AJCC 8 TNM Path Stg Grp	.			NPCR	
2415	NPI--Inst Referred From	R	.	.	CMS	
3647	NPCR Derived AJCC 8 TNM Post Therapy Stg Grp	.			NPCR	
3650	NPCR Derived Clin Stg Grp	.	.	.	NPCR	

NAACCR Item #	Required Data Items	Hosp	Rad/MD Office	Amb Sur/ Labs	Standard Setter	Newfor V23
3655	NPCR Derived Path Stg Grp	.	.	.	NPCR	
3105	NPI--Archive FIN	R	R	.	CMS	
2445	NPI--Following Registry	.			CMS	
2425	NPI--Inst Referred To	R	.	.	CMS	
2495	NPI--Physician 3	R	.	.	CMS	
2505	NPI--Physician 4	R	R	.	CMS	
2475	NPI--Physician--Follow-Up	R	.	.	CMS	
2465	NPI--Physician--Managing	R	.	.	CMS	
2485	NPI--Physician--Primary Surg	R	.	.	CMS	
45	NPI--Registry ID	.			CMS	
545	NPI--Reporting Facility	R	R	R	CMS	
3841	NRAS Mutational Analysis	.	.	.	NAACCR	
3897	Number of Cores Examined	RS			NAACCR	
3898	Number of Cores Positive	RS			NAACCR	
3899	Number of Examined Para-Aortic Nodes	RS			NAACCR	
3900	Number of Examined Pelvic Nodes	RS			NAACCR	
1532	Number of Phases of Rad Treatment to this Volume	R			CoC	
3901	Number of Positive Para-Aortic Nodes	RS			NAACCR	
3902	Number of Positive Pelvic Nodes	RS			NAACCR	
290	Occupation Source	.	.	.	NPCR	
3903	Oncotype Dx Recurrence Score-DCIS	RS			NAACCR	
3904	Oncotype Dx Recurrence Score-Invasive	RS			NAACCR	
3905	Oncotype Dx Risk Level-DCIS	RS			NAACCR	
3906	Oncotype Dx Risk Level-Invasive	RS			NAACCR	
3907	Organomegaly	RS			NAACCR	
1985	Over-ride Acsn/Class/Seq	R	R	.	CoC	
1990	Over-ride Age/Site/Morph	R	R	R*	SEER	
1987	Over-ride CoC-Site/Type	R	R	R*	CoC	
3750	Over-ride CS 1	RH	RH	.	AJCC	
3759	Over-ride CS 10	RH	RH	.	AJCC	
3760	Over-ride CS 11	RH	RH	.	AJCC	
3761	Over-ride CS 12	RH	RH	.	AJCC	
3762	Over-ride CS 13	RH	RH	.	AJCC	

NAACCR Item #	Required Data Items	Hosp	Rad/MD Office	Amb Sur/ Labs	Standard Setter	Newfor V23
3763	Over-ride CS 14	RH	RH	.	AJCC	
3764	Over-ride CS 15	RH	RH	.	AJCC	
3765	Over-ride CS 16	RH	RH	.	AJCC	
3766	Over-ride CS 17	RH	RH	.	AJCC	
3767	Over-ride CS 18	RH	RH	.	AJCC	
3768	Over-ride CS 19	RH	RH	.	AJCC	
3751	Over-ride CS 2	RH	RH	.	AJCC	
3769	Over-ride CS 20	RH	RH	.	AJCC/ NPCR	
3752	Over-ride CS 3	RH	RH	.	AJCC	
3753	Over-ride CS 4	RH	RH	.	AJCC	
3754	Over-ride CS 5	RH	RH	.	AJCC	
3755	Over-ride CS 6	RH	RH	.	AJCC	
3756	Over-ride CS 7	RH	RH	.	AJCC	
3757	Over-ride CS 8	RH	RH	.	AJCC	
3758	Over-ride CS 9	RH	RH	.	AJCC	
2040	Over-ride Histology	R	R	R	SEER	
1986	Over-ride HospSeq/DxConf	R	R	.	CoC	
1988	Over-ride HospSeq/Site	R	R	.	CoC	
2060	Over-ride Ill-define Site	.	.	.	SEER	
2070	Over-ride Leuk, Lymphoma	R	R	.	SEER	
2078	Over-ride Name/Sex	.			NAACCR	
2050	Over-ride Report Source	.	.	.	SEER	
2000	Over-ride SeqNo/DxConf	.	.	.	SEER	
2071	Over-ride Site/Behavior	R	R	R*	SEER	
2072	Over-ride Site/EOD/DX Dt	.			SEER	
2073	Over-ride Site/Lat/EOD	.			SEER	
2074	Over-ride Site/Lat/Morph	R	R	R	SEER	
2010	Over-ride Site/Lat/SeqNo	.	.	.	SEER	
1989	Over-ride Site/TNM-StgGrp	R	R	.	CoC	
2030	Over-ride Site/Type	R	R	R*	SEER	
1981	Over-ride SS/NodesPos	.	.	.	NAACCR	
1983	Over-ride SS/TNM-M	.	.	.	NAACCR	
1982	Over-ride SS/TNM-N	.	.	.	NAACCR	
2020	Over-ride Surg/DxConf	R	R	R*	SEER	
1994	Over-ride TNM 3	.			NAACCR	
1992	Over-ride TNM Stage	.			NAACCR	
1993	Over-ride TNM Tis	.			NAACCR	
3956	P16	.	.	.	NAACCR	
7320	Path Date Spec Collect 1	.			HL7	

NAACCR Item #	Required Data Items	Hosp	Rad/MD Office	Amb Sur/ Labs	Standard Setter	Newfor V23
7321	Path Date Spec Collect 2	.			HL7	
7322	Path Date Spec Collect 3	.			HL7	
7323	Path Date Spec Collect 4	.			HL7	
7324	Path Date Spec Collect 5	.			HL7	
7100	Path Order Phys Lic No 1	.			HL7	
7101	Path Order Phys Lic No 2	.			HL7	
7102	Path Order Phys Lic No 3	.			HL7	
7103	Path Order Phys Lic No 4	.			HL7	
7104	Path Order Phys Lic No 5	.			HL7	
7190	Path Ordering Fac No 1	.			HL7	
7191	Path Ordering Fac No 2	.			HL7	
7192	Path Ordering Fac No 3	.			HL7	
7193	Path Ordering Fac No 4	.			HL7	
7194	Path Ordering Fac No 5	.			HL7	
7090	Path Report Number 1	.			HL7	
7091	Path Report Number 2	.			HL7	
7092	Path Report Number 3	.			HL7	
7093	Path Report Number 4	.			HL7	
7094	Path Report Number 5	.			HL7	
7480	Path Report Type 1	.			HL7	
7481	Path Report Type 2	.			HL7	
7482	Path Report Type 3	.			HL7	
7483	Path Report Type 4	.			HL7	
7484	Path Report Type 5	.			HL7	
7010	Path Reporting Fac ID 1	.			HL7	
7011	Path Reporting Fac ID 2	.			HL7	
7012	Path Reporting Fac ID 3	.			HL7	
7013	Path Reporting Fac ID 4	.			HL7	
7014	Path Reporting Fac ID 5	.			HL7	
20	Patient ID Number	.	.	.	Reporting Registry	
21	Patient System ID-Hosp	.			NAACCR	
1120	Pediatric Stage	.			CoC	
1140	Pediatric Staged By	.			CoC	
1130	Pediatric Staging System	.			CoC	
3908	Percent Necrosis Post Neoadjuvant	RS			NAACCR	
3909	Perineural Invasion	RS			NAACCR	
3910	Peripheral Blood Involvement	RS			NAACCR	
3911	Peritoneal Cytology	RS			NAACCR	

NAACCR Item #	Required Data Items	Hosp	Rad/MD Office	Amb Sur/ Labs	Standard Setter	Newfor V23
1501	Phase I Dose per Fraction	R	R		CoC	
1503	Phase I Number of Fractions	R	R		CoC	
1504	Phase I Radiation Primary Treatment Volume	R	R		CoC	
1505	Phase I Radiation to Draining Lymph Nodes	R	R		CoC	
1506	Phase I Radiation Treatment Modality	R	R		CoC	
1507	Phase I Total Dose	R	R		CoC	
1511	Phase II Dose per Fraction	R	R		CoC	
1513	Phase II Number of Fractions	R	R		CoC	
1512	Phase II Radiation External Beam Planning Tech	R	R		CoC	
1514	Phase II Radiation Primary Treatment Volume	R	R		CoC	
1515	Phase II Radiation to Draining Lymph Nodes	R	R		CoC	
1516	Phase II Radiation Treatment Modality	R	R		CoC	
1517	Phase II Total Dose	R	R		CoC	
1521	Phase III Dose per Fraction	R	R		CoC	
1523	Phase III Number of Fractions	R	R		CoC	
1522	Phase III Radiation External Beam Planning Tech	R	R		CoC	
1524	Phase III Radiation Primary Treatment Volume	R	R		CoC	
1525	Phase III Radiation to Draining Lymph Nodes	R	R		CoC	
1526	Phase III Radiation Treatment Modality	R	R		CoC	
1527	Phase III Total Dose	R	R		CoC	
2490	Physician 3	.			CoC	
2500	Physician 4	.			CoC	
2470	Physician--Follow-Up	.			CoC	
2460	Physician--Managing	.	.	.	NAACCR	
2480	Physician--Primary Surg	.	.	.	CoC	
1940	Place of Death	.	.	.	NPCR	
1944	Place of Death--Country	.	.	.	NAACCR	
1942	Place of Death--State	.	.	.	NAACCR	
3913	Pleural Effusion	RS			NAACCR	
630	Primary Payer at DX	R	R	R*	CoC	

NAACCR Item #	Required Data Items	Hosp	Rad/MD Office	Amb Sur/ Labs	Standard Setter	Newfor V23
3917	PrimarySclerosing Cholangitis	RS			NAACCR	
400	Primary Site	R	R	R*	SEER/CoC	
3918	ProfoundImmune Suppression	RS			NAACCR	
3914	Progesterone Receptor Percent Positive or Range	RS			NAACCR	
3915	Progesterone Receptor Summary	RS			NAACCR	
3916	Progesterone Receptor Total Allred Score	RS			NAACCR	
3920	PSA(Prostatic Specific Antigen) Lab Value	RS			NAACCR	
1780	Quality of Survival	.			CoC	
160	Race 1	R	R	R	SEER/CoC	
161	Race 2	R	R	R	SEER/CoC	
162	Race 3	R	R	R	SEER/CoC	
163	Race 4	R	R	R	SEER/CoC	
164	Race 5	R	R	R	SEER/CoC	
170	Race Coding Sys--Current	R	R	R	NAACCR	
180	Race Coding Sys--Original	R	R	.	NAACCR	
193	Race--NAPIIA(derived API)	.			NAACCR	
3210	Rad--Boost Dose cGy	.	.	.	CoC	
3200	Rad--Boost RX Modality	.	.	.	CoC	
1531	RadiationTreatment Discontinued Early	R	R		CoC	
1550	Rad--Location of RX	R	R	.	CoC	
1520	Rad--No of Treatment Vol	.	.	.	CoC	
1510	Rad--Regional Dose: cGy	.	.	.	CoC	
1570	Rad--Regional RX Modality	.	.	.	CoC	
1540	Rad--Treatment Volume	.	.	.	CoC	
3190	Readm Same Hosp 30 Days	R			CoC	
1430	Reason for No Radiation	R	R	R	CoC	
1340	Reason for No Surgery	R	R	R	SEER/CoC	
1775	Record Number Recode	.			NAACCR	
10	Record Type	.	.	.	NAACCR	
1860	Recurrence Date--1st	R	R	.	CoC	
1861	Recurrence Date--1st Flag	R	R	.	NAACCR	
1880	Recurrence Type--1st	R	R	.	CoC	
830	Regional Nodes Examined	R	R	R*	SEER/CoC	
820	Regional Nodes Positive	R	R	R*	SEER/CoC	

NAACCR Item #	Required Data Items	Hosp	Rad/MD Office	Amb Sur/ Labs	Standard Setter	Newfor V23
40	Registry ID	.	.	.	NAACCR	
30	Registry Type	.	.	.	NAACCR	
540	Reporting Facility	R	R	R	CoC	
3921	Residual Tumor Volume Post Cytoreduction	RS			NAACCR	
3922	Response to Neoadjuvant Therapy	RS			NAACCR	
2155	RQRS NCDB Submission Flag	R			CoC	
339	RUCA 2000	.			NAACCR	
341	RUCA 2010	.			NAACCR	
3300	RuralUrban Continuum 1993	.			NAACCR	
3310	RuralUrban Continuum 2003	.			NAACCR	
3312	RuralUrban Continuum 2013	.			NAACCR	
1460	RX Coding System--Current	R	R	R	NAACCR	
1240	RX Date BRM	R	R	.	CoC	
1241	RX Date BRM Flag	R	R	.	NAACCR	
1220	RX Date Chemo	R	R	.	CoC	
1280	RX Date DX/Stg Proc	R	R	R	CoC	
1281	RX Date DX/Stg Proc Flag	R	R	R	NAACCR	
1230	RX Date Hormone	R	R	.	CoC	
3170	RX Date Mst Defn Srg	R	R	.	CoC	
3171	RX Date Mst Defn Srg Flag	R	R	.	NAACCR	
1250	RX Date Other	R	R	.	CoC	
3220	RX Date Rad Ended	R	R	.	CoC	
1210	RX Date Radiation	R	R	.	CoC	
1211	RX Date Radiation Flag	R	R	.	NAACCR	
3180	RX Date Surg Disch	R	R	.	CoC	
1200	RX Date Surgery	R	R	R*	CoC	
3230	RX Date Systemic	R	R	.	CoC	
720	RX Hosp--BRM	R	R	.	CoC	
700	RX Hosp--Chemo	R	R	.	CoC	
740	RX Hosp--DX/Stg Proc	R	R	.	CoC	
710	RX Hosp--Hormone	R	R	.	CoC	
730	RX Hosp--Other	R	R	.	CoC	
3280	RX Hosp--Palliative Proc	R	R	.	CoC	
690	RX Hosp--Radiation	.	.	.	SEER	
676	RX Hosp--Reg LN Removed	RH	RH	.	CoC	
747	RX Hosp--Scope Reg 98-02	RH	RH	.	CoC	
672	RX Hosp--Scope Reg LN Sur	R	R	.	CoC	
668	RX Hosp--Surg App 2010	R	R	.	CoC	

NAACCR Item #	Required Data Items	Hosp	Rad/MD Office	Amb Sur/ Labs	Standard Setter	Newfor V23
748	RX Hosp--Surg Oth 98-02	RH			CoC	
674	RX Hosp--Surg Oth Reg/Dis	R	R	.	CoC	
671	RX Hosp--Surg Prim Site 2023	R	R	.	Coc	New
746	RX Hosp--Surg Site 98-02	.	.	.	CoC	
1410	RX Summ--BRM	R	R	.	SEER/CoC	
1390	RX Summ--Chemo	R	R	.	SEER/CoC	
1350	RX Summ--DX/Stg Proc	R	R	R	CoC	
1400	RX Summ--Hormone	R	R	.	SEER/CoC	
1420	RX Summ--Other	R	R	R*	SEER/CoC	
3270	RX Summ--Palliative Proc	R	R	.	CoC	
1370	RX Summ--Rad to CNS	.	.	.	SEER/CoC	
1360	RX Summ--Radiation	.	.		SEER	
1330	RX Summ--Reconstruct 1st	RH	RH	.	SEER	
1296	RX Summ--Reg LN Examined	RH	RH	R*	SEER/CoC	
1647	RX Summ--Scope Reg 98-02	RH	RH	.	SEER/CoC	
1292	RX Summ--Scope Reg LN Sur	R	R	R*	SEER/CoC	
1648	RX Summ--Surg Oth 98-02	RH	RH	.	SEER/CoC	
1294	RX Summ--Surg Oth Reg/Dis	R	R	R*	SEER/CoC	
1290	RX Summ--Surg Prim Site	R	R	R*	SEER/CoC	
1291	RX Summ—Surg Prim Site 2023	R	R	.	SEER/CoC	New
1646	RX Summ--Surg Site 98-02	RH	RH	.	SEER/CoC	
1380	RX Summ--Surg/Rad Seq	R	R	.	SEER/CoC	
1640	RX Summ--Surgery Type	.	.	.	SEER	
1310	RX Summ--Surgical Approch	RH	RH	.	CoC	
1320	RX Summ--Surgical Margins	R	R	.	CoC	
1639	RX Summ--Systemic/Sur Seq	R	R	.	CoC	
3250	RX Summ--Transplnt/Endocr	R	R	.	CoC	
1285	RX Summ--Treatment Status	R	R	.	SEER/CoC	
2660	RX Text--BRM	.	R^	.	NPCR	
2640	RX Text--Chemo	.	R^	.	NPCR	
2650	RX Text--Hormone	.	R^	,	NPCR	
2670	RX Text--Other	.	R^	.	NPCR	
2620	RX Text--Radiation (Beam)	.	R^	.	NPCR	
2630	RX Text--Radiation Other	.	R^	.	NPCR	
2610	RX Text--Surgery	.	R^	R^	NPCR	
3923	S Category Clinical	RS			NAACCR	
3924	S Category Pathological	RS			NAACCR	
3925	Sarcomatoid Features	RS			NAACCR	
3926	Schema Discriminator 1	RS			NAACCR	

NAACCR Item #	Required Data Items	Hosp	Rad/MD Office	Amb Sur/ Labs	Standard Setter	Newfor V23
3927	Schema Discriminator 2	RS			NAACCR	
3928	Schema Discriminator 3	RS			NAACCR	
3800	Schema ID	D			NAACCR	
3780	Secondary Diagnosis 1	R	R	.	CoC	
3798	Secondary Diagnosis 10	R	R	.	CoC	
3782	Secondary Diagnosis 2	R	R	.	CoC	
3784	Secondary Diagnosis 3	R	R	.	CoC	
3786	Secondary Diagnosis 4	R	R	.	CoC	
3788	Secondary Diagnosis 5	R	R	.	CoC	
3790	Secondary Diagnosis 6	R	R	.	CoC	
3792	Secondary Diagnosis 7	R	R	.	CoC	
3794	Secondary Diagnosis 8	R	R	.	CoC	
3796	Secondary Diagnosis 9	R	R	.	CoC	
1914	SEER Cause Specific COD	.			SEER	
2120	SEER Coding Sys--Current	.			NAACCR	
2130	SEER Coding Sys--Original	.			NAACCR	
1915	SEER Other COD	.			SEER	
3700	SEER Site-Specific Fact 1	.			SEER	
3702	SEER Site-Specific Fact 2	.			SEER	
3704	SEER Site-Specific Fact 3	.			SEER	
3706	SEER Site-Specific Fact 4	.			SEER	
3708	SEER Site-Specific Fact 5	.			SEER	
3710	SEER Site-Specific Fact 6	.			SEER	
760	SEER Summary Stage 1977	RH	RH	.	SEER	
759	SEER Summary Stage 2000	RH	RH	.	SEER	
834	Sentinel Lymph Nodes Examined	RS			CoC	
835	Sentinel Lymph Nodes Positive	RS			CoC	
3929	Separate Tumor Nodules	RS			NAACCR	
380	Sequence Number--Central	.	.	.	SEER	
560	Sequence Number--Hospital	R	R	.	CoC	
3930	Serum Albumin Pretreatment Level	RS			NAACCR	
3931	Serum Beta-2 Microglobulin Pretreatment Level	RS			NAACCR	
220	Sex	R	R	R	SEER/CoC	
1960	Site (73-91) ICD-O-1	.			SEER	
450	Site Coding Sys--Current	R	R	R	NAACCR	
460	Site Coding Sys--Original	R	R	.	NAACCR	
2320	Social Security Number	R	R	R	CoC	

NAACCR Item #	Required Data Items	Hosp	Rad/MD Office	Amb Sur/ Labs	Standard Setter	Newfor V23
190	Spanish/Hispanic Origin	R	R	R	SEER/CoC	
81	State at DX Geocode 1970/80/90	.			NAACCR	
82	State at DX Geocode 2000	.			NAACCR	
83	State at DX Geocode 2010	.			NAACCR	
84	State at DX Geocode 2020	.			NAACCR	
2220	State/Requestor Items	.			Varies	
1675	Subsq RX 2nd Course BRM	.			CoC	
1673	Subsq RX 2nd Course Chemo	.			CoC	
1670	Subsq RX 2nd Course Codes	.				
1660	Subsq RX 2nd Course Date	.			CoC	
1674	Subsq RX 2nd Course Horm	.			CoC	
1676	Subsq RX 2nd Course Oth	.			CoC	
1672	Subsq RX 2nd Course Rad	.			CoC	
1671	Subsq RX 2nd Course Surg	.			CoC	
1661	Subsq RX 2ndCrs Date Flag	.			NAACCR	
1679	Subsq RX 2nd--Reg LN Rem	.			CoC	
1677	Subsq RX 2nd--Scope LN SU	.			CoC	
1678	Subsq RX 2nd--Surg Oth	.			CoC	
1695	Subsq RX 3rd Course BRM	.			CoC	
1693	Subsq RX 3rd Course Chemo	.			CoC	
1690	Subsq RX 3rd Course Codes	.				
1680	Subsq RX 3rd Course Date	.			CoC	
1694	Subsq RX 3rd Course Horm	.			CoC	
1696	Subsq RX 3rd Course Oth	.			CoC	
1692	Subsq RX 3rd Course Rad	.			CoC	
1691	Subsq RX 3rd Course Surg	.			CoC	
1681	Subsq RX 3rdCrs Date Flag	.			NAACCR	
1699	Subsq RX 3rd--Reg LN Rem	.			CoC	
1697	Subsq RX 3rd--Scope LN Su	.			CoC	
1698	Subsq RX 3rd--Surg Oth	.			CoC	
1715	Subsq RX 4th Course BRM	.			CoC	
1713	Subsq RX 4th Course Chemo	.			CoC	
1700	Subsq RX 4th Course Date	.			CoC	
1714	Subsq RX 4th Course Horm	.			CoC	
1716	Subsq RX 4th Course Oth	.			CoC	
1712	Subsq RX 4th Course Rad	.			CoC	
1711	Subsq RX 4th Course Surg	.			CoC	
1719	Subsq RX 4th--Reg LN Rem	.			CoC	
1717	Subsq RX 4th--Scope LN Su	.			CoC	
1718	Subsq RX 4th--Surg Oth	.			CoC	

NAACCR Item #	Required Data Items	Hosp	Rad/MD Office	Amb Sur/ Labs	Standard Setter	Newfor V23
1741	Subsq RX--Reconstruct Del	.			CoC	
764	Summary Stage 2023	R			SEER	
1782	Surv-Date Active Followup	.			NAACCR	
1788	Surv-Date DX Recode	.			NAACCR	
1785	Surv-Date Presumed Alive	.			NAACCR	
1783	Surv-Flag Active Followup	.			NAACCR	
1786	Surv-Flag Presumed Alive	.			NAACCR	
1784	Surv-Mos Active Followup	.			NAACCR	
1787	Surv-Mos Presumed Alive	.			NAACCR	
2360	Telephone			.	CoC	
2550	Text--DX Proc--Lab Tests	.	.	.	NPCR	
2560	Text--DX Proc--Op	.	.	.	NPCR	
2570	Text--DX Proc--Path	.	.	.	NPCR	
2520	Text--DX Proc--PE	.			NPCR	
2540	Text--DX Proc--Scopes	.			NPCR	
2530	Text--DX Proc--X-ray/Scan	.			NPCR	
2590	Text--Histology Title	.			NPCR	
2690	Text--Place of Diagnosis	.			NPCR	
2580	Text--Primary Site Title	.	.	.	NPCR	
2680	Text--Remarks	.	.	.	NPCR	
2600	Text--Staging	.			NPCR	
320	Text--Usual Industry	R*	R*	R*	NPCR	
310	Text--Usual Occupation	R*	R*	R*	NPCR	
3933	Thrombocytopenia	RS			NAACCR	
980	TNM Clin Descriptor	RH	RH	.	CoC	
960	TNM Clin M	RH	RH	.	AJCC	
950	TNM Clin N	RH	RH	.	AJCC	
970	TNM Clin Stage Group	RH	RH	.	AJCC	
990	TNM Clin Staged By	RH	RH	.	CoC	
940	TNM Clin T	RH	RH	.	AJCC	
1060	TNM Edition Number	R	R	.	CoC	
920	TNM Path Descriptor	RH	RH	.	CoC	
900	TNM Path M	RH	RH	.	AJCC	
890	TNM Path N	RH	RH	.	AJCC	
910	TNM Path Stage Group	RH	RH	.	AJCC	
930	TNM Path Staged By	RH	RH	.	CoC	
880	TNM Path T	RH	RH	.	AJCC	
344	Tobacco Use Smoking Status	R			NPCR	
1533	Total Dose	R			CoC	
3934	Tumor Deposits	RS			NAACCR	

NAACCR Item #	Required Data Items	Hosp	Rad/MD Office	Amb Sur/ Labs	Standard Setter	Newfor V23
3935	Tumor Growth Pattern	RS			NAACCR	
1150	Tumor Marker 1	RH	RH	.	SEER	
1160	Tumor Marker 2	RH	RH	.	SEER	
1170	Tumor Marker 3	RH	RH	.	SEER	
60	Tumor Record Number	.			NAACCR	
752	Tumor Size Clinical	.			SEER	
754	Tumor Size Pathologic	.			SEER	
756	Tumor Size Summary	R	R	R	NPCR/CoC	
500	Type of Reporting Source	.	R	R	SEER	
3936	Ulceration	RS			NAACCR	
1850	Unusual Follow-Up Method	.			NAACCR	
345	URIC 2000	.			NAACCR	
346	URIC 2010	.			NAACCR	
2170	Vendor Name	R	R	R	NAACCR	
3937	Visceral and Parietal Pleural Invasion	RS			NAACCR	
1760	Vital Status	R	R	R	SEER/CoC	
1762	Vital Status Recode	.			NAACCR	

	Codes for Recommendations
.	No recommendation
D	Derived
D*	Derived, when available
D+	Derived; central registries may collect either SEER Summary Stage 2000 or Collaborative Stage
R	Required
R#	Required; central registries may code available data using either SEER or CoC data items and associated rules
R*	Required, when available; central registries may code available data using either SEER or CoC data items and associated rules
R$	Requirements differ by year
R*	Required, when available
R^	Required, these text requirements may be met with one or several text block fields
R+	Required, central registries may collect either SEER Summary Stage 2000 or Collaborative Stage
RC	Collected by SEER from CoC-accredited hospitals
RH	Historically collected and currently transmitted
RH*	Historically collected and currently transmitted when available
RN	Collect according to NPCR stage transition schedule
RS	Required, site specific
RS#	Required, site specific; central registries may code available data using either SEER or CoC data items and associated rules
RS*	Required, site specific; when available
S	Supplementary/recommended
T	Data is vital to complete exchange record
T*	Transmit data if available for any case in exchange record
TH	Only certain historical cases may require these fields
TH*	Only certain historical cases may require these fields; transmit data if available for any case in exchange record

2023 Summary of Changes

Changes to this manual are made in accordance with the relevant source materials.

Removed Data Items

When a data item has been removed, it means MCR no longer requires the data item for the diagnosis years covered by this manual (2023 and forward), or additional years as indicated.

- RX Date Systemic (No longer required for any diagnosis year)
- RX Summ--Surg Prim Site 03-2022 [1290] (Still required for diagnosis years 2003-2022)
- NCDB--COVID19--Tx Impact (Still required when available for diagnosis years 2019-2022)
- NCDB--SARSCoV2—Pos (Still required when available for diagnosis years 2019-2022)
- NCDB--SARSCoV2--Pos Date (Still required when available for diagnosis years 2019-2022)
- NCDB--SARSCoV2—Test (Still required when available for diagnosis years 2019-2022)

Retired Data Items

Various date flag data items were retired in 2023. Those which had previously been collected by MCR but are now retired are listed below. When a data item has been retired, it means it is no longer required or transmitted for **any and all diagnosis years.**

Retirement of date flags does **not** mean you should attempt to code the flag value in other fields. Simply leave the date field empty if the date is unknown.

Item	Label
241	Date of Birth Flag
391	Date of Diagnosis Flag
581	Date of 1st Contact Flag
1201	RX Date Surgery Flag
1211	RX Date Radiation Flag
1221	RX Date Chemo Flag
1231	RX Date Hormone Flag
1241	RX Date BRM Flag
1251	RX Date Other Flag
1261	Date Initial RX SEER Flag
1751	Date of Last Contact Flag
3171	RX Date Mst Defn Srg Flag
3231	RX Date Systemic Flag

New Data Items

- Histologic Subtype
    - Site-specific data item. See Data Dictionary entry for details.
- Rx Summ—Surg Prim Site 2023
    - Replaces Rx Sum--Surg Prim Site [1290] for cases diagnosed 2023 forward.
    - Must be left blank for all cases diagnosis prior to 2023.

Changed Data Items

Name Changes

- RX Summ--Surg Prim Site [1290] *renamed to* **RX Summ--Surg Prim Site 03-2022 [1290]**
    - **Note**: This data item has been removed from the data dictionary as it applies to diagnosis years 2003-2022. Refer to historical data dictionaries and reference materials to code this item.

Appendix 3: Text Fields

Text Fields: Guidance on Entering Text into Specific Text Fields

Guidance below is excerpted from the NAACCR Data Standards and Data Dictionary, Version 23.0 available at https://www.naaccr.org/data-standards-data-dictionary/

Rationale:

"Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values."

Description of the table:

- The following table gives the name of each text field, a description of what text should be entered in column 2, and, in the third column, suggestions and examples of text and abbreviations that can be entered.

Text Field	Description of Text to Enter	Suggestions for Text to Enter, and Examples
Required Fields for All Reporting Facilities		
Text - Primary Site Title	Type in the primary site of the tumor being reported and the laterality (side of the body) if it is a paired site. (some sites are not paired such as the prostate, uterus, esophagus, pancreas, and colon)	**Suggestions for text:** - Location of the primary site of the tumor - Available information on tumor laterality (if paired site) **Examples:** - Lung, L lower lobe - Prostate - Breast, R upper outer quadrant - Sigmoid colon - Left temporal lobe of brain

Text - Histology	Review the pathology report and type in the histologic type (adenocarcinoma, squamous cell cancer, etc.), the "behavior" (malignant, in situ, benign), and the grade (differentiation) of the tumor being reported.	**Suggestions for text:** Histologic type and behavior Information on differentiation from scoring system such as Gleason score, Bloom-Richardson Score, Nottingham Score, Information on tumor laterality (if paired site) Examples: Adenocarcinoma of transverse colon, invasive, grade III Adenocarcinoma of prostate, Gleason score 5, Grade 2 Melanoma skin right arm, in situ, grade 0 Melanoma skin left leg, in situ, grade not stated
Text - Pathology	Review the pathology report and type in the text from cytology and histopathology reports.	**Suggestions for Text:** **Date(s) of procedure(s)** Type of tissue specimen(s) Tumor type and grade (include all modifying adjectives, i.e., predominantly, with features of, with foci of, elements of, etc.) Gross tumor size; Extent of tumor spread; Involvement of resection margins Number of lymph nodes involved and examined Record any additional comments from the pathologist, including differential diagnoses considered and any ruled out or favored Examples: 11/12/2016 colon polyp, 1.2x1.0x.0.8 cm. Adenocarcinoma contained within polyp showing invasion of submucosa. Stalk: no evidence of adenocarcinoma or dysplasia. 7/4/16 mastectomy of breast for R upper outer quadrant mass; 1.0 x 1.3 x .9 cm. Ductal carcinoma, infiltrating, Grade III. Margins clear; 12/12 lymph nodes negative for cancer; no

		metastasis noted; Positive histology; ERA negative.
Other Text Fields Required or Required as Available for Certain Facility Types (See Appendix 2 for list)		
Text - Remarks	Type in more information that you have or use if you run out of room in other text fields. Problematic coding issues can also be discussed in this section.	**Suggestions for Text:** Overflow of information from any other Text field Justification of over-ride flags Family and personal history of cancer Comorbidities Information on sequence numbers if a person was diagnosed with another cancer out-of-state or before the registry's reference date Place of birth Smoking history **Example:** Patient severely ill; could not undergo further surgery or staging; no treatment planned
Text - Laboratory	Text area for information from laboratory examinations other than cytology or histopathology. Data should verify/validate the coding of the following fields: Date of Diagnosis, Primary Site, Laterality, Histology ICD-O-3, Grade, Collaborative Stage variables, Diagnostic confirmation	**Suggestions for Text:** Type of lab test/tissue specimen(s) Record both positive and negative findings, record positive test results first. Information can include serum and urine electrophoresis, special studies **Date(s) of lab test(s)** Tumor markers included, but are not limited to o Breast Cancer: Estrogen Receptor Assay (ERA), Progesterone Receptor Assay (PRA), Her 2/neu. o Prostate Cancer: Prostatic Specific Antigen (PSA) o Testicular Cancer: Human Chorionic Gonadotropin
Text - Operations	Text area for manual documentation of all surgical procedures that provide information for staging. Data should verify/validate the coding of the following fields: Date	**Suggestions for Text:** **Dates** and descriptions of biopsies and all other surgical procedures from which staging information was derived.

	of 1st positive Bx; Date of Diagnosis; Rx Summary—diagnostic-staging procedures; Rx Summary—Surgery at primary site	□Number of lymph nodes removed □Size of tumor removed □Documentation of residual tumor □Evidence of invasion of surrounding areas
Text-Physical Examination	Text area for the history and physical examination related to the current tumor and the clinical description of the tumor.	**Suggestions for Text:** □**Date of physical exam** □Age, sex, race/ethnicity □History that relates to cancer diagnosis □Primary site □Histology (if diagnosis prior to this admission) □Tumor location □Tumor size □Palpable lymph nodes □Record positive and negative clinical findings. Record positive results first. □Treatment plan
Scopes Text	Text area for endoscopic examinations that provide information for staging and treatment.	**Suggestions for Text:** □**Date(s) of endoscopic exam(s)** □Primary site □Histology (if given) □Tumor location □Tumor size □Lymph nodes □Record positive and negative clinical findings. Record positive results first.
Text - X-Rays and Scans	Text area for all X-rays, scan, and/or other imaging examinations that provide information about staging.	**Suggestions for Text:** **Date(s) of X-ray/Scan(s)** Age, sex, race/ethnicity (when given) Primary site Histology (if given) Tumor location Tumor size Lymph nodes Record positive and negative clinical findings. Record positive results first Distant disease or metastasis
Text - Place of Diagnosis	Text area for the facility, physician office, city, state, or county where the diagnosis was made	**Suggestions for Text:** The complete name of the hospital or the physician office

		where the diagnosis occurred. The initials of a hospital are not adequate. For out-of-state residents and facilities, include the city and the state where the medical facility is located.
Text - Staging	Additional text area for staging information not already entered in the Text—Dx Proc areas	**Suggestions for Text:** Date(s) of procedure(s), including clinical procedures, that provided information for assigning state Organs involved by direct extension Size of tumor or depth of invasion to support the T value Status of margins Number and sites of positive lymph nodes to reflect the N value Site(s) of distant metastasis to reflect the M value Physician's specialty and comments

Other Text Fields Required or Required as Available for Certain Facility Types (See Appendix 2 for list)		
Treatment-Biologic Response Modifiers Text	Text area for information regarding the treatment of the tumor being reported with biological response modifiers or immunotherapy	**Suggestions for Text:** Date when Treatment was given, e.g., at this facility; at another facility Type of BRM agent, e.g., Interferon, BCG BRM procedures, e.g., bone marrow transplant, stem cell transplant Other treatment information, e.g., treatment cycle incomplete; unknown if BRM was given
Treatment-Chemotherapy Text	Text area for information regarding chemotherapy treatment of the reported tumor.	**Suggestions for Text:** Date when chemotherapy began Where treatment was given, e.g., name of agent(s) or protocol Other treatment information, e.g., treatment cycle incomplete, unknown if chemotherapy was given

Treatment–Hormonal Text	Text area for information about hormonal treatment	**Suggestions for Text:** Date treatment was started Where treatment was given, e.g., at this facility, at another facility Type of hormone or antihormone, e.g., Tamoxifen Type of endocrine surgery or radiation, e.g., orchiectomy Other treatment information, e.g., treatment cycle incomplete; unknown if hormones were given.
Treatment-Other Text	Text area for information regarding the treatment of the tumor being reported with treatment that cannot be defined as surgery, radiation, or systemic therapy. This includes experimental treatments and blinded clinical trials.	**Suggestions for Text:** Date treatment was started Where treatment was given, e.g., at this facility, at another facility Type of other treatment, e.g., blinded clinical trial, hyperthermia. Other treatment information, e.g., treatment cycle incomplete; unknown if other treatment was given.
Treatment-Radiation Text	Text area for information regarding treatment of the tumor being reported with beam radiation.	**Suggestions for Text:** Date when radiation treatment began Where treatment was given, e.g., at this facility, at another facility Type(s) of beam radiation, e.g., Orthovoltage, Cobalt 60, MV X-rays, Electrons, Mixed modalities Other treatment information, e.g., patient discontinued after 5 treatments; unknown if radiation was given
Treatment-Surgery Text	Text area for information describing all surgical procedures performed as part of treatment.	**Suggestions for Text:** Date of each procedure Type(s) of surgical procedure(s), including excisional biopsies and surgery to other and distant sites Lymph nodes removed Regional tissues removed Metastatic sites Facility where each procedure was performed Record positive and negative findings. Record positive findings first

Appendix 4: HIPAA Information

The Maryland Cancer Registry's Surveillance Responsibilities and The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This information sheet has been prepared to clarify and confirm the authority of staff of the Maryland Cancer Registry (MCR) or an agent of the Maryland Cancer Registry of MDH officially acting on the MCR's behalf, to receive, access, inspect, and/or abstract patient medical records and/or patient medical listings relating to the diagnosis and treatment of cancer and benign central nervous system (CNS) tumors. Such access, inspection, and/or abstraction relates to the review and abstracting of selected patient records and/or listings as a part of the MCR's quality control review of the completeness and accuracy of reporting of cancer and benign CNS tumors in Maryland. Periodic quality control review is a part of the MCR's ongoing public health surveillance activities.

Disclosure of cancer and benign CNS tumors to the MCR is required under the Maryland Department of Health (MDH) authority pursuant to Maryland Code Annotated, Health-General ("Health-General"), §18-204.

The Maryland Cancer Registry is a "public health authority," as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Federal regulations [see 45 CFR §164.512(a), (b), and (d) and §160.203(c)] authorize disclosure without patient consent in a number of circumstances, including the following:

> Disclosure is permitted to a public health authority authorized by law to access information to prevent/control disease, injury, disability, e.g., disease reporting, vital statistics reporting, public health surveillance, public health investigations, public health interventions and partner notification. See 45 CFR §164.512(b).

Because the MCR is a public health authority, cancer reporting and surveillance are required by state law, and the MCR is not performing such functions on behalf of the covered entity, reporting entities do not need to complete a business associate's agreement before providing reports that include the requested personally identifiable information to the MCR or to an agent of the Maryland Cancer Registry of MDH acting on the MCR's behalf. The required information is needed to conduct public health surveillance. MCR information is not a medical record under Health-General §4-301, and is protected under the confidentiality requirements of Health-General §4- 101 et seq.

If you have any questions with respect to the Maryland Cancer Registry's authority to receive, access, inspect and/or abstract personally identifiable information, please contact Kimberly S. Stern, MCR Director, at 410-767-5521.

This information sheet has been reviewed and approved by the legal counsel to the Maryland Cancer

Registry in the Attorney General's Office but is not a formal opinion of that office.

Appendix 5: Creating a Disease Index

PLEASE SUBMIT THIS "HIGH PRIORITY" REQUEST TO YOUR IT DEPARTMENT

CASE SELECTION INSTRUCTIONS

1. **Select patient encounters occurring from January 1, 2022 - December 31, 2023, and having any ICD-10-CM diagnosis/condition code included in the attached code list (Attachment).**
   - Include all inpatient encounters
   - Include all same day surgery encounters
   - Include all ambulatory cancer treatment encounters
   - Include patient encounters from 01/01/2023 – 12/31/2023.

RECORD LAYOUT AND FILE FORMAT INSTRUCTIONS

2. **Required Variables, Record Layout, and File Format for Flat File Submissions**
   NO SPECIAL CHARACTERS ALLOWED (except in ICD-10-CM Code Fields)

Variable	Length	Format	Condition
Facility ID Number	10	Char	Required Field – left justify, fill with leading zeros.
HospitalMedical Record Number	11	Char	Required Field – left justify
Patient Last Name	25	Char	Required Field – left justify, fill with trailing blanks, no special characters
Patient First Name	14	Char	Required Field – left justify, fill with trailing blanks, no special characters
PatientMiddle Name	14	Char	Optional – field can be blank or middle initial – left justify, fill with trailing blanks, no special characters
PatientMaiden Name	15	Char	Optional – field can be blank – left justify, fill with trailing blanks, no special characters
PatientDateof Birth	8	Char	Required Field – YYYYMMDD
Patient SSN	9	Char	Required Field – 9-fill if SSN is unknown
Sex	1	Char	Required Field – M = 1, F = 2, Other = 3, Transsexual = 4 Not stated/Unknown = 9.
Date of Service/ DateofAdmission	8	Char	Required Field – YYYYMMDD

Date of Service/ Date of Discharge	8	Char	Required Field – YYYYMMDD *Note: If ambulatory patient encounter (i.e. same day surgery), BOTH Dates of Service should be the same date*
ICD-10-CM Code Principle	6	Char	Required Field – Include decimal point in ICD-10-CM code Left justify
ICD-10-CM Code Secondary_1	6	Char	Required Field – (5 secondary) – Include decimal point in ICD-10-CM code - left justify
ICD-10-CM Code Secondary_2	6	Char	Required Field – (5 secondary) – Include decimal point in ICD-10-CM code - left justify
ICD-10-CM Code Secondary_3	6	Char	Required Field – (5 secondary) – Include decimal point in ICD-10-CM code - left justify
ICD-10-CM Code Secondary_4	6	Char	Required Field – (5 secondary) – Include decimal point in ICD-10-CM code - left justify
ICD-10-CM Code Secondary_5	6	Char	Required Field – (5 secondary) – Include decimal point in ICD-10-CM code - left justify

3. **Create the File**
   - Following the case selection criteria and required variables instructions, create the file as an Excel spreadsheet or CSV (comma separated value) file.
   - Order the Variables in the same sequence as above
   - Sort the File in alphabetical order by Patient Last Name, Patient First Name, and Date of Service
   -
4. **Name the File – be sure to designate 2023 in your file name**
   - *Facility ID*_2023 DiseaseIndex_*date*.xls OR *FacilityID*_2023DiseaseIndex_*date*.csv
   - *Note 1: Facility ID is your 10-digit Facility ID*
   - *Note 2: Date is the date the file was created*

5. **Save the File**
   - Save the file in .xls. xlsx, or .csv file format
   - Hint: You may want to zip the file using WinZip or other standard file compression software.

FILE SUBMISSION INSTRUCTIONS

6. **Submit the File to MCR**
   - MCR Web Plus File Upload Submission:
     - Login to the MCR secure Web Plus sever using your usual Login ID and Password; Login as a "File Uploader"
       - If you do not have "File Uploader" privileges – contact your Field Representative
     - Go to Upload File tab
     - **IMPORTANT: Select "Non-NAACCR" file type**
     - Upload the file using the standard MCR Web Plus file upload feature
       Contact the MCR Technical Help Line 1-866-986-6575 if you have any questions

Appendix 6: Case-finding Code List

COMPREHENSIVE ICD-10-CM Casefinding Code List for Reportable Tumors (EFFECTIVE DATES: 10/1/2023-9/30/2024) Please refer to your standard setter(s) for specific reporting requirements before using the Casefinding List	
ICD-10-CM Code	**Explanation of Code**
C00.-- C43.-, C4A.-, C45.-- C48.-, C49.-- C96.-	Malignant neoplasms (excluding category C44 and C49.A), stated or presumed to be primary (of specified site) and certain specified histologies
C44.00, C44.09	Unspecified/other malignant neoplasm of skin of lip
C44.10-, C44.19-	Unspecified/other malignant neoplasm of skin of eyelid
C44.13-	Sebaceous cell carcinoma of skin of eyelid, including canthus
C44.20-, C44.29-	Unspecified/other malignant neoplasm skin of ear and external auricular canal
C44.30-, C44.39-	Unspecified/other malignant neoplasm of skin of other/unspecified parts of face
C44.40, C44.49	Unspecified/other malignant neoplasm of skin of scalp & neck
C44.50-, C44.59-	Unspecified/other malignant neoplasm of skin of trunk
C44.60-, C44.69-	Unspecified/other malignant neoplasm of skin of upper limb, incl. shoulder
C44.70-, C44.79-	Unspecified/other malignant neoplasm of skin of lower limb, including hip
C44.80, C44.89	Unspecified/other malignant neoplasm of skin of overlapping sites of skin
C44.90, C44.99	Unspecified/other malignant neoplasm of skin of unspecified sites of skin
C49.A-	Gastrointestinal Stromal Tumors
D00.-- D05.-, D07.-- D09	In-situ neoplasms *Note 1: Excludes carcinoma in situ tumors of the cervix (D06._)* *Note 2: Excludes prostatic intraepithelial neoplasia (PIN III) (8148/2) of the prostate. Other prostate in situ histologies are reportable* *Note 3: For D04 (carcinoma in situ of skin), excludes basal and squamous cell in situ lesions*
D18.02	Hemangioma of intracranial structures and any site
D32.-	Benign neoplasm of meninges (cerebral, spinal and unspecified)
D33.-	Benign neoplasm of brain and other parts of central nervous system
D35.2 - D35.4	Benign neoplasm of pituitary gland, craniopharyngeal duct and pineal gland
D42.-, D43.-	Neoplasm of uncertain or unknown behavior of meninges, brain, CNS
D44.3 - D44.5	Neoplasm of uncertain or unknown behavior of pituitary gland, craniopharyngeal duct and pineal gland
D45	Polycythemia vera (9950/3) ICD-10-CM Coding instruction note: Excludes familial polycythemia (C75.0), secondary polycythemia (D75.1)
D46.-	Myelodysplastic syndromes (9980, 9982, 9983, 9985, 9986, 9989, 9993)
D47.02	Systemic mastocytosis
D47.1	Chronic myeloproliferative disease (9963/3, 9975/3) ICD-10-CM Coding instruction note: Excludes the following: Atypical chronic myeloid leukemia BCR/ABL-negative (C92.2_) Chronic myeloid leukemia BCR/ABL-positive (C92.1_) Myelofibrosis & Secondary myelofibrosis (D75.81) Myelophthisic anemia & Myelophthisis (D61.82)

COMPREHENSIVE ICD-10-CM Casefinding Code List for Reportable Tumors (EFFECTIVE DATES: 10/1/2023-9/30/2024) Please refer to your standard setter(s) for specific reporting requirements before using the Casefinding List	
ICD-10-CM Code	**Explanation of Code**
D47.3	Essential (hemorrhagic) thrombocythemia (9962/3) Includes: Essential thrombocytosis, idiopathic hemorrhagic thrombocythemia
D47.4	Osteomyelofibrosis (9961/3) Includes: Chronic idiopathic myelofibrosis Myelofibrosis (idiopathic) (with myeloid metaplasia) Myelosclerosis (megakaryocytic) with myeloid metaplasia) Secondary myelofibrosis in myeloproliferative disease
D47.9	Neoplasm of uncertain behavior of lymphoid, hematopoietic and related tissue, unspecified (9970/1, 9931/3)
D47.Z-	Neoplasm of uncertain behavior of lymphoid, hematopoietic and related tissue, unspecified (9960/3, 9970/1, 9971/3, 9931/3) *Note: Effective 1/1/2021, PTLD (9971/3) is no longer reportable (9971/1)*
D49.6, D49.7	Neoplasm of unspecified behavior of brain, endocrine glands and other CNS
D72.11-	Hypereosonophilic syndrome [HES] (9964/3)
K31.A22	Gastric intestinal metaplasia with high grade dysplasia
N85.02	Endometrial intraepithelial neoplasia [EIN]
R85.614	Cytologic evidence of malignancy on smear of anus
R87.614	Cytologic evidence of malignancy on smear of cervix
R87.624	Cytologic evidence of malignancy on smear of vagina
R90.0	Intracranial space-occupying lesion found on diagnostic imaging of central nervous system

Note: Beginning with cases diagnosed 1/1/2023, pilocytic astrocytoma are coded 9421/1.
***Cases* diagnosed prior to 1/1/2023 are coded 9421/3**

^ Based on the International Classification of Diseases, ICD-10-CM Tabular List of Diseases and Injuries, FY 2023

Source: https://seer.cancer.gov/tools/casefinding/icd-10-cm-casefinding-list.20231005.pdf

Appendix 7: Creating a Non-Reportable List

In addition to the Disease Index report and signed Certification from your IT department, we also request the registry send a non-reportable list (LIST ONLY) of the classes of case 32 and 33, and any other not reportable cases (not required to report to the state) for the past five years (You may exclude the years previously submitted).
Use the format below so we can eliminate these cases from your Disease Index reconciliation list. If variables are unknown they may be left blank, but please use the format below and upload the completed form to WebPlus.

Variable	Length	Format	Condition
Facility ID Number	10	Char	Required Field – left justify, fill with leading zeros.
Hospital Medical Record Number	11	Char	Required Field – left justify
Patient Last Name	25	Char	Required Field – left justify, fill with trailing blanks, no special characters
Patient First Name	14	Char	Required Field – left justify, fill with trailing blanks, no special characters
Patient Middle Name	14	Char	Optional – field can be blank or middle initial – left justify, fill with trailing blanks, no special characters
Patient Maiden Name	15	Char	Optional – field can be blank – left justify, fill with trailing blanks, no special characters
Patient Date of Birth	8	Char	Required Field – YYYYMMDD
Patient SSN	9	Char	Required Field – 9-fill if SSN is unknown
Sex	1	Char	Required Field – M = 1, F = 2, Other = 3, Transsexual = 4 Not stated/Unknown = 9.
Date of Service/ Date of Admission	8	Char	Required Field – YYYYMMDD. Date of 1st Contact
Date of Service/ Date of Discharge	8	Char	Required Field – YYYYMMDD *Note: If ambulatory patient encounter (i.e. same day surgery), BOTH Dates of Service should be the same date.* Date of last contact
ICD-O Code Principle	6	Char	Required Field – Include decimal point in ICD-9-CM code Left justify. Primary Site
Date of Diagnosis	8	Char	Required Field – YYYYMMDD. Date or year if noted
Text Field (PE/Remarks)		Char	Required Field – Any text field, for example PE or remarks, you may use to report why this case is non-reportable.

Appendix 8: CODING AND STAGING MANUALS & RESOURCES

SEER Program Coding and Staging Manual 2023
https://seer.cancer.gov/tools/codingmanuals/index.html

Summary Staging 2018 Manual
https://seer.cancer.gov/tools/staging/

Extent of Disease (EOD) 2018 General Instruction Manual
https://seer.cancer.gov/tools/staging/

Site-Specific Data Items (SSDI) Manual
https://apps.naaccr.org/ssdi/list/

COVID-19 Abstraction Guidance
https://seer.cancer.gov/tools/covid-19/

Hematopoietic & Lymphoid Neoplasm Database & Manual
https://seer.cancer.gov/seertools/hemelymph/

International Classification of Disease for Oncology (ICD-O-3.2) – Available for pdf download from the
World Health Organization at http://www.iacr.com.fr/index.php?Itemid=577

ICD-O-3.2 Implementation Guidelines
https://www.naaccr.org/implementation-guidelines/#ICDO3

SEER*RSA (SEER Registrar Staging Assistant)
https://staging.seer.cancer.gov/

American Joint Committee on Cancer (AJCC) TNM Staging Manual
https://www.facs.org/quality-programs/cancer-programs/american-joint-committee-on- cancer/

Collaborative Stage Data Collection System
https://www.facs.org/quality-programs/cancer-programs/american-joint-committee-on-cancer/collaborative-staging-schema-v0205/

Standards for Oncology Registry Entry (STORE) – for cases 2023 and forward https://www.facs.org/media/r0ajvh5j/store-manual-2023.pdf

CTR Guide to Coding Radiation Therapy Treatment (STORE) – for cases February 2022 and forward
https://www.facs.org/media/fr0phnbd/case-studies-for-coding-radiation-treatment-v4-0-_20220519064258_496407.pdf

Facility Oncology Registry Data Standards (FORDS) – for cases prior to 2018
https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/fordsmanual/

Commission on Cancer Program Standards
https://www.facs.org/quality-programs/cancer/coc/standards

Solid Tumor Rules 2021 (Multiple primaries and Histologies)
https://seer.cancer.gov/tools/solidtumor/

Casefinding Lists (ICD-9, ICD-10)
https://seer.cancer.gov/tools/casefinding/

Appendix 9: Contact Information

Maryland Cancer Registry (MCR)
Center for Cancer Prevention and Control (CCPC)
Maryland Department of Health (MDH)
201 West Preston Street, Room 400
Baltimore, MD 21201

MDH Staff List

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For assistance with data submission
please call Myriddian Technical Support Hotline at
1-866-986-6575
Or
410 344-2851
Fax: 240-833-4111
Email: MCRtech@myriddian.com

For all other questions please email
MCR@myriddian.com

MARYLAND CANCER REGISTRY (MCR)
Myriddian, LLC- Quality Assurance and Database Management (QADM) Contractor

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