Abstracted By (NAACCR)

Agency: NAACCR **Last changed: 03/29/1997**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Abstracted By [Std# 570]

Default Error Message

[1028] %F1 must be alphanumeric with no special characters
Abstracted By must be alphanumeric with no special characters

Description

Field must contain alphanumeric characters. Special characters are not allowed, and the field must not be blank.

Addr at DX--City (NAACCR)

Agency: NAACCR **Last changed: 04/05/2007**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Addr at DX--City [Std# 70]

Tables

CITY_SPC.DBF

Default Error Message

[1009] %F1 must contain letters and spaces only, left-justified
Addr at DX--City must contain letters and spaces only, left-justified

Additional Messages

[3202] More than one consecutive embedded space is not allowed

Description

Item may not be blank. Must be alpha, left-justified, and blank-filled. Mixed case is allowed, but uppercase is preferred by USPS. Embedded spaces are allowed, but no more than one consecutive embedded space is allowed. Special characters are not allowed.

Although dashes and numbers are generally not allowed, there are a few official USPS exceptions. The following city names will pass:

```
BLAIRSDEN-GRAEGLE
BLRSDN-GREAGL
57TH AVE
MCBH K-BAY
VLG OF 4 SSNS
BATESBURG-LEESVILLE
BATSBRG-LEVIL
```

Administrative Notes

This edit differs from the COC edit of the same name in that it does not allow the field to be blank.

Addr at DX--Country (NAACCR)

Agency: NAACCR **Last changed: 12/08/2014**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Addr at DX--Country [Std# 102]

Tables

CNTRY_ST.DBF

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of Addr at DX--Country" is not a valid value for Addr at DX--Country

Description

Addr at DX--Country must contain a valid ISO code or standard custom code for country.

Administrative Notes

New edit - added to NAACCR v13 metafile.

This edit differs from the COC edit of the same name in that it does not allow the field to be blank.

Modifications

NAACCR v15
Country code table (CNTRY_ST.DBF) has been updated:
Brunei - 'BND' changed to 'BRN'
Czechoslovakia (former) - 'XCZ' changed to 'CSK'
Slovakia - 'SWK' changed to 'SVK'
Vanuatu - 'VLT' changed to 'VUT'
Yugoslavia (former) - 'XYG' changed to 'YUG'

Added Saint-Martin (French part) - 'MAF'

Addr at DX--Country, Date of Diagnosis (NAACCR)

Agency: NAACCR **Last changed: 10/08/2014**

Edit Sets

HospitalScan16D

Fields

Addr at DX--Country [Std# 102]
Date of Diagnosis [Std# 390]

Default Error Message

[4992] %F1 cannot be %V1 if %F2 is greater than 2012
Addr at DX--Country cannot be "value of Addr at DX--Country" if Date of Diagnosis is greater than 2012

Description

```
This edit is skipped if either field is blank.

If year of Date of Diagnosis is 2013 or later, then Addr at DX--Country cannot be
any of the following "historic" codes:

XNI  North American Islands
XCB    Other Caribbean Islands
XEN    England, Channel Islands, Isle of Man
XSC    Scandinavia
XGR    Germanic Countries
XSL    Slavic Countries
XUM    Ukraine and Moldova
XNF    North Africa
XSD    Sudanese Countries
XWF    West Africa
XSF    South Africa
XEF    East Africa
XIF    African Islands
XET    Ethiopia and Eritrea
XAP    Arabian Peninsula
XIS    Israel and Palestine
XCR    Caucasian Republics of former USSR
XOR    Other Asian Republics of former USSR
XSE    Southeast Asia
XMS    Malaysia, Singapore, Brunei
XCH    China, NOS
XML    Melanesian Islands
XMC    Micronesian Islands
XPL    Polynesian Islands
```

Administrative Notes

New edit - added to NAACCR v13 metafile.

This edit differs from the COC edit of the same name in that it is skipped if either field is blank.

Modifications

NAACCR v15
The historic codes used for Yugoslavia (XYG) and Czechoslovakia (XCZ) have been removed from the list of historic codes.

Addr at DX--Country, State (NAACCR)

Agency: NAACCR **Last changed: 12/09/2014**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Addr at DX--Country [Std# 102]
Addr at DX--State [Std# 80]

Tables

CNTRY_ST.DBF

Default Error Message

[1016] %F1 and %F2 conflict
Addr at DX--Country and Addr at DX--State conflict

Description

This edit is skipped if any of the fields are blank.

This edit verifies that the Addr at DX--State code is valid for the Addr at DX--Country.

Administrative Notes

New edit - added to NAACCR v13 metafile.

Modifications

NAACCR v15
Country code table (CNTRY_ST.DBF) has been updated:
Brunei - 'BND' changed to 'BRN'
Czechoslovakia (former) - 'XCZ' changed to 'CSK'
Slovakia - 'SWK' changed to 'SVK'
Vanuatu - 'VLT' changed to 'VUT'
Yugoslavia (former) - 'XYG' changed to 'YUG'

Added Saint-Martin (French part) - 'MAF'

State codes 'XX' and 'YY' (instead of just 'YY') allowed with 'CSK' and 'YUG"

Addr at DX--No & Street (MCR)

Agency: **Last changed: 06/13/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Addr at DX--No & Street [Std# 2330]

Default Error Message

[1015] %F1 must contain alphanumeric and be left-justified
Addr at DX--No & Street must contain alphanumeric and be left-justified

Description

```
MCR: Anything except blank is OK.
```

Administrative Notes

MCR allows the street address to be expressed in any format that we can interpret visually. Format standardization for mail delivery or easier geocoding is not our concern. A data reporter should send us the street address as it's recorded in their medical record.

Addr at DX--Postal Code (NAACCR)

Agency: NAACCR **Last changed: 08/20/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Addr at DX--Postal Code [Std# 100]

Default Error Message

[1015] %F1 must contain alphanumeric and be left-justified
Addr at DX--Postal Code must contain alphanumeric and be left-justified

Description

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

Administrative Notes

This edit differs from the COC edit of the same name in that it does not allow the field to be blank.

Modifications:

NAACCR v14
- Logic updated to not allow embedded spaces

NAACCR v15A
This change was made in preparation for the move from EDITS v4 to EDITS v5:
- MATCH statement was updated to specify trailing blanks:
  "x{x}*" changed to "x{x}*{b}*"

Addr at DX--State (NAACCR)

Agency: NAACCR **Last changed: 04/27/2007**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Addr at DX--State [Std# 80]

Tables

STATE.DBF

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of Addr at DX--State" is not a valid value for Addr at DX--State

Description

```
Field must contain valid US postal code for state or Canadian province.

Special Codes:
    CD  Resident of Canada, NOS, and province, territory, commonwealth
        or possession is unknown
    US  Resident of United States, NOS, and state, territory,
        commonwealth or possession is unknown
    XX  Resident of country other than United States (including its
        territories, commonwealths, or possessions) or Canada, and
        country known
    YY  Resident of country other than United States (including its
        territories, commonwealths, or possessions) or Canada, and
        country unknown
    ZZ  Residence unknown
```

Administrative Notes

This edit differs from the COC edit of the same name in that it does not allow the field to be blank.

Modifications:

NACR110B
Added codes CD (Resident of Canada, NOS) and US (Resident of United States, NOS) to State.dbf table; updated edit description to include CD and US in list of Special Codes and to change description of ZZ from "Resident of U.S., NOS; Canada, NOS; Residence unknown" to "Residence unknown".

Age at Diagnosis (SEER AGEDX)

Agency: SEER **Last changed: 03/04/2003**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Age at Diagnosis [Std# 230]

Default Error Message

[262] Age at Diagnosis not valid
Age at Diagnosis not valid

Description

This field became a required (rather than optional) data item for COC as of 1/1/2003 and is required for all diagnosis years. Consequently this edit is now used by COC, as well as SEER, and will be added to the COC edit set.

Must be a valid value for Age at Diagnosis (000...120, 999).

Age at Diagnosis, Text--Usual Industry (NAACCR)

Agency: NAACCR **Last changed: 11/23/2009**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Age at Diagnosis [Std# 230]
Text--Usual Industry [Std# 320]
Date of Birth [Std# 240]
Date of Diagnosis [Std# 390]

Default Error Message

[1050] If %F1 > 013, %F2 cannot be blank
If Age at Diagnosis > 013, Text--Usual Industry cannot be blank

Additional Messages

ERROR_TEXT("Date of Birth: %DC")
ERROR_TEXT("Date of Diagnosis: %DC")

Description

```
This edit is skipped if the year of the Date of Diagnosis is less than 1996 or
blank.

If Age at Diagnosis > 013, Text--Usual Industry cannot be blank.

Age at Diagnosis is calculated if blank:

If the year of birth or year of diagnosis is blank (unknown), then the calculated
age at diagnosis = 999 (unknown).

If either month of birth or month of diagnosis is blank (unknown), then the
calculated age is computed as year of diagnosis - year of
birth.  Otherwise the age is computed as:

      ((year of diagnosis * 12 + month of diagnosis) - (year of
      birth * 12 + month of birth))/12.

If the months of diagnosis and birth are known and equal, and
the day of diagnosis is earlier than the day of birth, then 1
is subtracted from the calculated age.
```

Administrative Notes

Modifications:

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

Age at Diagnosis, Text--Usual Occupation (NAACCR)

Agency: NAACCR **Last changed: 11/23/2009**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Age at Diagnosis [Std# 230]
Text--Usual Occupation [Std# 310]
Date of Birth [Std# 240]
Date of Diagnosis [Std# 390]

Default Error Message

[1050] If %F1 > 013, %F2 cannot be blank
If Age at Diagnosis > 013, Text--Usual Occupation cannot be blank

Additional Messages

ERROR_TEXT("Date of Birth: %DC")
ERROR_TEXT("Date of Diagnosis: %DC")

Description

```
This edit is skipped if the year of the Date of Diagnosis is less than 1996 or
blank.

If Age at Diagnosis > 013, Text--Usual Occupation cannot be blank.

Age at Diagnosis is calculated if blank:

If the year of birth or year of diagnosis is unknown (9999), then the calculated
age at diagnosis = 999.

If either month of birth or month of diagnosis is unknown (99),
then the calculated age is computed as year of diagnosis - year of
birth.  Otherwise the age is computed as:

      ((year of diagnosis * 12 + month of diagnosis) - (year of
      birth * 12 + month of birth))/12.

If the months of diagnosis and birth are known and equal, and
the day of diagnosis is earlier than the day of birth, then 1
is subtracted from the calculated age.
```

Administrative Notes

Modifications:

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

Age, Birth Date, Date of Diagnosis (NAACCR IF13)

Agency: NAACCR **Last changed: 11/23/2009**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Age at Diagnosis [Std# 230]
Date of Diagnosis [Std# 390]
Date of Birth [Std# 240]
Over-ride Age/Site/Morph [Std# 1990]

Default Error Message

[1005] Conflict among %F1, %F2 and %F3
Conflict among Age at Diagnosis, Date of Diagnosis and Date of Birth

Additional Messages

ERROR_TEXT("Date of Birth: %DC")
ERROR_TEXT("Date of Diagnosis: %DC")

Description

```
This edit checks that Age at Diagnosis, Date of Birth, and Date of Diagnosis are in
agreement.

If the Age at Diagnosis is 000 and the Over-ride Age/Site/Morph code is 2 or 3, no
further checking is done. (Over-ride Age/Site/Morph may be set to 2 or 3 to
indicate a case has been diagnosed in utero.)
Note:
  Codes '2' and '3' have been added to the list of Over-ride Age/Site/Morph
  codes in the NAACCR v11.3 metafile. The code definitions are:
  1 = Reviewed: An unusual occurrence of a particular age/site/histology
      combination for a given age group has been reviewed
  2 = Reviewed: Case was diagnosed in utero.
  3 = Reviewed: Conditions 1 and 2 above both apply
  Blank = Not reviewed or reviewed and corrected


If the Age at Diagnosis is coded as 999 (unknown), then either the year
of Date of Birth or the year of Date of Diagnosis must be blank (unknown).

If either the year of Date of Birth or the year of Date of Diagnosis is blank
(unknown),  then Age at Diagnosis must be 999 (unknown).

If either month of birth or month of diagnosis is blank (unknown),
then a working age is computed as year of diagnosis - year of
birth.  Otherwise the working age is computed as the actual age:
      ((year of diagnosis * 12 + month of diagnosis) - (year of
      birth * 12 + month of birth))/12.

If the month of diagnosis or month of birth is blank (unknown), or if
the months of diagnosis and birth are known and equal and the
day of diagnosis or day of birth is blank (unknown), then Age at
```

```
Diagnosis must equal the working age or the working age - 1.

If the months of diagnosis and birth are known and equal, and
the day of diagnosis is earlier than the day of birth, then 1
is subtracted from the working age, and Age at Diagnosis must
equal the new working age.

For all other cases, Age at Diagnosis must equal the working age.
```

Administrative Notes

Modifications:

NAACCR v11.3
6/2008
Reference to "SEER edit of the same name" in Administrative Notes was deleted since this metafile does not include the SEER edit.

NAACCR v11.3A
1/2009
Added: If the Age at Diagnosis is 000 and the Over-ride Age/Site/Morph code is 2 or 3, no further checking is done. (Over-ride Age/Site/Morph may be set to 2 or 3 to indicate a case has been diagnosed in utero.)

NAACCR v12
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

Age, Primary Site, Morph ICDO3--Adult (SEER)

Agency: SEER **Last changed: 11/23/2009**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Over-ride Age/Site/Morph [Std# 1990]
Age at Diagnosis [Std# 230]
Primary Site [Std# 400]
Morph--Type&Behav ICD-O-3 [Std# 521]
Date of Diagnosis [Std# 390]

Default Error Message

[3145] Adult Age/Site/Hist conflict
Adult Age/Site/Hist conflict

Additional Messages

ERROR_TEXT("Date of Diagnosis: %DC")

Description

This edit and the edit Age, Primary Site, Morphology ICDO3--Pediatric (NPCR) replace the edit Age, Primary Site, Morphology ICDO3 (SEER IF15) for cases diagnosed on or after 01/01/2001. There is no overlap in the two edits. The edit Age, Primary Site, Morphology ICDO3--Pediatric (NPCR) is for ages 000 - 014 and this edit (Age, Primary Site, Morphology ICDO3--Adult (SEER)) is for ages 015 and older. The field Over-ride Age/Site/Morph is shared by both edits and contains a "1" when the case has been reviewed and accepted as is.

This edit is skipped if Morph--Type&Behav ICD-O-3 is blank or year of Date of Diagnosis is less than 2001.

The edit is also skipped if Age at Diagnosis is less than 15.

If the Over-ride Age/Site/Morph contains a '1' (review completed and case accepted as coded), no further checking is done.

For each specified age group in the following table, the Primary Site/Morphology combinations require review.

```
014 < Age < 020
   Esophagus C150-C159            | Any morphology
   Small intestine C170-C179      | Any morphology
   Colon C180-C189                | Any other than carcinoid 8240-8245
   Rectosigmoid C199              | Any morphology
   Rectum C209                    | Any morphology
   Anus, anal canal C210-C218     | Any morphology
   Gallbladder C239               | Any morphology
   Other biliary tract C240-C249  | Any morphology
   Pancreas C250-C259             | Any morphology
   Trachea C339                   | Any other than carcinoid 8240-8245
   Lung and bronchus C340-C349    | Any other than carcinoid 8240-8245
```

Pleura C384	Any morphology
Breast C500-C509	Any morphology
Uterus, NOS C559	Any morphology
Cervix uteri C530-C539	Any Histologic Type ICD-O-3 with Behavior ICD-O-3 of 3 (malignant)
Corpus uteri C540-C549	Any morphology

014 < Age < 030

Any site	Multiple Myeloma 9732
	Chronic myeloid leukemia 9863,9875,9876,9945
	Chronic lymphocytic leukemia 9823
Penis C609	Any morphology

014 < Age < 040

Prostate C619	Adenocarcinoma, NOS 8140

Age > 014

Eye C690-C699	Retinobastoma 9510-9514
Any site	Wilms tumor 8960
Any site	Juvenile myelomonocytic leukemia 9946

Age > 045

Placenta C589	Choriocarcinoma 9100

Additional Information:

Some cancers occur almost exclusively in certain age groups. For example, retinoblastoma is a tumor of young children, while prostate cancer occurs in older men. This edit checks that selected cancers are reported only for patients of specific ages at diagnosis. The expected ages are listed for each edited site/morphology combination in the "Description" field of the edit documentation.

First check that the primary site and histologic type are coded correctly and that the age, date of birth, and date of diagnosis are correct. These two dates are not actually used in the edit; however, they may have been used to calculate the age at diagnosis, which is used in this edit. Correction of errors may require inspection of the abstracted text, either online or as recorded on a paper abstract. Review of the original medical record may also be required.

If upon review, all items are correct as coded, an over-ride flag may be set so that the case will not be considered in error when the edit is run again. Enter a 1 in the field Over-ride Age/Site/Morph to indicate that the coding is correct.

EXAMPLE

AGE	35
PRIMARY SITE	PROSTATE, C61.9
MORPHOLOGY -TYPE AND BEHAVIOR	8140/3, ADENOCARCINOMA
DATE OF DIAGNOSIS	2/13/95
DATE OF BIRTH	1/10/60

The edit identifies prostate cancers occurring before age 45. On review, the birth date in this case is in error and should be 1/10/06. Enter the correct birth date. The age will recalculate to 89, and the case will no longer be in error.

Administrative Notes

In the SEER*Edits software, the title of this edit is: IF118

Modifications:

NACR110A
Juvenile myelomonocytic leukemia (9946) for ages > 14 and < 30 was removed from the group of age/histologies requiring review.

NAACCR v11.2
7/2007
Juvenile myelomonocytic leukemia (9946) for ages > 14 was added to the group of age/histologies requiring review.

NAACCR v11.3
6/08
Updated Administrative Notes with the title of the corresponding edit in the SEER*Edits software.

NAACCR v11.3A
12/2008
Edit changed to require review if age is less than 040 [instead of less than 045] and site is prostate (C619) and histology is Adenocarcinoma, NOS (8140).

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

Age, Primary Site, Morph ICDO3--Pediatric (NPCR)

Agency: NPCR **Last changed: 11/23/2009**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Over-ride Age/Site/Morph [Std# 1990]
Age at Diagnosis [Std# 230]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
Date of Diagnosis [Std# 390]

Default Error Message

[3141] Pediatric Age/Site/Hist conflict
Pediatric Age/Site/Hist conflict

Additional Messages

ERROR_TEXT("Date of Diagnosis: %DC")

Description

This edit and the edit Age, Primary Site, Morphology ICDO3--Adult (SEER) replace the edit Age, Primary Site, Morphology ICDO3 (SEER IF15) for cases diagnosed on or after 01/01/2001. There is no overlap in the two edits. This edit (Age, Primary Site, Morphology ICDO3--Pediatric (NPCR)) is for ages 000 - 014 and the edit Age, Primary Site, Morphology ICDO3--Adult (SEER) is for ages 015 and older. The field Over-ride Age/Site/Morph is shared by both edits and contains a "1" when the case has been reviewed and accepted as is.

This edit is based on the International Classification of Childhood Cancer (ICCC) CHILD-CHECK program edit of "Unlikely Combinations of Age and Tumour Type" as specified on page 11 of IARC Technical Report No. 29. It also includes SEER edits for ages 000 - 014 that were formerly part of the edit Age, Primary Site, Morphology ICDO3 (SEER IF15).

This edit is skipped if Histologic Type ICD-O-3 is blank or year of Date of Diagnosis is less than 2001.

This edit is skipped if Age at Diagnosis is greater than 14.

If the Over-ride Age/Site/Morph contains a '1' or '3' no further checking is done.
Note:
  Codes '2' and '3' have been added to the list of Over-ride Age/Site/Morph codes in the NAACCR v11.3 metafile. The code definitions are:
  1 = Reviewed: An unusual occurrence of a particular age/site/histology combination for a given age group has been reviewed
  2 = Reviewed: Case was diagnosed in utero.
  3 = Reviewed: Conditions 1 and 2 above both apply
  Blank = Not reviewed or reviewed and corrected

For each specified group in the following list, the Age/Primary Site/Morphology combinations require review.

Unlikely Combinations of Age and Tumor Type

ICCC Diagnostic Group: IIa Hodgkin Lymphoma

Histologic Type ICD-O-3: 9650-9667
Primary Site: Any
Age at Diagnosis: 000 - 002

ICCC Diagnostic Group: IVa Neuroblastoma and ganglioneuroblastoma

Histologic Type ICD-O-3: 9490, 9500
Primary Site: Any
Age at Diagnosis: 010 - 014

ICCC Diagnostic Group: V Retinoblastoma

Histologic Type ICD-O-3: 9510-9514
Primary Site: Any
Age at Diagnosis: 006 - 014

ICCC Diagnostic Group: VIa Wilms tumor, rhabdoid, and clear cell sarcoma

Histologic Type ICD-O-3: 8960, 8964
Primary Site: Any

Histologic Type ICD-O-3: 8963
Primary Site: C649, C809

Age at Diagnosis: 009 - 014

ICCC Diagnostic Group: VIb Renal carcinoma

Histologic Type ICD-O-3: 8010-8041, 8050-8075, 8082, 8120-8122,8130-8141, 8143, 8155, 8190-8201, 8210, 8211, 8221-8231, 8240,8241,8244-8246, 8260-8263, 8290, 8310, 8320, 8323, 8401, 8430, 8440, 8480-8490, 8504, 8510, 8550, 8560-8573
Primary Site: C649

Histologic Type ICD-O-3: 8312
Primary Site: Any

Age at Diagnosis: 000 - 008

ICCC Diagnostic Group: VIIa Hepatoblastoma

Histologic Type ICD-O-3: 8970
Primary Site: Any
Age at Diagnosis: 006 - 014

ICCC Diagnostic Group: VIIb Hepatic carcinoma

Histologic Type ICD-O-3: 8010-8041, 8050-8075, 8082, 8120-8122, 8140,8141, 8143, 8155, 8190-8201, 8210, 8211, 8230, 8231, 8240, 8241, 8244-8246, 8260-8263, 8310, 8320, 8323, 8401, 8430, 8440,

8480-8490, 8504, 8510, 8550, 8560-8573
Primary Site: C220, C221

Histologic Type ICD-O-3: 8160-8180
Primary Site: Any

Age at Diagnosis: 000 - 008

ICCC Diagnostic Group: VIIIa Osteosarcoma

Histologic Type ICD-O-3: 9180-9200
Primary Site: Any
Age at Diagnosis: 000 - 005

ICCC Diagnostic Group: VIIIb Chondrosarcoma

Histologic Type ICD-O-3: 9220-9230
Primary Site: Any

Histologic Type ICD-O-3: 9231, 9240
Primary Site: C400-C419

Age at Diagnosis: 000 - 005

ICCC Diagnostic Group: VIIIc Ewing sarcoma

Histologic Type ICD-O-3: 9260
Primary Site: C400-C419, C809

Histologic Type ICD-O-3: 9363, 9364
Primary Site: C400-C419

Age at Diagnosis: 000 - 003

ICCC Diagnostic Group: Xb Non-gonadal germ cell

Histologic Type ICD-O-3: 9060-9102
Primary Site: C000-C559, C570-C619, C630-C699, C739-C750, C754-C809
Age at Diagnosis: 008 - 014

ICCC Diagnostic Group: Xd Gonadal carcinoma

Histologic Type ICD-O-3: 8010-8041, 8050-8075, 8082, 8120-8122, 8130-8141, 8143, 8155, 8190-8201, 8210, 8211, 8221-8241, 8244-8246, 8260-8263, 8290, 8310, 8320, 8323, 8430, 8440, 8480-8490, 8504, 8510, 8550, 8560-8573
Primary Site: C569, C620-C629

Histologic Type ICD-O-3: 8380, 8381, 8441-8473
Primary Site: Any

Age at Diagnosis: 000 - 004

ICCC Diagnostic Group: XIb Thyroid carcinoma

Histologic Type ICD-O-3: 8010-8041, 8050-8075, 8082, 8120-8122 8130-8141, 8155, 8190, 8200, 8201, 8211, 8230, 8231, 8244-8246, 8260-8263, 8290, 8310, 8320, 8323, 8430, 8440, 8480, 8481, 8500-8573

Primary Site: C739

Histologic Type ICD-O-3: 8330-8350
Primary Site: Any

Age at Diagnosis: 000 - 005

ICCC Diagnostic Group: XIc Nasopharyngeal carcinoma

Histologic Type ICD-O-3: 8010-8041, 8050-8075, 8082, 8120-8122, 8130-8141, 8155, 8190, 8200, 8201, 8211, 8230, 8231, 8244-8246, 8260-8263, 8290, 8310, 8320, 8323, 8430, 8440, 8480, 8481,8504, 8510, 8550, 8560-8573
Primary Site: C110-C119
Age at Diagnosis: 000 - 005

ICCC Diagnostic Group: XIe Skin carcinoma

Histologic Type ICD-O-3: 8010-8041, 8050-8075, 8082, 8090-8110, 8140,8143, 8147, 8190, 8200, 8240, 8246, 8247, 8260, 8310, 8320, 8323, 8390-8420, 8430, 8480, 8542, 8560, 8570-8573, 8940
Primary Site: C440-C449
Age at Diagnosis: 000 - 004

ICCC Diagnostic Group: XIf NOS carcinoma

Histologic Type ICD-O-3: 8010-8082, 8120-8155, 8190-8263, 8290, 8310, 8314-8323, 8430-8440, 8480-8580, 8940, 8941
Primary Site: C000-C109, C129-C218, C239-C399, C480-C488, C500-C559, C570-C619, C630-C639, C659-C729, C750-C809
Age at Diagnosis: 000 - 004

ICCC Diagnostic Group: XIIa Mesothelial neoplasms (M905)

Histologic Type ICD-O-3: 9050-9053
Primary Site: Any
Age at Diagnosis: 000 - 014

Additional SEER Groups:

Cervix Uteri

Histologic Type ICD-O-3: Any
Behavior Code ICD-O-3: 2
Primary Site: C530-C539
Age at Diagnosis: 000 - 014

Placenta: choriocarcinoma

Histologic Type ICD-O-3: 9100
Primary Site: C589
Age at Diagnosis: 000 - 014

Esophagus, Small Intestine, Rectosigmoid, Rectum, Anus, Anal Canal, Gallbladder, Other Biliary Tract, Pancreas, Pleura, Breast, Uterus, NOS, Corpus Uteri, Penis

Histologic Type ICD-O-3: Any
Primary Site: C150-C159, C170-C179, C199, C209, C210-C218, C239,

```
      C240-C249, C250-C259, C384, C500-C509, C559, C540-C549, C609
      Age at Diagnosis: 000 - 014

Colon, Trachea, Lung and Bronchus

      Histologic Type ICD-O-3: Any other than carcinoid (8240-8245)
      Primary Site:  C180-C189, C339, C340-C349
      Age at Diagnosis: 000 - 014

Cervix Uteri

      Histologic Type ICD-O-3: Any with Behavior ICD-O-3 of 3
      Primary Site:  C530-C539
      Age at Diagnosis: 000 - 014

Prostate: adenocarcinoma

      Histologic Type ICD-O-3: 8140
      Primary Site:  C619
      Age at Diagnosis: 000 - 014

Multiple Myeloma

      Histologic Type ICD-O-3: 9732
      Primary Site:  Any
      Age at Diagnosis: 000 - 014

Chronic Myeloid Leukemia

      Histologic Type ICD-O-3: 9863, 9875, 9876, 9945
      Primary Site:  Any
      Age at Diagnosis: 000 - 014

Chronic Lymphocytic Leukemia

      Histologic Type ICD-O-3: 9823
      Primary Site:  Any
      Age at Diagnosis: 000 - 014
```

Administrative Notes

In the SEER*Edits software, the title of this edit is: IF119

Modifications:

NACR110A
1. Juvenile myelomonocytic leukemia (9946) was removed from the group of age/histologies requiring review
2. Edit logic modified to correctly generate error if Primary Site = C619 (prostate) and Histologic Type ICD-O-3 = 8140 (adenocarcinoma)

NAACCR v11.3
6/08
- Updated Administrative Notes with the title of the corresponding edit in the SEER*Edits software.
- Updated the edit to skip if the Over-ride Age/Site/Morph contains a 1 OR a 3
Note:
Over-ride Age/Site/Morph codes

1 = Reviewed: An unusual occurrence of a particular age/site/histology combination for a given age group has been reviewed
2 = Reviewed: Case was diagnosed in utero.
3 = Reviewed: Conditions 1 and 2 above both apply
Blank = Not reviewed or reviewed and corrected

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

Behavior Code, Histologic Type (NAACCR/MCR)

Agency: **Last changed: 06/13/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
Behavior (92-00) ICD-O-2 [Std# 430]
Histology (92-00) ICD-O-2 [Std# 420]

Default Error Message

[1129] Behavior not allowed for this ICDO2 histology for this dx year
Behavior not allowed for this ICDO2 histology for this dx year

Description

If Behavior (92-00) ICD-O-2 = 1 (borderline), then year of Date of Diagnosis must be greater than 2000 and Histology (92-00) ICD-O-2 must equal one of the following:

8931
9950
9960
9961
9962
9980
9981
9982
9983
9984
9989

These codes may have been entered as malignant in ICD-O-3, but converted to borderline in ICD-O-2.
MCR modification: Some histologies typical for 'benign brain tumors' are excluded as these were always reportable to the MCR.

Behavior ICDO2 (COC)

Agency: COC **Last changed: 07/07/2005**

Edit Sets

OfficeScan16D

Fields

Behavior (92-00) ICD-O-2 [Std# 430]

Default Error Message

[303] Behavior Code not valid - ICDO2
Behavior Code not valid - ICDO2

Description

This field is allowed to be blank because the item was not required after 2000. Another edit (Behavior ICDO2, Date of Diagnosis) verifies that this item is not blank if the year of Date of Diagnosis is less than 2001. Registries should include both edits in their edit set.

Must be a valid Behavior (92-00) ICD-O-2 code of 0 (benign), 1 (borderline), 2 (in situ) or 3 (malignant).

Behavior ICDO2, Behavior ICDO3 (SEER IF115)

Agency: SEER **Last changed: 06/27/2008**

Edit Sets

OfficeScan16D

Fields

Behavior (92-00) ICD-O-2 [Std# 430]
Behavior Code ICD-O-3 [Std# 523]

Default Error Message

[1016] %F1 and %F2 conflict
Behavior (92-00) ICD-O-2 and Behavior Code ICD-O-3 conflict

Description

```
If Behavior (92-00) ICD-O-2 = 2 and Behavior Code ICD-O-3 = 3, an error is
generated.

If Behavior (92-00) ICD-O-2 = 3 and Behavior Code ICD-O-3 = 2, an error is
generated.
```

Administrative Notes

In the SEER*Edits software, the title of this edit is: IF115

Modifications:

NAACCR v11.3
6/2008
Updated Administrative Notes with the title of the corresponding edit in the SEER*Edits software.

Behavior ICDO2, Summary Stage 1977 (NAACCR)

Agency: NAACCR **Last changed: 08/02/2005**

Edit Sets

OfficeScan16D

Fields

Behavior (92-00) ICD-O-2 [Std# 430]
SEER Summary Stage 1977 [Std# 760]
Type of Reporting Source [Std# 500]

Default Error Message

[1016] %F1 and %F2 conflict
Behavior (92-00) ICD-O-2 and SEER Summary Stage 1977 conflict

Description

```
This edit is skipped if SEER Summary Stage 1977 is blank or if case is death
certificate only (Type of Reporting Source = 7).

If Behavior (92-00) ICD-O-2 = 2 (in situ), then SEER Summary Stage 1977 must be 0.

If Behavior (92-00) ICD-O-2 = 3 (malignant), then SEER Summary Stage 1977 must be
greater than 0.
```

Behavior ICDO3 (COC)

Agency: COC **Last changed: 03/12/2003**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Behavior Code ICD-O-3 [Std# 523]

Default Error Message

[503] Behavior Code not valid - ICDO3
Behavior Code not valid - ICDO3

Description

This field is allowed to be blank because the item was not required until 2001. Another edit (Behavior ICDO3, Date of Diagnosis) verifies that this item is not blank if the year of Date of Diagnosis is greater than 2000 and not equal 9999. Registries should include both edits in their edit set.

Must be a valid Behavior Code ICD-O-3 code of 0 (benign), 1 (borderline), 2 (in situ) or 3 (malignant).

Behavior ICDO3 nonmalig, Summary Stage 2000 (MCR)

Agency: **Last changed: 02/23/2017**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Behavior Code ICD-O-3 [Std# 523]
SEER Summary Stage 2000 [Std# 759]
Type of Reporting Source [Std# 500]
Date of Diagnosis [Std# 390]
Class of Case [Std# 610]

Default Error Message

[1016] %F1 and %F2 conflict
Behavior Code ICD-O-3 and SEER Summary Stage 2000 conflict

Additional Messages

ERROR_TEXT("Date of Diagnosis: %DC")

Description

```
This edit is skipped if SEER Summary Stage 2000 is blank
This edit is skipped for Death Certificate-Only cases (Type of Reporting Source = 7
or Class of Case = 49).
This edit is skipped if year of Date of Diagnosis is empty, invalid, or less than
2004.

If Behavior Code ICD-O-3 = 0 or 1 (benign or borderline), then SEER Summary Stage
2000 must = 8 (not applicable).
```

Administrative Notes

v16D February 22, 2017 MCR original edit to make sure SS2000 code 8 is being used for benign/borderline behavior

Code 8 was added by the standard-setters to Summary Staging beginning with 2004 diagnoses for reportable benign/borderline brain/CNS tumors. (Although the code was not added into the SEER Summary Staging 2000 Manual, it is documented in the 2016 FORDS and SEER Program Coding and Staging Manual). In the 2004+ diagnosis years, MCR requires manually-entered Summary Stage 2000 for 2015+ diagnoses.

Behavior ICDO3, Date of Diagnosis (NAACCR)

Agency: NAACCR **Last changed: 11/27/2009**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
Behavior Code ICD-O-3 [Std# 523]

Default Error Message

[1113] If year of %F1 > 2000, then %F2 cannot be blank
If year of Date of Diagnosis > 2000, then Behavior Code ICD-O-3 cannot be blank

Additional Messages

ERROR_TEXT("Date of Diagnosis: %DC")

Description

If year of Date of Diagnosis is greater than 2000 and is not blank, then Behavior Code ICD-O-3 cannot be blank.

Administrative Notes

Modifications:

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

Behavior ICDO3, Histologic Type ICDO3 (NAACCR/MCR)

Agency: **Last changed: 08/21/2012**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
Behavior Code ICD-O-3 [Std# 523]
Histologic Type ICD-O-3 [Std# 522]

Default Error Message

[1128] Behavior not allowed for this ICDO3 histology for this dx year
Behavior not allowed for this ICDO3 histology for this dx year

Description

```
If Behavior Code ICD-O-3 = 1 (borderline), then year of Date of Diagnosis must be
less than 2001 and Histologic Type ICD-O-3 must equal one of the following: 8442,
8451, 8462, 8472, 8473.

These codes may have been entered as malignant in ICD-O-2, but converted to
borderline in ICD-O-3.
MCR requires benign, borderline brain and CNS for all years.
```

Administrative Notes

MCR removes NAACCR's 2004+ restriction on behaviors 0 & 1 for C70-C72, C751-C753.

Behavior ICDO3, Summary Stage 2000 (NAACCR)

Agency: NAACCR **Last changed: 12/15/2005**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Behavior Code ICD-O-3 [Std# 523]
SEER Summary Stage 2000 [Std# 759]
Type of Reporting Source [Std# 500]

Default Error Message

[1016] %F1 and %F2 conflict
Behavior Code ICD-O-3 and SEER Summary Stage 2000 conflict

Description

This edit is skipped if SEER Summary Stage 2000 is blank or if case is death certificate only (Type of Reporting Source = 7).

If Behavior Code ICD-O-3 = 2 (in situ), then SEER Summary Stage 2000 must be 0.

If Behavior Code ICD-O-3 = 3 (malignant), then SEER Summary Stage 2000 must be greater than 0.

Birthplace--Country (NAACCR)

Agency: NAACCR **Last changed: 12/08/2014**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Birthplace--Country [Std# 254]

Tables

CNTRY_ST.DBF

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of Birthplace--Country" is not a valid value for Birthplace--Country

Description

Birthplace--Country must contain a valid ISO code or standard custom code for country.

Administrative Notes

New edit - added to NAACCR v13 metafile.

This edit differs from the COC edit of the same name in that it does not allow the field to be blank.

Modifications

NAACCR v15
Country code table (CNTRY_ST.DBF) has been updated:
Brunei - 'BND' changed to 'BRN'
Czechoslovakia (former) - 'XCZ' changed to 'CSK'
Slovakia - 'SWK' changed to 'SVK'
Vanuatu - 'VLT' changed to 'VUT'
Yugoslavia (former) - 'XYG' changed to 'YUG'

Added Saint-Martin (French part) - 'MAF'

Birthplace--Country, Date of Diagnosis (NAACCR)

Agency: NAACCR **Last changed: 10/08/2014**

Edit Sets

HospitalScan16D

Fields

Birthplace--Country [Std# 254]
Date of Diagnosis [Std# 390]

Default Error Message

[4992] %F1 cannot be %V1 if %F2 is greater than 2012
Birthplace--Country cannot be "value of Birthplace--Country" if Date of Diagnosis is greater than 2012

Description

```
This edit is skipped if either field is blank.

If year of Date of Diagnosis is 2013 or later, then Birthplace--Country cannot be
any of the following "historic" codes:

XNI  North American Islands
XCB    Other Caribbean Islands
XEN    England, Channel Islands, Isle of Man
XSC    Scandinavia
XGR    Germanic Countries
XSL    Slavic Countries
XUM    Ukraine and Moldova
XNF    North Africa
XSD    Sudanese Countries
XWF    West Africa
XSF    South Africa
XEF    East Africa
XIF    African Islands
XET    Ethiopia and Eritrea
XAP    Arabian Peninsula
XIS    Israel and Palestine
XCR    Caucasian Republics of former USSR
XOR    Other Asian Republics of former USSR
XSE    Southeast Asia
XMS    Malaysia, Singapore, Brunei
XCH    China, NOS
XML    Melanesian Islands
XMC    Micronesian Islands
XPL    Polynesian Islands
```

Administrative Notes

New edit - added to NAACCR v13 metafile.

In the SEER*Edits software, the title of this edit is: IF399

This edit differs from the COC edit of the same name in that it is skipped if either field is blank.

Modifications

NAACCR v15
The historic codes used for Yugoslavia (XYG) and Czechoslovakia (XCZ) have been removed from the list of historic codes.

Birthplace--Country, State (NAACCR)

Agency: NAACCR **Last changed: 12/09/2014**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Birthplace--Country [Std# 254]
Birthplace--State [Std# 252]

Tables

CNTRY_ST.DBF

Default Error Message

[1016] %F1 and %F2 conflict
Birthplace--Country and Birthplace--State conflict

Description

This edit is skipped if any of the fields are blank.

This edit verifies that the Birthplace--State code is valid for the Birthplace--Country.

Administrative Notes

New edit - added to NAACCR v13 metafile.

In the SEER*Edits software, the title of this edit is: IF400

Modifications

NAACCR v15
- Edit updated to no longer allow Birthplace--State of XX (Resident of country other than U.S. or Canada, country known) with Birthplace--Country of ZZX (Not U.S. or Canada, country unknown)

Country code table (CNTRY_ST.DBF) has been updated:
Brunei - 'BND' changed to 'BRN'
Czechoslovakia (former) - 'XCZ' changed to 'CSK'
Slovakia - 'SWK' changed to 'SVK'
Vanuatu - 'VLT' changed to 'VUT'
Yugoslavia (former) - 'XYG' changed to 'YUG'

Added Saint-Martin (French part) - 'MAF'

State codes 'XX' and 'YY' (instead of just 'YY') allowed with 'CSK' and 'YUG"

Birthplace--State (NAACCR)

Agency: NAACCR **Last changed: 11/28/2012**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Birthplace--State [Std# 252]

Tables

CNTRY_ST.DBF

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of Birthplace--State" is not a valid value for Birthplace--State

Description

```
Birthplace--State must contain a valid ISO code or standard custom code for state.
```

Administrative Notes

New edit - added to NAACCR v13 metafile.

This edit differs from the COC edit of the same name in that it does not allow the field to be blank.

Birthplace--State, Date of Diagnosis (NAACCR)

Agency: NAACCR **Last changed: 12/11/2012**

Edit Sets

HospitalScan16D

Fields

Birthplace--State [Std# 252]
Date of Diagnosis [Std# 390]

Default Error Message

[4992] %F1 cannot be %V1 if %F2 is greater than 2012
Birthplace--State cannot be "value of Birthplace--State" if Date of Diagnosis is greater than 2012

Description

```
This edit is skipped if either field is blank.

If year of Date of Diagnosis is 2013 or later, then Birthplace--State cannot be any
of the following "historic" codes:

NN    New England and New Jersey
MM    Maritime Provinces
PP    Prairie Provinces
YN    Yukon and Northwest Territories
```

Administrative Notes

New edit - added to NAACCR v13 metafile.

In the SEER*Edits software, the title of this edit is: IF401

This edit differs from the COC edit of the same name in that it is skipped if either field is blank.

Bladder, RX Summ--Surg Prim Site, BRM (COC)

Agency: COC **Last changed: 04/11/2007**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
RX Summ--Surg Prim Site [Std# 1290]
RX Summ--BRM [Std# 1410]

Default Error Message

[1005] Conflict among %F1, %F2 and %F3
Conflict among Primary Site, RX Summ--Surg Prim Site and RX Summ--BRM

Description

This edit is skipped if either RX Summ--Surg Prim Site or RX Summ--BRM is empty.

If Primary Site = C670-C679 (bladder) and RX Summ--Surg Prim Site = 16, then RX Summ--BRM must = 01.

Administrative Notes

Modifications:

NACR111
12/11/06
The edit was updated so that it will be skipped if either RX Summ--Surg Prim Site or RX Summ--BRM is empty.

Class of Case (COC)

Agency: COC **Last changed: 04/08/2009**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Class of Case [Std# 610]

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of Class of Case" is not a valid value for Class of Case

Description

This field must contain a valid value for Class of Case (00, 10-14, 20-22, 30-38, 40-43, 49, or 99).

Administrative Notes

Modifications:

NACR110C
09/06
The description for this edit was updated.

NAACCR v12
04/09
- Class of Case was expanded from 1-digit to more explicit 2-digit codes.

Class, Date Diag, Date Last Cont, Vit Stat (COC)

Agency: COC **Last changed: 05/23/2010**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Class of Case [Std# 610]
Date of Last Contact [Std# 1750]
Date of Diagnosis [Std# 390]
Vital Status [Std# 1760]

Default Error Message

[1002] Conflict among %F1, %F2, %F3 and %F4
Conflict among Class of Case, Date of Last Contact, Date of Diagnosis and Vital Status

Additional Messages

ERROR_TEXT("Date of Diagnosis is invalid: %DC")
ERROR_TEXT("Date of Last Contact is invalid: %DC")

Description

This edit is skipped if either Date of Diagnosis or Date of Last Contact is empty.

If the case was diagnosed at autopsy or from a death certificate only (Class of Case coded 38 or 49), then Vital Status must be dead(code 0). If the case is autopsy only, then Date of Diagnosis and Date of Last Contact must be the same date. If both years are known, but either month is blank, then only the years are compared. If either day is blank, then only the years and months are compared.

Administrative Notes

Modifications

NAACCR v12.0:
- Autopsy Only Case is now identified by Class of Case 38 instead of code 5; DCO is identified by Class of Case 49 instead of code 8.
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.
- Logic deleted that requires the Date of Last Contact to equal the Date of Diagnosis for DCO case.

CS Eval Items, Class of Case (CS)

Agency: CS **Last changed: 10/04/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Class of Case [Std# 610]
Primary Site [Std# 400]
Behavior Code ICD-O-3 [Std# 523]
CS Tumor Size/Ext Eval [Std# 2820]
CS Lymph Nodes Eval [Std# 2840]
CS Mets Eval [Std# 2860]
Histologic Type ICD-O-3 [Std# 522]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3231] Conflict among CS Eval items and %F1
Conflict among CS Eval items and Class of Case

Description

```
This edit is skipped if any of the following conditions are true:
1. Class of Case is empty
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and
   schema is not Brain, CNSOther, or IntracranialGland
3. CS schema is invalid

If CS Tumor Size/Ext Eval, CS Lymph Nodes Eval, or CS Mets Eval = 8 (evidence from
autopsy only (tumor was unsuspected or undiagnosed prior to autopsy)), then Class
of Case must = 38 (diagnosed at autopsy).
```

Administrative Notes

Modifications:

NAACCR v11.2
8/2007
This edit was modified so that it will be skipped if Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and Primary Site is not C700-C729 (Brain and Other CNS) or C751-C753 (Intracranial Endocrine).

NAACCR v12.0
- Edit modified to use Class of Case code 38 instead 5 when checking for autopsy only cases.
- Edit modified to get schema name from function call to CS dll.

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Eval Items, Vital Status (CS)

Agency: CS **Last changed: 10/04/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Vital Status [Std# 1760]
Behavior Code ICD-O-3 [Std# 523]
CS Tumor Size/Ext Eval [Std# 2820]
CS Lymph Nodes Eval [Std# 2840]
CS Mets Eval [Std# 2860]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3231] Conflict among CS Eval items and %F1
Conflict among CS Eval items and Vital Status

Description

```
This edit is skipped if any of the following conditions are true:
1. Vital Status is empty
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and schema is not Brain,
CNSOther, or IntracranialGland
3. CS schema is invalid

Vital Status must = 0 or 4 (dead) for the following conditions:

1.  For all schemas: if CS Tumor Size/Ext Eval, CS Lymph Nodes Eval,
    or CS Mets Eval = 8 (evidence from autopsy only (tumor was
    unsuspected or undiagnosed prior to autopsy))

2. For cases using the Prostate schema
      If CS Tumor Size/Ext Eval = 3 [No surgical resection done, but
      evidence derived from autopsy (tumor was suspected or diagnosed
      prior to autopsy)]
   For all other schemas:
      If CS Tumor Size/Ext Eval = 2 [No surgical resection done, but
      evidence derived from autopsy (tumor was suspected or diagnosed
      prior to autopsy)]
```

Administrative Notes

In the SEER*Edits software, the title of this edit is: IF194

Modifications:

NAACCR v11.2
8/2007

This edit was modified so that it will be skipped if Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and Primary Site is not C700-C729 (Brain and Other CNS) or C751-C753 (Intracranial Endocrine).

NAACCR v11.3
6/2008
- Updated Administrative Notes with the title of the corresponding edit in the SEER*Edits software.
- Logic was added to verify that if prostate schema is used and CS Tumor Size/Ext Eval = 3 OR, for all other schemas, if CS Tumor Size/Ext Eval = 2, then Vital Status must = 0 or 4.

NAACCR v12.0
- Edit modified to get schema name from function call to CS dll.

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Ext, Histol ICDO3, Breast Schema (CS)

Agency: CS **Last changed: 10/04/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Extension [Std# 2810]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3356] Conflict among schema, %F2 (%V2), %F4 (%V4)
Conflict among schema, Histologic Type ICD-O-3 ("value of Histologic Type ICD-O-3"), CS Extension ("value of CS Extension"

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
This edit is skipped if any of the following conditions are true:
1. CS Extension is empty.
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
3. CS schema is invalid

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.

If CS schema is Breast:
    If Histology ICD-O-3 is coded as inflammatory carcinoma (8530),
        CS Extension must be coded as 710, 715, 725, 730, or 750.


Notes:
CS Extension 710 =
OBSOLETE DATA RETAINED V0200
Diagnosis of inflammatory carcinoma WITH a clinical description of inflammation,
erythema, edema, peau d'orange, etc., involving not more than 50% of the skin of
the breast,WITH or WITHOUT dermal lymphatic infiltration.
Diagnosis of inflammatory carcinoma WITH a clinical description of inflammation,
erythema, edema, peau d'orange, etc., involving not more than one-third (33%) of
the skin of the breast,WITH or WITHOUT dermal lymphatic infiltration

CS Extension 715 =
Diagnosis of inflammatory carcinoma WITH a clinical description of inflammation,
erythema, edema, peau d'orange, etc., involving not more than one-third (33%) of
the skin of the breast,WITH or WITHOUT dermal lymphatic infiltration
```

CS Extension 720 =
OBSOLETE - Should have been converted prior to implementing CSv2.
Diagnosis of inflammatory WITH a clinical diagnosis of inflammation, erythema, edema, peau d'orange, etc., of not more than 50% of the breast, WITH or WITHOUT dermal lymphatic infiltration.
Inflammatory carcinoma, NOS.
See code 710.

CS Extension 725 =
Diagnosis of inflammatory carcinoma WITH a clinical description of inflammation, erythema, edema, peau d'orange, etc., involving one-third (33%) or more but less than half (50%) of the skin of the breast,WITH or WITHOUT dermal lymphatic infiltration.

CS Extension 730 =
Diagnosis of inflammatory carcinoma
WITH a clinical description of inflammation, erythema, edema, peau d'orange, etc., involving more than 50% of the skin of the breast,
WITH or WITHOUT dermal lymphatic infiltration.

CS Extension 750 =
Diagnosis of inflammatory carcinoma
WITH a clinical description of inflammation, erythema, edema, peau d'orange, etc., but percent of involvement not stated,
WITH or WITHOUT dermal lymphatic infiltration. If percentage is known, code to 715, 725, or 730.
Diagnosis of inflammatory carcinoma WITHOUT a clinical description of inflammation, erythema, edema, peau d'orange, etc., WITH or WITHOUT dermal lymphatic infiltration.
Inflammatory carcinoma, NOS

Administrative Notes

New edit - added to NAACCR v11.3 metafile.

In the SEER*Edits software, the title of this edit is: IF197

Modifications:

NAACCR v12.0
- Edit modified to get schema name from function call to CS dll.
- Edit was modified to check CS Extension codes (per CSv2) of 710, 715, 725, 730, 750 for inflamatory carcinoma instead of CSv1.04 codes of 71, 72, and 73.

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Ext, LN, Mets at DX, SSF 1, Retinoblastoma (CS)

Agency: CS **Last changed: 10/04/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Extension [Std# 2810]
CS Lymph Nodes [Std# 2830]
CS Mets at DX [Std# 2850]
CS Site-Specific Factor 1 [Std# 2880]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3415] Conflict among schema, %F4 (%V4),%F5 (%V5),%F6 (%V6),%F7(%V7)
Conflict among schema, CS Extension ("value of CS Extension"),CS Lymph Nodes ("value of CS Lymph Nodes"),CS Mets at DX ("value of CS Mets at DX"),CS Site-Specific Factor 1("value of CS Site-Specific Factor 1"

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
This edit is skipped if any of the following conditions are true:
1. CS Extension, CS Lymph Nodes, CS Mets at DX, or CS Site-Specific Factor 1 is
blank
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
3. CS schema is invalid

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.

If schema = Retinoblastoma:

1. If CS Extension = 950 (no evidence of primary tumor), then at least one of the
following fields must show that tumor is present; that is, at least one of the
following must be true:
    CS Site-Specific Factor 1 must = 300-810, or 999
    CS Lymph Nodes must = 100-800
    CS Mets at DX must = 10-80

2. If CS Site-Specific Factor 1 = 950 (no evidence of primary tumor), then at least
one of the following fields must show that tumor is present; that is, at least one
of the following must be true:
    CS Extension must = 110-800
    CS Lymph Nodes must = 100-800
```

```
CS Mets at DX must = 10-80
```

Administrative Notes

New edit - added to NAACCR v12.1 metafile.

In the SEER*Edits software, the title of this edit is: IF349

Modifications

NAACCR v13A
Added SEER IF number (IF349)

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Ext, LN, Mets at DX, SSF 3, Prostate (CS)

Agency: CS **Last changed: 10/04/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Extension [Std# 2810]
CS Lymph Nodes [Std# 2830]
CS Mets at DX [Std# 2850]
CS Site-Specific Factor 3 [Std# 2900]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3415] Conflict among schema, %F4 (%V4),%F5 (%V5),%F6 (%V6),%F7(%V7)
Conflict among schema, CS Extension ("value of CS Extension"),CS Lymph Nodes ("value of CS Lymph Nodes"),CS Mets at DX ("value of CS Mets at DX"),CS Site-Specific Factor 3("value of CS Site-Specific Factor 3"

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
This edit is skipped if any of the following conditions are true:
1. CS Extension, CS Lymph Nodes, CS Mets at DX, or CS Site-Specific Factor 3 is
blank
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
3. CS schema is invalid

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.

If schema = Prostate:

1. If CS Extension = 950 (no evidence of primary tumor), then at least one of the
following fields must show that tumor is present; that is, at least one of the
following must be true:
    CS Site-Specific Factor 3 must = 000, 200-750, 990
    CS Lymph Nodes must = 100-800
    CS Mets at DX must = 11-60

2. If CS Site-Specific Factor 3 = 950 (no evidence of primary tumor), then at least
one of the following fields must show that tumor is present; that is, at least one
of the following must be true:
    CS Extension must = 000-750
    CS Lymph Nodes must = 100-800
```

```
CS Mets at DX must = 11-60
```

Administrative Notes

New edit - added to NAACCR v12.1 metafile.

In the SEER*Edits software, the title of this edit is: IF350

Modifications

NAACCR v13A
Added SEER IF number (IF350)

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Extension (CS)

Agency: CS **Last changed: 03/10/2010**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

CS Extension [Std# 2810]

Default Error Message

[1037] %F1 must be a three-digit number
CS Extension must be a three-digit number

Description

Must be a valid three-digit number (000-999) or blank.

Administrative Notes

Modifications:

NAACCR v12.0
The size of CS Extension was changed from 2 to 3 characters. Allowable codes changed from "00-99" to "000-999".

CS Extension, Brain Schema (CS)

Agency: CS **Last changed: 10/04/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
CS Extension [Std# 2810]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3328] Conflict between schema and %F3 (%V3)
Conflict between schema and CS Extension ("value of CS Extension"

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
The purpose of this edit is to verify the following:
1.CS Extension codes indicating infratentorial tumors are not coded to
supratentorial sites of the brain
2.CS Extension codes indicating supratentorial tumors are not coded to
infratentorial site of the brain
3. CS schema is invalid

This edit is skipped if CS Extension is empty.

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.

If schema is Brain:
1.  If Primary Site = C711-C715 (supratentorial), then CS Extension must not = 110,
120, 200, or 510 (infratentorial tumors).
2.  If Primary Site = C716-C717 (infratentorial), then CS Extension must not = 100
or 500 (supratentorial tumors).
```

Administrative Notes

New edit - added to NAACCR v11.3A metafile.

In the SEER*Edits software, the title of this edit is: IF212

Modifications

NAACCR v12.0:
- Edit modified to get schema name from function call to CS dll.

- Length of CS Extension changed from 2 to 3 characters.

NAACCR v14

- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Extension, CS Lymph Nodes, CS Mets at DX (CS)

Agency: CS **Last changed: 10/01/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Extension [Std# 2810]
CS Lymph Nodes [Std# 2830]
CS Mets at DX [Std# 2850]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3323] Conflict among schema, %F4 (%V4), %F5 (%V5), %F6 (%V6)
Conflict among schema, CS Extension ("value of CS Extension"), CS Lymph Nodes ("value of CS Lymph Nodes"), CS Mets at DX ("value of CS Mets at DX"

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
This edit is skipped if any of the following conditions are true:
1. CS Extension, CS Lymph Nodes, or CS Mets at DX is blank
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and
   schema is not Brain, CNSOther, or IntracranialGland
3. CS schema is invalid

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.

For all except Prostate and Retinoblastoma,
  if CS Extension = 950 (no evidence of primary tumor):
  then CS Lymph Nodes and CS Mets at DX cannot both specify none (000 and 00).

If CS schema is Breast:
  If CS Extension = 000 (in situ), then CS Lymph Nodes must = 000 (none;
  no regional lymph node involvement, or ITCs detected by immunohistochemistry
  or molecular methods ONLY) or 050 (none; no regional lymph nodes but with
  (ITCs) detected on routine H and E stains) and CS Mets at DX must = 00 (none).

If CS schema is IntracranialGland:
  If CS Extension = 000 (in situ), then CS Lymph Nodes must = 000 (obsolete data
retained v0200: none) or 988 (not applicable for this schema) and CS Mets at DX
must = 00 (none).
```

```
For the following schemas and in situ CS Extension codes, CS Lymph Nodes must = 000
(no lymph node involvement) and CS Mets at DX must = 00 (none):
  Schema              CS Extension
  Bladder             010, 030, 060
  KidneyRenalPelvis   050, 060
  Urethra             050, 060, 070, 080
  UrinaryOther        050, 060

If schema is not Breast, Bladder, KidneyRenalPelvis, Urethra or UrinaryOther:
  If CS Extension = 000, then both CS Lymph Nodes must = 000 (none) and CS Mets at
DX must = 00 (none).
```

Administrative Notes

In the SEER*Edits software, the title of this edit is: IF121

Modifications:

NACR111
11/02/06
Added logic: If CS Extension = 00 (in situ), then both CS Lymph Nodes and CS Mets at DX must = 00 (none).

NAACCR v11.1A
4/2007
The edit was modified:
1. It will be skipped if CS Extension, CS Lymph Nodes, or CS Mets at DX is blank.
2. It will be skipped if histology is Kaposi Sarcoma, Lymphoma, or Hematopoietic.
3. An exception was added for breast schema: If CS Extension = 00, then CS Lymph Nodes must = 00 or 05 and CS Mets at DX must = 00.

NAACCR v11.2
8/2007
This edit was modified so that it will be skipped if Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and Primary Site is not C700-C729 (Brain and Other CNS) or C751-C753 (Intracranial Endocrine).

This edit was also modified: If Primary Site = C670-C679 (Bladder):
If CS Extension = 01, 03, or 06 (in situ), then CS Lymph Nodes must = 00 (no lymph node involvement) and CS Mets at DX must = 00 (none).

Description updated: lymphoma and hematopoietic histologies are now grouped together in the list of histologies for which this edit is skipped.

NAACCR v11.3
6/2008
- Updated Administrative Notes with the title of the corresponding edit in the SEER*Edits software.
- An exception was added for the Placenta schema:
If CS Extension = 00 (in situ), then CS Mets at DX must = 00 (none).
(The edit no longer requires CS Lymph Nodes of 00 for CS Extension of 00... since the CS Lymph Nodes code is always 88 for the Placenta schema.)

NAACCR v12.0:
- Edit modified to get schema name from function call to CS dll.

- Edit was modified to check 3-digit CS Extension and CS Lymph Nodes codes (per CSv2) instead of 2-digit CSv1 codes.

NAACCR v12.1
- Additional schemas added to the edit: KidneyRenalPelvis, Urethra, and UrinaryOther.
- Statement on Placenta removed.

NAACCR v13
- Updated last paragraph of description: changed "For all other sites" to "If schema is not Breast, Bladder, KidneyRenalPelvis, Urethra or UrinaryOther".

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Default error message added
- Modified edit to allow, for IntracranialGland schema, CS Lymph Nodes of 988 (not applicable for this schema) when CS Extension = 000 (in situ)

CS Extension, CS Tumor Size, Breast Schema (CS)

Agency: CS **Last changed: 10/04/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Extension [Std# 2810]
CS Tumor Size [Std# 2800]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3325] Conflict among schema, %F4 (%V4), %F5 (%V5)
Conflict among schema, CS Extension ("value of CS Extension"), CS Tumor Size ("value of CS Tumor Size"

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

This edit verifies that CS Extension and CS Tumor Size are coded consistently for the Breast schema.

This edit is skipped if any of the following conditions are true:
1. CS Extension or CS Tumor Size is empty.
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
3. CS schema is invalid

This edit first determines the correct CS schema by doing a function call to the CS Dynamic Link Library (dll). The function call passes Primary Site, Histologic Type ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS schema name is returned.

If CS schema is Breast:

If CS Tumor Size = 997 (Paget disease of nipple without demonstrable tumor), CS Extension must = 050 (Paget without tumor) or 070 (Paget without tumor pathologically).

If CS Tumor size = 996 (Mammographic/xerographic diagnosis only, no size given; clinically not palpable), CS Extension must not equal 400 or higher (T4 tumors),except for code 999 (unknown extension).

If CS Extension = 170 (T1 with no other information on size or extension), CS Tumor Size must = 990, 991, or 992 (Stated as T1mic, T1b,T1NOS/T1c with no other information on size).

If CS Extension = 180 (T2 with no other information on size or extension),CS Tumor Size must = 995 (Stated as T2 with no other information on size).

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

In the SEER*Edits software, the title of this edit is: IF258

Modifications

NAACCR v12C
- Added closing brace "}" to edit logic. (The missing closing brace could make the logical output unpredictable.)

NAACCR v12.1
- Changed logic due to converted codes.
From:
If CS Tumor size = 996 (Mammographic/xerographic diagnosis only, no size given; clinically not palpable), CS Extension must not = 380, 390, or any code greater than 500 (T4 tumors), except for code 999 (unknown extension).
To:
If CS Tumor size = 996 (Mammographic/xerographic diagnosis only, no size given; clinically not palpable), CS Extension must not equal 400 or higher (T4 tumors),except for code 999 (unknown extension).

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Extension, CS Tumor Size, MycosisFungoides (CS)

Agency: CS **Last changed: 11/17/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Extension [Std# 2810]
CS Tumor Size [Std# 2800]
CS Site-Specific Factor25 [Std# 2879]
CS Version Input Original [Std# 2935]

Default Error Message

[3325] Conflict among schema, %F4 (%V4), %F5 (%V5)
Conflict among schema, CS Extension ("value of CS Extension"), CS Tumor Size ("value of CS Tumor Size"

Description

```
The purpose of this edit is to verify that CS Extension and CS Tumor Size are coded
consistently for MycosisFungoides cases that are originally coded using CSv02.05 or
higher.

CSv02.05 contains the following Note for MycosisFungoised Tumor Size:
Record the size of the largest tumor only.  For Mycosis Fungoides, a tumor is
described as a solid or nodular lesion at least 1 cm in diameter with evidence of
depth and/or vertical growth.  Do not record the size of individual patches,
papules, or plaques. Use code 999 if it is unknown if tumors are present, or if the
size of the largest tumor is unknown.

This edit is skipped under the following conditions:
1. CS Version Input Original is less than 020500
2. CS schema is not MycosisFungoides
3. CS Extension is empty
4. CS Tumor Size is empty.
5. Behavior Code ICD-O-3 = 0 (benign)or 1 (borderline)

If schema is MycosisFungoides:

      If CS Extension = 110, 120, 130, 150, 210, 220, 230, 300 (codes
    not indicating tumor)
    then
        CS Tumor Size must = 000 (no tumors present) or 999 (unknown)

    If CS Extension = 600 (one or more tumors equal to 1 cm or greater
    or cutaneous tumor, size not stated)
    then
        CS Tumor Size must not = 990 (microscopic focus or foci only
        and no size of focus given) or 991 (described as "less than 1
        centimeter")
```

This edit first determines the correct CS schema by doing a function call to the CS Dynamic Link Library (dll). The function call passes Primary Site, Histologic Type ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS schema name is returned.

Administrative Notes

New edit - added to NAACCR v14 metafile.

In the SEER*Edits software, the title of this edit is: IF463

CS Extension, CS Tumor Size, Site, Hist ICDO3 (CS)

Agency: CS **Last changed: 10/04/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Extension [Std# 2810]
CS Tumor Size [Std# 2800]
CS Site-Specific Factor 3 [Std# 2900]
CS Site-Specific Factor25 [Std# 2879]

Tables

MEL_HN.DBF

Default Error Message

[3325] Conflict among schema, %F4 (%V4), %F5 (%V5)
Conflict among schema, CS Extension ("value of CS Extension"), CS Tumor Size ("value of CS Tumor Size"

Additional Messages

[3323] Conflict among schema, CS Extension ("value of CS Extension"), CS Tumor Size ("value of CS Tumor Size"), CS Site-Specific Factor 3 ("value of CS Site-Specific Factor 3"
[3377] Conflict among schema, "stated as" CS Extension ("value of CS Extension"), CS Tumor Size ("value of CS Tumor Size"
SAVE_TEXT("t_schema_msg")

Description

```
This edit is skipped if any of the following conditions are true:
1. CS Extension or CS Tumor Size is empty.
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
3. CS schema is invalid

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.

If CS schema is not KaposiSarcoma, MelanomaSkin, Conjunctiva, MelanomaConjunctiva,
MelanomaChoroid, MelanomaIris, MelanomaCiliaryBody, LymphomaOcularAdnexa, or
Prostate:
      If CS Extension = 950 (no evidence of primary tumor), then CS Tumor Size must
= 000 (no mass/tumor found).

If CS schema is Prostate:
      If CS Extension = 950 and CS Site-Specific Factor 3 (pathologic extension) =
950, then CS Tumor Size must = 000.
```

If CS schema is not IllDefinedOther, one of the Mucosal Melanoma of Head and Neck schemas, or MycosisFungoides:

If CS Tumor Size = 000, then CS Extension must = 950.

The following schemas contain some CS Extension codes that are "stated as" values. These particular "stated as" codes reflect T values that match tumor size codes in the CS Tumor Size table. If the CS Extension is coded to one of the "stated as" values below, the CS Tumor Size must not be coded 999 (unknown; size not stated).

Schema	Extension "stated as" codes
AdrenalGland	200, 250
Anus	310, 320, 330
Bone	310, 350
Breast	110, 130, 140, 170, 180
BuccalMucosa	405, 410, 415
CarcinoidAppendix	320, 330, 335
FloorMouth	405, 410, 415
GISTAppendix	170, 210, 250, 270
GISTColon	170, 210, 250, 270
GISTEsophagus	170, 210, 250, 270
GISTPeritoneum	350, 360, 370, 380
GISTRectum	170, 210, 250, 270
GISTSmallIntestine	170, 210, 250, 270
GISTStomach	340, 390, 395, 398
GumLower	405, 410, 415
GumOther	405, 410, 415
GumUpper	405, 410, 415
HeartMediastinum	350, 375
Hypopharynx	305
KidneyParenchyma	310, 320, 330, 340, 350, 360
LacrimalGland	610, 620, 630
LipLower	405, 410, 415
LipOther	405, 410, 415
LipUpper	405, 410, 415
Lung	115, 120, 125
MerkelCellPenis	330, 560, 570
MerkelCellScrotum	310, 320, 330
MerkelCellSkin	600, 610, 620
MerkelCellVulva	450, 460, 470
MouthOther	405, 410, 415
NETAmpulla	310, 430
NETColon	170, 180, 190
NETRectum	170, 180, 190
NETSmallIntestine	170
NETStomach	170
Orbit	200, 300
Oropharynx	305, 310

```
PalateHard           405, 410, 415
PalateSoft           405, 410
PancreasBodyTail     150, 200
PancreasHead         150, 200
PancreasOther        150, 200
ParotidGland         305, 310
Peritoneum           350, 375
PharyngealTonsil     330, 350

Retroperitoneum      350, 375

SalivaryGlandOther   305, 310
Scrotum              310
Skin                 510
SoftTissue           302, 312, 322
SubmandibularGland   305, 310

Thyroid              405, 410, 415, 420
TongueAnterior       405, 410, 415
TongueBase           405, 410
```

Administrative Notes

In the SEER*Edits software, the title of this edit is: IF122

Modifications:

NAACCR v11.2
8/2007
This edit was modified so that it will be skipped if Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and Primary Site is not C700-C729 (Brain and Other CNS) or C751-C753 (Intracranial Endocrine).

NAACCR v11.3
6/2008
Updated Administrative Notes with the title of the corresponding edit in the SEER*Edits software.

NAACCR v12.0
- Added logic that checks schemas with CS Extension codes indicating "stated as" values and verifies that CS Tumor Size is not coded to 999.
- Edit modified to get schema name from function call to CS dll

NAACCR v12.1
- Revised to match CSv02.03 schemas

NAACCR v12.2C
- Edit modified to check CS SSF 3 (as well as CS Extension) for Prostate schema: if CS Extension = 950 and CS Site-Specific Factor 3 = 950, then CS Tumor Size must = 000.

NAACCR v14
- Edit modified to exclude MycosisFungoides schema when requiring CS Extension of 950 for CS Tumor Size of 000.
- Code 120 removed from list of Breast schema CS Extension "stated as" codes that require CS Tumor Size not be coded as 999.
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Extension, Hematopoietic (CS)

Agency: CS **Last changed: 10/04/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
CS Extension [Std# 2810]
Type of Reporting Source [Std# 500]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3328] Conflict between schema and %F3 (%V3)
Conflict between schema and CS Extension ("value of CS Extension"

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
This edit is skipped if any of the following conditions are true:
1. CS Extension is empty
2. Case is death certificate only (Type of Reporting Source = 7).
3. CS schema is invalid

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.

If schema is HemeRetic:

The CS Extension values of 100 (localized disease) and 999 (unknown) are allowed
only for Histologic Type ICD-O-3 codes 9740, 9750, 9751, 9755-9758, and 9930 in the
HemeRetic schema. This is because these particular histologies may be coded to
either 100 (localized) or 800 (systemic) and it is possible that it might be
unknown (999) whether the disease is localized or systemic. (Except for death
certificate only cases, all other hematopoietic histologies must be coded to 800.
This is edited by the CS algorithm program.)
```

Administrative Notes

In the SEER*Edits software, the title of this edit is: IF143

MODIFICATIONS:

NAACCR v11.1A
2/2007
The edit was modified:

1. It will be skipped if case is death certificate only (Type of Reporting Source = 7).
2. CS Extension of 99 (unknown) is allowed only for histologies in the hematopoietic schema that allow CS Extension of 10 (localized disease): 9731, 9734, 9740, 9750, 9755-9758, and 9930. This is because these particular histologies may be coded to either 10 (localized) or 80 (systemic) and it is possible that it might be unknown (99) whether the disease is localized or systemic. Other than death certificate only cases, all other histologies in the hematopoietic schema should be coded as 80.

NAACCR v11.2
Added code to skip if:
- Histologic Type ICD-O-3 = 9823 or 9827 and Primary Site is not C420, C421, or C424. (As of CS release 01.04, 9823 and 9827 are coded using the Lymphoma schema unless the Primary Site is C420, C42, or C424.)

NAACCR v11.3
6/2008
Updated Administrative Notes with the title of the corresponding edit in the SEER*Edits software.

NAACCR v12.0:
- Edit modified to get schema name from function call to CS dll.
- Length of CS Extension changed from 2 to 3 characters.
- Added code 9751 to list of histology codes that allow CS Extension codes of 100 and 999.

NAACCR v12.1
- 9731 and 9734 removed from list of histologies that can be coded to 100. (9731 and 9734 have been moved to the MyelomaPlasmaCellDisorder schema.)

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Extension, KidneyRenalPelvis Schema (CS)

Agency: CS **Last changed: 09/25/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Extension [Std# 2810]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3419] KidneyRenalPelvis schema: %F4 (%V4) allowed only for C659 (Renal Pelvis)
KidneyRenalPelvis schema: CS Extension ("value of CS Extension") allowed only for C659 (Renal Pelvis)

Additional Messages

[3420] KidneyRenalPelvis schema: CS Extension ("value of CS Extension") allowed only for C669 (Ureter)
SAVE_TEXT("t_schema_msg")

Description

```
This edit is skipped if any of the following conditions are true:
1. CS Extension is empty
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
3. CS schema is invalid

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.

If schema is KidneyRenalPelvis:

Renal Pelvis (C659) and Ureter (C669) belong to the same schema, but Renal Pelvis
can have CS Extension of 600, 665, and 670, while Ureter cannot. Ureter can have CS
Extension code 685, 690, and 695, while RenalPelvis cannot. All other CS Extension
values are the same for both sites and edited by the CS algorithm program.
```

Administrative Notes

In the SEER*Edits software, the title of this edit is: IF124

Modifications:

NAACCR v11.2
8/2007
This edit was modified so that it will be skipped if Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline).

NAACCR v11.3

6/2008
- Updated Administrative Notes with the title of the corresponding edit in the SEER*Edits software.
- Updated to skip the following histologies: 9140, 9590-9699,9702-9729, 9731-9989.

NAACCR v12.0:
- Changed edit name from "CS Extension, Renal Pelvis/Ureter Schema (CS)" to "CS Extension, KidneyRenalPelvis Schema (CS)".
- Edit modified to get schema name from function call to CS dll.
- Length of CS Extension changed from 2 to 3 characters.

NAACCR v12.1
- CS Extension code 665 and 670 added as code allowed for renal pelvis only; 685, 690, and 695 codes added for ureter only.

NAACCR v12.2
- Fixed typos in Administrative Notes

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Default error message added

CS Extension, Lymphoma Schema (CS)

Agency: CS **Last changed: 10/04/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
CS Extension [Std# 2810]
Type of Reporting Source [Std# 500]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3322] Conflict between %F1 (%V1) and %F3 (%V3)
Conflict between Primary Site ("value of Primary Site") and CS Extension ("value of CS Extension"

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
The purpose of this edit is to verify that CS Extension is coded properly for
lymphomas.

This edit is skipped if any of the following conditions are true:
1. CS Extension is empty
2. Case is death certificate only (Type of Reporting Source = 7).
3. CS schema is invalid

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.

If schema is Lymphoma:

If CS Extension = 100 (Involvement of a single lymph node region, Stage I), then
Primary Site must be one of the following:
    C770-C775, C779 (single lymph node region), C024 (lingual tonsil),
    C090-C099 (tonsil), C111 (pharyngeal tonsil), C142 (Waldeyer's ring),
    C172 (illeum), C181 (appendix) or C379 (thymus)

If CS Extension  = 110 (Localized involvement of a single extralymphatic
organ/ site in the absence of any lymph node involvement, multifocal involvement of
one extralymphatic organ/site, Stage IE), then Primary Site must NOT be one of the
following:
    C770-C775, C779, C379 or C422

If CS Extension  = 120 (Involvement of spleen only, Stage IS), then Primary Site
must be C422 (Spleen) .

Additionally,
```

```
If Primary Site = C778 (Multiple LNs), then CS Extension  must be > or = 200.

If Primary Site = C422 (Spleen), then CS Extension must be 120, 220, 230, 320, 330,
800, or 999.
```

Administrative Notes

New edit - added to NAACCR v11.2 metafile.

In the SEER*Edits software, the title of this edit is: IF195

NAACCR v11.3
6/2008
- Updated Administrative Notes with the title of the corresponding edit in the SEER*Edits software.
- Added C024 to list of primary sites allowed for CS Extension 10.

NAACCR v11.3A
9/2008
- Removed C024 (lingual tonsil), C090-C099 (tonsil), C111 (pharyngeal tonsil), C142 (Waldeyer's ring), C172 (illeum), and C181 (appendix) from list of primary sites NOT allowed for CS Extension 11.

NAACCR v12.0:
- Edit modified to get schema name from function call to CS dll.
- Length of CS Extension changed from 2 to 3 characters.

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Extension, Morphology, Bladder ICDO3 (CS)

Agency: CS **Last changed: 10/04/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Morph--Type&Behav ICD-O-3 [Std# 521]
CS Extension [Std# 2810]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[1005] Conflict among %F1, %F2 and %F3
Conflict among Primary Site, Histologic Type ICD-O-3 and Morph--Type&Behav ICD-O-3

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

This edit verifies that for cases coded using the CS Bladder schema, if the histology/behavior is 8130/2 (papillary transitional cell carcinoma, non-invasive), then CS Extension must not be coded to 100 (confined to mucosa, NOS).

Note: This edit is based on Note 3 of the CS Extension for Bladder schema: If a tumor is described as confined to mucosa AND as papillary, use extension code 010 or 030. Use code 100 (confined to mucosa) only if the tumor is described as confined to mucosa but is not described as papillary

This edit is skipped if any of the following conditions are true:
1. CS Extension is empty
2. CS schema is invalid

This edit first determines the correct CS schema by doing a function call to the CS Dynamic Link Library (dll). The function call passes Primary Site, Histologic Type ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS schema name is returned.

If schema is Bladder:

- If Morph--Type&Behav ICD-O-3 = 81302 (Papillary transitional cell carcinoma, non-invasive), then CS Extension must not = 100 (confined to mucosa, NOS).

- If CS Extension = 100, then Morph--Type&Behav ICD-O-3 must not = 81302.

Administrative Notes

New edit - added to NAACCR v11.3 metafile.

In the SEER*Edits software, the title of this edit is: IF210

NAACCR v12.0:
- Edit modified to get schema name from function call to CS dll.
- Length of CS Extension changed from 2 to 3 characters.

NAACCR v12.1
- Reference to "Note 8" changed to "Note 3".

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Extension, Mycosis Fungoides Schema (CS)

Agency: CS **Last changed: 11/05/2014**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
CS Extension [Std# 2810]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3253] Mycosis Fungoides Schema: %F1, %F3 conflict
Mycosis Fungoides Schema: Primary Site, CS Extension conflict

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
The purpose of this edit is to verify that CS Extension is coded properly for the
Mycosis Fungoides and Sezary Disease schema per Note 4 for CS Extension: Use code
150 when skin involvement is present but only a general location/site is mentioned
(i.e., face, legs, torso, arms). Use code 300 when there is skin involvement but
there is no mention of location/site.

This edit is skipped if:
1. CS Extension is empty.
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
3. CS schema is invalid

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.

If schema is MycosisFungoides:
    If Primary Site = C440-C448 (specified skin sites), then CS Extension must not
= 300 (Skin involvement, NOS).
```

Administrative Notes

New edit - added to NAACCR v11.3A metafile.

In the SEER*Edits software, the title of this edit is: IF215

Modifications

NAACCR v12.0:
- Edit modified to get schema name from function call to CS dll.

- Length of CS Extension changed from 2 to 3 characters.

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

NAACCR v15
- Description updated: “per Note 5 for CS Extension: Use code 250 when skin involvement is…” changed to “per Note 4 for CS Extension: Use code 150 when skin involvement is…”.

CS Extension, MyelomaPlasmaCellDisorder (CS)

Agency: CS **Last changed: 10/04/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
CS Extension [Std# 2810]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3328] Conflict between schema and %F3 (%V3)
Conflict between schema and CS Extension ("value of CS Extension"

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

The purpose of this edit is to verify that CS Extension is coded properly for the MyelomaPlasmaCellDisorder schema. The schema includes histologies 9731, 9732, and 9734, but some of the extension values apply only to a subset of the three histologies.

This edit is skipped if any of the following conditions are true:
1. CS Extension is empty
2. CS schema is invalid

This edit first determines the correct CS schema by doing a function call to the CS Dynamic Link Library (dll). The function call passes Primary Site, Histologic Type ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS schema name is returned.

If schema is MyelomaPlasmaCellDisorder:
1. The CS Extension values of 100 (localized disease) and 400 (Multiple osseous or multiple extraosseous plasmacytoma lesion) are allowed only for Histologic Type ICD-O-3 codes 9731 (Plasmacytoma, NOS) and 9734 (Plasmacytoma, extramedullary).

2. The CS Extension values of 110 (Single plasmacytoma lesion WITHOUT soft tissue extension or unknown if soft tissue extension), 200 (Single plasmacytoma lesion WITH soft tissue extension), and 500 (Plasmacytoma, NOS) are allowed only for Histologic Type ICD-O-3 code 9731 (Plasmacytoma, NOS).

3. The CS Extension value of 300 (Single plasmacytoma lesion occurring in tissue other than bone) is allowed only for Histologic Type ICD-O-3 code 9734 (Plasmacytoma, extramedullary).

4. The CS Extension value of 810 (Plasma cell myeloma/multiple myeloma/myelomatosis) and 820 (Myeloma, NOS) are allowed only for Histologic Type ICD-O-3 code 9732 (Multiple myeloma).

Administrative Notes

New edit - added to NAACCR v12.1 metafile.

In the SEER*Edits software, the title of this edit is: IF342

Modifications

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Extension, Primary Site, Behavior ICDO3 (CS)

Agency: CS **Last changed: 10/04/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Extension [Std# 2810]
CS Site-Specific Factor25 [Std# 2879]
Type of Reporting Source [Std# 500]

Default Error Message

[3243] Conflict among schema, %F3 (%V3), and %F4 (%V4)
Conflict among schema, Behavior Code ICD-O-3 ("value of Behavior Code ICD-O-3"), and CS Extension ("value of CS Extension"

Additional Messages

[3358] Conflict among schema, Histologic Type ICD-O-3 ("value of Histologic Type ICD-O-3"), Behavior Code ICD-O-3 ("value of Behavior Code ICD-O-3"), CS Extension ("value of CS Extension"
SAVE_TEXT("t_schema_msg")

Description

```
The purpose of this edit is to verify that the values coded in Behavior Code ICD-O-
3 and CS Extension are consistent.

This edit is skipped if any of the following conditions are true:
1. CS Extension is empty.
2. Case is death certificate only (Type of Reporting Source = 7)
3. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and
   schema is not Brain, CNSOther, or IntracranialGland
4. CS schema is invalid

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.

For all CS schemas except Prostate:
    If CS Extension = 000, then Behavior Code ICD-O-3 must = 2
    (in situ).

If schema is Stomach, SmallIntestine, GISTStomach, GISTSmallIntestine, NETStomach,
NETSmallIntestine, or EsophagusGEJunction:
    If CS Extension = 050, then Behavior Code ICD-O-3 must = 2.

If schema is Colon, Rectum, GISTColon, GISTRectum, NETColon, or NETRectum:
    If CS Extension = 050, then Behavior Code ICD-O-3 must = 2.
    If Histologic Type ICD-O-3 = 8210, 8261, or 8263 ('carcinoma in a
```

```
      polyp' codes), then if Behavior Code ICD-O-3 = 2, CS Extension
      must = 050.

If schema is Breast:
    If Behavior Code ICD-O-3 = 2, then CS Extension must = 000, 050,
    or 070.

If schema is Cervix:
    If CS Extension = 010, then Behavior Code ICD-O-3 must = 2.

If schema is Penis:
    If CS Extension = 050, then Behavior Code ICD-O-3 must = 2.

If schema is Brain schema, CNSOther, or IntracranialGland:
    If CS Extension = 050, then Behavior Code ICD-O-3 must = 0 (benign)
      or 1 (borderline).
    If Behavior Code ICD-O-3 = 0 or 1, then CS Extension must = 050.

If schema = EndocrineOther
    If Primary Site = C754 (carotid body), or C755 (aortic body
    and other paraganglia):
        CS Extension must not = 000.

If schema = KidneyRenalPelvis or UrinaryOther:
    If Behavior Code ICD-O-3 = 2, then CS Extension must = 050 or 060.
    If CS Extension = 050 or 060, then Behavior Code ICD-O-3 must = 2.

If schema = Urethra:
    If Behavior Code ICD-O-3 = 2, then CS Extension must = 050, 060, 070,
      or 080.
    If CS Extension = 050, 060, 070, or 080, then Behavior Code ICD-O-3
      must = 2.

If schema = Bladder:
    If Behavior Code ICD-O-3 = 2, then CS Extension must = 010, 030,
      060, or 100.
    If CS Extension = 010, 030, or 060, then Behavior Code ICD-O-3
      must = 2.

If schema = MelanomaConjunctiva:
    If CS Extension = 005, then Behavior Code ICD-O-3
      must = 3.
    If CS Extension = 100 or 120, then Behavior Code ICD-O-3
      may = 2 or 3.

If none of the above conditions are true:
    If CS Extension is greater than or equal to 100, then Behavior
      Code ICD-O-3 must = 3 (invasive).
```

Administrative Notes

In the SEER*Edits software, the title of this edit is: IF123

MODIFICATIONS:

NACR110B
Modified to skip DCO cases (Type of Reporting Source = 7).

NACR110C

Corrected typo in description.

NACR111:
09/25/06
Modified to require that, if after all exceptions have been checked, if CS Extension is greater than or equal to 10, then Behavior Code ICD-O-3 must = 3 (invasive).

NAACCR v11.1A
2/07
1. Added code to check if Primary Site = C379, C740-741, C749, C750-C755, and C758-C759 (Thymus, Adrenal (Suprarenal) Gland, and Other Endocrine Glands schema):
   A. If CS Extension = 05, then Primary Site must = C751, C752, or C753 and Behavior Code ICD-O-3 must = 0 (benign) or 1 (borderline).
   B. If Behavior Code ICD-O-3 = 0 or 1, then CS Extension must = 05.
2. Added code to skip borderline ovarian cases (Primary Site = C569, Histologic Type ICD-O-3 = 8442, 8451, 8462, 8472, or 8473, and Behavior Code ICD-O-3 = 1).
3. Added: If Primary Site = C180-C189 (Colon schema) or C199 or C209 (Rectum schema) and Histologic Type ICD-O-3 = 8210, 8261, or 8263 ('carcinoma in a polyp' codes), then if Behavior Code ICD-O-3 = 2, CS Extension must = 05.

NAACCR v11.2
8/2007
This edit was modified so that it will be skipped if Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and Primary Site is not C700-C729 (Brain and Other CNS) or C751-C753 (Intracranial Endocrine).

11/2007
- Description updated: lymphoma and hematopoietic histologies are now grouped together in the list of histologies for which this edit is skipped.
- Repeated code deleted from edit logic

NAACCR v11.3
6/2008
Updated Administrative Notes with the title of the corresponding edit in the SEER*Edits software.

NAACCR v11.3A
11/2008
Added:
1. If Primary Site = C160-C169 (Stomach schema) or C170-C179 (Small Intestine schema):
   If CS Extension = 05, then Behavior Code ICD-O-3 must = 2.
2. If Primary Site = C530-C539 (Cervix Uteri schema):
   If CS Extension = 01, then Behavior Code ICD-O-3 must = 2.
3. If Primary Site = C600-C609 (Penis schema):
   If CS Extension = 05, then Behavior Code ICD-O-3 must = 2.
4. If Primary Site = C740, C741, C749, C754, or C755, CS Extension must not = 00.

NAACCR v12.0:

- Edit modified to get schema name from function call to CS dll.
- Length of CS Extension changed from 2 to 3 characters.
- Additional schemas added.
- Deleted: if schema = AdrenalGland, CS Extension must not = 000.

NAACCRv12.1
- For the statement "If CS Extension = 000, then Behavior Code ICD-O-3 must = 2 (in situ)", an exception was added for the Prostate schema.
- CS Extension codes which require Behabior ICD-O-3 code of 2 were changed for the following schemas:
 KidneyRenalPelvis or UrinaryOther: changed from 000 and 050 to 050 and 060.
 Urethra: changed from 000, 010, 020, 050 to 050, 060, 070, 080
- Added: If schema = MelanomaConjunctiva and CS Extension = 005, then Behavior Code ICD-O-3 must = 3.
- Added error message 3243

NAACCRv12.2
- Added: If schema = MelanomaConjunctiva and CS Extension = 100 or 120, then Behavior Code ICD-O-3 may = 2 or 3.

NAACCR v14
 - Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Extension, Schema (CS)

Agency: CS **Last changed: 10/04/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Extension [Std# 2810]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3321] %F4 (%V4) is invalid for this schema
CS Extension ("value of CS Extension") is invalid for this schema

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that CS Extension is correct for a particular schema. The schema
determined by Primary Site, Histologic Type ICD-O-3, and sometimes CS Site-Specific
Factor25 (schema discriminator).

This edit is skipped if any of the following conditions are true:
1. CS Extension, Primary Site, or Histologic Type ICD-O-3 is blank
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and
   schema is not Brain, CNSOther, or IntracranialGland
3. CS schema is invalid

This edit verifies that CS Extension is valid for a particular schema by doing
function calls to the CS Dynamic Link Library (dll).

Note: This edit does not check for obsolete codes.  Obsolete codes for CS Extension
are edited by "Obsolete Codes - CS Extension (SEER IF146)".
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.
Replaces 'CS Extension, Primary Site, Histol ICDO3 (NAACCR)'

In the SEER*Edits software, the title of this edit is: IF227

Modifications

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Extension, SSF 1, Head and Neck Schemas (CS)

Agency: CS **Last changed: 11/17/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Extension [Std# 2810]
CS Site-Specific Factor 1 [Std# 2880]
CS Site-Specific Factor25 [Std# 2879]
CS Version Input Original [Std# 2935]

Tables

SCHEM_HN.DBF

Default Error Message

[3523] For this schema: If %F4 = %V4, then %F5 must = 000 or 999
For this schema: If CS Extension = "value of CS Extension", then CS Site-Specific Factor 1 must = 000 or 999

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
The purpose of this edit is to verify that CS Extension and CS Site-Specific Factor
1 (size of lymph nodes) are coded consistently for head and neck cases that are
originally coded using CSv02.05 or higher.

This edit is skipped if any of the following conditions are true:
1. CS Version Input Original is less than 020500
2. CS Extension is blank
3. Site-Specific Factor 1 is blank or 988
4. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)

This edit is skipped if CS schema is NOT one of the following Head and Neck
schemas:
 BuccalMucosa
 EpiglottisAnterior
 FloorMouth
 GumLower
 GumOther
 GumUpper
 Hypopharynx
 LarynxGlottic
 LarynxOther
 LarynxSupraglottic
 LarynxSubglottic
```

LipLower
LipOther
LipUpper
MelanomaLipUpper
MelanomaLipLower
MelanomaLipOther
MelanomaTongueAnterior
MelanomaGumUpper
MelanomaGumLower
MelanomaGumOther
MelanomaFloorMouth
MelanomaPalateHard
MelanomaMouthOther
MelanomaBuccalMucosa
MelanomaTongueBase
MelanomaPalateSoft
MelanomaOropharynx
MelanomaNasopharynx
MelanomaHypopharynx
MelanomaPharynxOther
MelanomaEpiglottisAnterior
MelanomaLarynxGlottic
MelanomaLarynxSupraglottic
MelanomaLarynxSubglottic
MelanomaLarynxOther
MelanomaNasalCavity
MelanomaSinusMaxillary
MelanomaSinusEthmoid
MelanomaSinusOther
MiddleEar
MouthOther
NasalCavity
Nasopharynx
Oropharynx
PalateHard
PalateSoft
ParotidGland
PharyngealTonsil
PharynxOther
SalivaryGlandOther
SinusEthmoid
SinusMaxillary
SinusOther
SubmandibularGland
TongueAnterior
TongueBase

If CS Extension = 000 (in situ, intraepithelial, noninvasive)
Then
    CS Site-Specific Factor 1 (size of lymph nodes) must = 000 (no involved regional
    nodes) or 999 (unknown)

This edit first determines the correct CS schema by doing a function call to the CS Dynamic Link Library (dll). The function call passes Primary Site, Histologic Type ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS schema name is returned.

Administrative Notes

New edit - added to NAACCR v14 metafile.

In the SEER*Edits software, the title of this edit is: IF464

CS Extension, SSF 1, Lung Schema (CS)

Agency: CS **Last changed: 10/04/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Extension [Std# 2810]
CS Site-Specific Factor 1 [Std# 2880]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[4862] Lung schema: If %F4 = %V4, %F5 must not = %V5
Lung schema: If CS Extension = "value of CS Extension", CS Site-Specific Factor 1 must not = "value of CS Site-Specific Factor 1"

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that for cases coded using the Lung schema, if extension
indicates in situ or no evidence of primary, then SSF 1 must not indicate separate
tumor nodules in ipsilateral lung.

If schema is Lung:
    If CS Extension code = 000, 950, or 980 (in situ or no evidence of primary)
    then CS Site-Specific Factor 1 must not = 010, 020, 030, or 040 which indicate
separate tumor nodules in the ipsilateral lung.


This edit is skipped if any of the following conditions are true:
1. CS Extension  is empty
2. CS Site-Specific Factor 1 is blank or 988
3. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
4. CS schema is invalid

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.
```

Administrative Notes

New edit - added to NAACCR v12.1A metafile.

In the SEER*Edits software, the title of this edit is: IF353

Modifications

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Extension, SSF 11, MerkelCellVulva Schema (CS)

Agency: CS **Last changed: 11/17/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Extension [Std# 2810]
CS Site-Specific Factor11 [Std# 2865]
CS Site-Specific Factor25 [Std# 2879]
CS Version Input Original [Std# 2935]

Default Error Message

[3536] MerkelCellVulva schema: If %F4 = %V4, then %F5 must = 000, 998, or 999
MerkelCellVulva schema: If CS Extension = "value of CS Extension", then CS Site-Specific Factor11 must = 000, 998, or 999

Description

```
The purpose of this edit is to verify that CS Extension and CS Site-Specific Factor
11 (regional lymph node - laterality) are coded consistently for MerkelCellVulva
non-invasive cases that are originally coded using CSv02.05 or higher.

This edit is skipped if any of the following conditions are true:
1. CS Version Input Original is less than 020500
2. CS Extension is blank
3. Site-Specific Factor11 is blank or 988
4. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)

If schema is MerkelCellVulva:

    If CS Extension = 000 (In situ, intraepidermal, intraepithelial, noninvasive)
    Then
        CS Site-Specific Factor11 (regional lymph node - laterality)
        must = 000 (all regional lymph nodes negative), 998 (lymph nodes
        not assessed) or 999 (unknown)

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.
```

Administrative Notes

New edit - added to NAACCR v14 metafile.

In the SEER*Edits software, the title of this edit is: IF465

CS Extension, SSF 11, Vulva Schema (CS)

Agency: CS **Last changed: 11/17/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Extension [Std# 2810]
CS Site-Specific Factor11 [Std# 2865]
CS Site-Specific Factor25 [Std# 2879]
CS Version Input Original [Std# 2935]

Default Error Message

[3543] Vulva schema: If %F4 = %V4, then %F5 must = 000, 998, or 999
Vulva schema: If CS Extension = "value of CS Extension", then CS Site-Specific Factor11 must = 000, 998, or 999

Description

```
The purpose of this edit is to verify that CS Extension and CS Site-Specific Factor
11 (regional lymph node - laterality) are coded consistently for non-invasive Vulva
cases that are originally coded using CSv02.05 or higher.

This edit is skipped if any of the following conditions are true:
1. CS Version Input Original is less than 020500
2. CS Extension is blank
3. Site-Specific Factor11 is blank or 988
4. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)

If schema is Vulva:

    If CS Extension = 000 (In situ, intraepithelial, noninvasive)
    Then
        CS Site-Specific Factor11 (regional lymph node - laterality)
        must = 000 (all regional lymph nodes negative), 998 (lymph
        nodes not assessed), or 999 (unknown)

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.
```

Administrative Notes

New edit - added to NAACCR v14 metafile.

In the SEER*Edits software, the title of this edit is: IF466

CS Extension, SSF 16, Scrotum Schema (CS)

Agency: CS **Last changed: 11/17/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Extension [Std# 2810]
CS Site-Specific Factor16 [Std# 2870]
CS Site-Specific Factor25 [Std# 2879]
CS Version Input Original [Std# 2935]

Default Error Message

[3539] Scrotum schema: If %F4 = %V4, then %F5 must = 000 or 999
Scrotum schema: If CS Extension = "value of CS Extension", then CS Site-Specific Factor16 must = 000 or 999

Description

```
The purpose of this edit is to verify that CS Extension and CS Site-Specific Factor
16 (size of lymph nodes) are coded consistently for non-invasive Scrotum cases that
are originally coded using CSv02.05 or higher.

This edit is skipped if any of the following conditions are true:
1. CS Version Input Original is less than 020500
2. CS Extension is blank
3. Site-Specific Factor16 is blank or 988
4. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)

If schema is Scrotum:

    If CS Extension = 000 (In situ, intraepidermal, intraepithelial, noninvasive)
    Then
        CS Site-Specific Factor16 (size of lymph nodes)
        must = 000 (no involved regional lymph nodes) or 999 (unknown)

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.
```

Administrative Notes

New edit - added to NAACCR v14 metafile.

In the SEER*Edits software, the title of this edit is: IF468

CS Extension, SSF 16, Skin Schema (CS)

Agency: CS **Last changed: 11/17/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Extension [Std# 2810]
CS Site-Specific Factor16 [Std# 2870]
CS Site-Specific Factor25 [Std# 2879]
CS Version Input Original [Std# 2935]

Default Error Message

[3538] Skin schema: If %F4 = %V4, then %F5 must = 000 or 999
Skin schema: If CS Extension = "value of CS Extension", then CS Site-Specific Factor16 must = 000 or 999

Description

```
The purpose of this edit is to verify that CS Extension and CS Site-Specific Factor
16 (size of lymph nodes) are coded consistently for non-invasive Skin cases that
are originally coded using CSv02.05 or higher.

This edit is skipped if any of the following conditions are true:
1. CS Version Input Original is less than 020500
2. CS Extension is blank
3. Site-Specific Factor16 is blank or 988
4. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)

If schema is Skin:

    If CS Extension = 000 (In situ, intraepidermal, intraepithelial, noninvasive)
    Then
        CS Site-Specific Factor16 (size of lymph nodes)
        must = 000 (no involved regional lymph nodes) or 999 (unknown)

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.
```

Administrative Notes

New edit - added to NAACCR v14 metafile.

In the SEER*Edits software, the title of this edit is: IF469

CS Extension, SSF 17, Penis Schema (CS)

Agency: CS **Last changed: 11/17/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Extension [Std# 2810]
CS Site-Specific Factor17 [Std# 2871]
CS Site-Specific Factor25 [Std# 2879]
CS Version Input Original [Std# 2935]

Default Error Message

[3537] Penis schema: If %F4 = %V4, then %F5 must = 000 or 999
Penis schema: If CS Extension = "value of CS Extension", then CS Site-Specific Factor17 must = 000 or 999

Description

```
The purpose of this edit is to verify that CS Extension and CS Site-Specific Factor
17 (extranodal extension of regional lymph nodes) are coded consistently for Penis
non-invasive cases that are originally coded using CSv02.05 or higher.

This edit is skipped if any of the following conditions are true:
1. CS Version Input Original is less than 020500
2. CS Extension is blank
3. Site-Specific Factor17 is blank or 988
4. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)

If schema is Penis:

    If CS Extension = 000 (In situ, intraepidermal, intraepithelial, noninvasive)
    Then
        CS Site-Specific Factor17 (extranodal extension of regional lymph nodes)
        must = 000 (no regional nodes involved) or 999 (unknown)

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.
```

Administrative Notes

New edit - added to NAACCR v14 metafile.

In the SEER*Edits software, the title of this edit is: IF471

CS Extension, SSF 2, Bladder Schema (CS)

Agency: CS **Last changed: 11/17/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Extension [Std# 2810]
CS Site-Specific Factor 2 [Std# 2890]
CS Site-Specific Factor25 [Std# 2879]
CS Version Input Original [Std# 2935]

Default Error Message

[3524] Bladder schema: If %F4 = %V4, then %F5 must = 000 or 999
Bladder schema: If CS Extension = "value of CS Extension", then CS Site-Specific Factor 2 must = 000 or 999

Description

```
The purpose of this edit is to verify that CS Extension and CS Site-Specific Factor
2 (size of metastasis in lymph nodes) are coded consistently for Bladder cases that
are originally coded using CSv02.05 or higher.

This edit is skipped if any of the following conditions are true:
1. CS Version Input Original is less than 020500
2. CS Extension is blank
3. Site-Specific Factor 2 is blank or 988
4. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
5. Schema is not Bladder

If schema is Bladder:

    If CS Extension = 010, 030, or 060 (codes indicating noninvasive
     or in situ carcinoma)
    Then
        CS Site-Specific Factor 2 (size of metastasis in lymph nodes)
        must = 000 (no regional lymph nodes involved) or 999 (unknown)

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.
```

Administrative Notes

New edit - added to NAACCR v14 metafile.

In the SEER*Edits software, the title of this edit is: IF473

CS Extension, SSF 3, Behavior, Prostate (CS)

Agency: CS **Last changed: 10/04/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Extension [Std# 2810]
CS Site-Specific Factor 3 [Std# 2900]
CS Site-Specific Factor25 [Std# 2879]
Type of Reporting Source [Std# 500]

Default Error Message

[4865] If %F4 = %V4 and %F5 = %V5, %F3 (%V3) must = 2
If CS Extension = "value of CS Extension" and CS Site-Specific Factor 3 = "value of CS Site-Specific Factor 3", Behavior Code ICD-O-3 ("value of Behavior Code ICD-O-3") must = 2

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
The purpose of this edit is to verify that the values coded in Behavior Code ICD-O-
3 and CS Extension are consistent.

This edit is skipped if any of the following conditions are true:
1. CS Extension is empty.
2. Case is death certificate only (Type of Reporting Source = 7)
3. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
4. CS schema is invalid

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.

If schema is Prostate:
    [If CS Extension = 000 and CS Site-Specific Factor 3 not = 200-750, or 985
      OR
    If CS Site-Specific Factor 3 = 000 and CS Extension not = 100-750]
     then Behavior Code ICD-O-3 must = 2 (in situ).
```

Administrative Notes

New edit - added to NAACCR v12.1 metafile.

In the SEER*Edits software, the title of this edit is: IF346

Modifications

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Extension, SSF 3, Breast Schema (CS)

Agency: CS **Last changed: 11/17/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Extension [Std# 2810]
CS Site-Specific Factor 3 [Std# 2900]
CS Site-Specific Factor25 [Std# 2879]
CS Version Input Original [Std# 2935]

Default Error Message

[3526] Breast schema: If %F4 = %V4, then %F5 must = 000, 098, or 099
Breast schema: If CS Extension = "value of CS Extension", then CS Site-Specific Factor 3 must = 000, 098, or 099

Description

```
The purpose of this edit is to verify that CS Extension and CS Site-Specific Factor
3 (number of positive ipsilateral level I-II axillary lymph nodes) are coded
consistently for Breast cases that are originally coded using CSv02.05 or higher.

This edit is skipped if any of the following conditions are true:
1. CS Version Input Original is less than 020500
2. CS Extension is blank
3. Site-Specific Factor 3 is blank or 988
4. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
5. Schema is not Breast

If schema is Breast:

    If CS Extension = 000 (mapping to in situ for AJCC staging)
    Then
        CS Site-Specific Factor 3 (number of positive ipsilateral level
        I-II axillary lymph nodes) must = 000 (all ipsilateral axillary
        nodes examined negative), 098 (no axillary nodes examined) or
        099 (unknown)


This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.
```

Administrative Notes

New edit - added to NAACCR v14 metafile.

In the SEER*Edits software, the title of this edit is: IF476

CS Extension, SSF 5, Testis Schema (CS)

Agency: CS **Last changed: 11/17/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Extension [Std# 2810]
CS Site-Specific Factor 5 [Std# 2920]
CS Site-Specific Factor25 [Std# 2879]
CS Version Input Original [Std# 2935]

Default Error Message

[3541] Testis schema: If %F4 = %V4, then %F5 must = 000 or 999
Testis schema: If CS Extension = "value of CS Extension", then CS Site-Specific Factor 5 must = 000 or 999

Description

```
The purpose of this edit is to verify that CS Extension and CS Site-Specific Factor
5 (size of metastasis in lymph nodes) are coded consistently for non-invasive
Testis cases that are originally coded using CSv02.05 or higher.

This edit is skipped if any of the following conditions are true:
1. CS Version Input Original is less than 020500
2. CS Extension is blank
3. Site-Specific Factor 5 is blank or 988
4. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)

If schema is Testis:

    If CS Extension = 000 (In situ, intraepithelial, noninvasive)
    Then
        CS Site-Specific Factor 5 (size of metastasis in lymph nodes)
        must = 000 (no lymph node metastasis) or 999 (unknown)

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.
```

Administrative Notes

New edit - added to NAACCR v14 metafile.

In the SEER*Edits software, the title of this edit is: IF484

CS Extension, Surgery, Prostate Schema (CS)

Agency: CS **Last changed: 10/04/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Extension [Std# 2810]
RX Summ--Surg Prim Site [Std# 1290]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]
CS Version Input Original [Std# 2935]

Default Error Message

[3325] Conflict among schema, %F4 (%V4), %F5 (%V5)
Conflict among schema, CS Extension ("value of CS Extension"), RX Summ--Surg Prim Site ("value of RX Summ--Surg Prim Site"

Additional Messages

ERROR_TEXT("Date of Diagnosis: %DC")
SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that, for cases coded using the CS Prostate schema, if CS
Extension indicates a TURP was done, then RX Summ--Surg Prim Site must also
indicate a TURP, at least, was done.

This edit is skipped if any of the following conditions are true:
1. Schema is not C619 (prostate)
2. CS Extension is blank
3. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
4. CS schema is invalid
5. Date of Diagnosis is blank
6. RX Summ--Surg Prim Site is blank

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.

If CS Extension is coded 130 or 140 (TURP was done), then
  RX Summ--Surg Prim Site must not = 00 (none) or 99 (unknown).

If year of Diagnosis is 2010 or higher OR CS Version Input Original is 020100 or
higher:
  If CS Extension is coded 100(TURP was done), then
    RX Summ--Surg Prim Site must not = 00 (none) or 99 (unknown).
```

```
Notes:
CS Extension 100 =
Incidental histologic finding on TURP, number of foci or percent involved tissue
not specified (clinically inapparent); Stage A, NOS; Stated as cT1, NOS

CS Extension 130 =
Incidental histologic finding on TURP in 5% or less of tissue resected (clinically
inapparent); Stated as cT1a based on TURP findings

CS Extension 140 =
Incidental histologic finding on TURP more than 5% of tissue resected (clinically
inapparent); Stated as cT1b based on TURP findings
```

Administrative Notes

New edit - added to NAACCR v11.3 metafile.

In the SEER*Edits software, the title of this edit is: IF199

Modifications:

NAACCR v12.0:
- Edit was modified to check 3-digit CS Extension codes (per CSv2) instead of 2-digit CSv1 codes.
- CS Extension code 100 was added as an additional code (along with 130 and 140)that requires at least a TURP be performed.

NAACCR v12A:
- Logic changed to include CS Extension code 100 as "TURP performed" only if year of Diagnosis is 2010+ or the case was originally coded using CSv2.

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Extension, TS/Ext Eval, Prostate Schema (CS)

Agency: CS **Last changed: 10/04/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Extension [Std# 2810]
CS Tumor Size/Ext Eval [Std# 2820]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3245] %F4 (%V4) and %F5 (%V5) conflict
CS Extension ("value of CS Extension") and CS Tumor Size/Ext Eval ("value of CS Tumor Size/Ext Eval") conflict

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that for cases coded using the CS Prostate schema, CS Extension
and CS Tumor Size/Ext Eval are consistent.

This edit is skipped if any of the following conditions are true:
1. CS Extension is blank
2. CS Tumor Size/Ext Eval is blank
3. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
4. CS schema is invalid


This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.

If CS schema is Prostate:
1.  If CS Extension is coded 130 [Incidental histologic
    finding in 5% or less of tissue resected (clinically inapparent);
    Stated as cT1a] or 140 [Incidental histologic finding more than 5% of
    tissue resected (clinically inapparent); Stated as cT1b]

    then:

    CS Tumor Size/Ext Eval must NOT = 0 (No prostatectomy done.
    Evaluation based on physical examination, imaging examination, or
    other non-invasive clinical evidence. No autopsy evidence used).

2.  If CS Tumor Size/Ext Eval = 2 (No prostatectomy done, but
```

```
    positive biopsy of extraprostatic tissue allows assignment to CS
    Extension Codes 410-700 (see Note 3)

    then:

    CS Extension must = 410-700.

3.  If CS Tumor Size/Ext Eval = 8 (Evidence from autopsy only)

    then:

    CS Extension must = 999 (Extension unknown).
```

Administrative Notes

New edit - added to NAACCR v11.3 metafile.

In the SEER*Edits software, the title of this edit is: IF200

NAACCR v11.3A
11/2008
- Deleted:
If CS Extension is coded 15, then CS Tumor Size/Ext Eval must NOT = 0
- Added:
If CS Tumor Size/Ext Eval = 2, CS Extension must = 41-70.

NAACCR v12.0:
- Edit modified to get schema name from function call to CS dll.
- Edit was modified to check 3-digit CS Extension codes (per CSv2) instead of 2-digit CSv1 codes. Miscellaneous wording changed to match CSv2.
- Added: If CS Tumor Size/Ext Eval = 8 (Evidence from autopsy only), CS Extension must = 999 (Extension unknown).

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Items - NPCR Required - Non-SSF (CS)

Agency: NPCR **Last changed: 03/25/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
Over-ride CS 20 [Std# 3769]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor25 [Std# 2879]
CS Extension [Std# 2810]
CS Lymph Nodes [Std# 2830]
CS Mets at DX [Std# 2850]
CS Version Input Original [Std# 2935]
CS Version Input Current [Std# 2937]
CS Tumor Size [Std# 2800]
CS Tumor Size/Ext Eval [Std# 2820]
Regional Nodes Examined [Std# 830]
Regional Nodes Positive [Std# 820]
Type of Reporting Source [Std# 500]

Default Error Message

[3136] Conflict between year of DX and CS items
Conflict between year of DX and CS items

Additional Messages

ERROR_TEXT("Date of Diagnosis: %DC")
SAVE_TEXT("If %F2 = %V2 and %F16 = %V16, CS Site-Specific Factor25 cannot be blank")
SAVE_TEXT("If %F2 = %V2 and %F16 = %V16, CS Tumor Size cannot be blank")
SAVE_TEXT("If %F2 = %V2 and %F16 = %V16, CS Version Input Current cannot be blank")
SAVE_TEXT("If %F2 = %V2 and %F16 = %V16, CS Version Input Original cannot be blank")
SAVE_TEXT("If %F2 = %V2 and %F16 = %V16, Regional Nodes Examined cannot be blank")
SAVE_TEXT("If %F2 = %V2 and %F16 = %V16, Regional Nodes Positive cannot be blank")
SAVE_TEXT("If DX > 2003, CS Site-Specific Factor25 cannot be blank")
SAVE_TEXT("If DX > 2003, CS Version Input Current cannot be blank")
SAVE_TEXT("If DX > 2003, CS Version Input Original cannot be blank")
SAVE_TEXT("If year of DX > 2003, CS Extension cannot be blank")
SAVE_TEXT("If year of DX > 2003, CS Lymph Nodes cannot be blank")
SAVE_TEXT("If year of DX > 2003, CS Mets at DX cannot be blank")
SAVE_TEXT("If year of DX > 2007, CS Tumor Size cannot be blank")
SAVE_TEXT("If year of DX > 2007, CS Tumor Size/Ext Eval cannot be blank")
SAVE_TEXT("If year of DX > 2011, Regional Nodes Examined cannot be blank")
SAVE_TEXT("If year of DX > 2011, Regional Nodes Positive cannot be blank")

Description

The purpose of this edit is to verify that all CS data items required by NPCR, other than the site-specific factors, are entered (not blank) per the NPCR requirements. For diagnosis year 2012 and later, NPCR permits the use of Directly Coded Summary Stage (SEER Summary Stage 2000 [759]) in those cases where collection of CSv02 is not feasible due to lack of data or due to staffing and time constraints at the local or central registry. The data item 'Over-ride CS 20' is used to flag a case where SEER Summary Stage 2000 is recorded in lieu of Derived SS2000 [3020]. When 'Over-ride CS 20' is equal to '1', SEER Summary Stage 2000 must be populated (not blank). The CS input fields may be populated, but are not required. When 'Over-ride CS 20' is blank, the Collaborative Stage input fields must be populated per NPCR requirements and SEER Summary Stage 2000 may also be populated, but is not required.

Beginning with the NAACCR v13 metafile, Over-ride CS 20 may be set to '1' for the types of reporting source 3-7 (listed below) for cases with a diagnosis year of 2004 or later. This is checked in another edit: CS Over-ride CS 20, Rpt Srce, CS Fields (NPCR).

Type of Reporting Source
- 3 (laboratory only)
- 4 (physician's office)
- 5 (nursing home)
- 6 (autopsy only)
- 7 (death certificate only)

The site-specific factors are edited schema-specifically in other edits.

This edit is skipped if:
1. Date of Diagnosis is blank or less than 2004.
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and schema is not Brain, CNSOther, or IntracranialGland.
3. CS Schema is invalid
4. Type reporting source 6 or 7

A. If Over-ride CS 20 is blank, indicating all CS items required by NPCR for staging are coded:

1. If year of Date of Diagnosis is 2004-2015, the following CS data items cannot be blank. If year of diagnosis is 2016 or later, they may be blank.
   - CS Extension
   - CS Lymph Nodes
   - CS Mets at DX
   - CS Version Input Original
   - CS Version Input Current

2. If year of Date of Diagnosis is 2008-2015, the following additional CS data items cannot be blank. If year of Date of Diagnosis is 2016 or later, they may be blank.
   - CS Tumor Size
   - CS Tumor Size/Ext Eval

3. If year of Date of Diagnosis is 2012 or later, the following additional CS data items cannot be blank:
   - Regional Nodes Examined
   - Regional Nodes Positive

Note: For cases diagnosed 2016 or later CS Version Input Current and CS Version Input Original may be blank, unless a CS Site Specific Factor is required. The

```
edits that check for required CS Site Specific Factors also check that CS Version
Input Current and CS Version Input Original are not blank.

B.  If Over-ride CS 20 is '1' and Type of Reporting Source is not 3-7, the
following CS data item cannot be blank:
    Regional Nodes Examined
    Regional Nodes Positive
    CS Tumor Size
    CS Version Input Original
    CS Version Input Current
    CS Site-Specific Factor25

C.  If Over-ride CS 20 is '1' and Type of Reporting Source = 3-7, all CS input
items may be left blank.
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile; replaces former edit "CS Items, Date of Diagnosis (NPCR)"

Modifications:

NAACCR v12.1
- CS Site-Specific Factor25 was added to the list of fields required for all cases diagnosed 2004 and later.

NAACCR v12.2
- Updated to require Regional Nodes Examined and Regional Nodes Positive for cases diagnosed 2012+.
- Updated to require Lymph-vascular Invasion for Penis and Testis schemas for cases diagnosed 2012+.
- Updated to require only Regional Nodes Examined, Regional Nodes Positive, CS Tumor Size, CS Version Input Original, CS Version Input Current, and CS Site-Specific Factor25 if Over-ride CS 20 is set to 1, indicating case is coded using directly coded SEER Summary Stage 2000 [759] for staging.

NAACCR v12.2A
- Updated to no longer require Lymph-vascular Invasion.

NAACCR v13
- Edit modified to take into account the use of Over-ride CS 20 for Type of Reporting Source = 3-7.

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

NAACCR v16
- CS Extension,CS Lymph Nodes, CS Mets at DX,,CS Site-Specific Factor25,CS Tumor Size, CS Tumor Size/Ext Eval,CS Version Input Original, and CS Version Input Current may be blank for cases diagnosed 2016 and after. Reflects NPCR reporting requirements for 2016.

CS Items - NPCR Required - SSF 1 (CS) - 2015

Agency: NPCR **Last changed: 07/18/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

CS Version Input Original [Std# 2935]
CS Version Input Current [Std# 2937]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor 1 [Std# 2880]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]
Over-ride CS 20 [Std# 3769]
Type of Reporting Source [Std# 500]

Tables

CS_SSF.DBF

Default Error Message

[4225] Conflict between %F6 and NPCR requirements
Conflict between CS Site-Specific Factor 1 and NPCR requirements

Additional Messages

[3177] For Date of Diagnosis of "value of Date of Diagnosis", CS Site-Specific Factor 1 must not be 988 for this schema
[4852] For DX Year > 2003, CS Site-Specific Factor 1 must not be blank
[4856] For DX Year > 2003, CS Site-Specific Factor 1 must not be 988
[4882] If Over-ride CS 20 = '1' and Type of Reporting Source = "value of Type of Reporting Source", then CS Site-Specific Factor 1 must not be blank or 988
ERROR_TEXT("Schema missing in SSF table")
SAVE_TEXT("t_schema_msg")

Description

The purpose of this edit is to verify that CS Site-Specific Factor 1 is entered for the schemas required by NPCR. For diagnosis year 2012 and later, NPCR permits the use of Directly Coded Summary Stage (SEER Summary Stage 2000 [759]) in those cases where collection of CSv02 is not feasible due to lack of data or due to staffing and time constraints at the local or central registry. The data item 'Over-ride CS 20' is used to flag a case where SEER Summary Stage 2000 is recorded in lieu of Derived SS2000 [3020]. When 'Over-ride CS 20' is equal to '1', SEER Summary Stage 2000 must be populated (not blank). The CS input fields may be populated, but are not required. When 'Over-ride CS 20' is blank, the Collaborative Stage input fields must be populated per NPCR requirements and SEER Summary Stage 2000 may also be populated, but is not required.

Beginning with the NAACCR v13 metafile, Over-ride CS 20 may also be set to '1' for the types of reporting source 3-7 (listed below) for cases with a diagnosis year of 2004 or later.

Type of Reporting Source
- 3 (laboratory only)
- 4 (physician's office)
- 5 (nursing home)
- 6 (autopsy only)
- 7 (death certificate only)

This edit is skipped if any of the following conditions are true:
1. CS Version Input Current is blank
2. CS Version Input Original is blank
3. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and schema is not Brain, CNSOther, or IntracranialGland
4. CS schema is invalid
5. Date of Diagnosis is blank OR invalid
6. Date of Diagnosis is 2016 or later

A. For all schemas, if year of Diagnosis is 2004 - 2015 AND Over-ride CS 20 (for 2012+ cases) is blank, CS SSF 1 cannot be blank.

B. If Over-ride CS 20 is blank, indicating case is coded using CS, then CS Site-Specific Factor 1 cannot = 988 or blank for the schemas for which CS Site-Specific Factor 1 is required by NPCR. See List 1 below.

Detailed logic for B:
If Over-ride CS 20 is blank:

1. If year of Diagnosis is 2011 - 2015
then
CS Site-Specific Factor 1 must not be 988 (not collected) or blank for any of the schemas for which it is required (see List 1).

2. If year of Diagnosis is 2010
then
CS Site-Specific Factor 1 must not be 988 or blank for Pleura, Breast, Lung, and Retinoblastoma schemas.

3. If year of Diagnosis is 2004-2009 AND CS Version Input Original is 01xxxx:
then
CS Site-Specific Factor 1 must not be 988 or blank for Pleura or Retinoblastoma.
Note: No need to check if CS Site-Specific Factor 1 is 988 for Retinoblastoma schema since 988 is not a valid code for Retinoblastoma.

C. If Over-ride CS 20 is '1' and Type of Reporting Source is not 3-7, CS Site-Specific Factor 1 must not be 988 or blank for the schemas listed in List 2 (see below).

Detailed logic for C:
If Over-ride CS 20 is '1' and Type of Reporting Source is not 3-7:
- CS Site-Specific Factor 1 must not be 988 or blank for Breast, Brain, CNSOther, and IntraCranialGland schemas.

D. If Over-ride CS 20 is '1' and Type of Reporting Source is 3-7, CS Site-Specific Factor 1 will pass if blank.

```
List 1: Schemas for which CS Site-Specific Factor 1 is required by NPCR
-------------------------------------------------------------------------------------
-------------
Required for cases diagnosed 2004 or later:
  Pleura

Additionally required only for cases diagnosed 2010 or later:
  Breast
  Lung
  Retinoblastoma

Additionally required only for cases diagnosed 2011 or later:
  Brain
  CNSOther
  IntraCranialGland



List 2: Schemas for which CS Site-Specific Factor 1 is required by NPCR even if the
case is coded using directly coded SEER Summary Stage 2000 [759] (indicated by
Over-ride CS 20 of '1' and Type of Reporting Source not = 3-7)
-------------------------------------------------------------------------------------
----------------------------------------
  Breast
  Brain
  CNSOther
  IntraCranialGland
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

Modifications:

NAACCR v12C:
- Added Lung to the schemas for which NPCR requires CS Site-Specific Factor 1. Table 'CS_SSF.dbf" was updated to enforce this requirement.

Modifications:

NAACCR v12.1
- Edit updated to correspond to the CSV0203 NPCR requirements.
- Brain, CNSOther, and IntraCranialGland added to list of schema requiring CS Site-Specific Factor 1.
- For all schemas, if year of Diagnosis is 2004 or later, CS Site-Specific Factor 1 cannot be blank.
- Edit updated to skip if behavior code is 0 or 1 ONLY if schema is not Brain, CNSOther, or IntracranialGland.

NAACCR v12.2
- Updated to require SSF 1 for only Breast, Brain, CNSOther, and IntraCranialGland schemas if Over-ride CS 20 is set to 1, indicating case is coded using directly coded SEER Summary Stage 2000 [759] for staging.
- CS versioning updated to work for CSv02.04.

NAACCR v13
- Edit modified to take into account the use of Over-ride CS 20 for Type of Reporting Source = 3-7.

NAACCR v14

- CS versioning updated to work for CSv02.05.
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Edit no longer takes into account CS Version Input Original when requiring SSF (cannot = 988). Requirement is now based on year of diagnosis only instead of [year of diagnosis OR CS Version Input Original].

NAACCR v16
- Edit modified to take into acocunt that CS is no longer required for cases diagnosed 2016 or later.
- For all schemas, if year of diagnosis is 2016 or later, the edit will skip. CS Items - NPCR Required - SSF 1 (CS) - 2016+ will check cases diagnosed 2016 or later.
- Name changed from CS Items - NPCR Required - SSF 1 (CS) to CS Items - NPCR Required - SSF 1 (CS) - 2015

NAACCR v16A
- Error messages corrected, fields out of order
- Administrative note for v16 updated to indicate name changed from CS Items - NPCR Required - SSF 1 (CS) to CS Items - NPCR Required - SSF 1 (CS) - 2015

CS Items - NPCR Required - SSF 1 (CS) - 2016+

Agency: NPCR **Last changed: 10/01/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
CS Site-Specific Factor 1 [Std# 2880]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Version Input Original [Std# 2935]
CS Version Input Current [Std# 2937]
Type of Reporting Source [Std# 500]

Default Error Message

[7125] If year of %F1 is 2016 or later, %F2 cannot be 988 or blank
If year of Date of Diagnosis is 2016 or later, CS Site-Specific Factor 1 cannot be 988 or blank

Additional Messages

[7126] CS Version Input Original cannot be left blank
[7127] CS Version Input Current cannot be left blank

Description

```
The purpose of this edit is to verify that CS Site-Specific Factor 1 is entered for
the schemas required by NPCR for diagnosis year 2016 and later.

This edit is skipped if any of the following conditions are true:
1. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and
   schema is not Brain, CNSOther, or IntracranialGland
2. CS schema is invalid
3. Date of Diagnosis is blank OR invalid
4. Date of Diagnosis is 2015 or prior
5. Type of Reporting Source = 6 (autopsy only) or 7 (death certificate only)


If year of Diagnosis is 2016 or later CS Site Specific Factor 1 must not be 988
(not collected) or blank for Prostate, Placenta, MycosisFungoides, Breast, Brain,
CNSother, and IntraCranialGland Schemas. If CS Site Specific Factor 1 is required,
this edit checks that CS Version Input Current and CS Version Input Original are
not blank.
```

Administrative Notes

New Edit for NAACCR v16
- Edit is skipped if diagnosis date is 2015 or prior

Modifications

NAACCR v16A
- Description and edit logic updated to skip if Type of Reporting Source = 6 or 7

NAACCR v16B
- Default error message changed from 7124 to 7125

CS Items - NPCR Required - SSF 10 (CS) - 2015

Agency: NPCR **Last changed: 07/18/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Version Input Original [Std# 2935]
CS Version Input Current [Std# 2937]
CS Site-Specific Factor10 [Std# 2864]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]
Over-ride CS 20 [Std# 3769]
Type of Reporting Source [Std# 500]

Tables

CS_SSF.DBF

Default Error Message

[4225] Conflict between %F6 and NPCR requirements
Conflict between CS Site-Specific Factor10 and NPCR requirements

Additional Messages

[3177] For Date of Diagnosis of "value of Date of Diagnosis", CS Site-Specific Factor10 must not be 988 for this schema
[3374] For DX Year < 2010, CS Version Input Original of "value of CS Version Input Original" and CS Version Input Current of "value of CS Version Input Current", CS Site-Specific Factor10 must be 988 for this schema
[4852] For DX Year > 2003, CS Site-Specific Factor10 must not be blank
[4882] If Over-ride CS 20 = '1' and Type of Reporting Source = "value of Type of Reporting Source", then CS Site-Specific Factor10 must not be blank or 988
ERROR_TEXT("Schema missing in SSF table")
SAVE_TEXT("t_schema_msg")

Description

The purpose of this edit is to verify that CS Site-Specific Factor10 is entered for the schemas required by NPCR. For diagnosis year 2012 and later, NPCR permits the use of Directly Coded Summary Stage (SEER Summary Stage 2000 [759]) in those cases where collection of CSv02 is not feasible due to lack of data or due to staffing and time constraints at the local or central registry. The data item 'Over-ride CS 20' is used to flag a case where SEER Summary Stage 2000 is recorded in lieu of Derived SS2000 [3020]. When 'Over-ride CS 20' is equal to '1', SEER Summary Stage 2000 must be populated (not blank). The CS input fields may be populated, but are not required. When 'Over-ride CS 20' is blank, the Collaborative Stage input

fields must be populated per NPCR requirements and SEER Summary Stage 2000 may also be populated, but is not required.

Beginning with the NAACCR v13 metafile, Over-ride CS 20 may also be set to '1' for the types of reporting source 3-7 (listed below) for cases with a diagnosis year of 2004 or later.

Type of Reporting Source
- 3 (laboratory only)
- 4 (physician's office)
- 5 (nursing home)
- 6 (autopsy only)
- 7 (death certificate only)

This edit is skipped if any of the following conditions are true:
1. CS Version Input Current is blank
2. CS Version Input Original is blank
3. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and schema is not Brain, CNSOther, or IntracranialGland
4. CS schema is invalid
5. Date of Diagnosis is blank or invalid
6. Date of Diagnosis is 2016 or later

A. For all schemas, if year of Diagnosis is 2004-2015 AND Over-ride CS 20 (for 2012+ cases) is blank, CS Site-Specific Factor10 cannot be blank.

B. If Over-ride CS 20 is blank, indicating case is coded using CS, then CS Site-Specific Factor10 cannot = 988 or blank for the schemas for which CS Site-Specific Factor10 is required by NPCR. See List 1 below.

Detailed logic for B:

If Over-ride CS 20 is blank:

1. If year of Diagnosis is 2014-2015 OR CS Version Input Original is 020550 (originally entered in CSv0205) or higher, then CS Site-Specific Factor10 must not be 988 (not applicable) for the schemas for which CS Site-Specific Factor10 is required for CSv0205 by NPCR.
   - NPCR requires CS Site-Specific Factor10 for no schemas for CSv0205

2. If year of Diagnosis is 2010-2013 then
   CS Site-Specific Factor10 must not be 988 for the schemas for which CS Site-Specific Factor10 is required (see List 1 below).

3. If year of Diagnosis is 2004-2009 AND CS Version Input Original is 01xxxx:

   A. If CS Version Input Current = 020510 (not changed since conversion from CSv01 to CSv02):

      CS Site-Specific Factor10 must be coded 988.

      Note: CS Site-Specific Factor 7-24 fields were all populated with 988 upon conversion from CSv01 to CSv02.

C. If Over-ride CS 20 is '1' and Type of Reporting Source is not 3-7 and CS Site-Specific Factor10 must not be 988 or blank for the schemas listed in List 2 (see below).

Detailed logic for C:

If Over-ride CS 20 is '1' and Type of Reporting Source is not 3-7:

If year of Diagnosis is 2014-2015 OR CS Version Input Original

```
        is 020550 (originally entered in CSv0205) or higher.
        Then
            CS Site-Specific Factor10 must not be blank for Breast schema
        Otherwise
            CS Site-Specific Factor10 must not be 988 or blank for Breast schema.

D.  If Over-ride CS 20 is '1' and Type of Reporting Source is 3-7, CS Site-Specific
Factor10 will pass if blank.

List 1: Schemas for which CS Site-Specific Factor10 is Required by NPCR
-------------------------------------------------------------------------------
Required only for cases diagnosed 2010-2013 OR entered originally in CSv0201-
CSv0204:
  Breast

List 2: Schemas for which CS Site-Specific Factor10 is required by NPCR even if the
case is coded using directly coded SEER Summary Stage 2000 [759] (indicated by
Over-ride CS 20 of '1' and Type of Reporting Source not = 3-7)

-------------------------------------------------------------------------------------
---------------------------------------
  Breast
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

Modifications:

NAACCR v12.1
- Edit updated to correspond to the CSV0203 NPCR requirements.
- For all schemas, if year of Diagnosis is 2004 or later, CS Site-Specific Factor10 cannot be blank.
- Edit updated to skip if behavior code is 0 or 1 ONLY if schema is not Brain, CNSOther, or IntracranialGland.

NAACCR v12.2
- Updated to require SSF 10 for only Breast schema if Over-ride CS 20 is set to 1, indicating case is coded using directly coded SEER Summary Stage 2000 [759] for staging.
- CS versioning updated to work for CSv02.04.

NAACCR v13
- Edit modified to take into account the use of Over-ride CS 20 for Type of Reporting Source = 3-7.

NAACCR v14
- CS versioning updated to work for CSv02.05
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Updated to handle changes in SSF requirements: SSF 10 is no longer required for Breast schema for cases diagnosed 2014 or later OR originally coded in CSv0205
- Edit no longer takes into account CS Version Input Original when requiring SSF (cannot = 988). Requirement is now based on year of diagnosis only instead of [year of diagnosis OR CS Version Input Original].

NAACCR v16
- Edit modified to take into account that CS is no longer required for cases diagnosed 2016 or later.
- For all schemas, if year of diagnosis is 2016 or later, the edit will skip. CS Items - NPCR Required - SSF 10 (CS) - 2016+ will check cases diagnosed 2016 or later in V16.
- Name changed from CS Items - NPCR Required - SSF 10 (CS) to CS Items - NPCR Required - SSF 10 (CS) - 2015

NAACCR v16A
- Administrative note for v16 updated to indicate name changed from CS Items - NPCR Required - SSF 10 (CS) to CS Items - NPCR Required - SSF 10 (CS) - 2015

CS Items - NPCR Required - SSF 10 (CS) - 2016+

Agency: NPCR **Last changed: 07/23/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
CS Site-Specific Factor10 [Std# 2864]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Version Input Original [Std# 2935]
CS Version Input Current [Std# 2937]
Type of Reporting Source [Std# 500]

Default Error Message

[7125] If year of %F1 is 2016 or later, %F2 cannot be 988 or blank
If year of Date of Diagnosis is 2016 or later, CS Site-Specific Factor10 cannot be 988 or blank

Additional Messages

[7126] CS Version Input Original cannot be left blank
[7127] CS Version Input Current cannot be left blank

Description

```
This edit verifies that CS Site-Specific Factor 10 is populated based on the NPCR
requirements.

This edit is skipped if:
1. Date of Diagnosis is blank or invalid
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and
   schema is not Brain, CNSOther, or IntracranialGland
3. Date of Diagnosis is 2015 or prior
4. CS schema is invalid
5. Type of Reporting Source = 6 (autopsy only) or 7 (death certificate only)

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, the CS schema name is returned.

If year of Diagnosis is 2016 or later then CS Site-Specific Factor 10 cannot be 988
(not collected) or blank for GISTPeritoneum and Prostate schemas.

If CS Site Specific Factor 10 is required, this edit checks that CS Version Input
Current and CS Version Input Original are not blank.
```

Administrative Notes

New edit - added to NAACCR v16 metafile.

Modifications:

NAACCR v16A
- Name changed from CS Items - NPCR Required - SSF 10 (CS) - 2016 to CS Items - NPCR Required - SSF 10 (CS) - 2016+
- Administrative note modified to identify new edit for v16 metafile
- Description and edit logic updated to skip if Type of Reporting Source = 6 or 7
- Description updated to include skip if CS schema is invalid

CS Items - NPCR Required - SSF 11 (CS) - 2015

Agency: NPCR **Last changed: 07/18/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Version Input Original [Std# 2935]
CS Version Input Current [Std# 2937]
CS Site-Specific Factor11 [Std# 2865]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]
Over-ride CS 20 [Std# 3769]
Type of Reporting Source [Std# 500]

Tables

CS_SSF.DBF

Default Error Message

[4225] Conflict between %F6 and NPCR requirements
Conflict between CS Site-Specific Factor11 and NPCR requirements

Additional Messages

[3177] For Date of Diagnosis of "value of Date of Diagnosis", CS Site-Specific Factor11 must not be 988 for this schema
[3374] For DX Year < 2010, CS Version Input Original of "value of CS Version Input Original" and CS Version Input Current of "value of CS Version Input Current", CS Site-Specific Factor11 must be 988 for this schema
[4852] For DX Year > 2003, CS Site-Specific Factor11 must not be blank
[4882] If Over-ride CS 20 = '1' and Type of Reporting Source = "value of Type of Reporting Source", then CS Site-Specific Factor11 must not be blank or 988
ERROR_TEXT("Schema missing in SSF table")
SAVE_TEXT("t_schema_msg")

Description

The purpose of this edit is to verify that CS Site-Specific Factor11 is entered for the schemas required by NPCR. For diagnosis year 2012 and later, NPCR permits the use of Directly Coded Summary Stage (SEER Summary Stage 2000 [759]) in those cases where collection of CSv02 is not feasible due to lack of data or due to staffing and time constraints at the local or central registry. The data item 'Over-ride CS 20' is used to flag a case where SEER Summary Stage 2000 is recorded in lieu of Derived SS2000 [3020]. When 'Over-ride CS 20' is equal to '1', SEER Summary Stage 2000 must be populated (not blank). The CS input fields may be populated, but are not required. When 'Over-ride CS 20' is blank, the Collaborative Stage input

fields must be populated per NPCR requirements and SEER Summary Stage 2000 may also be populated, but is not required.

Beginning with the NAACCR v13 metafile, Over-ride CS 20 may also be set to '1' for the types of reporting source 3-7 (listed below) for cases with a diagnosis year of 2004 or later.

Type of Reporting Source
- 3 (laboratory only)
- 4 (physician's office)
- 5 (nursing home)
- 6 (autopsy only)
- 7 (death certificate only)

This edit is skipped if any of the following conditions are true:
1. CS Version Input Current is blank
2. CS Version Input Original is blank
3. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and schema is not Brain, CNSOther, or IntracranialGland
4. CS schema is invalid
5. Date of Diagnosis is blank or invalid
6. Date of Diagnosis is 2016 or later.

A. For all schemas, if year of Diagnosis is 2004-2015 AND Over-ride CS 20 (for 2012+ cases) is blank, CS Site-Specific Factor11 cannot be blank.

B. If Over-ride CS 20 is blank, indicating case is coded using CS, then CS Site-Specific Factor11 cannot = 988 or blank for the schemas for which CS Site-Specific Factor11 is required by NPCR. See List 1 below.

Detailed logic for B:
If Over-ride CS 20 is blank:

1. If year of Diagnosis is 2010-2015
   then
   CS Site-Specific Factor11 must not be 988 for the schemas for which CS Site-Specific Factor11 is required (see List 1 below).

2. If year of Diagnosis is 2004-2009 AND CS Version Input Original is 01xxxx:

   A. If CS Version Input Current = 020510 (not changed since conversion from CSv01 to CSv02):

      CS Site-Specific Factor11 must be coded 988.

      Note: CS Site-Specific Factor 7-24 fields were all populated with 988 upon conversion from CSv01 to CSv02.

C. If Over-ride CS 20 is '1' and Type of Reporting Source is not 3-7, CS Site-Specific Factor11 must not be 988 or blank for the schemas listed in List 2 (see below).

Detailed logic for C:
If Over-ride CS 20 is '1' and Type of Reporting Source is not 3-7:
- CS Site-Specific Factor11 must not be 988 or blank for Breast schema.

D. If Over-ride CS 20 is '1' and Type of Reporting Source is 3-7, CS Site-Specific Factor11 will pass if blank.

```
List 1: Schemas for which CS Site-Specific Factor11 is required by NPCR
--------------------------------------------------------------------------------
Required only for cases diagnosed 2010-2015:
  Breast

List 2: Schemas for which CS Site-Specific Factor11 is required by NPCR even if the
case is coded using directly coded SEER Summary Stage 2000 [759] (indicated by
Over-ride CS 20 of '1' and Type of Reporting Source not = 3-7)
--------------------------------------------------------------------------------
---------------------------------------
  Breast
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

Modifications:

NAACCR v12.1
- Edit updated to correspond to the CSV0203 NPCR requirements.
- For all schemas, if year of Diagnosis is 2004 or later, CS Site-Specific Factor11 cannot be blank.
- Edit updated to skip if behavior code is 0 or 1 ONLY if schema is not Brain, CNSOther, or IntracranialGland.

NAACCR v12.2
- Updated to require SSF 11 for only Breast schema if Over-ride CS 20 is set to 1, indicating case is coded using directly coded SEER Summary Stage 2000 [759] for staging.
- CS versioning updated to work for CSv02.04.

NAACCR v13
- Edit modified to take into account the use of Over-ride CS 20 for Type of Reporting Source = 3-7.

NAACCR v14
- CS versioning updated to work for CSv02.05.
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Edit no longer takes into account CS Version Input Original when requiring SSF (cannot = 988). Requirement is now based on year of diagnosis only instead of [year of diagnosis OR CS Version Input Original].

NAACCR v16
- Edit modified to take into account that CS is no longer required for cases diagnosed 2016 or later.
- For all schemas, if year of diagnosis is 2016 or later, the edit will skip. CS Items - NPCR Required - SSF 11 (CS) - 2016+ will check cases diagnosed 2016 or later in V16.
- Name changed from CS Items - NPCR Required - SSF 11 (CS) to CS Items - NPCR Required - SSF 11 (CS) - 2015

NAACCR v16A
- Administrative note for v16 updated to indicate name changed from CS Items - NPCR Required - SSF 11 (CS) to CS Items - NPCR Required - SSF 11 (CS) - 2015

CS Items - NPCR Required - SSF 11 (CS) - 2016+

Agency: NPCR **Last changed: 07/19/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
CS Site-Specific Factor11 [Std# 2865]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Version Input Original [Std# 2935]
CS Version Input Current [Std# 2937]
Type of Reporting Source [Std# 500]

Default Error Message

[7125] If year of %F1 is 2016 or later, %F2 cannot be 988 or blank
If year of Date of Diagnosis is 2016 or later, CS Site-Specific Factor11 cannot be 988 or blank

Additional Messages

[7126] CS Version Input Original cannot be left blank
[7127] CS Version Input Current cannot be left blank

Description

```
This edit verifies that CS Site-Specific Factor 10 is populated based on the NPCR
requirements.

This edit is skipped if:
1. Date of Diagnosis is blank or invalid
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and
   schema is not Brain, CNSOther, or IntracranialGland
3. Date of Diagnosis is 2015 or prior
4. CS schema is invalid
5. Type of Reporting Source = 6 (autopsy only) or 7 (death certificate only

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, the CS schema name is returned.

If year of Diagnosis is 2016 or later then CS Site-Specific Factor 11 cannot be 988
(not collected) or blank for Appendix, Breast, GISTAppendix, GISTColon, and
GISTRectum schemas.

If CS Site Specific Factor 11 is required, this edit checks that CS Version Input
Current and CS Version Input Original are not blank.
```

Administrative Notes

New edit - added to NAACCR v16 metafile.

Modifications:

NAACCR v16A
- Administrative note modified to identify new edit for v16 metafile
- Description and edit logic updated to skip if Type of Reporting Source = 6 or 7
- Description updated to include skip if CS schema is invalid

CS Items - NPCR Required - SSF 12 (CS)

Agency: NPCR **Last changed: 07/18/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Version Input Original [Std# 2935]
CS Version Input Current [Std# 2937]
CS Site-Specific Factor12 [Std# 2866]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]
Over-ride CS 20 [Std# 3769]
Type of Reporting Source [Std# 500]

Tables

CS_SSF.DBF

Default Error Message

[4225] Conflict between %F6 and NPCR requirements
Conflict between CS Site-Specific Factor12 and NPCR requirements

Additional Messages

[3177] For Date of Diagnosis of "value of Date of Diagnosis", CS Site-Specific Factor12 must not be 988 for this schema
[3374] For DX Year < 2010, CS Version Input Original of "value of CS Version Input Original" and CS Version Input Current of "value of CS Version Input Current", CS Site-Specific Factor12 must be 988 for this schema
[4852] For DX Year > 2003, CS Site-Specific Factor12 must not be blank
[4882] If Over-ride CS 20 = '1' and Type of Reporting Source = "value of Type of Reporting Source", then CS Site-Specific Factor12 must not be blank or 988
ERROR_TEXT("Schema missing in SSF table")
SAVE_TEXT("t_schema_msg")

Description

The purpose of this edit is to verify that CS Site-Specific Factor12 is entered for the schemas required by NPCR. For diagnosis year 2012 and later, NPCR permits the use of Directly Coded Summary Stage (SEER Summary Stage 2000 [759]) in those cases where collection of CSv02 is not feasible due to lack of data or due to staffing and time constraints at the local or central registry. The data item 'Over-ride CS 20' is used to flag a case where SEER Summary Stage 2000 is recorded in lieu of Derived SS2000 [3020]. When 'Over-ride CS 20' is equal to '1', SEER Summary Stage 2000 must be populated (not blank). The CS input fields may be populated, but are not required. When 'Over-ride CS 20' is blank, the Collaborative Stage input

fields must be populated per NPCR requirements and SEER Summary Stage 2000 may also be populated, but is not required.

Beginning with the NAACCR v13 metafile, Over-ride CS 20 may also be set to '1' for the types of reporting source 3-7 (listed below) for cases with a diagnosis year of 2004 or later.

Type of Reporting Source
- 3 (laboratory only)
- 4 (physician's office)
- 5 (nursing home)
- 6 (autopsy only)
- 7 (death certificate only)

This edit is skipped if any of the following conditions are true:
1. CS Version Input Current is blank
2. CS Version Input Original is blank
3. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and schema is not Brain, CNSOther, or IntracranialGland
4. CS schema is invalid
5. Date of Diagnosis is blank or invalid
6. Date of Diagnosis is 2016 or later

A. For all schemas, if year of Diagnosis is 2004-2015 AND Over-ride CS 20 (for 2012+ cases) is blank, CS Site-Specific Factor12 cannot be blank.

B. If Over-ride CS 20 is blank, indicating case is coded using CS, then CS Site-Specific Factor12 cannot = 988 or blank for the schemas for which CS Site-Specific Factor12 is required by NPCR. See List 1 below.

Detailed logic for B:
If Over-ride CS 20 is blank:

1. If year of Diagnosis is 2014-2015 OR CS Version Input Original is 020550 (originally entered in CSv0205) or higher, then CS Site-Specific Factor12 must not be 988 (not applicable) for the schemas for which CS Site-Specific Factor12 is required for CSv0205 by NPCR.
   - NPCR requires CS Site-Specific Factor12 for no schemas for CSv0205

2. If year of Diagnosis is 2010-2013 then
   CS Site-Specific Factor12 must not be 988 for the schemas for which CS Site-Specific Factor12 is required (see List 1 below).

3. If year of Diagnosis is 2004-2009 AND CS Version Input Original is 01xxxx:

   A. If CS Version Input Current = 020510 (not changed since conversion from CSv01 to CSv02):

      CS Site-Specific Factor12 must be coded 988.

      Note: CS Site-Specific Factor 7-24 fields were all populated with 988 upon conversion from CSv01 to CSv02.

C. If Over-ride CS 20 is '1' and Type of Reporting Source is not 3-7,CS Site-Specific Factor12 must not be 988 or blank for the schemas listed in List 2 (see below).

Detailed logic for C:
If Over-ride CS 20 is '1' and Type of Reporting Source is not 3-7:

```
        If year of Diagnosis is 2014 or later OR CS Version Input Original
        is 020550 (originally entered in CSv0205) or higher.
        Then
            CS Site-Specific Factor12 must not be blank for Breast schema
        Otherwise
            CS Site-Specific Factor12 must not be 988 or blank for Breast schema.

D.  If Over-ride CS 20 is '1' and Type of Reporting Source is 3-7, CS Site-Specific
Factor12 will pass if blank.

List 1: Schemas for which CS Site-Specific Factor12 is required by NPCR
-------------------------------------------------------------------------------
Required only for cases diagnosed 2010-2015:
  Breast

List 2: Schemas for which CS Site-Specific Factor12 is required by NPCR even if the
case is coded using directly coded SEER Summary Stage 2000 [759] (indicated by
Over-ride CS 20 of '1' and Type of Reporting Source not = 3-7)

-------------------------------------------------------------------------------------
---------------------------------------
  Breast
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

Modifications:

NAACCR v12.1
- Edit updated to correspond to the CSV0203 NPCR requirements.
- For all schemas, if year of Diagnosis is 2004 or later, CS Site-Specific Factor12 cannot be blank.
- Edit updated to skip if behavior code is 0 or 1 ONLY if schema is not Brain, CNSOther, or IntracranialGland.

NAACCR v12.2
- Updated to require SSF 12 for only Breast schema if Over-ride CS 20 is set to 1, indicating case is coded using directly coded SEER Summary Stage 2000 [759] for staging.
- CS versioning updated to work for CSv02.04.

NAACCR v13
- Edit modified to take into account the use of Over-ride CS 20 for Type of Reporting Source = 3-7.

NAACCR v14
- CS versioning updated to work for CSv02.05.
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Updated to handle changes in SSF requirements: SSF 12 is no longer required for Breast schema for cases diagnosed 2014 or later OR originally coded in CSv0205
- Edit no longer takes into account CS Version Input Original when requiring SSF (cannot = 988). Requirement is now based on year of diagnosis only instead of [year of diagnosis OR CS Version Input Original].

NAACCR v16
- Edit modified to take into account that CS is no longer required for cases diagnosed 2016 or later.
- For all schemas, if year of diagnosis is 2016 or later, this edit will be skipped.
- Name changed from CS Items - NPCR Required - SSF 12 (CS) to CS Items - NPCR Required - SSF 12 (CS) - 2015

NAACCR v16A
- Administrative note for v16 updated to indicate name changed from CS Items - NPCR Required - SSF 12 (CS) to CS Items - NPCR Required - SSF 12 (CS) - 2015
- Name changed from CS Items - NPCR Required - SSF 12 (CS) - 2015 to CS Items - NPCR Required - SSF 12 (CS)

CS Items - NPCR Required - SSF 13 (CS) - 2015

Agency: NPCR **Last changed: 07/18/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Version Input Original [Std# 2935]
CS Version Input Current [Std# 2937]
CS Site-Specific Factor13 [Std# 2867]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]
Over-ride CS 20 [Std# 3769]
Type of Reporting Source [Std# 500]

Tables

CS_SSF.DBF

Default Error Message

[4225] Conflict between %F6 and NPCR requirements
Conflict between CS Site-Specific Factor13 and NPCR requirements

Additional Messages

[3177] For Date of Diagnosis of "value of Date of Diagnosis", CS Site-Specific Factor13 must not be 988 for this schema
[3374] For DX Year < 2010, CS Version Input Original of "value of CS Version Input Original" and CS Version Input Current of "value of CS Version Input Current", CS Site-Specific Factor13 must be 988 for this schema
[4852] For DX Year > 2003, CS Site-Specific Factor13 must not be blank
[4882] If Over-ride CS 20 = '1' and Type of Reporting Source = "value of Type of Reporting Source", then CS Site-Specific Factor13 must not be blank or 988
ERROR_TEXT("Schema missing in SSF table")
SAVE_TEXT("t_schema_msg")

Description

The purpose of this edit is to verify that CS Site-Specific Factor13 is entered for the schemas required by NPCR. For diagnosis year 2012 and later, NPCR permits the use of Directly Coded Summary Stage (SEER Summary Stage 2000 [759]) in those cases where collection of CSv02 is not feasible due to lack of data or due to staffing and time constraints at the local or central registry. The data item 'Over-ride CS 20' is used to flag a case where SEER Summary Stage 2000 is recorded in lieu of Derived SS2000 [3020]. When 'Over-ride CS 20' is equal to '1', SEER Summary Stage 2000 must be populated (not blank). The CS input fields may be populated, but are not required. When 'Over-ride CS 20' is blank, the Collaborative Stage input

fields must be populated per NPCR requirements and SEER Summary Stage 2000 may also be populated, but is not required.

Beginning with the NAACCR v13 metafile, Over-ride CS 20 may also be set to '1' for the types of reporting source 3-7 (listed below) for cases with a diagnosis year of 2004 or later.

Type of Reporting Source
- 3 (laboratory only)
- 4 (physician's office)
- 5 (nursing home)
- 6 (autopsy only)
- 7 (death certificate only)

This edit is skipped if any of the following conditions are true:
1. CS Version Input Current is blank
2. CS Version Input Original is blank
3. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and schema is not Brain, CNSOther, or IntracranialGland
4. CS schema is invalid
5. Date of Diagnosis is blank or invalid
6. Date of Diagnosis is 2016 or later

A. For all schemas, if year of Diagnosis is 2004-2015 AND Over-ride CS 20 (for 2012+ cases) is blank, CS Site-Specific Factor13 cannot be blank.

B. If Over-ride CS 20 is blank, indicating case is coded using CS, then CS Site-Specific Factor13 cannot = 988 or blank for the schemas for which CS Site-Specific Factor13 is required by NPCR. See List 1 below.

Detailed logic for B:
If Over-ride CS 20 is blank:

1. If year of Diagnosis is 2010-2015
   then
   CS Site-Specific Factor13 must not be 988 for the schemas for which CS Site-Specific Factor13 is required (see List 1 below).

2. If year of Diagnosis is 2004-2009 AND CS Version Input Original is 01xxxx:

   A. If CS Version Input Current = 020510 (not changed since conversion from CSv01 to CSv02):

      CS Site-Specific Factor13 must be coded 988.

      Note: CS Site-Specific Factor 7-24 fields were all populated with 988 upon conversion from CSv01 to CSv02.

C. If Over-ride CS 20 is '1' and Type of Reporting Source is not 3-7, CS Site-Specific Factor13 must not be 988 or blank for the schemas listed in List 2 (see below).

Detailed logic for C:
If Over-ride CS 20 is '1' and Type of Reporting Source is not 3-7:
- CS Site-Specific Factor13 must not be 988 or blank for Breast schema.

D. If Over-ride CS 20 is '1' and Type of Reporting Source is 3-7, CS Site-Specific Factor13 will pass if blank.

```
List 1: Schemas for which CS Site-Specific Factor13 is required by NPCR
--------------------------------------------------------------------------------
Required only for cases diagnosed 2010-2015:
  Breast

List 2: Schemas for which CS Site-Specific Factor13 is required by NPCR even if the
case is coded using directly coded SEER Summary Stage 2000 [759] (indicated by
Over-ride CS 20 of '1' and Type of Reporting Source not = 3-7)
--------------------------------------------------------------------------------
----------------------------------------
  Breast
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

Modifications:

NAACCR v12.1
- Edit updated to correspond to the CSV0203 NPCR requirements.
- For all schemas, if year of Diagnosis is 2004 or later, CS Site-Specific Factor13 cannot be blank.
- Edit updated to skip if behavior code is 0 or 1 ONLY if schema is not Brain, CNSOther, or IntracranialGland.

NAACCR v12.2
- Updated to require SSF 13 for only Breast schema if Over-ride CS 20 is set to 1, indicating case is coded using directly coded SEER Summary Stage 2000 [759] for staging.
- CS versioning updated to work for CSv02.04.

NAACCR v13
- Edit modified to take into account the use of Over-ride CS 20 for Type of Reporting Source = 3-7.

NAACCR v14
- CS versioning updated to work for CSv02.05.
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Edit no longer takes into account CS Version Input Original when requiring SSF (cannot = 988). Requirement is now based on year of diagnosis only instead of [year of diagnosis OR CS Version Input Original].

NAACCR v16
- Edit modified to take into account that CS is no longer required for cases diagnosed 2016 or later.
- For all schemas, if year of diagnosis is 2016 or later, the edit will skip. CS Items - NPCR Required - SSF 13 (CS) - 2016+ will check cases diagnosed 2016 or later in V16.
- Name changed from CS Items - NPCR Required - SSF 13 (CS) to CS Items - NPCR Required - SSF 13 (CS) - 2015

NAACCR v16A
- Administrative note for v16 updated to indicate name changed from CS Items - NPCR Required - SSF 13 (CS) to CS Items - NPCR Required - SSF 13 (CS) - 2015

CS Items - NPCR Required - SSF 13 (CS) - 2016+

Agency: NPCR **Last changed: 07/19/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
CS Site-Specific Factor13 [Std# 2867]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Version Input Original [Std# 2935]
CS Version Input Current [Std# 2937]
Type of Reporting Source [Std# 500]

Default Error Message

[7125] If year of %F1 is 2016 or later, %F2 cannot be 988 or blank
If year of Date of Diagnosis is 2016 or later, CS Site-Specific Factor13 cannot be 988 or blank

Additional Messages

[7126] CS Version Input Original cannot be left blank
[7127] CS Version Input Current cannot be left blank

Description

```
This edit verifies that CS Site-Specific Factor 10 is populated based on the NPCR
requirements.

This edit is skipped if:
1. Date of Diagnosis is blank or invalid
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and
   schema is not Brain, CNSOther, or IntracranialGland
3. Date of Diagnosis is 2015 or prior
4. CS schema is invalid
5. Type of Reporting Source = 6 (autopsy only) or 7 (death certificate only

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, the CS schema name is returned.

If year of Diagnosis is 2016 or later then CS Site-Specific Factor 13 cannot be 988
(not collected) or blank for Breast and Testis schemas.

If CS Site Specific Factor 13 is required, this edit checks that CS Version Input
Current and CS Version Input Original are not blank.
```

Administrative Notes

New edit - added to NAACCR v16 metafile.

Modifications:

NAACCR v16A
- Administrative note modified to identify new edit for v16 metafile
- Description and edit logic updated to skip if Type of Reporting Source = 6 or 7
- Description updated to include skip if CS schema is invalid

CS Items - NPCR Required - SSF 14 (CS) - 2015

Agency: NPCR **Last changed: 12/06/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Version Input Original [Std# 2935]
CS Version Input Current [Std# 2937]
CS Site-Specific Factor14 [Std# 2868]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]
Over-ride CS 20 [Std# 3769]
Type of Reporting Source [Std# 500]

Tables

CS_SSF.DBF

Default Error Message

[4225] Conflict between %F6 and NPCR requirements
Conflict between CS Site-Specific Factor14 and NPCR requirements

Additional Messages

[3177] For Date of Diagnosis of "value of Date of Diagnosis", CS Site-Specific Factor14 must not be 988 for this schema
[3374] For DX Year < 2010, CS Version Input Original of "value of CS Version Input Original" and CS Version Input Current of "value of CS Version Input Current", CS Site-Specific Factor14 must be 988 for this schema
[4852] For DX Year > 2003, CS Site-Specific Factor14 must not be blank
[4882] If Over-ride CS 20 = '1' and Type of Reporting Source = "value of Type of Reporting Source", then CS Site-Specific Factor14 must not be blank or 988
ERROR_TEXT("Schema missing in SSF table")
SAVE_TEXT("t_schema_msg")

Description

The purpose of this edit is to verify that CS Site-Specific Factor14 is entered for the schemas required by NPCR. For diagnosis year 2012 and later, NPCR permits the use of Directly Coded Summary Stage (SEER Summary Stage 2000 [759]) in those cases where collection of CSv02 is not feasible due to lack of data or due to staffing and time constraints at the local or central registry. The data item 'Over-ride CS 20' is used to flag a case where SEER Summary Stage 2000 is recorded in lieu of Derived SS2000 [3020]. When 'Over-ride CS 20' is equal to '1', SEER Summary Stage 2000 must be populated (not blank). The CS input fields may be populated, but are not required. When 'Over-ride CS 20' is blank, the Collaborative Stage input

fields must be populated per NPCR requirements and SEER Summary Stage 2000 may also be populated, but is not required.

Beginning with the NAACCR v13 metafile, Over-ride CS 20 may also be set to '1' for the types of reporting source 3-7 (listed below) for cases with a diagnosis year of 2004 or later.

Type of Reporting Source
- 3 (laboratory only)
- 4 (physician's office)
- 5 (nursing home)
- 6 (autopsy only)
- 7 (death certificate only)

This edit is skipped if any of the following conditions are true:
1. CS Version Input Current is blank
2. CS Version Input Original is blank
3. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and schema is not Brain, CNSOther, or IntracranialGland
4. CS schema is invalid
5. Date of Diagnosis is blank or invalid
6. Date of Diagnosis is 2016 or later

A. For all schemas, if year of Diagnosis is 2004-2015 AND Over-ride CS 20 (for 2012+ cases) is blank, CS Site-Specific Factor14 cannot be blank.

B. If Over-ride CS 20 is blank, indicating case is coded using CS, then CS Site-Specific Factor14 cannot = 988 or blank for the schemas for which CS Site-Specific Factor14 is required by NPCR. See List 1 below.

Detailed logic for B:
If Over-ride CS 20 is blank:

1. If year of Diagnosis is 2010-2015:
   then
   CS Site-Specific Factor14 must not be 988 for the schemas for which CS Site-Specific Factor14 is required (see List 1 below).

2. If year of Diagnosis is 2004-2009 AND CS Version Input Original is 01xxxx:

   A. If CS Version Input Current = 020510 (not changed since conversion from CSv01 to CSv02):

      CS Site-Specific Factor14 must be coded 988.

      Note: CS Site-Specific Factor 7-24 fields were all populated with 988 upon conversion from CSv01 to CSv02.

C. If Over-ride CS 20 is '1' and Type of Reporting Source is not 3-7, CS Site-Specific Factor14 must not be 988 or blank for the schemas listed in List 2 (see below).

Detailed logic for C:
If Over-ride CS 20 is '1' and Type of Reporting Source is not 3-7:
- CS Site-Specific Factor14 must not be 988 or blank for Breast schema.

D. If Over-ride CS 20 is '1' and Type of Reporting Source is 3-7, CS Site-Specific Factor14 will pass if blank.

```
List 1: Schemas for which CS Site-Specific Factor14 is required by NPCR
--------------------------------------------------------------------------------
Required only for cases diagnosed 2010-2015:
  Breast

List 2: Schemas for which CS Site-Specific Factor14 is required by NPCR even if the
case is coded using directly coded SEER Summary Stage 2000 [759] (indicated by
Over-ride CS 20 of '1' and Type of Reporting Source not = 3-7)
--------------------------------------------------------------------------------
---------------------------------------
  Breast
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

Modifications:

NAACCR v12.1
- Edit updated to correspond to the CSV0203 NPCR requirements.
- For all schemas, if year of Diagnosis is 2004 or later, CS Site-Specific Factor14 cannot be blank.
- Edit updated to skip if behavior code is 0 or 1 ONLY if schema is not Brain, CNSOther, or IntracranialGland.

NAACCR v12.2
- Updated to require SSF 14 for only Breast schema if Over-ride CS 20 is set to 1, indicating case is coded using directly coded SEER Summary Stage 2000 [759] for staging.
- CS versioning updated to work for CSv02.04.

NAACCR v13
- Edit modified to take into account the use of Over-ride CS 20 for Type of Reporting Source = 3-7.

NAACCR v14
- CS versioning updated to work for CSv02.05.
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Edit no longer takes into account CS Version Input Original when requiring SSF (cannot = 988). Requirement is now based on year of diagnosis only instead of [year of diagnosis OR CS Version Input Original].

NAACCR v16
- Edit modified to take into account that CS is no longer required for cases diagnosed 2016 or later.
- For all schemas, if year of diagnosis is 2016 or later, the edit will skip. CS Items - NPCR Required - SSF 14 (CS) - 2016+ will check cases diagnosed 2016 or later in V16.
- Name changed from CS Items - NPCR Required - SSF 14 (CS) to CS Items - NPCR Required - SSF 14 (CS) - 2015

NAACCR v16A
- Administrative note for v16 updated to indicate name changed from CS Items - NPCR Required - SSF 14 (CS) to CS Items - NPCR Required - SSF 14 (CS) - 2015

NAACCR v16D
- Logic corrected to pass if diagnosis year > 2015 (from diagnosis year > 2016)

CS Items - NPCR Required - SSF 14 (CS) - 2016+

Agency: NPCR **Last changed: 07/19/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
CS Site-Specific Factor14 [Std# 2868]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Version Input Original [Std# 2935]
CS Version Input Current [Std# 2937]
Type of Reporting Source [Std# 500]

Default Error Message

[7125] If year of %F1 is 2016 or later, %F2 cannot be 988 or blank
If year of Date of Diagnosis is 2016 or later, CS Site-Specific Factor14 cannot be 988 or blank

Additional Messages

[7126] CS Version Input Original cannot be left blank
[7127] CS Version Input Current cannot be left blank

Description

```
This edit verifies that CS Site-Specific Factor 14 is populated based on the NPCR
requirements.

This edit is skipped if any of the following conditions are true:
1. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and
   schema is not Brain, CNSOther, or IntracranialGland
2. CS schema is invalid
3. Date of Diagnosis is blank or invalid
4. Date of Diagnosis is 2015 or prior
5. Type of Reporting Source = 6 (autopsy only) or 7 (death certificate only)

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, the CS schema name is returned.

If year of Diagnosis is 2016 or later then CS Site-Specific Factor 14 cannot be 988
(not collected) or blank for Breast schema.

If CS Site Specific Factor 14 is required, this edit checks that CS Version Input
Current and CS Version Input Original are not blank.
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

Modifications:

NAACCR v12.1
- Edit updated to correspond to the CSV0203 NPCR requirements.
- For all schemas, if year of Diagnosis is 2004 or later, CS Site-Specific Factor14 cannot be blank.
- Edit updated to skip if behavior code is 0 or 1 ONLY if schema is not Brain, CNSOther, or IntracranialGland.

NAACCR v12.2
- Updated to require SSF 14 for only Breast schema if Over-ride CS 20 is set to 1, indicating case is coded using directly coded SEER Summary Stage 2000 [759] for staging.
- CS versioning updated to work for CSv02.04.

NAACCR v13
- Edit modified to take into account the use of Over-ride CS 20 for Type of Reporting Source = 3-7.

NAACCR v14
- CS versioning updated to work for CSv02.05.
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Edit no longer takes into account CS Version Input Original when requiring SSF (cannot = 988). Requirement is now based on year of diagnosis only instead of [year of diagnosis OR CS Version Input Original].

NAACCR v16
- Edit modified to take into acocunt that CS is no longer required for cases diagnosed 2016 or later except for Breast Schemas.
- For all schemas, if year of diagnosis is 2016 or later, CS Site-Specific Factor 14 can be blank except for Breast Schemas.

NAACCR v16A
- Default error message changed to 7125
- Description modified to reflect NPCR requirements for 2016 diagnosis year. Description from v15A was retained in v16 metafile.
- Description and edit logic updated to skip if Type of Reporting Source = 6 or 7.
Edit logic corrected to pass for Behavior Code ICD-O-3 if schema = Brain, CNSOther, IntracranialGland

CS Items - NPCR Required - SSF 15 (CS) - 2015

Agency: NPCR **Last changed: 07/18/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Version Input Original [Std# 2935]
CS Version Input Current [Std# 2937]
CS Site-Specific Factor15 [Std# 2869]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]
Over-ride CS 20 [Std# 3769]
Type of Reporting Source [Std# 500]

Tables

CS_SSF.DBF

Default Error Message

[4225] Conflict between %F6 and NPCR requirements
Conflict between CS Site-Specific Factor15 and NPCR requirements

Additional Messages

[3177] For Date of Diagnosis of "value of Date of Diagnosis", CS Site-Specific Factor15 must not be 988 for this schema
[3374] For DX Year < 2010, CS Version Input Original of "value of CS Version Input Original" and CS Version Input Current of "value of CS Version Input Current", CS Site-Specific Factor15 must be 988 for this schema
[4852] For DX Year > 2003, CS Site-Specific Factor15 must not be blank
[4882] If Over-ride CS 20 = '1' and Type of Reporting Source = "value of Type of Reporting Source", then CS Site-Specific Factor15 must not be blank or 988
ERROR_TEXT("Schema missing in SSF table")
SAVE_TEXT("t_schema_msg")

Description

The purpose of this edit is to verify that CS Site-Specific Factor15 is entered for the schemas required by NPCR. For diagnosis year 2012 and later, NPCR permits the use of Directly Coded Summary Stage (SEER Summary Stage 2000 [759]) in those cases where collection of CSv02 is not feasible due to lack of data or due to staffing and time constraints at the local or central registry. The data item 'Over-ride CS 20' is used to flag a case where SEER Summary Stage 2000 is recorded in lieu of Derived SS2000 [3020]. When 'Over-ride CS 20' is equal to '1', SEER Summary Stage 2000 must be populated (not blank). The CS input fields may be populated, but are not required. When 'Over-ride CS 20' is blank, the Collaborative Stage input

fields must be populated per NPCR requirements and SEER Summary Stage 2000 may also be populated, but is not required.

Beginning with the NAACCR v13 metafile, Over-ride CS 20 may also be set to '1' for the types of reporting source 3-7 (listed below) for cases with a diagnosis year of 2004 or later.

Type of Reporting Source
- 3 (laboratory only)
- 4 (physician's office)
- 5 (nursing home)
- 6 (autopsy only)
- 7 (death certificate only)

This edit is skipped if any of the following conditions are true:
1. CS Version Input Current is blank
2. CS Version Input Original is blank
3. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and schema is not Brain, CNSOther, or IntracranialGland
4. CS schema is invalid
5. Date of Diagnosis is blank or invalid
6. Date of Diagnosis is 2016 or later

A. For all schemas, if year of Diagnosis is 2004-2015 AND Over-ride CS 20 (for 2012+ cases) is blank, CS Site-Specific Factor15 cannot be blank.

B. If Over-ride CS 20 is blank, indicating case is coded using CS, then CS Site-Specific Factor15 cannot = 988 or blank for the schemas for which CS Site-Specific Factor15 is required by NPCR. See List 1 below.

Detailed logic for B:
If Over-ride CS 20 is blank:.

1. If year of Diagnosis is 2011-2015
   then
   CS Site-Specific Factor15 must not be 988 for the schemas for which CS Site-Specific Factor15 is required.

2. If year of Diagnosis is 2004-2009 AND CS Version Input Original is 01xxxx:

   A. If CS Version Input Current = 020510 (not changed since conversion from CSv01 to CSv02):

      CS Site-Specific Factor15 must = 988.

      Note: CS Site-Specific Factor 7-24 fields were all populated with 988 upon conversion from CSv01 to CSv02.

C. If Over-ride CS 20 is '1' and Type of Reporting Source is not 3-7, CS Site-Specific Factor15 must not be 988 or blank for the schemas listed in List 2 (see below).

Detailed logic for C:
If Over-ride CS 20 is '1' and Type of Reporting Source is not 3-7:
- CS Site-Specific Factor15 must not be 988 or blank for Breast schema.

D. If Over-ride CS 20 is '1' and Type of Reporting Source is 3-7, CS Site-Specific Factor15 will pass if blank.

```
List 1:Schemas for which CS Site-Specific Factor15 is required by NPCR
--------------------------------------------------------------------------------
Required only for cases diagnosed 2011-2015"
  Breast

List 2: Schemas for which CS Site-Specific Factor15 is required by NPCR even if the
case is coded using directly coded SEER Summary Stage 2000 [759] (indicated by
Over-ride CS 20 of '1' and Type of Reporting Source not = 3-7)
--------------------------------------------------------------------------------
---------------------------------------
  Breast
```

Administrative Notes

New edit - added to NAACCR v12.1 metafile.

Modifications:

NAACCR v12.2
- Updated to require SSF 15 for only Breast schema if Over-ride CS 20 is set to 1, indicating case is coded using directly coded SEER Summary Stage 2000 [759] for staging.
- CS versioning updated to work for CSv02.04.

NAACCR v13
- Edit modified to take into account the use of Over-ride CS 20 for Type of Reporting Source = 3-7.

NAACCR v14
- CS versioning updated to work for CSv02.05.
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Edit no longer takes into account CS Version Input Original when requiring SSF (cannot = 988). Requirement is now based on year of diagnosis only instead of [year of diagnosis OR CS Version Input Original].

NAACCR v16
- Edit modified to take into account that CS is no longer required for cases diagnosed 2016 or later.
- For all schemas, if year of diagnosis is 2016 or later, the edit will skip. CS Items - NPCR Required - SSF 15 (CS) - 2016+ will check cases diagnosed 2016 or later in V16.
- Name changed from CS Items - NPCR Required - SSF 15 (CS) to CS Items - NPCR Required - SSF 15 (CS) - 2015

NAACCR v16A
- Administrative note for v16 updated to indicate name changed from CS Items - NPCR Required - SSF 15 (CS) to CS Items - NPCR Required - SSF 15 (CS) - 2015

CS Items - NPCR Required - SSF 15 (CS) - 2016+

Agency: NPCR **Last changed: 07/19/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
CS Site-Specific Factor15 [Std# 2869]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Version Input Original [Std# 2935]
CS Version Input Current [Std# 2937]
Type of Reporting Source [Std# 500]

Default Error Message

[7125] If year of %F1 is 2016 or later, %F2 cannot be 988 or blank
If year of Date of Diagnosis is 2016 or later, CS Site-Specific Factor15 cannot be 988 or blank

Additional Messages

[7126] CS Version Input Original cannot be left blank
[7127] CS Version Input Current cannot be left blank

Description

```
This edit verifies that CS Site-Specific Factor 15 is populated based on the NPCR
requirements.

This edit is skipped if:
1. Date of Diagnosis is blank or invalid
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and
   schema is not Brain, CNSOther, or IntracranialGland
3. Date of Diagnosis is 2015 or prior
4. CS schema is invalid
5. Type of Reporting Source = 6 (autopsy only) or 7 (death certificate only

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, the CS schema name is returned.

If year of Diagnosis is 2016 or later then CS Site-Specific Factor 15 cannot be 988
(not collected) or blank for Breast and Testis schemas.

If CS Site Specific Factor 15 is required, this edit checks that CS Version Input
Current and CS Version Input Original are not blank.
```

Administrative Notes

New edit - added to NAACCR v16 metafile.

Modifications:

NAACCR v16A
- Administrative note modified to identify new edit for v16 metafile
- Description and edit logic updated to skip if Type of Reporting Source = 6 or 7
- Description updated to include skip if CS schema is invalid

CS Items - NPCR Required - SSF 16 (CS) - 2015

Agency: NPCR **Last changed: 07/18/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Version Input Original [Std# 2935]
CS Version Input Current [Std# 2937]
CS Site-Specific Factor16 [Std# 2870]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]
Over-ride CS 20 [Std# 3769]
Type of Reporting Source [Std# 500]

Tables

CS_SSF.DBF

Default Error Message

[4225] Conflict between %F6 and NPCR requirements
Conflict between CS Site-Specific Factor16 and NPCR requirements

Additional Messages

[3177] For Date of Diagnosis of "value of Date of Diagnosis", CS Site-Specific Factor16 must not be 988 for this schema
[3374] For DX Year < 2010, CS Version Input Original of "value of CS Version Input Original" and CS Version Input Current of "value of CS Version Input Current", CS Site-Specific Factor16 must be 988 for this schema
[4852] For DX Year > 2003, CS Site-Specific Factor16 must not be blank
[4882] If Over-ride CS 20 = '1' and Type of Reporting Source = "value of Type of Reporting Source", then CS Site-Specific Factor16 must not be blank or 988
ERROR_TEXT("Schema missing in SSF table")
SAVE_TEXT("t_schema_msg")

Description

The purpose of this edit is to verify that CS Site-Specific Factor16 is entered for the schemas required by NPCR. For diagnosis year 2012 and later, NPCR permits the use of Directly Coded Summary Stage (SEER Summary Stage 2000 [759]) in those cases where collection of CSv02 is not feasible due to lack of data or due to staffing and time constraints at the local or central registry. The data item 'Over-ride CS 20' is used to flag a case where SEER Summary Stage 2000 is recorded in lieu of Derived SS2000 [3020]. When 'Over-ride CS 20' is equal to '1', SEER Summary Stage 2000 must be populated (not blank). The CS input fields may be populated, but are not required. When 'Over-ride CS 20' is blank, the Collaborative Stage input

fields must be populated per NPCR requirements and SEER Summary Stage 2000 may also be populated, but is not required.

Beginning with the NAACCR v13 metafile, Over-ride CS 20 may also be set to '1' for the types of reporting source 3-7 (listed below) for cases with a diagnosis year of 2004 or later.

Type of Reporting Source
- 3 (laboratory only)
- 4 (physician's office)
- 5 (nursing home)
- 6 (autopsy only)
- 7 (death certificate only)

This edit is skipped if any of the following conditions are true:
1. CS Version Input Current is blank
2. CS Version Input Original is blank
3. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and schema is not Brain, CNSOther, or IntracranialGland
4. CS schema is invalid
5. Date of Diagnosis is blank or invalid
6. Date of Diagnosis is 2016 or later

A. For all schemas, if year of Diagnosis is 2004-2015 AND Over-ride CS 20 (for 2012+ cases) is blank, CS Site-Specific Factor16 cannot be blank.

B. If Over-ride CS 20 is blank, indicating case is coded using CS, then CS Site-Specific Factor16 cannot = 988 or blank for the schemas for which CS Site-Specific Factor16 is required by NPCR. See List 1 below.

Detailed logic for B:
If Over-ride CS 20 is blank:

1. If year of Diagnosis is 2011-2015
   then
   CS Site-Specific Factor16 must not be 988 for the schemas for which CS Site-Specific Factor16 is required.

2. If year of Diagnosis is 2004-2009 AND CS Version Input Original is 01xxxx:

   A. If CS Version Input Current = 020510 (not changed since conversion from CSv01 to CSv02):

      CS Site-Specific Factor16 must = 988.

      Note: CS Site-Specific Factor 7-24 fields were all populated with 988 upon conversion from CSv01 to CSv02.

C. If Over-ride CS 20 is '1' and Type of Reporting Source is not 3-7, CS Site-Specific Factor16 must not be 988 or blank for the schemas listed in List 2 (see below).

Detailed logic for C:
If Over-ride CS 20 is '1' and Type of Reporting Source is not 3-7:
- CS Site-Specific Factor16 must not be 988 or blank for Breast schema.

D. If Over-ride CS 20 is '1' and Type of Reporting Source is 3-7, CS Site-Specific Factor16 will pass if blank.

List 1:Schemas for which CS Site-Specific Factor16 is required by NPCR

```
--------------------------------------------------------------------------------
Required only for cases diagnosed 2011-2015:
  Breast


List 2: Schemas for which CS Site-Specific Factor16 is required by NPCR even if the
case is coded using directly coded SEER Summary Stage 2000 [759] (indicated by
Over-ride CS 20 of '1' and Type of Reporting Source not = 3-7)
--------------------------------------------------------------------------------
----------------------------------------
  Breast
```

Administrative Notes

New edit - added to NAACCR v12.1 metafile.

Modifications:

NAACCR v12.2
- Updated to require SSF 16 for only Breast schema if Over-ride CS 20 is set to 1, indicating case is coded using directly coded SEER Summary Stage 2000 [759] for staging.
- CS versioning updated to work for CSv02.04.

NAACCR v13
- Edit modified to take into account the use of Over-ride CS 20 for Type of Reporting Source = 3-7.

NAACCR v14
- CS versioning updated to work for CSv02.05.
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Edit no longer takes into account CS Version Input Original when requiring SSF (cannot = 988). Requirement is now based on year of diagnosis only instead of [year of diagnosis OR CS Version Input Original].

NAACCR v16
- Edit modified to take into account that CS is no longer required for cases diagnosed 2016 or later.
- For all schemas, if year of diagnosis is 2016 or later, the edit will skip. CS Items - NPCR Required - SSF 9 (CS) - 2016+ will check cases diagnosed 2016 or later in V16.

Name changed from CS Items - NPCR Required - SSF 16 (CS) to CS Items - NPCR Required - SSF 16 (CS) - 2015

NAACCR v16A
- Administrative note for v16 updated to indicate name changed from CS Items - NPCR Required - SSF 16 (CS) to CS Items - NPCR Required - SSF 16 (CS) - 2015

CS Items - NPCR Required - SSF 16 (CS) - 2016+

Agency: NPCR **Last changed: 07/19/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
CS Site-Specific Factor16 [Std# 2870]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Version Input Original [Std# 2935]
CS Version Input Current [Std# 2937]
Type of Reporting Source [Std# 500]

Default Error Message

[7125] If year of %F1 is 2016 or later, %F2 cannot be 988 or blank
If year of Date of Diagnosis is 2016 or later, CS Site-Specific Factor16 cannot be 988 or blank

Additional Messages

[7126] CS Version Input Original cannot be left blank
[7127] CS Version Input Current cannot be left blank

Description

```
This edit verifies that CS Site-Specific Factor 16 is populated based on the NPCR
requirements.

This edit is skipped if:
1. Date of Diagnosis is blank or invalid
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and
   schema is not Brain, CNSOther, or IntracranialGland
3. Date of Diagnosis is 2015 or prior
4. CS schema is invalid
5. Type of Reporting Source = 6 (autopsy only) or 7 (death certificate only

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, the CS schema name is returned.

If year of Diagnosis is 2016 or later then CS Site-Specific Factor 16 cannot be 988
(not collected) or blank for Breast and Testis schemas.

If CS Site Specific Factor 16 is required, this edit checks that CS Version Input
Current and CS Version Input Original are not blank.
```

Administrative Notes

New edit - added to NAACCR v16 metafile.

Modifications:

NAACCR v16A
- Administrative note modified to identify new edit for v16 metafile
- Description and edit logic updated to skip if Type of Reporting Source = 6 or 7
- Description updated to include skip if CS schema is invalid

CS Items - NPCR Required - SSF 17 (CS)

Agency: NPCR **Last changed: 07/18/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor17 [Std# 2871]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]
Over-ride CS 20 [Std# 3769]

Default Error Message

[4226] Conflict between %F4 and NPCR requirements
Conflict between CS Site-Specific Factor17 and NPCR requirements

Additional Messages

[4858] For DX Year > 2003, CS Site-Specific Factor17 must not be blank
ERROR_TEXT("Invalid site or histology")
ERROR_TEXT("Schema discriminator missing or invalid")
SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that CS Site-Specific Factor17 is populated based on the NPCR
requirements.

This edit is skipped if:
1. Date of Diagnosis is blank or invalid
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and
   schema is not Brain, CNSOther, or IntracranialGland
3. Over-ride CS 20 is '1' (case is 2012+ and coded using directly coded SEER
Summary Stage 2000 [759] )
4. Date of Diagnosis is 2016 or later

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.

For all schemas, if year of Diagnosis is 2004-2015, CS Site-Specific Factor17
cannot be blank.
```

Administrative Notes

New edit - added to NAACCR v12.1 metafile.

Modifications:

NAACCR v12.2
- Updated to skip if Over-ride CS 20 is set to 1, indicating case is coded using directly coded SEER Summary Stage 2000 [759] for staging.

NAACCR v14
- CS versioning updated to work for CSv02.05.
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

NAACCR v16
- Edit modified to take into account that CS is no longer required for cases diagnosed 2016 or later.
- For all schemas, if year of diagnosis is 2016 or later CS Site-Specific Factor17 can be skipped.
- Name changed from CS Items - NPCR Required - SSF 17 (CS) to CS Items - NPCR Required - SSF 17 (CS) - 2015

NAACCR v16A
- Administrative note for v16 updated to indicate name changed from CS Items - NPCR Required - SSF 17 (CS) to CS Items - NPCR Required - SSF 17 (CS) - 2015
- Name changed from CS Items - NPCR Required - SSF 17 (CS) - 2015 to CS Items - NPCR Required - SSF 17 (CS)

CS Items - NPCR Required - SSF 18 (CS)

Agency: NPCR **Last changed: 07/18/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor18 [Std# 2872]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]
Over-ride CS 20 [Std# 3769]

Default Error Message

[4226] Conflict between %F4 and NPCR requirements
Conflict between CS Site-Specific Factor18 and NPCR requirements

Additional Messages

[4858] For DX Year > 2003, CS Site-Specific Factor18 must not be blank
ERROR_TEXT("Invalid site or histology")
ERROR_TEXT("Schema discriminator missing or invalid")
SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that CS Site-Specific Factor18 is populated based on the NPCR
requirements.

This edit is skipped if:
1. Date of Diagnosis is blank or invalid.
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and
   schema is not Brain, CNSOther, or IntracranialGland
3. Over-ride CS 20 is '1' (case is 2012+ and coded using directly coded SEER
Summary Stage 2000 [759] )
4. Date of Diagnosis is 2016 or later.

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.

For all schemas, if year of Diagnosis is 2004-2015, CS Site-Specific Factor18
cannot be blank.
```

Administrative Notes

New edit - added to NAACCR v12.1 metafile.

Modifications:

NAACCR v12.2
- Updated to skip if Over-ride CS 20 is set to 1, indicating case is coded using directly coded SEER Summary Stage 2000 [759] for staging.

NAACCR v14
- CS versioning updated to work for CSv02.05.
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

NAACCR v16
- Edit modified to take into account that CS is no longer required for cases dianosed 2016 or later.
- For all schemas, if year of diagnosis is 2016 or later CS Site-Specific Factor18 can be skipped.
- Name changed from CS Items - NPCR Required - SSF 18 (CS) to CS Items - NPCR Required - SSF 18 (CS) - 2015

NAACCR v16A
- Administrative note for v16 updated to indicate name changed from CS Items - NPCR Required - SSF 18 (CS) to CS Items - NPCR Required - SSF 18 (CS) - 2015
- Name changed from CS Items - NPCR Required - SSF 18 (CS) - 2015 to CS Items - NPCR Required - SSF 18 (CS)

CS Items - NPCR Required - SSF 19 (CS)

Agency: NPCR **Last changed: 07/18/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor19 [Std# 2873]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]
Over-ride CS 20 [Std# 3769]

Default Error Message

[4226] Conflict between %F4 and NPCR requirements
Conflict between CS Site-Specific Factor19 and NPCR requirements

Additional Messages

[4858] For DX Year > 2003, CS Site-Specific Factor19 must not be blank
ERROR_TEXT("Invalid site or histology")
ERROR_TEXT("Schema discriminator missing or invalid")
SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that CS Site-Specific Factor19 is populated based on the NPCR
requirements.

This edit is skipped if:
1. Date of Diagnosis is blank or invalid
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and
   schema is not Brain, CNSOther, or IntracranialGland
3. Over-ride CS 20 is '1' (case is 2012+ and coded using directly coded SEER
Summary Stage 2000 [759] )
4. Date of Diagnosis is 2016 or later.

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.

For all schemas, if year of Diagnosis is 2004-2015, CS Site-Specific Factor19
cannot be blank.

For all schemas, if year of Diagnosis is 2016 or later, CS site-Specific Factor19
can be blank.
```

Administrative Notes

New edit - added to NAACCR v12.1 metafile.

Modifications:

NAACCR v12.2
- Updated to skip if Over-ride CS 20 is set to 1, indicating case is coded using directly coded SEER Summary Stage 2000 [759] for staging.

NAACCR v14
- CS versioning updated to work for CSv02.05.
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

NAACCR v16
- Edit modified to take into account that CS is no longer required for cases diagnosed 2016 or later.
- For all schemas, if year of diagnosis is 2016 or later CS Site-Specific Factor19 can be skipped.
- Name changed from CS Items - NPCR Required - SSF 19 (CS) to CS Items - NPCR Required - SSF 19 (CS) - 2015

NAACCR v16A
- Administrative note for v16 updated to indicate name changed from CS Items - NPCR Required - SSF 19 (CS) to CS Items - NPCR Required - SSF 19 (CS) - 2015
- Name changed from CS Items - NPCR Required - SSF 19 (CS) - 2015 to CS Items - NPCR Required - SSF 19 (CS)

CS Items - NPCR Required - SSF 2 (CS) - 2015

Agency: NPCR **Last changed: 07/20/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Version Input Original [Std# 2935]
CS Version Input Current [Std# 2937]
CS Site-Specific Factor 2 [Std# 2890]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]
Over-ride CS 20 [Std# 3769]
Type of Reporting Source [Std# 500]

Tables

CS_SSF.DBF

Default Error Message

[4225] Conflict between %F6 and NPCR requirements
Conflict between CS Site-Specific Factor 2 and NPCR requirements

Additional Messages

[3177] For Date of Diagnosis of "value of Date of Diagnosis", CS Site-Specific Factor 2 must not be 988 for this schema
[3374] For DX Year < 2010, CS Version Input Original of "value of CS Version Input Original" and CS Version Input Current of "value of CS Version Input Current", CS Site-Specific Factor 2 must be 988 for this schema
[4852] For DX Year > 2003, CS Site-Specific Factor 2 must not be blank
[4882] If Over-ride CS 20 = '1' and Type of Reporting Source = "value of Type of Reporting Source", then CS Site-Specific Factor 2 must not be blank or 988
ERROR_TEXT("Schema missing in SSF table")
SAVE_TEXT("t_schema_msg")

Description

The purpose of this edit is to verify that CS Site-Specific Factor 2 is entered for the schemas required by NPCR. For diagnosis year 2012 and later, NPCR permits the use of Directly Coded Summary Stage (SEER Summary Stage 2000 [759]) in those cases where collection of CSv02 is not feasible due to lack of data or due to staffing and time constraints at the local or central registry. The data item 'Over-ride CS 20' is used to flag a case where SEER Summary Stage 2000 is recorded in lieu of Derived SS2000 [3020]. When 'Over-ride CS 20' is equal to '1', SEER Summary Stage 2000 must be populated (not blank). The CS input fields may be populated, but are not required. When 'Over-ride CS 20' is blank, the Collaborative Stage input

fields must be populated per NPCR requirements and SEER Summary Stage 2000 may also be populated, but is not required.

Beginning with the NAACCR v13 metafile, Over-ride CS 20 may also be set to '1' for the types of reporting source 3-7 (listed below) for cases with a diagnosis year of 2004 or later.

Type of Reporting Source
- 3 (laboratory only)
- 4 (physician's office)
- 5 (nursing home)
- 6 (autopsy only)
- 7 (death certificate only)

This edit is skipped if any of the following conditions are true:
1. CS Version Input Current is blank
2. CS Version Input Original is blank
3. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and schema is not Brain, CNSOther, or IntracranialGland
4. CS schema is invalid
5. Date of Diagnosis is blank or invalid
6. Date of Diagnosis is 2016 or later

A. For all schemas, if year of Diagnosis is 2004 - 2015 AND Over-ride CS 20 (for 2012+ cases) is blank, CS Site-Specific Factor 2 cannot be blank.

B. If Over-ride CS 20 is blank, indicating case is coded using CS, then CS Site-Specific Factor 2 cannot = 988 or blank for the schemas for which CS Site-Specific Factor 2 is required by NPCR. See List 1 below.

Detailed logic for B:
If Over-ride CS 20 is blank:

1. If year of Diagnosis is 2010 - 2015
   then
   CS Site-Specific Factor 2 must not be 988 for the schemas for which CS Site-Specific Factor 2 is required (see List 1 below).

2. If year of Diagnosis is 2004-2009 AND CS Version Input Original is 01xxxx:

   A. If CS Version Input Current = 020510 (not changed since conversion from CSv01 to CSv02):

      1. If CS Site-Specific Factor 2 was not defined in CSv01 (see List 2 below),
         then
         CS Site-Specific Factor 2 must be coded 988.

C. If Over-ride CS 20 is '1' and Type of Reporting Source is not 3-7, CS Site-Specific Factor 2 must not be 988 or blank for the schemas listed in List 3 (see below).

Detailed logic for C:
If Over-ride CS 20 is '1' and Type of Reporting Source is not 3-7:
- CS Site-Specific Factor 2 must not be 988 or blank for Breast schema.

D. If Over-ride CS 20 is '1' and Type of Reporting Source is 3-7, CS Site-Specific Factor 2 will pass if blank.

List 1: Schemas for which CS Site-Specific Factor 2 is Required for CSv2 by NPCR

```
--------------------------------------------------------------------------------
Required only for cases diagnosed 2010 - 2015:
  Breast
  CorpusAdenosarcoma
  CorpusCarcinoma
  CorpusSarcoma


List 2: Schemas for which CS Site-Specific Factor 2, although required for CSv02,
was not defined in CSv01:
--------------------------------------------------------------------------------
CorpusAdenosarcoma
CorpusCarcinoma
CorpusSarcoma

List 3: Schemas for which CS Site-Specific Factor 2 is required by NPCR even if the
case is coded using directly coded SEER Summary Stage 2000 [759] (indicated by
Over-ride CS 20 of '1' and Type of Reporting Source not = 3-7)
--------------------------------------------------------------------------------
---------------------------------------
  Breast
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

Modifications:

NAACCR v12.1
- Edit updated to correspond to the CSV0203 NPCR requirements.
- For all schemas, if year of Diagnosis is 2004 or later, CS Site-Specific Factor 2 cannot be blank.
- Edit updated to skip if behavior code is 0 or 1 ONLY if schema is not Brain, CNSOther, or IntracranialGland.

NAACCR v12.2
- Updated to require SSF 2 for only Breast schema if Over-ride CS 20 is set to 1, indicating case is coded using directly coded SEER Summary Stage 2000 [759] for staging.
- CS versioning updated to work for CSv02.04.

NAACCR v13
- Edit modified to take into account the use of Over-ride CS 20 for Type of Reporting Source = 3-7.

NAACCR v14
- CS versioning updated to work for CSv02.05.
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Edit no longer takes into account CS Version Input Original when requiring SSF (cannot = 988). Requirement is now based on year of diagnosis only instead of [year of diagnosis OR CS Version Input Original].

NAACCR v16
- Edit modified to take into acocunt that CS is no longer required for cases diagnosed 2016 or later.
- For all schemas, if year of diagnosis is 2016 or later, the edit will skip. CS Items - NPCR Required - SSF 2 (CS) - 2016+ will check cases diagnosed 2016 or later.
- Name changed from CS Items - NPCR Required - SSF 2 (CS) to CS Items - NPCR Required - SSF 2 (CS) - 2015
- Removed reference to IF289

NAACCR v16A
- Administrative note for v16 updated to indicate name changed from CS Items - NPCR Required - SSF 2 (CS) to CS Items - NPCR Required - SSF 2 (CS) - 2015
- Administrative note updated for NAACCR v16 to indicate that reference to IF289 removed from edit

CS Items - NPCR Required - SSF 2 (CS) - 2016+

Agency: NPCR **Last changed: 10/01/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
CS Site-Specific Factor 2 [Std# 2890]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Version Input Original [Std# 2935]
CS Version Input Current [Std# 2937]
Type of Reporting Source [Std# 500]

Default Error Message

[7125] If year of %F1 is 2016 or later, %F2 cannot be 988 or blank
If year of Date of Diagnosis is 2016 or later, CS Site-Specific Factor 2 cannot be 988 or blank

Additional Messages

[7126] CS Version Input Original cannot be left blank
[7127] CS Version Input Current cannot be left blank

Description

```
The purpose of this edit is to verify that CS Site-Specific Factor 2 is entered for
the schemas required by NPCR for diagnosis year 2016 and later.

This edit is skipped if any of the following conditions are true:
1. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and
   schema is not Brain, CNSOther, or IntracranialGland
2. CS schema is invalid
3. Date of Diagnosis is blank OR invalid
4. Date of Diagnosis is 2015 or prior
5. Type of Reporting Source = 6 (autopsy only) or 7 (death certificate only


If year of Diagnosis is 2016 or later CS Site Specific Factor 2 must not be 988
(not collected) or blank for Breast.

If CS Site Specific Factor 2 is required, this edit checks that CS Version Input
Current and CS Version Input Original are not blank.
```

Administrative Notes

New Edit for NAACCR v16

Modifications

NAACCR v16A

- Description and edit logic updated to skip if Type of Reporting Source = 6 or 7

NAACCR v16B
- Default error message changed from 7124 to 7125

CS Items - NPCR Required - SSF 20 (CS)

Agency: NPCR **Last changed: 07/18/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor20 [Std# 2874]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]
Over-ride CS 20 [Std# 3769]

Default Error Message

[4226] Conflict between %F4 and NPCR requirements
Conflict between CS Site-Specific Factor20 and NPCR requirements

Additional Messages

[4858] For DX Year > 2003, CS Site-Specific Factor20 must not be blank
ERROR_TEXT("Invalid site or histology")
ERROR_TEXT("Schema discriminator missing or invalid")
SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that CS Site-Specific Factor20 is populated based on the NPCR
requirements.

This edit is skipped if:
1. Date of Diagnosis is blank or invalid.
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and
   schema is not Brain, CNSOther, or IntracranialGland
3. Over-ride CS 20 is '1' (case is 2012+ and coded using directly coded SEER
Summary Stage 2000 [759] )
4. Date of Diagnosis is 2016 or later.

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.

For all schemas, if year of Diagnosis is 2004-2015, CS Site-Specific Factor20
cannot be blank.
```

Administrative Notes

New edit - added to NAACCR v12.1 metafile.

Modifications:

NAACCR v12.2
- Updated to skip if Over-ride CS 20 is set to 1, indicating case is coded using directly coded SEER Summary Stage 2000 [759] for staging.

NAACCR v14
- CS versioning updated to work for CSv02.05.
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

NAACCR v16
- Edit modified to take into accoun that CS is no longer requried for cases diagnosed 2016 or later.
- For all schemas, if year of diagnosis is 2016 or later, CS Site-Specific Factor20 can be skipped.
- Name changed from CS Items - NPCR Required - SSF 20 (CS) to CS Items - NPCR Required - SSF 20 (CS) - 2015

NAACCR v16A
- Administrative note for v16 updated to indicate name changed from CS Items - NPCR Required - SSF 20 (CS) to CS Items - NPCR Required - SSF 20 (CS) - 2015
- Name changed from CS Items - NPCR Required - SSF 20 (CS) - 2015 to CS Items - NPCR Required - SSF 20 (CS)

CS Items - NPCR Required - SSF 21 (CS)

Agency: NPCR **Last changed: 07/18/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor21 [Std# 2875]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]
Over-ride CS 20 [Std# 3769]

Default Error Message

[4226] Conflict between %F4 and NPCR requirements
Conflict between CS Site-Specific Factor21 and NPCR requirements

Additional Messages

[4858] For DX Year > 2003, CS Site-Specific Factor21 must not be blank
ERROR_TEXT("Invalid site or histology")
ERROR_TEXT("Schema discriminator missing or invalid")
SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that CS Site-Specific Factor21 is populated based on the NPCR
requirements.

This edit is skipped if:
1. Date of Diagnosis is blank or invalid.
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and
   schema is not Brain, CNSOther, or IntracranialGland
3. Over-ride CS 20 is '1' (case is 2012+ and coded using directly coded SEER
Summary Stage 2000 [759] )
4. Date of Diagnosis is 2016 or later.

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.

For all schemas, if year of Diagnosis is 2004-2015, CS Site-Specific Factor21
cannot be blank.
```

Administrative Notes

New edit - added to NAACCR v12.1 metafile.

Modifications:

NAACCR v12.2
- Updated to skip if Over-ride CS 20 is set to 1, indicating case is coded using directly coded SEER Summary Stage 2000 [759] for staging.

NAACCR v14
- CS versioning updated to work for CSv02.05.
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

NAACCR v16
- Edit modified to take into account that CS is no longer requried for cases diagnosed 2016 or later.
- For all schemas, if year of diagnosis is 2016 or later, CS Site-Specific Factor21 can be skipped.
- Name changed from CS Items - NPCR Required - SSF 21 (CS) to CS Items - NPCR Required - SSF 21 (CS) - 2015

NAACCR v16A
- Administrative note for v16 updated to indicate name changed from CS Items - NPCR Required - SSF 21 (CS) to CS Items - NPCR Required - SSF 21 (CS) - 2015
- Name changed from CS Items - NPCR Required - SSF 21 (CS) - 2015 to CS Items - NPCR Required - SSF 21 (CS)

CS Items - NPCR Required - SSF 22 (CS)

Agency: NPCR **Last changed: 07/18/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor22 [Std# 2876]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]
Over-ride CS 20 [Std# 3769]

Default Error Message

[4226] Conflict between %F4 and NPCR requirements
Conflict between CS Site-Specific Factor22 and NPCR requirements

Additional Messages

[4858] For DX Year > 2003, CS Site-Specific Factor22 must not be blank
ERROR_TEXT("Invalid site or histology")
ERROR_TEXT("Schema discriminator missing or invalid")
SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that CS Site-Specific Factor22 is populated based on the NPCR
requirements.

This edit is skipped if:
1. Date of Diagnosis is blank or invalid
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and
   schema is not Brain, CNSOther, or IntracranialGland
3. Over-ride CS 20 is '1' (case is 2012+ and coded using directly coded SEER
Summary Stage 2000 [759] )
4. Date of Diagnosis is 2016 or later.


This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.

For all schemas, if year of Diagnosis is 2004-2015, CS Site-Specific Factor22
cannot be blank.
```

Administrative Notes

New edit - added to NAACCR v12.1 metafile.

Modifications:

NAACCR v12.2
- Updated to skip if Over-ride CS 20 is set to 1, indicating case is coded using directly coded SEER Summary Stage 2000 [759] for staging.

NAACCR v14
- CS versioning updated to work for CSv02.05.
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

NAACCR v16
- Edit modified to take into account aht CS is no longer requried for cases diagnosed 2016 or later.
- For all schemas, if year of diagnosis is 2016 or later, CS Site-Specific Factor22 can be skipped.
- Name changed from CS Items - NPCR Required - SSF 22 (CS) to CS Items - NPCR Required - SSF 22 (CS) - 2015

NAACCR v16A
- Administrative note for v16 updated to indicate name changed from CS Items - NPCR Required - SSF 22 (CS) to CS Items - NPCR Required - SSF 22 (CS) - 2015
- Name changed from CS Items - NPCR Required - SSF 22 (CS) - 2015 to CS Items - NPCR Required - SSF 22 (CS)

CS Items - NPCR Required - SSF 23 (CS)

Agency: NPCR **Last changed: 07/18/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor23 [Std# 2877]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]
Over-ride CS 20 [Std# 3769]

Default Error Message

[4226] Conflict between %F4 and NPCR requirements
Conflict between CS Site-Specific Factor23 and NPCR requirements

Additional Messages

[4858] For DX Year > 2003, CS Site-Specific Factor23 must not be blank
ERROR_TEXT("Invalid site or histology")
ERROR_TEXT("Schema discriminator missing or invalid")
SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that CS Site-Specific Factor23 is populated based on the NPCR
requirements.

This edit is skipped if:
1. Date of Diagnosis is blank or invalid
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and
   schema is not Brain, CNSOther, or IntracranialGland
3. Over-ride CS 20 is '1' (case is 2012+ and coded using directly coded SEER
Summary Stage 2000 [759] )
4. Date of Diagnosis is 2016 or later

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.

For all schemas, if year of Diagnosis is 2004-2015, CS Site-Specific Factor23
cannot be blank.
```

Administrative Notes

New edit - added to NAACCR v12.1 metafile.

Modifications:

NAACCR v12.2
- Updated to skip if Over-ride CS 20 is set to 1, indicating case is coded using directly coded SEER Summary Stage 2000 [759] for staging.

NAACCR v14
- CS versioning updated to work for CSv02.05.
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

NAACCR v16
- Edit modified to take into account htat CS is no longer requried for cases diagnosed 2016 or later.
- For all schemas, if year of diagnosis 2016 or later, CS Site-Specific Factor23 can be skipped.
- Name changed from CS Items - NPCR Required - SSF 23 (CS) to CS Items - NPCR Required - SSF 23 (CS) - 2015

NAACCR v16A
- Administrative note for v16 updated to indicate name changed from CS Items - NPCR Required - SSF 23 (CS) to CS Items - NPCR Required - SSF 23 (CS) - 2015
- Name changed from CS Items - NPCR Required - SSF 23 (CS) - 2015 to CS Items - NPCR Required - SSF 23 (CS)

CS Items - NPCR Required - SSF 24 (CS)

Agency: NPCR **Last changed: 07/18/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor24 [Std# 2878]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]
Over-ride CS 20 [Std# 3769]

Default Error Message

[4226] Conflict between %F4 and NPCR requirements
Conflict between CS Site-Specific Factor24 and NPCR requirements

Additional Messages

[4858] For DX Year > 2003, CS Site-Specific Factor24 must not be blank
ERROR_TEXT("Invalid site or histology")
ERROR_TEXT("Schema discriminator missing or invalid")
SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that CS Site-Specific Factor24 is populated based on the NPCR
requirements.

This edit is skipped if:
1. Date of Diagnosis is blank or invalid
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and
   schema is not Brain, CNSOther, or IntracranialGland
3. Over-ride CS 20 is '1' (case is 2012+ and coded using directly coded SEER
Summary Stage 2000 [759] )
4. Date of Diagnosis is 2016 or later

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.

For all schemas, if year of Diagnosis is 2004-2015, CS Site-Specific Factor24
cannot be blank.
```

Administrative Notes

New edit - added to NAACCR v12.1 metafile.

Modifications:

NAACCR v12.2
- Updated to skip if Over-ride CS 20 is set to 1, indicating case is coded using directly coded SEER Summary Stage 2000 [759] for staging.

NAACCR v14
- CS versioning updated to work for CSv02.05.
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

NAACCR v16
- Edit modified to take into account hat CS is no longer required for cases diagnosed 2016 or later.
- For all schemas, if year of diagnosis is 2016 or later, CS Site-Specific Factor24 can be skipped.
- Name changed from CS Items - NPCR Required - SSF 24 (CS) to CS Items - NPCR Required - SSF 24 (CS) - 2015

NAACCR v16A
- Administrative note for v16 updated to indicate name changed from CS Items - NPCR Required - SSF 24 (CS) to CS Items - NPCR Required - SSF 24 (CS) - 2015
- Name changed from CS Items - NPCR Required - SSF 24 (CS) - 2015 to CS Items - NPCR Required - SSF 24 (CS)

CS Items - NPCR Required - SSF 25 (CS) - 2016+

Agency: NPCR **Last changed: 07/19/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
CS Site-Specific Factor25 [Std# 2879]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Type of Reporting Source [Std# 500]

Tables

CS_SSF.DBF

Default Error Message

[7128] If year of %F1 is 2016 or later, %F2 cannot be blank
If year of Date of Diagnosis is 2016 or later, CS Site-Specific Factor25 cannot be blank

Additional Messages

ERROR_TEXT("Invalid site or histology")
ERROR_TEXT("Schema discriminator missing or invalid")

Description

```
The purpose of this edit is to verify that CS Site-Specific Factor25 is entered for
the schemas required by NPCR for diagnosis year 2016 and later.

This edit is skipped if any of the following conditions are true:
1. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and
   schema is not Brain, CNSOther, or IntracranialGland
2. CS schema is invalid
3. Date of Diagnosis is blank OR invalid
4. Date of Diagnosis is 2015 or prior
5. Primary site is C48.1, C48.2 or C48.8
6. Type of Reporting Source = 6 (autopsy only)or 7 (death certificate only)

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.

If year of Diagnosis is 2016 or later CS SSF 25 must not be blank for
BileDuctsDistal, BileDuctsPerihilar,
CysticDuct, EsophagusGEJunction, LacrimalGland, LacrimalSac, MelanomaCiliaryBody,
MelanomaIris, Nasopharynx,  PharyngealTonsil, and Stomach shemas.
```

Administrative Notes

New Edit for NAACCR v16

Modifications

NAACCR v16A
- Name changed from CS Items - NPCR Required - SSF 25 (CS) - 2016 to CS Items - NPCR Required - SSF 25 (CS) - 2016+
- Description updated to include notice that edit first determines correct CS schema by function call by passing Primary Site, Histologic Type ICD-O3, and CS Site-Specific Factor 25 to CS dll, and CS schema name is returned.
- Description and edit logic updated to skip if Type of Reporting Source = 6 or 7

CS Items - NPCR Required - SSF 3 (CS)

Agency: NPCR **Last changed: 07/18/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor 3 [Std# 2900]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]
Over-ride CS 20 [Std# 3769]

Default Error Message

[4226] Conflict between %F4 and NPCR requirements
Conflict between CS Site-Specific Factor 3 and NPCR requirements

Additional Messages

[4858] For DX Year > 2003, CS Site-Specific Factor 3 must not be blank
ERROR_TEXT("Invalid site or histology")
ERROR_TEXT("Schema discriminator missing or invalid")
SAVE_TEXT("t_schema_msg")

Description

This edit verifies that CS Site-Specific Factor 3 is populated based on the NPCR requirements. For diagnosis year 2012 and later, NPCR permits the use of Directly Coded Summary Stage (SEER Summary Stage 2000 [759]) in those cases where collection of CSv02 is not feasible due to lack of data or due to staffing and time constraints at the local or central registry. The data item 'Over-ride CS 20' is used to flag a case where SEER Summary Stage 2000 is recorded in lieu of Derived SS2000 [3020]. When 'Over-ride CS 20' is equal to '1', SEER Summary Stage 2000 must be populated (not blank). The CS input fields may be populated, but are not required. When 'Over-ride CS 20' is blank, the Collaborative Stage input fields must be populated per NPCR requirements and SEER Summary Stage 2000 may also be populated, but is not required.

This edit is skipped if:
1. Date of Diagnosis is blank or invalid
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and
   schema is not Brain, CNSOther, or IntracranialGland
3. Over-ride CS 20 is '1' (case is 2012+ and coded using directly coded SEER Summary Stage 2000 [759])
4. Date of Diagnosis is 2016 or later

This edit first determines the correct CS schema by doing a function call to the CS Dynamic Link Library (dll). The function call passes Primary Site, Histologic Type ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS schema name is returned.

For all schemas, if year of Diagnosis is between 2004-2015, CS Site-Specific Factor 3 cannot be blank.

For all schemas, if year of Diagnosis is 2016 or later, CS Site-Specific Factor 3 can be blank.

Note: There is no need to check for CS Site-Specific Factor 3 of 988 since 988 is not an allowable code for the Prostate schema.

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

Modifications:

NAACCR v12.1
- Edit updated to correspond to the NPCR requirements.
- For all schemas, if year of Diagnosis is 2004 or later, CS Site-Specific Factor 3 cannot be blank.
- Edit updated to skip if behavior code is 0 or 1 ONLY if schema is not Brain, CNSOther, or IntracranialGland.

NAACCR v12.2
- Updated to skip if Over-ride CS 20 is set to 1, indicating case is coded using directly coded SEER Summary Stage 2000 [759] for staging.NAACCR v14
- CS versioning updated to work for CSv02.05.
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

NAACCR v16
- Edit modified to take into acocunt that CS is no longer required for cases diagnosed 2016 or later.
- For all schemas, if year of diagnosis is 2016 or later, this edit will pass.
- Name changed from CS Items - NPCR Required - SSF 3 (CS) to CS Items - NPCR Required - SSF 3 (CS) - 2015

NAACCR v16A
- Administrative note for v16 updated to indicate name changed from CS Items - NPCR Required - SSF 3 (CS) to CS Items - NPCR Required - SSF 3 (CS) - 2015
- Name changed from CS Items - NPCR Required - SSF 3 (CS) - 2015 to CS Items - NPCR Required - SSF 3 (CS)

CS Items - NPCR Required - SSF 4 (CS)

Agency: NPCR **Last changed: 08/13/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor 4 [Std# 2910]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]
Over-ride CS 20 [Std# 3769]

Default Error Message

[4226] Conflict between %F4 and NPCR requirements
Conflict between CS Site-Specific Factor 4 and NPCR requirements

Additional Messages

[4858] For DX Year > 2003, CS Site-Specific Factor 4 must not be blank
ERROR_TEXT("Invalid site or histology")
ERROR_TEXT("Schema discriminator missing or invalid")
SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that CS Site-Specific Factor 4 is populated based on the NPCR
requirements.

This edit is skipped if:
1. Date of Diagnosis is blank or invalid
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and
   schema is not Brain, CNSOther, or IntracranialGland
3. Over-ride CS 20 is '1' (case is 2012+ and coded using directly coded SEER
Summary Stage 2000 [759] )
4. Date of Diagnosis is 2016 or later

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.

For all schemas, if year of Diagnosis is 2004-2015, CS Site-Specific Factor 4
cannot be blank.

For all schemas, if year of Diagnosis is 2016 or later, CS Site-Specific Factor 4
can be blank.
```

Administrative Notes

New edit - added to NAACCR v12.1 metafile.

Modifications:

NAACCR v12.2
- Updated to skip if Over-ride CS 20 is set to 1, indicating case is coded using directly coded SEER Summary Stage 2000 [759] for staging.

NAACCR v14
- CS versioning updated to work for CSv02.05.
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

NAACCR v16
- Edit modified to take into acocunt that CS is no longer required for cases diagnosed 2016 or later.
- For all schemas, if year of diagnosis is 2016 or later, this edit will pass.
- Name changed from CS Items - NPCR Required - SSF 4 (CS) to CS Items - NPCR Required - SSF 4 (CS) - 2015

NAACCR v16A
- Administrative note for v16 updated to indicate name changed from CS Items - NPCR Required - SSF 4 (CS) to CS Items - NPCR Required - SSF 4 (CS) - 2015
- Name changed from CS Items - NPCR Required - SSF 4 (CS) - 2015 to CS Items - NPCR Required - SSF 4 (CS)

NAACCR v16B
- Name change noted above for v16A missed, name change made in v16B: Name changed from CS Items - NPCR Required - SSF 4 (CS) - 2015 to CS Items - NPCR Required - SSF 4 (CS)

CS Items - NPCR Required - SSF 5 (CS) - 2015

Agency: NPCR **Last changed: 07/18/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor 5 [Std# 2920]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]
Over-ride CS 20 [Std# 3769]

Default Error Message

[4226] Conflict between %F4 and NPCR requirements
Conflict between CS Site-Specific Factor 5 and NPCR requirements

Additional Messages

[4858] For DX Year > 2003, CS Site-Specific Factor 5 must not be blank
ERROR_TEXT("Invalid site or histology")
ERROR_TEXT("Schema discriminator missing or invalid")
SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that CS Site-Specific Factor 5 is populated based on the NPCR
requirements.

This edit is skipped if:
1. Date of Diagnosis is blank or invalid
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and
   schema is not Brain, CNSOther, or IntracranialGland
3. Over-ride CS 20 is '1' (case is 2012+ and coded using directly coded SEER
Summary Stage 2000 [759] )
4. Date of Diagnosis is 2016 or later

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.

For all schemas, if year of Diagnosis is 2004-2015, CS Site-Specific Factor 5
cannot be blank.
```

Administrative Notes

New edit - added to NAACCR v12.1 metafile.

Modifications:

NAACCR v12.2
- Updated to skip if Over-ride CS 20 is set to 1, indicating case is coded using directly coded SEER Summary Stage 2000 [759] for staging.

NAACCR v14
- CS versioning updated to work for CSv02.05.
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

NAACCR v16
- Edit modified to take into acocunt that CS is no longer required for cases diagnosed 2016 or later except for GISTPeritoneum Schema.
- For all schemas, if year of diagnosis is 2016 or later, the edit will skip. CS Items - NPCR Required - SSF 5 (CS) - 2016+ will check cases diagnosed 2016 or later.
- Name changed from CS Items - NPCR Required - SSF 5 (CS) to CS Items - NPCR Required - SSF 5 (CS) - 2015

NAACCR v16A
- Administrative note for v16 updated to indicate name changed from CS Items - NPCR Required - SSF 5 (CS) to CS Items - NPCR Required - SSF 5 (CS) - 2015

CS Items - NPCR Required - SSF 5 (CS) - 2016+

Agency: NPCR **Last changed: 07/19/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
CS Site-Specific Factor 5 [Std# 2920]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Version Input Original [Std# 2935]
CS Version Input Current [Std# 2937]
Type of Reporting Source [Std# 500]

Default Error Message

[7125] If year of %F1 is 2016 or later, %F2 cannot be 988 or blank
If year of Date of Diagnosis is 2016 or later, CS Site-Specific Factor 5 cannot be 988 or blank

Additional Messages

[7126] CS Version Input Original cannot be left blank
[7127] CS Version Input Current cannot be left blank

Description

```
The purpose of this edit is to verify that CS Site-Specific Factor 5 is entered for
the schemas required by NPCR for diagnosis year 2016 and later.

This edit is skipped if:
1. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and
   schema is not Brain, CNSOther, or IntracranialGland
2. CS schema is invalid
3. Date of Diagnosis is blank or invalid
4. Date of Diagnosis is 2015 or prior
5. Type of Reporting Source = 6 (autopsy only) or 7 (death certificate only

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.

If year of Diagnosis is 2016 or later, CS Site-Specfic Factor 5 cannnot be 988 (not
collected) or blank for  GISTPeritoneum Schemas.

If CS Site Specific Factor 5 is required, this edit checks that CS Version Input
Current and CS Version Input Original are not blank.
```

Administrative Notes

New edit - added to NAACCR v16 metafile.

Modifications:

NAACCR v16A
- Administrative note modified to identify new edit for v16 metafile
- Description and edit logic updated to skip if Type of Reporting Source = 6 or 7

CS Items - NPCR Required - SSF 6 (CS) - 2015

Agency: NPCR **Last changed: 07/18/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor 6 [Std# 2930]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]
Over-ride CS 20 [Std# 3769]

Default Error Message

[4226] Conflict between %F4 and NPCR requirements
Conflict between CS Site-Specific Factor 6 and NPCR requirements

Additional Messages

[4858] For DX Year > 2003, CS Site-Specific Factor 6 must not be blank
ERROR_TEXT("Invalid site or histology")
ERROR_TEXT("Schema discriminator missing or invalid")
SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that CS Site-Specific Factor 6 is populated based on the NPCR
requirements.

This edit is skipped if:
1. Date of Diagnosis is blank or invalid
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and
   schema is not Brain, CNSOther, or IntracranialGland
3. Over-ride CS 20 is '1' (case is 2012+ and coded using directly coded SEER
Summary Stage 2000 [759] )
4. Date of Diagnosis is 2016 or later

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.

For all schemas, if year of Diagnosis is 2004 - 2015, CS Site-Specific Factor 6
cannot be blank.
```

Administrative Notes

New edit - added to NAACCR v12.1 metafile.

Modifications:

NAACCR v12.2
- Updated to skip if Over-ride CS 20 is set to 1, indicating case is coded using directly coded SEER Summary Stage 2000 [759] for staging.

NAACCR v14
- CS versioning updated to work for CSv02.05.
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

NAACCR v16
- Edit modified to take into acocunt that CS is no longer required for cases diagnosed 2016 or later except for Breast Schemas.
- For all schemas, if year of diagnosis is 2016 or later, the edit will skip. CS Items - NPCR Required - SSF 6 (CS) - 2016+ will check cases diagnosed 2016 or later.
- Name changed from CS Items - NPCR Required - SSF 6 (CS) to CS Items - NPCR Required - SSF 6 (CS) - 2015

NAACCR v16A
- Administrative note for v16 updated to indicate name changed from CS Items - NPCR Required - SSF 6 (CS) to CS Items - NPCR Required - SSF 6 (CS) - 2015

CS Items - NPCR Required - SSF 6 (CS) - 2016+

Agency: NPCR **Last changed: 07/19/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
CS Site-Specific Factor 6 [Std# 2930]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Version Input Original [Std# 2935]
CS Version Input Current [Std# 2937]
Over-ride CS 20 [Std# 3769]
Type of Reporting Source [Std# 500]

Default Error Message

[7125] If year of %F1 is 2016 or later, %F2 cannot be 988 or blank
If year of Date of Diagnosis is 2016 or later, CS Site-Specific Factor 6 cannot be 988 or blank

Additional Messages

[7126] CS Version Input Original cannot be left blank
[7127] CS Version Input Current cannot be left blank

Description

```
This edit verifies that CS Site-Specific Factor 6 is populated based on the NPCR
requirements.

This edit is skipped if:
1. Date of Diagnosis is blank or invalid
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and
   schema is not Brain, CNSOther, or IntracranialGland
3. Date of Diagnosis is 2015 or prior
4. CS schema is invalid
5. Type of Reporting Source = 6 (autopsy only) or 7 (death certificate only

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.

If year of Diagnosis is 2016 or later then CS Site-Specific Factor 6 cannot be 988
(not collected) or blank for GISTEsophagus, GISTSmallIntestine, and GISTStomach
schemas.

If CS Site Specific Factor 6 is required, this edit checks that CS Version Input
Current and CS Version Input Original are not blank.
```

Administrative Notes

New edit - added to NAACCR v16 metafile.

Modifications:

NAACCR v16A
- Administrative note modified to identify new edit for v16 metafile
- Description and edit logic updated to skip if Type of Reporting Source = 6 or 7
- Description updated to include skip if CS schema is invalid

CS Items - NPCR Required - SSF 7 (CS)

Agency: NPCR **Last changed: 07/18/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor 7 [Std# 2861]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]
Over-ride CS 20 [Std# 3769]

Default Error Message

[4226] Conflict between %F4 and NPCR requirements
Conflict between CS Site-Specific Factor 7 and NPCR requirements

Additional Messages

[4858] For DX Year > 2003, CS Site-Specific Factor 7 must not be blank
ERROR_TEXT("Invalid site or histology")
ERROR_TEXT("Schema discriminator missing or invalid")
SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that CS Site-Specific Factor 7 is populated based on the NPCR
requirements.

This edit is skipped if:
1. Date of Diagnosis is blank or invalid
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and
   schema is not Brain, CNSOther, or IntracranialGland
3. Over-ride CS 20 is '1' (case is 2012+ and coded using directly coded SEER
Summary Stage 2000 [759] )
4. Date of Diagnosis is 2016 or later

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.

For all schemas, if year of Diagnosis is 2004-2015, CS Site-Specific Factor 7
cannot be blank.

For all schemas, if year of diagnosis is 2016 or later CS Site-Specific Factor 7
can be skipped.
```

Administrative Notes

New edit - added to NAACCR v12.1 metafile.

Modifications:

NAACCR v12.2
- Updated to skip if Over-ride CS 20 is set to 1, indicating case is coded using directly coded SEER Summary Stage 2000 [759] for staging.

NAACCR v14
- CS versioning updated to work for CSv02.05.
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

NAACCR v16
- Edit modified to take into acocunt that CS is no longer required for cases diagnosed 2016 or later.
- For all schemas, if year of diagnosis is 2016 or later CS Site-Specific Factor 7 can be skipped.

CS Items - NPCR Required - SSF 8 (CS) - 2015

Agency: NPCR **Last changed: 07/18/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Version Input Original [Std# 2935]
CS Version Input Current [Std# 2937]
CS Site-Specific Factor 8 [Std# 2862]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]
Over-ride CS 20 [Std# 3769]
Type of Reporting Source [Std# 500]

Tables

CS_SSF.DBF

Default Error Message

[4225] Conflict between %F6 and NPCR requirements
Conflict between CS Site-Specific Factor 8 and NPCR requirements

Additional Messages

[3177] For Date of Diagnosis of "value of Date of Diagnosis", CS Site-Specific Factor 8 must not be 988 for this schema
[3374] For DX Year < 2010, CS Version Input Original of "value of CS Version Input Original" and CS Version Input Current of "value of CS Version Input Current", CS Site-Specific Factor 8 must be 988 for this schema
[4852] For DX Year > 2003, CS Site-Specific Factor 8 must not be blank
[4882] If Over-ride CS 20 = '1' and Type of Reporting Source = "value of Type of Reporting Source", then CS Site-Specific Factor 8 must not be blank or 988
ERROR_TEXT("Schema missing in SSF table")
SAVE_TEXT("t_schema_msg")

Description

The purpose of this edit is to verify that CS Site-Specific Factor 8 is entered for the schemas required by NPCR. For diagnosis year 2012 and later, NPCR permits the use of Directly Coded Summary Stage (SEER Summary Stage 2000 [759]) in those cases where collection of CSv02 is not feasible due to lack of data or due to staffing and time constraints at the local or central registry. The data item 'Over-ride CS 20' is used to flag a case where SEER Summary Stage 2000 is recorded in lieu of Derived SS2000 [3020]. When 'Over-ride CS 20' is equal to '1', SEER Summary Stage 2000 must be populated (not blank). The CS input fields may be populated, but are not required. When 'Over-ride CS 20' is blank, the Collaborative Stage input

fields must be populated per NPCR requirements and SEER Summary Stage 2000 may also be populated, but is not required.

Beginning with the NAACCR v13 metafile, Over-ride CS 20 may also be set to '1' for the types of reporting source 3-7 (listed below) for cases with a diagnosis year of 2004 or later.

Type of Reporting Source
- 3 (laboratory only)
- 4 (physician's office)
- 5 (nursing home)
- 6 (autopsy only)
- 7 (death certificate only)

This edit is skipped if any of the following conditions are true:
1. CS Version Input Current is blank
2. CS Version Input Original is blank
3. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and schema is not Brain, CNSOther, or IntracranialGland
4. CS schema is invalid
5. Date of Diagnosis is blank or invalid
6. Date of Diagnosis is 2016 or later

A. For all schemas, if year of Diagnosis is 2004-2015 AND Over-ride CS 20 (for 2012+ cases) is blank, CS Site-Specific Factor 8 cannot be blank.

B. If Over-ride CS 20 is blank, indicating case is coded using CS, then CS Site-Specific Factor 8 cannot = 988 or blank for the schemas for which CS Site-Specific Factor 8 is required by NPCR. See List 1 below.

Detailed logic for B:
If Over-ride CS 20 is blank:

1. If year of Diagnosis is 2010 or later
   then
   CS Site-Specific Factor 8 must not be 988 for the schemas for which CS Site-Specific Factor 8 is required (see List 1 below).

2. If year of Diagnosis is 2004-2009 AND CS Version Input Original is 01xxxx:

   A. If CS Version Input Current = 020510 (not changed since conversion from CSv01 to CSv02):

      CS Site-Specific Factor 8 must be coded 988.

      Note: CS Site-Specific Factor 7-24 fields were all populated with 988 upon conversion from CSv01 to CSv02.

3.

C. If Over-ride CS 20 is '1' and Type of Reporting Source is not 3-7, CS Site-Specific Factor 8 must not be 988 or blank for the schemas listed in List 2 (see below).

Detailed logic for C:
If Over-ride CS 20 is '1' and Type of Reporting Source is not 3-7:
- CS Site-Specific Factor 8 must not be 988 or blank for Breast schema.

D. If Over-ride CS 20 is '1' and Type of Reporting Source is 3-7, CS Site-Specific Factor 8 will pass if blank.

```
List 1: Schemas for which CS Site-Specific Factor 8 is required for CSv2 by NPCR
--------------------------------------------------------------------------------
Required only for cases diagnosed 2010-2015:
  Breast

List 2: Schemas for which CS Site-Specific Factor 8 is required by NPCR even if the
case is coded using directly coded SEER Summary Stage 2000 [759] (indicated by
Over-ride CS 20 of '1' and Type of Reporting Source not = 3-7)

--------------------------------------------------------------------------------
----------------------------------------
  Breast
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

Modifications:

NAACCR v12.1
- Edit updated to correspond to the CSV0203 NPCR requirements.
- For all schemas, if year of Diagnosis is 2004 or later, CS Site-Specific Factor 8 cannot be blank.
- Edit updated to skip if behavior code is 0 or 1 ONLY if schema is not Brain, CNSOther, or IntracranialGland.

NAACCR v12.2
- Updated to require SSF 8 for only Breast schema if Over-ride CS 20 is set to 1, indicating case is coded using directly coded SEER Summary Stage 2000 [759] for staging.
- CS versioning updated to work for CSv02.04.

NAACCR v13
- Edit modified to take into account the use of Over-ride CS 20 for Type of Reporting Source = 3-7.

NAACCR v14
- CS versioning updated to work for CSv02.05.
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Edit no longer takes into account CS Version Input Original when requiring SSF (cannot = 988). Requirement is now based on year of diagnosis only instead of [year of diagnosis OR CS Version Input Original].

NAACCR v16
- Edit modified to take into acocunt that CS is no longer required for cases diagnosed 2016 or later except for Breast Schemas.
- For all schemas, if year of diagnosis is 2016 or later, the edit will skip. CS Items - NPCR Required - SSF 8 (CS) - 2016+ will check cases diagnosed 2016 or later.
- Name changed from CS Items - NPCR Required - SSF 8 (CS) to CS Items - NPCR Required - SSF 8 (CS) - 2015

NAACCR v16A
- Administrative note for v16 updated to indicate name changed from CS Items - NPCR Required - SSF 8 (CS) to CS Items - NPCR Required - SSF 8 (CS) - 2015

CS Items - NPCR Required - SSF 8 (CS) - 2016+

Agency: NPCR **Last changed: 07/19/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
CS Site-Specific Factor 8 [Std# 2862]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Version Input Original [Std# 2935]
CS Version Input Current [Std# 2937]
Type of Reporting Source [Std# 500]

Default Error Message

[7125] If year of %F1 is 2016 or later, %F2 cannot be 988 or blank
If year of Date of Diagnosis is 2016 or later, CS Site-Specific Factor 8 cannot be 988 or blank

Additional Messages

[7126] CS Version Input Original cannot be left blank
[7127] CS Version Input Current cannot be left blank

Description

```
This edit verifies that CS Site-Specific Factor 8 is populated based on the NPCR
requirements.

This edit is skipped if:
1. Date of Diagnosis is blank or invalid
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and
   schema is not Brain, CNSOther, or IntracranialGland
3. Date of Diagnosis is 2015 or prior
4. CS schema is invalid
5. Type of Reporting Source = 6 (autopsy only) or 7 (death certificate only

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, the CS schema name is returned.

If year of Diagnosis is 2016 or later then CS Site-Specific Factor 8 cannot be 988
(not collected) or blank for Breast and Prostate schemas.

If CS Site Specific Factor 8 is required, this edit checks that CS Version Input
Current and CS Version Input Original are not blank.
```

Administrative Notes

New edit - added to NAACCR v16 metafile.

Modifications:

NAACCR v16A
- Default error message changed to 7125
- Administrative note modified to identify new edit for v16 metafile
- Description and edit logic updated to skip if Type of Reporting Source = 6 or 7
- Description updated to include skip if CS schema is invalid

CS Items - NPCR Required - SSF 9 (CS) - 2015

Agency: NPCR **Last changed: 07/18/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Version Input Original [Std# 2935]
CS Version Input Current [Std# 2937]
CS Site-Specific Factor 9 [Std# 2863]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]
Over-ride CS 20 [Std# 3769]
Type of Reporting Source [Std# 500]

Tables

CS_SSF.DBF

Default Error Message

[4225] Conflict between %F6 and NPCR requirements
Conflict between CS Site-Specific Factor 9 and NPCR requirements

Additional Messages

[3177] For Date of Diagnosis of "value of Date of Diagnosis", CS Site-Specific Factor 9 must not be 988 for this schema
[3374] For DX Year < 2010, CS Version Input Original of "value of CS Version Input Original" and CS Version Input Current of "value of CS Version Input Current", CS Site-Specific Factor 9 must be 988 for this schema
[4852] For DX Year > 2003, CS Site-Specific Factor 9 must not be blank
[4882] If Over-ride CS 20 = '1' and Type of Reporting Source = "value of Type of Reporting Source", then CS Site-Specific Factor 9 must not be blank or 988
ERROR_TEXT("Schema missing in SSF table")
SAVE_TEXT("t_schema_msg")

Description

The purpose of this edit is to verify that CS Site-Specific Factor 9 is entered for the schemas required by NPCR. For diagnosis year 2012 and later, NPCR permits the use of Directly Coded Summary Stage (SEER Summary Stage 2000 [759]) in those cases where collection of CSv02 is not feasible due to lack of data or due to staffing and time constraints at the local or central registry. The data item 'Over-ride CS 20' is used to flag a case where SEER Summary Stage 2000 is recorded in lieu of Derived SS2000 [3020]. When 'Over-ride CS 20' is equal to '1', SEER Summary Stage 2000 must be populated (not blank). The CS input fields may be populated, but are not required. When 'Over-ride CS 20' is blank, the Collaborative Stage input

fields must be populated per NPCR requirements and SEER Summary Stage 2000 may also be populated, but is not required.

Beginning with the NAACCR v13 metafile, Over-ride CS 20 may also be set to '1' for the types of reporting source 3-7 (listed below) for cases with a diagnosis year of 2004 or later.

Type of Reporting Source
- 3 (laboratory only)
- 4 (physician's office)
- 5 (nursing home)
- 6 (autopsy only)
- 7 (death certificate only)

This edit is skipped if any of the following conditions are true:
1. CS Version Input Current is blank
2. CS Version Input Original is blank
3. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and schema is not Brain, CNSOther, or IntracranialGland
4. CS schema is invalid
5. Date of Diagnosis is blank or invalid
6. Date of Diagnosis is 2016 or later

A. For all schemas, if year of Diagnosis is 2004-2015 AND Over-ride CS 20 (for 2012+ cases) is blank, CS Site-Specific Factor 9 cannot be blank.

B. If Over-ride CS 20 is blank, indicating case is coded using CS, then CS Site-Specific Factor 9 cannot = 988 or blank for the schemas for which CS Site-Specific Factor 9 is required by NPCR. See List 1 below.

Detailed logic for B:
If Over-ride CS 20 is blank:

1. If year of Diagnosis is 2010-2015
   then
   CS Site-Specific Factor 9 must not be 988 for the schemas for which CS Site-Specific Factor 9 is required (see List 1 below).

2. If year of Diagnosis is 2004-2009 AND CS Version Input Original is 01xxxx:

   A. If CS Version Input Current = 020510 (not changed since conversion from CSv01 to CSv02):

      CS Site-Specific Factor 9 must be coded 988.

      Note: CS Site-Specific Factor 7-24 fields were all populated with 988 upon conversion from CSv01 to CSv02.

C. If Over-ride CS 20 is '1' and Type of Reporting Source is not 3-7, CS Site-Specific Factor 9 must not be 988 or blank for the schemas listed in List 2 (see below).

Detailed logic for C:
If Over-ride CS 20 is '1':
- CS Site-Specific Factor 9 must not be 988 or blank for Breast schema.

D. If Over-ride CS 20 is '1' and Type of Reporting Source is 3-7, CS Site-Specific Factor 9 will pass if blank.

```
List 1: Schemas for which CS Site-Specific Factor 9 is required for CSv2 by NPCR
--------------------------------------------------------------------------------
Required only for cases diagnosed 2010-2015:
  Breast

List 2: Schemas for which CS Site-Specific Factor 9 is required by NPCR even if the
case is coded using directly coded SEER Summary Stage 2000 [759] (indicated by
Over-ride CS 20 of '1' and Type of Reporting Source not = 3-7)

--------------------------------------------------------------------------------
----------------------------------------
  Breast
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

Modifications:

NAACCR v12.1
- Edit updated to correspond to the CSV0203 NPCR requirements.
- For all schemas, if year of Diagnosis is 2004 or later, CS Site-Specific Factor 9 cannot be blank.
- Edit updated to skip if behavior code is 0 or 1 ONLY if schema is not Brain, CNSOther, or IntracranialGland.

NAACCR v12.2
- Updated to require SSF 9 for only Breast schema if Over-ride CS 20 is set to 1, indicating case is coded using directly coded SEER Summary Stage 2000 [759] for staging.
- CS versioning updated to work for CSv02.04.

NAACCR v13
- Edit modified to take into account the use of Over-ride CS 20 for Type of Reporting Source = 3-7.

NAACCR v14
- CS versioning updated to work for CSv02.05.
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Edit no longer takes into account CS Version Input Original when requiring SSF (cannot = 988). Requirement is now based on year of diagnosis only instead of [year of diagnosis OR CS Version Input Original].

NAACCR v16
- Edit modified to take into acocunt that CS is no longer required for cases diagnosed 2016 or later except for Breast Schemas.
- For all schemas, if year of diagnosis is 2016 or later, the edit will skip. CS Items - NPCR Required - SSF 9 (CS) - 2016+ will check cases diagnosed 2016 or later.
- Name changed from CS Items - NPCR Required - SSF 9 (CS) to CS Items - NPCR Required - SSF 9 (CS) - 2015

NAACCR v16A
- Administrative note for v16 updated to indicate name changed from CS Items - NPCR Required - SSF 9 (CS) to CS Items - NPCR Required - SSF 9 (CS) - 2015

CS Items - NPCR Required - SSF 9 (CS) - 2016+

Agency: NPCR **Last changed: 07/19/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
CS Site-Specific Factor 9 [Std# 2863]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Version Input Original [Std# 2935]
CS Version Input Current [Std# 2937]
Type of Reporting Source [Std# 500]

Default Error Message

[7125] If year of %F1 is 2016 or later, %F2 cannot be 988 or blank
If year of Date of Diagnosis is 2016 or later, CS Site-Specific Factor 9 cannot be 988 or blank

Additional Messages

[7126] CS Version Input Original cannot be left blank
[7127] CS Version Input Current cannot be left blank

Description

```
This edit verifies that CS Site-Specific Factor 9 is populated based on the NPCR
requirements.

This edit is skipped if:
1. Date of Diagnosis is blank or invalid
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and
   schema is not Brain, CNSOther, or IntracranialGland
3. Date of Diagnosis is 2015 or prior
4. CS schema is invalid
5. Type of Reporting Source = 6 (autopsy only) or 7 (death certificate only

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, the CS schema name is returned.

If year of Diagnosis is 2016 or later then CS Site-Specific Factor 9 cannot be 988
(not collected) or blank for Breast schema.

If CS Site Specific Factor 9 is required, this edit checks that CS Version Input
Current and CS Version Input Original are not blank.
```

Administrative Notes

New edit - added to NAACCR v16 metafile.

Modifications:

NAACCR v16A
- Default error message changed to 7125
- Administrative note modified to identify new edit for v16 metafile
- Description and edit logic updated to skip if Type of Reporting Source = 6 or 7
- Description is updated to include skip if CS schema is invalid

CS Lymph Nodes (CS)

Agency: CS **Last changed: 03/10/2010**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

CS Lymph Nodes [Std# 2830]

Default Error Message

[1037] %F1 must be a three-digit number
CS Lymph Nodes must be a three-digit number

Description

Must be a valid three-digit number (000-999) or blank.

Administrative Notes

Modifications:

NAACCR v12.0
The size of CS Lymph Nodes was changed from 2 to 3 characters. Allowable codes changed from "00-99" to "000-999".

CS Lymph Nodes Eval (CS)

Agency: CS **Last changed: 08/16/2009**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

CS Lymph Nodes Eval [Std# 2840]

Default Error Message

[1023] %F1 is not valid
CS Lymph Nodes Eval is not valid

Description

Must be a valid CS Lymph Nodes Eval code (0-3,5,6,8,9) or blank.

Administrative Notes

Modifications:

NAACCR v11.3
01/08
- Code 4 was removed from the list of allowable codes.

NAACCR v12.0
The edit name was changed from "CS Reg Nodes Eval (CS)" to "CS Lymph Nodes Eval (CS)". The data item name also changed from "CS Reg Nodes Eval" to "CS Lymph Nodes Eval".

CS Lymph Nodes Eval, Lymph Nodes, Breast Schema(CS

Agency: CS **Last changed: 10/04/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Lymph Nodes Eval [Std# 2840]
CS Lymph Nodes [Std# 2830]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3261] Breast schema: %F4 and %F5 conflict
Breast schema: CS Lymph Nodes Eval and CS Lymph Nodes conflict

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

The purpose of this edit is to verify that, for cases coded using the Breast Schema, that CS Lymph Nodes and CS Lymph Nodes Eval are coded consistently per Note 6 under CS Lymph Nodes:
Note 6: For the breast schema, the choice of the N category is dependent on the CS Lymph Nodes Eval field. There are certain CS Lymph Nodes codes that can only be used if the nodes are evaluated clinically (CS Lymph Nodes Eval is coded 0, 1, 5, or 9), which will be designated as "Evaluated clinically:" at the beginning of the code description. Similarly, there are certain CS Lymph Nodes codes that can only be used if the nodes are evaluated pathologically (CS Lymph Nodes Eval is coded 2, 3, 6, or 8), and these will be designated as "Evaluated pathologically:". All other codes can be used for clinical or pathologic evaluation

This edit is skipped if any of the following conditions are true:
1. CS Lymph Nodes is empty
2. CS Lymph Nodes Eval is empty
3. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
4. CS schema is invalid

This edit first determines the correct CS schema by doing a function call to the CS Dynamic Link Library (dll). The function call passes Primary Site, Histologic Type ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS schema name is returned.

If schema is Breast schema:
1. If CS Lymph Nodes = 255, 257, 510, 610, 735, or 810, then CS Lymph Nodes Eval must = 0, 1, 5, or 9.
2. If CS Lymph Nodes = 050, 130, 150, 155, 250, 258, 520, 620, 710, 720, 730, or 815, then CS Lymph Nodes Eval must = 2, 3, 6, or 8.

Administrative Notes

New edit - added to NAACCR v11.3A metafile.

In the SEER*Edits software, the title of this edit is: IF213

Modifications:

NAACCR v12.0:
- Edit name changed from 'CS Reg Nodes Eval, Lymph Nodes, Breast Schema(CS)' to 'CS Lymph Nodes Eval, Lymph Nodes, Breast Schema(CS)'.
- Data item name changed from 'CS Reg Nodes Eval' to 'CS Lymph Nodes Eval'
- Edit modified to get schema name from function call to CS dll.
- Edit was modified to check 3-digit CS Lymph Nodes codes (per CSv2) instead of 2-digit CSv1 codes. Also added code '255'.

NAACCR v12.1:
- Updated logic to match Note 6 which replaced Note 5.
  Changed logic from:
1. If CS Lymph Nodes Eval = 0, 1, 5, or 9, then CS Lymph Nodes must = 000, 255, 260, 290, 510, 600, 740, 750, 760, 770, 780, 790, 800, and 999.
2. If CS Lymph Nodes Eval = 2, 3, 6, or 8, then CS Lymph Nodes must not = 290 or 510.
  To:
1. If CS Lymph Nodes = 255, 257, 510, 610, 735, or 810, then CS Lymph Nodes Eval must = 0, 1, 5, or 9.
2. If CS Lympoh Nodes = 050, 130, 150, 155, 250, 258, 520, 620, 710, 720, 730, or 815, then CS Lymph Nodes Eval must = 2, 3, 6, or 8.

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Lymph Nodes Eval, Nodes Ex (CS)

Agency: CS **Last changed: 07/09/2014**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Lymph Nodes Eval [Std# 2840]
Regional Nodes Examined [Std# 830]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3245] %F4 (%V4) and %F5 (%V5) conflict
CS Lymph Nodes Eval ("value of CS Lymph Nodes Eval") and Regional Nodes Examined ("value of Regional Nodes Examined") conflict

Description

```
This edit is skipped if any of the following conditions are true:
1. CS Lymph Nodes Eval is blank
2. Regional Nodes Examined is blank
3. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and schema is not Brain,
CNSOther, or IntracranialGland.
4. CS schema is invalid
5. CS schema is Appendix, CarcinoidAppendix, Colon, GISTAppendix, GISTColon,
GISTRectum, LymphomaOcularAdnexa, MelanomaSkin, MerkelCellSkin, MerkelCellPenis,
MerkelCellVulva, MerkelCellScrotum, NetColon, NETRectum,Rectum, Retinoblastoma

If CS Lymph Nodes Eval = 3, 5, or 6, then Regional Nodes Examined must not = 00 (No
nodes were examined).

Note:
CS Lymph Nodes Eval code 3 = Regional lymph nodes removed for examination (removal
of at least 1 lymph node) WITHOUT pre-surgical systemic treatment or radiation OR
lymph nodes removed for examination, unknown if pre-surgical systemic treatment or
radiation performed.

CS Lymph Nodes Eval code 5 = Regional lymph nodes removed for examination WITH pre-
surgical systemic treatment or radiation, BUT lymph node evaluation based on
clinical evidence.

CS Lymph Nodes Eval code 6 = Regional lymph nodes removed for examination WITH pre-
surgical systemic treatment or radiation, and lymph node evaluation based on
pathologic evidence.
```

Administrative Notes

New edit - added to NAACCR v11.3 metafile.

In the SEER*Edits software, the title of this edit is: IF201

Modifications:

NAACCR v12.0
- Edit name changed from 'CS Reg Nodes Eval, RX Summ--Scope, Nodes Ex (CS)' to 'CS Lymph Nodes Eval, RX Summ--Scope, Nodes Ex (CS)'
- Data item name changed from 'CS Reg Nodes Eval' to 'CS Lymph Nodes Eval'
- Modified to get schema name from function call to CS dll.
- Skipped if CS schema is Appendix, CarcinoidAppendix, Colon, GISTAppendix, GISTColon, GISTRectum, LymphomaOcularAdnexa, MelanomaSkin, MerkelCellSkin, MerkelCellPenis, MerkelCellVulva, MerkelCellScrotum, NetColon, NETRectum,Rectum, Retinoblastoma.

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

NAACCR v14A
- Edit name changed from 'CS Lymph Nodes Eval, RX Summ--Scope, Nodes Ex (CS)' to 'CS Lymph Nodes Eval, Nodes Ex (CS)'
- Edit modified to no longer require RX Summ--Scope Reg LN Sur to not equal 0 when CS Lymph Nodes Eval = 3, 5, or 6. RX Summ--Scope Reg LN Surg no longer checked at all.

CS Lymph Nodes Eval, Schema (CS)

Agency: CS **Last changed: 10/07/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Lymph Nodes Eval [Std# 2840]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3321] %F4 (%V4) is invalid for this schema
CS Lymph Nodes Eval ("value of CS Lymph Nodes Eval") is invalid for this schema

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that CS Lymph Nodes Eval is correct for a particular schema. The
schema determined by Primary Site, Histologic Type ICD-O-3, and sometimes CS Site-
Specific Factor25 (schema discriminator).

This edit is skipped if any of the following conditions are true:
1. CS Lymph Nodes Eval, Primary Site, or Histologic Type ICD-O-3 is blank.
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and
   schema is not Brain, CNSOther, or IntracranialGland
3. CS schema is invalid

This edit verifies that CS Lymph Nodes Eval is valid for a particular schema by
doing function calls to the CS Dynamic Link Library (dll).
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.
Replaces 'CS Lymph Nodes Eval, Primary Site, Histol ICDO3 (NAACCR)'

In the SEER*Edits software, the title of this edit is: IF230

Modifications

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Lymph Nodes, IntracranialGland Schema (CS)

Agency: CS **Last changed: 10/04/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
CS Lymph Nodes [Std# 2830]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3392] Conflict among schema and %F3 (%V3)
Conflict among schema and CS Lymph Nodes ("value of CS Lymph Nodes"

Description

```
This edit is skipped if any of the following conditions are true:
1. CS Lymph Nodes is empty
2. CS schema is not IntracranialGland

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.

If CS schema is IntracranialGland:
    CS Lymph Nodes must = 988 (Not applicable) or 999 (OBSOLETE DATA RETAINED
V0200; Unknown; not stated).
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

In the SEER*Edits software, the title of this edit is: IF317

Modifications

NAACCR v13A
Added SEER IF number (IF317)

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Lymph Nodes, Lymph Nodes Eval, RNP (CS)

Agency: CS **Last changed: 01/08/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Lymph Nodes [Std# 2830]
CS Lymph Nodes Eval [Std# 2840]
Regional Nodes Positive [Std# 820]
Regional Nodes Examined [Std# 830]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]

Default Error Message

[4120] If %F4=%V4 and %F5=%V5, %F6 must not = %V6
If CS Lymph Nodes="value of CS Lymph Nodes" and CS Lymph Nodes Eval="value of CS Lymph Nodes Eval", Regional Nodes Positive must not = "value of Regional Nodes Positive"

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
This edit is skipped if any of the following conditions are true:
1. Year of Date of Diagnosis is less than 2010
2. CS Lymph Nodes is blank
3. CS Lymph Nodes Eval is blank
4. Regional Nodes Positive is blank
5. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
6. CS schema is invalid

This edit is skipped for the following schemas where something other than regional
nodes is also coded in CS Lymph Nodes:
  LymphomaOcularAdnexa - distant nodes also coded in CS Lymph Nodes
  Retinoblastoma - distant nodes also coded in CS Lymph Nodes
  MelanomaSkin - satellite nodules also coded in CS Lymph Nodes
  MerkelCellPenis - satellite nodules also coded in CS Lymph Nodes
  MerkelCellScrotum - satellite nodules also coded in CS Lymph Nodes
  MerkelCellSkin - satellite nodules also coded in CS Lymph Nodes
  MerkelCellVulva - satellite nodules also coded in CS Lymph Nodes

This edit is also skipped for the following schemas for certain CS Lymph Nodes
codes that indicate something other than regional nodes is coded in CS Lymph Nodes:
  Breast and CS Lymph Nodes = 050 (individual tumor cells coded in CS Lymph Nodes)
  EsophagusGEJunction and CS Lymph Nodes = 100 (tumor deposits coded in CS Lymph
Nodes)
  Stomach and CS Lymph Nodes = 100 or 110 (tumor deposits coded in CS Lymph Nodes)
  Colon and CS Lymph Nodes = 050 (tumor deposits coded in CS Lymph Nodes)
```

```
  Rectum and CS Lymph Nodes = 050 (tumor deposits coded in CS Lymph Nodes)
  NETStomach and CS Lymph Nodes = 050 or 100 (nodules in perigastric fat coded in
CS Lymph Nodes)
  NETColon and CS Lymph Nodes = 050 or 100 (nodules in pericolic fat coded in CS
Lymph Nodes)
  NETRectum and CS Lymph Nodes = 050 or 100 (nodules in perirectal fat coded in CS
Lymph Nodes)
  GISTAppendix and CS Lymph Nodes = 050 or 100 (nodules in pericolic fat coded in
CS Lymph Nodes)
  GISTStomach and CS Lymph Nodes = 050 or 100 (nodules in perigastric fat coded in
CS Lymph Nodes)
  GISTColon and CS Lymph Nodes = 050 or 100 (nodules in pericolic fat coded in CS
Lymph Nodes)
  GISTRectum and CS Lymph Nodes = 050 or 100 (nodules in perirectal fat coded in CS
Lymph Nodes)

If CS Lymph Nodes is not = 000 (no regional lymph node involvement)
     or 999 (unknown)
AND CS Lymph Nodes Eval = 3 or 6 (codes indicating pathologic eval)
THEN
    Regional Nodes Positive must not = 00 (all nodes examined negative) or
     98 (no nodes examined)

This edit first determines the CS schema by doing a function call to the CS Dynamic
Link Library (dll).  The function call passes Primary Site, Histologic Type ICD-O-
3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.
```

Administrative Notes

New edit - added to NAACCR v14 metafile.

In the SEER*Edits software, the title of this edit is: IF456

Modifications:

NAACCR v15
- Modified to skip for additional Schema/CS Lymph Nodes code combinations for which CS Lymph Nodes code indicates something other than regional nodes: codes 050 and 100 for NetStomach, NetColon, NetRectum, GISTAppendix, GISTStomach, GISTColon, GISTRectum schemas

CS Lymph Nodes, MyelomaPlasmaCellDisorder (CS)

Agency: CS **Last changed: 10/07/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
CS Lymph Nodes [Std# 2830]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3328] Conflict between schema and %F3 (%V3)
Conflict between schema and CS Lymph Nodes ("value of CS Lymph Nodes"

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
The purpose of this edit is to verify that the data item CS Lymph Nodes is coded
properly for the MyelomaPlasmaCellDisorder schema. The schema includes histologies
9731, 9732, and 9734, but some of the Lymph Nodes codes apply only to a subset of
the three histologies.

This edit is skipped if any of the following conditions are true:
1. CS Lymph Nodes is empty
2. CS schema is invalid

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.

If schema is MyelomaPlasmaCellDisorder:
1. The CS Lymph Nodes values of 000 (For extraosseous plasmacytomas (9734) only:
No regional lymph node involvement), 100 (For extraosseous plasmacytomas (9734)
only: Regional lymph node metastasis), and 999 (unknown) are allowed only for
Histologic Type ICD-O-3 codes 9734 (Plasmacytoma, extramedullary).

2. The CS Lymph Nodes value of 987 (Not applicable) is allowed only for 9731
(Plasmacytoma, NOS) and 9732 (Multiple myeloma).
```

Administrative Notes

New edit - added to NAACCR v12.1 metafile.

In the SEER*Edits software, the title of this edit is: IF347

Modifications

NAACCR v14

- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Lymph Nodes, Nodes Pos, ColoAppRectal (CS)

Agency: CS **Last changed: 10/04/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
Regional Nodes Positive [Std# 820]
CS Lymph Nodes [Std# 2830]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3245] %F4 (%V4) and %F5 (%V5) conflict
Regional Nodes Positive ("value of Regional Nodes Positive") and CS Lymph Nodes ("value of CS Lymph Nodes") conflict

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

The number of positive regional nodes is required to calculate the correct N category for this schema. Use codes 400-480 when the pathology report assigns an N1 or N2 category but does not specify the number of nodes involved, or the record identifies an N1 or N2 category but the specific information about number of nodes involved is not available. Use codes 110-300 rather than codes 400-480 when information about the number of positive nodes is available, or when nodes are clinically positive but not removed for examination." The actual number of involved nodes will be coded in Reg LN Pos."

This edit is skipped if any of the following conditions are true:
1. CS Lymph Nodes is blank
2. Regional Nodes Positive is blank
3. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
4. CS schema is invalid

This edit first determines the correct CS schema by doing a function call to the CS Dynamic Link Library (dll). The function call passes Primary Site, Histologic Type ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS schema number is returned.

For cases using the Colon, Appendix, or Rectum schemas:
If Regional Nodes Positive = 01 - 90 (number of positive nodes are known), CS Lymph Nodes must not = 400, 410, 420, 430, 450, 460, 470, 480.

If CS Lymph Nodes = 400, 410, 420, 430, 450, 460, 470, 480, then Regional Nodes Positive must = 95 (positive aspiration of lymph node(s) was performed) or 97 (Positive nodes are documented, but the number is unspecified).

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

In the SEER*Edits software, the title of this edit is: IF260

Modifications:

NAACCR v12.1:
- Added codes 430 and 480 to list of CS Lymph Nodes for which Regional Nodes Positive must = 95 or 97.

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Lymph Nodes, Nodes Pos, MelanomaSkin (CS)

Agency: CS **Last changed: 09/25/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Lymph Nodes [Std# 2830]
Regional Nodes Positive [Std# 820]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[4864] MelanomaSkin schema: If %F4 = %V4, then %F5 must not = %V5
MelanomaSkin schema: If CS Lymph Nodes = "value of CS Lymph Nodes", then Regional Nodes Positive must not = "value of Regional Nodes Positive"

Description

```
The purpose of this edit is to compare CS Lymph Nodes and Regional Nodes Positive
for cases coded using the MelanomaSkin schema.

If schema is MelanomaSkin:
1. If CS Lymph Nodes = 122, 123, 124, 152, 153, or 158 (evaluated pathologically)
   then
       Regional Nodes Positive must not = 00 or 98 (codes
       indicating no nodes positive pathologically)

This edit is skipped if any of the following conditions are true:
1. CS Lymph Nodes is empty
2. Regional Nodes Positive is empty
3. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
4. CS schema is invalid

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.
```

Administrative Notes

New edit - added to NAACCR v12.1A metafile.

In the SEER*Edits software, the title of this edit is: IF355

Modifications

NAACCR v12.2:
- Edit name changed from "CS Lymph Nodes, SSF3, RNP, MelanomaSkin (CS)" to "CS Lymph Nodes, Nodes Pos, MelanomaSkin (CS)".

- Edit re-worked to incorporate new codes and logic; CS SSF 3 logic deleted.

NAACCR v13A:
- Edit logic updated to include CS Lymph Nodes code 153 in list of codes indicating "evaluated pathologically". (Edit description was already correct.)

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Default error message added

CS Lymph Nodes, Nodes Pos, MerkelCell Schemas(CS)

Agency: CS **Last changed: 10/04/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Lymph Nodes [Std# 2830]
Regional Nodes Positive [Std# 820]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[4870] For this schema: If %F4 = %V4, then %F5 must not = %V5
For this schema: If CS Lymph Nodes = "value of CS Lymph Nodes", then Regional Nodes Positive must not = "value of Regional Nodes Positive"

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
The purpose of this edit is to compare CS Lymph Nodes and Regional Nodes Positive
for cases coded using the MerkelCell schemas.


If CS schema is MerkelCellScrotum, MerkelCellSkin, MerkelCellPenis, or
MerkelCellVulva:

1. If CS schema is MerkelCellScrotum or MerkelCellSkin:
   then
       If CS Lymph Nodes = 320, 340, 350 (evaluated pathologically)
       then
       Regional Nodes Positive must not = 00 or 98 (codes
       indicating no nodes positive pathologically)

2. If CS schema is MerkelCellPenis:
   then
       If CS Lymph Nodes = 120, 140, 150 (evaluated pathologically)
       then
       Regional Nodes Positive must not = 00 or 98

3. If CS schema is MerkelCellVulva:
   then
       If CS Lymph Nodes = 115, 120, 125 (evaluated pathologically)
       then
       Regional Nodes Positive must not = 00 or 98


This edit is skipped if any of the following conditions are true:
```

```
1. CS Lymph Nodes is empty
2. Regional Nodes Positive is empty
3. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
4. CS schema is invalid

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.
```

Administrative Notes

New edit - added to NAACCR v12.2 metafile.

In the SEER*Edits software, the title of this edit is: IF381

Modifications:

NAACCR v12.2C:
- Although the edit description was correct, the actual logic was missing some brackets, causing the edit to fail when it should pass. The brackets have been added.

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Lymph Nodes, Nodes Pos, SSF3, Breast Schema(CS)

Agency: CS **Last changed: 10/04/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Lymph Nodes [Std# 2830]
Regional Nodes Positive [Std# 820]
CS Site-Specific Factor 3 [Std# 2900]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3323] Conflict among schema, %F4 (%V4), %F5 (%V5), %F6 (%V6)
Conflict among schema, CS Lymph Nodes ("value of CS Lymph Nodes"), Regional Nodes Positive ("value of Regional Nodes Positive"), CS Site-Specific Factor 3 ("value of CS Site-Specific Factor 3"

Additional Messages

[3418] Breast schema: CS Site-Specific Factor 3 ("value of CS Site-Specific Factor 3") must be less than or = Regional Nodes Positive ("value of Regional Nodes Positive"
SAVE_TEXT("t_schema_msg")

Description

```
This edit is skipped if any of the following conditions are true:
1. CS Lymph Nodes, CS Site-Specific Factor 3, or Regional Nodes Positive is empty
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
3. CS schema is invalid

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.

If CS schema is Breast:

    If CS Lymph Nodes = 050 (none, no regional lymph nodes but with ITCs
    detected on routine H and E stains), then Regional Nodes Positive
    must = 00 (all nodes examined negative) and CS Site-Specific
    Factor 3 must = 000 (all ipsilateral nodes examined negative).

      If CS Lymph Nodes = 710, 730, 735, 740, 745, 764, or 770 (internal mammary
    without axillary nodes), then CS Site-Specific Factor 3 must
    not be 001-097 (axillary nodes positive).

    If CS Site-Specific Factor 3 = 001-097 (positive nodes),
    then
    CS Lymph Nodes must not = 000, 710, 730, 735, 740, 745, 764, or 770.
```

```
If CS Site-Specific Factor 3 = 000-089 and Regional Nodes Positive = 00-89
then
CS Site-Specific Factor 3 must be less than or = Regional Nodes Positive.
```

Administrative Notes

In the SEER*Edits software, the title of this edit is: IF188

MODIFICATIONS:

NAACCR v11.2
7/2007
The following logic was added:
If CS Lymph Nodes = 71, 73, 74, 77, or 78 (internal mammary without axillary nodes), then CS Site-Specific Factor 3 must not be 001-097 (axillary nodes positive).

This edit was also modified so that it will be skipped if Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline).

11/2007
Description updated: lymphoma and hematopoietic histologies are now grouped together in the list of histologies for which this edit is skipped.

NAACCR v11.3
6/2008
Updated Administrative Notes with the title of the corresponding edit in the SEER*Edits software.

NAACCR v12.0
- Edit modified to get schema name from function call to CS dll.
- Edit was modified to check CS Lymph Nodes codes (per CSv2) of 050, 710, 730, 740, 770, and 780 instead of CSv1 codes of 05, 71, 73, 74, 77, and 78.

NAACCR v12.1
- Changed:
If CS Lymph Nodes = 710, 730, 740, 770, or 780 (internal mammary without axillary nodes), then CS Site-Specific Factor 3 must not be 001-097 (axillary nodes positive).
To:
If CS Lymph Nodes = 710, 730, 735, 740, 745, 764, or 770 (internal mammary without axillary nodes), then CS Site-Specific Factor 3 must not be 001-097 (axillary nodes positive).

Added:
If CS Site-Specific Factor 3 = 000-089 and Regional Nodes Positive = 00-89,
then CS Site-Specific Factor 3 must be less than or = Regional Nodes Positive.

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Lymph Nodes, Regional Nodes Positive (CS)

Agency: CS **Last changed: 10/04/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
Regional Nodes Positive [Std# 820]
CS Lymph Nodes [Std# 2830]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3245] %F4 (%V4) and %F5 (%V5) conflict
Regional Nodes Positive ("value of Regional Nodes Positive") and CS Lymph Nodes ("value of CS Lymph Nodes") conflict

Description

```
This edit is skipped if any of the following conditions are true:
1. CS Lymph Nodes or Regional Nodes Positive is empty.
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and
   schema is not Brain, CNSOther, or IntracranialGland
3. CS schema is invalid

If Regional Nodes Positive = 01-97, then CS Lymph Nodes cannot = 000.
```

Administrative Notes

In the SEER*Edits software, the title of this edit is: IF158

Modifications:

NAACCR v11.2
8/2007
This edit was modified so that it will be skipped if Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and Primary Site is not C700-C729 (Brain and Other CNS) or C751-C753 (Intracranial Endocrine).

NAACCR v11.3
6/2008
Updated Administrative Notes with the title of the corresponding edit in the SEER*Edits software.

NAACCR v12.0:
- Edit was modified to check 3-digit CS Lymph Nodes codes (per CSv2) instead of 2-digit CSv1 codes.
- Error message corrected.
- Edit modified to get schema name from function call to CS dll.

NAACCR v14

- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Lymph Nodes, Schema (CS)

Agency: CS **Last changed: 10/07/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Lymph Nodes [Std# 2830]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3321] %F4 (%V4) is invalid for this schema
CS Lymph Nodes ("value of CS Lymph Nodes") is invalid for this schema

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that CS Lymph Nodes is correct for a particular schema. The
schema determined by Primary Site, Histologic Type ICD-O-3, and sometimes CS Site-
Specific Factor25 (schema discriminator).

This edit is skipped if any of the following conditions are true:
1. CS Lymph Nodes, Primary Site, or Histologic Type ICD-O-3 is blank
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and
   schema is not Brain, CNSOther, or IntracranialGland
3. CS schema is invalid

This edit verifies that CS Lymph Nodes is valid for a particular schema by doing
function calls to the CS Dynamic Link Library (dll).

Note: This edit does not check for obsolete codes.  Obsolete codes for CS Extension
are edited by "Obsolete Codes - CS Lymph Nodes (SEER IF147)".
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.
Replaces 'CS Lymph Nodes, Primary Site, Histol ICDO3 (NAACCR)'

In the SEER*Edits software, the title of this edit is: IF229

Modifications

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Lymph Nodes, SSF 1, Head/Neck Schemas (CS)

Agency: CS **Last changed: 10/04/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Lymph Nodes [Std# 2830]
CS Site-Specific Factor 1 [Std# 2880]
CS Site-Specific Factor25 [Std# 2879]

Tables

SCHEM_HN.DBF

Default Error Message

[3329] Conflict among schema, %F4 (%V4), %F5 (%V5]
Conflict among schema, CS Lymph Nodes ("value of CS Lymph Nodes"), CS Site-Specific Factor 1 ("value of CS Site-Specific Factor 1"

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
This edit is skipped if any of the following conditions are true:
1. CS Lymph Nodes is empty.
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
3. CS schema is invalid

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.

This edit is skipped if CS schema is NOT one of the following Head and Neck
schemas:
 BuccalMucosa
 EpiglottisAnterior
 FloorMouth
 GumLower
 GumOther
 GumUpper
 Hypopharynx
 LarynxGlottic
 LarynxOther
 LarynxSupraglottic
 LarynxSubglottic
 LipLower
```

```
LipOther
LipUpper
MelanomaLipUpper
MelanomaLipLower
MelanomaLipOther
MelanomaTongueAnterior
MelanomaGumUpper
MelanomaGumLower
MelanomaGumOther
MelanomaFloorMouth
MelanomaPalateHard
MelanomaMouthOther
MelanomaBuccalMucosa
MelanomaTongueBase
MelanomaPalateSoft
MelanomaOropharynx
MelanomaNasopharynx
MelanomaHypopharynx
MelanomaPharynxOther
MelanomaEpiglottisAnterior
MelanomaLarynxGlottic
MelanomaLarynxSupraglottic
MelanomaLarynxSubglottic
MelanomaLarynxOther
MelanomaNasalCavity
MelanomaSinusMaxillary
MelanomaSinusEthmoid
MelanomaSinusOther
MiddleEar
MouthOther
NasalCavity
Nasopharynx
Oropharynx
PalateHard
PalateSoft
ParotidGland
PharyngealTonsil
PharynxOther
SalivaryGlandOther
SinusEthmoid
SinusMaxillary
SinusOther
SubmandibularGland
TongueAnterior
TongueBase

If CS Lymph Nodes not = 000 (none) or 999 (unknown, not stated), then CS Site-
Specific Factor 1 must not = 000 (No involved regional nodes).
```

Administrative Notes

In the SEER*Edits software, the title of this edit is: IF128

Modifications:

NAACCR v11.2
8/2007
This edit was modified so that it will be skipped if Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline).

11/2007
Description updated: lymphoma and hematopoietic histologies are now grouped together in the list of histologies for which this edit is skipped.

NAACCR v11.3
6/2008
Updated Administrative Notes with the title of the corresponding edit in the SEER*Edits software.

NAACCR v12.0:
- Edit modified to get schema name from function call to CS dll.
- Length of CS Lymph Nodes changed from 2 to 3 characters.
- Additional Head and Neck schemas added.

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Lymph Nodes, SSF 4, 5, Breast Schema (CS)

Agency: CS **Last changed: 10/04/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Lymph Nodes [Std# 2830]
CS Site-Specific Factor 4 [Std# 2910]
CS Site-Specific Factor 5 [Std# 2920]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3056] Conflict among schema, %F4 (%V4), and CS Site-Specific Factors
Conflict among schema, CS Lymph Nodes ("value of CS Lymph Nodes"), and CS Site-Specific Factors

Additional Messages

SAVE_TEXT("Conflict among schema, CS Lymph Nodes, and CS Site-Specific Factor 4")
SAVE_TEXT("Conflict among schema, CS Lymph Nodes, and CS Site-Specific Factor 5")
SAVE_TEXT("t_schema_msg")

Description

```
This edit is skipped if any of the following conditions are true:
1. CS Lymph Nodes is empty
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
3. CS schema is invalid

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.

If CS schema is Breast:

    If CS Lymph Nodes = 000, then both CS Site-Specific Factor 4 and
    CS Site-Specific Factor 5 must not = 987 (not applicable; CS Lymph
    Nodes not coded 000)

    If CS Lymph Nodes not = 000, then both CS Site-Specific Factor 4
    and CS Site-Specific Factor 5, if not blank, must = 987 or 988
    (not applicable: information not collected for this case)


Notes:
CS Lymph Nodes 000 =
None; no regional lymph node involvement, or ITCs detected by immunohistochemistry
or molecular methods ONLY
```

Administrative Notes

In the SEER*Edits software, the title of this edit is: IF129

Modifications:

NAACCR v11.2
8/2007
This edit was modified so that it will be skipped if Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline).

11/2007
Description updated: lymphoma and hematopoietic histologies are now grouped together in the list of histologies for which this edit is skipped.

NAACCR v11.3
6/2008
Updated Administrative Notes with the title of the corresponding edit in the SEER*Edits software.

NAACCR v12.0
- Edit modified to get schema name from function call to CS dll.
- Edit was modified to check CS Lymph Nodes codes (per CSv2) of 000, 740, and 770 instead of CSv1 codes of 00, 74, and 77.

NAACCR v12C
- The following logic was changed from:
"If CS Lymph Nodes not = 000, then both CS Site-Specific Factor 4 and CS Site-Specific Factor 5, if not blank, must = 987"
To:
"If CS Lymph Nodes not = 000 or 050, then both CS Site-Specific Factor 4 and CS Site-Specific Factor 5, if not blank, must = 987 or 988"

NAACCR v12.1
- Edit name changed from "CS Lymph Nodes, SSF 3,4,5, Breast Schema (CS)"
to "CS Lymph Nodes, SSF 4,5, Breast Schema (CS)" since SSF 3 is no longer used in this edit.
The following logic was changed from:
-"If CS Lymph Nodes not = 000 or 050, then both CS Site-Specific Factor 4 and CS Site-Specific Factor 5, if not blank, must = 987"
To:
"If CS Lymph Nodes not = 000, then both CS Site-Specific Factor 4 and CS Site-Specific Factor 5, if not blank, must = 987 or 988"

Deleted:
If CS Site-Specific Factor 3 = 001-097 (positive nodes), then
CS Lymph Nodes must not = 000, 740, or 770.

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Lymph Nodes, SSF3, Nodes Eval, MelanomaSkin(CS)

Agency: CS **Last changed: 09/25/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor 3 [Std# 2900]
CS Lymph Nodes [Std# 2830]
CS Lymph Nodes Eval [Std# 2840]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3235] Conflict among schema, %F4 (%V4), %F5 (%V5), %F6 (%V6)
Conflict among schema, CS Site-Specific Factor 3 ("value of CS Site-Specific Factor 3"), CS Lymph Nodes ("value of CS Lymph Nodes"), CS Lymph Nodes Eval ("value of CS Lymph Nodes Eval"

Additional Messages

[4870] For this schema: If CS Site-Specific Factor 3 = "value of CS Site-Specific Factor 3", then CS Lymph Nodes must not = "value of CS Lymph Nodes"
[4871] For this schema: If CS Lymph Nodes = "value of CS Lymph Nodes", then CS Lymph Nodes Eval must not = "value of CS Lymph Nodes Eval"
[4872] For this schema: If CS Site-Specific Factor 3 = "value of CS Site-Specific Factor 3", then CS Lymph Nodes Eval must not = "value of CS Lymph Nodes Eval"
SAVE_TEXT("t_schema_msg")

Description

```
The purpose of this edit is to compare CS Lymph Nodes, CS Site-Specific 3, and CS
Lymph Nodes Eval for cases coded using the Melanoma of Skin Schema.

If schema is MelanomaSkin:

1.  If CS Site-Specific Factor 3 = 000 or 005 (see definitions below)
    then
        CS Lymph Nodes must not = 121 or 128 (codes that indicate case
        evaluated clinically)

2.  If CS Lymph Nodes = 121 or 128 (codes that indicate case
    evaluated clinically)
    then
        CS Lymph Nodes Eval must = 0, 1, 5 (codes that indicate
        case does not meet criteria for AJCC pathological stage)
        or 9 (unknown)

3.  If CS Lymph Nodes = 122, 123, 124, 152, 153, or 158 (codes that
    indicate case was evaluated pathologically)
    then
```

```
        CS Lymph Nodes Eval must = 2, 3, 6, 8 (codes that indicate
        case meets requirement for AJCC pathologic staging) or 9 (unknown)

4.  If CS Site-Specific Factor 3 = 020, 043, 045, 048, 050, 100, or 150
    (codes indicating 'clinically apparent')
    then
        CS Lymph Nodes Eval must not = 8 (diagnosed at autopsy)

*************************************************************
CS Site-Specific Factor 3 definitions for codes 000 and 005:
000 = OBSOLETE DATA RETAINED V0204
      No lymph node metastasis
005 = Clinically negative lymph node metastasis
      AND
      No pathologic examination performed
      Or unknown if pathologic examination performed
      Or nodes negative on pathologic examination
*************************************************************

This edit is skipped if any of the following conditions are true:
1. CS Lymph Nodes is empty
2. CS Site-Specific Factor 3 is empty or = 988
3. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
4. CS schema is invalid

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.
```

Administrative Notes

New edit - added to NAACCR v11.3A metafile.

In the SEER*Edits software, the title of this edit is: IF216

Modifications:

NAACCR v12.0:
- Edit name changed from "CS Lymph Nodes, SSF3, Nodes Eval, Melanoma(CS)" to "CS Lymph Nodes, SSF3, Nodes Eval, MelanomaSkin(CS)".
- Changed data item name CS Reg Nodes Eval to CS Lymph Nodes Eval.
- Edit modified to get schema name from function call to CS dll.
- Length of CS Lymph Nodes changed from 2 to 3 characters.

NAACCR v12.1:
- Modified so that edit is also skipped if CS Site-Specific Factor 3 is 988.
- Added code 154 to list of CS Lymph Node codes for which CS Site-Specific Factor 3 must = 000.
- Changed checks for CS Site-Specific Factor 3 code of 001 to 010 and 002 to 020 per conversion specifications.

NAACCR v12.2:
- Re-worked to incorporate new codes and logic.

NAACCR v12.2C:
- Although the edit description was correct, there were errors in the corresponding logic. The following corrections were made to the edit logic:

1. Changed from:
   If not CS Site-Specific Factor 3 = 000 or 005, then CS Lymph Nodes must not = 121 or 128
  To:
   If CS Site-Specific Factor 3 = 000 or 005, then CS Lymph Nodes must not = 121 or 128
2. Logic changed to allow CS Lymph Nodes Eval code 9 when CS Lymph Nodes = 121, 122, 123, 124, 128, 152, 153, 158

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Default error message added

CS Lymph Nodes, SSF3, Nodes Eval, MerkelCell (CS)

Agency: CS **Last changed: 10/04/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor 3 [Std# 2900]
CS Lymph Nodes [Std# 2830]
CS Lymph Nodes Eval [Std# 2840]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3235] Conflict among schema, %F4 (%V4), %F5 (%V5), %F6 (%V6)
Conflict among schema, CS Site-Specific Factor 3 ("value of CS Site-Specific Factor 3"), CS Lymph Nodes ("value of CS Lymph Nodes"), CS Lymph Nodes Eval ("value of CS Lymph Nodes Eval"

Additional Messages

[4870] For this schema: If CS Site-Specific Factor 3 = "value of CS Site-Specific Factor 3", then CS Lymph Nodes must not = "value of CS Lymph Nodes"
[4871] For this schema: If CS Lymph Nodes = "value of CS Lymph Nodes", then CS Lymph Nodes Eval must not = "value of CS Lymph Nodes Eval"
[4872] For this schema: If CS Site-Specific Factor 3 = "value of CS Site-Specific Factor 3", then CS Lymph Nodes Eval must not = "value of CS Lymph Nodes Eval"
SAVE_TEXT("t_schema_msg")

Description

```
The purpose of this edit is to compare CS Lymph Nodes, CS Site-Specific 3, and CS
Lymph Nodes Eval for cases coded using the MerkelCellScrotum, MerkelCellSkin,
MerkelCellPenis,and MerkelCellVulva schemas.

If CS schema is MerkelCellScrotum, MerkelCellSkin, MerkelCellPenis, or
MerkelCellVulva:

1. If CS schema is MerkelCellScrotum or MerkelCellSkin:
   A. If CS Site-Specific Factor 3 = 000 or 005 (see definitions below)
      then
          CS Lymph Nodes must = 000, 390, or 400, indicating no lymph node mets.

   B. If CS Lymph Nodes = 310 (evaluated clinically)
      then
          CS Lymph Nodes Eval must = 0, 1, 5 (codes that indicate
          case does not meet criteria for AJCC pathological stage)
          or 9 (unknown)

   C. If CS Lymph Nodes = 320, 340, 350 (codes that
      indicate case was evaluated pathologically)
```

```
      then
          CS Lymph Nodes Eval must = 2, 3, 6, 8 (codes that indicate
          case meets requirement for AJCC pathologic staging) or 9 (unknown)

   D. If CS Site-Specific Factor 3 = 020 (clinically apparent)
      then
          CS Lymph Nodes Eval must not = 8 (diagnosed at autopsy)


2. If CS schema is MerkelCellPenis:
   A. If CS Site-Specific Factor 3 = 000 or 005 (see definitions below)
      then
          CS Lymph Nodes must = 000, 410, 420, indicating no lymph node mets.

   B. If CS Lymph Nodes = 110 (evaluated clinically)
      then
          CS Lymph Nodes Eval must = 0, 1, 5 (codes that indicate
          case does not meet criteria for AJCC pathological stage)
          or 9 (unknown)

   C. If CS Lymph Nodes = 120, 140, 150 (codes that
      indicate case was evaluated pathologically)
      then
          CS Lymph Nodes Eval must = 2, 3, 6, 8 (codes that indicate
          case meets requirement for AJCC pathologic staging) or 9 (unknown)

   D. If CS Site-Specific Factor 3 = 020 (clinically apparent)
      then
          CS Lymph Nodes Eval must not = 8 (diagnosed at autopsy)


3. If CS schema is MerkelCellVulva:
   A. If CS Site-Specific Factor 3 = 000 or 005 (see definitions below)
      then
          CS Lymph Nodes must = 000, 510, 520, indicating no lymph node mets.

   B. If CS Lymph Nodes = 114 (evaluated clinically)
      then
          CS Lymph Nodes Eval must = 0, 1, 5 (codes that indicate
          case does not meet criteria for AJCC pathological stage)
          or 9 (unknown)

   C. If CS Lymph Nodes = 115, 120, 125(codes that
      indicate case was evaluated pathologically)
      then
          CS Lymph Nodes Eval must = 2, 3, 6, 8 (codes that indicate
          case meets requirement for AJCC pathologic staging) or 9 (unknown)

    D. If CS Site-Specific Factor 3 = 020 (clinically apparent)
       then
           CS Lymph Nodes Eval must not = 8 (diagnosed at autopsy)

************************************************************
CS Site-Specific Factor 3 definitions for codes 000 and 005:
000 = OBSOLETE DATA RETAINED V0204
      No lymph node metastasis
005 = Clinically negative lymph node metastasis
      AND
      No pathologic examination performed
      Or unknown if pathologic examination performed
```

```
      Or nodes negative on pathologic examination
************************************************************

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor 3 is blank or 988
2. CS Lymph Nodes is blank
3. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
4. CS schema is invalid

This edit first determines the CS schema by doing a function call to the CS Dynamic
Link Library (dll).  The function call passes Primary Site, Histologic Type ICD-O-
3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.
```

Administrative Notes

New edit - added to NAACCR v12.1 metafile.

In the SEER*Edits software, the title of this edit is: IF319

Modifications

NAACCR v12.2
- Edit name changed from "CS SSF 3, MerkelCell Schemas (CS)" to "CS Lymph Nodes, SSF3, Nodes Eval, MerkelCell(CS)".
- Re-worked to incorporate new codes and logic.

NAACCR v12.2C:
- Logic changed to allow CS Lymph Nodes Eval code 9 when editing CS Lymph Nodes Eval codes against CS Lymph Nodes codes; description was already correct.

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Default error message added

CS Mets at DX (CS)

Agency: CS **Last changed: 09/28/2003**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

CS Mets at DX [Std# 2850]

Default Error Message

[1036] %F1 must be a two-digit number
CS Mets at DX must be a two-digit number

Description

Must be a valid two-digit number (00-99) or blank.

CS Mets at DX, Lung, Laterality (CS)

Agency: CS **Last changed: 10/04/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
Laterality [Std# 410]
CS Mets at DX [Std# 2850]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3252] Lung schema: Conflict between Laterality and CS Mets at DX
Lung schema: Conflict between Laterality and CS Mets at DX

Description

```
Purpose: This edit verifies that, for lung cases, if bilateral involvement, then CS
Mets at DX is coded to bilateral as well.

This edit is skipped if any of the following conditions are true:
1. CS Mets at DX is empty
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
3. CS schema is invalid

If schema is Lung:
If Laterality = 4 (Bilateral involvement), then CS Mets at DX must = 23, 25, 26,
36, 38, 40, 41, 42, 43, 50, 51, 52, 53, 70, or 75.

Per the multiple primary rules, involvement of diffuse bilateral nodules "is the
only condition when laterality = 4."
```

Administrative Notes

New edit - added to NAACCR v11.3A metafile.

In the SEER*Edits software, the title of this edit is: IF217

Modifications

NAACCR v12.0:
- Edit modified to get schema name from function call to CS dll.
- Codes 23, 25, 26, 37, 42, 43, 51, 52, 53, 70, and 75 were added to CS Mets at DX codes that indicate involvement of contralateral lung.

NAACCR v12.1:
- Edit modified to get schema name from function call to CS dll.
- Codes 36 and 38 were added to CS Mets at DX codes that indicate involvement of contralateral lung.

NAACCR v12.2

- Added new CS Mets at DX code 41 to list of codes indicating bilateral involvement.
- Removed CS Mets at DX code 37 from list of codes indicating bilateral involvement.

NAACCR v14

- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Mets at DX, Schema (CS)

Agency: CS **Last changed: 10/07/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Mets at DX [Std# 2850]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3321] %F4 (%V4) is invalid for this schema
CS Mets at DX ("value of CS Mets at DX") is invalid for this schema

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that CS Mets at DX is correct for a particular schema. The
schema determined by Primary Site, Histologic Type ICD-O-3, and sometimes CS Site-
Specific Factor25 (schema discriminator).

This edit is skipped if any of the following conditions are true:
1. CS Mets at DX, Primary Site, or Histologic Type ICD-O-3 is blank
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and
   schema is not Brain, CNSOther, or IntracranialGland
3. CS schema is invalid

This edit verifies that CS Mets at DX is valid for a particular schema by doing
function calls to the CS Dynamic Link Library (dll).

Note: This edit does not check for obsolete codes.  Obsolete codes for CS Extension
are edited by "Obsolete Codes - CS Mets at DX (SEER IF148)".
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.
Replaces 'CS Mets at DX, Primary Site, Histol ICDO3 (NAACCR)'

In the SEER*Edits software, the title of this edit is: IF231

Modifications

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Mets Eval (CS)

Agency: CS **Last changed: 06/23/2008**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

CS Mets Eval [Std# 2860]

Default Error Message

[1023] %F1 is not valid
CS Mets Eval is not valid

Description

Must be a valid CS Mets Eval code (0-3,5,6,8,9) or blank.

Administrative Notes

Modifications:

NAACCR v11.3
01/08
- Code 4 was removed from the list of allowable codes.

CS Mets Eval, Mets at DX, CS Version Inp Orig (CS)

Agency: CS **Last changed: 03/04/2010**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

CS Mets Eval [Std# 2860]
CS Mets at DX [Std# 2850]
CS Version Input Original [Std# 2935]

Default Error Message

[1016] %F1 and %F2 conflict
CS Mets Eval and CS Mets at DX conflict

Description

```
This edit is skipped if either CS Mets Eval or CS Mets at DX are blank.
It is also skipped if CS Version Input Original is less than 010400 (version
01.04).

If CS Mets Eval = 2, 3 or 6, then CS Mets at DX cannot = 00 (none).

Note:
CS Mets Eval code 2 = No pathologic examination of metastatic tissue done prior to
death, but evidence derived from autopsy (tumor was suspected or diagnosed prior to
autopsy.

CS Mets Eval code 3 = Pathologic examination of metastatic tissue performed WITHOUT
pre-surgical systemic treatment or radiation OR pathologic examination of
metastatic tissue performed, unknown if presurgical systemic treatment or radiation
performed.

CS Mets Eval code 6 = Pathologic examination of metastatic tissue performed WITH
pre-surgical systemic treatment or radiation, BUT metastasis based on pathologic
evidence.
```

Administrative Notes

New edit - added to NAACCR v11.3 metafile.

In the SEER*Edits software, the title of this edit is: IF209

Modifications

NAACCR v12.0:
- Edit name changed from "CS Mets Eval, CS Mets at DX, CS Version 1st (CS)" to "CS Mets Eval, Mets at DX, CS Version Inp Orig (CS)"
- Field "CS Version 1st" changed to "CS Version Input Original"

CS Mets Eval, Schema (CS)

Agency: CS **Last changed: 10/07/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Mets Eval [Std# 2860]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3321] %F4 (%V4) is invalid for this schema
CS Mets Eval ("value of CS Mets Eval") is invalid for this schema

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that CS Mets Eval is correct for a particular schema. The schema
determined by Primary Site, Histologic Type ICD-O-3, and sometimes CS Site-Specific
Factor25 (schema discriminator).

This edit is skipped if any of the following conditions are true:
1. CS Mets Eval, Primary Site, or Histologic Type ICD-O-3 is blank
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and
   schema is not Brain, CNSOther, or IntracranialGland
3. CS schema is invalid

This edit verifies that CS Mets Eval is valid for a particular schema by doing
function calls to the CS Dynamic Link Library (dll).
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.
Replaces 'CS Mets Eval, Primary Site, Histol ICDO3 (NAACCR)'

In the SEER*Edits software, the title of this edit is: IF232

Modifications

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Over-ride CS 20, Class of Case (MCR)

Agency: **Last changed: 07/15/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Class of Case [Std# 610]
Over-ride CS 20 [Std# 3769]

Default Error Message

[9998] Over-ride CS 20 should be blank for analytic cases for the MCR.
Over-ride CS 20 should be blank for analytic cases for the MCR.

Description

Note: NPCR discontinued use of Over-ride CS 20 for diagnosis year 2016.

Over-ride CS 20 [3769] has been designated as a special-purpose flag to identify cases where SEER Summary Stage 2000 [NAACCR data item 759] is directly coded and reported in lieu of Derived SS2000 [NAACCR data item 3020], in accordance with the 2012 NPCR reporting requirements. The Over-ride CS 20 value of "1", set by the user, identifies a record with NAACCR data item 759 used to report Summary Stage 2000 as permitted by NPCR requirements only; Over-ride CS 20 is left blank for all other cases.

Codes for Over-ride CS 20:
1 = Directly coded SEER Summary Stage 2000 [759] used to report Summary Stage and Derived Summary Stage 2000 [3020] must be blank
Blank = Derived Summary Stage 2000 [3020] reported using the Collaborative Stage Data Collection System or case diagnosed prior to 2012

If Class of Case is analytic (00-22), then Over-ride CS 20 must be blank.

Administrative Notes

MCR-only edit new in 12.2. Beginning with 2004 diagnoses, we allow the directly-coded Summary Stage option for non-analytic cases. (Diagnosis year is checked in a standard edit.)
Year changed from 2012 to 2004 as of v13A when NPCR decided to allow the option back to 2004 for all Type of Reporting Source except 1, 2, 8.
CS Over-ride 20 is no longer applicable for 2016 diagnoses and forward as CS derivations were discontinued for NPCR. This is checked by another edit.

CS Over-ride CS 20, Date of Dx (NPCR/MCR)

Agency: **Last changed: 06/27/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
Over-ride CS 20 [Std# 3769]
Class of Case [Std# 610]

Default Error Message

[4881] If DX Year less than 2012 and %F3 = %V3, %F2 must be blank
If DX Year less than 2012 and Class of Case = "value of Class of Case", Over-ride CS 20 must be blank

Additional Messages

[4900] If DX Year less than 2004 or blank, Over-ride CS 20 must be blank
[7124] If year of Date of Diagnosis is 2016 or later, Over-ride CS 20 must be blank
ERROR_TEXT("Date of Diagnosis: %DC")

Description

Over-ride CS 20 [3769] has been designated as a special-purpose flag to identify cases where SEER Summary Stage 2000 [NAACCR data item 759] is directly coded and reported in lieu of Derived SS2000 [NAACCR data item 3020], in accordance with the 2012 NPCR reporting requirements. The Over-ride CS 20 value of "1", set by the user, identifies a record with NAACCR data item 759 used to report Summary Stage 2000 as permitted by NPCR requirements only; Over-ride CS 20 is left blank for all other cases.

Codes for Over-ride CS 20:
1 = Directly coded SEER Summary Stage 2000 [759] used to report Summary Stage and Derived Summary Stage 2000 [3020] must be blank
Blank = Derived Summary Stage 2000 [3020] reported using the Collaborative Stage Data Collection System or case diagnosed prior to 2012

If year of Date of Diagnosis is less than 2012 or is blank, then Over-ride CS 20 must be blank EXCEPT for the types of reporting source listed below for which Over-ride CS 20 may be populated for cases beginning with a diagnosis year of 2004.

Type of Reporting Source
  3 (laboratory only)
  4 (physician's office)
  5 (nursing home)
  6 (autopsy only)
  7 (death certificate only)

If year of Date of Diagnosis is 2016 or later then Over-ride CS 20 must be blank.

MCR modification: Use Class of Case 38-49 instead of Type of Reporting Source for records received at MCR. MCR generates Type of Reporting Source and does not collect it.

Administrative Notes

New edit - added to NAACCR v12.2 metafile.

Modifications:

NAACCR v13
- Edit modified to allow Over-ride CS 20 to be entered for cases diagnosed 2004 and later if Type of Reporting Source = 3-7.

MCR modification uses Class of Case 38-49.

CS Over-ride CS 20, Rpt Srce, Flds (NPCR/MCR)

Agency: **Last changed: 07/15/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Over-ride CS 20 [Std# 3769]
CS Extension [Std# 2810]
CS Tumor Size [Std# 2800]
CS Tumor Size/Ext Eval [Std# 2820]
CS Lymph Nodes [Std# 2830]
CS Lymph Nodes Eval [Std# 2840]
CS Mets at DX [Std# 2850]
CS Mets Eval [Std# 2860]
CS Site-Specific Factor 1 [Std# 2880]
CS Site-Specific Factor 2 [Std# 2890]
CS Site-Specific Factor 3 [Std# 2900]
CS Site-Specific Factor 4 [Std# 2910]
CS Site-Specific Factor 5 [Std# 2920]
CS Site-Specific Factor 6 [Std# 2930]
CS Site-Specific Factor 7 [Std# 2861]
CS Site-Specific Factor 8 [Std# 2862]
CS Site-Specific Factor 9 [Std# 2863]
CS Site-Specific Factor10 [Std# 2864]
CS Site-Specific Factor11 [Std# 2865]
CS Site-Specific Factor12 [Std# 2866]
CS Site-Specific Factor13 [Std# 2867]
CS Site-Specific Factor14 [Std# 2868]
CS Site-Specific Factor15 [Std# 2869]
CS Site-Specific Factor16 [Std# 2870]
CS Site-Specific Factor17 [Std# 2871]
CS Site-Specific Factor18 [Std# 2872]
CS Site-Specific Factor19 [Std# 2873]
CS Site-Specific Factor20 [Std# 2874]
CS Site-Specific Factor21 [Std# 2875]
CS Site-Specific Factor22 [Std# 2876]
CS Site-Specific Factor23 [Std# 2877]
CS Site-Specific Factor24 [Std# 2878]
CS Site-Specific Factor25 [Std# 2879]
CS Version Input Original [Std# 2935]
CS Version Input Current [Std# 2937]
Class of Case [Std# 610]

Additional Messages

[4200] CS Version Input Original cannot be left blank
[4201] CS Version Input Current cannot be left blank

[4202] Class of Case cannot be left blank

Description

Note: NPCR discontinued use of Over-ride CS 20 for diagnosis year 2016.

Background:
For diagnosis year 2012 and later, NPCR permits the use of Directly Coded Summary Stage (SEER Summary Stage 2000 [759]) in those cases where collection of CSv02 is not feasible due to lack of data or due to staffing and time constraints at the local or central registry. The data item 'Over-ride CS 20' is used to flag a case where SEER Summary Stage 2000 is recorded in lieu of Derived SS2000 [3020]. When 'Over-ride CS 20' is equal to '1', SEER Summary Stage 2000 must be populated (not blank). The CS input fields may be populated, but only a few are required. When 'Over-ride CS 20' is blank, the Collaborative Stage input fields must be populated per NPCR requirements and SEER Summary Stage 2000 may also be populated, but is not required.

Beginning with the NAACCR v13 metafile, Over-ride CS 20 may also be set to '1' for the types of reporting source 3-7 (listed below) for cases with a diagnosis year of 2004 or later. All CS input fields may be left blank; however, if any are entered, then the CS input version fields and SSF 25 must also be entered because accurate editing of the individual CS input fields is often based on CS schema and version information.

Type of Reporting Source
- 3 (laboratory only)
- 4 (physician's office)
- 5 (nursing home)
- 6 (autopsy only)
- 7 (death certificate only)

Another edit, 'CS Over-ride CS 20, Date of Diagnosis (NPCR)', verifies that Over-ride CS 20 is populated correctly based on year of Date of Diagnosis and Type of Reporting Source.

This edit verifies, for cases with Over-ride CS 20 of '1' and Type of Reporting Source 3-7, that CS SSF 25 and version fields are entered whenever any other CS input fields are populated.

MCR Modification: uses Class of Case 38-49 instead of Type of Reporting Source 3-7

Logic:
If Over-ride CS 20 is '1' and Class of Case = 38-49, all CS input items may be left blank. If ANY CS input items (see List of CS Input Data Items for This Edit below) are entered, then the following additional CS items must be entered:
- CS Version Input Original
- CS Version Input Current
- CS Site-Specific Factor25

List of CS Input Data Items for this Edit

- CS Extension
- CS Tumor Size
- CS Tumor Size/Ext Eval
- CS Lymph Nodes
- CS Lymph Nodes Eval
- CS Mets at DX
- CS Mets Eval
- CS Site-Specific Factor 1
- CS Site-Specific Factor 2

```
CS Site-Specific Factor 3
CS Site-Specific Factor 4
CS Site-Specific Factor 5
CS Site-Specific Factor 6
CS Site-Specific Factor 7
CS Site-Specific Factor 8
CS Site-Specific Factor 9
CS Site-Specific Factor10
CS Site-Specific Factor11
CS Site-Specific Factor12
CS Site-Specific Factor13
CS Site-Specific Factor14
CS Site-Specific Factor15
CS Site-Specific Factor16
CS Site-Specific Factor17
CS Site-Specific Factor18
CS Site-Specific Factor19
CS Site-Specific Factor20
CS Site-Specific Factor21
CS Site-Specific Factor22
CS Site-Specific Factor23
CS Site-Specific Factor24
```

Administrative Notes

New edit - added to NAACCR v13 metafile.

13A: MCR version using Class

v16: added note that O-R CS 20 is no longer used for 2016+ diagnoses.

CS Reg Nodes Ex, Pos, Site, Hist ICDO3, Report(CS)

Agency: CS **Last changed: 11/05/2014**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
Date of Diagnosis [Std# 390]
Type of Reporting Source [Std# 500]
Regional Nodes Examined [Std# 830]
Regional Nodes Positive [Std# 820]
CS Site-Specific Factor25 [Std# 2879]
CS Version Input Current [Std# 2937]

Default Error Message

[1108] Regional Nodes Positive/Examined conflict
Regional Nodes Positive/Examined conflict

Additional Messages

[1109] Death Certificate Only, Regional Nodes Positive and Examined must both = 99
[3382] Regional Nodes Positive and Examined must both = 99 for this schema
ERROR_TEXT("Date of Diagnosis: %DC")
SAVE_TEXT("t_schema_msg")

Description

```
This edit is skipped if any of the following conditions are true:
1. Year of Date of Diagnosis is less than 2004 or blank
2. Regional Nodes Examined or Regional Nodes Positive is blank
3. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and schema is not Brain,
CNSOther, or IntracranialGland
4. CS schema is invalid

If Death Certificate only case (Type of Reporting Source = '7') the Regional Nodes
Positive and Regional Nodes Examined must both be coded 99.

For the following CS schemas, Regional Nodes Positive and Regional Nodes Examined
must both be coded '99'.

1.  HemeRetic
2.  Lymphoma
3.  Brain
4.  CNSOther
5.  IllDefinedOther
6.  Placenta
7.  IntracranialGland
8.  MyelomaPlasmaCellDisorder except for histology 9734 (Extraosseous
plasmacytomas)
```

```
If year of Date of Diagnosis is less than 2010 and CS Version Input Current is
020510 (not changed since conversion from CSv01 to CSv02) or blank:
1.  If Regional Nodes Examined = 00, Regional Nodes Positive must = 98.
2.  If Regional Nodes Examined = 01 - 90, Regional Nodes Positive must
    = 97 or 99, or be less than or equal to Regional Nodes Examined.
3.  If Regional Nodes Examined = 95, 96, 97, or 98, Regional Nodes Positive
    must = 00 - 90, 95, 97, or 99.
4.  If Regional Nodes Examined = 99, then Regional Nodes Positive must = 99.

Otherwise:
1.  If Regional Nodes Examined = 00 , Regional Nodes Positive must = 98.
2.  If Regional Nodes Examined = 01 - 90, Regional Nodes Positive must
    = 95, 97 or 99, or be less than or equal to Regional Nodes Examined.
3.  If Regional Nodes Examined = 95, Regional Nodes Positive must
    = 00, 95, or 99.
4.  If Regional Nodes Examined = 96, 97, or 98, Regional Nodes Positive
    must = 00 - 90, 95, 97, or 99.
5.  If Regional Nodes Examined = 99, then Regional Nodes Positive must = 99.
```

Administrative Notes

In the SEER*Edits software, the title of this edit is: IF168

Modifications:

NAACCR v11.1A
02/2007
- Edit modified to work for all behavior codes instead of just behaviors 2 and 3
- Edit modified to require Regional Nodes Examined and Regional Nodes Positive of 99 for C589, C751, C752, and C753.

NAACCR v11.1B
08/2007
This edit was modified so that it will be skipped if year of Date of Diagnosis is less than 2004.

NAACCR v11.2
8/2007
This edit was modified so that it will be skipped if Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and Primary Site is not C700-C729 (Brain and Other CNS) or C751-C753 (Intracranial Endocrine).

NAACCR v11.3A
12/2008
This edit was modified to allow Regional Nodes Positive of 95 with Regional Nodes Examined of 98:
If Regional Nodes Examined = 98,
Regional Nodes Positive must = 00 - 90, 95, 97, or 99.

Modifications:
NAACCR v12.0
- Modified to get schema name from function call to CS dll.
- IntracranialGland deleted from list of schemas requiring both Regional Nodes Examined and Regional Noded Positive to be coded to 99.

NAACCR v12C
- Modifed edit to be consistent with the CSv2 definitions of code 95 for Regional Nodes Examined and Regional Nodes Positive.

NAACCR v12.1
- Added IntracranialGland and MyelomaPlasmaCellDisorder to list of schemas for which Regional Nodes Positive and Regional Nodes Examined must both be coded 99.

NAACCR v12.2A
- CSv01 rules for using the code 95 for Regional Nodes Positive differ from the CSv02 rules; the portion of the edit enforcing CSv01 rules for cases diagnosed 2004-2009 was changed from "If year of Date of Diagnosis is less than 2010 and CS Version Input Original is less than 020000 or blank" to "If year of Date of Diagnosis is less than 2010 and CS Version Input Current is 020410 (not changed since conversion from CSv01 to CSv02) or blank".

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

NAACCR v14A
- Changed CS Version Input Current code indicating "not changed since conversion from CSv01 to CSv02" from 020410 to 020510.

NAACCR v15
- Added exception for schemas for which Regional Nodes Examined and Regional Nodes Positive must be coded to 99:
For MyelomaPlasmaCellDisorder, other values are allowed per Note 1 under Regional Nodes Positive & Regional Nodes Examined, “Note 1: Extraosseous plasmacytomas (9734), especially those in the respiratory tract, may metastasize to regional lymph nodes. Record the number of positive nodes/nodes examined.”

CS Site-Specific Factor 1 (CS)

Agency: CS **Last changed: 09/28/2003**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

CS Site-Specific Factor 1 [Std# 2880]

Default Error Message

[1037] %F1 must be a three-digit number
CS Site-Specific Factor 1 must be a three-digit number

Description

Must be a valid three-digit number (000-999) or blank.

CS Site-Specific Factor 1, Schema (CS)

Agency: CS **Last changed: 06/08/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor 1 [Std# 2880]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3321] %F4 (%V4) is invalid for this schema
CS Site-Specific Factor 1 ("value of CS Site-Specific Factor 1") is invalid for this schema

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that CS Site-Specific Factor 1 is correct for a particular
schema. The schema determined by Primary Site, Histologic Type ICD-O-3, and
sometimes CS Site-Specific Factor25 (schema discriminator).

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor 1, Primary Site, or Histologic Type ICD-O-3 is blank2.
Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and schema is not Brain,
CNSOther, or IntracranialGland
2. CS schema is invalid

This edit verifies that CS Site-Specific Factor 1 is valid for a particular schema
by doing function calls to the CS Dynamic Link Library (dll).
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.
Replaces 'CS SSF 1, Primary Site, Histol ICDO3 (NAACCR)'

Modifications

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Site-Specific Factor 2 (CS)

Agency: CS **Last changed: 09/28/2003**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

CS Site-Specific Factor 2 [Std# 2890]

Default Error Message

[1037] %F1 must be a three-digit number
CS Site-Specific Factor 2 must be a three-digit number

Description

Must be a valid three-digit number (000-999) or blank.

CS Site-Specific Factor 2, Schema (CS)

Agency: CS **Last changed: 06/08/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor 2 [Std# 2890]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3321] %F4 (%V4) is invalid for this schema
CS Site-Specific Factor 2 ("value of CS Site-Specific Factor 2") is invalid for this schema

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that CS Site-Specific Factor 2 is correct for a particular
schema. The schema determined by Primary Site, Histologic Type ICD-O-3, and
sometimes CS Site-Specific Factor25 (schema discriminator).

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor 2, Primary Site, or Histologic Type ICD-O-3 is blank
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and schema is not Brain,
CNSOther, or IntracranialGland
3. CS schema is invalid

This edit verifies that CS Site-Specific Factor 2 is valid for a particular schema
by doing  function calls to the CS Dynamic Link Library (dll).
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.
Replaces 'CS SSF 2, Primary Site, Histol ICDO3 (NAACCR)'

Modifications

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Site-Specific Factor 3 (CS)

Agency: CS **Last changed: 09/28/2003**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

CS Site-Specific Factor 3 [Std# 2900]

Default Error Message

[1037] %F1 must be a three-digit number
CS Site-Specific Factor 3 must be a three-digit number

Description

Must be a valid three-digit number (000-999) or blank.

CS Site-Specific Factor 3, Schema (CS)

Agency: CS **Last changed: 06/08/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor 3 [Std# 2900]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3321] %F4 (%V4) is invalid for this schema
CS Site-Specific Factor 3 ("value of CS Site-Specific Factor 3") is invalid for this schema

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that CS Site-Specific Factor 3 is correct for a particular
schema. The schema determined by Primary Site, Histologic Type ICD-O-3, and
sometimes CS Site-Specific Factor25 (schema discriminator).

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor 3, Primary Site, or Histologic Type ICD-O-3 is blank
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and schema is not Brain,
CNSOther, or IntracranialGland
3. CS schema is invalid

This edit verifies that CS Site-Specific Factor 3 is valid for a particular schema
by doing  function calls to the CS Dynamic Link Library (dll).
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.
Replaces 'CS SSF 3, Primary Site, Histol ICDO3 (NAACCR)'

Modifications

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Site-Specific Factor 4 (CS)

Agency: CS **Last changed: 09/28/2003**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

CS Site-Specific Factor 4 [Std# 2910]

Default Error Message

[1037] %F1 must be a three-digit number
CS Site-Specific Factor 4 must be a three-digit number

Description

Must be a valid three-digit number (000-999) or blank.

CS Site-Specific Factor 4, Schema (CS)

Agency: CS **Last changed: 10/07/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor 4 [Std# 2910]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3321] %F4 (%V4) is invalid for this schema
CS Site-Specific Factor 4 ("value of CS Site-Specific Factor 4") is invalid for this schema

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that CS Site-Specific Factor 4 is correct for a particular
schema. The schema determined by Primary Site, Histologic Type ICD-O-3, and
sometimes CS Site-Specific Factor25 (schema discriminator).

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor 4, Primary Site, or Histologic Type ICD-O-3 is blank
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and schema is not Brain,
CNSOther, or IntracranialGland
3. CS schema is invalid

This edit verifies that CS Site-Specific Factor 4 is valid for a particular schema
by doing  function calls to the CS Dynamic Link Library (dll).
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.
Replaces 'CS SSF 4, Primary Site, Histol ICDO3 (NAACCR)'

In the SEER*Edits software, the title of this edit is: IF236

Modifications

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Site-Specific Factor 5 (CS)

Agency: CS **Last changed: 09/28/2003**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

CS Site-Specific Factor 5 [Std# 2920]

Default Error Message

[1037] %F1 must be a three-digit number
CS Site-Specific Factor 5 must be a three-digit number

Description

Must be a valid three-digit number (000-999) or blank.

CS Site-Specific Factor 5, Schema (CS)

Agency: CS **Last changed: 10/07/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor 5 [Std# 2920]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3321] %F4 (%V4) is invalid for this schema
CS Site-Specific Factor 5 ("value of CS Site-Specific Factor 5") is invalid for this schema

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that CS Site-Specific Factor 5 is correct for a particular
schema. The schema determined by Primary Site, Histologic Type ICD-O-3, and
sometimes CS Site-Specific Factor25 (schema discriminator).

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor 5, Primary Site, or Histologic Type ICD-O-3 is blank
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and schema is not Brain,
CNSOther, or IntracranialGland
3. CS schema is invalid

This edit verifies that CS Site-Specific Factor 5 is valid for a particular schema
by doing  function calls to the CS Dynamic Link Library (dll).
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.
Replaces 'CS SSF 5, Primary Site, Histol ICDO3 (NAACCR)'

In the SEER*Edits software, the title of this edit is: IF237

Modifications

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Site-Specific Factor 6 (CS)

Agency: CS **Last changed: 09/28/2003**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

CS Site-Specific Factor 6 [Std# 2930]

Default Error Message

[1037] %F1 must be a three-digit number
CS Site-Specific Factor 6 must be a three-digit number

Description

Must be a valid three-digit number (000-999) or blank.

CS Site-Specific Factor 6, Schema (CS)

Agency: CS **Last changed: 10/07/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor 6 [Std# 2930]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3321] %F4 (%V4) is invalid for this schema
CS Site-Specific Factor 6 ("value of CS Site-Specific Factor 6") is invalid for this schema

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that CS Site-Specific Factor 6 is correct for a particular
schema. The schema determined by Primary Site, Histologic Type ICD-O-3, and
sometimes CS Site-Specific Factor25 (schema discriminator).

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor 6, Primary Site, or Histologic Type ICD-O-3 is blank
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and schema is not Brain,
CNSOther, or IntracranialGland
3. CS schema is invalid

This edit verifies that CS Site-Specific Factor 6 is valid for a particular schema
by doing  function calls to the CS Dynamic Link Library (dll).
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.
Replaces 'CS SSF 6, Primary Site, Histol ICDO3 (NAACCR)'

In the SEER*Edits software, the title of this edit is: IF238

Modifications

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Site-Specific Factor 7 (CS)

Agency: CS **Last changed: 02/24/2009**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

CS Site-Specific Factor 7 [Std# 2861]

Default Error Message

[1037] %F1 must be a three-digit number
CS Site-Specific Factor 7 must be a three-digit number

Description

Must be a valid three-digit number (000-999) or blank.

Administrative Notes

New edit - added to NAACCR v12 metafile.

CS Site-Specific Factor 7, Schema (CS)

Agency: CS **Last changed: 10/07/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor 7 [Std# 2861]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3321] %F4 (%V4) is invalid for this schema
CS Site-Specific Factor 7 ("value of CS Site-Specific Factor 7") is invalid for this schema

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that CS Site-Specific Factor 7 is correct for a particular
schema. The schema determined by Primary Site, Histologic Type ICD-O-3, and
sometimes CS Site-Specific Factor25 (schema discriminator).

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor 7, Primary Site, or Histologic Type ICD-O-3 is blank
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and schema is not Brain,
CNSOther, or IntracranialGland
3. CS schema is invalid

This edit verifies that CS Site-Specific Factor 7 is valid for a particular schema
by doing  function calls to the CS Dynamic Link Library (dll).
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

In the SEER*Edits software, the title of this edit is: IF239

Modifications

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Site-Specific Factor 8 (CS)

Agency: CS **Last changed: 02/24/2009**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

CS Site-Specific Factor 8 [Std# 2862]

Default Error Message

[1037] %F1 must be a three-digit number
CS Site-Specific Factor 8 must be a three-digit number

Description

Must be a valid three-digit number (000-999) or blank.

Administrative Notes

New edit - added to NAACCR v12 metafile.

CS Site-Specific Factor 8, Schema (CS)

Agency: CS **Last changed: 10/07/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor 8 [Std# 2862]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3321] %F4 (%V4) is invalid for this schema
CS Site-Specific Factor 8 ("value of CS Site-Specific Factor 8") is invalid for this schema

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that CS Site-Specific Factor 8 is correct for a particular
schema. The schema determined by Primary Site, Histologic Type ICD-O-3, and
sometimes CS Site-Specific Factor25 (schema discriminator).

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor 8, Primary Site, or Histologic Type ICD-O-3 is blank
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and schema is not Brain,
CNSOther, or IntracranialGland
3. CS schema is invalid

This edit verifies that CS Site-Specific Factor 8 is valid for a particular schema
by doing  function calls to the CS Dynamic Link Library (dll).
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

In the SEER*Edits software, the title of this edit is: IF240

Modifications

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Site-Specific Factor 9 (CS)

Agency: CS **Last changed: 02/24/2009**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

CS Site-Specific Factor 9 [Std# 2863]

Default Error Message

[1037] %F1 must be a three-digit number
CS Site-Specific Factor 9 must be a three-digit number

Description

Must be a valid three-digit number (000-999) or blank.

Administrative Notes

New edit - added to NAACCR v12 metafile.

CS Site-Specific Factor 9, Schema (CS)

Agency: CS **Last changed: 10/07/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor 9 [Std# 2863]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3321] %F4 (%V4) is invalid for this schema
CS Site-Specific Factor 9 ("value of CS Site-Specific Factor 9") is invalid for this schema

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that CS Site-Specific Factor 9 is correct for a particular
schema. The schema determined by Primary Site, Histologic Type ICD-O-3, and
sometimes CS Site-Specific Factor25 (schema discriminator).

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor 9, Primary Site, or Histologic Type ICD-O-3 is blank
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and schema is not Brain,
CNSOther, or IntracranialGland
3. CS schema is invalid

This edit verifies that CS Site-Specific Factor 9 is valid for a particular schema
by doing  function calls to the CS Dynamic Link Library (dll).
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

In the SEER*Edits software, the title of this edit is: IF241

Modifications

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Site-Specific Factor10 (CS)

Agency: CS **Last changed: 02/24/2009**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

CS Site-Specific Factor10 [Std# 2864]

Default Error Message

[1037] %F1 must be a three-digit number
CS Site-Specific Factor10 must be a three-digit number

Description

Must be a valid three-digit number (000-999) or blank.

Administrative Notes

New edit - added to NAACCR v12 metafile.

CS Site-Specific Factor10, Schema (CS)

Agency: CS **Last changed: 06/08/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor10 [Std# 2864]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3321] %F4 (%V4) is invalid for this schema
CS Site-Specific Factor10 ("value of CS Site-Specific Factor10") is invalid for this schema

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that CS Site-Specific Factor10 is correct for a particular
schema. The schema determined by Primary Site, Histologic Type ICD-O-3, and
sometimes CS Site-Specific Factor25 (schema discriminator).

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor10, Primary Site, or Histologic Type ICD-O-3 is blank
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and schema is not Brain,
CNSOther, or IntracranialGland
3. CS schema is invalid

This edit verifies that CS Site-Specific Factor10 is valid for a particular schema
by doing  function calls to the CS Dynamic Link Library (dll).
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

Modifications

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Site-Specific Factor11 (CS)

Agency: CS **Last changed: 02/24/2009**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

CS Site-Specific Factor11 [Std# 2865]

Default Error Message

[1037] %F1 must be a three-digit number
CS Site-Specific Factor11 must be a three-digit number

Description

Must be a valid three-digit number (000-999) or blank.

Administrative Notes

New edit - added to NAACCR v12 metafile.

CS Site-Specific Factor11, Schema (CS)

Agency: CS **Last changed: 10/07/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor11 [Std# 2865]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3321] %F4 (%V4) is invalid for this schema
CS Site-Specific Factor11 ("value of CS Site-Specific Factor11") is invalid for this schema

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that CS Site-Specific Factor11 is correct for a particular
schema. The schema determined by Primary Site, Histologic Type ICD-O-3, and
sometimes CS Site-Specific Factor25 (schema discriminator).

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor11, Primary Site, or Histologic Type ICD-O-3 is blank
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and schema is not Brain,
CNSOther, or IntracranialGland
3. CS schema is invalid

This edit verifies that CS Site-Specific Factor11 is valid for a particular schema
by doing  function calls to the CS Dynamic Link Library (dll).
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

In the SEER*Edits software, the title of this edit is: IF243

Modifications

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Site-Specific Factor12 (CS)

Agency: CS **Last changed: 02/24/2009**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

CS Site-Specific Factor12 [Std# 2866]

Default Error Message

[1037] %F1 must be a three-digit number
CS Site-Specific Factor12 must be a three-digit number

Description

Must be a valid three-digit number (000-999) or blank.

Administrative Notes

New edit - added to NAACCR v12 metafile.

CS Site-Specific Factor12, Schema (CS)

Agency: CS **Last changed: 10/07/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor12 [Std# 2866]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3321] %F4 (%V4) is invalid for this schema
CS Site-Specific Factor12 ("value of CS Site-Specific Factor12") is invalid for this schema

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that CS Site-Specific Factor12 is correct for a particular
schema. The schema determined by Primary Site, Histologic Type ICD-O-3, and
sometimes CS Site-Specific Factor25 (schema discriminator).

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor12, Primary Site, or Histologic Type ICD-O-3 is blank
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and schema is not Brain,
CNSOther, or IntracranialGland
3. CS schema is invalid

This edit verifies that CS Site-Specific Factor12 is valid for a particular schema
by doing  function calls to the CS Dynamic Link Library (dll).
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

In the SEER*Edits software, the title of this edit is: IF244

Modifications

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Site-Specific Factor13 (CS)

Agency: CS **Last changed: 02/24/2009**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

CS Site-Specific Factor13 [Std# 2867]

Default Error Message

[1037] %F1 must be a three-digit number
CS Site-Specific Factor13 must be a three-digit number

Description

Must be a valid three-digit number (000-999) or blank.

Administrative Notes

New edit - added to NAACCR v12 metafile.

CS Site-Specific Factor13, Schema (CS)

Agency: CS **Last changed: 10/07/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor13 [Std# 2867]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3321] %F4 (%V4) is invalid for this schema
CS Site-Specific Factor13 ("value of CS Site-Specific Factor13") is invalid for this schema

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that CS Site-Specific Factor13 is correct for a particular
schema. The schema determined by Primary Site, Histologic Type ICD-O-3, and
sometimes CS Site-Specific Factor25 (schema discriminator).

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor13, Primary Site, or Histologic Type ICD-O-3 is blank
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and schema is not Brain,
CNSOther, or IntracranialGland
3. CS schema is invalid

This edit verifies that CS Site-Specific Factor13 is valid for a particular schema
by doing  function calls to the CS Dynamic Link Library (dll).
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

In the SEER*Edits software, the title of this edit is: IF245

Modifications

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Site-Specific Factor14 (CS)

Agency: CS **Last changed: 02/24/2009**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

CS Site-Specific Factor14 [Std# 2868]

Default Error Message

[1037] %F1 must be a three-digit number
CS Site-Specific Factor14 must be a three-digit number

Description

Must be a valid three-digit number (000-999) or blank.

Administrative Notes

New edit - added to NAACCR v12 metafile.

CS Site-Specific Factor14, Schema (CS)

Agency: CS **Last changed: 10/07/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor14 [Std# 2868]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3321] %F4 (%V4) is invalid for this schema
CS Site-Specific Factor14 ("value of CS Site-Specific Factor14") is invalid for this schema

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that CS Site-Specific Factor14 is correct for a particular
schema. The schema determined by Primary Site, Histologic Type ICD-O-3, and
sometimes CS Site-Specific Factor25 (schema discriminator).

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor14, Primary Site, or Histologic Type ICD-O-3 is blank
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and schema is not Brain,
CNSOther, or IntracranialGland
3. CS schema is invalid

This edit verifies that CS Site-Specific Factor14 is valid for a particular schema
by doing  function calls to the CS Dynamic Link Library (dll).
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

In the SEER*Edits software, the title of this edit is: IF246

Modifications

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Site-Specific Factor15 (CS)

Agency: CS **Last changed: 02/24/2009**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

CS Site-Specific Factor15 [Std# 2869]

Default Error Message

[1037] %F1 must be a three-digit number
CS Site-Specific Factor15 must be a three-digit number

Description

Must be a valid three-digit number (000-999) or blank.

Administrative Notes

New edit - added to NAACCR v12 metafile.

CS Site-Specific Factor15, Schema (CS)

Agency: CS **Last changed: 10/07/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor15 [Std# 2869]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3321] %F4 (%V4) is invalid for this schema
CS Site-Specific Factor15 ("value of CS Site-Specific Factor15") is invalid for this schema

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that CS Site-Specific Factor15 is correct for a particular
schema. The schema determined by Primary Site, Histologic Type ICD-O-3, and
sometimes CS Site-Specific Factor25 (schema discriminator).

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor15, Primary Site, or Histologic Type ICD-O-3 is blank
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and schema is not Brain,
CNSOther, or IntracranialGland
3. CS schema is invalid

This edit verifies that CS Site-Specific Factor15 is valid for a particular schema
by doing  function calls to the CS Dynamic Link Library (dll).
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

In the SEER*Edits software, the title of this edit is: IF247

Modifications

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Site-Specific Factor16 (CS)

Agency: CS **Last changed: 02/24/2009**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

CS Site-Specific Factor16 [Std# 2870]

Default Error Message

[1037] %F1 must be a three-digit number
CS Site-Specific Factor16 must be a three-digit number

Description

Must be a valid three-digit number (000-999) or blank.

Administrative Notes

New edit - added to NAACCR v12 metafile.

CS Site-Specific Factor16, Schema (CS)

Agency: CS **Last changed: 10/07/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor16 [Std# 2870]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3321] %F4 (%V4) is invalid for this schema
CS Site-Specific Factor16 ("value of CS Site-Specific Factor16") is invalid for this schema

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that CS Site-Specific Factor16 is correct for a particular
schema. The schema determined by Primary Site, Histologic Type ICD-O-3, and
sometimes CS Site-Specific Factor25 (schema discriminator).

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor16, Primary Site, or Histologic Type ICD-O-3 is blank
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and schema is not Brain,
CNSOther, or IntracranialGland
3. CS schema is invalid

This edit verifies that CS Site-Specific Factor16 is valid for a particular schema
by doing  function calls to the CS Dynamic Link Library (dll).
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

In the SEER*Edits software, the title of this edit is: IF248

Modifications

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Site-Specific Factor17 (CS)

Agency: CS **Last changed: 02/24/2009**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

CS Site-Specific Factor17 [Std# 2871]

Default Error Message

[1037] %F1 must be a three-digit number
CS Site-Specific Factor17 must be a three-digit number

Description

Must be a valid three-digit number (000-999) or blank.

Administrative Notes

New edit - added to NAACCR v12 metafile.

CS Site-Specific Factor17, Schema (CS)

Agency: CS **Last changed: 10/07/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor17 [Std# 2871]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3321] %F4 (%V4) is invalid for this schema
CS Site-Specific Factor17 ("value of CS Site-Specific Factor17") is invalid for this schema

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that CS Site-Specific Factor17 is correct for a particular
schema. The schema determined by Primary Site, Histologic Type ICD-O-3, and
sometimes CS Site-Specific Factor25 (schema discriminator).

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor17, Primary Site, or Histologic Type ICD-O-3 is blank
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and schema is not Brain,
CNSOther, or IntracranialGland
3. CS schema is invalid

This edit verifies that CS Site-Specific Factor17 is valid for a particular schema
by doing  function calls to the CS Dynamic Link Library (dll).
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

In the SEER*Edits software, the title of this edit is: IF249

Modifications

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Site-Specific Factor18 (CS)

Agency: CS **Last changed: 02/24/2009**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

CS Site-Specific Factor18 [Std# 2872]

Default Error Message

[1037] %F1 must be a three-digit number
CS Site-Specific Factor18 must be a three-digit number

Description

Must be a valid three-digit number (000-999) or blank.

Administrative Notes

New edit - added to NAACCR v12 metafile.

CS Site-Specific Factor18, Schema (CS)

Agency: CS **Last changed: 10/07/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor18 [Std# 2872]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3321] %F4 (%V4) is invalid for this schema
CS Site-Specific Factor18 ("value of CS Site-Specific Factor18") is invalid for this schema

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that CS Site-Specific Factor18 is correct for a particular
schema. The schema determined by Primary Site, Histologic Type ICD-O-3, and
sometimes CS Site-Specific Factor25 (schema discriminator).

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor18, Primary Site, or Histologic Type ICD-O-3 is blank
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and schema is not Brain,
CNSOther, or IntracranialGland
3. CS schema is invalid

This edit verifies that CS Site-Specific Factor18 is valid for a particular schema
by doing  function calls to the CS Dynamic Link Library (dll).
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

In the SEER*Edits software, the title of this edit is: IF250

Modifications

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Site-Specific Factor19 (CS)

Agency: CS **Last changed: 02/24/2009**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

CS Site-Specific Factor19 [Std# 2873]

Default Error Message

[1037] %F1 must be a three-digit number
CS Site-Specific Factor19 must be a three-digit number

Description

Must be a valid three-digit number (000-999) or blank.

Administrative Notes

New edit - added to NAACCR v12 metafile.

CS Site-Specific Factor19, Schema (CS)

Agency: CS **Last changed: 10/07/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor19 [Std# 2873]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3321] %F4 (%V4) is invalid for this schema
CS Site-Specific Factor19 ("value of CS Site-Specific Factor19") is invalid for this schema

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that CS Site-Specific Factor19 is correct for a particular
schema. The schema determined by Primary Site, Histologic Type ICD-O-3, and
sometimes CS Site-Specific Factor25 (schema discriminator).

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor19, Primary Site, or Histologic Type ICD-O-3 is blank
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and schema is not Brain,
CNSOther, or IntracranialGland
3. CS schema is invalid

This edit verifies that CS Site-Specific Factor19 is valid for a particular schema
by doing  function calls to the CS Dynamic Link Library (dll).
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

In the SEER*Edits software, the title of this edit is: IF251

Modifications

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Site-Specific Factor20 (CS)

Agency: CS **Last changed: 02/24/2009**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

CS Site-Specific Factor20 [Std# 2874]

Default Error Message

[1037] %F1 must be a three-digit number
CS Site-Specific Factor20 must be a three-digit number

Description

Must be a valid three-digit number (000-999) or blank.

Administrative Notes

New edit - added to NAACCR v12 metafile.

CS Site-Specific Factor20, Schema (CS)

Agency: CS **Last changed: 10/07/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor20 [Std# 2874]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3321] %F4 (%V4) is invalid for this schema
CS Site-Specific Factor20 ("value of CS Site-Specific Factor20") is invalid for this schema

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that CS Site-Specific Factor20 is correct for a particular
schema. The schema determined by Primary Site, Histologic Type ICD-O-3, and
sometimes CS Site-Specific Factor25 (schema discriminator).

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor20, Primary Site, or Histologic Type ICD-O-3 is blank
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and schema is not Brain,
CNSOther, or IntracranialGland
3. CS schema is invalid

This edit verifies that CS Site-Specific Factor20 is valid for a particular schema
by doing  function calls to the CS Dynamic Link Library (dll).
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

In the SEER*Edits software, the title of this edit is: IF252

Modifications

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Site-Specific Factor21 (CS)

Agency: CS **Last changed: 02/24/2009**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

CS Site-Specific Factor21 [Std# 2875]

Default Error Message

[1037] %F1 must be a three-digit number
CS Site-Specific Factor21 must be a three-digit number

Description

Must be a valid three-digit number (000-999) or blank.

Administrative Notes

New edit - added to NAACCR v12 metafile.

CS Site-Specific Factor21, Schema (CS)

Agency: CS **Last changed: 10/07/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor21 [Std# 2875]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3321] %F4 (%V4) is invalid for this schema
CS Site-Specific Factor21 ("value of CS Site-Specific Factor21") is invalid for this schema

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that CS Site-Specific Factor21 is correct for a particular
schema. The schema determined by Primary Site, Histologic Type ICD-O-3, and
sometimes CS Site-Specific Factor25 (schema discriminator).

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor21, Primary Site, or Histologic Type ICD-O-3 is blank
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and schema is not Brain,
CNSOther, or IntracranialGland
3. CS schema is invalid

This edit verifies that CS Site-Specific Factor21 is valid for a particular schema
by doing  function calls to the CS Dynamic Link Library (dll).
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

In the SEER*Edits software, the title of this edit is: IF253

Modifications

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Site-Specific Factor22 (CS)

Agency: CS **Last changed: 02/24/2009**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

CS Site-Specific Factor22 [Std# 2876]

Default Error Message

[1037] %F1 must be a three-digit number
CS Site-Specific Factor22 must be a three-digit number

Description

Must be a valid three-digit number (000-999) or blank.

Administrative Notes

New edit - added to NAACCR v12 metafile.

CS Site-Specific Factor22, Schema (CS)

Agency: CS **Last changed: 10/07/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor22 [Std# 2876]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3321] %F4 (%V4) is invalid for this schema
CS Site-Specific Factor22 ("value of CS Site-Specific Factor22") is invalid for this schema

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that CS Site-Specific Factor22 is correct for a particular
schema. The schema determined by Primary Site, Histologic Type ICD-O-3, and
sometimes CS Site-Specific Factor25 (schema discriminator).

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor22, Primary Site, or Histologic Type ICD-O-3 is blank
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and schema is not Brain,
CNSOther, or IntracranialGland
3. CS schema is invalid

This edit verifies that CS Site-Specific Factor22 is valid for a particular schema
by doing  function calls to the CS Dynamic Link Library (dll).
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

In the SEER*Edits software, the title of this edit is: IF254

Modifications

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Site-Specific Factor23 (CS)

Agency: CS **Last changed: 02/24/2009**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

CS Site-Specific Factor23 [Std# 2877]

Default Error Message

[1037] %F1 must be a three-digit number
CS Site-Specific Factor23 must be a three-digit number

Description

Must be a valid three-digit number (000-999) or blank.

Administrative Notes

New edit - added to NAACCR v12 metafile.

CS Site-Specific Factor23, Schema (CS)

Agency: CS **Last changed: 10/07/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor23 [Std# 2877]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3321] %F4 (%V4) is invalid for this schema
CS Site-Specific Factor23 ("value of CS Site-Specific Factor23") is invalid for this schema

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that CS Site-Specific Factor23 is correct for a particular
schema. The schema determined by Primary Site, Histologic Type ICD-O-3, and
sometimes CS Site-Specific Factor25 (schema discriminator).

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor23, Primary Site, or Histologic Type ICD-O-3 is blank
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and schema is not Brain,
CNSOther, or IntracranialGland
3. CS schema is invalid

This edit verifies that CS Site-Specific Factor23 is valid for a particular schema
by doing  function calls to the CS Dynamic Link Library (dll).
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

In the SEER*Edits software, the title of this edit is: IF255

Modifications

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Site-Specific Factor24 (CS)

Agency: CS **Last changed: 02/24/2009**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

CS Site-Specific Factor24 [Std# 2878]

Default Error Message

[1037] %F1 must be a three-digit number
CS Site-Specific Factor24 must be a three-digit number

Description

Must be a valid three-digit number (000-999) or blank.

Administrative Notes

New edit - added to NAACCR v12 metafile.

CS Site-Specific Factor24, Schema (CS)

Agency: CS **Last changed: 10/07/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor24 [Std# 2878]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3321] %F4 (%V4) is invalid for this schema
CS Site-Specific Factor24 ("value of CS Site-Specific Factor24") is invalid for this schema

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that CS Site-Specific Factor24 is correct for a particular
schema. The schema determined by Primary Site, Histologic Type ICD-O-3, and
sometimes CS Site-Specific Factor25 (schema discriminator).

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor24, Primary Site, or Histologic Type ICD-O-3 is blank
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and schema is not Brain,
CNSOther, or IntracranialGland
3. CS schema is invalid

This edit verifies that CS Site-Specific Factor24 is valid for a particular schema
by doing  function calls to the CS Dynamic Link Library (dll).
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

In the SEER*Edits software, the title of this edit is: IF256

Modifications

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Site-Specific Factor25 (CS)

Agency: CS **Last changed: 02/24/2009**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[1037] %F1 must be a three-digit number
CS Site-Specific Factor25 must be a three-digit number

Description

Must be a valid three-digit number (000-999) or blank.

Administrative Notes

New edit - added to NAACCR v12 metafile.

CS Site-Specific Factor25, Schema (CS)

Agency: CS **Last changed: 10/04/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[4625] %F4 [%V4] is invalid for this schema
CS Site-Specific Factor25 ["value of CS Site-Specific Factor25"] is invalid for this schema

Additional Messages

[4848] CS Site-Specific Factor25 ["value of CS Site-Specific Factor25"] must be 982 for this site ("value of Primary Site") within this schema
[4849] CS Site-Specific Factor25 ["value of CS Site-Specific Factor25"] must be 981 for this site ("value of Primary Site") within this schema
[4850] CS Site-Specific Factor25 ["value of CS Site-Specific Factor25"] must be 981 for site ("value of Primary Site")/histology ("value of Histologic Type ICD-O-3") within this schema
SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that CS Site-Specific Factor25 is correct for a particular
schema. The schema determined by Primary Site and Histologic Type ICD-O-3.

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor25, Primary Site, or Histologic Type ICD-O-3 is blank
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and schema is not Brain,
CNSOther, or IntracranialGland
3. CS schema is invalid

This edit verifies that CS Site-Specific Factor25 is valid for a particular schema
by doing  function calls to the CS Dynamic Link Library (dll).

The following sites within Nasopharynx and Stomach schemas should have CS Site-
Specific Factor25 of 981:
  Nasopharynx/PharyngealTonsil
    Primary Site: C110, C112, C113, C118, C119
  EsophagusGEJunction/Stomach
    Primary Site: C163-C169

The following sites within EsophagusGEJunction should have CS Site-Specific
Factor25 of 982:
  EsophagusGEJunction/Stomach
    Primary Site: C160
```

```
The following sites/histologies within Peritoneum schema should have CS Site-
Specific Factor25 of 981:
  Peritoneum/PeritoneumFemaleGen
   Primary Site: C481, C482,C488
    Histologic Type ICD-O-3:8580-8589,8680-8921,9120-9136,9141-9582,9700-9701
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

In the SEER*Edits software, the title of this edit is: IF257

Modifications:

NAACCR v12.1
- Updated to require:
1. CS Site-Specific Factor25 of 981 for sites C110, C112, C113, C118, C119 within Nasopharynx and sites C163-C169 within Stomach schema.
2. CS Site-Specific Factor25 of 982 for sites C160 within EsophagusGEJunction schema.
3. CS Site-Specific Factor25 of 981 for sites C481, C482,C488 coded with histologies 8580-8589,8680-8921,9120-9136,9141-9582,9700-9701 within Peritoneum schema.

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS SSF 1, Behavior, Lung Schema (CS)

Agency: CS **Last changed: 04/22/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor 1 [Std# 2880]
CS Site-Specific Factor25 [Std# 2879]
CS Version Input Original [Std# 2935]

Default Error Message

[3467] Lung schema: If %F6 = 020500 or higher and %F3 = %V3, %F4 must = 000
Lung schema: If CS Version Input Original = 020500 or higher and Behavior Code ICD-O-3 = "value of Behavior Code ICD-O-3", CS Site-Specific Factor 1 must = 000

Description

```
The purpose of this edit is to verify that CS Site-Specific Factor 1 and Behavior
Code ICD-O-3 are coded consistently for Lung cases that are originally coded using
CSv02.05 or higher.

This edit is skipped if any of the following conditions are true:
1. CS Version Input Original is less than 020500 and not empty
2. CS schema is not Lung
3. CS Site-Specific Factor 1 is blank or 988

If schema is Lung:
    If Behavior Code ICD-O-3 = 2 (in situ)
    then
        CS Site-Specific Factor 1 must = 000 (no separate tumor nodules noted)
```

Administrative Notes

New edit - added to NAACCR v14 metafile.

In the SEER*Edits software, the title of this edit is: IF492

NAACCR v16
- Edit is skiped if CS Version is less than 020500 and not empty

CS SSF 1, Brain, CNSOther, IntracranialGland (CS)

Agency: CS **Last changed: 04/22/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor 1 [Std# 2880]
RX Summ--Surg Prim Site [Std# 1290]
CS Site-Specific Factor25 [Std# 2879]
CS Version Input Original [Std# 2935]

Default Error Message

[3549] If %F4 = 998, %F5 must not = %V5
If CS Site-Specific Factor 1 = 998, RX Summ--Surg Prim Site must not = "value of RX Summ--Surg Prim Site"

Description

This edit verifies that for cases using the Brain, CNSOther, or IntracranialGland schema, CS Site-Specific Factor 1 (WHO grade) and RX Summ--Surg Prim Site are coded consistently. If CS Site-Specific Factor 1 specifies "no histologic examination of primary site", then RX Summ--Surg Prim Site must indicate "no specimen sent to pathology from surgical event."

This edit is skipped if any of the following conditions are true:
1. CS Version Input Original is less than 020500 and not empty
2. CS Site-Specific Factor 1 is blank or 988
3. RX Summ--Surg Prim Site is blank
4. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
5. CS schema is invalid

If CS schema is Brain, CNSOther, or IntracranialGland:
If CS Site-Specific Factor 1 = 998 (no histologic examination of primary site), then RX Summ--Surg Prim Site must = 00-19 (no specimen sent to pathology from surgical event).

This edit first determines the correct CS schema by doing a function call to the CS Dynamic Link Library (dll). The function call passes Primary Site, Histologic Type ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS schema name is returned.

Administrative Notes

New edit - added to NAACCR v14 metafile.

In the SEER*Edits software, the title of this edit is: IF499

NAACCR v16

- Edit changed to skip if CS Version Input Original is less than 020500 and not empty

CS SSF 1, RX Summ--Surg, Retinoblastoma (SEER)

Agency: SEER **Last changed: 12/06/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor 1 [Std# 2880]
RX Summ--Surg Prim Site [Std# 1290]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]
CS Extension [Std# 2810]

Default Error Message

[3329] Conflict among schema, %F4 (%V4), %F5 (%V5]
Conflict among schema, CS Site-Specific Factor 1 ("value of CS Site-Specific Factor 1"), RX Summ--Surg Prim Site ("value of RX Summ--Surg Prim Site"

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor 1 is empty
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
3. CS schema is invalid
4.  If year of Date of Diagnosis is 2016-2017 and CS Extension is empty


For cases using the Retinoblastoma schema, if an enucleation is coded in the
surgery field, it must be coded in CS Site-Specific Factor 1.

If enucleation performed (RX Summ--Surg Prim Site = 40 or 41),
then CS Site-Specific Factor 1 must not = 970 (No enucleation performed).
```

Administrative Notes

In the SEER*Edits software, the title of this edit is: IF132

Modifications:

NAACCR v11.2
8/2007
This edit was modified so that it will be skipped if Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline).

NAACCR v11.3

6/2008
Updated Administrative Notes with the title of the corresponding edit in the SEER*Edits software.

NAACCR v12.0:
- Edit modified to get schema name from function call to CS dll.
- CS Site-Specific Factor 1 code "000" changed to code "970"

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

NAACCR v16
-Different from CS edit of similiar name due to SEER reporting requirements for 2016 cases.

NAACCR v16D
- Description, logic modified to skip if diagnosis year = 2016-2017

CS SSF 1, SSF 2, SSF 15, SSF 16, Breast (CS)

Agency: CS **Last changed: 10/04/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor 1 [Std# 2880]
CS Site-Specific Factor 2 [Std# 2890]
CS Site-Specific Factor15 [Std# 2869]
CS Site-Specific Factor16 [Std# 2870]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]

Default Error Message

[3511] Breast schema: If %F4 = %V4, %F5 = %V5, %F6 = %V6, %F7 must not = %V7
Breast schema: If CS Site-Specific Factor 1 = "value of CS Site-Specific Factor 1", CS Site-Specific Factor 2 = "value of CS Site-Specific Factor 2", CS Site-Specific Factor15 = "value of CS Site-Specific Factor15", CS Site-Specific Factor16 must not = "value of CS Site-Specific Factor16"

Additional Messages

[4210] If CS Site-Specific Factor 1 = "value of CS Site-Specific Factor 1", CS Site-Specific Factor 2 = "value of CS Site-Specific Factor 2", and CS Site-Specific Factor15 = "value of CS Site-Specific Factor15", CS Site-Specific Factor16 must = 111
[4211] If CS Site-Specific Factor 1 = "value of CS Site-Specific Factor 1", CS Site-Specific Factor 2 = "value of CS Site-Specific Factor 2", and CS Site-Specific Factor15 = "value of CS Site-Specific Factor15", CS Site-Specific Factor16 must = 110
[4212] If CS Site-Specific Factor 1 = "value of CS Site-Specific Factor 1", CS Site-Specific Factor 2 = "value of CS Site-Specific Factor 2", and CS Site-Specific Factor15 = "value of CS Site-Specific Factor15", CS Site-Specific Factor16 must = 101
[4213] If CS Site-Specific Factor 1 = "value of CS Site-Specific Factor 1", CS Site-Specific Factor 2 = "value of CS Site-Specific Factor 2", and CS Site-Specific Factor15 = "value of CS Site-Specific Factor15", CS Site-Specific Factor16 must = 100
[4214] If CS Site-Specific Factor 1 = "value of CS Site-Specific Factor 1", CS Site-Specific Factor 2 = "value of CS Site-Specific Factor 2", and CS Site-Specific Factor15 = "value of CS Site-Specific Factor15", CS Site-Specific Factor16 must = 011
[4215] If CS Site-Specific Factor 1 = "value of CS Site-Specific Factor 1", CS Site-Specific Factor 2 = "value of CS Site-Specific Factor 2", and CS Site-Specific Factor15 = "value of CS Site-Specific Factor15", CS Site-Specific Factor16 must = 010
[4216] If CS Site-Specific Factor 1 = "value of CS Site-Specific Factor 1", CS Site-Specific Factor 2 = "value of CS Site-Specific Factor 2", and CS Site-Specific Factor15 = "value of CS Site-Specific Factor15", CS Site-Specific Factor16 must = 001

[4217] If CS Site-Specific Factor 1 = "value of CS Site-Specific Factor 1", CS Site-Specific Factor 2 = "value of CS Site-Specific Factor 2", and CS Site-Specific Factor15 = "value of CS Site-Specific Factor15", CS Site-Specific Factor16 must = 000
[4218] If CS Site-Specific Factor 1 = "value of CS Site-Specific Factor 1", CS Site-Specific Factor 2 = "value of CS Site-Specific Factor 2", and CS Site-Specific Factor15 = "value of CS Site-Specific Factor15", CS Site-Specific Factor16 must = 999

Description

```
This edit verifies that for cases using the Breast schema, SSF 1 (Estrogen Receptor
Assay), SSF 2 (Progesterone Receptor Assay), SSF 15 (HER2: Summary Result of
Testing) and SSF 16 (Combinations of ER, PR, and HER2 Results) are coded
consistently. ER results are coded in the first digit of SSF 16: 0 for negative and
1 for positive. PR results are coded in the second digit: 0 for negative and 1 for
positive. HER2 results are coded in the third digit: 0 for negative and 1 for
positive.

This edit is skipped if any of the following conditions are true:
1. Year of Date of Diagnosis is less than 2010
2. CS Site-Specific Factor 1 is blank or 988
3. CS Site-Specific Factor 2 is blank or 988
4. CS Site-Specific Factor15 is blank or 988
5. CS Site-Specific Factor16 is blank or 988
6. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
7. CS schema is invalid

If CS schema is Breast:
1.  If CS Site-Specific Factor 1 = 010 (positive/elevated)
    and CS Site-Specific Factor 2 = 010 (positive/elevated)
    and CS Site-Specific Factor15 = 010 (positive/elevated)

    THEN
        CS Site-Specific Factor16  must = 111 (ER Positive, PR Positive, HER2
        Positive)
2.  If CS Site-Specific Factor 1 = 010 (positive/elevated)
    and CS Site-Specific Factor 2 = 010 (positive/elevated)
    and CS Site-Specific Factor15 = 020 (negative/normal)
    THEN
        CS Site-Specific Factor16  must = 110 (ER Positive, PR Positive, HER2
        Negative)
3.  If CS Site-Specific Factor 1 = 010 (positive/elevated)
    and CS Site-Specific Factor 2 = 020 (negative/normal)
    and CS Site-Specific Factor15 = 010 (positive/elevated)
    THEN
        CS Site-Specific Factor16  must = 101 (ER Positive, PR Negative, HER2
        Positive)
4.  If CS Site-Specific Factor 1 = 010 (positive/elevated)
    and CS Site-Specific Factor 2 = 020 (negative/normal)
    and CS Site-Specific Factor15 = 020 (negative/normal)
    THEN
        CS Site-Specific Factor16  must = 100 (ER Positive, PR Negative, HER2
        Negative)
5.  If CS Site-Specific Factor 1 = 020 (negative/normal)
    and CS Site-Specific Factor 2 = 010 (positive/elevated)
    and CS Site-Specific Factor15 = 010 (positive/elevated)
    THEN
        CS Site-Specific Factor16  must = 011 (ER Negative, PR Positive, HER2
        Positive)
6.  If CS Site-Specific Factor 1 = 020 (negative/normal)
```

```
    and CS Site-Specific Factor 2 = 010 (positive/elevated)
    and CS Site-Specific Factor15 = 020 (negative/normal)
    THEN
        CS Site-Specific Factor16  must = 010 (ER Negative, PR Positive, HER2
        Negative)
7.  If CS Site-Specific Factor 1 = 020 (negative/normal)
    and CS Site-Specific Factor 2 = 020 (negative/normal)
    and CS Site-Specific Factor15 = 010 (positive/elevated)
    THEN
        CS Site-Specific Factor16  must = 001 (ER Negative, PR Negative, HER2
        Positive)
8.  If CS Site-Specific Factor 1 = 020 (negative/normal)
    and CS Site-Specific Factor 2 = 020 (negative/normal)
    and CS Site-Specific Factor15 = 020 (negative/normal)
    THEN
        CS Site-Specific Factor16  must = 000 (ER Negative, PR Negative, HER2
        Negative)
9.  If CS Site-Specific Factor 1 = 030, 996, 997, 998, or 999 (codes
    indicating borderline, results not interpretable or not in chart,
    or test not done or unknown if test done)
      or CS Site-Specific Factor 2 = 030, 996, 997, 998, or 999
      or CS Site-Specific Factor15 = 030, 997, 998, or 999
    THEN
        CS Site-Specific Factor16  must = 999 (one or more tests not performed,
        one or more tests unknown if performed, one or more tests unknown or
        borderline results, unknown)
```

This edit first determines the correct CS schema by doing a function call to the CS Dynamic Link Library (dll). The function call passes Primary Site, Histologic Type ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS schema name is returned.

Administrative Notes

New edit - added to NAACCR v13A metafile.

In the SEER*Edits software, the title of this edit is: IF444

Modifications:

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Edit was modified to skip if year of Date of Diagnosis is less than 2010.

CS SSF 1, Surg, DX/Stg, Sarcomas (CS)

Agency: CS **Last changed: 10/07/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor 1 [Std# 2880]
RX Summ--Surg Prim Site [Std# 1290]
RX Summ--DX/Stg Proc [Std# 1350]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3323] Conflict among schema, %F4 (%V4), %F5 (%V5), %F6 (%V6)
Conflict among schema, CS Site-Specific Factor 1 ("value of CS Site-Specific Factor 1"), RX Summ--Surg Prim Site ("value of RX Summ--Surg Prim Site"), RX Summ--DX/Stg Proc ("value of RX Summ--DX/Stg Proc"

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

This edit verifies that for cases coded using the HeartMediastinum, Soft Tissue, Retroperitoneum, and Peritoneum schemas, if CS Site-Specific Factor 1 (Grade for Sarcomas)indicates that there was not pathologic examination, then neither RX Summ--Surg Prim Site, nor RX Summ--DX/Stg Proc indicates that there was a specimen sent to pathology.

Please note that there is another edit, "CS SSF 1, RX Summ--Surg, Sarcomas (CS)", that is exactly the same as this edit EXCEPT that it does not include the field RX Summ--DX/Stg Proc. It should be used by registries that do not collect RX Summ--DX/Stg Proc.

If CS schema is HeartMediastinum, Soft Tissue, Retroperitoneum, or Peritoneum:
- If CS Site-Specific Factor 1 = 998 (No histologic examination), then RX Summ--Surg Prim Site must not be 20-89 and RX Summ--DX/Stg Proc must not = 02, 05, or 06.

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor 1 is blank or 988
2. RX Summ--Surg prim Site is blank
3. RX Summ--DX/Stg Proc is blank
4. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
5. CS schema is invalid

This edit first determines the CS schema by doing a function call to the CS Dynamic Link Library (dll). The function call passes Primary Site, Histologic Type ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS schema name is returned.

Administrative Notes

New edit - added to NAACCR v12.1A metafile.

Modifications

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS SSF 1, TS/Ext Eval, Retinoblastoma Schema (CS)

Agency: CS **Last changed: 06/14/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Tumor Size/Ext Eval [Std# 2820]
CS Site-Specific Factor 1 [Std# 2880]
CS Site-Specific Factor25 [Std# 2879]
CS Version Input Original [Std# 2935]

Default Error Message

[3480] If %F4 = %V4, %F5 must not = 970
If CS Tumor Size/Ext Eval = "value of CS Tumor Size/Ext Eval", CS Site-Specific Factor 1 must not = 970

Additional Messages

[3481] If CS Tumor Size/Ext Eval = "value of CS Tumor Size/Ext Eval", CS Site-Specific Factor 1 must not 950

Description

```
Purpose: For cases coded using the Retinoblastoma schema, if CS Tumor Size/Ext Eval
indicates surgical resection (codes 3, 5, 6), then CS Site Specific Factor 1
(extension evaluated at enucleation) must not indicate "no enucleation performed"
(code 970).  If CS Tumor Size/Ext Eval = 6 (surgical resection performed WITH pre-
surgical systemic treatment or radiation; tumor size and/or extension based on
pathologic evidence), then CS Site Specific Factor 1 must not indicate "no evidence
of primary tumor" (code 950).

This edit is skipped if any of the following conditions are true:
1. CS Version Input Original is less than 020500
2. CS Tumor Size/Ext Eval is blank
3. CS Site-Specific Factor 1 is blank or 988
4. CS schema is invalid

If CS schema is Retinoblastoma:

If CS Tumor Size/Ext Eval = 3, 5, 6 (codes indicating surgical resection)
then
    CS Site Specific Factor 1 must not = 970 (no enucleation performed)

If CS Tumor Size/Ext Eval = 6 (surgical resection performed WITH pre-surgical
systemic treatment or radiation; tumor size and/or extension based on pathologic
evidence)
then
    CS Site Specific Factor 1 must not = 950 (no evidence of primary tumor)
```

This edit first determines the CS schema by doing a function call to the CS Dynamic Link Library (dll). The function call passes Primary Site, Histologic Type ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS schema name is returned.

Administrative Notes

New edit - added to NAACCR v14 metafile.

In the SEER*Edits software, the title of this edit is: IF500

CS SSF 1, Upper GI Schemas (CS)

Agency: CS **Last changed: 10/07/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor 1 [Std# 2880]
Regional Nodes Positive [Std# 820]
CS Lymph Nodes [Std# 2830]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3323] Conflict among schema, %F4 (%V4), %F5 (%V5), %F6 (%V6)
Conflict among schema, CS Site-Specific Factor 1 ("value of CS Site-Specific Factor 1"), Regional Nodes Positive ("value of Regional Nodes Positive"), CS Lymph Nodes ("value of CS Lymph Nodes"

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that for cases coded using the Upper GI schemas (Esophagus,
EsophagusGEJunction, Stomach, and NETStomach), CS Site-Specific Factor 1 (Clinical
Assessment of Regional Lymph Nodes), Regional Nodes Positive, and CS Lymph Nodes
are coded consistently.

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor 1 is blank or 988
2. CS Lymph Nodes is blank
3. Regional Nodes Positive is blank
4. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
5. CS schema is invalid

This edit first determines the CS schema by doing a function call to the CS Dynamic
Link Library (dll).  The function call passes Primary Site, Histologic Type ICD-O-
3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.

If CS schema is Esophagus, EsophagusGEJunction, Stomach, or NETStomach:

1. If CS Site-Specific Factor 1 = 000 (nodes not clinically evident) and Regional
Nodes Positive = 00 (negative nodes pathologically),
then CS Lymph Nodes must = 000 (none).

2. If CS Site-Specific Factor 1 = 100-400 (positive nodes clinically) and Regional
Nodes Positive = 98 (no nodes examined),
then CS Lymph Nodes must not = 000 (none).
```

Administrative Notes

New edit - added to NAACCR v12.1A metafile.

In the SEER*Edits software, the title of this edit is: IF361

Modifications

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS SSF 10, SSF 11, Breast (CS)

Agency: CS **Last changed: 09/25/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor10 [Std# 2864]
CS Site-Specific Factor11 [Std# 2865]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3325] Conflict among schema, %F4 (%V4), %F5 (%V5)
Conflict among schema, CS Site-Specific Factor10 ("value of CS Site-Specific Factor10"), CS Site-Specific Factor11 ("value of CS Site-Specific Factor11"

Additional Messages

[3430] Breast schema: If CS Site-Specific Factor10 = 998, CS Site-Specific Factor11 ("value of CS Site-Specific Factor11") must = 998
[3432] Breast schema: If CS Site-Specific Factor11 = 998, CS Site-Specific Factor10 ("value of CS Site-Specific Factor10") must = 998
[4898] Breast schema: If CS Site-Specific Factor10 = "value of CS Site-Specific Factor10", CS Site-Specific Factor11 must not = "value of CS Site-Specific Factor11"
[4899] Breast schema: If CS Site-Specific Factor11 = "value of CS Site-Specific Factor11", CS Site-Specific Factor10 must not = "value of CS Site-Specific Factor10"
SAVE_TEXT("t_schema_msg")

Description

This edit verifies that for cases using the Breast schema, SSF 10 (HER2: FISH Lab Value) and SSF 11 (HER2: FISH Test Interpretation) are coded consistently. For example, if one specifies "test not done", the other must also specify "test not done".

If CS schema is Breast:
1. If CS Site-Specific Factor10 = 998 (test not done), then CS Site-Specific Factor11 must = 998 (test not done).

2. If CS Site-Specific Factor11 = 998, then CS Site-Specific Factor10 must = 998.

3. If CS Site-Specific Factor10 is 991 (ratio of less than 1.00), then CS Site-Specific Factor11 must not = 010 (positive/elevated; amplified).

4. If CS Site-Specific Factor11 = 010, then CS Site-Specific Factor10 must not = 991.

5. If CS Site-Specific Factor10 is greater than 500 and less than 981, then CS Site-Specific Factor11 must not = 020 (negative/normal; within normal limits; not amplified).

6. If CS Site-Specific Factor11 = 020, then CS Site-Specific Factor10 must be less than or = 500 or = 991 or 997.

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor10 is blank or 988
2. CS Site-Specific Factor11 is blank or 988
3. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
4. CS schema is invalid

This edit first determines the correct CS schema by doing a function call to the CS Dynamic Link Library (dll). The function call passes Primary Site, Histologic Type ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS schema name is returned.

Administrative Notes

New edit - added to NAACCR v12.1A metafile.

In the SEER*Edits software, the title of this edit is: IF362

Modifications

NAACCR v13
- Additional comparisons (#3-6) added for CS SSF 10 and 11.

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Default error message added

CS SSF 10, SSF 11, Surgery, DX/Stg, Breast (CS)

Agency: CS **Last changed: 09/25/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor10 [Std# 2864]
CS Site-Specific Factor11 [Std# 2865]
RX Summ--Surg Prim Site [Std# 1290]
RX Summ--DX/Stg Proc [Std# 1350]
RX Summ--Scope Reg LN Sur [Std# 1292]
RX Summ--Surg Oth Reg/Dis [Std# 1294]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3429] If no surgery/BX performed, both %F4 (%V4) and %F5 (%V5) must = 998
If no surgery/BX performed, both CS Site-Specific Factor10 ("value of CS Site-Specific Factor10") and CS Site-Specific Factor11 ("value of CS Site-Specific Factor11") must = 998

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

This edit verifies that for cases using the Breast schema, SSF 10 (HER2: FISH Lab Value) and SSF 11(HER2: FISH Test Interpretation) are coded to 998 (test not done) when no surgery or diagnostic procedure is performed yielding a pathologic specimen for testing.

If CS schema is Breast:
1. If RX Summ--Surg Prim Site = 00 and RX Summ--DX/Stg Proc = 00 and RX Summ--Scope Reg LN Sur = 0 and RX Summ--Surg Oth Reg/Dis = 0, then CS Site-Specific Factor10 must = 998 and CS Site-Specific Factor11 must = 998.

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor10 is blank or 988
2. CS Site-Specific Factor11 is blank or 988
3. RX Summ--Surg Prim Site is blank
4. RX Summ--DX/Stg Proc is blank
5. RX Summ--Scope Reg LN Sur is blank
6. RX Summ--Surg Oth Reg/Dis is blank
7. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
8. CS schema is invalid

This edit first determines the correct CS schema by doing a function call to the CS Dynamic Link Library (dll). The function call passes Primary Site, Histologic Type

ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS schema name is returned.

Administrative Notes

New edit - added to NAACCR v12.1A metafile.

Modifications:

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Default error message added

CS SSF 11, GISTAppendix, Colon, Rectum (CS)

Agency: CS **Last changed: 04/22/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor11 [Std# 2865]
RX Summ--Surg Prim Site [Std# 1290]
CS Site-Specific Factor25 [Std# 2879]
CS Version Input Original [Std# 2935]

Default Error Message

[3549] If %F4 = 998, %F5 must not = %V5
If CS Site-Specific Factor11 = 998, RX Summ--Surg Prim Site must not = "value of RX Summ--Surg Prim Site"

Description

```
This edit verifies that for cases using the GISTAppendix, GISTColon, or GISTRectum
schemas, CS Site-Specific Factor11 (mitotic count) and RX Summ--Surg Prim Site are
coded consistently. If CS Site-Specific Factor11 specifies "no histologic specimen
from primary site", then RX Summ--Surg Prim Site must indicate "no specimen sent to
pathology from surgical event."

This edit is skipped if any of the following conditions are true:
1. CS Version Input Original is less than 020500 and not empty
2. CS Site-Specific Factor11 is blank or 988
3. RX Summ--Surg Prim Site is blank
4. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
5. CS schema is invalid

If CS schema is GISTAppendix, GISTColon, or GISTRectum:
    If CS Site-Specific Factor11 = 998 (no histologic specimen from primary site),
then RX Summ--Surg Prim Site must = 00-19 (no specimen sent to pathology from
surgical event).

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.
```

Administrative Notes

New edit - added to NAACCR v14 metafile.

In the SEER*Edits software, the title of this edit is: IF501

NAACCR v16

- Edit changed to skip if CS Version Input Original is less than 020500 and not empty

CS SSF 11, Surg, DX/Stg Proc, Appendix Schema (CS)

Agency: CS **Last changed: 10/07/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor11 [Std# 2865]
RX Summ--Surg Prim Site [Std# 1290]
RX Summ--DX/Stg Proc [Std# 1350]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3323] Conflict among schema, %F4 (%V4), %F5 (%V5), %F6 (%V6)
Conflict among schema, CS Site-Specific Factor11 ("value of CS Site-Specific Factor11"), RX Summ--Surg Prim Site ("value of RX Summ--Surg Prim Site"), RX Summ--DX/Stg Proc ("value of RX Summ--DX/Stg Proc"

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that for cases coded using the Appendix schema, CS Site-Specific
Factor 11 (Histopathologic Grading), RX Summ--Surg Prim Site, and RX Summ--DX/Stg
Proc are coded consistently.

Please note that there is another edit, "CS SSF 11, Surg, Appendix Schema (CS)",
that is exactly the same as this edit EXCEPT that it does not include the field RX
Summ--DX/Stg Proc. It should be used by registries that do not collect RX Summ--
DX/Stg Proc.

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor 11 is blank or = 988
2. RX Summ--Surg prim Site is blank
3. RX Summ--DX/Stg Proc is blank
4. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
5. CS schema is invalid

This edit first determines the CS schema by doing a function call to the CS Dynamic
Link Library (dll).  The function call passes Primary Site, Histologic Type ICD-O-
3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.

If CS schema is Appendix:
 - If CS Site-Specific Factor11 = 998 (No pathologic confirmation of primary site
tumor),  then RX Summ--Surg Prim Site must be less than 20 and RX Summ--DX/Stg Proc
must not = 02, 05, 06.
```

Administrative Notes

New edit - added to NAACCR v12.1 metafile.

Modifications

NAACCR v14

- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS SSF 12, SSF 13, Breast (CS)

Agency: CS **Last changed: 09/25/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor12 [Std# 2866]
CS Site-Specific Factor13 [Std# 2867]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3325] Conflict among schema, %F4 (%V4), %F5 (%V5)
Conflict among schema, CS Site-Specific Factor12 ("value of CS Site-Specific Factor12"), CS Site-Specific Factor13 ("value of CS Site-Specific Factor13"

Additional Messages

[3430] Breast schema: If CS Site-Specific Factor12 = 998, CS Site-Specific Factor13 ("value of CS Site-Specific Factor13") must = 998
[3432] Breast schema: If CS Site-Specific Factor13 = 998, CS Site-Specific Factor12 ("value of CS Site-Specific Factor12") must = 998
SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that for cases using the Breast schema, SSF 12 (HER2: CISH Lab
Value) and SSF 13 (HER2: CISH Test Interpretation) are coded consistently. That is,
if one specifies "test not done", the other must also specify "test not done".

If CS schema is Breast:
1. If CS Site-Specific Factor12 = 998 (test not done), then CS Site-Specific
Factor13 must = 998 (test not done).
2. If CS Site-Specific Factor13 = 998, then CS Site-Specific Factor12 must = 998.

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor12 is blank or 988
2. CS Site-Specific Factor13 is blank or 988
3. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
4. CS schema is invalid

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.
```

Administrative Notes

New edit - added to NAACCR v12.1A metafile.

In the SEER*Edits software, the title of this edit is: IF365

Modifications:

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Default error message added

CS SSF 12, SSF 13, Surgery, DX/Stg, Breast (CS)

Agency: CS **Last changed: 09/25/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor12 [Std# 2866]
CS Site-Specific Factor13 [Std# 2867]
RX Summ--Surg Prim Site [Std# 1290]
RX Summ--DX/Stg Proc [Std# 1350]
RX Summ--Scope Reg LN Sur [Std# 1292]
RX Summ--Surg Oth Reg/Dis [Std# 1294]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3425] %F2 [%V2] must be 6 when %F1 = %V1
Histologic Type ICD-O-3 ["value of Histologic Type ICD-O-3"] must be 6 when Primary Site = "value of Primary Site"

Additional Messages

[3429] If no surgery/BX performed, both CS Site-Specific Factor12 ("value of CS Site-Specific Factor12") and CS Site-Specific Factor13 ("value of CS Site-Specific Factor13") must = 998
SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that for cases using the Breast schema, SSF 12 (HER2: CISH Lab
Value) and SSF 13 (HER2: CISH Test Interpretation) are coded to 998 (test not done)
when no surgery or diagnostic procedure is performed yielding a pathologic specimen
for testing.

If CS schema is Breast:
1. If RX Summ--Surg Prim Site  = 00 and RX Summ--DX/Stg Proc = 00 and RX Summ--
Scope Reg LN Sur = 0 and RX Summ--Surg Oth Reg/Dis = 0, then CS Site-Specific
Factor12 must = 998 and CS Site-Specific Factor13 must = 998.

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor12 is blank or 988
2. CS Site-Specific Factor13 is blank or 988
3. RX Summ--Surg Prim Site is blank
4. RX Summ--DX/Stg Proc is blank
5. RX Summ--Scope Reg LN Sur is blank
6. RX Summ--Surg Oth Reg/Dis is blank
7. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
8. CS schema is invalid
```

This edit first determines the correct CS schema by doing a function call to the CS Dynamic Link Library (dll). The function call passes Primary Site, Histologic Type ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS schema name is returned.

Administrative Notes

New edit - added to NAACCR v12.1A metafile.

Modifications:

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Default error message added

CS SSF 14, Surgery, DX/Stg, Breast (CS)

Agency: CS **Last changed: 09/25/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor14 [Std# 2868]
RX Summ--Surg Prim Site [Std# 1290]
RX Summ--DX/Stg Proc [Std# 1350]
RX Summ--Scope Reg LN Sur [Std# 1292]
RX Summ--Surg Oth Reg/Dis [Std# 1294]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3433] If no surgery/BX performed, %F4 (%V4) must = 998
If no surgery/BX performed, CS Site-Specific Factor14 ("value of CS Site-Specific Factor14") must = 998

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that for cases using the Breast schema, SSF 14 (HER2: Result of
Other or Unknown Test) is coded to 998 (test not done) when no surgery or
diagnostic procedure is performed yielding a pathologic specimen for testing.

If CS schema is Breast:
1. If RX Summ--Surg Prim Site  = 00 and RX Summ--DX/Stg Proc = 00 and RX Summ--
Scope Reg LN Sur = 0 and RX Summ--Surg Oth Reg/Dis = 0, then CS Site-Specific
Factor14 must = 998.

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor14 is blank or 988
2. RX Summ--Surg Prim Site is blank
3. RX Summ--DX/Stg Proc is blank
4. RX Summ--Scope Reg LN Sur is blank
5. RX Summ--Surg Oth Reg/Dis is blank
6. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
7. CS schema is invalid

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.
```

Administrative Notes

New edit - added to NAACCR v12.1A metafile.

Modifications:

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Default error message added

CS SSF 15, SSF 9, 11, 13, 14, Breast (CS)

Agency: CS **Last changed: 09/25/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor 9 [Std# 2863]
CS Site-Specific Factor11 [Std# 2865]
CS Site-Specific Factor13 [Std# 2867]
CS Site-Specific Factor14 [Std# 2868]
CS Site-Specific Factor15 [Std# 2869]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3434] If any of SSF 9, 11, 13, or 14 not = 988, 998 or 999, %F8 cannot = 998 or 999
If any of SSF 9, 11, 13, or 14 not = 988, 998 or 999, CS Site-Specific Factor15 cannot = 998 or 999

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

This edit applies only to cases coded using the Breast schema. It checks SSFs 9, 11, 13, and 14 (HER2 test interpretations) against SSF 15 (HER2: Summary Result of Testing). If any of SSFs 9, 11, 13, or 14 are not coded to blank, 988 (not collected), 998 (test not done) or 999 (unknown or no information), then SSF 15 must not = 998 or 999.

If CS schema is Breast:
1. If any of the HER2 test interpretations (CS Site-Specific Factor 9, 11, 13, 14) are coded to values other than blank, 988, 998 or 999, then CS Site-Specific Factor 15 must not be coded to 998 or 999.

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor 9, 11, 13, and 14 are all blank or 988
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
3. CS schema is invalid

This edit first determines the correct CS schema by doing a function call to the CS Dynamic Link Library (dll). The function call passes Primary Site, Histologic Type ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS schema name is returned.

Administrative Notes

New edit - added to NAACCR v12.1A metafile.

In the SEER*Edits software, the title of this edit is: IF366

Modifications:

NAACCR v12.1B
- Edit modified to skip only if CS Site-Specific Factor 9, 11, 13, and 14 are all blank or 988.
- If any of the HER2 test interpretations (CS Site-Specific Factor 9, 11, 13, 14) are coded to values other than blank, 988, 998 or 999, then CS Site-Specific Factor 15 must not be coded to 998 or 999.

Modifications:

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Default error message added

CS SSF 16, Skin and Scrotum Schemas (CS)

Agency: CS **Last changed: 10/01/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor16 [Std# 2870]
CS Lymph Nodes [Std# 2830]
Regional Nodes Positive [Std# 820]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3323] Conflict among schema, %F4 (%V4), %F5 (%V5), %F6 (%V6)
Conflict among schema, CS Site-Specific Factor16 ("value of CS Site-Specific Factor16"), CS Lymph Nodes ("value of CS Lymph Nodes"), Regional Nodes Positive ("value of Regional Nodes Positive"

Additional Messages

[3325] Conflict among schema, CS Site-Specific Factor16 ("value of CS Site-Specific Factor16"), CS Lymph Nodes ("value of CS Lymph Nodes"
[3410] Conflict among schema, CS Site-Specific Factor16 ("value of CS Site-Specific Factor16"), Regional Nodes Positive ("value of Regional Nodes Positive"
SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that for cases coded using the Skin and Scrotum schemas, CS
Site-Specific Factor 16 (Size of Lymph Nodes), Regional Nodes Positive, and CS
Lymph Nodes are coded consistently.

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor16 is blank
2. CS Lymph Nodes is blank
3. Regional Nodes Positive is blank
4. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
5. CS schema is invalid

This edit first determines the CS schema by doing a function call to the CS Dynamic
Link Library (dll).  The function call passes Primary Site, Histologic Type ICD-O-
3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.

If CS schema is Skin or Scrotum:

1. If CS Site-Specific Factor16 = 000 (no involved regional lymph nodes), then
Regional Nodes Positive must = 00 (all nodes examined negative), 98 (no nodes
examined) or 99 (unknown).
```

2. If CS Lymph Nodes = 000 (no regional lymph nodes involvement), then CS Site-Specific Factor16 must = 000 (no involved regional lymph nodes) or 988 (not applicable).

3. If CS Lymph Nodes = 999 (unknown), then CS Site-Specific Factor16 must = 988 (not applicable) or 999 (unknown if regional lymph nodes involved).

Administrative Notes

New edit - added to NAACCR v12.1 metafile.

In the SEER*Edits software, the title of this edit is: IF321

Modifications:

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Default error message added
- Modified edit to allow Regional Nodes Positive of 99 when CS Site-Specific Factor 16 = 000

CS SSF 2, LN, LN Eval, RNP, SmallIntestine (CS)

Agency: CS **Last changed: 10/04/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Lymph Nodes [Std# 2830]
CS Lymph Nodes Eval [Std# 2840]
Regional Nodes Positive [Std# 820]
CS Site-Specific Factor 2 [Std# 2890]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[4861] Small Intestine schema: If %F4=%V4, %F5=%V5, %F6=%V6, %F7 must=100, 200, or 400
Small Intestine schema: If CS Lymph Nodes="value of CS Lymph Nodes", CS Lymph Nodes Eval="value of CS Lymph Nodes Eval", Regional Nodes Positive="value of Regional Nodes Positive", CS Site-Specific Factor 2 must=100, 200, or 400

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
This edit checks cases coded using the SmallIntestine schema. If the CS lymph nodes
indicate lymph node involvement, lymph nodes eval code indicates clinical
assessment, and regional nodes positive show no nodes pathologically, then CS SSF 2
must = 100, 200, or 400 (clinical involvement of nodes).

If CS schema is SmallIntestine:
    If CS Lymph Nodes is 100-300 (nodes involved)
        and CS Lymph Nodes Evaluation is 0, 1, 5  (clinical assessment)
        and  Regional nodes positive = 00, 98, or 99 (no nodes pathologically)
    then
        CS Site-Specific Factor 2 must = 100, 200, or 400 (clinical involvement of
nodes)

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor 2 is blank or 988
2. CS Lymph Nodes is blank
3. CS Lymph Nodes Eval is blank
4. Regional Nodes Positive is blank
5. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
6. CS schema is invalid

This edit first determines the CS schema by doing a function call to the CS Dynamic
Link Library (dll).  The function call passes Primary Site, Histologic Type ICD-O-
3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.
```

Administrative Notes

New edit - added to NAACCR v12.1A metafile.

In the SEER*Edits software, the title of this edit is: IF368

Modifications

NAACCR v12.1B
- Extraneous code deleted from edit logic.

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS SSF 2, Lower GI Schemas (CS)

Agency: CS **Last changed: 10/04/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor 2 [Std# 2890]
Regional Nodes Positive [Std# 820]
CS Lymph Nodes [Std# 2830]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3323] Conflict among schema, %F4 (%V4), %F5 (%V5), %F6 (%V6)
Conflict among schema, CS Site-Specific Factor 2 ("value of CS Site-Specific Factor 2"), Regional Nodes Positive ("value of Regional Nodes Positive"), CS Lymph Nodes ("value of CS Lymph Nodes"

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that for cases coded using the Lower GI schemas (SmallIntestine,
Appendix, CarcinoidAppendix, Colon, Rectum, NETColon, and NETRectum), CS Site-
Specific Factor 2 (Clinical Assessment of Regional Lymph Nodes), Regional Nodes
Positive, and CS Lymph Nodes are coded consistently.

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor 2 is blank or 988
2. CS Lymph Nodes is blank
3. Regional Nodes Positive is blank
4. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
5. CS schema is invalid

This edit first determines the CS schema by doing a function call to the CS Dynamic
Link Library (dll).  The function call passes Primary Site, Histologic Type ICD-O-
3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.

If CS schema is SmallIntestine, Appendix, CarcinoidAppendix, Colon, Rectum,
NETColon, or NETRectum:

1. If CS Site-Specific Factor 2 = 000 (nodes not clinically evident) and Regional
Nodes Positive = 00 (negative nodes pathologically),
then CS Lymph Nodes must = 000 (none) or 050 (tumor deposits without regional node
metastasis).
Note: CS Lymph Nodes code 050 is used only in Colon, Rectum, NETColon, and
NETRectum schemas.
```

```
2. If CS Site-Specific Factor 2 = 010-400 (positive nodes clinically) and Regional
Nodes Positive = 98 (no nodes examined),
then CS Lymph Nodes must not = 000(none).
```

Administrative Notes

New edit - added to NAACCR v12.1A metafile.

In the SEER*Edits software, the title of this edit is: IF369

Modifications:

NAACCR v12.2
- Added 050 to CS Lymph Nodes allowed if CS SSF 2 = 000. New logic:
"If CS Site-Specific Factor 2 = 000 (nodes not clinically evident) and Regional Nodes Positive = 00 (negative nodes pathologically),
then CS Lymph Nodes must = 000 (none) or 050 (tumor deposits without regional node metastasis)."

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS SSF 25, PeritoneumFemaleGen (CS)

Agency: CS **Last changed: 12/06/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
CS Site-Specific Factor25 [Std# 2879]
Sex [Std# 220]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]

Default Error Message

[4090] For %F1 of %V1, %F2 of %V2 and %F3 of %V3, %F4 must = 002
For Date of Diagnosis of "value of Date of Diagnosis", CS Site-Specific Factor25 of "value of CS Site-Specific Factor25" and Sex of "value of Sex", Primary Site must = 002

Description

```
The purpose of this edit is to verify that Sex and CS Site-Specific Factor25 are
coded consistently for PeritoneumFemaleGen cases.

If Primary Site = C481, C482 or C488
  AND Histologic Type ICD-O-3 = 8000-8576, 8590-8671, 8930-8934 or 8940-9110
  AND Sex = 2 (female)
THEN
  CS Site-Specific Factor25 must = 002 (female) or 100 (obsolete data retained
v0200).

This edit is skipped
1. if CS Site-Specific Factor25 is empty
2. Date of diagnosis is 2016 or later
```

Administrative Notes

New edit - added to NAACCR v12.2C metafile.

NAACCR v16
- edit skipped if dx date 2016 or later.

NAACCR v16D
- Reference to SEER*Edits IF396 removed from Administrative Notes

CS SSF 3, Breast Schema (CS)

Agency: CS **Last changed: 10/04/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
Regional Nodes Examined [Std# 830]
CS Site-Specific Factor 3 [Std# 2900]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3325] Conflict among schema, %F4 (%V4), %F5 (%V5)
Conflict among schema, Regional Nodes Examined ("value of Regional Nodes Examined"), CS Site-Specific Factor 3 ("value of CS Site-Specific Factor 3"

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor 3 is empty or = 988 (not applicable: information not
collected for this case)
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
3. CS schema is invalid

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.

If CS schema is Breast:
    If Regional Nodes Examined = 00 (no nodes examined), then
    CS Site-Specific 3 must = 098 (axillary LNs = none examined)
```

Administrative Notes

In the SEER*Edits software, the title of this edit is: IF189

Modifications:

NAACCR v11.2
8/2007
This edit was modified so that it will be skipped if Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline).

Description updated: lymphoma and hematopoietic histologies are now grouped together in the list of histologies for which this edit is skipped.

NAACCR v11.3
6/2008
Updated Administrative Notes with the title of the corresponding edit in the SEER*Edits software.

NAACCR v12.0
- Edit modified to get schema name from function call to CS dll.

NAACCR v12.1
- Modified to skip if CS Site-Specific Factor 3 is 988.

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS SSF 3, RX Summ--Surg, Prostate Schema (CS)

Agency: CS **Last changed: 05/18/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
RX Summ--Surg Prim Site [Std# 1290]
CS Site-Specific Factor 3 [Std# 2900]
Type of Reporting Source [Std# 500]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3234] Conflict among %F1, %F2, %F4, %F5
Conflict among Primary Site, Histologic Type ICD-O-3, RX Summ--Surg Prim Site, CS Site-Specific Factor 3

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that, for cases using the CS Prostate schema, if no
prostatectomy is coded in the surgery field, CS Site-Specific Factor 3 must also
show no prostatectomy.

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor 3 is blank
2. Case is autopsy only (Type of Reporting Source = 6)
3. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
4. CS schema is invalid

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.

If CS schema is Prostate:

    If RX Summ--Surg Prim Site = 50 (Radical prostatectomy, NOS;
    total prostatectomy, NOS) or 70 (Prostatectomy WITH resection
    in continuity with other organs; pelvic exenteration), then
    CS Site-Specific Factor 3 must not = 960(unknown if prostatectomy,
    970 (no prostatectomy in first course of treatment), 980 (prostatectomy
    performed, but not first course of treatment), or 985 (autopsy performed,
    but extension unknown).
```

Administrative Notes

Modifications:

NAACCR v11.2
8/2007
This edit was modified so that it will be skipped if Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline).

11/2007
Description updated: lymphoma and hematopoietic histologies are now grouped together in the list of histologies for which this edit is skipped.

NAACCR v11.3
6/2008
Updated Administrative Notes with the title of the corresponding edit in the SEER*Edits software.

NAACCR v12.0:
- Edit modified to get schema name from function call to CS dll.
- CS Site-Specific Factor 3 codes indicating "no prostatectomy" were changed from "096, 097, 098" to "960, 970, 980".

NAACCR v12C:
_ Logic added:
If RX Summ--Surg Prim Site = 50 or 70, then CS Site-Specific Factor 3
must not = 960, 970, 980, or 985.

NAACCR v12.1
- The following logic was deleted:
If there was no prostatectomy (RX Summ--Surg Prim Site not = 30, 50, 70, 80, or 90), then CS Site-Specific Factor 3 must = 960, 970, or 980.

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

NAACCR v16
- Removed referece to IF133 from administrative notes.

CS SSF 3, TS/Ext Eval, Prostate Schema (CS)

Agency: CS **Last changed: 10/04/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor 3 [Std# 2900]
CS Tumor Size/Ext Eval [Std# 2820]
CS Extension [Std# 2810]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]
CS Version Input Original [Std# 2935]

Default Error Message

[3329] Conflict among schema, %F4 (%V4), %F5 (%V5]
Conflict among schema, CS Site-Specific Factor 3 ("value of CS Site-Specific Factor 3"), CS Tumor Size/Ext Eval ("value of CS Tumor Size/Ext Eval"

Additional Messages

[3323] Conflict among schema, CS Site-Specific Factor 3 ("value of CS Site-Specific Factor 3"), CS Tumor Size/Ext Eval ("value of CS Tumor Size/Ext Eval"), CS Extension ("value of CS Extension"

Description

This edit verifies that for cases coded using the CS Prostate schema, if CS Tumor Size/Ext Eval indicates prostatectomy done, CS Site-Specific Factor 3 must not indicate prostatectomy not done. Likewise, if CS Tumor Size/Ext Eval indicates no prostatectomy done, then CS Site-Specific Factor 3 must not indicate prostatectomy done.

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor 3 is empty
2. CS Tumor Size/Ext Eval is empty
3. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
4. CS Schema is invalid
5. Date of Diagnosis is blank or invalid

This edit first determines the CS schema by doing a function call to the CS Dynamic Link Library (dll). The function call passes Primary Site, Histologic Type ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS schema name is returned.

If CS schema is Prostate:

1. If CS Tumor Size/Ext Eval = 4, 5, or 6 (codes indicating prostatectomy performed), then CS Site-Specific Factor 3 must not = 960, 970, 980, or 985 (codes indicating prostatectomy not done or unknown).

2. If CS Extension = 950 or 999
Then
If CS Site-Specific Factor 3 = 000-750, then CS Tumor Size Ext/Eval must not = 0, 1, 2, 5, 9.

3. If year of Diagnosis is 2010 or later OR CS Version Input Original is greater than 020000
Then
If CS Extension = 200-240 (clinically apparent only)
Then
A. If CS Site-Specific Factor 3 = 960 (unknown if prostatectomy done)
Then
CS Tumor Size Ext/Eval must = 0 (based on clinical information only) or 9 (unknown if prostatectomy done).
B. If CS Site-Specific Factor 3 = 970 or 980 (codes indicating no prostatectomy)
Then
CS Tumor Size Ext/Eval must = 0

4. If Tumor Size/Ext Eval = 3 (no prostatectomy done, but evidence derived from autopsy) or 8 (evidence derived from autopsy only), then CS Site-Specific Factor 3 must not = 960, 970, 980, or 990. Tnese codes are not appropriate for cases coded using autopsy information.

5. If CS Tumor Size/Ext Eval = 3 , then CS Site-specific Factor 3 must not = 950.

6. If CS Tumor Size Ext/Eval = 6 (prostatectomy performed AFTER neoadjuvant therapy and tumor size/extension based on pathologic evidence), CS Site-specific Factor 3 must not = 950 or 990.

7. If CS Tumor Size Ext/Eval = 5 (prostatectomy performed AFTER neoadjuvant therapy and tumor size/extension based on clinical evidence)
AND CS Extension code not = 950 or 999
AND CS Site-Specific Factor 3 code not = 950-990,
then
CS Extension code must be equal to or greater than the CS Site-specific Factor 3 code, with the following exceptions:
CS Extension = 200-300 (T2) and CS Site-Specific Factor 3 code = 300, 320, or 400 (T2NOS)
CS Extension = 200, 240, 300 (T2NOS) and CS Site-Specific Factor 3 code = 210-230, 330-350, 402-406 (T2a, T2b, T2c)
CS Extension = 210 (T2a) and CS Site-Specific Factor 3 = 330 or 402 (T2a)
CS Extension = 220 (T2b) and CS Site-Specific Factor 3 = 330, 402 (T2a), 340 or 404 (T2b)
CS Extension = 230 (T2c) and CS Site-Specific Factor 3 = 330, 402 (T2a), 340, 404 (T2b) 350 or 406 (T2c)
CS Extension = 410-490 (T3) and CS Site-Specific Factor 3 = 495 (T3NOS)
CS Extension = 410 or 490 (T3NOS) and CS Site-Specific Factor 3 = 415 - 490 (T3a, T3b)
CS Extension = 420-445 (T3a) and CS Site-Specific Factor 3 = 430-483 (T3a)
CS Extension = 450-470 (T3b) and CS Site-Specific Factor 3 = 480-483 (T3a) or 485-490 (T3b)
CS Extension = 500 - 700 (T4) and CS Site-Specific Factor 3 code = 510 - 750 (T4)

8. If CS Site-Specific Factor 3 = 200-750 (tumor found on prostatectomy or autopsy)
Then
CS Tumor Size Ext/Eval must not = 0, 1 or 9 (codes indicating no prostatectomy done or unknown if done)

Administrative Notes

New edit - added to NAACCR v11.3 metafile.

In the SEER*Edits software, the title of this edit is: IF208

Modifications:

NAACCR v12.0
- Edit modified to get schema name from function call to CS dll.
- CS Site-Specific Factor 3 codes indicating "no prostatectomy" were changed from "096, 097, 098" to "960, 970, 980"; Code "095" indicating "No evidence of primary tumor" was changed to "950"
- Miscellaneous wording changed.
- Added: If CS Tumor Size/Ext Eval = 3 or 8 (evidence derived from autopsy), then CS Site-Specific Factor 3 must not = 960, 970, 980, or 990.

NAACCR v12.1
Deleted: If CS Site-Specific Factor 3 = 985 (autopsy performed but extension unknown), then CS Tumor Size/Ext Eval must = 3 (no prostatectomy done, but evidence derived from autopsy) or 8 (evidence from autopsy only).
- The rest of the edit was entirely reworked and CS Extension added to the logic.

NAACCR v12.1A
Edit updated:
If CS Extension not = 950 or 999 AND CS Site-Specific Factor 3 not = 950-990
then
If CS Tumor Size/Ext Eval = 5, CS Extension must be = to or greater than CS Site-Specific Factor 3, except for a given set of conditions.

NAACCR v12.2A
The following logic was added:
- If CS Extension = 200-240 and CS Site-Specific Factor 3 = 960, then CS Tumor Size Ext/Eval must = 0 or 9.
- If CS Extension = 200-240 and CS Site-Specific Factor 3 = 970 or 980, then CS Tumor Size Ext/Eval must = 0.

NAACCR v13
- Logic pertaining to CS Extension 200-240 was modified so that it applies only if year of Diagnosis is 2010 or later OR CS Version Input Original is greater than 020000.
- Added:
8. If CS Site-Specific Factor 3 = 200-750, then CS Tumor Size Ext/Eval must not = 0, 1 or 9

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS SSF 4, RX Summ--Surg, Testis Schema (CS)

Agency: CS **Last changed: 10/01/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
RX Summ--Surg Prim Site [Std# 1290]
CS Site-Specific Factor 4 [Std# 2910]
Type of Reporting Source [Std# 500]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3329] Conflict among schema, %F4 (%V4), %F5 (%V5]
Conflict among schema, RX Summ--Surg Prim Site ("value of RX Summ--Surg Prim Site"), CS Site-Specific Factor 4 ("value of CS Site-Specific Factor 4"

Description

```
Purpose: This edit verifies that, for cases coded using the CS Testis schema, if
there is no radical orchiectomy coded in the surgery field, CS Site-Specific Factor
4 must also show no radical orchiectomy done, and vice versa.

This edit is skipped if any of the following conditions are true:
1. Case is is a death certificate only (Type of Reporting Source = 7)
2. CS Site-Specific Factor 4 is blank
3. RX Summ--Surg Prim Site is blank
4. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
5. CS schema is invalid

This edit first determines the CS schema by doing a function call to the CS Dynamic
Link Library (dll).  The function call passes Primary Site, Histologic Type ICD-O-
3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.

For cases coded using the Testis schema:

If RX Summ--Surg Prim Site = 80 (orchiectomy, NOS), 90 (Surgery, NOS),or 99
(unknown if surgery performed),
then CS Site-Specific Factor 4 must = 000 (radical orchiectomy not performed) or
999 (unknown if radical orchiectomy performed).

Otherwise if there was no radical orchiectomy (RX Summ--Surg Prim Site not = 40),
then CS Site-Specific Factor 4 must = 000.

If CS Site-Specific Factor 4 = 000, then RX Summ--Surg Prim Site must not = 40.
```

Administrative Notes

In the SEER*Edits software, the title of this edit is: IF134

MODIFICATIONS:

NACR110C
6/24/06
Added: If RX Summ--Surg Prim Site = 80 (orchiectomy, NOS), 90 (Surgery, NOS), or 99 (unknown if surgery performed), then CS Site-Specific Factor 4 must = 000 (radical orchiectomy not performed) or 999 (unknown if radical orchiectomy performed).

NAACCR v11.1A
2/07
Modified to skip DCO cases (Type of Reporting Source = 7).

NAACCR v11.2
8/2007
This edit was modified so that it will be skipped if Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline).

11/2007
Description updated: lymphoma and hematopoietic histologies are now grouped together in the list of histologies for which this edit is skipped.

NAACCR v11.3
6/2008
Updated Administrative Notes with the title of the corresponding edit in the SEER*Edits software.

NAACCR v12.0:
- Edit modified to get schema name from function call to CS dll.

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Edit updated to skip if RX Summ--Surg Prim Site is blank

CS SSF 5, GISTPeritoneum (CS)

Agency: CS **Last changed: 06/08/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor 5 [Std# 2920]
RX Summ--Surg Prim Site [Std# 1290]
CS Site-Specific Factor25 [Std# 2879]
CS Version Input Original [Std# 2935]

Default Error Message

[3549] If %F4 = 998, %F5 must not = %V5
If CS Site-Specific Factor 5 = 998, RX Summ--Surg Prim Site must not = "value of RX Summ--Surg Prim Site"

Description

```
This edit verifies that for cases using the GISTPeritoneum schema, CS Site-Specific
Factor 5 (mitotic count) and RX Summ--Surg Prim Site are coded consistently. If CS
Site-Specific Factor 5 specifies "no histologic specimen from primary site", then
RX Summ--Surg Prim Site must indicate "no specimen sent to pathology from surgical
event."

This edit is skipped if any of the following conditions are true:
1. CS Version Input Original is less than 020500 and not empty
2. CS Site-Specific Factor 5 is blank or 988
3. RX Summ--Surg Prim Site is blank
4. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
5. CS schema is invalid

If CS schema is GISTPeritoneum:
    If CS Site-Specific Factor 5 = 998 (no histologic specimen from primary site),
then RX Summ--Surg Prim Site must = 00-19 (no specimen sent to pathology from
surgical event).

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.
```

Administrative Notes

New edit - added to NAACCR v14 metafile.

In the SEER*Edits software, the title of this edit is: IF503

NAACCR v16

- Edit skips if CS Version Input Original is less than 020500 and not empty

CS SSF 5, Lymph Nodes, Testis (CS)

Agency: CS **Last changed: 09/25/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor 5 [Std# 2920]
CS Lymph Nodes [Std# 2830]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[4054] Testis schema: If %F4 = %V4, %F5 must not = %V5
Testis schema: If CS Site-Specific Factor 5 = "value of CS Site-Specific Factor 5", CS Lymph Nodes must not = "value of CS Lymph Nodes"

Additional Messages

[4055] Testis schema: If CS Lymph Nodes = "value of CS Lymph Nodes", CS Site-Specific Factor 5 must not = "value of CS Site-Specific Factor 5"
SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that for cases using the Testis schema, SSF 5 (Size of
Metastasis in Lymph Nodes) and CS Lymph Nodes are coded consistently.

If CS schema is Testis:
1. If CS Site-Specific Factor 5 = 000 (no regional lymph nodes involved), then
CS Lymph Nodes must = 000 (no regional lymph nodes involved)

2. If CS Site-Specific Factor 5 = 010-030 (regional lymph nodes involved), then
CS Lymph Nodes must = 100-800 (regional nodes involved)

3.
a. IF CS Lymph Nodes = 510 (stated as N1), then CS Site-Specific Factor 5 must =
010 or 999.
b. IF CS Lymph Nodes = 520 (stated as N2), then CS Site-Specific Factor 5 must =
020 or 999.
c. IF CS Lymph Nodes = 530 (stated as N3), then CS Site-Specific Factor 5 must =
030 or 999.

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor 5 is blank or 988
2. CS Lymph Nodes is blank
3. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
4. CS schema is invalid

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
```

ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS schema name is returned.

Administrative Notes

New edit - added to NAACCR v12.2 metafile.

In the SEER*Edits software, the title of this edit is: IF385

Modifications:

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Default error message added

CS SSF 6, GISTEsoph, SmallIntest, Stomach (CS)

Agency: CS **Last changed: 04/22/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor 6 [Std# 2930]
RX Summ--Surg Prim Site [Std# 1290]
CS Site-Specific Factor25 [Std# 2879]
CS Version Input Original [Std# 2935]

Default Error Message

[3549] If %F4 = 998, %F5 must not = %V5
If CS Site-Specific Factor 6 = 998, RX Summ--Surg Prim Site must not = "value of RX Summ--Surg Prim Site"

Description

```
This edit verifies that for cases using the GISTEsophagus, GISTSmallIntestine, or
GISTStomach schemas, CS Site-Specific Factor 6 (mitotic count) and RX Summ--Surg
Prim Site are coded consistently. If CS Site-Specific Factor 6 specifies "no
histologic specimen from primary site", then RX Summ--Surg Prim Site must indicate
"no specimen sent to pathology from surgical event."

This edit is skipped if any of the following conditions are true:
1. CS Version Input Original is less than 020500 and not empty
2. CS Site-Specific Factor 6 is blank or 988
3. RX Summ--Surg Prim Site is blank
4. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
5. CS schema is invalid

If CS schema is GISTEsophagus, GISTSmallIntestine, or GISTStomach:
    If CS Site-Specific Factor 6 = 998 (no histologic specimen from primary site),
then RX Summ--Surg Prim Site must = 00-19 (no specimen sent to pathology from
surgical event).

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.
```

Administrative Notes

New edit - added to NAACCR v14 metafile.

In the SEER*Edits software, the title of this edit is: IF504

NAACCR v16

- Edit changed to skip if CS Version Input Original is less than 020500 and not empty

CS SSF 7, MelanomaSkin (CS)

Agency: CS **Last changed: 07/24/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor 7 [Std# 2861]
RX Summ--Surg Prim Site [Std# 1290]
CS Site-Specific Factor25 [Std# 2879]
CS Version Input Original [Std# 2935]

Default Error Message

[3549] If %F4 = 998, %F5 must not = %V5
If CS Site-Specific Factor 7 = 998, RX Summ--Surg Prim Site must not = "value of RX Summ--Surg Prim Site"

Description

```
This edit verifies that for cases using the MelanomaSkin schema, CS Site-Specific
Factor 7 (mitotic count) and RX Summ--Surg Prim Site are coded consistently. If CS
Site-Specific Factor 7 specifies "no histologic examination of primary site", then
RX Summ--Surg Prim Site must indicate "no specimen sent to pathology from surgical
event."

This edit is skipped if any of the following conditions are true:
1. CS Version Input Original is less than 020500 and not empty
2. CS Site-Specific Factor 7 is blank or 988
3. RX Summ--Surg Prim Site is blank
4. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
5. CS schema is invalid

If CS schema is MelanomaSkin:
    If CS Site-Specific Factor 7 = 998 (no histologic examination of primary site),
then RX Summ--Surg Prim Site must = 00-19 (no specimen sent to pathology from
surgical event).

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.
```

Administrative Notes

New edit - added to NAACCR v14 metafile.

In the SEER*Edits software, the title of this edit is: IF505

NAACCR v16

- Edit changed to skip if CS Version Input Original is less than 020500 and not empty

NAACCR v16A
- Administrative Note for v16 changed to indicate edit skipped if CS Version Input Original is less than 020500 from less than 020550

CS SSF 8, CS SSF 9, Breast (CS)

Agency: CS **Last changed: 09/25/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor 8 [Std# 2862]
CS Site-Specific Factor 9 [Std# 2863]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3430] Breast schema: If %F4 = 998, %F5 (%V5) must = 998
Breast schema: If CS Site-Specific Factor 8 = 998, CS Site-Specific Factor 9 ("value of CS Site-Specific Factor 9") must = 998

Additional Messages

[3432] Breast schema: If CS Site-Specific Factor 9 = 998, CS Site-Specific Factor 8 ("value of CS Site-Specific Factor 8") must = 998
SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that for cases using the Breast schema, SSF 8 (HER2: IHC Lab
Value) and SSF 9 (HER2: IHC Test Interpretation) are coded consistently. That is,
if one specifies "test not done", the other must also specify "test not done".

If CS schema is Breast:
1. If CS Site-Specific Factor 8 = 998 (test not done), then CS Site-Specific Factor
9 must = 998 (test not done).
2. If CS Site-Specific Factor 9 = 998, then CS Site-Specific Factor 8 must = 998.

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor 8 is blank or 988
2. CS Site-Specific Factor 9 is blank or 988
3. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
4. CS schema is invalid

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.
```

Administrative Notes

New edit - added to NAACCR v12.1A metafile.

In the SEER*Edits software, the title of this edit is: IF377

Modifications:

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Default error message added

CS SSF 8, CS SSF 9, Surgery, DX/Stg, Breast (CS)

Agency: CS **Last changed: 09/25/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor 8 [Std# 2862]
CS Site-Specific Factor 9 [Std# 2863]
RX Summ--Surg Prim Site [Std# 1290]
RX Summ--DX/Stg Proc [Std# 1350]
RX Summ--Scope Reg LN Sur [Std# 1292]
RX Summ--Surg Oth Reg/Dis [Std# 1294]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3429] If no surgery/BX performed, both %F4 (%V4) and %F5 (%V5) must = 998
If no surgery/BX performed, both CS Site-Specific Factor 8 ("value of CS Site-Specific Factor 8") and CS Site-Specific Factor 9 ("value of CS Site-Specific Factor 9") must = 998

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

This edit verifies that for cases using the Breast schema, SSF 8 (HER2: IHC Lab Value) and SSF 9 (HER2: IHC Test Interpretation) are coded to 998 (test not done) when no surgery or diagnostic procedure is performed yielding a pathologic specimen for testing.

If CS schema is Breast:
1. If RX Summ--Surg Prim Site = 00 and RX Summ--DX/Stg Proc = 00 and RX Summ--Scope Reg LN Sur = 0 and RX Summ--Surg Oth Reg/Dis = 0, then CS Site-Specific Factor 8 must = 998 and CS Site-Specific Factor 9 must = 998.

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor 8 is blank or 988
2. CS Site-Specific Factor 9 is blank or 988
3. RX Summ--Surg Prim Site is blank
4. RX Summ--DX/Stg Proc is blank
5. RX Summ--Scope Reg LN Sur is blank
6. RX Summ--Surg Oth Reg/Dis is blank
7. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
8. CS schema is invalid

This edit first determines the correct CS schema by doing a function call to the CS Dynamic Link Library (dll). The function call passes Primary Site, Histologic Type

ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS schema name is returned.

Administrative Notes

New edit - added to NAACCR v12.1A metafile.

Modifications:

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Default error message added

CS SSF 8, SSF 10, Grade, Prostate (SEER)

Agency: CS **Last changed: 06/14/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor 8 [Std# 2862]
CS Site-Specific Factor10 [Std# 2864]
Grade [Std# 440]
Date of Diagnosis [Std# 390]
Type of Reporting Source [Std# 500]

Default Error Message

[4275] Prostate schema: If %F4 = %V4 and %F5 = %V5, %F6 must = 1
Prostate schema: If CS Site-Specific Factor 8 = "value of CS Site-Specific Factor 8" and CS Site-Specific Factor10 = "value of CS Site-Specific Factor10", Grade must = 1

Additional Messages

[4276] Prostate schema: If CS Site-Specific Factor 8 = "value of CS Site-Specific Factor 8" and CS Site-Specific Factor10 = "value of CS Site-Specific Factor10", Grade must = 2
[4277] Prostate schema: If CS Site-Specific Factor 8 = "value of CS Site-Specific Factor 8" and CS Site-Specific Factor10 = "value of CS Site-Specific Factor10", Grade must = 3

Description

Purpose: This edit verifies that Grade is coded correctly for prostate cases diagnosed 2014 and later. A computer algorithm can be used to derive grade for prostate based on CS Site-Specific Factor 8 (Gleason's score on TURP and CS Site-Specific Factor10 (Gleason's score on prostatectomy/autopsy): if CS Site-Specific Factor 8 or CS Site-Specific Factor10 has known values for Gleason's, the information could be used to automatically derive the grade field.

Source: Instructions for Coding Grade for 2014+
http://www.seer.cancer.gov/tools/grade/

This edit is skipped if any of the following conditions are true:
1. Year of Date of Diagnosis is blank, invalid or less than 2014
2. CS Site-Specific Factor 8 is blank or 988
3. CS Site-Specific Factor10 is blank or 988
4. Case is death certificate only (Type of Reporting Source = 7).
5. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)

If Primary Site = C619 (Prostate) and Histologic Type ICD-O-3 = 8000-9136, 9141-9582, 9700-9701:

Using the table below, if Grade does not equal the CS Site-Specific Factor 8 and CS Site-Specific Factor10 combination, then an error message is generated. Grade

specified as "*" can't be automatically calculated and will not be checked by this edit. The detailed edit logic is provided below the table.

	GRADE											
SSF8 Codes	SSF 10 Codes 002	003	004	005	006	007	008	009	010	988	998	999
002	1	1	1	1	1	2	3	3	3	*	1	1
003	1	1	1	1	1	2	3	3	3	*	1	1
004	1	1	1	1	1	2	3	3	3	*	1	1
005	1	1	1	1	1	2	3	3	3	*	1	1
006	1	1	1	1	1	2	3	3	3	*	1	1
007	2	2	2	2	2	2	3	3	3	*	2	2
008	3	3	3	3	3	3	3	3	3	*	3	3
009	3	3	3	3	3	3	3	3	3	*	3	3
010	3	3	3	3	3	3	3	3	3	*	3	3
988	*	*	*	*	*	*	*	*	*	*	*	*
998	1	1	1	1	1	2	3	3	3	*	*	*
999	1	1	1	1	1	2	3	3	3	*	*	*

```
1. If CS Site-Specific Factor 8 = 002-006
   a. If CS Site-Specific Factor10 = 002-006, 998, 999
          Grade must = 1
   b. If CS Site-Specific Factor10 = 007
          Grade must = 2
   c. If CS Site-Specific Factor10 = 008-010
          Grade must = 3

2. If CS Site-Specific Factor 8 = 007
   a. If CS Site-Specific Factor10 = 002-007, 998, 999
          Grade must = 2
   b. If CS Site-Specific Factor10 = 008-010
          Grade must = 3

3. If CS Site-Specific Factor 8 = 008-010
   a. If CS Site-Specific Factor10 = 002-010, 998, 999
          Grade must = 3

4. If CS Site-Specific Factor 8 = 998, 999
   a. If CS Site-Specific Factor10 = 002-006
          Grade must = 1
   b. If CS Site-Specific Factor10 = 007
          Grade must = 2
   c. If CS Site-Specific Factor10 = 008-010
          Grade must = 3
```

Administrative Notes

New edit - added to NAACCR v15 metafile.

In the SEER*Edits software, the title of this edit is: IF535

CS TS/Ext Eval, Surg/Rad Seq, Prostate (CS)

Agency: CS **Last changed: 10/07/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Tumor Size/Ext Eval [Std# 2820]
RX Summ--Surg/Rad Seq [Std# 1380]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[4060] Prostate schema: If %F4 = %V4, %F5 must not = %V5
Prostate schema: If CS Tumor Size/Ext Eval = "value of CS Tumor Size/Ext Eval", RX Summ--Surg/Rad Seq must not = "value of RX Summ--Surg/Rad Seq"

Description

```
This edit verifies that for cases coded using the CS Prostate schema, if CS Tumor
Size/Ext Eval indicates prostatectomy performed WITHOUT pre-surgical systemic
treatment or radiation, then the surgery/radiation sequence field must NOT indicate
radiation given before surgery.

If CS schema is Prostate:
   If CS Tumor Size/Ext Eval = 4 (prostatectomy performed WITHOUT pre-surgical
systemic treatment or radiation), then RX Summ--Surg/Rad Seq must not = 2 or 4
(radiation given before surgery)

This edit is skipped if any of the following conditions are true:
1. CS Tumor Size/Ext Eval is empty
2. RX Summ--Surg/Rad Seq is empty
3. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
4. CS Schema is invalid

This edit first determines the CS schema by doing a function call to the CS Dynamic
Link Library (dll).  The function call passes Primary Site, Histologic Type ICD-O-
3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.
```

Administrative Notes

New edit - added to NAACCR v12.2 metafile.

In the SEER*Edits software, the title of this edit is: IF392

Modifications:

NAACCR v14

- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS TS/Ext Eval, Sys/Surg Seq, Prostate (CS)

Agency: CS **Last changed: 10/07/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Tumor Size/Ext Eval [Std# 2820]
RX Summ--Systemic/Sur Seq [Std# 1639]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[4060] Prostate schema: If %F4 = %V4, %F5 must not = %V5
Prostate schema: If CS Tumor Size/Ext Eval = "value of CS Tumor Size/Ext Eval", RX Summ--Systemic/Sur Seq must not = "value of RX Summ--Systemic/Sur Seq"

Description

```
This edit verifies that for cases coded using the CS Prostate schema, if CS Tumor
Size/Ext Eval indicates prostatectomy performed WITHOUT pre-surgical systemic
treatment or radiation, then the systemic therapy/surgery sequence field must NOT
indicate systemic therapy given before surgery.

If CS schema is Prostate:
   If CS Tumor Size/Ext Eval = 4 (prostatectomy performed WITHOUT pre-surgical
systemic treatment or radiation), then RX Summ--Systemic/Sur Seq must not = 2 or 4
(systemic therapy given before surgery)

This edit is skipped if any of the following conditions are true:
1. CS Tumor Size/Ext Eval is empty
2. RX Summ--Systemic/Sur Seq is empty
3. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
4. CS Schema is invalid

This edit first determines the CS schema by doing a function call to the CS Dynamic
Link Library (dll).  The function call passes Primary Site, Histologic Type ICD-O-
3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.
```

Administrative Notes

New edit - added to NAACCR v12.2 metafile.

In the SEER*Edits software, the title of this edit is: IF393

Modifications:

NAACCR v14

- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS TS/Ext Eval, Surgery, Bladder Schema (CS)

Agency: CS **Last changed: 10/04/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
RX Summ--Surg Prim Site [Std# 1290]
CS Extension [Std# 2810]
CS Tumor Size/Ext Eval [Std# 2820]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[4889] If %F4 = %V4 and %F5 = %V5, %F6 (%V6) must not = 5, 6, or 8
If RX Summ--Surg Prim Site = "value of RX Summ--Surg Prim Site" and CS Extension = "value of CS Extension", CS Tumor Size/Ext Eval ("value of CS Tumor Size/Ext Eval") must not = 5, 6, or 8

Additional Messages

[4897] If RX Summ--Surg Prim Site = "value of RX Summ--Surg Prim Site" and CS Extension = "value of CS Extension", CS Tumor Size/Ext Eval ("value of CS Tumor Size/Ext Eval") must not = 3, 5, 6, or 8

Description

The purpose of this edit is to verify that, for cases coded using the CS Bladder schema, the CS Tumor Size/Ext Eval code is correct for surgeries which do not meet the pathologic staging criteria. An exception is made for CS Extension codes mapping to the highest T category which may be pathologically evaluated (CS Tumor Size/Ext Eval code 3) without primary site resection.

This edit is skipped if any of the following conditions are true:
1. CS Tumor Size/Ext Eval is empty.
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline).
3. CS schema is invalid

This edit first determines the correct CS schema by doing a function call to the CS Dynamic Link Library (dll). The function call passes Primary Site, Histologic Type ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS schema name is returned.

For cases coded using the Bladder:

If RX Summ--Surg Prim Site = 10-27:
1. If CS Extension = 700-805 (CS Extension codes mapping to the highest T category which may be pathologically evaluated), then CS Tumor Size/Ext Eval must not = 5, 6 or 8.
2. For all other CS Extension codes, CS Tumor Size/Ext Eval must not = 3, 5, 6 or 8.

Administrative Notes

New edit - added to NAACCR v11.3A metafile.

In the SEER*Edits software, the title of this edit is: IF211

Modifications:

NAACCR v12.0:
- Edit modified to get schema name from function call to CS dll.

NAACCR v12.2A:
- Edit modified: "If RX Summ--Surg Prim Site = 10-27, then the CS Tumor Size/Ext Eval must not = 3, 5, 6, or 8" changed to: "If RX Summ--Surg Prim Site = 10-27 and CS Extension = 700-805, then the CS Tumor Size/Ext Eval must not = 5, 6, or 8".
- New error message (4889) added.

NAACCR v13:
- Added logic: If RX Summ--Surg Prim Site = 10-27 and CS Extension not = 700-805, then CS Tumor Size/Ext Eval must not = 3, 5, 6 or 8".
- New error message (4897) added.

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS TS/Ext Eval, Surgery, Prostate Schema (CS)

Agency: CS **Last changed: 10/04/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Tumor Size/Ext Eval [Std# 2820]
RX Summ--Surg Prim Site [Std# 1290]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3325] Conflict among schema, %F4 (%V4), %F5 (%V5)
Conflict among schema, CS Tumor Size/Ext Eval ("value of CS Tumor Size/Ext Eval"), RX Summ--Surg Prim Site ("value of RX Summ--Surg Prim Site"

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
For cases using the CS Prostate schema:
1. If RX Summ--Surg Prim Site = 22 (TURP, cancer is incidental finding during
surgery for benign disease), then the CS Tumor Size/Ext Eval should be coded as 1
(No prostatectomy done. Evaluation based on endoscopic examination, diagnostic
biopsy, including fine needle aspiration biopsy, or other invasive techniques
including surgical observation without biopsy) or 2 (No prostatectomy done, but
positive biopsy of extraprostatic tissue allows assignment to CS Extension Codes
410-700); otherwise  if only a TURP is performed (RX Summ--Surg Prim Site = 19-26),
then the CS Tumor Size/Ext Eval should be coded as 0 [No prostatectomy done.
Evaluation based on physical examination including  digital rectal examination
(DRE), imaging examination, or other non-invasive clinical evidence.  No autopsy
evidence used], 1 or 2.

2. If CS Tumor Size/Ext Eval = 4 (prostatectomy performed WITHOUT pre-surgical
systemic treatment or radiation), 5 (prostatectomy performed AFTER neoadjuvant
therapy and tumor size/extension based on clinical evidence), or 6 (prostatectomy
performed AFTER neoadjuvant therapy and tumor size/extension based on pathologic
evidence),  then RX Summ--Summ--Surg Prim Site must = 30-80 (prostatectomy
performed).


 The logic is:

  If schema is Prostate schema:

 1.   If RX Summ--Surg Prim Site = 22, then
    CS Tumor Size/Ext Eval must = 1 or 2.
```

```
    Otherwise:

      If RX Summ--Surg Prim Site = 19-26, then
    CS Tumor Size/Ext Eval must = 0, 1, or 2.

 2. If Tumor Size/Ext Eval = 4, 5, or 6 (prostatectomy performed) then
    RX Summ--Surg Prim Site must = 30-80

This edit is skipped if any of the following conditions are true:
1. CS Tumor Size/Ext Eval is empty.
2. RX Summ--Surg Prim Site is empty
3. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
4. CS schema is invalid

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.
```

Administrative Notes

In the SEER*Edits software, the title of this edit is: IF196

Modifications:

NAACCR v11.1A
05/07
1. The RX Summ--Surg Prim Site range requiring CS Tumor Size/Ext Eval of 1 was changed from 19-26 to 19-30.
2. Additional code was added to require CS Tumor Size/Ext Eval of 0 or 1 for RX Summ--Surg Prim Site code of 18.

NAACCR v11.2
8/2007
This edit was modified so that it will be skipped if Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline).

11/2007
Description updated: lymphoma and hematopoietic histologies are now grouped together in the list of histologies for which this edit is skipped.

NAACCR v11.3
6/2008
- Updated Administrative Notes with the title of the corresponding edit in the SEER*Edits software.
- Changed the range of surgery codes for "only TURP is performed" from 19-30 to 19-26; code 30 is not included because it indicates "subtotal, segmental, or simple prostatectomy, which may leave all or part of the capsule intact", which can be pathologic under rare circumstances.
- Deleted logic that requires CS Tumor Size/Ext Eval of 0 or 1 (no surgical resection done) for surgery code of 18 (local tumor destruction or excision, NOS); this is because surgery code 18 could plausibly involve a simple prostatectomy.

NAACCR v11.3A
11/2008
- Added "2" to CS Tumor Size/Ext Eval codes allowed if RX Summ--Surg Prim Site = 19-26.

NAACCR v12.0:
- Edit modified to get schema name from function call to CS dll
- Modified edit to allow CS Tumor Size/Ext Eval of 1 and 2 for RX Summ--Surg Prim Site of 22; allow CS Tumor Size/Ext Eval of 0, 1, and 2 for RX Summ--Surg Prim Site of 19-21, 23-26

NAACCR v12.2:
- Added: If CS Tumor Size/Ext Eval = 4, 5, or 6, then RX Summ--Summ--Surg Prim Site must = 30-80

NAACCR v12.2C:
- Error message corrected

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Tumor Size (CS)

Agency: CS **Last changed: 09/28/2003**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

CS Tumor Size [Std# 2800]

Default Error Message

[1037] %F1 must be a three-digit number
CS Tumor Size must be a three-digit number

Description

Must be a valid three-digit number (000-999) or blank.

CS Tumor Size, Schema (CS)

Agency: CS **Last changed: 10/07/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Tumor Size [Std# 2800]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3321] %F4 (%V4) is invalid for this schema
CS Tumor Size ("value of CS Tumor Size") is invalid for this schema

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that CS Tumor Size is correct for a particular schema. The
schema determined by Primary Site, Histologic Type ICD-O-3, and sometimes CS Site-
Specific Factor25 (schema discriminator).

This edit is skipped if any of the following conditions are true:
1. CS Tumor Size, Primary Site, or Histologic Type ICD-O-3 is blank
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and schema is not Brain,
CNSOther, or IntracranialGland
3. CS schema is invalid

This edit verifies that CS Tumor Size is valid for a particular schema by doing
function calls to the CS Dynamic Link Library (dll).
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.
Replaces 'CS Tumor Size, Primary Site, Histol ICDO3 (NAACCR)'

In the SEER*Edits software, the title of this edit is: IF226

Modifications

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Tumor Size, Site, Histol ICDO3 (CS)

Agency: CS **Last changed: 10/04/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Tumor Size [Std# 2800]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3356] Conflict among schema, %F2 (%V2), %F4 (%V4)
Conflict among schema, Histologic Type ICD-O-3 ("value of Histologic Type ICD-O-3"), CS Tumor Size ("value of CS Tumor Size"

Additional Messages

[3379] For Primary Site of "value of Primary Site", CS Tumor Size must = 999
SAVE_TEXT("t_schema_msg")

Description

```
This edit is skipped if any of the following conditions are true:
1. CS Tumor Size is empty.
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline).
3. CS schema is invalid

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.

For cases coded using the Colon or Rectum schemas:
- If CS Tumor Size = 998, then Histologic Type ICD-O-3 must = 8220 or 8221.
- If Histologic Type ICD-O-3 = 8220 or 8221, then CS Tumor Size must = 998

For cases coded using the IllDefinedOther schema:
- If Primary Site = Unknown Primary Site (C809), then CS Tumor Size must = 999.
```

Administrative Notes

In the SEER*Edits software, the title of this edit is: IF136

Modifications:

NAACCR v11.2
8/2007
This edit was modified so that it will be skipped if Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline).

NAACCR v11.3
6/2008
Updated Administrative Notes with the title of the corresponding edit in the SEER*Edits software.

NAACCR v12.0:
- Edit modified to get schema name from function call to CS dll.
- Added:- If Histologic Type ICD-O-3 = 8220 or 8221, then CS Tumor Size must = 998

NAACCR v12C
- Added closing brace "}" to edit logic. (The missing closing brace could make the logical output unpredictable.)

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Tumor Size, SSF 1, MelanomaConjunctiva (CS)

Agency: CS **Last changed: 10/04/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Tumor Size [Std# 2800]
CS Site-Specific Factor 1 [Std# 2880]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3325] Conflict among schema, %F4 (%V4), %F5 (%V5)
Conflict among schema, CS Tumor Size ("value of CS Tumor Size"), CS Site-Specific Factor 1 ("value of CS Site-Specific Factor 1"

Description

```
This edit is skipped if any of the following conditions are true:
1. CS Tumor Size is empty
2. CS Site-Specific Factor 1 is empty.
3. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline).
4. CS schema is invalid

If schema is MelanomaConjunctiva:
  If CS Tumor Size = 000 then, CS Site-Specific Factor 1 must = 000 and vice versa.
```

Administrative Notes

In the SEER*Edits software, the title of this edit is: IF137

Modifications:

NAACCR v11.2
8/2007
This edit was modified so that it will be skipped if Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline).

NAACCR v11.3
6/2008
Updated Administrative Notes with the title of the corresponding edit in the SEER*Edits software.

NAACCR v12.0
- Edit name changed from "CS Tumor Size, SSF 1, Malign Melanoma Schemas (CS)" to "CS Tumor Size, SSF 1, MelanomaConjunctiva(CS)".
- Changed to apply only to MelanomaConjunctiva schema.
- Modified to get schema name from function call to CS dll.

NAACCR v14

- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Tumor Size/Ext Eval (CS)

Agency: CS **Last changed: 10/08/2003**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

CS Tumor Size/Ext Eval [Std# 2820]

Default Error Message

[1023] %F1 is not valid
CS Tumor Size/Ext Eval is not valid

Description

Must be a valid CS Tumor Size/Ext Eval code (0-6,8,9) or blank.

CS Tumor Size/Ext Eval, Schema (CS)

Agency: CS **Last changed: 10/07/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Tumor Size/Ext Eval [Std# 2820]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[3321] %F4 (%V4) is invalid for this schema
CS Tumor Size/Ext Eval ("value of CS Tumor Size/Ext Eval") is invalid for this schema

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
This edit verifies that CS Tumor Size/Ext Eval is correct for a particular schema.
The schema determined by Primary Site, Histologic Type ICD-O-3, and sometimes CS
Site-Specific Factor25 (schema discriminator).

This edit is skipped if any of the following conditions are true:
1. CS Tumor Size/Ext Eval, Primary Site, or Histologic Type ICD-O-3 is blank
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline) and
   schema is not Brain, CNSOther, or IntracranialGland
3. CS schema is invalid

This edit verifies that CS Tumor Size/Ext Eval is valid for a particular schema by
doing  function calls to the CS Dynamic Link Library (dll).
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.
Replaces 'CS TS/Ext Eval, Primary Site, Histol ICDO3 (NAACCR)'

In the SEER*Edits software, the title of this edit is: IF228

Modifications

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Validate Schema (CS)

Agency: CS **Last changed: 10/07/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]

Default Error Message

[3380] CS schema is invalid
CS schema is invalid

Additional Messages

ERROR_TEXT("Date of Diagnosis: %DC")
ERROR_TEXT("Invalid site or histology")
ERROR_TEXT("Schema discriminator missing or invalid")

Description

```
The purpose of this edit is to verify that the schema is a valid CS schema.

This edit must be included in the edit sets for each standard setter since most
other CS edits will be skipped if the schema is invalid.

This edit is skipped if any of the following conditions are true:
1. Primary Site is empty.
2. Histologic Type ICD-O-3 is empty
3. Year of Date of Diagnosis is empty or less than 2004

This edit determines the CS schema by doing a function call to the CS Dynamic Link
Library (dll).  The function call passes Primary Site, Histologic Type ICD-O-3, and
CS Site-Specific Factor25 (schema discriminator) to the dll. An error is generated
if the schema is not found, or if CS Site-Specific Factor 25 is blank or coded 988
when the schema discriminator (CS SSF 25) is required to select the correct schema.
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

Modifications:

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

CS Validate Schema (NPCR/MCR)

Agency: **Last changed: 06/26/2014**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]
Over-ride CS 20 [Std# 3769]
Class of Case [Std# 610]

Default Error Message

[3380] CS schema is invalid
CS schema is invalid

Additional Messages

ERROR_TEXT("Date of Diagnosis: %DC")
ERROR_TEXT("Invalid site or histology")
ERROR_TEXT("Schema discriminator missing or invalid")

Description

```
The purpose of this edit is to verify that the schema is a valid CS schema.

This edit must be included in the edit sets for each standard setter since most
other CS edits will be skipped if the schema is invalid.

This edit is skipped if any of the following conditions are true:
1. Primary Site is empty.
2. Histologic Type ICD-O-3 is empty
3. Year of Date of Diagnosis is empty or less than 2004
4. Over-ride CS 20 is '1' AND Class of Case = 38-49 AND CS Site-Specific Factor25
is blank
      MCR modification is to use Class of Case in the 4th skip rule instead of Type
of Reporting Source = 3-7.

This edit determines the CS schema by doing a function call to the CS Dynamic Link
Library (dll).  The function call passes Primary Site, Histologic Type ICD-O-3, and
CS Site-Specific Factor25 (schema discriminator) to the dll. An error is generated
if the schema is not found, or if CS Site-Specific Factor 25 is blank or coded 988
when the schema discriminator (CS SSF 25) is required to select the correct schema.
```

Administrative Notes

New edit - added to NAACCR v13A metafile.

This edit differs from the CS edit of the same name in that the edit is skipped if Over-ride CS 20 is '1' AND Type of Reporting Source = 3-7 AND CS Site-Specific Factor25 is blank. Over-ride CS 20 is set to '1' when directly coded summary stage (SEER Summary Stage 2000 [759]) is recorded in lieu of Derived SS2000 [3020].

13A: MCR modification uses Class of Case 38-49 instead of Type of Reporting Source 3-7. MCR generates Type of Reporting Source and does not collect it.

14: updated CS dll name to cstage0205.

CS Version Input Current (CS)

Agency: CS **Last changed: 10/08/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

CS Version Input Current [Std# 2937]

Default Error Message

[4868] %F1 cannot = %V1; contact your software provider
CS Version Input Current cannot = "value of CS Version Input Current"; contact your software provider

Description

```
Must be a six-digit number or blank.

If not blank, the full six-digit number must be one of the following numbers:
020550 or higher (see next paragraph)
020540
020530
020520
020510

CS Version Input Current must also be less than or equal to the CS version that is
returned from a function call to the CS DLL. (The most current CS DLL always
contains the most current CS version number.)
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

Modifications:

NAACCR v12.1
- Edit updated to correspond to the CSV0203 requirements.

NAACCR v12.2
- Edit updated to correspond to the CSV0204 requirements.

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll"
- List of allowable codes updated

CS Version Input Original (CS)

Agency: CS **Last changed: 10/07/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

CS Version Input Original [Std# 2935]

Default Error Message

[4868] %F1 cannot = %V1; contact your software provider
CS Version Input Original cannot = "value of CS Version Input Original"; contact your software provider

Description

Must be a six-digit number or blank.

If not blank, the full six-digit number must be one of the following numbers:
020550 or higher (see next paragraph)
020440
020302
020200
020100
020001
010401
010400
010300
010200
010100
010005
010004
010003
010002
010000
000937

If the first 4 digits are 0205, then the full six-digit number must be greater than or equal to 020550. Codes less than 020550 are either reserved for converted cases or invalid and are never used in CS Version Input Original.

CS Version Input Original must also be less than or equal to the CS version that is returned from a function call to the CS DLL. (The most current CS DLL always contains the most current CS version number.)

Administrative Notes

Modifications:

NACR110C
09/06/06
The code "0103" was added to the list of allowable values.

NAACCR v11.2

11/07
The code "0104" was added to the list of allowable values.

NAACCR v12.0
- Edit name changed from "CS Version 1st (CS)" to "CS Version Input Original (CS)".
- - Edit updated to only allow '01' or '02' in first two digits or full number of '000937' (trial version). CS Version Input Original must also be less than or equal to the current CS version. A function call to the CS dll is performed to get the most current CS version.

NAACCR v12.1
- Edit updated to correspond to the CSV0203 requirements.

NAACCR v12.2
- Edit updated to correspond to the CSV0204 requirements.

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll"
- List of allowable codes updated

CS Version Input Original, Version Input Curr (CS)

Agency: CS **Last changed: 05/28/2010**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

CS Version Input Original [Std# 2935]
CS Version Input Current [Std# 2937]

Default Error Message

[3369] %F2 (%V2) must be > or = %F1 (%V1)
CS Version Input Current ("value of CS Version Input Current") must be > or = CS Version Input Original ("value of CS Version Input Original"

Description

This edit is skipped if either field is blank.

CS Version Input Current must be greater than or equal to CS Version Input Original.

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

In the SEER*Edits software, the title of this edit is: IF268

Date 1st Crs RX COC (COC)

Agency: COC **Last changed: 11/15/2012**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date 1st Crs RX COC [Std# 1270]

Default Error Message

[1003] %F1 (%V1) is an invalid date
Date 1st Crs RX COC ("value of Date 1st Crs RX COC") is an invalid date

Additional Messages

ERROR_TEXT("Date of 1st Crs RX--COC: %DC")

Description

```
This edit is skipped if Date 1st Crs RX COC is empty.

General Date Editing Rules:
Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD).
Month and day must have leading zeros for values 01...09.

The following date formats are allowed:
CCYYMMDD    Century+Year, Month and Day are provided.
CCYYMM__    Century+Year and Month. Day consists of two blank spaces.
CCYY____    Century+Year. Month and Day consist of four blank spaces.

Dates are checked first to ensure they conform to one of these formats, then for
errors in the components. Checking stops on the first non-valid situation.

Range checking:
Lowest allowed value:  January 1, 1850 (or in D1 format: 18500101)
Highest allowed value: current system date
When month is known, it is checked to ensure it falls within range 01...12.
When month and day are known, day is checked to ensure it falls within range for
that specific month. Accommodation is made for leap years.
```

Administrative Notes

MODIFICATIONS:

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

NAACCR v13
- Edit name changed from 'Date of 1st Crs RX--COC (COC)' to 'Date 1st Crs RX COC (COC)'.
- Data item name changed from 'Date of 1st Crs RX--COC' to 'Date 1st Crs RX COC'.

Date 1st Crs RX COC , Date Flag (COC)

Agency: COC **Last changed: 11/15/2012**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date 1st Crs RX COC [Std# 1270]
Date 1st Crs RX COC Flag [Std# 1271]

Default Error Message

[1016] %F1 and %F2 conflict
Date 1st Crs RX COC and Date 1st Crs RX COC Flag conflict

Additional Messages

[3264] If date is present, corresponding date flag must be blank
[3272] If Date 1st Crs RX COC is blank, corresponding Date 1st Crs RX COC Flag must = 10, 11, or 12

Description

```
General information on the inter-field editing of date and date flag fields:
The purpose of this inter-field edit is to verify that a date field and the
corresponding date flag field are in agreement. A blank flag field indicates that
the date was either filled in or intentionally not collected. Otherwise the date
flag should include a 2-digit code indicating the reason the date field is blank.

This edit requires Date 1st Crs RX COC; that is, it must always be populated OR its
corresponding flag must indicate the reason the field is blank.
1. If Date 1st Crs RX COC is populated, then Date 1st Crs RX COC Flag must be
blank.
2. If Date 1st Crs RX COC is blank, then Date 1st Crs RX COC Flag must = 10
(unknown whether treatment was administered), 11 (autopsy only case), or 12
(treatment administered but date is unknown).
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

This edit differs from the NPCR edit of the same name in that it does not allow both the date and flag fields to be blank; that is, if the date field is blank, the flag field must include a code indicating why the date is blank.

Modifications

NAACCR v13
- Edit name changed from 'Date of 1st Crs RX--COC, Date Flag (COC)' to 'Date 1st Crs RX COC , Date Flag (COC)'.
- Data item name changed from 'Date of 1st Crs RX--COC' to 'Date 1st Crs RX COC'.
- Data item name changed from 'Date of 1st Crs RX Flag' to 'Date 1st Crs RX COC Flag'.

Date 1st Crs RX COC Flag (NAACCR)

Agency: NAACCR **Last changed: 11/15/2012**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date 1st Crs RX COC Flag [Std# 1271]

Default Error Message

[3276] %F1 must be blank, 10, 11, or 12
Date 1st Crs RX COC Flag must be blank, 10, 11, or 12

Description

The Date 1st Crs RX COC Flag codes indicates why there is no appropriate value in the corresponding date field, Date 1st Crs RX COC.

Note: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates. See Flavors of Null table in its entirety which includes the NAACCR codes, HL7 codes and definitions.

Allowable codes:
10 No information whatsoever can be inferred from this exceptional value (e.g., unknown whether treatment was administered).

11 No proper value is applicable in this context (e.g., autopsy only case).

12 A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., treatment administered but date is unknown).

Blank A valid date value is provided in item Date 1st Crs RX COC, or the date was not expected to have been transmitted.

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

Modifications

NAACCR v13
- Edit name changed from 'Date of 1st Crs RX Flag (NAACCR)' to 'Date 1st Crs RX COC Flag (NAACCR)'.
- Data item name changed from 'Date of 1st Crs RX Flag' to 'Date 1st Crs RX COC Flag'.

Date 1st Crs RX COC, Date of Diagnosis (COC)

Agency: COC **Last changed: 11/15/2012**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date 1st Crs RX COC [Std# 1270]
Date of Diagnosis [Std# 390]

Default Error Message

[3332] %F1 (%V1) must be > or = %F2 (%V2)
Date 1st Crs RX COC ("value of Date 1st Crs RX COC") must be > or = Date of Diagnosis ("value of Date of Diagnosis"

Additional Messages

ERROR_TEXT("Date of 1st Crs RX--COC is invalid: %DC")
ERROR_TEXT("Date of Diagnosis is invalid: %DC")

Description

This edit is skipped if Date 1st Crs RX COC or Date of Diagnosis is blank.

Date 1st Crs RX COC must be greater than or equal to Date of Diagnosis. If both years are known, but either month is blank, then only the years are compared. If either day is blank, then only the years and months are compared.

Administrative Notes

Modifications:

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

NAACCR v13
- Edit name changed from 'Date of 1st Crs RX--COC, Date of DX (COC)' to 'Date 1st Crs RX COC, Date of Diagnosis (COC)'.
- Data item name changed from 'Date of 1st Crs RX--COC' to 'Date 1st Crs RX COC'.

Date 1st Crs RX COC, Date of Last Contact (COC)

Agency: COC **Last changed: 11/15/2012**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Last Contact [Std# 1750]
Date 1st Crs RX COC [Std# 1270]

Default Error Message

[3332] %F1 (%V1) must be > or = %F2 (%V2)
Date of Last Contact ("value of Date of Last Contact") must be > or = Date 1st Crs RX COC ("value of Date 1st Crs RX COC"

Additional Messages

ERROR_TEXT("Date of 1st Crs RX--COC is invalid: %DC")
ERROR_TEXT("Date of Last Contact is invalid: %DC")

Description

This edit is skipped if Date 1st Crs RX COC or Date of Last Contact is blank.

Date of Last Contact (also referred to as Date of Last Follow-Up or of Death) must be greater than or equal to Date 1st Crs RX COC. If both years are known, but either month is blank, then only the years are compared. If either day is blank, then only the years and months are compared.

Administrative Notes

Modifications:

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

NAACCR v13
- Edit name changed from 'Date of 1st Crs RX--COC, Date Last Contact (COC)' to 'Date 1st Crs RX COC, Date of Last Contact (COC)'.
- Data item name changed from 'Date of 1st Crs RX--COC' to 'Date 1st Crs RX COC'.

Date 1st Crs RX COC, Dates of RX (COC)

Agency: COC **Last changed: 10/08/2014**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date 1st Crs RX COC [Std# 1270]
Date 1st Crs RX COC Flag [Std# 1271]
RX Date Surgery [Std# 1200]
RX Date Surgery Flag [Std# 1201]
RX Date Radiation [Std# 1210]
RX Date Radiation Flag [Std# 1211]
RX Date Systemic [Std# 3230]
RX Date Systemic Flag [Std# 3231]
RX Date Other [Std# 1250]
RX Date Other Flag [Std# 1251]

Default Error Message

[1111] Conflict between %F1 and treatment dates
Conflict between Date 1st Crs RX COC and treatment dates

Additional Messages

ERROR_TEXT("Date of 1st Crs RX--COC: %DC")
ERROR_TEXT("RX Date Other: %DC")
ERROR_TEXT("RX Date Radiation: %DC")
ERROR_TEXT("RX Date Surgery: %DC")
ERROR_TEXT("RX Date Systemic: %DC")

Description

```
The Date 1st Crs RX COC is compared to the following treatment modality dates:
      RX Date Surgery/RX Date Surgery Flag
      RX Date Radiation/RX Date Radiation Flag
      RX Date Systemic/RX Date Systemic Flag
      RX Date Other/RX Date Other Flag

1.  The edit is skipped if any of the date/flag combinations are blank, indicating
the date was not collected:
    If Date 1st Crs RX COC and Date 1st Crs RX COC Flag are blank
    OR
    RX Date Surgery and RX Date Surgery Flag are blank
    OR
      RX Date Radiation and RX Date Radiation Flag are blank
    OR
      RX Date Systemic and RX Date Systemic Flag are blank
    OR
      RX Date Other and RX Date Other Flag are blank
```

```
2.  The edit is skipped if all four treatment modality dates indicate no treatment
or treatment planned, not yet given:
    If RX Date Surgery Flag = 11 (no surgery)
    AND
    RX Date Radiation Flag = 11 (no radiation) or 15 (planned, not yet given)
    AND
    RX Date Systemic Flag = 11 (no systemic rx) or 15 (planned, not yet given)
    AND RX Date Other Flag = 11 (none) or 15 (planned, not yet given)

3.  If any of the four treatment modality flags are not = 11 (none), then
    the Date 1st Crs RX COC Flag must not = 11 (none):
     IF RX Date Surgery Flag not = 11
       OR RX Date Radiation Flag not = 11
       OR RX Date Systemic Flag  not = 11
       OR RX Date Other Flag  not = 11
         Date 1st Crs RX COC Flag must not = 11 (none

4.  If Date 1st Crs RX COC Flag = 10 or 12 (unknown) and any of the four treatment
modality flags = 10 or 12, the edit passes.  If none of the four treatment modality
flags = 10 or 12, the edit fails:
    If Date 1st Crs RX COC Flag = 10 or 12
      AND
      (RX Date Surgery Flag = 10 or 12
       OR RX Date Radiation Flag  = 10 or 12
       OR RX Date Systemic Flag  = 10 or 12
       OR  RX Date Other Flag  = 10 or 12)
         PASS
    Otherwise
         FAIL;

5. To have gotten to this point, the Date 1st Crs RX COC must be a non-blank date.
It must equal the earliest non-blank treatment modality date.
```

Administrative Notes

Modifications:

NACR110C
07/13/06
Edit description was modified.

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

NAACCR v12B
- Corrected typo in description: change "ar" to "are"

NAACCR v13
- Edit name changed from 'Date of 1st Crs RX--COC, Dates of RX (COC)' to 'Date 1st Crs RX COC, Dates of RX (COC)'.
- Data item names changed:
  from 'Date of 1st Crs RX--COC' to 'Date 1st Crs RX COC'
  from 'Date of 1st Crs RX Flag' to 'Date 1st Crs RX COC Flag'
  from 'RX Date--Other' to 'RX Date Other'
  from 'RX Date--Other Flag' to 'RX Date Other Flag'
  from 'RX Date--Radiation' to 'RX Date Radiation'

from 'RX Date--Radiation Flag' to 'RX Date Radiation Flag'
from 'RX Date--Surgery' to 'RX Date Surgery'
from 'RX Date--Surgery Flag' to 'RX Date Surgery Flag'
from 'RX Date--Systemic' to 'RX Date Systemic'

NAACCR v15
- Added code 15 to list of RX Date Other Flag codes indicating no treatment or treatment planned, not yet given

Date Case Completed (NAACCR DATEEDIT)

Agency: NAACCR **Last changed: 09/28/2009**

Edit Sets

OfficeScan16D

Fields

Date Case Completed [Std# 2090]

Default Error Message

[1003] %F1 (%V1) is an invalid date
Date Case Completed ("value of Date Case Completed") is an invalid date

Additional Messages

ERROR_TEXT("Case Completed: %DC")

Description

```
This edit is skipped if Date Case Completed is empty.

General Date Editing Rules:
Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD).
Month and day must have leading zeros for values 01...09.

The following date formats are allowed:
CCYYMMDD    Century+Year, Month and Day are provided.
CCYYMM__    Century+Year and Month. Day consists of two blank spaces.
CCYY____    Century+Year. Month and Day consist of four blank spaces.

Dates are checked first to ensure they conform to one of these formats, then for
errors in the components. Checking stops on the first non-valid situation.

Range checking:
Lowest allowed value:  January 1, 1850 (or in D1 format: 18500101)
Highest allowed value: current system date
When month is known, it is checked to ensure it falls within range 01...12.
When month and day are known, day is checked to ensure it falls within range for
that specific month. Accommodation is made for leap years.
```

Administrative Notes

MODIFICATIONS:

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

Date Case Completed, Date of Diagnosis (NAACCR)

Agency: NAACCR **Last changed: 12/14/2009**

Edit Sets

OfficeScan16D

Fields

Date Case Completed [Std# 2090]
Date of Diagnosis [Std# 390]

Default Error Message

[3332] %F1 (%V1) must be > or = %F2 (%V2)
Date Case Completed ("value of Date Case Completed") must be > or = Date of Diagnosis ("value of Date of Diagnosis"

Additional Messages

ERROR_TEXT("Date Case Completed is invalid: %DC")
ERROR_TEXT("Date of Diagnosis is invalid: %DC")

Description

This edit is skipped if either field is blank.

Date Case Completed must be greater than or equal to Date of Diagnosis. If both years are known, but either month is blank, then only the years are compared. If either day is blank, then only the years and months are compared.

Administrative Notes

Modifications:

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

Date Case Report Exported (NAACCR DATEEDIT)

Agency: NAACCR **Last changed: 09/28/2009**

Edit Sets

OfficeScan16D

Fields

Date Case Report Exported [Std# 2110]

Default Error Message

[1003] %F1 (%V1) is an invalid date
Date Case Report Exported ("value of Date Case Report Exported") is an invalid date

Additional Messages

ERROR_TEXT("Date Case Report Exported: %DC")

Description

```
This edit is skipped if Date Case Report Exported is empty.

General Date Editing Rules:
Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD).
Month and day must have leading zeros for values 01...09.

The following date formats are allowed:
CCYYMMDD    Century+Year, Month and Day are provided.
CCYYMM__    Century+Year and Month. Day consists of two blank spaces.
CCYY____    Century+Year. Month and Day consist of four blank spaces.

Dates are checked first to ensure they conform to one of these formats, then for
errors in the components. Checking stops on the first non-valid situation.

Range checking:
Lowest allowed value:  January 1, 1850 (or in D1 format: 18500101)
Highest allowed value: current system date
When month is known, it is checked to ensure it falls within range 01...12.
When month and day are known, day is checked to ensure it falls within range for
that specific month. Accommodation is made for leap years.
```

Administrative Notes

MODIFICATIONS:

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

Date of 1st Contact (COC)

Agency: COC **Last changed: 09/28/2009**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of 1st Contact [Std# 580]

Default Error Message

[1003] %F1 (%V1) is an invalid date
Date of 1st Contact ("value of Date of 1st Contact") is an invalid date

Additional Messages

ERROR_TEXT("Date of 1st Contact: %DC")

Description

```
This edit is skipped if Date of 1st Contact is empty.

General Date Editing Rules:
Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD).
Month and day must have leading zeros for values 01...09.

The following date formats are allowed:
CCYYMMDD    Century+Year, Month and Day are provided.
CCYYMM__    Century+Year and Month. Day consists of two blank spaces.
CCYY____    Century+Year. Month and Day consist of four blank spaces.

Dates are checked first to ensure they conform to one of these formats, then for
errors in the components. Checking stops on the first non-valid situation.

Range checking:
Lowest allowed value:  January 1, 1850 (or in D1 format: 18500101)
Highest allowed value: current system date
When month is known, it is checked to ensure it falls within range 01...12.
When month and day are known, day is checked to ensure it falls within range for
that specific month. Accommodation is made for leap years.
```

Administrative Notes

MODIFICATIONS:

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

Date of 1st Contact Flag (NAACCR)

Agency: NAACCR **Last changed: 10/06/2009**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of 1st Contact Flag [Std# 581]

Default Error Message

[3265] %F1 must be blank or = 12
Date of 1st Contact Flag must be blank or = 12

Description

The Date of 1st Contact Flag explains why there is no appropriate value in the corresponding date field, Date of 1st Contact.

Note: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates. See Flavors of Null table in its entirety which includes the NAACCR codes, HL7 codes and definitions.

Allowable codes:

12 A proper value is applicable but not known. (e.g., date is unknown).

Blank A valid date value is provided in item Date of 1st Contact, or the date was not expected to have been transmitted.

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

Date of 1st Contact, Date Flag(NAACCR)

Agency: NAACCR **Last changed: 10/15/2009**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of 1st Contact [Std# 580]
Date of 1st Contact Flag [Std# 581]

Default Error Message

[1016] %F1 and %F2 conflict
Date of 1st Contact and Date of 1st Contact Flag conflict

Additional Messages

[3263] If date is blank, corresponding flag must = 12, indicating unknown date
[3264] If date is present, corresponding date flag must be blank

Description

```
General information on the inter-field editing of date and date flag fields:
The purpose of this inter-field edit is to verify that a date field and the
corresponding date flag field are in agreement. A blank flag field indicates that
the date was either filled in or intentionally not collected. Otherwise the date
flag should include a 2-digit code indicating the reason the date field is blank.

This edit requires Date of 1st Contact; that is, it must always be populated OR its
corresponding flag must indicate that the date is unknown.
1. If Date of 1st Contact is populated,then Date of 1st Contact Flag must be blank.
2. If Date of 1st Contact is blank, the Date of 1st Contact Flag must = 12,
indicating the Date of 1st Contact is unknown.
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

Date of Birth (NAACCR)

Agency: NAACCR **Last changed: 09/28/2009**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Birth [Std# 240]

Default Error Message

[3266] %F1 is an invalid date
Date of Birth is an invalid date

Additional Messages

ERROR_TEXT("Date of Birth: %DC")

Description

```
This edit is skipped if Date of Birth is empty.

General Date Editing Rules:
Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD).
Month and day must have leading zeros for values 01...09.

The following date formats are allowed:
CCYYMMDD    Century+Year, Month and Day are provided.
CCYYMM__    Century+Year and Month. Day consists of two blank spaces.
CCYY____    Century+Year. Month and Day consist of four blank spaces.

Dates are checked first to ensure they conform to one of these formats, then for
errors in the components. Checking stops on the first non-valid situation.

Range checking:
Lowest allowed value:  January 1, 1850 (or in D1 format: 18500101)
Highest allowed value: current system date
When month is known, it is checked to ensure it falls within range 01...12.
When month and day are known, day is checked to ensure it falls within range for
that specific month. Accommodation is made for leap years.
```

Administrative Notes

MODIFICATIONS:

NAACCR v12.0
- Edit name changed from "Birth Date (NAACCR DATEEDIT)" to "Date of Birth (NAACCR)" because data item "Birth Date" changed to "Date of Birth"
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

Date of Birth Flag (NAACCR)

Agency: NAACCR **Last changed: 10/06/2009**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Birth Flag [Std# 241]

Default Error Message

[3265] %F1 must be blank or = 12
Date of Birth Flag must be blank or = 12

Description

The Date of Birth Flag explains why there is no appropriate value in the corresponding date field, Date of Birth.

Note: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates. See Flavors of Null table in its entirety which includes the NAACCR codes, HL7 codes and definitions.

Allowable codes:

12 A proper value is applicable but not known. (e.g., date of birth is unknown).

Blank A valid date value is provided in item Date of Birth, or the date was not expected to have been transmitted.

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

Date of Birth, Date Flag (NAACCR)

Agency: NAACCR **Last changed: 05/28/2010**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Birth [Std# 240]
Date of Birth Flag [Std# 241]

Default Error Message

[1016] %F1 and %F2 conflict
Date of Birth and Date of Birth Flag conflict

Additional Messages

[3263] If date is blank, corresponding flag must = 12, indicating unknown date
[3264] If date is present, corresponding date flag must be blank

Description

```
General information on the inter-field editing of date and date flag fields:
The purpose of this inter-field edit is to verify that a date field and the
corresponding date flag field are in agreement. A blank flag field indicates that
the date was either filled in or intentionally not collected. Otherwise the date
flag should include a 2-digit code indicating the reason the date field is blank.

This edit requires Date of Birth; that is, it must always be populated OR its
corresponding flag must indicate that the date is unknown.
1. If Date of Birth is populated,then Date of Birth Flag must be blank.
2. If Date of Birth is blank, the Date of Birth Flag must = 12, indicating the date
of birth is unknown.
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

In the SEER*Edits software, the title of this edit is: IF225

Date of Birth, Date of Diagnosis (NAACCR IF47)

Agency: NAACCR **Last changed: 01/13/2010**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Birth [Std# 240]
Date of Diagnosis [Std# 390]
Over-ride Age/Site/Morph [Std# 1990]

Default Error Message

[1013] %F1 must not be later than %F2
Date of Birth must not be later than Date of Diagnosis

Additional Messages

ERROR_TEXT("Date of Birth is invalid: %DC")
ERROR_TEXT("Date of Diagnosis is invalid: %DC")
ERROR_TEXT("Please Review: Date of Birth cannot be more than 7 months after Diagnosis")
ERROR_TEXT("Please Review: Set over-ride to 2 or 3 if case diagnosed in utero")

Description

```
This edit verifies that Birth Date is not later than Date of Diagnosis unless the
case was diagnosed in utero.

Otherwise, Birth Date must not be later than Date of Diagnosis.  If either
year is blank (unknown), the edit is skipped.  If either month is blank, then only
the years are compared.  If either day is blank, then only the years and months are
compared.

If Birth Date is later than Date of Diagnosis, the difference in months is
calculated.  If the difference is no more than 7 full months AND the Over-ride
Age/Site/Morph code is 2 or 3, no further checking is done.(Over-ride
Age/Site/Morph may be set to 2 or 3 to indicate a case has been diagnosed in
utero.)
Note:
  Codes '2' and '3' have been added to the list of Over-ride Age/Site/Morph
  codes in the NAACCR v11.3 metafile. The code definitions are:
  1 = Reviewed: An unusual occurrence of a particular age/site/histology
      combination for a given age group has been reviewed
  2 = Reviewed: Case was diagnosed in utero.
  3 = Reviewed: Conditions 1 and 2 above both apply
  Blank = Not reviewed or reviewed and corrected
```

Administrative Notes

NAACCR v11.3
6/2008
If the Over-ride Age/Site/Morph code is 2 or 3, the edit is skipped.
(Over-ride Age/Site/Morph may be set to 2 or 3 to indicate a case has been diagnosed in utero.)
Note:

Over-ride Age/Site/Morph codes:
1 = Reviewed: An unusual occurrence of a particular age/site/histology combination for a given age group has been reviewed
2 = Reviewed: Case was diagnosed in utero.
3 = Reviewed: Conditions 1 and 2 above both apply
Blank = Not reviewed or reviewed and corrected

NAACCR v11.3A
1/2009
- Modified to check: If Birth Date is later than Date of Diagnosis, the difference in months is calculated. If the difference is no more than 7 full months AND the Over-ride Age/Site/Morph code is 2 or 3, no further checking is done.(Over-ride Age/Site/Morph may be set to 2 or 3 to indicate a case has been diagnosed in utero.)

NAACCR v12.0
- Edit name changed from 'Birth Date, Date of Diagnosis (NAACCR IF47)' to 'Date of Birth, Date of Diagnosis (NAACCR IF47)'.
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

Date of Diagnosis (NAACCR DATEEDIT)

Agency: NAACCR **Last changed: 09/28/2009**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]

Default Error Message

[1003] %F1 (%V1) is an invalid date
Date of Diagnosis ("value of Date of Diagnosis") is an invalid date

Additional Messages

ERROR_TEXT("Date of Diagnosis: %DC")

Description

```
This edit is skipped if Date of Diagnosis is empty.

General Date Editing Rules:
Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD).
Month and day must have leading zeros for values 01...09.

The following date formats are allowed:
CCYYMMDD    Century+Year, Month and Day are provided.
CCYYMM__    Century+Year and Month. Day consists of two blank spaces.
CCYY____    Century+Year. Month and Day consist of four blank spaces.

Dates are checked first to ensure they conform to one of these formats, then for
errors in the components. Checking stops on the first non-valid situation.

Range checking:
Lowest allowed value:  January 1, 1850 (or in D1 format: 18500101)
Highest allowed value: current system date
When month is known, it is checked to ensure it falls within range 01...12.
When month and day are known, day is checked to ensure it falls within range for
that specific month. Accommodation is made for leap years.
```

Administrative Notes

MODIFICATIONS:

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

Date of Diagnosis Flag (NAACCR)

Agency: NAACCR **Last changed: 10/06/2009**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis Flag [Std# 391]

Default Error Message

[3265] %F1 must be blank or = 12
Date of Diagnosis Flag must be blank or = 12

Description

The Date of Diagnosis Flag explains why there is no appropriate value in the corresponding date field, Date of Diagnosis.

Note: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates. See Flavors of Null table in its entirety which includes the NAACCR codes, HL7 codes and definitions.

Allowable codes:

12 A proper value is applicable but not known. (e.g., date of diagnosis is unknown).

Blank A valid date value is provided in item Date of Diagnosis, or the date was not expected to have been transmitted.

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

Date of Diagnosis, Date Flag (NAACCR)

Agency: NAACCR **Last changed: 05/28/2010**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
Date of Diagnosis Flag [Std# 391]

Default Error Message

[1016] %F1 and %F2 conflict
Date of Diagnosis and Date of Diagnosis Flag conflict

Additional Messages

[3263] If date is blank, corresponding flag must = 12, indicating unknown date
[3264] If date is present, corresponding date flag must be blank

Description

```
General information on the inter-field editing of date and date flag fields:
The purpose of this inter-field edit is to verify that a date field and the
corresponding date flag field are in agreement. A blank flag field indicates that
the date was either filled in or intentionally not collected. Otherwise the date
flag should include a 2-digit code indicating the reason the date field is blank.

This edit requires Date of Diagnosis; that is, it must always be populated OR its
corresponding flag must indicate the date is unknown.
1. If Date of Diagnosis is populated (not blank), then Date of Diagnosis Flag must
be blank.
2. If Date of Diagnosis is blank, the Date of Diagnosis Flag must = 12, indicating
the date of diagnosis is unknown.
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

In the SEER*Edits software, the title of this edit is: IF221

Date of Last Contact (NAACCR DATEEDIT)

Agency: NAACCR **Last changed: 09/28/2009**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Last Contact [Std# 1750]

Default Error Message

[1003] %F1 (%V1) is an invalid date
Date of Last Contact ("value of Date of Last Contact") is an invalid date

Additional Messages

ERROR_TEXT("Date of Last Contact: %DC")

Description

```
This edit is skipped if Date of Last Contact is empty.

General Date Editing Rules:
Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD).
Month and day must have leading zeros for values 01...09.

The following date formats are allowed:
CCYYMMDD    Century+Year, Month and Day are provided.
CCYYMM__    Century+Year and Month. Day consists of two blank spaces.
CCYY____    Century+Year. Month and Day consist of four blank spaces.

Dates are checked first to ensure they conform to one of these formats, then for
errors in the components. Checking stops on the first non-valid situation.

Range checking:
Lowest allowed value:  January 1, 1850 (or in D1 format: 18500101)
Highest allowed value: current system date
When month is known, it is checked to ensure it falls within range 01...12.
When month and day are known, day is checked to ensure it falls within range for
that specific month. Accommodation is made for leap years.
```

Administrative Notes

MODIFICATIONS:

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

Date of Last Contact Flag (NAACCR)

Agency: NAACCR **Last changed: 10/06/2009**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Last Contact Flag [Std# 1751]

Default Error Message

[3265] %F1 must be blank or = 12
Date of Last Contact Flag must be blank or = 12

Description

The Date of Last Contact Flag explains why there is no appropriate value in the corresponding date field, Date of Last Contact.

Note: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates. See Flavors of Null table in its entirety which includes the NAACCR codes, HL7 codes and definitions.

Allowable codes:

12 A proper value is applicable but not known. (e.g., date is unknown).

Blank A valid date value is provided in item Date of Last Contact, or the date was not expected to have been transmitted.

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

Date of Last Contact, Date Flag(NAACCR)

Agency: NAACCR **Last changed: 05/28/2010**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Last Contact [Std# 1750]
Date of Last Contact Flag [Std# 1751]

Default Error Message

[1016] %F1 and %F2 conflict
Date of Last Contact and Date of Last Contact Flag conflict

Additional Messages

[3263] If date is blank, corresponding flag must = 12, indicating unknown date
[3264] If date is present, corresponding date flag must be blank

Description

```
General information on the inter-field editing of date and date flag fields:
The purpose of this inter-field edit is to verify that a date field and the
corresponding date flag field are in agreement. A blank flag field indicates that
the date was either filled in or intentionally not collected. Otherwise the date
flag should include a 2-digit code indicating the reason the date field is blank.

This edit requires Date of Last Contact; that is, it must always be populated OR
its corresponding flag must indicate that the date is unknown.
1. If Date of Last Contact is populated,then Date of Last Contact Flag must be
blank.
2. If Date of Last Contact is blank, the Date of Last Contact Flag must = 12,
indicating the Date of Last Contact is unknown.
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

In the SEER*Edits software, the title of this edit is: IF223

Date of Last Contact, Date of Diag. (NAACCR IF19)

Agency: NAACCR **Last changed: 03/30/2010**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Last Contact [Std# 1750]
Date of Diagnosis [Std# 390]

Default Error Message

[3332] %F1 (%V1) must be > or = %F2 (%V2)
Date of Last Contact ("value of Date of Last Contact") must be > or = Date of Diagnosis ("value of Date of Diagnosis"

Description

This edit is skipped if Date of Last Contact or Date of Diagnosis is blank.

Date of Last Contact must be greater than or equal to Date of Diagnosis. If both years are known, but either month is blank, then only the years are compared. If either day is blank, then only the years and months are compared.

Administrative Notes

Modifications:

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

Diagnostic Confirmation (SEER DXCONF)

Agency: SEER **Last changed: 12/02/2009**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Diagnostic Confirmation [Std# 490]

Default Error Message

[275] Diagnostic Confirmation not valid
Diagnostic Confirmation not valid

Description

```
Must be a valid Diagnostic Confirmation code (1-9).

Microscopically confirmed
1  Positive histology
2  Positive cytology, no positive histology
3  Positive histology PLUS
     Positive immunophenotyping AND/OR
     Positive genetic studies
4  Positive microscopic confirmation, method not specified

Not microscopically confirmed
5  Positive laboratory test/marker study
6  Direct visualization without microscopic confirmation
7  Radiography and other imaging techniques without microscopic confirmation
8  Clinical diagnosis only (other than 5, 6, or 7)
9  Unknown whether or not microscopically confirmed
```

Administrative Notes

Modifications:

NAACCR v12.0
- Added code 3 (positive histology PLUS positive immunophenotyping AND/OR positive genetic studies)

Diagnostic Confirmation, Behavior ICDO3(SEER IF31)

Agency: SEER **Last changed: 06/27/2008**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Over-ride Histology [Std# 2040]
Diagnostic Confirmation [Std# 490]
Behavior Code ICD-O-3 [Std# 523]

Default Error Message

[511] Behavior & Dx_conf conflict - ICDO3
Behavior & Dx_conf conflict - ICDO3

Description

This edit is skipped if Behavior Code ICD-O-3 is blank. If a case has been previously reviewed and accepted as coded (Over-ride-Histology = 2 or 3), no further checking is done.

For in situ cases (Behavior Code ICD-O-3 = 2), Diagnostic Confirmation must specify microscopic confirmation (1, 2 or 4).

Additional Information:

The distinction between in situ and invasive is very important to a registry, since prognosis is so different, and in situ cases are usually excluded from incidence rate calculations. Since the determination that a neoplasm has not invaded surrounding tissue, i.e., is in situ, is made via the microscope, cases coded in situ in behavior should have a microscopic confirmation code. However, very rarely, a physician will designate a case noninvasive or in situ without microscopic evidence.

Check that Behavior Code and Diagnostic Confirmation have been coded correctly. Check carefully for any cytologic or histologic evidence that may have been missed in coding. Correction of errors may require inspection of the abstracted text, either online or as recorded on a paper abstract. Review of the original medical record may also be required.

If upon review all items are correct as coded, an over-ride flag may be set so that the case will not be considered in error when the edit is run again. Set the Over-ride--Histology field to 2 (or 3, if the flag is also being set for the Morphology -Type/Behavior (SEER MORPH) edit).

Administrative Notes

In the SEER*Edits software, the title of this edit is: IF31_3

Note: The COC version of this edit has been deleted since it, over time, has become equivalent to the SEER version of the edit. Edit sets in this metafile using the COC version have been updated to use the SEER version instead.

Modifications:

NAACCR v11.3
6/2008
Updated Administrative Notes with the title of the corresponding edit in the SEER*Edits software.

Diagnostic Confirmation, Histology ICDO3(SEER IF48

Agency: SEER **Last changed: 05/12/2010**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Diagnostic Confirmation [Std# 490]
Histologic Type ICD-O-3 [Std# 522]
Over-ride Leuk, Lymphoma [Std# 2070]

Default Error Message

[3312] %F1 (%V1) and %F2 (%V2) conflict
Diagnostic Confirmation ("value of Diagnostic Confirmation") and Histologic Type ICD-O-3 ("value of Histologic Type ICD-O-3") conflict

Description

This edit is skipped if Histologic Type ICD-O-3 is blank.

If a case has been previously reviewed and accepted as coded (Over-ride Leuk, Lymphoma = 1), no further checking is done.

If Histologic Type ICD-O-3 = 9590 - 9992 (lymphoma and leukemia) then Diagnostic Confirmation cannot be 6 (direct visualization).

If Diagnostic Confirmation is 3 (positive histology PLUS positive immunophenotyping AND/OR positive genetic studies), then Histologic Type ICD-O-3 must = 9590-9992.

Additional Information:

Since lymphoma and leukemia are almost exclusively microscopic diagnoses, this edit forces review of any cases of lymphoma or leukemia that have diagnostic confirmation 6 (direct visualization).

Check that the Histologic Type and Diagnostic Confirmation are correctly coded. Remember that positive hematologic findings and bone marrow specimens are included as histologic confirmation (code 1 in Diagnostic Confirmation) for leukemias. Correction of errors may require inspection of the abstracted text, either online or as recorded on a paper abstract.

If upon review, all items are correct as coded, an over-ride flag may be set so that the case will not be considered in error when the edit is run again. Enter a 1 in the field Over-ride Leuk,Lymphoma to indicate that the coding is correct.

EXAMPLE

```
HISTOLOGIC TYPE          9835/3
DIAGNOSTIC CONFIRMATION  6 (DIRECT VISUALIZATION)
```

On review, this leukemia diagnosis was based on a hematologic study, CBC. Correct the Diagnostic Confirmation code to 1 (Positive Histology).

Administrative Notes

In the SEER*Edits software, the title of this edit is: IF48_3

Note: The COC version of this edit has been deleted since it, over time, has become equivalent to the SEER version of the edit. Edit sets in this metafile using the COC version have been updated to use the SEER version instead.

Modifications:

NAACCR v11.3
6/2008
Updated Administrative Notes with the title of the corresponding edit in the SEER*Edits software.

NAACCR v12.0
- Added:
If Diagnostic Confirmation is 3 (positive histology PLUS positive immunophenotyping AND/OR positive genetic studies), then Histologic Type ICD-O-3 must = 9590-9992.
- Deleted logic that stated Diagnostic Confirmation cannot be 8 (clinical) for lymphoma
- Changed the range of histologies that cannot have Diagnostic Confirmation 6 (direct visualization) from "9590-9729, 9731-9948" to "9590-9992".

Follow-Up Source (COC)

Agency: COC **Last changed: 04/12/2007**

Edit Sets

HospitalScan16D

Fields

Follow-Up Source [Std# 1790]

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of Follow-Up Source" is not a valid value for Follow-Up Source

Description

Must be a valid Follow-Up Source code (0-5, 7-9). May be blank.

Administrative Notes

This edit differs from the NAACCR edit of the same name in that it allows the field to be blank because the item was not required by the COC until 2003. Another edit (Follow-Up Source, Date of Diagnosis) verifies that this item is not blank if the year of Date of Diagnosis is greater than 2002 and not equal 9999. Registries should include both edits in their edit set.

Grade (COC)

Agency: COC **Last changed: 07/24/1999**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Grade [Std# 440]

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of Grade" is not a valid value for Grade

Description

Must be a valid code for Grade (1-9).

Hist/Behav ICDO2, Hist/Behav ICDO3 (SEER IF126)

Agency: SEER **Last changed: 06/27/2008**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Morph--Type&Behav ICD-O-2 [Std# 419]
Morph--Type&Behav ICD-O-3 [Std# 521]

Default Error Message

[1115] %F1 and %F2 cannot both be blank
Morph--Type&Behav ICD-O-2 and Morph--Type&Behav ICD-O-3 cannot both be blank

Additional Messages

[3158] Histology (92-00) ICD-O-2/Behavior (92-00) ICD-O-2 conflict
[3159] Histologic Type ICD-O-3/Behavior Code ICD-O-3 conflict

Description

```
This edit checks the following:

1. Morph--Type&Behav ICD-O-2 and Morph--Type&Behav ICD-O-3 cannot both be blank.
2. If Histology (92-00) ICD-O-2 is not blank, then Behavior (92-00)ICD-O-2 must not
be blank and vice versa.
3. If Histologic Type ICD-O-3 is not blank, then Behavior Code ICD-O-3 must not be
blank and vice versa.
```

Administrative Notes

In the SEER*Edits software, the title of this edit is: IF126

Modifications:

NAACCR v11.3
6/2008
Updated Administrative Notes with the title of the corresponding edit in the SEER*Edits software.

Histologic Type ICDO2 (COC)

Agency: COC **Last changed: 09/03/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Histology (92-00) ICD-O-2 [Std# 420]

Tables

HISICDO2.DBF

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of Histology (92-00) ICD-O-2" is not a valid value for Histology (92-00) ICD-O-2

Description

This field is allowed to be blank because the item was not required after 2000. Another edit (Histology ICD02, Date DX, Date 1st Contact) verifies that this item is not blank if the year of Date of Diagnosis (or, if Date of Diagnosis is unknown, Date of 1st Contact),is less than 2001. Registries should include both edits in their edit set.

Must be a valid Histology (92-00) ICD-O-2 code (8000-9989). A table lookup verifies that the code is included in the International Classification of Diseases for Oncology, Second Edition (ICD-O-2).

Administrative Notes

Modifications

NAACCR v13A
- Edit updated so that it does a table lookup.
  Previous version performed a range check only and another edit [Morphology--Type/Behavior (SEER MORPH)] included the table lookup to verify that Histology (92-00) ICD-O-2 is a valid ICD-O-2 code. Both edits now include the table lookup.

NAACCR v15A
- Edit logic rewritten to use HISICD02.DBF (Histology ICD-O-2) instead of MORPH.BIN.

Histologic Type ICDO3 (SEER)

Agency: SEER **Last changed: 09/03/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Histologic Type ICD-O-3 [Std# 522]

Tables

HISICDO3.DBF

Default Error Message

[501] Histologic Type not valid - ICDO3
Histologic Type not valid - ICDO3

Description

Histologic Type ICD-O-3 must be a valid ICDO-O-3 histology code or blank.

Administrative Notes

Modifications:

NAACCR v15A
- Edit logic rewritten to look in HISICDO3.DBF (Histology ICD-O-3), instead of in MORPH01.BIN.

Histologic Type ICD-O-3, Behavior, Grade (SEER)

Agency: SEER **Last changed: 05/13/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
Grade [Std# 440]

Default Error Message

[501] Histologic Type not valid - ICDO3
Histologic Type not valid - ICDO3

Additional Messages

[3518] Grades 5-8 allowed only for histologies 9590-9992
[3519] This histology ("value of Histologic Type ICD-O-3") carries an implied grade of 1
[3520] This histology ("value of Histologic Type ICD-O-3") carries an implied grade of 2
[3521] This histology ("value of Histologic Type ICD-O-3") carries an implied grade of 4

Description

```
This edit is skipped if any of the following conditions are true:
1. Histologic Type ICD-O-3 is blank
2. Behavior Code ICD-O-3 is blank
3. Grade is blank

1. The following histology/grade combinations are impossible:
    Grades 5-8 with histologies not in the range 9590-9992

2. Some terms in ICD-O-3 carry an implied statement of grade.
   These histologies must be reported with the correct grade
   as stated below in format of histology/behavior & grade:

            8020/34     Carcinoma, undifferentiated
            8021/34     Carcinoma, anaplastic
            8331/31     Follicular adenocarcinoma, well differentiated
            9082/34     Malignant teratoma, undifferentiated
            9083/32     Malignant teratoma, intermediate type
            9401/34     Astrocytoma, anaplastic
            9451/34     Oligodendroglioma, anaplastic
            9511/31     Retinoblastoma, differentiated
            9512/34     Retinoblastoma, undifferentiated
```

Administrative Notes

New edit - added to NAACCR v13A metafile.
- This edit was split out from original edit Morphology--Type/Behavior ICDO3 (SEER MORPH)

In the SEER*Edits software, the title of this edit is: MorphICDO3_P3

Histology ICDO2, Histology ICDO3 (SEER IF94)

Agency: SEER **Last changed: 06/27/2008**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Histology (92-00) ICD-O-2 [Std# 420]
Histologic Type ICD-O-3 [Std# 522]

Default Error Message

[1115] %F1 and %F2 cannot both be blank
Histology (92-00) ICD-O-2 and Histologic Type ICD-O-3 cannot both be blank

Description

```
Histology (92-00) ICD-O-2 and Histologic Type ICD-O-3 cannot both be blank.
```

Administrative Notes

In the SEER*Edits software, the title of this edit is: IF94

Modifications:

NAACCR v11.3
6/2008
Updated Administrative Notes with the title of the corresponding edit in the SEER*Edits software.

Histology ICDO3, Date DX, Date 1st Cont (NAACCR)

Agency: NAACCR **Last changed: 12/24/2009**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Histologic Type ICD-O-3 [Std# 522]
Date of Diagnosis [Std# 390]
Date of 1st Contact [Std# 580]

Default Error Message

[1019] %F1 must not be blank
Histologic Type ICD-O-3 must not be blank

Additional Messages

[1144] If Date of Diagnosis > 2000, Histologic Type ICD-O-3 cannot be blank
[1145] If Date of Diagnosis is unknown and Date of 1st Contact > 2000, then Histologic Type ICD-O-3 cannot be blank
ERROR_TEXT("Date of 1st Contact: %DC")
ERROR_TEXT("Date of Diagnosis: %DC")

Description

If year of Date of Diagnosis is greater than 2000, then Histologic Type ICD-O-3 cannot be blank. However, if the Date of Diagnosis is blank (unknown), then the of Date of 1st Contact is checked. If the year of Date of 1st Contact is greater than 2000, then Histologic Type ICD-O-3 cannot be blank.

Administrative Notes

Modifications:

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

Histology ICDO3, Grade, Date of DX (SEER)

Agency: SEER **Last changed: 06/14/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Histologic Type ICD-O-3 [Std# 522]
Grade [Std# 440]
Date of Diagnosis [Std# 390]

Default Error Message

[3424] %F2 [%V2] must be 5 when %F1 = %V1
Grade ["value of Grade"] must be 5 when Histologic Type ICD-O-3 = "value of Histologic Type ICD-O-3"

Additional Messages

[3425] Grade ["value of Grade"] must be 6 when Histologic Type ICD-O-3 = "value of Histologic Type ICD-O-3"
[3426] Grade ["value of Grade"] must be 8 when Histologic Type ICD-O-3 = "value of Histologic Type ICD-O-3"
[3427] Grade ["value of Grade"] must be 9 when Histologic Type ICD-O-3 = "value of Histologic Type ICD-O-3"
[3508] Grade ["value of Grade"] must be 5, 8, or 9 when Histologic Type ICD-O-3 = "value of Histologic Type ICD-O-3"
[4239] Grade ["value of Grade"] must not = 1-4 when Histologic Type ICD-O-3 = "value of Histologic Type ICD-O-3"
[4344] Grade ["value of Grade"] must be 5 or 6 when Histologic Type ICD-O-3 = "value of Histologic Type ICD-O-3"

Description

```
This edit validates the coding of grade by histology based on the Hematopoietic and
Lymphoid Neoplasm Coding Manual and applies to cases diagnosed 2010 or later.

Sources:
- Hematopoietic and Lymphoid Neoplasm Database & Coding Manual (Appendix E)
- 2015 Implementation Guidelines and Recommendations (Appendix B)

This edit is skipped if any of the following conditions are true:
1. Date of Diagnosis is blank or invalid
2. Year of Date of Diagnosis is less than 2010
3. Grade is blank
4. Histologic Type ICD-O-3 is blank

Source: Hematopoietic and Lymphoid Neoplasm Coding Manual, Rule G2
Grade must be 5 for the following Histologic Type ICD-O-3 codes:
  9700, 9701, 9702, 9705, 9708, 9709, 9716, 9717, 9718, 9724,
  9725, 9726, 9827, 9834, 9837

Source: Hematopoietic and Lymphoid Neoplasm Coding Manual, Rule G3
Grade must be 6 for the following Histologic Type ICD-O-3 codes:
```

```
  9591, 9596, 9597, 9659, 9671, 9673, 9678, 9679, 9680,
  9687, 9688, 9689, 9690, 9691, 9695, 9698, 9699, 9712,
  9731, 9732, 9734, 9737, 9738, 9761, 9762, 9811, 9812, 9813, 9814,
  9815, 9816, 9817, 9818, 9823, 9826, 9833, 9940

Source: Hematopoietic and Lymphoid Neoplasm Coding Manual, Rule G2
Grade must be 5 or 6 for the following Histologic Type ICD-O-3 codes:
  9714

Source: Hematopoietic and Lymphoid Neoplasm Coding Manual, Rule G4
Grade must be 8 for the following Histologic Type ICD-O-3 codes:
  9719, 9948

Source: Hematopoietic and Lymphoid Neoplasm Coding Manual, Rule G1
Grade must be 9 for the following Histologic Type ICD-O-3 codes:
  9740, 9741, 9742, 9751, 9755, 9756, 9757, 9758, 9759, 9801,
  9806, 9807, 9808, 9809, 9875, 9876, 9945, 9946, 9950, 9961,
  9962, 9963, 9964, 9975, 9980, 9982, 9983, 9985, 9986, 9989,
  9991, 9992

Grade must be 5, 8, or 9 for the following Histologic Type ICD-O-3 code:
9831

Source: Hematopoietic and Lymphoid Neoplasm Database
Grade must not = 1-4 for the following Histologic Type ICD-O-3 codes:
9590, 9650, 9651, 9652, 9653, 9655, 9663, 9727, 9735, 9800, 9820, 9832, 9840, 9860,
9861, 9863, 9865-9867, 9869, 9870-9874, 9891, 9895-9898, 9910, 9911, 9920, 9930,
9931, 9965, 9966, 9967, 9971
```

Administrative Notes

New edit - added to NAACCR v12.1A metafile.

In the SEER*Edits software, the title of this edit is: IF380

Modifications:

NAACCR v12.2
- Modified to allow grades 5, 8, and 9 for 9831 instead of just grade 5.

NAACCR v13
- Modified for cases diagnosed 2012 and later:
  - grade must = 6 for 9826
  - grade must = 9 for 9756

NAACCR v15
- Histology code 9714 added as code that must be coded to grade 5 or 6 for diagnosis year 2010 and later
- Histology codes 9659 and 9761 added to list of codes that must be coded to grade 6 for diagnosis year 2010 and later
- Histology codes 9670, 9728, and 9836 removed from list of codes that must be coded to grade 6 for diagnosis year 2010 and later; these codes are obsolete
- Diagnosis year for which histology code 9826 must be coded to grade 6 changed from '2012 and later' to '2010 and later'

- Diagnosis year for which histology code 9756 must be coded to grade 9 changed from '2012 and later' to '2010 and later'
- Histology code 9805 removed from the list of codes that must be coded to grade 9 for diagnosis year 2010 and later; 9805 is obsolete and will be flagged as an error in another edit
- Added list of histologies for which grade must not be 1-4

Laterality (SEER LATERAL)

Agency: SEER **Last changed: 04/08/2009**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Laterality [Std# 410]

Default Error Message

[272] Laterality not valid
Laterality not valid

Description

Must be a valid Laterality code (0-5, 9).

Administrative Notes

Modifications

NAACCR v12
4/2009
- Code 5 (Paired site: midline tumor) added

Laterality, Primary Site (COC)

Agency: COC **Last changed: 06/10/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Laterality [Std# 410]
Primary Site [Std# 400]
Date of Diagnosis [Std# 390]

Default Error Message

[3312] %F1 (%V1) and %F2 (%V2) conflict
Laterality ("value of Laterality") and Primary Site ("value of Primary Site") conflict

Additional Messages

ERROR_TEXT("Date of Diagnosis: %DC")

Description

```
The following paired organ sites must have a code other than zero for laterality:

    C079      Parotid gland
    C080      Submandibular gland
    C081      Sublingual gland
    C090      Tonsillar fossa
    C091      Tonsillar pillar
    CO98-C099 Tonsil, NOS
    C301      Middle ear
    C310      Maxillary sinus
    C312      Frontal sinus
    C341-C349 Lung
    C384      Pleura
    C400      Long bones of upper limb, scapula and associated joints
    C401      Short bones of upper limb and associated joints
    C402      Long bones of lower limb and associated joints
    C403      Short bones of lower limb and associated joint
    C441      Skin of eyelid
    C442      Skin of external ear
    C443      Skin of other and unspecified parts of face
              (midline code `9' for pre-2010, code '5' for 2010+;
              code '5' may also be used for pre-2010 cases)
    C445      Skin of trunk (midline code `9' for pre-2010,
                         code '5' for 2010+; code '5' may also be used
              for pre-2010 cases)
    C446      Skin of upper limb and shoulder
    C447      Skin of lower limb and hip
    C471      Peripheral nerves and autonomic nervous system of upper
              limb and shoulder
    C472      Peripheral nerves and autonomic nervous system of lower
              limb and hip
    C491      Connective, subcutaneous, and other soft tissues of upper
              limb and shoulder
```

```
C492      Connective, subcutaneous, and other soft tissues of lower
          limb and hip
C500-C509 Breast
C569      Ovary
C570      Fallopian tube
C620-C629 Testis
C630      Epididymis
C631      Spermatic cord
C649      Kidney, NOS
C659      Renal pelvis
C669      Ureter
C690-C699 Eye
C740-C749 Adrenal gland
C754      Carotid body
```

If the year of Date of Diagnosis is greater than 2003 and not blank, then the following CNS Primary Sites must have a code other than zero for laterality:

```
C700      Cerebral meninges, NOS
C710      Cerebrum
C711      Frontal lobe
C712      Temporal lobe
C713      Parietal lobe
C714      Occipital lobe
C722      Olfactory nerve
C723      Optic nerve
C724      Acoustic nerve
C725      Cranial nerve, NOS
```

Administrative Notes

This edit differs from the SEER edit "Laterality, Primary Site,
Date of Diag (SEER IF24)" in that:
1. Except for the CNS sites, it does not use the Date of Diagnosis when requiring a laterality code other than zero for paired organ sites.
2. Laterality code 5 (Paired site: midline tumor) is allowed for all years of diagnosis.

Modifications:

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.
- Deleted logic requiring non-paired sites with diagnosis dates 2003+ to be coded with Laterality of 0; that is, non-paired sites may now be coded with laterality. This is true for all years of diagnosis.
- Edit is no longer skipped if Primary Site = C300, C340, C413, or C414.

NAACCR version of this edit will be deleted.

NAACCR v15A
- Description updated to specify use of code '5' (midline) for C443 and C445; logic is correct as is

Laterality, Primary Site, Morph ICDO3 (SEER IF42)

Agency: SEER **Last changed: 12/29/2009**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Laterality [Std# 410]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
Date of Diagnosis [Std# 390]
Over-ride Site/Lat/Morph [Std# 2074]

Tables

PAIRORGN.DBF

Default Error Message

[517] Lateral, Site, Behavior conflict - ICDO3
Lateral, Site, Behavior conflict - ICDO3

Additional Messages

ERROR_TEXT("Date of Diagnosis: %DC")

Description

```
This edit is skipped if any of the following is true:
1. Histologic Type ICD-O-3 is empty
2. Histologic Type ICD-O-3 >= 9590
3. Diagnosis year is greater than 1987 or is blank, and Histologic Type ICD-O-3 =
9140
4. Over-ride Site/Lat/Morph field contains a '1'(review complete)

If the Primary Site is a paired organ (see lists below) and the Behavior Code ICD-
O-3 is in situ (`2'), then Laterality must be `1', `2', '3', or `5', meaning right:
origin of primary; left: origin of primary; or only one side involved, right or
left origin unspecified; paired site: midline tumor.

For all diagnosis years the following are considered paired organ sites for
purposes of this edit:

    C079      Parotid gland
    C080      Submandibular gland
    C091      Tonsillar pillar
    C098-C099 Tonsil, NOS
    C301      Middle ear
    C310      Maxillary sinus
    C312      Frontal sinus
    C341-C349 Lung
    C384      Pleura
    C500-C509 Breast
```

```
    C569      Ovary
    C570      Fallopian tube
    C620-C629 Testis
    C630      Epididymis
    C631      Spermatic cord
    C649      Kidney, NOS
    C659      Renal pelvis
    C669      Ureter
    C690-C699 Eye
    C740-C749 Adrenal gland
    C754      Carotid body

For cases diagnosed after 1978 or if diagnosis date is blank, the following are
also considered paired organ sites for purposes of this edit:

    C081      Sublingual gland
    C090      Tonsillar fossa
    C400      Long bones of upper limb, scapula and associated joints
    C401      Short bones of upper limb and associated joints
    C402      Long bones of lower limb and associated joints
    C403      Short bones of lower limb and associated joints
    C441      Skin of eyelid
    C442      Skin of external ear
    C446      Skin of upper limb and shoulder
    C447      Skin of lower limb and hip
    C471      Peripheral nerves and autonomic nervous system of upper
              limb and shoulder
    C472      Peripheral nerves and autonomic nervous system of lower
              limb and hip
    C491      Connective, subcutaneous, and other soft tissues of upper
              limb and shoulder
    C492      Connective, subcutaneous, and other soft tissues of lower
              limb and hip
```

Administrative Notes

In the SEER*Edits software, the title of this edit is: IF42_3

Modifications:

NAACCR v11.3
6/2008
Updated Administrative Notes with the title of the corresponding edit in the SEER*Edits software.

NAACCR v12
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.
- Modified to include laterality code 5 (paired site: midline tumor).

Lymph-vascular Invasion (CS)

Agency: CS **Last changed: 11/22/2009**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Lymph-vascular Invasion [Std# 1182]

Default Error Message

[3311] %F1 (%V1) is invalid
Lymph-vascular Invasion ("value of Lymph-vascular Invasion") is invalid

Description

Must be a valid Lymph-vascular Invasion code: 0 (lymph-vascular invasion not present/not identified), 1 (lymph-vascular invasion present/identified), 8 (not applicable), 9 (unknown if lymph-vascular invasion present), or blank.

Administrative Notes

New edit - added to NAACCR v12 metafile.

Lymph-vascular Invasion, Histology, Behav (CS)

Agency: CS **Last changed: 07/10/2014**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Histologic Type ICD-O-3 [Std# 522]
Lymph-vascular Invasion [Std# 1182]
Behavior Code ICD-O-3 [Std# 523]

Default Error Message

[4042] If %F1 = 9590-9992, %F2 must = 8
If Histologic Type ICD-O-3 = 9590-9992, Lymph-vascular Invasion must = 8

Additional Messages

[3553] If Behavior Code ICD-O-3 = "value of Behavior Code ICD-O-3", Lymph-vascular Invasion must not = 1

Description

```
This edit is skipped if either Lymph-vascular Invasion or Histologic Type ICD-O-3
is blank.

If Histologic Type ICD-O-3 = 9590-9992 (lymphoma and hematopoietic), then Lymph-
vascular Invasion must = 8 (not applicable).

If Behavior Code ICD-O-3 = 0, 1, or 2, then Lymph-vascular Invasion must not = 1
(lymph-vascular invasion present/identified).
```

Administrative Notes

New edit - added to NAACCR v12C metafile.

This edit differs from the COC edit of the same name in that it allows a Lymph-vascular Invasion of 8 (not applicable) for cases that are not lymphoma and hematopoietic (Histologic Type ICD-O-3 = 9590-9992)

In the SEER*Edits software, the title of this edit is: IF318

Modifications

NAACCR v13A
Added SEER IF number (IF318)

NAACCR v14
- Information was added to the Administrative Notes explaining how this version of the edit differs from the COC edit of the same name.

Modifications

NAACCR v14A

- Edit name changed from 'Lymph-vascular Invasion, Histology ICDO3 (CS)' to 'Lymph-vascular Invasion, Histology, Behav (CS)'
- Added logic: If Behavior Code ICD-O-3 = 0, 1, or 2, then Lymph-vascular Invasion must not = 1 (lymph-vascular invasion present/identified).

Lymph-vascular Invasion, Penis and Testis (CS)

Agency: CS **Last changed: 10/07/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
Lymph-vascular Invasion [Std# 1182]
CS Site-Specific Factor25 [Std# 2879]

Default Error Message

[4206] Penis/Testis schema: %F4 must not = 8
Penis/Testis schema: Lymph-vascular Invasion must not = 8

Additional Messages

SAVE_TEXT("t_schema_msg")

Description

```
This edit is skipped if:
1. Lymph-vascular Invasion is blank
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)

If CS schema is Penis or Testis
THEN
    Lymph-vascular Invasion must not = 8 (not applicable).
```

Administrative Notes

New edit - added to NAACCR v13A

In the SEER*Edits software, the title of this edit is: IF459

Modifications

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"

MCR-CIMS (NOT REPORTABLE CASE)

Agency: **Last changed: 06/24/2016**

Edit Sets

OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
Primary Site [Std# 400]
Class of Case [Std# 610]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
Behavior (92-00) ICD-O-2 [Std# 430]
Histology (92-00) ICD-O-2 [Std# 420]

Default Error Message

[9999] Case can't be submitted to Master Db. It's not a reportable case
Case can't be submitted to Master Db. It's not a reportable case

Description

```
With diagnoses as of 1/1/1998, MCR is no longer accepting cases with
site: C510-C519,C529 and histology: 8077, behavior:2, DateDx:(1998-2003)
site: C530-C539, behavior:2, DateDx > 1997
site: C211, behavior:2, histology:8077, DateDx < 2004
site: C751-C753, behavior:(0,1), DateDx < 2004
```

Morphology--Type/Behavior ICDO2 (SEER MORPH)

Agency: SEER **Last changed: 09/03/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Histology (92-00) ICD-O-2 [Std# 420]
Behavior (92-00) ICD-O-2 [Std# 430]
Grade [Std# 440]
Over-ride Histology [Std# 2040]
Date of Diagnosis [Std# 390]

Tables

HISICDO2.DBF
MORPH.DBF

Default Error Message

[301] Histologic Type not valid - ICDO2
Histologic Type not valid - ICDO2

Additional Messages

[302] Benign Histology - Please Review - ICDO2
[304] Grade not valid - ICDO2
[305] Grade & Histology conflict - ICDO2
[306] Invalid Histology for In Situ - ICDO2
ERROR_TEXT("Date of Diagnosis: %DC")

Description

```
This edit is skipped if any of the following conditions are true:
1. Year of Date of Diagnosis is greater than 2000 or blank
2. Histology (92-00) ICD-O-2 is empty.

The morphology field is defined by the International Classification of Diseases for
Oncology, Second Edition (ICD-O-2) and consists of the following subfields:

    Histology (92-00) ICD-O-2 - 4 digits
    Behavior (92-00) ICD-O-2 - 1 digit
    Grade - 1 digit

I.  Single Subfield Checks

    Only those histology and grade codes defined by ICD-O-2 are valid.

    A.  Histology--must contain a number between 8000-9999.  However,
        not all numbers in this range are valid, so a further check
        is performed. Codes are validated at two levels. Histology
        codes listed with behavior codes of 2 or 3 in ICD-O-2 are
        considered valid whenever they appear.
```

Codes listed in ICD-O-2 with behavior codes of only 0 or 1 are also considered valid (i.e.,"reportable"), since use of the behavior matrix of ICD-O-2 allows for the elevation of the behavior of such histologies when the neoplasm is in situ or malignant. However, this edit requires review of these cases to verify that they are indeed in situ or malignant. If the histology and behavior are correct on review, then Over-ride--Histology is to be set to 1 (or 3, if the flag is used for both this edit and SEER IF31). An internal binary table is used to represent the histologies listed in ICD-O-2 according to their listed behaviors.

B. Grade--valid codes are 1-9.

II. Multi-Subfield Checks

The subfields are also checked for consistency among themselves.Each of these checks is defined in detail below.

A. Histology/Grade:
The over-ride cannot be used to indicate that these impossible combinations are correct.

1. The following histology/grade combinations are impossible:
grades 5-8 with histologies not in the range 9590-9941

2. Some terms in ICD-O-2 carry an implied statement of grade. These histologies must be reported with the correct grade as stated below:

8020/34	Carcinoma, undifferentiated
8021/34	Carcinoma, anaplastic
8331/31	Follicular adenocarcinoma, well differentiated
8851/31	Liposarcoma, well differentiated
9062/34	Seminoma, anaplastic
9082/34	Malignant teratoma, undifferentiated
9083/32	Malignant teratoma, intermediate type
9401/34	Astrocytoma, anaplastic
9451/34	Oligodendroglioma, anaplastic
9511/31	Retinoblastoma, differentiated
9512/34	Retinoblastoma, undifferentiated

3. The following lymphomas must carry either the implied grade or the T-cell, B-cell, null cell, or NK cell designation as grade:

9693/3	Malignant lymphoma, lymphocytic, well differentiated, nodular cannot be 2,3,4 or 9
9696/3	Malignant lymphoma, lymphocytic, poorly differentiated,nodular cannot be 1,2,4, or 9

B. Histology/Behavior:

In situ histologies: The following histologies are not accepted with a behavior code `2' insitu:

8000-8004
8020, 8021

8331, 8332
8800-9054
9062
9082, 9083
9110-9491
9501-9989

NOTE:
Over-ride Histology is also used for SEER edit IF31. Code 3 in Over-ride Histology indicates that both SEER's MORPH edit and IF31 are being over-ridden.

Additional Information:

This edit checks the validity of the histologic type subfields morphology and grade, and then performs several checks of the subfields morphology, behavior, and grade against each other. The subfield behavior is checked in a separate edit. The specific error message will identify which part of the code is problematic or which subfields are inconsistent.

1. The edit requires review of a case in which the 4-digit morphology code is one that appears in ICD-O-2 only with behavior codes of 0 or 1. Verify the coding of morphology, and that the behavior should be coded malignant or in situ. The registrar may need to consult a pathologist or medical advisor in problem cases. If the case is correctly coded, set the Over-ride--Histology flag to 1 (or 3, if the flag is also being set for the edit Diagnostic Confirmation, Behavior Code (SEER IF31).

2. Histology and grade are compared, and certain errors identified (these cannot be over-ridden). These are specified in detail in the "Description" field of the documentation.

- Grade codes 5-8 are T-cell, B-cell, and NK cell indicators used for leukemias and lymphomas only. Therefore, codes 5-8 may only be used with morphologies in the range 9590-9941.

- Some terms in ICD-O-2 carry an implied grade, and the appropriate grade code(s) must be used. These are specified in detail in the "Description" section of the documentation.

3. Histology and behavior codes are compared, and some combinations of in situ behavior and histology are not allowed. (These histologies are specified in the "Description" section of the documentation.) "In situ" is a concept that only pertains to epithelial neoplasms; therefore, an in situ behavior is not allowed with non-epithelial morphologies, such as sarcomas, leukemias, and lymphomas. In situ behavior is also disallowed for a handful of codes representing epithelial neoplasms which, by their nature, cannot be in situ.

Errors from this edit usually result from misapplication of coding rules. Correction of errors may require inspection of the abstracted text, either online or as recorded on a paper abstract. Review of the original medical record may be necessary. Review the coding of each subfield. Consult a pathologist or medical advisor when necessary.

EXAMPLE

HISTOLOGIC TYPE	9650/3, HODGKIN'S DISEASE, NOS
BEHAVIOR CODE	2, IN SITU
GRADE	9, UNKNOWN

```
A behavior code of 2, in situ, is not correct for Hodgkin's
disease.  Change the behavior to 3, malignant.
```

Administrative Notes

In the SEER*Edits software, the title of this edit is: MORPH

Note: The COC version of this edit has been deleted since it, over time, has become equivalent to the SEER version of the edit. Edit sets in this metafile using the COC version have been updated to use the SEER version instead.

Modifications:

NAACCR v15.0
9/2014
Edit logic rewritten to use DBF table instead of BIN table for lookup.

NAACCR v11.3
6/2008
Updated Administrative Notes with the title of the corresponding edit in the SEER*Edits software.

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

NAACCR v15A
 - Edit logic rewritten to use HISICDO2.DBF to validate ICD-O-2 histologies (instead of hard-coded list) and MORPH.DBF instead of MORPH.BIN.

Morphology--Type/Behavior ICDO3 (SEER MORPH)

Agency: SEER **Last changed: 09/03/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
Over-ride Histology [Std# 2040]
Date of Diagnosis [Std# 390]
Primary Site [Std# 400]

Tables

HISICDO3.DBF
MORPH01.DBF

Default Error Message

[501] Histologic Type not valid - ICDO3
Histologic Type not valid - ICDO3

Additional Messages

[502] Benign Histology - Please Review - ICDO3
[506] Invalid Histology for In Situ - ICDO3
[542] Behavior must be 3 for this histology
[543] Behavior must be 2 for this histology
[544] Histologic Type ICD-O-3 ("value of Histologic Type ICD-O-3") is not allowed if DX year < 2010
[545] If DX year < 2010, Behavior Code ICD-O-3 ("value of Behavior Code ICD-O-3") is not allowed for Histologic Type ICD-O-3 ("value of Histologic Type ICD-O-3"
ERROR_TEXT("Date of Diagnosis: %DC")

Description

```
This edit is skipped if any of the following conditions are true:
1. Histologic Type ICD-O-3 is blank
2. Behavior Code ICD-O-3 is blank
2. Date of Diagnosis is blank

The morphology field is defined by the International Classification of Diseases for
Oncology, Third Edition (ICD-O-3) and consists of the following subfields:

    Histologic Type ICD-O-3 - 4 digits
    Behavior Code ICD-O-3 - 1 digit

I.  Single Subfield Checks

    Only those histology/behavior codes defined by ICD-O-3 are valid.

    A. Histology (Histologic Type ICD-O-3)-- must contain a valid ICD-O-3
       code. Codes are validated at two levels. Histology codes listed
```

with behavior codes of 2 or 3 in ICD-O-3 are considered valid whenever they appear.

Codes listed in ICD-O-3 with behavior codes (Behavior Code ICD-O-3) of only 0 or 1 are also considered valid (i.e., "reportable"), since use of the behavior matrix of ICD-O-3 allows for the elevation of the behavior of such histologies when the neoplasm is in situ or malignant. However, this edit requires review of these cases to verify that they are indeed in situ or malignant. If the histology and behavior are correct on review, then Over-ride--Histology is to be set to 1 (or 3, if the flag is used for both this edit and SEER IF31). An internal binary table is used to represent the histologies listed in ICD-O-3 according to their listed behaviors.

Exceptions to the above rule are 8442, 8451, 8462, 8472, and 8473. These codes may have been entered in ICD-O-2 as malignant or in situ and correctly converted to ICD-O-3 as borderline (Behavior Code ICD-O-3 = 1). Such cases do not require review (that is, the Over-ride--Histology flag does not have to be set to 1 or 3).

Additional exceptions were added for all benign histologies for brain and other CNS (Primary Site = C700-C729) and intracranial glands (Primary Site = C751-C753). Another edit, "Primary Site, Morphology-Type,Beh ICDO3(SEER IF25)," verifies that site/histology/ benign behavior combination are correctly coded for these particular sites.

The code 9421 (juvenile astrocytoma), although moving from behavior code code 3 in ICD-O-2 to 1 in ICD-O-3, will CONTINUE to be collected with a behavior code of 3. This edit requires that 9421 be coded with a behavior of 3 and it cannot be over-ridden.

Additional exceptions were added to accommodate the collection of benign brain tumors diagnosed on or after 01/01/2004. The following benign histologies will pass without review:
8146, 8271, 8861, 8897, 9121, 9122, 9131, 9161, 9350, 9351, 9352, 9360, 9361, 9383, 9384, 9394, 9412, 9413, 9444, 9492, 9493, 9506, 9531, 9532, 9533, 9534, 9537, 9541, 9550, 9562, 9570.

To accommodate the new Hematopoietic and Lymphoid Neoplasm Rules effective for cases diagnosed 1/1/2010 and later:

1. The following Histologic Type ICD-O-3 codes are allowed only for cases with a year of Date of Diagnosis of 2010 and later:
9597, 9688, 9712, 9724, 9725, 9726, 9735, 9737, 9738, 9759, 9806, 9807, 9808, 9809, 9811, 9812, 9813, 9814, 9815, 9816, 9817, 9818, 9865, 9869, 9898, 9911, 9965, 9966, 9967, 9971, 9991, 9992

2. The following Histologic Type ICD-O-3 codes were considered benign and/or borderline prior to 2010 and, if coded with Behavior ICD-O-3 code of 3, required an over-ride. For cases diagnosed 2010 or later, these histologies are now reportable (with Behavior ICD-O-3 code of 3) and an over-ride should not be used:
9751
9831
9975

II. Multi-Subfield Checks

The subfields are also checked for consistency among themselves. Each of these checks is defined in detail below.

Histology/Behavior:

In situ histologies: The following histologies are not accepted with a behavior code `2' (in situ):

8000-8005
8020, 8021
8331, 8332
8800-9055
9062
9082, 9083
9110-9493
9501-9992

Malignant histologies: The following histology is not accepted with a behavior code `3' (malignant):
8077

NOTE:
Over-ride Histology is also used for SEER edit IF31. Code 3 in Over-ride Histology indicates that both SEER's MORPH edit and IF31 are being over-ridden.

Additional Information:

This edit checks the validity of the ICD-O-3 histologic type subfields histology and behavior. The subfield behavior is checked in a separate edit. The specific error message will identify which part of the code is problematic or which subfields are inconsistent.

1. The edit requires review of a case in which the 4-digit morphology code is one that appears in ICD-O-3 only with behavior codes of 0 or 1. Verify the coding of morphology, and that the behavior should be coded malignant or in situ. The registrar may need to consult a pathologist or medical advisor in problem cases. If the case is correctly coded, set the Over-ride--Histology flag to 1 (or 3, if the flag is also being set for the edit Diagnostic Confirmation, Behavior Code ICDO3 (SEER IF31).

2. Histology and behavior codes are compared, and some combinations of in situ behavior and histology are not allowed. (These histologies are specified in the "Description" section of the documentation.) "In situ" is a concept that only pertains to epithelial neoplasms; therefore, an in situ behavior is not allowed with non-epithelial morphologies, such as sarcomas, leukemias, and lymphomas. In situ behavior is also disallowed for a handful of codes representing epithelial neoplasms which, by their nature, cannot be in situ.

Errors from this edit usually result from misapplication of coding rules. Correction of errors may require inspection of the abstracted text, either online or as recorded on a paper abstract. Review of the original medical record may be necessary. Review the coding of each subfield. Consult a pathologist or medical advisor when necessary.

```
EXAMPLE

     HISTOLOGIC TYPE     9650/3, HODGKIN LYMPHOMA
     BEHAVIOR CODE       2, IN SITU

A behavior code of 2, in situ, is not correct for Hodgkin
lymphoma. Change the behavior to 3, malignant.
```

Administrative Notes

In the SEER*Edits software, the title of this edit is: Morph_3

Note: The COC version of this edit has been deleted since it, over time, has become equivalent to the SEER version of the edit. Edit sets in this metafile using the COC version have been updated to use the SEER version instead.

Modifications:

NACR110C
08/08
Updated edit to require that Histologic Type ICD-O-3 of 9421 (juvenile astrocytoma) be coded with a Behavior ICD-O-3 code of 3 (invasive) per the ICD-O-3 Implementation Guidelines. It cannot be over-ridden.

NACR111
12/14/06
Updated edit to not allow a Behavior ICD-O-3 code of 3 (malignant) with Histologic Type ICD-O-3 of 8077 (squamous intraepeithelial neoplasia, grade III). This logic cannot be over-ridden.

NAACCR v11.3
6/2008
Updated Administrative Notes with the title of the corresponding edit in the SEER*Edits software.

NAACCR v12.0
-- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules. Edit will be skipped if Date of Diagnosis is blank.
- The following Histologic Type ICD-O-3 codes are allowed only for cases with a year of Date of Diagnosis of 2010 and later:
9597, 9688, 9712, 9724, 9725, 9726, 9735, 9737, 9738, 9759, 9806, 9807, 9808, 9809, 9811, 9812, 9813, 9814, 9815, 9816, 9817, 9818, 9865, 9869, 9898, 9911, 9965, 9966, 9967, 9971, 9991, 9992
- The following Histologic Type ICD-O-3 codes were considered benign and/or borderline prior to 2010 and, if coded with Behavior ICD-O-3 code of 3, required an over-ride. For cases diagnosed 2010 or later, these histologies are now reportable (with Behavior ICD-O-3 code of 3) and an over-ride should not be used:
9751
9831
9975
- When checking histologies that are not accepted with behavior code `2' (in situ), the range "9501-9989" is now "9501-9992".

NAACCR v12C
- Changed range of histologies allowed for grades 5-8 from "9590-9948" to "9590-9992".

NAACCR v13A

- Grade checking moved from this edit into new edit: "Histologic Type ICD-O-3, Behavior, Grade (SEER)"
- Removed USR2 processing from logic and replaced with "return ERROR_MSG" processing

NAACCR v15
- Updated edit to allow all benign histologies for C700-C729 and C751-C753. Another edit, "Primary Site,Morphology-Type,Beh ICDO3(SEER IF25)," verifies that site/histology/behavior combinations are correctly coded for these particular sites.

NAACCR v15A
- Edit logic rewritten to use HISICDO3.DBF to validate ICD-O-3 histologies (instead of hard-coded list) and MORPH01.DBF instead of MORPH01.BIN.

NAACCR Record Version (NAACCR)

Agency: NAACCR **Last changed: 06/08/2016**

Edit Sets

OfficeScan16D

Fields

NAACCR Record Version [Std# 50]

Default Error Message

[1116] %F1 must equal "160" for this metafile
NAACCR Record Version must equal "160" for this metafile

Description

Must be "160" to indicate the current NAACCR standard for NAACCR Record Version 16.

Administrative Notes

Modifications

NAACCR v12
4/2009
- Changed the length of the field from 1 to 3 characters so that the full 3-character record version can be specified beginning with Version 12.
- Changed allowable code from "B", used to indicate version 11, 11.1, 11,2, and 11.3, to "120", to indicate version 12.0.

NAACCR v12.1
- Changed allowable code from "120" (version 12.0) to "121" (version 12.1).

NAACCR v12.2
- Changed allowable code from "121" (version 12.1) to "122" (version 12.2).

NAACCR v13
- Changed allowable code from "122" (version 12.2) to "130" (version 13).

NAACCR v14
- Changed allowable code from "130" (version 13) to "140" (version 14).

NAACCR v15
- Changed allowable code from "140" (version 14) to "150" (version 15).
NAACCR v16
- Changed allowable code from "150" (version 15) to "160" (version 16).

Name--Alias (SEER)

Agency: SEER **Last changed: 08/21/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Name--Alias [Std# 2280]

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of Name--Alias" is not a valid value for Name--Alias

Description

Note: This edit is not supported by the COC as of 1/1/2003; however, SEER has agreed to support this data item and edit.

Name--Alias may be blank. If entered, must be alpha, left-justified, and blank-filled. Mixed case, embedded spaces, hyphens, and apostrophes are also allowed. No other special characters are allowed.

Administrative Notes

Modifications:

NAACCR v12C
- Edit updated to use the full length of the field (now 40 characters as of v12) when verifying that only allowable characters are included in the data string.

NAACCR v12.1B
- Edit corrected to properly validate last character of name.

NAACCR v15A
This change was made in preparation for the move from EDITS v4 to EDITS v5:
- MATCH statement updated:
  "a{?}*" changed to "a{a,b,-,'}*"
- Lookup table of valid characters deleted since it is
  no longer needed

Name--First (NPCR)

Agency: NPCR **Last changed: 08/21/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Name--First [Std# 2240]

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of Name--First" is not a valid value for Name--First

Description

```
Name--First may not be blank. Must be alpha, left-justified, and blank-filled.
Mixed case, embedded spaces, hyphens, and apostrophes are also allowed. No other
special characters are allowed.
```

Administrative Notes

New edit - added to NAACCR v12.1 metafile.

This edit differs from the COC edit of the same name in that the field cannot be empty.

Modifications:

NAACCR v12.1A
- Updated to allow hyphens and apostrophes.

NAACCR v12.1B
- Edit corrected to properly validate last character of name.

NAACCR v15A
This change was made in preparation for the move from EDITS v4 to EDITS v5:
- MATCH statement updated:
  "a{?}*" changed to "a{a,b,-,'}*"
- Lookup table of valid characters deleted since it is
  no longer needed

Name--Last (COC)

Agency: COC **Last changed: 08/21/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Name--Last [Std# 2230]

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of Name--Last" is not a valid value for Name--Last

Description

Name--Last may not be blank. Must be alpha, left-justified, and blank-filled. Mixed case, embedded spaces, hyphens, and apostrophes are also allowed. No other special characters are allowed.

Administrative Notes

Note: As of the NAACCR v12.1 metafile, the NAACCR edit of the same name has been deleted. Registries are expected to follow the COC standard.

Modifications:

NAACCR v12C
- Edit updated to use the full length of the field (now 40 characters as of v12) when verifying that only allowable characters are included in the data string.

NAACCR v12.1B
- Edit corrected to properly validate last character of name.

NAACCR v15A
This change was made in preparation for the move from EDITS v4 to EDITS v5:
- MATCH statement updated:
  "a{?}*" changed to "a{a,b,-,'}*"
- Lookup table of valid characters deleted since it is
  no longer needed

Name--Maiden (SEER)

Agency: SEER **Last changed: 08/21/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Name--Maiden [Std# 2390]

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of Name--Maiden" is not a valid value for Name--Maiden

Description

Name--Maiden may be blank. If entered, must be alpha, left-justified, and blank-filled. Mixed case, embedded spaces, hyphens, and apostrophes are also allowed. No other special characters are allowed.

Administrative Notes

Note: This edit is not supported by the COC as of 1/1/2003; however, SEER has agreed to support this data item and edit.

Note: As of the NAACCR v12.1 metafile, the NAACCR edit of the same name has been deleted.

Modifications:

NAACCR v12C
- Edit updated to use the full length of the field (now 40 characters as of v12) when verifying that only allowable characters are included in the data string.

NAACCR v12.1B
- Edit corrected to properly validate last character of name.

NAACCR v15A
This change was made in preparation for the move from EDITS v4 to EDITS v5:
- MATCH statement updated:
  "a{?}*" changed to "a{a,b,-,'}*"
- Lookup table of valid characters deleted since it is
  no longer needed

Name--Middle (COC)

Agency: COC **Last changed: 08/21/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Name--Middle [Std# 2250]

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of Name--Middle" is not a valid value for Name--Middle

Description

Name--Middle may be blank. If entered, must be alpha, left-justified, and blank-filled.Mixed case, embedded spaces, hyphens, and apostrophes are also allowed. No other special characters are allowed.

Administrative Notes

Note: As of the NAACCR v12.1 metafile, the NAACCR edit of the same name has been deleted. Registries are expected to follow the COC standard in that embedded spaces are allowed.

Modifications:

NAACCR v12.1A
- Updated to allow hyphens and apostrophes.

NAACCR v12.1B
- Edit corrected to properly validate last character of name.

NAACCR v15A
This change was made in preparation for the move from EDITS v4 to EDITS v5:
- MATCH statement updated:
  "a{?}*" changed to "a{a,b,-,'}*"
- Lookup table of valid characters deleted since it is
  no longer needed

Non-Reportable Skin ICDO2 (SEER IF116)

Agency: SEER **Last changed: 01/21/2010**

Edit Sets

OfficeScan16D

Fields

Primary Site [Std# 400]
Histology (92-00) ICD-O-2 [Std# 420]
Date of Diagnosis [Std# 390]

Default Error Message

[3152] Non-Reportable Skin ICD-O-2
Non-Reportable Skin ICD-O-2

Additional Messages

ERROR_TEXT("Date of Diagnosis: %DC")

Description

This edit is skipped if Histology (92-00) ICD-O-2 is blank or year of Date of Diagnosis is greater than 2000 or is blank.

If Primary Site = C440-C449 (skin) and Histology (92-00) ICD-O-2 = 8000-8110, then an error is generated.

These cases are non reportable to SEER.

Administrative Notes

In the SEER*Edits software, the title of this edit is: IF116

Modifications:

NAACCR v11.3
6/2008
- Updated Administrative Notes with the title of the corresponding edit in the SEER*Edits software.
- This edit was modified so that it will be skipped if year of Date of Diagnosis is greater than 2000.

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

Non-Reportable Skin ICDO3 (SEER IF117)

Agency: SEER **Last changed: 06/27/2008**

Edit Sets

OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]

Default Error Message

[3153] Non-Reportable Skin ICD-O-3
Non-Reportable Skin ICD-O-3

Description

This edit is skipped if Histologic Type ICD-O-3 is blank.

If Primary Site = C440-C449 (skin) and Histologic Type ICD-O-3 = 8000-8110, then an error is generated.

These cases are non reportable to SEER.

Administrative Notes

In the SEER*Edits software, the title of this edit is: IF117

Modifications:

NAACCR v11.3
6/2008
Updated Administrative Notes with the title of the corresponding edit in the SEER*Edits software.

Obsolete Codes - CS Extension (CS)

Agency: CS **Last changed: 09/15/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
CS Extension [Std# 2810]
CS Version Input Original [Std# 2935]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]

Tables

CS_OBS.DBF

Default Error Message

[3545] %F3 [%V3] is obsolete
CS Extension ["value of CS Extension"] is obsolete

Additional Messages

[3359] CS Extension=OBSOLETE DATA RETAINED - not allowed if DX > 2009
[3363] CS Extension=OBSOLETE DATA CONVERTED V0102
[3364] CS Extension=OBSOLETE DATA CONVERTED V0104
[3365] CS Extension=OBSOLETE DATA CONVERTED V0200
[3366] CS Extension=OBSOLETE DATA REVIEWED AND CHANGED V0102
[3367] CS Extension=OBSOLETE DATA REVIEWED AND CHANGED V0103
[3368] CS Extension=OBSOLETE DATA REVIEWED AND CHANGED V0200
[3386] CS Extension=OBSOLETE DATA RETAINED - not allowed if CS Version Input Original > or = 020100
[3398] CS Extension=OBSOLETE DATA CONVERTED V0203
[3399] CS Extension=OBSOLETE DATA REVIEWED AND CHANGED V0203
[3400] CS Extension=OBSOLETE DATA REVIEWED V0203 - not allowed if DX > 2010
[3401] CS Extension=OBSOLETE DATA REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3402] CS Extension=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if DX > 2010
[3403] CS Extension=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3404] CS Extension=OBSOLETE DATA RETAINED V0203 - not allowed if DX > 2010
[3405] CS Extension=OBSOLETE DATA RETAINED V0203 - not allowed if CS Version Input Original > or = 020300
[3498] CS Extension=OBSOLETE DATA CONVERTED V0204
[3499] CS Extension=OBSOLETE DATA REVIEWED AND CHANGED V0204
[3500] CS Extension=OBSOLETE DATA RETAINED V0202 - not allowed if DX > 2010
[3501] CS Extension=OBSOLETE DATA RETAINED V0202 - not allowed if CS Version Input Original > or = 020200
[3502] CS Extension=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if DX > 2011

[3503] CS Extension=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if CS Version Input Original > or = 020440
[3504] CS Extension=OBSOLETE DATA RETAINED V0204 - not allowed if DX > 2011
[3505] CS Extension=OBSOLETE DATA RETAINED V0204 - not allowed if CS Version Input Original > or = 020440
[3506] CS Extension=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if DX > 2009
[3507] CS Extension=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if CS Version Input Original > or = 020100
ERROR_TEXT("Date of Diagnosis: %DC")
ERROR_TEXT("Invalid site or histology")
ERROR_TEXT("Schema discriminator missing or invalid")
SAVE_TEXT("t_schema_msg")

Description

This edit checks for all obsolete CS Extension codes. Obsolete codes should be re-coded per Collaborative Stage guidelines.

This edit is skipped if any of the following conditions are true:
1. CS Extension is blank
2. Date of Diagnosis is blank
3. CS Version Input Original is blank

This edit first determines the correct CS schema by doing a function call to the CS Dynamic Link Library (dll). The function call passes Primary Site, Histologic Type ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS schema name is returned.

Using the returned schema name, CS table number (CS Extension is table number 2), and CS Extension code, a table lookup is performed. If the code for a particular schema is determined to be obsolete based on the table lookup, the type of obsolete code must be evaluated. There are several types of obsolete codes:

1. OBSOLETE DATA CONVERTED AND RETAINED V0200
2. OBSOLETE DATA CONVERTED V0102
3. OBSOLETE DATA CONVERTED V0104
4. OBSOLETE DATA CONVERTED V0200
5. OBSOLETE DATA RETAINED V0100
6. OBSOLETE DATA RETAINED V0102
7. OBSOLETE DATA RETAINED V0200
8. OBSOLETE DATA REVIEWED AND CHANGED V0102
9. OBSOLETE DATA REVIEWED AND CHANGED V0103
10. OBSOLETE DATA REVIEWED AND CHANGED V0200
11. OBSOLETE DATA CONVERTED V0203
12. OBSOLETE DATA REVIEWED AND CHANGED V0203
13. OBSOLETE DATA REVIEWED V0203
14. OBSOLETE DATA RETAINED AND REVIEWED V0203
15. OBSOLETE DATA RETAINED V0203
16. OBSOLETE DATA RETAINED V0104
17. OBSOLETE DATA RETAINED V0202
18. OBSOLETE DATA RETAINED AND REVIEWED V0200
19. OBSOLETE DATA CONVERTED V0204
20. OBSOLETE DATA REVIEWED AND CHANGED V0204
21. OBSOLETE DATA RETAINED AND REVIEWED V0204
22. OBSOLETE DATA RETAINED V0204

1. If the type of obsolete code = OBSOLETE DATA CONVERTED AND RETAINED V0200:

A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Extension]

2. If the type of obsolete code = OBSOLETE DATA CONVERTED V0102:
an error is generated.
[Example: Schema = Breast, CS Extension = 720]

3. If the type of obsolete code = OBSOLETE DATA CONVERTED V0104:
an error is generated.
[Example: Schema = MelanomaHypopharynx, CS Extension = 510]

4. If the type of obsolete code = OBSOLETE DATA CONVERTED V0200:
an error is generated.
[Example: Schema = MelanomaHypopharynx, CS Extension = 150]

5. If the type of obsolete code = OBSOLETE DATA RETAINED V0100:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Extension]

6. If the type of obsolete code = OBSOLETE DATA RETAINED V0102:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Extension]

7. If the type of obsolete code = OBSOLETE DATA RETAINED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv2), an error is generated.
[Example: Schema = MelanomaHypopharynx, CS Extension = 800]

8. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0102:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: Schema = Prostate, CS Extension = 330]

9. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0103:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: none for CS Extension]

10. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0200:
an error is generated.
(These particular obsolete codes require review after conversion from CSV01 to CSV02.)
[Example: Schema = MelanomaConjunctiva, CS Extension = 400]

11. If the type of obsolete code = OBSOLETE DATA CONVERTED V0203:
an error is generated.
[Example: Schema = SmallIntestine, CS Extension = 095]

12. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0203:
an error is generated.

(These particular obsolete codes require review after conversion from CSV02xx to CSV0203.)
[Example: Schema = CarcinoidAppendix, CS Extension = 400]

13. If the type of obsolete code = OBSOLETE DATA REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: Schema = BileDuctsDistal, CS Extension = 605]

14. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: Schema = Appendix, CS Extension = 460]

15. If the type of obsolete code = OBSOLETE DATA RETAINED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: Schema = CarcinoidAppendix, CS Extension = 501]

16. If the type of obsolete code = OBSOLETE DATA RETAINED V0104:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv02), an error is generated.
[Example: none for CS Extension]

17. If the type of obsolete code = OBSOLETE DATA RETAINED V0202:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020200 or higher (indicating the case was originally coded using CSv0202), an error is generated.
[Example: Schema = Breast, CS Extension = 715]

18. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Extension]

19. If the type of obsolete code = OBSOLETE DATA CONVERTED V0204:
an error is generated.
[Example: none for CS Extension]

20. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0204:
an error is generated.
(These particular obsolete codes require review after conversion from CSV0203xx to CSV0204.)
[Example: none for CS Extension]

21. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0204:
A. If year of Diagnosis is 2012 or higher, an error is generated.
B. If CS version Input Original is 020440 or higher (indicating the case was originally coded using CSv0204), an error is generated.
[Example: Schema = BileDuctsIntraHepat, CS Extension = 750]

22. If the type of obsolete code = OBSOLETE DATA RETAINED V0204:
A. If year of Diagnosis is 2012 or higher, an error is generated.
B. If CS version Input Original is 020440 or higher (indicating the case was originally coded using CSv0204), an error is generated.

[Example: Schema = Ovary, CS Extension = 300]

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

In the SEER*Edits software, the title of this edit is: IF270

Modifications:

NAACCR v12.1
- Modified to handle the additional types of obsolete codes that were added for CSv0203.

NAACCR v12.2
- Updated to skip if CS Version Input Original is blank.
- Modified to include the additional types of obsolete codes that were added for CSv0204.
- Modified to include 3 types of obsolete codes left out of previous versions of the edit:
-- OBSOLETE DATA RETAINED V0203
-- OBSOLETE DATA RETAINED V0104
-- OBSOLETE DATA RETAINED V0202

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Default error message added

NAACCR v15A
- Duplicate variable declarations deleted from edit logic.

Obsolete Codes - CS Lymph Nodes (CS)

Agency: CS **Last changed: 09/15/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
CS Lymph Nodes [Std# 2830]
CS Version Input Original [Std# 2935]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]

Tables

CS_OBS.DBF

Default Error Message

[3545] %F3 [%V3] is obsolete
CS Lymph Nodes ["value of CS Lymph Nodes"] is obsolete

Additional Messages

[3359] CS Lymph Nodes=OBSOLETE DATA RETAINED - not allowed if DX > 2009
[3363] CS Lymph Nodes=OBSOLETE DATA CONVERTED V0102
[3364] CS Lymph Nodes=OBSOLETE DATA CONVERTED V0104
[3365] CS Lymph Nodes=OBSOLETE DATA CONVERTED V0200
[3366] CS Lymph Nodes=OBSOLETE DATA REVIEWED AND CHANGED V0102
[3367] CS Lymph Nodes=OBSOLETE DATA REVIEWED AND CHANGED V0103
[3368] CS Lymph Nodes=OBSOLETE DATA REVIEWED AND CHANGED V0200
[3386] CS Lymph Nodes=OBSOLETE DATA RETAINED - not allowed if CS Version Input Original > or = 020100
[3398] CS Lymph Nodes=OBSOLETE DATA CONVERTED V0203
[3399] CS Lymph Nodes=OBSOLETE DATA REVIEWED AND CHANGED V0203
[3400] CS Lymph Nodes=OBSOLETE DATA REVIEWED V0203 - not allowed if DX > 2010
[3401] CS Lymph Nodes=OBSOLETE DATA REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3402] CS Lymph Nodes=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if DX > 2010
[3403] CS Lymph Nodes=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3404] CS Lymph Nodes=OBSOLETE DATA RETAINED V0203 - not allowed if DX > 2010
[3405] CS Lymph Nodes=OBSOLETE DATA RETAINED V0203 - not allowed if CS Version Input Original > or = 020300
[3498] CS Lymph Nodes=OBSOLETE DATA CONVERTED V0204
[3499] CS Lymph Nodes=OBSOLETE DATA REVIEWED AND CHANGED V0204
[3500] CS Lymph Nodes=OBSOLETE DATA RETAINED V0202 - not allowed if DX > 2010
[3501] CS Lymph Nodes=OBSOLETE DATA RETAINED V0202 - not allowed if CS Version Input Original > or = 020200

[3502] CS Lymph Nodes=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if DX > 2011
[3503] CS Lymph Nodes=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if CS Version Input Original > or = 020440
[3504] CS Lymph Nodes=OBSOLETE DATA RETAINED V0204 - not allowed if DX > 2011
[3505] CS Lymph Nodes=OBSOLETE DATA RETAINED V0204 - not allowed if CS Version Input Original > or = 020440
[3506] CS Lymph Nodes=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if DX > 2009
[3507] CS Lymph Nodes=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if CS Version Input Original > or = 020100
ERROR_TEXT("Date of Diagnosis: %DC")
ERROR_TEXT("Invalid site or histology")
ERROR_TEXT("Schema discriminator missing or invalid")
SAVE_TEXT("t_schema_msg")

Description

This edit checks for all obsolete CS Lymph Nodes codes. Obsolete codes should be re-coded per Collaborative Stage guidelines.

This edit is skipped if any of the following conditions are true:
1. CS Lymph Nodes is blank
2. Date of Diagnosis is blank
3. CS Version Input Original is blank

This edit first determines the correct CS schema by doing a function call to the CS Dynamic Link Library (dll). The function call passes Primary Site, Histologic Type ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS schema name is returned.

Using the returned schema name, CS table number (CS Lymph Nodes is table number 4), and CS Lymph Nodes code, a table lookup is performed. If the code for a particular schema is determined to be obsolete based on the table lookup, the type of obsolete code must be evaluated. There are several types of obsolete codes:

1. OBSOLETE DATA CONVERTED AND RETAINED V0200
2. OBSOLETE DATA CONVERTED V0102
3. OBSOLETE DATA CONVERTED V0104
4. OBSOLETE DATA CONVERTED V0200
5. OBSOLETE DATA RETAINED V0100
6. OBSOLETE DATA RETAINED V0102
7. OBSOLETE DATA RETAINED V0200
8. OBSOLETE DATA REVIEWED AND CHANGED V0102
9. OBSOLETE DATA REVIEWED AND CHANGED V0103
10. OBSOLETE DATA REVIEWED AND CHANGED V0200
11. OBSOLETE DATA CONVERTED V0203
12. OBSOLETE DATA REVIEWED AND CHANGED V0203
13. OBSOLETE DATA REVIEWED V0203
14. OBSOLETE DATA RETAINED AND REVIEWED V0203
15. OBSOLETE DATA RETAINED V0203
16. OBSOLETE DATA RETAINED V0104
17. OBSOLETE DATA RETAINED V0202
18. OBSOLETE DATA RETAINED AND REVIEWED V0200
19. OBSOLETE DATA CONVERTED V0204
20. OBSOLETE DATA REVIEWED AND CHANGED V0204
21. OBSOLETE DATA RETAINED AND REVIEWED V0204
22. OBSOLETE DATA RETAINED V0204

1. If the type of obsolete code = OBSOLETE DATA CONVERTED AND RETAINED V0200:

A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Lymph Nodes]

2. If the type of obsolete code = OBSOLETE DATA CONVERTED V0102:
an error is generated.
[Example: none for CS Lymph Nodes]

3. If the type of obsolete code = OBSOLETE DATA CONVERTED V0104:
an error is generated.
[Example: none for CS Lymph Nodes]

4. If the type of obsolete code = OBSOLETE DATA CONVERTED V0200:
an error is generated.
[Example: Schema = Thryoid, CS Lymph Nodes = 140]

5. If the type of obsolete code = OBSOLETE DATA RETAINED V0100:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Lymph Nodes]

6. If the type of obsolete code = OBSOLETE DATA RETAINED V0102:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Lymph Nodes]

7. If the type of obsolete code = OBSOLETE DATA RETAINED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: Schema = Bladder, CS Lymph Nodes = 100]

8. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0102:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: Schema = Thyroid, CS Lymph Nodes = 200]

9. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0103:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: Schema = Thyroid, CS Lymph Nodes = 100]

10.If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0200:
an error is generated.
(These particular obsolete codes require review after conversion from CSV01 to CSV02.)
[Example: Schema = Vagina, CS Lymph Nodes = 100]

11. If the type of obsolete code = OBSOLETE DATA CONVERTED V0203:
an error is generated.
[Example: Schema = Breast, CS Lymph Nodes = 290]

12. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0203:
an error is generated.

(These particular obsolete codes require review after conversion from CSV02xx to CSV0203.)
[Example: Schema = Thyroid, CS Lymph Nodes = 130]

13. If the type of obsolete code = OBSOLETE DATA REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: Schema = BileDuctsIntrahepat, CS Lymph Nodes = 300]

14. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: Schema = Rectum, CS Lymph Nodes = 100]

15. If the type of obsolete code = OBSOLETE DATA RETAINED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none]

16. If the type of obsolete code = OBSOLETE DATA RETAINED V0104:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv02), an error is generated.

17. If the type of obsolete code = OBSOLETE DATA RETAINED V0202:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020200 or higher (indicating the case was originally coded using CSv0202), an error is generated.

18. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv2), an error is generated.

19. If the type of obsolete code = OBSOLETE DATA CONVERTED V0204:
an error is generated.

20. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0204:
an error is generated.
(These particular obsolete codes require review after conversion from CSV0203xx to CSV0204.)

21. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0204:
A. If year of Diagnosis is 2012 or higher, an error is generated.
B. If CS version Input Original is 020440 or higher (indicating the case was originally coded using CSv0204), an error is generated.

22. If the type of obsolete code = OBSOLETE DATA RETAINED V0204:
A. If year of Diagnosis is 2012 or higher, an error is generated.
B. If CS version Input Original is 020440 or higher (indicating the case was originally coded using CSv0204), an error is generated.

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

In the SEER*Edits software, the title of this edit is: IF272

Modifications:

NAACCR v12.1
- Modified to handle the additional types of obsolete codes that were added for CSv0203.

NAACCR v12.2
- Updated to skip if CS Version Input Original is blank.
- Modified to include the additional types of obsolete codes that were added for CSv0204.
- Modified to include 3 types of obsolete codes left out of previous versions of the edit:
-- OBSOLETE DATA RETAINED V0203
-- OBSOLETE DATA RETAINED V0104
-- OBSOLETE DATA RETAINED V0202

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Default error message added

NAACCR v15A
- Duplicate variable declarations deleted from edit logic.

Obsolete Codes - CS Lymph Nodes Eval (CS)

Agency: CS **Last changed: 09/15/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
CS Lymph Nodes Eval [Std# 2840]
CS Version Input Original [Std# 2935]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]

Tables

CS_OBS.DBF

Default Error Message

[3545] %F3 [%V3] is obsolete
CS Lymph Nodes Eval ["value of CS Lymph Nodes Eval"] is obsolete

Additional Messages

[3359] CS Lymph Nodes Eval=OBSOLETE DATA RETAINED - not allowed if DX > 2009
[3363] CS Lymph Nodes Eval=OBSOLETE DATA CONVERTED V0102
[3364] CS Lymph Nodes Eval=OBSOLETE DATA CONVERTED V0104
[3365] CS Lymph Nodes Eval=OBSOLETE DATA CONVERTED V0200
[3366] CS Lymph Nodes Eval=OBSOLETE DATA REVIEWED AND CHANGED V0102
[3367] CS Lymph Nodes Eval=OBSOLETE DATA REVIEWED AND CHANGED V0103
[3368] CS Lymph Nodes Eval=OBSOLETE DATA REVIEWED AND CHANGED V0200
[3386] CS Lymph Nodes Eval=OBSOLETE DATA RETAINED - not allowed if CS Version Input Original > or = 020100
[3398] CS Lymph Nodes Eval=OBSOLETE DATA CONVERTED V0203
[3399] CS Lymph Nodes Eval=OBSOLETE DATA REVIEWED AND CHANGED V0203
[3400] CS Lymph Nodes Eval=OBSOLETE DATA REVIEWED V0203 - not allowed if DX > 2010
[3401] CS Lymph Nodes Eval=OBSOLETE DATA REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3402] CS Lymph Nodes Eval=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if DX > 2010
[3403] CS Lymph Nodes Eval=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3404] CS Lymph Nodes Eval=OBSOLETE DATA RETAINED V0203 - not allowed if DX > 2010
[3405] CS Lymph Nodes Eval=OBSOLETE DATA RETAINED V0203 - not allowed if CS Version Input Original > or = 020300
[3498] CS Lymph Nodes Eval=OBSOLETE DATA CONVERTED V0204
[3499] CS Lymph Nodes Eval=OBSOLETE DATA REVIEWED AND CHANGED V0204
[3500] CS Lymph Nodes Eval=OBSOLETE DATA RETAINED V0202 - not allowed if DX > 2010

[3501] CS Lymph Nodes Eval=OBSOLETE DATA RETAINED V0202 - not allowed if CS Version Input Original > or = 020200
[3502] CS Lymph Nodes Eval=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if DX > 2011
[3503] CS Lymph Nodes Eval=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if CS Version Input Original > or = 020440
[3504] CS Lymph Nodes Eval=OBSOLETE DATA RETAINED V0204 - not allowed if DX > 2011
[3505] CS Lymph Nodes Eval=OBSOLETE DATA RETAINED V0204 - not allowed if CS Version Input Original > or = 020440
[3506] CS Lymph Nodes Eval=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if DX > 2009
[3507] CS Lymph Nodes Eval=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if CS Version Input Original > or = 020100
ERROR_TEXT("Date of Diagnosis: %DC")
ERROR_TEXT("Invalid site or histology")
ERROR_TEXT("Schema discriminator missing or invalid")
SAVE_TEXT("t_schema_msg")

Description

This edit checks for all obsolete CS Lymph Nodes Eval codes. Obsolete codes should be re-coded per Collaborative Stage guidelines.

This edit is skipped if any of the following conditions are true:
1. CS Lymph Nodes Eval is blank
2. Date of Diagnosis is blank
3. CS Version Input Original is blank

This edit first determines the correct CS schema by doing a function call to the CS Dynamic Link Library (dll). The function call passes Primary Site, Histologic Type ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS schema name is returned.

Using the returned schema name, CS table number (CS Lymph Nodes Eval is table number 5, and CS Lymph Nodes Eval code, a table lookup is performed. If the code for a particular schema is determined to be obsolete based on the table lookup, the type of obsolete code must be evaluated. There are several types of obsolete codes:

1. OBSOLETE DATA CONVERTED AND RETAINED V0200
2. OBSOLETE DATA CONVERTED V0102
3. OBSOLETE DATA CONVERTED V0104
4. OBSOLETE DATA CONVERTED V0200
5. OBSOLETE DATA RETAINED V0100
6. OBSOLETE DATA RETAINED V0102
7. OBSOLETE DATA RETAINED V0200
8. OBSOLETE DATA REVIEWED AND CHANGED V0102
9. OBSOLETE DATA REVIEWED AND CHANGED V0103
10. OBSOLETE DATA REVIEWED AND CHANGED V0200
11. OBSOLETE DATA CONVERTED V0203
12. OBSOLETE DATA REVIEWED AND CHANGED V0203
13. OBSOLETE DATA REVIEWED V0203
14. OBSOLETE DATA RETAINED AND REVIEWED V0203
15. OBSOLETE DATA RETAINED V0203
16. OBSOLETE DATA RETAINED V0104
17. OBSOLETE DATA RETAINED V0202
18. OBSOLETE DATA RETAINED AND REVIEWED V0200
19. OBSOLETE DATA CONVERTED V0204

20. OBSOLETE DATA REVIEWED AND CHANGED V0204
21. OBSOLETE DATA RETAINED AND REVIEWED V0204
22. OBSOLETE DATA RETAINED V0204

1. If the type of obsolete code = OBSOLETE DATA CONVERTED AND RETAINED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Lymph Nodes Eval]

2. If the type of obsolete code = OBSOLETE DATA CONVERTED V0102:
an error is generated.
[Example: none for CS Lymph Nodes Eval]

3. If the type of obsolete code = OBSOLETE DATA CONVERTED V0104:
an error is generated.
[Example: none for CS Lymph Nodes Eval]

4. If the type of obsolete code = OBSOLETE DATA CONVERTED V0200:
an error is generated.
[Example: none for CS Lymph Nodes Eval]

5. If the type of obsolete code = OBSOLETE DATA RETAINED V0100:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Lymph Nodes Eval]

6. If the type of obsolete code = OBSOLETE DATA RETAINED V0102:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Lymph Nodes Eval]

7. If the type of obsolete code = OBSOLETE DATA RETAINED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: Schema = MelanomaEyeOther, CS Lymph Nodes Eval = 0]

8. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0102:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: none for CS Lymph Nodes Eval]

9. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0103:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: none for CS Lymph Nodes Eval]

10.If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0200:
an error is generated.
(These particular obsolete codes require review after conversion from CSV01 to CSV02.)
[Example: none for CS Lymph Nodes Eval]

11. If the type of obsolete code = OBSOLETE DATA CONVERTED V0203:
an error is generated.

[Example: none for CS Lymph Nodes Eval]

12. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0203:
an error is generated.
(These particular obsolete codes require review after conversion from CSV02xx to CSV0203.)
[Example: none for CS Lymph Nodes Eval]

13. If the type of obsolete code = OBSOLETE DATA REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Lymph Nodes Eval]

14. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Lymph Nodes Eval]

15. If the type of obsolete code = OBSOLETE DATA RETAINED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Lymph Nodes Eval]

16. If the type of obsolete code = OBSOLETE DATA RETAINED V0104:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv02), an error is generated.

17. If the type of obsolete code = OBSOLETE DATA RETAINED V0202:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020200 or higher (indicating the case was originally coded using CSv0202), an error is generated.

18. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv2), an error is generated.

19. If the type of obsolete code = OBSOLETE DATA CONVERTED V0204:
an error is generated.

20. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0204:
an error is generated.
(These particular obsolete codes require review after conversion from CSV0203xx to CSV0204.)

21. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0204:
A. If year of Diagnosis is 2012 or higher, an error is generated.
B. If CS version Input Original is 020440 or higher (indicating the case was originally coded using CSv0204), an error is generated.

22. If the type of obsolete code = OBSOLETE DATA RETAINED V0204:
A. If year of Diagnosis is 2012 or higher, an error is generated.
B. If CS version Input Original is 020440 or higher (indicating the case was originally coded using CSv0204), an error is generated.

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

In the SEER*Edits software, the title of this edit is: IF273

Modifications:

NAACCR v12.1
- Modified to handle the additional types of obsolete codes that were added for CSv0203.

NAACCR v12.2
- Updated to skip if CS Version Input Original is blank.
- Modified to include the additional types of obsolete codes that were added for CSv0204.
- Modified to include 3 types of obsolete codes left out of previous versions of the edit:
-- OBSOLETE DATA RETAINED V0203
-- OBSOLETE DATA RETAINED V0104
-- OBSOLETE DATA RETAINED V0202

NAACCR v13
- Deleted duplicate error logic

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Default error message added

NAACCR v15A
- Duplicate variable declarations deleted from edit logic.

Obsolete Codes - CS Mets at DX (CS)

Agency: CS **Last changed: 09/15/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
CS Mets at DX [Std# 2850]
CS Version Input Original [Std# 2935]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]

Tables

CS_OBS.DBF

Default Error Message

[3545] %F3 [%V3] is obsolete
CS Mets at DX ["value of CS Mets at DX"] is obsolete

Additional Messages

[3359] CS Mets at DX=OBSOLETE DATA RETAINED - not allowed if DX > 2009
[3363] CS Mets at DX=OBSOLETE DATA CONVERTED V0102
[3364] CS Mets at DX=OBSOLETE DATA CONVERTED V0104
[3365] CS Mets at DX=OBSOLETE DATA CONVERTED V0200
[3366] CS Mets at DX=OBSOLETE DATA REVIEWED AND CHANGED V0102
[3367] CS Mets at DX=OBSOLETE DATA REVIEWED AND CHANGED V0103
[3368] CS Mets at DX=OBSOLETE DATA REVIEWED AND CHANGED V0200
[3386] CS Mets at DX=OBSOLETE DATA RETAINED - not allowed if CS Version Input Original > or = 020100
[3398] CS Mets at DX=OBSOLETE DATA CONVERTED V0203
[3399] CS Mets at DX=OBSOLETE DATA REVIEWED AND CHANGED V0203
[3400] CS Mets at DX=OBSOLETE DATA REVIEWED V0203 - not allowed if DX > 2010
[3401] CS Mets at DX=OBSOLETE DATA REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3402] CS Mets at DX=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if DX > 2010
[3403] CS Mets at DX=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3404] CS Mets at DX=OBSOLETE DATA RETAINED V0203 - not allowed if DX > 2010
[3405] CS Mets at DX=OBSOLETE DATA RETAINED V0203 - not allowed if CS Version Input Original > or = 020300
[3498] CS Mets at DX=OBSOLETE DATA CONVERTED V0204
[3499] CS Mets at DX=OBSOLETE DATA REVIEWED AND CHANGED V0204
[3500] CS Mets at DX=OBSOLETE DATA RETAINED V0202 - not allowed if DX > 2010
[3501] CS Mets at DX=OBSOLETE DATA RETAINED V0202 - not allowed if CS Version Input Original > or = 020200

[3502] CS Mets at DX=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if DX > 2011
[3503] CS Mets at DX=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if CS Version Input Original > or = 020440
[3504] CS Mets at DX=OBSOLETE DATA RETAINED V0204 - not allowed if DX > 2011
[3505] CS Mets at DX=OBSOLETE DATA RETAINED V0204 - not allowed if CS Version Input Original > or = 020440
[3506] CS Mets at DX=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if DX > 2009
[3507] CS Mets at DX=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if CS Version Input Original > or = 020100
ERROR_TEXT("Date of Diagnosis: %DC")
ERROR_TEXT("Invalid site or histology")
ERROR_TEXT("Schema discriminator missing or invalid")
SAVE_TEXT("t_schema_msg")

Description

This edit checks for all obsolete CS Mets at DX codes. Obsolete codes should be re-coded per Collaborative Stage guidelines.

This edit is skipped if any of the following conditions are true:
1. CS Mets at DX is blank
2. Date of Diagnosis is blank
3. CS Version Input Original is blank

This edit first determines the correct CS schema by doing a function call to the CS Dynamic Link Library (dll). The function call passes Primary Site, Histologic Type ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS schema name is returned.

Using the returned schema name, CS table number (CS Mets at DX is table number 8), and CS Mets at DX code, a table lookup is performed. If the code for a particular schema is determined to be obsolete based on the table lookup, the type of obsolete code must be evaluated. There are several types of obsolete codes:

1. OBSOLETE DATA CONVERTED AND RETAINED V0200
2. OBSOLETE DATA CONVERTED V0102
3. OBSOLETE DATA CONVERTED V0104
4. OBSOLETE DATA CONVERTED V0200
5. OBSOLETE DATA RETAINED V0100
6. OBSOLETE DATA RETAINED V0102
7. OBSOLETE DATA RETAINED V0200
8. OBSOLETE DATA REVIEWED AND CHANGED V0102
9. OBSOLETE DATA REVIEWED AND CHANGED V0103
10. OBSOLETE DATA REVIEWED AND CHANGED V0200
11. OBSOLETE DATA CONVERTED V0203
12. OBSOLETE DATA REVIEWED AND CHANGED V0203
13. OBSOLETE DATA REVIEWED V0203
14. OBSOLETE DATA RETAINED AND REVIEWED V0203
15. OBSOLETE DATA RETAINED V0203
16. OBSOLETE DATA RETAINED V0104
17. OBSOLETE DATA RETAINED V0202
18. OBSOLETE DATA RETAINED AND REVIEWED V0200
19. OBSOLETE DATA CONVERTED V0204
20. OBSOLETE DATA REVIEWED AND CHANGED V0204
21. OBSOLETE DATA RETAINED AND REVIEWED V0204
22. OBSOLETE DATA RETAINED V0204

1. If the type of obsolete code = OBSOLETE DATA CONVERTED AND RETAINED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Mets at DX]

2. If the type of obsolete code = OBSOLETE DATA CONVERTED V0102:
an error is generated.
[Example: none for CS Mets at DX]

3. If the type of obsolete code = OBSOLETE DATA CONVERTED V0104:
an error is generated.
[Example: none for CS Mets at DX]

4. If the type of obsolete code = OBSOLETE DATA CONVERTED V0200:
an error is generated.
[Example: Schema = Lung, CS Mets at DX = 10]

5. If the type of obsolete code = OBSOLETE DATA RETAINED V0100:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Mets at DX]

6. If the type of obsolete code = OBSOLETE DATA RETAINED V0102:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Mets at DX]

7. If the type of obsolete code = OBSOLETE DATA RETAINED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: Schema = Bladder, CS Mets at DX = 10]

8. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0102:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: none for CS Mets at DX]

9. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0103:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: Schema = Thyroid, CS Mets at DX = 10]

10.If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0200:
an error is generated.
(These particular obsolete codes require review after conversion from CSV01 to CSV02.)
[Example: Schema = Esophagus, CS Mets at DX = 12]

11. If the type of obsolete code = OBSOLETE DATA CONVERTED V0203:
an error is generated.
[Example: Schema = Appendix, CS Mets at DX = 07]

12. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0203:
an error is generated.

(These particular obsolete codes require review after conversion from CSV02xx to CSV0203.)
[Example: Schema = GISTEsophagus, CS Mets at DX = 50]

13. If the type of obsolete code = OBSOLETE DATA REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: Schema = Ovary, CS Mets at DX = 60]

14. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: Schema = Brain, CS Mets at DX = 10]

15. If the type of obsolete code = OBSOLETE DATA RETAINED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Mets at DX]

16. If the type of obsolete code = OBSOLETE DATA RETAINED V0104:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv02), an error is generated.

17. If the type of obsolete code = OBSOLETE DATA RETAINED V0202:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020200 or higher (indicating the case was originally coded using CSv0202), an error is generated.

18. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv2), an error is generated.

19. If the type of obsolete code = OBSOLETE DATA CONVERTED V0204:
an error is generated.

20. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0204:
an error is generated.
(These particular obsolete codes require review after conversion from CSV0203xx to CSV0204.)

21. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0204:
A. If year of Diagnosis is 2012 or higher, an error is generated.
B. If CS version Input Original is 020440 or higher (indicating the case was originally coded using CSv0204), an error is generated.

22. If the type of obsolete code = OBSOLETE DATA RETAINED V0204:
A. If year of Diagnosis is 2012 or higher, an error is generated.
B. If CS version Input Original is 020440 or higher (indicating the case was originally coded using CSv0204), an error is generated.

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

In the SEER*Edits software, the title of this edit is: IF274

Modifications:

NAACCR v12C
- Replaced reference to "CS Lymph Nodes" in description with "CS Mets at DX".

NAACCR v12.2
- Updated to skip if CS Version Input Original is blank.
- Modified to include the additional types of obsolete codes that were added for CSv0204.
- Modified to include 3 types of obsolete codes left out of previous versions of the edit:
-- OBSOLETE DATA RETAINED V0203
-- OBSOLETE DATA RETAINED V0104
-- OBSOLETE DATA RETAINED V0202

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Default error message added

NAACCR v15A
- Duplicate variable declarations deleted from edit logic.

Obsolete Codes - CS Mets Eval (CS)

Agency: CS **Last changed: 09/15/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
CS Mets Eval [Std# 2860]
CS Version Input Original [Std# 2935]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]

Tables

CS_OBS.DBF

Default Error Message

[3545] %F3 [%V3] is obsolete
CS Mets Eval ["value of CS Mets Eval"] is obsolete

Additional Messages

[3359] CS Mets Eval=OBSOLETE DATA RETAINED - not allowed if DX > 2009
[3363] CS Mets Eval=OBSOLETE DATA CONVERTED V0102
[3364] CS Mets Eval=OBSOLETE DATA CONVERTED V0104
[3365] CS Mets Eval=OBSOLETE DATA CONVERTED V0200
[3366] CS Mets Eval=OBSOLETE DATA REVIEWED AND CHANGED V0102
[3367] CS Mets Eval=OBSOLETE DATA REVIEWED AND CHANGED V0103
[3368] CS Mets Eval=OBSOLETE DATA REVIEWED AND CHANGED V0200
[3386] CS Mets Eval=OBSOLETE DATA RETAINED - not allowed if CS Version Input Original > or = 020100
[3398] CS Mets Eval=OBSOLETE DATA CONVERTED V0203
[3399] CS Mets Eval=OBSOLETE DATA REVIEWED AND CHANGED V0203
[3400] CS Mets Eval=OBSOLETE DATA REVIEWED V0203 - not allowed if DX > 2010
[3401] CS Mets Eval=OBSOLETE DATA REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3402] CS Mets Eval=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if DX > 2010
[3403] CS Mets Eval=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3404] CS Mets Eval=OBSOLETE DATA RETAINED V0203 - not allowed if DX > 2010
[3405] CS Mets Eval=OBSOLETE DATA RETAINED V0203 - not allowed if CS Version Input Original > or = 020300
[3498] CS Mets Eval=OBSOLETE DATA CONVERTED V0204
[3499] CS Mets Eval=OBSOLETE DATA REVIEWED AND CHANGED V0204
[3500] CS Mets Eval=OBSOLETE DATA RETAINED V0202 - not allowed if DX > 2010
[3501] CS Mets Eval=OBSOLETE DATA RETAINED V0202 - not allowed if CS Version Input Original > or = 020200
[3502] CS Mets Eval=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if DX > 2011

[3503] CS Mets Eval=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if CS Version Input Original > or = 020440
[3504] CS Mets Eval=OBSOLETE DATA RETAINED V0204 - not allowed if DX > 2011
[3505] CS Mets Eval=OBSOLETE DATA RETAINED V0204 - not allowed if CS Version Input Original > or = 020440
[3506] CS Mets Eval=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if DX > 2009
[3507] CS Mets Eval=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if CS Version Input Original > or = 020100
ERROR_TEXT("Date of Diagnosis: %DC")
ERROR_TEXT("Invalid site or histology")
ERROR_TEXT("Schema discriminator missing or invalid")
SAVE_TEXT("t_schema_msg")

Description

This edit checks for all obsolete CS Mets Eval codes. Obsolete codes should be re-coded per Collaborative Stage guidelines.

This edit is skipped if any of the following conditions are true:
1. CS Mets Eval is blank
2. Date of Diagnosis is blank
3. CS Version Input Original is blank

This edit first determines the correct CS schema by doing a function call to the CS Dynamic Link Library (dll). The function call passes Primary Site, Histologic Type ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS schema name is returned.

Using the returned schema name, CS table number (CS Mets Eval is table number 9, and CS Mets Eval code, a table lookup is performed. If the code for a particular schema is determined to be obsolete based on the table lookup, the type of obsolete code must be evaluated. There are several types of obsolete codes:

1. OBSOLETE DATA CONVERTED AND RETAINED V0200
2. OBSOLETE DATA CONVERTED V0102
3. OBSOLETE DATA CONVERTED V0104
4. OBSOLETE DATA CONVERTED V0200
5. OBSOLETE DATA RETAINED V0100
6. OBSOLETE DATA RETAINED V0102
7. OBSOLETE DATA RETAINED V0200
8. OBSOLETE DATA REVIEWED AND CHANGED V0102
9. OBSOLETE DATA REVIEWED AND CHANGED V0103
10. OBSOLETE DATA REVIEWED AND CHANGED V0200
11. OBSOLETE DATA CONVERTED V0203
12. OBSOLETE DATA REVIEWED AND CHANGED V0203
13. OBSOLETE DATA REVIEWED V0203
14. OBSOLETE DATA RETAINED AND REVIEWED V0203
15. OBSOLETE DATA RETAINED V0203
16. OBSOLETE DATA RETAINED V0104
17. OBSOLETE DATA RETAINED V0202
18. OBSOLETE DATA RETAINED AND REVIEWED V0200
19. OBSOLETE DATA CONVERTED V0204
20. OBSOLETE DATA REVIEWED AND CHANGED V0204
21. OBSOLETE DATA RETAINED AND REVIEWED V0204
22. OBSOLETE DATA RETAINED V0204

1. If the type of obsolete code = OBSOLETE DATA CONVERTED AND RETAINED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.

B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Mets Eval]

2. If the type of obsolete code = OBSOLETE DATA CONVERTED V0102:
an error is generated.
[Example: none for CS Mets Eval]

3. If the type of obsolete code = OBSOLETE DATA CONVERTED V0104:
an error is generated.
[Example: none for CS Mets Eval]

4. If the type of obsolete code = OBSOLETE DATA CONVERTED V0200:
an error is generated.
[Example: none for CS Mets Eval]

5. If the type of obsolete code = OBSOLETE DATA RETAINED V0100:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Mets Eval]

6. If the type of obsolete code = OBSOLETE DATA RETAINED V0102:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Mets Eval]

7. If the type of obsolete code = OBSOLETE DATA RETAINED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: Schema = MelanomaEyeOther, CS Mets Eval = 0]

8. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0102:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: none for CS Mets Eval]

9. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0103:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: none for CS Mets Eval]

10.If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0200:
an error is generated.
(These particular obsolete codes require review after conversion from CSV01 to CSV02.)
[Example: none for CS Mets Eval]

11. If the type of obsolete code = OBSOLETE DATA CONVERTED V0203:
an error is generated.
[Example: none for CS Mets Eval]

12. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0203:
an error is generated.
(These particular obsolete codes require review after conversion from CSV02xx to CSV0203.)

[Example: none for CS Mets Eval]

13. If the type of obsolete code = OBSOLETE DATA REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Mets Eval]

14. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Mets Eval]

15. If the type of obsolete code = OBSOLETE DATA RETAINED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Mets Eval]

16. If the type of obsolete code = OBSOLETE DATA RETAINED V0104:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv02), an error is generated.

17. If the type of obsolete code = OBSOLETE DATA RETAINED V0202:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020200 or higher (indicating the case was originally coded using CSv0202), an error is generated.

18. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv2), an error is generated.

19. If the type of obsolete code = OBSOLETE DATA CONVERTED V0204:
an error is generated.

20. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0204:
an error is generated.
(These particular obsolete codes require review after conversion from CSV0203xx to CSV0204.)

21. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0204:
A. If year of Diagnosis is 2012 or higher, an error is generated.
B. If CS version Input Original is 020440 or higher (indicating the case was originally coded using CSv0204), an error is generated.

22. If the type of obsolete code = OBSOLETE DATA RETAINED V0204:
A. If year of Diagnosis is 2012 or higher, an error is generated.
B. If CS version Input Original is 020440 or higher (indicating the case was originally coded using CSv0204), an error is generated.

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

In the SEER*Edits software, the title of this edit is: IF275

Modifications:

NAACCR v12.1
- Modified to handle the additional types of obsolete codes that were added for CSv0203.

NAACCR v12.2
- Updated to skip if CS Version Input Original is blank.
- Modified to include the additional types of obsolete codes that were added for CSv0204.
- Modified to include 3 types of obsolete codes left out of previous versions of the edit:
-- OBSOLETE DATA RETAINED V0203
-- OBSOLETE DATA RETAINED V0104
-- OBSOLETE DATA RETAINED V0202

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Default error message added

NAACCR v15A
- Duplicate variable declarations deleted from edit logic.

Obsolete Codes - CS Site-Specific Factor 1 (CS)

Agency: CS **Last changed: 09/15/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
CS Site-Specific Factor 1 [Std# 2880]
CS Version Input Original [Std# 2935]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]

Tables

CS_OBS.DBF

Default Error Message

[3545] %F3 [%V3] is obsolete
CS Site-Specific Factor 1 ["value of CS Site-Specific Factor 1"] is obsolete

Additional Messages

[3359] CS Site-Specific Factor 1=OBSOLETE DATA RETAINED - not allowed if DX > 2009
[3363] CS Site-Specific Factor 1=OBSOLETE DATA CONVERTED V0102
[3364] CS Site-Specific Factor 1=OBSOLETE DATA CONVERTED V0104
[3365] CS Site-Specific Factor 1=OBSOLETE DATA CONVERTED V0200
[3366] CS Site-Specific Factor 1=OBSOLETE DATA REVIEWED AND CHANGED V0102
[3367] CS Site-Specific Factor 1=OBSOLETE DATA REVIEWED AND CHANGED V0103
[3368] CS Site-Specific Factor 1=OBSOLETE DATA REVIEWED AND CHANGED V0200
[3386] CS Site-Specific Factor 1=OBSOLETE DATA RETAINED - not allowed if CS Version Input Original > or = 020100
[3398] CS Site-Specific Factor 1=OBSOLETE DATA CONVERTED V0203
[3399] CS Site-Specific Factor 1=OBSOLETE DATA REVIEWED AND CHANGED V0203
[3400] CS Site-Specific Factor 1=OBSOLETE DATA REVIEWED V0203 - not allowed if DX > 2010
[3401] CS Site-Specific Factor 1=OBSOLETE DATA REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3402] CS Site-Specific Factor 1=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if DX > 2010
[3403] CS Site-Specific Factor 1=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3404] CS Site-Specific Factor 1=OBSOLETE DATA RETAINED V0203 - not allowed if DX > 2010
[3405] CS Site-Specific Factor 1=OBSOLETE DATA RETAINED V0203 - not allowed if CS Version Input Original > or = 020300
[3498] CS Site-Specific Factor 1=OBSOLETE DATA CONVERTED V0204
[3499] CS Site-Specific Factor 1=OBSOLETE DATA REVIEWED AND CHANGED V0204
[3500] CS Site-Specific Factor 1=OBSOLETE DATA RETAINED V0202 - not allowed if DX > 2010

[3501] CS Site-Specific Factor 1=OBSOLETE DATA RETAINED V0202 - not allowed if CS Version Input Original > or = 020200
[3502] CS Site-Specific Factor 1=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if DX > 2011
[3503] CS Site-Specific Factor 1=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if CS Version Input Original > or = 020440
[3504] CS Site-Specific Factor 1=OBSOLETE DATA RETAINED V0204 - not allowed if DX > 2011
[3505] CS Site-Specific Factor 1=OBSOLETE DATA RETAINED V0204 - not allowed if CS Version Input Original > or = 020440
[3506] CS Site-Specific Factor 1=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if DX > 2009
[3507] CS Site-Specific Factor 1=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if CS Version Input Original > or = 020100
ERROR_TEXT("Date of Diagnosis: %DC")
ERROR_TEXT("Invalid site or histology")
ERROR_TEXT("Schema discriminator missing or invalid")
SAVE_TEXT("t_schema_msg")

Description

This edit checks for all obsolete CS Site-Specific Factor 1 codes. Obsolete codes should be re-coded per Collaborative Stage guidelines.

TThis edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor 1 is blank
2. Date of Diagnosis is blank
3. CS Version Input Original is blank

This edit first determines the correct CS schema by doing a function call to the CS Dynamic Link Library (dll). The function call passes Primary Site, Histologic Type ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS schema name is returned.

Using the returned schema name, CS table number (CS Site-Specific Factor 1 is table number 10), and CS Site-Specific Factor 1 code, a table lookup is performed. If the code for a particular schema is determined to be obsolete based on the table lookup, the type of obsolete code must be evaluated. There are several types of obsolete codes:

1. OBSOLETE DATA CONVERTED AND RETAINED V0200
2. OBSOLETE DATA CONVERTED V0102
3. OBSOLETE DATA CONVERTED V0104
4. OBSOLETE DATA CONVERTED V0200
5. OBSOLETE DATA RETAINED V0100
6. OBSOLETE DATA RETAINED V0102
7. OBSOLETE DATA RETAINED V0200
8. OBSOLETE DATA REVIEWED AND CHANGED V0102
9. OBSOLETE DATA REVIEWED AND CHANGED V0103
10. OBSOLETE DATA REVIEWED AND CHANGED V0200
11. OBSOLETE DATA CONVERTED V0203
12. OBSOLETE DATA REVIEWED AND CHANGED V0203
13. OBSOLETE DATA REVIEWED V0203
14. OBSOLETE DATA RETAINED AND REVIEWED V0203
15. OBSOLETE DATA RETAINED V0203
16. OBSOLETE DATA RETAINED V0104
17. OBSOLETE DATA RETAINED V0202
18. OBSOLETE DATA RETAINED AND REVIEWED V0200

19. OBSOLETE DATA CONVERTED V0204
20. OBSOLETE DATA REVIEWED AND CHANGED V0204
21. OBSOLETE DATA RETAINED AND REVIEWED V0204
22. OBSOLETE DATA RETAINED V0204

1. If the type of obsolete code = OBSOLETE DATA CONVERTED AND RETAINED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor 1]

2. If the type of obsolete code = OBSOLETE DATA CONVERTED V0102:
an error is generated.
[Example: Schema = MelanomaSkin, CS Site-Specific Factor 1 = 990]

3. If the type of obsolete code = OBSOLETE DATA CONVERTED V0104:
an error is generated.
[Example: none for CS Site-Specific Factor 1]

4. If the type of obsolete code = OBSOLETE DATA CONVERTED V0200:
an error is generated.
[Example: Schema = Prostate, CS Site-Specific Factor 1 = 000]

5. If the type of obsolete code = OBSOLETE DATA RETAINED V0100:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor 1]

6. If the type of obsolete code = OBSOLETE DATA RETAINED V0102:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor 1]

7. If the type of obsolete code = OBSOLETE DATA RETAINED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: Schema = CarcinoidAppendix, CS Site-Specific Factor 1 = 000]

8. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0102:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: none for CS Site-Specific Factor 1]

9. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0103:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: none for CS Site-Specific Factor 1]

10.If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0200:
an error is generated.
(These particular obsolete codes require review after conversion from CSV01 to CSV02.)
[Example: none for CS Site-Specific Factor 1]

11. If the type of obsolete code = OBSOLETE DATA CONVERTED V0203:

an error is generated.
[Example: Schema = Appendix, CS Site-Specific Factor 1 = 000]

12. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0203:
an error is generated.
(These particular obsolete codes require review after conversion from CSV02xx to CSV0203.)
[Example: none for CS Site-Specific Factor 1]

13. If the type of obsolete code = OBSOLETE DATA REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor 1]

14. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor 1]

15. If the type of obsolete code = OBSOLETE DATA RETAINED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: Schema = MyelomaPlasmaCellDisorder, CS Site-Specific Factor 1 = 000]

16. If the type of obsolete code = OBSOLETE DATA RETAINED V0104:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv02), an error is generated.

17. If the type of obsolete code = OBSOLETE DATA RETAINED V0202:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020200 or higher (indicating the case was originally coded using CSv0202), an error is generated.

18. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv2), an error is generated.

19. If the type of obsolete code = OBSOLETE DATA CONVERTED V0204:
an error is generated.

20. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0204:
an error is generated.
(These particular obsolete codes require review after conversion from CSV0203xx to CSV0204.)

21. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0204:
A. If year of Diagnosis is 2012 or higher, an error is generated.
B. If CS version Input Original is 020440 or higher (indicating the case was originally coded using CSv0204), an error is generated.

22. If the type of obsolete code = OBSOLETE DATA RETAINED V0204:
A. If year of Diagnosis is 2012 or higher, an error is generated.
B. If CS version Input Original is 020440 or higher (indicating the case was originally coded using CSv0204), an error is generated.

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

In the SEER*Edits software, the title of this edit is: IF276

Modifications:

NAACCR v12.1
- Modified to handle the additional types of obsolete codes that were added for CSv0203.

NAACCR v12.2
- Updated to skip if CS Version Input Original is blank.
- Modified to include the additional types of obsolete codes that were added for CSv0204.
- Modified to include 3 types of obsolete codes left out of previous versions of the edit:
-- OBSOLETE DATA RETAINED V0203
-- OBSOLETE DATA RETAINED V0104
-- OBSOLETE DATA RETAINED V0202

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Default error message added

NAACCR v15A
- Duplicate variable declarations deleted from edit logic.

Obsolete Codes - CS Site-Specific Factor 2 (CS)

Agency: CS **Last changed: 09/15/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
CS Site-Specific Factor 2 [Std# 2890]
CS Version Input Original [Std# 2935]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]

Tables

CS_OBS.DBF

Default Error Message

[3545] %F3 [%V3] is obsolete
CS Site-Specific Factor 2 ["value of CS Site-Specific Factor 2"] is obsolete

Additional Messages

[3359] CS Site-Specific Factor 2=OBSOLETE DATA RETAINED - not allowed if DX > 2009
[3363] CS Site-Specific Factor 2=OBSOLETE DATA CONVERTED V0102
[3364] CS Site-Specific Factor 2=OBSOLETE DATA CONVERTED V0104
[3365] CS Site-Specific Factor 2=OBSOLETE DATA CONVERTED V0200
[3366] CS Site-Specific Factor 2=OBSOLETE DATA REVIEWED AND CHANGED V0102
[3367] CS Site-Specific Factor 2=OBSOLETE DATA REVIEWED AND CHANGED V0103
[3368] CS Site-Specific Factor 2=OBSOLETE DATA REVIEWED AND CHANGED V0200
[3386] CS Site-Specific Factor 2=OBSOLETE DATA RETAINED - not allowed if CS Version Input Original > or = 020100
[3398] CS Site-Specific Factor 2=OBSOLETE DATA CONVERTED V0203
[3399] CS Site-Specific Factor 2=OBSOLETE DATA REVIEWED AND CHANGED V0203
[3400] CS Site-Specific Factor 2=OBSOLETE DATA REVIEWED V0203 - not allowed if DX > 2010
[3401] CS Site-Specific Factor 2=OBSOLETE DATA REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3402] CS Site-Specific Factor 2=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if DX > 2010
[3403] CS Site-Specific Factor 2=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3404] CS Site-Specific Factor 2=OBSOLETE DATA RETAINED V0203 - not allowed if DX > 2010
[3405] CS Site-Specific Factor 2=OBSOLETE DATA RETAINED V0203 - not allowed if CS Version Input Original > or = 020300
[3498] CS Site-Specific Factor 2=OBSOLETE DATA CONVERTED V0204
[3499] CS Site-Specific Factor 2=OBSOLETE DATA REVIEWED AND CHANGED V0204
[3500] CS Site-Specific Factor 2=OBSOLETE DATA RETAINED V0202 - not allowed if DX > 2010

[3501] CS Site-Specific Factor 2=OBSOLETE DATA RETAINED V0202 - not allowed if CS Version Input Original > or = 020200
[3502] CS Site-Specific Factor 2=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if DX > 2011
[3503] CS Site-Specific Factor 2=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if CS Version Input Original > or = 020440
[3504] CS Site-Specific Factor 2=OBSOLETE DATA RETAINED V0204 - not allowed if DX > 2011
[3505] CS Site-Specific Factor 2=OBSOLETE DATA RETAINED V0204 - not allowed if CS Version Input Original > or = 020440
[3506] CS Site-Specific Factor 2=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if DX > 2009
[3507] CS Site-Specific Factor 2=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if CS Version Input Original > or = 020100
ERROR_TEXT("Date of Diagnosis: %DC")
ERROR_TEXT("Invalid site or histology")
ERROR_TEXT("Schema discriminator missing or invalid")
SAVE_TEXT("t_schema_msg")

Description

This edit checks for all obsolete CS Site-Specific Factor 2 codes. Obsolete codes should be re-coded per Collaborative Stage guidelines.

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor 2 is blank
2. Date of Diagnosis is blank
3. CS Version Input Original is blank

This edit is also skipped if schema is MelanomaIris.

This edit first determines the correct CS schema by doing a function call to the CS Dynamic Link Library (dll). The function call passes Primary Site, Histologic Type ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS schema name is returned.

Using the returned schema name, CS table number (CS Site-Specific Factor 2 is table number 11), and CS Site-Specific Factor 2 code, a table lookup is performed. If the code for a particular schema is determined to be obsolete based on the table lookup, the type of obsolete code must be evaluated. There are several types of obsolete codes:

1. OBSOLETE DATA CONVERTED AND RETAINED V0200
2. OBSOLETE DATA CONVERTED V0102
3. OBSOLETE DATA CONVERTED V0104
4. OBSOLETE DATA CONVERTED V0200
5. OBSOLETE DATA RETAINED V0100
6. OBSOLETE DATA RETAINED V0102
7. OBSOLETE DATA RETAINED V0200
8. OBSOLETE DATA REVIEWED AND CHANGED V0102
9. OBSOLETE DATA REVIEWED AND CHANGED V0103
10. OBSOLETE DATA REVIEWED AND CHANGED V0200
11. OBSOLETE DATA CONVERTED V0203
12. OBSOLETE DATA REVIEWED AND CHANGED V0203
13. OBSOLETE DATA REVIEWED V0203
14. OBSOLETE DATA RETAINED AND REVIEWED V0203
15. OBSOLETE DATA RETAINED V0203
16. OBSOLETE DATA RETAINED V0104

17. OBSOLETE DATA RETAINED V0202
18. OBSOLETE DATA RETAINED AND REVIEWED V0200
19. OBSOLETE DATA CONVERTED V0204
20. OBSOLETE DATA REVIEWED AND CHANGED V0204
21. OBSOLETE DATA RETAINED AND REVIEWED V0204
22. OBSOLETE DATA RETAINED V0204

1. If the type of obsolete code = OBSOLETE DATA CONVERTED AND RETAINED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: Schema = BuccalMucosa, CS Site-Specific Factor 2 = 987]

2. If the type of obsolete code = OBSOLETE DATA CONVERTED V0102:
an error is generated.
[Example: none for CS Site-Specific Factor 2]

3. If the type of obsolete code = OBSOLETE DATA CONVERTED V0104:
an error is generated.
[Example: none for CS Site-Specific Factor 2]

4. If the type of obsolete code = OBSOLETE DATA CONVERTED V0200:
an error is generated.
[Example: Schema = Prostate, CS Site-Specific Factor 2 = 000]

5. If the type of obsolete code = OBSOLETE DATA RETAINED V0100:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor 2]

6. If the type of obsolete code = OBSOLETE DATA RETAINED V0102:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor 2]

7. If the type of obsolete code = OBSOLETE DATA RETAINED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: Schema = BuccalMucosa, CS Site-Specific Factor 2 = 000]

8. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0102:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: none for CS Site-Specific Factor 2]

9. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0103:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: none for CS Site-Specific Factor 2]

10.If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0200:
an error is generated.
(These particular obsolete codes require review after conversion from CSV01 to CSV02.)
[Example: none for CS Site-Specific Factor 2]

11. If the type of obsolete code = OBSOLETE DATA CONVERTED V0203:
an error is generated.
[Example: Schema = Breast, CS Site-Specific Factor 2 = 000]

12. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0203:
an error is generated.
(These particular obsolete codes require review after conversion from CSV02xx to CSV0203.)
[Example: Schema = Esophagus, CS Site-Specific Factor 2 = 100]

13. If the type of obsolete code = OBSOLETE DATA REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor 2]

14. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor 2]

15. If the type of obsolete code = OBSOLETE DATA RETAINED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor 2]

16. If the type of obsolete code = OBSOLETE DATA RETAINED V0104:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv02), an error is generated.

17. If the type of obsolete code = OBSOLETE DATA RETAINED V0202:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020200 or higher (indicating the case was originally coded using CSv0202), an error is generated.

18. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv2), an error is generated.

19. If the type of obsolete code = OBSOLETE DATA CONVERTED V0204:
an error is generated.

20. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0204:
an error is generated.
(These particular obsolete codes require review after conversion from CSV0203xx to CSV0204.)

21. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0204:
A. If year of Diagnosis is 2012 or higher, an error is generated.
B. If CS version Input Original is 020440 or higher (indicating the case was originally coded using CSv0204), an error is generated.

22. If the type of obsolete code = OBSOLETE DATA RETAINED V0204:
A. If year of Diagnosis is 2012 or higher, an error is generated.

B. If CS version Input Original is 020440 or higher (indicating the case was originally coded using CSv0204), an error is generated.

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

In the SEER*Edits software, the title of this edit is: IF277

Modifications:

NAACCR v12.1
- Modified to handle the additional types of obsolete codes that were added for CSv0203.

NAACCR v12.2
- Updated to skip if CS Version Input Original is blank.
- Modified to include the additional types of obsolete codes that were added for CSv0204.
- Modified to include 3 types of obsolete codes left out of previous versions of the edit:
-- OBSOLETE DATA RETAINED V0203
-- OBSOLETE DATA RETAINED V0104
-- OBSOLETE DATA RETAINED V0202

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Default error message added

NAACCR v15A
- Duplicate variable declarations deleted from edit logic.

Obsolete Codes - CS Site-Specific Factor 3 (CS)

Agency: CS **Last changed: 09/15/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
CS Site-Specific Factor 3 [Std# 2900]
CS Version Input Original [Std# 2935]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]

Tables

CS_OBS.DBF

Default Error Message

[3545] %F3 [%V3] is obsolete
CS Site-Specific Factor 3 ["value of CS Site-Specific Factor 3"] is obsolete

Additional Messages

[3359] CS Site-Specific Factor 3=OBSOLETE DATA RETAINED - not allowed if DX > 2009
[3363] CS Site-Specific Factor 3=OBSOLETE DATA CONVERTED V0102
[3364] CS Site-Specific Factor 3=OBSOLETE DATA CONVERTED V0104
[3365] CS Site-Specific Factor 3=OBSOLETE DATA CONVERTED V0200
[3366] CS Site-Specific Factor 3=OBSOLETE DATA REVIEWED AND CHANGED V0102
[3367] CS Site-Specific Factor 3=OBSOLETE DATA REVIEWED AND CHANGED V0103
[3368] CS Site-Specific Factor 3=OBSOLETE DATA REVIEWED AND CHANGED V0200
[3386] CS Site-Specific Factor 3=OBSOLETE DATA RETAINED - not allowed if CS Version Input Original > or = 020100
[3398] CS Site-Specific Factor 3=OBSOLETE DATA CONVERTED V0203
[3399] CS Site-Specific Factor 3=OBSOLETE DATA REVIEWED AND CHANGED V0203
[3400] CS Site-Specific Factor 3=OBSOLETE DATA REVIEWED V0203 - not allowed if DX > 2010
[3401] CS Site-Specific Factor 3=OBSOLETE DATA REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3402] CS Site-Specific Factor 3=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if DX > 2010
[3403] CS Site-Specific Factor 3=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3404] CS Site-Specific Factor 3=OBSOLETE DATA RETAINED V0203 - not allowed if DX > 2010
[3405] CS Site-Specific Factor 3=OBSOLETE DATA RETAINED V0203 - not allowed if CS Version Input Original > or = 020300
[3498] CS Site-Specific Factor 3=OBSOLETE DATA CONVERTED V0204
[3499] CS Site-Specific Factor 3=OBSOLETE DATA REVIEWED AND CHANGED V0204
[3500] CS Site-Specific Factor 3=OBSOLETE DATA RETAINED V0202 - not allowed if DX > 2010

[3501] CS Site-Specific Factor 3=OBSOLETE DATA RETAINED V0202 - not allowed if CS Version Input Original > or = 020200
[3502] CS Site-Specific Factor 3=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if DX > 2011
[3503] CS Site-Specific Factor 3=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if CS Version Input Original > or = 020440
[3504] CS Site-Specific Factor 3=OBSOLETE DATA RETAINED V0204 - not allowed if DX > 2011
[3505] CS Site-Specific Factor 3=OBSOLETE DATA RETAINED V0204 - not allowed if CS Version Input Original > or = 020440
[3506] CS Site-Specific Factor 3=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if DX > 2009
[3507] CS Site-Specific Factor 3=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if CS Version Input Original > or = 020100
ERROR_TEXT("Date of Diagnosis: %DC")
ERROR_TEXT("Invalid site or histology")
ERROR_TEXT("Schema discriminator missing or invalid")
SAVE_TEXT("t_schema_msg")

Description

This edit checks for all obsolete CS Site-Specific Factor 3 codes. Obsolete codes should be re-coded per Collaborative Stage guidelines.

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor 3 is blank
2. Date of Diagnosis is blank
3. CS Version Input Original is blank

This edit first determines the correct CS schema by doing a function call to the CS Dynamic Link Library (dll). The function call passes Primary Site, Histologic Type ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS schema name is returned.

Using the returned schema name, CS table number (CS Site-Specific Factor 3 is table number 12), and CS Site-Specific Factor 3 code, a table lookup is performed. If the code for a particular schema is determined to be obsolete based on the table lookup, the type of obsolete code must be evaluated. There are several types of obsolete codes:

1. OBSOLETE DATA CONVERTED AND RETAINED V0200
2. OBSOLETE DATA CONVERTED V0102
3. OBSOLETE DATA CONVERTED V0104
4. OBSOLETE DATA CONVERTED V0200
5. OBSOLETE DATA RETAINED V0100
6. OBSOLETE DATA RETAINED V0102
7. OBSOLETE DATA RETAINED V0200
8. OBSOLETE DATA REVIEWED AND CHANGED V0102
9. OBSOLETE DATA REVIEWED AND CHANGED V0103
10. OBSOLETE DATA REVIEWED AND CHANGED V0200
11. OBSOLETE DATA CONVERTED V0203
12. OBSOLETE DATA REVIEWED AND CHANGED V0203
13. OBSOLETE DATA REVIEWED V0203
14. OBSOLETE DATA RETAINED AND REVIEWED V0203
15. OBSOLETE DATA RETAINED V0203
16. OBSOLETE DATA RETAINED V0104
17. OBSOLETE DATA RETAINED V0202
18. OBSOLETE DATA RETAINED AND REVIEWED V0200

19. OBSOLETE DATA CONVERTED V0204
20. OBSOLETE DATA REVIEWED AND CHANGED V0204
21. OBSOLETE DATA RETAINED AND REVIEWED V0204
22. OBSOLETE DATA RETAINED V0204

1. If the type of obsolete code = OBSOLETE DATA CONVERTED AND RETAINED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor 3]

2. If the type of obsolete code = OBSOLETE DATA CONVERTED V0102:
an error is generated.
[Example: none for CS Site-Specific Factor 3]

3. If the type of obsolete code = OBSOLETE DATA CONVERTED V0104:
an error is generated.
[Example: none for CS Site-Specific Factor 3]

4. If the type of obsolete code = OBSOLETE DATA CONVERTED V0200:
an error is generated.
[Example: Schema = Prostate, CS Site-Specific Factor 3 = 020]

5. If the type of obsolete code = OBSOLETE DATA RETAINED V0100:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor 3]

6. If the type of obsolete code = OBSOLETE DATA RETAINED V0102:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor 3]

7. If the type of obsolete code = OBSOLETE DATA RETAINED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: Schema = Testis, CS Site-Specific Factor 3 = 000]

8. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0102:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: Schema = Prostate, CS Site-Specific Factor 3 = 031]

9. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0103:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: none for CS Site-Specific Factor 3]

10.If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0200:
an error is generated.
(These particular obsolete codes require review after conversion from CSV01 to CSV02.)
[Example: none for CS Site-Specific Factor 3]

11. If the type of obsolete code = OBSOLETE DATA CONVERTED V0203:

an error is generated.
[Example: Schema = Cervix, CS Site-Specific Factor 3 = 000]

12. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0203:
an error is generated.
(These particular obsolete codes require review after conversion from CSV02xx to CSV0203.)
[Example: none for CS Site-Specific Factor 3]

13. If the type of obsolete code = OBSOLETE DATA REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: Schema = Prostate, CS Site-Specific Factor 3 = 410]

14. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor 3]

15. If the type of obsolete code = OBSOLETE DATA RETAINED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor 3]

16. If the type of obsolete code = OBSOLETE DATA RETAINED V0104:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv02), an error is generated.

17. If the type of obsolete code = OBSOLETE DATA RETAINED V0202:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020200 or higher (indicating the case was originally coded using CSv0202), an error is generated.

18. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv2), an error is generated.

19. If the type of obsolete code = OBSOLETE DATA CONVERTED V0204:
an error is generated.

20. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0204:
an error is generated.
(These particular obsolete codes require review after conversion from CSV0203xx to CSV0204.)

21. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0204:
A. If year of Diagnosis is 2012 or higher, an error is generated.
B. If CS version Input Original is 020440 or higher (indicating the case was originally coded using CSv0204), an error is generated.

22. If the type of obsolete code = OBSOLETE DATA RETAINED V0204:
A. If year of Diagnosis is 2012 or higher, an error is generated.
B. If CS version Input Original is 020440 or higher (indicating the case was originally coded using CSv0204), an error is generated.

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

In the SEER*Edits software, the title of this edit is: IF278

Modifications:

NAACCR v12.1
- Modified to handle the additional types of obsolete codes that were added for CSv0203.

NAACCR v12.2
- Updated to skip if CS Version Input Original is blank.
- Modified to include the additional types of obsolete codes that were added for CSv0204.
- Modified to include 3 types of obsolete codes left out of previous versions of the edit:
-- OBSOLETE DATA RETAINED V0203
-- OBSOLETE DATA RETAINED V0104
-- OBSOLETE DATA RETAINED V0202

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Default error message added

NAACCR v15A
- Duplicate variable declarations deleted from edit logic.

Obsolete Codes - CS Site-Specific Factor 4 (CS)

Agency: CS **Last changed: 09/15/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
CS Site-Specific Factor 4 [Std# 2910]
CS Version Input Original [Std# 2935]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]

Tables

CS_OBS.DBF

Default Error Message

[3545] %F3 [%V3] is obsolete
CS Site-Specific Factor 4 ["value of CS Site-Specific Factor 4"] is obsolete

Additional Messages

[3359] CS Site-Specific Factor 4=OBSOLETE DATA RETAINED - not allowed if DX > 2009
[3363] CS Site-Specific Factor 4=OBSOLETE DATA CONVERTED V0102
[3364] CS Site-Specific Factor 4=OBSOLETE DATA CONVERTED V0104
[3365] CS Site-Specific Factor 4=OBSOLETE DATA CONVERTED V0200
[3366] CS Site-Specific Factor 4=OBSOLETE DATA REVIEWED AND CHANGED V0102
[3367] CS Site-Specific Factor 4=OBSOLETE DATA REVIEWED AND CHANGED V0103
[3368] CS Site-Specific Factor 4=OBSOLETE DATA REVIEWED AND CHANGED V0200
[3386] CS Site-Specific Factor 4=OBSOLETE DATA RETAINED - not allowed if CS Version Input Original > or = 020100
[3398] CS Site-Specific Factor 4=OBSOLETE DATA CONVERTED V0203
[3399] CS Site-Specific Factor 4=OBSOLETE DATA REVIEWED AND CHANGED V0203
[3400] CS Site-Specific Factor 4=OBSOLETE DATA REVIEWED V0203 - not allowed if DX > 2010
[3401] CS Site-Specific Factor 4=OBSOLETE DATA REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3402] CS Site-Specific Factor 4=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if DX > 2010
[3403] CS Site-Specific Factor 4=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3404] CS Site-Specific Factor 4=OBSOLETE DATA RETAINED V0203 - not allowed if DX > 2010
[3405] CS Site-Specific Factor 4=OBSOLETE DATA RETAINED V0203 - not allowed if CS Version Input Original > or = 020300
[3498] CS Site-Specific Factor 4=OBSOLETE DATA CONVERTED V0204
[3499] CS Site-Specific Factor 4=OBSOLETE DATA REVIEWED AND CHANGED V0204
[3500] CS Site-Specific Factor 4=OBSOLETE DATA RETAINED V0202 - not allowed if DX > 2010

[3501] CS Site-Specific Factor 4=OBSOLETE DATA RETAINED V0202 - not allowed if CS Version Input Original > or = 020200
[3502] CS Site-Specific Factor 4=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if DX > 2011
[3503] CS Site-Specific Factor 4=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if CS Version Input Original > or = 020440
[3504] CS Site-Specific Factor 4=OBSOLETE DATA RETAINED V0204 - not allowed if DX > 2011
[3505] CS Site-Specific Factor 4=OBSOLETE DATA RETAINED V0204 - not allowed if CS Version Input Original > or = 020440
[3506] CS Site-Specific Factor 4=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if DX > 2009
[3507] CS Site-Specific Factor 4=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if CS Version Input Original > or = 020100
ERROR_TEXT("Date of Diagnosis: %DC")
ERROR_TEXT("Invalid site or histology")
ERROR_TEXT("Schema discriminator missing or invalid")
SAVE_TEXT("t_schema_msg")

Description

This edit checks for all obsolete CS Site-Specific Factor 4 codes. Obsolete codes should be re-coded per Collaborative Stage guidelines.

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor 4 is blank
2. Date of Diagnosis is blank
3. CS Version Input Original is blank

This edit first determines the correct CS schema by doing a function call to the CS Dynamic Link Library (dll). The function call passes Primary Site, Histologic Type ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS schema name is returned.

Using the returned schema name, CS table number (CS Site-Specific Factor 4 is table number 13), and CS Site-Specific Factor 4 code, a table lookup is performed. If the code for a particular schema is determined to be obsolete based on the table lookup, the type of obsolete code must be evaluated. There are several types of obsolete codes:

1. OBSOLETE DATA CONVERTED AND RETAINED V0200
2. OBSOLETE DATA CONVERTED V0102
3. OBSOLETE DATA CONVERTED V0104
4. OBSOLETE DATA CONVERTED V0200
5. OBSOLETE DATA RETAINED V0100
6. OBSOLETE DATA RETAINED V0102
7. OBSOLETE DATA RETAINED V0200
8. OBSOLETE DATA REVIEWED AND CHANGED V0102
9. OBSOLETE DATA REVIEWED AND CHANGED V0103
10. OBSOLETE DATA REVIEWED AND CHANGED V0200
11. OBSOLETE DATA CONVERTED V0203
12. OBSOLETE DATA REVIEWED AND CHANGED V0203
13. OBSOLETE DATA REVIEWED V0203
14. OBSOLETE DATA RETAINED AND REVIEWED V0203
15. OBSOLETE DATA RETAINED V0203
16. OBSOLETE DATA RETAINED V0104
17. OBSOLETE DATA RETAINED V0202
18. OBSOLETE DATA RETAINED AND REVIEWED V0200

19. OBSOLETE DATA CONVERTED V0204
20. OBSOLETE DATA REVIEWED AND CHANGED V0204
21. OBSOLETE DATA RETAINED AND REVIEWED V0204
22. OBSOLETE DATA RETAINED V0204

1. If the type of obsolete code = OBSOLETE DATA CONVERTED AND RETAINED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor 4]

2. If the type of obsolete code = OBSOLETE DATA CONVERTED V0102:
an error is generated.
[Example: none for CS Site-Specific Factor 4]

3. If the type of obsolete code = OBSOLETE DATA CONVERTED V0104:
an error is generated.
[Example: none for CS Site-Specific Factor 4]

4. If the type of obsolete code = OBSOLETE DATA CONVERTED V0200:
an error is generated.
[Example: Schema = Appendix, CS Site-Specific Factor 4 = 888]

5. If the type of obsolete code = OBSOLETE DATA RETAINED V0100:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor 4]

6. If the type of obsolete code = OBSOLETE DATA RETAINED V0102:
A. If year of Diagnosis is 2010 or higher, an error is generated.
[Example: Schema = Prostate, CS Site-Specific Factor 4 = 000]

7. If the type of obsolete code = OBSOLETE DATA RETAINED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor 4]

8. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0102:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: none for CS Site-Specific Factor 4]

9. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0103:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: none for CS Site-Specific Factor 4]

10.If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0200:
an error is generated.
(These particular obsolete codes require review after conversion from CSV01 to CSV02.)
[Example: none for CS Site-Specific Factor 4]

11. If the type of obsolete code = OBSOLETE DATA CONVERTED V0203:
an error is generated.
[Example: Schema = Esophagus, CS Site-Specific Factor 4 = 990]

12. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0203:
an error is generated.
(These particular obsolete codes require review after conversion from CSV02xx to CSV0203.)
[Example: Schema = Esophagus, CS Site-Specific Factor 4 = 000]

13. If the type of obsolete code = OBSOLETE DATA REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor 4]

14. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor 4]

15. If the type of obsolete code = OBSOLETE DATA RETAINED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor 4]

16. If the type of obsolete code = OBSOLETE DATA RETAINED V0104:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv02), an error is generated.
[Example: none for CS Extension]

17. If the type of obsolete code = OBSOLETE DATA RETAINED V0202:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020200 or higher (indicating the case was originally coded using CSv0202), an error is generated.

18. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv2), an error is generated.

19. If the type of obsolete code = OBSOLETE DATA CONVERTED V0204:
an error is generated.

20. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0204:
an error is generated.
(These particular obsolete codes require review after conversion from CSV0203xx to CSV0204.)

21. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0204:
A. If year of Diagnosis is 2012 or higher, an error is generated.
B. If CS version Input Original is 020440 or higher (indicating the case was originally coded using CSv0204), an error is generated.

22. If the type of obsolete code = OBSOLETE DATA RETAINED V0204:
A. If year of Diagnosis is 2012 or higher, an error is generated.
B. If CS version Input Original is 020440 or higher (indicating the case was originally coded using CSv0204), an error is generated.

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

In the SEER*Edits software, the title of this edit is: IF279

Modifications:

NAACCR v12.1
- Modified to handle the additional types of obsolete codes that were added for CSv0203.

NAACCR v12.2
- Updated to skip if CS Version Input Original is blank.
- Modified to include the additional types of obsolete codes that were added for CSv0204.
- Modified to include 3 types of obsolete codes left out of previous versions of the edit:
-- OBSOLETE DATA RETAINED V0203
-- OBSOLETE DATA RETAINED V0104
-- OBSOLETE DATA RETAINED V0202

NAACCR v12.2A
- Description corrected: conditions 17-22 were included twice; first set removed.

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Default error message added

NAACCR v15A
- Duplicate variable declarations deleted from edit logic.

Obsolete Codes - CS Site-Specific Factor 5 (CS)

Agency: CS **Last changed: 09/15/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
CS Site-Specific Factor 5 [Std# 2920]
CS Version Input Original [Std# 2935]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]

Tables

CS_OBS.DBF

Default Error Message

[3545] %F3 [%V3] is obsolete
CS Site-Specific Factor 5 ["value of CS Site-Specific Factor 5"] is obsolete

Additional Messages

[3359] CS Site-Specific Factor 5=OBSOLETE DATA RETAINED - not allowed if DX > 2009
[3363] CS Site-Specific Factor 5=OBSOLETE DATA CONVERTED V0102
[3364] CS Site-Specific Factor 5=OBSOLETE DATA CONVERTED V0104
[3365] CS Site-Specific Factor 5=OBSOLETE DATA CONVERTED V0200
[3366] CS Site-Specific Factor 5=OBSOLETE DATA REVIEWED AND CHANGED V0102
[3367] CS Site-Specific Factor 5=OBSOLETE DATA REVIEWED AND CHANGED V0103
[3368] CS Site-Specific Factor 5=OBSOLETE DATA REVIEWED AND CHANGED V0200
[3386] CS Site-Specific Factor 5=OBSOLETE DATA RETAINED - not allowed if CS Version Input Original > or = 020100
[3398] CS Site-Specific Factor 5=OBSOLETE DATA CONVERTED V0203
[3399] CS Site-Specific Factor 5=OBSOLETE DATA REVIEWED AND CHANGED V0203
[3400] CS Site-Specific Factor 5=OBSOLETE DATA REVIEWED V0203 - not allowed if DX > 2010
[3401] CS Site-Specific Factor 5=OBSOLETE DATA REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3402] CS Site-Specific Factor 5=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if DX > 2010
[3403] CS Site-Specific Factor 5=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3404] CS Site-Specific Factor 5=OBSOLETE DATA RETAINED V0203 - not allowed if DX > 2010
[3405] CS Site-Specific Factor 5=OBSOLETE DATA RETAINED V0203 - not allowed if CS Version Input Original > or = 020300
[3498] CS Site-Specific Factor 5=OBSOLETE DATA CONVERTED V0204
[3499] CS Site-Specific Factor 5=OBSOLETE DATA REVIEWED AND CHANGED V0204
[3500] CS Site-Specific Factor 5=OBSOLETE DATA RETAINED V0202 - not allowed if DX > 2010

[3501] CS Site-Specific Factor 5=OBSOLETE DATA RETAINED V0202 - not allowed if CS Version Input Original > or = 020200
[3502] CS Site-Specific Factor 5=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if DX > 2011
[3503] CS Site-Specific Factor 5=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if CS Version Input Original > or = 020440
[3504] CS Site-Specific Factor 5=OBSOLETE DATA RETAINED V0204 - not allowed if DX > 2011
[3505] CS Site-Specific Factor 5=OBSOLETE DATA RETAINED V0204 - not allowed if CS Version Input Original > or = 020440
[3506] CS Site-Specific Factor 5=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if DX > 2009
[3507] CS Site-Specific Factor 5=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if CS Version Input Original > or = 020100
ERROR_TEXT("Date of Diagnosis: %DC")
ERROR_TEXT("Invalid site or histology")
ERROR_TEXT("Schema discriminator missing or invalid")
SAVE_TEXT("t_schema_msg")

Description

This edit checks for all obsolete CS Site-Specific Factor 5 codes. Obsolete codes should be re-coded per Collaborative Stage guidelines.

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor 5 is blank
2. Date of Diagnosis is blank
3. CS Version Input Original is blank

This edit first determines the correct CS schema by doing a function call to the CS Dynamic Link Library (dll). The function call passes Primary Site, Histologic Type ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS schema name is returned.

Using the returned schema name, CS table number (CS Site-Specific Factor 5 is table number 14), and CS Site-Specific Factor 5 code, a table lookup is performed. If the code for a particular schema is determined to be obsolete based on the table lookup, the type of obsolete code must be evaluated. There are several types of obsolete codes:

1. OBSOLETE DATA CONVERTED AND RETAINED V0200
2. OBSOLETE DATA CONVERTED V0102
3. OBSOLETE DATA CONVERTED V0104
4. OBSOLETE DATA CONVERTED V0200
5. OBSOLETE DATA RETAINED V0100
6. OBSOLETE DATA RETAINED V0102
7. OBSOLETE DATA RETAINED V0200
8. OBSOLETE DATA REVIEWED AND CHANGED V0102
9. OBSOLETE DATA REVIEWED AND CHANGED V0103
10. OBSOLETE DATA REVIEWED AND CHANGED V0200
11. OBSOLETE DATA CONVERTED V0203
12. OBSOLETE DATA REVIEWED AND CHANGED V0203
13. OBSOLETE DATA REVIEWED V0203
14. OBSOLETE DATA RETAINED AND REVIEWED V0203
15. OBSOLETE DATA RETAINED V0203
16. OBSOLETE DATA RETAINED V0104
17. OBSOLETE DATA RETAINED V0202
18. OBSOLETE DATA RETAINED AND REVIEWED V0200

19. OBSOLETE DATA CONVERTED V0204
20. OBSOLETE DATA REVIEWED AND CHANGED V0204
21. OBSOLETE DATA RETAINED AND REVIEWED V0204
22. OBSOLETE DATA RETAINED V0204

1. If the type of obsolete code = OBSOLETE DATA CONVERTED AND RETAINED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor 5]

2. If the type of obsolete code = OBSOLETE DATA CONVERTED V0102:
an error is generated.
[Example: none for CS Site-Specific Factor 5]

3. If the type of obsolete code = OBSOLETE DATA CONVERTED V0104:
an error is generated.
[Example: none for CS Site-Specific Factor 5]

4. If the type of obsolete code = OBSOLETE DATA CONVERTED V0200:
an error is generated.
[Example: Schema = Testis, CS Site-Specific Factor 5 = 001]

5. If the type of obsolete code = OBSOLETE DATA RETAINED V0100:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor 5]

6. If the type of obsolete code = OBSOLETE DATA RETAINED V0102:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor 5]

7. If the type of obsolete code = OBSOLETE DATA RETAINED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: Schema = Prostate, CS Site-Specific Factor 5 = 000]

8. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0102:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: none for CS Site-Specific Factor 5]

9. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0103:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: none for CS Site-Specific Factor 5]

10.If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0200:
an error is generated.
(These particular obsolete codes require review after conversion from CSV01 to CSV02.)
[Example: none for CS Site-Specific Factor 5]

11. If the type of obsolete code = OBSOLETE DATA CONVERTED V0203:

an error is generated.
[Example: Schema = Cervix, CS Site-Specific Factor 5 = 000]

12. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0203:
an error is generated.
(These particular obsolete codes require review after conversion from CSV02xx to CSV0203.)
[Example: Schema = Esophagus, CS Site-Specific Factor 5 = 000]

13. If the type of obsolete code = OBSOLETE DATA REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor 5]

14. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor 5]

15. If the type of obsolete code = OBSOLETE DATA RETAINED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor 5]

16. If the type of obsolete code = OBSOLETE DATA RETAINED V0104:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv02), an error is generated.

17. If the type of obsolete code = OBSOLETE DATA RETAINED V0202:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020200 or higher (indicating the case was originally coded using CSv0202), an error is generated.

18. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv2), an error is generated.

19. If the type of obsolete code = OBSOLETE DATA CONVERTED V0204:
an error is generated.

20. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0204:
an error is generated.
(These particular obsolete codes require review after conversion from CSV0203xx to CSV0204.)

21. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0204:
A. If year of Diagnosis is 2012 or higher, an error is generated.
B. If CS version Input Original is 020440 or higher (indicating the case was originally coded using CSv0204), an error is generated.

22. If the type of obsolete code = OBSOLETE DATA RETAINED V0204:
A. If year of Diagnosis is 2012 or higher, an error is generated.
B. If CS version Input Original is 020440 or higher (indicating the case was originally coded using CSv0204), an error is generated.

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

In the SEER*Edits software, the title of this edit is: IF280

Modifications:

NAACCR v12.1
- Modified to handle the additional types of obsolete codes that were added for CSv0203.

NAACCR v12.2
- Updated to skip if CS Version Input Original is blank.
- Modified to include the additional types of obsolete codes that were added for CSv0204.
- Modified to include 3 types of obsolete codes left out of previous versions of the edit:
-- OBSOLETE DATA RETAINED V0203
-- OBSOLETE DATA RETAINED V0104
-- OBSOLETE DATA RETAINED V0202

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Default error message added

NAACCR v15A
- Duplicate variable declarations deleted from edit logic.

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Default error message added

Obsolete Codes - CS Site-Specific Factor 6 (CS)

Agency: CS **Last changed: 09/15/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
CS Site-Specific Factor 6 [Std# 2930]
CS Version Input Original [Std# 2935]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]

Tables

CS_OBS.DBF

Default Error Message

[3545] %F3 [%V3] is obsolete
CS Site-Specific Factor 6 ["value of CS Site-Specific Factor 6"] is obsolete

Additional Messages

[3359] CS Site-Specific Factor 6=OBSOLETE DATA RETAINED - not allowed if DX > 2009
[3363] CS Site-Specific Factor 6=OBSOLETE DATA CONVERTED V0102
[3364] CS Site-Specific Factor 6=OBSOLETE DATA CONVERTED V0104
[3365] CS Site-Specific Factor 6=OBSOLETE DATA CONVERTED V0200
[3366] CS Site-Specific Factor 6=OBSOLETE DATA REVIEWED AND CHANGED V0102
[3367] CS Site-Specific Factor 6=OBSOLETE DATA REVIEWED AND CHANGED V0103
[3368] CS Site-Specific Factor 6=OBSOLETE DATA REVIEWED AND CHANGED V0200
[3386] CS Site-Specific Factor 6=OBSOLETE DATA RETAINED - not allowed if CS Version Input Original > or = 020100
[3398] CS Site-Specific Factor 6=OBSOLETE DATA CONVERTED V0203
[3399] CS Site-Specific Factor 6=OBSOLETE DATA REVIEWED AND CHANGED V0203
[3400] CS Site-Specific Factor 6=OBSOLETE DATA REVIEWED V0203 - not allowed if DX > 2010
[3401] CS Site-Specific Factor 6=OBSOLETE DATA REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3402] CS Site-Specific Factor 6=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if DX > 2010
[3403] CS Site-Specific Factor 6=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3404] CS Site-Specific Factor 6=OBSOLETE DATA RETAINED V0203 - not allowed if DX > 2010
[3405] CS Site-Specific Factor 6=OBSOLETE DATA RETAINED V0203 - not allowed if CS Version Input Original > or = 020300
[3498] CS Site-Specific Factor 6=OBSOLETE DATA CONVERTED V0204
[3499] CS Site-Specific Factor 6=OBSOLETE DATA REVIEWED AND CHANGED V0204
[3500] CS Site-Specific Factor 6=OBSOLETE DATA RETAINED V0202 - not allowed if DX > 2010

[3501] CS Site-Specific Factor 6=OBSOLETE DATA RETAINED V0202 - not allowed if CS Version Input Original > or = 020200
[3502] CS Site-Specific Factor 6=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if DX > 2011
[3503] CS Site-Specific Factor 6=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if CS Version Input Original > or = 020440
[3504] CS Site-Specific Factor 6=OBSOLETE DATA RETAINED V0204 - not allowed if DX > 2011
[3505] CS Site-Specific Factor 6=OBSOLETE DATA RETAINED V0204 - not allowed if CS Version Input Original > or = 020440
[3506] CS Site-Specific Factor 6=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if DX > 2009
[3507] CS Site-Specific Factor 6=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if CS Version Input Original > or = 020100
ERROR_TEXT("Date of Diagnosis: %DC")
ERROR_TEXT("Invalid site or histology")
ERROR_TEXT("Schema discriminator missing or invalid")
SAVE_TEXT("t_schema_msg")

Description

This edit checks for all obsolete CS Site-Specific Factor 6 codes. Obsolete codes should be re-coded per Collaborative Stage guidelines.

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor 6 is blank
2. Date of Diagnosis is blank
3. CS Version Input Original is blank

This edit first determines the correct CS schema by doing a function call to the CS Dynamic Link Library (dll). The function call passes Primary Site, Histologic Type ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS schema name is returned.

Using the returned schema name, CS table number (CS Site-Specific Factor 6 is table number 15), and CS Site-Specific Factor 6 code, a table lookup is performed. If the code for a particular schema is determined to be obsolete based on the table lookup, the type of obsolete code must be evaluated. There are several types of obsolete codes:

1. OBSOLETE DATA CONVERTED AND RETAINED V0200
2. OBSOLETE DATA CONVERTED V0102
3. OBSOLETE DATA CONVERTED V0104
4. OBSOLETE DATA CONVERTED V0200
5. OBSOLETE DATA RETAINED V0100
6. OBSOLETE DATA RETAINED V0102
7. OBSOLETE DATA RETAINED V0200
8. OBSOLETE DATA REVIEWED AND CHANGED V0102
9. OBSOLETE DATA REVIEWED AND CHANGED V0103
10. OBSOLETE DATA REVIEWED AND CHANGED V0200
11. OBSOLETE DATA CONVERTED V0203
12. OBSOLETE DATA REVIEWED AND CHANGED V0203
13. OBSOLETE DATA REVIEWED V0203
14. OBSOLETE DATA RETAINED AND REVIEWED V0203
15. OBSOLETE DATA RETAINED V0203
16. OBSOLETE DATA RETAINED V0104
17. OBSOLETE DATA RETAINED V0202
18. OBSOLETE DATA RETAINED AND REVIEWED V0200

19. OBSOLETE DATA CONVERTED V0204
20. OBSOLETE DATA REVIEWED AND CHANGED V0204
21. OBSOLETE DATA RETAINED AND REVIEWED V0204
22. OBSOLETE DATA RETAINED V0204

1. If the type of obsolete code = OBSOLETE DATA CONVERTED AND RETAINED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor 6]

2. If the type of obsolete code = OBSOLETE DATA CONVERTED V0102:
an error is generated.
[Example: none for CS Site-Specific Factor 6]

3. If the type of obsolete code = OBSOLETE DATA CONVERTED V0104:
an error is generated.
[Example: none for CS Site-Specific Factor 6]

4. If the type of obsolete code = OBSOLETE DATA CONVERTED V0200:
an error is generated.
[Example: Schema = Appendix, CS Site-Specific Factor 6 = 888]

5. If the type of obsolete code = OBSOLETE DATA RETAINED V0100:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor 6]

6. If the type of obsolete code = OBSOLETE DATA RETAINED V0102:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor 6]

7. If the type of obsolete code = OBSOLETE DATA RETAINED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: Schema = Prostate, CS Site-Specific Factor 6 = 000]

8. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0102:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: none for CS Site-Specific Factor 6]

9. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0103:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: none for CS Site-Specific Factor 6]

10.If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0200:
an error is generated.
(These particular obsolete codes require review after conversion from CSV01 to CSV02.)
[Example: none for CS Site-Specific Factor 6]

11. If the type of obsolete code = OBSOLETE DATA CONVERTED V0203:

an error is generated.
[Example: Schema = GISTEsophagus, CS Site-Specific Factor 6 = 995]

12. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0203:
an error is generated.
(These particular obsolete codes require review after conversion from CSV02xx to CSV0203.)
[Example: none for CS Site-Specific Factor 6]

13. If the type of obsolete code = OBSOLETE DATA REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor 6]

14. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor 6]

15. If the type of obsolete code = OBSOLETE DATA RETAINED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor 6]

16. If the type of obsolete code = OBSOLETE DATA RETAINED V0104:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv02), an error is generated.

17. If the type of obsolete code = OBSOLETE DATA RETAINED V0202:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020200 or higher (indicating the case was originally coded using CSv0202), an error is generated.

18. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv2), an error is generated.

19. If the type of obsolete code = OBSOLETE DATA CONVERTED V0204:
an error is generated.

20. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0204:
an error is generated.
(These particular obsolete codes require review after conversion from CSV0203xx to CSV0204.)

21. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0204:
A. If year of Diagnosis is 2012 or higher, an error is generated.
B. If CS version Input Original is 020440 or higher (indicating the case was originally coded using CSv0204), an error is generated.

22. If the type of obsolete code = OBSOLETE DATA RETAINED V0204:
A. If year of Diagnosis is 2012 or higher, an error is generated.
B. If CS version Input Original is 020440 or higher (indicating the case was originally coded using CSv0204), an error is generated.

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

In the SEER*Edits software, the title of this edit is: IF281

Modifications:

NAACCR v12.1
- Modified to handle the additional types of obsolete codes that were added for CSv0203.

NAACCR v12.2
- Updated to skip if CS Version Input Original is blank.
- Modified to include the additional types of obsolete codes that were added for CSv0204.
- Modified to include 3 types of obsolete codes left out of previous versions of the edit:
-- OBSOLETE DATA RETAINED V0203
-- OBSOLETE DATA RETAINED V0104
-- OBSOLETE DATA RETAINED V0202

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Default error message added

NAACCR v15A
- Duplicate variable declarations deleted from edit logic.

Obsolete Codes - CS Site-Specific Factor 7 (CS)

Agency: CS **Last changed: 09/15/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
CS Site-Specific Factor 7 [Std# 2861]
CS Version Input Original [Std# 2935]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]

Tables

CS_OBS.DBF

Default Error Message

[3545] %F3 [%V3] is obsolete
CS Site-Specific Factor 7 ["value of CS Site-Specific Factor 7"] is obsolete

Additional Messages

[3359] CS Site-Specific Factor 7=OBSOLETE DATA RETAINED - not allowed if DX > 2009
[3363] CS Site-Specific Factor 7=OBSOLETE DATA CONVERTED V0102
[3364] CS Site-Specific Factor 7=OBSOLETE DATA CONVERTED V0104
[3365] CS Site-Specific Factor 7=OBSOLETE DATA CONVERTED V0200
[3366] CS Site-Specific Factor 7=OBSOLETE DATA REVIEWED AND CHANGED V0102
[3367] CS Site-Specific Factor 7=OBSOLETE DATA REVIEWED AND CHANGED V0103
[3368] CS Site-Specific Factor 7=OBSOLETE DATA REVIEWED AND CHANGED V0200
[3386] CS Site-Specific Factor 7=OBSOLETE DATA RETAINED - not allowed if CS Version Input Original > or = 020100
[3398] CS Site-Specific Factor 7=OBSOLETE DATA CONVERTED V0203
[3399] CS Site-Specific Factor 7=OBSOLETE DATA REVIEWED AND CHANGED V0203
[3400] CS Site-Specific Factor 7=OBSOLETE DATA REVIEWED V0203 - not allowed if DX > 2010
[3401] CS Site-Specific Factor 7=OBSOLETE DATA REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3402] CS Site-Specific Factor 7=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if DX > 2010
[3403] CS Site-Specific Factor 7=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3404] CS Site-Specific Factor 7=OBSOLETE DATA RETAINED V0203 - not allowed if DX > 2010
[3405] CS Site-Specific Factor 7=OBSOLETE DATA RETAINED V0203 - not allowed if CS Version Input Original > or = 020300
[3498] CS Site-Specific Factor 7=OBSOLETE DATA CONVERTED V0204
[3499] CS Site-Specific Factor 7=OBSOLETE DATA REVIEWED AND CHANGED V0204
[3500] CS Site-Specific Factor 7=OBSOLETE DATA RETAINED V0202 - not allowed if DX > 2010

[3501] CS Site-Specific Factor 7=OBSOLETE DATA RETAINED V0202 - not allowed if CS Version Input Original > or = 020200
[3502] CS Site-Specific Factor 7=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if DX > 2011
[3503] CS Site-Specific Factor 7=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if CS Version Input Original > or = 020440
[3504] CS Site-Specific Factor 7=OBSOLETE DATA RETAINED V0204 - not allowed if DX > 2011
[3505] CS Site-Specific Factor 7=OBSOLETE DATA RETAINED V0204 - not allowed if CS Version Input Original > or = 020440
[3506] CS Site-Specific Factor 7=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if DX > 2009
[3507] CS Site-Specific Factor 7=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if CS Version Input Original > or = 020100
ERROR_TEXT("Date of Diagnosis: %DC")
ERROR_TEXT("Invalid site or histology")
ERROR_TEXT("Schema discriminator missing or invalid")
SAVE_TEXT("t_schema_msg")

Description

This edit checks for all obsolete CS Site-Specific Factor 7 codes. Obsolete codes should be re-coded per Collaborative Stage guidelines.

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor 7 is blank
2. Date of Diagnosis is blank
3. CS Version Input Original is blank

This edit first determines the correct CS schema by doing a function call to the CS Dynamic Link Library (dll). The function call passes Primary Site, Histologic Type ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS schema name is returned.

Using the returned schema name, CS table number (CS Site-Specific Factor 7 is table number 16), and CS Site-Specific Factor 7 code, a table lookup is performed. If the code for a particular schema is determined to be obsolete based on the table lookup, the type of obsolete code must be evaluated. There are several types of obsolete codes:

1. OBSOLETE DATA CONVERTED AND RETAINED V0200
2. OBSOLETE DATA CONVERTED V0102
3. OBSOLETE DATA CONVERTED V0104
4. OBSOLETE DATA CONVERTED V0200
5. OBSOLETE DATA RETAINED V0100
6. OBSOLETE DATA RETAINED V0102
7. OBSOLETE DATA RETAINED V0200
8. OBSOLETE DATA REVIEWED AND CHANGED V0102
9. OBSOLETE DATA REVIEWED AND CHANGED V0103
10. OBSOLETE DATA REVIEWED AND CHANGED V0200
11. OBSOLETE DATA CONVERTED V0203
12. OBSOLETE DATA REVIEWED AND CHANGED V0203
13. OBSOLETE DATA REVIEWED V0203
14. OBSOLETE DATA RETAINED AND REVIEWED V0203
15. OBSOLETE DATA RETAINED V0203
16. OBSOLETE DATA RETAINED V0104
17. OBSOLETE DATA RETAINED V0202
18. OBSOLETE DATA RETAINED AND REVIEWED V0200

19. OBSOLETE DATA CONVERTED V0204
20. OBSOLETE DATA REVIEWED AND CHANGED V0204
21. OBSOLETE DATA RETAINED AND REVIEWED V0204
22. OBSOLETE DATA RETAINED V0204

1. If the type of obsolete code = OBSOLETE DATA CONVERTED AND RETAINED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor 7]

2. If the type of obsolete code = OBSOLETE DATA CONVERTED V0102:
an error is generated.
[Example: none for CS Site-Specific Factor 7]

3. If the type of obsolete code = OBSOLETE DATA CONVERTED V0104:
an error is generated.
[Example: none for CS Site-Specific Factor 7]

4. If the type of obsolete code = OBSOLETE DATA CONVERTED V0200:
an error is generated.
[Example: Schema = GISTEsophagus, CS Site-Specific Factor 7 = 888]

5. If the type of obsolete code = OBSOLETE DATA RETAINED V0100:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor 7]

6. If the type of obsolete code = OBSOLETE DATA RETAINED V0102:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor 7]

7. If the type of obsolete code = OBSOLETE DATA RETAINED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor 7]

8. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0102:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: none for CS Site-Specific Factor 7]

9. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0103:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: none for CS Site-Specific Factor 7]

10.If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0200:
an error is generated.
(These particular obsolete codes require review after conversion from CSV01 to CSV02.)
[Example: none for CS Site-Specific Factor 7]

11. If the type of obsolete code = OBSOLETE DATA CONVERTED V0203:

an error is generated.
[Example: Schema = Cervix, CS Site-Specific Factor 7 = 000]

12. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0203:
an error is generated.
(These particular obsolete codes require review after conversion from CSV02xx to CSV0203.)
[Example: Schema = Brain, CS Site-Specific Factor 7 = 022]

13. If the type of obsolete code = OBSOLETE DATA REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor 7]

14. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor 7]

15. If the type of obsolete code = OBSOLETE DATA RETAINED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor 7]

16. If the type of obsolete code = OBSOLETE DATA RETAINED V0104:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv02), an error is generated.

17. If the type of obsolete code = OBSOLETE DATA RETAINED V0202:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020200 or higher (indicating the case was originally coded using CSv0202), an error is generated.

18. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv2), an error is generated.

19. If the type of obsolete code = OBSOLETE DATA CONVERTED V0204:
an error is generated.

20. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0204:
an error is generated.
(These particular obsolete codes require review after conversion from CSV0203xx to CSV0204.)

21. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0204:
A. If year of Diagnosis is 2012 or higher, an error is generated.
B. If CS version Input Original is 020440 or higher (indicating the case was originally coded using CSv0204), an error is generated.

22. If the type of obsolete code = OBSOLETE DATA RETAINED V0204:
A. If year of Diagnosis is 2012 or higher, an error is generated.
B. If CS version Input Original is 020440 or higher (indicating the case was originally coded using CSv0204), an error is generated.

Administrative Notes

New edit - added to NAACCR v12.1 metafile.

In the SEER*Edits software, the title of this edit is: IF324

Modifications:

NAACCR v12.2
- Updated to skip if CS Version Input Original is blank.
- Modified to include the additional types of obsolete codes that were added for CSv0204.
- Modified to include 3 types of obsolete codes left out of previous versions of the edit:
-- OBSOLETE DATA RETAINED V0203
-- OBSOLETE DATA RETAINED V0104
-- OBSOLETE DATA RETAINED V0202

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Default error message added

NAACCR v15A
- Duplicate variable declarations deleted from edit logic.

Obsolete Codes - CS Site-Specific Factor 8 (CS)

Agency: CS **Last changed: 09/15/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
CS Site-Specific Factor 8 [Std# 2862]
CS Version Input Original [Std# 2935]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]

Tables

CS_OBS.DBF

Default Error Message

[3545] %F3 [%V3] is obsolete
CS Site-Specific Factor 8 ["value of CS Site-Specific Factor 8"] is obsolete

Additional Messages

[3359] CS Site-Specific Factor 8=OBSOLETE DATA RETAINED - not allowed if DX > 2009
[3363] CS Site-Specific Factor 8=OBSOLETE DATA CONVERTED V0102
[3364] CS Site-Specific Factor 8=OBSOLETE DATA CONVERTED V0104
[3365] CS Site-Specific Factor 8=OBSOLETE DATA CONVERTED V0200
[3366] CS Site-Specific Factor 8=OBSOLETE DATA REVIEWED AND CHANGED V0102
[3367] CS Site-Specific Factor 8=OBSOLETE DATA REVIEWED AND CHANGED V0103
[3368] CS Site-Specific Factor 8=OBSOLETE DATA REVIEWED AND CHANGED V0200
[3386] CS Site-Specific Factor 8=OBSOLETE DATA RETAINED - not allowed if CS Version Input Original > or = 020100
[3398] CS Site-Specific Factor 8=OBSOLETE DATA CONVERTED V0203
[3399] CS Site-Specific Factor 8=OBSOLETE DATA REVIEWED AND CHANGED V0203
[3400] CS Site-Specific Factor 8=OBSOLETE DATA REVIEWED V0203 - not allowed if DX > 2010
[3401] CS Site-Specific Factor 8=OBSOLETE DATA REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3402] CS Site-Specific Factor 8=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if DX > 2010
[3403] CS Site-Specific Factor 8=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3404] CS Site-Specific Factor 8=OBSOLETE DATA RETAINED V0203 - not allowed if DX > 2010
[3405] CS Site-Specific Factor 8=OBSOLETE DATA RETAINED V0203 - not allowed if CS Version Input Original > or = 020300
[3498] CS Site-Specific Factor 8=OBSOLETE DATA CONVERTED V0204
[3499] CS Site-Specific Factor 8=OBSOLETE DATA REVIEWED AND CHANGED V0204
[3500] CS Site-Specific Factor 8=OBSOLETE DATA RETAINED V0202 - not allowed if DX > 2010

[3501] CS Site-Specific Factor 8=OBSOLETE DATA RETAINED V0202 - not allowed if CS Version Input Original > or = 020200
[3502] CS Site-Specific Factor 8=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if DX > 2011
[3503] CS Site-Specific Factor 8=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if CS Version Input Original > or = 020440
[3504] CS Site-Specific Factor 8=OBSOLETE DATA RETAINED V0204 - not allowed if DX > 2011
[3505] CS Site-Specific Factor 8=OBSOLETE DATA RETAINED V0204 - not allowed if CS Version Input Original > or = 020440
[3506] CS Site-Specific Factor 8=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if DX > 2009
[3507] CS Site-Specific Factor 8=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if CS Version Input Original > or = 020100
ERROR_TEXT("Date of Diagnosis: %DC")
ERROR_TEXT("Invalid site or histology")
ERROR_TEXT("Schema discriminator missing or invalid")
SAVE_TEXT("t_schema_msg")

Description

```
This edit checks for all obsolete CS Site-Specific Factor 8 codes. Obsolete codes
should be re-coded per Collaborative Stage guidelines.

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor 8 is blank
2. Date of Diagnosis is blank
3. CS Version Input Original is blank

This edit first determines the correct CS schema by doing a function call to the CS
Dynamic Link Library (dll).  The function call passes Primary Site, Histologic Type
ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS
schema name is returned.

Using the returned schema name, CS table number (CS Site-Specific Factor 8 is table
number 17), and CS Site-Specific Factor 8 code, a table lookup is performed. If the
code for a particular schema is determined to be obsolete based on the table
lookup, the type of obsolete code must be evaluated. There are several types of
obsolete codes:

1.    OBSOLETE DATA CONVERTED AND RETAINED V0200
2.    OBSOLETE DATA CONVERTED V0102
3.    OBSOLETE DATA CONVERTED V0104
4.    OBSOLETE DATA CONVERTED V0200
5.    OBSOLETE DATA RETAINED V0100
6.    OBSOLETE DATA RETAINED V0102
7.    OBSOLETE DATA RETAINED V0200
8.    OBSOLETE DATA REVIEWED AND CHANGED V0102
9.    OBSOLETE DATA REVIEWED AND CHANGED V0103
10.   OBSOLETE DATA REVIEWED AND CHANGED V0200
11.   OBSOLETE DATA CONVERTED V0203
12.   OBSOLETE DATA REVIEWED AND CHANGED V0203
13.   OBSOLETE DATA REVIEWED V0203
14.   OBSOLETE DATA RETAINED AND REVIEWED V0203
15.   OBSOLETE DATA RETAINED V0203
16.   OBSOLETE DATA RETAINED V0104
17.   OBSOLETE DATA RETAINED V0202
18.   OBSOLETE DATA RETAINED AND REVIEWED V0200
```

19. OBSOLETE DATA CONVERTED V0204
20. OBSOLETE DATA REVIEWED AND CHANGED V0204
21. OBSOLETE DATA RETAINED AND REVIEWED V0204
22. OBSOLETE DATA RETAINED V0204

1. If the type of obsolete code = OBSOLETE DATA CONVERTED AND RETAINED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor 8]

2. If the type of obsolete code = OBSOLETE DATA CONVERTED V0102:
an error is generated.
[Example: none for CS Site-Specific Factor 8]

3. If the type of obsolete code = OBSOLETE DATA CONVERTED V0104:
an error is generated.
[Example: none for CS Site-Specific Factor 8]

4. If the type of obsolete code = OBSOLETE DATA CONVERTED V0200:
an error is generated.
[Example: none for CS Site-Specific Factor 8]

5. If the type of obsolete code = OBSOLETE DATA RETAINED V0100:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor 8]

6. If the type of obsolete code = OBSOLETE DATA RETAINED V0102:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor 8]

7. If the type of obsolete code = OBSOLETE DATA RETAINED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor 8]

8. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0102:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: none for CS Site-Specific Factor 8]

9. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0103:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: none for CS Site-Specific Factor 8]

10.If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0200:
an error is generated.
(These particular obsolete codes require review after conversion from CSV01 to CSV02.)
[Example: none for CS Site-Specific Factor 8]

11. If the type of obsolete code = OBSOLETE DATA CONVERTED V0203:

an error is generated.
[Example: Schema = Breast, CS Site-Specific Factor 8 = 001]

12. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0203:
an error is generated.
(These particular obsolete codes require review after conversion from CSV02xx to CSV0203.)
[Example: none for CS Site-Specific Factor 8]

13. If the type of obsolete code = OBSOLETE DATA REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor 8]

14. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor 8]

15. If the type of obsolete code = OBSOLETE DATA RETAINED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor 8]

16. If the type of obsolete code = OBSOLETE DATA RETAINED V0104:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv02), an error is generated.

17. If the type of obsolete code = OBSOLETE DATA RETAINED V0202:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020200 or higher (indicating the case was originally coded using CSv0202), an error is generated.

18. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv2), an error is generated.

19. If the type of obsolete code = OBSOLETE DATA CONVERTED V0204:
an error is generated.

20. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0204:
an error is generated.
(These particular obsolete codes require review after conversion from CSV0203xx to CSV0204.)

21. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0204:
A. If year of Diagnosis is 2012 or higher, an error is generated.
B. If CS version Input Original is 020440 or higher (indicating the case was originally coded using CSv0204), an error is generated.

22. If the type of obsolete code = OBSOLETE DATA RETAINED V0204:
A. If year of Diagnosis is 2012 or higher, an error is generated.
B. If CS version Input Original is 020440 or higher (indicating the case was originally coded using CSv0204), an error is generated.

Administrative Notes

New edit - added to NAACCR v12.1 metafile.

In the SEER*Edits software, the title of this edit is: IF325

Modifications:

NAACCR v12.2
- Updated to skip if CS Version Input Original is blank.
- Modified to include the additional types of obsolete codes that were added for CSv0204.
- Modified to include 3 types of obsolete codes left out of previous versions of the edit:
-- OBSOLETE DATA RETAINED V0203
-- OBSOLETE DATA RETAINED V0104
-- OBSOLETE DATA RETAINED V0202

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Default error message added

NAACCR v15A
- Duplicate variable declarations deleted from edit logic.

Obsolete Codes - CS Site-Specific Factor 9 (CS)

Agency: CS **Last changed: 09/15/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
CS Site-Specific Factor 9 [Std# 2863]
CS Version Input Original [Std# 2935]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]

Tables

CS_OBS.DBF

Default Error Message

[3545] %F3 [%V3] is obsolete
CS Site-Specific Factor 9 ["value of CS Site-Specific Factor 9"] is obsolete

Additional Messages

[3359] CS Site-Specific Factor 9=OBSOLETE DATA RETAINED - not allowed if DX > 2009
[3363] CS Site-Specific Factor 9=OBSOLETE DATA CONVERTED V0102
[3364] CS Site-Specific Factor 9=OBSOLETE DATA CONVERTED V0104
[3365] CS Site-Specific Factor 9=OBSOLETE DATA CONVERTED V0200
[3366] CS Site-Specific Factor 9=OBSOLETE DATA REVIEWED AND CHANGED V0102
[3367] CS Site-Specific Factor 9=OBSOLETE DATA REVIEWED AND CHANGED V0103
[3368] CS Site-Specific Factor 9=OBSOLETE DATA REVIEWED AND CHANGED V0200
[3386] CS Site-Specific Factor 9=OBSOLETE DATA RETAINED - not allowed if CS Version Input Original > or = 020100
[3398] CS Site-Specific Factor 9=OBSOLETE DATA CONVERTED V0203
[3399] CS Site-Specific Factor 9=OBSOLETE DATA REVIEWED AND CHANGED V0203
[3400] CS Site-Specific Factor 9=OBSOLETE DATA REVIEWED V0203 - not allowed if DX > 2010
[3401] CS Site-Specific Factor 9=OBSOLETE DATA REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3402] CS Site-Specific Factor 9=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if DX > 2010
[3403] CS Site-Specific Factor 9=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3404] CS Site-Specific Factor 9=OBSOLETE DATA RETAINED V0203 - not allowed if DX > 2010
[3405] CS Site-Specific Factor 9=OBSOLETE DATA RETAINED V0203 - not allowed if CS Version Input Original > or = 020300
[3498] CS Site-Specific Factor 9=OBSOLETE DATA CONVERTED V0204
[3499] CS Site-Specific Factor 9=OBSOLETE DATA REVIEWED AND CHANGED V0204
[3500] CS Site-Specific Factor 9=OBSOLETE DATA RETAINED V0202 - not allowed if DX > 2010

[3501] CS Site-Specific Factor 9=OBSOLETE DATA RETAINED V0202 - not allowed if CS Version Input Original > or = 020200
[3502] CS Site-Specific Factor 9=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if DX > 2011
[3503] CS Site-Specific Factor 9=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if CS Version Input Original > or = 020440
[3504] CS Site-Specific Factor 9=OBSOLETE DATA RETAINED V0204 - not allowed if DX > 2011
[3505] CS Site-Specific Factor 9=OBSOLETE DATA RETAINED V0204 - not allowed if CS Version Input Original > or = 020440
[3506] CS Site-Specific Factor 9=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if DX > 2009
[3507] CS Site-Specific Factor 9=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if CS Version Input Original > or = 020100
ERROR_TEXT("Date of Diagnosis: %DC")
ERROR_TEXT("Invalid site or histology")
ERROR_TEXT("Schema discriminator missing or invalid")
SAVE_TEXT("t_schema_msg")

Description

This edit checks for all obsolete CS Site-Specific Factor 9 codes. Obsolete codes should be re-coded per Collaborative Stage guidelines.

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor 9 is blank
2. Date of Diagnosis is blank
3. CS Version Input Original is blank

This edit first determines the correct CS schema by doing a function call to the CS Dynamic Link Library (dll). The function call passes Primary Site, Histologic Type ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS schema name is returned.

Using the returned schema name, CS table number (CS Site-Specific Factor 9 is table number 18), and CS Site-Specific Factor 9 code, a table lookup is performed. If the code for a particular schema is determined to be obsolete based on the table lookup, the type of obsolete code must be evaluated. There are several types of obsolete codes:

1. OBSOLETE DATA CONVERTED AND RETAINED V0200
2. OBSOLETE DATA CONVERTED V0102
3. OBSOLETE DATA CONVERTED V0104
4. OBSOLETE DATA CONVERTED V0200
5. OBSOLETE DATA RETAINED V0100
6. OBSOLETE DATA RETAINED V0102
7. OBSOLETE DATA RETAINED V0200
8. OBSOLETE DATA REVIEWED AND CHANGED V0102
9. OBSOLETE DATA REVIEWED AND CHANGED V0103
10. OBSOLETE DATA REVIEWED AND CHANGED V0200
11. OBSOLETE DATA CONVERTED V0203
12. OBSOLETE DATA REVIEWED AND CHANGED V0203
13. OBSOLETE DATA REVIEWED V0203
14. OBSOLETE DATA RETAINED AND REVIEWED V0203
15. OBSOLETE DATA RETAINED V0203
16. OBSOLETE DATA RETAINED V0104
17. OBSOLETE DATA RETAINED V0202
18. OBSOLETE DATA RETAINED AND REVIEWED V0200

19. OBSOLETE DATA CONVERTED V0204
20. OBSOLETE DATA REVIEWED AND CHANGED V0204
21. OBSOLETE DATA RETAINED AND REVIEWED V0204
22. OBSOLETE DATA RETAINED V0204

1. If the type of obsolete code = OBSOLETE DATA CONVERTED AND RETAINED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor 9]

2. If the type of obsolete code = OBSOLETE DATA CONVERTED V0102:
an error is generated.
[Example: none for CS Site-Specific Factor 9]

3. If the type of obsolete code = OBSOLETE DATA CONVERTED V0104:
an error is generated.
[Example: none for CS Site-Specific Factor 9]

4. If the type of obsolete code = OBSOLETE DATA CONVERTED V0200:
an error is generated.
[Example: none for CS Site-Specific Factor 9]

5. If the type of obsolete code = OBSOLETE DATA RETAINED V0100:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor 9]

6. If the type of obsolete code = OBSOLETE DATA RETAINED V0102:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor 9]

7. If the type of obsolete code = OBSOLETE DATA RETAINED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor 9]

8. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0102:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: none for CS Site-Specific Factor 9]

9. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0103:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: none for CS Site-Specific Factor 9]

10.If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0200:
an error is generated.
(These particular obsolete codes require review after conversion from CSV01 to CSV02.)
[Example: none for CS Site-Specific Factor 9]

11. If the type of obsolete code = OBSOLETE DATA CONVERTED V0203:

an error is generated.
[Example: Schema = Cervix, CS Site-Specific Factor 9 = 000]

12. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0203:
an error is generated.
(These particular obsolete codes require review after conversion from CSV02xx to CSV0203.)
[Example: none for CS Site-Specific Factor 9]

13. If the type of obsolete code = OBSOLETE DATA REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor 9]

14. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor 9]

15. If the type of obsolete code = OBSOLETE DATA RETAINED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor 9]

16. If the type of obsolete code = OBSOLETE DATA RETAINED V0104:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv02), an error is generated.

17. If the type of obsolete code = OBSOLETE DATA RETAINED V0202:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020200 or higher (indicating the case was originally coded using CSv0202), an error is generated.

18. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv2), an error is generated.

19. If the type of obsolete code = OBSOLETE DATA CONVERTED V0204:
an error is generated.

20. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0204:
an error is generated.
(These particular obsolete codes require review after conversion from CSV0203xx to CSV0204.)

21. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0204:
A. If year of Diagnosis is 2012 or higher, an error is generated.
B. If CS version Input Original is 020440 or higher (indicating the case was originally coded using CSv0204), an error is generated.

22. If the type of obsolete code = OBSOLETE DATA RETAINED V0204:
A. If year of Diagnosis is 2012 or higher, an error is generated.
B. If CS version Input Original is 020440 or higher (indicating the case was originally coded using CSv0204), an error is generated.

Administrative Notes

New edit - added to NAACCR v12.1 metafile.

In the SEER*Edits software, the title of this edit is: IF326

Modifications:

NAACCR v12.2
- Updated to skip if CS Version Input Original is blank.
- Modified to include the additional types of obsolete codes that were added for CSv0204.
- Modified to include 3 types of obsolete codes left out of previous versions of the edit:
-- OBSOLETE DATA RETAINED V0203
-- OBSOLETE DATA RETAINED V0104
-- OBSOLETE DATA RETAINED V0202

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Default error message added

NAACCR v15A
- Duplicate variable declarations deleted from edit logic.

Obsolete Codes - CS Site-Specific Factor10 (CS)

Agency: CS **Last changed: 09/15/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
CS Site-Specific Factor10 [Std# 2864]
CS Version Input Original [Std# 2935]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]

Tables

CS_OBS.DBF

Default Error Message

[3545] %F3 [%V3] is obsolete
CS Site-Specific Factor10 ["value of CS Site-Specific Factor10"] is obsolete

Additional Messages

[3359] CS Site-Specific Factor10=OBSOLETE DATA RETAINED - not allowed if DX > 2009
[3363] CS Site-Specific Factor10=OBSOLETE DATA CONVERTED V0102
[3364] CS Site-Specific Factor10=OBSOLETE DATA CONVERTED V0104
[3365] CS Site-Specific Factor10=OBSOLETE DATA CONVERTED V0200
[3366] CS Site-Specific Factor10=OBSOLETE DATA REVIEWED AND CHANGED V0102
[3367] CS Site-Specific Factor10=OBSOLETE DATA REVIEWED AND CHANGED V0103
[3368] CS Site-Specific Factor10=OBSOLETE DATA REVIEWED AND CHANGED V0200
[3386] CS Site-Specific Factor10=OBSOLETE DATA RETAINED - not allowed if CS Version Input Original > or = 020100
[3398] CS Site-Specific Factor10=OBSOLETE DATA CONVERTED V0203
[3399] CS Site-Specific Factor10=OBSOLETE DATA REVIEWED AND CHANGED V0203
[3400] CS Site-Specific Factor10=OBSOLETE DATA REVIEWED V0203 - not allowed if DX > 2010
[3401] CS Site-Specific Factor10=OBSOLETE DATA REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3402] CS Site-Specific Factor10=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if DX > 2010
[3403] CS Site-Specific Factor10=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3404] CS Site-Specific Factor10=OBSOLETE DATA RETAINED V0203 - not allowed if DX > 2010
[3405] CS Site-Specific Factor10=OBSOLETE DATA RETAINED V0203 - not allowed if CS Version Input Original > or = 020300
[3498] CS Site-Specific Factor10=OBSOLETE DATA CONVERTED V0204
[3499] CS Site-Specific Factor10=OBSOLETE DATA REVIEWED AND CHANGED V0204
[3500] CS Site-Specific Factor10=OBSOLETE DATA RETAINED V0202 - not allowed if DX > 2010

[3501] CS Site-Specific Factor10=OBSOLETE DATA RETAINED V0202 - not allowed if CS Version Input Original > or = 020200
[3502] CS Site-Specific Factor10=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if DX > 2011
[3503] CS Site-Specific Factor10=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if CS Version Input Original > or = 020440
[3504] CS Site-Specific Factor10=OBSOLETE DATA RETAINED V0204 - not allowed if DX > 2011
[3505] CS Site-Specific Factor10=OBSOLETE DATA RETAINED V0204 - not allowed if CS Version Input Original > or = 020440
[3506] CS Site-Specific Factor10=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if DX > 2009
[3507] CS Site-Specific Factor10=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if CS Version Input Original > or = 020100
ERROR_TEXT("Date of Diagnosis: %DC")
ERROR_TEXT("Invalid site or histology")
ERROR_TEXT("Schema discriminator missing or invalid")
SAVE_TEXT("t_schema_msg")

Description

This edit checks for all obsolete CS Site-Specific Factor10 codes. Obsolete codes should be re-coded per Collaborative Stage guidelines.

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor10 is blank
2. Date of Diagnosis is blank
3. CS Version Input Original is blank

This edit first determines the correct CS schema by doing a function call to the CS Dynamic Link Library (dll). The function call passes Primary Site, Histologic Type ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS schema name is returned.

Using the returned schema name, CS table number (CS Site-Specific Factor10 is table number 19), and CS Site-Specific Factor10 code, a table lookup is performed. If the code for a particular schema is determined to be obsolete based on the table lookup, the type of obsolete code must be evaluated. There are several types of obsolete codes:

1. OBSOLETE DATA CONVERTED AND RETAINED V0200
2. OBSOLETE DATA CONVERTED V0102
3. OBSOLETE DATA CONVERTED V0104
4. OBSOLETE DATA CONVERTED V0200
5. OBSOLETE DATA RETAINED V0100
6. OBSOLETE DATA RETAINED V0102
7. OBSOLETE DATA RETAINED V0200
8. OBSOLETE DATA REVIEWED AND CHANGED V0102
9. OBSOLETE DATA REVIEWED AND CHANGED V0103
10. OBSOLETE DATA REVIEWED AND CHANGED V0200
11. OBSOLETE DATA CONVERTED V0203
12. OBSOLETE DATA REVIEWED AND CHANGED V0203
13. OBSOLETE DATA REVIEWED V0203
14. OBSOLETE DATA RETAINED AND REVIEWED V0203
15. OBSOLETE DATA RETAINED V0203
16. OBSOLETE DATA RETAINED V0104
17. OBSOLETE DATA RETAINED V0202
18. OBSOLETE DATA RETAINED AND REVIEWED V0200

19. OBSOLETE DATA CONVERTED V0204
20. OBSOLETE DATA REVIEWED AND CHANGED V0204
21. OBSOLETE DATA RETAINED AND REVIEWED V0204
22. OBSOLETE DATA RETAINED V0204

1. If the type of obsolete code = OBSOLETE DATA CONVERTED AND RETAINED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor10]

2. If the type of obsolete code = OBSOLETE DATA CONVERTED V0102:
an error is generated.
[Example: none for CS Site-Specific Factor10]

3. If the type of obsolete code = OBSOLETE DATA CONVERTED V0104:
an error is generated.
[Example: none for CS Site-Specific Factor10]

4. If the type of obsolete code = OBSOLETE DATA CONVERTED V0200:
an error is generated.
[Example: none for CS Site-Specific Factor10]

5. If the type of obsolete code = OBSOLETE DATA RETAINED V0100:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor10]

6. If the type of obsolete code = OBSOLETE DATA RETAINED V0102:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor10]

7. If the type of obsolete code = OBSOLETE DATA RETAINED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor10]

8. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0102:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: none for CS Site-Specific Factor10]

9. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0103:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: none for CS Site-Specific Factor10]

10.If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0200:
an error is generated.
(These particular obsolete codes require review after conversion from CSV01 to CSV02.)
[Example: none for CS Site-Specific Factor10]

11. If the type of obsolete code = OBSOLETE DATA CONVERTED V0203:

an error is generated.
[Example: Schema = Breast, CS Site-Specific Factor10 = 981-986]

12. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0203:
an error is generated.
(These particular obsolete codes require review after conversion from CSV02xx to CSV0203.)
[Example: none for CS Site-Specific Factor10]

13. If the type of obsolete code = OBSOLETE DATA REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor10]

14. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor10]

15. If the type of obsolete code = OBSOLETE DATA RETAINED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor10]

16. If the type of obsolete code = OBSOLETE DATA RETAINED V0104:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv02), an error is generated.

17. If the type of obsolete code = OBSOLETE DATA RETAINED V0202:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020200 or higher (indicating the case was originally coded using CSv0202), an error is generated.

18. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv2), an error is generated.

19. If the type of obsolete code = OBSOLETE DATA CONVERTED V0204:
an error is generated.

20. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0204:
an error is generated.
(These particular obsolete codes require review after conversion from CSV0203xx to CSV0204.)

21. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0204:
A. If year of Diagnosis is 2012 or higher, an error is generated.
B. If CS version Input Original is 020440 or higher (indicating the case was originally coded using CSv0204), an error is generated.

22. If the type of obsolete code = OBSOLETE DATA RETAINED V0204:
A. If year of Diagnosis is 2012 or higher, an error is generated.
B. If CS version Input Original is 020440 or higher (indicating the case was originally coded using CSv0204), an error is generated.

Administrative Notes

New edit - added to NAACCR v12.1 metafile.

In the SEER*Edits software, the title of this edit is: IF327

Modifications:

NAACCR v12.2
- Updated to skip if CS Version Input Original is blank.
- Modified to include the additional types of obsolete codes that were added for CSv0204.
- Modified to include 3 types of obsolete codes left out of previous versions of the edit:
-- OBSOLETE DATA RETAINED V0203
-- OBSOLETE DATA RETAINED V0104
-- OBSOLETE DATA RETAINED V0202

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Default error message added

NAACCR v15A
- Duplicate variable declarations deleted from edit logic.

Obsolete Codes - CS Site-Specific Factor11 (CS)

Agency: CS **Last changed: 09/15/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
CS Site-Specific Factor11 [Std# 2865]
CS Version Input Original [Std# 2935]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]

Tables

CS_OBS.DBF

Default Error Message

[3545] %F3 [%V3] is obsolete
CS Site-Specific Factor11 ["value of CS Site-Specific Factor11"] is obsolete

Additional Messages

[3359] CS Site-Specific Factor11=OBSOLETE DATA RETAINED - not allowed if DX > 2009
[3363] CS Site-Specific Factor11=OBSOLETE DATA CONVERTED V0102
[3364] CS Site-Specific Factor11=OBSOLETE DATA CONVERTED V0104
[3365] CS Site-Specific Factor11=OBSOLETE DATA CONVERTED V0200
[3366] CS Site-Specific Factor11=OBSOLETE DATA REVIEWED AND CHANGED V0102
[3367] CS Site-Specific Factor11=OBSOLETE DATA REVIEWED AND CHANGED V0103
[3368] CS Site-Specific Factor11=OBSOLETE DATA REVIEWED AND CHANGED V0200
[3386] CS Site-Specific Factor11=OBSOLETE DATA RETAINED - not allowed if CS Version Input Original > or = 020100
[3398] CS Site-Specific Factor11=OBSOLETE DATA CONVERTED V0203
[3399] CS Site-Specific Factor11=OBSOLETE DATA REVIEWED AND CHANGED V0203
[3400] CS Site-Specific Factor11=OBSOLETE DATA REVIEWED V0203 - not allowed if DX > 2010
[3401] CS Site-Specific Factor11=OBSOLETE DATA REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3402] CS Site-Specific Factor11=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if DX > 2010
[3403] CS Site-Specific Factor11=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3404] CS Site-Specific Factor11=OBSOLETE DATA RETAINED V0203 - not allowed if DX > 2010
[3405] CS Site-Specific Factor11=OBSOLETE DATA RETAINED V0203 - not allowed if CS Version Input Original > or = 020300
[3498] CS Site-Specific Factor11=OBSOLETE DATA CONVERTED V0204
[3499] CS Site-Specific Factor11=OBSOLETE DATA REVIEWED AND CHANGED V0204
[3500] CS Site-Specific Factor11=OBSOLETE DATA RETAINED V0202 - not allowed if DX > 2010

[3501] CS Site-Specific Factor11=OBSOLETE DATA RETAINED V0202 - not allowed if CS Version Input Original > or = 020200
[3502] CS Site-Specific Factor11=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if DX > 2011
[3503] CS Site-Specific Factor11=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if CS Version Input Original > or = 020440
[3504] CS Site-Specific Factor11=OBSOLETE DATA RETAINED V0204 - not allowed if DX > 2011
[3505] CS Site-Specific Factor11=OBSOLETE DATA RETAINED V0204 - not allowed if CS Version Input Original > or = 020440
[3506] CS Site-Specific Factor11=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if DX > 2009
[3507] CS Site-Specific Factor11=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if CS Version Input Original > or = 020100
ERROR_TEXT("Date of Diagnosis: %DC")
ERROR_TEXT("Invalid site or histology")
ERROR_TEXT("Schema discriminator missing or invalid")
SAVE_TEXT("t_schema_msg")

Description

This edit checks for all obsolete CS Site-Specific Factor11 codes. Obsolete codes should be re-coded per Collaborative Stage guidelines.

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor11 is blank
2. Date of Diagnosis is blank
3. CS Version Input Original is blank

This edit first determines the correct CS schema by doing a function call to the CS Dynamic Link Library (dll). The function call passes Primary Site, Histologic Type ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS schema name is returned.

Using the returned schema name, CS table number (CS Site-Specific Factor11 is table number 20), and CS Site-Specific Factor11 code, a table lookup is performed. If the code for a particular schema is determined to be obsolete based on the table lookup, the type of obsolete code must be evaluated. There are several types of obsolete codes:

1. OBSOLETE DATA CONVERTED AND RETAINED V0200
2. OBSOLETE DATA CONVERTED V0102
3. OBSOLETE DATA CONVERTED V0104
4. OBSOLETE DATA CONVERTED V0200
5. OBSOLETE DATA RETAINED V0100
6. OBSOLETE DATA RETAINED V0102
7. OBSOLETE DATA RETAINED V0200
8. OBSOLETE DATA REVIEWED AND CHANGED V0102
9. OBSOLETE DATA REVIEWED AND CHANGED V0103
10. OBSOLETE DATA REVIEWED AND CHANGED V0200
11. OBSOLETE DATA CONVERTED V0203
12. OBSOLETE DATA REVIEWED AND CHANGED V0203
13. OBSOLETE DATA REVIEWED V0203
14. OBSOLETE DATA RETAINED AND REVIEWED V0203
15. OBSOLETE DATA RETAINED V0203
16. OBSOLETE DATA RETAINED V0104
17. OBSOLETE DATA RETAINED V0202
18. OBSOLETE DATA RETAINED AND REVIEWED V0200

19. OBSOLETE DATA CONVERTED V0204
20. OBSOLETE DATA REVIEWED AND CHANGED V0204
21. OBSOLETE DATA RETAINED AND REVIEWED V0204
22. OBSOLETE DATA RETAINED V0204

1. If the type of obsolete code = OBSOLETE DATA CONVERTED AND RETAINED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor11]

2. If the type of obsolete code = OBSOLETE DATA CONVERTED V0102:
an error is generated.
[Example: none for CS Site-Specific Factor11]

3. If the type of obsolete code = OBSOLETE DATA CONVERTED V0104:
an error is generated.
[Example: none for CS Site-Specific Factor11]

4. If the type of obsolete code = OBSOLETE DATA CONVERTED V0200:
an error is generated.
[Example: Schema = NETColon, CS Site-Specific Factor11 = 888]

5. If the type of obsolete code = OBSOLETE DATA RETAINED V0100:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor11]

6. If the type of obsolete code = OBSOLETE DATA RETAINED V0102:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor11]

7. If the type of obsolete code = OBSOLETE DATA RETAINED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor11]

8. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0102:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: none for CS Site-Specific Factor11]

9. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0103:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: none for CS Site-Specific Factor11]

10.If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0200:
an error is generated.
(These particular obsolete codes require review after conversion from CSV01 to CSV02.)
[Example: none for CS Site-Specific Factor11]

11. If the type of obsolete code = OBSOLETE DATA CONVERTED V0203:

an error is generated.
[Example: Schema = GISTAppendix, CS Site-Specific Factor11 = 995]

12. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0203:
an error is generated.
(These particular obsolete codes require review after conversion from CSV02xx to CSV0203.)
[Example: none for CS Site-Specific Factor11]
Note: Although for Testis schema, CS Site-Specific Factor11 of 000, 010, and 999 are listed in CSv0203 as OBSOLETE DATA REVIEWED AND CHANGED V0203, it is a mistake and will be changed to OBSOLETE DATA RETAINED in the next release of CS. These three codes should not generate errors.

13. If the type of obsolete code = OBSOLETE DATA REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor11]

14. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor11]

15. If the type of obsolete code = OBSOLETE DATA RETAINED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor11]

16. If the type of obsolete code = OBSOLETE DATA RETAINED V0104:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv02), an error is generated.

17. If the type of obsolete code = OBSOLETE DATA RETAINED V0202:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020200 or higher (indicating the case was originally coded using CSv0202), an error is generated.

18. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv2), an error is generated.

19. If the type of obsolete code = OBSOLETE DATA CONVERTED V0204:
an error is generated.

20. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0204:
an error is generated.
(These particular obsolete codes require review after conversion from CSV0203xx to CSV0204.)

21. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0204:
A. If year of Diagnosis is 2012 or higher, an error is generated.
B. If CS version Input Original is 020440 or higher (indicating the case was originally coded using CSv0204), an error is generated.

22. If the type of obsolete code = OBSOLETE DATA RETAINED V0204:

```
A. If year of Diagnosis is 2012 or higher, an error is generated.
B. If CS version Input Original is 020440 or higher (indicating the case was
originally coded using CSv0204), an error is generated.
```

Administrative Notes

New edit - added to NAACCR v12.1 metafile.

In the SEER*Edits software, the title of this edit is: IF328

Modifications:

NAACCR v12.2
- Updated to skip if CS Version Input Original is blank.
- Modified to include the additional types of obsolete codes that were added for CSv0204.
- Modified to include 3 types of obsolete codes left out of previous versions of the edit:
-- OBSOLETE DATA RETAINED V0203
-- OBSOLETE DATA RETAINED V0104
-- OBSOLETE DATA RETAINED V0202

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Default error message added

NAACCR v15A
- Duplicate variable declarations deleted from edit logic.

Obsolete Codes - CS Site-Specific Factor12 (CS)

Agency: CS **Last changed: 09/15/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
CS Site-Specific Factor12 [Std# 2866]
CS Version Input Original [Std# 2935]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]

Tables

CS_OBS.DBF

Default Error Message

[3545] %F3 [%V3] is obsolete
CS Site-Specific Factor12 ["value of CS Site-Specific Factor12"] is obsolete

Additional Messages

[3359] CS Site-Specific Factor12=OBSOLETE DATA RETAINED - not allowed if DX > 2009
[3363] CS Site-Specific Factor12=OBSOLETE DATA CONVERTED V0102
[3364] CS Site-Specific Factor12=OBSOLETE DATA CONVERTED V0104
[3365] CS Site-Specific Factor12=OBSOLETE DATA CONVERTED V0200
[3366] CS Site-Specific Factor12=OBSOLETE DATA REVIEWED AND CHANGED V0102
[3367] CS Site-Specific Factor12=OBSOLETE DATA REVIEWED AND CHANGED V0103
[3368] CS Site-Specific Factor12=OBSOLETE DATA REVIEWED AND CHANGED V0200
[3386] CS Site-Specific Factor12=OBSOLETE DATA RETAINED - not allowed if CS Version Input Original > or = 020100
[3398] CS Site-Specific Factor12=OBSOLETE DATA CONVERTED V0203
[3399] CS Site-Specific Factor12=OBSOLETE DATA REVIEWED AND CHANGED V0203
[3400] CS Site-Specific Factor12=OBSOLETE DATA REVIEWED V0203 - not allowed if DX > 2010
[3401] CS Site-Specific Factor12=OBSOLETE DATA REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3402] CS Site-Specific Factor12=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if DX > 2010
[3403] CS Site-Specific Factor12=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3404] CS Site-Specific Factor12=OBSOLETE DATA RETAINED V0203 - not allowed if DX > 2010
[3405] CS Site-Specific Factor12=OBSOLETE DATA RETAINED V0203 - not allowed if CS Version Input Original > or = 020300
[3498] CS Site-Specific Factor12=OBSOLETE DATA CONVERTED V0204
[3499] CS Site-Specific Factor12=OBSOLETE DATA REVIEWED AND CHANGED V0204
[3500] CS Site-Specific Factor12=OBSOLETE DATA RETAINED V0202 - not allowed if DX > 2010

[3501] CS Site-Specific Factor12=OBSOLETE DATA RETAINED V0202 - not allowed if CS Version Input Original > or = 020200
[3502] CS Site-Specific Factor12=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if DX > 2011
[3503] CS Site-Specific Factor12=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if CS Version Input Original > or = 020440
[3504] CS Site-Specific Factor12=OBSOLETE DATA RETAINED V0204 - not allowed if DX > 2011
[3505] CS Site-Specific Factor12=OBSOLETE DATA RETAINED V0204 - not allowed if CS Version Input Original > or = 020440
[3506] CS Site-Specific Factor12=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if DX > 2009
[3507] CS Site-Specific Factor12=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if CS Version Input Original > or = 020100
ERROR_TEXT("Date of Diagnosis: %DC")
ERROR_TEXT("Invalid site or histology")
ERROR_TEXT("Schema discriminator missing or invalid")
SAVE_TEXT("t_schema_msg")

Description

This edit checks for all obsolete CS Site-Specific Factor12 codes. Obsolete codes should be re-coded per Collaborative Stage guidelines.

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor12 is blank
2. Date of Diagnosis is blank
3. CS Version Input Original is blank

This edit first determines the correct CS schema by doing a function call to the CS Dynamic Link Library (dll). The function call passes Primary Site, Histologic Type ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS schema name is returned.

Using the returned schema name, CS table number (CS Site-Specific Factor12 is table number 21), and CS Site-Specific Factor12 code, a table lookup is performed. If the code for a particular schema is determined to be obsolete based on the table lookup, the type of obsolete code must be evaluated. There are several types of obsolete codes:

1. OBSOLETE DATA CONVERTED AND RETAINED V0200
2. OBSOLETE DATA CONVERTED V0102
3. OBSOLETE DATA CONVERTED V0104
4. OBSOLETE DATA CONVERTED V0200
5. OBSOLETE DATA RETAINED V0100
6. OBSOLETE DATA RETAINED V0102
7. OBSOLETE DATA RETAINED V0200
8. OBSOLETE DATA REVIEWED AND CHANGED V0102
9. OBSOLETE DATA REVIEWED AND CHANGED V0103
10. OBSOLETE DATA REVIEWED AND CHANGED V0200
11. OBSOLETE DATA CONVERTED V0203
12. OBSOLETE DATA REVIEWED AND CHANGED V0203
13. OBSOLETE DATA REVIEWED V0203
14. OBSOLETE DATA RETAINED AND REVIEWED V0203
15. OBSOLETE DATA RETAINED V0203
16. OBSOLETE DATA RETAINED V0104
17. OBSOLETE DATA RETAINED V0202
18. OBSOLETE DATA RETAINED AND REVIEWED V0200

19. OBSOLETE DATA CONVERTED V0204
20. OBSOLETE DATA REVIEWED AND CHANGED V0204
21. OBSOLETE DATA RETAINED AND REVIEWED V0204
22. OBSOLETE DATA RETAINED V0204

1. If the type of obsolete code = OBSOLETE DATA CONVERTED AND RETAINED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor12]

2. If the type of obsolete code = OBSOLETE DATA CONVERTED V0102:
an error is generated.
[Example: none for CS Site-Specific Factor12]

3. If the type of obsolete code = OBSOLETE DATA CONVERTED V0104:
an error is generated.
[Example: none for CS Site-Specific Factor12]

4. If the type of obsolete code = OBSOLETE DATA CONVERTED V0200:
an error is generated.
[Example: none for CS Site-Specific Factor12]

5. If the type of obsolete code = OBSOLETE DATA RETAINED V0100:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor12]

6. If the type of obsolete code = OBSOLETE DATA RETAINED V0102:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor12]

7. If the type of obsolete code = OBSOLETE DATA RETAINED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor12]

8. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0102:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: none for CS Site-Specific Factor12]

9. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0103:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: none for CS Site-Specific Factor12]

10.If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0200:
an error is generated.
(These particular obsolete codes require review after conversion from CSV01 to CSV02.)
[Example: none for CS Site-Specific Factor12]

11. If the type of obsolete code = OBSOLETE DATA CONVERTED V0203:

an error is generated.
[Example: Schema = Breast, CS Site-Specific Factor12 = 981-986]

12. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0203:
an error is generated.
(These particular obsolete codes require review after conversion from CSV02xx to CSV0203.)
[Example: none for CS Site-Specific Factor12]

13. If the type of obsolete code = OBSOLETE DATA REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor12]

14. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor12]

15. If the type of obsolete code = OBSOLETE DATA RETAINED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor12]

16. If the type of obsolete code = OBSOLETE DATA RETAINED V0104:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv02), an error is generated.

17. If the type of obsolete code = OBSOLETE DATA RETAINED V0202:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020200 or higher (indicating the case was originally coded using CSv0202), an error is generated.

18. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv2), an error is generated.

19. If the type of obsolete code = OBSOLETE DATA CONVERTED V0204:
an error is generated.

20. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0204:
an error is generated.
(These particular obsolete codes require review after conversion from CSV0203xx to CSV0204.)

21. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0204:
A. If year of Diagnosis is 2012 or higher, an error is generated.
B. If CS version Input Original is 020440 or higher (indicating the case was originally coded using CSv0204), an error is generated.

22. If the type of obsolete code = OBSOLETE DATA RETAINED V0204:
A. If year of Diagnosis is 2012 or higher, an error is generated.
B. If CS version Input Original is 020440 or higher (indicating the case was originally coded using CSv0204), an error is generated.

Administrative Notes

New edit - added to NAACCR v12.1 metafile.

In the SEER*Edits software, the title of this edit is: IF329

Modifications:

NAACCR v12.2
- Updated to skip if CS Version Input Original is blank.
- Modified to include the additional types of obsolete codes that were added for CSv0204.
- Modified to include 3 types of obsolete codes left out of previous versions of the edit:
-- OBSOLETE DATA RETAINED V0203
-- OBSOLETE DATA RETAINED V0104
-- OBSOLETE DATA RETAINED V0202

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Default error message added

NAACCR v15A
- Duplicate variable declarations deleted from edit logic.

Obsolete Codes - CS Site-Specific Factor13 (CS)

Agency: CS **Last changed: 09/15/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
CS Site-Specific Factor13 [Std# 2867]
CS Version Input Original [Std# 2935]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]

Tables

CS_OBS.DBF

Default Error Message

[3545] %F3 [%V3] is obsolete
CS Site-Specific Factor13 ["value of CS Site-Specific Factor13"] is obsolete

Additional Messages

[3359] CS Site-Specific Factor13=OBSOLETE DATA RETAINED - not allowed if DX > 2009
[3363] CS Site-Specific Factor13=OBSOLETE DATA CONVERTED V0102
[3364] CS Site-Specific Factor13=OBSOLETE DATA CONVERTED V0104
[3365] CS Site-Specific Factor13=OBSOLETE DATA CONVERTED V0200
[3366] CS Site-Specific Factor13=OBSOLETE DATA REVIEWED AND CHANGED V0102
[3367] CS Site-Specific Factor13=OBSOLETE DATA REVIEWED AND CHANGED V0103
[3368] CS Site-Specific Factor13=OBSOLETE DATA REVIEWED AND CHANGED V0200
[3386] CS Site-Specific Factor13=OBSOLETE DATA RETAINED - not allowed if CS Version Input Original > or = 020100
[3398] CS Site-Specific Factor13=OBSOLETE DATA CONVERTED V0203
[3399] CS Site-Specific Factor13=OBSOLETE DATA REVIEWED AND CHANGED V0203
[3400] CS Site-Specific Factor13=OBSOLETE DATA REVIEWED V0203 - not allowed if DX > 2010
[3401] CS Site-Specific Factor13=OBSOLETE DATA REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3402] CS Site-Specific Factor13=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if DX > 2010
[3403] CS Site-Specific Factor13=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3404] CS Site-Specific Factor13=OBSOLETE DATA RETAINED V0203 - not allowed if DX > 2010
[3405] CS Site-Specific Factor13=OBSOLETE DATA RETAINED V0203 - not allowed if CS Version Input Original > or = 020300
[3498] CS Site-Specific Factor13=OBSOLETE DATA CONVERTED V0204
[3499] CS Site-Specific Factor13=OBSOLETE DATA REVIEWED AND CHANGED V0204
[3500] CS Site-Specific Factor13=OBSOLETE DATA RETAINED V0202 - not allowed if DX > 2010

[3501] CS Site-Specific Factor13=OBSOLETE DATA RETAINED V0202 - not allowed if CS Version Input Original > or = 020200
[3502] CS Site-Specific Factor13=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if DX > 2011
[3503] CS Site-Specific Factor13=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if CS Version Input Original > or = 020440
[3504] CS Site-Specific Factor13=OBSOLETE DATA RETAINED V0204 - not allowed if DX > 2011
[3505] CS Site-Specific Factor13=OBSOLETE DATA RETAINED V0204 - not allowed if CS Version Input Original > or = 020440
[3506] CS Site-Specific Factor13=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if DX > 2009
[3507] CS Site-Specific Factor13=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if CS Version Input Original > or = 020100
ERROR_TEXT("Date of Diagnosis: %DC")
ERROR_TEXT("Invalid site or histology")
ERROR_TEXT("Schema discriminator missing or invalid")
SAVE_TEXT("t_schema_msg")

Description

This edit checks for all obsolete CS Site-Specific Factor13 codes. Obsolete codes should be re-coded per Collaborative Stage guidelines.

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor13 is blank
2. Date of Diagnosis is blank
3. CS Version Input Original is blank

This edit first determines the correct CS schema by doing a function call to the CS Dynamic Link Library (dll). The function call passes Primary Site, Histologic Type ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS schema name is returned.

Using the returned schema name, CS table number (CS Site-Specific Factor13 is table number 22), and CS Site-Specific Factor13 code, a table lookup is performed. If the code for a particular schema is determined to be obsolete based on the table lookup, the type of obsolete code must be evaluated. There are several types of obsolete codes:

1. OBSOLETE DATA CONVERTED AND RETAINED V0200
2. OBSOLETE DATA CONVERTED V0102
3. OBSOLETE DATA CONVERTED V0104
4. OBSOLETE DATA CONVERTED V0200
5. OBSOLETE DATA RETAINED V0100
6. OBSOLETE DATA RETAINED V0102
7. OBSOLETE DATA RETAINED V0200
8. OBSOLETE DATA REVIEWED AND CHANGED V0102
9. OBSOLETE DATA REVIEWED AND CHANGED V0103
10. OBSOLETE DATA REVIEWED AND CHANGED V0200
11. OBSOLETE DATA CONVERTED V0203
12. OBSOLETE DATA REVIEWED AND CHANGED V0203
13. OBSOLETE DATA REVIEWED V0203
14. OBSOLETE DATA RETAINED AND REVIEWED V0203
15. OBSOLETE DATA RETAINED V0203
16. OBSOLETE DATA RETAINED V0104
17. OBSOLETE DATA RETAINED V0202
18. OBSOLETE DATA RETAINED AND REVIEWED V0200

19. OBSOLETE DATA CONVERTED V0204
20. OBSOLETE DATA REVIEWED AND CHANGED V0204
21. OBSOLETE DATA RETAINED AND REVIEWED V0204
22. OBSOLETE DATA RETAINED V0204

1. If the type of obsolete code = OBSOLETE DATA CONVERTED AND RETAINED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor13]

2. If the type of obsolete code = OBSOLETE DATA CONVERTED V0102:
an error is generated.
[Example: none for CS Site-Specific Factor13]

3. If the type of obsolete code = OBSOLETE DATA CONVERTED V0104:
an error is generated.
[Example: none for CS Site-Specific Factor13]

4. If the type of obsolete code = OBSOLETE DATA CONVERTED V0200:
an error is generated.
[Example: none for CS Site-Specific Factor13]

5. If the type of obsolete code = OBSOLETE DATA RETAINED V0100:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor13]

6. If the type of obsolete code = OBSOLETE DATA RETAINED V0102:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor13]

7. If the type of obsolete code = OBSOLETE DATA RETAINED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor13]

8. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0102:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: none for CS Site-Specific Factor13]

9. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0103:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: none for CS Site-Specific Factor13]

10.If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0200:
an error is generated.
(These particular obsolete codes require review after conversion from CSV01 to CSV02.)
[Example: none for CS Site-Specific Factor13]

11. If the type of obsolete code = OBSOLETE DATA CONVERTED V0203:

an error is generated.
[Example: Schema = BileDuctsDistal, CS Site-Specific Factor13 = 000]

12. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0203:
an error is generated.
(These particular obsolete codes require review after conversion from CSV02xx to CSV0203.)
[Example: none for CS Site-Specific Factor13]

13. If the type of obsolete code = OBSOLETE DATA REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor13]

14. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor13]

15. If the type of obsolete code = OBSOLETE DATA RETAINED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor13]

16. If the type of obsolete code = OBSOLETE DATA RETAINED V0104:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv02), an error is generated.

17. If the type of obsolete code = OBSOLETE DATA RETAINED V0202:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020200 or higher (indicating the case was originally coded using CSv0202), an error is generated.

18. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv2), an error is generated.

19. If the type of obsolete code = OBSOLETE DATA CONVERTED V0204:
an error is generated.

20. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0204:
an error is generated.
(These particular obsolete codes require review after conversion from CSV0203xx to CSV0204.)

21. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0204:
A. If year of Diagnosis is 2012 or higher, an error is generated.
B. If CS version Input Original is 020440 or higher (indicating the case was originally coded using CSv0204), an error is generated.

22. If the type of obsolete code = OBSOLETE DATA RETAINED V0204:
A. If year of Diagnosis is 2012 or higher, an error is generated.
B. If CS version Input Original is 020440 or higher (indicating the case was originally coded using CSv0204), an error is generated.

Administrative Notes

New edit - added to NAACCR v12.1 metafile.

In the SEER*Edits software, the title of this edit is: IF330

Modifications:

NAACCR v12.2
- Updated to skip if CS Version Input Original is blank.
- Modified to include the additional types of obsolete codes that were added for CSv0204.
- Modified to include 3 types of obsolete codes left out of previous versions of the edit:
-- OBSOLETE DATA RETAINED V0203
-- OBSOLETE DATA RETAINED V0104
-- OBSOLETE DATA RETAINED V0202

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Default error message added

NAACCR v15A
- Duplicate variable declarations deleted from edit logic.

Obsolete Codes - CS Site-Specific Factor15 (CS)

Agency: CS **Last changed: 09/15/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
CS Site-Specific Factor15 [Std# 2869]
CS Version Input Original [Std# 2935]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]

Tables

CS_OBS.DBF

Default Error Message

[3545] %F3 [%V3] is obsolete
CS Site-Specific Factor15 ["value of CS Site-Specific Factor15"] is obsolete

Additional Messages

[3359] CS Site-Specific Factor15=OBSOLETE DATA RETAINED - not allowed if DX > 2009
[3363] CS Site-Specific Factor15=OBSOLETE DATA CONVERTED V0102
[3364] CS Site-Specific Factor15=OBSOLETE DATA CONVERTED V0104
[3365] CS Site-Specific Factor15=OBSOLETE DATA CONVERTED V0200
[3366] CS Site-Specific Factor15=OBSOLETE DATA REVIEWED AND CHANGED V0102
[3367] CS Site-Specific Factor15=OBSOLETE DATA REVIEWED AND CHANGED V0103
[3368] CS Site-Specific Factor15=OBSOLETE DATA REVIEWED AND CHANGED V0200
[3386] CS Site-Specific Factor15=OBSOLETE DATA RETAINED - not allowed if CS Version Input Original > or = 020100
[3398] CS Site-Specific Factor15=OBSOLETE DATA CONVERTED V0203
[3399] CS Site-Specific Factor15=OBSOLETE DATA REVIEWED AND CHANGED V0203
[3400] CS Site-Specific Factor15=OBSOLETE DATA REVIEWED V0203 - not allowed if DX > 2010
[3401] CS Site-Specific Factor15=OBSOLETE DATA REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3402] CS Site-Specific Factor15=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if DX > 2010
[3403] CS Site-Specific Factor15=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3404] CS Site-Specific Factor15=OBSOLETE DATA RETAINED V0203 - not allowed if DX > 2010
[3405] CS Site-Specific Factor15=OBSOLETE DATA RETAINED V0203 - not allowed if CS Version Input Original > or = 020300
[3498] CS Site-Specific Factor15=OBSOLETE DATA CONVERTED V0204
[3499] CS Site-Specific Factor15=OBSOLETE DATA REVIEWED AND CHANGED V0204
[3500] CS Site-Specific Factor15=OBSOLETE DATA RETAINED V0202 - not allowed if DX > 2010

[3501] CS Site-Specific Factor15=OBSOLETE DATA RETAINED V0202 - not allowed if CS Version Input Original > or = 020200
[3502] CS Site-Specific Factor15=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if DX > 2011
[3503] CS Site-Specific Factor15=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if CS Version Input Original > or = 020440
[3504] CS Site-Specific Factor15=OBSOLETE DATA RETAINED V0204 - not allowed if DX > 2011
[3505] CS Site-Specific Factor15=OBSOLETE DATA RETAINED V0204 - not allowed if CS Version Input Original > or = 020440
[3506] CS Site-Specific Factor15=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if DX > 2009
[3507] CS Site-Specific Factor15=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if CS Version Input Original > or = 020100
ERROR_TEXT("Date of Diagnosis: %DC")
ERROR_TEXT("Invalid site or histology")
ERROR_TEXT("Schema discriminator missing or invalid")
SAVE_TEXT("t_schema_msg")

Description

This edit checks for all obsolete CS Site-Specific Factor15 codes. Obsolete codes should be re-coded per Collaborative Stage guidelines.

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor15 is blank
2. Date of Diagnosis is blank
3. CS Version Input Original is blank

This edit first determines the correct CS schema by doing a function call to the CS Dynamic Link Library (dll). The function call passes Primary Site, Histologic Type ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS schema name is returned.

Using the returned schema name, CS table number (CS Site-Specific Factor15 is table number 24), and CS Site-Specific Factor15 code, a table lookup is performed. If the code for a particular schema is determined to be obsolete based on the table lookup, the type of obsolete code must be evaluated. There are several types of obsolete codes:

1. OBSOLETE DATA CONVERTED AND RETAINED V0200
2. OBSOLETE DATA CONVERTED V0102
3. OBSOLETE DATA CONVERTED V0104
4. OBSOLETE DATA CONVERTED V0200
5. OBSOLETE DATA RETAINED V0100
6. OBSOLETE DATA RETAINED V0102
7. OBSOLETE DATA RETAINED V0200
8. OBSOLETE DATA REVIEWED AND CHANGED V0102
9. OBSOLETE DATA REVIEWED AND CHANGED V0103
10. OBSOLETE DATA REVIEWED AND CHANGED V0200
11. OBSOLETE DATA CONVERTED V0203
12. OBSOLETE DATA REVIEWED AND CHANGED V0203
13. OBSOLETE DATA REVIEWED V0203
14. OBSOLETE DATA RETAINED AND REVIEWED V0203
15. OBSOLETE DATA RETAINED V0203
16. OBSOLETE DATA RETAINED V0104
17. OBSOLETE DATA RETAINED V0202
18. OBSOLETE DATA RETAINED AND REVIEWED V0200

19. OBSOLETE DATA CONVERTED V0204
20. OBSOLETE DATA REVIEWED AND CHANGED V0204
21. OBSOLETE DATA RETAINED AND REVIEWED V0204
22. OBSOLETE DATA RETAINED V0204

1. If the type of obsolete code = OBSOLETE DATA CONVERTED AND RETAINED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor15]

2. If the type of obsolete code = OBSOLETE DATA CONVERTED V0102:
an error is generated.
[Example: none for CS Site-Specific Factor15]

3. If the type of obsolete code = OBSOLETE DATA CONVERTED V0104:
an error is generated.
[Example: none for CS Site-Specific Factor15]

4. If the type of obsolete code = OBSOLETE DATA CONVERTED V0200:
an error is generated.
[Example: none for CS Site-Specific Factor15]

5. If the type of obsolete code = OBSOLETE DATA RETAINED V0100:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor15]

6. If the type of obsolete code = OBSOLETE DATA RETAINED V0102:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor15]

7. If the type of obsolete code = OBSOLETE DATA RETAINED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor15]

8. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0102:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: none for CS Site-Specific Factor15]

9. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0103:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: none for CS Site-Specific Factor15]

10.If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0200:
an error is generated.
(These particular obsolete codes require review after conversion from CSV01 to CSV02.)
[Example: none for CS Site-Specific Factor15]

11. If the type of obsolete code = OBSOLETE DATA CONVERTED V0203:

an error is generated.
[Example: Schema = Vulva, CS Site-Specific Factor15 = 000]

12. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0203:
an error is generated.
(These particular obsolete codes require review after conversion from CSV02xx to CSV0203.)
[Example: none for CS Site-Specific Factor15]

13. If the type of obsolete code = OBSOLETE DATA REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor15]

14. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor15]

15. If the type of obsolete code = OBSOLETE DATA RETAINED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor15]

16. If the type of obsolete code = OBSOLETE DATA RETAINED V0104:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv02), an error is generated.

17. If the type of obsolete code = OBSOLETE DATA RETAINED V0202:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020200 or higher (indicating the case was originally coded using CSv0202), an error is generated.

18. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv2), an error is generated.

19. If the type of obsolete code = OBSOLETE DATA CONVERTED V0204:
an error is generated.

20. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0204:
an error is generated.
(These particular obsolete codes require review after conversion from CSV0203xx to CSV0204.)

21. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0204:
A. If year of Diagnosis is 2012 or higher, an error is generated.
B. If CS version Input Original is 020440 or higher (indicating the case was originally coded using CSv0204), an error is generated.

22. If the type of obsolete code = OBSOLETE DATA RETAINED V0204:
A. If year of Diagnosis is 2012 or higher, an error is generated.
B. If CS version Input Original is 020440 or higher (indicating the case was originally coded using CSv0204), an error is generated.

Administrative Notes

New edit - added to NAACCR v12.1 metafile.

In the SEER*Edits software, the title of this edit is: IF332

Modifications:

NAACCR v12.2
- Updated to skip if CS Version Input Original is blank.
- Modified to include the additional types of obsolete codes that were added for CSv0204.
- Modified to include 3 types of obsolete codes left out of previous versions of the edit:
-- OBSOLETE DATA RETAINED V0203
-- OBSOLETE DATA RETAINED V0104
-- OBSOLETE DATA RETAINED V0202

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Default error message added

NAACCR v15A
- Duplicate variable declarations deleted from edit logic.

Obsolete Codes - CS Site-Specific Factor19 (CS)

Agency: CS **Last changed: 09/15/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
CS Site-Specific Factor19 [Std# 2873]
CS Version Input Original [Std# 2935]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]

Tables

CS_OBS.DBF

Default Error Message

[3545] %F3 [%V3] is obsolete
CS Site-Specific Factor19 ["value of CS Site-Specific Factor19"] is obsolete

Additional Messages

[3359] CS Site-Specific Factor19=OBSOLETE DATA RETAINED - not allowed if DX > 2009
[3363] CS Site-Specific Factor19=OBSOLETE DATA CONVERTED V0102
[3364] CS Site-Specific Factor19=OBSOLETE DATA CONVERTED V0104
[3365] CS Site-Specific Factor19=OBSOLETE DATA CONVERTED V0200
[3366] CS Site-Specific Factor19=OBSOLETE DATA REVIEWED AND CHANGED V0102
[3367] CS Site-Specific Factor19=OBSOLETE DATA REVIEWED AND CHANGED V0103
[3368] CS Site-Specific Factor19=OBSOLETE DATA REVIEWED AND CHANGED V0200
[3386] CS Site-Specific Factor19=OBSOLETE DATA RETAINED - not allowed if CS Version Input Original > or = 020100
[3398] CS Site-Specific Factor19=OBSOLETE DATA CONVERTED V0203
[3399] CS Site-Specific Factor19=OBSOLETE DATA REVIEWED AND CHANGED V0203
[3400] CS Site-Specific Factor19=OBSOLETE DATA REVIEWED V0203 - not allowed if DX > 2010
[3401] CS Site-Specific Factor19=OBSOLETE DATA REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3402] CS Site-Specific Factor19=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if DX > 2010
[3403] CS Site-Specific Factor19=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3404] CS Site-Specific Factor19=OBSOLETE DATA RETAINED V0203 - not allowed if DX > 2010
[3405] CS Site-Specific Factor19=OBSOLETE DATA RETAINED V0203 - not allowed if CS Version Input Original > or = 020300
[3498] CS Site-Specific Factor19=OBSOLETE DATA CONVERTED V0204
[3499] CS Site-Specific Factor19=OBSOLETE DATA REVIEWED AND CHANGED V0204
[3500] CS Site-Specific Factor19=OBSOLETE DATA RETAINED V0202 - not allowed if DX > 2010

[3501] CS Site-Specific Factor19=OBSOLETE DATA RETAINED V0202 - not allowed if CS Version Input Original > or = 020200
[3502] CS Site-Specific Factor19=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if DX > 2011
[3503] CS Site-Specific Factor19=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if CS Version Input Original > or = 020440
[3504] CS Site-Specific Factor19=OBSOLETE DATA RETAINED V0204 - not allowed if DX > 2011
[3505] CS Site-Specific Factor19=OBSOLETE DATA RETAINED V0204 - not allowed if CS Version Input Original > or = 020440
[3506] CS Site-Specific Factor19=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if DX > 2009
[3507] CS Site-Specific Factor19=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if CS Version Input Original > or = 020100
ERROR_TEXT("Date of Diagnosis: %DC")
ERROR_TEXT("Invalid site or histology")
ERROR_TEXT("Schema discriminator missing or invalid")
SAVE_TEXT("t_schema_msg")

Description

This edit checks for all obsolete CS Site-Specific Factor19 codes. Obsolete codes should be re-coded per Collaborative Stage guidelines.

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor19 is blank
2. Date of Diagnosis is blank
3. CS Version Input Original is blank

This edit first determines the correct CS schema by doing a function call to the CS Dynamic Link Library (dll). The function call passes Primary Site, Histologic Type ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS schema name is returned.

Using the returned schema name, CS table number (CS Site-Specific Factor19 is table number 28), and CS Site-Specific Factor19 code, a table lookup is performed. If the code for a particular schema is determined to be obsolete based on the table lookup, the type of obsolete code must be evaluated. There are several types of obsolete codes:

1. OBSOLETE DATA CONVERTED AND RETAINED V0200
2. OBSOLETE DATA CONVERTED V0102
3. OBSOLETE DATA CONVERTED V0104
4. OBSOLETE DATA CONVERTED V0200
5. OBSOLETE DATA RETAINED V0100
6. OBSOLETE DATA RETAINED V0102
7. OBSOLETE DATA RETAINED V0200
8. OBSOLETE DATA REVIEWED AND CHANGED V0102
9. OBSOLETE DATA REVIEWED AND CHANGED V0103
10. OBSOLETE DATA REVIEWED AND CHANGED V0200
11. OBSOLETE DATA CONVERTED V0203
12. OBSOLETE DATA REVIEWED AND CHANGED V0203
13. OBSOLETE DATA REVIEWED V0203
14. OBSOLETE DATA RETAINED AND REVIEWED V0203
15. OBSOLETE DATA RETAINED V0203
16. OBSOLETE DATA RETAINED V0104
17. OBSOLETE DATA RETAINED V0202
18. OBSOLETE DATA RETAINED AND REVIEWED V0200

19. OBSOLETE DATA CONVERTED V0204
20. OBSOLETE DATA REVIEWED AND CHANGED V0204
21. OBSOLETE DATA RETAINED AND REVIEWED V0204
22. OBSOLETE DATA RETAINED V0204

1. If the type of obsolete code = OBSOLETE DATA CONVERTED AND RETAINED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor19]

2. If the type of obsolete code = OBSOLETE DATA CONVERTED V0102:
an error is generated.
[Example: none for CS Site-Specific Factor19]

3. If the type of obsolete code = OBSOLETE DATA CONVERTED V0104:
an error is generated.
[Example: none for CS Site-Specific Factor19]

4. If the type of obsolete code = OBSOLETE DATA CONVERTED V0200:
an error is generated.
[Example: none for CS Site-Specific Factor19]

5. If the type of obsolete code = OBSOLETE DATA RETAINED V0100:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor19]

6. If the type of obsolete code = OBSOLETE DATA RETAINED V0102:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor19]

7. If the type of obsolete code = OBSOLETE DATA RETAINED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor19]

8. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0102:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: none for CS Site-Specific Factor19]

9. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0103:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: none for CS Site-Specific Factor19]

10.If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0200:
an error is generated.
(These particular obsolete codes require review after conversion from CSV01 to CSV02.)
[Example: none for CS Site-Specific Factor19]

11. If the type of obsolete code = OBSOLETE DATA CONVERTED V0203:

an error is generated.
[Example: Schema = Breast, CS Site-Specific Factor19 = 998]

12. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0203:
an error is generated.
(These particular obsolete codes require review after conversion from CSV02xx to CSV0203.)
[Example: none for CS Site-Specific Factor19]

13. If the type of obsolete code = OBSOLETE DATA REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor19]

14. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor19]

15. If the type of obsolete code = OBSOLETE DATA RETAINED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor19]

16. If the type of obsolete code = OBSOLETE DATA RETAINED V0104:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv02), an error is generated.

17. If the type of obsolete code = OBSOLETE DATA RETAINED V0202:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020200 or higher (indicating the case was originally coded using CSv0202), an error is generated.

18. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv2), an error is generated.

19. If the type of obsolete code = OBSOLETE DATA CONVERTED V0204:
an error is generated.

20. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0204:
an error is generated.
(These particular obsolete codes require review after conversion from CSV0203xx to CSV0204.)

21. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0204:
A. If year of Diagnosis is 2012 or higher, an error is generated.
B. If CS version Input Original is 020440 or higher (indicating the case was originally coded using CSv0204), an error is generated.

22. If the type of obsolete code = OBSOLETE DATA RETAINED V0204:
A. If year of Diagnosis is 2012 or higher, an error is generated.
B. If CS version Input Original is 020440 or higher (indicating the case was originally coded using CSv0204), an error is generated.

Administrative Notes

New edit - added to NAACCR v12.1 metafile.

In the SEER*Edits software, the title of this edit is: IF336

Modifications:

NAACCR v12.2
- Updated to skip if CS Version Input Original is blank.
- Modified to include the additional types of obsolete codes that were added for CSv0204.
- Modified to include 3 types of obsolete codes left out of previous versions of the edit:
-- OBSOLETE DATA RETAINED V0203
-- OBSOLETE DATA RETAINED V0104
-- OBSOLETE DATA RETAINED V0202

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Default error message added

NAACCR v15A
- Duplicate variable declarations deleted from edit logic.

Obsolete Codes - CS Site-Specific Factor21 (CS)

Agency: CS **Last changed: 09/15/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
CS Site-Specific Factor21 [Std# 2875]
CS Version Input Original [Std# 2935]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]

Tables

CS_OBS.DBF

Default Error Message

[3545] %F3 [%V3] is obsolete
CS Site-Specific Factor21 ["value of CS Site-Specific Factor21"] is obsolete

Additional Messages

[3359] CS Site-Specific Factor21=OBSOLETE DATA RETAINED - not allowed if DX > 2009
[3363] CS Site-Specific Factor21=OBSOLETE DATA CONVERTED V0102
[3364] CS Site-Specific Factor21=OBSOLETE DATA CONVERTED V0104
[3365] CS Site-Specific Factor21=OBSOLETE DATA CONVERTED V0200
[3366] CS Site-Specific Factor21=OBSOLETE DATA REVIEWED AND CHANGED V0102
[3367] CS Site-Specific Factor21=OBSOLETE DATA REVIEWED AND CHANGED V0103
[3368] CS Site-Specific Factor21=OBSOLETE DATA REVIEWED AND CHANGED V0200
[3386] CS Site-Specific Factor21=OBSOLETE DATA RETAINED - not allowed if CS Version Input Original > or = 020100
[3398] CS Site-Specific Factor21=OBSOLETE DATA CONVERTED V0203
[3399] CS Site-Specific Factor21=OBSOLETE DATA REVIEWED AND CHANGED V0203
[3400] CS Site-Specific Factor21=OBSOLETE DATA REVIEWED V0203 - not allowed if DX > 2010
[3401] CS Site-Specific Factor21=OBSOLETE DATA REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3402] CS Site-Specific Factor21=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if DX > 2010
[3403] CS Site-Specific Factor21=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3404] CS Site-Specific Factor21=OBSOLETE DATA RETAINED V0203 - not allowed if DX > 2010
[3405] CS Site-Specific Factor21=OBSOLETE DATA RETAINED V0203 - not allowed if CS Version Input Original > or = 020300
[3498] CS Site-Specific Factor21=OBSOLETE DATA CONVERTED V0204
[3499] CS Site-Specific Factor21=OBSOLETE DATA REVIEWED AND CHANGED V0204
[3500] CS Site-Specific Factor21=OBSOLETE DATA RETAINED V0202 - not allowed if DX > 2010

[3501] CS Site-Specific Factor21=OBSOLETE DATA RETAINED V0202 - not allowed if CS Version Input Original > or = 020200
[3502] CS Site-Specific Factor21=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if DX > 2011
[3503] CS Site-Specific Factor21=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if CS Version Input Original > or = 020440
[3504] CS Site-Specific Factor21=OBSOLETE DATA RETAINED V0204 - not allowed if DX > 2011
[3505] CS Site-Specific Factor21=OBSOLETE DATA RETAINED V0204 - not allowed if CS Version Input Original > or = 020440
[3506] CS Site-Specific Factor21=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if DX > 2009
[3507] CS Site-Specific Factor21=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if CS Version Input Original > or = 020100
ERROR_TEXT("Date of Diagnosis: %DC")
ERROR_TEXT("Invalid site or histology")
ERROR_TEXT("Schema discriminator missing or invalid")
SAVE_TEXT("t_schema_msg")

Description

This edit checks for all obsolete CS Site-Specific Factor21 codes. Obsolete codes should be re-coded per Collaborative Stage guidelines.

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor21 is blank
2. Date of Diagnosis is blank
3. CS Version Input Original is blank

This edit first determines the correct CS schema by doing a function call to the CS Dynamic Link Library (dll). The function call passes Primary Site, Histologic Type ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS schema name is returned.

Using the returned schema name, CS table number (CS Site-Specific Factor21 is table number 30), and CS Site-Specific Factor21 code, a table lookup is performed. If the code for a particular schema is determined to be obsolete based on the table lookup, the type of obsolete code must be evaluated. There are several types of obsolete codes:

1. OBSOLETE DATA CONVERTED AND RETAINED V0200
2. OBSOLETE DATA CONVERTED V0102
3. OBSOLETE DATA CONVERTED V0104
4. OBSOLETE DATA CONVERTED V0200
5. OBSOLETE DATA RETAINED V0100
6. OBSOLETE DATA RETAINED V0102
7. OBSOLETE DATA RETAINED V0200
8. OBSOLETE DATA REVIEWED AND CHANGED V0102
9. OBSOLETE DATA REVIEWED AND CHANGED V0103
10. OBSOLETE DATA REVIEWED AND CHANGED V0200
11. OBSOLETE DATA CONVERTED V0203
12. OBSOLETE DATA REVIEWED AND CHANGED V0203
13. OBSOLETE DATA REVIEWED V0203
14. OBSOLETE DATA RETAINED AND REVIEWED V0203
15. OBSOLETE DATA RETAINED V0203
16. OBSOLETE DATA RETAINED V0104
17. OBSOLETE DATA RETAINED V0202
18. OBSOLETE DATA RETAINED AND REVIEWED V0200

19. OBSOLETE DATA CONVERTED V0204
20. OBSOLETE DATA REVIEWED AND CHANGED V0204
21. OBSOLETE DATA RETAINED AND REVIEWED V0204
22. OBSOLETE DATA RETAINED V0204

1. If the type of obsolete code = OBSOLETE DATA CONVERTED AND RETAINED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor21]

2. If the type of obsolete code = OBSOLETE DATA CONVERTED V0102:
an error is generated.
[Example: none for CS Site-Specific Factor21]

3. If the type of obsolete code = OBSOLETE DATA CONVERTED V0104:
an error is generated.
[Example: none for CS Site-Specific Factor21]

4. If the type of obsolete code = OBSOLETE DATA CONVERTED V0200:
an error is generated.
[Example: none for CS Site-Specific Factor21]

5. If the type of obsolete code = OBSOLETE DATA RETAINED V0100:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor21]

6. If the type of obsolete code = OBSOLETE DATA RETAINED V0102:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor21]

7. If the type of obsolete code = OBSOLETE DATA RETAINED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor21]

8. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0102:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: none for CS Site-Specific Factor21]

9. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0103:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: none for CS Site-Specific Factor21]

10.If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0200:
an error is generated.
(These particular obsolete codes require review after conversion from CSV01 to CSV02.)
[Example: none for CS Site-Specific Factor21]

11. If the type of obsolete code = OBSOLETE DATA CONVERTED V0203:

an error is generated.
[Example: Schema = Breast, CS Site-Specific Factor21 = 998]

12. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0203:
an error is generated.
(These particular obsolete codes require review after conversion from CSV02xx to CSV0203.)
[Example: none for CS Site-Specific Factor21]

13. If the type of obsolete code = OBSOLETE DATA REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor21]

14. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor21]

15. If the type of obsolete code = OBSOLETE DATA RETAINED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor21]

16. If the type of obsolete code = OBSOLETE DATA RETAINED V0104:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv02), an error is generated.

17. If the type of obsolete code = OBSOLETE DATA RETAINED V0202:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020200 or higher (indicating the case was originally coded using CSv0202), an error is generated.

18. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv2), an error is generated.

19. If the type of obsolete code = OBSOLETE DATA CONVERTED V0204:
an error is generated.

20. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0204:
an error is generated.
(These particular obsolete codes require review after conversion from CSV0203xx to CSV0204.)

21. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0204:
A. If year of Diagnosis is 2012 or higher, an error is generated.
B. If CS version Input Original is 020440 or higher (indicating the case was originally coded using CSv0204), an error is generated.

22. If the type of obsolete code = OBSOLETE DATA RETAINED V0204:
A. If year of Diagnosis is 2012 or higher, an error is generated.
B. If CS version Input Original is 020440 or higher (indicating the case was originally coded using CSv0204), an error is generated.

Administrative Notes

New edit - added to NAACCR v12.1 metafile.

In the SEER*Edits software, the title of this edit is: IF338

Modifications:

NAACCR v12.2
- Updated to skip if CS Version Input Original is blank.
- Modified to include the additional types of obsolete codes that were added for CSv0204.
- Modified to include 3 types of obsolete codes left out of previous versions of the edit:
-- OBSOLETE DATA RETAINED V0203
-- OBSOLETE DATA RETAINED V0104
-- OBSOLETE DATA RETAINED V0202

NAACCR v12.2A
- SEER IF# in Administrative Notes changed from IF339 to IF338.

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Default error message added

NAACCR v15A
- Duplicate variable declarations deleted from edit logic.

Obsolete Codes - CS Site-Specific Factor22 (CS)

Agency: CS **Last changed: 09/15/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
CS Site-Specific Factor22 [Std# 2876]
CS Version Input Original [Std# 2935]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]

Tables

CS_OBS.DBF

Default Error Message

[3545] %F3 [%V3] is obsolete
CS Site-Specific Factor22 ["value of CS Site-Specific Factor22"] is obsolete

Additional Messages

[3359] CS Site-Specific Factor22=OBSOLETE DATA RETAINED - not allowed if DX > 2009
[3363] CS Site-Specific Factor22=OBSOLETE DATA CONVERTED V0102
[3364] CS Site-Specific Factor22=OBSOLETE DATA CONVERTED V0104
[3365] CS Site-Specific Factor22=OBSOLETE DATA CONVERTED V0200
[3366] CS Site-Specific Factor22=OBSOLETE DATA REVIEWED AND CHANGED V0102
[3367] CS Site-Specific Factor22=OBSOLETE DATA REVIEWED AND CHANGED V0103
[3368] CS Site-Specific Factor22=OBSOLETE DATA REVIEWED AND CHANGED V0200
[3386] CS Site-Specific Factor22=OBSOLETE DATA RETAINED - not allowed if CS Version Input Original > or = 020100
[3398] CS Site-Specific Factor22=OBSOLETE DATA CONVERTED V0203
[3399] CS Site-Specific Factor22=OBSOLETE DATA REVIEWED AND CHANGED V0203
[3400] CS Site-Specific Factor22=OBSOLETE DATA REVIEWED V0203 - not allowed if DX > 2010
[3401] CS Site-Specific Factor22=OBSOLETE DATA REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3402] CS Site-Specific Factor22=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if DX > 2010
[3403] CS Site-Specific Factor22=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3404] CS Site-Specific Factor22=OBSOLETE DATA RETAINED V0203 - not allowed if DX > 2010
[3405] CS Site-Specific Factor22=OBSOLETE DATA RETAINED V0203 - not allowed if CS Version Input Original > or = 020300
[3498] CS Site-Specific Factor22=OBSOLETE DATA CONVERTED V0204
[3499] CS Site-Specific Factor22=OBSOLETE DATA REVIEWED AND CHANGED V0204
[3500] CS Site-Specific Factor22=OBSOLETE DATA RETAINED V0202 - not allowed if DX > 2010

[3501] CS Site-Specific Factor22=OBSOLETE DATA RETAINED V0202 - not allowed if CS Version Input Original > or = 020200
[3502] CS Site-Specific Factor22=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if DX > 2011
[3503] CS Site-Specific Factor22=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if CS Version Input Original > or = 020440
[3504] CS Site-Specific Factor22=OBSOLETE DATA RETAINED V0204 - not allowed if DX > 2011
[3505] CS Site-Specific Factor22=OBSOLETE DATA RETAINED V0204 - not allowed if CS Version Input Original > or = 020440
[3506] CS Site-Specific Factor22=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if DX > 2009
[3507] CS Site-Specific Factor22=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if CS Version Input Original > or = 020100
ERROR_TEXT("Date of Diagnosis: %DC")
ERROR_TEXT("Invalid site or histology")
ERROR_TEXT("Schema discriminator missing or invalid")
SAVE_TEXT("t_schema_msg")

Description

This edit checks for all obsolete CS Site-Specific Factor22 codes. Obsolete codes should be re-coded per Collaborative Stage guidelines.

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor22 is blank
2. Date of Diagnosis is blank
3. CS Version Input Original is blank

This edit first determines the correct CS schema by doing a function call to the CS Dynamic Link Library (dll). The function call passes Primary Site, Histologic Type ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS schema name is returned.

Using the returned schema name, CS table number (CS Site-Specific Factor22 is table number 31), and CS Site-Specific Factor22 code, a table lookup is performed. If the code for a particular schema is determined to be obsolete based on the table lookup, the type of obsolete code must be evaluated. There are several types of obsolete codes:

1. OBSOLETE DATA CONVERTED AND RETAINED V0200
2. OBSOLETE DATA CONVERTED V0102
3. OBSOLETE DATA CONVERTED V0104
4. OBSOLETE DATA CONVERTED V0200
5. OBSOLETE DATA RETAINED V0100
6. OBSOLETE DATA RETAINED V0102
7. OBSOLETE DATA RETAINED V0200
8. OBSOLETE DATA REVIEWED AND CHANGED V0102
9. OBSOLETE DATA REVIEWED AND CHANGED V0103
10. OBSOLETE DATA REVIEWED AND CHANGED V0200
11. OBSOLETE DATA CONVERTED V0203
12. OBSOLETE DATA REVIEWED AND CHANGED V0203
13. OBSOLETE DATA REVIEWED V0203
14. OBSOLETE DATA RETAINED AND REVIEWED V0203
15. OBSOLETE DATA RETAINED V0203
16. OBSOLETE DATA RETAINED V0104
17. OBSOLETE DATA RETAINED V0202
18. OBSOLETE DATA RETAINED AND REVIEWED V0200

19. OBSOLETE DATA CONVERTED V0204
20. OBSOLETE DATA REVIEWED AND CHANGED V0204
21. OBSOLETE DATA RETAINED AND REVIEWED V0204
22. OBSOLETE DATA RETAINED V0204

1. If the type of obsolete code = OBSOLETE DATA CONVERTED AND RETAINED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor22]

2. If the type of obsolete code = OBSOLETE DATA CONVERTED V0102:
an error is generated.
[Example: none for CS Site-Specific Factor22]

3. If the type of obsolete code = OBSOLETE DATA CONVERTED V0104:
an error is generated.
[Example: none for CS Site-Specific Factor22]

4. If the type of obsolete code = OBSOLETE DATA CONVERTED V0200:
an error is generated.
[Example: none for CS Site-Specific Factor22]

5. If the type of obsolete code = OBSOLETE DATA RETAINED V0100:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor22]

6. If the type of obsolete code = OBSOLETE DATA RETAINED V0102:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor22]

7. If the type of obsolete code = OBSOLETE DATA RETAINED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor22]

8. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0102:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: none for CS Site-Specific Factor22]

9. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0103:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: none for CS Site-Specific Factor22]

10.If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0200:
an error is generated.
(These particular obsolete codes require review after conversion from CSV01 to CSV02.)
[Example: none for CS Site-Specific Factor22]

11. If the type of obsolete code = OBSOLETE DATA CONVERTED V0203:

an error is generated.
[Example: Schema = Breast, CS Site-Specific Factor22 = 997]

12. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0203:
an error is generated.
(These particular obsolete codes require review after conversion from CSV02xx to CSV0203.)
[Example: none for CS Site-Specific Factor22]

13. If the type of obsolete code = OBSOLETE DATA REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor22]

14. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor22]

15. If the type of obsolete code = OBSOLETE DATA RETAINED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor22]

16. If the type of obsolete code = OBSOLETE DATA RETAINED V0104:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv02), an error is generated.

17. If the type of obsolete code = OBSOLETE DATA RETAINED V0202:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020200 or higher (indicating the case was originally coded using CSv0202), an error is generated.

18. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv2), an error is generated.

19. If the type of obsolete code = OBSOLETE DATA CONVERTED V0204:
an error is generated.

20. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0204:
an error is generated.
(These particular obsolete codes require review after conversion from CSV0203xx to CSV0204.)

21. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0204:
A. If year of Diagnosis is 2012 or higher, an error is generated.
B. If CS version Input Original is 020440 or higher (indicating the case was originally coded using CSv0204), an error is generated.

22. If the type of obsolete code = OBSOLETE DATA RETAINED V0204:
A. If year of Diagnosis is 2012 or higher, an error is generated.
B. If CS version Input Original is 020440 or higher (indicating the case was originally coded using CSv0204), an error is generated.

Administrative Notes

New edit - added to NAACCR v12.1 metafile.

In the SEER*Edits software, the title of this edit is: IF339

Modifications:

NAACCR v12.2
- Updated to skip if CS Version Input Original is blank.
- Modified to include the additional types of obsolete codes that were added for CSv0204.
- Modified to include 3 types of obsolete codes left out of previous versions of the edit:
-- OBSOLETE DATA RETAINED V0203
-- OBSOLETE DATA RETAINED V0104
-- OBSOLETE DATA RETAINED V0202

NAACCR v12.2A
- SEER IF# in Administrative Notes changed from IF340 to IF339.

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Default error message added

NAACCR v15A
- Duplicate variable declarations deleted from edit logic.

Obsolete Codes - CS Site-Specific Factor23 (CS)

Agency: CS **Last changed: 09/15/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
CS Site-Specific Factor23 [Std# 2877]
CS Version Input Original [Std# 2935]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]

Tables

CS_OBS.DBF

Default Error Message

[3545] %F3 [%V3] is obsolete
CS Site-Specific Factor23 ["value of CS Site-Specific Factor23"] is obsolete

Additional Messages

[3359] CS Site-Specific Factor23=OBSOLETE DATA RETAINED - not allowed if DX > 2009
[3363] CS Site-Specific Factor23=OBSOLETE DATA CONVERTED V0102
[3364] CS Site-Specific Factor23=OBSOLETE DATA CONVERTED V0104
[3365] CS Site-Specific Factor23=OBSOLETE DATA CONVERTED V0200
[3366] CS Site-Specific Factor23=OBSOLETE DATA REVIEWED AND CHANGED V0102
[3367] CS Site-Specific Factor23=OBSOLETE DATA REVIEWED AND CHANGED V0103
[3368] CS Site-Specific Factor23=OBSOLETE DATA REVIEWED AND CHANGED V0200
[3386] CS Site-Specific Factor23=OBSOLETE DATA RETAINED - not allowed if CS Version Input Original > or = 020100
[3398] CS Site-Specific Factor23=OBSOLETE DATA CONVERTED V0203
[3399] CS Site-Specific Factor23=OBSOLETE DATA REVIEWED AND CHANGED V0203
[3400] CS Site-Specific Factor23=OBSOLETE DATA REVIEWED V0203 - not allowed if DX > 2010
[3401] CS Site-Specific Factor23=OBSOLETE DATA REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3402] CS Site-Specific Factor23=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if DX > 2010
[3403] CS Site-Specific Factor23=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3404] CS Site-Specific Factor23=OBSOLETE DATA RETAINED V0203 - not allowed if DX > 2010
[3405] CS Site-Specific Factor23=OBSOLETE DATA RETAINED V0203 - not allowed if CS Version Input Original > or = 020300
[3498] CS Site-Specific Factor23=OBSOLETE DATA CONVERTED V0204
[3499] CS Site-Specific Factor23=OBSOLETE DATA REVIEWED AND CHANGED V0204
[3500] CS Site-Specific Factor23=OBSOLETE DATA RETAINED V0202 - not allowed if DX > 2010

[3501] CS Site-Specific Factor23=OBSOLETE DATA RETAINED V0202 - not allowed if CS Version Input Original > or = 020200
[3502] CS Site-Specific Factor23=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if DX > 2011
[3503] CS Site-Specific Factor23=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if CS Version Input Original > or = 020440
[3504] CS Site-Specific Factor23=OBSOLETE DATA RETAINED V0204 - not allowed if DX > 2011
[3505] CS Site-Specific Factor23=OBSOLETE DATA RETAINED V0204 - not allowed if CS Version Input Original > or = 020440
[3506] CS Site-Specific Factor23=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if DX > 2009
[3507] CS Site-Specific Factor23=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if CS Version Input Original > or = 020100
ERROR_TEXT("Date of Diagnosis: %DC")
ERROR_TEXT("Invalid site or histology")
ERROR_TEXT("Schema discriminator missing or invalid")
SAVE_TEXT("t_schema_msg")

Description

This edit checks for all obsolete CS Site-Specific Factor23 codes. Obsolete codes should be re-coded per Collaborative Stage guidelines.

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor23 is blank
2. Date of Diagnosis is blank
3. CS Version Input Original is blank

This edit first determines the correct CS schema by doing a function call to the CS Dynamic Link Library (dll). The function call passes Primary Site, Histologic Type ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS schema name is returned.

Using the returned schema name, CS table number (CS Site-Specific Factor23 is table number 32), and CS Site-Specific Factor23 code, a table lookup is performed. If the code for a particular schema is determined to be obsolete based on the table lookup, the type of obsolete code must be evaluated. There are several types of obsolete codes:

1. OBSOLETE DATA CONVERTED AND RETAINED V0200
2. OBSOLETE DATA CONVERTED V0102
3. OBSOLETE DATA CONVERTED V0104
4. OBSOLETE DATA CONVERTED V0200
5. OBSOLETE DATA RETAINED V0100
6. OBSOLETE DATA RETAINED V0102
7. OBSOLETE DATA RETAINED V0200
8. OBSOLETE DATA REVIEWED AND CHANGED V0102
9. OBSOLETE DATA REVIEWED AND CHANGED V0103
10. OBSOLETE DATA REVIEWED AND CHANGED V0200
11. OBSOLETE DATA CONVERTED V0203
12. OBSOLETE DATA REVIEWED AND CHANGED V0203
13. OBSOLETE DATA REVIEWED V0203
14. OBSOLETE DATA RETAINED AND REVIEWED V0203
15. OBSOLETE DATA RETAINED V0203
16. OBSOLETE DATA RETAINED V0104
17. OBSOLETE DATA RETAINED V0202
18. OBSOLETE DATA RETAINED AND REVIEWED V0200

19. OBSOLETE DATA CONVERTED V0204
20. OBSOLETE DATA REVIEWED AND CHANGED V0204
21. OBSOLETE DATA RETAINED AND REVIEWED V0204
22. OBSOLETE DATA RETAINED V0204

1. If the type of obsolete code = OBSOLETE DATA CONVERTED AND RETAINED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor23]

2. If the type of obsolete code = OBSOLETE DATA CONVERTED V0102:
an error is generated.
[Example: none for CS Site-Specific Factor23]

3. If the type of obsolete code = OBSOLETE DATA CONVERTED V0104:
an error is generated.
[Example: none for CS Site-Specific Factor23]

4. If the type of obsolete code = OBSOLETE DATA CONVERTED V0200:
an error is generated.
[Example: none for CS Site-Specific Factor23]

5. If the type of obsolete code = OBSOLETE DATA RETAINED V0100:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor23]

6. If the type of obsolete code = OBSOLETE DATA RETAINED V0102:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor23]

7. If the type of obsolete code = OBSOLETE DATA RETAINED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor23]

8. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0102:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: none for CS Site-Specific Factor23]

9. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0103:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: none for CS Site-Specific Factor23]

10.If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0200:
an error is generated.
(These particular obsolete codes require review after conversion from CSV01 to CSV02.)
[Example: none for CS Site-Specific Factor23]

11. If the type of obsolete code = OBSOLETE DATA CONVERTED V0203:

an error is generated.
[Example: Schema = Breast, CS Site-Specific Factor23 = 205]

12. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0203:
an error is generated.
(These particular obsolete codes require review after conversion from CSV02xx to CSV0203.)
[Example: none for CS Site-Specific Factor23]

13. If the type of obsolete code = OBSOLETE DATA REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor23]

14. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor23]

15. If the type of obsolete code = OBSOLETE DATA RETAINED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor23]

16. If the type of obsolete code = OBSOLETE DATA RETAINED V0104:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv02), an error is generated.

17. If the type of obsolete code = OBSOLETE DATA RETAINED V0202:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020200 or higher (indicating the case was originally coded using CSv0202), an error is generated.

18. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv2), an error is generated.

19. If the type of obsolete code = OBSOLETE DATA CONVERTED V0204:
an error is generated.

20. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0204:
an error is generated.
(These particular obsolete codes require review after conversion from CSV0203xx to CSV0204.)

21. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0204:
A. If year of Diagnosis is 2012 or higher, an error is generated.
B. If CS version Input Original is 020440 or higher (indicating the case was originally coded using CSv0204), an error is generated.

22. If the type of obsolete code = OBSOLETE DATA RETAINED V0204:
A. If year of Diagnosis is 2012 or higher, an error is generated.
B. If CS version Input Original is 020440 or higher (indicating the case was originally coded using CSv0204), an error is generated.

Administrative Notes

New edit - added to NAACCR v12.1 metafile.

In the SEER*Edits software, the title of this edit is: IF340

Modifications:

NAACCR v12.2
- Updated to skip if CS Version Input Original is blank.
- Modified to include the additional types of obsolete codes that were added for CSv0204.
- Modified to include 3 types of obsolete codes left out of previous versions of the edit:
-- OBSOLETE DATA RETAINED V0203
-- OBSOLETE DATA RETAINED V0104
-- OBSOLETE DATA RETAINED V0202

NAACCR v12.2A
- SEER IF# in Administrative Notes changed from IFxxx to IF340.

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Default error message added

NAACCR v15A
- Duplicate variable declarations deleted from edit logic.

Obsolete Codes - CS Site-Specific Factor25 (CS)

Agency: CS **Last changed: 09/15/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
CS Site-Specific Factor25 [Std# 2879]
CS Version Input Original [Std# 2935]
Date of Diagnosis [Std# 390]

Tables

CS_OBS.DBF

Default Error Message

[3545] %F3 [%V3] is obsolete
CS Site-Specific Factor25 ["value of CS Site-Specific Factor25"] is obsolete

Additional Messages

[3359] CS Site-Specific Factor25=OBSOLETE DATA RETAINED - not allowed if DX > 2009
[3363] CS Site-Specific Factor25=OBSOLETE DATA CONVERTED V0102
[3364] CS Site-Specific Factor25=OBSOLETE DATA CONVERTED V0104
[3365] CS Site-Specific Factor25=OBSOLETE DATA CONVERTED V0200
[3366] CS Site-Specific Factor25=OBSOLETE DATA REVIEWED AND CHANGED V0102
[3367] CS Site-Specific Factor25=OBSOLETE DATA REVIEWED AND CHANGED V0103
[3368] CS Site-Specific Factor25=OBSOLETE DATA REVIEWED AND CHANGED V0200
[3386] CS Site-Specific Factor25=OBSOLETE DATA RETAINED - not allowed if CS Version Input Original > or = 020100
[3398] CS Site-Specific Factor25=OBSOLETE DATA CONVERTED V0203
[3399] CS Site-Specific Factor25=OBSOLETE DATA REVIEWED AND CHANGED V0203
[3400] CS Site-Specific Factor25=OBSOLETE DATA REVIEWED V0203 - not allowed if DX > 2010
[3401] CS Site-Specific Factor25=OBSOLETE DATA REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3402] CS Site-Specific Factor25=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if DX > 2010
[3403] CS Site-Specific Factor25=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3404] CS Site-Specific Factor25=OBSOLETE DATA RETAINED V0203 - not allowed if DX > 2010
[3405] CS Site-Specific Factor25=OBSOLETE DATA RETAINED V0203 - not allowed if CS Version Input Original > or = 020300
[3498] CS Site-Specific Factor25=OBSOLETE DATA CONVERTED V0204
[3499] CS Site-Specific Factor25=OBSOLETE DATA REVIEWED AND CHANGED V0204
[3500] CS Site-Specific Factor25=OBSOLETE DATA RETAINED V0202 - not allowed if DX > 2010
[3501] CS Site-Specific Factor25=OBSOLETE DATA RETAINED V0202 - not allowed if CS Version Input Original > or = 020200

[3502] CS Site-Specific Factor25=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if DX > 2011
[3503] CS Site-Specific Factor25=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if CS Version Input Original > or = 020440
[3504] CS Site-Specific Factor25=OBSOLETE DATA RETAINED V0204 - not allowed if DX > 2011
[3505] CS Site-Specific Factor25=OBSOLETE DATA RETAINED V0204 - not allowed if CS Version Input Original > or = 020440
[3506] CS Site-Specific Factor25=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if DX > 2009
[3507] CS Site-Specific Factor25=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if CS Version Input Original > or = 020100
ERROR_TEXT("Date of Diagnosis: %DC")
ERROR_TEXT("Invalid site or histology")
ERROR_TEXT("Schema discriminator missing or invalid")
SAVE_TEXT("t_schema_msg")

Description

This edit checks for all obsolete CS Site-Specific Factor25 codes. Obsolete codes should be re-coded per Collaborative Stage guidelines.

This edit is skipped if any of the following conditions are true:
1. CS Site-Specific Factor25 is blank
2. Date of Diagnosis is blank
3. CS Version Input Original is blank

This edit first determines the correct CS schema by doing a function call to the CS Dynamic Link Library (dll). The function call passes Primary Site, Histologic Type ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS schema name is returned.

Using the returned schema name, CS table number (CS Site-Specific Factor25 is table number 34), and CS Site-Specific Factor25 code, a table lookup is performed. If the code for a particular schema is determined to be obsolete based on the table lookup, the type of obsolete code must be evaluated. There are several types of obsolete codes:

1. OBSOLETE DATA CONVERTED AND RETAINED V0200
2. OBSOLETE DATA CONVERTED V0102
3. OBSOLETE DATA CONVERTED V0104
4. OBSOLETE DATA CONVERTED V0200
5. OBSOLETE DATA RETAINED V0100
6. OBSOLETE DATA RETAINED V0102
7. OBSOLETE DATA RETAINED V0200
8. OBSOLETE DATA REVIEWED AND CHANGED V0102
9. OBSOLETE DATA REVIEWED AND CHANGED V0103
10. OBSOLETE DATA REVIEWED AND CHANGED V0200
11. OBSOLETE DATA CONVERTED V0203
12. OBSOLETE DATA REVIEWED AND CHANGED V0203
13. OBSOLETE DATA REVIEWED V0203
14. OBSOLETE DATA RETAINED AND REVIEWED V0203
15. OBSOLETE DATA RETAINED V0203
16. OBSOLETE DATA RETAINED V0104
17. OBSOLETE DATA RETAINED V0202
18. OBSOLETE DATA RETAINED AND REVIEWED V0200
19. OBSOLETE DATA CONVERTED V0204
20. OBSOLETE DATA REVIEWED AND CHANGED V0204

21. OBSOLETE DATA RETAINED AND REVIEWED V0204
22. OBSOLETE DATA RETAINED V0204

1. If the type of obsolete code = OBSOLETE DATA CONVERTED AND RETAINED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor25]

2. If the type of obsolete code = OBSOLETE DATA CONVERTED V0102:
an error is generated.
[Example: none for CS Site-Specific Factor25]

3. If the type of obsolete code = OBSOLETE DATA CONVERTED V0104:
an error is generated.
[Example: none for CS Site-Specific Factor25]

4. If the type of obsolete code = OBSOLETE DATA CONVERTED V0200:
an error is generated.
[Example: none for CS Site-Specific Factor25]

5. If the type of obsolete code = OBSOLETE DATA RETAINED V0100:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor25]

6. If the type of obsolete code = OBSOLETE DATA RETAINED V0102:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Site-Specific Factor25]

7. If the type of obsolete code = OBSOLETE DATA RETAINED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: Schema = BileDuctsDistal, CS Site-Specific Factor25 = 100]

8. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0102:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: none for CS Site-Specific Factor25]

9. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0103:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: none for CS Site-Specific Factor25]

10. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0200:
an error is generated.
(These particular obsolete codes require review after conversion from CSV01 to CSV02.)
[Example: none for CS Site-Specific Factor25]

11. If the type of obsolete code = OBSOLETE DATA CONVERTED V0203:
an error is generated.
[Example: Schema = LacrimalGland, CS Site-Specific Factor25 = 020]

12. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0203:
an error is generated.
(These particular obsolete codes require review after conversion from CSV02xx to CSV0203.)
[Example: Schema = LacrimalGland, CS Site-Specific Factor25 = 010]

13. If the type of obsolete code = OBSOLETE DATA REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor25]

14. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor25]

15. If the type of obsolete code = OBSOLETE DATA RETAINED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Site-Specific Factor25]

16. If the type of obsolete code = OBSOLETE DATA RETAINED V0104:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv02), an error is generated.

17. If the type of obsolete code = OBSOLETE DATA RETAINED V0202:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020200 or higher (indicating the case was originally coded using CSv0202), an error is generated.

18. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv2), an error is generated.

19. If the type of obsolete code = OBSOLETE DATA CONVERTED V0204:
an error is generated.

20. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0204:
an error is generated.
(These particular obsolete codes require review after conversion from CSV0203xx to CSV0204.)

21. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0204:
A. If year of Diagnosis is 2012 or higher, an error is generated.
B. If CS version Input Original is 020440 or higher (indicating the case was originally coded using CSv0204), an error is generated.

22. If the type of obsolete code = OBSOLETE DATA RETAINED V0204:
A. If year of Diagnosis is 2012 or higher, an error is generated.
B. If CS version Input Original is 020440 or higher (indicating the case was originally coded using CSv0204), an error is generated.

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

In the SEER*Edits software, the title of this edit is: IF282

Modifications:

NAACCR v12.1
- Modified to handle the additional types of obsolete codes that were added for CSv0203.

NAACCR v12.2
- Updated to skip if CS Version Input Original is blank.
- Modified to include the additional types of obsolete codes that were added for CSv0204.
- Modified to include 3 types of obsolete codes left out of previous versions of the edit:
-- OBSOLETE DATA RETAINED V0203
-- OBSOLETE DATA RETAINED V0104
-- OBSOLETE DATA RETAINED V0202

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Default error message added

NAACCR v15A
- Duplicate variable declarations deleted from edit logic.

Obsolete Codes - CS Tumor Size (CS)

Agency: CS **Last changed: 09/15/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
CS Tumor Size [Std# 2800]
CS Version Input Original [Std# 2935]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]

Tables

CS_OBS.DBF

Default Error Message

[3545] %F3 [%V3] is obsolete
CS Tumor Size ["value of CS Tumor Size"] is obsolete

Additional Messages

[3359] CS Tumor Size=OBSOLETE DATA RETAINED - not allowed if DX > 2009
[3363] CS Tumor Size=OBSOLETE DATA CONVERTED V0102
[3364] CS Tumor Size=OBSOLETE DATA CONVERTED V0104
[3365] CS Tumor Size=OBSOLETE DATA CONVERTED V0200
[3366] CS Tumor Size=OBSOLETE DATA REVIEWED AND CHANGED V0102
[3367] CS Tumor Size=OBSOLETE DATA REVIEWED AND CHANGED V0103
[3368] CS Tumor Size=OBSOLETE DATA REVIEWED AND CHANGED V0200
[3386] CS Tumor Size=OBSOLETE DATA RETAINED - not allowed if CS Version Input Original > or = 020100
[3398] CS Tumor Size=OBSOLETE DATA CONVERTED V0203
[3399] CS Tumor Size=OBSOLETE DATA REVIEWED AND CHANGED V0203
[3400] CS Tumor Size=OBSOLETE DATA REVIEWED V0203 - not allowed if DX > 2010
[3401] CS Tumor Size=OBSOLETE DATA REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3402] CS Tumor Size=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if DX > 2010
[3403] CS Tumor Size=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3404] CS Tumor Size=OBSOLETE DATA RETAINED V0203 - not allowed if DX > 2010
[3405] CS Tumor Size=OBSOLETE DATA RETAINED V0203 - not allowed if CS Version Input Original > or = 020300
[3498] CS Tumor Size=OBSOLETE DATA CONVERTED V0204
[3499] CS Tumor Size=OBSOLETE DATA REVIEWED AND CHANGED V0204
[3500] CS Tumor Size=OBSOLETE DATA RETAINED V0202 - not allowed if DX > 2010
[3501] CS Tumor Size=OBSOLETE DATA RETAINED V0202 - not allowed if CS Version Input Original > or = 020200

[3502] CS Tumor Size=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if DX > 2011
[3503] CS Tumor Size=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if CS Version Input Original > or = 020440
[3504] CS Tumor Size=OBSOLETE DATA RETAINED V0204 - not allowed if DX > 2011
[3505] CS Tumor Size=OBSOLETE DATA RETAINED V0204 - not allowed if CS Version Input Original > or = 020440
[3506] CS Tumor Size=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if DX > 2009
[3507] CS Tumor Size=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if CS Version Input Original > or = 020100
ERROR_TEXT("Date of Diagnosis: %DC")
ERROR_TEXT("Invalid site or histology")
ERROR_TEXT("Schema discriminator missing or invalid")
SAVE_TEXT("t_schema_msg")

Description

This edit checks for all obsolete CS Tumor Size codes. Obsolete codes should be re-coded per Collaborative Stage guidelines.

This edit is skipped if CS Tumor Size is blank,Date of Diagnosis is blank, or CS Version Input Original is blank.

This edit first determines the correct CS schema by doing a function call to the CS Dynamic Link Library (dll). The function call passes Primary Site, Histologic Type ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS schema name is returned.

Using the returned schema name, CS table number (CS Tumor Size is table number 1), and CS Tumor Size code, a table lookup is performed. If the code for a particular schema is determined to be obsolete based on the table lookup, the type of obsolete code must be evaluated. There are several types of obsolete codes:

1. OBSOLETE DATA CONVERTED AND RETAINED V0200
2. OBSOLETE DATA CONVERTED V0102
3. OBSOLETE DATA CONVERTED V0104
4. OBSOLETE DATA CONVERTED V0200
5. OBSOLETE DATA RETAINED V0100
6. OBSOLETE DATA RETAINED V0102
7. OBSOLETE DATA RETAINED V0200
8. OBSOLETE DATA REVIEWED AND CHANGED V0102
9. OBSOLETE DATA REVIEWED AND CHANGED V0103
10. OBSOLETE DATA REVIEWED AND CHANGED V0200
11. OBSOLETE DATA CONVERTED V0203
12. OBSOLETE DATA REVIEWED AND CHANGED V0203
13. OBSOLETE DATA REVIEWED V0203
14. OBSOLETE DATA RETAINED AND REVIEWED V0203
15. OBSOLETE DATA RETAINED V0203
16. OBSOLETE DATA RETAINED V0104
17. OBSOLETE DATA RETAINED V0202
18. OBSOLETE DATA RETAINED AND REVIEWED V0200
19. OBSOLETE DATA CONVERTED V0204
20. OBSOLETE DATA REVIEWED AND CHANGED V0204
21. OBSOLETE DATA RETAINED AND REVIEWED V0204
22. OBSOLETE DATA RETAINED V0204

1. If the type of obsolete code = OBSOLETE DATA CONVERTED AND RETAINED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.

B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Tumor Size]

2. If the type of obsolete code = OBSOLETE DATA CONVERTED V0102:
an error is generated.
[Example: none for CS Tumor Size]

3. If the type of obsolete code = OBSOLETE DATA CONVERTED V0104:
an error is generated.
[Example: none for CS Tumor Size]

4. If the type of obsolete code = OBSOLETE DATA CONVERTED V0200:
an error is generated.
[Example: Schema = HemeRetic, CS Tumor Size = 888]

5. If the type of obsolete code = OBSOLETE DATA RETAINED V0100:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Tumor Size]

6. If the type of obsolete code = OBSOLETE DATA RETAINED V0102:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Tumor Size]

7. If the type of obsolete code = OBSOLETE DATA RETAINED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: Schema = Conjunctiva, CS Tumor Size = 000]

8. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0102:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: none for CS Tumor Size]

9. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0103:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: none for CS Tumor Size]

10.If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0200:
an error is generated.
(These particular obsolete codes require review after conversion from CSV01 to CSV02.)
[Example: none for CS Tumor Size]

11. If the type of obsolete code = OBSOLETE DATA CONVERTED V0203:
an error is generated.
[Example: Schema = NETAmpulla, CS Tumor Size = 996]

12. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0203:
an error is generated.
(These particular obsolete codes require review after conversion from CSV02xx to CSV0203.)

[Example: Schema = CarcinoidAppendix, CS Tumor Size = 998]

13. If the type of obsolete code = OBSOLETE DATA REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Tumor Size]

14. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Tumor Size]

15. If the type of obsolete code = OBSOLETE DATA RETAINED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Tumor Size]

16. If the type of obsolete code = OBSOLETE DATA RETAINED V0104:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv02), an error is generated.

17. If the type of obsolete code = OBSOLETE DATA RETAINED V0202:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020200 or higher (indicating the case was originally coded using CSv0202), an error is generated.

18. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv2), an error is generated.

19. If the type of obsolete code = OBSOLETE DATA CONVERTED V0204:
an error is generated.

20. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0204:
an error is generated.
(These particular obsolete codes require review after conversion from CSV0203xx to CSV0204.)

21. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0204:
A. If year of Diagnosis is 2012 or higher, an error is generated.
B. If CS version Input Original is 020440 or higher (indicating the case was originally coded using CSv0204), an error is generated.

22. If the type of obsolete code = OBSOLETE DATA RETAINED V0204:
A. If year of Diagnosis is 2012 or higher, an error is generated.
B. If CS version Input Original is 020440 or higher (indicating the case was originally coded using CSv0204), an error is generated.

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

In the SEER*Edits software, the title of this edit is: IF269

Modifications:

NAACCR v12.1
- Modified to handle the additional types of obsolete codes that were added for CSv0203.

NAACCR v12.2
- Updated to skip if CS Version Input Original is blank.
- Modified to include the additional types of obsolete codes that were added for CSv0204.
- Modified to include 3 types of obsolete codes left out of previous versions of the edit:
-- OBSOLETE DATA RETAINED V0203
-- OBSOLETE DATA RETAINED V0104
-- OBSOLETE DATA RETAINED V0202

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Default error message added

NAACCR v15A
- Duplicate variable declarations deleted from edit logic.

Obsolete Codes - CS Tumor Size/Ext Eval (CS)

Agency: CS **Last changed: 09/15/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
CS Tumor Size/Ext Eval [Std# 2820]
CS Version Input Original [Std# 2935]
CS Site-Specific Factor25 [Std# 2879]
Date of Diagnosis [Std# 390]

Tables

CS_OBS.DBF

Default Error Message

[3545] %F3 [%V3] is obsolete
CS Tumor Size/Ext Eval ["value of CS Tumor Size/Ext Eval"] is obsolete

Additional Messages

[3359] CS Tumor Size/Ext Eval=OBSOLETE DATA RETAINED - not allowed if DX > 2009
[3363] CS Tumor Size/Ext Eval=OBSOLETE DATA CONVERTED V0102
[3364] CS Tumor Size/Ext Eval=OBSOLETE DATA CONVERTED V0104
[3365] CS Tumor Size/Ext Eval=OBSOLETE DATA CONVERTED V0200
[3366] CS Tumor Size/Ext Eval=OBSOLETE DATA REVIEWED AND CHANGED V0102
[3367] CS Tumor Size/Ext Eval=OBSOLETE DATA REVIEWED AND CHANGED V0103
[3368] CS Tumor Size/Ext Eval=OBSOLETE DATA REVIEWED AND CHANGED V0200
[3386] CS Tumor Size/Ext Eval=OBSOLETE DATA RETAINED - not allowed if CS Version Input Original > or = 020100
[3398] CS Tumor Size/Ext Eval=OBSOLETE DATA CONVERTED V0203
[3399] CS Tumor Size/Ext Eval=OBSOLETE DATA REVIEWED AND CHANGED V0203
[3400] CS Tumor Size/Ext Eval=OBSOLETE DATA REVIEWED V0203 - not allowed if DX > 2010
[3401] CS Tumor Size/Ext Eval=OBSOLETE DATA REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3402] CS Tumor Size/Ext Eval=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if DX > 2010
[3403] CS Tumor Size/Ext Eval=OBSOLETE DATA RETAINED AND REVIEWED V0203 - not allowed if CS Version Input Original > or = 020300
[3404] CS Tumor Size/Ext Eval=OBSOLETE DATA RETAINED V0203 - not allowed if DX > 2010
[3405] CS Tumor Size/Ext Eval=OBSOLETE DATA RETAINED V0203 - not allowed if CS Version Input Original > or = 020300
[3498] CS Tumor Size/Ext Eval=OBSOLETE DATA CONVERTED V0204
[3499] CS Tumor Size/Ext Eval=OBSOLETE DATA REVIEWED AND CHANGED V0204
[3500] CS Tumor Size/Ext Eval=OBSOLETE DATA RETAINED V0202 - not allowed if DX > 2010

[3501] CS Tumor Size/Ext Eval=OBSOLETE DATA RETAINED V0202 - not allowed if CS Version Input Original > or = 020200
[3502] CS Tumor Size/Ext Eval=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if DX > 2011
[3503] CS Tumor Size/Ext Eval=OBSOLETE DATA RETAINED AND REVIEWED V0204 - not allowed if CS Version Input Original > or = 020440
[3504] CS Tumor Size/Ext Eval=OBSOLETE DATA RETAINED V0204 - not allowed if DX > 2011
[3505] CS Tumor Size/Ext Eval=OBSOLETE DATA RETAINED V0204 - not allowed if CS Version Input Original > or = 020440
[3506] CS Tumor Size/Ext Eval=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if DX > 2009
[3507] CS Tumor Size/Ext Eval=OBSOLETE DATA RETAINED AND REVIEWED V0200 - not allowed if CS Version Input Original > or = 020100
ERROR_TEXT("Date of Diagnosis: %DC")
ERROR_TEXT("Invalid site or histology")
ERROR_TEXT("Schema discriminator missing or invalid")
SAVE_TEXT("t_schema_msg")

Description

This edit checks for all obsolete CS Tumor Size Ext/Eval codes. Obsolete codes should be re-coded per Collaborative Stage guidelines.

This edit is skipped if CS Tumor Size/Ext Eval is blank, Date of Diagnosis, or CS Version Input Original is blank.

This edit first determines the correct CS schema by doing a function call to the CS Dynamic Link Library (dll). The function call passes Primary Site, Histologic Type ICD-O-3, and CS Site-Specific Factor25 (schema discriminator) to the dll and the CS schema name is returned.

Using the returned schema name, CS table number (CS Tumor Size/Ext Eval is table number 3, and CS Tumor Size/Ext Eval code, a table lookup is performed. If the code for a particular schema is determined to be obsolete based on the table lookup, the type of obsolete code must be evaluated. There are several types of obsolete codes:

1. OBSOLETE DATA CONVERTED AND RETAINED V0200
2. OBSOLETE DATA CONVERTED V0102
3. OBSOLETE DATA CONVERTED V0104
4. OBSOLETE DATA CONVERTED V0200
5. OBSOLETE DATA RETAINED V0100
6. OBSOLETE DATA RETAINED V0102
7. OBSOLETE DATA RETAINED V0200
8. OBSOLETE DATA REVIEWED AND CHANGED V0102
9. OBSOLETE DATA REVIEWED AND CHANGED V0103
10. OBSOLETE DATA REVIEWED AND CHANGED V0200
11. OBSOLETE DATA CONVERTED V0203
12. OBSOLETE DATA REVIEWED AND CHANGED V0203
13. OBSOLETE DATA REVIEWED V0203
14. OBSOLETE DATA RETAINED AND REVIEWED V0203
15. OBSOLETE DATA RETAINED V0203
16. OBSOLETE DATA RETAINED V0104
17. OBSOLETE DATA RETAINED V0202
18. OBSOLETE DATA RETAINED AND REVIEWED V0200
19. OBSOLETE DATA CONVERTED V0204
20. OBSOLETE DATA REVIEWED AND CHANGED V0204
21. OBSOLETE DATA RETAINED AND REVIEWED V0204

22. OBSOLETE DATA RETAINED V0204

1. If the type of obsolete code = OBSOLETE DATA CONVERTED AND RETAINED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Tumor Size/Ext Eval]

2. If the type of obsolete code = OBSOLETE DATA CONVERTED V0102:
an error is generated.
[Example: none for CS Tumor Size/Ext Eval]

3. If the type of obsolete code = OBSOLETE DATA CONVERTED V0104:
an error is generated.
[Example: none for CS Tumor Size/Ext Eval]

4. If the type of obsolete code = OBSOLETE DATA CONVERTED V0200:
an error is generated.
[Example: none for CS Tumor Size/Ext Eval]

5. If the type of obsolete code = OBSOLETE DATA RETAINED V0100:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Tumor Size/Ext Eval]

6. If the type of obsolete code = OBSOLETE DATA RETAINED V0102:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: none for CS Tumor Size/Ext Eval]

7. If the type of obsolete code = OBSOLETE DATA RETAINED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 (indicating the case was originally coded using CSv2), an error is generated.
[Example: Schema = MelanomaEyeOther, CS Tumor Size/Ext Eval = 0]

8. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0102:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: none for CS Tumor Size/Ext Eval]

9. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0103:
an error is generated.
(Obsolete codes from CSV01 are expected to have been recoded prior to conversion to CSV02.)
[Example: none for CS Tumor Size/Ext Eval]

10.If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0200:
an error is generated.
(These particular obsolete codes require review after conversion from CSV01 to CSV02.)
[Example: none for CS Tumor Size/Ext Eval]

11. If the type of obsolete code = OBSOLETE DATA CONVERTED V0203:
an error is generated.
[Example: none for CS Tumor Size/Ext Eval]

12. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0203:
an error is generated.
(These particular obsolete codes require review after conversion from CSV02xx to CSV0203.)
[Example: none for CS Tumor Size/Ext Eval]

13. If the type of obsolete code = OBSOLETE DATA REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Tumor Size/Ext Eval]

14. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Tumor Size/Ext Eval]

15. If the type of obsolete code = OBSOLETE DATA RETAINED V0203:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020300 or higher (indicating the case was originally coded using CSv0203), an error is generated.
[Example: none for CS Tumor Size/Ext Eval]

16. If the type of obsolete code = OBSOLETE DATA RETAINED V0104:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv02), an error is generated.

17. If the type of obsolete code = OBSOLETE DATA RETAINED V0202:
A. If year of Diagnosis is 2011 or higher, an error is generated.
B. If CS version Input Original is 020200 or higher (indicating the case was originally coded using CSv0202), an error is generated.

18. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0200:
A. If year of Diagnosis is 2010 or higher, an error is generated.
B. If CS version Input Original is 020100 or higher (indicating the case was originally coded using CSv2), an error is generated.

19. If the type of obsolete code = OBSOLETE DATA CONVERTED V0204:
an error is generated.

20. If the type of obsolete code = OBSOLETE DATA REVIEWED AND CHANGED V0204:
an error is generated.
(These particular obsolete codes require review after conversion from CSV0203xx to CSV0204.)

21. If the type of obsolete code = OBSOLETE DATA RETAINED AND REVIEWED V0204:
A. If year of Diagnosis is 2012 or higher, an error is generated.
B. If CS version Input Original is 020440 or higher (indicating the case was originally coded using CSv0204), an error is generated.

22. If the type of obsolete code = OBSOLETE DATA RETAINED V0204:
A. If year of Diagnosis is 2012 or higher, an error is generated.
B. If CS version Input Original is 020440 or higher (indicating the case was originally coded using CSv0204), an error is generated.

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

In the SEER*Edits software, the title of this edit is: IF271

Modifications:

NAACCR v12.1
- Modified to handle the additional types of obsolete codes that were added for CSv0203.

NAACCR v12.2
- Modified to handle the additional types of obsolete codes that were added for CSv0204.
- Updated to skip if CS Version Input Original is blank.

NAACCR v14
- Function call to the CS Dynamic Link Library updated to call "CStage0205.dll" instead of "CStage.dll"
- Default error message added

NAACCR v15A
- Duplicate variable declarations deleted from edit logic.

Obsolete Histology ICDO3, Date of DX (SEER)

Agency: SEER **Last changed: 01/26/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
Histologic Type ICD-O-3 [Std# 522]

Default Error Message

[4237] For cases diagnosed 2010 and later, %F2 is obsolete
For cases diagnosed 2010 and later, Histologic Type ICD-O-3 is obsolete

Additional Messages

[4243] Histologic Type ICD-O-3 ("value of Date of Diagnosis") is obsolete; please use 8152 instead

Description

```
If year of Date of Diagnosis is blank, this edit is skipped.

The following histology is obsolete for all years.
Source: ICD-O-3 Update Implementation (December 2013)
- The current code to be used in place of the obsolete code is shown in the second
column.

Obsolete ICD-O-3 Code    Current ICD-O-3 Code
        8157                     8152

If the year of Date of Diagnosis is 2010 or later, the following Histologic Type
ICD-O-3 codes listed in the first column are obsolete and will generate an error if
used.
Source: Hematopoietic and Lymphoid Neoplasm Database & Coding Manual(Appendix E)
- The current code to be used in place of the obsolete code is shown in the second
column.

Obsolete ICD-O-3 Code    Current ICD-O-3 Code
         9654                     9653
         9661                     9650
         9662                     9650
         9664                     9663
         9665                     9663
         9667                     9663
         9670                     9823
         9675                     9690
         9684                     9680
         9728                     9811
         9729                     9837
         9733                     9732
         9750                     9751
         9752                     9751
         9753                     9751
         9754                     9751
```

9760	9761 or 9762
9764	9762
9805	9806-9809
9835	9811
9836	9811
9960	9975
9984	9983
9987	9920

Administrative Notes

New edit - added to NAACCR v13 metafile.

In the SEER*Edits software, the title of this edit is: IF440

Modifications:

NAACCR v15
- Histology code 8157 is obsolete for all years and should be replaced by 8152
- Diagnosis year for which listed histology codes are obsolete was changed from '2012 and later' to '2010 and later'
- Added code 9752
- Added column of current codes to be used in place of the obsolete codes

PIN III ICDO3, Date of Diagnosis (SEER IF110)

Agency: SEER **Last changed: 12/29/2009**

Edit Sets

OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]

Default Error Message

[3143] PIN III, Date of Diagnosis conflict
PIN III, Date of Diagnosis conflict

Additional Messages

ERROR_TEXT("Date of Diagnosis: %DC")

Description

```
If year of Date of Diagnosis is blank, this edit is skipped.

If the year of Date of Diagnosis is greater than 2000 and Primary Site = C619
(Prostate) and Histologic Type ICD-O-3 = 8148 and Behavior Code ICD-O-3 = 2 (PIN
III), an error is generated.

This edit should be used only by registries that do not collect and/or do not want
to submit PIN III cases for diagnosis years beginning with 2001.
```

Administrative Notes

Modifications:

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

Place of Death--Country (NAACCR)

Agency: NAACCR **Last changed: 12/08/2014**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Place of Death--Country [Std# 1944]

Tables

CNTRY_ST.DBF

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of Place of Death--Country" is not a valid value for Place of Death--Country

Description

Place of Death--Country must contain a valid ISO code or standard custom code for country. May be blank.

Administrative Notes

New edit - added to NAACCR v13 metafile.

Modifications

NAACCR v15
Country code table (CNTRY_ST.DBF) has been updated:
Brunei - 'BND' changed to 'BRN'
Czechoslovakia (former) - 'XCZ' changed to 'CSK'
Slovakia - 'SWK' changed to 'SVK'
Vanuatu - 'VLT' changed to 'VUT'
Yugoslavia (former) - 'XYG' changed to 'YUG'

Added Saint-Martin (French part) - 'MAF'

Place of Death--Country, Vital Status (NPCR)

Agency: NPCR **Last changed: 11/07/2012**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Place of Death--Country [Std# 1944]
Vital Status [Std# 1760]

Default Error Message

[1016] %F1 and %F2 conflict
Place of Death--Country and Vital Status conflict

Description

```
If Place of Death--Country is not blank, then Vital Status must = 0 (dead).
```

Administrative Notes

New edit - added to NAACCR v13 metafile.

Place of Death--State (NAACCR)

Agency: NAACCR **Last changed: 12/03/2012**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Place of Death--State [Std# 1942]

Tables

CNTRY_ST.DBF

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of Place of Death--State" is not a valid value for Place of Death--State

Description

Place of Death--State must contain a valid ISO code or standard custom code for state. May be blank.

Administrative Notes

New edit - added to NAACCR v13 metafile.

Place of Death--State, Vital Status (NPCR)

Agency: NPCR **Last changed: 11/07/2012**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Place of Death--State [Std# 1942]
Vital Status [Std# 1760]

Default Error Message

[1016] %F1 and %F2 conflict
Place of Death--State and Vital Status conflict

Description

```
If Place of Death--State is blank, then Vital Status must = 1 (alive).
If Place of Death--State is not blank, then Vital Status must = 0 (dead).
```

Administrative Notes

New edit - added to NAACCR v13 metafile.

Primary Payer at DX (NPCR)

Agency: NPCR **Last changed: 04/28/2007**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Payer at DX [Std# 630]

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of Primary Payer at DX" is not a valid value for Primary Payer at DX

Description

```
Must be a valid code for Primary Payer at DX  (01,02,10,20,21,31,35,60-68,99) or
blank.
```

Administrative Notes

This edit differs from the COC edit of the same name in that it allows the field to be blank.

Modications:

NACR110C
07/24/06
Description only modified: reference to another edit ("Primary Payer at DX, Date of DX") that requires field to be filled in for 2005+ cases was deleted. (The edit "Primary Payer at DX, Date of DX (NPCR)" was deleted because NPCR is requiring Primary Payer at DX only when available.)

Primary Site (SEER SITE)

Agency: SEER **Last changed: 05/14/2001**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]

Tables

SITE_TBL.DBF

Default Error Message

[270] Primary Site not valid
Primary Site not valid

Description

Must be one of the topography codes defined by the International Classification of Diseases for Oncology, Second Edition or Third Edition. (The decimal point is dropped and the `C' is required.)

Primary Site, Behavior Code (MCR/SEER IF39)

Agency: **Last changed: 06/13/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Over-ride Site/Behavior [Std# 2071]
Behavior (92-00) ICD-O-2 [Std# 430]

Default Error Message

[368] Behavior & Site conflict - ICDO2
Behavior & Site conflict - ICDO2

Description

MCR-modified version of Primary Site, Behavior Code (SEER IF39) because it uses the necessary fields.
In situ ICDO2 behavior not allowed for vague primary sites (standard edit); benign and borderline behavior allowed for some sites as MCR requires 'benign brain tumors' for all years (MCR portion of the edit).

Administrative Notes

8/10/10
Removed USR4 flag.

Primary Site, Behavior Code ICDO3 (SEER IF39)

Agency: SEER **Last changed: 06/27/2008**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Behavior Code ICD-O-3 [Std# 523]
Over-ride Site/Behavior [Std# 2071]

Default Error Message

[512] Behavior & Site conflict - ICDO3
Behavior & Site conflict - ICDO3

Description

This edit is skipped if Behavior Code ICD-O-3 is empty.

The following primary sites with a behavior of in situ (Behavior Code ICD-O-3 = 2) require review. If the Over-ride Site/Behavior field contains a '1', no further checking is done.

C269	Gastrointestinal tract, NOS
C399	Ill-defined sites within respiratory system
C559	Uterus, NOS
C579	Female genital tract, NOS
C639	Male genital organs, NOS
C689	Urinary system, NOS
C729	Nervous system, NOS
C759	Endocrine gland, NOS
C760-C768	Ill-defined sites
C809	Unknown primary site

Additional Information:

Since the designation of in situ is very specific and almost always requires microscopic confirmation, it is assumed that specific information should also be available regarding the primary site. Conversely, if inadequate information is available to determine a specific primary site, it is unlikely that information about a cancer being in situ is reliable. Therefore this edit does not allow an in situ behavior code to be used with specified organ system and ill-defined site codes.

Correction of errors may require inspection of the abstracted text, either online or as recorded on a paper abstract. Review of the original medical record may be necessary. Check the information available about primary site and histologic type carefully. If a specific in situ diagnosis is provided, try to obtain a more specific primary site. A primary site within an organ system may sometimes be assumed based on the diagnostic procedure or treatment given or on the histologic type. If no more specific site can be determined, it is probably preferable to code a behavior code of 3.

EXAMPLE

```
PRIMARY SITE CODE        C55.9, UTERUS NOS
BEHAVIOR CODE            2
```

The abstract reads, "Uterine D&C with squamous cell carcinoma in situ". The category "Uterus, NOS" is to be used when it cannot be determined whether a cancer arose in the cervix or corpus uteri. Based on the histologic type and diagnostic procedure, the most likely site in this case is cervix uteri rather than corpus. Change the primary site code to C53.9, Cervix uteri.

Administrative Notes

In the SEER*Edits software, the title of this edit is: IF39_3

Note: The COC version of this edit has been deleted since it, over time, has become equivalent to the SEER version of the edit. Edit sets in this metafile using the COC version have been updated to use the SEER version instead.

Modifications:

NAACCR v11.3
6/2008
Updated Administrative Notes with the title of the corresponding edit in the SEER*Edits software.

Primary Site, CS Extension (SEER IF176)

Agency: SEER **Last changed: 01/21/2010**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Extension [Std# 2810]
CS Mets at DX [Std# 2850]
Over-ride Site/EOD/DX Dt [Std# 2072]

Default Error Message

[3218] Primary Site, CS Extension, CS Mets at DX conflict
Primary Site, CS Extension, CS Mets at DX conflict

Additional Messages

ERROR_TEXT("Date of Diagnosis: %DC")

Description

```
The edit is skipped if any of the following conditions are true:
    1)  Over-ride Site/EOD/Dx Dt contains a '1' (review  complete)
    2)  Year of Date of Diagnosis is less than 2004 or is blank
    3)  Histologic Type ICD-O-3 equals 9140 (Kaposi Sarcoma)
    4)  Histologic Type ICD-O-3 greater than or equal to 9590
       (lymphoma, leukemia, or other lymphoreticular neoplasm)
    5)  Behavior Code ICD-O-3 equals 2 (in situ)

If CS Extension equals 100-300 (localized disease) and CS Mets at DX equals 00 or
99, the following Primary Site codes require review:
    C069 Mouth, NOS
    C260-C269 Other and ill-defined digestive organs
    C390-C399 Other and ill-defined respiratory or intrathoracic sites
    C409, C419 Bone, NOS
    C579 Female genital system, NOS
    C639 Male genital organs, NOS

If CS Extension= 100-320 (localized disease) and CS Mets at DX equals 00 or 99, the
following Primary Site codes require review:
    C479 Peripheral nerves, NOS
    C499 Connective tissue, NOS

If CS Extension= 100-400 (localized disease) and CS Mets at DX equals 00 or 99, the
following Primary Site codes require review:
    C189 Colon, NOS and not histology 8210, 8220, 8261 and 8263
    C559 Uterus, NOS
```

Administrative Notes

In the SEER*Edits software, the title of this edit is: IF176

Modifications:

NAACCR v11.3
6/2008
Updated Administrative Notes with the title of the corresponding edit in the SEER*Edits software.

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.
- Hematopoietic end range code was changed from 9989 to 9992.
- Length of CS Extension changed from 2 to 3 characters.

Primary Site, Heme Morph, DateDX, NoOverride(SEER)

Agency: SEER **Last changed: 01/27/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
Date of Diagnosis [Std# 390]

Default Error Message

[4110] Hemato case diagnosed 2010 and later, %F1 (%V1) is not valid for %F2 (%V2)
Hemato case diagnosed 2010 and later, Primary Site ("value of Primary Site") is not valid for Histologic Type ICD-O-3 ("value of Histologic Type ICD-O-3"

Additional Messages

[4244] Hemato case diagnosed 2010 or later, if Histologic Type ICD-O-3 = "value of Histologic Type ICD-O-3", Primary Site must = C420
[4245] Hemato case diagnosed 2010 or later, if Histologic Type ICD-O-3 = "value of Histologic Type ICD-O-3", Primary Site must = C421
[4253] Hemato case diagnosed 2010 or later, if Histologic Type ICD-O-3="value of Histologic Type ICD-O-3", Primary Site must not = C420, C423, C424
[4259] Hemato diag 2010 or later, if Histologic Type ICD-O-3 = "value of Histologic Type ICD-O-3", Primary Site must not = C420, C421, C423, C424
[4260] Hemato case diagnosed 2010 or later, if Histologic Type ICD-O-3 = "value of Histologic Type ICD-O-3", Primary Site must = C379, C381-C383
[4261] Hemato case diagnosed 2010 or later, if Histologic Type ICD-O-3 = "value of Histologic Type ICD-O-3", Primary Site must = C422
[4262] Hemato diag 2010 or later, if Histologic Type ICD-O-3 = "value of Histologic Type ICD-O-3", Primary Site must not = C420, C422, C423, C424
[4263] Hemato case diagnosed 2010 or later, if Histologic Type ICD-O-3 = "value of Histologic Type ICD-O-3", Primary Site must = C400-C419
[4264] Hemato diag 2010 or later, if Histologic Type ICD-O-3="value of Histologic Type ICD-O-3", Primary Site must not=C400-C419, C420, C423, C424
[4265] Hemato case diagnosed 2010 or later, if Primary Site="value of Primary Site", Histologic Type ICD-O-3 must = 9761
[4896] Hemato case diagnosed prior to 2010, 9823 is valid only for C420, C421, C424

Description

This edit validates the coding of primary site by histology based on the Hematopoietic and Lymphoid Neoplasm Coding Manual and Database. For cases diagnosed 2010 and later, specific histology codes are allowed only for specified sites. One combination (9823/C420, C421, C424) is allowed only for cases diagnosed prior to 2010.

The histology/primary site combinations in this edit are not overridable.

Sources:
- Hematopoietic and Lymphoid Neoplasm Database & Coding Manual (Appendix E)
- 2015 Implementation Guidelines and Recommendations (Appendix B)

This edit is skipped if any of the following conditions are true:
1. Primary Site is blank
2. Histologic Type ICD-O-3 is blank or not in range 9590-9992
3. Behavior Code ICD-O-3 is blank or not = 3
4. Date of Diagnosis is blank or invalid

If year of diagnosis is less than 2010, the following Histologic Type ICD-O-3 codes (with Behavior ICD-O-3 code 3) are allowed only for the listed Primary Site codes:

9823: C420, C421, C424

If year of diagnosis is 2010 or later, the following Histologic Type ICD-O-3 codes (with Behavior ICD-O-3 code 3) are allowed only for the listed Primary Site codes:

9761: C420 - vice versa is also true: if Primary Site is C420, then Histologic Type ICD-O-3 must = 9761

9732, 9741, 9742, 9800, 9801, 9806-9809, 9820, 9826, 9831-9834, 9840, 9860, 9861, 9863, 9865-9867, 9869-9876, 9891, 9895-9898, 9910, 9911, 9920, 9931, 9940, 9945, 9946, 9948, 9950, 9961-9967, 9975, 9980, 9982, 9983, 9985, 9986, 9989, 9991, 9992
C421

9590, 9591, 9596, 9597, 9650-9653, 9655, 9659, 9663, 9671, 9673, 9678, 9680, 9687, 9688, 9690, 9691, 9695, 9698, 9700-9702, 9705, 9708, 9709, 9712, 9714, 9717-9719, 9724-9727, 9735, 9737, 9738, 9740, 9751, 9755-9759, 9762, 9811-9818, 9823, 9827, 9837, 9971
Not C420, C423, C424

9679: C381-C383 or C379

9689: C422

9699: Not C420, C422, C423, C424

9716: C422

9731: C400-C419

9734: Not C400-C419, C420, C423, C424

9930: Not C420, C421, C423, C424

Administrative Notes

New edit - added to NAACCR v12.1 metafile.

In the SEER*Edits software, the title of this edit is: IF348

Modifications:

NAACCR v13:

- Edit name changed from 'Primary Site, Morphology, Date of DX (SEER)' to 'Primary Site, Hemato Morphology, Date of DX (SEER)'.
- Edit modified to check that, for cases diagnosed 2010 and later, specific histology codes are allowed only for specified sites. (Earlier version of this edit checked only: for 2010+, if histology = 9731/3, site must = C400-C419.)
- Edit also checks for cases diagnosed prior to 2012, that 9823/3 is allowed only for C420, C421, C424.
- Over-ride removed from the edit

NAACCR v13A
- Edit changed to limit Histologic Type ICD-O-3 code 9823 to C420, C421, and C424 for cases diagnosed prior to 2010; previous version (NAACCR v13) of this edit incorrectly checked diagnosis year 2012
- Added reference to SEER IF348 in Administrative Notes

NAACCR v14
- Over-ride added to edit: edit will be skipped if Over-ride Site/Type = 1, indicating the case has already been reviewed and accepted as coded

NAACCR v15
- Edit name changed from 'Primary Site, Hemato Morphology, Date of DX (SEER)' to 'Primary Site, Heme Morph, DateDX, NoOverride(SEER)'. This edit includes primary site/histology/diagnosis date combinations that are not over-rideable. Combinations that are over-rideable have been moved into a seperate edit:'Primary Site, Heme Morph, DateDX, Override (SEER)'
- Obsolete codes removed from edit since they will already fail 'Obsolete Histology ICDO3, Date of DX (SEER)'
- Histologies regrouped to match documentation from SEER

Primary Site, Heme Morph, DateDX, Override (SEER)

Agency: SEER **Last changed: 06/14/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
Date of Diagnosis [Std# 390]
Over-ride Site/Type [Std# 2030]

Default Error Message

[4266] Hemato case diagnosed 2010 or later, %F2=%V2,%F1 not=C770-C779; review required
Hemato case diagnosed 2010 or later, Histologic Type ICD-O-3="value of Histologic Type ICD-O-3",Primary Site not=C770-C779; review required

Additional Messages

[4267] Hemato diag 2010 or later, Histologic Type ICD-O-3="value of Histologic Type ICD-O-3",Primary Site not skin lymphoma; review required
[4268] Hemato case diagnosed 2010 or later, Histologic Type ICD-O-3 = "value of Histologic Type ICD-O-3", Primary Site = "value of Primary Site": review required
[4270] Hemato diag 2010+, Histologic Type ICD-O-3="value of Histologic Type ICD-O-3",Primary Site not skin or soft tissue lymphoma; review required

Description

This edit complements the edit 'Primary Site, Morphology-Type,Beh ICDO3(SEER IF25)' which is based on the ICD-O-3 SEER Site/Histology Validation List and requires review of unusual site/histology/behavior combinations. 'Primary Site, Morphology-Type,Beh ICDO3(SEER IF25)' does not check diagnosis year. This edit checks diagnosis year and narrows the list of preferred site codes for some hematopoietic histologies for cases diagnosed 2010 and later. Cases with primary sites that are not included in the preferred list must be reviewed. If upon review the site/type combination is found to be accurate and in conformance with coding rules, it may be left as coded and the Over-ride-Site/Type flag coded to 1.

This version of the edit includes the over-ride field 'Over-ride Site/Type' and should run at the central registry level. The hospital registry version of this edit is 'Primary Site, Heme Morph, DateDX, Override (COC)' and includes the hospital level field 'Over-ride COC-Site/Type' instead of the central registry field 'Over-ride Site/Type.'

Sources:
- Hematopoietic and Lymphoid Neoplasm Database & Coding Manual (Appendix E)
- 2015 Implementation Guidelines and Recommendations, Appendix B, Table 3

This edit is skipped if any of the following conditions are true:
1. Primary Site is blank
2. Histologic Type ICD-O-3 is blank or not in range 9590-9992

```
3. Behavior Code ICD-O-3 is blank or not = 3
4. Date of Diagnosis is blank or invalid
5. Over-ride Site/Type = 1

If year of diagnosis is 2010 or later, the following Primary Site codes are the
preferred codes for use with the listed Histologic Type ICD-O-3 codes.  If other
Primary Site codes are coded and, after review, determined to be correct, the Over-
ride Site/Type should be set to '1'.

9650, 9651, 9652, 9653, 9655, 9659, 9663,9688
    C770-C779

9597, 9700, 9701, 9709, 9718, 9725
    C440-C449, C510-C512, C518-C519, C600-C602, C608-C609, C632

9708, 9726
    C440-C449, C490-C499, C510-C512, C518-C519, C600-C602, C608-C609, C632

9719
    C050-C059, C110-C119, C300-C301, C310-C319

9751
    C340-C349, C400-C419, C421, C440-C449, C490-C499, C770-C779
```

Administrative Notes

New edit - added to NAACCR v15 metafile.

In the SEER*Edits software, the title of this edit is: IF510

This SEER edit differs from the COC edit of the same name as follows:
- This edit includes the over-ride field 'Over-ride Site/Type' and should be run by central registries. The COC version of the edit, 'Primary Site, Heme Morph, DateDX, Override (COC),' includes the over-ride field 'Over-ride COC-Site/Type' instead of the central registry field 'Over-ride Site/Type' and should be run at the facility level.

Some of this edit logic was previously included in the edit 'Primary Site, Hemato Morphology, Date of DX (SEER)', which has now been split into two edits, 'Primary Site, Heme Morph, DateDX, NoOverride(SEER)', which includes non over-rideable site/histology combinations, and this edit (COC and SEER versions) which allows a case to be reviewed and an over-ride flag to be set to '1' if the case is accurate as coded.

Modifications:

NAACCR v15A
- Logic fixed so that it will no longer inappropriately pass for 9719: it will now fail whenever Primary Site is not C050-C059, C110-C119, C300-C301, C310-C319

Primary Site, Laterality (SEER IF82)

Agency: SEER **Last changed: 01/21/2010**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Laterality [Std# 410]
Date of Diagnosis [Std# 390]

Default Error Message

[3254] C342 (lung, middle lobe), Laterality cannot equal 2 (left)
C342 (lung, middle lobe), Laterality cannot equal 2 (left)

Additional Messages

[3256] If DX > 2006 and site= C342 (lung, middle lobe), Laterality cannot=4 (bilateral)
ERROR_TEXT("Date of Diagnosis: %DC")

Description

```
If Primary Site C342 (lung, middle lobe), Laterality cannot = 2 (left) or, if year
of Date of Diagnosis > 2006 and is not blank, Laterality cannot = 4 (bilateral).
```

Administrative Notes

In the SEER*Edits software, the title of this edit is: IF82

Modifications:

NAACCR v11.3
6/2008
Updated Administrative Notes with the title of the corresponding edit in the SEER*Edits software.

NAACCR v11.3A
Added: If Primary Site C342 and year of Diagnois is > 2006, Laterality cannot = 4.

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

Primary Site, Laterality, CS Extension(SEER IF177)

Agency: SEER **Last changed: 12/06/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Laterality [Std# 410]
CS Extension [Std# 2810]
CS Mets at DX [Std# 2850]
Over-ride Site/Lat/EOD [Std# 2073]

Default Error Message

[3219] Primary Site, Laterality, CS Extension conflict
Primary Site, Laterality, CS Extension conflict

Additional Messages

ERROR_TEXT("Date of Diagnosis: %DC")

Description

```
This edit is skipped if any of the following conditions are true:
      1. Over-ride Site/Lat/EOD field contains a '1' (review complete)
      2. Year of Date of Diagnosis is less than 2004 or is blank
      3. Histologic Type ICD-O-3 = 9140, 9590-9992
    4. If year of diagnosis = 2016-2017 and CS Extension is blank


For the purpose of this edit the following sites are considered paired organs:

    C079        Parotid gland
    C080        Submandibular gland
    C081        Sublingual gland
    C090        Tonsillar fossa
    C091        Tonsillar pillar
    C098-C099   Tonsil, NOS
    C301        Middle ear
    C310        Maxillary sinus
    C312        Frontal sinus
    C341-C349   Lung
    C384        Pleura
    C400        Long bones of upper limb, scapula and associated joints
    C401        Short bones of upper limb and associated joints
    C402        Long bones of lower limb and associated joints
    C403        Short bones of lower limb and associated joints
    C441        Skin of eyelid
    C442        Skin of external ear
    C446        Skin of upper limb and shoulder
    C447        Skin of lower limb and hip
```

```
    C471        Peripheral nerves and autonomic nervous system of upper
                limb and shoulder
    C472        Peripheral nerves and autonomic nervous system of lower
                limb and hip
    C491        Connective, subcutaneous, and other soft tissues of upper
                limb and shoulder
    C492        Connective, subcutaneous, and other soft tissues of lower
                limb and hip
    C500-C509   Breast
    C569        Ovary
    C570        Fallopian tube
    C620-C629   Testis
    C630        Epididymis
    C631        Spermatic cord
    C649        Kidney, NOS
    C659        Renal pelvis
    C669        Ureter
    C690-C699   Eye
    C740-C749   Adrenal gland
    C754        Carotid body

For the above paired organ sites:

If the Laterality is '9', (no information concerning laterality), CS Extension
cannot specify in situ or localized.

If Laterality is '4' (bilateral involvement, lateral origin unknown: stated to be a
single primary), CS Extension cannot specify in situ or localized except for C090
(Tonsillar fossa), C091 (Tonsillar pillar), C098-C099 (Tonsil, NOS), C569 (Ovary),
C570 (fallopian tube), C649 (Kidney, NOS) and C692 (Retina).

There is an additional exception for cases diagnosed 2010 or later:
If Primary Site = C340-C349 (lung), CS Extension may = 000-300 only if CS Mets at
DX = {23, 25, 26, 36, 38, 40, 41, 42, 43, 50, 51, 52, 53, 70, 75}.

In situ or localized is coded in the CS Extension field as follows:
    000-100 for sites C500-C509 (breast)
    000-310 for sites C620-C629 (testis)
    000-320 for sites C471 (Peripheral nerves and autonomic nervous
                                        system of upper limb and shoulder)
                    C472 (Peripheral nerves and autonomic nervous
                                    system of lower limb and hip)
                    C491 (Connective, subcutaneous, and other soft
                                    tissues of upper limb and shoulder)
                    C492 (Connective, subcutaneous, and other soft
                                    tissues of lower limb and hip
    000-400 for sites C690-C699 (eye)
    000-300 for all other paired organ sites listed above
```

Administrative Notes

In the SEER*Edits software, the title of this edit is: IF177

MODIFICATIONS:

NAACCR v11.1A
3/2007

The edit was modified to include C570 (fallopian tube) in the list of paired sites that are exceptions to "if Laterality is '4' (bilateral involvement, lateral origin unknown: stated to be a single primary), CS Extension cannot specify in situ or localized".

NAACCR v11.3
6/2008
Updated Administrative Notes with the title of the corresponding edit in the SEER*Edits software.

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.
- Hematopoietic end range code was changed from 9989 to 9992.
- Length of CS Extension changed from 2 to 3 characters.

NAACCR v13
Added:
There is an additional exception for cases diagnosed 2010 or later:
If Primary Site = C340-C349 (lung), CS Extension may = 000-300 only if CS Mets at DX = {23, 25, 26, 36, 38, 40, 41, 42, 43, 50, 51, 52, 53, 70, 75}.

NAACCR v16
- Modified to skip if year of diagnosis = 2016 and CS Extension is blank.

NAACCR v16A
- Logic changed to match description, edit skipped if year of diagnosis is 2016, original logic included skip if year of diagnosis > 2015.

NAACCR v16D
- Description, logic modified to skip if diagnosis year = 2016-2017

Primary Site, M 2016 - Ed 7 (COC-NPCR)

Agency: COC **Last changed: 02/06/2017**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
TNM Edition Number [Std# 1060]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
Age at Diagnosis [Std# 230]
CS Site-Specific Factor10 [Std# 2864]
CS Site-Specific Factor25 [Std# 2879]
Grade [Std# 440]
TNM Clin M [Std# 960]
TNM Path M [Std# 900]
Sex [Std# 220]
Type of Reporting Source [Std# 500]

Tables

AC7G2016.DBF
NP7M2016.DBF

Default Error Message

[3290] TNM M code problem
TNM M code problem

Additional Messages

[3291] TNM Path M code is invalid for site/hist combination
[3292] TNM Clin M code is invalid for site/hist combination
[3293] TNM Clin M code should = "88" for site/hist combination
[3294] TNM Path M code should = "88" for site/hist combination

Description

```
TNM Clin M and TNM Path M may be blank.  If TNM Clin M is entered, it will be
edited by criteria below.  If TNM Path M is entered, it will be edited by criteria
below.

This edit is skipped if any of the following conditions are true:

1. Year of Date of Diagnosis is less than 2016, blank (unknown),or invalid
2  Type of Reporting Source = 7 (Death Certificate Only)
3. Histologic Type ICD-O-3 is blank
4. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
5. TNM Edition Number is not = 07 and not = 88
6. TNM Clin M and TNM Path M are both blank
```

The allowable values for

Clin M: (blank), c0,c0I+, c1, c1A, C1B, c1C, c1D, c1E, p1, p1A, p1B, p1C, p1D, p1E, 88
Path M: (blank), c0, c0I+, c1, c1A, C1B, c1C, c1D, c1E, p1, p1A, p1B, p1C, p1D, p1E, 88

This edit checks the subset of values that are valid for each of the site/histology groups that have a TNM M defined and checks for "88" if the site/histology group does not have a TNM M defined.

The number next to each site group indicates the chapter in the AJCC Cancer Staging Manual, Edition 7. The sites for each chapter are listed along with the histologies for which M is defined. The site-specific TNM values are listed below for each group or subgroup. The edit checks that "c" or "p" precedes the value given for both the Clin M and Path M except for "88" and blank.

The list of site/hist specific valid values does not list the appropriate c and p but the edit checks for it. For clin M unless stated otherwise, the list of valid values can have either a “c” or “p” and for Path M all values can have either a “c” or “p” except p0 (pM0), which is not valid for either the Clin or Path evaluation for any site/hist. This edit allows a blank as a valid code for either the Clin M or Path M.

For example if the documentation shows: M: 0,1
Then the case passes for:
Clin M: c0, c1, p1, (blank)
Path M: c0, c1, p1, (blank)

Breast lists both a clin and path set of values because c0I+ (cM0I+) is only valid for breast Clin or Path M and p0I+ is not valid.

The sites/histologies for each group are listed in the EditWriter table AC7G2016.DBF, except as noted below where special logic in this edit is used to assign or reassign sites/histologies to a specified group number.

This edit differs from the SEER edit of the same name in that it excludes MNOS categories that are not included in AJCC 7th Edition (Melanoma M1, Ocular Adnexal Lymphoma M1).

3. Lip and Oral Cavity

Sites:
C000-C006,C008,C009
C020-C023,C028,C029
C030,C031,C039
C040,C041,C048,C049
C050,C058,C059
C060-C062,C068,C069
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM M:
0,1

4. Pharynx

4A. Oropharynx and Hypopharynx

Sites:
C019, C024
C051-C052
C090-C091, C098-C099
C100, C102-C104, C108-C109
C129
C130-C132, C138-C139

Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM M:
0,1

4B. Nasopharynx
Sites:
C110, C112-C113, C118-C119
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981

4C. Nasopharynx
Sites:
C111
Discriminator (CS Site-Specific Factor25):
010
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM M:
0,1

4D. Oropharynx - Pharyngeal Tonsil
Sites:
C111
Discriminator (CS Site-Specific Factor25):
020
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981

Sites/histologies are assigned to group 4D from 4C based on Site-Specific Factor 25

TNM M:
0,1

5. Larynx

5A. Supraglottis, Subglottis, Other
Sites:
C101, C321-C322
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM M:
0,1

5B. Glottis
Sites:
C320, C328-C329

Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980, 8981
TNM M:
0,1

NOTE: TNM M 88 allowed for C328-C329

6. Nasal Cavity and Paranasal Sinuses

Sites:
C300, C310-C311
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM M:
0,1

7. Major Salivary Glands

Sites:
C079
C080,C081,C088,C089
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8982
TNM M:
0,1, 88

8. Thyroid Gland

8A. Thyroid: Papillary/follicular, age less than 045
Sites:
C739
Histologies Requiring AJCC Staging:
8000-8015, 8022, 8033-8344, 8350-8420, 8440-8508,
8514-8576, 8940-8950, 8980-8981
Age at Diagnosis: less than 045
Grade: 1-3 or 9

Site/histologies are assigned to group 8A from group 8 based on grade, age at diagnosis

TNM M:
0,1, 88

8B. Thyroid: Papillary/follicular, age greater than or equal 045 but not 999
Sites:
C739
Histologies Requiring AJCC Staging:
8000-8015, 8022, 8033-8344, 8350-8420, 8440-8508,
8514-8576, 8940-8950, 8980-8981
Age at Diagnosis: greater than or equal to 045, but not equal 999
Grade: 1-3 or 9

Site/histologies are assigned to group 8B from group 8 based on grade, age at diagnosis

TNM M:
0,1, 88

8C. Thyroid: Papillary/follicular, age equal 999 (unknown)
Sites:
C739
Histologies Requiring AJCC Staging:
8000-8015, 8022, 8033-8344, 8350-8420, 8440-8508,
8514-8576, 8940-8950, 8980-8981
Age at Diagnosis: equal 999
Grade: 1-3 or 9

Site/histologies are assigned to group 8C from group 8 based on grade, age at diagnosis

TNM M:
0,1, 88

8D. Thyroid: Medullary
Sites:
C739
Histologies Requiring AJCC Staging:
8345-8347, 8430, 8510, 8512-8513
Grade: 1-3 or 9

TNM M:
0,1, 88

8E. Thyroid: Anaplastic
Sites:
C739
Histologies Requiring AJCC Staging:
8020-8021, 8030-8032
TNM M:
0,1

8F. Thyroid: Anaplastic
Sites:
C739
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
Grade: 4

Site/histologies are assigned to group 8F from group 8 and group 8D based on grade

TNM M:
0,1

9. Mucosal Melanoma of the Head and Neck

Sites:

C000-C006, C008-C009
C019
C020-C024, C028-C029
C030-C031, C039
C040-C041, C048-C049
C050-C052, C058-C059
C060-C062, C068-C069
C090-C091, C098-C099
C100-C104, C108-C109
C110-C113, C118-C119
C129, C130-C132
C138-C139
C140, C142, C148
C300
C310-C311
C320-C323, C328-C329
Histologies Requiring AJCC Staging:
8720-8790
TNM M:
0,1, 88

10. Esophagus and Esophagus Gastric Junction

10A. Esophagus
Sites:
C150-C155, C158-C159
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM M:
0,1

10B. Esophagus Gastric Junction
Sites:
C160-C162
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981
Discriminator (CS Site-Specific Factor25):
020, 040, 060 (for C161-C162)

Site/histologies are assigned to group 10B from group 11 based on site and site-specific factor 25 as well as table lookup

TNM M:
0,1

11. Stomach

Sites:
C161-C162 and Discriminator (CS Site-Specific Factor 25) =
000, 030, 999
C163-C166, C168-C169
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8990
TNM M:
0,1

12. Small Intestine

Sites:
C170-C172, C178-C179
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981
TNM M:
0,1

13. Appendix

13A. Appendix: Carcinoma
Sites:
C181
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981
TNM M:
0,1,1A,1B

13B. Appendix: Carcinoid
Sites:
C181
Histologies Requiring AJCC Staging:
8240-8242, 8246, 8249, 8153
TNM M:
0,1, 88

14. Colon and Rectum

Sites:
C180, C182-C189
C199
C209
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981
TNM M:
0,1,1A,1B

15. Anus

Sites:
C210-C212, C218
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8250-8576, 8940-8950, 8980-8981
TNM M:
0,1

16. Gatrointestinal Stromal Tumor (GIST)

16A. GIST: Gastric
Sites:
C160-C169
C480-C488 and CS Site-Specific Factor 10 = 020 (Omentum)

Histologies Requiring AJCC Staging:
8935-8936

Sites/histologies are assigned to group 16A from group 16B based on site-specific factor 10
as well as table lookup

TNM M:
0,1, 88

16B. GIST: Small Intestine
Sites:
C150-C159
C170-C172, C178, C179
C180-C189
C199
C209
C480-C488 and CS Site-Specific Factor 10 not = 020 (Omentum)
Histologies Requiring AJCC Staging:
8935-8936
TNM M:
0,1, 88

17. Neuroendocrine Tumors (NET)

17A. NET: Stomach
Sites:
C160-C169
Histologies Requiring AJCC Staging:
8153, 8240-8242, 8246, 8249
TNM M:
0,1

17B. NET: Small Intestine and Ampulla of Vater
Sites:
C170-C179
C241
Histologies Requiring AJCC Staging:
8153, 8240-8242, 8246, 8249
TNM M:
0,1, 88

17C. NET: Colon and Rectum
Sites:
C180, C182-C189
C199, C209
Histologies Requiring AJCC Staging:
8153, 8240-8242, 8246, 8249
TNM M:
0,1, 88

18. Liver
Sites:
C220

Histologies Requiring AJCC Staging:
8170-8175
TNM M:
0,1,88

19. Intrahepatic Bile Ducts
Sites:
C221
Histologies Requiring AJCC Staging:
8160, 8161, 8180
TNM M:
0,1

20. Gallbladder

Sites:
C239
C240 and Discriminator (CS Site-Specific Factor 25) = 030
Histologies Requiring AJCC Staging:
8000-8152,8154-8231, 8243-8245, 8250-8576, 8940-8950, 8980-8981

Sites/histologies are assigned to group 20 from group 21 based on site-specific factor 25
as well as table lookup

TNM M:
0,1

21. Perihilar Bile Ducts

Sites:
C240 and Discriminator (CS Site-Specific Factor 25) = 010, 020, 050, 060, 999
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8250-8576, 8940-8950, 8980-8981
TNM M:
0,1

22. Distal Bile Duct

Sites:
C240 and Discriminator (CS Site-Specific Factor 25) = 040, 070
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8250-8576, 8940-8950, 8980-8981

Sites/histologies are assigned to group 22 from group 21 based on site-specific factor 25
as well as table lookup

TNM M:
0,1

23. Ampulla of Vater

Sites:
C241
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8250-8576, 8940-8950, 8980-8981
TNM N:
TNM M:
0,1

24. Exocrine and Endocrine Pancreas

Sites:
C250-C254, C257-C259
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8971, 8980-8981
TNM M:
0,1

25. Lung

Sites:
C340-C343,C348,C349
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM M:
0,1,1A,1B

26. Pleural Mesothelioma

Sites:
C384
Histologies Requiring AJCC Staging:
9050-9053
TNM M:
0,1

27. Bone

Sites:
C400-C403, C408-C409
C410-C414, C418-C419
Histologies Permitting AJCC Staging:
8800-9136, 9142-9582
TNM M:
0,1,1A,1B

28. Soft Tissue Sarcoma

Peritoneum - not female
Sites:
C481-C482, C488
Histologies:

8800-8820, 8823-8934, 8940-9136, 9142-9582
Sex is 1, 3-5, 9 (not female)

Peritoneum - female
Sites:
C481-C482, C488
Histologies:
8800-8820, 8823-8921, 9120-9136, 9142-9582
Sex is 2, 6 (female)

Heart,Mediastinum, Soft Tissue
Sites:
C380-C383, C388
C470-C476, C478-C479
C490-C496, C498-C499
Histologies:
8800-8820, 8823-8935, 8940-9136, 9142-9582

Retroperitoneum
Sites:
C480
Histologies:
8800-8820, 8823-8934, 8940-9136, 9142-9582

Specific sites/histologies assigned to group 28 based on sex

TNM M:
0,1

NOTE: TNM M 88 allowed for Mesothelioma, 9050-9055

29. Cutaneous Squamous Cell Carcinoma and other Cutaneous Carcinomas

Sites:
C440, C442-C449, C632
Histologies Requiring AJCC Staging:
8000-8246, 8248-8576, 8940-8950, 8980-8981
TNM M:
0,1

30. Merkel Cell Carcinoma

Sites:
C440, C442-C449,
C510-C512, C518-C519
C600-C602, C608-C609
C632
Histologies Requiring AJCC Staging:
8247
TNM M:
0,1,1A,1B,1C

31. Melanoma of the Skin

Sites:
C440-C449

C510-C512,C518,C519
C600-C602, C608, C609
C632
Histologies Requiring AJCC Staging:
8720-8790
TNM M:
0,1A,1B,1C

32. Breast

Sites:
C500-C506,C508,C509
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981, 9020
TNM M:
Clin: 0,0I+,1
Path: 1

33. Vulva

Sites:
C510-C512,C518,C519
Histologies Requiring AJCC Staging:
8000-8246, 8248-8576, 8940-8950, 8980-8981
TNM M:
0,1

34. Vagina

Sites:
C529
Histologies Requiring AJCC Staging:
8000-8576, 8800-8801, 8940-8950, 8980-8981
TNM M:
0,1

35. Cervix Uteri

Sites:
C530,C531,C538,C539
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM M:
0,1

36. Corpus Uteri

36A. Corpus Uteri: Carcinomas
Sites
C540-C543, C548-C549
C559
Histologies Requiring AJCC Staging:
8000-8790, 8950-8951, 8980-8981

TNM M:
0,1

36B. Corpus Uteri: Leiomyosarcoma and Endometrial Stromal Sarcoma
Sites:
C540-C543, C548-C549
C559
Histologies Requiring AJCC Staging:
8800, 8890-8898, 8900-8921, 8930-8931, 8935
TNM M:
0,1, 88

36C. Corpus Uteri: Adenosarcoma
Sites:
C540-C543, C548-C549
C559
Histologies Requiring AJCC Staging:
8933
TNM M:
0,1, 88

37. Ovary and Peritoneal Carcinomas

37A. Ovary
Sites:
C569
Histologies Requiring AJCC Staging:
8000-8576, 8590-8671, 8930-9110
TNM M:
0,1, 88

37B. Peritoneal Carcinomas
Sites:
C481-C482, C488
Sex = 2,6 (female)
Histologies Requiring AJCC Staging:
8000-8576, 8590-8671, 8930-8934, 8940-9110

Sex code checked for assignment to group 37B

TNM M:
0,1

38. Fallopian Tube

Sites:
C570
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM M:
0,1

39. Gestational Trophoblastic Tumors

Sites:

C589
Histologies Requiring AJCC Staging:
9100-9105
TNM M:
0,1,1A,1B,88

40. Penis

Sites:
C600-C602,C608,C609
Histologies Requiring AJCC Staging:
8000-8246, 8248-8576, 8940-8950, 8980-8981
TNM M:
0,1

41. Prostate

Sites:
C619
Histologies Requiring AJCC Staging:
8000-8110, 8140-8576, 8940-8950, 8980-8981
TNM M:
0,1,1A,1B,1C, 88

42. Testis

Sites:
C620,C621,C629

Histologies Requiring AJCC Staging:
8000-8576, 8590-8670, 8940-8950, 8980-8981, 9060-9090, 9100-9105

TNM M:
0,1,1A,1B

43. Kidney

Sites:
C649
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM M:
0,1, 88

44. Renal Pelvis and Ureter

Sites:
C659
C669
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM M:
0,1

45. Urinary Bladder

Sites:
C670-C679
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM M:
0,1

46. Urethra

Sites:
C680
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM M:
0,1

47. Adrenal

47A. Adrenal Cortex
Sites:
C740
Histologies Requiring AJCC Staging:
8010, 8140, 8370
TNM M:
0,1, 88

47B. Adrenal Cortical Carcinoma
Sites:
C749
Histologies Requiring AJCC Staging:
8370
TNM M:
0,1, 88

48. Carcinoma of the Eyelid

Sites:
C441
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM M:
0,1

49. Conjunctiva

Sites:
C690
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM M:
0,1

50. Malignant Melanoma of the Conjunctiva

Sites:
C690
Histologies Requiring AJCC Staging:
8720-8790
TNM M:
0,1

51. Malignant Melanoma of Uvea

51A. Ciliary Body and Choroid
Sites:
C693
C694 (CS Site-Specific Factor 25 = 010)
Histologies Requiring AJCC Staging:
8720-8790

Sites/histologies are assigned to group 51A from group 51 based on site-specific factor 25

TNM M:
0,1,1A,1B,1C

51B. Iris
Sites:
C694 (CS Site-Specific Factor 25 = 020)
Histologies Requiring AJCC Staging:
8720-8790

Sites/histologies are assigned to group 51B from group 51 based on site-specific factor 25

TNM M:
0,1,1A,1B,1C

52. Retinoblastoma

Sites:
C692
Histologies Requiring AJCC Staging:
9510-9514
TNM M:
0,1,1A,1B,1C,1D,1E

53. Carcinoma of the Lacrimal Gland
Sites:
C695 and CS Site-Specific Factor25 = 015
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM M:

0,1,88

54. Sarcoma of the Orbit

Sites:
C696, C698
Histologies Requiring AJCC Staging:
8800-8936, 8940-9136, 9141-9508, 9520-9582
TNM M:
0,1, 88

55. Ocular Adnexal Lymphoma

Sites:
C441, C690, C695-C696
Histologies Requiring AJCC Staging:
9590-9699, 9702-9738, 9811-9818, 9820-9837
TNM M:
0,1A,1B,1C

56. Brain and Spinal Cord

Sites:
C700, C701, C709, C710-C719, C720-C729, C751-C753
Histologies Requiring AJCC Staging:
8000, 8680-9136,9141-9582

TNM M:
88

57. Lymphoid Neoplasms

57A. Hodgkin and Non-Hodgkin
Sites:
C000-C440, C442-C689, C691-C694, C698-C809
Histologies Requiring AJCC Staging:
9590-9699, 9702-9727, 9735, 9737-9738
Sites:
C000-C419, C422-C423, C425-C440, C442-C689, C691-C694, C698-C809
Histologies Requiring AJCC Staging:
9811-9818, 9823, 9827, 9837

Sites/histologies are assigned to group 57A based on combinations of site and histology

TNM M:
88

57B. Primary Cutaneous Lymphomas
Sites:
C440-C449
C510-C512, C518-C519
C600-C602, C608-C609, C632
Histologies Requiring AJCC Staging:

```
     9700,9701
TNM M:
      0,1

57C.  Lymphoid/Hematopoietic
Sites:
     C420, C421, C424
Histologies Requiring AJCC Staging:
     9811-9818, 9837
TNM M:
     88


All Others
TNM M:
     88
```

Administrative Notes

New edit - added to NAACCR v16 metafile.

Modifications

NAACCR v16A

- Corrected logic for first INLIST of primary sites for site/histology group 57A, 000-419-440 changed to 000-440
- Corrected Description and Edit Logic to include 9727 as lymphoma rather than lymphoma/hematopoietic code, to delete 9728-9729 as obsolete codes
- Added Group 57C, C420, C421, C424, 9811-9818, 9837, TNM M 88.

NAACCR V16B
- Corrected edit logic for assigning site/histology group 011 to group 10B or 999 based on histology and CS Site-Specific Factor 25

NAACCR v16D
- Description, logic updated to allow clinical and pathologic TNM M 88 for mesothelioma, 9050-9055, site/histo group 028
- Removed substring variable declarations from logic, not used
- Description, logic updated to allow clinical and pathologic TNM M 88 for C32.8 and C32.9, site/histo group 05B

Primary Site, Morphology-Imposs ICDO3 (SEER IF38)

Agency: SEER **Last changed: 02/12/2014**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]

Tables

IF38IM01.DBF

Default Error Message

[513] Impossible Site & Morph combination - ICDO3
Impossible Site & Morph combination - ICDO3

Description

```
This edit is skipped if Histologic Type ICD-O-3 is empty.

The site/histology combinations on the following list are considered to be
impossible:

C000-C709, C728-C750, C752, C754-C809
  9440, 9441, 9442 (glioblastomas)

C480-C488 (Retroperitoneum & peritoneum)
  8720-8790 (Melanomas)

C300 (Nasal cavity)
  9250-9342 (Osteosarcomas--Giant cell, Ewing's, odontogenic)

C301 (Middle ear)
  9250-9342 (Osteosarcomas--Giant cell, Ewing's, odontogenic)

C310-C319 (Accessary sinuses)
  9250-9342 (Osteosarcomas--Giant cell, Ewing's, odontogenic)

C381, C382, C384, C388 (Pleura and mediastinum)
  8010-8245,8247-8671,8940-8941 (Carcinomas)
  8720-8790 (Melanomas)

C383 (Mediastinum, NOS)
  8010-8231,8241-8245,8247-8671,8940-8941 (Carcinomas)
  8720-8790 (Melanomas)

C470-C479 (Peripheral nerves)
  8010-8671,8940-8941 (Carcinomas)
  8720-8790 (Melanomas)

C490-C499 (Connective tissue)
  8720-8790 (Melanomas)
```

C700-C709 (Meninges)
  8010-8671,8940-8941 (Carcinomas)

C710-C719 (Brain)
  8010-8060, 8071-8671,8940-8941 (Carcinomas)

C720-C729 (Other central nervous system)
  8010-8671,8940-8941 (Carcinomas)

C400-C419 (Bone)
  8010-8060,8075-8671,8940-8941 (Carcinomas, except squamous cell)
  8720-8790 (Melanomas)

C760-C768 (Ill-defined sites)
  8720-8790 (Melanomas)
  8800-8811,8813-8830,8840-8921,9040-9044 (Sarcomas, except
    periosteal fibrosarcoma, dermatofibrosarcoma)
  8990-8991 (Mesenchymoma)
  8940-8941 (Mixed tumor, salivary gland type)
  9120-9170 (Blood vessel tumor, lymphatic vessel tumor)
  9240-9252 (Mesenchymal chondrosarcoma,
    and giant cell tumors)
  9540-9560 (Nerve sheath tumor)
  9580-9582 (Granular cell tumor and alveolar soft part sarcoma)

Additional Information:

Combinations of site and type are designated as impossible by this edit because the combination is biologically impossible, i.e., the particular form of cancer does not arise in the specified site, or because standard cancer registry conventions have been established to code certain combinations in certain ways.

In reviewing these errors, it is important to understand the biology of the disease and the clinical picture and history of the individual case before deciding on a correct code. It will often be useful to check medical references or to discuss specific problem cases with the registry's medical advisors. The suggestions below are a starting point for analyzing an error, but are not a substitute for a medical decision.

Correction of these errors will usually require inspection of the abstracted text, either online or as recorded on a paper abstract. Reference to the original medical record may also be required.

GENERAL

First review the case for the following:

1. Is the histologic type correctly coded? If not, correct the histologic type code. Note that the code for "Cancer" and "Malignancy" (8000/3) is NOT interchangeable with the code for "Carcinoma, NOS" (8010/3), which refers only to a malignancy of epithelial origin.

2. Is the primary site coded correctly? Check whether the site coded as the primary site could be instead the site of metastatic spread or the site where a biopsy was performed. If so, check for a more appropriate primary site.

SPECIFIC GUIDELINES

(The numbered categories refer to rows in the table of impossible combinations presented under "Description" in the documentation.)

1. Retroperitoneum/Peritoneum and Melanomas: If melanoma is identified in peritoneal or retroperitoneal tissue, it is almost certainly metastatic to that site. Try to identify the primary site of the melanoma. If no primary can be determined, the standard convention in cancer registries is to code the primary site as skin, NOS, C44.9, which puts the case in the most likely site group for analysis. Most histologic type codes for melanomas in ICD-O-3 list skin, C44._, as the appropriate primary site.

2. Nasal Cavity/Middle Ear/Accessory Sinuses and Osteosarcomas: Osteosarcomas arise in bone, and the specified site code in ICD-O-3 is C40._ or C41._. Osteosarcomas arising in the areas of the nose, middle ear, and sinuses should be assumed to have arisen in the bones of the skull and their primary site coded C41.0.

3. Pleura/Mediastinum and Carcinomas or Melanomas: If a carcinoma or melanoma is identified in the pleura or mediastinum, it is almost certainly metastatic to that site. Try to identify the primary site of the carcinoma or melanoma. For a carcinoma, if no primary can be determined, code unknown primary site, C80.9. For a melanoma, if no primary can be determined, the standard convention in cancer registries is to code the primary site as skin, NOS, C44.9, which puts the case in the most likely site group for analysis. Most histologic type codes for melanomas in ICD-O-3 list skin, C44._, as the appropriate primary site.

4. Peripheral Nerves and Carcinomas or Melanomas: If a carcinoma or melanoma is identified in peripheral nerves, it is almost certainly metastatic to that site. Try to identify the primary site of the carcinoma or melanoma. For a carcinoma, if no primary can be determined, code unknown primary site, C80.9. For a melanoma, if no primary can be determined, the standard convention in cancer registries is to code the primary site as skin, NOS, C44.9, which puts the case in the most likely site group for analysis. Most histologic type codes for melanomas in ICD-O-3 list skin, C44._, as the appropriate primary site.

5. Connective Tissue and Melanomas: If a melanoma is identified in connective tissue, it is almost certainly metastatic to that site. Try to identify the primary site of melanoma. For a melanoma, if no primary can be determined, the standard convention in cancer registries is to code the primary site as skin, NOS, C44.9, which puts the case in the most likely site group for analysis. Most histologic type codes for melanomas in ICD-O-3 list skin, C44._, as the appropriate primary site.

6. Meninges/Brain/Other CNS and Carcinomas: If a carcinoma is identified in the brain, meninges, or other central nervous system, it is almost certainly metastatic to that site. Try to identify the primary site of the carcinoma. Check that the tumor is indeed a carcinoma and not "Cancer" or "Malignancy" which would be coded 8000/3. If it is a carcinoma and no primary can be determined, code "Unknown primary site", C80.9.

7. Bone and Carcinomas or Melanomas: If a carcinoma or melanoma is identified in the bone, it is almost certainly metastatic to that site. Try to identify the primary site of the carcinoma or melanoma. For a carcinoma, if no primary can be determined, code unknown primary site, C80.9. For a melanoma, if no primary can be determined, the standard convention in cancer registries is to code the primary site as skin, NOS, C44.9, which puts the case in the most likely site group for analysis. Most histologic type codes for melanomas in ICD-O-3 list skin, C44._, as the appropriate primary site.

8. Ill-defined Sites and Various Histologies: Some histologic types are by convention more appropriately coded to a code representing the tissue in which such

tumors arise rather than the ill-defined region of the body, which contains multiple tissues.

Administrative Notes

In the SEER*Edits software, the title of this edit is: IF38_3

Modifications:

NAACCR v11.3
6/2008
Updated Administrative Notes with the title of the corresponding edit in the SEER*Edits software.

NAACCR v13
Corrected descriptions of impossible histologies for C760-C768 (Ill-defined sites)

NAACCR v13A
Added impossible primary site/histology combination:
Primary Sites: C000-C709, C728-C750, C752, C754-C809
Histologies: 9440, 9441, 9442 (glioblastomas)

NAACCR v14A
- The following site/histology combinations are now allowable:
C383 8240
C710-C719 8070

Primary Site, Morphology-Type,Beh ICDO3(SEER IF25)

Agency: SEER **Last changed: 09/09/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
Over-ride Site/Type [Std# 2030]

Tables

IF25_3.DBF
IF25_REF.DBF

Default Error Message

[510] Site & Morphology conflict - ICDO3
Site & Morphology conflict - ICDO3

Description

This edit is skipped if Histologic Type ICD-O-3 is blank.

If the case has already been reviewed and accepted as coded (Over-ride Site/Type = 1) no further editing is done.

The SEER Site/Histology Validation List (see SEER web site) designates all histologies/behaviors that do not require review for each site. Any site/histology/behavior combination not in the Site/Histology Validation List will be accepted only if the case has been reviewed, accepted as coded, and Over-ride--Site/Type = 1. All other combinations will generate the message "Incompatible site and morphology". Since basal and squamous cell carcinomas of non-genital skin sites are not reportable to SEER, these site/histology combinations do not appear on the validation list.

The Site/Histology Validation List contains those histologies commonly found in the specified primary site. Histologies that occur only rarely or never may not be included. Review of these rare combinations often results in changes to the primary site and/or morphology, rather than a decision that the combination is correct. The over-ride flag should not be set to 1 if the primary site or histologic type are changed to a combination that will pass the edit. However, if upon review the site/type combination is found to be accurate and in conformance with coding rules, it may be left as coded and the Over-ride--Site/Type flag coded to 1.

Additional Information:

This edit forces review of atypical site-type combinations. Combinations not requiring review are presented, by primary site, in the "SEER Site/Histology Validation List". This edit does not imply that there are errors but rather that the combination of site and histology are so unusual that they should be checked to

ensure that they correctly reflect what is in the medical record. Resolution of discrepancies may require inspection of the abstracted text, either online or as recorded on a paper abstract. Review of the original medical record may be necessary.

Review of these cases requires investigating whether a) the combination is biologically implausible, or b) there are cancer registry coding conventions that would dictate different codes for the diagnosis. The following resources can be checked:

Current oncology and pathology textbooks
Current medical journal articles, e.g., via MEDLINE
Pathologist advisors to the registry

If upon review it is decided that the case is appropriately coded, set the Over-ride--Site/Type flag to 1 so that the case will not be flagged for review when the edit is run again.

Administrative Notes

This edit differs from Primary Site, Morphology-Type ICDO3 (SEER IF25)in that this edit includes behavior.

This edit differs from the COC edit of the same name in that the COC version allows basal and squamous cell carcinomas of non-genital skin sites. Since these cases are not reportable to SEER, these site/histology combinations do not appear on the SEER validation list and are flagged as errors in this edit.

MODIFICATIONS:

NAACCR v11.2
11/07
- Replaces old version Primary Site, Morphology-Type ICDO3 (SEER IF25.
- Updated to now edit site/histology/behavior instead of just site/histology.
- Updated to allow meningiomas (9530 - 9539) only for meninges sites (C70_). Please note that it allows meningiomas outside of the meninges if the case is reviewed and the over-ride flag is set.

NAACCR v11.3
6/08
- The description of the above modification (11/07) was corrected: "NAACCR v11.2A" changed to "NAACCR v11.2".

NAACCR v11.3A
10/08
- Histology 8461/3 is now valid for sites C480-C482, C488
- Histology 8144/3 is no longer valid for C15, C17, C18, C19, C20, and C21
- Histology 9582/0 is now valid for C751

NAACCR v12
- Correction: added C209 8143/3 to table of valid site/hist/behavior combinations. It had mistakenly been removed from NAACCR v11.3A.

NAACCR v12D
- Modified: if year of diagnosis is 2010 or higher AND Histologic Type ICD-O-3 = 9731 (solitary plasmacytoma of bone) AND Behavior ICD-O-3 = 3 (malignant), then Primary Site must = C400-C419 (bone).

NAACCR v12.1
- Modified: logic to allow solitary plasmacytoma of bone (9731/3) only for bone (C400-C41) if year of diagnosis is 2010+, was removed from this edit. A separate edit was created: Primary Site, Morphology, Date of DX (SEER)

NAACCR v13
Revised IF25_3.DBF (site/histology/behavior table):
1. allow 9823/3 for all sites
2. allow 8441/3 and 8460/3 for C540-C543, C548-C549, C559
3. delete miscellaneous duplicate table entries

NAACCR v15
Revised IF25_3.DBF (site/histology/behavior table):
- added:
C150-C159: 9680/3
C170-C179: 8152/3
C260-C269: 8152/3
C440-C449: 9751/3
C470-C479, C490-C499: 9726/3
C510-C519, C529
 - 9597, 9700, 9708, 9709, 9718, 9725, 9726
C530-C539: 8098/3
C600-C609, C632
 - 9597, 9700, 9701, 9708, 9709, 9718, 9725, 9726
C809 - 8152/3
C751 - 9582/0 (replaced hardcoded logic with table entry)

NAACCR v15A
Revised IF25_3.DBF (site/histology/behavior table):
- added:
C470-C476, C478-C479, C490-C496, C498-C499: 9930/3
C440-C449: 9837/3
C340-C349: 8083/3
- removed duplicate codes:
C420 9823/3
C421 9823/3
C424 9823/3

Primary Site, N 2016 - Ed 7 (COC-NPCR)

Agency: COC **Last changed: 02/06/2017**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
TNM Edition Number [Std# 1060]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
Age at Diagnosis [Std# 230]
CS Site-Specific Factor10 [Std# 2864]
CS Site-Specific Factor25 [Std# 2879]
Grade [Std# 440]
TNM Clin N [Std# 950]
TNM Path N [Std# 890]
Sex [Std# 220]
Type of Reporting Source [Std# 500]

Tables

AC7G2016.DBF
NP7NCL16.DBF
NP7NPA16.DBF

Default Error Message

[3285] TNM N code problem
TNM N code problem

Additional Messages

[3286] TNM Path N code is invalid for site/hist combination
[3287] TNM Clin N code is invalid for site/hist combination
[3288] TNM Clin N code should = "88" for site/hist combination
[3289] TNM Path N code should = "88" for site/hist combination

Description

```
TNM Clin N and TNM Path N may be blank.  If TNM Clin N is entered, it is edited by
the criteria below. If TNM Path N is entered, it is edited by the criteria below.


This edit is skipped if any of the following conditions are true:

1. Year of Date of Diagnosis is less than 2016, blank (unknown), or invalid
2. Type of Reporting Source = 7 (Death Certificate Only)
3. Histologic Type ICD-O-3 is blank
4. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
5. TNM Edition Number is not = 07 and not = 88
```

6. TNM Clin N and TNM Path N are both empty

The allowable values for

Clinical N: (blank), cX, c0, c0A, c0B, c1, c1A, c1B, c1C, c2, c2A, c2B, c2C, c3, c3A, c3B, c3C, c4, 88
Path N: (blank), pX, c0, p0, p0I-, p0I+, p0M-, p0M+, p1MI, p0A, p0B, p1, p1A, p1B, p1C, p2, p2A, p2B, p2C, p3, p3A, p3B, p3C, p4, 88

This edit checks the subset of values that are valid for each of the site/histology groups that have a TNM N defined and checks for '88' if the site/histology group does not have a TNM N defined.

The number next to each site group indicates the chapter in the AJCC Cancer Staging Manual, Edition 7. The sites for each chapter are listed along with the histologies for which N is defined. The edit will pass when the codes listed are entered in TNM Clin N with "c" prefix or in TNM Path N with "p" prefix; "cN0" will also pass when entered in TNM Path N, and where specified "88" will pass the edit without the prefix. Blanks will also pass the edit but are not specified. For those cases where there is a difference between the clinical and pathologic N codes, such as Merkel Cell, Melanoma of Skin, Breast, Melanoma Conjunctiva, the N codes are listed separately for the clin and path assessment.

For example:
TNM N:
Clin: X,0,1,2,2A,2B,3,3A,3B,3C
Path: X,0,0I-,0I+,0M-,0M+,1,1A,1B,1C,1MI,2,2A,2B,3,3A,3B,3C

Translates to allowable codes of:
Clin: (blank),cX,c0,c1,c2,c2A,c2B,c3,c3A,c3B,c3C
Path: (blank),pX,c0,p0, p0I-,p0I+,p0M-
,p0M+,p1,p1A,p1B,p1C,p1MI,p2,p2A,p2B,p3,p3A,p3B,p3C

The sites/histologies for each group are listed in the EditWriter table AC7G2016.DBF, except as noted below where special logic in this edit is used to assign or reassign sites/histologies to a specified group number.

This edit differs from the SEER edit of the same name in that it excludes N NOS categories that are not included in AJCC 7th Edition (Melanoma of Conjunctiva cN0).

3. Lip and Oral Cavity

Sites:
C000-C006,C008,C009
C020-C023,C028,C029
C030,C031,C039
C040,C041,C048,C049
C050,C058,C059
C060-C062,C068,C069
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM N:
X,0,1,2,2A,2B,2C,3

4. Pharynx

4A. Oropharynx and Hypopharynx

Sites:
C019, C024
C051-C052
C090-C091, C098-C099
C100, C102-C104, C108-C109
C129
C130-C132, C138-C139

Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM N:
X,0,1,2,2A,2B,2C,3

4B. Nasopharynx
Sites:
C110, C112-C113, C118-C119
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM N:
X,0,1,2,3,3A,3B

4C. Nasopharynx
Sites:
C111
Discriminator (CS Site-Specific Factor25):
010
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM N:
X,0,1,2,3,3A,3B

4D. Oropharynx - Pharyngeal Tonsil
Sites:
C111
Discriminator (CS Site-Specific Factor25):
020
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981

Sites/histologies are assigned to group 4D from 4C based on Site-Specific Factor 25

TNM N:
X,0,1,2,2A,2B,2C,3

5. Larynx

5A. Supraglottis, Subglottis, Other
Sites:
C101, C321-C322
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM N:
X,0,1,2,2A,2B,2C,3

5B. Glottis
Sites:
C320, C328-C329
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980, 8981

TNM N:
X,0,1,2,2A,2B,2C,3

NOTE: TNM N 88 allowed for C328-C329

6. Nasal Cavity and Paranasal Sinuses

Sites:
C300, C310-C311
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM N:
X,0,1,2,2A,2B,2C,3

7. Major Salivary Glands

Sites:
C079
C080,C081,C088,C089
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8982
TNM N:
X,0,1,2,2A,2B,2C,3, 88

8. Thyroid Gland

8A. Thyroid: Papillary/follicular, age less than 045
Sites:
C739
Histologies Requiring AJCC Staging:
8000-8015, 8022, 8033-8344, 8350-8420, 8440-8508,
8514-8576, 8940-8950, 8980-8981
Age at Diagnosis: less than 045
Grade: 1-3 or 9

Site/histologies are assigned to group 8A from group 8 based on grade, age at diagnosis

TNM N:
X,0,1,1A,1B, 88

8B. Thyroid: Papillary/follicular, age greater than or equal 045 but not 999
Sites:
C739
Histologies Requiring AJCC Staging:
8000-8015, 8022, 8033-8344, 8350-8420, 8440-8508,
8514-8576, 8940-8950, 8980-8981
Age at Diagnosis: greater than or equal to 045, but not equal 999
Grade: 1-3 or 9

Site/histologies are assigned to group 8B from group 8 based on grade, age at diagnosis

TNM N:
X,0,1,1A,1B, 88

8C. Thyroid: Papillary/follicular, age equal 999 (unknown)

Sites:
C739
Histologies Requiring AJCC Staging:
8000-8015, 8022, 8033-8344, 8350-8420, 8440-8508,
8514-8576, 8940-8950, 8980-8981
Age at Diagnosis: equal 999
Grade: 1-3 or 9

Site/histologies are assigned to group 8C from group 8 based on grade, age at diagnosis

TNM N:
X,0,1,1A,1B, 88

8D. Thyroid: Medullary
Sites:
C739
Histologies Requiring AJCC Staging:
8345-8347, 8430, 8510, 8512-8513
Grade: 1-3 or 9
TNM N:
X,0,1,1A,1B, 88

8E. Thyroid: Anaplastic
Sites:
C739
Histologies Requiring AJCC Staging:
8020-8021, 8030-8032
TNM N:
X,0,1,1A,1B

8F. Thyroid: Anaplastic
Sites:
C739
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
Grade: 4

Site/histologies are assigned to group 8F from group 8 and group 8D based on grade

TNM N:
X,0,1,1A,1B

9. Mucosal Melanoma of the Head and Neck

Sites:
C000-C006, C008-C009
C019
C020-C024, C028-C029
C030-C031, C039
C040-C041, C048-C049
C050-C052, C058-C059
C060-C062, C068-C069
C090-C091, C098-C099
C100-C104, C108-C109
C110-C113, C118-C119
C129, C130-C132
C138-C139
C140, C142, C148

C300
C310-C311
C320-C323, C328-C329
Histologies Requiring AJCC Staging:
8720-8790
TNM N:
X,0,1, 88

10. Esophagus and Esophagus Gastric Junction

10A. Esophagus
Sites:
C150-C155, C158-C159
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM N:
X,0,1,2,3

10B. Esophagus Gastric Junction
Sites:
C160-C162
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981
Discriminator (CS Site-Specific Factor25):
020, 040, 060 (for C161-C162)

Site/histologies are assigned to group 10B from group 11 based on site and site-specific factor 25
as well as table lookup

TNM N:
X,0,1,2,3

11. Stomach

Sites:
C161-C162 and Discriminator (CS Site-Specific Factor 25) =
000, 030, 999
C163-C166, C168-C169
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8990
TNM N:
X,0,1,2,3,3A,3B

12. Small Intestine

Sites:
C170-C172, C178-C179
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981
TNM N:
X,0,1,2

13. Appendix

13A. Appendix: Carcinoma
Sites:

C181
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981
TNM N:
X,0,1,2

13B. Appendix: Carcinoid
Sites:
C181
Histologies Requiring AJCC Staging:
8240-8242, 8246, 8249, 8153
TNM N:
X,0,1, 88

14. Colon and Rectum

Sites:
C180, C182-C189
C199
C209
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981
TNM N:
X,0,1,1A,1B,1C,2,2A,2B

15. Anus

Sites:
C210-C212, C218
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8250-8576, 8940-8950, 8980-8981
TNM N:
X,0,1,2,3

16. Gatrointestinal Stromal Tumor (GIST)

16A. GIST: Gastric
Sites:
C160-C169
C480-C488 and CS Site-Specific Factor 10 = 020 (Omentum)
Histologies Requiring AJCC Staging:
8935-8936

Sites/histologies are assigned to group 16A from group 16B based on site-specific factor 10
as well as table lookup

TNM N:
0,1, 88

16B. GIST: Small Intestine
Sites:
C150-C159
C170-C172, C178, C179
C180-C189
C199
C209

C480-C488 and CS Site-Specific Factor 10 not = 020 (Omentum)
Histologies Requiring AJCC Staging:
8935-8936
TNM N:
0,1, 88

17. Neuroendocrine Tumors (NET)

17A. NET: Stomach
Sites:
C160-C169
Histologies Requiring AJCC Staging:
8153, 8240-8242, 8246, 8249
TNM N:
X,0,1

17B. NET: Small Intestine and Ampulla of Vater
Sites:
C170-C179
C241
Histologies Requiring AJCC Staging:
8153, 8240-8242, 8246, 8249
TNM N:
X,0,1, 88

17C. NET: Colon and Rectum
Sites:
C180, C182-C189
C199, C209
Histologies Requiring AJCC Staging:
8153, 8240-8242, 8246, 8249
TNM N:
X,0,1, 88

18. Liver
Sites:
C220
Histologies Requiring AJCC Staging:
8170-8175
TNM N:
X,0,1,88

19. Intrahepatic Bile Ducts
Sites:
C221
Histologies Requiring AJCC Staging:
8160, 8161, 8180
TNM N:
X,0,1

20. Gallbladder

Sites:
C239
C240 and Discriminator (CS Site-Specific Factor 25) = 030
Histologies Requiring AJCC Staging:
8000-8152,8154-8231, 8243-8245, 8250-8576, 8940-8950, 8980-8981

Sites/histologies are assigned to group 20 from group 21 based on site-specific factor 25
as well as table lookup

TNM N:
X,0,1,2

21. Perihilar Bile Ducts

Sites:
C240 and Discriminator (CS Site-Specific Factor 25) = 010, 020, 050, 060, 999
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8250-8576, 8940-8950, 8980-8981
TNM N:
X,0,1,2

22. Distal Bile Duct

Sites:
C240 and Discriminator (CS Site-Specific Factor 25) = 040, 070
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8250-8576, 8940-8950, 8980-8981

Sites/histologies are assigned to group 22 from group 21 based on site-specific factor 25
as well as table lookup

TNM N:
X,0,1

23. Ampulla of Vater

Sites:
C241
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8250-8576, 8940-8950, 8980-8981
TNM N:
X,0,1

24. Exocrine and Endocrine Pancreas

Sites:
C250-C254, C257-C259
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8971, 8980-8981
TNM N:
X,0,1

25. Lung

Sites:
C340-C343,C348,C349
Histologies Requiring AJCC Staging:

8000-8576, 8940-8950, 8980-8981
TNM N:
X,0,1,2,3

26. Pleural Mesothelioma

Sites:
C384
Histologies Requiring AJCC Staging:
9050-9053
TNM N:
X,0,1,2,3

27. Bone

Sites:
C400-C403, C408-C409
C410-C414, C418-C419
Histologies Permitting AJCC Staging:
8800-9136, 9142-9582
TNM N:
X,0,1

28. Soft Tissue Sarcoma

Peritoneum - not female
Sites:
C481-C482, C488
Histologies:
8800-8820, 8823-8934, 8940-9136, 9142-9582
Sex = 1,3-5, 9 (not female)

Peritoneum - female
Sites:
C481-C482, C488
Histologies:
8800-8820, 8823-8921, 9120-9136, 9142-9582
Sex = 2, 6 (female)

Heart,Mediastinum, Soft Tissue
Sites:
C380-C383, C388
C470-C476, C478-C479
C490-C496, C498-C499
Histologies:
8800-8820, 8823-8935, 8940-9136, 9142-9582

Retroperitoneum
Sites:
C480
Histologies:
8800-8820, 8823-8934, 8940-9136, 9142-9582

Specific sites/histologies assigned to group 28 based on sex

TNM N:
X,0,1

NOTE: TNM N 88 allowed for Mesothelioma, 9050-9055

29. Cutaneous Squamous Cell Carcinoma and other Cutaneous Carcinomas

Sites:
C440, C442-C449, C632
Histologies Requiring AJCC Staging:
8000-8246, 8248-8576, 8940-8950, 8980-8981
TNM N:
X,0,1,2,2A,2B,2C,3

30. Merkel Cell Carcinoma

Sites:
C440, C442-C449,
C510-C512, C518-C519
C600-C602, C608-C609
C632
Histologies Requiring AJCC Staging:
8247
TNM N:
Clin: X,0,1,2
Path: X,0,1,1A,1B,2

31. Melanoma of the Skin

Sites:
C440-C449
C510-C512,C518,C519
C600-C602, C608, C609
C632
Histologies Requiring AJCC Staging:
8720-8790
TNM N:
Clin: X,0,1,1A,1B,2,2C,3
Path: X,0,1,1A,1B,2,2A,2B,2C,3

32. Breast

Sites:
C500-C506,C508,C509
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981, 9020
TNM N:
Clin: X,0,1,2,2A,2B,3,3A,3B,3C
Path: X,0,0I-,0I+,0M-,0M+,1,1A,1B,1C,1MI,2,2A,2B,3,3A,3B,3C

33. Vulva

Sites:
C510-C512,C518,C519
Histologies Requiring AJCC Staging:
8000-8246, 8248-8576, 8940-8950, 8980-8981
TNM N:
X,0,1,1A,1B,2,2A,2B,2C,3

34. Vagina

Sites:
C529
Histologies Requiring AJCC Staging:
8000-8576, 8800-8801, 8940-8950, 8980-8981
TNM N:
X,0,1

35. Cervix Uteri

Sites:
C530,C531,C538,C539
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM N:
X,0,1

36. Corpus Uteri

36A. Corpus Uteri: Carcinomas
Sites
C540-C543, C548-C549
C559
Histologies Requiring AJCC Staging:
8000-8790, 8950-8951, 8980-8981
TNM N:
X,0,1,2

36B. Corpus Uteri: Leiomyosarcoma and Endometrial Stromal Sarcoma
Sites:
C540-C543, C548-C549
C559
Histologies Requiring AJCC Staging:
8800, 8890-8898, 8900-8921, 8930-8931, 8935
TNM N:
X,0,1, 88

36C. Corpus Uteri: Adenosarcoma
Sites:
C540-C543, C548-C549
C559
Histologies Requiring AJCC Staging:
8933
TNM N:
X,0,1, 88

37. Ovary and Peritoneal Carcinomas

37A. Ovary
Sites:
C569
Histologies Requiring AJCC Staging:
8000-8576, 8590-8671, 8930-9110
TNM N:
X,0,1, 88

37B. Peritoneal Carcinomas
Sites:
C481-C482, C488
Sex = 2,6 (female)
Histologies Requiring AJCC Staging:
8000-8576, 8590-8671, 8930-8934, 8940-9110

Sex code checked for assignment to group 37B

TNM N:
X,0,1

38. Fallopian Tube

Sites:
C570
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM N:
X,0,1

39. Gestational Trophoblastic Tumors

Sites:
C589
Histologies Requiring AJCC Staging:
9100-9105
TNM N:
88

40. Penis

Sites:
C600-C602,C608,C609
Histologies Requiring AJCC Staging:
8000-8246, 8248-8576, 8940-8950, 8980-8981
TNM N:
X,0,1,2,3

41. Prostate

Sites:
C619
Histologies Requiring AJCC Staging:
8000-8110, 8140-8576, 8940-8950, 8980-8981
TNM N:
X,0,1, 88

42. Testis

Sites:
C620,C621,C629
Histologies Requiring AJCC Staging:
8000-8576, 8590-8670, 8940-8950, 8980-8981, 9060-9090, 9100-9105
TNM N:

X,0,1,2,3

43. Kidney

Sites:
C649
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM N:
X,0,1, 88

44. Renal Pelvis and Ureter

Sites:
C659
C669
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM N:
X,0,1,2,3

45. Urinary Bladder

Sites:
C670-C679
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM N:
X,0,1,2,3

46. Urethra

Sites:
C680
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM N:
X,0,1,2

47. Adrenal

47A. Adrenal Cortex
Sites:
C740
Histologies Requiring AJCC Staging:
8010, 8140, 8370
TNM N:
X,0,1, 88

47B. Adrenal Cortical Carcinoma
Sites:
C749
Histologies Requiring AJCC Staging:
8370
TNM N:

X,0,1, 88

48. Carcinoma of the Eyelid

Sites:
C441
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM N:
X,0,1

49. Conjunctiva

Sites:
C690
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM N:
X,0,1

50. Malignant Melanoma of the Conjunctiva

Sites:
C690
Histologies Requiring AJCC Staging:
8720-8790
TNM N:
Clin: X,0A,0B,1
Path: X,0,0A,0B,1

51. Malignant Melanoma of Uvea

51A. Ciliary Body and Choroid
Sites:
C693
C694 (CS Site-Specific Factor 25 = 010)
Histologies Requiring AJCC Staging:
8720-8790

Sites/histologies are assigned to group 51A from group 51 based on site-specific factor 25

TNM N:
X,0,1,88

51B. Iris
Sites:
C694 (CS Site-Specific Factor 25 = 020)
Histologies Requiring AJCC Staging:
8720-8790

Sites/histologies are assigned to group 51B from group 51 based on site-specific factor 25

TNM N:
X,0,1,88

52. Retinoblastoma

Sites:
C692
Histologies Requiring AJCC Staging:
9510-9514
TNM N:
X,0,1,2

53. Carcinoma of the Lacrimal Gland
Sites:
C695 and CS Site-Specific Factor25 = 015
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM N:
X,0,1,88

54. Sarcoma of the Orbit

Sites:
C696, C698
Histologies Requiring AJCC Staging:
8800-8936, 8940-9136, 9141-9508, 9520-9582
TNM N:
X,0,1, 88

55. Ocular Adnexal Lymphoma

Sites:
C441, C690, C695-C696
Histologies Requiring AJCC Staging:
9590-9699, 9702-9738, 9811-9818, 9820-9837
TNM N:
X,0,1,2,3,4

56. Brain and Spinal Cord

Sites:
C700, C701, C709, C710-C719, C720-C729, C751-C753
Histologies Requiring AJCC Staging:
8000, 8680-9136,9141-9582

TNM N:
88

57. Lymphoid Neoplasms

57A. Hodgkin and Non-Hodgkin
Sites:
C000-C440, C442-C689, C691-C694, C698-C809
Histologies Requiring AJCC Staging:
9590-9699, 9702-9727, 9735, 9737-9738

```
Sites:
     C000-C419, C422-C423, C425-C440, C442-C689, C691-C694, C698-C809
Histologies Requiring AJCC Staging:
     9811-9818, 9823, 9827, 9837

Sites/histologies are assigned to group 57A based on combinations of site and
histology

TNM N:
     88

57B. Primary Cutaneous Lymphomas
Sites:
     C440-C449
     C510-C512, C518-C519
     C600-C602, C608-C609, C632
Histologies Requiring AJCC Staging:
     9700,9701
TNM N:
     X,0,1,1A,1B,2,2A,2B,3,88

57C.  Lymphoid/Hematopoietic
Sites:
     C420, C421, C424
Histologies Requiring AJCC Staging:
     9811-9818, 9837
TNM N:
     88

All Others
TNM N:
     88
```

Administrative Notes

New edit - added to NAACCR v16 metafile.

Modifications

NAACCR v16A

- Corrected logic for first INLIST of primary sites for site/histology group 57A, 000-419-440 changed to 000-440
- Updated description to indicate 0A and 0B allowable values for TNM Pathologic N for site/histology group 050, Melanoma of Conjunctiva. Table referenced by logic updated to include these codes.
- Corrected Description and Edit Logic to include 9727 as lymphoma rather than lymphoma/hematopoietic code, to delete 9728-9729 as obsolete codes
- Added Group 57C, C420, C421, C424, 9811-9818, 9837, TNM N 88.

NAACCR v16B
- Corrected edit logic for assigning site/histology group 011 to group 10B or 999 based on histology and CS Site-Specific Factor 25

NAACCR v16D
- Description, logic updated to allow clinical and pathologic TNM N 88 for mesothelioma, 9050-9055, site/histo group 028
- Removed substring variable declarations from logic, not used

- Description, logic updated to allow clinical and pathologic TNM M 88 for C32.8 and C32.9, site/histo group 05B

Primary Site, Stage Group 2016 - Ed 7 (NPCR)

Agency: NPCR **Last changed: 02/06/2017**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
TNM Edition Number [Std# 1060]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
CS Site-Specific Factor10 [Std# 2864]
CS Site-Specific Factor25 [Std# 2879]
Over-ride Site/TNM-StgGrp [Std# 1989]
Age at Diagnosis [Std# 230]
Grade [Std# 440]
Sex [Std# 220]
TNM Clin Stage Group [Std# 970]
TNM Path Stage Group [Std# 910]
Type of Reporting Source [Std# 500]

Tables

AC7G2016.DBF
CC7C2016.DBF
CC7P2016.DBF

Additional Messages

[3040] TNM Path Stage Group is invalid for site/hist combination
[3041] TNM Clin Stage Group is invalid for site/hist combination
[3148] TNM Clin Stage Group should = "88" for site/hist combination
[3149] TNM Path Stage Group should = "88" for site/hist combination
[3160] Over-ride applies only to pediatric cases (ages less than 25)
[3161] TNM Edition No/Stage groups must be coded 88 if over-ride set for pediatric case
[3161] TNM Edition No/Stage groups must be coded 88 if over-ride set for pediatric case
[6060] If Type of Reporting Source = "value of Type of Reporting Source", if TNM Clin Stage Group or TNM Path Stage Group is coded 88, both should be coded 88

Description

```
This edit checks that the TNM Clin Stage Group is valid for the site/histology.
This edit checks that the TNM Path Stage Group is valid for the site/histology.

This edit is skipped if any of the following conditions are true:

1. Year of Date of Diagnosis is less than 2016, blank (unknown), or invalid
2. Histologic Type ICD-O-3 is blank
3. TNM Edition Number not = 07, 88
4. TNM Clin Stage Group and TNM Path Stage Group are blank
```

Pediatric cases not staged according to AJCC are skipped and are identified in this edit by TNM Edition Number = 88, AJCC Clin Stage Group = 88 or blank, AJCC Path Stage Group = 88 or blank, and Over-ride Site/TNM-Stgrp = 1 if the patient is under 25 years old. It is assumed by the edit that patients age 25 or older will never be staged by a pediatric system, but most use of pediatric staging will be for patients under 19 years or so. Starting with cases diagnosed 2016 and later blanks are not allowed unless Type of Reporting Source is 6 or 7

The site-specific Stage Group values are listed below.The number next to each site group indicates the chapter in the AJCC Cancer Staging Manual, Edition 7. The sites for each chapter are listed along with the histologies requiring AJCC staging. The allowable values for the clinical and pathologic stage groups are listed under Stage Group. When there is a difference in allowable values for clinical and pathologic stage group, they will be specified separately.

The edit also passes if both Stage Group fields are coded 88 when Type of Reporting Source = 6 or 7. The edit fails if one Stage Group field is coded 88 but the other is not when Type of Reporting Source = 6 or 7.

For sites/histologies not included in the list below, TNM Path Stage Group and TNM Clin Stage Group should be coded to 88.

The sites/histologies for each group are listed in the EditWriter table AC7G2016.DBF, except as noted below where special logic in this edit is used to assign or reassign sites/histologies to a specified group number.

This edit differs from the SEER edit with the same name in requiring both TNM Clin Stage Group and TNM Path Stage Group to be coded 88 if one is coded 88, for Type of Reporting Source = 6 (autopsy only) or 7 (death certificate only). The edit does not require stage group fields to equal 88 if Type of Reporting Source = 7, as required by a separate SEER edit. Except for Autopsy Only and Death Certificate Only case, the edit does not allow Stage Group codes for stageable site/histology groups not specifically listed in the AJCC 7th Edition.

3. Lip and Oral Cavity

Sites:
C000-C006, C008-C009
C020-C023, C028-C029
C030-C031, C039
C040-C041, C048-C049
C050,C058-C059
C060-C062, C068-C069
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
Stage Group:
0, 1, 2, 3, 4A, 4B, 4C, 99

4. Pharynx

4A. Oropharynx and Hypopharynx
Sites:
C019, C024
C051-C052
C090-C091, C098-C099
C100, C102-C104, C108-C109
C129
C130-C132, C138-C139

Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
Stage Group:
0, 1, 2, 3, 4A, 4B, 4C, 99

4B. Nasopharynx
Sites:
C110, C112-C113, C118-C119
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
Stage Group:
0, 1, 2, 3, 4A, 4B, 4C, 99

4C. Nasopharynx
Sites:
C111
Discriminator (CS Site-Specific Factor25):
010
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
Stage Group:
0, 1, 2, 3, 4A, 4B, 4C, 99

4D. Oropharynx - Pharyngeal Tonsil
Sites:
C111
Discriminator (CS Site-Specific Factor25):
020
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981

Sites/histologies are assigned to group 4D from 4C based on Site-Specific Factor 25

Stage Group:
0, 1, 2, 3, 4A, 4B, 4C, 99

5. Larynx

5A. Supraglottis, Subglottis, Other
Sites:
C101, C321-C322
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
Stage Group:
0, 1, 2, 3, 4A, 4B, 4C, 99

5B. Glottis
Sites:
C320, C328-C329
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980, 8981
Stage Group:
0, 1, 2, 3, 4A, 4B, 4C, 99

NOTE: TNM Stage Group 88 allowed for C328-C329

6. Nasal Cavity and Paranasal Sinuses

Sites:
C300, C310-C311
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
Stage Group:
0, 1, 2, 3, 4A, 4B, 4C, 99

7. Major Salivary Glands

Sites:
C079
C080-C081, C088-C089
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8982
Stage Group:
1, 2, 3, 4A, 4B, 4C, 99, 88

8. Thyroid Gland

8A. Thyroid: Papillary/follicular, age less than 045
Sites:
C739
Histologies Requiring AJCC Staging:
8000-8015, 8022, 8033-8344, 8350-8420, 8440-8508,
8514-8576, 8940-8950, 8980-8981
Age at Diagnosis: less than 045
Grade: 1-3 or 9

Site/histologies are assigned to group 8A from group 8 based on grade, age at diagnosis

Stage Group:
1, 2, 99, 88

8B. Thyroid: Papillary/follicular, age greater than or equal 045 but not 999
Sites:
C739
Histologies Requiring AJCC Staging:
8000-8015, 8022, 8033-8344, 8350-8420, 8440-8508,
8514-8576, 8940-8950, 8980-8981
Age at Diagnosis: greater than or equal to 045, but not equal 999
Grade: 1-3 or 9

Site/histologies are assigned to group 8B from group 8 based on grade, age at diagnosis

Stage Group:
1, 2, 3, 4A, 4B, 4C, 99, 88

8C. Thyroid: Papillary/follicular, age equal 999 (unknown)
Sites:
C739
Histologies Requiring AJCC Staging:
8000-8015, 8022, 8033-8344, 8350-8420, 8440-8508,
8514-8576, 8940-8950, 8980-8981
Age at Diagnosis: equal 999

Grade: 1-3 or 9

Site/histologies are assigned to group 8C from group 8 based on grade, age at diagnosis

Stage Group:
99, 88

8D. Thyroid: Medullary
Sites:
C739
Histologies Requiring AJCC Staging:
8345-8347, 8430, 8510, 8512-8513
Grade: 1-3 or 9

Stage Group:
1, 2, 3, 4A, 4B, 4C, 99, 88

8E. Thyroid: Anaplastic
Sites:
C739
Histologies Requiring AJCC Staging:
8020-8021, 8030-8032
Stage Group:
Clin: 1, 2, 3, 4A, 4B, 4C, 99
Path: 4A, 4B, 4C

8F. Thyroid: Anaplastic
Sites:
C739
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
Grade: 4

Site/histologies are assigned to group 8F from group 8 and group 8D based on grade

Stage Group:
Clin: 1, 2, 3, 4A, 4B, 4C, 99
Path: 4A, 4B, 4C, 99

9. Mucosal Melanoma of the Head and Neck

Sites:
C000-C006, C008-C009
C019
C020-C024, C028-C029
C030-C031, C039
C040-C041, C048-C049
C050-C052, C058-C059
C060-C062, C068-C069
C090-C091, C098-C099
C100-C104, C108-C109
C110-C113, C118-C119
C129,C130-C132
C138-C139
C140, C142, C148
C300
C310-C311

C320-C323, C328-C329
Histologies Requiring AJCC Staging:
8720-8790
Stage Group:
3, 4A, 4B, 4C, 99, 88

10. Esophagus and Esophagus Gastric Junction

10A. Esophagus
Sites:
C150-C155, C158-C159
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
Stage Group:
0, 1A, 1B, 2A, 2B, 3A, 3B, 3C, 4, 99

10B. Esophagus Gastric Junction
Sites:
C160-C162
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981
Discriminator (CS Site-Specific Factor25):
020, 040, 060 (for C161-C162)

Site/histologies are assigned to group 10B from group 11 based on site and site-specific factor 25 as well as table lookup

Stage Group:
0, 1A, 1B, 2A, 2B, 3A, 3B, 3C, 4, 99

11. Stomach

Sites:
C161-C162 and Discriminator (CS Site-Specific Factor 25) =
000, 030,999
C163-C166, C168-C169
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8990
Stage Group:
0, 1A, 1B, 2A, 2B, 3A, 3B, 3C, 4,99

12. Small Intestine

Sites:
C170-C172, C178-C179
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981
Stage Group:
0, 1, 2A, 2B, 3A, 3B, 4, 99

13. Appendix

13A. Appendix: Carcinoma
Sites:
C181
Histologies Requiring AJCC Staging:

8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981
Stage Group:
0, 1, 2A, 2B, 2C, 3A, 3B, 3C, 4A, 4B, 4C, 99

13B. Appendix: Carcinoid
Sites:
C181
Histologies Requiring AJCC Staging:
8240-8242, 8246, 8249, 8153
Stage Group:
1, 2, 3, 4, 99, 88

14. Colon and Rectum

Sites:
C180, C182-C189
C199
C209
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981
Stage Group:
0, 1, 2A, 2B, 2C, 3A, 3B, 3C, 4A, 4B, 99

15. Anus

Sites:
C210-C212, C218
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8250-8576, 8940-8950, 8980-8981
Stage Group:
0, 1, 2, 3A, 3B, 4, 99

16. Gastrointestinal Stromal Tumor (GIST)

16A. GIST: Gastric
Sites:
C160-C169
C480-C488 and CS Site-Specific Factor 10 = 020 (Omentum)
Histologies Requiring AJCC Staging:
8935-8936

Sites/histologies are assigned to group 16A from group 16B based on site-specific factor 10
as well as table lookup

Stage Group:
1A, 1B, 2, 3A, 3B, 4, 99, 88

16B. GIST: Small Intestine
Sites:
C150-C159
C170-C172, C178, C179
C180-C189
C199
C209
C480-C488 and CS Site-Specific Factor 10 not = 020 (Omentum)
Histologies Requiring AJCC Staging:

8935-8936
Stage Group:
1, 2, 3A, 3B, 4, 99, 88

17. Neuroendocrine Tumors (NET)

17A. NET: Stomach
Sites:
C160-C169
Histologies Requiring AJCC Staging:
8153, 8240-8242, 8246, 8249
Stage Group:
0, 1, 2A, 2B, 3A, 3B, 4, 99

17B. NET: Small Intestine and Ampulla of Vater
Sites:
C170-C179
C241
Histologies Requiring AJCC Staging:
8153, 8240-8242, 8246, 8249
Stage Group:
1, 2A, 2B, 3A, 3B, 4, 99, 88

17C. NET: Colon and Rectum
Sites:
C180, C182-C189
C199, C209
Histologies Requiring AJCC Staging:
8153, 8240-8242, 8246, 8249
Stage Group:
1, 2A, 2B, 3A, 3B, 4, 99, 88

18. Liver
Sites:
C220
Histologies Requiring AJCC Staging:
8170-8175
Stage Group:
1, 2, 3A, 3B, 3C, 4A, 4B, 99, 88

19. Intrahepatic Bile Ducts
Sites:
C221
Histologies Requiring AJCC Staging:
8160, 8161, 8180
Stage Group:
0, 1, 2, 3, 4A, 4B, 99

20. Gallbladder

Sites:
C239
C240 and Discriminator (CS Site-Specific Factor 25) = 030
Histologies Requiring AJCC Staging:
8000-8152,8154-8231, 8243-8245, 8250-8576, 8940-8950, 8980-8981

Sites/histologies are assigned to group 20 from group 21 based on site-specific factor 25
as well as table lookup

Stage Group:
0, 1, 2, 3A, 3B, 4A, 4B, 99

21. Perihilar Bile Ducts

Sites:
C240 and Discriminator (CS Site-Specific Factor 25) = 010, 020, 050, 060, 999
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8250-8576, 8940-8950, 8980-8981
Stage Group:
0, 1, 2, 3A, 3B, 4A, 4B, 99

22. Distal Bile Duct

Sites:
C240 and Discriminator (CS Site-Specific Factor 25) = 040, 070
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8250-8576, 8940-8950, 8980-8981

Sites/histologies are assigned to group 22 from group 21 based on site-specific factor 25
as well as table lookup

Stage Group:
0, 1A, 1B, 2A, 2B, 3, 4, 99

23. Ampulla of Vater

Sites:
C241
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8250-8576, 8940-8950, 8980-8981
Stage Group:
0, 1A, 1B, 2A, 2B, 3, 4, 99

24. Exocrine and Endocrine Pancreas

Sites:
C250-C254, C257-C259
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8971, 8980-8981
Stage Group:
0, 1A, 1B, 2A, 2B, 3, 4, 99

25. Lung

Sites:
C340-C343, C348-C349
Histologies Requiring AJCC Staging:

8000-8576, 8940-8950, 8980-8981
Stage Group:
OC, 0, 1A, 1B, 2A, 2B, 3A, 3B, 4, 99

26. Pleural Mesothelioma

Sites:
C384
Histologies Requiring AJCC Staging:
9050-9053
Stage Group:
1, 1A, 1B, 2, 3, 4, 99

27. Bone

Sites:
C400-C403, C408-C409
C410-C414, C418-C419
Histologies Permitting AJCC Staging:
8800-9136, 9142-9582
Stage Group:
1A, 1B, 2A, 2B, 3, 4A, 4B, 99

28. Soft Tissue Sarcoma

Peritoneum - not female
Sites:
C481-C482, C488
Histologies:
8800-8820, 8823-8934, 8940-9136, 9142-9582
Sex = 1, 3-5, 9 (not female)

Peritoneum - female
Sites:
C481-C482, C488
Histologies:
8800-8820, 8823-8921, 9120-9136, 9142-9582
Sex = 2, 6 (female)

Heart,Mediastinum, Soft Tissue
Sites:
C380-C383, C388
C470-C476, C478-C479
C490-C496, C498-C499
Histologies:
8800-8820, 8823-8935, 8940-9136, 9142-9582

Retroperitoneum
Sites:
C480
Histologies:
8800-8820, 8823-8934, 8940-9136, 9142-9582

Specific sites/histologies assigned to group 28 based on sex

Stage Group:
1A, 1B, 2A, 2B, 3, 4, 99

NOTE: Stage Group 88 allowed for Mesothelioma, 9050-9055

29. Cutaneous Squamous Cell Carcinoma and other Cutaneous Carcinomas

Sites:
C440, C442-C449, C632
Histologies Requiring AJCC Staging:
8000-8246, 8248-8576, 8940-8950, 8980-8981
Stage Group:
0, 1, 2, 3, 4, 99

30. Merkel Cell Carcinoma

Sites:
C440, C442-C449,
C510-C512, C518-C519
C600-C602, C608-C609
C632
Histologies Requiring AJCC Staging:
8247
Stage Group:
Clin: 0, 1B, 2B, 2C, 3, 3B, 4, 99
Path: 0, 1A, 1B, 2A, 2B, 2C, 3A, 3B, 4, 99

31. Melanoma of the Skin

Sites:
C440-C449
C510-C512, C518-C519
C600-C602, C608-C609
C632
Histologies Requiring AJCC Staging:
8720-8790
Stage Group:
Clin: 0, 1A, 1B, 2A, 2B, 2C, 3, 4, 99
Path: 0, 1A, 1B, 2A, 2B, 2C, 3A, 3B, 3C, 4, 99

32. Breast

Sites:
C500-C506, C508-C509
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981, 9020
Stage Group:
0, 1A, 1B, 2A, 2B, 3A, 3B, 3C, 4, 99

33. Vulva

Sites:
C510-C512, C518-C519
Histologies Requiring AJCC Staging:
8000-8246, 8248-8576, 8940-8950, 8980-8981
Stage Group:
0, 1, 1A, 1B, 2, 3A, 3B, 3C, 4A, 4B, 99

34. Vagina

Sites:
C529
Histologies Requiring AJCC Staging:
8000-8576, 8800-8801, 8940-8950, 8980-8981
Stage Group:
0, 1, 2, 3, 4A, 4B, 99

35. Cervix Uteri

Sites:
C530-C531, C538-C539
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
Stage Group:
0, 1, 1A, 1A1, 1A2, 1B, 1B1, 1B2, 2, 2A, 2A1, 2A2, 2B, 3, 3A, 3B, 4A, 4B, 99

36. Corpus Uteri

36A. Corpus Uteri: Carcinomas
Sites
C540-C543, C548-C549
C559

Histologies Requiring AJCC Staging:
8000-8790, 8950-8951, 8980-8981
Stage Group:
0, 1, 1A, 1B, 2, 3, 3A, 3B, 3C, 3C1, 3C2, 4A, 4B, 99

36B. Corpus Uteri: Leiomyosarcoma and Endometrial Stromal Sarcoma
Sites:
C540-C543, C548-C549
C559
Histologies Requiring AJCC Staging:
8800, 8890-8898, 8900-8921, 8930-8931, 8935
Stage Group:
1, 1A, 1B, 2, 3A, 3B, 3C, 4A, 4B, 99, 88

36C. Corpus Uteri: Adenosarcoma
Sites:
C540-C543, C548-C549
C559
Histologies Requiring AJCC Staging:
8933
Stage Group:
1, 1A, 1B, 1C, 2, 3A, 3B, 3C, 4A, 4B, 99, 88

37. Ovary and Peritoneal Carcinomas

37A. Ovary
Sites:
C569
Histologies Requiring AJCC Staging:

8000-8576, 8590-8671, 8930-9110
Stage Group:
1, 1A, 1B, 1C, 2, 2A, 2B, 2C, 3, 3A, 3B, 3C, 4, 99, 88

37B. Peritoneal Carcinomas
Sites:
C481-C482, C488
Sex = 2,6 (female)
Histologies Requiring AJCC Staging:
8000-8576, 8590-8671, 8930-8934, 8940-9110

Sex code checked for assignment to group 37B

Stage Group:
3, 3A, 3B, 3C, 4, 99

38. Fallopian Tube

Sites:
C570
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
Stage Group:
0, 1, 1A, 1B, 1C, 2, 2A, 2B, 2C, 3, 3A, 3B, 3C, 4, 99

39. Gestational Trophoblastic Tumors

Sites:
C589
Histologies Requiring AJCC Staging:
9100-9105
Stage Group:
1, 1A, 1B, 2, 2A, 2B, 3, 3A, 3B, 4, 4A, 4B, 99

40. Penis

Sites:
C600-C602, C608-C609
Histologies Requiring AJCC Staging:
8000-8246, 8248-8576, 8940-8950, 8980-8981
Stage Group:
0, 1, 2, 3A, 3B, 4, 99

41. Prostate

Sites:
C619
Histologies Requiring AJCC Staging:
8000-8110, 8140-8576, 8940-8950, 8980-8981
Stage Group:
1, 2A, 2B, 3, 4, 99, 88

42. Testis

Sites:

C620-C621, C629
Histologies Requiring AJCC Staging:
8000-8576, 8590-8670, 8940-8950, 8980-8981, 9060-9090, 9100-9105
Stage Group:
0, 1, 1A, 1B, 1S, 2, 2A, 2B, 2C, 3, 3A, 3B, 3C, 99

43. Kidney

Sites:
C649
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
Stage Group:
1, 2, 3, 4, 99, 88

44. Renal Pelvis and Ureter

Sites:
C659
C669
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
Stage Group:
0IS, 0A, 1, 2, 3, 4, 99

45. Urinary Bladder

Sites:
C670-C679
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
Stage Group:
0IS, 0A, 1, 2, 3, 4, 99

46. Urethra

Sites:
C680
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
Stage Group:
0IS, 0A, 1, 2, 3, 4, 99

47. Adrenal

47A. Adrenal Cortex
Sites:
C740
Histologies Requiring AJCC Staging:
8010, 8140, 8370
Stage Group:
1, 2, 3, 4, 99, 88

47B. Adrenal Cortical Carcinoma
Sites:

C749
Histologies Requiring AJCC Staging:
8370
Stage Group:
1, 2, 3, 4, 99, 88

48. Carcinoma of the Eyelid

Sites:
C441
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
Stage Group:
0, 1A, 1B, 1C, 2, 3A, 3B, 3C, 4, 99

49. Conjunctiva

Sites:
C690
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
Stage Group:
88

50. Malignant Melanoma of the Conjunctiva

Sites:
C690
Histologies Requiring AJCC Staging:
8720-8790
Stage Group:
88

51. Malignant Melanoma of Uvea

51A. Ciliary Body and Choroid
Sites:
C693
C694 (CS Site-Specific Factor 25 = 010)
Histologies Requiring AJCC Staging:
8720-8790

Sites/histologies are assigned to group 51A from group 51 based on site-specific factor 25

Stage Group:
1, 2A, 2B, 3A, 3B, 3C, 4, 99.88

51B. Iris
Sites:
C694 (CS Site-Specific Factor 25 = 020)
Histologies Requiring AJCC Staging:
8720-8790

Sites/histologies are assigned to group 51B from group 51 based on site-specific factor 25

Stage Group:
1, 2A, 2B, 3A, 3B, 3C, 4, 99,88

52. Retinoblastoma

Sites:
C692
Histologies Requiring AJCC Staging:
9510-9514
Stage Group:
88

53. Carcinoma of the Lacrimal Gland
Sites:
C695 and CS Site-Specific Factor25 = 015
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
Stage Group:
88

54. Sarcoma of the Orbit

Sites:
C696, C698
Histologies Requiring AJCC Staging:
8800-8936, 8940-9136, 9141-9508, 9520-9582
Stage Group:
88

55. Ocular Adnexal Lymphoma

Sites:
C441, C690, C695-C696
Histologies Requiring AJCC Staging:
9590-9699, 9702-9738, 9811-9818, 9820-9837
Stage Group:
88

56. Brain and Spinal Cord

Sites:
C700-C701, C709, C710-C719, C720-C729, C751-C753
Histologies Requiring AJCC Staging:
8000, 8680-9136, 9141-9582
Stage Group:
88

57. Lymphoid Neoplasms

57A. Hodgkin and Non-Hodgkin
Sites:
C000-C440, C442-C689, C691-C694, C698-C809
Histologies Requiring AJCC Staging:

```
     9590-9699, 9702-9727, 9735, 9737-9738

Sites/histologies are assigned to group 57A based on combinations of site and
histology

Stage Group:
     1, 1A, 1B, 2, 2A, 2B, 3, 3A, 3B, 4, 4A, 4B, 99

Sites:
     C000-C419, C422-C423, C425-C440, C442-C689, C691-C694, C698-C809
Histologies Requiring AJCC Staging:
     9811-9818, 9823, 9827, 9837
Stage Group:
     1, 1A, 1B, 2, 2A, 2B, 3, 3A, 3B, 4, 4A, 4B, 99


57B. Primary Cutaneous Lymphomas
Sites:
     C440-C449
     C510-C512, C518-C519
     C600-C602, C608-C609, C632
Histologies Requiring AJCC Staging:
     9700,9701
Stage Group:
     1A, 1B, 2A, 2B, 3, 3A, 3B, 4A1, 4A2, 4B, 99,88

57C.  Lymphoid/Hematopoietic
Sites:
     C000-C440, C442-C689, C691-C694, C698-C809
Histologies Requiring AJCC Staging:
     9811-9818, 9837
TNM M:
     88

57C.  Lymphoid/Hematopoietic
Sites:
     C420, C421, C424
Histologies Requiring AJCC Staging:
     9811-9818, 9837
Stage Group:
     4, 4A, 4B, 88, 99


All Others
Stage Group:
     88
```

Administrative Notes

New edit - added to NAACCR v16 metafile.

Modifications

NAACCR v16A

- Corrected logic for first INLIST of primary sites for site/histology group 57A, 000-419-440 changed to 000-440
- Error message corrected, field out of order for 6060

- Corrected Description and Edit Logic to include 9727 as lymphoma rather than lymphoma/leukemia code, to delete 9728-9729 as obsolete codes
- Added Group 57C, C420, C421, C424, 9811-9818, 9837, Stage groups 4,4A,4B,99,88. Groups 57A and 57C differ from definitions of these groups in pre-2016 edits in only allowing these stage group values for these site/histologies. Pre-2016 edits allowed all lymphoma stage group values for these sites/histologies.

NAACCR v16B
- Corrected edit logic for assigning site/histology group 011 to group 10B or 999 based on histology and CS Site-Specific Factor 25

NAACCR v16D
- 99 added to description as valid pathologic stage group for site/histology groups 8E and 8F, anaplastic carcinoma of thyroid, lookup table also updated
- Description, logic updated to allow clinical and pathologic stage group 88 for mesothelioma, 9050-9055, site/histo group 028
- Description, logic updated to allow clinical and pathologic TNM M 88 for C32.8 and C32.9, site/histo group 05B
- Error message updated to specify TNM Edition No/Stage groups (previously TNM data items) must be coded 88 if over-ride set for pediatric case

Primary Site, T 2016 - Ed 7, ICDO3 (COC-NPCR)

Agency: COC **Last changed: 02/09/2017**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
TNM Edition Number [Std# 1060]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
Age at Diagnosis [Std# 230]
CS Site-Specific Factor10 [Std# 2864]
CS Site-Specific Factor25 [Std# 2879]
Grade [Std# 440]
TNM Clin T [Std# 940]
TNM Path T [Std# 880]
Sex [Std# 220]
Type of Reporting Source [Std# 500]

Tables

AC7G2016.DBF
NP7TCL16.DBF
NP7TPA16.DBF

Additional Messages

[3281] TNM Path T code is invalid for site/hist combination
[3282] TNM Clin T code is invalid for site/hist combination
[3283] TNM Clin T code should = "88" for site/hist combination
[3284] TNM Path T code should = "88" for site/hist combination

Description

TNM Clin T and TNM Path T may be blank. If TNM Clin T is entered, it is edited by the criteria below. If TNM Path T is entered, it is edited by the criteria below.

This edit is skipped if any of the following conditions are true:

1. Year of Date of Diagnosis is less than 2016, blank (unknown), or invalid
2. Type of Reporting Source = 7 (Death Certificate Only)
3. Histologic Type ICD-O-3 is blank
4. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
5. TNM Edition Number is not = 07 and not = 88
6. TNM Clin T and TNM Path T are both empty

The allowable values for

Clinical T: (blank), cX, c0, pA, pIS, pISU, PISD, c1MI, c1, c1A, c1A1, c1A2, c1B, c1B1, c1B2, c1C, c1D, c2, c2A, c2A1, c2A2, c2B, c2C, c2D, c3, c3A, c3B, c3C, c3D, c4, c4A, c4B, c4C, c4D, c4E, 88
Path T: (blank), pX, p0, pA, pIS, pISU, PISD, p1MI, p1, p1A, p1A1, p1A2, p1B, p1B1, p1B2, p1C, p1D, p2, p2A, p2A1, p2A2, p2B, p2C, p2D, p3, p3A, p3B, p3C, p3D, p4, p4A, p4B, p4C, p4D, p4E, 88

This edit checks the subset of values that are valid for each of the site/histology groups that have a TNM T defined and checks for "88" if the site/histology group does not have a TNM T defined.

The number next to each site group indicates the chapter in the AJCC Cancer Staging Manual, Edition 7. The sites for each chapter are listed along with the histologies requiring AJCC staging. The values for the clinical and pathologic T codes are listed under TNM T. All values listed must be prefixed with a “c” or “p” except code "88" and blank. All clinical T codes have a prefix of “c” except for IS, A, ISU, ISD which must have a prefix of “p”. The Path T codes all have the prefix of “p”. For cases where there is a difference in allowable values for clinical and pathologic T codes (Testis, Prostate, Melanoma Conjunctiva, and Retinoblastoma), the T codes are listed separately for clin and path.

For example for breast the edit lists
TNM T:
X,0,IS,1,1A,1B,1C,1MI,2,3,4,4A,4B,4C,4D

Which translates to allowable codes of:

Clin T: (blank),cX,c0,pIS,c1,c1A,c1B,c1C,c1MI,c2,c3,c4,c4A,c4B,c4C,c4D
Path T: (blank),pX,p0,pIS,p1,p1A,p1B,p1C,p1MI,p2,p3,p4,p4A,p4B,p4C,p4D

The sites/histologies for each group are listed in the EditWriter table AC7G2016.DBF, except as noted below where special logic in this edit is used to assign or reassign sites/histologies to a specified group number.

This edit differs from the SEER edit of the same name in that it excludes TNOS categories that are not included in AJCC 7th Edition (for site/histology groups listed below: 3, 4A, 4D, 5A-B, 6, 7, 8A-F, 9, 12, 14, 18, 19, 21, 33, 36A, 48). The edit does not allow cX or c0 for Mucosal Melanoma of Head and Neck, and does not allow A and B designations for T1 and T2 categories, Primary Cutaneous Lymphoma.

3. Lip and Oral Cavity

Sites:
C000-C006,C008,C009
C020-C023,C028,C029
C030,C031,C039
C040,C041,C048,C049
C050,C058,C059
C060-C062,C068,C069
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM T:
X,0,IS,1,2,3,4A,4B

4. Pharynx

4A. Oropharynx and Hypopharynx
Sites:

C019, C024
C051-C052
C090-C091, C098-C099
C100, C102-C104, C108-C109
C129
C130-C132, C138-C139

Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM T:
X,0,IS,1,2,3,4A, 4B

4B. Nasopharynx
Sites:
C110, C112-C113, C118-C119
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM T:
X,0,IS,1,2,3,4

4C. Nasopharynx
Sites:
C111
Discriminator (CS Site-Specific Factor25):
010
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM T:
X,0,IS,1,2,3,4

4D. Oropharynx - Pharyngeal Tonsil
Sites:
C111
Discriminator (CS Site-Specific Factor25):
020
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981

Sites/histologies are assigned to group 4D from 4C based on Site-Specific Factor 25

TNM T:
X,0,IS,1,2,3,4A,4B

5. Larynx

5A. Supraglottis, Subglottis, Other
Sites:
C101, C321-C322
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM T:
X,0,IS,1,2,3,4A,4B

5B. Glottis
Sites:
C320, C328-C329
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980, 8981
TNM T:

X,0,IS,1,1A,1B,2,3,4A,4B

NOTE: TNM T 88 allowed for C328-C329

6. Nasal Cavity and Paranasal Sinuses

Sites:
C300, C310-C311
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM T:
X,0,IS,1,2,3,4A,4B

7. Major Salivary Glands

Sites:
C079
C080,C081,C088,C089
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8982
TNM T:
X,0,1,2,3,4A,4B, 88

8. Thyroid Gland

8A. Thyroid: Papillary/follicular, age less than 045
Sites:
C739
Histologies Requiring AJCC Staging:
8000-8015, 8022, 8033-8344, 8350-8420, 8440-8508,
8514-8576, 8940-8950, 8980-8981
Age at Diagnosis: less than 045
Grade: 1-3 or 9

Site/histologies are assigned to group 8A from group 8 based on grade, age at diagnosis

TNM T:
X,0, 1,1A,1B,2,3,4A,4B,88

8B. Thyroid: Papillary/follicular, age greater than or equal 045 but not 999
Sites:
C739
Histologies Requiring AJCC Staging:
8000-8015, 8022, 8033-8344, 8350-8420, 8440-8508,
8514-8576, 8940-8950, 8980-8981
Age at Diagnosis: greater than or equal to 045, but not equal 999
Grade: 1-3 or 9

Site/histologies are assigned to group 8B from group 8 based on grade, age at diagnosis

TNM T:
X,0,1,1A,1B,2,3,4A,4B, 88

8C. Thyroid: Papillary/follicular, age equal 999 (unknown)

Sites:
C739
Histologies Requiring AJCC Staging:
8000-8015, 8022, 8033-8344, 8350-8420, 8440-8508,
8514-8576, 8940-8950, 8980-8981
Age at Diagnosis: equal 999
Grade: 1-3 or 9

Site/histologies are assigned to group 8C from group 8 based on grade, age at diagnosis

TNM T:
X,0,1,1A,1B,2,3,4A,4B, 88

8D. Thyroid: Medullary
Sites:
C739
Histologies Requiring AJCC Staging:
8345-8347, 8430, 8510, 8512-8513
Grade: 1-3 or 9

TNM T:
X,0,1,1A,1B,2,3,4A,4B, 88

8E. Thyroid: Anaplastic
Sites:
C739
Histologies Requiring AJCC Staging:
8020-8021, 8030-8032
TNM T:
Clin: X,0,1,1A,1B,2,3,4A,4B
Path: 4A,4B

8F. Thyroid: Anaplastic
Sites:
C739
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
Grade: 4

Site/histologies are assigned to group 8F from group 8 and group 8D based on grade

TNM T:
Clin: X,0,1,1A,1B,2,3,4A,4B
Path: 4A,4B

9. Mucosal Melanoma of the Head and Neck

Sites:
C000-C006, C008-C009
C019
C020-C024, C028-C029
C030-C031, C039
C040-C041, C048-C049
C050-C052, C058-C059
C060-C062, C068-C069
C090-C091, C098-C099
C100-C104, C108-C109

C110-C113, C118-C119
C129, C130-C132
C138-C139
C140, C142, C148
C300
C310-C311
C320-C323, C328-C329
Histologies Requiring AJCC Staging:
8720-8790
TNM T:
3,4A,4B, 88

10. Esophagus and Esophagus Gastric Junction

10A. Esophagus
Sites:
C150-C155, C158-C159
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM T:
X,0,IS,1,1A,1B,2,3,4,4A,4B

10B. Esophagus Gastric Junction
Sites:
C160-C162
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981
Discriminator (CS Site-Specific Factor25):
020, 040, 060 (for C161-C162)

Site/histologies are assigned to group 10B from group 11 based on site and site-specific factor 25 as well as table lookup

TNM T:
X,0,IS,1,1A,1B,2,3,4,4A,4B

11. Stomach

Sites:
C161-C162 and Discriminator (CS Site-Specific Factor 25) =
000, 030, 999
C163-C166, C168-C169
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8990
TNM T:
X,0,IS,1,1A,1B,2,3,4,4A,4B

12. Small Intestine

Sites:
C170-C172, C178-C179
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981
TNM T:
X,0,IS,1A,1B,2,3,4

13. Appendix

13A. Appendix: Carcinoma

Sites:
C181
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981
TNM T:
X,0,IS,1,2,3,4,4A,4B

13B. Appendix: Carcinoid

Sites:
C181
Histologies Requiring AJCC Staging:
8240-8242, 8246, 8249, 8153
TNM T:
X,0,1,1A,1B,2,3,4, 88

14. Colon and Rectum

Sites:
C180, C182-C189
C199
C209
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981
TNM T:
X,0,IS,1,2,3,4A,4B

15. Anus

Sites:
C210-C212, C218
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8250-8576, 8940-8950, 8980-8981
TNM T:
X,0,IS,1,2,3,4

16. Gastrointestinal Stromal Tumor (GIST)

16A. GIST: Gastric

Sites:
C160-C169
C480-C488 and CS Site-Specific Factor 10 = 020 (Omentum)
Histologies Requiring AJCC Staging:
8935-8936

Sites/histologies are assigned to group 16A from group 16B based on site-specific factor 10
as well as table lookup

TNM T:
X,0,1,2,3,4, 88

16B. GIST: Small Intestine

Sites:
C150-C159

C170-C172, C178, C179
C180-C189
C199
C209
C480-C488 and CS Site-Specific Factor 10 not = 020 (Omentum)
Histologies Requiring AJCC Staging:
8935-8936
TNM T:
X,0,1,2,3,4, 88

17. Neuroendocrine Tumors (NET)

17A. NET: Stomach
Sites:
C160-C169
Histologies Requiring AJCC Staging:
8153, 8240-8242, 8246, 8249
TNM T:
X,0,IS,1,2,3,4

17B. NET: Small Intestine and Ampulla of Vater
Sites:
C170-C179
C241
Histologies Requiring AJCC Staging:
8153, 8240-8242, 8246, 8249
TNM T:
X,0,1,2,3,4, 88

17C. NET: Colon and Rectum
Sites:
C180, C182-C189
C199, C209
Histologies Requiring AJCC Staging:
8153, 8240-8242, 8246, 8249
TNM T:
X,0,1,1A,1B,2,3,4, 88

18. Liver
Sites:
C220
Histologies Requiring AJCC Staging:
8170-8175
TNM T:
X,0,1,2,3A,3B,4, 88

19. Intrahepatic Bile Ducts

19. Sites:
C221
Histologies Requiring AJCC Staging:
8160, 8161, 8180
TNM T:
X,0,IS,1,2A,2B,3,4

20. Gallbladder

Sites:
C239
C240 and Discriminator (CS Site-Specific Factor 25) = 030
Histologies Requiring AJCC Staging:
8000-8152,8154-8231, 8243-8245, 8250-8576, 8940-8950, 8980-8981

Sites/histologies are assigned to group 20 from group 21 based on site-specific factor 25
as well as table lookup

TNM T:
X,0,IS,1,1A,1B,2,3,4

21. Perihilar Bile Ducts

Sites:
C240 and Discriminator (CS Site-Specific Factor 25) = 010, 020, 050, 060, 999
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8250-8576, 8940-8950, 8980-8981
TNM T:
X,0,IS,1,2A,2B,3,4

22. Distal Bile Duct

Sites:
C240 and Discriminator (CS Site-Specific Factor 25) = 040, 070
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8250-8576, 8940-8950, 8980-8981

Sites/histologies are assigned to group 22 from group 21 based on site-specific factor 25
as well as table lookup

TNM T:
X,0,IS,1,2,3,4

23. Ampulla of Vater

Sites:
C241
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8250-8576, 8940-8950, 8980-8981
TNM T:
X,0,IS,1,2,3,4

24. Exocrine and Endocrine Pancreas

Sites:
C250-C254, C257-C259
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8971, 8980-8981
TNM T:
X,0,IS,1,2,3,4

25. Lung

Sites:
C340-C343,C348,C349
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM T:
X,0,IS,1,1A,1B,2,2A,2B,3,4

26. Pleural Mesothelioma

Sites:
C384
Histologies Requiring AJCC Staging:
9050-9053
TNM T:
X,0,1,1A,1B,2,3,4

27. Bone

Sites:
C400-C403, C408-C409
C410-C414, C418-C419
Histologies Permitting AJCC Staging:
8800-9136, 9142-9582
TNM T:
X,0,1,2,3

28. Soft Tissue Sarcoma

Peritoneum - not female
Sites:
C481-C482, C488
Histologies:
8800-8820, 8823-8934, 8940-9136, 9142-9582
Sex = 1, 3-5, 9 (not female)

Peritoneum - female
Sites:
C481-C482, C488
Histologies:
8800-8820, 8823-8921, 9120-9136, 9142-9582
Sex = 2,6 (female)

Heart,Mediastinum, Soft Tissue
Sites:
C380-C383, C388
C470-C476, C478-C479
C490-C496, C498-C499
Histologies:
8800-8820, 8823-8935, 8940-9136, 9142-9582

Retroperitoneum
Sites:
C480

Histologies:
8800-8820, 8823-8934, 8940-9136, 9142-9582

Specific sites/histologies assigned to group 28 based on sex

TNM T:
X,0,1,1A,1B,2,2A,2B

NOTE: TNM T 88 allowed for Mesothelioma, 9050-9055

29. Cutaneous Squamous Cell Carcinoma and other Cutaneous Carcinomas

Sites:
C440, C442-C449, C632
Histologies Requiring AJCC Staging:
8000-8246, 8248-8576, 8940-8950, 8980-8981
TNM T:
X,0,IS,1,2,3,4

30. Merkel Cell Carcinoma

Sites:
C440, C442-C449,
C510-C512, C518-C519
C600-C602, C608-C609
C632
Histologies Requiring AJCC Staging:
8247
TNM T:
X,0,IS,1,2,3,4

31. Melanoma of the Skin

Sites:
C440-C449
C510-C512,C518,C519
C600-C602, C608, C609
C632
Histologies Requiring AJCC Staging:
8720-8790
TNM T:
X,0,IS,1,1A,1B,2,2A,2B,3,3A,3B,4,4A,4B

32. Breast

Sites:
C500-C506,C508,C509
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981, 9020
TNM T:
X,0,IS,1,1A,1B,1C,1MI,2,3,4,4A,4B,4C,4D

33. Vulva

Sites:
C510-C512,C518,C519

Histologies Requiring AJCC Staging:
8000-8246, 8248-8576, 8940-8950, 8980-8981
TNM T:
X,0,IS,1A,1B,2,3

34. Vagina

Sites:
C529
Histologies Requiring AJCC Staging:
8000-8576, 8800-8801, 8940-8950, 8980-8981
TNM T:
X,0,IS,1,2,3,4

35. Cervix Uteri

Sites:
C530,C531,C538,C539
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM T:
X,0,IS,1,1A,1A1,1A2,1B,1B1,1B2,2,2A,2A1,2A2,2B,3,3A,3B,4

36. Corpus Uteri

36A. Corpus Uteri: Carcinomas
Sites
C540-C543, C548-C549
C559
Histologies Requiring AJCC Staging:
8000-8790, 8950-8951, 8980-8981
TNM T:
X,0,IS,1,1A,1B,2,3A,3B,4

36B. Corpus Uteri: Leiomyosarcoma and Endometrial Stromal Sarcoma
Sites:
C540-C543, C548-C549
C559
Histologies Requiring AJCC Staging:
8800, 8890-8898, 8900-8921, 8930-8931, 8935
TNM T:
X,0,1,1A,1B,2,2A,2B,3,3A,3B,4, 88

36C. Corpus Uteri: Adenosarcoma
Sites:
C540-C543, C548-C549
C559
Histologies Requiring AJCC Staging:
8933
TNM T:
X,0,1,1A,1B,1C,2,2A,2B,3,3A,3B,4, 88

37. Ovary and Peritoneal Carcinomas

37A. Ovary

Sites:
C569
Histologies Requiring AJCC Staging:
8000-8576, 8590-8671, 8930-9110
TNM T:
X,0,1,1A,1B,1C,2,2A,2B,2C,3,3A,3B,3C, 88

37B. Peritoneal Carcinomas
Sites:
C481-C482, C488
Sex = 2,6 (female)
Histologies Requiring AJCC Staging:
8000-8576, 8590-8671, 8930-8934, 8940-9110

Sex code checked for assignment to group 37B

TNM T:
X,0,3,3A,3B,3C

38. Fallopian Tube

Sites:
C570
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM T:
X,0,IS,1,1A,1B,1C,2,2A,2B,2C,3,3A,3B,3C

39. Gestational Trophoblastic Tumors

Sites:
C589
Histologies Requiring AJCC Staging:
9100-9105
TNM T:
X,0,1,2,88

40. Penis

Sites:
C600-C602,C608,C609
Histologies Requiring AJCC Staging:
8000-8246, 8248-8576, 8940-8950, 8980-8981
TNM T:
X,0,IS,A,1A,1B,2,3,4

41. Prostate

Sites:
C619
Histologies Requiring AJCC Staging:
8000-8110, 8140-8576, 8940-8950, 8980-8981
TNM T:
Clin: X,0,1,1A,1B,1C,2,2A,2B,2C,3,3A,3B,4, 88
Path: X,0,2,2A,2B,2C,3,3A,3B,4, 88

42. Testis

Sites:
C620,C621,C629
Histologies Requiring AJCC Staging:
8000-8576, 8590-8670, 8940-8950, 8980-8981, 9060-9090, 9100-9105
TNM T:
Clin: cX, pIS
Path: pX,p0,pIS,p1,p2,p3,p4

43. Kidney

Sites:
C649
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM T:
X,0,1,1A,1B,2,2A,2B,3,3A,3B,3C,4, 88

44. Renal Pelvis and Ureter

Sites:
C659
C669
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM T:
X,0,IS,A,1,2,3,4

45. Urinary Bladder

Sites:
C670-C679
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM T: Clin: X,0,IS,A,1,2,3,4,4A,4B
Path: X,0,IS,A,1,2,2A,2B,3,3A,3B,4,4A,4B

46. Urethra

46A. Urethra - Female
Sites:
C680
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
Sex: 2,6 (female)
TNM T:
X,0,IS,A,1,2,3,4

46B. Urethra - not Female
Sites:
C680
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
Sex: 1,3-5,9 (not female)

TNM T:
X,0,IS,ISU,ISD,A,1,2,3,4

47. Adrenal

47A. Adrenal Cortex
Sites:
C740
Histologies Requiring AJCC Staging:
8010, 8140, 8370
TNM T:
X,0,1,2,3,4, 88

47B. Adrenal Cortical Carcinoma
Sites:
C749
Histologies Requiring AJCC Staging:
8370
TNM T:
X,0,1,2,3,4, 88

48. Carcinoma of the Eyelid

Sites:
C441
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM T:
X,0,IS,1,2A,2B,3A,3B,4

49. Conjunctiva

Sites:
C690
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM T:
X,0,IS,1,2,3,4,4A,4B,4C,4D

50. Malignant Melanoma of the Conjunctiva

Sites:
C690
Histologies Requiring AJCC Staging:
8720-8790
TNM T:
Clin: X,0,IS,1,1A,1B,1C,1D,2,2A,2B,2C,2D,3,3A,3B,3C,3D,4
Path: X,0,IS,1A,1B,1C,2A,2B,2C,3,4

51. Malignant Melanoma of Uvea

51A. Ciliary Body and Choroid
Sites:
C693
C694 (CS Site-Specific Factor 25 = 010)

Histologies Requiring AJCC Staging:
8720-8790

Sites/histologies are assigned to group 51A from group 51 based on site-specific factor 25

TNM T:
X,0,1,1A,1B,1C,1D,2,2A,2B,2C,2D,3,3A,3B,3C,3D,4,4A,4B,4C,4D,4E,88

51B. Iris
Sites:
C694 (CS Site-Specific Factor 25 = 020)
Histologies Requiring AJCC Staging:
8720-8790
Sites/histologies are assigned to group 51B from group 51 based on site-specific factor 25

TNM T:
X,0,1,1A,1B,1C,2,2A,3,3A,4,4A,4B,88

52. Retinoblastoma

Sites:
C692
Histologies Requiring AJCC Staging:
9510-9514
TNM T:
Clin: X,0,1,1A,1B,1C,2,2A,2B,3,3A,3B,4,4A,4B,4C,4D
Path: X,0,1,2,2A,2B,3,3A,3B,4,4A,4B

53. Carcinoma of the Lacrimal Gland
Sites:
C695 and CS Site-Specific Factor25 = 015
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM T:
X,0,1,2,3,4,4A,4B,4C,88

54. Sarcoma of the Orbit

Sites:
C696, C698
Histologies Requiring AJCC Staging:
8800-8936, 8940-9136, 9141-9508, 9520-9582
TNM T:
X,0,1,2,3,4,88

55. Ocular Adnexal Lymphoma

Sites:
C441, C690, C695-C696
Histologies Requiring AJCC Staging:
9590-9699, 9702-9738, 9811-9818, 9820-9837
TNM T:
X,0,1,1A,1B,1C,2,2A,2B,2C,2D,3,4,4A,4B,4C,4D

```
56. Brain and Spinal Cord

Sites:
     C700, C701, C709, C710-C719, C720-C729, C751-C753
Histologies Requiring AJCC Staging:
     8000, 8680-9136,9141-9582
TNM T:
     88


57. Lymphoid Neoplasms

57A. Hodgkin and Non-Hodgkin
Sites:
     C000-C440, C442-C689, C691-C694, C698-C809
Histologies Requiring AJCC Staging:
     9590-9699, 9702-9727, 9735, 9737-9738
Sites:
     C000-C419, C422-C423, C425-C440, C442-C689, C691-C694, C698-C809
Histologies Requiring AJCC Staging:
     9811-9818, 9823, 9827, 9837

Sites/histologies are assigned to group 57A based on combinations of site and
histology

TNM T:
     88

57B. Primary Cutaneous Lymphomas
Sites:
     C440-C449
     C510-C512, C518-C519
     C600-C602, C608-C609, C632
Histologies Requiring AJCC Staging:
     9700,9701
TNM T:
     1,1A,1B,2,2A,2B,3,4

57C.  Lymphoid/Hematopoietic
Sites:
     C420, C421, C424
Histologies Requiring AJCC Staging:
     9811-9818, 9837
TNM T:
     88

All Others
TNM T:
     88
```

Administrative Notes

New edit - added to NAACCR v16 metafile.

Modifications

NAACCR v16A
- Corrected logic for first INLIST of primary sites for site/histology group 57A, 000-419-440 changed to 000-440

- Corrected histology codes in Description for site/histology group 31, Melanoma of Skin, from 8720-87900 to 8720-8790
- Corrected Description and Edit Logic to include 9727 as lymphoma rather than lymphoma/leukemia code, to delete 9728-9729 as obsolete codes
- Added Group 57C, C420, C421, C424, 9811-9818, 9837, TNM T 88.

NAACCR v16B
- Description corrected, added value of 3 to group 8D, Thyroid Medullary
- Description updated, p4 removed as valid valued for site/histology group 042, Testis, TNM Clin T
- Table for TNM Clin T referenced by edit corrected, 042 cX and 042 pIS added as allowable values
- Table for TNM Clin T referenced by edit corrected, 05B, c2 added
- Table for TNM Path T referenced by edit corrected, 05B, p2 added
- Table for TNM Clin T referenced by edit corrected, 055 c2D added
- Table for TNM Path T referenced by edit corrected, 055 p2D added
- Corrected edit logic for assigning site/histology group 011 to group 10B or 999 based on histology and CS Site-Specific Factor 25

NAACCR v16D
- Description, tables referenced by edit updated to allow cTX, cT0,pTX,pT0 for site/histology group 37B, Primary Peritoneal Carcinoma
- Description, logic updated to allow clinical and pathologic TNM T 88 for mesothelioma, 9050-9055, site/histo group 028
- Removed substring variable declarations from logic, not used
- Description, logic updated to allow clinical and pathologic TNM T 88 for C32.8 and C32.9, site/histo group 05B
- Description, tables referenced by edit updated to allow 1A,1B,2A,2B for clin and path TNM T for site/histo group 57B, primary cutaneous lymphoma

Primary Site, TNM Clin Stage Valid A- Ed 7 (COC)

Agency: COC **Last changed: 02/16/2017**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

TNM Clin T [Std# 940]
TNM Clin N [Std# 950]
TNM Clin M [Std# 960]
TNM Clin Stage Group [Std# 970]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
Date of Diagnosis [Std# 390]
TNM Edition Number [Std# 1060]
Age at Diagnosis [Std# 230]
Grade [Std# 440]
CS Site-Specific Factor 5 [Std# 2920]
CS Site-Specific Factor 6 [Std# 2930]
CS Site-Specific Factor10 [Std# 2864]
CS Site-Specific Factor11 [Std# 2865]
CS Site-Specific Factor25 [Std# 2879]
Sex [Std# 220]
Type of Reporting Source [Std# 500]

Tables

AC7G2016.DBF
CLST7VAL.DBF

Default Error Message

[3038] TNM stage problem
TNM stage problem

Additional Messages

[6009] Inconsistency between TNM categories T"value of TNM Clin T" N"value of TNM Clin N" M"value of TNM Clin M" and assigned TNM stage "value of TNM Clin Stage Group"
[6010] Combination of T"value of TNM Clin T" N"value of TNM Clin N" M"value of TNM Clin M" is invalid for TNM staging
[6011] T"value of TNM Clin T" N"value of TNM Clin N" M"value of TNM Clin M", staging parameter for "value of Primary Site", inconsistent with TNM stage "value of TNM Clin Stage Group"
[6027] Combination T"value of TNM Clin T" N"value of TNM Clin N" M"value of TNM Clin M", staging parameter for "value of Primary Site", invalid forTNM staging

Description

This edit is skipped if any of the following conditions are true:

1. Year of Date of Diagnosis is less than 2016, blank (unknown), or invalid
2. Type of Reporting Source = 7 (Death Certificate Only)
3. Histologic Type ICD-O-3 is blank
4. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
2. TNM Edition Number is not = 07, U7, and not = 88
5. TNM Clin Stage Group is blank
6. TNM Clin T, TNM Clin N, or TNM Clin M is blank

The purpose of this edit is to validate the coded TNM categories, and site-specific staging parameters where used, with the coded Stage Group assignments. The edit is used for site/histology groups in AJCC 7th Edition chapters 3 through 28. Some TNM chapters require elements in addition to T, N, and M categories, such as grade or mitotic rate. for correct stage assignment. In this edit description, these elements are called staging parameters. The edit will not be skipped but will pass if a required staging parameter is blank.

The edit compares the combination of TNM Clin T, TNM Clin N, TNM Clin M categories, and staging parameter where required, with TNM Clin Stage Group.

The designation of "c" or "p" within the individual T, N, and M codes is ignored for this edit. Valid codes for individual fields (TNM Clin T, TNM Clin N, TNM Clin M, TNM Clin Stage Group), and for these individual fields by primary site, are checked in other edits.

An edit failure is returned if the Clin Stage Group is inconsistent with the expected group assignment for the coded T, N, M, and staging parameter if required, based on the AJCC stage tables. If a T, N, or M value is coded that is not included in the AJCC stage tables -- for example T4 is coded but only T4A and T4B are staged -- the stage assignment will not be checked and the edit will pass.

An edit failure is also returned if either the coded Clin Stage Group or the coded Path Stage Group returns "ERROR" from the lookup table, meaning that the combination of T, N, M, and staging parameter is invalid. Invalid combinations include T0N0M0/M0I+; T in situ with positive N and/or positive M category; and a Testis stage with an invalid S category. An invalid S category results when one or more of the 3 site-specific factors required to determine the category (SSF 13-AFP, SSF 15-hCG, SSF 16-LDH) is coded 988, meaning not applicable.

The site/histology groups are listed below. The number next to each site title indicates the respective chapter in the AJCC Cancer Staging Manual, Edition 7.The site/histology groups and group stage values are identified by site and histology in the edit Primary Site, Stage Group 2016 - Ed 7. Subdivisions of some groups were required for this edit; they are identified below with their criteria. Site-specific staging parameters are also identified. The description does not include the list of TNM categories, staging parameters, and stage groups; this information is contained in a table within EditWriter that contains around 14,000 records.

3. Lip and Oral Cavity

4. Pharynx

    4A. Oropharynx and Hypopharynx
    4B. Nasopharynx
    4C. Nasopharynx
    4D. Oropharynx - Pharyngeal Tonsil

5. Larynx

5A. Supraglottis, Subglottis, Other
5B. Glottis

6. Nasal Cavity and Paranasal Sinuses

7. Major Salivary Glands

8. Thyroid Gland

8A. Thyroid: Papillary/follicular, age less than 045
8B. Thyroid: Papillary/follicular, age greater than or equal 045 but not 999
8C. Thyroid: Papillary/follicular, age equal 999 (unknown)
8D. Thyroid: Medullary
8E. Thyroid: Anaplastic
8F. Thyroid: Anaplastic

9. Mucosal Melanoma of the Head and Neck

10. Esophagus and Esophagus Gastric Junction

10A. Esophagus

Division for Staging:
10C. Esophagus Adenocarcinoma
Histologies: 8050, 8140-8147, 8160-8162, 8170-8175, 8180-8221, 8250-8507, 8514-8551,8571-8574, 8576, 8940-8941
10D. Esophagus Squamous Cell Carcinoma
Histologies: 8000-8046, 8051-8131, 8148-8157, 8230-8249, 8508, 8510-8513, 8560-8570, 8575, 8905, 8980-8981
Sites and TNM not included in 10E, 10H
10E. Esophagus Squamous Cell Carcinoma
Site, TNM: C150, C151, C153, C154, cT2cN0cM0, cT3cN0cM0
10H: Esophagus Squamous Cell Carcinoma
Site, TNM: C152, C155, C158, C159 cT2cN0cM0, cT3cN0cM0

Staging Parameter: Grade

10B. Esophagus Gastric Junction

Division for Staging:
10F. Esophagus Gastric Junction Adenocarcinoma
Histologies: 8050, 8140-8147, 8160-8162, 8170-8175, 8180-8221, 8250-8507, 8514-8551,8571-8574, 8576, 8940-8941
10G. Esophagus Gastric Junction Squamous Cell Carcinoma
Histologies: 8000-8046, 8051-8131, 8148-8157, 8230-8249, 8508, 8510-8513, 8560-8570, 8575, 8905, 8980-8981

Staging Parameter: Grade

11. Stomach

12. Small Intestine

13. Appendix

13A. Appendix: Carcinoma

Staging Parameter: Grade for mucinous and non-mucinous tumors, as collected in CS SSF 11

13B. Appendix: Carcinoid

14. Colon and Rectum

15. Anus

16. Gastrointestinal Stromal Tumor (GIST)

16A. GIST: Gastric

Staging Parameter: Mitotic Count, as collected in CS SSF 6 for GIST Stomach, CS SSF 5 for GIST Omentum

16B. GIST: Small Intestine

Staging Parameter: Mitotic Count, as collected in CS SSF 6 for GIST Esophagus, CS SSF 11 for GIST
Small Intestine, GIST Colon and Rectum, CS SSF 5 for GIST Mesentery

17. Neuroendocrine Tumors (NET)

17A. NET: Stomach
17B. NET: Small Intestine and Ampulla of Vater
17C. NET: Colon and Rectum

18. Liver

19. Intrahepatic Bile Ducts

20. Gallbladder

21. Perihilar Bile Ducts

22. Distal Bile Duct

23. Ampulla of Vater

24. Exocrine and Endocrine Pancreas

25. Lung

26. Pleural Mesothelioma

27. Bone

Division for Staging:
27A. Bone Non-Ewing
Histologies: 8800-9136, 9142-9252, 9261-9363, 9365-9582

Staging Parameter: Grade, for Non-Ewing

27B. Bone Ewing
Histologies: 9260, 9364

28. Soft Tissue Sarcoma (not edited)

Staging Parameter: Grade

Administrative Notes

New edit - added to NAACCR v16 metafile

Modifications

NAACCR v16A
- Updated stage mapping in table referenced by logic for Thyroid, Esophagus, EsophagusGEJunction
- Updated description, edit logic to indicate that grade for site/histology group 028, Soft Tissue, is collected in the Grade field and not in CS Site-Specific Factor 1
- Removed "else" after special logic for TXN0M0 for site/histology group 025, causing edit to pass inappropriately for other sites
- Updated to not edit for site/histology group 028, Soft Tissue Sarcoma, issues with grade assignment, Description notes this group not edited
- Corrected Edit Logic to include 9727 as lymphoma rather than lymphoma/leukemia code, to delete 9728-9729 as obsolete codes
- Added Group 57C, C420, C421, C424, 9811-9818, 9837 to Edit Logic

NAACCR v16B
- Removed logic checking for Over-ride Site/TNM-StgGrp. This Over-ride allows pediatric cases to be coded with stage group 88. The stage tables do not look for combinations of 88 88 88 88, so any record with such a combination would not be edited with the edit. An edit failure based on incorrect setting of the Over-ride would duplicate the same edit failure in an edit that checks primary site, stage group values for 2016.
- Table referenced by edit updated: TIS,NX,M0, stage group changed to ERROR from 0
- Corrected edit logic for assigning site/histology group 011 to group 10B or 999 based on histology and CS Site-Specific Factor 25

NAACCR v16D
- Added U7 to required TNM Edition Numbers
- Table referenced by edit updated, TXN2M0, Stage 3 for lung updated to TXN2M0, Stage 99
- Table referenced by edit updated, T4NXM0, Stage 3 for lung updated to T4NXM0, Stage 99
- Logic updated to pass T1,T2,T3, or T4 with N0M0 and unknown mitotic rate for site/histo groups 16A, 16B, GIST

Primary Site, TNM Clin Stage Valid B-Ed 7 (COC)

Agency: COC **Last changed: 01/03/2017**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

TNM Clin T [Std# 940]
TNM Clin N [Std# 950]
TNM Clin M [Std# 960]
TNM Clin Stage Group [Std# 970]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
Date of Diagnosis [Std# 390]
TNM Edition Number [Std# 1060]
Age at Diagnosis [Std# 230]
Grade [Std# 440]
CS Site-Specific Factor 1 [Std# 2880]
CS Site-Specific Factor 8 [Std# 2862]
CS Site-Specific Factor10 [Std# 2864]
CS Site-Specific Factor13 [Std# 2867]
CS Site-Specific Factor15 [Std# 2869]
CS Site-Specific Factor16 [Std# 2870]
CS Site-Specific Factor25 [Std# 2879]
Sex [Std# 220]
Type of Reporting Source [Std# 500]

Tables

AC7G2016.DBF
CLST7VAL.DBF
SVALTEST.DBF

Default Error Message

[3038] TNM stage problem
TNM stage problem

Additional Messages

[6009] Inconsistency between TNM categories T"value of TNM Clin T" N"value of TNM Clin N" M"value of TNM Clin M" and assigned TNM stage "value of TNM Clin Stage Group"
[6010] Combination of T"value of TNM Clin T" N"value of TNM Clin N" M"value of TNM Clin M" is invalid for TNM staging
[6011] T"value of TNM Clin T" N"value of TNM Clin N" M"value of TNM Clin M", staging parameter for "value of Primary Site", inconsistent with TNM stage "value of TNM Clin Stage Group"
[6027] Combination T"value of TNM Clin T" N"value of TNM Clin N" M"value of TNM Clin M", staging parameter for "value of Primary Site", invalid forTNM staging

Description

This edit is skipped if any of the following conditions are true:

1. Year of Date of Diagnosis is less than 2016, blank (unknown), or invalid
2. Type of Reporting Source = 7 (Death Certificate Only)
3. Histologic Type ICD-O-3 is blank
4. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline
5. TNM Edition Number is not = 07,U7, 88
6. TNM Clin Stage Group is blank
7. TNM Clin T or TNM Clin M is blank

The purpose of this edit is to validate the coded TNM categories, and site-specific staging parameters where used, with the coded Stage Group assignments. The edit is used for site/histology groups in AJCC 7th Edition chapters 29 through 57. Some TNM chapters require elements in addition to T, N, and M categories, such as grade or mitotic rate. for correct stage assignment. In this edit description, these elements are called staging parameters. The edit will not be skipped but will pass if any of TNM Clin N or a required staging parameter is blank. (The exception for TNM Clin N allows for the possible coding of TNM Clin N as blank for site/histology group 39; if blank, TNM Clin N will be converted to "88" for the edit.)

The edit compares the combination of TNM Clin T, TNM Clin N, TNM Clin M categories, and staging parameter where required, with TNM Clin Stage Group.

The designation of "c" or "p" within the individual T, N, and M codes is ignored for this edit. Valid codes for individual fields (TNM Clin T, TNM Clin N, TNM Clin M, TNM Clin Stage Group), and for these individual fields by primary site, are checked in other edits.

An edit failure is returned if the Clin Stage Group is inconsistent with the expected group assignment for the coded T, N, M, and staging parameter if required, based on the AJCC stage tables. If a T, N, or M value is coded that is not included in the AJCC stage tables -- for example T4 is coded but only T4A and T4B are staged -- the stage assignment will not be checked and the edit will pass.

An edit failure is also returned if either the coded Clin Stage Group or the coded Path Stage Group returns "ERROR" from the lookup table, meaning that the combination of T, N, M, and staging parameter is invalid. Invalid combinations include T0N0M0/M0I+; T in situ with positive N and/or positive M category; and a Testis stage with an invalid S category. An invalid S category results when one or more of the 3 site-specific factors required to determine the category (SSF 13-AFP, SSF 15-hCG, SSF 16-LDH) is coded 988, meaning not applicable.

The site/histology groups are listed below. The number next to each site title indicates the respective chapter in the AJCC Cancer Staging Manual, Edition 7.The site/histology groups and group stage values are identified by site and histology in the edit Primary Site, Stage Group 2016 - Ed 7. Subdivisions of some groups were required for this edit; they are identified below with their criteria. Site-specific staging parameters are also identified. The description does not include the list of TNM categories, staging parameters, and stage groups; this information is contained in a table within EditWriter that contains around 14,000 records.

Site/histology groups 49, Carcinoma of Conjunctiva, 50, Malignant Melanoma of Conjunctiva, 52, Retinoblastoma, 53, Carcinoma of Lacrimal Gland, 54, Sarcoma of Orbit, 55, Ocular Adnexal Lymphoma, are listed below. However, staging for these site/histology groups is not validated by this edit, as no stage grouping applies. The T, N, M codes for site/histology groups 49, 50, 52, 53, 54, and 55 are

validated in the edits Primary Site, T 2016 - Ed 7, Primary Site, N 2016 - Ed 7, and Primary Site, M 2016 - Ed 7.

Site/histology group 57A, Lymphoid Neoplasms, is also listed below. However, staging for 57A does not include T, N, and M components, and stage is not validated in this edit. The T, N, M codes for site/histology group 57A are validated in the edits Primary Site, T 2016 - Ed 7, Primary Site, N 2016 - Ed 7, and Primary Site, M 2016 - Ed 7. Stage group for 57A is validated in the edit Primary Site, Stage Group 2016 - Ed 7. Site/histology group 55, Ocular Adnexal Lymphoma, will pass this edit if coded as Lymphoma (T=88,N=88,M=88,Stage Group = stage from Ch 57), or as Ocular Adnexal Lymphoma (T=T from Ch 55, N=N from Ch 55, M=M from Ch 55, Stage Group = 88).

29. Cutaneous Squamous Cell Carcinoma and other Cutaneous Carcinomas

30. Merkel Cell Carcinoma

31. Melanoma of the Skin

32. Breast

33. Vulva

34. Vagina

35. Cervix Uteri

36. Corpus Uteri

    36A. Corpus Uteri: Carcinomas
    36B. Corpus Uteri: Leiomyosarcoma and Endometrial Stromal Sarcoma
    36C. Corpus Uteri: Adenosarcoma

37. Ovary and Peritoneal Carcinomas

    37A. Ovary
    37B. Peritoneal Carcinomas

38. Fallopian Tube

39. Gestational Trophoblastic Tumors

Staging Parameter: Prognostic Scoring Index as collected in CS SSF 1

40. Penis

41. Prostate

Division for Staging:
    41A. PSA: 988, 997, 998, 999
    41B. PSA: 001-099
    41C. PSA: 100-199
    41D. PSA: 200-980

Staging Parameter: Gleason Score: As collected in CS SSF 8 for clinical stage

42. Testis

```
Staging Parameter: S value, based on calculation of:
                            post-orchiectomy AFP value as collected in CS SSF 13,
                   post-orchiectomy hCG value as collected in CS SSF 15,
                   post-orchiectomy LDH range as collected in CS SSF 16
43. Kidney

44. Renal Pelvis and Ureter

45. Urinary Bladder

46. Urethra

47. Adrenal

      47A. Adrenal Cortex
      47B. Adrenal Cortical Carcinoma

48. Carcinoma of the Eyelid

49. Conjunctiva

50.  Malignant Melanoma of the Conjunctiva

51.  Malignant Melanoma of Uvea

      51A. Ciliary Body and Choroid
      51B. Iris

52. Retinoblastoma

53. Carcinoma of the Lacrimal Gland

54. Sarcoma of the Orbit

55. Ocular Adnexal Lymphoma

57. Lymphoid Neoplasms

      57A. Hodgkin and Non-Hodgkin Lymphoma
      57B. Primary Cutaneous Lymphomas

Staging Parameter: Peripheral blood involvement, as collected in CS SSF 1
```

Administrative Notes

New edit - added to NAACCR v16 metafile

Modifications

NAACCR v16A
- Added stage mapping to table referenced by logic for T1A, T1B, T2A, T2B to site/group 57B, Primary Cutaneous Lymphoma
- Corrected site group in edit logic, 41E to 41A, defined for Prostate where CS Site-Specific Factor 1 = 988, 997, 998, 999
- Corrected Edit Logic to include 9727 as lymphoma rather than lymphoma/leukemia code, to delete 9728-9729 as obsolete codes
- Added Group 57C, C420, C421, C424, 9811-9818, 9837 to Edit Logic

NAACCR v16B

- Removed logic checking for Over-ride Site/TNM-StgGrp. This Over-ride allows pediatric cases to be coded with stage group 88. The stage tables do not look for combinations of 88 88 88 88, so any record with such a combination would not be edited with the edit. An edit failure based on incorrect setting of the Over-ride would duplicate the same edit failure in an edit that checks primary site, stage group values for 2016.
- Table referenced by edit updated: TA,NX,M0, stage group changed to ERROR from 0A; TISD,NX,M0,stage group changed to ERROR from 0IS; TISU,NX,M0, stage group changed to ERROR from 0IS; TIS,NX,M0, stage group changed to ERROR from 0
- Table referenced by logic updated, stage groups for 042 limited to cases with category TIS or TX with SX
- Corrected edit logic for assigning site/histology group 011 to group 10B or 999 based on histology and CS Site-Specific Factor 25

NAACCR v16D

- Added U7 to required TNM Edition Numbers
- Staging table referenced by edit updated for site/histology groups 032 (Breast), 51A (Uveal Melanoma), and 57B (Primary Cutaneous Lymphoma), values for NOS stage groups not listed in AJCC 7th Edition changed to 99 (e.g., 032, T4NXM0, Stage group 3, changed to T4NXM0, Stage group 99)
- Table referenced by edit updated, 57B, rows for T1A,T1B,T2A,T2B, M0 added

Primary Site, TNM M - c,p pre2016 (NPCR)

Agency: NPCR **Last changed: 07/29/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
TNM Edition Number [Std# 1060]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
Age at Diagnosis [Std# 230]
CS Site-Specific Factor10 [Std# 2864]
CS Site-Specific Factor25 [Std# 2879]
Grade [Std# 440]
TNM Clin M [Std# 960]
TNM Path M [Std# 900]
Type of Reporting Source [Std# 500]

Tables

AJC7MC.DBF
AJC7MP.DBF
AJC7SIGP.DBF

Default Error Message

[3290] TNM M code problem
TNM M code problem

Additional Messages

[3291] TNM Path M code is invalid for site/hist combination
[3292] TNM Clin M code is invalid for site/hist combination
[3293] TNM Clin M code should = "88" for site/hist combination
[3294] TNM Path M code should = "88" for site/hist combination

Description

```
This edit is skipped if any of the following conditions are true:

1. Year of Date of Diagnosis is less than 2014,blank (unknown), or invalid or
diagnosis date is greater than 2015.
2. Type of Reporting Source = 7 (Death Certificate Only)
4. Histologic Type ICD-O-3 is blank
5. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
6. TNM Edition Number is not = 07 and not = 88
7. TNM Clin M and TNM Path M are both blank
)
```

TNM Clin M and TNM Path M may be blank. If entered, they will be edited site-specifically. The edit will check valid TNM Clin M and TNM Path M codes either with or without the "c" or "p" component.

The site-specific TNM M values are listed below. The number next to each site group indicates the chapter in the AJCC Cancer Staging Manual, Edition 7. The sites for each chapter are listed along with the histologies requiring AJCC staging. The allowable values for the clinical and pathologic M codes are listed under TNM M. When there is a difference in allowable values for clinical and pathologic M codes, they will be specified separately.

3. Lip and Oral Cavity

Sites:
C000-C006,C008,C009
C020-C023,C028,C029
C030,C031,C039
C040,C041,C048,C049
C050,C058,C059
C060-C062,C068,C069
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM M:
Clin: 0,1
Path: 1

4. Pharynx

4A. Oropharynx and Hypopharynx
Sites:
C019, C024
C051-C052
C090-C091, C098-C099
C100, C102-C104, C108-C109
C129
C130-C132, C138-C139

Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM M:
Clin: 0,1
Path: 1

4B. Nasopharynx
Sites:
C110, C112-C113, C118-C119
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981

4C. Nasopharynx
Sites:
C111
Discriminator (CS Site-Specific Factor25):
010
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM M:
Clin: 0,1

Path: 1

4D. Oropharynx
Sites:
C111
Discriminator (CS Site-Specific Factor25):
020
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM M:
Clin: 0,1
Path: 1

5. Larynx

5A. Supraglottis, Subglottis, Other
Sites:
C101, C321-C322
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM M:
Clin: 0,1
Path: 1

5B. Glottis
Sites:
C320, C328-C329
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980, 8981
TNM M:
Clin: 0,1
Path: 1

6. Nasal Cavity and Paranasal Sinuses

Sites:
C300, C310-C311
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM M:
Clin: 0,1
Path: 1

7. Major Salivary Glands

Sites:
C079
C080,C081,C088,C089
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8982
TNM M:
Clin: 0,1, 88
Path: 1, 88

8. Thyroid Gland

8A. Thyroid: Papillary/follicular, age less than 045
Sites:
C739
Histologies Requiring AJCC Staging:
8000-8015, 8022, 8033-8344, 8350-8420, 8440-8508,
8514-8576, 8940-8950, 8980-8981
Age at Diagnosis: less than 045
Grade: 1-3 or 9

TNM M:
Clin: 0,1, 88
Path: 1, 88

8B. Thyroid: Papillary/follicular, age greater than or equal 045 but not 999
Sites:
C739
Histologies Requiring AJCC Staging:
8000-8015, 8022, 8033-8344, 8350-8420, 8440-8508,
8514-8576, 8940-8950, 8980-8981
Age at Diagnosis: greater than or equal to 045, but not equal 999
Grade: 1-3 or 9

TNM M:
Clin: 0,1, 88
Path: 1, 88

8C. Thyroid: Papillary/follicular, age equal 999 (unknown)
Sites:
C739
Histologies Requiring AJCC Staging:
8000-8015, 8022, 8033-8344, 8350-8420, 8440-8508,
8514-8576, 8940-8950, 8980-8981
Age at Diagnosis: equal 999
Grade: 1-3 or 9

TNM M:
Clin: 0,1, 88
Path: 1, 88

8D. Thyroid: Medullary
Sites:
C739
Histologies Requiring AJCC Staging:
8345-8347, 8430, 8510, 8512-8513
Grade: 1-3 or 9

TNM M:
Clin: 0,1, 88
Path: 1, 88

8E. Thyroid: Anaplastic
Sites:
C739
Histologies Requiring AJCC Staging:
8020-8021, 8030-8032
TNM M:
Clin: 0,1
Path: 1

8F. Thyroid: Anaplastic

Sites:
C739
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
Grade: 4

TNM M:
Clin: 0,1
Path: 1

9. Mucosal Melanoma of the Head and Neck

Sites:
C000-C006, C008-C009
C019
C020-C024, C028-C029
C030-C031, C039
C040-C041, C048-C049
C050-C052, C058-C059
C060-C062, C068-C069
C090-C091, C098-C099
C100-C104, C108-C109
C110-C113, C118-C119
C129
C132, C138-C139
C140, C142, C148
C300
C310-C311
C320-C323, C328-C329
Histologies Requiring AJCC Staging:
8720-8790
TNM M:
Clin: 0,1, 88
Path: 1, 88

10. Esophagus and Esophagus Gastric Junction

10A. Esophagus
Sites:
C150-C155, C158-C159
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM M:
Clin: 0,1
Path: 1

10B. Esophagus Gastric Junction
Sites:
C160-C162
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981
Discriminator (CS Site-Specific Factor25):
020, 040, 060 (for C161-C162), 982 (982 is for C160 only)
TNM M:
Clin: 0,1
Path: 1

11. Stomach

Sites:
C161-C162 and Discriminator (CS Site-Specific Factor 25) = 000, 030, 100, 999
C163-C166, C168-C169 and Discriminator (CS Site-Specific Factor 25) = 981
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8990
TNM M:
Clin: 0,1
Path: 1

12. Small Intestine

Sites:
C170-C172, C178-C179
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981
TNM M:
Clin: 0,1
Path: 1

13. Appendix

13A. Appendix: Carcinoma
Sites:
C181
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981
TNM M:
Clin: 0,1,1A,1B
Path: 1,1A,1B

13B. Appendix: Carcinoid
Sites:
C181
Histologies Requiring AJCC Staging:
8240-8242, 8246, 8249, 8153
TNM M:
Clin: 0,1, 88
Path: 1, 88

14. Colon and Rectum

Sites:
C180, C182-C189
C199
C209
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981
TNM M:
Clin: 0,1,1A,1B
Path: 1,1A,1B

15. Anus

Sites:
C210-C212, C218
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8250-8576, 8940-8950, 8980-8981
TNM M:
Clin: 0,1
Path: 1

16. Gatrointestinal Stromal Tumor (GIST)

16A. GIST: Gastric
Sites:
C160-C169
C480-C488 and CS Site-Specific Factor 10 = 020 (Omentum)
Histologies Requiring AJCC Staging:
8935-8936
TNM M:
Clin: 0,1, 88
Path: 1, 88

16B. GIST: Small Intestine
Sites:
C150-C159
C170-C172, C178, C179
C180-C189
C199
C209
C480-C488 and CS Site-Specific Factor 10 not = 020 (Omentum)
Histologies Requiring AJCC Staging:
8935-8936
TNM M:
Clin: 0,1, 88
Path: 1, 88

17. Neuroendocrine Tumors (NET)

17A. NET: Stomach
Sites:
C160-C169
Histologies Requiring AJCC Staging:
8153, 8240-8242, 8246, 8249
TNM M:
Clin: 0,1
Path: 1

17B. NET: Small Intestine and Ampulla of Vater
Sites:
C170-C179
C241
Histologies Requiring AJCC Staging:
8153, 8240-8242, 8246, 8249
TNM M:
Clin: 0,1, 88
Path: 1, 88

17C. NET: Colon and Rectum
Sites:

C180, C182-C189
C199, C209
Histologies Requiring AJCC Staging:
8153, 8240-8242, 8246, 8249
TNM M:
Clin: 0,1, 88
Path: 1, 88

18. Liver

18A. Sites:
C220
Histologies Requiring AJCC Staging:
8170-8175
TNM M:
Clin: 0,1,88
Path: 1,88

18B. Sites:
C221
Histologies Requiring AJCC Staging:
8170-8175
TNM M:
Clin: 0,1,88
Path: 1,88

19. Intrahepatic Bile Ducts

19A. Sites:
C220
Histologies Requiring AJCC Staging:
8160, 8161, 8180
TNM M:
Clin: 0,1,88
Path: 1,88

19B. Sites:
C221
Histologies Requiring AJCC Staging:
8160, 8161, 8180
TNM M:
Clin: 0,1
Path: 1

20. Gallbladder

Sites:
C239
C240 and Discriminator (CS Site-Specific Factor 25) = 030
Histologies Requiring AJCC Staging:
8000-8152,8154-8231, 8243-8245, 8250-8576, 8940-8950, 8980-8981
TNM M:
Clin: 0,1
Path: 1

21. Perihilar Bile Ducts

Sites:
C240 and Discriminator (CS Site-Specific Factor 25) = 010, 020, 050, 060, 999
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8250-8576, 8940-8950, 8980-8981
TNM M:
Clin: 0,1
Path: 1

22. Distal Bile Duct

Sites:
C240 and Discriminator (CS Site-Specific Factor 25) = 040, 070
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8250-8576, 8940-8950, 8980-8981
TNM M:
Clin: 0,1
Path: 1

23. Ampulla of Vater

Sites:
C241
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8250-8576, 8940-8950, 8980-8981
TNM N:
TNM M:
Clin: 0,1
Path: 1

24. Exocrine and Endocrine Pancreas

Sites:
C250-C254, C257-C259
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8971, 8980-8981
TNM M:
Clin: 0,1
Path: 1

25. Lung

Sites:
C340-C343,C348,C349
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM M:
Clin: 0,1,1A,1B
Path: 1,1A,1B

26. Pleural Mesothelioma

Sites:
C384

Histologies Requiring AJCC Staging:
     9050-9053
TNM M:
     Clin: 0,1
     Path: 1

27. Bone

Sites:
     C400-C403, C408-C409
     C410-C414, C418-C419
Histologies Permitting AJCC Staging:
       8800-9136, 9142-9582
TNM M:
     Clin: 0,1.1A.1B
     Path: 1.1A,1B

28. Soft Tissue Sarcoma

Peritoneum - not female
Sites:
     C481-C482, C488
Histologies:
    8800-8820, 8823-8934, 8940-9136, 9142-9582
CS Site-Specific Factor25 = not 002 (that is, not female)

Peritoneum - female
Sites:
     C481-C482, C488
Histologies:
    8800-8820, 8823-8921, 9120-9136, 9142-9582
CS Site-Specific Factor25 = 002 (female)

Heart,Mediastinum, Soft Tissue
Sites:
     C380-C383, C388
     C470-C476, C478-C479
     C490-C496, C498-C499
Histologies:
    8800-8820, 8823-8935, 8940-9136, 9142-9582

Retroperitoneum
Sites:
     C480
Histologies:
    8800-8820, 8823-8934, 8940-9136, 9142-9582

TNM M:
     Clin: 0,1
     Path: 1

29. Cutaneous Squamous Cell Carcinoma and other Cutaneous Carcinomas

Sites:
     C440, C442-C449, C632
Histologies Requiring AJCC Staging:
       8000-8246, 8248-8576, 8940-8950, 8980-8981

TNM M:
Clin: 0,1
Path: 1

30. Merkel Cell Carcinoma

Sites:
C440, C442-C449,
C510-C512, C518-C519
C600-C602, C608-C609
C632
Histologies Requiring AJCC Staging:
8247
TNM M:
Clin: 0,1,1A,1B,1C
Path: 1,1A,1B,1C

31. Melanoma of the Skin

Sites:
C440-C449
C510-C512,C518,C519
C600-C602, C608, C609
C632
Histologies Requiring AJCC Staging:
8270-8290
TNM M:
Clin: 0,1,1A,1B,1C
Path: 1,1A,1B,1C

32. Breast

Sites:
C500-C506,C508,C509
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981, 9020
TNM M:
Clin: 0,0I+,1
Path: 1

33. Vulva

Sites:
C510-C512,C518,C519
Histologies Requiring AJCC Staging:
8000-8246, 8248-8276, 8940-8950, 8980-8981
TNM M:
Clin: 0,1
Path: 1

34. Vagina

Sites:
C529
Histologies Requiring AJCC Staging:

8000-8576, 8800-8801, 8940-8950, 8980-8981
TNM M:
Clin: 0,1
Path: 1

35. Cervix Uteri

Sites:
C530,C531,C538,C539
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM M:
Clin: 0,1
Path: 1

36. Corpus Uteri

36A. Corpus Uteri: Carcinomas
Sites
C540-C543, C548-C549
C559
Histologies Requiring AJCC Staging:
8000-8790, 8950-8951, 8980-8981
TNM M:
Clin: 0,1
Path: 1

36B. Corpus Uteri: Leiomyosarcoma and Endometrial Stromal Sarcoma
Sites:
C540-C543, C548-C549
C559
Histologies Requiring AJCC Staging:
8800, 8890-8898, 8900-8921, 8930-8931, 8935
TNM M:
Clin: 0,1,88
Path: 1,88

36C. Corpus Uteri: Adenosarcoma
Sites:
C540-C543, C548-C549
C559
Histologies Requiring AJCC Staging:
8933
TNM M:
Clin: 0,1,88
Path: 1,88

37. Ovary and Peritoneal Carcinomas

37A. Ovary
Sites:
C569
Histologies Requiring AJCC Staging:
8000-8576, 8590-8671, 8930-9110
TNM M:
Clin: 0,1, 88
Path: 1, 88

37B. Peritoneal Carcinomas
Sites:
C481-C482, C488 (Sex = 2,female) and Discriminator (CS Site-Specific Factor 25) = 002
Histologies Requiring AJCC Staging:
8000-8576, 8590-8671, 8930-8934, 8940-9110
TNM M:
Clin: 0,1
Path: 1

38. Fallopian Tube

Sites:
C570
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM M:
Clin: 0,1
Path: 1

39. Gestational Trophoblastic Tumors

Sites:
C589
Histologies Requiring AJCC Staging:
9100-9105
TNM M:
Clin: 0,1,1A,1B,88
Path: 1,1A,1B,88

40. Penis

Sites:
C600-C602,C608,C609
Histologies Requiring AJCC Staging:
8000-8246, 8248-8576, 8940-8950, 8980-8981
TNM M:
Clin: 0,1
Path: 1

41. Prostate

Sites:
C619
Histologies Requiring AJCC Staging:
8000-8110, 8140-8576, 8940-8950, 8980-8981
TNM M:
Clin: 0,1,1A,1B,1C, 88
Path: 1,1A,1B,1C, 88

42. Testis

Sites:
C620,C621,C629

Histologies Requiring AJCC Staging:

8000-8576, 8590-8670, 8940-8950, 8980-8981, 9060-9090, 9100-9105

TNM M:
Clin: 0,1,1A,1B
Path: 1,1A,1B

43. Kidney

Sites:
C649
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM M:
Clin: 0,1, 88
Path: 1, 88

44. Renal Pelvis and Ureter

Sites:
C659
C669
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM M:
Clin: 0,1
Path: 1

45. Urinary Bladder

Sites:
C670-C679
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM M:
Clin: 0,1
Path: 1

46. Urethra

Sites:
C680
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM M:
Clin: 0,1
Path: 1

47. Adrenal

47A. Adrenal Cortex
Sites:
C740
Histologies Requiring AJCC Staging:
8010, 8140, 8370
TNM M:

Clin: 0,1, 88
Path: 1, 88

47B. Adrenal Cortical Carcinoma
Sites:
C749
Histologies Requiring AJCC Staging:
8370
TNM M:
Clin: 0,1, 88
Path: 1, 88

48. Carcinoma of the Eyelid

Sites:
C441
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM M:
Clin: 0,1
Path: 1

49. Conjunctiva

Sites:
C690
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM M:
Clin: 0,1
Path: 1

50. Malignant Melanoma of the Conjunctiva

Sites:
C690
Histologies Requiring AJCC Staging:
8720-8790
TNM M:
Clin: 0,1
Path: 1

51. Malignant Melanoma of Uvea

51A. Ciliary Body and Choroid
Sites:
C693
C694 (CS Site-Specific Factor 25 = 010 or 999)
Histologies Requiring AJCC Staging:
8720-8790
TNM M:
Clin: 0,1,1A,1B,1C,88
Path: 1,1A,1B,1C,88

51B. Iris

Sites:
C694 (CS Site-Specific Factor 25 = 020)
Histologies Requiring AJCC Staging:
8720-8790
TNM M:
Clin: 0,1,1A,1B,1C,88
Path: 1,1A,1B,1C,88

52. Retinoblastoma

Sites:
C692
Histologies Requiring AJCC Staging:
9510-9514
TNM M:
Clin: 0,1,1A,1B,1C,1D,1E
Path: 1,1A,1B,1C,1D,1E

53. Carcinoma of the Lacrimal Gland
Sites:
C695 and CS Site-Specific Factor25 = 015
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM M:
Clin: 0,1
Path: 1

54. Sarcoma of the Orbit

Sites:
C696, C698
Histologies Requiring AJCC Staging:
8800-8936, 8940-9136, 9141-9508, 9520-9582
TNM M:
Clin: 0,1, 88
Path: 1, 88

55. Ocular Adnexal Lymphoma

Sites:
C441, C690, C695-C696
Histologies Requiring AJCC Staging:
9590-9699, 9702-9738, 9811-9818, 9820-9837
TNM M:
Clin: 0,1,1A,1B,1C
Path: 1,1A,1B,1C

56. Brain and Spinal Cord

Sites:
C700, C701, C709, C710-C719, C720-C729, C751-C753
Histologies Requiring AJCC Staging:
8000, 8680-9136,9141-9582
TNM M:
88

```
57. Lymphoid Neoplasms

57A. Hodgkin and Non-Hodgkin
Sites:
     C000-C419, C422-C423, C425-C440, C442-C689, C691-C694, C698-C809
Histologies Requiring AJCC Staging:
     9590-9699, 9702-9729, 9735, 9737-9738, 9811-9818, 9823, 9827, 9837
TNM M:
     88

57B. Primary Cutaneous Lymphomas
Sites:
     C440-C449
     C510-C512, C518-C519
     C600-C602, C608-C609, C632
Histologies Requiring AJCC Staging:
     9700,9701
TNM M:
     Clin: 0,1,88
     Path: 1,88

All Others
TNM M:
     88
```

Administrative Notes

New edit - added to NAACCR v16 metafile. This edit is based on
Primary Site, AJCC M - Ed 7 ICD03, but it checks TNM Clin M and TNM Path M values for pre-2016 diagnoses coded either with or without "c" and "p" components. This edit could be used for either converted cases or pre2016 cases diagnosed in 2016 software.

Primary Site, TNM N - c,p pre2016 (NPCR)

Agency: NPCR **Last changed: 06/14/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
TNM Edition Number [Std# 1060]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
Age at Diagnosis [Std# 230]
CS Site-Specific Factor10 [Std# 2864]
CS Site-Specific Factor25 [Std# 2879]
Grade [Std# 440]
TNM Clin N [Std# 950]
TNM Path N [Std# 890]
Type of Reporting Source [Std# 500]

Tables

AJC7NC.DBF
AJC7NP.DBF
AJC7SIGP.DBF

Default Error Message

[3285] TNM N code problem
TNM N code problem

Additional Messages

[3286] TNM Path N code is invalid for site/hist combination
[3287] TNM Clin N code is invalid for site/hist combination
[3288] TNM Clin N code should = "88" for site/hist combination
[3289] TNM Path N code should = "88" for site/hist combination

Description

```
This edit is skipped if any of the following conditions are true:

1. Year of Date of Diagnosis is less than 2014, blank (unknown), or invalid, or
date of diagnosis is greater than 2015
2. Type of Reporting Source = 7 (Death Certificate Only)
3. Histologic Type ICD-O-3 is blank
4. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
5. TNM Edition Number is not = 07, U7, 88
6. TNM Clin N and TNM Path N are both blank
```

TNM Clin N and TNM Path N may be blank. If entered, they will be edited site-specifically. The edit will check valid TNM Clin N and TNM Path N codes either with or without the "c" or "p" component.

The site-specific TNM N values are listed below.The number next to each site group indicates the chapter in the AJCC Cancer Staging Manual, Edition 7. The sites for each chapter are listed along with the histologies requiring AJCC staging. The allowable values for the clinical and pathologic N codes are listed under TNM N. When there is a difference in allowable values for clinical and pathologic N codes, they will be specified separately.

3. Lip and Oral Cavity

Sites:
C000-C006,C008,C009
C020-C023,C028,C029
C030,C031,C039
C040,C041,C048,C049
C050,C058,C059
C060-C062,C068,C069
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM N:
X,0,1,2,2A,2B,2C,3

4. Pharynx

4A. Oropharynx and Hypopharynx
Sites:
C019, C024
C051-C052
C090-C091, C098-C099
C100, C102-C104, C108-C109
C129
C130-C132, C138-C139

Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM N:
X,0,1,2,2A,2B,2C,3

4B. Nasopharynx
Sites:
C110, C112-C113, C118-C119
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM N:
X,0,1,2,3,3A,3B

4C. Nasopharynx
Sites:
C111
Discriminator (CS Site-Specific Factor25):
010
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM N:
X,0,1,2,3,3A,3B

4D. Oropharynx
Sites:
C111
Discriminator (CS Site-Specific Factor25):
020
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM N:
X,0,1,2,2A,2B,2C,3

5. Larynx

5A. Supraglottis, Subglottis, Other
Sites:
C101, C321-C322
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM N:
X,0,1,2,2A,2B,2C,3

5B. Glottis
Sites:
C320, C328-C329
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980, 8981
TNM N:
X,0,1,2,2A,2B,2C,3

6. Nasal Cavity and Paranasal Sinuses

Sites:
C300, C310-C311
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM N:
X,0,1,2,2A,2B,2C,3

7. Major Salivary Glands

Sites:
C079
C080,C081,C088,C089
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8982
TNM N:
X,0,1,2,2A,2B,2C,3, 88

8. Thyroid Gland

8A. Thyroid: Papillary/follicular, age less than 045
Sites:
C739
Histologies Requiring AJCC Staging:
8000-8015, 8022, 8033-8344, 8350-8420, 8440-8508,
8514-8576, 8940-8950, 8980-8981

Age at Diagnosis: less than 045
Grade: 1-3 or 9
TNM N:
X,0,1,1A,1B, 88

8B. Thyroid: Papillary/follicular, age greater than or equal 045 but not 999
Sites:
C739
Histologies Requiring AJCC Staging:
8000-8015, 8022, 8033-8344, 8350-8420, 8440-8508,
8514-8576, 8940-8950, 8980-8981
Age at Diagnosis: greater than or equal to 045, but not equal 999
Grade: 1-3 or 9
TNM N:
X,0,1,1A,1B, 88

8C. Thyroid: Papillary/follicular, age equal 999 (unknown)
Sites:
C739
Histologies Requiring AJCC Staging:
8000-8015, 8022, 8033-8344, 8350-8420, 8440-8508,
8514-8576, 8940-8950, 8980-8981
Age at Diagnosis: equal 999
Grade: 1-3 or 9
TNM N:
X,0,1,1A,1B, 88

8D. Thyroid: Medullary
Sites:
C739
Histologies Requiring AJCC Staging:
8345-8347, 8430, 8510, 8512-8513
Grade: 1-3 or 9
TNM N:
X,0,1,1A,1B, 88

8E. Thyroid: Anaplastic
Sites:
C739
Histologies Requiring AJCC Staging:
8020-8021, 8030-8032
TNM N:
X,0,1,1A,1B

8F. Thyroid: Anaplastic
Sites:
C739
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
Grade: 4
TNM N:
X,0,1,1A,1B

9. Mucosal Melanoma of the Head and Neck

Sites:
C000-C006, C008-C009
C019
C020-C024, C028-C029

C030-C031, C039
C040-C041, C048-C049
C050-C052, C058-C059
C060-C062, C068-C069
C090-C091, C098-C099
C100-C104, C108-C109
C110-C113, C118-C119
C129
C132, C138-C139
C140, C142, C148
C300
C310-C311
C320-C323, C328-C329

Histologies Requiring AJCC Staging:
8720-8790

TNM N:
X,0,1, 88

10. Esophagus and Esophagus Gastric Junction

10A. Esophagus

Sites:
C150-C155, C158-C159

Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981

TNM N:
X,0,1,2,3

10B. Esophagus Gastric Junction

Sites:
C160-C162

Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981

Discriminator (CS Site-Specific Factor25):
020, 040, 060 (for C161-C162), 982 (982 is for C160 only)

TNM N:
X,0,1,2,3

11. Stomach

Sites:
C161-C162 and Discriminator (CS Site-Specific Factor 25) = 000, 030, 100, 999
C163-C166, C168-C169 and Discriminator (CS Site-Specific Factor 25) = 981

Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8990

TNM N:
X,0,1,2,3.3A,3B

12. Small Intestine

Sites:
C170-C172, C178-C179

Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981

TNM N:

X,0,1,2

13. Appendix

13A. Appendix: Carcinoma
Sites:
C181
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981
TNM N:
X,0,1,2,3

13B. Appendix: Carcinoid
Sites:
C181
Histologies Requiring AJCC Staging:
8240-8242, 8246, 8249, 8153
TNM N:
X,0,1, 88

14. Colon and Rectum

Sites:
C180, C182-C189
C199
C209
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981
TNM N:
X,0,1,1A,1B,1C,2,2A,2B

15. Anus

Sites:
C210-C212, C218
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8250-8576, 8940-8950, 8980-8981
TNM N:
X,0,1,2,3

16. Gatrointestinal Stromal Tumor (GIST)

16A. GIST: Gastric
Sites:
C160-C169
C480-C488 and CS Site-Specific Factor 10 = 020 (Omentum)
Histologies Requiring AJCC Staging:
8935-8936
TNM N:
X,0,1, 88

16B. GIST: Small Intestine
Sites:
C150-C159
C170-C172, C178, C179
C180-C189

C199
C209
C480-C488 and CS Site-Specific Factor 10 not = 020 (Omentum)
Histologies Requiring AJCC Staging:
8935-8936
TNM N:
X,0,1, 88

17. Neuroendocrine Tumors (NET)

17A. NET: Stomach
Sites:
C160-C169
Histologies Requiring AJCC Staging:
8153, 8240-8242, 8246, 8249
TNM N:
X,0,1

17B. NET: Small Intestine and Ampulla of Vater
Sites:
C170-C179
C241
Histologies Requiring AJCC Staging:
8153, 8240-8242, 8246, 8249
TNM N:
X,0,1, 88

17C. NET: Colon and Rectum
Sites:
C180, C182-C189
C199, C209
Histologies Requiring AJCC Staging:
8153, 8240-8242, 8246, 8249
TNM N:
X,0,1, 88

18. Liver

18A. Sites:
C220
Histologies Requiring AJCC Staging:
8170-8175
TNM N:
X,0,1,88

18B. Sites:
C221
Histologies Requiring AJCC Staging:
8170-8175
TNM N:
X,0,1,88

19. Intrahepatic Bile Ducts

19A. Sites:
C220
Histologies Requiring AJCC Staging:

8160, 8161, 8180
TNM N:
X,0,1, 88

19B. Sites:
C221
Histologies Requiring AJCC Staging:
8160, 8161, 8180
TNM N:
X,0,1

20. Gallbladder

Sites:
C239
C240 and Discriminator (CS Site-Specific Factor 25) = 030
Histologies Requiring AJCC Staging:
8000-8152,8154-8231, 8243-8245, 8250-8576, 8940-8950, 8980-8981
TNM N:
X,0,1,2

21. Perihilar Bile Ducts

Sites:
C240 and Discriminator (CS Site-Specific Factor 25) = 010, 020, 050, 060, 999
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8250-8576, 8940-8950, 8980-8981
TNM N:
X,0,1,2

22. Distal Bile Duct

Sites:
C240 and Discriminator (CS Site-Specific Factor 25) = 040, 070
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8250-8576, 8940-8950, 8980-8981
TNM N:
X,0,1

23. Ampulla of Vater

Sites:
C241
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8250-8576, 8940-8950, 8980-8981
TNM N:
X,0,1

24. Exocrine and Endocrine Pancreas

Sites:
C250-C254, C257-C259
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8971, 8980-8981

TNM N:
X,0,1

25. Lung

Sites:
C340-C343,C348,C349
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM N:
X,0,1,2,3

26. Pleural Mesothelioma

Sites:
C384
Histologies Requiring AJCC Staging:
9050-9053
TNM N:
X,0,1,2,3

27. Bone

Sites:
C400-C403, C408-C409
C410-C414, C418-C419
Histologies Permitting AJCC Staging:
8800-9136, 9142-9582
TNM N:
X,0,1

28. Soft Tissue Sarcoma

Peritoneum - not female
Sites:
C481-C482, C488
Histologies:
8800-8820, 8823-8934, 8940-9136, 9142-9582
CS Site-Specific Factor25 = not 002 (that is, not female)

Peritoneum - female
Sites:
C481-C482, C488
Histologies:
8800-8820, 8823-8921, 9120-9136, 9142-9582
CS Site-Specific Factor25 = 002 (female)

Heart,Mediastinum, Soft Tissue
Sites:
C380-C383, C388
C470-C476, C478-C479
C490-C496, C498-C499
Histologies:
8800-8820, 8823-8935, 8940-9136, 9142-9582

Retroperitoneum

Sites:
C480
Histologies:
8800-8820, 8823-8934, 8940-9136, 9142-9582

TNM N:
X,0,1

29. Cutaneous Squamous Cell Carcinoma and other Cutaneous Carcinomas

Sites:
C440, C442-C449, C632
Histologies Requiring AJCC Staging:
8000-8246, 8248-8576, 8940-8950, 8980-8981
TNM N:
X,0,1,2,2A,2B,2C,3

30. Merkel Cell Carcinoma

Sites:
C440, C442-C449,
C510-C512, C518-C519
C600-C602, C608-C609
C632
Histologies Requiring AJCC Staging:
8247
TNM N:
X,0,1,1A,1B,2

31. Melanoma of the Skin

Sites:
C440-C449
C510-C512,C518,C519
C600-C602, C608, C609
C632
Histologies Requiring AJCC Staging:
8720-8790
TNM N:
X,0,1,1A,1B,2,2A,2B,2C,3

32. Breast

Sites:
C500-C506,C508,C509
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981, 9020
TNM N:
Clin: X,0,1,2,2A,2B,3,3A,3B,3C
Path: X,0,0I-,0I+,0M-,0M+,1,1A,1B,1C,1MI,2,2A,2B,3,3A,3B,3C

33. Vulva

Sites:
C510-C512,C518,C519

Histologies Requiring AJCC Staging:
8000-8246, 8248-8576, 8940-8950, 8980-8981
TNM N:
X,0,1,1A,1B,2,2A,2B,2C,3

34. Vagina

Sites:
C529
Histologies Requiring AJCC Staging:
8000-8576, 8800-8801, 8940-8950, 8980-8981
TNM N:
X,0,1

35. Cervix Uteri

Sites:
C530,C531,C538,C539
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM N:
X,0,1

36. Corpus Uteri

36A. Corpus Uteri: Carcinomas
Sites
C540-C543, C548-C549
C559
Histologies Requiring AJCC Staging:
8000-8790, 8950-8951, 8980-8981
TNM N:
X,0,1,2

36B. Corpus Uteri: Leiomyosarcoma and Endometrial Stromal Sarcoma
Sites:
C540-C543, C548-C549
C559
Histologies Requiring AJCC Staging:
8800, 8890-8898, 8900-8921, 8930-8931, 8935
TNM N:
X,0,1,88

36C. Corpus Uteri: Adenosarcoma
Sites:
C540-C543, C548-C549
C559
Histologies Requiring AJCC Staging:
8933
TNM N:
X,0,1,88

37. Ovary and Peritoneal Carcinomas

37A. Ovary
Sites:

C569
Histologies Requiring AJCC Staging:
8000-8576, 8590-8671, 8930-9110
TNM N:
X,0,1, 88

37B. Peritoneal Carcinomas
Sites:
C481-C482, C488 (Sex = 2,female) and Discriminator (CS Site-Specific Factor 25) = 002
Histologies Requiring AJCC Staging:
8000-8576, 8590-8671, 8930-8934, 8940-9110
TNM N:
X,0,1

38. Fallopian Tube

Sites:
C570
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM N:
X,0,1

39. Gestational Trophoblastic Tumors

Sites:
C589
Histologies Requiring AJCC Staging:
9100-9105
TNM N:
0, 88

40. Penis

Sites:
C600-C602,C608,C609
Histologies Requiring AJCC Staging:
8000-8246, 8248-8576, 8940-8950, 8980-8981
TNM N:
X,0,1,2,3

41. Prostate

Sites:
C619
Histologies Requiring AJCC Staging:
8000-8110, 8140-8576, 8940-8950, 8980-8981
TNM N:
X,0,1, 88

42. Testis

Sites:
C620,C621,C629
Histologies Requiring AJCC Staging:

8000-8576, 8590-8670, 8940-8950, 8980-8981, 9060-9090, 9100-9105
TNM N:
X,0,1,2,3

43. Kidney

Sites:
C649
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM N:
X,0,1, 88

44. Renal Pelvis and Ureter

Sites:
C659
C669
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM N:
X,0,1,2,3

45. Urinary Bladder

Sites:
C670-C679
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM N:
X,0,1,2,3

46. Urethra

Sites:
C680
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM N:
X,0,1,2

47. Adrenal

47A. Adrenal Cortex
Sites:
C740
Histologies Requiring AJCC Staging:
8010, 8140, 8370
TNM N:
X,0,1, 88

47B. Adrenal Cortical Carcinoma
Sites:
C749
Histologies Requiring AJCC Staging:

8370
TNM N:
X,0,1, 88

48. Carcinoma of the Eyelid

Sites:
C441
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM N:
X,0,1

49. Conjunctiva

Sites:
C690
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM N:
X,0,1

50. Malignant Melanoma of the Conjunctiva

Sites:
C690
Histologies Requiring AJCC Staging:
8720-8790
TNM N:
Clin: X,0,0A,0B,1
Path: X,0,1

51. Malignant Melanoma of Uvea

51A. Ciliary Body and Choroid
Sites:
C693
C694 (CS Site-Specific Factor 25 = 010 or 999)
Histologies Requiring AJCC Staging:
8720-8790
TNM N:
X,0,1,88

51B. Iris
Sites:
C694 (CS Site-Specific Factor 25 = 020)
Histologies Requiring AJCC Staging:
8720-8790
TNM N:
X,0,1,88

52. Retinoblastoma

Sites:

C692
Histologies Requiring AJCC Staging:
9510-9514
TNM N:
X,0,1,2

53. Carcinoma of the Lacrimal Gland
Sites:
C695 and CS Site-Specific Factor25 = 015
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM N:
X,0,1

54. Sarcoma of the Orbit

Sites:
C696, C698
Histologies Requiring AJCC Staging:
8800-8936, 8940-9136, 9141-9508, 9520-9582
TNM N:
X,0,1

55. Ocular Adnexal Lymphoma

Sites:
C441, C690, C695-C696
Histologies Requiring AJCC Staging:
9590-9699, 9702-9738, 9811-9818, 9820-9837
TNM N:
X,0,1,2,3,4

56. Brain and Spinal Cord

Sites:
C700, C701, C709, C710-C719, C720-C729, C751-C753
Histologies Requiring AJCC Staging:
8000, 8680-9136,9141-9582
TNM N:
88

57. Lymphoid Neoplasms

57A. Hodgkin and Non-Hodgkin
Sites:
C000-C419, C422-C423, C425-C440, C442-C689, C691-C694, C698-C809
Histologies Requiring AJCC Staging:
9590-9699, 9702-9729, 9735, 9737-9738, 9811-9818, 9823, 9827, 9837
TNM N:
88

57B. Primary Cutaneous Lymphomas
Sites:
C440-C449
C510-C512, C518-C519

```
     C600-C602, C608-C609, C632
Histologies Requiring AJCC Staging:
     9700,9701
TNM N:
     X,0,1,1A,1B,2,2A,2B,3,88

All Others
TNM N:
     88
```

Administrative Notes

New edit - added to NAACCR v16 metafile. This edit is based on
Primary Site, AJCC N - Ed 7 ICD03, but it checks TNM Clin N and TNM Path N values for pre-2016 diagnoses coded either with or without "c" and "p" components. This edit could be used for either converted cases or pre2016 cases diagnosed in 2016 software.

Primary Site, TNM Path Stage Valid A-Ed 7 (COC)

Agency: COC **Last changed: 02/16/2017**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

TNM Path T [Std# 880]
TNM Path N [Std# 890]
TNM Path M [Std# 900]
TNM Path Stage Group [Std# 910]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
Date of Diagnosis [Std# 390]
TNM Edition Number [Std# 1060]
TNM Path Descriptor [Std# 920]
Age at Diagnosis [Std# 230]
Grade [Std# 440]
CS Site-Specific Factor 5 [Std# 2920]
CS Site-Specific Factor 6 [Std# 2930]
CS Site-Specific Factor10 [Std# 2864]
CS Site-Specific Factor11 [Std# 2865]
CS Site-Specific Factor25 [Std# 2879]
Sex [Std# 220]
Type of Reporting Source [Std# 500]

Tables

AC7G2016.DBF
PAST7VAL.DBF

Default Error Message

[3038] TNM stage problem
TNM stage problem

Additional Messages

[6009] Inconsistency between TNM categories T"value of TNM Path T" N"value of TNM Path N" M"value of TNM Path M" and assigned TNM stage "value of TNM Path Stage Group"
[6010] Combination of T"value of TNM Path T" N"value of TNM Path N" M"value of TNM Path M" is invalid for TNM staging
[6011] T"value of TNM Path T" N"value of TNM Path N" M"value of TNM Path M", staging parameter for "value of Primary Site", inconsistent with TNM stage "value of TNM Path Stage Group"
[6027] Combination T"value of TNM Path T" N"value of TNM Path N" M"value of TNM Path M", staging parameter for "value of Primary Site", invalid forTNM staging

Description

This edit is skipped if any of the following conditions are true:

1. Year of Date of Diagnosis is less than 2016, blank (unknown), or invalid
2. TNM Edition Number is not = 07,U7, 88
3. Histologic Type ICD-O-3 is blank
4. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
5. TNM Path Stage Group is blank
6. TNM Path T, TNM Path N,or TNM Path M is blank
7. TNM Path Descriptor = 4 or 6

The purpose of this edit is to validate the coded TNM categories, and site-specific staging parameters where used, with the coded Stage Group assignments. The edit is used for site/histology groups in AJCC 7th Edition chapters 3 through 28. Some TNM chapters require elements in addition to T, N, and M categories, such as grade or mitotic rate. for correct stage assignment. In this edit description, these elements are called staging parameters. The edit will not be skipped but will pass if a required staging parameter is blank.

The edit compares the combination of TNM Path T, TNM Path N, TNM Path M categories, and staging parameter where required, with TNM Path Stage Group. The edit is skipped if TNM Path Descriptor is 4 or 6, indicating stage assignment after neoadjuvant treatment. (With neoadjuvaant treatment, combinations of T, N, M and staging parameters are allowed that would not be valid otherwise.)

The designation of "c" or "p" within the individual T, N, and M codes is ignored for this edit. Valid codes for individual fields (TNM Path T, TNM Path N, TNM Path M, TNM Path Stage Group), and for these individual fields by primary site, are checked in other edits.

An edit failure is returned if the Path Stage Group is inconsistent with the expected group assignment for the coded T, N, M, and staging parameter if required, based on the AJCC stage tables. If a T, N, or M value is coded that is not included in the AJCC stage tables -- for example T4 is coded but only T4A and T4B are staged -- the stage assignment will not be checked and the edit will pass.

An edit failure is also returned if either the coded Path Stage Group returns "ERROR" from the lookup table, meaning that the combination of T, N, M, and staging parameter is invalid. Invalid combinations include T0N0M0/M0I+; T in situ with positive N and/or positive M category; and a Testis stage with an invalid S category. An invalid S category results when one or more of the 3 site-specific factors required to determine the category (SSF 13-AFP, SSF 15-hCG, SSF 16-LDH) is coded 988, meaning not applicable.

The site/histology groups are listed below. The number next to each site title indicates the respective chapter in the AJCC Cancer Staging Manual, Edition 7.The site/histology groups and group stage values are identified by site and histology in the edit Primary Site, Stage Group 2016 - Ed 7. Subdivisions of some groups were required for this edit; they are identified below with their criteria. Site-specific staging parameters are also identified. The description does not include the list of TNM categories, staging parameters, and stage groups; this information is contained in a table within EditWriter that contains around 14,700 records.

3. Lip and Oral Cavity

4. Pharynx

4A. Oropharynx and Hypopharynx
4B. Nasopharynx
4C. Nasopharynx
4D. Oropharynx - Pharyngeal Tonsil

5. Larynx

5A. Supraglottis, Subglottis, Other
5B. Glottis

6. Nasal Cavity and Paranasal Sinuses

7. Major Salivary Glands

8. Thyroid Gland

8A. Thyroid: Papillary/follicular, age less than 045
8B. Thyroid: Papillary/follicular, age greater than or equal 045 but not 999
8C. Thyroid: Papillary/follicular, age equal 999 (unknown)
8D. Thyroid: Medullary
8E. Thyroid: Anaplastic
8F. Thyroid: Anaplastic

9. Mucosal Melanoma of the Head and Neck

10. Esophagus and Esophagus Gastric Junction

10A. Esophagus

Division for Staging:
10C. Esophagus Adenocarcinoma
Histologies: 8050, 8140-8147, 8160-8162, 8170-8175, 8180-8221, 8250-8507, 8514-8551,8571-8574, 8576, 8940-8941
10D. Esophagus Squamous Cell Carcinoma
Histologies: 8000-8046, 8051-8131, 8148-8157, 8230-8249, 8508, 8510-8513, 8560-8570, 8575, 8905, 8980-8981
Sites and TNM not included in 10E, 10H
10E. Esophagus Squamous Cell Carcinoma
Site, TNM: C150, C151, C153, C154, pT2pN0cM0, pT3pN0cM0
10H: Esophagus Squamous Cell Carcinoma
Site, TNM: C152, C155, C158, C159 pT2pN0cM0, pT3pN0cM0

Staging Parameter: Grade

10B. Esophagus Gastric Junction

Division for Staging:
10F. Esophagus Gastric Junction Adenocarcinoma
Histologies: 8050, 8140-8147, 8160-8162, 8170-8175, 8180-8221, 8250-8507, 8514-8551,8571-8574, 8576, 8940-8941
10G. Esophagus Gastric Junction Squamous Cell Carcinoma
Histologies: 8000-8046, 8051-8131, 8148-8157, 8230-8249, 8508, 8510-8513, 8560-8570, 8575, 8905, 8980-8981

Staging Parameter: Grade

11. Stomach

12. Small Intestine

13. Appendix

13A. Appendix: Carcinoma

Staging Parameter: Grade for mucinous and non-mucinous tumors, as collected in CS SSF 11

13B. Appendix: Carcinoid

14. Colon and Rectum

15. Anus

16. Gastrointestinal Stromal Tumor (GIST)

16A. GIST: Gastric

Staging Parameter: Mitotic Count, as collected in CS SSF 6 for GIST Stomach, CS SSF 5 for GIST Omentum

16B. GIST: Small Intestine

Staging Parameter: Mitotic Count, as collected in CS SSF 6 for GIST Esophagus, CS SSF 11 for GIST
Small Intestine, GIST Colon and Rectum, CS SSF 5 for GIST Mesentery

17. Neuroendocrine Tumors (NET)

17A. NET: Stomach
17B. NET: Small Intestine and Ampulla of Vater
17C. NET: Colon and Rectum

18. Liver

19. Intrahepatic Bile Ducts

20. Gallbladder

21. Perihilar Bile Ducts

22. Distal Bile Duct

23. Ampulla of Vater

24. Exocrine and Endocrine Pancreas

25. Lung

26. Pleural Mesothelioma

27. Bone

Division for Staging:
27A. Bone Non-Ewing
Histologies: 8800-9136, 9142-9252, 9261-9363, 9365-9582

Staging Parameter: Grade, for Non-Ewing

```
      27B. Bone Ewing
      Histologies: 9260, 9364

28. Soft Tissue Sarcoma (not edited)

Staging Parameter: Grade
```

Administrative Notes

New edit - added to NAACCR v16 metafile

Modifications

NAACCR v16A
- Updated stage mapping in table referenced by logic for Thyroid, Esophagus, EsophagusGEJunction
- Updated description, edit logic to indicate that grade for site/histology group 028, Soft Tissue, is collected in the Grade field and not in CS Site-Specific Factor 1
- Removed "else" after special logic for TXN0M0 for Lung, causing edit to pass inappropriately for other sites
- Updated to not edit for site/histology group 028, Soft Tissue Sarcoma, issues with grade assignment, Description notes this group not edited
- Corrected Edit Logic to include 9727 as lymphoma rather than lymphoma/leukemia code, to delete 9728-9729 as obsolete codes
- Added Group 57C, C420, C421, C424, 9811-9818, 9837 to Edit Logic

NAACCR v16B
- Removed logic checking for Over-ride Site/TNM-StgGrp. This Over-ride allows pediatric cases to be coded with stage group 88. The stage tables do not look for combinations of 88 88 88 88, so any record with such a combination would not be edited with the edit. An edit failure based on incorrect setting of the Over-ride would duplicate the same edit failure in an edit that checks primary site, stage group values for 2016.
- Corrected edit logic for assigning site/histology group 011 to group 10B or 999 based on histology and CS Site-Specific Factor 25

NAACCR v16D
- Added U7 to required TNM Edition Numbers
- Table referenced by edit updated, TXN2M0, Stage 3 for lung updated to TXN2M0, Stage 99
- Table referenced by edit updated, T4NXM0, Stage 3 for lung updated to T4NXM0, Stage 99
- Logic updated to pass T1,T2,T3, or T4 with N0M0 and unknown mitotic rate for site/histo groups 16A, 16B, GIST

Primary Site, TNM Path Stage Valid B- Ed 7 (COC)

Agency: COC **Last changed: 01/17/2017**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

TNM Path T [Std# 880]
TNM Path N [Std# 890]
TNM Path M [Std# 900]
TNM Path Stage Group [Std# 910]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
Date of Diagnosis [Std# 390]
TNM Edition Number [Std# 1060]
TNM Path Descriptor [Std# 920]
Age at Diagnosis [Std# 230]
Grade [Std# 440]
CS Site-Specific Factor 1 [Std# 2880]
CS Site-Specific Factor 8 [Std# 2862]
CS Site-Specific Factor10 [Std# 2864]
CS Site-Specific Factor13 [Std# 2867]
CS Site-Specific Factor15 [Std# 2869]
CS Site-Specific Factor16 [Std# 2870]
CS Site-Specific Factor25 [Std# 2879]
Sex [Std# 220]
Type of Reporting Source [Std# 500]

Tables

AC7G2016.DBF
PAST7VAL.DBF
SVALTEST.DBF

Default Error Message

[3038] TNM stage problem
TNM stage problem

Additional Messages

[6009] Inconsistency between TNM categories T"value of TNM Path T" N"value of TNM Path N" M"value of TNM Path M" and assigned TNM stage "value of TNM Path Stage Group"
[6010] Combination of T"value of TNM Path T" N"value of TNM Path N" M"value of TNM Path M" is invalid for TNM staging
[6011] T"value of TNM Path T" N"value of TNM Path N" M"value of TNM Path M", staging parameter for "value of Primary Site", inconsistent with TNM stage "value of TNM Path Stage Group"
[6027] Combination T"value of TNM Path T" N"value of TNM Path N" M"value of TNM Path M", staging parameter for "value of Primary Site", invalid forTNM staging

Description

This edit is skipped if any of the following conditions are true:

1. Year of Date of Diagnosis is less than 2016, blank (unknown), or invalid
2. Type of Reporting Source = 7 (Death Certificate Only)
3. Histologic Type ICD-O-3 is blank
4. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
5. TNM Edition Number is not = 07, U7, 88
6. TNM Path Stage Group is blank
6. TNM Path T or TNM Path M is blank
6. TNM Path Descriptor = 4 or 6

The purpose of this edit is to validate the coded TNM categories, and site-specific staging parameters where used, with the coded Stage Group assignments. Some TNM chapters require elements in addition to T, N, and M categories, such as grade or mitotic rate. for correct stage assignment. In this edit description, these elements are called staging parameters. The edit will not be skipped but will pass if any of TNM Clin N or a required staging parameter is blank. (The exception for TNM Path N allows for the possible coding of TNM Path N as blank for site/histology group 39; if blank, TNM Path N will be converted to "88" for the edit.)

The edit compares the combination of TNM Path T, TNM Path N, TNM Path M categories, and staging parameter where required, with TNM Path Stage Group. The edit is skipped if TNM Path Descriptor is 4 or 6, indicating stage assignment after neoadjuvant treatment. (With neoadjuvaant treatment, combinations of T, N, M and staging parameters are allowed that would not be valid otherwise.)

The designation of "c" or "p" within the individual T, N, and M codes is ignored for this edit. Valid codes for individual fields (TNM Path T, TNM Path N, TNM Path M, TNM Path Stage Group), and for these individual fields by primary site, are checked in other edits.

An edit failure is returned if the Path Stage Group is inconsistent with the expected group assignment for the coded T, N, M, and staging parameter if required, based on the AJCC stage tables. If a T, N, or M value is coded that is not included in the AJCC stage tables -- for example T4 is coded but only T4A and T4B are staged -- the stage assignment will not be checked and the edit will pass.

An edit failure is also returned if either the coded Path Stage Group returns "ERROR" from the lookup table, meaning that the combination of T, N, M, and staging parameter is invalid. Invalid combinations include T0N0M0/M0I+; T in situ with positive N and/or positive M category; and a Testis stage with an invalid S category. An invalid S category results when one or more of the 3 site-specific factors required to determine the category (SSF 13-AFP, SSF 15-hCG, SSF 16-LDH) is coded 988, meaning not applicable.

The site/histology groups are listed below. The number next to each site title indicates the respective chapter in the AJCC Cancer Staging Manual, Edition 7.The site/histology groups and group stage values are identified by site and histology in the edit Primary Site, Stage Group 2016 - Ed 7. Subdivisions of some groups were required for this edit; they are identified below with their criteria. Site-specific staging parameters are also identified. The description does not include the list of TNM categories, staging parameters, and stage groups; this information is contained in a table within EditWriter that contains around 14,700 records.

Site/histology groups 49, Carcinoma of Conjunctiva, 50, Malignant Melanoma of Conjunctiva, 52, Retinoblastoma, 53, Carcinoma of Lacrimal Gland, 54, Sarcoma of

Orbit, 55, Ocular Adnexal Lymphoma, are listed below. However, staging for these site/histology groups is not validated by this edit, as no stage grouping applies. The T, N, M codes for site/histology groups 49, 50, 52, 53, 54, and 55 are validated in the edits Primary Site, T 2016 - Ed 7, Primary Site, N 2016 - Ed 7, and Primary Site, M 2016 - Ed 7.

Site/histology group 57A, Lymphoid Neoplasms, is also listed below. However, staging for 57A does not include T, N, and M components, and stage is not validated in this edit. The T, N, M codes for site/histology group 57A are validated in the edits Primary Site, T 2016 - Ed 7, Primary Site, N 2016 - Ed 7, and Primary Site, M 2016 - Ed 7. Stage group for 57A is validated in the edit Primary Site, Stage Group 2016 - Ed 7. Site/histology group 55, Ocular Adnexal Lymphoma, will pass this edit if coded as Lymphoma (T=88,N=88,M=88,Stage Group = stage from Ch 57), or as Ocular Adnexal Lymphoma (T=T from Ch 55, N=N from Ch 55, M=M from Ch 55, Stage Group = 88).

29. Cutaneous Squamous Cell Carcinoma and other Cutaneous Carcinomas

30. Merkel Cell Carcinoma

31. Melanoma of the Skin

32. Breast

33. Vulva

34. Vagina

35. Cervix Uteri

36. Corpus Uteri

    36A. Corpus Uteri: Carcinomas
    36B. Corpus Uteri: Leiomyosarcoma and Endometrial Stromal Sarcoma
    36C. Corpus Uteri: Adenosarcoma

37. Ovary and Peritoneal Carcinomas

    37A. Ovary
    37B. Peritoneal Carcinomas

38. Fallopian Tube

39. Gestational Trophoblastic Tumors

Staging Parameter: Prognostic Scoring Index as collected in CS SSF 1

40. Penis

41. Prostate

Division for Staging:
    41A. PSA: 988, 997, 998, 999
    41B. PSA: 001-099
    41C. PSA: 100-199
    41D. PSA: 200-980

Staging Parameter: Gleason Score: As collected in CS SSF 8 or CS SSF 10, whichever value is greater, excluding 988, 998, and 999 for CS SSF 8

```
42. Testis

Staging Parameter: S value, based on calculation of:
                            post-orchiectomy AFP value as collected in CS SSF 13,
                   post-orchiectomy hCG value as collected in CS SSF 15,
                   post-orchiectomy LDH range as collected in CS SSF 16
43. Kidney

44. Renal Pelvis and Ureter

45. Urinary Bladder

46. Urethra

47. Adrenal

      47A. Adrenal Cortex
      47B. Adrenal Cortical Carcinoma

48. Carcinoma of the Eyelid

49. Conjunctiva

50.  Malignant Melanoma of the Conjunctiva

51.  Malignant Melanoma of Uvea

      51A. Ciliary Body and Choroid
      51B. Iris

52. Retinoblastoma

53. Carcinoma of the Lacrimal Gland

54. Sarcoma of the Orbit

55. Ocular Adnexal Lymphoma

57. Lymphoid Neoplasms

      57A. Hodgkin and Non-Hodgkin Lymphoma
      57B. Primary Cutaneous Lymphomas

Staging Parameter: Peripheral blood involvement, as collected in CS SSF 1
```

Administrative Notes

New edit - added to NAACCR v16 metafile

Modifications

NAACCR v16A
- Added stage mapping to table referenced by logic for T1A, T1B, T2A, T2B to site/group 57B, Primary Cutaneous Lymphoma
- Corrected logic to only edit for site/histology groups 029 through 57B
- Corrected Edit Logic to include 9727 as lymphoma rather than lymphoma/leukemia code, to delete 9728-9729 as obsolete codes

- Added Group 57C, C420, C421, C424, 9811-9818, 9837 to Edit Logic

NAACCR v16B
- Removed logic checking for Over-ride Site/TNM-StgGrp. This Over-ride allows pediatric cases to be coded with stage group 88. The stage tables do not look for combinations of 88 88 88 88, so any record with such a combination would not be edited with the edit. An edit failure based on incorrect setting of the Over-ride would duplicate the same edit failure in an edit that checks primary site, stage group values for 2016.
- Table referenced by logic updated:
    031,IS,X,0,ERROR changed to IS,X,0,0
    031, 1A,X,0,99 changed to 1A,X,0,1A
    045,A,X,0 ,0A changed to A,X,0,99
    045,IS,X,0,0IS changed to IS,X,0,99
- Corrected edit logic for assigning site/histology group 011 to group 10B or 999 based on histology and CS Site-Specific Factor 25

NAACCR v16D
- Description, logic modified to use SSF 8 or SSF 10 in validating stage group, whichever is higher. SSF 8 = 988, 998, 999 not included in comparison of SSF 8 and SSF 10
- Added U7 to required TNM Edition Numbers
- Staging table referenced by edit updated for site/histology groups 51A (Uveal Melanoma), and 57B (Primary Cutaneous Lymphoma), values for NOS stage groups not listed in AJCC 7th Edition changed to 99 (e.g., 57B, T4NXM0B2, Stage group 4A, changed to T4NXM0B2, Stage group 99)
- Table referenced by edit updated, rows for 57B, T1A,T1B,T2A,T2B, M0 added

Primary Site, TNM T - c,p pre2016 (NPCR)

Agency: NPCR **Last changed: 07/20/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
TNM Edition Number [Std# 1060]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
Age at Diagnosis [Std# 230]
CS Site-Specific Factor10 [Std# 2864]
CS Site-Specific Factor25 [Std# 2879]
Grade [Std# 440]
TNM Clin T [Std# 940]
TNM Path T [Std# 880]
Sex [Std# 220]
Type of Reporting Source [Std# 500]

Tables

AJC7SIGP.DBF
AJC7TC.DBF
AJC7TP.DBF

Default Error Message

[3280] TNM T code problem
TNM T code problem

Additional Messages

[3281] TNM Path T code is invalid for site/hist combination
[3282] TNM Clin T code is invalid for site/hist combination
[3283] TNM Clin T code should = "88" for site/hist combination
[3284] TNM Path T code should = "88" for site/hist combination

Description

```
This edit is skipped if any of the following conditions are true:

1. Year of Date of Diagnosis is less than 2014, or blank (unknown), or invalid, or
year of diagnosis is greater than 2015
2. Type of Reporting Source = 7 (Death Certificate Only)
3. Histologic Type ICD-O-3 is blank
4. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
5. TNM Edition Number is not = 07 and not = 88
6. TNM Clin T and TNM Path T are both blank
```

TNM Clin T and TNM Path T may be blank. If entered, they will be edited site-specifically. The edit will check valid TNM Clin N and TNM Path N codes either with or without the "c" or "p" component.

The site-specific TNM T values are listed below.The number next to each site group indicates the chapter in the AJCC Cancer Staging Manual, Edition 7. The sites for each chapter are listed along with the histologies requiring AJCC staging. The allowable values for the clinical and pathologic T codes are listed under TNM T. When there is a difference in allowable values for clinical and pathologic T codes, they will be specified separately.

3. Lip and Oral Cavity

Sites:
C000-C006,C008,C009
C020-C023,C028,C029
C030,C031,C039
C040,C041,C048,C049
C050,C058,C059
C060-C062,C068,C069
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM T:
X,0,IS,1,2,3,4,4A,4B

4. Pharynx

4A. Oropharynx and Hypopharynx
Sites:
C019, C024
C051-C052
C090-C091, C098-C099
C100, C102-C104, C108-C109
C129
C130-C132, C138-C139

Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM T:
X,0,IS,1,2,3,4, 4A, 4B

4B. Nasopharynx
Sites:
C110, C112-C113, C118-C119
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM T:
X,0,IS,1,2,3,4

4C. Nasopharynx
Sites:
C111
Discriminator (CS Site-Specific Factor25):
010
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM T:
X,0,IS,1,2,3,4

4D. Oropharynx
Sites:
C111
Discriminator (CS Site-Specific Factor25):
020
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM T:
X,0,IS,1,2,3,4,4A,4B

5. Larynx

5A. Supraglottis, Subglottis, Other
Sites:
C101, C321-C322
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM T:
X,0,IS,1,2,3,4,4A,4B

5B. Glottis
Sites:
C320, C328-C329
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980, 8981
TNM T:
X,0,IS,1,1A,1B,2,3,4,4A,4B

6. Nasal Cavity and Paranasal Sinuses

Sites:
C300, C310-C311
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM T:
X,0,IS,1,2,3,4,4A,4B

7. Major Salivary Glands

Sites:
C079
C080,C081,C088,C089
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8982
TNM T:
X,0,1,2,3,4,4A,4B, 88

8. Thyroid Gland

8A. Thyroid: Papillary/follicular, age less than 045
Sites:
C739
Histologies Requiring AJCC Staging:
8000-8015, 8022, 8033-8344, 8350-8420, 8440-8508,
8514-8576, 8940-8950, 8980-8981

Age at Diagnosis: less than 045
Grade: 1-3 or 9

TNM T:
X,0,1,1A,1B,2,3,4,4A,4B, 88

8B. Thyroid: Papillary/follicular, age greater than or equal 045 but not 999
Sites:
C739
Histologies Requiring AJCC Staging:
8000-8015, 8022, 8033-8344, 8350-8420, 8440-8508,
8514-8576, 8940-8950, 8980-8981
Age at Diagnosis: greater than or equal to 045, but not equal 999
Grade: 1-3 or 9

TNM T:
X,0,1,1A,1B,2,3,4,4A,4B, 88

8C. Thyroid: Papillary/follicular, age equal 999 (unknown)
Sites:
C739
Histologies Requiring AJCC Staging:
8000-8015, 8022, 8033-8344, 8350-8420, 8440-8508,
8514-8576, 8940-8950, 8980-8981
Age at Diagnosis: equal 999
Grade: 1-3 or 9

TNM T:
X,0,1,1A,1B,2,3,4,4A,4B, 88

8D. Thyroid: Medullary
Sites:
C739
Histologies Requiring AJCC Staging:
8345-8347, 8430, 8510, 8512-8513
Grade: 1-3 or 9

TNM T:
X,0,1,1A,1B,2,3,4,4A,4B, 88

8E. Thyroid: Anaplastic
Sites:
C739
Histologies Requiring AJCC Staging:
8020-8021, 8030-8032
TNM T:
4,4A,4B

8F. Thyroid: Anaplastic
Sites:
C739
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
Grade: 4

TNM T:
4,4A,4B

9. Mucosal Melanoma of the Head and Neck

Sites:
C000-C006, C008-C009
C019
C020-C024, C028-C029
C030-C031, C039
C040-C041, C048-C049
C050-C052, C058-C059
C060-C062, C068-C069
C090-C091, C098-C099
C100-C104, C108-C109
C110-C113, C118-C119
C129
C132, C138-C139
C140, C142, C148
C300
C310-C311
C320-C323, C328-C329
Histologies Requiring AJCC Staging:
8720-8790
TNM T:
X,3,4,4A,4B, 88

10. Esophagus and Esophagus Gastric Junction

10A. Esophagus
Sites:
C150-C155, C158-C159
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM T:
X,0,IS,1,1A,1B,2,3,4,4A,4B

10B. Esophagus Gastric Junction
Sites:
C160-C162
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981
Discriminator (CS Site-Specific Factor25):
020, 040, 060 (for C161-C162), 982 (982 is for C160 only)

TNM T:
X,0,IS,1,1A,1B,2,3,4,4A,4B

11. Stomach

Sites:
C161-C162 and Discriminator (CS Site-Specific Factor 25) =
000, 030, 100, 999
C163-C166, C168-C169 and Discriminator (CS Site-Specific Factor 25) =
981
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8990
TNM T:
X,0,IS,1,1A,1B,2,3,4,4A,4B

12. Small Intestine

Sites:
C170-C172, C178-C179
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981
TNM T:
X,0,IS,1,1A,1B,2,3,4

13. Appendix

13A. Appendix: Carcinoma
Sites:
C181
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981
TNM T:
X,0,IS,1,2,3,4,4A,4B

13B. Appendix: Carcinoid
Sites:
C181
Histologies Requiring AJCC Staging:
8240-8242, 8246, 8249, 8153
TNM T:
X,0,1,1A,1B,2,3,4, 88

14. Colon and Rectum

Sites:
C180, C182-C189
C199
C209
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8576, 8940-8950, 8980-8981
TNM T:
X,0,IS,1,2,3,4,4A,4B

15. Anus

Sites:
C210-C212, C218
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8250-8576, 8940-8950, 8980-8981
TNM T:
X,0,IS,1,2,3,4

16. Gastrointestinal Stromal Tumor (GIST)

16A. GIST: Gastric
Sites:
C160-C169
C480-C488 and CS Site-Specific Factor 10 = 020 (Omentum)
Histologies Requiring AJCC Staging:
8935-8936

TNM T:
X,0,1,2,3,4, 88

16B. GIST: Small Intestine
Sites:
C150-C159
C170-C172, C178, C179
C180-C189
C199
C209
C480-C488 and CS Site-Specific Factor 10 not = 020 (Omentum)
Histologies Requiring AJCC Staging:
8935-8936
TNM T:
X,0,1,2,3,4, 88

17. Neuroendocrine Tumors (NET)

17A. NET: Stomach
Sites:
C160-C169
Histologies Requiring AJCC Staging:
8153, 8240-8242, 8246, 8249
TNM T:
X,0,IS,1,2,3,4

17B. NET: Small Intestine and Ampulla of Vater
Sites:
C170-C179
C241
Histologies Requiring AJCC Staging:
8153, 8240-8242, 8246, 8249
TNM T:
X,0,1,2,3,4, 88

17C. NET: Colon and Rectum
Sites:
C180, C182-C189
C199, C209
Histologies Requiring AJCC Staging:
8153, 8240-8242, 8246, 8249
TNM T:
X,0,1,1A,1B,2,3,4, 88

18. Liver

18A. Sites:
C220
Histologies Requiring AJCC Staging:
8170-8175
TNM T:
X,0,1,2,3,3A,3B,4,88

18B. Sites:
C221
Histologies Requiring AJCC Staging:
8170-8175
TNM T:

X,0,1,2,3,3A,3B,4,88

19. Intrahepatic Bile Ducts

19A. Sites:
C220
Histologies Requiring AJCC Staging:
8160, 8161, 8180
TNM T:
X,0,IS,1,2,2A,2B,3,4,88

19B. Sites:
C221
Histologies Requiring AJCC Staging:
8160, 8161, 8180
TNM T:
X,0,IS,1,2,2A,2B,3,4

20. Gallbladder

Sites:
C239
C240 and Discriminator (CS Site-Specific Factor 25) = 030
Histologies Requiring AJCC Staging:
8000-8152,8154-8231, 8243-8245, 8250-8576, 8940-8950, 8980-8981
TNM T:
X,0,IS,1,1A,1B,2,3,4

21. Perihilar Bile Ducts

Sites:
C240 and Discriminator (CS Site-Specific Factor 25) = 010, 020, 050, 060, 999
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8250-8576, 8940-8950, 8980-8981
TNM T:
X,0,IS,1,2,2A,2B,3,4

22. Distal Bile Duct

Sites:
C240 and Discriminator (CS Site-Specific Factor 25) = 040, 070
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8250-8576, 8940-8950, 8980-8981
TNM T:
X,0,IS,1,2,3,4

23. Ampulla of Vater

Sites:
C241
Histologies Requiring AJCC Staging:
8000-8152, 8154-8231, 8243-8245, 8250-8576, 8940-8950, 8980-8981
TNM T:
X,0,IS,1,2,3,4

24. Exocrine and Endocrine Pancreas

Sites:
C250-C254, C257-C259
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8971, 8980-8981
TNM T:
X,0,IS,1,2,3,4

25. Lung

Sites:
C340-C343,C348,C349
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM T:
X,0,IS,1,1A,1B,2,2A,2B,3,4

26. Pleural Mesothelioma

Sites:
C384
Histologies Requiring AJCC Staging:
9050-9053
TNM T:
X,0,1,1A,1B,2,3,4

27. Bone

Sites:
C400-C403, C408-C409
C410-C414, C418-C419
Histologies Permitting AJCC Staging:
8800-9136, 9142-9582
TNM T:
X,0,1,2,3

28. Soft Tissue Sarcoma

Peritoneum - not female
Sites:
C481-C482, C488
Histologies:
8800-8820, 8823-8934, 8940-9136, 9142-9582
CS Site-Specific Factor25 = not 002 (that is, not female)

Peritoneum - female
Sites:
C481-C482, C488
Histologies:
8800-8820, 8823-8921, 9120-9136, 9142-9582
CS Site-Specific Factor25 = 002 (female)

Heart,Mediastinum, Soft Tissue

Sites:
C380-C383, C388
C470-C476, C478-C479
C490-C496, C498-C499
Histologies:
8800-8820, 8823-8935, 8940-9136, 9142-9582

Retroperitoneum
Sites:
C480
Histologies:
8800-8820, 8823-8934, 8940-9136, 9142-9582

TNM T:
X,0,1,1A,1B,2,2A,2B

29. Cutaneous Squamous Cell Carcinoma and other Cutaneous Carcinomas

Sites:
C440, C442-C449, C632
Histologies Requiring AJCC Staging:
8000-8246, 8248-8576, 8940-8950, 8980-8981
TNM T:
X,0,IS,1,2,3,4

30. Merkel Cell Carcinoma

Sites:
C440, C442-C449,
C510-C512, C518-C519
C600-C602, C608-C609
C632
Histologies Requiring AJCC Staging:
8247
TNM T:
X,0,IS,1,2,3,4

31. Melanoma of the Skin

Sites:
C440-C449
C510-C512,C518,C519
C600-C602, C608, C609
C632
Histologies Requiring AJCC Staging:
8720-8790
TNM T:
X,0,IS,1,1A,1B,2,2A,2B,3,3A,3B,4,4A,4B

32. Breast

Sites:
C500-C506,C508,C509
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981, 9020
TNM T:

X,0,IS,1,1A,1B,1C,1MI,2,3,4,4A,4B,4C,4D

33. Vulva

Sites:
C510-C512,C518,C519
Histologies Requiring AJCC Staging:
8000-8246, 8248-8576, 8940-8950, 8980-8981
TNM T:
Clin: X,0,IS,1,1A,1B,2,3
Path: X,0,IS,1,1A,1B,2,3

34. Vagina

Sites:
C529
Histologies Requiring AJCC Staging:
8000-8576, 8800-8801, 8940-8950, 8980-8981
TNM T:
X,0,IS,1,2,3,4

35. Cervix Uteri

Sites:
C530,C531,C538,C539
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM T:
X,0,IS,1,1A,1A1,1A2,1B,1B1,1B2,2,2A,2A1,2A2,2B,3,3A,3B,4

36. Corpus Uteri

36A. Corpus Uteri: Carcinomas
Sites
C540-C543, C548-C549
C559
Histologies Requiring AJCC Staging:
8000-8790, 8950-8951, 8980-8981
TNM T:
X,0,IS,1,1A,1B,2,3,3A,3B,4

36B. Corpus Uteri: Leiomyosarcoma and Endometrial Stromal Sarcoma
Sites:
C540-C543, C548-C549
C559
Histologies Requiring AJCC Staging:
8800, 8890-8898, 8900-8921, 8930-8931, 8935
TNM T:
X,0,1,1A,1B,2,2A,2B,3,3A,3B,4,88

36C. Corpus Uteri: Adenosarcoma
Sites:
C540-C543, C548-C549
C559
Histologies Requiring AJCC Staging:

8933
TNM T:
X,0,1,1A,1B,1C,2,2A,2B,3,3A,3B,4,88

37. Ovary and Peritoneal Carcinomas

37A. Ovary
Sites:
C569
Histologies Requiring AJCC Staging:
8000-8576, 8590-8671, 8930-9110
TNM T:
X,0,1,1A,1B,1C,2,2A,2B,2C,3,3A,3B,3C, 88

37B. Peritoneal Carcinomas
Sites:
C481-C482, C488 (Sex = 2,female) and Discriminator (CS Site-Specific Factor 25) = 002
Histologies Requiring AJCC Staging:
8000-8576, 8590-8671, 8930-8934, 8940-9110
TNM T:
X,0,1,1A,1B,1C,2,2A,2B,2C,3,3A,3B,3C

38. Fallopian Tube

Sites:
C570
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM T:
X,0,IS,1,1A,1B,1C,2,2A,2B,2C,3,3A,3B,3C

39. Gestational Trophoblastic Tumors

Sites:
C589
Histologies Requiring AJCC Staging:
9100-9105
TNM T:
X,0,1,2,88

40. Penis

Sites:
C600-C602,C608,C609
Histologies Requiring AJCC Staging:
8000-8246, 8248-8576, 8940-8950, 8980-8981
TNM T:
X,0,IS,A,1,1A,1B,2,3,4

41. Prostate

Sites:
C619
Histologies Requiring AJCC Staging:

8000-8110, 8140-8576, 8940-8950, 8980-8981
TNM T:
X,0,1,1A,1B,1C,2,2A,2B,2C,3,3A,3B,4, 88

42. Testis

Sites:
C620,C621,C629
Histologies Requiring AJCC Staging:
8000-8576, 8590-8670, 8940-8950, 8980-8981, 9060-9090, 9100-9105
TNM T:
X,0,IS,1,2,3,4

43. Kidney

Sites:
C649
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM T:
X,0,1,1A,1B,2,2A,2B,3,3A,3B,3C,4, 88

44. Renal Pelvis and Ureter

Sites:
C659
C669
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM T:
X,0,IS,A,1,2,3,4

45. Urinary Bladder

Sites:
C670-C679
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM T:
X,0,IS,A,1,2,2A,2B,3,3A,3B,4,4A,4B

46. Urethra

46A. Urethra - Female
Sites:
C680
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
Sex: 2(female)
TNM T:
X,0,IS,A,1,2,3,4

46B. Urethra - not Female
Sites:

C680
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
Sex: not 2 (female)
TNM T:
X,0,IS,ISPU,ISPD,A,1,2,3,4

47. Adrenal

47A. Adrenal Cortex
Sites:
C740
Histologies Requiring AJCC Staging:
8010, 8140, 8370
TNM T:
X,0,1,2,3,4, 88

47B. Adrenal Cortical Carcinoma
Sites:
C749
Histologies Requiring AJCC Staging:
8370
TNM T:
X,0,1,2,3,4, 88

48. Carcinoma of the Eyelid

Sites:
C441
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM T:
X,0,IS,1,2,2A,2B,3,3A,3B,4

49. Conjunctiva

Sites:
C690
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM T:
X,0,IS,1,2,3,4,4A,4B,4C,4D

50. Malignant Melanoma of the Conjunctiva

Sites:
C690
Histologies Requiring AJCC Staging:
8720-8790
TNM T:
Clin: X,0,IS,1,1A,1B,1C,1D,2,2A,2B,2C,2D,3,3A,3B,3C,3D,4
Path: X,0,IS,1,1A,1B,1C,2,2A,2B,2C,3,4

51. Malignant Melanoma of Uvea

51A. Ciliary Body and Choroid
Sites:
C693
C694 (CS Site-Specific Factor 25 = 010 or 999)
Histologies Requiring AJCC Staging:
8720-8790
TNM T:
X,0,1,1A,1B,1C,1D,2,2A,2B,2C,2D,3,3A,3B,3C,3D,4,4A,4B,4C,4D,4E,88

51B. Iris
Sites:
C694 (CS Site-Specific Factor 25 = 020)
Histologies Requiring AJCC Staging:
8720-8790
TNM T:
X,0,1,1A,1B,1C,2,2A,3,3A,4,4A,4B,88

52. Retinoblastoma

Sites:
C692
Histologies Requiring AJCC Staging:
9510-9514
TNM T:
Clin: X,0,1,1A,1B,1C,2,2A,2B,3,3A,3B,4,4A,4B,4C,4D
Path: X,0,1,2,2A,2B,3,3A,3B,4,4A,4B

53. Carcinoma of the Lacrimal Gland
Sites:
C695 and CS Site-Specific Factor25 = 015
Histologies Requiring AJCC Staging:
8000-8576, 8940-8950, 8980-8981
TNM T:
X,0,1,2,3,4,4A,4B,4C,88

54. Sarcoma of the Orbit

Sites:
C696, C698
Histologies Requiring AJCC Staging:
8800-8936, 8940-9136, 9141-9508, 9520-9582
TNM T:
X,0,1,2,3,4,88

55. Ocular Adnexal Lymphoma

Sites:
C441, C690, C695-C696
Histologies Requiring AJCC Staging:
9590-9699, 9702-9738, 9811-9818, 9820-9837
TNM T:
X,0,1,1A,1B,1C,2,2A,2B,2C,2D,3,4,4A,4B,4C,4D

56. Brain and Spinal Cord

```
Sites:
     C700, C701, C709, C710-C719, C720-C729, C751-C753
Histologies Requiring AJCC Staging:
     8000, 8680-9136,9141-9582
TNM T:
     88


57. Lymphoid Neoplasms

57A. Hodgkin and Non-Hodgkin
Sites:
     C000-C419, C422-C423, C425-C440, C442-C689, C691-C694, C698-C809
Histologies Requiring AJCC Staging:
     9590-9699, 9702-9729, 9735, 9737-9738, 9811-9818, 9823, 9827, 9837
TNM T:
     88

57B. Primary Cutaneous Lymphomas
Sites:
     C440-C449
     C510-C512, C518-C519
     C600-C602, C608-C609, C632
Histologies Requiring AJCC Staging:
     9700,9701
TNM T:
     1,1A,1B,2,2A,2B,3,4,88

All Others
TNM T:
     88
```

Administrative Notes

New edit - added to NAACCR v16 metafile. This edit is based on
Primary Site, AJCC N - Ed 7 ICD03, but it checks TNM Clin N and TNM Path N values for pre-2016 diagnoses coded either with or without "c" and "p" components. This edit could be used for either converted cases or pre2016 cases diagnosed in 2016 software.

Modifications

NAACCR v16A
- Corrected histology codes in Description for site/histology group 31, Melanoma of Skin, from 8720-87900 to 8720-8790

Race 1 (SEER RACE)

Agency: SEER **Last changed: 10/05/2009**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Race 1 [Std# 160]

Default Error Message

[263] Race not valid
Race not valid

Description

Must be a valid Race 1 code (01-08, 10-17,20-22,25-28,30-32,96-99).

Administrative Notes

Modifications

NAACCR v12.0
- Codes 15 (Asian Indian or Pakistani, NOS), 16 (Asian Indian), and 17 (Pakistani) have been added; code 09 (Asian Indian,Pakistani) was retired effective with Version 12.

Note 1: Recode code 09 to code 15 for all years prior to 2010.
Note 2: Standard setters may ask that old code 09 (new code 15) be reviewed and recoded to code 16 and 17 for earlier years depending on the availability of information.

Race 1, Race 2, Race 3, Race 4, Race 5 (SEER IF93)

Agency: SEER **Last changed: 06/14/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Race 1 [Std# 160]
Race 2 [Std# 161]
Race 3 [Std# 162]
Race 4 [Std# 163]
Race 5 [Std# 164]

Default Error Message

[1073] If a race code = 88, all subsequent race codes must = 88
If a race code = 88, all subsequent race codes must = 88

Additional Messages

[1074] If a race code = spaces, all subsequent race codes must = spaces
[1075] If a race code = 99, all race codes must = 99
[1076] A race code (other than spaces, 88, or 99) must not be entered more than once
[3233] A race code of 01 (white) must be the last recorded race

Description

```
Race 1, Race 2, Race 3, Race 4, and Race 5 are compared as follows:

If any race codes (for Race 2, 3, 4, and 5) = spaces, all subsequent race codes
must = spaces.

If more than the Race 1 code is entered, if any race = 99 (unknown), all race codes
(Race 1, 2, 3, 4, and 5) must = 99.

If more than the Race 1 code is entered, if any race codes (for Race 2, 3, 4, and
5) = 88 (no further race documented), then all subsequent race codes must also =
88.

A particular race code (other than spaces, 88, or 99) must not occur more than
once.

If a patient has a race code of 01 (white), it must be the last recorded race for
that patient; that is, the last race code not coded to 88 or spaces..
```

Administrative Notes

In the SEER*Edits software, the title of this edit is: IF93

This edit differs from the NAACCR edit of the same name in that if a patient has a race code of 01 (white), it must be the lastrecorded race for that patient; that is, the last race code not coded to 88 or spaces.

MODIFICATIONS:

NAACCR v11.2
7/2007

This edit was updated to match the logic in SEER*Edits:
1. The edit no longer checks Date of Diagnosis.
2. The following logic was added:
   - If any race codes (for Race 2, 3, 4, and 5) = spaces, all subsequent race codes must = spaces.
   - If more than the Race 1 code is entered, if any race = 99 (unknown), then all race codes (Race 1, 2, 3, 4, and 5) must = 99.
   - If more than the Race 1 code is entered, if any race codes (for Race 2, 3, 4, and 5) = 88 (no further race documented), then all subsequent race codes must also = 88.
   - A particular race code (other than spaces, 88, or 99) must not occur more than once.
   - If a patient has a race code of 01 (white), it must be the last recorded race for that patient; that is, the last race code not coded to 88 or spaces.

NAACCR v11.3
6/2008
Updated Administrative Notes with the title of the corresponding edit in the SEER*Edits software.

Race 2 (NAACCR)

Agency: NAACCR **Last changed: 12/11/2009**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Race 2 [Std# 161]

Default Error Message

[1023] %F1 is not valid
Race 2 is not valid

Description

This edit allows the field to be blank because the item was not required by the COC until 2000. Another edit (Race 2, Date of DX) verifies that this item is not blank if the year of Date of Diagnosis is greater than 1999. Registries should include both edits in their edit set.

Must be a valid Race 2 code (01-08, 10-17,20-22,25-28,30-32,88,96-99) or blank.

Administrative Notes

Modifications

NAACCR v12.0
- Codes 15 (Asian Indian or Pakistani, NOS), 16 (Asian Indian), and 17 (Pakistani) have been added; code 09 (Asian Indian,Pakistani) was retired effective with Version 12.

Note 1: Recode code 09 to code 15 for all years prior to 2010.
Note 2: Standard setters may ask that old code 09 (new code 15) be reviewed and recoded to code 16 and 17 for earlier years depending on the availability of information.

Race 2, Date of DX (SEER IF89)

Agency: SEER **Last changed: 03/19/2010**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
Race 2 [Std# 161]

Default Error Message

[1071] If year of %F1 is greater than 1999, then %F2 must not be blank
If year of Date of Diagnosis is greater than 1999, then Race 2 must not be blank

Additional Messages

ERROR_TEXT("Date of Diagnosis: %DC")

Description

This edit is skipped if Date of Diagnosis is blank.

If year of Date of Diagnosis is greater than 1999, Race 2 must not be blank.

Administrative Notes

In the SEER*Edits software, the title of this edit is: IF89

Modifications:

NAACCR v11.3
6/2008
Updated Administrative Notes with the title of the corresponding edit in the SEER*Edits software.

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

Race 3 (NAACCR)

Agency: NAACCR **Last changed: 12/11/2009**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Race 3 [Std# 162]

Default Error Message

[1023] %F1 is not valid
Race 3 is not valid

Description

This edit allows the field to be blank because the item was not required by the COC until 2000. Another edit (Race 3, Date of DX) verifies that this item is not blank if the year of Date of Diagnosis is greater than 1999. Registries should include both edits in their edit set.

Must be a valid Race 3 code (01-08, 10-17,20-22,25-28,30-32,88,96-99) or blank.

Administrative Notes

Modifications

NAACCR v12.0
- Codes 15 (Asian Indian or Pakistani, NOS), 16 (Asian Indian), and 17 (Pakistani) have been added; code 09 (Asian Indian,Pakistani) was retired effective with Version 12.

Note 1: Recode code 09 to code 15 for all years prior to 2010.
Note 2: Standard setters may ask that old code 09 (new code 15) be reviewed and recoded to code 16 and 17 for earlier years depending on the availability of information.

Race 3, Date of DX (SEER IF90)

Agency: SEER **Last changed: 03/19/2010**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
Race 3 [Std# 162]

Default Error Message

[1071] If year of %F1 is greater than 1999, then %F2 must not be blank
If year of Date of Diagnosis is greater than 1999, then Race 3 must not be blank

Additional Messages

ERROR_TEXT("Date of Diagnosis: %DC")

Description

This edit is skipped if Date of Diagnosis is blank.

If year of Date of Diagnosis is greater than 1999, Race 3 must not be blank.

Administrative Notes

In the SEER*Edits software, the title of this edit is: IF90

Modifications:

NAACCR v11.3
6/2008
Updated Administrative Notes with the title of the corresponding edit in the SEER*Edits software.

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

Race 4 (NAACCR)

Agency: NAACCR **Last changed: 12/11/2009**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Race 4 [Std# 163]

Default Error Message

[1023] %F1 is not valid
Race 4 is not valid

Description

This edit allows the field to be blank because the item was not required by the COC until 2000. Another edit (Race 4, Date of DX) verifies that this item is not blank if the year of Date of Diagnosis is greater than 1999. Registries should include both edits in their edit set.

Must be a valid Race 4 code (01-08, 10-17,20-22,25-28,30-32,88,96-99) or blank.

Administrative Notes

Modifications

NAACCR v12.0
- Codes 15 (Asian Indian or Pakistani, NOS), 16 (Asian Indian), and 17 (Pakistani) have been added; code 09 (Asian Indian,Pakistani) was retired effective with Version 12.

Note 1: Recode code 09 to code 15 for all years prior to 2010.
Note 2: Standard setters may ask that old code 09 (new code 15) be reviewed and recoded to code 16 and 17 for earlier years depending on the availability of information.

Race 4, Date of DX (SEER IF91)

Agency: SEER **Last changed: 03/19/2010**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
Race 4 [Std# 163]

Default Error Message

[1071] If year of %F1 is greater than 1999, then %F2 must not be blank
If year of Date of Diagnosis is greater than 1999, then Race 4 must not be blank

Additional Messages

ERROR_TEXT("Date of Diagnosis: %DC")

Description

This edit is skipped if Date of Diagnosis is blank.

If year of Date of Diagnosis is greater than 1999, Race 4 must not be blank.

Administrative Notes

In the SEER*Edits software, the title of this edit is: IF91

Modifications:

NAACCR v11.3
6/2008
Updated Administrative Notes with the title of the corresponding edit in the SEER*Edits software.

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

Race 5 (NAACCR)

Agency: NAACCR **Last changed: 12/11/2009**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Race 5 [Std# 164]

Default Error Message

[1023] %F1 is not valid
Race 5 is not valid

Description

This edit allows the field to be blank because the item was not required by the COC until 2000. Another edit (Race 5, Date of DX) verifies that this item is not blank if the year of Date of Diagnosis is greater than 1999. Registries should include both edits in their edit set.

Must be a valid Race 5 code (01-08, 10-17,20-22,25-28,30-32,88,96-99) or blank.

Administrative Notes

Modifications

NAACCR v12.0
- Codes 15 (Asian Indian or Pakistani, NOS), 16 (Asian Indian), and 17 (Pakistani) have been added; code 09 (Asian Indian,Pakistani) was retired effective with Version 12.

Note 1: Recode code 09 to code 15 for all years prior to 2010.
Note 2: Standard setters may ask that old code 09 (new code 15) be reviewed and recoded to code 16 and 17 for earlier years depending on the availability of information.

Race 5, Date of DX (SEER IF92)

Agency: SEER **Last changed: 03/19/2010**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
Race 5 [Std# 164]

Default Error Message

[1071] If year of %F1 is greater than 1999, then %F2 must not be blank
If year of Date of Diagnosis is greater than 1999, then Race 5 must not be blank

Additional Messages

ERROR_TEXT("Date of Diagnosis: %DC")

Description

This edit is skipped if Date of Diagnosis is blank.

If year of Date of Diagnosis is greater than 1999, Race 5 must not be blank.

Administrative Notes

In the SEER*Edits software, the title of this edit is: IF92

Modifications:

NAACCR v11.3
6/2008
Updated Administrative Notes with the title of the corresponding edit in the SEER*Edits software.

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

Rad--Regional RX Modality (NPCR)

Agency: NPCR **Last changed: 04/12/2007**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Rad--Regional RX Modality [Std# 1570]

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of Rad--Regional RX Modality" is not a valid value for Rad--Regional RX Modality

Description

Must be a valid code for Rad--Regional RX Modality (00, 20-32, 40-43, 50-55, 60-62, 80, 85, 98, 99). Must be a two-digit number. May be blank.

Administrative Notes

This edit differs from the COC edit of the same name in that it allows the field to be blank because the item was not required by NPCR until 2006. Another edit (Rad--Regional RX Modality, Date of Diagnosis (NPCR)) verifies that this item is not blank if the year of Date of Diagnosis is greater than 2005 and not equal 9999.

Rad--Regional RX Modality, Date of Diagnosis(NPCR)

Agency: NPCR **Last changed: 02/10/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
Rad--Regional RX Modality [Std# 1570]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]

Default Error Message

[4884] If DX year = 2006-2014, %F3 = %V3 and %F4 = %V4, %F2 cannot be blank
If DX year = 2006-2014, Primary Site = "value of Primary Site" and Histologic Type ICD-O-3 = "value of Histologic Type ICD-O-3", Rad--Regional RX Modality cannot be blank

Additional Messages

[3580] If DX year = 2015 or later, Rad--Regional RX Modality cannot be blank
ERROR_TEXT("Date of Diagnosis: %DC")

Description

```
If year of Date of Diagnosis is blank, this edit is skipped.

Rad--Regional RX Modality cannot be blank for cases that meet the following
criteria:
1. Year of Date of Diagnosis is 2006-2014
     AND
   Case is one of the following site/histologies
   A. Breast (Primary Site = C500-C509 and Histologic Type ICD-O-3 =
      8000-9044, 9060-9136, or 9141-9582)
   B. Colon (Primary Site = C180-C189 and Histologic Type ICD-O-3 =
      8000-9044, 9060-9136, or 9141-9582)
   C. Rectum (Primary Site = C199 or C209 and Histologic Type ICD-O-3
      = 8000-9044, 9060-9136, or 9141-9582)

2. Year of Date of Diagnosis is 2015 or later
   - All cases
 .
```

Administrative Notes

Modifications:

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

NAACCR v12.2
- Modified to require Rad--Regional RX Modality only for cancers of the breast, colon, and rectum (instead of all sites) diagnosed 2006 and later.

NAACCR v15

- Edit modified to require Rad--Regional RX Modality for all cases diagnosed 2015 or later. For cases diagnosed 2006-2014, Rad--Regional RX Modality is required only for breast, colon, and rectum cases.

Rad--Regional RX Modality, Reason for No Rad (COC)

Agency: COC **Last changed: 01/14/2010**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Reason for No Radiation [Std# 1430]
Rad--Regional RX Modality [Std# 1570]

Default Error Message

[1016] %F1 and %F2 conflict
Reason for No Radiation and Rad--Regional RX Modality conflict

Description

```
This edit is skipped if either field is blank.

If Rad--Regional RX Modality  = 00 (radiation treatment not performed), Reason for
No Radiation must not = 0 (radiation performed).

If Rad--Regional RX Modality = 20-98 (radiation performed), Reason for No Radiation
must = 0 (radiation performed) and vice versa.
```

Administrative Notes

MODIFICATIONS:

NAACCR v12.0
- Modified to skip if either field is blank.

Reason for No Radiation (NAACCR)

Agency: NAACCR **Last changed: 01/14/2010**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Reason for No Radiation [Std# 1430]

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of Reason for No Radiation" is not a valid value for Reason for No Radiation

Description

```
Must be a valid code for Reason for No Radiation (0-2,5-9) or blank.
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

This edit differs from the COC edit of the same name in that it allows the field to be blank. Registries that want to edit this field only if it is present should choose this version of the edit when building a state-specific edit set.

Reason for No Radiation, Date of DX (NPCR)

Agency: NPCR **Last changed: 02/10/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
Reason for No Radiation [Std# 1430]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]

Default Error Message

[3581] If DX year = 2011-2014, %F3 = %V3 and %F4 = %V4, %F2 cannot be blank
If DX year = 2011-2014, Primary Site = "value of Primary Site" and Histologic Type ICD-O-3 = "value of Histologic Type ICD-O-3", Reason for No Radiation cannot be blank

Additional Messages

[3580] If DX year = 2015 or later, Reason for No Radiation cannot be blank
ERROR_TEXT("Date of Diagnosis: %DC")

Description

```
This edit is skipped if Date of Diagnosis is blank.

This edit requires Reason for No Radiation for cases that meet all of the following
criteria:
1. Year of Date of Diagnosis is 2011-2014
     AND
   Case is one of the following site/histologies
   A. Breast (Primary Site = C500-C509 and Histologic Type ICD-O-3 =
      8000-9044, 9060-9136, or 9141-9582)
   B. Colon (Primary Site = C180-C189 and Histologic Type ICD-O-3 =
      8000-9044, 9060-9136, or 9141-9582)
   C. Rectum (Primary Site = C199 or C209 and Histologic Type ICD-O-3
      = 8000-9044, 9060-9136, or 9141-9582)

2. Year of Date of Diagnosis is 2015 or later
   - All cases
```

Administrative Notes

New edit - added to NAACCR v12.1A metafile.

Modifications:

NAACCR v12.2
- Modified to require Reason for No Radiation only for cancers of the breast, colon, and rectum (instead of all sites) diagnosed 2011 and later.

NAACCR v12.2A

- Edit description corrected to state that Reason for No Radiation is required for breast, colon, and rectum cases if year of Date of Diagnosis is "2011 or later" instead of "2010 or later".

NAACCR v15
- Edit modified to require Reason for No Radiation for all cases diagnosed 2015 or later. For cases diagnosed 2011-2014, Reason for No Radiation is required only for breast, colon, and rectum cases.

Reason for No Radiation, RX Date Radiation (COC)

Agency: COC **Last changed: 11/25/2012**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Reason for No Radiation [Std# 1430]
RX Date Radiation [Std# 1210]
RX Date Radiation Flag [Std# 1211]
Date of Diagnosis [Std# 390]

Default Error Message

[3352] If %F3 = 15, then %F1 must = 8
If RX Date Radiation Flag = 15, then Reason for No Radiation must = 8

Additional Messages

[3355] If Reason for No Radiation = 8, then RX Date Radiation Flag must = 15
[3393] If RX Date Radiation Flag = 12 or RX Date Radiation is not empty, then Reason for No Radiation must = 0
[4084] If Reason for No Radiation = "value of Reason for No Radiation" and Date of Diagnosis > 2011, RX Date Radiation Flag must = 10
ERROR_TEXT("Date of Diagnosis: %DC")

Description

```
This edit is skipped if any of the following conditions are true:
1.  Reason for No Radiation is blank
2.  Both RX Date Radiation and RX Date Radiation Flag are blank, indicating the
date was intentionally not collected.

The edig works as follows:

1. If Reason for No Radiation equals 8 (radiation was recommended, but it is
unknown if it was administered), then RX Date Radiation Flag must equal 15 (when
radiation is planned as part of the first course of therapy, but had not been
started at the time of the most recent follow-up).

2. If RX Date Radiation Flag equals 15, then Reason for No Radiation must equal 8.

3. If RX Date Radiation Flag equals 12 (date is unknown) or RX Date Radiation is
not blank, then Reason for No Radiation must equal 0 (radiation was administered).

4.  If Reason for No Radiation equals 9 (unknown if given):
    -  If year of Date of Diagnosis is 2012 or later, then RX Date Radiation Flag
must = 10 (unknown if given).
```

Administrative Notes

Modifications

NAACCR v12
- Edit modified to use RX Date--Radiation Flag
- Also added logic that checks if date is unknown (RX Date--Radiation Flag equals 12) or RX Date--Radiation is not blank, then Reason for No Radiation must equal 0 (radiation was administered).

NAACCR v12.2
- Edit modified to only allow specific date flag codes for cases diagnosed 2012 and later.

NAACCR v13
- Edit name changed from 'Reason for No Radiation, RX Date--Radiation (COC)' to 'Reason for No Radiation, RX Date Radiation (COC)'.
- Data item name changed from 'RX Date--Radiation' to 'RX Date Radiation'.
- Data item name changed from 'RX Date--Radiation Flag' to 'RX Date Radiation Flag'.

Reason for No Radiation, Vital Status (COC)

Agency: COC **Last changed: 07/08/2003**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Reason for No Radiation [Std# 1430]
Vital Status [Std# 1760]

Default Error Message

[1016] %F1 and %F2 conflict
Reason for No Radiation and Vital Status conflict

Description

```
If Reason for No Radiation = 5 (radiation therapy was not administered because the
patient died prior to planned or recommended treatment), then Vital Status cannot =
1 (alive).
```

Reason for No Surgery (SEER NCDSURG)

Agency: SEER **Last changed: 04/12/2007**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Reason for No Surgery [Std# 1340]

Default Error Message

[284] Reason for No Surgery not valid
Reason for No Surgery not valid

Description

Must be a valid Reason for No Surgery code (0-2,5-9).

Administrative Notes

This edit differs from the NPCR edit of the same name in that it does not allow the field to be blank.

Reason for No Surgery, Date of DX (NPCR)

Agency: NPCR **Last changed: 01/12/2010**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
Reason for No Surgery [Std# 1340]

Default Error Message

[2000] If year of %F1 > 2005, then %F2 cannot be blank
If year of Date of Diagnosis > 2005, then Reason for No Surgery cannot be blank

Additional Messages

ERROR_TEXT("Date of Diagnosis: %DC")

Description

```
If year of Date of Diagnosis is blank, this edit is skipped.

If year of Date of Diagnosis is greater than 2005, then Reason for No Surgery
cannot be blank.
```

Administrative Notes

Modifications:

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

Reason for No Surgery, Vital Status (COC)

Agency: COC **Last changed: 07/08/2003**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Reason for No Surgery [Std# 1340]
Vital Status [Std# 1760]

Default Error Message

[1016] %F1 and %F2 conflict
Reason for No Surgery and Vital Status conflict

Description

If Reason for No Surgery = 5 (surgery of the primary site was not performed because the patient died prior to planned or recommended surgery), then Vital Status cannot = 1 (alive).

Regional Nodes Ex, Reg Nodes Pos (COC)

Agency: COC **Last changed: 09/02/2010**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Regional Nodes Examined [Std# 830]
Regional Nodes Positive [Std# 820]
Date of Diagnosis [Std# 390]
CS Version Input Original [Std# 2935]

Default Error Message

[1002] Conflict among %F1, %F2, %F3 and %F4
Conflict among Regional Nodes Examined, Regional Nodes Positive, Date of Diagnosis and CS Version Input Original

Additional Messages

ERROR_TEXT("Date of Diagnosis: %DC")

Description

```
This edit is skipped if:
1. Regional Nodes Examined is blank
2. Regional Nodes Positive is blank
3. Year of Date of Diagnosis is blank

If year of Date of Diagnosis is less than 2010 and CS Version Input Original is
less than 020000 or blank:
1.  If Regional Nodes Examined = 00, Regional Nodes Positive must = 98.
2.  If Regional Nodes Examined = 01 - 90, Regional Nodes Positive must
    = 97 or 99, or be less than or equal to Regional Nodes Examined.
3.  If Regional Nodes Examined = 95, 96, 97, or 98, Regional Nodes Positive
    must = 00 - 90, 95, 97, or 99.
4.  If Regional Nodes Examined = 99, then Regional Nodes Positive must = 99.

If year of Date of Diagnosis is 2010 or later OR if CS Version Input original is
greater than 020000:
1.  If Regional Nodes Examined = 00 , Regional Nodes Positive must = 98.
2.  If Regional Nodes Examined = 01 - 90, Regional Nodes Positive must
    = 95, 97 or 99, or be less than or equal to Regional Nodes Examined.
3.  If Regional Nodes Examined = 95, Regional Nodes Positive must
    = 00, 95, or 99.
4.  If Regional Nodes Examined = 96, 97, or 98, Regional Nodes Positive
    must = 00 - 90, 95, 97, or 99.
5.  If Regional Nodes Examined = 99, then Regional Nodes Positive must = 99.
```

Administrative Notes

Modifications:

NACR110C

06/06/06

Condition 3 was changed to include code 95 in Regional Nodes Examined and Regional Nodes Positive:

Changed from:

If Regional Nodes Examined = 96, 97, or 98, Regional Nodes Positive must = 00 - 90, 97, or 99

to:

If Regional Nodes Examined = 95, 96, 97, or 98, Regional Nodes Positive must = 00 - 90, 95, 97, or 99

Condition 5 (If Regional Nodes Examined = 95, Regional Nodes Positive must = 00, 95, or 99) was deleted

NAACCR v12.0:

Modifed edit to be consistent with the CSv2 definitions of code 95 for Regional Nodes Examined and Regional Nodes Positive.

- This additional logic applies to cases diagnosed 2010 or later and to cases with CS Version Input Original of greater than 020000.
- Changed "If Regional Nodes Examined = 01 - 90, Regional Nodes Positive must = 97 or 99, or be less than or equal to Regional Nodes Examined"

to "If Regional Nodes Examined = 01 - 90, Regional Nodes Positive must = 95, 97 or 99, or be less than or equal to Regional Nodes Examined"

- Added "If Regional Nodes Examined = 95, Regional Nodes Positive must = 00, 95, or 99"
- Changed "If Regional Nodes Examined = 95, 96, 97, or 98, Regional Nodes Positive must = 00 - 90, 95, 97, or 99"

to "If Regional Nodes Examined = 96, 97, or 98, Regional Nodes Positive must = 00 - 90, 95, 97, or 99"

NAACCR v12C:

Updated description to state certain logic is performed if CS Version Input Original is less than 020000 or blank.

Regional Nodes Examined (NAACCR)

Agency: NAACCR **Last changed: 01/18/2010**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Regional Nodes Examined [Std# 830]

Default Error Message

[1038] %F1 must be numeric (00-90, 95-99)
Regional Nodes Examined must be numeric (00-90, 95-99)

Description

Regional Nodes Examined must be a two-digit number with values of 00-90, 95-99, or blank.

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

This edit differs from the COC edit of the same name in that it allows the field to be blank. Registries that want to edit this field only if it is present should choose this version of the edit when building a state-specific edit set.

Regional Nodes Positive (NAACCR)

Agency: NAACCR **Last changed: 01/18/2010**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Regional Nodes Positive [Std# 820]

Default Error Message

[3142] Regional Nodes Positive must be numeric (00-90, 95, 97-99)
Regional Nodes Positive must be numeric (00-90, 95, 97-99)

Description

Regional Nodes Positive must be a two-digit number with values of 00-90, 95, 97-99, or blank.

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

This edit differs from the COC edit of the same name in that it allows the field to be blank. Registries that want to edit this field only if it is present should choose this version of the edit when building a state-specific edit set.

RX Date BRM (COC)

Agency: COC **Last changed: 11/24/2012**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Date BRM [Std# 1240]

Default Error Message

[1003] %F1 (%V1) is an invalid date
RX Date BRM ("value of RX Date BRM") is an invalid date

Additional Messages

ERROR_TEXT("RX Date BRM: %DC")

Description

```
This edit is skipped if RX Date BRM is empty.

General Date Editing Rules:
Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD).
Month and day must have leading zeros for values 01...09.

The following date formats are allowed:
CCYYMMDD    Century+Year, Month and Day are provided.
CCYYMM__    Century+Year and Month. Day consists of two blank spaces.
CCYY____    Century+Year. Month and Day consist of four blank spaces.

Dates are checked first to ensure they conform to one of these formats, then for
errors in the components. Checking stops on the first non-valid situation.

Range checking:
Lowest allowed value:  January 1, 1850 (or in D1 format: 18500101)
Highest allowed value: current system date
When month is known, it is checked to ensure it falls within range 01...12.
When month and day are known, day is checked to ensure it falls within range for
that specific month. Accommodation is made for leap years.
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

Note: The COC single-field edit on RX Date--BRM was deleted from earlier versions of the metafile because, as of 2003, RX Date--Systemic replaced RX Date--BRM, RX Date--Chemo, and RX Date--Hormone. Beginning with cases diagnosed 2010 and later, the COC once again requires RX Date--BRM, RX Date--Chemo, and RX Date--Hormone.

Modifications

NAACCR v13

- Edit name changed from 'RX Date--BRM (COC)' to 'RX Date BRM (COC)'.
- Data item name changed from 'RX Date--BRM' to 'RX Date BRM'.

RX Date BRM Flag (NAACCR)

Agency: NAACCR **Last changed: 11/24/2012**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Date BRM Flag [Std# 1241]

Default Error Message

[3267] %F1 must be blank, 10, 11, 12, or 15
RX Date BRM Flag must be blank, 10, 11, 12, or 15

Description

The RX Date BRM Flag codes indicates why there is no appropriate value in the corresponding date field, RX Date BRM.

Note: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates. See Flavors of Null table in its entirety which includes the NAACCR codes, HL7 codes and definitions.

Allowable codes:
10 No information whatsoever can be inferred from this exceptional value (e.g., unknown if immunotherapy administered).

11 No proper value is applicable in this context (e.g., no immunotherapy administered; autopsy only case).

12 A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., immunotherapy administered but date is unknown).

15 Information is not available at this time, but it is expected that it will be available later (e.g.,immunotherapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow-up).

Blank A valid date value is provided in item RX Date BRM, or the date was not expected to have been transmitted.

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

Modifications

NAACCR v13
- Edit name changed from 'RX Date--BRM Flag(NAACCR)' to 'RX Date BRM Flag(NAACCR)'.
- Data item name changed from 'RX Date--BRM Flag' to 'RX Date BRM Flag'.

RX Date BRM, Date Flag (COC)

Agency: COC **Last changed: 06/14/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Date BRM Flag [Std# 1241]
RX Date BRM [Std# 1240]

Default Error Message

[3264] If date is present, corresponding date flag must be blank
If date is present, corresponding date flag must be blank

Additional Messages

[3279] If date is blank, corresponding flag must = blank, 10, 11, 12, or 15

Description

```
General information on the inter-field editing of date and date flag fields:
The purpose of this inter-field edit is to verify that a date field and the
corresponding date flag field are in agreement. A blank flag field indicates that
the date was either filled in or intentionally not collected. Otherwise the date
flag should include a 2-digit code indicating the reason the date field is blank.

This edit does not require RX Date BRM because it was not required by the COC for
cases diagnosed 2003-2009; that is, RX Date BRM and its corresponding date flag, RX
Date BRM Flag, may both be blank, indicating the date was intentionally not
collected. However, if either field is populated, they must be in agreement.
1. If both fields are blank, the edit is skipped.
2. If RX Date BRM is populated,then RX Date BRM Flag must be blank.
3. If RX Date BRM is blank and RX Date BRM Flag is not blank, then RX Date BRM Flag
must = 10 (unknown if immunotherapy administered), 11 (immunotherapy not given), 12
(immunotherapy given, but date is unknown), or 15 (planned, not yet given).

Note: Another edit [RX Date BRM, Date Flag, DX Date (COC)] verifies that either the
date or the flag is populated for cases diagnosed prior to 2003 and 2010 and later.
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

In the SEER*Edits software, the title of this edit is: IF511

This edit differs from the NAACCR edit of the same name in that it allows both RX Date BRM and RX Date BRM Flag to be blank.

Modifications

NAACCR v13

- Edit name changed from 'RX Date--BRM, Date Flag (COC)' to 'RX Date BRM, Date Flag (COC)'.
- Data item name changed from 'RX Date--BRM' to 'RX Date BRM'.
- Data item name changed from 'RX Date--BRM Flag' to 'RX Date BRM Flag'.

NAACCR v15
- Added SEER IF number (IF511)

RX Date BRM, Date Flag, DX Date (NPCR)

Agency: NPCR **Last changed: 02/10/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Date BRM [Std# 1240]
RX Date BRM Flag [Std# 1241]
Date of Diagnosis [Std# 390]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]

Default Error Message

[4883] If DX year = 2011-2014, %F4=%V4 and %F5=%V5, %F1 and %F2 cannot both be blank
If DX year = 2011-2014, Primary Site="value of Primary Site" and Histologic Type ICD-O-3="value of Histologic Type ICD-O-3", RX Date BRM and RX Date BRM Flag cannot both be blank

Additional Messages

[3579] If DX year = 2015 or later, RX Date BRM and RX Date BRM Flag cannot both be blank

Description

```
General information on the inter-field editing of date and date flag fields:
The purpose of this inter-field edit is to verify that a date field and the
corresponding date flag field are in agreement. A blank flag field indicates that
the date was either filled in or intentionally not collected. Otherwise the date
flag should include a 2-digit code indicating the reason the date field is blank.

This edit requires RX Date BRM OR RX Date BRM Flag for cases that meet the
following criteria:
1. Year of Date of Diagnosis is 2011-2014
     AND
   Case is one of the following site/histologies
   A. Breast (Primary Site = C500-C509 and Histologic Type ICD-O-3 =
      8000-9044, 9060-9136, or 9141-9582)
   B. Colon (Primary Site = C180-C189 and Histologic Type ICD-O-3 =
      8000-9044, 9060-9136, or 9141-9582)
   C. Rectum (Primary Site = C199 or C209 and Histologic Type ICD-O-3
      = 8000-9044, 9060-9136, or 9141-9582)

2. Year of Date of Diagnosis is 2015 or later
   - All cases
```

Administrative Notes

New edit - added to NAACCR v12.1 metafile.

This edit differs from the COC, "RX Date BRM, Date Flag, DX Date (COC)", in that NPCR requires RX Date BRM or RX Date BRM Flag only for cancers of the breast, colon, and rectum diagnosed 2011-2014 and for all cases

diagnosed 2015 and later, while the COC edit requires the date or flag for cases diagnosed prior to 2003 and cases diagnosed 2010 or later.

Modifications:

NAACCR v12.2
- Modified to require date or date flag only for cancers of the breast, colon, and rectum diagnosed 2011 and later.

NAACCR v13
- Edit name changed from 'RX Date--BRM, Date Flag, DX Date (NPCR)' to 'RX Date BRM, Date Flag, DX Date (NPCR)'.
- Data item name changed from 'RX Date--BRM' to 'RX Date BRM'.
- Data item name changed from 'RX Date--BRM Flag' to 'RX Date BRM Flag'.

NAACCR v15
- Edit modified to require date or flag for all cases diagnosed 2015 or later. For cases diagnosed 2011-2014, date or flag is required only for breast, colon, and rectum cases.

RX Date BRM, Date Last Contact (COC)

Agency: COC **Last changed: 01/09/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Date BRM [Std# 1240]
Date of Last Contact [Std# 1750]

Default Error Message

[3333] %F1 (%V1) must be < or = %F2 (%V2)
RX Date BRM ("value of RX Date BRM") must be < or = Date of Last Contact ("value of Date of Last Contact"

Additional Messages

ERROR_TEXT("Date of Last Contact is invalid: %DC")
ERROR_TEXT("RX Date BRM is invalid: %DC")

Description

This edit is skipped if any of the fields are blank.

RX Date BRM must be less than or equal to Date of Last Contact. If both years are known, but either month is blank, then only the years are compared. If either day is blank, then only the years and months are compared.

Administrative Notes

New edit - added to NAACCR v12.1 metafile.

In the SEER*Edits software, the title of this edit is: IF512

Modifications

NAACCR v13
- Edit name changed from 'RX Date--BRM, Date Last Contact (COC)' to 'RX Date BRM, Date Last Contact (COC)'.
- Data item name changed from 'RX Date--BRM' to 'RX Date BRM'.

NAACCR v15
- Added SEER IF number (IF512)

RX Date BRM, Date of Diagnosis (COC)

Agency: COC **Last changed: 01/09/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Date BRM [Std# 1240]
Date of Diagnosis [Std# 390]

Default Error Message

[3332] %F1 (%V1) must be > or = %F2 (%V2)
RX Date BRM ("value of RX Date BRM") must be > or = Date of Diagnosis ("value of Date of Diagnosis"

Description

This edit is skipped if any of the fields are blank or invalid.

RX Date BRM must be greater than or equal to Date of Diagnosis. If both years are known, but either month is blank, then only the years are compared. If either day is blank, then only the years and months are compared.

Administrative Notes

New edit - added to NAACCR v12.1A metafile.

In the SEER*Edits software, the title of this edit is: IF513

Modifications

NAACCR v13
- Edit name changed from 'RX Date--BRM, Date of Diagnosis (COC)' to 'RX Date BRM, Date of Diagnosis (COC)'.
- Data item name changed from 'RX Date--BRM' to 'RX Date BRM'.

NAACCR v15
- Added SEER IF number (IF513)

RX Date BRM, RX Date Systemic (COC)

Agency: COC **Last changed: 11/24/2012**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Date BRM [Std# 1240]
RX Date Systemic [Std# 3230]

Default Error Message

[3332] %F1 (%V1) must be > or = %F2 (%V2)
RX Date BRM ("value of RX Date BRM") must be > or = RX Date Systemic ("value of RX Date Systemic"

Description

This edit is skipped if any of the fields are blank or invalid.

RX Date BRM must be greater than or equal to RX Date Systemic. If both years are known, but either month is blank, then only the years are compared. If either day is blank, then only the years and months are compared.

Administrative Notes

New edit - added to NAACCR v12.1 metafile.

Modifications

NAACCR v13
- Edit name changed from 'RX Date--BRM, RX Date--Systemic (COC)' to 'RX Date BRM, RX Date Systemic (COC)'.
- Data item name changed from 'RX Date--BRM' to 'RX Date BRM'.
- Data item name changed from 'RX Date--Systemic' to 'RX Date Systemic'.

RX Date Chemo (COC)

Agency: COC **Last changed: 11/24/2012**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Date Chemo [Std# 1220]

Default Error Message

[3266] %F1 is an invalid date
RX Date Chemo is an invalid date

Additional Messages

ERROR_TEXT("RX Date Chemo: %DC")

Description

```
This edit is skipped if RX Date Chemo is empty.

General Date Editing Rules:
Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD).
Month and day must have leading zeros for values 01...09.

The following date formats are allowed:
CCYYMMDD    Century+Year, Month and Day are provided.
CCYYMM__    Century+Year and Month. Day consists of two blank spaces.
CCYY____    Century+Year. Month and Day consist of four blank spaces.

Dates are checked first to ensure they conform to one of these formats, then for
errors in the components. Checking stops on the first non-valid situation.

Range checking:
Lowest allowed value:  January 1, 1850 (or in D1 format: 18500101)
Highest allowed value: current system date
When month is known, it is checked to ensure it falls within range 01...12.
When month and day are known, day is checked to ensure it falls within range for
that specific month. Accommodation is made for leap years.
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

Note: The COC single-field edit on RX Date--Chemo was deleted from earlier versions of the metafile because, as of 2003, RX Date--Systemic replaced RX Date--BRM, RX Date--Chemo, and RX Date--Hormone. Beginning with cases diagnosed 2010 and later, the COC once again requires RX Date--BRM, RX Date--Chemo, and RX Date--Hormone.

Modifications

NAACCR v13

- Edit name changed from 'RX Date--Chemo (COC)' to 'RX Date Chemo (COC)'.
- Data item name changed from 'RX Date--Chemo' to 'RX Date Chemo'.

RX Date Chemo Flag (NAACCR)

Agency: NAACCR **Last changed: 11/24/2012**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Date Chemo Flag [Std# 1221]

Default Error Message

[3267] %F1 must be blank, 10, 11, 12, or 15
RX Date Chemo Flag must be blank, 10, 11, 12, or 15

Description

The RX Date Chemo Flag codes indicates why there is no appropriate value in the corresponding date field, RX Date Chemo.

Note: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates. See Flavors of Null table in its entirety which includes the NAACCR codes, HL7 codes and definitions.

Allowable codes:
10 No information whatsoever can be inferred from this exceptional value (e.g., unknown if chemotherapy administered).

11 No proper value is applicable in this context (e.g., no chemotherapy administered; autopsy only case).

12 A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., chemotherapy administered but date is unknown).

15 Information is not available at this time, but it is expected that it will be available later (e.g.,chemotherapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow-up).

Blank A valid date value is provided in item RX Date Chemo, or the date was not expected to have been transmitted.

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

Modifications

NAACCR v13
- Edit name changed from 'RX Date--Chemo Flag(NAACCR)' to 'RX Date Chemo Flag(NAACCR)'.
- Data item name changed from 'RX Date--Chemo Flag' to 'RX Date Chemo Flag'.

RX Date Chemo, Date Flag (COC)

Agency: COC **Last changed: 06/14/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Date Chemo [Std# 1220]
RX Date Chemo Flag [Std# 1221]

Default Error Message

[3264] If date is present, corresponding date flag must be blank
If date is present, corresponding date flag must be blank

Additional Messages

[3279] If date is blank, corresponding flag must = blank, 10, 11, 12, or 15

Description

```
General information on the inter-field editing of date and date flag fields:
The purpose of this inter-field edit is to verify that a date field and the
corresponding date flag field are in agreement. A blank flag field indicates that
the date was either filled in or intentionally not collected. Otherwise the date
flag should include a 2-digit code indicating the reason the date field is blank.

This edit does not require RX Date Chemo because it was not required by the COC for
cases diagnosed 2003-2009; that is, RX Date Chemo and its corresponding date flag,
RX Date Chemo Flag, may both be blank, indicating the date was intentionally not
collected. However, if either field is populated, they must be in agreement.
1. If both fields are blank, the edit is skipped.
2. If RX Date Chemo is populated,then RX Date Chemo Flag must be blank.
3. If RX Date Chemo is blank and RX Date Chemo Flag is not blank, then RX Date
Chemo Flag must = 10 (unknown if chemo given), 11 (chemo not given), 12 (chemo
given, but date is unknown), or 15 (planned, not yet given).

Note: Another edit [RX Date Chemo, Date Flag, DX Date (COC)] verifies that either
the date or the flag is populated for cases diagnosed prior to 2003 and 2010 and
later.
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

In the SEER*Edits software, the title of this edit is: IF514

This edit differs from the NAACCR edit of the same name in that it allows both RX Date Chemo and RX Date Chemo Flag to be blank.

Modifications

NAACCR v13
- Edit name changed from 'RX Date--Chemo, Date Flag (COC)' to 'RX Date Chemo, Date Flag (COC)'.
- Data item name changed from 'RX Date--Chemo' to 'RX Date Chemo'.
- Data item name changed from 'RX Date--Chemo Flag' to 'RX Date Chemo Flag'.

NAACCR v15
- Added SEER IF number (IF514)

RX Date Chemo, Date Flag, DX Date (NPCR)

Agency: NPCR **Last changed: 02/10/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Date Chemo [Std# 1220]
RX Date Chemo Flag [Std# 1221]
Date of Diagnosis [Std# 390]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]

Default Error Message

[4883] If DX year = 2011-2014, %F4=%V4 and %F5=%V5, %F1 and %F2 cannot both be blank
If DX year = 2011-2014, Primary Site="value of Primary Site" and Histologic Type ICD-O-3="value of Histologic Type ICD-O-3", RX Date Chemo and RX Date Chemo Flag cannot both be blank

Additional Messages

[3579] If DX year = 2015 or later, RX Date Chemo and RX Date Chemo Flag cannot both be blank

Description

```
General information on the inter-field editing of date and date flag fields:
The purpose of this inter-field edit is to verify that a date field and the
corresponding date flag field are in agreement. A blank flag field indicates that
the date was either filled in or intentionally not collected. Otherwise the date
flag should include a 2-digit code indicating the reason the date field is blank.

This edit requires RX Date Chemo OR RX Date Chemo Flag for cases that meet the
following criteria:
1. Year of Date of Diagnosis is 2011-2014
     AND
   Case is one of the following site/histologies
   A. Breast (Primary Site = C500-C509 and Histologic Type ICD-O-3 =
      8000-9044, 9060-9136, or 9141-9582)
   B. Colon (Primary Site = C180-C189 and Histologic Type ICD-O-3 =
      8000-9044, 9060-9136, or 9141-9582)
   C. Rectum (Primary Site = C199 or C209 and Histologic Type ICD-O-3
      = 8000-9044, 9060-9136, or 9141-9582)

2. Year of Date of Diagnosis is 2015 or later
   - All cases
```

Administrative Notes

New edit - added to NAACCR v12.1 metafile.

This edit differs from the COC, "RX Date Chemo, Date Flag, DX Date (COC)", in that NPCR requires RX Date Chemo or RX Date Chemo Flag only for cancers of the breast, colon, and rectum diagnosed 2011-2014 and for all

cases diagnosed 2015 and later, while the COC edit requires the date or flag for all cases diagnosed prior to 2003 and cases diagnosed 2010 or later.

Modifications:

NAACCR v12.2
- Modified to require date or date flag only for cancers of the breast, colon, and rectum diagnosed 2011 and later.

NAACCR v13
- Edit name changed from 'RX Date--Chemo, Date Flag, DX Date (NPCR)' to 'RX Date Chemo, Date Flag, DX Date (NPCR)'.
- Data item name changed from 'RX Date--Chemo' to 'RX Date Chemo'.
- Data item name changed from 'RX Date--Chemo Flag' to 'RX Date Chemo Flag'.

NAACCR v15
- Edit modified to require date or flag for all cases diagnosed 2015 or later. For cases diagnosed 2011-2014, date or flag is required only for breast, colon, and rectum cases.

RX Date Chemo, Date Last Contact (COC)

Agency: COC **Last changed: 01/09/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Date Chemo [Std# 1220]
Date of Last Contact [Std# 1750]

Default Error Message

[3333] %F1 (%V1) must be < or = %F2 (%V2)
RX Date Chemo ("value of RX Date Chemo") must be < or = Date of Last Contact ("value of Date of Last Contact"

Additional Messages

ERROR_TEXT("Date of Last Contact is invalid: %DC")
ERROR_TEXT("RX Date Chemo is invalid: %DC")

Description

This edit is skipped if any of the fields are blank.

RX Date Chemo must be less than or equal to Date of Last Contact. If both years are known, but either month is blank, then only the years are compared. If either day is blank, then only the years and months are compared.

Administrative Notes

New edit - added to NAACCR v12.1 metafile.

In the SEER*Edits software, the title of this edit is: IF515

Modifications

NAACCR v13
- Edit name changed from 'RX Date--Chemo, Date Last Contact (COC)' to 'RX Date Chemo, Date Last Contact (COC)'.
- Data item name changed from 'RX Date--Chemo' to 'RX Date Chemo'.

NAACCR v15
- Added SEER IF number (IF515)

RX Date Chemo, Date of Diagnosis (COC)

Agency: COC **Last changed: 01/09/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Date Chemo [Std# 1220]
Date of Diagnosis [Std# 390]

Default Error Message

[3332] %F1 (%V1) must be > or = %F2 (%V2)
RX Date Chemo ("value of RX Date Chemo") must be > or = Date of Diagnosis ("value of Date of Diagnosis"

Description

This edit is skipped if any of the fields are blank or invalid.

RX Date Chemo must be greater than or equal to Date of Diagnosis. If both years are known, but either month is blank, then only the years are compared. If either day is blank, then only the years and months are compared.

Administrative Notes

New edit - added to NAACCR v12.1A metafile.

In the SEER*Edits software, the title of this edit is: IF516

Modifications

NAACCR v13
- Edit name changed from 'RX Date--Chemo, Date of Diagnosis (COC)' to 'RX Date Chemo, Date of Diagnosis (COC)'.
- Data item name changed from 'RX Date--Chemo' to 'RX Date Chemo'.

NAACCR v15
- Added SEER IF number (IF516)

RX Date Chemo, RX Date Systemic (COC)

Agency: COC **Last changed: 11/25/2012**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Date Chemo [Std# 1220]
RX Date Systemic [Std# 3230]

Default Error Message

[3332] %F1 (%V1) must be > or = %F2 (%V2)
RX Date Chemo ("value of RX Date Chemo") must be > or = RX Date Systemic ("value of RX Date Systemic"

Description

This edit is skipped if any of the fields are blank or invalid.

RX Date Chemo must be greater than or equal to RX Date Systemic. If both years are known, but either month is blank, then only the years are compared. If either day is blank, then only the years and months are compared.

Administrative Notes

New edit - added to NAACCR v12.1 metafile.

Modifications

NAACCR v13
- Edit name changed from 'RX Date--Chemo, RX Date--Systemic (COC)' to 'RX Date Chemo, RX Date Systemic(COC)'.
- Data item name changed from 'RX Date--Chemo' to 'RX Date Chemo'.
- Data item name changed from 'RX Date--Systemic' to 'RX Date Systemic'.

RX Date DX/Stg Proc (COC)

Agency: COC **Last changed: 12/14/2012**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Date DX/Stg Proc [Std# 1280]

Default Error Message

[1003] %F1 (%V1) is an invalid date
RX Date DX/Stg Proc ("value of RX Date DX/Stg Proc") is an invalid date

Additional Messages

ERROR_TEXT("RX Date DX/Stg Proc: %DC")

Description

```
This edit is skipped if RX Date DX/Stg Proc is empty.

General Date Editing Rules:
Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD).
Month and day must have leading zeros for values 01...09.

The following date formats are allowed:
CCYYMMDD    Century+Year, Month and Day are provided.
CCYYMM__    Century+Year and Month. Day consists of two blank spaces.
CCYY____    Century+Year. Month and Day consist of four blank spaces.

Dates are checked first to ensure they conform to one of these formats, then for
errors in the components. Checking stops on the first non-valid situation.

Range checking:
Lowest allowed value:  January 1, 1850 (or in D1 format: 18500101)
Highest allowed value: current system date
When month is known, it is checked to ensure it falls within range 01...12.
When month and day are known, day is checked to ensure it falls within range for
that specific month. Accommodation is made for leap years.
```

Administrative Notes

MODIFICATIONS:

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

NAACCR v13
- Edit name changed from 'RX Date--DX/Stg Proc (COC)' to 'RX Date DX/Stg Proc (COC)'.
- Data item name changed from 'RX Date--DX/Stg Proc' to 'RX Date DX/Stg Proc'.

RX Date Dx/Stg Proc Flag (NAACCR)

Agency: NAACCR **Last changed: 12/14/2012**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Date Dx/Stg Proc Flag [Std# 1281]

Default Error Message

[3276] %F1 must be blank, 10, 11, or 12
RX Date Dx/Stg Proc Flag must be blank, 10, 11, or 12

Description

The RX Date DX/Stg Proc Flag codes indicates why there is no appropriate value in the corresponding date field, RX Date DX/Stg Proc.

Note: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates. See Flavors of Null table in its entirety which includes the NAACCR codes, HL7 codes and definitions.

Allowable codes:
10 No information whatsoever can be inferred from this exceptional value (e.g., unknown if any diagnostic or staging procedure performed).

11 No proper value is applicable in this context (e.g., no diagnostic or staging procedure performed; autopsy only case).

12 A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., diagnostic or staging procedure performed but date is unknown).

Blank A valid date value is provided in item RX Date DX/Stg Proc, or the date was not expected to have been transmitted.

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

Modifications

NAACCR v13
- Edit name changed from 'RX Date--DX/Stg Proc Flag(NAACCR)' to 'RX Date DX/Stg Proc Flag(NAACCR)'.
- Data item name changed from 'RX Date--DX/Stg Proc Flag' to 'RX Date DX/Stg Proc Flag'.

RX Date DX/Stg Proc, Date Flag (COC)

Agency: COC **Last changed: 11/25/2012**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Date DX/Stg Proc [Std# 1280]
RX Date Dx/Stg Proc Flag [Std# 1281]

Default Error Message

[1016] %F1 and %F2 conflict
RX Date DX/Stg Proc and RX Date Dx/Stg Proc Flag conflict

Additional Messages

[3264] If date is present, corresponding date flag must be blank
[3272] If RX Date DX/Stg Proc is blank, corresponding RX Date Dx/Stg Proc Flag must = 10, 11, or 12

Description

```
General information on the inter-field editing of date and date flag fields:
The purpose of this inter-field edit is to verify that a date field and the
corresponding date flag field are in agreement. A blank flag field indicates that
the date was either filled in or intentionally not collected. Otherwise the date
flag should include a 2-digit code indicating the reason the date field is blank.

This edit requires RX Date DX/Stg Proc; that is, it must always be populated OR its
corresponding flag must indicate the reason the field is blank.
1. If RX Date DX/Stg Proc is populated, then RX Date DX/Stg Proc Flag must be
blank.
2. If RX Date DX/Stg Proc is blank, then RX Date DX/Stg Proc Flag must = 10
(unknown if any
diagnostic or staging procedure performed), 11 (no diagnostic or staging procedure
performed;
autopsy only case), or 12 (diagnostic or staging procedure performed but date is
unknown).
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

Modifications

NAACCR v13
- Edit name changed from 'RX Date--DX/Stg Proc, Date Flag (COC)' to 'RX Date DX/Stg Proc, Date Flag (COC)'.
- Data item name changed from 'RX Date--DX/Stg Proc' to 'RX Date DX/Stg Proc'.
- Data item name changed from 'RX Date--DX/Stg Proc Flag' to 'RX Date DX/Stg Proc Flag'.

RX Date DX/Stg Proc, Date Last Contact (COC)

Agency: COC **Last changed: 11/25/2012**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Last Contact [Std# 1750]
RX Date DX/Stg Proc [Std# 1280]

Default Error Message

[3332] %F1 (%V1) must be > or = %F2 (%V2)
Date of Last Contact ("value of Date of Last Contact") must be > or = RX Date DX/Stg Proc ("value of RX Date DX/Stg Proc"

Additional Messages

ERROR_TEXT("Date of Last Contact is invalid: %DC")
ERROR_TEXT("RX Date DX/Stg Proc is invalid: %DC")

Description

This edit is skipped if RX Date DX/Stg Proc or Date of Last Contact is blank.

Date of Last Contact must not precede RX Date DX/Stg Proc. If both years are known, but either month is unknown (99), then only the years are compared. If either day is unknown (99), then only the years and months are compared.

Date of Last Contact must be greater than or equal to RX Date DX/Stg Proc. If both years are known, but either month is blank, then only the years are compared. If either day is blank, then only the years and months are compared.

Administrative Notes

Modifications:

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

NAACCR v13
- Edit name changed from 'RX Date--DX/Stg Proc, Date Last Contact (COC)' to 'RX Date DX/Stg Proc, Date Last Contact (COC)'.
- Data item name changed from 'RX Date--DX/Stg Proc' to 'RX Date DX/Stg Proc'.

RX Date Hormone (COC)

Agency: COC **Last changed: 11/24/2012**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Date Hormone [Std# 1230]

Default Error Message

[1003] %F1 (%V1) is an invalid date
RX Date Hormone ("value of RX Date Hormone") is an invalid date

Additional Messages

ERROR_TEXT("RX Date Hormone: %DC")

Description

```
This edit is skipped if RX Date Hormone is empty.

General Date Editing Rules:
Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD).
Month and day must have leading zeros for values 01...09.

The following date formats are allowed:
CCYYMMDD    Century+Year, Month and Day are provided.
CCYYMM__    Century+Year and Month. Day consists of two blank spaces.
CCYY____    Century+Year. Month and Day consist of four blank spaces.

Dates are checked first to ensure they conform to one of these formats, then for
errors in the components. Checking stops on the first non-valid situation.

Range checking:
Lowest allowed value:  January 1, 1850 (or in D1 format: 18500101)
Highest allowed value: current system date
When month is known, it is checked to ensure it falls within range 01...12.
When month and day are known, day is checked to ensure it falls within range for
that specific month. Accommodation is made for leap years.
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

Note: The COC single-field edit on RX Date--Hormone was deleted from earlier versions of the metafile because, as of 2003, RX Date--Systemic replaced RX Date--BRM, RX Date--Chemo, and RX Date--Hormone. Beginning with cases diagnosed 2010 and later, the COC once again requires RX Date--BRM, RX Date--Chemo, and RX Date--Hormone.

Modifications

NAACCR v13

- Edit name changed from 'RX Date--Hormone (COC)' to 'RX Date Hormone (COC)'.
- Data item name changed from 'RX Date--Hormone' to 'RX Date Hormone'.

RX Date Hormone Flag (NAACCR)

Agency: NAACCR **Last changed: 11/24/2012**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Date Hormone Flag [Std# 1231]

Default Error Message

[3267] %F1 must be blank, 10, 11, 12, or 15
RX Date Hormone Flag must be blank, 10, 11, 12, or 15

Description

The RX Date Hormone Flag codes indicates why there is no appropriate value in the corresponding date field, RX Date Hormone.

Note: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates. See Flavors of Null table in its entirety which includes the NAACCR codes, HL7 codes and definitions.

Allowable codes:
10 No information whatsoever can be inferred from this exceptional value (e.g., unknown if hormone therapy administered).

11 No proper value is applicable in this context (e.g., no hormone therapy administered; autopsy only case).

12 A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., hormone therapy administered but date is unknown).

15 Information is not available at this time, but it is expected that it will be available later (e.g.,hormone therapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow-up).

Blank A valid date value is provided in item RX Date Hormone, or the date was not expected to have been transmitted.

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

Modifications

NAACCR v13
- Edit name changed from 'RX Date--Hormone Flag(NAACCR)' to 'RX Date Hormone Flag(NAACCR)'.
- Data item name changed from 'RX Date--Hormone Flag' to 'RX Date Hormone Flag'.

RX Date Hormone, Date Flag (COC)

Agency: COC **Last changed: 06/14/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Date Hormone [Std# 1230]
RX Date Hormone Flag [Std# 1231]

Default Error Message

[3264] If date is present, corresponding date flag must be blank
If date is present, corresponding date flag must be blank

Additional Messages

[3279] If date is blank, corresponding flag must = blank, 10, 11, 12, or 15

Description

General information on the inter-field editing of date and date flag fields:
The purpose of this inter-field edit is to verify that a date field and the corresponding date flag field are in agreement. A blank flag field indicates that the date was either filled in or intentionally not collected. Otherwise the date flag should include a 2-digit code indicating the reason the date field is blank.

This edit does not require RX Date Hormone because it was not required by the COC for cases diagnosed 2003-2009; that is, RX Date Hormone and its corresponding date flag, RX Date Hormone Flag, may both be blank, indicating the date was intentionally not collected. However, if either field is populated, they must be in agreement.
1. If both fields are blank, the edit is skipped.
2. If RX Date Hormone is populated,then RX Date Hormone Flag must be blank.
3. If RX Date Hormone is blank and RX Date Hormone Flag is not blank, then RX Date Hormone Flag must = 10 (unknown if Hormone therapy given), 11 (Hormone therapy not given), 12 (Hormone therapy given, but date is unknown), or 15 (planned, not yet given).

Note: Another edit [RX Date Hormone, Date Flag, DX Date (COC)] verifies that either the date or the flag is populated for cases diagnosed prior to 2003 and 2010 and later.

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

In the SEER*Edits software, the title of this edit is: IF517

This edit differs from the NAACCR edit of the same name in that it allows both RX Date Hormone and RX Date Hormone Flag to be blank.

Modifications

NAACCR v13
- Edit name changed from 'RX Date--Hormone, Date Flag (COC)' to 'RX Date Hormone, Date Flag (COC)'.
- Data item name changed from 'RX Date--Hormone' to 'RX Date Hormone'.
- Data item name changed from 'RX Date--Hormone Flag' to 'RX Date Hormone Flag'.

NAACCR v15
- Added SEER IF number (IF517)

RX Date Hormone, Date Flag, DX Date (NPCR)

Agency: NPCR **Last changed: 02/10/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Date Hormone [Std# 1230]
RX Date Hormone Flag [Std# 1231]
Date of Diagnosis [Std# 390]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]

Default Error Message

[4883] If DX year = 2011-2014, %F4=%V4 and %F5=%V5, %F1 and %F2 cannot both be blank
If DX year = 2011-2014, Primary Site="value of Primary Site" and Histologic Type ICD-O-3="value of Histologic Type ICD-O-3", RX Date Hormone and RX Date Hormone Flag cannot both be blank

Additional Messages

[3579] If DX year = 2015 or later, RX Date Hormone and RX Date Hormone Flag cannot both be blank

Description

```
General information on the inter-field editing of date and date flag fields:
The purpose of this inter-field edit is to verify that a date field and the
corresponding date flag field are in agreement. A blank flag field indicates that
the date was either filled in or intentionally not collected. Otherwise the date
flag should include a 2-digit code indicating the reason the date field is blank.

This edit requires RX Date Hormone OR RX Date Hormone Flag for cases that meet the
following criteria:
1. Year of Date of Diagnosis is 2011-2014
     AND
   Case is one of the following site/histologies
   A. Breast (Primary Site = C500-C509 and Histologic Type ICD-O-3 =
      8000-9044, 9060-9136, or 9141-9582)
   B. Colon (Primary Site = C180-C189 and Histologic Type ICD-O-3 =
      8000-9044, 9060-9136, or 9141-9582)
   C. Rectum (Primary Site = C199 or C209 and Histologic Type ICD-O-3
      = 8000-9044, 9060-9136, or 9141-9582)

2. Year of Date of Diagnosis is 2015 or later
   - All cases
```

Administrative Notes

New edit - added to NAACCR v12.1 metafile.

This edit differs from the COC, "RX Date Hormone, Date Flag, DX Date (COC)", in that NPCR requires RX Date Hormone or RX Date Hormone Flag only for cancers of the breast, colon, and rectum diagnosed 2011-2014 and

for all cases diagnosed 2015 and later, while the COC edit requires the date or flag for cases diagnosed prior to 2003 and cases diagnosed 2010 or later.

Modifications:

NAACCR v12.2
- Modified to require date or date flag only for cancers of the breast, colon, and rectum diagnosed 2011 and later.

NAACCR v13
- Edit name changed from 'RX Date--Hormone, Date Flag, DX Date (NPCR)' to 'RX Date Hormone, Date Flag, DX Date (NPCR)'.
- Data item name changed from 'RX Date--Hormone' to 'RX Date Hormone'.
- Data item name changed from 'RX Date--Hormone Flag' to 'RX Date Hormone Flag'.

NAACCR v15
- Edit modified to require date or flag for all cases diagnosed 2015 or later. For cases diagnosed 2011-2014, date or flag is required only for breast, colon, and rectum cases.

RX Date Hormone, Date Last Contact (COC)

Agency: COC **Last changed: 01/09/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Date Hormone [Std# 1230]
Date of Last Contact [Std# 1750]

Default Error Message

[3333] %F1 (%V1) must be < or = %F2 (%V2)
RX Date Hormone ("value of RX Date Hormone") must be < or = Date of Last Contact ("value of Date of Last Contact"

Additional Messages

ERROR_TEXT("Date of Last Contact is invalid: %DC")
ERROR_TEXT("RX Date Hormone is invalid: %DC")

Description

This edit is skipped if any of the fields are blank.

RX Date Hormone must be less than or equal to Date of Last Contact. If both years are known, but either month is blank, then only the years are compared. If either day is blank, then only the years and months are compared.

Administrative Notes

New edit - added to NAACCR v12.1 metafile.

In the SEER*Edits software, the title of this edit is: IF518

Modifications

NAACCR v13
- Edit name changed from 'RX Date--Hormone, Date Last Contact (COC)' to 'RX Date Hormone, Date Last Contact (COC)'.
- Data item name changed from 'RX Date--Hormone' to 'RX Date Hormone'.

NAACCR v15
- Added SEER IF number (IF518)

RX Date Hormone, Date of Diagnosis (COC)

Agency: COC **Last changed: 01/09/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Date Hormone [Std# 1230]
Date of Diagnosis [Std# 390]

Default Error Message

[3332] %F1 (%V1) must be > or = %F2 (%V2)
RX Date Hormone ("value of RX Date Hormone") must be > or = Date of Diagnosis ("value of Date of Diagnosis"

Description

This edit is skipped if any of the fields are blank or invalid.

RX Date Hormone must be greater than or equal to Date of Diagnosis. If both years are known, but either month is blank, then only the years are compared. If either day is blank, then only the years and months are compared.

Administrative Notes

New edit - added to NAACCR v12.1A metafile.

In the SEER*Edits software, the title of this edit is: IF519

Modifications

NAACCR v13
- Edit name changed from 'RX Date--Hormone, Date of Diagnosis (COC)' to 'RX Date Hormone, Date of Diagnosis (COC)'.
- Data item name changed from 'RX Date--Hormone' to 'RX Date Hormone'.

NAACCR v15
- Added SEER IF number (IF519)

RX Date Hormone, RX Date Systemic (COC)

Agency: COC **Last changed: 11/25/2012**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Date Hormone [Std# 1230]
RX Date Systemic [Std# 3230]

Default Error Message

[3332] %F1 (%V1) must be > or = %F2 (%V2)
RX Date Hormone ("value of RX Date Hormone") must be > or = RX Date Systemic ("value of RX Date Systemic"

Description

This edit is skipped if any of the fields are blank or invalid.

RX Date Hormone must be greater than or equal to RX Date Systemic. If both years are known, but either month is blank, then only the years are compared. If either day is blank, then only the years and months are compared.

Administrative Notes

New edit - added to NAACCR v12.1 metafile.

Modifications

NAACCR v13
- Edit name changed from 'RX Date--Hormone, RX Date--Systemic (COC)' to 'RX Date Hormone, RX Date Systemic(COC)'.
- Data item name changed from 'RX Date--Hormone' to 'RX Date Hormone'.
- Data item name changed from 'RX Date--Systemic' to 'RX Date Systemic'.

RX Date Mst Defn Srg (COC)

Agency: COC **Last changed: 11/24/2012**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Date Mst Defn Srg [Std# 3170]

Default Error Message

[1003] %F1 (%V1) is an invalid date
RX Date Mst Defn Srg ("value of RX Date Mst Defn Srg") is an invalid date

Additional Messages

ERROR_TEXT("RX Date Most Defin Surg: %DC")

Description

```
This edit is skipped if RX Date Mst Defn Srg is empty.

General Date Editing Rules:
Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD).
Month and day must have leading zeros for values 01...09.

The following date formats are allowed:
CCYYMMDD    Century+Year, Month and Day are provided.
CCYYMM__    Century+Year and Month. Day consists of two blank spaces.
CCYY____    Century+Year. Month and Day consist of four blank spaces.

Dates are checked first to ensure they conform to one of these formats, then for
errors in the components. Checking stops on the first non-valid situation.

Range checking:
Lowest allowed value:  January 1, 1850 (or in D1 format: 18500101)
Highest allowed value: current system date
When month is known, it is checked to ensure it falls within range 01...12.
When month and day are known, day is checked to ensure it falls within range for
that specific month. Accommodation is made for leap years.
```

Administrative Notes

MODIFICATIONS:

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

NAACCR v13
- Edit name changed from 'RX Date--Most Defin Surg (COC)' to 'RX Date Mst Defn Srg (COC)'.
- Data item name changed from 'RX Date--Most Defin Surg' to 'RX Date Mst Defn Srg'.

RX Date Mst Defn Srg Flag (NAACCR)

Agency: NAACCR **Last changed: 11/24/2012**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Date Mst Defn Srg Flag [Std# 3171]

Default Error Message

[3276] %F1 must be blank, 10, 11, or 12
RX Date Mst Defn Srg Flag must be blank, 10, 11, or 12

Description

The RX Date Mst Defn Srg Flag codes indicates why there is no appropriate value in the corresponding date field, RX Date Mst Defn Srg.

Note: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates. See Flavors of Null table in its entirety which includes the NAACCR codes, HL7 codes and definitions.

Allowable codes:
10 No information whatsoever can be inferred from this exceptional value (e.g., unknown if any surgical procedure of the primary site was performed).

11 No proper value is applicable in this context (e.g., no surgical resection of the primary site was performed and for cases diagnosed at autopsy).

12 A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., surgery of the primary site was performed but date is unknown).

Blank A valid date value is provided in item RX Date Mst Defn Srg, or the date was not expected to have been transmitted.

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

Modifications

NAACCR v13
- Edit name changed from 'RX Date--Mst Defn Srg Flag(NAACCR)' to 'RX Date Mst Defn Srg Flag(NAACCR)'.

RX Date Mst Defn Srg, Date Flag (COC)

Agency: COC **Last changed: 12/14/2012**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Date Mst Defn Srg [Std# 3170]
RX Date Mst Defn Srg Flag [Std# 3171]

Default Error Message

[1016] %F1 and %F2 conflict
RX Date Mst Defn Srg and RX Date Mst Defn Srg Flag conflict

Additional Messages

[3264] If date is present, corresponding date flag must be blank
[3272] If RX Date Mst Defn Srg is blank, corresponding RX Date Mst Defn Srg Flag must = 10, 11, or 12

Description

```
General information on the inter-field editing of date and date flag fields:
The purpose of this inter-field edit is to verify that a date field and the
corresponding date flag field are in agreement. A blank flag field indicates that
the date was either filled in or intentionally not collected. Otherwise the date
flag should include a 2-digit code indicating the reason the date field is blank.

This edit does not require RX Date Mst Defn Srg; that is, RX Date Mst Defn Srg and
its corresponding date flag, RX Date Mst Defn Srg Flag, may both be blank,
indicating the date was intentionally not collected. However, if either field is
populated, they must be in agreement.
1. If both fields are blank, the edit is skipped.
2. If RX Date Mst Defn Srg is populated,then RX Date Mst Defn Srg Flag must be
blank.
3. If RX Date Mst Defn Srg is blank and RX Date Mst Defn Srg Flag is not blank,
then RX Date Mst Defn Srg Flag must = 10 (unknown if any surgical procedure of the
primary site was performed), 11 (no surgical procedure  of the primary site was
performed;autopsy only case), or 12 (surgerical treatment of the primary site was
performed but the date is unknown).
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

Modifications

NAACCR v13
- Edit name changed from 'RX Date--Most Defin Surg, Date Flag (COC)' to 'RX Date Mst Defn Srg, Date Flag (COC)'.
- Data item name changed from 'RX Date--Most Defin Surg' to 'RX Date Mst Defn Srg'.

RX Date Mst Defn Srg, Date Last Contact (COC)

Agency: COC **Last changed: 11/25/2012**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Date Mst Defn Srg [Std# 3170]
Date of Last Contact [Std# 1750]

Default Error Message

[3333] %F1 (%V1) must be < or = %F2 (%V2)
RX Date Mst Defn Srg ("value of RX Date Mst Defn Srg") must be < or = Date of Last Contact ("value of Date of Last Contact"

Additional Messages

ERROR_TEXT("Date of Last Contact is invalid: %DC")
ERROR_TEXT("RX Date Most Defin Surg is invalid: %DC")

Description

This edit is skipped if any of the fields are blank.

RX Date Mst Defn Srg must be less than or equal to Date of Last Contact. If both years are known, but either month is blank, then only the years are compared. If either day is blank, then only the years and months are compared.

Administrative Notes

Modifications:

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

NAACCR v13
- Edit name changed from 'RX Date--Most Defin Surg, Date Last Contact (COC)' to 'RX Date Mst Defn Srg, Date Last Contact (COC)'.
- Data item name changed from 'RX Date--Most Defin Surg' to 'RX Date Mst Defn Srg'.

RX Date Mst Defn Srg, Date of DX (COC)

Agency: COC **Last changed: 12/14/2012**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Date Mst Defn Srg [Std# 3170]
Date of Diagnosis [Std# 390]

Default Error Message

[3332] %F1 (%V1) must be > or = %F2 (%V2)
RX Date Mst Defn Srg ("value of RX Date Mst Defn Srg") must be > or = Date of Diagnosis ("value of Date of Diagnosis"

Additional Messages

ERROR_TEXT("Date of Diagnosis is invalid: %DC")
ERROR_TEXT("RX Date Most Defin Surg is invalid: %DC")

Description

This edit is skipped if RX Date Mst Defn Srg or Date of Diagnosis is blank.

RX Date Mst Defn Srg must be greater than or equal to Date of Diagnosis. If both years are known, but either month is blank, then only the years are compared. If either day is blank, then only the years and months are compared.

Administrative Notes

Modifications:

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.
- Edit no longer checks that RX Date--Most Defin Surg is populated for cases diagnosed 2003 and later. That particular processing is now performed in the edit 'RX Date--Most Defin Surg, Date Flag, DX Date (COC)'.

NAACCR v13
- Edit name changed from 'RX Date--Most Defin Surg, Date of DX (COC)' to 'RX Date Mst Defn Srg, Date of DX (COC)'.
- Data item name changed from 'RX Date--Most Defin Surg' to 'RX Date Mst Defn Srg'.

RX Date Mst Defn Srg, RX Date Surgery (COC)

Agency: COC **Last changed: 12/14/2012**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Date Mst Defn Srg [Std# 3170]
RX Date Surgery [Std# 1200]

Default Error Message

[3332] %F1 (%V1) must be > or = %F2 (%V2)
RX Date Mst Defn Srg ("value of RX Date Mst Defn Srg") must be > or = RX Date Surgery ("value of RX Date Surgery"

Additional Messages

ERROR_TEXT("RX Date Most Defin Surg is invalid: %DC")
ERROR_TEXT("RX Date Surgery is invalid: %DC")

Description

This edit is skipped if any of the fields are blank.

RX Date Mst Defn Srg must be greater than or equal to RX Date Surgery (date of first surgical procedure). If both years are known, but either month is blank, then only the years are compared. If either day is blank, then only the years and months are compared.

Administrative Notes

Modifications:

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

NAACCR v13
- Edit name changed from 'RX Date--Most Defin Surg, RX Date--Surgery (COC)' to 'RX Date Mst Defn Srg, RX Date Surgery (COC)'.
- Data item name changed from 'RX Date--Most Defin Surg' to 'RX Date Mst Defn Srg'.
- Data item name changed from 'RX Date--Surgery' to 'RX Date Surgery'.

RX Date Mst Defn Srg, Surg Prim Site (COC)

Agency: COC **Last changed: 12/14/2012**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Summ--Surg Prim Site [Std# 1290]
RX Date Mst Defn Srg [Std# 3170]
RX Date Mst Defn Srg Flag [Std# 3171]
Date of Diagnosis [Std# 390]

Additional Messages

[4064] If RX Summ--Surg Prim Site = "value of RX Summ--Surg Prim Site", RX Date Mst Defn Srg Flag must = 11
[4065] If RX Summ--Surg Prim Site = "value of RX Summ--Surg Prim Site" and RX Date Mst Defn Srg is blank, if year of Date of Diagnosis < 2012, RX Date Mst Defn Srg Flag must = 10 or 12
[4066] If RX Summ--Surg Prim Site = "value of RX Summ--Surg Prim Site" and RX Date Mst Defn Srg is blank, if year of Date of Diagnosis > 2011, RX Date Mst Defn Srg Flag must = 12
[4074] If RX Summ--Surg Prim Site = "value of RX Summ--Surg Prim Site", if year of Date of Diagnosis < 2012, RX Date Mst Defn Srg Flag must = 10 or 12
[4075] If RX Summ--Surg Prim Site = "value of RX Summ--Surg Prim Site", if year of Date of Diagnosis > 2011, RX Date Mst Defn Srg Flag must = 10
ERROR_TEXT("Date of Diagnosis: %DC")

Description

```
This edit is skipped if any of the following conditions are true:
1.  RX Summ--Surg Prim Site is blank
2.  Both RX Date Mst Defn Srg and RX Date Mst Defn Srg Flag are blank, indicating
the date was intentionally not collected.
3. Date of Diagnosis is blank

The edit works as follows:

1. If RX Summ--Surg Prim Site = 00 or 98, then RX Date Mst Defn Srg Flag must = 11
(no surgical resection of the primary site was performed).

2. If RX Summ--Surg Prim Site = 99:
 - If year of Date of Diagnosis is < 2012, then RX Date Mst Defn Srg Flag may = 10
(unknown if surgery of primary site) or 12 (surgery performed, but date is
unknown).
 - If year of Date of Diagnosis is 2012 or later, then RX Date Mst Defn Srg Flag
must = 10.

3. If RX Summ--Surg Prim Site not = 00, 98, 99 and RX Date Mst Defn Srg is blank:
 - If year of Date of Diagnosis is < 2012, then RX Date Mst Defn Srg Flag may = 10
(unknown if surgery of primary site) or 12 (surgery performed, but date is
unknown).
 - If year of Date of Diagnosis is 2012 or later, then RX Date Mst Defn Srg Flag
must = 12.
```

Note: Date flag codes 10 and 12 were sometimes used interchangeably for pre-2012 cases due to conversion limitations. For cases diagnosed 2012 and later, the codes must be used correctly.

Administrative Notes

Modifications:

NAACCR v12
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

NAACCR v12.2
- Edit modified to only allow specific date flag codes for cases diagnosed 2012 and later.

NAACCR v13
- Edit name changed from 'RX Date--Most Defin Surg, Surg Prim Site (COC)' to 'RX Date Mst Defn Srg, Surg Prim Site (COC)'.
- Data item name changed from 'RX Date--Most Defin Surg' to 'RX Date Mst Defn Srg'.

RX Date Other (COC)

Agency: COC **Last changed: 11/24/2012**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Date Other [Std# 1250]

Default Error Message

[1003] %F1 (%V1) is an invalid date
RX Date Other ("value of RX Date Other") is an invalid date

Additional Messages

ERROR_TEXT("RX Date Other: %DC")

Description

```
This edit is skipped if RX Date Other is empty.

General Date Editing Rules:
Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD).
Month and day must have leading zeros for values 01...09.

The following date formats are allowed:
CCYYMMDD    Century+Year, Month and Day are provided.
CCYYMM__    Century+Year and Month. Day consists of two blank spaces.
CCYY____    Century+Year. Month and Day consist of four blank spaces.

Dates are checked first to ensure they conform to one of these formats, then for
errors in the components. Checking stops on the first non-valid situation.

Range checking:
Lowest allowed value:  January 1, 1850 (or in D1 format: 18500101)
Highest allowed value: current system date
When month is known, it is checked to ensure it falls within range 01...12.
When month and day are known, day is checked to ensure it falls within range for
that specific month. Accommodation is made for leap years.
```

Administrative Notes

MODIFICATIONS:

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

NAACCR v13
- Edit name changed from 'RX Date--Other (COC)' to 'RX Date Other (COC)'.
- Data item name changed from 'RX Date--Other' to 'RX Date Other'.

RX Date Other Flag (NAACCR)

Agency: NAACCR **Last changed: 10/07/2014**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Date Other Flag [Std# 1251]

Default Error Message

[3267] %F1 must be blank, 10, 11, 12, or 15
RX Date Other Flag must be blank, 10, 11, 12, or 15

Description

The RX Date Other Flag codes indicates why there is no appropriate value in the corresponding date field, RX Date Other.

Note: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates. See Flavors of Null table in its entirety which includes the NAACCR codes, HL7 codes and definitions.

Allowable codes:
10 No information whatsoever can be inferred from this exceptional value (e.g., unknown if other therapy performed).

11 No proper value is applicable in this context (e.g., no other treatment performed; autopsy only case).

12 A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., other treatment performed but date is unknown).

15 Other therapy is planned as part of first course of therapy, but had not been started at the time of the most recent follow-up.

Blank A valid date value is provided in item RX Date Other, or the date was not expected to have been transmitted.

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

Modifications

NAACCR v13
- Edit name changed from 'RX Date--Other Flag(NAACCR)' to 'RX Date Other Flag(NAACCR)'.
- Data item name changed from 'RX Date--Other Flag' to 'RX Date Other Flag'.

NAACCR v15

- Added code 15 'Other therapy is planned as part of first course of therapy, but had not been started at the time of the most recent follow-up'

RX Date Other, Date Flag (NAACCR)

Agency: NAACCR **Last changed: 01/09/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Date Other [Std# 1250]
RX Date Other Flag [Std# 1251]

Default Error Message

[1016] %F1 and %F2 conflict
RX Date Other and RX Date Other Flag conflict

Additional Messages

[3264] If date is present, corresponding date flag must be blank
[3270] If RX Date Other is blank, RX Date Other Flag must be 10, 11, 12, or 15

Description

General information on the inter-field editing of date and date flag fields:
The purpose of this inter-field edit is to verify that a date field and the corresponding date flag field are in agreement. A blank flag field indicates that the date was either filled in or intentionally not collected. Otherwise the date flag should include a 2-digit code indicating the reason the date field is blank.

This edit does not require RX Date Other because it was not rquired by the COC until 1996; that is, RX Date Other and its corresponding date flag, RX Date Other Flag, may both be blank, indicating the date was intentionally not collected. However, if either field is populated, they must be in agreement.
1. If both fields are blank, the edit is skipped.
2. If RX Date Other is populated,then RX Date Other Flag must be blank.
3. If RX Date Other is blank and RX Date Other Flag is not blank, then RX Date Other Flag must = 10 (unknown if other therapy administered), 11 (no other treatment administered; autopsy only case), 12 (other therapy administered, but the date is unknown), or 15 (other therapy is planned as part of first course therapy, but not yet started at time of most recent follow-up.

Note: Another edit [RX Date Other, Date Flag, DX Date (COC)] verifies that either the date or the flag is populated for cases diagnosed 1996 or later.

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

In the SEER*Edits software, the title of this edit is: IF520

Modifications

NAACCR v13

- Edit name changed from 'RX Date--Other, Date Flag (NAACCR)' to 'RX Date Other, Date Flag (NAACCR)'.
- Data item name changed from 'RX Date--Other' to 'RX Date Other'.
- Data item name changed from 'RX Date--Other Flag' to 'RX Date Other Flag'.

NAACCR v15
- Added code 15 'Other therapy is planned as part of first course of therapy, but had not been started at the time of the most recent follow-up'
- Added SEER IF number (IF520)

RX Date Other, Date Flag, DX Date (NPCR)

Agency: NPCR **Last changed: 02/10/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Date Other [Std# 1250]
RX Date Other Flag [Std# 1251]
Date of Diagnosis [Std# 390]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]

Default Error Message

[4883] If DX year = 2011-2014, %F4=%V4 and %F5=%V5, %F1 and %F2 cannot both be blank
If DX year = 2011-2014, Primary Site="value of Primary Site" and Histologic Type ICD-O-3="value of Histologic Type ICD-O-3", RX Date Other and RX Date Other Flag cannot both be blank

Additional Messages

[3579] If DX year = 2015 or later, RX Date Other and RX Date Other Flag cannot both be blank

Description

```
General information on the inter-field editing of date and date flag fields:
The purpose of this inter-field edit is to verify that a date field and the
corresponding date flag field are in agreement. A blank flag field indicates that
the date was either filled in or intentionally not collected. Otherwise the date
flag should include a 2-digit code indicating the reason the date field is blank.

This edit requires RX Date Other OR RX Date Other Flag for cases that meet the
following criteria:
1. Year of Date of Diagnosis is 2011-2014
     AND
   Case is one of the following site/histologies
   A. Breast (Primary Site = C500-C509 and Histologic Type ICD-O-3 =
      8000-9044, 9060-9136, or 9141-9582)
   B. Colon (Primary Site = C180-C189 and Histologic Type ICD-O-3 =
      8000-9044, 9060-9136, or 9141-9582)
   C. Rectum (Primary Site = C199 or C209 and Histologic Type ICD-O-3
      = 8000-9044, 9060-9136, or 9141-9582)

2. Year of Date of Diagnosis is 2015 or later
   - All cases
```

Administrative Notes

New edit - added to NAACCR v12.1 metafile.

This edit differs from the COC, "RX Date Other, Date Flag, DX Date (COC)", in that NPCR requires RX Date Other or RX Date Other Flag only for cancers of the breast, colon, and rectum diagnosed 2011-2014 and for all cases diagnosed 2015 and later, while the COC edit requires the date or flag for cases diagnosed 1996 or later.

Modifications:

NAACCR v12.2
- Modified to require date or date flag only for cancers of the breast, colon, and rectum diagnosed 2011 and later.

NAACCR v13
- Edit name changed from 'RX Date--Other, Date Flag, DX Date (NPCR)' to 'RX Date Other, Date Flag, DX Date (NPCR)'.
- Data item name changed from 'RX Date--Other' to 'RX Date Other'.
- Data item name changed from 'RX Date--Other Flag' to 'RX Date Other Flag'.

NAACCR v15
- Edit modified to require date or flag for all cases diagnosed 2015 or later. For cases diagnosed 2011-2014, date or flag is required only for breast, colon, and rectum cases.

RX Date Other, Date Last Contact (COC)

Agency: COC **Last changed: 01/09/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Date Other [Std# 1250]
Date of Last Contact [Std# 1750]

Default Error Message

[3333] %F1 (%V1) must be < or = %F2 (%V2)
RX Date Other ("value of RX Date Other") must be < or = Date of Last Contact ("value of Date of Last Contact"

Additional Messages

ERROR_TEXT("Date of Last Contact is invalid: %DC")
ERROR_TEXT("RX Date Other is invalid: %DC")

Description

This edit is skipped if RX Date Other or Date of Last Contact is blank.

RX Date Other must be less than or equal to Date of Last Contact. If both years are known, but either month is blank, then only the years are compared. If either day is blank, then only the years and months are compared.

Administrative Notes

Modifications:

In the SEER*Edits software, the title of this edit is: IF521

Modifications

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

NAACCR v13
- Edit name changed from 'RX Date--Other, Date Last Contact (COC)' to 'RX Date Other, Date Last Contact (COC)'.
- Data item name changed from 'RX Date--Other' to 'RX Date Other'.

NAACCR v15
- Added SEER IF number (IF521)

RX Date Other, Date of Diagnosis (COC)

Agency: COC **Last changed: 01/09/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Date Other [Std# 1250]
Date of Diagnosis [Std# 390]

Default Error Message

[3332] %F1 (%V1) must be > or = %F2 (%V2)
RX Date Other ("value of RX Date Other") must be > or = Date of Diagnosis ("value of Date of Diagnosis"

Description

This edit is skipped if any of the fields are blank or invalid.

RX Date Other must be greater than or equal to Date of Diagnosis. If both years are known, but either month is blank, then only the years are compared. If either day is blank, then only the years and months are compared.

Administrative Notes

New edit - added to NAACCR v12.1A metafile.

In the SEER*Edits software, the title of this edit is: IF522

Modifications

NAACCR v13
- Edit name changed from 'RX Date--Other, Date of Diagnosis (COC)' to 'RX Date Other, Date of Diagnosis (COC)'.
- Data item name changed from 'RX Date--Other' to 'RX Date Other'.

NAACCR v15
- Added SEER IF number (IF522)

RX Date Radiation (COC)

Agency: COC **Last changed: 11/24/2012**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Date Radiation [Std# 1210]

Default Error Message

[1003] %F1 (%V1) is an invalid date
RX Date Radiation ("value of RX Date Radiation") is an invalid date

Additional Messages

ERROR_TEXT("RX Date Radiation: %DC")

Description

```
This edit is skipped if RX Date Radiation is empty.

General Date Editing Rules:
Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD).
Month and day must have leading zeros for values 01...09.

The following date formats are allowed:
CCYYMMDD    Century+Year, Month and Day are provided.
CCYYMM__    Century+Year and Month. Day consists of two blank spaces.
CCYY____    Century+Year. Month and Day consist of four blank spaces.

Dates are checked first to ensure they conform to one of these formats, then for
errors in the components. Checking stops on the first non-valid situation.

Range checking:
Lowest allowed value:  January 1, 1850 (or in D1 format: 18500101)
Highest allowed value: current system date
When month is known, it is checked to ensure it falls within range 01...12.
When month and day are known, day is checked to ensure it falls within range for
that specific month. Accommodation is made for leap years.
```

Administrative Notes

MODIFICATIONS:

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

NAACCR v13
- Edit name changed from 'RX Date--Radiation (COC)' to 'RX Date Radiation (COC)'.
- Data item name changed from 'RX Date--Radiation' to 'RX Date Radiation'.

RX Date Radiation Flag (NAACCR)

Agency: NAACCR **Last changed: 11/24/2012**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Date Radiation Flag [Std# 1211]

Default Error Message

[3267] %F1 must be blank, 10, 11, 12, or 15
RX Date Radiation Flag must be blank, 10, 11, 12, or 15

Description

The RX Date Radiation Flag codes indicates why there is no appropriate value in the corresponding date field, RX Date Radiation.

Note: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates. See Flavors of Null table in its entirety which includes the NAACCR codes, HL7 codes and definitions.

Allowable codes:
10 No information whatsoever can be inferred from this exceptional value (e.g., unknown if radiation therapy administered).

11 No proper value is applicable in this context (e.g., no radiation therapy administered; autopsy only case).

12 A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., date radiation ended is unknown).

15 Information is not available at this time, but it is expected that it will be available later (e.g.,radiation was administered and was ongoing at the time of most recent follow-up).

Blank A valid date value is provided in item RX Date Radiation, or the date was not expected to have been transmitted.

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

Modifications

NAACCR v13
- Edit name changed from 'RX Date--Radiation Flag(NAACCR)' to 'RX Date Radiation Flag(NAACCR)'.
- Data item name changed from 'RX Date--Radiation Flag' to 'RX Date Radiation Flag'.

RX Date Radiation, Date Flag, DX Date (NPCR)

Agency: NPCR **Last changed: 02/10/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Date Radiation [Std# 1210]
RX Date Radiation Flag [Std# 1211]
Date of Diagnosis [Std# 390]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]

Default Error Message

[4883] If DX year = 2011-2014, %F4=%V4 and %F5=%V5, %F1 and %F2 cannot both be blank
If DX year = 2011-2014, Primary Site="value of Primary Site" and Histologic Type ICD-O-3="value of Histologic Type ICD-O-3", RX Date Radiation and RX Date Radiation Flag cannot both be blank

Additional Messages

[3579] If DX year = 2015 or later, RX Date Radiation and RX Date Radiation Flag cannot both be blank

Description

```
General information on the inter-field editing of date and date flag fields:
The purpose of this inter-field edit is to verify that a date field and the
corresponding date flag field are in agreement. A blank flag field indicates that
the date was either filled in or intentionally not collected. Otherwise the date
flag should include a 2-digit code indicating the reason the date field is blank.

This edit requires RX Date Radiation OR RX Date Radiation Flag for cases that meet
the following criteria:
1. Year of Date of Diagnosis is 2011-2014
     AND
   Case is one of the following site/histologies
   A. Breast (Primary Site = C500-C509 and Histologic Type ICD-O-3 =
      8000-9044, 9060-9136, or 9141-9582)
   B. Colon (Primary Site = C180-C189 and Histologic Type ICD-O-3 =
      8000-9044, 9060-9136, or 9141-9582)
   C. Rectum (Primary Site = C199 or C209 and Histologic Type ICD-O-3
      = 8000-9044, 9060-9136, or 9141-9582)

2. Year of Date of Diagnosis is 2015 or later
   - All cases
```

Administrative Notes

New edit - added to NAACCR v12.1 metafile.

This edit differs from the COC, "RX Date Radiation, Date Flag (COC)", in that NPCR requires RX Date Radiation or RX Date Radiation Flag only for cancers of the breast, colon, and rectum diagnosed 2011-2014 and for all cases diagnosed 2015 and later, while the COC edit requires the date or flag for all cases.

Modifications:

NAACCR v12.2
- Modified to require date or date flag only for cancers of the breast, colon, and rectum diagnosed 2011 and later.

NAACCR v13
- Edit name changed from 'RX Date--Radiation, Date Flag, DX Date (NPCR)' to 'RX Date Radiation, Date Flag, DX Date (NPCR)'.
- Data item name changed from 'RX Date--Radiation' to 'RX Date Radiation'.
- Data item name changed from 'RX Date--Radiation Flag' to 'RX Date Radiation Flag'.

NAACCR v15
- Edit modified to require date or flag for all cases diagnosed 2015 or later. For cases diagnosed 2011-2014, date or flag is required only for breast, colon, and rectum cases.

RX Date Radiation, Date Last Contact (COC)

Agency: COC **Last changed: 01/09/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Date Radiation [Std# 1210]
Date of Last Contact [Std# 1750]

Default Error Message

[3333] %F1 (%V1) must be < or = %F2 (%V2)
RX Date Radiation ("value of RX Date Radiation") must be < or = Date of Last Contact ("value of Date of Last Contact"

Additional Messages

ERROR_TEXT("Date of Last Contact is invalid: %DC")
ERROR_TEXT("RX Date Radiation is invalid: %DC")

Description

This edit is skipped if any of the fields are blank.

RX Date Radiation must be less than or equal to Date of Last Contact. If both years are known, but either month is blank, then only the years are compared. If either day is blank, then only the years and months are compared.

Administrative Notes

New edit - added to NAACCR v12.1 metafile.

In the SEER*Edits software, the title of this edit is: IF524

Modifications

NAACCR v13
- Edit name changed from 'RX Date--Radiation, Date Last Contact (COC)' to 'RX Date Radiation, Date Last Contact (COC)'.
- Data item name changed from 'RX Date--Radiation' to 'RX Date Radiation'.

NAACCR v15
- Added SEER IF number (IF524)

RX Date Radiation, Date of Diagnosis (COC)

Agency: COC **Last changed: 01/09/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Date Radiation [Std# 1210]
Date of Diagnosis [Std# 390]

Default Error Message

[3332] %F1 (%V1) must be > or = %F2 (%V2)
RX Date Radiation ("value of RX Date Radiation") must be > or = Date of Diagnosis ("value of Date of Diagnosis"

Description

This edit is skipped if any of the fields are blank or invalid.

RX Date Radiation must be greater than or equal to Date of Diagnosis. If both years are known, but either month is blank, then only the years are compared. If either day is blank, then only the years and months are compared.

Administrative Notes

New edit - added to NAACCR v12.1A metafile.

In the SEER*Edits software, the title of this edit is: IF525

Modifications

NAACCR v13
- Edit name changed from 'RX Date--Radiation, Date of Diagnosis (COC)' to 'RX Date Radiation, Date of Diagnosis (COC)'.
- Data item name changed from 'RX Date--Radiation' to 'RX Date Radiation'.

NAACCR v15
- Added SEER IF number (IF525)

RX Date Radiation, Rad--Regional RX Modality (COC)

Agency: COC **Last changed: 11/25/2012**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Rad--Regional RX Modality [Std# 1570]
RX Date Radiation [Std# 1210]
RX Date Radiation Flag [Std# 1211]

Default Error Message

[3342] If %F3 = %V3, then %F1 must = 00
If RX Date Radiation Flag = "value of RX Date Radiation Flag", then Rad--Regional RX Modality must = 00

Description

```
This edit is skipped if any of the following conditions are true:
1.  Rad--Regional RX Modality is blank
2.  Both RX Date Radiation and RX Date Radiation Flag are blank, indicating the
date was intentionally not collected.

Note: Another edit, "RX Date Radiation, Date Flag (COC)", verifies that the date
and flag fields are in agreement.

If RX Date Radiation Flag = 11 (no radiation therapy administered), then Rad--
Regional RX Modality must equal 00 (none).

Note: The RX Date Radiation Flag code indicates why there is no appropriate value
in the corresponding date field, RX Date Radiation. A flag value of 11 =
traditional date of 00000000.
```

Administrative Notes

Modifications

NAACCR v12
- Edit modified to use RX Date--Radiation Flag

NAACCR v13
- Edit name changed from 'RX Date--Radiation, Rad--Regional RX Modality (COC' to 'RX Date Radiation, Rad--Regional RX Modality (COC)'.
- Data item name changed from 'RX Date--Radiation' to 'RX Date Radiation'.
- Data item name changed from 'RX Date--Radiation Flag' to 'RX Date Radiation Flag'.

RX Date Surgery (COC)

Agency: NAACCR **Last changed: 11/24/2012**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Date Surgery [Std# 1200]

Default Error Message

[1003] %F1 (%V1) is an invalid date
RX Date Surgery ("value of RX Date Surgery") is an invalid date

Additional Messages

ERROR_TEXT("RX Date Surgery: %DC")

Description

```
This edit is skipped if RX Date Surgery is empty.

General Date Editing Rules:
Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD).
Month and day must have leading zeros for values 01...09.

The following date formats are allowed:
CCYYMMDD    Century+Year, Month and Day are provided.
CCYYMM__    Century+Year and Month. Day consists of two blank spaces.
CCYY____    Century+Year. Month and Day consist of four blank spaces.

Dates are checked first to ensure they conform to one of these formats, then for
errors in the components. Checking stops on the first non-valid situation.

Range checking:
Lowest allowed value:  January 1, 1850 (or in D1 format: 18500101)
Highest allowed value: current system date
When month is known, it is checked to ensure it falls within range 01...12.
When month and day are known, day is checked to ensure it falls within range for
that specific month. Accommodation is made for leap years.
```

Administrative Notes

MODIFICATIONS:

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

NAACCR v13
- Edit name changed from 'RX Date--Surgery (COC)' to 'RX Date Surgery (COC)'.
- Data item name changed from 'RX Date--Surgery' to 'RX Date Surgery'.

RX Date Surgery Flag (NAACCR)

Agency: NAACCR **Last changed: 11/24/2012**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Date Surgery Flag [Std# 1201]

Default Error Message

[3276] %F1 must be blank, 10, 11, or 12
RX Date Surgery Flag must be blank, 10, 11, or 12

Description

The RX Date Surgery Flag codes indicates why there is no appropriate value in the corresponding date field, RX Date Surgery.

Note: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates. See Flavors of Null table in its entirety which includes the NAACCR codes, HL7 codes and definitions.

Allowable codes:
10 No information whatsoever can be inferred from this exceptional value (e.g., unknown if any surgical procedure of the primary site was performed).

11 No proper value is applicable in this context (e.g., no surgical procedure was performed; autopsy only case).

12 A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., surgery of the primary site was performed but date is unknown).

Blank A valid date value is provided in item RX Date Surgery, or the date was not expected to have been transmitted.

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

Modifications

NAACCR v13
- Edit name changed from 'RX Date--Surgery Flag(NAACCR)' to 'RX Date Surgery Flag(NAACCR)'.
- Data item name changed from 'RX Date--Surgery Flag' to 'RX Date Surgery Flag'.

RX Date Surgery, Date Flag (COC)

Agency: COC **Last changed: 12/14/2012**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Date Surgery [Std# 1200]
RX Date Surgery Flag [Std# 1201]

Default Error Message

[1016] %F1 and %F2 conflict
RX Date Surgery and RX Date Surgery Flag conflict

Additional Messages

[3264] If date is present, corresponding date flag must be blank
[3272] If RX Date Surgery is blank, corresponding RX Date Surgery Flag must = 10, 11, or 12

Description

```
General information on the inter-field editing of date and date flag fields:
The purpose of this inter-field edit is to verify that a date field and the
corresponding date flag field are in agreement. A blank flag field indicates that
the date was either filled in or intentionally not collected. Otherwise the date
flag should include a 2-digit code indicating the reason the date field is blank.

This edit requires RX Date Surgery; that is, it must always be populated OR its
corresponding flag must indicate the reason the field is blank.
1. If RX Date Surgery is populated, then RX Date Surgery Flag must be blank.
2. If RX Date Surgery is blank, then RX Date Surgery Flag must = 10 (unknown if any
surgery was performed), 11 (no surgical procedure was performed;autopsy only case),
or 12 (surgery was performed but the date is unknown).
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

Modifications

NAACCR v13
- Edit name changed from 'RX Date--Surgery, Date Flag (COC)' to 'RX Date Surgery, Date Flag (COC)'.
- Data item name changed from 'RX Date--Surgery' to 'RX Date Surgery'.
- Data item name changed from 'RX Date--Surgery Flag' to 'RX Date Surgery Flag'.

RX Date Surgery, Date Last Contact (COC)

Agency: COC **Last changed: 01/09/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Date Surgery [Std# 1200]
Date of Last Contact [Std# 1750]

Default Error Message

[3333] %F1 (%V1) must be < or = %F2 (%V2)
RX Date Surgery ("value of RX Date Surgery") must be < or = Date of Last Contact ("value of Date of Last Contact"

Additional Messages

ERROR_TEXT("Date of Last Contact is invalid: %DC")
ERROR_TEXT("RX Date Surgery is invalid: %DC")

Description

This edit is skipped if any of the fields are blank.

RX Date Surgery must be less than or equal to Date of Last Contact. If both years are known, but either month is blank, then only the years are compared. If either day is blank, then only the years and months are compared.

Administrative Notes

Modifications:

In the SEER*Edits software, the title of this edit is: IF527

Modifications

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

NAACCR v13
- Edit name changed from 'RX Date--Surgery, Date Last Contact (COC)' to 'RX Date Surgery, Date Last Contact (COC)'.
- Data item name changed from 'RX Date--Surgery' to 'RX Date Surgery'.

NAACCR v15
- Added SEER IF number (IF527)

RX Date Surgery, Date of Diagnosis (COC)

Agency: COC **Last changed: 01/09/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Date Surgery [Std# 1200]
Date of Diagnosis [Std# 390]

Default Error Message

[3332] %F1 (%V1) must be > or = %F2 (%V2)
RX Date Surgery ("value of RX Date Surgery") must be > or = Date of Diagnosis ("value of Date of Diagnosis"

Description

This edit is skipped if any of the fields are blank or invalid.

RX Date Surgery must be greater than or equal to Date of Diagnosis. If both years are known, but either month is blank, then only the years are compared. If either day is blank, then only the years and months are compared.

Administrative Notes

New edit - added to NAACCR v12.1A metafile.

In the SEER*Edits software, the title of this edit is: IF528

Modifications

NAACCR v13
- Edit name changed from 'RX Date--Surgery, Date of Diagnosis (COC)' to 'RX Date Surgery, Date of Diagnosis (COC)'.
- Data item name changed from 'RX Date--Surgery' to 'RX Date Surgery'.

NAACCR v15
- Added SEER IF number (IF528)

RX Date Surgery, RX Text--Surgery (NAACR/MCR)

Agency: **Last changed: 06/13/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Date Surgery [Std# 1200]
Date of Diagnosis [Std# 390]
Class of Case [Std# 610]
RX Text--Surgery [Std# 2610]

Default Error Message

[1187] If %F1 = %V1, RX Text--Surgery cannot be blank
If RX Date Surgery = "value of RX Date Surgery", RX Text--Surgery cannot be blank

Description

```
If RX Date Surgery is not empty, the first 79 characters of RX Text--Surgery must
not be blank.
MCR modification: No text required for non-analytic class.  No text required before
2001 diagnoses.
```

RX Date Systemic (COC)

Agency: COC **Last changed: 11/24/2012**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Date Systemic [Std# 3230]

Default Error Message

[1003] %F1 (%V1) is an invalid date
RX Date Systemic ("value of RX Date Systemic") is an invalid date

Additional Messages

ERROR_TEXT("RX Date Systemic: %DC")

Description

```
This edit is skipped if RX Date Systemic is empty.

General Date Editing Rules:
Date fields are recorded in the D1 date format of year, month, day (CCYYMMDD).
Month and day must have leading zeros for values 01...09.

The following date formats are allowed:
CCYYMMDD    Century+Year, Month and Day are provided.
CCYYMM__    Century+Year and Month. Day consists of two blank spaces.
CCYY____    Century+Year. Month and Day consist of four blank spaces.

Dates are checked first to ensure they conform to one of these formats, then for
errors in the components. Checking stops on the first non-valid situation.

Range checking:
Lowest allowed value:  January 1, 1850 (or in D1 format: 18500101)
Highest allowed value: current system date
When month is known, it is checked to ensure it falls within range 01...12.
When month and day are known, day is checked to ensure it falls within range for
that specific month. Accommodation is made for leap years.
```

Administrative Notes

MODIFICATIONS:

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

NAACCR v13
- Edit name changed from 'RX Date--Systemic (COC)' to 'RX Date Systemic (COC)'.
- Data item name changed from 'RX Date--Systemic' to 'RX Date Systemic'.

RX Date Systemic Flag (NAACCR)

Agency: NAACCR **Last changed: 11/24/2012**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Date Systemic Flag [Std# 3231]

Default Error Message

[3267] %F1 must be blank, 10, 11, 12, or 15
RX Date Systemic Flag must be blank, 10, 11, 12, or 15

Description

The RX Date Systemic Flag codes indicates why there is no appropriate value in the corresponding date field, RX Date Systemic.

Note: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates. See Flavors of Null table in its entirety which includes the NAACCR codes, HL7 codes and definitions.

Allowable codes:
10 No information whatsoever can be inferred from this exceptional value (e.g., unknown if systemic therapy administered).

11 No proper value is applicable in this context (e.g., no systemic therapy administered; autopsy only case).

12 A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., systemic therapy administered but date is unknown).

15 Information is not available at this time, but it is expected that it will be available later (e.g.,systemic therapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow-up).

Blank A valid date value is provided in item RX Date Systemic, or the date was not expected to have been transmitted.

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

Modifications

NAACCR v13
- Edit name changed from 'RX Date--Systemic Flag(NAACCR)' to 'RX Date Systemic Flag(NAACCR)'.

RX Date Systemic, Date Last Contact (COC)

Agency: COC **Last changed: 11/25/2012**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Date Systemic [Std# 3230]
Date of Last Contact [Std# 1750]

Default Error Message

[3333] %F1 (%V1) must be < or = %F2 (%V2)
RX Date Systemic ("value of RX Date Systemic") must be < or = Date of Last Contact ("value of Date of Last Contact"

Additional Messages

ERROR_TEXT("Date of Last Contact is invalid: %DC")
ERROR_TEXT("RX Date Systemic is invalid: %DC")

Description

This edit is skipped if any of the fields are blank.

RX Date Systemic must be less than or equal to Date of Last Contact. If both years are known, but either month is blank, then only the years are compared. If either day is blank, then only the years and months are compared.

Administrative Notes

Modifications:

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

NAACCR v13
- Edit name changed from 'RX Date--Systemic, Date Last Contact (COC)' to 'RX Date Systemic, Date Last Contact (COC)'.
- Data item name changed from 'RX Date--Systemic' to 'RX Date Systemic'.

RX Date Systemic, Systemic RX (COC)

Agency: COC **Last changed: 12/14/2012**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Summ--BRM [Std# 1410]
RX Summ--Chemo [Std# 1390]
RX Summ--Hormone [Std# 1400]
RX Summ--Transplnt/Endocr [Std# 3250]
RX Date Systemic [Std# 3230]
RX Date Systemic Flag [Std# 3231]
Date of Diagnosis [Std# 390]

Default Error Message

[1160] Conflict between %F1 (%V1), %F2 (%V2) and Systemic RX items
Conflict between RX Summ--BRM ("value of RX Summ--BRM"), RX Summ--Chemo ("value of RX Summ--Chemo") and Systemic RX items

Additional Messages

[4076] If RX Summ--BRM = "value of RX Summ--BRM", RX Summ--Chemo = "value of RX Summ--Chemo", RX Summ--Hormone = "value of RX Summ--Hormone", and RX Summ--Transplnt/Endocr = "value of RX Summ--Transplnt/Endocr", RX Date Systemic Flag must = 11
[4077] If systemiic rx given & RX Date Systemic is blank, if year of Date of Diagnosis < 2012, RX Date Systemic Flag must = 10 or 12
[4078] If systemiic rx given & RX Date Systemic is blank, if year of Date of Diagnosis > 2011, RX Date Systemic Flag must = 12
[4079] If RX Summ--BRM, RX Summ--Chemo, RX Summ--Hormone, or RX Summ--Transplnt/Endocr = 88, & no systemic rx given, RX Date Systemic Flag must = 15
[4081] If all systemiic rx = 99, if year of Date of Diagnosis > 2011, RX Date Systemic Flag must = 10
ERROR_TEXT("Date of Diagnosis: %DC")

Description

```
This edit is skipped if any of the following conditions are true:
1.  Any of RX Summ--Chemo, RX Summ--Hormone, RX Summ--BRM, or RX Summ--
Transplnt/Endocr are blank
2.  Both RX Date Systemic and RX Date Systemic Flag are blank, indicating the date
was intentionally not collected.
3. Date of Diagnosis is blank

The edit works as follows:

1. If RX Summ--Chemo, RX Summ--Hormone, RX Summ--BRM, and RX Summ--Transplnt/Endocr
all = 00 or 82-87, then RX Date Systemic Flag must = 11 (no systemic rx).

2. If (RX Summ--Chemo = 01, 02, 03 or RX Summ--Hormone = 01 or RX Summ--BRM = 01 or
RX Summ--Transplnt/Endocr = 10-40) AND RX Date Systemic is blank:
```

- If year of Date of Diagnosis is < 2012, then RX Date System Flag may = 10 (unknown if administered) or 12 (administered, but date is unknown).
- If year of Date of Diagnosis is 2012 or later, then RX Date Systemic Flag must = 12.

3. If at least one of the summary treatment fields (RX Summ--Chemo, RX Summ--Hormone, RX Summ--BRM or RX Summ--Transplnt/Endocr) = 88, and:
If all of the remaining summary treatment fields = 00 or 82-88, then RX Date Systemic Flag must = 15 (planned, not yet given).

4. If RX Summ--Chemo, RX Summ--Hormone, RX Summ--BRM, AND RX Summ--Transplnt/Endocr = 99:
- If year of Date of Diagnosis is 2012 or later, then RX Date Systemic Flag must = 10.

Note: Date flag codes 10 and 12 were sometimes used interchangeably for pre-2012 cases due to conversion limitations. For cases diagnosed 2012 and later, the codes must be used correctly.

Administrative Notes

Modifications:

NAACCR v12
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

NAACCR v12.2
- Edit modified to only allow specific date flag codes for cases diagnosed 2012 and later.

NAACCR v13
- Edit name changed from 'RX Date--Systemic, Systemic RX (COC)' to 'RX Date Systemic, Systemic RX(COC)'.
- Data item name changed from 'RX Date--Systemic' to 'RX Date Systemic'.

RX Hosp--BRM (NAACCR)

Agency: NAACCR **Last changed: 01/14/2010**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Hosp--BRM [Std# 720]

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of RX Hosp--BRM" is not a valid value for RX Hosp--BRM

Description

```
Must be a valid RX Hosp--BRM code (00, 01, 82, 85-88, 99) or blank.
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

This edit differs from the COC edit of the same name in that it allows the field to be blank. Registries that want to edit this field only if it is present should choose this version of the edit when building a state-specific edit set.

RX Hosp--BRM, RX Summ--BRM (COC)

Agency: COC **Last changed: 01/18/2010**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Hosp--BRM [Std# 720]
RX Summ--BRM [Std# 1410]

Default Error Message

[1016] %F1 and %F2 conflict
RX Hosp--BRM and RX Summ--BRM conflict

Description

This edit is skipped if any of the fields are blank.

If RX Hosp--BRM is equal to 01, then RX Summ--BRM must also be equal to 01.

Administrative Notes

MODIFICATIONS:

NAACCR v12.0
- Modified so that edit will be skipped if either field is blank.

RX Hosp--Chemo (NAACCR)

Agency: NAACCR **Last changed: 01/14/2010**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Hosp--Chemo [Std# 700]

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of RX Hosp--Chemo" is not a valid value for RX Hosp--Chemo

Description

```
Must be a valid RX Hosp--Chemo code (00,01,02,03,82,85,86,87,88,99) or blank.
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

This edit differs from the COC edit of the same name in that it allows the field to be blank. Registries that want to edit this field only if it is present should choose this version of the edit when building a state-specific edit set.

RX Hosp--Chemo, RX Summ--Chemo (COC)

Agency: COC **Last changed: 01/18/2010**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Hosp--Chemo [Std# 700]
RX Summ--Chemo [Std# 1390]

Default Error Message

[1016] %F1 and %F2 conflict
RX Hosp--Chemo and RX Summ--Chemo conflict

Description

This edit is skipped if any of the fields are blank.

If RX Hosp--Chemo is equal to 01-03 (given), then RX Summ--Chemo must equal 01-03 (given).

Administrative Notes

MODIFICATIONS:

NAACCR v12.0
- Modified so that edit will be skipped if either field is blank.

RX Hosp--DX/Stg Proc (COC)

Agency: COC **Last changed: 01/27/2003**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Hosp--DX/Stg Proc [Std# 740]

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of RX Hosp--DX/Stg Proc" is not a valid value for RX Hosp--DX/Stg Proc

Description

Must be a numeric value (00-07, 09).

RX Hosp--DX/Stg Proc, RX Summ--DX/Stg Proc (COC)

Agency: COC **Last changed: 01/18/2010**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Hosp--DX/Stg Proc [Std# 740]
RX Summ--DX/Stg Proc [Std# 1350]

Default Error Message

[1016] %F1 and %F2 conflict
RX Hosp--DX/Stg Proc and RX Summ--DX/Stg Proc conflict

Description

This edit is skipped if any of the fields are blank.

If RX Hosp--DX/Stg Proc = 01-07 (given) then RX Summ--DX/Stg Proc must also = 01-07 (given).

Administrative Notes

MODIFICATIONS:

NAACCR v12.0
- Modified so that edit will be skipped if either field is blank.

RX Hosp--Hormone (NAACCR)

Agency: NAACCR **Last changed: 01/14/2010**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Hosp--Hormone [Std# 710]

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of RX Hosp--Hormone" is not a valid value for RX Hosp--Hormone

Description

```
Must be a valid RX Hosp--Hormone code (00,01,82,85,86,87,88,99) or blank.
```

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

This edit differs from the COC edit of the same name in that it allows the field to be blank. Registries that want to edit this field only if it is present should choose this version of the edit when building a state-specific edit set.

RX Hosp--Hormone, RX Summ--Hormone (COC)

Agency: COC **Last changed: 01/18/2010**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Hosp--Hormone [Std# 710]
RX Summ--Hormone [Std# 1400]

Default Error Message

[1016] %F1 and %F2 conflict
RX Hosp--Hormone and RX Summ--Hormone conflict

Description

This edit is skipped if any of the fields are blank.

If RX Hosp--Hormone is equal to 01 (given), then RX Summ--Hormone must equal 01 (given).

Administrative Notes

MODIFICATIONS:

NAACCR v12.0
- Modified so that edit will be skipped if either field is blank.

RX Hosp--Other (COC)

Agency: COC **Last changed: 03/30/2004**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Hosp--Other [Std# 730]

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of RX Hosp--Other" is not a valid value for RX Hosp--Other

Description

This field is allowed to be blank because the item was not required until 2003. Another edit (RX Hosp--Other, Date of Diagnosis) verifies that this item is not blank if the year of Date of Diagnosis is greater than 2002 and not equal 9999. Registries should include both edits in their edit set.

Must be a valid RX Hosp--Other code (0-3, 6-9) or blank.

RX Hosp--Other, RX Summ--Other (COC)

Agency: COC **Last changed: 01/18/2010**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Hosp--Other [Std# 730]
RX Summ--Other [Std# 1420]

Default Error Message

[1016] %F1 and %F2 conflict
RX Hosp--Other and RX Summ--Other conflict

Description

```
This edit is skipped if any of the fields are blank.

If RX Hosp--Other = 1-6 (given) then RX Summ--Other must = 1-6 (given).
```

Administrative Notes

MODIFICATIONS:

NAACCR v12.0
- Modified so that edit will be skipped if either field is blank.

RX Hosp--Palliative Proc (NAACCR)

Agency: NAACCR **Last changed: 01/14/2010**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Hosp--Palliative Proc [Std# 3280]

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of RX Hosp--Palliative Proc" is not a valid value for RX Hosp--Palliative Proc

Description

This field must contain 0-7, 9, or blank.

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

This edit differs from the COC edit of the same name in that it allows the field to be blank. Registries that want to edit this field only if it is present should choose this version of the edit when building a state-specific edit set.

RX Hosp--Palliative Proc, RX Summ--Pall Proc (COC)

Agency: COC **Last changed: 01/18/2010**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Hosp--Palliative Proc [Std# 3280]
RX Summ--Palliative Proc [Std# 3270]

Default Error Message

[1016] %F1 and %F2 conflict
RX Hosp--Palliative Proc and RX Summ--Palliative Proc conflict

Description

This edit is skipped if any of the fields are blank.

If RX Hosp--Palliative Proc = 1-7 (given) then RX Summ--Palliative Proc must = 1-7 (given).

Administrative Notes

MODIFICATIONS:

NAACCR v12.0
- Modified so that edit will be skipped if either field is blank.

RX Hosp--Scope LN Sur, RX Summ--Scope LN Sur(COC)

Agency: COC **Last changed: 01/18/2010**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Hosp--Scope Reg LN Sur [Std# 672]
RX Summ--Scope Reg LN Sur [Std# 1292]

Default Error Message

[1016] %F1 and %F2 conflict
RX Hosp--Scope Reg LN Sur and RX Summ--Scope Reg LN Sur conflict

Description

This edit is skipped if any of the fields are blank.

If RX Hosp--Scope Reg LN Sur is greater than 0, RX Summ--Scope Reg LN Sur must also be greater than 0. If RX Hosp--Scope Reg LN Sur = 1-7 (performed) then RX Summ--Scope Reg LN Sur must not = 0 (no regional lymph nodes removed) or 9 (unknown).

Administrative Notes

MODIFICATIONS:

NAACCR v12.0
- Modified so that edit will be skipped if either field is blank.

RX Hosp--Scope Reg LN Sur (COC)

Agency: COC **Last changed: 02/13/2003**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Hosp--Scope Reg LN Sur [Std# 672]

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of RX Hosp--Scope Reg LN Sur" is not a valid value for RX Hosp--Scope Reg LN Sur

Description

```
Must be a valid RX Hosp--Scope Reg LN Sur (0-7,9).
```

RX Hosp--Scope Reg LN Sur, Primary Site,ICDO3(COC)

Agency: COC **Last changed: 02/10/2010**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Hosp--Scope Reg LN Sur [Std# 672]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Date of Diagnosis [Std# 390]

Default Error Message

[1180] %F1 must = 9 for this site/histology
RX Hosp--Scope Reg LN Sur must = 9 for this site/histology

Additional Messages

ERROR_TEXT("Date of Diagnosis: %DC")

Description

```
This edit is skipped if either Histologic Type ICD-O-3 or RX Hosp--Scope Reg LN Sur
is empty.

RX Hosp--Scope Reg LN Sur must = 9 for the following:

    A.  Primaries of the meninges, brain, spinal cord, cranial
        nerves, and other parts of the central nervous system
        (Primary Site = C700-C729)

    B.  Hematopoietic, reticuloendothelial, immunoproliferative,
        or myeloproliferative disease:

        For all sites:
        1.  If year of Date of Diagnosis < 2010:
        If Histologic Type ICD-O-3 = [9750, 9760-9764,
        9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989]:
        RX Hosp--Scope Reg LN Sur must = 9.

        2.  If year of Date of Diagnosis is 2010 or later:
        If Histologic Type ICD-O-3 = [9727, 9733, 9741-9742, 9764-9809,
        9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992]:
        RX Hosp--Scope Reg LN Sur must = 9.


        If Primary Site = C420, C421, C423, or C424, then
        RX Hosp--Scope Reg LN Sur must = 9.

    C.  Hodgkin and non-hodgkin lymphoma with a lymph node primary site:

        1.  If year of Date of Diagnosis < 2010:
        If Histologic Type ICD-O-3 = 9590-9699,9702-9729 AND
        Primary Site = C770-C779, then RX Summ--Surgical
```

```
Margins must = 9.

2.  If year of Date of Diagnosis is 2010 or later:
If Histologic Type ICD-O-3 = [9590-9726, 9728-9732, 9734-9740,
9750-9762, 9811-9831, 9940, 9948, 9971] AND Primary Site = C770-C779:
RX Summ--Surgical Margins must = 9.


D.  Unknown and ill-defined sites (C760-C768, C809) must also = 9.
```

Administrative Notes

Modifications:

NAACCR v12.0
- Changed list of hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease histologies that are coded 9:
-- For cases diagnosed prior to 2010, codes remain the same.
-- For cases diagnosed 2010+, histology codes:
9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992

- Changed list of lymphoma histologies to be coded 9 when sited to lymph nodes:
-- For cases diagnosed prior to 2010, codes remain the same.
-- For cases diagnosed 2010+, histology codes:
9590-9726, 9728-9732, 9734-9740, 9750-9762, 9811-9831, 9940, 9948 and 9971

RX Hosp--Surg Oth Reg, RX Summ--Surg Oth Reg (COC)

Agency: COC **Last changed: 01/18/2010**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Hosp--Surg Oth Reg/Dis [Std# 674]
RX Summ--Surg Oth Reg/Dis [Std# 1294]

Default Error Message

[1016] %F1 and %F2 conflict
RX Hosp--Surg Oth Reg/Dis and RX Summ--Surg Oth Reg/Dis conflict

Description

This edit is skipped if any of the fields are blank.

If RX Hosp--Surg Oth Reg/Dis is equal to 1-5 (given), then RX Summ--Surg Oth Reg/Dis must equal 1-5 (given).

Administrative Notes

MODIFICATIONS:

NAACCR v12.0
- Modified so that edit will be skipped if either field is blank.

RX Hosp--Surg Oth Reg/Dis (COC)

Agency: COC **Last changed: 01/23/2003**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Hosp--Surg Oth Reg/Dis [Std# 674]

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of RX Hosp--Surg Oth Reg/Dis" is not a valid value for RX Hosp--Surg Oth Reg/Dis

Description

```
Must be a valid RX Hosp--Surg Oth Reg/Dis (0-5,9).
```

RX Hosp--Surg Pri Sit, RX Summ--Surg Pri Sit (COC)

Agency: COC **Last changed: 01/18/2010**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Hosp--Surg Prim Site [Std# 670]
RX Summ--Surg Prim Site [Std# 1290]

Default Error Message

[1016] %F1 and %F2 conflict
RX Hosp--Surg Prim Site and RX Summ--Surg Prim Site conflict

Description

This edit is skipped if any of the fields are blank.

If RX Hosp--Surg Prim Site is greater than 00, RX Summ--Surg Prim Site must also be greater than 00. If RX Hosp--Surg Prim Site = 10-90 (given) then RX Summ--Surg Prim Site must not = 00 (no surgery of primary site) or 99 (unknown if surgery of primary site performed).

Administrative Notes

MODIFICATIONS:

NAACCR v12.0
- Modified so that edit will be skipped if either field is blank.

RX Hosp--Surg Prim Site (COC)

Agency: COC **Last changed: 08/15/2003**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Hosp--Surg Prim Site [Std# 670]

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of RX Hosp--Surg Prim Site" is not a valid value for RX Hosp--Surg Prim Site

Description

Must be a numeric value (00, 10-90, 98, 99).

RX Hosp--Surg Prim Site, Primary Site, ICDO2 (COC)

Agency: COC **Last changed: 11/02/2009**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Hosp--Surg Prim Site [Std# 670]
Primary Site [Std# 400]
Histology (92-00) ICD-O-2 [Std# 420]
Date of Diagnosis [Std# 390]

Tables

SITGRP03.DBF
SURG03.DBF

Default Error Message

[1166] Conflict among %F1, %F2, and %F3
Conflict among RX Hosp--Surg Prim Site, Primary Site, and Histology (92-00) ICD-O-2

Additional Messages

ERROR_TEXT("Date of Diagnosis: %DC")

Description

This edit is skipped if Histology (92-00) ICD-O-2 is empty or year of Date of Diagnosis is greater than 2000 or is blank.

The valid RX Hosp--Surg Prim Site codes for each Primary Site are specified in Appendix B of the FORDS Manual-2003.

Exceptions are as follows:

For all sites, if Histology (92-00) ICD-O-2 = 9720, 9760-9764, 9800-9820, 9826, 9840-9894, 9910, 9931-9962, 9980-9989, then RX Hosp--Surg Prim Site must = 98.

If Primary Site = C420, C421, C423, or C424, then RX Hosp--Surg Prim Site must = 98.

Administrative Notes

Modifications:

NAACCR v11.3
This edit was modified so that it will be skipped if year of Date of Diagnosis is greater than 2000.

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

RX Hosp--Surg Prim Site, Primary Site, ICDO3 (COC)

Agency: COC **Last changed: 02/17/2011**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Hosp--Surg Prim Site [Std# 670]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Date of Diagnosis [Std# 390]

Tables

SITGRP03.DBF
SURG03.DBF

Default Error Message

[1166] Conflict among %F1, %F2, and %F3
Conflict among RX Hosp--Surg Prim Site, Primary Site, and Histologic Type ICD-O-3

Additional Messages

ERROR_TEXT("Date of Diagnosis: %DC")

Description

This edit is skipped if either Histologic Type ICD-O-3 or RX Hosp--Surg Prim Site is empty.

The valid RX Hosp--Surg Prim Site codes for each Primary Site are specified in Appendix B of the FORDS Manual-2003.

Exceptions are as follows:

For all sites:
1. If year of Date of Diagnosis is < 2010 and Histologic Type ICD-O-3 = [9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989], then RX Hosp--Surg Prim Site must = 98.
2. If year of Date of Diagnosis is 2010 or later and Histologic Type ICD-O-3 = [9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992], then RX Hosp--Surg Prim Site must = 98.

If Primary Site = C420, C421, C423, or C424, then RX Hosp--Surg Prim Site must = 98.

If Primary Site group is All Other Sites (group 30 in the table used for this edit) and RX Hosp--Surg Prim Site = 41 (enucleation for eye surgery only), then Primary Site must = C690-C699.

Unknown and ill-defined sites (C760-C768, C809) must also = 98.

Administrative Notes

Modifications:

NAACCR v12.0
- Hematopoietic end range code was changed from 9989 to 9992.
- Modified to skip if either Histologic Type ICD-O-3 or RX Hosp--Surg Prim Site is empty.

NAACCR v12D
- Changed list of hematopoietic histologies that require RX Summ--Surg Prim Site code of 98:
-- For cases diagnosed prior to 2010, codes remain the same.
-- For cases diagnosed 2010+, codes requiring RX Summ--Surg Prim Site code of 98:
9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992

NAACCR v12.1:
Added code 76 as allowable surgery code for primary site of breast.

RX Summ--BRM (NPCR)

Agency: NPCR **Last changed: 12/09/2011**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Summ--BRM [Std# 1410]

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of RX Summ--BRM" is not a valid value for RX Summ--BRM

Description

```
Must be a valid RX Summ--BRM code (00, 01, 82, 85-88, 99) or blank.
```

Administrative Notes

This edit differs from the COC edit of the same name in that it allows the field to be blank because the item was not required by NPCR until 2006. Another edit (RX Summ--BRM, Date of DX (NPCR)) verifies that this item is not blank for cancers of the breast, colon, and rectum diagnosed 2006 and later.

Modifications:

NAACCR v12.2
- Corrected portion of Administrative Notes that explains how this edit differs from COC edit of the same name.

RX Summ--BRM, Date of DX (NPCR)

Agency: NPCR **Last changed: 02/10/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
RX Summ--BRM [Std# 1410]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]

Default Error Message

[4884] If DX year = 2006-2014, %F3 = %V3 and %F4 = %V4, %F2 cannot be blank
If DX year = 2006-2014, Primary Site = "value of Primary Site" and Histologic Type ICD-O-3 = "value of Histologic Type ICD-O-3", RX Summ--BRM cannot be blank

Additional Messages

[3580] If DX year = 2015 or later, RX Summ--BRM cannot be blank
ERROR_TEXT("Date of Diagnosis: %DC")

Description

```
This edit is skipped if Date of Diagnosis is blank.

This edit requires RX Summ--BRM for cases that meet all of the following criteria:
1. Year of Date of Diagnosis is 2006-2014
     AND
   Case is one of the following site/histologies
   A. Breast (Primary Site = C500-C509 and Histologic Type ICD-O-3 =
      8000-9044, 9060-9136, or 9141-9582)
   B. Colon (Primary Site = C180-C189 and Histologic Type ICD-O-3 =
      8000-9044, 9060-9136, or 9141-9582)
   C. Rectum (Primary Site = C199 or C209 and Histologic Type ICD-O-3
      = 8000-9044, 9060-9136, or 9141-9582)

2. Year of Date of Diagnosis is 2015 or later
   - All cases
```

Administrative Notes

Modifications:

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

NAACCR v12.2
- Modified to require RX Summ--BRM only for cancers of the breast, colon, and rectum (instead of all sites) diagnosed 2006 and later.

NAACCR v15

- Edit modified to require RX Summ--BRM for all cases diagnosed 2015 or later. For cases diagnosed 2006-2014, RX Summ--BRM is required only for breast, colon, and rectum cases.

RX Summ--BRM, RX Date BRM (COC)

Agency: COC **Last changed: 11/25/2012**

Edit Sets

HospitalScan16D

Fields

RX Summ--BRM [Std# 1410]
RX Date BRM [Std# 1240]
RX Date BRM Flag [Std# 1241]
Date of Diagnosis [Std# 390]

Additional Messages

[4064] If RX Summ--BRM = "value of RX Summ--BRM", RX Date BRM Flag must = 11
[4065] If RX Summ--BRM = "value of RX Summ--BRM" and RX Date BRM is blank, if year of Date of Diagnosis < 2012, RX Date BRM Flag must = 10 or 12
[4066] If RX Summ--BRM = "value of RX Summ--BRM" and RX Date BRM is blank, if year of Date of Diagnosis > 2011, RX Date BRM Flag must = 12
[4067] If RX Summ--BRM = "value of RX Summ--BRM" and Date of Diagnosis < 2012, RX Date BRM Flag must = 10, 11, 12, 15
[4068] If RX Summ--BRM = "value of RX Summ--BRM" and Date of Diagnosis > 2011, RX Date BRM Flag must = 15
[4069] If RX Summ--BRM = "value of RX Summ--BRM", RX Date BRM Flag must = 10
ERROR_TEXT("Date of Diagnosis: %DC")

Description

```
This edit is skipped if any of the following conditions are true:
1.  RX Summ--BRM is blank
2.  Both RX Date BRM and RX Date BRM Flag are blank, indicating the date was
intentionally not collected.
3.  Date of Diagnosis is blank

Note: Another edit, "RX Date BRM, Date Flag (COC)", verifies that the date and flag
fields are in agreement.

The logic below takes into account that the RX Summ--BRM code of 88 was allowed
historically to be coded with RX Date BRM codes of 00000000 and 99999999.

1. If RX Summ--BRM = 00, 82, or 85-87 (BRM not given), then RX Date BRM Flag field
must = 11 (no BRM).

2.  If RX Summ--BRM = 01 (BRM given) and RX Date BRM is blank, then RX Date BRM
Flag field must indicate why the date is blank.
 - If year of Date of Diagnosis is < 2012, then RX Date BRM Flag may = 10 (unknown
if administered) or 12 (administered, but date is unknown).
 - If year of Date of Diagnosis is 2012 or later, then RX Date BRM Flag must = 12.

3.  If RX Summ--BRM = 88 (recommended, but unknown if given), then RX Date BRM Flag
must indicate the reason.
 - If year of Date of Diagnosis < 2012, then RX Date BRM Flag may = 10 (unknown if
administered), 11 (no BRM), 12 (administered, but date is unknown), or 15 (planned,
not yet given).
```

- If year of Date of Diagnosis is 2012 or later, then RX Date BRM Flag must = 15.

4. If RX Summ--BRM = 99 (unknown if given), then RX Date BRM Flag must = 10 (unknown if administered).

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

Modifications:

NAACCR v12.2
- Edit modified to only allow specific date flag codes for cases diagnosed 2012 and later.

NAACCR v13
- Edit name changed from 'RX Summ--BRM, RX Date--BRM (COC)' to 'RX Summ--BRM, RX Date BRM (COC)'.
- Data item name changed from from "RX Date--BRM" to "RX Date BRM".
- Data item name changed from from "RX Date--BRM Flag" to "RX Date BRM Flag".

RX Summ--BRM, RX Date BRM (COC/MCR)

Agency: **Last changed: 06/12/2013**

Edit Sets

OfficeScan16D

Fields

RX Summ--BRM [Std# 1410]
RX Date BRM [Std# 1240]
RX Date BRM Flag [Std# 1241]
Date of Diagnosis [Std# 390]

Additional Messages

[4064] If RX Summ--BRM = "value of RX Summ--BRM", RX Date BRM Flag must = 11
[4065] If RX Summ--BRM = "value of RX Summ--BRM" and RX Date BRM is blank, if year of Date of Diagnosis < 2012, RX Date BRM Flag must = 10 or 12
[4066] If RX Summ--BRM = "value of RX Summ--BRM" and RX Date BRM is blank, if year of Date of Diagnosis > 2011, RX Date BRM Flag must = 12
[4067] If RX Summ--BRM = "value of RX Summ--BRM" and Date of Diagnosis < 2012, RX Date BRM Flag must = 10, 11, 12, 15
[4068] If RX Summ--BRM = "value of RX Summ--BRM" and Date of Diagnosis > 2011, RX Date BRM Flag must = 15
[4069] If RX Summ--BRM = "value of RX Summ--BRM", RX Date BRM Flag must = 10
ERROR_TEXT("Date of Diagnosis: %DC")

Description

```
This edit is skipped if any of the following conditions are true:
1.  RX Summ--BRM is blank
2.  Both RX Date BRM and RX Date BRM Flag are blank, indicating the date was
intentionally not collected.
3.  Date of Diagnosis is blank
4.  Date of Diagnosis is less than 2006 (MCR modification)

Note: Another edit, "RX Date BRM, Date Flag (COC)", verifies that the date and flag
fields are in agreement.

The logic below takes into account that the RX Summ--BRM code of 88 was allowed
historically to be coded with RX Date BRM codes of 00000000 and 99999999.

1. If RX Summ--BRM = 00, 82, or 85-87 (BRM not given), then RX Date BRM Flag field
must = 11 (no BRM).

2.  If RX Summ--BRM = 01 (BRM given) and RX Date BRM is blank, then RX Date BRM
Flag field must indicate why the date is blank.
 - If year of Date of Diagnosis is < 2012, then RX Date BRM Flag may = 10 (unknown
if administered) or 12 (administered, but date is unknown).
 - If year of Date of Diagnosis is 2012 or later, then RX Date BRM Flag must = 12.

3.  If RX Summ--BRM = 88 (recommended, but unknown if given), then RX Date BRM Flag
must indicate the reason.
```

- If year of Date of Diagnosis < 2012, then RX Date BRM Flag may = 10 (unknown if administered), 11 (no BRM), 12 (administered, but date is unknown), or 15 (planned, not yet given).
- If year of Date of Diagnosis is 2012 or later, then RX Date BRM Flag must = 15.

4. If RX Summ--BRM = 99 (unknown if given), then RX Date BRM Flag must = 10 (unknown if administered).

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

Modifications:

MCR: Edit is skipped for diagnoses before 2006.

NAACCR v12.2
- Edit modified to only allow specific date flag codes for cases diagnosed 2012 and later.

NAACCR v13
- Edit name changed from 'RX Summ--BRM, RX Date--BRM (COC)' to 'RX Summ--BRM, RX Date BRM (COC)'.
- Data item name changed from from "RX Date--BRM" to "RX Date BRM".
- Data item name changed from from "RX Date--BRM Flag" to "RX Date BRM Flag".

RX Summ--BRM, RX Text--BRM (NAACCR/MCR)

Agency: **Last changed: 07/15/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Summ--BRM [Std# 1410]
Date of Diagnosis [Std# 390]
Class of Case [Std# 610]
RX Text--BRM [Std# 2660]

Default Error Message

[1188] If %F1 = %V1, RX Text--BRM cannot be blank
If RX Summ--BRM = "value of RX Summ--BRM", RX Text--BRM cannot be blank

Description

```
If RX Summ--BRM = 01 (biological response modifier administered), RX Text--BRM must
not be blank.
MCR modification: no text required for pre-2001 diagnoses nor non-analytic classes
of case.
```

Administrative Notes

v16: removed check on transplant code vs. text; NAACCR edit does not require text for transplants.

RX Summ--BRM, Vital Status (COC)

Agency: COC **Last changed: 07/08/2003**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Summ--BRM [Std# 1410]
Vital Status [Std# 1760]

Default Error Message

[1016] %F1 and %F2 conflict
RX Summ--BRM and Vital Status conflict

Description

```
If RX Summ--BRM = 85 (immunotherapy was not administered because the patient died
prior to planned or recommended therapy), then Vital Status cannot = 1 (alive).
```

RX Summ--Chemo (NPCR)

Agency: NPCR **Last changed: 12/09/2011**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Summ--Chemo [Std# 1390]

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of RX Summ--Chemo" is not a valid value for RX Summ--Chemo

Description

```
Must be a valid RX Summ--Chemo code (00-03,82,85-88,99) or blank.
```

Administrative Notes

This edit differs from the COC edit of the same name in that it allows the field to be blank because the item was not required by NPCR until 2006. Another edit (RX Summ--Chemo, Date of DX (NPCR)) verifies that this item is not blank for cancers of the breast, colon, and rectum diagnosed 2006 and later.

Modifications:

NAACCR v12.2
- Corrected portion of Administrative Notes that explains how this edit differs from COC edit of the same name.

RX Summ--Chemo, Date of DX (NPCR)

Agency: NPCR **Last changed: 02/10/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
RX Summ--Chemo [Std# 1390]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]

Default Error Message

[4884] If DX year = 2006-2014, %F3 = %V3 and %F4 = %V4, %F2 cannot be blank
If DX year = 2006-2014, Primary Site = "value of Primary Site" and Histologic Type ICD-O-3 = "value of Histologic Type ICD-O-3", RX Summ--Chemo cannot be blank

Additional Messages

[3580] If DX year = 2015 or later, RX Summ--Chemo cannot be blank
ERROR_TEXT("Date of Diagnosis: %DC")

Description

```
This edit is skipped if Date of Diagnosis is blank.

This edit requires RX Summ--Chemo for cases that meet all of the following
criteria:
1. Year of Date of Diagnosis is 2006-2014
     AND
   Case is one of the following site/histologies
   A. Breast (Primary Site = C500-C509 and Histologic Type ICD-O-3 =
      8000-9044, 9060-9136, or 9141-9582)
   B. Colon (Primary Site = C180-C189 and Histologic Type ICD-O-3 =
      8000-9044, 9060-9136, or 9141-9582)
   C. Rectum (Primary Site = C199 or C209 and Histologic Type ICD-O-3
      = 8000-9044, 9060-9136, or 9141-9582)

2. Year of Date of Diagnosis is 2015 or later
   - All cases
```

Administrative Notes

Modifications:

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

NAACCR v12.2
- Modified to require RX Summ--Chemo only for cancers of the breast, colon, and rectum (instead of all sites) diagnosed 2006 and later.

NAACCR v15

- Edit modified to require RX Summ--Chemo for all cases diagnosed 2015 or later. For cases diagnosed 2006-2014, RX Summ--Chemo is required only for breast, colon, and rectum cases.

RX Summ--Chemo, RX Date Chemo (COC)

Agency: COC **Last changed: 11/25/2012**

Edit Sets

HospitalScan16D

Fields

RX Summ--Chemo [Std# 1390]
RX Date Chemo [Std# 1220]
RX Date Chemo Flag [Std# 1221]
Date of Diagnosis [Std# 390]

Additional Messages

[4064] If RX Summ--Chemo = "value of RX Summ--Chemo", RX Date Chemo Flag must = 11
[4065] If RX Summ--Chemo = "value of RX Summ--Chemo" and RX Date Chemo is blank, if year of Date of Diagnosis < 2012, RX Date Chemo Flag must = 10 or 12
[4066] If RX Summ--Chemo = "value of RX Summ--Chemo" and RX Date Chemo is blank, if year of Date of Diagnosis > 2011, RX Date Chemo Flag must = 12
[4067] If RX Summ--Chemo = "value of RX Summ--Chemo" and Date of Diagnosis < 2012, RX Date Chemo Flag must = 10, 11, 12, 15
[4068] If RX Summ--Chemo = "value of RX Summ--Chemo" and Date of Diagnosis > 2011, RX Date Chemo Flag must = 15
[4069] If RX Summ--Chemo = "value of RX Summ--Chemo", RX Date Chemo Flag must = 10
ERROR_TEXT("Date of Diagnosis: %DC")

Description

```
This edit is skipped if any of the following conditions are true:
1.  RX Summ--Chemo is blank
2.  Both RX Date Chemo and RX Date Chemo Flag are blank, indicating the date was
intentionally not collected.
3.  Date of Diagnosis is blank

Note: Another edit, "RX Date Chemo, Date Flag (COC)", verifies that the date and
flag fields are in agreement.

The logic below takes into account that the RX Summ--Chemo code of 88 was allowed
historically to be coded with RX Date Chemo codes of 00000000 and 99999999.

1. If RX Summ--Chemo = 00, 82, or 85-87 (chemo not given) then RX Date Chemo Flag
field must = 11 (no chemo).

2.  If RX Summ--Chemo = 01-03 (chemo given) and RX Date Chemo is blank, then RX
Date Chemo Flag field must indicate why the date is blank.
 - If year of Date of Diagnosis is < 2012, then RX Date Chemo Flag may = 10
(unknown if administered) or 12 (administered, but date is unknown).
 - If year of Date of Diagnosis is 2012 or later, then RX Date Chemo Flag must =
12.

3.  If RX Summ--Chemo = 88 (recommended, but unknown if administered), then RX Date
Chemo Flag must indicate the reason.
```

- If year of Date of Diagnosis < 2012, then RX Date Chemo Flag may = 10 (unknown if administered), 11 (no Chemo), 12 (administered, but date is unknown), or 15 (planned, not yet given).
- If year of Date of Diagnosis is 2012 or later, then RX Date Chemo Flag must = 15.

4. If RX Summ--Chemo = 99 (unknown if given), then RX Date Chemo Flag must = 10 (unknown if administered).

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

Modifications:

NAACCR v12.2
- Edit modified to only allow specific date flag codes for cases diagnosed 2012 and later.

NAACCR v13
- Edit name changed from 'RX Summ--Chemo, RX Date--Chemo (COC)' to 'RX Summ--Chemo, RX Date Chemo (COC)'.
- Data item name changed from from "RX Date--Chemo" to "RX Date Chemo".
- Data item name changed from from "RX Date--Chemo Flag" to "RX Date Chemo Flag".

RX Summ--Chemo, RX Date Chemo (COC/MCR)

Agency: **Last changed: 06/12/2013**

Edit Sets

OfficeScan16D

Fields

RX Summ--Chemo [Std# 1390]
RX Date Chemo [Std# 1220]
RX Date Chemo Flag [Std# 1221]
Date of Diagnosis [Std# 390]

Additional Messages

[4064] If RX Summ--Chemo = "value of RX Summ--Chemo", RX Date Chemo Flag must = 11
[4065] If RX Summ--Chemo = "value of RX Summ--Chemo" and RX Date Chemo is blank, if year of Date of Diagnosis < 2012, RX Date Chemo Flag must = 10 or 12
[4066] If RX Summ--Chemo = "value of RX Summ--Chemo" and RX Date Chemo is blank, if year of Date of Diagnosis > 2011, RX Date Chemo Flag must = 12
[4067] If RX Summ--Chemo = "value of RX Summ--Chemo" and Date of Diagnosis < 2012, RX Date Chemo Flag must = 10, 11, 12, 15
[4068] If RX Summ--Chemo = "value of RX Summ--Chemo" and Date of Diagnosis > 2011, RX Date Chemo Flag must = 15
[4069] If RX Summ--Chemo = "value of RX Summ--Chemo", RX Date Chemo Flag must = 10
ERROR_TEXT("Date of Diagnosis: %DC")

Description

```
This edit is skipped if any of the following conditions are true:
1.  RX Summ--Chemo is blank
2.  Both RX Date Chemo and RX Date Chemo Flag are blank, indicating the date was
intentionally not collected.
3.  Date of Diagnosis is blank
4.  Date of Diagnosis is less than 2009 (MCR modification).

Note: Another edit, "RX Date Chemo, Date Flag (COC)", verifies that the date and
flag fields are in agreement.

The logic below takes into account that the RX Summ--Chemo code of 88 was allowed
historically to be coded with RX Date Chemo codes of 00000000 and 99999999.

1. If RX Summ--Chemo = 00, 82, or 85-87 (chemo not given) then RX Date Chemo Flag
field must = 11 (no chemo).

2.  If RX Summ--Chemo = 01-03 (chemo given) and RX Date Chemo is blank, then RX
Date Chemo Flag field must indicate why the date is blank.
 - If year of Date of Diagnosis is < 2012, then RX Date Chemo Flag may = 10
(unknown if administered) or 12 (administered, but date is unknown).
 - If year of Date of Diagnosis is 2012 or later, then RX Date Chemo Flag must =
12.

3.  If RX Summ--Chemo = 88 (recommended, but unknown if administered), then RX Date
Chemo Flag must indicate the reason.
```

- If year of Date of Diagnosis < 2012, then RX Date Chemo Flag may = 10 (unknown if administered), 11 (no Chemo), 12 (administered, but date is unknown), or 15 (planned, not yet given).
- If year of Date of Diagnosis is 2012 or later, then RX Date Chemo Flag must = 15.

4. If RX Summ--Chemo = 99 (unknown if given), then RX Date Chemo Flag must = 10 (unknown if administered).

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

Modifications:

NAACCR v12.2
- Edit modified to only allow specific date flag codes for cases diagnosed 2012 and later.

NAACCR v13
- Edit name changed from 'RX Summ--Chemo, RX Date--Chemo (COC)' to 'RX Summ--Chemo, RX Date Chemo (COC)'.
- Data item name changed from from "RX Date--Chemo" to "RX Date Chemo".
- Data item name changed from from "RX Date--Chemo Flag" to "RX Date Chemo Flag".

The MCR modification is to skip pre-2009 diagnoses. The Chemo modality was not edited against its date 2003-2009 when COC was not requiring this date.

RX Summ--Chemo, RX Text--Chemo (NAACCR/MCR)

Agency: **Last changed: 06/13/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Summ--Chemo [Std# 1390]
Date of Diagnosis [Std# 390]
Class of Case [Std# 610]
RX Text--Chemo [Std# 2640]

Default Error Message

[1189] If %F1 = %V1, RX Text--Chemo cannot be blank
If RX Summ--Chemo = "value of RX Summ--Chemo", RX Text--Chemo cannot be blank

Description

```
If RX Summ--Chemo = 01-03 (chemotherapy administered), RX Text--Chemo must not be
blank.
MCR modification: no text required for pre-2001 diagnoses nor non-analytic classes
of case
```

RX Summ--Chemo, Vital Status (COC)

Agency: COC **Last changed: 07/08/2003**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Summ--Chemo [Std# 1390]
Vital Status [Std# 1760]

Default Error Message

[1016] %F1 and %F2 conflict
RX Summ--Chemo and Vital Status conflict

Description

```
If RX Summ--Chemo = 85 (chemotherapy was not administered because the patient died
prior to planned or recommended therapy), then Vital Status cannot = 1 (alive).
```

RX Summ--DX/Stg Proc (COC)

Agency: COC **Last changed: 06/24/2002**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Summ--DX/Stg Proc [Std# 1350]

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of RX Summ--DX/Stg Proc" is not a valid value for RX Summ--DX/Stg Proc

Description

Must be a numeric value (00-07, 09).

RX Summ--DX/Stg Proc, RX Date DX/Stg Proc (COC)

Agency: COC **Last changed: 11/25/2012**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Summ--DX/Stg Proc [Std# 1350]
RX Date DX/Stg Proc [Std# 1280]
RX Date Dx/Stg Proc Flag [Std# 1281]
Date of Diagnosis [Std# 390]

Additional Messages

[4064] If RX Summ--DX/Stg Proc = "value of RX Summ--DX/Stg Proc", RX Date Dx/Stg Proc Flag must = 11
[4065] If RX Summ--DX/Stg Proc = "value of RX Summ--DX/Stg Proc" and RX Date DX/Stg Proc is blank, if year of Date of Diagnosis < 2012, RX Date Dx/Stg Proc Flag must = 10 or 12
[4066] If RX Summ--DX/Stg Proc = "value of RX Summ--DX/Stg Proc" and RX Date DX/Stg Proc is blank, if year of Date of Diagnosis > 2011, RX Date Dx/Stg Proc Flag must = 12
[4069] If RX Summ--DX/Stg Proc = "value of RX Summ--DX/Stg Proc", RX Date Dx/Stg Proc Flag must = 10
ERROR_TEXT("Date of Diagnosis: %DC")

Description

```
This edit is skipped if any of the following conditions are true:
1.  RX Summ--DX/Stg Proc is blank
2.  Both RX Date DX/Stg Proc and RX Date DX/Stg Proc Flag are blank, indicating the
date was intentionally not collected.
3. Date of Diagnosis is blank

Note: Another edit, "RX Date DX/Stg Proc, Date Flag (COC)", verifies that the date
and flag fields are in agreement.

The edit works as follows:

1. If RX Summ--DX/Stg Proc = 00 (no diagnostic or staging procedure performed),
then RX Date DX/Stg Proc Flag must = 11 (no diagnostic or staging procedure
performed).

2. If RX Summ--DX/Stg Proc = 01-07 (diagnostic or staging procedure performed) and
RX Date DX/Stg Proc is blank, then RX Date DX/Stg Proc Flag must indicate why the
date is blank.
 - If year of Date of Diagnosis is < 2012, then RX Date DX/Stg Proc Flag may = 10
(unknown if performed) or 12 (performed, but date is unknown).
 - If year of Date of Diagnosis is 2012 or later, then RX Date DX/Stg Proc Flag
must = 12.

3. If RX Summ--DX/Stg Proc = 09 (no information about whether a diagnostic or
staging procedure was performed), then RX Date DX/Stg Proc Flag must = 10 (unknown
if diagnostic or staging procedure performed).
```

Administrative Notes

MODIFICATIONS:

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules

NAACCR v12.2
- Edit modified to only allow specific date flag codes for cases diagnosed 2012 and later.

NAACCR v13
- Edit name changed from 'RX Summ--DX/Stg Proc, RX Date--DX/Stg Proc (COC)' to 'RX Summ--DX/Stg Proc, RX Date DX/Stg Proc (COC)'.
- Data item name changed from from "RX Date--DX/Stg Proc" to "RX Date DX/Stg Proc".
- Data item name changed from from "RX Date--DX/Stg Proc Flag" to "RX Date DX/Stg Proc Flag".

RX Summ--Hormone (NPCR)

Agency: NPCR **Last changed: 12/09/2011**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Summ--Hormone [Std# 1400]

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of RX Summ--Hormone" is not a valid value for RX Summ--Hormone

Description

```
Must be a valid RX Summ--Hormone code (00, 01, 82, 85-88, 99) or blank.
```

Administrative Notes

This edit differs from the COC edit of the same name in that it allows the field to be blank because the item was not required by NPCR until 2006. Another edit (RX Summ--Hormone, Date of DX (NPCR)) verifies that this item is not blank for cancers of the breast, colon, and rectum diagnosed 2006 and later.

Modifications:

NAACCR v12.2
- Corrected portion of Administrative Notes that explains how this edit differs from COC edit of the same name.

RX Summ--Hormone, Date of DX (NPCR)

Agency: NPCR **Last changed: 02/10/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
RX Summ--Hormone [Std# 1400]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]

Default Error Message

[4884] If DX year = 2006-2014, %F3 = %V3 and %F4 = %V4, %F2 cannot be blank
If DX year = 2006-2014, Primary Site = "value of Primary Site" and Histologic Type ICD-O-3 = "value of Histologic Type ICD-O-3", RX Summ--Hormone cannot be blank

Additional Messages

[3580] If DX year = 2015 or later, RX Summ--Hormone cannot be blank
ERROR_TEXT("Date of Diagnosis: %DC")

Description

```
This edit is skipped if Date of Diagnosis is blank.

This edit requires RX Summ--Hormone for cases that meet all of the following
criteria:
1. Year of Date of Diagnosis is 2006-2014
     AND
   Case is one of the following site/histologies
   A. Breast (Primary Site = C500-C509 and Histologic Type ICD-O-3 =
      8000-9044, 9060-9136, or 9141-9582)
   B. Colon (Primary Site = C180-C189 and Histologic Type ICD-O-3 =
      8000-9044, 9060-9136, or 9141-9582)
   C. Rectum (Primary Site = C199 or C209 and Histologic Type ICD-O-3
      = 8000-9044, 9060-9136, or 9141-9582)

2. Year of Date of Diagnosis is 2015 or later
   - All cases
```

Administrative Notes

Modifications:

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

NAACCR v12.2
- Modified to require RX Summ--Hormone only for cancers of the breast, colon, and rectum (instead of all sites) diagnosed 2006 and later.

NAACCR v15

- Edit modified to require RX Summ--Hormone for all cases diagnosed 2015 or later. For cases diagnosed 2006-2014, RX Summ--Hormone is required only for breast, colon, and rectum cases.

RX Summ--Hormone, RX Date Hormone (COC)

Agency: COC **Last changed: 11/25/2012**

Edit Sets

HospitalScan16D

Fields

RX Summ--Hormone [Std# 1400]
RX Date Hormone [Std# 1230]
RX Date Hormone Flag [Std# 1231]
Date of Diagnosis [Std# 390]

Additional Messages

[4064] If RX Summ--Hormone = "value of RX Summ--Hormone", RX Date Hormone Flag must = 11
[4065] If RX Summ--Hormone = "value of RX Summ--Hormone" and RX Date Hormone is blank, if year of Date of Diagnosis < 2012, RX Date Hormone Flag must = 10 or 12
[4066] If RX Summ--Hormone = "value of RX Summ--Hormone" and RX Date Hormone is blank, if year of Date of Diagnosis > 2011, RX Date Hormone Flag must = 12
[4067] If RX Summ--Hormone = "value of RX Summ--Hormone" and Date of Diagnosis < 2012, RX Date Hormone Flag must = 10, 11, 12, 15
[4068] If RX Summ--Hormone = "value of RX Summ--Hormone" and Date of Diagnosis > 2011, RX Date Hormone Flag must = 15
[4069] If RX Summ--Hormone = "value of RX Summ--Hormone", RX Date Hormone Flag must = 10
ERROR_TEXT("Date of Diagnosis: %DC")

Description

```
This edit is skipped if any of the following conditions are true:
1.  RX Summ--Hormone is blank
2.  Both RX Date Hormone and RX Date Hormone Flag are blank, indicating the date
was intentionally not collected.
3.  Date of Diagnosis is blank

Note: Another edit, "RX Date Hormone, Date Flag (COC)", verifies that the date and
flag fields are in agreement.

The logic below takes into account that the RX Summ--Hormone code of 88 was allowed
historically to be coded with RX Date Hormone codes of 00000000 and 99999999.

1. If RX Summ--Hormone = 00, 82, or 85-87 (Hormone not given) then RX Date Hormone
Flag field must = 11 (no Hormone).

2.  If RX Summ--Hormone = 01-03 (Hormone rx given) and RX Date Hormone is blank,
then RX Date Hormone Flag field must indicate why the date is blank.
 - If year of Date of Diagnosis is < 2012, then RX Date Hormone Flag may = 10
(unknown if administered) or 12 (administered, but date is unknown).
 - If year of Date of Diagnosis is 2012 or later, then RX Date Hormone Flag must =
12.

3.  If RX Summ--Hormone = 88 (recommended, but unknown if given), then RX Date
Hormone Flag must indicate the reason.
```

- If year of Date of Diagnosis < 2012, then RX Date Hormone Flag may = 10 (unknown if administered), 11 (no Hormone), 12 (administered, but date is unknown), or 15 (planned, not yet given).
- If year of Date of Diagnosis is 2012 or later, then RX Date Hormone Flag must = 15.

4. If RX Summ--Hormone = 99 (unknown if given), then RX Date Hormone Flag must = 10 (unknown if administered).

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

Modifications:

NAACCR v12.2
- Edit modified to only allow specific date flag codes for cases diagnosed 2012 and later.

NAACCR v13
- Edit name changed from 'RX Summ--Hormone, RX Date--Hormone (COC)' to 'RX Summ--Hormone, RX Date Hormone (COC)'.
- Data item name changed from from "RX Date--Hormone" to "RX Date Hormone".
- Data item name changed from from "RX Date--Hormone Flag" to "RX Date Hormone Flag".

RX Summ--Hormone, RX Date Hormone (COC/MCR)

Agency: **Last changed: 06/13/2013**

Edit Sets

OfficeScan16D

Fields

RX Summ--Hormone [Std# 1400]
RX Date Hormone [Std# 1230]
RX Date Hormone Flag [Std# 1231]
Date of Diagnosis [Std# 390]

Additional Messages

[4064] If RX Summ--Hormone = "value of RX Summ--Hormone", RX Date Hormone Flag must = 11
[4065] If RX Summ--Hormone = "value of RX Summ--Hormone" and RX Date Hormone is blank, if year of Date of Diagnosis < 2012, RX Date Hormone Flag must = 10 or 12
[4066] If RX Summ--Hormone = "value of RX Summ--Hormone" and RX Date Hormone is blank, if year of Date of Diagnosis > 2011, RX Date Hormone Flag must = 12
[4067] If RX Summ--Hormone = "value of RX Summ--Hormone" and Date of Diagnosis < 2012, RX Date Hormone Flag must = 10, 11, 12, 15
[4068] If RX Summ--Hormone = "value of RX Summ--Hormone" and Date of Diagnosis > 2011, RX Date Hormone Flag must = 15
[4069] If RX Summ--Hormone = "value of RX Summ--Hormone", RX Date Hormone Flag must = 10
ERROR_TEXT("Date of Diagnosis: %DC")

Description

```
This edit is skipped if any of the following conditions are true:
1.  RX Summ--Hormone is blank
2.  Both RX Date Hormone and RX Date Hormone Flag are blank, indicating the date
was intentionally not collected.
3.  Date of Diagnosis is blank
4.  Date of Diagnosis is less than 2006 (MCR modification)

Note: Another edit, "RX Date Hormone, Date Flag (COC)", verifies that the date and
flag fields are in agreement.

The logic below takes into account that the RX Summ--Hormone code of 88 was allowed
historically to be coded with RX Date Hormone codes of 00000000 and 99999999.

1. If RX Summ--Hormone = 00, 82, or 85-87 (Hormone not given) then RX Date Hormone
Flag field must = 11 (no Hormone).

2.  If RX Summ--Hormone = 01-03 (Hormone rx given) and RX Date Hormone is blank,
then RX Date Hormone Flag field must indicate why the date is blank.
 - If year of Date of Diagnosis is < 2012, then RX Date Hormone Flag may = 10
(unknown if administered) or 12 (administered, but date is unknown).
 - If year of Date of Diagnosis is 2012 or later, then RX Date Hormone Flag must =
12.

3.  If RX Summ--Hormone = 88 (recommended, but unknown if given), then RX Date
Hormone Flag must indicate the reason.
```

- If year of Date of Diagnosis < 2012, then RX Date Hormone Flag may = 10 (unknown if administered), 11 (no Hormone), 12 (administered, but date is unknown), or 15 (planned, not yet given).
- If year of Date of Diagnosis is 2012 or later, then RX Date Hormone Flag must = 15.

4. If RX Summ--Hormone = 99 (unknown if given), then RX Date Hormone Flag must = 10 (unknown if administered).

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

Modifications:

NAACCR v12.2
- Edit modified to only allow specific date flag codes for cases diagnosed 2012 and later.

The MCR modification is to skip pre-2006 diagnoses. Before 2003 diagnoses, this date field covered Hormone and Endocrine surgery/radiation. The COC edit fails pre-2003 cases where we have the date of an endocrine procedure filled but the Hormone modality = 00. We begin editing with 2006 diagnoses because this is when NPCR began requiring Hormone. Between 2003 and 2009 when COC did not require this date, it was not edited by MCR.

NAACCR v13
- Edit name changed from 'RX Summ--Hormone, RX Date--Hormone (COC)' to 'RX Summ--Hormone, RX Date Hormone (COC)'.
- Data item name changed from from "RX Date--Hormone" to "RX Date Hormone".
- Data item name changed from from "RX Date--Hormone Flag" to "RX Date Hormone Flag".

RX Summ--Hormone, RX Text--Hormone (NAACCR/MCR)

Agency: **Last changed: 07/15/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Summ--Hormone [Std# 1400]
Date of Diagnosis [Std# 390]
Class of Case [Std# 610]
RX Text--Hormone [Std# 2650]

Default Error Message

[1190] If %F1 = %V1, RX Text--Hormone cannot be blank
If RX Summ--Hormone = "value of RX Summ--Hormone", RX Text--Hormone cannot be blank

Description

```
If RX Summ--Hormone = 01 (hormone treatment administered), RX Text--Hormone must
not be blank.
MCR modification: no text required for pre-2001 diagnoses nor non-analytic classes
or case
```

Administrative Notes

v16: removed check on Endocrine Procedures; NAACCR edit does not require text for Endocrine Procedures.

RX Summ--Hormone, Vital Status (COC)

Agency: COC **Last changed: 07/08/2003**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Summ--Hormone [Std# 1400]
Vital Status [Std# 1760]

Default Error Message

[1016] %F1 and %F2 conflict
RX Summ--Hormone and Vital Status conflict

Description

```
If RX Summ--Hormone = 85 (hormone therapy was not administered because the patient
died prior to planned or recommended therapy), then Vital Status cannot = 1
(alive).
```

RX Summ--Other (NPCR)

Agency: NPCR **Last changed: 12/09/2011**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Summ--Other [Std# 1420]

Default Error Message

[290] RX Summ--Other not valid
RX Summ--Other not valid

Description

```
Must be a valid RX Summ--Other code (0-3, 6-9) or blank.
```

Administrative Notes

This edit differs from the SEER edit of the same name in that it allows the field to be blank because the item was not required by NPCR until 2006. Another edit (RX Summ--Other, Date of DX (NPCR)) verifies that this item is not blank for cancers of the breast, colon, and rectum diagnosed 2006 and later.

Modifications:

NAACCR v12.2
- Corrected portion of Administrative Notes that explains how this edit differs from SEER edit of the same name.

RX Summ--Other, Date of DX (NPCR)

Agency: NPCR **Last changed: 02/10/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
RX Summ--Other [Std# 1420]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]

Default Error Message

[4884] If DX year = 2006-2014, %F3 = %V3 and %F4 = %V4, %F2 cannot be blank
If DX year = 2006-2014, Primary Site = "value of Primary Site" and Histologic Type ICD-O-3 = "value of Histologic Type ICD-O-3", RX Summ--Other cannot be blank

Additional Messages

[3580] If DX year = 2015 or later, RX Summ--Other cannot be blank
ERROR_TEXT("Date of Diagnosis: %DC")

Description

```
This edit is skipped if Date of Diagnosis is blank.

This edit requires RX Summ--Other for cases that meet all of the following
criteria:
1. Year of Date of Diagnosis is 2006-2014
     AND
   Case is one of the following site/histologies
   A. Breast (Primary Site = C500-C509 and Histologic Type ICD-O-3 =
      8000-9044, 9060-9136, or 9141-9582)
   B. Colon (Primary Site = C180-C189 and Histologic Type ICD-O-3 =
      8000-9044, 9060-9136, or 9141-9582)
   C. Rectum (Primary Site = C199 or C209 and Histologic Type ICD-O-3
      = 8000-9044, 9060-9136, or 9141-9582)

2. Year of Date of Diagnosis is 2015 or later
   - All cases
```

Administrative Notes

Modifications:

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

NAACCR v12.2
- Modified to require RX Summ--Other only for cancers of the breast, colon, and rectum (instead of all sites) diagnosed 2006 and later.

NAACCR v15

- Edit modified to require RX Summ--Other for all cases diagnosed 2015 or later. For cases diagnosed 2006-2014, RX Summ--Other is required only for breast, colon, and rectum cases.

RX Summ--Other, RX Date Other (COC)

Agency: COC **Last changed: 10/08/2014**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Summ--Other [Std# 1420]
RX Date Other [Std# 1250]
RX Date Other Flag [Std# 1251]
Date of Diagnosis [Std# 390]

Default Error Message

[3330] Conflict among %F1 (%V1), %F2 (%V2), and %F3 (%V3)
Conflict among RX Summ--Other ("value of RX Summ--Other"), RX Date Other ("value of RX Date Other"), and RX Date Other Flag ("value of RX Date Other Flag"

Additional Messages

[4241] If RX Summ--Other = "value of RX Summ--Other" and Date of Diagnosis < 2015, RX Date Other Flag must = 10, 11, 12, 15
[4242] If RX Summ--Other = "value of RX Summ--Other" and Date of Diagnosis > 2014, RX Date Other Flag must = 15
ERROR_TEXT("Date of Diagnosis: %DC")

Description

```
This edit is skipped if any of the following conditions are true:
1.  RX Summ--Other is blank
2.  Both RX Date Other and RX Date Other Flag are blank, indicating the date was
intentionally not collected.

Note: Another edit, "RX Date Other, Date Flag (COC)", verifies that the date and
flag fields are in agreement.

If RX Summ--Other = 0 or 7 (no other treatment), then RX Date Other Flag must = 11
(no other treatment).

2.  If RX Summ--Other = 1-3 or 6 (other treatment given), then the RX Date Other
Flag field must = 10 (unknown if administered) or 12 (given, but date is unknown).

3.  If RX Summ--Other = 8 (recommended):
 -  If year of Date of Diagnosis < 2015, then RX Date Other Flag may = 10 (unknown
if administered), 11 (no other treatment), 12 (given, but date is unknown), or 15
(planned, not yet given).
 -  If year of Date of Diagnosis is 2015 or later, then RX Date Other Flag must =
15.

4.  If RX Summ--Other = 9 (unknown if given), then RX Date Other Flag must = 10.
```

Administrative Notes

MODIFICATIONS:

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules

NAACCR v13
- Edit name changed from 'RX Summ--Other, RX Date--Other (COC)' to 'RX Summ--Other, RX Date Other (COC)'.
- Data item name changed from from "RX Date--Other" to "RX Date Other".
- Data item name changed from from "RX Date--Other Flag" to "RX Date Other Flag".

NAACCR v15
- Edit modified to allow date flag code of 15 when RX Summ--Other = 8; for cases diagnosed 2015+, date flag must = 15 when RX Summ--Other = 8

RX Summ--Other, RX Text--Other (NAACCR/MCR)

Agency: **Last changed: 06/14/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Summ--Other [Std# 1420]
Date of Diagnosis [Std# 390]
Class of Case [Std# 610]
RX Text--Other [Std# 2670]

Default Error Message

[1191] If %F1 = %V1, RX Text--Other cannot be blank
If RX Summ--Other = "value of RX Summ--Other", RX Text--Other cannot be blank

Description

```
If RX Summ--Other = 1-3 or 6 (other treatment administered), RX Text--Other must
not be blank.
MCR modification: text not required for non-analytic classes of case nor pre-2001
diagnoses.
```

RX Summ--Palliative Proc (NAACCR)

Agency: NAACCR **Last changed: 01/14/2010**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Summ--Palliative Proc [Std# 3270]

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of RX Summ--Palliative Proc" is not a valid value for RX Summ--Palliative Proc

Description

This field must contain 0-7, 9, or blank.

Administrative Notes

New edit - added to NAACCR v12.0 metafile.

This edit differs from the COC edit of the same name in that it allows the field to be blank. Registries that want to edit this field only if it is present should choose this version of the edit when building a state-specific edit set.

RX Summ--Scope Reg LN Sur (COC)

Agency: COC **Last changed: 04/12/2007**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Summ--Scope Reg LN Sur [Std# 1292]

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of RX Summ--Scope Reg LN Sur" is not a valid value for RX Summ--Scope Reg LN Sur

Description

```
Must be a valid RX Summ--Scope Reg LN Sur code (0-7, 9).
```

Administrative Notes

This edit differs from the SEER edit of the same name in that it does not allow the field to be blank.

Modifications:

NACR110C
08/21/06
The edit description was modified to explain how the COC version of this edit differs from the SEER edit of the same name.

RX Summ--Scope Reg LN Sur, Site, ICDO3 (SEER IF109

Agency: SEER **Last changed: 02/10/2010**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Summ--Scope Reg LN Sur [Std# 1292]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Date of Diagnosis [Std# 390]

Default Error Message

[537] RX Summ--Scope Reg LN Sur, Primary Site/Histology conflict
RX Summ--Scope Reg LN Sur, Primary Site/Histology conflict

Additional Messages

ERROR_TEXT("Date of Diagnosis: %DC")

Description

```
This edit is skipped if RX Summ--Scope Reg LN Sur, Histologic Type ICD-O-3 or Date
of Diagnosis is empty.

RX Summ--Scope Reg LN Sur must = 9 for the following:

1.  Primaries of the meninges, brain, spinal cord, cranial
    nerves, other parts of the central nervous system, and intracranial
    other endocrine(Primary Site = C700-C729, C751-C753)

2.  Hodgkin and non-hodgkin lymphoma with a lymph node primary site:
    A.  If year of Date of Diagnosis < 2010:
    If Histologic Type ICD-O-3 = 9590-9729 AND Primary Site = C770-C779

    B.  If year of Date of Diagnosis is 2010 or later:
    If Histologic Type ICD-O-3 = [9590-9726, 9728-9732, 9734-9740,
    9750-9762, 9811-9831, 9940, 9948, 9971] AND Primary Site = C770-C779

3.  Unknown and ill-defined sites (C760-C768, C809) must also = 9.

4.  Hematopoietic, reticuloendothelial, immunoproliferative, or
    myeloproliferative disease:

    For all sites:
    A. If year of Date of Diagnosis < 2010:
    If Histologic Type ICD-O-3 = [9750, 9760-9764,
    9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989]

    B.  If year of Date of Diagnosis is 2010 or later:
    If Histologic Type ICD-O-3 = [9727, 9733, 9741-9742, 9764-9809,
    9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992]

    If Primary Site = C420, C421, C423, or C424
```

Administrative Notes

In the SEER*Edits software, the title of this edit is: IF109

Note: The COC version of this edit has been deleted since it, over time, has become equivalent to the SEER version of the edit. Edit sets in this metafile using the COC version have been updated to use the SEER version instead.

Modifications:

NACR111
10/23/06
Changed histology grouping for hodgkin and non-hodgkin lymphoma from "9590-9699, 9702-9729" to "9590-9729"; that is 9700 and 9701 are now included.

NAACCR v11.3
6/2008
- Updated Administrative Notes with the title of the corresponding edit in the SEER*Edits software.
- Added intracranial other endocrine (C751, C752, C753) to list of primary sites that require Summ--Scope Reg LN Sur to = 9.

NAACCR v12.0
- Changed list of hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease histologies that are coded 9:
-- For cases diagnosed prior to 2010, codes remain the same.
-- For cases diagnosed 2010+, histology codes:
9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992

- Changed list of lymphoma histologies to be coded 9 when sited to lymph nodes:
-- For cases diagnosed prior to 2010, codes remain the same.
-- For cases diagnosed 2010+, histology codes:
9590-9726, 9728-9732, 9734-9740, 9750-9762, 9811-9831, 9940, 9948 and 9971

RX Summ--Surg Oth Reg/Dis (COC)

Agency: COC **Last changed: 04/12/2007**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Summ--Surg Oth Reg/Dis [Std# 1294]

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of RX Summ--Surg Oth Reg/Dis" is not a valid value for RX Summ--Surg Oth Reg/Dis

Description

```
Must be a valid RX Summ--Surg Oth Reg/Dis code (0-5,9).
```

Administrative Notes

This edit differs from the SEER edit of the same name in that it does not allow the field to be blank.

Modifications:

NACR110C
08/21/06
The edit description was modified to explain how the COC version of this edit differs from the SEER edit of the same name.

RX Summ--Surg Prim Site (COC)

Agency: COC **Last changed: 04/12/2007**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Summ--Surg Prim Site [Std# 1290]

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of RX Summ--Surg Prim Site" is not a valid value for RX Summ--Surg Prim Site

Description

Must be a numeric value (00, 10-90, 98, 99).

Administrative Notes

This edit differs from the SEER edit of the same name in that it does not allow the field to be blank.

RX Summ--Surg Prim Site, Diag Conf (SEER IF76)

Agency: SEER **Last changed: 02/25/2011**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Summ--Surg Prim Site [Std# 1290]
Diagnostic Confirmation [Std# 490]
Over-ride Surg/DxConf [Std# 2020]

Default Error Message

[1016] %F1 and %F2 conflict
RX Summ--Surg Prim Site and Diagnostic Confirmation conflict

Description

This edit is skipped if RX Summ--Surg Prim Site is blank.

If the case was previously reviewed and accepted as coded (Over-ride Surg/Dx Conf = 1) no further checking is performed.

For anyone with RX Summ--Surg Prim Site = 20-90 the diagnosis should be histologically confirmed (Diagnostic Confirmation 1-4).

Additional Information:

If the patient had a surgical procedure, most likely there was a microscopic examination of the cancer. This edit forces review of cases with a surgical procedure coded in the RX Summ--Surg Prim Site field but not a microscopic confirmation code in Diagnostic Confirmation. Verify the surgery and diagnostic confirmation codes, and correct any errors. Correction of errors may require inspection of the abstracted text, either online or as recorded on a paper abstract. Review of the original medical record may be necessary.

Sometimes there are valid reasons why no microscopic confirmation is achieved with surgery, for example, the tissue removed may be inadequate for evaluation. If upon review, the items are correct as coded, an over-ride flag may be set so that the case will not be considered in error when the edit is run again. Enter a 1 in the field Over-ride Surg/DxConf to indicate that the coding is correct.

Administrative Notes

In the SEER*Edits software, the title of this edit is: IF76

Modifications:

NAACCR v11.3
6/2008
Updated Administrative Notes with the title of the corresponding edit in the SEER*Edits software.

NAACCR v12.1

- Added code 3 to list of Diagnostic Confirmation codes that indicate histologic confirmation.

RX Summ--Surg Prim Site, Primary Site, ICDO3 (COC)

Agency: COC **Last changed: 02/17/2011**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Summ--Surg Prim Site [Std# 1290]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Date of Diagnosis [Std# 390]

Tables

SITGRP03.DBF
SURG03.DBF

Default Error Message

[1166] Conflict among %F1, %F2, and %F3
Conflict among RX Summ--Surg Prim Site, Primary Site, and Histologic Type ICD-O-3

Additional Messages

ERROR_TEXT("Date of Diagnosis: %DC")

Description

This edit is skipped if Histologic Type ICD-O-3, RX Summ--Surg Prim Site, or Date of Diagnosis is blank.

The valid RX Summ--Surg Prim Site codes for each Primary Site are specified in Appendix B of the FORDS Manual-2003.

Exceptions are as follows:

For all sites:
1. If year of Date of Diagnosis is < 2010 and Histologic Type ICD-O-3 = [9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989], then RX Summ--Surg Prim Site must = 98.
2. If year of Date of Diagnosis is 2010 or later and Histologic Type ICD-O-3 = [9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992], then RX Summ--Surg Prim Site must = 98.

If Primary Site = C420, C421, C423, or C424, then RX Summ--Surg Prim Site must = 98.

If Primary Site group is All Other Sites (group 30 in the table used for this edit) and RX Summ--Surg Prim Site = 41 (enucleation for eye surgery only), then Primary Site must = C690-C699.

Unknown and ill-defined sites (C760-C768, C809) must also = 98.

Administrative Notes

This edit differs from the SEER edit of the same name in that it does not allow a code of 99 for the hematopoietic histologies/sites and the ill-defined sites.

Please note that this edit should not be used on Death Certificate Only cases. It is meant to be used on data collected at a hospital. At the central registry level, it can be used on incoming abstracts from hospitals. (Hospitals do not collect Death Certificate Only cases.)

Modifications:

NACR110C:
9/8/06
Edit updated so that it will be skipped if RX Summ--Surg Prim Site is empty.

NAACCR v12.0
- Changed list of hematopoietic histologies that require RX Summ--Surg Prim Site code of 98:
-- For cases diagnosed prior to 2010, codes remain the same.
-- For cases diagnosed 2010+, codes requiring RX Summ--Surg Prim Site code of 98:
9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992

NAACCR v12.1:
Added code 76 as allowable surgery code for primary site of breast.

RX Summ--Surg/Rad Seq (NPCR)

Agency: NPCR **Last changed: 12/12/2011**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Summ--Surg/Rad Seq [Std# 1380]

Default Error Message

[286] RX Summ--Surg/Rad Seq not valid
RX Summ--Surg/Rad Seq not valid

Description

```
Must be a valid RX Summ--Surg/Rad Seq code (0,2-7,9) or blank.

Codes
0  No radiation and/or no surgery; unknown if surgery and/or radiation given
2  Radiation before surgery
3  Radiation after surgery
4  Radiation both before and after surgery
5  Intraoperative radiation
6  Intraoperative radiation with other radiation given before and/or after surgery
7  Surgery both before and after radiation
9  Sequence unknown, but both surgery and radiation were given
```

Administrative Notes

This edit differs from the SEER edit of the same name in that it allows the field to be blank because the item was not required by NPCR until 2006. Another edit (RX Summ--Surg/Rad Seq, Date of DX (NPCR)) verifies that this item is not blank if the year of Date of Diagnosis is greater than 2005.

Modifications:

NAACCR v12.2
- Added code 7.

RX Summ--Surg/Rad Seq, Date of DX (NPCR)

Agency: NPCR **Last changed: 03/30/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
RX Summ--Surg/Rad Seq [Std# 1380]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]

Default Error Message

[1020] If %F1 = %V1, %F2 cannot be blank
If Date of Diagnosis = "value of Date of Diagnosis", RX Summ--Surg/Rad Seq cannot be blank

Additional Messages

ERROR_TEXT("Date of Diagnosis: %DC")

Description

```
This edit is skipped if Date of Diagnosis is blank.

This edit requires RX Summ--Surg/Rad Seq not be blank for
1. Year of Date of Diagnosis is 2006 - 2015 and Case is one of the following
site/histologies
   A. Breast (Primary Site = C500-C509 and Histologic Type ICD-O-3 = 8000-9044,
9060-9136, or 9141-9582)
   B. Colon (Primary Site = C180-C189 and Histologic Type ICD-O-3 = 8000-9044,
9060-9136, or 9141-9582)
   C. Rectum (Primary Site = C199 or C209 and Histologic Type ICD-O-3 = 8000-9044,
9060-9136, or 9141-9582)
2. Year of Date of Diagnosis is 2016 and later, for all cases.
```

Administrative Notes

Modifications:

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

NAACCR v12.2
- Modified to require RX Summ--Surg/Rad Seq only for cancers of the breast, colon, and rectum (instead of all sites) diagnosed 2006 and later.

NAACCR v12.2A
- Edit description corrected to state that RX Summ--Surg/Rad Seq is required for breast, colon, and rectum cases if year of Date of Diagnosis is "2006 or later" instead of "2010 or later".

NAACCR v16

- For cases diagnosed 2016 or later RX Summ--Surg/Rad Seq is reguired for all cases

RX Summ--Systemic/Sur Seq (COC)

Agency: COC **Last changed: 12/12/2011**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Summ--Systemic/Sur Seq [Std# 1639]

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of RX Summ--Systemic/Sur Seq" is not a valid value for RX Summ--Systemic/Sur Seq

Description

```
This field is allowed to be blank because the item is not required until 2006.
Another edit (RX Summ--Systemic/Sur Seq, Date of DX) verifies that this item is not
blank if the year of Date of Diagnosis is greater than 2005.

Must be a valid RX Summ--Systemic/Sur Seq code (0, 2-7, 9) or blank.

Codes
0  No systemic therapy and/or surgical procedures; unknown if surgery and/or
systemic therapy given
2  Systemic therapy before surgery
3  Systemic therapy after surgery
4  Systemic therapy both before and after surgery
5  Intraoperative systemic therapy
6  Intraoperative systemic therapy with other therapy administered before and/or
after surgery
7  Surgery both before and after systemic therapy
9  Sequence unknown, but both surgery and systemic therapy given
```

Administrative Notes

Modifications:

NACR111
09/2006
The name of the data item RX Summ--Systemic Sur Seq was changed to RX Summ--Systemic/Sur Seq.

NAACCR v12.2
- Added code 7.

RX Summ--Systemic/Sur Seq, Date of DX (NPCR)

Agency: NPCR **Last changed: 07/19/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
RX Summ--Systemic/Sur Seq [Std# 1639]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]

Default Error Message

[1020] If %F1 = %V1, %F2 cannot be blank
If Date of Diagnosis = "value of Date of Diagnosis", RX Summ--Systemic/Sur Seq cannot be blank

Additional Messages

ERROR_TEXT("Date of Diagnosis: %DC")

Description

```
This edit is skipped if Date of Diagnosis is blank.

This edit requires RX Summ--Systemic/Sur Seq not be blank for:
1. Year of Date of Diagnosis is 2006-2015 and case is one of the following
site/histologies
   A. Breast (Primary Site = C500-C509 and Histologic Type ICD-O-3 = 8000-9044,
9060-9136, or 9141-9582)
   B. Colon (Primary Site = C180-C189 and Histologic Type ICD-O-3 = 8000-9044,
9060-9136, or 9141-9582)
   C. Rectum (Primary Site = C199 or C209 and Histologic Type ICD-O-3 = 8000-9044,
9060-9136, or 9141-9582)
2. Year of Date of Diagnosis is 2016 and later, for all cases.
```

Administrative Notes

New edit - added to NAACCR v12.2 metafile.

Modifications

NAACCR v16
- For cases diagnosed 2016 or later RX Summ--Systemic/Sur Seq is required for all cases
- Name changed from RX Summ--Systemic/Sur Seq, Date of DX (NPCR) to RX Summ--Systemic/Sur Seq, Date of DX - 2016 (NPCR)

NAACCR V16A
- Administrative Note for v16 updated to indicate name changed from RX Summ--Systemic/Sur Seq, Date of DX (NPCR) to RX Summ--Systemic/Sur Seq, Date of DX (NPCR) - 2016
- Name changed from RX Summ-Systemic/Sur Seq, Date of DX (NPCR) - 2016 to RX Summ--Systemic/Sur Seq, Date of DX (NPCR)

RX Summ--Transplnt/Endocr (NPCR)

Agency: NPCR **Last changed: 04/12/2007**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Summ--Transplnt/Endocr [Std# 3250]

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of RX Summ--Transplnt/Endocr" is not a valid value for RX Summ--Transplnt/Endocr

Description

This field must contain 00, 10-12, 20, 30, 40, 82, 85-88, 99 or blank.

Administrative Notes

This edit differs from the COC edit of the same name in that it allows the field to be blank because the item was not required by NPCR until 2006. Another edit (RX Summ--Transplnt/Endocr, Date of DX (NPCR)) verifies that this item is not blank if the year of Date of Diagnosis is greater than 2005 and not equal 9999.

RX Summ--Transplnt/Endocr, Date of DX (NPCR)

Agency: NPCR **Last changed: 02/10/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
RX Summ--Transplnt/Endocr [Std# 3250]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]

Default Error Message

[4884] If DX year = 2006-2014, %F3 = %V3 and %F4 = %V4, %F2 cannot be blank
If DX year = 2006-2014, Primary Site = "value of Primary Site" and Histologic Type ICD-O-3 = "value of Histologic Type ICD-O-3", RX Summ--Transplnt/Endocr cannot be blank

Additional Messages

[3580] If DX year = 2015 or later, RX Summ--Transplnt/Endocr cannot be blank
ERROR_TEXT("Date of Diagnosis: %DC")

Description

```
This edit is skipped if Date of Diagnosis is blank.

This edit requires RX Summ--Transplnt/Endocr for cases that meet all of the
following criteria:
1. Year of Date of Diagnosis is 2006-2014
     AND
   Case is one of the following site/histologies
   A. Breast (Primary Site = C500-C509 and Histologic Type ICD-O-3 =
      8000-9044, 9060-9136, or 9141-9582)
   B. Colon (Primary Site = C180-C189 and Histologic Type ICD-O-3 =
      8000-9044, 9060-9136, or 9141-9582)
   C. Rectum (Primary Site = C199 or C209 and Histologic Type ICD-O-3
      = 8000-9044, 9060-9136, or 9141-9582)

2. Year of Date of Diagnosis is 2015 or later
   - All cases
```

Administrative Notes

Modifications:

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

NAACCR v12.2
- Modified to require RX Summ--Transplnt/Endocr only for cancers of the breast, colon, and rectum (instead of all sites) diagnosed 2006 and later.

NAACCR v15

- Edit modified to require RX Summ--Transplnt/Endocr for all cases diagnosed 2015 or later. For cases diagnosed 2006-2014, RX Summ--Transplnt/Endocr is required only for breast, colon, and rectum cases.

RX Summ--Transplnt/Endocr, Primary Site (SEER IF28

Agency: SEER **Last changed: 07/16/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
RX Summ--Transplnt/Endocr [Std# 3250]
Date of Diagnosis [Std# 390]
Registry ID [Std# 40]

Default Error Message

[1181] Codes 30 and 40 allowed only for breast and prostate sites
Codes 30 and 40 allowed only for breast and prostate sites

Additional Messages

ERROR_TEXT("Date of Diagnosis: %DC")

Description

```
This edit is skipped under the following conditions:
    1.  Year of Date of Diagnosis is less than 2000 and Registry ID
        is equal to 0000001544 (New Jersey)
    2.  Year of Date of Diagnosis is blank

Endocrine surgery and/or endocrine radiation are only reported for prostate and
breast.  If Primary Site is not breast (C500-C509) or prostate (C619), then RX
Summ--Transplnt/Endocr may not be coded '30'  or 40.
```

Administrative Notes

In the SEER*Edits software, the title of this edit is: IF128

Modifications:

NAACCR v11.3
6/2008
Updated Administrative Notes with the title of the corresponding edit in the SEER*Edits software.

NAACCR v16A
- Description and logic updated to skip if Registry ID is 0000001544 (New Jersey) and Year of Diagnosis less than 2000, or Year of Diagnosis is blank.

RX Summ--Transplnt/Endocr, Vital Status (COC)

Agency: COC **Last changed: 07/08/2003**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Summ--Transplnt/Endocr [Std# 3250]
Vital Status [Std# 1760]

Default Error Message

[1016] %F1 and %F2 conflict
RX Summ--Transplnt/Endocr and Vital Status conflict

Description

```
If RX Summ--Transplnt/Endocr = 85 (hematologic transplant and/or endocrine
surgery/radiation was not administered because the patient died prior to planned or
recommended therapy), then Vital Status cannot = 1 (alive).
```

RX Summ--Treatm Stat, Date 1st Crs RX COC (COC)

Agency: COC **Last changed: 11/05/2014**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Summ--Treatment Status [Std# 1285]
Date 1st Crs RX COC [Std# 1270]
Date 1st Crs RX COC Flag [Std# 1271]
Class of Case [Std# 610]

Additional Messages

[3310] Conflict between RX Summ--Treatment Status ("value of RX Summ--Treatment Status") and Class of Case ("value of Class of Case"
[3322] Conflict between RX Summ--Treatment Status ("value of RX Summ--Treatment Status") and Date 1st Crs RX COC Flag ("value of Date 1st Crs RX COC Flag"
[4859] Conflict among RX Summ--Treatment Status ("value of RX Summ--Treatment Status"), Date 1st Crs RX COC Flag ("value of Date 1st Crs RX COC Flag") and Class of Case ("value of Class of Case"

Description

```
The purpose of this edit is to verify that RX Summ--Treatment Status and Date 1st
Crs RX COC/Date 1st Crs RX COC Flag are coded consistently. The edit also checks
that these fields are consistent for autopsy only cases (Class of Case = 38).

Note: Because there are other edits that check consistency between Date 1st Crs RX
COC and its corresponding flag, this edit only needs to check the date flag field.

This edit is skipped under the following conditions:
1. RX Summ--Treatment Status is blank
2. Class of Case is blank
3. Both Date 1st Crs RX COC and Date 1st Crs RX COC Flag are blank, indicating the
date was intentionally not collected.


If RX Summ--Treatment Status = 9 (unknown if treatment given),
THEN
1. Date 1st Crs RX COC Flag must = blank (a valid Date 1st Crs RX COC was provided)
or 10 (unknown whether treatment was administered)
2. Class of Case must NOT = 38 (autopsy only)

If RX Summ--Treatment Status = 1 (treatment given) or 2 (active surveillance),
THEN
1. Date 1st Crs RX COC Flag must = blank (a valid Date 1st Crs RX COC was provided)
or 12 (treatment administered, but date is unknown)
2. Class of Case must NOT = 38 (autopsy only)

For all RX Summ--Treatment Status codes:
1. If Class of Case = 38 (autopsy only)
   THEN
       Date 1st Crs RX COC Flag must = 11 (autopsy only case)
2. If Class of Case NOT = 38 (autopsy)
```

```
   THEN
       Date 1st Crs RX COC Flag must = blank, 10, or 12

Note: CoC requires Date 1st Crs RX COC to represent the date treatment began, the
date active surveillance was selected, or the date on which a decision was made not
to treat the cancer.  CoC does not require a date, and uses the flag = 11, only for
autopsy-only cases.  For cases that are not autopsy-only, if no treatment was given
and the date of that decision is totally unknown, the applicable date flag is 12.
When treatment status is unknown and the date is unknown, then a flag of 10
applies.
```

Administrative Notes

New edit - added to NAACCR v12.1 metafile.

Modifications:

NAACCR v12.1A
- Note added to description:
Note: If RX Summ-Treatment Status is 0 (no treatment given) and the Date of 1st Crs RX-COC is blank, the date flag should indicate why the date of the decision not to treat is not recorded in the Date of 1st Crs RX-COC field.

NAACCR v12.2
- Removed logic that checked for RX Summ--Treatment Status of 0 (no treatment given) when requiring Date of 1st Crs Flag to equal 11 (autopsy) for Class of Case of 38 (autopsy only) and blank, 10, or 12 for non-autopsy only cases.

NAACCR v13
- Edit name changed from 'RX Summ--Treatm Stat, Date of 1st Crs RX--COC(COC)' to 'RX Summ--Treatm Stat, Date 1st Crs RX COC (COC)'.
- Data item name changed from 'Date of 1st Crs RX--COC' to 'Date 1st Crs RX COC'.
- Data item name changed from 'Date of 1st Crs RX Flag' to 'Date 1st Crs RX COC Flag'.

NAACCR v15
- Updated Note in description to clarify the meaning of the date flag codes.

RX Summ--Treatm Stat, Treatment (COC)

Agency: COC **Last changed: 03/23/2012**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Summ--Treatment Status [Std# 1285]
RX Summ--Surg Prim Site [Std# 1290]
RX Summ--Surg Oth Reg/Dis [Std# 1294]
RX Summ--BRM [Std# 1410]
RX Summ--Chemo [Std# 1390]
RX Summ--Hormone [Std# 1400]
RX Summ--Transplnt/Endocr [Std# 3250]
RX Summ--Other [Std# 1420]
Rad--Regional RX Modality [Std# 1570]

Additional Messages

[4874] Conflict between RX Summ--Treatment Status and treatment codes

Description

```
The purpose of this edit is to verify that RX Summ--Treatment Status and treatment
fields are coded consistently.

This edit is skipped under the following conditions:
1. RX Summ--Treatment Status is blank

1.  If any of the treatment fields indicate treatment given, then RX Summ--
Treatment Status must equal 1 (treatment given). Treatment is considered "given" if
any of the following is true:
  RX Summ--Surg Prim Site = 10-90
  RX Summ--Surg Oth Reg/Dis = 1-5
  RX Summ--BRM = 01
  RX Summ--Chemo = 01-03
  RX Summ--Hormone = 01
  RX Summ--Transplnt/Endocr = 10-40
  RX Summ--Other = 1, 2, 3, 6
  Rad--Regional RX Modality = 20-98

2.  If RX Summ--Treatment Status = 0 (no treatment) or 2 (active surveillance),
then the treatment fields must all indicate "no treatment".
Treatment is considered "not given" if all of the following conditions are true:
  RX Summ--Surg Prim Site = 00, 98
  RX Summ--Surg Oth Reg/Dis = 0
  RX Summ--BRM = 00, 80-88
  RX Summ--Chemo = 00, 80-88
  RX Summ--Hormone = 00, 80-88
  RX Summ--Transplnt/Endocr = 00, 80-88
  RX Summ--Other = 0, 7-8
  Rad--Regional RX Modality = 00
```

```
3.  If RX Summ--Treatment Status = 9 (unknown if any treatment), then at least one
of the treatment fields must indicate "unknown if treatment" (codes 9 and 99 below)
and the remaining should indicate either "unknown if treatment" or "no treatment".
  RX Summ--Surg Prim Site = 00, 98, 99
  RX Summ--Surg Oth Reg/Dis = 0, 9
  RX Summ--BRM = 00, 80-88, 99
  RX Summ--Chemo = 00, 80-88, 99
  RX Summ--Hormone = 00, 80-88, 99
  RX Summ--Transplnt/Endocr = 00, 80-88, 99
  RX Summ--Other = 0, 7-8, 9
  Rad--Regional RX Modality = 00,99
```

Administrative Notes

New edit - added to NAACCR v12.2 metafile.

Modifications:

NAACCR v12.2B
- Removed problem logic that references Date of 1st Crs RX--COC and its corresponding date flag. (These fields are correctly edited in the edit "RX Summ--Treatm Stat, Date of 1st Crs RX--COC(COC)".)

RX Summ--Treatment Status (COC)

Agency: COC **Last changed: 10/05/2011**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Summ--Treatment Status [Std# 1285]

Default Error Message

[3311] %F1 (%V1) is invalid
RX Summ--Treatment Status ("value of RX Summ--Treatment Status") is invalid

Description

```
Must be a valid RX Summ--Treatment Status code (0-2, 9) or blank.

Codes
0 No treatment given
1 Treatment given
2 Active surveillance (watchful waiting)
9 Unknown if treatment was given
```

Administrative Notes

New edit - added to NAACCR v12 metafile.

Modifications:

NAACCR v12.2
- Updated edit description

RX Summ--Treatment Status, Date of DX (NPCR)

Agency: NPCR **Last changed: 02/10/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
RX Summ--Treatment Status [Std# 1285]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]

Default Error Message

[4886] If DX year > 2009, %F3 = %V3 and %F4 = %V4, %F2 cannot be blank
If DX year > 2009, Primary Site = "value of Primary Site" and Histologic Type ICD-O-3 = "value of Histologic Type ICD-O-3", RX Summ--Treatment Status cannot be blank

Additional Messages

[3580] If DX year = 2015 or later, RX Summ--Treatment Status cannot be blank
ERROR_TEXT("Date of Diagnosis: %DC")

Description

```
If year of Date of Diagnosis is blank, this edit is skipped.

RX Summ--Treatment Status cannot be blank for cases that meet the following
criteria:
1. Year of Date of Diagnosis is 2010-2014
     AND
   Case is one of the following site/histologies
   A. Breast (Primary Site = C500-C509 and Histologic Type ICD-O-3 =
      8000-9044, 9060-9136, or 9141-9582)
   B. Colon (Primary Site = C180-C189 and Histologic Type ICD-O-3 =
      8000-9044, 9060-9136, or 9141-9582)
   C. Rectum (Primary Site = C199 or C209 and Histologic Type ICD-O-3
      = 8000-9044, 9060-9136, or 9141-9582)

2. Year of Date of Diagnosis is 2015 or later
   - All cases
```

Administrative Notes

New edit - added to NAACCR v12.2 metafile.

This edit differs from the COC, "RX Summ--Treatment Status, Date of DX (COC)" in that NPCR requires RX Summ--Treatment Status only for cancers of the breast, colon, and rectum diagnosed 2010-2014 and for all cases diagnosed 2015 and later, while the COC edit requires RX Summ--Treatment Status for all cases diagnosed 2010 or later.

Modifications:

NAACCR v15

- Edit modified to require RX Summ--Treatment Status for all cases diagnosed 2015 or later. For cases diagnosed 2010-2014, RX Summ--Treatment Status is required only for breast, colon, and rectum cases.

Sex (SEER Sex)

Agency: SEER **Last changed: 03/22/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Sex [Std# 220]

Default Error Message

[265] Sex (%V1) must = 1-6 or 9
Sex ("value of Sex") must = 1-6 or 9

Description

```
Must have a valid Sex code (1-6,9).

Codes
1  Male
2  Female
3  Other (intersex, disorders of sexual development/DSD). The word hermaphrodite
formally classified under this code is an outdated term.
4  Transsexual, NOS
5  Transsexual, natal male
6  Transsexual, natal female
9  Not stated/unknown
```

Administrative Notes

Modifications

NAACCR v15
- Updated code 4 to Transsexual, NOS
- Added code 5 Transsexual, natal male
- Added code 6 Transsexual, natal female

NAACCR V16
-Updated code 3 Other (intersex, disorders of sexual development/DSD). The word hermaphrodite formally classified under this code is an outdated term.

Sex, Primary Site (SEER IF17)

Agency: SEER **Last changed: 10/04/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Sex [Std# 220]
Primary Site [Std# 400]

Default Error Message

[347] Site & Sex conflict
Site & Sex conflict

Description

Primary Site codes C510-C589 (female genital organs) are invalid for Sex codes 1 (male),and 9 (not stated/unknown).
Primary Site codes in the range C600-C639 (male genital organs) are invalid for Sex codes 2 (female),and 9.

Administrative Notes

In the SEER*Edits software, the title of this edit is: IF17

Modifications:

NAACCR v11.3
6/2008
Updated Administrative Notes with the title of the corresponding edit in the SEER*Edits software.

NAACCR v14
Edit updated to not allow Sex code 9 (not stated/unknown) with Primary Site codes C510-C589 (female genital organs) and C600-C639 (male genital organs).

NAACCR v16
Edit does not allow code 5 (Transsexual; natal male) for female genital organs or code 6(Transsexual; natal female) for male genital organs.

NAACCR v16B
- Description and edit logic changes made for V16 removed. Edit DOES allow code 5 (Transsexual; natal male) for female genital organs and code 6 (Transsexual; natal female) for male genital organs.

Social Security Number, Date of Diagnosis (COC)

Agency: COC **Last changed: 01/18/2010**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Social Security Number [Std# 2320]
Date of Diagnosis [Std# 390]

Default Error Message

[1041] %F1 cannot be blank if %F2 is greater than 1995
Social Security Number cannot be blank if Date of Diagnosis is greater than 1995

Additional Messages

ERROR_TEXT("Date of Diagnosis: %DC")

Description

This edit is skipped if Date of Diagnosis is blank.

If Year of Date of Diagnosis is greater than 1995, Social Security Number cannot be blank.

Administrative Notes

Modifications:

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

Spanish/Hispanic Origin (SEER SPANORIG)

Agency: SEER **Last changed: 09/20/2004**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Spanish/Hispanic Origin [Std# 190]

Default Error Message

[264] Spanish/Hispanic Origin not valid
Spanish/Hispanic Origin not valid

Description

Must be a valid Spanish/Hispanic Origin code (0-9).

SS2000, TNM M c,p pre2016 (MCR/NAACCR)

Agency: **Last changed: 08/05/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

SEER Summary Stage 2000 [Std# 759]
TNM Path M [Std# 900]
TNM Clin M [Std# 960]
Primary Site [Std# 400]
Over-ride SS/TNM-M [Std# 1983]
Date of Diagnosis [Std# 390]
Type of Reporting Source [Std# 500]
Behavior Code ICD-O-3 [Std# 523]

Default Error Message

[1005] Conflict among %F1, %F2 and %F3
Conflict among SEER Summary Stage 2000, TNM Path M and TNM Clin M

Description

```
This edit is skipped if any is true:
      year of Date of Diagnosis is not 2014-2015
      DCO (Type of Reporting Source = 7)
      benign or borderline (ICD-O-3 Behavior = 0,1)
      Summary Stage 2000 is blank or 8
      TNM Path M and TNM Clin M are both blank or both 88
      Over-ride SS/TNM-M is set (= 1)

TNM Path M has precedence over TNM Clin M as follows: if TNM Path M is empty or
equal to X or pX or 88 and TNM Clin M is not empty and equal to any value other
than X or cX or 88, then TNM Clin M is used.

The following combinations of SEER Summary Stage 2000 and TNM M are usually wrong
and will produce an error. If, upon review, the combination is found to be
accurate, it may be left as coded and the Over-ride SS/TNM-M coded to 1.

1.  SEER Summary Stage 2000 = [0 (in situ), 1 (localized), 3 (regional lymph
nodes), or 9 (unknown)] and TNM M = 1, c1 or p1 (distant mets)


The following combinations of SEER Summary Stage 2000 and TNM M are often wrong and
will produce a warning. If, upon review, the combination is found to be accurate,
it may be left as coded and the Over-ride SS/TNM-M coded to 1.

1.  SEER Summary Stage 2000 = [2 (regional direct extension), 4 (regional nodes and
direct extension), or 5 (regional, NOS)] and TNM M = 1, c1 or p1 (distant mets)

2.  SEER Summary Stage 2000 = 7 (distant metastases) and TNM M = 0 or c0 (no
distant mets)
    - There are some common exceptions to this rule. These exceptions
    are for the following sites and they will not generate warnings:
```

C000, C011, C021, C079, C099, C119, C180-C189, C199, C250-C259,
C340-C349, C384, C541, C569, C570, C670-C679, and C680

Additional Information:

Most of the time, a discrepancy between SEER Summary Stage 2000 and the M code in TNM will indicate a coding error in one of the two data items. Check the coding of each field carefully and correct any errors. Occasionally, however, there may be a legitimate discrepancy, most likely due to differences in the time period rules used to code the two items. SEER Summary Stage 2000 has been variously coded using all information available within 2 months of diagnosis or within 4 months of diagnosis. AJCC rules for TNM often stipulate specific test results to be included in coding for clinical and pathological staging separately, and relates time periods of coding to the initiation of therapy. Rules are provided for each primary site. Registries may differ in which rules were used, and when they were used. Ascertain the time period rules used by the registry at the time the case was collected, and verify that the appropriate time period rules were used to code the data items involved. If the discrepancy remains, set the Over-ride SS/TNM-M flag to 1 to indicate that the case is correct as coded.

Administrative Notes

Modifications:

NAACCR v11.2
11/2007

A warning is no longer generated for the combination of SEER Summary Stage 2000 of 7 (distant metastates) and TNM M code of 0 for the following sites:
C000, C011, C021, C079, C099, C119, C180-C189, C199, C250-C259,
C340-C349, C384, C541, C569, C570, C670-C679, and C680
(A warning is still generated for all other sites.)

NAACCR v12.0
- Fixed logic to handle increase in size of TNM M from 2 to 4 characters

v15:
The MCR modification is to skip pre-2014 diagnoses.

v16: MCR modification runs on 2014 and 2015 diagnoses only, with mixed bag of c and p codes being present or absent. Underlying source edit is "SS2000, TNM M c,p pre2016(NAACCR)".

SS2000, TNM N c,p pre2016 (MCR/NAACCR)

Agency: **Last changed: 08/05/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

SEER Summary Stage 2000 [Std# 759]
TNM Path N [Std# 890]
TNM Clin N [Std# 950]
Date of Diagnosis [Std# 390]
Over-ride SS/TNM-N [Std# 1982]
Type of Reporting Source [Std# 500]
Behavior Code ICD-O-3 [Std# 523]

Default Error Message

[1005] Conflict among %F1, %F2 and %F3
Conflict among SEER Summary Stage 2000, TNM Path N and TNM Clin N

Description

```
This edit is skipped if any is true:
      year of Date of Diagnosis is not 2014-2015
      DCO (Type of Reporting Source = 7)
      benign or borderline (ICD-O-3 Behavior = 0,1)
      Summary Stage 2000 is blank or > 4 (only codes 0-4 are used)
      TNM Path N and Clin N are both blank or both 88
      Over-ride SS/TNM-N is set (= 1)

TNM Path N has precedence over TNM Clin N as follows: if TNM Path N is empty or
equal to X or pX or 88 and TNM Clin N is not empty and equal to any value other
than X or cX or 88, then TNM Clin N is used.

The following combinations of SEER Summary Stage 2000 and TNM N are usually wrong
and require review. If, upon review, the combination is found to be accurate, it
may be left as coded and the Over-ride SS/TNM-N set to 1.

1.  SEER Summary Stage 2000 = [0 (in situ) or 1 (localized) or 2 (regional direct
extension)] and TNM N code = 1-4, c1-c4 or p1-p4 (regional nodes involved)

2.  SEER Summary Stage 2000 = [3 (regional lymph nodes) or 4 (regional direct
extension and nodes)] and TNM N code = 0, c0 or p0 (no regional nodes involved)


Additional Information:

Most of the time, a discrepancy between SEER Summary Stage 2000 and the N code in
TNM will indicate a coding error in one of the two data items.  Check the coding of
each field carefully and correct any errors.  Occasionally, however, there may be a
legitimate discrepancy, most likely due to differences in the time period rules
used to code the two items.  SEER Summary Stage 2000 has been variously coded using
all information available within 2 months of diagnosis or within 4 months of
diagnosis. AJCC rules for TNM often stipulate specific test results to be included
```

in coding for clinical and pathological staging separately, and relates time periods of coding to the initiation of therapy. Rules are provided for each primary site. Registries may differ in which rules were used, and when they were used. Ascertain the time period rules used by the registry at the time the case was collected, and verify that the appropriate time period rules were used to code the data items involved. If the discrepancy remains, set the Over-ride SS/TNM-N flag to 1 to indicate that the case is correct as coded.

Administrative Notes

Modifications:

NAACCR v12.0
- Fixed logic to handle increase in size of TNM N from 2 to 4 characters

NAACCR v14
- Removed print function (used for debugging) from edit logic

v15:
The MCR modification is to skip pre-2014 diagnoses.

v16: MCR modification runs on 2014 and 2015 diagnoses only, with mixed bag of c and p codes being present or absent. Underlying source edit is "SS2000, TNM N c,p pre2016 (NAACCR)". Codes for N4 are valid for ocular adnexal lymphomas in AJCC 7th Edition codes.

Summ Stg 2000, Site, Hist ICDO3, Class (NAACCR)

Agency: NAACCR **Last changed: 11/01/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
SEER Summary Stage 2000 [Std# 759]
Class of Case [Std# 610]
Behavior Code ICD-O-3 [Std# 523]
Date of Diagnosis [Std# 390]

Default Error Message

[1005] Conflict among %F1, %F2 and %F3
Conflict among Primary Site, Histologic Type ICD-O-3 and SEER Summary Stage 2000

Additional Messages

[1123] Death Certificate Only; SEER Summary Stage 2000 must = 9
[1124] Unknown or Ill-Defined Site; SEER Summary Stage 2000 must = 9
[1196] If Primary Site = "value of Primary Site" and Histologic Type ICD-O-3 = "value of Histologic Type ICD-O-3", SEER Summary Stage 2000 must = 1, 5, 7, or 9
[1197] If Primary Site = "value of Primary Site" and Histologic Type ICD-O-3 = "value of Histologic Type ICD-O-3", SEER Summary Stage 2000 must = 5, 7, or 9
[1198] If Primary Site = "value of Primary Site" and Histologic Type ICD-O-3 = "value of Histologic Type ICD-O-3", SEER Summary Stage 2000 must = 1, 7, or 9
[1199] If Primary Site = "value of Primary Site" and Histologic Type ICD-O-3 = "value of Histologic Type ICD-O-3", SEER Summary Stage 2000 must = 7
[1200] If Primary Site = "value of Primary Site" and Histologic Type ICD-O-3 = "value of Histologic Type ICD-O-3", SEER Summary Stage 2000 must = 1-4, 7, or 9
[1201] If Primary Site = "value of Primary Site" and Histologic Type ICD-O-3 = "value of Histologic Type ICD-O-3", SEER Summary Stage 2000 must = 0-2, 5, 7, or 9
[1202] If year of Date of Diagnosis < 2010, Primary Site = "value of Primary Site" and Histologic Type ICD-O-3 = "value of Histologic Type ICD-O-3", SEER Summary Stage 2000 must = 1, 7, or 9
[1203] If year of Date of Diagnosis > 2009,Primary Site = "value of Primary Site" and Histologic Type ICD-O-3 = "value of Histologic Type ICD-O-3", SEER Summary Stage 2000 must = 7
[1204] If Primary Site = "value of Primary Site" and Histologic Type ICD-O-3 = "value of Histologic Type ICD-O-3", SEER Summary Stage 2000 must = 0-5, 7, or 9
[1205] If Primary Site = "value of Primary Site" and Histologic Type ICD-O-3 = "value of Histologic Type ICD-O-3", SEER Summary Stage 2000 must = 1-5, 7, or 9
[1210] If Primary Site = "value of Primary Site" and Histologic Type ICD-O-3 = "value of Histologic Type ICD-O-3", SEER Summary Stage 2000 must = 2, 4, 5, 7, or 9
ERROR_TEXT("Date of Diagnosis: %DC")

Description

This edit is skipped if any of the fields are blank; it is also skipped if Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline).

If case is death certificate only (Class of Case = 49) then SEER Summary Stage 2000 must = 9.

This edit allows a SEER Summary Stage 2000 code of 0-5, 7, 9 for all Primary Sites and Histologic Type ICD-O-3 codes with the following exceptions:

Kaposi Sarcoma of All Sites
(M-9140)
Allowable values: 1-4, 7, 9

Hodgkin and Non-Hodgkin Lymphoma of All Sites
[M-9590-9699, 9702-9729, 9735, 9738, 9811-9818,9837] (excluding C441, C690, C695-C696)
[M-9823, 9827] [excluding C420, C421, C424, C441, C690, C695-C696 (see Hematopoietic group for these primary sites)]
Allowable values: 1, 5, 7, 9 with the following exception:
    If primary site is C77.8, then SEER Summary Stage 2000 must not=1

Lymphoma Ocular Adnexa
C441, C690, C695-C696
M-9590-9699, 9702-9738, 9811-9818, 9820-9837
Allowable values: 1, 5, 7, 9

Multiple Myeloma and Plasma Cell Neoplasms of All Sites
[M-9731, 9732, 9734] (Excluding C441, C690, C695-C696)
  M-9731 - Allowable values: 1, 7, 9
  M-9732 - Allowable value: 7
  M-9734 - Allowable values: 1, 5, 7, 9

Hematopoietic and Myeloproliferative Neoplasms of All Sites
M-9740, 9750-9752, 9755-9758, 9930
  Allowable values: 1, 7, 9
M-9764
  If diagnosis year is less than 2010: Allowable values: 1, 7, 9
  If diagnosis year = 2010 or later: Allowable values: 7
M-9731-9992 for all sites not included in the above lymphoma and multiple myeloma groups
  Allowable value: 7

Heart, Mediastinum
C380-C383, C388
Allowable values: 1-5, 7, 9

Pleura
C384
Allowable values: 1-5, 7, 9

Other and Ill-Defined Respiratory Sites and Intrathoracic Organs
C390, C398-C399
Allowable values: 1-5, 7, 9

Bones, Joints, and Articular Cartilage
C400-C403, C408-C409, C410-C414, C418-C419
Allowable values: 1-5, 7, 9

```
Mycosis Fungoides and Sezary Disease of Skin, Vulva, Penis, Scrotum
C440-C449, C510-C512, C518-C519, C600-C601, C608-C609, C632
(M-9700-9701)
Allowable values: 1-5, 7, 9

Peripheral Nerves and Autonomic Nervous System; Connective, Subcutaneous, and Other
Soft Tissues
C470-C476, C478-C479, C490-C496, C498-C499
Allowable values: 1-5, 7, 9

Retroperitoneum and Peritoneum
C480-C482, C488
Allowable values: 1-5, 7, 9

Retinoblastoma
C692, C699
(M-9510-9514)
Allowable values: 1-5, 7, 9

Brain and Cerebral Meninges
C700, C710-C719
Allowable values: 1, 5, 7, 9

Other Parts of Central Nervous System
C701, C709, C720-C725, C728-C729
Allowable values: 1, 5, 7, 9

Pituitary Gland, Craniopharyngeal Duct, Pineal Gland
C751-C753
Allowable values: 0-2, 5, 7, 9

Breast
C500-C509
If Histologic Type ICD-O-3 = 8530 (inflammatory carcinoma), then SEER Summary Stage
2000 must only = 2,4, 5, 7, or 9.
Otherwise SEER Summary Stage 2000 must = 0-5, 7, or 9.

Other and Ill-Defined Sites, Unknown Primary Site
C760-C765, C767-C768, C809, C42 and C77
 - excluding 9140, 9590-9596, 9650-9699, 9702-9719,9727-9729,  9731-9992
Allowable values: 9
```

Administrative Notes

Modifications:

NAACCR v11.1A
02/2007
Deleted: "If Histologic Type ICD-O-3 is in the range of 8800-9055, 9110-9136, 9141-9508, or 9520-9582, then SEER Summary Stage 2000 must not = 0."
(These histology ranges are now allowed to be coded with a behavior of 2 (in situ) in the edit "Morphology--Type/Behavior ICDO3 (SEER MORPH)" as long as the case has been reviewed and the Over-ride Histology flag has been set to 1 or 3.)

NAACCR v12.0:
- DCO is identified by Class of Case 49 instead of code 8.

NAACCR v12.2A
- Description and logic modified for Hodgkin and Non-Hodgkin Lymphoma, Lymphoma Ocular Adnexa, Multiple Myeloma and Plasma Cell Neoplasms, and Hematopoietic and Myeloproliferative Neoplasms.
- Added more descriptive error messages

NAACCR v16B
- Corrected Description and Edit Logic for Breast, histology 8530, Inflammatory carcinoma: valid codes for Summary Stage 2000 are 2,4,5,7, or 9 (1 and 3 no longer valid)
- Updated Description and Edit Logic to allow 9811-9818, 9837 with primary site codes C420,C421, and C424 to be coded as either hematopoietic or lymphoid malignancy, according to agreement reached between SEER and COC. (Valid Summary Stage codes for lymphoma include valid codes for hematopoietic malignancy.)

NAACCR v16D
- Error message corrected for C700-C729

Summary Stage 2000 (NAACCR)

Agency: NAACCR **Last changed: 02/10/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

SEER Summary Stage 2000 [Std# 759]

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of SEER Summary Stage 2000" is not a valid value for SEER Summary Stage 2000

Description

This field is allowed to be blank because the item was not required until 2001. Another edit (Summary Stage 2000, Date of Diagnosis) verifies that this item is not blank if the year of Date of Diagnosis is 2001-2003 or 2015 or later. Central registries should include both edits in their edit set.

Must be a valid SEER Summary Stage 2000 code (0-5, 7-9) or blank.

Administrative Notes

Modifications

NAACCR v15
- Updated description: "Another edit (Summary Stage 2000, Date of Diagnosis) verifies that this item is not blank if the year of Date of Diagnosis is 2001-2003 or 2015 or later."

Summary Stage 2000, Date DX, Date 1st Cont (NAACCR

Agency: NAACCR **Last changed: 02/10/2015**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

SEER Summary Stage 2000 [Std# 759]
Date of Diagnosis [Std# 390]
Date of 1st Contact [Std# 580]

Additional Messages

[3348] If year of Date of Diagnosis > 2000 and < 2004, then SEER Summary Stage 2000 cannot be blank
[3349] If Date of Diagnosis is blank and year of Date of 1st Contact > 2000 and < 2004, then SEER Summary Stage 2000 cannot be blank
[4633] If Date of Diagnosis is blank and year of Date of 1st Contact = 2015 or later, then SEER Summary Stage 2000 cannot be blank
ERROR_TEXT("Date of 1st Contact: %DC")

Description

If year of Date of Diagnosis is 2001-2003 or 2015 or later , then SEER Summary Stage 2000 cannot be blank. However, if the Date of Diagnosis is unknown (blank), then the of Date of 1st Contact is checked. If the year of Date of 1st Contact is 2001-2003 or 2015 or later, then SEER Summary Stage 2000 cannot be blank.

Administrative Notes

Modifications:

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

NAACCR v15
- Modified to require SEER Summary Stage 2000 if Date of Diagnosis is blank, but Date of 1st Contact is 2015 or later

Summary Stage 2000, Over-ride CS 20 (NPCR)

Agency: CS **Last changed: 12/01/2011**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

SEER Summary Stage 2000 [Std# 759]
Over-ride CS 20 [Std# 3769]

Default Error Message

[4878] If %F2 = '1', then %F1 must not be blank
If Over-ride CS 20 = '1', then SEER Summary Stage 2000 must not be blank

Description

For diagnosis year 2012 and later, NPCR permits the use of Directly Coded Summary Stage (SEER Summary Stage 2000 [759]) in those cases where collection of CSv02 is not feasible due to lack of data or due to staffing and time constraints at the local or central registry. The data item 'Over-ride CS 20' is used to flag a case where SEER Summary Stage 2000 is permitted in lieu of Derived SS2000 [3020]. When 'Over-ride CS 20' is equal to '1', SEER Summary Stage 2000 must be populated (not blank). The CS input fields may be populated, but are not required. When 'Over-ride CS 20' is blank, the Collaborative Stage input fields must be populated per NPCR requirements and SEER Summary Stage 2000 may also be populated, but is not required.

Please note that another edit, "CS Over-ride CS 20, Date of Diagnosis" verifies that Over-ride CS 20 is blank for pre-2012 cases.

If Over-ride CS 20 is '1', then SEER Summary Stage 2000 [759] cannot be blank.

Administrative Notes

New edit - added to NAACCR v12.2 metafile.

Summary Stage 2000, Regional Nodes Pos (NAACCR)

Agency: NAACCR **Last changed: 04/30/2007**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

SEER Summary Stage 2000 [Std# 759]
Regional Nodes Positive [Std# 820]
Over-ride SS/NodesPos [Std# 1981]

Default Error Message

[1016] %F1 and %F2 conflict
SEER Summary Stage 2000 and Regional Nodes Positive conflict

Description

This edit is skipped if either SEER Summary Stage 2000 or Regional Nodes Positive is blank.

If Over-ride SS/NodesPos = 1 or if SEER Summary Stage 2000 is greater than 4, the edit is skipped.

The following combinations of SEER Summary Stage 2000 and Regional Nodes Positive are usually wrong and will produce an error. If, upon review, the combination is found to be accurate, it may be left as coded and the Over-ride SS/NodesPos coded to 1.

1. SEER Summary Stage 2000 equals 0 (in situ) and Regional Nodes Positive equals 01-97

2. SEER Summary Stage 2000 equals 1 (localized) and Regional Nodes Positive equals 01-97

3. SEER Summary Stage 2000 equals 2 (regional by direct extension only) and Regional Nodes Positive equals = 01-97

4. SEER Summary Stage 2000 equals 3 (regional to lymph nodes only) and Regional Nodes Positive equals 00

5. SEER Summary Stage 2000 equals 4 (both regional by direct extension and regional to lymph nodes) and Regional Nodes Positive equals 00

The following combinations of SEER Summary Stage 2000 and Regional Nodes Positive are often wrong and will produce a warning. If, upon review, the combination is found to be accurate, it may be left as coded and the Over-ride SS/NodesPos coded to 1.

1. SEER Summary Stage 2000 equals 3 (regional to lymph nodes only) and Regional Nodes Positive equals 99

2. SEER Summary Stage 2000 equals 4 (both regional by direct extension and regional to lymph nodes) and Regional Nodes Positive equals 99

Additional Information:

Most of the time, a discrepancy between SEER Summary Stage 2000 and Regional Nodes Positive will indicate a coding error in one of the two data items. Check the coding of each field carefully and correct any errors. Occasionally, however, there may be a legitimate discrepancy, most likely due to differences in the time period rules used to code the two items. SEER Summary Stage 2000 has been variously coded using all information available within 2 months of diagnosis or within 4 months of diagnosis. SEER rules for collection of Regional Nodes Positive included a 2-month time period rule until 1998 when a 4-month rule was implemented. ROADS instructions for Regional Nodes Positive specify to record lymph nodes removed as part of the first course of therapy. Registries may differ in which rules were used, and when they were used. Ascertain the time period rules used by the registry at the time the case was collected, and verify that the appropriate time period rules were used to code the data items involved. If the discrepancy remains, set the Over-ride SS/NodesPos flag to 1 to indicate that the case is correct as coded.

Summary Stage 2000, TNM M 2016 (NAACCR)

Agency: NAACCR **Last changed: 07/30/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

SEER Summary Stage 2000 [Std# 759]
TNM Path M [Std# 900]
TNM Clin M [Std# 960]
Date of Diagnosis [Std# 390]
Type of Reporting Source [Std# 500]
Behavior Code ICD-O-3 [Std# 523]

Default Error Message

[1005] Conflict among %F1, %F2 and %F3
Conflict among SEER Summary Stage 2000, TNM Path M and TNM Clin M

Description

```
This edit is to be used for cases collected 2016 and later.

TNM Path M has precedence over TNM Clin M as follows: The edit checks TNM Path M if
it does not equal blank or "88".  If TNM Path M = blank or "88", the edit checks
TNM Clin M if it does not equal blank, or "88".

This edit is skipped under the following conditions:
1. Diagnosis date is less than 2016, blank (unknown), or invalid.
2. Type of Reporting Source = 7 (Death Certificate Only)
3. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
4. SEER Summary Stage 2000 is blank
5. TNM Path M and TNM Clin M are both blank, both = 88.


TNM Path M has precedence over TNM Clin M as follows: The edit checks TNM Path M if
it does not equal blank or "88".  If TNM Path M = blank or "88", the edit checks
TNM Clin M if it does not equal blank, or "88".

The following combinations of SEER Summary Stage 2000 and TNM M are usually wrong
and will produce an error.

1.  SEER Summary Stage 2000 equals 0 (in situ) and TNM M code equals p1 or c1

2.  SEER Summary Stage 2000 equals 1 (localized) and TNM M code equals p1 or c1

3.    SEER Summary Stage 2000 equals 9 (unknown) and TNM M code = p1 or c1
```

Administrative Notes

New edit for v16 metafile.

Modifications

NAACCR v16A
- Default error message changed from 1002 to 1005
- Skip for Over-ride deleted from Description
- The description and edit logic were modified for NAACCR v16 to not compare SEER Summary Stage codes 2, 3, 4, 5, and 7 with TNM M codes. The pre-2016 versions of the edit, SS2000, TNM M c,p pre-2016 (NAACCR) and Summary Stage 2000, TNM M (NAACCR), do edit combinations of Summary Stage codes 2, 3, 4, 5, and 7 with TNM M codes. These edits include warnings and over-rides to allow correctly coded combinations of Summary Stage and TNM codes, removed from this edit, to pass.

Summary Stage 2000, TNM N 2016 (NAACCR)

Agency: NAACCR **Last changed: 11/19/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

SEER Summary Stage 2000 [Std# 759]
TNM Path N [Std# 890]
TNM Clin N [Std# 950]
Date of Diagnosis [Std# 390]
Type of Reporting Source [Std# 500]
Behavior Code ICD-O-3 [Std# 523]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]

Default Error Message

[1005] Conflict among %F1, %F2 and %F3
Conflict among SEER Summary Stage 2000, TNM Path N and TNM Clin N

Description

This edit is to be used for cases collected 2016 and later.

TNM Path N has precedence over TNM Clin N as follows: The edit checks TNM Path N if it does not equal blank, "pX", or "88". If TNM Path N = blank, "pX", or "88", the edit checks TNM Clin N if it does not equal blank, "cX", or "88". The edit passes if TNM Path N = "pX" and TNM Clin N = "cX".

This edit is skipped under the following conditions:
1. Diagnosis date is less than 2016, blank (unknown), or invalid.
2. Type of Reporting Source = 7 (Death Certificate Only)
3. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
4. SEER Summary Stage 2000 is blank
5. TNM Path N and TNM Clin N are both blank, both = 88.

TNM Path N has precedence over TNM Clin N as follows: The edit checks TNM Path N if it does not equal blank, "pX", or "88". If TNM Path N = blank, "pX", or "88", the edit checks TNM Clin N if it does not equal blank, "cX", or "88". The edit passes if TNM Path N = "pX" and TNM Clin N = "cX".

The following combinations of SEER Summary Stage 2000 and TNM N are incorrect and require review.

1. SEER Summary Stage 2000 equals 0 (in situ) and TNM N code equals c1-c3 or p1-p3

2. SEER Summary Stage 2000 equals 1 (localized) and TNM N code equals c1-c3 or p1-p3

3. SEER Summary Stage 2000 equals 2 (regional by direct extension only) and TNM N code equals c1-c3 or p1-p3

```
The following TNM site/histology groups/Path N codes are exceptions to the above
and will not generate errors:

Chapter 14: Colon and Rectum
  TNM Path N = p1C (tumor deposits)

Chapter 31: Melanoma of the Skin
  TNM Path N = p2C (satellite nodules)

Chapter 30: Merkel Cell Carcinoma
  TNM Path N = p2 (in transit metastases)

Chapter 52: Retinoblastoma
  TNM Path N = p2 (distant nodes)

Chapter 55: Ocular Adnexal Lymphoma
  TNM Path N = p3 or p4 (codes indicating distant nodes)
```

Administrative Notes

New edit for v16 metafile, EC. Modification of Summary Stage 2000, TNM N (NAACCR), to allow c and p

Modifications

NAACCR v16A
- Edit logic updated to skip for Type of Reporting Source = 7, Behavior Code ICD-O-3 = 0 or 1
- c4, p4 removed from logic checking TNM Path values with Summary Stage 2000
- Skip for Over-ride deleted from Description and Edit Logic
- Description and edit logic modified to pass for specific N values coded for site/histology groups where cN or pN is assigned for involvement other than regional nodes.
- Description and edit logic updated to not compare SEER Summary Stage 2000 codes 3 and 4 with TNM N codes. SEER extent of disease assignment may conflict with TNM Path T assignment for example in cases with clinically positive nodes but pathologically negative nodes after neoadjuvant treatment. The pre-2016 versions of the edit, SS2000, TNM N c,p pre2016 (NAACCR) and Summary Stage 2000, TNM N (NAACCR) compare SEER Summary Stage 2000 3 and 4 with TNM codes. These edits do not include the exceptions noted for this edit, and they include over-rides for the checks with SS2000 3 and 4 that have been removed from this edit.

NAACCR v16B
- Reference to Over-ride removed from edit description.

Surgery, Rad, Surg/Rad Seq (COC)

Agency: COC **Last changed: 08/13/2012**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Summ--Surg Prim Site [Std# 1290]
RX Summ--Scope Reg LN Sur [Std# 1292]
RX Summ--Surg Oth Reg/Dis [Std# 1294]
Rad--Regional RX Modality [Std# 1570]
RX Summ--Surg/Rad Seq [Std# 1380]
Regional Nodes Examined [Std# 830]
Date of Diagnosis [Std# 390]

Default Error Message

[1039] Conflict among surgery items, %F4, %F5
Conflict among surgery items, Rad--Regional RX Modality, RX Summ--Surg/Rad Seq

Additional Messages

ERROR_TEXT("Date of Diagnosis: %DC")

Description

```
This edit is skipped if any of the fields are blank.

A.  If surgery was performed and if radiation was given ((Rad--Regional RX Modality
= 20-98), then RX Summ--Surg/Rad Seq must specify sequence (codes 2-7, 9).
Surgery is considered "performed" if ANY of the following three conditions are
true:
  1.  RX Summ--Surg Prim Site = 10-90
  2.  RX Summ--Scope Reg LN Sur:
         For cases diagnosed prior to 2012:
           1-7
         For cases diagnosed 2012 or later:
           1
           2 (only if Regional Nodes Examined = 01-98)
           3-7
  3.  RX Summ--Surg Oth Reg/Dis = 1-5

B.  If surgery was not performed or no radiation was given (Rad--Regional RX
Modality = 00), then RX Summ--Surg/Rad Seq must specify no (0). Surgery is
considered "not performed" if ALL of the following three conditions are true:
  1.  RX Summ--Surg Prim Site = 00
  2.  RX Summ--Scope Reg LN Sur:
         For cases diagnosed prior to 2012:
           0
         For cases diagnosed 2012 or later:
           0 (for all cases)
           2 (only if Regional Nodes Examined = 00 or 99)
  3.  RX Summ--Surg Oth Reg = 0
```

```
C. Surgery is also considered not performed if ANY of the following three
conditions are true:
  1.  RX Summ--Surg Prim Site = 98 (coded for hematopoietic, ill-defined and
unknown sites)
  2.  RX Summ--Scope Reg LN Sur: 9
  3.  RX Summ--Surg Oth Reg = 0
```

Administrative Notes

Modifications:

NAACCR v12.2
- Added code 7 to list of codes indicating surg/rad sequence.
- Reworked parentheses in edit logic.

NAACCR v12.2C
- Modified so that definition of "surgery performed" for RX Summ--Scope Reg LN Sur is 1-7 for cases diagnosed pre-2012, and 1, 2 (only if Regional Nodes Examined = 01-98), 3-7, for cases diagnosed 2012 and later. This is because code 2, as of 2012, can mean that a SLNBx was attempted but the patient failed to map and no nodes were removed.
- When determining whether surgery was "not performed", RX Summ--Scope Reg LN Sur codes of 0 (for all years of diagnosis) and 2 (for cases diagnosed 2012 and later with Reg Nodes Examined of 00 or 99) are considered "no regional lymph node surgery".
- Codes indicating surgery of other regional or distant sites corrected: changed from RX Summ--Surg Oth Reg codes 1-8 to 1-5.

Surgery, Reason No Surg (COC)

Agency: COC **Last changed: 02/27/2007**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Summ--Surg Prim Site [Std# 1290]
Reason for No Surgery [Std# 1340]

Default Error Message

[1016] %F1 and %F2 conflict
RX Summ--Surg Prim Site and Reason for No Surgery conflict

Description

```
This edit is skipped if any of the fields are blank.

If surgery of the primary site was performed (RX Summ--Surg Prim Site = 10-90),
Reason for No Surgery must = 0 (surgery performed).

If surgery of the primary site was not performed (RX Summ--Surg Prim Site = 00 or
98, Reason for No Surgery must not = 0 (surgery performed).

If RX Summ--Surg Prim Site = 99 (unknown), Reason for No Surgery cannot be 0
(surgery performed).
```

Administrative Notes

Modifications:

NAACCR v11.1
02/2007
Added the following check: If RX Summ--Surg Prim Site = 99 (unknown), Reason for No Surgery cannot be 0 (surgery performed).

Surgery, RX Date Surgery, ICDO3 (COC)

Agency: COC **Last changed: 02/12/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Summ--Surg Prim Site [Std# 1290]
RX Summ--Scope Reg LN Sur [Std# 1292]
RX Summ--Surg Oth Reg/Dis [Std# 1294]
RX Date Surgery [Std# 1200]
RX Date Surgery Flag [Std# 1201]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Date of Diagnosis [Std# 390]
Regional Nodes Examined [Std# 830]

Additional Messages

[4070] If RX Summ--Surg Prim Site = "value of RX Summ--Surg Prim Site", RX Summ--Scope Reg LN Sur = "value of RX Summ--Scope Reg LN Sur", and RX Summ--Surg Oth Reg/Dis = "value of RX Summ--Surg Oth Reg/Dis", RX Date Surgery Flag must = 11
[4071] If surgery performed and RX Date Surgery is blank,if year of Date of Diagnosis < 2012, RX Date Surgery Flag must = 10 or 12
[4072] If surgery performed and RX Date Surgery is blank, if year of Date of Diagnosis > 2011, RX Date Surgery Flag must = 12
ERROR_TEXT("Date of Diagnosis: %DC")

Description

```
This edit is skipped if any of the following conditions are true:
1. Date of Diagnosis is blank
2. Histologic Type ICD-O-3 is blank
3. Both RX Date Surgery and RX Date Surgery Flag are blank, indicating the date was
intentionally not collected.
4. RX Summ--Surg Prim Site is blank
5. RX Summ--Scope Reg LN Sur is blank
6. RX Summ--Surg Oth Reg/Dis is blank

This edit compares the three surgery code fields (RX Summ--Surg Prim Site, RX Summ-
-Scope Reg LN Sur, RX Summ--Surg Oth Reg/Dis) against the date of first surgical
procedure (RX Date Surgery) and corresponding date flag (RX Date Surgery Flag).  If
any of the three surgery code fields indicate that surgery was performed, then the
flag may = either 10 (unknown if any surgical procedure was performed) or 12
(surgical procedure performed, but date is unknown) for pre-2012 cases or 12 for
2012+ cases. (Note: Date flag codes 10 and 12 were sometimes used interchangeably
for pre-2012 cases due to conversion limitations.  For cases diagnosed 2012 and
later, the codes must be used correctly.) If all of the three fields show that no
surgery was performed, then the flag must = 11 (no surgical procedure performed).

The edit works as follows:
```

1. If surgery was performed and RX Date Surgery is blank, then RX Date Surgery Flag field must indicate why the date is blank.
- If year of Date of Diagnosis is < 2012, then RX Date Surgery Flag may = 10 or 12
- If year of Date of Diagnosis is 2012 or later, then RX Date Surgery Flag must = 12.

Surgery is considered "performed" if any of the following three conditions are true:

1. RX Summ--Surg Prim Site = 10-90
2. RX Summ--Scope Reg LN Sur = 1-7 for cases diagnosed prior to 2012
   For cases diagnosed 2012 or later:
   RX Summ--Scope Reg LN Sur = 1
   2 (only if Regional Nodes Examined = 01-98)
   3-7
3. RX Summ--Surg Oth Reg/Dis = 1-5

2. If surgery was not performed, then RX Date Surgery Flag must = 11. Surgery is considered "not performed" if all of the following three conditions are true:

1. RX Summ--Surg Prim Site = 00 (none) or 98 (not applicable)
2. RX Summ--Scope Reg LN Sur = 9 (not applicable) for the following:
   a. Primaries of the meninges, brain, spinal cord, cranial nerves, and other parts of the central nervous system (Primary Site = C700-C729)
   b. If year of Date of Diagnosis < 2010: Lymphomas (Histologic Type ICD-O-3 = 9590-9699, 9702-9729) with a lymph node primary site (Primary Site = C770-C779)
   c. If year of Date of Diagnosis is 2010 or later: Lymphomas (Histologic Type ICD-O-3 = 9590-9726, 9728-9732, 9734-9740, 9750-9762, 9811-9831, 9940, 9948, 9971) with a lymph node primary site (Primary Site = C770-C779)
   d. If year of Date of Diagnosis < 2010: Hematopoietic, reticuloendothelial, immunoproliferative, and myeloproliferative neoplasms (Primary Site = C420, C421, C423, or C424 or Histologic Type ICD-O-3 = 9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)
   e. If year of Date of Diagnosis is 2010 or later: Hematopoietic, reticuloendothelial, immunoproliferative, and myeloproliferative neoplasms (Primary Site = C420, C421, C423, or C424 or Histologic Type ICD-O-3 = 9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946,9950-9967, 9975-9992)
   f. Unknown or ill-defined primary site (Primary Site codes C760-C765, C767, C768, C809)

   RX Summ--Scope Reg LN Sur = 2 (if diagnosed 2012 or later and Regional Nodes Examined = 00 or 99)

   RX Summ--Scope Reg LN Sur = 0 (none) for all other cases

3. RX Summ--Surg Oth Reg/Dis = 0 (none)

Administrative Notes

Modifications:

NAACCR v12.0
- Modified to use the date format of CCYYMMDD and the new interoperability date functions and rules.

- Changed list of hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease histologies that expect RX Summ--Scope Reg LN Sur of 9:
-- For cases diagnosed prior to 2010, codes remain the same.
-- For cases diagnosed 2010+, histology codes:
9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992

- Changed list of lymphoma histologies that expect RX Summ--Scope Reg LN Sur of 9 when sited to lymph nodes:
-- For cases diagnosed prior to 2010, codes remain the same.
-- For cases diagnosed 2010+, histology codes:
9590-9726, 9728-9732, 9734-9740, 9750-9762, 9811-9831, 9940, 9948 and 9971

NAACCR v12.2
- Edit modified to only allow specific date flag codes for cases diagnosed 2012 and later.

NAACCR v12.2C
- Modified so that definition of "surgery performed" for RX Summ--Scope Reg LN Sur is 1-7 for cases diagnosed pre-2012, and 1, 2 (only if Regional Nodes Examined = 01-98), 3-7 for cases diagnosed 2012 and later. This is because code 2, as of 2012, can mean that a SLNBx was attempted but the patient failed to map and no nodes were removed.
- When determining whether surgery was "not performed", RX Summ--Scope Reg LN Sur code 2 (for cases diagnosed 2012 and later with Reg Nodes Examined = 00 or 99) added to conditions considered "no regional lymph node surgery".
- Codes indicating surgery of other regional or distant sites corrected: changed from 1-8 to 1-5.

NAACCR v13
- Edit name changed from 'Surgery, RX Date--Surgery ICDO3 (COC)' to ''Surgery, RX Date Surgery ICDO3 (COC)'.
- Field name "RX Date--Surgery" changed to "RX Date Surgery".
- Field name "RX Date--Surgery Flag" changed to "RX Date Surgery Flag".
- Corrected description: when referencing lymph node primary sites, "C700-C779" changed to "C770-C779"; logic was correct.
- Corrected logic: added C760-C768 to list of primary site codes for which scope of regional lymph node surgery is coded to 9.

NAACCR v13A
- Corrected edit logic to check hematopoietic code range of "9980-9989" instead "9980-9992" for pre-2010 cases. (Note: Histology codes 9991 and 9992, if entered for pre-2010 cases, would fail the edit Morphology--Type/Behavior ICDO3 (SEER Morph)).
- Updated description: change "and/or" to "or".

Systemic RX, Surgery, Systemic/Sur Seq (COC)

Agency: COC **Last changed: 02/12/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

RX Summ--Surg Prim Site [Std# 1290]
RX Summ--Scope Reg LN Sur [Std# 1292]
RX Summ--Surg Oth Reg/Dis [Std# 1294]
RX Summ--BRM [Std# 1410]
RX Summ--Chemo [Std# 1390]
RX Summ--Hormone [Std# 1400]
RX Summ--Transplnt/Endocr [Std# 3250]
RX Summ--Systemic/Sur Seq [Std# 1639]
Regional Nodes Examined [Std# 830]
Date of Diagnosis [Std# 390]

Default Error Message

[2002] Conflict among Systemic RX, Surgery, and Systemic Sur Seq
Conflict among Systemic RX, Surgery, and Systemic Sur Seq

Additional Messages

ERROR_TEXT("Date of Diagnosis: %DC")

Description

```
This edit is skipped if any of the fields are blank.

1.  If surgery was performed AND if systemic therapy was given, then RX Summ--
Systemic/Sur Seq must specify a sequence (codes 2-7, 9).

  A.  Surgery is considered performed if ANY of the following three conditions are
true:
      1.  RX Summ--Surg Prim Site = 10-90
      2.  RX Summ--Scope Reg LN Sur:
             For cases diagnosed prior to 2012:
               1-7
             For cases diagnosed 2012 or later:
               1
               2 (only if Regional Nodes Examined = 01-98)
               3-7
      3.  RX Summ--Surg Oth Reg/Dis = 1-5

  B.  Systemic therapy is considered performed if ANY of the following four
conditions are true:
      1.  RX Summ--BRM = 01
      2.  RX Summ--Chemo = 01-03
      3.  RX Summ--Hormone = 01
      4.  RX Summ--Transplnt/Endocr = 10-40
```

```
2.  If surgery was not performed OR there was no systemic therapy, then RX Summ--
Systemic/Sur Seq must = 0 (no systemic therapy and/or surgical procedures).

  A.  Surgery is considered not performed if ALL of the following conditions are
true:
       1.  RX Summ--Surg Prim Site = 00
       2.  RX Summ--Scope Reg LN Sur:
             For cases diagnosed prior to 2012:
               0
             For cases diagnosed 2012 or later:
               0 (for all cases)
               2 (only if Regional Nodes Examined 00 or 99)
       3.  RX Summ--Surg Oth Reg = 0

  B.  Surgery is also considered not performed if ALL of the following conditions
are true:
       1.  RX Summ--Surg Prim Site = 98 (coded for hematopoietic, ill-defined and
unknown sites)
       2.  RX Summ--Scope Reg LN Sur: 9
       3.  RX Summ--Surg Oth Reg = 0

  C.  Systemic therapy is considered not performed if ALL of the following four
conditions are true:
      1.  RX Summ--BRM = 00, 82-88
      2.  RX Summ--Chemo = 00, 82-88
      3.  RX Summ--Hormone = 00, 82-88
      4.  RX Summ--Transplnt/Endocr = 00, 82-88
```

Administrative Notes

In the SEER*Edits software, the title of this edit is: IF160

Modifications:

NACR110C
09/06/06
The edit was updated to treat systemic treatment (RX Summ--BRM, RX Summ--Chemo, RX Summ--Hormone, and RX Summ--Transplnt/Endocr) code 88 (recommended, but unknown if administered) the same as the code 00 (none).

NACR111
09/2006
The name of the data item RX Summ--Systemic Sur Seq was changed to RX Summ--Systemic/Sur Seq.

NAACCR v11.3
6/2008
Updated Administrative Notes with the title of the corresponding edit in the SEER*Edits software.

NAACCR v12.2
- Added code 7 to list of codes indicating systemic/surg sequence.
- Reworked parentheses in edit logic.

NAACCR v12.2C
- Modified so that definition of "surgery performed" for RX Summ--Scope Reg LN Sur is 1-7 for cases diagnosed pre-2012, and 1, 2 (only if Regional Nodes Examined = 01-98), 3-7 for cases diagnosed 2012 and later. This is

because code 2, as of 2012, can mean that a SLNBx was attempted but the patient failed to map and no nodes were removed.
- When determining whether surgery was "not performed", RX Summ--Scope Reg LN Sur codes of 0 (for all years of diagnosis) and 2 (for cases diagnosed 2012 and later with Reg Nodes Examined of 00 or 99) are considered "no regional lymph node surgery".
- Codes indicating surgery of other regional or distant sites corrected: changed from 1-8 to 1-5.

NAACCR v13:
- The description was corrected: In steps 2.A, 2.B and 2.C, "not performed if ANY of the following conditions are true" changed to "not performed if ALL of the following conditions are true".

NAACCR v13A:
- Modified edit logic so that when determining if RX Summ--Scope Reg LN Sur codes are considered "surgery performed" for 2012+ cases, instead of just checking codes 1, 3-7, it now also considers code 2 as "surgery performed" if Regional Nodes Examined = 01-98. (Description was correct; logic was wrong.)

Text--Dx Proc--Path, Diagnostic Conf (NAACCR/MCR)

Agency: **Last changed: 06/13/2013**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Diagnostic Confirmation [Std# 490]
Text--Dx Proc--Path [Std# 2570]
Class of Case [Std# 610]

Default Error Message

[1057] If %F1 is 1-4, Text--Dx Proc--Path cannot be blank
If Diagnostic Confirmation is 1-4, Text--Dx Proc--Path cannot be blank

Description

```
If Diagnostic Confirmation equals 1, 2, 3, or 4, the first 79 characters of Text--
Dx Proc--Path cannot be blank.

MCR modification: Skip if class is non-analytic except autopsy-only or pathology-
only.  MCR does not require text for most non-analytic cases.
```

Text--Histology Title (NAACCR)

Agency: NAACCR **Last changed: 04/05/1999**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Text--Histology Title [Std# 2590]

Default Error Message

[1019] %F1 must not be blank
Text--Histology Title must not be blank

Description

Text--Histology Title cannot be blank.

Text--Primary Site Title (NAACCR)

Agency: NAACCR **Last changed: 05/18/1999**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Text--Primary Site Title [Std# 2580]

Default Error Message

[1019] %F1 must not be blank
Text--Primary Site Title must not be blank

Description

Text--Primary Site Title cannot be blank.

TNM Clin Descriptor, Date of Diagnosis (NPCR)

Agency: NPCR **Last changed: 03/22/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

TNM Clin Descriptor [Std# 980]
Date of Diagnosis [Std# 390]

Default Error Message

[4629] %F1 must = 0-3, 5, or 9
TNM Clin Descriptor must = 0-3, 5, or 9

Description

```
This edit is skipped if any of the following conditions are true:

1. Year of Date of Diagnosis is less than 2014, blank (unknown), or invalid
2. TNM Clin Descriptor is blank

Must be a valid TNM Clin Descriptor code (0-3, 5, or 9)
```

Administrative Notes

New edit - added to NAACCR v14 metafile.

This NPCR edit differs from the COC edit of the same name as follows:
- This edit is skipped if year of Date of Diagnosis is less than 2014

TNM Clin Descriptor, Histologies - Ed 7 (COC)

Agency: COC **Last changed: 02/06/2017**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
Type of Reporting Source [Std# 500]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
TNM Clin Descriptor [Std# 980]

Default Error Message

[3589] If %F6 = %V6, %F3 (%V3) and %F4 (%V4) must indicate lymphoma
If TNM Clin Descriptor = "value of TNM Clin Descriptor", Primary Site ("value of Primary Site") and Histologic Type ICD-O-3 ("value of Histologic Type ICD-O-3") must indicate lymphoma

Description

```
This edit is skipped if any of the following conditions are true:

1. Year of Date of Diagnosis is less than 2016, blank (unknown), or invalid
2. Type of Reporting Source = 7 (Death Certificate Only)
3. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
3. TNM Clin Descriptor is blank
4. TNM Clin Descriptor not = 1, 2, 5


This edit verifies that TNM Clin Descriptor codes 1 [E (Extranodal, lymphomas
only)], 2 [S (Spleen, lymphomas only)], and 5 [E & S (Extranodal and spleen,
lymphomas only)] are coded only for lymphoma cases.

If TNM Clin Descriptor = 1, 2, 5 and case is not a lymphoma as specified below, an
error is generated.

Ocular Adnexal Lymphoma:
Primary Site:
    C441, C690, C695-C696
Histologic Type ICD-O-3
    9590-9699, 9702-9738, 9811-9818, 9820-9837

Primary Cutaneous Lymphomas:
Primary Site:
     C440-C449
     C510-C512, C518-C519
     C600-C602, C608-C609, C632
Histologic Type ICD-O-3:
     9700,9701

Neoplasms manifesting as leukemia or lymphoma:
```

```
Primary Site:
      C000-C419,C422-C423,
    C440,C442-C689,
    C691-C694,C698-C809
Histologic Type ICD-O-3:
      9823,9827,9811-9818, 9837

Primary Site:
      C420, C421, C424
Histologic Type ICD-O-3:
      9811-9818, 9837


Other lymphomas:
Primary Site:
    All except C441, C690, C695-C696
Histologic Type ICD-O-3
    9590-9699, 9702-9727, 9735, 9737-9738
```

Administrative Notes

New edit - added to NAACCR v16 metafile
SEER IF599

Modifications

NAACCR v16A
- Error message corrected, field out of order

NAACCR v16B
- Description and Edit Logic modified to include histologies 9811-9818, 9837, with primary site C420, C421, and C424 as lymphoma, according to agreement reached between SEER and COC. Valid TNM Clin Descriptor codes may be coded (but are not required) for these sites and histologies.

NAACCR v16D
- Administrative note for v16B corrected to read that histology 9837 (previously edientified as 9827) was included as lymphoma for primary site C420, C421, C424.

TNM Clin Descriptor, Stage, Lymphoma (COC)

Agency: COC **Last changed: 08/13/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
Histologic Type ICD-O-3 [Std# 522]
Primary Site [Std# 400]
TNM Clin Descriptor [Std# 980]
TNM Clin Stage Group [Std# 970]
Type of Reporting Source [Std# 500]
Behavior Code ICD-O-3 [Std# 523]

Default Error Message

[5002] Conflict between %F5 (%V5) and %F4(%V4) for %F3(%V3) and %F2(%V2)
Conflict between TNM Clin Stage Group ("value of TNM Clin Stage Group") and TNM Clin Descriptor("value of TNM Clin Descriptor") for Primary Site("value of Primary Site") and Histologic Type ICD-O-3("value of Histologic Type ICD-O-3"

Description

```
This edit is skipped if any of the following conditions are true:

1. Year of Date of Diagnosis is less than 2016, blank (unknown), or invalid
2. Type of Reporting Source = 7 (Death Certificate Only)
3. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
4. TNM Clin Descriptor is blank

1. If Histology is 9590-9699,9702-9727,9735,9737,9738,9811-9818,9823,9827,9837
   and Primary site is
C770,C771,C772,C773,C774,C775,C779,C024,C090,C091,C098,C099,C111,C142,C379
   and TNM Clin Stage Group equals 1 (involvement of single lymphatic site)
   then TNM Clin Descriptor must not equal 1 (E, extranodal),2 (S, spleen), or 5
(E&S, Extranodal and spleen).

2. If Histology is 9590-9699,9702-9727,9735,9737,9738,9811-9818,9823,9827,9837
   and Primary site is C422 (spleen)
   then TNM Clin Descriptor must equal 2 (S, spleen).

3. If Histology is 9590-9699,9702-9727,9735,9737,9738,9811-9818,9823,9827,9837
   and Primary site is C778 (involvement of multiple lymph node regions)
   then TNM Clin Stage Group must be greater than or equal to 2 (Involvement of 2
or more lymph node regions).
```

Administrative Notes

New TNM Edit for NAACCR v16

Modifications

NAACCR v16B
- Description and Edit Logic corrected to include 9827 in lists of histology codes checked for this edit

TNM Clin M c,p pre2016 (MCR/NAACCR)

Agency: **Last changed: 02/22/2017**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

TNM Clin M [Std# 960]
Date of Diagnosis [Std# 390]

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of TNM Clin M" is not a valid value for TNM Clin M

Description

```
This edit will check valid TNM Clin M codes, either with or without the "c" or "p"
component.

This edit is skipped if any of the following is true:
      Year of Date of Diagnosis is empty or in valid
      Year of Date of Diagnosis is not 2014-2015
      TNM Clin M is blank

Must be a valid code for TNM Clin M and must be left justified. Subcategory letters
must be uppercase, "c" or "p" if present in code must be lowercase.  May be blank.

The codes in the first column are valid for AJCC 7th Edition.  The codes in the
second column represent converted codes, or codes for pre-2016 cases abstracted in
2016 software.  Codes not included in the list (X, p0, p0I+) will fail the edit.

  0    c0
  0I+  c0I+
  1    c1
       p1
  1A   c1A
       p1A
  1B   c1B
       p1B
  1C   c1C
       p1C
  1D   c1D
       p1D
  1E   c1E
       p1E
  88   88
```

Administrative Notes

New edit for v16 metafile, EC

v16D: NAACCR added skip for empty year of diagnosis

The MCR modification is to run on 2014-2015 diagnoses only. The valid c/p codes are from the 2016 edit "TNM Clin M, Date of Diagnosis (COC)" but mixed-bag codes without c/p are also included.

TNM Clin M, Date of Diagnosis (COC)

Agency: COC **Last changed: 11/19/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

TNM Clin M [Std# 960]
Date of Diagnosis [Std# 390]
TNM Edition Number [Std# 1060]

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of TNM Clin M" is not a valid value for TNM Clin M

Description

```
This edit is skipped if any of the following conditions are true:

1.Diagnosis date < 2016, blank (unknown), or invalid.
2. TNM Clin M is blank.
3. TNM Edition Number not = 07, U7

Must be a valid code for TNM Clin M and must be left-justified. Subcategory letters
must be uppercase, "c" or "p" in code must be lowercase. May be blank.



The following codes are valid for AJCC 7th TNM edition, 2016 diagnosis year:
      c0
    c0I+
      c1
      c1A
      c1B
      c1C
    c1D
    c1E
      p1
      p1A
      p1B
      p1C
    p1D
    p1E
      88
```

Administrative Notes

New edit for v16
SEER IF545

Modifications

NAACCR v16

- Edit logic corrected, expressions using 2,4 changed to 2,3 (start from second character and read for 3 characters, for a 4-character data item).

NAACCR v16D
- Added skip if TNM Edition Number not = 07,U7

TNM Clin N c,p pre2016 (MCR/NAACCR)

Agency: **Last changed: 02/22/2017**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

TNM Clin N [Std# 950]
Date of Diagnosis [Std# 390]

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of TNM Clin N" is not a valid value for TNM Clin N

Description

```
This edit will check valid TNM Clin N codes, either with or without the "c"
component.

This edit is skipped if any of the following is true:
      Yeaer of Date of Diagnosis is empty or invalid
      Year of Date of Diagnosis is not 2014-2015
      TNM Clin N is blank

Must be a valid code for TNM Clin N and must be left justified. Subcategory letters
must be uppercase, "c" if present in code must be lowercase.  May be blank.


The codes in the first column are valid for AJCC 7th Edition.  The codes in the
second column represent converted codes, or codes for pre-2016 cases abstracted in
2016 software:

  X    cX
  0    c0
  0A   c0A
  0B   c0B
  1    c1
  1A   c1A
  1B   c1B
  1C   c1C
   2    c2
  2A   c2A
  2B   c2B
  2C   c2C
  3    c3
  3A   c3A
  3B   c3B
  3C   c3C
  4    c4
  88   88
```

Administrative Notes

New edit for v16 metafile, EC

v16D: NAACCR added skip for empty diagnosis year

The MCR modification is to run on 2014-2015 diagnosis years only. The valid codes are from the 2016 edit "TNM Clin N, Date of Diagnosis (COC)" but mixed-bag codes without "c" are also included. The v16A updates to the underlying edit did not apply.

TNM Clin N, Date of Diagnosis (COC)

Agency: COC **Last changed: 11/19/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

TNM Clin N [Std# 950]
Date of Diagnosis [Std# 390]
TNM Edition Number [Std# 1060]

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of TNM Clin N" is not a valid value for TNM Clin N

Description

```
This edit is skipped if any of the following conditions are true:

1.Diagnosis date < 2016, blank, (unknown), or invalid.
2. TNM Clin N is blank.
3. TNM Edition Number not = 07, U7

Must be a valid code for TNM Clin N and must be left
justified. Subcategory letters must be uppercase, "c" in code must be lowercase.
May be blank.


The following codes are valid for AJCC 7th edition, 2016 diagnosis year:
  cX
  c0
  c0A
  c0B
  c1
  c1A
  c1B
  c1C
  c2
  c2A
  c2B
  c2C
  c3
  c3A
  c3B
  c3C
  c4
  88
```

Administrative Notes

New edit for v16

SEER IF546

Modifications

NAACCR v16D
- Added skip if TNM Edition Number not = 07,U7

TNM Clin Stage Group, 2014-2017 (MCR/COC)

Agency: **Last changed: 02/22/2017**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

TNM Clin Stage Group [Std# 970]
Date of Diagnosis [Std# 390]
TNM Edition Number [Std# 1060]

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of TNM Clin Stage Group" is not a valid value for TNM Clin Stage Group

Description

```
Must be a valid code for TNM Clin Stage Group and must be left-justified. Letters
must be uppercase.

This edit is skipped if Year of Date of Diagnosis < 2014, empty or invalid.
This edit is skipped if TNM Edition Number is not 07 or "U7".

The following AJCC 7th Edition codes are valid:
    0
    0A
    0S
    0IS
    1
    1A
    1A1
    1A2
    1B
    1B1
    1B2
    1C
    1S
    2
    2A
    2A1
    2A2
    2B
    2C
    3
    3A
    3B
    3C
    3C1
    3C2
    4
    4A
    4A1
    4A2
    4B
```

```
    4C
    88
    99
    OC
The field may be blank for pre-2016 diagnoses.
```

Administrative Notes

New for NAACCR v16 metafile - EC

v16D: COC added skip for TNM Edition Number not 07 or "U7".

The MCR modification is to run the 2016 edit on 2014+. Blanks are allowed for pre-2016 diagnoses. v16D: extended 2016 requirements forward (into 2017).

TNM Clin T, Date of Diagnosis (COC)

Agency: COC **Last changed: 11/19/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

TNM Clin T [Std# 940]
Date of Diagnosis [Std# 390]
TNM Edition Number [Std# 1060]

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of TNM Clin T" is not a valid value for TNM Clin T

Description

```
This edit is skipped if any of the following conditions are true:

1.Diagnosis date < 2016, blank (unknown), or invalid.
2. TNM Clin T is blank.
3. TNM Edition Number not = 07, U7

Must be a valid code for TNM Clin T and must be left-justified. Subcategory letters
must be uppercase, "c" or "p" in code must be lowercase.  May be blank.

The following codes are valid for AJCC 7th edition, 2016 diagnosis year:
  cX
  c0
  c1
  c1A
  c1A1
  c1A2
  c1B
  c1B1
  c1B2
  c1C
  c1D
  c1MI
  c2
  c2A
  c2A1
  c2A2
  c2B
  c2C
  c2D
  c3
  c3A
  c3B
  c3C
  c3D
  c4
  c4A
  c4B
```

```
c4C
c4D
c4E
pA
pIS
pISU
pISD
88
```

Administrative Notes

New edit for v16
This edit differs from the SEER version of the edit in that it allows p4 (for Testis)

Modifications

NAACCR v16

- Edit logic corrected, expressions using 2,4 changed to 2,3 (start from second character and read for 3 characters, for a 4-character data item).

NAAACCR v16B
- Description and logic updated, p4 removed as valid value

NAACCR v16D
- Added skip if TNM Edition Number not = 07,U7

TNM Clin T, Date of Diagnosis pre2016 (MCR/COC)

Agency: **Last changed: 02/22/2017**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

TNM Clin T [Std# 940]
Date of Diagnosis [Std# 390]
TNM Edition Number [Std# 1060]

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of TNM Clin T" is not a valid value for TNM Clin T

Description

```
This edit is skipped if any of the following is true:
      Year of Date of Diagnosis is not 2014-2015
      TNM Clin T is blank
      TNM Edition Number is not 07 or "U7"

Must be a valid TNM Clin T code from AJCC 7th Edition and left-justified (4
characters).  Letters must be uppercase other than the c/p prefixes (if present).
X                 cX
0(zero)           c0
IS                      pIS
ISPU              pISU
ISPD              pISD
A                       pA
1                 c1
1A                c1A
1A1               c1A1
1A2               c1A2
1B                c1B
1B1               c1B1
1B2               c1B2
1C                c1C
1D                c1D
1MI               c1MI
2                 c2
2A                c2A
2A1               c2A1
2A2               c2A2
2B                c2B
2C                c2C
2D                c2D
3                 c3
3A                c3A
3B                c3B
3C                c3C
3D                c3D
4                 c4    p4
4A                c4A
```

```
4B                  c4B
4C                  c4C
4D                  c4D
4E                  c4E
88
```

Administrative Notes

New edit - added to MCR v15 metafile.

v16 modification: "TNM Clin T, Date of Diagnosis (COC)" for 2014-2015 diagnoses and AJCC 7th Edition codes. It allows mixed-bag codes with or without the c/p. Updates to the underlying edit in v16A did not apply.

v16D: COC added skip for TNM Edition Number not 07 or "U7"

TNM Clin T, Histology, Grade, Thyroid (CoC)

Agency: COC **Last changed: 05/18/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

TNM Clin T [Std# 940]
TNM Path T [Std# 880]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Grade [Std# 440]
Date of Diagnosis [Std# 390]
Type of Reporting Source [Std# 500]
Behavior Code ICD-O-3 [Std# 523]

Default Error Message

[6055] %F1 of %V1 is not valid where %F2 = %V2 for Anaplastic CA of Thyroid
TNM Clin T of "value of TNM Clin T" is not valid where TNM Path T = "value of TNM Path T" for Anaplastic CA of Thyroid

Description

```
This edit verifies that TNM Clin T is coded consistently for anaplastic carcinomas
of the thyroid when TNM Path T is blank.  Anaplastic carcinomas are identified by
stated grade of 4 or histologic type with implied grade of 4.

This edit is skipped if any of the following conditions are true:

1. Year of Date of Diagnosis is less than 2016, blank (unknown), or invalid
2. Type of Reporting Source = 7 (Death Certificate Only)
4. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
5. Site is not C739
6. TNM Clin T is blank or 88
7. Grade is blank

A.  If Primary Site is Thyroid (C73.9), histology is 8000-8019, 8022-8029, 8033-
8576, 8940-8950, 8980-8981, Grade = 4, and TNM Path T is blank
      then TNM Clin T must = c4, c4A, or c4B

A.  If Primary Site is Thyroid (C73.9), histology is 8020, 8021, 8030, 8031, or
8032 (implied grade of 4) and TNM Path T is blank
      then TNM Clin T must = c4, c4A, or c4B
```

Administrative Notes

New edit - added to NAACCR v16 metafile, EC
SEER IF569

TNM Clin T, N, M, In Situ (COC)

Agency: COC **Last changed: 01/29/2017**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
TNM Clin T [Std# 940]
TNM Clin N [Std# 950]
TNM Clin M [Std# 960]
TNM Clin Stage Group [Std# 970]
Age at Diagnosis [Std# 230]
CS Site-Specific Factor10 [Std# 2864]
CS Site-Specific Factor25 [Std# 2879]
Grade [Std# 440]
Sex [Std# 220]
Type of Reporting Source [Std# 500]
TNM Edition Number [Std# 1060]

Tables

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Default Error Message

[3623] For %F5 (%V5), %F8 (%V8) must be coded in situ stage group
For TNM Clin T ("value of TNM Clin T"), TNM Clin Stage Group ("value of TNM Clin Stage Group") must be coded in situ stage group

Additional Messages

[3621] For TNM Clin T ("value of TNM Clin T"), TNM Clin M ("value of TNM Clin M") must be coded as negative for involvement
[6064] For TNM Clin T ("value of TNM Clin T"), TNM Clin N ("value of TNM Clin N") must be coded as negative for involvement

Description

The purpose of this edit is to verify that TNM Clin N, TNM Clin M, and TNM Clin Stage Group are coded consistently for cases where TNM Clin T indicates an in situ tumor(TNM Clin T = pIS, pA, pISU, pISD, or pA).

This edit enforces the statement in the AJCC manual on page 12: "Carcinoma in situ (CIS) is an exception to the stage grouping guidelines. By definition, CIS has not involved any structure in the primary organ that would allow tumor cells to spread to regional nodes or distant sites.

This edit is skipped if any of the following conditions are true:
1. Year of Date of Diagnosis is less than 2016, blank (unknown), or invalid
2. Type of Reporting Source = 7
3. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
4. TNM Clin T is not = pIS, pA, pISU, pISD, or pA
5. TNM Edition Number not = 07, U7

If TNM Clin T = pIS, pA, pISU, or pISD:

TNM Clin N must = c0, c0A, c0B (no clinically positive nodes)
TNM Clin M must = c0, c0I+ (metastasis clinically negative)
TNM Clin Stage Group must = 0, 0A, or 0IS (stage group clinical = in situ)

Only TNM Clin and TNM Clin M are edited for the following TNM groups. In situ carcinomas are recognized by AJCC, but there is no stage grouping.

49. Carcinoma of Conjunctiva
50. Malignant Melanoma of Conjunctiva

This edit is skipped for the following TNM groups (AJCC does not recognize or does not stage in situ tumors for these sites, though in situ may be assigned by a pathologist):
7. Major Salivary Glands
8. Thyroid Gland (08A-08F)
9. Mucosal Melanoma Head and Neck
13B. Appendix, Carcinoid
16. GIST
17. NET Small Intestine and Ampulla of Vater, NET Colon and Rectum (17B, 17C)
18. Liver
36B. Corpus Sarcoma
36C. Corpus Adenosarcoma
37A. Ovary
39. Gestational Trophoblastic Tumors
41. Prostate
43. Kidney
47. Adrenal (47A, 47B)
51A. Melanoma of Choroid
51B. Melanoma of Iris
53. Carcinoma of the Lacrimal Gland
54. Sarcoma of the Orbit
57B. Primary Cutaneous Lymphoma

Administrative Notes

New edit - added to NAACCR v16B metafile

Modifications

NAACCR v16D
- Added skip if TNM Edition Number not = 07,U7
- Modified logic, format of character string, e.g. "cxxb", 2,3
- In the SEER*Edits software the title of this edit is IF623
- Logic corrected to skip for site/histo group 009, Mucosal Melanoma of Head and Neck
- Logic corrected for invalid MATCH pattern If (not MATCH (#S"TNM Clin M", "c0, c0I{!+}")) (does not account for trailing blanks in field). Replaced with INLIST (no match mask).

TNM Clin T, Surgery, Prostate (CoC)

Agency: COC **Last changed: 01/12/2017**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

TNM Clin T [Std# 940]
RX Summ--Surg Prim Site [Std# 1290]
Date of Diagnosis [Std# 390]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Type of Reporting Source [Std# 500]
Behavior Code ICD-O-3 [Std# 523]

Default Error Message

[3627] Prostate: If %F1 = %V1, %F2 must not = 00 or 99
Prostate: If TNM Clin T = "value of TNM Clin T", RX Summ--Surg Prim Site must not = 00 or 99

Description

```
This edit is skipped if any of the following conditions are true:

1. Year of Date of Diagnosis is less than 2016, blank (unknown), or invalid
2. Type of Reporting Source = 7
3. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
4. TNM Clin T is blank or 88
5. RX Summ--Surg Prim Site is blank


If Primary Site = C619
  and Histologic Type ICD-O-3 = 8000-8110, 8140-8576, 8940-8950, 8980-8981
Then
    If TNM Clin T = c1A or c1B (codes indicating TURP was done)
    Then
        RX Summ--Surg Prim Site must not = 00 or 99
```

Administrative Notes

New edit - added to NAACCR v16 metafile
IF570

Modifications

NAACCR v16D
- Modified format of character string, e.g. "cxxb",2,3

TNM Edition Number, Date of Diagnosis (MCR/NPCR)

Agency: **Last changed: 02/22/2017**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

TNM Edition Number [Std# 1060]
Date of Diagnosis [Std# 390]
Type of Reporting Source [Std# 500]
Class of Case [Std# 610]

Default Error Message

[4627] %F1 must = 07 or 88
TNM Edition Number must = 07 or 88

Description

```
This edit is skipped if any of the following is true:
1. Year of Date of Diagnosis is less than 2014, blank (unknown), or invalid
2. TNM Edition Number = blank and Diagnosis Year is 2015.
3. Year of Date of Diagnosis is 2016-2017 and Type of Reporting Source is 6 or 7
and TNM Edition Number is blank.
4. Year of Date of Diagnosis is 2016-2017 and Class of Case is 38 or 49 and TNM
Edition Number is blank.

TNM Edition Number may be blank if diagnosis year is prior to 2016.
If diagnosis year is 2015 and TNM Edition Number is not blank, then it must = 07 or
88.
If diagnosis year is 2016-2017, TNM Edition number must = 07 or 88 unless Autopsy-
Only or DCO (Type of Reporting Source = 6 or 7, or Class of Case = 38 or 49). For
Autopsy-Only or DCO TNM Edition Number must = blank, 07 or 88.
```

Administrative Notes

New edit - added to NAACCR v14 metafile.

This NPCR edit differs from the COC edit of the same name as follows:
1. This edit is skipped if year of Date of Diagnosis is less than 2014
2. The only allowable codes for TNM Edition are 07, 88, or blanks.

Modifications:

NAACCR v14A
- Edit logic fixed so that edit will be skipped if TNM Edition Number is blank

NAACCR V16
-Updated to reflect 2016 requirements. If diagnosis year is 2016 TNM Edition number may not be blank and it must equal 07 or 88 (not applicable) unless type of reporting source equals 6 or 7. If type of reporting source is 6 or 7 and diagnosis year is 2016, then TNM edition number must be blank, 07, or 88.

MCR modification is to add Class of Case to identify Autopsy-Only and DCO cases.

v16D: NPCR extended 2016 requirements into 2017.

TNM Groups Beh 3 with Insitu 88 (CoC)

Agency: COC **Last changed: 10/01/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
TNM Clin T [Std# 940]
TNM Clin N [Std# 950]
TNM Clin M [Std# 960]
TNM Clin Stage Group [Std# 970]
TNM Path T [Std# 880]
TNM Path N [Std# 890]
TNM Path M [Std# 900]
TNM Path Stage Group [Std# 910]
Age at Diagnosis [Std# 230]
CS Site-Specific Factor10 [Std# 2864]
CS Site-Specific Factor25 [Std# 2879]
Grade [Std# 440]
Sex [Std# 220]
Type of Reporting Source [Std# 500]

Tables

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Default Error Message

[6057] For %F2 (%V2), %F3 (%V3), and %F4 (%V4), all TNM fields must not =88
For Primary Site ("value of Primary Site"), Histologic Type ICD-O-3 ("value of Histologic Type ICD-O-3"), and Behavior Code ICD-O-3 ("value of Behavior Code ICD-O-3"), all TNM fields must not =88

Description

This edit is skipped if any of the following conditions are true:

1. Year of Date of Diagnosis is less than 2016, blank (unknown), or invalid
2. Type of Reporting Source = 7 (Death Certificate Only)
3. Behavior Code ICD-O-3 = 0 (benign), 1 (borderline), or 2 (in situ)

For following TNM Groups, if Behavior Code ICD-O-3 is 3, then TNM Clin T, TNM Clin N, TMN Clin M, TNM Clin Stage Group, TNM Path T, TNM Path N, TNM Path M, and TNM Path Stage Group must not = 88. AJCC does not consider these cases stageable for in situ, but they are stageable for invasive behavior. ("88" is allowed for TNM Clin N and TNM Path N for site/histology group 039, Gestational Trophoblastic Tumors. "88" is allowed for TNM Clin Stage Group and TNM Path Stage Group for site/histology groups 053, Carcinoma of Lacrimal Gland, and 054, Sarcoma of Orbit.)

```
7.   Major Salivary Glands
8.   Thyroid Gland (08A-08F)
9.   Mucosal Melanoma of the Head and Neck
13B. Appendix: Carcinoid
16.  GIST (16A-16B)
17B. NET: Small Intestine and Ampulla of Vater
17C. NET: Colon and Rectum
18.  Liver
36B. Corpus Sarcoma
36C. Corpus Adenosarcoma
37A. Ovary
39.  Gestational Trophoblastic Tumors
41.  Prostate
43.  Kidney
47.  Adrenal (47A, 47B)
51A. Melanoma of Choroid
51B. Melanoma of Iris
53.  Carcinoma of the Lacrimal Gland
54.  Sarcoma of the Orbit
57B. Primary Cutaneous Lymphomas
```

Administrative Notes

New edit - added to NAACCR v16 metafile

Modifications

NAACCR v16A

- Corrected logic for first INLIST of primary sites for site/histology group 57A, 000-419-440 changed to 000-440
- Corrected logic to edit for site/histology groups 36B and 36C rather than 36A and 36B.
- Corrected Edit Logic to include 9727 as lymphoma rather than lymphoma/leukemia code, to delete 9728-9729 as obsolete codes
- Added Group 57C, C420, C421, C424, 9811-9818, 9837,to Edit Logic

NAACCR v16B
- Corrected Description and Edit Logic for site/histology groups 053,054, edit does not fail on TNM Clin Stage Group = 88 or TNM Path Stage Group = 88 for 053,054
- Added check for Behavior Code ICD-O-3 for site/histology group 039
- Corrected edit logic for assigning site/histology group 011 to group 10B or 999 based on histology and CS Site-Specific Factor 25

TNM Groups Not Stageable - Insitu (CoC)

Agency: COC **Last changed: 10/01/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
TNM Clin T [Std# 940]
TNM Clin N [Std# 950]
TNM Clin M [Std# 960]
TNM Clin Stage Group [Std# 970]
TNM Path T [Std# 880]
TNM Path N [Std# 890]
TNM Path M [Std# 900]
TNM Path Stage Group [Std# 910]
Age at Diagnosis [Std# 230]
CS Site-Specific Factor10 [Std# 2864]
CS Site-Specific Factor25 [Std# 2879]
Grade [Std# 440]
Sex [Std# 220]
Type of Reporting Source [Std# 500]

Tables

AC7G2016.DBF

Additional Messages

[3612] For Primary Site ("value of Primary Site"), Histologic Type ICD-O-3 ("value of Histologic Type ICD-O-3"), and Behavior Code ICD-O-3 ("value of Behavior Code ICD-O-3"): all TNM fields must = 88
SAVE_TEXT("t_tnm_msg")

Description

```
This edit is skipped if any of the following conditions are true:
1. Year of Date of Diagnosis is less than 2016, blank (unknown), or invalid
2. Type of Reporting Source = 7 (Death certificate only)
3. Behavior Code ICD-O-3 = 0 (benign), 1 (borderline), or 3 (invasive)


For following TNM Groups, if Behavior Code ICD-O-3 is 2, then TNM Clin T, TNM Clin
N, TMN Clin M, TNM Clin Stage Group, TNM Path T, TNM Path N, TNM Path M, and TNM
Path Stage Group must all = 88. AJCC does not consider these cases stageable.

  7.   Major Salivary Glands
  8.   Thyroid Gland (08A-08F)
  9.   Mucosal Melanoma of the Head and Neck
  13B. Appendix: Carcinoid
```

```
16.  GIST (16A-16B)
17B. NET: Small Intestine and Ampulla of Vater
17C. NET: Colon and Rectum
18.  Liver
36B. Corpus Sarcoma
36C. Corpus Adenosarcoma
37A. Ovary
39.  Gestational Trophoblastic Tumors
41.  Prostate
43.  Kidney
47.  Adrenal (47A, 47B)
51A. Melanoma of Choroid
51B. Melanoma of Iris
53.  Carcinoma of the Lacrimal Gland
54.  Sarcoma of the Orbit
57B. Primary Cutaneous Lymphomas
```

Administrative Notes

New edit - added to NAACCR v16 metafile
SEER IF601

Modifications

NAACCR v16A
- Corrected logic for first INLIST of primary sites for site/histology group 57A, 000-419-440 changed to 000-440
- Changed default error message to 3612, added Primary Site value to list of fields returned by error message.
- Corrected logic to edit for site/histology groups 36B and 36C rather than 36A and 36B.
- Corrected Edit Logic to include 9727 as lymphoma rather than lymphoma/leukemia code, to delete 9728-9729 as obsolete codes
- Added Group 57C, C420, C421, C424, 9811-9818, 9837,to Edit Logic

NAACCR v16B
- Corrected edit logic for assigning site/histology group 011 to group 10B or 999 based on histology and CS Site-Specific Factor 25

TNM Path Descriptor, Date of Diagnosis (NPCR)

Agency: NPCR **Last changed: 03/22/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

TNM Path Descriptor [Std# 920]
Date of Diagnosis [Std# 390]

Default Error Message

[4628] %F1 must =0-6 or 9
TNM Path Descriptor must =0-6 or 9

Description

```
This edit is skipped if any of the following conditions are true:

1. Year of Date of Diagnosis is less than 2014, blank (unknown), or invalid
2. TNM Path Descriptor is blank


Must be a valid TNM Path Descriptor code (0-6, 9).
```

Administrative Notes

New edit - added to NAACCR v14 metafile.

This NPCR edit differs from the COC edit of the same name as follows:
- This edit is skipped if year of Date of Diagnosis is less than 2014

TNM Path Descriptor, RX Dates - Ed 7 (CoC)

Agency: COC **Last changed: 05/04/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
TNM Edition Number [Std# 1060]
Behavior Code ICD-O-3 [Std# 523]
TNM Path Descriptor [Std# 920]
RX Date Mst Defn Srg [Std# 3170]
RX Date Radiation [Std# 1210]
RX Date Radiation Flag [Std# 1211]
RX Date BRM [Std# 1240]
RX Date BRM Flag [Std# 1241]
RX Date Chemo [Std# 1220]
RX Date Chemo Flag [Std# 1221]
RX Date Hormone [Std# 1230]
RX Date Hormone Flag [Std# 1231]
RX Date Other [Std# 1250]
RX Date Other Flag [Std# 1251]

Default Error Message

[3590] If %F4 = %V4, at least one rx date must be less than %F5 (%V5) or date flag = 12
If TNM Path Descriptor = "value of TNM Path Descriptor", at least one rx date must be less than RX Date Mst Defn Srg ("value of RX Date Mst Defn Srg") or date flag = 12

Description

```
This edit is skipped if any of the following conditions are true:

1. Year of Date of Diagnosis is less than 2016 or blank (unknown)
2. TNM Edition Number is not = 07
3. TNM Path Descriptor is blank
4. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
5. RX Date Mst Defn Srg is blank


If TNM Path Descriptor = 4 [Y (Classification after initial multimodality therapy)—
pathologic staging only] or 6 [M & Y (Multiple primary tumors and initial
multimodality therapy)]
Then
    At least one of the following dates must be less than RX Date Mst Defn Srg. If
any are blank, then the associated date flag is checked and, if equal to 12
(treatment given, date unknown), the edit will pass.
      RX Date Radiation/RX Date Radiation Flag
      RX Date BRM/RX Date BRM Flag
      RX Date Chemo/RX Date Chemo Flag
      RX Date Hormone/RX Date Hormone Flag
      RX Date Other/RX Date Other Flag
```

Partial Dates:
1. When comparisons include partial dates, the treatment date can be less than or equal to the RX Date Mst Defn Srg.
2. When comparing dates, if both years are known, but either month is blank, then only the years are compared and may be equal. If either day is blank, then only the years and months are compared. Consequently, the edit may pass due to not having enough information to compare beyond years or year/month. For example, a RX Date Radiation of 201403 (ccyymm), when compared to RX Date Mst Defn Srg of 20140315 (ccyymmdd), will pass because the edit has to assume that the unknown dd portion of RX Date Radiation could be less than the dd portion of RX Date Mst Defn Srg.

Administrative Notes

New edit - added to NAACCR v16 metafile, EC

TNM Path M, Date of Diagnosis (COC)

Agency: COC **Last changed: 01/29/2017**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

TNM Path M [Std# 900]
Date of Diagnosis [Std# 390]
TNM Edition Number [Std# 1060]

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of TNM Path M" is not a valid value for TNM Path M

Description

```
This edit is skipped if any of the following conditions are true:

1.Diagnosis date < 2016, blank (unknown), or invalid.
2. TNM Path M is blank.
3. TNM Edition Number not = 07, U7

Must be a valid code for TNM Path M and must be left-justified. Subcategory letters
must be uppercase, "c" or "p" in code must be lowercase.  May be blank.



The following codes are valid for AJCC 7th edition, 2016 diagnosis year:
c0
c0I+
c1
c1A
c1B
c1C
c1D
c1E
p1
p1A
p1B
p1C
p1D
p1E
88
```

Administrative Notes

New edit for v16
SEER IF548

Modifications

NAACCR v16A

- c0I+ and 88 added to Description as allowable values for TNM Path M

NAACCR v16D
- Added skip if TNM Edition Number not = 07,U7
- Edit logic: Corrected MATCH mask for code C0I+ (removed trailing blank)

TNM Path M, Date of Diagnosis pre2016 (MCR/COC)

Agency: **Last changed: 02/22/2017**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

TNM Path M [Std# 900]
Date of Diagnosis [Std# 390]
TNM Edition Number [Std# 1060]

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of TNM Path M" is not a valid value for TNM Path M

Description

```
This edit is skipped if any of the following is true:
      Year of Date of Diagnosis is not 2014-2015
      TNM Edition Number is not 07 or "U7"
      TNM Path M is blank

Must be a valid code for TNM Path M and must be left-justified. Subcategory letters
must be uppercase, "c" or "p" in code must be lowercase.

The following codes are valid for AJCC 7th Edition:

0     c0
0I+   c0I+
1     c1     p1
1A    c1A    p1a
1B    c1B    p1B
1C    c1C    p1C
1D    c1D    p1D
1E    c1E    p1E
88
```

Administrative Notes

New edit for v16, EC
SEER IF548

MCR modification: checks these AJCC 7th Edition codes for 2014-2015 with mixed-bag of c/p present or absent

16D: COC added skip for TNM Edition Number not 07 or "U7"; removed trailing blank code "b" from c0I+ match.

TNM Path N, Date of Diagnosis (COC)

Agency: COC **Last changed: 11/19/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

TNM Path N [Std# 890]
Date of Diagnosis [Std# 390]
TNM Edition Number [Std# 1060]

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of TNM Path N" is not a valid value for TNM Path N

Description

```
This edit is skipped if any of the following conditions are true:

1.Diagnosis date < 2016, blank (unknown), or invalid.
2.TNM Path N is blank.
3.TNM Edition not = 07,U7

Must be a valid code for TNM Path N and must be left justified.  Subcategory
letters must be upper case, "c" or "p" in code must be lowercase.  May be blank.

The following codes are valid for AJCC 7th edition, 2016 diagnosis year:
pX
p0
p0I-
p0I+
p0M-
p0M+
p1
p1A
p1B
p1C
p1M
p1MI
p2
p2A
p2B
p2C
p3
p3A
p3B
p3C
p4
c0
88
p0A
p0B
```

Administrative Notes

New edit for v16
SEER IF549

Modifications

NAACCR v16A
- Added p0A, p0B to description, edit logic. Codes allowed by COC and SEER for Melanoma of Conjunctiva for pathologic N.

NAACCR v16D
- Added skip if TNM Edition Number not = 07,U7

TNM Path N, Date of Diagnosis pre2016 (MCR/COC)

Agency: **Last changed: 02/22/2017**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

TNM Path N [Std# 890]
Date of Diagnosis [Std# 390]
TNM Edition Number [Std# 1060]

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of TNM Path N" is not a valid value for TNM Path N

Description

```
This edit is skipped if any of the following is true:
      Year of Date of Diagnosis is not 2014-2015
      TNM Edition Number is not 07 or "U7"
      TNM Path N is blank

Must be a valid code for TNM Path N and must be left justified.  Subcategory
letters must be upper case, "c" or "p" (if present) must be lowercase.

The following codes are valid for AJCC 7th Edition:

X           pX
0     c0    p0
0I-         p0I-
0I+         p0I+
0M-         p0M-
0M+         p0M+
1           p1
1A          p1A
1B          p1B
1C          p1C
1MI         p1MI
2           p2
2A          p2A
2B          p2B
2C          p2C
3           p3
3A          p3A
3B          p3B
3C          p3C
4           p4
88
```

Administrative Notes

New edit for v16, EC
SEER IF549

MCR modification is checking for AJCC 7th Edition codes in 2014-2015 diagnoses with mixed-bag c/p present or absent.

16D: COC added skip for TNM Edition Number not 07 pr "U7"

TNM Path N, Reg Nodes Ex - Ed 7 (MCR/CoC)

Agency: **Last changed: 02/22/2017**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
Type of Reporting Source [Std# 500]
Behavior Code ICD-O-3 [Std# 523]
TNM Path N [Std# 890]
Regional Nodes Examined [Std# 830]
Class of Case [Std# 610]

Default Error Message

[6065] If %F5 = 00 or 99, %F4 must = pX, c0, or blank
If Regional Nodes Examined = 00 or 99, TNM Path N must = pX, c0, or blank

Description

```
This edit is skipped if any of the following is true:

1. Year of Date of Diagnosis is less than 2016, blank (unknown), or invalid
2. Autopsy-Only (Type of Reporting Source = 6 or Class of Case = 38) or DCO (Type
of Reporting Source = 7 or Class of Case = 49)
3. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
3. TNM Path N is blank or 88
4. Regional Nodes Examined is blank



IF Regional Nodes Examined = 00 or 99
Then
    TNM Path N must = pX, c0, or blank
```

Administrative Notes

New edit - added to NAACCR v16 metafile, EC
SEER IF579

MCR modification is to define Autopsy-Only and DCO using Class of Case in addition to Type of Reporting Source.

TNM Path N, Reg Nodes Pos - Ed 7 (MCR/COC)

Agency: **Last changed: 02/22/2017**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
Type of Reporting Source [Std# 500]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
TNM Path N [Std# 890]
Regional Nodes Positive [Std# 820]
Class of Case [Std# 610]
TNM Edition Number [Std# 1060]

Default Error Message

[3587] If %F6 = %V6, %F7 must not = 00, 98, 99
If TNM Path N = "value of TNM Path N", Regional Nodes Positive must not = 00, 98, 99

Description

```
This edit is skipped if any of the following is true:

1. Year of Date of Diagnosis is less than 2016, blank (unknown), or invalid
2. Case is autopsy only (Type of Reporting Source = 6 or Class of Case = 38) or
death certificate only (Type of Reporting Source = 7 or Class of Case = 49)
3. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
4. TNM Edition Number is not 07 or "U7"
5. TNM Path N is blank or 88
6. Regional Nodes Positive is blank

At least one positive lymph node is required if TNM Pathologic N is 1 or higher.

If the second character of TNM Path N = 1, 2, or 3, indicating metastasis in at
least one lymph node
Then
      Regional Nodes Positive must not = 00 (all nodes examined are negative), 98
(no nodes were examined), 99 (unknown whether nodes are positive)

The following TNM site/histology groups/Path N codes are exceptions to the above
and will not generate errors:

Chapter 14: Colon and Rectum
  TNM Path N = p1C (tumor deposits)

Chapter 31: Melanoma of the Skin
  TNM Path N = p2C (satellite nodules)

Chapter 30: Merkel Cell Carcinoma
  TNM Path N = p2 (in-transit metastases)
```

```
Chapter 52: Retinoblastoma
  TNM Path N = p2 (distant nodes)

Chapter 55: Ocular Adnexal Lymphoma
  TNM Path N = p3 or p4 (distant nodes)
```

Administrative Notes

New edit - added to NAACCR v16 metafile, EC
SEER IF580

MCR modification is to define Autopsy-Only and DCO using Class of Case in addition to Type of Reporting Source.

v16D: COC added skip for TNM Edition Number not 07 or "U7"; changed matching of codes using blanks and "2,3"

TNM Path N, Reg Nodes Pos,Ex, Breast - Ed 7 (CoC)

Agency: COC **Last changed: 01/29/2017**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
TNM Path N [Std# 890]
Regional Nodes Positive [Std# 820]
Regional Nodes Examined [Std# 830]
Type of Reporting Source [Std# 500]
TNM Edition Number [Std# 1060]
TNM Path Descriptor [Std# 920]

Default Error Message

[4991] Conflict among %F4 (%V4), %F5 (%V5), %F6 (%V6)
Conflict among TNM Path N ("value of TNM Path N"), Regional Nodes Positive ("value of Regional Nodes Positive"), Regional Nodes Examined ("value of Regional Nodes Examined"

Description

```
This edit verifies that nodes are examined for "0I-", "0I+", "0M-", and "0M+
categories, and that ITCs are not considered positive nodes for breast.

This edit is skipped if any of the following conditions are true:

1. Year of Date of Diagnosis is less than 2016, blank (unknown),or invalid
2. Type of Reporting Source = 7 (Death Certificate Only)
3. Site/histology group is not 032 (Breast)
4. TNM Path N is blank or 88
5. Regional Nodes Positive is blank
6. Regional Nodes Examined is blank
7. TNM Edition Number not = 07, U7
8. TNM Path Descriptor = 4,6



If TNM Path N = p0I+, p0I-, p0M+, p0M-
      then Regional Nodes Examined must not = 00, 99 (no nodes examined or unknown
if    nodes examined)
      Regional Nodes Positive must = 00 (all nodes examined are negative)
```

Administrative Notes

New edit - added to NAACCR v16 metafile
SEER IF581

Modifications

NAACCR v16A
- Error message corrected, field out of order

NAACCR v16D
- Added skip if TNM Edition Number not = 07,U7
- Added skip if TNM Path Descriptor = 4,6
- Corrected MATCH mask for p0I+, p0I-, p0M+, p0M- to accommodate EDITS50 regular expressions processor.

TNM Path N, RNP, Site Spec - Ed 7, ICDO3 (COC)

Agency: COC **Last changed: 01/05/2017**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Regional Nodes Positive [Std# 820]
TNM Path N [Std# 890]
Date of Diagnosis [Std# 390]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor10 [Std# 2864]
CS Site-Specific Factor25 [Std# 2879]
Grade [Std# 440]
Age at Diagnosis [Std# 230]
Sex [Std# 220]
Type of Reporting Source [Std# 500]
TNM Edition Number [Std# 1060]
TNM Path Descriptor [Std# 920]

Tables

AC7G2016.DBF
PATHNNUM.DBF

Default Error Message

[3038] TNM stage problem
TNM stage problem

Additional Messages

[6028] TNM Path N of "value of TNM Path N" is not consistent with Regional Nodes Positive of "value of Regional Nodes Positive"
SAVE_TEXT("t_tnm_msg")

Description

```
This edit is skipped if any of the following conditions are true:

1. Year of Date of Diagnosis is less than 2016, blank unknown), or invalid
2. Type of Reporting Source = 7 (Death Certificate Only)
3. Histologic Type ICD-O-3 is blank
4. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
5. Site/Histology where Path N is not dependent on number of positive nodes
6. TNM Path N is blank or 88
7. Regional Nodes Positive is empty
8. Regional Nodes Positive is coded "95", "Positive aspiration of lymph nodes
performed".
```

9. Regional Nodes Positive is coded "97", "Positive nodes are documented but the number is unspecified".
10. TNM Edition Number not = 07, U7
11. TNM Path Descriptor = 4,6

TNM Path N may be blank. If entered, it will be edited site-specifically. A pN category entered in TNM Path N will be compared to Regional Nodes Positive. An edit failure will be returned if the number of positive nodes is outside the range of positive nodes for the listed pN category. "90", "90 or more nodes are positive", is the highest possible number of positive nodes.

The site-specific TNM Pathologic N values with the corresponding number of positive regional nodes are listed below. The number next to each site title indicates the respective chapter in the AJCC Cancer Staging Manual, Edition 7. The list includes only those sites/histology groups where pathologic N is based on the number of positive regional nodes. The site/histology groups are identified by site and histology in the edits Primary Site, AJCC Stage Group 2016 - Ed 7 (COC), Primary Site, Stage Group 2016 - Ed 7 (NPCR), and Primary Site, Stge Group 2016 - Ed 7 (SEER).

3. Lip and Oral Cavity

TNM N:		1,2A 2B
Reg Nodes Pos	01-01	02-90

4. Pharynx

4A. Oropharynx and Hypopharynx
4D. Oroopharynx

TNM N:		1,2A 2B
Reg Nodes Pos	01-01	02-90

5. Larynx

5A. Supraglottis, Subglottis, Other
5B. Glottis

TNM N:		1,2A 2B
Reg Nodes Pos	01-01	02-90

6. Nasal Cavity and Paranasal Sinuses

TNM N:		1,2A 2B
Reg Nodes Pos	01-01	02-90

7. Major Salivary Glands

TNM N:		1,2A 2B
Reg Nodes Pos	01-01	02-90

10. Esophagus and Esophagus Gastric Junction

10A. Esophagus
10B. Esophagus Gastric Junction

TNM N:		1	2	3
Reg Nodes Pos	01-02	03-06	07-90	

11. Stomach

TNM N:		1	2	3	3A	3B
Reg Nodes Pos	01-02	03-06	>06	07-15	16-90	

12. Small Intestine

TNM N:		1	2
Reg Nodes Pos	01-03	04-90	

13. Appendix

13A. Appendix: Carcinoma

TNM N:		1	2
Reg Nodes Pos	01-03	04-90	

14. Colon and Rectum

TNM N:		1	1A	1B	2	2A	2B
Reg Nodes Pos	01-03	01-01	02-03	04-90	04-06	07-90	

29. Cutaneous Squamous Cell Carcinoma and other Cutaneous Carcinomas

TNM N:		1,2A	2B
Reg Nodes Pos	01-01	02-90	

31. Melanoma of the Skin

TNM N:		1	1A	1B	2A	2B
Reg Nodes Pos	01-01	01-01	01-01	02-03	02-03	

32. Breast

TNM N:		1A	2A
Reg Nodes Pos	01-03	04-09	

33. Vulva

TNM N:		1	1A	1B	2A	2B
Reg Nodes Pos	01-02	01-02	01-01	03-90	02-90	

40. Penis

TNM N:		1	2
Reg Nodes Pos	01-01	02-90	

42. Testis

TNM N:		1
Reg Nodes Pos	01-05	

44. Renal Pelvis and Ureter

TNM N:		1
Reg Nodes Pos	01-01	

```
45. Urinary Bladder

TNM N:                    1           2
Reg Nodes Pos     01-01 02-90

46. Urethra

TNM N:                    1
Reg Nodes Pos     01-01
```

Administrative Notes

New edit - added to NAACCR v16 metafile

Modifications

NAACCR v16A

- Corrected logic for first INLIST of primary sites for site/histology group 57A, 000-419-440 changed to 000-440
- Corrected Edit Logic to include 9727 as lymphoma rather than lymphoma/leukemia code, to delete 9728-9729 as obsolete codes
- Added Group 57C, C420, C421, C424, 9811-9818, 9837,to Edit Logic

NAACCR v16B
- Description updated to reference 3 edits where site/histology groups are identified: Primary Site, AJCC Stage Group 2016 - Ed 7 (COC), Primary Site, Stage Group 2016 - Ed 7 (NPOCR), and Primary Site, Stage Group 2016 - Ed 7 (SEER).
- In the SEER*Edits software, the title of this edit is: IF614
- Corrected edit logic for assigning site/histology group 011 to group 10B or 999 based on histology and CS Site-Specific Factor 25

NAACCR v16D
- Added skip if TNM Edition Number not = 07,U7
- Added skip if TNM Path Descriptor = 4,6
- Site/group 13B, Appendix Carcinoid, deleted from edit
- Description and table referenced by edit updated: For site/histology groups 003, 04A, 04D, 05A, 05B, 006, 007, 029:N2C, 02-90 deleted

TNM Path Stage Group, 2014-2017 (MCR/COC)

Agency: **Last changed: 02/22/2017**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

TNM Path Stage Group [Std# 910]
Date of Diagnosis [Std# 390]
TNM Edition Number [Std# 1060]

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of TNM Path Stage Group" is not a valid value for TNM Path Stage Group

Description

```
Must be a valid code for TNM Path Stage Group and must be left-justified. Letters
must be uppercase.

This edit is skipped if Year of Date of Diagnosis < 2014, blank (unknown), or
invalid.

This edit is skipped if TNM Edition Number is not 07 or "U7".

The following codes are valid for AJCC 7th Edition:
    0
    0A
    0S
    0IS
    1
    1A
    1A1
    1A2
    1B
    1B1
    1B2
    1C
    1S
    2
    2A
    2A1
    2A2
    2B
    2C
    3
    3A
    3B
    3C
    3C1
    3C2
    4
    4A
    4A1
```

```
    4A2
    4B
    4C
    88
    99
    OC
The field may be blank for pre-2016 diagnoses.
```

Administrative Notes

New for NAACCR v16 metafile - EC

MCR modification extends the 2016 edit back to 2014 diagnoses. Blanks are allowed for pre-2016 diagnoses. Source edit is "TNM Path Stage Group, 2016 (COC)".

v16D: COC added skip for TNM Edition Number not 07 or "U7". 2016 requirements are extended into 2017.

TNM Path Stg Grp, Prim Site, Surg - Ed 7 (MCR/CoC)

Agency: **Last changed: 07/01/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
Type of Reporting Source [Std# 500]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
TNM Path Stage Group [Std# 910]
RX Summ--Surg Prim Site [Std# 1290]
Class of Case [Std# 610]

Default Error Message

[3610] For %F3 (%V3), %F4 (%V4), %F6 (%V6): %F7 (%V7) must = 20 - 90
For Primary Site ("value of Primary Site"), Histologic Type ICD-O-3 ("value of Histologic Type ICD-O-3"), TNM Path Stage Group ("value of TNM Path Stage Group"): RX Summ--Surg Prim Site ("value of RX Summ--Surg Prim Site") must = 20 - 90

Additional Messages

[3609] For Primary Site ("value of Primary Site"), Histologic Type ICD-O-3 ("value of Histologic Type ICD-O-3"), TNM Path Stage Group ("value of TNM Path Stage Group"): RX Summ--Surg Prim Site ("value of RX Summ--Surg Prim Site") must = 30-90.

Description

```
This edit is skipped if any of the following is true:

1. Year of Date of Diagnosis is less than 2016, blank (unknown), or invalid
2. Case is autopsy only (Type of Reporting Source = 6 or Class of Case = 38) or DCO
(Type of Reporting Source = 7 or Class of Case = 49)
3. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
4. TNM Path Stage Group is blank or 88
5. RX Summ--Surg Prim Site is blank

Definitive surgical resection is required for TNM Path Stage Group 0, 0IS, and 0A.

A. For all site/histology groups except Urinary Bladder (Chapter 45):

If TNM Path Stage Group = 0, 0IS, OA
Then
    RX Summ--Surg Prim Site must be equal to or greater than 20
    and not equal 99 (unknown)

B. For TNM site/histology group Urinary Bladder:

If TNM Path Stage Group = 0IS or 0A
Then
```

```
RX Summ--Surg Prim Site must be equal to or greater than 30
and not equal 99 (unknown)
```

Administrative Notes

New edit - added to NAACCR v16 metafile, EC
SEER IF584

MCR modification is to define Autopsy-Only and DCO using Class of Case in addition to Type of Reporting Source.

TNM Path T, Date of Diagnosis (COC)

Agency: COC **Last changed: 11/19/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

TNM Path T [Std# 880]
Date of Diagnosis [Std# 390]
TNM Edition Number [Std# 1060]

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of TNM Path T" is not a valid value for TNM Path T

Description

```
This edit is skipped if any of the following conditions are true:

1.Diagnosis date < 2016, blank (unknown), or invalid
2. TNM Path T is blank.
3. TNM Edition Number not = 07, U7

Must be a valid code for TNM Path T and must be left-justified.Subcategory letters
must be uppercase,"p" in code must be lowercase.  May be blank.

The following codes are valid for AJCC 7th edition, 2016 diagnosis year:
  pX
  p0
  pIS
  pISU
  pISD
  pA
  p1
  p1A
  p1A1
  p1A2
  p1B
  p1B1
  p1B2
  p1C
  p1D
  p1MI
  p2
  p2A
  p2A1
  p2A2
  p2B
  p2C
  p2D
  p3
  p3A
  p3B
  p3C
```

```
p3D
p4
p4A
p4B
p4C
p4D
p4E
88
```

Administrative Notes

New edit for v16
SEER IF550

Modifications

NAACCR v16

- Edit logic corrected, expressions using 2,4 changed to 2,3 (start from second character and read for 3 characters, for a 4-character data item).

NAACCR v16D
- Added skip if TNM Edition Number not = 07,U7

TNM Path T, Date of Diagnosis pre2016 (MCR/COC)

Agency: **Last changed: 02/22/2017**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

TNM Path T [Std# 880]
Date of Diagnosis [Std# 390]
TNM Edition Number [Std# 1060]

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of TNM Path T" is not a valid value for TNM Path T

Description

```
This edit is skipped if any of the following is true:
      Year of Date of Diagnosis is not 2014-2015
      TNM Edition Number is not 07 or "U7"
      TNM Path T is blank

Must be a valid code for TNM Path T and must be left-justified. Subcategory letters
must be uppercase,"p" (if present) in code must be lowercase. May be blank.

The following codes are valid for AJCC 7th Edition:
X           pX
0           p0
IS    pIS
ISPU        pISU
ISPD        pISD
A           pA
1           p1
1A    p1A
1A1   p1A1
1A2   p1A2
1B    p1B
1B1   p1B1
1B2   p1B2
1C    p1C
1D    p1D
1MI   p1MI
2           p2
2A    p2A
2A1   p2A1
2A2   p2A2
2B    p2B
2C    p2C
2D    p2D
3           p3
3A    p3A
3B    p3B
3C    p3C
3D    p3D
```

```
4           p4
4A    p4A
4B    p4B
4C    p4C
4D    p4D
4E    p4E
88
```

Administrative Notes

New edit for v16, EC
SEER IF550

NAACCR v16A

- Edit logic corrected, expressions using 2,4 changed to 2,3 (start from second character and read for 3 characters, for a 4-character data item).

MCR modification checks for 2016 codes on 2014-2015 diagnoses. Mix-bag codes with or without c/p.

v16D: COC added skip for TNM Edition Number not 07 or "U7".

TNM Path T, N, M, In Situ (COC)

Agency: COC **Last changed: 01/29/2017**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
TNM Path T [Std# 880]
TNM Path N [Std# 890]
TNM Path M [Std# 900]
TNM Path Stage Group [Std# 910]
TNM Path Descriptor [Std# 920]
Age at Diagnosis [Std# 230]
CS Site-Specific Factor10 [Std# 2864]
CS Site-Specific Factor25 [Std# 2879]
Grade [Std# 440]
Sex [Std# 220]
Type of Reporting Source [Std# 500]
TNM Edition Number [Std# 1060]

Tables

AC7G2016.DBF

Default Error Message

[3038] TNM stage problem
TNM stage problem

Additional Messages

[3621] For TNM Path T ("value of TNM Path T"), TNM Path M ("value of TNM Path M") must be coded as negative for involvement
[3623] For TNM Path T ("value of TNM Path T"), TNM Path Stage Group ("value of TNM Path Stage Group") must be coded in situ stage group
[6064] For TNM Path T ("value of TNM Path T"), TNM Path N ("value of TNM Path N") must be coded as negative for involvement

Description

The purpose of this edit is to verify that TNM Path N, TNM Path M, and TNM Path Stage Group are coded consistently for cases where TNM Path T indicates an in situ tumor(TNM Path T = pIS, pA, pISU, pISD, or pA).

This edit enforces the statement in the AJCC manual on page 12: "Carcinoma in situ (CIS) is an exception to the stage grouping guidelines. By definition, CIS has not involved any structure in the primary organ that would allow tumor cells to spread to regional nodes or distant sites. Therefore, pTis cN0 cM0 should be reported as

both cliical and pathologic stage 0." The statement on page 499 for bladder takes precedence for this site: "Pathologic staging is based on the histologic review of the radical or partial cystectomy specimen."

This edit is skipped if any of the following conditions are true:
1. Year of Date of Diagnosis is less than 2016, blank (unknown), or invalid
2. Type of Reporting Source = 7
3. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
4. TNM Path T is not = pIS, pA, pISU, pISD, or pA
5. TNM Editition Number not = 07,U7
5. TNM Path Descriptor = 4, 6

1. If TNM Path T = pIS, pA, pISU, or pISD:

A. If TNM site/histology group = Bladder:
TNM Path N must = p0 (negative nodes pathologically), c0 (clinically negative nodes), or blank (criteria not met for pathologic staging of bladder)
TNM Path M must = c0 (no clinically positive metastasis), or blank (criteria not met for pathologic staging of bladder)
TNM Path Stage Group must = 0IS or 0A (codes indicating in situ/noninvasive based on pathologic evaluation of T and N) or 99 (criteria not met for pathologic staging of bladder).

B. For all other AJCC groups:
TNM Path N must = p0, p0I-, p0I+, p0M-, p0M+ (negative nodes pathologically), or c0 (clinically negative nodes).
TNM Path M must = c0, c0I+ (no clinically positive metastasis)
TNM Path Stage Group must = 0, 0A, or 0IS (codes indicating pathologic stage group based on AJCC instructions for pTis) or 99

Only TNM Path N and TNM Path M are edited for the following TNM groups. In situ carcinomas are recognized by AJCC, but there is no stage grouping.

49. Carcinoma of Conjunctiva
50. Malignant Melanoma of Conjunctiva

This edit is skipped for the following TNM groups (AJCC does not recognize or does not stage in situ tumors for these sites, though in situ may be assigned by a pathologist):
7. Major Salivary Glands
8. Thyroid Gland (08A-08F)
9. Mucosal Melanoma Head and Neck
13B. Appendix, Carcinoid
16. GIST
17. NET Small Intestine and Ampulla of Vater, NET Colon and Rectum (17B, 17C)
18. Liver
36B. Corpus Sarcoma
36C. Corpus Adenosarcoma
37A. Ovary
39. Gestational Trophoblastic Tumors
41. Prostate
43. Kidney
47. Adrenal (47A, 47B)
51A. Melanoma of Choroid
51B. Melanoma of Iris
53. Carcinoma of the Lacrimal Gland
54. Sarcoma of the Orbit
57B. Primary Cutaneous Lymphoma

Administrative Notes

New edit - added to NAACCR v16 metafile
SEER IF605

Modifications

NAACCR v16A

- Corrected logic for first INLIST of primary sites for site/histology group 57A, 000-419-440 changed to 000-440.
- Description and logic updated to skip edit for Carcinoma of Conjunctiva, Melanoma of Conjunctiva.
- Corrected Edit Logic to include 9727 as lymphoma rather than lymphoma/leukemia code, to delete 9728-9729 as obsolete codes
- Added Group 57C, C420, C421, C424, 9811-9818, 9837,to Edit Logic

NAACCR v16B
- Name changed from TNM T,N,M, In Situ (CoC) to TNM Path T,N,M, In Situ (COC)
- Description and Edit Logic updated to allow TNM Clin T to be blank and TNM Clin Stage Group to equal 99 when TNM Path T is in situ. This logic assumes that In situ carcinoma was not diagnosed clinically and is an incidental finding at surgery.
- Logic statements requiring that TNM Clin N, TNM Clin M, and TNM Clin Stage Group are also coded consistently with TNM Path T = in situ removed from edit; consistency of coding for TNM Clin fields checked in another edit, TNM Clin T,N,M, In Situ (COC).
- Description and logic updated to edit Carcinoma of Conjunctiva and Melanoma of Conjunctiva for TNM Path N and TNM Path M and only skip for TNM Path Stage Group
- Error messages updated to be more specific about coding problems
- Corrected edit logic for assigning site/histology group 011 to group 10B or 999 based on histology and CS Site-Specific Factor 25

NAACCR v16D
- Description, logic modified to skip if TNM Edition Number not = 07,U7
- Description, edit logic modified to omit comparison between clin TNM and stage group and path TNM and stage group values.
- Modified logic, format of character string, e.g. "pxxb", 2,3
- Logic corrected to skip for group 009, Mucosal Melanoma of Head and Neck
- Description, logic modified to not include pNX as allowable code for in situ carcinomas
- Corrected MATCH patterns (they were not precise enough for EDITS50)

TNM Stage, Date Dx,Type Report Source (MCR/NPCR)

Agency: **Last changed: 08/05/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
TNM Clin Stage Group [Std# 970]
TNM Path Stage Group [Std# 910]
Type of Reporting Source [Std# 500]
Class of Case [Std# 610]

Additional Messages

[5005] TNM Clin Stage Group cannot be blank if Date of Diagnosis is greater than or equal to 2016
[5006] TNM Path Stage Group cannot be blank if Date of Diagnosis is greater than or equal to 2016
ERROR_TEXT("Date of Diagnosis: %DC")

Description

This edit checks that TNM Clin Stage Group and TNM Path Stage Group are not blank for date of diagnosis 2016 and greater. TNM Clin Stage Group and TNM Path Stage Group are allowed to be blank if Autopsy-Only (Type of Reporting Source = 6) or DCO (Type of Reporting Source = 7).

The edit skips (passes) for Class of Case = 38 (Autopsy-Only) or Class = 49 (DCO).

This edit is skipped if Year of Date of Diagnosis is less than 2016 or blank.

Administrative Notes

New Edit for NAACCR v16

MCR modification is to define Autopsy-Only and DCO using Class of Case in addition to Type of Reporting Source.

TNM T, Breast, Inflam Carcinoma (CoC)

Agency: COC **Last changed: 01/12/2017**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

TNM Clin T [Std# 940]
TNM Path T [Std# 880]
Date of Diagnosis [Std# 390]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Type of Reporting Source [Std# 500]
Behavior Code ICD-O-3 [Std# 523]

Default Error Message

[3626] Breast: If %F5 = %V5, %F1 must = c4D or %F2 must = p4D
Breast: If Histologic Type ICD-O-3 = "value of Histologic Type ICD-O-3", TNM Clin T must = c4D or TNM Path T must = p4D

Description

```
This edit is skipped if any of the following conditions are true:

1. Year of Date of Diagnosis is less than 2016, blank (unknown), or invalid
2. Type of Reporting Source = 7 (Death Certificate Only)
3. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
4. Primary Site not = C500-C509
5. TNM Clin T and TNM Path T are both blank, 88



If Histologic Type ICD-O-3 = 8530 (inflammatory carcinoma)
Then
    TNM Clin T must = c4D or TNM Path T must = p4D
```

Administrative Notes

New edit - added to NAACCR v16 metafile
SEER IF589

Modifications

NAACCR v16D
- EC removed from Administrative Note

TNM T, Clin and Path Stage, Behavior 2 (CoC)

Agency: COC **Last changed: 02/06/2017**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
Type of Reporting Source [Std# 500]
TNM Clin T [Std# 940]
TNM Path T [Std# 880]
TNM Path Descriptor [Std# 920]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor10 [Std# 2864]
CS Site-Specific Factor25 [Std# 2879]
Grade [Std# 440]
Age at Diagnosis [Std# 230]
Sex [Std# 220]
TNM Edition Number [Std# 1060]

Tables

AC7G2016.DBF

Default Error Message

[3602] Behavior must = 2 for this combination of clin and path TNM
Behavior must = 2 for this combination of clin and path TNM

Additional Messages

SAVE_TEXT("t_tnm_msg")

Description

```
This edit is skipped if any of the following conditions are true:
1. Year of Date of Diagnosis is less than 2016, blank (unknown), or invalid
2. Type of Reporting Source = 7 (Death Certificate Only)
3. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
4. TNM Edition Number not = 07, U7

Note: The number next to each TNM group indicates the chapter in the AJCC Cancer
Staging Manual, Edition 7. The subheadings (A, B, etc) refer to site/histology
groups listed in the edit Primary Site, Stage Group 2016 - Ed 7.


A.  For the following TNM Group/TNM Clin T or TNM Path T code combinations,
Behavior Code ICD-O-3 may = 2 or 3. These TNM Group/TNM Clin T or TNM Path T code
combinations are passed (excluded from further editing). If TNM Path T is blank,
the edit checks the values in TNM Clin T.  If TNM Path T is not blank, the edit
checks the values in TNM Path T.
```

1. TNM Group Breast (32): TNM Clin T = pIS and Histologic Type ICD-O-3 = 8540,8541, and 8543 (codes indicating Paget disease).
TNM Path T = pIS and Histologic Type ICD-O-3 = 8540,8541, and 8543 (codes indicating Paget disease).

2. TNM Group Penis (40): TNM Clin T = pA (verrucous carcinoma)
TNM Path T = pA (verrucous carcinoma)

3. TNM Group Urinary Bladder (45): TNM Clin T = pIS (tumors described as "confined to mucosa")
TNM Path T = pIS (tumors described as "confined to mucosa")

B. For all other TNM Groups except Colon and Rectum (14),
Carcinoma of Appendix (13A), NET Stomach (17A),
Melanoma of Conjunctiva (50)

1. If TNM Path T is blank,
if TNM Clin T = pA, pIS, pISU, pISD,
then
Behavior Code ICD-O-3 must = 2.

2. If TNM Path T = pA, pIS, pISU, pISD
and TNM Path Descriptor is not = 4 or 6 (Codes indicating pathologic staging after multimodality treatment)
Then
Behavior Code ICD-O-3 must = 2

Note: The four exceptions listed in B are site/histology groups where AJCC maps an extension considered "invasive" by ICD-O-3 to a "Tis" category.

Administrative Notes

New edit - added to NAACCR v16 metafile
SEER IF603

Modifications

NAACCR v16B
- Corrected edit logic for assigning site/histology group 011 to group 10B or 999 based on histology and CS Site-Specific Factor 25

NAACCR v16D
- Added skip if TNM Edition Number not = 07,U7
- Modified logic, format of character string, e.g. "pxxb", 2,3
- IF604 in Administrative Notes corrected to IF603
- Description, logic updated to delete occult carcinoma of Lung from list of site/histologies which can be coded with behavior /2 or /3

TNM T, Clin and Path Stage, Behavior 3 (CoC)

Agency: COC **Last changed: 11/20/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
Type of Reporting Source [Std# 500]
TNM Clin T [Std# 940]
TNM Clin N [Std# 950]
TNM Clin M [Std# 960]
TNM Path T [Std# 880]
TNM Path N [Std# 890]
TNM Path M [Std# 900]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
TNM Clin Stage Group [Std# 970]
TNM Path Stage Group [Std# 910]
CS Site-Specific Factor10 [Std# 2864]
CS Site-Specific Factor25 [Std# 2879]
Grade [Std# 440]
Age at Diagnosis [Std# 230]
Sex [Std# 220]
TNM Edition Number [Std# 1060]

Tables

AC7G2016.DBF

Default Error Message

[3608] Behavior must = 3 for this combination of clin and path TNM
Behavior must = 3 for this combination of clin and path TNM

Additional Messages

SAVE_TEXT("t_tnm_msg")

Description

```
This edit is skipped if any of the following conditions are true:
1. Year of Date of Diagnosis is less than 2016, blank (unknown), or invalid.
2. Type of Reporting Source = 7 (Death Certificate Only)
3. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
4. All TNM fields are coded 88 (AJCC staging not applicable)
        TNM Clin T = 88
      TNM Clin N = 88
      TNM Clin M = 88
      TNM Clin Stage Group = 88
      TNM Path T = 88
```

```
      TNM Path N = 88
      TNM Path M = 88
      TNM Path Stage Group = 88
5. If all of the following conditions are true, fields have probably been defaulted
and the edit is skipped:
      TNM Clin T = cX
      TNM Clin N = cX
      TNM Clin M = cX
      TNM Clin Stage Group = 99
      TNM Path T = pX
      TNM Path N = pX
      TNM Path M = pX, cX
      TNM Path Stage Group = 99
6. TNM Edition Number not = 07, U7

Not in situ, Behavior ICD-O-3 = 3

Note:  The edit will pass if TNM Clin T, TNM Clin Stage Group, TNM Path T, and TNM
Path Stage Group are blank.  The edit will not pass if some but not all of these 4
fields are coded 88.

For all TNM Groups:


   A.  If TNM Path T and TNM Path Stage Group are empty:
                  If TNM Clin T is not pIS, pA, pISU, pISD
                  and TNM Clin Stage Group is not 0, 0A, 0IS
            Then Behavior Code ICD-O-3 must = 3.

      B. If TNM Path T and TNM Path Stage Group are not empty:
            If TNM Path T is not pIS, pA, pISU, pISD
            and TNM Clin Stage Group is not 0, 0A, 0IS
        and TNM Path Stage Group is not 0, 0A, 0IS
        Then Behavior Code ICD-O-3 must = 3
```

Administrative Notes

New edit - added to NAACCR v16 metafile. EC
SEER IF590

Modifications

NAACCR v16B
- Corrected edit logic for assigning site/histology group 011 to group 10B or 999 based on histology and CS Site-Specific Factor 25

NAACCR v16D
- Added skip if TNM Edition Number not = 07,U7

TNM T, Deep Sites Soft Tissue (COC)

Agency: COC **Last changed: 12/12/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

TNM Clin T [Std# 940]
TNM Path T [Std# 880]
Date of Diagnosis [Std# 390]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Sex [Std# 220]
Type of Reporting Source [Std# 500]
Behavior Code ICD-O-3 [Std# 523]
TNM Edition Number [Std# 1060]

Default Error Message

[3312] %F1 (%V1) and %F2 (%V2) conflict
TNM Clin T ("value of TNM Clin T") and TNM Path T ("value of TNM Path T") conflict

Additional Messages

[6041] Conflict between TNM Path T ("value of TNM Path T") and Primary Site ("value of Primary Site"
[6052] Conflict between TNM Clin T ("value of TNM Clin T") and Primary Site ("value of Primary Site"

Description

```
Purpose: This edit verifies that TNM T is coded as deep tumor for certain Soft
Tissue Sarcoma sites: heart/mediastinum, peritoneum, and retroperitoneum.

This edit is skipped if any of the following conditions are true:

1. Year of Date of Diagnosis is less than 2016, blank (unknown), or invalid
2. Type of Reporting Source = 7 (Death Certificate Only)
3. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
4. TNM Clin T and TNM Path T are blank or 88
5. TNM Edition Number not = 07, U7



For soft tissue sarcoma:

If site = C380-C383, C388 (8800-8820, 8823-8935, 8940-9136, 9142-9582),
          C481-C482, C488 (8800-8820,8823-8934. 8940-9136, 9142-9582 (not female),
          C481-C482, C488 (8800-8820, 8823-8921, 9120-8136, 9142-9582 (female
only), or
          C480 (8800-8820, 8823-8934, 8940-9136, 9140-9582)
      then TNM Clin T must = c1B, c2B, cX or blank, and TNM Path T must = p1B,
p2B,pX, or blank.
```

Administrative Notes

New edit - added to NAACCR v16 metafile.
SEER IF604

Modifications

NAACCR v16D
- Added skip if TNM Edition Number not = 07,U7
- SEER IF605 in Administrative Notes corrected to IF604

TNM T, N, M - No Primary Found (CoC)

Agency: COC **Last changed: 01/30/2017**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Date of Diagnosis [Std# 390]
Behavior Code ICD-O-3 [Std# 523]
TNM Clin T [Std# 940]
TNM Clin N [Std# 950]
TNM Clin M [Std# 960]
TNM Path T [Std# 880]
TNM Path N [Std# 890]
TNM Path M [Std# 900]
Type of Reporting Source [Std# 500]

Default Error Message

[4279] If %F3 = %V3, %F4, %F5, %F6, %F7 and %F8 cannot all = c/p0, c/p X, or blank
If TNM Clin T = "value of TNM Clin T", TNM Clin N, TNM Clin M, TNM Path T, TNM Path N and TNM Path M cannot all = c/p0, c/p X, or blank

Additional Messages

[4280] If TNM Path T = "value of TNM Path T", TNM Clin T, TNM Clin N, TNM Clin M, TNM Path N and TNM Path M cannot all = c/p0, c/p X, or blank

Description

```
This edit is skipped if any of the following conditions are true:

1. Year of Date of Diagnosis is less than 2016, blank (unknown), or invalid
2. Type of Reporting Source = 7 (Death Certificate Only)
2. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)

This edit requires that there is some evidence for tumor involvement of nodal or
metastatic sites if there is no evidence of primary tumor.

For all site/histology groups:

If there is no evidence of primary tumor clinically and no pathologic assessment of
tumor, nodes or metastasis must be known clinically or pathologically:

  If TNM Clin T = c0
  Then
      TNM Clin N, TNM Clin M, TNM Path T, TNM Path N and TNM Path M
      must not all equal c/p0, c/pX, or blank


If there is no evidence of primary tumor on pathologic examination, there must be
some other evidence of tumor clinically or pathologically:
```

```
If TNM Path T = p0
Then
    TNM Clin T, TNM Clin N, TNM Clin M, TNM Path N and TNM Path M
    must not all equal c/p0, c/pX, or blank
```

Administrative Notes

New edit - added to NAACCR v16 metafile
SEER IF592

Modifications

NAACCR v16D

- Edit logic reworked to correct MATCH masks. Wrote a replacement implementation using AT() function; much more readable and maintainable. See KB notes in logic.

TNM T, SSize, Site Spec - Ed 7, ICDO3 (CoC)

Agency: COC **Last changed: 12/06/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Tumor Size Summary [Std# 756]
TNM Clin T [Std# 940]
TNM Path T [Std# 880]
Date of Diagnosis [Std# 390]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor10 [Std# 2864]
CS Site-Specific Factor25 [Std# 2879]
Grade [Std# 440]
Age at Diagnosis [Std# 230]
Sex [Std# 220]
Type of Reporting Source [Std# 500]
TNM Edition Number [Std# 1060]

Tables

AC7G2016.DBF
CLINTSIZ.DBF
PATHTSIZ.DBF

Default Error Message

[3038] TNM stage problem
TNM stage problem

Additional Messages

[6015] TNM Clin T of "value of TNM Clin T" and TNM Path T of "value of TNM Path T" not consistent with Tumor Size Summary of "value of Tumor Size Summary"
[6028] TNM Clin T of "value of TNM Clin T" is not consistent with Tumor Size Summary of "value of Tumor Size Summary"
[6029] TNM Path T of "value of TNM Path T" is not consistent with Tumor Size Summary of "value of Tumor Size Summary"
SAVE_TEXT("t_tnm_msg")

Description

```
This edit is skipped if any of the following conditions are true:

1. Year of Date of Diagnosis is less than 2016, blank (unknown), or invalid
2. Type of Reporting Source = 7 (Death Certificate Only)
3. Histologic Type ICD-O-3 is blank
4. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
```

5. Site/Histology where T is not dependent on tumor size
6. TNM Clin T and TNM Path T are both blank or 88
7. Tumor Size Summary is blank or 999
8. TNM Edition Number not = 07, U7

TNM Clin T and TNM Path T may be blank. If entered, they will be edited site-specifically. The edit will first compare Tumor Size Summary to pT category entered in TNM Path T, and then to cT category entered in TNM Clin T.The edit comparisons will proceed as follows:

1. If TNM PATH T is empty:
   a. TNM Clin T and Tumor Size Summary: Pass, edit passes
   b. TNM Clin T and Tumor Size Summary: Fail, edit fails
2. If TNM Path T is coded:
   a. TNM Path T and Tumor Size Summary: Pass, edit passes.
   b. TNM Path T and Tumor Size Summary: Fail
      1. If TNM Clin T is empty, edit fails
      2. If TNM Clin T is coded:
         a. TNM Clin T and Tumor Size Summary: Pass, edit passes
         b. TNM Clin T and Tumor Size Summary: Fail, edit fails

"989", "989 millimeters or larger", is the largest possible size for Tumor Size Summary. 990 (microscopic focus) will be accepted for c/p1 (c/p1A, c/p1MI) for all sites/histologies included in this edit.

The site-specific TNM Clinical T values with the corresponding clinical tumor size in millimeters are listed below. The number next to each site title indicates the respective chapter in the AJCC Cancer Staging Manual, Edition 7. The list includes only those sites/histology groups where clinical T is based on clinical tumor size. The site/histology groups are identified by site and histology in the edits Primary Site, AJCC Stage Group 2016 - Ed 7 (COC), Primary Site, Stage Group 2016 - Ed 7 (NPCR), and Primary Site, Stge Group 2016 - Ed 7 (SEER). Subdivision of the 4A site/histology group, Oropharynx and Hypopharynx, was required for this edit; the site codes for Hypopharynx were removed to site group 4E.

3. Lip and Oral Cavity

TNM T:	1	2	3
Tumor Size Summ	001-020, 990	021-040	041-989

4. Pharynx

4A. Oropharynx and Hypopharynx

Division for T category:
4A. Oropharynx only
Sites: C019, C024, C051-C052, C090-C091, C098-C099, C100, C102-C104, C108-C109

TNM T:	1	2
Tumor Size Summ	001-020, 990	021-040

4E. Hypopharynx
Sites: C129, C130-C139

TNM T:	1
Tumor Size	001-020, 990

4D. Oropharynx

TNM T:	1	2
Tumor Size Summ	001-020, 990	021-040

7. Major Salivary Glands

TNM T:	1	2
Tumor Size Summ	001-020, 990	021-040

8. Thyroid Gland

8A. Thyroid: Papillary/follicular, age less than 045
8B. Thyroid: Papillary/follicular, age greater than or equal 045 but not 999
8C. Thyroid: Papillary/follicular, age equal 999 (unknown
8D. Thyroid: Medullary

TNM T:	1	1A	1B	2
Tumor Size Summ	001-020, 990	001-010, 990	011-020	021-040

13. Appendix

13B. Appendix: Carcinoid

TNM T:	1	1A	1B
Tumor Size Summ	001-020, 990	001-010, 990	011-020

15. Anus

TNM T:	1	2	3
Tumor Size Summ	001-020, 990	021-050	051-989

16. Gastrointestinal Stromal Tumor (GIST)

16A. GIST: Gastric
16B. GIST: Small Intestine

TNM T:	1	2	3	4
Tumor Size Summ	001-020, 990	021-050	051-100	101-989

17. Neuroendocrine Tumors (NET)

17A. NET: Stomach
17B. NET: Small Intestine

TNM T:	1
Tumor Size Summ	001-010, 990

17D. NET: Ampulla

TNM T:	1	2
Tumor Size Summ	001-010, 990	011-989

24. Exocrine and Endocrine Pancreas

TNM T: 1 2
Tumor Size Summ 001-020, 990 021-989

25. Lung

TNM T: 1 1A 1B
2A 2B
Tumor Size Summ 001-030, 990 001-020, 990 021-030 001-050,
990 051-070

27. Bone

TNM T: 1 2
Tumor Size Summ 001-080, 990 081-989

28. Soft Tissue Sarcoma

TNM T: 1 2
Tumor Size Summ 001-050, 990 051-989

29. Cutaneous Squamous Cell Carcinoma and other Cutaneous Carcinomas

TNM T: 1
Tumor Size Summ 001-020, 990

31. Merkel Cell Carcinoma

TNM T: 1 2 3

Tumor Size Summ 001-020, 990 021-050 051-989

32. Breast

TNM T: 1 1M 1A
1B 1C 2
Tumor Size Summ 001-020, 990 001-001, 990 001-005, 990 005-010
011-020 021-050

3
051-989

43. Kidney

TNM T: 1 1A 1B
2 2A 2B
Tumor Size Summ 001-070, 990 001-040, 990 041-070 071-989
071-100 101-989

47. Adrenal

47A. Adrenal Cortex
47B. Adrenal Cortical Carcinoma

TNM T: 1 2

Tumor Size Summ 001-050, 990 051-989

49. Conjunctiva

```
TNM T:                        1                       2

Tumor Size Summ   001-005, 990      006-989
```

53. Carcinoma of the Lacrimal Gland

```
TNM T:                        1                       2                 3

Tumor Size Summ   001-020, 990      021-040           041-989
```

54. Sarcoma of the Orbit

```
TNM T:                        1                       2

Tumor Size Summ   001-015, 990      016-989
```

Administrative Notes

New edit - added to NAACCR v16 metafile

Modifications

NAACCR v16A
- Corrected logic for first INLIST of primary sites for site/histology group 57!, 000-419-440 changed to 000-440
- Corrected edit logic to include 9727 as lymphoma rather than lymphoma/leukemia code, to delete 9728-9729 as obsolete codes
- Added Group 57C, C420, C421, C424, 9811-9818, 9837, to Edit Logic

NAACCR v16B
- Description updated to reference 3 edits where site/histology groups are identified: Primary Site, AJCC Stage Group 2016 - Ed 7 (COC), Primary Site, Stage Group 2016 - Ed 7 (NPOCR), and Primary Site, Stage Group 2016 - Ed 7 (SEER).
- Description corrected to show size range of 001-050, 990 for group 025,T2A, Lung.
- Logic updated to pass Tumor Size Summary of 990 for T2A, Lung
- Tables referenced by edit updated to include size range of 001-050 for T2A, Lung.
- Corrected edit logic for assigning site/histology group 011 to group 10B or 999 based on histology and CS Site-Specific Factor 25

NAACCR v16C
- Updated Administrative Notes to show this is a new edit for NAACCR v16, not NAACCR v15

NAACCR v16D
- Added skip if TNM Edition Number not = 07,U7
- Reformatted logic statements for greater clarity (edit returns not changed)

TNM T3, Carcinoma of Skin (CoC)

Agency: COC **Last changed: 12/28/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

TNM Clin T [Std# 940]
TNM Path T [Std# 880]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Date of Diagnosis [Std# 390]
Type of Reporting Source [Std# 500]
Behavior Code ICD-O-3 [Std# 523]

Default Error Message

[6056] %F1 of %V1 or %F2 of %V2 is invalid for %F3 of %V3
TNM Clin T of "value of TNM Clin T" or TNM Path T of "value of TNM Path T" is invalid for Primary Site of "value of Primary Site"

Description

```
Purpose: This edit verifies that TNM T3 (Tumor with invasion of maxilla, mandible,
orbit, or temporal bone) is coded for carcinomas of the head and neck only.

This edit is skipped if any of the following conditions are true:

1. Year of Date of Diagnosis is less than 2016, blank (unknown), or invalid
2. Type of Reporting Source = 7 (Death Certificate Only)
3. Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
4. Site/histology group is not 029 (Carcinoma of Skin)
5. TNM Clin T and TNM Path T are blank or 88



This edit is evaluated only for Carcinomas of Skin, site/histology group 29.
Sites, histologies included in this group are identified in the edit Primary Site,
Stage Group 2016 - Ed 7.

For Carcinomas of Skin

If TNM Clin T = c3 or TNM Path T = p3,
      then primary site must = C440, C442-C444, C448-C449
```

Administrative Notes

New edit - added to NAACCR v16 metafile.

Modifications

NAACCR v16D
- Edit logic updated to correctly edit for histology codes included in site/histology group 029.

Tobacco History (MCR-CIMS)

Agency: **Last changed: 07/15/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Tobacco History [Std# 340]

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of Tobacco History" is not a valid value for Tobacco History

Description

```
MCR-modified version of old edit Tobacco History (COC). Can't be blank for MCR.
Valid codes are from ROADS Manual:
0 never used tobacco
1 current cigarette smoker
2 current cigar/pipe smoker
3 current snuff/chew tobacco user
4 current combination use (1-3)
5 former smoker/previous tobacco use
9 unknown
```

Administrative Notes

Field retired from NAACCR layout but local researchers/cancer control personnel insist on having it. This requires a non-NAACCR layout for editing.
v16: added valid code categories into description

Tumor Size Summary (NPCR)

Agency: NPCR **Last changed: 06/05/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Tumor Size Summary [Std# 756]

Default Error Message

[1023] %F1 is not valid
Tumor Size Summary is not valid

Description

Must be a valid three-digit number (000-990, 998, 999) or blank.

Administrative Notes

New Edit for NAACCR v16

Tumor Size Summary, Date of Diagnosis (NPCR)

Agency: NPCR **Last changed: 06/15/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Tumor Size Summary [Std# 756]
Date of Diagnosis [Std# 390]

Default Error Message

[1300] If year of %F2 > 2015, then %F1 cannot be blank
If year of Date of Diagnosis > 2015, then Tumor Size Summary cannot be blank

Additional Messages

ERROR_TEXT("Date of Diagnosis: %DC")

Description

```
If year of Date of Diagnosis is blank, this edit is skipped.

If year of Date of Diagnosis is greater than 2015, then Tumor Size Summary cannot
be blank.
```

Administrative Notes

Added to the v16 metafile

Tumor Size Summary, Primary Site (COC)

Agency: COC **Last changed: 05/10/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Tumor Size Summary [Std# 756]
Date of Diagnosis [Std# 390]

Default Error Message

[1012] %V2 is not a valid %F2 for a %F1 of %V1
"value of Tumor Size Summary" is not a valid Tumor Size Summary for a Primary Site of "value of Primary Site"

Description

```
This edit is skipped if any of the following conditions are true:

1.Diagnosis date < 2016 or empty (unknown).
2.Tumor Size Summary is empty.


If Tumor Size Summary is coded 998, primary site must be coded C199, C209, C182-
C189, C150-C155, C158, C159, C160-C166, C168, C169, C340-C343, C348, C349, C500-
C506, C508, C509. (Sites listed in NAACCR Data Dictionary)
```

Administrative Notes

New edit for v16, EC

Tumor Size Summary, TNM Clin/Path T (COC)

Agency: COC **Last changed: 05/10/2016**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

TNM Clin T [Std# 940]
TNM Path T [Std# 880]
Tumor Size Summary [Std# 756]
Date of Diagnosis [Std# 390]
Type of Reporting Source [Std# 500]

Default Error Message

[6008] %V3 is not a valid %F3 for %F1 of %V1 and %F2 of %V2
"value of Tumor Size Summary" is not a valid Tumor Size Summary for TNM Clin T of "value of TNM Clin T" and TNM Path T of "value of TNM Path T"

Description

```
This edit is skipped if any of the following conditions are true:

1.Diagnosis date < 2016, blank (unknown), or invalid.
2.Type of Reporting Source = 7 (Death Certificate Only)
3.Behavior Code ICD-O-3 = 0 (benign) or 1 (borderline)
4.Both TNM Clin T and TNM Path T are blank or 88
5.Tumor Size Summary is blank.

If Tumor Size Summary is coded 000, both TNM Clin T and TNM Path T must be coded 0,
or one of them must be coded 0 and the other must be empty.
If both TNM Clin T and TNM Path T are coded 0, Tumor Size Summary must be coded
000.
```

Administrative Notes

New edit for v16, EC

Unknown Site, Laterality (SEER IF138)

Agency: SEER **Last changed: 06/27/2008**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Primary Site [Std# 400]
Laterality [Std# 410]

Default Error Message

[1064] Unknown Site, Laterality must = 0
Unknown Site, Laterality must = 0

Description

This edit verifies that an unknown Primary Site (C809) has a Laterality of 0.

Administrative Notes

In the SEER*Edits software, the title of this edit is: IF138

Modifications:

NAACCR v11.3
6/2008
Updated Administrative Notes with the title of the corresponding edit in the SEER*Edits software.

Vital Status (COC)

Agency: COC **Last changed: 04/12/2007**

Edit Sets

HospitalScan16D
OfficeScan16D

Fields

Vital Status [Std# 1760]

Default Error Message

[1008] %V1 is not a valid value for %F1
"value of Vital Status" is not a valid value for Vital Status

Description

```
Must be a valid Vital Status code (0,1).
```

Administrative Notes

This edit differs from the SEER edit of the same name in that the Vital Status code used to indicate "dead" = 0. SEER uses a code of 4 in Vital Status to indicate "dead".