Texas Cancer Reporting News

Spring 2025
Volume XXVIII | Issue 1

Texas Cancer Registry
Texas Department of State Health Services
dshs.texas.gov/tcr cancerdata@dshs.texas.gov

In this Issue

TCR Updates

Timely Reporting Calendars 2024-2025

By Allison Vasquez, BS, ODS-C

The Texas Cancer Registry (TCR) has finalized our reporting calendars for 2024 and 2025 cancer cases. The calendars are available to help reporters stay compliant with reporting guidelines. Both calendars follow TCR's standard policy of reporting cases within six months. Visit TCR's Hospital Reporting page for a list of the most recent Timely Reporting Calendars. The site also has reporting calendars for previous diagnosis years.

Continuing Education In-Person (CEIP) Opportunity

By Allison Vasquez, BS, ODS-C

As of January 1, 2025, the National Cancer Registrars Association (NCRA) – Continuing Education in Person (CEIP) requirement needs Oncology Data Specialist certified (ODS-C) professionals to earn at least eight continuing education (CE) credits of in-person education over four years. TCR has received questions and concerns from our reporting community. In response, TCR will provide interactive live event trainings. This is one of the options ODS-certified professionals can pursue to meet the CEIP requirement. These events will start with our 2025 TCR Statewide Education, conducted by Denise C. Harrison, LLC this spring.

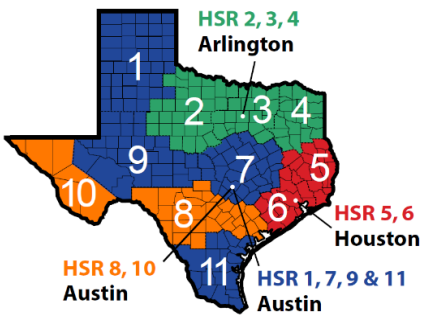
The new option for training participation allows ODS-certified professionals to gather in the same room to watch the statewide education webinar live. A room moderator will be responsible for ensuring that all attendees sign in. You must sign in to receive CEIP-required credits. Participants can also elect to go through the training on their own. There will be two CE numbers provided for these trainings. One is for those who meet the CEIP requirement. This includes those who have participated in a group setting, meeting in the same location for the live webinar. The other is for virtual CE credits (participated alone). We will provide more information when registration opens.

For further information, including updated FAQ, please visit the NCRA CEIP webpage.

COMPLETENESS BY REGION

Diagnosis year 2023
As of May 14, 2025

99.72%	Texas Overall
88.40%	Region 1
100.00%	Region 2
99.74%	Region 3
100.00%	Region 4
100.00%	Region 5
99.59%	Region 6
97.54%	Region 7
100.00%	Region 8
91.79%	Region 9
83.24%	Region 10
100.00%	Region 11



Call for Earlier Case Submissions

By Allison Vasquez, BS, ODS-C

TCR has several annual data submissions for the Center for Disease Control's National Program of Cancer Registries (CDC-NPCR), North American Association of Cancer Registries (NAACCR), and the National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) Program, where completeness is evaluated. This year, Texas' interim Call for Data submission to SEER (for diagnosis year 2023) met the National Cancer Institute's goal of 95% case completeness for the first time! TCR intends to continue meeting completeness goals. That includes the November 2025 Call for Data submission requirement of 98% completeness for diagnosis year 2023.

To meet the 98% completeness goal by November, TCR aims to have received all 2023 cases no later than the end of September. This newsletter includes TCR's compliance measures for each region as of the date of publication. Moving forward, please review our newsletter for regional compliance status. For questions about this report, please contact your regional representative.

We want to acknowledge the hard work of reporting facilities who have been diligent in continuing to provide timely and quality data. Your efforts help us succeed as we strive to complete these goals earlier in the year. Thank you so much!

Thank you to the 2025 Statewide Training CEIP Hosting Sites

TCR wants to express our sincere appreciation to the following facilities below for hosting our 2025 Statewide training on April 7, 2025, and/or April 10, 2025, in several locations across the state. Your support helped our staff and cancer registrars throughtout Texas to meet the new CEIP requirement from NCRA.

Hosting Facilities

- Doctor's Hospital at Renaissance - Edinburg
- Joe Arrington Cancer Center - Lubbock
- M D Anderson Cancer Center - Houston
- Memorial Hermann - Houston
- San Jacinto College - Houston
- Texas Health Presbyterian Hospital - Dallas
- University Medical Center - El Paso

Training Corner

Making Every Cancer Count

By Elizabeth Harvey, BS, ODS-C

Making every cancer count means ensuring that every reportable cancer case is accurately recorded and used in research and data analysis. This way, we can identify patterns, trends, and potential areas for treatment improvement. These cancer control efforts differ based on whether they focus on adult or pediatric and young adult cancers. Adult cancer control focuses on prevention and early detection and treatment. Success is measured by following effectiveness through incidence trends. In contrast, pediatric and young adult cancer control includes improving diagnosis and treatment, increasing access to care, and raising awareness.

Pediatric and young adult cancers present a challenge for cancer control efforts due to their unique presentation and rarity. Pediatric, adolescent, and young adult cancers have few or no modifiable causes and no known prevention. Without the ability to collect the vital data needed on a large scale for analysis, pediatric and young adult cancer has remained an understudied population. In response to these challenges, the National Cancer Institute (NCI) created the National Childhood Cancer Registry (NCCR). The rapidly growing public health surveillance data resource provides a platform to address the gaps in pediatric and young adult cancer data collection. The accumulation of internationally consistent data on pediatric and young adult cancer stage by population-based registries is essential for epidemiologic analysis, international benchmarking, and comparisons of childhood cancer incidence and outcomes. TCR works with NCCR to help with childhood cancer control efforts. Together, we aim to improve cancer care for children in Texas. TCR will start collecting staging information on pediatric and adolescent/young adult populations (ages 0-39) for all cases diagnosed since January 1, 2025 from all of our reporting facilities.

As participation in childhood cancer control efforts expands, the growing amount of data requires standardization for how it is received to ensure accuracy. Therefore, the Toronto Pediatric Cancer Staging Guidelines was implemented, providing a standardized set of instructions on how population-based cancer registries collect and analyze data for pediatric and young adult cancers. The guidelines refer to a set of staging protocols used for the classification and management of childhood cancers. These guidelines help health care professionals determine the extent of the disease and plan appropriate treatment strategies.

Pediatric staging typically refers to the assessment and classification of diseases, particularly cancer, in children. Staging helps determine the extent of the disease, guides treatment plans, and provides information about prognosis. While there are various diseases that may need staging, one of the most common contexts for pediatric staging is childhood cancers, especially leukemia and solid tumors like neuroblastoma, Wilms tumor, and retinoblastoma.

For childhood cancers, staging often varies significantly compared to adult cancers. The classification and staging can differ depending on the type of cancer, as pediatric cancers may not follow the typical Tumor, Node, Metastasis (TNM) classification used for many adult cancers.

The guidelines recommend the malignancy-specific staging system most suitable for use by population registries for 16 of the most common childhood malignancies. The following data items are defined by year of diagnosis, primary site, histology/behavior, and age at diagnosis:

- Pediatric Primary Tumor #1136
- Pediatric Primary Lymph Nodes #1137
- Pediatric Mets #1138
- Applicable Site-specific Data Items 15 schemas

Please see the NAACCR Pediatric webpage for more information, including the Pediatric Staging Manual, Toronto Staging Guidelines, pediatric trainings (short webinars), and pediatric coding questions.

For questions related to the content of pediatric staging, please refer to Ask a SEER Registrar.

Have questions about TCR education and training opportunities?

Email us at tcr.training@dshs.texas.gov

You Asked, We Answered

Question:
Could you please clarify when a colonoscopy with a polypectomy is used to code the pathological grade versus the clinical grade for a colorectal case? If it was a "screening colonoscopy and polypectomy" would the intent be diagnostic (clinical grade) even though it removed all of the tumor? Or does that make it treatment versus diagnostic if the margins are negative?

Answer:
The removal of polyps can have diagnostic implications. This can include sending them for histopathological examination to determine if they are benign or malignant. While there is a diagnostic component, it can be classified as a treatment procedure. The main goal of a polypectomy is to treat and reduce the risk of potential progression to cancer.
When coding clinical and pathological grade data items, we have to look at the physician's intent. Was it a diagnostic procedure to be followed by surgical resection or is the polypectomy the treatment of the disease?
If there was a polypectomy ONLY (regardless of margins) we consider it as treatment.

- Document the *Grade Clinical* data field as 9.
- Document the *Grade Pathological* data field using the pathology report and grade manual.
    - If there was a polypectomy and subsequent resection (regardless of residual or no tumor) we have met the clinical and pathological criteria.
- Document the polypectomy in the *Grade Clinical* data field.
- Document the *Grade Pathological* data field (using clinical and pathological information).

For more information and examples, please see Colon Grade - CAnswer Forum

Education and Opportunities

By Elizabeth Harvey, BS, ODS-C

TCR offers various training opportunities throughout the year to assist Texas reporters. TCR sponsors live and recorded training sessions, including NAACCR webinars, ODS-C exam prep courses, basic and advanced webinars, and Web Plus training. Read below for more details about these online training opportunities.

TCR also publishes a yearly cancer reporting guide that provides guidance to registrars reporting cancer cases in Texas. You can find the most recent version, the 2024 Cancer Reporting Guide, on TCR's Cancer Reporting Guides webpage. The TCR 2025 Cancer Reporting Guide is scheduled for release early this summer.

2024-2025 NAACCR Webinar Series

TCR sponsors the 2024-2025 NAACCR Webinar Series at no cost to Texas reporters. NAACCR presents a webinar covering a new topic at the beginning of each month, October 2024 through September 2025. Each webinar lasts three hours and provides applicable CEs.

NAACCR ODS-C Exam Preparation & Review Webinar Series

For Texas reporters planning to sit for the ODS-C certification exam, TCR offers a discounted price of $60 for the NAACCR ODS Exam Preparation & Review Webinar Series. The eight-week webinar series is available three times a year. It includes live presentations, recordings, quizzes, helpful study tools, and an active discussion board to share study tips and provide support. Check the NAACCR website for information about the next webinar series.

FLccSC

FlccSC is a free, web-based education platform available to cancer reporters. Through FLccSC, TCR provides a variety of recorded webinars, handouts, and quizzes. Use this resource to increase your knowledge and sharpen your abstracting and coding skills. It is accessible for all cancer reporters 24/7 at no cost.

Epidemiology Corner

Hysterectomy Adjustment for Cervical and Uterine Cancers

By Erin Gardner, MPH

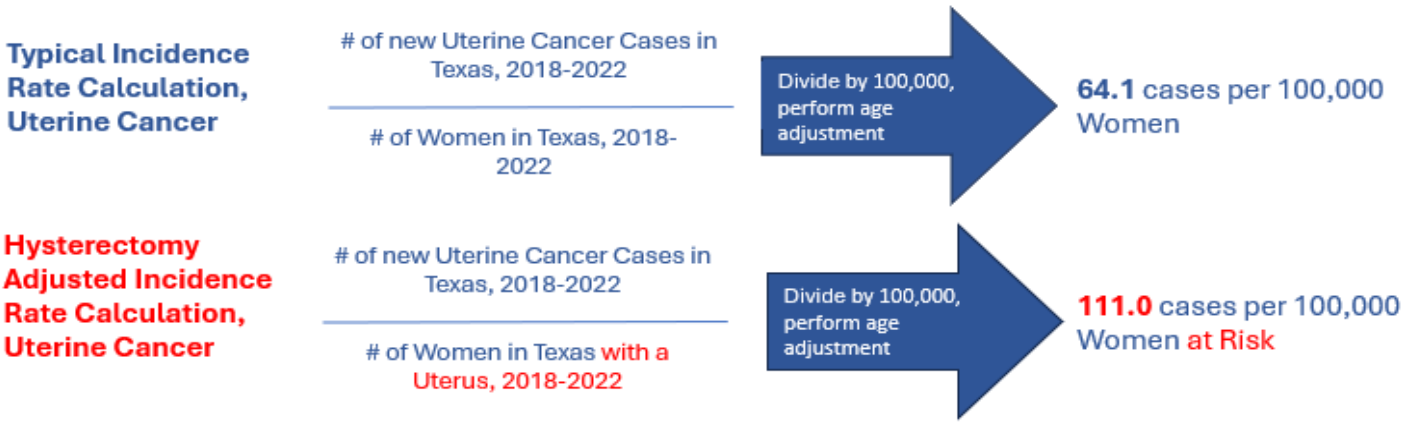
In Texas, about one in three women ages 45-64 and nearly half of women 65 and older have undergone a hysterectomy. A hysterectomy is an operation that removes the uterus. A total hysterectomy removes the uterus and cervix. A partial hysterectomy removes only the uterus. Women may need a hysterectomy for different reasons. These include cancer, fibroids, endometriosis, or uterine prolapse. Hysterectomy prevalence varies by race, ethnicity, age, and geographic location, among other factors. If women who have had hysterectomies are not accounted for when calculating cancer incidence rates for uterine and cervical cancer, the resulting rates would be an underestimate because the number of women who are **not at risk** for these cancers—as they do not have a uterus or cervix—are included in the population at risk. In other words, the number of women at risk (the denominator) in the incidence calculation is larger than the true number at risk.

At TCR, when generating cancer incidence rates, the at-risk population used depends on the rate to be calculated. For instance, with cancers that occur in only one sex, such as prostate cancer in men or cervical cancer in women, we would use the respective population of men or women to calculate incidence rates. After attending an informative NAACCR conference presentation on this topic in June 2024, TCR epidemiologists began exploring methods to define the population at risk for cancers impacted by hysterectomy more accurately. This includes methods that would remove women who have had a hysterectomy from the population at risk.

To achieve this, TCR epidemiologists created a new population file to use in SEER*Stat software. It incorporates reductions to the female population based on hysterectomy prevalence estimates obtained from the Behavioral Risk Factor Surveillance System (BRFSS). When the population at risk is smaller, the resulting incidence rates calculated in SEER*Stat are higher. Furthermore, because rates of hysterectomy differ by demographic characteristics such as age and race/ethnicity, the impact of reducing the population size can be made even more specific to these subsets of the female population.

There are important limitations to consider with this approach. Hysterectomy prevalence information from BRFSS is an estimate. It also does not distinguish between total and partial hysterectomy. Still, this approach can improve our understanding of uterine and cervical cancer epidemiology. In addition, because hysterectomy prevalence varies by race, ethnicity, and age, adjusting for hysterectomy can prevent the underestimation of incidence rates and masking of potential disparities.

To allow for comparisons to national and other publicly available cancer data, and for consistency with currently available standardized methodology, TCR will likely continue to present uterine and cervical cancer rates based on actual population data in its reports. However, we will carry on exploring these alternative methods with the goal of presenting this work at upcoming conferences.



Coding in Practice

Primary Payer at DX: NAACCR Item #630

By Alicia Smith, ODS-C

The struggle to code primary payer at diagnosis (DX) is no secret. At TCR, we understand the many challenges reporters face coding this data item. Varying factors to consider when coding this item include the point at which a cancer patient's encounter at your facility is reportable (Class of Case), the type of reporting facility, and the health system's choice of commercial Electronic Health Record (EHR) system.

The accurate collection of primary payer at DX (NAACCR Data Item #630) provides all oncology service line stakeholders with the necessary data to analyze how an individual patient's cancer treatment costs are covered. With this information, experts can improve a health system's cancer care delivery model, inform effective public health policies and initiatives, identify disparities in equitable access to cancer care, and determine cancer patient survival outcomes based on payment status.

Reporters can find standard setter guidance on coding this field accurately in the appropriate manual like for any data collection scenario. Since Texas is a SEER state, reporters should refer first to the relevant diagnosis year of these resources for help: the SEER Coding & Staging Manual, the NAACCR Data Dictionary, or, for Commission on Cancer (CoC) reporting facilities, the STORE Manual.

In general, reporters should code Class of Case 00, 10-14, 20-22, and 30 reportable encounters according to the guidance provided by the appropriate manual. This outlines how to capture the payment status or insurance coverage throughout first course treatment. It is preferable to harvest this data from either the specific reportable encounter's face sheet or discharge form. However, reporters often lack EHR access to this financial data. If so, reporters can code the coverage data listed in the EHR's demographics section. This will generally reflect the patient's current payment status. Class of Case 32 encounters will always be coded to 99 since that patient's cancer was not diagnosed or treated at the reporting facility.

Read below for a few real-world scenarios coding primary payer at DX:

- A single reportable encounter at the reporting facility; Class of Case 10; a patient presents to the ED with complaints related to shortness of breath and a persistent sharp pain in the right rib area when breathing for the past two weeks; imaging is done, finding a right upper lobe mass determined to be suspicious for primary lung cancer; the patient is discharged with a referral to a local cancer treatment center for workup; the face sheet and billing form for this encounter are not accessible to the reporter.
    - The patient's EHR demographic data lists the insurance provider as Aetna PPO; code to 20 private insurance: managed care, HMO, or PPO.
- Coding several first course treatment encounters at the reporting facility; Class of Case 22; patient receives all first course chemotherapy and radiation therapy.
    - The face sheet for the initial encounter with the medical oncologist for treatment planning lists no insurance coverage; a subsequent face sheet related to chemotherapy infusion lists charity payment; code to 01 not insured, patient has no insurance and is declared a charity write-off.

To help your reporters navigate the many obstacles coding primary payer at DX, TCR recommends developing a primary payer policy and procedure for your facility. Using this procedure, reporters should clearly understand how to consistently and accurately code and provide text documentation. Additionally, facilities should request EHR access to face sheets for reporters, allowing them to adhere to standard setter guidance as closely as possible.

Though it is not easy, the information collected provides valuable insight into many aspects of cancer care. This vital payment coverage data is not just useful to central registries, national stakeholders, and researchers, but also facilities. Facilities can leverage this same data to forecast budgets, staffing, and cancer care services. We hope this helps your facility develop a clear and concise coding strategy for primary payer at DX. As always, if you have any questions feel free to reach out to TCR extra additional support. Happy coding out there!

The following resources are available for more information on reportability:

- 2024 NAACCR Data Dictionary
- 2024 SEER Coding & Staging Manual; p. 88-89
- 2024 STORE Manual; p. 81-82
- 2024 Cancer Reporting Guide

Want to stay on top of TCR's most recent publications?

Our publications page features a list of our latest publications, data use, and a link to our cancer statistics.

Texas Cancer Registry
Texas Department of State Health Services
dshs.texas.gov/tcr cancerdata@dshs.texas.gov