SECTION TWO:
Coding Instructions

Patient Identification

ACCESSION NUMBER

Item Length: 9
NAACCR Item #550
Revised 01/04

Description

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

Rationale

This data item protects the identity of the patient and allows cases to be identified on a local, state, and national level.

Instructions for Coding

- When a patient is deleted from the database, **do not** reuse the accession number for another patient.
- The first four numbers specify the year and the last five numbers are the numeric order in which the patient was entered into the registry database.
- Numeric gaps are allowed in accession numbers.
- A patient's accession number is never reassigned.
- If a patient is first accessioned into the registry, then the registry later changes its reference date and the patient is subsequently accessioned into the registry with a new primary, use the original accession number associated with the patient and code the data item *Sequence Number* (NAACCR Item #560) appropriately.

Code	Definition
(fill spaces)	Nine-digit number used to identify the year in which the patient was first seen at the reporting facility for the diagnosis and/or treatment of cancer.

Examples:

Code	Reason
200300033	Patient enters the hospital in 2003, and is diagnosed with breast cancer. The patient is the 33rd patient accessioned in 2003.
200300033	A patient with the accession number 200300033 for a breast primary returns to the hospital with a subsequent colon primary in 2004. The accession number will remain the same. *Sequence Number* (NAACCR Item #560) will reflect this primary.
200300010	Patient is diagnosed in November 2002, at another facility. Enters the reporting facility in January 2003, and is the tenth case accessioned in 2003.
200300012	Patient is diagnosed in staff physician office in December 2002. Enters the reporting facility in January 2003, and is the 12th case accessioned in 2003.
199100067	Patient enters the hospital in 1991, and is diagnosed with prostate cancer. The registry later sets a new reference date of January 1, 1997. The same patient presents with a diagnosis of lymphoma in 2005.
200300001	First patient diagnosed/treated and entered into the registry database for 2003.
200300999	999th patient diagnosed/treated and entered into the registry database for 2003.
200309999	9999th patient diagnosed/treated and entered into the registry database for 2003.
200401504	1504th patient diagnosed/treated and entered into the registry database for 2004.

SEQUENCE NUMBER

Item Length: 2
Allowable Values: 00–59, 60–88, 99
NAACCR Item #560
Revised 06/05, 04/07

Description
Indicates the sequence of malignant and non-malignant neoplasms over the lifetime of the patient.

Rationale
This data item is used to distinguish among cases having the same accession numbers, to select patients with only one malignant primary tumor for certain follow-up studies, and to analyze factors involved in the development of multiple tumors.

Instructions for Coding

- Codes 00–59 and 99 indicate neoplasms of in situ or malignant behavior (Behavior equals 2 or 3). Codes 60–88 indicate neoplasms of non-malignant behavior (Behavior equals 0 or 1).
- Code 00 only if the patient has a single malignant primary. If the patient develops a subsequent malignant or in situ primary tumor, change the code for the first tumor from 00 to 01, and number subsequent tumors sequentially.
- Code 60 only if the patient has a single non-malignant primary. If the patient develops a subsequent non-malignant primary, change the code for the first tumor from 60 to 61, and assign codes to subsequent non-malignant primaries sequentially.
- If two or more malignant or in situ neoplasms are diagnosed at the same time, assign the lowest sequence number to the diagnosis with the worst prognosis. If no difference in prognosis is evident, the decision is arbitrary.
- If two or more non-malignant neoplasms are diagnosed at the same time, assign the lowest sequence number to the diagnosis with the worst prognosis. If no difference in prognosis is evident, the decision is arbitrary.
- Any tumor in the patient’s past which is reportable or reportable-by-agreement must be taken into account when sequencing subsequently accessioned tumors.
- Sequence numbers should be reassigned if the facility learns later of an unaccessioned tumor that affects the sequence.

Malignant or in situ

Code	Definition
00	One malignant or in situ primary only in the patient’s lifetime
01	First of two or more independent malignant or in situ primaries
02	Second of two or more independent malignant or in situ primaries
...	
...	(Actual sequence of this malignant or in situ primary)
...	
59	Fifty-nine or more independent malignant or in situ primaries
99	Unspecified malignant or in situ sequence number or unknown

Non-Malignant

Code	Definition
60	Only one non-malignant primary
61	First of two or more independent non-malignant primaries
62	Second of two or more independent non-malignant primaries
...	
...	(Consecutive number of non-malignant primaries)
...	
87	Twenty-seventh of twenty-seven independent non-malignant primaries
88	Unspecified number of neoplasms in this category.

Examples:

Code	Reason
00	A patient with no history of previous cancer is diagnosed with in situ breast carcinoma June 13, 2003.
01	The sequence number is changed when the patient with breast carcinoma diagnosed on June 13, 2003, is diagnosed with a subsequent skin melanoma on August 30, 2003.
02	The sequence number assigned to a skin melanoma diagnosed on August 30, 2003, following a breast carcinoma diagnosed on June 13, 2003.
04	A nursing home patient is admitted to a hospital for first course surgery for a colon adenocarcinoma. The patient had three previous primary cancers that the CoC requires to be accessioned, but was not seen for them at this facility. No sequence numbers 01, 02 or 03 are entered for this patient.
60	The sequence number assigned to a benign brain tumor diagnosed on November 1, 2005, following a breast carcinoma diagnosed on June 13, 2003, and a skin melanoma diagnosed on August 30, 2003.
63	Myeloproliferative disease (9975/1) is diagnosed by the facility in 2003 and accessioned as Sequence 60. A benign brain tumor was diagnosed and treated elsewhere in 2002; patient comes to the facility with a second independent benign brain tumor in 2004. Unaccessioned earlier brain tumor is counted as Sequence 61, myeloproliferative disease is resequenced to 62, and second benign brain tumor is Sequence 63.

MEDICAL RECORD NUMBER

Item Length: 11
Right Justified, Leading Blanks
NAACCR Item #2300

Description
Records the medical record number usually assigned by the reporting facility's health information management (HIM) department.

Rationale
This number identifies the patient within a reporting facility. It can be used to reference a patient record and it helps to identify multiple reports on the same patient.

Instructions for Coding
- Record the medical record number.
- When a patient enters a military hospital as a family member of a military sponsor, do not code the patient's relationship to the military sponsor in this field. See data item *Military Medical Record Number Suffix* (NAACCR Item #2310).

Examples:

Code	Reason
_ _ _ _ _000000	If the medical record number is fewer than 11 characters, right justify the characters and allow leading blanks.
_ _ _ _ _ _ _ _ _ RT (Radiology) _ _ _ _ _ _ _ _ _ SU (One-day surgery clinic)	Record standard abbreviations for departments that do not use HIM medical record numbers.
_ _ _ _ _ _ _ _ UNK	The medical record number is unknown.

SOCIAL SECURITY NUMBER

Item Length: 9
NAACCR Item #2320

Description
Records the patient's Social Security number.

Rationale
This data item can be used to identify patients with similar names.

Instructions for Coding
- Code the patient's Social Security number.
- A patient's Medicare claim number may not always be identical to the person's Social Security number.
- Code Social Security numbers that end with "B" or "D" as 999999999. The patient receives benefits under the spouse's number and this is the spouse's Social Security number.

Code	Definition
(fill spaces)	Record the patient's Social Security number (SSN) without dashes.
999999999	When the patient does not have a Social Security number, or the information is not available.

MILITARY MEDICAL RECORD NUMBER SUFFIX

Item Length: 2
Allowable Values: 01–20, 30–69, 98, 99
NAACCR Item #2310

Description
Records the patient identifier used by military hospitals to record the relationship of the patient to the sponsor.

Rationale
This data item supplements the medical record number in a military medical facility by describing the patient's relationship to the military sponsor.

Instructions for Coding
- Record the Family Member Prefix (FMP) codes assigned by individual military medical facilities.
- Leave blank for non-military facilities.

Code	Label
01–19	Child
20	Sponsor
30–39	Spouse
40–44	Mother
45–49	Father
50–54	Mother-in-law
55–59	Father-in-law
60–69	Other eligible dependents
98	Civilian emergency (AF/Navy)
99	Not classified elsewhere/stillborn
(leave blank)	Not a military facility

LAST NAME

Item Length: 25
Mixed Case
Left Justified
NAACCR Item #2230
Revised 01/04

Description
Identifies the last name of the patient.

Rationale
This data item is used by hospitals as a patient identifier.

Instructions for Coding
- Truncate name if more than 25 letters long. Blanks, spaces, hyphens, and apostrophes are allowed. Do not use other punctuation.
- Do not leave blank; code as unknown if the patient's last name is unknown.
- This field may be updated, if the last name changes.

Examples:

Code	Reason
Mc Donald	Recorded with space as Mc Donald.
O'Hara	Recorded with apostrophe as O'Hara.
Smith-Jones	Janet Smith marries Fred Jones and changes her name to Smith-Jones.
UNKNOWN	If the patient's last name is unknown, enter UNKNOWN.

FIRST NAME

Item Length: 14
Mixed Case
Left Justified
NAACCR Item #2240

Description
Identifies the first name of the patient.

Rationale
This data item is used by hospitals to differentiate between patients with the same last names.

Instructions for Coding
Truncate name if more than 14 letters long. Do not use punctuation.

Examples:

Code	Reason
Michael	Patient is admitted as Michael Hogan. Enter Hogan as the last name and Michael as the first name.
(leave blank)	If patient's first name is unknown, do not fill in the space.

MIDDLE NAME
(MIDDLE INITIAL)

Item Length: 14
Mixed Case
Left Justified
NAACCR Item #2250

Description
Identifies the middle name or middle initial of the patient.

Rationale
This data item helps distinguish between patients with identical first and last names.

Instructions for Coding
Truncate the name if more than 14 letters long. Record the middle initial if the complete name is not provided. Do not use punctuation.

Examples:

Code	Reason
David	Patient is admitted as Michael David Hogan. Enter Hogan as the last name, Michael as the first name, and David as the middle name.
D	Patient is admitted as Michael D. Hogan. Enter Hogan as the last name, Michael as the first name, and D as the middle name.
(leave blank)	Leave blank. If patient does not have a middle name or initial, or if the middle name or initial are unknown, do not fill in the space.

PATIENT ADDRESS (NUMBER AND STREET) AT DIAGNOSIS

Item Length: 40
Upper-case
Left Justified
NAACCR Item #2330

Description
Identifies the patient's address (number and street) at the time of diagnosis.

Rationale
The address is part of the patient's demographic data and has multiple uses. It indicates referral patterns and allows for the analysis of cancer clusters or environmental studies.

Instructions for Coding

- Record the number and street address or the rural mailing address of the patient's usual residence when the tumor was diagnosed.
- The address should be fully spelled out with standardized use of abbreviations and punctuation per U.S. Postal Service postal addressing standards. The USPS Postal Addressing Standards, Pub 28, November 2000 can be found on the Internet at *http://pe.usps.gov/cpim/ftp/pubs/pub28/pub28.pdf*.
- Abbreviations should be limited to those recognized by the Postal Service standard abbreviations. They include, but are not limited to: AVE (avenue), BLVD (boulevard), CIR (circle), CT (court), DR (drive), PLZ (plaza), PARK (park), PKWY (parkway), RD (road), SQ (square), ST (street), APT (apartment), BLDG (building), FL (floor), STE (suite), UNIT (unit), RM (room), DEPT (department), N (north), NE (northeast), NW (northwest), S (south), SE (southeast), SW (southwest), E (east), W (west). A complete list of recognized street abbreviations is provided in Appendix C of USPS Pub 28.
- Punctuation is normally limited to periods (ie, 39.2 RD), slashes for fractional addresses (ie, 101 ½ MAIN ST), and hyphens when a hyphen carries meaning (ie, 289-01 MONTGOMERY AVE). Use of the pound sign (#) to designate address units should be avoided whenever possible. The preferred notation is as follows: 102 MAIN ST APT 101. If a pound sign is used, there must be a space between the pound sign and the secondary number (ie, 425 FLOWER BLVD # 72).
- If the patient has multiple tumors, the address may be different for subsequent primaries.
- Do not update this data item if the patient's address changes.
- See "Residency Rules" in Section One for further instructions.

Code	Definition
103 FIRST AVE SW APT 102	The use of capital letters is preferred by the USPS; use recognized USPS standardized abbreviations; do not use punctuation unless absolutely necessary to clarify an address; leave blanks between numbers and words.
UNKNOWN	If the patient's address is unknown, enter UNKNOWN.

PATIENT ADDRESS AT DIAGNOSIS –SUPPLEMENTAL

Item Length: 40
Upper-case
Left Justified
NAACCR Item #2335
Revised 09/06

Description
Provides the ability to store additional address information such as the name of a place or facility (ie, a nursing home or name of an apartment complex) at the time of diagnosis.

Rationale
A registry may receive the name of a facility instead of a proper street address containing the street number, name, direction, and other elements necessary to locate an address on a street file for the purpose of geocoding.

Instructions for Coding
- Record the place or facility (ie, a nursing home or name of an apartment complex) of the patient's usual residence when the tumor was diagnosed.
- If the patient has multiple tumors, the address may be different for subsequent primaries.
- Do not use this data item to record the number and street address of the patient.
- Do not update this data item if the patient's address changes.
- See "Residency Rules" in Section One for further instructions.

Code	Definition
VALLEYVIEW NURSING HOME	The use of capital letters is preferred by the USPS; use recognized USPS standardized abbreviations; do not use punctuation unless absolutely necessary to clarify an address; leave blanks between numbers and words.
(leave blank)	If this address space is not needed, then leave blank.

CITY/TOWN AT DIAGNOSIS
(CITY OR TOWN)

Item Length: 20
Upper-case
Left Justified
NAACCR Item #70

Description
Identifies the name of the city or town in which the patient resides at the time the tumor is diagnosed and treated.

Rationale
The city or town is part of the patient's demographic data and has multiple uses. It indicates referral patterns and allows for the analysis of cancer clusters or environmental studies.

Instructions for Coding
- If the patient resides in a rural area, record the name of the city or town used in his or her mailing address.
- If the patient has multiple malignancies, the city or town may be different for subsequent primaries.
- Do not update this data item if the patient's city/town of residence changes.
- See "Residency Rules" in Section One for further instructions.

Code	Definition
CITY NAME	Do not use punctuation, special characters, or numbers. The use of capital letters is preferred by the USPS; it also guarantees consistent results in queries and reporting. Abbreviate where necessary.
UNKNOWN	If the patient's city or town is unknown.

STATE AT DIAGNOSIS
(STATE)

Item Length: 2
Upper-case
NAACCR Item #80
Revised 09/06

Description
Identifies the patient's state of residence at the time of diagnosis.

Rationale
The state of residence is part of the patient's demographic data and has multiple uses. It indicates referral patterns and allows for the analysis of cancer clusters or environmental studies.

Instructions for Coding
- U.S. Postal Service abbreviation for the state, territory, commonwealth, U.S. possession, or Canadian province/territory in which the patient resides at the time the tumor is diagnosed and treated.
- If the patient has multiple tumors, the state of residence may be different for subsequent primaries.
- If the patient is a foreign resident, then code either XX or YY depending on the circumstance.
- Do not update this data item if the patient's state of residence changes.

Code	Definition
IL	If the state in which the patient resides at the time of diagnosis and treatment is Illinois, then use the USPS code for the state of Illinois.
XX	Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and the country *is known*.
YY	Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and the country *is unknown*.
ZZ	Residence unknown.

Common abbreviations (Refer to the ZIP Code directory for further listings):

State		State		State	
Alabama	AL	Massachusetts	MA	Tennessee	TN
Alaska	AK	Michigan	MI	Texas	TX
Arizona	AZ	Minnesota	MN	Utah	UT
Arkansas	AR	Mississippi	MS	Vermont	VT
California	CA	Missouri	MO	Virginia	VA
Colorado	CO	Montana	MT	Washington	WA
Connecticut	CT	Nebraska	NE	West Virginia	WV
Delaware	DE	Nevada	NV	Wisconsin	WI
District of Columbia	DC	New Hampshire	NH	Wyoming	WY
Florida	FL	New Jersey	NJ	United States, state unknown	US
Georgia	GA	New Mexico	NM	American Samoa	AS
Hawaii	HI	New York	NY	Guam	GU
Idaho	ID	North Carolina	NC	Puerto Rico	PR
Illinois	IL	North Dakota	ND	Virgin Islands	VI
Indiana	IN	Ohio	OH	Palau	PW
Iowa	IA	Oklahoma	OK	Micronesia	FM
Kansas	KS	Oregon	OR	Marshall Islands	MH
Kentucky	KY	Pennsylvania	PA	Outlying Islands	UM
Louisiana	LA	Rhode Island	RI	APO/FPO Armed Services America	AA
Maine	ME	South Carolina	SC	APO/FPO Armed Services Europe	AE
Maryland	MD	South Dakota	SD	APO/FPO Armed Services Pacific	AP

The following are abbreviations for Canadian provinces and territories:

Province/Territory		Province/Territory	
Alberta	AB	Nunavut	NU
British Columbia	BC	Ontario	ON
Manitoba	MB	Prince Edward Island	PE
New Brunswick	NB	Quebec	QC
Newfoundland and Labrador	NL	Saskatchewan	SK
Northwest Territories	NT	Yukon	YT
Nova Scotia	NS	Canada, province unknown	CD

POSTAL CODE AT DIAGNOSIS (ZIP CODE)

Item Length: 9
Left Justified
NAACCR Item #100
Revised 01/04

Description
Identifies the postal code of the patient's address at diagnosis.

Rationale
The postal code is part of the patient's demographic data and has multiple uses. It will provide a referral pattern report and allow analysis of cancer clusters or environmental studies.

Instructions for Coding
- For U.S. residents, record the patient's nine-digit extended postal code at the time of diagnosis and treatment.
- For Canadian residents, record the six-character postal code.
- When available, record the postal code for other countries.
- If the patient has multiple malignancies, the postal code may be different for subsequent primaries.
- Do not update this data item if the patient's postal code changes.
- See "Residency Rules" in Section One for further instructions.

Code	Definition
(fill spaces)	The patient's nine-digit U.S. extended postal code. Do not record hyphens.
60611_ _ _ _	When the nine-digit extended U.S. ZIP Code is not available, record the five-digit postal code, left justified, followed by four blanks.
M6G2S8_ _ _	The patient's six-character Canadian postal code left justified, followed by three blanks.
88888_ _ _ _ or 888888888	Permanent address in a country other than Canada, United States, or U.S. possessions **and** postal code is unknown.
99999_ _ _ _ or 999999999	Permanent address in Canada, United States, or U.S. possession **and** postal code is unknown.

COUNTY AT DIAGNOSIS

Item Length: 3
Allowable Values: 001–997, 998, 999
NAACCR Item #90
Revised 09/06

Description
Identifies the county of the patient's residence at the time the reportable tumor is diagnosed.

Rationale
This data item may be used for epidemiological purposes. For example, to measure the cancer incidence in a particular geographic area.

Instructions for Coding
- For U.S. residents, use codes issued by the Federal Information Processing Standards (FIPS) publication, *Counties and Equivalent Entities of the United States, Its Possessions, and Associated areas*. This publication is available in a reference library or can be accessed on the Internet through the U.S. EPA's Envirofacts Data Warehouse and Applications Web site at *http://www.epa.gov/*.
- If the patient has multiple tumors, the county codes may be different for each tumor.
- If the patient is a non-U.S. resident and is coded XX in *State at Diagnosis* (NAACCR Item #80), then code the patient's country of residence in this space.
- For country codes, see *The SEER Program Coding and Staging Manual*, (*http://seer.cancer.gov/*) or *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary Version 11.1*, Eleventh Edition, (*http://www.naaccr.org*).*
- Do not update this data item if the patient's county of residence changes.

Code	Label	Definition
001–997	County at diagnosis	Valid FIPS code.
998	Outside state/county code unknown	Known town, city, state, or country of residence, but county code not known AND a resident outside of the state of the reporting institution (must meet all criteria).
999	County unknown	The county of the patient is unknown. It is not documented in the patient's medical record.

*Johnson C, ed. *The SEER Program Coding and Staging Manual 2004*, Revision 1. NIH, NCI Publication 04-5581, 2004.

*Havener L, Hultstrom D, eds. *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary Version 11.1*, Eleventh Edition. Springfield, IL: North American Association for Central Cancer Registries, April 2006.

PATIENT ADDRESS (NUMBER AND STREET)– CURRENT

Item Length: 40
Upper-case
Left Justified
NAACCR Item #2350
Revised 09/04

Description
Identifies the patient's current address (number and street).

Rationale
This data item provides a current address used for follow-up purposes. It is different from *Patient Address at Diagnosis* (NAACCR #2330).

Instructions for Coding

- Record the number and street address or the rural mailing address of the patient's current usual residence.
- The address should be fully spelled out with standardized use of abbreviations and punctuation per U.S. Postal Service postal addressing standards. The USPS Postal Addressing Standards, Pub 28, November 2000 can be found on the Internet at *http://pe.usps.gov/cpim/ftp/pubs/pub28/pub28.pdf*.
- Abbreviations should be limited to those recognized by the Postal Service standard abbreviations. They include, but are not limited to: AVE (avenue), BLVD (boulevard), CIR (circle), CT (court), DR (drive), PLZ (plaza), PARK (park), PKWY (parkway), RD (road), SQ (square), ST (street), APT (apartment), BLDG (building), FL (floor), STE (suite), UNIT (unit), RM (room), DEPT (department), N (north), NE (northeast), NW (northwest), S (south), SE (southeast), SW (southwest), E (east), W (west). A complete list of recognized street abbreviations is provided in Appendix C of USPS Pub 28.
- Punctuation is normally limited to periods (ie, 39.2 RD), slashes for fractional addresses (ie, 101 ½ MAIN ST), and hyphens when a hyphen carries meaning (ie, 289-01 MONTGOMERY AVE). Use of the pound sign (#) to designate address units should be avoided whenever possible. The preferred notation is as follows: 102 MAIN ST APT 101. If a pound sign is used, there must be a space between the pound sign and the secondary number (ie, 425 FLOWER BLVD # 72).
- Update this data item if the patient's address changes.
- Do not change this item when the patient dies.
- See "Residency Rules" in Section One for further instructions.

Code	Definition
103 FIRST AVE SW APT 102	The use of capital letters is preferred by the USPS; use recognized USPS standardized abbreviations; do not use punctuation unless absolutely necessary to clarify an address; leave blanks between numbers and words.
UNKNOWN	The patient's street address is unknown.

PATIENT ADDRESS CURRENT –SUPPLEMENTAL

Item Length: 40
Upper-case
Left Justified
NAACCR Item #2355
Revised 09/06

Description
Provides the ability to store additional address information such as the name of a place or facility (ie, a nursing home or name of an apartment complex).

Rationale
A registry may receive the name of a facility instead of a proper street address containing the street number, name, direction, and other elements necessary to locate an address on a street file for the purpose of geocoding.

Instructions for Coding
- Record the place or facility (ie, a nursing home or name of an apartment complex) of the patient's current usual residence.
- If the patient has multiple tumors, the address may be different for subsequent primaries.
- Update this data item if a patient's address changes.
- Do not use this data item to record the number and street address of the patient.
- Do not change this item when the patient dies.
- See "Residency Rules" in Section One for further instructions.

Code	Definition
VALLEYVIEW NURSING HOME	The use of capital letters is preferred by the USPS; use recognized USPS standardized abbreviations; do not use punctuation unless absolutely necessary to clarify an address; leave blanks between numbers and words.
(leave blank)	If this address space is not needed, then leave blank.

CITY/TOWN–CURRENT

Item Length: 20
Upper-case
Left Justified
NAACCR Item #1810
Revised 09/04

Description
Identifies the name of the city or town of the patient's current usual residence.

Rationale
This data item provides a current city/town used for follow-up purposes. It is different from *City/Town at Diagnosis* (NAACCR Item #70).

Instructions for Coding

- If the patient resides in a rural area, record the name of the city or town used in his or her mailing address.
- If the patient has multiple malignancies, the current city or town should be the same for all tumors.
- Update this data item if the patient's city/town of residence changes.
- Do not change this item when the patient dies.
- See "Residency Rules" in Section One for further instructions.

Code	Definition
CITY NAME	Do not use punctuation, special characters, or numbers. The use of capital letters is preferred by the USPS; it also guarantees consistent results in queries and reporting. Abbreviate where necessary.
UNKNOWN	The city in which the patient resides is unknown.

STATE–CURRENT

Item Length: 2
Upper-case
NAACCR Item #1820
Revised 09/06

Description
Identifies the patient's current state of residence.

Rationale
This item provides a current state of residence used for follow-up purposes. It is different from *State at Diagnosis* (NAACCR Item #80).

Instructions for Coding
- U.S. Postal Service abbreviation for the state, territory, commonwealth, U.S. possession, or Canadian province/territory of the patient's current usual residence.
- If the patient has multiple tumors, the current state of residence should be the same for all tumors.
- If the patient is a foreign resident, then code either XX or YY depending on the circumstance.
- Update this data item if the patient's state of residence changes.
- Do not change this item when the patient dies.

Code	Definition
IL	If the state in which the patient resides at the time of diagnosis and treatment is Illinois, then use the USPS code for the state of Illinois.
XX	Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and the country *is known*.
YY	Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and the country *is unknown*.
ZZ	Residence unknown.

Common abbreviations (Refer to the ZIP Code directory for further listings):

State		State		State	
Alabama	AL	Massachusetts	MA	Tennessee	TN
Alaska	AK	Michigan	MI	Texas	TX
Arizona	AZ	Minnesota	MN	Utah	UT
Arkansas	AR	Mississippi	MS	Vermont	VT
California	CA	Missouri	MO	Virginia	VA
Colorado	CO	Montana	MT	Washington	WA
Connecticut	CT	Nebraska	NE	West Virginia	WV
Delaware	DE	Nevada	NV	Wisconsin	WI
District of Columbia	DC	New Hampshire	NH	Wyoming	WY
Florida	FL	New Jersey	NJ	United States, state unknown	US
Georgia	GA	New Mexico	NM	American Samoa	AS
Hawaii	HI	New York	NY	Guam	GU
Idaho	ID	North Carolina	NC	Puerto Rico	PR
Illinois	IL	North Dakota	ND	Virgin Islands	VI
Indiana	IN	Ohio	OH	Palau	PW
Iowa	IA	Oklahoma	OK	Micronesia	FM
Kansas	KS	Oregon	OR	Marshall Islands	MH
Kentucky	KY	Pennsylvania	PA	Outlying Islands	UM
Louisiana	LA	Rhode Island	RI	APO/FPO Armed Services America	AA
Maine	ME	South Carolina	SC	APO/FPO Armed Services Europe	AE
Maryland	MD	South Dakota	SD	APO/FPO Armed Services Pacific	AP

The following are abbreviations for Canadian provinces or territories:

Province/Territory		Province/Territory	
Alberta	AB	Nunavut	NU
British Columbia	BC	Ontario	ON
Manitoba	MB	Prince Edward Island	PE
New Brunswick	NB	Quebec	QC
Newfoundland and Labrador	NL	Saskatchewan	SK
Northwest Territories	NT	Yukon	YT
Nova Scotia	NS	Canada, province unknown	CD

POSTAL CODE–CURRENT
(ZIP CODE)

Item Length: 9
Left Justified
NAACCR Item #1830
Revised 01/04

Description
Identifies the postal code of the patient's current address**.**

Rationale
This data item provides a current postal code for follow-up purposes and should be updated. It is different from *Postal Code at Diagnosis* (NAACCR Item #100).

Instructions for Coding
- For U.S. residents, record the nine-digit extended postal code for the patient's current usual residence.
- For Canadian residents, record the six-character postal code.
- When available, record the postal code for other countries.
- If the patient has multiple tumors, the postal code should be the same.
- Update this data item if the patient's postal code changes.

Code	Definition
(fill spaces)	The patient's nine-digit U.S. extended postal code. Do not record hyphens.
60611_ _ _ _	When the nine-digit extended U.S. ZIP Code is not available, record the five-digit postal code, left justified, followed by four blanks.
M6G2S8_ _ _	The patient's six-character Canadian postal code left justified, followed by three blanks.
88888_ _ _ _ or 888888888	Permanent address in a country other than Canada, United States, or U.S. possessions **and** postal code is unknown.
99999_ _ _ _ or 999999999	Permanent address in Canada, United States, or U.S. possession **and** postal code is unknown.

TELEPHONE

Item Length: 10
NAACCR Item #2360

Description
Records the current telephone number with area code for the patient.

Rationale
This data item may be used by the hospital registry to contact the patient for follow-up.

Instructions for Coding
- The telephone number should be the current number with area code of the patient.
- Update this data item if the patient's telephone number changes.

Code	Definition
(fill spaces)	Number is entered without dashes.
0000000000	Patient does not have a telephone.
9999999999	Telephone number is unavailable or unknown.

PLACE OF BIRTH

Item Length: 3
Allowable Values: 000–750, 998, 999
NAACCR Item #250
Revised 09/06

Description
Records the patient's place of birth.

Rationale
This data item is used to evaluate medical care delivery to special populations and to identify populations at special risk for certain cancers.

Instructions for Coding
- Use the most specific code.
- Use the SEER Geocodes for "Place of Birth." These codes include states of the United States as well as foreign countries.
- For SEER Geocodes, see *The SEER Program Coding and Staging Manual*, (*http://seer.cancer.gov/*) or *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary Version 11.1*, Eleventh Edition *(http://www.naaccr.org*).*

Code	Definition
000–750	SEER Geocode
998	Place of birth outside of the United States, no other detail known.
999	Place of birth unknown.

*Johnson C, ed. *The SEER Program Coding and Staging Manual 2004*, Revision 1. NIH, NCI Publication 04-5581, 2004.

*Havener L, Hultstrom D, eds. *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary Version 11.1*, Eleventh Edition. Springfield, IL: North American Association for Central Cancer Registries, April 2006.

DATE OF BIRTH

Item Length: 8
NAACCR Item #240

Description
Identifies the date of birth of the patient.

Rationale
This data item is useful for patient identification. It is also useful when analyzing tumors according to patient cohort.

Instructions for Coding
Record the patient’s date of birth as indicated in the patient record.

Code	Definition
MMDDCCYY	The date of birth is the month, day, and year that the patient was born. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year.

Month
01 January
02 February
03 March
04 April
05 May
06 June
07 July
08 August
09 September
10 October
11 November
12 December
99 Month unknown

Day
01
02
03
...
...
25
31
99 Day unknown

Year
Use four-digit year
9999 Year unknown

Examples:

Code	Reason
06301906	The patient’s date of birth is June 30, 1906.
99991940	The patient is 60 years old on June 15, 2000. The medical record does not have a date of birth. Record unknown month (99) and day (99). Calculate the year as 1940.
99991927	The medical record contains only the year of birth (1927).

AGE AT DIAGNOSIS

Item Length: 3
Allowable Values: 000–120, 999
Right Justified, Zero-filled
NAACCR Item #230
Revised 09/01/08

Description
Records the age of the patient at his or her last birthday before diagnosis.

Rationale
This data item is useful for patient identification. It may also be useful when analyzing tumors according to specific patient age.

Instructions for Coding
If the patient has multiple primaries, then the age at diagnosis may be different for subsequent primaries.

Code	Definition
000	Less than one year old; diagnosed *in utero*.
001	One year old, but less than two years old.
002	Two years old.
...	Show actual age in years.
120	One hundred twenty years old.
999	Unknown age.

RACE 1

Item length: 2
Allowable Values: 01–14,
20–22, 25–28, 30–32, 96–99
NAACCR Item #160

Revised 01/04, 09/08

Description
Identifies the primary race of the person.

Rationale
Racial origin captures information used in research and cancer control activities comparing stage at diagnosis and/or treatment by race. The full coding system should be used to allow for an accurate national comparison.

Instructions for Coding

- Additional races reported by the person should be coded in *Race 2, Race 3, Race 4*, and *Race 5*.
- *Race 1* is the field used to compare with race data on cases diagnosed prior to January 1, 2000.
- "Race" is analyzed with *Spanish/Hispanic Origin* (NAACCR Item #190). Both items must be recorded. All tumors for the same patient should have the same race code.
- If the patient is multiracial, then code all races using *Race 2* (NAACCR Item #161) through *Race 5* (NAACCR Item #164), and code all remaining *Race* items 88.
- If the person is multiracial and one of the races is white, code the other race(s) first with white in the next race field.
- If the person is multiracial and one of the races is Hawaiian, code Hawaiian as Race 1, followed by the other race(s).
- If *Race 1* is coded 99, then *Race 2* through *Race 5* must all be coded 99.
- Codes 08–13 became effective with diagnoses on or after January 1, 1988.
- Code 14 became effective with diagnoses on or after January 1, 1994.
- Codes 20–97 became effective with diagnoses on or after January 1, 1991. SEER participants in San Francisco, San Jose–Monterey, and Los Angeles are permitted to use codes 14 and 20–97 for cases diagnosed after January 1, 1987.
- If *Race Coding System–Current* (NAACCR Item #170) is less than six (6) for cases diagnosed prior to January 1, 2000, then *Race 2* through *Race 5* must be blank.
- If a patient diagnosed prior to January 1, 2000, develops a subsequent primary after that date, then *Race Coding System–Current* must be six (6), and data items *Race 2* through *Race 5* that do not have specific race recorded must be coded 88.

Codes		Codes	
01	White	21	Chamorran
02	Black	22	Guamanian, NOS
03	American Indian, Aleutian, or Eskimo	25	Polynesian, NOS
04	Chinese	26	Tahitian
05	Japanese	27	Samoan
06	Filipino	28	Tongan
07	Hawaiian	30	Melanesian, NOS
08	Korean	31	Fiji Islander
09	Asian Indian, Pakistani	32	New Guinean
10	Vietnamese	96	Other Asian, including Asian, NOS and Oriental, NOS
11	Laotian	97	Pacific Islander, NOS
12	Hmong	98	Other
13	Kampuchean (including Khmer and Cambodian)	99	Unknown
14	Thai		
20	Micronesian, NOS		

Examples:

Code	Reason
01	A patient was born in Mexico of Mexican parentage. Code also *Spanish/Hispanic Origin* (NAACCR Item #190).
02	A black female patient. A specific race code (other than blank or 99) must not occur more than once. For example, do not code "Black" in *Race 1* for one parent and "Black" in *Race 2* for the other parent.
05	A patient has a Japanese father and a Caucasian mother. (Caucasian will be coded to *Race 2*). If a person's race is recorded as a combination of white and any other race, code to the appropriate *other* race in this field and then code Caucasian as "White" in the next race field.
05	A patient's race is listed as Asian and the birthplace is Japan. Code to birthplace. When the race is recorded as "Oriental," "Mongolian," or "Asian," and the place of birth is recorded as China, Japan, the Philippines, or another Asian nation, code the race based on birthplace information.
07	A patient has a Hawaiian father, black mother, Japanese grandfather, and Korean grandmother. If a person's race is recorded as a combination of Hawaiian and any other race(s), code the person's primary race as Hawaiian and code the other races in *Race 2*, *Race 3*, *Race 4*, and *Race 5* as appropriate. In this case, black to *Race 2*; Japanese to *Race 3*; and Korean to *Race 4*.
08	A patient is of Korean and Asian ancestry. Do not code "Asian" in a subsequent race field if a specific Asian race(s) has already been coded.
25	A patient with a Polynesian mother, Tahitian father, and Samoan grandparents.
99	A patient's race is unknown. *Race 2* through *Race 5* must also be 99.

RACE 2

Item Length: 2
Allowable Values: 01–14, 20–22, 25–28, 30–32, 88, 96–99
NAACCR Item #161
Revised 01/04, 09/08

Description
Identifies the patient's race.

Rationale
Racial origin captures information used in research and cancer control activities comparing stage at diagnosis and/or treatment by race. The full coding system should be used to allow for an accurate national comparison.

Instructions for Coding
- "Race" is analyzed with *Spanish/Hispanic Origin* (NAACCR Item #190). Both items must be recorded. All tumors for the same patient should have the same race code.
- If *Race 1* (NAACCR Item #160) is coded 99, then *Race 2* must be coded 99.
- Codes 08–13 became effective with diagnoses on or after January 1, 1988.
- Code 14 became effective with diagnoses on or after January 1, 1994.
- Codes 20–97 became effective with diagnoses on or after January 1, 1991. SEER participants in San Francisco, San Jose–Monterey, and Los Angeles are permitted to use codes 14 and 20–97 for cases diagnosed after January 1, 1987.
- See the instructions for *Race 1* (NAACCR Item # 160) for coding sequences for entering multiple races.

Codes		Codes	
01	White	21	Chamorran
02	Black	22	Guamanian, NOS
03	American Indian, Aleutian, or Eskimo	25	Polynesian, NOS
04	Chinese	26	Tahitian
05	Japanese	27	Samoan
06	Filipino	28	Tongan
07	Hawaiian	30	Melanesian, NOS
08	Korean	31	Fiji Islander
09	Asian Indian, Pakistani	32	New Guinean
10	Vietnamese	88	No further race documented
11	Laotian	96	Other Asian, including Asian, NOS and Oriental, NOS
12	Hmong	97	Pacific Islander, NOS
13	Kampuchean (including Khmer and Cambodian)	98	Other
14	Thai	99	Unknown
20	Micronesian, NOS		

RACE 3

Item Length: 2
Allowable Values: 01–14, 20–22, 25–28, 30–32, 88, 96–99
NAACCR Item #162
Revised 01/04, 09/08

Description
Identifies the patient's race.

Rationale
Racial origin captures information used in research and cancer control activities comparing stage at diagnosis and/or treatment by race. The full coding system should be used to allow for an accurate national comparison.

Instructions for Coding

- "Race" is analyzed with *Spanish/Hispanic Origin* (NAACCR Item #190). Both items must be recorded. All tumors for the same patient should have the same race code.
- If *Race 2* (NAACCR Item #161) is coded 88 or 99, then *Race 3* must be coded with the same value.
- Codes 08–13 became effective with diagnoses on or after January 1, 1988.
- Code 14 became effective with diagnoses on or after January 1, 1994.
- Codes 20–97 became effective with diagnoses on or after January 1, 1991. SEER participants in San Francisco, San Jose–Monterey, and Los Angeles are permitted to use codes 14 and 20–97 for cases diagnosed after January 1, 1987.
- See the instructions for *Race 1* (NAACCR Item # 160) for coding sequences for entering multiple races.

Codes		Codes	
01	White	21	Chamorran
02	Black	22	Guamanian, NOS
03	American Indian, Aleutian, or Eskimo	25	Polynesian, NOS
04	Chinese	26	Tahitian
05	Japanese	27	Samoan
06	Filipino	28	Tongan
07	Hawaiian	30	Melanesian, NOS
08	Korean	31	Fiji Islander
09	Asian Indian, Pakistani	32	New Guinean
10	Vietnamese	88	No further race documented
11	Laotian	96	Other Asian, including Asian, NOS and Oriental, NOS
12	Hmong	97	Pacific Islander, NOS
13	Kampuchean (including Khmer and Cambodian)	98	Other
14	Thai	99	Unknown
20	Micronesian, NOS		

RACE 4

Item Length: 2
Allowable Values: 01–14, 20–22, 25–28, 30–32, 88, 96–99
NAACCR Item #163
Revised 01/04, 09/08

Description
Identifies the patient's race.

Rationale
Racial origin captures information used in research and cancer control activities comparing stage at diagnosis and/or treatment by race. The full coding system should be used to allow for an accurate national comparison.

Instructions for Coding
- "Race" is analyzed with *Spanish/Hispanic Origin* (NAACCR Item #190). Both items must be recorded. All tumors for the same patient should have the same race code.
- If *Race 3* (NAACCR Item #162) is coded 88 or 99, then *Race 4* must be coded with the same value.
- Codes 08–13 became effective with diagnoses on or after January 1, 1988.
- Code 14 became effective with diagnoses on or after January 1, 1994.
- Codes 20–97 became effective with diagnoses on or after January 1, 1991. SEER participants in San Francisco, San Jose–Monterey, and Los Angeles are permitted to use codes 14 and 20–97 for cases diagnosed after January 1, 1987.
- See the instructions for *Race 1* (NAACCR Item # 160) for coding sequences for entering multiple races.

Codes		Codes	
01	White	21	Chamorran
02	Black	22	Guamanian, NOS
03	American Indian, Aleutian, or Eskimo	25	Polynesian, NOS
04	Chinese	26	Tahitian
05	Japanese	27	Samoan
06	Filipino	28	Tongan
07	Hawaiian	30	Melanesian, NOS
08	Korean	31	Fiji Islander
09	Asian Indian, Pakistani	32	New Guinean
10	Vietnamese	88	No further race documented
11	Laotian	96	Other Asian, including Asian, NOS and Oriental, NOS
12	Hmong	97	Pacific Islander, NOS
13	Kampuchean (including Khmer and Cambodian)	98	Other
14	Thai	99	Unknown
20	Micronesian, NOS		

RACE 5

Item Length: 2
Allowable Values: 01–14, 20–22, 25–28, 30–32, 88, 96–99
NAACCR Item #164
Revised 01/04, 09/08

Description
Identifies the patient's race.

Rationale
Racial origin captures information used in research and cancer control activities comparing stage at diagnosis and/or treatment by race. The full coding system should be used to allow for an accurate national comparison.

Instructions for Coding
- "Race" is analyzed with *Spanish/Hispanic Origin* (NAACCR Item #190). Both items must be recorded. All tumors for the same patient should have the same race code.
- If *Race 4* (NAACCR Item #163) is coded 88 or 99, then *Race 5* must be coded with the same value.
- Codes 08–13 became effective with diagnoses on or after January 1, 1988.
- Code 14 became effective with diagnoses on or after January 1, 1994.
- Codes 20–97 became effective with diagnoses on or after January 1, 1991. SEER participants in San Francisco, San Jose–Monterey, and Los Angeles are permitted to use codes 14 and 20–97 for cases diagnosed after January 1, 1987.
- See the instructions for *Race 1* (NAACCR Item # 160) for coding sequences for entering multiple races.

Codes		Codes	
01	White	21	Chamorran
02	Black	22	Guamanian, NOS
03	American Indian, Aleutian, or Eskimo	25	Polynesian, NOS
04	Chinese	26	Tahitian
05	Japanese	27	Samoan
06	Filipino	28	Tongan
07	Hawaiian	30	Melanesian, NOS
08	Korean	31	Fiji Islander
09	Asian Indian, Pakistani	32	New Guinean
10	Vietnamese	88	No further race documented
11	Laotian	96	Other Asian, including Asian, NOS and Oriental, NOS
12	Hmong	97	Pacific Islander, NOS
13	Kampuchean (including Khmer and Cambodian)	98	Other
14	Thai	99	Unknown
20	Micronesian, NOS		

SPANISH ORIGIN—ALL SOURCES (SPANISH/HISPANIC ORIGIN)

Item Length: 1
Allowable Values: 0–7, 9
NAACCR Item #190
Revised 09/04

Description
Identifies persons of Spanish or Hispanic origin.

Rationale
This code is used by hospital and central registries to identify whether or not the person should be classified as "Hispanic" for purposes of calculating cancer rates. Hispanic populations have different patterns of occurrence of cancer from other populations that may be included in the 01 (White category) of *Race 1*through *Race 5* (NAACCR Item #s 160–164).

Instructions for Coding
- Persons of Spanish or Hispanic origin may be of any race, but these categories are generally not used for Native Americans, Filipinos, or others who may have Spanish names.
- Code 0 (Non-Spanish; non-Hispanic) for Portuguese and Brazilian persons.
- If the patient has multiple tumors, all records should have the same code.

Code	Label
0	Non-Spanish; non-Hispanic
1	Mexican (includes Chicano)
2	Puerto Rican
3	Cuban
4	South or Central America (except Brazil)
5	Other specified Spanish/Hispanic origin (includes European; excludes Dominican Republic)
6	Spanish, NOS; Hispanic, NOS; Latino, NOS (There is evidence other than surname or maiden name that the person is Hispanic, but he/she cannot be assigned to any category of 1–5)
7	Spanish surname only (The only evidence of the person's Hispanic origin is surname or maiden name, and there is no contrary evidence that the person is not Hispanic)
8	Dominican Republic (for use with patients who were diagnosed with cancer on January 1, 2005, or later)
9	Unknown whether Spanish or not; not stated in patient record

SEX

Item Length: 1
Allowable Values: 1–4, 9
NAACCR Item #220

Description
Identifies the sex of the patient.

Rationale
This data item is used to compare cancer rates and outcomes by site. The same sex code should appear in each medical record for a patient with multiple tumors.

Instructions for Coding
Record the patient's sex as indicated in the medical record.

Code	Label
1	Male
2	Female
3	Other (hermaphrodite)
4	Transsexual
9	Not stated in patient record

PRIMARY PAYER AT DIAGNOSIS

Item Length: 2
Allowable Values: 01, 02, 10, 20, 21, 31, 35, 60–68, 99
NAACCR Item #630
Revised 06/05

Description

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

Rationale

This item is used in financial analysis and as an indicator for quality and outcome analyses. Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires the patient admission page to document the type of insurance or payment structure that will cover the patient while being cared for at the hospital.

Instructions for Coding

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

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

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

Examples:

Code	Reason
01	An indigent patient is admitted with no insurance coverage.
20	A patient is admitted for treatment and the patient admission page states the primary insurance carrier is an HMO.
62	A 65-year old male patient is admitted for treatment and the patient admission page states the patient is covered by Medicare with additional insurance coverage from a PPO.

COMORBIDITIES AND COMPLICATIONS #1
(Secondary Diagnoses)

Item Length: 5
Allowable Values: 00000, 00100–13980, 24000–99990, E8700–E8799, E9300–E9499, V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049
Left Justified, Zero-filled
NAACCR Item #3110
Revised 06/05

Description

Records the patient's preexisting medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer using ICD-9-CM codes. All are considered secondary diagnoses.

Rationale

Preexisting medical conditions, factors influencing health status, and/or complications may affect treatment decisions and influence patient outcomes. Information on comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes. Complications may be related to the quality of care.

Instructions for Coding

- Secondary diagnoses must be reported for patients that have inpatient hospitalizations at your facility.
- Secondary diagnoses should be reported for patients receiving outpatient care or treated in oncology clinics at your facility when available.
- Consult the patient record for the discharge abstract. Secondary diagnoses are found on the discharge abstract. Information from the billing department at your facility may be consulted when a discharge abstract is not available.
- Code the secondary diagnoses in the sequence in which they appear on the discharge abstract or are recorded by the billing department at your facility.
- Report the secondary diagnoses for this cancer using the following priority rules:
  -Surgically treated patients:
    a) following the most definitive surgery of the primary site
    b) following other non-primary site surgeries
  -Non-surgically treated patients:
    following the first treatment encounter/episode
  -In cases of non-treatment:
    following the last diagnostic/evaluative encounter
- If the data item *Readmission To The Same Hospital Within 30 Days Of Surgical Discharge* (NAACCR Item #3190) is coded 1, 2, or 3, then use available *Comorbidities and Complications* data items to record E codes appearing on the "readmission" discharge abstract.
- **Do not** record any neoplasms (ICD-9-CM codes 140–239.9) listed as secondary diagnoses for this data item.
- **Do not** record causes of injury and poisoning unrelated to the patient's medical care (ICD-9-CM codes E800–E869.9, E880–E929.9, or E950–E999).
- **Do not** record the following factors influencing health status and contact with health services (ICD-9-CM codes V01-V07.1, V07.4-V09.91, V16-V21.9, V23.2-V25.3, V25.5-V43.89, V46-V50.4, or V50.8-V83.89).
- If no secondary diagnoses were documented, then code 00000 in this data item, and leave the remaining "Comorbidities and Complications" data items blank.
- If fewer than 10 secondary diagnoses are listed, then code the diagnoses listed, and leave the remaining "Comorbidities and Complications" data items blank.

Code	Definition
(fill spaces)	Report the ICD-9-CM codes for up to 10 comorbid conditions or complications. *Note:* For comorbid conditions (ICD-9-CM codes 001–139.8 and 240–999.9) there is an assumed decimal point between the 3rd and 4th characters. *Note:* For complications (ICD-9-CM "E"codes) and factors influencing health status (ICD-9-CM "V" codes) there is an assumed decimal point between the 4th and 5th characters.
00000	No comorbid conditions or complications documented.

Examples:

Code	Reason
49600	COPD (ICD-9-CM code 496)
25001	Type 1 diabetes mellitus (ICD-9-CM code 250.01)
40100	Hypertension (ICD-9-CM code 401)
E8732	The patient was inadvertently exposed to an overdose of external beam radiation (ICD-9-CM code E873.2)
E8782	The patient with colon cancer underwent surgical resection and subsequently experienced an anastomotic leak (ICD-9-CM code E878.2)
E9300	During hospitalization, the patient has an adverse reaction to Ampicillin, a semisynthetic form of penicillin (ICD-9-CM code E930.0)
V1030	The patient has a personal history of breast cancer (ICD-9-CM code V10.3)

COMORBIDITIES AND COMPLICATIONS #2
(Secondary Diagnoses)

Item Length: 5
Allowable Values:00100–13980, 24000–99990, E8700–E8799, E9300–E9499,V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049
Left Justified, Zero-filled
NAACCR Item #3120
Revised 06/05

Description
Records the patient's preexisting medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer. Both are considered secondary diagnoses.

Rationale
Preexisting medical conditions, factors influencing health status, and/or complications may affect treatment decisions and influence patient outcomes. Information on comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes. Complications may be related to the quality of care.

Instructions for Coding
- If only one comorbid condition or complication is listed, then leave this data item blank.
- If only two comorbid conditions or complications are listed, then code the diagnoses listed and leave the remaining "Comorbidities and Complications" items blank.
- For further coding instructions, see *Comorbidities and Complications #1* (NAACCR Item #3110).

Code	Definition
(fill spaces)	Report the ICD-9-CM codes for up to 10 comorbid conditions or complications. *Note:* For comorbid conditions (ICD-9-CM codes 001–139.8 and 240–999.9) there is an assumed decimal point between the 3rd and 4th characters. *Note:* For complications (ICD-9-CM "E"codes) and factors influencing health status (ICD-9-CM "V" codes) there is an assumed decimal point between the 4th and 5th characters.
(leave blank)	Fewer than two comorbid conditions or complications documented.

COMORBIDITIES AND COMPLICATIONS #3
(Secondary Diagnoses)

Item Length: 5
Allowable Values: 00100–13980, 24000–99990, E8700–E8799, E9300–E9499,V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049
Left Justified, Zero-filled
NAACCR Item #3130
Revised 06/05

Description

Records the patient's preexisting medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer. Both are considered secondary diagnoses.

Rationale

Preexisting medical conditions, factors influencing health status, and/or complications may affect treatment decisions and influence patient outcomes. Information on comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes. Complications may be related to the quality of care.

Instructions for Coding

- If fewer than three comorbid conditions or complications are listed, then leave this data item blank.
- If only three comorbid conditions or complications are listed, then code the diagnoses listed and leave the remaining "Comorbidities and Complications"items blank.
- For further coding instructions, see *Comorbidities and Complications #1* (NAACCR Item #3110).

Code	Definition
(fill spaces)	Report the ICD-9-CM codes for up to 10 comorbid conditions or complications. *Note:* For comorbid conditions (ICD-9-CM codes 001–139.8 and 240–999.9) there is an assumed decimal point between the 3rd and 4th characters. *Note:* For complications (ICD-9-CM "E"codes) and factors influencing health status (ICD-9-CM "V" codes) there is an assumed decimal point between the 4th and 5th characters.
(leave blank)	Fewer than three comorbid conditions or complications documented.

COMORBIDITIES AND COMPLICATIONS #4
(Secondary Diagnoses)

Item Length: 5
Allowable Values: 00100–13980, 24000–99990, E8700–E8799, E9300–E9499,E9300–E9499, V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049
Left Justified, Zero-filled
NAACCR Item #3140
Revised 06/05

Description

Records the patient's preexisting medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer. Both are considered secondary diagnoses.

Rationale

Preexisting medical conditions, factors influencing health status, and/or complications may affect treatment decisions and influence patient outcomes. Information on comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes. Complications may be related to the quality of care.

Instructions for Coding

- If fewer than four comorbid conditions or complications are listed, then leave this data item blank.
- If only four comorbid conditions or complications are listed, then code the diagnoses listed and leave the remaining "Comorbidities and Complications" items blank.
- For further coding instructions, see *Comorbidities and Complications #1* (NAACCR Item #3110).

Code	Definition
(fill spaces)	Report the ICD-9-CM codes for up to 10 comorbid conditions or complications. *Note:* For comorbid conditions (ICD-9-CM codes 001–139.8 and 240–999.9) there is an assumed decimal point between the 3rd and 4th characters. *Note:* For complications (ICD-9-CM "E"codes) and factors influencing health status (ICD-9-CM "V" codes) there is an assumed decimal point between the 4th and 5th characters.
(leave blank)	Fewer than four comorbid conditions or complications documented.

COMORBIDITIES AND COMPLICATIONS #5
(Secondary Diagnoses)

Item Length: 5
Allowable Values:00100–13980, 24000–99990, E8700–E8799, E9300–E9499, E9300–E9499, V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049
Left Justified, Zero-filled
NAACCR Item #3150
Revised 06/05

Description
Records the patient's preexisting medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer. Both are considered secondary diagnoses.

Rationale
Preexisting medical conditions, factors influencing health status, and/or complications may affect treatment decisions and influence patient outcomes. Information on comorbidities is used to risk adjust outcome statistics when evaluating patient survival and other outcomes. Complications may be related to the quality of care.

Instructions for Coding
- If fewer than five comorbid conditions or complications are listed, then leave this data item blank.
- If only five comorbid conditions or complications are listed, then code the diagnoses listed and leave the remaining "Comorbidities and Complications" items blank.
- For further coding instructions, see *Comorbidities and Complications #1* (NAACCR Item #3110).

Code	Definition
(fill spaces)	Report the ICD-9-CM codes for up to 10 comorbid conditions or complications. *Note:* For comorbid conditions (ICD-9-CM codes 001–139.8 and 240–999.9) there is an assumed decimal point between the 3rd and 4th characters. *Note:* For complications (ICD-9-CM "E"codes) and factors influencing health status (ICD-9-CM "V" codes) there is an assumed decimal point between the 4th and 5th characters.
(leave blank)	Fewer than five comorbid conditions or complications documented.

COMORBIDITIES AND COMPLICATIONS #6
(Secondary Diagnoses)

Item Length: 5
Allowable Values: 00100–13980, 24000–99990, E8700–E8799, E9300–E9499,E9300–E9499, V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049
Left Justified, Zero-filled
NAACCR Item #3160
Revised 06/05

Description
Records the patient's preexisting medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer. Both are considered secondary diagnoses.

Rationale
Preexisting medical conditions, factors influencing health status, and/or complications may affect treatment decisions and influence patient outcomes. Information on comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes. Complications may be related to the quality of care.

Instructions for Coding
- If fewer than six comorbid conditions or complications are listed, then leave this data item blank.
- If only six comorbid conditions or complications are listed, then code the diagnoses listed and leave the remaining "Comorbidities and Complications" items blank.
- For further coding instructions, see *Comorbidities and Complications #1* (NAACCR Item #3110).

Code	Definition
(fill spaces)	Report the ICD-9-CM codes for up to 10 comorbid conditions or complications. *Note:* For comorbid conditions (ICD-9-CM codes 001–139.8 and 240–999.9) there is an assumed decimal point between the 3rd and 4th characters. *Note:* For complications (ICD-9-CM "E"codes) and factors influencing health status (ICD-9-CM "V" codes) there is an assumed decimal point between the 4th and 5th characters.
(leave blank)	Fewer than six comorbid conditions and complications documented.

COMORBIDITIES AND COMPLICATIONS #7
(Secondary Diagnoses)

Item Length: 5
Allowable Values: 00100–13980, 24000–99990, E8700–E8799, E9300–E9499,E9300–E9499, V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049
Left Justified, Zero-filled
NAACCR Item #3161
Added 06/05

Description
Records the patient's preexisting medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer. Both are considered secondary diagnoses.

Rationale
Preexisting medical conditions, factors influencing health status, and/or complications may affect treatment decisions and influence patient outcomes. Information on comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes. Complications may be related to the quality of care.

Instructions for Coding
- *Comorbidities and Complications #7* is to be used for patients diagnosed on or after January 1, 2006.
- If fewer than seven comorbid conditions or complications are listed, then leave this data item blank.
- If only seven comorbid conditions or complications are listed, then code the diagnoses listed and leave the remaining "Comorbidities and Complications" items blank.
- For further coding instructions, see *Comorbidities and Complications #1* (NAACCR Item #3110).

Code	Definition
(fill spaces)	Report the ICD-9-CM codes for up to 10 comorbid conditions or complications. *Note:* For comorbid conditions (ICD-9-CM codes 001–139.8 and 240–999.9) there is an assumed decimal point between the 3rd and 4th characters. *Note:* For complications (ICD-9-CM "E"codes) and factors influencing health status (ICD-9-CM "V" codes) there is an assumed decimal point between the 4th and 5th characters.
(leave blank)	Fewer than seven comorbid conditions and complications documented.

COMORBIDITIES AND COMPLICATIONS #8
(Secondary Diagnoses)

Item Length: 5
Allowable Values: 00100–13980, 24000–99990, E8700–E8799, E9300–E9499,E9300–E9499, V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049
Left Justified, Zero-filled
NAACCR Item #3162
Added 06/05

Description

Records the patient's preexisting medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer. Both are considered secondary diagnoses.

Rationale

Preexisting medical conditions, factors influencing health status, and/or complications may affect treatment decisions and influence patient outcomes. Information on comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes. Complications may be related to the quality of care.

Instructions for Coding

- *Comorbidities and Complications #8* is to be used for patients diagnosed on or after January 1, 2006.
- If fewer than eight comorbid conditions or complications are listed, then leave this data item blank.
- If only eight comorbid conditions or complications are listed, then code the diagnoses listed and leave the remaining "Comorbidities and Complications" items blank.
- For further coding instructions, see *Comorbidities and Complications #1* (NAACCR Item #3110).

Code	Definition
(fill spaces)	Report the ICD-9-CM codes for up to 10 comorbid conditions or complications. *Note:* For comorbid conditions (ICD-9-CM codes 001–139.8 and 240–999.9) there is an assumed decimal point between the 3rd and 4th characters. *Note:* For complications (ICD-9-CM "E"codes) and factors influencing health status (ICD-9-CM "V" codes) there is an assumed decimal point between the 4th and 5th characters.
(leave blank)	Fewer than eight comorbid conditions and complications documented.

COMORBIDITIES AND COMPLICATIONS #9
(Secondary Diagnoses)

Item Length: 5
Allowable Values: 00100–13980, 24000–99990, E8700–E8799, E9300–E9499,E9300–E9499, V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049
Left Justified, Zero-filled
NAACCR Item #3163
Added 06/05

Description

Records the patient's preexisting medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer. Both are considered secondary diagnoses.

Rationale

Preexisting medical conditions, factors influencing health status, and/or complications may affect treatment decisions and influence patient outcomes. Information on comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes. Complications may be related to the quality of care.

Instructions for Coding

- *Comorbidities and Complications #9* is to be used for patients diagnosed on or after January 1, 2006.
- If fewer than nine comorbid conditions or complications are listed, then leave this data item blank.
- If only nine comorbid conditions or complications are listed, then code the diagnoses listed and leave the remaining "Comorbidities and Complications" items blank.
- For further coding instructions, see *Comorbidities and Complications #1* (NAACCR Item #3110).

Code	Definition
(fill spaces)	Report the ICD-9-CM codes for up to 10 comorbid conditions or complications. *Note:* For comorbid conditions (ICD-9-CM codes 001–139.8 and 240–999.9) there is an assumed decimal point between the 3rd and 4th characters. *Note:* For complications (ICD-9-CM "E"codes) and factors influencing health status (ICD-9-CM "V" codes) there is an assumed decimal point between the 4th and 5th characters.
(leave blank)	Fewer than nine comorbid conditions and complications documented.

COMORBIDITIES AND COMPLICATIONS #10
(Secondary Diagnoses)

Item Length: 5
Allowable Values: 00100–13980, 24000–99990, E8700–E8799, E9300–E9499,E9300–E9499, V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049
Left Justified, Zero-filled
NAACCR Item #3164
Added 06/05

Description

Records the patient's preexisting medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer. Both are considered secondary diagnoses.

Rationale

Preexisting medical conditions, factors influencing health status, and/or complications may affect treatment decisions and influence patient outcomes. Information on comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes. Complications may be related to the quality of care.

Instructions for Coding

- *Comorbidities and Complications #10* is to be used for patients diagnosed on or after January 1, 2006.
- If fewer than 10 comorbid conditions or complications are listed, then leave this data item blank.
- For further coding instructions, see *Comorbidities and Complications #1* (NAACCR Item #3110).

Code	Definition
(fill spaces)	Report the ICD-9-CM codes for up to 10 comorbid conditions or complications. *Note:* For comorbid conditions (ICD-9-CM codes 001–139.8 and 240–999.9) there is an assumed decimal point between the 3rd and 4th characters. *Note:* For complications (ICD-9-CM "E"codes) and factors influencing health status (ICD-9-CM "V" codes) there is an assumed decimal point between the 4th and 5th characters.
(leave blank)	Fewer than 10 comorbid conditions and complications documented.

NPI–MANAGING PHYSICIAN

Item Length: 10
Allowable Value: Ten digits
NAACCR Item #2465
Revised 04/07, 09/08

Description
Identifies the physician who is responsible for the overall management of the patient during diagnosis and/or treatment of this cancer.

Rationale
The managing physician is responsible for the patient's work-up, plans the treatment, and directs the delivery of patient care in accordance with CoC Standards. In most cases, the managing physician is responsible for AJCC staging.

Instructions for Coding
- Record the 10-digit NPI for the physician responsible for managing the patient's care.
- Check with the billing or health information departments to determine the physician's NPI or search at *https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do*.
- NPI should be recorded as available for cases diagnosed during 2007, and is required to be recorded for all cases diagnosed January 1, 2008, and later.
- NPI may be blank for cases diagnosed on or before December 31, 2006.
- Do not update this item. Once the registry has designated a managing physician for the patient, this item should not be changed even if a different managing physician is assigned.

Code	Definition
(fill spaces)	10-digit NPI number for the managing physician.
(leave blank)	NPI for the managing physician is unknown or not available.

FOLLOWING PHYSICIAN
(FOLLOW-UP PHYSICIAN)

Item Length: 8
Left Justified
NAACCR Item #2470

Description
Records the identification number of the person currently responsible for the patient's medical care.

Rationale
The following physician is the first contact for obtaining information on a patient's status and subsequent treatment. This information may be used for outcomes studies.

Instructions for Coding
- The registry assigns a unique number to the following physician. Many registries use the physician's state medical license number.
- Change this data item when patient follow-up becomes the responsibility of another physician.

Code	Definition
(fill spaces)	The identification number may include numbers and letters.
99999999	The following physician is unknown or an identification number is not assigned.

NPI–FOLLOWING PHYSICIAN

Item Length: 10
Allowable Value: Ten digits
NAACCR Item #2475
Revised 04/07, 09/08

Description

Records the NPI for the physician currently responsible for the patient's medical care.

Rationale

The following physician is the first contact for obtaining information on a patient's status and subsequent treatment. This information may be used for outcomes studies.

NPI–Following Physician is the NPI equivalent of *Following Physician* (NAACCR Item #2470). Both are required during a period of transition.

Instructions for Coding

- Record the 10-digit NPI for the physician currently responsible for the patient's medical care.
- Check with the billing or health information departments to determine the physician's NPI or search at *https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do*.
- Change this data item when patient follow-up becomes the responsibility of another physician.
- NPI should be recorded as available for cases diagnosed during 2007, and is required to be recorded for all cases diagnosed January 1, 2008, and later.
- NPI may be blank for cases diagnosed on or before December 31, 2006.

Code	Definition
(fill spaces)	10-digit NPI number for the following physician.
(leave blank)	NPI for the following physician is unknown or not available.

PRIMARY SURGEON

Item Length: 8
Left Justified
NAACCR Item #2480

Description
Records the identification number of the physician who performed the most definitive surgical procedure.

Rationale
Administrative, physician, and service referral reports are based on this data item.

Instructions for Coding
- The registry assigns a unique number to the primary surgeon. Many registries use the physician's state medical license number.
- Once the registry has designated a primary surgeon for the patient, the information should not be changed or updated even if the patient receives care from another surgeon.
- Do not update this data item.

Code	Definition
(fill spaces)	The identification number may include numbers and letters. *Note:* If the patient did not have surgery, use the code for the surgeon who performed any surgery or did a surgical consultation.
00000000	If the patient had no surgery and no surgical consultation.
88888888	If the physician who performed a surgical procedure was not a surgeon, i.e radiation oncologist, diagnostic radiologist, or general practitioner.
99999999	The primary surgeon is unknown or an identification number is not assigned.

NPI–PRIMARY SURGEON

Item Length: 10
Allowable Value: Ten digits
NAACCR Item #2485
Revised 04/07, 09/08

Description

Identifies the physician who performed the most definitive surgical procedure.

Rationale

Administrative, physician, and service referral reports are based on this item.

NPI–Primary Surgeon is the NPI equivalent of *Primary Surgeon* (NAACCR Item #2480). Both are required during a period of transition.

Instructions for Coding

- Record the 10-digit NPI for the physician who performed the most definitive surgical procedure.
- Check with the billing or health information departments to determine the physician's NPI or search at *https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do*.
- NPI should be recorded as available for cases diagnosed during 2007, and is required to be recorded for all cases diagnosed January 1, 2008, and later.
- NPI may be blank for cases diagnosed on or before December 31, 2006.
- Do not update this item. Once the registry has designated a primary surgeon for the patient, the information should not be changed or updated even if the patient receives care from another surgeon.

Code	Definitions
(fill spaces)	10-digit NPI number for the primary surgeon.
(leave blank)	The patient did not have surgery; NPI for the primary surgeon is unknown or not available; or the physician who performed the surgical procedure was not a surgeon (i.e. general practitioner).

PHYSICIAN #3 (OTHER PHYSICIAN)

Item Length: 8
Left Justified
NAACCR Item #2490
Revised 01/04

Description

Records the identification number of another physician involved in the care of the patient. The Commission on Cancer recommends that this data item identify the physician who performed the most definitive radiation therapy.

Rationale

Administrative, physician, and service referral reports are based on this data item. It also can be used for follow-up purposes.

Instructions for Coding

- The registry assigns a unique number to this data item. Many registries use the physician's state medical license number.
- If this item is used to identify the radiation oncologist, then the following definitions can be used. If the facility chooses to identify another physician, the facility will need to develop and implement definitions for analysis.
- If the registry has designated a primary radiation oncologist for the patient, the information in this data item should not be changed or updated even if the patient receives care from another radiation oncologist.
- Do not update this data item.

Code	Definition
(fill spaces)	The identification number may include numbers and letters.
00000000	None; no additional physician.
99999999	Physician is unknown or an identification number is not assigned.

NPI–PHYSICIAN #3
(Radiation Oncologist–CoC Preferred Use)

Item Length: 10
Allowable Value: Ten digits
NAACCR Item #2495
Revised 04/07, 09/08

Description
Records the NPI for a physician involved in the care of the patient. The Commission on Cancer recommends that this item identify the physician who performed the most definitive radiation therapy.

Rationale
Administrative, physician, and service referral reports are based on this data item. It also can be used for follow-up purposes.

NPI–Physician #3 is the NPI equivalent of *Physician #3* (NAACCR Item #2490). Both are required during a period of transition.

Instructions for Coding
- Record the 10-digit NPI for the physician.
- Check with the billing or health information departments to determine the physician's NPI or search at *https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do*.
- If this item is used to identify the primary radiation oncologist, then the following definitions pertaining to the radiation oncologist can be used. If the facility chooses to identify another physician, the facility should develop and implement definitions for analysis.
- Do not update this item. If the registry has designated a primary radiation oncologist for the patient, the information in this data item should not be changed or updated even if the patient receives care from another radiation oncologist.
- NPI should be recorded as available for cases diagnosed during 2007, and is required to be recorded for all cases diagnosed January 1, 2008, and later.
- NPI may be blank for cases diagnosed on or before December 31, 2006.

Code	Definition
(fill spaces)	10-digit NPI number for the primary radiation oncologist.
(leave blank)	NPI for the primary radiation oncologist is unknown or not available.

PHYSICIAN #4
(OTHER PHYSICIAN)

Item Length: 8
Left Justified
NAACCR Item #2500
Revised 01/04

Description
Records the identification number of another physician involved in the care of the patient. The Commission on Cancer recommends that this data item identify the physician who gives the most definitive systemic therapy.

Rationale
Administrative, physician, and service referral reports are based on this data item. It also can be used for follow-up purposes.

Instructions for Coding
- The registry assigns a unique number to this data item. Many registries use the physician's state medical license number.
- If this item is used to identify the medical oncologist, then the following definitions can be used. If the facility chooses to identify another physician, the facility will need to develop and implement definitions for analysis.
- If the registry has designated a primary medical oncologist for the patient, the information in this data item should not be changed or updated even if the patient receives care from another medical oncologist.
- Do not update this data item.

Code	Definition
(fill spaces)	The identification number may include numbers and letters.
00000000	None; no additional physician.
99999999	Physician is unknown or an identification number is not assigned.

NPI–PHYSICIAN #4
(Medical Oncologist–CoC Preferred Use)

Item Length: 10
Allowable Value: Ten digits
NAACCR Item #2505
Revised 04/07, 09/08

Description
Records the NPI for a physician involved in the care of the patient. The Commission on Cancer recommends that this data item identify the physician who gives the most definitive systemic therapy.

Rationale
Administrative, physician, and service referral reports are based on this data item. It also can be used for follow-up purposes.

NPI–Physician #4 is the NPI equivalent of *Physician #4* (NAACCR Item #2500). Both are required during a period of transition.

Instructions for Coding
- Record the 10-digit NPI for the physician.
- Check with the billing or health information departments to determine the physician's NPI or search at *https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do*.
- If this item is used to identify the medical oncologist, then the following definitions pertaining to the medical oncologist can be used. If the facility chooses to identify another physician, the facility should develop and implement definitions for analysis.
- Do not update this item. If the registry has designated a primary medical oncologist for the patient, the information in this data item should not be changed or updated even if the patient receives care from another radiation oncologist.
- NPI should be recorded as available for cases diagnosed during 2007, and is required to be recorded for all cases diagnosed January 1, 2008, and later.
- NPI may be blank for cases diagnosed on or before December 31, 2006.

Code	Definition
(fill spaces)	10-digit NPI number for the primary medical oncologist.
(leave blank)	NPI for the primary medical oncologist is unknown or not available.