SEER Auto-Consolidation Work Group

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SEER FACE TO FACE MEETING

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Workgroup Goals

- To develop a process to identify tumor related data fields that could be auto-consolidated.

- To create and test auto-consolidation guidelines and rules for each data field

Progress

- ❑ Developed a process /workflow

- ❑ Completed the process for two tumor related fields
  - ✓Type of Reporting Source
  - ✓Diagnostic Confirmation

The Process

1. Select data element for possible auto-consolidation

2. Identify any coding instructions applicable to consolidating the data item – Reference: SEER – STORE – AJCC – NAACCR

3. Identify all data items that may be used in the manual decision-making process

The Process cont.

4. Develop logic/rules that would identify the record with the best value for the consolidated (CTC) record

5. Design a test to determine how well the new logic/rules worked – Did the auto-consolidated value matched the manually consolidated value?

6. Conduct test – using existing data to validate

The Process cont.

7. Analyze results
8. Make adjustments based on analysis
9. Re-Test (Step 6)
10. Determine how to implement into production

Results – Type of Reporting Source

- Consolidating instructions found in SEER manual
- Logic/Rules developed and tested
- Issues
  - ✓ Not all records have Reporting Source
  - ✓ DC's created DCO's vs MDO's
- Logic approved – Ready to be implemented

Results – Dx Confirmation

- 2 separate categories -> Solid vs Heme/Lymph
- No consolidating instructions for Heme/Lymph
- Logic/Rules created and tested
- Issues
  - ✓ Dx Confirmation code 3


Next Step

Lymph-vascular Invasion (LVI)

Code	Description
0	Lymph-vascular Invasion stated as Not Present
1	Lymph-vascular Invasion Present/Identified
2	Lymphatic and small vessel invasion only (L)
3	Venous (large vessel) invasion only (V)
4	BOTH lymphatic and small vessel AND venous (large vessel) invasion
8	Not applicable
9	Unknown/Indeterminate/not mentioned in path report

Note: SEER requires LVI recorded for penis and testis cases only.

LVI – Coding Instructions

1. Code from the path report, if available.

- **LVI is impossible for benign, borderline, or in situ cases. These are coded 0.**

2. Use code 0 when the path report indicates no lymph-vascular invasion.

3. Use code 1 when the path report or physician statement indicates LVI is present.

4. Use code 8 for lymphomas, hematopoietic and reticuloendothelial diseases, plasma cell myelomas, and schemas other than Penis or Testis, if the registry has opted not to collect it.

5. Use code 9 when there is no microscopic exam of primary tumor, the tissue sample is very small, it is not possible to determine if LVI is present, LVI is not mentioned in the path report, or the primary site is unknown.

LVI – Rules for Consolidation

1. Code 8 if case is not testis or penis.

2. Code 8 if case is lymphoma, hematopoietic and reticuloendothelial disease, or plasma cell myeloma

3. Code 0 if behavior code is 0, 1, or 2.

4. Take reported codes in this hierarchy: (most specific/extensive first)

- **4- Both lymphatic and venous**
- **3- Venous invasion only**
- **2- Lymphatic invasion only**
- **1- LVI present**
- **0- LVI Not present**
- **9- Unknown**

Primary Payer at Diagnosis

Code	Definition
1	Not insured
02	Not insured, self pay
10	Insurance, NOS
20	Managed Care, HMO, PPO
21	Private Insurance: Fee-for-service
31	Medicaid
35	Medicaid administered through a Managed Care Plan
60	Medicare without supplement, Medicare, NOS
61	Medicare with supplement
62	Medicare administered through a Managed Care Plan
63	Medicare with private supplement
64	Medicare with Medicaid eligibility
65	TRICARE (Formerly CHAMPUS)
66	Military
67	Veterans Affairs
68	Indian/Public Health Service
99	Insurance status unknown

Payer – Coding Instructions

1. Code the type of insurance reported on the patient's admission record

2. Code the **first** insurance mentioned when multiple insurance carriers are listed on one admission record

3. Code the type of insurance reported **closest to the date of diagnosis** when there are multiple insurance carriers reported for multiple admissions and/or multiple physician encounters

4. Code the patient's insurance at the time of **initial diagnosis and/or treatment**. Do not change the insurance information based on subsequent information.

5. Use code **02** when the only information available is "self-pay"

6. Use code **10** for prisoners when no further information is available

7. Assign code **99** for death certificate only (DCO) cases when the primary payer at diagnosis is unknown

Payer – Rules for Consolidation

Code the type of insurance reported **closest to the date of diagnosis** when there are multiple insurance carriers reported for multiple admissions and/or multiple physician encounters

Use a class of case hierarchy to determine reporting source closest to date of diagnosis

- Class 0
- Class 10-14
- Class 20-22
- Class 30-32
- Class 43 (path specimen)
- Class 40-43 (staff physicians)
- Class 33-37 (various non-analytic scenarios)
- Class 38, 49, 99 (autopsy, DCO, unknown)

Future Directions

1. Should we articulate our long range goals and overall plans for this committee?

2. Are there broad steps, or general rules, that can be implemented for all cases (e.g., known values over unknown values)?

3. What can we accomplish in 2019 toward more auto-consolidation?

4. Stage data items are a priority. Should we start with Tumor size and Grade, then consider an approach to consolidating EOD items, and then SSDIs?


OPEN
FOR
DISCUSSION