SEER*DMS Auto-Consolidation Work Group
Source Record Validation Subgroup
Teleconference Summary
September 19, 2019
3:00 to 4:30 p.m. EDT

Representatives from the NCI, IMS, the Scientific Consulting Group, Inc. (SCG), and 14 cancer registries participated in the SEER*DMS Auto-Consolidation Workgroup (WG) conference call on September 19, 2019. Participants included:

REGISTRIES:
Alaska
California Central
Connecticut
Detroit
Georgia
Idaho
Iowa (Bobbi Matt, Chair)
Kentucky (Frances Ross, Chair)
Louisiana
Minnesota
New Jersey
New York
Seattle
Utah

NCI: Peggy Adamo, Melissa Bruno, Lois Dickie, Marina Matatova, Serban Negoita

IMS: Suzanne Adams, Linda Coyle, Nicki Schussler

Action Items

Participants agreed to the following action items:

- Linda will work with Cheryl Moody to review the Central California registry logic, make comparisons using the system test, and then determine whether a record polisher to recode Class of Case is necessary.
- Registries should review the surgical margins priority codes and provide comments via Squish. IMS will run the coding logic and note any issues prior to placing the rules into production.
- Linda will incorporate a flag to initiate a manual review when a pathology report (HL7) has a date that precedes the Date of Diagnosis.
- Linda will create a Squish issue to allow registry staff to brainstorm about options for handling abstract errors. Registry representatives should review and provide comments for discussion during the next call.

Auto-Consolidation

Grouping Extent of Disease (EOD) at Metastasis (Mets) and Mets at Diagnosis (DX) Fields

At a previous meeting, the WG tentatively identified the EOD Mets (1115-1117) and Mets at DX (772, 774) fields as data item groupings to auto-consolidate. Suzanne expressed concern that some information collected by individual facilities would be lost during auto-consolidation.

Discussion

Participants discussed the prioritization of EOD Mets. For example, would the more specific code rank higher than the not otherwise specified (NOS). A separate EOD WG is deciding this priority logic, which will vary by schema. The problem is fields from one facility might override higher order EOD Mets fields from another facility. Registry participants recommended ungrouping the fields.

Linda asked how the registries manually consolidate these fields currently. The EOD Mets fields typically are checked to make sure they match with the Mets at DX fields; if EOD Mets is 00 then the Mets at DX also should be 00. EOD Nodes should not conflict with Regional Nodes Positive and Examined.

Participants agreed to consider the EOD fields separately for auto-consolidation rather than grouping them. The aim of auto-consolidation would be to select the more useful value and rely on edit checks to flag any inconsistencies. Cheryl suggested considering the role of Class of Case analytic versus nonanalytic cases in the draft auto-consolidation logic.

Primary Payer at Diagnosis (DX) Algorithms

IMS implemented an auto-consolidation rule for the Primary Payer at DX data field at the New York registry using an algorithm modified based on this WG's input.

Discussion

Linda asked about the registries' need for capturing insurance information at treatment rather than at diagnosis. The California Central registry representative had previously expressed interest in giving primary payer at treatment a higher priority than at diagnosis. Linda and Suzanne examined the existing logic created by the workgroup and believed that it was in fact giving priority to information from treatment via the class of case priority order. Linda opened this up to the group for confirmation, and the group agreed.

Linda reminded participants of the system test that IMS designed to examine logic across registries. She suggested discussing this topic after registries have run the system test to examine the logic. Participants mentioned the need to ensure that coding criteria/logic align with existing SEER coding instructions, particularly with regard to primary payer at diagnosis or primary payer at treatment.

Francis noted that Class of Case 32 (nonanalytic) with Medicaid will not take precedence over a code 00, which might include self-pay. It is unclear which code is preferable, however, but coding options could be improved.

The Iowa registry needs more time to run the system test on its data because Class of Case is not routinely edited. The Central California registry runs Class of Case rules and has an autocorrect feature. They do not collect the more discrete codes; for example, codes 14, 12, or 10 all are classified as a 10. The registry developed these coding criteria partly in response to large numbers of Class of Case errors. Bobbi suggested that the Central California registry share its coding criteria and logic for combining these fields.. Linda agreed to work with Cheryl to review the Central California registry logic using the system test. A record polisher to recode Class of Case across registries may be needed and also would be helpful in developing other rules. Any changes will be made available to the registries for comment.

Consolidation Rules for Surgical Margins

NCI SEER is focusing on capturing recurrence data. The topic of surgical margins always surfaces in discussions about recurrence, so it would be useful to review priority rules for surgical margin coding . The current priority (from lowest to highest) is: 9, unknown; 0, no residual tumor/NOS; 1, no residual tumor; 2, microscopic, residual tumor; 3, macroscopic, residual tumor; 4, multiple margins; 5, macroscopic involvement; 7, margins not evaluable; 8, no primary site surgery. Participants proposed a new priority order of 9, 8, 7, 1–5, 0, with no residual tumor (i.e., 0).

Discussion

Participants discussed changing the surgical margins priority rules. Surgical Margins data might not currently be collected at all registries at the summary level. The group agreed that the first step is to determine the "best" or most extensive surgery code (handled separately during surgery code summarization). If more than one record has the "best" code, then the priority order logic would be applied. Participants further agreed that macroscopic residual tumor should take priority over microscopic residual tumor.

Linda recommended that registries test updated priority rules before implementing them in SEER*DMS. Peggy agreed to verify the priority order. A registry participant pointed out that the surgical margins data field is contained in the NAACCR list, but the requirements coding this field are unclear in the *SEER Program Coding and Staging Manual* (SEER Manual).

The next steps will be for registries to review the surgical margins priority codes Squish issue and respond with comments. IMS will run the proposed coding logic and note any issues prior to placing the rules into production.

Rules for Other Data Fields

Linda created Squish #7719 with a data search to test the auto-consolidation rules for Date of Diagnosis that currently are being used in two SEER registries. The initial search generated higher than expected values indicating that additional work is needed to account for record type and handling of death certificates.

Discussion

The Utah registry reported that the Date of Diagnosis logic worked for most cases reviewed, but some results returned a date of diagnosis from an hl7 that preceded the date of diagnosis on an abstract; manually, they would have chosen the date from the abstract. Linda suggested implementing a manual review when a pathology report has a date that precedes the diagnosis date on an abstract

The Detroit registry representative explained that, since the cases reviewed at the registry already were edited, the dates in SEER*DMS were considered more accurate rather than the date on the pathology report. The registry found that the program favored the date of suspicious cytology, which cannot be used as a date of diagnosis even if confirmed at a later date.

Linda pointed out that the program will not override any dates in a registry database but would trigger a manual review if the date of specimen collection in the pathology report was problematic. IMS will revisit the data search criteria regarding HL7 data.

Source Record Validation

Update on the Source Records Edits Task

The instructions for evaluating source records edit failures across registries are pending. IMS will provide updates at the next meeting.

Define List of Edits Required for Auto-Consolidation

The WG will need to determine the source document for critical edits that would be required prior to applying auto-consolidation logic.

Process for Handling Abstracts with Edit Errors

After the WG defines critical edits for source validation, a process for handling abstracts with these edit errors will need to be discussed. Linda suggested brainstorming the options.

Discussion

Central registries cannot correct all errors. A possible approach is to avoid auto-consolidating any records failing the edits. This approach would activate a manual review and prompt changes at the facility level.

Marina suggested creating a Squish issue with the options for handling abstract errors for registries to review and provide comments. The comments could be discussed during the next call.

Upcoming Auto-Consolidation Work Group Calls

The next Auto-Consolidation WG call is scheduled for October 17, 2019, from 3 to 4:30 p.m. and will focus on both auto-consolidation and source validation.