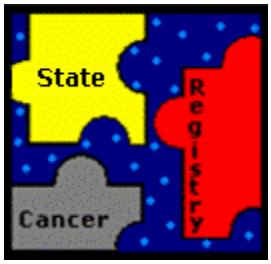
OKLAHOMA
State Department
of Health

Oklahoma Central Cancer Registry

Web Plus User Manual



Updated June 2025

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Section 1

Core instructions for Reporting Facilities

OKLAHOMA State Department of Health

Electronic Coding Manuals/Databases

Oklahoma Central Cancer Registry Cancer Data Reporting Manual

The Oklahoma Central Cancer Registry (OCCR) Cancer Data Reporting Manual is the OCCR's comprehensive manual for reporting cancer to the central cancer registry. Please refer to this manual for an in-depth explanation of data items, coding instructions and reportability requirements.

You may access the manual on the OCCR website at https://oklahoma.gov/health/health-education/data-and-statistics/center-for-health-statistics/oklahoma-central-cancer-registry-occr.html

Scroll down to OCCR Documents> Manual and Forms

Use: To obtain detailed instructions on casefinding, determining reportability, as well as for each required data item and more**.** In some instances, the OCCR Cancer Data Reporting Manual may refer you to another manual or database for further instructions. These additional resources are provided below for your reference. OCCR strongly recommends that each of these be added to your web browser's bookmarks or favorites for easy access when needed.

International Classification of Diseases for Oncology (ICD-O) Manual, Third Edition

Use: To determine applicable codes for primary site (topography), and histology (morphology). The ICD-O-3 book (purple book) has three main sections: topography, morphology, and the alphabetic index. There is also a brief listing of behavior codes and grades. The alphabetic index contains both topography and morphology codes which make it an excellent starting point when looking for key words within a diagnosis or primary site. Codes in the alphabetic index can be looked up in the topography and morphology sections for additional terms which qualify for a specific code.

The World Health Organization (WHO) publishes the ICD-O manuals. There is updated content for ICD-O-3.2 with an updated list of histology codes. The completion of a new manual has been delayed due to the COVID-19 pandemic. However, there are instructions and spreadsheets listing the updates. All updates to ICD-O terms and codes are issued through the North American Association of Central Cancer Registries (NAACCR). Abstractors should refer to the following updates to determine ICD-O histology codes.

ICD-O-3.1

Use for General Instructions and primary site codes only. **Do not use manual for histology codes since it is out-of-date.**

https://apps.who.int/iris/handle/10665/96612

ICD-O-3.2

2024 Revisions

https://www.naaccr.org/icdo3/

2024 ICD-O-3 Update to be used jointly with ICD-O-3.2, Solid Tumor Rules, and Hematopoietic and Lymphoid Neoplasm Database.

The 2024 ICD-O-3.2 Update Guidelines includes comprehensive tables listing changes to ICD-O-3.2 including new ICD-O codes, terminology and reportability changes effective for cases diagnosed 1/1/2023 forward. The 2024 update represents changes identified in recently published 5th Ed WHO Classification of Tumors books. Included in these guidelines are instructions for using the tables together with ICD-O-3.2.

Do not use the ICD-O tables to code hematopoietic or lymphoid neoplasms. Refer to the online Hematopoietic Database and Coding Manual for these cases. (Histology codes 9590/3 – 9993/3)

Standards for Oncology Registry Entry (STORE) Manual

https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-data-submission/

Use: To provide current data standards for the collection of cancer registry data. This manual provides instructions and standards for coding all required data items and should be the first manual referenced to determine applicable codes, unless indicated otherwise.

SEER Program Coding & Staging Manual 2025
https://seer.cancer.gov/tools/codingmanuals/index.html

Use: To provide additional data standards for the collection of cancer registry data. This manual provides instructions and standards for coding all required data items and should be used as the secondary manual referenced to determine applicable codes, unless indicated otherwise.

SEER Summary Stage 2018, v3.2 (published November 2024)
(Effective for cases diagnosed January 1, 2018, and forward)
https://seer.cancer.gov/tools/ssm/

Note: SEER Summary Stage is the staging system used by the Oklahoma Central Cancer Registry and is a required data item.

Use: To determine SEER Summary Stage.

Summary stage is the most basic way of categorizing how far a cancer has spread from its point of origin. The 2018 Summary Staging Manual includes all anatomical sites including lymphoma and leukemia. All information in the medical record is used to establish stage and does not limit staging based on whether or not the patient has had primary site surgery. The manual includes a general instructions chapter along with modules for each specific site. As with all cancer coding manuals, the **general instructions** must be reviewed **first** to avoid coding errors**.**

Note: SEER Summary Stage is also included in SEER*RSA. However, general instructions are only available in the summary stage manual.

NAACCR Edit Detail Report
https://www.naaccr.org/wp-content/uploads/2025/05/Edits-Detail-Report-V25B.pdf

Use: To help understand and resolve edits. The NAACCR Edit Detail Report is an index of errors abstractors may encounter when running data edits on an abstract. If an error occurs, this file can be helpful in understanding why it occurred and how to resolve it. See Section 3, page 43 for more details on how to clear errors.

Grade Coding Instructions and Tables Manual (Grade Manual)
Published September 2024, Version 3.2, effective with cases diagnosed 01/01/2018 and forward

https://apps.naaccr.org/ssdi/list/ Select Grade Manual under Resources.

Use: used to code grade clinical, grade pathological, grade post therapy (yc) and grade post therapy (yp).

Site-Specific Data Items (SSDI) Manual
Published October 2024, Version 3.2, effective with cases diagnosed 01/01/2018 and forward

https://apps.naaccr.org/ssdi/list/

Use: To determine codes for site-specific data items (SSDIs). SSDIs identify additional information needed to generate stage or provide predictive/prognostic factors that have an effect on stage or survival.

Solid Tumor Rules (STR)
https://seer.cancer.gov/tools/solidtumor/
Updated 12/09/2024 and Effective with cases diagnosed 01/01/2018 and forward

*Note: Melanoma module is effective 2021 and forward & Other Sites module is effective 2023 and forward. Prior to these years you should use the 2007 MPH Rules for these two modules.

Use: To determine if a tumor is considered one or multiple primaries based on its site and histology, and to determine histology codes for solid tumors.

The STR manual provides general instructions and site-specific rules. It is highly recommended that the general instructions be entirely reviewed prior to utilizing the site-specific rules. There are two separate sets of rules. The multiple primary rules are used to determine the number of primaries. The histology coding rules are used to determine histology. The rules are hierarchical and must be followed in order. Use the first rule that applies and then stop, do not go any further. *Note:* The rules do not apply to hematopoietic primaries (lymphoma and leukemia) of any site. Use the Hematopoietic Coding Manual for determining multiple primaries and histology.

Hematopoietic Database and Manual
https://seer.cancer.gov/seertools/hemelymph/

Use: used for coding leukemia, lymphoma, and myeloid neoplasm histology

https://seer.cancer.gov/tools/heme/Hematopoietic_Instructions_and_Rules.pdf

Use: determining multiple primaries and histologies for leukemia, lymphoma, and myeloid neoplasm

Steps for Using the Heme DB and Hematopoietic Coding Manual see page 23 in the manual. SEER*Educate provides training on how to use the Heme Manual and DB. Step-by-step instructions are provided for each case scenario to learn how to use the application and manual to arrive at the answer provided.

SEER Rx-Interactive Antineoplastic Drugs Database
https://seer.cancer.gov/seertools/seerrx/

Use: database of systemic therapy drugs, i.e., chemotherapy, hormone therapy, immunotherapy, and chemotherapy regimens.

Other Resources

SEER Training Modules
http://training.seer.cancer.gov/ and http://seer.cancer.gov/tools/heme/training/

NAACCR Data Dictionary Version 25
https://apps.naaccr.org/data-dictionary/data-dictionary/version=25/chapter-view/

Use: Provides a general description, specific codes, and definitions for cancer registry data items.

SEER Glossary for Registrars
https://seer.cancer.gov/seertools/glossary/

Use: The glossary features definitions for terms used by cancer registrars. Each entry includes information on where the term is used, as well as any applicable alternate names, abstractor notes, histology, and primary sites.

Submission Schedule

Date of 1st contact for Diagnosis, Treatment or Recurrence/Persistence of cancer:	Required to be Submitted to OCCR in:
January	July
February	August
March	September
April	October
May	November
June	December
July	January
August	February
September	March
October	April
November	May
December	June

Reportable Conditions List

REPORTABLE CONDITIONS as of 01/01/2025

Malignancies with an ICD-O-3 behavior code of 2 (in-situ) or 3 (malignant) are reportable for all sites with the following **exceptions**:

	Condition	Reportable/Not reportable
Melanoma	Early or evolving melanoma in situ, or any other early or evolving melanoma effective with cases diagnosed 01/01/2021 and forward.	Reportable
Gastrointestinal Stromal Tumor	All GIST tumors are reportable effective with cases diagnosed 01/01/2021 and forward. The behavior code is /3 in ICD-O-3.2.	Reportable
Thymoma	Nearly all thymomas are reportable effective with cases diagnosed 01/01/2021 and forward. The behavior code is /3 in ICD-O-3.2. ***Exceptions:*** microscopic thymoma or thymoma benign (8580/0), micronodular thymoma with lymphoid stroma (8580/1), and ectopic hamartomatous thymoma (8587/0).	Reportable with exceptions
Teratoma	Mature teratoma of the testis in adults is malignant (assign 9080/3) but continues to be non-reportable in prepubescent children (9080/0). Report only if pubescence is explicitly stated in the medical record. ***Do not report if there is no mention of pubescence in the medical record.***	Reportable with exceptions
Astrocytoma	Juvenile astrocytoma, pilocytic astrocytoma, or piloid astrocytoma listed as 9421/1 in ICD-O-3. (Assign code 9421/3).	Reportable
Carcinoid Tumor of Appendix	Code 8240/1 for carcinoid tumor, NOS of appendix is obsolete. Carcinoid tumors of the appendix (C18.1) **must be coded to 8240/3** effective with cases diagnosed 1/1/2015 and forward.	Reportable
Appendiceal Mucinous Neoplasm	Low-grade appendiceal mucinous neoplasm (LAMN) behavior changed to 2 effective 2022. High-grade appendiceal mucinous neoplasm (HAMN) behavior changed to 3 effective 2022 effective with cases diagnosed 1/1/2022 and forward.	Reportable
Intraepithelial Neoplasia	Vulvar intraepithelial neoplasia (VIN III), vaginal intraepithelial neoplasia (VAIN III), anal intraepithelial neoplasia (AIN III) with a behavior code of 2 in ICD-O-3	Reportable
Breast Neoplasia	Lobular neoplasia grade III (LN III)/lobular intraepithelial neoplasia grade III (LIN III) breast C500-C509 effective with cases diagnosed 2016+.	Reportable
Pancreatic Neoplasia	Pancreatic intraepithelial neoplasia (PanIN III) (2016+).	Reportable
Penile Neoplasia	Penile intraepithelial neoplasia III (PeIN III) (2016+).	Reportable
Non-Reportable Skin	Malignant primary skin cancers (C44._) with histology codes 8000-8110. (Examples: squamous cell carcinoma (8070) and basal cell carcinoma (8090) of skin are not reportable).	Not Reportable
Non-Reportable In Situ & Intraepithelial neoplasia	Carcinoma in situ (CIS) of the cervix, squamous intraepithelial neoplasia (SIN III), cervical intraepithelial neoplasia grade III (CIN III), and prostatic intraepithelial neoplasia (PIN III).	Not Reportable
Non-Malignant Primary Intracranial and Central Nervous System Tumors		
diagnosed on or after 1/1/04 with an ICD-O-3 behavior code of 0 or 1 are reportable for the following sites		
Meninges (C70._)		
Brain (C71._)		
Spinal cord, cranial nerves, and other parts of the central nervous system (C72._)		
Pituitary gland (C75.1)		
Craniopharyngeal duct (C75.2)		

Case-finding

Case-finding is the means by which a facility identifies patients with a reportable tumor. The following case-finding list(s) should be used by your facility to identify these patients. The list is available in Excel and PDF format. It is recommended to use the Excel spreadsheet and only the codes listed as reportable. *Do not use the codes listed as supplemental.* Generate a report, called a disease index, from your EMR listing all discharged patients with a diagnosis of a reportable tumor. The report should be sorted alphabetically to group patients with multiple encounters. All patients on the report should be reviewed to determine their eligibility for reporting. Patients admitted to your facility for an eligible tumor diagnosis, for tumor-directed treatment or the patient expires at your facility with active cancer must be reported and a tumor abstract completed.

No tumor abstract is necessary if it is determined that a patient was admitted with only a history of a malignancy, with a history of benign intracranial/central nervous system tumor (the patient does not have active disease) or the patient has active disease, but no diagnosis or treatment was performed at your facility (diagnosed and treated elsewhere).

The patient discharge report should include the following:

1. Patient last name
2. Patient first name
3. Patient middle name
4. Medical record number
5. Date of birth
6. Social security number
7. Date of service
8. ICD-10 codes
9. Type of encounter

An electronic version of the case-finding list in both PDF and Excel is available on the SEER website.
https://seer.cancer.gov/tools/casefinding/

Please refer to the OCCR 's comprehensive Cancer Data Reporting Manual for more in-depth instructions for casefinding.

An electronic version of the case-finding list is available on the SEER website.
https://seer.cancer.gov/tools/casefinding/

Comprehensive ICD-10-CM Case-finding Code List for Reportable Tumors

Effective October 1, 2024 – September 30, 2025

ICD-10-CM Code	Explanation of ICD-10-CM code
C00.- - C43.-, C4A.-, C45.- - C48.-, C49.- - C96.-	Malignant neoplasms (excluding category C44 and C49.A), stated or presumed to be primary (of specified site) and certain specified histologies
C44.00, C44.09	Unspecified/other malignant neoplasm of skin of lip
C44.10-, C44.19_	Unspecified/other malignant neoplasm of skin of eyelid
C44.13-	Sebaceous cell carcinoma of skin of eyelid, including canthus
C44.20-, C44.29-	Unspecified/other malignant neoplasm skin of ear and external auricular canal
C44.30-, C44.39-	Unspecified/other malignant neoplasm of skin of other/unspecified parts of face
C44.40, C44.49	Unspecified/other malignant neoplasm of skin of scalp & neck
C44.50-, C44.59-	Unspecified/other malignant neoplasm of skin of trunk
C44.60-, C44.69-	Unspecified/other malignant neoplasm of skin of upper limb, incl. shoulder
C44.70-, C44.79-	Unspecified/other malignant neoplasm of skin of lower limb, including hip
C44.80, C44.89	Unspecified/other malignant neoplasm of skin of overlapping sites of skin
C44.90, C44.99	Unspecified/other malignant neoplasm of skin of unspecified sites of skin
C49.A-	Gastrointestinal Stromal Tumors Note: All GIST tumors are now reportable starting in 2021 (per ICD-O-3.2), including GIST, NOS
D00.- - D05.-, D07.--D09	In-situ neoplasms *Note 1: Excludes carcinoma in situ of the cervix (D06._)* *Note 2: Excludes prostatic intraepithelial neoplasia (PIN III-8148/2) of the prostate. Other prostate in situ histologies are reportable.* *Note 3: For D04 (carcinoma in situ of the skin), excludes basal and squamous cell in situ lesions.*
D18.02	Hemangioma of intracranial structures and any site
D32.-	Benign neoplasm of meninges (cerebral, spinal and unspecified)
D33.-	Benign neoplasm of brain and other parts of central nervous system
D35.2 - D35.4	Benign neoplasm of pituitary gland, craniopharyngeal duct and pineal gland
D42.-, D43.-	Neoplasm of uncertain or unknown behavior of meninges, brain, CNS
D44.3 - D44.5	Neoplasm of uncertain or unknown behavior of pituitary gland, craniopharyngeal duct and pineal gland
D45	Polycythemia vera (9950/3) ICD-10-CM Coding instruction note: Excludes familial polycythemia (C75.0), secondary polycythemia (D75.1)
D46.-	Myelodysplastic syndromes (9980, 9982, 9983, 9985, 9986, 9989, 9991, 9992, 9993)
D47.02	Systemic mastocytosis

D47.1	Chronic myeloproliferative disease (9963/3, 9975/3) ICD-10-CM Coding instruction note: Excludes the following: Atypical chronic myeloid leukemia BCR/ABL-negative (C92.2_) Chronic myeloid leukemia BCR/ABL-positive (C92.1_) Myelofibrosis & Secondary myelofibrosis (D75.81) Myelophthisic anemia & Myelophthisis (D61.82)
D47.3	Essential (hemorrhagic) thrombocythemia (9962/3) Includes: Essential thrombocytosis, idiopathic hemorrhagic thrombocythemia
D47.4	Osteomyelofibrosis (9961/3) Includes: Chronic idiopathic myelofibrosis Myelofibrosis (idiopathic) (with myeloid metaplasia) Myelosclerosis (megakaryocytic) with myeloid metaplasia) Secondary myelofibrosis in myeloproliferative disease
D47.9	Neoplasm of uncertain behavior of lymphoid, hematopoietic and related tissue, unspecified (9970/1, 9931/3)
D47.Z-	Neoplasm of uncertain behavior of lymphoid, hematopoietic and related tissue, unspecified (9960/3, 9970/1, 9971/3, 9931/3) **Note**: Effective 1/1/2021, PTLD (9971/3) is no longer reportable (9971/1)
D49.6, D49.7	Neoplasm of unspecified behavior of brain, endocrine glands and other CNS
D72.11-	Hypereosonophilic syndrome [HES] (9964/3)
K31.A22	Gastric intestinal metaplasia with high grade dysplasia
N85.05	Endometrial intraepithelial neoplasia [EIN]
R85.614	Cytologic evidence of malignancy on smear of anus
R87.613	High grade squamous intraepithelial lesion on cytologic smear of anus (HGSIL)
R87.614	Cytologic evidence of malignancy on smear of cervix
R87.614	Cytologic evidence of malignancy on smear of cervix
R87.623	High grade squamous intraepithelial lesion on cytologic smear of vagina (HGSIL)
R87.624	Cytologic evidence of malignancy on smear of vagina
R90.0	Intracranial space-occupying lesion found on diagnostic imaging of central nervous system

Ambiguous Terminology for Determining Reportability

As part of the case-finding activities, all diagnostic reports (radiology, pathology, autopsy, history and physical, discharge summary) should be reviewed to confirm whether a case is required to be reported. If the terminology is ambiguous, use the following guidelines to determine whether a particular case should be reported.

The following lists of terms should be used ONLY to determine if a cancer case is reportable.

Ambiguous Terms that Constitute a Reportable Diagnosis	
Apparent(ly)	Most likely
Appears	Presumed
Comparable with	Probable
Compatible with	Suspect(ed)
Consistent with	Suspicious (for)
Favor(s)	Typical of
Malignant appearing	

Additional Terms that Constitute a Reportable Diagnosis for **Nonmalignant Primary Intracranial and Central Nervous System Tumors Only***	
Neoplasm	Tumor
*Beginning with diagnosis year 2004 and only for C70.0-C72.9 and C75.1-C75.3	

Note 1: Do not substitute synonyms such as 'supposed' for 'presumed', or 'equal' for 'comparable'. Do not substitute 'likely' for 'most likely'. Use only the exact words on the list or their conjugate forms, for example, "favored" is allowed as a substitute for "favor." Do not use terms that constitute a diagnosis in conjunction with the term "mass" as this is not defined as cancer. The term "neoplasm" can only be used in the context above. Otherwise, neoplasm can be benign or malignant and is not defined as cancer.

Note 2: If a **cytology report** uses only an ambiguous term for the diagnosis, do not interpret it as a diagnosis of cancer. Do not report ambiguous cytology *unless* a physician makes a statement of malignancy or if the patient receives cancer-directed therapy. If a tissue diagnosis confirms ambiguous cytology, use the cytology date as the date of diagnosis.

Note 3: The ambiguous terms list is applicable to hematopoietic and lymphoid neoplasms for determining **reportability only**. The use of ambiguous terms for assigning and reporting histology is covered in the Hematopoietic and Lymphoid Neoplasms Coding Manual.

https://seer.cancer.gov/tools/heme/Hematopoietic_Instructions_and_Rules.pdf

Ambiguous Terms that **DO NOT** Constitute a Reportable Diagnosis	
Cannot be ruled out	Questionable
Equivocal	Rule out
Possible	Suggests
Potentially malignant	Worrisome

Examples of Ambiguous Diagnostic Terms

Do report - The inpatient discharge summary documents a chest x-ray consistent with carcinoma of the right upper lobe. The patient refused work-up and treatment. *Consistent with carcinoma* is reportable terminology and this case will be abstracted.

Do report – Mammogram report states breast mass is **suspicious** for malignancy. Suspicious for malignancy is reportable ambiguous terminology. Please note, BI-RADS terms are not considered diagnostic on their own. For example, BI-RADS 4, suspicious abnormality, does not constitute a diagnosis.

Do not report – An outpatient CT scan of the chest documents a right lower lobe lung nodule, **possible** malignancy. The patient has no other encounters with your facility. Possible is not a reportable ambiguous term.

Differential Diagnosis

A **differential** diagnosis is made when a physician does not have enough information to assign a **definitive** diagnosis. Only report cases with a differential diagnosis if all possible disease processes are reportable.

Do report – CT exam of the chest shows a nodule in the left lower lung. The radiologist report has a differential diagnosis of **suspicious** for lung cancer vs **metastatic** lung lesion. Both are reportable terms.

Do report – Pathology report of brain tissue states **CNS lymphoma** vs **CNS metastasis** from unknown primary. Both are reportable conditions.

Do not report – MRI of the left thigh says deep tissue mass consistent with **atypical lipoma** or **liposarcoma**. The patient does not return to your facility. Atypical lipoma is not a reportable condition.
Do not report – Bone survey states patient has a solitary lesion in the right humerus compatible with a **bone island** or **solitary plasmacytoma**. "Compatible" is a reportable ambiguous term, but a bone island is not a reportable condition.

Class of Case

Class of case reflects the facility's relationship to the patient and its role in the diagnosis and/or treatment of the cancer. Code the Class that most precisely describes the patient's relationship to your facility/physician office.

***Class of Case* 00 - 14** indicates that the patient was diagnosed at your facility or in the office of a physician with admitting privileges at your facility.
***Class of Case* 20 - 22** indicates that the patient was diagnosed somewhere else (not at your facility and not in the office of a physician with admitting privileges at your facility).

Class of Case

Analytic Cases		R=Required N=Not Required
Initial diagnosis at the reporting facility or in a staff physician's office		**R**
00	Initial diagnosis at the reporting facility/physician office AND all treatment or a decision not to treat was done elsewhere *Note: 00 only applies when it is known that the patient went elsewhere for treatment. If you do not know that this information, you should code Class of Case 10.*	**R**
10	Initial diagnosis at the reporting facility/physician office or, for hospitals, in an office of a physician with admitting privileges AND part or all of first course treatment or a decision not to treat was at the reporting facility, NOS.	**R**
11	Initial diagnosis in an office of a physician with admitting privileges AND part of first course treatment was done at the reporting facility. *Note: used by hospitals only. Physician offices, ambulatory surgery centers and treatment centers use class of case 13.*	**R**
12	Initial diagnosis in an office of a physician with admitting privileges AND all first course treatment or a decision not to treat was done at the reporting facility. *Note: used by hospitals only. Physician offices, ambulatory surgery centers and treatment centers use class of case 14.*	**R**

13	Initial diagnosis at the reporting facility/physician office AND part of first course treatment was done at the reporting facility/physician office; part of first course treatment was done elsewhere	**R**
14	Initial diagnosis at the reporting facility/physician office AND all first course treatment or a decision not to treat was done at the reporting facility/physician office	**R**
Initial diagnosis elsewhere		**R**
20	Initial diagnosis elsewhere AND all or part of first course treatment was done at the reporting facility/physician office, NOS	**R**
21	Initial diagnosis elsewhere AND part of first course treatment was done at the reporting facility/physician office; part of first course treatment was done elsewhere.	**R**
22	Initial diagnosis elsewhere AND all first course treatment or a decision not to treat was done at the reporting facility/physician office	**R**
Non–analytic Cases		
Patient appears in person at reporting facility		
30	Initial diagnosis and all first course treatment elsewhere AND reporting facility performed a confirmation biopsy after being diagnosed on imaging elsewhere. ***Note**: only reportable for confirmation biopsy of initial diagnosis. You must know the patient was clinically diagnosed elsewhere on imaging or physician statement and document that in text. ***DO NOT** report consult only, treatment plan only, staging workup only after initial diagnosis elsewhere)*	**R***
31	Initial diagnosis and all first course treatment elsewhere AND reporting facility provided in-transit care; or hospital provided care that facilitated treatment elsewhere (for example, stent placement)	**N**
32	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility/physician office for diagnosis or treatment of disease recurrence or persistence (active disease). *Note: 32 includes patients that expire at the reporting facility with a reportable active disease that does not meet the criteria for an analytic Class of Case.*	**R**
33	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility/physician office with disease history only (disease not active)	**N**
34*	***Reportable only for the following histology and primary sites: squamous intraepithelial neoplasia, grade III (8077/2) to include AIN III (C21.1), VIN III (C51.*) VAIN III (C52.*). LN III/LIN III (C500-C509), PanIN III, PeIN III 2016+. LCIS for CoC accredited hospitals only.*** Initial diagnosis AND part or all of first course treatment by reporting facility/physician office *for the above diagnoses only.*	**R***
35	Case diagnosed before facility's Reference Date AND initial diagnosis AND all or part of first course treatment by reporting facility	**N**
36*	***Reportable only for the following histology and primary sties: squamous intraepithelial neoplasia, grade III (8077/2) to include AIN III (C21.1), VIN III (C51.*) VAIN III (C52.*). LN III/LIN III (C500-C509), PanIN III, PeIN III 2016+. LCIS for CoC accredited hospitals only.*** Initial diagnosis elsewhere AND all or part of first course treatment by reporting facility/physician office.	**R***
37	Case diagnosed before facility's Reference Date AND initial diagnosis elsewhere AND all or part of first course treatment by facility	**N**
38	Initial diagnosis established by autopsy at the reporting facility, cancer not suspected prior to death ***(for use by hospitals only)*** ***Note: 38 should only be used if the reporting facility performs autopsies***	**R**
Patient does not appear in person at reporting facility		
40	Diagnosis AND all first course treatment given at the same staff physician's office ***(for use by hospitals only)***	**N**
41	Diagnosis and all first course treatment given in two or more different offices of physicians with admitting privileges. ***(for use by hospitals only)***	**N**

42	Non-staff physician or non-CoC accredited clinic or other facility, not part of reporting facility, accessioned by reporting facility for diagnosis and/or treatment by that entity (for example, hospital abstracts cases from an independent radiation facility) ***(for use by hospitals only)***	**N**
43	Pathology or other lab specimens only ***(for use by hospitals only)***	**N**
49	Death certificate only (central registry only)	**N**
99	Nonanalytic case of unknown relationship to facility (not for use by CoC accredited cancer programs for analytic cases). **DO NOT USE**	**N**

Additional explanation:

Class of Case 00 can be used only if the patient was diagnosed at your facility, and you know the patient received treatment elsewhere. If, after diagnosis at your facility, it is unknown if the patient received any treatment, you must code *Class of Case* as 10.

"No therapy" is considered a treatment (i.e., patient refuses treatment, patient expires before treatment is given, or physician recommends no treatment). If a decision of no treatment is made at your facility, class of case should reflect "treatment was administered at your facility".

Examples of class of case:

1. Patient admitted to your facility with rectal bleeding. Colonoscopy performed after admission shows the patient has colon cancer. Two days later, the patient has a hemicolectomy to remove the cancer. The surgeon states the cancer is Stage I and no further treatment is necessary.
    - This is a *class of case* 14 – initial diagnosis at the reporting facility and all first course of treatment was administered at the reporting facility.

2. 90-year old patient with multiple comorbidities admitted to reporting facility with shortness of breath. Lung biopsy is positive for small cell carcinoma. Patient opts to receive no treatment.
    - This is a *class of case* 14 – initial diagnosis and all first course treatment administered at the reporting facility. ("No treatment" is treatment).

3. Patient presents to ER having a cardiovascular event and a history of colon cancer. During the hospitalization it is determined that patient has a newly diagnosed liver lesion confirmed to be metastasis from colon cancer on pathology examination. The reporting facility does not treat this metastasis.
    - This is a *class of case* 32- diagnosis of recurrence or progression of disease. All first course treatment is administered elsewhere AND patient presents to the reporting facility with disease recurrence or persistence (active disease). This case is reportable since progression of disease was diagnosed at the reporting facility.

4. Patient presents to the reporting physician office for a mole that has been present for years. It has recently changed in shape and color. The reporting physician performs a shave biopsy. The pathology results return malignant melanoma with positive peripheral and deep margins. Your physician refers the patient to a surgeon who performs a wide local excision and sentinel lymph node biopsy at an ambulatory surgery center.
    - This is a *class of case* 13 diagnosed at the reporting physician's office, part of the first course treatment was done at the reporting physician's office and part of the first course treatment was done at an ambulatory surgery center.
      A shave biopsy with only microscopic positive margins (not gross positive margins) is considered an excisional biopsy which is surgery code 27 (first course treatment).

5. Patient presents to the reporting hospital for right upper quadrant pain. A CT of the abdomen and pelvis is performed. The impression on the report states a 3.2 cm mass in the liver is highly suspicious for hepatocellular carcinoma. The patient is transferred to another hospital for a higher level of care. It is unknown if the patient received treatment.
    - This is *class of case* 10 – diagnosed at your hospital and unknown if the patient received treatment elsewhere. The patient was diagnosed at the reporting facility on CT with ambiguous terms that constitute a diagnosis. There is no mention in the medical record of any cancer treatment the patient received at the outside facility.

Laterality

Laterality must be recorded for the following paired organs as 1-5 or 9. Organs that are not paired are coded as 0. Midline organs are coded 5. "Midline" in this context refers to the point where the "right" and "left" sides of paired organs come into direct contact and a tumor forms at that point. Most paired sites cannot develop midline tumors. For example, skin of trunk can have a midline tumor, but breast cannot.

Code	Label
0	Organ is not a paired site
1	Origin of primary is right
2	Origin of primary is left
3	Only one side involved, right or left origin not specified
4	Bilateral involvement at time of diagnosis, lateral origin unknown for a single primary; or both ovaries involved simultaneously, single histology; bilateral retinoblastomas; bilateral Wilms tumors
5	Paired site: midline tumor
9	Paired site, but no information concerning laterality

List of Paired Organ Sites

ICD-O-3 Code	Paired Organ Sites
C07.9	Parotid gland
C08.0	Submandibular gland
C08.1	Sublingual gland
C09.0	Tonsillar fossa
C09.1	Tonsillar pillar
C09.8	Overlapping lesion of tonsil
C09.9	Tonsil, NOS
C30.0	Nasal cavity (excluding nasal cartilage and nasal septum)
C30.1	Middle ear
C31.0	Maxillary sinus
C31.2	Frontal sinus
C34.0	Main bronchus (excluding carina)
C34.1-C34.9	Lung
C38.4	Pleura
C40.0	Long bones of upper limb and scapula
C40.1	Short bone of upper limb
C40.2	Long bones of lower limb

C40.3	Short bones of lower limb
C41.3	Rib and clavicle (excluding sternum)
C41.4	Pelvic bones (excluding sacrum, coccyx and symphysis pubis)
C44.1	Skin of eyelid
C44.2	Skin of external ear
C44.3	Skin of other and unspecified parts of face
C44.4	Skin of Scalp and Neck
C44.5	Skin of trunk
C44.6	Skin of upper limb and shoulder
C44.7	Skin of lower limb and hip
C47.1	Peripheral nerves and autonomic nervous system of upper limb and shoulder
C47.2	Peripheral nerves and autonomic nervous system of lower limb and hip
C49.1	Connective, subcutaneous and other soft tissues of upper limb and shoulder
C49.2	Connective, subcutaneous and other soft tissues of lower limb and hip
C50.0-C50.9	Breast
C56.9	Ovary
C57.0	Fallopian tube
C62.0-62.9	Testis
C63.0	Epididymis
C63.1	Spermatic cord
C64.9	Kidney
C65.9	Renal pelvis
C66.9	Ureter
C69.0-C69.9	Eye and lacrimal gland
C70.0	Cerebral meninges, NOS
C71.0	Cerebrum
C71.1	Frontal lobe
C71.2	Temporal lobe
C71.3	Parietal lobe
C71.4	Occipital lobe
C72.2	Olfactory nerve
C72.3	Optic nerve
C72.4	Acoustic nerve
C72.5	Cranial nerve, NOS
C74.0-74.9	Adrenal gland
C75.4	Carotid body

Diagnostic Confirmation for Solid Tumors

Diagnostic confirmation is an indicator of the precision of diagnosis. The codes for diagnostic confirmation are in priority order; code 1 has the highest priority.

Codes 1, 2, and 4 indicate that the diagnosis of cancer was microscopically confirmed. The cancer diagnosis will be confirmed in a pathology report.

Codes 5, 6, 7 and 8 indicate that the diagnosis was clinically confirmed. There will be no pathology report associated with this diagnosis of cancer. The confirmation will be a physician statement using either definitive terminology or ambiguous terminology. The physician statement may be in a discharge summary, progress note, radiology report, history and physical examination, or other physician note. Code 5 will rarely be used as a means of diagnostic confirmation since laboratory tests/tumor markers are not usually diagnostic of cancer.

Codes for Solid Tumors

Code	Label	Definition
1	Positive histology	Histologic confirmation (tissue microscopically examined).
2	Positive cytology	Cytologic confirmation (no tissue microscopically examined; fluid cells microscopically examined).
4	Positive microscopic confirmation, method not specified	Microscopic confirmation is all that is known. It is unknown if the cells were from histology or cytology.
5	Positive laboratory test/marker study	A clinical diagnosis of cancer is based on laboratory tests/marker studies which are clinically diagnostic for cancer. Examples include alpha-fetoprotein for liver primaries. Elevated PSA is not diagnostic of cancer. However, if the physician uses the PSA as a basis for diagnosing prostate cancer with no other workup, record as code 5.
6	Direct visualization without microscopic confirmation	The tumor was visualized during a surgical or endoscopic procedure only with no tissue resected for microscopic examination.
7	Radiography and other imaging techniques without microscopic confirmation	The malignancy was reported by the physician from an imaging technique report only.
8	Clinical diagnosis only, other than 5, 6 or 7	The malignancy was reported by the physician in the medical record.
9	Unknown whether or not microscopically confirmed	A statement of malignancy was reported in the medical record, but there is no statement of how the cancer was diagnosed (usually nonanalytic).

Examples of diagnostic confirmation

1. Patient admits to the reporting facility with shortness of breath and productive cough. CT scan of the chest demonstrates a right upper lobe lung mass with enlarged

mediastinal lymph nodes. The patient refuses any additional work-up. On the discharge summary, the attending physician states the final diagnosis is lung cancer.

- The diagnostic confirmation code assigned is 8 – clinical diagnosis only. The physician gave a definitive diagnosis in the discharge summary.

2. Patient referred to the reporting facility for a breast biopsy. The biopsy is performed, and the pathologic diagnosis is infiltrating duct carcinoma of the right breast.
    - The diagnostic confirmation code assigned is 1 – positive histology. There is a pathology report with a histologic diagnosis of cancer.

Estimating Dates

If an exact date is not available, use all the information available to calculate the month and year to estimate a date. **Blank dates are not allowed in Web Plus**.

Documentation	Date code/description
Spring	April (04)
Summer or Middle of the Year	July (07)
Fall or Autumn	October (10)
Winter	Determine if this means the beginning or end of the year. Use December (12) or January (01) as determined.
Early in the Year	January (01)
Late in the Year	December (12)
Recently	Use the year and month of admission and leave the day blank. If patient was admitted during the first week of a month, use the previous month.
Several Months Ago	If the patient was not previously treated or if first course treatment started elsewhere was continued at the reporting facility, assume the case was first diagnosed three months before admission with day unknown (blank).
A Couple of Years	Code two years earlier
A Few Years	Code three years earlier

Example 1:
A patient was admitted to your facility on June 15, 2018. The History and Physical states the patient has lung carcinoma diagnosed about two months ago. Record the date of diagnosis as 201804__.

Example 2:

A patient was admitted to your facility on October 30, 2019. The History and Physical states the patient has bone metastasis from prostate cancer diagnosed in the spring. Record the date of diagnosis as 201904__.

OCCR Standardized Text Format

Overview

Text documentation that is comprehensive and detailed helps minimize confusion and is essential to the central registry when consolidating multiple records. The purpose of text fields is to justify the codes within the abstract. **Every code and date MUST be supported with clear and concise text documentation**. Additionally, proper use of recommended abbreviations can shorten the amount of text needed for accurate documentation. Please refer the texting table in the OCCR's Comprehensive Cancer Data Reporting Manual for examples of how to properly document text.

Provide the following information:

1. Dates or date ranges of procedure, exam, or treatment
2. Facility at which said procedure or exam was performed
3. Name of procedure, exam method or treatment
4. Names of drugs administered
5. Pertinent abnormal findings
6. Measurements of tumors or lymph nodes
7. If dates are estimated, please follow date with, (Est Date)
8. Information to support Summary Stage 2018
9. Additional pertinent information to support code/date fields

*__DO NOT leave text fields blank__ when information is unknown or not applicable, record 'N/A' , 'None"' or 'Unknown'.

*Further clarification of specific text fields can be found in the NAACCR Standards for Cancer Registries Data Dictionary.

Recommended Abbreviations

Abbreviations are used by abstractors to limit the amount of text but can often generate confusion. Since abbreviations can vary among different institutions and even between different specialties, standardization is necessary. To be useful, an abbreviation must be clearly understood by any individual who encounters it. Consequently, the use of abbreviations is beneficial only when universally recognized and understood. NAACCR has developed a listing of recommended abbreviations for abstractors to use and can be found in *Appendix G* of the NAACCR Standards for Cancer Registries and Data Dictionary. The listings are not exhaustive, but many of the most commonly used terms are included. A web link to the *Appendix G* listing is provided below.

NAACCR Recommended Abbreviations for Abstractors

Section 2

Web Plus Training Narrative

Enter New Abstract

Please refer to the OCCR's Comprehensive Cancer Data Reporting Manual for detailed instructions for each data item.

NOTE: there are several abstract displays in Web Plus. Reporting facilities are assigned a specific display based on facility type, number of cases reported, and whether or not the facility provides cancer directed treatment. Not all data items are included in every display. Refer to the OCCR Cancer Data Reporting for complete instructions and coding rules.

The Asterisk indicates a required field that must be completed.

Abstracting Notes

Note 1: All dates are entered using the following format: YYYYMMDD.

- If the day is unknown, leave blank (YYYYMM_ _).
- If the month and day are both unknown, leave both blank (YYYY_ _ _ _).
- If the entire date is unknown, leave field blank.

Do your best to estimate a diagnosis date using instructions for estimating dates. Very rarely should you have a blank date of diagnosis.

Note 2: Some fields have a drop down arrow.  Use this arrow to display a list of available choices to use for coding.

Note 3: Some fields have a search icon.  Click the search icon to display a search bar/list of available choices for coding.

Note 4: All fields with an asterisk (*) are required fields and must be completed by the reporter, unless otherwise specified.

**Not all required fields can be forced to require entry since some fields do not apply to all cases. Please refer to the OCCR's comprehensive Cancer Data Reporting Manual for the full list of required data items.

Note 5: To navigate within the abstract, use the "Enter" key, the "Tab" key, or the mouse.

Save Abstract and Run Data Edits

Click the "Save" button in the lower left corner of the screen. The abstract will be saved, and data edits will run. Edit errors and missing critical fields will be displayed on the right side of the screen. All edit errors and critical fields must be resolved before the abstract can be considered complete and ready to be released.

Section 3

Web Plus Training Manual for Facility Abstractors

OKLAHOMA State Department of Health

Centers for Disease Control and Prevention

National Center for Chronic Disease Prevention and Health Promotion

Division of Cancer Prevention and Control

National Program of Cancer Registries

1/6/2025

Web Plus Version 3.13

Introduction

Web Plus Features

Web Plus is used by facilities to report cancer cases to Central Cancer Registries. A variety of facility types (hospitals, physicians offices, laboratories, radiation facilities and so on) use Web Plus for cancer case reporting. Smaller hospitals and other low-volume reporters use Web Plus for online entry of cancer case abstracts. Larger facilities, particularly hospitals, use Web Plus to report via upload of NAACCR-formatted files (abstracts are created in a separate system, bundled, and uploaded in Web Plus). All facilities can use Web Plus to upload and download supporting documents in any file format.

All records are saved in a database at the hosting central cancer registry and cases entered by one facility or office are not visible to other facilities. Data entered are validated by the CDC EDITS Engine running on a web server. Users, display types, and edit configurations are managed at the hosting central registry. Web Plus is hosted on a secure web server that has a digital certificate installed; the communication between the client and the server is encrypted with Secure Socket Layer (SSL) technology.

Facility User Roles

Roles	Description
Facility Abstractor	Works in a facility or doctor's office and handles patients' medical records and paperwork. When a patient is diagnosed with cancer, the Facility Abstractor reports the case to the state's central cancer registry. The Facility Abstractor also completes and submits any follow-back abstracts that the central registry has posted for their facility.
File Uploader	Uploads either files of abstracts in the appropriate NAACCR format that were not abstracted using Web Plus or non-NAACCR files in any format, views EDITS error report and cleans, or works with abstractors to clean, errors on rejected abstracts prior to resubmitting, downloads files posted by the central registry, and views reports.

A facility user can be assigned multiple facilities; upon login, the user will see the facilities and the roles assigned. Clicking on a display type or file upload will take the user to the available menu items.

Online Abstracting

Log In

1. Open your Internet browser and enter the following web address in the address bar:

   https://occrweb.health.ok.gov/

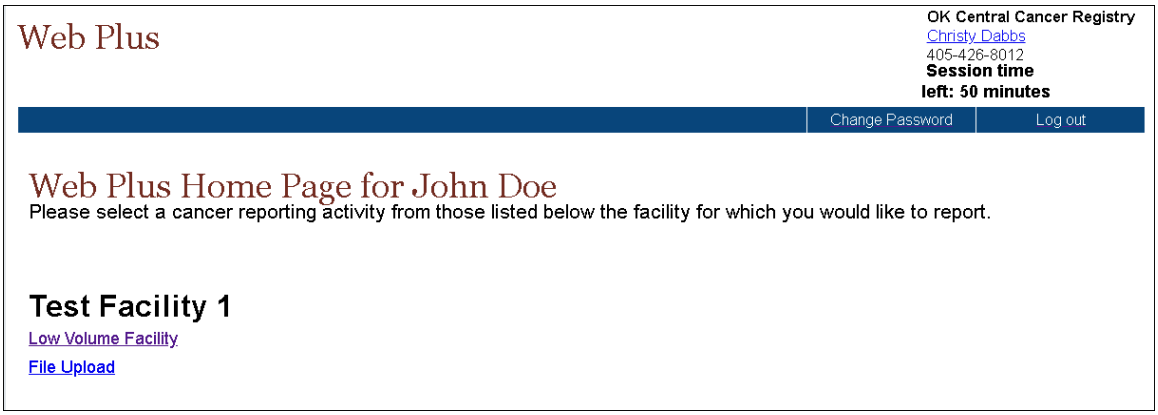
2. Press **Enter**.

   Result: The Oklahoma Central Cancer Registry Web Plus Log in page opens.

   Enter the User ID and password provided to you by your central registry into the User ID and Password fields.

3. Click **Log in**.

   Result: Your Web Plus homepage opens with a list of links to the facilities and roles that have been assigned to you. You can also change your password from this screen.



4. Click the link for the assigned Display: **Dermatology 2023 and forward, Low Vol Facility Providing TX, or Low Vol Facility-No Treatment.**

Result: The Facility Abstractor menu items are displayed in the blue bar.

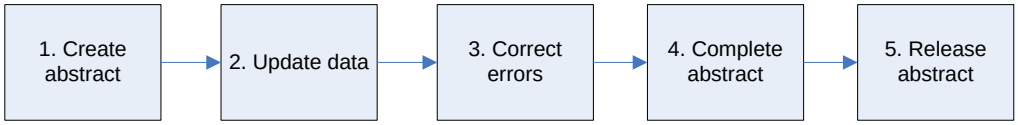
From this page you can access the main sections of Web Plus. Click on a menu option to open the page for the option.

This table describes the menu options on the home page:

Menu option	Description
Home	Opens the user's home page, which displays a list of links for the facilities and roles that have been assigned to you; to work on abstracts of a particular source, click on the link for the type of abstract
New Abstract	Opens the data entry page for a new abstract
Find/Open Abstract	Opens the page to search for existing abstracts
Release Abstracts	Opens the page that lists all abstracts that are completed and ready for release
Reports	Opens the page that lists the reports available for viewing
Change Password	Opens the change password page
Help	About - Opens a page with the Web Plus, NAACCR, and Collaborative Staging Algorithm Version information
Log out	Logs the user out of Web Plus; opens Web Plus Log in page

Abstracting

The process of creating an abstract, entering data and ultimately releasing it to the central registry will all be done in Web Plus. After you create an abstract, you can save it at any time and return to your work at a later time. You can release the abstract to your central registry only after you have completed it and eliminated any errors it may contain.



The process of generating an abstract includes the following steps:

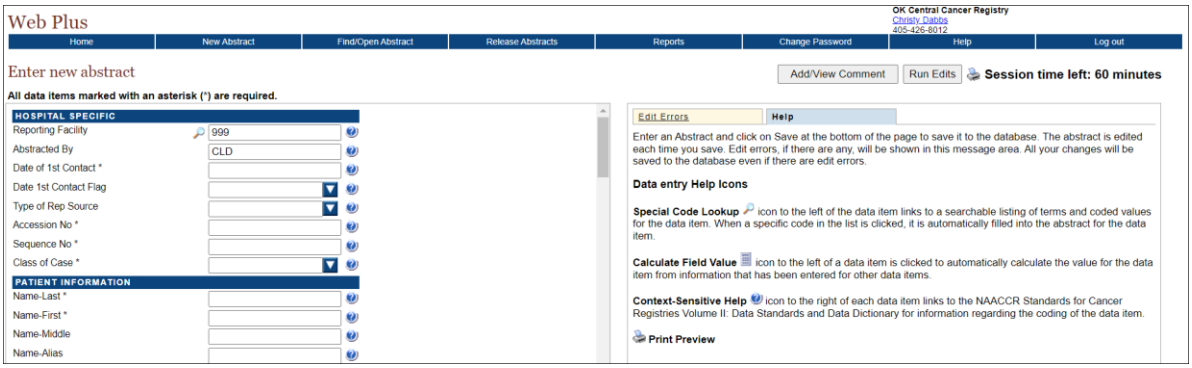
1. Create the abstract with the patient's name and social security number and save. You can add more information to the abstract and complete it whenever you want.
2. Enter codes using the codes supplied by the Web Plus application in the drop down lists and text in the data entry fields. Save the abstract to retain the information you have entered.
3. Correct errors. Each time you open or save the abstract, Web Plus automatically checks for errors in the entered information for accuracy and completeness using the edit set and required fields chosen by the OCCR Web Plus Administrator.
4. After you have entered all your data , corrected all errors, and entered all missing critical fields save the abstract and the system will designate your new abstract as complete.
5. Release the completed abstract to the central registry. You can release abstracts individually at the time of completion or several at a time as a bundle.

Create a New Abstract

Enter your case information on the new abstract page. To open the new abstract page and view its content, follow these steps:

1. In the Web Plus menu, click **New Abstract**.

Result: The Data Entry page opens.



There are two main sections; the box on the left contains the fields where case information is entered, and the box on the right has two tabs: Help and Edit Errors. In addition, there are two buttons to the right (**Add/View Comment** and **Run Edits**), a printer icon, and information on the time left in the session (inactivity causes the session time left to decrease).

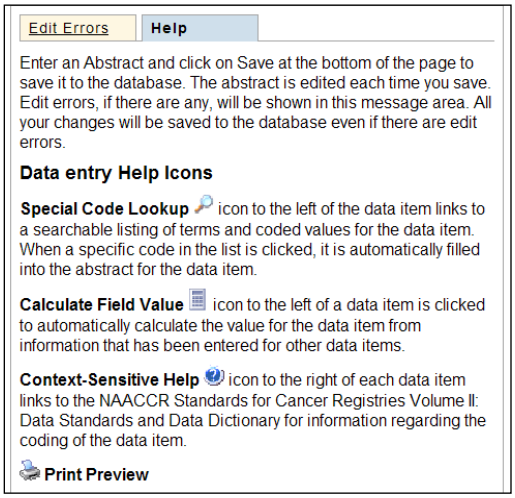
2. In the entry box on the left, scroll down the list to view all of the fields in the data entry grid, including the text fields.

   The fields you see depend on your facility or center and the set up chosen by your central registry Web Plus Administrator. The headings, such as Hospital Specific and Demographic, can vary. These are only headings; they do not signify a group of required fields. Your Web Plus Administrator uses them to organize the fields for clearer viewing and to help with data entry.

   In the right box, click each of the tabs to see the content for **Edit Errors** and **Help**

Tab	**Description**
Edit Errors	This area lists any errors that exist after you have opened or saved the abstract. This editing feature helps you complete the abstract until it meets the standards acceptable to the central registry. You will learn more about the edit errors tab on page 43.
Help	This area describes the saving and editing of an abstract and provides a description of the data entry help icons available to the abstractor.

3. The Help tab describes saving and editing an abstract and provides a description of the data entry Help icons.



These are the Web Plus icons:

Icon	Description	Click the icon to . . .
	Special Lookups	open a listing of codes and terms to choose from. Find the term that best applies and click on the code to the left of the term. When a specific code is clicked, it is automatically filled into the abstract for the data item.
	Calculate Field Value	calculate a value for a field from values in other fields.
	Context-sensitive Help	open Help page with the NAACCR Standards for Cancer Registries Volume II: Data Standards and Data Dictionary for information about the data item.
	Print Preview	open page that shows all of the fields and the content you have entered in your abstract; this page allows you to print a copy of your abstract.

4. **Saving: It is very important to Save regularly while abstracting**. Web Plus does not automatically save an abstract. When you click **Save**, the Edit Errors tab will open on the right and a list of edit errors will appear in the window. You don't have to immediately fix the errors, as entering more information will clear many errors.

   Also, when clicking save, you will be taken to the top of the abstract (even if that is not where you were last entering information).

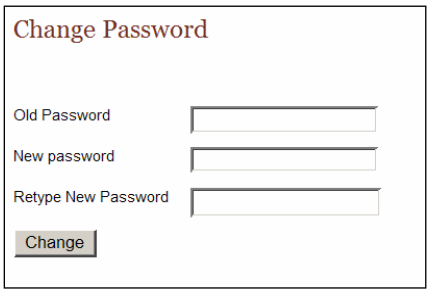
   Reminder: Be sure to save your abstract before the timer expires to avoid losing all your information.

Changing Your Password

To change your password, complete these steps:

1. On the Home page menu, click **Change Password**.

Result: The Change Password page opens.



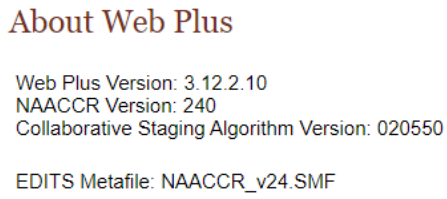
2. Type your **current** password in the **Old Password** field.
3. Type your **new** password in both of the **New Password** fields.
4. Click **Change**.

Web Plus Version Information

To view Web Plus, NAACCR, and Collaborative Staging Algorithm Version information, complete these steps:

1. On the Web Plus menu, select **Help.**
2. Select **About.**

   Result: A page opens with information about the version of the Web Plus application, the NAACCR and Collaborative Staging Algorithm versions included in the Web Plus application and the edit metafile version.



Logging Out

To log out of the Web Plus application, click **Log out** on the Home page menu.

Result: The Web Plus Log In page opens

Adding Data to a Saved Abstract

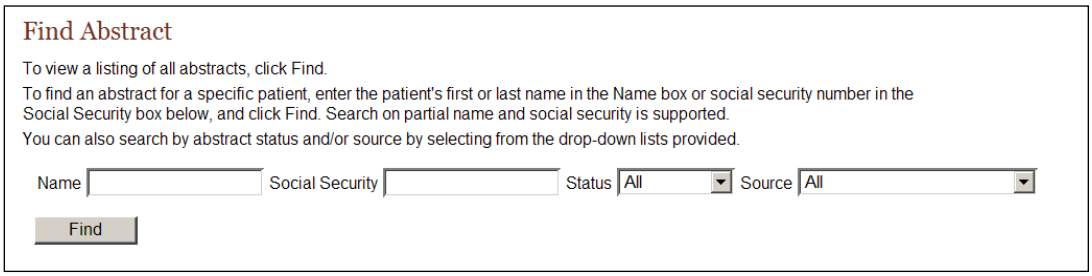
Opening and Updating an Abstract

In this section, you learn to find an existing abstract and open it, use a calculator field, and use pop-up window information.

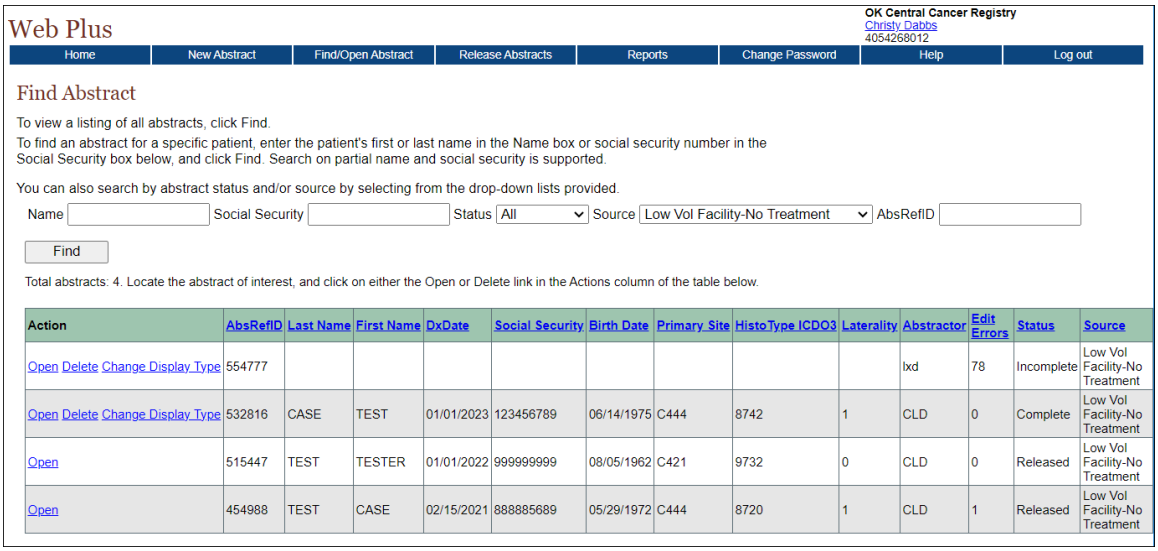
To update an abstract, follow these steps:

1. Log in, if you are not already, as instructed in "Log In," page 35.
2. On the Web Plus menu, click **Find/Open Abstract**.

Result: The **Find Abstract** page opens.



The Find Abstract page is searchable by patient name, social security number, abstract status, abstract source or AbsRefID.



The list of abstracts has the following columns:

Column Header	Description
Actions	You have the option to open or delete an abstract
AbsRefID	A system-generated number identifying the abstract
Last Name	Last name of patient
First Name	First name of patient
DxDate	Diagnosis date
Social Security	Patients' social security number
Birth Date	Patient's date of birth
Primary Site	The location of the major tumor
HistoTpe ICDO3	ICD-O 3 Histology code (specific type of cancer)
Laterality	Code for the side of a paired organ, or the side of the body on which the reportable tumor originated
Abstractor	Initials for the person who created the abstract
Edit Errors	The number of errors found in the edit process after an abstract has been saved
Status	Web Plus has three types of statuses: • Incomplete (not all data have been entered) • Complete (all errors have been addressed) • Released (sent to the central registry)
Source	The type of Web Plus abstract; this is the name of the link that you clicked on your home page

***NOTE*: Released abstracts have been sent to the Central Registry and are no longer editable. Released abstracts are view only.**

3. The list of abstracts can be sorted in ascending order on any column by clicking the header.
4. Click on **Open** in the Action column of an incomplete abstract, and the data entry page will open and display previously entered information. The heading of the abstract, above data entry fields will be **Update Abstract**. In addition, upon opening the incomplete abstracts, edits will be automatically run, and errors displayed on the right.

Print Preview

The Print Preview feature allows you to view all of the fields and the content you have entered in your abstract. You can also print a copy of the abstract from the Print Preview window.

1. Open an abstract.
2. Click **Print Preview**  .

   Result: A separate window opens that displays all of your abstract entry fields and content.
3. To print a copy of the abstract, use your browser's printer.

Correcting Edit Errors

Understanding Edit Sets

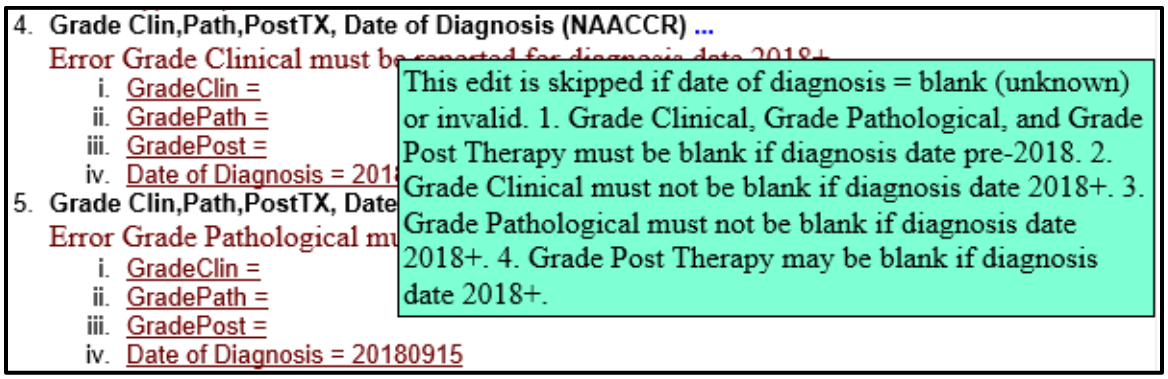
Each abstract is edited for data quality and completeness whenever you save or open it. The edits applied to the information depend on the edit set selected by the Web Plus Administrator at your central registry.

As an abstractor you must correct all identified errors and missing critical fields to complete your abstract prior to releasing it to the central registry.

Edit Errors Tab

The edit errors pane lists edits in the abstract. The edit set runs each time the abstract is saved or re-opened.

Each edit errors includes the name of the edit, the description of the error, and a link to the field (s) involved with the edit. Following the name of the edit is an ellipses (…); click on the ellipses to view detailed information about the edit. For example, clicking on the ellipses after edit error 4 below brings up the text in with the green background, which is further information about the edit.



To correct abstract edit errors, you can click on the link to the field associated with the edit error, which is displayed just below the error description. This will take you to that field, which will now be located at the top of the abstract display on the left.

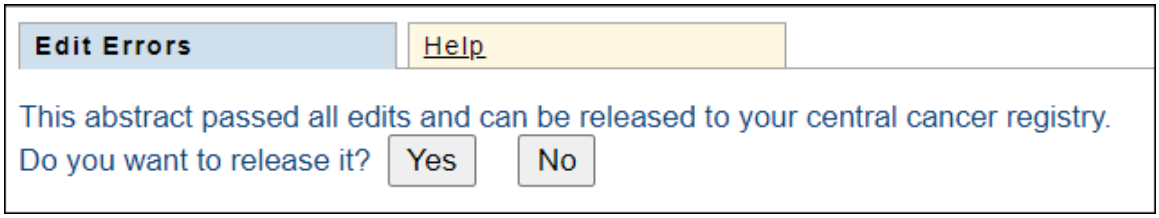
Edits Busy Message

Users may sometimes get the message "Edits busy, please try again later" upon saving an abstract. This message appears when two (or more) users are running edits at the same time. The system is not able to accommodate more than one user running edits at a time, so it lets users know it is busy. They can continue to work and will be able to run edits when the edits are available. This might be particularly noticeable when many users are entering cases at the same time, or when a large file is being uploaded (and edits are being run on it) while users are also entering cases.

Completing and Releasing Abstracts

Completing the Abstract

As mentioned, you must resolve all edit errors and fill in all critical (required) fields in order to complete an abstract. Once you have resolved all edit errors and completed all missing critical fields, upon the next save of the abstract, Web Plus informs you that the abstract is complete and ready for release to the central registry.

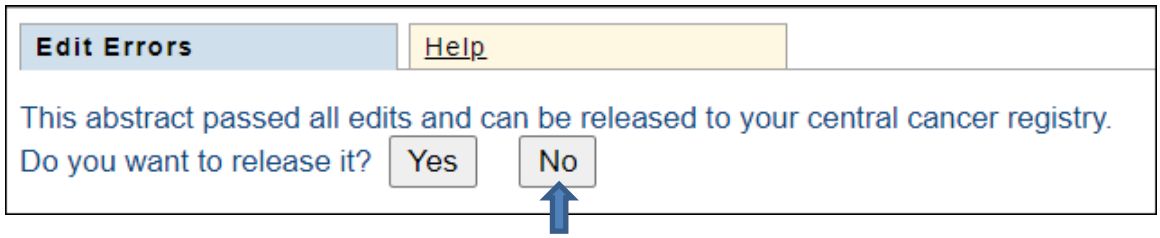


Note

Critical (required) fields are labeled with an asterisk (*).

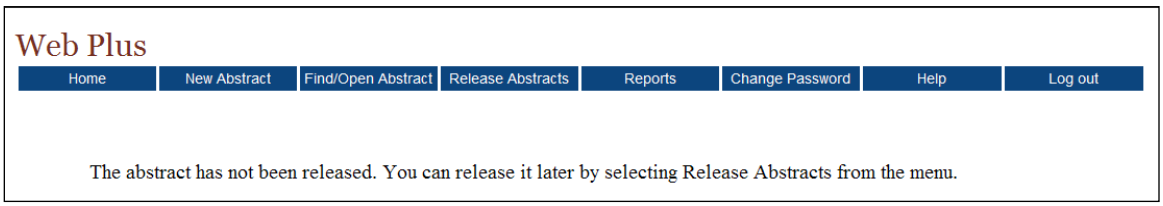
1. Click **Save** to save the last entries that you made.

   Result: Edits are run; the **Edit Result** shows **no errors**, and the application informs you that the abstract is **complete** and **ready for release** to the central registry.



2. **Do not** release the abstract now. Click **No** and go to the next section of this training manual, "Releasing the Abstract".

   Result: The abstract is saved and completed, but not released.

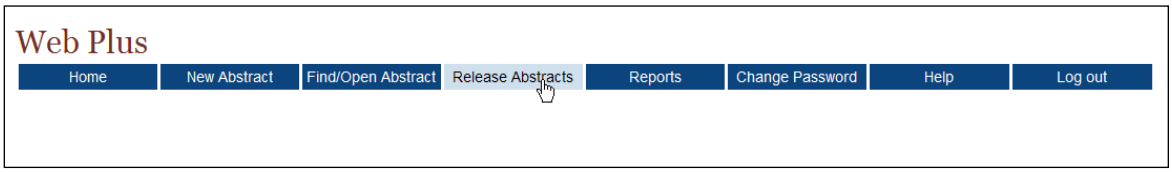


Releasing the Abstract

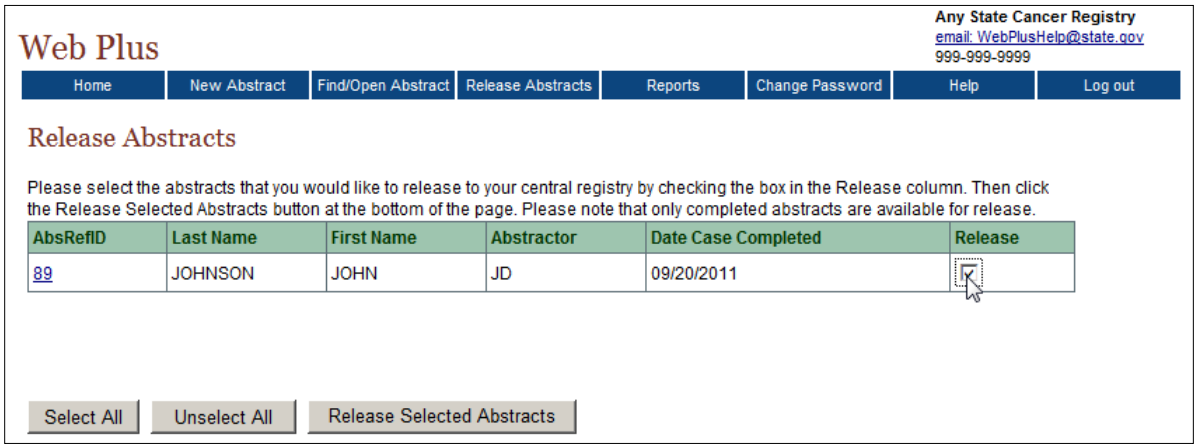
Once your abstract has no errors and no missing critical fields, it is complete, and you can release it to the central registry.

Follow these steps to release an abstract:

1. On the Web Plus menu, click **Release Abstracts**.



   Result: The system displays a list of completed abstracts.



2. Click the box in the Release column for the abstract(s) you would like to release to the central registry.

To select all of the abstracts listed, click the **Select All** button.

3. Click **Release Selected Abstracts**.

   Result: The system releases the selected abstracts to your designated central registry and changes the status of the abstracts to Released. Use the Find/Open page to view the released abstracts. ***Note that you can view an abstract that has been released but cannot revise it.***

It is highly recommended to release abstracts in bundles to provide yourself an opportunity to review cases for incorrect codes or text prior to releasing the case.

Correcting Errors in Released Cases

After cases are released to the OCCR, they may be reviewed for completeness and accuracy. It is important to note that edits are not able to determine all errors within an abstract. Therefore, a manual review by the OCCR may be completed. This is a critical step in the data review process to ensure that accurate data is submitted to the Centers for Disease Control and Prevention in the annual call for data.

If a case is chosen for review:

1. The OCCR will review released cases for completeness and accuracy.
2. Comments for each case will be provided to the abstractor with a description of the data item, the correct coding or text format and the reason for the change.
3. The cases will be sent back for correction and will be listed as status *incomplete* in find/open abstracts.
4. The OCCR will email the abstractor with specific instructions for making corrections. A deadline for completion will be included.
5. The abstractor will make the corrections and release the case.
6. The OCCR will review the released case and verify that ll corrections have been made. If there is still a significant amount of errors, the case will be returned to the abstractor for correction.
7. If there are minimal errors, the OCCR will make the corrections, enter additional comments for corrections that were made and accept the case. The abstractor will be notified by email and can open each case, now status released, to view the additional comments.
8. If there are no errors, the case will be accepted. No additional email will be sent to the abstractor.

This publication was issued by the Oklahoma State Department of Health (OSDH), an equal opportunity employer and provider. A digital file has been deposited with the Publications Clearinghouse of the Oklahoma Department of Libraries in compliance with section 3-114 of Title 65 of the Oklahoma Statutes and is available for download at www.documents.ok.gov .| Issued June 2024