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Item Number	Variable Name	Column Length	Column Begin	Column End	Codes / Format / Comments	Edit Checks/Skip Patterns
All Patients Sections: These sections must be completed for each MDE record when NBCCEDP funds are used to pay for all or part of at least one of the screening or diagnostic procedure(s).						
Section 1: Program, Patient, and Record Location						
1.01	State, Territorial, or Tribal Program [PN Abbreviated Field]	2	1	2	**Right Justify** (i.e. California = ~6 and Texas = 48, where ~ = a blank character.	Valid code for your program.
1.02	Unique Patient ID Number [PN Abbreviated Field]	15	3	17	If Social Security Number (SSN) is used, it must be encoded. The ID number should be unique and constant for each patient in order to track the patient over time. This field should not contain any identifiable information, including partial names or dates. **Alphanumeric (no special symbols), left justify.** **Alphabetic characters must be entered consistently in uppercase or lowercase for all records for each patient.**	
1.03	Record Identifier [PN Abbreviated Field]	8	18	25	**Right Justify.** This field will be used to uniquely identify one record among many for a woman. This could be a cycle number, a visit date, or a record number. In this context, record and screening cycle have the same meaning.	
Section 2: Patient Demographic Information						
2.01	County of Residence [PN Abbreviated Field]	3	26	28	FIPS Code, **Right Justify**. (If unknown, blank fill). Not required if Zip Code of residence is reported.	Valid FIPS code for the county.
2.02	State or Territory of Residence [PN Abbreviated Field]	2	29	30	FIPS Code, **Right Justify**. (If unknown, blank fill).	Valid FIPS code for the state or territory.

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Item Number	Variable Name	Column Length	Column Begin	Column End	Codes / Format / Comments	Edit Checks/Skip Patterns
2.03	ZIP Code of Residence [PN Abbreviated Field]	5	31	35	**Right Justify**. (If unknown, blank fill) Not required if county of residence is reported.	Valid 5 digit numeric zip code.
2.04	Date of Birth [PN Abbreviated Field]	6	36	41	MMYYYY (i.e. Jan 1942 = 011942). If unknown, blank fill.	Check for validity, i.e. no one too old or too young at date of enrollment. See edit guidelines for dates at the end of this document.
2.05	Hispanic or Latino Origin (self-reported) [PN Abbreviated Field]	1	42	42	1. Yes 2. No 3. Unknown	Range check.
2.06.1	Race 1 (self-reported) [PN Abbreviated Field]	1	43	43	1. White 2. Black or African American 3. Asian 4. Native Hawaiian or Other Pacific Islander 5. American Indian or Alaska Native 7. Unknown 8. Asian/Pacific Islander (v4.1 only)* *8 - Asian/Pacific Islander (v4.1 only) may only be reported for data collected prior to 10/01/2002.	Range check. This race field should be populated first. If a woman self identifies more than one race, then each race identified should be reported in a separate race field. Report up to five (5) separate races. It is recommended that your Program no longer collect 'Other' race on your data collection forms. However, if your Program collects 'Other' as a race category, please export this to '7' (Unknown) in the MDEs.
2.06.2	Race 2 (self-reported) [PN Abbreviated Field]	1	44	44	1. White 2. Black or African American 3. Asian 4. Native Hawaiian or Other Pacific Islander 5. American Indian or Alaska Native 7. Unknown	This field should be left blank, unless the woman reports more than one race.

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Item Number	Variable Name	Column Length	Column Begin	Column End	Codes / Format / Comments	Edit Checks/Skip Patterns
2.06.3	Race 3 (self-reported) [PN Abbreviated Field]	1	45	45	1. White 2. Black or African American 3. Asian 4. Native Hawaiian or Other Pacific Islander 5. American Indian or Alaska Native 7. Unknown	This field should be left blank, unless the woman reports more than two races.
2.06.4	Race 4 (self-reported) [PN Abbreviated Field]	1	46	46	1. White 2. Black or African American 3. Asian 4. Native Hawaiian or Other Pacific Islander 5. American Indian or Alaska Native 7. Unknown	This field should be left blank, unless the woman reports more than three races.
2.06.5	Race 5 (self-reported) [PN Abbreviated Field]	1	47	47	1. White 2. Black or African American 3. Asian 4. Native Hawaiian or Other Pacific Islander 5. American Indian or Alaska Native 7. Unknown	This field should be left blank, unless the woman reports more than four races.

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Item Number	Variable Name	Column Length	Column Begin	Column End	Codes / Format / Comments	Edit Checks/Skip Patterns
Section 3: Patient Navigation						
3.01	Patient Navigation Paid by NBCCEDP funds [PN Abbreviated Field]	1	48	48	1. Yes 2. No 3. Unknown	Data collection for this field is effective 01/01/2019. This field is asking whether PN was paid with NBCCEDP funds, not whether PN was delivered. Historical data should be coded as '3' Unknown. If patient navigation is delivered (consistent with CDC policy) using NBCCEDP funds to support the navigation (e.g. reimbursement fee-for-service, paid for staff delivering PN), select '1' Yes. '2' No should be selected if NBCCEDP funds were not used or PN was not delivered. '3' Unknown
Section 4: Cervical Screening Information						
4.01	Previous Pap Test	1	49	49	1. Yes 2. No 3. Unknown	Range check.
4.02	Date of Previous Pap Test	6	50	55	If "Previous Pap Test" = '1' then enter MMYYYY (if known) or blank fill (if unknown). If "Previous Pap Test" = '2' or '3', blank fill.	If not blank, must be a valid date. Check the skip pattern.

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Item Number	Variable Name	Column Length	Column Begin	Column End	Codes / Format / Comments	Edit Checks/Skip Patterns
4.03	Indication for Pap Test	1	56	56	1. Screening 2. Surveillance 3. Non-program Pap, Referred in for diagnostic evaluation 4. No Pap 5. No Cervical Service 6. Pap after primary HPV+ 9. Unknown	If Indication for Pap Test is '5' then items 4.04 – 4.13 should be blank. Data collection for this field is effective 01/01/2009. Historical data can be reported if accurately collected; otherwise, code as '9' (Unknown). '1' (Screening) should be reported for a Pap test performed as part of a routine screening schedule. Items 4.04 – 4.13 should be reported as appropriate. Item 4.06 should be blank. '2' (Surveillance) should be reported for a Pap test performed on a woman under management for a cervical abnormality (abnormal Pap or HPV) detected prior to this cycle. Items 4.04 – 4.13 should be reported as appropriate. Item 4.06 should be blank. '3' (Referred) should be reported when a patient has had a Pap test performed outside of the Program, and is referred to the Program for diagnostic work-up. Referral Date (4.06) must be completed, and a valid Pap test Result should be provided: (4.07) '1'-'11' or '14'. '4' (No Pap) should be reported when the patient does not have a screening Pap test and goes directly to Diagnostic Work-up or only had a primary HPV test. Items 4.06 – 4.09 should be blank. '5' (No Cervical Service) should be reported when no cervical services are provided or reported in this record, only breast services. Items 4.04 – 4.13 should be blank. '6' (Pap after primary HPV+) should be reported when a Pap test is done as follow-up to a positive (other 12) primary HPV test. Items 4.04 – 4.13 should be reported as appropriate. Item 4.06 should be blank.

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Item Number	Variable Name	Column Length	Column Begin	Column End	Codes / Format / Comments	Edit Checks/Skip Patterns
4.04	Cervical Service Paid by NBCCEDP Funds [PN Abbreviated Field]	1	57	57	1. Yes 2. No 3. Unknown	Data collection for this field is effective 01/01/2019. Historical data can be reported if accurately collected; otherwise, code as '3' (Unknown). This field should be left blank if "Indication for Pap Test" (4.03) is '5'. If Pap test, HPV test, or at least one cervical diagnostic procedure was paid by NBCCEDP Funds, then this field should be set to '1' (Yes).
4.05	High Risk for Cervical Cancer	1	58	58	1. Yes 2. No 9. Not assessed/Unknown	Data collection for this field is effective 01/01/2019. Historical data should be coded as '9' (Unknown). This field should be left blank if "Indication for Pap Test" (4.03) is '5'. '1' (Yes) should be reported if risk was assessed and determined to be high risk, as defined as prior DES exposure and/or immunocompromised patients. '2' (No) should be reported if risk was assessed and not determined to be high risk '9' (Not assessed/Unknown) should be reported if risk was not assessed, family history was not taken, genetic testing was not done or if risk is unknown.
4.06	Cervical Diagnostic Referral Date	8	59	66	If "Indication for Pap Test" = '3', enter MMDDYYYY; otherwise leave blank	Data collection for this field is effective 01/01/2009. Historical data can be reported if accurately collected; otherwise, leave blank. If not blank, must be a valid date. Check the skip pattern. See edit guidelines for skip patterns at the end of this document. This field should indicate the enrollment date for a patient referred in to the program for diagnostic evaluation following an abnormal Pap test provided outside of the program.

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Item Number	Variable Name	Column Length	Column Begin	Column End	Codes / Format / Comments	Edit Checks/Skip Patterns
4.07	Result of Pap Test Simplified categories from all Bethesda Reporting Systems [PN Abbreviated Field]	2	67	68	1. Negative for intraepithelial lesion or malignancy 2. Infection/Inflammation/Reactive Changes (Beth1991) 3. Atypical squamous cells of undetermined significance (ASC-US) 4. Low Grade SIL (including HPV changes) 5. Atypical squamous cells cannot exclude HSIL (ASC-H Beth2001) 6. High Grade SIL 7. Squamous Cell Carcinoma 8. Atypical Glandular Cells (Beth2014) 9. Adenocarcinoma in situ (AIS) (Beth2014) 10. Adenocarcinoma (Beth2014) 11. Other 12. Unsatisfactory 13. Result Pending 14. Result unknown, presumed abnormal, Pap test from non-program funded source	Data collection for this field is effective 01/01/2019. Please reference MDE v6 to v7 Conversion Specifications in Appendix 6 to map historical data. This field should be left blank if “Indication for Pap Test” (4.03) is ‘4’ or ‘5’. If the result of this Pap test is not 12 or 13 and the clinician determines a diagnostic work-up should be done, the Cervical Diagnosis Information Section MUST also be completed. This field should = ‘14’ only when “Indication for Pap test” (4.03) is 3 (Non-program Pap, Referred in for diagnostic evaluation) and the actual result of the Pap test is not known.
4.08	Other Pap Test Result [PN Abbreviated Field]	20	69	88	If "Result of Pap Test" = ‘11’, enter "Result" in free text format.	This field should be left blank if “Indication for Pap Test” (4.03) is ‘4’ or ‘5’.
4.09	Date of Pap Test [PN Abbreviated Field]	8	89	96	If "Result of Pap Test" ≤ ‘12’, enter MMDDYYYY. If you know the date for ‘13’ or ‘14’, enter MMDDYYYY, otherwise blank fill.	This field should be left blank if “Indication for Pap Test” (4.03) is ‘4’ or ‘5’.

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Item Number	Variable Name	Column Length	Column Begin	Column End	Codes / Format / Comments	Edit Checks/Skip Patterns
4.10	Indication for HPV Test	1	97	97	1. Co-Test/Screening 2. Reflex 3. Test not done 9. Unknown	Data collection for this field is effective 01/01/2019. For cycles before 01/01/2019 where an HPV test was not performed, code as '3' (Test Not Done). Other historical data were an HPV test was done can be reported if accurately collected; otherwise code as '9' (Unknown). This field should be left blank if "Indication for Pap Test" (4.03) is '5'. '1' (Co-Test/Screening) should be reported if HPV test is performed alone or in combination with a Pap test as part of cervical cancer screening. '2' (Reflex) should be reported if a HPV test is performed as a follow-up test after a screening Pap test. '3' (Test not done)

Item Number	Variable Name	Column Length	Column Begin	Column End	Codes / Format / Comments	Edit Checks/Skip Patterns
4.11	HPV Test Result [PN Abbreviated Field]	1	98	98	1. Positive with genotyping not done/unknown 2. Negative 4. Positive with positive genotyping 5. Positive with negative genotyping 9. Unknown	Data collection for this field is effective 01/01/2009. Historical data can be reported if accurately collected; otherwise, leave blank. This field should be left blank if “Indication for Pap Test” (4.03) is ‘5’. This field should be left blank if “Indication for HPV Test” (4.10) is ‘3’. ‘1’ should be reported if HPV test was positive and genotyping was not done or unknown. ‘2’ should be reported if HPV test was negative. ‘4’ should be reported if HPV test was positive and genotyping identifies type 16 or 18. ‘5’ should be reported if HPV test was positive and genotyping does not identify type 16 or 18.
4.12	Date of HPV Test [PN Abbreviated Field]	8	99	106	If “HPV Test Result” = ‘1’- ‘5 or ‘9’, then enter MMDDYYYY Date of HPV Test is the date of the sample collection.	Data collection for this field is effective 01/01/2009. Historical data can be reported if accurately collected; otherwise, leave blank. This field should be left blank if “Indication for Pap Test” (4.03) is ‘5’. This field should be left blank if “Indication for HPV Test” (4.10) is ‘3’.

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Item Number	Variable Name	Column Length	Column Begin	Column End	Codes / Format / Comments	Edit Checks/Skip Patterns
4.13	Diagnostic Work-up Planned for Cervical Dysplasia or Cancer	1	107	107	1. Diagnostic work-up planned 2. Diagnostic work-up not planned 3. Diagnostic work-up plan not yet determined	If "Indication for Pap Test" (4.03) is '1', '2', '3', '4', '6' or '9' this field must be completed; otherwise, leave blank. If this field is coded as '1', the Cervical Diagnosis Information Section must be completed. If this field is coded as '2' or '3', the Cervical Diagnosis Information Section must be blank.

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Item Number	Variable Name	Column Length	Column Begin	Column End	Codes / Format / Comments	Edit Checks/Skip Patterns
Section 5: Breast Screening Information						
5.01	Indication for Initial Mammogram	1	108	108	1. Screening 2. Diagnostic 3. Non-program mammogram, Referred in for diagnostic evaluation 4. No mammogram 5. No Breast Service 9. Unknown	If Indication for Initial Mammogram is '5' then items 5.02 – 5.11 should be blank. Data collection for this field is effective 01/01/2009, but no records should be blank. Historical data can be reported if accurately collected; otherwise, report a cycle with mammogram data as '9' (Unknown). A cycle with cervical only data should be reported as '5' (No Breast Service). '1' (Screening) should be reported for a mammogram performed as part of a routine or annual screening schedule and in the absence of symptoms or a recent positive CBE. '2' (Diagnostic) should be reported for a mammogram performed as additional evaluation of a recent mammogram prior to this cycle, evaluation of current symptoms or abnormal CBE finding, or prior history of breast cancer. '3' (Referred) should be reported when a patient has had a mammogram performed outside of the Program, and is referred to the Program for diagnostic work-up. Referral Date (5.03) must be completed, and a valid Mammogram Result (5.07) of '1' – '5', '7', '11', or '14' – '15' should be reported. '4' (No Mam) should be reported when the patient only received a CBE or screening MRI; or when the patient does not have an initial mammogram performed and goes directly to Diagnostic Work-up. Items 5.07 – 5.08 should be blank. '5' (No Breast Service) should be reported when no breast services are provided or reported in this record, only cervical services. Items 5.02 – 5.11 should be blank.

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Item Number	Variable Name	Column Length	Column Begin	Column End	Codes / Format / Comments	Edit Checks/Skip Patterns
5.02	Breast Service Paid by NBCCEDP Funds [PN Abbreviated Field]	1	109	109	1. Yes 2. No 3. Unknown	Data collection for this field is effective 01/01/2019. Historical data can be reported if accurately collected; otherwise, code as '3' (Unknown). This field should be left blank if "Indication for Mammogram" (5.01) is '5'. If Mammogram, CBE, MRI or at least one breast imaging or diagnostic procedures was paid by NBCCEDP Funds, then this field should be set to '1' (Yes).
5.03	Breast Diagnostic Referral Date	8	110	117	If "Indication for Initial Mammogram" (5.01) = '3', enter MMDDYYYY. If "Indication for Initial Mammogram" (5.01) = '4' then 5.03 MAY be completed as MMDDYYYY; otherwise leave blank.	Data collection for this field is effective 01/01/2009. Historical data can be reported if accurately collected; otherwise, leave blank.
5.04	High Risk for Breast Cancer	1	118	118	1. Yes 2. No 9. Not Assessed/Unknown	Data collection for this field is effective 01/01/2019. Historical data should be coded as '9' (Unknown). This field should be left blank if "Indication for Mammogram" (5.01) is '5'. '1' (Yes) should be reported if risk was assessed and determined to be high risk as defined as a woman with BRCA mutation, a first-degree relative who is a BRCA carrier, a lifetime risk of 20-25% or greater as defined by risk assessment models, radiation treatment to the chest between ages 10-30, or personal or family history of genetic syndromes like Li-Fraumeni syndrome. '2' (No) should be reported if risk was assessed and not determined to be high risk '9' (Not Assessed/Unknown) should be reported if risk was not assessed, family history was not taken, genetic testing was not done or if risk is unknown.

Item Number	Variable Name	Column Length	Column Begin	Column End	Codes / Format / Comments	Edit Checks/Skip Patterns
5.05	Screening MRI results	1	119	119	1. Negative (Category 1) 2. Benign Finding (Category 2) 3. Probably Benign indicated (Category 3) 4. Suspicious (Category 4) 5. Highly Suggestive of Malignancy (Category 5) 6. Known Malignancy (Category 6) 7. Incomplete — Need Additional Imaging Evaluation (Category 0) 8. Results Pending 9. Not done	Data collection for this field is effective 01/01/2019. Historical data should NOT be reported. This field should be left blank if “Indication for Mammogram” (5.01) is ‘5’ or “High Risk of Breast Cancer” (5.04) ≠ ‘1’.
5.06	Date of Screening MRI	8	120	127	If MRI Results (5.05) ≤ “7", enter MMDDYYYY. If you know the date for ‘8’, enter MMDDYYYY, otherwise blank fill. If MRI Results (5.05) = “9" blank fill.	If not blank, must be a valid date. This field should be left blank if “Indication for Mammogram” (5.01) is ‘5’ or if “Screening MRI Results” (5.05) is ‘9’.
5.07	Initial Mammography Test Result (includes **all** mammograms which were the first mammogram of a screening cycle) Categories from the American College of Radiology Breast Imaging Reporting and Database System [PN Abbreviated Field]	2	128	129	1. Negative (BI-RADS 1) 2. Benign Finding (BI-RADS 2) 3. *Probably Benign – Initial short interval follow-up suggested (BI-RADS 3) 4. Suspicious Abnormality - Biopsy should be considered (BI-RADS 4) 5. Highly Suggestive of Malignancy - Appropriate action should be taken (BI-RADS 5) 7. Unsatisfactory - This applies if the mammogram was technically unsatisfactory and could not be interpreted by radiologist. 10. Result pending 11. Result unknown, presumed abnormal, mammogram from non-program funded source 14. Need evaluation or film comparison (BI-RADS 0) 15. Known Biopsy-Proven Malignancy (BI-RADS 6) *Based on new BI-RADS guidance from the Fourth Edition 2003, (3) Probably Benign should not be reported as the initial mammogram result unless a complete work-up was performed prior to the screening cycle either within or outside of the program. Please refer to the Field Description in the Data User’s Manual for further details.	This field should be left blank if “Indication for Mammogram” (5.01) is ‘4’ or ‘5’. If the result of the initial mammogram is ‘4’, ‘5’, ‘11’ or ‘14’, the ”Additional procedures needed to complete breast cycle“ (5.11) should = ‘1’. A result of ‘7’ (Unsatisfactory) indicates that the cycle should be considered complete, and a new cycle will begin with the repeat mammogram. This variable should be the initial result of the first mammographic film only. If any additional imaging is needed, to obtain a final imaging result or if a film comparison is necessary to obtain a final imaging result, then report ‘14’. This field should = ‘11’ only when “Indication for Initial Mammogram” (5.01) is ‘4’ (Non-program mammogram, Referred in for diagnostic evaluation) and the actual result of the initial mammogram is not known.

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Item Number	Variable Name	Column Length	Column Begin	Column End	Codes / Format / Comments	Edit Checks/Skip Patterns
5.08	Date of Initial Mammogram [PN Abbreviated Field]	8	130	137	If "Initial Mammography Test Result" ≤ '5', '7', '14', or '15' enter MMDDYYYY. If you know the date for '10' or '11', enter MMDDYYYY, otherwise blank fill.	If not blank, must be a valid date. This field should be left blank if "Indication for Mammogram" (5.01) is '4' or '5'.
5.09	Clinical Breast Exam	1	138	138	1. Normal/Benign findings – schedule for routine CBE in one year 2. Abnormality suspicious for cancer – diagnostic evaluation needed 5. Not performed	This field should be left blank if "Indication for Mammogram" (5.01) is '5'.
5.10	Date of Clinical Breast Exam	8	139	146	If "Clinical Breast Exam" = '1' or '2', enter MMDDYYYY If "Clinical Breast Exam" = 5 blank fill.	This field should be left blank if "Indication for Mammogram" (5.01) is '5'. If "Clinical Breast Exam" (5.09) = '1' or '2', enter MMDDYYYY If "Clinical Breast Exam" (5.09) = '5', blank fill.
5.11	Additional Procedures Needed to Complete Breast Cycle	1	147	147	1. Additional procedures needed or planned. 2. Additional procedures not needed or planned. 3. Need or plan for additional procedures not yet determined	If "Indication for Mammogram" (5.01) is '1', '2', '3', '4' or '9' this field must be completed; otherwise, leave blank. If this field is coded as '1', the Breast Diagnosis Information Section must be completed. If this field is coded as '2' or '3', the Breast Diagnosis Information Section must be blank. If "Indication for Initial Mammogram" (5.01) is '3', then this field must = '1' (Additional procedures needed or planned) and the Breast Diagnosis Information Section must be completed.
5.12	MDE Version Number	2	148	149	21. For CBE data collected through 9/30/1994 70. For all other data collected	Note that the period in the version number is not included. For example, version 7.0 will be submitted as '70'. Only certain records with historical CBE data should use '21'.

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Item Number	Variable Name	Column Length	Column Begin	Column End	Codes / Format / Comments	Edit Checks/Skip Patterns
Cervical Final Diagnosis and Treatment Sections: These sections must be completed if Diagnostic Work-up Planned for Cervical Dysplasia or Cancer (4.13) = '1' (planned), otherwise leave blank.						
Section 6: Cervical Final Diagnosis Information						
6.01	Status of Final Diagnosis	1	150	150	1. Work-up complete 2. Work-up pending 3. Lost to follow-up 4. Work-up refused 9. Irreconcilable A response of "9" will be used for those records, which after clinical review; it was determined that there was no sufficient way to translate the clinical scenario into the MDE data record. An example would be: If the clinician refers the woman for short-term follow-up instead of following the guideline for immediate diagnostic work-up, enter a '9' to indicate a closed cycle with an irreconcilable status.	Range check. A status of "Work-up complete" means that the diagnostic testing is complete, and that "Final Diagnosis" (6.02) and "Date of Final Diagnosis" (6.04) are known.
6.02	Final Diagnosis [PN Abbreviated Field]	1	151	151	1. Normal/Benign reaction/inflammation 2. HPV/Condylomata/Atypia 3. CIN1/mild dysplasia (biopsy diagnosis) 4. CIN2/moderate dysplasia (biopsy diagnosis) 5. CIN3/severe dysplasia/Carcinoma in situ (Stage 0) or Adenocarcinoma In Situ of the cervix (AIS) (biopsy diagnosis) 6. Invasive Cervical Carcinoma (biopsy diagnosis) 7. Other 8. Low grade SIL (biopsy diagnosis) 9. High grade SIL (biopsy diagnosis)	Range check. Low grade SIL and High grade SIL are provided as alternatives to diagnoses 2-5 and only one diagnosis should be submitted. Invasive Adenocarcinoma of the cervix should be coded as a '6' (Invasive Cervical Carcinoma). Adenocarcinoma In Situ (AIS) of the cervix should be coded as '5' (CIN3 /severe dysplasia/CIS/AIS).
6.03	Final Diagnosis – Other [PN Abbreviated Field]	20	152	171	Free text format, Description of "Final Diagnosis - Other".	Check the skip pattern.

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Item Number	Variable Name	Column Length	Column Begin	Column End	Codes / Format / Comments	Edit Checks/Skip Patterns
6.04	Date of Final Diagnosis	8	172	179	If Status of Final Diagnosis (6.01) = '1' enter MMDDYYYY, the date of diagnosis of cancer or precancerous lesion or date the decision made that no cancer is present. If Status of Final Diagnosis (6.01) = '2' then blank fill. If Status of Final Diagnosis (6.01) = '3', '4' or '9' then enter MMDDYYYY, the date of administrative closeout.	See edit guidelines for dates at the end of this document.
Section 7: Cervical Cancer Treatment Information – This section is completed based on the results of MDE Item 6.02 (Final Diagnosis).						
7.01	Status of Treatment	1	180	180	1. Treatment started 2. Treatment pending 3. Lost to follow-up 4. Treatment refused 5. Treatment not needed	A woman should be classified as having started treatment when the Program has confirmed that a plan for treatment of the cancer or precancerous lesion has been developed and started. Range and skip pattern check. If Final Diagnosis (6.02) = '4', '5', '6', or '9' then complete 7.01 and 7.02. If Final Diagnosis (6.02) = '2', '3', '7', or '8' then 7.01 and 7.02 MAY be completed. If Final Diagnosis (6.02) = '1', then 7.01 and 7.02 should be left blank. If a woman dies before treatment has started, enter a '3' (Lost to follow-up).
7.02	Date of Treatment Status	8	181	188	If Status of Treatment (7.01) = '1' enter MMDDYYYY, the date that treatment of cancer or precancerous lesion began. If Status of Treatment (7.01) = '2' then blank fill. If Status of Treatment (7.01) = '3', '4', or '5' then enter MMDDYYYY, the date of administrative closeout.	Check the skip pattern. If not blank, should be ≥ "Date of Final Diagnosis" (6.04).

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Item Number	Variable Name	Column Length	Column Begin	Column End	Codes / Format / Comments	Edit Checks/Skip Patterns
Breast Final Diagnosis and Treatment Sections: These sections must be completed if Additional Procedures Needed to Complete Breast Cycle (5.11) = '1' (planned), otherwise leave blank.						
Section 8: Breast Final Diagnosis Information						
8.01	Status of Final Diagnosis / Imaging	1	189	189	1. Work-up complete 2. Work-up pending 3. Lost to follow-up 4. Work-up refused 9. Irreconcilable A response of '9' will be used for those records, which after clinical review; it was determined that there was no sufficient way to translate the clinical scenario into the MDE data record. An example would be: If the clinician refers the woman for short-term follow-up instead of following the guideline for immediate diagnostic work-up, enter a '9' to indicate a closed cycle with an irreconcilable status.	Range check. A status of "Work-up complete" means that all additional imaging and diagnostic testing (if applicable) is complete, and that the "Final Diagnosis" (8.02) and "Date of Final Diagnosis" (8.03) are known.
8.02	Final Diagnosis [PN Abbreviated Field]	1	190	190	1. Carcinoma In Situ, Other* 2. Invasive Breast Cancer 3. Breast Cancer Not Diagnosed 4. Lobular Carcinoma In Situ (LCIS) - (Stage 0) 5. Ductal Carcinoma In Situ (DCIS) - (Stage 0) *Category (1) - CIS, Other is not a current reporting option for Final Diagnosis. It was used to report CIS diagnoses prior to 10/01/1999.	Range check. If a patient gets a final imaging outcome that requires no further diagnostic procedures, then this field should be coded as '3' (Breast Cancer Not Diagnosed).
8.03	Date of Final Diagnosis / Imaging	8	191	198	If Status of Final Diagnosis/Imaging (8.01) = '1', then enter MMDDYYYY, the date of diagnosis of cancer or date that decision made that no cancer is present. If Status of Final Diagnosis/Imaging (8.01) = '2', then blank fill. If Status of Final Diagnosis/Imaging (8.01) = '3', '4' or '9' then enter MMDDYYYY, the administrative date of closeout of this episode.	See edit guidelines for dates at the end of this document. The "Date of Final Diagnosis/Imaging" (8.03) should be the date of the definitive procedure indicating cancer or not cancer

National Breast and Cervical Cancer Early Detection Program
Minimum Data Elements (MDE) Data Definition Table

Item Number	Variable Name	Column Length	Column Begin	Column End	Codes / Format / Comments	Edit Checks/Skip Patterns
Section 9: Breast Cancer Treatment Information – This section is completed based on the results of Final Diagnosis (8.02).						
9.01	Status of Treatment	1	199	199	1. Treatment started 2. Treatment pending 3. Lost to follow-up 4. Treatment refused 5. Treatment not needed If a woman dies before treatment has started, enter a '3' (Lost to follow-up).	Range and skip pattern check. A woman should be classified as having started treatment when the Program has confirmed that a plan for treatment of the cancer or precancerous lesion has been developed and started. If Final Diagnosis (8.02) = '1', '2' or '5' then complete 9.01 and 9.02. If Final Diagnosis (8.02) = '4', then 9.01 and 9.02 MAY be completed. If Final Diagnosis (8.02) = '3', then 9.01 and 9.02 should be blank.
9.02	Date of Treatment Status	8	200	207	If Status of Treatment (9.01) = '1', then enter MMDDYYYY, the date that treatment for cancer began. If Status of Treatment (9.01) = '2', then blank fill. If Status of Treatment (9.01) = '3', '4', or '5' then enter MMDDYYYY, the date of administrative closeout.	Check the skip pattern. If not blank, should be ≥ "Date of Final Diagnosis" (8.03).

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Minimum Data Elements (MDE) Data Definition Table

Item Number	Variable Name	Column Length	Column Begin	Column End	Codes / Format / Comments	Edit Checks/Skip Patterns
Cervical and Breast Cancer Registry Data Sections						
Section 10: Cervical Cancer Registry Data – If Final Diagnosis (6.02) is a '6' (Invasive Cervical Carcinoma) and the patient was screened as of January 1, 2004, then this section must be completed. This section is reserved for data acquired through a State Central Cancer Registry or an equivalent data source approved by CDC/IMS. **NAACCR Record Data Standards and Data Dictionary are available at www.naaccr.org.**						
10.01	Registry Linkage Status	1	208	208	1. Linkage process pending 2. Linkage process complete, record matched 3. Linkage process attempted, record not matched	Range check.
10.02	Registry Date of Diagnosis [NAACCR data item #390]	8	209	216	MMDDYYYY	Leave blank if 10.01 = 1, 3. If not blank, must be a valid date.
10.03	Registry Summary Stage [NAACCR data item: #764 When 10.02 ≥ 01/01/2018 #759 When 10.02 = 1/1/2016 – 12/31/2017 #3020 When 10.02 = 01/01/2004 – 12/31/2015 #759 When 10.02 = 01/01/2001 – 12/31/2003 #760 When 10.02 ≤ 12/31/2000]	1	217	217	0. In situ (IS) 1. Localized (L) 2. Regional, direct extension only (RE) 3. Regional, regional lymph nodes only (RN) 4. Regional, extension and nodes (RE+RN) 5. Regional, NOS (RNOS) 7. Distant (D) 8. Not Applicable (NA) 9. Unknown/unstaged (U)	Range check. Leave blank if 10.01 = 1, 3. Note: These NAACCR data items are specific to definitions in place for the calendar year of the Registry Date of Diagnosis (10.02).

National Breast and Cervical Cancer Early Detection Program
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Item Number	Variable Name	Column Length	Column Begin	Column End	Codes / Format / Comments	Edit Checks/Skip Patterns
10.04	Registry Collaborative Stage (CS) – Derived AJCC Stage Group [NAACCR data item: #3000 when 10.02 is between years 2004-2009 (AJCC 6th Edition) #3430 when 10.02 is between years 2010-2015 (AJCC 7th Edition)]	2	218	219	**Right Justify With Leading Zeroes** Range: 00-99	Leave blank if 10.01 = 1, 3. Complete only if Registry Date of Diagnosis (10.02) = 01/01/2004 – 12/31/2015; otherwise leave blank. Complete CS-Derived AJCC Stage Group 6th Edition as available since not required by NPCR registries. While CS-Derived AJCC Stage Group expanded from 2-digits in the 6th Edition to 3-digits in the 7th Edition, the CDC does not plan to expand to 3-digis in the MDEs at this time. When reporting AJCC 7th, edition cases from 2010 forward, the MDEs will collect the first 2-digits of the 3-digit code which provide a general classification. Programs are encouraged to consult with their IT staff/system vendor and their Cancer Registry to assess the feasibility and need to expand this field to 3-digits in their database system. Programs are advised to truncate the 3-digit value when creating the MDE file by reporting the first two digits and dropping the last of the three digits.

National Breast and Cervical Cancer Early Detection Program
Minimum Data Elements (MDE) Data Definition Table

Item Number	Variable Name	Column Length	Column Begin	Column End	Codes / Format / Comments	Edit Checks/Skip Patterns
Section 11: Breast Cancer Registry Data – If Final Diagnosis (8.02) is a '1' (Carcinoma In Situ, Other), '2' (Invasive Breast Cancer), '4' (Lobular Carcinoma In Situ) or '5' (Ductal Carcinoma In Situ) and the patient was screened as of January 1, 2004, then this section must be completed. This section is reserved for data acquired through a State Central Cancer Registry or an equivalent data source approved by CDC/IMS. **NAACCR Record Data Standards and Data Dictionary are available at www.naaccr.org.**						
11.01	Registry Linkage Status	1	220	220	1. Pending linkage 2. Linked, matched 3. Linked, not matched	Range check.
11.02	Registry Date of Diagnosis [NAACCR data item #390]	8	221	228	MMDDYYYY	Leave blank if 11.01 = 1, 3. If not blank, must be a valid date.
11.03	Registry Summary Stage [NAACCR data item: #764 When 11.02 ≥ 01/01/2018 #759 When 11.02 = 1/1/2016 – 12/31/2017 #3020 When 11.02 = 01/01/2004 – 12/31/2015 #759 When 11.02 = 01/01/2001 – 12/31/2003 #760 When 11.02 ≤ 12/31/2000]	1	229	229	0. In situ (IS) 1. Localized (L) 2. Regional, direct extension only (RE) 3. Regional, regional lymph nodes only (RN) 4. Regional, extension and nodes (RE+RN) 5. Regional, NOS (RNOS) 7. Distant (D) 8. Not Applicable (NA) 9. Unknown/unstaged (U)	Range check. Leave blank if 11.01 = 1, 3. Note: These NAACCR data items are specific to definitions in place for the calendar year of the Registry Date of Diagnosis (11.02).

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Item Number	Variable Name	Column Length	Column Begin	Column End	Codes / Format / Comments	Edit Checks/Skip Patterns
11.04	Registry Collaborative Stage (CS) – Derived AJCC Stage Group [NAACCR data item: #3000 when 11.02 is between years 2004-2009 (AJCC 6th Edition) #3430 when 11.02 is between years 2010-2015 (AJCC 7th Edition)]	2	230	231	**Right Justify With Leading Zeroes** Range: 00-99	Leave blank if 11.01 = 1, 3. Complete only if Registry Date of Diagnosis (11.02) = 01/01/2004 – 12/31/2015; otherwise leave blank. Complete CS-Derived AJCC Stage Group 6th Edition as available since not required by NPCR registries. While CS-Derived AJCC Stage Group expanded from 2-digits in the 6th Edition to 3-digits in the 7th Edition, the CDC does not plan to expand to 3-digis in the MDEs at this time. When reporting AJCC 7th, edition cases from 2010 forward, the MDEs will collect the first 2-digits of the 3-digit code which provide a general classification. Programs are encouraged to consult with their IT staff/system vendor and their Cancer Registry to assess the feasibility and need to expand this field to 3-digits in their database system. Programs are advised to truncate the 3-digit value when creating the MDE file by reporting the first two digits and dropping the last of the three digits.
End of Record Mark – Completed for each MDE record						
	End of Record/Newline	1	232	232	Character that ends the current record and begins a new line of text.	Example: Carriage Return-Line Feed

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General edit guidelines for:

Dates: If your data processing system does not store dates as complete dates (i.e. they are separate month, day, and year fields), you need to verify the individual fields. The month needs to be between 1 and 12 and the day, if specified, between 1 and 31 and appropriate for the month (i.e. no June 31). A common situation for some dates could be that the year is known, but the month or day is not. If this occurs, please blank fill only the unknown fields.

Correct date sequences: A correct sequence of dates that track screening, diagnosis, and treatment is very important. These relationships have been specified in the edit section above or in the Edits Application. Please check these date relationships to ensure that the date sequences are reasonable.

Range checks: These are performed on fields like Hispanic Origin (2.05), Race (2.06.x),, etc. where specific values are requested. A simple check of these data before they are submitted will ensure that, for example, Hispanic Origin only has values of '1' to '3' as specified in the MDE documentation.

Skip patterns: There are fields in the MDEs that are supposed to be completed under certain circumstances and left blank in others. For example, Clinical Breast Exam Date (5.10) should only be completed if Clinical Breast Exam (5.09) is a '1' or '2'. Thus please check to see that if, for example, 10 women have a '1' or a '2' for Clinical Breast Exam, that there are no more than 10 Clinical Breast Exam Dates (5.10).