

CASEFINDING FOR COMPLETENESS OF REPORTING

The *Texas Cancer Incidence Reporting Act (Chapter 82, Health and Safety Code)* requires every health care facility, clinical laboratory, and health care practitioner center to submit cancer information for each reportable diagnosis.

Casefinding is a system for identifying all eligible cases. Facility sources used to identify cases include disease indices, pathology and laboratory reports, patient logs, and similar resources. Refer to the Casefinding sources list on page 19. Every inpatient and/or outpatient with active disease and/or receiving cancer-directed therapy must be reported to the TCR regardless of the patient's state or country of residence.

REPORTABLE CANCER CASES

Cases of cancer to be reported to the TCR include:

1. All neoplasms with a **behavior code** of /2 (in situ) or /3 (malignant) in the *International Classification of Diseases for Oncology 3rd Edition (ICD-O-3)*, with some exceptions (see page 21).

Note: Cases diagnosed prior to 1995 are no longer required to be reported.

2. All primary tumors with a **behavior code** of /0 (benign), /1 (borderline), or /3 (malignant) occurring in any of the following sites:
 - a. Brain (C710–C719), meninges (C700–C709), spinal cord (720), cauda equina (C721), cranial nerve or nerves (C722–C725), or any other part of the central nervous system (CNS) (C728–C729)
 - b. Pituitary gland (C751), pineal gland (C753), or craniopharyngeal duct (C752); 2003 cases and forward.

Note: A benign/borderline reportable CNS diagnosis can include the term *neoplasm* or *tumor*.

Note: All lesions of the brain and CNS must have the morphology term and code listed in ICD-O-3. If the morphology term and code are not listed in the ICD-O-3, then it is not reportable.

Required Sites for Benign and Borderline Primary Intracranial and Central Nervous System Tumors:

GENERAL TERM	SPECIFIC SITES	ICD-O-3 TOPOGRAPHY CODE
Meninges	Cerebral meninges	C700
	Spinal meninges	C701
	Meninges, NOS	C709
Brain	Cerebrum	C710
	Frontal lobe	C711
	Temporal lobe	C712
	Parietal lobe	C713
	Occipital lobe	C714
	Ventricle, NOS	C715
	Cerebellum, NOS	C716
	Brain stem	C717
	Overlapping lesion of brain	C718
	Brain, NOS	C719
Spinal cord, cranial nerves, and other parts of the central nervous system	Spinal cord	C720
	Cauda equina	C721
	Olfactory nerve	C722
	Optic nerve	C723
	Acoustic nerve	C724
	Cranial nerve, NOS	C725
	Overlapping lesion of brain and central nervous system	C728
	Nervous system, NOS	C729
Pituitary, craniopharyngeal duct and pineal gland	Pituitary gland	C751
	Craniopharyngeal duct	C752
	Pineal gland	C753

*Note: Benign and borderline tumors of the cranial bones (C410) are **not reportable**.*

CASES DIAGNOSED CLINICALLY ARE REPORTABLE

In the absence of a histologic or cytologic confirmation of a reportable diagnosis, accession the case based on the **clinical diagnosis** (when a recognized medical practitioner says the patient has a cancer or carcinoma). A clinical diagnosis may be recorded in the final diagnosis, on the face sheet, or in other parts of the medical record.

Note: A pathology report normally takes precedence over a clinical diagnosis. If the patient has a biopsy that disproves the clinical diagnosis the case is not reportable.

EXCEPTION: *If the physician treats a patient for cancer in spite of the negative biopsy, accession the case.*

EXCEPTION: *If enough time has passed that it is reasonable to assume that the physician has seen the negative pathology report, and the clinician continues to call this a reportable disease, accession the case. A reasonable amount of time would be 6 months or more.*

CASEFINDING METHODS

There are two types of casefinding methods—*active and passive*:

- 1. Active casefinding:** The personnel responsible for reporting obtain and review all sources for eligible cases.
- 2. Passive casefinding:** The personnel responsible for reporting rely on others to notify the reporter of possible eligible cases.

Active casefinding is more comprehensive and precise. **Passive casefinding** has a greater potential for missed cases. A combination of active and passive casefinding is a more effective method and ensures fewer missed cases. Casefinding procedures should be evaluated from time to time and amended as facility procedures or services change.

It is strongly recommended that every facility have a Casefinding Policy and Procedure in place. Casefinding procedures should be evaluated from time to time and amended as facility procedures or services change.

CASEFINDING SOURCES

- | | |
|------------------------------------|-----------------------------------|
| 1. Medical Records Department | 3. Surgery Department |
| a. Disease indices | 4. Outpatient Departments |
| b. Admission and discharge reports | 5. Medical and Diagnostic Imaging |
| 2. Pathology Department | 6. Radiation Oncology |
| a. Histology reports | 7. Medical Oncology |
| b. Cytology reports | 8. Emergency Room reports |
| c. Hematology reports | |
| d. Autopsy reports | |

CASEFINDING PROCESS

Cooperation and a good working relationship between reporting personnel and other departments are essential for accurate case ascertainment. The reporter is responsible for identifying all casefinding sources under their facility licensure and arranging access to these sources, for example, rural health clinics, surgery centers across town or off campus.

A disease index including both **inpatient and outpatient** admissions should be obtained after

medical records are completed and coded (monthly or quarterly). The index **must** be based on **year of admit**. It should be sorted **alphabetically** by last name and should include the following: **last name, first name, medical record number, admission/discharge date, date of birth, social security number, all primary and secondary ICD-9 diagnosis codes and admission type**.

Attachment A (page 32) is an example of a disease index that can be modified for individual facilities.

The following list includes some helpful hints for the casefinding process:

- Review the disease index for reportable cancer codes to insure the facility has reported all of its reportable cases to the TCR.
- Request a TCR Facility Data Report from your regional office. A Facility Data Report is a complete listing of cases submitted by the facility.
- Compare the patients with reportable codes on the disease index to the TCR Facility Data Report.
- Review any patient charts with reportable codes that are missing from the TCR Facility Data Report for reportability.
- Prepare an abstract for each reportable case missing from the TCR Facility Data Report.
- If a previously reported patient is found to have a subsequent primary, assign the new primary the patient's original registry number. Change the sequence number to reflect the new primary and abstract the pertinent cancer information.

*Note: If a facility uses an automated casefinding method (for example: the hospital's mainframe extracts possible reportable cases and places these into cancer registry software suspense file), a manual disease index should be run at the end of the reporting year. **Insure that the ICD-9-CM codes used are the most current for the reporting year.** This disease index is then checked against the cancer registry database to insure that all cases were either reported or clearly documented as non-reportable and why. At the end of each reporting year, send the disease index and non-reportable list along with the casefinding check-list (Attachment C, page 34) to your facility's health service region. Refer to page 12 for a list of all regional offices.*

The following lists are intended to assist the cancer data reporter in identifying the reportable neoplasms.

REPORTABLE NEOPLASMS

- Malignant neoplasms (*exclusions noted on page 21*)
- Benign and borderline neoplasms of central nervous system
- Pituitary adenomas diagnosed as of 2003
- Carcinoma in-situ (*exclusions noted on page 21*)
- Carcinoid, NOS (*excluding appendix, C181, unless stated to be malignant*)
- Pilocytic/juvenile astrocytoma is reportable and should be coded to 9421/3 per ICD-O-3 errata
- Squamous intraepithelial neoplasia grade III (8077/2) of vulva [VIN], vagina [VAIN], and anus [AIN] **beginning with 2001 cases**

Note: All tumors and neoplasms of the brain and other CNS sites must have a morphology

term and code in ICD-O-3. If there is no morphology term and code, it is not reportable. Tumors and neoplasms diagnosed prior to 2001 must have a morphology term and code in ICD-O-2 to be reportable.

Notes:

1. Malignant neoplasms of the skin of genital sites **are reportable**. These sites include: vagina (C529), clitoris (C512), vulva (C519), prepuce (C600), penis (C609), and scrotum (C632).
2. Reportable skin tumors such as adnexal carcinomas (carcinomas of the sweat gland, ceruminous gland, and hair follicle), adenocarcinomas, lymphomas, melanomas, sarcomas, and Merkel cell tumor **must be reported regardless of site**. Any carcinoma arising in a hemorrhoid is reportable since hemorrhoids arise in mucosa, not in skin.

NON-REPORTABLE NEOPLASMS

- Basal cell carcinoma (8090–8110) of the skin (C440-C449) **except genital sites**
- Basal and squamous cell carcinoma (8070–8110) of skin of anus (C445)
- Epithelial carcinomas (8010–8046) of the skin (C440-C449)
- Papillary and squamous cell carcinomas (8050–8084) of the skin (C440-C449) **except genital sites**
- Malignant neoplasms, NOS (8000–8005) of the skin (C440-C449)
- In situ neoplasms of cervix regardless of histology (behavior of /2; C539)
- Intraepithelial neoplasms of the cervix (CIN) (8077/2; C539) or prostate (PIN)(8148/2; C619)
- Borderline cystadenomas (8442, 8451, 8462, 8472, 8473) of the ovaries (C569) with behavior code 1 are **not** collected as of January 01, 2001
- Cases diagnosed prior to 1995 are no longer required to be reported.
- Benign and borderline tumors of the cranial bones (C410)
- Cysts or lesions of the brain or CNS diagnosed January 01, 2004 or later which have no ICD-O-3 morphology code

Example:

On 04/12/2008, a patient was diagnosed with cholesteatoma in the cerebral meninges. This is not a reportable CNS case since there is no code for cholesteatoma listed in *ICD-O-3*.

COMPREHENSIVE REPORTABLE LISTS

The following comprehensive lists are intended to aid appropriate staff (for example: Information Services, Data Management) in creating the disease index with the required reportable neoplasms and other ICD-9-CM codes. The reporter should review all admissions (inpatient and outpatient) with the following diagnosis codes for reportability. **Bolded codes are new as of October 2008.**

ICD-9-CM CODE	DIAGNOSIS
CODE RANGES	PREFERRED ICD-O-3 TERMINOLOGY
140.0 - 209.30	Malignant neoplasms
225.0 - 225.9	Benign neoplasms of brain and spinal cord
227.3 - 227.4	Benign neoplasms of pituitary gland, pineal body, and other intracranial endocrine-related structures
230.0 - 234.9	Carcinoma in-situ (exclude 233.1, cervix)
237.0 - 237.9	Neoplasms of uncertain behavior (borderline) of endocrine glands and nervous system
511.81	Malignant Pleural Effusion

The table below lists a sample of codes and is not all-inclusive. The full range of codes must be checked.

INDIVIDUAL CODES	PREFERRED ICD-O-3 TERMINOLOGY
042.	AIDS (review records for AIDS-related malignancies)
203.1	Plasma cell leukemia (9733/3)
205.1	Chronic neutrophilic leukemia (9963/3)
227.3	Benign neoplasm of pituitary (body, fossa, gland, lobe)
227.3	Benign neoplasm of craniopharyngeal (duct, pouch)
227.4	Benign neoplasm of pineal (body, gland)
238.4	Polycythemia vera (9950/3)
238.6	Solitary plasmacytoma (9731/3) Extramedullary plasmacytoma (9734/3)
238.71	Essential thrombocythemia (9962/3) Essential hemorrhagic thrombocythemia Essential thrombocytosis Idiopathic thrombocythemia Idiopathic hemorrhagic thrombocythemia Primary thrombocythemia Thrombocythemia vera Note: Primary thrombocythemia, thrombocythemia vera and essential thrombocytosis are considered synonyms for essential thrombocythemia but are not listed in ICD-O-3. In the absence of a specific code for the synonym, code to the preferred term. Refer to <i>Abstracting and Coding Guide for the Hematopoietic Diseases</i>.

238.72	Low grade myelodysplastic syndrome lesions Refractory anemia (RA) (9980/3) Refractory anemia with ringed sideroblasts (RARS) (9982/3) Refractory cytopenia with multilineage dysplasia (RCMD) (9985/3) Refractory cytopenia with multilineage dysplasia and ringed sideroblasts (RCMD-RS) (9985/3)
238.73	High grade Myelodysplastic syndrome lesions Refractory anemia with excess blasts-1 (RAEB-1) (9983/3) Refractory anemia with excess blasts-2 (RAEB-2) (9983/3)
238.74	Myelodysplastic syndrome with 5q deletion (9986/3) Excludes: constitutional 5q deletion (not reportable)
238.75	Myelodysplastic syndrome, unspecified (9985/3, 9989/3)
238.76	Myelofibrosis with myeloid metaplasia (9961/3) Agnogenic myeloid metaplasia Idiopathic myelofibrosis (chronic) Myelosclerosis with myeloid metaplasia Primary myelofibrosis Excludes: myelofibrosis NOS myelophthisis anemia (not reportable) myelophthisis (not reportable)
238.79	Other lymphatic and hematopoietic tissues Megakaryocytic myelosclerosis (9961/3) Myeloproliferative disease (chronic) NOS (9960/3) Panmyelosis (acute) (9931/3)
273.2	Gamma heavy chain disease (9762/3)
273.3	Waldenstrom's macroglobulinemia
288.3	Hypereosinophilic syndrome (9964/3)
289.83	Myelofibrosis Myelofibrosis NOS Secondary myelofibrosis

Admissions with the following procedure codes must be screened for reportable neoplasms:

ICD-9-CM CODES	PROCEDURE DESCRIPTION
V07.3	Other prophylactic chemotherapy (screen carefully for miscoded malignancies)
V07.5 - V07.59	Prophylactic use of agents affecting estrogen receptors and estrogen levels (Tamoxifen, arimidex, etc.)
V07.8	Other specified prophylactic measures
V10.0 - V10.9	Personal history of malignancy (review these for recurrences, subsequent primaries, subsequent treatment, and diagnosis date)
V58.0	Admission for radiotherapy

V58.11	Admission for chemotherapy
V58.12	Admission for antineoplastic immunotherapy
V66.1	Convalescence following radiotherapy
V66.2	Convalescence following chemotherapy
V67.1	Radiation therapy follow-up
V67.2	Chemotherapy follow-up
V76.0–V76.9	Special screening for malignant neoplasm
V86.0	Estrogen receptor positive status (ER+) (new code)
V86.1	Estrogen receptor negative (ER-) (new code)

Cases with the following codes should be screened as registry time allows. Check for incorrectly coded malignancies.

ICD-9-CM CODES	DIAGNOSIS/TERMINOLOGY
210.0 – 229.9	Benign neoplasms
235.0 – 238.9	Neoplasms of uncertain behavior
239.0 – 239.9	Neoplasms of unspecified behavior
273.9	Unspecified disorder of plasma protein metabolism (screen for potential 273.3 miscodes)

SEER suggests that the following codes be screened as deemed appropriate by the individual reporting facility and as time allows. These are neoplasm related secondary conditions for which there should also be a primary diagnosis of a reportable neoplasm

ICD-9-CM CODES	DIAGNOSIS/TERMINOLOGY
E879.2	Adverse effect of radiation therapy
E930.7	Adverse effect of antineoplastic therapy
E933.1	Adverse effect of immunosuppressive therapy

The following are **exclusions** and **do not** need to be reported to the TCR:

MORPHOLOGY CODES	DIAGNOSIS/TERMINOLOGY
8000–8005	Neoplasms, malignant, NOS of the skin
8010/2	Carcinoma in-situ of cervix (CIN) beginning with 1996 cases
8010–8046	Epithelial carcinomas of the skin
8050–8084	Papillary and squamous cell carcinomas of the skin except genital sites
8077/2	Squamous Intraepithelial Neoplasia, grade III of cervix beginning with 1996 cases; CIN
8090–8110	Basal cell carcinomas of the skin except genital sites
8148/2	Prostatic Intraepithelial Neoplasia (PIN)

In 2001 the behavior code for certain ICD-O codes changed from borderline to malignant and from malignant to borderline. These codes can be found in the *ICD-O-3* and in *TCR CRH Revised 2007*.

OTHER METHODS

Other methods for identifying reportable cancer cases can be developed to assure complete case reporting. Since the patient's medical record is the primary source of information, arrangements should be made so the appropriate charts can be routed to the personnel responsible for reporting. These charts could be stamped and placed on a shelf marked for Tumor Registry review.

Pathology

The pathology department reports must be routinely checked. The best procedure is to have a copy of ALL pathology reports routed to the personnel responsible for reporting. All pathology reports (both positive and negative) must be reviewed by the reporter to ensure all eligible cases are identified. The reporter should request that all cytology, hematology, bone marrow biopsies, and autopsies be included. Both computerized and manual methods of reviewing pathology reports must include a way to track reports to ensure that every report has been included in the review. Facilities that send all pathology specimens to outside labs should keep a log of all specimens, to include date sent out, date received, and the diagnosis. The reporter should be given a copy of all reports.

Radiation Oncology

For facilities with radiation oncology departments, a procedure must be established to identify patients receiving radiation therapy. This should include all inpatient and outpatient treatments. Different options, such as providing copies of the treatment summary, a treatment card, or even a daily appointment book may be available to identify these cases. Many cancer patients are seen in the outpatient department, hematology clinic, laboratory, emergency room, nuclear medicine, and diagnostic radiology and oncology departments. A method to identify reportable cases from these departments must also be established.

Oncology/Hematology

Many facilities now have a designated oncology/hematology unit where patients receive chemotherapy treatments as an inpatient. In some cases, patients receive chemotherapy in an ambulatory setting, a freestanding facility, or a physician's office. The registrar/reporter must establish a policy and procedure for identifying patients who receive chemotherapy in these settings if affiliated with their facility.

Suspense File

A reportable case should be abstracted after review of the patient's complete record, not just from the unit record for the admission in question. If reportable cases are identified at the time of discharge, the complete medical record may not be available at the time the case is abstracted. A suspense file should be compiled of all cases identified as eligible or potentially eligible for abstracting. The suspense file can be something as simple as a manila folder to hold the various casefinding source documents (monthly disease index, pathology reports and outpatient log sheets and so forth) in alphabetical order and/or by date of diagnosis to assess timeliness of the abstracting process.

Non-Reportable List

Personnel responsible for reporting should review the table of terms that indicate a diagnosis of cancer on page 20. Upon review of the disease index, cases may be identified as TCR non-reportable cases. Examples of these would be basal and squamous cell carcinoma of the skin (173.0-9) (excluding genital sites), and CIN of the cervix (233.1). A list of these cases must be kept each year because the TCR needs to review the disease index and the non-reportable list when it conducts casefinding audits after facilities have completed reporting for a given year (see page 11). The non-reportable list will answer any questions TCR staff may have regarding the non-reporting of these cases. The list should include patient name, date of birth, social security number, medical record number, admission date, casefinding source, and the reason the case was not reportable.

Attachment B (page 33) is a sample form that can be used as a history file of the non-reportable cases. Non-reportable cases can also be documented on the disease index. Place the notation “NR” next to the patient information and include a justification if the case is determined not reportable. Another method would be to develop an electronic spreadsheet that can be sorted alphabetically, such as Excel or Word. An alphabetical index card file can also be used. If cases are abstracted and reported using SCL v.10, a non-reportable log may be kept. Please refer to the *SCL User’s Guide* for instructions.

Examples:

- a. The ICD-9-CM billing code indicates current disease. Reason for admission was radiology and laboratory testing. Radiology and laboratory findings do not indicate active disease. **This case is not reportable, unless the physician states the patient has active, metastatic, or recurrent disease.**
- b. Patient is admitted for staging procedures. Radiology reports no abnormal findings. The discharge summary states that the patient has recently been diagnosed with prostate cancer and is in the process of deciding treatment options. **This case is reportable because even though the radiology report shows no abnormal findings, the discharge summary states the patient has prostate cancer.**
- c. The discharge summary and face sheet states history of cancer and there is no other information within the chart to indicate active or stable disease. **This case is not reportable because the patient has a history of cancer with no evidence of active disease.**
- d. A patient is admitted for evaluation of congestive heart failure. The patient had a mastectomy for breast cancer 8 years ago and there is no evidence of recurrent or metastatic disease. **This case is not reportable because there is no indication that the patient has current disease.**
- e. A patient comes in for lab work. Face sheet states lung cancer. No other information or documentation indicating active disease is available. **This case is not reportable because there is not information regarding whether the patient has current lung cancer.**

- f. A patient was diagnosed with adenocarcinoma of the stomach in 1985 with no evidence of recurrent or metastatic disease. In 2008, the patient was admitted and diagnosed with small cell carcinoma of the lung. **The 2008 case is reportable because the patient has active disease.**
- g. Discharge summary diagnosis states cancer and the ICD-9-CM billing code indicates current disease. All laboratory findings are negative for active disease, but one radiology report indicates active disease compatible with malignancy. **This case is reportable because according to the radiology report the patient has active disease.**
- h. A patient is admitted to your facility with an acute cerebrovascular accident. The H&P states the patient was diagnosed with metastatic lung cancer four months prior to admission. He was treated with palliative care and referred to the Hospice program. All indications are that this patient still has active cancer. **This case is reportable because apparently the patient has active disease.**
- i. A patient was diagnosed with cervical cancer in 2000 and has had no recurrence. She is now admitted and diagnosed with a second primary in the lung. **The lung case is reportable because the patient has active lung cancer.**
- j. A patient comes to your facility for port-a-cath insertion to allow for chemotherapy for a malignancy. Documentation indicates the patient has active disease. **This case is reportable because the patient has active disease and is receiving cancer directed therapy, even though the therapy may be given at a different facility.**
- k. Patient with a recent excisional biopsy for melanoma of skin of arm is admitted to your facility for a wide excision. The pathology report shows no residual melanoma. **This case is reportable because the wide excision is considered treatment for the melanoma.**
- l. In 2009 a patient comes in to your facility for a colonoscopy. The record states that the patient was diagnosed with breast cancer in 2007. She is still being treated with Tamoxifen which was part of the first course of treatment. It is unknown if the patient has evidence of disease at this time. **This case is reportable because the patient is still receiving hormone treatment.**
- m. A patient is admitted to the hospital after a heart attack. The chart states the patient has a history of prostate cancer and is on Lupron. There is no other information regarding the patient's history. **Report this case because the patient is on treatment could be related to the history of prostate cancer.**

Note: Refer to Appendix O to determine multiple primaries and histology for cases diagnosed on or after 1/1/2007.

AMBIGUOUS TERMINOLOGY FOR CASEFINDING:

In most cases, the patient's record clearly presents the diagnosis by use of specific terms which are synonymous with cancer. However, there will be times when a physician is not certain or the documented language is not definitive. Ambiguous terminology may originate from any source document, such as pathology report, radiology report or a clinical report. *The entire medical record should be reviewed before basing reportability on one of these terms.* The terms listed below are reportable.

Ambiguous terms that are reportable (used to determine reportability)

- Apparent(ly)
- Appears
- Comparable with
- Compatible with
- Consistent with
- Favor(s)
- Malignant appearing
- Most likely
- Neoplasm (beginning with 2004 diagnosis and only for C700-C729, C751-C753)
- Presumed
- Probable
- Suspect(ed)
- Suspicious (for)
- Tumor (beginning with 2004 diagnosis and only for C700-C729, C751-C753)
- Typical (of)

Note: *This list should be used only for determining case reportability. Do not use this list to determine the appropriate histology or stage.*

Example:

Pathology report states: "Prostate biopsy with markedly abnormal cells typical of adenocarcinoma."
Accession the case because "typical (of)" is an ambiguous term that is reportable.

EXCEPTION: *If cytology is reported as "suspicious for neoplasm" do not interpret this as a diagnosis of cancer. Report the case only if a positive biopsy or a physician's clinical impression of cancer supports the cytology findings or if cancer directed therapy is administered.*

Note: *When phrases such as strongly suspicious or highly favors are used, disregard the modifying term and refer to the guidelines above regarding the primary term. A patient stated to have "known" cancer should be reported to the TCR.*

Note: *If the word or an equivalent term does not appear on the reportable list and is not a form of a word on the reportable list, the term is not diagnostic of cancer. Do not accession the case. If forms of the word are used such as: "Favored" rather than "Favor(s)";*

“appeared to be” rather than “appears”, the case is reportable. Do not substitute synonyms such as “supposed” for presumed or “equal” for comparable.

Note: *If one section of the medical record(s) uses a reportable term such as “apparently” and another section of the medical record(s) uses a term that is not on the reportable list, accept the reportable term and accession the case.*

Exception: *If the ambiguous diagnosis is proven to be not reportable by biopsy, cytology, or physician’s statement, do not accession the case.*

ADDITIONAL GUIDELINES FOR CASE REPORTING

- In some instances it is unclear whether cancer cases seen in a clinic are reportable through an associated facility. The cases **should be included** in the facility’s caseload **when**:
 - a. The clinic is owned by the facility
 - b. The facility is legally responsible for the medical charts in the clinic
 - c. The facility receives revenue from the medical charts at the clinic
 - d. The clinical charts are filed in the same location as the facility charts, or
 - e. The facility pays the physicians to work in the clinic
- Cases diagnosed and/or treated for cancer prior to admission **should be reported** if there is evidence of **active disease**, whether or not diagnostic or therapeutic procedures were performed. *Stable disease indicates active disease.*
- Cases diagnosed at autopsy are reportable.
- Patients with active cancer coming into a facility for “consultation only” should be reported.
- Abstract cases with a reportable diagnosis using the medical record from the first admission (inpatient or outpatient) to your facility. Use information from subsequent admissions to supplement documentation and to include all first course treatment information. *Do not submit a report for each admission; submit one report per primary tumor.*
- Cases in which the disease is **no longer active** should only be reported if the patient is still receiving cancer-directed therapy, i.e., leukemia in remission receiving chemotherapy.

Example:

A patient diagnosed 6 months ago with acute myelocytic leukemia is now in remission and on a maintenance dose of chemotherapy. The patient was admitted for evaluation of neutropenia following the most recent course of chemotherapy. If this is the first admission to your facility, this patient should be reported because cancer-directed treatment (chemotherapy) is being administered.

Note: *Remember, physicians may refer to patients diagnosed with cancer prior to coming to a facility as having a “history of” cancer. These cases should be reviewed closely to*

determine if the patient has active disease and/or is receiving cancer-directed treatment. If you have any questions regarding the eligibility of a case, call your TCR health service region.

Examples for Determining Case Reportability:

- a. A patient comes to Facility A for a bone scan. The face sheet has been coded to prostate cancer. The bone scan is negative and there is no other information to indicate that this patient has active disease or is receiving cancer directed treatment. ***This case is not reportable for Facility A because there is no information to indicate if this patient has active disease.***
- b. A patient comes to the emergency room. He tells the attending physician that he had cancer years ago. There is no other information documented to indicate that he has active disease or is on cancer-directed therapy. ***This case is not reportable because there is no information confirming the patient has active disease.***
- c. A patient comes into the emergency room for a broken wrist. The history/physical states that the patient is currently undergoing chemotherapy for lung cancer, but the facility does not render any treatment for the cancer diagnosis; the patient is only being treated for the broken wrist. ***This case is reportable because the patient is currently undergoing cancer directed treatment at another facility.***
- d. A patient is admitted to Facility A with a breast lump. The history/physical states that the patient was diagnosed elsewhere with breast cancer five years ago and treated with a lumpectomy. There is now recurrence of the disease and the patient was referred to Facility A for a mastectomy. ***This case is reportable by Facility A due to active disease.***
- e. A patient comes to your facility for lab work. The face sheet states “cancer.” The only other information available is the lab results. ***This case would not be reportable. A physician must state the patient has active disease, recurrence, or metastatic disease to make this case reportable.***

Note: Every effort should be made to identify multiple primary tumors. Refer to Appendix O. See Appendix E for Hematologic Malignancies. Refer to the TCR Cancer Reporting Handbook, Revised 2007 for cases diagnosed prior to 2007.

To prevent reporting the same patient with the same primary twice, compare the patient name and primary cancer site from the registry database (accession list or SCL facility data report) to the TCR facility data report. The TCR facility data report lists all the patients a facility has reported to TCR for multiple years.

Complete cancer reporting is an important element in a cancer registry quality assurance program. The TCR performs casefinding audits on a regular basis to determine the completeness of case ascertainment and timeliness of reporting at facilities across the state. These audits are a part of TCR’s data quality procedures and are necessary both to assure complete and accurate cancer

information and to meet the state's federal funding obligations. The results of a casefinding audit are reported back to the facility. **The percentage of missed reportable cases identified from a casefinding audit should not exceed 5%.**

HELPFUL HINTS TO CONDUCT CASEFINDING:

- All possible sources of cancer cases in a facility should be reviewed to achieve complete and accurate casefinding.
- Review pathology reports monthly.
- Review disease index monthly.
- Review radiation oncology logs weekly.
- Have coders route medical charts to the registrar/reporter on all identified cancer patients.
- Review outpatient and emergency room visits for reportability. Arrangements can be made to have these routed to the registrar/reporter, or the registrar/reporter can physically review them in the department.
- Maintain a list of non-reportable cases or document non-reportable cases on the disease index.
- When reporting by the facility is complete for a given year, check the *Yes* column on the “*All Forms Submitted For the Year*” section on the transmittal form.

When reporting is complete for the year, send the following items to your TCR state health region:

- The disease index (see Attachment A, page 32) along with documentation of the parameters used to generate the index
- The casefinding checklist (see Attachment C, page 34)
- If SCL is not being used, send the non-reportable list (see Attachment B, page 33).

Note: Confidential data must be submitted via CD, data must be encrypted, zipped, password protected and **mailed via a courier service that can be tracked**. The password must never be sent with the diskette/CD. Please call your state health region to provide the password.

Contact your state health region for an assessment of your casefinding procedures. This will better prepare you for an audit.

Attachment A

Sample Facility Disease Index

Cancer Cases with 2008 Admit Date

Run Date: 10/07/2008		Case Mix/Abstracting							
Run Time: 0855									
MR #	Name	Unit #	DOB	SS#	Sex	PT Class/Type	Admit Date	Discharge Date	Diagnosis/Description
V01644608	Rogers, Clyde	V323436	3/5/1938	455-66-9090	M	IN, MCR	05/02/08	05/03/08	162.9 Mal Neo Bronch/Lung NOS
V00853788	Small, Adam	V174297	9/19/1956	422-23-2323	M	IN, MCR	04/05/08	04/07/08	V58.1 Chemo Encounter
V00923847	Small, Adam	V174297	9/19/1956	422-23-2323	M	SCD, MCR	05/11/08	05/11/08	189.0 Mal Neo Kidney
V01782648	Small, Adam	V174297	9/19/1956	422-23-2323	M	IN, MCR	09/06/08	09/14/08	198.3 Sec Mal Neo Brain
V02548046	Small, Tim	V416004	2/13/1942	566-66-6666	M	IN,OTH	10/16/08	10/20/08	185 Mal Neo Prostate
V00817429	Thorn, Alice	V197988	6/15/1959	500-00-5000	F	CLL,MCR	03/22/08	03/22/08	217 Benign Neo Breast
V00952770	Thorn, Alice	V197988	6/15/1959	500-00-5000	F	IN,MCR	05/29/08	06/02/08	174.4 Mal Neo Breast UOQ
V00978817	Thorn, Alice	V197988	6/15/1959	500-00-5000	F	IN,MCR	05/29/08	06/02/08	196.3 Mal Neo Lymph-Axlla
V0879666	Thorn, Alice	V197988	6/15/1959	500-00-5000	F	RCR,MCR	07/13/08	07/13/08	V58.0 Radiotherapy Encounter

ATTACHMENT B**Non-Reportable List**

Facility Name: _____ Facility ID# _____ Reviewed by: _____ Telephone: _____

Patient Name	Med Rec #	Admit Date	Date of Birth	SS#	Casefinding Source	N/R Code

*****KEEP A COPY FOR YOUR RECORDS****NON-REPORTABLE (N/R) CODES:****01 – Benign****02 – Non-Reportable Skin Cancer** (Site=C44.*, Morph=8000-8110)**03 – No Evidence of Disease (NED)** (History of Cancer but No Evidence of Treatment Currently and No Evidence of Cancer Currently)**04 – Cancer Not Proven****05 – Duplicate Case** (This Cancer has already been reported to TCR)**06 – In situ Cancer of Cervix, CINIII****07 – No Cancer Mentioned in Record****08 – Diagnosed prior to 1995****09 – Lab only****10 – Other** (Include Explanation)

ATTACHMENT C

A casefinding checklist must be used to document all sources utilized to achieve complete casefinding. Upon completion of abstracting for each year, the casefinding checklist must be completed and mailed to your regional TCR office. *****Keep a copy for your records.**

Facility Name :	Facility ID#:	Expected # Cases:	Year:
Casefinding Source	Available Y/N or NA	Reviewed Y/N or NA	Comments
Accession Register			
Ambulatory Setting			
Day Surgery			
Diagnostic Radiology & Oncology			
Emergency Room			
Free-standing facility			
Hematology Clinic			
Hospice			
Medical Records Disease Index			
Nuclear Medicine			
Outpatient Department			
Pathology Department			
Autopsy Reports			
Bone Marrow Biopsies			
Cytology			
Hematology			
Histology			
Physician's Office			
Radiation Oncology Dept.			
Daily Appointment Book			
Treatment Card			
Treatment Summary			

Reviewed by: _____ Date _____

Mailed to Texas Cancer Registry on: _____ Telephone _____