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 used to identify all eligible cases to be reported to the TCR. Casefinding sources include disease indices, pathology and laboratory reports, patient logs, and similar resources specific to each facility. Refer to the Casefinding sources list on page 19 for a more detailed list. 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. The requirements for reporting depend on the governing agencies of the registry. For example, hospitals participating in the Approvals Program of the Commissions on Cancer (CoC) of the American College of Surgeons follow the guidelines set forth by CoC; however, they must also adhere to the TCR reporting criteria. **Remember that cases diagnosed prior to 1995 are no longer required to be reported.**

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).

2. All primary tumors with a **behavior code** of /0 (benign), /1 (borderline), or /3 (malignant) occurring in any of the following sites:

a. Meninges (C700-C709), brain (C710-C719), spinal cord (C720), 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), craniopharyngeal duct (C752), or pineal gland (C753)

Note: All diagnoses of the brain and CNS must have a morphology term and code listed in ICD-O-3 to be reportable. If there is no morphology term or code listed in the ICD-O-3 it is not reportable.

Remember: According to MP/H rules (Appendix O page 108), the terms tumor, mass, lesion and neoplasm are interchangeable for benign and malignant brain and CNS sites. Therefore, a diagnosis with these terms and no other information would be reportable for brain and CNS and the histology would be coded 8000/0 for benign tumor or 8000/1 for Neoplasm, NOS.

Note: Benign and borderline CNS cases diagnosed **prior to 2004** are no longer required to be submitted to the TCR.

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 states the patient has a reportable diagnosis). A clinical diagnosis may be recorded in the final diagnosis, in a clinic note, on an x-ray report, 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 or fine-needle aspiration that disproves the clinical diagnosis the case is not reportable.

Exception: If the physician treats a patient for cancer in spite of a 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.

Example: In February 2012 a patient has a CT that shows possible lung cancer. The physician states this is probably lung cancer. A fine-needle aspiration is non-diagnostic and the physician advises the patient to have further tests. The patient refuses any further work-up or treatment. In September 2012 the physician sees the patient again and states that this is probable lung cancer based on previous x-rays, continued symptoms, and further decline in health.

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. This method is more comprehensive and precise.

2. Passive casefinding: The personnel responsible for reporting rely on others to notify the reporter of possible eligible cases. There is a greater potential for missed cases using this method.

A combination of active and passive casefinding is a more effective method and ensures fewer missed cases. It is strongly recommended that every facility have a Casefinding Policy and Procedure in place. The procedures should be evaluated from time to time and amended as facility procedures or services change.

Casefinding Sources

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

Disease indices should be obtained after medical records are completed and coded (monthly or quarterly). The indices must include both **inpatient and outpatient** admissions **and must** be based

on **year of admit.** It must be sorted **alphabetically** by last name and 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 41) is an example of a disease index that can be modified for individual facilities. See page 22 for further instructions on disease index procedures.

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

- Review the disease index for reportable cancer codes to ensure the facility has reported all of its reportable cases to the TCR.
- Request a TCR Facility Data Report from your regional office when needed during the reporting year. A Facility Data Report is a complete listing of cases submitted by a 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. **Ensure 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 ensure that all cases were either reported or clearly documented as non-reportable with the reason it is not reportable.

At the end of each reporting year, TCR requires that each facility send the disease index, non-reportable list, and the casefinding check-list (Attachment C, page 43) to the facility's health service region. Refer to page 11 for a list of all regional offices.

Reportable Neoplasms

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

- Malignant neoplasms *(exclusions noted on page 21)*
- Benign and borderline neoplasms of central nervous system (CNS) diagnosed 2004 and forward
- Pituitary adenomas diagnosed as of 2004
- *Carcinoma in-situ (*exclusions noted on page 21)*
- Carcinoid, NOS ***(excluding appendix,C181, unless stated to be malignant)***
  Note: Extension into surrounding tissue does not make a carcinoid of the appendix reportable. Benign tumors can and do extend into surrounding tissue.
- 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:** According to AJCC high grade/severe dysplasia may be synonymous with insitu carcinoma within the gastrointestinal tract. However, they give no further instruction. Each facility should consult their cancer committee, physician advisor, and pathologists to determine how the phrase is used within the facility. This will determine whether or not a case diagnosed as high grade or severe dysplasia should be reported.

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: clitoris (C512), vulva (C519), vagina (C529), 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 (Exclusions)

- 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 CNS cases diagnosed **prior to 2004** are no longer required
- 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 04/12/2012, 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 (DI) with the required reportable neoplasms and ICD-9-CM codes.

Two separate DI's must be requested:
1. A DI with reportable ICD-9-CM codes - 100% review required. This DI will include the Inpatient and Outpatient admissions based on ICD-9-CM diagnosis codes. This list also includes some V-Codes.

2. A DI with supplementary ICD-9-CM codes - 5% review: The purpose of this review is to guarantee complete case ascertainment and improve casefinding outcomes. This can assist in determining codes requiring additional review for the facility. The 5% review of this list will be based on number of patients and not number of diagnosis codes. If a patient on this DI also appears on the DI with a reportable code, they may be crossed off this list to avoid duplicate reviews. After removing duplicate patients, review 5% of the total number of remaining patients. If cases for a particular code were identified as reportable, this information should be documented, and the following year this code should be reviewed 100%. If no reportable cases are identified after reviewing the supplementary list for a year then it may be acceptable to omit this process for the next 2 to 3 years. However, in the event that circumstances change (for example, new coders are hired or new codes are added to the list), then the supplementary list should be reviewed sooner to ensure complete casefinding. Some facilities may find that it works best to review the supplementary codes every 3 or every 6 months.

All admissions (inpatient and outpatient) with the following reportable diagnosis codes must be reviewed for reportability.

Note: Some of the codes contain conditions that are not reportable. The records need to be reviewed and evaluated separately to determine whether they are reportable to TCR.

Note: Some ranges of codes are expressed with only 1 decimal place (237.0-237.9) while some codes within that range may have two decimal places (237.71 and 237.72). All codes within the range are included and must be reviewed.

Reportable ICD-9-CM Codes

ICD-9-CM CODE (100% Review Required)	**DIAGNOSIS**
140.0 - 208.92	Malignant neoplasms
209.0-209.29	Malignant carcinoid tumors
209.30-209.36	Malignant poorly differentiated neuroendocrine carcinoma; Merkel cell carcinoma
209.70-209.79	Secondary neuroendocrine tumors
225.0 - 225.9	Benign neoplasms of brain and spinal cord

ICD-9-CM CODE (100% Review Required)	DIAGNOSIS
227.3	Benign neoplasms of pituitary gland and craniopharyngeal duct (pouch) Reportable inclusion terms: Benign neoplasm of craniobuccal pouch, hypophysis, Rathke's pouch or sella turcica
227.4	Benign neoplasm of pineal gland
228.02	Hemangioma; of intracranial structures Reportable inclusion terms: Angioma NOS, Cavernous nevus, Glomus tumor, Hemangioma (benign)
228.1	Lymphangioma, any site This code includes Lymphangiomas of Brain, Other parts of nervous system and endocrine glands, which are reportable
230.0 - 234.9	Carcinoma in-situ (exclude 233.1, cervix)
236.0	Endometrial stroma, low grade (8931/1) Reportable inclusion terms: Stromal endometriosis (8931/3 per ICD-O-3) Stromal myosis (endolymphatic) (8931/3 per ICD-O-3) Stromatosis, endometrial (8931/3 per ICD-O-3)
237.0 - 237.1	Neoplasm of uncertain behavior (borderline) of pituitary gland, craniopharyngeal duct and pineal gland.
237.5 - 237.6	Neoplasm of uncertain behavior (borderline) of brain, spinal cord and meninges
237.72	Neurofibromatosis, type 2 (acoustic neurofibromatosis) Note: Acoustic neuromas growing along the acoustic nerve. See supplementary list for Neurofibromatosis, unspecified (237.70) and Neurofibromatosis, type 1 (237.71)
237.9	Neoplasm of other and unspecified parts of nervous system (cranial nerves)
238.4	Polycythemia vera (9950/3)
238.6	Neoplasms of uncertain behavior of other and unspecified sites and tissues, Plasma cells (Plasmacytoma, extramedullary, 9734/3) Reportable inclusion terms: Plasmacytoma NOS (9731/3) Solitary myeloma (9731/3)
238.7	Other lymphatic and hematopoietic tissues Note: This code was expanded 10/2006. It is now a subcategory and is no longer valid for use for coding purposes. It should be included in extract programs for quality control purposes.

ICD-9-CM CODE (100% Review Required)	DIAGNOSIS
238.71	Essential thrombocythemia (9962/3) Reportable inclusion terms: Essential hemorrhagic thrombocythemia Essential thrombocytosis Idiopathic 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 *2012 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual.***
238.72	Low grade myelodysplastic syndrome lesions (includes 9980/3, 9982/3, 9983/3, 9985/3) Reportable inclusion terms: Refractory anemia (RA) (9980/3) Refractory anemia with excess blasts-1 (RAEB-1) (9983/3) 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 (includes 9983/3) Reportable inclusion terms: Refractory anemia with excess blasts-2 (RAEB-2)
238.74	Myelodysplastic syndrome with 5q deletion (9986/3) Reportable inclusion terms: 5q minus syndrome NOS
238.75	Myelodysplastic syndrome, unspecified (9985/3, 9987/3)
238.76	Myelofibrosis with myeloid metaplasia (9961/3) Reportable inclusion terms: Agnogenic myeloid metaplasia Idiopathic myelofibrosis (chronic) Myelosclerosis with myeloid metaplasia Primary myelofibrosis Excludes: myelofibrosis NOS myelophthisis anemia (not reportable) myelophthisis(not reportable)
238.77	Post transplant lymphoproliferative disorder (9987/3)

ICD-9-CM CODE (100% Review Required)	DIAGNOSIS
238.79	Other lymphatic and hematopoietic tissues (includes 9960/3, 9961/3, 9970/1, 9931/3) Reportable inclusion terms Lymphoproliferative disease (chronic) NOS (9970/1) Megakaryocytic myelosclerosis (9961/3) Myeloproliferative disease (chronic) NOS (9960/3) Panmyelosis (acute) (9931/3)
239.6	Neoplasms of unspecified nature, brain
239.7	Neoplasms of unspecified nature; endocrine glands, and other parts of nervous system
273.2	Other paraproteinemias Reportable inclusion terms: Franklin's disease (heavy chain) (9762/3) Heavy chain disease (9762/3) Mu heavy chain disease (9762/3)
273.3	Macroglobulinemia Reportable inclusion terms: Waldenstrom's macroglobulinemia (9761/3) Waldenstrom's (macroglobulinemia) syndrome
277.89	Other specified disorders of metabolism Hand-Schuller-Christian disease Histiocytosis (acute) (chronic) Histiocytosis (chronic)
288.4	Hemophagocytic Syndromes (9751/3, 9754/3) Reportable inclusion term: Histiocytic syndromes
V10.0-V10.89	Personal history of malignancy Note: Screen for recurrences, subsequent primaries, and/or subsequent treatment
V10.90	Personal history of unspecified malignant neoplasm Screen for recurrences, subsequent primaries, and/or subsequent treatment.
V10.91	Personal history of malignant neuroendocrine tumor, carcinoid tumor, Merkel cell carcinoma Screen for recurrences, subsequent primaries, and/or subsequent treatment.
V12.41	Personal history of benign neoplasm of the brain

Supplementary ICD-9-CM Codes

Many new codes and conditions have been added to the Supplementary ICD-9-CM Code List in order to improve casefinding outcomes for benign brain and CNS tumors, hematopoietic and lymphoid neoplasms, and other reportable diseases. Some codes represent neoplasm-related secondary conditions for which there should also be a primary diagnosis of a reportable neoplasm. There should be a 5% review of cases with the following codes. See Instruction 2 on page 22.

Supplementary ICD-9-CM Code List

ICD-9-CM CODES (5% Review Required)	**EXPLANATION OF CODES**
042	Acquired Immunodeficiency Syndrome (AIDS) Note: This is not a malignancy. Medical coders are instructed to add codes for AIDS-associated malignancies. Screen 042 for history of cancers that might not be coded.
079.4	Human papillomavirus (HPV)
079.50-079.59	Retrovirus (HTLV, types I, II and 2)
209.40 - 209.69	Benign carcinoid tumors
210.0-229.9	Benign neoplasms (except for 225.0-225.9, 227.3, 227.4, 228.02, and 228.1, which are listed in the Reportable list) Note: Screen for incorrectly coded malignancies or reportable by agreement tumors.
235.0-236.7 236.90-236.99	Neoplasms of uncertain behavior (except for 236.0, which is listed in the Reportable list) Note: Screen for incorrectly coded malignancies or reportable by agreement tumors.
237.2-237.4	Neoplasm of uncertain behavior of adrenal gland, paraganglia and other and unspecified endocrine glands Note: Screen for incorrectly coded malignancies or reportable by agreement tumors.
237.70-237.71	Neurofibromatosis, unspecified and Type 1 Note: An inherited condition with developmental changes in the nervous system, muscles, bones and skin; multiple soft tumors (neurofibromas) distributed over the whole body. (See Reportable list for Neurofibromatosis, type 2, 237.72)
237.73	Schwannomatosis Note: Screen for incorrectly coded malignancies or reportable by agreement tumors.
237.79	Other neurofibromatosis Note: Screen for incorrectly coded malignancies or reportable by agreement tumors.
238.0-239.9	Neoplasms of uncertain behavior (except for 238.4, 238.6, 238.71-238.79, 239.6, 239.7, which are listed in the Reportable list.) Note: Screen for incorrectly coded malignancies or reportable by

ICD-9-CM CODES (5% Review Required)	EXPLANATION OF CODES
	agreement tumors.
249.20	Secondary diabetes with hypersmolarity
253.6*	Syndrome of inappropriate secretion of antidiuretic hormone
259.2*	Carcinoid Syndrome
259.8*	Other specified endocrine disorders
273.0	Polyclonal hypergammaglobulinemia (Waldenstrom) Note: Review for miscodes
273.1	Monoclonal gammopathy of undetermined significance (9765/1) Note: Screen for incorrectly coded Waldenstrom's macroglobulinemia or progression.
273.8	Other disorders of plasma protein metabolism
273.9	Unspecified disorder of plasma protein metabolism Note: Screen for incorrectly coded Waldenstrom's macroglobulinemia
275.42*	Hypercalcemia
277.88	Tumor lysis syndrome/Tumor lysis syndrome following antineoplastic drug therapy
279.02-279.06	Selective IgM immunodeficiency Note: Associated with lymphoproliferative disorders
279.2-279.9	Combined immunity deficiency-Unspecified disorder of immune mechanism
284.1	Pancytopenia
284.81	Red cell aplasia (acquired, adult, with thymoma)
284.89	Other specified aplastic anemias due to drugs (chemotherapy or immunotherapy), infection, radiation
284.9	Aplastic anemia, unspecified Note: Review for miscodes
285.0	Sideroblastic anemia
285.3	Antineoplastic chemotherapy induced anemia (Anemia due to antineoplastic chemotherapy)
287.39, 287.49, 287.5	Other primary, secondary and unspecified thrombocytopenia
288.03	Drug induced neutropenia
288.3	Eosinophilia **Note:** This is the code for eosinophilia (9964/3). Not every case of eosinophilia is associated with a malignancy. Diagnosis must be "Hypereosinophilic syndrome" to be reportable.
289.6	Familial polycythemia **Note:** This is a symptom of polycythemia vera.
289.89	Other specified diseases of blood and blood-forming organs Note: Review for miscodes
289.9	Unspecified diseases of blood and blood forming organs
323.81	Encephalomyelitis: specified cause NEC

ICD-9-CM CODES (5% Review Required)	EXPLANATION OF CODES
337.9	Unspecified disorder of autonomic nervous system
338.3	Neoplasm related pain (acute) (chronic)
352.9	Unspecified disorder of cranial nerves
353.8	Other nerve root and plexus disorders
379.5_	Nystagmus and other irregular eye movements
512.82	Secondary spontaneous pneumothorax
516.5	Adult pulmonary Langerhans cell histiocytosis (Effective 10/1/2011)
528.01	Mucositis due to antineoplastic therapy
630	Hydatidiform Mole (9100/0) Note: This is a benign tumor that can become malignant. If malignant, it should be reported as Choriocarcinoma (9100/3) and will have a malignancy code in the 140-209 range.
648.9_	Other current conditions classifiable elsewhere
686.01*	Pyoderma gangrenosum
694.4*	Pemphigus
695.89*	Other specified erythematous conditions
701.2*	Acquired Acanthosis nigricans
710.3*	Dermatomyositis
710.4*	Polymyositis
713.8	Arthropathy associated with other conditions classified elsewhere
728.9	Unspecified disorder of muscle, ligament, and fascia
731.1	Osteitis deformans in diseases classified elsewhere
731.3	Major osseous defect
733.10-733.16	Pathologic fracture Note: pathologic fractures can be due to bone structure weakening by pathological processes (e.g. osteoporosis, neoplasms and osteomalacia)
758.0	Down's Syndrome Note: Screen for myeloid leukemia associated with Down's Syndrome (9898/3)
780.79	Neoplastic (malignant) related fatigue
785.6	Enlargement of lymph nodes Note: Screen for large B-cell lymphoma arising in HHV8-associated multicentric Castleman disease (9738/3)
789.51	Malignant ascites **Note:** Code first malignancy
790.93	Elevated prostate specific antigen (PSA)
791.9	Other non-specific findings on examination of urine
792.0, 792.2, 792.4, 792.9	Non specified abnormal findings in specified and unspecified body structures
793.11	Solitary pulmonary nodule (Effective 10/1/2011)
793.8_	Non-specific (abnormal) findings on radiological and examination of

ICD-9-CM CODES (5% Review Required)	EXPLANATION OF CODES
	body structure (breast)
795.0	Papanicolaou smear of cervix with cytologic evidence of malignancy
795.1	Papanicolaou smear of anus with cytologic evidence of malignancy
795.4	Other nonspecific abnormal histological findings
795.8_	Abnormal tumor markers: Elevated tumor associated antigens (TAA); Elevated tumor specific antigens (TSA); Excludes: elevated prostate specific antigen (PSA) (790.93)
962.1, 963.1	Poisoning by hormones, antineoplastic, immunosuppressive drugs
990	Effects of radiation, unspecified
996.54	Mechanical complication of other specified prosthetic device, implant, and graft-due to breast prosthesis
796.7	Papanicolaou smear of anus with cytologic evidence of malignancy
996.85	Complication of transplanted organ
999.3_	Other infection due to central venous catheter, transfusion, infusion (Effective 10/1/2011
E858.0-E858.2	Accidental poisonings
E873.2	Failure in dosage, overdose of radiation in therapy
E878.0	Abnormal reaction of surgical operation with transplant of whole organ
E879.2	Adverse effect of radiation therapy
E930.7	Adverse effect of antineoplastic therapy
E932.1	Adverse reaction to antineoplastic therapy
E933.1	Adverse effect of immunosuppressive drugs
V07.5_	Prophylactic use of agents affecting estrogen receptors and estrogen levels
V13.89	Personal history of unspecified malignant neoplasm and history of in-situ neoplasm of other site
V15.22	Personal history of undergoing in utero procedure during pregnancy
V15.3	Irradiation: previous exposure to therapeutic or ionizing radiation
V16._	Family history of malignant neoplasm
V42.81	Organ or tissue replaced by transplant, Bone marrow transplant
V42.82	Transplant; Peripheral stem cells
V51.0	Encounter for breast reconstruction following mastectomy
V52.4	Breast prosthesis and implant
V54.2	Aftercare for healing pathologic fracture
V58.0	Encounter for radiation therapy
V58.1_	Encounter for antineoplastic chemotherapy and immunotherapy Note: This code was discontinued as of 10/2006 but should be included in extract programs for quality control purposes.

ICD-9-CM CODES (5% Review Required)	EXPLANATION OF CODES
V58.11	Encounter for antineoplastic chemotherapy
V58.12	Encounter for antineoplastic immunotherapy
V58.42	Aftercare following surgery for neoplasm
V66.1	Convalescence following radiotherapy
V66.2	Convalescence following chemotherapy
V66.7	Encounter for palliative care
V67.1	Radiation therapy follow up
V67.2	Chemotherapy follow up
V71.1	Observation for suspected malignant neoplasm
V72.83	Other specified pre-operative examination
V76.0-V76.9	Special screening for malignant neoplasm
V78.0-V78.9	Special screening for disorders of blood and blood-forming organs
V86._	Estrogen receptor positive status
V87.41, V87.43, V87.46	Personal history of antineoplastic chemotherapy, estrogen therapy and immunosuppression therapy

*Note: These diseases are part of the paraneoplastic syndrome. Paraneoplastic syndrome is not cancer. It is a disease or symptom that is the consequence of cancer but is not due to the local presence of cancer cells. A paraneoplastic syndrome may be the first sign of cancer.

The codes in the following supplementary list are not reportable as such but they should alert registrars to look for the first malignant neoplasm associated with these codes.

ICD-9-CM Code	Explanation of Code
258.0	Multiple endocrine neoplasia (MEN) type IIA and IIB (rare familial cancer syndrome) Note: use additional codes to identify any malignancies and other conditions associated with the syndrome
284.2	Myelophthisis
285.22	Anemia in neoplastic disease Note: Assign also a code for the neoplasm causing the anemia Excludes: anemia due to antineoplastic chemotherapy, new code 285.3
289.83	Myelofibrosis (NOS) (9961/3) Note: Not every case of myelofibrosis is associated with a malignancy. Review terms included in ICD-O-3 to determine if case is reportable. See the current ICD-9-CM.
331.7	Cerebral degeneration in diseases classified elsewhere
336.3	Myelopathy in other diseases classified elsewhere
338.3	Neoplasm related pain (acute, chronic); Cancer associated pain; Pain due to malignancy (primary/secondary); Tumor associated pain

ICD-9-CM Code	Explanation of Code
357.3	Polyneuropathy in malignant disease
358.1	Myasthenic syndromes in other diseases classified elsewhere
358.31	Eaton-Lambert syndrome in neoplastic disease (Effective 10/1/2011)
511.81	Malignant pleural effusion Note: Code first malignant neoplasm if known. If the primary site is not known, code 199.0, disseminated carcinomatosis, or code 199.1, malignancy NOS, should be assigned.
789.51	Malignant ascites Note: Code first malignant neoplasm if known. If the primary site is not known, code 199.0, disseminated carcinomatosis, or code 199.1, malignancy NOS, should be assigned

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

ICD-O-3 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)

The following table shows newly reportable terms with new ICD-O codes that are documented in the 2008 *WHO Classification of Tumors of Hematopoietic and Lymphoid Tissues.*

2008 WHO Classification of Tumors of Hematopoietic and Lymphoid Tissues
Additional Histology Terms and Codes - Numerical Order

This table contains a numeric list of hematopoietic and lymphoid neoplasm histology codes and terms documented in the *WHO Classification of Tumours of Haematopoietic and Lymphoid Tissues,* 4th Ed. published in 2008. These codes are not listed in ICD-O-3, but can be found in the *2012 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual* at http://seer.cancer.gov/tools/heme/index.html. Column 1 is the more specific histology term; column 2 is the new code WHO proposed for that specific histology. These neoplasms are not newly reportable; they are more specific terms for diseases that would otherwise be coded in NOS categories. Do not use these codes for neoplasms diagnosed prior to 2010. The new codes went into effect with cases diagnosed 1/1/2010 and after.

Term	**ICD-O Code**
Primary cutaneous follicle centre lymphoma	9597/3

Term	ICD-O Code
T-cell/histiocyte rich large B-cell lymphoma	9688/3
Intravascular large B-cell lymphoma	9712/3
Systemic EBV positive T-cell lymphoproliferative disease of childhood	9724/3
Hydroa vaccinforme-like lymphoma	9725/3
Primary cutaneous gamma-delta T-cell lymphoma	9726/3
Plasmablastic lymphoma	9735/3
ALK positive large B-cell lymphoma	9737/3
Large B-cell lymphoma arising in HHV8-associated multicentric Castleman disease	9738/3
Fibroblastic reticular cell tumor	9759/3
Mixed phenotype acute leukemia with t(9;22)(q34;11.2); BCR-ABL1	9806/3
Mixed phenotype acute leukemia with t(v;11q23); MLL rearranged	9807/3
Mixed phenotype acute leukemia, B/myeloid, NOS	9808/3
Mixed phenotype acute leukemia, T/myeloid, NOS	9809/3
B lymphoblastic leukemia/lymphoma, NOS	9811/3
B lymphoblastic leukemia/lymphoma with t(9;22)(q34;q11.2); BCR-ABL1	9812/3
B lymphoblastic leukemia/lymphoma with t(v;11q23); MLL rearranged	9813/3
B lymphoblastic leukemia/lymphoma with t(12;21)(p13;q22); TEL-AML1 (ETV6-RUNX1)	9814/3
B lymphoblastic leukemia/lymphoma with hyperdiploidy	9815/3
B lymphoblastic leukemia/lymphoma with hypodiploidy (hypodiploid ALL)	9816/3
B lymphoblastic leukemia/lymphoma with t(5;14)(q31:q32); IL3-IGH	9817/3
B lymphoblastic leukemia/lymphoma with t(1;19)(q23;p13.3); E2A PPBX1 (TCF3 PBX1)	9818/3
T lymphoblastic leukemia/lymphoma	9837/3
Acute myeloid leukemia with t(6;9)(p23;q34) DEK-NUP214	9865/3
Acute myeloid leukemia with inv(3)(q21q26.2) or t(3;3)(q21;q26.2); RPN1EVI1	9869/3
Myeloid leukemia associated with Down Syndrome	9898/3
Acute myeloid leukemia (megakaryoblastic with t(1;22)(p13;q13); RBM15-MKL1	9911/3
Myeloid and lymphoid neoplasms with PDGFRB rearrangement	9965/3
Myeloid and lymphoid neoplasms with PDGFRB arrangement	9966/3
Myeloid and lymphoid neoplasm with FGFR1 abnormalities	9967/3
Polymorphic PTLD	9971/3
Refractory neutropenia	9991/3

Term	ICD-O Code
Refractory thrombocytopenia	9992/3

Histologic Terms and Codes with Changes in Case Reportability (Newly Reportable Conditions)

The following table shows existing ICD-O codes which changed from non-reportable (/1) to reportable (/3) for cases diagnosed January 1, 2010 and forward. Prior to 2010 these neoplasms were reported only if the physician stated they were malignant.

Name	ICD-O-3 Code
Chronic lymphoproliferative disorder of NK-cells T-cell large granular lymphocytic leukemia	9831/3
Langerhans cell histiocytosis, NOS (previously 9751/1) Langerhans cell histiocytosis, unifocal (previously 9752/1) Langerhans cell histiocytosis, multifocal (previously 9753/1)	9751/3
Myelodysplastic/Myeloproliferative neoplasm, unclassifiable Myeloproliferative neoplasm, unclassifiable	9975/3

OTHER CASEFINDING METHODS

Other methods for identifying reportable cancer cases should 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.

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.

Note: If a hospital sends a specimen to another hospital to be read, and the patient is never seen at the reading facility, only the hospital that performed diagnostic procedures or administered treatment for a cancer diagnosis is responsible for reporting the case. The reading facility should document this process in their policy and procedure for consistency.

Exception: To ensure complete reporting, if the specimen is sent from a **physician's office** to a reading facility, the reading facility would be responsible for reporting the case.

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 17. 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**.

The TCR will 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 14). 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 42) 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.

Note: There is not a non-reportable log in the Web Plus system. Reporters using Web Plus may create and use a form such as the sample Attachment B, or make a not reportable notation for each case on the disease index. The non-reportable list must be submitted to TCR after reporting is complete for the year.

The following examples are a resource to determine if a case is reportable to the TCR. It is critical that these scenarios be applied appropriately. If a patient has active disease and/or is on cancer directed therapy, the case must be reported.

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 since there is no indication that the patient has current 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 no 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 2012, the patient was admitted and diagnosed with small cell carcinoma of the lung. **The lung cancer is reportable for 2012 because the patient has active lung cancer.**

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 2012 a patient comes 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.**

Note: When Tamoxifen is used as adjuvant therapy for breast cancer it is generally prescribed for 5 years. It has been shown that when taken for 5 years it reduces the chance of the original breast cancer coming back in the same breast or metastasizing. Therefore, if the patient has a history of breast cancer and is on Tamoxifen a*nd*

- it is known that the diagnosis was within the past 5 years, **report the case.**
- it is unknown how long ago the breast cancer was diagnosed, **report the case.**
- it is known that the diagnosis of breast cancer was greater than 5 years ago and there is no evidence of disease, and no evidence of other treatment being given at the time of admit, **it is not necessary to report the case.**

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 that could be related to the history of prostate cancer.**

n. A patient comes in for a bone scan. The physician orders state prostate cancer, but the bone scan report states no evidence of disease. There is no other information in the chart. **Do not report this case since there is no evidence of disease and no mention of current treatment.**

Summary: If there is any indication within the medical record that the patient has evidence of disease, or is on cancer directed treatment, the case is reportable. This would include but not limited to radiology reports, pathology reports, consults, history and physicals, and clinic notes.

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 **only**)
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: Do not substitute synonyms such as "supposed" for presumed or "equal" for comparable. Do not substitute "likely" for "most likely."

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 malignancy" 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.** Cytology is the examination of cells obtained by aspiration, washing, smear, or scraping.

Examples:
a. A patient with persistent hematuria has a urinalysis done in your facility and the cytology report states cells suspicious for malignancy. The patient does not return for any further work-up. Do not report this case based on the suspicious cytology alone.

b. A fine needle aspirate of a thyroid nodule is suspicious for follicular carcinoma. The patient has a thyroid biopsy which shows papillary follicular carcinoma. This case should be reported because the biopsy was positive for malignancy.

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. For instance, a patient with a history of leukemia in remission, but is still 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 a facility 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 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; the patient is only 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 a facility with a breast lump. The H&P states that the patient was diagnosed elsewhere with breast cancer seven years ago and treated with a lumpectomy. There is now recurrence of the disease and the patient was referred for a mastectomy. ***Report due to active disease***.

e. A patient comes to your facility for lab work only. 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.***

Note: Every effort should be made to identify multiple primary tumors. Refer to Appendix O and to the *2012 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual*
To prevent reporting the same primary twice for a patient, compare the patient name and primary cancer site from the registry database 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 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 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 minimum acceptable completeness rate is 97%.**

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

- The disease index (see Attachment A, page 41) along with documentation of the parameters used to generate the index
- The casefinding checklist (see Attachment C, page 43)
- The non-reportable list (see Attachment B, page 42).

Note: The Reporting Tools section is no longer located in the TCR Handbook. The instructions are located on the TCR website at http://www.dshs.state.tx.us/tcr/reporting.shtm.

Contact your health service 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 2012 Admit Date

MR#	Name	DOB	SS#	Sex	PT Class/Type	Admit Date	Discharge Date	Diagnosis/ Description
123123	Roberts, Jim	2/10/1959	455-66-9090	M	IN, MCR	05/02/12	05/03/12	209.1 Mal Carcinoid Tumor Duodenum
431124	Smith, Bob	6/29/1938	422-23-2323	M	IN, MCR	04/05/12	04/07/12	V58.1 Chemo Encounter
C5412	Smith, Bob	6/29/1938	422-23-2323	M	SCD, MCR	05/11/12	05/11/12	189.0 Mal Neo Kidney
431124	Smith, Bob	6/29/1938	422-23-2323	M	IN, MCR	09/06/12	09/14/12	198.3 Sec Mal Neo Brain
MR421	Sun, Len	11/4/1980	566-66-6666	M	IN, OTH	10/16/12	10/20/12	285.22 Anemia in Neoplastic Disease
MR311	Timms, Emma	6/15/1959	500-00-5000	F	CLL,	03/22/12	03/22/12	217 Benign Neo Breast
C1234	Timms, Emma	6/15/1959	500-00-5000	F	MCR	05/29/12	06/02/12	174.4 Mal Neo Breast UOQ
C1234	Timms, Emma	6/15/1959	500-00-5000	F	IN, MCR	05/29/12	06/02/12	196.3 Mal Neo Lymph-Axilla
MR311	Timms, Emma	6/15/1959	500-00-5000	F	IN, MCR RCR, MCR	07/13/12	07/13/12	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 submitted 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			

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