

Chapter 1

DETERMINING REPORTABILITY

Casefinding Techniques, Cases that Must be Reported and How to Determine if a Case Does Not Need to be Reported

Before filling out a report on a newly diagnosed cancer, one must be able to determine if the case is reportable to the State. This chapter will provide you with the information needed to make that determination.

Casefinding Techniques

Reportable cases may come from a variety of sources. The hospital pathology laboratory can provide cases diagnosed by histology, cytology, hematology, bone marrow or autopsy. Other resources include daily discharges, ICD-9 coding logs, disease indices, inpatient and outpatient surgery logs, radiotherapy consults, treatment reports and logs, and oncology clinic treatment reports, CPT procedure codes and logs. Never rely solely on the pathology department to provide reportable cases. Doing so could exclude cases for which the facility has no diagnostic tissue reports. Cases diagnosed elsewhere but treated at your facility and those diagnosed radiographically or clinically only, without tissue confirmation, would be missed during casefinding unless additional resources are employed. It is essential to include review of the disease index (usually provided by Health Information Management/Medical Records). Other tracking tools such as medical and radiation oncology clinic logs can help to ensure that all reportable cases are identified. It would be advisable to form an alliance with staff from the aforementioned departments. This will help to establish and develop a systematic method to routinely receive necessary information from them.

Cases That Must Be Reported

Refer to the Disease Index Codes list beginning on page C1-3 when casefinding. Not all ICD-9-CM codes listed will need to be used by all facilities, depending on the type of facility, etc.

- Cases diagnosed on or after January 1, 1976 (hospitals) or on or after January 1, 1992 (clinics/physician offices).
- All active primary cancers, regardless of patient residence. Wisconsin has data exchange agreements with 19 states – they provide us with reports on Wisconsin residents and we provide them with reports on their residents. Interstate data exchange is an NPCR requirement.
- Cases with diagnosis codes specified on the ICD-9-CM reportable list that meet the reportable criteria established by WCRS.

- Invasive or *in situ* (noninvasive) malignancies (behavior code of /2 or /3 in ICD-O-3 coding manual).
- Beginning with cases diagnosed on or after January 1, 2004, non-malignant primary intracranial and central nervous system tumors are required to be reported. See Table below.

Topography Codes for Benign Brain Tumors	
Codes	Description
C70.0 – C70.9	Meninges
C71.0 – C71.9	Brain
C72.0 – C72.5, C72.8, C72.9	Spinal Cord, Cranial Nerves, Other parts of Central Nervous System
C75.1 – C75.3	Other Endocrine Glands and Related Structures

- Beginning with cases diagnosed on or after January 1, 2002, the following type of squamous neoplasia is reportable to the State (per NPCR requirement):

Squamous Intraepithelial Neoplasia, Grade III (8077/2)	ICD-O-3 Site Code
AIN III	C21.1
VIN III	C51.x
VAIN III	C52.x

- Patients diagnosed with a reportable cancer at your facility or elsewhere and/or receiving all or part of the first course of cancer-directed therapy at your facility. **Recurrence or metastatic disease is not required to be reported if the initial abstract on the primary tumor was submitted by your facility.**
- Patients with a reportable cancer previously diagnosed and first course of therapy **at another facility** that are seen at your facility for diagnosis and/or treatment of recurrent or metastatic disease. Record all available information regarding the **original** diagnosis and first-course treatment, if information is available. (Hospital requirement only)

Example 1: Patient was originally diagnosed with prostate cancer in 1997 at another facility and is admitted to your facility in 2003 with questionable chest x-ray. A biopsy shows metastatic adenocarcinoma consistent with prostate primary. **THIS CASE IS REPORTABLE.** Report all information you have on the **ORIGINAL** prostate cancer diagnosis.

Example 2: Patient with a history of breast cancer diagnosed elsewhere five years ago is admitted for a broken hip. Patient was not diagnosed with a recurrence or

treated for her breast cancer during this admission. **THIS CASE IS NOT REPORTABLE.**

- Patients diagnosed at a staff physician's office and receiving any or all of the entire first course of treatment in a hospital. This case is reportable by the hospital. This case is only reportable by the physician office if any treatment was provided by the physician office OR if the case was not referred to a WISCONSIN hospital.
- Patients who die at your facility with **active** cancer, who were neither diagnosed nor treated at your facility, are also reportable.
- Basal cell carcinomas and squamous cell cancers that originate in mucoepidermoid sites:

Sites	ICD-O-3 Site Codes
Lip	C00.0-C00.9
Anus	C21.0
Vulva	C51.0-C51.9
Vagina	C52.9
Penis	C60.0- C60.9
Scrotum	C63.2

*Note: Basal and squamous cell carcinomas of **skin** (ICD-O-3 codes C44.x) are NOT reportable to WCRS.*

- Malignant tumors of the **skin** such as adnexal carcinoma/ adenocarcinoma (8390/3-8420/3), adenocarcinoma, lymphoma, melanoma, sarcoma, and Merkel cell tumor **ARE** reportable. Any carcinoma arising in a hemorrhoid is reportable, since hemorrhoids arise in mucosa, not in the skin.
- Pilocytic/juvenile astrocytoma will continue to be collected as a malignant cancer even though the behavior code changed to borderline malignant in the ICD-O-3 coding manual. NPCR requires state registries to collect these cases as malignant.

Disease Index Codes for Casefinding

The following codes should be used as an aid in casefinding:

ICD-9-CM Codes	Diagnosis (in preferred ICD-O-3 terminology)
042	AIDS (review cases for AIDS-related malignancies)
140.0 - 208.9	Malignant neoplasms
203.1	Plasma cell leukemia (9733/3)
205.1	Chronic neutrophilic leukemia (9963/3)
225.0 – 225.4	Benign neoplasm of brain, cranial nerves, cerebral meninges, cerebral

ICD-9-CM Codes	Diagnosis (in preferred ICD-O-3 terminology)
	meningioma, spinal cord, cauda equine, spinal meninges, spinal meningioma
225.8	Benign neoplasm of other specified sites of nervous system
225.9	Benign neoplasm of nervous system, part unspecified
227.3–227.4	Benign neoplasm of pituitary, craniopharyngeal duct, craniobuccal pouch, hypophysis, rathke's pouch, sella turcica, pineal gland, pineal body
230.0-234.9	Carcinoma <i>in situ</i>
235.0-238.9	Neoplasms of uncertain behavior
238.4	Polycythemia vera (9950/3)
238.5	Mast cell disease (9741/3)
238.6	Solitary plasmacytoma (9731/3), Extramedullary plasmacytoma (9734/3)
238.7	Chronic myeloproliferative disease (9960/3), Myelosclerosis with myeloid metaplasia (9961/3), Essential thrombocythemia (9962/3), Refractory cytopenia with multilineage dysplasia (9985/3), Myelodysplastic syndrome with 5q- syndrome (9986/3), Therapy-related myelodysplastic syndrome (9987/3), Refractory anemia with ringed sideroblasts (9982/3), Refractory anemia with excel blasts (9983/3), Refractory anemia with excess blasts in transformation (9984/3)
239.0 - 239.9	Neoplasms of unspecified behavior (includes neoplasm of uncertain behavior of pituitary gland, craniopharyngeal duct, pineal gland, brain, spinal cord, meninges, nos, cerebral, spinal, neurofibromatosis (unspecified, Type one and Type two von Recklinghausen's disease), other and unspecified parts of nervous system, cranial nerves)
273.2	Gamma heavy chain disease; Franklin's disease
273.3	Waldenstrom's macroglobulinemia
273.9	Unspecified disorder of plasma protein metabolism (screen for potential 273.3 miscodes)
285.22	Anemia in neoplastic disease
288.3	Hypereosinophilic syndrome (9964/3)
289.83	Myelofibrosis (NOS) (9961/3) (New code effective 10/1/2006)
289.89	Acute myelofibrosis (9932/3)
V07.3	Other prophylactic chemotherapy (screen carefully for miscoded malignancies)
V07.8	Other specified prophylactic measure
V10.0 - V10.9	Personal history of malignancy (review these for recurrences, subsequent primaries, and/or subsequent treatment)
V58.0	Admission for radiotherapy
V58.1	Admission for chemotherapy, has been deleted and replaced by subcategory V58.1 Encounter for antineoplastic chemotherapy and immunotherapy, and expanded to include two new codes.

ICD-9-CM Codes	Diagnosis (in preferred ICD-O-3 terminology)
	(changed/added 1/26/2006)
V58.11	Encounter for antineoplastic chemotherapy (changed/added 1/26/2006)
V58.12	Encounter for immunotherapy for neoplastic condition (changed/added 1/26/2006)
V66.1	Convalescence following radiotherapy
V66.2	Convalescence following chemotherapy
V67.1	Radiation therapy follow-up
V67.2	Chemotherapy follow-up
V71.1	Observation for suspected malignant neoplasm
V76.0-V76.9	Special screening for malignant neoplasm
62.2 – 62.4	Orchiectomies
92.20– 92.29	Radioisotopes (I-131) (changed/added 1/26/2006)
92.3-92.39	Stereotactic radiosurgery

Cases Not Required To Be Reported

<i>Cases Not Required To Be Reported</i>
Any skin cancer (site = C44.x) of the following types: malignant neoplasms, NOS; epithelial carcinomas, papillary and squamous cell carcinomas, basal cell carcinomas (histology codes of 8000-8110).
Patients who have a history of cancer but no diagnosis or treatment at your facility.
Records, slides or patients seen only in consultation to confirm a diagnosis. No chart is created for this patient in your facility.
Pathology cases that are consultative readings of slides submitted from outside facilities.
Patients with carcinoma <i>in situ</i> (non-invasive) of the cervix, cervical intraepithelial neoplasia (CIN) diagnosed on or after January 1, 2001 or prostatic intraepithelial neoplasia (PIN) diagnosed on or after January 1, 2003.
Patients with a pre-cancerous condition or benign tumor NOT described on page C1-2.
Patients diagnosed before 1976 (hospital) or before 1992 (clinic/physician office).
Metastatic sites or recurrences of a previously reported cancer.

Note: *If you report for an ACoS-approved registry, your cancer committee may decide to require additional benign or borderline cases. Please do not submit these reportable-by-agreement-only cases to WCRS.*

Ambiguous Diagnostic Terms

A patient has a reportable malignancy when stated by a recognized medical practitioner. The medical record usually presents the diagnosis clearly; however, physicians sometimes use vague or ambiguous terms to describe a tumor when its behavior is uncertain. This may occur in the absence of a cytologic/histologic diagnosis, as well as when there is a cytologic/histologic diagnosis.

Reporting requirements depend on the term used. Some malignancies may be first diagnosed radiographically with ambiguous terms. Reportable terms must always include a reference to malignancy, cancer, etc. (Exception: non-malignant primary intracranial and central nervous system tumors.)

Example 1: Discharge summary and X-ray results report “CT of the chest *compatible with* carcinoma of left lung.” Although there may be no further work-up or treatment, the case is radiographically diagnosed and is reportable.

Example 2: Barium enema (BE) reveals a suspicious sigmoid mass. Colonoscopy reveals a sigmoid mass, “*questionable* malignant neoplasm.” The patient is referred for biopsy and colon resection at another facility revealing carcinoma. The case is NOT reportable for your facility because mass and neoplasm are not associated with a reportable malignant term, whereas if it had been stated “suspicious sigmoid mass, probable malignant neoplasm,” it would be reportable.

●* **Exception:** Do not report cytology suspicious for malignancy, unless confirmed by biopsy or the physician states that the case supports a malignant diagnosis.

Physicians may use other ambiguous terms related to staging. Some indicate tumor involvement or extension, while others are not considered to be involvement. Please make sure to reference the following lists when determining if a case is reportable. Refer to the Collaborative Staging Manual for a list of ambiguous terms used only for staging a cancer.

Lists of Ambiguous Terms	
Terms that constitute a diagnosis; case should be reported	
Apparent (ly)	Most likely
Appears	Presumed
Comparable with	Probable
Compatible with	Suspect (ed)
Consistent with	Suspicious (for)
Favors	Typical of
Malignant appearing	
Neoplasm* or Tumor (beginning with 2004 diagnoses and only for C70.0-C72.9, C75.1-C75.3)	
Terms that DO NOT constitute a diagnosis; case should NOT be reported**	
Approaching	Questionable
Cannot be ruled out	Rule out
Equivocal	Suggests
Possible	Very Close to
Potentially malignant	Worrisome

*Additional terms for non-malignant primary intracranial and central nervous system tumors only

**Unless additional information is available

