Casefinding 7/7/11

Complete Case Identification and Ascertainment

July 7, 2011
NAACCR 2010-2011 Webinar Series

Case Finding – 5 W’s

Who
What
When
Where
Why
NAACCR 2010-2011 Webinar Series
July 7, 2011
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Fabulous Prizes!

Question of the Month!
• The participant that submits the best question of the session will receive a fabulous Prize!

Tip of the Month!
• The participant that sends in the best tip related to the topic will win a spectacular prize!
Q&A
Please submit all questions concerning webinar content through the Q&A panel

Fabulous Prizes!!!

Agenda
• Casefinding: 5 W’s
  – Reportable lists
  – Benign intracranial and CNS tumors
  – Class of case overview
  – Ambiguous Terminology
  – Case Finding Sources
  – Suspense File uses
  – Other helpful tips
• Coding Moment
  – CS LN Eval
Case Finding

- One of the more important functions of a hospital based cancer registry.
  - Provides an accurate account of the cancer experience in that hospital.
  - Identifies the cases to be included in the registry.
  - Can help to identify service needs.
  - Can be used in determining staffing needs within the registry.

Case Finding

- Identify who you are required to report cancer data to.
  - Commission on Cancer – CoC Accreditation
  - NCDB
  - State Public Health Department – State Cancer Registry
    • NPCR & NAACCR
  - SEER – Surveillance, Epidemiology and End-Results
  - Cancer Committee
  - Hospital Administration

Case Finding

- Establish a Reportable List for your facility
  - Reportable Lists should contain all diagnosis to be included or exclude from your registry database.
  - This will vary depending upon the people and agencies that use the registry data.
  - NCDB – CoC Accredited program
  - State Cancer Registry – Public Health Department
  - SEER – National Cancer Institute
  - Cancer Committee at your facility
Case Finding

• Requirements change over time
  – Cervix in-situ –
    • Previously collected by SEER & CoC until Jan. 1, 1996
  – Skin cancers (Basal & Squamous Cell) with Stage II or high
    • Previously collected by CoC until Jan. 1, 2003
  – Non-malignant intracranial & CNS
  – Hematopoietic diseases – Jan. 1, 2010 changes

Current Reporting Requirements

Commission on Cancer - CoC

Malignancies with an ICD-O-3 behavior code 2 or 3

EXCEPTION: Juvenile astrocytoma, listed as 9241/1 in ICD-0-3, is required and should be recorded as 9421/3.

EXCEPTION: Malignant skin cancers with histology codes 8000/3-8110/3 are not required. Previously abstracted skin cases (prior to 1993) with 8000-8110 must remain in registry and followed.

EXCEPTION: Carcinoma in-situ of cervix (CIS) and intraepithelial neoplasia grade III (8077/2) of cervix, prostate, vulva, vagina and anus are not required.

5th Digit Behavior Code for Neoplasms

– /0 Benign
– /1 Uncertain whether benign or malignant
  Borderline malignancy
  Low Malignant potential
  Uncertain malignant potential
– /2 Carcinoma in situ
  Intraepithelial
  Noninfiltrating
  Noninvasive

Pg. 66 – ICD-0-3
• 5th Digit Behavior Code for Neoplasms
  - /3 Malignant, primary site
  - /6 Malignant, metastatic site
  - /9 Malignant, uncertain whether primary or metastatic site

Pg. 66 – ICD-0-3

Current Reporting Requirements
Commission on Cancer - CoC
Non-Malignant primary intracranial and CNS tumors
Diagnosed on or after Jan. 1, 2004 with ICD-0-3 behavior code 0 or 1 are required for following sites:
  - Meninges – C70_
  - Brain – C71_
  - Spinal cord, cranial nerves and other parts of CNS – C72_
  - Pituitary gland – C75.1
  - Craniopharyngeal duct – C75.2
  - Pineal gland – C75.3
WHY - collect Non-malignant intracranial and CNS tumors?

Meninges

Cranial Nerves
Non-malignant primary intracranial & CNS tumors

- Diagnosis are often clinical - radiograph only
- There is no AJCC staging schema
- CS does have coding instructions
- Treatment is often focused on symptom management

- It is estimated that approximately $3.7 billion is spent in the United States each year on brain cancer treatment.

Hematopoietic Disease

2010 changes
Current Reporting Requirements

SEER

ICD-9-CM code list for Reportable tumors – effective 1/1/2010

140.0 – 208.92 Malignant Neoplasms
209.00 – 209.29 Neuroendocrine tumors
209.30 Malignant poorly diff neuroendocrine carcinoma
209.31 – 209.36 Merkel cell carcinoma – effective 10/1/2009
209.70 – 209.79 Secondary neuroendocrine tumors – effective 10/1/2009
225.0 – 225.9 Benign neoplasm of brain and spinal cord neoplasm
227.3 Benign neoplasm of pituitary and craniopharyngeal duct

Current Reporting Requirements

SEER

ICD-9-CM code list for Reportable tumors – effective 1/1/2010

227.4 Benign neoplasm of pineal gland
227.9 Benign neoplasm; endocrine gland, site unspecified
(This code is deleted in 2011 Reportable code listing)
228.02 Hemangioma; of intracranial structures
228.1 Lymphangioma, any site
230.0 – 234.9 Carcinoma, in-situ
236.0 Endometrial stroma, low grade (8931/1)
### Current Reporting Requirements

**SEER**

ICD-9-CM code list for Reportable tumors – effective 1/1/2010

- **237.0 – 237.9** Neoplasm of uncertain behavior (borderline) of endocrine glands and nervous system
  - (237.2 – 237.4 removed in 2011)
- **238.4** Polycythemia vera (9950/3)
- **238.6** Neoplasm of uncertain behavior of other & unspecified site and tissues, Plasma cells.
- **238.7** Other lymphatic and hematopoietic tissues
- **238.71** Essential thrombocythemia (9962/3)
- **238.72** Low grade myelodysplastic syndrome lesions (9980/3, 9982/3, 9983/3, 9985/3, 9991/3, 9992/3)

### Additional Information
- **238.73** High grade myelodysplastic syndrome lesions (9983/3)
- **238.74** Myelodysplastic syndrome with 5q deletion (9986/3)
- **238.75** Myelodysplastic syndrome, unclassified (9985/3, 9987/3, 9989/3)
- **238.76** Myelofibrosis with myeloid metaplasia (9961/3)
- **238.77** Polymorphic Post-Transplant Lymphoproliferative Disorder (9971/3)
- **238.78** Post transplant lymphoproliferative disorder (9977/3)
- **238.79** Other lymphatic and hematopoietic tissues (9951/3, 9960/3, 9961/3, 9965/3, 9966/3, 9967/3, 9970/3, 9975/3)
- **239.6** Neoplasms of unspecified nature, brain
- **239.7** Neoplasms of unspecified nature, endocrine glands & other parts of nervous system
- **239.81-239.89** Neoplasms of unspecified nature; other specified sites (Removed from reportable list for 2011)
- **273.2** Other paraproteinemias
- **273.3** Macroglobulinemia
- **288.3** Eosinophilia – Do not abstract unless Dx is Hypereosinophilia syndrome – 9964/3

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### Current Reporting Requirements

**SEER**

ICD-9-CM code list for Reportable tumors – effective 1/1/2010

- **238.3** Neoplasm of uncertain behavior (borderline) of endocrine glands and nervous system

### Additional Information
- **238.3** Neoplasm of uncertain behavior (borderline) of endocrine glands and nervous system
- **238.4** Polycythemia vera (9950/3)
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### Current Reporting Requirements

**SEER**

ICD-9-CM code list for Reportable tumors – effective 1/1/2010

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Current Reporting Requirements

**SEER**

ICD-9-CM code list for Reportable tumors – effective 1/1/2010

- 288.4 Hemophagocytic syndromes
- 795.06 Pap smear of cervix with cytologic evidence of malignancy
- 795.16 Pap smear of vagina with cytologic evidence of malignancy
- 796.76 Pap smear of anus with cytologic evidence of malignancy
- V10.0 – V10.89 Personal history of malignancy
- V10.90 Personal history of unspecific malignant neoplasm
- V10.91 Personal history of malignant neuroendocrine tumor, carcinoid tumor, Merkel cell carcinoma
- V12.41 Personal history of benign neoplasm of brain

Class of Case overview

2010 – Codes expanded to 2 digits to allow facilities to more accurately reflect the variety of ways patients present and how their data is recorded in the registry.

**Patients Present at Your Facility**

- 00 – Initial Dx at your facility AND all treatment or decision to not treat elsewhere
- 10 – Default code for conversion of older cases. Should not be used in 2010 or later
- 11 – Initial Dx at staff physician office AND all 1st course treatment at your hospital
- 12 – Initial Dx at staff physician office AND decision to not treat was done at your hospital
- 13 – Initial Dx at your facility AND part of treatment given at your facility
- 14 – Initial Dx at your facility AND all 1st course treatment at your hospital

Class of Case overview

Patients present at your facility with initial diagnosis established elsewhere

- 20 – Default code for conversion of older cases. Should not be used in 2010 or later
- 21 – Initial Dx elsewhere AND part of treatment given at your hospital
- 22 – Initial Dx elsewhere AND all of treatment given at your hospital

Class 00 – 22 are Analytic cases and diagnosis, stage and treatment information should be captured as completely as possible in CoC accredited programs.
Class of Case overview
CASES NOT REQUIRED BY CoC – Your state or Cancer Committee may require these

30 – Initial Dx and all 1st course treatment elsewhere AND your facility participated in diagnostic work-up (consult only, staging work-up
31 – Initial Dx and all 1st course treatment elsewhere AND your facility provided in-transit care
32 – Dx and all 1st course treatment elsewhere AND pt. presents with recurrence or progression of disease
33 – Dx and all 1st course treatment elsewhere AND pt. presents with history of cancer
34 – Other CoC non-required case AND initial Dx AND 1st course treatment at your facility

Class of Case overview
CASES NOT REQUIRED BY CoC – Your state or Cancer Committee may require these

35 – Cases diagnosed before your reference date AND initial Dx AND Tx at your facility
36 – Other CoC non-required case AND initial Dx elsewhere AND all or part of 1st course treatment at your facility
37 – Cases diagnosed before your reference date AND initial Dx elsewhere AND all or part of 1st course treatment at your facility
38 – Initial Diagnosis at autopsy at your facility, cancer not suspected prior to death

Ambiguous Terminology
• Terms that constitute a Diagnosis
  Apparent(ly) Presumed
  Appears Probable
  Comparable with Suspect(ed)
  Compatible with Suspicious (for)
  Consistent with Typical of
  Favors Most likely
Ambiguous Terminology

• Terms that Constitute a Diagnosis
  Malignant appearing
  Neoplasm
  Tumor

EXCEPTION: Cytology reported as SUSPICIOUS, do not interpret it as diagnosis of cancer.

Ambiguous Terms that DO NOT Constitute DX

• Cannot be ruled out
• Equivocal
• Possible
• Potentially malignant

Questionable
Rule Out
Suggests
Worrisome

Reportable by Agreement

- These may be additional cases that your State Registry requires.
  - Non-Analytic cases
    - Class of Case 30 – 38 (patient appears at your facility)
    - Class of Case 40 – 43 (patient does not come to your facility)
    - Class of Case 49 – Death Certificate only
  - Pathology only cases – Class of case 43

Other Considerations

- Laterality
- In-Situ vs. Invasive Disease
- 2nd primary vs. Recurrence

- All above refer to Multiple primary manual & Hematopoietic database (when applicable)

Where to Look

- Pathology
- Cytology
- Disease Index
- Radiation Oncology daily logs
- Medical Oncology daily logs
- Mammography - BiRad
Where to Look

- Radiology – CT, x-rays
- PET scans
- Surgical Scheduling
- Pharmacy
What is required in Suspense Record

- Patient Demographic – Name
- MR #
- 1st contact date vs. diagnosis date
- Primary Site
- Histology
- Class of case
- Last contact date

Ways to use Suspense Data

- Timeliness of abstracting
- Current trends
- Clinical Trial eligibility
- Marketing support groups
- Referral to ACS services
  - Personal Health Managers
RQRS – Rapid Quality Reporting System

- Early reporting of CP³R cases
  - BCS cases should receive XRT
  - Hormone positive cases should receive Hormone therapy
  - Hormone negative cases should be offered chemo
  - Colon resections should have 12 nodes
  - Stage III colon should be offered chemo
  - Rectal cases should be offered XRT

RQRS

- Changes the way you collect data
- More intense data capture at time of casefinding
- Requires approval/authorization by several people

Coming up...

- August 4, 2011
  - NAACCR Interoperability Activities and the Electronic Health Record
  - Presented by NAACCR Path Data Workgroup
- September 1, 2011
  - Coding Pitfalls
2011-2012 NAACCR Webinar Series

• Registration is open!