

# **New York State Cancer Registry Casefinding Guide for Physician Medical Practices**

## **1. Purpose of casefinding**

Casefinding is a systematic method of locating all potentially eligible cases to be reported to the New York State Cancer Registry (NYSCR). Casefinding identifies both new cases and cases that may have already been identified. They are entered into a tracking mechanism, and those that are reportable are subsequently submitted to the NYSCR.

## **2. Casefinding overview**

- Identify all reportable cancer cases diagnosed and/or treated in your office. (See sections 3 and 4 below.)
- Use several sources of documentation (reports or logs) to identify all cases diagnosed and/or treated at the practice. (See section 5, below.)
- The NYSCR strongly recommends that practices use a log to track cases identified and reported to the NYSCR. See section 6 below for suggestions in using a tracking log. The NYSCR has created template logs using MS Excel and MS Word for your convenience. (See Physician Casefinding Log Template.) If preferred, the practice can create its own tracking system using the following recommended fields:
  - Date of diagnosis
  - Date of visit
  - Hospital inpatient admission indicator (yes/no)
  - Hospital inpatient admission date
  - Medical record number, if applicable
  - Patient's last name
  - Patient's first name
  - Date of birth (DOB)
  - Type of cancer/primary site (origin of tumor)
  - ICD-9-CM diagnosis code
  - Date submitted to NYSCR
  - Reason not submitted to NYSCR
  - Comments
- Casefinding procedures and case submissions should be routinely performed at time intervals determined jointly by the NYSCR and the medical practice. Typically, submissions occur on a monthly or quarterly basis.
- Ideally, the personnel involved in casefinding and reporting should be limited in number and familiar with reportable diagnoses.

### 3. Determining which patients to report and when to report

- Report cases for patients diagnosed with a reportable cancer.
- Patients diagnosed and/or treated in the physician office setting with a reportable cancer (see section 4 below) who have not been admitted to the hospital as an *inpatient* to treat the same malignancy must be reported.
  - If hospitalization status is uncertain, the case must be reported.
- The case should be reported as soon as the first course of treatment is started.
  - If there is a *decision not to treat* or a decision for *active surveillance*, the case still must be reported.
- Cases do not need to be histologically confirmed (that is, confirmed by pathological analysis). If the physician states the patient has cancer and/or the physician is treating the patient for the malignancy, the case is reportable.
- If a patient is diagnosed with a different type of cancer or if a malignancy has transformed to a different diagnosis (e.g., transformation of myelodysplastic syndrome to acute leukemia), report the new tumor/malignancy to the NYSCR.

### 4. ICD-9-CM codes that identify reportable cancer cases

The following ICD-9-CM ranges can be used for generating casefinding lists to identify reportable neoplasms.

140.0 – 209.79	Malignant neoplasms (primary and secondary). Note: basal or squamous (173.x) skin cancer is not reportable.
225.0 – 225.9	Benign neoplasms of brain and other parts of nervous system
227.3 – 227.4	Benign neoplasms of pituitary gland and pineal gland
230.0 – 234.9	Carcinoma in situ; note: in situ carcinoma of cervix (233.1) is not reportable
237.0 – 237.9	Neoplasms of uncertain behavior of endocrine glands and nervous system
238.4 – 238.79	Neoplasms of uncertain behavior of lymphatic and hematopoietic tissues
239.6 – 239.7	Neoplasms of unspecified nature of the brain, endocrine glands, other parts of nervous system and optic nerve
273.2– 273.3	Heavy chain disease; Waldenstrom macroglobulinemia
288.3	Hypereosinophilic syndrome
289.6	Familial polycythemia
289.83	Acute myelofibrosis
748.1	Astrocytoma, astroglioma, astroblastoma of nose
V58.11	Encounter for antineoplastic chemotherapy
V58.12	Encounter for antineoplastic immunotherapy

The above provides ranges of ICD-9-CM codes that contain diagnoses for neoplasms; however, not all diagnoses in each range are reportable to the NYSCR. Use the separate reportability document (*Guide to Determine Reportability for Physician Medical*

*Practices*) and thoroughly review all available medical information to determine reportability for specific diagnoses for each patient.

## **5. Examples of reports/logs that can be used for casefinding**

The ability to generate reports or logs electronically is ideal; however, this process can also be done by manual review of various logs. Obtaining reports/logs containing data fields listed in section 2.C. will assist in tracking cases that were previously identified and submitted.

The following are examples of logs that can be electronically generated or manually reviewed:

- *Disease index* that is created based on a range of ICD-9-CM diagnosis codes; it might include date of diagnosis, date of first visit, patient name, DOB, Social Security number, and the ICD-9-CM code.
- *Billing reports* that generate lists of procedures or treatments given to a patient, such as bone marrow aspiration or chemotherapy. These reports might also include ICD-9-CM diagnosis codes.
- *Laboratory testing logs* that document tests performed or sent out for analysis, such as tissue biopsies, bone marrow aspirations/biopsies, flow cytometry, genetic testing, and tumor markers. If such a log is not maintained, then individual reports of cancer-related testing that are returned from external laboratories must be reviewed and flagged for reporting.
- *Appointment reports or books* from which cases may be identified.
- *Chemotherapy treatment logs or books*, if applicable.

Use multiple logs to perform the most comprehensive case identification. Select the reports/logs available within the medical practice that will identify cases most completely (e.g., disease index) or uniquely (e.g., laboratory test logs that identify tests like JAK2 mutation).

The NYSCR staff can assist in determining suitable casefinding procedures for the medical practice. For help, call the field representative assigned to physician reporting at 518-474-0971.

## **6. Using the tracking log to monitor casefinding and case submission to the NYSCR**

- A tracking log, either provided by the NYSCR or created by the practice, is important for documenting cases identified and submitted to the NYSCR.
  - Cases can be entered into an MS Excel spreadsheet for tracking purposes. The advantage of this system is the ability to use search functions to look for a specific patient on the list or to sort by a particular data field.
  - MS Word tables can be used electronically or on paper to track identified patients.

- The medical practice may develop any system it chooses for tracking case identification and reporting; however, it is important to put a system in place that allows documentation of reporting (for efficiency and to avoid duplication of reporting) and documentation of why specific patients were not reported (e.g., determined not to be a reportable cancer or the patient was hospitalized as an inpatient for the malignancy).
- The following steps describe how to use the tracking log provided by the NYSCR.
  - Record all cases identified through reports/patient logs described in section 5 on the tracking log.
  - Review medical records for reportability, using sections 3 and 4 above for assistance.
    - If the patient is determined not to have a reportable malignant condition, the case should not be reported. Enter the reason in the “Reason Not Submitted to the NYSCR” Section.
  - Determine whether the patient has been hospitalized as an inpatient for treatment of the same malignancy.
    - If the patient has been hospitalized as an inpatient, enter “Y” or “Yes” in the Hospital Inpatient Admission (Hosp Admit (Y/N)) field, document the hospital admission date, and leave the date submitted field blank. This case does not need to be reported to the NYSCR.
    - If the patient has not been hospitalized as an inpatient, enter “N” or “No” in the Hospital Inpatient Admission (Hosp Admit (Y/N)) field. This case **must be reported** to the NYSCR.
    - If it is uncertain whether or not the patient has been hospitalized, the case **must be reported** to the NYSCR.
  - If the case is reportable, enter detailed information about the patient, diagnosis, and treatment in the Web-based application on the New York State Department of Health’s Health Commerce System (HCS). See the *Physician Reporting Manual*.
- The fields included in the NYSCR template were selected because they will help locate the patient record as well as assist the physician office in determining reportability.
- The log is intended as a tool for tracking patients identified and reported and will be helpful to the practice reporter(s) in the event of an audit by the NYSCR.
- If the practice decides to use an electronic tracking log, it is recommended that it be backed up on a CD, external hard drive, or network drive for preservation of work.

For assistance or any questions regarding casefinding, contact the New York State Cancer Registry at 518-474-0971 and ask for the Physician Reporting field representative.