

The New York State CANCER REGISTRY

Facility Reporting Manual



2019 - EDITION



THE NEW YORK STATE DEPARTMENT OF HEALTH

STATE OF NEW YORK
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The NYSCR Reporting Manual

Revised January 2019

New York State Cancer Registry Reporting Manual

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ACKNOWLEDGEMENT

We wish to acknowledge the Centers for Disease Control and Prevention's National Program of Cancer Registries for its support. Production of this Reporting Manual was supported in part by a cooperative agreement awarded to the New York State Department of Health. Its contents are solely the responsibility of the New York State Department of Health and do not necessarily represent the official views of the Centers for Disease Control and Prevention.

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1.1 WHAT IS THE NEW YORK STATE CANCER REGISTRY?

The New York State Cancer Registry (NYSCR) collects and processes information on cancer cases in New York State. In addition, the NYSCR produces reports on cancer incidence and mortality statewide and in each county, by gender and anatomic site (i.e., breast, lung, colon, prostate, etc.). Because of its comprehensive database of information on cancer cases in New York, the NYSCR serves as an important resource for citizens, health care professionals and researchers.

One of the oldest cancer registries in the country, the NYSCR has been collecting information on patients with cancer for more than 65 years. The first state regulation requiring the reporting of cancer cases diagnosed in New York State, excluding New York City, was passed in 1940. In 1972, the law was amended to include the reporting of information on cancer patients diagnosed in New York City. Evaluation of reporting patterns over time indicates that 1976 is the first year that is considered complete enough to use for the analysis of statewide cancer trends.

In 1995, the NYSCR began receiving additional funding from the Centers for Disease Control and Prevention (CDC) under the federal Cancer Registries Amendment Act. These funds have permitted us to make many improvements in the collection and processing of data. We have increased the number of data elements collected on each cancer patient, consistent with the standards of the National Program of Cancer Registries (NPCR). In September 1996, all Registry data from 1979 to the present were converted into a new database for processing and storage.

In 2018 the NYSCR was selected to become a National Cancer Institute-funded Surveillance, Epidemiology, and End Results (SEER) Registry. SEER's data are extensively used by researchers, clinicians, public health entities and others. As a part of the SEER Program the information collected by the NYSCR will be included in this comprehensive program's database and thus available for such important research. Moreover, New York's data will also be included in SEER's incidence, mortality and survival publications.

1.2 WHY REPORT TO THE NYSCR?

The NYSCR is a population-based cancer incidence registry responsible for the collection of demographic, diagnostic and treatment information on all patients diagnosed with and/or treated for cancer at hospitals, laboratories and other health care facilities throughout New York State. Submission of data is mandated under Public Health Law, section 2401 (Appendix A).

According to the Public Health Law, the person in charge of every reporting facility shall immediately, but not later than one hundred eighty days give notice of every case of cancer or malignant disease coming under the care of the institution to the department. For a complete listing of reportable conditions refer to **Part 3: Reportable Conditions** of this manual.

NOTE: Registrars are encouraged to obtain the most accurate and complete information for each case. Therefore, in most instances, the NYS Cancer Registry **will not accept** any

cases through electronic submission if they are received **less** than one hundred twenty days (four months) after the diagnosis date.

The NYSCR collects a wide variety of information that can be used for research and public health planning and evaluation. The first objective of the Registry is to monitor cancer levels to detect potential public health risks. The Registry also responds to concerns of New Yorkers who perceive that their community may have an elevated level of cancer. Because the Registry data are population-based, they can be used to monitor cancer incidence patterns in New York State. Data collected by the Registry are used:

- to determine cancer rates and trends;
- to prepare health policy and planning;
- for research in epidemiological studies (including case-control studies);
- for evaluation of cancer control interventions;
- to identify and target high-risk populations; and
- to respond to public concerns regarding perceived excesses of cancer in population-based settings.

The NYSCR also plays an important role in research to identify the causes of cancer. Researchers have used the data collected by the Registry to identify cancer patients who could be interviewed about possible exposures they had before they were diagnosed with cancer. These responses can be compared to interview responses of people without cancer to determine whether they had different exposures. One recent study of this kind, conducted with Registry data, found a possible association between alcohol intake and breast cancer. Researchers can also use Registry data to determine whether groups of people with specific exposures, for example, those working in certain occupations, are more likely to develop cancer than people who do not have these exposures.

1.3 WHO REPORTS?

In accordance with the NYS Public Health Law every physician, dentist and other health care provider shall give notice immediately, but no later than one hundred eighty days, of every case of cancer or other malignant disease coming under his or her care, to the department. This includes all:

- Hospitals
- Diagnostic and Treatment Centers;
- Radiation Treatment Centers;
- Ambulatory Surgery Centers;
- Nursing Homes;
- Clinics;
- Laboratories; and
- Managed Care Organizations.

A complete copy of section 2401 of the NYS Public Health Law is available in Appendix A.

1.4 RECIPROCAL AGREEMENTS

In order that cancer-reporting in New York State be as complete as possible, the NYSCR has established formal agreements with several states, including all neighboring states, to exchange information regarding cancer patients.

1.5 WHAT INFORMATION IS COLLECTED ABOUT PATIENTS WITH CANCER?

When the NYSCR first started collecting data, only a minimal amount of information about the patient and tumor was collected. Over the years, the volume of cancer cases has increased and the amount of data collected for each case has expanded. Basically, data collected by the Registry can be divided into two major types: information pertaining to the disease process and information about the patient. Regarding the disease, the Registry collects data on the:

- anatomic site of the tumor;
- stage at diagnosis;
- cell type of the cancer; and
- type of treatment rendered.

If a person is diagnosed with more than one type of cancer, this same information is collected for each unique tumor.

The Registry also collects specific socio-demographic information on each person diagnosed with cancer consisting of, but not limited to:

- age;
- sex;
- ethnicity;
- race;
- residence; and
- place of birth.

Information about the date and cause of death of persons diagnosed with cancer is also stored on the Registry's databases. In total, more than 100 different pieces of information on each person are contained on the Registry database.

The Registry includes reports of all malignant cancers, except selected skin cancers. Malignant cancers include those with both invasive and in situ behavior. In situ cancers are very early cancers while invasive cancers have more potential to spread. The Registry also collects data on brain and nervous system tumors classified as benign or which have an uncertain behavior. Benign tumors are growths that do not have the potential to metastasize beyond the tissue where they originated. (See **Part 3: Reportable Conditions** of this manual for a detailed list of reportable conditions and terminology.)

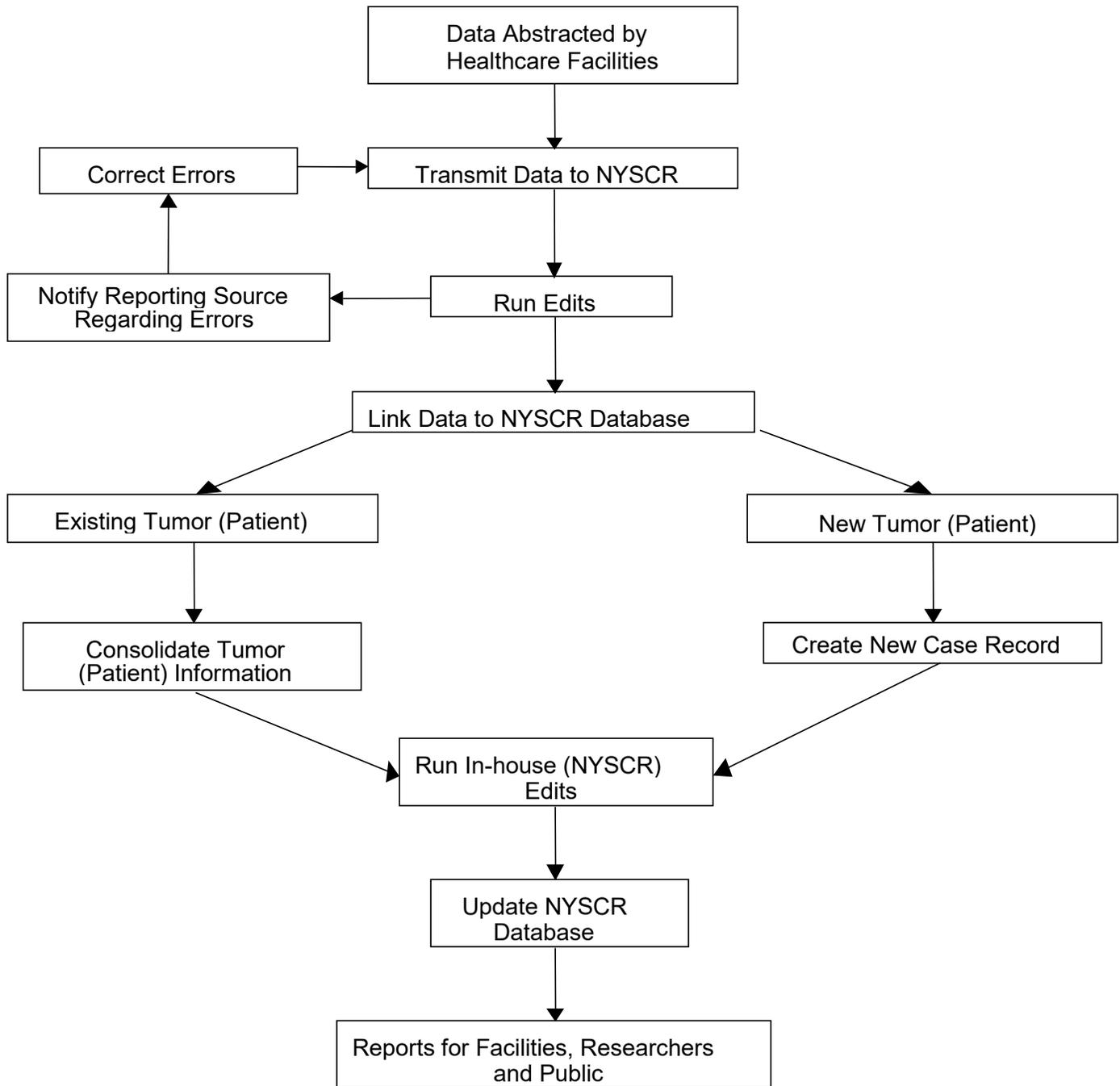
1.6 HOW ARE THE CANCER CASE REPORTS SENT AND PROCESSED?

The NYS Department of Health and the NYSCR utilize the Health Commerce System (HCS), a secure Intranet site, for all data-reporting. The Registry offers, to interested facilities, a software application called Abstract Plus at no charge for electronic reporting purposes. In addition to the enhanced *Windows* format, Abstract Plus contains the most recent North American Association of Central Cancer Registry (NAACCR) file.

Facilities must electronically transmit cancer cases to the NYSCR via the HCS at least once a month. If the facility has nothing to report for a particular month, the person(s) responsible for submitting cancer data must contact his/her Field Representative and inform them of that fact in writing.

Once received at the Registry, cancer reports are processed through a series of computerized and manual operations before they can be used for data analysis. One of the primary strengths of the NYSCR is multiple-source reporting for diagnosed cases. Approximately 3 reports are received for each primary tumor diagnosed. All incoming reports are electronically matched against records on file for patients diagnosed during the past 30+ years in New York State. About six percent of all cancers are second primaries (new cases occurring among those who already were diagnosed with a previous cancer). For some sites, such as oral cavity and pharynx, the number of multiple primaries in an individual may be quite high. Registry staff must look at all tumor reports that match to reports already on the database to determine whether the new report represents a new primary cancer or a cancer previously diagnosed. The diagram on the following page illustrates the various steps of NYSCR data processing.

1.6.1 Flow of data from reporting facilities through the NYSCR



In a process known as “geocoding”, the address information is used to assign a census tract and, in New York City, health districts. Much of the geocoding process is automated; however, about 15 percent of New York State addresses cannot be geocoded electronically and must be manually geocoded by Cancer Registry staff. There are several kinds of addresses that cannot be coded by the computer. These include addresses with incomplete information on the record, mailing addresses not identified by street name (P.O. Boxes, rural routes, apartment buildings) and addresses located on newly added streets or long streets that cross between several towns or counties.

The field services staff monitor the number of cases submitted by each facility and the total number of cancer cases for a given diagnosis year. Although facilities are required to submit cases within six months, some case reports are not received until after a year or more has passed. The Registry is actively working to improve the timeliness of facility reporting. When most of the data for a given year are received and processed, then death information processing begins.

1.7 WHAT IS DEATH INFORMATION PROCESSING?

When the Health Department receives death certificates, an underlying cause of death is assigned based on the entire list of primary and secondary causes of death. Any mention of cancer on the death certificate is also recorded regardless of whether the person died as a direct result of the cancer. All records of people who die from cancer or with a mention of cancer are cross-referenced to the NYSCR database. If no match is found, or if the site of cancer on the death certificate is different from that recorded on the Registry database, then follow-back is initiated by contacting the facility where the death occurred and requesting any additional information they may have. This is an important process because year of diagnosis, stage, histology and many other important pieces of information are not available on the death certificate. Of all tumors recorded at the Registry, approximately 3 percent are reported from death certificates for which no additional information is available. This usually occurs because the deaths occurred at home, in nursing homes or out of state. In some cases, the deceased had been diagnosed and treated for cancer at a facility other than the one in which he or she passed away and further information cannot be found. These cases are called “death certificate only cases,” or DCOs. Further information has been provided in **Part 6: Death Certificate Only and Death Clearance Lists**.

1.8 FILE RETENTION

There is no statute governing how long cancer case files must be kept by reporting facilities: however, retention for at least five years is strongly recommended by the NYSCR. As with most cancer data software, Abstract Plus contains a backup function and backup is strongly recommended following any data entry. Abstract Plus users can direct questions regarding file backup to their Field Representative, while commercial software users should contact their software representative or someone from their facility’s information technology services.

1.9 ARE THERE OTHER MEASURES OF QUALITY APPLIED TO THE CANCER REGISTRY?

Three indicators commonly measure the quality of cancer reporting:

- the percentage of cases reported by death certificates only;
- the percentage of cases confirmed microscopically; and
- the percentage of cases with nonspecific diagnoses.

The number of “death certificate only” cases gives an indication of the completeness of registration. The number of microscopically confirmed cases and the number with nonspecific diagnoses indicate the accuracy of diagnostic information. These measures are related to the overall quality of data and indicate potential for improved reporting from individual facilities. A high percent of cases without microscopic confirmation or with nonspecific diagnoses indicates that either (1) there was inadequate medical record abstracting and reporting or (2) the diagnostic work-ups at the facility may not have been as complete as they could have been. The latter sometimes occurs following a clinical diagnosis of cancer in those patients whose work-ups may be compromised due to co morbid conditions.

Measures of data quality vary considerably among cancer sites. They are affected by many factors including the available methods of early detection, the survival associated with a particular site/histology and the age group primarily affected.

In addition to these measures of completeness and diagnostic accuracy, other data quality factors affect the analysis and interpretation of cancer registry data. While almost all cancer cases reported to the Registry have information about gender, age and county of residence, other data important for research or program planning are less complete; particularly race, ethnicity and stage at diagnosis.

1.10 UNDER WHAT CIRCUMSTANCES IS INFORMATION CORRECTED OR CHANGED?

The change/correction procedure ensures that the most accurate information is available to users of NYSCR data by enabling reporting facilities to provide updated or corrected information to the NYSCR after the original case has been transmitted.

Example: At the time a case was reported to the NYSCR, the primary site was unknown. On a subsequent admission several months later, the primary site was documented as upper lobe of the left lung. An update should be submitted to revise the primary site, laterality and any other information that may have become available. The NYSCR will update this information on the patient’s consolidated abstract in the NYSCR database.

Example: A case was received at the NYSCR that stated the patient’s primary site was a cervical lymph node and the morphology was an adenocarcinoma. Because a lymph node is a secondary site (a metastatic site) of an adenocarcinoma, the facility would be contacted to request further review of the patient’s medical record to determine the correct primary site of this malignancy.

Example: A case was reported before the radiation treatment was started or completed. Update the abstract and resubmit to NYSCR with updated radiation treatment information.

A representative from the NYSCR may contact a reporting facility when questionable or inconsistent information is received. In addition to correcting the information in the software being used at the facility, corrected information must be relayed to the NYSCR representative as soon as possible. Registrars are encouraged to obtain the most accurate and complete information for each case.

1.10.1 What to Change

Change required data items when incorrect or unknown information was initially reported or when more specific/accurate information is subsequently available.

Examples:

- Update diagnostic information such as diagnosis date, primary site or histology if originally submitted with incorrect information.
- Change staging information as indicated in specific staging manuals (i.e. SEER Summary Stage, AJCC TNM) if additional information becomes available.
- Update 1st Course of Treatment data items if initially submitted with incorrect codes or unknown values and more accurate information becomes available.
- Change service type information and other applicable fields if a patient subsequently presents to the facility following submission as a “lab only” case.
- Submit changes to name as applicable (e.g., name spelled incorrectly on original abstract, name changed due to marital status).

Do Not submit changes to update address changes or admission/discharge dates when the patient is re-admitted.

NOTE: Please include text regarding any change(s) in the “Remarks” field, so that NYSCR staff will know which record is correct.

1.10.2 How to Submit Changes

Facilities utilizing Abstract Plus software are required to wait one (1) calendar day before making any corrections to an abstract. Cases are re-marked as unsent cases in Abstract Plus after necessary changes are made, and the case is saved. These corrected cases should be exported separately from regular cases as “M” type records, for submission to the NYSCR. Facilities that use commercial software packages should refer to the appropriate section of the software’s manual.

1.10.3 When to Submit Changes

Changes or corrections should be made within ten (10) days of the original submission date and can be included in any of your regular submissions.

1.10.4 Quality Control

Reporting facilities should have quality control measures in place to make sure cancer data reported to the NYSCR are complete, accurate and timely. Please refer to **Part 8 - Quality Assessment**.

1.11 ARE THERE NATIONAL CANCER DATA OR DATA FROM OTHER STATES TO COMPARE WITH NEW YORK?

The U.S. Congress passed the Cancer Registries Amendment Act in 1992, which authorized the National Program of Cancer Registries (NPCR) of the Centers for Disease Control and Prevention. The NYSCR has received support from the NPCR since 1996, which has enabled the New York State Cancer Registry to achieve 'gold' status for the quality and completeness of its cancer data. Through ongoing collaboration with the SEER program, the NPCR provides nationwide, regional, and state-based cancer incidence and mortality data published in the [United States Cancer Statistics](#) and in the [CDC WONDER](#) web-based query system. The United States Cancer Statistics currently covers 99% of the United States population.

The New York State Cancer Registry is a member of the North American Association of Central Cancer Registries (NAACCR), which sets data standards and best practices for population-based registries. Thanks to the advent of federal funding for cancer registries, the NAACCR membership now includes central registries in all fifty states and the District of Columbia, as well as in the Canadian provinces, and in Puerto Rico and Guam. NAACCR compiles and publishes [Cancer in North America](#) and associated data products.

When the New York State Cancer Registry updated its database in 1996, it adopted the SEER and NAACCR standards for coding data. One major change in the collection and coding of multiple primary tumors was important for the interpretation of cancer incidence statistics. For cancer cases diagnosed prior to 1996, New York used the International Agency for Research on Cancer (IARC) rule for counting primary tumors, which allows only one primary per site per person per lifetime. Thus, the Cancer Registry would count only one breast cancer or one lung cancer per person. The SEER coding rules allow for multiple primary cancers in an anatomic site, based on the histology, length of time between the two tumors and the oncologist's determination as to whether a second cancer represents a second primary or a recurrence. According to data from the SEER program, about five percent of breast cancers, for example, are second primary cancers among women previously diagnosed with breast cancer. Because all data for cancers diagnosed prior to 1996 were coded using the IARC rules, New York data for some sites of cancer are not directly comparable to the SEER or NAACCR data. The extent of the effect for each cancer site is dependent on the site-specific probability of multiple primaries. Beginning with cases diagnosed in 1996, New York State's data are comparable to both SEER and NAACCR data. [SEER data](#), which currently represent approximately 35% of the U.S. population.

1.12 WHAT IS THE DIFFERENCE BETWEEN THE CANCER REGISTRY AND THE HOSPITAL DISCHARGE FILES (SPARCS)?

The Statewide Planning and Research Cooperative System (SPARCS) maintains a database of all hospital discharges in New York State. This is a valuable source of information on treatment, cost and patterns of care related to cancer. Cancer patients may be admitted to the hospital many times over the course of their treatment and recovery. Often, a patient is seen at several different hospitals over the course of several years. The NYSCR counts the number of tumors, not the number of hospital admissions. Reports from different hospitals and different years are matched to the

database so that an accurate count of the number of tumors can be made. This is not possible with the SPARCS data, because the discharge files do not contain important clinical information needed to determine whether a cancer is a new tumor or a recurrence. Many data elements important for studying cancer – such as stage at diagnosis, histology, behavior and laterality – are not available in the discharge files.

1.13 WHAT DOES THE CANCER REGISTRY DO TO PROTECT PRIVACY?

All information reported to the NYSCR is considered confidential. Policies and procedures are in place to protect every patient's privacy. Access to Registry offices is restricted. All employees are trained in handling confidential information. Strict policies govern the release of data to outside investigators. All research studies involving data with patient identifiers must be reviewed and approved by the NYS Department of Health Institutional Review Board (IRB), which protects a patient's right to privacy. Individual-level data without identifiers for small geographic areas are also protected by data release policies. Statistics for areas smaller than the county level are only released when there are enough cases in the area to guard against revealing confidential information about an individual. When there are fewer than six cases of a particular type of cancer in small area, (e.g., four cases of bladder cancer), then the exact number of cases is not revealed. Instead, the table, which displays the number of cases for the small area, will indicate "fewer than six cases".

1.14 WHAT KINDS OF DATA DOES THE CANCER REGISTRY RELEASE?

The NYSCR publishes [Cancer Incidence and Mortality in New York State](#) annually. This report provides the number of cancer cases or deaths and the age-adjusted rates by county, cancer site and gender, for the most recent five-year period. Five years of data are combined since the number of cases and rates for single years may vary considerably, particularly for most of the counties outside metropolitan areas and cities. Cancer Incidence and Mortality in New York State also provides the number of cancer cases or deaths and age-adjusted rates by age, race and year of diagnosis, as well as the proportion of cases diagnosed at an early stage for New York State, New York City and New York State excluding New York City. Periodically, special reports are released that include more detailed data than are available in the annual publication. For additional information on special reports produced by NYSCR, visit the [NYSCR website](#).

Staff in the analytic unit of the NYSCR also respond to special requests for cancer data. Often, a researcher requests data to evaluate a public health intervention or to test a hypothesis.

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Part Two – Confidentiality

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2.1 DEFINITION

Confidential is defined by Webster's Dictionary as: private, secret; entrusted with confidence; containing information whose unauthorized disclosure could be prejudicial.

2.2 LEGAL AND ETHICAL ASPECTS

2.2.1 Why Safeguard Confidentiality?

Cancer data are highly confidential and one of the most important responsibilities of cancer registry professionals is to safeguard the confidentiality of cancer patient information. Improper disclosure of these data could result in emotional, psychological and financial harm to patients and their families. The standard of confidentiality maintained by cancer registries is like that of the doctor-patient relationship and it extends indefinitely – even after the patient is deceased.

2.2.2 The Public Health Law

New York State Public Health Law provides the NYSCR with the legislative authority to collect confidential cancer information. Specifically, section 2401 states:

Every physician, dentist and other health care provider shall give notice immediately but not later than one hundred eighty days of every case of cancer or other malignant disease coming under his or her care, to the department, except as otherwise provided.

The NYS Department of Health has also instituted stringent regulations to ensure maximum confidentiality of records received. New York Codes, Rules and Regulations (NYCRR) protect the confidentiality of all cancer case information received by the NYSCR. Title 101.31 of the NYCRR states:

The identity of any person contained in a report of cancer made pursuant to the provisions of Section 2401 of the Public Health Law, or cancer data collected for other specific research studies, shall not be disclosed except to governmental or government-sponsored research projects for the purpose of scientific studies and research when the State Commissioner of Health determines that substantial knowledge may be gained by such disclosure leading toward the reduction of morbidity and mortality. The recipient shall limit the use of such information to the specific study of research purpose for which such disclosure is made, shall not further disclose such information and shall satisfy the State Commissioner of Health that the confidentiality of the patient's identity will be maintained.

Additionally, Department regulation Subpart 50-1 through 50-4 governs the storage, access and disposal of patient information and requires the development of unit specific protocols to ensure confidentiality of personal health related information.

2.2.3 The Health Insurance Portability and Accountability Act (HIPAA)

Federal regulations [see 45 C.F.R. s164.512] authorize disclosure without patient consent in certain circumstances, including the following:

Disclosure is permitted to a public health authority authorized by law to access information to prevent/control disease, injury, disability (e.g., disease reporting, vital statistics reporting, public health surveillance, public health investigations, public health interventions and partner notification).

Under the HIPAA a 'Public Health Authority' refers to "an agency or authority of the United States, a State or territory, a political subdivision of a State or territory, an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is responsible for public health matters as part of its official mandate." ¹ "...Such agencies are authorized by law to collect or receive such information for the purposes of preventing or controlling disease, injury, vital events such as birth or death and the conduct of public health surveillance, public health investigations and public health interventions." ² *Central Cancer Registries* are considered public health authorities because their duties are mandated by state laws.

¹ C.F.R. 164.501

² C.F.R. 164.512

Cancer reporting and surveillance are required by New York State law. Public health reporting under the authority of New York State law is specifically exempted from HIPAA preemption, per 45 C.F.R. § 160.203(c). Access to patient medical records relating to the diagnosis and treatment of cancer by the NYSCR has been determined to be the minimum necessary for protected health information for the state purpose in compliance with 45 C.F.R. s164.502. It is not necessary to complete a Business Associate Agreement before providing the NYSCR with the requested personally identifiable information. The requested information is needed to conduct public health surveillance and will remain confidential. See Appendix B for more information regarding HIPAA.

2.3 POLICIES AND PROCEDURES

Anyone, whose position requires access to cancer data, whether at the NYSCR or a reporting facility, is responsible for ensuring confidentiality is always maintained. Reporting facilities are urged to consider implementing the following policies and procedures, if they are not already in place.

2.3.1 Confidentiality Pledge/Agreement

It is strongly recommended that anyone with access to confidential patient information first sign a **Confidentiality Pledge/Agreement**. This pledge/agreement should clearly state the expectations of the facility regarding the signatory's handling of confidential information and any penalties that may be imposed in the event of a violation. In addition, this requirement should extend beyond employees of the facility to consultants, auditors, etc. A sample confidentiality statement is available at the end of this section (Part 2).

2.4 DATA SECURITY

Every measure must be taken to ensure the confidentiality of all medical records is protected. This includes Electronic Medical Records (EMRs). Anyone requiring access to confidential patient information should be required to sign a confidentiality pledge before authorization is approved.

The following additional guidelines are offered to Health Information Management personnel to maintain security of confidential patient information whether stored on paper or in an EMR database.

2.4.1 Paper records

Central storage sites containing confidential patient files must be always secured. A chain of custody should be maintained on every record removed from the central storage site, citing the name and department of the individual removing the record, along with the date and time of removal and return.

Individuals who sign out records must ensure that those records remain secure while in their possession.

2.4.2 Electronic records

If not already in place, strict security procedures must be instituted, preventing any unauthorized access to EMRs. Confidential medical information, which is abstracted and entered onto an EMR, must be done so only by authorized personnel. Each authorized user should be assigned a personal access identification and/or password. This ID/password must never be shared with others. Access to confidential medical data should be limited to those individuals and/or agencies with a legitimate use for such data. As previously mentioned, NYS Public Health Law provides for the transmission of confidential cancer data to the NYSCR.

Facilities must remove any individual user's ID/password, which may provide access to confidential patient data, from their system upon termination of employment.

2.5 PROCEDURES FOR RELEASE OF CONFIDENTIAL CANCER PATIENT INFORMATION

Telephone: If a caller is not immediately known, the identity of the caller must be confirmed before any information is released.

Facsimile: When transmitting confidential information via fax, the following guidelines should be implemented to ensure that the information is received by an authorized party only:

1. Transmit data only to a fax machine that is located within a secure area, offering limited access.
2. Verify that the appropriate individual is present before transmitting confidential data.
3. Accompany each fax transmission with a cover sheet, which includes a notice of confidentiality.

Example: The documents accompanying this facsimile contain confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual(s) or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party and is required to destroy the information after its stated need has been fulfilled, unless otherwise required by law.

If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this facsimile in error, please notify the sender immediately to arrange for return of these documents.

4. Verify that the intended recipient has received the faxed information.

Electronic Mail: Common e-mail should never be used to transmit confidential patient information. If someone wishes to send confidential data electronically, s/he should use the *Secure File Transfer Utility* on the Department's Health Commerce System (HCS). An HCS account is necessary to access and transmit information via the *Secure File Transfer Utility*. This system allows for secure transmission of files up to 2 GB. Assistance using the *Secure File Transfer Utility* is available from your Field Representative.

Regular Mail: All confidential patient information sent to the NYSCR via postal mail, or other couriers, must be prominently marked "confidential". Use of registered or express mail is recommended. This allows the sender to track the package, as well as confirm receipt. Use of reinforced envelopes/packaging is also strongly recommended.

2.6 SAMPLE CONFIDENTIALITY PLEDGE

I understand and accept the responsibility of maintaining the confidentiality of all data and information collected and processed by _____ (*Facility Name*).

I also understand my role in ensuring the right to privacy of persons and institutions cooperating with the cancer registry data collection activities.

I understand that _____ (*Facility Name*) has policies that protect the patient's right to consideration of privacy regarding his or her medical and personal information.

I understand that I must not reveal any confidential information to anyone except those individuals authorized to receive such information, such as another staff member or the original reporting source.

I also understand that failure to adhere to this policy may result in disciplinary action up to and including dismissal.

I have read and understand the _____ (*Facility Name*) confidentiality policy and procedures and pledge to act in accordance with these policies and procedures.

Name (Please print): _____

Signature: _____ **Date:** _____

Witness Name (Please print): _____

Signature: _____ **Date:** _____

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Part Three - Reportable Conditions and Terminology

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3.1 INTRODUCTION

In general, the following types of cases ARE reportable:

- Each form of in situ (behavior code 2) cancer, EXCEPT for all types carcinoma in situ of the cervix uteri (including adenocarcinoma in situ), CIN III (cervical intraepithelial neoplasia, grade three), all types of carcinoma in situ of the prostate, PIN III (prostatic intraepithelial neoplasia, grade three), evolving/early melanomas (including evolving melanoma in situ) and in situ lymphomas
- Each form of malignant (behavior code 3) cancer, EXCEPT skin of non-mucoepidermoid sites with the following histologies:
 - Malignant neoplasm (8000-8005)
 - Epithelial carcinoma (8010-8046)
 - Papillary and squamous cell carcinoma (8050-8084)
 - AIN III arising in perianal skin (8077)
 - Basal cell carcinoma (8090-8110)
- All PRIMARY central nervous system tumors, regardless of behavior, with the following ICD-O topography codes:
 - Meninges, C70.0 – C70.9
 - Brain, C71.0 – C71.9
 - Spinal cord, cranial nerves and other parts of CNS, C72.0 – C72.9
 - Pituitary gland, craniopharyngeal duct and pineal glands, C75.1 – C75.3
 - Nerve roots for the following sites: C47.0, C47.3, C47.5, C47.6
- Borderline ovarian tumors
 - Serous cystadenoma, borderline malignancy 8442/1
 - Serous tumor of low malignant potential 8442/1
 - Atypical proliferating serous tumor 8442/1
 - Papillary cystadenoma, borderline malignancy 8451/1
 - Serous papillary cystic tumor of borderline malignancy 8462/1
 - Papillary serous cystadenoma, borderline malignancy 8462/1
 - Papillary serous tumor of low malignant potential 8462/1
 - Atypical proliferative papillary serous tumor 8462/1
 - Serous surface papillary tumor of borderline malignancy 8463/1
 - Atypical proliferative mucinous tumor 8472/1
 - Mucinous cystic tumor of borderline malignancy 8472/1
 - Mucinous cystadenoma, borderline malignancy 8472/1
 - Mucinous tumor, NOS, of low malignant potential 8472/1
 - Pseudomucinous cystadenoma, borderline malignancy 8472/1
 - Papillary mucinous cystadenoma, borderline malignancy 8473/1
 - Papillary pseudomucinous cystadenoma, borderline 8473/1
 - Papillary mucinous tumor of low malignant potential 8473/1
 - Seromucinous borderline tumor of the ovary 8474/1
 - malignancy

3.2 RULES FOR REPORTING

3.2.1 Active Cancer

Any person diagnosed with active cancer, EXCEPT basal and squamous cell cancers of skin, after January 1950 must be reported to the NYSCR. Active cancer is defined as requiring therapy or management of the cancer or recurrence of the cancer. If a patient is diagnosed

with or treated for metastatic cancer at your facility, report the PRIMARY SITE the first time the patient is seen at your facility for cancer.

If ANY type of cancer-related service or management is provided for the patient at your facility, the case IS reportable.

Example: A patient is diagnosed at another facility but seen at your facility for planned breast reconstruction, which is part of the first course of treatment.

Example: A patient is diagnosed at another facility with melanoma and is seen at your facility for wide excision. This is reportable even if the pathology results from the wide excision are negative.

Patients seen at your facility for a reason completely unrelated to an active case of cancer are NOT reportable.

Example: A patient is treated for a broken leg. The patient also has a secondary diagnosis of breast cancer. The patient is not treated for breast cancer while at your facility.

Autopsy/death certificate cases are exceptions. See section 3.2.1.4 for more information.

Active cancer includes:

3.2.1.1 Consult-Only Cases

Report consultation only services provided by your facility to establish or confirm a diagnosis of or a treatment plan for active cancer.

Examples of reportable consult-only cases:

- A biopsy is done elsewhere and the specimen (including electronically transmitted microscopic images) is sent to your facility. The patient never enters your institution; however, your facility diagnoses a reportable cancer in a pathology report. These cases are referred to as “Lab Only Cases.” This category also includes specimens sent to your facility, which test positive for malignancy using immunohistochemistry testing and lab test (ex. ER/PR testing, HER2/neu testing). If the patient returns to your facility for treatment the case must be updated with the correct service type and any additional demographic/treatment information and resubmitted.
- An outpatient CT scan of the chest reads, “probable carcinoma of the right lung.” The clinical impression is confirmed at your facility and is reported back to the referring facility or physician.
- A patient comes to your facility for a second opinion, where staff physicians order diagnostic tests that support the original diagnosis and treatment plan. The patient returns to the referring institution for treatment.
- The patient does not have treatment at the hospital but the MD presented the patient with treatment options. The patient does not return (service type “16”).

Note: Consult-only services for a patient whose primary residence is NOT in the United States are NOT reportable to the NYSCR.

3.2.1.2 Transient Care

Report cancer cases when patients receive transient care at your facility to avoid interrupting a course of therapy started elsewhere.

Examples of reportable transient care:

- A patient from out of state is visiting relatives in the area. The oncology department at your facility administers the scheduled chemotherapy.
- Due to equipment failure, an institution refers a patient to your facility for radiation therapy. Your facility administers treatment until the equipment is repaired.

3.2.1.3 Terminal Care

Report cases for patients with active cancer, admitted to your facility for the purpose of receiving supportive care, palliative care, pain management and/or hospice services.

3.2.1.4 Autopsy/Death Certificate Only Cases

This refers to an incidental finding of cancer at autopsy where there was no suspicion of cancer before the autopsy. To avoid Death Certificate Only (DCO) follow-back cases later, facilities should establish a mechanism to review death certificates for the presence of cancer diagnoses. See Part 6 for more information on DCO cases.

3.2.1.5 Clinical Cases

Report clinical cases. Clinical cases are where a physician states that the patient has cancer, but the cancer has not been histologically confirmed. The medical history and physical examination section of a medical record often ends with the physician's impression of the diagnosis, but the impression MUST be substantiated by the discharge summary or other supporting documentation. Do NOT report "rule out" only cases. See Section 3.5.1 for terms considered diagnostic of cancer.

3.2.1.6 Neoplasms of the Central Nervous System (CNS) (See 3.3)

Report all PRIMARY central nervous system tumors with any of the following ICD-O-3 topography codes:

- Meninges, C70.0 – C70.9
- Brain, C71.0 – C71.9
- Spinal cord, cranial nerves and other parts of CNS, C72.0 – C72.9
- Pituitary and pineal glands, C75.1 – C75.3
- Nerve roots for the following sites: C47.0, C47.3, C47.5, C47.6

The NYSCR has actively collected benign and borderline CNS neoplasms for many years prior to their collection nationally, starting in 2004. Therefore, the NYSCR will accept all CNS neoplasms with diagnosis dates prior to 2004.

3.2.1.7 Leukemia in Remission

Leukemia in remission is reportable if the patient receives treatment while at your facility. Cases in which the disease is *no longer active* should only be reported if the patient is still receiving cancer-directed therapy, e.g., leukemia in remission receiving chemotherapy.

Example: A patient diagnosed six 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 last course of chemotherapy. If this is the first admission to your facility, this patient should be reported because cancer-directed treatment (e.g., chemotherapy) is being administered.

3.2.1.8 Mucoepidermoid Sites

Mucoepidermoid sites include the vulva (i.e., labia, vaginal opening, clitoris and clitoral hood), vagina, penis, scrotum and portions of the lip and anus.

3.2.1.8.1 Reportable Lip Cases

The codes for the mucoepidermoid portions of the lip are C00.0-C00.9. These include the inner mucosal surface of the lip, the vermilion surface of the lip (i.e., the pinkish colored area where lipstick is applied) and the vermilion border of the lip. Report all malignancies involving these sites.

3.2.1.8.2 Reportable Anal Cases

C21.0 is the code that includes the mucoepidermoid portion of the anus called the anoderm. The anoderm is the lining of the anal canal immediately inferior to the dentate line and extending for about 1.5 cm to the anal verge. It is devoid of hair and sebaceous and sweat glands; therefore, it is NOT true skin. Report all malignancies involving this site.

3.2.1.8.3 Reportable Basal Cell Carcinomas

Basal cell carcinomas ARE reportable when they arise in the:

Vulva	(C51.0-C51.9)
Vagina	(C52.9)
Penis	(C60.0 - 60.9)
Scrotum	(C63.2)

Basal cell carcinomas do NOT arise in the mucoepidermoid portion of the lip and anus. They can only arise in the skin of these two sites and are therefore NOT REPORTABLE.

3.2.1.8.4 Reportable Squamous Cell Carcinomas

Squamous cell carcinomas ARE reportable when they arise in the mucoepidermoid sites of the:

Vulva	(C51.0-C51.9)
Vagina	(C52.9)
Penis	(C60.0-C60.9)
Scrotum	(C63.2)
Lip	(C00.0-C00.9)
Anus	(C21.0)

3.2.2 First-Seen Rule

Submit a report on every patient first diagnosed or treated at your facility. If first seen with a cancer recurrence or metastatic disease, report the information from the INITIAL diagnosis of the PRIMARY site (i.e., not metastatic site[s]). Report a patient again ONLY if the patient is diagnosed with another primary cancer. Create a new abstract for every new primary of each patient.

3.2.3 Infusion Ports/Sleeve Placements/Fiducial Markers

Report patients who come to your facility for insertion of an infusion port (e.g., mediport, infusaport, port-a-cath, or chemotherapy port), when the record states the device will be used to provide central access for chemotherapy for a reportable cancer at a treating facility. These cases are reportable even if the patient is to receive their subsequent chemotherapy at another facility. Patients who are seen for sleeve placements and insertion of fiducial markers for subsequent radiation therapy are also reportable. It is understood that the patient's medical record may contain minimal information related to his/her diagnosis.

Service Type for these cases should be coded as "18 Port/Cath" and Class of Case as "31: Initial diagnosis and all first course treatment elsewhere AND reporting facility provided in-transit care."

3.2.4 MammoSite Radiation Therapy

Report patients who come to your facility for the insertion of a MammoSite balloon catheter. The MammoSite Radiation Therapy System utilizes a specialized balloon catheter to deliver brachytherapy directly to the site of a lumpectomy, following a diagnosis of malignancy. These cases are reportable even if the patient is to receive their subsequent radiation therapy at another facility. It is understood that the patient's medical record may contain minimal information related to her/his diagnosis.

3.2.5 Behavior Code

Patients diagnosed with a behavior code of 2 (in situ) or 3 (malignant) as defined in the International Classification of Disease for Oncology, Third Edition (ICD-O-3) and the 2018 ICD-O update must be reported, except as otherwise noted.

3.2.5.1 Behavior Code 2 (In Situ) Terms That Are Reportable

Synonymous terms for behavior code 2 (in situ) that ARE reportable to the NYSCR (except for basal and squamous cell carcinomas of the SKIN) include:

- AIN III (anal intraepithelial neoplasia)
- Clark level 1 for melanoma (limited to epithelium)
- Confined to epithelium
- DIN III* (ductal intraepithelial neoplasia)
- Intraductal
- Intraepidermal, NOS
- Intraepithelial, NOS
- Involvement up to but not including the basement membrane
- Lentigo maligna (C44. _) also known as Hutchinson melanotic freckle, NOS (C44. _)
- LIN III* (Laryngeal Intraepithelial Neoplasia, grade III)
- Lobular neoplasia grade III* (LIN III) (C50. _)
- Non-infiltrating
- Non-invasive
- No stromal invasion
- PanIN III* (Pancreatic Intraepithelial Neoplasia, grade III)
- SIN III* (Squamous Intraepithelial Neoplasia, grade III)
- VAIN III* (vaginal intraepithelial neoplasia, grade III)
- VIN III* (vulvar intraepithelial neoplasia, grade III)

3.2.5.2 Behavior Code 2 (In Situ) Terms That Are Not Reportable

Synonymous terms for behavior code 2 (in situ) that are NOT reportable to the NYSCR include:

- Bowen disease of SKIN
- CIN III (cervical intraepithelial neoplasia, grade III)
- PIN III (prostatic intraepithelial neoplasia, grade III)

3.2.6 Key Words and Conditions

Reportable conditions are defined in terms of key words and other specified conditions. The most comprehensive source for determining reportability is the International Classification of Diseases for Oncology, Third Edition (ICD-O-3), and the 2018 ICD-O update, published by the World Health Organization (WHO). The ICD-O presents definitive information related to site, morphology, behavior, synonyms, codes and rules. Section 3.8 of this manual contains a list of MOST of the terms that are reportable to the NYSCR.

3.2.7 Terms That May Not Sound Malignant but ARE Reportable

The following is a non-inclusive list of terms that may not sound malignant, but ARE reportable to the NYSCR.

Acute myelofibrosis	Linitis plastica
Acute panmyelosis	Lymphoma
Acute progressive histiocytosis X	Lymphomatoid papulosis (C44_)
Adamantinoma	Lymphoproliferative disorder (C44_)
Agnogenic myeloid metaplasia	Malignant (except malignant hypertension)
Alpha heavy chain disease	Melanoma
Anal intraepithelial neoplasia (AIN III)	Meningioma
Askin tumor	Merkel cell tumor (skin)
Astrocytoma	Mesothelioma
Atypical carcinoid	Mixed mesodermal tumor
Blastoma	Multiple myeloma
Carcinoma in situ (except for cervix)	Mycosis fungoides
CASTLE	Myelofibrosis, acute
Dysgerminoma	Neoplasm, malignant
Ependymoma	Oligodendroglioma
Ewing tumor (bone)	Paget disease (breast)
Franklin disease	Paget disease, extra-mammary
Gamma heavy chain disease	Pagetoid reticulosis
Generalized Langerhans cell histiocytosis	PanIN (Pancreatic Intraepithelial Neoplasia grade III)
Glioma	Peripheral neuroectodermal tumor
Heavy chain disease	Phyllodes tumor, malignant (breast)
Hepatoma	Pinealoma
Hodgkin disease	Plasmacytoma
Hypereosinophilic syndrome	Primitive neuroectodermal tumor
Hypernephroma	Sarcoma
Immunoproliferative small intestinal disease	Seminoma
Intratubular germ cell neoplasia	SETTLE
Kaposi sarcoma	Sezary disease
Klatskin tumor	Therapy related myelodysplastic syndrome
Krukenberg tumor	Vaginal intraepithelial neoplasia (VAIN III)
Letterer-Siwe disease	Vulvar intraepithelial neoplasia (VIN III)
Leukemia	Waldenstrom macroglobulinemia
Leukemic reticuloendotheliosis	

3.3 REPORTABLE BENIGN, BORDERLINE AND MALIGNANT INTRACRANIAL AND CENTRAL NERVOUS SYSTEM TUMORS

3.3.1 Anatomic Sites

Report the following anatomic sites for PRIMARY intracranial and central nervous system (CNS) tumors, REGARDLESS of behavior.

Abducens nerve	Falx, NOS
Accessory nerve, NOS	Filum terminale
Acoustic nerve	Fourth ventricle, NOS
Anterior cranial fossa	Frontal lobe
Arachnoid, NOS	Frontal pole
Basal ganglia	Globus pallidus
Basis pedunculi	Glossopharyngeal nerve
Brain, NOS	Hippocampus
Brain stem	Hypoglossal nerve
Cauda equina	Hypophysis
Central nervous system	Hypothalamus
Central white matter	Infratentorial brain, NOS
Cerebellopontine angle	Insula
Cerebellum, NOS	Internal capsule
Cerebral cortex	Intracranial arachnoid
Cerebral hemisphere	Intracranial meninges
Cerebral meninges	Intracranial site
Cerebral peduncle	Island of Reil
Cerebral ventricle	Lateral ventricle, NOS
Cerebral white matter	Lumbar cord
Cerebrum	Medulla oblongata
Cervical cord	Meninges, NOS
Choroid plexus, NOS	Midbrain
Choroid plexus of fourth ventricle	Middle cranial fossa
Choroid plexus of lateral ventricle	Nervous system, NOS
Choroid plexus of third ventricle	Occipital lobe
Conus medullaris	Occipital pole
Corpus callosum	Oculomotor nerve
Corpus striatum	Olfactory nerve
Cranial dura mater	Olive
Cranial fossa, NOS	Operculum
Cranial meninges	Optic chiasm
Cranial nerve, NOS	Optic nerve
Cranial pia mater	Optic tract
Craniopharyngeal duct	Other parts of brain
Dura, NOS	Overlapping lesion of brain
Dura mater, NOS	Overlapping lesion of brain and central nervous system
Ependymal	Pallium
Epidural	Parasellar
Extradural	Parietal lobe
Facial nerve	Pia mater, NOS
Falx cerebelli	Pineal gland
Falx cerebri	

Pituitary fossa
 Pituitary gland
 Pituitary, NOS
 Pons
 Posterior cranial fossa
 Putamen
 Pyramid
 Rathke pouch
 Rhinencephalon
 Sacral cord
 Sella turcica
 Spinal accessory nerve
 Spinal arachnoid
 Spinal cord
 Spinal dura mater
 Spinal meninges
 Spinal nerve root

Spinal pia mater
 Suprasellar
 Supratentorial brain, NOS
 Tapetum
 Temporal lobe
 Tentorium cerebelli
 Tentorium, NOS
 Thalamus
 Third ventricle, NOS
 Thoracic cord
 Trigeminal nerve
 Trochlear nerve
 Uncus
 Vagus nerve
 Ventricle, NOS
 Vermis of cerebellum

3.3.2 Histology/Morphology Terms

Report the following histology/morphology terms for PRIMARY intracranial and central nervous system (CNS) tumors, REGARDLESS of behavior.

Acoustic neuroma
 Acidophil adenoma
 Adenoma, NOS
 Angioblastic meningioma
 Angioblastoma
 Angiocentric immunoproliferative
 Lesion
 Angiocentric glioma
 Angiolipoma, NOS
 Angiomatous meningioma
 Atypical choroid plexus papilloma
 Atypical fibrous histiocytoma
 Atypical fibroxanthoma
 Atypical meningioma
 Basophil adenoma
 Capillary Hemangioma
 Cavernous Hemangioma
 Central neurocytoma
 Cerebellar neurocytoma
 Cerebellar liponeurocytoma
 Chordoid glioma of third ventricle
 Choroid plexus papilloma, NOS
 Chromophobe adenoma
 Craniopharyngioma
 Dermoid cyst, NOS
 Desmoplastic infantile astrocytoma and
 ganglioglioma
 Diffuse astrocytoma, IDH mutant

Diffuse meningiomatosis
 Dysembryoplastic neuroepithelial tumor
 Dysplastic gangliocytoma of cerebellum
 (D=Lhemitte-Duclos)
 Endotheliomatous meningioma
 Ependymoma
 Epithelioid hemangioendothelioma, NOS
 Extra-adrenal paraganglioma, NOS
 Extraventricular neurocytoma
 Fibroblastic meningioma
 Fibroma, NOS
 Fibrous histiocytoma, NOS
 Fibrous meningioma
 Fibroxanthoma, NOS
 Follicular Adenoma
 Gangliocytoma
 Ganglioglioma
 Ganglioneuroma
 Glioneuroma
 Granular cell tumor, NOS
 Hemangioblastic meningioma
 Hemangioblastoma
 Hemangioma
 Hemangioendothelioma, benign
 Hemangiopericytic meningioma
 Hemangiopericytoma, benign
 Hemangiopericytoma, NOS
 Hurthle cell adenoma

Hurthle cell tumor
 Langerhans Cell Histiocytosis
 Lipoma
 Lymphoproliferative disease, NOS
 Melanocytic Schwannoma
 Meningioma, NOS
 Meningiomatosis, NOS
 Meningotheliomatous meningioma
 Mesenchymoma, benign
 Mesenchymoma, NOS
 Microfollicular adenoma
 Mixed acidophil-basophil adenoma
 Mixed cell adenoma
 Mixed meningioma
 Monomorphic adenoma
 Mucoid cell adenoma
 Multiple meningiomas
 Multiple neurofibromatosis
 Myxopapillary ependymoma
 Neoplasm, benign
 Neoplasm, uncertain whether benign
 or malignant
 Neurilemmoma, NOS
 Neurinoma
 Neuroastrocytoma
 Neurocytoma
 Neurofibroma, NOS
 Neurofibromatosis, NOS
 Neurothekeoma
 Neuroma, NOS
 Oligodendroglioma IDH mutant and
 1p/19q-codeleted
 Oncocytic adenoma
 Oncocytoma
 Oxyphilic adenoma
 Papillary adenoma, NOS
 Papillary ependymoma
 Papillary glioneuronal tumor
 Papillary meningioma

Paraganglioma, NOS
 Perineuroma
 Pigmented Schwannoma
 Pilocytic/juvenile astrocytoma
 Pinealoma
 Pineoblastoma
 Pineocytoma
 Pituicytoma
 Pleomorphic xanthroastrocytoma
 Plexiform neurofibroma
 Plexiform neuroma
 Prolactinoma
 Psammomatous meningioma
 Rathke pouch tumor
 Recklinghausen disease (except of
 Bone)
 Rhabdomyoma, NOS
 Rosette-forming glioneuronal tumor
 Schwannoma, NOS
 Solitary fibrous tumor
 Soft tissue tumor, benign
 Spindle cell oncocytoma
 Subependymal astrocytoma
 Subependymal giant cell
 astrocytoma
 Subependymal glioma
 Subependymoma
 Syncytial meningioma
 Teratoma, NOS
 Teratoma, benign
 Transitional meningioma
 Tumor cells, benign
 Tumor cells, uncertain whether
 benign or malignant
 Tumorlets
 Von Recklinghausen disease (except
 of Bone)
 Xanthofibroma

3.4 WHAT IS NOT REPORTABLE TO THE NYSCR

3.4.1 History of

Do NOT report patients with a history of malignancy who are clinically free of disease.

If a patient with a history of breast cancer receives Tamoxifen therapy, report the case only if the breast cancer was the reason for admission (i.e., principal diagnosis).

Exception: When a history of malignancy case appears on a Death Certificate Only (DCO) list, follow it back to the NYSCR. The reason a case appears on a DCO list is because the

patient and/or tumor associated with that patient was not reported at the time of the original diagnosis. It is likely that the facility reconciling the DCO case will have limited documentation about the tumor and that numerous data fields will be coded as “unknown.” For more information on DCO cases, see Part 6.

3.4.2 Recurrence

A recurrent diagnosis is the SAME cancer arising in or from the SAME primary site where it appeared earlier and when it is NOT considered by the physician to be a new primary cancer. DO report a recurrent diagnosis if this is the first time seen at your facility. Do NOT report a recurrent diagnosis if you have previously reported the primary cancer. Report information related to the INITIAL diagnosis and ORIGINAL primary site for a case that is first seen at your facility with a recurrent cancer or metastatic disease.

3.4.3 Readmitted Patients

Do NOT report readmitted patients if you have previously reported that primary. If a patient is readmitted to your facility and new or additional metastatic sites are diagnosed and/or treated, the case is NOT reportable provided your facility previously has reported the ORIGINAL primary cancer. Review records of readmitted patients to determine if a NEW primary has been diagnosed. Report each new primary separately.

3.4.4 Basal and Squamous Cell Cancer of Skin

Basal and squamous cell cancer originating in SKIN (i.e., non-mucoepidermoid sites), is NOT reportable, regardless of stage at diagnosis.

3.4.5 “Evolving” Melanoma

Evolving melanoma and evolving melanoma in situ are not reportable. As per the Multiple Primary and Histology Coding Rules Manual, evolving melanoma are tumors of uncertain biologic behavior. Histological changes of borderline evolving melanoma are too subtle for a definitive diagnosis of melanoma in situ. The tumors may be described as "proliferation of atypical melanocytes confined to epidermal and adnexal epithelium," "atypical intraepidermal melanocytic proliferation," "atypical intraepidermal melanocytic hyperplasia"; or “severe melanocytic dysplasia.”

3.4.6 High Grade/Severe Dysplasia

High grade dysplasia is not reportable. Some pathologists use the terms “high grade/severe dysplasia” interchangeably with “carcinoma in situ”. High grade dysplasia should only be reported as carcinoma in situ when your facility’s pathologist verifies s/he considers them to be the same. When reporting such cases, document the histology as carcinoma in situ and include a comment that the behavior was confirmed with the pathologist.

3.5 GUIDELINES FOR INTERPRETATION OF EQUIVOCAL DIAGNOSTIC TERMINOLOGY

3.5.1 Ambiguous Terminology that Constitute a Diagnosis

Terms listed below ARE reportable*. These terms are NOT to be used when determining multiple primaries. The Multiple Primary/Histology manual contains a separate list of ambiguous terms:

Apparent(ly)	Neoplasm (C70.0-C72.9, C75.1-C75.3)
Appears	Presumed
Comparable with	Probable
Compatible with	Suspect(ed)
Consistent with	Suspicious (for)
Favors	Tumor (C70.0-C72.9, C75.1-C75.3)
Malignant appearing	Typical of
Most likely	

Exception: If a CYTOLOGY is identified only with one or more of the above ambiguous terms, do not interpret it as a diagnosis of cancer. Report the case only if the cytology findings are supported by a positive biopsy or a physician's clinical impression of cancer

When a RADIOLOGY report mentions a "suspicious mass", BUT there is no other documentation or mention of the mass in the medical record, do NOT report this case. The report is however, useful for casefinding, indicating the need to search for additional information to support the observation on the imaging report.

3.5.2 Ambiguous Terms That Do Not Constitute A Diagnosis

Terms listed below are NOT considered diagnostic of cancer without additional information. If a phrase such as "strongly suggestive," "highly worrisome," or "very possible" is used, disregard the modifying phrase (i.e., "strongly," "highly," "very"), and refer to the primary term (i.e., "suggestive," "worrisome," "possible") to determine involvement.

Cannot be ruled out	Questionable
Equivocal	Rule-out
Possible	Suggests
Potentially malignant	Worrisome

3.5.3 Coding reference priority

When the diagnosis is vague, inconclusive, or conflicting, the priority for coding reference, in descending order, is:

- 1) Pathology report
- 2) Operation report
- 3) Radiology or other diagnostic imaging techniques
- 4) Clinical observation

Note: When there are questions concerning terminology, consult the primary physician or pathologist.

3.6 RULES FOR DETERMINING MULTIPLE PRIMARIES FOR SOLID TUMORS

The NYSCR follows the SEER rules for determining multiple primaries for solid tumors. The current structure was revised with cases diagnosed January 1, 2018. Specific rules are outlined for Head and Neck, Colon, Lung, Cutaneous Melanoma, Breast, Kidney, Urinary (Renal Pelvis, Ureter and Bladder), and Malignant and Non-Malignant CNS tumors. One additional set of rules addresses all other sites not included in one of the site-specific rule sets. Electronic manuals with the new rules and associated data items are available on the [SEER Solid Tumor Rules](#) website.

3.7 RULES FOR DETERMINING MULTIPLE PRIMARIES FOR HEMATOPOIETIC AND LYMPHOID NEOPLASMS

The NYSCR also follows the SEER rules for determining multiple primaries for hematopoietic and lymphoid neoplasms. The current structure was implemented with cases diagnosed January 1, 2010. The rules set consists of both a database and manual. Each are available in either stand-alone or web-based versions via the [SEER Hematopoietic Project](#) website.

3.8 CASEFINDING LISTS FOR ICD-9-CM CODES

Use the following list as a guide for identifying cases that MAY be reportable to the NYSCR. Thoroughly review all available medical information to determine reportability.

ICD-9-CM Codes	Diagnosis (in preferred ICD-O-3 terminology)
042	AIDS (review cases for AIDS-related malignancies)
140.0 - 208.92	Malignant neoplasms
203.1	Plasma cell leukemia (9733/3)
205.1	Chronic neutrophilic leukemia (9963/3)
209.00 – 209.36	Malignant carcinoid/neuroendocrine tumors and Markel cell carcinoma
209.70-209.79	Secondary neuroendocrine tumors
210.0 - 229.9	Benign neoplasms
230.0 - 234.9	Carcinoma in situ
235.0 - 238.9	Neoplasms of uncertain behavior
237.73	Third Type-Schwannomatosis
237.79	Neurofibromatosis, other
238.4	Polycythemia vera (9950/3)
238.6	Solitary plasmacytoma (9731/3)
238.6	Extramedullary plasmacytoma (9734/3)
238.71	Essential thrombocythemia (9962/3)
238.72	Refractory cytopenia with multilineage dysplasia (9985/3)
238.71	Refractory anemia (9980/3)
238.72	Refractory anemia with ringed sideroblasts (9982/3)
238.73	High grade myelodysplastic syndrome lesions
238.72	Refractory anemia with excess blasts (9983/3)
238.72	Refractory anemia with excess blasts in transformation (9984/3)
238.74	Myelodysplastic syndrome with 5q- syndrome (9987/3)
238.75	Therapy-related myelodysplastic syndrome (9987/3)
238.76	Myelosclerosis with myeloid metaplasia (9961/3)
238.77	Post transplant lymphoproliferative disorder (9987/3)

ICD-9-CM Codes	Diagnosis (in preferred ICD-O-3 terminology)
238.79	Chronic myeloproliferative disease (9960/3)
239.0 - 239.9	Neoplasms of unspecified behavior
259.2	Carcinoid Syndrome
273.2	Gamma heavy chain disease; Franklin disease
273.3	Waldenstrom macroglobulinemia
273.9	Unspecified disorder of immune mechanism (screen for potential 273.3 miscodes)
288.3	Hypereosinophilic syndrome (9964/3)
289.6	Familial Polycythemia (per SEER, synonym for Polycythemia vera (9950/3))
289.83	Acute myelofibrosis (9931/3)
748.1	Astrocytoma, astroglioma, astroblastoma of nose
789.51	Malignant Ascites
V07.39	Other prophylactic chemotherapy (screen carefully for miscoded malignancies)
V10.0 - V10.9	Personal history of malignancy (review these for recurrences, subsequent primaries and/or subsequent treatment)
V50.41	Prophylactic organ removal, breast
V50.42	Prophylactic organ removal, ovary
V50.49	Prophylactic organ removal, other
V58.0	Admission for radiotherapy
V58.11	Admission for chemotherapy
V58.12	Admission for immunotherapy for neoplastic condition
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

Refer to ICD-O-3 for inclusive listing of morphology terms.

3.9 CASEFINDING LIST FOR ICD-10-CM CODES

Use the following list as a guide for identifying cases that MAY be reportable to the NYSCR. Thoroughly review all available medical information to determine reportability.

ICD-10-CM Codes	Description
B20	Human immunodeficiency virus [HIV] disease with other diseases
	Note: Excludes HIV with malignancy (B21), see reportable list
B97.33, B97.34, B97.35	Human T-cell lymphotropic virus, (type I [HTLV-1], type II [HTLV-II], type 2 [HIV 2]) as the cause of diseases classified elsewhere
B97.7	Papillomavirus as the cause of diseases classified elsewhere
C00._ - C43._, C4A._, C45._ - C48._, C49._ - C96._	Malignant neoplasms (excluding category C44 and C49.A), stated or presumed to be primary (of specified site) and certain specified histologies <i>NEW for FY2018:</i> <i>C96.20 Malignant mast cell neoplasm, unspecified</i> <i>C96.21 Aggressive systemic mastocytosis</i> <i>C96.22 Mast cell sarcoma</i> <i>C96.29 Other malignant cell neoplasm</i>
C44.00, C44.09	Unspecified/other malignant neoplasm of skin of lip
C44.01, C44.02	Basal/squamous cell carcinoma of skin of lip
C44.10_, C44.19_	Unspecified/other malignant neoplasm of skin of eyelid
C44.20_, C44.29_	Unspecified/other malignant neoplasm skin of ear and external auricular canal
C44.21_, C44.22_	Basal/squamous cell carcinoma of skin of ear and external auricular canal
C44.30_, C44.39_	Unspecified/other malignant neoplasm of skin of other/unspecified parts of face
C44.31_, C44.32_	Basal/squamous cell carcinoma of skin of other and unspecified parts of face
C44.40, C44.49	Unspecified/other malignant neoplasm of skin of scalp & neck
C44.50_, C44.59_	Unspecified/other malignant neoplasm of skin of trunk
C44.60_, C44.69_	Unspecified/other malignant neoplasm of skin of upper limb, including shoulder
C44.70_, C44.79_	Unspecified/other malignant neoplasm of skin of lower limb, including hip
C44.80, C44.89	Unspecified/other malignant neoplasm of skin of overlapping sites of skin
C44.90, C44.99	Unspecified/other malignant neoplasm of skin of unspecified sites of skin

ICD-10-CM Codes	Description
C49.A	Gastrointestinal Stromal Tumors Note: GIST is only reportable when it is malignant (/3). GIST, NOS (not stated whether malignant or benign) is a /1 and is not reportable
D00._ – D09._	In-situ neoplasms (<i>Note: Carcinoma in situ of the cervix (CIN III-8077/2) and Prostatic Intraepithelial Carcinoma (PIN III-8148/2) are not reportable</i>).
D3A._	Benign carcinoid tumors
D10._ – D31._, D33._ D34, D35.0, D35.1, D35.5_ D35.9, D36._	Benign neoplasms (see “must collect” list for reportable benign neoplasms) Note: Screen for incorrectly coded malignancies or reportable by agreement tumors
D18.01	Lymphangioma, any site (<i>Note: Includes Lymphangiomas of Brain, Other parts of nervous system and endocrine glands, which are reportable</i>)
D18.02	Hemangioma of intracranial structures and any site
D32._	Benign neoplasm of meninges (cerebral, spinal and unspecified)
D33._	Benign neoplasm of brain and other parts of central nervous system
D35.2 - D35.4	Benign neoplasm of pituitary gland, craniopharyngeal duct and pineal gland
D37._ – D41._	Neoplasms of uncertain or unknown behavior (see “must collect” list for reportable neoplasms of uncertain or unknown behavior) Note: Screen for incorrectly coded malignancies or reportable by agreement tumors
D42._, D43._	Neoplasm of uncertain or unknown behavior of meninges, brain, CNS
D44.0 – D44.2, D44.6 – D44.9	Neoplasm of uncertain or unknown behavior of other endocrine glands Note: Screen for incorrectly coded malignancies or reportable by agreement tumors
D44.3 – D44.5	Neoplasm of uncertain or unknown behavior of pituitary gland, craniopharyngeal duct and pineal gland
D45	Polycythemia vera (9950/3) <i>ICD-10-CM Coding instruction note: Excludes familial polycythemia (C75.0), secondary polycythemia (D75.1)</i>
D46._	Myelodysplastic syndromes (9980, 9982, 9983, 9985, 9986, 9989, 9991, 9992)
D47.0	Histiocytic and mast cell tumors of uncertain behavior
D47.01	Cutaneous mastocytosis (9740/1) Note: Effective 10/1/2017

ICD-10-CM Codes	Description
D47.09	Other mast cell neoplasms of uncertain behavior Note: Effective 10/1/2017
D47.1	Chronic myeloproliferative disease (9963/3)
D47.2	Monoclonal gammopathy Note: Screen for incorrectly coded Waldenstrom macroglobulinemia
D47.3	Essential (hemorrhagic) thrombocythemia (9962/3) <i>Includes: Essential thrombocytosis, idiopathic hemorrhagic thrombocythemia</i>
D47.Z_	Neoplasm of uncertain behavior of lymphoid, hematopoietic and related tissue, unspecified (9960/3, 9970/1, 9971/3, 9931/3)
D47.Z2	Castleman disease
D47.9	Neoplasm of uncertain behavior of lymphoid, hematopoietic and related tissue, unspecified (9970/1, 9931/3)
D48._	Neoplasm of uncertain behavior of other and unspecified sites
D49.6, D49.7	Neoplasm of unspecified behavior of brain, endocrine glands and other CNS
D49.0 – D49.9	Neoplasm of unspecified behavior (except for D49.6 and D49.7)
D61.1	Drug-induced aplastic anemia (also known as “ <i>aplastic anemia due to antineoplastic chemotherapy</i> ”) <i>ICD-10-CM Coding instruction note: Use additional code for adverse effect, if applicable, to identify drug</i>
D61.18_	Pancytopenia
D61.810	Antineoplastic chemotherapy induced pancytopenia
D61.82	Myelophthisis <i>ICD-10-CM Coding instruction: Code first the underlying disorder, such as: malignant neoplasm of breast (C50._)</i>
D63.0	Anemia in neoplastic disease <i>ICD-10-CM Coding instruction: Code first neoplasm (C00-C49)</i>
D64.81	Anemia due to antineoplastic chemotherapy
D69.49, D69.59, D69.6	Other thrombocytopenia Note: Screen for incorrectly coded thrombocythemia
D70.1	Agranulocytosis secondary to cancer chemotherapy <i>ICD-10-CM Coding instruction: Code also underlying neoplasm</i>
D72.1	Eosinophilia <i>(Note: Code for eosinophilia (9964/3). Not every case of eosinophilia is a malignancy. Reportable Diagnosis is "Hypereosinophilic syndrome.")</i>
D75.81	Myelofibrosis (note: this is not primary myelofibrosis [9961/3]) <i>ICD-10-CM Coding instruction note: Code first the underlying disorder, such as: malignant neoplasm of breast (C50._)</i>

ICD-10-CM Codes	Description
D76._	Other specified diseases with participation of lymphoreticular and reticulohistiocytic tissue
D89.0, D89.1	Other disorders involving the immune mechanism, not elsewhere classified <i>Note: Review for miscodes</i>
D89.4	Mast cell activation syndrome and related disorders <i>Note: Review for miscodes</i>
E08	Diabetes mellitus due to underlying condition <i>ICD-10-CM Coding instruction note: Code first the underlying condition, such as: malignant neoplasm (C00-C96)</i>
E31.2_	Multiple endocrine neoplasia [MEN] syndromes <i>ICD-10-CM Coding instruction: Code also any associated malignancies and other conditions associated with the syndromes</i>
E34.0	Carcinoid syndrome <i>ICD-10-CM Coding instruction: May be used as an additional code to identify functional activity associated with a carcinoid tumor</i>
E83.52	Hypercalcemia
E88.09	Other disorders of plasma-protein metabolism, not elsewhere classified
E88.3	Tumor lysis syndrome (following antineoplastic chemotherapy)
G13.0	Paraneoplastic neuromyopathy and neuropathy <i>ICD-10-CM Coding instruction note: Code first underlying neoplasm (C00-D49)</i>
G13.1	Other systemic atrophy primarily affecting central nervous system in neoplastic disease <i>ICD-10-CM Coding instruction note: Code first underlying neoplasm (C00-D49)</i>
G32.8	Other specified degenerative disorders of nervous system in diseases classified elsewhere <i>ICD-10-CM Coding instruction note: Code first underlying disease, such as: cerebral degeneration (due to) neoplasm (C00-D49)</i>
G53	Cranial nerve disorders in diseases classified elsewhere <i>Note: Code first underlying neoplasm (C00-D49)</i>
G55	Nerve root and plexus compressions in diseases classified elsewhere <i>ICD-10-CM Coding instruction note: Code also underlying disease, such as neoplasm (C00-D49)</i>
G63	Polyneuropathy in diseases classified elsewhere <i>ICD-10-CM Coding instruction note: Code first underlying disease, such as: neoplasm (C00-D49)</i>
G73.1	Lambert-Eaton syndrome in neoplastic disease <i>ICD-10-CM Coding instruction: Code first underlying neoplasm (C00-D49)</i>
G89.3	Neoplasm related pain (acute)(chronic)

ICD-10-CM Codes	Description
G99.2	Myelopathy in diseases classified elsewhere <i>ICD-10-CM Coding instruction: Code first underlying disease, such as: neoplasm (C00-D49)</i>
H47.42	Disorders of optic chiasm in (due to) neoplasm <i>ICD-10-CM Coding instruction: Code also underlying condition</i>
H47.52_	Disorders of visual pathways in (due to) neoplasm <i>ICD-10-CM Coding instruction: Code also underlying condition</i>
H47.63_	Disorders of visual cortex in (due to) neoplasm <i>ICD-10-CM Coding instruction: Code also underlying condition</i>
J34.81	Nasal mucositis (ulcerative)
J91.0	Malignant pleural effusion <i>ICD-10-CM Coding instruction: Code first underlying neoplasm</i>
J93.12	Secondary spontaneous pneumothorax <i>ICD-10-CM Coding instruction: Code first underlying condition, such as: Malignant neoplasm of bronchus and lung (C34._) Secondary malignant neoplasm of lung (C78.0_)</i>
K12.31	Oral mucositis (ulcerative) due to antineoplastic therapy
K12.33	Oral mucositis (ulcerative) due to radiation
K22.711	Barrett's esophagus with high grade dysplasia
K62.7	Radiation proctitis
K62.82	Dysplasia of anus (AIN I and AIN II)
K92.81	Gastrointestinal mucositis (ulcerated) (due to antineoplastic therapy)
M36.0	Dermato(poly)myositis in neoplastic disease <i>ICD-10-CM Coding instruction: Code first underlying neoplasm (C00-D49)</i>
M36.1	Arthropathy in neoplastic disease <i>ICD-10-CM Coding instruction: Code first underlying neoplasm, such as: Leukemia (C91-C95), malignant histiocytosis (C96.A), multiple myeloma (C90.0)</i>
M84.5_	Pathologic fracture in neoplastic disease <i>ICD-10-CM Coding instruction: Code also underlying neoplasm (C00-D49)</i>
M90.6_	Osteitis deformans in neoplastic disease <i>ICD-10-CM Coding instruction: Code first the neoplasm (C40._, C41._)</i>
N42.3	Dysplasia of prostate (PIN I and PIN II)
N76.81	Mucositis (ulcerative) of vagina and vulva
N87._	Dysplasia of cervix uteri (CIN I and CIN II)
N89.0, N89.1, N89.3	Vaginal dysplasia (VIN I and VIN II)
N90.0, N90.1, N90.3	Vulvar dysplasia (VAIN I and VAIN II)

ICD-10-CM Codes	Description
O01._	Hydatidiform mole Note: Benign tumor that can become malignant. If malignant, report as Choriocarcinoma (9100/3,) malignancy code in the C00- C97 range
O9A.1_	Malignant neoplasm complicating pregnancy, childbirth and the puerperium (conditions in C00-C96) <i>ICD-10-CM Coding instruction: Use additional code to identify neoplasm</i>
Q85.0_	Neurofibromatosis (nonmalignant) (9540/1) <i>Note: Neurofibromatosis is not cancer. These tumors can be precursors to acoustic neuromas, which are reportable</i>
R18.0	Malignant ascites <i>ICD-10-CM Coding instruction: Code first malignancy, such as: Malignant neoplasm of ovary (C56._), secondary malignant neoplasm of retroperitoneum and peritoneum (C78.6)</i>
R53.0	Neoplastic (malignant) related fatigue <i>ICD-10-CM Coding instruction: Code first associated neoplasm</i>
R59._	Enlarged lymph nodes
R85.6_	Abnormal findings on cytological and histological examination of digestive organs <i>Note: see "must collect" list for R85.614</i>
R85.614	Cytologic evidence of malignancy on smear of anus
R87.61_, R87.62_	Abnormal findings on cytological/histological examination of female genital organs <i>Note: see "must collect" list for R87.614 and R87.624</i>
R87.614	Cytologic evidence of malignancy on smear of cervix
R87.624	Cytologic evidence of malignancy on smear of vagina
(92._	Abnormal findings on diagnostic imaging of breast
R97._	Abnormal tumor markers
T38.6_	Poisoning by antigonadotropins, antiestrogens, antiandrogens, not elsewhere classified
T38.8_, T38.9_	Poisoning by hormones and their synthetic substitutes
T45.1_	Poisoning by, adverse effect of and under dosing of antineoplastic and immunosuppressive drugs
T45.8_, T45.9_	Poisoning by primary systemic and hematological agent, unspecified
T66	Unspecified effects of radiation
T80.1	Vascular complications following infusion, transfusion and therapeutic injection
T80.2_	Infections following infusion, transfusion and therapeutic injection
T80.810	Extravasation of vesicant antineoplastic chemotherapy
T80.818	Extravasation of other vesicant agent

ICD-10-CM Codes	Description
T86.0	Complications of bone marrow transplant <i>ICD-10-CM Coding instruction: Use addition code to identify other transplant complications, such as: malignancy associated with organ transplant (C80.2) or post-transplant lymphoproliferative disorders (PTLD) (D47.Z1)</i>
Y63.2	Overdose of radiation given during therapy
Y84.2	Radiological procedure and radiotherapy as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure
Z03.89	Encounter for observation for other suspected diseases and conditions ruled out
Z08	Encounter for follow-up examination after completed treatment for malignant neoplasm (medical surveillance following completed treatment) <i>ICD-10-CM Coding instruction: Use additional code to identify the personal history of malignant neoplasm (Z85._)</i>
Z12._	Encounter for screening for malignant neoplasms
Z13.0	Encounter for screening for diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism
Z15.0	Genetic susceptibility to malignant neoplasm <i>ICD-10-CM Coding instruction: Code first, if applicable, any current malignant neoplasm (C00-C75, C81-C96); Use additional code, if applicable, for any personal history of malignant neoplasm (Z85._)</i>
Z17.0, Z17.1	Estrogen receptor positive and negative status
Z40.0_	Encounter for prophylactic surgery for risk factors related to malignant neoplasms
Z42.1	Encounter for breast reconstruction following mastectomy
Z48.3	Aftercare following surgery for neoplasm <i>ICD-10-CM Coding instruction: Use additional code to identify the neoplasm</i>
Z48.290	Encounter for aftercare following bone marrow transplant
Z51.0	Encounter for antineoplastic radiation therapy
Z51.1_	Encounter for antineoplastic chemotherapy and immunotherapy
Z51.5, Z51.89	Encounter for palliative care and other specified aftercare
Z79.81	Long term (current) use of agents affecting estrogen receptors and estrogen levels <i>ICD-10-CM Coding instruction: Code first, if applicable, malignant neoplasm of breast (C50._), malignant neoplasm of prostate (C61)</i>
Z80._	Family history of primary malignant neoplasm
Z85._	Personal history of malignant neoplasm
Z86.0_, Z86.01_, Z86.03	Personal history of in situ and benign neoplasms and neoplasms of uncertain behavior

ICD-10-CM Codes	Description
Z92.21, Z29.23, Z92.25, Z92.3	Personal history of antineoplastic chemotherapy, estrogen therapy, immunosuppression therapy or irradiation (radiation)
Z94.81, Z94.84	Bone marrow and stem cell transplant status

3.10 REPORTABLE TERMS LIST

The following list identifies MOST of the NYSCR's reportable terms. This list is not comprehensive. Refer to the footnotes at the bottom of each page for explanations of the various font types used in the list. The DEFINITIVE references are the Solid Tumor Rules and 2018 ICD-O Update.

REPORTABLE LIST:

<u>A</u>	
Acidophil adenocarcinoma	Acute lymphatic leukemia
ACIDOPHIL ADENOMA	Acute lymphoblastic leukemia, Burkitt type
Acidophil-basophil carcinoma, mixed	Acute lymphoblastic leukemia, L2 type, NOS
Acidophil carcinoma	Acute lymphoblastic leukemia, mature B-cell type
Acinar adenocarcinoma	Acute lymphoblastic leukemia, NOS
Acinar adenocarcinoma, Sarcomatoid (C61.9)	Acute lymphoblastic leukemia, precursor-cell type
Acinar carcinoma	Acute lymphocytic leukemia
Acinar cell carcinoma	Acute lymphoblastic leukemia-lymphoma, NOS
Acinar cell cystadenocarcinoma	Acute lymphoid leukemia
Acinic cell adenocarcinoma	Acute megakaryoblastic leukemia
ACOUSTIC NEUROMA	Acute mixed lineage leukemia
Acquired cystic disease-associated renal cell carcinoma (C64.9)	Acute monoblastic leukemia
Acral lentiginous melanoma, malignant	Acute monocytic leukemia
Acute basophilic leukemia	Acute myeloblastic leukemia
Acute bilineal leukemia	Acute myeloblastic leukemia
Acute biphenotypic leukemia	Acute myelocytic leukemia
Acute differentiated progressive histiocytosis	Acute myelocytic leukemia with maturation
Acute erythremia [obs]	Acute myelofibrosis
Acute erythremic myelosis [obs]	Acute myelogenous leukemia
Acute erythroid leukemia	
Acute granulocytic leukemia	
Acute leukemia, NOS	

Refer to ICD-O-3 for inclusive listing of morphology terms.

*Non-reportable if skin of non-mucoepidermoid anatomic site (ICD-O-3: C44_)

Bold indicates a term that is reportable with cases diagnosed on or after 1/1/2001

SMALL CAPS indicate benign/borderline/uncertain tumors that are reportable if they occur intracranially or in the central nervous system

BOLD SMALL CAPS indicate a term that was NOT reportable between 1/1/2001 and 12/31/2002; and was reportable before 1/1/2001 AND on or after 1/1/2003 (applicable to ovarian primaries only).

[obs] = Obsolete

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Acute myeloid leukemia
 Acute myeloid leukemia with abnormal marrow eosinophils (includes all variants)
 Acute myeloid leukemia with maturation
 Acute myeloid leukemia with multilineage dysplasia
 Acute myeloid leukemia (megakaryoblastic) with t(1;22)(p13;q13); RBM15-MKL1
 Acute myeloid leukemia without maturation
 Acute myeloid leukemia, 11q23 abnormalities
 Acute myeloid leukemia, AML1 (CBF-alpha) / ETO
 Acute myeloid leukemia, CBF-beta/MYH11
 Acute myeloid leukemia, inv(16)(p13;q22)
 Acute myeloid leukemia with inv(3)(q21q26.2) or t(3;3)(q21;q26.2); RPN1EVI1
 Acute myeloid leukemia, M6 type
 Acute myeloid leukemia, minimal differentiation
 Acute myeloid leukemia, MLL
 Acute myeloid leukemia, NOS (FAB or WHO type not specified)
 Acute myeloid leukemia, PML/RAR-alpha
 Acute myeloid leukemia, t(15;17)(q22;q11-12)
 Acute myeloid leukemia, t(16;16)(p13;q11)
 Acute myeloid leukemia, t(8;21)(q22;q22)
 Acute myeloid leukemia with prior myelodysplastic syndrome
 Acute myeloid leukemia with t(6;9)(p23;q34) DEK-NUP214
 Acute myeloid leukemia without prior myelodysplastic syndrome
 Acute myelomonocytic leukemia

Acute myelomonocytic leukemia with abnormal eosinophils
 Acute myelosclerosis
 Acute non-lymphocytic leukemia
 Acute panmyelosis
 Acute panmyelosis with myelofibrosis (C42.1)
 Acute progressive histiocytosis X
 Acute promyelocytic leukemia
 Acute promyelocytic leukemia, PML/RAR-alpha
 Acute promyelocytic leukemia, t(15;17)(q22;q11-12)
 Adamantinoma, NOS
 Adamantinoma of long bones
 Adenoacanthoma
 Adenocarcinoid tumor
 Adenocarcinoma and epidermoid carcinoma mixed
 Adenocarcinoma and squamous cell carcinoma, mixed
 Adenocarcinoma combined with other types of carcinoma
 Adenocarcinoma in a polyp, NOS
 Adenocarcinoma in a polypoid adenoma
 Adenocarcinoma in adenomatous polyp
 Adenocarcinoma in adenomatous polyposis coli
 Adenocarcinoma in multiple adenomatous polyps
 Adenocarcinoma in situ in a polyp, NOS
 Adenocarcinoma in situ in adenomatous polyp
 Adenocarcinoma in situ in polypoid adenoma
 Adenocarcinoma in situ in tubular adenoma
 Adenocarcinoma in situ in tubulovillous adenoma
 Adenocarcinoma in situ in villous adenoma
 Adenocarcinoma in situ, NOS
 Adenocarcinoma in tubular adenoma

Refer to ICD-O-3 for inclusive listing of morphology terms.

*Non-reportable if skin of non-mucoepidermoid anatomic site (ICD-O-3: C44_)

Bold indicates a term that is reportable with cases diagnosed on or after 1/1/2001

SMALL CAPS indicate benign/borderline/uncertain tumors that are reportable if they occur intracranially or in the central nervous system

BOLD SMALL CAPS indicate a term that was NOT reportable between 1/1/2001 and 12/31/2002; and was reportable before 1/1/2001 AND on or after 1/1/2003 (applicable to ovarian primaries only).

[obs] = Obsolete

Adenocarcinoma in tubulovillous adenoma
 Adenocarcinoma in villous adenoma
 Adenocarcinoma of anal ducts (C21.1)
 Adenocarcinoma of anal glands (C21.1)
 Adenocarcinoma of rete ovarii (C56.9)
 Adenocarcinoma with apocrine metaplasia
 Adenocarcinoma with cartilaginous and osseous metaplasia
 Adenocarcinoma with cartilaginous metaplasia
 Adenocarcinoma with mixed subtypes
 Adenocarcinoma with neuroendocrine differentiation
 Adenocarcinoma with osseous metaplasia
 Adenocarcinoma with spindle cell metaplasia
 Adenocarcinoma with squamous metaplasia
 Adenocarcinoma, cylindroid
 Adenocarcinoma, diffuse type
 Adenocarcinoma, endocervical type
 Adenocarcinoma, intestinal type
 Adenocarcinoma, NOS
 Adenocarcinoma, pancreatobiliary-type (C24.1)
 Adenocystic carcinoma
 Adenoid basal carcinoma (C53. _)
 Adenoid cystic carcinoma
 Adenoid squamous cell carcinoma*
 ADENOMA, NOS
 Adenomyoepithelioma with carcinoma (C50. _)
 Adenosarcoma
 Adenosquamous carcinoma
 Adnexal carcinoma
 Adrenal cortical adenocarcinoma
 Adrenal cortical carcinoma
 Adrenal cortical tumor, malignant
 Adrenal medullary paraganglioma, malignant (C74.1)
 Adult T-cell leukemia
 Adult T-cell leukemia/lymphoma

Adult T-cell leukemia/lymphoma (HTLV-1 positive) Includes all variants
 Adult T-cell lymphoma
 Adult T-cell lymphoma/leukemia
 Aggressive NK-cell leukemia
 Agnogenic myeloid metaplasia
 AIN II-III (anal intraepithelial neoplasia, grade II-III)
 AIN III (C21.1)
 Aleukemic granulocytic leukemia [obs]
 Aleukemic leukemia, NOS [obs]
 Aleukemic lymphatic leukemia [obs]
 Aleukemic lymphocytic leukemia [obs]
 Aleukemic lymphoid leukemia [obs]
 Aleukemic monocytic leukemia [obs]
 Aleukemic myelogenous leukemia [obs]
 Aleukemic myeloid leukemia [obs]
 ALK positive large B-cell lymphoma
 Alpha cell tumor, malignant
 Alpha heavy chain disease
 Alveolar adenocarcinoma
 Alveolar carcinoma
 Alveolar cell carcinoma
 Alveolar rhabdomyosarcoma
 Alveolar soft part sarcoma
 Amelanotic melanoma
 Ameloblastic carcinoma
 Ameloblastic fibrodentinosa sarcoma
 Ameloblastic fibro-odontosarcoma
 Ameloblastic odontosarcoma
 Ameloblastic sarcoma
 Ameloblastoma, fibrosarcoma
 Ameloblastoma, malignant
 AML M6
 Anal intraepithelial neoplasia, grade II-III (AIN III) (C21.1)
 Anaplastic astrocytoma, IDH-mutant (C71. _)
 Anaplastic astrocytoma, IDH-wildtype (C71. _)
 Anaplastic large B-cell lymphoma
 Anaplastic large cell lymphoma, CD30+
 Anaplastic large cell lymphoma, NOS
 Anaplastic large cell lymphoma, T cell and Null cell type

Refer to ICD-O-3 for inclusive listing of morphology terms.

*Non-reportable if skin of non-mucoepidermoid anatomic site (ICD-O-3: C44. _)

Bold indicates a term that is reportable with cases diagnosed on or after 1/1/2001

SMALL CAPS indicate benign/borderline/uncertain tumors that are reportable if they occur intracranially or in the central nervous system

BOLD SMALL CAPS indicate a term that was NOT reportable between 1/1/2001 and 12/31/2002; and was reportable before 1/1/2001 AND on or after 1/1/2003 (applicable to ovarian primaries only).

[obs] = Obsolete

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Anaplastic oligoastrocytoma (C71._)
 Anaplastic oligodendroglioma, IDH-mutant
 and 1p/19q-codeleted (C71._)
 Anaplastic pleomorphic
 xanthoastrocytoma (C71._)
 Androblastoma, malignant
 ANGIOBLASTIC MENINGIOMA
 ANGIOBLASTOMA
 ANGIOCENTRIC GLIOMA
 ANGIOCENTRIC IMMUNOPROLIFERATIVE
 LESION
 Angiocentric T-cell lymphoma [obs]
 Angioendotheliomatosis
 Angioimmunoblastic lymphoma
 Angioimmunoblastic T-cell lymphoma
 ANGIOLIPOMA, NOS
 ANGIOMATOUS MENINGIOMA
 Angiomyosarcoma
 Angiosarcoma
 Angiotropic lymphoma
 Apocrine adenocarcinoma
 Argentaffinoma, malignant
 Arrhenoblastoma, NOS
 Askin tumor
 Astroblastoma
 Astrocytic glioma
 Astrocytoma
 Astrocytoma, anaplastic
 Astrocytoma, low grade (C71._)
 Astroglioma
 Atypical carcinoid
 Atypical carcinoid tumor
 Atypical choroid plexus papilloma
 Atypical chronic myeloid leukemia,
 BCR/ABL1 negative
 Atypical chronic myeloid leukemia,
 Philadelphia chromosome (Ph1)
 negative
 ATYPICAL FIBROUS HISTIOCYTOMA
 ATYPICAL FIBROXANTHOMA
 Atypical medullary carcinoma (C50._)
 Atypical meningioma
 ATYPICAL PROLIFERATIVE MUCINOUS TUMOR
 ATYPICAL PROLIFERATIVE PAPILLARY
 SEROUS TUMOR

ATYPICAL PROLIFERATING SEROUS TUMOR
 Atypical teratoid/rhabdoid tumor
 Atypical teratoid/rhabdoid tumor (C71._)
B
 B cell lymphoma, NOS
 B lymphoblastic leukemia/lymphoma with
 t(12;21)(p13;q22; TEL-AML1 (ETV6-
 RUNX1)
 B lymphoblastic leukemia/lymphoma with
 t(9;22)(q34;q11.2); BCR-ABL1
 B lymphoblastic leukemia/lymphoma with
 t(v;11q23); MLL rearranged
 B lymphoblastic leukemia/lymphoma,
 NOS
 B lymphoblastic leukemia/lymphoma with
 hyperdiploidy
 B lymphoblastic leukemia/lymphoma with
 hypodiploidy (hypodiploid ALL)
 B lymphoblastic leukemia/lymphoma with
 t(1;19)(q23;p13.3); E2A PBX1 (TCF3
 PBX1)
 B lymphoblastic leukemia/lymphoma with
 t(5;14)(q31;q32); IL3-IGH
 B lymphoblastic leukemia/lymphoma, not
 otherwise specified
 B-ALL [obs]
 Balloon cell melanoma
 BALT Lymphoma
 Basal cell adenocarcinoma
 Basal cell carcinoma*
 Basal cell carcinoma, fibroepithelial*
 Basal cell carcinoma, morpheic*
 Basal cell epithelioma*
 Basaloid carcinoma
 Basaloid squamous cell carcinoma
 Basal-squamous cell carcinoma, mixed*
 Basophil adenocarcinoma
 BASOPHIL ADENOMA
 Basophil carcinoma
 Basophilic leukemia
 Basosquamous carcinoma*
 B-cell chronic lymphocytic
 leukemia/small lymphocytic
 lymphoma
 Bednar tumor

Refer to ICD-O-3 for inclusive listing of morphology terms.

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Bellini duct carcinoma (C64.9)
 Beta cell tumor, malignant
 Bile duct adenocarcinoma
 Bile duct carcinoma
 Bile duct cystadenocarcinoma
 Biliary intraepithelial neoplasia 3 (8148/2)
 Biliary intraepithelial neoplasia, high grade (8148/2)
 Biphenotypic sinonasal sarcoma
 Blast cell leukemia
 Blastoma, NOS*
 Blue nevus, malignant
 Botryoid sarcoma
 Brenner tumor, malignant
 Bronchial adenoma, carcinoid
 Bronchial adenoma, cylindroid
 Bronchial-associated lymphoid tissue lymphoma
 Bronchiolar adenocarcinoma
 Bronchiolar carcinoma
 Bronchiolo-alveolar adenocarcinoma
 Bronchiolo-alveolar carcinoma
 Bronchiolo-alveolar carcinoma, Clara cell (C34._)
 Bronchiolo-alveolar carcinoma, Clara cell and goblet cell type (C34._)
 Bronchiolo-alveolar carcinoma, goblet cell type (C34._)
 Bronchiolo-alveolar carcinoma, indeterminate type (C34._)
 Bronchiolo-alveolar carcinoma, mixed mucinous and non-mucinous (C34._)
 Bronchiolo-alveolar carcinoma, mucinous (C34._)
 Bronchiolo-alveolar carcinoma, non-mucinous (C34._)
 Bronchiolo-alveolar carcinoma, type II pneumocyte (C34._)
 Bronchiolo-alveolar carcinoma, type II pneumocyte and goblet cell type (C34._)
 Burkitt cell leukemia
 Burkitt-like lymphoma
 Burkitt lymphoma, NOS
 Burkitt tumor

C

C cell carcinoma
 C cell carcinoma (C73.9)
 C-ALL
 Cancer*
 CAPILLARY HEMANGIOMA
 Carcinofibroma
 Carcinoid, NOS (including appendix, effective with 2015 diagnoses)
 Carcinoid tumor, argentaffin, malignant
 Carcinoid tumor, NOS (including appendix, effective with 2015 diagnoses)
 Carcinoma in a polyp, NOS
 Carcinoma in adenomatous polyp
 Carcinoma in pleomorphic adenoma
 Carcinoma in situ in a polyp, NOS
 Carcinoma in situ in adenomatous polyp
 Carcinoma in situ, NOS*
 Carcinoma showing thymus-like differentiation
 Carcinoma showing thymus-like element
 Carcinoma simplex
 Carcinoma with apocrine metaplasia
 Carcinoma with chondroid differentiation (C50._)
 Carcinoma with neuroendocrine Differentiation
 Carcinoma with osseous differentiation (C50._)
 Carcinoma with osteoclast-like giant Cells
 Carcinoma with other types mesenchymal differentiation (C50._)
 Carcinoma with productive fibrosis
 Carcinoma, anaplastic*
 Carcinoma, diffuse type
 Carcinoma, intestinal type
 Carcinoma, NOS*
 Carcinoma, undifferentiated*
 Carcinosarcoma, embryonal
 Carcinosarcoma, NOS
 CASTLE
 CAVERNOUS ANGIOMA
 CAVERNOUS HEMANGIOMA

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CD30+ lymphoproliferative disorder
 Cell adenocarcinoma, mixed
 Cellular ependymoma (C71._)
 Central neuroblastoma (C71._)
 Central neurocytoma
 Central osteosarcoma (C40._, C41._)
 Central primitive neuroectodermal tumor, NOS (C71._)
 Cerebellar liponeurocytoma
 Cerebellar sarcoma, NOS
 Ceruminous adenocarcinoma
 Ceruminous carcinoma
 Chloroma
 Cholangiocarcinoma
 Cholangiocarcinoma and hepatocellular carcinoma, combined
 Chondroblastic osteosarcoma
 Chondroblastoma, malignant
 Chondroid chordoma
 Chondrosarcoma grade II/III (grade 2/3)
 Chondrosarcoma, NOS
 Chordoid glioma of third ventricle
 Chordoma
 Choriocarcinoma combined with embryonal carcinoma
 Choriocarcinoma combined with other germ cell elements
 Choriocarcinoma combined with teratoma
 Choriocarcinoma, NOS
 Choroid epithelioma
 Choroid plexus carcinoma (C71.5)
 Choroid plexus papilloma, anaplastic
 Choroid plexus papilloma, malignant
 CHOROID PLEXUS PAPILLOMA, NOS
 Chromophobe adenocarcinoma
 CHROMOPHOBE ADENOMA
 Chromophobe carcinoma
 Chromophobe cell renal carcinoma (C64.9)
 Chronic eosinophilic leukemia
 Chronic erythremia [obs]
 Chronic granulocytic leukemia
 Chronic granulocytic leukemia, BCR/ABL

Chronic granulocytic leukemia, Philadelphia chromosome (Ph1) positive
 Chronic granulocytic leukemia, T (9;22)(q34;q11)
 Chronic idiopathic myelofibrosis
 Chronic leukemia, NOS [obs]
 Chronic lymphatic leukemia
 Chronic lymphocytic leukemia
 Chronic lymphocytic leukemia, B-cell type (includes all variants of BCLL)
 Chronic lymphoid leukemia
 Chronic monocytic leukemia [obs]
 Chronic myelocytic leukemia
 Chronic myelomonocytic leukemia, NOS
 Chronic myelogenous leukemia
 Chronic myelogenous leukemia, BCR/ABL1 positive
 Chronic myelogenous leukemia, Philadelphia chromosome (Ph1) positive
 Chronic myelogenous leukemia, t(9;22)(q34;q11)
 Chronic myeloid leukemia
 Chronic myelomonocytic leukemia
 Chronic myelomonocytic leukemia in transformation [obs]
 Chronic myelomonocytic leukemia, NOS
 Chronic myelomonocytic leukemia, Type I
 Chronic myelomonocytic leukemia, Type II
Chronic myeloproliferative disease, NOS
Chronic myeloproliferative disorder
 Chronic neutrophilic leukemia
 Circumscribed arachnoidal cerebellar sarcoma
 Classical Hodgkin lymphoma, lymphocyte depletion, diffuse fibrosis
 Classical Hodgkin lymphoma, lymphocyte depletion, NOS
 Classical Hodgkin lymphoma, lymphocyte depletion, reticular

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Classical Hodgkin lymphoma, lymphocyte-rich
 Classical Hodgkin lymphoma, mixed cellularity, NOS
 Classical Hodgkin lymphoma, nodular sclerosis, cellular phase
 Classical Hodgkin lymphoma, nodular sclerosis, grade 1
 Classical Hodgkin lymphoma, nodular sclerosis, grade 2
 Classical Hodgkin lymphoma, nodular sclerosis, NOS
 Clear cell adenocarcinofibroma (C56.9)
 Clear cell adenocarcinoma, mesonephroid
 Clear cell adenocarcinoma, NOS
 Clear cell carcinoma
 Clear cell chondrosarcoma (C40._, C41._)
 Clear cell cystadenocarcinofibroma (C56.9)
 Clear cell ependymoma (C71._)
 Clear cell (glycogen-rich) urothelial carcinoma
 Clear cell sarcoma
 Clear cell sarcoma of kidney
 Clear cell sarcoma of tendons and aponeuroses
 Cloacogenic carcinoma
 CNS embryonal tumor with rhabdoid features (C71._)
 Collecting duct carcinoma (C64.9)
 Colloid adenocarcinoma
 Colloid carcinoma
 Combined carcinoid and adenocarcinoma
 Combined hepatocellular carcinoma and Cholangiocarcinoma
 Combined large cell neuroendocrine carcinoma
 Combined small cell carcinoma
 Combined small cell-adenocarcinoma
 Combined small cell-squamous cell carcinoma
 Comedocarcinoma, noninfiltrating

Comedocarcinoma, NOS
 Common ALL
 Common precursor B ALL
 Composite carcinoid
 Composite Hodgkin and non-Hodgkin lymphoma
 Condylomatous carcinoma
 Congenital fibrosarcoma
 Conventional central osteosarcoma (C40._, C41._)
 Cortical T ALL
 CPNET (C71._)
 CRANIOPHARYNGIOMA
 Cribriform carcinoma
 Cribriform comedo-type carcinoma (C18._, C19.9, C20.9)
 Cutaneous lymphoma
 Cutaneous T-cell lymphoma, NOS (C44._)
 Cylindrical cell carcinoma (C30.0, C31._)
 Cylindroma, NOS (except of skin)
 Cystadenocarcinoma, NOS
 Cyst-associated renal cell carcinoma (C64.9)
 Cystic astrocytoma
 Cystic hypersecretory carcinoma (C50._)
 Cystosarcoma phyllodes, malignant

D

DCIS, comedo type (C50._)
 DCIS, NOS (C50._)
 DCIS, papillary (C50._)
 Dedifferentiated chondrosarcoma (C40._, C41._)
 Dedifferentiated chordoma
 Dedifferentiated liposarcoma
 Dendritic cell sarcoma, NOS
 Dermatofibrosarcoma protuberans, NOS
 Dermatofibrosarcoma, NOS
 Dermoid cyst of Brain
 Dermoid cyst with malignant transformation
 Dermoid cyst with secondary tumor

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DERMOID CYST, NOS
 DESMOPLASTIC INFANTILE ASTROCYTOMA
 AND GANGLIOGLIOMA
 Desmoplastic medulloblastoma
 Desmoplastic melanoma, amelanotic
 (C44. _)
 Desmoplastic melanoma, malignant
 Desmoplastic mesothelioma
 Desmoplastic nodular medulloblastoma
 (C71.6)
 Desmoplastic small round cell tumor
 Di Guglielmo disease [obs]
 Diffuse astrocytoma (C71. _)
 Diffuse astrocytoma, IDH-mutant (C71. _)
 Diffuse astrocytoma, IDH-wildtype (C71. _)
 Diffuse astrocytoma, low grade (C71. _)
 Diffuse leptomeningeal glioneuronal tumor
 (C71. _)
 Diffuse midline glioma, H3 K27M-mutant
 (C71. _)
 DIFFUSE MENINGIOMATOSIS
 Digital papillary adenocarcinoma
 (C44. _)
 Diktyoma
 Diktyoma, malignant (C69. _)
 DIN III (ductal intraepithelial neoplasia III)
 (C50. _)
 Duct adenocarcinoma
 Duct carcinoma
 Duct carcinoma, desmoplastic type
 Duct cell carcinoma
 Ductal carcinoma
 Ductal carcinoma in situ, comedo type
 (C50. _)
 Ductal carcinoma in situ, cribriform type
 (C50. _)
 Ductal carcinoma in situ, micropapillary
 (C50. _)
 Ductal carcinoma in situ, NOS (C50. _)
 Ductal carcinoma in situ, papillary
 (C50. _)
 Ductal carcinoma in situ, solid type
 (C50. _)
 Ductal carcinoma, cribriform type
 (C50. _)

Ductal intraepithelial neoplasia III (DIN III)
 (C50. _)
 DYSEMBRYOPLASTIC NEUROEPITHELIAL
 TUMOR
 Dysgerminoma
 DYSPLASTIC GANGLIOCYTOMA OF
 CEREBELLUM (D=LHEMITTE-DUCLOS)

E

EC cell carcinoid
 Eccrine adenocarcinoma (C44. _)
 Eccrine papillary adenocarcinoma
 (C44. _)
 Eccrine poroma, malignant
 ECL cell carcinoid, malignant
 Ectomesenchymoma
 Embryonal adenocarcinoma
 Embryonal carcinoma
 Embryonal carcinoma and teratoma,
 mixed
 Embryonal carcinoma, infantile
 Embryonal carcinoma, polyembryonal
 type
 Embryonal hepatoma
 Embryonal rhabdomyosarcoma
 Embryonal rhabdomyosarcoma,
 pleomorphic
 Embryonal sarcoma
 Embryonal teratoma
 Embryonal tumor with multilayered
 rosettes C19MC-altered (C71. _)
 Embryonal tumor with multilayered
 rosettes, NOS (C71. _)
 Embryonal tumor with rhabdoid features
 (C71.0)
 Encapsulated follicular variant of papillary
 thyroid carcinoma, NOS (EFVPTC,
 NOS) (C73.9)
 Encapsulated papillary carcinoma (C50. _)
 Encapsulated papillary carcinoma with
 invasion (C50. _)
 Endocervical adenocarcinoma usual type
 (C53. _)
 Endodermal sinus tumor
 Endolymphatic stromal myosis

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Endolymphatic stromal myosis (C54.1)
 Endometrial sarcoma, NOS
 Endometrial stromal sarcoma
 Endometrial stromal sarcoma, high grade (C54.1)
Endometrial stromal sarcoma, low grade (C54.1)
Endometrial stromatosis (C54.1)
 Endometrioid adenocarcinoma
 Endometrioid adenocarcinoma, ciliated cell variant
 Endometrioid adenocarcinoma, secretory variant (C56.9)
 Endometrioid adenocarcinoma, villoglandular
 Endometrioid adenofibroma, malignant
 Endometrioid carcinoma
 Endometrioid carcinoma with squamous differentiation
 Endometrioid cystadenocarcinoma
 Endometrioid cystadenofibroma, malignant
 ENDOTHELIOMATOUS MENINGIOMA
 Enteric adenocarcinoma
 Enterochromaffin cell carcinoid
 Enterochromaffin-like cell tumor, malignant
 Enteroglucagonoma, malignant
 Enteropathy associated T-cell lymphoma
 Enteropathy type intestinal T-cell lymphoma
 Eosinophil adenocarcinoma
 Eosinophil carcinoma
 Eosinophilic leukemia
 Ependymoblastoma
 Ependymoma, anaplastic
 Ependymoma, NOS
 Ependymoma, RELA fusion-positive
 Epidermoid carcinoma in situ with questionable stromal invasion*
 Epidermoid carcinoma in situ, NOS*
 Epidermoid carcinoma, keratinizing*
 Epidermoid carcinoma, large cell, nonkeratinizing*

Epidermoid carcinoma, NOS*
 Epidermoid carcinoma, small cell nonkeratinizing*
 Epidermoid carcinoma, spindle cell*
 Epithelial ependymoma
 Epithelial tumor, malignant*
 Epithelial-myoepithelial carcinoma
 Epithelioid and spindle cell melanoma, mixed
 Epithelioid cell melanoma
 Epithelioid cell sarcoma
 Epithelioid glioblastoma
 Epithelioid hemangioendothelioma, malignant
 EPITHELIOID HEMANGIOENDOTHELIOMA, NOS
 Epithelioid leiomyosarcoma
 Epithelioid malignant peripheral nerve sheath tumor
 Epithelioid mesothelioma, NOS
 Epithelioid MPNST
 Epithelioid sarcoma
 Epithelioid trophoblastic tumor
 Epithelioma, malignant*
 Epithelioma, NOS*
 Erythremic myelosis, NOS
 Erythroleukemia
Essential hemorrhagic thrombocythemia
Essential thrombocythemia
Essential thrombocytosis
 Esthesioneuroblastoma
 Esthesioneurocytoma
 Esthesioneuroepithelioma
 Ewing sarcoma
 Ewing tumor
 Extra-adrenal paraganglioma, malignant
 EXTRA-ADRENAL PARAGANGLIOMA, NOS
 Extramedullary plasmacytoma
 Extraventricular neurocytoma

E

FAB L1
 FAB L2
 FAB L3 [obs]

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FAB M0
 FAB M1
 FAB M2, AML1(CBF-alpha)/ETO
 FAB M2, NOS
 FAB M2, t(8;21)(q22;q22)
 FAB M3 (includes all variants)
 FAB M4
 FAB M4Eo
 FAB M5 (includes all variants)
 FAB M6
 FAB M7
 Fascial fibrosarcoma
 Fetal adenocarcinoma
 Fibrillary astrocytoma
 Fibroblastic liposarcoma
 FIBROBLASTIC MENINGIOMA
 Fibroblastic osteosarcoma
 Fibroblastic reticular cell tumor
 Fibrochondrosarcoma
 Fibroepithelial basal cell carcinoma,
 Pinkus type*
 Fibroepithelioma of Pinkus type*
 Fibroepithelioma, NOS*
 Fibroliposarcoma
 FIBROMA, NOS
 Fibromatosis-like metaplastic carcinoma
 (C50.)
 Fibromyxosarcoma
 Fibrosarcoma, NOS
 Fibrosarcomatous dermatofibrosarcoma
 protuberans
 Fibrous astrocytoma
 Fibrous histiocytoma, malignant
 FIBROUS HISTIOCYTOMA, NOS
 FIBROUS MENINGIOMA
 Fibrous mesothelioma, malignant
 Fibrous mesothelioma, NOS
 Fibroxanthoma, malignant
 FIBROXANTHOMA, NOS
 Follicular adenocarcinoma, moderately
 differentiated
 Follicular adenocarcinoma, NOS
 Follicular adenocarcinoma, trabecular
 Follicular adenocarcinoma, well
 differentiated

FOLLICULAR ADENOMA
 Follicular carcinoma, encapsulated
 (C73.9)
 Follicular carcinoma, minimally invasive
 (C73.9)
 Follicular carcinoma, moderately
 differentiated
 Follicular carcinoma, NOS
 Follicular carcinoma, oxyphilic cell
 (C73.9)
 Follicular carcinoma, trabecular
 Follicular carcinoma, well differentiated
 Follicular dendritic cell sarcoma
 Follicular dendritic cell tumor
 Follicular lymphoma, grade 1
 Follicular lymphoma, grade 2
 Follicular lymphoma, grade 3
 Follicular lymphoma, NOS
 Follicular thyroid carcinoma (FTC),
 encapsulated angioinvasive
 (C73.9)
 Franklin disease

G

G cell tumor, malignant
 Gamma heavy chain disease
 GANGLIOCYTOMA
 GANGLIOGLIOMA
 Ganglioglioma, anaplastic
 Ganglioneuroblastoma
 GANGLIONEUROMA
 Gastrin cell tumor, malignant
 Gastrinoma, malignant
 Gastrointestinal stromal sarcoma
 Gastrointestinal stromal tumor,
 malignant
 Gelatinous adenocarcinoma
 Gelatinous carcinoma
 Gemistocytic astrocytoma
 Gemistocytoma

 Generalized Langerhans cell
 histiocytosis
 Germ cell tumor
 Germ cell tumor, mixed

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Germ cell tumor, nonseminomatous (C62._)
 Germ cell tumors with associated hematological malignancy (C37.9)
 Germinoma
 Ghost cell odontogenic carcinoma
 Giant cell and spindle cell carcinoma*
 Giant cell carcinoma*
 Giant cell glioblastoma
 Giant cell sarcoma (except of Bone)
 Giant cell sarcoma of bone
 Giant cell tumor of bone, malignant
 Giant cell tumor of tendon sheath, malignant (C49._)
 GIST, malignant
 Glassy cell carcinoma
 Glioblastoma, IDH-mutant
 Glioblastoma, IDH wildtype
 Glioblastoma multiforme
 Glioblastoma with sarcomatous component
 Glioblastoma, NOS
 Glioma, malignant
 Glioma, mixed
 Glioma, NOS (except Nasal glioma, not neoplastic)
 Gliomatosis cerebri
 GLIONEUROMA
 Gliosarcoma
 Glomangiosarcoma
 Glomoid sarcoma
 Glomus tumor, malignant
 Glucogonoma, malignant
 Glycogen-rich carcinoma
 Goblet cell carcinoid
 Granular cell carcinoma
 Granular cell myoblastoma, malignant
 Granular cell tumor, malignant
 GRANULAR CELL TUMOR, NOS
 Granulocytic leukemia, NOS
 Granulocytic sarcoma
 Granulosa cell carcinoma
 Granulosa cell tumor, malignant

Granulosa cell tumor, sarcomatoid (C56.9)
 Grawitz tumor

H

Hairy cell leukemia
 Hairy cell leukemia variant
 Heavy chain disease
 Heavy chain disease, NOS
 HEMANGIOBLASTIC MENINGIOMA
 HEMANGIOBLASTOMA
 Hemangioendothelial sarcoma
 HEMANGIOENDOTHELIOMA, BENIGN
 Hemangioendothelioma, malignant
 HEMANGIOMA, NOS
 HEMANGIOPERICYTIC MENINGIOMA
 HEMANGIOPERICYTOMA, BENIGN
 Hemangiopericytoma, malignant
 HEMANGIOPERICYTOMA, NOS
 Hemangiosarcoma
 Hepatoblastoma
 Hepatocarcinoma
 Hepatocellular and bile duct carcinoma, mixed
 Hepatocellular carcinoma
 Hepatocellular carcinoma, clear cell type (C22.0)
 Hepatocellular carcinoma, fibrolamellar
 Hepatocellular carcinoma, pleomorphic type (C22.0)
 Hepatocellular carcinoma, sarcomatoid (C22.0)
 Hepatocellular carcinoma, scirrhous (C22.0)
 Hepatocellular carcinoma, spindle cell variant (C22.0)
 Hepatocholangiocarcinoma
 Hepatoid adenocarcinoma
 Hepatoid carcinoma
 Hepatoid yolk sac tumor
 Hepatoma, malignant
 Hepatoma, NOS
 Hepatosplenic gamma-delta cell lymphoma

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Hereditary leiomyomatosis & RCC-associated renal cell carcinoma (C64.9)
 Hidradenocarcinoma (C44._)
 High grade intraurothelial neoplasia
 High-grade neuroendocrine carcinoma
 High-grade serous carcinoma
 High grade surface osteosarcoma (C40._, C41._)
 Histiocyte-rich large B-cell lymphoma
 Histiocytic medullary reticulosis [obs]
 Histiocytic sarcoma
 Hodgkin disease, lymphocyte predominance, diffuse [obs]
 Hodgkin disease, lymphocyte predominance, NOS [obs]
 Hodgkin disease, lymphocytic depletion, diffuse fibrosis
 Hodgkin disease, lymphocytic depletion, NOS
 Hodgkin disease, lymphocytic depletion, reticular
 Hodgkin disease, lymphocytic-histiocytic predominance [obs]
 Hodgkin disease, lymphocytic predominance, diffuse
 Hodgkin disease, lymphocytic predominance, nodular
 Hodgkin disease, lymphocytic predominance, NOS
 Hodgkin disease, mixed cellularity, NOS
 Hodgkin disease, nodular sclerosis, cellular phase
 Hodgkin disease, nodular sclerosis, lymphocytic depletion
 Hodgkin disease, nodular sclerosis, lymphocytic predominance
 Hodgkin disease, nodular sclerosis, mixed cellularity
 Hodgkin disease, nodular sclerosis, NOS
 Hodgkin disease, nodular sclerosis, syncytial variant
 Hodgkin disease, NOS
 Hodgkin granuloma

Hodgkin lymphoma, mixed cellularity, NOS
 Hodgkin lymphoma, lymphocyte depletion, NOS
 Hodgkin lymphoma, lymphocytic depletion, diffuse fibrosis
 Hodgkin lymphoma, lymphocyte depletion, reticular
 Hodgkin lymphoma, lymphocyte-rich
 Hodgkin lymphoma, nodular lymphocyte predominance
 Hodgkin lymphoma, nodular sclerosis, cellular phase
 Hodgkin lymphoma, nodular sclerosis, grade 1
 Hodgkin lymphoma, nodular sclerosis, grade 2
 Hodgkin lymphoma, nodular sclerosis, NOS
 Hodgkin paragranuloma, nodular [obs]
 Hodgkin paragranuloma, nodular
 Hodgkin paragranuloma, NOS [obs]
 Hodgkin sarcoma
 Hurthle adenocarcinoma
 HURTHLE CELL ADENOMA
 Hurthle cell carcinoma
 HURTHLE CELL TUMOR
 Hutchinson melanotic freckle, NOS
 Hydroa vacciniforme-like lymphoma
 Hypereosinophilic (idiopathic) syndrome
 Hypernephroma

!

Idiopathic hemorrhagic thrombocythemia
Idiopathic thrombocythemia
 IMMATURE TERATOMA
 Immature teratoma, malignant
 Immunoblastic sarcoma
 Immunocytoma
 Immunoproliferative disease, NOS
 Immunoproliferative small intestinal disease
 Infantile fibrosarcoma
 Infiltrating and papillary adenocarcinoma

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Infiltrating basal cell carcinoma, non-sclerosing (C44._)
 Infiltrating basal cell carcinoma, NOS (C44._)
 Infiltrating basal cell carcinoma, sclerosing (C44._)
 Infiltrating duct adenocarcinoma
 Infiltrating duct and colloid carcinoma (C50._)
 Infiltrating duct and cribriform carcinoma (C50._)
 Infiltrating duct and lobular carcinoma
 Infiltrating duct and lobular carcinoma in situ
 Infiltrating duct and mucinous carcinoma (C50._)
 Infiltrating duct and tubular carcinoma (C50._)
 Infiltrating duct carcinoma
 Infiltrating duct mixed with other types of carcinoma (C50._)
 Infiltrating ductular carcinoma
 Infiltrating lobular carcinoma
 Infiltrating lobular carcinoma and ductal carcinoma in situ (C50._)
 Infiltrating lobular mixed with other types of carcinoma (C50._)
 Infiltrating papillary adenocarcinoma
 Inflammatory adenocarcinoma
 Inflammatory carcinoma
 Inflammatory liposarcoma
 Insular carcinoma (C73.9)
 Insulinoma, malignant
 Interdigitating cell sarcoma
 Interdigitating dendritic cell sarcoma
 Interstitial cell tumor, malignant
 Intestinal-type adenocarcinoma
 Intestinal T-cell lymphoma
 Intimal sarcoma
 Intracortical osteosarcoma (C40._, C41._)
 Intracystic carcinoma, NOS
 Intracystic papillary adenocarcinoma
 Intracystic papillary neoplasm with associated invasive carcinoma

Intraductal adenocarcinoma, noninfiltrating, NOS
 Intraductal and lobular carcinoma
 Intraductal carcinoma and lobular carcinoma in situ
 Intraductal carcinoma, clinging (C50._)
 Intraductal carcinoma, noninfiltrating, NOS
 Intraductal carcinoma, NOS
 Intraductal carcinoma, solid type
 Intraductal micropapillary carcinoma (C50._)
 Intraductal papillary adenocarcinoma with invasion
 Intraductal papillary adenocarcinoma, NOS
 Intraductal papillary carcinoma, NOS
 Intraductal papillary mucinous carcinoma, invasive (C25._)
 Intraductal papillary mucinous carcinoma, non-invasive (C25._)
 Intraductal papillary mucinous neoplasm (IPMN) with an associated invasive carcinoma (C25._)
 Intraductal papillary mucinous neoplasm with high-grade dysplasia (C25._)
 Intraductal papilloma with ductal carcinoma in situ (C50._)
 Intraductal papilloma with lobular carcinoma in situ (C50._)
 Intraductal tubulopapillary neoplasm (C25._)
 Intraepidermal carcinoma, NOS*
 Intraepithelial carcinoma, NOS*
 Intraepithelial squamous cell carcinoma*
 Intraosseous carcinoma
 Intraosseous low grade osteosarcoma (C40._, C41._)
 Intraosseous well differentiated osteosarcoma (C40._, C41._)
 Intratubular germ cell neoplasia (C62._)
 Intratubular malignant germ cells (C62._)
 Intravascular B-cell lymphoma

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Intravascular bronchial alveolar tumor (C34. _) [obs]
 Intravascular large B-cell lymphoma (C49.9)
 Invasive carcinoma of no special type (C50. _)
 Invasive carcinoma, NST (C50. _)
 Invasive encapsulated follicular variant of papillary thyroid carcinoma (invasive EFVPTC) (C73.9)
 Invasive lobular carcinoma (C50. _)
 Invasive lobular carcinoma, alveolar type (C50. _)
 Invasive lobular carcinoma, solid type (C50. _)
 Invasive lobular carcinoma, tubulolobular variant (C50. _)
 Invasive mammary carcinoma (C50. _)
 Invasive micropapillary carcinoma (C50. _)
 Invasive mucinous adenocarcinoma (C34. _)
 Islet cell adenocarcinoma
 Islet cell and exocrine adenocarcinoma, mixed
 Islet cell carcinoma

J

JUVENILE ASTROCYTOMA (C71. _)
 Juvenile carcinoma of breast
 Juvenile chronic myelomonocytic leukemia
 Juvenile myelomonocytic leukemia
 Juxtacortical chondrosarcoma
 Juxtacortical osteosarcoma (C40. _, C41. _)

K

Kaposi sarcoma
 Klatskin tumor
 Krukenberg tumor
 Kupffer cell sarcoma

L

LANGERHANS CELL HISTIOCYTOSIS
 Langerhans Cell Histiocytosis

Langerhans cell histiocytosis, disseminated
 Langerhans cell histiocytosis, generalized
 Langerhans cell sarcoma
 Large B-cell lymphoma arising in HHV8-associated multicentric Castleman disease
 Large cell (Ki-1+) lymphoma
 Large cell carcinoma with rhabdoid phenotype
 Large cell carcinoma, NOS*
 Large cell medulloblastoma (C71.6)
 Large cell neuroendocrine carcinoma
 LCIS, NOS (C50. _)
 Leather bottle stomach (Linitis plastica, the gross description of gastric cancer known also as leather bottle stomach has a characteristic radiographic appearance)
 Leiomyosarcoma, NOS
 Lennert lymphoma
 Lentigo maligna melanoma
 Lepidic adenocarcinoma (C34. _)
 Lepidic predominant adenocarcinoma (C34. _)
 Lipid-rich urothelial carcinoma
 Leptomeningeal sarcoma
 Letterer-Siwe disease
 Leukemia, NOS
 Leukemic reticuloendotheliosis
 Leydig cell tumor, malignant
 Linitis plastica
 Lipid-rich carcinoma
 LIPOMA
 Lipoma-like liposarcoma
 Liposarcoma, differentiated
 Liposarcoma, mixed
 Liposarcoma, NOS
 Liposarcoma, well differentiated
 Liver cell carcinoma
 Lobular adenocarcinoma
 Lobular and ductal carcinoma
 Lobular carcinoma in situ
 Lobular carcinoma, NOS

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Low grade adenosquamous carcinoma (C50. _)
 Low grade cribriform cystadenocarcinoma (LGCCC)
 Low-grade central osteosarcoma
 Low-grade fibromyxoid sarcoma
 Low-grade intramedullary osteosarcoma
 Low-grade myofibroblastic sarcoma
 Low-grade serous carcinoma
 Lymphangioendothelial sarcoma
 Lymphangioendothelioma, malignant
 Lymphangiosarcoma
 Lymphoblastic leukemia, NOS
 Lymphoblastoma [obs]
 Lymphocytic leukemia, NOS
 Lymphoepithelial carcinoma*
 Lymphoepithelioid lymphoma
 Lymphoepithelioma*
 Lymphoepithelioma-like carcinoma
 Lymphoid leukemia, NOS
 Lymphoma, NOS
 Lymphomatoid papulosis (C44. _)
 LYMPHOPROLIFERATIVE DISEASE, NOS
 Lymphosarcoma cell leukemia [obs]
 Lymphosarcoma, diffuse [obs]
 Lymphosarcoma, NOS [obs]

M

M6A
 M6B
 Macroglobulinemia, Waldenstrom
 Malignancy*
 Malignant chondroid syringoma (C44. _)
 Malignant cystic nephroma (C64.9)
 Malignant eccrine spiradenoma (C44. _)
 Malignant fibrous histiocytoma (MFH) of bone
 Malignant giant cell tumor of soft parts
 Malignant histiocytosis
 Malignant lymphoma, centroblastic, diffuse
 Malignant lymphoma, centroblastic, follicular
 Malignant lymphoma, centroblastic, NOS

Malignant lymphoma, centroblastic-centrocytic, diffuse [obs]
 Malignant lymphoma, centroblastic-centrocytic, follicular
 Malignant lymphoma, centrocytic [obs]
 Malignant lymphoma, cleaved cell, NOS [obs]
 Malignant lymphoma, convoluted cell [obs]
 Malignant lymphoma, diffuse, NOS
 Malignant lymphoma, follicle center, Follicular
 Malignant lymphoma, follicle center, NOS
 Malignant lymphoma, follicular, NOS
 Malignant lymphoma, histiocytic, diffuse
 Malignant lymphoma, histiocytic, nodular
 Malignant lymphoma, histiocytic, NOS
 Malignant lymphoma, Hodgkin
 Malignant lymphoma, immunoblastic, NOS
 Malignant lymphoma, large B-cell, diffuse, NOS
 Malignant lymphoma, large B-cell, diffuse, centroblastic, NOS
 Malignant lymphoma, large B-cell, diffuse, immunoblastic, NOS
 Malignant lymphoma, large cell, cleaved and noncleaved
 Malignant lymphoma, large cell, cleaved, diffuse
 Malignant lymphoma, large cell, cleaved, NOS
 Malignant lymphoma, large cell, diffuse, NOS
 Malignant lymphoma, large cell, follicular, NOS
 Malignant lymphoma, large cell, immunoblastic
 Malignant lymphoma, large cell, noncleaved, diffuse
 Malignant lymphoma, large cell, noncleaved, follicular

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Malignant lymphoma, large cell,
 noncleaved, NOS
 Malignant lymphoma, large cell, NOS
 Malignant lymphoma, large cleaved cell,
 Follicular
 Malignant lymphoma, large cleaved cell,
 NOS
 Malignant lymphoma, lymphoblastic
 Malignant lymphoma, lymphocytic,
 diffuse, NOS
 Malignant lymphoma, lymphocytic,
 intermediate differentiation, diffuse
 Malignant lymphoma, lymphocytic,
 intermediate differentiation, nodular
 [obs]
 Malignant lymphoma, lymphocytic,
 nodular, NOS
 Malignant lymphoma, lymphocytic, NOS
 Malignant lymphoma, lymphocytic,
 poorly differentiated, diffuse [obs]
 Malignant lymphoma, lymphocytic,
 poorly differentiated, nodular [obs]
 Malignant lymphoma, lymphocytic, well
 differentiated, diffuse
 Malignant lymphoma, lymphocytic, well
 differentiated, nodular [obs]
 Malignant lymphoma,
 lymphoplasmacytic
 Malignant lymphoma,
 lymphoplasmacytoid
 Malignant lymphoma, mixed cell type,
 follicular
 Malignant lymphoma, mixed cell type,
 nodular
 Malignant lymphoma, mixed
 lymphocytic-histiocytic nodular
 Malignant lymphoma, mixed small
 cleaved and large cell, follicular
 Malignant lymphoma, nodular, NOS
 Malignant lymphoma, noncleaved,
 diffuse, NOS
 Malignant lymphoma, noncleaved,
 follicular, NOS
 Malignant lymphoma, noncleaved, NOS

Malignant lymphoma, non-Hodgkin,
 NOS
 Malignant lymphoma, NOS
 Malignant lymphoma, plasmacytoid
 Malignant lymphoma, small B
 lymphocytic, NOS
 Malignant lymphoma, small cell diffuse
 Malignant lymphoma, small cell
 noncleaved, diffuse
 Malignant lymphoma, small cell, diffuse,
 NOS
 Malignant lymphoma, small cell,
 noncleaved, diffuse [obs]
 Malignant lymphoma, small cell, NOS
 Malignant lymphoma, small cleaved cell,
 diffuse
 Malignant lymphoma, small cleaved cell,
 diffuse [obs]
 Malignant lymphoma, small cleaved cell,
 follicular
 Malignant lymphoma, small cleaved cell,
 NOS
 Malignant lymphoma, small cleaved cell,
 NOS [obs]
 Malignant lymphoma, small lymphocytic,
 diffuse
 Malignant lymphoma, small lymphocytic,
 NOS
 Malignant lymphoma, small noncleaved,
 Burkitt, diffuse
 Malignant lymphoma, undifferentiated
 cell type,
 Malignant lymphoma, undifferentiated
 cell type, NOS [obs]
 Malignant lymphoma, undifferentiated,
 Burkitt type
 Malignant lymphoma, undifferentiated
 cell, non-Burkitt [obs]
 Malignant lymphomatous polyposis
 [obs]
 Malignant mast cell tumor
 Malignant mastocytoma
 Malignant mastocytosis

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Malignant melanoma in congenital melanocytic nevus (C44.)
 Malignant melanoma in giant pigmented nevus
 Malignant melanoma in junctional nevus
 Malignant melanoma in precancerous melanosis
 Malignant melanoma, NOS
 Malignant melanoma, regressing
 Malignant midline reticulosis [obs]
 Malignant mucinous adenofibroma (C56.9)
 Malignant mucinous cystadenofibroma (C56.9)
 Malignant multilocular cystic nephroma (C64.9)
 Malignant myelosclerosis [obs]
 Malignant myoepithelioma
 Malignant peripheral nerve sheath tumor
 Malignant peripheral nerve sheath tumor with rhabdomyoblastic differentiation
 Malignant perivascular epithelial cell tumor
 Malignant reticulosis, NOS [obs]
 Malignant rhabdoid tumor
 Malignant Schwannoma with rhabdomyoblastic differentiation
 Malignant serous adenofibroma (C56.9)
 Malignant serous cystadenofibroma (C56.9)
 Malignant tenosynovial giant cell tumor (C49.)
 Malignant teratoma, anaplastic
 Malignant teratoma, intermediate
 Malignant teratoma, trophoblastic
 Malignant teratoma, undifferentiated
 Malignant tumor, clear cell type
 Malignant tumor, fusiform cell type*
 Malignant tumor, giant cell type*
 Malignant tumor, small cell type*
 Malignant tumor, spindle cell type*
 MALT lymphoma
 Mammary carcinoma, in situ (C50.)
 Mantle cell lymphoma
 Mantle zone lymphoma
 Marginal zone B-cell lymphoma, NOS

Marginal zone lymphoma, NOS
 Mast cell leukemia (C42.1)
 Mast cell sarcoma
 Mast cell tumor, NOS
 Mastocytoma, malignant
 Matrical carcinoma (C44.)*
 Mature T ALL
 Mature T-cell lymphoma, NOS
 Mature teratoma of testis in adult
 Mediastinal large B-cell lymphoma (C38.3)
 Mediterranean lymphoma
 Medullary adenocarcinoma
 Medullary carcinoma with amyloid stroma (C73.9)
 Medullary carcinoma with lymphoid stroma
 Medullary carcinoma, NOS
 Medullary osteosarcoma (C40. , C41.)
 Medullary thyroid carcinoma (C73.9)
 Medulloblastoma
 Medulloblastoma, classic
 Medulloblastoma, group 3 (C71.)
 Medulloblastoma, group 4 (C71.)
 Medulloblastoma, non-WNT/non-SHH (C71.)
 Medulloblastoma, SHH-activated and TP53-mutant (C71.)
 Medulloblastoma, SHH-activated and TP53-wildtype (C71.)
 Medulloblastoma, WNT-activated (C71.)
 Medulloepithelioma, NOS
 Medullomyoblastoma
 Megakaryocytic leukemia
Megakaryocytic myelosclerosis
 Melanoma in situ
 Melanoma, malignant of soft parts
 Melanoma, NOS
 Melanotic medulloblastoma (C71.6)
 Melanotic MPNST
 Melanotic psammomatous MPNST
 MELANOTIC SCHWANNOMA
 Meningeal melanoma (C71.)
 Meningeal melanomatosis (C70.9)
 Meningeal sarcoma

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Meningeal sarcomatosis
 Meningioma, anaplastic
 Meningioma, malignant
 MENINGIOMA, NOS
 MENINGIOMATOSIS, NOS
 MENINGOTHELIAL MENINGIOMA
 Meningothelial sarcoma
 Merkel cell carcinoma
 Merkel cell tumor
 Mesenchymal chondrosarcoma
 Mesenchymal tumor, malignant
 MESENCHYMOMA, BENIGN
 Mesenchymoma, malignant
 MESENCHYMOMA, NOS
 Mesodermal mixed tumor
 Mesonephric adenocarcinoma
 Mesonephroma, malignant
 Mesonephroma, NOS
 Mesothelioma, biphasic, NOS
 Mesothelioma, malignant
 Metaplastic carcinoma of no special type
 (C50. _)
 Metaplastic carcinoma, NOS
 Metaplastic carcinoma with chondroid
 differentiation (C50. _)
 Metaplastic carcinoma with osseous
 differentiation (C50. _)
 Metaplastic carcinoma with other types
 Mesenchymal differentiation (C50. _)
 Metatypical carcinoma*
 Microcystic adnexal carcinoma (C44. _)
 Microcystic urothelial carcinoma
 MICROFOLLICULAR ADENOMA
 MICROGLIOMA (C71. _) [obs]
 Micropapillary adenocarcinoma (C34. _)
 Micropapillary carcinoma, NOS
 Micropapillary serous carcinoma (C56.9)
 Midline carcinoma of children and young
 adults with NUT rearrangement
 Minimally invasive adenocarcinoma,
 mucinous (C34. _)
 Minimally invasive adenocarcinoma, non-
 mucinous (C34. _)
 Minimally invasive adenocarcinoma, NOS
 (C34. _)

MiT family translocation renal cell
 carcinoma (C64.9)
 MIXED ACIDOPHIL-BASOPHIL ADENOMA
 Mixed acidophil-basophil carcinoma
 Mixed acinar ductal carcinoma
 Mixed acinar-endocrine carcinoma
 (C25. _)
 Mixed adenocarcinoma and epidermoid
 carcinoma
 Mixed adenocarcinoma and squamous
 cell carcinoma
 Mixed basal-squamous cell carcinoma*
 Mixed carcinoid-adenocarcinoma
 Mixed cell adenocarcinoma
 MIXED CELL ADENOMA
 Mixed ductal-endocrine carcinoma
 (C25. _)
 Mixed embryonal carcinoma and
 teratoma
 Mixed embryonal rhabdomyosarcoma
 and alveolar rhabdomyosarcoma
 Mixed epithelioid and spindle cell
 melanoma
 Mixed germ cell tumor
 Mixed glioma
 Mixed hepatocellular and bile duct
 carcinoma
 Mixed invasive mucinous and non-
 mucinous adenocarcinoma (C34. _)
 Mixed islet cell and exocrine
 adenocarcinoma
 Mixed liposarcoma
 Mixed medullary-follicular carcinoma
 (C73.9)
 Mixed medullary-papillary carcinoma
 (C73.9)
 MIXED MENINGIOMA
 Mixed mesenchymal sarcoma
 Mixed mesodermal tumor, NOS
 Mixed Mullerian tumor
 Mixed pancreatic endocrine and exocrine
 tumor, malignant (C25. _)
 Mixed phenotype acute leukemia with
 t(9;22)(q34;q11.2); BCR-ABL1

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Mixed phenotype acute leukemia with t(v;11q23); MLL rearranged
Mixed phenotype acute leukemia, B/myeloid, NOS
Mixed phenotype acute leukemia, T/myeloid, NOS
Mixed pineal tumor (C75.3)
Mixed pineal tumor, transitional pineal tumor
Mixed pineocytoma-pineoblastoma (C75.3)
Mixed small cell carcinoma
Mixed teratoma and seminoma
Mixed tumor, malignant. NOS
Mixed type rhabdomyosarcoma
Monoblastic leukemia, NOS
Monocytic leukemia, NOS
Monocytoid B-cell lymphoma
MONOMORPHIC ADENOMA
Monstrocellular sarcoma (C71._) [obs]
MPNST with glandular differentiation
MPNST with mesenchymal differentiation
MPNST with rhabdomyoblastic differentiation
MPNST, NOS
Mu heavy chain disease
Mucinous adenocarcinofibroma (C56.9)
Mucinous adenocarcinoma
Mucinous adenocarcinoma, endocervical type
Mucinous carcinoid
Mucinous carcinoma
Mucinous carcinoma, gastric type (C53. _)
Mucinous carcinoma, intestinal type (C53. _)
Mucinous cystadenocarcinofibroma (C56.9)
Mucinous cystadenocarcinoma, non-invasive (C25. _)
Mucinous cystadenocarcinoma, NOS
MUCINOUS CYSTADENOMA, BORDERLINE MALIGNANCY

Mucinous cystic neoplasm (MCN) (non-invasive) of the pancreas with high-grade dysplasia
MUCINOUS CYSTIC TUMOR OF BORDERLINE MALIGNANCY
Mucinous cystic tumor with associated invasive carcinoma (C25. _)
Mucinous tubular and spindle cell carcinoma (C64.9)
MUCINOUS TUMOR, NOS, OF LOW MALIGNANT POTENTIAL
Mucin-producing adenocarcinoma
Mucin-producing carcinoma
Mucin-secreting adenocarcinoma
Mucin-secreting carcinoma
Mucocarcinoid tumor
Mucoepidermoid carcinoma
Mucoid adenocarcinoma
Mucoid cell adenocarcinoma
MUCOID CELL ADENOMA
Mucosal lentiginous melanoma
Mucosal-associated lymphoid tissue lymphoma
Mucous adenocarcinoma
Mucous carcinoma
Mullerian adenosarcoma
Mullerian mixed tumor
Multicentric basal cell carcinoma*
Multifocal superficial basal cell carcinoma (C44. _)
Multiple hemorrhagic sarcoma
MULTIPLE MENINGIOMAS
Multiple myeloma
MULTIPLE NEUROFIBROMATOSIS
Mycosis fungoides
Myelocytic leukemia, NOS
Myelodysplastic syndrome, NOS
Myelodysplastic syndrome with 5q-syndrome
Myelodysplastic syndrome with 5q deletion (5q-) syndrome
Myelofibrosis as a result of myeloproliferative disease

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Myelofibrosis with myeloid metaplasia

Myelogenous leukemia, NOS
 Myeloid leukemia, NOS
 Myeloid and lymphoid neoplasm with
 FGFR1 abnormalities
 Myeloid and lymphoid neoplasms with
 PDGFRB rearrangement
 Myeloid leukemia associated with Down
 Syndrome
 Myeloid and lymphoid neoplasms with
 PDGFRB arrangement
 Myeloid sarcoma
 Myeloid neoplasms with PDGFRB
 rearrangement
 Myeloma, NOS
 Myelomatosis
 Myelomonocytic leukemia, NOS
 Myeloproliferative disease, NOS
 Myeloproliferative neoplasm,
 unclassifiable

Myelosclerosis with myeloid metaplasia

Myoepithelial carcinoma
 Myosarcoma
 Myxoid chondrosarcoma
 Myxoid leiomyosarcoma
 Myxoid liposarcoma
 Myxoliposarcoma
 Myxopapillary ependymoma
 MYXOPAPILLARY EPENDYMOMA
 Myxosarcoma

N

NEOPLASM, BENIGN
 Neoplasm, malignant*
 NEOPLASM, UNCERTAIN WHETHER BENIGN
 OR MALIGNANT
 Nephroblastoma, NOS
 Nephroma, NOS
 Nested urothelial carcinoma
 Neurilemmoma, malignant
 NEURILEMMOMA, NOS
 Neurilemosarcoma
 NEURINOMA
 NEUROASTROCYTOMA

Neuroblastoma, NOS
 NEUROCYTOMA
 Neuroectodermal tumor, NOS
 Neuroendocrine carcinoma
 Neuroendocrine carcinoma, poorly
 differentiated (C50. _)
 Neuroendocrine tumor, well differentiated
 (C50. _)
 Neuroepithelioma, NOS
 NEUROFIBROMA, NOS
 NEUROFIBROMATOSIS, NOS
 NEUROFIBROMATOSIS, OTHER
 Neurofibrosarcoma
 Neurogenic sarcoma
 NEUROMA, NOS
 Neurosarcoma
 NEUROTHEKEOMA
 Neurotropic melanoma, malignant
 NK/T-cell lymphoma, nasal and nasal-
 type
 Nodal marginal zone lymphoma
 Nodular hidradenoma, malignant
 (C44. _)
 Nodular melanoma
 Nonchromaffin paraganglioma,
 malignant
 Nonencapsulated sclerosing
 adenocarcinoma
 Nonencapsulated sclerosing carcinoma
 Nonencapsulated sclerosing tumor
 Non-Hodgkin lymphoma, NOS
 Noninfiltrating intracystic carcinoma
 Noninfiltrating intraductal papillary
 adenocarcinoma
 Noninfiltrating intraductal papillary
 carcinoma nonkeratinizing*
 Non-invasive EFVPTC (C73.9)
 Non-invasive encapsulated follicular
 variant of papillary thyroid
 carcinoma (non-invasive EFVPTC)
 (C73.9)
 Non-invasive follicular thyroid neoplasm
 with papillary-like nuclear features
 (NIFTP) (C73.9)
 Non-invasive FTP (C73.9)

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Non-invasive low grade serous carcinoma (C56.9)
 Non-invasive mammary carcinoma (C50._)
 Nonlipid reticuloendotheliosis [obs]
 Nonlipid reticuloendotheliosis NOS
 Non-lymphocytic leukemia, NOS
 Non-small cell carcinoma (C34._)
 NUT carcinoma
 NUT midline

O

Oat cell carcinoma*
 Odontogenic carcinoma
 Odontogenic carcinosarcoma
 Odontogenic fibrosarcoma
 Odontogenic sarcoma
 Odontogenic tumor, malignant
 Olfactory neuroblastoma
 Olfactory neurocytoma (C30.0)
 Olfactory neuroepithelioma
 Olfactory neurogenic tumor
 Oligoastrocytoma, NOS
 Oligodendroblastoma
 Oligodendroglioma, anaplastic
 Oligodendroglioma IDH mutant and 1p/19q-codeleted
 Oligodendroglioma, NOS
 Oncocytic adenocarcinoma
 ONCOCYTIC ADENOMA
 Oncocytic carcinoma
 ONCOCYTOMA
 Orchioblastoma
 Ossifying fibromyxoid tumor, malignant (C49._)
 Osteoblastic sarcoma
 Osteochondrosarcoma
 Osteoclastoma, malignant
 Osteofibrosarcoma
 Osteogenic sarcoma, NOS
 Osteosarcoma in Paget disease of bone
 Osteosarcoma, NOS
 Oxyphilic adenocarcinoma
 OXYPHILIC ADENOMA

P

Paget disease and infiltrating duct carcinoma of breast
 Paget disease, extramammary (except Paget disease of breast)
 Paget disease of bone in osteosarcoma
 Paget disease, mammary
 Pagetoid reticulosis
 Pancoast tumor (a tumor in the apex of the chest with Horner syndrome)
 Pancreatobiliary-type carcinoma (C24.1)
 Pancreatoblastoma
 PanIN III (Pancreatic Intraepithelial Neoplasia grade III)
 Pancreatic Endocrine Tumor, malignant
 Pancreatic Neuroendocrine Tumor
 Papillary adenocarcinoma, follicular variant
 Papillary adenocarcinoma, NOS
 PAPILLARY ADENOMA, NOS
 Papillary and follicular adenocarcinoma
 Papillary and follicular carcinoma
 Papillary carcinoma in situ*
 Papillary carcinoma of thyroid (C73.9)
 Papillary carcinoma, columnar cell (C73.9)
 Papillary carcinoma, diffuse sclerosing (C73.9)
 Papillary carcinoma, encapsulated (C73.9)
 Papillary carcinoma, follicular variant
 Papillary carcinoma, NOS*
 Papillary carcinoma, oxyphilic cell (C73.9)
 Papillary carcinoma, tall cell (C73.9)
 Papillary cystadenocarcinoma, NOS
PAPILLARY CYSTADENOMA, BORDERLINE MALIGNANCY
 PAPILLARY EPENDYMOMA
Papillary ependymoma
 Papillary epidermoid carcinoma*
 PAPILLARY GLIONEURONAL TUMOR
 PAPILLARY MENINGIOMA
Papillary meningioma

Refer to ICD-O-3 for inclusive listing of morphology terms.

*Non-reportable if skin of non-mucoepidermoid anatomic site (ICD-O-3: C44._)

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[obs] = Obsolete

The NYSCR Reporting Manual – Part Three – Reportable Conditions and Terminology

Papillary microcarcinoma (C73.9)
 Papillary mucinous cystadenocarcinoma
**PAPILLARY MUCINOUS CYSTADENOMA,
 BORDERLINE MALIGNANCY**
**PAPILLARY MUCINOUS TUMOR OF LOW
 MALIGNANT POTENTIAL**
 Papillary pseudomucinous
 cystadenocarcinoma
**PAPILLARY PSEUDOMUCINOUS
 CYSTADENOMA, BORDERLINE
 MALIGNANCY**
 Papillary renal cell carcinoma (C64.9)
 Papillary serous adenocarcinoma
 Papillary serous cystadenocarcinoma
**PAPILLARY SEROUS CYSTADENOMA,
 BORDERLINE MALIGNANCY**
**PAPILLARY SEROUS TUMOR OF LOW
 MALIGNANT POTENTIAL**
 Papillary squamous cell carcinoma*
 Papillary squamous cell carcinoma
 in situ
 Papillary squamous cell carcinoma, non-
 invasive
 Papillary transitional cell carcinoma
 Papillary transitional cell carcinoma,
 non-invasive (C67. _)
 Papillary tumor of the pineal region
 Papillary urothelial carcinoma (C67. _)
 Papillary urothelial carcinoma, non-
 invasive (C67. _)
 Papilocystic adenocarcinoma
 Papillotubular adenocarcinoma
 Parafollicular cell carcinoma (C73.9)
 Paraganglioma, malignant
 PARAGANGLIOMA, NOS
 Parietal cell adenocarcinoma (C16. _)
 Parietal cell carcinoma (C16. _)
 Parosteal osteosarcoma (C40. _ , C41. _)
 PEComa, malignant
 Periductal stromal tumor, low grade
 (C50. _)
 Perineural MPNST
 Perineurioma, malignant
 PERINEUROMA

Periosteal chondrosarcoma (C40. _ ,
 C41. _)
 Periosteal fibrosarcoma
 Periosteal osteosarcoma
 Periosteal osteosarcoma (C40. _ , C41. _)
 Periosteal sarcoma, NOS
 Peripheral neuroectodermal tumor
 Peripheral primitive neuroectodermal
 tumor, NOS
 Peripheral T-cell lymphoma, AILD
 (Angioimmunoblastic
 Lymphadenopathy with
 Dysproteinemia)
 Peripheral T-cell lymphoma, large cell
 Peripheral T-cell lymphoma,
 pleomorphic medium and large cell
 Peripheral T-cell lymphoma,
 pleomorphic medium and large cell
 Peripheral T-cell lymphoma,
 pleomorphic small cell
 Peripheral T-cell lymphoma,
 pleomorphic small cell
 Perivascular epithelioid cell tumor,
 malignant
 Pheochromoblastoma
 Pheochromocytoma, malignant
 Phosphaturic mesenchymal tumor,
 malignant
 Phyllodes tumor, malignant
 Pigmented basal cell carcinoma*
 Pigmented dermatofibrosarcoma
 protuberans
 PIGMENTED SCHWANNOMA
 PILOCYTIC ASTROCYTOMA (C71. _)
 PILOCYTIC/JUVENILE ASTROCYTOMA (C71. _)
 PILOID ASTROCYTOMA
 PILOID ASTROCYTOMA (C71. _)
 Pilomatricoma, malignant (C44. _)
 Pilomatrix carcinoma*
 Pilomatrixoma, malignant*
 Pilomyxoid astrocytoma
 Pineal parenchymal tumor of
 intermediate differentiation (C75.3)
 Pinealoma

Refer to ICD-O-3 for inclusive listing of morphology terms.

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The NYSCR Reporting Manual – Part Three – Reportable Conditions and Terminology

Pineoblastoma
 PINEOCYTOMA
 Pinkus tumor
 PITUICYTOMA
 Pituitary carcinoma, NOS (C75.1)
 Plasma cell leukemia (C42.1)
 Plasma cell myeloma
 Plasma cell tumor
 Plasmablastic lymphoma
 Plasmacytic leukemia (C42.1)
 Plasmacytic lymphoma
 Plasmacytoma of bone (C40._, C41._)
 Plasmacytoma, extramedullary (not occurring in bone)
 Plasmacytoma, NOS
 Pleomorphic carcinoma*
 Pleomorphic cell sarcoma
 Pleomorphic liposarcoma
 Pleomorphic lobular carcinoma (C50._)
 Pleomorphic lobular carcinoma in situ (C50._)
 Pleomorphic rhabdomyosarcoma
 Pleomorphic rhabdomyosarcoma, adult type
 Pleomorphic xanthoastrocytoma
 Pleuropulmonary blastoma
 PLEXIFORM NEUROFIBROMA
 PLEXIFORM NEUROMA
 PNET, NOS
 Pneumoblastoma
 Polar spongioblastoma (C71._)
Polycythemia rubra vera
Polycythemia vera
 Polyembryoma
 Polygonal cell carcinoma*
 Polymorphic PTLD
 Polymorphic reticulosis [obs]
 Polymorphous low grade adenocarcinoma
 Polyvesicular vitelline tumor
 Porocarcinoma (C44._)
 PPNET
 Pre-B ALL
 Precancerous melanosis
 Precursor B-cell lymphoblastic leukemia

Precursor B-cell lymphoblastic lymphoma, NOS
 Precursor cell lymphoblastic leukemia, NOS
 Precursor cell lymphoblastic leukemia, not phenotyped
 Precursor cell lymphoblastic lymphoma, NOS
 Precursor T-cell lymphoblastic leukemia
 Precursor T-cell lymphoblastic lymphoma, NOS
Preleukemia
Preleukemic syndrome
 Pre-T ALL
 Primary cutaneous anaplastic large cell lymphoma (C44._)
 Primary cutaneous CD30+ large T-cell lymphoma (C44._)
 Primary cutaneous CD30+ T-cell lymphoproliferative disorder (C44._)
 Primary cutaneous follicle centre lymphoma
 Primary cutaneous gamma-delta T-cell lymphoma
 Primary cutaneous neuroendocrine carcinoma (C44._)
 Primary effusion lymphoma
 Primary intraosseous carcinoma
 Primary serous papillary carcinoma of peritoneum (C48.1)
 Primitive neuroectodermal tumor
 Primitive polar spongioblastoma (C71._) [obs]
 Pro-B ALL
 Prolactinoma
Proliferative polycythemia
 Polymphocytic leukemia
 Polymphocytic leukemia, B-cell type
 Polymphocytic leukemia, NOS
 Polymphocytic leukemia, T-cell type
 Pro-T ALL
 Protoplasmic astrocytoma
 Psammomatous meningioma
 Pseudoglandular squamous cell carcinoma*

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Pseudomucinous adenocarcinoma
 Pseudomucinous cystadenocarcinoma,
 NOS
**PSEUDOMUCINOUS CYSTADENOMA,
 BORDERLINE MALIGNANCY**
 Pseudomyxoma peritonei
 Pseudomyxoma peritonei with unknown
 primary site (C80.9)
 Pseudosarcomatous carcinoma*
 Pulmonary artery intimal sarcoma
 Pulmonary blastoma
 Pulmonary myxoid sarcoma with EWSR1-
 CREB1 translocation (C34._)

Q

Queyrat erythroplasia*

R

RAEB
 RAEB I
 RAEB II
 RAEB-T
 RARS
 RATHKE POUCH TUMOR
 RECKLINGHAUSEN DISEASE (EXCEPT OF
 BONE)
 Refractory anemia
Refractory anemia, NOS
Refractory anemia with excess blasts
Refractory anemia with excess blasts
in transformation
Refractory anemia with ringed
sideroblasts
Refractory anemia with sideroblasts
Refractory anemia without
sideroblasts
Refractory cytopenia with
multilineage dysplasia
 Refractory neutropenia
 Refractory thrombocytopenia
 Renal carcinoma, collecting duct type
 (C64.9)
 Renal cell adenocarcinoma
 Renal cell carcinoma

Renal cell carcinoma, chromophobe cell
 (C64.9)
 Renal cell carcinoma, sarcomatoid
 (C64.9)
 Renal cell carcinoma, spindle cell
 (C64.9)
 Renal cell carcinoma, unclassified (C64.9)
 Renal medullary carcinoma (C64.9)
 Reserve cell carcinoma*
 Reticulosarcoma, diffuse [obs]
 Reticulosarcoma, NOS [obs]
 Reticulum cell sarcoma, diffuse
 Reticulum cell sarcoma, diffuse [obs]
 Reticulum cell sarcoma, NOS [obs]
 Retinoblastoma, differentiated
 Retinoblastoma, diffuse (C69.2)
 Retinoblastoma, NOS
 Retinoblastoma, undifferentiated
 Rhabdoid meningioma
 Rhabdoid sarcoma
 Rhabdoid tumor, NOS
 RHABDOMYOMA, NOS
 Rhabdomyosarcoma with ganglionic
 differentiation
 Rhabdomyosarcoma, NOS
 Rhabdosarcoma
 Rodent ulcer*
 ROSETTE-FORMING GLIONEURONAL TUMOR
 Round cell carcinoma*
 Round cell liposarcoma
 Round cell osteosarcoma (C40._,
 C41._)
 Round cell sarcoma

S

Salivary duct carcinoma
 SALT lymphoma
 Sarcoma botryoides
 Sarcoma, NOS
 Sarcomatoid carcinoma*
 Sarcomatoid mesothelioma
 Schmincke tumor
 Schneiderian carcinoma
 SCHWANNOMA, NOS

Refer to ICD-O-3 for inclusive listing of morphology terms.

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Scirrhous adenocarcinoma
 Scirrhous carcinoma
 Sclerosing epithelioid fibrosarcoma
 Sclerosing hepatic carcinoma (C22.0)
 Sclerosing liposarcoma
 Sclerosing rhabdomyosarcoma
 Sclerosing sweat duct carcinoma
 (C44.)
 Sebaceous adenocarcinoma
 Sebaceous carcinoma
 Secretory carcinoma of breast
 Seminoma with high mitotic index
 (C62.)
 Seminoma, anaplastic
 Seminoma, NOS
 Seromucinous borderline tumor (C56.9)
 Seromucinous carcinoma
 Serotonin producing carcinoid
 Serous adenocarcinofibroma (C56.9)
 Serous adenocarcinoma, NOS
 Serous carcinoma, NOS
 Serous cystadenocarcinofibroma
 (C56.9)
 Serous cystadenocarcinoma, NOS
**SEROUS CYSTADENOMA, BORDERLINE
 MALIGNANCY**
 Serous endometrial intraepithelial
 carcinoma
**SEROUS PAPILLARY CYSTIC TUMOR OF
 BORDERLINE MALIGNANCY**
 Serous surface papillary carcinoma
**SEROUS SURFACE PAPILLARY TUMOR OF
 BORDERLINE MALIGNANCY**
 Serous tubal intraepithelial carcinoma
 (C57.0)
**SEROUS TUMOR, NOS, OF LOW MALIGNANT
 POTENTIAL**
 Serrated adenocarcinoma
 Sertoli cell carcinoma
 Sertoli-Leydig cell tumor, poorly
 differentiated
 Sertoli-Leydig cell tumor, poorly
 differentiated, with heterologous
 elements
 Sertoli-Leydig cell tumor, sarcomatoid

SETTLE
 Sezary disease
 Sezary syndrome
 Signet ring cell adenocarcinoma
 Signet ring cell carcinoma
 Skin appendage carcinoma
 Skin-associated lymphoid tissue
 lymphoma
 Small cell carcinoma, fusiform cell*
 Small cell carcinoma, intermediate cell*
 Small cell carcinoma, NOS*
 Small cell carcinoma pulmonary type
 (C56.9)
 Small cell carcinoma, hypercalcemic type
 (C56.9)
 Small cell neuroendocrine carcinoma
 Small cell osteosarcoma
 Small cell sarcoma
 Small cell-large cell carcinoma*
 Soft tissue sarcoma
 SOFT TISSUE TUMOR, BENIGN
 Soft tissue tumor, malignant
 Solid adenocarcinoma with mucin
 formation
 Solid carcinoma with mucin formation
 Solid carcinoma, NOS
 Solid papillary carcinoma in situ (C50.)
 Solid papillary carcinoma with invasion
 (C50.)
 Solid pseudopapillary carcinoma
 (C25.)
 Solitary fibrous
 tumor/Hemangiopericytoma
 Solitary fibrous
 tumor/hemangiopericytoma Grade 1
 (CNS) (C71.)
 Solitary fibrous
 tumor/hemangiopericytoma Grade 2
 (CNS) (C71.)
 Solitary fibrous
 tumor/hemangiopericytoma Grade 3
 (CNS) (C71.)
 Solitary myeloma
 Solitary plasmacytoma
 Somatostatin cell tumor, malignant

Refer to ICD-O-3 for inclusive listing of morphology terms.

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The NYSCR Reporting Manual – Part Three – Reportable Conditions and Terminology

Somatostatinoma, malignant
 Spermatocytic seminoma
 Spermatocytoma
 Spindle cell carcinoma*
 Spindle cell melanoma
 Spindle cell melanoma, type A
 Spindle cell melanoma, type B
 SPINDLE CELL ONCOCYTOMA
 Spindle cell rhabdomyosarcoma
 Spindle cell sarcoma
 Spindle epithelial tumor with thymus-like differentiation
 Spindle epithelial tumor with thymus-like element
 Spindled mesothelioma
 Splenic lymphoma with villous lymphocytes (C42.2)
 Splenic marginal zone B-cell lymphoma (C42.2)
 Splenic marginal zone lymphoma, NOS (C42.2)
 SPONGIOBLASTOMA MULTIFORME
 SPONGIOBLASTOMA POLARE
 SPONGIOBLASTOMA, NOS
 SPONGIONEUROBLASTOMA
 Squamotransitional cell carcinoma (C53. _)
 Squamous carcinoma*
 Squamous cell carcinoma, HPV-negative
 Squamous cell carcinoma, HPV-positive
 Squamous cell carcinoma in situ with questionable stromal invasion*
 Squamous cell carcinoma in situ, NOS*
 Squamous cell carcinoma with horn formation*
 Squamous cell carcinoma, acantholytic*
 Squamous cell carcinoma, clear cell type*
 Squamous cell carcinoma, keratinizing, NOS*
 Squamous cell carcinoma, large cell, keratinizing*
 Squamous cell carcinoma, large cell, nonkeratinizing*
 Squamous cell carcinoma, microinvasive*

Squamous cell carcinoma, nonkeratinizing, NOS*
 Squamous cell carcinoma, NOS*
 Squamous cell carcinoma, sarcomatoid*
 Squamous cell carcinoma, small cell*
 Squamous cell carcinoma, spindle cell*
 Squamous cell epithelioma*
 Squamous intraepithelial neoplasia, grade III
 Squamous intraepithelial neoplasia, grade III, vulva and vagina
 Stem cell leukemia
 Steroid cell tumor, malignant
Stromal endometriosis (C54.1)
Stromal myosis, NOS
 Stromal myosis, NOS (C54.1)
 Stromal sarcoma, NOS
 Struma ovarii, malignant
 Subacute granulocytic leukemia [obs]
 Subacute leukemia, NOS [obs]
 Subacute lymphatic leukemia [obs]
 Subacute lymphocytic leukemia [obs]
 Subacute lymphoid leukemia [obs]
 Subacute monocytic leukemia [obs]
 Subacute myelogenous leukemia [obs]
 Subacute myeloid leukemia [obs]
 Subcutaneous panniculitis-like T-cell lymphoma
 SUBEPENDYMAL ASTROCYTOMA
 SUBEPENDYMAL GIANT CELL ASTROCYTOMA
 SUBEPENDYMAL GLIOMA
 SUBEPENDYMOMA
 Superficial spreading adenocarcinoma
 Superficial spreading melanoma
 Supratentorial PNET (C71. _)
 Sweat gland adenocarcinoma
 Sweat gland carcinoma
 Sweat gland tumor, malignant
 Sympathicoblastoma
 SYNCYTIAL MENINGIOMA
 Synovial sarcoma, biphasic
 Synovial sarcoma, epithelioid cell
 Synovial sarcoma, monophasic fibrous
 Synovial sarcoma, NOS

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The NYSCR Reporting Manual – Part Three – Reportable Conditions and Terminology

Synovial sarcoma, spindle cell
 Synovioma, NOS
 Synovioma, malignant
 Syringomatous carcinoma (C44._)
 Systemic EBV positive T-cell
 lymphoproliferative disease of childhood
 Systemic tissue mast cell disease

I

T-cell lymphoma, NOS
 T-cell /histiocyte-rich large B-cell
 lymphoma
 T-cell rich large B-cell lymphoma
 T/NK-cell lymphoma
 Tanycytic ependymoma (C71._)
 Tectal plate lipoma of brain
 Telangiectatic osteosarcoma
 Teratoblastoma, malignant
 Teratocarcinoma
 Teratoid medulloepithelioma
 Teratoma with malignant transformation
 TERATOMA, BENIGN
 Teratoma, malignant, NOS
 Teratoma, mature, of testis in adult
 TERATOMA, NOS
 Terminal duct adenocarcinoma
 THIRD TYPE-SCHWANNAMATOSIS
 Thecoma, malignant
 Therapy-related acute myeloid leukemia,
 NOS
 Therapy-related acute myeloid leukemia
 and myelodysplastic syndrome, NOS
 Therapy-related acute myeloid
 leukemia, alkylating agent related
 Therapy-related acute myeloid
 leukemia, epidopophyllotoxin-related
 Therapy-related myelodysplastic
 syndrome, NOS
 Therapy-related myelodysplastic
 syndrome, alkylating agent related
 Therapy-related myelodysplastic
 syndrome, epidopophyllotoxin-related
 Therapy-related myelodysplastic
 syndrome, NOS
 Thymic carcinoma (C37.9)

Thymic carcinoma with adenoid cystic
 carcinoma-like features (C37.9)
 Thymic large B-cell lymphoma (C37.9)
 Thymoma, atypical, malignant (C37.9)
 Thymoma, cortical, malignant (C37.9)
 Thymoma, epithelial, malignant (C37.9)
 Thymoma, lymphocyte-rich, malignant
 (C37.9)
 Thymoma, lymphocytic, malignant
 (C37.9)
 Thymoma, malignant
 Thymoma, medullary, malignant (C37.9)
 Thymoma, mixed type, malignant
 (C37.9)
 Thymoma, organoid, malignant (C37.9)
 Thymoma, predominantly cortical,
 malignant (C37.9)
 Thymoma, spindle cell, malignant
 (C37.9)
 Thymoma, type A, malignant (C37.9)
 Thymoma, type AB, malignant (C37.9)
 Thymoma, type B1, malignant (C37.9)
 Thymoma, type B2, malignant (C37.9)
 Thymoma, type B3, malignant (C37.9)
 Thymoma, type C (C37.9)
 Tibial adamantinoma
 Trabecular adenocarcinoma
 T lymphoblastic leukemia/lymphoma
 Trabecular carcinoma
 Transitional carcinoma
 Transitional cell carcinoma in situ
 Transitional cell carcinoma,
 micropapillary (C67._)
 Transitional cell carcinoma, NOS
 Transitional cell carcinoma, sarcomatoid
 Transitional cell carcinoma, spindle cell
 TRANSITIONAL MENINGIOMA
 Transitional pineal tumor (C75.3)
 Trichilemmal carcinoma (C44._)*
 Trichilemmocarcinoma (C44._)*
 Trophoblastic tumor, epithelioid
 True histiocytic lymphoma [obs]
 Tubular adenocarcinoma
 Tubular carcinoma
 Tubulocystic renal cell carcinoma (C64.9)

Refer to ICD-O-3 for inclusive listing of morphology terms.

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Tubulolobular carcinoma (C50. _)
 Tubulopapillary adenocarcinoma
 TUMOR CELLS, BENIGN
 Tumor cells, malignant*
 TUMOR CELLS, UNCERTAIN WHETHER
 BENIGN OR MALIGNANT
 Tumor malignant, NOS*
 TUMORLET
 Typical carcinoid
 T-zone lymphoma

U

Unclassified tumor, malignant*
 Undifferentiated epithelioid sarcoma

 Undifferentiated high-grade pleomorphic
 sarcoma
 Undifferentiated high-grade pleomorphic
 sarcoma of bone (C40. _)
 Undifferentiated leukemia
 Undifferentiated pleomorphic sarcoma
 Undifferentiated round cell sarcoma
 Undifferentiated sarcoma
 Undifferentiated spindle cell sarcoma
 Undifferentiated uterine sarcoma
 Urachal carcinoma
 Urothelial carcinoma
 Urothelial carcinoma in situ
 Urothelial carcinoma with divergent
 differentiation
 Urothelial carcinoma with squamous
 differentiation
 Urothelial carcinoma with trophoblastic
 differentiation

V

Vaginal intraepithelial neoplasia, grade
 III (VAIN III) (C52. _)
 VAIN III
 Verrucous carcinoma, NOS*
 Verrucous epidermoid carcinoma*
 Verrucous squamous cell carcinoma*
 Villoglandular carcinoma (C53. _)
 Villous adenocarcinoma
 VIN, III (vulvar intraepithelial neoplasia,
 grade III)
 Vipoma
 Vipoma, malignant
 VON RECKLINGHAUSEN DISEASE (EXCEPT
 OF BONE)
 Vulvar intraepithelial neoplasia, grade III

W

Waldenstrom macroglobulinemia
 Warty carcinoma*
 Water-clear cell adenocarcinoma
 Well differentiated thymic carcinoma
 (C37.9)
 Wilms tumor
 Wolffian duct carcinoma

X

XANTHOFIBROMA

Y

Yolk sac tumor

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New York State Cancer Registry Reporting Manual

Part Four - Data Items and Descriptions

This section of the manual has been reduced to those data items that are NYSCR specific. For information on all other required data items, refer to the [Standards for Oncology Registry Entry \(STORE\) manual](#) and/or the [SEER Program Coding and Staging Manual 2018](#). For a complete list of NYSCR Required Fields, contact your field representative at (518) 474-0971.

FACILITY TYPE (SOURCE TYPE)	1
MANAGING PHYSICIAN FIRST NAME	2
MANAGING PHYSICIAN LAST NAME	3
MANAGING PHYSICIAN ADDRESS	4
MANAGING PHYSICIAN CITY	5
MANAGING PHYSICIAN STATE	6
MANAGING PHYSICIAN ZIP	7
MANAGING PHYSICIAN PHONE NUMBER	8
NYS OVER-RIDE NAME/SEX	9
NYS TOBACCO HISTORY	10
PATH REPORT AVAILABLE	11
PARENT PHONE NUMBER	12
PATIENT CONTROL NUMBER	13
PFI (PERMANENT FACILITY IDENTIFIER) NUMBER	14
REQ/REF FIRST NAME	15
REQ/REF LAST NAME	16
REQ/REF ADDRESS	17
REQ/REF CITY	18
REQ/REF STATE	19
REQ/REF ZIP CODE	20

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FACILITY TYPE (SOURCE TYPE)

Reporting Status: Required

Section: State Requested Items

Alternate Name	Item #	Length	Source of Standard	Column #
Source Type	9522	2	NYSCR	3051-3052

Description

Code for the type of facility reporting the case. This field is invisible in Abstract Plus. The code is defaulted based on the chosen PFI #.

Codes

- 01 Inpatient
- 03 Laboratory Report Only
- 04 Clinic Within Facility
- 05 Autopsy Only
- 06 DCO/Followback, Unreported Tumor
- 08 Hospice
- 11 Radiation Treatment Only
- 12 DCO/Followback, Unreported Tumor, No Cancer Workup
- 14 DCO/Followback, Reported Tumor, DCO Site Correct
- 16 Consult Only, Non-Laboratory
- 17 Private Medical Practitioner, Office Visit
- 18 Port/Cath
- 19 DCO/Followback, Reported Tumor, DCO Site Incorrect
- 20 Outpatient, Non-Surgical
- 21 Outpatient, Surgical
- 24 ECC – Early Case Capture Childhood Submission

MANAGING PHYSICIAN FIRST NAME

Reporting Status: Required When Available

Section: State Requested Items

Alternate Name	Item #	Length	Source of Standard	Column #
	9540	40	NYSCR	3197-3236

Description

The first name of the patient's managing physician.

Rationale

This information will be used as needed to follow up on cases with limited information.

MANAGING PHYSICIAN LAST NAME

Reporting Status: Required When Available

Section: State Requested Items

Alternate Name	Item #	Length	Source of Standard	Column #
	9541	40	NYSCR	3237-3276

Description

The last name of the patient's managing physician.

Rationale

This information will be used as needed to follow up on cases with limited information.

MANAGING PHYSICIAN ADDRESS

Reporting Status: Required When Available

Section: State Requested Items

Alternate Name	Item #	Length	Source of Standard	Column #
	9542	60	NYSCR	3277-3336

Description

The number and street address of the patient's managing physician.

Rationale

This information will be used as needed to follow up on cases with limited information.

MANAGING PHYSICIAN CITY

Reporting Status: Required When Available

Section: State Requested Items

Alternate Name	Item #	Length	Source of Standard	Column #
	9543	50	NYSCR	3337-3386

Description

The name of the city used in the mailing address of the patient's managing physician.

Rationale

This information will be used as needed to follow up on cases with limited information.

MANAGING PHYSICIAN STATE

Reporting Status: Required When Available

Section: State Requested Items

Alternate Name	Item #	Length	Source of Standard	Column #
	9544	2	NYSCR	3387-3388

Description

USPS abbreviation for the state used in the mailing address of the patient's managing physician.

Rationale

This information will be used as needed to follow up on cases with limited information.

MANAGING PHYSICIAN ZIP

Reporting Status: Required When Available

Section: State Requested Items

Alternate Name	Item #	Length	Source of Standard	Column #
	9545	9	NYSCR	3389-3397

Description

Postal code used in the mailing address of the patient's managing physician.

Rationale

This information will be used as needed to follow up on cases with limited information.

MANAGING PHYSICIAN PHONE NUMBER

Reporting Status: Required When Available

Section: State Requested Items

Alternate Name	Item #	Length	Source of Standard	Column #
	9546	10	NYSCR	3398-3407

Description

The phone number of the patient's managing physician.

Rationale

This information will be used as needed to follow up on cases with limited information.

NYS OVER-RIDE NAME/SEX

Reporting Status: Required When Available

Section: Special Use

Alternate Name	Item #	Length	Source of Standard	Column #
	2078	1	NYSCR	2595

Description

Codes

1 Reviewed

Blank Not reviewed or reviewed and corrected

NYS TOBACCO HISTORY

Reporting Status: Required

Section: Special Use

Alternate Name	Item #	Length	Source of Standard	Column #
	9536	1	NYSCR	3195

Description

Code the patient's past or current use of tobacco. Do not record the use of e-cigarettes or "vaping."

Codes

- 0 Never Used
- 1 Cigarette Smoker, Current
- 2 Cigar / Pipe Smoker, Current
- 3 Snuff / Chew / Smokeless, Current
- 4 Combination Use, Current
- 5 Previous Use
- 9 Unknown

PATH REPORT AVAILABLE

Reporting Status: Required (for Cases Diagnosed January 1, 2001 and Later)

Section: State Requested Items

Alternate Name	Item #	Length	Source of Standard	Column #
	9525	1	NYSCR	3084

Description

Indicates the availability of a pathology report.

Rationale

The field was added to enable the NYSCR to enforce the requirement of the field Text-DX Proc-Path (item #2570) when a pathology report is available to the abstractor. When this field is coded with a value of "1-Yes", then the Test-DX Proc-Path (item #2570) field (not a state-specific field) will also be required. The field of "Path Report Available?" is not required for Lab Only Consult cases because the field of Text-DX Proc-Path (item #2570) is a required field for all Laboratory Only Consults.

Codes

0 No
1 Yes

PARENT PHONE NUMBER

Reporting Status: Required When Available

Section: State Requested Items

Alternate Name	Item #	Length	Source of Standard	Column #
	9547	10	NYSCR	3408-3417

Description

Phone number of the patient's parent (or next of kin). Applies to patients under 18 years of age.

PATIENT CONTROL NUMBER

Reporting Status: Required

Section: State Requested Items

Alternate Name	Item #	Length	Source of Standard	Column #
	9524	20	NYSCR	3064-3083

Description

Patient's admission number, account number, or laboratory identification number. This number is usually an additional number to the medical record number.

Rationale

The "Patient Control Number" is a unique patient identification number assigned by your facility to the patient upon admission. The number is used by the hospital account office to identify the patient and the period of hospitalization. It is useful in identifying a specific admission or transaction with the facility if additional information or clarification is needed at a future date.

Codes

If the patient control number is fewer than 20 characters, right-justify the characters and allow leading blanks.

Example: Patient Control Number 811234 would be recorded:

-----811234.

PFI (PERMANENT FACILITY IDENTIFIER) NUMBER

Reporting Status: Required

Section: State Requested Items

Alternate Name	Item #	Length	Source of Standard	Column #
	9523	11	NYSCR	3053-3063

Description

A unique numerical identifier assigned to the location of the physical plant of the facility. Record your PFI number as assigned by New York State.

Rationale

A method of identifying a facility by location. This identifier remains constant regardless of facility status changes or ownership.

Codes

Unique individual codes as assigned by NYSCR.

REQ/REF FIRST NAME

Reporting Status: Required Lab Only/Consult/Port-A-Cath (for Cases Diagnosed January 1, 2003 and Later)

Status: State Requested Item

Alternate Name	Item #	Length	Source of Standard	Column #
	9526	40	NYSCR	3085-3098

Description

First name of the requesting provider (e.g., managing physician. Submit the referring facility information only when information about the individual referring physician is not available.

Rationale

This information will be used as needed to follow up on cases with limited information.

REQ/REF LAST NAME

Reporting Status: Required Lab Only/Consult/Port-A-Cath (for Cases Diagnosed January 1, 2003 and Later)

Status: State Requested Item

Alternate Name	Item #	Length	Source of Standard	Column #
	9527	25	NYSCR	3099-3123

Description

Last name of the requesting provider or name of the referring facility. Submit the referring facility information only when information about the individual referring physician is not available.

Rationale

This information will be used as needed to follow up on cases with limited information.

REQ/REF ADDRESS

Reporting Status: Required Lab Only/Consult/Port-A-Cath (for Cases Diagnosed January 1, 2003 and Later)

Status: State Requested Item

Alternate Name	Item #	Length	Source of Standard	Column #
	9528	40	NYSCR	3124-3163

Description

The number and street address of the requesting provider or referring facility. Submit the referring facility information only when information about the individual referring physician is not available.

Rationale

This information will be used as needed to follow up on cases with limited information.

REQ/REF CITY

Reporting Status: Required Lab Only/Consult/Port-A-Cath (for Cases Diagnosed January 1, 2003 and Later)

Status: State Requested Item

Alternate Name	Item #	Length	Source of Standard	Column #
	9529	20	NYSCR	3164-3183

Description

Name of the city used in the mailing address of the requesting provider or referring facility. Submit the referring facility information only when information about the individual referring physician is not available.

Rationale

This information will be used as needed to follow up on cases with limited information.

REQ/REF STATE

Reporting Status: Required Lab Only/Consult/Port-A-Cath (for Cases Diagnosed January 1, 2003 and Later)

Status: State Requested Item

Alternate Name	Item #	Length	Source of Standard	Column #
	9530	2	NYSCR	3184-3185

Description

USPS abbreviation for the state used in the mailing address of the requesting provider or referring facility. Submit the referring facility information only when information about the individual referring physician is not available.

Rationale

This information will be used as needed to follow up on cases with limited information.

REQ/REF ZIP CODE

Reporting Status: Required Lab Only/Consult/Port-A-Cath (for Cases Diagnosed January 1, 2003 and Later)

Status: State Requested Item

Alternate Name	Item #	Length	Source of Standard	Column #
	9531	9	NYSCR	3186-3194

Description

Postal code used in the mailing address of the requesting provider or referring facility. Submit the referring facility information only when information about the individual referring physician is not available.

Rationale

This information will be used as needed to follow up on cases with limited information.

New York State Cancer Registry Reporting Manual

Part Five - Casefinding

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5.1 DEFINITION OF CASEFINDING

Casefinding is a systematic method of locating all eligible cases to be included in a cancer registry database. Although the hospital remains the primary source for most cases at the central registry, various non-hospital sources have become critically important in accurately assessing cancer incidence. Comprehensive casefinding includes investigating all diagnostic and therapeutic services to look for active cancer cases. Casefinding identifies both new cases and cases that have already been identified and entered into the registry.

5.2 CASEFINDING LIST FOR ICD-9-CM AND ICD-10-CM CODES

Refer to the casefinding lists included in sections 3.8 and 3.9 respectively.

5.3 CASEFINDING PROCEDURES

Registrars must rely on several sources of documentation to identify all cancer cases diagnosed and/or treated at the facility. More than one type of documentation is generally needed to capture all required information for each patient. Therefore, registrars must investigate every department or area where a patient may be seen or treated within a facility, to identify eligible cases. These sources differ depending on the facility type, the services provided, the size, etc. To ensure completeness, the task of casefinding should be limited to those who are familiar with the various reportable terms and conditions. Note that the American College of Surgeons (ACoS) and/or a facility's cancer committee may require registrars to report certain cases, in addition to NYSCR requirements.

Effective communication skills are essential in the casefinding process. Registrars will likely interact with other facility staff while researching and compiling information on eligible cases. The NYSCR recommends that registrars explain the purpose of their visits to departments and requests for information. It can be helpful to explain the nature of cancer case reporting and the function of the state registry, underscoring how accurate, timely and complete data collection at the provider level benefits the public, facility and patient with cancer. Cooperation of ancillary departments involved in cancer care is critical to achieving maximum casefinding results.

The need for open communication extends to relationships registrars have among themselves, with fellow members of the cancer committee and with their NYSCR field representative. NYSCR field representatives serve as liaisons between the NYSCR and the reporting facility. Registrars are encouraged to contact their field representative when questions and concerns arise. The NYSCR is committed to maintaining open communication with reporting facilities and encourages questions and/or comments. Working together, facility registrars and NYSCR field staff can usually resolve most issues quickly and completely.

5.3.1 Hospital Departments Involved in Casefinding

The sources listed below identify the departments/services where eligible cancer cases may be identified. Not all facilities contain every department, or offer all services listed. Registrars should review their facility's NYSDOH Operating Certificate for a complete list of all cancer related diagnostic and/or therapeutic services provided by the facility, both at their main campus, as well as at any satellite locations.

Each of the following departments/services is a potential source for eligible cancer cases:

- Laboratory Services: Pathology (Including Autopsy Reports), Cytology and Hematology (both on-site and contracted laboratory services)
- Health Information Management/Medical Records
- Outpatient, Clinic and Ambulatory Care Services/Surgery
- Oncology-Related Services (Chemotherapy, Radiation Therapy)
- Diagnostic Radiation
- Staff Physician's Offices
- Long-Term Care Facility/Skilled Nursing Facility
- Hospice and Other Palliative Care Services
- Emergency Department (ED)

5.3.1.1 Laboratory: Pathology (including autopsy reports), Cytology and Hematology

The laboratory department is generally the primary casefinding source for eligible cases to be included in the registry database. Personnel who are thoroughly knowledgeable in cancer case reporting must review every pathology report, including all autopsy, bone marrow, hematology and cytology reports.

There are different ways to accomplish the review of all laboratory reports. Registrars can manually review every report to identify eligible cases, or they may choose to run an electronic report that lists ICD-O histology and behavior codes to identify reportable diagnoses.

There can be distinct divisions of the pathology department, which may include subspecialties such as dermatopathology, eye pathology, oral pathology, GYN pathology and/or pediatric bone marrow pathology. Each division should be reviewed for reportable cancer diagnoses.

Experience demonstrates that trained registry personnel perform the most complete and accurate screening of pathology reports. If someone outside the registry reviews the pathology reports, a registrar should audit the findings periodically, to ensure complete and accurate casefinding. See Part 8: Quality Assessment for further information.

5.3.1.2 Health Information Management / Medical Records

The secondary source of cancer casefinding is the HIM/Medical Records Department, especially through the Disease Index. The Disease Index is usually a periodic listing (in an electronic format or as a hard copy) in numerical order by ICD code or medical record number. The index should contain the ICD diagnosis codes, the patient name and medical record number. Additional information may include admission and/or discharge dates, physician's name and/or license/ID number, length of stay and ICD codes for associated diagnoses and/or procedures. When requesting a Disease Index, the cancer registrar should specify the reportable ICD cancer codes to identify pertinent inpatient and outpatient visits.

The value of the Disease Index cannot be overstated. Not every reportable case has a positive histological diagnosis at each facility. Frequently in fact, a case is histologically diagnosed at one facility, or in a physician's office, and the patient is then seen at a different facility for treatment. These cases often can be identified through the Disease Index.

Health Information Management/Medical Records Departments can also be a source of information associated with discharges, specifically discharges following a death (death log). Regular review of all hospital deaths reduces the likelihood of future Death Certificate Only (DCO) cases. See Part 6 for more information on DCO cases.

5.3.1.3 Outpatient, Clinic and Ambulatory Care Services/Surgery

Registrars should establish casefinding procedures with all outpatient departments to find reportable cancer cases. Surgery and clinic visit logs are examples of possible casefinding sources. Review of billing records may also be helpful these contain both the diagnoses and applicable ICD codes. Inpatient and outpatient Disease Indices are often available separately.

5.3.1.4 Diagnostic Radiology

Registrars should regularly review reports from diagnostic radiology for eligible cancer diagnoses. In addition to plain x-rays, sources should include specialized imaging as applicable for the facility, such as ultrasound, mammography, MRI, CT, PET, fluoroscopy and nuclear medicine.

5.3.1.5 Oncology-Related Services (Chemotherapy, Radiation Therapy)

Registrars should review radiation oncology and chemotherapy appointment logs/books to identify eligible cases. In addition, thorough review of transcription reports related to patient consultation, treatment and follow-up visits may identify reportable cases.

5.3.1.6 Staff Physicians' Offices

A staff physician is one who has privileges to admit patients to and/or practice in a healthcare facility. When a facility employs a physician, the facility owns the staff physician's medical records. As a result, cancer registrars are responsible for reporting eligible cancer cases identified from these records.

5.3.1.7 Long-Term Care Facility / Skilled Nursing Facility

A long-term care facility and/or skilled nursing facility affiliated with a facility are potential sources for casefinding. Routinely review records to identify reportable cases.

5.3.1.8 Hospice

Monitor admissions to facility hospice units for casefinding purposes. Report eligible cases when patients receive palliative or comfort care. To reduce the likelihood of future Death Certificate Only (DCO) cases, report active cancer cases to the NYSCR whether patients have been diagnosed and/or have received treatment at the facility or not.

5.3.1.9 Emergency Department (ED)

ED records are a casefinding source. Review ED logs and death certificates to capture and report eligible cases of patients who expire in the ED or are dead on arrival (DOA).

5.4 QUALITY OF CASEFINDING / PERIODIC INTERNAL CASEFINDING AUDITS

The NYSCR strongly encourages every reporting facility to conduct periodic internal casefinding checks to ensure that every eligible case is identified and reported. Facilities may develop their own system of internal review or speak with other facility registrars or their field representatives for ideas. Registrars should look for changes in services and/or staffing when significant changes occur in the annual reporting total average. Registrars are encouraged to address fluctuations in reporting totals with their NYSCR field representatives as soon as they are noted. See Part 8 – Quality Assessment for further information.

New York State Cancer Registry Reporting Manual

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6.1 INTRODUCTION

The following section contains specific information pertaining to Death Certificate Only (DCO) and Death Clearance Lists.

A DCO case is one that is reported to the NYSCR via the office of Vital Statistics or from the Statewide Planning and Research Cooperative System (SPARCS), following mention of cancer or other malignant disease on a Death Certificate, which in turn cannot be matched with any cases stored in the NYSCR database. The SPARCS records are limited to those records with cancer-related admissions, but in some cases the type of cancer identified on the SPARCS record is different than that listed on the death certificate. Occasionally, a previously reported case appears on a facility's DCO list. The circumstances that lead to this are discussed later in this section. DCO lists are transmitted to facilities on a yearly basis.

6.2 HOW A CASE BECOMES A DCO

The NYSCR receives a data file from Vital Statistics and SPARCS that contains information on every New York State death certificate filed or has a cancer-related admission for a given year. This file contains information related to the underlying cause of death, any contributing causes of death, date of death, the institution where death was declared and various pieces of demographic information (e.g., name, social security number, address). A computerized program at the NYSCR attempts to match the cases on the Vital Statistics and SPARCS file to those already in the Registry's database to determine whether

- the deceased was previously listed with the Registry (information which is of interest to the Registry, whether or not the person died of cancer); or
- a potentially reportable tumor, mentioned on a death certificate, cannot be matched to anyone in the Registry, in which case follow-back is initiated with the institution where the individual expired.

Potential matches are given to Registry coding staff via an internal software program. The coders must then determine whether the Vital Statistics or SPARCS case matches any patient in the NYSCR database.

- When a death certificate case does not match any previously reported case in the Registry's database, it becomes a DCO.
- If a match is established, the coder follows special tumor matching rules to determine whether the tumor reported on the Death Certificate matches a previously reported tumor for that patient.

Often the tumor reported on the Death Certificate reflects metastases from a previously reported tumor. Therefore, Death Certificate cases with common metastatic sites are always matched to previously reported tumors. Any death case matching a case on the registry database, but containing a tumor that does not match a previously reported tumor, also becomes a DCO case.

6.3 DCO LISTS AS COMPLETENESS INDICATORS

DCO lists serve as a measure of the completeness of cancer reporting from individual facilities. The smaller the list, the more complete a facility's cancer reporting. The facility should also look at the number of cases on the DCO list in comparison to their average annual caseload (your field representative can provide this figure). In addition, the cause of death code for each patient on the list may offer clues to weaknesses with casefinding procedures. For example, if the number of leukemia, lymphoma and multiple myeloma cases is high, the facility might not be identifying cases seen only by hematologists.

6.4 METHODS FOR REDUCING DCO LISTS

A proactive approach to reducing the number of DCOs at a facility involves determining how and where death certificates are processed. The individual responsible for reporting to the NYSCR can then establish a mechanism to ensure that the facility obtains copies of all death certificates for review.

6.5 RECONCILIATION OF DCO LISTS

It is imperative that facilities reconcile *all* DCOs in a timely manner. Facilities must submit reportable cases and provide information for any non-reportable and/or missing cases within four weeks of receiving their DCO list. Therefore, the person responsible for reconciling DCOs should request the medical records for these cases as soon as the list is received. This is especially true for cases that might be stored at an off-site location. The facility's field representative will contact the registrar if all cases are not received by the deadline.

Cases must be submitted electronically via Abstract Plus or the facility's vendor software. Specific abstracting instructions may vary from year to year so it is important to read the instructions that accompany the DCO list carefully.

6.5.1 Reportable Cases

DCOs confirmed by a facility to be reportable, but which have not been previously reported, must be submitted via their cancer-reporting software. The Registry recognizes that information might be limited on some of these patients due to a brief admission during the terminal phase of their illness, or if the patient died in the emergency room or was DOA. Information should be reported as it appears in the patient's medical record, even though it may differ from that found on the death certificate.

6.5.2 “History Only” Cases

According to regular reporting guidelines, “History Only” cases of cancer are not reportable. However, when they appear on a DCO list, they must be followed back to the NYSCR. The reason a case appears on a DCO list is because the patient and/or tumor associated with that patient was not reported at the time of the original diagnosis. It is understood that the facility reconciling the DCO case probably has limited documentation related to the cancer and that many of the data fields may be submitted as “unknown”.

During casefinding, a case may present as history only, however the patient dies at the facility. As a proactive measure, the facility may choose to abstract and hold these cases in their suspense file. This may be easier than retrieving records at a later date, should the case appear on the DCO list.

6.5.3 Non-Reportable Cases

If, after reviewing the medical record for a DCO case, it is determined that the patient did not have cancer or had been diagnosed with a non-reportable tumor, the registrar should inform his/her field representative. Cases deemed non-reportable will be deleted from the NYSCR database. To prevent a reportable case from being inappropriately deleted, supporting documentation showing the case is not reportable may be requested.

6.5.4 Previously Reported Cases

Registrars should contact their field representative if it is believed that a DCO case has been previously reported. The field representative will assist the registrar in determining whether the DCO should be re-submitted. The field representative can check the NYSCR’s database to confirm whether a report was received from the facility for that patient. If a report is found on the database, the field representative determines whether the malignancy reported on the death certificate is reflective of the primary site that was originally reported. If a report cannot be found on the Registry’s database, or if it is determined that the patient had been diagnosed with multiple primary tumors, the facility must report the case.

6.5.5 Patient Not in Database

The registrar should notify his/her field representative regarding any DCO case(s) that cannot be located within the facility’s patient database. The registrar must exhaust all resources prior to deciding that a patient was not seen at the facility. Resources that should be checked include, but are not limited to, emergency room logs, review of actual death certificates and so on.

6.5.6 Medical Record Cannot Be Located

Registrars should notify their NYSCR field representative about any DCO case that cannot be completed due to a lost or misfiled medical record. These cases will remain on the facility’s outstanding DCO list until they are reconciled.

6.5.7 Digital Storage

If the medical record for a DCO case is being scanned for digital storage, the registrar should ascertain how long it could take for him/her to reconcile the case and notify their field representative.

6.6 DEATH CLEARANCE LISTS (DCLs)

The NYSCR, in conjunction with the NYSDOH Bureau of Vital Statistics, routinely prepares Death Clearance Lists (DCLs) to assist registrars with any patient follow-up conducted by their facility. Facilities with formal cancer registries that perform routine follow-up activities find the DCLs most useful. The DCLs provide information on individuals who had a reportable condition mentioned on their death certificate or whose Cause of Death code was reflective of a reportable tumor. DCLs contain information only for those cases that the facility previously reported to the NYSCR.

Electronic files are prepared for a given death year and sent to health facilities over the HCS by request. DCL files contain hospital-specific information regarding the death of individuals who were previously reported to the NYSCR by an institution (death clearance list) and cases reported by a facility that were subsequently seen somewhere else (non-death follow-up list). An instruction sheet with information regarding the DCL files is sent to the requesting health facility in a separate e-mail by the facility's field representative.

New York State Cancer Registry Reporting Manual

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7.1 INTRODUCTION

Quality Assurance (QA) measures and Continuous Quality Improvement (CQI) procedures are used to achieve the highest quality cancer data. Good quality control measures are necessary to assess registry data and identify areas of excellence and opportunities for improvement.

These measures and controls allow registry professionals the benefit of a shared frame of reference, a common language and a better understanding of the importance of quality assurance measures. By applying these techniques, cancer registries can improve the quality of their data, and create an opportunity to improve communication within their facility and among the cancer data organizations with which they associate.

An effective cancer registry is staffed by individuals who have well-defined goals that are clearly documented. A registry can remain focused and maintain a sense of direction if the staff has a concrete knowledge of the types of questions their registry can answer.

7.2 TERMINOLOGY

Quality Assurance (QA) - Webster's Dictionary defines "quality" as a degree of excellence. There are various terms with common meanings, including:

- Quality Control / Quality Assessment – These assure the data are useful. The processes may also ensure that data and information meet a previously defined standard.
- Continuous Quality Improvement (CQI) – CQI is a mechanism that ensures ongoing quality assurance activities in an effective and efficient manner. One CQI method is to assess quality as the information occurs (i.e., concurrently) rather than after the fact (retrospectively).

Concurrent assessment of information can reduce the amount of work needed to provide quality data, enhance the knowledge of the registrar and improve the usefulness of the database, since it occurs as the data are collected. Errors are immediately identified and corrected.

7.3 IMPORTANCE OF QUALITY DATA

Cancer registrars are a critical resource in the war against cancer as they are on the front lines, collecting vital information. To be effective, this information must be complete, timely and accurate. In the cancer registry field, data are the building blocks of information and they are measurable. For instance, if the grade of a tumor is accurately recorded, it becomes a fact that can be used for clinical decisions. Cancer registry professionals must always be mindful of the fact that cancer data are used to help reduce the cancer burden on patients and society in general.

Registrars are familiar with numbers, reports, charts and rates, but are often isolated from the patients who are affected by their work. Registry data, or information summaries based on the data, are used to assess risk, recommend therapies and monitor patient outcomes. This information can also be used to educate cancer patients about the treatment decisions they face. Researchers use the data to increase public knowledge of the disease process. Public health officials use the data to monitor the

burden of the diseases in populations – to plan, prioritize, implement and evaluate cancer control interventions.

7.4 TIMELINESS

Timely data collection is important to both the hospital and central cancer registry, and comes with advantages and challenges. For instance, in clinical trials; early patient and tumor identification assists in determining whether a patient is eligible. For the registrar, it is a challenge to determine staging and treatment information due to the lack of complete information at the time of abstracting. Different organizations have different timeliness standards. Most central registries have legislative mandates for the timing requirements of data collection. NYS Public Health Law Section 2401 states: Every physician, dentist and other health care provider shall give notice immediately but not later than one hundred eighty days of every case of cancer or other malignant disease coming under his or her care, to the department, except as otherwise provided. See Appendix A.

7.4.1 National Program of Cancer Registries (NPCR)

NPCR standards require that (1) within 12 months of the close of a diagnosis year, 90 percent of expected, unduplicated cases are available to be counted as incident cases and (2) within 24 months of the close of a diagnosis year, 95 percent of expected, unduplicated cases are available to be counted.

7.4.2 North American Association of Central Cancer Registries (NAACCR)

The NAACCR definition for timely reporting states that within 18 months of the close of a diagnosis year, the registry should contain 95 percent of expected cases.

7.4.3 Surveillance Epidemiology and End Results (SEER)

SEER agreements with participating registries state that the registry must provide counts of new cases for a calendar year within 20 months of the end of a diagnosis year.

7.4.4 American College of Surgeons (ACoS) Commission on Cancer (CoC)

CoC-approved programs are required to accession all eligible cases within six months of diagnosis or admission for treatment to the reporting facility. This is usually done retroactively since cancer is a disease for which treatment can be administered over many months. A patient may still be receiving first course of treatment and the medical record may be unavailable to the registry for review immediately upon discharge.

While these things may affect the reporting schedule, frequent data submission allows not only for a more even workload distribution, it also enhances data quality since misunderstandings may be caught and corrected early.

7.4.5 Monitoring timely reporting

There are several ways to monitor reporting. Registrar can calculate the number of cases abstracted to-date for the current accession year as a percentage of the total number of cases expected for the current year. The expected number of cases can be determined by past reporting years, adjusted for changes in service delivery. This is then compared to the amount of time that has elapsed to-date in the current accession year, minus the allowable reporting time frame. For example, if the reporting time is six months, the number of cases abstracted by January 1st, should be 50 percent or more of the total number expected for the previous year. If so, the registry is within timeliness standards.

Another way to monitor timeliness is to have a computer generate the lag time. Lag time is the number of days between central registry submission date and discharge date or date of first contact (if there is no discharge date). If lag time is \leq 180 days, the registry is within timeliness standards.

7.5 ACCURACY

Data must be accurate. The consistent use of national standard data definitions allows for reliable comparison among all data collection agencies and facilitates the compilation of aggregate of data.

Central and hospital registries share a common mission, albeit occasionally different goals and/or strategies. Viewing each registry as a stand-alone system however, minimizes the effectiveness of cancer registration as a system, and can lead to a lack of cohesion and cooperation. Central and hospital registries each report to various entities, including groups outside the cancer registry community, such as state legislatures, hospital administrators and the public at-large. Over the course of the last few years, all organizations involved in cancer data collection have begun to work collaboratively to minimize differences in data collection standards. They recognize that conflict in data standards and goals hampers reliable comparison studies. In addition, differing data collection standards place an undue burden on registrars in reporting facilities by requiring duplicate as well as different coding. Most of the differences between central and hospital databases can be resolved through improved collaboration. It therefore behooves central and hospital registries to pursue the path of cooperation and collaboration by looking to the common goal and adopting methods that benefit everyone and facilitate success.

Data accuracy is also dependent upon a clear understanding of the goals of the registry program. Knowledgeable and experienced individuals must oversee the design, collection and disbursement of information. In the hospital setting, discrepancies in staging and other core data items must be resolved by interaction among the hospital registrars, the medical staff and the central registry. To resolve discrepancies, copies of abstracts can be sent to attending physicians to provide opportunities for discussion. Sending copies of abstracts is especially important as advances in therapies often evolve faster than many registrar's ability to track them.

Open discussion among physicians and hospital and central registrars, provides excellent learning opportunities. Ongoing routine, as well as random, review of the data

by multiple participants can provide an excellent system of checks and balances. Many registrars do not have access to the professional development opportunities that a multi-staff department can provide. Building a network of professional resources to act as mentors or sounding boards can enhance knowledge and confidence.

Central registries provide an objective check of the data by assessing the quality and consistency of coding as it relates to supporting documentation. Without access to the patient's medical record, the central registry must rely solely on the supporting text narrative provided by the hospital registrar. Poor documentation contributes to inaccurate coding. Detailed documentation can reduce misunderstandings in rule interpretations and provide the opportunity to correct inaccuracies in a timely and objective manner.

7.5.1 Computerized Edits

Standardized edits are one of the most important QA tools a cancer registry can use. Current cancer-reporting software, including Abstract Plus, provides computerized edit checks that are applied automatically to records as they are processed and submitted. The two (2) common types of computerized edits available in Abstract Plus, as well as for commercial cancer-reporting software products, are:

- Range Edit Checks – which look for allowable values. If a value is outside the allowable range, the field cannot be populated (e.g., the acceptable range for ICD-O; C00_ - C80_).
- Inter-Field Edit Checks – which look at the relationship between variables on the same record to identify unlikely or improbable code combinations (e.g., a female with prostate cancer).

Abstract Plus also provides prompts, error messages, drop-down coding choice lists and online help (e.g., STORE manual and SEER program code manual) to assist in making accurate coding choices.

7.5.2 Visual Edits

Although convenient, auto-coding should only be used in conjunction with a visual review of all text and codes. Computer-generated text should never be used when reporting information to the NYSCR. Text should be typed as it appears in the patient's medical record (i.e., in natural language). A visual review provides a check of the narrative text to the codes and ensures that all information from the medical record is included in the abstract. The individuals involved in abstract review must be familiar with all data item requirements and coding instructions used by the NYSCR and be knowledgeable and well trained in abstracting cancer data from patient records.

7.5.3 Cancer File Submission Reports

As part of their QA procedures, reporting facilities should routinely review their NYSCR Cancer Case Submission Report. This report provides routine, detailed and objective measures of the quality and consistency of coding. In addition to confirming the receipt of cases by the NYSCR, this report provides a statistical breakdown of:

- the number of non-reportable tumors and early reported tumors;
- the number of records, including lab reports, within a batch that were rejected for errors and/or warnings; and
- the accepted number of records.

These variables – along with others such as percent of death certificate cases and percent of lab only cases – can be used to monitor patterns in reporting. The reporting facility should establish a procedure to retrieve, review and file all submission reports. All rejected cases and major errors identified on the submission report must be corrected and resubmitted to the NYSCR within 10 days of the original submission date. For more information on Submission Reports, see Part Eight of this manual (Electronic Reporting).

7.6 COMPLETENESS

Completeness can be assessed from two perspectives: completeness of a case and completeness of the registry database. Complete data within a case is necessary to avoid misleading or misconstrued conclusions regarding treatment patterns or other factors that could affect the care of future patients. Obtaining all data elements is challenging for registrars given that patient care is often provided at many different facilities. Many times, the cancer registry is the only place within a facility where the complete picture of a patient's care is documented. Therefore, the registry plays a crucial role in providing the facility with good QA information.

An important function in any registry's operation is to monitor the completeness of the database. Hospital-based registries must ensure that casefinding sources such as the disease index are updated whenever the ICD codes change. Caseloads from previous year(s) should be compared, to determine fluctuations. If the caseload appears to be decreasing, the registrar should check to see whether all the proper cases are being captured, and determine if any major events occurred that would justify a reduction in caseload. Examples of potential reductions in caseload could be the loss of an oncologist or the termination of certain cancer-related treatment services. In such instances the registrar could expect to see a decrease in the number of cancer cases.

A casefinding audit can be completed to assess the facility's completeness and determine if and where missing cases are found. More information on this can be found in the audit section (8.9). Obtaining complete treatment and follow-up information yearly from physician contacts can also assist in maintaining completeness.

At the central registry, the Death Certificate Only (DCO) method is used to monitor case completeness, and inpatient facilities with incomplete casefinding may expect to see a higher DCO rate than similar facilities that are complete. For additional information regarding DCOs, refer to Part Six of this manual.

7.7 MEASURABILITY

For data collected by the NYSCR to be useful in research, public health planning and evaluation, the data must be standard, reliable and valid. Poorly documented, infrequently collected and/or non-standard data items are no less time-intensive to collect as are valid items. For example, quality of life and co-morbidity are topics of considerable interest. If all participants are not using the same measures, indicators, and definitions, the information is difficult to compare with the experience of others, difficult to interpret, and impossible to generalize for increasing the knowledge base.

Use of this manual, as well as the SEER reporting manuals, and CoC's Standards for Oncology Registry Entry (STORE) manual as the basis of data collection ensures that data collection is the consistent in all facilities and makes data comparison more relevant.

7.8 QUALITY ASSURANCE (QA) METHODS

There are many methods available to monitor standards at the central and hospital registries. The cancer registry professional should understand the concepts of Continuous Quality Improvement (CQI) and be able to appropriately implement QA procedures.

7.8.1 Accreditation

Gaining and maintaining approval through a formalized survey process is one method healthcare facilities can use to ensure that QA mechanisms are in place.

For example, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) provides standards on quality of data and services to which the facility must demonstrate compliance. The American College of Surgeons (ACoS), Commission on Cancer (CoC) provides standards specifically designed for quality of cancer data and services to which to which an accredited facility must demonstrate compliance. By receiving approval through a nationally recognized organization, a reporting facility's cancer program is measured against a pre-defined standard of accountability, care and quality. The presumption is that a facility approved through one of these surveys has a higher standard of care than facilities that are not approved. Communication is an essential component of applying for and maintaining approval. Gaining approval takes a large amount of time, money, cooperation and coordination of various facility resources.

7.8.2 Central Registry Certification

Central registries are affected by changes in the various organization's data collection standards. Therefore, they must stay abreast of what the reporting requirements are for all reporting facilities approved by these and similar organizations, as well as the requirements of NAACCR and the federal SEER and NPCR programs. This awareness is vital to the NYSCR when considering modifications to reporting requirements, if necessary, and to provide the best possible communication and service to reporting facilities throughout New York State. Ongoing communication must be maintained among all accrediting organizations and central registries. This issue has become extremely important over the last few years as there have been national efforts to collect

data fields in all states and regions that are consistent, timely and meet high standards of quality.

The NAACCR Registry Certification Committee has established a process by which NAACCR Full Member Registries may annually receive an objective evaluation and confidential feedback of their achievement in case ascertainment, case linkage, completeness of information abstracted on critical variables, data accuracy and timeliness of case reporting. When population-based cancer registries achieve excellence in all areas, they are certified. Certification provides each registry with an objective and confidential report that identifies areas of strength and weakness. Central registries are encouraged to share the findings with appropriate partners and staff.

If used appropriately, the certification process can help a registry prioritize procedures to maximize the quality of data outcomes, achieve excellence and, ultimately, NAACCR certification.

7.9 AUDITS

The types of audits conducted by the NYSCR include:

- Casefinding (case completeness)
- Re-abstracting
- Site-specific data quality
- Accession register
- MRDI Desk audit

The purpose of an audit is to ensure that all reportable cases are abstracted and that the information contained in each abstract is complete and accurate. The NYSCR conducts casefinding and re-abstracting audits at reporting facilities to assess reporting completeness and monitor data validity in abstracting. Many central registries require a higher percentage of case completeness from their reporting facilities to obtain total population based reporting.

7.9.1 Casefinding Audit

Casefinding audits are conducted to determine whether all cases eligible for reporting have been reported for a given period.

7.9.1.1 Central Registry

The goal of a central registry is to record, at least 95 percent of the tumors occurring among individuals in a specifically identified geographic district and to ensure that source reports are received from all potential sources (hospitals, outpatient services, physician offices, death certificates and central registries in adjacent regions).

As previously stated, the NYSCR conducts regular, organized casefinding audits of reporting facilities. As part of a casefinding audit, field staff at the central registry review the disease index, the pathology department files, and all other applicable sources (e.g., oncology clinic logbook, radiation therapy logbook, outpatient clinics, etc.) for a specified period.

The central registry field staff make note of all reportable cases found within these sources and identify any of those cases that do not appear in the NYSCR database.

The audits are conducted after reporting is complete for a calendar year. All audit findings are clearly documented in writing to the applicable registrar(s), their supervisor and any other appropriate facility staff, as well as to the director of the NYSCR.

7.9.1.2 Facilities

Complete casefinding by a facility presents challenges, as it requires identifying cases from multiple sources. Cooperation and clear lines of communication with all applicable departments within the facility (e.g., pathology, cytology, radiology and radiation oncology departments), as well as any satellite clinics and/or outpatient surgery centers operated by the facility, are essential to meet this goal. Requests for data that need to be forwarded to other departments can be accomplished more directly if registrars have good communication with the various department supervisors regarding the purpose and process of the casefinding procedures.

Providing the validation and underlying principle for cooperation enhances the awareness, support, involvement and understanding necessary to capture all reportable cases. Because cancer patients are seen in multiple departments, it is necessary to look at all potential sources to accurately assess case completeness. Casefinding audits can help to identify areas where cases are missed. Facilities can then use this information as a tool to improve their routine casefinding procedures.

7.9.2 Re-abstracting Audits

Re-abstracting audits are performed to determine the quality of the data that are being reported to the registry.

7.9.2.1 Central Registry

In this type of audit, NYSCR staff select a random sample of abstracts the facility has previously reported. The NYSCR then provides a written request for corresponding medical records of the selected abstracts to be photocopied or scanned and sent to the NYSCR. Once received, NYSCR field staff review the medical records and perform a re-abstracting. The data collected from the re-abstractation are then compared with the original abstracted provided by the facility to identify discrepancies. Detailed reports are then presented to the facility to express the findings. These audits are successful only if there is clear communication between the NYSCR and facility staff regarding the criteria, methods, standards and findings. It is strongly recommended the audited facility staff use findings of audit to in the development of in-service training programs.

7.9.2.2 Hospital Registry

At the hospital/facility level, re-abstracting audits are a valuable measurement tool that can significantly contribute to quality data. For example, a physician may choose to re-abstract 10 percent or more of the registry's cases to assess agreement with abstracting guidelines.

7.9.3 Site-specific Audits

Periodic site-specific audits (e.g., colon, breast, lung) are a valuable QA tool for both the NYSCR and facilities, as it allows registry staff to potentially identify and correct errors quickly.

7.9.4 Accession Register Audits

This type of audit is undertaken to verify that all abstracted cases entered into a facility's database have been successfully transmitted to the NYSCR.

7.9.5 Desk Audit

Desk audits consist of a review of a facility's Medical Record Disease Index (MRDI) to determine whether all reportable cancer encounters have been reported for a designated period.

7.10 QUARTERLY FEEDBACK REPORTS

Quarterly feedback reports are used to evaluate predefined data items based on predefined standards. Registry data items and standards are set by the NYSCR, NPCR, SEER and/or NAACCR. One of the goals of NAACCR is to bring together the various parties involved in setting standards, so that cancer data in the US and Canada are collected in the same way, applying unified standards.

To be successful and consistent in standardized data collection, it is best to evaluate data items and standards required and defined by standards-setting organizations. It is important to know the data items that best meet the needs of local users or customers. The quarterly feedback report is a valuable tool that should be used to review data collection and improve the value of the cancer registry database.

The quarterly feedback report summarizes the reporting status of individual facilities. The time interval between diagnosis and/or discharge and transmittal of reports to the NYSCR is measured. A comparison is done on the number of unique tumors transmitted by a facility against an expected number of unique tumors, based on historical reporting patterns. Uniqueness is based on medical record number, social security number, date of diagnosis, ICD-O codes and date of discharge.

Facility quality standards are also computed and summarized. Completeness of reporting is determined by identifying the number of unique tumors submitted for a given year and comparing that to the expected number of unique tumors, based on an average of several previous years. NYS Public Health Law stipulates that all cancers must be reported within six months (180 days).

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New York State Cancer Registry Reporting Manual

Part Eight – Electronic Reporting

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8.1 CREATING AN EXPORT FILE

The first step in preparing a file for submission to the NYSCR is the creation of an export file. Facilities using commercial software products should follow the instructions provided by their respective software vendor. Individual export files should be limited to a maximum of 500 abstracts each. Registrars should work with their software vendors to ensure that files do not contain more than 500 abstracts.

Abstract Plus users unfamiliar with the export process should click on the **Help** tab on the menu bar and select **Contents**. Next, they should select **Abstract Plus Users Guide** located at the bottom of the list of manuals included on the right side of the Help screen; scroll down to **Working with Abstracts**; and select **Exporting Abstracts** from the list of options.

Note: It is no longer necessary to compress files and create a .pak file using the NYS Cancer Case Submission Program. These files (i.e., .pak) will no longer be accepted.

8.2 SUBMITTING TO THE NYSCR VIA THE HEALTH COMMERCE SYSTEM (HCS)

All cancer abstracts are submitted to the NYSCR electronically via the HCS. Follow the steps below to transmit a file to the NYSCR.

1. Connect to the HCS at <https://commerce.health.state.ny.us>.
2. Click **CR Facility Reporting**, found under the **My Applications** header, located to the left of the screen* (Figure 1).
3. Once on the Cancer Registry page, click **Browse** (Figure 2) and select the appropriate .txt or .zip file from the appropriate export folder (Figure 3). For Abstract Plus users, the file will be located in **C:\Regplus\AbstractPlus\Exports**. **Again, note that .pak files created using the NYS Cancer Case Submission Program are no longer accepted.**
4. Click **Open** (Figure 3) and the file name will appear in the **Upload File** box (Figure 4).
5. Click **Upload** (Figure 4).
6. Following completion of a successful file upload, the user should receive a similar message (Figure 5). Users should allow up to ½ hour for processing, after which the user will be able to view the file information in the same **CR Facility Reporting** application on the HCS website.

*If you do not have the **CR Facility Reporting** application, contact your HCS Coordinator and request they add the role of Facility Cancer Reporting Submitter to your HCS account. This role must be assigned separately through each facility the user submits cases for. If you have any questions, contact your NYSCR Field Services Representative at (518) 474-0971.

Welcome Megan L. Leone

Search

My Applications

- Acronyms & Abbreviations
- Cancer Data Entry - Physicians
- CR Facility Reporting
- Emergency Contacts
- Facility Cancer Reporting

Important Health Events

CYBERSECURITY
ZIKA VIRUS RESPONSE

NYS PMP
PROFESSIONAL PROGRAM ASSOCIATION

2018
Train the Trainer

Important Health Notifications

Posted	Priority	Keyword	Source	Audience	Description	Recipients
10/19/2018	Drill	Admin	Alpha Sort		Test	Recipients

Figure 1

Welcome Megan L. Leone

FAQ

Home Batch Search Broadcast Message Help

System Messages
System will be functional starting Nov 12th

UPLOAD A FILE

Select the file for upload

Browse... Upload

Large files can take a few minutes to upload please be patient!

Figure 2

Select Input File

Local Disk (C:) > RegPlus > AbstractPlus > Exports

Search Exports

Organize New folder

Name	Date modified	Type	Size
DOH0001.txt	6/23/2016 3:30 PM	Text Document	90 KB

File name: DOH0001.txt All (*.*)

Open Cancel

Figure 3

System Messages
System will be functional starting Nov 12th

UPLOAD A FILE

Select the file for upload

Large files can take a few minutes to upload please be patient!

Figure 4

System Messages
System will be functional starting Nov 12th

UPLOAD A FILE

File Successfully Uploaded. FileID Assigned: 200043

Figure 5

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New York State Cancer Registry Reporting Manual

Appendix A - NYS Public Health Law

Section 1. Short title.

This act shall be known and may be cited as the "Cancer Research Improvement Act of 1997".

Section 2. Section 2401 of the public health law is amended to read as follows:

Article 24. Title 1.

§ 2401. Cancer; duty to report.

1. Every physician, dentist and other health care provider shall give notice immediately but not later than one hundred eighty days of every case of cancer or other malignant disease coming under his or her care, to the department, except as otherwise provided.
2. Whenever an examination of a tissue specimen in a laboratory discloses the existence of cancer or other malignant disease, the person in charge of such laboratory or the person making such examination shall immediately but not later than one hundred eighty days report the same together with all the facts in connection therewith to the department.
3. The person in charge of every cancer reporting facility shall immediately but not later than one hundred eighty days give notice of every case of cancer or malignant disease coming under the care of the institution to the department.
4. All abstracting work performed by a cancer reporting facility pursuant to the reporting provisions of this section shall be performed by a certified tumor registrar. Cancer reporting facilities may establish consortia to engage a certified tumor registrar to perform the reporting requirements of this section. A "certified tumor registrar" is an individual certified by a nationally recognized not-for-profit organization which certifies tumor registrars. The provisions of this subdivision shall not apply to any cancer reporting facility which renders services for one hundred or fewer cases of cancer and malignant disease per year as determined by the commissioner.
5. The department shall establish and update as necessary a manual designating which specific data elements shall be reported to the department pursuant to this section. The department shall make such manual available to every cancer reporting facility, physician, dentist and other health care provider required to comply with the provisions of this section.

6. The department shall establish and update as necessary a data dictionary to standardize information interpretation of data elements reported by cancer reporting facilities and other health care providers. The department shall make such dictionary available to every cancer reporting facility, physician, dentist and other health care provider required to comply with the provisions of this section.
7. The department shall, to the extent funds are made available, establish or contract for regional training programs to provide training to any cancer reporting facility, physician, dentist or other health care provider required to comply with the provisions of this section. Such regional training programs shall provide training relating to the specific data elements which must be reported pursuant to this section, the data dictionary established pursuant to this section, and any other subjects which are intended to ensure quality, timely and complete compliance with this section.
8. The department shall, meet cancer registry goals established by a nationally recognized central cancer registry organization unless any such goal is contrary to any provision of law.
9. Where a cancer reporting facility fails to comply with the provisions of this section, the department may elect to perform registry services for such facility. Such cancer reporting facility shall reimburse the department for actual expenses incurred.
10. A physician, dentist, laboratory, cancer reporting facility or other health care provider which violates any provision of this section shall be subject to a civil penalty as provided in section twelve of this chapter.
11. The notices required by this section shall be upon forms supplied by the commissioner and shall contain such information as shall be required by the commissioner.
12. For the purpose of this section, a "cancer reporting facility" means a hospital as defined in article twenty-eight of this chapter, clinic or any organization certified pursuant to article forty-four of this chapter, or other similar public or private institution.
13. The commissioner shall have the power to promulgate any such rules and regulations as shall be necessary and proper to effectuate the purposes of this section.

§ 2401-a. Reporting.

1. Annual report. The commissioner shall, submit an annual report to the governor, the temporary president of the senate and the speaker of the assembly. The report shall include an evaluation of the cancer registry as it relates to timeliness, quality and completeness; an evaluation of the utility of the registry for scientific research; an evaluation of the access, timeliness and quality of reporting information to researchers and other similar individuals; an evaluation of the registry's data elements, including treatment, stage of disease, occupation and residence; an evaluation of the feasibility and utility of inclusion of occupational history and residence history; and an evaluation of integrating the registry with other data bases maintained by state agencies and departments, including the statewide planning and research cooperative system.

2. Quarterly report. The commissioner shall submit a quarterly report to the governor, the temporary president of the senate and the speaker of the assembly. The quarterly report shall include an evaluation of whether the registry is achieving cancer registry goals established by a nationally recognized central cancer registry organization, including numerical goals concerning timeliness, quality and completeness.

3. Skin cancer reporting. The department shall annually submit a written report to the governor and the legislature on the incidence of skin cancer in the state of New York, by type and as a percentage of the overall number of reported cases of all types of cancer, as well as the associated causes of each type of skin cancer, if such causes are readily ascertainable. Such report shall be generated based on data gathered and reviewed pursuant to this title, and shall provide information which is as current as practicable; provided, however, a retrospective of the past ten years of information collected pursuant to this title and predominant trends associated with such information, as concerns skin cancer and its associated causes, shall be a component of such report and each report submitted thereafter. At the discretion of the commissioner, such reports may provide additional information other than the information required by this subdivision. The first report created pursuant to this subdivision shall be submitted one year after the effective date of this subdivision. The reports generated pursuant to this subdivision shall be made available to the public on the department's website.

§ 2402. Cancer; reports confidential.

The reports of cancer cases made pursuant to the provisions of this article shall not be divulged or made public so as to disclose the identity of any person to whom they relate, by any person, except in so far as may be authorized in the sanitary code.

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New York State Cancer Registry Reporting Manual

Appendix B – HIPAA Information

This information sheet has been prepared to clarify and confirm the authority of NYSCR staff to access patient medical records relating to the diagnosis and treatment of cancer. Access to this information is sought under NYSDOH authority, pursuant to Public Health Law 2401, which provides that “... every physician or other health care provider shall give notice immediately but not later than 180 days of every case of cancer or malignant disease coming under his or her care, to the Department of Health, except as otherwise provided.”

Such access has been determined by the NYSDOH/NYSCR to be the minimum necessary for protected health information for the state purpose in compliance with 45 C.F.R. s164.502. Please note that federal regulations permit reasonable reliance given attendant circumstances regarding requests for information made by public officials for stated purposes. [45 C.F.R. s164.514(d).]

The NYSDOH is a “public health authority”, as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Federal regulations [see 45 C.F.R. s164.512] authorize disclosure without patient consent in a number of circumstances, including the following:

Disclosure is permitted to a public health authority authorized by law to access information to prevent/ control disease, injury, disability, e.g., disease reporting, vital statistics reporting, public health surveillance, public health investigations, public health interventions and partner notification.

Because the NYSDOH is a public health authority and because cancer reporting and surveillance are required by state law, it is not necessary to complete a business associate’s agreement before providing the NYSCR with the requested personally identifiable information. The requested information is needed to conduct public health surveillance and will remain confidential.

If you have any questions with respect to the NYSCR’s authority to access protected health information, please contact Maria Schymura, Ph.D., Director, NYSCR, at 518-474-2255.

Frequently Asked Questions and Answers About HIPAA and Cancer Reporting

The below FAQs and answers about HIPAA were excerpted and revised by New York State from a document prepared by the North American Association of Central Cancer Registries (NAACCR). If you have any specific questions about HIPAA and cancer reporting that are not addressed below, please contact your NYSCR representative.

1. What is a 'Public Health Authority' under HIPAA?

Under HIPAA, a 'Public Health Authority' refers to "an agency or authority of the United States, a State or territory, a political subdivision of a State or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is responsible for public health matters as part of its official mandate."¹ "...Such agencies are authorized by law to collect or receive such information for the purposes of preventing or controlling disease, injury, vital events such as birth or death and the conduct of public health surveillance, public health investigations and public health interventions."² *Central cancer registries* are considered public health authorities because their duties are mandated by state laws.

¹ C.F.R. 164.501

² C.F.R. 164.512

2. What is a 'Covered Entity' under HIPAA?

A 'Covered Entity' is a health care plan, a healthcare clearinghouse, or a health care provider who transmits any health information in electronic form for financial and administrative transactions. A 'health care provider' is "a provider of medical or health services and any other person who furnishes, bills or is paid for health care in the normal course of business."¹

¹ C.F.R. 160.103

3. How does HIPAA impact the data collection of non-reportable/benign diseases (i.e. benign brain, CIN III, Co-morbid conditions)?

HIPAA does not obstruct any state law that supports or mandates the reporting of such cases.

4. Are private practice physicians still required to report new cancer cases?

Yes, reporting is required when in compliance with state reporting regulations. The central cancer registry has a reportable list that identifies which cancers are reportable and all reportable cancers should be reported, as required by state law.

5. What, if any, are the consequences of not reporting new cancer case information to the New York State Cancer Registry?

Penalties for failing to comply with state reporting are specified in the state law. A fine may be levied up to \$2,000 per violation and if violation is willful, imprisonment of up to one year is possible. PHL §§ 12 and 12-b.

6. Doesn't HIPAA nullify or preempt the state law for reporting cancer cases to central cancer registries?

No. Public health reporting under the authority of state law is specifically exempted from HIPAA preemption, per 45 C.F.R. § 160.203(c).