New York State Cancer Registry Reporting Manual

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New York State Cancer Registry Reporting Manual

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The NYSCR Reporting Manual – Part One – Overview

Revised January 2019
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**

- **Data Abstracted by Healthcare Facilities**
  - Correct Errors
  - Transmit Data to NYSCR
    - Run Edits
      - Notify Reporting Source Regarding Errors
      - Link Data to NYSCR Database
        - Existing Tumor (Patient)
          - Consolidate Tumor (Patient) Information
            - Run In-house (NYSCR) Edits
              - Update NYSCR Database
                - Reports for Facilities, Researchers and Public
        - New Tumor (Patient)
          - Create New Case Record

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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. §164.512] 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. §164.502. 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

3.1 INTRODUCTION

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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

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
- Acute panmyelosis
- Acute progressive histiocytosis X
- Adamantinoma
- Agnogenic myeloid metaplasia
- Alpha heavy chain disease
- Anal intraepithelial neoplasia (AIN III)
- Askin tumor
- Astrocytoma
- Atypical carcinoid
- Blastoma
- Carcinoma in situ (except for cervix)
- CASTLE
- Dysgerminoma
- Ependymoma
- Ewing tumor (bone)
- Franklin disease
- Gamma heavy chain disease
- Generalized Langerhans cell histiocytosis
- Glioma
- Heavy chain disease
- Hepatoma
- Hodgkin disease
- Hypereosinophilic syndrome
- Hypernephroma
- Immunoproliferative small intestinal disease
- Intratubular germ cell neoplasia
- Kaposi sarcoma
- Klatskin tumor
- Krukenberg tumor
- Letterer-Siwe disease
- Leukemia
- Leukemic reticuloendotheliosis
- Linitis plastica
- Lymphoma
- Lymphomatoid papulosis (C44_)
- Lymphoproliferative disorder (C44_)
- Malignant (except malignant hypertension)
- Melanoma
- Meningioma
- Merkel cell tumor (skin)
- Mesothelioma
- Mixed mesodermal tumor
- Multiple myeloma
- Mycosis fungoides
- Myelofibrosis, acute
- Neoplasm, malignant
- Oligodendroglioma
- Paget disease (breast)
- Paget disease, extra-mammary
- Pagetoid reticulosis
- PanIN (Pancreatic Intraepithelial Neoplasia grade III)
- Peripheral neuroectodermal tumor
- Phyllodes tumor, malignant (breast)
- Pinealoma
- Plasmacytoma
- Primitive neuroectodermal tumor
- Sarcoma
- Seminoma
- SETTLE
- Sezary disease
- Therapy related myelodysplastic syndrome
- Vaginal intraepithelial neoplasia (VAIN III)
- Vulvar intraepithelial neoplasia (VIN III)
- Waldenstrom macroglobulinemia
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
Accessory nerve, NOS
Acoustic nerve
Anterior cranial fossa
Arachnoid, NOS
Basal ganglia
Basis pedunculi
Brain, NOS
Brain stem
Cauda equina
Central nervous system
Central white matter
Cerebellopontine angle
Cerebellum, NOS
Cerebral cortex
Cerebral hemisphere
Cerebral meninges
Cerebral peduncle
Cerebral ventricle
Cerebral white matter
Cerebrum
Cervical cord
Choroid plexus, NOS
Choroid plexus of fourth ventricle
Choroid plexus of lateral ventricle
Choroid plexus of third ventricle
Conus medullaris
Corpus callosum
Corpus striatum
Cranial dura mater
Cranial fossa, NOS
Cranial meninges
Cranial nerve, NOS
Cranial pia mater
Craniopharyngeal duct
Dura, NOS
Dura mater, NOS
Ependymal
Epidural
Extradural
Facial nerve
Falx cerebelli
Falx cerebri
Falx, NOS
Filum terminale
Fourth ventricle, NOS
Frontal lobe
Frontal pole
Globus pallidus
Glossopharyngeal nerve
Hippocampus
Hypoglossal nerve
Hypophysis
Hypothalamus
Infratentorial brain, NOS
Insula
Internal capsule
Intracranial arachnoid
Intracranial meninges
Intracranial site
Island of Reil
Lateral ventricle, NOS
Lumbar cord
Medulla oblongata
Meninges, NOS
Midbrain
Middle cranial fossa
Nervous system, NOS
Occipital lobe
Occipital pole
Oculomotor nerve
Olfactory nerve
Olive
Operculum
Optic chiasm
Optic nerve
Optic tract
Other parts of brain
Overlapping lesion of brain
Overlapping lesion of brain and central nervous system
Pallium
Parasellar
Parietal lobe
Pia mater, NOS
Pineal gland
| Pituitary fossa | Spinal pia mater |
| Pituitary gland | Suprasellar |
| Pituitary, NOS | Supratentorial brain, NOS |
| Pons | Tapetum |
| Posterior cranial fossa | Temporal lobe |
| Putamen | Tentorium cerebelli |
| Pyramid | Tentorium, NOS |
| Rathke pouch | Thalamus |
| Rhinencephalon | Third ventricle, NOS |
| Sella turcica | Thoracic cord |
| Spinal accessory nerve | Trigeminal nerve |
| Spinal arachnoid | Trochlear nerve |
| Spinal cord | Uncus |
| Spinal dura mater | Vagus nerve |
| Spinal meninges | Ventricle, NOS |
| Spinal nerve root | 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 | Diffuse meningiomatosis |
| Acidophil adenoma | Dysembryoplastic neuroepithelial tumor |
| Adenoma, NOS | Dysplastic gangliocytoma of cerebellum |
| Angioblastic meningioma | (D=Lhemitte-Duclos) |
| Angioblastoma | Endotheliomatous meningioma |
| Angiocentric immunoproliferative lesion | Ependymoma |
| Angiocentric glioma | Epithelioid hemangioendothelioma, NOS |
| Angiolipoma, NOS | Extra-adrenal parangangioma, NOS |
| Angiomatous meningioma | Extraventricular neurocytoma |
| Atypical choroid plexus papilloma | Fibroblastic meningioma |
| Atypical fibrous histiocytoma | Fibroma, NOS |
| Atypical fibroxanthoma | Fibrous histiocytoma, NOS |
| Atypical meningioma | Fibrous meningioma |
| Basophil adenoma | Fibroxanthoma, NOS |
| Capillary Hemangioma | Follicular Adenoma |
| Cavernous Hemangioma | Gangliocytoma |
| Central neurocytoma | Ganglioglioma |
| Cerebellar neurocytoma | Ganglioneneuroma |
| Cerebellar liponeurocytoma | Giioneuroma |
| Choroid glioma of third ventricle | Granular cell tumor, NOS |
| Choroid plexus papilloma, NOS | Hemangioblastic meningioma |
| Chromophobe adenoma | Hemangioblastoma |
| Craniopharyngioma | Hemangioma |
| Dermoid cyst, NOS | Hemangioendothelioma, benign |
| Desmoplastic infantile astrocytoma and ganglioglioma | Hemangiopericytoma, benign |
| Diffuse astrocytoma, IDH mutant | Hemangiopericytoma, NOS |
| | Hurthle cell adenoma |
### 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

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<table>
<thead>
<tr>
<th>Neoplasm, benign</th>
<th>Paraganglioma, NOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neoplasm, uncertain whether benign or malignant</td>
<td>Perineuroma</td>
</tr>
<tr>
<td>Neurilemmoma, NOS</td>
<td>Pigmented Schwannoma</td>
</tr>
<tr>
<td>Neurinoma</td>
<td>Pilocytic/juvenile astrocytoma</td>
</tr>
<tr>
<td>Neuroastrocytoma</td>
<td>Pinealoma</td>
</tr>
<tr>
<td>Neurocytoma</td>
<td>Pineoblastoma</td>
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<tr>
<td>Neurofibroma, NOS</td>
<td>Pineocytoma</td>
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<tr>
<td>Neurofibromatosis, NOS</td>
<td>Pituicytoma</td>
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<tr>
<td>Neurothekeoma</td>
<td>Pleomorphic xanthroastrocytoma</td>
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<tr>
<td>Neuroma, NOS</td>
<td>Plexiform neurofibroma</td>
</tr>
<tr>
<td>Oligodendroglioma IDH mutant and 1p/19q-codeleted</td>
<td>Plexiform neuroma</td>
</tr>
<tr>
<td>Oncocytic adenoma</td>
<td>Psammomatous meningioma</td>
</tr>
<tr>
<td>Oncocytoma</td>
<td>Rathke pouch tumor</td>
</tr>
<tr>
<td>Oxyphilic adenoma</td>
<td>Recklinghausen disease (except of Bone)</td>
</tr>
<tr>
<td>Papillary adenoma, NOS</td>
<td>Rhabdomyoma, NOS</td>
</tr>
<tr>
<td>Papillary ependymoma</td>
<td>Rosette-forming glioneuronal tumor</td>
</tr>
<tr>
<td>Papillary glioneuronal tumor</td>
<td>Schwannoma, NOS</td>
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<tr>
<td>Papillary meningioma</td>
<td>Solitary fibrous tumor</td>
</tr>
<tr>
<td>Tumor cells, benign</td>
<td>Spindle cell oncocytoma</td>
</tr>
<tr>
<td>Tumor cells, uncertain whether benign or malignant</td>
<td>Subependymal astrocytoma</td>
</tr>
<tr>
<td>Tumorlets</td>
<td>Subependymal giant cell astrocytoma</td>
</tr>
<tr>
<td>Von Recklinghausen disease (except of Bone)</td>
<td>Subependymal glioma</td>
</tr>
<tr>
<td>Xanthofibroma</td>
<td>Syncytial meningioma</td>
</tr>
<tr>
<td></td>
<td>Teratoma, NOS</td>
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<tr>
<td></td>
<td>Teratoma, benign</td>
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<tr>
<td></td>
<td>Transitional meningioma</td>
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<tr>
<td></td>
<td>Tumor cells, benign</td>
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<tr>
<td></td>
<td>Tumor cells, uncertain whether benign or malignant</td>
</tr>
<tr>
<td></td>
<td>Xanthofibroma</td>
</tr>
</tbody>
</table>
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 Constiute 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:

<table>
<thead>
<tr>
<th>Term</th>
<th>Code Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apparent(ly)</td>
<td>Neoplasm (C70.0-C72.9, C75.1-C75.3)</td>
</tr>
<tr>
<td>Appears</td>
<td>Presumed</td>
</tr>
<tr>
<td>Comparable with</td>
<td>Probable</td>
</tr>
<tr>
<td>Compatible with</td>
<td>Suspect(ed)</td>
</tr>
<tr>
<td>Consistent with</td>
<td>Suspicious (for)</td>
</tr>
<tr>
<td>Favors</td>
<td>Tumor (C70.0-C72.9, C75.1-C75.3)</td>
</tr>
<tr>
<td>Malignant appearing</td>
<td>Typical of</td>
</tr>
<tr>
<td>Most likely</td>
<td></td>
</tr>
</tbody>
</table>

**Exception:** If a CYTOLOGY is identified only with one or more of the above ambiguous terms, do not interpret is 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.

<table>
<thead>
<tr>
<th>Term</th>
<th>Code Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannot be ruled out</td>
<td>Questionable</td>
</tr>
<tr>
<td>Equivocal</td>
<td>Rule-out</td>
</tr>
<tr>
<td>Possible</td>
<td>Suggests</td>
</tr>
<tr>
<td>Potentially malignant</td>
<td>Worrisome</td>
</tr>
</tbody>
</table>

#### 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.

<table>
<thead>
<tr>
<th>ICD-9-CM Codes</th>
<th>Diagnosis (in preferred ICD-O-3 terminology)</th>
</tr>
</thead>
<tbody>
<tr>
<td>042</td>
<td>AIDS (review cases for AIDS-related malignancies)</td>
</tr>
<tr>
<td>140.0 - 208.92</td>
<td>Malignant neoplasms</td>
</tr>
<tr>
<td>203.1</td>
<td>Plasma cell leukemia (9733/3)</td>
</tr>
<tr>
<td>205.1</td>
<td>Chronic neutrophilic leukemia (9963/3)</td>
</tr>
<tr>
<td>209.00 – 209.36</td>
<td>Malignant carcinoid/neuroendocrine tumors and Markel cell carcinoma</td>
</tr>
<tr>
<td>209.70-209.79</td>
<td>Secondary neuroendocrine tumors</td>
</tr>
<tr>
<td>210.0 - 229.9</td>
<td>Benign neoplasms</td>
</tr>
<tr>
<td>230.0 - 234.9</td>
<td>Carcinoma in situ</td>
</tr>
<tr>
<td>235.0 - 238.9</td>
<td>Neoplasms of uncertain behavior</td>
</tr>
<tr>
<td>237.73</td>
<td>Third Type-Schwannomatosis</td>
</tr>
<tr>
<td>237.79</td>
<td>Neurofibromatosis, other</td>
</tr>
<tr>
<td>238.4</td>
<td>Polycythemia vera (9950/3)</td>
</tr>
<tr>
<td>238.6</td>
<td>Solitary plasmacytoma (9731/3)</td>
</tr>
<tr>
<td>238.6</td>
<td>Extramedullary plasmacytoma (9734/3)</td>
</tr>
<tr>
<td>238.71</td>
<td>Essential thrombocythemia (9962/3)</td>
</tr>
<tr>
<td>238.72</td>
<td>Refractory cytopenia with multilineage dysplasia (9985/3)</td>
</tr>
<tr>
<td>238.71</td>
<td>Refractory anemia (9980/3)</td>
</tr>
<tr>
<td>238.72</td>
<td>Refractory anemia with ringed sideroblasts (9982/3)</td>
</tr>
<tr>
<td>238.73</td>
<td>High grade myelodysplastic syndrome lesions</td>
</tr>
<tr>
<td>238.72</td>
<td>Refractory anemia with excess blasts (9983/3)</td>
</tr>
<tr>
<td>238.72</td>
<td>Refractory anemia with excess blasts in transformation (9984/3)</td>
</tr>
<tr>
<td>238.74</td>
<td>Myelodysplastic syndrome with 5q- syndrome (9987/3)</td>
</tr>
<tr>
<td>238.75</td>
<td>Therapy-related myelodysplastic syndrome (9987/3)</td>
</tr>
<tr>
<td>238.76</td>
<td>Myelosclerosis with myeloid metaplasia (9961/3)</td>
</tr>
<tr>
<td>238.77</td>
<td>Post transplant lymphoproliferative disorder (9987/3)</td>
</tr>
<tr>
<td>ICD-9-CM Codes</td>
<td>Diagnosis (in preferred ICD-O-3 terminology)</td>
</tr>
<tr>
<td>---------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>238.79</td>
<td>Chronic myeloproliferative disease (9960/3)</td>
</tr>
<tr>
<td>239.0 - 239.9</td>
<td>Neoplasms of unspecified behavior</td>
</tr>
<tr>
<td>259.2</td>
<td>Carcinoid Syndrome</td>
</tr>
<tr>
<td>273.2</td>
<td>Gamma heavy chain disease; Franklin disease</td>
</tr>
<tr>
<td>273.3</td>
<td>Waldenstrom macroglobulinemia</td>
</tr>
<tr>
<td>273.9</td>
<td>Unspecified disorder of immune mechanism (screen for potential 273.3 miscodes)</td>
</tr>
<tr>
<td>288.3</td>
<td>Hypereosinophilic syndrome (9964/3)</td>
</tr>
<tr>
<td>289.6</td>
<td>Familial Polycythemia (per SEER, synonym for Polycythemia vera (9950/3))</td>
</tr>
<tr>
<td>289.83</td>
<td>Acute myelofibrosis (9931/3)</td>
</tr>
<tr>
<td>748.1</td>
<td>Astrocytoma, astroglioma, astroblastoma of nose</td>
</tr>
<tr>
<td>789.51</td>
<td>Malignant Ascites</td>
</tr>
<tr>
<td>V07.39</td>
<td>Other prophylactic chemotherapy (screen carefully for miscoded malignancies)</td>
</tr>
<tr>
<td>V10.0 - V10.9</td>
<td>Personal history of malignancy (review these for recurrences, subsequent primaries and/or subsequent treatment)</td>
</tr>
<tr>
<td>V50.41</td>
<td>Prophylactic organ removal, breast</td>
</tr>
<tr>
<td>V50.42</td>
<td>Prophylactic organ removal, ovary</td>
</tr>
<tr>
<td>V50.49</td>
<td>Prophylactic organ removal, other</td>
</tr>
<tr>
<td>V58.0</td>
<td>Admission for radiotherapy</td>
</tr>
<tr>
<td>V58.11</td>
<td>Admission for chemotherapy</td>
</tr>
<tr>
<td>V58.12</td>
<td>Admission for immunotherapy for neoplastic condition</td>
</tr>
<tr>
<td>V66.1</td>
<td>Convalescence following radiotherapy</td>
</tr>
<tr>
<td>V66.2</td>
<td>Convalescence following chemotherapy</td>
</tr>
<tr>
<td>V67.1</td>
<td>Radiation therapy follow-up</td>
</tr>
<tr>
<td>V67.2</td>
<td>Chemotherapy follow-up</td>
</tr>
<tr>
<td>V71.1</td>
<td>Observation for suspected malignant neoplasm</td>
</tr>
<tr>
<td>V76.0 - V76.9</td>
<td>Special screening for malignant neoplasm</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>ICD-10-CM Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>B20</td>
<td>Human immunodeficiency virus [HIV] disease with other diseases</td>
</tr>
<tr>
<td></td>
<td>Note: Excludes HIV with malignancy (B21), see reportable list</td>
</tr>
<tr>
<td>B97.33, B97.34, B97.35</td>
<td>Human T-cell lymphotrophic virus, (type I [HTLV-1], type II [HTLV-II], type 2 [HIV 2]) as the cause of diseases classified elsewhere</td>
</tr>
<tr>
<td>B97.7</td>
<td>Papillomavirus as the cause of diseases classified elsewhere</td>
</tr>
<tr>
<td>C00._ - C43.<em>, C44.</em>, C45._ - C48.<em>, C49.</em> - C96._</td>
<td>Malignant neoplasms (excluding category C44 and C49.A), stated or presumed to be primary (of specified site) and certain specified histologies</td>
</tr>
<tr>
<td></td>
<td><strong>NEW for FY2018:</strong></td>
</tr>
<tr>
<td></td>
<td>C96.20 Malignant mast cell neoplasm, unspecified</td>
</tr>
<tr>
<td></td>
<td>C96.21 Aggressive systemic mastocytosis</td>
</tr>
<tr>
<td></td>
<td>C96.22 Mast cell sarcoma</td>
</tr>
<tr>
<td></td>
<td>C96.29 Other malignant cell neoplasm</td>
</tr>
<tr>
<td>C44.00, C44.09</td>
<td>Unspecified/other malignant neoplasm of skin of lip</td>
</tr>
<tr>
<td>C44.01, C44.02</td>
<td>Basal/squamous cell carcinoma of skin of lip</td>
</tr>
<tr>
<td>C44.10_. C44.19_</td>
<td>Unspecified/other malignant neoplasm of skin of eyelid</td>
</tr>
<tr>
<td>C44.20_. C44.29_</td>
<td>Unspecified/other malignant neoplasm skin of ear and external auricular canal</td>
</tr>
<tr>
<td>C44.21_. C44.22_</td>
<td>Basal/squamous cell carcinoma of skin of ear and external auricular canal</td>
</tr>
<tr>
<td>C44.30_. C44.39_</td>
<td>Unspecified/other malignant neoplasm of skin of other/unspecified parts of face</td>
</tr>
<tr>
<td>C44.31_. C44.32_</td>
<td>Basal/squamous cell carcinoma of skin of other and unspecified parts of face</td>
</tr>
<tr>
<td>C44.40, C44.49</td>
<td>Unspecified/other malignant neoplasm of skin of scalp &amp; neck</td>
</tr>
<tr>
<td>C44.50_. C44.59_</td>
<td>Unspecified/other malignant neoplasm of skin of trunk</td>
</tr>
<tr>
<td>C44.60_. C44.69_</td>
<td>Unspecified/other malignant neoplasm of skin of upper limb, including shoulder</td>
</tr>
<tr>
<td>C44.70_. C44.79_</td>
<td>Unspecified/other malignant neoplasm of skin of lower limb, including hip</td>
</tr>
<tr>
<td>C44.80, C44.89</td>
<td>Unspecified/other malignant neoplasm of skin of overlapping sites of skin</td>
</tr>
<tr>
<td>C44.90, C44.99</td>
<td>Unspecified/other malignant neoplasm of skin of unspecified sites of skin</td>
</tr>
<tr>
<td>ICD-10-CM Codes</td>
<td>Description</td>
</tr>
<tr>
<td>----------------</td>
<td>-------------</td>
</tr>
</tbody>
</table>
| 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 (Note: Carcinoma in situ of the cervix (CIN III-8077/2) and Prostatic Intraepithelial Carcinoma (PIN III-8148/2) are not reportable) |
| D3A._          | Benign carcinoid tumors |
| D10._ – D31.,  | Benign neoplasms (see “must collect” list for reportable benign neoplasms)  
D34, D35.0,  
D35.1, D35.5,  
D35.9, D36._  |
| D18.01         | Lymphangioma, any site (Note: Includes Lymphangiomas of Brain, Other parts of nervous system and endocrine glands, which are reportable) |
| 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, | Neoplasm of uncertain or unknown behavior of other endocrine glands  
D44.6 – D44.9 |
| D44.3 – D44.5  | Neoplasm of uncertain or unknown behavior of pituitary gland, craniopharyngeal duct and pineal gland |
| D45            | Polycythemia vera (9950/3)  
*ICD-10-CM Coding instruction note: Excludes familial polycythemia (C75.0), secondary polycythemia (D75.1)* |
| 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 |
<table>
<thead>
<tr>
<th>ICD-10-CM Codes</th>
<th>Description</th>
</tr>
</thead>
</table>
| 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) thrombocytthemia (9962/3)  
*Includes: Essential thrombocytosis, idiopathic hemorrhagic thrombocytthemia* |
| 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 "aplastic anemia due to antineoplastic chemotherapy")  
*ICD-10-CM Coding instruction note: Use additional code for adverse effect, if applicable, to identify drug* |
| D61.18_        | Pancytopenia |
| D61.810        | Antineoplastic chemotherapy induced pancytopenia |
| D61.82         | Myelophthisis  
*ICD-10-CM Coding instruction: Code first the underlying disorder, such as: malignant neoplasm of breast (C50._)* |
| D63.0          | Anemia in neoplastic disease  
*ICD-10-CM Coding instruction: Code first neoplasm (C00-C49)* |
| D64.81         | Anemia due to antineoplastic chemotherapy |
| D69.49, D69.59, D69.6 | Other thrombocytopenia  
**Note:** Screen for incorrectly coded thrombocytopenia |
| D70.1          | Agranulocytosis secondary to cancer chemotherapy  
*ICD-10-CM Coding instruction: Code also underlying neoplasm* |
| D72.1          | Eosinophilia  
*(Note: Code for eosinophilia (9964/3). Not every case of eosinophilia is a malignancy. Reportable Diagnosis is "Hypereosinophilic syndrome.")* |
| D75.81         | Myelofibrosis (note: this is not primary myelofibrosis [9961/3]  
*ICD-10-CM Coding instruction note: Code first the underlying disorder, such as: malignant neoplasm of breast (C50._)* |
<table>
<thead>
<tr>
<th>ICD-10-CM Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D76._</td>
<td>Other specified diseases with participation of lymphoreticular and reticulohistiocytic tissue</td>
</tr>
</tbody>
</table>
| D89.0, D89.1   | Other disorders involving the immune mechanism, not elsewhere classified  
*Note: Review for miscodes* |
| D89.4          | Mast cell activation syndrome and related disorders  
*Note: Review for miscodes* |
| E08            | Diabetes mellitus due to underlying condition  
*ICD-10-CM Coding instruction note: Code first the underlying condition, such as: malignant neoplasm (C00-C96)* |
| E31.2_         | Multiple endocrine neoplasia [MEN] syndromes  
*ICD-10-CM Coding instruction: Code also any associated malignancies and other conditions associated with the syndromes* |
| E34.0          | Carcinoid syndrome  
*ICD-10-CM Coding instruction: May be used as an additional code to identify functional activity associated with a carcinoid tumor* |
| 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  
*ICD-10-CM Coding instruction note: Code first underlying neoplasm (C00-D49)* |
| G13.1          | Other systemic atrophy primarily affecting central nervous system in neoplastic disease  
*ICD-10-CM Coding instruction note: Code first underlying neoplasm (C00-D49)* |
| G32.8          | Other specified degenerative disorders of nervous system in diseases classified elsewhere  
*ICD-10-CM Coding instruction note: Code first underlying disease, such as: cerebral degeneration (due to) neoplasm (C00-D49)* |
| G53            | Cranial nerve disorders in diseases classified elsewhere  
*Note: Code first underlying neoplasm (C00-D49)* |
| G55            | Nerve root and plexus compressions in diseases classified elsewhere  
*ICD-10-CM Coding instruction note: Code also underlying disease, such as neoplasm (C00-D49)* |
| G63            | Polyneuropathy in diseases classified elsewhere  
*ICD-10-CM Coding instruction note: Code first underlying disease, such as: neoplasm (C00-D49)* |
| G73.1          | Lambert-Eaton syndrome in neoplastic disease  
*ICD-10-CM Coding instruction: Code first underlying neoplasm (C00-D49)* |
<p>| G89.3          | Neoplasm related pain (acute)(chronic) |</p>
<table>
<thead>
<tr>
<th>ICD-10-CM Codes</th>
<th>Description</th>
</tr>
</thead>
</table>
| G99.2           | Myelopathy in diseases classified elsewhere  
  *ICD-10-CM Coding instruction: Code first underlying disease, such as: neoplasm (C00-D49)* |
| H47.42          | Disorders of optic chiasm in (due to) neoplasm  
  *ICD-10-CM Coding instruction: Code also underlying condition* |
| H47.52_         | Disorders of visual pathways in (due to) neoplasm  
  *ICD-10-CM Coding instruction: Code also underlying condition* |
| H47.63_         | Disorders of visual cortex in (due to) neoplasm  
  *ICD-10-CM Coding instruction: Code also underlying condition* |
| J34.81          | Nasal mucositis (ulcerative) |
| J91.0           | Malignant pleural effusion  
  *ICD-10-CM Coding instruction: Code first underlying neoplasm* |
| J93.12          | Secondary spontaneous pneumothorax  
  *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_)* |
| 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  
  *ICD-10-CM Coding instruction: Code first underlying neoplasm (C00-D49)* |
| M36.1           | Arthropathy in neoplastic disease  
  *ICD-10-CM Coding instruction: Code first underlying neoplasm, such as: Leukemia (C91-C95), malignant histiocytosis (C96.A), multiple myeloma (C90.0)* |
| M84.5_          | Pathologic fracture in neoplastic disease  
  *ICD-10-CM Coding instruction: Code also underlying neoplasm (C00-D49)* |
| M90.6_          | Osteitis deformans in neoplastic disease  
  *ICD-10-CM Coding instruction: Code first the neoplasm (C40._, C41._)* |
<p>| 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) |</p>
<table>
<thead>
<tr>
<th>ICD-10-CM Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>O01._</td>
<td>Hydatidiform mole Note: Benign tumor that can become malignant. If malignant, report as Choriocarcinoma (9100/3,) malignancy code in the C00- C97 range</td>
</tr>
<tr>
<td>O9A.1_</td>
<td>Malignant neoplasm complicating pregnancy, childbirth and the puerperium (conditions in C00-C96) <em>ICD-10-CM Coding instruction: Use additional code to identify neoplasm</em></td>
</tr>
</tbody>
</table>
| Q85.0_          | Neurofibromatosis (nonmalignant) (9540/1)  
*Note: Neurofibromatosis is not cancer. These tumors can be precursors to acoustic neuromas, which are reportable* |
| R18.0           | Malignant ascites  
*ICD-10-CM Coding instruction: Code first malignancy, such as: Malignant neoplasm of ovary (C56._), secondary malignant neoplasm of retroperitoneum and peritoneum (C78.6)* |
| R53.0           | Neoplastic (malignant) related fatigue  
*ICD-10-CM Coding instruction: Code first associated neoplasm* |
| R59._           | Enlarged lymph nodes |
| R85.6_          | Abnormal findings on cytological and histological examination of digestive organs  
*Note: see "must collect" list for R85.614* |
| R85.614         | Cytologic evidence of malignancy on smear of anus |
| R87.61_, R87.62_ | Abnormal findings on cytological/histological examination of female genital organs  
*Note: see "must collect" list for R87.614 and R87.624* |
<p>| 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 |</p>
<table>
<thead>
<tr>
<th>ICD-10-CM Codes</th>
<th>Description</th>
</tr>
</thead>
</table>
| T86.0           | Complications of bone marrow transplant  
*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)* |
| 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)  
*ICD-10-CM Coding instruction: Use additional code to identify the personal history of malignant neoplasm (Z85._)* |
| 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  
*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._)* |
| 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  
*ICD-10-CM Coding instruction: Use additional code to identify the neoplasm* |
| 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  
*ICD-10-CM Coding instruction: Code first, if applicable, malignant neoplasm of breast (C50._), malignant neoplasm of prostate (C61)* |
| 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 |
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:

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

*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

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[obs] = Obsolete

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

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<table>
<thead>
<tr>
<th>Acute myeloid leukemia</th>
<th>Acute myelomonocytic leukemia with abnormal eosinophils</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute myeloid leukemia with abnormal marrow eosinophils (includes all variants)</td>
<td>Acute myelosclerosis</td>
</tr>
<tr>
<td>Acute myeloid leukemia with maturation</td>
<td>Acute non-lymphocytic leukemia</td>
</tr>
<tr>
<td>Acute myeloid leukemia with multilineage dysplasia</td>
<td>Acute panmyelosis</td>
</tr>
<tr>
<td>Acute myeloid leukemia (megakaryoblastic) with t(1;22)(p13;q13); RBM15-MKL1</td>
<td>Acute panmyelosis with myelofibrosis (C42.1)</td>
</tr>
<tr>
<td>Acute myeloid leukemia without maturation</td>
<td>Acute progressive histiocytosis X</td>
</tr>
<tr>
<td>Acute myeloid leukemia, 11q23 abnormalities</td>
<td>Acute promyelocytic leukemia</td>
</tr>
<tr>
<td>Acute myeloid leukemia, AML1 (CBF-alpha) / ETO</td>
<td>Acute promyelocytic leukemia, PML/RAR-alpha</td>
</tr>
<tr>
<td>Acute myeloid leukemia, CBF-beta/MYH11</td>
<td>Acute promyelocytic leukemia, t(15;17)(q22;q11-12)</td>
</tr>
<tr>
<td>Acute myeloid leukemia, inv(16)(p13;q22)</td>
<td>Adamantinoma, NOS</td>
</tr>
<tr>
<td>Acute myeloid leukemia with inv(3)(q21q26.2) or t(3;3)(q21;q26.2); RPN1EVI1</td>
<td>Adamantinoma of long bones</td>
</tr>
<tr>
<td>Acute myeloid leukemia, M6 type</td>
<td>Adenocanthoma</td>
</tr>
<tr>
<td>Acute myeloid leukemia, minimal differentiation</td>
<td>Adenocarcinoid tumor</td>
</tr>
<tr>
<td>Acute myeloid leukemia, MLL</td>
<td>Adenocarcinoma and epidermoid carcinoma mixed</td>
</tr>
<tr>
<td>Acute myeloid leukemia, NOS (FAB or WHO type not specified)</td>
<td>Adenocarcinoma and squamous cell carcinoma, mixed</td>
</tr>
<tr>
<td>Acute myeloid leukemia, PML/RAR-alpha</td>
<td>Adenocarcinoma combined with other types of carcinoma</td>
</tr>
<tr>
<td>Acute myeloid leukemia, t(15;17)(q22;q11-12)</td>
<td>Adenocarcinoma in a polyp, NOS</td>
</tr>
<tr>
<td>Acute myeloid leukemia, t(8;21) (q22;q22)</td>
<td>Adenocarcinoma in a polypoid adenoma</td>
</tr>
<tr>
<td>Acute myeloid leukemia with prior myelodysplastic syndrome</td>
<td>Adenocarcinoma in adenomatous polyp</td>
</tr>
<tr>
<td>Acute myeloid leukemia with t(6;9)(p23;q34) DEK-NUP214</td>
<td>Adenocarcinoma in adenomatous polyposis coli</td>
</tr>
<tr>
<td>Acute myeloid leukemia without prior myelodysplastic syndrome</td>
<td>Adenocarcinoma in multiple adenomatous polyps</td>
</tr>
<tr>
<td>Acute myelomonocytic leukemia</td>
<td>Adenocarcinoma in situ in a polyp, NOS</td>
</tr>
</tbody>
</table>

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

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Revised January 2019
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 (C53.0)
Adenoid cystic carcinoma
Adenoid squamous cell carcinoma
Adenoma, NOS
Adenomyoepithelioma with carcinoma (C50.0)
Adenosarcoma
Adenosquamous carcinoma
Adrenal 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 (an 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 fibrodytinosarcoma
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 (C71.0)
Anaplastic astrocytoma, IDH-wildtype (C71.0)
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.

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[obs] = Obsolete

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Revised January 2019
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]
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._)
Astroglcoma
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 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

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Revised January 2019
| Bellini duct carcinoma (C64.9) | C cell carcinoma |
| Beta cell tumor, malignant | C cell carcinoma (C73.9) |
| Bile duct adenocarcinoma | C-ALL |
| Bile duct carcinoma | Cancer* |
| Bile duct cystadenocarcinoma | CAPILLARY HEMANGIOMA |
| Biliary intraepithelial neoplasia 3 (8148/2) | Carcinofibroma |
| Biliary intraepithelial neoplasia, high grade (8148/2) | Carcinoid, NOS (including appendix, effective with 2015 diagnoses) |
| Biphenotypic sinonasal sarcoma | Carcinoid tumor, argentaffin, malignant |
| Blast cell leukemia | Carcinoid tumor, NOS (including appendix, effective with 2015 diagnoses) |
| Blastoma, NOS* | Carcinoma in a polyp, NOS |
| Blue nevus, malignant | Carcinoma in adenomatous polyp |
| Botryoid sarcoma | Carcinoma in pleomorphic adenoma |
| Brenner tumor, malignant | Carcinoma in situ in a polyp, NOS |
| Bronchial adenoma, carcinoid | Carcinoma in situ in adenomatous polyp |
| Bronchial adenoma, cylindroid | Carcinoma in situ, NOS* |
| Bronchial-associated lymphoid tissue lymphoma | Carcinoma showing thymus-like differentiation |
| Bronchiolar adenocarcinoma | Carcinoma showing thymus-like element |
| Bronchiolar carcinoma | Carcinoma simplex |
| Bronchiole-alveolar adenocarcinoma | Carcinoma with apocrine metaplasia |
| Bronchiole-alveolar carcinoma | Carcinoma with chondroid differentiation (C50._) |
| Bronchiole-alveolar carcinoma, Clara cell (C34._) | Carcinoma with neuroendocrine differentiation |
| Bronchiole-alveolar carcinoma, Clara cell and goblet cell type (C34._) | Carcinoma with osseous differentiation (C50._) |
| Bronchiole-alveolar carcinoma, goblet cell type (C34._) | Carcinoma with osteoclast-like giant Cells |
| Bronchiole-alveolar carcinoma, indeterminate type (C34._) | Carcinoma with other types mesenchymal differentiation (C50._) |
| Bronchiole-alveolar carcinoma, mixed mucinous and non-mucinous (C34._) | Carcinoma with productive fibrosis |
| Bronchiole-alveolar carcinoma, mucinous (C34._) | Carcinoma, anaplastic* |
| Bronchiole-alveolar carcinoma, non-mucinous (C34._) | Carcinoma, diffuse type |
| Bronchiole-alveolar carcinoma, type II pneumocyte (C34._) | Carcinoma, intestinal type |
| Bronchiole-alveolar carcinoma, type II pneumocyte and goblet cell type (C34._) | Carcinoma, NOS* |
| Burkitt cell leukemia | Carcinoma, undifferentiated* |
| Burkitt-like lymphoma | Carcinosarcoma, embryonal |
| Burkitt lymphoma, NOS | Carcinosarcoma, NOS |
| Burkitt tumor | CASTLE |

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[op] = Obsolete

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Revised January 2019
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
Chorioepithelioma
Choroid plexus carcinoma (C71.5)
Choroid plexus papilloma, anaplastic
Choroid plexus papilloma, malignant
CHOROID PLEXUS PAPILLOMA, NOS
Chromophobe adenocarcinoma
CHROMOPHOBECADENOMA
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) positive
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

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Refer to ICD-O-3 for inclusive listing of morphology terms.
<table>
<thead>
<tr>
<th>Classical Hodgkin lymphoma, lymphocyte-rich</th>
<th>Comedocarcinoma, NOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Classical Hodgkin lymphoma, mixed cellularity, NOS</td>
<td>Common ALL</td>
</tr>
<tr>
<td>Classical Hodgkin lymphoma, nodular sclerosis, cellular phase</td>
<td>Common precursor B ALL</td>
</tr>
<tr>
<td>Classical Hodgkin lymphoma, nodular sclerosis, grade 1</td>
<td>Composite carcinoid</td>
</tr>
<tr>
<td>Classical Hodgkin lymphoma, nodular sclerosis, grade 2</td>
<td>Composite Hodgkin and non-Hodgkin lymphoma</td>
</tr>
<tr>
<td>Classical Hodgkin lymphoma, nodular sclerosis, NOS</td>
<td>Condylomatous carcinoma</td>
</tr>
<tr>
<td>Clear cell adenocarcinofibroma (C56.9)</td>
<td>Congenital fibrosarcoma</td>
</tr>
</tbody>
</table>
| Clear cell adenocarcinoma, mesonephroid | Conventional central osteosarcoma  
(C40._, C41._) |
| Clear cell adenocarcinoma, NOS | Cortical T ALL |
| Clear cell carcinoma | CPNET (C71._) |
| Clear cell chondrosarcoma (C40._, C41._) | CRANIOPHARYNGIOMA |
| Clear cell cystadenocarcinofibroma (C56.9) | Cribriform carcinoma |
| Clear cell ependymoma (C71._) | Cribriform comedo-type carcinoma (C18._, C19.9, C20.9) |
| Clear cell (glycogen-rich) urothelial carcinoma | Cutaneous lymphoma |
| Clear cell sarcoma | Cutaneous T-cell lymphoma, NOS (C44._) |
| Clear cell sarcoma of kidney | Cylindrical cell carcinoma (C30.0, C31._) |
| Clear cell sarcoma of tendons and aponeuroids | Cylindroma, NOS (except of skin) |
| Cloacogenic carcinoma | Cystadenocarcinoma, NOS |
| CNS embryonal tumor with rhabdoid features (C71._) | Cyst-associated renal cell carcinoma (C64.9) |
| Collecting duct carcinoma (C64.9) | Cystic astrocytoma |
| Colloid adenocarcinoma | Cystic hypersecretory carcinoma (C50._) |
| Colloid carcinoma | Cystosarcoma phyllodes, malignant |
| Combined carcinoind and adenocarcinoma | DCIS, comedo type (C50._) |
| Combined hepatocellular carcinoma and Cholangiocarcinoma | DCIS, NOS (C50._) |
| Combined large cell neuroendocrine carcinoma | DCIS, papillary (C50._) |
| Combined small cell carcinoma | Dedifferentiated chondrosarcoma (C40._, C41._) |
| Combined small cell-adenocarcinoma | Dedifferentiated chordoma |
| Combined small cell-squamous cell carcinoma | Dedifferentiated liposarcoma |
| Comedocarcinoma, noninfiltrating | 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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<table>
<thead>
<tr>
<th>Term</th>
<th>ICD-O-3 Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dermoid cyst, NOS</td>
<td></td>
</tr>
<tr>
<td>Desmoplastic infantile astrocytoma and ganglioglioma</td>
<td></td>
</tr>
<tr>
<td>Desmoplastic medulloblastoma</td>
<td></td>
</tr>
<tr>
<td>Desmoplastic melanoma, amelanotic</td>
<td>(C44._</td>
</tr>
<tr>
<td>Desmoplastic melanoma, malignant</td>
<td></td>
</tr>
<tr>
<td>Desmoplastic mesothelioma</td>
<td></td>
</tr>
<tr>
<td>Desmoplastic nodular medulloblastoma</td>
<td>(C71.6</td>
</tr>
<tr>
<td>Desmoplastic small round cell tumor</td>
<td></td>
</tr>
<tr>
<td>Di Guglielmo disease [obs]</td>
<td></td>
</tr>
<tr>
<td>Diffuse astrocytoma (C71._</td>
<td></td>
</tr>
<tr>
<td>Diffuse astrocytoma, IDH-mutant (C71._</td>
<td></td>
</tr>
<tr>
<td>Diffuse astrocytoma, IDH-wildtype (C71._</td>
<td></td>
</tr>
<tr>
<td>Diffuse astrocytoma, low grade (C71._</td>
<td></td>
</tr>
<tr>
<td>Diffuse leptomeningeal glioneuronal tumor (C71._</td>
<td></td>
</tr>
<tr>
<td>Diffuse midline glioma, H3 K27M-mutant (C71._</td>
<td></td>
</tr>
<tr>
<td>Diffuse meningiomatosis</td>
<td></td>
</tr>
<tr>
<td>Digital papillary adenocarcinoma</td>
<td>(C44._</td>
</tr>
<tr>
<td>Diktyoma</td>
<td></td>
</tr>
<tr>
<td>Diktyoma, malignant (C69._</td>
<td></td>
</tr>
<tr>
<td>DIN III (ductal intraepithelial neoplasia III)</td>
<td>(C50._</td>
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<tr>
<td>Duct adenocarcinoma</td>
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<tr>
<td>Duct carcinoma</td>
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<tr>
<td>Duct carcinoma, desmoplastic type</td>
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<tr>
<td>Duct cell carcinoma</td>
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<tr>
<td>Ductal carcinoma</td>
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<tr>
<td>Ductal carcinoma in situ, comedo type</td>
<td>(C50._</td>
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<tr>
<td>Ductal carcinoma in situ, cribriform type</td>
<td>(C50._</td>
</tr>
<tr>
<td>Ductal carcinoma in situ, micropapillary</td>
<td>(C50._</td>
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<tr>
<td>Ductal carcinoma in situ, NOS</td>
<td>(C50._</td>
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<tr>
<td>Ductal carcinoma in situ, papillary</td>
<td>(C50._</td>
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<tr>
<td>Ductal carcinoma in situ, solid type</td>
<td>(C50._</td>
</tr>
<tr>
<td>Ductal carcinoma, cribriform type</td>
<td>(C50._</td>
</tr>
<tr>
<td>Ductal intraepithelial neoplasia III (DIN III)</td>
<td>(C50._</td>
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<tr>
<td>Dysembryoplastic neuroepithelial tumor</td>
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<tr>
<td>Dysergerminoma</td>
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<tr>
<td>Dysplastic gangliocytoma of cerebellum (D=LHemite-Duclos)</td>
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<tr>
<td>EC cell carcinoma</td>
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<tr>
<td>Eccrine adenocarcinoma (C44._</td>
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<tr>
<td>Eccrine papillary adenocarcinoma</td>
<td>(C44._</td>
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<tr>
<td>Eccrine poroma, malignant</td>
<td>(C44._</td>
</tr>
<tr>
<td>ECL cell carcinoid, malignant</td>
<td></td>
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<tr>
<td>Ectomesenchymoma</td>
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<tr>
<td>Embryonal adenocarcinoma</td>
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<tr>
<td>Embryonal carcinoma</td>
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<tr>
<td>Embryonal carcinoma and teratoma, mixed</td>
<td></td>
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<tr>
<td>Embryonal carcinoma, infantile</td>
<td></td>
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<tr>
<td>Embryonal carcinoma, polyembryonal type</td>
<td></td>
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<tr>
<td>Embryonal hepatoma</td>
<td></td>
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<tr>
<td>Embryonal rhabdomyosarcoma</td>
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<tr>
<td>Embryonal sarcoma</td>
<td></td>
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<tr>
<td>Embryonal teratoma</td>
<td></td>
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<tr>
<td>Embryonal tumor with multilayered rosettes C19MC-altered (C71._</td>
<td></td>
</tr>
<tr>
<td>Embryonal tumor with multilayered rosettes, NOS (C71._</td>
<td></td>
</tr>
<tr>
<td>Embryonal tumor with rhabdoid features (C71.0)</td>
<td></td>
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<tr>
<td>Encapsulated follicular variant of papillary thyroid carcinoma, NOS (EFVPTC, NOS) (C73.9)</td>
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<tr>
<td>Encapsulated papillary carcinoma (C50._</td>
<td></td>
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<tr>
<td>Encapsulated papillary carcinoma with invasion (C50._</td>
<td></td>
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<tr>
<td>Endocervical adenocarcinoma usual type (C53._</td>
<td></td>
</tr>
<tr>
<td>Endodermal sinus tumor</td>
<td></td>
</tr>
<tr>
<td>Endolympathic stromal myosis</td>
<td></td>
</tr>
</tbody>
</table>

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[obs] = Obsolete

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**Endolympathic 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 carcinoma
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

| FAB L1 | FAB L2 | FAB L3 [obs] |

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| FAB M0                   | FOLLCULAR ADENOMA                        |
| FAB M1                   | Follicular carcinoma, encapsulated       |
| FAB M2, AML1(CBF-alpha)/ETO | (C73.9)                                 |
| FAB M2, NOS              | Follicular carcinoma, minimally invasive |
| FAB M2, t(8;21)(q22;q22) | (C73.9)                                 |
| FAB M3 (includes all variants) | Follicular carcinoma, moderately       |
| FAB M4                   | differentiated                           |
| FAB M4Eo                 | Follicular carcinoma, NOS               |
| FAB M5 (includes all variants) | Follicular carcinoma, oxyphilic cell   |
| FAB M6                   | (C73.9)                                 |
| FAB M7                   | Follicular carcinoma, trabecular        |
| Fascial fibrosarcoma     | Follicular carcinoma, well differentiated|
| Fetal adenocarcinoma     | Follicular dendritic cell sarcoma       |
| Fibrillary astrocytoma   | Follicular dendritic cell tumor         |
| Fibroblastic liposarcoma | Follicular lymphoma, grade 1            |
| Fibroblastic liposarcoma | Follicular lymphoma, grade 2            |
| Fibroblastic meningioma  | Follicular lymphoma, grade 3            |
| Fibroblastic osteosarcoma| Follicular lymphoma, NOS                |
| Fibroblastic reticular cell tumor | Follicular thyroid carcinoma (FTC), |
| Fibrochondrosarcoma      | encapsulated angioinvasive              |
| Fibroepithelial basal cell carcinoma, Pinkus type* | Franklin disease |
| Fibroepithelioma of Pinkus type* |                                         |
| Fibroepithelioma, NOS*   |                                         |
| Fibroepithelioma         |                                         |
| 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 |                                         |

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Revised January 2019
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
HURTHE CELL ADENOMA
Hurthle cell carcinoma
HURTHE CELL TUMOR
Hutchinson melanotic freckle, NOS
Hydroa vacciniforme-like lymphoma
Hypereosinophilic (idiopathic) syndrome
Hypereosinophrom

Idiopathic hemorrhagic thrombocytopenia
Idiopathic thrombocytopenia
IMMATURE TERATOMA
Immature teratoma, malignant
Immunoblastic sarcoma
Immunocytooma
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 carcinoma 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
Inflammatotary adenocarcinoma
Inflammatotary carcinoma
Inflammatotary 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, 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._) | Malignant lymphoma, centroblastic-centrocytic, diffuse [obs] |
| Low grade cribriform cystadenocarcinoma (LGCCC) | Malignant lymphoma, centroblastic-centrocytic, follicular |
| Low-grade central osteosarcoma | Malignant lymphoma, centrocytic [obs] |
| Low-grade fibromyxoid sarcoma | Malignant lymphoma, cleaved cell, NOS [obs] |
| Low-grade intramedullary osteosarcoma | Malignant lymphoma, convoluted cell [obs] |
| Low-grade myofibroblastic sarcoma | Malignant lymphoma, diffuse, NOS |
| Low-grade serous carcinoma | Malignant lymphoma, follicle center, Follicular |
| Lymphangioendothelial sarcoma | Malignant lymphoma, follicle center, NOS |
| Lymphangioendothelioma, malignant Lymphangiosarcoma | Malignant lymphoma, follicular, NOS |
| Lymphoblastic leukemia, NOS | Malignant lymphoma, histiocytic, diffuse |
| Lymphoblastoma [obs] | Malignant lymphoma, histiocytic, nodular |
| Lymphocytic leukemia, NOS | Malignant lymphoma, histiocytic, NOS |
| Lymphoepithelial carcinoma* | Malignant lymphoma, Hodgkin |
| Lymphoepithelioid lymphoma | Malignant lymphoma, immunoblastic, NOS |
| Lymphoepithelioma* | Malignant lymphoma, large B-cell, diffuse, NOS |
| Lymphoepithelioma-like carcinoma | Malignant lymphoma, large B-cell, diffuse, centroblastic, NOS |
| Lymphoid leukemia, NOS | Malignant lymphoma, large B-cell, diffuse, immunoblastic, NOS |
| Lymphoma, NOS | Malignant lymphoma, large cell, cleaved and noncleaved |
| Lymphomatoid papulosis (C44._) | Malignant lymphoma, large cell, cleaved, NOS |
| LYMPHOPROLIFERATIVE DISEASE, NOS | Malignant lymphoma, large cell, cleaved, diffuse |
| Lymphosarcoma cell leukemia [obs] | Malignant lymphoma, large cell, cleaved, NOS |
| Lymphosarcoma, diffuse [obs] | Malignant lymphoma, large cell, diffuse, NOS |
| Lymphosarcoma, NOS [obs] | Malignant lymphoma, large cell, follicular, NOS |

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

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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, 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 [obs]
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, 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
Medial 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
Medulomyoblastoma
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
MICROGIOMA (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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**Myelofibrosis with myeloid metaplasia**
- Myelogenous leukemia, NOS
- Myeloid leukemia, NOS
- Myeloid and lymphoid neoplasm with FGFR1 abnormalities
- Myeloid and lymphoid neoplasms with PDGFRA rearrangement
- Myeloid leukemia associated with Down Syndrome
- Myeloid and lymphoid neoplasms with PDGFRA arrangement
- Myeloid sarcoma
- Myeloid neoplasms with PDGFRA 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 intraductal 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
ONCOYTOMA
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 EPENDYOMA
Papillary ependymoma
Papillary epidermoid carcinoma*
PAPILLARY GLIONEURONAL TUMOR
PAPILLARY MENINGIOMA
Papillary meningioma

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Papillary microcarcinoma (C73.9)
Papillary mucinous cystadenocarcinoma

**PAPILLARY MUCINOUS CYSTADENOMA, BORDERLINE MALIGNANCY**
Papillary pseudomucinous cystadenocarcinoma

**PAPILLARY PSEUDOMUCINOUS CYSTADENOMA, BORDERLINE MALIGNANCY**
Papillary renal cell carcinoma (C64.9)
Papillary serous adenocarcinoma

**PAPILLARY SEROUS CYSTADENOMA, BORDERLINE MALIGNANCY**
Papillary transitional cell carcinoma
Papillary transitional cell carcinoma, non-invasive

**PAPILLARY SEROUS TUMOR OF LOW MALIGNANT POTENTIAL**
Papillary squamous cell carcinoma*
Papillary squamous cell carcinoma in situ
Papillary squamous cell carcinoma, non-invasive

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 dermofibrosarcoma protuberans
Pigmented Schwannoma
Pilocytic Astrocytoma (C71._)
Pilocytic/Juvenile Astrocytoma (C71._)
Pilocytic/Juvenile Astrocytoma
Pilocytic/Juvenile Astrocytoma
Pilocytic/Juvenile Astrocytoma
Pilomatrix carcinoma*
Pilomatrixoma, malignant
Pilomatrixoma
Pineal parenchymal tumor of intermediate differentiation (C75.3)
Pinealoma

[195x139]Refer to ICD-O-3 for inclusive listing of morphology terms.

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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._)
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*
Polyorphic PTLD
Polymorphic reticulosis [obs]
Polymorphous low grade adenocarcinoma
Polyvesicular vitelline tumor
Porocarcinoma (C44._)
PNET
Pre-B ALL
Precancerous melanosis
Precursor B-cell lymphoblastic leukemia

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

Prolymphocytic leukemia
Prolymphocytic leukemia, B-cell type
Prolymphocytic leukemia, NOS
Prolymphocytic 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 (C34.9)

PSEUDOMUCINOUS CYSTADENOCARCINOMA

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Pseudomyxoma peritonei

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
Rhabdomyosarcoma with ganglionic differentiation
Rhabdomyosarcoma, NOS
Rhabdomyosarcoma, NOS
Rodent ulcer*
Rosette-forming glioneuronal tumor
Round cell carcinoma*
Round cell liposarcoma
Round cell osteosarcoma (C40.9, C41.9)
Round cell sarcoma

Rhabdomyosarcoma with ganglionic differentiation
Rhabdomyosarcoma, NOS
Rhabdosarcoma
Rodent ulcer*

Rhabdomyosarcoma with ganglionic differentiation
Rhabdomyosarcoma, NOS
Rhabdosarcoma
Rodent ulcer*
Rosette-forming glioneuronal tumor
Round cell carcinoma*
Round cell liposarcoma
Round cell osteosarcoma (C40.9, C41.9)
Round cell sarcoma

Round cell sarcoma

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

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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
Somatostatinoma

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<th><strong>Squamous cell carcinoma, nonkeratinizing, NOS</strong></th>
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<td><strong>Spermatocytic seminoma</strong></td>
<td><strong>Squamous cell carcinoma, NOS</strong></td>
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<td><strong>Spermatocytoma</strong></td>
<td><strong>Squamous cell carcinoma, sarcomatoid</strong></td>
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<td><strong>Spindle cell carcinoma</strong></td>
<td><strong>Squamous cell carcinoma, small cell</strong></td>
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<td><strong>Squamous cell carcinoma, spindle cell</strong></td>
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<td><strong>Spindle cell melanoma, type A</strong></td>
<td><strong>Squamous cell epithelioma</strong></td>
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<td><strong>Spindle cell melanoma, type B</strong></td>
<td><strong>Squamous intraepithelial neoplasia, grade III</strong></td>
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<td><strong>SPINDLE CELL ONCYCTOMA</strong></td>
<td><strong>Squamous intraepithelial neoplasia, grade III, vulva and vagina</strong></td>
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<td><strong>Spindle cell rhabdomyosarcoma</strong></td>
<td><strong>Steroid cell tumor, malignant</strong></td>
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<td><strong>Spindle cell sarcoma</strong></td>
<td><strong>Stromal myosis, NOS</strong></td>
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<tr>
<td><strong>Spindle epithelial tumor with thymus-like differentiation</strong></td>
<td><strong>Stromal myosis, NOS (C54.1)</strong></td>
</tr>
<tr>
<td><strong>Spindle epithelial tumor with thymus-like element</strong></td>
<td><strong>Stromal sarcoma, NOS</strong></td>
</tr>
<tr>
<td>Spindled mesothelioma</td>
<td><strong>Struma ovarii, malignant</strong></td>
</tr>
<tr>
<td><strong>Splenial lymphoma with villous lymphocytes (C42.2)</strong></td>
<td><strong>Subacute granulocytic leukemia [obs]</strong></td>
</tr>
<tr>
<td><strong>Splenial marginal zone B-cell lymphoma (C42.2)</strong></td>
<td><strong>Subacute leukemia, NOS [obs]</strong></td>
</tr>
<tr>
<td><strong>Splenial marginal zone lymphoma, NOS (C42.2)</strong></td>
<td><strong>Subacute lymphatic leukemia [obs]</strong></td>
</tr>
<tr>
<td><strong>SPONGIOBLASTOMA MULTIFORME</strong></td>
<td><strong>Subacute lymphocytic leukemia [obs]</strong></td>
</tr>
<tr>
<td><strong>SPONGIOBLASTOMA POLARE</strong></td>
<td><strong>Subacute lymphoid leukemia [obs]</strong></td>
</tr>
<tr>
<td><strong>SPONGIOBLASTOMA, NOS</strong></td>
<td><strong>Subacute monocytic leukemia [obs]</strong></td>
</tr>
<tr>
<td><strong>SPONGIONEUROBLASTOMA</strong></td>
<td><strong>Subacute myelogenous leukemia [obs]</strong></td>
</tr>
<tr>
<td><strong>Squamous transitional cell carcinoma (C53._)</strong></td>
<td><strong>Subacute myeloid leukemia [obs]</strong></td>
</tr>
<tr>
<td><strong>Squamous carcinoma</strong></td>
<td><strong>Subcutaneous panniculitis-like T-cell lymphoma</strong></td>
</tr>
<tr>
<td><strong>Squamous cell carcinoma, HPV-negative</strong></td>
<td><strong>SUBEPENDYMYAL ASTROCYTOMA</strong></td>
</tr>
<tr>
<td><strong>Squamous cell carcinoma, HPV-positive</strong></td>
<td><strong>SUBEPENDYMYAL GIANT CELL</strong></td>
</tr>
<tr>
<td><strong>Squamous cell carcinoma in situ with questionable stromal invasion</strong></td>
<td><strong>ASTROCYTOMA</strong></td>
</tr>
<tr>
<td><strong>Squamous cell carcinoma in situ, NOS</strong></td>
<td><strong>SUBEPENDYMYAL GLIOMA</strong></td>
</tr>
<tr>
<td><strong>Squamous cell carcinoma with horn formation</strong></td>
<td><strong>SUBEPENDYMOMA</strong></td>
</tr>
<tr>
<td><strong>Squamous cell carcinoma, acaholyticy</strong></td>
<td><strong>Superficial spreading adenocarcinoma</strong></td>
</tr>
<tr>
<td><strong>Squamous cell carcinoma, clear cell type</strong></td>
<td><strong>Superficial spreading melanoma</strong></td>
</tr>
<tr>
<td><strong>Squamous cell carcinoma, keratinizing, NOS</strong></td>
<td><strong>Supratentorial PNET (C71._)</strong></td>
</tr>
<tr>
<td><strong>Squamous cell carcinoma, large cell, keratinizing</strong></td>
<td><strong>Sweat gland adenocarcinoma</strong></td>
</tr>
<tr>
<td><strong>Squamous cell carcinoma, large cell, nonkeratinizing</strong></td>
<td><strong>Sweat gland carcinoma</strong></td>
</tr>
<tr>
<td><strong>Squamous cell carcinoma, microinvasive</strong></td>
<td><strong>Sweat gland tumor, malignant</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Sympathicoblastoma</strong></td>
</tr>
<tr>
<td></td>
<td><strong>SYNCYTIAL MENINGIOMA</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Synovial sarcoma, biphasic</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Synovial sarcoma, epithelioid cell</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Synovial sarcoma, monophasic fibrous</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Synovial sarcoma, NOS</strong></td>
</tr>
</tbody>
</table>

*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

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

Revised January 2019
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

**T**

T-cell lymphoma, NOS
T-cell /histiocytic-rich large B-cell lymphoma
T-cell rich large B-cell lymphoma
T/NK-cell lymphoma
Tannycytic 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-SCHWANNOMATOSIS
Thecomma, 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, epipodophyllotoxin-related
Therapy-related myelodysplastic syndrome, NOS
Therapy-related myelodysplastic syndrome, alkylating agent related
Therapy-related myelodysplastic syndrome, epidopodophyllotoxin-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
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.

*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

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

Revised January 2019
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

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

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[obs] = Obsolete

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

Revised January 2019
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
**FACILITY TYPE (SOURCE TYPE)**

**Reporting Status:** Required  
Section: State Requested Items

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<thead>
<tr>
<th>Alternate Name</th>
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<th>Length</th>
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<th>Column #</th>
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<td>NYSCR</td>
<td>3051-3052</td>
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</table>

**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

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<td>9540</td>
<td>40</td>
<td>NYSCR</td>
<td>3197-3236</td>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Alternate Name</th>
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<th>Column #</th>
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</tbody>
</table>

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

<table>
<thead>
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</table>

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

<table>
<thead>
<tr>
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<td>3337-3386</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Alternate Name</th>
<th>Item #</th>
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<td>9544</td>
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<td>NYSCR</td>
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</tr>
</tbody>
</table>

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

<table>
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<td>3389-3397</td>
</tr>
</tbody>
</table>

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

<table>
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<td>NYSCR</td>
<td>3398-3407</td>
</tr>
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</table>

**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

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<th>Alternate Name</th>
<th>Item #</th>
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<th>Column #</th>
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<tr>
<td></td>
<td>2078</td>
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<td>NYSCR</td>
<td>2595</td>
</tr>
</tbody>
</table>

**Description**

**Codes**

1   Reviewed  
Blank   Not reviewed or reviewed and corrected
NYS TOBACCO HISTORY

Reporting Status: Required
Section: Special Use

<table>
<thead>
<tr>
<th>Alternate Name</th>
<th>Item #</th>
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<td></td>
<td>9536</td>
<td>1</td>
<td>NYSCR</td>
<td>3195</td>
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</table>

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

<table>
<thead>
<tr>
<th>Alternate Name</th>
<th>Item #</th>
<th>Length</th>
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<tr>
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<td>3084</td>
</tr>
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</table>

**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

<table>
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<tr>
<th>Alternate Name</th>
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<td>3408-3417</td>
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</table>

**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

<table>
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<tr>
<th>Alternate Name</th>
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<td>3064-3083</td>
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</table>

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

<table>
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<tr>
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<th>Source of Standard</th>
<th>Column #</th>
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<td>NYSCR</td>
<td>3053-3063</td>
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</table>

**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

<table>
<thead>
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**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

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<td>9527</td>
<td>25</td>
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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

<table>
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<th>Alternate Name</th>
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<td></td>
<td>9528</td>
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<td>NYSCR</td>
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</table>

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

<table>
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**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

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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

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

## Part Six - Death Certificate Only and Death Clearance Lists

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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.
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Part Seven – Quality Assessment

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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 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-abstraction 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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Part Eight – Electronic Reporting

8.1 CREATING AN EXPORT FILE ................................................................. 1
8.2 SUBMITTING TO THE NYSCR VIA THE HEALTH COMMERCE SYSTEM (HCS) ................................................................. 1
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.
Figure 1

Figure 2

Figure 3
## Figure 4

### UPLOAD A FILE

Select the file for upload:

![Facility Cancer Reporting](image)

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

## Figure 5

### UPLOAD A FILE

File Successfully Uploaded. FileID Assigned: 200042

![Facility Cancer Reporting](image)
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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.

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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.
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).