CAST A WIDE NET:
CASEFINDING AND REPORTABILITY 101

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Overview

- Understand what casefinding is and why it is necessary
- Learn where to find possible cases and determine reportability
- Review examples of casefinding sources

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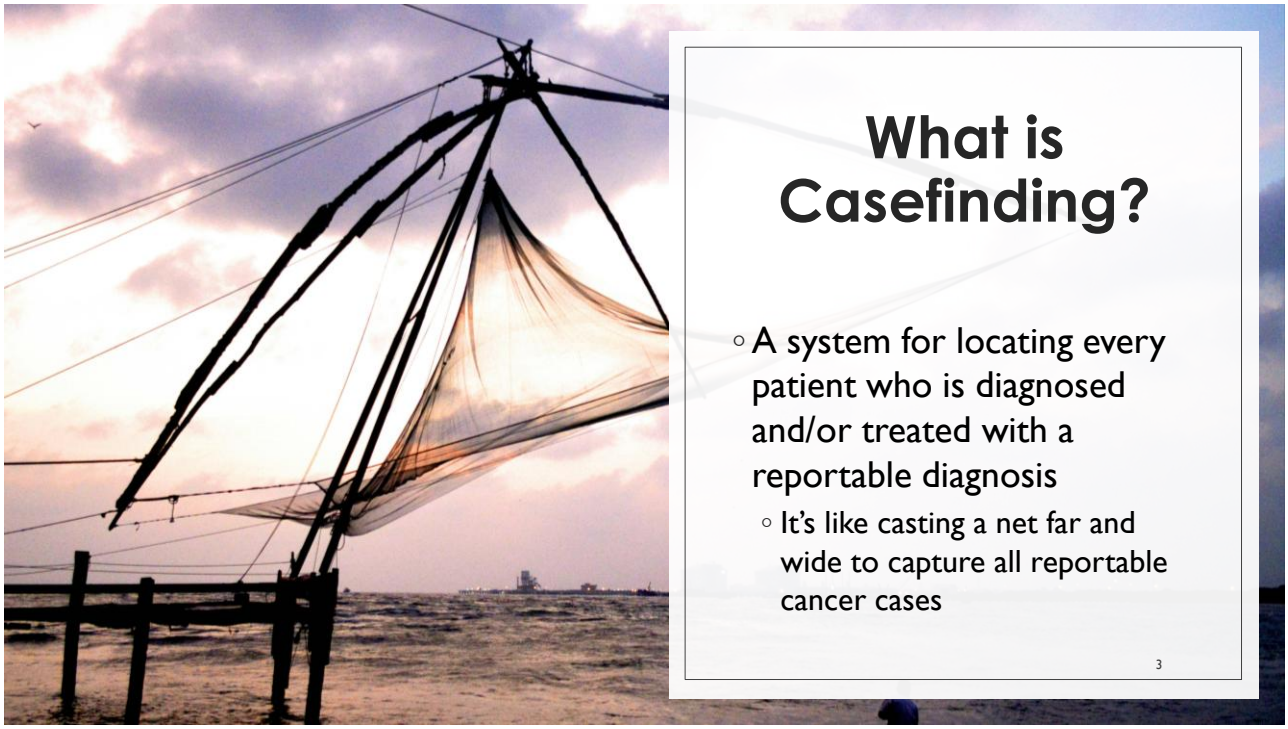

What is Casefinding?

- A system for locating every patient who is diagnosed and/or treated with a reportable diagnosis
  - It's like casting a net far and wide to capture all reportable cancer cases

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Casefinding List

- A casefinding list is **NOT** the same as a reportable list
  - Casefinding list:
    - Intended for searching a variety of sources as to not miss any reportable solid tumor, hematopoietic, benign/borderline brain cases
    - A screening tool for prospective cases and identify cases for inclusion in the registry
    - Different types: disease index, discharge list, E-path, radiology/treatment lists
  - Reportable list:
    - Reportable diseases that are required to be collected and reported
    - Exceptions to reporting requirements – what is not reportable
    - SEER is the standard setter in Iowa

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How is Casefinding Performed?

- **Active**:
  - Cancer registry staff retrieve all source documents
  - Staff screen the documents for reportable cases
  - More thorough and accurate
- **Passive**:
  - Other departments notify the registry of potential reportable cases
  - Not as accurate as active
    - Non-registry staff are not as familiar with reporting criteria and terminology

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How is Casefinding Performed?

- **Automated**:
  - Certified EHR/EMR technology with the ability to identify reportable case and treatment to the provider and facilitate electronic reporting either automatically or upon verification
    - Rapid Case Ascertainment
      - Electronic download process of eligible cancer cases into registry software
      - Supplemental review of source documents by staff
  - Natural Language Processing (NLP)
    - Application of linguistics and computer science to extract and interpret linguistic information from health care documents (path report, imaging, treatment summaries, clinical notes)

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Casefinding Source Documents

- **Pathology reports/E-path** (HL7)
  - Lab reports: cytology, bone marrow, autopsy
  - Typically, 90% of all cancers are histologically confirmed
    - Pathology – resected specimens (tissue) microscopically examined
    - Cytology – microscopic exam of cells in body fluids from aspirations, washings, scrapings, and smears

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Pathology Casefinding

- **Daily or Weekly review recommended**
- Complete path casefinding involves a review of all reports both positive and negative
  - A computerized list of reportable diagnoses can decrease the number of pathology reports for visual review
- Both manual and computerized review should have a tracking system to ensure all reports were evaluated

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ICD Coding

- **International Classification of Disease** (ICD)
  - Method of classifying diseases, injuries, and causes of death
  - ICD-10 first published by WHO in 1992
    - ICD-10-CM based on this and adopted by US in 1999 for cause of death only and in 2015 for morbidity purposes
  - Unites States is the only country using ICD-10-CM (clinical modification)
    - Billing purposes
  - ICD-10-PCS – procedure coding

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ICD Coding

- **ICD-O** (Oncology)
  - Dual classification with coding systems for both topography and morphology
  - Standard tool for coding diagnoses of neoplasms by cancer registrars
  - Currently using ICD-O-3 (3rd ed.)
    - Used since 2001
    - Histology codes have been undergoing updates since 2018
      - ICD-O-3.2 histology updates based WHO Blue Books 5th ed.

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Casefinding Source Documents

- **Medical records disease index** (DI)
  - ICD-10-CM codes run for reportable diseases
    - Inpatient & Outpatient visits
    - Use the most current list of codes for the reporting year
  - Most large CoC accredited facilities review the list **monthly**
    - Smaller facilities may review the list quarterly or annually
      - Dependent upon time availability and staffing
    - Is patient in the registry with the coded cancer?
    - Is patient in the registry as a suspense case?
    - Not in the registry?
      - Review medical record to determine if reportable

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Disease Index Casefinding

- **SEER Casefinding List –** https://seer.cancer.gov/tools/casefinding/
  - **Comprehensive List –**
    - required
  - **Supplemental List –**
    - As time allows

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Disease Index Casefinding

- **Automated DI casefinding**
  - Hospital's EMR/coding system extracts possible reportable cases and places these into the registry software suspense file
    - A manual DI should be run at the end of the reporting year to ensure all cases were either reported or clearly documented as non-reportable

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Casefinding Source Documents

- **Radiation Therapy** and **Medical Oncology** logs
  - Depending on size of facility the review should be performed periodically
  - Helps ensure complete ascertainment of all cases
  - It can also be a good system for collecting follow up
  - Request new patients

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Casefinding Source Documents

- **List from ICR**
  - Information from disease index and pathology report review
    - AFL – Abstract Facility Lead
  - Organize your list and review:
    1. No patient
       - Patient not in ICR database
    2. No tumor
       - Patient is in the ICR database, but the tumor is not
    3. No facility
       - Patient and tumor is in the database, but not from your facility

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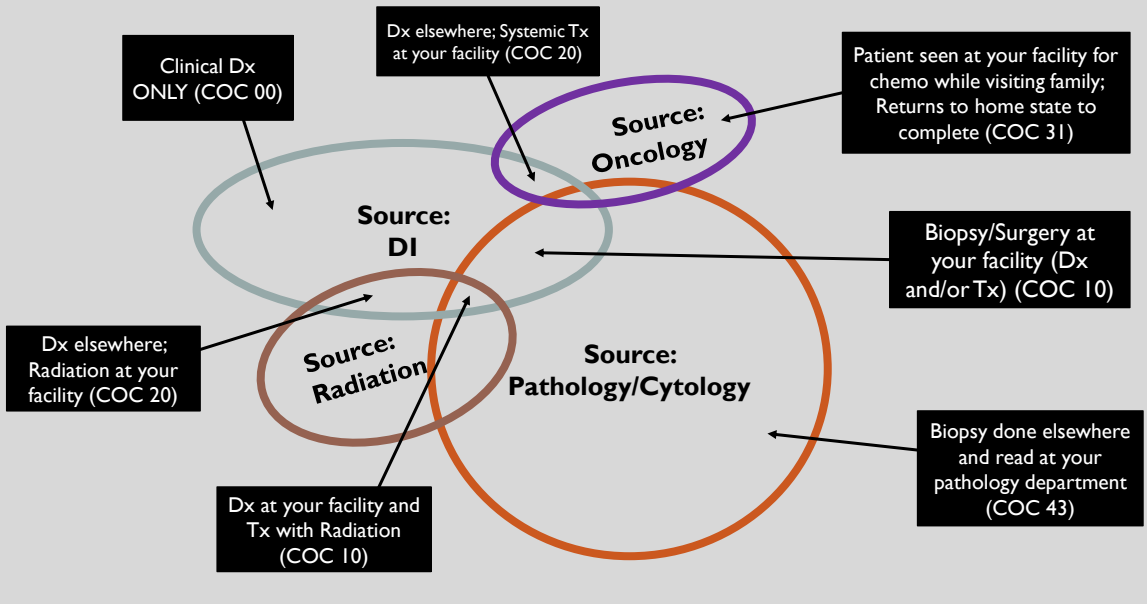

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Casefinding Process

- List of patients found from the source documents (disease index, e-path, ICR list etc.)
- Review the patient's information in the EMR
  - Rad/Med Onc consults; Imaging; Pathology; Discharge summaries; Op reports
- Ask the following….
  - Does the information confirm a reportable disease?
  - Does the patient have active disease?
  - Is the patient receiving treatment for a reportable disease?
  - If 'yes' to any of the above, then you have a reportable case

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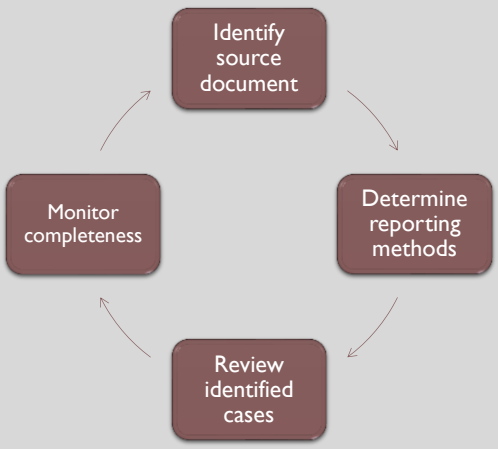
Casefinding Cycle



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Make the Determination

- Always check the patient against the current registry database **BEFORE** abstracting
  - Is the patient in the database?
    - **Yes**
      - Is it for the same tumor (site/histology)?
      - Is it metastatic from the primary in the database?
      - Update information in the abstract
    - **No**
      - This is a new case and should be abstracted

Use the Solid Tumor Rules or Heme/Lymph Manual Multiple Primary rules

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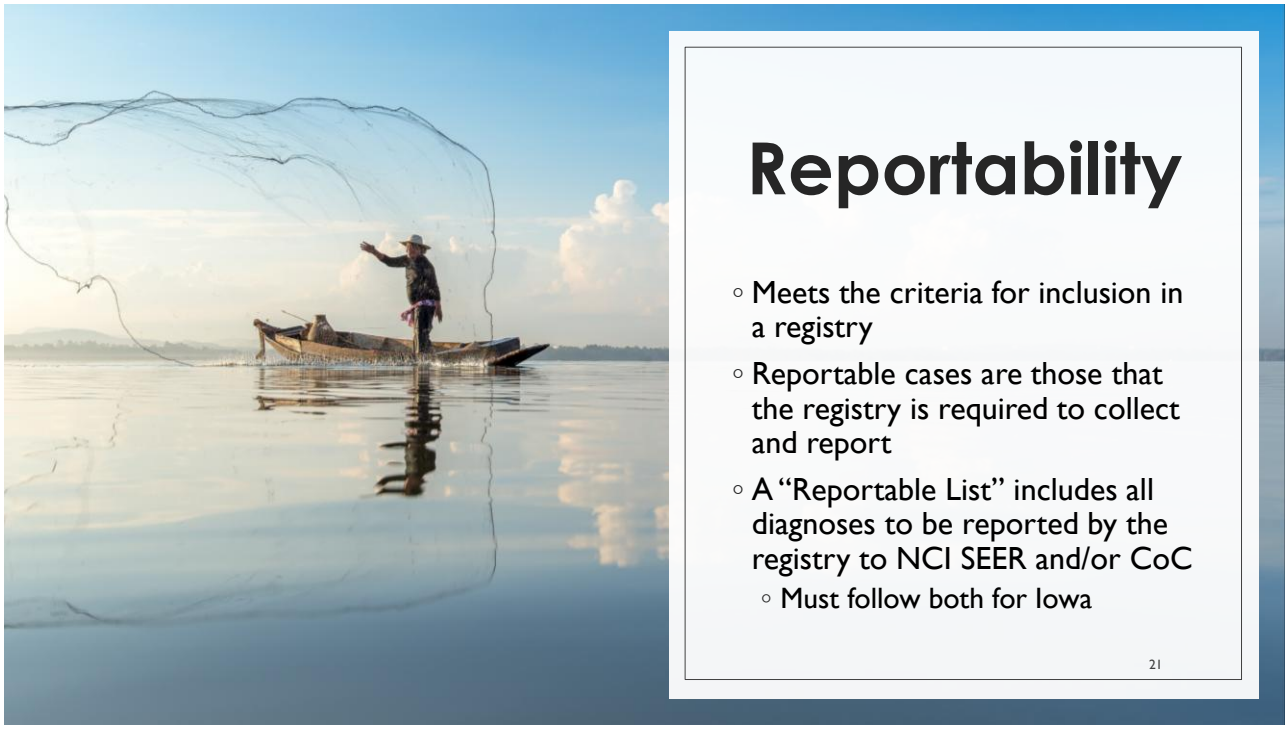

Reportability

- Meets the criteria for inclusion in a registry
- Reportable cases are those that the registry is required to collect and report
- A "Reportable List" includes all diagnoses to be reported by the registry to NCI SEER and/or CoC
  - Must follow both for Iowa

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Reportable List - SEER

https://seer.cancer.gov/manuals/2024/SPCSM_2024_MainDoc.pdf

- **Malignant histologies**
  - Behavior codes /2 and /3 (in situ and invasive)
  - *Exceptions*:
    - Skin primary (C440-C449) – SCC and Basal cell CA
      - 8000-8005; 8010-8046; 8050-8084; 8077; 8090-8110
    - Any in situ behavior of cervix (C530-C539)
    - PIN III
    - Colon atypical hyperplasia
    - High grade dysplasia colorectal sites
- **Non-Malignant histologies** (benign/borderline) – 2004+
  - Primary intracranial and CNS tumors (C700-C709; C710-C719; C720-C729;C751-C753)
  - Behavior codes /0 or /1

SEER Appendix E Reportable/Non-reportable Examples: https://seer.cancer.gov/manuals/2024/SPCSM_2024_Appendix_E.pdf

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Reportable List - CoC

https://www.facs.org/media/bfxlv0eu/store-manual-2024.pdf

- **Malignancies with behavior /2 or /3** (in-situ and invasive)
  - *Exceptions*:
    - Skin primaries (C44x) and histology = 8000-8110
    - In situ of cervix (C53x)
    - **LCIS of breast (C50x)**
    - **Intraepithelial neoplasia grade III (8072/2)**
      - Cervix, prostate, **vulva, vagina, anus**, larynx
      - Squamous intraepithelial neoplasia
    - Colon atypical hyperplasia
    - High grade dysplasia colorectal sites
- **Non-Malignant histologies** (benign/borderline) – 2004+
  - Primary intracranial and CNS tumors (C700-C709; C710-C719; C720-C729;C751-C753)
  - Behavior codes /0 or /1

SEER reportability takes priority

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Ambiguous Terms - SEER

- **Reportable Terms**
  - Apparent(ly)
  - Appears
  - Comparable with
  - Compatible with
  - Consistent with
  - Favor(s)(ed)
  - Malignant appearing
  - Most likely
  - Presumed
  - Probable
  - Suspect(ed)
  - Suspicious (for)
  - Typical (of)

- **Intracranial or CNS Neoplasms <u>ONLY</u>:**
  - **Reportable terms –**
    - Neoplasm
    - Tumor
  - **<u>NOT</u> reportable terms –**
    - Mass
    - Lesion

Do **not** abstract a case based **<u>ONLY</u>** on suspicious cytology. Follow back on cytology diagnoses using ambiguous terms. Accession the case when a reportable diagnosis is confirmed later (date of diagnosis is date of suspicious cytology)

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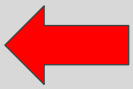
Class of Case

- For CoC facilities cases are assigned a Class of Case
  - Relationship between the facility and patient
    - **Analytic cases** (class of case 00-22)
      - Report to NCDB and ICR
    - **Nonanalytic cases** (class of case 30-99)
      - Not required to be abstracted for CoC
      - **ARE** required to be abstracted and submitted to ICR
        - SEER reportability takes precedence



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Non-analytic Class of Case

Code	Label	Description	Report to ICR
30	Diagnosis & 1st course treatment **elsewhere**; Seen in-person at reporting facility	Reporting facility participated in diagnostic work up (consult only; treatment plan only; staging workup after diagnosis elsewhere)	Yes
31		Diagnosis & Treatment elsewhere; Reporting facility provided **in-transit care** or **facilitated treatment** (stent placement)	Yes
32		Diagnosis & Treatment elsewhere; Patient seen at reporting facility with disease recurrence or persistence (active disease)	Yes
33		Diagnosis & Treatment elsewhere; Patient has **disease history only** (no active dz)	No
34	Case not required by CoC (i.e. VIN 3, AIN 3, VAIN 3, etc.); Seen in-person at reporting facility	Diagnosis and all/part 1st course treatment **at reporting facility**	Possible
36		Diagnosis **elsewhere** and all/part 1st course treatment **at reporting facility**	Possible

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Non-analytic Class of Case

Code	Label	Description	Report to ICR
35	Diagnosed **before facility's reference date**; Seen in-person at reporting facility	Diagnosis and all/part 1st course treatment at reporting facility	Yes
37		Diagnosis elsewhere and all/part 1st course treatment at reporting facility	Yes
38	Seen in-person at reporting facility	**Diagnosed at autopsy** at the reporting facility and cancer not suspected prior to death	Yes
42	Not seen in-person at reporting facility	Nonstaff physician or non-CoC accredited clinical or other facility **abstract by reporting facility for diagnosis and/or treatment** (contract/agreement between facilities)	Yes
99		Unknown relationship to facility	Yes

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Reportability

- **Residency** (IA resident or out of state)
  - Was the patient diagnosed and/or treated in an Iowa facility?
    - **Yes** – report the case
  - Was the patient seen in an Iowa facility with active disease?
    - **Yes** – report the case
  - Was the patient seen in an Iowa facility with a history of a reportable cancer?
    - Is there active disease?
      - **No** – don't report the case

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Reportability

- **Reference Date**
  - Iowa Cancer Registry: 1/1/1973
    - Hospitals with approved cancer programs will have their own reference date
      - Even if diagnosed/treated prior to facility reference date **report the case**
        - **Class of Case 35 or 37**
        - *Example*: Facility A has reference date of 1/1/2023. Patient is seen at Facility A in 2022 for breast cancer diagnosed elsewhere. Facility A administers first course treatment in 2022. Abstract the case and submit to ICR (*class of case 37*)

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Reportability

Did your facility diagnose the reportable cancer?

- **Yes** – Report the case

Is the patient receiving treatment at your facility for a reportable cancer?

- **Yes** – Report the case

Does the patient have active disease?

- **Yes** – Report the case

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CASE EXAMPLES

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Example 1

- 1/2/24 CT Chest: large abnormal appearing mass in RUL, 1.3cm, consistent with malignancy.
- Patient never returns to the facility

Is this case reportable?

Yes, the reporting facility diagnosed the case

Ambiguous term: consistent with malignancy

Makes this a reportable case without further information

Source: SPCSM, page 18 Ambiguous Terms for Reportability

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Example 2

- Patient has had an abnormal mass left calf, here for biopsy
- 3/4/24 Left calf muscle, biopsy: atypical fibroxanthoma (superficial malignant fibrous histiocytoma)
- Only visit at facility

Should this case be reported?

Yes, the information in parentheses on biopsy provides more detail and confirms a reportable malignancy

Malignant Fibrous Histiocytoma: 8830/3

Sources:
1. ICD-O-3.2 Annotated list: https://www.naaccr.org/icdo3/
2. SPCSM, page 14

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Example 3

Facility A

- 5/16/24 Screening mammogram: abnormal mass in the 2:00 position left breast
- 5/22/24 Left breast ultrasound: suspicious mass, 0.9cm, 2:00 position
- 5/29/24 Left breast, 2:00, biopsy: atypical ductal hyperplasia

Facility B

- 6/18/24 Patient with known atypical ductal hyperplastic mass in left breast. Patient is concerned because mass is increasing in size.
- 6/18/24 Left breast, lumpectomy: Ductal carcinoma in situ, 0.5cm. No invasive portion noted.

Which facility should report the case?

Facility A: No diagnosis or treatment

Facility B: Diagnosis and part of 1st course treatment

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Example 4

8/9/24 Screening mammogram: abnormal microcalcifications in the 9:30 area right breast and mass noted at 10:00 right breast; left breast normal. BIRADS 5: highly suggestive of malignancy

Should this case be reported?

No, based on this information alone we don't have a diagnosis of cancer.

BIRADS 4, 4A, 4B, 4C, or 5 information alone are not diagnostic (**SEER Appendix E2**)

https://seer.cancer.gov/manuals/2024/SPCSM_2024_Appendix_E.pdf

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Example 5

- 10/11/24 colonoscopy: abnormal appearing mass in rectum
  - Rectal biopsy: very atypical hyperplasia concern for malignancy
  - Rectal biopsy consult: no findings of malignancy
- 11/1/24 Radiation Oncology: per MRI patient has a rectal cancer abutting mesorectal fat, involved lymph nodes; recent biopsy concerning for malignancy; plan: neoadjuvant radiation
  - 11/5/24 neoadjuvant radiation began

Should this case be reported?

Yes, the patient diagnosed with rectal cancer per Rad Onc and received treatment

SPCSM, Reportability List/Instructions, pages 13-22

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Resources

- SEER Casefinding Lists:
  https://seer.cancer.gov/tools/casefinding/
- SEER Program Coding and Staging Manual (SPCSM) – pages 13-22
  - Reportability: https://seer.cancer.gov/tools/codingmanuals/
  - Reportable/Non-reportable examples:
    https://seer.cancer.gov/manuals/2024/SPCSM_2024_Appendix_E.pdf
- STORE Manual 2024 (CoC facilities)
  https://www.facs.org/media/bfxlv0eu/store-manual-2024.pdf
- Comparison of Reportable Cancers: CoC, SEER, NPCR, CCCR
  https://apps.naaccr.org/data-dictionary/data-dictionary/version=25/chapter-view/standards-for-tumor-inclusion-and-reportability/comparison-of-reportable-cancers-coc-seer-npcr-and-cccr/

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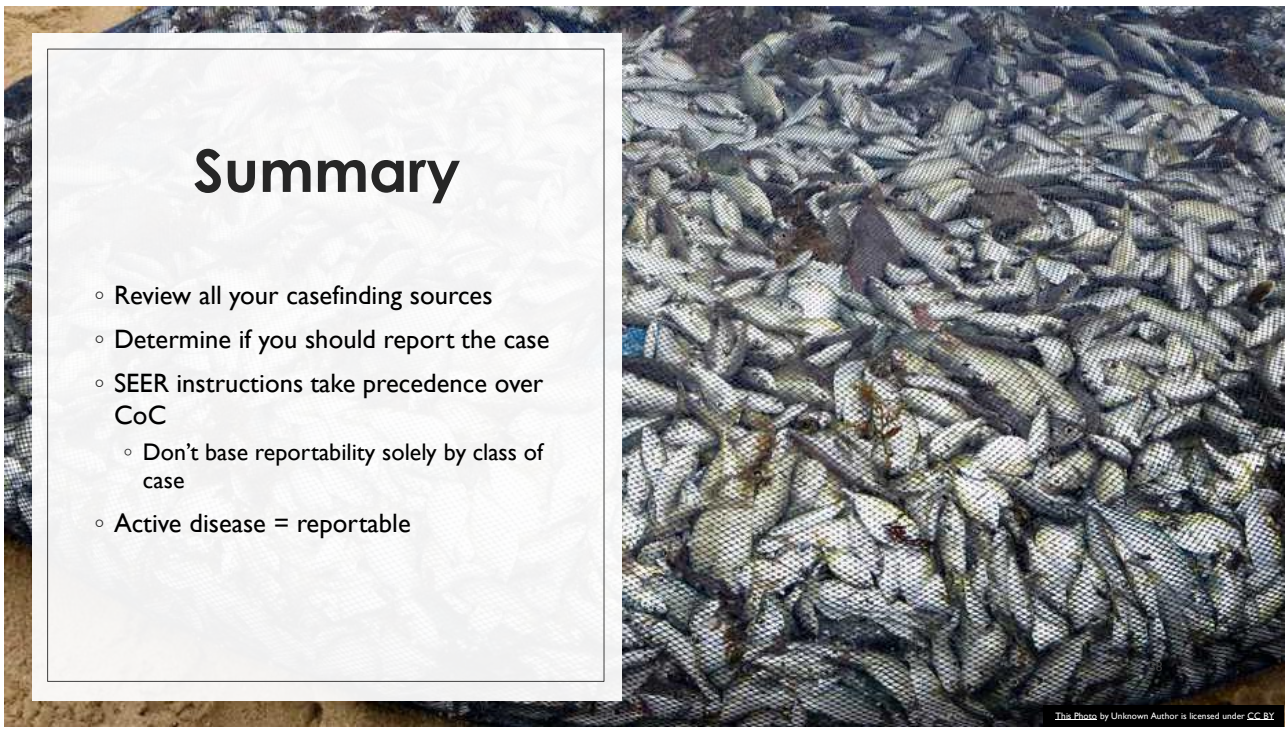

Summary

- Review all your casefinding sources
- Determine if you should report the case
- SEER instructions take precedence over CoC
  - Don't base reportability solely by class of case
- Active disease = reportable

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Questions?

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