



## Arkansas Central Cancer Registry

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## 2008 Non Hospital Reporting Manual

*Second Edition*



ARKANSAS DEPARTMENT OF

**Health**

*Keeping Your Hometown Healthy*



## **Our Mission...**

The mission of the Arkansas Central Cancer Registry is to reduce incidence and mortality of cancer in Arkansas. By collecting, analyzing, researching and disseminating cancer data, we hope to decrease cancer incidence and mortality rates in Arkansas over time.

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## INTRODUCTION

The Arkansas Central Cancer Registry (ACCR) Non-hospital Reporting Manual has been created to assist non-hospital facilities in reporting cancer cases to the central cancer registry. Implementation of this edition of the manual is to begin with cancer cases diagnosed January 1, 2007.

The Arkansas General Assembly originally established the Arkansas Central Cancer Registry in 1938. The registry only collected minimal data and was only for indigent patients who were referred to participating tumor clinics throughout the state of Arkansas. No funds were available from the state until 1945. By 1970, the data collected was computerized, but due to a state-funding crisis in 1979, The Arkansas Central Cancer Registry was eliminated.

In 1989, Arkansas again authorized a state cancer registry to be located at the Arkansas Department of Health, although funding was not available to staff the registry or collect the data. In 1992, The United States Congress passed the "Cancer Registries Amendment Act" (Public Law 102-515), which provided federal funding for state cancer registries. The law was carried out through efforts by the Centers for Disease Control and Prevention (CDC) in Atlanta, Georgia. Funding for a cancer program in Arkansas began in 1994, when the first federal funds were awarded through the National Program for Cancer Registries (NPCR).

NPCR requires central registries to:

- ◆ Collect incidence data on residents of Arkansas,
- ◆ Have legislation mandating the reporting of cancer cases by all facilities that diagnose and/or treat cancer,
- ◆ Provide training for state personnel, hospital registry and non-hospital reporting facility staff,
- ◆ Follow a standard data set when collecting cancer cases and data must be submitted in NAACCR file format
- ◆ Publish an annual report within 24 months of the end of the diagnostic year,
- ◆ Conduct case finding and quality assurance audits to determine the completeness and quality of all cancer cases being submitted to the registry.

In 1994, the Arkansas Board of Health mandated cancer as a reportable disease in the State of Arkansas. The reference date for the Arkansas Central Cancer Registry is January 1, 1996. This is the first time since 1979 that cancer data was collected in Arkansas.

There has been a shift toward outpatient diagnosis and treatment, which has caused cases not to be reported to the central registry. Some of the cases that are in this category are prostate, malignant melanoma and bladder cancers. This is an attempt to encourage and assist medical facilities in collecting and submitting this data. Without this data, our research and studies cannot be accurate. The ACCR staff is available to

assist with any questions and/or provide in-services to better prepare you for the process. (Refer to Appendix B to review registry personnel.)

## I. GENERAL INSTRUCTIONS

The following information provides some basic rules regarding cancer reporting to the state central cancer registry.

The cancer reporting law applies to all types of medical facilities, including outpatient surgery clinics, hospices, nursing homes, out patient clinics, etc.

All cancer cases diagnosed and/or treated for cancer in your facility, on or after January 1, 1996, must be reported to the ACCR. For skilled nursing homes (not intermediate or residential care facilities and hospices this includes:

- ◆ Cases initially diagnosed while residing in your facility;
- ◆ Cases diagnosed with cancer and/or treated for a recurrence while residing in your facility; and
- ◆ Cases clinically diagnosed while residing in your facility.

The completed case should be submitted to the central registry quarterly for skilled nursing homes and hospices.

For ambulatory surgery centers, freestanding cancer clinics, etc this includes

- ◆ Cases initially diagnosed at your facility;
- ◆ Cases treated at your facility only, without having any treatment performed at a hospital; and
- ◆ Cases that have pathology performed at the treating facility (dermatology clinics).

The completed case should be submitted to the central registry monthly for ambulatory surgery centers, freestanding cancer clinics, treatment centers and physician's offices.

The recommended reporting method is electronic reporting using WebPlus. WebPlus is free software offered to all medical facilities reporting cases to the Arkansas Central Cancer Registry.

The paper reporting form (in back of manual) requires information on a variety of cancer related items. There may be times when the medical record does not have all of the appropriate information to assist in coding these fields. If there is not information to complete all of the items on the form, complete the form with as much

information as possible. The name of the attending physician and the hospital in which the patient may have been admitted should be included on the patient form so that the facility can be contacted if more information is needed. **If information cannot be found, please document by writing “unknown” or “information not available”, rather than leave the fields blank.**

Pertinent portions of the patient’s chart (i.e. history and physical, operative summary, pathology report) can be submitted to the registry for our review. You will not be responsible for contacting physicians for any information on cancer cases.

In addition to the manual, there are instructions on the back of the patient information forms. These instructions will better help you to understand the information that is being collected.

## **A. SUBMISSION GUIDELINES**

1. WebPlus, using a secure electronic web-based browser
2. Paper form, type or handwritten using the required reporting forms (**Use only for facilities reporting five (5) or less cases per year**).

### Changing Information

It is possible that after a case has been submitted to the ACCR additional information added to the patient’s chart would change specific data items. It is permissible to change any data item, including the primary site and histology. For changes made on five (5) or less cases, please call ACCR and report changes. For changes to more than five cases, make corrections to cases and resubmit via WebPlus, case can be included with next submission. If path report is amended, the amended report can be faxed to ACCR and changes will be made. For paper abstract form, complete the cancer form with the new information and write, **“AMENDED”** across the form in **red**.

### Follow-up Information

Additional follow-up information is not required by ACCR on any case.

### Patient List

A list of patients submitted to ACCR via WebPlus will be made available to all submitting facility.

For cases submitted using paper forms; after the information has been recorded and reviewed for completeness and accuracy, please make a list of patient cases submitted. Keeping a list of patients that have been reported to the ACCR may assist in the future to verify that the patient has been reported. This list should include:

- a. Patient Name
- b. Social security number
- c. Date of birth
- d. Date of diagnosis
- e. Primary site
- f. Date case was submitted to the ACCR

Submit all forms and information in “confidential” envelope to:

Wanda Rhodes, RHIT, CTR  
Arkansas Central Cancer Registry  
4815 West Markham, Slot 7  
Little Rock, AR 72205

## B. REPORTABILITY

All facilities reporting more than five (5) cases per year are required to report cancer cases electronically to the ACCR. The following requirements are listed below:

1. **Patients diagnosed and/or treated at your facility (physician's office, freestanding clinics and ambulatory surgery centers, etc)**
  - a. Diagnosis might be clinical (X-rays, CT scans, clinical exam, etc)
  - b. Diagnosis might be pathological (biopsy, cytology, bone marrow, etc)
  - c. Treatment given inside your institution (Chemo, hormonal, immunotherapy, etc)
  - d. Surgery is performed inside of your institution (TURP, lumpectomy, etc)
  - e. No treatment is given (supportive care or "observation" only). This includes palliative treatment.
  
2. **Long term facilities (skilled nursing homes and hospices)**
  - a. Any patient diagnosed with cancer prior to admission in your facility and undergoing cancer directed treatment.
  - b. Any patient diagnosed with cancer, but is being treated at your facility for other reasons (hip fracture, dementia, etc)
  - c. Any patient with a history of cancer who has been without disease for several months or several years, who is diagnosed and/or treated for recurrence of the original cancer.

Deaths should be reported as they occur. This will ensure all necessary data is included on the patient information form before the medical record has been removed and placed in storage. The storage sites are usually off site and can cause inconvenience when the data has to be collected.

### **What information is required?**

Any details related to the **diagnosis, treatment and staging of this cancer**. Any information providing the name of the physician or hospital where the patient was treated will enable the retrieval of more accurate information. This information may be found in the facility or hospital history and physical, discharge summaries, pathology reports, etc. Please include the date of death if the patient dies before the case is submitted to the ACCR.

## C. CONFIDENTIALITY AND HIPAA

The ACCR has policies and procedures that address patient confidentiality. It is also stated in the state law Section 20-15-203. Confidentiality and Section V. Confidentiality in the “Rules and Regulations”, states that “all information exposed to the Arkansas Department of Health shall be confidential and shall not be disclosed under any circumstances except (1) to other state cancer registries with which the Department of Health has agreements that insure confidentiality; (2) to other state health officials who are obligated to keep such information confidential; and (3) to approved cancer research centers under specific conditions where names and identities of the individuals are appropriately protected, and when such research is conducted for the purpose of cancer prevention, control and treatment.

The Arkansas Central Cancer Registry annual incidence report is electronic via the ACCR website at <http://www.healthyarkansas.com/arkcancer/arkcancer.html>. Reports obtained from this site are age-adjusted invasive cancer incidence rates by county and region. Reports can further be defined with details by age, sex, race and year; as well as the top ten cancers in the state. Data requests that cannot be fulfilled via the online query system are referred to the ACCR epidemiologist. **(See website or appendix B for contact information).**

Based on HIPAA privacy regulations, the ACCR is a “public health authority authorized by law to collect and receive such information for the purpose of preventing and controlling disease, injury and disability, including ... reporting of disease ... and the conduct of public health surveillance...” [C.F.R. 164.512 (b)(1)(i)(2001)] This makes it possible for any facility that is eligible to report cancer to the central registry (i.e. hospital, hospice, etc) without obtaining an individual informed consent.

**For more information, see Appendix C, “Frequently Asked Questions and Answers about the HIPAA Regarding Cancer Reporting.”**

## D. REPORTABLE TERMINOLOGY

There are certain ambiguous terms used by cancer registries to help determine if this case should/should not be reported to the central registry. The following terms indicate involvement of disease and **should** be reported to the central registry:

- ◆ compatible with
- ◆ consistent with
- ◆ most likely
- ◆ probable
- ◆ suspect
- ◆ suspicious

Example: CT of the pelvis shows mass in right kidney **consistent with** renal cell carcinoma. No other workup was done and due to patient's other medical conditions, no treatment will be performed. This case should be reported to the central registry. **(For more information on ambiguous terminology, please refer to Appendix D).**

If it is unclear whether a case should be reported or not, complete the patient information form with an explanation of the uncertainty of this case or call ACCR toll free number (800) 651-3493, ext. 2089 for assistance.

## CASES NOT REQUIRED TO BE REPORTED

There are certain cases that **do not** have to be reported to the central registry. They are as follows:

- ◆ Patients with a history of cancer and at the time of admission to your facility, but have no evidence of disease.
- ◆ Patients who are admitted into your facility and treated for a recurrence of a cancer, but the patient is **not** an Arkansas resident.
- ◆ Patients who are admitted into your facility and treated for a recurrence, but were diagnosed before January 1, 1996.
- ◆ Basal or squamous cell carcinomas of the skin.
- ◆ Insitu of the cervix (CIN III or CIS) or prostate (PIN III)

## REPORTING DEATHS

Death information is important in completing cancer data in the registry database. Here are some important tips to help in reporting death cases:

- ◆ If there is information about the death of a patient, it should be reported at the time the cancer is being reported.
- ◆ Cancer or a history of cancer can be reported at patient's death. The primary cause of death may or may not be related to the cancer diagnosis. These cases are reviewed based on the information that is coded on the death certificate. If deaths are reported as they occur, it can eliminate or greatly decrease the number of requests for death information from the central registry.
- ◆ If you have previously submitted a cancer case on a patient, you do not have to report the patient's death. The death will be captured during the death clearance process.
- ◆ Deaths can be submitted using same methods as reporting cancer cases. Make sure a date of diagnosis is documented, if available. If the exact diagnosis date is unknown but you know the approximate date diagnosed, please give that.

## DEATH CLEARANCE PROCESS

Death clearance is a process in which death certificates with cancer as the cause of death is matched with cancer patients in the registry database. Cancer may or may not be the cause of death for some of the patients that are in the database. Death certificates that do not match with the registry database and have a cause of death as cancer are followed to determine the eligibility of the cases identified.

## CANCER REPORTING FORMS

Instructions for entering cases using WebPlus are included in the WebPlus manual that will be given to each WebPlus user facility during the training period.

There are instructions on the back of the paper cancer reporting form that serve as a quick reference to assist in accurate completion of the form. **If there is any information that cannot be located to complete a certain data field, record "unknown" or "Information not available, rather than leave the data field blank.**

## REPORTING FACILITY IDENTIFICATION

The information entered in this area is used to identify the facility that is reporting the cancer case.

Instructions in WebPlus manual for WebPlus users

Paper Form: Record full name and address of the facility, telephone number, fax number, name and e-mail address of contact person. The contact person is the one responsible for completing the form.

### A. PATIENT IDENTIFICATION INFORMATION

#### 01. PATIENT NAME

- ◆ Record the patient's last name, then first name, followed by the middle name. Record middle initial if full middle name is not available.
- ◆ Titles such as MD or Jr., may be recorded after the last name
- ◆ Hyphenated last names are acceptable
- ◆ Record any nicknames, aliases, or maiden names listed in parenthesis.

#### 02. ADDRESS

Record the patient's address when patient was diagnosed with cancer. If unknown, record where the patient is currently living.

#### 03. GENDER

Circle the appropriate gender for the patient

#### 04. BIRTH DATE

Complete the patient's birth date, recording the month in the first two spaces, the day in the next two spaces, and the four-digit birth year in the last four spaces.

If the month and day of birth are unknown, but the year is known, record as \*99/99/1937.

**EXAMPLE:** The history and physical states that the patient is 71 years old at the time he is admitted into your facility, January 15, 2008; there is no birth date documented; record the date of birth as \*99/99/1937. \*9" or "99" is used by cancer registries to indicate unknown information.

#### 05. SOCIAL SECURITY NUMBER

Record the patient's Social Security number, if known. Do not record the spouse's number. Use **9s** if unknown and **0s** if no social security number.

#### 06. PHONE NUMBER

Patient's resident number or contact phone number

## 07. OCCUPATION

Occupation at the time of diagnosis, if known

## 08. RACE AND HISPANIC ORIGIN

Use the following to record race

Codes		Codes	
01	White	21	Chamorro
02	Black	22	Guamanian, NOS
03	American Indian, Aleutian, or Eskimo	25	Polynesian, NOS
04	Chinese	26	Tahitian
05	Japanese	27	Samoan
06	Filipino	28	Tongan
07	Hawaiian	30	Melanesian, NOS
08	Korean	31	Fiji Islander
09	Asian Indian, Pakistani	32	New Guinean
10	Vietnamese	88	No further race documented
11	Laotian	96	Other Asian, including Asian, NOS and Oriental, NOS
12	Hmong	97	Pacific Islander, NOS
13	Kampuchean (including Khmer and Cambodian)	98	Other
14	Thai	99	Unknown
15	Micronesian, NOS		

- ◆ White includes Mexican, Puerto Rican, Cuban, and all other Caucasians.
- ◆ African-American includes Black.
- ◆ A combination of White and African-American is coded to African-American.

### HISPANIC ORIGIN

Indicate if the patient is of Spanish/Hispanic origin.

- ◆ Mexican (includes Chicano)
- ◆ Puerto Rican
- ◆ Cuban
- ◆ South or Central American (Brazil)
- ◆ Other specified Spanish/Hispanic origin (includes European)
- ◆ Spanish, Hispanic, Latino, NOS; Evidence other than surname or maiden name the person is Hispanic
- ◆ Spanish surname only (Only evidence of the person's Hispanic origin is surname or maiden name – no evidence verifying that the person is not Hispanic)

**09. PRIMARY PAYER**

Circle the one application at the time of initial diagnosis and/or treatment.  
(See Appendix C for explanation of insurance types).

**10. TOBACCO HISTORY**

Circle current, former, none or unknown. Tobacco history includes the use of cigarettes, cigars and chewing tobacco.

**11. ALCOHOL HISTORY**

Circle current, former, none or unknown

**12. FAMILY HISTORY**

Circle one, is there history of this cancer in the family

**13. NEW VERSUS RECURRENCE**

The first thing that should be established about the patient's cancer is whether it is a new cancer or one that has been previously diagnosed and treated before the patient is seen at your facility (recurrence). Look for statements made in the history and physical, progress report, etc., such as "this is a newly-diagnosed cancer" or "this cancer was diagnosed 10 years ago. The physician may offer no information about the diagnosis. If so, record "unknown".

**14. PROCEDURE PERFORMED**

Record the type of procedure that was performed to diagnose the patient's cancer

## B. CANCER IDENTIFICATION INFORMATION

### 15. PRIMARY CANCER

The primary site is the organ or site where the cancer is located or originated. A patient's disease may spread (metastasize) or be active in several areas of the body, but the **original site** is the one that should be recorded.

Please be as specific as possible when describing sites. "Upper Lobe of Lung" would be preferable to "Lung". If the term in the medical record is general, (e.g. breast) that is acceptable

Breast cancer is recorded in different ways. The quadrant may not be specified (Upper outer quadrant), but the position where the cancer is in recorded as 1o'clock, etc. Record this in this field.

Some primary sites may not be identified, but the patient has an area that is confirmed for cancer. Record this site as an "**unknown primary**".

Lymphomas are generally located in lymph nodes, but it can be found in an organ (stomach, intestine, etc). If you are unable to determine where the disease began, record "**Lymphoma, NOS**".

Leukemia and other diseases of the blood (myeloproliferative disorders, myelodysplastic syndromes, anemia, etc) are systemic (involving the whole body) and originate in the bone marrow, record "**not applicable**" (**N/A**) in this field.

### 16. DATE OF DIAGNOSIS

Record the month, day and year this cancer was **originally** diagnosed by a medical practitioner. If this is a recurrence of a previously diagnosed cancer, the date is still the date the cancer was **first** diagnosed. Though it may be more difficult to find an exact diagnosis date for a recurrence, follow the rules as for a newly diagnosed cancer.

- ◆ If the month or year of diagnosis is not documented, estimate as close as possible instead of recording **unknown**.
- ◆ If only the time of year, spring, fall, or winter of the year is documented, use April, July, October, or December (also for end of the year) and January for beginning of the year.
- ◆ No information is available for date, record **unknown**.

## 17. PAIRED ORGANS (LATERALITY)

Laterality refers to one side of a paired organ (breast, lung, kidney, etc). If the information is available, record which side is involved. See list below.

### PRIMARY SITES – LATERALITY

This list includes the most frequently diagnosed primary sites. Please be as specific as possible when recording primary site. Bold terms indicate sites that should be coded for laterality (right or left).

<b>Adrenal Gland</b>	Gallbladder	Palate (soft or hard)	Submandibular gland
Anus	Glottis		Supraglottis
Appendix	Gum	Pancreas	
Ascending colon	Heart	<b>Parotid gland</b>	<b>Testis</b>
Bladder	Hepatic Flexure of colon	Penis	Thymus
Bone marrow	Hypopharynx	Pharynx	Thyroid gland
<b>Bones</b> (specific body area, leg, arm, etc)	Ileum	Prostate	Tongue
Brain	Jejunum	Pyriiform sinus	<b>Tonsil</b>
<b>Breast</b>	<b>Kidney</b>	Rectosigmoid Junction	Trachea
Cecum	Larynx	Rectum	Transverse colon
Cervix (cervix Uteri)	Lip	<b>Renal pelvis</b>	Unknown
Colon	Liver	Retroperitoneum	Urethra
<b>Connective Tissue</b> (specific body area, leg, arm, etc.)	<b>Lung</b>	Salivary gland	Uterus (corpus uteri)
Descending colon	Lymph nodes (specific region, axillary, groin, etc. or organ)	Sigmoid colon	Vagina
Duodenum	Mediastinum	<b>Sinus</b>	Vulva
Epiglottis	Mouth	<b>Skin</b>	
Esophagus	Nasal cavity	Small intestine	
<b>Eye</b>	Nasopharynx	Spinal cord	
	Oropharynx	Spleen	
	<b>Ovary</b>	Splenic flexure of colon	
		Stomach	

## 18. TUMOR SIZE

Record the size of the tumor **before** treatment. The tumor size information may be found on the imaging scans (CT, MRI), operative report and pathology report.

## 19. HISTOLOGY TYPE and behavior

Histology refers to cell type; this information can be found on the pathology report. It describes the type of cancer cells (adenocarcinoma, squamous, etc.). The pathology report will include a complete description of the tissue appearance.

“Behavior” describes the way a neoplasm acts or behaves. Tumors are considered to be malignant or benign. If they are benign, they are non cancerous and not to be reported to the central cancer registry with the exception of benign tumors of the brain and central nervous system. (In the ICD-O coding manual benign tumors will have the number “0 or 1” at the end of the histology code (9530/1).

Cancers that have to be reported to the central registry are either **in situ** or **malignant**. These will have codes “2” and “3” at the end of the histology codes in the ICD-O coding

manual. In situ tumors are at their earliest stages (precancerous) and are not life threatening. Malignant tumors have cells that are cancerous and potentially life threatening. There are hundreds of terms classifying histologies. Here are some major ones:

### **List of Common Histologies Indicating Malignancy**

Chronic myeloproliferative disease, NOS  
Essential thrombocythemia  
Chronic neutrophilic leukemia  
Hypereosinophilic leukemia  
Adenocarcinoma  
Astrocytoma (brain)  
Carcinoma  
Glioma (brain)  
Hodgkin lymphoma (many more specific terms are used)  
Infiltrating ductal (breast)  
Intraductal carcinoma (breast)  
Large cell carcinoma  
Leukemia (acute, chronic, etc)  
Melanoma  
Mucinous cystadenocarcinoma or adenocarcinoma  
Multiple myeloma  
Myelodysplastic syndromes  
Non-Hodgkin lymphoma (many more specific terms are used)  
Non-small cell carcinoma  
Papillary transitional cell carcinoma (urinary organs)  
Polycythemia Vera  
Refractory anemia  
Sarcoma (soft tissue)  
Small cell carcinoma  
Squamous cell carcinoma  
Transitional cell carcinoma (urinary organs)

### **List of Common Terms Synonymous with In Situ Histologies**

Bowen's disease  
Hutchinson's melanotic freckle, NOS  
Intraductal  
Intraepithelial, NOS  
Lentigo maligna  
Non-invasive  
Non-infiltrating

## 20. GRADE OR DIFFERENTIATION

Describes how much or how little a tumor resembles the normal tissue from which it arose. This can usually be found on the pathology report. It is the 6<sup>th</sup> digit code for histologic grading and differentiation. Codes are as follow:

Code		
1	Grade 1	Well differentiated Differentiated, NOS
2	Grade II	Moderately differentiated Moderately well differentiated Intermediate differentiation
3	Grade III	Poorly differentiated
4	Grade IV	Undifferentiated Anaplastic
9		Grade or differentiation not determined, not stated or not applicable

## 21. LYMPH NODES POSITIVE AND REMOVED

Refers to number of lymph nodes positive for cancer and how many lymph nodes were removed.

## 22. PREOPERATIVE TUMOR MAKERS

Refers to prognostic indicators of cancer for certain sites

## 23. STAGE OF DISEASE AT DIAGNOSIS

Cancer staging describes the extent of disease or how far the disease has spread in the patient's body. This information determines treatment recommendations as well as prognosis of the patient.

A cancer may be described as local, regional or advanced. Record the stage that is mentioned by the physician in the patient's medical record. If the physician states localized, record "localized". If there is no stage mentioned, record "unknown" or "no information in chart". Below is table that will assist you in determining stage.

DESCRIPTION
<b>In-situ; precancerous</b>
<b>Localized;</b> tumor confined to organ of origin; no evidence of spread beyond the primary site
<b>Regional by direct extension;</b> tumor extends directly beyond the primary site surrounding (regional) organs or tissues
<b>Regional to lymph nodes;</b> tumor extends beyond the organ of origin (primary site) into the regional lymph nodes
<b>Regional by direct extension and to lymph nodes;</b> tumor extends beyond primary site by direct extension, into regional lymph nodes AND adjacent tissues
<b>Distant metastasis;</b> widely disseminated; tumor has spread from primary site to remote areas of the body, through the blood stream or lymph system

**Unstaged; unknown; unspecified** – use for unknown primaries and those cases where adequate staging information is NOT available

If a physician states the patient has “Stage I” disease, record “Stage I” in the stage field. The physician may also state that the patient has a T1NOMO disease; this is the TNM staging system. Record the TNM as stated in the patient’s record in the stage field.

Familiarity with different staging systems is recommended.

## C. TREATMENT

Treatment or therapy for cancer should modify, control, remove or destroy cancer tissue (cancer directed treatment). Therapy can be used to treat cancer tissue in primary or metastatic site(s).

### 24. FIRST COURSE THERAPY

The first course therapy should include all cancer-directed treatments described in the initial treatment plan and delivered to the patient. Treatment may begin at one facility and continues at another or delivered within another facility.

There are times when treatment has been *refused, comorbid conditions may affect the patient’s quality of life and treatment is not recommended, or the patient is under observation or watchful waiting*. This is considered first course therapy. Record “no treatment” in the treatment field and the date that no treatment is decided in the treatment date field. If the physician uses a “*wait and see approach*”, this is termed as “*observation only*”; record “*observation only*” in the treatment field and record the date that the “*observation only*” was determined.

### TREATMENT FOR RECURRENCE

If a patient has a disease-free period of several months or several years and the cancer returns to the same region of the original cancer or to regional or distant sites, it is considered a recurrence. If the cancer returns while residing at a facility, the case is to be reported to the ACCR by that facility with indications that this is **not** a new cancer. The diagnosis date should be the date of the **ORIGINAL** diagnosis. The remainder of the information will pertain to the treatment of the recurrence.

### TYPES OF TUMOR-DIRECTED TREATMENT

Record all known cancer-directed therapy administered to patient at the facility or another facility. The complete cancer directed treatment is important when calculating survival rates and other issues regarding patient mortality.

Record all treatment considered to be chemotherapy, hormonal, immunotherapy or palliative care, documenting the type of treatment that was given in the treatment field. If it is unknown whether the patient received treatment, record “**unknown**” or “**information not available**”. Do not leave any spaces blank.

## **SURGERY**

Record the type of surgical procedure(s) performed on the patient from the operative report. The pathology report may also have the type of surgical procedure(s).

## **RADIATION THERAPY**

Record the type and date the radiation therapy was received by the patient. These are some types of radiation therapy given:

- ◆ Beam Radiation – Includes x-ray, cobalt, linear accelerator, stereotactic radiosurgery, such as gamma knife and proton beam.
- ◆ Radioactive implants – often used for prostate cancer.
- ◆ Radioisotopes – such as iodine-131 or phosphorus-32, given orally, or by intravenous injection (often used for bone pain).

## **CHEMOTHERAPY, HORMONAL THERAPY, IMMUNOTHERAPY**

Record any drug given to treat the patient's cancer. Some drugs may be given alone and some are given with a combination of other drugs (CHOP, ABVD, VAD, etc). It is okay to record the abbreviations.

Hormonal treatments are drugs such as tamoxifen for breast cancer, lupron (treatment for prostate cancer).

Immunotherapy treatment includes bone marrow transplants, interferon, BCG. Patients in long-term care facilities will not be eligible for these treatments.

## **PALLIATIVE CARE**

For many patients, cancer directed treatment may not be an option. In these patients, medications may be used to provide relief from symptoms, for pain control, or to limit side effects from other medications.

## **OTHER CANCER-DIRECTED THERAPY**

Sometimes patients chose to have alternative treatments for their cancer, uncommon methods and drugs. Record the information regarding these treatments if documented.

### **Treatment Dates**

If it proves difficult to determine dates for treatments use the following to assist you in completing these fields. It is preferable to estimate the date of a treatment than to leave it blank.

- ◆ Record the month, day and four-digit year in which cancer directed treatment was given.
- ◆ If the exact date of treatment is unknown, it is best to estimate the date, using the information that is currently available.
- ◆ Record “**NONE**” when no treatment is given and “**UNKNOWN**” when it is unknown if treatment was given.

**25. PHYSICIAN**

Record the physician who is responsible for managing the treatment of the patient; this can include primary care physicians and specialty physicians such as urologist, dermatologists, etc. Names and all contact information should be included. This allows the ACCR staff to contact the physician if more information is needed

**26. DATE OF LAST CONTACT/DEATH**

If the patient is still living, record the date that you are completing the form. If the patient has transferred to another facility, record the date of transfer. If the patient died and the date of death is known, record the date of death.

**27. PATIENT STATUS**

Refers to last known condition of the patient. The patient was alive with/without cancer, patient alive, cancer status unknown, patient deceased with/without cancer, patient deceased and cancer status unknown.

## **APPENDIX A**

### **State Law**

#### **Subchapter 2 – Cancer**

##### **20-15-201. Reporting requirements.**

The Arkansas Department of Health shall accumulate such data concerning cancer in Arkansas and its residents as is deemed appropriate for the purpose of describing the frequency of cancer, furnishing reports to health professionals and the public, and for planning and evaluating cancer prevention and control programs. Such data shall be collected under the authority of regulations promulgated by the Arkansas State Board of Health.

##### **20-15-202. State Cancer Plan.**

A task force consisting of public and private entities will be established by the Director of the Department of Health to assist the department to develop a strategic plan for a coordinated, comprehensive, statewide network of cancer resources, services, and programs.

##### **20-15-203. Confidentiality.**

Information accumulated and maintained in the Cancer Registry of Arkansas shall not be divulged except as statistical information which does not identify individuals and for purposes of such research as approved by the Arkansas State Board of Health.

##### **20-15-204. Agreements with other states.**

The Arkansas Department of Health is hereby authorized to enter into agreement with other states and federal organizations authorized to exchange registry data. Such agreements shall prohibit divulging information to entities without prior approval of the Arkansas State Department of Health.

##### **20-15-205. Gifts, grants, and donations.**

The Department of Health is authorized to receive gifts, grants, and donations for the purpose of this subchapter.

## ACCR Rules and Regulations

### Section I. Authority

The following rules and regulations pertaining to Arkansas Cancer Registry are duly adopted and promulgated by the Arkansas State Board of Health pursuant to the authority expressly conferred by the laws of the State of Arkansas.

### Section II. Purpose

Since cancer is one of the leading causes of death in Arkansas it is essential that the specific information concerning this group of disease be collected, analyzed and reported. All Arkansans will benefit from the epidemiological surveillance of this group of diseases.

### Section III. Definitions

- A. Registry. Means the system for the reporting, collection, and analysis of cancer cases by the Arkansas Department of Health.
- B. Reporting. Means the notification furnished to the Arkansas Department of Health of cases of in situ or invasive neoplasms of the human body, not including squamous cell and basal cell carcinoma of the skin.

### Section IV. General Requirements

- A. Each hospital or other medical facility providing screening, diagnostic or therapeutic service, physicians, including surgeons, and all other health care practitioners or their designees shall report the following information concerning each case.
  - 1. Personal Information.
    - a. Name.
    - b. Address.
    - c. Date of Birth.
    - d. Place of Birth.
    - e. Race and Spanish/Hispanic Origin.

- f. Sex.
- g. Social Security Number
- h. County of Residence
- i. Marital Status.
- j. Maiden Name, if applicable.
- k. Alias.
- l. Occupation History, if available.

2. Diagnosis.

- a. Class of case.
- b. Date of Diagnosis.
- c. Primary Site.
- d. Laterality.
- e. Histology.

3. Treatment.

- a. Grade.
- b. Diagnostic Confirmation.
- c. Staging (American Joint Committee for Cancer – AJCC).
- d. Reporting identification of the facility or person reporting.

4. Summary of Treatment

- a. Date first course started.
- b. Name of Physician.
- c. First course of treatment, i.e., surgery, radiation, chemotherapy, hormone therapy.

5. Follow-Up.

6. Recurrence.

B. In order to insure the accuracy and completeness of the cancer registry within the Department of Health, staff and agents shall be permitted access to records of hospitals, other medical facilities, physicians (including surgeons), nursing

homes and other individuals or agencies providing services wherein records concerning patients in which cases of cancer are identified are located.

- C. All reporting shall be made on forms or in an acceptable manner in accordance with directives of the Department of Health. All cancer cases shall be reported within six months after the date of discharge or diagnosis is made or within six months after a cancer case is known, even if diagnosed elsewhere. Where appropriate cancer data will be in the format recognized by the American Association of Central Cancer Registries.
- D. Each hospital licensed by the Department of Health shall designate a person who shall be responsible for accurate and timely reporting pursuant to this rule. Such hospital shall also adopt a policy which ensures the designation of such person and the hospital's reporting to the Registry.

## Section V. Confidentiality

All information reported to the Department of Health shall be confidential and shall not be disclosed under any circumstances except (1) to other state cancer registries with which the Department of Health has agreements that insure confidentiality; (2) to other state health officials who are obligated to keep such information confidential; and (3) to approved cancer research centers under specific conditions where names and identities of the individuals are appropriately protected, and when such research is conducted for the purpose of cancer prevention, control and treatment.

## Section VI. Severability

If any provision of these rules and regulations, or the application thereof to any person or circumstances is held invalid, such invalidity shall not affect other provisions or applications of these rules and regulations which can give effect without the invalid provisions or applications, and to this end the provisions hereto are declared to be severable.

## Section VII. Repeal

All regulations and parts of regulations in conflict herewith are hereby repealed.

## APPENDIX B

### RESOURCES/ADDITIONAL FORMS

#### ACCR STAFF RESOURCES

For more information regarding:

- Installation of WebPlus software
- Completing cancer reporting forms
- Forms or reprints of ACCR materials
- Scheduling in-service

CONTACT:

Wanda Rhodes, RHIT, CTR

QA Coordinator

800-651-3493 ext 2089 or (501) 661-2089

[wanda.rhodes@arkansas.gov](mailto:wanda.rhodes@arkansas.gov)

For more information regarding:

- ◆ General administrative issues

CONTACT:

Gigi White, CTR

Director

800-651-3493, ext 2463 or (501) 661-2463

[glynis.white@arkansas.gov](mailto:glynis.white@arkansas.gov)

For more information regarding:

- ◆ Studies or reports
- ◆ Special data requests

Contact:

Appathurai Balamurugan, M.D.

Senior Epidemiologist

800-651-3493 ext 4830 or 501-280-4830

[appathuria.balamurugan@arkansas.gov](mailto:appathuria.balamurugan@arkansas.gov)

To access the cancer registry's website go to:

[www.healthyarkansas.com/arkcancer/arkcancer.html](http://www.healthyarkansas.com/arkcancer/arkcancer.html)

## APPENDIX C

### FREQUENTLY ASKED QUESTIONS AND ANSWERS REGARDING CANCER REPORTING

#### 1. When did Health Insurance Portability and Accountability Act (HIPAA) become effective?

President Bush approved the regulations on April 12, 2001.

The official effective date of the regulations was April 14, 2001. Covered entities, including hospital and physicians, had two (2) years to comply (by April 14, 2003), except for small health plans which were effective April 14, 2004.

#### 2. 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 of persons or entities to whom it has granted authority, that is responsible for public health matters as part of its official mandate."<sup>1</sup> "...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."<sup>2</sup> ***Central cancer registries and hospital cancer registries if required to report cancer cases are considered public health authorities because state laws mandate their duties.***

#### 3. 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."<sup>3</sup>

#### 4. What if a patient does not want follow-up information to be collected?

State-mandated cancer reporting typically does not require patient informed consent nor can individuals elect to be removed from reporting. In a state, which allows the collection of follow-up cancer data for public health purposes, it can be collected regardless of consent from a patient.

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<sup>1</sup> C.F.R. 164.501

<sup>2</sup> C.F.R. 164.512

<sup>3</sup> C.F.R. 160.103

**5. Will private practice physicians be permitted to continue to provide follow-up information to hospital cancer registries without patient consent?**

Yes. Although private practice physicians are health providers, and thus covered under the provisions of the HIPAA privacy regulations<sup>2</sup>, there are several reasons why they can continue to provide follow-up information to hospital cancer registries without patient consent. First, the hospital cancer registry is likely to be viewed as public health authority<sup>1</sup> because it is an entity acting under a grant of authority from or contract with a State, tribal, or local public health agency to provide for public health surveillance.<sup>1</sup>

The HIPAA regulations specify that covered entities may use or disclose protected health information without the written consent or authorization of the individual...under specific circumstances. These include disclosures for public health activities and purposes to public health authorities authorized by law to collect or receive such information for the purpose of preventing or controlling disease or conduct public health surveillance.<sup>3</sup>

As public health authorities, hospital cancer registries are exempt from the HIPAA regulations and may continue to seek public health data from providers the same as before the HIPAA regulations were finalized. DHHS did not attempt to interfere with state and local public health matters such as cancer surveillance through the implementation of these regulations.

Second, even if some hospital cancer registries are not public health authorities (because they are not associated with a state or local public health agency to work on public health matters), physicians may still have to provide follow-up information. HIPAA regulation Sec. 164-512(a) specifically states that: a covered entity may use or disclose protected health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law.

Thus, where a hospital cancer registry is required by state or local law to collect cancer data, physicians must follow the follow-up requirements of the registry to the exclusions of HIPAA privacy protections.

Finally, the consent requirement for disclosures under the HIPAA regulations does not limit the types of disclosures allowed. Provided a

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<sup>1</sup> 45 C.F.R. § 164.501 (2001).

<sup>2</sup> 45 C.F.R. 160.103

<sup>3</sup> 45 C.F.R. 164.512

patient consents to the use or disclosure of his or her health data to a hospital cancer registry as part of the broader consent language, regularly sharing data between physicians and hospital cancer registries is permissible. In future cases, patient consents may specifically reference the sharing of data with all hospital cancer registries. For existing cases, written patient consent may also suffice for the purpose of authorizing these exchanges.

**6. 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.

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

Yes, 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.

**8. Is there specific legal documentation that supports the requirement to release cancer patient information to any agency?**

Individual state laws and regulations document cancer reporting requirements. Central registries should be able to provide copies of their state's law(s) and regulations(s) upon request.

**9. What, if any, are the consequences of not cooperating with state cancer registry requests for new cancer case information?**

HIPAA does not obstruct any state law that supports or mandates the reporting of diseases or injury for public health purposes. Penalties for failing to comply with state reporting are specified in the state law and often consist of significant fines.

**10. Doesn't HIPAA nullify the state law for reporting cancer cases to Central Cancer Registry?**

No. Public health reporting under the authority of state law is specifically exempted from HIPAA rules.

**11. Once HIPAA is in place, will pathology labs be able to continue to send new cancer case information to the state cancer registry?**

Yes. Public health reporting under the authority of state law is specifically exempted from HIPAA rules.

**12. Since HIPAA, is federal, will it override the state laws?**

No. HIPAA does not obstruct any state law that supports or mandates the reporting of diseases or injury for public health purposes.

**13. If the government-authorized public health entity is not located in the same state as the covered entity, is it still ok under HIPAA to provide the data?**

Yes. In fact, the definition of a 'public health entity' was broadened in the section "Uses and Disclosures for Public Health Activities", which states specifically "...We broaden the scope of allowable disclosures ...by allowing covered entities to disclose protected health information not only to U.S. public health authorities but also, at the direction of a public health authority, to an official of a foreign government agency that is acting in collaboration with a public health authority."<sup>1,2</sup>

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<sup>1</sup> F.R. p.82525

<sup>2</sup> 45 C.F.R. 164.512

## APPENDIX D

### PRIMARY PAYER CODES

CODES	DEFINITION	
01	Not Insured	Patient has no insurance and declared a charity write-off
02	Not insured, self-pay	Patient has no insurance and is declared responsible for charges
10	Insurance, NOS	Type of insurance unknown or other than the types listed in codes 20, 20, 31, 35, 60-68
20	Private Insurance Managed Care, HMO, or PPO	An organized system of prepaid care for a group of enrollees usually within a defined geographic area. Generally formed as one of four types: a group model, an independent physician association (IPA), a network, or a staff model. "Gate-keeper model" is another term for describing this type of insurance
21	Private Insurance: Fee-for-Service	An insurance plan that does not have negotiated fee structure with the participating hospital. Type of insurance plan not coded as 20.
31	Medicaid	State government administered insurance for persons who are uninsured, below the poverty level, or covered under entitlement programs.
35	Medicaid-Administered through a Managed Care plan	Patient is enrolled in Medicaid through a Managed-Care program (e.g. HMO or PPO). The managed care plan pays for all incurred costs.
60	Medicare without supplement, Medicare, NOS	Federal government funded insurance for persons who are 62 years of age or older, or are chronically disabled (social security insurance eligible). Not described in codes 61, 62, or 63.
61	Medicare with supplement, NOS	Patient has Medicare and another type of unspecified insurance to pay costs not covered by Medicare.
62	Medicare-Administered through a Managed Care plan	Patient is enrolled in Medicare through a Managed Care plan (e.g. HMO or PPO). The Managed Care plan pays for all incurred costs.
63	Medicare with private supplement	Patient has Medicare and private insurance to pay costs not covered by Medicare.

64	Medicare with Medicaid eligibility	Federal government Medicare insurance with State Medicaid administered supplement.
65	TRICARE	Department of Defense program providing supplementary civilian- sector hospital and medical services beyond a military treatment facility to military dependents, retirees, and their dependents. Formally CHAMPUS (Civilian Health and Medical Program of the Uniformed Services).
66	Military	Military personnel or their dependents who are treated at a military facility.
67	Veterans Affairs	Veterans who are treated in Veterans Affairs facilities
68	Indian/Public Health Service	Patient who receives care at an Indian Health Service facility or at another facility, and the medical costs are reimbursed by the Indian Health Service.
99	Insurance status unknown	It is unknown from the patient's medical record whether or not the patient is insured.

## APPENDIX E AMBIGUOUS TERMINOLOGY

### DIAGNOSIS

#### Terms That Constitute A Diagnosis

For the purpose of determining reportable cases, interpret the following as a diagnosis of cancer.

- |                   |                 |
|-------------------|-----------------|
| • Apparent(ly)    | Favor(s)        |
| • Appears to      | Presumed        |
| • Compatible with | Probable        |
| • Consistent with | Suspect         |
| • Most likely     | Suspicious(for) |

Example: The inpatient discharge summary documents that the patient had a chest x-ray **consistent with** a carcinoma of the right upper lobe. The patient refused further work-up or treatment.

**Do not interpret cytology as a diagnosis of cancer.**

#### Terms That **Do Not** Constitute A Diagnosis

Do not interpret the following as a diagnosis of malignancy. **Do not** include patients who have a diagnosis consisting of these terms:

- |                |             |
|----------------|-------------|
| • Equivocal    | • Suggests  |
| • Possible     | • Worrisome |
| • Questionable |             |

Example: Final diagnosis is reported as **possible** carcinoma of the breast.

### STAGING

#### Terms that Constitute Tumor Involvement/Extension

In the absence of cytologic or histologic confirmation, interpret the following terms as evidence of tumor involvement. The description may be taken from the clinical, operative, or pathologic documentation.

- |                    |            |
|--------------------|------------|
| • Adherent         | • Into     |
| • Apparent         | • Onto     |
| • Compatible with  | • Out onto |
| • Consistent with  | • Probable |
| • Encroaching upon | • Suspect  |

- Fixation, fixed
- Induration
- Suspicious
- To

Terms That **Do Not** Constitute Tumor Involvement/Extension

The following terms are **NOT** interpreted as tumor involvement

- Approaching
- Equivocal
- Possible
- Questionable
- Suggests
- Very close to

**APPENDIX F  
ACCR REPORTABLE LIST  
ICD-9 Casefinding Codes for ICD-O-3 Reportable Diseases**

Any reportable neoplasms diagnosed on or after January 1, 1996 should be reported to the Arkansas Central Cancer Registry.

**Reportable Neoplasms:**

- Malignant neoplasms (exclusions noted below)
- Benign and borderline neoplasms of the central nervous system (cases diagnosed on or after January 1, 2004)
- Carcinoma in-situ (exclusions noted below)
- Carcinoid, NOS (excluding appendix, unless stated to be malignant)
- Pilocytic/juvenile astrocytoma is listed as 9421/1 in ICD-0-3, is reportable, and should be coded 9421/3.
- Squamous intraepithelial neoplasia grade III of vulva (**VIN**), vagina (**VAIN**), and anus (**AIN**) beginning with 2001 cases.

■ Primary tumors that originate in a mucous membrane **are reportable** and include the following:

Lip	C00.1-C00.9	Vulva	C51.9
Anus	C21.0	Vagina	C52.9
Labia	C51.0-C51.1	Prepuce	C60.0
Clitoris	C51.2	Penis	C60.1-C60.9
Scrotum	C63.2		

**Non-Reportable Neoplasms**

The following are **exclusions** and **do not** need to be reported to ACCR

Morphology Codes	Diagnosis/Terminology
8000-8004	Neoplasms, malignant, NOS of skin
8010/2	Carcinoma in-situ of cervix (CIS)
8010-8045	Epithelial carcinomas of the skin
8050-8084	Papillary and squamous cell carcinoma of the skin
8077/2	Squamous Intraepithelial Neoplasia, grade III of cervix (CIN III)
8090-8110	Basal cell carcinoma of the skin
8148/2	Prostatic Intraepithelial Neoplasia

NOTE:

■ Borderline cystadenomas M-8442, 8451, 8462, 8472, 8473 of the ovaries which moved from /3 to /1 are **NOT** collected as of 1/1/2001.

The following lists are intended to assist in reportable neoplasm casefinding activities that are performed in casefinding sources that use ICD-9-CM\* codes to classify the diagnoses. Any reportable neoplasms diagnosed on or after January 1, 1996 should be reported to the Arkansas Central Cancer Registry

\*

042	AIDS with specified malignant neoplasms
140.0-208.9	Malignancies (primary and secondary)
209.0-209.30	Neuroendocrine tumors
230.0-234.9	Carcinoma in-situ-all sites
238.4	Polycythemia vera (9950/3)*
238.6	Solitary plasmocytoma (9731/3)*
238.6	Extramedullary plasmacytoma (9734/3)*
238.7	Chronic myeloproliferative disease (9960/3)*
238.76	Myelosclerosis/Myelofibrosis with myeloid metaplasia (9961/3)*
238.71	Essential thrombocythemia (9962/3)*
238.7	Refractory cytopenia w/multilineage dysplasia (9985/3)*
238.72	Myelodysplastic syndrome w/5q – syndrome (9986/3)*
238.7	Therapy related myelodysplastic syndrome (9987/3)*
273.2	Gamma Heavy Chain Disease; Franklins Disease
273.3	Waldenstrom's macroglobulinemia
285.0	Refractory Anemia w/ringed sideroblasts (9982/3)*
285.0	Refractory Anemia w/excess blasts (9983/3)*
285.0	Refractory Anemia w/excess blasts in transformation (9984/3)*
288.3	Hypereosinophilic syndrome (9964/3)*
289.89	Acute myelofibrosis (9932/3)*
789.51	Malignant ascites

## Benign Brain Tumor Codes

225.0	Benign neoplasm of brain
225.1	Benign neoplasm of cranial nerves
225.2	Benign neoplasm of cerebral meninges; cerebral meningioma
225.3	Benign neoplasm of spinal cord, cauda equina
225.4	Benign neoplasm of spinal meninges; spinal meningioma
225.8	Benign neoplasm of other specified sites of nervous system
225.9	Benign neoplasm of nervous system, part unspecified
227.3	Benign of pituitary, craniopharyngeal duct, craniobuccal pouch, hypophysis, rathke's pouch, sella turcica
227.4	Benign neoplasm of pineal gland, pineal body
237.0	Neoplasm of uncertain behavior of pituitary gland and craniopharyngeal duct
237.1	Neoplasm of uncertain behavior of pineal gland
237.5	Neoplasm of uncertain behavior brain and spinal cord
237.6	Neoplasm of uncertain meninges: NOS, cerebral, spinal

237.70	Neurofibromatosis, Unspecified von Recklinghausen's Disease
237.71	Neurofibromatosis, Type One von Recklinghausen's Disease
237.72	Neurofibromatosis, Type Two von Recklinghausen's Disease
237.9	Neoplasm of uncertain behavior of other and unspecified parts of nervous system; cranial nerves

The following terms are synonymous with in-situ disease (Behavior code 2)

Adenocarcinoma in an adenomatous polyp with no invasion of stalk  
 Clark's level I melanoma or limited to epithelium  
 Noninfiltrating comedocarcinoma, confined to epithelium  
 Hutchison's melanotic freckle NOS, intracystic-noninfiltrating, intraductal, intraepithelium NOS, intraepidermal NOS (involvement up to but not including basement membrane.)  
 Lentigo maligna, lobular neoplasia, lobular-noninfiltrating, noninvasive, no stromal involvement, papillary noninfiltrating or intraductal  
 Vaginal intraepithelial neoplasia Grade III or VAIN III  
 Vulvar intraepithelial neoplasia Grade III or VIN III  
 Anal intraepithelial neoplasia Grade III or AIN III

- ◇ If any invasion is present, no matter how limited – cases must be coded to invasive behavior
- ◇ If other benign or borderline disease are required to be collected by your hospital cancer committee or other appointed officials, they are not required to be reported to ACCR.

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