GEORGIA DEPARTMENT OF PUBLIC HEALTH

Georgia Cancer Registry

Policy and Procedure Manual for Reporting Facilities

October 28, 2020

To download an electronic copy of this manual please visit our website at:
http://dph.georgia.gov/reporting-cancer

TABLE OF CONTENTS

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Georgia Cancer Registry
Reporting Manual

Section 1: Introduction

INTRODUCTION

The Georgia Comprehensive Cancer Registry (GCCR) is a population-based cancer registry that includes all cancer cases diagnosed in Georgia residents since January 1, 1995. The GCCR serves the entire state of Georgia, which includes a population of approximately 10.52 million people.

The purpose of the GCCR is to collect, analyze, utilize and disseminate cancer incidence information. Such information helps state agencies, health care providers and Georgia citizens to monitor cancer incidence trends; plan and implement cancer control and prevention activities; develop public and professional education programs; and stimulate scientific cancer research.

Legal authority of the Georgia Department of Public Health (DPH) to collect health information established the GCCR. The Official Code of Georgia (O.C.G.A.) Chapter 12 § 31-12-1 empowers the DPH to "… conduct studies, research and training appropriate to the prevention of diseases….". O.C.G.A. § 31-12-2 allows the DPH to require certain diseases and injuries to be reported in a manner and at such times as may be prescribed. (A copy of the official codes can be referenced in Section 8 of this manual).

All health care providers in the state of Georgia are required to report specific information on cancer in their patient population to the Georgia Comprehensive Cancer Registry. This includes all facilities providing diagnostic evaluations and/or treatment for cancer patients, such as: hospitals, outpatient surgical facilities, laboratories, radiation therapy and medical oncology facilities, and physician offices. In addition, reporting agreements are maintained with neighboring states so that Georgia residents who are diagnosed or treated in facilities out of state can be identified.

The code also addresses the confidentiality of information requested by DPH, and releases from civil liability providers reporting this information (§ 31-12-2 (a)). This section states, "…all such reports shall be deemed confidential and shall not be open to inspection by the public."

The GCCR participates in the National Program for Cancer Registries (NPCR). NPCR was established by the Centers for Disease Control and Prevention (CDC) in 1992 through the Federal Cancer Registry Amendment Act (Public Law 102-515). NPCR provides funding and guidance for the development of cancer registries throughout the United States.

The GCCR is a member of the North American Association of Central Cancer Registries (NAACCR), which is a professional society that was established in 1987. NAACCR provides ongoing development of cancer registries and the establishment of registry standards.

The Georgia Department of Public Health has designated the Georgia Center for Cancer Statistics (GCCS) at the Rollins School of Public Health of Emory University as its agent for the purpose of collecting and editing cancer data. The GCCS is one of the eighteen population-based cancer registries supported by the Surveillance, Epidemiology, and End Results (SEER) Program of the National Cancer Institute. The SEER Program is the most

authoritative source of information on cancer incidence and survival in the United States. Since 1975, the GCCS has collected detailed information on incident cases of cancer in a five-county area of metropolitan Atlanta. In 1978, ten rural Georgia counties were added to the SEER program creating the Metropolitan Atlanta and Rural Georgia SEER Registry. In August 2010, the remaining counties of Georgia were added to the SEER program making Georgia a statewide SEER registry. Given its extensive background in cancer registration, the GCCS was selected to be the designated agent of DPH to conduct the day-to-day data management activities for the entire state of Georgia.

The Georgia Comprehensive Cancer Registry and the Georgia Center for Cancer Statistics as a combined Georgia registry will furthermore be referenced as the Georgia Cancer Registry (GCR).

Georgia Cancer Registry
Reporting Manual

Section 2: Reporting Guidelines

GCR REPORTING GUIDELINES

A. CURRENT REPORTING MANDATE

Please refer to Section 8 of this manual for the Georgia's current reporting mandate.

B. REPORTABLE DIAGNOSES

The Notifiable Disease Law, Official Code of Georgia Annotated (O.C.G.A.) § 31-12-2, mandates the reporting of certain diseases including cancer. All cancers diagnosed since January 1, 1995, in persons receiving cancer diagnostic and/or management services or who have active disease must be reported to the Georgia Cancer Registry (GCR) unless previously reported by that facility. This includes all cancers indicated in the appropriate version of the International Classification of Diseases for Oncology (ICD-O), with a behavior code of 2 or 3.

As of January 1, 2004, any case diagnosed with benign brain or central nervous system tumors are also reportable. The reportable list below is based on the NPCR required data set.

For 2018, there were 114 new terms added to the existing codes in ICD-O-3 for use in the United States beginning with cases diagnosed on or after January 1, 2018. Of these terms, 85 were Malignant (/3) terms, 12 were in situ (/2), and three were benign or borderline (/0 and 1) tumors of the central nervous system. All are reportable.

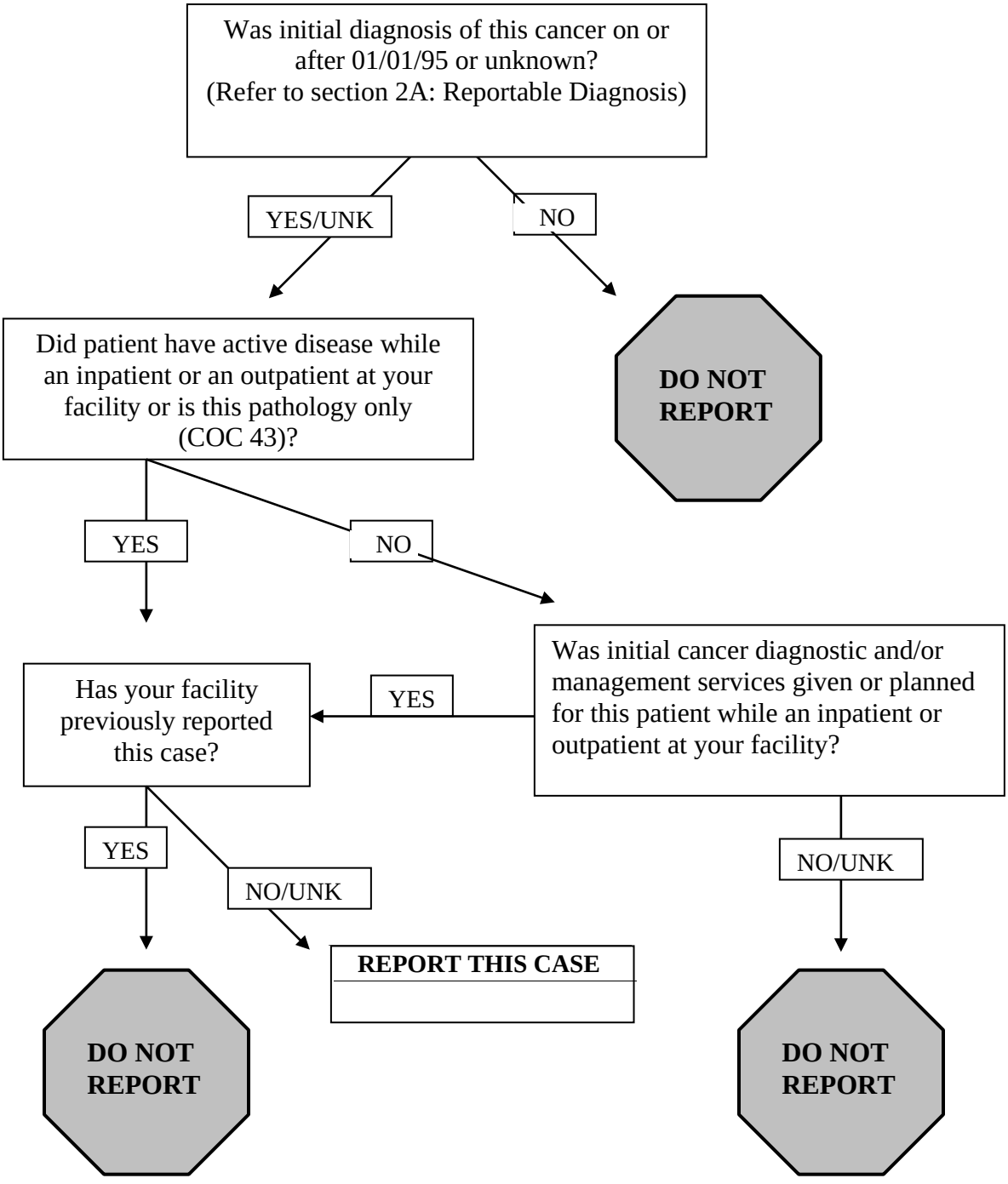
For 2018, 37 new codes and terms were proposed to be added to ICD-O-3. Twenty-three are reportable malignant (/3) tumors, two are reportable in situ (/2) tumors, three are reportable borderline (/1) tumors of primary intracranial and central nervous system tumors, and four are non-reportable tumors. Nine of the 32 new codes were listed in the prior cross-walk effective for January 1, 2015.

Please use the following link to access the 2018 ICD-O-3 Coding Guidelines and Coding tables in PDF or Excel format: **https://www.naaccr.org/implementation-guidelines/#ICDO3**

Please refer to the 2018 SEER Program Code Manual Appendix E for reportable and non-reportable Example. **https://seer.cancer.gov/manuals/2018/SPCSM_2018_AppendixE.pdf**

For cases diagnosed prior to 2018, please use the following link to access historical SEER Program Coding and Staging Manuals: **https://seer.cancer.gov/tools/codingmanuals/historical.html**

C. REPORTING CHART



D. WHO IS REQUIRED TO REPORT

All providers of health care for cancer patients including, but not limited to, hospitals, outpatient surgical facilities, laboratories (hospital and free standing), radiation therapy facilities which are independent and/or free standing facilities, nursing homes, hospice facilities not owned or managed by a hospital, medical oncology facilities and Physicians that diagnose or treat cancer patients that include but not limited to Urologists, Dermatologists, and Hematologists. NOTE: The hospital that receives a pathology specimen diagnostic of cancer from another hospital is not required to report the case. It is the responsibility of the hospital or outpatient facility that first collected or received the specimen to report the case. However, if a hospital receives a pathology specimen diagnostic of cancer from a physician's office, the hospital is required to report the case.

E. HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) does not impact the status of cancer reporting procedures. HIPAA allows for the reporting of identifiable cancer data and other reportable conditions to public health entities. The GCR falls under the definition of a public health entity. HIPAA allows all facilities to continue reporting data to the GCR in compliance with state law. For interpretations of HIPAA rules, refer to the Georgia Department of Public Health website at www.health.state.ga.us. Additional information can be found in Section 8 (Reporting Law and Mandate) of this manual.

F. WHAT TO REPORT

Report all required data elements as described in Section 4 (GCR Required Data Set and Instructions for Abstracting and Coding.)

G. HOW TO REPORT

All facilities with an average annual case load of **greater than** or equal to **50** cases or more a year must submit the required data electronically using Abstract Plus software provided free of charge by GCR, or using other available registry software. Facilities should utilize the monthly data upload feature on our secure web site for submitting electronic data. The facility will be notified by GCR when the data submission has been received. Electronic files (encrypted) may be submitted via e-mail attachment to gccs@sph.emory.edu utilizing the GCR provided encryption software and file naming conventions outlined in the GCR Policy and Procedure Manual section 2 H.2.

All facilities with an average annual case load of **less than 50** cases a year (Small Reporting Facility) may also submit the required data electronically. Alternatively, scanned copies of medical records may be submitted through the Georgia Health Information Network (GaHIN) GaDirect webmail (gccs@gccs.gadirect.net) or uploading scanned copies to a secure File Transfer Protocol (sFTP) account provided by the GCR. Please contact your Regional Coordinator for obtaining a GaDirect account or sFTP account.

Guidelines for ALL facilities regardless of size:

A large facility will be considered delinquent for the monthly submission if data has not been received at GCR by the last day of the month.

If a facility has no reportable cases for a month, an email should be submitted stating so. Also, if it is not possible for a facility to submit during a given month, a notice must be submitted by email stating the reason and when the facility plans to report cases. The facility will not be considered delinquent if notice is received by the last day of the month. Acceptable reasons for not reporting include 1) recent personnel losses, 2) recent computer problems (software/hardware), 3) natural disasters, and 4) no cases to report.

Small facilities should submit their yearly disease index in excel format in January following the year of diagnosis or date of first contact for cancer.

Small facilities are encouraged to provide electronic access of their medical record to their Regional Coordinator to facilitate/assist in screening for reportability to the GCR. Alternatively, all medical records with a cancer code on the disease index may be submitted.

Medical record submission for small facilities should be submitted with their disease index, but no later than March following the year of diagnosis or date of first contact for cancer

The following reports from the medical record should be submitted: Face sheet, H&P, pathology report, relevant labs and tumor markers, operative report, discharge summary, X-Rays, scans, scopes, and other diagnostic reports.

The facility will receive a notification by e-mail from GCR that the data submission has been received. **If you do not receive the notification by e-mail within a week after sending your submission, you should contact GCR for confirmation.**

H. ELECTRONIC REPORTING FACILITIES

a. DATA EDITING

GCR requires all submitted data to be edited by the GA edit software. GCR recommends an edit report be attached to or included with each submitted data file. To obtain the GA edit software please contact your regional coordinator. The GA edit software is free of charge and available to all hospitals.

b. File naming conventions for data sent to the Georgia Cancer Registry

GCR requires all confidential data to be encrypted before the electronic transmission of data. Hospitals should use the encryption software provided by GCR “Advanced Encryption Package developed by Secure Action.

Small Facilities (less than 50 cases a month) should contact their Regional Coordinator for methods for securing their data during transmission to the GCR.

Submitted files should follow the format:

XXXXXXMMMYY_#EXT.txt where**,**

XXXXXX = the 6 digit facility number of the facility submitting the data
MMM = the first 3 characters of the month in which the file is submitted
YY = the last 2 digits of the year in which the file is submitted
_ = an 'underscore' character (hold shift key and press minus sign)
# = the submission number for that month of the same file type (see EXT below)
EXT = a file extension indicating the type of the data submission (see below)
.txt = a text file extension

Re-submitted files due to records rejected during a prior submission should follow the format: **XXXXXXMMMYY_#EXTR.txt.,** where the R represents the file is a resubmission.

Valid file extensions (EXT) include:

HOS: Monthly hospital submission
HOSR: Monthly hospital resubmission
(resubmitted data from corresponding rejected abstract reports)
CFA: Case-finding audit submission
(data identified as missing from the registry based on the Casefinding audit match or other GCR activities)
DCO: Death clearance submission
(data identified as missing from the Registry based on the state death certificates)
DIS: Hospital discharge submission
(data identified as missing from the Registry based on Hospital discharge match)
ICU: Incidental Update Form Submission
(changes, deletions or updates to previously reported cases)
CSA: Cancer state aid submission
(data identified as missing from the Registry based on the Cancer State Aid match)
RCA: Rapid Case Ascertainment
(data identified as part of rapid case ascertainment process)
MOD: Modified Records
(Monthly modification/correction files are required to be submitted on a monthly basis)
MSC: Any other miscellaneous data submission
(all other submissions not falling into any of the above categories should include detailed text describing exactly what the miscellaneous submission includes)
OFF: Yearly Offload Submission
(entire year's reportable cancer cases for selected diagnostic year)

Examples:

Facility Number	Type of Data Submission	Data Submitted in Month Current Year	Submission number that month for the same file type	Appropriate File Name
380000	Monthly Hospital	January 2019	1	380000JAN19_1HOS.txt
380000	Monthly Hospital (2nd submission, same month and year)	January 2019	2	380000JAN19_2HOS.txt
380000	Resubmission of January 2019 rejected data	January 2019	1	380000JAN19_1HOSR.txt
380000	Case-Finding Audit	March 2019	1	380000MAR19_1CFA.txt
380000	Death Clearance	January 2019	1	380000JAN19_1DCO.txt

c. ADVANCED ENCRYPTION PACKAGE

Encryption Software for Electronic Reporting Facilities

The GCR has purchased encryption software for all reporting facilities. This software will allow you to encrypt files so that you can safely and quickly submit your data to the GCR by email. The encryption software was purchased from SecureAction and should be downloaded from our website http://web1.sph.emory.edu/GCCS/cms/reporting/index.html under the Applications Download Link. The encryption algorithm uses "very strong military grade encryption to make sure that your private data remains confidential."
Your facility can be provided with up to two licensed copies of this software. Refer to the instructions below for properly using the encryption software before you submit your data via email.

- Name your data file as described in "H.2 File naming conventions for data sent to the Georgia Cancer Registry" above.
- Start the application.
- Click the "**Encryption**" button in the upper right corner of the screen.
- Using the file manager on the left side of the screen, locate and select the file you would like to encrypt.
- Under "***Encryption***" enter the password provided to you in both the "**Password:**" and "**Again:**" text boxes.
- Select "**DESX**" as the encryption algorithm.
- Select "**Leave it alone**" for the original file option.
- Make sure the "**Pack file, then crypt**" option is checked.
- Press "**Encrypt Now!"** The encrypted file will be created in the same directory as the original file and will have an ".aep" extension.

For additional information on the Advanced Encryption Package, contact your Regional Coordinator (Section 9: Resources and References.)

Submission Receipts – Each electronic data monthly submission will receive an electronic data receipt including a summary of cases submitted, rejected and duplicated. The e-mail receipt will include such reports as encrypted attachments unless the submission is made by a contractor for the facility. If the contractor has a facility (hospital) based e-mail address, the encrypted reports will be included. If the contractor does not have a facility-based e-mail address, only a summary of the submission will be sent. It is up to the contractor to obtain any reports containing rejected or edit error data and to resubmit any pending resubmissions in a timely manner.

I. WHEN TO REPORT

GCR should comply with the established goals and standards set by the National Program for Cancer Registries (NPCR) of the Centers for Disease Control and Prevention (CDC) for timeliness of data collection. The established standard for timeliness is to have each cancer reported to the central registry within six months from the date of diagnosis of the cancer.

1. Large facilities should report monthly by electronic submission. Facilities should utilize the monthly data upload feature on our secure web site for submitting electronic data. Facilities will be notified by GCR when the data submission has been received.

2. Small facilities should upload an electronic file (ex: excel, csv) of their prior year disease index once a year in January. Medical record documents for reportable diagnoses are to be submitted with the disease index, or no later than March following the year of diagnosis/admission. These documents must be submitted to GCR through the Georgia Health Information Network (GaHIN) GaDirect webmail, or by sFTP to an account provided by the GCR. Facilities will be notified by GCR when the data submission has been received.

3. A large facility will be considered delinquent for the monthly submission if data has not been received at GCR by the end of the business day of the last day of the month. For example, January submissions should be received on or before 5:00 pm, January 31st to be considered timely. If it is not possible for a facility to submit data during a given month, a notice should be submitted by email to gccs@sph.emory.edu or gccs@gccs.gadirect.net prior to the end of the month stating both the reason for not submitting data and when the hospital plans to report. If an acceptable reason is provided the facility will not be considered delinquent. Acceptable reasons for not reporting include but are not limited to 1) recent personnel losses, 2) recent computer problems (software/hardware), 3) natural disasters, and 4) no data to report.

4. Timeliness will be monitored by GCR staff. The facility will receive communication from the GCR Regional Coordinator if a data submission is overdue.

J. WHERE TO SEND REPORTS

GCR requires all confidential data be encrypted before the electronic transmission of data. Hospitals should have the encryption software "Advanced Encryption Package." Contact your Regional Coordinator to obtain a copy of the encryption software. Refer to Section 9: Resources and References in this manual. To email via secure webmail: gccs@gccs.gadirect,net or upload to a sFTP account: Contact your Regional Coordinator for instructions.

K. REPORTING EDITS, REJECTIONS, UPDATES, AND DELETIONS TO THE GCR

Rejected data must be resubmitted to the GCR within 30 days of the date stated on the email receipt your facility receives. Re-submitted files due to records rejected during a prior submission should follow the format stated in H.2 File naming conventions for data sent to the GCR. **Only rejected abstracts should be electronically resubmitted. Do not resubmit the entire original submission.** Edited error reports should be emailed (encrypted) to gccs@gccs.emory.edu or to gccs@gccs.gadirect.net from your GaDirect account (can be sent unencrypted through the GaDirect webmail).
Modification/correction files are required to be submitted to GCR Monthly.
Facilities using registry software that is capable of identifying abstracts containing modifications/corrections made since the abstract was transmitted to the central registry, will be able to send a separate file of these corrections. Modification/correction abstracts are identified by the NAACCR data item number 10 – Record Type as 'M'.
You DO NOT need to run edits on this submission.
Please note the following:

- This submission file is not counted as your regular monthly submission and should be submitted as a separate file
- Use 'MOD' file extension for the name of the file i.e. 380000Jul19_1MOD.txt
- Be sure you compact/compress the file when you encrypt it prior to sending
- File can be uploaded using the Monthly Data submission link on our web site

L. CONFIDENTIALITY

The Georgia Cancer Registry maintains the confidentiality of the information in submitted reports. For specific policies and procedures, see Section 3: Confidentiality.

2018 CODING AND STAGING RESOURCE DOCUMENTS

https://seer.cancer.gov/tools/staging/

- ICD-O-3 https://www.naaccr.org/implementation-guidelines/
  Appendix E – Reportable and Non-reportable Examples
  https://seer.cancer.gov/tools/codingmanuals/
    * *ICD-O-3 is not to be used for coding hematopoietic or lymphoid neoplasms after 1/1/2017*
- 2018 SEER Program Code and Staging Manual
  https://seer.cancer.gov/tools/codingmanuals/
- Extent of Disease 2018 General Instructions https://seer.cancer.gov/tools/staging/
- Summary Stage 2018 Manual https://seer.cancer.gov/tools/ssm/
- SEER*RSA https://staging.seer.cancer.gov/

- Site – Specific Data Items (SSDI) Manual, SSDI Appendix A & SSDI Appendix B https://seer.cancer.gov/tools/staging/
- Grade Manual https://www.naaccr.org/SSDI/Grade-Manual.pdf?v=1527608547
- Hematopoietic Database https://seer.cancer.gov/tools/heme/
  Please note: The stand-alone version of the Hematopoietic database is no longer provided. The web based tool is the most up-to-date information.

M. REQUIRED CODING AND INSTRUCTION DOCUMENTS 2017 and Earlier

https://seer.cancer.gov/tools/codingmanuals/historical.html

N. ICD-O-3 MANUAL CHANGES/UPDATE

For updates and errata to ICD-O-3 see the NAACCR website at https://www.naaccr.org/implementation-guidelines/

O. CASEFINDING

Casefinding is the system used to identify patients with reportable cancer. Casefinding involves thorough, systematic monitoring of records maintained by various departments throughout the hospital. Multiple sources should be used to ensure complete reporting of all cases.

Casefinding Sources:
Admission and discharge documents
Autopsy reports
Disease indexes
Outpatients medical records/logs
Surgery schedules/logs
Nuclear medicine documents
Pathology and Cytology reports
Radiation oncology logs
Hematology reports
Medical oncology logs
Diagnostic imaging
Neurology clinics

ICD-9-CM and ICD-10-CM CODES FOR CASEFINDING BY DISEASE INDEX SCREENING

Casefinding in medical records/health information should be done using both inpatient and outpatient disease/diagnostic indexes. Review all records with the following ICD-9 or ICD-10 codes. **Current year and past years' case finding lists can be found: http://www.seer.cancer.gov/tools/casefinding/index.html.**
Please review this website for any update.

D-10-CM Casefinding List, 2018

Based on the* International *Classification of Diseases, ICD-10-CM Tabular List of Diseases and Injuries, FY 2018

COMPREHENSIVE ICD-10-CM Casefinding Code List for Reportable Tumors (EFFECTIVE DATES: 10/1/2017-9/30/2018) Please refer to your standard setter(s) for specific reporting requirements before using the Casefinding List	
ICD-10 Code	**Explanation of Code**
C00.- - C43.-, C4A.-, C45.- - C48.-, C49.- - C96.-	Malignant neoplasms (excluding category C44 and C49.A), stated or presumed to be primary (of specified site) and certain specified histologies ***NEW for FY2018:*** *C96.20 Malignant mast cell neoplasm, unspecified* *C96.21 Aggressive systemic mastocytosis* *C96.22 Mast cell sarcoma* *C96.29 Other malignant cell neoplasm*
C44.00, C44.09	Unspecified/other malignant neoplasm of skin of lip
C44.10-, C44.19-	Unspecified/other malignant neoplasm of skin of eyelid
C44.20-, C44.29-	Unspecified/other malignant neoplasm skin of ear and external auricular canal
C44.30-, C44.39-	Unspecified/other malignant neoplasm of skin of other/unspecified parts of face
C44.40, C44.49	Unspecified/other malignant neoplasm of skin of scalp & neck
C44.50-, C44.59-	Unspecified/other malignant neoplasm of skin of trunk
C44.60-, C44.69-	Unspecified/other malignant neoplasm of skin of upper limb, incl. shoulder
C44.70-, C44.79-	Unspecified/other malignant neoplasm of skin of lower limb, including hip
C44.80, C44.89	Unspecified/other malignant neoplasm of skin of overlapping sites of skin
C44.90, C44.99	Unspecified/other malignant neoplasm of skin of unspecified sites of skin
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*
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
D42.-, D43.-	Neoplasm of uncertain or unknown behavior of meninges, brain, CNS
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)
D47.02	Systemic mastocytosis *Note: Effective 10/1/2017*
D47.1	Chronic myeloproliferative disease (9963/3, 9975/3) *ICD-10-CM Coding instruction note: Excludes the following:* *Atypical chronic myeloid leukemia BCR/ABL-negative (C92.2_)* *Chronic myeloid leukemia BCR/ABL-positive (C92.1_)*

ICD-10-CM Casefinding List, 2018

Based on the* International *Classification of Diseases, ICD-10-CM Tabular List of Diseases and Injuries, FY 2018

COMPREHENSIVE ICD-10-CM Casefinding Code List for Reportable Tumors (EFFECTIVE DATES: 10/1/2017-9/30/2018) Please refer to your standard setter(s) for specific reporting requirements before using the Casefinding List	
ICD-10 Code	**Explanation of Code**
	Myelofibrosis & Secondary myelofibrosis (D75.81) *Myelophthisic anemia & Myelophthisis (D61.82)*
D47.3	Essential (hemorrhagic) thrombocythemia (9962/3) *Includes: Essential thrombocytosis, idiopathic hemorrhagic thrombocythemia*
D47.4	Osteomyelofibrosis (9961/3) Includes: Chronic idiopathic myelofibrosis Myelofibrosis (idiopathic) (with myeloid metaplasia) Myelosclerosis (megakaryocytic) with myeloid metaplasia) Secondary myelofibrosis in myeloproliferative disease
D47.Z-	Neoplasm of uncertain behavior of lymphoid, hematopoietic and related tissue, unspecified (9960/3, 9970/1, 9971/3, 9931/3)
D47.9	Neoplasm of uncertain behavior of lymphoid, hematopoietic and related tissue, unspecified (9970/1, 9931/3)
D49.6, D49.7	Neoplasm of unspecified behavior of brain, endocrine glands and other CNS
R85.614	Cytologic evidence of malignancy on smear of anus
R87.614	Cytologic evidence of malignancy on smear of cervix
R87.624	Cytologic evidence of malignancy on smear of vagina

1 *Note: Pilocytic/juvenile astrocytoma M-9421 moved from behavior /3 (malignant) to /1 (borderline malignancy) in ICD-O-3. However, SEER registries will CONTINUE to report these cases and code behavior as /3 (malignant).*

NOTE: Cases with the codes listed below should be screened as registry time allows. Experience in the SEER registries has shown that using the supplemental list increases casefinding for benign brain and CNS, hematopoietic neoplasms, and other reportable diseases.

SUPPLEMENTAL LIST ICD-10-CM (EFFECTIVE DATES: 10/1/2017-9/30/2018)	
ICD-10-CM Code	**Explanation of Code**
B20	Human immunodeficiency virus [HIV] disease with other diseases
B97.33, B97.34, B97.35	Human T-cell lymphotrophic virus, (type I [HTLV-1], type II [HTLV-II], type 2 [HIV 2]) as the cause of diseases classified elsewhere
B97.7	Papillomarvirus as the cause of diseases classified elsewhere
C44.01, C44.02	Basal/squamous cell carcinoma of skin of lip
C44.11-, C44.12-	Basal/squamous cell carcinoma of skin of eyelid
C44.21-, C44.22-	Basal/squamous cell carcinoma of skin of ear and external auricular canal
C44.31-, C44.32-	Basal/squamous cell carcinoma of skin of other and unspecified parts of face
C44.41, C44.42	Basal/squamous cell carcinoma of skin of scalp and neck
C44.51-, C44.52-	Basal/squamous cell carcinoma of skin of trunk
C44.61-, C44.62-	Basal/squamous cell carcinoma of skin of upper limb, including shoulder

ICD-10-CM Casefinding List, 2018

Based on the* International *Classification of Diseases, ICD-10-CM Tabular List of Diseases and Injuries, FY 2018

SUPPLEMENTAL LIST ICD-10-CM (EFFECTIVE DATES: 10/1/2017-9/30/2018)	
ICD-10-CM Code	**Explanation of Code**
C44.71-, C44.72-	Basal/squamous cell carcinoma of skin of lower limb, including hip
C44.81, C44.82	Basal/squamous cell carcinoma of skin of overlapping sites of skin
C44.91, C44.92	Basal/squamous cell carcinoma of skin of unspecified sites of skin
D10.- - D31.-, D34, D35.0, D35.1, D35.5-D35.9, D36.-	Benign neoplasms (see "must collect" list for reportable benign neoplasms) *Note: Screen for incorrectly coded malignancies or reportable by agreement tumors* *Note: Borderline cystadenomas M-8442, 8451, 8462, 8472, 8473, of the ovaries moved from behavior /3 (malignant) to /1 (borderline malignancy) in ICD-O-3. SEER registries are not required to collect these cases for diagnoses made 1/1/2001 and after. However, cases diagnosed prior to 1/1/2001 should still be abstracted and reported to SEER.*
D3A._	Benign carcinoid tumors
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*
D44.0 - D44.2, D44.6-D44.9	Neoplasm of uncertain or unknown behavior of other endocrine glands (see "must collect" list for D44.3-D44.5) *Note: Screen for incorrectly coded malignancies or reportable by agreement tumors*
D47.01	Cutaneous mastocytosis (9740/1) *Note: Effective 10/1/2017*
D47.09	Other mast cell neoplasms of uncertain behavior *Note: Effective 10/1/2017*
D47.2	Monoclonal gammopathy *Note: Screen for incorrectly coded Waldenstrom's macroglobulinemia*
D47.Z2	Castleman disease
D48.-	Neoplasm of uncertain behavior of other and unspecified sites
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*
D61.810	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 thrombocythemia*

ICD-10-CM Casefinding List, 2018

Based on the* International *Classification of Diseases, ICD-10-CM Tabular List of Diseases and Injuries, FY 2018

SUPPLEMENTAL LIST ICD-10-CM (EFFECTIVE DATES: 10/1/2017-9/30/2018)	
ICD-10-CM Code	**Explanation of Code**
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 "Hypereosonophilic 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. _)*
D76.-	Other specified diseases with participation of lymphoreticular and reticulohistiocytic tissue
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: Effective 10/1/2016*
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)*

ICD-10-CM Casefinding List, 2018

Based on the* International *Classification of Diseases, ICD-10-CM Tabular List of Diseases and Injuries, FY 2018

SUPPLEMENTAL LIST ICD-10-CM (EFFECTIVE DATES: 10/1/2017-9/30/2018)	
ICD-10-CM Code	**Explanation of Code**
G73.1	Lambert-Eaton syndrome in neoplastic disease *ICD-10-CM Coding instruction: Code first underlying neoplasm (C00-D49)*
G89.3	Neoplasm related pain (acute)(chronic)
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._)*
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)
O01.-	Hydatidiform mole

ICD-10-CM Casefinding List, 2018

Based on the* International *Classification of Diseases, ICD-10-CM Tabular List of Diseases and Injuries, FY 2018

SUPPLEMENTAL LIST ICD-10-CM (EFFECTIVE DATES: 10/1/2017-9/30/2018)	
ICD-10-CM Code	**Explanation of Code**
	Note: Benign tumor that can become malignant. If malignant, report as Choriocarcinoma (9100/3,) malignancy code in the C00- C97 range
O9A.1-	Malignant neoplasm complicating pregnancy, childbirth and the puerperium (conditions in C00-C96) *ICD-10-CM Coding instruction: Use additional code to identify neoplasm*
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*
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*
R92.-	Abnormal findings on diagnostic imaging of breast
R97.-	Abnormal tumor markers
T38.6-	Poisoning by antigonadotrophins, 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
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

ICD-10-CM Casefinding List, 2018

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SUPPLEMENTAL LIST ICD-10-CM (EFFECTIVE DATES: 10/1/2017-9/30/2018)	
ICD-10-CM Code	**Explanation of Code**
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 *ICD-10-CM Coding instruction: Code first malignant neoplasm of breast (C50._)*
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 *ICD-10-CM Coding instruction: Code first any follow-up examination after treatment of malignant neoplasm (Z08)*
Z86.0-, Z86.01-, Z86.03	Personal history of in situ and benign neoplasms and neoplasms of uncertain behavior
Z92.21, Z92.23, Z92.25. Z92.3	Personal history of antineoplastic chemotherapy, estrogen therapy, immunosuppression therapy or irradiation (radiation)
Z94.81, Z94.84	Bone marrow and stem cell transplant status

P. Nursing Home and Hospice Facilities Reporting Guide

Nursing Home and Hospice Facilities

In April 2011, GCR required Nursing Home and Hospice facilities to report their diagnosed cancer patients. Facilities are required to complete a reporting form in its entirety by its designee when the patient is admitted to its service.

- Each cancer needs to be reported by the facility only once. It is of note that **all** the fields on the form are important, with special emphasis on the diagnosis date of the patient's cancer, be it an exact date or estimation.
- This form is to be submitted monthly to Anne Washington whose name and contact information appears at the bottom of the form. Regional Coordinators will follow back to facilities for any clarifications or questions.
- The information reported is entered into a tracking database to allow the GCR to contact the diagnosing facility or physician if the patient has not been reported to GCR by the end of the diagnosed year. The requirement to report will facilitate complete cancer incidence reporting in Georgia and reduce the number of death certificate only cases.
- The following form is to be used for Nursing Home and Hospice Reporting.
  Please contact Anne Washington for a copy of the form.

GEORGIA DEPARTMENT OF PUBLIC HEALTH

Kathleen E. Toomey, M.D., M.P.H., **Commissioner** / Brian Kemp, **Governor**

2 Peachtree Street, NW, 15th Floor
Atlanta, Georgia 30303-3142

dph.ga.gov

Please complete on admission for cancer patients

Facility Name: _____

No new patients to report this month (mark ☐ box) Name the month: _____

Patient's Name: _____

Date of Admission: _____ Social Security Number: _____

Sex: (Please check) Male: _____ Female: _____ Date of Birth: _____

Race (Black, White, Asian, etc..): _____ Date of Death, if applicable: _____

Type of Cancer (ex: stomach, lymphoma, breast, etc..): _____

Date of cancer diagnosis: _____

Patient's residence at diagnosis (may be different from present address):

Street Address: _____

City/State/Zip: _____

List hospitals that previously treated/admitted patient for the cancer:

_____

_____

Name and address of **patient's personal physician, referring physician, and/or oncologist, Hospice physician only if patient has no other physician:

National Provider Identifier (NPI): _____

Physician: _____ **Relation to patient: _____

Street Address: _____

City/State/zip: _____

Legal authority for the Georgia Department of Public Health (Department) to collect health information is provided in Chapter 12 of the Official Code of Georgia Annotated (O.C.G.A.). O.C.G.A. section 31-12-1 empowers the Department to " ... conduct studies, research, and training appropriate to the prevention of diseases .... " O.C.G.A. section 31-12 -2 allows the Department to declare certain diseases and injuries to be reported in a manner and within prescribed times. Under this authority, information about persons with cancer is required to be reported to the Department or its designated agent.

Fax: 404-727-7261
Phone: 404-727-7696
Georgia Center for Cancer Statistics, 1518 Clifton Road, NE, 7th Floor, GCR Building, Atlanta, GA 30322

https://dph.georgia.gov/reporting-cancer

Please contact Rana Bayakly at 404-657-2617 or via email at rana.bayakly@dph.ga.gov if you have any questions or concerns. I greatly appreciate your invaluable help in tracking and fighting cancer in our state.

Sincerely,
Cherie Drenzek, DVM, MS
State Epidemiologist
Chief Science Officer

Cc: Rana Bayakly, MPH
Kevin Ward, PhD, MPH, CTR

Q. DATA QUALITY and COMPLETENESS IMPROVEMENT ACTIVITIES

1. Casefinding Audits

Annually, the GCR director selects hospitals that will undergo casefinding audits. NPCR Program Standards requires at least once every 5 years, a combination of case-finding and re-abstracting audits are conducted for each hospital-based reporting facility. The purpose of the casefinding audits is to provide reporting facilities with an external assessment of the completeness of their reporting. A hospital also can request an audit be conducted on their facility. To do so, please contact your regional coordinator. Refer to Section 9 (Resources and References) of this manual to find the regional coordinator in your region. The following steps are taken when a hospital participates in a casefinding audit:

a. Regional coordinator contacts the facility to schedule an audit.
b. GCR provides the regional coordinator with a list of reported patients for the facility.
c. Regional coordinator identifies all casefinding sources at the hospital.
d. Regional coordinator requests and reviews a disease index for the audit period.
e. Once the screening of hospital records is done, the regional coordinator compares the list of cases reported by the hospital before the audit with the cancer identified during the audit.
f. Regional coordinator provides a list of all patients missed by the hospital to the appropriate hospital personnel.
g. Hospital submits missed cases within 60 days after the end of the casefinding audit.
h. The Casefinding Audit report is completed by the Regional Coordinator and sent to the GCR Director and Director of Registry Operations.

CASEFINDING AUDIT SUMMARY REPORT

Facility Name:_____ Facility ID: _____

Date of Audit: _____

	Date Range Audited (Ex: Jan- Feb 2014)	Number reviewed	Number Potentially Missed	Number New Incidence	Completeness Rate

_____

_____

GCR Regional Coordinator Form

2. Re-Abstracting Audits

Annually GCR and/or the Regional Coordinator selects hospitals for a re-abstracting audit. The purpose of the re-abstracting audit is to provide facility abstractors with an external assessment of their abstracting quality. A Facility Registry Manager can also request a re-abstracting audit be conducted for their facility. To do so, please contact your Regional Coordinator. Refer to Section 9 of this manual to find the regional coordinator in your region. The following steps are taken when a hospital has a re-abstracting audit.

a. Regional Coordinator contacts the facility to schedule an audit.
b. Regional Coordinator establishes primary sites, number of cases, and data items to be re-abstracted.
c. GCCS randomly selects facility cases.
d. Regional coordinator blindly re-abstracts selected data items using Abstract Plus.
e. Regional Coordinator compares re-abstracted data items to facility's abstract submitted to the GCR.
f. Regional Coordinator provides facility with a final report summarizing abstractor data item discrepancies as well as facility results with any recommendations.
g. The Re-abstraction Audit Summary report is sent to the GCR Director and Director of Registry Operations.

RE-ABSTRACTING AUDIT SUMMARY REPORT

Facility Name:_____ Facility ID: _____

Date of Audit: _____

Primary Site	Total Records Abstracted	Abstractor One	Comments	Abstractor Two	Comments	Abstractor Three	Comments
Total							

GCR Regional Coordinator Form

3. Hospital Discharge Review

The hospital discharge linkage is another method used by GCR to improve completeness. Each year the Hospital Discharge Reports are sent to the responsible Regional Coordinator for each hospital in their region. The hospital discharge is then reviewed with the tumors reported by that facility. This review is necessary to ensure that all reportable tumors are reported.

a. GCR Data Manager links the hospital discharge database records to the cancer registry database records with three possible outcomes: positive matches, possible matches and non-matches.
b. Data Manager sends non-match list to the appropriate Regional Coordinator.
c. Regional Coordinator and the appropriate hospital review the non-matches and determine case reportability based on Section 2A in this manual.
d. Hospitals submit identified missed cases within 30 days to the GCR. See Section I2: (Where to Send Reports) and Section H2: (Electronic Reporting Facilities) the appropriate naming and submission of the hospital discharge follow-back records.
e. Hospital Discharge Summary Report is sent to the GCR Director and Director of Registry Operations.

HOSPITAL DISCHARGE SUMMARY REPORT

Facility Name:_____ Facility ID: _____

Date Completed: _____Total Number Unique Patients (not visits): _____

Total Number Non-Reportable:_____ Total Number Potentially Missed: _____

Total Number Abstracts Submitted:_____ Date Abstracts Offloaded: _____

File Name: _____

Remarks:

_____

_____

GCR Regional Coordinator Form

4. DEATH CLEARANCE

Death clearance is conducted every year by GCR to improve completeness of reporting. The first step matches Death Certificates that list a reportable cancer as a cause of death against the data base of reported cancers. This initial step produces three outcomes: positive matches, possible matches and non-matches. The non-matches create a follow-back list which is distributed to the institution mentioned on the death certificate or hospital discharge file. The facility is to find information about the specific cancer diagnosis listed on their follow-back list. Hospitals are expected to send the follow-back data to GCR within 60 days from the date they receive the list.

See Section J2: (Where to Send Reports) and Section H2: (Electronic Reporting Facilities) for the appropriate naming and submission of the death follow-back records.

5. RAPID CASE ASCERTAINMENT

Rapid Case Ascertainment, RCA, is a case finding procedure to identify newly diagnosed reportable cancer cases as rapidly as possible following diagnosis. Information obtained through RCA will serve as one method to assess case completeness, will provide an additional source of quality control for incoming data, and will permit cancer incidence in Georgia to be reported earlier than would otherwise be possible. The RCA system can also assist researchers in identifying cases that may be eligible to participate in research studies approved by the Georgia Department of Public Health, Institutional Review Board (DPH/IRB) (see Section 3: Confidentiality).

The Georgia Cancer Registry (GCR) implemented a statewide policy for RCA requiring the monthly submission of pathology reports related to reportable cancers from all facilities in Georgia beginning January 1, 2011. The adoption of electronic pathology reporting for all electronic reporting facilities is paramount to the timely, efficient collection and integration of these critical data into the GCR. Electronic data can be more effectively imported into existing cancer data management systems while paper reports still require a substantial amount of manual effort related to data integration. To move this important effort forward, the GCR is mandating the electronic submission of pathology reports from all electronic reporting facilities/labs in Georgia and from all other non-electronic facilities as available, effective in 2017.

The procedures below outline the options currently available for RCA. Option A is the only option available to electronic reporting facilities as electronic reporting is now mandatory.

RCA Options

A. Epath, an electronic pathology reporting system, is the preferred and most efficient method to meet the requirement for timely pathology reporting. Epath is an application that can be installed on an existing machine (or virtual machine) in the pathology laboratory. Pathology reports are filtered by the Epath system to identify and send only reportable cancer reports. The security infrastructure of Epath is compliant with HIPAA requirements. Reports are encrypted and electronically transmitted in real time to a dedicated computer at the GCR. For hospital pathology laboratories, the same reports are simultaneously sent to the hospital tumor registry facilitating efficient and timely registry pathology case finding.
Electronic reporting facilities that cannot, or elect not to report through Epath, must report their pathology through another electronic (machine readable) format. Please contact your Regional Coordinator for other electronic options.

B. Non-electronic pathology facilities should utilize the Georgia Health Information Network Georgia Direct (GaHIN GaDirect) webmail to send pathology reports and accompanying patient demographics as an attachment. For facilities that are unable to obtain a GaDirect webmail address, the cancer reports can be uploaded to a secure sFTP site provided by the GCR. Please contact the GCR at gccs@sph.emory.edu to establish a sFTP site for your facility. Non-electronic reporting facilities will receive a confirmation email of receipt from the GCR GaDirect email or gccs@sph.emory.edu upon receiving their submission.

C. Non electronic facilities without a pathology laboratory are to send an electronic (i.e., excel, csv) disease index file at the end of each month, or as instructed by your Regional Coordinator, to the GCR using a GaDirect webdirect account or sFTP account. A receipt confirmation is sent by email to facilities.

6. YEARLY DATA OFFLOADS

Each year, GCR may require that facilities offload all reportable cancer cases diagnosed within a particular year in order to assure that all cases from each facility are being reported. Please see section H2 for the naming convention for these files. The extract should be based on **diagnosis year** for the specified year. Do not use the date of first contact or accession number to extract the file.

7. SOFTWARE CONVERSION

Facilities converting software from one vendor to a different vendor must ensure that data is not compromised and all data is converted accurately. An accounting of all complete, suspense and incomplete abstracts should be made prior to conversion, as well as identifying abstracts that have not been transmitted to the state versus those previously transmitted. The facility must confirm that abstracts are not flagged erroneously as transmitted. At the request of the facility, GCR will provide a list of all abstracts submitted by the facility to the state prior to the conversion for comparison.

8. INTERNAL REVIEW

An internal review of facility or individual abstractor's submitted cases will be performed on an as needed basis. Coding issues identified by GCR editors or requests by facility managers may precipitate these reviews.

A detailed data item report is provided to the facility manager. Please contact your regional coordinator whenever you would like an assessment. Refer to Section 9 (Resources and References) of this manual to find the regional coordinator in your region.

9. DATA LINKAGES

The GCR links with the Social Security Administration vital status data on a yearly basis. All persons who are alive and do not have an updated follow-up date are sent for linkage. Date of last contact and vital status are updated in the registry with the results from the linkage.

The GCR also links with the National Death Index on a yearly basis. All alive persons in the registry as well as those people whose vital status is dead but there is an unknown cause of death are sent for linkage. Those that link with the National Death Index are dead and have died in a state other than Georgia. Vital status, date of last contact, death state, and primary and secondary causes of death are updated in the registry.

Bi-annually (May and November) a tumor registry follow-up report is sent to cancer registries at the facility level with the most recent date of last contact and cause of death. The available formats for the report are available for software vendors who can then electronically update the facility's cancer registry database with the incoming information from the central registry. Excel lists as well as Access database are also available to facilities.

10. CANCER REGISTRY ABSTRACTOR REGISTRATION

https://cfusion.sph.emory.edu/hospitalinfo/Abstractors/index.cfm

Effective January 1, 2014 all abstractors must complete a registration process to obtain a state-assigned three digit Abstractor ID, which is required to be recorded in the Abstracted By data item field (NAACCR Item #570) for abstracts submitted to the state of Georgia.

Once the abstractor has completed the registration process, a unique ID will be assigned. This ID is to be used by the abstractor for abstracting in any facility in Georgia. The registration process allows the registrar to associate any Georgia facility with their name and the assigned ID.

Please contact your Regional Coordinator for any questions you may have during the registration process. Refer to Section 9 (Resources and References) of this manual to find the Regional Coordinator in your region.

The state database will be linked to the registration ID for each abstractor. Abstracts that are submitted to the state without the unique abstractor ID will not be imported into the State database. An email will be generated to the appropriate supervisor for that facility notifying them of the rejected abstracts.

As a service to our facilities, all new abstractors will have a sampling of 10 cases abstracted early in their employment reviewed for quality assurance (coding and text), and the Regional Coordinator will provide the facility manager with the findings. The facility manager may request an additional review of 10 abstracts should

that be required. GCR will assist the facility with recommendations for training as appropriate.

The unique ID for each abstractor will expire once a year and the abstractor will need to re-register before submitting any further abstracts. Advance notices will be automatically sent to the email address of the abstractor and to the abstractor's facility manager.

Georgia Cancer Registry
Reporting Manual

Section 3: Confidentiality

CONFIDENTIALITY

INTRODUCTION

Confidentiality of data is of great concern to the Georgia Cancer Registry (there in after referred to as Registry) and is extremely important to the operation and maintenance of the Registry. The following are critical elements of the Registry's comprehensive confidentiality policies and procedures that relate to research use, reporting, and release of cancer data.

Confidentiality policies, pledges, and procedures are required in all phases of the Registry operation in order to:

- Protect the privacy of the individual cancer patient.
- Protect the privacy of the facilities reporting the case.
- Protect the privacy of the physicians and other providers responsible for the care of the cancer patient.
- Provide public assurance that the data will not be abused.

OFFICIAL CODE OF GEORGIA ANNOTATED (O.C.G.A.)

Since 1989 cancer has been a reportable disease in Georgia and the Registry has been delegated with the responsibility for collecting data on cancer from health care facilities or providers, including but not limited to hospitals, outpatient surgical facilities, laboratories (hospital and free standing), radiation therapy facilities which are independent and/or free standing facilities, nursing homes and hospice facilities not hospital owned or operated, medical oncology facilities and physicians that diagnose or treat cancer patients that include but not limited to Urologists, Dermatologists and Hematologists.

Furthermore, the GCR database under O.C.G.A § 31-12-2(b) protects persons submitting reports or data to the Registry, in good faith, from liability for any civil damages. (Refer to Section 8: Reporting Laws and Mandate)

DEFINITION OF CONFIDENTIAL DATA

The Registry defines confidential as all data that identifies patient-specific information. The Registry also treats information that specifically identifies a health care provider or an institution as confidential. Information that characterizes the caseload of a specific institution or health care professional is considered proprietary and confidential.

THE RESPONSIBILITIES OF REGISTRY PERSONNEL

It is the responsibility of the Registry to protect the data from unauthorized access and release. The Registry maintains the same standards of confidentiality as customarily apply to the physician-patient relationship as well as the confidentiality of medical records. This obligation extends indefinitely, even after the patient is deceased.

The costs of inappropriate release of confidential data are many. Inappropriate release of data could damage an individual whose diagnosis of cancer is made public. In addition,

support and cooperation of facilities providing data to the Registry could also be severely compromised. Registry personnel responsible for violating confidentiality policies and procedures will be administratively disciplined up to and including dismissal from employment.

Security of data maintained both on paper and in electronic form are addressed below in DATA SECURITY.

Each staff member, as part of his/her employment agreement, reads the confidentiality policy and signs a pledge that confidential information will not be released to unauthorized persons (Exhibit A). The pledge remains in effect after cessation of employment. The Registry Director maintains a file of staff members who have signed pledges.

The orientation and training of each new staff member includes instructions concerning the confidentiality of data.

Failure to observe the confidentiality policies will result in firm disciplinary action up to and including dismissal from employment. In extreme circumstances legal action may be warranted against a staff member who fails to comply with the Registry's confidentiality policies.

Non-registry personnel or organizations, including medical investigators, may request access to confidential registry data. Requests should be in writing with an agreement to adhere to the same confidentiality standards practiced by registry staff members.

DATA SECURITY

The Registry Director is responsible for data security.

Registry staff are responsible for the confidentiality of all data encountered during the collection of cancer data.

The following components are required to assure data security in all area of registry operation.

1. Suitable locks are installed to control access to the Registry and custodial staff are notified of the importance of maintaining a secure environment.

2. Confidential data will not be transmitted from the registry by any means (mail, telephone, electronic, or facsimile) without explicit authority from the Registry PI or a staff member to whom such authority has been delegated. All mail with confidential data must be marked "confidential".

3. Precautions must be taken, for both physical and electronic security of confidential data sent on electronic media, to include secure packaging, tracking (i.e. using federal express for deliveries to be delivered only to the appropriate person) and marking data not to be X-rayed (to ensure data integrity).

4. The use of desktop and notebook computers for the ascertainment and management of confidential data must be controlled by electronic and physical measures to protect the security of the data. These include passwords, screen savers, and whole disk encryption utilizing two-factor authentication.

5. Training and demonstration of computer systems must be performed with separate fictitious and/or anonymous data sets, or when this is not possible (i.e. training registry staff on new procedures, or during data audit for quality assurance), observers are required to sign confidentiality agreements.

6. The physical security of confidential data stored on paper documents, computer printouts, microfiche/microfilm and other media present in the Registry must be ensured. For instance when reports, computer printouts, and microfiche/microfilm printouts are no longer necessary, they are disposed by shedding. Data abstracts are kept secure in a locked room and have limited access by the Registry staff. Microfiche/microfilm are stored in designated cabinets with secure locks.

7. Confidential documents to be destroyed are kept in a secure environment (i.e. kept in a box labeled "confidential documents to be shredded" and kept in a locked room with limited Registry staff access) until they are shredded.

Computer security safeguards must be followed, including, but not limited to:

- whole disk encryption is required for all desktops and laptops, as are secure passwords (e.g. database content is password protected, password is changed every 90 days.)
- secure network password and logins must be used and in-house printer must be used for all print jobs.
  (Printer for copying confidential data located in a locked room)
- all back-ups of registry data must be encrypted (See the GCCS Information System Security plan for all of the detailed security guidelines).

RELEASE OF REGISTRY DATA

Release of registry data for clinical purposes, research, and health care planning is central to the purpose of the Registry. The Registry has developed procedures for data release that ensure the maintenance of confidentiality.

For the purpose of complete case ascertainment, the Registry exchanges confidential data with the other state registries with whom Georgia has reciprocal case-sharing agreements.

The Registry may release limited patient data to providers of health services for that patient. Such data will not include the names of the other health care providers used by the patient.

Individual patient information may also be released in response to a request to computer link or provide confidential data for approved research projects where a written agreement specifies and ensures the protection of information identifying any individual patient. Such studies should be approved by the Registry management team and the appropriate Institutional Review Board (IRB).

No information identifying an individual health care provider or facility will be made available except as required by Georgia Law or with written consent of that health care provider or facility.

Copies of specific patient information will not be provided to individuals (patients), except when required by Georgia Law.

Confidential information will not, under any circumstances, be published or made available to the general public.

Inquiries from the press should be referred to the cancer registry director, state epidemiologist, state chronic disease epidemiologist or other persons designated by the Georgia Department of Public Health. Inquiries could be referred to the Georgia Center for Cancer Statistics (GCCS) co-directors or another member of the staff who has been delegated the authority to respond. Measures will be taken to eliminate the possible identification of individual patients from data table cells containing very small numbers (i.e. less than five).

Researchers are reminded that all publications resulting from research performed under the National Cancer Institute (NCI), Department of Public Health (DPH), and Centers for Disease Control and Prevention (CDC), or other funded contract shall acknowledge support of the supporting organization.

Any data released or published where it is known that fewer than 90% of the expected cancer cases have been registered should include a qualifier indicating this fact (e.g. Data in this geographic area is less than 90% complete).

INAPPROPRIATE USES OF CONFIDENTIAL INFORMATION

Confidential data will never be made available for commercial purposes including but not limited to:

- Businesses that are trying to market a product to cancer patients.
- Health care institutions that are trying to recruit new patients.
- Insurance companies that are trying to determine the status of an individual patient.

The Registry has a data request form (Exhibit B) for use by researchers, registry staff, and others. The form serves as internal documentation of data requests, documents all requests for information, assists in the monitoring of staff efforts, and is used to prepare periodic data request summary reports.

Statistical data requests received via the telephone and in writing (such as cancer inquiries from citizens) are processed by the Registry's Program Director. Written documentation of the requested data is prepared for the programming staff. Copies of all correspondence along with a computer output of the data are filed in locked cabinets at the Georgia Department of Public Health to be used for summary tabulations to prepare routine reports.

DATA FOR SUMMARY STATISTICS

Reports of summary statistics do not generally raise concerns about confidentiality. However, confidential information may be inadvertently conveyed through summary statistics. The Registry has instituted a policy to suppress the publication of summary statistics in some instances, especially where data are being presented for geographic areas with small populations. For example, the Registry will suppress the reporting of statistical data when there are fewer than five cases reported in a single cell of a table, if a cell of the table represents a combination of variables, such as small geographic area, race, age, and sex, which can inadvertently identify individuals. However, breakdowns by age, sex, and large geographic areas such as the state of Georgia and having cells with less than five cases will not be suppressed.

DATA FOR RESEARCH

The Registry uses the following guidelines for controlling access to registry data for research purposes:

Requests for research data should be in writing and include a detailed outline of the proposed research and justification for the need of any confidential data.

The Registry management team (i.e. director of the registry, co-directors of the Georgia Center for Cancer Statistics, and the chronic disease chief epidemiologist) and others, who serve in an advisory capacity, review and approve research requests.

The written proposed research plan will be reviewed by the appropriate registry management team or committee to assess the following:

a. Scientific and technical merit of the study
b. Type of confidential and/or non-confidential data required
c. Adherence to Registry's guidelines on confidentiality
d. Approval of the appropriate Institutional Review Board (IRB)
e. Credentials of the researcher
f. Costs incurred and budget requirements

The investigator should assure that he/she requests consent to conduct this research from each health care facility. In addition physician consent should be obtained for each case to be contacted and consent should be obtained from each patient (a copy of the consents should be attached to the research proposal).

IRB approval is required before releasing registry data on individual patients. If the researcher is affiliated with another institution, then IRB approval is also required from that institution (e.g. academic institution, health care facility, government agency, etc.).

The scientific objectives of the study should be peer reviewed to ensure scientific validity.

After the review of the research proposal, the registry management team may request the researcher to revise the data request, work plan, and/or the cost estimate. Work will not begin on the data request until there is a mutually agreed upon plan and cost estimate.

The researcher must sign a written agreement to adhere to all confidentiality policies. Written agreements will include provisions for use of this information and for its return or destruction at the end of the study (see Exhibit C: Georgia Cancer Registry Research Agreement). The researcher should demonstrate adequate resources to conduct the research, including funding, staff, and technical expertise.

The Registry will ensure that confidential information is not under any circumstances published or displayed in reports that summarize the research results. The Registry will retain the right to review any reports prior to their dissemination to ensure that confidentiality has been respected.

A researcher who receives computerized data sets from the Registry should provide assurances that any confidential data will be destroyed or returned to the Registry after the project ends. Confidential data should be protected after the research investigator leaves the employment of the institution. The researcher is liable for civil damages for improper use of data.

DATA FOR QUALITY ASSURANCE STUDIES

Quality control studies of the cancer registry data, including re-abstracting and completeness studies will be conducted periodically by Registry staff and funding agency contractors. Registry staff and agency contractor persons are subject to the same confidentiality standards as indicated in this document. The results of the quality control audits for each individual institution will be kept confidential and only shared with that institution See Sec.1 O1 & O2.

PATIENT CONTACT FOR PARTICIPATION IN EPIDEMIOLOGIC STUDIES

The Registry assists in the identification of cancer patients as potential subjects for epidemiologic studies. In these instances, the investigator should meet all the criteria outlined above. Nationally, philosophies differ as to whether physician permission is needed prior to patient contact. Several patient advocacy groups maintain that only a patient has the right to decide study participation, and his/her physician does not have the right to make the choice on the patient's behalf.

The policy at the Registry is, except under unusual circumstances (i.e. physician could not be identified or available or selects not to be contacted), a patient’s physician will be asked for permission to contact the patient and asked whether there are any contra-indications to contacting the patient (patient too ill, patient unaware of the diagnosis, etc.). This procedure involves the physicians in the research activity and provides an opportunity for him/her to refuse patient contact.

EXHIBIT A

GEORGIA CANCER REGISTRY CONFIDENTIALITY STATEMENT

I understand that the records and information I will have access to as an employee of (including contractors and temporary employees) the Georgia Department of Public Health (DPH) are confidential and protected by the state and federal law and by DPH Rules and Regulations. Confidential information includes, but is not limited to, medical, financial and demographic information about clients and employees. Confidential information can be verbal or it can be contained in an electronic or a hard copy format.

I agree to share pertinent and confidential information only in the context of my job responsibilities and only with appropriate department personnel. I agree not to discuss confidential information, including but not limited to the names of clients, outside the appropriate work situation.

I understand that if I have any questions about the confidentiality of information or the appropriateness of its disclosure, it is my responsibility to notify my immediate supervisor.

I understand that a breach of this confidentiality will result in disciplinary action, up to and including termination of employment, as well as possible civil and/or criminal liability for me and/or the DPH.

I understand that even when I am no longer an employee (contractor, temporary employee) at DPH, the information I had access to must continue to be kept confidential.

My signature certifies the following:

1. The DPH Confidentiality Policies and Procedures have been explained to me and I have had the opportunity to ask questions about the policies.
2. I have received a copy of the DPH Confidentiality Policies and Procedures.
3. I understand the DPH Confidentiality Policies and Procedures and agree to comply with them.

_____ _____

Employee's (contractor) Signature Date

_____ _____

Supervisor's Signature Date

EXHIBIT B

Georgia Cancer Registry

Cancer Data Request Form

Date:_____Consultant Name: _____

Name of Requester: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone:_____E-mail: _____

Incidence Years:_____ Sites:_____

Geographical Area: _____

Comments: _____

Mortality Years:_____ Sites:_____

Geographical Area: _____

Comments: _____

Date of Response:_____Action: e-mail telephone mail fax other

Resolution: _____

_____

EXHIBIT C

GEORGIA CANCER REGISTRY RESEARCH AGREEMENT

This Agreement is entered into as of (date), by (investigator's institution) and between

_____, _____, and ("Recipient").

RECITALS

A. Recipient is involved in study entitled ("Study"). A description of the Study is incorporated as part of this document (Exhibit A).

B. For purposes of the study, Recipient would like to access to the information described on Exhibit B to this Agreement ("Information").

C. The Department of Public Health is willing to provide the information subject to the terms of this Agreement.

1. Confidentiality of Information: Recipient agrees that all information is confidential and proprietary to the Department of Public Health and its contractor (hereafter referred to as DPH). Recipient agrees that the information is being provided by DPH solely in furtherance of the Study and for no other purpose. Recipient further acknowledges that a confidential relationship exists between it and DPH and that the Information is being disclosed to it in reliance on that confidential relationship as well as the terms of this Agreement.

2. Reimbursement of Expenses: Recipient agrees to pay DPH and contractor a fixed fee for providing the Information to Recipient. Payment will be made on the following terms:

80% of fixed fee upon execution of this agreement

20% of fixed fee upon receipt by Recipient of the file containing the data outlined in Exhibit A.

Payment will be made by Recipient no more than 30 calendar days after receipt of an invoice from DPH. DPH will submit one copy of the invoice for payment to: (person responsible for payment).

3. Use of Information:

a. Recipient agrees that it will maintain the confidentiality of and will not make use of, copy, or disclose any and all Information either orally or in writing except as expressly permitted by this Agreement. Recipient may use the information in connection with the Study and may furnish the information to its employees, consultants, or advisors working on the Study provided that Recipient has first obtained their written agreement to comply with the terms of this Agreement and has on file a signed 'Confidentiality Pledge' (sample is attached).

EXHIBIT C

b. Information may be published as part of the Study provided that neither the identity of any patient nor the primary source of the information is determinable from the publication. Publications and other forms of presentation to any third party which disseminate, or contain information provided by the DPH must be reviewed and approved by the Department of Public Health prior to publication or dissemination. Recipient agrees to provide DPH with a copy of any proposed publication, presentation or other disclosure in any form disseminating, using, or containing Information at least 60 days prior to its publication, presentation, or dissemination to any third party. Recipient agrees to acknowledge the contribution of DPH investigator(s) and the Georgia Center for Cancer Statistics (GCCS) investigator(s), and if applicable, include them as co-authors. Any publication, presentation, or other disclosure in any form disseminating, using or containing information will carry a footnote acknowledging assistance from DPH and/or contractor.

c. This agreement will not prohibit Recipient from using, copying, or disclosing information which (1) at the time of its receipt is or later becomes available to the public through no fault of Recipient; (2) is independently known by Recipient prior to its receipt from GCR as shown by Recipient's written records; or 3) is obtained without an obligation of confidentiality from a third party who had a legal right to disclose the information to Recipient.

d. Recipient agrees that it will comply with all laws regarding the use or disclosure of health care or other personal information.

4. Standard of Care: Recipient agrees that it will exercise reasonable and appropriate care to protect the confidentiality of all information and will use its best efforts to prevent any disclosure of the information except in accordance with this Agreement.

5. Return of Information: Upon completion of the Study or expiration of the term of the agreement whichever comes first, Recipient agrees to return all Information and all copies thereof in its possession or the possession of anyone receiving the Information from Recipient to DPH. Information may not be used for any other purpose without the written, prior approval of DPH.

6. Disclosure Required by Law: If Recipient is required by law to disclose Information including without limitation by discovery, subpoena, or other legal or administrative process, Recipient agrees to provide DPH prompt notice of the required disclosure to permit DPH, at its option and expense, to seek an appropriate protective order or waive the requirements of this Agreement. If no protective order or waiver is obtained and disclosure is legally required, such disclosure may be made but only to the extent required. Recipient agrees that it will cooperate with DPH and will not oppose any action by DPH to obtain a protective order or other assurance that information which must be disclosed will be accorded confidential treatment.

7. Remedies: Recipient acknowledges that the unauthorized disclosure or use of the information could cause irreparable harm and significant injury, which may be difficult to ascertain. Accordingly, Recipient agrees that DPH shall have the right to seek an immediate injunction enjoining any breach of this Agreement and shall be entitled to equitable relief in addition to other remedies and recovery of costs and attorney's fees.

8. Indemnity: Recipient agrees to indemnify, defend and hold harmless DPH and its trustees, officers, professional staff, employees, contractors, and agents and the respective successors, heirs and assigns for and against any one or more of the following:

EXHIBIT C

a. All claims, liabilities, damages or losses which arise from or relate to or are alleged to arise from or relate to (i) the disclosure of the information by DPH to Recipient, (ii) the disclosure by Recipient to any other person of the information; or (iii) any breach of this Agreement by Recipient.

b. All action, suits, proceedings, demands, assessments, adjustments, costs and expenses arising from or incident to the foregoing, including without limitation, reasonable attorney's fees, litigation costs and other out-of-pocket expenses.

This indemnification shall apply whether or not the matter for which indemnification is sought is attributable to the negligent acts or omissions of any one or more of the Indemnities.

9. Institutional Review: No work shall commence under this Agreement until the Department of Public Health Institutional Review Board has reviewed and approved the Study. Recipient agrees to submit the Study for ongoing Department of Public Health Institutional Review Board on at least an annual basis in accordance with all DPH procedures and policies as long as activities using Information provided by DPH are active.

Signature _____ Date _____

Print Name _____ Phone Number _____

Georgia Cancer Registry
Reporting Manual

Section 4: GCR Required Data Set and Instructions for Abstracting and Coding

Coding and Staging Links
and
GCR Required Data Set

International Classification of Diseases for Oncology (ICD-O-3 Online)

- *2018 and later:* https://www.naaccr.org/implementation-guidelines/#ICDO3
- *Prior to 2018:* http://codes.iarc.fr/

International Classification of Diseases for Oncology. Third Edition. Geneva: World Health Organization, 2000**.** Fritz A, Percy C, Jack A, Shanmugaratnam K, Sobin L, Parkin D, Whelan S, eds.

Collaborative Stage Data Collection System Version 2 (CSv2.05)

- *Prior to 2018:* https://cancerstaging.org/cstage/Pages/default.aspx

SEER Reporting Guidelines 2018 and later

Casefinding Lists; SEER Program Coding and Staging Manual; SEER EOD, Hematopoietic Project; 2018 Solid Tumor Rules; Summary Stage 2018,Historical Staging and Coding Manuals, MP/H Rules, Appendix C (Site Specific Coding Modules, Appendix D (Race Codes)

https://seer.cancer.gov/registrars/guidelines.html

- *2018 Solid Tumor Rules (General Instructions, Multiple Primaries, Histology Rules)*

https://seer.cancer.gov/tools/solidtumor/

- *2018 SEER EOD*

https://seer.cancer.gov/tools/staging/2018-EOD-General-Instructions.pdf

- *SEER Summary Stage 2018*

https://seer.cancer.gov/tools/ssm/

TNM 7th Edition Staging

- *Facility Oncology Registry Data Standards (FORDS)*

TNM 8th Edition Staging

- *STandards for Oncology Registry Entry (STORE)*

http://www.facs.org/cancer/coc/fordsmanual.html

North American Association of Central Cancer Registries, Standards forCancer Registries Volume II, Data Standards and Data Dictionary
https://www.naaccr.org/data-standards-data-dictionary/

GCR Required Data Set for 2018 and 2019
http://web1.sph.emory.edu/GCCS/cms/reporting/registrar_resources.html

2018 Required Data Set

Changes in requirements from 2017 are highlighted in yellow		
NAACCR Item #	NAACCR Item Name	Comment
446	Multiplicity Counter	Diagnosis year 2007-2012
448	Date Conclusive DX Flag	Diagnosis year 2007-2012, Date Conclusive DX and Date Conclusive DX Flag cannot both be blank
449	Grade Path System	Diagnosis year 2010-2013
490	Diagnostic Confirmation	
500	Type of Reporting Source	
501	Casefinding Source	Diagnosis year 2006 and later
522	Histologic Type ICD-O-3	Diagnosis year 2001 and later
523	Behavior Code ICD-O-3	Diagnosis year 2001 and later
540	Reporting Facility	
545	NPI--Reporting Facility	Diagnosis year 2007 and later as available
550	Accession Number--Hosp	Not required for Abstract Plus users.
560	Sequence Number--Hospital	
570	Abstracted By	For abstracts with Date Case Initiated 1/1/2014 and later, the three-digit state assigned Abstractor ID must be used.
580	Date of 1st Contact	Date of 1st Contact and Date of 1st Contact Flag cannot both be blank.
581	Date of 1st Contact Flag	
610	Class of Case	
630	Primary Payer at DX	Diagnosis year 2006 and later
670	RX Hosp--Surg Prim Site	
672	RX Hosp--Scope Reg LN Sur	
674	RX Hosp--Surg Oth Reg/Dis	
682	Date Regional Lymph Node Dissection	Diagnosis year 2018 and later, Date Regional Lymph Node Dissection and Date Regional Lymph Node Dissection Flag cannot both be blank
683	Date Regional Lymph Node Dissection Flag	
700	RX Hosp--Chemo	
710	RX Hosp--Hormone	
720	RX Hosp--BRM	
730	RX Hosp--Other	
752	Tumor Size Clinical	Diagnosis year 2016 and later
754	Tumor Size Pathologic	Diagnosis year 2016 and later
756	Tumor Size Summary	Diagnosis year 2016 and later
759	SEER Summary Stage 2000	Diagnosis year 2001-2003 and 2015-2017
760	SEER Summary Stage 1977	Diagnosis year 1995-2000
764	Summary Stage 2018	Diagnosis year 2018 and later
772	EOD Primary Tumor	Diagnosis year 2018 and later
774	EOD Regional Nodes	Diagnosis year 2018 and later
776	EOD Mets	Diagnosis year 2018 and later
780	EOD--Tumor Size	Diagnosis year 1999-2003
790	EOD--Extension	Diagnosis year 1999-2003
800	EOD--Extension Prost Path	Diagnosis year 1999-2003
810	EOD--Lymph Node Involv	Diagnosis year 1999-2003
820	Regional Nodes Positive	Diagnosis year 1999 and later
830	Regional Nodes Examined	Diagnosis year 1999 and later

Changes in requirements from 2017 are highlighted in yellow		
NAACCR Item #	NAACCR Item Name	Comment
1270	Date 1st Crs RX CoC	Date 1st Crs RX CoC and Date 1st Crs RX CoC Flag cannot both be blank
1271	Date 1st Crs RX CoC Flag	
1285	RX Summ--Treatment Status	Diagnosis year 2010 and later
1290	RX Summ--Surg Prim Site	Diagnosis year 2003 and later
1292	RX Summ--Scope Reg LN Sur	Diagnosis year 2003 and later
1294	RX Summ--Surg Oth Reg/Dis	Diagnosis year 2003 and later
1296	RX Summ--Reg LN Examined	Diagnosis year 1998-2002
1320	RX Summ--Surgical Margins	Required, when available
1330	RX Summ--Reconstruct 1st	Diagnosis year 1998-2002 (Breast)
1340	Reason for No Surgery	
1360	RX Summ--Radiation	Required through diagnosis year 2017
1380	RX Summ--Surg/Rad Seq	
1390	RX Summ--Chemo	
1400	RX Summ--Hormone	
1410	RX Summ--BRM	
1420	RX Summ--Other	
1430	Reason for No Radiation	
1501	Phase I Dose per Fraction	Required, when available
1502	Phase I Radiation External Beam Planning Tech	Required, when available
1503	Phase I Number of Fractions	Required, when available
1504	Phase I Radiation Primary Treatment Volume	Required, when available
1505	Phase I Radiation to Draining Lymph Nodes	Required, when available
1506	Phase I Radiation Treatment Modality	Required
1507	Phase I Total Dose	Required, when available
1511	Phase II Dose per Fraction	Required, when available
1512	Phase II Radiation External Beam Planning Tech	Required, when available
1513	Phase II Number of Fractions	Required, when available
1514	Phase II Radiation Primary Treatment Volume	Required, when available
1515	Phase II Radiation to Draining Lymph Nodes	Required, when available
1516	Phase II Radiation Treatment Modality	Required
1517	Phase II Total Dose	Required, when available
1521	Phase III Dose per Fraction	Required, when available
1522	Phase III Radiation External Beam Planning Tech	Required, when available
1523	Phase III Number of Fractions	Required, when available
1524	Phase III Radiation Primary Treatment Volume	Required, when available
1525	Phase III Radiation to Draining Lymph Nodes	Required, when available

Changes in requirements from 2017 are highlighted in yellow		
NAACCR Item #	NAACCR Item Name	Comment
1526	Phase III Radiation Treatment Modality	Required
1527	Phase III Total Dose	Required, when available
1531	Radiation Treatment Discontinued Early	Required, when available
1532	Number of Phases of Rad Treatment to this Volume	Required, when available
1533	Total Dose	Required, when available
1570	Rad--Regional RX Modality	Diagnosis year 2006-2014 site-specific and 2015-2017
1639	RX Summ--Systemic/Sur Seq	Diagnosis year 2006 and later
1640	RX Summ--Surgery Type	Diagnosis year 1995-1997
1646	RX Summ--Surg Site 98-02	Diagnosis year 1998-2002
1647	RX Summ--Scope Reg 98-02	Diagnosis year 1998-2002
1648	RX Summ--Surg Oth 98-02	Diagnosis year 1998-2002
1750	Date of Last Contact	Date of Last Contact and Date of Last Contact Flag cannot both be blank
1751	Date of Last Contact Flag	
1760	Vital Status	
1810	Addr Current--City	Diagnosis year 2013 and later
1820	Addr Current--State	Diagnosis year 2013 and later
1830	Addr Current--Postal Code	Diagnosis year 2013 and later
1832	Addr Current--Country	Diagnosis year 2013 and later
1942	Place of Death--State	Required, when available
1944	Place of Death--Country	Required, when available
1981-2078	*Edit Over-ride Flags*	
2085	Date Case Initiated	System generated
2152	CoC Accredited Flag	System generated
2170	Vendor Name	
2230	Name--Last	
2240	Name--First	
2250	Name--Middle	
2270	Name--Suffix	
2280	Name--Alias	
2290	Name--Spouse/Parent	
2300	Medical Record Number	
2320	Social Security Number	
2330	Addr at DX--No & Street	
2335	Addr at DX--Supplementl	
2350	Addr Current--No & Street	Diagnosis year 2013 and later
2355	Addr Current--Supplementl	Diagnosis year 2013 and later
2360	Telephone	
2390	Name--Maiden	
2415	NPI--Inst Referred From	Diagnosis year 2007 and later as available

Changes in requirements from 2017 are highlighted in yellow		
NAACCR Item #	NAACCR Item Name	Comment
2425	NPI--Inst Referred To	Diagnosis year 2007 and later as available
2460	Physician--Managing	The NPI is the preferred ID number for collection. If NPI--Physician--Managing is blank, Physician--Managing cannot be blank.
2465	NPI--Physician--Managing	
2470	Physician--Follow-Up	The NPI is the preferred ID number for collection. If NPI--Physician--Follow-Up is blank, Physician--Follow-up cannot be blank.
2475	NPI--Physician--Follow-Up	
2480	Physician--Primary Surg	The NPI is the preferred ID number for collection.If NPI--Physician--Primary Surg is blank, Physician--Primary Surg cannot be blank. **Exception**: if RX Summ--Surg Prim Site = 00 or 98, NPI--Physician--Primary Surg and Physician-- Primary Surg may both be blank.
2485	NPI--Physician--Primary Surg	
2490	Physician 3	The NPI is the preferred ID number for collection. NPI--Physician 3 or Physician 3 are Required, when available.
2495	NPI--Physician 3	
2500	Physician 4	The NPI is the preferred ID number for collection. NPI--Physician 4 or Physician 4 are Required, when available.
2505	NPI--Physician 4	
2520	Text--DX Proc--PE	There MUST be text to support coding of data fields in the cancer identification, stage and treatment sections of the abstract.
2530	Text--DX Proc--X-ray/Scan	
2540	Text--DX Proc--Scopes	
2550	Text--DX Proc--Lab Tests	
2560	Text--DX Proc--Op	
2570	Text--DX Proc--Path	
2580	Text--Primary Site Title	
2590	Text--Histology Title	
2600	Text--Staging	
2610	RX Text--Surgery	
2620	RX Text--Radiation (Beam)	
2630	RX Text--Radiation Other	
2640	RX Text--Chemo	
2650	RX Text--Hormone	
2660	RX Text--BRM	
2670	RX Text--Other	
2680	Text--Remarks	Additional text or overflow from other text fields
2690	Text--Place of Diagnosis	Text about facility, physician office, city, state, or county where the diagnosis was made.
2800	CS Tumor Size	Diagnosis year 2004-2017
2810	CS Extension	Diagnosis year 2004-2017
2820	CS Tumor Size/Ext Eval	Diagnosis year 2004-2017
2830	CS Lymph Nodes	Diagnosis year 2004-2017
2840	CS Lymph Nodes Eval	Diagnosis year 2004-2017
2850	CS Mets at DX	Diagnosis year 2004-2017
2851	CS Mets at DX-Bone	Diagnosis year 2010-2015

Changes in requirements from 2017 are highlighted in yellow		
NAACCR Item #	NAACCR Item Name	Comment
2852	CS Mets at DX-Brain	Diagnosis year 2010-2015
2853	CS Mets at DX-Liver	Diagnosis year 2010-2015
2854	CS Mets at DX-Lung	Diagnosis year 2010-2015
2860	CS Mets Eval	Diagnosis year 2004-2017
2861	CS Site-Specific Factor 7	Diagnosis year 2004-2017 For CS Site-Specific Factor coding requirements, see the NCI-SEER website: **Required Factors** **SEER, Version 0205** http://seer.cancer.gov/csreqstatus/application.html ?report=requiredFactors&setter=seer&version=0205 &schema=0&years=0
2862	CS Site-Specific Factor 8	
2863	CS Site-Specific Factor 9	
2864	CS Site-Specific Factor10	
2865	CS Site-Specific Factor11	
2866	CS Site-Specific Factor12	
2867	CS Site-Specific Factor13	
2868	CS Site-Specific Factor14	
2869	CS Site-Specific Factor15	
2870	CS Site-Specific Factor16	
2871	CS Site-Specific Factor17	
2872	CS Site-Specific Factor18	
2873	CS Site-Specific Factor19	
2874	CS Site-Specific Factor20	
2875	CS Site-Specific Factor21	
2876	CS Site-Specific Factor22	
2877	CS Site-Specific Factor23	
2878	CS Site-Specific Factor24	
2879	CS Site-Specific Factor25	
2880	CS Site-Specific Factor 1	
2890	CS Site-Specific Factor 2	
2900	CS Site-Specific Factor 3	
2910	CS Site-Specific Factor 4	
2920	CS Site-Specific Factor 5	
2930	CS Site-Specific Factor 6	
2935	CS Version Input Original	Diagnosis year 2004-2017
2936	CS Version Derived	Diagnosis year 2004-2017
2937	CS Version Input Current	Diagnosis year 2004-2017
2940	Derived AJCC-6 T	Diagnosis year 2004-2017
2950	Derived AJCC-6 T Descript	Diagnosis year 2004-2017
2960	Derived AJCC-6 N	Diagnosis year 2004-2017
2970	Derived AJCC-6 N Descript	Diagnosis year 2004-2017
2980	Derived AJCC-6 M	Diagnosis year 2004-2017
2990	Derived AJCC-6 M Descript	Diagnosis year 2004-2017
3000	Derived AJCC-6 Stage Grp	Diagnosis year 2004-2017
3010	Derived SS1977	Diagnosis year 2004-2017
3020	Derived SS2000	Diagnosis year 2004-2017
3030	Derived AJCC--Flag	Diagnosis year 2004-2017
3040	Derived SS1977--Flag	Diagnosis year 2004-2017
3050	Derived SS2000--Flag	Diagnosis year 2004-2017
3170	RX Date Mst Defn Srg	Diagnosis year 2015 and later, RX Date Mst Defn Srg and RX Date Mst Defn Srg Flag cannot both be blank
3171	RX Date Mst Defn Srg Flag	

Changes in requirements from 2017 are highlighted in yellow		
NAACCR Item #	NAACCR Item Name	Comment
3200	Rad--Boost RX Modality	
3230	RX Date Systemic	RX Date Systemic and RX Date Systemic Flag cannot both be blank.
3231	RX Date Systemic Flag	
3250	RX Summ--Transplnt/Endocr	
3400	Derived AJCC-7 T	Diagnosis year 2010-2017
3402	Derived AJCC-7 T Descript	Diagnosis year 2010-2017
3410	Derived AJCC-7 N	Diagnosis year 2010-2017
3412	Derived AJCC-7 N Descript	Diagnosis year 2010-2017
3420	Derived AJCC-7 M	Diagnosis year 2010-2017
3422	Derived AJCC-7 M Descript	Diagnosis year 2010-2017
3430	Derived AJCC-7 Stage Grp	Diagnosis year 2010-2017
3700	SEER Site-Specific Fact 1	Diagnosis year 2018 and later schema-specific
3800	Schema ID	System generated
3801	Chromosome 1p: Loss of Heterozygosity (LOH)	Diagnosis year 2018 and later schema-specific
3802	Chromosome 19q: Loss of Heterozygosity (LOH)	Diagnosis year 2018 and later schema-specific
3803	Adenoid Cystic Basaloid Pattern	Diagnosis year 2018 and later schema-specific
3804	Adenopathy	Diagnosis year 2018 and later schema-specific
3805	AFP Post-Orchiectomy Lab Value	Diagnosis year 2018 and later schema-specific
3806	AFP Post-Orchiectomy Range	Diagnosis year 2018 and later schema-specific
3807	AFP Pre-Orchiectomy Lab Value	Diagnosis year 2018 and later schema-specific
3808	AFP Pre-Orchiectomy Range	Diagnosis year 2018 and later schema-specific
3809	AFP Pretreatment Interpretation	Diagnosis year 2018 and later schema-specific
3810	AFP Pretreatment Lab Value	Diagnosis year 2018 and later schema-specific
3811	Anemia	Diagnosis year 2018 and later schema-specific
3812	B symptoms	Diagnosis year 2018 and later schema-specific
3813	Bilirubin Pretreatment Total Lab Value	Diagnosis year 2018 and later schema-specific
3814	Bilirubin Pretreatment Unit of Measure	Diagnosis year 2018 and later schema-specific
3815	Bone Invasion	Diagnosis year 2018 and later schema-specific
3816	Brain Molecular Markers	Diagnosis year 2018 and later schema-specific
3817	Breslow Tumor Thickness	Diagnosis year 2018 and later schema-specific
3818	CA-125 Pretreatment Interpretation	Diagnosis year 2018 and later schema-specific
3819	CEA Pretreatment Interpretation	Diagnosis year 2018 and later schema-specific
3820	CEA Pretreatment Lab Value	Diagnosis year 2018 and later schema-specific
3821	Chromosome 3 Status	Diagnosis year 2018 and later schema-specific
3822	Chromosome 8q Status	Diagnosis year 2018 and later schema-specific
3823	Circumferential Resection Margin (CRM)	Diagnosis year 2018 and later schema-specific
3824	Creatinine Pretreatment Lab Value	Diagnosis year 2018 and later schema-specific

Changes in requirements from 2017 are highlighted in yellow		
NAACCR Item #	NAACCR Item Name	Comment
3825	Creatinine Pretreatment Unit of Measure	Diagnosis year 2018 and later schema-specific
3826	Estrogen Receptor Percent Positive or Range	Diagnosis year 2018 and later schema-specific
3827	Estrogen Receptor Summary	Diagnosis year 2018 and later schema-specific
3828	Estrogen Receptor Total Allred Score	Diagnosis year 2018 and later schema-specific
3829	Esophagus and EGJ Tumor Epicenter	Diagnosis year 2018 and later schema-specific
3830	Extranodal Extension Clin (non-Head and Neck)	Diagnosis year 2018 and later schema-specific
3831	Extranodal Extension Head and Neck Clinical	Diagnosis year 2018 and later schema-specific
3832	Extranodal Extension Head and Neck Pathological	Diagnosis year 2018 and later schema-specific
3833	Extranodal Extension Path (non-Head and Neck)	Diagnosis year 2018 and later schema-specific
3834	Extravascular Matrix Patterns	Diagnosis year 2018 and later schema-specific
3835	Fibrosis Score	Diagnosis year 2018 and later schema-specific
3836	FIGO Stage	Diagnosis year 2018 and later schema-specific
3837	Gestational Trophoblastic Prognostic Scoring Index	Diagnosis year 2018 and later schema-specific
3838	Gleason Patterns Clinical	Diagnosis year 2018 and later schema-specific
3839	Gleason Patterns Pathological	Diagnosis year 2018 and later schema-specific
3840	Gleason Score Clinical	Diagnosis year 2018 and later schema-specific
3841	Gleason Score Pathological	Diagnosis year 2018 and later schema-specific
3842	Gleason Tertiary Pattern	Diagnosis year 2018 and later schema-specific
3843	Grade Clinical	Diagnosis year 2018 and later
3844	Grade Pathological	Diagnosis year 2018 and later
3845	Grade Post Therapy	Diagnosis year 2018 and later schema-specific
3846	hCG Post-Orchiectomy Lab Value	Diagnosis year 2018 and later schema-specific
3847	hCG Post-Orchiectomy Range	Diagnosis year 2018 and later schema-specific
3848	hCG Pre-Orchiectomy Lab Value	Diagnosis year 2018 and later schema-specific
3849	hCG Pre-Orchiectomy Range	Diagnosis year 2018 and later schema-specific
3850	HER2 IHC Summary	Diagnosis year 2018 and later schema-specific when available
3851	HER2 ISH Dual Probe Copy Number	Diagnosis year 2018 and later schema-specific when available
3852	HER2 ISH Dual Probe Ratio	Diagnosis year 2018 and later schema-specific when available
3853	HER2 ISH Single Probe Copy Number	Diagnosis year 2018 and later schema-specific when available
3854	HER2 ISH Summary	Diagnosis year 2018 and later schema-specific when available
3855	HER2 Overall Summary	Diagnosis year 2018 and later schema-specific
3856	Heritable Trait	Diagnosis year 2018 and later schema-specific

Changes in requirements from 2017 are highlighted in yellow		
NAACCR Item #	NAACCR Item Name	Comment
3857	High Risk Cytogenetics	Diagnosis year 2018 and later schema-specific
3858	High Risk Histologic Features	Diagnosis year 2018 and later schema-specific
3859	HIV Status	Diagnosis year 2018 and later schema-specific
3860	International Normalized Ratio Prothrombin Time	Diagnosis year 2018 and later schema-specific
3861	Ipsilateral Adrenal Gland Involvement	Diagnosis year 2018 and later schema-specific
3862	JAK2	Diagnosis year 2018 and later schema-specific
3863	Ki-67	Diagnosis year 2018 and later schema-specific
3864	Invasion Beyond Capsule	Diagnosis year 2018 and later schema-specific
3865	KIT Gene Immunohistochemistry	Diagnosis year 2018 and later schema-specific
3866	KRAS	Diagnosis year 2018 and later schema-specific
3867	LDH Post-Orchiectomy Range	Diagnosis year 2018 and later schema-specific
3868	LDH Pre-Orchiectomy Range	Diagnosis year 2018 and later schema-specific
3869	LDH Pretreatment Level	Diagnosis year 2018 and later schema-specific
3870	LDH Upper Limits of Normal	Diagnosis year 2018 and later schema-specific
3871	LN Assessment Method Femoral-Inguinal	Diagnosis year 2018 and later schema-specific
3872	LN Assessment Method Para-Aortic	Diagnosis year 2018 and later schema-specific
3873	LN Assessment Method Pelvic	Diagnosis year 2018 and later schema-specific
3874	LN Distant Assessment Method	Diagnosis year 2018 and later schema-specific
3875	LN Distant: Mediastinal Scalene	Diagnosis year 2018 and later schema-specific
3876	LN Head and Neck Levels I-III	Diagnosis year 2018 and later schema-specific
3877	LN Head and Neck Levels IV-V	Diagnosis year 2018 and later schema-specific
3878	LN Head and Neck Levels VI-VII	Diagnosis year 2018 and later schema-specific
3879	LN Head and Neck Other	Diagnosis year 2018 and later schema-specific
3880	LN Isolated Tumor Cells (ITC)	Diagnosis year 2018 and later schema-specific
3881	LN Laterality	Diagnosis year 2018 and later schema-specific
3882	LN Positive Axillary Level I-II	Diagnosis year 2018 and later schema-specific
3883	LN Size	Diagnosis year 2018 and later schema-specific
3884	LN Status Femoral-Inguinal, Para-Aortic, Pelvic	Diagnosis year 2018 and later schema-specific
3885	Lymphocytosis	Diagnosis year 2018 and later schema-specific
3886	Major Vein Involvement	Diagnosis year 2018 and later schema-specific
3887	Measured Basal Diameter	Diagnosis year 2018 and later schema-specific
3888	Measured Thickness	Diagnosis year 2018 and later schema-specific
3889	Methylation of O6-Methylguanine Methyltransferase	Diagnosis year 2018 and later schema-specific
3890	Microsatellite Instability (MSI)	Diagnosis year 2018 and later schema-specific
3891	Microvascular Density	Diagnosis year 2018 and later schema-specific
3892	Mitotic Count Uveal Melanoma	Diagnosis year 2018 and later schema-specific
3893	Mitotic Rate Melanoma	Diagnosis year 2018 and later schema-specific
3894	Multigene Signature Method	Diagnosis year 2018 and later schema-specific

Changes in requirements from 2017 are highlighted in yellow		
NAACCR Item #	NAACCR Item Name	Comment
3895	Multigene Signature Results	Diagnosis year 2018 and later schema-specific
3896	NCCN International Prognostic Index (IPI)	Diagnosis year 2018 and later schema-specific
3897	Number of Cores Examined	Diagnosis year 2018 and later schema-specific
3898	Number of Cores Positive	Diagnosis year 2018 and later schema-specific
3899	Number of Examined Para-Aortic Nodes	Diagnosis year 2018 and later schema-specific
3900	Number of Examined Pelvic Nodes	Diagnosis year 2018 and later schema-specific
3901	Number of Positive Para-Aortic Nodes	Diagnosis year 2018 and later schema-specific
3902	Number of Positive Pelvic Nodes	Diagnosis year 2018 and later schema-specific
3903	Oncotype Dx Recurrence Score-DCIS	Diagnosis year 2018 and later schema-specific
3904	Oncotype Dx Recurrence Score-Invasive	Diagnosis year 2018 and later schema-specific
3905	Oncotype Dx Risk Level-DCIS	Diagnosis year 2018 and later schema-specific
3906	Oncotype Dx Risk Level-Invasive	Diagnosis year 2018 and later schema-specific
3907	Organomegaly	Diagnosis year 2018 and later schema-specific
3908	Percent Necrosis Post Neoadjuvant	Diagnosis year 2018 and later schema-specific
3909	Perineural Invasion	Diagnosis year 2018 and later schema-specific
3910	Peripheral Blood Involvement	Diagnosis year 2018 and later schema-specific
3911	Peritoneal Cytology	Diagnosis year 2018 and later schema-specific
3913	Pleural Effusion	Diagnosis year 2018 and later schema-specific
3914	Progesterone Receptor Percent Positive or Range	Diagnosis year 2018 and later schema-specific
3915	Progesterone Receptor Summary	Diagnosis year 2018 and later schema-specific
3916	Progesterone Receptor Total Allred Score	Diagnosis year 2018 and later schema-specific
3917	Primary Sclerosing Cholangitis	Diagnosis year 2018 and later schema-specific
3918	Profound Immune Suppression	Diagnosis year 2018 and later schema-specific
3919	Prostate Pathological Extension	Diagnosis year 2018 and later schema-specific
3920	PSA (Prostatic Specific Antigen) Lab Value	Diagnosis year 2018 and later schema-specific
3921	Residual Tumor Volume Post Cytoreduction	Diagnosis year 2018 and later schema-specific
3922	Response to Neoadjuvant Therapy	Diagnosis year 2018 and later schema-specific
3923	S Category Clinical	Diagnosis year 2018 and later schema-specific
3924	S Category Pathological	Diagnosis year 2018 and later schema-specific
3925	Sarcomatoid Features	Diagnosis year 2018 and later schema-specific
3926	Schema Discriminator 1	Diagnosis year 2018 and later schema-specific
3927	Schema Discriminator 2	Diagnosis year 2018 and later schema-specific
3928	Schema Discriminator 3	Diagnosis year 2018 and later schema-specific
3929	Separate Tumor Nodules	Diagnosis year 2018 and later schema-specific

Changes in requirements from 2017 are highlighted in yellow		
NAACCR Item #	NAACCR Item Name	Comment
3930	Serum Albumin Pretreatment Level	Diagnosis year 2018 and later schema-specific
3931	Serum Beta-2 Microglobulin Pretreatment Level	Diagnosis year 2018 and later schema-specific
3932	LDH Pretreatment Lab Value	Diagnosis year 2018 and later schema-specific
3933	Thrombocytopenia	Diagnosis year 2018 and later schema-specific
3934	Tumor Deposits	Diagnosis year 2018 and later schema-specific
3935	Tumor Growth Pattern	Diagnosis year 2018 and later schema-specific
3936	Ulceration	Diagnosis year 2018 and later schema-specific
3937	Visceral and Parietal Pleural Invasion	Diagnosis year 2018 and later schema-specific
7090	Path Report Number 1	Required, when available

Georgia Cancer Registry
Reporting Manual

Section 5: Special Reporting Projects

1) COVID-19

As the coronavirus 2019 (COVID-19) pandemic continues, people with compromised immune systems are at an increased risk for infection with severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), the virus that causes COVID-19. Based on the National Cancer Institute (NCI), more than 15,700,000 people are estimated to be living with cancer in the United States. Incidence of COVID-19 has been reported to be higher among cancer patients than in the general population. Additionally, recent studies have shown patients with cancer had higher observed death rates, higher rates of ICU admission, and higher risk of complications when compared to non-cancer patients. Radiotherapy, chemotherapy, and immunotherapy may be postponed in order to decrease the risk of infection of COVID-19 or increase in treatment co-morbidity. A technical report stated that 8% of cancer patients had alterations in treatment plans due to COVID-19. These patients had delays in treatment and for almost half of these patients, treatment was indefinitely delayed or stopped entirely due to confirmed COVID-19 infections. Even with the small sample sizes of these studies, the COVID-19 pandemic has observable and potentially long-lasting effects on cancer outcomes. It is imperative to collect SARS-CoV-2 infection status and modifications to treatment for both incident and prevalent cases at the population-level, using the existing cancer surveillance infrastructure and standards. (see https://seer.cancer.gov/tools/covid-19/ for references page 13)

General Instructions for Documenting COVID-19 as Part of Regular Case Abstraction

Following the above rationale, the COVID-19 Data Abstraction Guidance (Guidance v1.0. available at https://seer.cancer.gov/tools/covid-19/COVID-19-Abstraction-Guidance.pdf) provides directions for using NAACCR text data items and standards to collect information on cancer patients' SARS-CoV-2 laboratory tests, infection status, and delays or modifications of the treatment plan (**Page 4-12, 14-15).** The implementation of this guidance will take advantage of existing data items and text blocks, with minimal additional efforts for collection of COVID- 19 information. Meanwhile, the abstraction of COVID-19 information will not require changes to case ascertainment, reportability rules, list of required data items, modifications of edits metafiles, or other alterations of the current data acquisition process. In the application of directions listed in the Guidance, there is no expectation that registrars seek medical documents beyond the sources they currently use routinely for case abstraction and coding.

Abstracting Instructions

The following directions for recording COVID-19 information in the required NAACCR text data items are applicable to **cases diagnosed January 1st, 2020 or later and completed on or after June 1st, 2020.** COVID-19 Information must be entered in the text fields **shown below** to facilitate data retrieval. Entering text in a way that is different from this guidance (page 4-12 and as available on https://seer.cancer.gov/tools/covid-19/COVID-19-Abstraction-Guidance.pdf) will make the information useless. Please follow the instructions for entering COVID-19 information in the following eight required NAACCR text data items.

TEXT DX PROC--LAB TESTS (NAACCR # 2500)
TEXT REMARKS (NAACCR # 2680)
RX TEXT SURGERY (NAACCR # 2610)
RX TEXT RADIATION (BEAM) (NAACCR # 2620)
RX TEXT RADIATION Other (NAACCR # 2630)
RX TEXT CHEMO (NAACCR # 2640)
RX TEXT HORMONE (NAACCR # 2640)
RX TEXT BRM (NAACCR # 2640)

2) Cancer Recurrence

The National Cancer Institute estimates there are over 17 million cancer survivors in the United States today and these numbers are rising rapidly thanks to advances in early diagnosis and treatment. Georgia's cancer registries are on the frontline in facilitating the capture of the necessary data to monitor our state's progress in cancer prevention and control. Registries also provide clinical data that is critical to our research community. As our survivor population grows, it is ever more important that we capture additional outcomes to assess progress in life following a diagnosis of cancer.

Effective with cases diagnosed 2013 forward, the Georgia Cancer Registry is adding recurrence to its list of reportable data. We know that facilities participating in the Commission on Cancer Program have been collecting some data on recurrence for years but we need to expand the collection to all patients in our state and ensure that patients are followed for recurrence regardless of where they receive their future cancer care. As part of this new reporting mandate, **we are not asking for any additional work on behalf of our cancer registrars in Georgia**. The Georgia Cancer Registry is building an infrastructure to utilize data streams to provide signals of cancer recurrence. These signals will be validated by Georgia Cancer Registry staff on a sample of patients and then the algorithms defining the recurrence signals will be refined to improve their accuracy. This iterative process will continue until the algorithms are optimized. **Once optimized, the Georgia Cancer Registry will share the recurrence data we have collected with any interested facility in Georgia for their respective set of cancer patients in the registry.**

In order to minimize the burden of this work on cancer registrars in our state, we will be conducting the recurrence signal validation ourselves as discussed above. Our Regional Coordinators will be reaching out to you to facilitate setting up periodic access for GCR staff to visit your facility to conduct the validation. We know this does require some advanced planning in order to establish a space for our staff to work and as such we will reach out well in advance to ensure ample time to prepare. **If there is any possible way to facilitate remote access for Georgia Cancer Registry staff to complete this work, we would greatly appreciate this and will complete any necessary paperwork that is required**. We can provide a log of every cases that will be reviewed if that would be helpful along with any other information that is required.

Georgia Cancer Registry Reporting Manual

Section 6: SEER Site Specific Surgery of Primary Site Surgery Codes

SEER SITE SPECIFIC SURGERY OF PRIMARY SITE CODES

This section in GCR Policy and Procedure Manual for Reporting Facilities can be found in link: https://seer.cancer.gov/manuals/2018/appendixc.html (Appendix C). This is a live link and will have the current codes and rules by primary site.

Each topic can be printed however; the entire Appendix C cannot be printed as a complete manual. Appendix C is arranged by primary site and will have current surgery codes for each primary site.

Appendix C brings together the site-specific instructions needed to abstract a case. The Site Specific Coding Modules (SPCM) includes the following sections/documents for each primary site grouping:

*Coding Guidelines document whenever there are guidelines for a primary site
*Solid Tumor Rules
*2018 EOD Schemas
*Surgery codes

For older surgery code manuals use the following link:
http://www.seer.cancer.gov/tools/codingmanuals/historical.html
Scroll down until you see "Surgery". There are two historical manuals available for reference: Diagnostic Procedures April 1997, effective 1997- 1987 and Site-Specific Surgery Codes, effective 1983- 1997.

Surgery codes for 1998 – 2017 are in Appendix C of the SEER Program Code Manual (SPCM), 3rd Ed., located in historical manuals section.

Georgia Cancer Registry
Reporting Manual

Section 7: Determining Multiple Primaries

This section of the GCR Policy and Procedure Manual for Reporting Facilities can be found in the link for 2018 Solid Tumor Rules:
https://seer.cancer.gov/tools/solidtumor/

This is a live link and will have the current Multiple Primary/ Histology Rules.

Appendix C is arranged by primary site, and will have Multiple Primary/Histology rules for each primary site. Go to Other Sites when a Primary site does not have its own set of Multiple Primary/Histology rules.

Historical Cases for diagnosis years 1995 through 2017. Use link for manuals for historical cases: http://www.seer.cancer.gov/tools/codingmanuals/historical.html

LIST OF PAIRED ORGAN SITES

ICD-O-3	Site	ICD-O-3	Site
C07.9	Parotid gland	C44.7	Skin of lower limb and hip
C08.0	Submandibular gland	C47.2	Peripheral nerves and autonomic nervous system of lower limb and hip
C08.1	Sublingual gland	C49.1	Connective, subcutaneous, and other soft tissues of upper limb and shoulder
C09.0	Tonsillar fossa	C49.2	Connective, subcutaneous, and other soft tissues of lower limb and hip
C09.1	Tonsillar pillar	C50.0-C50.9	Breast
C09.8	Overlapping lesion of tonsil	C56.9	Ovary
C09.9	Tonsil, NOS	C57.0	Fallopian tube
C30.0	Nasal cavity (excluding nasal cartilage and nasal septum)	C62.0-C62.9	Testis
C30.1	Middle ear	C63.0	Epididymis
C31.0	Maxillary sinus	C63.1	Spermatic cord
C31.2	Frontal sinus	C64.9	Kidney, NOS
C34.0	Main bronchus (excluding carina)	C65.9	Renal pelvis
C34.1-34.9	Lung	C66.9	Ureter
C38.4	Pleura	C69.0-C69.9	Eye and lacrimal gland
C40.0	Long bones of upper limb and scapula	C70.0	Cerebral meninges, NOS
C40.1	Short bones of upper limb	C71.0	Cerebrum
C40.2	Long bones of lower limb	C71.1	Frontal lobe
C40.3	Short bones of lower limb	C71.2	Temporal lobe
C41.3	Rib and clavicle (excluding sternum)	C71.3	Parietal lobe
C41.4	Pelvic bones (excluding sacrum, coccyx, and symphysis pubis)	C71.4	Occipital lobe
C44.1	Skin of eyelid	C72.2	Olfactory nerve
		C72.3	Optic nerve
C44.2	Skin of external ear	C72.4	Acoustic nerve
C44.3	Skin of other and unspecified parts of face	C72.5	Cranial nerve, NOS
C44.5	Skin of trunk	C74.0-C74.9	Adrenal gland
C44.6	Skin of upper limb and shoulder	C75.4	Carotid body

Georgia Cancer Registry
Reporting Manual

Section 8: Reporting Laws and Mandate

Kathleen E. Toomey, M.D., M.P.H., **Commissioner** / Brian Kemp, **Governor**

2 Peachtree Street, NW, 15th Floor
Atlanta, Georgia 30303-3142

dph.ga.gov

May 2, 2019

Dear Colleague:

Legal authority for the Georgia Department of Public Health (Department) to collect health information is provided in Chapter 12 of the Official Code of Georgia Annotated (O.C.G.A.). O.C.G.A. section 31-12-1 empowers the Department to " ... conduct studies, research, and training appropriate to the prevention of diseases .... " O.C.G.A. section 31-12 -2 allows the Department to declare certain diseases and injuries to be reported in a manner and within prescribed times. Under this authority, information about persons with cancer is required to be reported to the Department or its designated agent.

The Department is empowered to determine such reporting requirements. This letter is to serve as a written directive requiring selected information about patients diagnosed or treated for cancer in Georgia to be reported to the Department or to our appointed agent. Individuals and agencies required to report include, but are not limited to, all healthcare providers and facilities located in Georgia, such as:
1) Physicians; 2) Hospitals; 3) Laboratories; and 4) Free standing diagnostic or treatment facilities.

Under the provisions of this law, it is not necessary to obtain individual patient consent to allow the Department or its designated agent to collect information about patients with cancer from medical records or related documents for public health purposes. O.C.G.A. Code 31-12-2a addresses the confidentiality of information requested by the Department, and releases providers from civil liability when releasing information. O.C.G.A. Code 31- 2-2b states that " ... all such reports shall be deemed confidential and shall not be opened to inspection by the public." Only aggregate reports without identifiers can be released.

The Georgia Department of Public Health has designated the Georgia Center for Cancer Statistics (GCCS) at the Emory University Rollins School of Public Heath as its agent for the purpose of collecting, editing, consolidating, and monitoring cancer data and its reporting in Georgia. Strict measures are in place at the Department and at the Rollins School of Public Health to protect the confidentiality of the data in your reports; patient names and other identifiers will not be released.

Information about reporting a diagnosis of cancer to GCCS and the Department, including our "Georgia Comprehensive Cancer Registry Policy and Procedure Manual," can be found on our website at: https:/dph.georgia.gov/reporting-cancer.

Please contact Rana Bayakly at 404-657-2617 or via email rana.bayakly@dph.ga.gov if you have any questions or concerns. I greatly appreciate your invaluable help in tracking and fighting cancer in our state.

Sincerely,

Cherie Drenzek, D.V.M., M.S.
State Epidemiologist & Chief Science Officer

CC: Rana Bayakly, M.P.H.
Kevin Ward, Ph.D., M.P.H., C.T.R

We protect lives.

Brenda Fitzgerald, MD, Commissioner Nathan Deal, Governor

2 Peachtree St NW, 15th Floor
Atlanta, Georgia 30303-3142
www.health.state.ga.us

October 13, 2011

SUBJECT: Reporting of Cancer

Dear Colleagues:

I am writing to let you know that the new Georgia Department of Public Health has taken over the responsibility of tracking reports from health care providers on diseases classified as "reportable," including cancer.

For the last several years, the Georgia Department of Community Health has defined "reportable diseases" pursuant to O.C.G.A. § 31-12-7, and you have been making your reports to that Department. Effective 1 July 2011, with the creation of the Department of Public Health, those functions have been transferred from Community Health to Public Health. See O.C.G.A. § 31-7A-2(a); 31-12-1. Accordingly, when you encounter a reportable disease, please make your report to the Department of Public Health and not the Department of Community Health.

The Department of Public Health has designated the Georgia Center for Cancer Statistics (GCCS) at the Rollins School of Public Health as its agent for the purpose of collecting reports on cancer in Georgia. Strict measures are in place at our Department and at the Rollins School to protect the confidentiality of the data in your reports; patient names and other identifiers will not be released.

Information on reporting a diagnosis of cancer to GCCS, including our "Georgia Comprehensive Cancer Registry Policy and Procedure Manual," can be found on our website at:

http://health.state.ga.us/programs/gccr/reporting.asp

Please contact Rana Bayakly at 404-657-2617 if you have any questions or concerns. I greatly appreciate your invaluable help in tracking and fighting cancer in our State.

Sincerely,

Brenda Fitzgerald, MD
Commissioner
State Health Officer

cc: Cherie Drenzek, D.V.M., M.S.
A. Rana Bayakly, M.P.H.
Kevin Ward, Ph.D., M.P.H., CT.R.

Equal Opportunity Employer

DHR

Maria Greene, Acting Commissioner

Georgia Department of Human Resources • Division of Public Health • Kathleen E. Toomey, M.D., M.P.H., Director
2 Peachtree Street NW • Suite 15.470 • Atlanta, Georgia 30303-3142 , 404-657-2700 • FAX: 404-657-2715

March 22, 2004

Dear Colleague:

The President signed the Benign Brain Tumor Cancer Registries Amendment Act in October 2002. This Act became Public Law 107-260. Effective with 2004 diagnosis, this Act requires the collection of benign brain and borderline intracranial and central nervous system tumors by all registries participating in the federal National Program of Cancer Registries (NPCR) of the Centers for disease Control and Prevention. The Georgia Comprehensive Cancer Registry (GCCR) of the Department of Human Resources is a participating registry.

On January 21, 2004, the Georgia Board of Human Resources added the benign brain and central nervous system tumors to the Department's official list of notifiable diseases. All Georgia cases diagnosed as of January 1, 2004, are to be reported to the Georgia Comprehensive Cancer Registry.

Thank you for your cooperation in implementing this new reporting requirement. If you have any questions, please contact Rana Bayakly at (404) 657-1943.

Sincerely,

Kathleen E. Toomey, M.D., M.P.H.
Director
Georgia Division of Public Health

DHR

B. J. Walker, Commissioner

Georgia Department of Human Resources • Division of Public Health • Stuart T. Brown, M.D., Director
2 Peachtree Street NW • Suite 15.470 • Atlanta, Georgia 30303-3142
404-657-2700 • FAX: 404-657-2715

April 26, 2006

Dear Colleague:

Legal authority for the Georgia Department of Human Resources to collect health information is provided in Chapter 12 of the Official Code of Georgia.

Official Code 31-12-1 empowers the Department to "...conduct studies, research, and training appropriate to the prevention of diseases…."

Official Code 31-12-2 allows the Department to declare certain diseases and injuries to be reported in a manner and at such times as may be prescribed. Under this authority, information on persons with cancer is required to be reported to the Department or its designated agent.

As the Director of the Division of Public Health, I am empowered to issue directives to health care providers regarding reporting requirements. This letter is to serve as a written directive requiring the reporting of selected information on patients diagnosed with or treated for cancer in Georgia. Such information must be reported to the Department or our appointed agent. Individuals and agencies required to report include, but are not limited to, all health care providers and facilities located in Georgia, such as the following:

1. Physicians;
2. Hospitals;
3. Laboratories; and
4. Free-standing diagnostic and treatment facilities

Under the provisions of this law, it is not necessary to obtain individual patient consent to allow the Department or its designated agent to collect information on patients with cancer from medical records or related documents for surveillance purposes.

Official Code 31-12-2a addresses the confidentiality of information requested by the Department, and releases from civil liability providers reporting information. Official Code 31-12-2b states that "... all such reports shall be deemed confidential and shall not be open to inspection by the public." Only aggregate reports without name identifiers can be released.

The Department has designated the Georgia Center for Cancer Statistics (GCCS) at the Rollins School of Public Health of Emory University as its designated agent for the purpose of collecting and editing cancer data to help monitor the incidence of cancer throughout Georgia. Strict measures to protect the confidentiality of these documents are in place at both the Department of Human Resources and the Rollins School of Public Health. As documented in the surveillance protocol, patient names and other identifiers will not be released by the Department or the Rollins School of Public Health.

Please contact A. Rana Bayakly at (404) 657-1943 if you have any questions.

Sincerely,

Stuart T. Brown, M.D.
Director

cc: John Horan, M.D., M.P.H.
John Young, Dr.P.H., CTR

Jim Martin, Commissioner
Kathleen E. Toomey, M.D., M.P.H., Division Director

Georgia Department of Human Resources • Division of Public Health • Epidemiology Branch • Chronic Disease, Injury and Environmental Epidemiology Section • Two Peachtree Street, NW • 14th Floor • Atlanta, Georgia 30303-3186

December 3, 2001

F & Lname
CEO/CFO/Administrator
Hospital Name
Address
City, GA zip

Dear Mr/s Lname:

I am writing to provide you with information about the new cancer reporting requirements in the Hospital Participation Agreement you have recently signed with the Georgia Department of Community Health (DCH). The pertinent component of the Agreement is as follows:

> "3.11 Statewide Cancer Registry. Hospital agrees to timely and accurately report to the Georgia Comprehensive Cancer Registry certain information on cancer for patients who receive Hospital Services at the Hospital as required by the Georgia Department of Human Resources, Division of Public Health ("DHR/DPH") pursuant to O.C.G.A. § 31-12-2(a) and as more specifically set forth in the Georgia Comprehensive Cancer Registry Policy and Procedures Manual ("Cancer Registry Manual") issued by DHR/DPH. A copy of the Cancer Registry Manual has been provided to the Hospital by DHR/DPH and is hereby incorporated herein by reference. In the event Hospital fails to meet its obligation to timely and accurately report cases of cancer as required by the Cancer Registry Manual, DCH may, in its sole discretion and in addition to any other remedies under this Agreement, require Hospital to submit a corrective plan of action to DCH which, if approved by DCH, will permit Hospital to become compliant with this provision within a prescribed time period."

In order to comply with the provision of the agreement, the Division of Public Health has arranged with the Department of Community Health for the following reporting procedures:

1. Frequency of reporting: As stated in the Georgia Comprehensive Cancer Registry (GCCR) Policy and Procedures Manual (Section 3, GCCR Cancer Reporting) hospitals are to report monthly to the GCCR. Reports are to be received by the 5th of every month, and a report is required even if there are no cases to report. Beginning January 2002, the names of hospitals which have not reported in at least 2 of the last 3 months will be provided to the DCH.

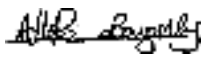
2. Completeness of reporting: As stated in the Manual (Section 3, GCCR Cancer Reporting) hospitals are expected to report cases within 6 months from the date of diagnosis. Beginning July 2002 the names of hospitals which have not reported at least 90% of the expected number of cases for 2000 and 95% of the expected number for 1999 will be provided to the DCH. Please note that in July 2002 hospitals will be provided with six extra months to achieve the goals for completeness of reporting.

Beginning July 2003 the names of hospitals which have not reported at least 90% of the expected number of cases for their hospital for 2001 and 95% of the expected number for 2000 will be provided to DCH.

3. Accuracy of reporting: Beginning January 2003, the names of hospitals from which more than 1% of submitted records were rejected because of multiple errors or errors of vital information will be reported to DCH.

Please contact me at 404-657-1943 if you have any questions about our procedures.

Sincerely,



Rana Bayakly, MPH
Director/Epidemiologist
Georgia Comprehensive Cancer Registry

cc: Kathleen Toomey, Director, Division of Public Health
Carol Steiner, Director, Cancer Control Section
Kathy Driggers, Director of Managed Care, DCH
Clyde Reese, General Counsel, DCH
Gary Redding, Commisioner, DCH
Vi Naylor, Vice President, Georgia Hospital Association

Tommy C. Olmstead, Commissioner
Kathleen E. Toomey, M.D., M.P.H., Division Director

Georgia Department of Human Resources• 2 Peachtree Street, NW• Atlanta, Georgia 30303-3142
Division of Public Health • 2 Peachtree Street, NW • Atlanta, Georgia 30303-3142 • (404) 657-2700

July 10, 1999

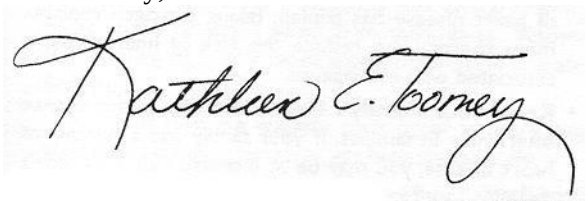
Dear Colleague:

The Centers for Disease Control and Prevention (CDC) is encouraging states participating in the National Program of Cancer Registries (NPCR) to change their method of staging cancers from summary staging to Surveillance, Epidemiology and End Results (SEER) Extent of Disease (EOD). The Georgia Cancer Control Advisory Committee, Cancer Registry Subcommittee, has approved the change. Reporting entities such as physicians, hospitals, laboratories and free-standing diagnostic or treatment facilities shall immediately begin reporting SEER EOD for cases diagnosed as of January 1, 1999.

To differentiate between summary staging and SEER EOD, reporting entities are currently using summary staging, which is also called general staging, to report the staging information to the Georgia Comprehensive Cancer Registry (GCCR). This staging classifies cancer into five categories: In Situ, Localized, Regional, Distant, and Unknown. These categories are so broad that a wide variety of cases are included. Detailed analysis and matching of cancers between cancer programs is limited and sometimes not possible. SEER EOD is for all cancer sites and is based on a combined clinical and operative/pathological assessment. Gross observations at surgery are particularly important when all malignant tissue is not removed. In the event of a discrepancy between pathology and operative reports concerning excised tissue, priority is given to the pathology report.

Thank you for your cooperation in implementing this new reporting requirement. If you have any questions, please contact Rana Bayakly at (404) 657-1943.

Sincerely,



Kathleen E. Toomey, M.D., M.P.H.

CC: James H. Brannon
Carol B. Steiner
John L. Young Jr.

Jim Martin, Commissioner
Kathleen E. Toomey, M.D., M.P.H., Division Director
Georgia Department of Human Resources • Division of Public Health
Two Peachtree Street NW • Suite 15-470 • Atlanta, Georgia 30303-3142 • Tel: (404) 657-2700 • Fax: (404) 657-2715

October 17, 2002

F & Lname
CEO/CFO/Administrator
Hospital Name
Address
City, GA zip

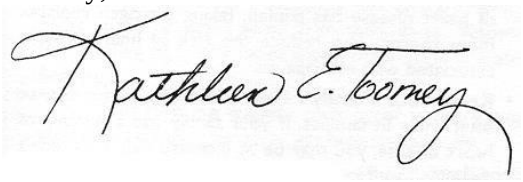
Dear Mr/s Lname:

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) became law April 14, 2001. Although most organizations have until April 14, 2003 to comply, we have already received questions regarding how this new law will affect cancer reporting.

HIPAA regulations will not impact current state cancer reporting procedures. HIPAA allows for the reporting of identifiable cancer data and other reportable conditions to public health entities. Because the Georgia Comprehensive Cancer Registry (GCCR) falls under the definition of a public health entity, HIPAA allows your facility to continue to report data to the GCCR in compliance with state law. Written informed consent from each cancer patient reported to public health entities is not required; rather hospitals must simply document that reporting has occurred. Documentation could be done by keeping a log of the data submitted monthly and keeping a copy of the email/post card sent from the Georgia Center for Cancer Statistics (GCCS) acknowledging receipt of the submission.

Enclosed is a list of frequently asked questions and answers as well as copies of a letter from the legal counsel of the North American Association of Central Cancer Registries (NAACCR) and an academic interpretation of HIPAA from Professor James G. Hodge, Jr., J.D., LL.M., of the Georgetown University Law Center. Please let us know if you have any further questions or concerns. Thank you for your support for our cancer registry program.

Sincerely,



Kathleen E. Toomey, M.D., M.P.H.
Director
Division of Public Health

Enclosures
cc: Name, Medical Record Director

AN EQUAL OPPORTUNITY EMPLOYER

For Georgia Reporting Law and Mandate, please go to:

http://dph.georgia.gov/reporting-cancer

For Public Laws, Cancer Registry Amendment Act please go to:

CDC Cancer Control and Prevention, Cancer Registries Amendment Act

http://www.cdc.gov/cancer/npcr/npcrpdfs/publaw.pdf

Public Law 107-260, Benign Brain Tumor Cancer Registries Amendment Act
http://frwebgate.access.gpo.gov/cgibin/getdoc.cgi?dbname=107_cong_public_laws&docid=f:publ260.107

Georgia Cancer Registry
Reporting Manual

Section 9: Resources and References

GUIDE TO EFFECTIVE DATES: STANDARD REFERENCES, NEW DATA FIELDS AND NEW CODES

International Classification of Diseases for Oncology, ICD-)

books: ICD-O-1, First Edition: 1976 – 1991
ICD-O-2, Second Edition: 1992 – 2000
ICD-O-3, Third Edition: 2001 – 2017
ICD-O-3, Third Edition Histology Revisions 2018
https://www.naaccr.org/2018-implementation/#Histology

SEER Extent of Disease Manuals

(EOD) First Edition: 1988 – 1991
Second Edition: 1992 – 1997
Third Edition: 1998 – 2003
Extent of Disease 2018 General Instructions **https://seer.cancer.gov/tools/staging/**

Collaborative Staging System: 2004 –

CS Version 02.02 effective 2010
CS Version 02.03 effective 2011
CS version 02.04 effective 2012
CS version 02.05 effective 2014 - 2017

Summary Staging

Summary Staging Guide, General Stage, field N760, 1977 – 2000
SEER Summary Staging, Summary Stage 2000, field N759, 2001 – 2003
SEER Summary Stage 2018 Manual **https://seer.cancer.gov/tools/staging/**

SEER Rx Interactive Antineoplastic Drugs Database

Application first available 2005. Link to download application and to sign up for email updates: **https://seer.cancer.gov/tools/seerrx/**

SEER Hematopoietic Project: Hematopoietic and Lymphoid Database

Application for cases diagnoses January 1, 2010 and later. Replaces ICD-O-3 for hematopoietic and lymphoid neoplasms
https://seer.cancer.gov/tools/heme/

Effective Date	Field Name (s)	NAACCR Item Number or Other Comments
2000	Race 2, 3, 4, 5	161, 162, 163, 164
2001	Histology ICD-O-3	522
	Behavior ICD-O-3	523
	Summary Stage 2000	759
2003	RxSumm – Surg Primary Site	1290
	RxSumm – Scope Reg LN Surg	1292
	RxSumm – Surg Oth Reg/Dis	1294
2004	Benign Brain	Behavior code 0 or 1; Sequence number starts at 60
	Collaborative Stage coded EOD 10-digit no longer coded	
2006	Case Finding Source	501
	Primary Payer at Diagnosis	630

	Rx Sum Systemic Surg Seq	1639
2007-2012	Ambiguous Terminology DX	442
	Date Conclusive DX	443
	Mult Tum Rpt as One Primary	444
	Date of Mult Tumors	445
	Multiplicity Counter	446
	Date Conclusive DX Flag	448
	Multiple Primary/Histology Rules	
	Grade Path Value 2010 - 2013	441
	Grade Path System 2010 - 2013	449
2010	Lymphovascular Invasion	1182
	CS Mets at Dx – Bone 2010 - 2015	2851
	CS Mets at Dx – Brain 2010 - 2015	2852
	CS Mets at Dx – Liver 2010 - 2015	2853
	CS Mets at Dx – Lung 2010 - 2015	2854
	Laterality code 5 added Midline tumor	410
	Race Code 15 added	Code 15: Asian Indian or Pakistani
	Race Code 16 added	Code 16: Asian Indian
	Race Code 17 added	Code 17: Pakistani
2016	Tumor Size Clinical	752
	Tumor Size Pathologic	754
	Tumor Size Summary	756
	Mets at DX-Bone	1112
	Mets at DX-Brain	1113
	Mets at DX-Distant LN	1114
	Mets at DX-Liver	1115
	Mets at DX-Lung	1116
	Mets at DX-Other	1117
2018	Collaborative Stage no longer coded	
	ICD-O-3 histology and behavior update	
	2018 Solid Tumor Coding Rules and SEER Hematopoietic Database update	
	Date Reg Lymph Node Dissection and Flag	682, 683
	Summary Stage 2018	764
	EOD Primary Tumor, Reg Nodes and Mets	772, 774, 776
	Date of Sentinel Lymph Node Biopsy and Flag (Breast and Skin Melanoma)	832, 833
	Sentinel Lymph Nodes Pos and Examined	835, 834
	Phase I – Phase III Radiation fields	1501 - 1533
	SEER Site-Specific Factor 1	3700
	Site-Specific Data Items (SSDIs), includes Grade Clinical, Grade Pathological and Grade Post Therapy	3800 - 3937

USEFUL REFERENCES FOR CANCER REGISTRARS: RESOURCE LIST

1. Anatomy book
2. Medical dictionary
3. AJCC Manual for Staging of Cancer - current edition
4. SEER Self Instructional Manuals (1-5, and 7)
5. American Cancer Society Textbook of Clinical Oncology
6. Physician's Desk Reference or other drug reference book, current edition
7. Cancer Registry Management Principles and Practice, *Carol L. Hutchison, Steven D. Roffers, April G. Fritz.*

8. **SEER Self Instructional Manuals (Book 1 – Book 8) for Tumor Registrars:**
To download manuals go to *http://seer.cancer.gov/training/manuals/*

Book 1 - Objectives and Functions of a Tumor Registry (1999) Self-instructional Manual, describes the functions, objectives, activities required to run a tumor registry, and the various portions of a registry. (e.g. describes the various record systems required to run a registry accession file, case file, follow-up cards).

Book 2 - Cancer Characteristics and Selection of Cases (1991) Self-instructional Manual, provides instruction in the terminology associated with cancer. Brief description of the natural history of the major cancer types. Introduces the use of ICD-O.

Book 3 - Tumor Registrar Vocabulary: The Composition of Medical Terms (1992) Self-instructional Manual, medical terminology.

Book 4 - Human Anatomy as Related to Tumor Formation (1995) Self-instructional Manual, introduction to human anatomy and neoplasm(s) associated with each body system.

Book 5 - Abstracting Medical Record: Patient Identification, History, and Examinations (1993) Self-instructional Manual, describes the medical record, how to locate and record the information related to a cancer registry (abstract case information).

Book 6 - Out of print, substitute: Summary Staging Guide (1977) Provides anatomical diagrams and rules for determining localized, regional and distant stage for major cancer sites.

Book 7 - Statistics and Epidemiology for Cancer Registries (1994) Self-instructional Manual, introduces tumor registrar to the statistics required to run a registry: includes discussion of incidence, mortality, and survival.

Book 8 – Antineoplastic Drugs (Third Edition, 1993) See SEER*Rx - Interactive Antineoplastic Drugs Database, which was developed to replace Book 8 as an annually updated list of oncology drug and regimen treatment categories.

STUDY GUIDES FOR THE CERTIFIED TUMOR REGISTRAR'S EXAMINATION:

CTR Workshops by NCRA. Go to http://www.ncra-usa.org. Then select Education, CTR Exam Prep Resources for current workshop dates and location.

North American Association of Central Cancer Registries (NAACCR)
2050 W. Iles, Suite A
Springfield, IL 62704-4194
Phone : 217-698-0800
Fax: 271-698-0188
http://www.naaccr.org/
Click on Education and Training Tab to obtain CTR Prep & Review Webinar Series dates and registration forms.

INTERNET SITES OF INTEREST FOR INFORMATION

AJCC COC Cancer Forum AJCC COC Cancer Forum: **http://cancerbulletin.facs.org/forums/**

American Cancer Society: Cancer statistics, information, research and community activities
http://www.cancer.org/docroot/home/index.asp

American College of Surgeons (ACOS): **www.facs.org**

Brain and Neurosurgery Information Center: **http://www.brain-surgery.com**

Brain Tumor Foundation: **http://www.braintumorfoundation.org/**

Brain Tumor Guide: **http://virtualtrials.com/faq/**

Cancer Quest: Information on cancer biology, treatment and a lot more: **www.cancerquest.org**

Central Brain Tumor Registry of the US: **www.cbtrus.org**

Collaborative Stage Data Collection System: latest version CS coding manual Part I & II, other information:
http://www.cancerstaging.org/cstage/

FFIEC County Look Up: **http://www.ffiec.gov/Geocode/default.aspx**

GA Center for Cancer Statistics (GCCS): **http://web1.sph.emory.edu/GCCS/cms/index.html**

GCCS NAACCR Webinars: **https://cfusion.sph.emory.edu/hospitalinfo/NAACCR_Webinar/login.cfm**

GCCS Cancer Data Request: **https://cfusion.sph.emory.edu/hospitalinfo/DataUpload/datarequest.cfm**

Georgia Composite Medical Board: **https://services.georgia.gov/dch/mebs/jsp/index.jsp**

GA Comprehensive Cancer Registry (GCCR): http://dph.georgia.gov/reporting-cancer

GA Tumor Registrar's Association (GATRA): www.gatraweb.org

National Cancer Institute (NCI): Cancer information, research, cancer statistics and resources. http://www.cancer.gov

National Cancer Registrar's Association (NCRA): www.ncra-usa.org

National Comprehensive Cancer Network (NCCN): https://www.nccn.org/professionals/physician_gls/default.aspx

National Library of Medicine: www.nlm.nih.gov

National Program Cancer Registries (NPCR): http://www.cdc.gov/cancer/npcr/

North American Association of Central Cancer Registries (NAACCR): www.naaccr.org

NPI Registry Search:
https://nppes.cms.hhs.gov/NPPES/NPIRegistrySearch.do?subAction=reset&searchType=ind

Online ICD-9 codes: http://icd9cm.chrisendres.com/index.php?action=child&recordid=1184

Online ICD-10 codes: http://www.icd10data.com/

SEER Training: https://seer.cancer.gov/training/

SEER*Educate https://seer.cancer.gov/training/

Zip Code Look Up: look up zip and county w known address, or know zip and find city and county
http://www.zipinfo.com/search/zipcode.htm

Region 1 Cancer Registry Coordinator

LeRue Perry, CTR
North Region Coordinator
284 First St
Statham GA 30666

Phone/Fax: 770-725-6258
Cellular: 706-983-2676
Email: LeRue.Perry@dph.ga.gov

Facility Name	County	Health District
AdventHealth Gordon	Gordon	Northwest (Rome) Health District (1-1)
AdventHealth Murray	Murray	North Georgia (Dalton) Health District (1-2)
Cartersville Medical Center	Bartow	Northwest (Rome) Health District (1-1)
Chatuge Regional Hospital	Towns	North (Gainesville) Health District (2-0)
CHI Memorial (formerly Hutcheson)	Catoosa	Northwest (Rome) Health District (2-0)
Elbert Memorial Hospital	Elbert	Northeast (Athens) Health District (10-0)
Fannin Regional Hospital	Fannin	North Georgia (Dalton) Health District (1-2)
Floyd Medical Center	Floyd	Northwest (Rome) Health District (1-1)
Habersham County Medical Center	Habersham	North (Gainesville) Health District (2-0)
Hamilton Medical Center	Whitfield	North Georgia (Dalton) Health District (1-2)
Harbin Clinic	Floyd	Northwest (Rome) Health District (1-1)
Mountain Lakes Medical Center	Rabun	North (Gainesville) Health District (2-0)
Northeast Georgia Medical Center, Inc.	Hall	North (Gainesville) Health District (2-0)
Northeast Georgia Medical Center Barrow (previously Barrow Regional)	Barrow	Northeast (Athens) Health District (10-0)
Northridge Medical Center	Jackson	Northeast (Athens) health District (10-0)
Northside Hospital – Cherokee (reports through Metro region: Contact Metro Reg Coord)	Cherokee	North Georgia (Dalton) Health District (1-2)
Northside Hospital – Forsyth (reports through Metro region: Contact Metro Reg Coord)	Forsyth	North (Gainesville) Health District (2-0)
Piedmont Athens Regional Medical Center	Clarke	Northeast (Athens) Health District (10-0)
Piedmont Mountainside Hospital	Pickens	North Georgia (Dalton) Health District (1-2)
Piedmont Walton (previously Clearview Medical Center)	Walton	Northeast (Athens) Health District (10-0_
Polk Medical Center	Polk	Northwest (Rome) Health District (1-1)
Redmond Regional Medical Center	Floyd	Northwest (Rome) Health District (1-1)
Saint Mary's Health Care System, Inc.	Clarke	Northeast (Athens) Health District (10-0)
Saint Mary's Good Samaritan Hospital	Greene	Northeast (Athens) Health District (10-0)
Saint Mary's Sacred Heart (formerly TyCobb)	Franklin	North (Gainesville Health District (2-0)
Stephens County Hospital	Stephens	North (Gainesville Health District (2-0)
Tanner Health System – Higgins General Hospital (reports through Central region: Contact Central Regional Coord)	Rabun	Northwest (Rome) Health District (1-1)
Union General Hospital	Union	North (Gainesville) Health District (2-0)
Vantage Oncology @ Blairsville	Union	North (Gainesville) Health District (2-0)
Wildwood Lifestyle Center and Hospital	Dade	Northwest (Rome) Health District (1-1)

Region 2 Cancer Registry Coordinator

Robin Billet, MA, CTR
Georgia Center for Cancer Statistics
1518 Clifton Road NE
Atlanta, GA 30322

Phone: 404-727-8694
Cell: 678- 438-2584
Fax: 404-727-7261
Email: rbillet@emory.edu

Facility Name	County	Health District
Atlanta Oncology Associates – Atlanta Medical Center	Fulton	Fulton Health District (3-2)
Children's Healthcare of Atlanta	Fulton	Fulton Health District (3-2)
Eastside Medical Center	Gwinnett	East Metro (Lawrenceville) Health District (3-4)
Emory Decatur Hospital	DeKalb	DeKalb Health District (3-5)
Emory Hillandale Hospital	DeKalb	DeKalb Health District (3-5)
Emory John's Creek Hospital	Fulton	Fulton Health District (3-5)
Emory Saint Joseph's Hospital Atlanta	Fulton	Fulton Health District (3-5)
Emory University Hospital	DeKalb	DeKalb Health District (3-5)
Emory University Midtown Hospital	Fulton	Fulton Health District (3-5)
Grady Health System	Fulton	Fulton Health District (3-5)
Gwinnett Health System	Gwinnett	East Metro (Lawrenceville) Health District (3-4)
Kaiser Permanente Network	Fulton	Fulton Health District (3-5)
Northside Hospitals	Fulton	Fulton Health District (3-5)
Piedmont Hospital	Fulton	Fulton Health District (3-5)
Piedmont Newton Hospital	Newton	East Metro ((Lawrenceville) Health District (3-4)
Piedmont Rockdale Hospital	Rockdale	East Metro (Lawrenceville) Health District (3-4)
Piedmont Radiation Oncology Services	Clayton	Clayton (Morrow) Health District (3-3)
Southern Regional Medical Center	Clayton	Clayton (Morrow) Health District (3-3)
VA Medical Center Atlanta	DeKalb	DeKalb Health District (3-5)
Vantage Oncology	DeKalb	
Vantage Oncology Cancer Center at Lawrenceville	Gwinnett	East Metro (Lawrenceville) Health District (3-4)
Wellstar Atlanta Medical Center Main	Fulton	Fulton Health District (3-5)
Wellstar Atlanta Medical Center South	Fulton	Fulton Health District (3-5)
Wellstar Health System - Cobb	Cobb	Cobb/Douglas Health District (3-1)
Wellstar Health System - Douglas	Douglas	Cobb/Douglas Health District (3-1)
Wellstar Health System - Kennestone	Cobb	Cobb/Douglas Health District (3-1)
Wellstar Health System - North Fulton Hospital	Fulton	Fulton Health District (3-5)
Wellstar Health System - Paulding	Paulding	Cobb/Douglas Health District (3-1)
Wellstar Health System – Windy Hill	Cobb	Cobb/Douglas Health District (3-1)

Region 3 Registry Coordinator

Debbie Chambers, CTR
North Central Georgia Health District
950 Ousley Place
Macon, GA 31210

Phone: 478-319-3450
Fax: 478-599-9833
Cell: 478-319-3450
Email: Debbie.Chambers@dph.ga.gov

Facility Name	County	Health District
Augusta State Medical Prison	Richmond	East Central (Augusta) Health District (6-0)
Augusta University Medical Center	Richmond	East Central (Augusta) Health District (6-0)
Coliseum Health System	Bibb	North Central (Macon) Health District (5-2)
Coliseum Northside Hospital	Bibb	North Central (Macon) Health District (5-2)
Crisp Regional Hospital	Crisp	West Central (Columbus) Health District (7-0)
CTCA at Southeastern Regional Medical Ctr	Coweta	LaGrange Health District (4-0)
Doctor's Hospital – Augusta	Richmond	East Central (Augusta) Health District (6-0)
Donalsonville Hospital	Seminole	Southwest (Albany) Health District (8-2)
Dwight D. Eisenhower Army Medical Center	Richmond	East Central (Augusta) Health District (6-0)
Houston Medical Center	Houston	North Central (Macon) Health District (5-2)
Jasper Memorial Hospital	Jasper	North Central (Macon) Health District (5-2)
Lifebrite Community Hospital of Early County	Early	Southwest (Albany) Health District (8-2)
Medical Center - Navicent Health	Bibb	North Central (Macon) Health District (5-2)
Medical Center Peach County – Navicent Health	Peach	North Central (Macon) Health District (5-2)
Memorial Hospital and Manor	Decatur	Southwest (Albany) Health District (8-2)
Monroe County Hospital	Monroe	North Central (Macon) Health District (5-2)
Morgan Memorial Hospital	Morgan	Northeast (Athens) Health District (10)
Navicent Health Baldwin	Baldwin	North Central (Macon) Health District (5-2)
Perry Hospital	Houston	North Central (Macon) Health District (5-2)
Phoebe Putney Memorial Hospital	Dougherty	Southwest (Albany) Health District (8-2)
Phoebe Sumter Medical Center	Sumter	West Central (Columbus) health District (7-0)
Piedmont Columbus Regional - Midtown	Muscogee	West Central (Columbus) Health District (7-0)
Piedmont Fayette Hospital	Fayette	LaGrange Health District (4-0)
Piedmont Henry Hospital	Henry	LaGrange Health District (4-0)
Piedmont Newnan Hospital	Coweta	LaGrange Health District (4-0)
Putnam General Hospital	Putnam	North Central (Macon) Health District (5-2)
Saint Francis Hospital	Muscogee	West Central (Columbus) Health District (7-0)
Southwest Georgia Regional Medical Center	Randolph	West Central (Columbus) Health District (7-0)
Tanner Health System	Carroll	LaGrange Health District (4-0)
Tanner Medical Center/Carrollton	Carroll	LaGrange Health District (4-0)
University Hospital	Richmond	East Central (Augusta) Health District (6-0)
Upson Regional Medical Center	Upson	LaGrange Health District (4-0)
VA Medical Center Augusta	Richmond	East Central (Augusta) Health District (6-0)
Warm Springs Medical Center	Meriwether	LaGrange Health District (4-0)
Washington County Regional Medical Center	Washington	Northeast (Athens) Health District (5-2)
Wellstar Spalding Regional Hospital	Spalding	LaGrange Health District (4-0)
Wellstar West Georgia Health System	Troup	LaGrange Health District (4-0)
Wills Memorial	Wilkes	East Central (Augusta) Health District (6-0)

Region 4 Cancer Registry Coordinator

Sheree Holloway, RN, CTR Cell: 912-663-8721

Southeast Georgia Health District Email: Sheree.Holloway@dph.ga.gov
16 Commodore Court Savannah, GA 31410

Facility Name	County	Health District
Appling Health Care System	Camden	Southeast (Waycross) Health District (9-2)
Bacon County Health Services	Glynn	Southeast (Waycross) health District (9-2)
Bleckley Memorial Hospital	Bleckley	South Central (Dublin) Health District (5-1)
Brooks County	Brooks	Southeast (Waycross) Health District (9-2)
Burke Medical Center	Burke	East Central (Augusta) Health District (6-0)
Candler County Hospital	Candler	South Central (Dublin) Health District (5/1)
Clinch Memorial Hospital	Clinch	Southeast (Waycross) Health District (9-2)
Coffee Regional Medical Center	Coffee	Southeast (Waycross) Health District (9-2)
Colquitt Regional Medical Center	Colquitt	Southeast (Waycross) Health District (9-2)
Cook Medical	Cook	South (Valdosta) health District (8-1)
Dodge County Hospital	Dodge	South Central (Dublin) health District (5-1)
Dorminy Medical	Ben Hill	South (Valdosta) health District (8-1)
East Georgia Regional Medical Center	Bulloch	Southeast (Waycross) Health District (9-2)
Effingham Health System	Effingham	East (Savannah) Health District (9-1)
Emanuel Medical Center	Emanuel	East Central (Augusta) health District (6-0)
Evans Memorial Hospital	Evans	Southeast (Waycross) Health District (9-2)
Fairview Park Hospital	Laurens	South Central (Dublin) Health District (5-1)
Grady General	Grady	Southeast (Waycross) Health District (9-2)
Irwin County	Irwin	Southeast (Waycross) Health District (9-2)
Jeff Davis Hospital	Jeff Davis	Southeast (Waycross) Health District (9-2)
Jefferson County Hospital	Jefferson	East Central (Augusta) Health District (6-0)
Jenkins Hospital	Jenkins	East Central (Augusta) Health District (6-0)
John D. Archbold Memorial Hospital	Thomas	Southeast (Waycross) Health District (9-2)
Liberty Regional Medical Center	Liberty	East (Savannah) Health District (9-1)
Meadows Regional Medical Center	Toombs	Southeast (Waycross) Health District (9-2)
Memorial Health UMC	Chatham	East (Savannah) Health District (9-1)
Memorial Satilla Health	Ware	Southeast (Waycross) Health District (9-2)
Miller County	Miller	Southwest (Albany) Health District (8-2)
Mitchell County	Mitchell	Southwest (Albany) Health District (8-2)
Optim Medical Center - Screven	Screven	East Central (Augusta) Health District (6-0)
Optim Medical - Tattnall	Tattnall	Southeast (Waycross) Health District (9-2)
Phoebe Worth Medical Center	Worth	Southwest (Albany) Health District (8-2)
Saint Joseph Candler Health Systems	Chatham	East (Savannah) Health District 9-1)
Southeast GA Health Sys-Brunswick Campus	Glynn	East (Savannah) Health District 9-1)
Southeast GA Health Sys-Camden Campus	Camden	East (Savannah) Health District 9-1)
South Georgia Medical Center	Lowndes	South (Valdosta) Health District (8-1)
Taylor Regional Hospital	Pulaski	South Central (Dublin) Health District (5-1)
Tift Regional Medical Center	Tift	South (Valdosta) Health District (8-1)
VA Medical Center Dublin	Laurens	South Central (Dublin) Health District (5-1)
Wayne Memorial Hospital	Wayne	Southeast (Waycross) Health District (9-2)
Winn Army Community Hospital	Liberty	East (Savannah) Health District 9-1)

GEORGIA CANCER REGISTRY DATA SUBMISSION WEB PAGE

‘

Georgia Comprehensive Cancer Registry Web Page
http://www.sph.emory.edu/GCCS/GaHospitals.php
Features of each link:

- Application Downloads Page – facility number and password needed for access
    1. Abstract Plus System - free software for cancer abstracting
    2. Incidental Update Form - form to provide updated data on previously submitted abstracts
    3. Advanced Encryption Package 2012 Professional – Software for encrypting confidential data
    4. Georgia Hospital Edits - Software application for running Georgia's State specific edits

- Monthly Submission Data Upload -facility number and password needed for access. You can upload your monthly data thru our secure web site

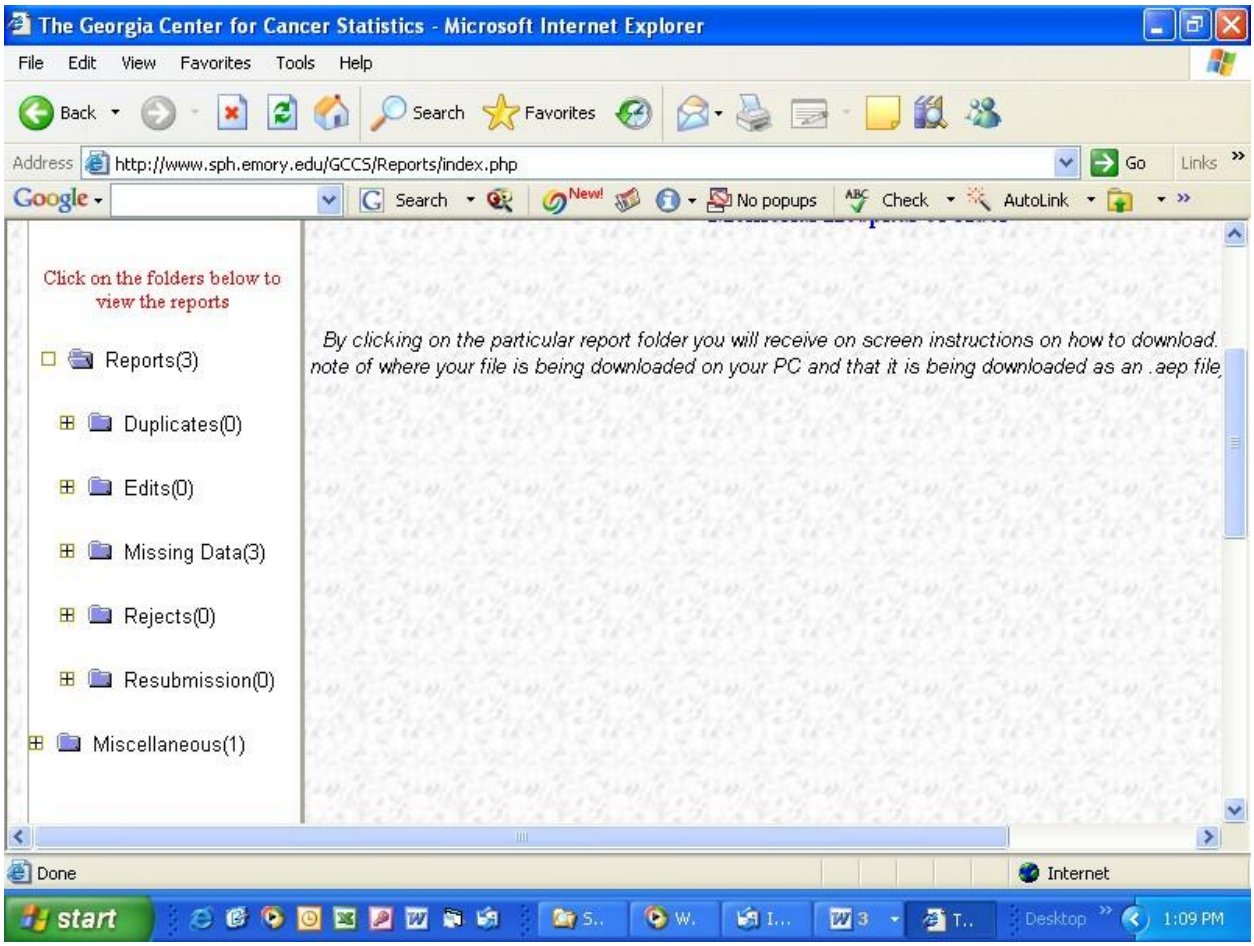
- Monthly Submission Reports – facility number and password needed for access. You can download copies of submission receipts for each monthly submission up to a year’s worth of data.

- Facility Contact Information - facility number and password needed for access
    1. Update Facility Information
    2. View Facility Information
    3. Update Facility Password
    4. Facility Name Change

Accessing Monthly Submission Reports on GCR web site

http://web1.sph.emory.edu/GCCS/cms/reporting/index.html

You can now access via our secured web site your monthly submission reports. All reports are encrypted. You will need your facility number and password in order to access your reports as well as the encryption software. Enter facility number and password.



The folders to the left of your screen show the five types of reports that are generated with each submission. You must click on the folder icon to open a particular folder. Below is a description of each folder and the reports that are found within. You can refer to each folder for more information regarding each report.

Edits - Report is generated if there are edit errors within a particular monthly submission.

Rejects - Report shows a summary of the abstracts submitted, accepted, rejected, and duplicate abstracts.

Resubmissions - Report showing your resubmission progress for rejected/edit error reports

Some reports are named using the naming conventions that have been established i.e. 380000May04_1HOS***.PDF.AEP. Refer to section 2 page 5 of this Manual.

PDF—Portable Document Format uses Adobe Acrobat Reader to view.

AEP = Advanced Encryption Program format (File is encrypted and must be decrypted in order to be viewed).

Once you open a particular folder you can download any or all reports found within the folder. By clicking on the particular report you will receive on screen instructions on how to download. (Be sure you make note of where your file is being downloaded on your PC and that it is being downloaded as an .aep file)

*** = See specific report folders for explanation.

Georgia Cancer Registry
Reporting Manual

Section 10: GA County Codes

County	FIPS Code		County	FIPS Code		County	FIPS Code
Appling	001		Evans	109		Newton	217
Atkinson	003		Fannin	111		Oconee	219
Bacon	005		Fayette	113		Oglethorpe	221
Baker	007		Floyd	115		Paulding	223
Baldwin	009		Forsyth	117		Peach	225
Banks	011		Franklin	119		Pickens	227
Barrow	013		Fulton	121		Pierce	229
Bartow	015		Gilmer	123		Pike	231
Ben Hill	017		Glascock	125		Polk	233
Berrien	019		Glynn	127		Pulaski	235
Bibb	021		Gordon	129		Putnam	237
Bleckley	023		Grady	131		Quitman	239
Brantley	025		Greene	133		Rabun	241
Brooks	027		Gwinnett	135		Randolph	243
Bryan	029		Habersham	137		Richmond	245
Bulloch	031		Hall	139		Rockdale	247
Burke	033		Hancock	141		Schley	249
Butts	035		Haralson	143		Screven	251
Calhoun	037		Harris	145		Seminole	253
Camden	039		Hart	147		Spalding	255
Candler	043		Heard	149		Stephens	257
Carroll	045		Henry	151		Stewart	259
Catoosa	047		Houston	153		Sumter	261
Charlton	049		Irwin	155		Talbot	263
Chatham	051		Jackson	157		Taliaferro	265
Chattahoochee	053		Jasper	159		Tattnall	267
Chattooga	055		Jeff Davis	161		Taylor	269
Cherokee	057		Jefferson	163		Telfair	271
Clarke	059		Jenkins	165		Terrell	273
Clay	061		Johnson	167		Thomas	275
Clayton	063		Jones	169		Tift	277
Clinch	065		Lamar	171		Toombs	279
Cobb	067		Lanier	173		Towns	281
Coffee	069		Laurens	175		Treutlen	283
Colquitt	071		Lee	177		Troup	285
Columbia	073		Liberty	179		Turner	287
Cook	075		Lincoln	181		Twiggs	289
Coweta	077		Long	183		Union	291
Crawford	079		Lowndes	185		Upson	293
Crisp	081		Lumpkin	187		Walker	295
Dade	083		McDuffie	189		Walton	297
Dawson	085		McIntosh	191		Ware	299
Decatur	087		Macon	193		Warren	301
DeKalb	089		Madison	195		Washington	303
Dodge	091		Marion	197		Wayne	305
Dooly	093		Meriwether	199		Webster	307
Dougherty	095		Miller	201		Wheeler	309
Douglas	097		Mitchell	205		White	311
Early	099		Monroe	207		Whitfield	313
Echols	101		Montgomery	209		Wilcox	315
Effingham	103		Morgan	211		Wilkes	317
Elbert	105		Murray	213		Wilkinson	319
Emanuel	107		Muscogee	215		Worth	321

For US Zip Codes go to: http://www.usps.com/zip4

Georgia Cancer Registry
Reporting Manual

Section 11: ABSTRACTING GUIDE

ABSTRACT PLUS USERS ONLY

Abstract Plus is an abstracting tool used to summarize the medical record into an electronic report of cancer diagnosis and treatment. This software was developed by the Centers for Disease Control and Prevention (CDC) in support of CDC's National Program of Cancer Registries (NPCR).

A customized version of Abstract Plus for Georgia state reporting and accompanying Help documents are available in the Abstract Plus section of the Georgia Center for Cancer Statistics (GCCS) web site at the Application Download link:

http://web1.sph.emory.edu/GCCS/cms/reporting/index.html

New users of Abstract Plus should contact their Regional Coordinator or GCR at gccs@sph.emory.edu for assistance with installation and use of Abstract Plus.

Abstract Plus users reporting changes, deletions or updates to cases should complete and submit the incidental form “GCR Incidental Updates”, on the following page. A printed copy of the hospital abstract may be sent; highlighting the fields that have been changed, deleted and/or updated. Submit this information via fax or email electronically (encrypted) to the above address. It is important to notify the GCR of any changes in your database so that GCR can maintain an up-to-date registry.

GCR Incidental Updates

Facility Name/Number:_____Submitted to state: _____

Pt Last name, First name MI	DOB	SSN	Tum Seq	Field Name	Old Value	New Value (include date if applicable)

APPENDIX G

RECOMMENDED ABBREVIATIONS FOR ABSTRACTORS

The use of abbreviations in cancer abstraction is becoming more commonplace as the demands on abstractors increase. Abbreviations often are used by cancer abstractors to shorten the written narratives entered into text fields to facilitate the electronic storage and transmission of the information. However, abbreviations can generate confusion, because abbreviations may vary among different institutions and even between different specialties within the same institution. To be useful, an abbreviation must be clearly understood by any individual who encounters it. Consequently, the use of abbreviations is a useful abstracting practice only if universally recognized and understood abbreviations are used.

The NAACCR Recommended Abbreviations Listings were developed for utilization by cancer report abstractors and the agencies to which they submit their data. These lists were compiled to reduce some of the confusion that can result from the use of common and not-so-common abbreviations when abstracting reports of cancer from the medical record. Although the lists may shed some light on abbreviations used in the medical record, please note that these lists are intended to be used as a primary reference by the cancer abstractor, to help abstract necessary information into a limited number of text fields for storage and transmission of cancer information.

The NAACCR Recommended Abbreviations Listings consist of two main lists of almost 500 word/terms and their recommended abbreviations/symbols, as well as a special table delineating context-sensitive abbreviations. The first main listing is ordered by word/term to enable the look-up of a recommended abbreviation for a particular word or term, and the second main listing is ordered by abbreviation/symbol to enable the look-up of the word or term for a particular abbreviation or symbol. The context-sensitive abbreviations list consists of a subset of the abbreviations from the main lists where a different context for the same abbreviation conveys a different meaning (for example, CA may mean calcium or carcinoma/ML may mean milliliter or middle lobe). For these context-sensitive abbreviations, the meaning of the abbreviation should be readily apparent from the context in which it is used.

The listings were compiled from abbreviation lists from SEER Book 3, the NAACCR Pathology Committee, the Veterans Administration, Dr. Jay Piccirillo's comorbid conditions training materials, the Florida Cancer Data System, and the California Cancer Registry. Terms included in the lists are limited to those that are commonly utilized when abstracting cancer information. The listings are not exhaustive, but many of the most commonly used terms were included. Abbreviations for chemotherapy drugs and/or regimens are not included. Please note that although abbreviations are presented in uppercase, either upper- or lowercase may be utilized when entering abbreviations within abstraction software. When abstracting into text fields, the use of abbreviations should be limited to those that appear on these lists whenever practical. Abbreviations and symbols should be used carefully. Any questions or suggestions for new/modified abbreviations may be e-mailed to either of the current Chairpersons of the NAACCR Registry Operations Committee.

NAACCR RECOMMENDED ABBREVIATION LIST
ORDERED BY WORD/TERM(S)

WORD/TERM(S)	ABBREVIATION/SYMBOL
Abdomen (abdominal)	ABD
Abdominal perineal	AP
Abnormal	ABN
Above	^
Above knee (amputation)	AK(A)
Absent/Absence	ABS
Abstract/Abstracted	ABST
Achilles tendon reflex	ATR
Acid phosphatase	ACID PHOS
Acquired Immune Deficiency Syndrome	AIDS
Activities of daily living	ADL
Acute granulocytic leukemia	AGL
Acute lymphocytic leukemia	ALL
Acute myelogenous leukemia	AML
Acute myocardial infarction	AMI
Acute Respiratory Distress (Disease) Syndrome	ARDS
Acute tubular necrosis	ATN
Acute renal failure	ARF
Adenocarcinoma	ADENOCA
Adenosine triphosphate	ATP
Adjacent	ADJ
Adult-onset Diabetes Mellitus	AODM
Admission/Admit	ADM
Adrenal cortical hormone	ACH
Adrenal cortex	AC
Adrenocorticotrophic hormone	ACTH
Affirmative	AFF
Against medical advice	AMA
AIDS-related condition (complex)	ARC
AIDS-related disease	ARD
Air contrast barium enema	ACBE
Albumin	ALB
Alcohol	ETOH
Alkaline phosphatase	ALK PHOS
Alpha-fetoprotein	AFP
Also known as	AKA
Ambulatory	AMB
Amount	AMT
Amputation	AMP
Amyotrophic lateral sclerosis	ALS
Anal intraepithelial neoplasia, grade III	AIN III
Anaplastic	ANAP

WORD/TERM(S)	ABBREVIATION/SYMBOL
And	&
Angiography/Angiogram	ANGIO
Anterior	ANT
Anteroposterior	AP
Antidiuretic hormone	ADH
Antigen	AG
Aortic stenosis	A-STEN
Appendix	APP
Apparently	APPL'Y
Approximately	APPROX
Arrhythmia	ARRHY
Arterial blood gases	ABG
Arteriosclerotic cardiovascular disease	ASCVD
Arteriosclerotic heart disease	ASHD
Arteriosclerotic Peripheral Vascular Disease	ASPVD
Arteriosclerosis/Arteriosclerotic	AS
Arteriovenous	AV
Arteriovenous malformation	AVM
Artery (ial)	ART
Ascending colon	A-COLON
Aspiration	ASP
Aspirin, Acetylsalicylic acid	ASA
As soon as possible	ASAP
At	@
Atrial fibrillation	A FIB
Atrial flutter	A FLUTTER
Atrial stenosis/insufficiency/incompetence	AI
Atrial premature complexes	APC
Auscultation & percussion	A&P
Autonomic nervous system	ANS
Autopsy	AUT
Autoimmune hemolytic anemia	AIHA
Average	AVG
Axilla(ry)	AX
Bacillus Calmette-Guerin	BCG
Barium	BA
Barium enema	BE
Bartholin's, Urethral & Skene's	BUS
Basal cell carcinoma	BCC
Before noon	AM
Below knee (amputation)	BK(A)
Benign prostatic hypertrophy/hyperplasia	BPH
Bilateral	BIL
Bilateral salpingo-oophorectomy	BSO

WORD/TERM(S)	ABBREVIATION/SYMBOL
Bile duct	BD
Biological response modifier	BRM
Biopsy	BX
Bipolar affective disorder	BAD
Black female	B/F
Black male	B/M
Bladder tumor	BT
Blood pressure	BP
Blood urea nitrogen	BUN
Blood volume	BV
Bone marrow	BM
Bone marrow transplant	BMT
Bowel movement	BM
Brother	BRO
Calcium	CA
Capsule (s)	CAP(S)
Carcinoembryonic antigen	CEA
Carcinoma	CA
Carcinoma *in situ*	CIS
Cardiovascular disease	CVD
CAT/CT scan/Computerized axial tomography	CT
Centimeter	CM
Central nervous system	CNS
Cerebrospinal fluid	CSF
Cerebrovascular accident	CVA
Cervical intraepithelial neoplasia	CIN
Cervical intraepithelial neoplasia, grade III	CIN III
Cervical vertebrae	C1-C7
Cervical spine	C-SPINE
Change	CHG
Chemotherapy	CHEMO
Chest X-ray	CXR
Chronic	CHR
Chronic granulocytic leukemia	CGL
Chronic lymphocytic leukemia	CLL
Chronic myeloid (myelocytic) leukemia	CML
Chronic obstructive lung disease	COLD
Chronic obstructive pulmonary disease	COPD
Chronic renal failure	CRF
Chronic ulcerative colitis	CUC
Cigarettes	CIG
Clear	CLR
Cobalt 60	CO60
Collaborative stage	CS

WORD/TERM(S)	ABBREVIATION/SYMBOL
Colon, Ascending	A-COLON
Colon, Descending	D-COLON
Colon, Sigmoid	SIG COLON
Colon, Transverse	TRANS-COLON
Colony-stimulating factor	C-SF
Complaint (-ning) of	C/O
Complete blood count	CBC
Congenital heart disease	CHD
Congestive heart failure	CHF
Consistent with	C/W
Continue/continuous	CONT
Contralateral	CONTRA
Coronary artery bypass graft	CABG
Coronary artery disease	CAD
Coronary care unit	CCU
Cubic centimeter	CC
Cystoscopy	CYSTO
Cytology	CYTO
Cystic fibrosis	CF
Date of birth	DOB
Date of death	DOD
Dead on arrival	DOA
Decrease(d)	DECR
Deep tendon reflex	DTR
Deep vein thrombosis	DVT
Deoxyribonucleic acid	DNA
Descending colon	D-COLON
Dermatology	DERM
Diabetes mellitus	DM
Diagnosis	DX
Diameter	DIAM
Diethylstilbestrol	DES
Differentiated/differential	DIFF
Digital rectal examination	DRE
Dilatation and curettage	D&C
Discharge	DISCH
Discontinue(d)	DC
Disease	DZ
Disseminated intravascular coagulopathy	DIC
Ductal carcinoma *in situ*	DCIS
Dyspnea on exertion	DOE
Ears, nose, and throat	ENT
Electrocardiogram	ECG/EKG

WORD/TERM(S)	ABBREVIATION/SYMBOL
Electroencephalogram	EEG
Electromyogram	EMG
Emergency room	ER
Endoscopic retrograde cholangiopancreatography	ERCP
End stage renal disease	ESRD
Enlarged	ENLGD
Equal(s)	=
Esophagogastro-duodenoscopy	EGD
Estrogen receptor (assay)	ER, ERA
Evaluation	EVAL
Every	Q
Every day	QD
Examination	EXAM
Excision/excised	EXC(D)
Expired	EXP
Exploratory	EXPL
Exploratory laparotomy	EXPL LAP
Extend/extension	EXT
Fever of unknown origin	FUO
Fine needle aspiration	FNA
Fine needle aspiration biopsy	FNAB
Floor of mouth	FOM
Fluid	FL
Fluoroscopy	FLURO
Follow-up	FU
For example	E.G.
Fracture	FX
Frequent/Frequency	FREQ
Frozen section	FS
Full thickness skin graft	FTSG
Gallbladder	GB
Gastroesophageal	GE
Gastroesophageal reflux disease	GERD
Gastrointestinal	GI
General/Generalized	GEN
Genitourinary	GU
Grade	GR
Greater/Greater than	>
Gynecology	GYN
Hematocrit	HCT
Hemoglobin	HGB
Hepatitis A (virus)	HAV

WORD/TERM(S)	ABBREVIATION/SYMBOL
Hepatitis B (virus)	HBV
Hepatitis C (virus)	HCV
Hepatitis D (virus)	HDV
Hepatosplenomegaly	HSM
History	HX
History and physical	H&P
History of	H/O
Hormone	HORM
Hospital	HOSP
Hour/Hours	HR(S)
Human chorionic gonadotropin	HCG
Human Immunodeficiency Virus	HIV
Human Papilloma Virus	HPV
Human T-Lymphotrophic Virus, (Type III)	HTLV
Hypertension	HTN
Hypertensive cardiovascular disease	HCVD
Hypertensive vascular disease	HVD
Hysterectomy	HYST
Idiopathic hypertrophic subaortic stenosis	IHSS
Idiopathic thrombocytopenia	ITP
Immunoglobulin	IG
Immunohistochemical	IHC
Impression	IMP
Incision & drainage	I&D
Includes/Including	INCL
Increase(d)	INCR
Inferior	INF
Inferior vena cava	IVC
Infiltrating	INFILT
Inflammatory bowel disease	IBD
Inpatient	IP
Insulin-dependent diabetes mellitus	IDDM
Intensive care unit	ICU
Intercostal margin	ICM
Intercostal space	ICS
Intermittent positive pressure breathing	IPPB
Internal	INT
Interstitial lung disease	ILD
Intramuscular	IM
Intrathecal	IT
Intravenous	IV
Intravenous cholangiogram	IVCA
Intravenous pyelogram	IVP
Invade(s)/invading/invasion	INV

WORD/TERM(S)	ABBREVIATION/SYMBOL
Involve(s)/involvement/involving	INVL
Ipsilateral	IPSI
Irregular	IRREG
Jugular venous distention	JVD
Juvenile rheumatic arthritis	JRA
Kaposi sarcoma	KS
Kidneys, ureters, bladder	KUB
Kilogram	KG
Kilovolt	KV
laboratory	LAB
Lactic dehydrogenase	LDH
Laparotomy	LAP
Large	LRG
Last menstrual period	LMP
Lateral	LAT
Left	LT
Left bundle branch block	LBBB
Left costal margin	LCM
Left lower extremity	LLE
Left lower lobe	LLL
Left lower quadrant	LLQ
Left salpingo-oophorectomy	LSO
Left upper extremity	LUE
Left upper lobe	LUL
Left upper quadrant	LUQ
Left upper outer quadrant	LUOQ
Less/Less than	<
Licensed practical nurse	LPN
Linear accelerator	LINAC
Liver/spleen scan	LS SCAN
Lower extremity	LE
Lower inner quadrant	LIQ
Lower outer quadrant	LOQ
Lumbar vertebra	L1-L5
Lumbar spine	L-SPINE
Lumbosacral	LS
Lymphadenopathy-associated virus	LAV
Lymph node(s)	LN(S)
Lymph node dissection	LND
Lupus erythematosus	LUP ERYTH
Macrophage colony-stimulating factor	M-CSF

WORD/TERM(S)	ABBREVIATION/SYMBOL
Magnetic resonance imaging	MRI
Magnetic resonance cholangiopancreatography	MRCP
Main stem bronchus	MSB
Malignant	MALIG
Mandible/mandibular	MAND
Maximum	MAX
Medical center	MC
Medication	MED
Metastatic/Metastasis	METS
Methicillin Resistant Staphylococcus Aureus	MRSA
Microgram	MCG
Microscopic	MICRO
Middle lobe	ML
Millicurie (hours)	MC(H)
Milligram (hours)	MG(H)
Milliliter	ML
Millimeter	MM
Million electron volts	MEV
Minimum	MIN
Minus	-
Minute	MIN
Mitral valve prolapse	MVP
Mixed combined immunodeficiency	MCID
Mixed connective tissue disease	MCTD
Moderate (ly)	MOD
Moderately differentiated	MD, MOD DIFF
Modified radical mastectomy	MRM
More/More than	>
Multifocal arterial tachycardia	MAT
Multifocal premature ventricular contraction	MPVC
Multiple	MULT
Multiple sclerosis	MS
Multiple myeloma	MM
Myasthenia gravis	MG
Myocardial infarction	MI
Neck vein distention	NVD
Negative	NEG
Negative	-
Neoplasm	NEOPL
Neurology	NEURO
No evidence of disease	NED
No significant findings	NSF
Non-Hodgkins lymphoma	NHL
Normal	NL

WORD/TERM(S)	ABBREVIATION/SYMBOL
Non small cell carcinoma	NSCCA
Not applicable	NA
Not otherwise specified	NOS
Not recorded	NR
Number	#
Nursing home	NH
Obstetrics	OB
Obstructed (-ing, -ion)	OBST
Operating room	OR
Operative report	OP RPT
Organic brain syndrome	OBS
Orthopedics	ORTHO
Otology	OTO
Ounce	OZ
Outpatient	OP
Packs per day	PPD
Palpated (-able)	PALP
Papanicolaou smear	PAP
Papillary	PAP
Past/personal (medical) history	PMH
Pathology	PATH
Patient	PT
Pediatrics	PEDS
Pelvic inflammatory disease	PID
Peptic ulcer disease	PUD
Percutaneous	PERC
Percutaneous transhepatic cholecystogram	PTC
Peripheral vascular disease	PVD
Prescription	RX
Primary medical physician	PMP
Phosphorus 32	P32
Physical examination	PE
Physiotherapy/Physical therapy	PT
Platelets	PLT
Plus	+
Poorly differentiated	PD, POOR DIFF
Positive	POS
Positive	+
Positron emission tomography	PET
Possible	POSS
Posterior	POST
Postoperative (-ly)	POST OP
Pound(s)	LB(S)

WORD/TERM(S)	ABBREVIATION/SYMBOL
Pound(s)	#
Premature atrial contraction	PAC
Preoperative (-ly)	PRE OP
Previous	PREV
Prior to admission	PTA
Probable (-ly)	PROB
Proctoscopy	PROCTO
Progesterone receptor (assay)	PR, PRA
Prostatic intraepithelial neoplasia, grade III	PIN III
Prostatic specific antigen	PSA
Pulmonary	PULM
Quadrant	QUAD
Radiation absorbed dose	RAD
Radiation therapy	RT
Radioimmunoassay	RIA
Received	REC'D
Red blood cells (count)	RBC
Regarding	RE
Regional medical center	RMC
Regular	REG
Regular sinus rhythm	RSR
Resection (ed)	RESEC
Review of outside films	ROF
Review of outside slides	ROS
Rheumatoid arthritis	RA
Rheumatic heart disease	RHD
Right	RT
Right bundle branch block	RBBB
Right costal margin	RCM
Right inner quadrant	RIQ
Right lower extremity	RLE
Right lower lobe	RLL
Right lower quadrant	RLQ
Right middle lobe	RML
Right outer quadrant	ROQ
Right salpingo-oophorectomy	RSO
Right upper extremity	RUE
Right upper lobe	RUL
Right upper quadrant	RUQ
Rule out	R/O
Sacral spine	S-SPINE
Sacral vertebra	S1-S5

WORD/TERM(S)	ABBREVIATION/SYMBOL
Salpingo-oophorectomy	SO
Satisfactory	SATIS
Serum glutamic oxaloacetic transaminase	SGOT
Serum glutamic pyruvic transaminase	SGPT
Severe combined immunodeficiency syndrome	SCID
Short(ness) of breath	SOB
Sick sinus syndrome	SSS
Sigmoid colon	SIG COLON
Small	SM
Small bowel	SB
Specimen	SPEC
Spine, Cervical	C-SPINE
Spine, Lumbar	L-SPINE
Spine, Sacral	S-SPINE
Spine, Thoracic	T-SPINE
Split thickness skin graft	STSG
Squamous	SQ
Squamous cell carcinoma	SCC
Status post	S/P
Subcutaneous	SUBCU
Summary stage	SS
Superior vena cava	SVC
Surgery/Surgical	SURG
Suspicious/suspected	SUSP
Symptoms	SX
Syndrome of inappropriate ADH	SIADH
Systemic lupus erythematosus	SLE
Thoracic spine	T-SPINE
Thrombotic thrombocytopenia purpura	TTP
Times	X
Total abdominal hysterectomy	TAH
Total abdominal hysterectomy- bilateral salpingo-oophorectomy	TAH-BSO
Total vaginal hysterectomy	TVH
Transient ischemic attack	TIA
Transitional cell carcinoma	TCC
Transurethral resection	TUR
Transurethral resection bladder	TURB
Transurethral resection prostate	TURP
Transverse colon	TRANS-COLON
Treatment	TX
True vocal cord	TVC
Tuberculosis	TB
Twice a day (daily)	BID
Ultrasound	US

WORD/TERM(S)	ABBREVIATION/SYMBOL
Undifferentiated	UNDIFF
Unknown	UNK
Upper extremity	UE
Upper gastrointestinal (series)	UGI
Upper inner quadrant	UIQ
Upper outer quadrant	UOQ
Upper respiratory infection	URI
Urinary tract infection	UTI
Vagina/Vaginal	VAG
Vaginal hysterectomy	VAG HYST
Vaginal intraepithelial neoplasia (grade III)	VAIN III
Vulvar intraepithelial neoplasia (grade III)	VIN III
Well differentiated	WD, WELL DIFF
White blood cells (count)	WBC
White female	W/F
White male	W/M
With	W/
Within normal limits	WNL
Without	W/O
Wolff-Parkinson-White syndrome	WPW
Work-up	W/U
Xray	XR
Year	YR

NAACCR RECOMMENDED ABBREVIATION LIST
ORDERED BY ABBREVIATION/SYMBOL

ABBREVIATION/SYMBOL	WORD/TERM(S)
^	above
@	at
&	and
<	less, less than
=	equals
>	greater than, more, more than
-	negative, minus
#	number, pound(s)
+	plus, positive
X	times
A-COLON	Ascending colon
A FIB	Atrial fibrillation
A FLUTTER	Atrial flutter
A-STEN	Aortic stenosis
A&P	Auscultation & percussion
ABD	Abdomen (abdominal)
ABG	Arterial blood gases
ABN	Abnormal
ABS	Absent/Absence
ABST	Abstract/Abstracted
AC	Adrenal cortex
ACBE	Air contrast barium enema
ACH	Adrenal cortical hormone
ACID PHOS	Acid phosphatase
ACTH	Adrenocorticotrophic hormone
ADENOCA	Adenocarcinoma
ADH	Antidiuretic hormone
ADJ	Adjacent
ADL	Activities of daily living
ADM	Admission/Admit
AFF	Affirmative
AFP	Alpha-fetoprotein
AG	Antigen
AGL	Acute granulocytic leukemia
AI	Atrial stenosis/insufficiency/incompetence
AIDS	Acquired Immune Deficiency Syndrome
AIHA	Autoimmune hemolytic anemia
AIN III	Anal intraepithelial neoplasia, grade III
AK(A)	Above knee (amputation)
AKA	Also known as
ALB	Albumin
ALK PHOS	Alkaline phosphatase

ABBREVIATION/SYMBOL	WORD/TERM(S)
ALL	Acute lymphocytic leukemia
ALS	Amyotrophic lateral sclerosis
AM	Before noon
AMA	Against medical advice
AMB	Ambulatory
AMI	Acute myocardial infarction
AML	Acute myelogenous leukemia
AMP	Amputation
AMT	Amount
ANAP	Anaplastic
ANGIO	Angiography/Angiogram
ANS	Autonomic nervous system
ANT	Anterior
AODM	Adult-onset Diabetes Mellitus
AP	Abdominal perineal
AP	Anteroposterior
APC	Atrial premature complexes
APP	Appendix
APPL'Y	Apparently
APPROX	Approximately
ARC	AIDS-related condition (complex)
ARD	AIDS-related disease
ARDS	Acute Respiratory Distress (Disease) Syndrome
ARF	Acute renal failure
ARRHY	Arrhythmia
ART	Artery (ial)
AS	Arteriosclerosis/Arteriosclerotic
ASA	Aspirin, Acetylsalicylic acid
ASAP	As soon as possible
ASCVD	Arteriosclerotic cardiovascular disease
ASHD	Arteriosclerotic heart disease
ASP	Aspiration
ASPVD	Arteriosclerotic Peripheral Vascular Disease
ATN	Acute tubular necrosis
ATP	Adenosine triphosphate
ATR	Achilles tendon reflex
AUT	Autopsy
AV	Arteriovenous
AVG	Average
AVM	Arteriovenous malformation
AX	Axilla(ry)
B/F	Black female
B/M	Black male
BA	Barium

ABBREVIATION/SYMBOL	WORD/TERM(S)
BAD	Bipolar affective disorder
BCC	Basal cell carcinoma
BCG	Bacillus Calmette-Guerin
BD	Bile duct
BE	Barium enema
BID	Twice a day (daily)
BIL	Bilateral
BK(A)	Below knee (amputation)
BM	Bone marrow
BM	Bowel movement
BMT	Bone marrow transplant
BP	Blood pressure
BPH	Benign prostatic hypertrophy/hyperplasia
BRM	Biological response modifier
BRO	Brother
BSO	Bilateral salpingo-oophorectomy
BT	Bladder tumor
BUN	Blood urea nitrogen
BUS	Bartholin's, Urethral & Skene's
BV	Blood volume
BX	Biopsy
C/O	Complaint (-ning) of
C/W	Consistent with
C1-C7	Cervical vertebrae
CA	Calcium
CA	Carcinoma
CABG	Coronary artery bypass graft
CAD	Coronary artery disease
CAP(S)	Capsule (s)
CBC	Complete blood count
CC	Cubic centimeter
CCU	Coronary care unit
CEA	Carcinoembryonic antigen
CF	Cystic fibrosis
CGL	Chronic granulocytic leukemia
CHD	Congenital heart disease
CHEMO	Chemotherapy
CHF	Congestive heart failure
CHG	Change
CHR	Chronic
CIG	Cigarettes
CIN	Cervical intraepithelial neoplasia
CIN III	Cervical intraepithelial neoplasia, grade III
CIS	Carcinoma *in situ*

ABBREVIATION/SYMBOL	WORD/TERM(S)
CLL	Chronic lymphocytic leukemia
CLR	Clear
CM	Centimeter
CML	Chronic myeloid (myelocytic) leukemia
CNS	Central nervous system
CO60	Cobalt 60
COLD	Chronic obstructive lung disease
CONT	Continue/continuous
CONTRA	Contralateral
COPD	Chronic obstructive pulmonary disease
CRF	Chronic renal failure
CS	Collaborative stage
CSF	Cerebrospinal fluid
C-SF	Colony stimulating factor
C-SPINE	Cervical spine
CT	CAT/CT scan/Computerized axial tomography
CUC	Chronic ulcerative colitis
CVA	Cerebrovascular accident
CVD	Cardiovascular disease
CXR	Chest X-ray
CYSTO	Cystoscopy
CYTO	Cytology
D-COLON	Descending colon
D&C	Dilatation and curettage
DC	Discontinue(d)
DCIS	Ductal carcinoma *in situ*
DECR	Decrease(d)
DERM	Dermatology
DES	Diethylstilbestrol
DIAM	Diameter
DIC	Disseminated intravascular coagulopathy
DIFF	Differentiated/differential
DISCH	Discharge
DM	Diabetes mellitus
DNA	Deoxyribonucleic acid
DOA	Dead on arrival
DOB	Date of birth
DOD	Date of death
DOE	Dyspnea on exertion
DRE	Digital rectal examination
DTR	Deep tendon reflex
DVT	Deep vein thrombosis
DX	Diagnosis
DZ	Disease

ABBREVIATION/SYMBOL	WORD/TERM(S)
E.G.	For example
ECG/EKG	Electrocardiogram
EEG	Electroencephalogram
EGD	Esophagogastro-duodenoscopy
EMG	Electromyogram
ENLGD	Enlarged
ENT	Ears, nose, and throat
ER	Emergency room
ER, ERA	Estrogen receptor (assay)
ERCP	Endoscopic retrograde cholangiopancreatography
ESRD	End stage renal disease
ETOH	Alcohol
EVAL	Evaluation
EXAM	Examination
EXC(D)	Excision/excised
EXP	Expired
EXPL	Exploratory
EXPL LAP	Exploratory laparotomy
EXT	Extend/extension
FL	Fluid
FLURO	Fluoroscopy
FNA	Fine needle aspiration
FNAB	Fine needle aspiration biopsy
FOM	Floor of mouth
FREQ	Frequent/Frequency
FS	Frozen section
FTSG	Full thickness skin graft
FU	Follow-up
FUO	Fever of unknown origin
FX	Fracture
GB	Gallbladder
GE	Gastroesophageal
GEN	General/Generalized
GERD	Gastroesophageal reflux disease
GI	Gastrointestinal
GR	Grade
GU	Genitourinary
GYN	Gynecology
H&P	History and physical
H/O	History of
HAV	Hepatitis A (virus)

ABBREVIATION/SYMBOL	WORD/TERM(S)
HBV	Hepatitis B (virus)
HCG	Human chorionic gonadotropin
HCT	Hematocrit
HCV	Hepatitis C (virus)
HCVD	Hypertensive cardiovascular disease
HDV	Hepatitis D (virus)
HGB	Hemoglobin
HIV	Human Immunodeficiency Virus
HORM	Hormone
HOSP	Hospital
HPV	Human Papilloma Virus
HR(S)	Hour/Hours
HSM	Hepatosplenomegaly
HTLV	Human T-Lymphotrophic Virus, (Type III)
HTN	Hypertension
HVD	Hypertensive vascular disease
HX	History
HYST	Hysterectomy
I&D	Incision & drainage
IBD	Inflammatory bowel disease
ICM	Intercostal margin
ICS	Intercostal space
ICU	Intensive care unit
IDDM	Insulin-dependent diabetes mellitus
IG	Immunoglobulin
IHC	Immunohistochemical
IHSS	Idiopathic hypertrophic subaortic stenosis
ILD	Interstitial lung disease
IM	Intramuscular
IMP	Impression
INCL	Includes/Including
INCR	Increase(d)
INF	Inferior
INFILT	Infiltrating
INT	Internal
INV	Invade(s)/invading/invasion
INVL	Involve(s)/involvement/involving
IP	Inpatient
IPPB	Intermittent positive pressure breathing
IPSI	Ipsilateral
IRREG	Irregular
IT	Intrathecal
ITP	Idiopathic thrombocytopenia
IV	Intravenous

ABBREVIATION/SYMBOL	WORD/TERM(S)
IVC	Inferior vena cava
IVCA	Intravenous cholangiogram
IVP	Intravenous pyelogram
JRA	Juvenile rheumatic arthritis
JVD	Jugular venous distention
KG	Kilogram
KS	Kaposi sarcoma
KUB	Kidneys, ureters, bladder
KV	Kilovolt
L-SPINE	Lumbar spine
L1-L5	Lumbar vertebra
LAB	laboratory
LAP	Laparotomy
LAT	Lateral
LAV	Lymphadenopathy-associated virus
LB	Pound
LBBB	Left bundle branch block
LCM	Left costal margin
LDH	Lactic dehydrogenase
LE	Lower extremity
LINAC	Linear accelerator
LIQ	Lower inner quadrant
LLE	Left lower extremity
LLL	Left lower lobe
LLQ	Left lower quadrant
LMP	Last menstrual period
LN(S)	Lymph node(s)
LND	Lymph node dissection
LOQ	Lower outer quadrant
LPN	Licensed practical nurse
LRG	Large
LS	Lumbosacral
LS SCAN	Liver/spleen scan
LSO	Left salpingo-oophorectomy
LT	Left
LUE	Left upper extremity
LUL	Left upper lobe
LUOQ	Left upper outer quadrant
LUP ERYTH	Lupus erythematosus
LUQ	Left upper quadrant
M-CSF	Macrophage colony-stimulating factor

ABBREVIATION/SYMBOL	WORD/TERM(S)
MALIG	Malignant
MAND	Mandible/mandibular
MAT	Multifocal arterial tachycardia
MAX	Maximum
MC	Medical center
MC(H)	Millicurie (hours)
MCG	Microgram
MCID	Mixed combined immunodeficiency
MCTD	Mixed connective tissue disease
MD	Moderately differentiated
MED	Medication
METS	Metastatic/Metastasis
MEV	Million electron volts
MG	Myasthenia gravis
MG(H)	Milligram (hours)
MI	Myocardial infarction
MICRO	Microscopic
MIN	Minimum
MIN	Minute
ML	Middle lobe
ML	Milliliter
MM	Millimeter
MM	Multiple myeloma
MOD	Moderate (ly)
MOD DIFF	Moderately differentiated
MPVC	Multifocal premature ventricular contraction
MRCP	Magnetic resonance cholangiopancreatography
MRI	Magnetic resonance imaging
MRM	Modified radical mastectomy
MRSA	Methicillin Resistant StaphyloCoCcus Aureus
MS	Multiple sclerosis
MSB	Main stem bronchus
MULT	Multiple
MVP	Mitral valve prolapse
NA	Not applicable
NED	No evidence of disease
NEG	Negative
NEOPL	Neoplasm
NEURO	Neurology
NH	Nursing home
NHL	Non-Hodgkins lymphoma
NL	Normal
NOS	Not otherwise specified
NR	Not recorded

ABBREVIATION/SYMBOL	WORD/TERM(S)
NSCCA	Non small cell carcinoma
NSF	No significant findings
NVD	Neck vein distention
OB	Obstetrics
OBS	Organic brain syndrome
OBST	Obstructed (-ing, -ion)
OP	Outpatient
OP RPT	Operative report
OR	Operating room
ORTHO	Orthopedics
OTO	Otology
OZ	Ounce
P32	Phosphorus 32
PAC	Premature atrial contraction
PALP	Palpated (-able)
PAP	Papanicolaou smear
PAP	Papillary
PATH	Pathology
PD	Poorly differentiated
PE	Physical examination
PEDS	Pediatrics
PERC	Percutaneous
PET	Positron emission tomography
PID	Pelvic inflammatory disease
PIN III	Prostatic intraepithelial neoplasia, grade III
PLT	Platelets
PMH	Past/personal (medical) history
PMP	Primary medical physician
POOR DIFF	Poorly differentiated
POS	Positive
POSS	Possible
POST	Posterior
POST OP	Postoperative (-ly)
PPD	Packs per day
PR, PRA	Progesterone receptor (assay)
PRE OP	Preoperative (-ly)
PREV	Previous
PROB	Probable (-ly)
PROCTO	Proctoscopy
PSA	Prostatic specific antigen
PT	Patient
PT	Physiotherapy/Physical therapy
PTA	Prior to admission

ABBREVIATION/SYMBOL	WORD/TERM(S)
PTC	Percutaneous transhepatic cholecystogram
PUD	Peptic ulcer disease
PULM	Pulmonary
PVD	Peripheral vascular disease
Q	Every
QD	Every day
QUAD	Quadrant
R/O	Rule out
RA	Rheumatoid arthritis
RAD	Radiation absorbed dose
RBBB	Right bundle branch block
RBC	Red blood cells (count)
RCM	Right costal margin
RE	Regarding
REC'D	Received
REG	Regular
RESEC	Resection (ed)
RHD	Rheumatic heart disease
RIA	Radioimmunoassay
RIQ	Right inner quadrant
RLE	Right lower extremity
RLL	Right lower lobe
RLQ	Right lower quadrant
RMC	Regional medical center
RML	Right middle lobe
ROF	Review of outside films
ROQ	Right outer quadrant
ROS	Review of outside slides
RSO	Right salpingo-oophorectomy
RSR	Regular sinus rhythm
RT	Radiation therapy
RT	Right
RUE	Right upper extremity
RUL	Right upper lobe
RUQ	Right upper quadrant
RX	Prescription
S/P	Status post
S1-S5	Sacral vertebra
S-SPINE	Sacral spine
SATIS	Satisfactory
SB	Small bowel
SCC	Squamous cell carcinoma

ABBREVIATION/SYMBOL	WORD/TERM(S)
SCID	Severe combined immunodeficiency syndrome
SGOT	Serum glutamic oxaloacetic transaminase
SGPT	Serum glutamic pyruvic transaminase
SIADH	Syndrome of inappropriate ADH
SIG COLON	Sigmoid colon
SLE	Systemic lupus erythematosus
SM	Small
SO	Salpingo-oophorectomy
SOB	Short(ness) of breath
SPEC	Specimen
SQ	Squamous
SS	Summary stage
SSS	Sick sinus syndrome
STSG	Split thickness skin graft
SUBCU	Subcutaneous
SURG	Surgery/Surgical
SUSP	Suspicious/suspected
SVC	Superior vena cava
SX	Symptoms
T-SPINE	Thoracic spine
TAH	Total abdominal hysterectomy
TAH-BSO	Total abdominal hysterectomy- bilateral
TB	Tuberculosis
TCC	Transitional cell carcinoma
TIA	Transient ischemic attack
TRANS-COLON	Transverse colon
TTP	Thromboticthrombocytopenia purpura
TUR	Transurethral resection
TURB	Transurethral resection bladder
TURP	Transurethral resection prostate
TVC	True vocal cord
TVH	Total vaginal hysterectomy
TX	Treatment
UE	Upper extremity
UGI	Upper gastrointestinal (series)
UIQ	Upper inner quadrant
UNDIFF	Undifferentiated
UNK	Unknown
UOQ	Upper outer quadrant
URI	Upper respiratory infection
US	Ultrasound
UTI	Urinary tract infection

ABBREVIATION/SYMBOL	WORD/TERM(S)
VAG	Vagina/Vaginal
VAG HYST	Vaginal hysterectomy
VAIN III	Vaginal intraepithelial neoplasia (grade III)
VIN III	Vulvar intraepithelial neoplasia (grade III)
W/	With
W/F	White female
W/M	White male
W/O	Without
W/U	Work-up
WBC	White blood cells (count)
WD	Well differentiated
WELL DIFF	Well differentiated
WNL	Within normal limits
WPW	Wolff-Parkinson-White syndrome
XR	Xray
YR	Year

NAACCR RECOMMENDED ABBREVIATION LIST
CONTEXT-SENSITIVE ABBREVIATIONS

ABBREVIATION/SYMBOL	WORD/TERM(S)
AP	Anteroposterior
AP	Abdominal perineal
BM	Bone marrow
BM	Bowel movement
CA	Calcium
CA	Carcinoma
MIN	Minimum
MIN	Minute
ML	Milliliter
ML	Middle lobe
MM	Millimeter
MM	Multiple myeloma
PAP	Papillary
PAP	Papanicolaou smear
PT	Patient
PT	Physiotherapy/Physical therapy
RT	Right
RT	Radiation therapy

Coding Text for Abstracting
"Perfecting the Art of Abstracting"

The **main principle** is one should be able to enter abstract codes from one's written text. Therefore, put the text in first and then code the abstract. If unable to code the data field from the text, refer back to the medical record and revise the text.

The **second principle** is to include only the text that is relevant to the specific cancer that is abstracted. For example, if the cancer is lymphoma include information on HIV and B symptoms. This information is not relevant and should not be included in text for a breast cancer abstract. If patient has more than one primary diagnosed at the same time, do not enter information for other primaries in the same abstract. Only include text information for the specific cancer that is coded on the abstract. It is tempting to put text in one abstract for both primaries and copy text to next tumor…. DON'T DO THIS!!!

The **third** principle is to Date all relative fields: all procedures and PE.

The following is a brief outline of relevant information and format to use for the basic text fields in an abstract.

PE: date and location of visit, age, sex, race, marital status, brief description of symptoms relevant to specific cancer, where patient resided at diagnosis, if not diagnosed at your facility, and patient's previous history of **reportable** cancers, insurance.

Xray/Scans: date and location, type of scan, relevant findings of mass; size, position in organ, organs or structures within normal limits, impression with qualifying terms used to identify cancer. If nothing is found on scans, state Negative.

Labs: date and test type. Only information relative to tumor with ranges. Specifically: Breast ER, PR, Her2; Prostate: PSA; Colon & Rectum: CEA; Testis & Liver: AFP; Ovary: CA-125; Kaposi Sarcoma & Lymphoma: HIV/AIDS and B symptoms; Hematopoietic: blood work relevant to diagnosis. If test is not done, text should state test name, not done with field coded 000; if test is not in the medical record, state test name, not in MR and enter code 999 in abstract field. Whatever code is entered in the abstract must have text documentation! Include text for applicable Site Specific Factors or SSDIs.

Pathology report: date, path lab name if not your facility, path number, name of tissue, laterality, final diagnosis histology, grade, tumor size, number lymph nodes positive and negative, and margins. If more information is required to code lymph node information include this also like extracapsular extension, size of involved lymph node and for Head & Neck tumors, the lymph node levels. For a breast primary, include information on IHC tests for CS SSFs 4 & 5. Include text for applicable Site Specific Factors.

Primary Site: specific site or subsite and laterality (for paired sites where the cancer arose). Do not code the biopsy site, if there are other areas of involvement and it is not stated that the biopsy site is the primary; particularly for head and necks tumors and

lymphomas. Name the source that identified the H&N primary site using rules for determining primary site from MP/H rules, Head and Neck module.

Histology: histology name from most definitive surgical pathology final and highest grade from any specimen prior to treatment; if do not have path report, record physician's diagnostic statement. For cases **2018 and later**, follow the site specific Solid Tumor Rules, which in most cases instructs to code the most specific histology from the biopsy or resection.

Stage: give brief description of stage and state staged T_N_M

Op Report: date and location, procedure name, pertinent information in report specific to cancer: location of tumor, size, if other organs and tissue in the area are mentioned as involved or normal.

Treatment: start date and location for all treatment (if estimated so state), and list surgery type, chemo/hormone/immunotherapy agents and radiation type, regional and boost modality and dose. For **2018 and later**, refer to the 2018 STORE Manual for updated radiation coding instructions. Document physician name administering treatment.

Place of diagnosis: name the facility where patient was diagnosed. If diagnosed at your facility, state here.

Measurement Conversion Guidelines for Cases prior to 2018

* Refer to CS Manual for Size Rules & Codes

Tumor Size Coded in Millimeters

Millimeters to Centimeters
5 mm = 0.5 cm
10 mm = 1 cm
989 mm = 98.9 cm

General Codes for Tumor Size

Tumor Size	Code
0.5 cm tumor (5 mm)	005
1 cm tumor (10 mm)	010
10 cm tumor (100 mm)	100
98.9 cm (989 mm & larger)	989
99 cm tumor (999 mm)	989
Diffuse Tumor (for specific sites)*	998

Skin Melanoma Depth, Breslow's , SSF1
***Prior t0 2018 melanoma depth-Breslow coded in hundreth's of mm, not 10ths**

Depth in **ten**ths of millimeters*	Code
0.05 mm	005
0.1 mm (0.01 cm)	010
5 mm (.5 cm)	500
9.80 mm (0.98 cm or larger)	980
10 mm (1 cm)	980

Prostate PSA value, CS SSF 1

PSA Value	Code
4.4 ng/ml	044
4.44 ng/ml	044
4.46 ng/ml	045
20 ng/ml	200
98.0 ng/ml or greater	980
120 ng/ml	980

Head & Neck Sites Measured (Depth)-SSF 11
Path only. If no path statement of depth,
3rd dimension of size. Example: 1 x 2 x .1

Depth in tenths of millimeters	Code
0.1 mm	001
4.2 mm	042
10 mm (1.0 cm)	100
100 mm (10.0 cm)	980
In Situ tumor	987
Microinvasion, no size stated	990
No surgical specimen	998

Date of Diagnosis Estimation

GCR has reviewed the Revisions for 2010 SEER Program Coding and Staging Manual "Date of Diagnosis" document below. We have added more specific instructions (in bold type) to be followed by Georgia registrars. We are requiring the year, month, and day of diagnosis for analytic cases. Please follow back with the physician to confirm a date, or estimate as best as possible. Age at diagnosis and survival cannot be calculated without the complete YYYYMMDD diagnosis date known or estimated. This data element is critical for all analytical cases.

Please review the following document and note the more specific instructions

TO: SEER Registries and other users of the SEER Program Coding and Staging Manual (SPCSM)
RE: Revisions for *2010 SEER Program Coding and Staging Manual*, Section IV, NAACCR Item
390, Date of Diagnosis, page 49
Effective Date: January 1, 2010

REVISIONS:

Date of diagnosis must be transmitted in the YYYYMMDD format. Date of diagnosis may be recorded in the transmission format, or recorded in the traditional format (MMDDYYYY) and converted electronically to the transmission format. Regardless of the format, at least **Year** of diagnosis **must be known or estimated for analytic cases**. Year of diagnosis **cannot be blank or unknown for analytic cases**. **Month and day cannot be blank or unknown for analytic cases.**

Transmitting Dates

Transmit date fields in the year, month, day format (YYYYMMDD). Leave the month, day and/or year* blank when they cannot be estimated or are unknown.

Common Formats

YYYYMMDD	Complete date is known
YYYYMM	Year and month are known/estimated; day is unknown
YYYY	Year is known/estimated; month and day cannot be estimated or are unknown
Blank	Year*, month, and day cannot be estimated or are unknown

*Non-analytic cases only – **Whenever possible, an attempt should be made to get an accurate diagnosis date from the physician or estimate the complete date. This is to be done especially for class of case 30: "reporting facility participated in diagnostic workup (consult only, staging workup after initial diagnosis elsewhere".**

Transmit Instructions

1. Transmit date fields in the year, month, day format (YYYYMMDD).
2. Leave the month, and/or day blank when they cannot be estimated or are unknown.
3. Most SEER registries collect the month, day, and year of diagnosis. When the full date (YYYYMMDD) is transmitted, the seventh and eighth digits (day) will be deleted when the data are received by SEER.

Definitions:

Analytic case: Case for which the registry has information on the original diagnosis and/or the first course of treatment. For definition of first course treatment, see the *2018 SEER Program Coding and Staging Manual* Section VI, First Course of Therapy.

Non-analytic case: All cases for which the registry does not have information on the original diagnosis and/or first course of treatment. Examples of those cases would be a patient who moved to your state after the original diagnosis and first course of treatment were complete and treatment was for persistent disease or metastatic disease; DCO with history of cancer, unknown when and where patient was diagnosed; follow-back gives no additional information. **(Note: SEER instructions indicate an attempt at follow back should be made for non-analytic cases as well)**.

Instructions:

Analytic cases

1. Follow-back must be done to obtain the date of diagnosis. If no information can be found, follow instruction 2.
2. Date of diagnosis must be estimated. See the *2018 SEER Program Coding and Staging Manual*, Section IV, Date of Diagnosis, Coding Instructions, Coding instruction for estimating date of diagnosis.
3. For reports dated December or January of a given year code the month of the report or the month of admission (instruction 9a viii). Coding the month of the report or the month of admission results in a better estimate of the date of diagnosis than coding month as 99 and having the computer assign July as the month of diagnosis, for example.
4. When the diagnosis date is stated to be spring, summer, fall, or winter, follow instructions 9a i, ii, iii, and iv.

Non-analytic cases

Please refer to the Date of Diagnosis Estimation (Page 121).

Class of Case 30 should have complete diagnosis date known or estimated.

Providing the diagnosis date at the time of reporting may positively impact the amount of your death clearance follow-back.

Consider getting your facility to update their patient information history page that a patient completes when seeing a physician or being admitted to include Diagnosis of Cancer, site of cancer, date of diagnosis, where living at diagnosis (City and State)

DATE OF DIAGNOSIS NAACCR Item # 390
Effective 2/1/2011
Records the date of **initial diagnosis** by a Health Care Professional for the tumor being reported.

Instructions for Coding
• Use the first date of diagnosis whether clinically or histologically confirmed.
• If the physician states that in retrospect the patient had cancer at an earlier date, use the earlier date as the date of diagnosis.
• Use the date therapy was started as the date of diagnosis if the patient receives a first course of treatment before a definitive diagnosis.
• The date of death is the date of diagnosis for a Class of Case 49.
• **Avoid using code 9's** unknown for month, day or year.

Use all information in the medical record to estimate the date of diagnosis if the exact date cannot be determined. The date of initial diagnosis is the month, day, and year that this primary cancer was **first diagnosed** by a recognized medical practitioner. **If estimated, clearly document in the text that the diagnosis date is estimated.**

Class of Case (COC) 30, 31, 32, 33, 40, 41, 42, and 43 should have an accurate or estimated date of diagnosis using the following guidelines:

Condition	Estimate Date Suggestion
Accurate Diagnosis Date	Date 1st called cancer or suspicious for Cancer by physician, scan, pathology report, see list of ambiguous terms considered involvement.
Workup	Estimate Dx Date 1 to 2 weeks before workup date for blood work , scans, etc.
Treatment Date	Estimate Dx two weeks before 1st TX date
Estimate month dx	
Spring Summer	April July
Middle of Year Fall/Autumn	July October
Winter	Use information to estimate either December or January
Early In Year	January
Late In Year	December
Couple of weeks ago	2 weeks prior to admission date
Couple of months ago	2 months prior to admission date
Few weeks ago Few months ago	3 weeks prior to admission date 3 months prior to admission date
Several weeks ago	4 weeks prior to admission date
Several months ago	4 months prior to admission date
Diagnosed X months ago	X months prior to admission date
Estimate Year: Couple Years	 Subtract 2 years from admission date
Few Years	Subtract 3 years from admission date
Several Years	Subtract 4 years from admission date
Site C22._,C24._, C25._	Since these have poorest prognosis, estimate date within 1 year of death
Site C15._,C16._, C34._	Since these have usually a poor prognosis, estimate date within 2 years of date 1st contact without other more specific information of Dx Date.

Georgia Cancer Registry
Reporting Manual

Section 12: Casefinding Manual

The purpose of this section is to supplement the Georgia Cancer Registry Policy and Procedure Manual for Reporting Facilities by providing further detail in casefinding and reporting.

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Table of Contents

CASEFINDING

Casefinding is a systematic method of locating and identifying all eligible cases that are to be reported to the Georgia Cancer Registry (GCR). The method of casefinding must include all points of service from which a patient may enter the health care delivery system for diagnostic and/or therapeutic services for the management of cancer. Casefinding will identify both new cases and cases already entered into the registry.

Multiple sources must be used to ensure complete reporting.

Included in these sources are:

Admission and discharge documentation	Disease indexes
Outpatient medical records/logs	Autopsy reports
Surgery schedules/logs	Diagnostic imaging
Pathology and cytology reports	Medical Oncology logs
Radiation Oncology logs	Neurology clinics
Nuclear medicine documents	Hematology reports

Resources used to identify eligible cases:

- Health Information Management Department (HIM)/Medical Records Dept. This department maintains the medical records and a disease index that identifies the patient, date of service, and the diagnosis. *** See Section 2 of this manual for ICD-9-CM and ICD-10-CM codes and procedures for casefinding by Disease Index.**

- Pathology and Cytology Departments. The histology, cytology, bone marrow, and autopsy reports are source documents for identifying eligible cases.

- Oncology-related services. Radiation and medical oncology treatment areas are sources of casefinding. All in-patient and outpatient services should be checked.

- Staff physician's office. The physician's office is a source of casefinding.

SELECTION AND IDENTIFICATION OF CASES

The Notifiable Disease Law, Official Code of Georgia (OCGA) Annotated 31-12-2, mandates the reporting of certain diseases including cancer. All CANCERS diagnosed since January 1, 1995 in persons receiving cancer diagnostic and/or management services or who have active disease MUST be reported to the Georgia Cancer Registry (GCR), unless previously reported by that facility. *See Section 8 for links to Reporting Laws and Mandates.*

All health care providers in the state of Georgia are required to report specific information on cancer in their patient population to the Georgia Cancer Registry. This includes all facilities providing diagnostic evaluations and/or treatment for cancer patients, such as: hospitals, outpatient surgical facilities, laboratories, radiation therapy and medical oncology facilities, physicians and physician's offices.

The Georgia Cancer Registry requires the following cases to be reported:

- **All neoplasms diagnosed or treated in a hospital with a behavior code of "2" or "3", as specified in the International Classification of Diseases for Oncology, appropriate edition according to the year of diagnosis, regardless of class of case.**

- **As of January 1, 2004, any case diagnosed with benign brain and central nervous system tumors are reportable.**

- **Patients with active disease while an inpatient or outpatient at a facility, regardless of reason for admission or service. Also patients who had cancer diagnostic and/or management services given or planned while at the facility even without active disease.**

- **Patients whose diagnoses are not histologically confirmed (clinical diagnoses).**

- **Georgia and non-Georgia residents.**

Refer to "REPORTABLE DIAGNOSES" Table for exceptions.

TYPES OF CASES TO INCLUDE

For specific codes and explanation for Class of Case please, see Appendix F

Inpatient and Outpatient:

All *inpatient* and *outpatient* cases must be included in the casefinding process. This includes outpatient departments located within the facility and also those physically located outside the facility *IF* the facility owns the medical record. An example of this would be if a hospital owns a freestanding outpatient surgical center. The cases from this center would be identified and reported.

All class of cases (analytic and non-analytic) See Appendix F

All accessioned cases are assigned a *Class of Case* (NAACCR Item #610) based on the nature of involvement of the facility in the care of the patient.

Analytic Cases
Class of Case 00-22: Cases diagnosed and/or administered any of the first course of treatment at the accessioning facility after the registry's reference date are analytic. A network clinic or outpatient center belonging to the facility is part of the facility. *Class of Case* 10-22 are included in treatment and survival analysis.
Class of Case 00: Cases diagnosed on or after January 1, 2006, are not required to be staged or followed. *Class of Case* 00 is reserved for patients who are originally diagnosed by the reporting facility and receive all of their treatment elsewhere or a decision not to treat is made elsewhere. If the patient receives no treatment, either because the patient refuses recommended treatment or a decision is made not to treat, the *Class of Case* is 14. If there is no information about whether or where the patient was treated, the *Class of Case* is *10*.

Nonanalytic Cases
Class of Case 30-99 are not usually included in routine treatment or survival statistics. The CoC does not require registries in accredited programs to accession, abstract, or follow these cases, but **the GCR requires them**.

Modifications to Class of Case in 2010
Class of Case was redefined for use beginning in 2010. The codes in this manual allow differentiation between analytic and nonanalytic cases and make additional distinctions. For analytic cases, the codes distinguish cases diagnosed in a staff physician's office from those diagnosed initially by the facility and patients fully treated at the facility from those partially treated by the reporting facility. Nonanalytic cases are distinguished by whether the patient received care at the facility or did not personally appear there.
Patients who received care from the facility are distinguished by the reasons a case may not be analytic: diagnosed prior to the patient's reference date, type of cancer that is not required by CoC to be abstracted, consultation, in-transit care, and care for recurrent or persistent disease. Patients who did not receive care from the reporting facility are distinguished by care given in one or more staff physician offices, care given through an agency whose cancer cases are abstracted by the reporting facility but are not part of it, pathology only cases, and death certificate only cases. Treatment in staff physician offices is now coded "treated elsewhere" because the hospital has no more responsibility over this treatment than it would if the patient were treated in another hospital.

Clinical diagnoses:

It is important to remember that all *clinical diagnoses* are also reportable. Histologic confirmation is not required for these cases. The clarification regarding ambiguous terminology (page 6 of this manual) may be helpful in determining if a case with an unclear diagnosis is reportable. **NOTE**: Radiology only cases (x-rays and scans) must be reported if diagnostic of cancer, including those with reportable ambiguous terminology; however **Lab only cases are not required to be reported** (for example PSA reports).

Tissue Only cases (pathology):

This is sometimes referred to as "tissue, no body" and occurs when a facility's pathology department processes and interprets specimens that were collected from outside sources, such as another hospital or from a physician's office. If the facility receives a pathology specimen diagnostic of cancer from another hospital, the facility is NOT required to report the case. **The facility that receives a pathology specimen diagnostic of cancer from a physician's office must report that case**. It is the responsibility of the reporting facility that **first** collected or received the specimen to report the case. Just remember to follow two basic guidelines:

- If the specimen originates (or is collected) from a physician's office, report the case.
- If the specimen is from another hospital, do not report the case.

Remember:

ALL items in the GCR Required Data Set must be **completed** if reporting electronically or **included** if submitting photocopies of medical records.

A. Data needed by GCR includes all information from the date of initial diagnosis (OR FIRST VISIT TO YOUR FACILITY) through the next four months.
If you discover a case that was previously diagnosed, you should go back and submit the first admission to your facility indicating the presence of cancer. The earliest information available regarding a patient's cancer is needed. Of course, if you had previously submitted that case, you would not need to submit it again. For example, you are doing your casefinding for June 2018 and you have a patient on your disease index with a diagnosis of colon cancer. The H & P states that the patient is being admitted for a bowel obstruction, possibly a recurrence. First determine the patient does not have a new primary using the Multiple Primary and Histology Rules. If not a new primary, and in reviewing the record you see that the patient was admitted to your facility in October 2017 for colon cancer, but not reported at that time., you would need to go back and update your abstract to include the October 2017 admission. This would be sent as an update to GCR in your monthly Modified Record submission.

AMBIGUOUS TERMINOLOGY:

Terms That Constitute a Diagnosis

Interpret the following terms as a diagnosis of cancer. The database must include patients who have a diagnosis using one or more of these terms.

1. Apparently
1. Appears to
2. Compatible (comparable) with
3. Consistent with
4. Favor(s
5. Most likely

- Malignant Appearing
- Presumed
- Probable
- Suspect
- Suspicious
- Typical of

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.

Example: If the cytology is reported as "suspicious", do not interpret it as a diagnosis of cancer. Abstract the case only if a positive biopsy or a physician's clinical impression of cancer supports the cytology findings.

***For non-malignant primary intracranial and CNS tumors (C70.0-C72.9, C75.1-C75.3), the terms "tumor" and "neoplasm" are considered diagnostic for the purpose of case reporting, in addition to the terms generally applicable to malignant tumors.**

Terms That Do Not Constitute a Diagnosis*

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

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

REPORTABLE DIAGNOSES

Please refer to Section 1 of this 2018 GCR Policy and Procedure Manual

Reporting Time Table

This table below may be helpful in determining when cases should be abstracted and/or submitted to GCR. For example, during your casefinding in January, you identify a patient that was diagnosed during that month; but you would wait until June 2017 to actually submit the data. The "four month rule" requires you to include all information (admissions, tests, etc.) for the first four months after diagnosis. This information is included on the initial abstract. Therefore, if a patient were diagnosed January 30th, you would need to collect all additional data for February, March, April, and May and then submit in June. For this reason the pending file (page 11) is useful and allows you to "hold" cases until the appropriate time to submit them.

The first column of months indicates the month the patient was diagnosed (or seen at your facility, if diagnosed elsewhere) and the second row of months is the month you should actually submit the abstract or photocopies of the record to the State. Since facilities actually have 6 months from diagnosis before they are considered delinquent, this system would allow time (one extra month) for cases whose records were not complete or available until that time.

Diagnosis month	*Submission Month
January	June
February	July
March	August
April	September
May	October
June	November
July	December
August	January
September	February
October	March
November	April
December	May

*Remember to submit cases by the last day of each month.

ICD-9-CM and ICD-10-CM CODES FOR CASEFINDING BY DISEASE INDEX SCREENING.

Please refer to Section 2 of this manual.

Casefinding in medical records/health information should be done using both inpatient and outpatient disease/diagnostic indexes. Review all records with the listed ICD-9/ICD-10 codes. **Current year and past years' case finding lists can be found: http://www.seer.cancer.gov/tools/casefinding/index.html. Please review this website for any update.**

Procedures for Disease Index Casefinding:

1. Generate list using appropriate ICD-9/IDC-10 codes.
2. Delete any codes not reportable (visual review of codes to eliminate any benign codes). NOTE: Some codes, such 238 & 239, require chart review to determine if reportable.
3. Review charts of cases on list and check for reportability- submit only cases that meet the criteria as outlined on reportable chart.

Things to consider:

- Know the Codes (specific to your facility) - Do your disease index codes reflect codes for procedures, symptoms, provisional diagnosis, diagnosis as stated on order from doctor, or final diagnosis? (You need to use the final diagnosis code for Casefinding.)
- Are all points of service included on disease index?
- How are x-rays and scans coded- Is there a way to obtain abnormal reports to review?
- V-Codes- no need to include these. **If** diagnosis is being coded correctly and they have active disease, code will reflect the 'cancer code'
- **This is a SCREENING TOOL ONLY.**

Procedures for Pathology Review:

1) Visually review ALL path reports, not just positive cases sent to you from the pathology department.
2) Check for missing numbers in sequential accession numbers
3) Note the clinical diagnosis if listed on the path report (patient may have a negative path that was treatment for a cancer)

Things to consider:

- Time spent reviewing ALL reports is well worth time and effort and will assure all cases are identified at that point
- Don't forget to review cytology and autopsy reports
- Report cases from a doctor's office but **not** from another hospital

External Casefinding Procedures

Casefinding Audits:
The GCR director and regional coordinators select hospitals to undergo casefinding audits. The purpose of these audits is to provide facilities with an external assessment of the completeness of their reporting. A hospital can also request an audit on their facility.

Death Clearance:
Death clearance is conducted every year by GCR to improve completeness of reporting. This is accomplished through a linkage of the death records from Georgia's Vital Statistics to the cancer registry records.

Hospital Discharge Linkage:
Hospital Discharge data linkage is another method used by GCR to improve completeness. GCR links the hospital discharge data base to the central cancer registry database. Cases with an ICD-9-CM/ICD-10-CM diagnosis code of cancer in the discharge database but not reported to GCR are evaluated further for reportability.

Rapid Case Ascertainment:
Rapid Case Ascertainment (RCA) is a casefinding procedure to identify cancer cases very soon after diagnosis. Information obtained through this method serves as a basis for quality control of GCR case completeness and also permits cancer incidence in Georgia to be reported earlier than through normal abstract submissions. RCA can also assist researchers in identifying cases that may be eligible to participate in research studies.

SUSPENSE FILE

The **suspense file** documents and organizes casefinding and is an essential component of reporting. This file is used to store or keep a record of the cases which have been determined to be reportable. The cases are kept in this file until they are actually abstracted or submitted, within SIX MONTHS from the date of diagnosis of cancer.

These files can be set up in a variety of modes. They can be either computerized or a manual set-up. Either way, preliminary data, such as name, medical record number, primary site, histology, lab number, and other identifying information is entered into these systems. This file is later converted to a primary site file once the case is abstracted or submitted.

Some registries use copies of pathology reports, which are checked against the patient index and then filed alphabetically by month. In addition to the pathology report, a listing of cases identified from other sources/departments is maintained. A printout of the hospital's diagnostic indices by month may also be placed in the pending file.

A computer program can serve as your pending file. In this case, preliminary data is entered into the program and once the case is completed, by adding all required data to the file, it would then be converted to a primary site file (abstract).

Your pending file is also helpful in preventing duplication. When a new case is identified, you should check it against your patient index file (master file) *and* against

your pending file to make sure the case hasn't already been identified. Another method that is helpful in preventing duplication is to "flag" the medical record charts of the submitted cases. A sticker or stamp on the chart would easily identify the case as previously being reported. It is important to use the Multiple Primary and Histology Rules to determine if a cancer is a duplicate or a new primary. Your Regional Coordinator can assist you in determining multiple primaries.

How To Submit:
Facilities reporting to the GCR with an annual caseload of less than or equal to 50:

Please see Appendix B.

.**Guidelines for ALL facilities regardless of size:**

A facility will be considered delinquent for the monthly submission if data has not been received by GCR by the last day of the month.

* If a facility had NO reportable cases for a month, an email to gccs@sph.emory.edu or gccs@gccs.gadirect.net should be submitted stating so. If it is not possible for a facility to submit during a given month, a notice must be submitted by email stating the reason and when the hospital plans to report. The facility will not be considered delinquent if notice is received by the last day of the non-reporting month. Acceptable reasons for not reporting include 1) recent personnel losses, 2) recent computer problems (software/hardware), and 3) natural disasters.

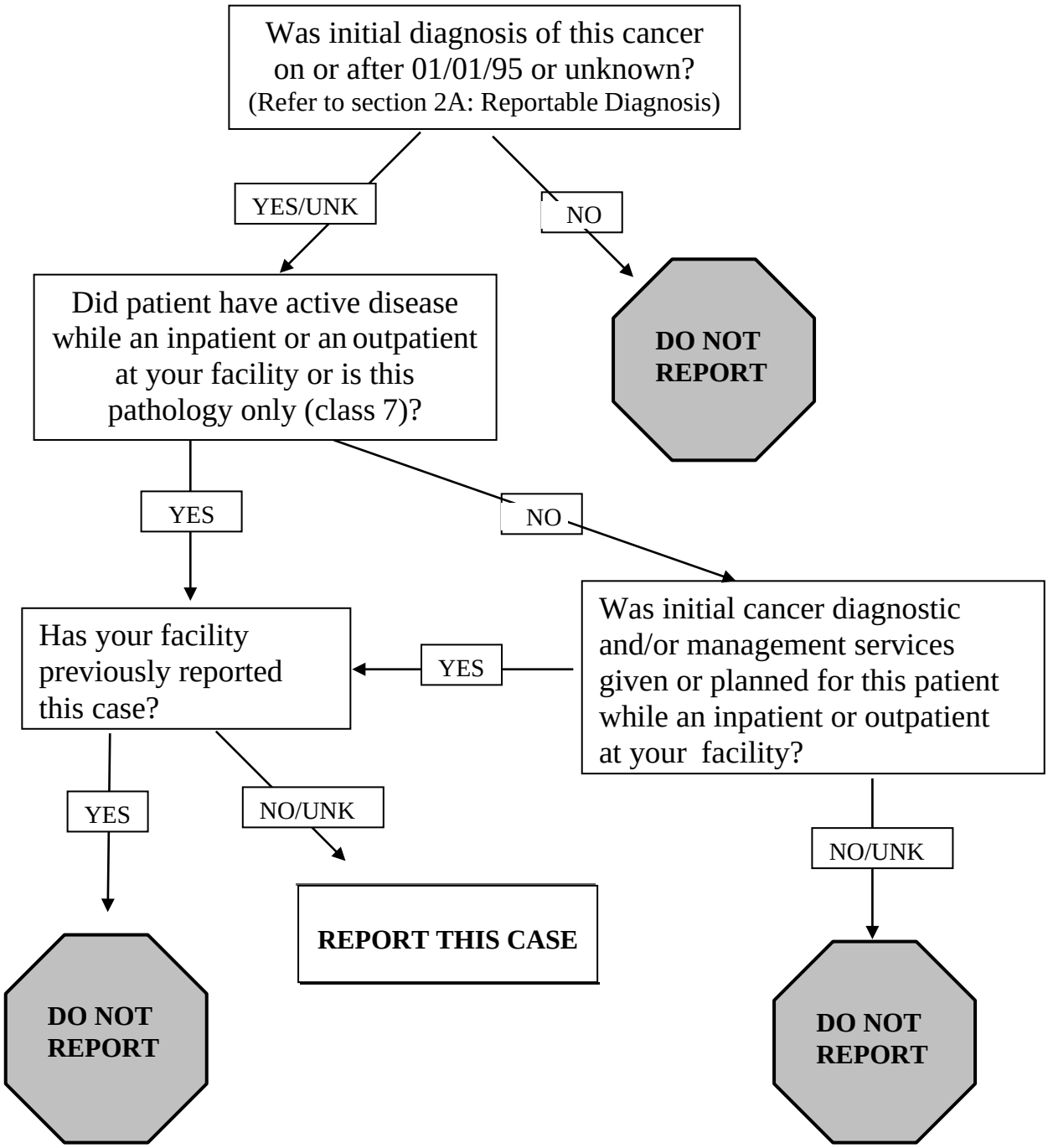
The facility will receive an email notification from GCR notifying the facility that the data submission has been received. If you do not receive this notification within a week after sending your submission, you should contact GCR for confirmation. You should maintain a copy of your confirmations for future reference.

WHERE TO SEND Submissions:

GCR requires all confidential data be encrypted before electronic transmission of data. Facilities should have the encryption software "Advanced Encryption Package 2012". Contact your Regional Coordinator to obtain a copy of the encryption software. Refer to GCR P&P manual for encryption procedures (Section 2.) or submitting confidential data by other means. Email: gccs@sph.emory.edu

Appendix A

B. REPORTING CHART



Appendix B

SMALL FACILITY REPORTING AND SUBMISSION METHODS

Disease Index and Pathology Reporting:

Facilities reporting to the GCR with an annual caseload of **less than or equal to 50 cancer cases** per year will be required to submit a disease index on a yearly basis to the GCR.

- The disease index should be in electronic format (ex: Excel, CSV). A template provided by your Regional Coordinator with minimum required fields must be used for reporting your disease index. Additional fields may be submitted if available from your electronic medical record system. Pathology reports may be in an electronic or pdf format.
- If you or your IT representative needs assistance in this format, please contact your Regional Coordinator.

Medical Record/Abstract Submissions:

Facilities reporting to the GCR with an annual caseload of **less than or equal to 50** cancer cases per year

- May submit abstracts electronically using Abstract Plus (free software from GCR) or other registry software.
- May submit medical records to the GCR to be abstracted.

Submission Methods:

All records, including the monthly disease index, pathology and supporting medical records, should be submitted using one of the method(s) below:

- ☐ Attach an electronic version of the disease index, pdf copy of pathology, and scanned medical records in an email using the GaHIN GaDirect webmail. **Data does not have to be encrypted**. An automatic receipt is sent. ***Important: Unencrypted reports must only be sent to and from a GaHIN webmail. Sending to and from another email account (.com, etc.) will not be processed and you will not receive confirmation.***
- ☐ Upload an electronic version of the disease index, pdf copy of pathology and scanned medical records to a secure GaHIN GaDirect webmail, or GCR assigned sFTP site. **Data does not have to be encrypted**.
- ☐ Provide the GCR and Regional Coordinator access to the facility's Electronic Medical Record. The Regional Coordinator will use the access to screen the disease index for reportable cases. GCR will then abstract the cancer data as a service to the facility.

Medical records submitted must include the following:

A cover sheet should indicate the following: 1) Reporting facility, 2) date of submission, and, 3) number of cases being sent.

Individual records must include the following:

- Demographic or Face Sheet
- Discharge Summary
- History and Physical, Consult, and Progress Reports
- Pertinent x-ray reports, scans. Do not send routine laboratory reports unless specific for the cancer
- Operative report
- Pathology Report
- Cytology Report
- Cancer Treatment Information

Please make sure all records and all admissions on each patient are placed together.

When scanning records, please make sure copies are legible.

The facility should contact GCR if they do not receive a receipt confirmation by email within 5 business days.

Your Regional Coordinator is available to assist in your transition to these options for reporting to the GCR.

Guidelines for Small facilities regardless of size:

A facility will be considered delinquent for the monthly submission if data has not been received by GCR by the last day of the month except for Small Facilities. Small facilities should submit an entire year disease index for the prior year in January of the year following diagnosis or admission for cancer. Disease indexes must be in excel or csv format, submitted via GaDirect, or uploaded to a GCCS sFTP account. Medical records should be submitted between January and March of the following year of diagnosis or admission for cancer.

* If a facility had NO reportable cases for a month, an email to gccs@sph.emory.edu or gccs@gccs.gadirect.net should be submitted stating so. If it is not possible for a facility to submit during a given month, a notice must be submitted by email stating the reason and when the hospital plans to report. The facility will not be considered delinquent if notice is received by the last day of the non-reporting month. Acceptable reasons for not reporting include 1) recent personnel losses, 2) recent computer problems (software/hardware), and 3) natural disasters.

The facility will receive an email notification from GCR notifying the facility that the data submission has been received. If you do not receive this notification within a week after sending your submission, you should contact GCR for confirmation. You should maintain a copy of your confirmations for future reference.

Appendix C

CASE FINDING LISTS

Please refer to Section 2 of this manual.

CODING AND STAGING LINKS

Please refer to Section 4 of this manual.

GCR REQUIRED DATA SET for 2018 and 2019

Please refer to Section 4 of this manual.

Appendix D

RESOURCES AND REFERENCES

Please refer to Section 9 of this manual.

Appendix E

GEORGIA CANCER REGISTRY DATA SUBMISSION WEB PAGE

Georgia Comprehensive Cancer Registry Web Page
http://www.sph.emory.edu/GCCS/GAHospitals.php

Features of each link:

Application Downloads Page – facility number and password needed for
access Abstract Plus System - free software for cancer abstracting
Incidental Update Form - form to provide updated data on previously submitted abstracts
Advanced Encryption Package 2012 Professional – Software for encrypting confidential data

Georgia Hospital Edits - Software application for running Georgia's State specific edits

- Monthly Submission Data Upload -facility number and password needed for access. You can upload your monthly data thru our secure web site

- Monthly Submission Reports – facility number and password needed for access. You can download copies of submission receipts for each monthly submission up to a year's worth of data.

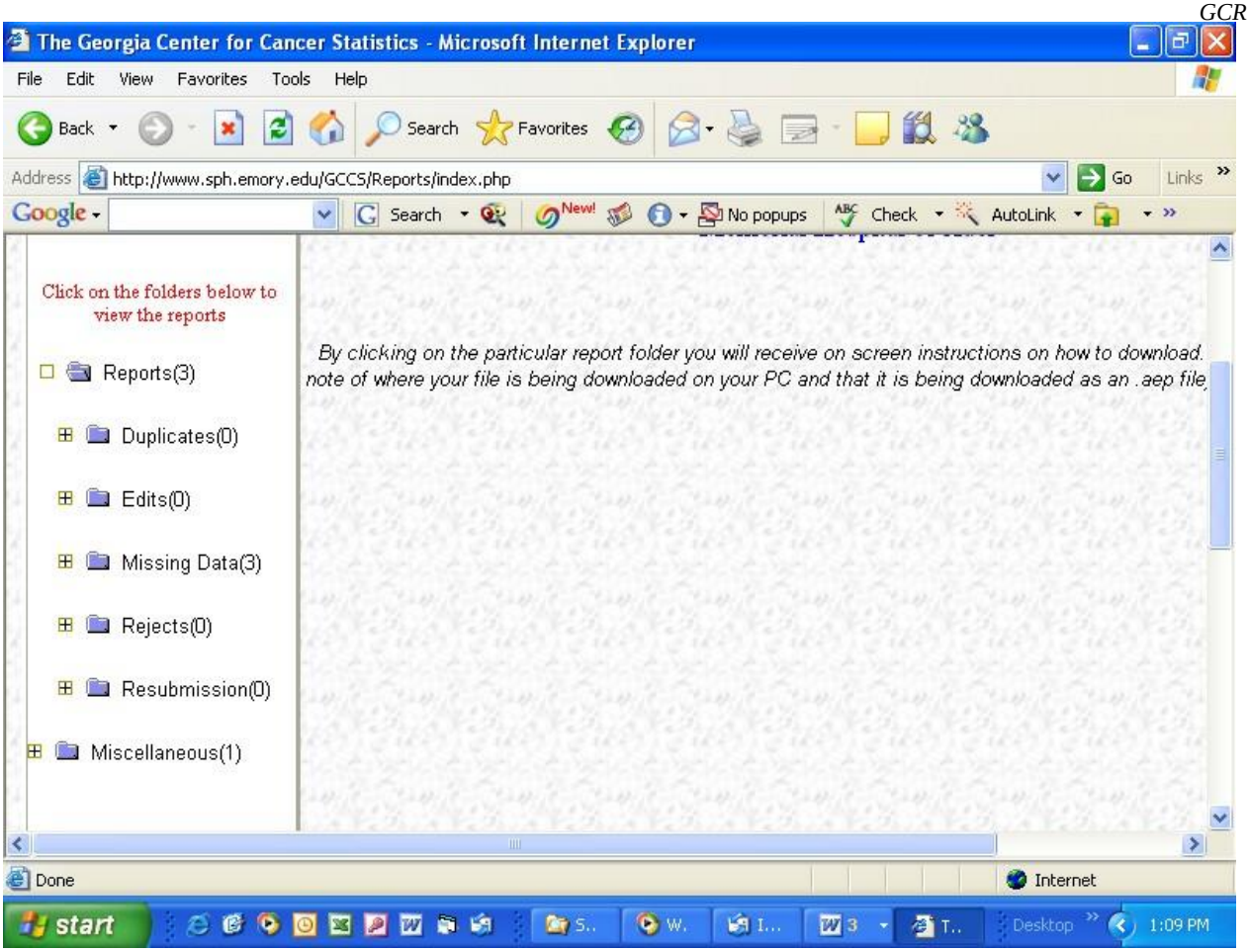
- Facility Contact Information - facility number and password needed for access

Update Facility Information
View Facility Information
Update Facility Password
Facility Name Change

Accessing Monthly Submission Reports on GCR web site

http://web1.sph.emory.edu/GCCS/cms/reporting/index.html

You can now access via our secured web site your monthly submission reports. All reports are encrypted. You will need your facility number and password in order to access your reports as well as the encryption software. Enter facility number and password.



The folders to the left of your screen show the five types of reports that are generated with each submission. You must click on the folder icon to open a particular folder. Below is a description of each folder and the reports that are found within. You can refer to each folder for more information regarding each report.

Edits - Report is generated if there are edit errors within a particular monthly submission.

Rejects - Report shows a summary of the abstracts submitted, accepted, rejected, and duplicate abstracts.

Resubmissions - Report showing your resubmission progress for rejected/edit error reports

Some reports are named using the naming conventions that have been established i.e. 380000May17_1HOS***.PDF.AEP. Refer to section 2 page 5 of this Manual.

PDF—Portable Document Format uses Adobe Acrobat Reader to view.

AEP = Advanced Encryption Program format (File is encrypted and must be decrypted in order to be viewed).

Once you open a particular folder you can download any or all reports found within the folder. By clicking on the particular report you will receive on screen instructions on how to download. (Be sure you make note of where your file is being downloaded on your PC and that it is being downloaded as an .aep file)

*** = See specific report folders for explanation.

GEORGIA REPORTING LAW AND MANDATE

Please refer to Section 8 of this manual.

STUDY GUIDES FOR THE CERTIFIED TUMOR REGISTRAR'S EXAMINATION:

Please refer to Section 9 of this manual.

INTERNET SITES OF INTEREST FOR INFORMATION

Please refer to Section 9 of this manual.

LIST OF PAIRED ORGAN SITES

Please refer to Section 7 of this manual.

FILE NAMING CONVENTIONS FOR DATA SENT TO THE GEORGIA CANCER REGISTRY

Please refer to Section 2 of this manual.

APPENDIX F

CLASS OF CASE

Description

Class of Case divides cases into two groups.

Analytic cases (codes 00–22) are those that are required by CoC to be abstracted because of the program's primary responsibility in managing the cancer. Analytic cases are grouped according to the location of diagnosis and first course of treatment.

Nonanalytic cases (codes 30–49 and 99) may be abstracted by the facility to meet central registry requirements or in response to a request by the facility's cancer program. Nonanalytic cases are grouped according to the reason a patient who received care at the facility is nonanalytic, or the reason a patient who never received care at the facility may have been abstracted.

Rationale

Class of Case reflects the facility's role in managing the cancer, whether the cancer is required to be reported by CoC, and whether the case was diagnosed after the program's Reference Date.

Instructions for Coding

The code structure for this item was revised in 2010. See *NAACCR Inc. 2010 Implementation Guidelines and Recommendations* for conversion instructions between code structures. Code the *Class of Case* that most precisely describes the patient's relationship to the facility.

Code 00 applies only when it is known the patient went elsewhere for treatment. If is not known that the patient actually went somewhere else, code *Class of Case* 10.
It is possible that information for coding *Class of Case* will change during the patient's first course of care. If that occurs, change the code accordingly.
Document *NPI–Institution Referred To* (NAACCR Item #2425) or the applicable physician NPI (NAACCR #s 285, 2495, 2505) for patients coded 00 to establish that the patient went elsewhere for treatment.

Code 34 or 36 if the diagnosis benign or borderline (*Behavior* 0 or 1) for any site diagnosed before 2004 or for any site other than meninges (C70._), brain (C71._), spinal cord, cranial nerves, and other parts of central nervous system (C72._), pituitary gland (C75.1), craniopharyngeal duct (C75.2) and pineal gland (C75.3) that were diagnosed in 2004 or later.

Code 34 or 36 for carcinoma in situ of the cervix (CIS) and intraepithelial neoplasia grade III (8077/2 or 8148/2) of the cervix (CIN III), prostate (PIN III), vulva (VIN III), vagina (VAIN III), and anus (AIN III).
A staff physician (codes 10-12, 41) is a physician who is employed by the reporting facility, under contract with it, or a physician who has routine practice privileges there. Treatment provided in a staff physician's office is provided "elsewhere". That is because care given in a physician's office is not within the hospital's realm of responsibility. If the hospital has purchased a physician practice, it will be necessary to determine whether the practice is now legally considered part of the hospital (their activity is coded as the hospital's) or not. If the practice is not legally part of the hospital, it will be necessary to determine whether the physicians involved are staff physicians or not, as with any other physician. "In-transit" care is care given to a patient who is temporarily away from the patient's usual practitioner for continuity of care. If these cases are abstracted, they are *Class of Case* 31. If a patient begins first course radiation or chemotherapy elsewhere and continues at the reporting facility, and the care is not in-transit, then the case is analytic (*Class of Case* 21).

Codes

Analytic Classes of Case (Required by CoC to be abstracted by accredited programs)

Initial diagnosis at reporting facility or in a staff physician's office

00 Initial diagnosis at the reporting facility AND all treatment or a decision not to treat was done elsewhere
10 Initial diagnosis at the reporting facility or in a staff physician's office AND part or all of first course treatment or a decision not to treat was at the reporting facility, NOS
11 Initial diagnosis in staff physician's office AND part of first course treatment was done at the reporting facility
12 Initial diagnosis in staff physician's office AND all first course treatment or a decision not to treat was done at the reporting facility

13 Initial diagnosis at the reporting facility AND part of first course treatment was done at the reporting facility; part of first course treatment was done elsewhere.
14 Initial diagnosis at the reporting facility AND all first course treatment or a decision not to treat was done at the reporting facility
20 Initial diagnosis elsewhere AND all or part of first course treatment was done at the reporting facility, NOS
21 Initial diagnosis elsewhere AND part of first course treatment was done at the reporting facility; part of first course treatment was done elsewhere.
22 Initial diagnosis elsewhere AND all first course treatment or a decision not to treat was done at the reporting facility

Classes of Case not required by CoC to be abstracted (May be required by Cancer Committee, state or regional registry, or other entity- <u>REQUIRED BY GEORGIA, USE GA REFERENCE DATE: 1995)</u>

Patient appears in person at reporting facility
30 Initial diagnosis and all first course treatment elsewhere AND reporting facility participated in diagnostic workup (for example, consult only, treatment plan only, staging workup after initial diagnosis elsewhere)
31 Initial diagnosis and all first course treatment elsewhere AND reporting facility provided in-transit care; or hospital provided care that facilitated treatment elsewhere (for example, stent placement)
32 Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease recurrence or persistence (active disease)
33 Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease history only (disease not active)
34 Type of case not required by CoC to be accessioned (for example, a benign colon tumor) AND initial diagnosis AND part or all of first course treatment by reporting facility
35 Case diagnosed before program's Reference Date AND initial diagnosis AND all or part of first course treatment by reporting facility
36 Type of case not required by CoC to be accessioned (for example, a benign colon tumor) AND initial diagnosis elsewhere AND all or part of first course treatment by reporting facility
37 Case diagnosed before program's Reference Date AND initial diagnosis elsewhere AND all or part of first course treatment by facility
38 Initial diagnosis established by autopsy at the reporting facility, cancer not suspected prior to death *Patient does not appear in person at reporting facility*
40 Diagnosis AND all first course treatment given at the same staff physician's office
41 Diagnosis and all first course treatment given in two or more different staff physician offices
42 Nonstaff physician or non-CoC accredited clinic or other facility, not part of reporting facility, accessioned by reporting facility for diagnosis and/or treatment by that entity (for example, hospital abstracts cases from an independent radiation facility)
43 Pathology or other lab specimens only
49 Death certificate only
99 Nonanalytic case of unknown relationship to facility (not for use by CoC accredited cancer programs for Analytic

<u>Examples:</u>
00- Leukemia was diagnosed at the facility, and all care was given in a staff physician's office. The treatment may be abstracted if the cancer committee desires, but the case is *Class of Case* 00.
13 Breast cancer was diagnosed at the reporting hospital and surgery performed there. Radiation was given at the hospital across the street with which the reporting hospital has an agreement.
10 Reporting hospital found cancer in a biopsy, but was unable to discover whether the homeless patient actually received any treatment elsewhere.
32 After treatment failure, the patient was admitted to the facility for supportive care
11 Patient was diagnosed by a staff physician, received neoadjuvant radiation at another facility, then underwent surgical resection at the reporting facility
42 Patients from an unaffiliated, free-standing clinic across the street that hospital abstracts with its cases because many physicians work both at the clinic and the hospital.
31 Patient received chemotherapy while attending daughter's wedding in the reporting hospital's city, then returned to the originating hospital for subsequent treatments.

Georgia Department of Public Health

Georgia Comprehensive Cancer Registry

2 Peachtree Street NW

Atlanta, GA 30303

GCR Policy and Procedure Manual
Publication Number: DPH0364P
Revised Date: March 1, 2019