



Commonwealth of Virginia

Department of Health

***The Honorable Tim Kaine,
Governor***

***Robert B Stroube, MD, MPH,
State Health Commissioner***

VIRGINIA CANCER REGISTRY MANUAL
October 2007

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PREFACE

The rate of new cancer cases in Virginia is a public health concern. More than 30,000 Virginia residents are diagnosed with cancer each year. Without information on these new cases of cancer, it is difficult to plan prevention, education, screening, early detection, treatment, and rehabilitation programs. The Virginia Cancer Registry (VCR) records the incidence of cancer for the Commonwealth of Virginia and provides data to help public health authorities, physicians, researchers, and other health professionals plan and evaluate cancer programs. The registry also directly serves the citizens of the Commonwealth by providing and interpreting statistical information on cancer in the state.

In 1970, hospitals began voluntarily contributing cancer reports to the Virginia Tumor Registry. In 1990, the Virginia General Assembly mandated that the Virginia Cancer Registry be established in the Virginia Department of Health (see Appendix A). The legislation prescribed the purpose of the statewide cancer registry to include:

- Determining means of improving the diagnosis and treatment of cancer patients.
- Determining the need for and means of providing better long-term, follow-up care of cancer patients.
- Conducting epidemiological analyses of the incidence, prevalence, survival, and risk factors associated with the occurrence of cancer in Virginia.
- Collecting data to evaluate the possible carcinogenic effects of environmental hazards including exposure to dioxin and the defoliant, Agent Orange.
- Improving rehabilitative programs for cancer patients.
- Assisting in the training of hospital personnel.
- Determining other needs of cancer patients and health personnel.

As a population-based cancer incidence registry, the VCR collects demographic, diagnostic, and first course treatment information on all Virginia residents diagnosed with cancer. All information collected and maintained in the VCR database is strictly confidential. Only summary statistical information is published for general distribution and public knowledge. The Virginia Department of Health may permit use of in-depth information for research, subject to careful screening, strict supervision, and only to accomplish approved program objectives.

To fulfill some of the goals the state legislature set for the registry, VCR is an active partner with Virginia Department of Health programs that promote cancer prevention and control. These programs include the Virginia Comprehensive Cancer Control Program and the Virginia Breast and Cervical Early Detection Program. VCR data are used for cancer research and surveillance activities, and for epidemiologic and other special studies. Virginia incidence and mortality data are published annually in the national summary *United States Cancer Statistics (USCS)*, (<http://apps.nccd.cdc.gov/uscs/>). USCS is a joint publication that CDC and the National Cancer Institute (NCI) produce. It includes the most recent five years of data. A large variety of cancer incidence data broken out by site and demographic variables is available on the VCR website at <http://www.vahealth.org/cdpc/cancer/index.asp>. Virginia data are also published in *Cancer in North America (CINA)*, which is an annual report the North American Association of central Cancer Registries (NAACCR) publishes. *CINA* is available at the NAACCR web site, <http://www.naacr.org/>.

VCR is recognized as an up-and-coming cancer reporting system and a valuable resource for cancer data. VCR uses current technology and national data collection standards to enhance the completeness, accuracy, and timeliness of cancer data. As the volume of VCR incidence data increases over time, the utility of these data for program planning, evaluation, and epidemiologic studies increases as well. The VCR depends on all cancer reporters for support, cooperation, and accurate reporting for the ongoing operation of the statewide cancer registry. As VCR staff work together with staff of reporting facilities statewide, complete and reliable cancer incidence data will continue to be available to provide answers to our questions, to reduce the burden of cancer in Virginia, and to improve the lives of both present and future patients.

**PART ONE:
REPORTING REQUIREMENTS**

VCR MANUAL, OCTOBER 2007 EDITION

This manual shall be used to submit reportable cases with a Date Diagnosis on or after January 1, 2008 except where noted.

WHAT IS THE VCR

The Virginia Cancer Registry (VCR) is a population-based cancer incidence registry responsible for the collection of demographic, diagnostic, and treatment information on all cancer patients diagnosed and treated at hospitals, laboratories, and other health care facilities in Virginia with reportable cancer. Population-based cancer registries collect information on cancers among the entire population for which they are responsible.

The VCR is also defined as an incidence only cancer registry rather than a multi-purpose registry. Incidence only registries gather only the information necessary to determine the incidence of cancer by geographic areas, by demographic characteristics, and by stage at diagnosis for each type of cancer. Treatment information has also been added to the information collected.

The term *central cancer registry* is also used in referring to the VCR. Although a central registry does not have to be population-based, this term is frequently used to mean a statewide cancer registry. A central registry is designed to aggregate data from various sources. The contributing sources required to report to the VCR provide statewide coverage of the population.

WHY REPORT TO THE VCR

The mission of the VCR is to collect and provide complete, accurate, and timely statewide incidence data for determination of cancer rates and trends in the population. To fulfill this mission, the VCR depends on complete ascertainment of cases and use of the data.

1. The Law and Regulations - Statewide collection and dissemination of data on cancer by the Virginia Department of Health is mandated in the *Code of Virginia* and Virginia Department of Health disease reporting regulations. The state laws include Chapter 2 (§32.1-70 *et seq.*) of Title 32.1(*VCR Manual Appendix A*) According to these statutes, each hospital, clinic, and independent pathology laboratory in the Commonwealth is required to report all cases of cancer, which are diagnosed or treated at the hospital, clinic or laboratory. Physicians are required to report when they know the case has not been reported by a hospital, clinic or in-state laboratory. These cases are to be submitted in the format prescribed by the Virginia Cancer Registry. Regulations mandating reporting cancer cases by hospitals, clinics, laboratories, other health care facilities and health care practitioners appear Part VIII of the State Board of Health publication *Regulations for Disease Reporting and Control*. (*VCR Manual Appendix B*)

WHY REPORT TO THE VCR, continued

2. **Cancer Control** - The ultimate value of the registry lies not in collection of the data but in the degree to which the data are used for cancer control. The basis for any successful cancer control program is a comprehensive registry system. Registry data provide answers to questions, the means to target limited cancer control resources, and the mechanism to evaluate cancer control activities.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

HIPAA allows for the reporting of identifiable cancer data to public health entities. Because the VCR falls under the definition of a public health entity, HIPAA allows you to report data to the VCR in compliance with Virginia state laws and regulations. Written informed consent from each cancer patient reported to public health entities is not required under HIPAA.

The VCR depends on reporting facilities to submit quality data. Through the dedicated efforts of these facilities, the VCR is able to provide accurate information used to establish and enhance cancer control programs, and thus improve the lives of present and future patients with cancer.

VCR REFERENCE DATE

Reference date refers to the start date after which all eligible records must be included in the registry. The VCR reference date is January 1, 1990. This means complete statewide cancer incidence data are available from the VCR for 1990 to the present.

Note: In order to assure complete case ascertainment, reference date is not used to determine what cases are reportable to the VCR. See *VCR Manual Part One, Date of Diagnosis Reportability*.

VCR REPORTING SOURCES

The Code of Virginia mandates each designated hospital, physician and laboratory in the Commonwealth shall report all cases of cancer, which are diagnosed and/or treated at the hospital, physician office, or laboratory. In addition, the VCR has agreements with other states to exchange data.

VCR REPORTING SOURCES, continued**Hospitals**

1. Registry Hospitals - The term *registry hospital* refers to hospitals with cancer registries functioning as an integral component of the hospital cancer program. They may or may not be accredited by the American College of Surgeons Commission on Cancer. Generally, the cancer registrar or cancer program manager at a registry hospital is delegated the responsibility of reporting to the VCR.
2. Non Registry Hospitals - The term *non registry hospital* refers to hospitals that do not have cancer registries functioning as an integral component of a hospital cancer program. Generally, personnel in the Health Information Management (HIM) Department are delegated the responsibility of reporting to the VCR.

Laboratories

The addition of these cases provides the VCR data on cases never seen in the hospital setting, thereby increasing the overall completeness of VCR data.

1. Hospital Laboratories - Required reporting of cases by hospital laboratories is performed by cancer registry or HIM personnel as described above.
2. Free-Standing Pathology Laboratories - Reporting of cases by designated free-standing laboratories is required.

Non-Hospital Sources

The Board of Health's regulations concerning the Regulations for Disease Reporting were revised in January 2002 to expand cancer reporting requirements to include additional non-hospital sources.

Part VIII, 12 VAC 5-90-170 requires hospitals, clinical laboratories, or other health care facilities providing screening, diagnostic or therapeutic services for cancer patients to report cases of cancer. Reporting by "other health care facilities" will be phased in as follows: 1) Radiation Centers, 2) Medical Oncology Centers, 3) Hematology/Oncology Practices, and 4) Ambulatory Surgery Centers.

Data Exchange

The VCR has written agreements to exchange data with other cancer registries including all contiguous states. This insures a resident of Virginia who was diagnosed and/or treated out-of-state will be included in the VCR database.

HOSPITAL REPORTING METHODS

Reporting facilities are encouraged to submit all their cases electronically. Electronic reporting is the submission of reportable cases to the VCR on media (diskette or compact disc (CD)) using commercial, hospital-developed or AbstractPlus software. Written approval from the VCR is required to report electronically. See *VCR Manual Appendix C, Electronic Reporting*.

1. Commercial/Hospital-Developed Software - Registry hospitals are required to electronically report cases included in the hospital cancer registry using commercial or hospital-developed software after all VCR approval criteria are met.

REPORTABLE CONDITIONS

VCR List of Reportable Conditions

The *VCR List of Reportable Conditions* is found in the *VCR Manual Appendix D*. This section identifies diagnoses that must be reported to the VCR. Conditions are to be reported if the diagnosis includes the words *malignant, cancer, carcinoma, and lymphoma*. Most *leukemias* and *sarcomas* are reportable except when noted as exclusions on the listing. In addition, there are other conditions, which do not include these particular terms but are reportable such as *Wilms tumor, blastoma, and carcinoid*. It is therefore very important to refer to the *VCR List of Reportable Conditions* to make sure all reportable conditions are identified.

All primary intracranial and central nervous system (CNS) tumors are reportable. This includes benign, malignant and borderline tumors for the following sites:

- Meninges (C70.0 - C70.9)
- Brain (C71.0 - C71.9)
- Spinal Cord (C72.0)
- Cauda equina (C72.1)
- Cranial nerves (C72.2 - C72.5)
- Other CNS (C72.8, C72.9)
- Pituitary gland (C75.1)
- Craniopharyngeal duct (C75.2)
- Pineal gland (C75.3)

Ambiguous Terminology

A patient has a reportable condition if a *recognized medical practitioner* says so. In most cases the patient's record clearly presents the diagnosis by use of specific terms, which are synonymous with the diagnosis. However, the physician may not always be certain or the recorded language definitive. VCR rules concerning the usage of ambiguous terminology are as follows:

REPORTABLE CONDITIONS continued
--

1. Terms That Constitute a Diagnosis - Interpret the following terms as a reportable diagnosis:

<i>apparent(ly)</i>	<i>consistent with</i>	<i>neoplasm</i>	<i>suspicious (for)</i>
<i>appears</i>	<i>favor(s)</i>	<i>presumed</i>	<i>tumor</i>
<i>comparable with</i>	<i>malignant appearing</i>	<i>probable</i>	<i>typical (of)</i>
<i>compatible with</i>	<i>most likely</i>	<i>suspect(ed)</i>	

2. Terms That Do Not Constitute a Diagnosis - Do not interpret the following terms as a diagnosis. Do not report patients who have a final diagnosis consisting only of these terms without additional information to support reportability:

<i>cannot be ruled out</i>	<i>potentially malignant</i>	<i>suggests</i>
<i>equivocal</i>	<i>questionable</i>	<i>worrisome</i>
<i>possible</i>	<i>rule(d) out</i>	

3. How To Use Ambiguous Terminology For Case Ascertainment

- a. In Situ and Invasive (Behavior codes /2 and /3)

1. If any of the reportable **ambiguous terms precede** a word that is **synonymous** with an in situ or invasive tumor (e.g., cancer, carcinoma, malignant neoplasm, etc.), the case is reportable.

Example 1: The pathology report says: Prostate biopsy with markedly abnormal cells that are typical of adenocarcinoma. Report the case.

Example 2: The final diagnosis on the outpatient report reads: Rule out leukemia. Do not report the case.

2. Discrepancies: If one section of the medical record(s) uses a reportable term such as “apparently” and another section of the medical record(s) uses a non-reportable term such as “cannot be ruled out”, accept the reportable term and report the case.

Exception: Do not report a case based only on suspicious cytology. The case is reported only if proven by positive cytology or other diagnostic methods including a physician’s clinical diagnosis.

REPORTABLE CONDITIONS, continued

3. Use these terms when **screening** diagnoses on pathology reports, operative reports, scans, mammograms, and other diagnostic testing other than tumor markers.

Note: If the ambiguous diagnosis is **proven to be not reportable** by biopsy, cytology, or physician's statement, **do not report** the case.

Example: Mammogram shows calcifications suspicious for intraductal carcinoma. The biopsy of the area surrounding the calcifications is negative for malignancy. Do not report the case.

b. Benign and borderline primary intracranial and CNS tumors

1. Use the "Ambiguous Terms that are Reportable" list to identify benign and borderline primary intracranial and CNS tumors that are reportable.
2. If any of the reportable **ambiguous terms precede** either the word "**tumor**" or the word "**neoplasm**," the case is reportable. Report the case.

Example: The mass on the CT scan is consistent with pituitary tumor. Report the case.

3. Discrepancies: If one section of the medical record(s) uses a reportable term such as "apparently" and another section of the medical record(s) uses a non-reportable term such as "cannot be ruled out", accept the reportable term and accession the case.

Exception: Do not report a case based only on suspicious cytology. The case is reported only if proven by positive cytology or other diagnostic methods including a physician's clinical diagnosis.

4. Use these terms when **screening** diagnoses on pathology reports, scans, ultrasounds, and other diagnostic testing other than tumor markers.

Note: If the **ambiguous** diagnosis is proven to be **not reportable** by biopsy, cytology, or physician's statement, **do not report** the case.

- c. Confirmation of an Ambiguous Diagnosis - Subsequent admissions for patients whose initial diagnosis contained ambiguous terminology must be reviewed. It is established practice to accept the information at the time of the latest admission, or the most complete or detailed information.

REPORTABLE CODES

ICD-9-CM Codes

Use the following ICD-9-CM codes to identify reportable conditions. Conditions in *italics* are reportable only when diagnosed on or after January 1, 2001. Conditions in brackets [] are only reportable when the diagnosis date is prior to January 1, 2001.

140 - 199	Malignant Neoplasms
200 - 208	Lymphoma/Leukemia/Multiple Myeloma
210 – 229.9	Benign Neoplasms
225.0- 225.4	Benign neoplasm of brain, cranial nerves, cerebral meninges, spinal cord, cauda equina, spinal meninges
225.8	Benign neoplasm of other specified sites of nervous system
225.9	Benign of nervous system, part unspecified
227.3	Benign neoplasm of pituitary, craniopharyngeal duct, craniobuccal pouch, hypophysis, Rathke's pouch, sella turcica
227.4	Benign neoplasm of pineal gland, pineal body
230 – 234	Carcinoma in situ (Exclude 233.1*)
235.0 – 238.9	Neoplasms of uncertain behavior
[235.4]	[Peritoneum/Cystadenoma, Borderline Malignancy]
236.0	<i>Endolymphatic Stromal Myosis/Endometrial Stromatosis/ Stromal Endometriosis/Stromal Myosis</i>
[236.2]	[Tumor of Ovary/Cystadenoma, Borderline Malignancy of Low Malignant Potential]
237.0	Neoplasm of uncertain behavior of pituitary gland and craniopharyngeal duct
237.1	Neoplasm of uncertain behavior of pineal gland
237.5	Neoplasm of uncertain behavior of brain and spinal cord. <i>Papillary Ependymoma</i>
237.6	Neoplasm of uncertain behavior of meninges: NOS, cerebral, spinal. <i>Papillary Meningioma</i>
237.70	Neurofibromatosis, Unspecified von Recklinghausen's Disease
237.71**	Neurofibromatosis, Type One von Recklinghausen's Disease
237.72	Neurofibromatosis, Type Two von Recklinghausen's Disease
237.9	Neoplasm of uncertain behavior of other & unspecified parts of nervous system; cranial nerves
238.3	Phyllodes Tumor, Malignant (Cystosarcoma Phyllodes)
238.4	<i>Polycythemia Vera (Proliferative, Primary or Rubra Vera)</i>
238.6	Plasmacytoma/Solitary Myeloma
238.7	<i>Acute Panmyelosis/Chronic Myeloproliferative Disease/Myelosclerosis with Myeloid Metaplasia/ Essential Thrombocythemia/Refractory Cytopenia with Multilineage Dysplasia/Myelodysplastic Syndrome with 5q-Syndrome/Therapy-Related Myelodysplastic Syndrome/Myelodysplastic Syndrome, NOS</i>
273.2	Alpha Heavy Chain Disease/Franklin disease/Gamma Heavy Chain Disease
273.3	Waldenstrom Macroglobulinemia
273.9	Unspecified disorder of immune mechanism (screen for potential 273.3 miscodes)
284.9 - 285.0	<i>Refractory Anemia</i>
288.3	<i>Hypereosinophilic Syndrome</i>
289.8	Acute Myelofibrosis
V58.0	Admission for Radiotherapy
V58.1	Admission for Chemotherapy
V67.1	Radiation therapy follow-up
V67.2	Chemotherapy follow-up

* Carcinoma in situ of the cervix is not reportable; quality control procedures must be in place to make sure if micro-invasion is present the medical record is not coded to 233.1.

** Code 237.71 may not be reportable; however, this diagnosis may indicate a reportable condition and should be reviewed.

REPORTABLE CODES, continued

If time and resources permit, review of the following codes may assist in casefinding activities:

042	AIDS (review cases for AIDS-related malignancies)
273.9	Unspecified disorder of immune mechanism (screen for potential 273.3 miscodes)
V07.3	Other Prophylactic Chemotherapy (screen carefully for miscoded malignancies)
V07.8	Other specified prophylactic measure
V10	Personal history of malignancy (screen for subsequent primaries and/or subsequent treatment)
V66.1	Convalescence following Radiotherapy
V66.2	Convalescence following Chemotherapy
V71.1	Observation for suspected malignant neoplasm
V76	Special screening for malignant neoplasm

ICD-O Behavior Codes

All records with a behavior code of /2 (in situ) or /3 (malignant) in the *International Classification of Diseases for Oncology, Second Edition (ICD-O-2)* or *Third Edition (ICD-O-3)* are reportable. (These references are used primarily by registry hospitals.)

Exception 1: Cervical intraepithelial neoplasia, grade III, also called CIN III (code 8077/2 with primary site C53.X in ICD-O-3) is not reportable.

Exception 2: Prostatic intraepithelial neoplasia, grade III, also called PIN III (code 8148/2 in ICD-O-3) is not reportable.

Exception 3: Pilocytic/Juvenile astrocytoma (code 9421/3 in ICD-O-2 and 9421/1 in ICD-O-3) is reportable and must be coded with a behavior of /3 (malignant).

If a pathologist verifies a /0 (benign) or /1 (uncertain whether benign or malignant) behavior code term in ICD-O as /2 (in situ) or /3 (malignant), these records are reportable.

Cases diagnosed with primary intracranial and central nervous system tumors with a behavior code of /0 or /1 (benign and borderline or "non-malignant") are reportable regardless of histologic type for the sites listed below:

- Meninges (C70.0 - C70.9)
- Brain (C71.0 - C71.9)
- Spinal Cord (C72.0)
- Cauda equina (C72.1)
- Cranial nerves (C72.2 - C72.5)
- Other CNS (C72.8, C72.9)
- Pituitary gland (C75.1)
- Craniopharyngeal duct (C75.2)
- Pineal gland (C75.3)

MULTIPLE PRIMARY DETERMINATION

More Than One Cancer

If more than one primary is diagnosed, a separate record must be submitted on each primary.

Determining Multiple Primary Cancers

The VCR, like most registries in the United States, follows the rules of the Surveillance, Epidemiology and End Results (SEER) Program for determination of multiple primary cancers. Beginning with cases diagnosed on January 1, 2007 the SEER rules for determining multiple primary cancers are documented in the SEER 2007 *Multiple Primary and Histology Coding Rules*. For cases diagnosed prior to 2007, the SEER rules for determining multiple primary cancers are documented in the *VCR Manual Appendix E, Multiple Primary Determination*.

DATE OF DIAGNOSIS REPORTABILITY

All reportable cases included on the *VCR List of Reportable Conditions* (See *VCR Manual Appendix D, Reportable Conditions*) diagnosed or treated at the facility are required to be reported to the VCR regardless of Date of Diagnosis. This includes patients with an unknown date of initial diagnosis.

Exception 1: Conditions only reportable if diagnosed on January 1, 2001 and after (the conditions with ** in *VCR Manual, Appendix D*) are not reportable if the date of diagnosis is unknown.

Example 1: If a patient is admitted on January 3, 2004 and is diagnosed with lung cancer on January 7, 2004, the case is reportable.

Example 2: If a patient is admitted on January 3, 2004 and receives palliative care for bone metastasis from a breast primary diagnosed in 1990, the case is reportable.

Example 3: If a patient is admitted on January 3, 2004 and receives palliative care for bone metastasis from a breast primary for which a diagnosis date is not stated in the medical record, the case is required to be reported using 99999999 for the Date of Diagnosis.

Example 4: If a patient is admitted on January 3, 2004 and receives a blood transfusion for polycythemia vera, originally diagnosed in November 1999, the case is not reportable per the *VCR List of Reportable Conditions* and *Exception 1* above.

REPORTABLE CASES

Reportable Diagnosis

A diagnosis is reportable to the VCR if it is included on the *VCR List of Reportable Conditions* (See *VCR Manual Appendix D, Reportable Conditions*). The following guidelines provide further clarification for the specified conditions:

1. Basal and Squamous Cell Carcinomas – Basal and squamous cell carcinomas are reportable except when primary to the skin, C44.0-C44.9 (see *VCR Manual Part One, Exclusions*). Carcinomas originating in mucoepidermoid sites are reportable. These sites include: lip (C00.0-C00.9), anus (C21.0), vulva (C51.0-C51.9), vagina (C52.9), penis (C60.0-C60.9), and scrotum (C63.2). Basal and squamous cell carcinomas originating in the nasal cavity (C30.0) and middle ear (C30.1) are also reportable.
2. Class IV and Class V Cytologies – Cytology results of Class IV or Class V are reportable to the VCR.

Exception: If the terminology on the cytology report further defines the Class IV and Class V as *suspicious* then the record is not reportable. Report this record only if a positive biopsy or a physician's clinical impression of cancer supports the cytology findings.

Note: See *VCR Manual Part Three, Data Item Instructions, Diagnostic Confirmation* for clarification of histology and cytology using cell block and smear preparation of specimens.

3. Low Malignant Potential/Borderline Malignancy of Ovary or Peritoneum- Cystadenomas or tumors primary to the ovary or peritoneum qualified by the phrases *borderline malignancy* or *low malignant potential* are reportable only if diagnosed prior to January 1, 2001.
4. Intraepithelial Neoplasia – Patients with the following diagnoses of intraepithelial neoplasia are reportable:
 - Vaginal intraepithelial neoplasia 3 (VAIN III)
 - Vulvar intraepithelial neoplasia 3 (VIN III)
 - Anal intraepithelial neoplasia 3 (AIN III)

See also *VCR Manual Appendix D, Reportable Conditions* and *VCR Manual Part One, Exclusions, Intraepithelial Neoplasia*.

5. Non-Malignant Intracranial and Central Nervous System Tumors – All primary intracranial and central nervous system (CNS) tumors are reportable. This includes benign, malignant and borderline tumors for the following sites:

<ul style="list-style-type: none"> • Meninges (C70.0 - C70.9) • Brain (C71.0 - C71.9) • Spinal Cord (C72.0) • Cauda equina (C72.1) • Cranial nerves (C72.2 - C72.5) 	<ul style="list-style-type: none"> • Other CNS (C72.8, C72.9) • Pituitary gland (C75.1) • Craniopharyngeal duct (C75.2) • Pineal gland (C75.3)
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REPORTABLE CASES, continued**Reportable Situations**

A case is reportable to the VCR if it is a condition included on the *VCR List of Reportable Conditions* (See *VCR Manual Appendix D, Reportable Conditions*) and meets the following criteria:

1. Patients diagnosed or treated in your inpatient or outpatient departments, emergency room, ambulatory care center, or other units included under your hospital license.
 - a. Patients Diagnosed At Your Hospital – The reportable diagnosis has been made at your hospital. This diagnosis can be made on the basis of histology (including autopsy), hematology, cytology, endoscopy or other direct visualization, diagnostic radiology or clinical findings.
 1. Clinical Diagnosis Only – A “clinical diagnosis only” is a diagnosis based solely on clinical judgment; diagnostic procedures were not performed or did not confirm the diagnosis. Patients diagnosed clinically are reportable to the VCR.
 - b. Patients Treated at Your Hospital - The VCR requires patients receiving treatment, cancer-directed or non cancer-directed, to be reported provided they have not been previously reported by your hospital.

The VCR recognizes the following definitions of treatment:

1. Cancer-Directed Treatment – Cancer-directed treatment is tumor directed, and its purpose is to modify, control, remove or destroy primary or metastatic cancer tissue. Physicians administer the therapy (ies) to remove or minimize the size of tumor or to delay the spread of disease.
2. Patients Diagnosed at Autopsy – Final autopsy reports containing reportable diagnoses or incidental findings of reportable conditions must be reported to the VCR.
3. Patients Diagnosed Elsewhere – Patients diagnosed elsewhere and newly admitted to your hospital for further diagnostic workup or treatment, cancer-directed or non cancer-directed are to be reported. Although this may result in multiple records on one patient, it enables the VCR to assure complete statewide casefinding and to have the most comprehensive information on each patient. Because the VCR is a population-based registry, every attempt must be made to receive all cases diagnosed within Virginia to provide accurate statistical reports.
4. Recurrence - Recurrence refers to the same cancer arising in or from the same primary site where it appeared earlier. A recurrent diagnosis is reportable as instructed in the *Multiple Primary and Histology Coding Rules, January 01, 2007*.
5. Residual Tumor – The VCR requires all records in which the pathology report states "no residual tumor" to be reported. The re-excision is considered cancer-directed treatment.

Example: Outside the hospital setting, a patient has a biopsy and is diagnosed with a malignant melanoma. The patient is seen at your hospital for a wide excision. The tissue report from the excision states no residual tumor. This record is reportable to the VCR. Even though the cancer was diagnosed elsewhere, the patient's hospital visit was for cancer related treatment.

REPORTABLE CASES, continued

6. Private Outpatient Specimens (POP) (Path Only) – Private outpatient specimens (POP) are specimens submitted from a physician’s office to be read by the hospital pathologist as part of the Pathology Department’s regular course of business. The patient is not registered as an inpatient or outpatient at the hospital. POPs are reportable to the VCR as a Class of Case 7 and a Reporting Source code of 3.

Example: A physician performs a biopsy in the office and sends the specimen to your Pathology Department where a reportable diagnosis is made.

- a. POP reports should be held for two to three months because many of these patients may return for treatment and more information can be obtained from these records.
 - b. If the patient does not return as an inpatient or hospital outpatient, abstract the record using all available information. Every effort must be made to obtain accurate information. This information can be found through hospital billing systems, clinical history, or if needed by contacting physician offices.
 - c. Data items should be completed as unknown only after further investigation does not provide more specific information.
7. Ownership of the Medical Record – When the distinction between a hospital department and a freestanding facility cannot readily be made, such as a radiation therapy group practice versus a hospital unit, the ownership of the medical record is used to determine whether or not a record must be reported by the owner of the record. If the medical record is the property of the institution, the record must be reported. If the hospital is part of a corporation, ownership of the record refers to the facility, not the corporation.

EXCLUSIONS

Non-Reportable Diagnosis

The following diagnoses are not reportable to the VCR:

1. Skin Cancers

a. The following site/histology combinations for skin cancers are not reportable:

8000-8005	Neoplasms malignant, NOS of the skin (C44.0-C44.9)
8010-8046	Epithelial carcinomas of the skin (C44.0-C44.9)
8050-8084	Papillary and squamous cell carcinomas of the skin (C44.0-C44.9)
8090-8110	Basal cell carcinomas of the skin (C44.0-C44.9)

b. ICD-O codes C44.0-C44.9 include skin of the lip, eyelid, external ear, face, nose, scalp, neck, trunk, perineum, (peri) anus, umbilicus, upper and lower limbs, shoulders, hips, and skin around ostomy sites.

Note: The above lesions are reportable when the primary tumor originates in a mucoepidermoid site (See *VCR Manual Part One, Reportable Records*).

c. Skin of nose – Basal and squamous cell carcinomas originating in the external nose (C44.3) are not reportable; however, those primary to the nasal cavity (C30.0) such as nostril, nasal septum, and nares are reportable.

d. Metastasis from non-reportable sites – If the primary site is not reportable but the cancer has metastasized to other sites, the record is still not reportable.

2. Carcinoma-In-Situ of the Cervix (CIS) - The diagnosis carcinoma in situ of the cervix (CIS) is not reportable. Terms indicating in situ include: *noninvasive*, *preinvasive*, *intraepithelial*, and *FIGO Stage 0*. A diagnosis of carcinoma in situ with endocervical gland involvement is still considered in situ and is not reportable.

Note: Diagnoses of invasive carcinoma of the cervix are reportable. A diagnosis of carcinoma in situ of the cervix with microinvasion is considered invasive and is therefore reportable.

3. Intraepithelial Neoplasia – Patients with the following diagnoses of intraepithelial neoplasia are not reportable:

- Cervical intraepithelial neoplasia (CIN)
- Prostatic intraepithelial neoplasia (PIN)

See also *VCR Manual Part One, Reportable Cases, Intraepithelial Neoplasia*.

EXCLUSIONS, continued

4. Other Precancerous Conditions and Benign Tumors – Patients with precancerous conditions or benign tumors are not reportable. An example of such a diagnosis includes atypical adenoma. Registry hospitals may elect to collect these cases; however, they are not reportable to the VCR.

Exception 1: Ovary and Peritoneum- Cystadenomas or tumors primary to the ovary or peritoneum qualified by the phrases *borderline malignancy* or *low malignant potential* are reportable if diagnosed prior to January 1, 2001.

Exception 2: Brain and Central Nervous System- All primary intracranial and central nervous system (CNS) tumors are reportable. This includes benign and borderline tumors for the following sites:

- Meninges (C70.0 - C70.9)
- Brain (C71.0 - C71.9)
- Spinal Cord (C72.0)
- Cauda equina (C72.1)
- Cranial nerves (C72.2 - C72.5)
- Other CNS (C72.8, C72.9)
- Pituitary gland (C75.1)
- Craniopharyngeal duct (C75.2)
- Pineal gland (C75.3)

Non-Reportable Situations

A case is ***not*** reportable to the VCR if it meets any of the following criteria:

1. Consult Only Records – Patients seen in consultation to provide a second opinion to confirm an established diagnosis or treatment plan are not reportable. Also, if the reporting institution provides services not available at the diagnosing or treatment facility, such as Computerized Tomography (CT) scans or Magnetic Resonance Imaging (MRI) scans, the case is not reportable.
2. Slide Reviews – Records in which slides are sent to your hospital’s pathologist for a second opinion are encouraged to be reported, but are not required. Since the slide was already read by another pathologist, the facility requesting the slide review is required to report the final diagnosis as determined after the slide review.
3. History of – Patients with a history of a reportable condition who are clinically free of disease are not reportable. If, however, the patient has actually received treatment during this admission the record must be reported. For example: if a patient is admitted for an unrelated condition, has a history of breast cancer and the hospital administers tamoxifen during their admission, the case is reportable.

Exception: If a patient expires at your facility with a history of cancer, even though the patient was clinically disease free, the case **is** reportable

EXCLUSIONS, continued

4. **Transient Care** – Patients receiving transient care at the reporting institution to prevent interruption of the first course of treatment are not reportable. This only applies to patients vacationing or visiting in the area, or equipment failure at the primary treating institution which requires the patient to temporarily receive treatment elsewhere.

Exception: Cancer patients evacuated to other states due to natural disasters may receive diagnostic/treatment services in facilities in that state. If this occurs at your facility, consider these cases reportable to the Virginia Cancer Registry (VCR). They should not be excluded as transient care or consult only cases.

When abstracting these cases, please record the patient's usual residence when the tumor was diagnosed in the Address at Diagnosis fields. Do not enter the patient's current address if the patient was diagnosed prior to relocating permanently or temporarily to Virginia or other nearby state.

5. **Recurrence** – Recurrence is defined as the same cancer arising in or from the same primary site where it appeared earlier and is not considered a new primary cancer by the physician. Do not report a recurrent diagnosis when you have previously reported it.

Exception: If an in situ tumor is followed by an invasive cancer in the same site more than two months apart, report as two primaries even if stated to be a recurrence. The invasive primary should be reported with the date of the *invasive* diagnosis. See also *VCR Manual Part One, Reportable Cases, Recurrence*.

6. **Readmitted Patients** – If a patient is readmitted and new or additional metastatic sites are diagnosed or documented, the record is not reportable provided it has already been reported for the original primary site. Records of readmitted patients must be reviewed to determine if a new primary site has been diagnosed. Each new primary must be reported separately.
7. **Metastatic Sites** – Do not report the metastatic or secondary sites of a malignant neoplasm; however, check to make sure the primary site was previously reported. A diagnosis of metastatic cancer with an unknown primary site not previously reported should be submitted with the primary site documented or coded as unknown.
8. **Special Units** – Patients admitted to a skilled nursing unit or other separately licensed units are encouraged to be reported but are not required. These patients are either discharged from an acute care hospital unit and readmitted to a separately licensed unit or are admitted directly to the separately licensed unit.

CONFLICTING STANDARDS

When standards of regulatory agencies differ, hospitals must implement procedures to comply with VCR standards.

WHEN IN DOUBT

When in doubt about submitting records to the VCR, ask the following question:

Did your facility diagnose and/or treat the patient for a condition included on the *VCR List of Reportable Conditions*? (See *VCR Manual Appendix D, Reportable Conditions*)

If the answer is yes to this question and the record was not previously submitted by your hospital, report the record. If you are in doubt about a particular record, submit the record with a note of explanation or call your VCR Cancer Surveillance Specialist at (804) 864-7877

VCR REQUIRED DATA ITEMS

The VCR requires specific data items to be completed for each reportable case. These data items include demographic, cancer identification, treatment, hospital-specific and text information. A listing of the VCR Required Data Set is included in *VCR Manual Appendix K*. Instructions on completing each data item are provided in *VCR Manual Part Three, Data Item Instructions*.

All data items required for participation in the National Program of Cancer Registries (NPCR) are included in the VCR data set. VCR-required codes and definitions comply with national standards established by the North American Association of Central Cancer Registries (NAACCR) and American College of Surgeons Commission on Cancer (ACOS COC).

PHOTOCOPIES OF HEALTH RECORD DOCUMENTATION FOR NON-ELECTRONIC REPORTERS

When Must Photocopies Be Submitted?

Photocopies of health record documentation are required to supplement the text fields for non-electronic reporters for the following reasons:

1. For data evaluation in facilities when there is a new VCR contact, new software or updated reporting format
2. For periodic quality control monitoring of reported data
3. Facilities without electronic reporting capabilities.

See *VCR Manual Appendix C, Electronic Reporting, Approval Process*.

PHOTOCOPIES OF HEALTH RECORD DOCUMENTATION FOR NON-ELECTRONIC REPORTERS

What Photocopies Must Be Submitted?

A copy of the pathology and/or autopsy report and operative report is required for all histologically confirmed cases for electronic approval/evaluation. The discharge summary, consultations, progress notes, radiology reports and other reports should be attached as needed to describe pertinent diagnostic findings and treatment and to provide information on previously diagnosed primaries. If the diagnosis of a reportable condition was not histologically confirmed but was made by radiology, cytology, physician's final diagnosis on the discharge summary, a copy of the report that confirms or supports the diagnosis must be attached. A copy of the face sheet must be attached to support the demographic information.

CHANGING INFORMATION

A change includes updating or correcting previously submitted information.

Importance of Change/Deletion Procedure

The change procedure insures the most accurate information is available to users of VCR data by enabling reporting facilities to provide updated or corrected information after a record has been accessioned by the VCR.

Example 1: At the time a record was reported to the VCR, the primary site was unknown. On a subsequent admission, the primary site was documented as upper lobe of left lung. A change sheet must be submitted to update the primary site, laterality, and stage (as was known during first course of treatment). The VCR will update this information on the patient's record on the VCR data file.

Example 2: At the time a record was reported to the VCR, the patient's initial diagnosis was *probable carcinoma*. After further review, it was determined the patient does not have cancer. Such cases must be deleted. Complete change records as indicated below, mark "DELETE" and document reason for deletion.

What to Change

1. Change any required data item when incorrect or unknown information was initially reported or when more specific/correct information is later available.
2. Change Collaborative Stage data items only if additional information is available through completion of surgery (ies) in the first course of treatment or within four months of diagnosis in the absence of disease progression whichever is longer.
3. Change SEER Summary Stage 2000 only if additional information is available through completion of surgery(ies) in the first course of treatment or within four months of diagnosis in the absence of disease progression whichever is longer for cases diagnosed on or after January 1, 2001. Change SEER Summary Stage 1977 only if additional information is available within two months of diagnosis (four months for prostate primaries) for cases diagnosed prior to January 1, 2001.

CHANGING INFORMATION, continued

4. Submit a change for name when incorrectly spelled on a record and when name is changed due to marital status or other reason. Clearly indicate previous and current name.
5. Do not submit changes to update address changes or admission/discharge dates when the patient is readmitted.

When to Submit Changes

Changes should be included with the next monthly shipment.

How to Change Information

1. As corrections are made to records previously accessioned by the VCR, print a consolidated paper abstract from your software system and **highlight** the changed information. Include these changes with your regular shipments as change records. (If name and/or spelling of name changes, indicate original name or spelling above corrected name.)
2. Document number of change records on VCR Submission Form on the *Total Number of Change Records* line. Do not include these with *Total Number of New Records*.

Note: Corrections *may NOT* be transmitted electronically.

VCR SUBMISSION FORM

The VCR Submission Form must be included for each electronic file. (See copy of submission form on next page.) Facility-specific submission forms with facility name; VCR four-digit identification number and ACOS COC facility identification number are available from the VCR.

Instructions

1. Date – Enter date shipment was sent.
2. File Name – Enter name of electronic output transmit file.
3. Number of Change Records Enclosed – Enter number of change records enclosed.
4. Number of New Records Enclosed – Enter number of records enclosed (excluding change records).
5. No Records To Report – If a facility has no cancer records to report, a completed submission form with zero (0) entered for number of new records must be forwarded to the VCR on the 5th of the month. In addition, the reason for not submitting any records must be documented on the submission form in the space provided.



**Virginia Cancer Registry
Submission Report
for Electronic Registries**

(Month of Submission)

VCR Use Only Date Received Facility # 1
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Facility Information

Facility:	<u>St. Elsewhere Hospital (sample)</u>
City:	<u>Planet Kozar</u>
Your Name:	_____
Phone:	<u>999 999-9999</u>

Submission Information

Date:	_____
Date Last Submission:	_____
Method (check):	- Disk _____
	- Vendor* _____
	- E-mail** _____
Password:	_____

File Information

Name of File:	_____
NAACCR Version:	_____ (Specify)
NAACCR Edits Available?	_____ Run? (check): _____ Yes _____ No
Accession # Range (approx.) :	_____
Number of	<ul style="list-style-type: none"> • Analytic Cases (Class of Case 0-2): _____ • Non-Analytic Cases (Class of Case 3-6; 9): _____ • Pathology-Only Cases: _____ • Total New Cases For This Report: _____
Comments:	_____

Instructions: Complete all fields on this form and return it with each diskette or set of diskettes submitted to the Virginia Cancer Registry **by the 5th of each month**. Please note in "Comments" field any information that will facilitate loading and merging your facility's data. If during this reporting period your facility has no cancer cases to report, we request that you notify us by completing this form and indicating zero ("0") for "Total Number of New Cases for This Report".

*If your software vendor sends your data to the VCR, forward this form to us whenever you transmit data to your vendor.
 **If you are submitting your facility's cases by E-mail, please fax or mail this completed report (including your password) when you send your E-mail.

Virginia Cancer Registry
 109 Governor Street, 10th Floor
 Richmond, VA 23219
 Phone (804) 864-7866
 Fax (804) 864-7870



HOW TO REPORT

Records containing all required data items must be submitted to the VCR electronically. Detailed instructions for completing the required data items can be found in the *VCR Manual Part Three, Data Item Instructions*.

Use the following instructions to prepare shipments:

1. Create Media (email file, diskette or CD) - Create the media containing all records to be reported to the VCR since your last shipment. Create a file for email transmission or use a newly formatted diskette or a new CD. A diskette will hold 245 records in current transmission format. If you have more than 245 records to transmit, you must use software to compress the data into a ZIP archive or use multiple diskettes or a CD.
2. Prepare Backup - Prepare and verify a backup of all records transmitted. Maintain this backup at your facility until you receive confirmation the records were accepted by the VCR.
3. Label the Media - If using a diskette, remove the old label before a new label is applied. Record the following information on the label using a felt tip pen:
 - a) File name of the output Transmit File using the following rules:
 1. The file name can be up to eight (8) characters long. In addition, you can include an extension up to three (3) characters long.
 2. The file name is not case sensitive; it does not matter whether you use upper case or lower case letters.
 3. The name can contain letters, numbers, special characters, and spaces.

Exception: Do not use back slash (\), slash (/), colon (:), exponent (^), question mark (?), double quotes ("), less than (<), greater than (>), or end ().
 - b) Your facility name and VCR ID number
 - b) Number of records being transmitted
 - c) Date you are transmitting the records
4. Complete a VCR Submission Form for Each Media Submitted - See *VCR Manual Part One, VCR Submission Form*.
5. Prepare Mailer - Place media in a protective mailer. Address the mailer with the VCR's address (See *VCR Manual Part One, Where to Report*) and your facility's address as the return address. This will ensure proper identification if the media becomes separated from the rest of the shipment.
6. Prepare the Shipment for Mailing - Place mailer, VCR Submission Form, Transmit List, and corrections (if applicable) in an envelope.

WHEN TO REPORT

Transmission Date

Reporting facilities must mail shipments/transmit files by the 5th of every month. If the 5th falls on a weekend or holiday, shipments must be mailed/transmitted on the last working day before the 5th.

Timeliness of Reporting

1. 180 Days - The VCR requires 90% of abstracts submitted by reporting facilities to be received by the VCR within 180 days from *Date of Diagnosis*.
2. Year End Deadline - The first working day in July is the deadline for submitting all reportable cases from the previous year. The months of May and June should be used to perform quality assurance procedures to ensure all cases have been identified and reported. These cases may fall into the 10% over 180 days. This is expected and acceptable. The timeliness requirement was established at 90% to provide a cushion of 10% to encourage late reporting of missed cases to assure reporting completeness.

Long-Term Hospitalizations

When patients are hospitalized for a period of six (6) months or longer, records should be submitted 180 days from Date of Admission/1st Contact. Enter the current date in the Date of Discharge field. Date of Discharge may not be left blank and the exact Date of Discharge should be submitted later as a change. See *VCR Manual Part One, Changing Information*.

WHERE TO REPORT

Mailing Instructions

1. Mail to - Virginia Cancer Registry
Virginia Department of Health
109 Governor St 10th Floor
Richmond VA 23219
2. Record the name of your facility and three or four digit VCR I.D.# in the upper left hand corner of the envelope prior to mailing shipments to the VCR.
3. Do not place media directly in VCR envelope without a protective mailer. Damaged media will be returned without being processed.

DOCUMENT RETENTION

There is no statute governing how long copies of the yearly Accession Lists must be kept. Retention for at least five years is strongly recommended by the VCR; however, if space is limited, maintaining copies until your facility has had a VCR Quality Assessment Review for that year would be an acceptable alternative.

FACILITY CONTACT PERSON FOR VCR

One person at each reporting facility is designated as the VCR contact person. This person is the primary contact for all correspondence and routine communication with the facility. Each facility designates the VCR contact person such as the cancer registrar, supervisor, or director.

To maintain proper communication, inform the VCR of any changes in the contact person at your facility by sending a letter to the address listed in *VCR Manual Part One, Where to Report* or calling (804) 764-7860.

TRAININGS

The VCR conducts trainings throughout the year to provide specific information on VCR reporting requirements and data collection. Trainings are free of charge. See *VCR Manual Part Four, Quality Control: VCR, Trainings*.

Announcements listing dates and locations of trainings are mailed to VCR contacts periodically. If interested in attending a training, refer to the announcement or call the VCR.

VCR PHONE NUMBERS

If you have any questions regarding the VCR, contact us at the central number: 1-804-864-7873 or:

Region 1	Northwest Virginia	Tina Hall	1-804-864-7864
Region 2	Northern Virginia	Michael Bowman, CTR	1-804-864-7856
Region 3	Southwest Virginia	Dianne Collins, CTR	1-804-864-7857
Region 4	Central Virginia	James Newton	1-804-864-7859
Region 5	Tidewater	Michael Peyton, CTR	1-804-864-7885
Quality Assurance Coordinator		Bonita Bryant, CTR	1-804-864-7860
Statistical Analysis Coordinator		Carolyn Halbert, MA, MPH	1-804-864-7861
Training Coordinator		Jayne Holubowsky, CTR	1-804-864-7873