

**PART TWO:  
CASEFINDING**



## CASEFINDING

Casefinding is a system for identifying patients with a reportable diagnosis. Because cancer incidence can be most accurately reflected only when every reportable diagnosis is identified and submitted to the central registry, effective casefinding procedures are essential.

Although casefinding procedures will vary among reporting facilities, the key to effective casefinding is the identification of reportable conditions in all areas where patients are diagnosed or treated in a routine and systematic manner. The following concepts should be considered when developing procedures to insure complete identification of cases reportable to Virginia Cancer Registry (VCR).

### Reportable Conditions

The first step in establishing effective casefinding procedures is to know what conditions are reportable. These conditions are defined in the following references:

1. List of Reportable Conditions - VCR Manual Appendix D provides documentation of all conditions reportable to the VCR. It is structured alphabetically by the main histologic term.
2. ICD-9-CM Codes - VCR Manual Part One, Reportable Codes provides a list of ICD-9-CM codes used to identify reportable diagnoses.

### Casefinding Sources

The second step in establishing effective casefinding procedures is to identify all areas in the facility where these reportable conditions are either diagnosed or treated and the sources for casefinding in each area. The Health Information Management (HIM) Department and Pathology Department must be included as casefinding sources by all facilities; the remaining sources listed below should be included as applicable. Copies of reports forwarded for review to the person responsible for reporting to the VCR serve as a pending or tickler file to cross-reference with medical records flagged in the HIM Department.

The term “records” as used in the descriptions below refers to all patient records, i.e., inpatient, outpatient, Emergency Room, ambulatory care, short stay procedures, radiation therapy, chemotherapy. For each source, review all of the following reports and records.

1. Health Information Management Department (HIM)
  - a. Chart Assembler/Coder/Analyst - All records with a diagnosis included in *VCR Manual Appendix D* or *ICD-9-CM Codes* listed in *VCR Manual Part One, Reportable Codes* should be flagged for the person responsible for VCR reporting.
  - b. Disease Index - Records assigned an ICD-9-CM code included on the list provided in *VCR Manual Part One, Reportable Codes* should be reviewed to identify reportable cases. In addition to casefinding, the disease index should also be used as a quality control measure to make sure all reportable diagnoses have been submitted. See also *VCR Manual Part Four, Quality Control: Reporting Facilities*.

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- c. Transcription - All discharge summaries with a reportable condition in the final diagnosis and operative reports bearing a post-operative reportable diagnosis should be copied and forwarded to the person responsible for reporting to VCR.
2. Pathology Department/Laboratory Medicine- Casefinding from Pathology Department/Laboratory Medicine must include identification of reportable diagnoses made on inpatient, outpatient, and private outpatient (POP) specimens.
  - a. Histology - Surgical pathology reports should be reviewed for a reportable diagnosis. If your Pathology Department screens the reports and forwards copies of those reports to the person responsible for VCR reporting, they must be provided with a copy of *VCR Manual Appendix D*. Surgical pathology reports showing “no residual malignancy (or tumor)” and reports resulting from orchiectomy or oophorectomy performed for prostate or breast malignancies or wide re-excisions for melanomas should be included in what is copied and forwarded to the person responsible for VCR reporting.
  - b. Cytology - All cytology reports should be reviewed for a malignant diagnosis and, when identified, a copy forwarded to the person responsible for VCR reporting. An alternative would be to review a log of positive or abnormal cytologies.
  - c. Hematology - Peripheral blood reports should be reviewed for a diagnosis of malignancy and, when identified, a copy forwarded to the person responsible for VCR reporting. Bone Marrow - All bone marrow reports should be reviewed for a diagnosis of malignancy and, when identified, a copy forwarded to the person responsible for VCR reporting.
  - d. Autopsy - All final autopsy reports should be reviewed for reportable diagnoses including incidental findings and, when identified, a copy forwarded to the person responsible for VCR reporting. Reportable diagnoses on autopsy reports from coroner’s cases should also be identified. See *VCR Manual Part One, Patients Diagnosed at Autopsy*.
3. Outpatient Departments
  - a. Short Procedure/Same Day Surgery/Ambulatory Care Unit - A system must be implemented to routinely review all outpatient records maintained within or separate from the HIM Department for diagnoses. If reporting criteria are met, cases must be submitted to the VCR.
  - b. Emergency Room (ER) - Pathology and cytology reports from procedures performed in the ER should be screened and reported if a reportable diagnosis is made or if the patient expires with a history of a reportable disease.
4. Oncology Services
  - a. Radiation Therapy - Radiation therapy records, appointment logs, or patient rosters must be reviewed. If reporting criteria are met, cases must be submitted to the VCR. Patients diagnosed elsewhere but treated at your facility must be reported.
  - b. Medical Oncology/Chemotherapy - Chemotherapy records, appointment logs, or patient rosters must be reviewed. If reporting criteria are met, cases must be submitted to the VCR. Patients diagnosed elsewhere but treated at your facility must be reported.\

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5. Other Areas- Records from other areas of the hospital where reportable conditions are either diagnosed or treated must be reviewed and submitted if a reportable diagnosis is made.

### Completeness of Casefinding

After all reportable diagnoses have been identified through routine casefinding procedures, the final step to effective casefinding is quality control. Procedures should be in place to verify all cases were identified and reported to the VCR. *VCR Manual Part Four, Quality Control* describes various quality control strategies to assure complete casefinding and reporting.

### Most Effective Casefinding Procedure

The most effective approach to identifying all reportable diagnoses for reporting to the VCR should include the following:

1. Flag all inpatient and outpatient medical records with an ICD-9-CM diagnosis code as listed in *VCR Manual Part One, Reportable Codes*.
2. Review reports from all inpatient, outpatient, and private outpatient (POP) pathology, cytology, bone marrow, hematology, and autopsy specimens analyzed at your facility.
3. Review records, appointment logs, or rosters of patients seen in the chemotherapy, radiation therapy, and any other area where reportable conditions are diagnosed or treated.
4. Review the ICD-9-CM disease index monthly to identify reportable diagnoses.
5. Perform quality control procedures to assure all reportable cases were identified and reported to the VCR.

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