Wyoming Cancer

SURVEILLANCE PROGRAM

Cancer Reporting Manual

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INTRODUCTION

The Wyoming Cancer Surveillance Program is a population-based statewide cancer incidence reporting system that collects, analyzes, and disseminates information on all new cases of cancer. A statewide cancer registry is the foundation for cancer prevention and control. This central repository of information is a valuable and essential tool for identifying populations at high risk for cancer, monitoring of cancer incidence trends and mortality, facilitating studies related to cancer prevention, evaluating cancer control initiatives, planning health care delivery systems, and developing educational awareness programs. It is dependent on complete, timely and accurate reporting.

The Wyoming Cancer Surveillance Program Oncology Data Reporting Manual has been developed to assist and direct healthcare providers in reporting cancer cases to the central cancer registry. This manual has been implemented due to the requirements from the National Program of Cancer Registries (NPCR), Centers for Disease Control and Prevention (CDC); North American Association of Central Cancer Registries (NAACCR); Surveillance, Epidemiology, and End Results Program (SEER) of the National Cancer Institute (NCI); and the American College of Surgeons (ACoS).

The Wyoming Cancer Surveillance Program (WCSP) is a statewide population-based cancer registry. Our mission is to maintain a nationally comparable population-based cancer incidence, follow-up, treatment and mortality monitoring system that collects, analyzes and disseminates information on all new cancer cases in Wyoming. In operation since 1966, the WCSP has been collecting cancer data on all cancer cases diagnosed or treated in Wyoming since 1962. The WCSP monitors cancer incidence through pathology reports and uniform reporting of information by health care providers in Wyoming. In 1977, a law was passed requiring reporting by all entities detecting, diagnosing and treating cancer cases in Wyoming (statute 35-1-240[b] and public law 102-515).

In 1995, the WCSP became member of the National Program of Cancer Registries (NPCR). The NPCR was established by Congress through the Cancer Registries Amendment Act in 1992, and administered by the Centers for Disease Control and Prevention (CDC); the NPCR collects data on the occurrence of cancer; the type, extent, and location of the cancer; and the type of initial treatment. The CDC provides funding for states to implement and enhance existing registries to meet national standards for completeness, timeliness and data quality.

In 1987, the first employee of the WCSP became a member of the North American Association of Central Cancer Registries (NAACCR). NAACCR is a professional organization that develops and promotes uniform data standards for cancer registration; provides education and training; certifies population-based registries; aggregates and publishes data from central cancer registries and promotes the use of cancer surveillance data and systems for cancer control and epidemiologic research, public health programs and patient care to reduce the burden of cancer in North America.

The following sources were used in the preparation of this manual:

• The 2007 SEER Program Coding and Staging Manual (SPCSM) with 2008 Revisions, National Cancer Institute, NIH (Also known as the 2008 Coding and Staging Manual on CD-ROM) Updated December 22, 2008 Pub. No. 07-5581, Bethesda, MD, 2004.

• Standards of the Commission on Cancer Volume II: Facility Oncology Registry Data Standards (FORDS). Chicago: American College of Surgeons Commission on Cancer, January 2003, revised 2/13/09.

• NAACCR Standards for Cancer Registries, Volume II, Data Standards and Data Dictionary, Eleventh Edition, Record Layout Version 12.

• Source: Cancer Reporting in California: Abstracting and Coding Procedures for Hospitals (California Cancer Reporting System Standards, Vol. I) updated May 2007. California Cancer Registry, Public Health Institute.

• International Classification of Diseases for Oncology. 3rd Edition (ICD-O-3). Geneva: World Health Organization, 2000.

• Wyoming's statute W.S. 35-1-240 (b) and P.L. 102-515.

• SEER*Rx Version 1.3.0. The Cancer Registrar's Interactive Antineoplastic Drug Database. U.S. Department of Health and Human Services, Public Health Services, National Institutes of Health, Bethesda, MD, 2005 (applicable for cases diagnosed January 1, 2005 forward). Updated 5/01/09.

• Collaborative Staging Task Force of the American Joint Committee on Cancer. Collaborative Staging Manual and Coding Instructions, version 01.04.00. Jointly published by American Joint Committee on Cancer (Chicago, IL) and U.S. Department of Health and Human Services (Bethesda, MD), 2004. NIH Pub. No. 04-5496. Incorporates updates through October 31, 2007.

• Abstracting and Coding Guide for the Hematopoietic Diseases, National Cancer Institute, NIH Pub. No. 02-5146, with errata Pub. No. 03-5146, Bethesda, MD.

• Data Collection of Primary Central Nervous Tumors National Program of Cancer Registries Training Materials 2004, U.S. Department of Health and Human Services, CDC.

• Multiple Primary and Histology Coding Rules January 1, 2007, revised May 6, 2008, National Cancer Institute. Bethesda, MD.

GENERAL INSTRUCTIONS

The following information provides some basic rules regarding cancer reporting to the Wyoming Cancer Surveillance Program.

Hospitals are required by Wyoming (statute 35-1-240[b] and public law 102-515) to report and/or abstract inpatient and outpatient cancer cases. Inclusion of outpatients was effective with January 2000 cases.

All cases diagnosed and/or treated for cancer in a Wyoming medical facility on or after January 1, 1996, must be abstracted and/or reported.

The following information provides some basic rules regarding cancer reporting to the Wyoming Cancer Surveillance Program.

A. Healthcare providers including, but not limited to, hospitals, ambulatory surgery centers, laboratories, radiation therapy facilities, oncology facilities and physician offices are required to report cancer cases to the Wyoming Cancer Surveillance Program. Hospitals need to abstract and/or report inpatient and outpatient cancer cases.

B. All required data items should be collected and reported to the Wyoming Cancer Surveillance Program. The list is based on the rules and regulations of NPCR and NAACCR.

C. The ICD-O-3 coding scheme must be used for site and histology for cases diagnosed on or after January 1, 2001. The ICD-O-2 coding scheme must be used for cases diagnosed prior to January 1, 2001.

D. The Collaborative Staging Manual is to be used for cases diagnosed on or after January 1, 2004. The SEER Summary Staging Manual – 2000 is to be used for staging for cases diagnosed between January 1, 2001 and December 31, 2003. The SEER Summary Staging Guide, 1986 reprint, is to be used for cases diagnosed prior to January 1, 2001.

E. The Multiple Primary and Histology Coding Rules Manual is to be used for cases diagnosed January 1, 2007 and later.

F. All cases diagnosed and/or treated for cancer in Wyoming medical facilities on or after January 1, 1996, must be abstracted and reported to the Wyoming Cancer Surveillance Program.

For ALL reporting facilities:

Benign brain and Central Nervous System (CNS) cases are reportable if diagnosed on or after January 1, 2004.

Incomplete abstracts (i.e., abstracts with required fields not completed) will be returned to the facility. The facility must supply data for the missing required fields and re-submit the records to WCSP.

The following coding manuals are required to complete case reporting for WCSP. Information has been provided on how to download these manuals if not already on site at the reporting facility.

1. Facility Oncology Registry Data Standards (FORDS)
http://www.facs.org/cancer/coc/fords/2009/fords2009.pdf
Use this manual to determine case eligibility, coding principles and coding instructions.

Site-specific surgery information
http://www.facs.org/cancer/coc/fordsmanual.html
Use this section of the FORDS Manual to identify the correct surgery options for individual sites and choose the correct code when abstracting electronically.

2. Collaborative Stage Manual (CS) Versions 1 and 2.
http://www.cancerstaging.org/cstage/manuals.html
The Collaborative Staging Manual must be used to stage cases diagnosed on or after January 1, 2004. The SEER Summary Staging Manual 2000 is to be used for cases diagnosed between January 1, 2001 and December 31, 2003. The SEER Summary Staging Guide 1977 is to be used for cases diagnosed prior to January 1, 2001. See Appendix V for a complete list of websites where these manuals are available.

3. Multiple Primary and Histology Coding Rules (MP/H)
http://www.seer.cancer.gov/tools/mphrules/download.html
Use this coding manual to determine the number of reports needed to complete for each case.

4. Data Collection of Primary Central Nervous System Tumors
http://www.cdc.gov/cancer/npcr/training/pdfs/braintumorguide.pdf
Use this manual to determine reportability and correct coding for benign brain and CNS tumors (reportable to WCSP beginning January 1, 2004).

5. SEER*Rx - Interactive Antineoplastic Drugs Database
http://seer.cancer.gov/tools/seerrx/index.html
Use this tool to determine correct coding of oncology drug and regimen treatment categories.

REPORTING RESPONSIBILITIES

Completed cases should be submitted to the Central Registry within six months after date of first contact for cancer diagnosis and/or treatment with your facility.

Recurrences (with some exceptions) and metastatic sites (for primary cases previously reported) are not reportable; however, it is important for those healthcare providers that maintain their own abstracting to document the recurrence or metastatic information via an update in their cancer registry database. Patients presenting with metastatic disease or recurrence for which the original primary diagnosis was NOT reported by the hospital are reportable (the original primary diagnosis is reportable, not the recurrence or metastases).

Clinics/physician offices are required to report all active primary cancers for which treatment is provided for diagnoses on or after 1992. If treatment is not provided, the cancer must still be reported if the patient is NOT referred to a Wyoming hospital within two months from the time first seen at the facility.

All pathology reports with a diagnosis of cancer that are read by hospital pathology laboratories should be forwarded to the WCSP. The Wyoming Cancer Surveillance Program will be responsible for contacting the physicians on the pathology reports to obtain the information needed to include the case into the registry database.

It is important for all reporting facilities to submit data in a timely manner. This will ensure that all data will be processed at the time of data merging and de-duplication. The requirements for data submissions are as follows: Annual caseload >100 Monthly and Annual caseload <100 Monthly or quarterly.

All facilities submitting data electronically are required to perform EDITS on these cases to detect any errors that may exist in the data. Upon arrival to the Wyoming Cancer Surveillance Program, all files will undergo additional edit checks. If there are an unacceptable amount of errors, the file will be returned to the facility along with the error summary to be corrected before it can be resubmitted to the central registry. The reporting facility has a maximum of 14 days to return the corrected, error free data to the registry. The WCSP will also notify the facility either by phone or e-mail that cases are being sent back and will provide training to the facility so there are no more repeat errors.

If after submission to the WCSP, additional information is learned from the patient's chart that would change specific data items, please call Wyoming Cancer Surveillance Program and report changes. For changes to more than five cases, make corrections to cases and resubmit via a secure email, a password protected encrypted CD, or cases can be included with next submission. If a pathology report is amended, the amended report should be faxed to Wyoming Cancer Surveillance Program and changes will be made. For paper abstract form, complete the cancer form with the new information and write, "AMENDED" across the form in red.

NON-REPORTABLE FILE

All facilities are requested to submit a list of non-reportable cancer cases to the WCSP twice a year, January and October. These cases are to be documented and submitted electronically on an Excel spreadsheet. The following information should be included: Facility Name and Number, months/year being submitted, Patient Name, last and first, Social Security Number, Cancer Diagnosis (ICD-9 code), Cancer Site, Date of Birth, and Date of Diagnosis

DATA SUBMISSION PROCEDURES

Electronic Data Transmissions

Electronic data must be sent using the NAACCR Version 12 layout. Data should be electronically submitted to the WCSP via a secure email, a password protected encrypted CD, or in another manner that has been pre-approved and coordinated with the WCSP.

FOLLOW-UP INFORMATION

Follow-up information is required by Wyoming Cancer Surveillance Program. Hospitals and other healthcare providers are requested to review the patient's medical record on an annual basis for:

- Patient status
- Cancer status
- Date of death
- Place of death if known

The WCSP uses a variety of methods to collect vital status follow-up information for cases not known to be deceased. The primary follow-up method involves linking the Registry case file to a death certificate file provided by the Wyoming Department of Health - Bureau of Vital Records and Health Statistics.

When a Wyoming resident is diagnosed with cancer and it is reported to the Wyoming Cancer Surveillance Program (WCSP), the case is entered into the main database. Fourteen (14) months later, the follow-up process begins and will continue on a fourteen (14) month interval cycle for the rest of that person's life. We strive to maintain the most accurate, current and complete data possible.

These data are reported annually to the National Program of Cancer Registries (NPCR) which is administered by the Centers for Disease Control and Prevention (CDC), and to the North American Association of Central Cancer Registries (NAACCR).

According to the CDC, "Data collected by state cancer registries help public health professionals understand and address the nation's cancer burden. Vital information about cancer cases and cancer deaths improves health agencies' ability to report on cancer trends, assess the impact of cancer prevention and control efforts, participate in research, and respond to reports of suspected increases in cancer occurrence." While the gathered follow-up data are primarily used for incidence and mortality statistics at the state level, the potential is there for a multitude of other valuable uses.

WCSP Follow-Up Process:

- Fourteen (14) months after the date of last contact the WCSP staff sends an initial follow-up request for information from the patient's primary physician of record.
- In the event that the primary physician does not return a response; the WCSP initiates a secondary follow-up system. A letter is generated that contacts, in sequential order, the next four (4) physicians or medical entities identified in the patient's medical information. Once a valid response with pertinent follow-up information is received the process is suspended until the next follow up period for the identified patient.
- Each patient is followed at fourteen (14) month intervals until the WCSP has been notified of their demise.

CONFIDENTIALITY

According to State Cancer Law (statute 35-1-240[b] and public law 102-515), information accumulated and maintained in the Wyoming Cancer Surveillance Program (WCSP) shall not be divulged except as statistical information which does not identify individuals and for purposes of such research as approved by the Wyoming State Board of Health. All information reported to the Department of Health shall be confidential and shall not be disclosed under any circumstances except (1) to other state cancer registries with which the Department of Health has agreements that insure confidentiality; (2) to other state health officials who are obligated to keep such information confidential; and (3) to approved cancer research centers under specific conditions where names and identities of the individuals are appropriately protected, and when such research is conducted for the purpose of cancer prevention, control and treatment.

WCSP staff is required to sign confidentiality agreements and follow confidentiality procedures as stated in the Wyoming Cancer Surveillance Program Central Cancer Registry Policy and Procedure Manual.

HIPAA allows reporting of cancer cases to the Wyoming Cancer Surveillance Program, due to the fact that the registry is considered as a public health authority. HIPAA allows facilities to continue to report cancer incidence data to the registry in compliance with the current state statutes

Written informed consent is not required from the cancer patient under HIPAA or a Business Associate Agreement, but healthcare providers must document that reporting is occurring.

DISCLOSURE OF DATA

According to Public Law 102-515 Chapter 4, Section 1. Disclosure of Data Confidential Case Data. The protection and release of confidential statistical records shall be in accordance with W.S. 16-4-201, et seq, the Wyoming Public Records Act, and the Wyoming Department of Health Information Practices Rules.

Non-Confidential Statistical Data. Non-confidential statistical data shall be released to all hospitals, physicians, or other healthcare providers and interested persons in compliance with the latest written policies set forth by the Wyoming State Epidemiologist.

The Wyoming Cancer Surveillance Program may exchange patient-specific information with the reporting facility or clinical facility for the purpose of completing a case record, provided these facilities comply with all Wyoming Cancer Surveillance Program confidentiality policies.

To achieve complete case ascertainment, the Wyoming Cancer Surveillance Program may exchange patient-specific information with other state cancer registries if reciprocal data sharing agreements and confidentiality provisions are in place.

AUDITS

A Wyoming Cancer Surveillance Program Certified Tumor Registrar (CTR) will conduct annual casefinding and quality assurance (re-abstracting) audits as required by NPCR.

All Wyoming hospitals must be audited by June 2012; Wyoming Cancer Surveillance Program will begin audit procedures in 2010. The purpose of these audits is to ensure that all reportable cases are being identified and reported to the Wyoming Cancer Surveillance Program and that all information submitted is of good quality and accurately coded.

The audit will consist of two parts:
Casefinding – Inpatient/Outpatient hospital disease indices, pathology reports and other pertinent casefinding documents are reviewed and all reportable codes are compared with the WCSP database for the facility being audited. All cases that are not identified in the database will be reconciled by the registrar/HIM Director at the audited facility. The registrar/HIM Director will have a minimum of 30 days to complete the reconciliation process and return an updated list to WCSP with reasons why the identified cases were not abstracted and/or reported or if the cases are reportable and were missed during the original abstracting period. Cases that are reportable but were missed must be abstracted into their database and submitted to WCSP.

All cases diagnosed before January 1, 1996 or cases diagnosis/treatment was not performed at the reporting facility are removed from the reconciliation log and a percentage is calculated at that time. A report is sent to the facility cancer registry director and/or administrator of the facility that summarizes the percentage of case ascertainment and provides suggestions to help improve the case ascertainment process.

Re-abstraction – (Applies to all facilities, contracted agencies or individuals that perform abstracting and/or reporting to the WCSP.) The re-abstracting audit consists of Certified Tumor Registrars re-abstracting specific required fields on a small sample of cases from a pre-determined diagnosis year, and comparing results to the original abstracted data submission. Discrepancies are discussed with the hospital reporters; abstracting and coding guidelines are reinforced. Attempts are always made during the resolution process to determine if reporters had additional information not available to the auditors.

A report will be provided to the facility cancer registry director and/or administrator, which summarize the percentage of case ascertainment or completeness and any suggestions that would help to improve the reporting process.

CASE ASCERTAINMENT

CASEFINDING TECHNIQUES

ALL HEALTHCARE PROVIDERS must perform case finding to identify all patients with a new diagnosis of cancer or history of cancer which meets the case eligibility criteria. Every patient; inpatient and/or outpatient, who is diagnosed with and/or treated for a reportable diagnosis, must be reported by all healthcare providers.

Cases can be identified via many sources. The pathology reports can provide cases diagnosed by histology, cytology, hematology, bone marrow or autopsy. Other sources are clinic admission logs, daily discharges, disease indices, radiology reports, inpatient and outpatient surgery logs, radiotherapy consults, treatment reports and logs, oncology clinic treatment reports and logs. The pathology reports should never be the only source of casefinding, due to the fact that cases not diagnosed, only treated at your facility may not have a path report. Oncology clinic logs will be a good source in locating these cases. Cases not diagnosed histologically will be either confirmed by the physician in the patient's record or on the medical record disease index. A system should be established that would enable you to receive a copy of the disease index.

At a minimum, a system must be established to create a complete disease index of all reportable conditions as identified on the "Comprehensive Reportability List" on page 19.

ALL HEALTHCARE PROVIDERS shall provide to the WCSP, a disease index of cancer cases identified by ICD-9 codes as identified in the "Comprehensive Reportability List" on pages 19 and 20 of this document within thirty (30) days of written request by the WCSP. All patients identified as having a history of a specific disease as identified on the "Comprehensive Reportability List" on pages 19 and 20 are to also be included on the disease index.

SUGGESTED BEST PRACTICE FOR CREATING A DISEASE INDEX:

A disease index should be defined to identify all inpatient, outpatient, emergency department and ancillary services provided for patients with a primary discharge diagnosis and/or billing diagnosis with any ICD-9 code as identified on the "Comprehensive Reportability List" on pages 19 and 20. The Disease Index should be created in, or exported to, an Excel file that can be provided to the WCSP. Submission of the Disease Index must occur via a secure email or password protected encrypted CD.
At a minimum the Disease index must include the following data elements:

- Medical Record Number
- Patient Name
- Age
- Date of Birth
- Date of Service
- Type of Service/Service Code
- First ten (ten) ICD-9 diagnosis codes as identified on the discharge diagnosis and/or billing diagnosis.

CASE ELIGIBILITY BASED ON DIAGNOSTIC TERMS

The American College of Surgeons Commission on Cancer (CoC) requires registries in approved hospital programs to accession, abstract, and conduct follow-up activities for required tumors diagnosed and/or initially treated at the abstracting facility. The tumors must meet the criteria for analytic cases (classes of case 0, 1, or 2), and pathologically and clinically diagnosed inpatients and outpatients must be included.

For diagnoses made beginning in 2006 the following differences in reportability exist between the COC and the WCSP. All facilities in Wyoming are required to report WCSP-reportable cases to the central registry regardless of their reportability status according to the Commission on Cancer standards and guidelines.

• Non-analytic cases of Class 3, 4, 5, 6, 7 and 9 are required to be reported to the WCSP. The WCSP will follow back to the ordering physician for complete information when necessary.
• Cases in which the patient receives only transient first-course treatment while temporarily in Wyoming are reportable to the WCSP.

As part of the central cancer and hospital cancer registry case-finding activities, all pathology reports should be reviewed to confirm whether a case is required. If the terminology is ambiguous, use the following guidelines to determine whether a particular case should be included.

LIST OF AMBIGUOUS TERMS

Lists of Ambiguous Terms Terms that constitute a diagnosis; case should be reported		
Apparent (ly)	Favors	Suspect (ed)
Appears	Malignant appearing	Suspicious (for)
Comparable with	Most likely	Typical of
Compatible with	Presumed	
Consistent with	Probable	
Consistent with Tumor (beginning with 2004 diagnoses and only for C70.0–C72.9, C75.1–75.3)		
Neoplasm or Tumor (beginning with 2004 diagnoses and only for C70.0-C72.9, C75.1 C75.3)		
Terms that DO NOT constitute a diagnosis; case should NOT be reported**		
Approaching	Potentially malignant	Suggests
Cannot be ruled out	Questionable	Very close to
Equivocal	Rule out	Worrisome
Possible		

NOTE:
Malignant neoplasms of the skin of genital sites are reportable. These sites include: vagina (C529), clitoris (C512), vulva (C519), prepuce (C600), penis (C609), and scrotum (C632).

Reportable skin tumors such as adnexal carcinomas (carcinomas of the sweat gland, ceruminous gland, and hair follicle), adenocarcinomas, lymphomas, melanomas, sarcomas, and Merkel cell tumor must be reported regardless of site. Any carcinoma arising in a hemorrhoid is reportable since hemorrhoids arise in mucosa, not in skin.

NON-REPORTABLE NEOPLASMS

• Basal cell carcinoma (8090–8110) of the skin (C440-C449) except genital sites
• Basal and squamous cell carcinoma (8070–8110) of skin of anus (C445)
• Epithelial carcinomas (8010–8046) of the skin (C440-C449)
• Papillary and squamous cell carcinomas (8050–8084) of the skin (C440-C449) except genital sites
• Malignant neoplasms, NOS (8000–8005) of the skin (C440-C449)
• In situ neoplasms of cervix regardless of histology (behavior of /2; C539)
• Intraepithelial neoplasms of the cervix (CIN) (8077/2; C539) or prostate (PIN) (8148/2; C619)
• Borderline cystadenomas (8442, 8451, 8462, 8472, and 8473) of the ovaries (C569) with behavior code 1 are not collected as of January 01, 2001
• Cases diagnosed prior to 1995 are no longer required to be reported.
• Benign and borderline tumors of the cranial bones (C410)
• Cysts or lesions of the brain or CNS diagnosed January 01, 2004 or later which have no ICDO- 3 morphology code

This list is for the codes only. Use this list to give to the IT programmers.

Comprehensive ICD-9-CM Casefinding Code List for Reportable Tumors (Effective Date: 1/1/2011)	
ICD-9-CM Code^	**Explanation of Code**
140.0 – 209.36	Malignant Neoplasms
209.70 – 209.29	Secondary neuroendocrine tumors
225.0 – 225.9	Benign neoplasm of brain and spinal cord neoplasm
227.3 – 22.74	Benign neoplasm of pituitary gland, craniopharyngeal duct (pouch) and pineal gland
228.02	Hemangioma; of intracranial structures
228.1	Lymphangioma, any site
230.0 – 234.9	Carcinoma in situ
236.0	Endometrial stroma, low grade
237.0 – 237.1	Neoplasm of uncertain behavior [borderline] of pituitary gland, craniopharyngeal duct and pineal gland
237.5 – 237.6	Neoplasm of uncertain behavior [borderline] of brain, spinal cord and meninges
237.72	Neurofibromatosis, type 2 [acoustic neurofibromatosis]
237.9	Neoplasm of other and unspecified parts of nervous system (cranial nerves)
238.4	Polycythemia vera
238.6 – 238.79	Other lymphatic and hematopoietic tissues
239.6 – 239.7	Neoplasms of unspecified nature, brain, endocrine glands and other parts of nervous system
273.2	Other paraproteinemias
273.3	Macroglobulinemia
288.4	Hemophagocytic syndrome (9751/3, 9754/3)
795.06	Papanicolaou smear of cervix with cytologic evidence of malignancy
795.16	Papanicolaou smear of vagina with cytologic evidence of malignancy
796.76	Papanicolaou smear of anus with cytologic evidence of malignancy
V10.0 – V10.91	Personal history of malignancy
V12.41	Personal history of benign neoplasm of the brain

The following codes are not reportable per se, but they should alert registrars to look for the first malignant neoplasm associated with these codes.

Supplementary List #1-ICD-9-CM Codes that Should Be Followed by or Associated with a Neoplasm Code^	
ICD-9-CM Code^	**Explanation of Code**
258.02 – 258.03	Multiple endocrine neoplasia (MEN) type IIA and IIB
285.22	Anemia in neoplastic disease
289.83	Myelofibrosis (NOS) (9961/3)
338.3	Neoplasm related pain (acute, chronic); Cancer associated pain

511.81	Malignant pleural effusion (code first malignant neoplasm if known)
789.51	Malignant ascites (code first malignant neoplasm if known)

NOTE: Cases with these codes should be screened as registry time allows. These are neoplasm-related secondary conditions for which there should also be a primary diagnosis of a reportable neoplasm.

Supplementary List #2-ICD-9-CM Code List to Screen for Cancer Cases Not Identified by Other Codes (Effective Date: 1/1/2011)^	
ICD-9-CM Code^	**Explanation of Code**
042	Acquired Immunodeficiency Syndrome (AIDS)
079.4	Human papillomavirus
079.50 – 079.59	Retrovirus (HTLV, types I, II and 2)
209.40 – 209.69	Benign carcinoid tumors
210.0 – 229.9	Benign neoplasms (except for 225.0-225.9, 227.3, 227.4, 228.02, and 228.1, which are listed in the Reportable list)
235.0 – 239.9	Neoplasms of uncertain behavior (except for 236.0, 237.0-237.1, 237.5-237.6, 237.72, 237.9, 238.4, 238.6, 238.71-238.79, 239.6, 239.7)
253.6	Syndrome of inappropriate secretion of antidiuretic hormone
259.2, 259.8	Other endocrine disorders
273.0 – 273.1, 273.8 – 273.9	Disorders of plasma protein metabolism
275.42	Hypercalcemia
277.88 – 277.89	Other specified disorders of metabolism
279._	Disorders involving the immune mechanism (except for 279.01, 279.11, 279.19)
284.81 –284.9	Other and unspecified aplastic anemias
285.0 – 285.3	Other and unspecified anemias
288.03	Drug induced neutropenia
288.3	Eosinophilia
289.6	Familial polycythemia
289.89 – 289.9	Other specified diseases of blood and blood-forming organs
323.81	Encephalomyelitis; specified cause NEC
379.59	Opsoclonia
528.01	Mucositis due to antineoplastic therapy
630	Hydatidiform Mole
686.01	Pyoderma gangrenosum
695.89	Sweet's syndrome
701.2	Acanthosis nigricans
710.3 – 710.4	Diseases of connective tissue
733.10 – 733.16	Pathologic fracture
758.0	Down's Syndrome
785.6	Enlargement of lymph nodes

790.93	Elevated prostate specific antigen [PSA]
795.81 – 795.89	Abnormal tumor markers
999.31	Infection due to central venous catheter (porta-cath)
999.81	Extravasation of vesicant chemotherapy
E879.2	Adverse effect of radiation therapy
E930.7	Adverse effect of antineoplastic therapy
E933.1	Adverse effect of immunosuppressive drugs
V07.31, V07.39	Other prophylactic chemotherapy
V07.8	Other specified prophylactic measure
V12.72	History of colonic polyps
V15.3	Irradiation: previous exposure to therapeutic or ionizing radiation
V42.81 – V42.82	Organ or tissue replaced by transplant, Bone marrow transplant
V51.0	Encounter for breast reconstruction following mastectomy
V52.4	Breast prosthesis and implant
V54.2	Aftercare for healing pathologic fracture
V58.0 – V58.12	Encounter for radiation and chemotherapy
V58.42	Aftercare following surgery for neoplasm
V66.1 – V66.2	Convalescence following radiotherapy and/or chemotherapy
V66.7	Encounter for palliative therapy
V67.01	Follow-up vaginal pap smear
V67.1 – V67.2	Radiation and chemotherapy follow up
V71.1	Observation for suspected malignant neoplasm
V76.0 – V76.9	Special screening for malignant neoplasm
V78.0 – V78.9	Special screening for disorders of blood and blood-forming organs
V82.71, V82.79, V82.89, V82.09	Screening for genetic disease carrier status
V84.01 – V84.09	Genetic susceptibility to malignant neoplasm
V84.81	Genetic susceptibility to multiple endocrine neoplasia [MEN]
V86.0 – V86.1	Estrogen receptor status
V87.41	Personal history of antineoplastic chemotherapy

^ *International Classification of Diseases, Ninth Revision, Clinical Modification, 2011.*

PATIENT DEMOGRAPHICS

PATIENT ADDRESS AND RESIDENCY RULES

General Coding Instructions for Place of Residence at Diagnosis
The Wyoming Cancer Surveillance Program collects information on place of residence at diagnosis. Rules for determining residency at diagnosis are either identical or comparable to rules used by the U.S. Census Bureau, to ensure comparability of definitions of cases (numerator) and the population at risk (denominator).
Coding Priorities/Sources

1. Code the street address of usual residence as stated by the patient. Definition: U.S. Census Bureau Instructions: "The place where he or she lives and sleeps most of the time or the place the person says is his or her usual home."

2. Post Office Box is not a reliable source to identify the residency at diagnosis. Post office box addresses do not provide accurate geographic information for analyzing cancer incidence. Use the post office box address only if no street address information is available after follow-back.

3. Use residency information from a death certificate only when residency from other sources is coded as unknown. Review each case carefully and apply the U.S. Census Bureau rules for determining residence. The death certificate may give the person's previous home address rather than the nursing home address as the place of residence; use the nursing home address as the place of residence.

4. Do NOT use legal status or citizenship to code residence.

Persons with No Usual Residence
Homeless people and transients are examples of persons with no usual residence. Code the patient's residence at diagnosis such as the shelter or hospital where diagnosis was confirmed.

Temporary Residents of the Wyoming Area Code the place of usual residence rather than the temporary address for: Migrant workers Educators temporarily assigned to a university in the Wyoming area Persons temporarily residing with family during cancer treatment.

Military personnel on temporary duty assignments (TDY) Boarding school students below college level (code the parent's residence)

Code the residence where the student is living while attending college.

Code the address of the institution for Persons in Institutions. U.S. Census Bureau definition: "Persons under formally authorized, supervised care or custody are

residents of the institution." Persons who are incarcerated Persons who are physically handicapped, mentally retarded, or mentally ill who are residents of homes, schools, hospitals or wards Residents of nursing, convalescent, and rest homes Long-term residents of other hospitals such as Veteran's Administration (VA) hospitals

Persons in the Armed Forces and on Maritime Ships (Merchant Marine)
Armed Forces
For military personnel and their family members, code the address of the military installation or surrounding community as stated by the patient.

Personnel Assigned to Navy, Coast Guard, and Maritime Ships
The U.S. Census Bureau has detailed rules for determining residency for personnel assigned to these ships. The rules refer to the ship's deployment, port of departure, destination, and homeport. Refer to U.S. Census Bureau Publications for detailed rules: http://www.census.gov

County-Current and County at DX
NAACCR has adopted the Federal Information Processing Standards (FIPS) codes for county as the standard in this volume (see Appendix C for Wyoming specific codes).

- CoC requires the use of FIPS county codes as their standard, plus the special codes 998 and 999. However, the FORDS manual also provides for use of geocodes for countries of residence outside the United States and Canada to be used in this field.

- NPCR requires the use of FIPS codes for counties in the United States, plus the special code 999, starting with cancers diagnosed on or after January 1, 2002.

RACE AND ETHNICITY

Race and ethnicity are two of the most important data items to epidemiologists who investigate cancer. Differences in incidence rates among ethnic groups generate hypotheses for research. The National Cancer institute has recognized the need to better explain the cancer burden in racial/ethnic minorities and is concerned with research on the full diversity of the U.S. population.

Race

Race code documentation must be supported by text documentation for those cases where there is conflicting information. A text statement indicating patient's race is required. Text validation should be entered in the physical exam text field.

Cases that lack supporting text documentation may be returned as queries and counted as discrepancies.

January 1, 2004 and Forward

Effective with cases diagnosed January 1, 2004 forward, apply the following SEER race coding guideline:

Races (and ethnicity) are defined by specific physical, heredity and cultural traditions or origins, not necessarily by birthplace, place of residence, or citizenship. 'Origin' is defined by the Census Bureau as the heritage, nationality group, lineage, or in some cases, the country of birth of the person or the person's parents or ancestors before their arrival in the United States.

1. All resources in the facility, including the medical record, face-sheet, physician and nursing notes, photographs, and any other sources, must be used to determine race. If a facility does not print race in the medical record but does maintain it in electronic form, the electronic data must also be reviewed.

2. Record the primary race(s) of the patient in fields Race 1, Race 2, Race 3, Race 4, and Race 5. The five race fields allow for the coding of multiple races consistent with the Census 2000. Rules 2 - 8 further specify how to code Race 1, Race 2, Race 3, Race 4 and Race 5. See the editing guidelines that follow for further instructions. If a person's race is a combination of white and any other race(s), code to the appropriate other race(s) first and code white in the next race field.

3. The fields Place of Birth, Race, Marital Status, Name, Maiden Name, and Hispanic Origin are inter-related. Use the following guidelines in order:

a. Code the patient's stated race, if possible.

b. If the patient's race is determined on the basis of the races of relatives, there is no priority to coding race, other than to list the non-white race(s) first

c. If no race is stated in the medical record, or if the stated race cannot be coded, review the documentation for a statement of a race category.

d. If race is unknown or not stated in the medical record and birth place is recorded, in some cases race may be inferred from the nationality. Refer to Appendix W "Race and Nationality Descriptions from the 2000 Census and Bureau of Vital Statistics" to identify nationalities from which race codes may be inferred.

e. Use of patient name in determining race.

4. Death certificate information may be used to supplement antemortem race information only when race is coded unknown in the patient record or when the death certificate information is more specific.

For cases diagnosed prior to January 1, 2000, only the first race field is to be completed and patients of mixed parentage are to be classified according to the race or ethnicity of the mother.

For cases diagnosed January 1, 2000 and later, this no longer applies. Enter each race given. For cases diagnosed prior to January 1, 2004, no "primary" race is designated, and multiple races may be listed in any order, consistent with the 2000 Census.

Ethnicity

SPANISH/HISPANIC ORIGIN (HISPANIC ETHNICITY)

The primary source for coding is an ethnic identifier stated in the medical record.

Procedures for determining ethnicity include:

- Recording ethnicity from information found in the medical record.
- Recording ethnicity based on a combination of patient demographic information that may include last name, maiden name, birthplace, or a statement of ethnicity in the record.

The Spanish/Hispanic Origin field is for identifying patients of Spanish or Hispanic origin or descent. Coding is independent of the Race field, since persons of Hispanic origin might be described as white, black, or some other race in the medical record. Spanish origin is not the same as birth in a Spanish language country. Birthplace might provide guidance in determining the correct code, but do not rely on it exclusively. Information about birthplace is entered separately.

General Coding Instructions for Reporting Ethnicity

1. Coding Spanish Surname or Origin is not dependent on race. A person of Spanish descent may be white, black, or any other race.

2. Portuguese, Brazilians and Filipinos are not Spanish; code non-Spanish (code ‘0’).

3. All information should be used to determine the Spanish/Hispanic Origin including the stated ethnicity in the medical record, stated Hispanic origin on the death certificate, birthplace, information about life history and/or language spoken found in the abstracting process and a last name and maiden name found on a list of Hispanic/Spanish names. Assign code ‘7’ when the only evidence of the patient’s Hispanic origin is a surname or maiden name and there is no evidence that the patient is not Hispanic. Code ‘7’ is ordinarily for central registry use only. If the origin is not stated in the medical record and the hospital registry does not have a list of Hispanic surnames, assign code ‘9,’ “Unknown whether Spanish/Hispanic or not.” Code ‘7’ was adapted for use effective with January 1, 1994 diagnoses.

OCCUPATION AND INDUSTRY

Information on the occupation and industry of cancer patients can be used in research on possible links between workplace exposures and cancer. Occupation and industry information from the central registry is often used by researchers as a partial proxy indicator of socioeconomic status. Specific occupational information can also help identify a patient being reported by multiple hospitals in different ways.

Data on usual occupation and industry are unavailable in an unknown, but significant, proportion of medical records. Even when available, the quality of the data in the medical record is generally untested and often limited to less useful information such as —retired.

Effort should be made to record the occupation and the industry in which the patient **works or worked**, regardless of whether the patient was employed at the time of admission. Ideally, the information should pertain to the longest held job. Review all admissions in the patient's medical record, including those before the diagnosis of cancer, and record the best information available. It is not necessary to request parts of the medical record predating diagnosis solely to determine occupation and industry, but review all admissions in the parts pulled for abstracting.

- Do not leave these fields empty.
- Always enter supporting documentation in an appropriate text field

Occupation

Enter any available information about the kind of work performed (e.g., television repairman, chemistry teacher, bookkeeper, construction worker), up to 40 characters associated with the longest held occupation.

- Avoid the use of abbreviations where possible.
- If an occupation is recorded in the chart without mention of its being the longest held, indicate this with an asterisk next to the entry (e.g., insurance salesman*).
- If the patient is not employed, try to determine the longest held occupation.
- Do not enter a term such as "homemaker," "student," "retired," "unemployed or "disabled" unless no other information can be obtained.
- If no information is available, enter "NR" (not recorded). Do not leave this field blank.

Industry

Enter any available information about the industry associated with the longest held occupation (e.g., automotive repair, junior high school, trucking, house construction), up to 40 characters.

If the chart identifies the employer's name but does not describe the industry, enter the employer's name (and city if available). If only an abbreviation is given for the industry or employer (e.g., PERS, USD, or FDIC), record it even if it’s meaning is not known. However, avoid the use of abbreviations where possible.

The following rules and guidelines apply to the occupation and industry fields:

No occupation/industry information	Enter “Unknown” in both the Usual Occupation and Usual Industry/ Type of Business fields.	Do not use the term "none" which could mean that the individual has never worked.
Incomplete information	Enter Unknown in the Usual Industry field if information on occupation, but not industry, is available. If only information on industry is available, enter Unknown for Usual Occupation	You need not have specific information in both fields if it is unavailable Do not use the term "none" which could mean that the individual has never worked.
More than one occupation/industry	Try to determine the occupation/industry held during most of the patient's life.	
Only a current occupation/industry listed	If you know only the most recent or current occupation/industry, record this information.	
Housewives/persons at home	If no information is available for an occupation outside the home enter Housewife/ husband in the Usual Occupation field. Enter “At Home or Own Home” in the Usual Industry field.	

STAGING SYSTEMS

Cancer Staging

Historically, four major staging schemes have been widely used in cancer registries in the United States. The schemes, AJCC TNM, SEER Extent of Disease, SEER Historic Stage, and SEER Summary Stage, differ in complexity, purpose, structure, rules, and definitions. AJCC TNM staging provides forward flexibility and clinical utility. SEER EOD provides longitudinal stability for epidemiological studies. And, SEER Historic and Summary Stage provide population surveillance staging capability. In January 2004, the Collaborative Staging System was introduced to reduce duplication of effort and provide a common staging schema for registry use and from which the other major staging categories could be electronically derived. All standard setters in the United States required the use of the Collaborative Staging

System version 1 for cases diagnosed January 1, 2004- December 31, 2009, but not every standard setter required every data element. CS version 2 is based on AJCC 7th edition and was renamed the Collaborative Stage (CS) Data Collection System. CS version 2 is effective for cases diagnosed January 1, 2010, and later.

AJCC Staging

Both clinical and pathologic staging fields are collected by the WCSP. If you have enoughinformation to specifically stage a case clinically and pathologically, then both stages shouldbe specifically reported. Use the codes for "unknown" and "not applicable" to complete the staging fields whenever appropriate.

The WCSP is not concerned with who staged the case, as long as the information is correct and is coded correctly. The "Staged By" fields are not collected by the WCSP. If the coded staginginformation in the AJCC fields is known to be incorrect or questionable, please explain the situation in a Staging narrative text fields.

None of the TNM fields may be left empty for pre-2004 diagnoses.

Collaborative Stage

The Collaborative Stage (CS) data set is a combination of data items (most of which have traditionally been collected as a part of regular cancer surveillance activities) that include tumor size, extension, lymph node status, metastatic status, evaluation fields describing the hierarchy of the data collected, and relevant site-specific information. This unified data set was specifically designed for cancer reporting and includes an algorithm which derives three different staging systems from the data collected and resolves subtle staging rule differences. The systems for which staging currently can be derived include AJCC TNM 6th Edition, AJCC TNM 7th Edition, SEER Summary Stage 1977, and SEER Summary Stage 2000.

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Wyoming County Codes

County	City/Town	Zip Code/ County Code
Albany County		001
	Arlington	82083
	Bosler	82051
	Bosler	82070
	Bosler	82072
	Buford	82052
	Centennial	82055
	Foxpark	82070
	Foxpark	82072
	Garrett	82058
	Jelm	82063
	Jelm	82070
	Jelm	82072
	Lookout	82051
	McFadden	82083
	Mountain Home	82072
	Tie Siding	82084
	Woods Landing	82063
	Rock River	82058
	Rock River	82083
	Laramie	82051
	Laramie	82063
	Laramie	82070
	Laramie	82071
	Laramie	82072
	Laramie	82073
Big Horn County		003
	Basin	82410
	Burlington	82411
	Byron	82412
	Cowley	82420
	Deaver	82421
	Greybull	82426
	Lovell	82431
	Manderson	82432
	Emblem	82422
	Hyattville	82428
	Otto	82434
	Shell	82441

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County	City/Town	Zip Code/ County Code
Campbell County		005
	Gillette	82716
	Gillette	82717
	Gillette	82718
	Gillette	82731
	Gillette	82732
	Wright	82732
	Recluse	82725
	Rozet	82727
	Weston	82731
Carbon County		007
	Baggs	82321
	Casper	82615
	Dixon	82323
	Elk Mountain	82324
	Hanna	82327
	Medicine Bow	82329
	Riverside	82325
	Saratoga	82331
	Sinclair	82334
	Creston	82301
	Elmo	82327
	Encampment	82325
	Fort Steele	82301
	Kortes Dam	82327
	Leo	82327
	Muddy Gap	82301
	Riner	82301
	Ryan Park	82331
	Savery	82332
	Shirley Basin	82615
	Walcott	82335
Converse County		009
	Douglas	82633
	Glenrock	82637
	Lost Springs	82224
	Rolling Hills	82637
	Bill	82633
	Orin	82633
	Parkerton	82637

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County	City/Town	Zip Code/ County Code
	Shawnee	82229
Crook County		011
	Hulett	82720
	Moorcroft	82721
	Pine Haven	82721
	Sundance	82729
	Alva	82711
	Beulah	82712
	Carlile	82721
	Devils Tower	82714
	New Haven	82720
	Oshoto	82721
Freemont County		013
	Dubois	82513
	Hudson	82515
	Lander	82520
	Pavillion	82523
	Rawlins	82301
	Rawlins	82310
	Riverton	82501
	Shoshoni	82649
	Arapahoe	82510
	Atlantic City	82520
	Burris	82512
	Crowheart	82512
	Ethete	82520
	Fort Washakie	82514
	Gas Hills	82501
	Jeffrey City	82310
	Kinnear	82516
	Lost Cabin	82642
	Lucky Maccamp	82501
	Lysite	82642
	Midval	82501
	Morton	82501
	Sand Draw	82501
	South Pass City	82520
	St. Stephens	82524
	Sweetwater Station	82520
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County	City/Town	Zip Code/ County Code
Goshen County		015
	Fort Laramie	82212
	La Grange	82221
	Lingle	82223
	Torrington	82240
	Yoder	82244
	Hawk Springs	82217
	Huntley	82218
	Jay Em	82219
	Prairie Center	82240
	Rockeagle	82223
	Veteran	82243
Hot Springs County		017
	East Thermopolis	82430
	Kirby	82430
	Thermopolis	82443
	Worland	82430
	Grass Creek	82443
	Hamilton Dome	82443
Johnson County		019
	Buffalo	82834
	Buffalo	82840
	Kaycee	82639
	Linch	82640
	Mayoworth	82639
	Saddlestring	82840
	Sussex	82639
Laramie County		021
	Albin	82050
	Burns	82053
	Cheyenne	82001
	Cheyenne	82002
	Cheyenne	82003
	Cheyenne	82005
	Cheyenne	82006
	Cheyenne	82007
	Cheyenne	82008
	Cheyenne	82009
	Pines Bluff	82010

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County	City/Town	Zip Code/ County Code
	Pine Bluffs	82082
	Archer	82009
	Carpenter	82053
	Carpenter	82054
	Egbert	82053
	Granite Canyon	82059
	Harriman	82059
	Hillsdale	82060
	Horse Creek	82061
	Iron Mountain	82009
	Lindbergh	82082
	Meriden	82081
Lincoln County		023
	Afton	83110
	Alpine	83128
	Cokeville	83114
	Diamondville	83116
	Kemmerer	83101
	La Barge	83123
	Opal	83124
	Thayne	83127
	Auburn	83111
	Bedford	83112
	Etna	83118
	Fairview	83119
	Fontenelle	83101
	Freedom	83120
	Frontier	83121
	Grover	83122
	Hamsfork	83101
	Raymond	83114
	Smoot	83126
	Turnerville	83110
	Turnerville	83112
Natrona County		025
	Bar Nunn	82601
	Bar Nunn	82609
	Casper	82630
	Casper	82638
	Casper	82646
	Edgerton	82635
Appendix A-Page 6		
County	City/Town	Zip Code/ County

		Code
	Evansville	82636
	Midwest	82643
	Mills	82604
	Mills	82644
	Alcova	82620
	Allendale	82609
	Arminto	82630
	Hiland	82638
	Moneta	82638
	Natrona	82646
	Powder River	82648
Niobarara County		027
	Lusk	82225
	Manville	82227
	Van Tassell	82242
	Keeline	82227
	Kirtley	82225
	Lance Creek	82222
	Node	82225
Park County		029
	Cody	82414
	Frannie	82423
	Meeteetse	82433
	Powell	82435
	Garland	82435
	Heart Mountain	82435
	Mammoth Hot Springs	82190
	Mantua	82435
	Ralston	82440
	Wapiti	82450
	Willwood	82435
	Yellowstone National Park	82190
Platte County		031
	Chugwater	82210
	Glendo	82213
	Guernsey	82214
	Hartville	82215
	Wheatland	82201
	Bordeaux	82201
	Diamond	82210
	Slater	82201

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County	City/Town	Zip Code/ County

		Code
	Sunrise	82215
	Uva	82201
Sheridan County		033
	Clearmont	82835
	Dayton	82836
	Ranchester	82839
	Ranchester	82844
	Sheridan	82801
	Acme	82839
	Arvada	82831
	Banner	82832
	Big Horn	82833
	Leiter	82837
	Parkman	82838
	Story	82832
	Story	82842
	Wolf	82844
	Wyarno	82845
Sublette County		035
	Big Piney	83113
	Marbleton	83113
	Pinedale	82941
	Bondurant	82922
	Boulder	82923
	Cora	82925
	Daniel	83115
Sweetwater County		037
	Bairoil	82322
	Granger	82934
	Green River	82935
	Green River	82938
	Rock Springs	82901
	Rock Springs	82902
	Rock Springs	82942
	Superior	82945
	Wamsutter	82336
	Bitter Creek	82901
	Eden	82932
	Farson	82932
	Lamont	82322
	Little America	82929
	McKinnon	82938
Appendix A-Page 8		
County	City/Town	Zip Code/ County

		Code
	Point of Rocks	82942
	Quealy	82901
	Red Desert	82336
	Reliance	82943
	Tipton	82336
Teton County		039
	Jackson	83001
	Jackson	83002
	Jackson	83025
	Alta	83414
	Alta	82711
	Colter Bay	83013
	Jackson Hole	83001
	Jackson Hole	83002
	Jenny Lake	83012
	Kelly	83011
	Moose	83012
	Moran	83013
	Teton Village	83025
	Wilson	83014
Uinta County		041
	Bear River	82930
	Evanston	82930
	Evanston	82931
	Lyman	82937
	Mountain View	82939
	Fort Bridger	82933
	Lonetree	82936
	Piedmont	82933
	Robertson	82944
	Urie	82937
Washakie County		043
	Ten Sleep	82442
	Worland	82401
Weston County		045
	Newcastle	82701
	Newcastle	82715
	Upton	82730
	Four Corners	82715
	Osage	82723

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Fourteenth Edition, Record Layout Version 12
(Effective January 1, 2010)

FIPS CODES FOR COUNTIES AND EQUIVALENT ENTITIES
Version 12 – Appendix A: FIPS Codes for Counties and Equivalent Entities
STATE NAME: WYOMING, ALPHABETIC CODE: WY, NUMERIC CODE: 56

001 Albany	017 Hot Springs	033 Sheridan
003 Big Horn	019 Johnson	035 Sublette
005 Campbell	021 Laramie	037 Sweetwater
007 Carbon	023 Lincoln	039 Teton
009 Converse	025 Natrona	041 Uinta
011 Crook	027 Niobrara	043 Washakie
013 Fremont	029 Park	045 Weston
015 Goshen	031 Platte	

WCSP Facility List (Updated January 2009)

Name of Facility	Facility Number	Type of Facility	Address	City, Zip Code
Alpine Family Medical Clinic		Treats children, adults and families for routine check-ups, illnesses, and emergencies. X-rays and other emergency services are available.	230 Elkrun Hwy. 89	Alpine, 83128
Banner Health Wyoming		A 25-bed critical access hospital	2000 Campbell Drive	Torrington, 82240
Big Horn Basin Radiation Oncology Center		Radiation therapy at the Center is backed by the Northern Rockies Radiation Oncology Center	1025 Ninth Street	Cody, 82414
Big Horn Clinic			509 W B St.	Basin, 82410
Campbell County Memorial Hospital	68301 15	Medicare provider code: 530002 Number of beds: 76 Phillip McMahil l, MD	501 South Burma Avenue	Gillette, 82716-3426
Castle Rock Hospital District		Specialty: Radiology	1400 Uinta Drive	Green Rive, 82935

APPENDIX B – Page 2

Name of Facility	Facility Number	Type of Facility	Address	City, Zip Code
Cheyenne Regional Medical Center - West	10000403	Medicare provider code: 530014 Number of beds: 214	214 East 23rd Street	Cheyenne, 82001-3790
Cheyenne Regional Medical Center -East	10000403		2600 East 18 Street	Cheyenne, 82001
Cheyenne VA Medical Center	6830060	Medicare provider code: 777777 Number of beds: 71	2360 East Pershing Boulevard	Cheyenne, 82001-5392
Crook County Medical Services District	6830261	Medicare provider code: 530031 Number of beds: 48	713 Oak Street, Box 517	Sundance, 82729
Elkhorn Valley Rehabilitation Hospital		EVRH provides comprehensive physical medicine and rehabilitation services to patients with functional deficits resulting from injury or illness	5715 E. 2nd Street	Casper, 82609
Evanston Regional Hospital	6830085	Medicare provider code: 530032 Number of beds: 42	190 Arrowhead Drive	Evanston, 82930
Francis E. Warren AFB Hospital	6830055	US Air Force Hospital		
APPENDIX B– Page 3				

Name of Facility	Facility Number	Type of Facility	Address	City, Zip Code
Hot Springs County Memorial Hospital	6830262	Medicare provider code: 530004 Number of beds: 49	150 East Arapahoe Street	Thermopolis, 82443-2498
Ivinson Memorial Hospital	6830190	Medicare provider code: 530025 Number of beds: 82 Clinton Merrill, MD	255 North 30th Street	Laramie, 82070-5195
Johnson County Healthcare Center	6830035	Medicare provider code: 530026 Number of beds: 65	497 West Lott Street	Buffalo, 82834-1691
Johnson County Memorial Hospital		Number of beds: 24	497 W Lott St	Buffalo, 82834
Lander Regional Hospital	6830175	Number of beds: 81 Full time Level 2 emergency room The hospital has a Magnetic Resonance Imaging (MRI) unit and a Stereotactic Breast Biopsy unit. Medicare provider code: 530010 Number of beds: 102	1320 Bishop Randall Dr	Lander, 82520
Memorial Hospital of Carbon County	6830227	Medicare provider code: 530009 Number of beds: 45	2221 West Elm Street	Rawlins, 82301-0460
APPENDIX B– Page 4				

Name of Facility	**Facility Number**	**Type of Facility**	**Address**	**City, Zip Code**
Memorial Hospital Of Converse County	6830080	Medicare provider code: 530005 Number of beds: 34	111 South Fifth Street	Douglas, 82633-1450
Memorial Hospital of Sweetwater County	6830230	Medicare provider code: 530011 Number of beds: 99	1200 College Drive	Rock Springs, 82901-5868
Mountain Towers Healthcare and Rehabilitation Center		The nursing center provides a full range of medical services to treat the residents who live with us and the patients who come to us for short-term, episodic medical or rehabilitative care.	3128 Boxelder Drive	Cheyenne, 82001
Mountain View Regional Hospital		Specializing in CNS	6550 East Second Street	Casper, 82609
Niobrara Health and Life Center	6830210	Emergency room services, 4 acute-care beds, and 20 long term care beds. The facility includes a Rural Health Clinic staffed by physicians and a nurse practitioner.	921 S. Ballancee	Lusk, 82225
North Big Horn Hospital	6830205	Medicare provider code: 530029 Number of beds: 98	1115 Lane 12	Lovell, 82431-9537
APPENDIX B– Page 5				

Name of Facility	**Facility Number**	**Type of Facility**	**Address**	**City, Zip Code**
Platte County Memorial Hospital	6830268	Medicare provider code: 530019 Number of beds: 86	201 14th Street	Wheatland, 82201-3201
Powell Hospital	6830225	Medicare provider code: 530007 Number of beds: 129	777 Avenue 'H'	Powell, 82435-2296
Riverton Memorial Hospital	6830240	Medicare provider code: 530008 Number of beds: 59	2100 West Sunset Drive	Riverton, 82501-2274
Sheridan Memorial Hospital	6830250,	Medicare provider code: 530006 Number of beds: 62	1401 West Fifth Street	Sheridan, 82801-2799
South Big Horn County Hospital	6830125		RIVER ROUTE	GREYBULL, 82426
South Lincoln Medical Center	6830160	Medicare provider code: 530017 Number of beds: 40	711 Onyx Street	Kemmerer, 83101-3214
St. John's Hospital & Living Center	6830150	Medicare provider code: 530015 Number of beds: 101	625 East Broadway Street	Jackson, 83001
St. John's Medical Center		Number of beds: 108, Number of physicians: 81	625 E. Broadway	Jackson, 83001
Star Valley Medical Center	6830010	Medicare provider code: 530023 Number of beds: 35	901 Adams Street	Afton, 83110-0579
VA Sheridan Medical Center	6839029	Medicare provider code: 777777 Number of beds: 119	1898 Fort Road	Sheridan, 82801-8320
Washakie Medical Center	6830280	Medicare provider code: 530022 Number of beds: 30	400 South 15th Street	Worland, 82401-3531

Name of Facility	Facility Number	Type of Facility	Address	City, Zip Code
Welch Cancer Center at Sheridan Hospital		Specialty: Cancer, Radiology. Also includes CT Scanner, Medical Linear Accelerators, Multileaf Collimator (MLC)	1585 West 5th Street	Sheridan, 82801
West Park Hospital	6830072	Medicare provider code: 530016 Number of beds: 117	707 Sheridan Avenue	Cody, 82414-3409
Weston County Health Services Hospital	6830224	Medicare provider code: 530003 Number of beds: 74	1124 Washington Boulevard	Newcastle, 82701-2996
Wyoming Behavioral Institute		Medicare provider code: 534003 Number of beds: 70	2521 East 15th Street	Casper, 82602
Wyoming Medical Center	6830040	Medicare provider code: 530012 Number of beds: 216	1233 East Second Street	Casper, 82601-2988
Wyoming State Hospital		Medicare provider code: 532002 Number of beds: 122	831 Highway 150 South	Evanston, 82930
Cheyenne Hematology-Oncology		Robert L Lanier MD, Mohamed El-Tarably, MD and Maristela Batezini, MD	-2301 House Avenue Suite 201	Cheyenne, 82001
APPENDIX B– Page 7				

Name of Facility	**Facility Number**	**Type of Facility**	**Address**	**City, Zip Code**
Family Medical Center		Kim Fehir, MD	497 W Lott St	Buffalo,
Hematolog y Oncology Center -		David Christian son MD	1585 W 5th Street	Sherida n 82801
Hematolog y Oncology Centers		Benjamin T Marchell o MD	1025 9th Street # B	Cody, 82414
Hematology Oncology Centers - Laramie Oncology/Hematol ogy		Tom Anderson , MD	1025 9th St	Cody, 82414
Rocky Mountain Oncology		Diane C Henshaw MD, Robert Tobin MD, Joseph Rosen MD	6501 E 2nd Street	Casper, 82609
Rocky Mountain Oncology -		John D Purviance MD	6501 E 2nd Street	Casper, 82609
Wyoming Cancer Specialists LLC		Keith Mills MD	511 N 12th Street	East Riverton, 82501
Wyoming Cancer Specialists LLC		Keith Mills MD	400 2nd St Ste D	Rock Springs, 82901

Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fourteenth Edition Record Layout Table with References.

NAACCR	Release Date	Effective Date*	Reference Manuals Accommodated	NAACCR Metafile Version
Version 12	02/2009	1/1/2010	CoC FORDS Revised for 2010 Metafile Version 12 SEER Program Coding and Staging Manual WHO ICD-O-3, 2000 SEER Summary Staging Manual, 2000 AJCC Staging Manual, Seventh Edition, 2010 Collaborative Stage Data Collection System, Version 02.00.00	Metafile Version 12
Version 11.3	4/1/2008	1/1/2009	CoC FORDS Revised for 2007 Metafile Version 11.3 SEER Program Coding & Staging Manual 2007, Revision 1 WHO ICD-O-3, 2000 SEER Summary Staging Manual, 2000 AJCC Staging Manual, Sixth Edition, 2002 Collaborative Staging Manual and Coding Instructions, Version 01.04.00	Metafile Version 11.3
Version 11.2	4/1/2007	1/1/2008	Same as Version 11.1	Metafile Version 11.2
Version 11.1	4/1/2006	1/1/2007	CoC FORDS Revised for 2007 Metafile Version 11.1 SEER Program Coding and Staging Manual 2007 WHO ICD-O-3, 2000 SEER Summary Staging Manual, 2000 AJCC Staging Manual, Sixth Edition, 2002 Collaborative Staging Manual and Coding Instructions, Version 01.03.00	Metafile Version 11.1
Version 11	10/1/2004	1/1/2006	CoC FORDS: Revised for 2004 Metafile Version 11 SEER Program Code Manual WHO ICD-O-3, 2000 SEER Summary Staging Manual, 2000 AJCC Staging Manual, Sixth Edition, 2002Collaborative Staging Manual and Coding Instructions, Version 01.02.00	Metafile Version 11
Version 10.2	3/1/2004	1/1/2005	Same as Version 10.1	Metafile Version 10.2

Wyoming Cancer Surveillance Program Fields Required to be Reported	
Record Type	Required
Patient ID Number	Required
Registry ID Number	Required
NAACCR Record Version	Required
Date of 1st Contact	Required
Class of Case	Required
Type of Reporting Source	Required
Sequence Number--Hospital	Required
Name--Last	Required
Name--First	Required
Name--Middle	Required
Name Maiden	Required
Name Alias	Required
Social Security Number	Required
Birth Date	Required
Birthplace	Required
Addr at DX--No & Street	Required
Addr at DX--Supplemental	Required
Addr at DX--City	Required
Addr at DX--State	Required
Addr at DX--Postal Code	Required
County at DX	Required
Sex	Required
Race 1	Required
Race 2	Required
Race 3	Required
Race 4	Required
Race 5	Required
Spanish/Hispanic Origin	Required
Text--Usual Industry	Required When Available
Text--Usual Occupation	Required When Available
Date of Diagnosis	Required
Primary Site	Required
Laterality	Required
Histologic Type ICD-O3	Required
Behavior Code ICD-O3	Required

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Grade	Required
Diagnostic Confirmation	Required
Type of Reporting Source	Required
Age at Diagnosis	Required
CS Tumor Size	Required
CS Extension	Required
CS Tumor Size/Ext Eval	Required
CS Lymph Nodes	Required
CS Mets at DX	Required
CS Site Specific Factor 1	Required
CS Site Specific Factor 2	Required
CS Site Specific Factor 3	Required
CS Site Specific Factor 4	To Be Determined
CS Site Specific Factor 5	To Be Determined
CS Site Specific Factor 6	To Be Determined
CS Site Specific Factor 7	To Be Determined
CS Site Specific Factor 8	To Be Determined
CS Site Specific Factor 9	To Be Determined
CS Site Specific Factor 10	To Be Determined
CS Site Specific Factor 11	To Be Determined
CS Site Specific Factor 12	To Be Determined
CS Site Specific Factor 13	To Be Determined
CS Site Specific Factor 14	To Be Determined
CS Site Specific Factor 15	To Be Determined
CS Site Specific Factor 16	To Be Determined
CS Site Specific Factor 17	To Be Determined
CS Site Specific Factor 18	To Be Determined
CS Site Specific Factor 19	To Be Determined
CS Site Specific Factor 20	To Be Determined
CS Site Specific Factor 21	To Be Determined
CS Site Specific Factor 22	To Be Determined
CS Site Specific Factor 23	To Be Determined
CS Site Specific Factor 23	To Be Determined
CS Site Specific Factor 25	Required
Derived SS2000	Required
Derived SS2000 Flag	Required

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CS Version Input Original	Required
CS Version Derived	Required
CS Version Input Current	Required
Date of 1st Crs RX--COC	Required
RX Summ--Surg Primary Site	Required When Available
RX Date--Surgery	Required When Available
RX Summ--Surg/Rad Seq	Required When Available
RX Summ Scope Reg LN Sur	Required When Available
RX Summ--Surg Oth Reg/Dis	Required When Available
Reason for No Surgery	Required
Rad--Regional RX Modality	Required
RX Date--Radiation	Required When Available
RX Summ-Chemo	Required
RX Date--Chemo	Required When Available
RX Summ--Hormone	Required
RX Date--Hormone	Required When Available
RX Summ--BRM	Required
RX Summ--Other	Required
RX Date--Other	Required When Available
RX Summ--Transplant/Endocr	Required
RX Date--Systemic	Required When Available
RX Summ Systemic/Sur Seq	Required
RX Coding System--Current	Required
NAACCR Record Version	Required
Site Coding Sys--Current	Required
Morph Coding Sys--Current	Required
Date of Last Contact	Required
Vital Status	Required
Cause of Death	Required
ICD Revision Number	Required
Place of Death	Required
Text--DX Proc--PE	Required
Text--DX Proc--X-ray/scan	Required
Text--DX Proc--Scopes	Required
Text--DX Proc--Lab Test	Required
Text--DX Proc--Op	Required
Text--DX Proc--Path	Required

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Text--Primary Site Title	Required
Text--Histology Title	Required
Text--Staging	Required
Place of Diagnosis	Required
RX Text--Surgery	Required
RX Text--Radiation (BEAM)	Required
RX Text-- Radiation Other	Required
RX Text-- Chemo	Required
RX Text-- Hormone	Required
RX Text-- BRM	Required
ICDO-3 Conversion Flag	Required

APPENDIX E

1980 CENSUS LIST OF SPANISH SURNAMES

Instructions for Using 1980 Census List of Spanish Surnames

This list can be used to code last names in most areas of the United States.

- All names are listed alphabetically in upper-case letters without any blanks or spaces. For example, names such as "De Leon," "De la Torre," or "La Luz" are shown as "DELEON," DELATORRE," or "LALUZ."
- Spanish surnames often have accent marks (’) or a tilde (~) over the n (ñ). Disregard accent marks or tildes as these marks have been omitted from the list. For example, the names "Martínez" with an accent (’) and "Nuñez" with a tilde (~) are listed as "MARTINEZ" and "NUNEZ."
- If a surname consists of two names, separated by a dash or a space, code the person as Spanish if either name appears on the list. For example, for "Collins-Garcia," check "COLLINS" on the list. Since it does not appear, check for "GARCIA." If the name appeared as 'Garcia-Collins," then "GARCIA"" would be checked first.
- If the surname is of the form "Lopez R.," ignore the initial and look up the name, "LOPEZ."
- If the surname consists of two surnames separated by "de" such as "Perez de Seda," first look up the name written first, i.e., "PEREZ;" if it is not on the list, look up the final name including the word "de," i.e., "DESEDA;" if it is still not on the list, look up the final name without the word "de," i.e., "SEDA."
- Surnames written with spaces which begin "de," "de la," or "del," such as "de la Cruz," should be looked up with and without the prefix words, i.e., "CRUZ," "LACRUZ," and "DELACRUZ." If any of the combinations is listed, the surname should be considered Spanish.

APPENDIX F

Wyoming Cancer Surveillance Program
Needed Documentation

Face Sheet
History and Physical
Pathology reports
Operative Reports
X-rays,
CT Scans
MRI's
Consultations (all)
Radiation/ Oncology reports (if any)
Laboratory tests – i.e., PSA's. CEA's. CA-125
Discharge Summaries
Discharge instruction sheet

APPENDIX G

TUMOR REGISTRY RULES AND REGULATIONS

CHAPTER 1

GENERAL PROVISIONS

Section 1. **Authority.** The statutory authority for these rules is W.S. § 35-1-240(b) and P.L.102-515.

Section 2. **Definitions.** The following definitions shall apply in the interpretation and enforcement of these rules and regulations.

(a)"ACoS" means the American College of Surgeons Commission on Cancer.

(b) "Billing Period" means January 1 through December 31 of each calendar year.

(c) "Cancer" means diagnosis of disease to include carcinoma, sarcoma, melanoma, leukemia and lymphoma.

(d) "Case Eligibility Criteria" means criteria determined by the ACoS as reportable cases of cancer, supplied by the State Agency.

(e) "Case Finding" means screen hospital listing of patient admit and outpatient visits by ICD-9 code to determine patients with a new diagnosis or history of cancer. Screen pathology department autopsy, cytology and pathology reports to determine patients with a new diagnosis or history of cancer.

(f) "Clinical Laboratory" means a facility for the microbiological, serological, chemical, hematological, biophysical, cytological or pathological examination of materials derived from a human body for the purpose of obtaining information for the diagnosis, prevention or treatment of disease or assessment of medical conditions

(g) "Completed Registration" means all of a cancer patient's available data items required by the ACoS in format specified in manuals required by the State Agency

(h) "Confidential statistical records" means a group of any records under the control of an agency from which information is retrieved by the name of the individual or by some identifying number, symbol, or other identifying particular assigned to the individual.

(i) “Epidemiologist” means one who specializes in the practice of the science concerned with the study of the factors determining and influencing the frequency and distribution of disease, injury and other health-related events and their causes in a defined human population for the purpose of establishing programs to prevent and control their development and spread.

(j) “Health Care Provider” means a person who is licensed, certified or otherwise authorized by the law of this state to provide health care in the ordinary course of business or practice of a profession, but does not include a person who provide health care solely through the sale or dispensing of drugs.

(k) “Hospitals” means establishments with organized medical staffs, with permanent facilities that include in-patient; beds and with medical services, including physician services and continuous nursing services; to provide diagnosis, treatment, and continuity of care for patients.

(l) “Hospital Authority” means administrator or person appointed by the administrator

(m) “Hospital Cancer Registrar” means a person on staff or contracted by a Wyoming Hospital, who is assigned the responsibility of completed registration of all required cancer cases to the State Agency.

(n) “Infirmaries of Wyoming Institutional Facilities” means a place where ill persons are cared for within lodging facilities owned and operated by the State of Wyoming.

(o) “ICD-9” means International Classification of Diseases.

(p) “NAACCR” means North American Association of Central Cancer Registries.

(q) “Nonconfidential statistical data” means nonidentifying masses of numerical data which summarize disease factors.

(r) “Nursing Care Facilities” means a facility which is currently licensed and certified to provide skilled nursing services and/or intermediate nursing services.

(s) “Patient” means an individual who receives or has received health care and/or a deceased individual who has received health care.

(t) “Patient Follow-up” means annual investigation and recording of patient status and of patient’s disease required by ACoS.

(u) “Physician” means a term used to indicate individuals appropriately licensed in Wyoming.

(v) “Private Office” means a term used to indicate office space used by physician in private practice.

(w) “Rules” means to be construed to embrace and be synonymous with the term “regulation”.

(x) “Semi-Annually” means every six months (twice a year). Schedule will be established and agreed on between each individual hospital and the State Agency.

(y) “Shall” means State Agency requirement.

(z) “State Agency” means the Wyoming Department of Health, Division of Public Health, Preventive Medicine Branch, office of the Wyoming Central Tumor Registry.

Section 3. **Applicability.**

(a) Chapters 1, 2 and 3 of these regulations shall apply to all hospitals, physicians and other health care providers licensed and performing patient care in Wyoming.

(i) Exception: Wyoming State (Psychiatric) Hospital.

(b) Chapters 1 and 4 of these regulations shall apply to any person employed by the State Agency, epidemiologist, researcher and any other persons or organizations utilizing statewide cancer registry data.

Section 4. **Immunity from Civil Action.**

(a) Any person who complies with W.S. § 35-1-240(b) is immune from any civil action with respect to a cancer case report provided to the State Agency or with respect to access to cancer case information provided to the registry.

Section 5. **Standards.** The State Agency has adopted the latest version of “Standards for Cancer Registries” published by the North American Association of Central Cancer Registries (NAACCR).

(a) Data Completeness: 95% of unduplicated, expected malignant cases of reportable cancer occurring in Wyoming residents in a diagnosis year shall be reported to the state cancer registry.

(b) Data Timeliness: Cancer cases shall be reported to the state cancer registry within six (6) months of diagnosis date.

(c) Data Quality: Comply with standards for data quality including standardized data format as promulgated by the NAACCR.

CHAPTER 2

UNIFORM REGISTRATION AND REPORTING OF CANCER CASES

Section 1. **Training.**

(a) All hospitals shall arrange for a minimum of one (1) person and a maximum of three (3) persons, to attend initial training at the State Agency unless a waiver is granted to the hospital by the State Agency. Waivers will be granted at the sole discretion of the agency upon a showing of good cause; i.e., proof of contract with an independent contractor or proof that current hospital personnel have previously received training.

(b) Initial educational training of Hospital Cancer Registrars shall be done in the State Agency offices by a qualified trainer at no cost to the hospital. Hospital's employee expenses shall be the responsibility of the hospital.

(c) Hospitals shall be responsible for utilizing the initially trained employees to train other personnel to insure a continuum of trained personnel.

(d) Additional training of Hospital Cancer Registrars shall be provided by the State Agency or a suitable alternative within a reasonable time of individual hospital's request.

Section 2. **All Hospitals, Physicians and Other Health Care Providers.**

(a) and other health care providers shall grant State Agency access to all records that would identify cases of cancer or would establish characteristics of the cancer, treatment or medical status of any identified patient.

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(b) Hospitals, physicians and other health care providers shall not be held liable in any civil action with respect to a cancer case report provided to the statewide cancer registry, or with respect to access to cancer case information provided to the statewide cancer registry per W.S. § 35-2-609 (Disclosure without patient's authorization).

Section 3. **All Hospitals.**

(a) Hospitals shall perform case finding to determine all patients with a new diagnosis of cancer or history of cancer which meets the case eligibility criteria.

(b) Hospitals shall provide semi-annually to the State Agency a listing of cancer cases by ICD-9 codes which includes the diagnosis of cancer and history of cancer. The State Agency shall be authorized to inspect same, to verify the completeness of cancer reporting.

(c) Hospitals shall perform patient follow-up on all living patients annually per ACoS guidelines. Follow-up shall be submitted to the State Agency on a monthly basis.

(d) All hospitals shall have the right to establish a contract, to meet Tumor Registry requirements, with an independent contractor or hospital previously trained.

Section 4. **Registration Options**

(a) All hospitals shall select one of the following options relative to the registration of cancer patients seen in their hospital:

(i) Option 1.

(A) Submit completed registration to the State Agency of all cases within the facility which meet case eligibility criteria. New case registrations shall be reported to the State Agency on a monthly basis.

(ii) Option 2.

(A) Pay the designated fee per cancer case as defined in Chapter 3, Section 1.

(B) Mail all required documentation to the State Agency on a monthly basis for case registration to be completed within the State Agency.

(b) Hospitals selecting option 2 shall notify the State Agency in writing of their selection no later than December 1st of the calendar year.

(c) Option selection may be reviewed and/or changed after December 1st of the current years by hospital authority or by State Agency by providing thirty (30)days written notice.

Section 5. **Physicians.**

(a) Physicians shall report to the State Agency, all cancer patients who meet case eligibility criteria who are diagnosed and/or treated in a private office and who are not admitted to a Wyoming Hospital.

(b) Physicians shall supply all available information requested by the State Agency concerning cancer patients who meet case eligibility criteria.

(c) Physicians shall supply all available information requested by their Hospital Cancer Registrar, concerning cancer patients who meet case eligibility criteria.

Section 6. **Other Health Care Providers.**

(a) Clinical Laboratories in Wyoming shall provide copies of all tissue, cytology and autopsy reports on cancer patients seen outside a Wyoming Hospital.

(b) Infirmaries of Wyoming Institutional Facilities shall supply all available information requested by the State Agency concerning cancer patients who meet case eligibility criteria.

(c) Nursing Care Facilities shall supply all available information requested by the State Agency concerning cancer patients who meet case eligibility criteria.

CHAPTER 3

REGISTRATION FEES

Section 1. **Fee Assessment.**

(a) Fees shall be assessed only to those hospitals which select option 2 as defined in Chapter 2, Section 4(ii).

(b) Hospitals which select option 2 as defined in Chapter 2, Section 4(ii), shall be assessed a fee of twenty-five dollars ($25) per new case.

(c) Cancer cases diagnosed prior to July 1, 1994 shall not be subject to fee assessment.

(d) Cancer case count for assessment of fees shall be calculated by State Agency's record of cases added to each hospital's file during each billing period.

(e) State Agency shall assess hospital fees annually for each cancer case registered within each billing period.

(f) Fees shall be payable to the state general fund within sixty (60) days of receipt of billing.

(g) Individual physicians shall not be assessed fees.

CHAPTER 4

PUBLIC LAW 102-515

Section 1. **Disclosure of Data**

(a) Confidential Case Data. The protection and release of confidential statistical records shall be in accordance with W.S. § 16-4-201, et seq, the Wyoming Public Records Act, and the Wyoming Department of Health Information Practices Rules.

(b) Nonconfidential Statistical Data. Nonconfidential statistical data shall be released to all hospitals, physicians, other health providers and interested persons in compliance with the latest written policies set forth by the Wyoming State Epidemiologist.