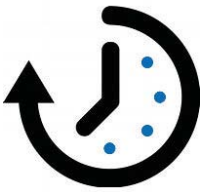
Software Vendor Quick Facts for Cancer Reporting to the California Cancer Registry

Reporting Requirements

It is the responsibility of the original pathologist to report all cancer diagnoses. Any slide review, second opinion, report correction, addendums, etc. related to the original specimen diagnosis that either change the original incidence of cancer (i.e., reportable to non-reportable, or vice versa) or changes the histology and/or behavior of the original specimen is to be electronically transmitted to CCR by the original pathologist within two weeks of finalizing the revised pathology documentation.



Timeline

- Now Open: Electronic Pathology Registration Portal (https://pathreporting.ccr.ca.gov/registration/).
- Now Open: Vendor Self-Initiated Testing Portal.
- July 1, 2018: Pathology Laboratory Registration Deadline.
- July 31, 2018: Pathology Direct Data Entry Web Portal.
- January 1, 2019: Data submission to CCR must be established by pathology labs on behalf of represented pathologists before the January 1, 2019 deadline.

What is the Registration Process?

Facilities and/or Pathology labs are required to register for reporting on behalf of represented pathologists within an organization or lab.

Registration information includes:

- Lead physician contact
- Lab management contact
- Technical interface contact
- LIS and/or EHR vendor information for the purpose of providing a certificate for submission to the web service where applicable.

What are the Transmission Methods?

CCR will accept electronic pathology reports through four methods of transmission:

- A web service
- Secure File Transfer Protocol (SFTP)
- Minimal Lower Layer Protocol (MLLP)
- Direct Data Entry Web Portal.

In What Formats can Pathologist Send their Data?

CCR is limiting the formatting of pathology reports to four options:

- Simple Narrative
- Synoptically Structured Health Level Seven (HL7)
- Synoptically Structured HL7 using College of American Pathologists (CAP) Electronic Cancer Checklist (eCC)
- CAP eCC Structured Data Captured(SDC) Extensible Markup Language (XML)

What are the Reportable Diagnoses Criteria?

- All reportable neoplasms meeting the criteria as outlined in the CCR Electronic Pathology Reporting Standards Implementation Guide are to be transmitted to the CCR. Neoplasms outlined under the Non-Reportable Diagnoses are not to be transmitted.
- In the event an ambiguous term(s) precede a reportable cancer diagnoses, the case is to be considered reportable. Examples of ambiguous terminology include, but are not limited to the following: apparently, appear to, suspicious, likely or most likely, favors, comparable, consistent with, typical (of), probable, presumed, malignant appearing.

Over

1/2018

For more information contact us at AB2325Help@cdph.ca.gov or go to our website to submit your question: *www.ccrcal.org/AB2325.shtml*

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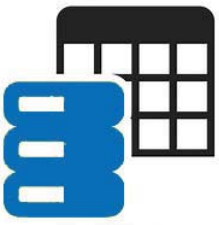
What are the Reportable Pathology Report Types?

The following types of pathology reports that provide information on reportable neoplasms are to be transmitted to CCR:

- Surgical Pathology Reports:
  - Biopsy (Needle Core, Excisional, Incisional, Bone Marrow Aspirates)
  - Surgical Resection
  - Surgical Re-excision
- Cytology Reports:
  - Biopsy (fine needle aspiration)
  - Brushings (e.g., endoscopic evaluation of pancreas, PAP smear)
  - Fluids (Urine, Peritoneal, Pleural, Cerebrospinal
  - Fluid, Broncheoalveolar lavage)
  - Hematologic Specific Reports:
  - Immunohistochemistry (IHC)
  - Peripheral Blood Count Flow Cytometry
  - Molecular Reports:
    - Molecular Diagnosis PCR
    - RT-PCR
    - Sequencing (NGS, Pyrosequencing, etc)
    - ISH
    - FISH
    - Gene Array
- Consults
- Slide Reviews
- Biomarker results
- Pathology Report Addenda



What are the Required Data Elements?

CCR requires all data elements listed in the California Cancer Registry NAACCR Volume 5 Version 4.0 – HL7 2.5.1 Constraints Document are required or required if accessible. These data elements include:

- Facilities Information
- Ordering Provider Information
- Patient Demographics
- Tumor Specific Information

Facilities and ordering provider information is required in order to successfully match pathology information to existing records in its database and/or to match to the criteria for research studies/ clinical trials.

Patient demographic items are essential for epidemiological incidence and mortality research.

CCR recognizes that not all facility/patient information may be available to all pathologists. However, it is likely that ordering facility/office EHR systems will contain many of these facility/ patient data elements, so CCR recommends that LIS vendors work with ordering facilities/offices and their EHR vendors to enable these kinds of data elements to be transmitted to CCR.

Identifying Reportable Cancers

Pathology labs reporting to CCR are required to implement filtering for reportable cancer cases. There are multiple approaches in which to implement filtering logic to disseminate reportable cancers. Options include using an ICD-10 list, ICD-02/ICD-03 list or a Cancer Case Finding Selection Criteria Word List. Specific codes associated with ICD reportable lists are referenced below please click on the hyperlink to view. Specifics relative to the NAACCR Path Lab Search Terms are referenced below please go to the website to view. CCR is not authorized to retain information on non-reportable neoplasms.

International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM): http://www.ccrcal.org/pdf/AB2325/CA_ICD-10-CM.xlsx

NAACCR Path Lab Search Terms: https://www.naaccr.org/naaccr-path-lab-search-terms/

International Classification of Diseases for Oncology (ICDO-3) ICDO-3 is used by National Cancer Institute (NCI) INCLUSIONS:

- All neoplasms diagnosed prior to the year 2001 with a behavior code of '2' or '3' in the International Classification of Diseases for Oncology, Second Edition (ICD-O-2) are reportable.
- All neoplasms diagnosed in 2001 and later with a behavior code of '2' or '3' in the International Classification of Diseases for Oncology, Third Edition (ICD-O-3) are reportable.
- Epithelial carcinomas (8010-8046) in ICD-O-2 or ICD-O-3 are reportable for sites other than skin (C44.0-C44.9) including but not limited to vagina, clitoris, vulva, prepuce, penis and scrotum (sites C52.9, C51.0-C51.9, C60.0, C60.9, and C63.2).
- If a '0' or '1' behavior code term in ICD-O-2 or ICD-O-3 is verified as in situ, '2', or malignant, '3', by a pathologist, these cases are reportable.
- Tumors of the brain and central nervous system (C70.0-C72.9, C75.1-C75.3) with a behavior code of '0' or '1' beginning with January 1, 2001 diagnoses are reportable.

EXCLUSIONS:

- Cervix carcinoma in situ are not reportable.
- The following histology and site 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)

Vendor Self-Initiated Testing

A vendor self-initiated test portal is available to upload test files for automatic evaluation and feedback on pathology reports. The self-testing tool validates test messages for structure and format. The file is checked to determine that it is parsable, and that the required fields are completed. Edits are run against the submitted file. Multiple record types from pathology laboratory vendors may be needed. If the files pass, the service will update the user account allowing user to send that version of the record to CCR. If the file fails, a list of errors will be returned and/ or displayed.

Vendor Self-Initiated Testing Link: https://pathreporting.ccr.ca.gov/selftesting/

On-boarding Process

CCR conducts outreach to entities registered to initiate organization and laboratory specific testing. Organization and laboratory specific testing requires a defined method of reporting to be finalized. Depending upon the method of reporting, subsequent tasks involved to create and establish a direct connection with CCR may be required. Pathology labs submitting data on behalf of pathologists are required to participate in a testing and validation process with CCR. CCR works with pathology labs, their representatives, and/or vendor representatives to ensure the data being submitted to CCR meets formatting and completeness requirements.