MONTANA CENTRAL TUMOR REGISTRY ABSTRACTING MANUAL

for use with the Hospital Cancer Abstracting Form Rev 06/21

For cases diagnosed 01/01/2021 and after

MONTANA CENTRAL TUMOR REGISTRY
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Yellow highlights reflect changes from previous manual

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Public Health IN THE 406 | MONTANA DPHHS

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General Principles

Preface

Implementation of this manual will be required with cancer cases diagnosed on or after January 1, 2021.

Required fields are either required by the Montana Central Tumor Registry law (Duty to Report Tumors 50-15-703), Administrative Rules of Montana (37.8.1801 – 37.8.1808), Public Law 102-515 (Cancer Registries Amendment Act), or NPCR Required Status Table under cooperative agreement with the Centers for Disease Control and Prevention, PA 02060, National Program of Cancer Registries (cooperative agreement number DP17-1701).

Purpose

Central cancer registries collect, store, analyze, and interpret cancer data on people who are diagnosed and/or treated for cancer in population-based areas. The primary objective of the MCTR is to analyze the incidence, mortality, survival, and the changing frequency of cancer in Montana residents. Analysis is possible with complete, timely and quality data reporting.

Casefinding

Casefinding is the method of locating all eligible cancer cases and retrieving the required information on all patients diagnosed with or treated for cancer who are to be included in the MCTR, inpatient or outpatient regardless of the type of service. Casefinding will identify both new cases and cases already entered. Active casefinding (involves the registrar retrieving all source documents) is recommended for identifying reportable cases. Reportable cases could easily be missed with passive casefinding as non-registry staff are not familiar with reporting criteria and terminology. For example, non-registry staff could miss the collection of cases with terms that may not sound cancerous (such as linitis plastica or Waldenstrom's macroglobulinemia).

A procedure for obtaining complete and relevant data on all cancer patients with a reportable tumor should be established. The following casefinding sources may identify possible cancer cases:

- Pathology reports (histology, cytology, autopsy, bone marrow, hematology, pathologic addenda and consultations)
  - Pathology-only cases must be reported even if the patient was not seen in your facility
- Medical Record Disease Indices (all services: inpatient, outpatient, clinics, inpatient hospice, etc.)
  - History and Physical
  - Consultation Notes
  - Progress Notes
  - Discharge Summary
- Daily admissions and discharges
- Notes from physician's offices
- Diagnostic Imaging reports (X-ray, MRI, CT, PET, mammogram)
- Surgery schedule
- Medical oncology logs
- Radiation oncology logs
- Infusion or Treatment Center
- Outpatient Departments (including cancer specialty clinics, chemotherapy clinics, infusion centers, day surgery, etc.)

These sources should be checked thoroughly and periodically to ensure that all cancer patients receiving inpatient or outpatient services from the hospital are included in the registry.

Reference Date

The reference date is the start date after which all eligible cases must be included in the tumor registry. The Montana Legislature established Montana's reference date as January 1, 1979.

Resources for Cancer Reporting

Manual	Website	Questions directed to
AJCC 8th Edition	https://cancerstaging.org/#s/default.aspx	
AJCC 8th Edition Updates and Histologies	https://cancerstaging.org/references-tools/deskreferences/Pages/8EUpdates.aspx	http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging-8th-edition
AJCC Cancer Staging Form Supplement	https://cancerstaging.org/references-tools/deskreferences/Pages/Cancer-Staging-Forms.aspx	
Ask a SEER Registrar	https://seer.cancer.gov/registrars/contact.html	
CAnswer Forum	http://cancerbulletin.facs.org/forums/help	
CoC STORE Manual	https://www.facs.org/quality-programs/cancer/ncdb/registrymanuals/cocmanuals	
EOD 2018	https://seer.cancer.gov/tools/staging/rsa.html	https://seer.cancer.gov/registrars/contact.html
Grade Manual	http://naaccr.org/SSDI/Grade-Manual.pdf	http://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018
Hematopoietic and Lymphoid Neoplasm DB	https://seer.cancer.gov/tools/heme/	https://seer.cancer.gov/registrars/contact.html
ICD-O-3 Histology Revisions	https://www.naaccr.org/implementation-guidelines/	https://seer.cancer.gov/registrars/contact.html
ICD-O-3.2	http://www.iacr.com.fr/index.php?option-com_content&view=article&id-149:icd-o-3-2&catid-80:newsflashes&itemid=545	
MCTR 2021 Reporting Manual	https://dphhs.mt.gov/publichealth/Cancer/TumorRegistry	
NAACCR Data Exchange XML Standard	https://www.naaccr.org/xml-data-exchange-standard/	
NAACCR v21 Data Standards and Dictionary	https://www.naaccr.org/data-standards-data-dictionary/	
SEER Program Manual	https://seer.cancer.gov/tools/codingmanuals/	https://seer.cancer.gov/registrars/contact.html
SEER*RSA	https://seer.cancer.gov/tools/staging/rsa.html	https://seer.cancer.gov/registrars/contact.html
SEER*Rx	https://seer.cancer.gov/seertools/seerrx/	https://seer.cancer.gov/registrars/contact.html
Site-Specific Data Items	https://www.naaccr.org/SSDI/SSDI-Manual.pdf	http://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018
Solid Tumor Rules	https://seer.cancer.gov/tools/solidtumor/	https://seer.cancer.gov/registrars/contact.html
Summary Stage 2018	https://seer.cancer.gov/tools/ssm/	https://seer.cancer.gov/registrars/contact.html

Reportable List

According to the Administrative Rules of Montana (37.8.1801), the following tumors are to be submitted for reporting. Reportable cancer cases should be submitted to the MCTR within six months after the patient's date of first contact. The list is based on those cases which are categorized as malignant, in-situ, or benign (for types listed below) by the International Classification of Diseases for Oncology. The MCTR requires non-analytic and pathology-only cases to be reported.

<table>
<tr><th>Type</th><th>Description</th></tr>
<tr><td>Reportable Diagnoses</td><td>
1. All malignant neoplasms (including in-situ) (behavior code 2 or 3)
2. BCC and SCC of the labia, vagina, vulva, clitoris, penis, scrotum, prepuce, and anus
3. Cervix (CIN III), prostate (PIN III), vulva (VIN III), vagina (VAIN III), anus (AIN III), and (LIN III) larynx
4. All benign tumors of the brain (behavior code 0 or 1) INCLUDES: meninges, brain, spinal cord, cranial nerves, and other parts of the CNS, pituitary gland, craniopharyngeal duct, and pineal gland
NOTE: Juvenile astrocytoma, listed as 9421/1 in ICD-O-3, is required and should be recorded as 9421/3
5. All carcinoid tumors (malignant, benign, and NOS)
NOTE: Carcinoid tumors of the appendix must be coded to 8240/3 and must be reported with a behavior code 3
6. All gastro-intestinal stromal tumors (GIST) and thymomas are reportable (behavior code 3) unless stated to be benign effective January 1, 2021
7. LCIS (lobular carcinoma in situ of breast)
</td></tr>
<tr><td>Ambiguous Terminology Considered Diagnostic of Cancer</td><td>
<table>
<tr><td>Apparent(ly)</td><td>Most likely</td></tr>
<tr><td>Appears</td><td>Presumed</td></tr>
<tr><td>Comparable with</td><td>Probable</td></tr>
<tr><td>Compatible with</td><td>Suspect(ed)</td></tr>
<tr><td>Consistent with</td><td>Suspicious (for)</td></tr>
<tr><td>Favor</td><td>Typical (of)</td></tr>
<tr><td>Malignant appearing</td><td>Neoplasm or Tumor for C70.0-C72.9, C75.1-C75.3</td></tr>
</table>
Exception: If a cytology is identified only with an ambiguous term, do not interpret it as a diagnosis of cancer. Abstract the case only if a positive biopsy or a physician's clinical impression of cancer supports the cytology findings.

Do not substitute synonyms such as "supposed" for "presumed", "equal" for "comparable" or "likely" for "most likely".

<u>Examples of reportable ambiguous terms</u>:
• Chest x-ray states consistent with carcinoma of the right upper lobe of the lung. The patient refused further work-up or treatment. Consistent with carcinoma is indicative of cancer.
• CT of brain suspicious for neoplasm. Neoplasm is reportable for C70.0-C72.9, C75.1-C75.3.
• The pathology report states suspicious for malignancy. Suspicious for malignancy is indicative of cancer.
</td></tr>
</table>

Type	Description
Exceptions (not reportable)	1. Basal Cell Carcinoma (BCC) or Squamous Cell Carcinoma (SCC) of skin (C44._) with histologies 8000-8005, 8010-8046, 8050-8084, 8090-8110 2. Patients with a history of malignancy who are clinically free of disease when seen at your facility 3. Patients diagnosed with a probable carcinoma and subsequently ruled out (see list of Ambiguous Terms) *Example*: A patient was diagnosed with probable lung carcinoma in June 1995 and a biopsy performed in July 1995 revealed no evidence of cancer. 4. Patients who receive transient care to avoid interrupting a course of therapy started elsewhere *Example*: A patient who lives in Idaho is visiting and receives scheduled chemotherapy started in Idaho. 5. Out-of-state patients with a history of or evidence of cancer who are not receiving cancer treatment or are seen for an unrelated medical condition 6. Genetic findings in the absence of pathologic or clinical evidence of reportable disease are indicative of risk only and do not constitute a diagnosis
Ambiguous Terminology NOT Considered Diagnostic of Cancer	Cannot be ruled out — Questionable Equivocal — Rule out Possible — Worrisome Potentially malignant — Suggests Examples of non-reportable ambiguous terms: • Chest x-ray states *consistent with neoplasm* of left upper lobe of lung. The patient refused further work-up or treatment. *Consistent with neoplasm* is not indicative of cancer. While "consistent with" can indicate involvement, "neoplasm" without specification of malignancy is not diagnostic except for non-malignant primary intracranial and central nervous system tumors. • Mammogram notes p*ossible carcinoma* of the breast. "Possible" is not a diagnostic term for cancer. • Mammogram notes *suspicious* density. While "suspicious" can indicate a problem, "density" is not indicative of cancer.

Reportable ICD-10-CM Codes (review for reportability)

ICD-10-CM Code	Description
C00._ - C43._, C4A._, C45._ - C96._	Malignant neoplasms Includes: BCC and SCC of the labia (C51.0-C51.1), vagina (C52.9), vulva (C51.9), clitoris (C51.2), penis (C60.1-C60.9), scrotum (C63.2), prepuce (C60.0), and anus (C21.0)
C49.A-	Gastrointestinal Stromal Tumors
C7A._	Malignant carcinoid tumors
C84.A_	Cutaneous T-cell lymphoma
C84.Z_	Other mature T/NK-cell lymphoma
C91.A_	Mature B-cell leukemia Burkitt-type
C91.Z_	Other lymphoid leukemia
C92.A_	Acute myeloid leukemia with multi-lineage dysplasia
C92.Z_	Other myeloid leukemia
C93.Z_	Other monocytic leukemia
C96.2_	Malignant mast cell neoplasms
C96.A_	Histiocytic sarcoma
C96.Z_	Other specified malignant neoplasm of lymphoid, hematopoietic, and related tissue
D00._ - D09._	In situ neoplasms Note: Carcinoma in-situ of the cervix (CIS), intraepithelial neoplasia grade III (8077/2) of the cervix (CIN III), prostate (PIN III), vulva (VIN III), vagina (VAIN III), anus (AIN III), and (LIN III) larynx are reportable
D18.02	Hemangioma of intracranial structures and any site
D3Aa._	Carcinoid tumors (any behavior) and neuroendocrine tumor (malignant only)
D32._	Benign neoplasms of meninges (cerebral, spinal and unspecified)
D33._	Benign neoplasm of brain and other parts of central nervous system
D35.2 - D35.4	Benign neoplasm of pituitary gland, craniopharyngeal duct and pineal body
D42._, D43._	Neoplasm of uncertain or unknown behavior or meninges, brain, CNS
D44.3 - D44.5	Neoplasm of uncertain or unknown behavior of pituitary gland, craniopharyngeal duct and pineal gland
D45	Polycythemia vera (9950/3) Note: Excludes familial polycythemia (C75.0), secondary polycythemia (D75.1)
D46._	Myelodysplastic syndromes (9980, 9982/ 9983, 9985, 9986, 9989, 9991, 9992)
D47._	Myeloproliferative diseases (9931, 9740, 9741, 9742, 9960, 9961, 9962, 9963, 9965, 9966, 9967, 9970, 9971, 9975, 9987)
D47.Z1	Post-transplant lymphoproliferative disorder (PTLD)
D47.3	Essential (hemorrhagic) thrombocythemia (9962/3) Includes: essential thrombocytosis, idiopathic hemorrhagic thrombocythemia
D49.6, D49.7	Neoplasms of unspecified behavior of brain, endocrine glands and other CNS
J91.0	Malignant pleural effusion
R18.0	Malignant ascites
R85.614	Cytologic evidence of malignancy on smear of anus
R87.614	Cytologic evidence of malignancy on smear of cervix
R87.624	Cytologic evidence of malignancy on smear of vagina
Z51.0	Encounter for antineoplastic radiation therapy
Z51.1_	Encounter for antineoplastic chemotherapy and immunotherapy

Quality Control

Accuracy and consistency are essential in tumor registry reporting. The MCTR will perform quality assurance tasks upon receipt of abstracts from each reporting institution. QC may include visual review of abstracts, review of accession register and abstracts, and periodic re-abstracting of cases. The reporting facility will be required to resolve incomplete, incorrect, or inconsistent data upon MCTR query.

Follow-Up

Annual follow-up of patients is an important cancer registry function. The MCTR conducts yearly lifetime follow-up on all reported cases. Follow-up is based on the date of last contact and is delinquent (lost) if no contact has been made within 15 months after the date of last follow-up information. Cases that are lost-to-follow-up (delinquent) should remain in the follow-up process until follow-up information is obtained.

Follow-up data must include the date(s) and type(s) of treatment for cancer, the site(s) of distant metastasis, date and type of recurrence, subsequent treatment for progressive disease or recurrence, the site and histology of any subsequent primary, the date of last contact, the patient's current physician, and the status of the patient and the cancer.

Confidentiality

All data concerning cancer patients is held in strict confidence by the MCTR. Confidentiality is of paramount importance; the privacy of patients, physicians, and hospitals is strictly maintained. As it is elsewhere, confidentiality is an issue of increasing concern to cancer registries. The MCTR's Data Release Policy can be found on the website https://dphhs.mt.gov/publichealth/Cancer/TumorRegistry.

Procedure Manual

Tumor registries should maintain a complete, up-to-date procedure manual that documents each phase of its operations. A procedure manual is a valuable and necessary tool used to organize and maintain an effective, efficient program. When adhered to, this manual will ensure a smooth operation with consistent and accurate abstracting, systematic and continuous follow-up, and complete and timely reporting.

The procedure manual should contain:

- The objectives of the cancer registry
- Job descriptions and specifications of registry positions
- Case eligibility criteria
- The reportable list
- Procedures for casefinding, maintaining and using a suspense file, and accessioning
- A description of the registry filing system
- Documentation of data collection methods, including principles of abstracting, detailed definitions for each data item, references used for coding systems, if applicable, and staging systems used
- Follow-up procedures
- Documentation of quality control procedures
- A description of reporting mechanisms
- Policy statements about confidentiality and release of information

Multiple Primaries

The **SEER Solid Tumor Rules** and **SEER Hematopoietic and Lymphoid Neoplasm Database** should be used to determine the number of primaries to be reported and for coding detailed histology and primary sites.

Paired Organs

A list of paired organ sites can be found with the coding instructions for *Laterality*. Refer to the **SEER Solid Tumor Rules** to determine whether involvement of paired sites should be coded as one or two primaries.

Estimating Dates

Estimating the Month

- Code “Spring” to April
- Code “Summer” or “middle of the year” to July
- Code “Fall” or “Autumn” to October
- For “Winter of”, try to determine if the physician means the first of the year or the end of the year and code January or December as appropriate.
- Code “early in the year” to January
- Code “late in the year” to December
- Code the month of admission when there is no basis for estimation

Estimating the Year

- Code “a couple years” to two years earlier
- Code “a few years” to three years earlier
- Use whatever information is available to calculate the year
- Code the year of admission when there is no basis for estimation

Outcomes

The outcomes data items describe the known clinical and vital status of the patient. Follow-up information is obtained at least annually for all living patients included in a cancer registry’s database. Recorded follow-up data should reflect the most recent information available to the registry that originates from reported patient hospitalizations, known patient readmissions, contact with the patient’s physician, and/or direct contact with the patient. Use the MCTR Followup Form to submit updated patient status.

Follow-up for *Vital Status* and *Cancer Status* should be conducted annually for all cases in the cancer registry.

Once the patient’s death has been recorded, no further follow-up is performed.

In Utero Diagnosis and Treatment

Beginning in 2009, diagnosis and treatment dates for a fetus prior to birth are to be assigned the actual date of the event. In the past, those dates were set by the rule to the date the baby was born. The exact date may be used for cases diagnosed prior to 2009.

Embolization

The term embolization refers to the intentional blocking of an artery or vein. The mechanism and the reason for embolization determine how and whether it is to be recorded.

Chemoembolization is a procedure in which the blood supply to the tumor is blocked surgically or mechanically and anticancer drugs are administered directly into the tumor. This permits a higher concentration of drug to be in contact with the tumor for a longer period of time.

Radioembolization is embolization combined with injection of small radioactive beads or coils into an organ or tumor.

Embolization is coded as *Other Treatment* if the embolizing agent is alcohol, or if the embolized site is other than the liver and the only information in the record is that the patient was given “embolization” with no reference to the agent.

Do not code pre-surgical embolization of hypervascular tumors with particles, coils, or alcohol. These pre-surgical embolizations are typically performed to make the resection of the primary tumor easier. Examples where pre-surgical embolization is used include meningiomas, hemangioblastomas, paragangliomas, and renal cell metastases in the brain.

Reporting Facility Information

Reporting Hospital: Record the name of the hospital reporting this case.

Abstracted By: Record the full name of the person completing the form. This is useful for feedback.

Date Abstracted: Record the date this form is completed. The date is recorded to measure timeliness of reporting.

Facility #: Record your Facility # that has been assigned by the Montana Central Tumor Registry. If you are unsure of your Facility #, please contact the MCTR.

Accession #: Record the patient's accession number for this tumor. *Accession Number* and *Sequence Number* provide a unique identifier for the patient (and tumor). Each patient is assigned a unique accession number and each primary cancer for that patient is assigned a different sequence number. The accession number consists of the year in which the patient was first seen at the reporting facility (with a reportable cancer) and the consecutive order in which the patient was abstracted. Assign a unique accession number to each patient; do not assign two patients the same number.

- Use the same accession number for all subsequent cancer diagnoses.
- The first four numbers specify the year (of first contact with cancer) and the last five numbers are the numeric order in which the patient was entered into the registry database.

Examples

Code	Reason
201900033	Patient enters the hospital in 2019 and is diagnosed with breast cancer. The patient is the 33rd patient accessioned in 2019.
201900033	A patient with the accession number 201000033 for a breast primary returns to the hospital with a subsequent colon primary in 2020. The accession number will remain the same. *Sequence Number* will reflect this second primary.
201900010	Patient is diagnosed in November 2018, at another facility enters the reporting facility in January 2019, and is the tenth case accessioned in 2019.
202000012	Patient is diagnosed in staff physician office in December 2019 enters the reporting facility in January 2020, and is the 12th case accessioned in 2020.
202000001	First patient diagnosed/treated and entered into the registry database for 2020.
201900999	999th patient diagnosed/treated and entered into the registry database for 2019.
200401504	1504th patient diagnosed/treated and entered into the registry database for 2004.

Sequence #: Record the sequence number for this tumor. *Sequence Number* indicates the sequence of reportable malignant and non-malignant neoplasms over the lifetime of the patient. A registry may contain a single abstract for a patient with a sequence number of 02, because the first tumor had been either diagnosed and treated elsewhere or diagnosed and/or treated before the facility's reference date. Use the *Other Primary Tumors* box on the Cancer Abstracting Form to document previous tumors.

- Code 00 only if the patient has a single malignant primary. If the patient develops a subsequent malignant or in situ primary tumor, change the code for the first tumor from 00 to 01, and number the subsequent tumors sequentially.
- If two or more malignant or in situ neoplasms are diagnosed at the same time, assign the lowest sequence number to the diagnosis with the worst prognosis. If no difference in prognosis is evident, the decision is arbitrary.
- If two or more non-malignant neoplasms are diagnosed at the same time, assign the lowest sequence number to the diagnosis with the worst prognosis. If no difference in prognosis is evident, the decision is arbitrary.
- Any tumor in the patient's past which is reportable or reportable-by-agreement at the time the current tumor is diagnosed must be taken into account when sequencing subsequently accessioned tumors.

Examples

Code	Definition
00	One malignant or in-situ primary only in the patient's lifetime
01	First of two or more independent malignant or in-situ primaries
02	Second of two or more independent malignant or in-situ primaries
…	
59	Fifty-ninth of 59 or more independent malignant or in-situ primaries

Date of First Contact: Record the date of first contact for this tumor. *Date of First Contact* is the date of the facility's first inpatient or outpatient contact with the patient for diagnosis or treatment of the cancer. Usually, the *Date of First Contact* is the date of admission for diagnosis or for treatment. This data item can be used to measure the time between first contact and the date that the case was abstracted. It can also be used to measure the length of time between the first contact and treatment for quality of care reports.

- Record the date the patient first had contact with the facility as either an inpatient or outpatient for diagnosis and/or treatment of a reportable tumor. The date may be the date of an outpatient visit for a biopsy, X-ray, or laboratory test, or the date a pathology specimen was collected at the hospital.
- If this is an autopsy-only, then record the date of death.
- When a patient is diagnosed in a staff physician's office, the date of first contact is the date the patient was physically first seen at the reporting facility.

Examples

Code	Reason
02122019	A patient has an outpatient mammography that is suspicious for malignancy on February 12, 2019, and subsequently undergoes an excisional biopsy or radical surgical procedure on February 14, 2019
09142020	Patient undergoes a biopsy in a physician's office on September 8, 2020. The pathology specimen was sent to the reporting facility and was read as malignant melanoma. The patient enters that same reporting facility on September 14, 2020 for wide re-excision.
12072019	Patient has an MRI of the brain on December 7, 2019 for symptoms including severe headache and disorientation. The MRI findings are suspicious for astrocytoma. Surgery on December 19 removes all gross tumor.
04992020	If information is limited to the description "Spring, 2020".
07992020	If information is limited to the description "The middle of the year, 2020".
10992019	If information is limited to the description "Fall, 2019".
12992019 or 01992020	If information is limited to the description "Winter", try to determine if this means the beginning or the end of the year.

Medical Record Number: Record the medical record number assigned by the reporting facility's health information management (HIM) department. This number identifies the patient within a reporting facility. It can be used to reference a patient record and it helps to identify multiple reports on the same patient.

Primary Payer: Record the patient's primary payer upon the patient's first visit for this tumor. *Primary Payer* identifies the patient's primary payer/insurance carrier at the time of initial diagnosis and/or treatment. This item is used in financial analysis and as an indicator for quality and outcome analyses. Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires the patient admission page to document the type of insurance or payment structure that will cover the patient while being cared for at the hospital.

- If the patient is diagnosed at the reporting facility, record the payer at the time of diagnosis.
- If the patient was admitted at the time of diagnosis with no insurance or self-pay, record no insurance or self-pay even if the patient subsequently gains insurance after diagnosis.
- If the patient is diagnosed elsewhere or the payer at the time of diagnosis is not known, record the payer when the patient is initially admitted for treatment.
- If the patient's payer or insurance carrier changes, do not change the initially recorded code.

Patient Information

Full name, Maiden, and Alias of Patient: Record all known information for the patient's first, last, middle, maiden, and alias names.

Name of Spouse/Parent: If married, record the patient's spouse. If a child, record the parent's name.

Physical Address; No & Street, City, County, State, Zip Code: Record the permanent *physical* address of residence at the time of diagnosis; not a temporary relocation home for treatment. Street address takes priority over post office box number. The address is part of the patient's demographic data and has multiple uses. It indicates referral patterns and allows for the analysis of cancer clusters or environmental studies.

Patient Address and Residency Rules

The patient's address at diagnosis is the patient's place of residence at the time of original diagnosis. It does not change if the patient moves. If the patient has more than one primary tumor, the address at diagnosis may be different for each primary.

Normally a residence is the home named by the patient. Legal status and citizenship are not factors in residency decisions. Rules of residency are identical to or comparable with the rules of the Census Bureau whenever possible. The registry can resolve residency questions by using the Census Bureau's definition, "the place where he or she lives and sleeps most of the time or the place the person considers to be his or her usual home". Vital statistic rules may differ from Census rules. Do not record residence from the death certificate. Review each case carefully.

Rules for Persons with Ambiguous Residences

Persons with More Than One Residence (summer and winter homes): Use the address the patient specifies if a usual residence is not apparent.

Persons with No Usual Residence (transients, homeless): Use the address of the place the patient was staying when the cancer was diagnosed. This could be a shelter or the diagnosing facility.

Persons Away at School: College students are residents of the school area. Boarding school students below the college level are residents of their parents' homes.

Persons in Institutions: The Census Bureau states, "Persons under formally authorized, supervised care or custody", are residents of the institution. This includes the following:

- Incarcerated persons
- Persons in nursing, convalescent, and rest homes
- Persons in homes, schools, hospitals, or wards for the physically disabled, mentally retarded, or mentally ill.
- Long-term residents of other hospitals, such as Veterans Affairs (VA) hospitals.

Persons in the Armed Forces and on Maritime Ships: Members of the armed forces are residents of the installation area. Use the stated address for military personnel and their families. Military personnel may use the installation address or the surrounding community's address. The Census Bureau has detailed residency rules for Navy personnel, Coast Guard, and maritime ships. Refer to Census Bureau publications for the detailed rules.

Place of Birth: Record the patient's place of birth, if known. This data item is used to evaluate medical care delivery to special populations and to identify populations at special risk for certain cancers.

Social Security Number: Record the patient's social security number. Do not record a spouse's number. If you only know the last 4 digits of the SSN, please record that.

Date of Birth: Record the patient's birthdate in MM/DD/YYYY format.

Age: Record the patient's age at diagnosis.

Referred From: Record where or who the patient was referred from.

Referred To: Record where the patient is referred to. If the patient was referred out of state for treatment, note what state.

Race: Check the box to identify the patient's race: White, American Indian, Black, Asian, Unknown, or Other. If the patient is anything other than what the check boxes offer, please make notation in the Diagnostic Summary box. Check all boxes that apply. Racial origin captures information used in research and cancer control activities comparing stage at diagnosis and/or treatment by race.

Hispanic Ethnicity: Check the box to identify the patient's ethnicity: Yes, No, or Unknown. This field is used to identify whether or not the person should be classified as "Hispanic" for purposes of calculating cancer rates. Hispanic populations have different patterns of occurrence of cancer from other populations that may be included in the White category.

- Persons of Spanish or Hispanic origin may be of any race, but these categories are generally not used for Native Americans, Filipinos, or others who may have Spanish names.
- Record Non-Spanish or non-Hispanic for Portuguese and Brazilian persons.

Sex: Check male or female. If the patient is transgender, record gender at birth or document details in the Diagnostic Summary box.

Marital Status: Check Single, Married, Divorced, Widowed, Separated, or Unknown at time of diagnosis.

Telephone Number: Record the patient's phone number including area code.

Tobacco History: Check Never, Cigarette, Pipe, Chew, e-Cig, Vape, Liquid, Previous Use, or Unknown for patient's tobacco history.

Alcohol History: Check Yes, No, Previous, or Unknown for patient's alcohol history. Any amount of alcohol use should be checked yes. This item indicates the patient's past or current consumption of alcoholic beverages.

Usual Occupation: Record the patient's usual occupation or work performed during most of the patient's life prior to the diagnosis of cancer. *Usual Occupation* describes information about the patient's usual occupation, also known as usual type of job or work. This data item applies only to patients who are age 14 years or older at the time of diagnosis.

- Do not record "retired".
- If usual occupation is not available or is unknown, record the patient's current or most recent occupation, or any known occupation.
- If the patient was a housewife/househusband and also worked outside the home most of his/her adult life, record the usual occupation outside of the home. If the patient was a housewife/househusband and did not work outside the home for most of his/her adult life, record "housewife" or "househusband".
- If the patient was not a student or housewife and never worked, record "never worked" as the usual occupation.
- If no information is available, record "unknown".
- Spell out acronyms of occupations; do not just record the acronym. For example, spell out Registered Nurse rather than RN.

Usual Industry: Record the primary type of activity carried on by the business or industry where the patient was employed for most of his/her life prior to the diagnosis of cancer. *Usual Industry* describes information about the patient's usual industry; also known as usual kind of business/industry. This data item applies only to patients who are age 14 years or older at the time of diagnosis.

- Be sure to distinguish among "manufacturing", "wholesale", "retail", and "service" components of an industry which performs more than one of these components.
- If the primary activity carried on at the location where the patient worked is unknown, it may be sufficient to record the name of the company (with city or town) for which the patient performed his/her usual occupation. In these situations, if resources permit, a central registry may be able to use the employer name and city/town to determine the type of activity conducted at that location
- If current or most recent occupation, rather than usual occupation was recorded, record the patient's current or most recent business/industry.
- Update this field if better information is obtained as to the usual industry of the patient. However, it is not the responsibility of the registrar to update abstracts with industry information provided on death certificates.
- There should be an entry for "usual industry" if any occupation is recorded. If no information is available regarding industry in which the reported occupation was carried out, record "unknown".
- Spell out acronyms of industry/company; do not just record the acronym. For example, spell out Department of Public Health and Human Services rather than DPHHS.
- Describe the company if the name of the company is not in itself descriptive. For example, describe "Sam's" as "Sam's Exxon Gas Station".

Follow-Up Contact: Identifies a contact person available for contact if the patient is unavailable. First and last name, in natural order, of a person, other than the patient or a physician, who can be contacted to obtain follow-up information for the patient.

Cancer Information

Date of Diagnosis: Record in MM/DD/YYYY format. The date of diagnosis refers to the first diagnosis of this tumor by any recognized medical practitioner. Usually, the date of biopsy is the date of diagnosis. If unknown, record "unknown". The timing for staging and treatment of cancer begins with the date of initial diagnosis for cancer.

- Use the first date of diagnosis whether clinically or histologically confirmed.
- If the physician states that in retrospect the patient had cancer at an earlier date, use the earlier date as the date of diagnosis.
- Use the date treatment was started as the date of diagnosis if the patient receives a first course of treatment before a definitive diagnosis.
- Refer to the list of "Ambiguous Terms" on page 6 for language that represents a diagnosis of cancer.
- The date of death is the date of diagnosis for cases diagnosed at autopsy or death certificate only.
- Use the actual date of diagnosis for an *in utero* diagnosis, for cases diagnosed on January 1, 2009 or later. For cases diagnosed before January 1, 2009, assign the date of birth.
- If the year of diagnosis cannot be identified, it must be approximated. In that instance, the month and date are unknown.

Examples

Code	Reason
06/30/2019	June 30, 2019
03/12/2019	A March 12, 2019 mammogram reveals a mass in the upper-outer quadrant of a patient's right breast consistent with a carcinoma. On March 20, 2019, the patient has an excisional breast biopsy that confirms infiltrating ductal carcinoma.
05/12/2019	A physician notes a prostate nodule that is suspicious for cancer during a May 12, 2019 physical examination. On June 15, 2019, an ultrasound guided needle biopsy of the prostate provides Histologic confirmation of adenocarcinoma.
01/99/2020	A patient has a total abdominal hysterectomy for endometriosis in January 2020. The patient is admitted to the hospital with abdominal pain and distention in November 2020. A laparoscopy with omental biopsy shows metastatic cystadenocarcinoma. Pathologists review the January 2020 hysterectomy specimen. They identify an area of cystadenocarcinoma in the left ovary.
09/99/2020	If the exact date of the beginning of treatment is not available, then record an approximate date. For example, September 2020.
04/99/2020	If information is limited to the description "Spring, 2020".
07/99/2020	If information is limited to the description "The middle of the year, 2020".
10/99/2020	If information is limited to the description "Fall, 2020".
12/99/2019 or 01/99/2020	If information is limited to the description "Winter", try to determine if this means the beginning or the end of the year. Code January or December as indicated.

Primary Site: Record the site of origin of the tumor. It is important to identify the primary site and not a metastatic site. Record the sub-site, if known. Example: upper right shoulder. Primary Site is a basis for staging and determination of treatment options.

Laterality: Check Right, Left, Midline, or Unknown of primary site. Laterality identifies the side of a paired organ or the side of the body on which the reportable tumor originated. This applies to the primary site only. Laterality supplements staging and extent of disease information and defines the number of primaries involved.

Laterality must be recorded for the following paired organs.

Site
Parotid gland
Submandibular gland
Sublingual gland
Tonsillar fossa
Tonsillar pillar
Overlapping lesion of tonsil
Tonsil, NOS
Nasal cavity (excluding nasal cartilage and nasal septum)
Middle ear
Maxillary sinus
Frontal sinus
Main bronchus(excluding carina)
Lung
Pleura
Long bones of upper limb and scapula
Short bones of upper limb
Long bones of lower limb
Short bones of lower limb
Rib and clavicle (excluding sternum)
Pelvic bones (excluding sacrum, coccyx, and symphysis pubis)
Skin of eyelid
Skin of external ear
Skin of other and unspecified parts of face
Skin of trunk
Skin of upper limb and shoulder
Skin of lower limb and hip
Peripheral nerves and autonomic nervous system of upper limb and shoulder
Peripheral nerves and autonomic nervous system of lower limb and hip
Connective, subcutaneous, and other soft tissues of upper limb and shoulder
Connective, subcutaneous, and other soft tissues of lower limb and hip
Breast
Ovary
Fallopian tube
Testis
Epididymis
Spermatic cord
Kidney, NOS
Renal pelvis
Ureter
Eye and lacrimal gland
Cerebral meninges, NOS
Cerebrum and Frontal lobe
Temporal, Parietal, and Occipital lobes
Olfactory, Optic, Acoustic, and Cranial nerves, NOS
Adrenal gland
Carotid body

Other Primary Tumors: If the patient has a history of cancer, record the type and date when they were diagnosed. For example, type Prostate ca, Dec 2005. Exclude non-reportable types of cancers such as BCC Skin and SCC Skin since they are not reportable or counted. Identification of other tumors may affect the sequence.

Place of Diagnosis: Check This Hospital, Other Hospital, Physician's Office, or Other (and describe). This area to describe where diagnosis took place is helpful for the MCTR when cases are reported from multiple sources.

Diagnostic Confirmation: Records the best method of diagnostic confirmation of the cancer being reported at any time in the patient's history. This item is an indicator of the precision of diagnosis.

- This is a hierarchical schema to identify how the malignancy was determined – from histologic confirmation being most precise to unknown being the least. Histologic confirmation is the highest determination and takes precedence.
- Record Histology for positive hematologic findings and bone marrow specimens for leukemia, including peripheral blood smears and aspiration biopsies.
- Record Cytology for positive brushings, washings, cell aspiration, and hematologic findings (except for leukemia).

Check	Definition
Positive histology	Histologic confirmation (tissue microscopically examined).
Positive cytology	Cytologic confirmation (no tissue microscopically examined; fluid cells microscopically examined).
Positive microscopic confirmation, method not specified	Microscopic confirmation is all that is known. It is unknown if the cells were from histology or cytology.
Positive laboratory test/marker study	A clinical diagnosis of cancer is based on laboratory tests/marker studies which are clinically diagnostic for cancer. This includes alpha-fetoprotein for liver cancer and abnormal electrophoretic spike for multiple myeloma. Elevated PSA is not diagnostic of cancer.
Direct visualization without microscopic confirmation	The tumor was visualized during a surgical or endoscopic procedure only with no tissue resected for microscopic examination.
Radiography and other imaging techniques without microscopic confirmation	The malignancy was reported by the physician from an imaging technique report only.
Clinical diagnosis only (other than 5, 6, or 7)	The malignancy was reported by the physician in the medical record.
Unknown whether or not microscopically confirmed	A statement of malignancy was reported in the medical record, but there is no statement of how the cancer was diagnosed (usually non-analytic).

Diagnostic Summary: Diagnostic Summary documents information from the patient's physical evaluation, pathology reports, scopes, x-rays/scans, and lab tests. Information documented in the Diagnostic Summary substantiates the patient's cancer diagnosis. Review and record results from all reports related to the diagnosis even if results are negative.

Suggestions for Content

Physical Evaluation

- date(s) of physical exam
- physician involved
- results of exam(s)
- signs and symptoms causing patient evaluation
- patient age, sex, race/ethnicity, place of birth
- smoking history, alcohol history
- patient history related to this cancer diagnosis, family history of cancer
- primary site and histology of this cancer
- description of tumor, tumor location, tumor size, and palpable lymph nodes
- record positive and negative clinical findings that are relevant
- physician impression
- treatment plan
- comorbidities
- anything unusual about the case that may seem relevant to the patient's diagnosis or treatment

Pathology from biopsy or surgery:

- date(s) specimen collected
- facility where procedure was done including excisional biopsies and surgery to other or distant sites
- procedure(s) done
- slide or path #

- specimen type (body location)
- final microscopic results
- histology (include all modifying adjectives (i.e., predominantly, with features of, with foci of , elements of, etc))
- grade
- behavior
- tumor size
- extension or extent of spread
- regional tissues removed
- metastatic sites
- lymph node(s) involved/examined Record additional comments from the pathologist, including differential diagnosis considered and any ruled out or favored
- evidence of invasion of surrounding areas
- residual tumor
- surgical margins
- record positive and negative findings
- any other treatment information that is relevant (such as if surgery was aborted)

Scopes

- date(s) of scope
- facility where scope was done
- type of scope
- results of scope
- site of tumor
- histology if given
- tumor location
- tumor size
- biopsy if done
- lymph nodes
- record positive and negative clinical findings

Xray/Scans

- date(s) of xray/scan
- facility where procedure was done
- body location
- results of tests
- sites involved or not involved
- tumor location
- tumor size
- lymph nodes
- record positive and negative findings
- distant disease or metastasis

Lab Tests

- date(s) of lab test
- facility where lab test was done
- type of test (or tissue specimen)
- tumor markers such as ER/PR/HER2 for breast, PSA for prostate, hCG for testes, among others
- serum and urine electrophoresis
- include positive and negative results

Size of Tumor: Describe the largest dimension of the diameter of the primary tumor in millimeters (this is not the size of the excision). Record size from the pathology report first, if available; otherwise, use the size from imaging or physical exam. Tumor size is the diameter of the tumor, not the depth of thickness of the tumor. Tumor size at diagnosis is an independent prognostic indicator for many tumors.

Extension/Spread: Extension identifies contiguous growth (extension) of the primary tumor within the organ of origin or its direct extension into neighboring organs. Tumor extension at diagnosis is a prognostic indicator used to stage the cancer.

- Record the farthest documented extension of the primary tumor.
- Refer to the Ambiguous Terminology for terms that constitute tumor involvement or extension.
- If the information in the medical record is ambiguous or incomplete regarding the extent to which the tumor has spread, the extent of disease may be inferred from the T category stated by the physician.

Regional Lymph Nodes Positive: Record the number of regional lymph nodes examined by the pathologist and found to contain metastasis. This data item is necessary for pathologic staging.

- Only record information about regional lymph nodes in this data item. Involved distant lymph nodes should be coded in *Sites of Distant Metastases*.
- This item is based on pathology information only. If no lymph nodes were removed for examination, or if a lymph node drainage area was removed, but no lymph nodes were found, record none.
- Record the total number of regional lymph nodes removed and found to be positive by pathologic examination.
  - The number of regional lymph nodes positive is cumulative from all procedures that removed lymph nodes through the completion of surgeries in the first course of treatment.
  - This item is to be recorded regardless of whether the patient received preoperative treatment.

Regional Lymph Nodes Examined: Record the number of lymph nodes examined by the pathologist. This data item is a quality measure of the pathologic and surgical evaluation and treatment of the patient.

- Only record information about regional lymph nodes in this data item. Involved distant lymph nodes should be coded in *Sites of Distant Metastases*.
- This item is based on pathology information only. If no lymph nodes were removed for examination, or if a lymph node drainage area was removed, but no lymph nodes were found, record none.
- Record the total number of regional lymph nodes removed and examined by the pathologist.
  - The number of regional lymph nodes examined is cumulative from all procedures that removed lymph nodes through the completion of surgeries in the first course of treatment.
  - This item is to be recorded regardless of whether the patient received preoperative treatment.
- If a lymph node biopsy was performed, code the number of nodes removed, if known. If the number of nodes removed by biopsy is not known, record unknown.

Sites of Distant Metastases: This data item is used to document sites of distant metastasis and verify or confirm stage at diagnosis. The presence of metastatic disease at diagnosis is an independent prognostic indicator and is used to stage the cancer.

Describe Stage: Documentation about staging decisions is heavily utilized for quality control and special studies. Text is needed to justify coded values and document supplemental information not generally included in coded values.

Summary Stage at Diagnosis: Stage describes the extent of disease. See Summary Stage Manual https://seer.cancer.gov/tools/ssm/2018-Summary-Stage-Manual.pdf.

In-situ: Tumor has not progressed through the basement membrane of the organ involved.
Local: Tumor is limited to the site of origin; progressed through the basement membrane but not beyond the walls of the organ involved.
Regional DE: Direct extension to adjacent organs or tissues only.
Regional LN: Involvement of regional lymph nodes only. Check both Regional DE and Regional LN if both are applicable.
Distant: Tumor has direct extension beyond adjacent organs or tissues, or metastases to distant sites or distant nodes. If the stage is distant at diagnosis, use the “describe” section to record distant sites.
Unknown: No information is available to determine extent of disease.

AJCC Staging: Record Clinical or Pathological T, N, M, and Stage Group, when available as documented by the patient’s provider. AJCC TNM Stage is based on the clinical, operative, and pathologic assessment of the anatomic extent of disease and is used to make appropriate treatment decisions, determine prognosis, and measure end results.

Treatment Information

The first course of treatment includes all methods of treatment recorded in the treatment plan and administered to the patient before disease progression or recurrence. “No therapy” is a treatment option that occurs if the patient refuses treatment, the family or guardian refuses treatment, the patient dies before treatment starts, or the physician recommends no treatment.

Cumulative Treatment Summary: Cumulative Treatment Summary records information describing all treatment procedures performed as part of treatment.

- Approved abbreviations should be used (listed in Appendix B)
- If no treatment is given, record the date of the decision not to treat, the date of patient refusal, or the date the patient expired.

A treatment plan describes the type(s) of therapies intended to modify, control, remove, or destroy proliferating cancer cells. The documentation confirming a treatment plan may be found in several different sources; for example, medical or clinical records, consultation reports, and outpatient records. If there is no treatment plan, established protocol, or management guidelines, and consultation with a physician advisor is not possible, use the principle: “initial treatment must begin within four months of the date of initial diagnosis”.

Suggestions for Content

Biopsy

- date specimen collected
- facility where biopsy was taken
- pathology number
- body part where biopsy was taken

Surgery

- date of surgery
- facility where surgery was done
- name of procedure
- lymph node removal
- surgery of regional or distant sites

Radiation

- Dates when radiation was started and ended
- facility where radiation was done
- body site radiated
- type of radiation (if known)
- modality
- cGy
- number of treatments
- treatment volume
- any other relevant information

Systemic (chemotherapy, hormone therapy, BRM (biological response modifiers)

- date when systemic treatment started and ended
- facility where chemotherapy was given
- names of agents given
- any other relevant information about systemic treatments

Other Treatment

- dates other type of treatment was given
- facility where treatment was given
- type of treatment given such as blinded clinical trial, hyperthemia, other non-traditional treatments, experimental treatments, etc)

Outcomes

Date of Last Contact or Death: Record the date last seen or date of death in MM/DD/YYYY format. This information is used for patient follow-up and outcome studies.

Vital Status: Record the patient's vital status at date last seen. This information is used for patient follow-up and outcome studies.

Cancer Status: This refers to the patient's cancer status of this cancer at the date the patient was last known to be alive or dead.

- Cancer status is based on information from the patient's physician or other official source such as a death certificate.
- The patient's cancer status should be changed **only** if new information is received from the patient's physician or other official source. If information is obtained from the patient, a family member, or other non-physician, then cancer status is not updated.
- Cancer status changes if the patient has a recurrence or relapse.
- If a patient has multiple primaries, each primary could have a different cancer status.

Autopsy: Indicate if patient had an autopsy.

Place of Death: Record where the patient died: name of facility, city, state, etc.

Recurrence Date: Record the date of the patient's first recurrence as documented by the patient's physician after a disease-free period. This data item is used to measure the efficacy of the first course of treatment.

Recurrence Type: This field identifies the type of first recurrence after a period of documented disease-free intermission or remission. This item is used to evaluate treatment efficacy and as a long-term prognostic factor. The first recurrence may occur well after completion of the first course of treatment or after subsequent treatment. Once a recurrence has been recorded, subsequent recurrences are not collected.

Describe: Describe the information known about the recurrence such as site(s) of recurrence.

Comorbidities and Complications: Comorbidities are preexisting medical conditions or conditions that were present at the time the patient was diagnosed with this cancer (e.g., chronic conditions such as COPD, diabetes, and hypertension). Complications are conditions that occur during the hospital stay, while the patient is being treated for the cancer (e.g., postoperative urinary tract infection or pneumonia). Comorbidities and Complications identify the patient's preexisting medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer using ICD-10-CM codes. Preexisting medical conditions, factors influencing health status, and/or complications may affect treatment decisions and influence patient outcomes. Information on comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes. Complications may be related to the quality of care.

- Code the secondary diagnoses in the sequence in which they appear on the discharge abstract or are recorded by the billing department at your facility.
- **Do not** record any neoplasms (ICD-9-CM codes 140-239.9) listed as secondary diagnoses for this data item.
- **Do not** record causes of injury and poisoning unrelated to the patient's medical care.

Physicians: List physicians who will be treating or re-examining the patient for cancer including the surgeon, a following physician, managing physicians, or any other physician participating in the patient's care.

Appendix A
Montana Zip Codes

City	County	Zip	City	County	Zip
Absarokee	Stillwater	59001	Acton	Yellowstone	59002
Alberton	Mineral	59820	Alder	Madison	59710
Alzada	Carter	59311	Anaconda	Deer Lodge	59711
Angela	Rosebud	59312	Antelope	Sheridan	59211
Arlee	Lake	59821	Ashland	Rosebud	59003
Augusta	Lewis & Clark	59410	Avon	Powell	59713
Babb	Glacier	59411	Bainville	Roosevelt	59212
Baker	Fallon	59313	Ballantine	Yellowstone	59006
Basin	Jefferson	59631	Bearcreek	Carbon	59007
Belfry	Carbon	59008	Belgrade	Gallatin	59714
Belt	Cascade	59412	Biddle	Powder River	59314
Big Arm	Lake	59910	Bigfork	Flathead	59911
Bighorn	Treasure	59010	Big Sandy	Chouteau	59520
Big Sky	Gallatin	59716	Big Timber	Sweet Grass	59011
Billings	Yellowstone	59101	Billings	Yellowstone	59102
Billings	Yellowstone	59103	Billings	Yellowstone	59104
Billings	Yellowstone	59105	Billings	Yellowstone	59106
Billings	Yellowstone	59107	Billings	Yellowstone	59108
Birney	Rosebud	59012	Black Eagle	Cascade	59414
Bloomfield	Dawson	59315	Bonner	Missoula	59823
Boulder	Jefferson	59632	Box Elder	Hill	59521
Boyd	Carbon	59013	Boyes	Carter	59316
Bozeman	Gallatin	59715	MSU Bozeman	Gallatin	59717
Bozeman	Gallatin	59718	Bozeman	Gallatin	59719
Bozeman	Gallatin	59771	Bozeman	Gallatin	59772
Bozeman	Gallatin	59773	Brady	Pondera	59416
Bridger	Carbon	59014	Broadus	Powder River	59317
Broadview	Yellowstone	59015	Brockton	Roosevelt	59213
Brockway	McCone	59214	Browning	Glacier	59417
Brusett	Garfield	59318	Buffalo	Fergus	59418
Busby	Big Horn	59016	Butte	Silver Bow	59701
Butte	Silver Bow	59702	Butte	Silver Bow	59703
Butte	Silver Bow	59750	Bynum	Teton	59419
Cameron	Madison	59720	Canyon Creek	Lewis & Clark	59633
Capitol	Carter	59319	Cardwell	Jefferson	59721
Carter	Chouteau	59420	Cascade	Cascade	59421
Cat Creek	Petroleum	59087	Charlo	Lake	59824
Chester	Liberty	59522	Chinook	Blaine	59523
Choteau	Teton	59422	Circle	McCone	59215
Clancy	Jefferson	59634	Clinton	Missoula	59825
Clyde Park	Park	59018	Coffee Creek	Fergus	59424
Cohagen	Garfield	59322	Colstrip	Rosebud	59323
Columbia Falls	Flathead	59912	Columbus	Stillwater	59019
Condon	Missoula	59826	Conner	Ravalli	59827
Conrad	Pondera	59425	Cooke City	Park	59020
Coram	Flathead	59913	Corvallis	Ravalli	59828
Corwin Springs	Park	59030	Craig	Lewis & Clark	59648
Crane	Richland	59217	Creston	Flathead	59902
Crow Agency	Big Horn	59022	Culbertson	Roosevelt	59218

City	County	Zip	City	County	Zip
Custer	Yellowstone	59024	Cut Bank	Glacier	59427
Dagmar	Sheridan	59219	Darby	Ravalli	59829
Dayton	Lake	59914	De Borgia	Mineral	59830
Decker	Big Horn	59025	Deer Lodge	Powell	59722
Dell	Beaverhead	59724	Denton	Fergus	59430
Dillon	Beaverhead	59725	Divide	Silver Bow	59727
Dixon	Sanders	59831	Dodson	Phillips	59524
Drummond	Granite	59832	Dupuyer	Pondera	59432
Dutton	Teton	59433	East Glacier	Glacier	59434
East Helena	Lewis & Clark	59635	Edgar	Carbon	59026
Ekalaka	Carter	59324	Elliston	Powell	59728
Elmo	Lake	59915	Emigrant	Park	59027
Ennis	Madison	59729	Essex	Flathead	59916
Ethridge	Toole	59435	Eureka	Lincoln	59917
Evergreen	Flathead	59901	Fairfield	Teton	59436
Fairview	Richland	59221	Fallon	Prairie	59326
Fishtail	Stillwater	59028	Flaxville	Daniels	59222
Florence	Ravalli	59833	Floweree	Chouteau	59440
Forestgrove	Fergus	59441	Forsyth	Rosebud	59327
Fort Benton	Chouteau	59442	Fort Harrison	Lewis & Clark	59636
Fort Peck	Valley	59223	Fort Shaw	Cascade	59443
Fort Smith	Big Horn	59035	Fortine	Lincoln	59918
Four Buttes	Daniels	59263	Frazer	Valley	59225
Frenchtown	Missoula	59834	Froid	Roosevelt	59226
Fromberg	Carbon	59029	Galata	Toole	59444
Gallatin Gateway	Gallatin	59730	Gardiner	Park	59030
Garneill	Fergus	59445	Garrison	Powell	59731
Garryowen	Big Horn	59031	Geraldine	Chouteau	59446
Geyser	Judith Basin	59447	Gildford	Hill	59525
Glasgow	Valley	59230	Glen	Beaverhead	59732
Glendive	Dawson	59330	Glentana	Valley	59240
Gold Creek	Powell	59733	Grantsdale	Ravalli	59835
Grass Range	Fergus	59032	Great Falls	Cascade	59401
Great Falls	Cascade	59402	Great Falls	Cascade	59403
Great Falls	Cascade	59404	Great Falls	Cascade	59405
Great Falls	Cascade	59406	Greenough	Missoula	59836
Greycliff	Sweet Grass	59033	Hall	Granite	59837
Hamilton	Ravalli	59840	Hammond	Carter	59332
Hardin	Big Horn	59034	Harlem	Blaine	59526
Harlowton	Wheatland	59036	Harrison	Madison	59735
Hathaway	Rosebud	59333	Haugan	Mineral	59842
Havre	Hill	59501	Hays	Blaine	59527
Heart Butte	Pondera	59448	Helena	Lewis & Clark	59601
Helena	Lewis & Clark	59602	Helena	Lewis & Clark	59604
Helena	Lewis & Clark	59620	Helena	Lewis & Clark	59624
Helena	Lewis & Clark	59626	Helmville	Powell	59843
Heron	Sanders	59844	Highwood	Chouteau	59450
Hilger	Fergus	59451	Hingham	Hill	59528
Hinsdale	Valley	59241	Hobson	Judith Basin	59452
Hogeland	Blaine	59529	Homestead	Roosevelt	59242
Hot Springs	Sanders	59845	Hungry Horse	Flathead	59919
Huntley	Yellowstone	59037	Huson	Missoula	59846
Hysham	Treasure	59038	Ingomar	Rosebud	59039
Inverness	Hill	59530	Ismay	Custer	59336

City	County	Zip	City	County	Zip
Jackson	Beaverhead	59736	Jefferson City	Jefferson	59638
Joliet	Carbon	59041	Joplin	Liberty	59531
Jordan	Garfield	59337	Judith Gap	Wheatland	59453
Kalispell	Flathead	59901	Kalispell	Flathead	59902
Kalispell	Flathead	59903	Kalispell	Flathead	59904
Kevin	Toole	59454	Kila	Flathead	59920
Kinsey	Custer	59338	Kremlin	Hill	59532
Lake McDonald	Flathead	59921	Lakeside	Flathead	59922
Lambert	Richland	59243	Lame Deer	Rosebud	59043
Larslan	Valley	59244	Laurel	Yellowstone	59044
Lavina	Golden Valley	59046	Ledger	Pondera	59456
Lewistown	Fergus	59457	Libby	Lincoln	59923
Lima	Beaverhead	59739	Lincoln	Lewis & Clark	59639
Lindsay	Dawson	59339	Livingston	Park	59047
Lloyd	Blaine	59535	Lodge Grass	Big Horn	59050
Lolo	Missoula	59847	Loma	Chouteau	59460
Lonepine	Sanders	59848	Loring	Phillips	59537
Lothair	Liberty	59461	Lothair	Toole	59474
Lustre	Valley	59225	Luther	Carbon	59068
Malmstrom AFB	Cascade	59402	Malta	Phillips	59538
Manhattan	Gallatin	59741	Marion	Flathead	59925
Martin City	Flathead	59926	Martinsdale	Meagher	59053
Marysville	Lewis & Clark	59640	McAllister	Madison	59740
McCabe	Roosevelt	59245	McLeod	Sweet Grass	59052
Medicine Lake	Sheridan	59247	Melrose	Silver Bow	59743
Melstone	Musselshell	59054	Melville	Sweet Grass	59055
Mildred	Prairie	59341	Miles City	Custer	59301
Mill Iron	Carter	59324	Milltown	Missoula	59851
Missoula	Missoula	59801	Missoula	Missoula	59802
Missoula	Missoula	59803	Missoula	Missoula	59804
Missoula	Missoula	59806	Missoula	Missoula	59807
Missoula	Missoula	59808	Moccasin	Judith Basin	59462
Moiese	Lake	59824	Molt	Stillwater	59057
Monarch	Cascade	59463	Montana City	Jefferson	59634
Moore	Fergus	59464	Mosby	Garfield	59058
Musselshell	Musselshell	59059	Nashua	Valley	59248
Neihart	Cascade	59465	Niarada	Sanders	59845
Norris	Madison	59745	Noxon	Sanders	59853
Nye	Stillwater	59061	Oilmont	Toole	59466
Olive	Powder River	59343	Olney	Flathead	59927
Opheim	Valley	59250	Otter	Powder River	59062
Outlook	Sheridan	59252	Ovando	Powell	59854
Pablo	Lake	59855	Paradise	Sanders	59856
Park City	Stillwater	59063	Peerless	Daniels	59253
Pendroy	Teton	59467	Phillipsburg	Granite	59858
Pinesdale	Ravalli	59841	Plains	Sanders	59859
Plentywood	Sheridan	59254	Plevna	Fallon	59344
Polaris	Beaverhead	59746	Polebridge	Flathead	59928
Polson	Lake	59860	Pompeys Pillar	Yellowstone	59064
Pony	Madison	59747	Poplar	Roosevelt	59255
Powderville	Powder River	59345	Power	Teton	59468
Pray	Park	59065	Proctor	Lake	59914
Proctor	Lake	59929	Pryor	Big Horn	59066
Radersburg	Broadwater	59641	Ramsay	Silver Bow	59748

City	County	Zip	City	County	Zip
Rapelje	Stillwater	59067	Ravalli	Lake	59863
Raymond	Sheridan	59256	Raynesford	Judith Basin	59469
Red Lodge	Carbon	59068	Redstone	Sheridan	59257
Reedpoint	Stillwater	59069	Reserve	Sheridan	59258
Rexford	Lincoln	59930	Richey	Dawson	59259
Richland	Valley	59260	Ringling	Meagher	59642
Roberts	Carbon	59070	Rollins	Lake	59931
Ronan	Lake	59864	Roscoe	Carbon	59071
Rosebud	Rosebud	59347	Roundup	Musselshell	59072
Roy	Fergus	59471	Rudyard	Hill	59540
Ryegate	Golden Valley	59074	Saco	Phillips	59261
Saint Ignatius	Lake	59865	Saint Marie	Valley	59231
Saint Mary	Glacier	59417	Saint Regis	Mineral	59866
Saint Xavier	Big Horn	59075	Saltese	Mineral	59867
Sand Coulee	Cascade	59472	Sand Springs	Garfield	59077
Sanders	Treasure	59076	Sanders	Treasure	59038
Santa Rita	Glacier	59473	Savage	Richland	59262
Scobey	Daniels	59263	Seeley Lake	Missoula	59868
Shawmut	Wheatland	59078	Shelby	Toole	59474
Shepherd	Yellowstone	59079	Sheridan	Madison	59749
Shonkin	Chouteau	59450	Sidney	Richland	59270
Silesia	Carbon	59041	Silver Gate	Park	59081
Silver Star	Madison	59751	Simms	Cascade	59477
Somers	Flathead	59932	Sonnette	Powder River	59348
Springdale	Park	59082	Stanford	Judith Basin	59479
Stevensville	Ravalli	59870	Stockett	Cascade	59480
Stryker	Lincoln	59933	Sula	Ravalli	59871
Sumatra	Rosebud	59083	Sun River	Cascade	59483
Sunburst	Toole	59482	Superior	Mineral	59872
Swan Lake	Flathead	59911	Sweetgrass	Toole	59484
Teigen	Petroleum	59084	Terry	Prairie	59349
Thompson Falls	Sanders	59873	Three Forks	Gallatin	59752
Toston	Broadwater	59643	Townsend	Broadwater	59644
Trego	Lincoln	59934	Trout Creek	Sanders	59874
Troy	Lincoln	59935	Turner	Blaine	59542
Twin Bridges	Madison	59754	Twodot	Wheatland	59085
Ulm	Cascade	59485	Valier	Pondera	59486
Vandalia	Valley	59273	Vaughn	Cascade	59487
Victor	Ravalli	59875	Vida	McCone	59274
Virginia City	Madison	59755	Volborg	Custer	59351
Walkerville	Silver Bow	59701	Warmsprings	Deer Lodge	59756
Westby	Sheridan	59275	West Glacier	Flathead	59936
West Yellowstone	Gallatin	59758	Whitefish	Flathead	59937
Whitehall	Jefferson	59759	Wht Sulphur Spr	Meagher	59645
Whitetail	Daniels	59276	Whitlash	Liberty	59545
Wibaux	Wibaux	59353	Willard	Fallon	59354
Willow Creek	Gallatin	59760	Wilsall	Park	59086
Winifred	Fergus	59489	Winnett	Petroleum	59087
Winston	Broadwater	59647	Wisdom	Beaverhead	59761
Wise River	Beaverhead	59762	Wolf Creek	Lewis & Clark	59648
Wolf Point	Roosevelt	59201	Worden	Yellowstone	59088
Wyola	Big Horn	59089	Yellowtail	Big Horn	59035
Zortman	Phillips	59546	Zurich	Blaine	59547

Appendix B
Common Abbreviations

Name	Abbreviation
Abdomen	ABD
Abdominal Perineal	AP
Abnormal	ABN
Above Knee Amputation	AK(A)
Acid Phosphatase	ACID PHOS
Acquired Immunodeficiency Syndrome	AIDS
Acute Granulocytic Leukemia	AGL
Acute Lymphocytic Leukemia	ALL
Acute Myelogenous Leukemia	AML
Adenocarcinoma	ADENOCA
Adjacent	ADJ
Admission; Admit	ADM
Against Medical Advice	AMA
AIDS Related Complex	ARC
Alcohol	ETOH
Alkaline Phosphatase	ALK PHOS
Alpha-fetoprotein	AFP
Also Known As	AKA
Ambulatory	AMB
Anal Intraepithelial Neoplasia	AIN
Anaplastic	ANAP
Angiography	ANGIO
Anterior	ANT
Anteroposterior	AP
Appendix	APP
Approximately	APPROX
Arterial Blood Gas	ABG
Arteriosclerotic Cardiovascular Disease	ASCVD
Arteriosclerotic Heart Disease	ASHD
Arteriovenous	AV
Aspiration	ASP
Associated	ASSOC
Auscultation & Percussion	A&P
Autopsy	AUT
Axilla(ry)	AX
Bacillus Calmette-Guerin	BCG
Barium	BA
Barium Enema	BE
Bartholin's, Urethral, and Skene's Glands	BUS
Below the Knee Amputation	BK(A)
Benign Prostatic Hypertrophy/Hyperplasia	BPH
Bilateral	BILAT
Bilateral Salpingo-Oophorectomy	BSO
Biological Response Modifier	BRM
Biopsy	BX, Bx
Blood Urea Nitrogen	BUN
Bone Marrow	BM
Bone Scan	BSC
Bowel Movement	BM

Name	Abbreviation
Bowel Sounds	BS
Breath Sounds	BS, BRS
Bright Red Blood Per Rectum	BRB(PR)
Cancer, Carcinoma	CA
Carcinoembryonic Antigen	CEA
Carcinoma In-situ	CIS
CAT Scan	CT, CT SC
Centimeter	CM
Central Nervous System	CNS
Cerebrospinal Fluid	CSF
Cervical Intraepithelial Neoplasia	CIN
Cervical Vertebra	C1-C7
Cervix	CX
Chemotherapy	CHEMO
Chest X-ray	CXR
Chief Complaint	CC
Cholangiopancreatography	ERCP
Chronic Granulocytic Leukemia	CGL
Chronic Lymphocytic Leukemia	CLL
Chronic Myelogenous Leukemia	CML
Chronic Obstructive Pulmonary Disease	COPD
Cigarettes	CIG
Clear	CLR
Colon:	
Ascending Colon	ASC COLON
Descending Colon	DESC COLON
Sigmoid Colon	SIGM COLON
Transverse Colon	TRANS COLON
Complaining of	C/O
Complete Blood Count	CBC
Computerized Axial Tomography	CAT
Congestive Heart Failure	CHF
Consistent with	C/W
Continue	CONT
Coronary Artery Disease	CAD
Creatine Phosphokinase	CPK
Cubic Centimeter	CC
Cystoscopy	CYSTO
Cytology	CYTO
Cytomegalovirus	CMV
Date of Birth	DOB
Dead on Arrival	DOA
Decreased	DECR (or <)
Dermatology	DERM
Diabetes Mellitus	DM
Diagnosis	DX
Diameter	DIAM
Differentiated	DIFF
Dilation & Curettage	D&C
Discharge	DISCH
Discontinued	DISC
Disease	DZ, DIS
Disorder	D/O
Doctor	DR, MD

Name	Abbreviation
Dyspnea on Exertion	DOE
Ears, Nose & Throat	ENT
Electrocardiogram	EKG, ECG
Electroencephalogram	EEG
Electromyogram	EMG
Emergency Room	ER
Endoscopic Retrograde	
Cholangiopancreatography	ERCP
Esophagogastroduodenoscopy	EGD
Estrogen Receptor (Assay)	ERA
Evaluation	EVAL
Evidence	EVID
Examination	EXAM
Examination under Anesthesia	EUA
Excision	EXC
Exploratory Laparotomy	EXP LAP
Extend	EXT
Extended Care Facility	ECF
Extension	EXT
External	EXT
Extremity	EXT
Eyes, Ears, Nose & Throat	EENT
Family (Medical) History	FHx
Fever Unknown Origin	FUO
Follow-up	FU
Fracture	Fx
Gallbladder	GB
Gastroenterostomy	GE
Gastroesophageal	GE
Gastroesophageal Reflux Disease	GERD
Gastrointestinal	GI
Genitourinary	GU
Grade	GR
Gram	GM
Gynecology	GYN
Head, Eyes, Ears, Nose & Throat	HEENT
Hematocrit	HCT
Hemoglobin	HB, HGB
High Grade Prostatic Intra-epithelial Neoplasia	HGPIN
History	HX
History & Physical	H&P
History of	HO
History of Present Illness	HPI
Hormone	HORM
Hormone Replacement Therapy	HRT
Hospital	HOSP
Hour/Hours	HR, HRS
Human Chorionic Gonadotropin	HCG
Human Immunodeficiency Virus	HIV
Human Papilloma Virus	HPV
Human T-Lymphotrophic Virus Type III	HTLV-III
Hypertension	HTN
Hysterectomy	HYST
Immunoglobulin	Ig

Name	Abbreviation
Impression	IMP
Includes, Including	INCL
Increase	INCR (or >)
Inferior Vena Cava	IVC
Infiltrating	INFILT
Inpatient	IN-PT
Insulin-Dependent Diabetes Mellitus	IDDM
Intercostal Margin (space)	ICM(S)
Internal Mammary Artery	IMA
Intrathecal	IT
Intravenous	IV
Intravenous Pyelogram	IVP
Intravenous Urography	IVU
Iodine	I
Irregular	IRREG
Irritable Bowel Syndrome	IBS
Jugular Venous Distention	JVD
Kidneys, Ureter, Bladder	KUB
Kilogram	KG
Kilovolt	KV
Laboratory	LAB
Laparotomy	LAP
Large	LG
Last Menstrual Period	LMP
Lateral	LAT
Left	LT
Left Costal Margin	LCM
Left Lower Extremity	LLE
Left Lower Lobe	LLL
Left Lower Quadrant	LLQ
Left Middle Lobe	LML
Left Salpingo-oophorectomy	LSO
Left Upper Extremity	LUE
Left Upper Lobe	LUL
Left Upper Quadrant	LUQ
Liter	L
Liver, Kidney, Spleen (Bladder)	LKS(B)
Lower Extremity	LE
Lower Inner Quadrant	LIQ
Lower Outer Quadrant	LOQ
Lumbar Puncture	LP
Lumbar Vertebra	L1-L5
Lumbosacral	LS
Lymphadenopathy-Associated Virus	LAV
Lymph Node(s)	LN, LNS
Magnetic Resonance Imaging	MRI
Malignant	MALIG
Mandible	MAND
Mastectomy	MAST
Maxillary	MAX
Maximum	MAX
Medical Doctor	MD, DR
Medicine	MED
Metastatic, Metastasis	MET, METS

Name	Abbreviation
Microscopic	MICRO
Midclavicular Line	MCL
Middle Lobe	ML
Milliliter	ML
Millimeter	MM
Minimum	MIN
Mitral Valve Prolapse	MVP
Moderate	MOD
Moderately Differentiated	MD, MOD DIFF
Modified Radical Mastectomy	MRM
Month	MO
Nausea & Vomiting	N&V
Negative	NEG (or -)
Neurology	NEURO
No Evidence of Disease	NED
No Evidence of Metastatic Disease	NEMD
No Significant Findings	NSF
Normal	NL
Not Applicable	NA
Not Otherwise Specified	NOS
Not Recorded	NR
Nursing Home	NH
Obstructed(-ing,-ion)	OBST
Operating Room	OR
Operation	OP
Operative Report	OP RPT
Ounce	OZ
Outpatient	OP
Packs Per Day	PPD
Palpated(-able)	PALP
Papanicolaou Smear	PAP
Papillary	PAP
Past Medical History	PMH
Pathology	PATH
Patient	PT
Pelvic Inflammatory Disease	PID
Percussion & Auscultation	P&A
Percutaneous	PERC
Personal (Primary) Medical Doctor	PMD
Physical Examination	PE
Platelets	PLT
Poorly Differentiated	PD, POOR DIFF
Positive	POS (or +)
Positron Emission Tomography	PET
Possible	POSS
Posterior	POST
Posteroanterior	PA
Postoperative(-ly)	PO, POSTOP
Preoperative(-ly)	PREOP
Prescription	Rx
Present Illness	PID
Prior to Admission	PTA
Probable(-ly)	PROB
Progesterone Receptor (Assay)	PRA

Name	Abbreviation
Prostatic Intraepithelial Neoplasia	PIN
Prostatic Specific Antigen	PSA
Pulmonary	PULM
Radiation	RAD
Radiation Absorbed Dose	RAD
Radiation Therapy	RAD TX
Radical	RAD
Radioimmunoassay	RIA
Red Blood Cells	RBC
Resection	RESEC
Respiratory	RESP
Review of Systems	ROS
Right	RT
Right Costal Margin	RCM
Right Lower Extremity	RLE
Right Lower Lobe	RLL
Right Lower Quadrant	RLQ
Right Middle Lobe	RML
Right Salpingo-oophorectomy	RSO
Right Upper Extremity	RUE
Right Upper Lobe	RUL
Right Upper Quadrant	RUQ
Rule Out	R/O
Sacral Vertebra	S1-S5
Salpingo-oophorectomy	SO
Serum Glutamic Oxaloacetic Transaminase	SGOT
Serum Glutamic Pyruvic Transaminase	SGPT
Shortness of Breath	SOB
Signs & Symptoms	S/S
Skilled Nursing Facility	SNF
Small	SM, SML
Small Bowel	SB, SM BWL
Specimen	SPEC
Spine	
Cervical Spine	C-SPINE
Lumbar Spine	L-SPINE
Sacral Spine	S-SPINE
Thoracic Spine	T-SPINE
Split Thickness Skin Graft	STSG
Squamous	SQ, SQUAM
Squamous Cell Carcinoma	SCC, SCCA
Status Post	S/P
Subcutaneous	SUBQ, SQ
Superior Vena Cava	SVC
Surgery, Surgical	SURG
Symptoms	SX
Thoracic	T
Thoracic Vertebra	T1-T12
Total Abdominal Hysterectomy	TAH
Total Abdominal Hysterectomy-	
Bilateral Salpingo-oophorectomy	TAH-BSO
Total Parenteral Nutrition	TPN
Total Vaginal Hysterectomy	TVH
Toxic Multi-Nodular Goiter	TMNG

Name	Abbreviation
Transitional Cell Carcinoma	TCC
Transurethral Resection	TUR
Transurethral Resection Bladder (Tumor)	TURBT
Transurethral Resection of Prostate	TURP
Treatment	TX
Tumor Size	TS
Ultrasound	US
Undifferentiated	UNDIFF
Upper Extremity	UE
Upper Gastrointestinal	UGI
Upper Inner Quadrant	UIQ
Upper Outer Quadrant	UOQ
Vagina, Vaginal	VAG
Vaginal Hysterectomy	VAG HYST
Vaginal Intraepithelial Neoplasia	VAIN
Vascular	VASC
Veterans Administration	VA
Vulvar Intraepithelial Neoplasia	VIN
Well Differentiated	WD, WELL DIFF
White Blood Cells	WBC
With	W/
Within Normal Limits	WNL
Without	W/OUT, W/O
Work-up	W/U
X-ray	XR
X-ray Therapy	XRT
Year	YR
Year-Old	Y/O
Symbols	
At	@
Comparison	/
Decrease, Less than	<
Equals	=
Increase, More than	>
Negative	-
Number*	#
Positive	+
Pounds**	#
Questionable	??
Times	X
* If it appears before a numeral.	
** If it appears after a numeral.	

Appendix C
Montana Law and Rules

TUMOR REGISTRY LAW

TITLE 50. HEALTH AND SAFETY
CHAPTER 15. VITAL STATISTICS

Part 7. Tumor Registry

50-15-701. Short title. This part may be cited as the "Tumor Registry Act".

History: En. Sec. 1, Ch. 354, L. 1981.

50-15-702. Definitions. As used in this part, the following definitions apply:

(1) "Department" means the department of public health and human services provided for in 2-15-2201.

(2) "Health care practitioner" means a person licensed pursuant to Title 37, chapter 3, to practice medicine or pursuant to Title 37, chapter 4, to practice dentistry.

(3) "Hospital" means a facility that provides, by or under the supervision of licensed physicians, services for medical diagnosis, treatment, rehabilitation, and care of injured, disabled, or sick persons.

(4) "Medical services" means diagnosis or treatment of illness in a human being by or under the supervision of a health care practitioner.

History: En. Sec. 2, Ch. 354, L. 1981; amd. Sec. 106, Ch. 418, L. 1995; amd. Sec. 283, Ch. 546, L. 1995; amd. Sec. 1, Ch. 101, L. 1997.

50-15-703. Duty to report tumors. The following persons or entities shall report to the department on forms provided by the department all medical and personal information as specified in rules of the department and laboratory results pertaining to the treatment and condition of a person with a reportable tumor:

(1) a hospital that provides medical services relating to the tumor;

(2) a clinical laboratory, as defined in 50-5-101, that is not owned or operated by a hospital and that provides laboratory services relating to the tumor; and

(3) a health care practitioner or health care facility, not covered by subsection (1) or (2), providing medical services relating to the tumor.

History: En. Sec. 3, Ch. 354, L. 1981; amd. Sec. 1, Ch. 12, L. 1985; amd. Sec. 2, Ch. 101, L. 1997.

50-15-704. Confidentiality. Information received by the department pursuant to this part may not be released unless:

(1) it is in statistical, nonidentifiable form;

(2) the provisions of Title 50, chapter 16, part 6, are satisfied;

(3) the release or transfer is to a person or organization that is qualified to perform data processing or data analysis and that has safeguards against unauthorized disclosure of that information;

(4) the release or transfer is to a central tumor registry of another state and is of information concerning a person who is residing in that state; or

(5) the release is to a health care practitioner or health care facility that is providing or has provided medical services to a person who has or has had a reportable tumor.

History: En. Sec. 4, Ch. 354, L. 1981; amd. Sec. 27, Ch. 632, L. 1987; amd. Sec. 3, Ch. 101, L. 1997.

50-15-705. Tumor registry. The department shall maintain a registry containing the names of all persons reported to it and all other information submitted to the department concerning those persons pursuant to 50-15-703.

History: En. Sec. 5, Ch. 354, L. 1981.

50-15-706. Rules. The department may adopt rules implementing this part, including:

(1) the types of tumors that are reportable; and

(2) the information on each patient having a reportable tumor that must be submitted to the department.

History: En. Sec. 6, Ch. 354, L. 1981.

50-15-707 through 50-15-709 reserved. 50-15-710. Immunity from liability. A person other than the department may not be held liable in a civil or criminal action for complying with the reporting requirements of 50-15-703 or for lawfully using information provided by the tumor registry in a manner that does not violate the Tumor Registry Act.

History: En. Sec. 4, Ch. 101, L. 1997.

https://leg.mt.gov/bills/mca/title_0500/chapter_0150/part_0070/section_0010/0500-0150-0070-0010.html

37.8.1801 **DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES**
RECORDS AND STATISTICS
Subchapter 18
Tumor Registry

37.8.1801 REPORTABLE TUMORS

(1) The following tumors are designated as reportable:

(a) malignant neoplasm, with the exception of a basal or squamous carcinoma of the skin;

(b) skin cancer of the labia, vulva, penis or scrotum;

(c) benign tumor of the brain, including a:

(i) meningioma (cerebral meninges);

(ii) pinealoma (pineal gland); or

(iii) adenoma (pituitary gland);

(d) carcinoid tumor, whether malignant, benign or not otherwise specified (NOS).

(2) A benign tumor other than one of those listed in (1) may be reported to the department for inclusion in the tumor registry if prior approval has been obtained from the Department of Public Health and Human Services, Public Health and Safety Division, Montana Central Tumor Registry, 1400 Broadway, PO Box 202951, Helena, MT 59620-2951.

(3) A tumor which is otherwise reportable, but has been diagnosed and recorded using the words "apparently", "appears", "comparable with", "compatible with", "consistent with", "favors", "malignant appearing", "most likely", "presumed", "probable", "suspected", "suspicious", or "typical of" with reference to that tumor is considered reportable.

(4) In order for the department to maintain current reporting, hospitals and physicians shall submit to the department information on reportable tumors within six months from the first inpatient or outpatient date that the patient was seen with cancer; independent laboratories shall submit to the department information on reportable tumors within six months from the date the laboratory service associated with the tumor was rendered.

History: 50-15-706, MCA; IMP , 50-15-703, MCA; NEW , 1982 MAR p. 391, Eff. 2/26/82; AMD , 1985 MAR p. 1857, Eff. 11/30/85; AMD , 1988 MAR p. 726, Eff. 4/15/88; TRANS , from DHES, 1997 MAR p. 1460; AMD , 2003 MAR p. 2441, Eff. 10/31/03; AMD , 2009 MAR p. 87, Eff. 1/30/09.

37.8.1802 REQUIRED RECORDS, INITIAL ADMISSION AND TREATMENT

(1) Whenever a hospital initially provides medical services to any patient relating to a tumor designated as reportable by ARM 37.8.1801, it must collect, record, and make available to the department the following information about that patient:

(a) name and current physical address of patient;

(b) patient's physical address at time of diagnosis;

(c) social security number;

(d) name of spouse, if any;

(e) phone number;

(f) race, Hispanic origin if applicable, sex, and marital status;

(g) age at diagnosis, place of birth, and month, day, and year of birth;

(h) name, address, and phone number of friend or relative to act as contact, plus relationship of that contact to patient;

(i) date and place of initial diagnosis;

(j) primary site of tumor (paired organ);
(k) sequence of primary tumors if more than one;
(l) other primary tumors;
(m) method of confirming diagnosis;
(n) histology, including dates, place, histologic type and slide number;
(o) summary staging, including whether in situ, localized, regional, distant or unstaged, with no information, or whether AJCC or TNM staging is utilized, and, if so, the findings of this staging;
(p) description of tumor and its spread, if any, including size in centimeters, number of positive nodes, number of nodes examined and site of distant metastases;
(q) procedures done to diagnose or stage tumors including dates, procedures, and results (such as physical exams, scopes, x-rays, scans, or lab tests);
(r) cumulative summary of all therapy directed at the subject tumor, including:
(i) date of therapy;
(ii) specific type of surgery or radiation therapy, if any, and details of chemical, hormonal, or other kinds of treatment; and
(iii) if no therapy given, reason for lack of therapy.
(s) status at time of latest recorded information, i.e., whether alive or dead, tumor in evidence, or recurring, or status unknown;
(t) if recurrence of tumor, date, type, and distant sites of first recurrence;
(u) names of physicians primarily and secondarily responsible for follow up;
(v) date of each follow up;
(w) if patient has died, date of death, place, cause, and whether autopsy performed;
(x) primary payer at diagnosis;
(y) usual occupation and industry; and
(z) tobacco and alcohol use history.

History: 50-15-706, MCA; IMP , 50-15-703, MCA; NEW , 1982 MAR p. 391, Eff. 2/26/82; TRANS , from DHES, 1997 MAR p. 1460; AMD , 2003 MAR p. 2441, Eff. 10/31/03; AMD , 2009 MAR p. 87, Eff. 1/30/09.

37.8.1803 REQUIRED RECORDS, FOLLOW UP

(1) Whenever a patient for whom information has been provided to the tumor registry is admitted to the hospital providing the information on an inpatient or outpatient basis for further treatment related to the tumor for which original registration in the tumor registry was made, the hospital must keep on file the following information:

(a) patient's name, noting any change from previous records;
(b) any paired organ involvement, noting sequence;
(c) subsequent histology, including dates, place, histology type, slide number and procedure;
(d) date, type of procedure and findings of any surgery or other exploratory measure;
(e) date and type of any administration of radiation;
(f) date of any administration of hormones, chemotherapy, immunotherapy or any other kind of treatment;
(g) date of death and/or last follow up;
(h) if death has occurred, the place, cause and whether an autopsy was performed;
(i) if an autopsy was performed, its findings pertaining to cancer;
(j) status at time of latest recorded information, i.e., whether alive or dead, tumor in evidence, or has recurred, or status is unknown;
(k) if recurrence of tumor, date, type, and distant sites of first recurrence; and
(l) names of those physicians primarily and secondarily responsible for follow up treatment.

History: 50-15-706, MCA; IMP , 50-15-703, MCA; NEW , 1982 MAR p. 391, Eff. 2/26/82; TRANS , from DHES, 1997 MAR p. 1460; AMD , 2003 MAR p. 2441, Eff. 10/31/03; AMD , 2009 MAR p. 87, Eff. 1/30/09.

Rules 37.8.1804 through 37.8.1807 reserved

37.8.1808 REQUIRED RECORDS, INDEPENDENT CLINICAL LABORATORIES

(1) Whenever a clinical laboratory which is not owned or operated by a hospital provides laboratory services for any patient relating to a tumor designated as reportable by ARM 37.8.1801, it must collect, record, and make available to the department the following information about that patient:

(a) name and current address of patient;
(b) patient's address at time of diagnosis;
(c) social security number;
(d) name of spouse, if any;
(e) race, sex, and marital status;
(f) age at diagnosis, month, day, and year of birth;
(g) date and place of initial diagnosis;
(h) primary site of tumor (paired organ);
(i) sequence of primary tumors, if more than one;
(j) method of confirming diagnosis;
(k) histology, including dates, place, histologic type, and slide number;
(l) summary staging, including whether in situ, localized, regional, distant or unstaged, with no information, or whether AJCC or TNM staging is utilized, and, if so, the findings of the staging;
(m) description of tumor and its spread, if any, including size in centimeters, number of positive nodes, number of nodes examined, and site of distant metastasis;
(n) status at time of latest recorded information, i.e., whether alive or dead, tumor in evidence, or recurring, or status unknown; and
(o) names of physicians primarily and secondarily responsible for follow up.

History: 50-15-706, MCA; IMP , 50-15-703, MCA; NEW , 1985 MAR p. 1857, Eff. 11/30/85; TRANS , from DHES, 1997 MAR p. 1460; AMD , 2003 MAR p. 2441, Eff. 10/31/03; AMD , 2009 MAR p. 87, Eff. 1/30/09.