Physician Cancer Reporting Requirements in Montana

Montana Central Tumor Registry
Department of Public Health and Human Services
Public Health and Safety Division
Chronic Disease Prevention and Health Promotion Bureau
PO Box 202952
Helena, MT 59620
(406) - 444 - 2618

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Summary

Cancer became a reportable disease in Montana in 1979. Montana Law requires hospitals, independent pathology labs, and physicians to report cancer cases to the Montana Central Tumor Registry (MCTR). This valuable resource enables Montanans to know the incidence trends of cancer in Montana. The primary objective of the MCTR is to analyze the incidence, mortality, survival, and the changing frequency of cancer in Montana residents.

Beginning with patients diagnosed in 2010, physicians are required to initiate a cancer report as soon as possible but not longer than 6 months after a diagnosis for cancer is made if the following criteria are met:

1. **The patient is <u>not</u> seen or treated in a Montana hospital for this cancer or**
2. **The case is <u>not</u> confirmed by a pathology lab licensed in Montana.**

The goal for physician reporting is to collect information for those patients who are diagnosed but decide against workup and/or treatment *or* are solely diagnosed and treated in the physician's office. Statistically, cases reported solely from physicians may represent 3-5% of all cancer cases missed in the statewide cancer registry. Certain specialties may represent a higher amount of missed cases such as urology (prostate cases), dermatology (melanoma), hematology (lymphoma and leukemia) that may be diagnosed and not treated (watchful waiting) or diagnosed and treated entirely in the physician's office.

Hospitals still have the primary responsibility for reporting cancer information. However, since an increasing number of people with cancer are not hospitalized at the time of diagnosis, a supplemental reporting mechanism is essential to assure that the data accurately reflect the incidence of cancer in Montana.

Physicians must report cancers and tumors described in the Required Cases section below. Physicians must report diagnoses for those patients who do not undergo diagnostic procedures or treatment of their cancers or tumors at a hospital or pathology lab licensed in Montana.

Montana law does not require written or verbal patient consent to report, and specifically exempts reporters from any legal action or damages from meeting their legal obligation to report cancer cases or to provide access to those patient's medical records.

HIPAA Information

The Health Information Portability and Accountability Act (HIPAA) does not change or affect the mandate for reporting cancer in Montana. The MCTR is considered a Public Health Authority and disclosure of protected health information to the MCTR is permitted by HIPAA without a patient's signed consent. Please contact the MCTR for documentation regarding HIPAA legislation information, if needed.

Confidentiality

Confidentiality of data collected is strictly maintained in accordance with Montana Law 50-15-704 and Federal Law PL 104-191.

Information about individual patients is never released to unauthorized persons or agencies, and safeguards have been established throughout the reporting system to maintain confidentiality.

Required Cases

All malignant neoplasms (including in-situ)

EXCEPTION: All non-genital Basal Cell Carcinoma (BCC) or Squamous Cell Carcinoma (SCC) of skin.

NOTE: BCC and SCC of the labia, vagina, vulva, clitoris, penis, scrotum, prepuce, and anus must be reported. Carcinoma in-situ of the cervix (CIS), intraepithelial neoplasia grade III of the cervix (CIN III), prostate (PIN III), vulva (VIN III), vagina (VAIN III), and anus (AIN III) are reportable because of their in-situ classification.

All benign tumors of the brain

INCLUDES: meninges, brain, spinal cord, cranial nerves, and other parts of the CNS, pituitary gland, craniopharyngeal duct, and pineal gland

All carcinoid tumors (malignant, benign, and NOS)

Ambiguous Terms (*with indication of reportable cancer*) without additional information

Apparent(ly)	**Most likely**
Appears	**Neoplasm or Tumor for Brain or CNS**
Comparable with	**Presumed**
Compatible with	**Probable**
Consistent with	**Suspect(ed)**
Favor(s)	**Suspicious (for)**
Malignant appearing	**Typical (of)**

Exception: If cytology is reported as *suspicious*, do not interpret it as a diagnosis of cancer. Report the case only if a positive biopsy or a physician's clinical impression of cancer supports the cytology findings.

Non-Required Cases

A. Patients with a history of malignancy who are clinically free of disease when seen at your facility.
B. Patients with BCC or SCC skin cancer that do not meet the site requirements defined in the Reportable List.
C. Patients diagnosed with a probable carcinoma and subsequently ruled out (see list of Ambiguous Terms).
D. Patients who receive transient care to avoid interrupting a course of therapy started elsewhere.
E. 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.
F. Patients only seen in consultation to confirm a diagnosis or develop a treatment plan

List of Reportable ICD-9-CM and ICD-10-CM Codes

ICD-9-CM Code	ICD-10-CM Code	Description
042	B20	AIDS (*review for AIDS-related malignancies*)
140.0 – 172.9 174.0 – 209.36 209.7	C00.0 – C43.9, C45.0 – C96.9	Malignant neoplasms **except 173.0 - 173.9 or C44.00 – C44.99**
209.00 - 209.69	D3Aa._	Carcinoid tumors (any behavior) and neuroendocrine tumor (malignant only)
225.0 - 225.9	D32.0 – D33.9	Benign neoplasms of brain and spinal cord
227.3 - 227.4	D35.2, D35.3	Benign neoplasm of pituitary gland, pineal body, and other intracranial endocrine-related structures
228.02	D18.02	Hemangioma of intracranial structures
228.1	D18.1	Lymphangioma (of brain, nervous system, and reportable endocrine glands only)
230.0 - 234.9	D00.0 – D09.9	Carcinoma in-situ except **232.0 - 232.9**
236.0	D39.0	Stromal endometriosis (8931/3 per ICD-O-3)
237.0 - 237.9	D42.0 – D42.9, D43.0 – D43.9, D44.3 – D44.5	Neoplasm of uncertain behavior of endocrine glands and nervous system **except 237.2 - 237.4**
238.4	D45	Polycythemia vera (9950/3)
238.6	D47.0 – D47.9	Solitary plasmacytoma (9731/3), extramedullary plasmacytoma (9734/3)
238.71 – 238.79	D46.0 – D47.9	Other lymphatic and hematopoietic diseases
239.6-239.7	D49.6	Neoplasms of unspecified behavior of brain and other parts of nervous system
273.2	C88.2	Gamma heavy chain disease (9762/3); Franklin's disease (9762/3)
273.3	C88.0	Waldenstrom's macroglobulinemia (9761/3)
277.89	C96.5, C96.6	Other specified disorders of metabolism. Reportable terms include Hand-Schuller-Christian disease; histiocytosis (acute) (chronic); histiocytosis X (chronic)
285.3	D64.81	Anemia due to antineoplastic chemotherapy
288.3	D72.1	Hypereosinophilic syndrome (9964/3). Diagnosis must be "hypereosonophilic syndrome" to be reportable
288.4	D76.1 – D76.3	Hemophagocytic syndrome (histiocytic syndromes)
289.6	D45	Familial polycythemia (synonym for polycythemia vera)
289.83	D75.81	Chronic Myelofibrosis (NOS) (9961/3),
338.3	G89.3	Neoplasm-related pain (acute) (chronic); Cancer associated pain; Pain due to malignancy
511.81	J91.0	Malignant pleural effusion
789.51	R18.0	Malignant ascites
990	T66	Effects of radiation, unspecified (radiation sickness)
V10.00 - V10.9	Z85.0_ - Z85.8_	Personal history of malignancy (*review for recurrence, subsequent cancers, and/or subsequent tx*)
V58.0-V58.12	Z51.0, Z51.1_	Encounter or admission for radiotherapy, chemotherapy, or immunotherapy (*review for reportability*)
V66.1-V66.2	Z51.89	Convalescence following radiotherapy or chemotherapy (*review for reportability*)
V67.1-V67.2	Z08	Follow-up exam following radiotherapy or chemotherapy (*review for reportability*)
V86.0 - V86.1	Z17	Estrogen receptor positive or negative status [ER + / ER -]
E873.2	Y63.2	Failure in dosage, overdose of radiation in therapy (radiation sickness)
E879.2	Y84.2	Adverse effect of radiation therapy
E930.7	None	Adverse effect of antineoplastic antibiotics
E933.1	None	Adverse effect of antineoplastic and immunosuppressive drugs

Reporting Procedures

To report a diagnosis, please complete the Physician Cancer Reporting Form inserted into this document and mail or fax to the MCTR. The fax is secure in the Tumor Registry office. This form is also available on the MCTR website at www.cancer.mt.gov. A separate form is required for each primary cancer or tumor. For example, if the patient is diagnosed with a melanoma and a leukemia, a form must be submitted for each diagnosis.

Reports should be sent in monthly and not less often than every three months. Send completed forms to the Montana Central Tumor Registry, PO Box 202952, 1400 Broadway, C317, Helena, MT 59620 or securely fax the form to (406) 444-6557.

Please complete the form as accurately and completely as possible.

Please provide the following information:

Reporting Physician Information

Physician Name and Address: Record the complete name and address of the physician reporting this case.
Physician Phone: Record the physician's phone number.
Physician License or NPI #: Record the physician's Montana license number or NPI number.
Date Form Completed: Record the date this form is completed.
Form Completed By: Record the full name of the person completing the form.

Patient Information

Full name, Maiden, and Alias of Patient: Record all known information.
Name of Spouse/Parent: Record the patient's spouse, if married, or parent, if a child.
Social Security Number: Record the patient's social security number. Do not record a spouse's number.
Date of Birth: Record 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 patient's race: White, American Indian, Black, Asian, Unknown, Other. If the patient is anything other than check boxes offer, please make notation under boxes. Check all boxes that apply.
Hispanic Ethnicity: Check Yes, No, or Unknown if the patient is of Hispanic descent.
Sex: Check male or female.
Marital Status: Check Single, Married, Divorced, Widowed, Separated, or Unknown at time of diagnosis.
Place of Birth: Record the patient's place of birth, if known.
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.
Telephone Number: Record the patient's phone number. A land line is preferable over a mobile phone number. The MCTR does not contact patients but occasionally uses a phone number to verify residence using the internet.
Family History of Cancer: Check Yes, No, or Unknown if there is any family history of cancer.

Tobacco History: Check Never, Cigarette, Pipe, Chew, Previous Use, or Unknown for patient's tobacco history.
Alcohol History: Check Yes, No, Previous, or Unknown for patient's alcohol history.
Primary Payer: Record the patient's primary payer or insurance at time of diagnosis.
Usual Occupation: Record the patient's usual occupation or work performed during most of the patient's life prior to the diagnosis of cancer. Do not record retired. If usual occupation is not known, record the patient's current or most recent occupation or any known occupation. Record "homemaker" for women never employed outside the home.
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. Do not record retired.

Cancer Information

Date of Initial Diagnosis: Record in MM/DD/YYYY format. The date of diagnosis refers to the first diagnosis of this tumor by any recognized medical practitioner. If unknown, record "unknown". If diagnosed elsewhere, record the facility name and location.
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 outer quadrant of left breast.
Laterality: Check Right, Left, or Unknown of primary site.
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 1992. Exclude non-reportable types of cancers such as BCC Skin and SCC Skin since they are not reportable or counted.
Physical Findings: Describe physical findings that led to diagnosis or determined staging and treatment. Describe the dates and results from scopes, x-rays, scans, lab tests, and physical evaluations.
Pathology (Histology and Grade): Attach copies of pathology and surgical reports, if available. Document results from cytology or histopathology reports. Include the date of the procedure, type of specimen, extent of tumor spread, involvement of margins, information from second opinions, name of procedure, and results. Record the histology of the primary tumor. Report the final pathologic diagnosis.
Size of Tumor: Describe the largest dimension of the diameter of the primary tumor in millimeters. Record size from the pathology report first, if available; otherwise, use the size from imaging or physical exam. Record the size as stated for purely in-situ tumors. If both in-situ and invasive tumor is present, record the size of the invasive component, even if it is smaller. Do not add pieces or chips together to create a whole.
Lymph Node Involvement: Record the number of regional lymph nodes examined by the pathologist and found to contain metastasis. Record the number of lymph nodes examined by the pathologist.
Stage at Diagnosis: This describes the extent of disease. You may document TNM stage, if that is known.
- 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.

For Melanoma: Record the Breslow's information (tumor thickness), Clark's level (depth of invasion), and if ulceration is present.

For Prostate: Document the most recent PSA level just prior to biopsy or treatment.

For Breast: Record the ERA, PRA, and HER2 status.

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 be given.

Surgery: Record the date(s) and the type of surgical procedure(s). Be specific regarding incisional and excisional biopsies. Record reason if surgery is not done.

Radiation: Record the start date(s) and end date(s) and type of radiation therapy given. Include cGy and where treatment was done. Record reason if radiation is not done.

Systemic Therapy: Record date systemic therapy (chemotherapy, hormone therapy, immunotherapy, or biological response modifiers) began. Document the agents and where systemic therapy was given. Record reason if systemic therapy is not done.

Outcomes

Date of Last Contact or Death: Record the date last seen or date of death in MM/DD/YYYY format.

Vital Status: Record the patient's vital status at date last seen.

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

Cause of Death: If the patient is expired, record the cause of death, if known.

Place of Death: If the patient is expired, record the place of death, if known.

Physicians: List any additional physicians who will be treating or re-examining this patient for cancer.

PHYSICIAN CANCER REPORTING FORM

Form TR-003
Revised 11/08

Reporting Physician and Address	Physician Phone	Date Form Completed	Date Received by MCTR
	Physician License or NPI #	Form Completed By	

PATIENT INFORMATION

Name of Patient Last First Middle Maiden Alias | Name of Spouse/Parent

Social Security Number | Date of Birth | Age | Referred From | Referred To

Race ☐ White ☐ Am. Ind ☐ Black ☐ Asian ☐ Unk ☐ Other _____ | Hispanic Ethnicity ☐ Yes ☐ No ☐ Unk | Sex ☐ Male ☐ Female | Marital Status ☐ Single ☐ Married ☐ Div ☐ Widow ☐ Sep ☐ Unk

Physical Address No & Street City County State Zip Code | Place of Birth

Telephone Number | Family History of Cancer ☐ Yes ☐ No ☐ Unk | Tobacco History ☐ Never ☐ Cigarette ☐ Pipe ☐ Chew ☐ Previous Use ☐ Unk | Alcohol History ☐ Yes ☐ No ☐ Previous ☐ Unk

Primary Payer | Usual Occupation | Usual Industry

CANCER INFORMATION

Date of Initial Diagnosis | Primary Site | Laterality ☐ Not Applicable ☐ Right ☐ Left ☐ Unk | Other Primary Tumors

Physical Findings (x-ray, scans, scopes)

Pathology (Histology and Grade) (attach copies of reports)

Size of Tumor

Lymph Node Involvement

SEER Summary Staging
- ☐ In-situ
- ☐ Local
- ☐ Regional DE*
- ☐ Regional LN*
- ☐ Distant*
- ☐ Unknown

* Describe: _____

For Melanoma
Depth of Invasion (Breslow's): _____ Ulceration: ☐ Yes ☐ No
Clarks Level: ☐ I ☐ II ☐ III ☐ IV

For Prostate
PSA Level prior to bx: _____

For Breast
ERA/PRA Status: _____
HER2 Status: _____

TREATMENT INFORMATION

Surgery ☐ Yes ☐ No
Type
Date

Radiation ☐ Yes ☐ No
Type and cGy
Date Started and Ended

Systemic Therapy ☐ Yes ☐ No
Agents
Date Started

OUTCOMES

Status
Date of Last Contact or Death _____
Vital Status ☐ Alive ☐ Dead Cancer Status ☐ No Evidence ☐ Evidence ☐ Unknown
Cause of Death _____ Place of Death _____

Physicians
Surgeon _____
Following _____
Other _____

Please submit supporting text/documentation (e.g., pathology reports, radiology findings, pre-operative H&P, etc), to verify diagnosis, staging, histology, treatment, etc.

Please mail this form and documentation to the Montana Central Tumor Registry, PO Box 202952, 1400 Broadway, Room C-317, Helena, MT 59620.

Or fax the reports to (406) 444-6557. For questions, contact the MCTR at (406) 444-6786. This document is also on chronicdiseaseprevention.mt.gov.

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.