Casefinding

All participating institutions should establish procedures for complete casefinding within their institution. In many hospitals, records are housed in one location (i.e., the medical records department). In others, procedures for identifying patients from multiple independent ancillary service areas may be necessary (i.e., outpatient clinics, radiation therapy, etc). It is important that the following multiple sources in the hospital be searched to keep missed reportable cases to a minimum. The procedures outlined below should be adapted to each individual hospital.

1. Medical record disease discharge diagnostic index:

Any patient record coded with the diagnoses listed below should be reviewed to determine if the case is one which meets KCR reportability criteria. Note that a diagnosis is not necessarily reportable simply because it falls within the codes below; refer to the Case Reportability Requirements to make sure the case is truly reportable to KCR.

2024 ICD-10-CM Codes (Effective 10-01-2023 through 09-30-2024) PDF: **icd-10-cm-casefinding-list.20231005.pdf** Excel: **icd-10-cm-casefinding-list.20231005.xlsx**

2023 ICD-10-CM Codes (Effective 10-01-2022 through 09-30-2023) PDF: **icd-10-cm-casefinding-list.20230403.pdf** Excel: **icd-10-cm-casefinding-list.20230403.xlsx**

2022 ICD-10-CM Codes (Effective 10-01-2021 through 09-30-2022) PDF: **icd-10-cm-casefinding-list.20220105.pdf** Excel: **icd-10-cm-casefinding-list.20220105.xlsx**

2021 ICD-10-CM Codes (Effective 10-01-2020 through 09-30-2021) PDF: **icd-10-cm-casefinding-list.20201211.pdf** Excel: **icd-10-cm-casefinding-list.20201211.xlsx**

2020 ICD-10-CM Codes (Effective 10-01-2019 through 09-30-2020) PDF: **fy2020-casefindinglist-icd10cm.pdf** Excel: **fy2020-casefindinglist-icd10cm.xlsx**

2019 ICD-10-CM Codes (Effective 10-01-2018 through 09-30-2019) PDF: **fy2019-casefindinglist-icd10cm.pdf** Excel: **fy2019-casefindinglist-icd10cm.xlsx**

2018 ICD-10-CM Codes (Effective 10-01-2017 through 09-30-2018) Visit: **https://seer.cancer.gov/tools/casefinding/case2018-icd10cm.html**

2007-2017 ICD-10-CM Codes: Visit: **https://seer.cancer.gov/tools/codingmanuals/historical.html#0**

1. Note: Pilocytic/juvenile astrocytoma M-9421 moved from behavior /3 (malignant) to /1 (borderline malignancy) in ICD-O-3. However, SEER registries will CONTINUE to report these cases and code behavior as /3 (malignant).
NOTE: Cases with the codes listed below should be screened as registry time allows. Experience in the SEER registries has shown that using the supplemental list increases casefinding for benign brain and CNS, hematopoietic neoplasms, and other reportable diseases

A list of detailed and supplemental ICD-10-CM codes which may also be used for casefinding is available in APPENDIX M.

Follow this link for a casefinding list of reportable ICD-10 codes effective for years 2019 and before which includes a comprehensive list plus a supplemental list. https://seer.cancer.gov/tools/casefinding/

2. Pathology reports:

All pathology reports on both inpatients and outpatients should be reviewed for case reportability. Since most cancer patients have a biopsy or operative resection performed, nearly all of the reportable cases can be identified through pathology reports alone. Histologic diagnoses are based upon microscopic examination of tissue taken from such procedures as biopsy, frozen section, surgery, or D & C. Expand path report screening to include benign CNS tumors, beginning with 1-1-04 diagnoses. Check for cases of anal intraepithelial neoplasia, grade III (AIN III), ductal intraepithelial neoplasia 3 (DIN 3), vaginal intraepithelial neoplasia, grade III (VAIN III), vulvar intraepithelial neoplasia, grade III (VIN III), **Laryngeal intraepithelial neoplasia III (LIN III), Lobular neoplasia grade III (LN III)/lobular intraepithelial neoplasia grade III (LIN III), Penile intraepithelial neoplasia, grade III (PeIN III), and Squamous intraepithelial neoplasia III (SIN III) excluding cervix**.

NOTE: Path reports may be the best source for finding cases of VIN, VAIN, and AIN (8077/2) and DIN (8500/2).

3. Cytology reports:

All cytology reports for both inpatients and outpatients should be reviewed for case reportability. Cytologic diagnoses are based upon microscopic examination of cells as contrasted with tissues. Included are smears from sputum, bronchial bushings, bronchial washings, tracheal washings, prostatic secretions, breast secretions, gastric fluid, spinal fluid, peritoneal fluid, pleural fluid, and urinary sediment. Cervical and vaginal smears are common examples.

4. Autopsy reports.

5. Radiation Therapy Department logs.

6. Medical Oncology Department logs.

7. Outpatient Department:

New patient registration rosters, clinic appointment books, surgery schedules, diagnostic imaging, and billing departments are additional casefinding sources.

8. Alpha listing of previously included cases:

Casefinding cannot be considered complete until the CPDMS.net accession list and any previous registry accession lists have been checked to be sure that this is a new patient or a new primary.

Creating and Maintaining a Nonreportable List

In the course of routine casefinding activities, cases which are found to be nonreportable by your hospital should be added to a nonreportable list. The list should consist of each patient's name, DOB, SSN, medical record number, the type/site of cancer, and a brief explanation of why the case is not reportable to the hospital registry (i.e., "patient was seen for consult only, no dx or tx," or "patient originally diagnosed prior to reference date"). A well-maintained nonreportable list will save registrars time by preventing them from reviewing a chart multiple times to check on a particular primary that does not need to be abstracted. The list can be invaluable during casefinding audits by allowing quick resolution of possible missed cases. It is also helpful during the death clearance process.

Bear in mind that cases which are not reportable by your hospital, but which **ARE** reportable to KCR (see Case Reporting Requirements) should be sent to the central registry to be abstracted there. These may include:

• A specimen from an outside doctor's office which was sent to your hospital's path lab

• Any case that was diagnosed and/or treated only in a nonhospital facility

• A Kentucky resident who was initially diagnosed or treated out of state