Instructions and Reporting Requirements

Electronic Reporting for Dermatology Physician Practices

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North Carolina Central Cancer Registry

State Center for Health Statistics
Division of Public Health
Department of Health and Human Services
1908 Mail Service Center
Raleigh, NC 27699-1908
http://www.schs.state.nc.us/units/CCR/

North Carolina Public Health
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PART I: INTRODUCTION

Section I.1: Background and the Physician Reporting Program

The North Carolina Central Cancer Registry (NCCCR) collects, processes and analyzes data on all cancer cases diagnosed among North Carolina residents. This is primarily a cancer surveillance activity, monitoring the incidence of cancer among the various populations of the state.

All health care providers are required by law to report cases to the NCCCR (as in nearly all other states). Traditional data collection for central cancer registries has been primarily from hospitals. As medical advances have occurred, diagnosis and treatment of certain cancers has moved from the acute care setting to being fully cared for within the physician/clinic office and therefore never received and counted. Examples include melanoma of the skin; prostate cancer; and many hematopoietic malignancies like chronic lymphocytic leukemia, polycythemia vera and myelodysplastic syndrome.

The NCCCR supplements hospital data with reports from physician/clinic offices who diagnose cases that are not seen in a hospital. In addition, death certificates and pathology laboratory reports are used to help identify cases that are missed in this routine reporting by hospitals and physician/clinic offices. Any duplicate reports are consolidated in the data editing process. The purpose of this concerted effort is to alleviate under-reporting or a delay in reporting which can adversely affect incidence rates and research from incomplete data collection.

The NCCCR has developed a program to assist physician/clinic offices in complying with the public health law. It is acknowledged that the responsibility for reporting might be assigned to staff of varying levels of medical experience, computer skills and time availability. A secure, online, user-friendly application has been created specifically for physician dermatology offices to report eligible cases. In addition, various tools to assist in identifying cases, determining which cases to report, using the on-line application and assistance from designated representatives are being provided. Contact information may be found at the end of this document.

This document is intended for physician/clinic office staff responsible for the electronic reporting of eligible cancer case information to the NCCCR. It describes the reporting guidelines, the instructions for using the Eureka electronic reporting form and tools for completing the reporting form.

Section I.2: Authority

The NCCCR is a unit of the North Carolina State Center for Health Statistics (SCHS) within the North Carolina Department of Health and Human Services (DHHS). The Central Cancer Registry is established by North Carolina General Statute Chapter 130A - Article 7. Its administrative rules are codified as North Carolina Administrative Code Title 10A - Chapter 47 Subchapter B.

The NCCCR was founded by law as a statewide, population-based cancer registry in 1945 through the General Assembly Statute Article 7, Chronic Disease, Part 1, Cancer, 130A – 105 to 130A – 215 with the mission to “compile, tabulate and preserve statistical, clinical and other reports and records relating to the incidence, treatment and cure of cancer.” Legislation has
been passed in pursuant years clarifying roles and activities with regard to not only the NCCCR but to its responsibilities to Federal government legislation (such as the Health Insurance Portability and Accountability Act – HIPAA, State legislation, and health care facility and health care provider responsibilities).

In 1990, additional detailed legislation was enacted by the General Assembly that built upon the authority given in 1945 and pursuant amendments. This 1990 legislation identified and clarified the responsibilities of the NCCCR (General Assembly Chapter 10a – Subchapter 47B – Cancer Registry, Section .0101 – Cancer Registry). Included in the 1990 legislation is more detailed information on reporting structure, definitions, confidentiality, reporting of cancer, cooperation of the CCR with health facilities, release of CCR data for research and assistance, consultation for public health work and failure by health care facilities/providers to report.

The Health Information Portability and Accountability Act (HIPAA) does not change or affect the mandate for reporting cancer in North Carolina. The NC Central Cancer Registry is considered a Public Health authority and disclosure of protected health information to the NCCCR is permitted by HIPAA without patient signed consent. HIPAA federal regulations citation: 45 CFR 164.512.

The entire legislative documents may be viewed by going to the following website links:
- http://www.schs.state.nc.us/units/ccr/article_7.htm
- http://reports.oah.state.nc.us/ncac.asp
- www.naaccr.org/Research/HIPAA.aspx

Section I.3: Reporting Deadlines

Every case of cancer or other reportable condition coming under the care of the reporting physician’s office are reportable as soon as possible but not longer than six months after the date of initial diagnoses.

Because reporting treatment information is very important, please wait to enter the report until after the treatment plan is established and initiated. For patients that refuse treatment, are not treated for any reason, or there is a decision not to treat (watchful waiting or active surveillance), specifically record that decision in the treatment text area.

Use the following guidelines as the minimum reporting deadlines:

<table>
<thead>
<tr>
<th>Cases first seen in the office in the:</th>
<th>Must be entered by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>First quarter (January February, March)</td>
<td>Oct. 1&lt;sup&gt;st&lt;/sup&gt;</td>
</tr>
<tr>
<td>Second quarter (April, May, June)</td>
<td>Jan. 1&lt;sup&gt;st&lt;/sup&gt;</td>
</tr>
<tr>
<td>Third quarter (July, August September)</td>
<td>April 1&lt;sup&gt;st&lt;/sup&gt;</td>
</tr>
<tr>
<td>Fourth quarter (October, November, December)</td>
<td>July 1&lt;sup&gt;st&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

Example: A newly reportable case first seen in January 2012 must be reported by Oct. 1, 2012, but can be reported earlier if the treatment plan is known.
PART II: REPORTING REQUIREMENTS

Section II.1: Reporting Procedures

To report an eligible case of cancer, the on-line Eureka Dermatology Reporting Form must be used. A separate report must be completed and submitted for each independent primary tumor. For example, if a patient is diagnosed with bladder cancer and a separate kidney cancer, a separate report must be submitted for each diagnosis.

Please complete the Eureka Dermatology Reporting Form as ACCURATELY and COMPLETELY as possible. Once the report is free of errors and is successfully submitted, it is considered as having been reported to the NCCCR. Copies of the medical record, paper version of the reporting form or lists of reported patients are not required to be sent to the NCCCR.

The following provides a brief summary of the steps required to report cases. Each of these steps will be described in detail throughout this document.

- Obtain a Eureka account for each physician office group.
- Obtain a Eureka user id and password for every staff person designated to report cases. Consider limiting this to two or three staff per practice. Each user must have a personal user id and password.
- Identify potential cases using the suggested casefinding procedures.
- Determine if the case should be reported using the case eligibility criteria.
- Access the on-line Eureka Dermatology Reporting Form to enter and submit cases using the required data-entry specifications.
- Track cases that have been reported to avoid duplicate reporting.

Section II.2: Cases Required to be Reported

The NCCCR requires all health care facilities and providers to report eligible cancer cases and non-malignant Central Nervous System (CNS) tumors (including brain, meninges and other CNS) that are screened, diagnosed, treated or seen with evidence of cancer. Clinically diagnosed cases (not histologically confirmed) must also be reported. Consider the following terms as equivalent: tumor, mass, lesion, neoplasm. Reporting is required for all diagnoses that meet the following criteria:

- **Primary Site:**
  - C44.0 – C44.9 Skin
  - C51.0 – C51.1 Labium
  - C51.2 Clitoris
  - C51.8 – C51.9 Vulva
  - C60.0 – C60.2 & C60.8 – C60.9 Penis

  Note: Dermatology physician practices are being asked to only report cases that have a skin or genital-related primary site (the sites listed above). If the practice makes the discovery of another non-GU malignancy and no other medical facility has reported it, please notify the Physician Reporting Representative. This will occur infrequently and can be handled on a case-by-case basis.

- **Cell Type/Histology:**
  - Any tumor/condition described as:
- Malignant
- Cancer
- Carcinoma (adenocarcinoma, transitional cell carcinoma, etc.)
- Sarcoma
- Melanoma
- Lymphoma
- Leukemia

- Intraepithelial Neoplasia, Grade III (8077/2) of the following sites:
  - Anal [AIN III]
  - Vaginal [VAIN III]
  - Vulvar [VIN III]

- Squamous cell carcinoma originating in a mucoepidermoid site:
  - Lip C00.1 - C00.9
  - Anus C21.0
  - Labia C51.0 - C51.1
  - Clitoris C51.2
  - Vulva C51.9
  - Vagina C52.9
  - Prepuce C60.0
  - Penis C60.1 - C60.9
  - Scrotum C63.2

- Behavior Code:
  - Tumors that are invasive (ICD-O-3 Behavior code of /3)
  - Tumors that are in-situ (ICD-O-3 Behavior code of /2)
  - If the usual behavior code is /0 (benign) or /1 (uncertain) but a pathologist designates the tumor as “in situ” or “malignant,” these cases are reportable.

- Diagnostic Confirmation (Method used to confirm the diagnosis):
  - Histologically confirmed cases (tissue examined and confirmed to be cancer)
  - Cytologically confirmed cases (fluid examined and confirmed to be cancer)
  - Clinically diagnosed cases (confirmed by means other than microscopic examination such as positive radiology or laboratory results). A diagnosis must be reported even if it has not been microscopically confirmed.
If the physician states the patient has cancer, the case is reportable.
If the diagnosis could not be definitively confirmed but is being treated as a malignancy, the case is reportable.

Section II.3: Cases NOT Required to be Reported

The following types of cases are not required to be reported:
- Prostate Intraepithelial Neoplasia, Grade III (PIN III) 8148/2
- Cervix Intraepithelial Neoplasia, Grade III (CIN III) 8077/2
- Carcinoma in situ (CIS) of the cervix only. All other in situ cases are reportable.
- Basal and Squamous cell cancers (histology codes: 8000-8110) of the skin only (site code: C44._ only). Basal cell and squamous cell cancers of any other site are reportable. Skin of labia (C51.0), vulva (C51.9), penis (C60.9) and scrotum (C63.2) are reportable.
- Patients seen only in consultation to provide a second opinion to confirm a diagnosis or a treatment plan
- Patients in remission (there is no evidence of active disease) and not receiving prophylactic or adjuvant therapy.

The NCCCR understands the scope of work required to meet these requirements. Therefore, physicians are not being asked to report cases that meet either of the following two criteria:
- It is documented that the patient was previously seen as an inpatient or outpatient at a hospital or cancer treatment facility in North Carolina for the diagnosis or treatment for this tumor.
- It is documented that the patient later went to a hospital or cancer treatment facility in North Carolina and it is known that the other facility provided management for the diagnosis or treatment of this tumor.

In this situation, the other facility must be in North Carolina and cannot be another physician’s office or treatment center not associated with a N.C. facility. Also, the other facility must have provided cancer directed management of this tumor. If the patient was seen at another facility for a condition other than this tumor, or for reasons other than the direct management of this tumor, the case must be reported by the physician.

If in doubt about whether the diagnosis meets the reportability criteria, please submit a report. This will reduce the need to report these as a missed case at a later time.

PART III: CASEFINDING

Section III.1: Purpose of Casefinding

Casefinding is a systematic method of locating all potentially eligible cases to be reported to the NCCCR. Casefinding identifies both new cases and cases that may have already been identified and reported. A tracking mechanism should be utilized to track all potential cases identified through the casefinding process. This will prevent duplicate case reporting and assist in identifying new cases that have not been reported. Only new cases that are required to be reported, but have not yet been reported by the physician practice, should be reported using the on-line Eureka Dermatology Reporting Form.

The best method of casefinding varies depending on several factors. This includes the practice specialty, patient caseload, and the availability of patient reports and logs such as; billing reports for procedures and treatments, appointment logs, and laboratory/pathology reports.
Each physician practice should have a systematic approach for identifying and reporting cases diagnosed and/or treated in the private practice.

This section will provide several suggestions for developing a comprehensive casefinding system. Please contact the NCCCR if additional help is needed. The following provides a brief summary of the steps that should be considered when developing a casefinding process.

- Determine the staff responsible for casefinding and case reporting.
  - Ideally, the staff involved should be limited in number and familiar with reportable diagnostic terms and conditions.
- Determine the casefinding reports that will be utilized and the frequency in which they will be reviewed.
  - Generate lists of potential cases using the provided ICD-9-CM codes.
  - If electronic lists are not available, review billing reports, pathology reports and appointment logs to find cases.
  - Do not rely on only one casefinding source. Use several sources of documentation (reports or logs) to identify all cases diagnosed and/or treated at the practice.
- Review all available medical information for each patient on these lists to determine whether the patient’s diagnosis is a reportable condition according to the NCCCR reporting requirements. Exclude patients that do not have a reportable condition.
- Determine and exclude patients known and documented to be seen at a N.C. hospital for direct management of \textit{this tumor}.
- Determine and exclude patients known to have already been reported by your practice for \textit{this tumor}.
- Report remaining newly reportable cases according to the reporting deadlines.
- Include the specified information for each patient and tumor (reportable and not reportable) from the casefinding lists on the tracking mechanism to assist in future casefinding efforts.
- Routinely review casefinding procedures should changes occur in computer systems or the availability of casefinding sources.

\textbf{Section III.2: ICD-9-CM Casefinding Code List}

Certain ICD-9-CM codes can be used to identify reportable cases from billing and other reports. Refer to Appendix A: ICD-9-CM Screening Codes for Casefinding for a detailed list of these ICD-9-CM codes. Casefinding procedures should include the review of reports with these specified ICD-9-CM codes. These codes are designed to identify potential cases. Apply all of the NCCCR reporting requirements and criteria and thoroughly review all available medical information before making a final determination as to whether a case is reportable or not.

Note: Appendix A provides a list of ICD-9-CM code ranges that are used to identify diagnoses reportable to the NCCCR. There are some ranges that include multiple terms (conditions); some are reportable and some are not reportable. For example, the range for 230.0-234.9 (ICD-9-CM) includes all in situ carcinomas (CIS). However, CIS of the cervix (233.1) is not reportable. Additional notes have been provided in the table to assist with isolating only reportable conditions using the ICD-9-CM codes.
Section III.3: Examples of Reports/Logs that can be used for Casefinding

The ability to generate reports or logs electronically is ideal; however, this process can also be done by manual review. Obtaining reports or logs containing data fields listed in Section III.4 will assist in tracking cases that were previously identified and submitted.

The following are examples of logs that should be considered for casefinding:

- Disease index that is created based on a range of ICD-9-CM diagnosis codes. It should include date of diagnosis, date of first visit, patient name, DOB, Social Security number and the ICD-9-CM code.
- Billing reports that generate lists of procedures or treatments given to a patient, such as bone marrow aspiration or chemotherapy. These reports might also include ICD-9-CM diagnosis codes.
- Laboratory testing logs that document tests performed or sent out for analysis, such as tissue biopsies, bone marrow aspirations/biopsies, flow cytometry, genetic testing, and tumor markers. If such a log is not maintained, then individual reports of cancer-related testing that are returned from external laboratories must be reviewed.
- Appointment reports or books from which cases may be identified.
- Treatment logs or books, such as chemo or Radiation Therapy (RT), if applicable.

Use multiple logs to perform the most comprehensive case identification. Select the reports/logs available within the medical practice that will identify cases most completely (e.g., disease index) or uniquely (e.g., laboratory logs that identify tests like PSA). The NC-CCR staff can assist in determining suitable casefinding procedures for the medical practice.

Section III.4: Tracking Reported Cases

It is recommended that the physician practice use a system to track patients identified through the casefinding process. It is important to put a system in place that allows documentation of reporting (for efficiency and to avoid duplication of reporting) and documentation of why specific patients were not reported (e.g., determined not to be a reportable cancer or the patient was seen at a N.C. hospital for management of this tumor).

The practice may develop any system it chooses for tracking case identification and reporting. A template has been provided in *Appendix B: Physician Practice Casefinding Tracking Log* that can be used by the practice. An electronic version of this log in MS Excel may be requested. The advantage of the electronic spreadsheet is the ability to use search functions to look for a specific patient on the list or to sort by a particular data field.

The log is intended as a tool for tracking patients identified and reported and will be helpful to the practice reporter(s) in the event of questions from the NCCCR. The fields included in the NCCCR template were selected because they will assist the reporter in matching patients and tumors for determining reportability. The log also describes recommended information to record in each column.

If the practice prefers to create its own tracking system, the fields included in the template should be considered for inclusion in the tracking system. If the practice decides to use an electronic tracking system, it is recommended that it be backed up regularly on a CD, external hard drive or network drive for preservation of work.
PART IV: WORKSTATION REQUIREMENTS AND PRE-CONDITIONS

Section IV.1: Workstation Requirements

The New Cases Abstract Form works with most computers and monitors. The following describes the minimum specifications:

**Operating System**
Windows XP (or newer)

**Monitor**
Data entry screens will work with any monitor, including older monitors (768 pixel width). Holding down the Control key and pressing + or – expands or shrinks the display works with most computers.

**Web access**
Internet Explorer (IE) (must be IE version 8 or older). You may experience problems if using a web browser other than Internet Explorer 32 bit.

Section IV.2: Pre-Conditions

The following must be performed on each computer being used to access Eureka. Eureka will not run properly without these changes.

Install MSXML 4.0 Service Pack 3 (Microsoft XML Core Services)

1. Go to the Microsoft MSXML 4.0 Service Pack 3 (SP3) website at:
2. Click on the [Download] button
3. Select msxml.msi and click Next
4. Follow the instructions for downloading to your computer. This will only take a few minutes to download.
Set the pop-up blocker software to allow pop-ups from https://www.eureka.ncdhhs.gov.

1. In Internet Explorer (IE), access the Pop-up Blocker Settings. The following is a screenshot using IE8 32 bit. This may be different depending on the version of IE being used.
2. Enter https://www.eureka.ncdhhs.gov
3. Click [Add]
4. Click [Close]

PART V: USER ACCOUNTS AND PASSWORDS

Accounts are granted only to staff designated by the primary contact for the physician’s office. Once accounts are established, designated staff may only enter cases for the physician’s office under which they have been granted an affiliation.

Section V.1: Request a User ID and Password

Each designated staff person must personally request his or her own user id and password by sending an email to the Eureka Accounts Representative. Passwords cannot be shared. The abstractor’s initials for the person reporting the case is tied directly to the account’s user id.

To request a user id and password, submit the following information to the Eureka Accounts Representative:

- User’s full name (first, middle initial and last) and contact information including phone number and email address.
- The physician office’s contact information including the practice name, street address, phone number and specialty.
- The physician office’s primary contact person. This may be the office manager, a designated physician or other staff person.
Accessing the Eureka Dermatology Reporting Form requires two separate passwords. Each physician’s office is also assigned a unique Facility Identification Number (FIN) that is entered for each case to specify the practice reporting the case.

Allow three to five business days to receive account information. The following information will be sent to the user via email:

- User name and password to access the North Carolina CCR Secure Access SSL VPN page
- User name and password to access the NCCCR Eureka database
- Facility Identification Number (FIN)

Upon your first log in to the VPN page and Eureka, you will be prompted to change your password to one that you designate. You will also be asked to select a security question that is used in the management of passwords. Passwords rules:

- Must be mixed case
- Must contain at least one number
- May contain special characters (#, $, %, *, etc.)
- Must be 8 characters in length
- Example: EacP4w*3

**Section V.2: Managing Passwords**

Eureka has certain requirements for password management to protect the security and integrity of the data. In addition, Eureka provides the user several options for managing his or her own passwords. If the current password has been forgotten, a user may change his or her password at any time or request a new password without the aid of an administrator. Be sure to keep any written/recorded passwords in a secure location.

**Required Password Changes:**

Passwords for the Eureka database are required to be changed every 30 days. When you login to Eureka, the system will prompt you to change your password before continuing with the login process. The last 10 passwords are retained. A previous password can be reused but only after nine other passwords have been used.

Note: The system does not require password changes to the “North Carolina CCR Secure Access SSL VPN” page. Once you have designated a password for this page, it will remain the same.

**Disabled Accounts due to Failed Login Attempts:**

Eureka will disable the user’s account if three consecutive attempts have been made to login to Eureka with an incorrect password. To unlock the user account, an email requesting the account to be reset must be sent to EurekaSupport@NCMail.net. All other support questions should be sent to the Eureka Accounts Representative. You will receive a generic password via email. Upon your next login to Eureka, you will be prompted to change your password to one that you designate.
To Change a Password:

A user can only change his or her password if the user’s account is active and has not been disabled due to failed login attempts.

1. At the Login screen for Eureka, click on “Change Password”

2. Enter your user name and current (old) password
3. Enter your new password and enter a second time to confirm
4. Click on Login

If You Have Forgotten Your Password:

5. At the Login screen for Eureka, click on “Forgot Password?”
6. An email will be sent to you containing a generic password. You will be prompted to change this password when you attempt to login.

Note: You must contact the Eureka Accounts Representative for any other password problems, including password problems on the “North Carolina CCR Secure Access SSL VPN” page.

To Change Your Security Question:

7. Login to Eureka using your username and password.
8. Click on Help from the menu bar at the top of the screen.
9. Click on Change Security Question.
10. Follow the prompts to change your security question and/or answer.
PART VI: ACCESSING THE EUREKA DERMATOLOGY REPORTING FORM

Before a user can access the Eureka Dermatology Reporting Form, each user must have a user account and the following:

- User name and password to access the North Carolina CCR Secure Access SSL VPN page
- User name and password to access the NCCCR Eureka database
- Facility Identification Number (FIN)

See Part V: User Accounts for instructions on how to obtain a user account and passwords.

Section VI.1: Logging into the NCCCR Secure Access SSL VPN Page

The website URL for Eureka is listed below. You should bookmark this link in your IE Favorites folder.

1. Go to the Eureka website at:
   https://www.eureka.ncdhhs.gov
2. Enter your user name for the NCCCR Secure Access SSL VPN Page
3. Enter your password for the NCCCR Secure Access SSL VPN Page
4. In the Realm box, use the drop down menu to select “NC Incident Hospitals.” Each time you log in, this choice should remain. However, if you have a failed login in attempt, first double-check to make sure this option was not reset to a different selection.
5. Click on [Sign In]
Section VI.2: Logging into the Eureka Database

After you have successfully logged in to the VPN, the page to login to Eureka will display.

1. Click on Eureka

2. Enter your user name for the Eureka database
3. Enter your password for the Eureka database
4. Click on [Login]
Section VI.3: Accessing the Eureka Dermatology Reporting Form

After you have successfully logged in to the Eureka database, the Eureka database home page will display.

1. On the Eureka menu bar at the top of the screen, select “File”
2. In the drop down menu, select “Enter Dermatology Report”

3. The Dermatology Report will display and you may now begin entering cases.
Section VI.4: Logging out of Eureka

After you have completed entering cases, or you need to leave the system for any reason, log out of the system completely and close your Internet Explorer browser.

1. On the Eureka menu bar at the top of the screen, select “System”
2. In the drop down menu, select “Logout”
3. On the Eureka screen, click on “Sign Out” from the icons on the right side of the screen.
4. Close your Internet Explorer browser.

PART VII: GENERAL NOTES FOR USING THE DERMATOLOGY REPORTING FORM

Section VII.1: Orientation to the Data Entry Screens

- The size of the screen can be adjusted to fit the monitor by holding down the <Control> key and pressing <+> to expand the display or pressing <-> to shrink the display.
- For consistency and ease in typing, set the <Caps Lock> to on. Entering all information in ALL CAPS is preferred.

Section VII.2: General Instructions for Using the Data Entry Screens

Defaulted Values
When a user opens a new Dermatology Report, several fields are automatically assigned a default value. Default values can and should be changed if a more appropriate value applies.

Moving from Field to Field
The <Tab> key or the mouse can be used to advance between fields. The <Enter> key can be used but will not advance to the next field while in a text box.

**Required Fields**
Fields marked with * following the field label may not be left blank. Any required fields left blank will receive an error message on submit.

In addition, any field that has a drop down menu may not be left blank. There are designated codes (values) for situations when there is no applicable information for that field. For example, if the patient’s place of birth is unknown, then select code 999 (unknown).

**Selection (Drop Down) Menus**
Selection menus are provided for data fields that are limited to a defined set of codes. For fields that provide a selection menu, the value in the field must be one of the menu box options.

Entering free text is not allowed. To open the selection menu, click on the triangle beside the data field.

There are two main types of selection menus. For the first type of selection menu, the user may:

1. Search for a menu option by entering letters or numbers of the search criteria in the Search box. The system highlights the options as the entry is typed. Keep typing to continue drilling down to a more specific option. Click <Enter> or use the mouse, to select the option and Close the menu.

2. Scroll through the options using the scroll bar on right side of box. Highlight the menu option by clicking on the desired selection.

3. Once the desired selection is highlighted, click Close to update the field with the selection. Note: For the Date Flag fields, click Update to update the field. Once a selection is made, the user cannot type in the field but can make another selection from the drop down menu.

4. For the second type of selection menu, the user may simply select an option by clicking on the menu option. The menu box will close when the selection is made.
Text Boxes

Text is critical. Most of the information being entered will be in the form of text. Some text boxes are a single row and are designated to capture specific information, such as Last Name. Some text boxes have multiple rows and allow free form text to describe the facts about the case. Refer to the specific data fields in Part VIII for a description of the requirements for each designated text box.

The following describes helpful tips for using the text boxes:

- Copy and paste from electronic medical reports is not allowed in text boxes.
- The number of characters allowed for each text box varies according to the requirements for the data item. Hover over the text box with the mouse pointer to display a message specifying the maximum amount of characters allowed for that text box. The system will display an alert and text is cut off after the maximum number of allowed characters has been reached.
- Do not use the <Enter> key within a text area to go to the next line as this interferes with data transmission conducted later by NCCCR staff. Instead, use periods to separate sentences and paragraphs.
- Use the <TAB> key or the mouse to move to the next field.

Date Fields

Dates are entered in month, day and year (MMDDYYYY) format. Slashes between month, day and year numbers can be entered but are not required.

Unknowns should be avoided. If an exact date is unknown, try to estimate as closely as possible, even if it is only the year. An attempt to estimate at least the year should be done. A reasonable estimate is better than unknown.

Eureka will accept partial dates. Record as much as can be determined using the following as a guideline:

- If the complete date is known or can be estimated, enter the full 8-digit date; for example, 08012012.
- If only the month and year are known or can be estimated, enter the 6-digit date for the month and year only; for example, 082012.
- If only the year is known or can be estimated, enter the 4-digit year; for example, 2012.

Date fields may only be used to specify a complete or partial valid date (one that can be referenced on a calendar). In situations where a valid date is unknown or not applicable, the date field is to be left blank. The date field may be left blank only under the following conditions:

- None of the date information can be determined or estimated. The month, day and year are unknown.
- The date is not applicable. For example, the patient did not receive radiation therapy therefore, a radiation therapy start date is not applicable.
Date Flag Fields

For certain date fields, a **special date flag field** has been provided to explain why the date field was left blank. If the date field is being left blank, and that date field has an associated date flag, a **date flag code** must be selected to indicate why the date is unknown or not applicable.

A Date and a Date Flag cannot both be entered. They are mutually exclusive where only one or the other can be used. Entering one will set the other to blank. If a date is applicable, the flag field will be set to blank automatically.

To select the **date flag code**, open the selection menu, click on the appropriate code and then click **[Update]**. The **[Close]** button merely closes the box and does not enter the selection for the date flag.

The table below describes when each date flag code should be used. Remember that a flag code is only assigned when the associated date field is being left blank.

<table>
<thead>
<tr>
<th>Code</th>
<th>When to Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Entered/Not Expected</td>
<td>This is used by the system to indicate that the flag is being left blank. In this situation, there must be a complete or partial valid date in the associated date field.</td>
</tr>
<tr>
<td>Code 10</td>
<td>Use this code if it is unknown if this event occurred. In this situation, the event would be indicated or suspected but confirmation that the event took place could not be confirmed. For example, the patient was referred for a radiation therapy consult but it is unknown if treatment was recommended.</td>
</tr>
<tr>
<td>Code 11 (most commonly used code)</td>
<td>Use this code when it is known that the event did not occur. Therefore, a valid date is not applicable.</td>
</tr>
<tr>
<td>Code 12 (avoid unknown, estimate if possible)</td>
<td>Use this code when it is known that the event occurred but a valid date (complete or partial) is not known and could not be estimated. In this situation, the date is entirely unknown. This should be avoided. Estimating is preferred over coding unknown.</td>
</tr>
<tr>
<td>Code 15 (try to wait until the date is known)</td>
<td>Use this code when it is expected that the event will occur in the future but has not yet occurred. For example, it is known that radiation therapy was recommended but the treatment had not started at the time of entering the case. Note: It is preferred that the user wait to enter the case until the start</td>
</tr>
</tbody>
</table>
PART VIII: ENTERING INFORMATION INTO THE DERMATOLOGY REPORT FORM

Before beginning a new report, read the following **VERY IMPORTANT** information:

A separate report must be completed and submitted for each independent primary tumor. For example, if a patient is diagnosed with bladder cancer and a separate kidney cancer, a separate report must be submitted for each diagnosis. Please complete the Eureka Dermatology Reporting Form as **ACCURATELY** and **COMPLETELY** as possible. Once the report is free of errors and is successfully submitted, it is considered as having been reported to the NCCCR.

Before opening a new reporting form and beginning data entry:
- Make sure all information necessary for entering the case is available and on hand
- Review the chart in its entirety
- Make notes on a notepad or scrap paper if necessary to facilitate data entry
- Confirm any information that is confusing or unclear with the physician

*Session times out after 30 minutes if no activity takes place.* All information entered for the case (and not submitted) will be lost. All information necessary for completing the case should be on hand prior to beginning data entry for that case.

*There is a Save function.* Cases are not submitted until the case is completely entered, one of the Submit options is selected, and all error messages are cleared. If it is known that more information is needed or will be forthcoming, hold the case for a later time. Do not start data entry. Cases started, but not completed, can be accessed at a later time.

*Treatment information is very important.* Please wait to enter the report until after the treatment plan is established and the start dates for each treatment modality are known. It is not required that all treatment be completed as treatment may continue for months or years. For patients that refuse treatment, do not receive treatment for any reason or when there is a decision not to treat (watchful waiting or active surveillance) specifically record that decision of why there was no treatment in the treatment text area.

*Text is CRITICAL!* Over 100 additional data items will be coded by the NCCCR staff after the report is submitted. This coding is highly dependent on the text provided. Provide as much information and detail as possible to describe the case, as this is critical to the accuracy and completeness of the final coding for the reported case.

A screen shot for each tab is provided below along with a table that lists each data field on that tab and any additional coding instructions. Each screen shot shows an example of what a completed screen would look like using a hypothetical prostate case. Pay particular attention to the format and content of the text areas used to describe the case.
- * Indicates a required field.
- Text boxes allow a limited number of characters. Hover over the box with the mouse pointer to display the maximum number of characters allowed.
Section VIII.1-2: Entering Patient Personal & Diagnostic Data on the Patient/Dx/Stage tab

<table>
<thead>
<tr>
<th>Data Field Name</th>
<th>Special Coding Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name*</td>
<td>Special characters (, / : ' ~ @ # &amp; *) are not allowed in name fields. Enter the name without special characters. For example, enter OHARA for O’Hara.</td>
</tr>
<tr>
<td>First Name*</td>
<td>Letters, numbers and periods only are allowed.</td>
</tr>
<tr>
<td>Middle</td>
<td></td>
</tr>
<tr>
<td>Suffix</td>
<td></td>
</tr>
<tr>
<td>SSN*</td>
<td>The SSN can be entered with or without hyphens. Unknown should be avoided. 999-99-9999 is only allowed if the patient refused to provide his or her SSN.</td>
</tr>
<tr>
<td>Sex/Gender*</td>
<td>Unknown should be avoided.</td>
</tr>
<tr>
<td>Insurance</td>
<td></td>
</tr>
<tr>
<td><strong>Birth Date</strong>&lt;sup&gt;*&lt;/sup&gt;</td>
<td>Date of birth may not be blank or unknown.</td>
</tr>
<tr>
<td>--------------------------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td><strong>Place of Birth</strong></td>
<td>Code 999 (unknown) if not specifically stated. Do not assume patient was born in the United States</td>
</tr>
<tr>
<td><strong>Race</strong>&lt;sup&gt;*&lt;/sup&gt;</td>
<td>Unknown should be avoided if at all possible. Race is very important in demographic studies. Request that this be dictated by the physician if not requested from the patient on the pre-visit paperwork.</td>
</tr>
<tr>
<td></td>
<td>- If patient is multiracial and one race is white, code the other race.</td>
</tr>
<tr>
<td></td>
<td>Persons of Spanish or Hispanic origin may be of any race.</td>
</tr>
<tr>
<td><strong>Spanish Origin</strong></td>
<td>If the patient is of Spanish or Hispanic origin, select the code that describes the specific origin.</td>
</tr>
<tr>
<td></td>
<td>- Use Code 0 (Non-Spanish) if there is no indication that patient is of Spanish/Hispanic Origin.</td>
</tr>
<tr>
<td></td>
<td>- Use Code 6 (Spanish/Hispanic NOS) if there is evidence (other than surname or maiden name) that the person is Hispanic, but cannot be assigned to the category in codes 1–5.</td>
</tr>
<tr>
<td></td>
<td>- Use Code 7 (Spanish Surname) when it is unknown if the patient is of Spanish/Hispanic Origin but the patient has a Spanish/Hispanic Surname.</td>
</tr>
<tr>
<td><strong>Industry and Occupation</strong></td>
<td>Record the occupation and industry where the patient worked for the majority of his or her lifetime.</td>
</tr>
<tr>
<td></td>
<td>Example: Industry: Education, Occupation: Teacher</td>
</tr>
<tr>
<td></td>
<td>- If the usual occupation is not clear, enter the current occupation.</td>
</tr>
<tr>
<td></td>
<td>- If no information is known about the patient's occupation, leave blank. Do not record “Unknown.”</td>
</tr>
<tr>
<td></td>
<td>- If the patient is a minor, or a student, or has never held an occupation (such as a homemaker), record “Minor,” “Student” or “Never Worked.”</td>
</tr>
<tr>
<td><strong>Address at diagnosis</strong></td>
<td>- Record the primary residence for the patient at the time of diagnosis. The address should be fully spelled out with standardized use of abbreviations and punctuation per U.S. Postal Service postal addressing standards. This is not necessarily the same as the patient’s current address.</td>
</tr>
<tr>
<td></td>
<td>- If it is known that the patient was living at a different address at the time of diagnosis, enter as much as is known and record “UNKNOWN” in the remaining address fields. For example, if all that is known is the city, then enter the city, state and ZIP and enter “UNKNOWN” in the street address.</td>
</tr>
<tr>
<td></td>
<td>- If no information regarding the address at diagnosis is known, then enter the current address. This is preferred over recording the address as entirely unknown.</td>
</tr>
</tbody>
</table>
### City*  

### State*  

### Zip Code*  

If the last 4 digits of the zip code are known, enter them preceded by a hyphen.

### County*  

Use the drop down menu to make a selection. Type the county name to begin the search. Special Codes:

- 998 – Residence not in North Carolina. The address at diagnosis was a state other than North Carolina.
- 999 - County is unknown. This is only allowed if the city is unknown.

### Date of Last Appointment  

This is the last date the patient was seen at your office, regardless of the reason for the visit or the disease status. This should not be blank or unknown.

### Vital Status  

The Vital Status should remain “Alive” unless there is documentation of the patient’s death prior to reporting the case.

### Date of Death  

If Date of Death is entered, it must be the latest date entered in the record.

### Date of Death Flag  

- If Vital Status is Alive, leave the default flag of 11.
- If Vital Status is Dead, set the flag to12 ONLY if exact date is not known.
- If the date of death is known, this flag should be left blank.

Refer to Section VII.2: General Instructions for Using the Data Entry Screens for more information on how to complete the Date and Date Flag fields.

<table>
<thead>
<tr>
<th>Data Field Name</th>
<th>Special Coding Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Site</strong>*</td>
<td>Select the organ/tissue in which the primary tumor arose/originated. Only the codes for dermatology related sites have been provided in the drop down menu.</td>
</tr>
</tbody>
</table>
| **Date of Dx*** | Enter the first date it was stated the patient had this cancer. This may be a physician's statement of diagnosis or it may be based on the results of a diagnostic test or procedure.  
- Date of Diagnosis cannot be blank or unknown and must be the earliest of all dates except for Birth Date.  
- Estimate as closely as possible if an exact date is unknown. At least a valid year must be recorded.  
- If there is absolutely no information to even estimate the year, record the same year as the patient’s first visit to your office.  
Refer to Section VII.2: General Instructions for Using the Data Entry Screens for more information on how to complete the Date and Date Flag fields. |
Use free text in the following designated text areas to describe the results/findings of any diagnostic workup, staging workup, biopsies, and surgical procedures performed.

For each procedure, record the date of the procedure, the procedure name, the place where the procedure took place and the pertinent results/findings of the procedure. This should include pertinent negative findings in addition to positive findings. Example:

10/19/2011, CT ABD/CHEST, DERM ASSOC. LESION ON SKIN LT CHEST. NO ADENOPATHY. NO MET DZ SEEN.

<table>
<thead>
<tr>
<th>Physical Exam</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Include age, race and sex of patient.</td>
</tr>
<tr>
<td>• Include pertinent information from the H&amp;P including the evaluation of the location and extent of the tumor and other symptoms that may suggest further disease spread.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>X-Rays</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Include the results of any imaging tests performed to evaluate the tumor in the Other Staging text area.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Scopes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Include the results of any endoscopies, ultra-sounds, etc in the Other Staging text area.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Histology*</th>
<th>Select the code that best describes the histology of the tumor. Only histologies that commonly arise in dermatology related sites have been provided in the drop down menu.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Record the histology based on the <strong>FINAL DIAGNOSIS</strong> (this includes addendums, comments and revised/amended diagnoses) of the pathology report that contained the most representative tumor specimen examined.</td>
<td></td>
</tr>
<tr>
<td>• If there was not a pathology report, use the following priority order to identify which report best represents the histology to be coded.</td>
<td></td>
</tr>
<tr>
<td>• Cytology report</td>
<td></td>
</tr>
<tr>
<td>• Documentation in the record that references pathology or cytology findings</td>
<td></td>
</tr>
<tr>
<td>• Any mention of the type of cancer (histology) in the medical record.</td>
<td></td>
</tr>
<tr>
<td>• If the exact histology is not listed in the menu, select the term that best matches the histology. If that cannot be done, code to 80003, Malignancy NOS.</td>
<td></td>
</tr>
<tr>
<td>• <strong>Note:</strong> It is very important to enter the description of the site and histology EXACTLY as stated in the pathology report (or record).</td>
<td></td>
</tr>
</tbody>
</table>

Pay particular attention to the behavior code in the drop down list. The behavior code is the number at the end of each code. Many terms are listed...
twice, once as in situ (ends with 2) and another as invasive (ends with 3). Select the code with the appropriate behavior code to describe whether the tumor was in situ (/2) or invasive (/3).

<table>
<thead>
<tr>
<th>Laterality*</th>
<th>If the primary site is a bilateral organ, the side in which the tumor originated (laterality) must be specified. The following are the paired organs for dermatology related sites only.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>* C44.1 Skin of eyelid</td>
</tr>
<tr>
<td></td>
<td>* C44.2 Skin of external ear</td>
</tr>
<tr>
<td></td>
<td>* C44.3 Skin of other and unspecified parts of face</td>
</tr>
<tr>
<td></td>
<td>* C44.5 Skin of trunk</td>
</tr>
<tr>
<td></td>
<td>* C44.6 Skin of upper limb and shoulder</td>
</tr>
<tr>
<td></td>
<td>* C44.7 Skin of lower limb and hip</td>
</tr>
<tr>
<td></td>
<td>* Use code 0 for all other non-paired organs</td>
</tr>
<tr>
<td></td>
<td>* Use code 4 if the following conditions are met (e.g., bilateral Wilm’s tumors):</td>
</tr>
<tr>
<td></td>
<td>* there was bilateral involvement at time of diagnosis, it contained the same histology, and it is considered a single primary.</td>
</tr>
</tbody>
</table>

| Tumor Status | At the time of the last visit to your office, indicate whether the patient had evidence of this disease or was considered disease free.                                                                                                                         |
| Tumor Size   | Record the largest dimension or diameter of the primary tumor.                                                                                                                                                                                                |
|             | * Must be exactly three numbers. Enter leading zeroes to equal three numbers.                                                                                                                                                                                 |
|             | * Record the tumor size in millimeters.                                                                                                                                                                                                                      |
|             | * Convert centimeters to millimeters by multiplying the dimension by 10.                                                                                                                                                                                       |
|             | * Tumor is 2.5 cm. Record as 025 (2.5 cm = 25 mm)                                                                                                                                                                                                             |
|             | * Tumor is 4 cm. Record as 040 (4 cm = 40 mm)                                                                                                                                                                                                                  |
|             | * Round up or down to the nearest millimeter                                                                                                                                                                                                                 |
|             | * Tumor is 6.5 millimeters. Record as 007 (round up)                                                                                                                                                                                                          |
|             | * Tumor is 2.3 millimeters. Record as 002 (round down)                                                                                                                                                                                                        |
|             | Record 999 if the tumor size is unknown or not stated.                                                                                                                                                                                                        |

Use free text in the following designated text areas to describe the facts.
about the stage (extent of disease) of the cancer at the time of diagnosis.

- These 3 text areas may not be left blank. This information will be used by the NCCCR staff to code 42 data items related to the stage of the tumor.

- Be as specific as possible, even if it means repeating information from the previous tab.

- Include descriptive words such as consistent with, probably, suggests, with features of, abutting, extending to, etc.

- Enter “NONE” to indicate there was no information available from the workup to evaluate that particular extent of disease (extension, Mets at Dx, or lymph node involvement.

- Summarize the extent of the disease using all of the workup performed (clinical and pathologic). This includes the findings from the physical exam, imaging, scopes, lab work, biopsies, surgeries, etc.

For these 3 text areas, the date or place of the procedure does not need to be repeated unless it is needed to clarify the information.

<table>
<thead>
<tr>
<th>From all of the workup performed, summarize the extent of the primary tumor. Summarize the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Tumor size</td>
</tr>
<tr>
<td>- Involvement within the primary organ</td>
</tr>
<tr>
<td>- Extension into surrounding tissues.</td>
</tr>
</tbody>
</table>

| Mets at Dx* | From all of the workup performed, summarize any evidence of metastatic disease present at the time of diagnosis. It is very important to differentiate metastatic disease present at the time of diagnosis and metastatic disease discovered after initial diagnosis and treatment. |

<table>
<thead>
<tr>
<th>Lymph Node Involvement*</th>
<th>From all of the workup performed, summarize any evidence of regional lymph node involvement present at the time of diagnosis. Summarize the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Name of the lymph node chain involved</td>
<td></td>
</tr>
<tr>
<td>- Number of lymph nodes involved</td>
<td></td>
</tr>
<tr>
<td>- Number of lymph nodes examined</td>
<td></td>
</tr>
<tr>
<td>- Any documentation that the lymph nodes were evaluated and were negative.</td>
<td></td>
</tr>
</tbody>
</table>
Section VIII.3: Entering Facility Data on the Office/Provider/Facilities

![Image of the Create Dermatology Cancer Registry Report form]

<table>
<thead>
<tr>
<th>Data Field Name</th>
<th>Special Coding Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility information</td>
<td>Must be entered by the user each time the user logs on to the Eureka system. Facility information only needs to be entered for first case entered. Both Submit buttons will retain the facility information for subsequent cases entered during this active session.</td>
</tr>
<tr>
<td>Facility Name*</td>
<td>Enter the official name of the facility you are reporting cases for.</td>
</tr>
<tr>
<td>Address 1* and Address 2</td>
<td>Post Office Box addresses are not accepted for Facility address.</td>
</tr>
<tr>
<td>City*</td>
<td></td>
</tr>
<tr>
<td>State*</td>
<td></td>
</tr>
<tr>
<td>Zip*</td>
<td></td>
</tr>
<tr>
<td>County*</td>
<td>Use the drop down menu to make a selection. Type the county name to begin the search. <strong>Unknown is not allowed.</strong></td>
</tr>
</tbody>
</table>

Electronic Reporting for Dermatology Physician Practices (March 2014) 29
| Facility #* | Select the Facility Identification Number assigned to the physician office in which you are reporting cases. This was the number assigned to your office when you requested a Eureka account. |

If the patient was seen at another hospital, treatment center or physician’s office for the management of *this tumor*, select the appropriate code for Referred From or Referred To from the drop down menu.

- If the facility or physician’s office for the Referred From or Referred To fields was not an available option in the associated selection boxes, leave the default of 0000000000 and record the name of the facility in the Remarks text section.
- There are several special codes for when the exact facility name is not known or the patient was referred out of state. Search the menu options carefully before making a final selection.

| Referred From | Patient seen elsewhere for management of this tumor *before* visit at your office. If the patient was not referred, leave the default of 0000000000. |
| Referred To | Patient seen elsewhere for the management of this tumor *after* visit at your office. If the patient was not referred, leave the default of 0000000000. |
| Attending MD | Enter the name of the physician at your office caring for the patient. |
| Surgeon | Enter the name of the physician who performed the cancer-directed surgery for the treatment of this tumor. |
| NPI Numbers | For each facility and physician recorded above, enter their NPI number assigned by CMS. |

- This must be entered as a 10-digit number.
- To obtain NPI numbers for your office and other local providers start with the billing department. It may be helpful to create a list of numbers for physicians and hospitals commonly participating in the care of your patients to have on hand when entering cases.
- For NPI numbers not available by the billing department, use the Centers for Medicare and Medicaid Services (CMS) website. The Data Dissemination page provides further links to access a searchable database where you can search for individual providers.
- Click on "Data Dissemination."
| Place of Dx | Enter the facility, treatment center or physician’s office that performed the first test or made the first statement that confirmed this diagnosis.  
- If this was at your office, then enter your office name.  
If this is unknown, then record UNKNOWN. |
Section VIII.4: Entering Tumor Data on Diagnostic Test tab

<table>
<thead>
<tr>
<th>Data Field</th>
<th>Special Coding Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dx Confirmation</td>
<td>Select the code that describes the best diagnostic method used to <strong>confirm</strong> the cancer being reported.</td>
</tr>
<tr>
<td></td>
<td>• The codes are listed in <strong>priority order</strong>. Code 1 has the highest priority.</td>
</tr>
<tr>
<td></td>
<td>• If the presence of cancer is confirmed with multiple diagnostic methods, select the code with the lower numeric value.</td>
</tr>
<tr>
<td></td>
<td>• Code 1 (positive histology) includes: Tissue specimens from biopsy, frozen section, surgery, autopsy or D&amp;C, aspiration or biopsy of bone marrow.</td>
</tr>
<tr>
<td></td>
<td>• Code 2 (positive cytology) includes: Cytologic examination of <strong>cells</strong> such as sputum smears, bronchial brushings, bronchial washings, prostatic secretions, breast secretions, gastric fluid, spinal fluid, peritoneal fluid, pleural fluid, urinary sediment, cervical smears and vaginal smears, or from paraffin block specimens from concentrated spinal, pleural or peritoneal fluid.</td>
</tr>
<tr>
<td>Lab Values</td>
<td>• In addition to the lab test and result, state whether the test was considered to be <strong>normal</strong>, <strong>abnormal</strong>, or <strong>not performed</strong>.</td>
</tr>
</tbody>
</table>
Only lab tests that are diagnostic or prognostic for that primary site need to be summarized. Examples include CA-125, CEA, PSA, etc.

Routing blood tests such as CBC do not need to be included.

**Path/Autopsy**
This section is very important. Include the findings from all cytologic (FNA, brushings, etc.) and histologic (biopsy, surgical resection, etc.) examinations performed. Clearly separate each procedure and findings with separate statements. In addition to the basic text elements such as date, procedure, place and findings, include the status of the following:

- Final diagnosis as written on the report
- Location of the tumor (primary site and laterality)
- Histology (EXACTLY as stated on the report)
- Behavior (invasive or in situ)
- Grade including site specific grade such as Gleason
- Tumor size
- Tumor extension into other surrounding tissues
- Surgical margins
- Number of lymph nodes removed and positive
- Examination of metastatic tissues
- Ancillary studies such as tumor markers

Relevant findings from the gross examination including aids in identifying the primary site and extent of disease

**Remarks**

Required text: This is very important in making sure the best site and histology codes are recorded during final coding by the NCCCR staff. Record the following EXACTLY as stated in the medical record:

- Primary site, including exact sub site and laterality.
- Histology, including whether it was invasive or in situ, and the grade (including site specific grading systems).
- Include descriptive phrases such as consistent with, probably, suggests, with features of, abutting, extending to, etc.

In addition, use this area to provide the following information:

- Record the date of diagnosis and primary site for any other primaries this patient has had in his or her lifetime, regardless if it is being reported by your office.
- If the facility for the Referred From or Referred To fields was not an available
option in the associated selection boxes, record the name of the facility here. For example, “Referred from Any Town Hospital.”

- Use this text area to provide any additional pertinent information about this case.

Section VIII.5: Entering Tumor Data on Treatment tab

<table>
<thead>
<tr>
<th>Data Field Name</th>
<th>Special Coding Instructions</th>
</tr>
</thead>
</table>
| Surgery Date, Flag, Text | Record the first date cancer-directed surgery was performed as part of the first course of therapy.  
- If multiple surgical procedures were performed, record the date of the first surgical procedure.  
- Do not include biopsy dates unless the biopsy removed the entire tumor.  
In the Remarks text area, describe as much as is known about the following:  
- Procedure date  
- Place/facility performed  
- Name of procedure including lymph node resections  
It is important to delineate the specific details for each procedure performed. While biopsies are not included in the Surgery Date, a summary of any biopsies should be  |

Each procedure must include a date.
Definition of First Course of Treatment:
First course of treatment includes all methods of treatment recorded in the treatment plan and administered to the patient at the time of the initial diagnosis and before disease progression or recurrence. A treatment plan describes the type(s) of therapies intended to modify or control the malignancy. The documentation confirming a treatment plan may be found in several different sources; for example, medical or clinic records, consultation reports and outpatient records. All therapies specified in the physician(s) treatment plan are a part of the first course of treatment if they are actually administered to the patient.

An established protocol or accepted management guidelines for the disease can be considered a treatment plan in the absence of other written documentation. If there is no treatment plan, established protocol or management guidelines--and consultation with a physician advisor is not possible--only record treatment that begin within four months of the date of initial diagnosis.

PART IX: FINALIZING AND SUBMITTING THE DERMATOLOGY REPORT FORM

Section IX.1: Final Review

Perform a final review of all information on each tab to ensure the record is complete and accurate and all information has been entered. DOUBLE CHECK THE FACILITY NUMBER. Once the case is submitted, further revisions to the case cannot be made.

Section IX.2: Submit Options

There are two [SUBMIT] options. Each option will prepare the report for the next case. With either option, the Facility specific information will be retained and does not need to be entered again during this active session. When all information has been entered and verified, select the appropriate [SUBMIT] button.
1. **Submit & Clear** for Next Patient (most common choice)
   - Use this option if the next case is for a DIFFERENT patient.
   - Clears all data from the Demographic, Dx/Staging and Tumor Data Tabs.
   - All default values are restored.

2. **Submit & Retain** Info. for Second Primary Cancer
   - Use this option if the next case is for a DIFFERENT primary cancer for the SAME patient. For example, the patient has more than one primary cancer that needs to be reported.
   - Prior to clicking on this [SUBMIT] button, the user may check the “Keep Patient Address” check box on the DX/Staging Tab to retain the current address information.
     - Important: This can be a real time saver but MUST be cleared when entering a different patient.
   - Clears all data from the Dx/Staging and Tumor Data Tabs.
   - All default values are restored.
   - On the Demographic Tab, all Patient Personal Data is retained.

Section IX.3: Clearing Quality Check Errors

Certain quality checks have been included in the Dermatology Reporting Form. When a [SUBMIT] option is selected, the system will check for required fields, valid values and conflicts in logic. When an error is detected, the user will be notified of the error at the top of the Reporting Form. Error messages will display in red and are listed in the same order as the fields in each tab. All error messages must be cleared by making the appropriate correction to the data. Required fields cannot be left blank and will generate an error message. All required field errors must be cleared before logic error messages can be displayed.

If there are errors, correct all errors listed and select the desired [SUBMIT] button again. Continue this process until all errors have been corrected and the case is error free. In some cases, clearing one error may create a different error. It may take a few cycles to clear all errors. Tips for clearing the error are included with the error message.
When the case is error free, and one of the [SUBMIT] options has been selected, the program will submit the report to the NCCCR database. There will not be a “Report Submitted” message. Upon successful submission of a report, the system will display a new report form ready for a new case to be entered. The application returns to the first tab (the Office/Provider/Facility tab) and all defaults are applied.
PART X: CONTACT INFORMATION

For assistance or questions regarding case eligibility, reporting requirements, data entry, the Eureka system, or the Administrative Reporting Laws, please contact: the NC Central Cancer Registry at 919-733-4728.

For assistance **unlocking a user account**, an email requesting the account to be reset must be sent to EurekaSupport@dhhs.nc.gov. All other support questions should be sent to the Eureka Accounts Representative.

For assistance with passwords or to request a new account user id and password, please contact the Eureka Accounts Representative: Nichole Baker, 919-716-0122, Nichole.Baker@dhhs.nc.gov.

PART XI: PERTINENT WEBSITE INFORMATION

**Eureka (NCCCR Database):**
https://www.eureka.ncdhhs.gov

**The North Carolina Central Cancer Registry Website:**
http://www.schs.state.nc.us/units/CCR/

The cancer registry utilizes several resources for ensuring consistent and accurate data collection and coding. These resources include a brief description of the resource and the website address to access and/or download the resource. All information needed to report eligible cases using the Eureka Dermatology Reporting Form has been provided in this document. More detailed information may be sought from these additional resources.

**NCCCR Cancer Collection and Reporting Manual (CCARM):**
http://www.schs.state.nc.us/units/CCR/reporting.htm

A free, downloadable manual that provides a detailed description of the reporting requirements, eligibility criteria and the coding instructions for each data item required to be collected by the NCCCR. All information needed to report eligible cases using the Eureka Dermatology Reporting Form has been provided in this document. More detailed information may be sought from these additional resources.

**Collaborative Stage Data Collection System:**
www.cancerstaging.org/cstage/manuals/index.html

A free, on-line reference tool that provides a unified data collection system designed to meet all of the necessary requirements to derive the two main staging systems used in cancer surveillance: AJCC TNM and SEER Summary Stage. Contains a medically relevant set of data items that describe how far a cancer has spread at the time of diagnosis. This can be useful for determining what information is pertinent to be documented in the text so that the stage can later be coded by the NCCCR staff based on the provided text.

**SEER*Rx- Interactive Antineoplastic Drugs Database:**

This is a free, downloadable database that provides a one-step lookup for coding oncology drug and regimen treatment categories in cancer registries. This can be useful for determining if a drug should be classified as chemotherapy, hormone therapy, immunotherapy (BRM), radiation therapy or other type of treatment in the report.
SEER Multiple Primary and Histology Coding Rules:
This is a free, downloadable manual that contains the rules and instructions that guide and standardize the process of determining the number of primaries and the histology for solid tumors when multiple tumors or multiple histologic terms are involved. This can be useful for determining how many reports for the SAME patient should be reported in cases where there is more than one tumor or there is a question as to the number of reportable primary cancers.

SEER Hematopoietic Database:
This is a free, downloadable database that contains the reportability instructions and rules for determining the number of primaries, the primary site and histology and the cell lineage or phenotype for hematopoietic neoplasms. This can be useful for determining how many reports for the SAME patient should be reported in cases where there is more than one tumor or there is a question as to the number of reportable primary cancers.

WHO International Classification of Disease for Oncology, 3rd Edition (ICD-O-3)
Year 2000
ICD-O is a dual classification used principally in cancer registries with coding systems for both topography (site) and morphology (histology). This publication is not available for download or for free. A copy of the ICD-O-3 may be purchased directly from the World Health Organization at:
http://apps.who.int/bookorders/anglais/detart1.jsp?sesslan=1&codlan=1&codcol=15&codcch=3350

ISBN-10: 9241545348
Order Number: 11503350
Price: U.S. $72.00
Appendix A: ICD-9-CM Screening Codes for Casefinding
(Includes updates through October 1, 2013 to September 30, 2014)

The following lists are intended to assist in identifying reportable neoplasms in casefinding source that use ICD-9-CM or CD-10-CM codes to codify the diagnoses. Revision and updates to these codes are released annually. This list should be reviewed annually and any changes made. Casefinding should include a review of the primary diagnoses as well as all subsequent or secondary diagnoses that can be generated by the report.

Note: For the code range, "_" is used to designate the range of 0-9. For example, code 173._0 includes 173.00, 173.10, 173.20, 173.30, 173.40, 173.50, 173.60, 173.70, 173.80, 173.90.

Table 1: Specific codes for reportable neoplasms and cancer treatment related visits required for review

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>140._ - 172.<em>, 174.</em> - 205.36, 209.7_</td>
<td>Malignant neoplasms (excluding category 173), stated or presumed to be primary (of specified sites) and certain specified histologies¹</td>
</tr>
<tr>
<td>173.00, 173.09</td>
<td>Unspecified/other malignant neoplasm of skin of lip</td>
</tr>
<tr>
<td>173.10, 173.19</td>
<td>Unspecified/other malignant neoplasm of eyelid, including canthus</td>
</tr>
<tr>
<td>173.20, 173.29</td>
<td>Unspecified/other malignant neoplasm of ear and external auricular canal</td>
</tr>
<tr>
<td>173.30, 173.39</td>
<td>Unspecified/other malignant neoplasm of skin of other/unspecified parts of face</td>
</tr>
<tr>
<td>173.40, 173.49</td>
<td>Unspecified/other malignant neoplasm of scalp and skin of neck</td>
</tr>
<tr>
<td>173.50, 173.59</td>
<td>Unspecified/other malignant neoplasm of skin of trunk, except scrotum</td>
</tr>
<tr>
<td>173.60, 173.69</td>
<td>Unspecified/other malignant neoplasm of skin of upper limb, including shoulder</td>
</tr>
<tr>
<td>173.70, 173.79</td>
<td>Unspecified/other malignant neoplasm of skin of lower limb, including hip</td>
</tr>
<tr>
<td>173.80, 173.89</td>
<td>Unspecified/other malignant neoplasm of other specified sites of skin</td>
</tr>
<tr>
<td>173.90, 173.99</td>
<td>Unspecified/other malignant neoplasm of skin, site unspecified</td>
</tr>
<tr>
<td>225.0 - 225.9</td>
<td>Benign neoplasm of brain and spinal cord neoplasm</td>
</tr>
<tr>
<td>227.3, 227.4</td>
<td>Benign neoplasm of pituitary gland, craniohypophyseal duct (pouch) and pineal gland</td>
</tr>
<tr>
<td>228.02</td>
<td>Hemangioma; of intracranial structures</td>
</tr>
<tr>
<td>228.1</td>
<td>Lymphangioma, any site (Note: Includes only lymphangioma of the brain, other parts of nervous system and endocrine gland)</td>
</tr>
<tr>
<td>230.0-234.9</td>
<td>Carcinoma in situ</td>
</tr>
<tr>
<td>237.0-237.1</td>
<td>Neoplasm of uncertain behavior of endocrine glands and nervous system: pituitary gland, craniohypophyseal duct and pineal gland</td>
</tr>
<tr>
<td>237.5, 237.6, 237.9</td>
<td>Neoplasm of uncertain behavior of endocrine glands &amp; nervous system: brain &amp; spinal cord, meninges, endocrine glands &amp; other &amp; unsp. parts of nervous system</td>
</tr>
<tr>
<td>238.4</td>
<td>Polycythemia vera</td>
</tr>
<tr>
<td>238.7</td>
<td>Other lymphatic and hematopoietic diseases</td>
</tr>
<tr>
<td>239.6, 239.7</td>
<td>Neoplasms of unspecified nature, brain, endocrine glands and other parts of nervous system</td>
</tr>
<tr>
<td>273.3</td>
<td>Macroglobulinemia (Waldenström’s macroglobulinemia)</td>
</tr>
<tr>
<td>277.89</td>
<td>Other specified disorders of metabolism (Reportable includes terms: Hand-Schüller-Christian disease; histiocytosis (acute)(chronic); histiocytosis X (chronic))</td>
</tr>
</tbody>
</table>

¹Note: 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)

Notes:
173._ Skin (C44._ ) with histology codes 8000-8110 is only reported if diagnosed prior to 1/1/03 and the AJCC stage group at diagnosis was II (T3), III or IV.
Melanoma of skin should be coded to 172_. _ 173 codes should still be screened.
2009 Neuroendocrine tumors (includes carcinoid tumors)
  ° 209.0-209.3 includes the malignant carcinoid tumors
  ° 209.11 Malignant carcinoid tumor of the appendix can be excluded as these are not reportable.
## Appendix B: Physician Practice Casefinding Tracking Log

<table>
<thead>
<tr>
<th>Medical Record #</th>
<th>Last Name</th>
<th>First Name</th>
<th>Date of Birth</th>
<th>ICD-9-CM Code</th>
<th>Type of Cancer (Primary Site)</th>
<th>Date of Diagnosis</th>
<th>Date of First Visit</th>
<th>Last Date Record Reviewed</th>
<th>Date Submitted to NC CCDB</th>
<th>Reason not Submitted to NC CCDB / Other Comments</th>
<th>NC Hospital that managed this Tumor</th>
<th>Hospital Name</th>
<th>Hospital Visit Date</th>
</tr>
</thead>
</table>

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Electronic Reporting for Dermatology Physician Practices (March 2014)