Missouri Cancer Registry

Low Volume Facility Manual

Effective
2/1/2024

Contents

INTRODUCTION

Role of Hospitals

The primary source for obtaining epidemiological information is the hospital cancer registry. A registry is responsible for providing a listing of cancer patients and pertinent information regarding their diagnoses. A registry may be small or large, and the extent of information submitted varies, depending on hospital size and the reporting methods for each facility. Some hospitals have had their own registries for years in accordance with the American College of Surgeons- Commission on Cancer (ACoS-CoC) requirements, while others have limited registries and collect or provide only the state mandated reporting requirements. As a "Low Volume Facility" (LVF) you identify cancer cases seen for diagnosis or treatment at your facility and provide us with copies of pertinent information from your medical record. MCR staff then abstract into registry software at our offices. To qualify as an LVF, your facility must have less than 50 cancer cases per year and not be part of a larger hospital system employing a cancer registrar. Small hospitals that have a cancer registry within their affiliated system need to be abstracted and reported by the system's cancer registry and not by the methods described in this manual.

Role of Missouri Cancer Registry

MCR's role is to gather information from hospitals and other sources to monitor the incidence of cancer in the state for epidemiological research that may be used to develop and evaluate cancer prevention and control activities in Missouri. The data is received electronically from hospitals that have on-site or contract registrars. As mentioned above, facilities without a registrar having an annual caseload of 50 or fewer cases are called low-volume facilities (LVF). Information from these facilities is accepted in chart form, uploaded via Web Plus and MCR staff complete the abstracts. The data collected is invaluable in targeting risk factors in certain populations, studying the impact of environmental factors, identifying ethnic and social variations and evaluating the effectiveness of state cancer control programs.

The MCR staff is available to answer registry-related questions and to provide one-on-one training through Zoom sessions. Please refer to the MCR website for complete information.

Confidentiality

Per Missouri statute (192.655, RSMo 1999), the "department of health shall protect the identity of the patient, physician, health care provider, hospital, pathology laboratory, ambulatory

surgical center, residential care facilities I or II, intermediate care facilities or skilled nursing facilities, and free-standing cancer clinic or treatment center… and that such identity shall not be revealed except…only upon written consent…" This confidentiality provision is necessary to assure all reporting entities that neither their identity nor the confidential data they submit will be subject to unauthorized release.

In addition, MCR employees are required to sign confidentiality agreements and follow confidentiality procedures set forth in the Missouri Cancer Registry Policy and Procedure Manual. These regulations include the use of locked cabinets for confidential data, employing secure work station practices, adhering to procedures for handling requests for data, etc. MCR employees also recognize the importance of compliance with ARRA HITECH provisions.

Note: The Health Insurance Portability and Accountability Act known as HIPAA allows for the reporting of identifiable cancer data to public health entities. Because the Missouri Cancer Registry falls under the definition of a public health authority; HIPAA allows your facility to continue reporting cancer incidence data in compliance with state statutes (192.650-192.657 RSMo) and regulations (19 CSR 70-21). ***Written informed consent from each cancer patient reported to public health entities is not required under HIPAA nor is a Business Associate Agreement required; rather, hospitals must simply document that reporting has occurred.***

Audits

MCR periodically conducts case completeness and data quality audits as required by the NPCR. The intent of the audits is to assist hospitals with case finding issues to ensure complete, high quality data is submitted to MCR. Each Missouri hospital is audited every five years. After completion of the audits, detailed summary reports are prepared and shared with the hospital registrar and other related hospital staff. Per NPCR guidelines, the acceptable accuracy rate for all audits is 95 – 100%.

CDC National Program of Cancer Registry (NPCR) Audits: Case completeness and data quality audits are periodically conducted by NPCR on the Missouri Cancer Registry data. While a few hospitals are requested to provide data, the audits are conducted on MCR, not on the individual facilities. These audits provide an opportunity for NPCR to assess the completeness and quality of the data after it has gone through MCR's quality assurance process. The audit feedback may be instrumental in improving the quality of the data as well as MCR's quality assurance processes.

GENERAL INSTRUCTIONS

Important Items to Remember

Reporting cancer cases to MCR can be confusing. When unplanned, the activity can take a significant amount of time, with results that may not be the most accurate. To make the process less time-consuming and more efficient, here are a few suggestions:

- Designate a specific person to perform the case finding.
- Allow adequate time to identify cases, copy and submit charts.
- Conduct case finding activities on a regular basis at least quarterly.
- Collaborate with the pathology laboratory and other departments/sources that may provide tumor information.
- Send only charts for the specific malignances listed for patients diagnosed and/or treated for cancer at your facility. (See the Reportablility Section of the manual)

All reportable cancer cases diagnosed and/or treated in your facility after August 28, 1984 must be reported to MCR.

Chart Submission

You are required to submit your cancer cases to us at a minimum every quarter. Please see Appendix C for the Low Volume Facility submission deadlines. If you are not directly entering your cases into Web Plus every quarter, you should send a transmittal form, the annotated MRDI and charts. ***If the MRDI review results contain no report-able cases, you must still submit the MRDI and transmittal form, explaining the reason for no charts.*** To send your charts securely please refer to the Data Security Section of the manual.

During routine case finding, registrars can assist themselves and MCR by maintaining a non-reportable list (patient name, date of birth or social security number, ICD-10-CM code of the non-reportable malignancy, date seen and reason not reported). Another method is to note the reason a case is non-reportable on the registrar's case finding source, such as the Medical Records Disease Index (MRDI). The listing or notations will help registrars avoid duplication of efforts related to case finding and identification of non-reportable cases in the audit process. For example, you might note "case not reportable due to basal cell cancer of the skin," etc. That way if we have questions about a particular patient you may quickly review your information rather than pulling the chart.

We also recommend that you check your facility's account in Web Plus for a list of patients that

have been abstracted from the charts previously submitted (to avoid duplication). You can copy these logs and paste in an excel sheet.

Data Security

When sending emails to MCR, ***DO NOT INCLUDE Protected Health Information (PHI) or other confidential information either in the text of the e-mail or as an attachment***. If PHI is received in an email, MCR staff will alert the registrar, so that the information can be deleted from all e-mails.

Confidential information on individual cases may be uploaded using the Web Plus non-NAACCR upload function, or it may be transmitted via fax if only a small number of pages (less than 20) are to be submitted. The MCR uses a secure, virtual fax system which is accessible only to MCR personnel. MCR's fax number is 573-884-9655.

A completed transmittal form and MRDI must accompany each quarterly submission. In addition, a completed transmittal form and MRDI should be sent to MCR-ARC even if no data is submitted for the designated reporting period.

Delinquency

We will send out a mid-reporting year letter that will serve as your notice that you have or have not been delinquent in your reporting. If you have not submitted 50% of expected cases by that time, you will have 60 days from the date of the letter to respond and take corrective action. If that deadline is missed we will send a letter to your supervisor. They will be given 30 days from the date of that letter to respond and take corrective action. If there is no response and corrective action after this 90-day period our Operations Director will send a letter to your hospital Administrator/CEO.

Missouri Cancer Registry Website

The Missouri Cancer Registry Website, https://cancerregistry.missouri.edu/, is a good resource for information. On the website you will find the specific cancer-reporting statues and regulations, questions in regards to HIPAA, as well as a link to Web Plus. Although we try to communicate with you in regards to changes, updates, and training opportunities the website will contain the most up to date information in these areas.

REPORTABILITY

ICD-10-CM Codes

It is the responsibility of the facility to review cases for reportability. Attached are the reportable ICD-10-CM cancer codes to become familiar with when reporting cancer cases.

Submitting batches of charts that may not meet the reporting guidelines is strongly discouraged. Investing time up-front for case finding will reduce time involved in locating documents for submission, and will free up time for other duties at your facility.

For reportability, MCR utilizes ICD-10 codes as required by the National Program of Cancer Registries (NPCR) and the North American Association of Central Cancer Registries (NAACCR).

See Appendix A. These are the codes used by central registries throughout the US and Canada. The ICD-10 list may change annually. Please refer to the MCR website for the most up to date information. While the ICD-10-CM list mainly includes malignancies, there are a few inclusions and exclusions you need to know.

Inclusions

Beginning with cases diagnosed in 2004, benign brain tumors are required to be reported to MCR.

ICD-10-CM codes for benign brain tumors that must be reported are:
D32.0 – D32.9 (for benign Meninges and Brain)
D33.0 – D33.9 (for Spinal Cord, Cranial Nerves and other)
D35.2 – D35.4 (for other endocrine glands, etc)

Other inclusions include intraepithelial neoplasia for certain sites. These sites are by ICD-10-CM codes:
D12.9 AIN (anal)
N89-N909 233.32 Female Genital Organs including VIN (vulvar) and VAIN (vaginal)

Laryngeal intraepithelial neoplasia, grade III (LINIII) (8077/2), C320-C329 is REPORTABLE.
Squamous intraepithelial neoplasia, grade III (SINIII) (8077/2), except Cervix and Skin, is REPORTABLE.

Exclusions

Do not report:

- Basal and squamous cell skin cancers
- In situ carcinoma of the cervix uteri
- Cervical intraepithelial neoplasia (CIN)
- Prostatic intraepithelial neoplasia (PIN)
- Consult only cases
- When a patient has *only a history of cancer*
- When a patient is on hospice

Ambiguous Terminology

A patient has a reportable malignancy when the diagnosis is stated by a recognized medical practitioner. Some specific ambiguous terms that are used by physicians constitute a reportable diagnosis, while others do not. This may occur in the absence of tissue (histology) or fluid (cytology) diagnosis, as well as when there is a cytologic/histologic diagnosis. Some malignancies may be first diagnosed radiographically with ambiguous terms. These terms may originate from any source document such as pathology, radiology, discharge summary and clinical reports and may lead to minor problems during case finding because some ambiguous terms for ICD-10 coding may not mean the same thing regarding reporting status. For example, 'possible' cancer may be coded as a malignancy by ICD-10 coders but 'possible' is a non-reportable ambiguous term for cancer registry reporting. When reviewing the medical record if ambiguous terminology is used in the diagnosis, refer to the following lists to determine reporting status. **For a cancer case to be reportable, the ambiguous term must always include a reference to the reportable diagnosis being described, eg., favors carcinoma or suspicious for malignancy.**

Ambiguous Terms That Constitute a Diagnosis	
Apparent (ly)	Most likely
Appears	Presumed
Comparable with	Probable
Compatible with	Suspect (ed)
Consistent with	Suspicious (for)
Favors	Typical of
Neoplasm*	Tumor*

*additional terms for nonmalignant primary intracranial and central nervous system tumors only

Exception: Do not report cytology suspicious for malignancy, unless confirmed by biopsy or a statement by the physician that the cases supports a malignant diagnosis.

Ambiguous Terms That Do NOT Constitute a Diagnosis	
Cannot be ruled out	Questionable
Equivocal	Rule Out
Possible	Suggests
Potentially malignant	Worrisome

Note: Terms that designate a reportable case must always include a reference to malignancy, cancer or other similar term, except when the diagnosis is for a benign primary tumor of the intracranial region, the brain or the central nervous system. For example a radiology report may refer to a neoplasm in the brain. This would be reportable for that site.

Examples:

- CT scan results state "cancer cannot be ruled out." **– This is NOT reportable**.

- CT scan results state "probable cancer." – **This is reportable**.

- Discharge summary and X-ray results report "CT of the chest compatible with carcinoma of the left lung. Although there may be no further work-up or treatment, **the case is radiographically diagnosed and is reportable.**

- Barium enema (BE) reveals a suspicious sigmoid mass. Colonoscopy reveals a sigmoid mass, "questionable malignant neoplasm."- **This case is NOT reportable.**

CASE FINDING

Case finding Standard

The MRDI will be generated by including specific parameters (as indicated below) for the facility to determine which cases to report and attaching copies of the necessary documents as listed in Appendix B.

Medical Record Disease Index

The Medical Record Disease Index or MRDI is one of the most complete sources for locating reportable cases. You will need to work with your IT department to create an MRDI report from your billing software to be used for case finding by searching the codes listed in the SEER Casefinding Lists. The MRDI is also annotated and submitted to MCR with each case submission and can be used by MCR for casefinding audits. The MRDI should include cases from the following billing sources: inpatients, outpatients, ambulatory surgery, hospital outpatient and clinic visits for chemo-therapy, radiotherapy or other definitive cancer treatment. It should also include diagnostic visits with procedures such as imaging (mammogram, CXR, CT, MRI, bone scan, ultrasound), scopes and biopsies. To generate the MRDI, run as a single report, rather than individual monthly reports or reports based on patient class, then save as an Excel file. The format must include codes to identify all potential cases based on the ICD-10-CM reportable list. Search your billing software for any of the codes listed on the comprehensive section of the list. Codes from the supplemental section may also be used at your discretion. For each patient admission, include the top six ICD-10 codes and include procedure codes listing them in the order in which they were originally coded. Also include:

- patient last name,
- first name,
- date of birth,
- social security number,
- admission and discharge dates,
- admission type/service code, and
- medical record number

The list needs to be sorted alphabetically by last name so that all visits for a given patient are grouped together. **IMPORTANT:** MRDIs sorted other than alphabetically will not be useful. If your departmental program does not have the capability to generate reports in Excel, collaborate with your IT department to run the report in the requested format. We are available to speak directly to the IT staff to answer any questions.

Resources

There are other resources at your facility that will be of assistance to you in your case finding. You can collaborate with staff in the pathology department to share a list or copies of path reports that mention a reportable diagnosis and or treatment for malignancies. You can also consult with your radiology department on mammograms, chest x-rays, CT scans, MRIs and ultrasounds for tests that may contain ambiguous terminology that constitute a reportable diagnosis. You can also run a report of patients receiving specialty procedures such as colonoscopies, bronchoscopies or orchiectomies. Other sources for locating potential cases include outpatient listings, same-day surgery center lists, and other satellite clinics. Assess whether these other methods identify cases not found on the MRDI.

Tips for Improved Casefinding

Recent audits by MCR have revealed that we have not provided enough training on casefinding for certain sites. These diseases may not sound like cancer, may not be pathologically diagnosed, or may be seen at your facility for treatment other than surgery and chemotherapy. Special attention is needed so as not to miss the following types of reportable cases:

- Lung, pancreas and brain cancers diagnosed only by imaging reports. Patient refuses work-up or is referred elsewhere. This is your case because it was diagnosed via imaging. Sometimes these are Emergency Department visits.
- Diagnostic mammograms if report states “suspicious for malignancy”, not just BIRADS 4 or 5
- Digital rectal exam if report states “suspicious for cancer” or “suspicious for malignancy”
- Hormone treatment for prostate (Lupron shots, etc) or breast cancer (oral tamoxifen, aromatase inhibitors, etc)
- Diagnosis of a cancer recurrence or metastasis (by biopsy or imaging) on a case not previously reported
- Instillation of BCG during cystoscopy
- Phlebotomy treatment for polycythemia vera if diagnosed after 2001
- Aspirin or Anagrelide treatment for essential thrombocythemia if diagnosed after 2001
- Clinical diagnosis of Myelodysplastic Syndrome or various Refractory Anemias (may also have bone marrow biopsy) if diagnosed after 2001.

Documents to)ÎÃÌÕÄÅ

Charts from visits in which the patient was diagnosed and/or treated for cancer should be sent. It is important when submitting documents that the pertinent information ***pertaining to the cancer*** is included. Please review the ***Documents to LýŐftlzŘŜ Liăt*** in **Appendix B** for a list of the documents that need to be copied and submitted to us. Please remember not all the documents mentioned will apply to every cancer case.

DEATH CLEARANCE

Death Clearance (DC) is a process of matching registered deaths in a population against reportable conditions in the registry database to identify cancer cases that would otherwise not have been reported. For each case not found in the registry database, death clearance procedures require follow-back to the facility listed on the death certificate to obtain more complete diagnosis and/or treatment details. For this process your facility will be notified by email that the DC process has begun. Resolution of all cases will be done through your Web Plus account and full instructions will be provided to guide you through the process. The case(s) may or may not be reportable for your facility but the purpose of death clearance followback is to determine if patients were diagnosed prior to death. Even if not reportable for your facility, any available information regarding diagnosis date, treatment details or any other information that proves a patient was seen elsewhere for the malignancy prior to death is helpful to us.

Please note: even though you will receive an email every year stating that the DC process has begun it does not mean that you have cases to process. If there are no cases for your facility to resolve you will receive no other communication from MCR but it is still good practice to check Web Plus to be sure. 'Outstanding Follow-back Requests' will show for your facility under the Reprting Display and File Upload option on your Web Plus Home Page.

For more information and a YouTube Video on the DC process please visit the DC Follow-Back section on our website https://cancerregistry.missouri.edu/reporting/cancer-reporting-hospital/.

Appendix A: ICD-10-CM Reporting Codes List

For reportability, MCR utilizes ICD-10 codes as required by the National Program of Cancer Registries (NPCR) and the North American Association of Central Cancer Registries (NAACCR). These are the codes used by central registries throughout the US and Canada.

The ICD-10 list may change annually, so please refer to the MCR website for the 'SEER Casefinding List' link. https://cancerregistry.missouri.edu/reporting/cancer-reporting-hospital/.

Appendix B: Documents to Include (covering whole time frame of patient diagnosis and treatment)

Documents to Include

Documents to Include	
Face Sheet	All demographical information **including Social Security Number and Race**
History and Physical Summaries	
Progress Notes	Only ones pertaining to patient's diagnosis, work-up, staging, treatment, etc.
Physician's Orders	Only include orders with any indication of cancer diagnosis or treatment
Initial Nursing Assessment	
Imaging Reports	X-rays, CT scans, MRI, bone scans, mammograms, US, BE, etc, that pertain to the diagnosis of the primary malignancy or workup to determine regional extension or metastatic disease. These documents are very important and useful to MCR abstractors in determining the appropriate stage.
Consultations	Cancer-related only
Endoscopy reports	As they apply to this diagnosis: colonoscopy, EGD, bronchoscopy, thoracoscopy, etc.
Lab/Marker Study	Very few other lab tests are diagnostic of cancer. Petrinent tests (PSA, CEA, AFP, etc.) are often noted in orders or progress notes.
Operative Reports	
Pathology Reports	This includes incisional/excisional biopsies, surgical resection, bone marrow biopsies etc.
Cytology Reports	This includes fine needle aspirations (FNA), thoracentesis, paracentesis, washings, etc
Treatment Summaries	Chemotherapy, radiation therapy, hormonal, etc.
Autopsy Report	If available
Death Certificate	If available

Do Not Include	
Complete nurses' notes	
Physical or rehabilitation therapy assessments and notes	
Patient's rights	
Conditions of admission	
Living Wills	
EKG Series	
Non-cancer related imaging reports	Those necessary for co-morbid conditions, such as cardiac
Daily lab work	Most pertinent lab will be documented in the physician's orders and progress notes

CALENDAR

From the Missouri Cancer Registry and Research Center (MCR-ARC)

LVF & Non-hospital Reporting Schedule

Quarterly Reporting Schedule		
Reporting Period	**Cases Diagnosed**	**Due Date**
Monthly or Quarterly	Jan- March April-June July-September October- December	mid-October mid-January mid-April mid-July

Updated January 2024

Missouri Cancer Registry Transmittal Form

1095 Hospital Drive- PS7
Columbia MO 65211

Fax: (573) 884-9655
Toll free: (800) 392-2829
Website: umurl.us/Missouri-Cancer-Registry

Date received: _____

Date loaded: _____

Range numbers: _____

Log number: _____

Batch number: _____

For MCR Use Only

Please complete for each reporting period

Facility Information

Hospital Name:

Hospital #:

Contact Person:

Phone #:

Email:

Date Transmitted/Mailed Charts:

Data Type/Information

Submissions in NAACCR format:

Electronic file name:
File name assigned by Web Plus (.bun):
Year: # of Cases:
Year: # of Cases:

Electronic file name:
File name assigned by Web Plus (.bun):
Year: # of Cases:
Year: # of Cases:

Electronic file name:
File name assigned by Web Plus (.bun):
Year: # of Cases:
Year: # of Cases:

Submissions in Non-NAACCR format:

Please indicate which type of file by placing an 'x' in the column preceding the file name

- ☐ File name MRDI:
- ☐ File name accession register:
- ☐ File name audit files:
- ☐ File name other (please specify):

Low Volume Facilities Only:

For paper charts

Month(s) **Year**

- ☐ **Number of paper charts**
- ☐ **Paper MRDI included**

Additional Information

Comments:

EXAMPLE OF MEDICAL RECORD DISEASE INDEX

Last Name	First Name	MI	DOB	SSN	Service Code	Admit Date	Discharge Date	MR #	Dx 1	Dx 1 Desc	Dx 2	Dx 2 Desc	Dx 3	Dx 3 Desc	Proc 1	Proc 2
AAAA	BBBBB	C	10/02/00	999559999	Clinic	09/11/19	09/11/19	000000	C06.89	Malignant neoplasm of overlapping s	M17.12	Unilateral primary osteoarthritis,	.			
DDDD	EEEEE	F	05/25/75	999559999	Clinic	11/06/19	11/06/19	000000	C06.9	Malignant neoplasm of mouth, unspec	R09.82	Postnasal drip	E03.9			
GGGG	HHHH	J	10/18/02	999559999	Clinic	01/07/19	01/07/19	000000	C15.9	Malignant neoplasm of esophagus, un	R60.9	Edema, unspecified	Z79.899	Polyp of colon	0DBH8ZX	0DBL8ZX
KKKKK	LLLLL	M	06/10/04	999559999	Clinic	12/16/19	12/16/19	000000	C16.0	Malignant neoplasm of cardia	.		.	Hyperlipidemia, unspecified		
NNNN	OOOO	P	07/18/50	999559999	OffSite	06/10/19	06/16/19	000000	C16.9	Malignant neoplasm of stomach, unsp	G20.	Parkinson's disease	I10.			
NNNN	OOOO	P	07/18/50	999559999	OffSite	04/18/19	05/03/19	000000	C34.90	Malignant neoplasm of unsp part of	C79.31	Secondary malignant neoplasm of bra	C78.7			
TTTT	UUUU	V	12/24/00	999559999	Clinic	05/10/19	05/10/19	000000	C34.90	Malignant neoplasm of unsp part of	R06.2	Shortness of breath	I35.8			
WWW	XXX	Y	02/18/55	999559999	Hospice	04/01/19	04/05/19	000000	C34.90	Malignant neoplasm of unsp part of	J44.9	Chronic obstructive pulmonary disea	J18.9			
ZZZZ	AAAA	B	09/20/00	999559999	Outpt	06/25/19	06/27/19	000000	C34.90	Malignant neoplasm of unsp part of	C78.7	Secondary malig neoplasm of liver a	R19.7	Other long term (current) drug ther		
CCCC	DDD	E	10/23/50	999559999	Clinic	01/14/19	01/14/19	000000	C34.90	Malignant neoplasm of unsp part of	C79.31	Secondary malignant neoplasm of bra	Z87.891		3C1ZX8Z	
FFFF	GGGG	H	08/13/75	999559999	OffSite	08/26/19	08/26/19	000000	C34.90	Malignant neoplasm of unsp part of	E83.52	Hypercalcemia	J44.9	Chest pain, unspecified		
IIII	JJJJ	K	12/20/44	999559999	Clinic	12/02/19	12/02/19	000000	C34.90	Malignant neoplasm of unsp part of	C14.0	Malignant neoplasm of pharynx, unsp	Z11.1			

LVF File Upload Instructions for Web Plus

Important: In order for Web Plus to function properly, the Pop-up Blocker should be turned off, or Web Plus should be added to the list of Allowed Sites.

Tip: Be sure to change the name of your data file **before** you try and upload the file to Web Plus. Please use the following naming convention for your files: 10-digit FIN_YYYYMMDD (example: 0001110222_20070717). In order to change your file name you would find your file by double-clicking on My Computer icon on your desktop and then locate where you stored the file. Highlight the file and right-click and choose the **Rename** option from the menu. The name will still be highlighted but you will have a blinking cursor at the end of the name. You can start typing your file name like above and then hit **Enter** to save the new name. This step **must be** completed outside of Web Plus.

1. Use the following link to access Web Plus: https://webplusmo.umh.edu/webplus/logonen.aspx

2. This should take you to the Web Plus Login screen.

3. Enter your MCR assigned '**Username**' and '**Password**'.

4. Click the '**Login**' button.

5. Once you have logged in successfully you should choose the '**File Upload**' option.

6. Once you have chosen the file upload option, click on the '**New Upload'** button under the word Web Plus in the upper left part of the screen.

7. This will take you to the next screen. Make sure the '**Non-NAACCR File'** option is chosen. (Web Plus is not defaulted to this option). Click on the circle to select that option.

8. You will need to click on the '**Browse'** button to locate the file that you will be uploading unless you remember the path to your file then type it into the Select a file to upload box.

9. Once you have located your file you should be able to click on the file name once to highlight the file then choose the '**Open**' button. The path and file name should appear in the '**Select a file to upload box**' on the Web Plus screen.

10. ***Please add your facility name in the comments section after you have added your file. Any comments about the file itself should be added to the transmittal form comments sections.***

11. You should now be able to click on the '**Upload**' button and your file will begin uploading. When the file is finished uploading you should receive a message stating ***your file was uploaded successfully***.

12. Please complete the transmittal form **AFTER** you've successfully uploaded your data file. The transmittal form needs to have the bundle name that Web Plus called your file after it was uploaded. You can find that bundle name by going to **Previous Uploads** and look for your file. Next to it should be a file that is similar to this: F0000001.bun. This is the "bundle" name we need on the transmittal form.

13. Uploading your transmittal form and MRDI is similar to uploading your patient files. There is only one difference; you don't have to rename the transmittal form or MRDI. When uploading the transmittal form use the **Non-NAACCR** file format. You can choose this by clicking on the circle in front of the Non-NAACCR option. Follow the same procedures to upload the transmittal form (steps 8 – 11). ***Please add your facility name in the comments section after you have added your file.***

14. If you receive the message, 'file not uploaded successfully' or any other error message, please re-submit file(s).

If you have any questions or receive an error message, please feel free to contact:

Sue Stulgo, Web Plus Administrator
573-882-7775 ext 26 or e-mail: stulgos@health.missouri.edu

For data completeness, we ask that *ALL* fields be completed when information is available

Missouri Cancer Registry
Hospital-Facility Update Form

1095 Hospital Drive- PS7
Columbia MO 65211
Fax: (573) 884-9655
Toll free: (800) 392-2829
Website: umurl.us/Missouri-Cancer-Registry

Entered by: _____

Date: _____

☐ Web Plus
☐ Tracking
☐ Suspense
☐ CRS Plus

For MCR Use Only

Date updated: _____

Please print or type all information below

ADMINISTRATIVE FACILITY INFORMATION

Facility Name:	Address (Street or PO Box):	
City, State, Zip code:		
Facility Number (FIN):	NPI Number:	Main Phone:
Administrator (with title & credentials):		
Supervisor (with title & credentials):	Department:	Phone:
Main contact (please include title):	Department:	Phone:
Email:		Fax:
Alternate contact (please include title and department):	Phone:	Alternate contact email:

FACILITY-SPECIFIC INFORMATION

Bed size: _____

Reporting Mechanism:

☐ Computerized
(indicate software) _____

☐ Low-volume
(less than 50 cases annually)

Reporting Status:

☐ Incidence

☐ Survival

ACoS Accredited:

☐ Yes ☐ No

Registry Reference Year: _____

Estimated number of cancer cases reported annually: _____

Data submitted:

☐ Registry abstract

☐ Copies from medical record

Data Transmission Method:

☐ Fax ☐ FTP

☐ Web Plus upload

☐ Other _____

Do you report cases for another facility?

☐ Yes ☐ No

Name(s)of facilities*:

_____

_____

_____

**Please fill out a separate form for each facility.*

FOR PATH LABS ONLY

How does your Information System retrieve diagnostic information?

☐ ICD-10 ☐ SNOMED

☐ CPT ☐ Free Text

☐ Other _____

What software program/vendor do you use?

_____

What format is available for exported data:

☐ .txt file ☐ .xls file

☐ Other _____

☐ **Please indicate here if your facility does not process anatomic, cytology, bone marrow or autopsy specimen types.**

Created/Updated 10/2023

Please FAX completed forms to the number listed at the top of the form