28-70-2. Reporting requirements. (a)(1) Each administrator of a hospital, an ambulatory surgery center, a radiology oncology center, or a pathology laboratory shall, within six months of the date of diagnosis, report to the registry each case of cancer diagnosed or treated, unless exempted under subsection (d) of this regulation.

- (2) Each report shall provide all required information available in the medical or administrative records that are under the direct control of the reporting administrator. No administrator shall be required to contact the patient, the patient's family, or another health care provider to obtain additional information not contained in the medical or administrative records.
- (b) Each person who is either licensed to practice medicine and surgery or licensed to practice dentistry and who practices in a clinic or physician's office and each administrator of a hospice or adult care home shall provide the following to the registry:
- (1) If used to confirm each cancer diagnosis, a list of in-state and out-of-state pathologists, or pathology laboratories and dermatopathologists; and
- (2) for each patient for whom a cancer diagnosis has been confirmed, pathologically or clinically, a list that includes the name, social security number, date of birth, and cancer site. The social security number shall be used only for confirmation of patient identity.
- (c) Upon receipt of any written request for information from the registry regarding a patient, each reporting party specified in subsection (a) or (b) shall provide the requested information that is contained in medical or administrative records under the direct control of the reporting party. The requested information may consist of either of the following:
- (1) Any information specified in subsection (e), even if the patient's cancer has not been diagnosed or treated by the hospice or adult care home or by the health care provider or licensee

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specified in subsection (a) or (b); or

- (2) annual follow-up information, including tumor recurrence and follow-up treatment.
- (d) The reports specified in this regulation shall not be required for the following types of cancer:
- (1) Squamous cell carcinoma of the skin, unless located on a lip of the face or in the genital area; or unless spread beyond local tissues at the time of diagnosis;
- (2) basal cell carcinoma of the skin, unless located on a lip of the face or in the genital areas; or unless spread beyond local tissues at the time of diagnosis; and
 - (3) carcinoma in situ of the uterine cervix.
- (e) Each report from any reporting party specified in subsection (a) or (b) shall include the following information, if available:
 - (1) Patient identifiers and demographics;
 - (2) cancer screening history;
 - (3) cancer diagnosis, including the cancer site and histology;
 - (3) (4) personal and family history;
 - (4) (5) vital status, including the date of death and cause of death, if applicable;
 - (5) (6) cancer-related treatment information;
 - (6) (7) follow-up information, including the date of last contact with the patient; and
 - (7) (8) third-party payer information; and
 - (9) risk factors for cancer.

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- (f) Each report to the registry shall be submitted in one of the following formats:
- (1) American standard code for information interchange (ASCII) file in the North American association of central cancer registries (NAACCR) format;
 - (2) electronic or paper forms provided by the registry;
- (3) any other format equivalent to any format specified in paragraph (f)(1) or (2) this subsection that is acceptable to the cancer registry director.
 - (g) All data transferred to the registry shall be secure and confidential.
- (1) All paper data transferred to the registry shall be sealed in an envelope marked "CONFIDENTIAL" and addressed to the cancer registry director.
 - (2) Electronic data transfer may shall be made by one of the following means:
- (A) Diskette mailed in a sealed envelope marked "CONFIDENTIAL" and addressed to the cancer registry director; or

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