Comorbidities/Complications and Secondary Diagnosis Quick Reference Coding Guide

These fields record three general categories of information: **comorbidities** (preexisting medical conditions or conditions present at the time the cancer dx is rendered); **complications** (adverse effects or conditions that occur during the hospital stay, while the patient is being treated for cancer or may follow the completion of therapy resulting in a readmission to the hospital) and **factors influencing the health status of patients** (circumstances or problems that are not current illnesses or injuries).

Accurate collection of this information is important because they affect treatment decisions; influence patient outcomes and is used to adjust outcome statistics when evaluating patient survival and other outcomes such as quality of care provided.

**GENERAL CODING RULES:**

- Record from discharge abstract or billing information (only when discharge abstract is not available)
- Left justify with omitted decimal points and record codes in the sequence as they appear on the discharge abstract or as recorded by the billing department
- Report using these PRIORITY RULES:
  - SURGICALLY TREATED PATIENTS:
    - Record codes following the most definitive surgery of the primary site OR other non-primary site surgeries
  - NON-SURGICALLY TREATED PATIENTS:
    - Record codes following the first treatment encounter/episode
  - NON-TREATMENT
    - Record codes following the last diagnostic/evaluative encounter
  - READMISSION SAME HOSPITAL W/IN 30DAYS OF SURGICAL DISCHARGE
    - Record codes from the “readmission” discharge abstract

**CORMORBIDITIES AND COMPLICATIONS (#1-10): effective for cases diagnosed ≥ 01/01/2006**

- Five-digit field that records **ONLY ICD-9-CM CODES**
- **Allowable Values:**
  - 00000—used when there are no comorbidities or complications documented; remaining fields are blank; CER Source Comorbidity=0
  - 00100-13980; 24000-99990
  - E8700-E8799; E9300-E9499
  - V0720-V0739; V1000-V1590; V2220-V2310; V2540; V4400-V4589; V5041-V5049

**SECONDARY DIAGNOSIS (#1-10): effective for cases diagnosed ≥01/01/2013**

- Seven-digit field that records **ONLY ICD-10-CM CODES**
- All Alpha characters are capitalized
- **Allowable Values:**
  - 0000000—used when there are no secondary diagnoses documented; remaining fields are blank
  - All values beginning with A-B; E; G-P; R-S
    - All C-D; F and Q codes are invalid
  - T36-T50996ZZ
  - Y62-Y849ZZZ
  - Z1401-Z229ZZZ; Z681-Z6854ZZ; Z80-Z809ZZZ; Z8500-Z9989ZZ