LSU Health NEW ORLEANS
Louisiana Tumor Registry

# 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**