

## 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 to 12/31/2017 (retired in NAACCR v26; no longer collected as of 1/1/2026)

- **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 forward (required 2015+)

- **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-T50996Z**
  - **U070-U071**
  - **Y62-Y849ZZZ**
  - **Z1401-Z229ZZZ; Z681-Z6854ZZ; Z751-Z753; Z80-Z809ZZZ; Z8500-Z9989ZZ**