

# Comorbidity

Organization	Field Name	ID	Required
KCR	Comorbidity 1 (Comorbid1)	31540	no
NAACCR	Comorbid/Complication 1	<a href="#">3110</a>	no
KCR	Comorbidity 2 (Comorbid2)	31550	no
NAACCR	Comorbid/Complication 2	<a href="#">3120</a>	no
KCR	Comorbidity 3 (Comorbid3)	31560	no
NAACCR	Comorbid/Complication 3	<a href="#">3130</a>	no
KCR	Comorbidity 4 (Comorbid4)	31570	no
NAACCR	Comorbid/Complication 4	<a href="#">3140</a>	no
KCR	Comorbidity 5 (Comorbid5)	31580	no
NAACCR	Comorbid/Complication 5	<a href="#">3150</a>	no
KCR	Comorbidity 6 (Comorbid6)	31590	no
NAACCR	Comorbid/Complication 6	<a href="#">3160</a>	no
KCR	Comorbidity 7 (Comorbid7)	31600	no
NAACCR	Comorbid/Complication 7	<a href="#">3161</a>	no
KCR	Comorbidity 8 (Comorbid8)	31610	no
NAACCR	Comorbid/Complication 8	<a href="#">3162</a>	no
KCR	Comorbidity 9 (Comorbid9)	31620	no
NAACCR	Comorbid/Complication 9	<a href="#">3163</a>	no
KCR	Comorbidity 10 (Comorbid10)	31630	no
NAACCR	Comorbid/Complication 10	<a href="#">3164</a>	no

Record the patient's preexisting medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer using ICD-9-CM codes. These are considered the same as secondary diagnoses.

## Instructions for Coding

- Depending on whether the hospital has implemented use of ICD-10-CM, this information may be identified either in ICD-9-CM or ICD-10-CM form. Do not record ICD-10-CM codes in the comorbidity fields ; use the secondary diagnoses fields to record ICD-10-CM codes.
- Some ICD-10-CM codes are more than 5 characters long. Only enter the first five characters.
- Omit the decimal point between the third and fourth characters.
- If there are fewer than five characters, use zeros after the code to fill the spaces.
- Secondary diagnoses and complications must be reported for patients that have inpatient hospitalizations at your facility.
- Secondary diagnoses and complications should be reported for patients receiving outpatient care or treated in oncology clinics at your facility when available.
- Consult the patient record for the discharge abstract. Secondary diagnoses are found under secondary diagnoses on the discharge abstract. Information from the billing department at your facility may be consulted when a discharge abstract is not available.
- Code the secondary diagnoses in the sequence in which they appear on the discharge abstract or billing list..
- Report the secondary diagnoses for this cancer using the following priority rules:

### - Surgically treated patients:

- following the most definitive surgery of the primary site
- following other non-primary site surgeries

### - Non-surgically treated patients:

following the first treatment encounter/episode

### - In cases of non-treatment:

following the last diagnostic/evaluative encounter

- If the data item [Readmission To The Same Hospital Within 30 Days of Surgical Discharge](#) is coded 1, 2, or 3, then use available Comorbidities and Complications data items to record codes appearing on the "readmission" discharge abstracts that are coded using ICD-9-CM.
- If no ICD-9-CM comorbid conditions or complications were documented, then code 00000 in the first field, and leave the remaining "Comorbidities and Complications" data items blank.
- If fewer than ten secondary diagnoses are listed, then code the diagnoses listed, and leave the remaining "Comorbidities and Complications" data items blank.

- Allowable ICD-9-CM values are:

00100-13980, 24000-99990,

E8700-E8799, E9300-E9499

V0720-V0739, V1000-V1590,

V2220-V2310, V2540,

V4400-V4589, V5041-V5049