

Additional Data Items for Collection as of March 15, 2013 for cases beginning January 1, 2012 and forward

Comorbidities and Complications #1 - #10 (NAACCR Item #3110, 3120, 3130, 3140, 3150, 3160, 3161, 3162, 3163, and 3164) (FORDS pgs 73-83)

Description

Records 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. All are considered secondary diagnoses.

Explanation

Preexisting medical conditions, factors influencing health status, and/or complications may affect treatment decisions and influence patient outcomes. Information on Comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes. Complications may be related to the quality of care.

Coding Instructions

1. Use only ICD-9-CM codes.
2. Secondary diagnoses are found on the discharge abstract or coding summary. Information from the billing department at your facility may be consulted when a discharge abstract is not available.
3. Code the secondary diagnoses in the sequence in which they appear on the discharge abstract or are recorded by the billing department at your facility.
4. Report the secondary diagnoses for this cancer using the following priority rules:
 - a. Surgically treated patients
 - i. Following the most definitive surgery of the primary site
 - ii. Following other non-primary site surgeries
 - b. Non-surgically treated patients:
 - i. Following the first treatment encounter/episode
 - c. In cases of non-treatment:

i. following the last diagnostic/evaluative encounter

5. If there was an unplanned re-admission following surgical discharge, check for an ICD-9-CM “E” code and record, space allowing, as additional *Comorbidities and Complications*

6. If no secondary diagnoses were documented, then code 00000 in the first data item, and leave the remaining *Comorbidities and Complications* data items blank. **Do not leave the first data item blank.**

7. If fewer than 10 secondary diagnoses are listed, then code the diagnoses listed, and leave the remaining

Comorbidities and Complications data items blank.

8. For non analytic cases code the first data item 00000 and leave the remaining data items blank.

ICD-9-CM Or ICD-10-CM	Code	Definition, Specific Instructions
Both	00000	No comorbid conditions or complications. Code only the first field and leave the remaining fields blank.
ICD-9-CM	00100-13980, 24000-99990	Comorbid conditions: Omit the decimal point between the third and fourth characters.
ICD-9-CM	E8700-E8799, G; 522/G; 6; ;	Complications: Omit the decimal point between the fourth and fifth characters
ICD-9-CM	V0720-V0739, V1000-V1590, V2220- V2310, V2540, V4400- V4589, V5041- V5049	Factors affecting health status: Omit the decimal point between the fourth and fifth characters

Examples

Code	Reason (ICD-9-CM)
49600	COPD (ICD-9-CM code 496)
25001	Type 1 diabetes mellitus (ICD-9-CM code 250.01)
E8732	The patient was inadvertently exposed to an overdose of external beam radiation
V1030	The patient has a personal history of breast cancer (ICD-9-CM code V10.3)

Source Comorbidity (Non-NAACCR Standard Data Item 9970) (Source CDC/NPCR-CER)**Description**

This data item records the data source from which comorbidities/complications (NAACCR Data Items 3110, 3120, 3130, 3140, 3150, 3160, 3161, 3162, 3163, and 3164) were collected.

Coding Instructions

1. Do not leave this data item blank. If no comorbid condition or complications are identified in the patient's record use code 0.

Code	Description
0	No comorbid condition or complication identified/Not Applicable
1	Collected from facility face sheet
2	Linkage to facility/hospital discharge data set
3	Linkage to Medicare/Medicaid data set
4	Linkage with another claims data set
5	Combination of two or more sources above
9	Other source

Height (Non-NAACCR Standard Item 9960) (Source CDC/NPCR-CER)**Description**

Height is required for breast, colorectal and CML when chemotherapy and/or other drugs were given, and should be entered when available for all other sites/histologies.

Coding Instructions

1. Different tumors for the same patient may have different values.
2. Height should be collected from source records once for each cancer.
3. Height should be taken from the Nursing Interview Guide, Flow Chart, or Vital Stats section from the patient's hospital medical record or physician office record.
4. The height entered should be that listed at or around the time of diagnosis. If no height was listed on the date of diagnosis, use the height recorded on the date closest to the date of diagnosis and before treatment was started.
5. Enter height as a 2 digit number measured in inches. Round all inches values to the nearest whole number; values with decimal place x.5 and greater should be rounded up (code 62.5 inches as 63 inches).

6. Do not leave this field blank. If the information is not available use code 99 (Unknown).

Note: An online conversion calculator is available at http://manuelweb.com/ft_in_cm.htm.

Code	Description
XX	Exact number in inches (up to 98 inches)
98	98 inches or greater
99	Unknown height

Weight (Non-NAACCR Standard Data Item 9961) (Source CDC/NPCR-CER)

Description

Weight is required for breast, colorectal and CML when chemotherapy and/or other drugs were given, and should be entered when available for all other sites/histologies.

Coding Instructions

1. Different tumors for the same patient may have different values.
2. Weight should be collected from source records once for each cancer.
3. Weight should be taken from the Nursing Interview Guide, Flow Chart, or Vital Stats section from the patient's medical record or physician office record.
4. The weight entered should be that listed on the date of diagnosis. If no weight was listed on the date of diagnosis, please use the weight recorded on the date closest to the date of diagnosis and before treatment was started.
5. Enter the weight as a 3 digits number measured in pounds. Round values to the nearest whole number. Values with decimal place x.5 should be rounded up (Code 155.5 pounds as 156). Code a weight of less than 100 pounds with a leading 0 (Code 95 pounds as 095)
6. Do not leave this field blank. If the information is not available use code 999 (Unknown).

Note: An online conversion calculator is available at http://manuelweb.com/kg_lbs.htm.

Code	Description
XXX	Exact weight in pounds
999	Unknown weight