ICD-9-CM Official Guidelines for Coding and Reporting

Effective November 15, 2006
Narrative changes appear in bold text
Items underlined have been moved within the guidelines since December 2005
The guidelines include the updated V Code Table

The Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS), two departments within the U. S. Federal Government's Department of Health and Human Services (DHHS) provide the following guidelines for coding and reporting using the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM). These guidelines should be used as a companion document to the official version of the ICD-9-CM as published on CD-ROM by the U.S. Government Printing Office (GPO).

These guidelines have been approved by the four organizations that make up the Cooperating Parties for the ICD-9-CM: the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), CMS, and NCHS. These guidelines are included on the official government version of the ICD-9-CM, and also appear in "*Coding Clinic for ICD-9-CM*" published by the AHA.

These guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-9-CM itself. These guidelines are based on the coding and sequencing instructions in Volumes I, II and III of ICD-9-CM, but provide additional instruction. Adherence to these guidelines when assigning ICD-9-CM diagnosis and procedure codes is required under the Health Insurance Portability and Accountability Act (HIPAA). The diagnosis codes (Volumes 1-2) have been adopted under HIPAA for all healthcare settings. Volume 3 procedure codes have been adopted for inpatient procedures reported by hospitals. A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. These guidelines have been developed to assist both the healthcare provider and the coder in identifying those diagnoses and procedures that are to be reported. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved. The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.

The term encounter is used for all settings, including hospital admissions. In the context of these guidelines, the term provider is used throughout the guidelines to mean physician or any qualified health care practitioner who is legally accountable for establishing the patient's diagnosis. Only this set of guidelines, approved by the Cooperating Parties, is official.

The guidelines are organized into sections. Section I includes the structure and conventions of the classification and general guidelines that apply to the entire classification, and chapter-specific guidelines that correspond to the chapters as they are arranged in the classification. Section II includes guidelines for selection of principal diagnosis for non-outpatient settings. Section III includes guidelines for reporting additional diagnoses in non-outpatient settings. Section IV is for outpatient coding and reporting.

Section I. Conventions, general coding guidelines and chapter specific guidelines

The conventions, general guidelines and chapter-specific guidelines are applicable to all health care settings unless otherwise indicated.

A. Conventions for the ICD-9-CM

The conventions for the ICD-9-CM are the general rules for use of the classification independent of the guidelines.   These conventions are incorporated within the index and tabular of the ICD-9-CM as instructional notes. The conventions are as follows:

1.   Format:

The ICD-9-CM uses an indented format for ease in reference

2.   Abbreviations

a.   Index abbreviations

NEC   "Not elsewhere classifiable"
This abbreviation in the index represents "other specified" when a specific code is not available for a condition the index directs the coder to the "other specified" code in the tabular.

b.   Tabular abbreviations

NEC   "Not elsewhere classifiable"
This abbreviation in the tabular represents "other specified". When a specific code is not available for a condition the tabular includes an NEC entry under a code to identify the code as the "other specified" code.
(See Section I.A.5.a. "Other" codes").

NOS   "Not otherwise specified"
This abbreviation is the equivalent of unspecified.
(See Section I.A.5.b., "Unspecified" codes)

3.   Punctuation

[ ]   Brackets are used in the tabular list to enclose synonyms, alternative wording or explanatory phrases. Brackets are used in the index to identify manifestation codes.
(See Section I.A.6. "Etiology/manifestations")

( )   Parentheses are used in both the index and tabular to enclose supplementary words that may be present or absent in the statement of a disease or procedure without affecting the code number to which it is

assigned. The terms within the parentheses are referred to as nonessential modifiers.

:   Colons are used in the Tabular list after an incomplete term which needs one or more of the modifiers following the colon to make it assignable to a given category.

4.   Includes and Excludes Notes and Inclusion terms

Includes: This note appears immediately under a three-digit code title to further define, or give examples of, the content of the category.

Excludes: An excludes note under a code indicates that the terms excluded from the code are to be coded elsewhere. In some cases the codes for the excluded terms should not be used in conjunction with the code from which it is excluded. An example of this is a congenital condition excluded from an acquired form of the same condition. The congenital and acquired codes should not be used together. In other cases, the excluded terms may be used together with an excluded code. An example of this is when fractures of different bones are coded to different codes. Both codes may be used together if both types of fractures are present.

Inclusion terms: List of terms is included under certain four and five digit codes. These terms are the conditions for which that code number is to be used. The terms may be synonyms of the code title, or, in the case of "other specified" codes, the terms are a list of the various conditions assigned to that code. The inclusion terms are not necessarily exhaustive. Additional terms found only in the index may also be assigned to a code.

5.   Other and Unspecified codes

a.   "Other" codes

Codes titled "other" or "other specified" (usually a code with a 4th digit 8 or fifth-digit 9 for diagnosis codes) are for use when the information in the medical record provides detail for which a specific code does not exist. Index entries with NEC in the line designate "other" codes in the tabular. These index entries represent specific disease entities for which no specific code exists so the term is included within an "other" code.

b.   "Unspecified" codes

Codes (usually a code with a 4th digit 9 or 5th digit 0 for diagnosis codes) titled "unspecified" are for use when the information in the medical record is insufficient to assign a more specific code.

6. Etiology/manifestation convention ("code first", "use additional code" and "in diseases classified elsewhere" notes)

Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. For such conditions, the ICD-9-CM has a coding convention that requires the underlying condition be sequenced first followed by the manifestation. Wherever such a combination exists, there is a "use additional code" note at the etiology code, and a "code first" note at the manifestation code. These instructional notes indicate the proper sequencing order of the codes, etiology followed by manifestation.

In most cases the manifestation codes will have in the code title, "in diseases classified elsewhere." Codes with this title are a component of the etiology/ manifestation convention. The code title indicates that it is a manifestation code. "In diseases classified elsewhere" codes are never permitted to be used as first listed or principal diagnosis codes. They must be used in conjunction with an underlying condition code and they must be listed following the underlying condition.

There are manifestation codes that do not have "in diseases classified elsewhere" in the title. For such codes a "use additional code" note will still be present and the rules for sequencing apply.

In addition to the notes in the tabular, these conditions also have a specific index entry structure. In the index both conditions are listed together with the etiology code first followed by the manifestation codes in brackets. The code in brackets is always to be sequenced second.

The most commonly used etiology/manifestation combinations are the codes for Diabetes mellitus, category 250. For each code under category 250 there is a use additional code note for the manifestation that is specific for that particular diabetic manifestation. Should a patient have more than one manifestation of diabetes, more than one code from category 250 may be used with as many manifestation codes as are needed to fully describe the patient's complete diabetic condition. The category 250 diabetes codes should be sequenced first, followed by the manifestation codes.

"Code first" and "Use additional code" notes are also used as sequencing rules in the classification for certain codes that are not part of an etiology/ manifestation combination.
See - Section I.B.9. "Multiple coding for a single condition".

7. "And"

The word "and" should be interpreted to mean either "and" or "or" when it appears in a title.

8. "With"

The word "with" in the alphabetic index is sequenced immediately following the main term, not in alphabetical order.

9. "See" and "See Also"

The "see" instruction following a main term in the index indicates that another term should be referenced. It is necessary to go to the main term referenced with the "see" note to locate the correct code.

A "see also" instruction following a main term in the index instructs that there is another main term that may also be referenced that may provide additional index entries that may be useful. It is not necessary to follow the "see also" note when the original main term provides the necessary code.

B. General Coding Guidelines

1. Use of Both Alphabetic Index and Tabular List

Use both the Alphabetic Index and the Tabular List when locating and assigning a code. Reliance on only the Alphabetic Index or the Tabular List leads to errors in code assignments and less specificity in code selection.

2. Locate each term in the Alphabetic Index

Locate each term in the Alphabetic Index and verify the code selected in the Tabular List. Read and be guided by instructional notations that appear in both the Alphabetic Index and the Tabular List.

3. Level of Detail in Coding

Diagnosis and procedure codes are to be used at their highest number of digits available.

ICD-9-CM diagnosis codes are composed of codes with either 3, 4, or 5 digits. Codes with three digits are included in ICD-9-CM as the heading of a category of codes that may be further subdivided by the use of fourth and/or fifth digits, which provide greater detail.

A three-digit code is to be used only if it is not further subdivided. Where fourth-digit subcategories and/or fifth-digit subclassifications are provided, they must be assigned. A code is invalid if it has not been coded to the full number of digits required for that code. For example, Acute myocardial infarction, code 410, has fourth digits that describe the location of the infarction (e.g., 410.2, Of inferolateral wall), and fifth digits that identify the episode of care. It would be incorrect to report a code in category 410 without a fourth and fifth digit.

ICD-9-CM Volume 3 procedure codes are composed of codes with either 3 or 4 digits. Codes with two digits are included in ICD-9-CM as the heading of a

category of codes that may be further subdivided by the use of third and/or
fourth digits, which provide greater detail.

4. Code or codes from 001.0 through V84.8

The appropriate code or codes from 001.0 through V84.8 must be used to
identify diagnoses, symptoms, conditions, problems, complaints or other
reason(s) for the encounter/visit.

5. Selection of codes 001.0 through 999.9

The selection of codes 001.0 through 999.9 will frequently be used to describe
the reason for the admission/encounter. These codes are from the section of
ICD-9-CM for the classification of diseases and injuries (e.g., infectious and
parasitic diseases; neoplasms; symptoms, signs, and ill-defined conditions,
etc.).

6. Signs and symptoms

Codes that describe symptoms and signs, as opposed to diagnoses, are
acceptable for reporting purposes when a related definitive diagnosis has not
been established (confirmed) by the provider. Chapter 16 of ICD-9-CM,
Symptoms, Signs, and Ill-defined conditions (codes 780.0 - 799.9) contain
many, but not all codes for symptoms.

7. Conditions that are an integral part of a disease process

Signs and symptoms that are integral to the disease process should not be
assigned as additional codes**, unless otherwise instructed by the
classification**.

8. Conditions that are not an integral part of a disease process

Additional signs and symptoms that may not be associated routinely with a
disease process should be coded when present.

9. Multiple coding for a single condition

In addition to the etiology/manifestation convention that requires two codes to
fully describe a single condition that affects multiple body systems, there are
other single conditions that also require more than one code. "Use additional
code" notes are found in the tabular at codes that are not part of an
etiology/manifestation pair where a secondary code is useful to fully describe
a condition. The sequencing rule is the same as the etiology/manifestation
pair - , "use additional code" indicates that a secondary code should be added.

For example, for infections that are not included in chapter 1, a secondary
code from category 041, Bacterial infection in conditions classified elsewhere
and of unspecified site, may be required to identify the bacterial organism
causing the infection. A "use additional code" note will normally be found at
the infectious disease code, indicating a need for the organism code to be
added as a secondary code.

"Code first" notes are also under certain codes that are not specifically manifestation codes but may be due to an underlying cause. When a "code first" note is present and an underlying condition is present the underlying condition should be sequenced first.

"Code, if applicable, any causal condition first", notes indicate that this code may be assigned as a principal diagnosis when the causal condition is unknown or not applicable. If a causal condition is known, then the code for that condition should be sequenced as the principal or first-listed diagnosis.

Multiple codes may be needed for late effects, complication codes and obstetric codes to more fully describe a condition. See the specific guidelines for these conditions for further instruction.

10.   Acute and Chronic Conditions

If the same condition is described as both acute (subacute) and chronic, and separate subentries exist in the Alphabetic Index at the same indentation level, code both and sequence the acute (subacute) code first.

11.   Combination Code

A combination code is a single code used to classify:
Two diagnoses, or
A diagnosis with an associated secondary process (manifestation)
A diagnosis with an associated complication

Combination codes are identified by referring to subterm entries in the Alphabetic Index and by reading the inclusion and exclusion notes in the Tabular List.

Assign only the combination code when that code fully identifies the diagnostic conditions involved or when the Alphabetic Index so directs. Multiple coding should not be used when the classification provides a combination code that clearly identifies all of the elements documented in the diagnosis. When the combination code lacks necessary specificity in describing the manifestation or complication, an additional code should be used as a secondary code.

12.   Late Effects

A late effect is the residual effect (condition produced) after the acute phase of an illness or injury has terminated. There is no time limit on when a late effect code can be used. The residual may be apparent early, such as in cerebrovascular accident cases, or it may occur months or years later, such as that due to a previous injury. Coding of late effects generally requires two codes sequenced in the following order: The condition or nature of the late effect is sequenced first.   The late effect code is sequenced second.

An exception to the above guidelines are those instances where the code for late effect is followed by a manifestation code identified in the Tabular List and title, or the late effect code has been expanded (at the fourth and fifth-digit levels) to include the manifestation(s). The code for the acute phase of an illness or injury that led to the late effect is never used with a code for the late effect.

13. Impending or Threatened Condition

Code any condition described at the time of discharge as "impending" or "threatened" as follows:

> If it did occur, code as confirmed diagnosis.
> If it did not occur, reference the Alphabetic Index to determine if the condition has a subentry term for "impending" or "threatened" and also reference main term entries for "Impending" and for "Threatened."
> If the subterms are listed, assign the given code.
> If the subterms are not listed, code the existing underlying condition(s) and not the condition described as impending or threatened.

C. Chapter-Specific Coding Guidelines

In addition to general coding guidelines, there are guidelines for specific diagnoses and/or conditions in the classification. Unless otherwise indicated, these guidelines apply to all health care settings. Please refer to Section II for guidelines on the selection of principal diagnosis.

1. Chapter 1: Infectious and Parasitic Diseases (001-139)

a. Human Immunodeficiency Virus (HIV) Infections

1) Code only confirmed cases

Code only confirmed cases of HIV infection/illness. This is an exception to the hospital inpatient guideline Section II, H.

In this context, "confirmation" does not require documentation of positive serology or culture for HIV; the provider's diagnostic statement that the patient is HIV positive, or has an HIV-related illness is sufficient.

2) Selection and sequencing of HIV codes

(a) Patient admitted for HIV-related condition

If a patient is admitted for an HIV-related condition, the principal diagnosis should be 042, followed by additional diagnosis codes for all reported HIV-related conditions.

(b)   Patient with HIV disease admitted for unrelated condition

If a patient with HIV disease is admitted for an unrelated condition (such as a traumatic injury), the code for the unrelated condition (e.g., the nature of injury code) should be the principal diagnosis. Other diagnoses would be 042 followed by additional diagnosis codes for all reported HIV-related conditions.

(c)   Whether the patient is newly diagnosed

Whether the patient is newly diagnosed or has had previous admissions/encounters for HIV conditions is irrelevant to the sequencing decision.

(d)   Asymptomatic human immunodeficiency virus

V08 Asymptomatic human immunodeficiency virus [HIV] infection, is to be applied when the patient without any documentation of symptoms is listed as being "HIV positive," "known HIV," "HIV test positive," or similar terminology. Do not use this code if the term "AIDS" is used or if the patient is treated for any HIV-related illness or is described as having any condition(s) resulting from his/her HIV positive status; use 042 in these cases.

(e)   Patients with inconclusive HIV serology

Patients with inconclusive HIV serology, but no definitive diagnosis or manifestations of the illness, may be assigned code 795.71, Inconclusive serologic test for Human Immunodeficiency Virus [HIV].

(f)   Previously diagnosed HIV-related illness

Patients with any known prior diagnosis of an HIV-related illness should be coded to 042. Once a patient has developed an HIV-related illness, the patient should always be assigned code 042 on every subsequent admission/encounter. Patients previously diagnosed with any HIV illness (042) should never be assigned to 795.71 or V08.

(g)   HIV Infection in Pregnancy, Childbirth and the Puerperium

During pregnancy, childbirth or the puerperium, a patient admitted (or presenting for a health care encounter) because of an HIV-related illness should receive a principal diagnosis code of 647.6X, Other

specified infectious and parasitic diseases in the mother classifiable elsewhere, but complicating the pregnancy, childbirth or the puerperium, followed by 042 and the code(s) for the HIV-related illness(es). Codes from Chapter 15 always take sequencing priority.

Patients with asymptomatic HIV infection status admitted (or presenting for a health care encounter) during pregnancy, childbirth, or the puerperium should receive codes of 647.6X and V08.

(h)   **Encounters for testing for HIV**

If a patient is being seen to determine his/her HIV status, use code V73.89, Screening for other specified viral disease. Use code V69.8, Other problems related to lifestyle, as a secondary code if an asymptomatic patient is in a known high risk group for HIV. Should a patient with signs or symptoms or illness, or a confirmed HIV related diagnosis be tested for HIV, code the signs and symptoms or the diagnosis. An additional counseling code V65.44 may be used if counseling is provided during the encounter for the test.

When a patient returns to be informed of his/her HIV test results use code V65.44, HIV counseling, if the results of the test are negative.

If the results are positive but the patient is asymptomatic use code V08, Asymptomatic HIV infection. If the results are positive and the patient is symptomatic use code 042, HIV infection, with codes for the HIV related symptoms or diagnosis. The HIV counseling code may also be used if counseling is provided for patients with positive test results.

b.   Septicemia, Systemic Inflammatory Response Syndrome (SIRS), Sepsis, Severe Sepsis, and Septic Shock

1)   SIRS, Septicemia, and Sepsis

(a)   The terms *septicemia* and *sepsis* are often used interchangeably by providers, however they are not considered synonymous terms. The following descriptions are provided for reference but do not preclude querying the provider for clarification about terms used in the documentation:

(i) **Septicemia generally refers to a systemic disease associated with the presence of pathological microorganisms or toxins in the blood, which can include bacteria, viruses, fungi or other organisms.**

(ii) **Systemic inflammatory response syndrome (SIRS) generally refers to the systemic response to infection, trauma/burns, or other insult (such as cancer) with symptoms including fever, tachycardia, tachypnea, and leukocytosis.**

(iii) **Sepsis generally refers to SIRS due to infection.**

(iv) **Severe sepsis generally refers to sepsis with associated acute organ dysfunction.**

(b) **The coding of SIRS, sepsis and severe sepsis requires a minimum of 2 codes: a code for the underlying cause (such as infection or trauma) and a code from subcategory 995.9 Systemic inflammatory response syndrome (SIRS).**

(i) **The code for the underlying cause (such as infection or trauma) must be sequenced before the code from subcategory 995.9 Systemic inflammatory response syndrome (SIRS).**

(ii) **Sepsis and severe sepsis require a code for the systemic infection (038.xx, 112.5, etc.) and either code 995.91, Sepsis, or 995.92, Severe sepsis. If the causal organism is not documented, assign code 038.9, Unspecified septicemia.**

(iii) **Severe sepsis requires additional code(s) for the associated acute organ dysfunction(s).**

(iv) **If a patient has sepsis with multiple organ dysfunctions, follow the instructions for coding severe sepsis.**

(v) **Either the term sepsis or SIRS must be documented to assign a code from subcategory 995.9.**

(vi) *See Section I.C.17.g), Injury and poisoning, for information regarding systemic inflammatory response syndrome (SIRS) due to trauma/burns and other non-infectious processes.*

(c) **Due to the complex nature of sepsis and severe sepsis, some cases may require querying the provider prior to assignment of the codes.**

2) **Sequencing sepsis and severe sepsis**

(a) **Sepsis and severe sepsis as principal diagnosis**
If sepsis **or severe sepsis** is present on admission, and meets the definition of principal diagnosis, the **systemic infection code** (e.g., 038.xx, 112.5, etc) should be assigned as the principal diagnosis, followed by code 995.91, **Sepsis**, or **995.92**, **Severe sepsis**, as required by the sequencing rules in the Tabular List. Codes from subcategory 995.9 can never be assigned as a principal diagnosis. **A code should also be assigned for any localized infection, if present.**

(b) **Sepsis and severe sepsis as secondary diagnoses**
When sepsis **or severe sepsis** develops during the encounter (it was not present on admission), the **systemic infection code and code 995.91 or 995.92 should** be assigned as secondary diagnoses.

(c) **Documentation unclear as to whether sepsis or severe sepsis is present on admission**
Sepsis or severe sepsis may be present on admission but the diagnosis may not be confirmed until sometime after admission. If the documentation is not clear whether the sepsis **or severe sepsis** was present on admission, the provider should be queried.

3) **Sepsis/SIRS with Localized Infection**
If the reason for admission is both sepsis, severe sepsis, or SIRS and a localized infection, such as pneumonia or cellulitis, a code for the systemic infection (038.xx, 112.5, etc) should be assigned first, then code 995.91 or 995.92, followed by the code for the localized infection. If the patient is admitted with a localized infection, such as pneumonia, and sepsis/SIRS doesn't develop until after admission, see guideline 2b).

Note: The term urosepsis is a nonspecific term. If that is the only term documented then only code 599.0 should be assigned based on the default for the term in the ICD-9-CM index, in addition to the code for the causal organism if known.

4) **Bacterial Sepsis and Septicemia**

In most cases, it will be a code from category 038, Septicemia, that will be used in conjunction with a code from subcategory 995.9 such as the following:

(a) **Streptococcal sepsis**

If the documentation in the record states streptococcal sepsis, codes 038.0, Streptococcal septicemia, and code 995.91 should be used, in that sequence.

(b) **Streptococcal septicemia**

If the documentation states streptococcal septicemia, only code 038.0 should be assigned, however, the provider should be queried whether the patient has sepsis, an infection with SIRS.

5) **Acute organ dysfunction that is not clearly associated with the sepsis**

If a patient has sepsis and an acute organ dysfunction, but the medical record documentation indicates that the acute organ dysfunction is related to a medical condition other than the sepsis, do not assign code 995.92, Severe sepsis. An acute organ dysfunction must be associated with the sepsis in order to assign the severe sepsis code. If the documentation is not clear as to whether an acute organ dysfunction is related to the sepsis or another medical condition, query the provider.

6) **Septic shock**

(a) **Sequencing of septic shock**

Septic shock **generally refers to circulatory failure** associated with severe sepsis**, and, therefore, it represents a type of acute organ dysfunction.**

For all cases of septic shock, the code for the systemic infection should be sequenced first, followed by codes 995.92 and 785.52. Any additional codes for other **acute organ dysfunctions should also be assigned.** As noted in the sequencing instructions in

the Tabular List, the code for septic shock cannot be assigned as a principal diagnosis.

(b) **Septic Shock without documentation of severe sepsis**

Septic shock **indicates the presence of** severe sepsis.

Code 995.92, Severe sepsis, must be assigned with code 785.52, Septic shock, even if the term severe sepsis is not documented in the record. The "use additional code" note and the "code first" note **in the tabular support this guideline.**

7) **Sepsis and septic shock complicating abortion and pregnancy**

Sepsis and septic shock **complicating** abortion, ectopic pregnancy, and molar pregnancy are classified to category codes in Chapter 11 (630-639).
See section I.C.11.

8) **Negative or inconclusive blood cultures**

Negative or inconclusive blood cultures do not preclude a diagnosis of septicemia or sepsis in patients with clinical evidence of the condition, however, the provider should be queried.

9) **Newborn sepsis**

See Section I.C.15.j for information on the coding of newborn sepsis.

10) **Sepsis due to a Postprocedural Infection**

Sepsis resulting from a postprocedural infection is a complication of care. For such cases, **the postprocedural infection, such as code 998.59, Other postoperative infection, or 674.3x, Other complications of obstetrical surgical wounds,** should be coded first followed by the appropriate sepsis **codes (systemic infection code and either code 995.91or 995.92). An additional code(s) for any acute organ dysfunction should also be assigned for cases of severe sepsis.**

11) **External cause of injury codes with SIRS**

Refer to Section I.C.19.a.7 for instruction on the use of external cause of injury codes with codes for SIRS resulting from trauma.

12) **Sepsis and Severe Sepsis Associated with Non-infectious Process**

In some cases, a non-infectious process, such as trauma, may lead to an infection which can result in sepsis or severe sepsis. If sepsis or severe sepsis is documented as associated with a non-infectious condition, such as a burn or serious injury, and this condition meets the definition for principal diagnosis, the code for the non-infectious condition should be sequenced first, followed by the code for the systemic infection and either code 995.91, Sepsis, or 995.92, Severe sepsis. Additional codes for any associated acute organ dysfunction(s) should also be assigned for cases of severe sepsis. If the sepsis or severe sepsis meets the definition of principal diagnosis, the systemic infection and sepsis codes should be sequenced before the non-infectious condition. *See Section I.C.1.b.2)(a) for guidelines pertaining to sepsis or severe sepsis as the principal diagnosis.* When both the associated non-infectious condition and the sepsis or severe sepsis meet the definition of principal diagnosis, either may be assigned as principal diagnosis.

Only one SIRS code, representing the sepsis or severe sepsis, should be assigned for patients with sepsis or severe sepsis associated with trauma or other non-infectious condition. Do not assign codes 995.93, Systemic inflammatory response syndrome due to non-infectious process without acute organ dysfunction, or 995.94, Systemic inflammatory response syndrome due to non-infectious process with acute organ dysfunction, in addition to 995.91, Sepsis, or 995.92, Severe sepsis, if the patient has sepsis or severe sepsis associated with a non-infectious condition.

See Section I.C.17.g for information on the coding of SIRS due to trauma/burns or other non-infectious disease processes.

2. Chapter 2: Neoplasms (140-239)

General guidelines

Chapter 2 of the ICD-9-CM contains the codes for most benign and all malignant neoplasms. Certain benign neoplasms, such as prostatic adenomas, may be found in the specific body system chapters. To properly code a neoplasm it is necessary to determine from the record if the neoplasm is benign, in-situ, malignant, or of uncertain histologic behavior. If malignant, any secondary (metastatic) sites should also be determined.

The neoplasm table in the Alphabetic Index should be referenced first. However, if the histological term is documented, that term should be referenced first, rather than going immediately to the Neoplasm Table, in order to determine which column in the Neoplasm Table is appropriate. For example, if the documentation indicates "adenoma," refer to the term in the Alphabetic Index to review the entries under this term and the instructional note to "see also neoplasm, by site, benign." The table provides the proper code based on the type of neoplasm and the site. It is important to select the proper column in the table that corresponds to the type of neoplasm. The tabular should then be referenced to verify that the correct code has been selected from the table and that a more specific site code does not exist. *See Section I. C. 18.d.4. for information regarding V codes for genetic susceptibility to cancer.*

a. Treatment directed at the malignancy

If the treatment is directed at the malignancy, designate the malignancy as the principal diagnosis.

b. Treatment of secondary site

When a patient is admitted because of a primary neoplasm with metastasis and treatment is directed toward the secondary site only, the secondary neoplasm is designated as the principal diagnosis even though the primary malignancy is still present.

c. Coding and sequencing of complications

Coding and sequencing of complications associated with the malignancies or with the therapy thereof are subject to the following guidelines:

1) Anemia associated with malignancy

When admission/encounter is for management of an anemia associated with the malignancy, and the treatment is only for anemia, the appropriate anemia code (such as code 285.22, Anemia in neoplastic disease) is designated as the principal diagnosis and is followed by the appropriate code(s) for the malignancy.

Code 285.22 may also be used as a secondary code if the patient suffers from anemia and is being treated for the malignancy.

2) Anemia associated with chemotherapy, immunotherapy and radiation therapy

When the admission/encounter is for management of an anemia associated with chemotherapy, immunotherapy or radiotherapy and the only treatment is for the anemia, the anemia is

sequenced first followed by code E933.1. The appropriate neoplasm code should be assigned as an additional code.

3) **Management of dehydration due to the malignancy**

When the admission/encounter is for management of dehydration due to the malignancy or the therapy, or a combination of both, and only the dehydration is being treated (intravenous rehydration), the dehydration is sequenced first, followed by the code(s) for the malignancy.

4) **Treatment of a complication resulting from a surgical procedure**

When the admission/encounter is for treatment of a complication resulting from a surgical procedure, designate the complication as the principal or first-listed diagnosis if treatment is directed at resolving the complication.

d. Primary malignancy previously excised

When a primary malignancy has been previously excised or eradicated from its site and there is no further treatment directed to that site and there is no evidence of any existing primary malignancy, a code from category V10, Personal history of malignant neoplasm, should be used to indicate the former site of the malignancy. Any mention of extension, invasion, or metastasis to another site is coded as a secondary malignant neoplasm to that site. The secondary site may be the principal or first-listed with the V10 code used as a secondary code.

e. Admissions/Encounters involving chemotherapy, immunotherapy and radiation therapy

1) **Episode of care involves surgical removal of neoplasm**

When an episode of care involves the surgical removal of a neoplasm, primary or secondary site, followed by adjunct chemotherapy or radiation treatment during the same episode of care, the neoplasm code should be assigned as principal or first-listed diagnosis, using codes in the 140-198 series or where appropriate in the 200-203 series.

2) **Patient admission/encounter solely for administration of chemotherapy, immunotherapy and radiation therapy**

If a patient admission/encounter is solely for the administration of chemotherapy, immunotherapy or radiation therapy assign code V58.0, Encounter for radiation therapy, or V58.11,

Encounter for antineoplastic chemotherapy, or V58.12, Encounter for antineoplastic immunotherapy as the first-listed or principal diagnosis. If a patient receives more than one of these therapies during the same admission more than one of these codes may be assigned, in any sequence.

3) Patient admitted for radiotherapy/chemotherapy and immunotherapy and develops complications

When a patient is admitted for the purpose of radiotherapy, immunotherapy or chemotherapy and develops complications such as uncontrolled nausea and vomiting or dehydration, the principal or first-listed diagnosis is V58.0, Encounter for radiotherapy, or V58.11, Encounter for antineoplastic chemotherapy, or V58.12, Encounter for antineoplastic immunotherapy followed by any codes for the complications.
See Section I.C.18.d.7. for additional information regarding aftercare V codes.

f. Admission/encounter to determine extent of malignancy

When the reason for admission/encounter is to determine the extent of the malignancy, or for a procedure such as paracentesis or thoracentesis, the primary malignancy or appropriate metastatic site is designated as the principal or first-listed diagnosis, even though chemotherapy or radiotherapy is administered.

g. Symptoms, signs, and ill-defined conditions listed in Chapter 16

Symptoms, signs, and ill-defined conditions listed in Chapter 16 characteristic of, or associated with, an existing primary or secondary site malignancy cannot be used to replace the malignancy as principal or first-listed diagnosis, regardless of the number of admissions or encounters for treatment and care of the neoplasm.
See section I.C.18.d.14, Encounter for prophylactic organ removal.

h. Admission/encounter for pain control/management

See Section I.C.6.a.5 for information on coding admission/encounter for pain control/management.

3. Chapter 3: Endocrine, Nutritional, and Metabolic Diseases and Immunity Disorders (240-279)

a. Diabetes mellitus

Codes under category 250, Diabetes mellitus, identify complications/manifestations associated with diabetes mellitus. A fifth-digit is required for all category 250 codes to identify the type of

diabetes mellitus and whether the diabetes is controlled or uncontrolled.

1) **Fifth-digits for category 250:**

The following are the fifth-digits for the codes under category 250:

0   type II or unspecified type, not stated as uncontrolled
1   type I, [juvenile type], not stated as uncontrolled
2   type II or unspecified type, uncontrolled
3   type I, [juvenile type], uncontrolled

The age of a patient is not the sole determining factor, though most type I diabetics develop the condition before reaching puberty. For this reason type I diabetes mellitus is also referred to as juvenile diabetes.

2) **Type of diabetes mellitus not documented**

If the type of diabetes mellitus is not documented in the medical record the default is type II.

3) **Diabetes mellitus and the use of insulin**

All type I diabetics must use insulin to replace what their bodies do not produce. However, the use of insulin does not mean that a patient is a type I diabetic. Some patients with type II diabetes mellitus are unable to control their blood sugar through diet and oral medication alone and do require insulin. If the documentation in a medical record does not indicate the type of diabetes but does indicate that the patient uses insulin, the appropriate fifth-digit for type II must be used. For type II patients who routinely use insulin, code V58.67, Long-term (current) use of insulin, should also be assigned to indicate that the patient uses insulin. Code V58.67 should not be assigned if insulin is given temporarily to bring a type II patient's blood sugar under control during an encounter.

4) **Assigning and sequencing diabetes codes and associated conditions**

When assigning codes for diabetes and its associated conditions, the code(s) from category 250 must be sequenced before the codes for the associated conditions. The diabetes codes and the secondary codes that correspond to them are paired codes that follow the etiology/manifestation convention of the classification *(See Section I.A.6., Etiology/manifestation convention).* Assign as many codes from category 250 as needed to identify all of the associated conditions that the

patient has. The corresponding secondary codes are listed under each of the diabetes codes.

(a) Diabetic retinopathy/diabetic macular edema

Diabetic macular edema, code 362.07, is only present with diabetic retinopathy. Another code from subcategory 362.0, Diabetic retinopathy, must be used with code 362.07. Codes under subcategory 362.0 are diabetes manifestation codes, so they must be used following the appropriate diabetes code.

5) Diabetes mellitus in pregnancy and gestational diabetes

(a) For diabetes mellitus complicating pregnancy, see Section I.C.11.f., Diabetes mellitus in pregnancy.

(b) For gestational diabetes, see Section I.C.11, g., Gestational diabetes.

6) Insulin pump malfunction

(a) Underdose of insulin due insulin pump failure

An underdose of insulin due to an insulin pump failure should be assigned 996.57, Mechanical complication due to insulin pump, as the principal or first listed code, followed by the appropriate diabetes mellitus code based on documentation.

(b) Overdose of insulin due to insulin pump failure

The principal or first listed code for an encounter due to an insulin pump malfunction resulting in an overdose of insulin, should also be 996.57, Mechanical complication due to insulin pump, followed by code 962.3, Poisoning by insulins and antidiabetic agents, and the appropriate diabetes mellitus code based on documentation.

4. Chapter 4: Diseases of Blood and Blood Forming Organs (280-289)

a. Anemia of chronic disease

Subcategory 285.2, Anemia in chronic illness, has codes for anemia in chronic kidney disease, code 285.21; anemia in neoplastic disease, code 285.22; and anemia in other chronic illness, code 285.29. These codes can be used as the principal/first listed code if the reason for the

encounter is to treat the anemia. They may also be used as secondary codes if treatment of the anemia is a component of an encounter, but not the primary reason for the encounter. When using a code from subcategory 285 it is also necessary to use the code for the chronic condition causing the anemia.

1) Anemia in chronic kidney disease

When assigning code 285.21, Anemia in chronic kidney disease, it is also necessary to assign a code from category 585, Chronic kidney disease, to indicate the stage of chronic kidney disease.
See I.C.10.a. Chronic kidney disease (CKD).

2) Anemia in neoplastic disease

When assigning code 285.22, Anemia in neoplastic disease, it is also necessary to assign the neoplasm code that is responsible for the anemia. Code 285.22 is for use for anemia that is due to the malignancy, not for anemia due to antineoplastic chemotherapy drugs, which is an adverse effect.
See I.C.2.c.1 Anemia associated with malignancy.
See I.C.2.c.2 Anemia associated with chemotherapy, immunotherapy and radiation therapy.
See I.C.17.e.1. Adverse effects.

5. Chapter 5: Mental Disorders (290-319)

Reserved for future guideline expansion

6. Chapter 6: Diseases of Nervous System and Sense Organs (320-389)

a. Pain - Category 338

1) General coding information

Codes in category 338 may be used in conjunction with codes from other categories and chapters to provide more detail about acute or chronic pain and neoplasm-related pain. If the pain is not specified as acute or chronic, do not assign codes from category 338, except for post-thoracotomy pain, postoperative pain or neoplasm related pain.

A code from subcategories 338.1 and 338.2 should not be assigned if the underlying (definitive) diagnosis is known, unless the reason for the encounter is pain control/

management and not management of the underlying condition.

(a)   **Category 338 Codes as Principal or First-Listed Diagnosis**

Category 338 codes are acceptable as principal diagnosis or the first-listed code for reporting purposes:
- **When the related definitive diagnosis has not been established (confirmed) by the provider, or**
- **When pain control or pain management is the reason for the admission/encounter (e.g., a patient with displaced intervertebral disc, nerve impingement and severe back pain presents for injection of steroid into the spinal canal). The underlying cause of the pain should be reported as an additional diagnosis, if known.**

(b)   **Use of Category 338 Codes in Conjunction with Site Specific Pain Codes**

(i) **Assigning Category 338 Codes and Site-Specific Pain Codes**

Codes from category 338 may be used in conjunction with codes that identify the site of pain (including codes from chapter 16) if the category 338 code provides additional information. For example, if the code describes the site of the pain, but does not fully describe whether the pain is acute or chronic, then both codes should be assigned.

(ii) **Sequencing of Category 338 Codes with Site-Specific Pain Codes**

The sequencing of category 338 codes with site-specific pain codes (including chapter 16 codes), is dependent on the circumstances of the encounter/admission as follows:

- **If the encounter is for pain control or pain management, assign the code from category 338 followed by the code identifying the specific site of pain (e.g., encounter for pain**

management for acute neck pain from trauma is assigned code 338.11, Acute pain due to trauma, followed by code 723.1, Cervicalgia, to identify the site of pain).

- **If the encounter is for any other reason except pain control or pain management, and a related definitive diagnosis has not been established (confirmed) by the provider, assign the code for the specific site of pain first, followed by the appropriate code from category 338.**

2) Pain due to devices

Pain associated with devices or foreign bodies left in a surgical site is assigned to the appropriate code(s) found in Chapter 17, Injury and Poisoning (for example painful retained suture).

3) Postoperative Pain

Post-thoracotomy pain and other postoperative pain are classified to subcategories 338.1 and 338.2, depending on whether the pain is acute or chronic. The default for post-thoracotomy and other postoperative pain not specified as acute or chronic is the code for the acute form.

Postoperative pain not associated with a specific postoperative complication is assigned to the appropriate postoperative pain code in category 338.

Postoperative pain associated with a specific postoperative complication (such as a device left in the body) is assigned to the appropriate code(s) found in Chapter 17, Injury and Poisoning. Since the complication represents the underlying (definitive) diagnosis associated with the pain, no additional code should be assigned from category 338. If pain control/management is the reason for the encounter, a code from category 338 should be assigned as the principal or first-listed diagnosis in accordance with *Section I.C.6.a.1.a above*.

Postoperative pain may be reported as the principal or first-listed diagnosis when the stated reason for the admission/encounter is documented as postoperative pain control/management.

Postoperative pain may be reported as a secondary diagnosis code when a patient presents for outpatient surgery and develops an unusual or inordinate amount of postoperative pain.

Routine or expected postoperative pain immediately after surgery should not be coded.

The provider's documentation should be used to guide the coding of postoperative pain, as well as *Section III. Reporting Additional Diagnoses* and *Section IV. Diagnostic Coding and Reporting in the Outpatient Setting.*

See Section II.I.2 for information on sequencing of diagnoses for patients admitted to hospital inpatient care following post-operative observation.

See Section II.J for information on sequencing of diagnoses for patients admitted to hospital inpatient care from outpatient surgery.

See Section IV.A.2 for information on sequencing of diagnoses for patients admitted for observation.

4) **Chronic pain**

Chronic pain is classified to subcategory 338.2. There is no time frame defining when pain becomes chronic pain. The provider's documentation should be used to guide use of these codes.

5) **Neoplasm Related Pain**

Code 338.3 is assigned to pain documented as being related, associated or due to cancer, primary or secondary malignancy, or tumor. This code is assigned regardless of whether the pain is acute or chronic.

This code may be assigned as the principal or first-listed code when the stated reason for the admission/encounter is documented as pain

> > **control/pain management. The underlying neoplasm should be reported as an additional diagnosis.**
> >
> > **When the reason for the admission/encounter is management of the neoplasm and the pain associated with the neoplasm is also documented, code 338.3 may be assigned as an additional diagnosis.**
> >
> > *See Section I.C.2 for instructions on the sequencing of neoplasms for all other stated reasons for the admission/encounter (except for pain control/pain management).*

> **6) Chronic pain syndrome**
> > **This condition is different than the term "chronic pain," and therefore this code should only be used when the provider has specifically documented this condition.**

7. Chapter 7: Diseases of Circulatory System (390-459)

a. Hypertension

Hypertension Table

The Hypertension Table, found under the main term, "Hypertension", in the Alphabetic Index, contains a complete listing of all conditions due to or associated with hypertension and classifies them according to malignant, benign, and unspecified.

1) Hypertension, Essential, or NOS

Assign hypertension (arterial) (essential) (primary) (systemic) (NOS) to category code 401 with the appropriate fourth digit to indicate malignant (.0), benign (.1), or unspecified (.9). Do not use either .0 malignant or .1 benign unless medical record documentation supports such a designation.

2) Hypertension with Heart Disease

Heart conditions (425.8, 429.0-429.3, 429.8, 429.9) are assigned to a code from category 402 when a causal relationship is stated (due to hypertension) or implied (hypertensive). Use an additional code from category 428 to identify the type of heart failure in those patients with heart failure. More than one code from category 428 may be assigned if the patient has systolic or diastolic failure and congestive heart failure.

The same heart conditions (425.8, 429.0-429.3, 429.8, 429.9) with hypertension, but without a stated causal relationship, are coded separately. Sequence according to the circumstances of the admission/encounter.

3) Hypertensive <u>Chronic</u> Kidney Disease

Assign codes from category 403, Hypertensive **chronic** kidney disease, when conditions classified to categories 585-587 are present. Unlike hypertension with heart disease, ICD-9-CM presumes a cause-and-effect relationship and classifies **chronic kidney disease (CKD)** with hypertension as hypertensive **chronic** kidney disease.

Fifth digits for category 403 should be assigned as follows:

- **0 with CKD stage I through stage IV, or unspecified.**
- **1 with CKD stage V or end stage renal disease. The appropriate code from category 585, Chronic kidney disease, should be used as a secondary code with a code from category 403 to identify the stage of chronic kidney disease.**

See Section I.C.10.a for information on the coding of chronic kidney disease.

4) Hypertensive Heart and <u>Chronic</u> Kidney Disease

Assign codes from combination category 404, Hypertensive heart and **chronic** kidney disease, when both hypertensive kidney disease and hypertensive heart disease are stated in the diagnosis. Assume a relationship between the hypertension and the **chronic** kidney disease, whether or not the condition is so designated. Assign an additional code from category 428, to identify the type of heart failure. More than one code from category 428 may be assigned if the patient has systolic or diastolic failure and congestive heart failure.

Fifth digits for category 404 should be assigned as follows:
- **0 without heart failure and with chronic kidney disease (CKD) stage I through stage IV, or unspecified**
- **1 with heart failure and with CKD stage I through stage IV, or unspecified**
- **2 without heart failure and with CKD stage V or end stage renal disease**
- **3 with heart failure and with CKD stage V or end stage renal disease**

The appropriate code from category 585, Chronic kidney disease, should be used as a secondary code with a code from category 404 to identify the stage of kidney disease. *See Section I.C.10.a for information on the coding of chronic kidney disease.*

5) **Hypertensive Cerebrovascular Disease**

First assign codes from 430-438, Cerebrovascular disease, then the appropriate hypertension code from categories 401-405.

6) **Hypertensive Retinopathy**

Two codes are necessary to identify the condition. First assign the code from subcategory 362.11, Hypertensive retinopathy, then the appropriate code from categories 401-405 to indicate the type of hypertension.

7) **Hypertension, Secondary**

Two codes are required: one to identify the underlying etiology and one from category 405 to identify the hypertension. Sequencing of codes is determined by the reason for admission/encounter.

8) **Hypertension, Transient**

Assign code 796.2, Elevated blood pressure reading without diagnosis of hypertension, unless patient has an established diagnosis of hypertension. Assign code 642.3x for transient hypertension of pregnancy.

9) **Hypertension, Controlled**

Assign appropriate code from categories 401-405. This diagnostic statement usually refers to an existing state of hypertension under control by therapy.

10) **Hypertension, Uncontrolled**

Uncontrolled hypertension may refer to untreated hypertension or hypertension not responding to current therapeutic regimen. In either case, assign the appropriate code from categories 401-405 to designate the stage and type of hypertension. Code to the type of hypertension.

11) **Elevated Blood Pressure**

For a statement of elevated blood pressure without further specificity, assign code 796.2, Elevated blood pressure reading without diagnosis of hypertension, rather than a code from category 401.

b. Cerebral infarction/stroke/cerebrovascular accident (CVA)

The terms stroke and CVA are often used interchangeably to refer to a cerebral infarction. The terms stroke, CVA, and cerebral infarction NOS are all indexed to the default code 434.91, Cerebral artery occlusion, unspecified, with infarction. Code 436, Acute, but ill-defined, cerebrovascular disease, should not be used when the documentation states stroke or CVA.

c. Postoperative cerebrovascular accident

A cerebrovascular hemorrhage or infarction that occurs as a result of medical intervention is coded to 997.02, Iatrogenic cerebrovascular infarction or hemorrhage. Medical record documentation should clearly specify the cause- and-effect relationship between the medical intervention and the cerebrovascular accident in order to assign this code. A secondary code from the code range 430-432 or from a code from subcategories 433 or 434 with a fifth digit of "1" should also be used to identify the type of hemorrhage or infarct.

This guideline conforms to the use additional code note instruction at category 997. Code 436, Acute, but ill-defined, cerebrovascular disease, should not be used as a secondary code with code 997.02.

d. Late Effects of Cerebrovascular Disease

1) Category 438, Late Effects of Cerebrovascular disease

Category 438 is used to indicate conditions classifiable to categories 430-437 as the causes of late effects (neurologic deficits), themselves classified elsewhere. These "late effects" include neurologic deficits that persist after initial onset of conditions classifiable to 430-437. The neurologic deficits caused by cerebrovascular disease may be present from the onset or may arise at any time after the onset of the condition classifiable to 430-437.

2) Codes from category 438 with codes from 430-437

Codes from category 438 may be assigned on a health care record with codes from 430-437, if the patient has a current cerebrovascular accident (CVA) and deficits from an old CVA.

3) Code V12.59

Assign code V12.59 (and not a code from category 438) as an additional code for history of cerebrovascular disease when no neurologic deficits are present.

e. Acute myocardial infarction (AMI)

1) ST elevation myocardial infarction (STEMI) and non ST elevation myocardial infarction (NSTEMI)

The ICD-9-CM codes for acute myocardial infarction (AMI) identify the site, such as anterolateral wall or true posterior wall. Subcategories 410.0-410.6 and 410.8 are used for ST elevation myocardial infarction (STEMI). Subcategory 410.7, Subendocardial infarction, is used for non ST elevation myocardial infarction (NSTEMI) and nontransmural MIs.

2) Acute myocardial infarction, unspecified

Subcategory 410.9 is the default for the unspecified term acute myocardial infarction. If only STEMI or transmural MI without the site is documented, query the provider as to the site, or assign a code from subcategory 410.9.

3) AMI documented as nontransmural or subendocardial but site provided

If an AMI is documented as nontransmural or subendocardial, but the site is provided, it is still coded as a subendocardial AMI. If NSTEMI evolves to STEMI, assign the STEMI code. If STEMI converts to NSTEMI due to thrombolytic therapy, it is still coded as STEMI.

8. Chapter 8: Diseases of Respiratory System (460-519)

a. Chronic Obstructive Pulmonary Disease [COPD] and Asthma

1) Conditions that comprise COPD and Asthma

The conditions that comprise COPD are obstructive chronic bronchitis, subcategory 491.2, and emphysema, category 492. All asthma codes are under category 493, Asthma. Code 496, Chronic airway obstruction, not elsewhere classified, is a nonspecific code that should only be used when the documentation in a medical record does not specify the type of COPD being treated.

2) Acute exacerbation of chronic obstructive bronchitis and asthma

The codes for chronic obstructive bronchitis and asthma distinguish between uncomplicated cases and those in acute exacerbation. An acute exacerbation is a worsening or a

decompensation of a chronic condition. An acute exacerbation is not equivalent to an infection superimposed on a chronic condition, though an exacerbation may be triggered by an infection.

3) Overlapping nature of the conditions that comprise COPD and asthma

Due to the overlapping nature of the conditions that make up COPD and asthma, there are many variations in the way these conditions are documented. Code selection must be based on the terms as documented. When selecting the correct code for the documented type of COPD and asthma, it is essential to first review the index, and then verify the code in the tabular list. There are many instructional notes under the different COPD subcategories and codes. It is important that all such notes be reviewed to assure correct code assignment.

4) Acute exacerbation of asthma and status asthmaticus

An acute exacerbation of asthma is an increased severity of the asthma symptoms, such as wheezing and shortness of breath. Status asthmaticus refers to a patient's failure to respond to therapy administered during an asthmatic episode and is a life threatening complication that requires emergency care. If status asthmaticus is documented by the provider with any type of COPD or with acute bronchitis, the status asthmaticus should be sequenced first. It supersedes any type of COPD including that with acute exacerbation or acute bronchitis. It is inappropriate to assign an asthma code with 5th digit 2, with acute exacerbation, together with an asthma code with 5th digit 1, with status asthmatics. Only the 5th digit 1 should be assigned.

b. Chronic Obstructive Pulmonary Disease [COPD] and Bronchitis

1) Acute bronchitis with COPD

Acute bronchitis, code 466.0, is due to an infectious organism. When acute bronchitis is documented with COPD, code 491.22, Obstructive chronic bronchitis with acute bronchitis, should be assigned. It is not necessary to also assign code 466.0. If a medical record documents acute bronchitis with COPD with acute exacerbation, only code 491.22 should be assigned. The acute bronchitis included in code 491.22 supersedes the acute exacerbation. If a medical record documents COPD with acute exacerbation without mention of acute bronchitis, only code 491.21 should be assigned.

c. Acute Respiratory Failure

1) Acute respiratory failure as principal diagnosis

Code 518.81, Acute respiratory failure, may be assigned as a principal diagnosis when it is the condition established after study to be chiefly responsible for occasioning the admission to the hospital, and the selection is supported by the Alphabetic Index and Tabular List. However, chapter-specific coding guidelines (such as obstetrics, poisoning, HIV, newborn) that provide sequencing direction take precedence.

2) Acute respiratory failure as secondary diagnosis

Respiratory failure may be listed as a secondary diagnosis if it occurs after admission, or if it is present on admission, but does not meet the definition of principal diagnosis.

3) Sequencing of acute respiratory failure and another acute condition

When a patient is admitted with respiratory failure and another acute condition, (e.g., myocardial infarction, cerebrovascular accident), the principal diagnosis will not be the same in every situation. Selection of the principal diagnosis will be dependent on the circumstances of admission. If both the respiratory failure and the other acute condition are equally responsible for occasioning the admission to the hospital, and there are no chapter-specific sequencing rules, the guideline regarding two or more diagnoses that equally meet the definition for principal diagnosis *(Section II, C.)* may be applied in these situations.

If the documentation is not clear as to whether acute respiratory failure and another condition are equally responsible for occasioning the admission, query the provider for clarification.

9. Chapter 9: Diseases of Digestive System (520-579)

Reserved for future guideline expansion

10. Chapter 10: Diseases of Genitourinary System (580-629)

a. Chronic kidney disease

1) Stages of chronic kidney disease (CKD)

The ICD-9-CM classifies CKD based on severity. The severity of CKD is designated by stages I-V. Stage II, code 585.2, equates to mild CKD; stage III, code 585.3, equates to moderate CKD; and stage IV, code 585.4, equates to severe CKD. Code 585.6, End stage renal disease (ESRD), is assigned when the provider has documented end-stage-renal disease (ESRD).

If both a stage of CKD and ESRD are documented, assign code 585.6 only.

2) Chronic kidney disease and kidney transplant status

Patients who have undergone kidney transplant may still have some form of CKD, because the kidney transplant may not fully restore kidney function. Therefore, the presence of CKD alone does not constitute a transplant complication. Assign the appropriate 585 code for the patient's stage of CKD and code V42.0. If a transplant complication such as failure or rejection is documented, see section I.C.17.f.1.b for information on coding complications of a kidney transplant. If the documentation is unclear as to whether the patient has a complication of the transplant, query the provider.

3) Chronic kidney disease with other conditions

Patients with CKD may also suffer from other serious conditions, most commonly diabetes mellitus and hypertension. The sequencing of the CKD code in relationship to codes for other contributing conditions is based on the conventions in the tabular list.
See I.C.3.a.4 for sequencing instructions for diabetes.
See I.C.4.a.1 for anemia in CKD.
*See I.C.7.a.3 for hypertensive **chronic** kidney disease.*
See I.C.17.f.1.b, Kidney transplant complications, for instructions on coding of documented rejection or failure.

11. Chapter 11: Complications of Pregnancy, Childbirth, and the Puerperium (630-677)

a. General Rules for Obstetric Cases

1) Codes from chapter 11 and sequencing priority

Obstetric cases require codes from chapter 11, codes in the range 630-677, Complications of Pregnancy, Childbirth, and the Puerperium. Chapter 11 codes have sequencing priority over codes from other chapters. Additional codes from other chapters may be used in conjunction with chapter 11 codes to further specify conditions. Should the provider document that the pregnancy is incidental to the encounter, then code V22.2 should be used in place of any chapter 11 codes. It is the provider's responsibility to state that the condition being treated is not affecting the pregnancy.

2) Chapter 11 codes used only on the maternal record

Chapter 11 codes are to be used only on the maternal record, never on the record of the newborn.

3) Chapter 11 fifth-digits

Categories 640-648, 651-676 have required fifth-digits, which indicate whether the encounter is antepartum, postpartum and whether a delivery has also occurred.

4) Fifth-digits, appropriate for each code

The fifth-digits, which are appropriate for each code number, are listed in brackets under each code. The fifth-digits on each code should all be consistent with each other. That is, should a delivery occur all of the fifth-digits should indicate the delivery.

b. Selection of OB Principal or First-listed Diagnosis

1) Routine outpatient prenatal visits

For routine outpatient prenatal visits when no complications are present codes V22.0, Supervision of normal first pregnancy, and V22.1, Supervision of other normal pregnancy, should be used as the first-listed diagnoses. These codes should not be used in conjunction with chapter 11 codes.

2) Prenatal outpatient visits for high-risk patients

For prenatal outpatient visits for patients with high-risk pregnancies, a code from category V23, Supervision of high-risk pregnancy, should be used as the principal or

first-listed diagnosis. Secondary chapter 11 codes may be used in conjunction with these codes if appropriate.

3) Episodes when no delivery occurs

In episodes when no delivery occurs, the principal diagnosis should correspond to the principal complication of the pregnancy, which necessitated the encounter. Should more than one complication exist, all of which are treated or monitored, any of the complications codes may be sequenced first.

4) When a delivery occurs

When a delivery occurs, the principal diagnosis should correspond to the main circumstances or complication of the delivery. In cases of cesarean delivery, the selection of the principal diagnosis should correspond to the reason the cesarean delivery was performed unless the reason for admission/encounter was unrelated to the condition resulting in the cesarean delivery.

5) Outcome of delivery

An outcome of delivery code, V27.0-V27.9, should be included on every maternal record when a delivery has occurred. These codes are not to be used on subsequent records or on the newborn record.

c. Fetal Conditions Affecting the Management of the Mother

1) Codes from category 655

Known or suspected fetal abnormality affecting management of the mother, and category 656, Other fetal and placental problems affecting the management of the mother, are assigned only when the fetal condition is actually responsible for modifying the management of the mother, i.e., by requiring diagnostic studies, additional observation, special care, or termination of pregnancy. The fact that the fetal condition exists does not justify assigning a code from this series to the mother's record.

2) In utero surgery

In cases when surgery is performed on the fetus, a diagnosis code from category 655, Known or suspected fetal abnormalities affecting management of the mother, should be assigned identifying the fetal condition. Procedure code 75.36,

Correction of fetal defect, should be assigned on the hospital inpatient record.

No code from Chapter 15, the perinatal codes, should be used on the mother's record to identify fetal conditions. Surgery performed in utero on a fetus is still to be coded as an obstetric encounter.

d. HIV Infection in Pregnancy, Childbirth and the Puerperium

During pregnancy, childbirth or the puerperium, a patient admitted because of an HIV-related illness should receive a principal diagnosis of 647.6X, Other specified infectious and parasitic diseases in the mother classifiable elsewhere, but complicating the pregnancy, childbirth or the puerperium, followed by 042 and the code(s) for the HIV-related illness(es).

Patients with asymptomatic HIV infection status admitted during pregnancy, childbirth, or the puerperium should receive codes of 647.6X and V08.

e. Current Conditions Complicating Pregnancy

Assign a code from subcategory 648.x for patients that have current conditions when the condition affects the management of the pregnancy, childbirth, or the puerperium. Use additional secondary codes from other chapters to identify the conditions, as appropriate.

f. Diabetes mellitus in pregnancy

Diabetes mellitus is a significant complicating factor in pregnancy. Pregnant women who are diabetic should be assigned code 648.0x, Diabetes mellitus complicating pregnancy, and a secondary code from category 250, Diabetes mellitus, to identify the type of diabetes.

Code V58.67, Long-term (current) use of insulin, should also be assigned if the diabetes mellitus is being treated with insulin.

g. Gestational diabetes

Gestational diabetes can occur during the second and third trimester of pregnancy in women who were not diabetic prior to pregnancy. Gestational diabetes can cause complications in the pregnancy similar to those of pre-existing diabetes mellitus. It also puts the woman at greater risk of developing diabetes after the pregnancy. Gestational diabetes is coded to 648.8x, Abnormal glucose tolerance. Codes 648.0x and 648.8x should never be used together on the same record.

Code V58.67, Long-term (current) use of insulin, should also be assigned if the gestational diabetes is being treated with insulin.

h. Normal Delivery, Code 650

1) Normal delivery
Code 650 is for use in cases when a woman is admitted for a full-term normal delivery and delivers a single, healthy infant without any complications antepartum, during the delivery, or postpartum during the delivery episode. Code 650 is always a principal diagnosis. It is not to be used if any other code from chapter 11 is needed to describe a current complication of the antenatal, delivery, or perinatal period. Additional codes from other chapters may be used with code 650 if they are not related to or are in any way complicating the pregnancy.

2) Normal delivery with resolved antepartum complication
Code 650 may be used if the patient had a complication at some point during her pregnancy, but the complication is not present at the time of the admission for delivery.

3) V27.0, Single liveborn, outcome of delivery
V27.0, Single liveborn, is the only outcome of delivery code appropriate for use with 650.

i. The Postpartum and Peripartum Periods

1) Postpartum and peripartum periods
The postpartum period begins immediately after delivery and continues for six weeks following delivery. The peripartum period is defined as the last month of pregnancy to five months postpartum.

2) Postpartum complication
A postpartum complication is any complication occurring within the six-week period.

3) Pregnancy-related complications after 6 week period
Chapter 11 codes may also be used to describe pregnancy-related complications after the six-week period should the provider document that a condition is pregnancy related.

4) Postpartum complications occurring during the same admission as delivery

Postpartum complications that occur during the same admission as the delivery are identified with a fifth digit of "2." Subsequent admissions/encounters for postpartum complications should be identified with a fifth digit of "4."

5) Admission for routine postpartum care following delivery outside hospital

When the mother delivers outside the hospital prior to admission and is admitted for routine postpartum care and no complications are noted, code V24.0, Postpartum care and examination immediately after delivery, should be assigned as the principal diagnosis.

6) Admission following delivery outside hospital with postpartum conditions

A delivery diagnosis code should not be used for a woman who has delivered prior to admission to the hospital. Any postpartum conditions and/or postpartum procedures should be coded.

j. Code 677, Late effect of complication of pregnancy

1) Code 677

Code 677, Late effect of complication of pregnancy, childbirth, and the puerperium is for use in those cases when an initial complication of a pregnancy develops a sequelae requiring care or treatment at a future date.

2) After the initial postpartum period

This code may be used at any time after the initial postpartum period.

3) Sequencing of Code 677

This code, like all late effect codes, is to be sequenced following the code describing the sequelae of the complication.

k. Abortions

1) Fifth-digits required for abortion categories

Fifth-digits are required for abortion categories 634-637. Fifth-digit 1, incomplete, indicates that all of the products of conception have not been expelled from the uterus. Fifth-digit

2, complete, indicates that all products of conception have been expelled from the uterus prior to the episode of care.

2) Code from categories 640-648 and 651-659

A code from categories 640-648 and 651-659 may be used as additional codes with an abortion code to indicate the complication leading to the abortion.

Fifth digit 3 is assigned with codes from these categories when used with an abortion code because the other fifth digits will not apply. Codes from the 660-669 series are not to be used for complications of abortion.

3) Code 639 for complications

Code 639 is to be used for all complications following abortion. Code 639 cannot be assigned with codes from categories 634-638.

4) Abortion with Liveborn Fetus

When an attempted termination of pregnancy results in a liveborn fetus assign code 644.21, Early onset of delivery, with an appropriate code from category V27, Outcome of Delivery. The procedure code for the attempted termination of pregnancy should also be assigned.

5) Retained Products of Conception following an abortion

Subsequent admissions for retained products of conception following a spontaneous or legally induced abortion are assigned the appropriate code from category 634, Spontaneous abortion, or 635 Legally induced abortion, with a fifth digit of "1" (incomplete). This advice is appropriate even when the patient was discharged previously with a discharge diagnosis of complete abortion.

12. Chapter 12: Diseases Skin and Subcutaneous Tissue (680-709)

Reserved for future guideline expansion

13. Chapter 13: Diseases of Musculoskeletal and Connective Tissue (710-739)

a. Coding of Pathologic Fractures

1) Acute Fractures vs. Aftercare

Pathologic fractures are reported using subcategory 733.1, when the fracture is newly diagnosed. Subcategory 733.1 may be used while the patient is receiving active treatment for the fracture. Examples of active treatment are: surgical treatment, emergency department encounter, evaluation and treatment by a new physician.

Fractures are coded using the aftercare codes (subcategories V54.0, V54.2, V54.8 or V54.9) for encounters after the patient has completed active treatment of the fracture and is receiving routine care for the fracture during the healing or recovery phase. Examples of fracture aftercare are: cast change or removal, removal of external or internal fixation device, medication adjustment, and follow up visits following fracture treatment.

Care for complications of surgical treatment for fracture repairs during the healing or recovery phase should be coded with the appropriate complication codes.

Care of complications of fractures, such as malunion and nonunion, should be reported with the appropriate codes.

See Section I. C. 17.b for information on the coding of traumatic fractures.

14. Chapter 14: Congenital Anomalies (740-759)

a. Codes in categories 740-759, Congenital Anomalies

Assign an appropriate code(s) from categories 740-759, Congenital Anomalies, when an anomaly is documented. A congenital anomaly may be the principal/first listed diagnosis on a record or a secondary diagnosis.

When a congenital anomaly does not have a unique code assignment, assign additional code(s) for any manifestations that may be present.

When the code assignment specifically identifies the congenital anomaly, manifestations that are an inherent component of the anomaly should not be coded separately. Additional codes should be assigned for manifestations that are not an inherent component.

Codes from Chapter 14 may be used throughout the life of the patient. If a congenital anomaly has been corrected, a personal history code should be used to identify the history of the anomaly. Although present at birth, a congenital anomaly may not be identified until later in life. Whenever the condition is diagnosed by the physician, it is appropriate to assign a code from codes 740-759.

For the birth admission, the appropriate code from category V30, Liveborn infants, according to type of birth should be sequenced as the principal diagnosis, followed by any congenital anomaly codes, 740-759.

## 15.	Chapter 15: Newborn (Perinatal) Guidelines (760-779)

For coding and reporting purposes the perinatal period is defined as **before** birth through the 28th day following birth. The following guidelines are provided for reporting purposes. Hospitals may record other diagnoses as needed for internal data use.

### a.	General Perinatal Rules

#### 1)	Chapter 15 Codes

They are <u>never</u> for use on the maternal record. Codes from Chapter 11, the obstetric chapter, are never permitted on the newborn record. Chapter 15 code may be used throughout the life of the patient if the condition is still present.

#### 2)	Sequencing of perinatal codes

Generally, codes from Chapter 15 should be sequenced as the principal/first-listed diagnosis on the newborn record, with the exception of the appropriate V30 code for the birth episode, followed by codes from any other chapter that provide additional detail. The "use additional code" note at the beginning of the chapter supports this guideline. If the index does not provide a specific code for a perinatal condition, assign code 779.89, Other specified conditions originating in the perinatal period, followed by the code from another chapter that specifies the condition. Codes for signs and symptoms may be assigned when a definitive diagnosis has not been established.

3) Birth process or community acquired conditions

If a newborn has a condition that may be either due to the birth process or community acquired and the documentation does not indicate which it is, the default is due to the birth process and the code from Chapter 15 should be used. If the condition is community-acquired, a code from Chapter 15 should not be assigned.

4) Code all clinically significant conditions

All clinically significant conditions noted on routine newborn examination should be coded. A condition is clinically significant if it requires:

- clinical evaluation; or
- therapeutic treatment; or
- diagnostic procedures; or
- extended length of hospital stay; or
- increased nursing care and/or monitoring; or
- has implications for future health care needs

Note: The perinatal guidelines listed above are the same as the general coding guidelines for "additional diagnoses", except for the final point regarding implications for future health care needs. Codes should be assigned for conditions that have been specified by the provider as having implications for future health care needs. Codes from the perinatal chapter should not be assigned unless the provider has established a definitive diagnosis.

b. Use of codes V30-V39

When coding the birth of an infant, assign a code from categories V30-V39, according to the type of birth. A code from this series is assigned as a principal diagnosis, and assigned only once to a newborn at the time of birth.

c. Newborn transfers

If the newborn is transferred to another institution, the V30 series is not used at the receiving hospital.

d. Use of category V29

1) Assigning a code from category V29

Assign a code from category V29, Observation and evaluation of newborns and infants for suspected conditions not found, to identify those instances when a healthy newborn is evaluated for a suspected condition that is determined after study not to be present. Do not use a code from category V29 when the

patient has identified signs or symptoms of a suspected problem; in such cases, code the sign or symptom.

A code from category V29 may also be assigned as a principal code for readmissions or encounters when the V30 code no longer applies. Codes from category V29 are for use only for healthy newborns and infants for which no condition after study is found to be present.

2) V29 code on a birth record

A V29 code is to be used as a secondary code after the V30, Outcome of delivery, code.

e. Use of other V codes on perinatal records

V codes other than V30 and V29 may be assigned on a perinatal or newborn record code. The codes may be used as a principal or first-listed diagnosis for specific types of encounters or for readmissions or encounters when the V30 code no longer applies.
See Section I.C.18 for information regarding the assignment of V codes.

f. Maternal Causes of Perinatal Morbidity

Codes from categories 760-763, Maternal causes of perinatal morbidity and mortality, are assigned only when the maternal condition has actually affected the fetus or newborn. The fact that the mother has an associated medical condition or experiences some complication of pregnancy, labor or delivery does not justify the routine assignment of codes from these categories to the newborn record.

g. Congenital Anomalies in Newborns

For the birth admission, the appropriate code from category V30, Liveborn infants according to type of birth, should be used, followed by any congenital anomaly codes, categories 740-759. Use additional secondary codes from other chapters to specify conditions associated with the anomaly, if applicable.
Also, see Section I.C.14 for information on the coding of congenital anomalies.

h. Coding Additional Perinatal Diagnoses

1) Assigning codes for conditions that require treatment

Assign codes for conditions that require treatment or further investigation, prolong the length of stay, or require resource utilization.

2) Codes for conditions specified as having implications for future health care needs

Assign codes for conditions that have been specified by the provider as having implications for future health care needs.

Note: This guideline should not be used for adult patients.

3) Codes for newborn conditions originating in the perinatal period

Assign a code for newborn conditions originating in the perinatal period (categories 760-779), as well as complications arising during the current episode of care classified in other chapters, only if the diagnoses have been documented by the responsible provider at the time of transfer or discharge as having affected the fetus or newborn.

i.   Prematurity and Fetal Growth Retardation

Providers utilize different criteria in determining prematurity. A code for prematurity should not be assigned unless it is documented. The 5th digit assignment for codes from category 764 and subcategories 765.0 and 765.1 should be based on the recorded birth weight and estimated gestational age.

A code from subcategory 765.2, Weeks of gestation, should be assigned as an additional code with category 764 and codes from 765.0 and 765.1 to specify weeks of gestation as documented by the provider in the record.

j.   Newborn sepsis

Code 771.81, Septicemia [sepsis] of newborn, should be assigned with a secondary code from category 041, Bacterial infections in conditions classified elsewhere and of unspecified site, to identify the organism. It is not necessary to use a code from subcategory 995.9, Systemic inflammatory response syndrome (SIRS), on a newborn record. A code from category 038, Septicemia, should not be used on a newborn record. Code 771.81 describes the sepsis.

16. Chapter 16: Signs, Symptoms and Ill-Defined Conditions (780-799)

Reserved for future guideline expansion

17. Chapter 17: Injury and Poisoning (800-999)

a. Coding of Injuries

When coding injuries, assign separate codes for each injury unless a combination code is provided, in which case the combination code is assigned. Multiple injury codes are provided in ICD-9-CM, but should not be assigned unless information for a more specific code is not available. These codes are not to be used for normal, healing surgical wounds or to identify complications of surgical wounds.

The code for the most serious injury, as determined by the provider and the focus of treatment, is sequenced first.

1) Superficial injuries

Superficial injuries such as abrasions or contusions are not coded when associated with more severe injuries of the same site.

2) Primary injury with damage to nerves/blood vessels

When a primary injury results in minor damage to peripheral nerves or blood vessels, the primary injury is sequenced first with additional code(s) from categories 950-957, Injury to nerves and spinal cord, and/or 900-904, Injury to blood vessels. When the primary injury is to the blood vessels or nerves, that injury should be sequenced first.

b. Coding of <u>Traumatic</u> Fractures

The principles of multiple coding of injuries should be followed in coding fractures. Fractures of specified sites are coded individually by site in accordance with both the provisions within categories 800-829 and the level of detail furnished by medical record content. Combination categories for multiple fractures are provided for use when there is insufficient detail in the medical record (such as trauma cases transferred to another hospital), when the reporting form limits the number of codes that can be used in reporting pertinent clinical data, or when there is insufficient specificity at the fourth-digit or fifth-digit level. More specific guidelines are as follows:

1) **Acute Fractures vs. Aftercare**

   Traumatic fractures are coded using the acute fracture codes (800-829) while the patient is receiving active treatment for the fracture.   Examples of active treatment are: surgical treatment, emergency department encounter, and evaluation and treatment by a new physician.

   Fractures are coded using the aftercare codes (subcategories V54.0, V54.1, V54.8, or V54.9) for encounters after the patient has completed active treatment of the fracture and is receiving routine care for the fracture during the healing or recovery phase. Examples of fracture aftercare are: cast change or removal, removal of external or internal fixation device, medication adjustment, and follow up visits following fracture treatment.

   Care for complications of surgical treatment for fracture repairs during the healing or recovery phase should be coded with the appropriate complication codes.

   Care of complications of fractures, such as malunion and nonunion, should be reported with the appropriate codes.

   Pathologic fractures are not coded in the 800-829 range, but instead are assigned to subcategory 733.1. *See Section I.C.13.a for additional information.*

2) **Multiple fractures of same limb**

   Multiple fractures of same limb classifiable to the same three-digit or four-digit category are coded to that category.

3) **Multiple unilateral or bilateral fractures of same bone**

   Multiple unilateral or bilateral fractures of same bone(s) but classified to different fourth-digit subdivisions (bone part) within the same three-digit category are coded individually by site.

4) **Multiple fracture categories 819 and 828**

   Multiple fracture categories 819 and 828 classify bilateral fractures of both upper limbs (819) and both lower limbs (828), but without any detail at the fourth-digit level other than open and closed type of fractures.

5) **Multiple fractures sequencing**

Multiple fractures are sequenced in accordance with the severity of the fracture. The provider should be asked to list the fracture diagnoses in the order of severity.

c. Coding of Burns

Current burns (940-948) are classified by depth, extent and by agent (E code). Burns are classified by depth as first degree (erythema), second degree (blistering), and third degree (full-thickness involvement).

1) **Sequencing of burn and related condition codes**

Sequence first the code that reflects the highest degree of burn when more than one burn is present.

a. When the reason for the admission or encounter is for treatment of external multiple burns, sequence first the code that reflects the burn of the highest degree.

b. When a patient has both internal and external burns, the circumstances of admission govern the selection of the principal diagnosis or first-listed diagnosis.

c. When a patient is admitted for burn injuries and other related conditions such as smoke inhalation and/or respiratory failure, the circumstances of admission govern the selection of the principal or first-listed diagnosis.

2) **Burns of the same local site**

Classify burns of the same local site (three-digit category level, 940-947) but of different degrees to the subcategory identifying the highest degree recorded in the diagnosis.

3) **Non-healing burns**

Non-healing burns are coded as acute burns.
Necrosis of burned skin should be coded as a non-healed burn.

4) **Code 958.3, Posttraumatic wound infection**

Assign code 958.3, Posttraumatic wound infection, not elsewhere classified, as an additional code for any documented infected burn site.

5) **Assign separate codes for each burn site**

When coding burns, assign separate codes for each burn site. Category 946 Burns of Multiple specified sites, should only be used if the location of the burns are not documented.

Category 949, Burn, unspecified, is extremely vague and should rarely be used.

6)   Assign codes from category 948, Burns

Burns classified according to extent of body surface involved, when the site of the burn is not specified or when there is a need for additional data. It is advisable to use category 948 as additional coding when needed to provide data for evaluating burn mortality, such as that needed by burn units. It is also advisable to use category 948 as an additional code for reporting purposes when there is mention of a third-degree burn involving 20 percent or more of the body surface.

In assigning a code from category 948:

Fourth-digit codes are used to identify the percentage of total body surface involved in a burn (all degree).

Fifth-digits are assigned to identify the percentage of body surface involved in third-degree burn.

Fifth-digit zero (0) is assigned when less than 10 percent or when no body surface is involved in a third-degree burn.

Category 948 is based on the classic "rule of nines" in estimating body surface involved: head and neck are assigned nine percent, each arm nine percent, each leg 18 percent, the anterior trunk 18 percent, posterior trunk 18 percent, and genitalia one percent. Providers may change these percentage assignments where necessary to accommodate infants and children who have proportionately larger heads than adults and patients who have large buttocks, thighs, or abdomen that involve burns.

7)   Encounters for treatment of late effects of burns

Encounters for the treatment of the late effects of burns (i.e., scars or joint contractures) should be coded to the residual condition (sequelae) followed by the appropriate late effect code (906.5-906.9). A late effect E code may also be used, if desired.

8) Sequelae with a late effect code and current burn

When appropriate, both a sequelae with a late effect code, and a current burn code may be assigned on the same record (when both a current burn and sequelae of an old burn exist).

d. Coding of Debridement of Wound, Infection, or Burn

Excisional debridement involves surgical removal or cutting away, as opposed to a mechanical (brushing, scrubbing, washing) debridement.

For coding purposes, excisional debridement is assigned to code 86.22.

Nonexcisional debridement is assigned to code 86.28.

e. Adverse Effects, Poisoning and Toxic Effects

The properties of certain drugs, medicinal and biological substances or combinations of such substances, may cause toxic reactions. The occurrence of drug toxicity is classified in ICD-9-CM as follows:

1) Adverse Effect

When the drug was correctly prescribed and properly administered, code the reaction plus the appropriate code from the E930-E949 series. Codes from the E930-E949 series must be used to identify the causative substance for an adverse effect of drug, medicinal and biological substances, correctly prescribed and properly administered. The effect, such as tachycardia, delirium, gastrointestinal hemorrhaging, vomiting, hypokalemia, hepatitis, renal failure, or respiratory failure, is coded and followed by the appropriate code from the E930-E949 series.

Adverse effects of therapeutic substances correctly prescribed and properly administered (toxicity, synergistic reaction, side effect, and idiosyncratic reaction) may be due to (1) differences among patients, such as age, sex, disease, and genetic factors, and (2) drug-related factors, such as type of drug, route of administration, duration of therapy, dosage, and bioavailability.

2) Poisoning

(a) Error was made in drug prescription

Errors made in drug prescription or in the administration of the drug by provider, nurse, patient, or other person, use the appropriate poisoning code from the 960-979 series.

(b) Overdose of a drug intentionally taken

If an overdose of a drug was intentionally taken or administered and resulted in drug toxicity, it would be coded as a poisoning (960-979 series).

(c) Nonprescribed drug taken with correctly prescribed and properly administered drug

If a nonprescribed drug or medicinal agent was taken in combination with a correctly prescribed and properly administered drug, any drug toxicity or other reaction resulting from the interaction of the two drugs would be classified as a poisoning.

(d) Sequencing of poisoning

When coding a poisoning or reaction to the improper use of a medication (e.g., wrong dose, wrong substance, wrong route of administration) the poisoning code is sequenced first, followed by a code for the manifestation. If there is also a diagnosis of drug abuse or dependence to the substance, the abuse or dependence is coded as an additional code.
See Section I.C.3.a.6.b. if poisoning is the result of insulin pump malfunctions and Section I.C.19 for general use of E-codes.

3) Toxic Effects

(a) Toxic effect codes

When a harmful substance is ingested or comes in contact with a person, this is classified as a toxic effect. The toxic effect codes are in categories 980-989.

(b) Sequencing toxic effect codes

A toxic effect code should be sequenced first, followed by the code(s) that identify the result of the toxic effect.

(c) External cause codes for toxic effects

An external cause code from categories E860-E869 for accidental exposure, codes E950.6 or E950.7 for intentional self-harm, category E962 for assault, or categories E980-E982, for undetermined, should also be assigned to indicate intent.

f.   Complications of care

1)   Transplant complications

(a)   Transplant complications other than kidney

Codes under subcategory 996.8, Complications of transplanted organ, are for use for both complications and rejection of transplanted organs. A transplant complication code is only assigned if the complication affects the function of the transplanted organ. Two codes are required to fully describe a transplant complication, the appropriate code from subcategory 996.8 and a secondary code that identifies the complication.

Pre-existing conditions or conditions that develop after the transplant are not coded as complications unless they affect the function of the transplanted organs.

(b)   Kidney transplant <u>complications</u>

Code 996.81 should be assigned for documented complications of a kidney transplant, such as transplant failure or rejection. Code 996.81 should not be assigned for post kidney transplant patients who have chronic kidney (CKD) unless a transplant complication such as transplant failure or rejection is documented. If the documentation is unclear as to whether the patient has a complication of the transplant, query the provider.

For patients with CKD following a kidney transplant, but who do not have a complication such as failure or rejection, *see section I.C.10.a.2, Chronic kidney disease and kidney transplant status*.

g.   <u>SIRS due to Non-infectious Process</u>

The systemic inflammatory response syndrome (SIRS) can develop as a result of certain non-infectious disease processes, such as trauma, malignant neoplasm, or pancreatitis. When SIRS is documented with a noninfectious condition, and no subsequent infection is documented, the code for the underlying condition, such as an injury, should be assigned, followed by code 995.93, Systemic inflammatory response syndrome due to noninfectious process without acute organ dysfunction, or 995.94, Systemic inflammatory response syndrome due to non-infectious process with acute organ dysfunction. If an acute organ dysfunction is

documented, the appropriate code(s) for the associated acute organ dysfunction(s) should be assigned in addition to code 995.94. If acute organ dysfunction is documented, but it cannot be determined if the acute organ dysfunction is associated with SIRS or due to another condition (e.g., directly due to the trauma), the provider should be queried.

When the non-infectious condition has led to an infection that results in SIRS, *see Section I.C.1.b.11 for the guideline for sepsis and severe sepsis associated with a non-infectious process.*

18. Classification of Factors Influencing Health Status and Contact with Health Service (Supplemental V01-V84)

Note: The chapter specific guidelines provide additional information about the use of V codes for specified encounters.

a. Introduction

ICD-9-CM provides codes to deal with encounters for circumstances other than a disease or injury. The Supplementary Classification of Factors Influencing Health Status and Contact with Health Services (V01.0 - V84.8) is provided to deal with occasions when circumstances other than a disease or injury (codes 001-999) are recorded as a diagnosis or problem.

There are four primary circumstances for the use of V codes:

1) A person who is not currently sick encounters the health services for some specific reason, such as to act as an organ donor, to receive prophylactic care, such as inoculations or health screenings, or to receive counseling on health related issues.

2) A person with a resolving disease or injury, or a chronic, long-term condition requiring continuous care, encounters the health care system for specific aftercare of that disease or injury (e.g., dialysis for renal disease; chemotherapy for malignancy; cast change). A diagnosis/symptom code should be used whenever a current, acute, diagnosis is being treated or a sign or symptom is being studied.

3) Circumstances or problems influence a person's health status but are not in themselves a current illness or injury.

4) Newborns, to indicate birth status

b.   V codes use in any healthcare setting

V codes are for use in any healthcare setting. V codes may be used as either a first listed (principal diagnosis code in the inpatient setting) or secondary code, depending on the circumstances of the encounter. Certain V codes may only be used as first listed, others only as secondary codes.
See Section I.C.18.e, V Code Table.

c.   V Codes indicate a reason for an encounter

They are not procedure codes. A corresponding procedure code must accompany a V code to describe the procedure performed.

d.   Categories of V Codes

1)   Contact/Exposure

Category V01 indicates contact with or exposure to communicable diseases. These codes are for patients who do not show any sign or symptom of a disease but have been exposed to it by close personal contact with an infected individual or are in an area where a disease is epidemic. These codes may be used as a first listed code to explain an encounter for testing, or, more commonly, as a secondary code to identify a potential risk.

2)   Inoculations and vaccinations

Categories V03-V06 are for encounters for inoculations and vaccinations. They indicate that a patient is being seen to receive a prophylactic inoculation against a disease. The injection itself must be represented by the appropriate procedure code. A code from V03-V06 may be used as a secondary code if the inoculation is given as a routine part of preventive health care, such as a well-baby visit.

3)   Status

Status codes indicate that a patient is either a carrier of a disease or has the sequelae or residual of a past disease or condition. This includes such things as the presence of prosthetic or mechanical devices resulting from past treatment. A status code is informative, because the status may affect the course of treatment and its outcome. A status code is distinct from a history code. The history code indicates that the patient no longer has the condition.

A status code should not be used with a diagnosis code from one of the body system chapters, if the diagnosis code includes the information provided by the status code. For example,

code V42.1, Heart transplant status, should not be used with code 996.83, Complications of transplanted heart. The status code does not provide additional information. The complication code indicates that the patient is a heart transplant patient.

The status V codes/categories are:

V02   Carrier or suspected carrier of infectious diseases
           Carrier status indicates that a person harbors the specific organisms of a disease without manifest symptoms and is capable of transmitting the infection.

V08   Asymptomatic HIV infection status
           This code indicates that a patient has tested positive for HIV but has manifested no signs or symptoms of the disease.

V09   Infection with drug-resistant microorganisms
           This category indicates that a patient has an infection that is resistant to drug treatment. Sequence the infection code first.

V21   Constitutional states in development

V22.2   Pregnant state, incidental
           This code is a secondary code only for use when the pregnancy is in no way complicating the reason for visit. Otherwise, a code from the obstetric chapter is required.

V26.5x   Sterilization status

V42   Organ or tissue replaced by transplant

V43   Organ or tissue replaced by other means

V44   Artificial opening status

V45   Other postsurgical states

V46   Other dependence on machines

V49.6   Upper limb amputation status

V49.7   Lower limb amputation status

V49.81   Postmenopausal status

V49.82   Dental sealant status

V49.83   Awaiting organ transplant status

V58.6   Long-term (current) drug use
           This subcategory indicates a patient's continuous use of a prescribed drug (including such things as aspirin therapy) for the long-term treatment of a condition or for prophylactic use. It is not for use for patients who have addictions to drugs.

           Assign a code from subcategory V58.6, Long-term (current) drug use, if the patient is receiving a medication for an extended period as a prophylactic

measure (such as for the prevention of deep vein thrombosis) or as treatment of a chronic condition (such as arthritis) or a disease requiring a lengthy course of treatment (such as cancer). Do not assign a code from subcategory V58.6 for medication being administered for a brief period of time to treat an acute illness or injury (such as a course of antibiotics to treat acute bronchitis).

V83 Genetic carrier status
Genetic carrier status indicates that a person carries a gene, associated with a particular disease, which may be passed to offspring who may develop that disease. The person does not have the disease and is not at risk of developing the disease.

V84 Genetic susceptibility status
Genetic susceptibility indicates that a person has a gene that increases the risk of that person developing the disease.

Codes from category V84, Genetic susceptibility to disease, should not be used as principal or first-listed codes. If the patient has the condition to which he/she is susceptible, and that condition is the reason for the encounter, the code for the current condition should be sequenced first. If the patient is being seen for follow-up after completed treatment for this condition, and the condition no longer exists, a follow-up code should be sequenced first, followed by the appropriate personal history and genetic susceptibility codes. If the purpose of the encounter is genetic counseling associated with procreative management, a code from subcategory V26.3, Genetic counseling and testing, should be assigned as the first-listed code, followed by a code from category V84. Additional codes should be assigned for any applicable family or personal history.
See Section I.C. 18.d.14 for information on prophylactic organ removal due to a genetic susceptibility.

V86 Estrogen receptor status

Note: Categories V42-V46, and subcategories V49.6, V49.7 are for use only if there are no complications or malfunctions

of the organ or tissue replaced, the amputation site or the equipment on which the patient is dependent.

4) History (of)

There are two types of history V codes, personal and family. Personal history codes explain a patient's past medical condition that no longer exists and is not receiving any treatment, but that has the potential for recurrence, and therefore may require continued monitoring. The exceptions to this general rule are category V14, Personal history of allergy to medicinal agents, and subcategory V15.0, Allergy, other than to medicinal agents. A person who has had an allergic episode to a substance or food in the past should always be considered allergic to the substance.

Family history codes are for use when a patient has a family member(s) who has had a particular disease that causes the patient to be at higher risk of also contracting the disease.

Personal history codes may be used in conjunction with follow-up codes and family history codes may be used in conjunction with screening codes to explain the need for a test or procedure. History codes are also acceptable on any medical record regardless of the reason for visit. A history of an illness, even if no longer present, is important information that may alter the type of treatment ordered.

The history V code categories are:
V10   Personal history of malignant neoplasm
V12   Personal history of certain other diseases
V13   Personal history of other diseases
       Except: V13.4, Personal history of arthritis, and
       V13.6, Personal history of congenital
       malformations. These conditions are life-long so
       are not true history codes.
V14   Personal history of allergy to medicinal agents
V15   Other personal history presenting hazards to health
       Except: V15.7, Personal history of contraception.
V16   Family history of malignant neoplasm
V17   Family history of certain chronic disabling diseases
V18   Family history of certain other specific diseases
V19   Family history of other conditions

5) Screening

Screening is the testing for disease or disease precursors in seemingly well individuals so that early detection and

treatment can be provided for those who test positive for the disease. Screenings that are recommended for many subgroups in a population include: routine mammograms for women over 40, a fecal occult blood test for everyone over 50, an amniocentesis to rule out a fetal anomaly for pregnant women over 35, because the incidence of breast cancer and colon cancer in these subgroups is higher than in the general population, as is the incidence of Down's syndrome in older mothers.

The testing of a person to rule out or confirm a suspected diagnosis because the patient has some sign or symptom is a diagnostic examination, not a screening. In these cases, the sign or symptom is used to explain the reason for the test.

A screening code may be a first listed code if the reason for the visit is specifically the screening exam. It may also be used as an additional code if the screening is done during an office visit for other health problems. A screening code is not necessary if the screening is inherent to a routine examination, such as a pap smear done during a routine pelvic examination.

Should a condition be discovered during the screening then the code for the condition may be assigned as an additional diagnosis.

The V code indicates that a screening exam is planned. A procedure code is required to confirm that the screening was performed.

The screening V code categories:
V28   Antenatal screening
V73-V82   Special screening examinations

6)   **Observation**

There are two observation V code categories. They are for use in very limited circumstances when a person is being observed for a suspected condition that is ruled out. The observation codes are not for use if an injury or illness or any signs or symptoms related to the suspected condition are present. In such cases the diagnosis/symptom code is used with the corresponding E code to identify any external cause.

The observation codes are to be used as principal diagnosis only. The only exception to this is when the principal diagnosis is required to be a code from the V30, Live born infant, category. Then the V29 observation code is sequenced after

the V30 code. Additional codes may be used in addition to the observation code but only if they are unrelated to the suspected condition being observed.

The observation V code categories:

V29   Observation and evaluation of newborns for suspected condition not found
         For the birth encounter, a code from category V30 should be sequenced before the V29 code.
V71   Observation and evaluation for suspected condition not found

7)   **Aftercare**

Aftercare visit codes cover situations when the initial treatment of a disease or injury has been performed and the patient requires continued care during the healing or recovery phase, or for the long-term consequences of the disease. The aftercare V code should not be used if treatment is directed at a current, acute disease or injury. The diagnosis code is to be used in these cases. Exceptions to this rule are codes V58.0, Radiotherapy, and codes from subcategory V58.1, Encounter for chemotherapy and immunotherapy for neoplastic conditions. These codes are to be first listed, followed by the diagnosis code when a patient's encounter is solely to receive radiation therapy or chemotherapy for the treatment of a neoplasm. Should a patient receive both chemotherapy and radiation therapy during the same encounter code V58.0 and V58.1 may be used together on a record with either one being sequenced first.

The aftercare codes are generally first listed to explain the specific reason for the encounter. An aftercare code may be used as an additional code when some type of aftercare is provided in addition to the reason for admission and no diagnosis code is applicable. An example of this would be the closure of a colostomy during an encounter for treatment of another condition.

Certain aftercare V code categories need a secondary diagnosis code to describe the resolving condition or sequelae, for others, the condition is inherent in the code title.

Additional V code aftercare category terms include, fitting and adjustment, and attention to artificial openings.

Status V codes may be used with aftercare V codes to indicate the nature of the aftercare. For example code V45.81,

Aortocoronary bypass status, may be used with code V58.73, Aftercare following surgery of the circulatory system, NEC, to indicate the surgery for which the aftercare is being performed. Also, a transplant status code may be used following code V58.44, Aftercare following organ transplant, to identify the organ transplanted. A status code should not be used when the aftercare code indicates the type of status, such as using V55.0, Attention to tracheostomy with V44.0, Tracheostomy status.

The aftercare V category/codes:

V52	Fitting and adjustment of prosthetic device and implant
V53	Fitting and adjustment of other device
V54	Other orthopedic aftercare
V55	Attention to artificial openings
V56	Encounter for dialysis and dialysis catheter care
V57	Care involving the use of rehabilitation procedures
V58.0	Radiotherapy
V58.11	Encounter for antineoplastic chemotherapy
V58.12	Encounter for antineoplastic immunotherapy
V58.3x	**Attention to dressings and sutures**
V58.41	Encounter for planned post-operative wound closure
V58.42	Aftercare, surgery, neoplasm
V58.43	Aftercare, surgery, trauma
V58.44	Aftercare involving organ transplant
V58.49	Other specified aftercare following surgery
V58.7x	Aftercare following surgery
V58.81	Fitting and adjustment of vascular catheter
V58.82	Fitting and adjustment of non-vascular catheter
V58.83	Monitoring therapeutic drug
V58.89	Other specified aftercare

8) Follow-up

The follow-up codes are used to explain continuing surveillance following completed treatment of a disease, condition, or injury. They imply that the condition has been fully treated and no longer exists. They should not be confused with aftercare codes that explain current treatment for a healing condition or its sequelae. Follow-up codes may be used in conjunction with history codes to provide the full picture of the healed condition and its treatment. The follow-up code is sequenced first, followed by the history code.

A follow-up code may be used to explain repeated visits. Should a condition be found to have recurred on the follow-up

visit, then the diagnosis code should be used in place of the follow-up code.

The follow-up V code categories:
V24   Postpartum care and evaluation
V67   Follow-up examination

9) Donor

Category V59 is the donor codes. They are used for living individuals who are donating blood or other body tissue. These codes are only for individuals donating for others, not for self donations. They are not for use to identify cadaveric donations.

10) Counseling

Counseling V codes are used when a patient or family member receives assistance in the aftermath of an illness or injury, or when support is required in coping with family or social problems. They are not necessary for use in conjunction with a diagnosis code when the counseling component of care is considered integral to standard treatment.

The counseling V categories/codes:
V25.0   General counseling and advice for contraceptive management
V26.3   Genetic counseling
V26.4   General counseling and advice for procreative management
V61   Other family circumstances
V65.1   Person consulted on behalf of another person
V65.3   Dietary surveillance and counseling
V65.4   Other counseling, not elsewhere classified

11) Obstetrics and related conditions

See Section I.C.11., the Obstetrics guidelines for further instruction on the use of these codes.

V codes for pregnancy are for use in those circumstances when none of the problems or complications included in the codes from the Obstetrics chapter exist (a routine prenatal visit or postpartum care). Codes V22.0, Supervision of normal first pregnancy, and V22.1, Supervision of other normal pregnancy, are always first listed and are not to be used with any other code from the OB chapter.

The outcome of delivery, category V27, should be included on all maternal delivery records. It is always a secondary code.

V codes for family planning (contraceptive) or procreative management and counseling should be included on an obstetric record either during the pregnancy or the postpartum stage, if applicable.

Obstetrics and related conditions V code categories:

V22   Normal pregnancy
V23   Supervision of high-risk pregnancy
         Except: V23.2, Pregnancy with history of abortion. Code 646.3, Habitual aborter, from the OB chapter is required to indicate a history of abortion during a pregnancy.
V24   Postpartum care and evaluation
V25   Encounter for contraceptive management
         Except V25.0x
         (See Section I.C.18.d.11, Counseling)
V26   Procreative management
         Except V26.5x, Sterilization status, V26.3 and V26.4
         (See Section I.C.18.d.11., Counseling)
V27   Outcome of delivery
V28   Antenatal screening
         (See Section I.C.18.d.6., Screening)

12) Newborn, infant and child

See Section I.C.15, the Newborn guidelines for further instruction on the use of these codes.

Newborn V code categories:

V20   Health supervision of infant or child
V29   Observation and evaluation of newborns for suspected condition not found
         (See Section I.C.18.d.7, Observation)
V30-V39   Liveborn infant according to type of birth

13) Routine and administrative examinations

The V codes allow for the description of encounters for routine examinations, such as, a general check-up, or, examinations for administrative purposes, such as, a pre-employment physical. The codes are not to be used if the examination is for diagnosis of a suspected condition or for treatment purposes. In such cases the diagnosis code is used. During a routine exam, should a diagnosis or condition be discovered, it should be

coded as an additional code. Pre-existing and chronic conditions and history codes may also be included as additional codes as long as the examination is for administrative purposes and not focused on any particular condition.

Pre-operative examination V codes are for use only in those situations when a patient is being cleared for surgery and no treatment is given.

The V codes categories/code for routine and administrative examinations:

V20.2   Routine infant or child health check
          Any injections given should have a corresponding procedure code.
V70   General medical examination
V72   Special investigations and examinations
          Codes V72.5 and V72.6 may be used if the reason for the patient encounter is for routine laboratory/radiology testing in the absence of any signs, symptoms, or associated diagnosis. If routine testing is performed during the same encounter as a test to evaluate a sign, symptom, or diagnosis, it is appropriate to assign both the V code and the code describing the reason for the non-routine test.

14)   **Miscellaneous V codes**

The miscellaneous V codes capture a number of other health care encounters that do not fall into one of the other categories. Certain of these codes identify the reason for the encounter, others are for use as additional codes that provide useful information on circumstances that may affect a patient's care and treatment.

Prophylactic Organ Removal

For encounters specifically for prophylactic removal of breasts, ovaries, or another organ due to a genetic susceptibility to cancer or a family history of cancer, the principal or first listed code should be a code from subcategory V50.4, Prophylactic organ removal, followed by the appropriate genetic susceptibility code and the appropriate family history code.

If the patient has a malignancy of one site and is having prophylactic removal at another site to prevent either a new primary malignancy or metastatic disease, a code for the malignancy should also be assigned in addition to a code from

subcategory V50.4. A V50.4 code should not be assigned if the patient is having organ removal for treatment of a malignancy, such as the removal of the testes for the treatment of prostate cancer.

Miscellaneous V code categories/codes:

V07	Need for isolation and other prophylactic measures
V50	Elective surgery for purposes other than remedying health states
V58.5	Orthodontics
V60	Housing, household, and economic circumstances
V62	Other psychosocial circumstances
V63	Unavailability of other medical facilities for care
V64	Persons encountering health services for specific procedures, not carried out
V66	Convalescence and Palliative Care
V68	Encounters for administrative purposes
V69	Problems related to lifestyle
V85	**Body Mass Index**

15)   Nonspecific V codes

Certain V codes are so non-specific, or potentially redundant with other codes in the classification, that there can be little justification for their use in the inpatient setting. Their use in the outpatient setting should be limited to those instances when there is no further documentation to permit more precise coding. Otherwise, any sign or symptom or any other reason for visit that is captured in another code should be used.

Nonspecific V code categories/codes:

V11	Personal history of mental disorder A code from the mental disorders chapter, with an in remission fifth-digit, should be used.
V13.4	Personal history of arthritis
V13.6	Personal history of congenital malformations
V15.7	Personal history of contraception
V23.2	Pregnancy with history of abortion
V40	Mental and behavioral problems
V41	Problems with special senses and other special functions
V47	Other problems with internal organs
V48	Problems with head, neck, and trunk
V49	Problems with limbs and other problems

Exceptions:

V49.6	Upper limb amputation status
V49.7	Lower limb amputation status
V49.81	Postmenopausal status

	V49.82	Dental sealant status
	V49.83	Awaiting organ transplant status
V51	Aftercare involving the use of plastic surgery
V58.2	Blood transfusion, without reported diagnosis
V58.9	Unspecified aftercare

See Section IV.K. and Section IV.L. of the Outpatient guidelines.

V CODE TABLE
October 1, 2006 (FY2007)
Items in bold indicate a new entry or change from the December 2005 table
Items underlined have been moved within the table since December 2005

This year's update includes a new V code table format that will make utilizing the table easier and more efficient to use and update. The table contains columns for 1st listed, 1st or additional, additional only, and non-specific. Each code or category is listed on the left hand column and the allowable sequencing of the code or codes within the category is noted under the appropriate column.

Code(s)	Description	1st Dx Only[1]	1st or Add'l Dx[2]	Add'l Dx Only[3]	Non-Specific Diagnosis[4]
V01.X	Contact with or exposure to communicable diseases		X		
V02.X	Carrier or suspected carrier of infectious diseases		X		
V03.X	Need for prophylactic vaccination and inoculation against bacterial diseases		X		
V04.X	Need for prophylactic vaccination and inoculation against certain diseases		X		
V05.X	Need for prophylactic vaccination and inoculation against single diseases		X		
V06.X	Need for prophylactic vaccination and inoculation against combinations of diseases		X		
V07.X	Need for isolation and other prophylactic measures		X		
V08	Asymptomatic HIV infection status		X		
V09.X	Infection with drug resistant organisms			X	
V10.X	Personal history of malignant neoplasm		X		
V11.X	Personal history of mental disorder				X
V12.X	Personal history of certain other diseases		X		
V13.0X	Personal history of other disorders of urinary system		X		
V13.1	Personal history of trophoblastic disease		X		
V13.2X	Personal history of other genital system and obstetric disorders		X		

[1]Generally for use as first listed only but may be used as additional if patient has more than one encounter on one day
[2]These codes may be used as first listed or additional codes
[3]These codes are only for use as additional codes
[4]These codes are primarily for use in the nonacute setting and should be limited to encounters for which no sign or symptom or reason for visit is documented in the record. Their use may be as either a first listed or additional code.

Code(s)	Description	1st Dx Only[1]	1st or Add'l Dx[2]	Add'l Dx Only[3]	Non-Specific Diagnosis[4]
V13.3	Personal history of diseases of skin and subcutaneous tissue		X		
V13.4	Personal history of arthritis				X
V13.5	Personal history of other musculoskeletal disorders		X		
V13.61	Personal history of hypospadias			X	
V13.69	Personal history of congenital malformations				X
V13.7	Personal history of perinatal problems		X		
V13.8	Personal history of other specified diseases		X		
V13.9	Personal history of unspecified disease				**X**
V14.X	Personal history of allergy to medicinal agents			X	
V15.0X	Personal history of allergy, other than to medicinal agents			X	
V15.1	Personal history of surgery to heart and great vessels			X	
V15.2	Personal history of surgery to other major organs			X	
V15.3	Personal history of irradiation			X	
V15.4X	Personal history of psychological trauma			X	
V15.5	Personal history of injury			X	
V15.6	Personal history of poisoning			X	
V15.7	Personal history of contraception				X
V15.81	Personal history of noncompliance with medical treatment			X	
V15.82	Personal history of tobacco use			X	
V15.84	Personal history of exposure to asbestos			X	
V15.85	Personal history of exposure to potentially hazardous body fluids			X	
V15.86	Personal history of exposure to lead			X	
V15.87	Personal history of extracorporeal membrane oxygenation [ECMO]			X	
V15.88	History of fall		X		
V15.89	Other specified personal history presenting hazards to health			X	
V16.X	Family history of malignant neoplasm		X		

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Code(s)	Description	1st Dx Only[1]	1st or Add'l Dx[2]	Add'l Dx Only[3]	Non-Specific Diagnosis[4]
V17.X	Family history of certain chronic disabling diseases		X		
V18.X	Family history of certain other specific conditions		X		
V19.X	Family history of other conditions		X		
V20.X	Health supervision of infant or child	X			
V21.X	Constitutional states in development			X	
V22.0	Supervision of normal first pregnancy	X			
V22.1	Supervision of other normal pregnancy	X			
V22.2	Pregnancy state, incidental			X	
V23.X	Supervision of high-risk pregnancy		X		
V24.X	Postpartum care and examination	X			
V25.X	Encounter for contraceptive management		X		
V26.0	Tuboplasty or vasoplasty after previous sterilization		X		
V26.1	Artificial insemination		X		
V26.2X	Procreative management investigation and testing		X		
V26.3X	Procreative management, genetic counseling and testing		X		
V26.4	Procreative management, genetic counseling and advice		X		
V26.5X	Procreative management, sterilization status			X	
V26.8	Other specified procreative management		X		
V26.9	Unspecified procreative management		X		
V27.X	Outcome of delivery			X	
V28.X	**Encounter for antenatal screening of mother**		X		
V29.X	Observation and evaluation of newborns for suspected condition not found	X			
V30.X	Single liveborn	X			
V31.X	Twin, mate liveborn	X			
V32.X	Twin, mate stillborn	X			
V33.X	Twin, unspecified	X			
V34.X	Other multiple, mates all liveborn	X			
V35.X	Other multiple, mates all stillborn	X			

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Code(s)	Description	1st Dx Only[1]	1st or Add'l Dx[2]	Add'l Dx Only[3]	Non-Specific Diagnosis[4]
V36.X	Other multiple, mates live- and stillborn	X			
V37.X	Other multiple, unspecified	X			
V39.X	Unspecified	X			
V40.X	Mental and behavioral problems				X
V41.X	Problems with special senses and other special functions				X
V42.X	Organ or tissue replaced by transplant			X	
V43.0	Organ or tissue replaced by other means, eye globe			X	
V43.1	Organ or tissue replaced by other means, lens			X	
V43.21	Organ or tissue replaced by other means, heart assist device			X	
V43.22	Fully implantable artificial heart status		X		
V43.3	Organ or tissue replaced by other means, heart valve			X	
V43.4	Organ or tissue replaced by other means, blood vessel			X	
V43.5	Organ or tissue replaced by other means, bladder			X	
V43.6X	Organ or tissue replaced by other means, joint			X	
V43.7	Organ or tissue replaced by other means, limb			X	
V43.8X	Other organ or tissue replaced by other means			X	
V44.X	Artificial opening status			X	
V45.0X	Cardiac device in situ			X	
V45.1	Renal dialysis status			X	
V45.2	Presence of cerebrospinal fluid drainage device			X	
V45.3	Intestinal bypass or anastomosis status			X	
V45.4	Arthrodesis status			X	
V45.5X	Presence of contraceptive device			X	
V45.6X	States following surgery of eye and adnexa			X	
V45.7X	Acquired absence of organ		X		
V45.8X	Other postprocedural status			X	

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Code(s)	Description	1st Dx Only[1]	1st or Add'l Dx[2]	Add'l Dx Only[3]	Non-Specific Diagnosis[4]
V46.0	Other dependence on machines, aspirator			X	
V46.11	Dependence on respiratory, status			X	
V46.12	Encounter for respirator dependence during power failure	X			
V46.13	Encounter for weaning from respirator [ventilator]	X			
V46.14	Mechanical complication of respirator [ventilator]		X		
V46.2	Other dependence on machines, supplemental oxygen			X	
V46.8	Other dependence on other enabling machines			X	
V46.9	Unspecified machine dependence				**X**
V47.X	Other problems with internal organs				X
V48.X	Problems with head, neck and trunk				X
V49.0	Deficiencies of limbs				X
V49.1	Mechanical problems with limbs				X
V49.2	Motor problems with limbs				X
V49.3	Sensory problems with limbs				X
V49.4	Disfigurements of limbs				X
V49.5	Other problems with limbs				X
V49.6X	Upper limb amputation status		X		
V49.7X	Lower limb amputation status		X		
V49.81	Asymptomatic postmenopausal status (age-related) (natural)		X		
V49.82	Dental sealant status			X	
V49.83	Awaiting organ transplant status			X	
V49.84	Bed confinement status		X		
V49.89	Other specified conditions influencing health status		X		
V49.9	Unspecified condition influencing health status				X
V50.X	Elective surgery for purposes other than remedying health states		X		
V51	Aftercare involving the use of plastic surgery				X

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Code(s)	Description	1st Dx Only[1]	1st or Add'l Dx[2]	Add'l Dx Only[3]	Non-Specific Diagnosis[4]
V52.X	Fitting and adjustment of prosthetic device and implant		X		
V53.X	Fitting and adjustment of other device		X		
V54.X	Other orthopedic aftercare		X		
V55.X	Attention to artificial openings		X		
V56.0	Extracorporeal dialysis	X			
V56.1	Encounter for fitting and adjustment of extracorporeal dialysis catheter		X		
V56.2	Encounter for fitting and adjustment of peritoneal dialysis catheter		X		
V56.3X	Encounter for adequacy testing for dialysis		X		
V56.8	Encounter for other dialysis and dialysis catheter care		X		
V57.X	Care involving use of rehabilitation procedures	X			
V58.0	Radiotherapy	X			
V58.11	Encounter for antineoplastic chemotherapy	X			
V58.12	Encounter for antineoplastic immunotherapy	X			
V58.2	Blood transfusion without reported diagnosis				X
V58.3X	**Attention to dressings and sutures**		X		
V58.4X	Other aftercare following surgery		X		
V58.5	Encounter for orthodontics				X
V58.6X	Long term (current) drug use			X	
V58.7X	Aftercare following surgery to specified body systems, not elsewhere classified		X		
V58.8X	Other specified procedures and aftercare		X		
V58.9	Unspecified aftercare				X
V59.X	Donors	X			
V60.X	Housing, household, and economic circumstances			X	
V61.X	Other family circumstances		X		
V62.X	Other psychosocial circumstances			X	
V63.X	Unavailability of other medical facilities for care		X		
V64.X	Persons encountering health services for specified procedure, not carried out			X	

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[4]These codes are primarily for use in the nonacute setting and should be limited to encounters for which no sign or symptom or reason for visit is documented in the record. Their use may be as either a first listed or additional code.

Code(s)	Description	1st Dx Only[1]	1st or Add'l Dx[2]	Add'l Dx Only[3]	Non-Specific Diagnosis[4]
V65.X	Other persons seeking consultation without complaint or sickness		X		
V66.0	Convalescence and palliative care following surgery	X			
V66.1	Convalescence and palliative care following radiotherapy	X			
V66.2	Convalescence and palliative care following chemotherapy	X			
V66.3	Convalescence and palliative care following psychotherapy and other treatment for mental disorder	X			
V66.4	Convalescence and palliative care following treatment of fracture	X			
V66.5	Convalescence and palliative care following other treatment	X			
V66.6	Convalescence and palliative care following combined treatment	X			
V66.7	Encounter for palliative care			X	
V66.9	Unspecified convalescence	X			
V67.X	Follow-up examination		X		
V68.X	Encounters for administrative purposes	X			
V69.X	Problems related to lifestyle		X		
V70.0	Routine general medical examination at a health care facility	X			
V70.1	General psychiatric examination, requested by the authority	X			
V70.2	General psychiatric examination, other and unspecified	X			
V70.3	Other medical examination for administrative purposes	X			
V70.4	Examination for medicolegal reasons	X			
V70.5	Health examination of defined subpopulations	X			
V70.6	Health examination in population surveys	X			
V70.7	Examination of participant in clinical trial		X		

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[4]These codes are primarily for use in the nonacute setting and should be limited to encounters for which no sign or symptom or reason for visit is documented in the record. Their use may be as either a first listed or additional code.

Code(s)	Description	1st Dx Only[1]	1st or Add'l Dx[2]	Add'l Dx Only[3]	Non-Specific Diagnosis[4]
V70.8	Other specified general medical examinations	X			
V70.9	Unspecified general medical examination	X			
V71.X	Observation and evaluation for suspected conditions not found	X			
V72.0	Examination of eyes and vision		**X**		
V72.1X	Examination of ears and hearing		**X**		
V72.2	Dental examination		**X**		
V72.3X	Gynecological examination		**X**		
V72.4X	Pregnancy examination or test		X		
V72.5	Radiological examination, NEC		X		
V72.6	Laboratory examination		X		
V72.7	Diagnostic skin and sensitization tests		**X**		
V72.81	Preoperative cardiovascular examination		**X**		
V72.82	Preoperative respiratory examination		**X**		
V72.83	Other specified preoperative examination		**X**		
V72.84	Preoperative examination, unspecified		**X**		
V72.85	Other specified examination		X		
V72.86	Encounter for blood typing		X		
V72.9	Unspecified examination				**X**
V73.X	Special screening examination for viral and chlamydial diseases		X		
V74.X	Special screening examination for bacterial and spirochetal diseases		X		
V75.X	Special screening examination for other infectious diseases		X		
V76.X	Special screening examination for malignant neoplasms		X		
V77.X	Special screening examination for endocrine, nutritional, metabolic and immunity disorders		X		
V78.X	Special screening examination for disorders of blood and blood-forming organs		X		
V79.X	Special screening examination for mental disorders and developmental handicaps		X		

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[4]These codes are primarily for use in the nonacute setting and should be limited to encounters for which no sign or symptom or reason for visit is documented in the record. Their use may be as either a first listed or additional code.

Code(s)	Description	1st Dx Only[1]	1st or Add'l Dx[2]	Add'l Dx Only[3]	Non-Specific Diagnosis[4]
V80.X	Special screening examination for neurological, eye, and ear diseases		X		
V81.X	Special screening examination for cardiovascular, respiratory, and genitourinary diseases		X		
V82.X	Special screening examination for other conditions		X		
V83.X	Genetic carrier status		X		
V84	Genetic susceptibility to disease			X	
V85	Body mass index			X	
V86	**Estrogen receptor status**			**X**	

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[2]These codes may be used as first listed or additional codes
[3]These codes are only for use as additional codes
[4]These codes are primarily for use in the nonacute setting and should be limited to encounters for which no sign or symptom or reason for visit is documented in the record. Their use may be as either a first listed or additional code.

19.   Supplemental Classification of External Causes of Injury and Poisoning (E-codes, E800-E999)

Introduction: These guidelines are provided for those who are currently collecting E codes in order that there will be standardization in the process. If your institution plans to begin collecting E codes, these guidelines are to be applied. The use of E codes is supplemental to the application of ICD-9-CM diagnosis codes. E codes are never to be recorded as principal diagnoses (first-listed in non-inpatient setting) and are not required for reporting to CMS.

External causes of injury and poisoning codes (E codes) are intended to provide data for injury research and evaluation of injury prevention strategies. E codes capture how the injury or poisoning happened (cause), the intent (unintentional or accidental; or intentional, such as suicide or assault), and the place where the event occurred.

Some major categories of E codes include:
> transport accidents
> poisoning and adverse effects of drugs, medicinal substances and biologicals
> accidental falls
> accidents caused by fire and flames
> accidents due to natural and environmental factors
> late effects of accidents, assaults or self injury
> assaults or purposely inflicted injury
> suicide or self inflicted injury

These guidelines apply for the coding and collection of E codes from records in hospitals, outpatient clinics, emergency departments, other ambulatory care settings and provider offices, and nonacute care settings, except when other specific guidelines apply.

a.   General E Code Coding Guidelines

1)   Used with any code in the range of 001-V84.8
An E code may be used with any code in the range of 001-V84.8, which indicates an injury, poisoning, or adverse effect due to an external cause.

2)   Assign the appropriate E code for all initial treatments
Assign the appropriate E code for the initial encounter of an injury, poisoning, or adverse effect of drugs, not for subsequent treatment.

External cause of injury codes (E-codes) may be assigned while the acute fracture codes are still applicable.
See Section I.C.17.b.1 for coding of acute fractures.

3) Use the full range of E codes

Use the full range of E codes to completely describe the cause, the intent and the place of occurrence, if applicable, for all injuries, poisonings, and adverse effects of drugs.

4) Assign as many E codes as necessary

Assign as many E codes as necessary to fully explain each cause. If only one E code can be recorded, assign the E code most related to the principal diagnosis.

5) The selection of the appropriate E code

The selection of the appropriate E code is guided by the Index to External Causes, which is located after the alphabetical index to diseases and by Inclusion and Exclusion notes in the Tabular List.

6) E code can never be a principal diagnosis

An E code can never be a principal (first listed) diagnosis.

7) External cause code(s) with systemic inflammatory response syndrome (SIRS)

An external cause code is not appropriate with a code from subcategory 995.9, unless the patient also has an injury, poisoning, or adverse effect of drugs.

b. Place of Occurrence Guideline

Use an additional code from category E849 to indicate the Place of Occurrence for injuries and poisonings. The Place of Occurrence describes the place where the event occurred and not the patient's activity at the time of the event.

Do not use E849.9 if the place of occurrence is not stated.

c. Adverse Effects of Drugs, Medicinal and Biological Substances Guidelines

1) Do not code directly from the Table of Drugs

Do not code directly from the Table of Drugs and Chemicals. Always refer back to the Tabular List.

2) **Use as many codes as necessary to describe**

Use as many codes as necessary to describe completely all drugs, medicinal or biological substances.

3) **If the same E code would describe the causative agent**

If the same E code would describe the causative agent for more than one adverse reaction, assign the code only once.

4) **If two or more drugs, medicinal or biological substances**

If two or more drugs, medicinal or biological substances are reported, code each individually unless the combination code is listed in the Table of Drugs and Chemicals. In that case, assign the E code for the combination.

5) **When a reaction results from the interaction of a drug(s)**

When a reaction results from the interaction of a drug(s) and alcohol, use poisoning codes and E codes for both.

6) **If the reporting format limits the number of E codes**

If the reporting format limits the number of E codes that can be used in reporting clinical data, code the one most related to the principal diagnosis. Include at least one from each category (cause, intent, place) if possible.

If there are different fourth digit codes in the same three digit category, use the code for "Other specified" of that category. If there is no "Other specified" code in that category, use the appropriate "Unspecified" code in that category.

If the codes are in different three digit categories, assign the appropriate E code for other multiple drugs and medicinal substances.

7) **Codes from the E930-E949 series**

Codes from the E930-E949 series must be used to identify the causative substance for an adverse effect of drug, medicinal and biological substances, correctly prescribed and properly administered. The effect, such as tachycardia, delirium, gastrointestinal hemorrhaging, vomiting, hypokalemia, hepatitis, renal failure, or respiratory failure, is coded and followed by the appropriate code from the E930-E949 series.

d. Multiple Cause E Code Coding Guidelines

If two or more events cause separate injuries, an E code should be assigned for each cause. The first listed E code will be selected in the following order:

E codes for child and adult abuse take priority over all other E codes.
See Section I.C.19.e., Child and Adult abuse guidelines.

E codes for terrorism events take priority over all other E codes except child and adult abuse

E codes for cataclysmic events take priority over all other E codes except child and adult abuse and terrorism.

E codes for transport accidents take priority over all other E codes except cataclysmic events and child and adult abuse and terrorism.

The first-listed E code should correspond to the cause of the most serious diagnosis due to an assault, accident, or self-harm, following the order of hierarchy listed above.

e. Child and Adult Abuse Guideline

1) Intentional injury

When the cause of an injury or neglect is intentional child or adult abuse, the first listed E code should be assigned from categories E960-E968, Homicide and injury purposely inflicted by other persons, (except category E967). An E code from category E967, Child and adult battering and other maltreatment, should be added as an additional code to identify the perpetrator, if known.

2) Accidental intent

In cases of neglect when the intent is determined to be accidental E code E904.0, Abandonment or neglect of infant and helpless person, should be the first listed E code.

f. Unknown or Suspected Intent Guideline

1) If the intent (accident, self-harm, assault) of the cause of an injury or poisoning is unknown

If the intent (accident, self-harm, assault) of the cause of an injury or poisoning is unknown or unspecified, code the intent as undetermined E980-E989.

2) **If the intent (accident, self-harm, assault) of the cause of an injury or poisoning is questionable**

If the intent (accident, self-harm, assault) of the cause of an injury or poisoning is questionable, probable or suspected, code the intent as undetermined E980-E989.

g. Undetermined Cause

When the intent of an injury or poisoning is known, but the cause is unknown, use codes: E928.9, Unspecified accident, E958.9, Suicide and self-inflicted injury by unspecified means, and E968.9, Assault by unspecified means.

These E codes should rarely be used, as the documentation in the medical record, in both the inpatient outpatient and other settings, should normally provide sufficient detail to determine the cause of the injury.

h. Late Effects of External Cause Guidelines

1) **Late effect E codes**

Late effect E codes exist for injuries and poisonings but not for adverse effects of drugs, misadventures and surgical complications.

2) **Late effect E codes (E929, E959, E969, E977, E989, or E999.1)**

A late effect E code (E929, E959, E969, E977, E989, or E999.1) should be used with any report of a late effect or sequela resulting from a previous injury or poisoning (905-909).

3) **Late effect E code with a related current injury**

A late effect E code should never be used with a related current nature of injury code.

4) **Use of late effect E codes for subsequent visits**

Use a late effect E code for subsequent visits when a late effect of the initial injury or poisoning is being treated. There is no late effect E code for adverse effects of drugs.
Do not use a late effect E code for subsequent visits for follow-up care (e.g., to assess healing, to receive rehabilitative therapy) of the injury or poisoning when no late effect of the injury has been documented.

i. Misadventures and Complications of Care Guidelines

1) Code range E870-E876

Assign a code in the range of E870-E876 if misadventures are stated by the provider.

2) Code range E878-E879

Assign a code in the range of E878-E879 if the provider attributes an abnormal reaction or later complication to a surgical or medical procedure, but does not mention misadventure at the time of the procedure as the cause of the reaction.

j. Terrorism Guidelines

1) Cause of injury identified by the Federal Government (FBI) as terrorism

When the cause of an injury is identified by the Federal Government (FBI) as terrorism, the first-listed E-code should be a code from category E979, Terrorism. The definition of terrorism employed by the FBI is found at the inclusion note at E979. The terrorism E-code is the only E-code that should be assigned. Additional E codes from the assault categories should not be assigned.

2) Cause of an injury is suspected to be the result of terrorism

When the cause of an injury is suspected to be the result of terrorism a code from category E979 should not be assigned. Assign a code in the range of E codes based circumstances on the documentation of intent and mechanism.

3) Code E979.9, Terrorism, secondary effects

Assign code E979.9, Terrorism, secondary effects, for conditions occurring subsequent to the terrorist event. This code should not be assigned for conditions that are due to the initial terrorist act.

4) Statistical tabulation of terrorism codes

For statistical purposes these codes will be tabulated within the category for assault, expanding the current category from E960-E969 to include E979 and E999.1.

Section II. Selection of Principal Diagnosis

The circumstances of inpatient admission always govern the selection of principal diagnosis. The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."

The UHDDS definitions are used by hospitals to report inpatient data elements in a standardized manner. These data elements and their definitions can be found in the July 31, 1985, Federal Register (Vol. 50, No, 147), pp. 31038-40.

Since that time the application of the UHDDS definitions has been expanded to include all non-outpatient settings (acute care, short term, long term care and psychiatric hospitals; home health agencies; rehab facilities; nursing homes, etc).

In determining principal diagnosis the coding conventions in the ICD-9-CM, Volumes I and II take precedence over these official coding guidelines.
(See Section I.A., Conventions for the ICD-9-CM)

The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation the application of all coding guidelines is a difficult, if not impossible, task.

A. Codes for symptoms, signs, and ill-defined conditions

Codes for symptoms, signs, and ill-defined conditions from Chapter 16 are not to be used as principal diagnosis when a related definitive diagnosis has been established.

B. Two or more interrelated conditions, each potentially meeting the definition for principal diagnosis.

When there are two or more interrelated conditions (such as diseases in the same ICD-9-CM chapter or manifestations characteristically associated with a certain disease) potentially meeting the definition of principal diagnosis, either condition may be sequenced first, unless the circumstances of the admission, the therapy provided, the Tabular List, or the Alphabetic Index indicate otherwise.

C. Two or more diagnoses that equally meet the definition for principal diagnosis

In the unusual instance when two or more diagnoses equally meet the criteria for principal diagnosis as determined by the circumstances of admission, diagnostic workup and/or therapy provided, and the Alphabetic Index, Tabular List, or another coding guidelines does not provide sequencing direction, any one of the diagnoses may be sequenced first.

D. Two or more comparative or contrasting conditions.

In those rare instances when two or more contrasting or comparative diagnoses are documented as "either/or" (or similar terminology), they are coded as if the diagnoses

were confirmed and the diagnoses are sequenced according to the circumstances of the admission. If no further determination can be made as to which diagnosis should be principal, either diagnosis may be sequenced first.

E. A symptom(s) followed by contrasting/comparative diagnoses

When a symptom(s) is followed by contrasting/comparative diagnoses, the symptom code is sequenced first. All the contrasting/comparative diagnoses should be coded as additional diagnoses.

F. Original treatment plan not carried out

Sequence as the principal diagnosis the condition, which after study occasioned the admission to the hospital, even though treatment may not have been carried out due to unforeseen circumstances.

G. Complications of surgery and other medical care

When the admission is for treatment of a complication resulting from surgery or other medical care, the complication code is sequenced as the principal diagnosis. If the complication is classified to the 996-999 series and the code lacks the necessary specificity in describing the complication, an additional code for the specific complication should be assigned.

H. Uncertain Diagnosis

If the diagnosis documented at the time of discharge is qualified as "probable", "suspected", "likely", "questionable", "possible", or "still to be ruled out", **or other similar terms indicating uncertainty,** code the condition as if it existed or was established. The bases for these guidelines are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that correspond most closely with the established diagnosis.

Note: This guideline is applicable only to short-term, acute, long-term care and psychiatric hospitals.

I. Admission from Observation Unit

1. Admission Following Medical Observation

When a patient is admitted to an observation unit for a medical condition, which either worsens or does not improve, and is subsequently admitted as an inpatient of the same hospital for this same medical condition, the principal diagnosis would be the medical condition which led to the hospital admission.

2. Admission Following Post-Operative Observation

When a patient is admitted to an observation unit to monitor a condition (or complication) that develops following outpatient surgery, and then is subsequently admitted as an inpatient of the same hospital, hospitals should

apply the Uniform Hospital Discharge Data Set (UHDDS) definition of principal diagnosis as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."

J. Admission from Outpatient Surgery

When a patient receives surgery in the hospital's outpatient surgery department and is subsequently admitted for continuing inpatient care at the same hospital, the following guidelines should be followed in selecting the principal diagnosis for the inpatient admission:

- If the reason for the inpatient admission is a complication, assign the complication as the principal diagnosis.
- If no complication, or other condition, is documented as the reason for the inpatient admission, assign the reason for the outpatient surgery as the principal diagnosis.
- If the reason for the inpatient admission is another condition unrelated to the surgery, assign the unrelated condition as the principal diagnosis.

Section III. Reporting Additional Diagnoses

GENERAL RULES FOR OTHER (ADDITIONAL) DIAGNOSES

For reporting purposes the definition for "other diagnoses" is interpreted as additional conditions that affect patient care in terms of requiring:

clinical evaluation; or
therapeutic treatment; or
diagnostic procedures; or
extended length of hospital stay; or
increased nursing care and/or monitoring.

The UHDDS item #11-b defines Other Diagnoses as "all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded." UHDDS definitions apply to inpatients in acute care, short-term, long term care and psychiatric hospital setting. The UHDDS definitions are used by acute care short-term hospitals to report inpatient data elements in a standardized manner. These data elements and their definitions can be found in the July 31, 1985, Federal Register (Vol. 50, No, 147), pp. 31038-40.

Since that time the application of the UHDDS definitions has been expanded to include all non-outpatient settings (acute care, short term, long term care and psychiatric hospitals; home health agencies; rehab facilities; nursing homes, etc).

The following guidelines are to be applied in designating "other diagnoses" when neither the Alphabetic Index nor the Tabular List in ICD-9-CM provide direction. The listing of the diagnoses in the patient record is the responsibility of the attending provider.

A. Previous conditions

If the provider has included a diagnosis in the final diagnostic statement, such as the discharge summary or the face sheet, it should ordinarily be coded. Some providers include in the diagnostic statement resolved conditions or diagnoses and status-post procedures from previous admission that have no bearing on the current stay. Such conditions are not to be reported and are coded only if required by hospital policy.

However, history codes (V10-V19) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

B. Abnormal findings

Abnormal findings (laboratory, x-ray, pathologic, and other diagnostic results) are not coded and reported unless the provider indicates their clinical significance. If the findings are outside the normal range and the attending provider has ordered other tests to evaluate the condition or prescribed treatment, it is appropriate to ask the provider whether the abnormal finding should be added.

Please note: This differs from the coding practices in the outpatient setting for coding encounters for diagnostic tests that have been interpreted by a provider.

C. Uncertain Diagnosis

If the diagnosis documented at the time of discharge is qualified as "probable", "suspected", "likely", "questionable", "possible", or "still to be ruled out" **or other similar terms indicating uncertainty**, code the condition as if it existed or was established. The bases for these guidelines are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that correspond most closely with the established diagnosis.
Note: This guideline is applicable only to short-term, acute, long-term care and psychiatric hospitals.

Section IV. Diagnostic Coding and Reporting Guidelines for Outpatient Services

These coding guidelines for outpatient diagnoses have been approved for use by hospitals/ providers in coding and reporting hospital-based outpatient services and provider-based office visits.

Information about the use of certain abbreviations, punctuation, symbols, and other conventions used in the ICD-9-CM Tabular List (code numbers and titles), can be found in Section IA of

these guidelines, under "Conventions Used in the Tabular List." Information about the correct sequence to use in finding a code is also described in Section I.

The terms encounter and visit are often used interchangeably in describing outpatient service contacts and, therefore, appear together in these guidelines without distinguishing one from the other.

Though the conventions and general guidelines apply to all settings, coding guidelines for outpatient and provider reporting of diagnoses will vary in a number of instances from those for inpatient diagnoses, recognizing that:

> The Uniform Hospital Discharge Data Set (UHDDS) definition of principal diagnosis applies only to inpatients in acute, short-term, long-term care and psychiatric hospitals.

> Coding guidelines for inconclusive diagnoses (probable, suspected, rule out, etc.) were developed for inpatient reporting and do not apply to outpatients.

A. Selection of first-listed condition

In the outpatient setting, the term first-listed diagnosis is used in lieu of principal diagnosis.

In determining the first-listed diagnosis the coding conventions of ICD-9-CM, as well as the general and disease specific guidelines take precedence over the outpatient guidelines.

Diagnoses often are not established at the time of the initial encounter/visit. It may take two or more visits before the diagnosis is confirmed.

The most critical rule involves beginning the search for the correct code assignment through the Alphabetic Index. Never begin searching initially in the Tabular List as this will lead to coding errors.

1. Outpatient Surgery

When a patient presents for outpatient surgery, code the reason for the surgery as the first-listed diagnosis (reason for the encounter), even if the surgery is not performed due to a contraindication.

2. Observation Stay

When a patient is admitted for observation for a medical condition, assign a code for the medical condition as the first-listed diagnosis.

When a patient presents for outpatient surgery and develops complications requiring admission to observation, code the reason for the surgery as the first reported diagnosis (reason for the encounter), followed by codes for the complications as secondary diagnoses.

B. Codes from 001.0 through V84.8

The appropriate code or codes from 001.0 through V84.8 must be used to identify diagnoses, symptoms, conditions, problems, complaints, or other reason(s) for the encounter/visit.

C. Accurate reporting of ICD-9-CM diagnosis codes

For accurate reporting of ICD-9-CM diagnosis codes, the documentation should describe the patient's condition, using terminology which includes specific diagnoses as well as symptoms, problems, or reasons for the encounter. There are ICD-9-CM codes to describe all of these.

D. Selection of codes 001.0 through 999.9

The selection of codes 001.0 through 999.9 will frequently be used to describe the reason for the encounter. These codes are from the section of ICD-9-CM for the classification of diseases and injuries (e.g. infectious and parasitic diseases; neoplasms; symptoms, signs, and ill-defined conditions, etc.).

E. Codes that describe symptoms and signs

Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a diagnosis has not been established (confirmed) by the provider. Chapter 16 of ICD-9-CM, Symptoms, Signs, and Ill-defined conditions (codes 780.0 - 799.9) contain many, but not all codes for symptoms.

F. Encounters for circumstances other than a disease or injury

ICD-9-CM provides codes to deal with encounters for circumstances other than a disease or injury. The Supplementary Classification of factors Influencing Health Status and Contact with Health Services (V01.0- V84.8) is provided to deal with occasions when circumstances other than a disease or injury are recorded as diagnosis or problems*. See Section I.C. 18 for information on V-codes*

G. Level of Detail in Coding

1. ICD-9-CM codes with 3, 4, or 5 digits

ICD-9-CM is composed of codes with either 3, 4, or 5 digits. Codes with three digits are included in ICD-9-CM as the heading of a category of codes that may be further subdivided by the use of fourth and/or fifth digits, which provide greater specificity.

2. Use of full number of digits required for a code

A three-digit code is to be used only if it is not further subdivided. Where fourth-digit subcategories and/or fifth-digit subclassifications are provided, they must be assigned. A code is invalid if it has not been coded to the full number of digits required for that code.
See also discussion under Section I.b.3., General Coding Guidelines, Level of Detail in Coding.

H. ICD-9-CM code for the diagnosis, condition, problem, or other reason for encounter/visit

List first the ICD-9-CM code for the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the services provided. List additional codes that describe any coexisting conditions. In some cases the first-listed diagnosis may be a symptom when a diagnosis has not been established (confirmed) by the physician.

I. <u>Uncertain diagnosis</u>

Do not code diagnoses documented as "probable", "suspected," "questionable," "rule out," or "working diagnosis" **or other similar terms indicating uncertainty**. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.
Please note: This differs from the coding practices used by short-term, acute care, long-term care and psychiatric hospitals.

J. Chronic diseases

Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s)

K. Code all documented conditions that coexist

Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (V10-V19) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

L. Patients receiving diagnostic services only

For patients receiving diagnostic services only during an encounter/visit, sequence first the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the outpatient services provided during the encounter/visit. Codes for other diagnoses (e.g., chronic conditions) may be sequenced as additional diagnoses.

For encounters for routine laboratory/radiology testing in the absence of any signs, symptoms, or associated diagnosis, assign V72.5 and V72.6. If routine testing is performed during the same encounter as a test to evaluate a sign, symptom, or diagnosis, it is appropriate to assign both the V code and the code describing the reason for the non-routine test.

For outpatient encounters for diagnostic tests that have been interpreted by a physician, and the final report is available at the time of coding, code any confirmed or definitive diagnosis(es) documented in the interpretation. Do not code related signs and symptoms as additional diagnoses.

Please note: This differs from the coding practice in the hospital inpatient setting regarding abnormal findings on test results.

M. Patients receiving therapeutic services only

For patients receiving therapeutic services only during an encounter/visit, sequence first the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the outpatient services provided during the encounter/visit. Codes for other diagnoses (e.g., chronic conditions) may be sequenced as additional diagnoses.

The only exception to this rule is that when the primary reason for the admission/encounter is chemotherapy, radiation therapy, or rehabilitation, the appropriate V code for the service is listed first, and the diagnosis or problem for which the service is being performed listed second.

N. Patients receiving preoperative evaluations only

For patients receiving preoperative evaluations only, sequence **first** a code from category V72.8, Other specified examinations, to describe the pre-op consultations. Assign a code for the condition to describe the reason for the surgery as an additional diagnosis. Code also any findings related to the pre-op evaluation.

O. Ambulatory surgery

For ambulatory surgery, code the diagnosis for which the surgery was performed. If the postoperative diagnosis is known to be different from the preoperative diagnosis at the time the diagnosis is confirmed, select the postoperative diagnosis for coding, since it is the most definitive.

P. Routine outpatient prenatal visits

For routine outpatient prenatal visits when no complications are present, codes V22.0, Supervision of normal first pregnancy, or V22.1, Supervision of other normal pregnancy, should be used as the principal diagnosis. These codes should not be used in conjunction with chapter 11 codes.

Appendix I
Present on Admission Reporting Guidelines
[Added to the Official Coding Guidelines October 1, 2006]

Introduction

These guidelines are to be used as a supplement to the *ICD-9-CM Official Guidelines for Coding and Reporting* to facilitate the assignment of the Present on Admission (POA) indicator for each diagnosis and external cause of injury code reported on claim forms (UB-04 and 837 Institutional).

These guidelines are not intended to replace any guidelines in the main body of the *ICD-9-CM Official Guidelines for Coding and Reporting*. The POA guidelines are not intended to provide guidance on when a condition should be coded, but rather, how to apply the POA indicator to the final set of diagnosis codes that have been assigned in accordance with Sections I, II, and III of the official coding guidelines. Subsequent to the assignment of the ICD-9-CM codes, the POA indicator should then be assigned to those conditions that have been coded.

As stated in the Introduction to the ICD-9-CM Official Guidelines for Coding and Reporting, a joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Medical record documentation from any provider involved in the care and treatment of the patient may be used to support the determination of whether a condition was present on admission or not. In the context of the official coding guidelines, the term "provider" means a physician or any qualified healthcare practitioner who is legally accountable for establishing the patient's diagnosis.

General Reporting Requirements

All claims involving inpatient admissions to general acute care hospitals or other facilities that are subject to a law or regulation mandating collection of present on admission information.

Present on admission is defined as present at the time the order for inpatient admission occurs -- conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as present on admission.

POA indicator is assigned to principal and secondary diagnoses (as defined in Section II of the Official Guidelines for Coding and Reporting) and the external cause of injury codes.

Issues related to inconsistent, missing, conflicting or unclear documentation must still be resolved by the provider.

If a condition would not be coded and reported based on UHDDS definitions and current official coding guidelines, then the POA indicator would not be reported.

Reporting Options
Y - Yes
N - No
U - Unknown
W – Clinically undetermined
Unreported/Not used – (Exempt from POA reporting)

Reporting Definitions
Y = present at the time of inpatient admission
N = not present at the time of inpatient admission
U = documentation is insufficient to determine if condition is present on admission
W = provider is unable to clinically determine whether condition was present on admission or not

Assigning the POA Indicator

Condition is on the "Exempt from Reporting" list
Leave the "present on admission" field blank if the condition is on the list of ICD-9-CM codes for which this field is not applicable. This is the only circumstance in which the field may be left blank.

POA Explicitly Documented
Assign Y for any condition the provider explicitly documents as being present on admission.

Assign N for any condition the provider explicitly documents as not present at the time of admission.

Conditions diagnosed prior to inpatient admission
Assign "Y" for conditions that were diagnosed prior to admission (example: hypertension, diabetes mellitus, asthma)

Conditions diagnosed during the admission but clearly present before admission
Assign "Y" for conditions diagnosed during the admission that were clearly present but not diagnosed until after admission occurred.

Diagnoses subsequently confirmed after admission are considered present on admission if at the time of admission they are documented as suspected, possible, rule out, differential diagnosis, or constitute an underlying cause of a symptom that is present at the time of admission.

Condition develops during outpatient encounter prior to inpatient admission
Assign Y for any condition that develops during an outpatient encounter prior to a written order for inpatient admission.

Documentation does not indicate whether condition was present on admission

Assign "U" when the medical record documentation is unclear as to whether the condition was present on admission. "U" should not be routinely assigned and used only in very limited circumstances. Coders are encouraged to query the providers when the documentation is unclear.

Documentation states that it cannot be determined whether the condition was or was not present on admission

Assign "W" when the medical record documentation indicates that it cannot be clinically determined whether or not the condition was present on admission.

Chronic condition with acute exacerbation during the admission

If the code is a combination code that identifies both the chronic condition and the acute exacerbation, see POA guidelines pertaining to combination codes.

If the combination code only identifies the chronic condition and not the acute exacerbation (e.g., acute exacerbation of CHF), assign "Y."

Conditions documented as possible, probable, suspected, or rule out at the time of discharge

If the final diagnosis contains a possible, probable, suspected, or rule out diagnosis, and this diagnosis was suspected at the time of inpatient admission, assign "Y."

If the final diagnosis contains a possible, probable, suspected, or rule out diagnosis, and this diagnosis was based on symptoms or clinical findings that were not present on admission, assign "N".

Conditions documented as impending or threatened at the time of discharge

If the final diagnosis contains an impending or threatened diagnosis, and this diagnosis is based on symptoms or clinical findings that were present on admission, assign "Y".

If the final diagnosis contains an impending or threatened diagnosis, and this diagnosis is based on symptoms or clinical findings that were **not** present on admission, assign "N".

Acute and Chronic Conditions

Assign "Y" for acute conditions that are present at time of admission and N for acute conditions that are not present at time of admission.

Assign "Y" for chronic conditions, even though the condition may not be diagnosed until after admission.

If a single code identifies both an acute and chronic condition, see the POA guidelines for combination codes.

Combination Codes

Assign "N" if any part of the combination code was not present on admission (e.g., obstructive chronic bronchitis with acute exacerbation and the exacerbation was not present on admission; gastric ulcer that does not start bleeding until after admission; asthma patient develops status asthmaticus after admission)

Assign "Y" if all parts of the combination code were present on admission (e.g., patient with diabetic nephropathy is admitted with uncontrolled diabetes)

If the final diagnosis includes comparative or contrasting diagnoses, and both were present, or suspected, at the time of admission, assign "Y".

For infection codes that include the causal organism, assign "Y" if the infection (or signs of the infection) was present on admission, even though the culture results may not be known until after admission (e.g., patient is admitted with pneumonia and the provider documents pseudomonas as the causal organism a few days later).

Obstetrical conditions

Whether or not the patient delivers during the current hospitalization does not affect assignment of the POA indicator. The determining factor for POA assignment is whether the pregnancy complication or obstetrical condition described by the code was present at the time of admission or not.

If the pregnancy complication or obstetrical condition was present on admission (e.g., patient admitted in preterm labor), assign "Y".

If the pregnancy complication or obstetrical condition was not present on admission (e.g., 2nd degree laceration during delivery, postpartum hemorrhage that occurred during current hospitalization, fetal distress develops after admission), assign "N".

If the obstetrical code includes more than one diagnosis and any of the diagnoses identified by the code were not present on admission assign "N".
> (e.g., Code 642.7, Pre-eclampsia or eclampsia superimposed on pre-existing hypertension).

If the obstetrical code includes information that is not a diagnosis, do not consider that information in the POA determination.
> (e.g. Code 652.1x, Breech or other malpresentation successfully converted to cephalic presentation should be reported as present on admission if the fetus was breech on admission but was converted to cephalic presentation after admission (since the conversion to cephalic presentation does not represent a diagnosis, the fact that the conversion occurred after admission has no bearing on the POA determination).

Perinatal conditions

Newborns are not considered to be admitted until after birth. Therefore, any condition present at birth or that developed in utero is considered present at admission and should be assigned "Y". This includes conditions that occur during delivery (e.g., injury during delivery, meconium aspiration, exposure to streptococcus B in the vaginal canal).

Congenital conditions and anomalies

Assign "Y" for congenital conditions and anomalies. Congenital conditions are always considered present on admission.

External cause of injury codes

Assign "Y" for any E code representing an external cause of injury or poisoning that occurred prior to inpatient admission (e.g., patient fell out of bed at home, patient fell out of bed in emergency room prior to admission)

Assign "N" for any E code representing an external cause of injury or poisoning that occurred during inpatient hospitalization (e.g., patient fell out of hospital bed during hospital stay, patient experienced an adverse reaction to a medication administered after inpatient admission)

Categories and Codes

Exempt from

Diagnosis Present on Admission Requirement

Note: "Diagnosis present on admission" for these code categories are exempt because they represent circumstances regarding the healthcare encounter or factors influencing health status that do not represent a current disease or injury or are always present on admission

137-139, Late effects of infectious and parasitic diseases

268.1, Rickets, late effect

326, Late effects of intracranial abscess or pyogenic infection

438, Late effects of cerebrovascular disease

650, Normal delivery

660.7, Failed forceps or vacuum extractor, unspecified

677, Late effect of complication of pregnancy, childbirth, and the puerperium

905-909, Late effects of injuries, poisonings, toxic effects, and other external causes
V02, Carrier or suspected carrier of infectious diseases

V03, Need for prophylactic vaccination and inoculation against bacterial diseases

V04, Need for prophylactic vaccination and inoculation against certain viral diseases

V05, Need for other prophylactic vaccination and inoculation against single diseases

V06, Need for prophylactic vaccination and inoculation against combinations of diseases

V07, Need for isolation and other prophylactic measures

V10, Personal history of malignant neoplasm

V11, Personal history of mental disorder

V12, Personal history of certain other diseases

V13, Personal history of other diseases

V14, Personal history of allergy to medicinal agents

V15, Other personal history presenting hazards to health

V16, Family history of malignant neoplasm

V17, Family history of certain chronic disabling diseases

V18, Family history of certain other specific conditions

V19, Family history of other conditions

V20, Health supervision of infant or child

V21, Constitutional states in development

V22, Normal pregnancy

V23, Supervision of high-risk pregnancy

V24, Postpartum care and examination

V25, Encounter for contraceptive management

V26, Procreative management

V27, Outcome of delivery

V28, Antenatal screening

V29, Observation and evaluation of newborns for suspected condition not found
V30-V39, Liveborn infants according to type of birth

V42, Organ or tissue replaced by transplant

V43, Organ or tissue replaced by other means

V44, Artificial opening status

V45, Other postprocedural states

V46, Other dependence on machines

V49.60-V49.77, Upper and lower limb amputation status

V49.81-V49.84, Other specified conditions influencing health status

V50, Elective surgery for purposes other than remedying health states
V51, Aftercare involving the use of plastic surgery
V52, Fitting and adjustment of prosthetic device and implant
V53, Fitting and adjustment of other device

V54, Other orthopedic aftercare

V55, Attention to artificial openings

V56, Encounter for dialysis and dialysis catheter care

V57, Care involving use of rehabilitation procedures

V58, Encounter for other and unspecified procedures and aftercare

V59, Donors

V60, Housing, household, and economic circumstances

V61, Other family circumstances

V62, Other psychosocial circumstances

V64, Persons encountering health services for specific procedures, not carried out

V65, Other persons seeking consultation

V66, Convalescence and palliative care

V67, Follow-up examination

V68, Encounters for administrative purposes

V69, Problems related to lifestyle

V70, General medical examination

V71, Observation and evaluation for suspected condition not found

V72, Special investigations and examinations

V73, Special screening examination for viral and chlamydial diseases

V74, Special screening examination for bacterial and spirochetal diseases

V75, Special screening examination for other infectious diseases

V76, Special screening for malignant neoplasms

V77, Special screening for endocrine, nutritional, metabolic, and immunity disorders

V78, Special screening for disorders of blood and blood-forming organs

V79, Special screening for mental disorders and developmental handicaps

V80, Special screening for neurological, eye, and ear diseases

V81, Special screening for cardiovascular, respiratory, and genitourinary diseases

V82, Special screening for other conditions

V83, Genetic carrier status

V84, Genetic susceptibility to disease

V85 Body Mass Index

V86 Estrogen receptor status

E800-E807, Railway accidents
E810-E819, Motor vehicle traffic accidents
E820-E825, Motor vehicle nontraffic accidents
E826-E829, Other road vehicle accidents
E830-E838, Water transport accidents
E840-E845, Air and space transport accidents
E846-E848, Vehicle accidents not elsewhere classifiable
E849.0-E849.6, Place of occurrence
E849.8-E849.9, Place of occurrence
E883.1, Accidental fall into well
E883.2, Accidental fall into storm drain or manhole
E884.0, Fall from playground equipment
E884.1, Fall from cliff
E885.0, Fall from (nonmotorized) scooter
E885.1, Fall from roller skates
E885.2, Fall from skateboard
E885.3, Fall from skis
E885.4, Fall from snowboard

E886.0, Fall on same level from collision, pushing, or shoving, by or with other person, In sports
E890.0-E89.9, Conflagration in private dwelling
E893.0, Accident caused by ignition of clothing, from controlled fire in private dwelling
E893.2, Accident caused by ignition of clothing, from controlled fire not in building or structure
E894, Ignition of highly inflammable material
E895, Accident caused by controlled fire in private dwelling
E897, Accident caused by controlled fire not in building or structure
E898.0-E898.1, Accident caused by other specified fire and flames
E917.0, Striking against or struck accidentally by objects or persons, in sports without subsequent fall
E917.1, Striking against or struck accidentally by objects or persons, caused by a crowd, by collective fear or panic without subsequent fall
E917.2, Striking against or struck accidentally by objects or persons, in running water without subsequent fall
E917.5, Striking against or struck accidentally by objects or persons, object in sports with subsequent fall
E917.6, Striking against or struck accidentally by objects or persons, caused by a crowd, by collective fear or panic with subsequent fall
E919, Accidents caused by machinery
E921.0-E921.9, Accident caused by explosion of pressure vessel
E922.0-E922.9, Accident caused by firearm and air gun missile
E924.1, Caustic and corrosive substances
E926.2, Visible and ultraviolet light sources
E927, Overexertion and strenuous movements
E928.0-E928.8, Other and unspecified environmental and accidental causes
E929.0-E929.9, Late effects of accidental injury
E959, Late effects of self-inflicted injury
E970-E978, Legal intervention
E979, Terrorism
E981.0-E980.9, Poisoning by gases in domestic use, undetermined whether accidentally or purposely inflicted
E982.0-E982.9, Poisoning by other gases, undetermined whether accidentally or purposely inflicted
E985.0-E985.7, Injury by firearms, air guns and explosives, undetermined whether accidentally or purposely inflicted
E987.0, Falling from high place, undetermined whether accidentally or purposely inflicted, residential premises
E987.2, Falling from high place, undetermined whether accidentally or purposely inflicted, natural sites
E989, Late effects of injury, undetermined whether accidentally or purposely inflicted
E990-E999, Injury resulting from operations of war

POA Examples

General Medical Surgical

1. Patient is admitted for diagnostic work-up for cachexia. The final diagnosis is malignant neoplasm of lung with metastasis.

    Assign "Y" on the POA field for the malignant neoplasm. The malignant neoplasm was clearly present on admission, although it was not diagnosed until after the admission occurred.

2. A patient undergoes outpatient surgery. During the recovery period, the patient develops atrial fibrillation and the patient is subsequently admitted to the hospital as an inpatient.

    Assign "Y" on the POA field for the atrial fibrillation since it developed prior to a written order for inpatient admission.

3. A patient is treated in observation and while in Observation, the patient falls out of bed and breaks a hip. The patient is subsequently admitted as an inpatient to treat the hip fracture.

    Assign "Y" on the POA field for the hip fracture since it developed prior to a written order for inpatient admission.

4. A patient with known congestive heart failure is admitted to the hospital after he develops decompensated congestive heart failure.

    Assign "Y" on the POA field for the congestive heart failure. The ICD-9-CM code identifies the chronic condition and does not specify the acute exacerbation.

5. A patient undergoes inpatient surgery. After surgery, the patient develops fever and is treated aggressively. The physician's final diagnosis documents "possible postoperative infection following surgery."

    Assign "N" on the POA field for the postoperative infection since final diagnoses that contain the terms "possible", "probable", "suspected" or "rule out" and that are based on symptoms or clinical findings that were not present on admission should be reported as "N".

6. A patient with severe cough and difficulty breathing was diagnosed during his hospitalization to have lung cancer.

    Assign "Y" on the POA field for the lung cancer. Even though the cancer was not diagnosed until after admission, it is a chronic condition that was clearly present before the patient's admission.

7. A patient is admitted to the hospital for a coronary artery bypass surgery. Postoperatively he developed a pulmonary embolism.

    Assign "N" on the POA field for the pulmonary embolism. This is an acute condition that was not present on admission.

8. A patient is admitted with a known history of coronary atherosclerosis, status post myocardial infarction five years ago is now admitted for treatment of impending myocardial infarction. The final diagnosis is documented as "impending myocardial infarction."

    Assign "Y" to the impending myocardial infarction because the condition is present on admission.

9. A patient with diabetes mellitus developed uncontrolled diabetes on day 3 of the hospitalization.

    Assign "N" to the diabetes code because the "uncontrolled" component of the code was not present on admission.

10. A patient is admitted with high fever and pneumonia. The patient rapidly deteriorates and becomes septic. The discharge diagnosis lists sepsis and pneumonia. The documentation is unclear as to whether the sepsis was present on admission or developed shortly after admission.

    Query the physician as to whether the sepsis was present on admission, developed shortly after admission, or it cannot be clinically determined as to whether it was present on admission or not.

11. A patient is admitted for repair of an abdominal aneurysm. However, the aneurysm ruptures after hospital admission.

    Assign "N" for the ruptured abdominal aneurysm. Although the aneurysm was present on admission, the "ruptured" component of the code description did not occur until after admission.

12. A patient with viral hepatitis B progresses to hepatic coma after admission.

    Assign "N" for the viral hepatitis B with hepatic coma because part of the code description did not develop until after admission.

13. A patient with a history of varicose veins and ulceration of the left lower extremity strikes the area against the side of his hospital bed during an inpatient hospitalization. It bleeds profusely. The final diagnosis lists varicose veins with ulcer and hemorrhage.

Assign "Y" for the varicose veins with ulcer. Although the hemorrhage occurred after admission, the code description for varicose veins with ulcer does not mention hemorrhage.

Obstetrics

1. A female patient was admitted to the hospital and underwent a normal delivery.

   Leave the "present on admission" (POA) field blank. Code 650, Normal delivery, is on the "exempt from reporting" list.

2. Patient admitted in late pregnancy due to excessive vomiting and dehydration. During admission patient goes into premature labor

   Assign "Y" for the excessive vomiting and the dehydration.
   Assign "N" for the premature labor

3. Patient admitted in active labor. During the stay, a breast abscess is noted when mother attempted to breast feed. Provider is unable to determine whether the abscess was present on admission

   Assign "W" for the breast abscess.

4. Patient admitted in active labor. After 12 hours of labor it is noted that the infant is in fetal distress and a Cesarean section is performed

   Assign "N" for the fetal distress.

Newborn

1. A single liveborn infant was delivered in the hospital via Cesarean section. The physician documented fetal bradycardia during labor in the final diagnosis in the newborn record.

   Assign " Y" because the bradycardia developed prior to the newborn admission (birth).

2. A newborn developed diarrhea which was believed to be due to the hospital baby formula.

   Assign " N" because the diarrhea developed after admission.