

ICD-9-CM Official Guidelines for Coding and Reporting

Effective October 1, 2009

Narrative changes appear in **red text**

Items underlined have been moved within the guidelines since October 1, 2008

Table of Contents

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

B. General Coding Guidelines

4. Code or codes from 001.0 through ~~V89~~ V89.09

17. **Syndromes**

C. Chapter-Specific Coding Guidelines

2. Chapter 2: Neoplasms (140-239)

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

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

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

d. Influenza due to **certain** identified **viruses**

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

a. **Codes in categories 740-759, Congenital Anomalies**

18. Chapter 18: Classification of Factors Influencing health Status and Contact with Health Service (Supplemental V01-V89)

e. **V Codes That May Only be Principal/First-Listed Diagnosis**

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

~~d. Multiple Cause E-Code Coding Guidelines~~

d. Child and Adult Abuse Guideline

e. Unknown or Suspected Intent Guideline

f. Undetermined Cause

g. Late Effects of External Cause Guidelines

h. Misadventures and Complications of Care Guidelines

i. Terrorism Guidelines

j. **Activity Code Guidelines**

k. **External cause status**

Section IV. Diagnostic Coding and Reporting Guidelines for Outpatient Services

B. Codes from 001.0 through ~~V86.1~~ V89

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. **The conventions and instructions of the classification take precedence over guidelines.**

B. General Coding Guidelines

4. Code or codes from 001.0 through V89.09

The appropriate code or codes from 001.0 through V89.09 must be used to identify diagnoses, symptoms, conditions, problems, complaints or other reason(s) for the encounter/visit.

17. **Syndromes**

Follow the Alphabetic Index guidance when coding syndromes. In the absence of index guidance, assign codes for the documented manifestations of the syndrome.

C. Chapter-Specific Coding Guidelines

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

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

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.i.7. for information on the coding of puerperal sepsis.

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

See Section I.C.1.b.2.a. for guidelines pertaining to sepsis or severe sepsis as the principal diagnosis.

Only one code from subcategory 995.9 should be assigned. Therefore, when a non-infectious condition leads to an infection resulting in sepsis or severe sepsis, assign either code 995.91 or 995.92. Do not additionally assign code 995.93, Systemic

Text noted in **red** indicates new text added for the 2009 ICD-9-CM year

Text noted in **blue** with a strikethrough indicates the text has been deleted for 2009

inflammatory response syndrome due to **noninfectious** process without acute organ dysfunction, or 995.94, Systemic inflammatory response syndrome with acute organ dysfunction.

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)

c. Coding and sequencing of complications

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.

Code 285.22, Anemia in neoplastic disease, and code 285.3, Antineoplastic chemotherapy induced anemia, may both be assigned if anemia in neoplastic disease and anemia due to antineoplastic chemotherapy are both documented.

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.

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

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.](#)

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

a. Diabetes mellitus

7) Secondary Diabetes Mellitus

**(d) Assigning and sequencing secondary diabetes codes and its causes
(i) Secondary diabetes mellitus due to pancreatectomy**

For postpancreatectomy diabetes mellitus (lack of insulin due to the surgical removal of all or part of the pancreas), assign code 251.3, Postsurgical hypoinsulinemia. **Assign a code from subcategory 249 and code V45.79, Other acquired absence of organ, as additional codes.** ~~A code from subcategory 249 should not be assigned for secondary diabetes mellitus due to pancreatectomy.~~ Code also any diabetic manifestations (e.g. diabetic nephrosis 581.81).

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

a. Anemia of chronic disease

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~~. **Assign code 285.3 for anemia due to antineoplastic chemotherapy.**

See I.C.2.c.1 Anemia associated with malignancy.

See I.C.2.c.2 Anemia associated with chemotherapy, immunotherapy and radiation therapy.

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, unless otherwise indicated below.

If the pain is not specified as acute or chronic, do not assign codes from category 338, except for post-thoracotomy pain, postoperative pain, neoplasm related pain, or central pain syndrome.

[See I.C.17.e.1. Adverse effects](#)

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.

Text noted in **red** indicates new text added for the 2009-2010 ICD-9-CM year

Text noted in **blue** with a strikethrough indicates the text has been deleted for the 2009-2010 ICD-9-CM year

8. **Chapter 8: Diseases of Respiratory System (460-519)**
- d. **Influenza due to ~~certain identified avian influenza viruses (avian influenza)~~**
 Code only confirmed cases of avian influenza (**code 488.0, Influenza due to identified avian influenza virus) or novel H1N1 influenza virus (H1N1 or swine flu, code 488.1)**). This is an exception to the hospital inpatient guideline Section II, H. (Uncertain Diagnosis).
 In this context, “confirmation” does not require documentation of positive laboratory testing specific for avian **or novel H1N1** influenza. However, coding should be based on the provider’s diagnostic statement that the patient has avian **or novel H1N1 (H1N1 or swine flu)** influenza.
 If the provider records “suspected or possible or probable avian **or novel H1N1 influenza (H1N1 or swine flu)**,” the appropriate influenza code from category 487 should be assigned. ~~Code A code from category 488, Influenza due to certain identified influenza avian influenza viruses~~, should not be assigned.
11. **Chapter 11: Complications of Pregnancy, Childbirth, and the Puerperium (630-679)**
- b. **Selection of OB Principal or First-listed Diagnosis**
- 2) **Prenatal outpatient visits for high-risk patients**
 For **routine** prenatal outpatient visits for patients with high-risk pregnancies, a code from category V23, Supervision of high-risk pregnancy, should be used as the first-listed diagnosis. Secondary chapter 11 codes may be used in conjunction with these codes if appropriate.
- 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 be the condition established after study that was responsible for the patient’s admission. If the patient was admitted with a condition that resulted in the performance of a cesarean procedure, that condition should be selected as the principal diagnosis. If the reason for the admission/encounter was unrelated to the condition resulting in the cesarean delivery, the condition related to the reason for the admission/encounter should be selected as the principal diagnosis, even if a cesarean was performed.**
- i. **The Postpartum and Peripartum Periods**
- 7) **Puerperal sepsis**
Code 670.2x, Puerperal sepsis, should be assigned with a secondary code to identify the causal organism (e.g., for a bacterial infection, assign a code from category 041, Bacterial infections in conditions classified elsewhere and of unspecified site). A code from category 038, Septicemia, should not be used for puerperal sepsis. Do not assign code 995.91, Sepsis, as code 670.2x describes the sepsis. If applicable, use additional codes to identify severe sepsis (995.92) and any associated acute organ dysfunction.
- k. **Abortions**
- 1) **Fifth-digits required for abortion categories**
 Fifth-digits are required for abortion categories 634-637. **Fifth digit assignment is based on the status of the patient at the beginning (or start) of the encounter.** 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.
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 **traumatic injury** codes are not to be used for normal, healing surgical wounds or to identify complications of surgical wounds.
18. **Chapter 18: Classification of Factors Influencing Health Status and Contact with Health Service (Supplemental V01-V89)**
- 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 - **V89.09**) 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:
- 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

Text noted in red indicates new text added for the 2009-2010 ICD-9-CM year

Text noted in blue with a strikethrough indicates the text has been deleted for the 2009-2010 ICD-9-CM year

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 Codes That May Only be Principal/First-Listed Diagnosis.**

3) **Status**

V85 Body Mass Index (BMI)

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 **and pre-procedural laboratory examination** V codes are for use only in those situations when a patient is being cleared for **a procedure or 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 V72.62** 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**

Miscellaneous V code categories/codes:

~~V85 Body Mass Index~~

~~CODE TABLE October 1, 2008 (FY2009) Items in bold indicate a new entry or change from the October 2007 table Items underlined have been moved within the table since October 2007~~

e. V Codes That May Only be Principal/First-Listed Diagnosis

The ~~list of V codes/categories~~ table below ~~contains columns for 1st listed, 1st or additional, additional only, and non-specific. Each code or category is listed in the left hand column, and the allowable sequencing of the code or codes within the category is noted under the appropriate column. As indicated by the footnote in the "1st Dx Only" column, the V codes designated as first-listed may only are generally intended to be reported as the a first-listed only principal/first-listed diagnosis, but may be reported as an additional diagnosis in those situations except when there are multiple encounters on the patient has more than one encounter on a single same day and the codes medical records for the multiple encounters are combined or when there is more than one V code that meets the definition of principal diagnosis (e.g., a patient is admitted to home healthcare for both aftercare and rehabilitation and they equally meet the definition of principal diagnosis). The V These codes designated as first-listed only should not be reported if they do not meet the definition of principal or first-listed diagnosis.~~

~~See Section II and Section IV.A for information on selection of principal and first-listed diagnosis.~~

~~See Section II.C for information on two or more diagnoses that equally meet the definition for principal diagnosis.~~

~~V01.X Contact with or exposure to communicable diseases~~

~~V02.X Carrier or suspected carrier of infectious diseases~~

~~V03.X Need for prophylactic vaccination and inoculation against bacterial diseases~~

~~V04.X Need for prophylactic vaccination and inoculation against certain diseases~~

~~V05.X Need for prophylactic vaccination and inoculation against single diseases~~

~~V06.X Need for prophylactic vaccination and inoculation against combinations of diseases~~

~~V07.0 Isolation~~

~~V07.1 Desensitization to allergens~~

~~V07.2 Prophylactic immunotherapy~~

~~V07.3X Other prophylactic chemotherapy~~

Text noted in **red** indicates new text added for the 2009-2010 ICD-9-CM year

Text noted in **blue** with a strikethrough indicates the text has been deleted for the 2009-2010 ICD-9-CM year

V07.4	Hormone replacement therapy (postmenopausal)
V07.5X	Prophylactic use of agents affecting estrogen receptors and estrogen levels
V07.8	Other specified prophylactic measure
V07.9	Unspecified prophylactic measure
V08	Asymptomatic HIV infection status
V09.X	Infection with drug-resistant organisms
V10.X	Personal history of malignant neoplasm
V11.X	Personal history of mental disorder
V12.X	Personal history of certain other diseases
V13.0X	Personal history of other disorders of urinary system
V13.1	Personal history of trophoblastic disease
V13.2X	Personal history of other genital system and obstetric disorders
V13.3	Personal history of diseases of skin and subcutaneous tissue
V13.4	Personal history of arthritis
V13.5	Personal history of other musculoskeletal disorders
V13.61	Personal history of hypospadias
V13.69	Personal history of congenital malformations
V13.7	Personal history of perinatal problems
V13.8	Personal history of other specified diseases
V13.9	Personal history of unspecified disease
V14.X	Personal history of allergy to medicinal agents
V15.0X	"Personal history of allergy, other than to medicinal agents"
V15.1	Personal history of surgery to heart and great vessels
V15.2X	Personal history of surgery to other organs
V15.3	Personal history of irradiation
V15.4X	Personal history of psychological trauma
V15.5X	Personal history of injury
V15.6	Personal history of poisoning
V15.7	Personal history of contraception
V15.81	Personal history of noncompliance with medical treatment
V15.82	Personal history of tobacco use
V15.84	Personal history of exposure to asbestos
V15.85	Personal history of exposure to potentially hazardous body fluids
V15.86	Personal history of exposure to lead
V15.87	Personal history of extracorporeal membrane oxygenation [ECMO]
V15.88	History of fall
V15.89	Other specified personal history presenting hazards to health
V16.X	Family history of malignant neoplasm
V17.X	Family history of certain chronic disabling diseases
V18.X	Family history of certain other specific conditions
V19.X	Family history of other conditions
V21.X	Constitutional states in development
V22.2	Pregnancy state, incidental
V23.X	Supervision of high-risk pregnancy
V25.X	Encounter for contraceptive management
V26.0	Tuboplasty or vasoplasty after previous sterilization
V26.1	Artificial insemination
V26.2X	Procreative management investigation and testing
V26.3X	Procreative management, genetic counseling and testing
V26.4	"Procreative management, genetic counseling and advice
V26.5X	Procreative management, sterilization status
V26.8	Other specified procreative management
V26.81	Encounter for assisted reproductive fertility procedure cycle
V26.82	Encounter for fertility preservation procedure
V26.9	Unspecified procreative management
V27.X	Outcome of delivery
V28.X	Encounter for antenatal screening of mother
V29.X	Observation and evaluation of newborns for suspected condition not found
V40.0	Mental and behavioral problems
V41.X	Problems with special senses and other special functions
V42.X	Organ or tissue replaced by transplant
V43.0	Organ or tissue replaced by other means, eye globe
V43.1	Organ or tissue replaced by other means, lens
V43.21	Organ or tissue replaced by other means, heart assist device
V43.22	Fully implantable artificial heart status

Text noted in **red** indicates new text added for the 2009-2010 ICD-9-CM year

Text noted in **blue** with a strikethrough indicates the text has been deleted for the 2009-2010 ICD-9-CM year

V43.3	Organ or tissue replaced by other means, heart valve
V43.4	Organ or tissue replaced by other means, blood vessel
V43.5	Organ or tissue replaced by other means, bladder
V43.6X	Organ or tissue replaced by other means, joint
V43.7	Organ or tissue replaced by other means, limb
V43.8X	Other organ or tissue replaced by other means
V44.X	Artificial opening status
V45.0X	Cardiac device in situ
V45.1X	Renal dialysis status
V45.2	Presence of cerebrospinal fluid drainage device
V45.3	Intestinal bypass or anastomosis status
V45.4	Arthrodesis status
V45.5X	Presence of contraceptive device
V45.6X	States following surgery of eye and adnexa
V45.7X	Acquired absence of organ
V45.8X	Other postprocedural status
V46.0	Other dependence on machines, aspirator
V46.11	Dependence on respiratory, status
V46.14	Mechanical complication of respirator [ventilator]
V46.2	Other dependence on machines, supplemental oxygen
V46.3	Wheelchair dependence
V46.8	Other dependence on other enabling machines
V46.9	Unspecified machine dependence
V47.X	Other problems with internal organs
V48.X	Problems with head, neck and trunk
V49.0	Deficiencies of limbs
V49.1	Mechanical problems with limbs
V49.2	Motor problems with limbs
V49.3	Sensory problems with limbs
V49.4	Disfigurements of limbs
V49.5	Other problems with limbs
V49.6X	Upper limb amputation status
V49.7X	Lower limb amputation status
V49.81	Asymptomatic postmenopausal status (age related) (natural)
V49.82	Dental sealant status
V49.83	Awaiting organ transplant status
V49.84	Bed confinement status
V49.89	Other specified conditions influencing health status
V49.9	Unspecified condition influencing health status
V50.X	Elective surgery for purposes other than remedying health states
V51.8	Other aftercare involving the use of plastic surgery
V51	Aftercare involving the use of plastic surgery
V52.X	Fitting and adjustment of prosthetic device and implant
V53.X	Fitting and adjustment of other device
V54.X	Other orthopedic aftercare
V55.X	Attention to artificial openings
V56.1	Encounter for fitting and adjustment of extracorporeal dialysis catheter
V56.2	Encounter for fitting and adjustment of peritoneal dialysis catheter
V56.3X	Encounter for adequacy testing for dialysis
V56.8	Encounter for other dialysis and dialysis catheter care
V58.2	Blood transfusion without reported diagnosis
V58.3X	Attention to dressings and sutures
V58.4X	Other aftercare following surgery
V58.5	Encounter for orthodontics
V58.6X	Long term (current) drug use
V58.7X	Aftercare following surgery to specified body systems, not elsewhere classified
V58.8X	Other specified procedures and aftercare
V58.9	Unspecified aftercare
V60.X	Housing, household, and economic circumstances
V61.X	Other family circumstances
V62.X	Other psychosocial circumstances
V63.X	Unavailability of other medical facilities for care
V64.X	Persons encountering health services for specified procedure, not carried out
V65.X	Other persons seeking consultation without complaint or sickness

Text noted in *red* indicates new text added for the 2009-2010 ICD-9-CM year

Text noted in *blue* with a strikethrough indicates the text has been deleted for the 2009-2010 ICD-9-CM year

V66.7	Encounter for palliative care
V67.X	Follow-up examination
V69.X	Problems related to lifestyle
V70.7	Examination of participant in clinical trial
V72.0	Examination of eyes and vision
V72.1X	Examination of ears and hearing
V72.2	Dental examination
V72.3X	Gynecological examination
V72.4X	Pregnancy examination or test
V72.5	Radiological examination, NEC
V72.6	Laboratory examination
V72.7	Diagnostic skin and sensitization tests
V72.81	Preoperative cardiovascular examination
V72.82	Preoperative respiratory examination
V72.83	Other specified preoperative examination
V72.84	Preoperative examination, unspecified
V72.85	Other specified examination
V72.86	Encounter for blood typing
V72.9	Unspecified examination
V73.X	Special screening examination for viral and chlamydial diseases
V74.X	Special screening examination for bacterial and spirochetal diseases
V75.X	Special screening examination for other infectious diseases
V76.X	Special screening examination for malignant neoplasms
V77.X	Special screening examination for endocrine, nutritional, metabolic and immunity disorders
V78.X	Special screening examination for disorders of blood and blood-forming organs
V79.X	Special screening examination for mental disorders and developmental handicaps
V80.X	Special screening examination for neurological, eye, and ear diseases
V81.X	Special screening examination for cardiovascular, respiratory, and genitourinary diseases
V82.X	Special screening examination for other conditions
V83.X	Genetic carrier status
V84.X	Genetic susceptibility to disease
V85	Body mass index
V86	Estrogen receptor status
V87.0X	Contact with and (suspected) exposure to hazardous metals
V87.1X	Contact with and (suspected) exposure to hazardous aromatic compounds
V87.2	Contact with and (suspected) exposure to other potentially hazardous chemicals
V87.3X	Contact with and (suspected) exposure to other potentially hazardous substances
V87.4X	Personal history of drug therapy
V88.0X	Acquired absence of cervix and uterus
V89.0X	Suspected maternal and fetal anomalies not found

Section III: Supplemental Classification of External Causes of Injury and Poisoning

(E-codes, E800-E999)

External causes of injury and poisoning codes (~~E-codes~~) (categories E000 and E800-E999) are intended to provide data for injury research and evaluation of injury prevention strategies. **Activity codes (categories E001-E030) are intended to be used to describe the activity of a person seeking care for injuries as well as other health conditions, when the injury or other health condition resulted from an activity or the activity contributed to a condition.** E codes capture how the injury-~~or~~, **poisoning, or adverse effect** happened (cause), the intent (unintentional or accidental; or intentional, such as suicide or assault), **the person's status (e.g. civilian, military), the associated activity** and the place where the event occurred.

a. General E Code Coding Guidelines

1) Used with any code in the range of 001-V89

An E code **from categories E800-E999** may be used with any code in the range of 001-V89, which indicates an injury, poisoning, or adverse effect due to an external cause.

An activity E code (categories E001-E030) may be used with any code in the range of 001-V89 that indicates an injury, or other health condition that

Text noted in red indicates new text added for the 2009-2010 ICD-9-CM year

Text noted in blue with a strikethrough indicates the text has been deleted for the 2009-2010 ICD-9-CM year

- 3) Use the full range of E codes**
 Use the full range of E codes (**E800 – E999**) to completely describe the cause, the intent and the place of occurrence, if applicable, for all injuries, poisonings, and adverse effects of drugs.
See a.1.), j.), and k.) in this section for information on the use of status and activity E codes.
- 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.~~
- 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 **another condition for which an E code would be appropriate (such as** an injury, poisoning, or adverse effect of drugs).
- 8) Multiple Cause E Code Coding Guidelines**
More than one E-code is required to fully describe the external cause of an illness, injury or poisoning. The assignment of E-codes should be sequenced in the following priority:
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, child and adult abuse and terrorism.
Activity and external cause status codes are assigned following all causal (intent) E codes.
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.
- 9) 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, report the code for the cause/intent most related to the principal diagnosis. If the format permits capture of additional E codes, the cause/intent, including medical misadventures, of the additional events should be reported rather than the codes for place, activity or external status.
- 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**
- 2) Use as many codes as necessary to describe**
 Use as many codes as necessary to describe completely all drugs, medicinal or biological substances.
If the reporting format limits the number of E codes, and there are different fourth digit codes in the same three digit category, use the code for “Other specified” of that category of drugs, medicinal or biological substances. If there is no “Other specified” code in that category, use the appropriate “Unspecified” code in that category.
If the reporting format limits the number of E codes, and the codes are in different three digit categories, assign the appropriate E code for other multiple drugs and medicinal substances.
- ~~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.~~
- 6) Codes from the E930-E949 series**
~~d. Multiple Cause E Code Coding Guidelines~~

Text noted in *red* indicates new text added for the 2009-2010 ICD-9-CM year

Text noted in *blue* with a strikethrough indicates the text has been deleted for the 2009-2010 ICD-9-CM year

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.

- d. Child and Adult Abuse Guideline**
- e. Unknown or Suspected Intent Guideline**
- f. Undetermined Cause**
- g. Late Effects of External Cause Guidelines**
- h. 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. **When applying the E code guidelines pertaining to sequencing, these E codes are considered causal codes.**
- i. Terrorism Guidelines**
- j. Activity Code Guidelines**
Assign a code from category E001-E030 to describe the activity that caused or contributed to the injury or other health condition.
Unlike other E codes, activity E codes may be assigned to indicate a health condition (not just injuries) resulted from an activity, or the activity contributed to the condition.
The activity codes are not applicable to poisonings, adverse effects, misadventures or late effects.
- k. External cause status**
A code from category E000, External cause status, should be assigned whenever any other E code is assigned for an encounter, including an Activity E code, except for the events noted below. Assign a code from category E000, External cause status, to indicate the work status of the person at the time the event occurred. The status code indicates whether the event occurred during military activity, whether a non-military person was at work, whether an individual including a student or volunteer was involved in a non-work activity at the time of the causal event.
A code from E000, External cause status, should be assigned, when applicable, with other external cause codes, such as transport accidents and falls. The external cause status codes are not applicable to poisonings, adverse effects, misadventures or late effects.
Do not assign a code from category E000 if no other E codes (cause, activity) are applicable for the encounter.
Do not assign code E000.9, Unspecified external cause status, if the status is not stated.

Section IV. Diagnostic Coding and Reporting Guidelines for Outpatient Services

- L. Patients receiving diagnostic services only
For encounters for routine laboratory/radiology testing in the absence of any signs, symptoms, or associated diagnosis, assign V72.5 and a code from subcategory V72.6.

Appendix I. Present on Admission Reporting Guidelines

Introduction

General Reporting Requirements

Reporting Options

Y - Yes

N - No

U - Unknown

W - Clinically undetermined

Unreported/Not used (or "1" for Medicare usage) – (Exempt from POA reporting)

For more specific instructions on Medicare POA indicator reporting options, refer to

http://www.cms.hhs.gov/HospitalAcqCond/02_Statute_Regulations_Program_Instructions.asp#TopOfPage

Text noted in red indicates new text added for the 2009-2010 ICD-9-CM year

Text noted in blue with a strikethrough indicates the text has been deleted for the 2009-2010 ICD-9-CM year

Assigning the POA Indicator

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 **based on signs, symptoms or clinical findings** 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 **signs, symptoms or clinical findings** that were not present on admission, assign “N”.

Categories and Codes

Exempt from Diagnosis Present on Admission Requirement

- V15.80, Other personal history, History of failed moderate sedation
- V15.83, Other personal history, Underimmunization status
- V15.84, Other personal history, Contact with and (suspected) exposure to asbestos
- V15.85, Other personal history, Contact with and (suspected) exposure to potentially hazardous body fluids
- V15.86, Other personal history, Contact with and (suspected) exposure to lead
- V87.32, Contact with and (suspected) exposure to algae bloom
- E000, External cause status
- E001-E030, Activity

POA Examples

The POA examples have been removed from the guidelines.

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.~~
- ~~1. 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.~~
- ~~1. 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.~~
- ~~1. 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.~~
- ~~1. 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”.~~
- ~~1. 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.~~
- ~~1. 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.~~
- ~~1. 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.~~
- ~~1. 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.~~
- ~~1. 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.~~
- ~~1. 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.~~

Text noted in **red** indicates new text added for the 2009-2010 ICD-9-CM year

Text noted in **blue** with a strikethrough indicates the text has been deleted for the 2009-2010 ICD-9-CM year

- 1. ~~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.~~
- 1. ~~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.~~
- 1. ~~The nursing initial assessment upon admission documents the presence of a decubitus ulcer. There is no mention of the decubitus ulcer in the physician documentation until several days after admission.
Query the physician as to whether the decubitus ulcer was present on admission, or developed after admission. Both diagnosis code assignment and determination of whether a condition was present on admission must be based on provider documentation in the medical record (per the definition of “provider” found at the beginning of these POA guidelines and in the introductory section of the ICD-9-CM Official Guidelines for Coding and Reporting). If it cannot be determined from the provider documentation whether or not a condition was present on admission, the provider should be queried.~~
- ~~A urine culture is obtained on admission. The provider documents urinary tract infection when the culture results become available a few days later.
Assign “Y” to the urinary tract infection since the diagnosis is based on test results from a specimen obtained on admission. It may not be possible for a provider to make a definitive diagnosis for a period of time after admission. There is no required timeframe as to when a provider must identify or document a condition to be present on admission.~~
- 1. ~~A patient tested positive for Methicillin resistant Staphylococcus (MRSA) on routine nasal culture on admission to the hospital. During the hospitalization, he underwent insertion of a central venous catheter and later developed an infection and was diagnosed with MRSA sepsis due to central venous catheter infection.
Assign “Y” to the positive MRSA colonization. Assign “N” for the MRSA sepsis due to central venous catheter infection since the patient did not have a MRSA infection at the time of admission.~~

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.~~
- ~~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~~
- ~~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.~~
- 1. ~~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.~~
- 1. ~~Pregnant female was admitted in labor and fetal nuchal cord entanglement was diagnosed. Physician is queried, but is unable to determine whether the cord entanglement was present on admission or not.
Assign “W” for the fetal nuchal cord entanglement.~~

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).~~
- 1. ~~A newborn developed diarrhea which was believed to be due to the hospital baby formula.
Assign “N” because the diarrhea developed after admission.~~
- 1. ~~A newborn born in the hospital, birth complicated by nuchal cord entanglement.
Assign “Y” for the nuchal cord entanglement on the baby’s record. Any condition that is present at birth or that developed in utero is considered present at admission, including conditions that occur during delivery.~~

Text noted in **red** indicates new text added for the 2009-2010 ICD-9-CM year

Text noted in **blue** with a strikethrough indicates the text has been deleted for the 2009-2010 ICD-9-CM year