ICD-9-CM Official Guidelines for Coding and Reporting

Effective April 1, 2005
Narrative changes appear in bold text
The guidelines have been updated to include the 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 are 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.

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) Sepsis as principal diagnosis or secondary diagnosis

(a) Sepsis as principal diagnosis

If sepsis is present on admission, and meets the definition of principal diagnosis, the underlying systemic infection code (e.g., 038.xx, 112.5, etc) should be assigned as the principal diagnosis, followed by code 995.91, Systemic inflammatory response syndrome due to infectious process without organ dysfunction, as required by the sequencing rules in the Tabular List. Codes from subcategory 995.9 can never be assigned as a principal diagnosis.

(b) Sepsis as secondary diagnoses

When sepsis develops during the encounter (it was not present on admission), the sepsis codes may be assigned as secondary diagnoses, following the sequencing rules provided in the Tabular List.

(c) Documentation unclear as to whether sepsis present on admission

If the documentation is not clear whether the sepsis was present on admission, the provider should be queried. After provider query, if sepsis is determined at that point to have met the definition of principal diagnosis, the underlying systemic infection (038.xx, 112.5, etc) may be used as principal diagnosis along with code 995.91, Systemic inflammatory response syndrome due to infectious process without organ dysfunction.

2) Septicemia/Sepsis

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 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.

(c) Sepsis or SIRS must be documented

Either the term sepsis or SIRS must be documented, to assign a code from subcategory 995.9.

3) Terms sepsis, severe sepsis, or SIRS

If the terms sepsis, severe sepsis, or SIRS are used with an underlying infection other than septicemia, such as pneumonia, cellulitis or a nonspecified urinary tract infection, a code from category 038 should be assigned first, then code 995.91, followed by the code for the initial infection. The use of the terms sepsis or SIRS indicates that the patient's infection has advanced to the point of a systemic infection so the systemic infection should be sequenced before the localized infection. The instructional note under subcategory 995.9 instructs to assign the underlying systemic infection first.

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) Severe sepsis

For patients with severe sepsis, the code for the systemic infection (e.g., 038.xx, 112.5, etc) or trauma should be sequenced first, followed by either code 995.92, Systemic inflammatory response syndrome due to infectious process with organ dysfunction, or code 995.94, Systemic inflammatory response syndrome due to noninfectious process with organ dysfunction. Codes for the specific organ dysfunctions should also be assigned.

5) Septic shock

(a) Sequencing of septic shock

Septic shock is a form of organ dysfunction associated with severe sepsis. A code for the initiating underlying systemic infection followed by a code for SIRS (code 995.92) must be assigned before the code for septic shock. 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 cannot occur in the absence of severe sepsis. A code from subcategory 995.9 must be sequenced before the code for septic shock. The use additional code notes and the code first note provide sequencing instructions.

6) Sepsis and septic shock associated with abortion

Sepsis and septic shock associated with abortion, ectopic pregnancy, and molar pregnancy are classified to category codes in Chapter 11 (630-639).

7) 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.

8) Newborn sepsis

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

9) Sepsis due to a Postprocedural Infection

Sepsis resulting from a postprocedural infection is a complication of care. For such cases code 998.59, Other postoperative infections, should be coded first followed by the appropriate codes for the sepsis. The other guidelines for coding sepsis should then be followed for the assignment of additional codes.

10) External cause of injury codes with SIRS

An external cause code is not needed with codes 995.91, Systemic inflammatory response syndrome due to infectious process without organ dysfunction, or code 995.92, Systemic inflammatory response syndrome due to infectious process with organ dysfunction.

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.

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 anemia is designated at the principal diagnosis and is followed by the appropriate code(s) for the malignancy.

2) Anemia associated with chemotherapy

When the admission/encounter is for management of an anemia associated with chemotherapy or radiotherapy and the only treatment is for the anemia, the anemia is sequenced first followed by the appropriate code(s) for the malignancy.

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 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, 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

If a patient admission/encounter is solely for the administration of chemotherapy or radiation therapy code V58.0, Encounter for radiation therapy, or V58.1, Encounter for chemotherapy, should be the first-listed or principal diagnosis. If a patient receives both chemotherapy and radiation therapy both codes should be listed, in either order of sequence.

3) Patient admitted for radiotherapy/chemotherapy and develops complications

When a patient is admitted for the purpose of radiotherapy 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 V58.1, Encounter for chemotherapy, followed by any codes for the complications.

See Section I.C.18.d.8. 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.

h. Encounter for 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 of 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.

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.

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)

Reserved for future guideline expansion

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

Reserved for future guideline expansion

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

Reserved for future guideline expansion

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 casual relationship, are coded separately. Sequence according to the circumstances of the admission/encounter.

3) Hypertensive Renal Disease with Chronic Renal Failure

Assign codes from category 403, Hypertensive renal 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 renal failure with hypertension as hypertensive renal disease.

4) Hypertensive Heart and Renal Disease

Assign codes from combination category 404, Hypertensive heart and renal disease, when both hypertensive renal disease and hypertensive heart disease are stated in the diagnosis. Assume a relationship between the hypertension and the renal 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.

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.

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.

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

Reserved for future guideline expansion

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

Reserved for future guideline expansion

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)

Reserved for future guideline expansion

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. Use additional secondary codes from other chapters to specify conditions associated with the anomaly, if applicable. 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.

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 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 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) 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.

2) 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.

3) 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.

4) 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 codes

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

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 an excisional debridement (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.

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.

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.

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. These are always secondary codes.

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 V58.1, Chemotherapy. 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
V58.1	Chemotherapy
V58.3	Attention to surgical 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 for use as first listed codes only, and 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
Except V72.5 and V72.6

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.

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

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
V72.5	Radiological examination, NEC
V72.6	Laboratory examination

Codes V72.5 and V72.6 are not to be used if any sign or symptoms, or reason for a test is documented. See Section IV.K. and Section IV.L. of the Outpatient guidelines.

V Code Table
Items in bold indicate a change from the October 2003 table
Items underlined have been moved within the table since October 2003

FIRST LISTED: V codes/categories/subcategories which are only acceptable as principal/first listed.

Codes:

V22.0 Supervision of normal first pregnancy
V22.1 Supervision of other normal pregnancy
V46.12 Encounter for respirator dependence during power failure
V56.0 Extracorporeal dialysis
V58.0 Radiotherapy
V58.1 Chemotherapy
V58.0 and V58.1 may be used together on a record with either one being sequenced first, when a patient receives both chemotherapy and radiation therapy during the same encounter code.

Categories/Subcategories:

V20 Health supervision of infant or child
V24 Postpartum care and examination
V29 Observation and evaluation of newborns for suspected condition not found
Exception: A code from the V30-V39 may be sequenced before the V29 if it is the newborn record.
V30-V39 Liveborn infants according to type of birth
V59 Donors
V66 Convalescence and palliative care
Exception: V66.7 Palliative care
V68 Encounters for administrative purposes
V70 General medical examination
Exception: V70.7 Examination of participant in clinical trial
V71 Observation and evaluation for suspected conditions not found
V72 Special investigations and examinations
Exceptions:
V72.5 Radiological examination, NEC
V72.6 Laboratory examination

FIRST OR ADDITIONAL: V code categories/subcategories which may be either principal/first listed or additional codes

Codes:

V43.22 Fully implantable artificial heart status
V49.81 Asymptomatic postmenopausal status (age-related) (natural)
V70.7 Examination of participant in clinical trial

Categories/Subcategories:

V01 Contact with or exposure to communicable diseases
V02 Carrier or suspected carrier of infectious diseases
V03-06 Need for prophylactic vaccination and inoculations
V07 Need for isolation and other prophylactic measures
V08 Asymptomatic HIV infection status

V10	Personal history of malignant neoplasm
V12	Personal history of certain other diseases
V13	Personal history of other diseases Exception: V13.4 Personal history of arthritis V13.69 Personal history of other congenital malformations
V16-V19	Family history of disease
V23	Supervision of high-risk pregnancy
V25	Encounter for contraceptive management
V26	Procreative management Exception: V26.5 Sterilization status
V28	Antenatal screening
V45.7	Acquired absence of organ
V50	Elective surgery for purposes other than remedying health states
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 **Exception: V56.0 Extracorporeal dialysis**
V57	Care involving use of rehabilitation procedures
V58.3	Attention to surgical dressings and sutures
V58.4	Other aftercare following surgery
V58.6	Long-term (current) drug use
V58.7	Aftercare following surgery to specified body systems, not elsewhere classified
V58.8	Other specified procedures and aftercare
V61	Other family circumstances
V63	Unavailability of other medical facilities for care
V65	Other persons seeking consultation without complaint or sickness
V67	Follow-up examination
V69	Problems related to lifestyle
V73-V82	Special screening examinations
V83	Genetic carrier status

ADDITIONAL ONLY: V code categories/subcategories which may only be used as additional codes, not principal/first listed

Codes:

V13.61	Personal history of hypospadias
V22.2	Pregnancy state, incidental
V49.82	Dental sealant status
V49.83	**Awaiting organ transplant status**
V66.7	Palliative care

Categories/Subcategories:

V09	Infection with drug-resistant microorganisms

V14 Personal history of allergy to medicinal agents
V15 Other personal history presenting hazards to health
Exception: V15.7 Personal history of contraception
V21 Constitutional states in development
V26.5 Sterilization status
V27 Outcome of delivery
V42 Organ or tissue replaced by transplant
V43 Organ or tissue replaced by other means
Exception: V43.22 Fully implantable artificial heart status
V44 Artificial opening status
V45 Other postsurgical states
Exception: Subcategory V45.7 Acquired absence of organ
V46 Other dependence on machines
Exception: V46.12 Encounter for respirator dependence during power failure
V49.6x Upper limb amputation status
V49.7x Lower limb amputation status
V60 Housing, household, and economic circumstances
V62 Other psychosocial circumstances
V64 Persons encountering health services for specified procedure, not carried out
V84 Genetic susceptibility to disease

NONSPECIFIC CODES AND CATEGORIES:
V11 Personal history of mental disorder
V13.4 Personal history of arthritis
V13.69 Personal history of congenital malformations
V15.7 Personal history of contraception
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 (age-related) (natural)
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
V58.5 Orthodontics
V58.9 Unspecified aftercare
V72.5 Radiological examination, NEC
V72.6 Laboratory examination

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.**

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(s) may be used with codes 995.93, Systemic inflammatory response syndrome due to noninfectious process without organ dysfunction, and 995.94, Systemic inflammatory response syndrome due to noninfectious process with organ dysfunction, if trauma was the initiating insult that precipitated the SIRS. The external cause(s) code should correspond to the most serious injury resulting from the trauma. The external cause code(s) should only be assigned if the trauma necessitated the admission in which the patient also developed SIRS. If a patient is admitted with SIRS but the trauma has been treated previously, the external cause codes should not be used.

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", 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 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", 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.

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.

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. "Probable", "suspected", "questionable", "rule out", or "working diagnosis"

Do not code diagnoses documented as "probable", "suspected," "questionable," "rule out," or "working diagnosis". 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 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.