

ICD-9-CM Official Guidelines For Coding and Reporting

Effective October 1, 2002

Narrative changes appear in bold text

The Centers for Medicare and Medicaid Services (CMS) formerly the Health Care Financing Administration (HCFA) and the National Center for Health Statistics (NCHS), two departments within the Department of Health and Human Services (DHHS) present 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.

These guidelines for coding and reporting have been developed and approved by the Cooperating Parties for ICD-9-CM: the American Hospital Association, the American Health Information Management Association, CMS, and the NCHS. These guidelines, published by the Department of Health and Human Services have also appeared in the Coding Clinic for ICD-9-CM, published by the American Hospital Association.

These guidelines have been developed to assist the user in coding and reporting in situations where the ICD-9-CM does not provide direction. Coding and sequencing instructions in volumes I, II, and III of ICD-9-CM take precedence over any guidelines. The conventions, general guidelines and chapter-specific guidelines apply to the proper use of ICD-9-CM, regardless of the health care setting. A joint effort between the attending physician and coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. **These guidelines have been developed and approved by the Cooperating Parties to assist both the physician and the coder in identifying those diagnoses that are to be reported. 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.**

These guidelines are not exhaustive. The cooperating parties are continuing to conduct reviews of these guidelines and develop new guidelines as needed. Users of the ICD-9-CM should be aware that only guidelines approved by the cooperating parties are official. Revision of these guidelines and new guidelines will be published by the U.S. Department of Health and Human Services when they are approved by the cooperating parties. The term “admitted” is used generally to mean a health care encounter in any setting.

The guidelines have been reorganized into several new sections including an enhanced introduction that provides more detail about the structure and conventions of the classification usually found in the classification itself. The other new section, General Guidelines, brings together overarching guidelines that were previously found throughout the various sections of the guidelines. The new format of the guidelines also includes a resequencing of the disease-specific guidelines. They are sequenced in the same order as they appear in the tabular list chapters (Infectious and Parasitic diseases, Neoplasms, etc.)

These changes will make it easier for coders, experienced and beginners, to more easily find the specific portion of the coding guideline information they seek.

Table of Contents

Section I ICD-9-CM Conventions, General Coding Guidelines and Chapter-specific Guidelines

A. ICD-9-CM conventions

Conventions of the ICD-9-CM

Abbreviations

Etiology/manifestation convention

Format

Includes and Excludes Notes and Inclusion Terms

Other and Unspecified Codes

Punctuation

B. General Coding Guidelines

Acute and Chronic Conditions

Combination Codes

Conditions that are integral part of disease

Conditions that are not integral part of disease

Impending or Threatened Conditions

Late Effects

Level of Detail in Coding

Multiple Coding of Single Conditions

Signs and Symptoms

Other and Unspecified (NOS) Code Titles

Other Multiple Coding for Single Condition

Code, if applicable

Use additional code

Use of Alphabetic Index and Tabular List

C. Chapter-specific Guidelines

C1. Infectious and Parasitic diseases

A. Human Immunodeficiency Virus (HIV) Infections

Asymptomatic HIV Infection

Confirmed Cases of HIV Infection/Illness

HIV Infection in Pregnancy, Childbirth and the Puerperium

Inconclusive Lab Test for HIV

Previously Diagnosed HIV-related Illness

Selection **and Sequencing** of HIV Code

Testing for HIV

B. Septicemia and Shock

C2. Neoplasms

C3. Endocrine, Nutritional, and Metabolic Diseases and Immunity Disorders
Reserved for future guidelines expansion

C4. Diseases of Blood and Blood Forming Organs
Reserved for future guideline expansion

C5. Mental Disorders
Reserved for future guideline expansion

C6. Diseases of Nervous System and Sense Organs
Reserved for future guideline expansion

C7. Diseases of Circulatory System

A. Hypertension

Controlled Hypertension

Elevated Blood Pressure

Essential Hypertension

Hypertension with Heart Disease

Hypertensive Cerebrovascular Disease

Hypertensive Heart and Renal Disease

Hypertensive Renal Disease with Chronic Renal Failure

Hypertensive Retinopathy

Secondary Hypertension

Transient Hypertension

Uncontrolled Hypertension

B. Late Effect of Cerebrovascular Accident

C8. Diseases of Respiratory System
Reserved for future guideline expansion

C9. Diseases of Digestive System
Reserved for future guideline expansion

C10. Diseases of Genitourinary System
Reserved for future guideline expansion

C11. Complications of Pregnancy, Childbirth, and the Puerperium

Abortions

Chapter 11 Fifth-digits

Fetal Conditions Affecting Management of Mother

General Rules

HIV Infection in Pregnancy, Childbirth and Puerperium

Late Effects of Complications of Pregnancy, Childbirth and the Puerperium

Normal Delivery 650

Postpartum Period

Selection of Principal Diagnosis

- C12. Diseases Skin and Subcutaneous Tissue
 - Reserved for future guideline expansion

- C13. Diseases of Musculoskeletal and Connective Tissue
 - Reserved for future guideline expansion

- C14. Congenital Anomalies
 - Reserved for future guideline expansion

- C15. Certain Conditions Originating in the Newborn (Perinatal) Period
 - Clinically Significant Conditions
 - Congenital Anomalies
 - General Perinatal Rule
 - Maternal Causes of Perinatal Morbidity
 - Newborn Transfers
 - Other (Additional) Diagnoses
 - Prematurity and Fetal Growth Retardation
 - Use of Category V29
 - Use of Codes V30-V39

- C16. Signs, Symptoms and Ill-Defined Conditions
 - Reserved for future guideline expansion

- C17. Injury and Poisoning
 - Adverse Effect
 - Adverse Effects, Poisonings and Toxic Effects
 - Coding of Fractures
 - Coding of Injuries
 - Coding of Burns
 - Coding of Debridement of Wound, Infection or Burn
 - Coding of Adverse Effects, Poisoning and Toxic Effects

- C18. Supplemental Classification of Factors Influencing Health Status and Contact with Health Service (V-Codes)
 1. Contact/Exposure
 2. Inoculations and vaccinations
 3. Status
 4. History (of)
 5. Screening
 6. Observation
 7. Aftercare
 8. Follow-up
 9. Donor
 10. Counseling
 11. Obstetrics
 12. Newborn, infant and child
 13. Routine and administrative examinations

- 14. Miscellaneous V codes
- 15. Nonspecific V codes

C19. Supplemental Classification of External Causes of Injury and Poisoning

- Child and Adult Abuse
- General Coding guidelines
- Late effects
- Misadventures and complications of care
- Multiple external causes
- Place of occurrence
- Poisonings and adverse effects of drugs
- Terrorism**
- Undetermined cause
- Unknown intent

Section II Selection of Principal Diagnosis(es) for Inpatient, Short-term, Acute Care Hospital Records

- Complications of Surgery and Other Medical Care
- Original Treatment Plan Not Carried Out
- Symptoms, Signs, and Ill-defined Conditions
- Symptom Followed by Contrasting/Comparative Diagnoses
- Two or More Comparative or Contrasting Conditions
- Two or More Equally Meet Definition
- Two or More Interrelated Conditions
- Uncertain Diagnosis

Section III Reporting Additional Diagnoses for Inpatient, Short-term, Acute Care Hospital Records

- Abnormal Findings
- General Rules
- Previous Conditions
- Uncertain Diagnosis**

Section IV Diagnostic Coding and Reporting Guidelines for Outpatient Services

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 “Other” codes)

NOS “Not otherwise specified” This abbreviation is the equivalent of unspecified. (see “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 etiology/manifestations)

() Parentheses are used in both the index and tabular to enclose supplementary words which 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 indicate 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 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 - Other multiple coding for a single condition in the General Guidelines section.

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 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. The appropriate code or codes from 001.0 through V83.89 must be used to identify diagnoses, symptoms, conditions, problems, complaints or other reason(s) for the encounter/visit.

5. 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. 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 physician. 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, “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 infection code indicates 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 may 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.

C1. Infectious and Parasitic Diseases

A. Human Immunodeficiency Virus (HIV) Infections

1. 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 physician’s diagnostic statement that the patient is HIV positive, or has an HIV-related illness is sufficient.

2. Selection and sequencing
 - a. 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. 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 or has had previous admissions/encounters for HIV conditions is irrelevant to the sequencing decision.
 - d. 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, 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 had 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 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 and Septic Shock

1. When the diagnosis of septicemia with shock or the diagnosis of general sepsis with septic shock is documented, code and list the septicemia first and report the septic shock code as a secondary condition. The septicemia code assignment should identify the type of bacteria if it is known.
2. Sepsis and septic shock associated with abortion, ectopic pregnancy, and molar pregnancy are classified to category codes in Chapter 11 (630-639).
3. Negative or inconclusive blood cultures do not preclude a diagnosis of septicemia in patients with clinical evidence of the condition.

C2. Neoplasms

Chapter 2 of the ICD-9-CM contains the code 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. 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.

- A. If the treatment is directed at the malignancy, designate the malignancy as the principal diagnosis.
- B. 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 associated with the malignant neoplasm or with the therapy thereof are subject to the following guidelines:
 - 1. When admission/encounter is for management of an anemia associated with the malignancy, and the treatment is only for anemia, the anemia is designated as the principal diagnosis and is followed by the appropriate code(s) for the malignancy.
 - 2. 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. 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. When the admission/encounter is for treatment of a complication resulting from a surgical procedure performed for the treatment of an intestinal malignancy, designate the complication as the principal or first-listed diagnosis if

treatment is directed at resolving the complication.

- D. 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. When an episode of care involves the surgical removal of a neoplasm, primary or secondary site, followed by chemotherapy or radiation treatment, the neoplasm code should be assigned as principal or first-listed diagnosis. When an episode of inpatient care involves surgical removal of a primary site or secondary site malignancy followed by adjunct chemotherapy or radiotherapy, code the malignancy as the principal or first-listed diagnosis, using codes in the 140-198 series or where appropriate in the 200-203 series.
 - 2. 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. 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.
- F. 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 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.

- C3. Endocrine, Nutritional, and Metabolic Diseases and Immunity Disorders
Reserved for future guideline expansion
- C4. Diseases of Blood and Blood Forming Organs
Reserved for future guideline expansion
- C5. Mental Disorders
Reserved for future guideline expansion
- C6. Diseases of Nervous System and Sense Organs
Reserved for future guideline expansion
- C7. Diseases of Circulatory System
 - A. Hypertension

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, 428, 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. 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.

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. 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.

C8. Diseases of Respiratory System
Reserved for future guideline expansion

C9. Diseases of Digestive System
Reserved for future guideline expansion

- C10. Diseases of Genitourinary System
Reserved for future guideline expansion
- C11. Complications of Pregnancy, Childbirth, and the Puerperium

- A. General Rules for Obstetric Cases

1. Obstetric cases require codes from chapter 11, codes in the range 630-677, Complications of Pregnancy, Childbirth, and the Puerperium. Should the physician 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 physician's responsibility to state that the condition being treated is not affecting the pregnancy.
2. 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. For example, sepsis and septic shock associated with abortion, ectopic pregnancy, and molar pregnancy are classified to category codes in Chapter 11 (630-639).
3. Chapter 11 codes are to be used only on the maternal record, never on the record of the newborn.
4. Categories 640-648, 651-676 have required fifth-digits, which indicate whether the encounter is antepartum, postpartum and whether a delivery has also occurred.
5. 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.
6. 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. A thorough review of any pertinent excludes note is necessary to be certain that these V codes are being used properly.
7. 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.

8. 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.

B. Selection of OB Principal or First-listed Diagnosis

1. 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.
2. 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.

C. Fetal Conditions Affecting the Management of the Mother

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.

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). This is an exception to the sequencing rule found in above.

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

E. Normal Delivery, 650

1. 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.
2. 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. 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.
4. V27.0, Single liveborn, is the only outcome of delivery code appropriate for use with 650.

F. The Postpartum Period

1. The postpartum period begins immediately after delivery and continues for six weeks following delivery.
2. A postpartum complication is any complication occurring within the six-week period.
3. Chapter 11 codes may also be used to describe pregnancy-related complications after the six-week period should the physician document that a condition is pregnancy related.
4. 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. 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. A delivery diagnosis code should not be used for a woman who has delivered prior to admission to the hospital. Any postpartum procedures should be coded.

G. Code 677, Late effect of complication of pregnancy, childbirth, and the puerperium

1. 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. This code may be used at any time after the initial postpartum period.
3. This code, like all late effect codes, is to be sequenced following the code describing the sequelae of the complication.

H. Abortions

1. 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. A code from categories 640-648 and 651-657 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 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 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.

- C12. Diseases Skin and Subcutaneous Tissue
Reserved for future guideline expansion
- C13. Diseases of Musculoskeletal and Connective Tissue
Reserved for future guideline expansion
- C14. Congenital Anomalies
Reserved for future guideline expansion
- C15. Newborn (Perinatal) Guidelines

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 Rule

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. Whether or not a condition is clinically significant can only be determined by the physician.

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. 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.
2. A V29 code is to be used as a secondary code after the V30, Outcome of delivery, code. It may also be assigned as a principal code for readmissions or encounters when the V30 code no longer applies. It is for use only for healthy newborns and infants for which no condition after study is found to be present.

E. 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.

F. Congenital Anomalies

Assign an appropriate code from categories 740-759, Congenital Anomalies, as an additional diagnosis when a specific abnormality is diagnosed for an infant. Congenital anomalies may also be the principal or first listed diagnosis for admissions/encounters subsequent to the newborn admission. Such abnormalities may occur as a set of symptoms or multiple malformations. A code should be assigned for each presenting manifestation of the syndrome if the syndrome is not specifically indexed in ICD-9-CM.

G. Coding of Additional Perinatal Diagnoses

1. Assign codes for conditions that require treatment or further investigation, prolong the length of stay, or require resource utilization.
2. Assign codes for conditions that have been specified by the physician as having implications for future health care needs.

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

3. 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 physician at the time of transfer or discharge as having affected the fetus or newborn.

H. Prematurity and Fetal Growth Retardation

Codes from **category 764** and **subcategories 765.0 and 765.1** should not be assigned based solely on recorded birthweight or estimated gestational age, but on the attending physician's clinical assessment of maturity of the infant. NOTE: Since physicians may utilize different criteria in determining prematurity, do not code the diagnosis of prematurity unless the physician documents this condition.

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 physician.

C16. Signs, Symptoms and Ill-Defined Conditions
Reserved for future guideline expansion

C17. Injury and Poisoning

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 physician, is sequenced first.

1. Superficial injuries such as abrasions or contusions are not coded when associated with more severe injuries of the same site.
2. 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 classifiable to the same three-digit or four-digit category are coded to that category.
2. 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 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 are sequenced in accordance with the severity of the fracture and the physician 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. Sequence first the code that reflects the highest degree of burn when more than one burn is present.
2. 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 are coded as acute burns.

Necrosis of burned skin should be coded as a non-healed burn.

4. Assign code 958.3, Posttraumatic wound infection, not elsewhere classified, as an additional code for any documented infected burn site.
5. 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 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. Physicians 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 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. When appropriate, both a sequelae with a late effect code, and a current burn code may be assigned on the same record.

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

Excisional debridement may be performed by a physician and/or other health care provider and involves an excisional, as opposed to a mechanical (brushing, scrubbing, washing) debridement.

For coding purposes, excisional debridement, 86.22.

Nonexcisional debridement is assigned to 86.28.

Modified based on *Coding Clinic*, 2nd Quarter 2000, p. 9.

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. When an error was made in drug prescription or in the administration of the drug by physician, nurse, patient, or other person, use the appropriate poisoning code from the 960-979 series.
- b. 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. 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. 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.

C18. Classification of Factors Influencing Health Status and Contact with Health Service

- A. 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 - V83.89) 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. When 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 issue.**
- 2. When 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. When circumstances or problems influence a person's health status but are not in themselves a current illness or injury.**
- 4. For newborns, to indicate birth status.**

- B. V codes are for use in both the inpatient and outpatient setting but are generally more applicable to the outpatient 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.**

- 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.

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 which 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

V48.81 Postmenopausal status

V49.82 Dental sealant 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

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 use 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
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suspected condition not found

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.

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
V53.42 Aftercare, surgery, neoplasm
V53.43 Aftercare, surgery, trauma
V58.49 Other specified aftercare following surgery
V53.71-V53.78 Aftercare following surgery
V58.81 Fitting and adjustment of vascular catheter
V58.82 Fitting and adjustment of non-vascular catheter
V53.83 Monitoring therapeutic drug
V58.89 Other specified aftercare

8. Follow-up

The follow-up codes are for use to explain continuing surveillance following completed treatment of a disease, condition, or injury. They infer that the condition has been fully treated and no longer exists. They should not be confused with aftercare codes which 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 for use 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 for use for 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 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) 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 counseling above)
- V26 Procreative management**
 Except V26.5x, Sterilization status, V26.3 and V26.4 (Counseling)
- V27 Outcome of delivery**
- V28 Antenatal screening**
 See Screening- see section 5 of this article

12. Newborn, infant and child

See 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 Observation, section 6 of this article.**
- 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 which provide useful information on circumstances which 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 which 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**
- 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 K and L of the outpatient guidelines.

C19. Supplemental Classification of External Causes of Injury and Poisoning (E-codes)

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 diagnosis (first-listed in noninpatient 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 physician offices, and nonacute care settings, except when other specific guidelines apply. (See Section III, Reporting Diagnostic Guidelines for Hospital-based Outpatient Services/Reporting Requirements for Physician Billing.)

A. General E Code Coding Guidelines

1. An E code may be used with any code in the range of 001-V83.89, which indicates an injury, poisoning, or adverse effect due to an external cause.
2. Assign the appropriate E code for all initial treatments of an injury, poisoning, or adverse effect of drugs.
3. 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.
4. 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.
5. 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.
6. 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.
7. An E code can never be a principal (first listed) diagnosis.

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 and Chemicals. Always refer back to the Tabular List.
2. 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 for more than one adverse reaction, assign the code only once.
4. 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) and alcohol, use poisoning codes and E codes for both.
6. 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 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 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. 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. 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 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, 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 exist for injuries and poisonings but not for adverse effects of drugs, misadventures and surgical complications.
2. 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. A late effect E code should never be used with a related current nature of injury code.

I. Misadventures and Complications of Care Guidelines

1. Assign a code in the range of E870-E876 if misadventures are stated by the physician.
2. Assign a code in the range of E878-E879 if the physician 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. **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. **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 on the circumstances on the documentation of intent and mechanism.

- 3. 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. 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(es) for Inpatient, Short-term, Acute Care Hospital Records

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 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.

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 IA).

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, an additional code for the specific complication may 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.

Section III Reporting Additional Diagnoses for Inpatient, Short-term, Acute Care Hospital Records

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, 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.**

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 physician.

A. Previous conditions

If the physician has included a diagnosis in the final diagnostic statement, such as the discharge summary or the face sheet, it should ordinarily be coded. Some physicians 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 physician indicates their clinical significance. If the findings are outside the normal range and the **attending** physician has ordered other tests to evaluate the condition or prescribed treatment, it is appropriate to ask the physician 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 physician.

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.

Section IV Diagnostic Coding and Reporting Guidelines for Outpatient Services

These coding guidelines for outpatient diagnoses have been approved for use by hospitals/physicians in coding and reporting hospital-based outpatient services and physician 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 physician 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, general 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. The appropriate code or codes from 001.0 through V83.89 must be used to identify diagnoses, symptoms, conditions, problems, complaints, or other reason(s) for the encounter/visit.
- C. 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. 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, as opposed to diagnoses, are acceptable for reporting purposes when a diagnosis has not been established (confirmed) by the physician. 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. 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- V83.89) 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 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. 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, General Coding Guidelines, Level of Detail.
- H. 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.

- I. 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 hospital medical record departments for coding the diagnosis of acute care, short-term hospital inpatients.

- J. 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 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. 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. 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. For patient’s receiving preoperative evaluations only, sequence 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. 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. 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 principal diagnoses. These codes should not be used in conjunction with chapter 11 codes.