CODING MANUAL

For Hospitals and Other Healthcare Institutions

1st June 2012

2011 Code Sets

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Coding Guidelines

Chapter One

1.1. STATEMENT OF CODING ETHICS

1.1.1. INTRODUCTION

1.1.1.1. The Standards of Ethical Coding are based on the American Health Information Management Association's (AHIMA's) Code of Ethics. Both sets of principles reflect expectations of professional conduct for coding professionals involved in diagnostic and/or procedural coding or other health record data abstraction.

1.1.1.2. The AHIMA Code of Ethics (available on the AHIMA web site) is relevant to all AHIMA members and credentialed HIM professionals and students, regardless of their professional functions, the settings in which they work, or the populations they serve. Coding is one of the core HIM functions, and due to the complex regulatory requirements affecting the health information coding process, coding professionals are frequently faced with ethical challenges. The AHIMA Standards of Ethical Coding are intended to assist coding professionals and managers in decision-making processes and actions, outline expectations for making ethical decisions in the workplace, and demonstrate coding professionals' commitment to integrity during the coding process, regardless of the purpose for which the codes are being reported. They are relevant to all coding professionals and those who manage the coding function, regardless of the healthcare setting in which they work or whether they are AHIMA members or nonmembers.

1.1.1.3. These Standards of Ethical Coding have been revised in order to reflect the current healthcare environment and modern coding practices. The previous revision was published in 1999.

1.1.2. STANDARDS OF ETHICAL CODING:

1.1.2.1. Coding professionals should:

1.1.2.1.1. Apply accurate, complete, and consistent coding practices for the production of high-quality healthcare

1.1.2.1.2. Report all healthcare data elements (e.g. diagnosis and procedure codes, present on admission indicator, discharge status) required for external reporting purposes (e.g. reimbursement and other administrative uses, population health, quality and patient safety measurement, and research) completely and accurately, in accordance with regulatory and documentation standards and requirements and applicable official coding conventions, rules, and guidelines.

1.1.2.1.3. Assign and report only the codes and data that are clearly and consistently supported by health record documentation in accordance with applicable code set and abstraction conventions, rules, and guidelines.

1.1.2.1.4. Query provider (physician or other qualified healthcare practitioner) for clarification and additional documentation prior to code assignment when there is conflicting, incomplete, or ambiguous information in the health record regarding a significant

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reportable condition or procedure or other reportable data element dependent on health record.

1.1.2.1.5. Refuse to change reported codes or the narratives of codes so that meanings are misrepresented.

1.1.2.1.6. Refuse to participate in or support coding or documentation practices intended to inappropriately increase payment, qualify for insurance policy coverage, or skew data by means that do not comply with federal and state statutes, regulations and official rules and guidelines.

1.1.2.1.7. Facilitate interdisciplinary collaboration in situations supporting proper coding practices.

1.1.2.1.8. Advance coding knowledge and practice through continuing education.

1.1.2.1.9. Refuse to participate in or conceal unethical coding or abstraction practices or procedures.

1.1.2.1.10. Protect the confidentiality of the health record at all times and refuse to access protected health information not required for coding-related activities (examples of coding-related activities include completion of code assignment, other health record data abstraction, coding audits, and educational purposes).

1.1.2.1.11. Demonstrate behavior that reflects integrity, shows a commitment to ethical and legal coding practices, and fosters trust in professional activities.

1.1.3. **RESOURCES:**

1.1.3.1. AHIMA Code of Ethics: Available at http://www.ahima.org/about/ethics.asp

1.1.3.2. ICD-9-CM Official Guidelines for Coding and Reporting: http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/icdguide07.pdf

1.1.3.3. HIMA's position statement on Quality Health Data and Information: Available at http://www.ahima.org/dc/positions

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Chapter Two

1.2. CODING TERMS DEFINITIONS:

1.2.1. **Acute Condition** – An acute condition is a type of illness or injury that ordinarily lasts less than three months was first noticed less than 3 months before the reference data of the interview and was serious enough to have had an impact on behavior or having a short and relatively severe course. (Pregnancy is also considered to be an acute condition despite lasting longer than three months.)

1.2.2. **Autopsy** – The postmortem examination of a body, including the internal organs and structures after dissection, so as to determine the cause of death or the nature of pathological changes.

1.2.3. **Chronic Condition** – Conditions that are not cured once acquired (such as heart disease, diabetes, and hypertension) and are considered chronic.

1.2.4. **Coding Books, Alphabetical** – An alphabetical index to diseases with corresponding ICD codes.

1.2.5. **Coding Books, Tabular** – A numerical list of the ICD disease code numbers.

1.2.6. **Complication** (diagnosis) – In coding, a complication generally refers to a misadventure of a medical or surgical procedure, an adverse outcome from therapy. In medicine, an additional problem that arises following a procedure, treatment or illness and is secondary to it. A complication complicates the situation.

1.2.7. **Co-morbidity (diagnosis)** – Co-morbidities are conditions that exist at the same time as the principal condition in the same patient (for example hypertension is a co-morbidity of ischemic heart disease or diabetes), e.g. two or more coexisting medical conditions or disease processes that are additional to an initial diagnosis.

1.2.7.1. **Diagnosis**

1.2.7.1.1. **Principal Diagnosis:**

1.2.7.1.1.1. **Inpatients:**

- Condition established, after study, to be chiefly responsible for occasioning the admission of the patient to the healthcare facility including a suspected diagnosis or a rule-out diagnosis and is based on the patient's presenting history and physical and the physician's review of symptoms.

1.2.7.1.1.2. **Outpatients:**

- The condition or problem that is the reason the patient presented to healthcare and the clinician's assessment of these presenting symptoms/problems and corresponds to the tests or services provided.

- Or a symptom where the underlying causes has yet to be determined.

- Or The reason why the patient presented to healthcare

1.2.7.1.2. **Secondary Diagnosis:**

1.2.7.1.2.1. **Inpatients:**

- All conditions that co-exist at the time of admission, including chronic conditions, or develop subsequently, which affect the treatment received and/or the length of stay - that affect patient care in terms of requiring: Clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of hospital stay, increased nursing care and/or monitoring; excluding diagnoses that refer to an earlier episode that have no bearing on the current hospital stay.

- External causes of injury, poisoning or adverse affect are coded as supplementary codes to the diagnosis codes of the actual condition.

1.2.7.1.2.2. **Outpatients:**

- All co-existing conditions, including chronic conditions that exist at the time of the Encounter or visit and require or affect patient management; excluding diagnoses that have no bearing on the current encounter.

- External causes of injury, poisoning or adverse affect are coded as supplementary codes to the diagnosis codes of the actual condition.

1.2.7.1.3. **Admitting Diagnosis:**

1.2.7.1.3.1. The diagnosis that the physician identifies at time of Inpatient admission or Emergency Department visit. This diagnosis may differ from the Principal diagnosis.

1.2.8. **Discharge Summary** – Generally a transcribed document that is a concise recapitulation of the patient's course in the hospital to include: reason for admission, principal diagnoses, additional diagnoses, significant findings, operations and procedures performed, consultations, medications and other treatments, condition at discharge, discharge instructions and medications and follow up.

1.2.9. **DRG** – refers to the International Refined Diagnosis Related groupings, as developed by 3M. The definitions manual is available from HAAD.

1.2.10. **E-Code** – Specific ICD-9-CM supplemental codes used to identify the external cause of injury, poisoning and other adverse effects, never coded as a principal or Stand-alone.

1.2.11. **Etiology** (diagnosis) – The cause or origin of a disease.

1.2.12. **Facesheet** – Generally a form that sits at the front of the inpatient admission that documents the demographic information for the patient at the time of the admission, the admission and discharge dates as well as a list of diagnoses and procedures that are relevant to that admission.

1.2.13. **Guidelines** - Set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-9-CM and Current Procedural Terminology. The instructions and conventions of the classification take precedence over guidelines. These include the coding and sequencing instructions. Adherence to these guidelines when assigning diagnosis and procedure codes is required.

1.2.14. **History Of (diagnosis)** – A diagnosis of a condition that is no longer active, however does impact the current visit of the patient in terms of length of stay, follow-up considerations and/or residual effects. Examples of important history conditions for coding are cancers, organ replacements, traumas with residual effects such as amputations.

1.2.15. **ICD-9-CM** – International Classification of Diseases, 9th Revision, Clinical Modification. This is a clinical modification of the World Health Organization's ICD9 coding system. The term "clinical" is used to emphasize the modification intent; namely to serve as a useful tool in the area of classification of morbidity data for indexing medical records.

1.2.16. **Late Effect (code)** – A late effect is defined as residual effects (results produced) after termination of the acute phase of the illness or injury. Late effects are classified by the residues (nature of late affect) and by the cause of the late effect.

1.2.17. **Manifestation (diagnosis)** – The visible expression of a disease, for example shortness of breath for a patient with congestive heart failure.

1.2.18. **Maternal Death** – Is defined by the WHO as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management.

1.2.19. **Miscarriage** – Loss of the products of conception from the uterus before the fetus is viable, before 22 weeks gestation; spontaneous abortion. (After 22 weeks this is a stillborn.)

1.2.20. **Morbidity** – A diseased condition or state; the incidence or prevalence of a disease or of all diseases in a population.

1.2.21. **Mortality** – In coding this means "death" as in the mortality rate or death rate.

1.2.22. **Neonatal** –. For coding purposes this refers to the time period from birth through the 28th day.

1.2.23. **Neoplasm** – any new and abnormal growth; specifically a new growth of tissue in which the growth is uncontrolled and progressive. An abnormal growth of tissue. The word neoplasm is not synonymous with cancer. A neoplasm may be benign or malignant. The word neoplasm literally means a new growth, from the Greek neo-, new + plasma, that which is formed, or a growth = a new growth.

1.2.24. **Newborn** – for coding purposes a newborn is only coded with the live born infant codes (V30…) with 4th digit to signify whether born in or outside of the hospital.

- Generally, codes from Chapter 15 should be sequenced as the principal/first-listed diagnosis on the newborn record, with the exception of the appropriate V30 code for the birth episode, followed by codes from any other chapter that provide additional detail.

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1.2.25. **Operative Report** – is a summary report, generally typed, that describes the events occurring during the operation of the patient.

1.2.26. **Outpatient** – a patient who receives medical services in a clinic, ambulatory care or emergency department without occupying a bed overnight.

1.2.27. **Pediatric** – Infants, children, and adolescents. The age limit of such patients ranges from 12 to 21 with the average age limit being 17 or 18 years of age. A medical practitioner who specializes in this area is known as a pediatrician.

1.2.28. **Perinatal** - For coding and reporting purposes the perinatal period is defined as before birth through the 28th day following birth.

1.2.29. **Post-mortem Examination** – an examination of a body of a patient after death; not an autopsy.

1.2.30. **Procedure, Principal** – This is the procedure performed for definitive treatment, rather than one performed for diagnostic or exploratory purposes or was necessary to take care of a complication. If there appear to be two procedures that are principal, then the one most related to the principal diagnosis should be selected as the principal procedure.

1.2.31. **Procedure, Secondary** – All other significant procedures are to be reported as secondary procedures. A significant procedure is one that is surgical in nature or carries a procedural risk or carries an anesthetic risk or requires specialized training.

1.2.32. **Provider** - the term provider is used throughout the guidelines to mean physician or any qualified health care practitioner who is legally accountable for establishing the patient's diagnosis.

1.2.33. **Residual Condition** – In coding this refers to the on-going effect of a previous illness or injury. For example a patient who had a CVA (cerebrovascular accident) in the past and has a residual condition of aphasia.

1.2.34. **Rule-Out Diagnosis** – When a physician is performing tests on a patient to determine the final diagnosis, he may be working on a suspected diagnosis that he is attempting to "rule-out" or prove right or wrong. Sometimes the "rule-out" diagnosis is still the final diagnosis because the tests aren't yet conclusive and the true diagnosis hasn't been determined.

1.2.35. **Stillbirth** – The delivery of a dead infant, at least 22 weeks gestation.

1.2.36. **Symptom** (diagnosis) – Any subjective evidence of a patient's disease or condition, such as a fever is a symptom of a urinary tract infection.

1.2.37. **Unspecified** (diagnosis) – In coding, this occurs when a physician fails to be as specific in his diagnosis as the coding system is, for example listing hypertension as a diagnosis and not specifying whether it is benign or malignant.

1.2.38. **Underlying Cause of Death** – When the immediate cause of death is a symptom or a manifestation of a diagnosis, the underlying cause of death is the diagnosis responsible for the symptom or manifestation that lead to the death. For example, cardiopulmonary arrest due to myocardial infarction or respiratory failure due to acute pneumonia. The World Health Organization (WHO)

defines the underlying cause of death as the disease or injury that initiated the train of events (circumstances) leading directly to the death.

1.2.39. **V-Code** – In ICD-9-CM, V-codes are used in classifying supplementary factors that are influencing the patient's health status and/or contact with health services. An example is the outcome of delivery codes in the V27 category or history of cancer in the V10 category. (*See V Code Table)*

1.2.40. **Versus Diagnosis** – In coding this refers to a situation where the physician has not yet determined which diagnosis is responsible for the condition of the patient and has two or more choices that are equally valid.

1.2.41. **Visit Reason** (diagnosis) – Generally visit reasons are used for outpatient visits. They can be symptoms or diagnoses or other reasons for contact with healthcare professionals, for example a follow up for healed fracture of the foot.

1.2.42. **REFERENCES**:

1.2.42.1. National Center for Health Statistics, USA

1.2.42.2. National Health Interview Survey, USA

1.2.42.3. European Observatory on Health Care Systems

1.2.42.4. International Classification of Diseases, 9th Revision, Clinical Modification, 6th Edition

1.2.42.5. The American Heritage Stedman's Medical Dictionary

1.2.42.6. American Hospital Association Coding Clinic

1.2.42.7. Medical Records Management by Edna Huffman

1.2.42.8. Dorland's Illustrated Medical Dictionary

1.2.42.9. The Merck Manual, 7th Edition

Chapter Three

1.3. Health Data Elements for Standardization

1.3.1. Refer to the HAAD Data Elements Common Type Schema as well as the Validation rules on the HAAD website at www.shafafiya.org

1.3.1. Code Sets for reporting and claiming:

1.3.1.1. Diagnostic Coding:

- ICD 9 CM 2008 valid until Service Date 1st Aprl, 2012
- ICD 9 CM 2011 valid as of Service Dated 1st April, 2012

1.3.1.2. Procedure Coding:

- CPT 4th Edition 2008 valid until Service Date 1st April, 2012
- CPT 4th Edition 2011 valid as of Service Date 1st April, 2012

1.3.1.3. Consumable Coding:

- HCPCS 2008 valid until Service Date 1st April, 2012
- HCPCS 2011 valid as of Service Dated 1st April, 2012

1.3.1.4. Dental Coding:

- Canadian Dental Codes (CDA) 2008 valid until Service Date 1st April, 2012

- Canadian Dental Codes (CDA 2011 valid as of Service Date 1st April, 2012

Chapter Four

1.4. Coding Conventions

1.4.1. Section One: General

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

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

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

1.4.1.4. **"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

1.4.1.5. **"Unspecified" Codes**: Codes titled "unspecified" are for use when the information in the medical record is insufficient to assign a more specific code.

1.4.1.6. **Etiology/Manifestation Convention**: (Appears as "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 coding convention requires that 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.

- 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.

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- 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 alphabetical index entry structure. In the index both conditions are listed together with the etiology code first followed by the manifestation codes in brackets. The code in brackets is always to be sequenced second.

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

- “Code first” and “Use additional code” notes are also used as sequencing rules in the classification for certain codes that are not part of an etiology/manifestation combination.

1.4.1.7. **Level of Detail in Diagnostic Coding:**

- Diagnosis codes must be used at the highest number of digits available, at the greatest specificity possible.

- A three digit code is to be used only if it is not further subdivided. If fourth and fifth digit subcategories are provided, they must be assigned.

1.4.1.8. **Signs and Symptoms**: Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has **not** been established by the care provider.

1.4.1.9. **Conditions that are an integral part of the disease process**: Signs and symptoms that are integral to the disease process should not be assigned as additional codes unless otherwise instructed by the coding books.

1.4.1.10. **Conditions that are <u>not</u> 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.

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

- Multiple codes may be needed for late effects, complication codes and obstetric codes to more fully describe a condition.

1.4.1.12. **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.

1.4.1.13. **Combination Codes:**

- A combination code is a single code used to classify two diagnoses or a diagnosis with an associated secondary process (manifestation) or a diagnosis with an associated complication.

- Combination codes are identified by referring to subterm entries in the Alphabetic Index of the ICD 9 CM and by reading the inclusion and exclusion notes in the Tabular List of the ICD 9 CM.

- Assign only the combination code when that code **fully identifies** the diagnostic conditions involved or when the Alphabetic Index in the ICD 9 CM so directs.

- **NOTE:** ***Multiple coding must not be used when the classification provides a combination code that clearly identifies all of the elements documented in the diagnosis.*** However, if the combination code lacks the necessary specificity in describing the manifestation or complication, then an additional code should be used as a secondary code.

1.4.1.14. **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 condition may appear 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 with the condition or nature of the late effect first and the late effect code second.

- An exception to the above is in those instances where the code for the late effect is followed by a manifestation code identified in the Tabular List in the ICD 9 CM or where the late effect code has been expanded (at the 4th and 5th 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.

1.4.1.15. **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 in the ICD 9 CM to determine if the condition has a subentry term for “impending” or “threatened” and also reference main term entries for “impending” or “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.

1.4.1.16. **Documentation for BMI and Pressure Ulcer Stages:** For the Body Mass Index (BMI) and pressure ulcer stage codes, code assignment may be based on medical record documentation from clinicians who are not the patient’s provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient’s diagnosis), since this information is typically documented by other clinicians involved in the care of the patient (e.g., a dietitian often documents the BMI and nurses often documents the pressure ulcer stages). However, the associated diagnosis (such as overweight, obesity, or pressure ulcer) must be documented by the patient’s provider. If there is conflicting medical record documentation, either from the same clinician or different clinicians, the patient’s attending provider should be queried for clarification.

- The BMI and pressure ulcer stage codes should only be reported as secondary diagnoses. As with all other secondary diagnosis codes, the BMI and pressure ulcer stage codes should only be assigned when they meet the definition of a reportable additional diagnosis (see Section III, Reporting Additional Diagnoses).

1.4.1.17. **Medical and Surgical Complications**: If the physician has documented that the patient’s diagnosis/condition is a complication of previous medical or surgical treatment, then it is to be coded as a “complication” code.

- First search in the ICD 9 CM Tabular for the condition under the main term of “complication” and follow any instructions as indicated. If the condition is not specified, then use a code from the section “Complications of Surgical and Medical Care, Not Otherwise Specified” codes 996 to 999.
- Code also the specific complication documented.
- For quality purposes, it is important to be able to track Hospital-acquired infections by coding E849.7 as a supplemental code as well as the relevant ICD 9 CM Complications of Surgical and Medical Care NOS (996 – 999) codes

1.4.2. Section Two: <u>Admitting Diagnosis</u>

1.4.2.1. The admitting diagnosis that the physician identifies at the time of admission into an inpatient facility. This diagnosis may differ from the Principal diagnosis.

1.4.2.2. The admitting diagnosis will generally be documented by the physician in the history and physical exam, either on the form or in the progress notes or the orders. It may also be listed as an impression in the patient assessment.

1.4.2.3. If there are multiple admitting diagnoses, then pick the most resource intensive diagnosis for reporting purposes.

- If the patient is admitted through the Emergency Room, then use the diagnosis that brought the patient to the ER as the admitting diagnosis.

1.4.3. Section Three: Principal Diagnosis

1.4.3.1. **Principal Diagnosis:**

1.4.3.1.1. **Inpatients:**

- Condition established, after study, to be chiefly responsible for occasioning the admission of the patient to the healthcare facility including a suspected diagnosis or a rule-out diagnosis and is based on the patient's presenting history and physical and the physician's review of symptoms.

1.4.3.1.2. **Outpatients:**

1.4.3.1.2.2. The condition or problem that is the reason the patient presented to healthcare and the clinician's assessment of these presenting symptoms/problems and corresponds to the tests or services provided. [1 See Note]

1.4.3.1.2.3. Or a symptom where the underlying causes has yet to be determined.

1.4.3.1.2.4. Or The reason why the patient presented to healthcare

- Note: For quality purposes, it is important to be able to track Hospital-acquired infections by coding E849.7 as a supplemental code as well as the relevant ICD 9 CM Complications of Surgical and Medical Care NOS (996 – 999) codes

- The circumstances of the inpatient admission always govern the selection of the principal diagnosis. The principal diagnosis is defined earlier as the "condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."

1.4.3.1.3. **Long Term Care:**

1.4.3.1.3..1. Principal Diagnosis in Long Term Care

- Condition established, after study, to be chiefly responsible for occasioning the admission to and/or continuation of the long term care encounter.

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

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

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

1.4.3.1.6. **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.

1.4.3.1.7. **Two or more interrelated Conditions**: 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 circumstances of the admission, the therapy provided, the Tabular List or the Alphabetic Index indicate otherwise.

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

1.4.3.1.9. **Contrasting/Comparative Diagnoses**: 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, then either diagnosis may be sequenced first.

1.4.3.1.10. **Symptom with Contrasting/Comparative Diagnoses**: When a symptom is followed by contrasting/comparative diagnoses, the symptom code is sequenced first. All the contrasting/comparative diagnoses should be coded as additional diagnoses.

1.4.3.1.11. **Original Treatment Cancelled**: If the original treatment plan is not carried out, continue to use the definition of principal diagnosis as above, when coding the visit, regardless of the cancelled or delayed treatment.

1.4.3.1.12. **Complication as Principal Diagnosis**: 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. An additional code for the specific complication should also be signed as well as relevant E code.

1.4.3.1.13. **"Possible" Diagnoses as Principal**: If the diagnosis documented at the time of discharge is qualified as "probable", "suspected", "likely", "questionable", "possible" or "still to be ruled out", or other similar terms indicating uncertainty, code the condition as if it existed or was established. (This rule does not apply to a diagnosis of HIV. In order to add a code for HIV there must be a definitive diagnosis or positive blood test for HIV also see *Section 8 D* (Code only confirmed cases of avian influenza (codes 488.01-488.02, 488.09, Influenza due to identified avian influenza virus) or novel H1N1 influenza virus (H1N1 or swine flu, code 488.11-488.12, 488.19)).

1.4.3.1.14. **This rule also does not apply to outpatient or ambulatory visits; see ambulatory visit section for more details.)**

1.4.3.1.15. **Admission From Day Care/Surgery**: When a patient is admitted directly from a day care or day surgery visit:

- If the inpatient admission is for a complication of the day care or day surgery, assign the complication as the principal diagnosis.
- If there is no complication or any other reason for the inpatient admission, assign the reason for the day care or day surgery visit as the principal diagnosis.
- If the reason for the inpatient admission is another condition unrelated to the surgery, assign the unrelated condition as the principal diagnosis.

1.4.4. Section Four: <u>Secondary Diagnoses</u>

1.4.4.1. Secondary Diagnosis:

1.4.3.1.1. **Inpatients:**

- All conditions that co-exist at the time of admission, including chronic conditions, or develop subsequently, which affect the treatment received and/or the length of stay - that affect patient care in terms of requiring: Clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of hospital stay, increased nursing care and/or monitoring; excluding diagnoses that refer to an earlier episode that have no bearing on the current hospital stay.
- External causes of injury, poisoning or adverse affect are coded as supplementary codes to the diagnosis codes of the actual condition.

1.4.3.1.2. **Outpatients:**

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- All co-existing conditions, including chronic conditions that exist at the time of the Encounter or visit and require or affect patient management; excluding diagnoses that have no bearing on the current encounter.

- External causes of injury, poisoning or adverse affect are coded as supplementary codes to the diagnosis codes of the actual condition.

1.4.3.1.3 **Long Term Care:**

- For reporting purposes the definition for secondary diagnosis 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

1.4.3.2. For reporting purposes, the definition for secondary or 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.

1.4.3.3. The secondary diagnoses were defined earlier in this document as "all conditions that co-exist 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."

1.4.3.3.1. **Previous Conditions** - If the doctor includes a diagnosis on the face sheet, discharge summary or discharge note it should normally be coded. Some times however, doctors list resolved conditions or diagnoses and status-post procedures from previous admissions that have no bearing on the current stay. Such conditions are not to be coded or reported for that visit. However, history codes (V10 – V19) should be used as secondary diagnoses if the historical condition or family history has an impact on the current care or influences treatment. V10 history of cancer codes should **always** be used if the patient has had a personal history of cancer that is resolved.

1.4.3.3.2. **Abnormal Findings** – Abnormal findings such as laboratory, radiology, pathologic and others are not coded and reported unless the doctor indicates their clinical significance. If the findings are outside the normal range and the doctor has ordered other tests to evaluate the condition or prescribed treatment, it is appropriate to code them if the doctor lists them as a discharge diagnosis.

1.4.3.3.3. **Uncertain Diagnosis** – If the diagnosis documented at the time of discharge is qualified as "probable", "suspected", "likely", "questionable", "possible" or "still to be ruled out", or other uncertain qualifier, code the condition as if it existed, as above in Principal Diagnosis (***Inpatient only).***

1.4.4. Section Five: Outpatient and Ambulatory Patient Coding

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1.4.4.1. The terms encounter and visit are often used interchangeably in describing outpatient or ambulatory patient service contacts. These can range from Emergency Room visits to Specialty Clinic visits to Ancillary Services encounters.

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

1.4.4.2.1. **Outpatient Surgery**: When a patient presents for outpatient surgery, code the reason for the surgery as the principal diagnosis (reason for encounter) even if the procedure is not performed for any reason. You can use an additional code to describe why the procedure was not performed, if appropriate.

1.4.4.2.2. **Observation**: When a patient is admitted for observation for a medical condition, assign a code for the medical condition as the principal diagnosis.

1.4.4.2.3. **Complication**: When a patient presents for outpatient surgery and develops a complication requiring **admission for observation**, code the reason for the surgery as the principal diagnosis, followed by codes for the complication as secondary diagnoses.

1.4.4.2.4. **Symptoms and Signs**: Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a diagnosis has not been established or confirmed by the care giver.

1.4.4.2.5. **Other Encounter**: There are also codes to deal with encounters for circumstances other than injury or illness. These can be found in the V-code section and are explained below. (IV – V Codes).

1.4.4.2.6. **Sequencing**: A similar definition of principal diagnosis is used for ambulatory visits; that is the condition, problem or other reason for the encounter/visit shown in the medical record documentation to be chiefly responsible for the services provided. List additional codes that describe any co-existing conditions.

1.4.4.2.7. **Uncertain Diagnoses**: Do **not** code diagnoses documented as "probable", "suspected", "questionable", "rule out", or "working diagnosis" or other similar terms indicating uncertainty in Outpatient Setting. 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. **NOTE**: ***This differs from the coding rule for inpatient admissions.***

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

1.4.4.2.9. **Coexisting Conditions:** 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.

1.4.4.2.10. **Diagnostic Services Only:** For patients receiving **diagnostic** services **only** during an encounter/visit, sequence first the diagnosis, condition, problem or other reason for

the encounter/visit, as shown in the medical record to be chiefly responsible for the outpatient diagnostic services provided during the encounter/visit. Codes for other diagnoses (e.g. chronic conditions) may be sequenced as additional diagnoses.

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

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

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

1.4.4.2.11. **Therapeutic Services Only:** For patients receiving **therapeutic** services **only** during an encounter/visit, sequence first the diagnosis, condition, problem or other reason for the encounter/visit, as shown in the medical record to be chiefly responsible for the outpatient therapeutic 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, then the appropriate V-code for the service is listed first and the diagnosis or problem for which the service is being performed is listed second.

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

1.4.4.4. **Ambulatory Surgery**: Code the diagnosis for which the surgery was performed as the principal diagnosis. 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.

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

II.

Coding Diagnostic Guidelines

Chapter One

2.1. Body Systems

2.1.1. Section One: Infectious and Parasitic Diseases (001-139)

2.1.1.1. Human Immunodeficiency Virus (HIV) Infections

2.1.1.1.1. **Code only confirmed cases**

- Code only confirmed cases of HIV infection/illness. This is an exception to the hospital inpatient guidelines.
- In this context, “confirmation” does not require documentation of positive serology or culture for HIV; the provider’s diagnostic statement that the patient is HIV positive, or has an HIV-related illness is sufficient.

2.1.1.1.2. **Selection and sequencing of HIV codes**

2.1.1.1.1.1. **Patient admitted for HIV-related condition**

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

2.1.1.1.1.2. **Patient with HIV disease admitted for unrelated condition**

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

2.1.1.1.1.3. **Whether the patient is newly diagnosed**

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

2.1.1.1.1.4. **Asymptomatic human immunodeficiency virus**

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

2.1.1.1.1.5. **Patients with inconclusive HIV serology**

- Patients with inconclusive HIV serology, but no definitive diagnosis or manifestations of the illness, may be assigned to code 795.71, Inconclusive serologic test for HIV.

2.1.1.1.1.6. **Previously diagnosed HIV-related illness**

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

2.1.1.1.1.7. **HIV Infection in Pregnancy, Childbirth and the Puerperium**

- During pregnancy, childbirth or the puerperium, a patient admitted (or presenting for a health care encounter) because of an HIV-related illness should receive a principal diagnosis code of 647.6X, Other specified infectious and parasitic diseases in the mother classifiable elsewhere, but complicating the pregnancy, childbirth or the puerperium, followed by 042 and the code(s) for the HIV-related illness(es). Codes from Chapter 15 always take sequencing priority

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

- See Section 11, I, D HIV Infection in Pregnancy, Childbirth and the Puerperium

2.1.1.1.1.8. **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.

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

2.1.1.2.1. SIRS, Septicemia, and Sepsis

2.1.1.2.1.1. **The terms septicemia and sepsis are often used interchangeably** by providers, however they are not considered synonymous terms.

- Septicemia generally refers to a systemic disease associated with the presence of pathological microorganisms or toxins in the blood, which can include bacteria, viruses, fungi or other organisms.
- Systemic inflammatory response syndrome (SIRS) generally refers to the systemic response to infection, trauma/burns, or other insult (such as cancer) with symptoms including fever, tachycardia, tachypnea, and leukocytosis.
- Sepsis generally refers to SIRS due to infection.
- Severe sepsis generally refers to sepsis with associated acute organ dysfunction.

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

- The code for the underlying cause (such as infection or trauma) must be sequenced before the code from subcategory 995.9 Systemic inflammatory response syndrome (SIRS).
- Sepsis and severe sepsis require a code for the systemic infection (038.xx, 112.5, etc.) and either code 995.91, Sepsis, or 995.92, Severe sepsis. If the causal organism is not documented, assign code 038.9, unspecified septicemia.
- Severe sepsis requires additional code(s) for the associated acute organ dysfunction(s).
- If a patient has sepsis with multiple organ dysfunctions, follow the instructions for coding severe sepsis.
- Either the term sepsis or SIRS must be documented to assign a code from subcategory 995.9.

- For further information see below, Injury and poisoning, for information regarding systemic inflammatory response syndrome (SIRS) due to trauma/burns and other non-infectious processes.

2.1.1.2.2. Sequencing sepsis and severe sepsis

2.1.1.2.2.1. Sepsis and severe sepsis as principal diagnosis.

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

2.1.1.2.2.2. Sepsis and severe sepsis as secondary diagnoses.

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

- See Section Eleven, I – 7 Puerperal sepsis

2.1.1.2.2.3. Sepsis/SIRS with Localized Infection

- If the reason for admission is sepsis, severe sepsis, or SIRS and a localized infection, such as pneumonia or cellulitis, a code for the systemic infection (038.xx, 112.5, etc) should be assigned first, then code 995.91 or 995.92, followed by the code for the localized infection. If the patient is admitted with a localized infection, such as pneumonia, and sepsis/SIRS does not develop until after admission, see guideline 2b above).

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

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

2.1.1.2.1.4.1. Streptococcal sepsis

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

2.1.1.2.1.4.2. Streptococcal septicemia

- If the documentation states streptococcal septicemia, only code 038.0 should be assigned, however, the caregiver should be questioned as to whether the patient has sepsis, an infection with SIRS.

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

2.1.1.2.1.6. **Septic shock**

2.1.1.2.1.6.1. **Sequencing of septic shock.**

- Septic shock generally refers to circulatory failure associated with severe sepsis, and, therefore, it represents a type of acute organ dysfunction. For all cases of septic shock, the code for the systemic infection should be sequenced first, followed by codes 995.92 and 785.52. Any additional codes for other acute organ dysfunctions should also be assigned. As noted in the sequencing instructions in the Tabular List, the code for septic shock cannot be assigned as a principal diagnosis.

2.1.1.2.1.6.2. **Septic Shock without documentation of severe sepsis.**

- Septic shock indicates the presence of severe sepsis. Code 995.92, severe sepsis, must be assigned with 785.52, Septic shock, even if the term “severe sepsis” is not documented in the record.

2.1.1.2.1.7. **Sepsis and septic shock complicating abortion and pregnancy**

- Sepsis and septic shock complicating abortion, ectopic pregnancy and molar pregnancy are classified to category codes 630 – 639 (Chapter 11)

2.1.1.2.1.8. **Sepsis due to a post-procedural infection**

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

2.1.1.2.1.9. **Sepsis and Severe Sepsis Associated with Non-infectious Process**

- In some cases, a non-infectious process, such as trauma, may lead to an infection which can result in sepsis or severe sepsis. If sepsis or severe sepsis is documented as associated with a non-infectious condition, such

as a burn or serious injury, and this condition meets the definition for principal diagnosis, the code for the non-infectious condition should be sequenced first, followed by the code for the systemic infection and either code 995.91, Sepsis, or 995.92, Severe sepsis.

- Additional codes for any associated acute organ dysfunction(s) should also be assigned for cases of severe sepsis. If the sepsis or severe sepsis meets the definition of principal diagnosis, the systemic infection and sepsis codes should be sequenced before the non-infectious condition. When both the associated non-infectious condition and the sepsis or severe sepsis meet the definition of principal diagnosis, either may be assigned as principal diagnosis.

- Only one code from subcategory 995.9 should be assigned. Therefore, when a non-infectious condition leads to an infection resulting in sepsis or severe sepsis, assign either code 995.91 or 995.92. Do not additionally assign code 995.93, Systemic inflammatory response syndrome due to non-infectious process without acute organ dysfunction, or 995.94, Systemic inflammatory response syndrome with acute organ dysfunction.

2.1.1.3. Methicillin Resistant Staphylococcus aureus (MRSA) Conditions

2.1.1.3.1. Selection and sequencing of MRSA codes

2.1.1.3.1.1. **Combination codes for MRSA infection**

- When a patient is diagnosed with an infection that is due to methicillin resistant Staphylococcus aureus (MRSA), and that infection has a combination code that includes the causal organism (e.g., septicemia, pneumonia) assign the appropriate code for the condition (e.g., code 038.12, Methicillin resistant Staphylococcus aureus septicemia or code 482.42, Methicillin resistant pneumonia due to Staphylococcus aureus). Do not assign code 041.12, Methicillin resistant Staphylococcus aureus, as an additional code because the code includes the type of infection and the MRSA organism. Do not assign a code from subcategory V09.0, Infection with microorganisms resistant to penicillins, as an additional diagnosis.

2.1.1.3.1.2. **Other codes for MRSA infection**

- When there is documentation of a current infection (e.g., wound infection, stitch abscess, urinary tract infection) due to MRSA, and that infection does not have a combination code that includes the causal organism, select the appropriate code to identify the condition along with code 041.12, Methicillin

resistant Staphylococcus aureus, for the MRSA infection. Do not assign a code from subcategory V09.0, Infection with microorganisms resistant to penicillins.

2.1.1.3.1.3. **Methicillin susceptible Staphylococcus aureus (MSSA) and MRSA colonization**

- The condition or state of being colonized or carrying MSSA or MRSA is called colonization or carriage, while an individual person is described as being colonized or being a carrier. Colonization means that MSSA or MSRA is present on or in the body without necessarily causing illness. A positive MRSA colonization test might be documented by the provider as “MRSA screen positive” or “MRSA nasal swab positive”.

- Assign code V02.54, Carrier or suspected carrier, Methicillin resistant Staphylococcus aureus, for patients documented as having MRSA colonization. Assign code V02.53, Carrier or suspected carrier, Methicillin susceptible Staphylococcus aureus, for patient documented as having MSSA colonization. Colonization is not necessarily indicative of a disease process or as the cause of a specific condition the patient may have unless documented as such by the provider.

- Code V02.59, Other specified bacterial diseases, should be assigned for other types of staphylococcal colonization (e.g., S. epidermidis, S. saprophyticus). Code V02.59 should not be assigned for colonization with any type of Staphylococcus aureus (MRSA, MSSA).

2.1.1.3.1.4. **MRSA colonization and infection**

- If a patient is documented as having both MRSA colonization and infection during a hospital admission, code V02.54, Carrier or suspected carrier, Methicillin resistant *Staphylococcus aureus*, and a code for the MRSA infection may both be assigned.

2.1.2. Section Two: <u>Neoplasms (140 - 239)</u>

2.1.2.1. General Guidelines Neoplasms

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

- The neoplasm table in the Alphabetic Index should be referenced first. However, if the histological term is documented, that term should be referenced first, rather than going immediately to the Neoplasm Table, in order to determine which column in the Neoplasm Table is appropriate. For example, if the documentation indicates “adenoma,” refer to the term in the Alphabetic Index to review the entries under this term and the instructional note to “see also neoplasm, by site, benign.” The table provides the proper code based on the type of neoplasm and the site. It is important to select the proper column in the table that corresponds to the type of neoplasm. The tabular should then be referenced to verify that the correct code has been selected from the table and that a more specific site code does not exist.

2.1.2.1.1. **Treatment directed at the malignancy**

- If the treatment is directed at the malignancy, designate the malignancy as the principal diagnosis. The only exception to this guideline is if a patient admission/encounter is solely for the administration of chemotherapy, immunotherapy or radiation therapy, assign the appropriate V58.x code as the first-listed or principal diagnosis, and the diagnosis or problem for which the service is being performed as a secondary diagnosis.

2.1.2.1.2. **Treatment of secondary site**

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

2.1.2.1.3. **Coding and sequencing of complications**

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

2.1.2.1.3.1. **Anemia associated with malignancy**

  - When admission/encounter is for management of an anemia associated with the malignancy, and the treatment is only for anemia, the appropriate anemia code (such as code 285.22, Anemia in neoplastic disease) is designated as the principal diagnosis and is followed by the appropriate code(s) for the malignancy. Code 285.22 may also be used as a secondary code if the patient suffers from anemia and is being treated for the malignancy.

  - Code 285.22, Anemia in neoplastic disease, and code 285.3, Antineoplastic chemotherapy induced anemia, may both be assigned

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if anemia in neoplastic disease and anemia due to antineoplastic chemotherapy are both documented.

2.1.2.1.3.2. **Anemia associated with chemotherapy, immunotherapy and radiation therapy**

- When the admission/encounter is for management of an anemia associated with chemotherapy, immunotherapy or radiotherapy and the only treatment is for the anemia, the anemia is sequenced first. The appropriate neoplasm code should be assigned as an additional code.

2.1.2.1.3.3. **Management of dehydration due to the malignancy**

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

2.1.2.1.4. **Primary malignancy previously excised**

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

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

2.1.2.1.5.1. **Episode of care involves surgical removal of neoplasm**

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

2.1.2.1.5.2. **Patient admission/encounter solely for administration of chemotherapy, immunotherapy and radiation therapy**

- If a patient admission/encounter is solely for the administration of chemotherapy, immunotherapy or radiation therapy, assign code V58.0, Encounter for radiation therapy, or V58.11, Encounter for antineoplastic chemotherapy, or V58.12, Encounter for antineoplastic immunotherapy as the principal diagnosis. If a patient receives more

than one of these therapies during the same admission more than one of these codes may be assigned, in any sequence. The malignancy for which the therapy is being administered should be assigned as a secondary diagnosis

2.1.2.1.5.3. **Patient admitted for radiotherapy/chemotherapy and immunotherapy and develops complications**

- When a patient is admitted for the purpose of radiotherapy, immunotherapy or chemotherapy and develops complications such as uncontrolled nausea and vomiting or dehydration, the principal diagnosis is V58.0, Encounter for radiotherapy, or V58.11, Encounter for antineoplastic chemotherapy, or V58.12, Encounter for antineoplastic immunotherapy followed by any codes for the complications.

2.1.2.1.6. **Admission/encounter to determine extent of malignancy**

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

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

- Symptoms, signs, and ill-defined conditions listed in Chapter 16 characteristic of, or associated with, an existing primary or secondary site malignancy, cannot be used to replace the malignancy as principal diagnosis, regardless of the number of admissions or encounters for treatment and care of the neoplasm.

2.1.2.1.6.2. **Admission/encounter for pain control/management**

- See Section 6 for information on coding admission/encounter for pain control/management.

2.1.2.1.6.3. **Malignant neoplasm associated with transplanted organ**

- A malignant neoplasm of a transplanted organ should be coded as a transplant complication. Assign first the appropriate code from subcategory 996.8, Complications of transplanted organ, followed by code 199.2, malignant neoplasm associated with transplanted organ. Use an additional code for the specific malignancy

2.1.3. Section Three: <u>Endocrine, Nutritional and Metabolic Diseases and Immunity Disorders (240 - 279)</u>

2.1.3.1. Diabetes mellitus

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

2.1.3.1.1. Fifth-digits for category 250:

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

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

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

2.1.3.1.2. Type of diabetes mellitus not documented

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

2.1.3.1.3. Diabetes mellitus and the use of insulin

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

2.1.3.1.4. Assigning and sequencing diabetes codes and associated conditions

- When assigning codes for diabetes and its associated conditions, the code(s) from category 250 must be sequenced before the codes for the associated conditions. The diabetes codes and the secondary codes that correspond to them are paired codes that follow the etiology/manifestation convention of the classification. Assign as many codes from category 250 as needed to identify all of the associated conditions that the patient has. The corresponding secondary codes are listed under each of the diabetes codes.

2.1.3.1..1. **Diabetic retinopathy/diabetic macular edema**

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

2.1.3.1.5. Diabetes mellitus in pregnancy and gestational diabetes

- For diabetes mellitus complicating pregnancy, see Section 11 F, Diabetes mellitus in pregnancy.
- For gestational diabetes, see Section 11 G, Gestational diabetes.

2.1.3.1.6. Insulin pump malfunction

2.1.3.1.6.1. Under-dose of insulin due insulin pump failure

- An under-dose of insulin due to an insulin pump failure should be assigned 996.57, Mechanical complication due to insulin pump, as the principal diagnosis, followed by the appropriate diabetes mellitus code based on documentation.

2.1.3.1.6.2. Overdose of insulin due to insulin pump failure

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

2.1.3.1.7. Secondary Diabetes Mellitus

2.1.3.1.7.1. Fifth-digits for category 249

- A fifth-digit is required for all category 249 codes to identify whether the diabetes is controlled or uncontrolled.

2.1.3.1.7.2. Secondary diabetes mellitus and the use of insulin

- For patients who routinely use insulin, code V58.67, Long-term (current) use of insulin, should also be assigned. Code V58.67 should not be assigned if insulin is given temporarily to bring a patient's blood sugar under control during an encounter.

2.1.3.1.7.3. Assigning and sequencing secondary diabetes codes and associated conditions

- When assigning codes for secondary diabetes and its associated conditions (e.g. renal manifestations), the code(s) from category 249 must be sequenced before the codes for the associated conditions. The secondary diabetes codes and the diabetic manifestation codes that correspond to them are paired

codes that follow the etiology/manifestation convention of the classification. Assign as many codes from category 249 as needed to identify all of the associated conditions that the patient has. The corresponding codes for the associated conditions are listed under each of the secondary diabetes codes. For example, secondary diabetes with diabetic nephrosis is assigned to code 249.40, followed by 581.81.

2.1.3.1.7.4. **Assigning and sequencing secondary diabetes codes and its causes**

- The sequencing of the secondary diabetes codes in relationship to codes for the cause of the diabetes is based on the reason for the encounter, applicable ICD-9-CM sequencing conventions, and chapter-specific guidelines.
- If a patient is seen for treatment of the secondary diabetes or one of its associated conditions, a code from diagnosis, with the cause of the secondary diabetes (e.g. cystic fibrosis) sequenced as an additional diagnosis.
- If, however, the patient is seen for the treatment of the condition causing the secondary diabetes (e.g., malignant neoplasm of pancreas), the code for the cause of the secondary diabetes should be sequenced as the principal or first-listed diagnosis followed by a code from category 249.

2.1.3.1.7.4.1. **Secondary diabetes mellitus due to pancreatectomy**

- For postpancreatectomy diabetes mellitus (lack of insulin due to the surgical removal of all or part of the pancreas), assign code 251.3, Postsurgical hypoinsulinemia. Assign a code from subcategory 249, Secondary diabetes mellitus and a code from subcategory V88.1, Acquired absence of pancreas as additional codes. Code also any diabetic manifestations (e.g. diabetic nephrosis 581.81).

2.1.3.1.7.4.2. **Secondary diabetes due to drugs**

- Secondary diabetes may be caused by an adverse effect of correctly administered medications, poisoning or late effect of poisoning.

2.1.4. Section Four: <u>Diseases of Blood and Blood Forming Organs (280 - 289)</u>

2.1.4.1. Anemia of chronic disease

- Subcategory 285.2, Anemia in chronic illness, has codes for anemia in chronic kidney disease, code 285.21; anemia in neoplastic disease, code 285.22; and anemia in other chronic illness, code 285.29. These codes can be used as the principal/first listed code if the reason for the encounter is to treat the anemia. They may also be used as secondary codes if treatment of the anemia is a component of an encounter, but not the primary reason for the encounter. When using a code from subcategory 285 it is also necessary to use the code for the chronic condition causing the anemia.

2.1.4.1.1. **Anemia in chronic kidney disease**

- When assigning code 285.21, Anemia in chronic kidney disease, it is also necessary to assign a code from category 585, chronic kidney disease, to indicate the stage of chronic kidney disease.

2.1.4.1.2. **Anemia in neoplastic disease**

- When assigning code 285.22, Anemia in neoplastic disease, it is also necessary to assign the neoplasm code that is responsible for the anemia. Code 285.22 is for use for anemia that is due to the malignancy, not for anemia due to antineoplastic Chemotherapy drugs.. Assign code 285.3 for anemia due to antineoplastic chemotherapy.

2.1.5. Section Five: Mental Disorders (290 – 319)

2.1.5.1. See Guidelines in 'General Guidelines'.

2.1.6. Section Six: Diseases of Nervous System and Sense Organs (320-389)

2.1.6.1. Pain - Category 338

2.1.6.1.1. **General coding information**

- Codes in category 338 may be used in conjunction with codes from other categories and chapters to provide more detail about acute or chronic pain and neoplasm-related pain. If the pain is not specified as acute or chronic, do not assign codes from category 338, except for post-thoracotomy pain, postoperative pain or neoplasm related pain or central pain syndrome. A code from subcategories 338.1 and 338.2 should not be assigned if the underlying (definitive) diagnosis is known, **unless** the reason for the encounter is pain control/management and not management of the underlying condition.

2.1.6.1.1.1. **Category 338 Codes as Principal Diagnosis**

- When pain control or pain management is the reason for the admission/encounter (e.g., a patient with displaced intervertebral disc, nerve impingement and severe back pain presents for injection of steroid into the spinal canal). The underlying cause of the pain should be reported as an additional diagnosis, if known.

- When an admission or encounter is for a procedure aimed at treating the underlying condition (e.g., spinal fusion, kyphoplasty), a code for the underlying condition (e.g., vertebral fracture, spinal stenosis) should be assigned as the principal diagnosis. No code from category 338 should be assigned.

- When a patient is admitted for the insertion of a neurostimulator for pain control, assign the appropriate pain code as the principal or

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first listed diagnosis. When an admission or encounter is for a procedure aimed at treating the underlying condition and a neurostimulator is inserted for pain control during the same admission/encounter, a code for the underlying condition should be assigned as the principal diagnosis and the appropriate pain code should be assigned as a secondary diagnosis.

2.1.6.1.1.2. **Use of Category 338 Codes in Conjunction with Site Specific Pain Codes**

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

- **Sequencing of Category 338 Codes with Site-Specific Pain Codes:** The sequencing of category 338 codes with site-specific pain codes (including chapter 16 codes), is dependent on the circumstances of the encounter or admission as follows:

  - If the encounter is for pain control or pain management, assign the code from category 338 followed by the code identifying the specific site of pain (e.g., encounter for pain management for acute neck pain from trauma is assigned code 338.11, Acute pain due to trauma, followed by code 723.1, Cervicalgia, to identify the site of pain).

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

2.1.6.1.2. **Pain due to devices, implants and grafts**

- Pain associated with devices, implants or grafts left in a surgical site (for example painful hip prosthesis) is assigned to the appropriate code(s) found in Chapter 17, Injury and Poisoning. Use additional code(s) from category 338 to identify acute or chronic pain due to presence of the device, implant or graft (338.18-338.19 or 338.28-338.29).

2.1.6.1.3. **Postoperative Pain**

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

specified as acute or chronic, is the code for the acute form. (Routine or expected postoperative pain immediately after surgery should not be coded)

2.1.6.1.3.1. **Postoperative pain not associated with a specific postoperative complication**

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

2.1.6.1.3.2. **Postoperative pain associated with specific postoperative complication**

- Postoperative pain associated with a specific postoperative complication (such as painful wire sutures) is assigned to the appropriate code(s) found in Chapter 17, Injury and Poisoning. If appropriate, use additional code(s) from category 338 to identify acute or chronic pain (338.18 or 338.28). If pain control/management is the reason for the encounter, a code from category 338 should be assigned as the principal or first-listed diagnosis.

2.1.6.1.3.3. **Postoperative pain as principal or first-listed diagnosis**

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

2.1.6.1.3.4. **Postoperative pain as secondary diagnosis**

- Postoperative pain may be reported as a secondary diagnosis code when a patient presents for outpatient surgery and develops an unusual or inordinate amount of postoperative pain. The provider's documentation should be used to guide the coding of postoperative pain.

2.1.6.1.4. **Chronic pain**

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

2.1.6.1.5. **Neoplasm Related Pain**

- Code 338.3 is assigned to pain documented as being related, associated or due to cancer, primary or secondary malignancy, or tumor. This code is assigned regardless of whether the pain is acute or chronic. This code may be assigned as the principal or first-listed code when the stated reason for the

admission/encounter is documented as pain control/pain management. The underlying neoplasm should be reported as an additional diagnosis.

- When the reason for the admission/encounter is management of the neoplasm and the pain associated with the neoplasm is also documented, code 338.3 may be assigned as an additional diagnosis.

2.1.6.1.6. **Chronic pain syndrome**

- This condition is different than the term “chronic pain,” and therefore this code should only be used when the caregiver has specifically documented this condition.

2.1.7. Section Seven: Diseases of Circulatory System (390-459)

2.1.7.1. Hypertension Table

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

2.1.7.1.1. **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.

2.1.7.1.2. **Hypertension with Heart Disease**

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

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

2.1.7.1.3. **Hypertensive Chronic Kidney Disease**

- Assign codes from category 403, Hypertensive chronic kidney disease, when conditions classified to category 585 or code 587 are

present with hypertension. Unlike hypertension with heart disease, ICD-9-CM presumes a cause-and-effect relationship and classifies chronic kidney disease (CKD) with hypertension as hypertensive chronic kidney disease

- **Fifth digits for category 403 should be assigned as follows:**

2.1.7.1.3..1. 0 with CKD stage I through stage IV, or unspecified.

2.1.7.1.3..2. 1 with CKD stage V or end stage renal disease.

- The appropriate code from category 585, chronic kidney disease, should be used as a secondary code with a code from category 403 to identify the stage of chronic kidney disease.

2.1.7.1.4. **Hypertensive Heart and Chronic Kidney Disease**

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

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

- The appropriate code from category 585, Chronic Kidney Disease, should be used as a secondary code with a code from category 404 to identify the stage of chronic kidney disease.

2.1.7.1.5. **Hypertensive Cerebrovascular Disease**

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

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2.1.7.1.6. **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.

2.1.7.1.7. **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.

2.1.7.1.8. **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.

2.1.7.1.9. **Hypertension, Controlled**

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

2.1.7.1.10. **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.

2.1.7.1.11. **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 than a code from category 401.

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

- The terms stroke and CVA are often used interchangeably to refer to a cerebral infarction. The terms stroke, CVA, and cerebral infarction NOS are all indexed to the default code 434.91, cerebral artery occlusion, unspecified, with infarction. *Additional code(s) should be assigned for any neurologic deficits associated with the acute CVA, regardless of whether or not the neurologic deficit resolves prior to discharge*

2.1.7.3. Postoperative cerebrovascular accident

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

2.1.7.4. Late Effects of Cerebrovascular Disease

2.1.7.4.1. **Category 438, Late Effects of Cerebrovascular disease**

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

- Codes in category 438 are only for use for late effects of cerebrovascular disease, not for neurologic deficits associated with an acute CVA.

2.1.7.4.2. **Codes from category 438 with codes from 430-437**

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

2.1.7.4.3. **Code V12.54**

- Assign code V12.54, Transient ischemic attack (TIA), and cerebral infarction without residual deficits (and not a code from category 438) as an additional code for history of cerebrovascular disease when no neurologic deficits are present.

2.1.7.5. Acute myocardial infarction (AMI)

2.1.7.5.1. **ST elevation myocardial infarction (STEMI) and non ST elevation myocardial infarction (NSTEMI)**

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

2.1.7.5.2. **Acute myocardial infarction, unspecified**

- Subcategory 410.9 is the default for the unspecified term acute myocardial infarction. If only STEMI or transmural MI without the site is documented, ask the caregiver for the specific site, or assign a code from subcategory 410.9.

2.1.7.5.3. **AMI documented as nontransmural or subendocardial but site provided**

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

2.1.8. Section Eight: Diseases of Respiratory System (460-519)

2.1.8.1. Chronic Obstructive Pulmonary Disease [COPD] and Asthma

2.1.8.1.1. **Conditions that comprise COPD and Asthma**

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

2.1.8.1.2. **Acute exacerbation of chronic obstructive bronchitis and asthma**

- The codes for chronic obstructive bronchitis and asthma distinguish between uncomplicated cases and those in acute exacerbation. Acute exacerbation is a worsening or a decompensation of a chronic condition. An acute exacerbation is not equivalent to an infection superimposed on a chronic condition, although an exacerbation may be triggered by an infection.

2.1.8.1.3. **Overlapping nature of the conditions that comprise COPD and asthma**

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

2.1.8.1.4. **Acute exacerbation of asthma and status asthmaticus**

- An acute exacerbation of asthma is an increased severity of the asthma symptoms, such as wheezing and shortness of breath. Status asthmaticus

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

2.1.8.2. Chronic Obstructive Pulmonary Disease [COPD] and Bronchitis

2.1.8.2.1. **Acute bronchitis with COPD**

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

2.1.8.3. Acute Respiratory Failure

2.1.8.3.1. **Acute respiratory failure as principal diagnosis**

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

2.1.8.3.2. **Acute respiratory failure as secondary diagnosis**

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

2.1.8.3.3. **Sequencing of acute respiratory failure and another acute condition**

- When a patient is admitted with respiratory failure and another acute condition, (e.g., myocardial infarction, cerebrovascular accident, aspiration pneumonia), the principal diagnosis will not be the same in every situation. This applies whether the other acute condition is a respiratory or nonrespiratory condition. Selection of the principal diagnosis will be dependent on the circumstances of admission. If both the respiratory failure and the other acute condition are equally responsible for occasioning the admission to the hospital, and there are no chapter-specific sequencing rules,

the guideline regarding two or more diagnoses that equally meet the definition for principal diagnosis may be applied in these situations. If the documentation is not clear as to whether acute respiratory failure and another condition are equally responsible for occasioning the admission, query the provider for clarification.

2.1.8.4. Influenza due to certain identified viruses

- Code only confirmed cases of avian influenza (codes 488.01-488.02, 488.09, Influenza due to identified avian influenza virus) or novel H1N1 influenza virus (H1N1 or swine flu, code 488.11-488.12, 488.19). This is an exception to the hospital inpatient guideline *in Chapter Four Section Three Principal Diagnosis ("Possible" Diagnoses as Principal).*

- In this context, "confirmation" does not require documentation of positive laboratory testing specific for avian or novel H1N1 influenza. However, coding should be based on **the provider's diagnostic statement** that the patient has avian or novel H1N1 (H1N1 or swine flu) influenza.

- If the provider records "suspected or possible or probable avian or novel H1N1 influenza (H1N1 or swine flu)," the appropriate influenza code from category 487 should be assigned. A code from category 488, Influenza due to certain identified influenza viruses, should not be assigned.

2.1.9. Section Nine: Diseases of Digestive System (520-579)

2.1.9.1. See Guidelines in 'General Guidelines'.

2.1.10. Section Ten: Diseases of Genitourinary System (580-629)

2.1.10.1. Chronic kidney disease

2.1.10.1.1. **Stages of chronic kidney disease (CKD)**

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

2.1.10.1.2. **Chronic kidney disease and kidney transplant status**

- Patients who have undergone kidney transplant may still have some form of CKD, because the kidney transplant may not fully restore kidney function. Therefore, the presence of CKD alone does not constitute a transplant complication. Assign the appropriate 585 code for the patient's stage of CKD and code V42.0. If a transplant complication such as failure or rejection is documented, code it as complications of a kidney transplant. If the

documentation is unclear as to whether the patient has a complication of the transplant, query the provider.

2.1.10.1.3. **Chronic kidney disease with other conditions**

- Patients with CKD may also suffer from other serious conditions, most commonly diabetes mellitus and hypertension. The sequencing of the CKD code in relationship to codes for other contributing conditions is based on the conventions in the tabular list.

2.1.10.1.3..1. *See Section Three, 4) Assigning and sequencing diabetes codes*

2.1.10.1.3..2. *See Section Four, A 1) Anemia in chronic kidney disease*

2.1.10.1.3..3. See Section Seven: A 3) Hypertensive Chronic Kidney Disease

2.1.11. Section Eleven: <u>Complications of Pregnancy, Childbirth, and the Puerperium (630-679)</u>

2.1.11.1. General Rules for Obstetric Cases

2.1.11.1.1. **Codes from chapter 11 and sequencing priority**

- Obstetric cases require codes from chapter 11, codes in the range 630-679, Complications of Pregnancy, Childbirth, and the Puerperium. Chapter 11 codes have sequencing priority over codes from other chapters. Additional codes from other chapters may be used in conjunction with chapter 11 codes to further specify conditions. Should the provider document that the pregnancy is incidental to the encounter, then code V22.2 should be used in place of any chapter 11 codes. It is the provider's responsibility to state that the condition being treated is not affecting the pregnancy.

2.1.11.1.2. **Chapter 11 codes used only on the maternal record**

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

2.1.11.1.3. **Chapter 11 fifth-digits**

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

2.1.11.1.4. **Fifth-digits, appropriate for each code**

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

2.1.11.2. Selection of OB Principal or First-listed Diagnosis

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2.1.11.2.1. **Routine outpatient prenatal visits**

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

2.1.11.2.2. **Prenatal outpatient visits for high-risk patients**

- For routine prenatal outpatient visits for patients with high-risk pregnancies, a code from category V23, Supervision of high-risk pregnancy, should be used as the principal diagnosis. Secondary chapter 11 codes may be used in conjunction with these codes, as appropriate.

2.1.11.2.3. **Episodes when no delivery occurs**

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

2.1.11.2.4. **When a delivery occurs**

- When a delivery occurs, the principal diagnosis should correspond to the main circumstances or complication of the delivery. In cases of cesarean delivery, the selection of the principal diagnosis should be the condition established after study that was responsible for the patient’s admission. If the patient was admitted with a condition that resulted in the performance of a cesarean procedure that condition should be selected as the principal diagnosis. If the reason for the admission/encounter was unrelated to the condition resulting in the cesarean delivery, the condition related to the reason for the admission/encounter should be selected as the principal diagnosis, even if a cesarean was performed.

2.1.11.2.5. **Outcome of delivery**

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

2.1.11.3. Fetal Conditions Affecting the Management of the Mother

2.1.11.3.1. **Codes from category 655 and 656**

- Codes from categories 655, Known or suspected fetal abnormality affecting management of the mother, and 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.

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2.1.11.3.2. **In-utero surgery**

- In cases when surgery is performed on the fetus, a diagnosis code from category 655, known or suspected fetal abnormalities affecting management of the mother, should be assigned identifying the fetal condition. Procedure code 75.36, Correction of fetal defect, should be assigned on the hospital inpatient record. No code from Chapter 15, the perinatal codes, should be used on the mother's record to identify fetal conditions. Surgery performed in-utero on a fetus is still to be coded as an obstetric encounter.

2.1.11.4. HIV Infection in Pregnancy, Childbirth and the Puerperium

- During pregnancy, childbirth or the puerperium, a patient admitted because of an HIV-related illness should receive a principal diagnosis of 647.6X, Other specified infectious and parasitic diseases in the mother classifiable elsewhere, but complicating the

  pregnancy, childbirth or the puerperium, followed by 042 and the code(s) for the HIV-related illness(es).

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

2.1.11.5. Current Conditions Complicating Pregnancy

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

2.1.11.6. Diabetes mellitus in pregnancy

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

2.1.11.7. Gestational diabetes

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

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

2.1.11.8. Normal Delivery, Code 650

2.1.11.8.1. **Normal delivery**

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

2.1.11.8.2. **Normal delivery with resolved antepartum complication**

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

2.1.11.8.3. **V27.0, Single live born, outcome of delivery**

- V27.0, Single live born, is the only outcome of delivery code appropriate for use with 650.

2.1.11.9. The Postpartum and Peripartum Periods

2.1.11.9.1. **Postpartum and peripartum periods defined**

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

2.1.11.9.2. **Postpartum complication**

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

2.1.11.9.3. **Pregnancy-related complications after 6 week period**

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

2.1.11.9.4. **Postpartum complications occurring during the same admission as delivery**

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

2.1.11.9.5. **Admission for routine postpartum care following delivery outside hospital**

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

2.1.11.9.6. **Admission following delivery outside hospital with postpartum conditions**

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

2.1.11.9.7. **Puerperal sepsis**

- Code 670.2x, Puerperal sepsis, should be assigned with a secondary code to identify the causal organism (e.g., for a bacterial infection, assign a code from category 041, Bacterial infections in conditions classified elsewhere and of unspecified site). A code from category 038, Septicemia, should not be used for puerperal sepsis. Do not assign code 995.91, Sepsis, as code 670.2x describes the sepsis. If applicable, use additional codes to identify severe sepsis (995.92) and any associated acute organ dysfunction.

2.1.11.10.Code 677, Late effect of complication of pregnancy

2.1.11.10.1. **Code 677**

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

2.1.11.10.2.**After the initial postpartum period**

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

2.1.11.10.3.**Sequencing of Code 677**

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

2.1.11.11.Abortions

2.1.11.11.1.**Fifth-digits required for abortion categories**

- Fifth-digits are required for abortion categories 634-637 Fifth digit assignment is based on the status of the patient at the beginning (or start) of the encounter. Fifth-digit 1, incomplete, indicates that all of the products of conception have not been expelled from the uterus. Fifth-digit 2, complete, indicates that all products of conception have been expelled from the uterus.

2.1.11.11.2.**Code from categories 640-648 and 651-659**

- A code from categories 640-648 and 651-659 may be used as additional codes with an abortion code to indicate the complication leading to the abortion. Fifth digit 3 is assigned with codes from these categories when used with an abortion code because the other fifth digits will not apply. Codes from the 660-669 series are not to be used for complications of abortion.

2.1.11.11.3.**Code 639 for complications**

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

2.1.11.11.4. **Abortion with Live born Fetus**

- When an attempted termination of pregnancy results in a live born 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 preggnancy should also be assigned.

2.1.11.11.5. **Retained Products of Conception following an abortion**

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

2.1.12. Section Twelve: Diseases Skin and Subcutaneous Tissue (680-709)

2.1.12.1. Pressure ulcer stage codes

2.1.12.1.1. **Pressure ulcer stages**

- Two codes are needed to completely describe a pressure ulcer: A code from subcategory 707.0, Pressure ulcer, to identify the site of the pressure ulcer and a code from subcategory 707.2, Pressure ulcer stages.

- The codes in subcategory 707.2, Pressure ulcer stages, are to be used as an additional diagnosis with a code(s) from subcategory 707.0, Pressure Ulcer. Codes from 707.2, Pressure ulcer stages, may not be assigned as a principal or first-listed diagnosis. The pressure ulcer stage codes should only be used with pressure ulcers and not with other types of ulcers (e.g., stasis ulcer).

- The ICD-9-CM classifies pressure ulcer stages based on severity, which is designated by stages I-IV and unstageable

2.1.12.1.2. **Unstageable pressure ulcer**

- Assignment of code 707.25, Pressure ulcer, unstageable, should be based on the clinical documentation. Code 707.25 is used for pressure ulcers whose stage cannot be clinically determined (e.g., the ulcer is covered by eschar or has been treated with a skin or muscle graft) and pressure ulcers that are documented as deep tissue injury but not documented as due to trauma. This code should not be confused with code 707.20, Pressure ulcer, stage unspecified. Code 707.20 should be assigned when there is no documentation regarding the stage of the pressure ulcer

2.1.12.1.3. **Documented pressure ulcer stage**

- Assignment of the pressure ulcer stage code should be guided by clinical documentation of the stage or documentation of the terms found in the index. For clinical terms describing the stage that are not found in the index, and there is no documentation of the stage, the provider should be queried.

2.1.12.1.4. **Bilateral pressure ulcers with same stage**

- When a patient has bilateral pressure ulcers (e.g., both buttocks) and both pressure ulcers are documented as being the same stage, only the code for the site and one code for the stage should be reported.

2.1.12.1.5. **Bilateral pressure ulcers with different stages**

- When a patient has bilateral pressure ulcers at the same site (e.g., both buttocks) and each pressure ulcer is documented as being at a different stage, assign one code for the site and the appropriate codes for the pressure ulcer stage

2.1.12.1.6. **Multiple pressure ulcers of different sites and stages**

- When a patient has multiple pressure ulcers at different sites (e.g., buttock, heel, shoulder) and each pressure ulcer is documented as being at different stages (e.g., stage 3 and stage 4), assign the appropriate codes for each different site and a code for each different pressure ulcer stage

2.1.12.1.7. **Patients admitted with pressure ulcers documented as healed**

- No code is assigned if the documentation states that the pressure ulcer is completely healed.

2.1.12.1.8. **Patients admitted with pressure ulcers documented as healing**

- Pressure ulcers described as healing should be assigned the appropriate pressure ulcer stage code based on the documentation in the medical record. If the documentation does not provide information about the stage of the healing pressure ulcer, assign code 707.20, Pressure ulcer stage, unspecified.

- If the documentation is unclear as to whether the patient has a current (new) pressure ulcer or if the patient is being treated for a healing pressure ulcer, query the provider

2.1.12.1.9. **Patients admitted with pressure ulcers evolving into another stage during the admission**

- If a patient is admitted with a pressure ulcer at one stage and it progresses to a higher stage, assign the code for highest stage reported for that site

2.1.12.1.10. **Patient with Acne**

- Code 706.1 must always be accompanied with a bacterial code or 041.9 if infected To specify the infective nature of acne in a patient, 706.1 is to be coded with an additional

bacterial code or code 041.9 - Bacterial infection, unspecified If the following conditions are documented:

- Acne conglobata
- Cystic acne
- Pustular acne
- Acne vulgaris

2.1.13. Section Thirteen: Diseases of Musculoskeletal and Connective Tissue (710-739)

2.1.13.1. Coding of Pathologic Fractures

2.1.13.1.1. Acute Fractures vs. Aftercare

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

- Non-acute, healed fractures are coded using the aftercare codes (subcategories V54.0, V54.2, V54.8 or V54.9) for encounters after the patient has completed active treatment of the fracture and is receiving routine care for the fracture during the healing or recovery phase. Examples of fracture aftercare are: cast change or removal, removal of external or internal fixation device, medication adjustment, and follow up visits following fracture treatment. Malunion and non-union will be coded with the appropriate code for this condition.

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

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

2.1.14. Section Fourteen: Congenital Anomalies (740-759)

2.1.14.1. Codes in categories 740-759, Congenital Anomalies

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

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

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

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

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

2.1.15. Section Fifteen: Newborn (Perinatal) Guidelines (760-779)

- For coding and reporting purposes the perinatal period is defined as **before** birth through the 28th day following birth.

2.1.15.1. General Perinatal Rules

2.1.15.1.1. **Chapter 15 Codes**

- Chapter 15 codes are never for use on the maternal record.(Chapter 11 codes are never on the newborn record). Chapter 15 codes may be used throughout the life of the patient if the condition is still present.

2.1.15.1.2. **Sequencing of perinatal codes**

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

2.1.15.1.3. **Birth process or community acquired conditions**

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

2.1.15.1.4. **Code all clinically significant conditions**

- All clinically significant conditions noted on routine newborn examination should be coded. A condition is clinically significant if it requires: clinical evaluation; or therapeutic treatment; or diagnostic procedures; or extended length of hospital stay; or increased nursing care and/or monitoring; or has implications for future health care needs.

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

2.1.15.2. 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 and are only coded on the Infant's record.

2.1.15.3. Newborn transfers

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

2.1.15.4. Use of category V29

2.1.15.4.1. **Assigning a code from category V29**

- Assign a code from category V29, Observation and evaluation of newborns and infants for suspected conditions not found, to identify those instances when a healthy newborn is evaluated for a suspected condition that is determined after study not to be present. Do not use a code from category V29 when the patient has identified signs or symptoms of a suspected problem; in such cases, code the sign or symptom. A code from category V29 may also be assigned as a principal code for readmissions or encounters when the V30 code no longer applies. Codes from category V29 are for use only for healthy newborns and infants for which no condition after study is found to be present.

2.1.15.4.2. **V29 code on a birth record**

- A V29 code can be used as a secondary code after the V30, Outcome of delivery code, if appropriate.

2.1.15.5. Use of other V codes on perinatal records

- V codes other than V30 and V29 may be assigned on a perinatal or newborn record code. The codes may be used as Principal diagnosis for specific types of encounters or for readmissions or encounters when the V30 code no longer applies.

2.1.15.6. 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.

2.1.15.7. Congenital Anomalies in Newborns

- For the birth admission, the appropriate code from category V30, Live born infants according to type of birth, should be used, followed by any congenital anomaly codes, categories 740-759. Use additional secondary codes from other chapters to specify conditions associated with the anomaly, if applicable.

2.1.15.8. Coding Additional Perinatal Diagnoses

2.1.15.8.1. **Assigning codes for conditions that require treatment**

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

2.1.15.8.2. **Codes for conditions specified as having implications for future health care needs**

- Assign codes for conditions that have been specified by the caregiver as having implications for future health care needs.
- Note: This guideline should not be used for adult patients.

2.1.15.8.3. **Codes for newborn conditions originating in the perinatal period**

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

2.1.15.9. Prematurity and Fetal Growth Retardation

- Providers utilize different criteria in determining prematurity. A code for prematurity should not be assigned unless it is documented. The 5th digit assignment for codes from category 764 and subcategories 765.0 and 765.1 should be based on the recorded birth weight and estimated gestational age. A code from subcategory 765.2, Weeks of gestation, should be assigned as an

additional code with category 764 and codes from 765.0 and 765.1 should be based on the recorded birth weight and estimated gestational age.

2.1.15.10. Newborn sepsis

- Code 771.81, Septicemia [sepsis] of newborn, should be assigned with a secondary code from category 041, Bacterial infections in conditions classified elsewhere and of unspecified site, to identify the organism. A code from category 038, Septicemia, should not be used on a newborn record. Do not assign code 995.91, Sepsis, as code 771.81 describes the sepsis. If applicable, use additional codes to identify severe sepsis (995.92) and any associated acute organ dysfunction.

2.1.16. Section Sixteen: Signs, Symptoms and Ill-Defined Conditions (780-799)

2.1.16.1. See Guidelines in 'General Guidelines'.

2.1.17. Section Seventeen: Injury and Poisoning (800-999)

2.1.17.1. 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 caregiver and the focus of treatment, is sequenced first.

2.1.17.1.1. **Superficial injuries**

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

2.1.17.1.2. **Primary injury with damage to nerves/blood vessels**

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

2.1.17.2. Coding of Traumatic 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 from 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:

2.1.17.2.1. **Acute Fractures vs. Aftercare**

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

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

- Care for complications of surgical treatment for fracture repairs during the healing or recovery phase should be coded with the appropriate complication codes. Care of complications of fractures, such as malunion and nonunion, should be reported with the appropriate codes.

- **Pathologic fractures** are not coded in the 800-829 range, but instead are assigned to subcategory 733.1

2.1.17.2.2. **Multiple fractures of same limb**

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

2.1.17.2.3. **Multiple unilateral or bilateral fractures of the same bone**

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

2.1.17.2.4. **Multiple fracture categories 819 and 828**

- Multiple fracture categories 819 and 828 classify bilateral fractures of both upper limbs (819) and both lower limbs (828),

but without any detail at the fourth-digit level other than open and closed type of fractures.

2.1.17.2.5. **Multiple fractures sequencing**

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

2.1.17.3. 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).

2.1.17.3.1. **Sequencing of burn and related condition codes**

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

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

2.1.17.3.1.2. When a patient has both internal and external burns, the circumstances of admission govern the selection of the principal diagnosis.

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

2.1.17.3.2. **Burns of the same local site**

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

2.1.17.3.3. **Non-healing burns**

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

2.1.17.3.4. **Code 958.3, Posttraumatic wound infection**

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

2.1.17.3.5. **Assign separate codes for each burn site**

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

2.1.17.3.6. **Assign codes from category 948, Burns**

- Burns are classified according to the 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:

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

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

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

  2.1.17.3.6.4. 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. Caregivers 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.

2.1.17.3.7. **Encounters for treatment of late effects of burns**

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

2.1.17.3.8. **Sequelae with a late effect code and current burn**

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

2.1.17.4. 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:

2.1.17.4.1. **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.

2.1.17.4.2. **Poisoning**

2.1.17.4.2.1. **Error was made in drug prescription**

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

2.1.17.4.2.2. **Overdose of a drug intentionally taken**

- If an overdose of a drug was intentionally taken or administered and

resulted in drug toxicity, it would be coded as a poisoning (960-979 series).

2.1.17.4.2.3. **Non-prescribed drug taken with correctly prescribed and properly administered drug**

- If a non-prescribed 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.

2.1.17.4.2.4. **Interaction of drug(s) and alcohol**

- When a reaction results from the interaction of a drug(s) and alcohol, this would be classified as poisoning.

2.1.17.4.2.5. **Sequencing of poisoning**

- When coding a poisoning or reaction to the improper use of a medication (e.g., wrong dose, wrong substance, and 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.

2.1.17.4.3. **Toxic Effects**

2.1.17.4.3.1. **Toxic effect codes**

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

2.1.17.4.3.2. **Sequencing toxic effect codes**

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

2.1.17.4.3.3. **External cause codes for toxic effects**

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

2.1.17.5. Complications of care

2.1.17.5.1. **Complications of care**

2.1.17.5.1.1. **Documentation of complications of care**

- As with all procedural or postprocedural complications, code assignment is based on the provider's documentation of the relationship between the condition and the procedure.

2.1.17.5.2. **Transplant complications**

2.1.17.5.2.1. **Transplant complications other than kidney**

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

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

2.1.17.5.2.2. **Chronic kidney disease and kidney transplant complications**

- Patients who have undergone kidney transplant may still have some form of chronic kidney disease (CKD) because the kidney transplant may not fully

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

2.1.17.5.3. **Ventilator associated pneumonia**

2.1.17.5.3.1. **Documentation of Ventilator associated Pneumonia**

- As with all procedural or postprocedural complications code assignment is based on the provider's documentation of the relationship between the condition and the procedure.

- Code 997.31, Ventilator associated pneumonia, should be assigned only when the provider has documented ventilator associated pneumonia (VAP). An additional code to identify the organism (e.g., Pseudomonas aeruginosa, code 041.7) should also be assigned. Do not assign an additional code from categories 480-484 to identify the type of pneumonia.

- Code 997.31 should not be assigned for cases where the patient has pneumonia and is on a mechanical ventilator but the provider has not specifically stated that the pneumonia is ventilator-associated pneumonia If the documentation is unclear as to whether the patient has a pneumonia that is a complication attributable to the mechanical ventilator, query the provider.

2.1.17.5.3.2. **Patient admitted with pneumonia and develops VAP**

- A patient may be admitted with one type of pneumonia (e.g., code 481, Pneumococcal pneumonia) and subsequently develop VAP. In this instance, the principal diagnosis would be the appropriate code from categories 480-484

for the pneumonia diagnosed at the time of admission. Code 997.31, Ventilator associated pneumonia, would be assigned as an additional diagnosis when the provider has also documented the presence of ventilator associated pneumonia.

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

2.1.17.6.1. The systemic inflammatory response syndrome (SIRS) can develop as a result of certain non-infectious disease processes, such as trauma, malignant neoplasm, or pancreatitis. When SIRS is documented with a noninfectious condition, and no subsequent infection is documented, the code for the underlying condition, such as an injury, should be assigned, followed by code 995.93, Systemic inflammatory response syndrome due to noninfectious process without acute organ dysfunction, or 995.94, Systemic inflammatory response syndrome due to non-infectious process with acute organ dysfunction. If an acute organ dysfunction is documented, the appropriate code(s) for the associated acute organ dysfunction(s) should be assigned in addition to code 995.94. If acute organ dysfunction is documented, but it cannot be determined if the acute organ dysfunction is associated with SIRS or due to another condition (e.g., directly due to the trauma), the provider should be queried.

2.1.18. Section Eighteen: <u>Classification of Factors Influencing Health Status and Contact with Health Service (Supplemental V01-V91)</u>

2.1.18.1. **Introduction**

- ICD-9-CM provides codes to deal with encounters for circumstances other than a disease or injury. The Supplementary Classification of Factors Influencing Health Status and Contact with Health Services (V01.0 – V91.99) is provided to deal with occasions when circumstances other than a disease or injury (codes 001-999) are recorded as a diagnosis or problem.

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

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

- 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.

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

- Newborns, to indicate birth status

2.1.18.2. **V codes use in any healthcare setting**

- V codes are for use in any healthcare setting. V codes may be used as either a principal diagnosis code or secondary code, depending on the circumstances of the encounter. Certain V codes may only be used as first listed, others only as secondary codes. *See V Code Table below*

2.1.18.3. **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, if applicable.

2.1.18.4. **Categories of V Codes**

2.1.18.4.1. **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 principal diagnosis code to explain an encounter for testing, or, more commonly, as a secondary code to identify a potential risk.

2.1.18.4.2. **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.

2.1.18.4.3. **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 or has another factor influencing a person's health. This includes such things as the presence of prosthetic or mechanical devices resulting from past treatment. A status code is informative, because the status may affect the course of treatment and its outcome. A status code is distinct from a history code. The history code indicates that the patient no longer has the condition.

- A status code should not be used with a diagnosis code from one of the body system chapters, if the diagnosis code includes the information provided by the status code. For example, code V42.1, Heart transplant status, should not be used with code 996.83, Complications of transplanted heart. The status code does not provide additional information. The complication code indicates that the patient is a heart transplant patient.

2.1.18.4.3.1. **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.

- V07.5X Use of agents affecting estrogen receptors and estrogen level this code indicates when a patient is receiving a drug that affects estrogen receptors and estrogen levels for prevention of cancer.

- V08 Asymptomatic HIV infection status. This code indicates that a patient has tested positive for HIV but has manifested no signs or symptoms of the disease. V09 Infection with drug-resistant microorganisms. This category indicates that a patient has an infection that is resistant to drug treatment. Sequence the infection code first.

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

- V21 Constitutional states in development

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

- V26.5x Sterilization status

- V42 Organ or tissue replaced by transplant

- V43 Organ or tissue replaced by other means

- V44 Artificial opening status

- V45 Other post surgical states

    - Assign code V45.87, Transplant organ removal status, to indicate that a transplanted organ has been previously removed. This code should not be assigned for the encounter in which the transplanted organ is removed. The complication necessitating removal of the

transplant organ should be assigned for that encounter. V46 Other dependence on machines

- Assign code V45.88, Status post administration of tPA (rtPA) in a different facility within the last 24 hours prior to admission to the current facility, as a secondary diagnosis when a patient is received by transfer into a facility and documentation indicates they were administered tissue plasminogen activator (tPA) within the last 24 hours prior to admission to the current facility. This guideline applies even if the patient is still receiving the tPA at the time they are received into the current facility. The appropriate code for the condition for which the tPA was administered (such as cerebrovascular disease or myocardial infarction) should be assigned first.

- Code V45.88 is only applicable to the receiving facility record and not to the transferring facility record.

  - V46 Other dependence on machine

  - V49.6 Upper limb amputation status

  - V49.7 Lower limb amputation status

  - Note: Categories V42-V46, and subcategories V49.6, V49.7 are for use only if there are no complications or malfunctions of the organ or tissue replaced, the amputation site or the equipment on which the patient is dependent.

  - V49.81 Asymptomatic postmenopausal status (age-related) (natural)

  - V49.82 Dental sealant status

  - V49.83 Awaiting organ transplant status

  - V49.86 Do not resuscitate status This code may be used when it is documented by the provider that a patient is on do not resuscitate status at any time during the stay.

  - V49.87 Physical restraint status this code may be used when it is documented by the provider that a patient has been put in restraints during the current encounter. Please note that this code should not be reported when it is documented by the provider that a patient is temporarily restrained during a procedure.

  - V58.6x Long-term (current) drug use Codes from this subcategory indicate a patient’s continuous use of a

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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. This subcategory is not for use of medications for detoxification or maintenance programs to prevent withdrawal symptoms in patients with drug dependence (e.g., methadone maintenance for opiate dependence). Assign the appropriate code for the drug dependence instead.

- Assign a code from subcategory V58.6, Long-term (current) drug use, if the patient is receiving a medication for an extended period as a prophylactic measure (such as for the prevention of deep vein thrombosis) or as treatment of a chronic condition (such as arthritis) or a disease requiring a lengthy course of treatment (such as cancer). Do not assign a code from subcategory V58.6 for medication being administered for a brief period of time to treat an acute illness or injury (such as a course of antibiotics to treat acute bronchitis). V83 Genetic carrier status Genetic carrier status indicates that a person carries a gene, associated with a particular disease, which may be passed to offspring who may develop that disease. The person does not have the disease and is not at risk of developing the disease. V84 Genetic susceptibility status Genetic susceptibility indicates that a person has a gene that increases the risk of that person developing the disease.

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

- V84 Genetic susceptibility status Genetic susceptibility indicates that a person has a gene that increases the risk of that person developing the disease. Codes from category V84, Genetic susceptibility to disease, should not be used as principal or first-listed codes. If the patient has the condition to which he/she is susceptible, and that condition is the reason for the encounter, the code for the current condition should be sequenced first. If the patient is being seen for follow-up after completed treatment for this condition, and the condition no longer exists, a follow-up code should be sequenced first, followed by the appropriate personal history and genetic susceptibility codes. If the purpose of the encounter is genetic counseling associated with procreative management, a code from subcategory V26.3, Genetic counseling and testing, should be assigned as the first-listed code, followed by a code

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from category V84. Additional codes should be assigned for any applicable family or personal history

- V85 Body Mass Index (BMI)
- V86 Estrogen receptor status
- V88 Acquired absence of other organs and tissue
- V90 Retained foreign body

2.1.18.4.4. **History (of)**

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

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

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

- The history V code categories are:
    - V10 Personal history of malignant neoplasm = this code should **always** be used for every encounter when the neoplasm has been removed or is no longer active.
    - V12 Personal history of certain other diseases
    - V13 Personal history of other diseases Except: V13.4, Personal history of arthritis, and **subcategory** V13.6, **Personal history of congenital (corrected)** 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
- V87 Other specified personal exposures and history presenting hazards to health

2.1.18.4.5. **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

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2.1.18.4.6. **Observation**

- There are three 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.

- **<u>The observation codes are to be used as principal diagnosis only</u>**. 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.

- Codes from subcategory V89.0, Suspected maternal and fetal conditions not found, may either be used as a first listed or as an additional code assignment depending on the case. They are for use in very limited circumstances on a maternal record when an encounter is for a suspected maternal or fetal condition that is ruled out during that encounter (for example, a maternal or fetal condition may be suspected due to an abnormal test result). These codes should not be used when the condition is confirmed. In those cases, the confirmed condition should be coded. In addition, these codes are not for use if an illness or any signs or symptoms related to the suspected condition or problem are present. In such cases the diagnosis/symptom code is used.

- Additional codes may be used in addition to the code from subcategory V89.0, but only if they are unrelated to the suspected condition being evaluated.

- Codes from subcategory V89.0 may not be used for encounters for antenatal screening of mother. For encounters for suspected fetal condition that are inconclusive following testing and evaluation, assign the appropriate code from category 655, 656, 657 or 658.

- The observation V code categories:

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

  - V71 Observation and evaluation for suspected condition not found.

  - V89 Suspected maternal and fetal conditions not found

2.1.18.4.7. **Aftercare**

- Aftercare visit codes cover situations when the initial treatment of a disease or injury has been performed and the patient requires continued care during the healing or recovery phase, or for the long-term consequences of the disease. The aftercare V code should not be used if treatment is directed at

- A current, acute disease or injury. The diagnosis code is to be used in these cases. Exceptions to this rule are codes V58.0, Radiotherapy, and codes from subcategory V58.1, Encounter for chemotherapy and immunotherapy for neoplastic conditions. These codes are to be first listed, followed by the diagnosis code when a patient's encounter is solely to receive radiation therapy or chemotherapy for the treatment of a neoplasm. Should a patient receive both chemotherapy and radiation therapy during the same encounter code V58.0 and V58.1 may be used together on a record with either one being sequenced first.

- Aftercare codes should be used in conjunction with any other aftercare codes or other diagnosis codes to provide better detail on the specifics of an aftercare encounter visit, unless otherwise directed by the classification. The sequencing of multiple aftercare codes is discretionary.. An example of this would be the closure of a colostomy during an encounter for treatment of another condition.

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

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

- Status V codes may be used with aftercare V codes to indicate the nature of the aftercare. For example code V45.81, Aortocoronary bypass status, may be used with code V58.73, Aftercare following surgery of the circulatory system, NEC, to indicate the surgery for which the aftercare is being performed. Also, a transplant status code may be used following code V58.44, Aftercare following organ transplant, to identify the organ transplanted. A status code should **not** be used when the aftercare code indicates the type of status, such as using V55.0, Attention to tracheostomy with V44.0, Tracheostomy status.

- **The aftercare V category/codes:**
    - V51.0 Encounter for breast reconstruction following mastectomy
    - V52 Fitting and adjustment of prosthetic device and implant

- V53 Fitting and adjustment of other device
- V54 Other orthopedic aftercare
- V55 Attention to artificial openings
- V56 Encounter for dialysis and dialysis catheter care
- V57 Care involving the use of rehabilitation procedures
- V58.0 Radiotherapy
- V58.11 Encounter for antineoplastic chemotherapy
- V58.12 Encounter for antineoplastic immunotherapy
- V58.3x Attention to dressings and sutures
- V58.41 Encounter for planned post-operative wound closureV58.42 Aftercare, surgery, neoplasm
- V58.42 Aftercare, surgery, neoplasm
- V58.43 Aftercare, surgery, trauma
- V58.44 Aftercare involving organ transplant
- V58.49 Other specified aftercare following surgery
- V58.7x Aftercare following surgery
- V58.81 Fitting and adjustment of vascular catheter
- V58.82 Fitting and adjustment of non-vascular catheter
- V58.83 Monitoring therapeutic drug
- V58.89 Other specified aftercare

2.1.18.4.8. **Follow-up**

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

- A follow-up code may be used to explain repeated visits. Should a condition be found to have recurred on the follow-up visit, then the diagnosis code should be used in place of the follow-up code.

- The follow-up V code categories:

  - V24 Postpartum care and evaluation

  - V67 Follow-up examination

2.1.18.4.9. **Donor**

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

2.1.18.4.10. **Counseling**

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

- The counseling V categories/codes:

  - V25.0 General counseling and advice for contraceptive management

  - V26.3 Genetic counseling

  - V26.4 General counseling and advice for procreative management

  - V61.X 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

2.1.18.4.11. **Obstetrics and related conditions**

- V codes for pregnancy are for use in those circumstances when none of the problems or complications included in the codes from the Obstetrics chapter exist (a routine prenatal visit or postpartum care). Codes V22.0, Supervision of normal first pregnancy, and V22.1,

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Supervision of other normal pregnancy, are always principal diagnoses 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

  - V26 Procreative management - Except V26.5x, Sterilization status, V26.3 and V26.4

    - V27 Outcome of delivery

    - V28 Antenatal screening

2.1.18.4.12. **Newborn, infant and child**

- Newborn V code categories:

  - V20 Health supervision of infant or child

  - V29 Observation and evaluation of newborns for suspected condition not found

  - V30-V39 Live-born infant according to type of birth

2.1.18.4.13. **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 or general checkup. The codes are not to be used if the examination is for diagnosis of a suspected condition or for treatment purposes. In such cases the diagnosis code is used. During a routine exam, should a diagnosis or condition be discovered, it should be coded as an

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

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

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

    - V20.2 Routine infant or child health check. Any injections given should have a corresponding procedure code.

    - V70 General medical examination

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

2.1.18.4.14. **Miscellaneous V codes**

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

- **Prophylactic Organ Removal**

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

- If the patient has a malignancy of one site and is having prophylactic removal at another site to prevent either a new primary malignancy or metastatic disease, a code for the malignancy should also be assigned in addition to a code from subcategory V50.4. A V50.4 code should not be assigned if the patient is having organ removal for **treatment** of a malignancy, such as the removal of the testes for the treatment of prostate cancer.

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- Miscellaneous V code categories/codes:
    - V07 Need for isolation and other prophylactic measures - Except V07.5X, Use of agents affecting estrogen receptors and estrogen level
    - 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

2.1.18.4.15. **Nonspecific V codes**

- Certain V codes are so non-specific, or potentially redundant with other codes in the classification, that there can be little justification for their use in the inpatient setting. Their use in the outpatient

  setting should be limited to those instances when there is no further documentation to permit more precise coding. Otherwise, any sign or symptom or any other reason for visit that is captured in another code should be used.

- Nonspecific V code categories/codes:
    - V11 Personal history of mental disorder. A code from the mental disorders chapter, with an “in remission” fifth-digit, should be used.
    - V13.4 Personal history of arthritis
    - V13.6 Personal history of congenital malformations V15.7 Personal history of contraception
    - V23.2 Pregnancy with history of abortion
    - V40 Mental and behavioral problems

- V41 Problems with special senses and other special functions \
- V47 Other problems with internal organs
- V48 Problems with head, neck, and trunk
- V49 Problems with limbs and other problems
- **Exceptions:**
  - V49.6 Upper limb amputation status
  - V49.7 Lower limb amputation status
  - V49.81 Asymptomatic postmenopausal status (age-related) (natural)
  - V49.82 Dental sealant status
  - V49.83 Awaiting organ transplant status
  - V49.86 Do not resuscitate status
  - V49.87 Physical restraints statuV51 Aftercare involving the use of plastic surgery
- V51.8 Other aftercare involving the use of plastic surgery
- V58.2 Blood transfusion, without reported diagnosis
- V58.9 Unspecified aftercare

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

- The list of V codes/categories below may only be reported as the principal/first-listed diagnosis, except when there are multiple encounters on the same day and the medical records for the encounters are combined or when there is more than one V code that meets the definition of principal diagnosis (e.g., a patient is admitted to home healthcare for both aftercare and rehabilitation and they equally meet the definition of principal diagnosis). These codes should not be reported if they do not meet the definition of principal or first-listed diagnosis.
- See Chapter Four Section Three for information on selection of principal and first-listed diagnosis.

- See Chapter Four Section Three information on two or more diagnoses that equally meet the definition for principal diagnosis
  - V20.X Health supervision of infant or child
  - V22.0 Supervision of normal first pregnancy

- V22.1 Supervision of other normal pregnancy
- V24.X Postpartum care and examination
- V26.81 Encounter for assisted reproductive fertility procedure cycle
- V26.82 Encounter for fertility preservation procedure
- V30.X Single liveborn
- V31.X Twin, mate liveborn
- V32.X Twin, mate stillborn
- V33.X Twin, unspecified
- V34.X Other multiple, mates all liveborn
- V35.X Other multiple, mates all stillborn
- V36.X Other multiple, mates live- and stillborn
- V37.X Other multiple, unspecified
- V39.X Unspecified
- V46.12 Encounter for respirator dependence during power failure
- V46.13 Encounter for weaning from respirator [ventilator]
- V51.0 Encounter for breast reconstruction following mastectomy
- V56.0 Extracorporeal dialysis
- V57.X Care involving use of rehabilitation procedures
- V58.0 Radiotherapy
- V58.11 Encounter for antineoplastic chemotherapy
- V58.12 Encounter for antineoplastic immunotherapy
- V59.X Donors
- V66.0 Convalescence and palliative care following surgery
- V66.1 Convalescence and palliative care following radiotherapy
- V66.2 Convalescence and palliative care following chemotherapy
- V66.3 Convalescence and palliative care following psychotherapy and other treatment for mental disorder

- V66.4 Convalescence and palliative care following treatment of fracture
- V66.5 Convalescence and palliative care following other treatment
- V66.6 Convalescence and palliative care following combined treatment
- V66.9 Unspecified convalescence
- V68.X Encounters for administrative purposes
- V70.0 Routine general medical examination at a health care facility
- V70.1 General psychiatric examination, requested by the authority
- V70.2 General psychiatric examination, other and unspecified
- V70.3 Other medical examination for administrative purposes
- V70.4 Examination for medico legal reasons
- V70.5 Health examination of defined subpopulations
- V70.6 Health examination in population surveys
- V70.8 Other specified general medical examinations
- V70.9 Unspecified general medical examination
- V71.X Observation and evaluation for suspected conditions not found

2.1.18.6. **V Codes Table for Sequencing:**

Code(s)	Description	1st Dx Only (Used for Principal Dx Only)	1st or Add'l Dx (Can be Principal or Additional Dx	Add'l Dx Only (Used as a Additional Dx Only)	Non-Specific Dx (Generally for nonacute or for when no sign or symptom - Can be Principal or Additional Dx)
V01.0	Cholera Contact		X		
V01.1	Tuberculosis Contact		X		
V01.2	Poliomyelitis Contact		X		
V01.3	Smallpox Contact		X		
V01.4	Rubella Contact		X		
V01.5	Rabies Contact		X		
V01.6	Venereal Dis Contact		X		
V01.71	Varicella Contact/Exp		X		
V01.79	Viral Dis Contact Nec		X		

Code(s)	Description	1st Dx Only (Used for Principal Dx Only)	1st or Add'l Dx (Can be Principal or Additional Dx	Add'l Dx Only (Used as a Additional Dx Only)	Non-Specific Dx (Generally for nonacute or for when no sign or symptom - Can be Principal or Additional Dx)
V01.81	Contact/Exposure-Anthrax		X		
V01.82	Exposure To Sars		X		
V01.83	E. Coli Contact/Exp		X		
V01.84	Meningococcus Contact		X		
V01.89	Communic Dis Contact Nec		X		
V01.9	Communic Dis Contact Nos		X		
V02.0	Cholera Carrier		X		
V02.1	Typhoid Carrier		X		
V02.2	Amebiasis Carrier		X		
V02.3	Gi Pathogen Carrier Nec		X		
V02.4	Diphtheria Carrier		X		
V02.51	Group B Streptoc Carrier		X		
V02.52	Streptococus Carrier Nec		X		
V02.54	Carrier or suspected carrier of Methicillin resistant Staphylococcus aureus		X		
V02.59	Bacteria Dis Carrier Nec		X		
V02.60	Viral Hep Carrier Nos		X		
V02.61	Hepatitis B Carrier		X		
V02.62	Hepatitis C Carrier		X		
V02.69	Viral Hep Carrier Nec		X		
V02.7	Gonorrhea Carrier		X		
V02.8	Venereal Dis Carrier Nec		X		
V02.9	Carrier Nec		X		
V03.1	Vacc-Typhoid-Paratyphoid		X		
V03.2	Vaccin For Tuberculosis		X		
V03.3	Vaccin For Plague		X		
V03.4	Vaccin For Tularemia		X		
V03.5	Vaccin For Diphtheria		X		
V03.6	Vaccin For Pertussis		X		
V03.7	Tetanus Toxoid Inoculat		X		
V03.81	Nd Vac Hmophlus Inflnz B		X		
V03.82	Nd Vac Strptcs Pneumni B		X		
V03.89	Nd Other Specf Vacnation		X		
V03.9	Vaccin For Bact Dis Nos		X		
V04.0	Vaccin For Poliomyelitis		X		
V04.1	Vaccin For Smallpox		X		
V04.2	Vaccin For Measles		X		
V04.3	Vaccin For Rubella		X		
V04.4	Vaccin For Yellow Fever		X		

V04.5	Vaccin For Rabies		X		
V04.6	Vaccin For Mumps		X		
V04.7	Vaccin For Common Cold		X		
Code(s)	**Description**	**1st Dx Only (Used for Principal Dx Only)**	**1st or Add'l Dx (Can be Principal or Additional Dx**	**Add'l Dx Only (Used as a Additional Dx Only)**	**Non-Specific Dx (Generally for nonacute or for when no sign or symptom - Can be Principal or Additional Dx)**
V04.81	Vaccin For Influenza		X		
V04.82	Vaccination For Rsv		X		
V04.89	Vaccn/Inoc Viral Dis Nec		X		
V05.0	Arbovirus Enceph Vaccin		X		
V05.1	Vacc Arboviral Dis Nec		X		
V05.2	Vaccin For Leishmaniasis		X		
V05.3	Need Prphyl Vc Vrl Hepat		X		
V05.4	Need Prphyl Vc Varicella		X		
V05.8	Vaccin For Disease Nec		X		
V05.9	Vaccin For Singl Dis Nos		X		
V06.0	Vaccin For Cholera + Tab		X		
V06.1	Vaccination For Dtp-Dtap		X		
V06.2	Vaccin For Dtp + Tab		X		
V06.3	Vaccin For Dtp + Polio		X		
V06.4	Vac-Measle-Mumps-Rubella		X		
V06.5	Vaccination For Td-Dt		X		
V06.6	Nd Vac Strp Pnumn/Inflnz		X		
V06.8	Vac-Dis Combinations Nec		X		
V06.9	Vac-Dis Combinations Nos		X		
V07.0	Prophylactic Isolation		X		
V07.1	Desensitiza To Allergens		X		
V07.2	Prophylact Immunotherapy		X		
V07.31	Prophylac Fluoride Admin		X		
V07.39	Other Prophylac Chemothr		X		
V07.4	Hormone Replace Postmeno		X		
V07.51	Prophylactic use of selective estrogen receptor modulators (SERMs)			X	
V07.52	Prophylactic use of aromatase inhibitors			X	
V07.59	Prophylactic use of other agents affecting estrogen receptors and estrogen levels			X	
V07.8	Prophylactic Measure Nec				X
V07.9	Prophylactic Measure Nos		X		
V08	Asymp Hiv Infectn Status		X		
V09.0	Inf Mcrg Rstn Pncllins			X	
V09.1	Inf Mcrg Rstn B-Lactam			X	
V09.2	Inf Mcrg Rstn Macrolides			X	

Code(s)	Description	1st Dx Only (Used for Principal Dx Only)	1st or Add'l Dx (Can be Principal or Additional Dx	Add'l Dx Only (Used as a Additional Dx Only)	Non-Specific Dx (Generally for nonacute or for when no sign or symptom - Can be Principal or Additional Dx)
V09.3	Inf Mcrg Rstn Ttrcycln			X	
V09.4	Inf Mcrg Rstn Amnglcsds			X	
V09.50	Inf Mcr Rst Qn Flr Nt Ml			X	
V09.51	Inf Mcrg Rstn Qn Flrq Ml			X	
V09.6	Inf Mcrg Rstn Sulfnmides			X	
V09.70	Inf Mcr Rst Oth Ag Nt Ml			X	
V09.71	Inf Mcrg Rstn Oth Ag Mlt			X	
V09.80	Inf Mcr Rst Ot Drg Nt Ml			X	
V09.81	Inf Mcrg Rstn Oth Drg Ml			X	
V09.90	Infc Mcrg Drgrst Nt Mult			X	
V09.91	Infc Mcrg Drgrst Mult			X	
V10.00	Hx Of Gi Malignancy Nos		X		
V10.01	Hx Of Tongue Malignancy		X		
V10.02	Hx-Oral/Pharynx Malg Nec		X		
V10.03	Hx-Esophageal Malignancy		X		
V10.04	Hx Of Gastric Malignancy		X		
V10.05	Hx Of Colonic Malignancy		X		
V10.06	Hx-Rectal & Anal Malign		X		
V10.07	Hx Of Liver Malignancy		X		
V10.09	Hx Of Gi Malignancy Nec		X		
V10.11	Hx-Bronchogenic Malignan		X		
V10.12	Hx-Tracheal Malignancy		X		
V10.20	Hx-Resp Org Malignan Nos		X		
V10.21	Hx-Laryngeal Malignancy		X		
V10.22	Hx-Nose/Ear/Sinus Malig		X		
V10.29	Hx-Intrathoracic Mal Nec		X		
V10.3	Hx Of Breast Malignancy		X		
V10.40	Hx-Female Genit Malg Nos		X		
V10.41	Hx-Cervical Malignancy		X		
V10.42	Hx-Uterus Malignancy Nec		X		
V10.43	Hx Of Ovarian Malignancy		X		
V10.44	Hx-Female Genit Malg Nec		X		
V10.45	Hx-Male Genit Malig Nos		X		
V10.46	Hx-Prostatic Malignancy		X		
V10.47	Hx-Testicular Malignancy		X		
V10.48	Hx-Epididymis Malignancy		X		
V10.49	Hx-Male Genit Malig Nec		X		
V10.50	Hx-Urinary Malignan Nos		X		

Code(s)	Description	1st Dx Only (Used for Principal Dx Only)	1st or Add'l Dx (Can be Principal or Additional Dx	Add'l Dx Only (Used as a Additional Dx Only)	Non-Specific Dx (Generally for nonacute or for when no sign or symptom - Can be Principal or Additional Dx)
V10.51	Hx Of Bladder Malignancy		X		
V10.52	Hx Of Kidney Malignancy		X		
V10.53	Hx Malig Renal Pelvis		X		
V10.59	Hx-Urinary Malignan Nec		X		
V10.60	Hx Of Leukemia Nos		X		
V10.61	Hx Of Lymphoid Leukemia		X		
V10.62	Hx Of Myeloid Leukemia		X		
V10.63	Hx Of Monocytic Leukemia		X		
V10.69	Hx Of Leukemia Nec		X		
V10.71	Hx-Lymphosarcoma		X		
V10.72	Hx-Hodgkin'S Disease		X		
V10.79	Hx-Lymphatic Malign Nec		X		
V10.81	Hx Of Bone Malignancy		X		
V10.82	Hx-Malig Skin Melanoma		X		
V10.83	Hx-Skin Malignancy Nec		X		
V10.84	Hx Of Eye Malignancy		X		
V10.85	Hx Of Brain Malignancy		X		
V10.86	Hx-Malign Nerve Syst Nec		X		
V10.87	Hx Of Thyroid Malignancy		X		
V10.88	Hx-Endocrine Malign Nec		X		
V10.89	Hx Of Malignancy Nec		X		
V10.90	Personal history of unspecified malignant neoplasm				X
V10.91	Personal history of malignant neuroendocrine tumor		X		
V11.0	Hx Of Schizophrenia				X
V11.1	Hx Of Affective Disorder				X
V11.2	Hx Of Neurosis				X
V11.3	Hx Of Alcoholism				X
V11.4	Personal history of combat and operational stress reaction				X
V11.8	Hx-Mental Disorder Nec				X
V11.9	Hx-Mental Disorder Nos				X
V12.00	Prsnl Hst Unsp Nfct Prst		X		
V12.01	Prsnl Hst Tuberculosis		X		
V12.02	Prsnl Hst Poliomyelitis		X		
V12.03	Personal Histry Malaria		X		
V12.04	Personal history of Methicillin resistant Staphylococcus aureus		X		
V12.09	Prsnl Hst Oth Nfct Parst		X		

Code(s)	Description	1st Dx Only (Used for Principal Dx Only)	1st or Add'l Dx (Can be Principal or Additional Dx	Add'l Dx Only (Used as a Additional Dx Only)	Non-Specific Dx (Generally for nonacute or for when no sign or symptom - Can be Principal or Additional Dx)
V12.1	Hx-Nutrition Deficiency		X		
V12.2	Hx-Endocr/Meta/Immun Dis		X		
V12.3	Hx-Blood Diseases		X		
V12.40	Hx Nerv Sys/Snse Org Nos		X		
V12.41	Hx Benign Neoplasm Brain		X		
V12.42	Personl Hx Infection Cns		X		
V12.49	Hx Nerv Sys/Snse Org Nec		X		
V12.50	Hx-Circulatory Dis Nos		X		
V12.51	Hx-Ven Thrombosis/Embols		X		
V12.52	Hx-Thrombophlebitis		X		
V12.53	Hx Sudden Cardiac Arrest		X		
V12.54	Hx Tia/Stroke W/O Resid		X		
V12.59	Hx-Circulatory Dis Nec		X		
V12.60	Hx Resp System Dis Nos		X		
V12.61	Prsnl Hx Recur Pneumonia		X		
V12.69	Hx Resp System Dis Nec		X		
V12.70	Prsnl Hst Unspc Dgstv Ds		X		
V12.71	Prsnl Hst Peptic Ulcr Ds		X		
V12.72	Prsnl Hst Colonic Polyps		X		
V12.79	Prsnl Hst Ot Spf Dgst Ds		X		
V13.00	Prsnl Hst Urnr Dsrd Unsp		X		
V13.01	Prsnl Hst Urnr Dsrd Calc		X		
V13.02	Personal History Uti		X		
V13.03	Personl Hx Nephrotic Syn		X		
V13.09	Prsn Hst Ot Spf Urn Dsrd		X		
V13.1	Personal history of trophoblastic disease		X		
V13.21	History-Pre-Term Labor		X		
V13.22	Hx Of Cervical Dysplasia		X		
V13.23	Personal history of vaginal dysplasia		X		
V13.24	Personal history of vulvar dysplasia		X		
V13.29	Hx-Genital/Obs Dis Nec		X		
V13.3	Personal history of skin and subcutaneous tissue		X		
V13.4	Personal history of arthritis				X
V13.51	Personal history of pathologic fracture		X		
V13.52	Personal history of stress fracture		X		
V13.59	Personal history of other musculoskeletal disorders				X
V13.61	Personal history of hypospadias			X	

Code(s)	Description	1st Dx Only (Used for Principal Dx Only)	1st or Add'l Dx (Can be Principal or Additional Dx	Add'l Dx Only (Used as a Additional Dx Only)	Non-Specific Dx (Generally for nonacute or for when no sign or symptom - Can be Principal or Additional Dx)
V13.62	Personal history of other (corrected) congenital malformations of genitourinary system			X	
V13.63	Personal history of (corrected) congenital malformations of nervous system			X	
V13.64	Personal history of (corrected) congenital malformations of eye, ear, face and neck			X	
V13.65	Personal history of (corrected) congenital malformations of heart and circulatory system			X	
V13.66	Personal history of (corrected) congenital malformations of respiratory system			X	
V13.67	Personal history of (corrected) congenital malformations of digestive system			X	
V13.68	Personal history of (corrected) congenital malformations of integument, limbs, and musculoskeletal systems			X	
V13.69	Personal history of congenital malformations				X
V13.7	Personal history of perinatal problems		X		
V13.8	Personal history of other specified diseases		X		
V13.9	Personal history of unspecified disease				**X**
V14.0	Hx-Penicillin Allergy			X	
V14.1	Hx-Antibiot Allergy Nec			X	
V14.2	Hx-Sulfonamides Allergy			X	
V14.3	Hx-Anti-Infect Allergy			X	
V14.4	Hx-Anesthetic Allergy			X	
V14.5	Hx-Narcotic Allergy			X	
V14.6	Hx-Analgesic Allergy			X	
V14.7	Hx-Vaccine Allergy			X	
V14.8	Hx-Drug Allergy Nec			X	
V14.9	Hx-Drug Allergy Nos			X	
V15.01	Hx-Peanut Allergy			X	
V15.02	Hx-Milk Prod Allergy			X	
V15.03	Hx-Eggs Allergy			X	
V15.04	Hx-Seafood Allergy			X	
V15.05	Hx-Other Food Allergy			X	
V15.06	Allergy to insects and arachnids			X	
V15.06	Hx-Insects Allergy			X	
V15.07	Hx-Latex Allergy			X	
V15.08	Hx-Radiogrphc Dye Allrgy			X	
V15.09	Hx-Allergy Nec			X	
V15.0X	Personal history of allergy, other than to medicinal agents			X	

Code(s)	Description	1st Dx Only (Used for Principal Dx Only)	1st or Add'l Dx (Can be Principal or Additional Dx	Add'l Dx Only (Used as a Additional Dx Only)	Non-Specific Dx (Generally for nonacute or for when no sign or symptom - Can be Principal or Additional Dx)
V15.1	Personal history of surgery to heart and great vessels			X	
V15.21	Personal history of undergoing in utero procedure during pregnancy			X	
V15.22	Personal history of undergoing in utero procedure while a fetus			X	
V15.29	Personal history of surgery to other organs			X	
V15.3	Personal history of irridiation			X	
V15.41	Hx Of Physical Abuse			X	
V15.42	Hx Of Emotional Abuse			X	
V15.49	Psychological Trauma Nec			X	
V15.51	Personal history of traumatic fracture			X	
V15.52	Personal history of traumatic brain injury			X	
V15.53	Personal history of retained foreign body fully removed			X	
V15.59	Personal history of other injury			X	
V15.6	Personal history of poisoning			X	
V15.7	Personal history of contraception			X	
V15.80	Personal history of failed moderate sedation				X
V15.81	Personal history of noncompliance with medical treatment			X	
V15.82	Personal history of tobacco use			X	
V15.83	Personal history of underimmunization status			X	
V15.84	Personal history of contact with and (suspected) exposure to asbestos			X	
V15.85	Personal history of contact with and (suspected) exposure to potentially hazardous body fluids			X	
V15.86	Personal history of contact with and (suspected) exposure to lead			X	
V15.87	Personal history of extracorporeal membrane oxygenation [ECMO]			X	
V15.88	History of fall		X		
V15.89	Other specified personal history presenting hazards to health			X	
V15.9	Uspeciffied personal history presenting hazards to health				X
V16.0	Family Hx-Gi Malignancy		X		
V16.1	Fm Hx-Trach/Bronchog Mal		X		
V16.2	Fam Hx-Intrathoracic Mal		X		
V16.3	Family Hx-Breast Malig		X		
V16.40	Fm Hx Genital Malig Nos		X		
V16.41	Fm Hx Ovary Malignancy		X		

Code(s)	Description	1st Dx Only (Used for Principal Dx Only)	1st or Add'l Dx (Can be Principal or Additional Dx	Add'l Dx Only (Used as a Additional Dx Only)	Non-Specific Dx (Generally for nonacute or for when no sign or symptom - Can be Principal or Additional Dx)
V16.42	Fm Hx Prostate Malig		X		
V16.43	Fm Hx Testis Malig		X		
V16.49	Fm Hx Genital Malig Nec		X		
V16.51	Family Hx-Kidney Malig		X		
V16.52	Fam Hx-Bladder Malig		X		
V16.59	Fam Hx-Urinry Malig Nec		X		
V16.6	Family Hx-Leukemia		X		
V16.7	Fam Hx-Lymph Neoplas Nec		X		
V16.8	Family Hx-Malignancy Nec		X		
V16.9	Family Hx-Malignancy Nos		X		
V17.0	Fam Hx-Psychiatric Cond		X		
V17.1	Family Hx-Stroke		X		
V17.2	Fam Hx-Neurolog Dis Nec		X		
V17.3	Fam Hx-Ischem Heart Dis		X		
V17.41	Fam Hx Sudden Card Death		X		
V17.49	Fam Hx-Cardiovas Dis Nec		X		
V17.5	Family Hx-Asthma		X		
V17.6	Fam Hx-Chr Resp Cond Nec		X		
V17.7	Family Hx-Arthritis		X		
V17.81	Family Hx Osteoporosis		X		
V17.89	Fam Hx Musculosk Dis Nec		X		
V18.0	Fam Hx-Diabetes Mellitus		X		
V18.11	Fam Hx Men Syndrome		X		
V18.19	Fm Hx Endo/Metab Dis Nec		X		
V18.2	Family Hx-Anemia		X		
V18.3	Fam Hx-Blood Disord Nec		X		
V18.4	Fam Hx-Mental Retardat		X		
V18.51	Family Hx Colonic Polyps		X		
V18.59	Fam Hx Digest Disord Nec		X		
V18.61	Fam Hx-Polycystic Kidney		X		
V18.69	Fam Hx-Kidney Dis Nec		X		
V18.7	Family Hx-Gu Disease Nec		X		
V18.8	Fm Hx-Infect/Parasit Dis		X		
V18.9	Fam Hx Genet Dis Carrier		X		
V19.0	Family Hx-Blindness		X		
V19.1	Family Hx-Eye Disord Nec		X		
V19.2	Family Hx-Deafness		X		
V19.3	Family Hx-Ear Disord Nec		X		

Code(s)	Description	1st Dx Only (Used for Principal Dx Only)	1st or Add'l Dx (Can be Principal or Additional Dx	Add'l Dx Only (Used as a Additional Dx Only)	Non-Specific Dx (Generally for nonacute or for when no sign or symptom - Can be Principal or Additional Dx)
V19.4	Family Hx-Skin Condition		X		
V19.5	Fam Hx-Congen Anomalies		X		
V19.6	Family Hx-Allergic Dis		X		
V19.7	Consanguinity		X		
V19.8	Family Hx-Condition Nec		X		
V20.0	Foundling Health Care	X			
V20.1	Care Of Healthy Chld Nec	X			
V20.2	Routin Child Health Exam	X			
V20.31	Health supervision for newborn under 8 days old	X			
V20.32	Health supervision for newborn 8 to 28 days old	X			
V21.0	Rapid Childhood Growth			X	
V21.1	Puberty			X	
V21.2	Adolescence Growth Nec			X	
V21.30	Low Birthwt Status Nos			X	
V21.31	Low Birthwt Status <500G			X	
V21.32	Low Birthwt 500-999G			X	
V21.33	Low Birthwt 1000-1499G			X	
V21.34	Low Birthwt 1500-1999G			X	
V21.35	Low Birthwt 2000-2500G			X	
V21.8	Constit State In Dev Nec			X	
V21.9	Constit State In Dev Nos			X	
V22.0	Supervision of normal first pregnancy	X			
V22.1	Supervision of other normal pregnancy	X			
V22.2	Pregnancy state, incidental			X	
V23.0	Preg W Hx Of Infertility		X		
V23.1	Preg W Hx-Trophoblas Dis		X		
V23.2	Preg W Hx Of Abortion		X		
V23.3	Grand Multiparity		X		
V23.41	Preg W Hx Pre-Term Labor		X		
V23.49	Preg W Poor Obs Hx Nec		X		
V23.5	Preg W Poor Reproduct Hx		X		
V23.7	Insufficnt Prenatal Care		X		
V23.81	Suprv Elderly Primigrav		X		
V23.82	Suprv Elderly Multigrav		X		
V23.83	Suprv Young Primigravida		X		
V23.84	Suprv Young Multigravida		X		
V23.85	Pregnancy resulting from assisted reproductive technology		X		

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V23.86	Pregnancy with history of in utero procedure during previous pregnancy		X		
V23.89	Suprv High-Risk Preg Nec		X		
V23.9	Suprv High-Risk Preg Nos		X		
V24.0	Postpart Care After Del	X			
V24.1	Postpart Care-Lactation	X			
V24.2	Rout Postpart Follow-Up	X			
V25.01	Prescrip-Oral Contracept		X		
V25.02	Initiate Contracept Nec		X		
V25.03	Contracept Mgmt-Emergncy		X		
V25.04	Natrl Fam Pln-Avoid Preg		X		
V25.09	Contraceptive Mangmt Nec		X		
V25.11	Encounter for insertion of intrauterine contraceptive device		X		
V25.12	Encounter for removal of intrauterine contraceptive device		X		
V25.13	Encounter for removal and reinsertion of intrauterine contraceptive device		X		
V25.2	Sterilization		X		
V25.3	Menstrual Extraction		X		
V25.40	Contracept Surveill Nos		X		
V25.41	Contracept Pill Surveill		X		
V25.42	Iud Surveillance		X		
V25.43	Srvl Mplnt Sbdrm Cntrcep		X		
V25.49	Contracept Surveill Nec		X		
V25.5	Nsrt Mplnt Sbdrm Cntrcep		X		
V25.8	Contraceptive Mangmt Nec		X		
V25.9	Contraceptive Mangmt Nos		X		
V26.0	Tuboplasty or vasoplasty after previous sterilization		X		
V26.1	Artificial insemination		X		
V26.21	Fertility Testing		X		
V26.22	Sterilzation Rev Aftcare		X		
V26.29	Investigate & Test Nec		X		
V26.31	Fem Genetic Test Dis Car		X		
V26.32	Female Genetic Test Nec		X		
V26.33	Genetic Counseling		X		
V26.34	Male Genetc Test Dis Car		X		
V26.35	Encounter for testing of male partner of female with recurrent pregnancy loss		X		

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V26.39	Male Genetic Test Nec		X		
V26.41	Natrl Family Plan Counsl		X		
V26.42	Encounter for fertility preservation counseling				
V26.49	Procr Mgmt Cnsl/Adv Nec		X		
V26.51	Tubal Ligation Status			X	
V26.52	Vasectomy Status			X	
V26.81	Assist Repro Fertility		X		
V26.82	Encounter for fertility preservation procedure		X		
V26.89	Procreative Managemt Nec		X		
V26.9	Procreative Mangmt Nos		X		
V27.0	Deliver-Single Liveborn			X	
V27.1	Deliver-Single Stillborn			X	
V27.2	Deliver-Twins, Both Live			X	
V27.3	Del-Twins, 1 Nb, 1 Sb			X	
V27.4	Deliver-Twins, Both Sb			X	
V27.5	Del-Mult Birth, All Live			X	
V27.6	Del-Mult Brth, Some Live			X	
V27.7	Del-Mult Birth, All Sb			X	
V27.9	Outcome Of Delivery Nos			X	
V28.0	Screening-Chromosom Anom		X		
V28.1	Screen-Alphafetoprotein		X		
V28.2	Screen By Amniocent Nec		X		
V28.3	Encounter for routine screening for malformation using ultrasonics		X		
V28.3	Screen-Fetal Malform		X		
V28.4	Screen-Fetal Retardation		X		
V28.5	Screen-Isoimmunization		X		
V28.6	Antenatal Screen Strep B		X		
V28.81	Encounter for fetal anatomic survey		X		
V28.82	Encounter for screening for risk of pre-term labor		X		
V28.89	Other specified antenatal screening				X
V28.9	Antenatal Screening Nos		X		
V29.0	Nb Obsrv Suspct Infect		X		
V29.1	Nb Obsrv Suspct Neurlgcl		X		
V29.2	Obsrv Nb Suspc Resp Cond		X		
V29.3	Nb Obs Genetc/Metabl Cnd		X		
V29.8	Nb Obsrv Oth Suspct Cond		X		
V29.9	Nb Obsrv Unsp Suspct Cnd		X		
V30.00	Single Lb In-Hosp W/O Cs	X			

V30.01	Single Lb In-Hosp W Cs	X			
V31.00	Twin-Mate Lb-Hosp W/O Cs	X			
V31.01	Twin-Mate Lb-In Hos W Cs	X			
V31.1	Twin, Mate Lb-Before Adm	X			
V31.2	Twin, Mate Lb-Nonhosp	X			
V32.00	Twin-Mate Sb-Hosp W/O Cs	X			
V32.01	Twin-Mate Sb-Hosp W Cs	X			
V32.1	Twin, Mate Sb-Before Adm	X			
V32.2	Twin, Mate Sb-Nonhosp	X			
V33.00	Twin-Nos-In Hosp W/O Cs	X			
V33.01	Twin-Nos-In Hosp W Cs	X			
V33.1	Twin Nos-Before Admissn	X			
V33.2	Twin Nos-Nonhosp	X			
V34.00	Oth Mult Lb-Hosp W/O Cs	X			
V34.01	Oth Mult Lb-In Hosp W Cs	X			
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V34.1	Oth Mult Nb-Before Adm	X			
V34.2	Oth Multiple Nb-Nonhosp	X			
V35.00	Oth Mult Sb-Hosp W/O Cs	X			
V35.01	Oth Mult Sb-In Hosp W Cs	X			
V35.1	Oth Mult Sb-Before Adm	X			
V35.2	Oth Multiple Sb-Nonhosp	X			
V36.00	Mult Lb/Sb-In Hos W/O Cs	X			
V36.01	Mult Lb/Sb-In Hosp W Cs	X			
V36.1	Mult Nb/Sb-Before Adm	X			
V36.2	Multiple Nb/Sb-Nonhosp	X			
V37.00	Mult Brth Nos-Hos W/O Cs	X			
V37.01	Mult Birth Nos-Hosp W Cs	X			
V37.1	Mult Brth Nos-Before Adm	X			
V37.2	Mult Birth Nos-Nonhosp	X			
V39.00	Liveborn Nos-Hosp W/O Cs	X			
V39.01	Liveborn Nos-Hosp W Cs	X			
V39.1	Liveborn Nos-Before Adm	X			
V39.2	Liveborn Nos-Nonhosp	X			
V40.0	Problems With Learning				X
V40.1	Prob With Communication				X
V40.2	Mental Problems Nec				X
V40.3	Behavioral Problems Nec				X
V40.9	Mental/Behavior Prob Nos				X

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V41.0	Problems With Sight				X
V41.1	Eye Problems Nec				X
V41.2	Problems With Hearing				X
V41.3	Ear Problems Nec				X
V41.4	Voice Production Problem				X
V41.5	Smell And Taste Problem				X
V41.6	Problem W Swallowing				X
V41.7	Sexual Function Problem				X
V41.8	Probl W Special Func Nec				X
V41.9	Probl W Special Func Nos				X
V42.0	Kidney Transplant Status			X	
V42.1	Heart Transplant Status			X	
V42.2	Heart Valve Transplant			X	
V42.3	Skin Transplant Status			X	
V42.4	Bone Transplant Status			X	
V42.5	Cornea Transplant Status			X	
V42.6	Lung Transplant Status			X	
V42.7	Liver Transplant Status			X	
V42.81	Trnspl Status-Bne Marrow			X	
V42.82	Trspl Sts-Perip Stm Cell			X	
V42.83	Trnspl Status-Pancreas			X	
V42.84	Trnspl Status-Intestines			X	
V42.89	Trnspl Status Organ Nec			X	
V42.9	Transplant Status Nos			X	
V43.0	Eye Replacement Nec			X	
V43.1	Lens Replacement Nec			X	
V43.21	Heart Assist Dev Replace			X	
V43.22	Artficial Heart Replace		X		
V43.3	Heart Valve Replac Nec			X	
V43.4	Blood Vessel Replac Nec			X	
V43.5	Bladder Replacement Nec			X	
V43.60	Joint Replaced Unspcf			X	
V43.61	Joint Replaced Shoulder			X	
V43.62	Joint Replaced Elbow			X	
V43.63	Joint Replaced Wrist			X	
V43.64	Joint Replaced Hip			X	
V43.65	Joint Replaced Knee			X	
V43.66	Joint Replaced Ankle			X	

V43.69	Oth Spcf Joint Replaced			X	
V43.7	Limb Replacement Nec			X	
V43.81	Larynx Replacement			X	
V43.82	Breast Replacement			X	
V43.83	Artific Skin Repl Status			X	
V43.89	Organ/Tiss Replacmnt Nec			X	
V44.0	Tracheostomy Status			X	
V44.1	Gastrostomy Status			X	
V44.2	Ileostomy Status			X	
V44.3	Colostomy Status			X	
V44.4	Enterostomy Status Nec			X	
V44.50	Cystostomy Status Nos			X	
V44.51	Cutaneous-Vesicos Status			X	
V44.52	Appendico-Vesicos Status			X	
V44.59	Cystostomy Status Nec			X	
V44.6	Urinostomy Status Nec			X	
V44.7	Artificial Vagina Status			X	
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V44.8	Artif Open Status Nec			X	
V44.9	Artif Open Status Nos			X	
V45.00	Status Cardc Dvce Unspcf			X	
V45.01	Status Cardiac Pacemaker			X	
V45.02	Status Autm Crd Dfbrltr			X	
V45.09	Status Oth Spcf Crdc Dvc			X	
V45.11	Renal dialysis status			X	
V45.12	Noncompliance with renal dialysis			X	
V45.2	Ventricular Shunt Status			X	
V45.3	Intestinal Bypass Status			X	
V45.4	Arthrodesis Status			X	
V45.51	Prsc Ntrutr Cntrcptv Dvc			X	
V45.52	Prsc Sbdrml Cntrcp Mplnt			X	
V45.59	Prsc Other Cntrcptv Dvc			X	
V45.61	Cataract Extract Status			X	
V45.69	Post-Proc St Eye/Adn Nec			X	
V45.71	Acquired Absence Breast		X		
V45.72	Acquire Absnce Intestine		X		
V45.73	Acquired Absence Kidney		X		
V45.74	Acq Absence Urinary Trct		X		
V45.75	Acq Absence Of Stomach		X		

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V45.76	Acq Absence Of Lung		X		
V45.77	Acq Absnce Genital Organ		X		
V45.78	Acquired Absence Of Eye		X		
V45.79	Acq Absence Of Organ Nec		X		
V45.81	Aortocoronary Bypass			X	
V45.82	Status-Post Ptca			X	
V45.83	Breast Impl Remov Status			X	
V45.84	Dental Restoratn Status			X	
V45.85	Insulin Pump Status			X	
V45.86	Bariatric Surgery Status			X	
V45.87	Transplanted organ removal status			X	
V45.88	Status post administration of tPA (rtPA) in a different facility within the last 24 hours prior to admission to current facility			X	
V45.89	Post-Proc States Nec			X	
V46.0	Dependence On Aspirator			X	
V46.11	Respirator Depend Status			X	
V46.12	Resp Depend-Powr Failure	X			
V46.13	Weaning From Respirator	X			
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V46.14	Mech Comp Respirator		X		
V46.2	Depend-Supplement Oxygen			X	
V46.3	Wheelchair dependence			X	
V46.8	Machine Dependence Nec			X	
V46.9	Machine Dependence Nos				X
V47.0	Intern Organ Deficiency				X
V47.1	Mech Prob W Internal Org				X
V47.2	Cardiorespirat Probl Nec				X
V47.3	Digestive Problems Nec				X
V47.4	Urinary Problems Nec				X
V47.5	Genital Problems Nec				X
V47.9	Probl W Internal Org Nos				X
V48.0	Deficiencies Of Head				X
V48.1	Deficiencies Neck/Trunk				X
V48.2	Mechanical Prob W Head				X
V48.3	Mech Prob W Neck & Trunk				X
V48.4	Sensory Problem W Head				X
V48.5	Sensor Prob W Neck/Trunk				X
V48.6	Disfigurements Of Head				X
V48.7	Disfigurement Neck/Trunk				X

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V48.8	Prob-Head/Neck/Trunk Nec				X
V48.9	Prob-Head/Neck/Trunk Nos				X
V49.0	Deficiencies Of Limbs				X
V49.1	Mechanical Prob W Limbs				X
V49.2	Motor Problems W Limbs				X
V49.3	Sensory Problems W Limbs				X
V49.4	Disfigurements Of Limbs				X
V49.5	Limb Problems Nec				X
V49.60	Status Amput Up Lmb Nos		X		
V49.61	Status Amput Thumb		X		
V49.62	Status Amput Oth Fingers		X		
V49.63	Status Amput Hand		X		
V49.64	Status Amput Wrist		X		
V49.65	Status Amput Below Elbow		X		
V49.66	Status Amput Above Elbow		X		
V49.67	Status Amput Shoulder		X		
V49.70	Status Amput Lwr Lmb Nos		X		
V49.71	Status Amput Great Toe		X		
V49.72	Status Amput Othr Toe(S)		X		
V49.73	Status Amput Foot		X		
V49.74	Status Amput Ankle		X		
V49.75	Status Amput Below Knee		X		
V49.76	Status Amput Above Knee		X		
V49.77	Status Amput Hip		X		
V49.81	Asympt Postmeno Status		X		
V49.82	Dental Sealant Status			X	
V49.83	Await Organ Transplnt St			X	
V49.84	Bed Confinement Status		X		
V49.85	Dual Sensory Impairment			X	
V49.86	Do not resuscitate status		X		
V49.87	Physical restraints status		X		
V49.89	Conditn Influ Health Nec		X		
V49.9	Probl Influ Health Nos				X
V50.0	Hair Transplant		X		
V50.1	Plastic Surgery Nec		X		
V50.2	Routine Circumcision		X		
V50.3	Ear Piercing		X		
V50.41	Prphylct Orgn Rmvl Brst		X		

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V50.42	Prphylct Orgn Rmvl Ovary		X		
V50.49	Prphylct Orgn Rmvl Other		X		
V50.8	Elective Surgery Nec		X		
V50.9	Elective Surgery Nos		X		
V51.0	Encounter for breast reconstruction following mastectomy	X			
V51.8	Other aftercare involving the use of plastic surgery				X
V52.0	Fitting Artificial Arm		X		
V52.1	Fitting Artificial Leg		X		
V52.2	Fitting Artificial Eye		X		
V52.3	Fitting Dental Prosthes		X		
V52.4	Fit/Adj Breast Pros/Impl		X		
V52.8	Fitting Prosthesis Nec		X		
V52.9	Fitting Prosthesis Nos		X		
V53.01	Adj Cerebral Vent Shunt		X		
V53.02	Adjust Neuropacemaker		X		
V53.09	Adj Nerv Syst Device Nec		X		
V53.1	Fit Contact Lens/Glasses		X		
V53.2	Adjustment Hearing Aid		X		
V53.31	Ftng Cardiac Pacemaker		X		
V53.32	Ftng Autmtc Dfibrillator		X		
V53.39	Ftng Oth Cardiac Device		X		
V53.4	Fit Orthodontic Device		X		
V53.50	Fitting and adjustment of intestinal appliance and device		X		
V53.51	Fitting and adjustment of gastric lap band		X		
V53.59	Fitting and adjustment of other gastrointestinal appliance and device				X
V53.6	Fitting Urinary Devices		X		
V53.7	Fit Orthopedic Devices		X		
V53.8	Adjustment Of Wheelchair		X		
V53.90	Fit/Adjust Device Nos		X		
V53.91	Fit/Adjust Insulin Pump		X		
V53.99	Fit/Adjust Device Nec		X		
V54.01	Removal Int Fixation Dev		X		
V54.02	Length/Adjust Growth Rod		X		
V54.09	Aftrcre Int Fixation Dev		X		
V54.10	Aftrcre Traum Fx Arm Nos		X		
V54.11	Aftrcare Traum Fx Up Arm		X		

V54.12	Aftrcre Traum Fx Low Arm		X		
V54.13	Aftrcre Traumatic Fx Hip		X		
V54.14	Aftrcre Traum Fx Leg Nos		X		
V54.15	Aftrcare Traum Fx Up Leg		X		
V54.16	Aftrcre Traum Fx Low Leg		X		
V54.17	Aftrcre Traum Fx Vertebr		X		
V54.19	Aftrce Traum Fx Bone Nec		X		
V54.20	Aftrcare Path Fx Arm Nos		X		
V54.21	Aftercare Path Fx Up Arm		X		
V54.22	Aftrcare Path Fx Low Arm		X		
V54.23	Aftercare Path Fx Hip		X		
V54.24	Aftrcare Path Fx Leg Nos		X		
V54.25	Aftrcare Path Fx Up Leg		X		
V54.26	Aftrcare Path Fx Low Leg		X		
V54.27	Aftrcare Path Fx Vertebr		X		
V54.29	Aftrcre Path Fx Bone Nec		X		
V54.81	Aftercare Joint Replace		X		
V54.89	Orthopedic Aftercare Nec		X		
V54.9	Orthopedic Aftercare Nos		X		
V55.0	Atten To Tracheostomy		X		
V55.1	Atten To Gastrostomy		X		
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V55.2	Atten To Ileostomy		X		
V55.3	Atten To Colostomy		X		
V55.4	Atten To Enterostomy Nec		X		
V55.5	Atten To Cystostomy		X		
V55.6	Atten To Urinostomy Nec		X		
V55.7	Atten Artificial Vagina		X		
V55.8	Attn To Artif Open Nec		X		
V55.9	Attn To Artif Open Nos		X		
V56.0	Renal Dialysis Encounter	X			
V56.1	Ft/Adj Xtrcorp Dial Cath		X		
V56.2	Fit/Adj Perit Dial Cath		X		
V56.31	Hemodialysis Testing		X		
V56.32	Peritoneal Dialysis Test		X		
V56.8	Dialysis Encounter, Nec		X		
V57.0	Breathing Exercises	X			
V57.1	Physical Therapy Nec	X			
V57.21	Encntr Occupatnal Thrpy	X			

V57.22	Encntr Vocational Thrpy	X			
V57.3	Speech Therapy	X			
V57.4	Orthoptic Training	X			
V57.81	Orthotic Training	X			
V57.89	Rehabilitation Proc Nec	X			
V57.9	Rehabilitation Proc Nos	X			
V58.0	Radiotherapy Encounter	X			
V58.11	Antineoplastic Chemo Enc	X			
V58.12	Immunotherapy Encounter	X			
V58.2	Blood Transfusion, No Dx				X
V58.30	Attn Rem Nonsurg Dressng		X		
V58.31	Attn Rem Surg Dressing		X		
V58.32	Attn Removal Of Sutures		X		
V58.41	Encntr Plnd Po Wnd Clsr		X		
V58.42	Aftercare Neoplasm Surg		X		
V58.43	Aftrcare Inj/Trauma Surg		X		
V58.44	Aftercare Organ Transplt		X		
V58.49	Postop Oth Specfd Aftrcr		X		
V58.5	Orthodontics Aftercare				X
V58.61	Long-Term Use Anticoagul			X	
V58.62	Long-Term Use Antibiotic			X	
V58.63	Lng Use Antiplte/Thrmbtc			X	
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V58.64	Long-Term Anti-Inflamtry			X	
V58.65	Long-Term Use Steroids			X	
V58.66	Long-Term Use Of Aspirin			X	
V58.67	Long-Term Use Of Insulin			X	
V58.69	Long-Term Use Meds Nec			X	
V58.71	Aft Surg Sense Org Nec		X		
V58.72	Aftcre Surg Nerv Sys Nec		X		
V58.73	Aft Surg Circ Syst Nec		X		
V58.74	Aftrcre Surg Respsys Nec		X		
V58.75	Aft Oral Cav/Dig Sys Nec		X		
V58.76	Aftrcre Surg Gu Syst Nec		X		
V58.77	Aft Surg Skin/Subcu Nec		X		
V58.78	Aftrcre Surg Ms Syst Nec		X		
V58.81	Fit/Adj Vascular Cathetr		X		
V58.82	Fit/Adj Non-Vsc Cath Nec		X		
V58.83	Therapeutic Drug Monitor		X		

Code(s)	Description	1st Dx Only (Used for Principal Dx Only)	1st or Add'l Dx (Can be Principal or Additional Dx	Add'l Dx Only (Used as a Additional Dx Only)	Non-Specific Dx (Generally for nonacute or for when no sign or symptom - Can be Principal or Additional Dx)
V58.89	Other Specfied Aftercare		X		
V58.9	Aftercare Nos				X
V59.01	Blood Donor-Whole Blood	X			
V59.02	Blood Donor-Stem Cells	X			
V59.09	Blood Donor Nec	X			
V59.1	Skin Donor	X			
V59.2	Bone Donor	X			
V59.3	Bone Marrow Donor	X			
V59.4	Kidney Donor	X			
V59.5	Cornea Donor	X			
V59.6	Liver Donor	X			
V59.70	Egg Donor Nec	X			
V59.71	Egg Donor Age <35 Anon	X			
V59.72	Egg Donor Age <35 Desig	X			
V59.73	Egg Donor Age 35+ Anon	X			
V59.74	Egg Donor Age 35+ Desig	X			
V59.8	Org Or Tissue Donor Nec	X			
V59.9	Org Or Tissue Donor Nos	X			
V60.0	Lack Of Housing			X	
V60.1	Inadequate Housing			X	
V60.2	Economic Problem			X	
V60.3	Person Living Alone			X	
V60.4	No Family Able To Care			X	
V60.5	Holiday Relief Care			X	
V60.6	Person In Resident Inst			X	
V60.81	Foster care (status)			X	
V60.89	Other specified housing or economic circumstances			X	
V60.9	Housing/Econo Circum Nos			X	
V61.01	Family disruption due to family member on military deployment		X		
V61.02	Family disruption due to return of family member from military deployment		X		
V61.03	Family disruption due to divorce or legal separation		X		
V61.04	Family disruption due to parent-child estrangement		X		
V61.05	Family disruption due to child in welfare custody		X		
V61.06	Family disruption due to child in foster care or in care of non-parental family member		X		
V61.07	Family disruption due to death of family member		X		

V61.08	Family disruption due to other extended absence of family member				X
V61.09	Other family disruption				X
V61.10	Consl Partner Prob		X		
V61.11	Cnsl Victm Partner Abuse		X		
V61.12	Cnsl Perp Partner Abuse		X		
V61.20	Cnsl Prnt-Chld Prob Nos		X		
V61.21	Cnsl Victim Child Abuse		X		
V61.22	Cnsl Perp Parent Chld Ab		X		
V61.23	Counseling for parent-biological child problem		X		
V61.24	Counseling for parent-adopted child problem		X		
V61.25	Counseling for parent (guardian)-foster child problem		X		
V61.29	Other parent-child problems		X		
V61.3	Problem W Aged Parent		X		
V61.41	Alcoholism In Family		X		
V61.42	Substance abuse in family		X		
V61.49	Family Health Probl Nec		X		
V61.5	Multiparity		X		
V61.6	Illegitimate Pregnancy		X		
V61.7	Unwanted Pregnancy Nec		X		
V61.8	Family Circumstances Nec		X		
V61.9	Family Circumstance Nos		X		
V62.0	Unemployment			X	
V62.1	Adverse Eff-Work Environ			X	
V62.21	Personal current military deployment status		X		
Code(s)	**Description**	**1st Dx Only (Used for Principal Dx Only)**	**1st or Add'l Dx (Can be Principal or Additional Dx**	**Add'l Dx Only (Used as a Additional Dx Only)**	**Non-Specific Dx (Generally for nonacute or for when no sign or symptom - Can be Principal or Additional Dx)**
V62.22	Personal history of return from military deployment		X		
V62.29	Other occupational circumstances or maladjustment				X
V62.3	Educational Circumstance			X	
V62.4	Social Maladjustment			X	
V62.5	Legal Circumstances			X	
V62.6	Refusal Of Treatment			X	
V62.81	Interpersonal Probl Nec			X	
V62.82	Bereavement, Uncomplicat			X	
V62.83	Cnsl Perp Phys/Sex Abuse			X	
V62.84	Suicidal Ideation			X	
V62.85	Homicidal ideation		X		
V62.89	Psychological Stress Nec			X	

V62.9	Psychosocial Circum Nos			X	
V63.0	Home Remote From Hospitl		X		
V63.1	No Medical Serv In Home		X		
V63.2	Wait Adm To Oth Facility		X		
V63.8	No Med Facilities Nec		X		
V63.9	No Med Facilities Nos		X		
V64.00	No Vaccination Nos			X	
V64.01	No Vaccin-Acute Illness			X	
V64.02	No Vaccin-Chronc Illness			X	
V64.03	No Vaccin-Immune Comp			X	
V64.04	No Vaccin-Allergy To Vac			X	
V64.05	No Vaccin-Caregiv Refuse			X	
V64.06	No Vaccination-Pt Refuse			X	
V64.07	No Vaccination-Religion			X	
V64.08	No Vaccin-Prev Disease			X	
V64.09	No Vaccination Nec			X	
V64.1	No Proc/Contraindication			X	
V64.2	No Proc/Patient Decision			X	
V64.3	No Proc For Reasons Nec			X	
V64.41	Lap Surg Convert To Open			X	
V64.42	Thoracoscop Conv To Open			X	
V64.43	Arthroscopc Conv To Open			X	
V65.0	Healthy Person W Sick			X	
V65.11	Ped Pre-Birth Visit-Mom		X		
V65.19	Person Consult For Anoth		X		
V65.2	Person Feigning Illness		X		
Code(s)	**Description**	**1st Dx Only (Used for Principal Dx Only)**	**1st or Add'l Dx (Can be Principal or Additional Dx**	**Add'l Dx Only (Used as a Additional Dx Only)**	**Non-Specific Dx (Generally for nonacute or for when no sign or symptom - Can be Principal or Additional Dx)**
V65.3	Dietary Surveil/Counsel		X		
V65.40	Counseling Nos		X		
V65.41	Exercise Counseling		X		
V65.42	Counslng Sbstn Use Abuse		X		
V65.43	Counseling Injry Prevent		X		
V65.44	Hiv Counseling		X		
V65.45	Consln Ot Sex Trnsmt Dis		X		
V65.46	Insulin Pump Training		X		
V65.49	Other Specfd Counseling		X		
V65.5	Persn W Feared Complaint		X		
V65.8	Reason For Consult Nec		X		
V65.9	Reason For Consult Nos		X		

Code(s)	Description	1st Dx Only (Used for Principal Dx Only)	1st or Add'l Dx (Can be Principal or Additional Dx	Add'l Dx Only (Used as a Additional Dx Only)	Non-Specific Dx (Generally for nonacute or for when no sign or symptom - Can be Principal or Additional Dx)
V66.0	Surgical Convalescence	X			
V66.1	Radiotherapy Convalescen	X			
V66.2	Chemotherapy Convalescen	X			
V66.3	Mental Dis Convalescence	X			
V66.4	Fracture Treatmnt Conval	X			
V66.5	Convalescence Nec	X			
V66.6	Comb Treatment Convales	X			
V66.7	Encountr Palliative Care			X	
V66.9	Convalescence Nos	X			
V67.00	Follow-Up Surgery Nos		X		
V67.01	Follow-Up Vag Pap Smear		X		
V67.09	Follow-Up Surgery Nec		X		
V67.1	Radiotherapy Follow-Up		X		
V67.2	Chemotherapy Follow-Up		X		
V67.3	Psychiatric Follow-Up		X		
V67.4	Fu Exam Treatd Healed Fx		X		
V67.51	High-Risk Rx Nec Exam		X		
V67.59	Follow-Up Exam Nec		X		
V67.6	Comb Treatment Follow-Up		X		
V67.9	Follow-Up Exam Nos		X		
V68.01	Disability Examination	X			
V68.09	Issue Of Med Certif Nec	X			
V68.1	Issue Repeat Prescript	X			
V68.2	Request Expert Evidence	X			
V68.81	Referral-No Exam/Treat	X			
V68.89	Administrtve Encount Nec	X			
V68.9	Administrtve Encount Nos	X			
Code(s)	Description	1st Dx Only (Used for Principal Dx Only)	1st or Add'l Dx (Can be Principal or Additional Dx	Add'l Dx Only (Used as a Additional Dx Only)	Non-Specific Dx (Generally for nonacute or for when no sign or symptom - Can be Principal or Additional Dx)
V69.0	Lack Of Physical Exercse		X		
V69.1	Inapprt Diet Eat Habits		X		
V69.2	High-Risk Sexual Behavr		X		
V69.3	Gambling And Betting		X		
V69.4	Lack Of Adequate Sleep		X		
V69.5	Behav Insomnia-Childhood		X		
V69.8	Oth Prblms Rltd Lfstyle		X		
V69.9	Prblm Rltd Lfstyle Nos		X		
V70.0	Routine Medical Exam	X			
V70.1	Psych Exam-Authority Req	X			
V70.2	Gen Psychiatric Exam Nec	X			

V70.3	Med Exam Nec-Admin Purp	X			
V70.4	Exam-Medicolegal Reasons	X			
V70.5	Health Exam-Group Survey	X			
V70.6	Health Exam-Pop Survey	X			
V70.7	Exam-Clincal Trial		X		
V70.8	General Medical Exam Nec	X			
V70.9	General Medical Exam Nos	X			
V71.01	Obsv-Adult Antisoc Behav	X			
V71.02	Obsv-Adolesc Antisoc Beh	X			
V71.09	Observ-Mental Cond Nec	X			
V71.1	Obsv-Suspct Mal Neoplasm	X			
V71.2	Observ-Suspect Tb	X			
V71.3	Observ-Work Accident	X			
V71.4	Observ-Accident Nec	X			
V71.5	Observ Following Rape	X			
V71.6	Observ-Inflicted Inj Nec	X			
V71.7	Obs-Susp Cardiovasc Dis	X			
V71.81	Observe-Abuse & Neglect	X			
V71.82	Obs/Eval Sus Exp Anthrax	X			
V71.83	Obs/Eval Exp Biol Nec	X			
V71.89	Observ-Suspect Cond Nec	X			
V71.9	Observ-Suspect Cond Nos	X			
V72.0	Eye & Vision Examination		X		
V72.11	Hearing Exam-Fail Screen		X		
V72.12	Hearing Conservatn/Trtmt		X		
V72.19	Exam Ears & Hearing Nec		X		
V72.2	Dental Examination		X		
V72.31	Routine Gyn Examination		X		
Code(s)	**Description**	**1st Dx Only (Used for Principal Dx Only)**	**1st or Add'l Dx (Can be Principal or Additional Dx**	**Add'l Dx Only (Used as a Additional Dx Only)**	**Non-Specific Dx (Generally for nonacute or for when no sign or symptom - Can be Principal or Additional Dx)**
V72.32	Pap Smear Confirmation		X		
V72.40	Pregnancy Test Unconfirm		X		
V72.41	Pregnancy Test Negative		X		
V72.42	Pregnancy Test-Positive		X		
V72.5	Radiological Exam Nec		X		
V72.60	Laboratory examination, unspecified				X
V72.61	Antibody response examination		X		
V72.62	Laboratory examination ordered as part of a routine general medical examination		X		
V72.63	Pre-procedural laboratory examination		X		
V72.69	Other laboratory examination				X

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V72.7	Skin/Sensitization Tests		X		
V72.81	Preop Cardiovsclr Exam		X		
V72.82	Preop Respiratory Exam		X		
V72.83	Oth Spcf Preop Exam		X		
V72.84	Preop Exam Unspcf		X		
V72.85	Oth Specified Exam		X		
V72.86	Blood Typing Encounter		X		
V72.9	Examination Nos				X
V73.0	Screening-Poliomyelitis		X		
V73.1	Screening For Smallpox		X		
V73.2	Screening For Measles		X		
V73.3	Screening For Rubella		X		
V73.4	Screening-Yellow Fever		X		
V73.5	Screening-Arbovirus Dis		X		
V73.6	Screening For Trachoma		X		
V73.81	Special Screen Exam Hpv		X		
V73.88	Scrn Oth Spcf Chlmyd Dis		X		
V73.89	Scrn Oth Spcf Viral Dis		X		
V73.98	Scrn Unspcf Chlmyd Dis		X		
V73.99	Scrn Unspcf Viral Dis		X		
V74.0	Screening For Cholera		X		
V74.1	Screening-Pulmonary Tb		X		
V74.2	Screening For Leprosy		X		
V74.3	Screening For Diphtheria		X		
V74.4	Screen-Bact Conjunctivit		X		
V74.5	Screen For Veneral Dis		X		
V74.6	Screening For Yaws		X		
V74.8	Screen-Bacterial Dis Nec		X		
V74.9	Screen-Bacterial Dis Nos		X		
V75.0	Screen-Rickettsial Dis		X		
V75.1	Screening For Malaria		X		
V75.2	Screen For Leishmaniasis		X		
V75.3	Screen-Trypanosomiasis		X		
V75.4	Screen-Mycotic Infect		X		
V75.5	Screen-Schistosomiasis		X		
V75.6	Screen For Filariasis		X		
V75.7	Screen For Helminthiasis		X		
V75.8	Screen-Parasitic Dis Nec		X		

V75.9	Screen For Infec Dis Nos		X		
V76.0	Screen Mal Neop-Resp Org		X		
V76.10	Scrn Mal Neo Breast Nos		X		
V76.11	Screen Mammogram Hi Risk		X		
V76.12	Screen Mammogram Nec		X		
V76.19	Scrn Mal Neo Breast Nec		X		
V76.2	Screen Mal Neop-Cervix		X		
V76.3	Screen Mal Neop-Bladder		X		
V76.41	Screen Mal Neop-Rectum		X		
V76.42	Screen Mal Neop-Oral Cav		X		
V76.43	Screen Mal Neop-Skin		X		
V76.44	Scrn Malig Neop-Prostate		X		
V76.45	Screen Malig Neop-Testis		X		
V76.46	Screen Malig Neop-Ovary		X		
V76.47	Screen Malig Neop-Vagina		X		
V76.49	Screen Mal Neop Oth Site		X		
V76.50	Scrn Malig Neo-Intes Nos		X		
V76.51	Screen Malig Neop-Colon		X		
V76.52	Scrn Mal Neo-Small Intes		X		
V76.81	Screen Neop-Nervous Syst		X		
V76.89	Screen Neoplasm Nec		X		
V76.9	Screen-Neoplasm Nos		X		
V77.0	Screen-Thyroid Disorder		X		
V77.1	Screen-Diabetes Mellitus		X		
V77.2	Screen For Malnutrition		X		
V77.3	Screen-Phenylketonuria		X		
V77.4	Screen For Galactosemia		X		
V77.5	Screening For Gout		X		
V77.6	Screen-Cystic Fibrosis		X		
Code(s)	**Description**	**1st Dx Only (Used for Principal Dx Only)**	**1st or Add'l Dx (Can be Principal or Additional Dx**	**Add'l Dx Only (Used as a Additional Dx Only)**	**Non-Specific Dx (Generally for nonacute or for when no sign or symptom - Can be Principal or Additional Dx)**
V77.7	Screen-Inborn Err Metab		X		
V77.8	Screening For Obesity		X		
V77.91	Screen Lipoid Disorders		X		
V77.99	Screen-Endoc/Nut/Met Nec		X		
V78.0	Screen-Iron Defic Anemia		X		
V78.1	Screen-Defic Anemia Nec		X		
V78.2	Screen-Sickle Cell Dis		X		
V78.3	Scrn-Hemoglobinopath Nec		X		
V78.8	Screen-Blood Dis Nec		X		

V78.9	Screen-Blood Dis Nos		X		
V79.0	Screening For Depression		X		
V79.1	Screening For Alcoholism		X		
V79.2	Screen-Mental Retardat		X		
V79.3	Screen-Development Prob		X		
V79.8	Screen-Mental Dis Nec		X		
V79.9	Screen-Mental Dis Nos		X		
V80.01	Special screening for traumatic brain injury		X		
V80.09	Special screening for other neurological conditions				X
V80.1	Screening For Glaucoma		X		
V80.2	Screening-Eye Cond Nec		X		
V80.3	Screening For Ear Dis		X		
V81.0	Scrn-Ischemic Heart Dis		X		
V81.1	Screen For Hypertension		X		
V81.2	Screen-Cardiovasc Nec		X		
V81.3	Screen-Bronch/Emphysema		X		
V81.4	Screen-Respir Cond Nec		X		
V81.5	Screen For Nephropathy		X		
V81.6	Screen For Gu Cond Nec		X		
V82.0	Screen For Skin Cond		X		
V82.1	Screen-Rheumatoid Arthr		X		
V82.2	Screen-Rheumat Dis Nec		X		
V82.3	Screen-Cong Hip Dislocat		X		
V82.4	Mat Pstntl Scr-Chrm Anom		X		
V82.5	Screen-Contamination Nec		X		
V82.6	Multiphasic Screening		X		
V82.71	Screen-Gentc Dis Carrier		X		
V82.79	Genetic Screening Nec		x		
V82.81	Screen - Osteoporosis		X		
V82.89	Screen For Condition Nec		X		

Code(s)	**Description**	**1st Dx Only (Used for Principal Dx Only)**	**1st or Add'l Dx (Can be Principal or Additional Dx**	**Add'l Dx Only (Used as a Additional Dx Only)**	**Non-Specific Dx (Generally for nonacute or for when no sign or symptom - Can be Principal or Additional Dx)**
V82.9	Screen For Condition Nos		X		
V83.01	Asympt Hemoph A Carrier		X		
V83.02	Sympt Hemophil A Carrier		X		
V83.81	Cystic Fibrosis Gene Car		X		
V83.89	Genetic Carrier Stat Nec		X		
V84.01	Genetc Sus Mal Neo Brest			X	
V84.02	Genetc Sus Mal Neo Ovary			X	
V84.03	Genetc Sus Mal Neo Prost			X	

Code(s)	Description	1st Dx Only (Used for Principal Dx Only)	1st or Add'l Dx (Can be Principal or Additional Dx	Add'l Dx Only (Used as a Additional Dx Only)	Non-Specific Dx (Generally for nonacute or for when no sign or symptom - Can be Principal or Additional Dx)
V84.04	Genetc Susc Mal Neo Endo			X	
V84.09	Genetic Susc Mal Neo Nec			X	
V84.81	Genetc Sus Mult Endo Neo			X	
V84.89	Genetic Suscept Dis Nec			X	
V85.0	Bmi Less Than 19,Adult			X	
V85.1	Bmi Between 19-24,Adult			X	
V85.21	Bmi 25.0-25.9,Adult			X	
V85.22	Bmi 26.0-26.9,Adult			X	
V85.23	Bmi 27.0-27.9,Adult			X	
V85.24	Bmi 28.0-28.9,Adult			X	
V85.25	Bmi 29.0-29.9,Adult			X	
V85.30	Bmi 30.0-30.9,Adult			X	
V85.31	Bmi 31.0-31.9,Adult			X	
V85.32	Bmi 32.0-32.9,Adult			X	
V85.33	Bmi 33.0-33.9,Adult			X	
V85.34	Bmi 34.0-34.9,Adult			X	
V85.35	Bmi 35.0-35.9,Adult			X	
V85.36	Bmi 36.0-36.9,Adult			X	
V85.37	Bmi 37.0-37.9,Adult			X	
V85.38	Bmi 38.0-38.9,Adult			X	
V85.39	Bmi 39.0-39.9,Adult			X	
V85.41	Body Mass Index 40.0-44.9, adult			X	
V85.42	Body Mass Index 45.0-49.9, adult			X	
V85.43	Body Mass Index 50.0-59.9, adult			X	
V85.44	Body Mass Index 60.0-69.9, adult			X	
V85.45	Body Mass Index 70 and over, adult			X	
V85.51	Bmi,Pediatric <5%			X	
V85.52	Bmi,Pediatric 5% - <85%			X	
V85.53	Bmi,Pediatric 85% - <95%			X	
V85.54	Bmi,Pediatric >= 95%			X	
V86.0	Estrogen Recep Pstv Stat			X	
V86.1	Estrogen Recep Neg Stat			X	
V87.01	Contact with and (suspected) exposure to arsenic		X		
V87.09	Contact with and (suspected) exposure to other hazardous metals				X
V87.11	Contact with and (suspected) exposure to aromatic amines		X		
V87.12	Contact with and (suspected) exposure to benzene		X		

Code(s)	Description	1st Dx Only (Used for Principal Dx Only)	1st or Add'l Dx (Can be Principal or Additional Dx	Add'l Dx Only (Used as a Additional Dx Only)	Non-Specific Dx (Generally for nonacute or for when no sign or symptom - Can be Principal or Additional Dx)
V87.19	Contact with and (suspected) exposure to other hazardous aromatic compounds				X
V87.2	Contact with and (suspected) exposure to other potentially hazardous chemicals				X
V87.31	Contact with and (suspected) exposure to mold		X		
V87.32	Contact with and (suspected) exposure to algae bloom		X		
V87.39	Contact with and (suspected) exposure to other potentially hazardous substances				X
V87.41	Personal history of antineoplastic chemotherapy			X	
V87.42	Personal history of monoclonal drug therapy			X	
V87.43	Personal history of estrogen therapy			X	
V87.44	Personal history of inhaled steroid therapy			X	
V87.45	Personal history of systemic steroid therapy			X	
V87.46	Personal history of immunosuppressive therapy			X	
V87.49	Personal history of other drug therapy			X	
V88.01	Acquired absence of both cervix and uterus			X	
V88.02	Acquired absence of uterus with remaining cervical stump			X	
V88.03	Acquired absence of cervix with remaining uterus			X	
V88.11	Acquired total absence of pancreas		X		
V88.12	Acquired partial absence of pancreas		X		
V89.01	Suspected problem with amniotic cavity and membrane not found		X		
V89.02	Suspected placental problem not found		X		
V89.03	Suspected fetal anomaly not found		X		
V89.04	Suspected problem with fetal growth not found		X		
V89.05	Suspected cervical shortening not found		X		
V89.09	Other suspected maternal and fetal condition not found		X		
V90.01	Retained depleted uranium fragments		X		
V90.09	Other retained radioactive fragments				X
V90.10	Retained metal fragments, unspecified		X		
V90.11	Retained magnetic metal fragments		X		
V90.12	Retained nonmagnetic metal fragments		X		
V90.2	Retained plastic fragments		X		
Code(s)	Description	1st Dx Only (Used for Principal Dx Only)	1st or Add'l Dx (Can be Principal or Additional Dx	Add'l Dx Only (Used as a Additional Dx Only)	Non-Specific Dx (Generally for nonacute or for when no sign or symptom - Can be Principal or Additional Dx)
V90.31	Retained animal quills or spines		X		
V90.32	Retained tooth		X		
V90.33	Retained wood fragments		X		
V90.39	Other retained organic fragments				X

V90.81	Retained glass fragments		X		
V90.83	Retained stone or crystalline fragments		X		
V90.89	Other specified retained foreign body				X
V90.9	Retained foreign body, unspecified material		X		
V91.00	Twin gestation, unspecified number of placenta, unspecified number of amniotic sacs		X		
V91.01	Twin gestation, monochorionic/monoamniotic (one placenta, one amniotic sac)		X		
V91.02	Twin gestation, monochorionic/diamniotic (one placenta, two amniotic sacs)		X		
V91.03	Twin gestation, dichorionic/diamniotic		X		
V91.09	Twin gestation, unable to determine number of placenta and number of amniotic sacs		X		
V91.10	Triplet gestation, unspecified number of placenta and unspecified number of amniotic sacs		X		
V91.11	Triplet gestation, with two or more monochorionic fetuses		X		
V91.12	Triplet gestation, with two or more monoamniotic fetuses		X		
V91.19	Triplet gestation, unable to determine number of placenta and number of amniotic sacs		X		
V91.20	Quadruplet gestation, unspecified number of placenta and unspecified number of amniotic sacs		X		
V91.21	Quadruplet gestation, with two or more monochorionic fetuses		X		
V91.22	Quadruplet gestation, with two or more monoamniotic fetuses		X		
V91.29	Quadruplet gestation, unable to determine number of placenta and number of amniotic sacs		X		
V91.90	Other specified multiple gestation, unspecified number of placenta and unspecified number of amniotic sacs		X		
V91.91	Other specified multiple gestation, with two or more monochorionic fetuses		X		
V91.92	Other specified multiple gestation, with two or more monoamniotic fetuses		X		
V91.99	Other specified multiple		X		

2.1.19. Section Nineteen: Supplemental Classification of External Causes of Injury and Poisoning (E-codes, E800-E999)

2.1.19.1. Introduction: The use of E codes is supplemental to the application of ICD-9-CM diagnosis codes. E codes are never to be recorded as principal diagnoses.

2.1.19.2. 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, adverse effect or poisoning happened (cause), the intent (unintentional or accidental; or intentional, such as suicide or assault), and the place where the event occurred.

2.1.19.3. 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 and other ambulatory care settings.

2.1.19.3.1. **General E Code Coding Guidelines**

2.1.19.3.1.1. **Used with any code in the range of 001-V91**

- An E codes (E800=E999) may be used with any code in the range of 001-V91, which indicates an injury, poisoning, or adverse effect due to an external cause.
- An activity E code (categories E001-E030) may be used with any code in the range of 001-V91 that indicates an injury, or other health condition that resulted from an activity, or the activity contributed to a condition.

2.1.19.3.1.2. **Assign the appropriate E code for all initial treatments**

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

  External cause of injury codes (E-codes) may be assigned while the acute fracture codes are still applicable.

2.1.19.3.1.3. **Use the full range of E codes**

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

2.1.19.3.1.4. **Assign as many E codes as necessary**

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

2.1.19.3.1.5. **The selection of the appropriate E code**

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

2.1.19.3.1.6. **E code can never be a principal diagnosis**

- An E code can never be a principal diagnosis.

2.1.19.3.1.7. **External cause code(s) with systemic inflammatory response syndrome (SIRS)**

- An external cause code is not appropriate with a code from subcategory 995.9, unless the patient also has another condition for which an E code would be appropriate (such as an injury, poisoning, or adverse effect of drugs.

2.1.19.3.1.8. **Multiple Cause E Code Coding Guidelines**

- More than one E-code is required to fully describe the external cause of an illness, injury or poisoning. The assignment of E-codes should be sequenced in the following priority:

- If two or more events cause separate injuries, an E code should be assigned for each cause. The first listed E code will be selected in the following order: E codes for child and adult abuse take priority over all other E codes.

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

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

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

- Activity and external cause status codes are assigned following all causal (intent) E codes.

- Code E000.0 External Cause Status, Civilian activity done for income or pay, will be assigned additionally with the 'place of occurrence' E codes and injury codes to denote a work-related injury/condition, regardless where this occurs. This is a valid ICD 9CM code as of 1st July, 2011

- 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.

2.1.19.3.1.9. **If the reporting format limits the number of E codes**

- If the reporting format limits the number of E codes that can be used in reporting clinical data, report the code for the cause/intent most related to the principal diagnosis. If the format permits capture of additional E codes, the cause/intent, including medical misadventures, of the additional events should be reported rather than the codes for place, activity or external status.

2.1.19.3.2. **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.

2.1.19.3.3. **Adverse Effects of Drugs, Medicinal and Biological Substances Guidelines**

2.1.19.3.3.1. **Do not code directly from the Table of Drugs**

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

2.1.19.3.3.2. **Use as many codes as necessary to describe**

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

2.1.19.3.3.3. **If the same E code would describe the causative agent**

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

2.1.19.3.3.4. **If two or more drugs, medicinal or biological substances**

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

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

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

2.1.19.3.3.6. **Codes from the E930 – E949 series**

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

2.1.19.3.4. **Child and Adult Abuse Guideline**

2.1.19.3.4.1. **Intentional injury**

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

2.1.19.3.4.2. **Accidental intent**

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

2.1.19.3.5. **Unknown or Suspected Intent Guideline**

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

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

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

- If the intent of the cause of an injury or poisoning is questionable, probable or suspected, code the intent as undetermined E980-E989.

2.1.19.3.6. **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.

2.1.19.3.7. **Late Effects of External Cause Guidelines**

2.1.19.3.7.1. **Late effect E codes**

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

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

- A late effect E code should be used with any report of a late effect or sequela resulting from a previous injury or poisoning (905-909).

2.1.19.3.7.3. **Late effect E code with a related current injury**

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

2.1.19.3.7.4. **Use of late effect E codes for subsequent visits**

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

2.1.19.3.8. **Misadventures and Complications of Care Guidelines**

2.1.19.3.8.1. **Code range E870-E876**

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

2.1.19.3.8.2. **Code range E878-E879**

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

2.1.19.3.9. **Terrorism Guidelines**

2.1.19.3.9.1. **Cause of injury identified as terrorism**

- When the cause of an injury is identified as terrorism, the first-listed E-code should be a code from category E979, Terrorism. The definition of terrorism 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.

2.1.19.3.9.2. **Cause of an injury is suspected to be the result of terrorism**

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

2.1.19.3.9.3. **Code E979.9, Terrorism, secondary effects**

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

2.1.19.3.9.4. **Statistical tabulation of terrorism codes**

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

2.1.19.3.10. **Activity Code Guidelines**

- Assign a code from category E001-E030 to describe the activity that caused or contributed to the injury or other health condition.

- Unlike other E codes, activity E codes may be assigned to indicate a health condition (not just injuries) resulted from an activity, or the activity contributed to the condition.
- The activity codes are not applicable to poisonings, adverse effects, misadventures or late effects. **Do not assign E030, Unspecified activity, if the activity is not stated.**

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III.

CPT 4th Edition 2011 PROCEDURE CODING GUIDELINES

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Chapter One

3.1. Introduction

3.1.1. *Current Procedural Terminology,* (*CPT*®) Fourth Edition, is a set of codes, descriptions, and guidelines intended to describe procedures and services performed by physicians and other health care providers. Each procedure or service is identified with a five-digit code. This is the code set required for all procedure coding within the Emirate of Abu Dhabi. Only CPT five-digit or T Codes will be used for any procedure coding and all CPT Guidelines will take precedence too all other procedural Guidelines or Rules.

3.1.2. Inclusion of a descriptor and its associated five-digit code number in the CPT codebook is based on whether the procedure is consistent with contemporary medical practice and is performed by many practitioners in clinical practice in multiple locations. Inclusion in the CPT codebook does not represent endorsement by the American Medical Association (AMA) of any particular diagnostic or therapeutic procedure. Inclusion or exclusion of a procedure does not imply any health insurance coverage or reimbursement policy.

3.1.3. The CPT code set is published annually in the late summer or early fall as both electronic data files and books in the United States of America. The release of CPT data files on the internet typically precedes the book by several weeks. In any case, January 1 is the effective date for use of the update of the CPT code set in the United States of America. In the Emirate of Abu Dhabi, the Clinical Coding Steering Committee has set the effective date as service date 1st July. The interval between the release of the update and the effective date is considered the implementation period and is intended to allow physicians and other providers, payers, and vendors to incorporate CPT changes into their systems.

3.1.4. It is important to recognize that the listing of a service or procedure and its code number in a specific section of this book does not restrict its use to a specific specialty group. Any procedure or service in any section of this book may be used to designate the services rendered by any qualified physician or other qualified health care professional as long as it meets the following criteria:

3.1.4.1. The code does not specify the specialty e.g. a geneticist

3.1.4.2. The code is within the Scope of Work of the healthcare professional

3.1.4.3. The documentation fully supports the assignation of the code

3.1.5. Check with individual payers for reimbursement policies regarding these codes.

3.1.6. Select the name of the procedure or service that accurately identifies the service performed. **Do not** select a CPT code that **merely approximates** the service provided. If no such procedure or service exists, then report the service using the appropriate unlisted procedure or service code. *(See Chapter Five)*

3.1.7. When reporting codes for services provided, it is important to ensure the accuracy and quality of coding through verification of the intent of the code by use of the related

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guidelines, parenthetical instructions, and coding resources, including *CPT Assistant* and other publications resulting from collaborative efforts of the American Medical Association with the medical specialty societies (e.g., *Clinical Examples in Radiology*).

Chapter Two

3.2. Procedure Coding Terms and Guidelines

3.2.1. **Add-on Codes -** Some of the listed procedures are commonly carried out in addition to the primary procedure performed. These additional or supplemental procedures are designated as add-on codes with the "✚" symbol and they are listed in Appendix D of the CPT codebook. *(See Chapter Six)*

3.2.2. **Chief Complaint -** A concise statement describing the symptom, problem, condition, diagnosis or other factor that is the reason for the encounter, usually stated in the patient's words.

3.2.3. **Closed treatment** - specifically means that the fracture site is not surgically opened (exposed to the external environment and directly visualized). This terminology is used to describe procedures that treat fractures by three methods: (1) without manipulation; (2) with manipulation; or (3) with or without traction.

3.2.4. **Concurrent Care -** Concurrent care is the provision of similar services, eg, hospital visits, to the same patient by more than one physician on the same day.

3.2.5. **Consultation** - A consultation is a type of evaluation and management service provided by a physician at the request of another physician or appropriate source to either recommend care for a specific condition or problem or to determine whether to accept responsibility for ongoing management of the patient's entire care or for the care of a specific condition or problem. A physician consultant may initiate diagnostic and/or therapeutic services at the same or subsequent visit.

3.2.6. A "consultation" initiated by a patient and/or family, and not requested by a physician or other appropriate source (e.g., physician assistant, nurse practitioner, doctor of chiropractic, physical therapist, occupational therapist, speech-language pathologist, psychologist, social worker, lawyer, or insurance company), is not reported using the consultation codes but may be reported using the office visit, home service, or domiciliary/rest home care codes as appropriate.

3.2.7. The written or verbal request for consult may be made by a physician or other appropriate source and documented in the patient's medical record by either the consulting or requesting physician or appropriate source. The consultant's opinion and any services that were ordered or performed must also be documented in the patient's medical record and communicated by written report to the requesting physician or other appropriate source.

3.2.8. If subsequent to the completion of a consultation the consultant assumes responsibility for management of a portion or all of the patient's condition(s), the appropriate **Evaluation and Management** services code for the site of service should be reported. In the hospital or nursing facility setting, the consulting physician should use the appropriate inpatient consultation code for the initial encounter and then subsequent hospital or nursing facility care codes. In the office setting, the physician should use the appropriate office or other

outpatient consultation codes and then the established patient office or other outpatient services codes.

3.2.9. **Counseling** - Counseling is a discussion with a patient and/or family concerning one or more of the following areas:

3.2.9.1. Diagnostic results, impressions, and/or recommended diagnostic studies

3.2.9.2. Prognosis

3.2.9.3. Risks and benefits of management (treatment) options

3.2.9.4. Instructions for management (treatment) and/or follow-up

3.2.9.5. Importance of compliance with chosen management (treatment) options

3.2.9.6. Risk factor reduction

3.2.9.7. Patient and family education

3.2.10. **Destruction -** the ablation of benign, premalignant or malignant tissues by any method, with or without curettement, including local anesthesia, and not usually requiring closure. Any method includes electrosurgery, cryosurgery, laser and chemical treatment. Lesions include condylomata, papillomata, molluscum contagiosum, herpetic lesions, warts (i.e., common, plantar, flat), milia, or other benign, pre-malignant (e.g., actinic keratoses), or malignant lesions. Surgical destruction is a part of a surgical procedure and different methods of destruction are not ordinarily listed separately unless the technique substantially alters the standard management of a problem or condition. Exceptions under special circumstances are provided for by separate code numbers

3.2.11. **Excision** - is defined as full-thickness (through the dermis) removal of a lesion, including margins, and includes simple (non-layered) closure when performed.

3.2.12. **External fixation** - is the usage of skeletal pins plus an attaching mechanism/device used for temporary or definitive treatment of acute or chronic bony deformity.

3.2.13. **Family History -** A review of medical events in the patient's family that includes significant information about:

3.2.13.1. The health status or cause of death of parents, siblings, and children

3.2.13.2. Specific diseases related to problems identified in the Chief Complaint or History of the Present Illness, and/or System Review

3.2.13.3. Diseases of family members that may be hereditary or place the patient at risk

3.2.14. **Guidelines –** These are specific guidelines which are presented at the beginning of each of the six sections. These guidelines define items that are necessary to appropriately interpret and report the procedures and services contained in that section.

3.2.15. **HCPCS** - Healthcare Common Procedure Coding System – The System which coding is broken down into two primary subsystems, which are referred to as level I and level II. Level I HCPCS

coding includes the Current Procedural Terminology (CPT) codes, which are a numerical coding system maintained by the American Medical Association. CPT codes numerically identify medical services and procedures. HCPCS coding level II was established in the 1980s as way to assign codes to services, supplies, and procedures not included in the CPT coding system, but still covered by and billable to insurance companies. Level II HCPCS coding consists of a single letter followed by four numbers. Level II HCPCS procedure codes are **not** assigned in the Emirate of Abu Dhabi as the only code set for procedure coding is the Level I CPT codes.

3.2.16. **History of Present Illness** - A chronological description of the development of the patient's present illness from the first sign and/or symptom to the present. This includes a description of location, quality, severity, timing, context, modifying factors, and associated signs and symptoms significantly related to the presenting problem(s).

3.2.17. **Manipulation** - is used throughout the musculoskeletal fracture and dislocation subsections to specifically mean the attempted reduction or restoration of a fracture or joint dislocation to its normal anatomic alignment by the application of manually applied forces.

3.2.18. **Modifiers – Category I and Category II -** A modifier provides the means to report or indicate that a service or procedure that has been performed has been altered by some specific circumstance **but not changed** in its definition or code. Modifiers also enable health care professionals to effectively respond to payment policy requirements established by other entities. The judicious application of modifiers obviates the necessity for separate procedure listings that may describe the modifying circumstance. *(See Chapter Four)*

3.2.19. **New and Established Patient in E & M Coding -** Solely for the purposes of distinguishing between new and established patients,

3.2.19.1. A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.

3.2.19.2. An established patient is one who has received professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.

3.2.19.3. In the instance where a physician is on call for or covering for another physician, the patient's encounter will be classified as it would have been by the physician who is not available. No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

3.2.20. **Open treatment - is** used when the fractured bone is either: (1) surgically opened (exposed to the external environment) and the fracture (bone ends) visualized and internal fixation may be used; or (2) the fractured bone is opened remote from the fracture site in order to insert an intramedullary nail across the fracture site (the fracture site is not opened and visualized).

3.2.21. **Percutaneous skeletal fixation -** describes fracture treatment which is neither open nor closed. In this procedure, the fracture fragments are not visualized, but fixation (eg, pins) is placed across the fracture site, usually under X-ray imaging.

3.2.22. **Professional services** - are those face-to-face services rendered by a physician or healthcare provider and reported by a specific CPT code(s).

3.2.23. **Principal Procedure** – Is defined as the procedure performed for definitive treatment, rather than one performed for diagnostic or exploratory purposes or was necessary to take care of a complication. If there are two or more therapeutic procedures, then it is the one most related to the principal diagnosis. If all procedures are diagnostic, then it is the one most related to the principal diagnosis. If there is more than one, then it is the most resource intensive. The hierarchy is as follows:

3.2.23.1. Therapeutic

3.2.23.2. Related to Principal Diagnosis

3.2.23.3. Most resource intensive

3.2.23.4. If there is more than one procedure to be reported in a hospital or ambulatory visit, then the procedures need to be sequenced as principal or secondary for reporting purposes.

3.2.24. **Repair Closure -** The repair of wounds may be classified as Simple, Intermediate or Complex. *(See also Chapter 10 section 9*)

3.2.25. ***Simple repair*** is used when the wound is superficial; e.g., involving primarily epidermis or dermis, or subcutaneous tissues without significant involvement of deeper structures, and requires simple one layer closure. This includes local anesthesia and chemical or electrocauterization of wounds not closed.

3.2.26. ***Intermediate repair*** includes the repair of wounds that, in addition to the above, require layered closure of one or more of the deeper layers of subcutaneous tissue and superficial (non-muscle) fascia, in addition to the skin (epidermal and dermal) closure. Single-layer closure of heavily contaminated wounds that have required extensive cleaning or removal of particulate matter also constitutes intermediate repair.

3.2.27. ***Complex repair*** includes the repair of wounds requiring more than layered closure, viz., scar revision, debridement, (e.g., traumatic lacerations or avulsions), extensive undermining, stents or retention sutures. Necessary preparation includes creation of a defect for repairs (e.g., excision of a scar requiring a complex repair) or the debridement of complicated lacerations or avulsions. Complex repair does not include excision of benign (11400-11446) or malignant (11600-11646) lesions, excisional preparation of a wound bed (15002-15005) or debridement of an open fracture or open dislocation.

3.2.28. **Results/Testing/Reports** - Results are the technical component of a service. Testing leads to results; results lead to interpretation. Reports are the work product of the interpretation of numerous test results.

3.2.29. **Secondary Procedures** – All other significant procedures are to be reported as secondary procedures. A significant procedure is one that:

3.2.29.1. Is surgical in nature

3.2.29.2. Carries a procedural risk

3.2.29.3. Carries an anesthetic risk

3.2.29.4. Requires specialized training.

3.2.30. **Separate Procedure -** Procedures that can be performed along with the primary procedure, but are not essential to complete that procedure. Often these codes are identified by CPT nomenclature as “separate procedures. The code with such instructions may be a component of another code and therefore it would be incorrect to report both codes even when the component service is performed. The codes designated as "separate procedure" should not be reported in addition to the code for the total procedure or service of which it is considered an integral component.

3.2.30.1. These instructions are not intended as a listing of all possible code combinations that should not be reported, nor to indicate all possible code combinations that are appropriately reported.

3.2.30.2. If there is more than one procedure to be reported in a hospital or ambulatory visit, then the procedures need to be sequenced as principal or secondary for reporting purposes.

3.2.31. **Shaving of Epidermal or Dermal Lesions (11300-11313) -** Shaving is the sharp removal by transverse incision or horizontal slicing to remove epidermal and dermal lesions without a full-thickness dermal excision. This includes local anesthesia, chemical or electrocauterization of the wound. The wound does not require suture closure.

3.2.32. **Supervision & Interpretation** - Supervision and interpretation (S&I) codes are used to describe the personal supervision of the performance of the radiologic portion of a procedure by one or more physicians and the interpretation of the findings. These codes would not be assigned when the S & I is included in the procedure code descriptor.

3.2.33. **Technical Component** - Certain procedures or services described in CPT involve a technical component which is the ‘test’ component.

3.2.34. **Traction -** Skeletal traction is the application of a force (distracting or traction force) to a limb segment through a wire, pin, screw, or clamp that is attached (e.g., penetrates) to bone.

3.2.34.1. Skin traction is the application of a force (longitudinal) to a limb using felt or strapping applied directly to skin only.

3.2.35. **Transfer of care** - is the process whereby a physician who is providing management for some or all of a patient's problems relinquishes this responsibility to another physician who explicitly agrees to accept this responsibility and who, from the initial encounter, is not providing consultative services. The physician transferring care is then no longer providing care for these problems though he or she may continue providing care for other conditions when appropriate. Consultation codes should not be reported by the physician who has agreed to accept transfer of care before an initial evaluation but are appropriate to report if the decision to accept transfer of care cannot be made until after the initial consultation evaluation, regardless of site of service.

3.2.36. **Unbundling** - To inappropriately bill more CPT/HCPCS codes than necessary, applied when certain codes represent procedures that are basic steps to accomplish a primary procedure already on the bill and, by definition, are included in the reimbursement of the primary procedure.

3.2.37. **Unlisted Procedure/Service** – These are services or procedures performed by physicians or other qualified health care professionals that are not found in the CPT codebook. *(See Chapter Five)*

Chapter Three

3.3. Place-of-Service Codes for Claims

3.3.1. Listed below are place-of-service codes and descriptions which are utilized in the Emirate of Abu Dhabi. These codes should be used on claims in the Encounter Type. They specify the entity where service(s) were rendered along with the established Encounter Type. Check with individual payers for reimbursement policies regarding these codes.

Place of Service Code(s)	Place of Service Name	Place of Service Description
1	Outpatient	No Bed + No Emergency room
2	Emergency Room	No Bed + Emergency room
3	Inpatient	Inpatient Bed + No Emergency room
4	Inpatient	Inpatient Bed + Emergency room
5	Daycase	Daycase Bed + No Emergency room
6	Daycase	Daycase Bed + Emergency room
7		National Screening
8		New Visa Screening
9		Renewal Visa Screening
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted Living Facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.
15	Mobile Unit	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.
41	Ambulance - Land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
42	Ambulance – Air or Water	An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.

3.3.2. **Encounter Type as specified by the Data Standards Panel**

3.3.2.1.1 = No Bed + No emergency room 2 = No Bed + Emergency room 3 = Inpatient Bed + No emergency room 4 = Inpatient Bed + Emergency room 5 = Daycase Bed + No emergency room 6 = Daycase Bed + Emergency room 7 = Nationals Screening 8 = New Visa Screening 9 = Renewal Visa Screening 12 = Home 13 = Assisted Living Facility 15 = Mobile Unit 41 = Ambulance - Land 42 = Ambulance - Air or Water Note | There are different ways to classify Encounters as inpatients, daycases, emergencies and outpatients. They vary according to whether the Encounter went past midnight, lasted for more than 24 hours, and involved a hospital bed and whether they involved an emergency room. To benchmark with different countries, one needs to know, whether the patient was in the emergency room, and whether the patient occupied a hospital bed. Inpatient bed | A licensed bed approved by the competent authority which is assigned to a patient who is arriving to a health care facililty for an emergent, urgent or elective/planned Encounter. Beds assigned temporarily for "holding" purposes in a no bed situation may be designated and included in hospital occupancy rate calculation (e.g. emergency room, recovery room). Only beds included in the licensed inpatient bed complement will be used for purposes of hospital occupancy rate calculation. Beds may have an associated accommodation value such as private (i.e. single bed/room) or shared (i.e. multiple beds/room). Beds included in the inpatient bed complement: • Beds in general wards or units set up and staffed for inpatient services • Beds in special care units set up and staffed for inpatient services such as intensive care, coronary care, neonatal intensive care, pediatric intensive care, medical and surgical step-down, burn units Beds excluded from the inpatient bed complement: • Beds/cots for healthy newborns • Beds in Day Care units, such as surgical, medical, pediatric day care, interventional radiology • Beds in Dialysis units • Beds in Labor Suites (e.g. birth day beds, birthing chairs) • Beds in Operating Theatre • Temporary beds such as stretchers • Chairs, Cots or Beds used to accommodate sitters, parents, guardians accompanying patients or sick children and healthy baby accompanying a hospitalized breast feeding mother • Beds closed during renovation of patient care areas when approved by the competent authority Daycase bed | Daycase beds, also known as observation beds, are beds used in Day Care units such as surgical, medical, pediatric day care interventional radiology. They are not included in the inpatient bed complement. Restrictions: Only values allowed are: 1 = No Bed + No emergency room 2 = No Bed + Emergency room 3 = Inpatient Bed + No emergency room 4 = Inpatient Bed + Emergency room 5 = Daycase Bed + No emergency room 6 = Daycase Bed + Emergency room 7 = Nationals Screening 8 = New Visa Screening 9 = Renewal Visa Screening 12 = Home 13 = Assisted Living Facility 15 = Mobile Unit 41 = Ambulance - Land 42 = Ambulance - Air or Water.

3.3.3. ***See the HAAD Data Elements (alphabetical)*** www.shafafiya.org

Chapter Four

3.4. Modifiers

3.4.1. Selected modifiers have been approved for assignation in the Emirate of Abu Dhabi; however, the time frame for requirement has not as yet been defined. Please refer to Data Standard Panel minutes for the defined timeframe and format. *(See lists below3.4.2.1.3 and 3.4.2.2.3)*

3.4.2. There are two levels of Modifiers.:

3.4.2.1.Level I Modifier

3.4.2.1.1. Two digits like 25

3.4.2.1.2. Updated annually by AMA

3.4.2.1.3. List of approved Level I Modifiers

CCSC Decision, 080 and 081: Implement selected Level I (CPT) Modifiers:

To give a CPT services or procedure code(s) added information/ specificity, without changing the definition of the code the following Level I Modifiers (commonly referred to as CPT modifiers) may be added:

- 50 Bilateral Procedure: Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session should be identified by adding the modifier 50 to the appropriate five digit code.
- 52 Reduced Services: Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.
- 63 Procedure Performed on Infants less than 4 kg: Procedures performed on neonates and infants up to a present body weight of 4 kg may involve significantly increased complexity and physician work commonly associated with these patients. Note: Unless otherwise designated, this modifier may only be appended to procedures/services listed in the 20000–69999 code series. Modifier 63 should not be appended to any CPT codes listed in the Evaluation and Management Services, Anesthesia, Radiology, Pathology/Laboratory, or Medicine sections.
- 26 This modifier is used only for the professional component (physician) of a service or a procedure.

3.4.2.2.Level II

3.4.2.2.1. 2 digits (A-V)

3.4.2.2.2. Updated annually by CMS

3.4.2.2.3. List of approved Level I Modifiers

CCSC Decision, 082 and 083: Implement selected Level II (HCPCS) Modifiers:

To give a CPT services or procedure code(s) added information/ specificity, without changing the definition of the code the following Level II Modifiers (commonly referred to as HCPCS modifiers) may be added:

- GG Performance and Payment of a screening mammogram and diagnostic mammogram on the same patient, same day
- GH Diagnostic Mammogram converted from screening mammogram on same day
- RT Right Side (used to identify procedures performed on the right side of the body (paired body parts))
- LT Left Side (used to identify procedures performed on the left side of the body (paired body parts))
- TC - Technical Component (used to identify the technical component of a service as opposed to 26 which is the professional component)

3.4.3. A modifier provides the means by which the reporting physician can indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code. The judicious application of modifiers obviates the necessity for separate procedure listings that may describe the modifying circumstance. Modifiers may be used to indicate to the recipient of a report that:

3.4.3.1. A service or procedure had both a professional and technical component.

3.4.3.2. A service or procedure was performed by more than one physician and/or in more than one location.

3.4.3.3. A service or procedure was increased or reduced.

3.4.3.4. Only part of a service was performed.

3.4.3.5. An adjunctive service was performed.

3.4.3.6. A bilateral procedure was performed.

3.4.3.7. A service or procedure was provided more than once.

3.4.3.8. Unusual events occurred.

Chapter Five

3.5. Unlisted Procedure or Service codes

3.5.1. It is recognized that there may be services or procedures performed by physicians that are not found in the CPT codebook. Therefore, a number of specific code numbers have been designated for reporting unlisted procedures. Each of these unlisted procedural code numbers relates to a specific section of the book and is presented in the guidelines of that section. In the Emirate of Abu Dhabi, to report the unlisted procedure or service the following should be implemented:

3.5.1.1. List the specific “unlisted” procedure code from the relevant chapter in CPT (i.e., do not use the service code for undefined services)

3.5.1.2. Charge the pre-agreed price for this code. If no specific charge has been pre-agreed, then use the charge of the most closely related procedure, and describe this procedure in an Observation (Type=Text,Code=ClosestUnlistedProcedure,Value=Text description of procedure);

3.5.1.3. Disagreements on price can be resolved through the remittance/resubmission process

3.5.1.4. For the avoidance of doubt, the process of claiming for unlisted procedures does not alter the benefits coverage for members

Chapter Six

3.6. Add – On Codes

3.6.1. Add-on codes in CPT 2011 can be readily identified by specific descriptor nomenclature that includes phrases such as "each additional" or "(List separately in addition to primary procedure)."

3.6.2. The add-on code concept in CPT 2011 applies only to add-on procedures or services performed by the **same physician**. Add-on codes describe additional intra-service work associated with the primary procedure, e.g., additional digit(s), lesion(s), neurorrhaphy(s), vertebral segment(s), tendon(s), joint(s).

3.6.3. Add-on codes are always performed in addition to the primary service or procedure and must **never be reported as a stand-alone code**.

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Chapter Seven

3.7. Time

3.7.1. Time in Procedure Codes

3.7.1.1. The CPT code set contains many codes with a time basis for code selection. The following standards shall apply to time measurement**, unless there are code or code- range-specific instructions in guidelines, parenthetical instructions, or code descriptors to the contrary.**

3.7.1.2. Time is the face-to-face time with the patient. Phrases such as "interpretation and report" in the code descriptor are not intended to indicate in all cases that report writing is part of the reported time.

3.7.1.3. A unit of time is attained when the mid-point is passed. For example, an hour is attained when 31 minutes have elapsed (more than midway between zero and sixty minutes). A second hour is attained when a total of 91 minutes have elapsed. When codes are ranked in sequential typical times and the actual time is between two typical times, the code with the typical time closest to the actual time is used. (*See also Chapter Eight the Evaluation and Management (E/M) Services Guidelines*). When another service is performed concurrently with a time based service, the time associated with the concurrent service should not be included in the time used for reporting the time-based service.

3.7.1.4. Some services measured in units other than days extend across calendar dates. When this occurs a continuous service does not reset and create a first hour. However, any disruption in the service does create a new initial service. For example, if intravenous hydration (96360, 96361) is given from 11 PM to 2 AM 96360 would be reported once and 96361 twice. However, if instead of a continuous infusion, a medication was given by intravenous push at 10 PM and 2 AM, as the service was not continuous; both administrations would be reported as initial (96374). For continuous services that last beyond midnight, use the date in which the service began and report the total units of time provided continuously.

3.7.2. Time in Evaluation & Management Coding

3.7.2.1. The inclusion of time in the definitions of levels of E/M services is done to assist physicians in selecting the most appropriate level of E/M services. It should be recognized that the specific times expressed in the visit code descriptors are *averages*, and therefore represent a range of times which may be higher or lower depending on actual clinical circumstances.

3.7.2.2. Time is **not** a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time. Therefore, it is often difficult for physicians to provide accurate estimates of the time spent face-to-face with the patient.

3.7.2.2.1. **Intra-service times** are defined as **face-to-face** time for office and other outpatient visits and as unit/floor time for hospital and other inpatient visits. This distinction is necessary because most of the work of typical office visits takes place during the face-

to-face time with the patient, while most of the work of typical hospital visits takes place during the time spent on the patient's floor or unit. When prolonged time occurs in either the office or the inpatient areas, the appropriate add-on code should be reported.

3.7.2.2.2. ***Face-to-face time (office and other outpatient visits and office consultations):*** For coding purposes, face-to-face time for these services is defined as only that time that the physician spends face-to-face with the patient and/or family. This includes the time in which the physician performs such tasks as obtaining a history, performing an examination, and counseling the patient.

- Physicians also spend time doing work before or after the face-to-face time with the patient, performing such tasks as reviewing records and tests, arranging for further services, and communicating further with other professionals and the patient through written reports and telephone contact.
- This **non face-to-face** time for office services - also called pre- and post-encounter time - is not included in the time component described in the E/M codes. However, the pre-and post-non-face-to-face work associated with an encounter was included in calculating the total work of typical services in physician surveys.
- Thus, the face-to-face time associated with the services described by any E/M code is a valid proxy for the total work done before, during, and after the visit.

3.7.2.2.3. Unit/floor time (hospital observation services, inpatient hospital care, and initial inpatient hospital consultations, nursing facility): For reporting purposes, intraservice time for these services is defined as unit/floor time, which includes the time that the physician is present on the patient's hospital unit and at the bedside rendering services for that patient. This includes the time in which the physician establishes and/or reviews the patient's chart, examines the patient, writes notes, and communicates with other professionals and the patient's family.

- In the hospital, pre- and post-time includes time spent off the patient's floor performing such tasks as reviewing pathology and radiology findings in another part of the hospital.

- This pre- and post visit time is not included in the time component described in these codes. However, the pre- and post-work performed during the time spent off the floor or unit was included in calculating the total work of typical services in physician surveys. Thus, the unit/floor time associated with the services described by any code is a valid proxy for the total work done before, during, and after the visit.

- When **counseling and/or coordination of care dominates (more than 50%)** the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), then time shall be considered the key or controlling factor to qualify for a particular level of E/M services. This includes time spent with parties who have assumed responsibility for the care of the patient or decision making whether or not they are family members (eg, foster parents, person acting in loco parentis, legal guardian). The extent of counseling and/or coordination of care must be documented in the medical record.

3.7.3. **Time as a Factor in the Emergency Department Setting**

3.7.3.1. Time is not a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time. Therefore, it is often difficult for physicians to provide accurate estimates of the time spent face-to-face with the patient.

Chapter Eight

3.8. Evaluation & Management

3.8.1. In addition to the information presented in the Chapter One **Introduction**, several other items unique to this section are defined or identified here.

3.8.2. Any significant separately identifiable procedure (e.g., identified with a specific CPT code) performed on or subsequent to the date of initial or subsequent "E/M Services" should be reported separately.

3.8.3. The actual performance and/or interpretation of diagnostic tests/studies ordered during a patient encounter are not included in the levels of E/M services. Physician performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately, in addition to the appropriate E/M code. The physician's interpretation of the results of diagnostic tests/studies (e.g., professional component) with preparation of a separate distinctly identifiable signed written report may also be reported separately, using the appropriate CPT code.

3.8.4. The physician may need to document that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant separately identifiable E/M service above and beyond other services provided or beyond the usual preservice and postservice care associated with the procedure that was performed. The E/M service may be caused or prompted by the symptoms or condition for which the procedure and/or service was provided.

3.8.4.1. **Classification of Evaluation and Management (E/M) Services**

3.8.4.1.1. The E/M section is divided into broad categories such as office visits, hospital visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) (*please see Chapter Two Commonly Used Terms*). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes. This classification is important because the nature of physician work varies by type of service, place of service, and the patient's status.

3.8.4.1.2. In the CPT 4th Edition 2011 code book, the basic format of the levels of E/M services is the same for most categories. First, a unique code number is listed. Second, the place and/or type of service is specified, eg, office consultation. Third, the content of the service is defined, e.g., comprehensive history and comprehensive examination. (*See "Levels of E/M Services" below for details on the content of E/M services.*) Fourth, the nature of the presenting problem(s) usually associated with a given level is described. Fifth, the time typically required to provide the service is specified. (*See Chapter Seven Time)*

3.8.4.1.3. In the Emirate of Abu Dhabi, E & M codes are used for coding and billing in the Outpatient Setting. (Inpatient Settings are coded and billed through IR DRG, (*See III IR DRG in the Emirate of Abu Dhabi*)). It was confirmed by the Clinical Coding Steering Committee that all Outpatient categories of E & M codes will be valid E & M codes for Outpatient coding and billing in the Emirate of Abu Dhabi. As long as the E & M Outpatient Code is within the scope of work and meets the documentation criteria *(See 3. Levels of E & M Codes below*), any approved Outpatient E & M Code, as published by the CCSC Coding Manual, may be used to designate the services rendered by any qualified licensed physician or other qualified licensed healthcare professional (See Chapter One Introduction) as follows:

3.8.4.1.3.1.Registered School Nurse

3.8.4.1.3.2.Registered Nurses

3.8.4.1.3.3.Registered Midwife

3.8.4.1.3.4.Optometrist

3.8.4.1.3.5.Podiatrists

3.8.4.1.3.6.Chiropractic Practioner

3.8.4.1.3.7.Osteopathy Practioner

3.8.4.1.4. However, it is important to liaise with the Payor(s) as to whether these codes will be reimbursed.

3.8.4.2.**Auditing for E & M codes**

3.8.4.2.1. All Healthcare Facilities will be required to pass a HAAD/CCSC Clinical Coding Audit to be listed as a Coding Certified Facility (*See Section IV, Chapter Four CCSC Audit)* before being certified to bill with the Levels of the Outpatient E & M codes and/or Telemedicine Service Codes.

3.8.4.3.**Outpatient Consultation E & M Codes (99241 – 99245)**

3.8.4.3.1. A consultation is a type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source. Do not confuse with a "referral" which is a transfer of a patient's care to another physician. Therefore the physician performing the consultation must document the intent to return the patient to the attending physician after the opinion or advice for the specific problem is completed.

3.8.4.3.2. A physician consultant may initiate diagnostic and/or therapeutic services at the same or subsequent visit.

3.8.4.3.3. The written or verbal request for a consult may be made by a physician or other appropriate source and documented in the patient's medical record. The consultant's

opinion and any services that were ordered or performed must also be documented in the patient's medical record and communicated by written report to the requesting physician or other appropriate source

3.8.4.3.4. These codes are used to report consultations provided in the physician's office or in an outpatient or other ambulatory facility, including hospital observation services, home services, domiciliary, rest home, or emergency department (see the preceding consultation definition above). Follow-up visits in the consultant's office or other outpatient facility that are initiated by the physician consultant or patient are reported using the appropriate codes for established patients, office visits

3.8.4.4. **Telemedicine and Telephone Services NEVER TO BE CODED TOGETHER**

3.8.4.4.1. Telephone Services (99441-99443)

- Telephone services are non-face-to-face evaluation and management (E/M) services provided by a physician to a patient using the telephone. These codes are used to report episodes of care by the physician initiated by an established patient or guardian of an established patient. If the telephone service ends with a decision to see the patient within 24 hours or next available urgent visit appointment, the code is not reported; rather the encounter is considered part of the preservice work of the subsequent E/M service, procedure, and visit. Likewise if the telephone call refers to an E/M service performed and reported by the physician within the previous seven days (either physician requested or unsolicited patient follow-up) or within the postoperative period of the previously completed procedure, then the service(s) are considered part of that previous E/M service or procedure. (Do not report 99441-99443 if reporting 99441-99444 performed in the previous seven days.)

3.8.4.4.2. Telemedicine

- Telemedicine refers to healthcare services provided via a range of technology enabled communication media other than face-to-face interactions, such as telephone, internet, video and others.
- Coding will follow the HAAD Standard for Tele-counseling in the Emirate of Abu Dhabi and this Coding Manual with the assignment of the relevant HAAD service codes and ICD 9 CM diagnostic codes.
- Documentation to support the following Telemedicine/tele-consulting service codes will follow all documentation rules and guidelines as stated in Section

- Level 1 – Telemed call for the evaluation and/or management of a patient, which requires these 2 key components:
  A problem focused history;
  Straightforward medical decision making.
  Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.
  Usually, the presenting problem(s) are self limited or minor.

- Level 2 – Telemed call for the evaluation and/or management of a patient, which requires these 2 key components:
  An expanded problem focused history;

Medical decision making of low complexity.
Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.
Usually, the presenting problem(s) are of low to moderate severity.

- Level 3 – Telemed call for the evaluation and/or management of a patient, which requires these 2 key components:
  An expanded problem focused history;
  Medical decision making of moderate complexity.
  Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs
  Usually, the presenting problem(s) are of moderate severity

3.8.4.5..**Levels of E/M Services**

- Within each category or subcategory of E/M service, there are three to five levels of E/M services available for reporting purposes. Levels of E/M services are **not** interchangeable among the different categories or subcategories of service. For example, the first level of E/M serves in the subcategory of office visit, new patient, does not have the same definition as the first level of E/M services in the subcategory of office visit, established patient.

- The levels of E/M services include examinations, evaluations, and treatments, conferences with or concerning patients, preventive pediatric and adult health supervision, and similar medical services, such as the determination of the need and/or location for appropriate care.

  Medical screening includes the history, examination, and medical decision-making required to determine the need and/or location for appropriate care and treatment of the patient (eg, office and other outpatient setting, emergency department, nursing facility, etc.). The levels of E/M services encompass the wide variations in skill, effort, time, responsibility and medical knowledge required for the prevention or diagnosis and treatment of illness or injury and the promotion of optimal health. Each level of E/M services may be used by all physicians and non-physicians, providing the appropriate documentation is evident and the level of work is within the scope of his/her license, also that the guidelines for said code does not specify it as being for a specific specialty.

- The descriptors for the levels of E/M services recognize seven components, six of which are used in defining the levels of E/M services. These components are:

  - History
  - Examination
  - Medical decision making
  - Counseling
  - Coordination of care

  - Nature of presenting problem
  - Time

- The first three of these components (history, examination and medical decision making) are considered the **key** components in selecting a level of E/M services.

- The next three components (counseling, coordination of care and the nature of the presenting problem) are considered **contributory** factors in the majority of encounters. Although the first two of these contributory factors are important E/M services, it is not required that these services be provided at every patient encounter. Coordination of care with other providers or agencies without a patient encounter on that day is reported using the case management codes. The final component is time.

3.8.4.5.1. **Family History -** A review of medical events in the patient's family that includes significant information about:

- The health status or cause of death of parents, siblings, and children
- Specific diseases related to problems identified in the Chief Complaint or History of the Present Illness, and/or System Review
- Diseases of family members which may be hereditary or place the patient at risk

3.8.4.5.2. **History of Present Illness -** A chronological description of the development of the patient's present illness from the first sign and/or symptom to the present. This includes a description of location, quality, severity, timing, context, modifying factors and associated signs and symptoms significantly related to the presenting problem(s).

3.8.4.5.3. **Past History -** A review of the patient's past experiences with illnesses, injuries, and treatments that includes significant information about:

- Prior major illnesses and injuries
- Prior operations
- Prior hospitalizations
- Current medications
- Allergies (e.g., drug, food)
- Age appropriate immunization status
- Age appropriate feeding/dietary status

3.8.4.5.4. **Social History -** An age appropriate review of past and current activities that includes significant information about:

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- Marital status and/or living arrangements
- Current employment
- Occupational history
- Use of drugs, alcohol, and tobacco
- Level of education
- Sexual history
- Other relevant social factors

3.8.4.5.5. **System Review (Review of Systems) –**

- An inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced. For the purposes of the CPT codebook the following elements of a system review have been identified:
    - Constitutional symptoms (fever, weight loss, etc.)
    - Eyes
    - Ears, Nose, Mouth, Throat
    - Cardiovascular
    - Respiratory
    - Gastrointestinal
    - Genitourinary
    - Musculoskeletal
    - Integumentary (skin and/or breast)
    - Neurological
        - Psychiatric
        - Endocrine
        - Hematologic/Lymphatic
        - Allergic/Immunologic
- The review of systems helps define the problem, clarify the differential diagnosis, identify needed testing, or serves as baseline data on other systems that might be affected by any possible management options.

3.8.4.5.6. **Counseling -** Counseling is a discussion with a patient and/or family concerning one or more of the following areas:

- Diagnostic results, impressions, and/or recommended diagnostic studies
- Prognosis
- Risks and benefits of management (treatment) options
- Instructions for management (treatment) and/or follow-up
- Importance of compliance with chosen management (treatment) options
- Risk factor reduction
- Patient and family education

3.8.4.5.7. **Nature of Presenting Problem**

- A presenting problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason for encounter, with or without a diagnosis being established at the time of the encounter. The E/M codes recognize five types of presenting problems that are defined as follows:
  - ***Minimal:*** A problem that may not require the presence of the physician, but service is provided under the physician's supervision.
  - ***Self-limited or minor:*** A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status OR has a good prognosis with management/compliance.
  - ***Low severity:*** A problem where the risk of morbidity without treatment is low; there is little to no risk of mortality without treatment; full recovery without functional impairment is expected.
  - ***Moderate severity:*** A problem where the risk of morbidity without treatment is moderate; there is moderate risk of mortality without treatment; uncertain prognosis OR increased probability of prolonged functional impairment.
  - ***High severity:*** A problem where the risk of morbidity without treatment is high to extreme; there is a moderate to high risk of mortality without treatment OR high probability of severe, prolonged functional impairment.

3.8.4.5.8. **Time** – *(See Chapter Seven Time)*

3.8.4.5.9. **Determine the Extent of History Obtained**

- The extent of the history is dependent upon clinical judgment and on the nature of the presenting problem(s). The levels of E/M services recognize four types of history that are defined as follows:
    - ***Problem focused:*** chief complaint; brief history of present illness or problem.
    - ***Expanded problem focused:*** chief complaint; brief history of present illness; problem pertinent system review.
    - ***Detailed:*** chief complaint; extended history of present illness; problem pertinent system review extended to include a review of a limited number of additional systems; **pertinent** past, family, and/or social history **directly related to the patient's problems.**
    - ***Comprehensive:*** chief complaint; extended history of present illness; review of systems which is directly related to the problem(s) identified in the history of the present illness plus a review of all additional body systems; **complete** past, family and social history.
        - The comprehensive history obtained as part of the preventive medicine evaluation and management service is not problem-oriented and does not involve a chief complaint or present illness. It does, however, include a comprehensive system review and comprehensive or interval past, family and social history as well as a comprehensive assessment/history of pertinent risk factors.

3.8.4.5.10. **Determine the Extent of Examination Performed**

- The extent of the examination performed is dependent on clinical judgment and on the nature of the presenting problem(s). The levels of E/M services recognize four types of examination that are defined as follows:
    - ***Problem focused:*** a limited examination of the affected body area or organ system.
    - ***Expanded problem focused:*** a limited examination of the affected body area or organ system and other symptomatic or related organ system(s).
    - ***Detailed:*** an extended examination of the affected body area(s) and other symptomatic or related organ system(s).
    - ***Comprehensive:*** a general multi-system examination or a complete examination of a single organ system. **Note:** The comprehensive examination performed as part of the preventive medicine evaluation and management service is multi-system, but its extent is based on age and risk factors identified.
- For the purposes of these CPT definitions, the following body areas are recognized:
    - Head, including the face
    - Neck

- Chest, including breasts and axilla
- Abdomen
- Genitalia, groin, buttocks
- Back
- Each extremity

- For the purposes of these CPT definitions, the following organ systems are recognized:
  - Eyes
  - Ears, Nose, Mouth and Throat
  - Cardiovascular
  - Respiratory
  - Gastrointestinal
  - Genitourinary
  - Musculoskeletal
  - Skin
  - Neurologic
  - Psychiatric
  - Hematologic/Lymphatic/Immunologic

3.8.4.5.11. **Determine the Complexity of Medical Decision Making**

- Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:
  - the number of possible diagnoses and/or the number of management options that must be considered
  - the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed
  - the risk of significant complications, morbidity and/or mortality, as well as co morbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management option

- Four types of medical decision making are recognized: straightforward; low complexity; moderate complexity; and high complexity. To qualify for a given type of decision making, two of the three elements in the table below must be met or exceeded.

- Co morbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M services *unless* their presence significantly increases the complexity of the medical decision making.

Complexity of Medical Decision Making

Number of Diagnoses or Management Options	Amount and/or Complexity of Data to be Reviewed	Risk of Complications and/or Morbidity or Mortality	Type of Decision Making
minimal	minimal or none	minimal	**straightforward**
limited	limited	low	**low complexity**
multiple	moderate	moderate	**moderate complexity**
extensive	extensive	high	**high complexity**

3.8.4.6.**Select the Appropriate Level of E/M Services Based on the Following**

- For the following categories/subcategories, **all of the key components,** e.g., history, examination, and medical decision making, must meet or exceed the stated requirements to qualify for a particular level of E/M service: office, new patient; hospital observation services; initial hospital care; office consultations; initial inpatient consultations; emergency department services; initial nursing facility care; domiciliary care, new patient; and home, new patient.

- For the following categories/subcategories, **two of the three key components** (e.g., history, examination, and medical decision making) must meet or exceed the stated requirements to qualify for a particular level of E/M services: office, established patient; subsequent hospital are; subsequent nursing facility care; domiciliary care, established patient; and home, established patient.

- When the patient is admitted to the hospital as an inpatient in the course of an encounter in another site of service (e.g., hospital emergency department, physician's office/clinic) all evaluation and management services provided by that physician in conjunction with that admission are considered part of the initial hospital care when performed on the same date as the admission. The inpatient care level of service reported by the admitting physician should include the services related to the admission he/she provided in the other sites of service as well as in the inpatient setting. If on a different day, then it can be reported additionally.

- When counseling and/or coordination of care dominates (more than 50%) the physician/patient and/or family encounter *(See Chapter Seven Time)*

- Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory. Where these are indicated, e.g., "Inpatient Hospital Care," special instructions will be presented preceding the levels of E/M services.

- The CCSC recommends the 1995 Guidelines for Evaluation and Management codes be utilized for assigning Evaluation and Management codes. However, if a facility has utilized the 1997 Guidelines prior to the CCSC's written announcement in September 2010, it may state this at the onset of the Clinical Coding audit, the auditor will then audit strictly using the 1997 guidelines and state this fact in his report as well as showing this in the record of the audit. The facility must state one guideline or another. A usage of a combination of these two guidelines is not acceptable. *(See the Clinical Coding Steering Committee Audit Methodology 2012)*

- For Telemedicine/tele-consulting, the Service Codes levels will be based on the criteria of the Key Elements of History and Medical Decision Making being met or exceeded, as per the documentation requirements for all CPT Emergency Department Evaluation and Management codes without the third Key Element of Exam.

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Chapter Nine

3.9. Anesthesia

3.9.1. The reporting of anesthesia services is appropriate by or under the responsible supervision of a physician. These services may include but are not limited to general, regional, supplementation of local anesthesia, or other supportive services in order to afford the patient the anesthesia care deemed optimal by the anesthesiologist during any procedure. Unless specified in the procedure code, they are assigned in addition to the procedure code.

3.9.2. These services include the usual preoperative and postoperative visits, the anesthesia care during the procedure, the administration of fluids and/or blood and the usual monitoring services (e.g., ECG, temperature, blood pressure, oximetry, capnography, and mass spectrometry). Unusual forms of monitoring (e.g., intra-arterial, central venous, and Swan-Ganz) are not included.

3.9.3. **Moderate Sedation -** For the procedures, when a second physician other than the health care professional performing the diagnostic or therapeutic services provides moderate (conscious) sedation in the facility setting (e.g., hospital, outpatient hospital/ambulatory surgery center, skilled nursing facility), the second physician reports the associated moderate sedation procedure/service 99148-99150; when these services are performed by the second physician in the nonfacility setting (e.g., physician office, freestanding imaging center), codes 99148-99150 would not be reported. Moderate sedation does not include minimal sedation (anxiolysis), deep sedation, or monitored anesthesia care (00100-01999).

3.9.4. For a summary of codes that include Moderate (Conscious) Sedation see Appendix G in the CPT codebook.

3.9.5. **Separate or Multiple Procedures -** When multiple surgical procedures are performed during a single anesthetic administration, the anesthesia code representing the most complex procedure is reported. The time reported is the combined total for all procedures

3.9.6. **Time for Reporting -** Anesthesia time begins when the anesthesiologist begins to prepare the patient for the induction of anesthesia in the operating room or in an equivalent area and ends when the anesthesiologist is no longer in personal attendance, that is, when the patient may be safely placed under postoperative supervision.

3.9.7. **Aborted Procedure -** Unlisted Procedure code 01999 will be coded for aborted or discontinued anesthesia procedures in addition to the relevant anesthesia code

3.9.8. *For further information See Chapter Ten, 1. CPT Surgical Package as well as the HAAD Claims and Adjudication Rules*

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Chapter Ten

3.10. Surgery

- Physicians' services rendered in the office, home, or hospital, consultations, and other medical services are listed in the section entitled **Evaluation and Management Services** (99201-99499) *(See Chapter Eight E & M Codes)*

3.10.1. CPT Surgical Package

- The services provided by the physician to any patient by their very nature are variable. The CPT codes that represent a readily identifiable surgical procedure thereby include, on a procedure-by-procedure basis, a variety of services. In defining the specific services "included" in a given CPT surgical code, the following services are always included in addition to the operation per se:
    - Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia;
    - Subsequent to the decision for surgery, one related E/M encounter on the date immediately prior to or on the date of procedure (including history and physical);
    - Immediate postoperative care, including dictating operative notes, talking with the family and other physicians;
    - Writing orders;
    - Evaluating the patient in the postanesthesia recovery area;
    - Typical postoperative follow-up care.

3.10.2. Follow-up Care for Diagnostic Procedures

- Follow-up care for diagnostic procedures (e.g., endoscopy, arthroscopy, injection procedures for radiography) includes only that care related to recovery from the diagnostic procedure itself. Care of the condition for which the diagnostic procedure was performed or of other concomitant conditions is not included and may be listed separately.

3.10.3. Follow-up Care for Therapeutic Surgical Procedures

- Follow-up care for therapeutic surgical procedures includes only that care which is usually a part of the surgical service. Complications, exacerbations, recurrence, or the presence of other diseases or injuries requiring additional services should be separately reported.

3.10.4. Materials Supplied by Physician

- Supplies and materials provided by the physician (e.g., sterile trays/drugs), over and above those usually included with the procedure(s) rendered are reported separately. List drugs, trays, supplies, and materials provided. Identify as 99070 or specific supply code.

3.10.5. **Subsection Information**

- Many of the Subheadings and Subsections in the CPT book have special needs or instructions unique to that section. The coder is to always refer to these guidelines when assigning codes and these guidelines, as stated in the CPT book, are the rules for coding all code(s) in the Emirate of Abu Dhabi. Where these are indicated (e.g., "Maternity Care and Delivery"), special "Notes" will be presented preceding those procedural terminology listings, referring to that subsection specifically. If there is an "Unlisted Procedure" code number (see below) for the individual subsection, it will also be shown.

3.10.6. **Unlisted Procedures Code(s) (Surgery Section)**

- A service or procedure may be provided that is not listed in the *CPT.2011 Edition.* When reporting such a service, the appropriate "Unlisted Procedure" code may be used to indicate the service. The "Unlisted Procedures" and accompanying codes for Surgery are as follows:

    - 15999 Unlisted procedure, excision pressure ulcer
    - 17999 Unlisted procedure, skin, mucous membrane and subcutaneous tissue
    - 19499 Unlisted procedure, breast
    - 20999 Unlisted procedure, musculoskeletal system, general
    - 21089 Unlisted maxillofacial prosthetic procedure
    - 21299 Unlisted craniofacial and maxillofacial procedure
    - 21499 Unlisted musculoskeletal procedure, head
    - 21899 Unlisted procedure, neck or thorax
    - 22899 Unlisted procedure, spine
    - 22999 Unlisted procedure, abdomen, musculoskeletal system
    - 23929 Unlisted procedure, shoulder
    - 24999 Unlisted procedure, humerus or elbow
    - 25999 Unlisted procedure, forearm or wrist
    - 26989 Unlisted procedure, hands or fingers
    - 27299 Unlisted procedure, pelvis or hip joint
    - 27599 Unlisted procedure, femur or knee
    - 27899 Unlisted procedure, leg or ankle
    - 28899 Unlisted procedure, foot or toes
    - 29799 Unlisted procedure, casting or strapping
    - 29999 Unlisted procedure, arthroscopy
    - 30999 Unlisted procedure, nose
    - 31299 Unlisted procedure, accessory sinuses
    - 31599 Unlisted procedure, larynx

- 31899 Unlisted procedure, trachea, bronchi
- 32999 Unlisted procedure, lungs and pleura
- 33999 Unlisted procedure, cardiac surgery
- 36299 Unlisted procedure, vascular injection
- 37501 Unlisted vascular endoscopy procedure
- 37799 Unlisted procedure, vascular surgery
- 38129 Unlisted laparoscopy procedure, spleen
- 38589 Unlisted laparoscopy procedure, lymphatic system
- 38999 Unlisted procedure, hemic or lymphatic system
- 39499 Unlisted procedure, mediastinum
- 39599 Unlisted procedure, diaphragm
- 40799 Unlisted procedure, lips
- 40899 Unlisted procedure, vestibule of mouth
- 41599 Unlisted procedure, tongue, floor of mouth
- 41899 Unlisted procedure, dentoalveolar structures
- 42299 Unlisted procedure, palate, uvula
- 42699 Unlisted procedure, salivary glands or ducts
- 42999 Unlisted procedure, pharynx, adenoids, or tonsils
- 43289 Unlisted laparoscopy procedure, esophagus
- 43499 Unlisted procedure, esophagus
- 43659 Unlisted laparoscopy procedure, stomach
- 43999 Unlisted procedure, stomach
- 44238 Unlisted laparoscopy procedure, intestine (except rectum)
- 44799 Unlisted procedure, intestine
- 44899 Unlisted procedure, Meckel's diverticulum and the mesentery
- 44979 Unlisted laparoscopy procedure, appendix
- 45499 Unlisted laparoscopy procedure, rectum
- 45999 Unlisted procedure, rectum
- 46999 Unlisted procedure, anus
- 47379 Unlisted laparoscopic procedure, liver
- 47399 Unlisted procedure, liver
- 47579 Unlisted laparoscopy procedure, biliary tract
- 47999 Unlisted procedure, biliary tract
- 48999 Unlisted procedure, pancreas
- 49329 Unlisted laparoscopy procedure, abdomen, peritoneum and omentum

- 49659 Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy
- 49999 Unlisted procedure, abdomen, peritoneum and omentum
- 50549 Unlisted laparoscopy procedure, renal
- 50949 Unlisted laparoscopy procedure, ureter
- 51999 Unlisted laparoscopy procedure, bladder
- 53899 Unlisted procedure, urinary system
- 54699 Unlisted laparoscopy procedure, testis
- 55559 Unlisted laparoscopy procedure, spermatic cord
- 55899 Unlisted procedure, male genital system
- 58578 Unlisted laparoscopy procedure, uterus
- 58579 Unlisted hysteroscopy procedure, uterus
- 58679 Unlisted laparoscopy procedure, oviduct, ovary
- 58999 Unlisted procedure, female genital system (nonobstetrical)
- 59897 Unlisted fetal invasive procedure, including ultrasound guidance, when performed
- 59898 Unlisted laparoscopy procedure, maternity care and delivery
- 59899 Unlisted procedure, maternity care and delivery
- 60659 Unlisted laparoscopy procedure, endocrine system
- 60699 Unlisted procedure, endocrine system
- 64999 Unlisted procedure, nervous system
- 66999 Unlisted procedure, anterior segment of eye
- 67299 Unlisted procedure, posterior segment
- 67399 Unlisted procedure, ocular muscle
- 67599 Unlisted procedure, orbit
- 67999 Unlisted procedure, eyelids
- 68399 Unlisted procedure, conjunctiva
- 68899 Unlisted procedure, lacrimal system
- 69399 Unlisted procedure, external ear
- 69799 Unlisted procedure, middle ear
- 69949 Unlisted procedure, inner ear
- 69979 Unlisted procedure, temporal bone, middle fossa approach

- **Unlisted Procedure Codes in Abu Dhabi:**
  - According to the Data Standard Panel agenda item 129, the following applies to Unlisted Procedures in the Emirate of Abu Dhabi:

- Report the specific "unlisted" procedure code from the chapter in CPT that it belongs to and is relevant for the documentation (i.e., don't use the service code for undefined services)
- Charge the pre-agreed price for this code. If no specific charge has been pre-agreed, then use the charge of the most closely related procedure, and describe this procedure in an Observation (Type=Text,Code=ClosestUnlistedProcedure,Value=Text description of procedure);
- Disagreements on price can be resolved through the remittance/resubmission process
- For the avoidance of doubt, the process of claiming for unlisted procedures does not alter the benefits coverage for members

3.10.7. **Application of Casts, Strapping and Fixation**

- The listed procedures apply when the cast application or strapping is a replacement procedure used during or after the period of follow-up care, or when the cast application or strapping is an initial service performed without a restorative treatment or procedure(s) to stabilize or protect a fracture, injury or dislocation and/or to afford comfort to a patient. Restorative treatment or procedure(s) rendered by another physician following the application of the initial cast/splint/strap may be reported with a treatment of fracture and/or dislocation code.

- A physician who applies the initial cast, strap or splint and also assumes all of the subsequent fracture, dislocation, or injury care cannot use the application of casts and strapping codes as an initial service, since the first cast/splint or strap application is included in the treatment of fracture and/or dislocation codes. A temporary cast/splint/strap is not considered to be part of the preoperative care. Additional evaluation and management services are reportable only if significant identifiable further services are provided at the time of the cast application or strapping.

- The type of fracture (e.g., open, compound, closed) does not have any coding correlation with the type of treatment (e.g., closed, open, or percutaneous) provided. The codes for treatment of fractures and joint injuries (dislocations) are categorized by the type of manipulation (reduction) and stabilization (fixation or immobilization). These codes can apply to either open (compound) or closed fractures or joint injuries.

- Codes for external fixation are to be used only when external fixation is not already listed as part of the basic procedure.

3.10.8. **Excision of tumours**

- Excision of subcutaneous soft tissue tumours (including simple or intermediate repair) involves the simple or marginal resection of tumours confined to subcutaneous tissue below the skin but above the deep fascia. These tumours are usually benign and are resected without removing a significant amount of surrounding normal tissue. Code selection is based on the location and size of the tumour. Code selection is determined by measuring the greatest
diameter of the tumour plus that margin required for complete excision of the tumour. The margins refer to the narrowest margin required to adequately excise the tumour, based on the physician's judgment. The measurement of the tumour plus margin is made at the time of the excision. Appreciable vessel exploration and/or neuroplasty should be reported separately. Extensive undermining or other techniques to close a defect created by skin excision may

require a complex repair which should be reported separately. Dissection or elevation of tissue planes to permit resection of the tumour is included in the excision.

- Excision of fascial or subfascial soft tissue tumours (including simple or intermediate repair) involves the resection of tumours confined to the tissue within or below the deep fascia, but not involving the bone. These tumours are usually benign, are often intramuscular, and are resected without removing a significant amount of surrounding normal tissue. Code selection is based on size and location of the tumour. Code selection is determined by measuring the greatest diameter of the tumour plus that margin required for complete excision of the tumour. The margins refer to the narrowest margin required to adequately excise the tumour, based on the physician's judgment. The measurement of the tumour plus margin is made at the time of the excision. Appreciable vessel exploration and/or neuroplasty should be reported separately. Extensive undermining or other techniques to close a defect created by skin excision may require a complex repair which should be reported separately. Dissection or elevation of tissue planes to permit resection of the tumour is included in the excision.

- Radical resection of soft tissue tumours (including simple or intermediate repair) involves the resection of the tumour with wide margins of normal tissue. Appreciable vessel exploration and/or neuroplasty repair or reconstruction (e.g., adjacent tissue transfer[s], flap[s]) should be reported separately. Extensive undermining or other techniques to close a defect created by skin excision may require a complex repair which should be reported separately. Dissection or elevation of tissue planes to permit resection of the tumour is included in the excision. Although these tumours may be confined to a specific layer (e.g., subcutaneous, subfascial), radical resection may involve removal of tissue from one or more layers. Radical resection of soft tissue tumours is most commonly used for malignant tumours or very aggressive benign tumours. Code selection is based on size and location of the tumour. Code selection is determined by measuring the greatest diameter of the tumour plus that margin required for complete excision of the tumour. The margins refer to the narrowest margin required to adequately excise the tumour, based on the physician's judgment. The measurement of the tumour plus margin is made at the time of the excision. For radical resection of tumours of cutaneous origin, (e.g., melanoma) see 11600-11646.

- Radical resection of bone tumours (including simple or intermediate repair) involves the resection of the tumour with wide margins of normal tissue. Appreciable vessel exploration and/or neuroplasty and complex bone repair or reconstruction (e.g., adjacent tissue transfer[s], flap[s]) should be reported separately. Extensive undermining or other techniques to close a defect created by skin excision may require a complex repair which should be reported separately. Dissection or elevation of tissue planes to permit resection of the tumour is included in the excision. It may require removal of the entire bone if tumour growth is extensive (e.g., clavicle). Radical resection of bone tumours is usually performed for malignant tumours or very aggressive benign tumours. If surrounding soft tissue is removed during these procedures, the radical resection of soft tissue tumour codes should not be reported separately. Code selection is based solely on the location of the tumour, not on the size of the tumour or whether the tumour is benign or malignant, primary or metastatic.

3.10.9. **Repair (Closure)**

- Use the codes in the Integumentary Section to designate wound closure utilizing sutures, staples, or tissue adhesives (e.g., 2-cyanoacrylate), either singly or in combination with each other, or in combination with adhesive strips. Wound closure utilizing adhesive strips as the sole repair material should be coded using the appropriate E/M code. (. *(See Chapter Two*

Procedure Coding Terms and Guidelines) Instructions for listing services at time of wound repair:

- The repaired wound(s) should be measured and recorded in centimeters, whether curved, angular, or stellate.

- When multiple wounds are repaired, add together the lengths of those in the same classification (see above) and from all anatomic sites that are grouped together into the same code descriptor. For example, add together the lengths of intermediate repairs to the trunk and extremities. Do not add lengths of repairs from different groupings of anatomic sites (e.g., face and extremities). Also, do not add together lengths of different classifications (e.g., intermediate and complex repairs).

  - When more than one classification of wounds is repaired, list the more complicated as the primary procedure and the less complicated as the secondary procedure, using modifier 51.

- Decontamination and/or debridement: Debridement is considered a separate procedure only when gross contamination requires prolonged cleansing, when appreciable amounts of devitalized or contaminated tissue are removed, or when debridement is carried out separately without immediate primary closure.

  - (For extensive debridement of soft tissue and/or bone, not associated with open fracture(s) and/or dislocation(s) resulting from penetrating and/or blunt trauma, see 11042-11047.)

  - (For extensive debridement of subcutaneous tissue, muscle fascia, muscle, and/or bone associated with open fracture(s) and/or dislocation(s), see 11010-11012.)

- Involvement of nerves, blood vessels and tendons: Report under appropriate system (Nervous, Cardiovascular, Musculoskeletal) for repair of these structures. The repair of these associated wounds is included in the primary procedure unless it qualifies as a complex repair, in which case modifier 51 applies.

- Simple ligation of vessels in an open wound is considered as part of any wound closure. Simple "exploration" of nerves, blood vessels or tendons exposed in an open wound is also considered part of the essential treatment of the wound and is not a separate procedure unless appreciable dissection is required. If the wound requires enlargement, extension of dissection (to determine penetration), debridement, removal of foreign body(s), ligation or coagulation of minor subcutaneous and/or muscular blood vessel(s) of the subcutaneous tissue, muscle fascia, and/or muscle, not requiring thoracotomy or laparotomy, use codes 20100-20103, as appropriate.

3.10.10 Cervical, thoracic, and lumbar spine.

- Within the spine section, bone grafting procedures are reported separately and in addition to arthrodesis. For bone grafts in other Musculoskeletal sections, see specific code(s) descriptor(s) and/or accompanying guidelines.

- Within the spine section, instrumentation is reported separately and in addition to arthrodesis. To report instrumentation procedures performed with definitive vertebral procedure(s), see 22840-22855. Instrumentation procedure codes 22840-22848 and 22851 are reported in addition to the definitive procedure(s).

3.10.11 Endoscopy/Arthroscopy (29800-29999)

- Surgical endoscopy/arthroscopy always includes a diagnostic endoscopy/arthroscopy.
-

3.10.12 Cardiovascular System

- Selective vascular catheterizations should be coded to include introduction and all lesser order selective catheterizations used in the approach (eg, the description for a selective right middle cerebral artery catheterization includes the introduction and placement catheterization of the right common and internal carotid arteries). Additional second and/or third order arterial catheterizations within the same family of arteries supplied by a single first order artery should be expressed by 36218 or 36248. Additional first order or higher catheterizations in vascular families supplied by a first order vessel different from a previously selected and coded family should be separately coded using the conventions described above.

3.10.13 Arteries and Veins

- Primary vascular procedure listings include establishing both inflow and outflow by whatever procedures necessary. Also included is that portion of the operative arteriogram performed by the surgeon, as indicated. Sympathectomy, when done, is included in the listed aortic procedures.

3.10.14 Chemotherapy

- For provision of chemotherapeutic agents, report both the specific service in addition to code(s) for the specific substance(s) or drug(s) provided. Use Greenrain Drug codes NOT CPT product codes.

3.10.15 Maternity Care and Delivery

- The services normally provided in uncomplicated maternity cases include antepartum care, delivery, and postpartum care; however, at this time in the Emirate of Abu Dhabi these 'package' codes are not utilized do to Billing Rules with the Payor.

- Delivery services include admission to the hospital, the admission history and physical examination, management of uncomplicated labor, vaginal delivery (with or without episiotomy, with or without forceps), or cesarean delivery. When reporting delivery only services (59409, 59514, 59612, 59620), report inpatient post delivery management and discharge services using Evaluation and Management Services codes. Delivery and

- postpartum services (59410, 59515, 59614, and 59622) include delivery services and all inpatient and outpatient postpartum services. *Medical problems complicating labor and delivery management may require additional resources and should be identified by utilizing the codes in the Medicine and Evaluation and Management Services section in addition to codes for maternity care.*

- The code(s) for Antepartum care includes the initial and subsequent history, physical examinations, recording of weight, blood pressures, fetal heart tones, routine chemical urinalysis, and monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation, and weekly visits until delivery. Any other visits or services within this time period should be coded separately.

- The code(s) for Postpartum care only services (59430) include office or other outpatient visits following vaginal or cesarean section delivery. Postpartum care includes hospital and office visits following vaginal or cesarean section delivery.

3.10.16Operating Microscope (69990)

3.10.16.1.1 The surgical microscope is employed when the surgical services are performed using the techniques of microsurgery. Code 69990 should be reported in addition to the code for the primary procedure performed. Do not use 69990 for visualization with magnifying loupes or corrected vision. Do not report 69990 in addition to procedures where use of the operating microscope is an inclusive component (15756-15758, 15842, 19364, 19368, 20955-20962, 20969-20973, 22551, 22552, 22856-22861, 26551-26554, 26556, 31526, 31531, 31536, 31541, 31545, 31546, 31561, 31571, 43116, 43496, 49906, 61548, 63075-63078, 64727, 64820-64823, 65091-68850, 0184T, 0226T, 0227T).

Chapter Eleven

3.11 Radiology Guidelines (Including Nuclear Medicine and Diagnostic Ultrasound)

3.11.1 Subject Listings

- All codes in this Section apply when radiological services are performed by or under the responsible supervision of a physician.

3.11.2 Unlisted Procedure(s) Radiology Section

- A service or procedure may be provided that is not listed in this edition of the CPT codebook. When reporting such a service, the appropriate "Unlisted Procedure" code may be used to indicate the service, identifying it by "Special Report" as discussed below. The "Unlisted Procedures" and accompanying codes for Radiology (Including Nuclear Medicine and Diagnostic Ultrasound) are as follows: *(See Chapter Five Unlisted Procedures)*
    - 76496 Unlisted fluoroscopic procedure (e.g., diagnostic, interventional)
    - 76497 Unlisted computed tomography procedure (e.g., diagnostic, interventional)
    - 76498 Unlisted magnetic resonance procedure (e.g., diagnostic, interventional)
    - 76499 Unlisted diagnostic radiographic procedure
    - 76999 Unlisted ultrasound procedure (e.g., diagnostic, interventional)

- 77299 Unlisted procedure, therapeutic radiology clinical treatment planning
- 77399 Unlisted procedure, medical radiation physics, dosimetry and treatment devices, and special service
- 77499 Unlisted procedure, therapeutic radiology treatment management
- 77799 Unlisted procedure, clinical brachytherapy
- 78099 Unlisted endocrine procedure, diagnostic nuclear medicine
- 78199 Unlisted hematopoietic, reticuloendothelial and lymphatic procedure, diagnostic nuclear medicine
- 78299 Unlisted gastrointestinal procedure, diagnostic nuclear medicine
- 78399 Unlisted musculoskeletal procedure, diagnostic nuclear medicine
- 78499 Unlisted cardiovascular procedure, diagnostic nuclear medicine
- 78599 Unlisted respiratory procedure, diagnostic nuclear medicine
- 78699 Unlisted nervous system procedure, diagnostic nuclear medicine
- 78799 Unlisted genitourinary procedure, diagnostic nuclear medicine
- 78999 Unlisted miscellaneous procedure, diagnostic nuclear medicine
- 79999 Radiopharmaceutical therapy, unlisted procedure

3.11.3 Separate Procedures

- Some of the procedures or services listed in the CPT codebook that are commonly carried out as an integral component of a total service or procedure have been identified by the inclusion of the term "separate procedure." The codes designated as "separate procedure" should not be reported in addition to the code for the total procedure or service of which it is considered an integral component.

3.11.4 Subsection Information

- Several of the subheadings or subsections have Guidelines &/or special needs or instructions unique to that section. Where these are indicated (e.g., "Radiation Oncology") special "Notes" will be presented preceding those procedural and coding coders are directed to adhere to these Guidelines.

3.11.5 Supervision and Interpretation

- When a procedure is performed by two physicians, the radiologic portion of the procedure is designated as "radiological supervision and interpretation." When a physician performs both the procedure and provides imaging supervision and interpretation, a combination of procedure codes outside the 70000 series and imaging supervision and interpretation codes are to be used.

- (The Radiological Supervision and Interpretation codes are not applicable to the Radiation Oncology subsection.)

3.11.6 Administration of Contrast Material(s)

- The phrase "with contrast" used in the codes for procedures performed using contrast for imaging enhancement represents contrast material administered intravascularly, intra-particularly or intrathecally.

- For intra-articular injection, use the appropriate joint injection code. If radiographic arthrography is performed, also use the arthrography supervision and interpretation code for the appropriate joint (which includes fluoroscopy). If computed tomography (CT) or magnetic resonance (MR) arthrography are performed without radiographic arthrography, use the appropriate joint injection code, the appropriate CT or MR code (“with contrast” or “without followed by contrast”), and the appropriate imaging guidance code for needle placement for contrast injection.

- For spine examinations using computed tomography, magnetic resonance imaging, magnetic resonance angiography, “with contrast” includes intrathecal or intravascular injection. For intrathecal injection, use also 61055 or 62284.

- Injection of intravascular contrast material is part of the “with contrast” CT, computed tomographic angiography (CTA), magnetic resonance imaging (MRI), and magnetic resonance angiography (MRA) procedures.

- Oral and/or rectal contrast administration alone does not qualify as a study “with contrast.”

3.11.7 Written Report(s)

- A written report signed by the interpreting physician should be considered an integral part of a radiologic procedure or interpretation

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Chapter Twelve

3.11. Pathology & Laboratory

3.12.1 Services in Pathology and Laboratory

- Services in Pathology and Laboratory are provided by a physician or by technologists under responsible supervision of a physician.

3.12.2 Separate or Multiple Procedures

- It is appropriate to designate multiple procedures that are rendered on the same date by separate entries.

3.12.3 Subsection Information

- Several of the subheadings or subsections have Guidelines and/or special needs or instructions unique to that section. Where these are indicated, (e.g., "Panel Tests"), special "Notes" will be presented preceding those procedural terminology listings referring to that subsection specifically and coders must adhere to these. If there is an "Unlisted Procedure" code number (see the following section) for the individual subsection, it will be shown.

3.12.4 Unlisted Service or Procedure (Pathology & Laboratory)

- A service or procedure may be provided that is not listed in this edition of the CPT codebook. When reporting such a service, the appropriate "Unlisted Procedure" code may be used to indicate the service, The "Unlisted Procedures" and accompanying codes for Pathology and Laboratory are as follows:

  - 81099 Unlisted urinalysis procedure
  - 84999 Unlisted chemistry procedure
  - 85999 Unlisted hematology and coagulation procedure
  - 86486 Unlisted antigen, each
  - 86849 Unlisted immunology procedure
  - 86999 Unlisted transfusion medicine procedure
  - 87999 Unlisted microbiology procedure
  -
  - 88099 Unlisted necropsy (autopsy) procedure
  - 88199 Unlisted cytopathology procedure
  - 88299 Unlisted cytogenetic study
  - 88399 Unlisted surgical pathology procedure

- 88749 Unlisted in vivo (e.g., transcutaneous) laboratory service
- 89240 Unlisted miscellaneous pathology test
- 89398 Unlisted reproductive medicine laboratory procedure

3.12.5 Organ or Disease-Oriented Panels (80047-80076)

- These panels were developed for coding purposes only and should not be interpreted as clinical parameters. The tests listed with each panel identify the defined components of that panel.
- These panel components are not intended to limit the performance of other tests. If one performs tests in addition to those specifically indicated for a particular panel, those tests should be reported separately in addition to the panel code.
- Do not report two or more panel codes that include any of the same constituent tests performed from the same patient collection. If a group of tests overlaps two or more panels, report the panel that incorporates the greater number of tests to fulfill the code definition and report the remaining tests using individual test codes (e.g., do not report 80047 in conjunction with 80053).

3.12.6 Surgical Pathology (88300-88399)

- Services 88300 through 88309 include accession, examination, and reporting. They do not include the services designated in codes 88311 through 88365 and 88399, which are coded in addition when provided.
- The unit of service for codes 88300 through 88309 is the specimen. A specimen is defined as tissue or tissues that is (are) submitted for individual and separate attention, requiring individual examination and pathologic diagnosis. Two or more such specimens from the same patient (eg, separately identified endoscopic biopsies, skin lesions) are each appropriately assigned an individual code reflective of its proper level of service.
- Service code 88300 is used for any specimen that in the opinion of the examining pathologist can be accurately diagnosed without microscopic examination. Service code 88302 is used when gross and microscopic examination is performed on a specimen to confirm identification and the absence of disease. Service codes 88304 through 88309 describe all other specimens requiring gross and microscopic examination, and represent additional ascending levels of physician work. Levels 88302 through 88309 are specifically defined by the assigned specimens.
- Any unlisted specimen should be assigned to the code which most closely reflects the physician work involved when compared to other specimens assigned to that code.

Chapter Thirteen

3.12. Medicine

3.13.1 Multiple Procedures

- It is appropriate to designate multiple procedures that are rendered on the same date by separate entries. For example: If individual medical psychotherapy (90829) is rendered in addition to subsequent hospital care (e.g., 99231), the psychotherapy would be reported separately from the hospital visit. In this instance, both 99231 and 90829 would be reported.

3.13.2 Subsection Information

- Several of the subheadings or subsections have special instructions &/or Guidelines unique to that section. These special instructions &/or Guidelines will be presented preceding those procedural terminology listings, referring to that subsection specifically and coders must adhere to these. Whereas all codes within the CPT code book are appropriate to assign, it is advisable to refer to the Payer as to whether the specific code will be reimbursed. This is especially true in the Medicine Section.

3.13.3 Unlisted Service or Procedure

- A service or procedure may be provided that is not listed in this edition of *CPT*. When reporting such a service, the appropriate "Unlisted Procedure" code may be used to indicate the service. The "Unlisted Procedures" and accompanying codes for Medicine are as follows:

  - 90399 Unlisted immune globulin
  - 90749 Unlisted vaccine/toxoid
  - 90899 Unlisted psychiatric service or procedure
  - 90999 Unlisted dialysis procedure, inpatient or outpatient
  - 91299 Unlisted diagnostic gastroenterology procedure
  - 92499 Unlisted ophthalmological service or procedure
  - 92700 Unlisted otorhinolaryngological service or procedure
  - 93799 Unlisted cardiovascular service or procedure
  - 94799 Unlisted pulmonary service or procedure
  - 95199 Unlisted allergy/clinical immunologic service or procedure
  - 95999 Unlisted neurological or neuromuscular diagnostic procedure
  - 96379 Unlisted therapeutic, prophylactic, or diagnostic intravenous or intra-arterial injection or infusion
  - 96549 Unlisted chemotherapy procedure

- 96999 Unlisted special dermatological service or procedure
- 97039 Unlisted modality (specify type and time if constant attendance)
- 97139 Unlisted therapeutic procedure (specify)
- 97799 Unlisted physical medicine/rehabilitation service or procedure
- 99199 Unlisted special service, procedure or report
- 99600 Unlisted home visit service or procedure

3.13.4 Immune Globulins, Serum or Recombinant Products (90281-90399)

- Codes 90281-90399 identify the serum globulins, extracted from human blood; or recombinant immune globulin products created in a laboratory through genetic modification of human and/or animal proteins. These Product codes are **not** assigned in the Emirate of Abu Dhabi. For correct coding and billing one must assign the required Mandatory Tariff version of the Pharmacy Drug Codes (Greenrain codes) as defined by HAAD Pharma and regulated by MoH.

- Both Pharmacy Drug Code(s) (Pharmacy Drug Codes (Greenrain codes) as defined by HAAD Pharma and regulated by MoH.) in addition to the administration codes 96365-96368, 96372, 96374, 96375 are reported as appropriate. Modifier 51should not be reported with this section of products codes when performed with another procedure

3.13.5 Vaccines, Toxoids (90476-90749)

- These vaccine and toxoid codes are **not** assigned in the Emirate of Abu Dhabi. For correct coding and billing one must assign the required Mandatory Tariff version of the Pharmacy Drug Codes (Greenrain codes) as defined by HAAD Pharma and regulated by MoH. The Pharmacy Drug Code(s) must be reported in addition to the administration code(s) 90460 and 90461 with the following criteria:

    - Report codes 90460 and 90461 only when the physician or qualified health care professional provides face-to-face counseling of the patient and family during the administration of a vaccine. For immunization administration of any vaccine that is not accompanied by face-to-face physician or qualified health care professional counseling to the patient/family or for administration of vaccines to patients over 18 years of age, report codes 90471-90474.

    - If a significant separately identifiable Evaluation and Management service (e.g., office or other outpatient services, preventive medicine services) is performed, the appropriate E/M service code should be reported in addition to the vaccine and toxoid administration codes.

Chapter Fourteen

3.13. Category II (0001F-7025F)

- Category II Codes are supplemental tracking codes that can be used for performance measurement. These codes are intended to facilitate data collection about the quality of care rendered by coding certain services and test results that support nationally established performance measures and that have an evidence base as contributing to quality patient care.

- The use of these codes is ***optional.*** The codes are not required for correct coding and may not be used as a substitute for Category I codes.

- These codes describe clinical components that may be typically included in evaluation and management services or clinical services and, therefore, do not have a relative value associated with them. Category II codes may also describe results from clinical laboratory or radiology tests and other procedures, identified processes intended to address patient safety practices, or services reflecting compliance with state or federal law.

- Category II codes, often referred to as "F Codes" make use of alphabetical characters as the 5th character in the string (ie, 4 digits followed by the letter F). These digits are not intended to reflect the placement of the code in the regular (Category I) part of the CPT codebook.

- Category II codes are reviewed by the Performance Measures Advisory Group (PMAG), an advisory body to the CPT Editorial Panel and the CPT/HCPAC Advisory Committee. The PMAG is comprised of performance measurement experts representing the Agency for Healthcare Research and Quality (AHRQ), the American Medical Association (AMA), the Centers for Medicare and Medicaid Services (CMS), The Joint Commission (TJC), and the Physician Consortium for Performance Improvement® (PCPI). The PMAG may seek additional expertise and/or input from other national health care organizations, as necessary, for the development of tracking codes. These may include national medical specialty societies, other national health care professional associations, accrediting bodies, and federal regulatory agencies.

Chapter Fifteen

3.14. Category III Codes (0019T-0259T)

- This section contains a set of temporary codes for emerging technology, services, and procedures. Category III codes will allow data collection for these services/procedures. If a Category III code is available, this code **must** be reported instead of a Category I unlisted code.

- All CPT codes are relevant for assignation; however, it is advised that the coder communicate with the Payer prior to assigning these codes for billing purposes. Services/procedures described in this section make use of alphanumeric characters.

- These codes have an alpha character as the 5th character in the string, preceded by four digits. The digits are not intended to reflect the placement of the code in the Category I section of CPT nomenclature.

- Codes in this section may or may not eventually receive a Category I CPT code. In either case, in general, a given Category III code will be archived five years from its date of publication or revision in the CPT code book unless it is demonstrated that a temporary code is still needed. Services/procedures described by Category III codes which have been archived after five years, without conversion, may be reported using the Category I unlisted code. New codes in this section are released semi-annually via the AMA/CPT internet site, to expedite dissemination for reporting. The full set of temporary codes for emerging technology, services, and procedures are published annually in the CPT codebook. Go to www.ama-assn.org/go/cpt for the most current listing.

IV.

Internationally Refined DRG

Chapter One

4.1 Purpose and Scope of IR DRG

4.1.1 Purpose

- The HAAD Standard establishes and mandates the diagnosis related groupings system, definitions and rules for the management and monitoring of health insurance claims by healthcare providers and payers under the health insurance scheme of Abu Dhabi. . *(See HAAD Standard establishing the Diagnosis Related Groupings System Reference: HSF/DRG/1.0 as well as HAAD Claims and Adjudication Rules)*

4.1.1. Scope

- The Standard applies to all inpatient healthcare services – except for long-term care services, as defined by the HAAD Standard for the Provision of Long-Term Care, and dental inpatient cases –provided by all HAAD licensed healthcare providers and payers operating in the emirate of Abu Dhabi. Inpatient healthcare services are defined according to the Clinical Coding Steering Committee's (CCSC) criteria. The diagnosis related groupings (DRGs) payments are applicable to all inpatient encounters as defined by the Clinical Coding Steering Committee.

- DRGs must be used for payment for the Basic Product from service date 1 August 2010, and 31December 2011 for all other products. The HAAD Grouper (currently provided by 3M) prevails in case of conflict between the parties. *(See HAAD Standard establishing the Diagnosis Related Groupings System Reference: HSF/DRG/1.0 as well as HAAD Claims and Adjudication Rules)*

Chapter Two

4.2. Standard Definitions

4.2.1. The following definitions apply in the interpretation and enforcement of the Standard, The definitions manual is available from HAAD. *(See IR DRG Standard on* www.shafafiya.org)

- IR DRG – refers to the International Refined Diagnosis Related groupings, as developed by 3M.
- Base DRG – is defined as the first two-digit MDC plus the 3-digit DRG (excluding the 6th and 7th digit severity of illness and risk of mortality digits).
- Weight – is a factor reflecting the degree of resources consumed by the particular DRG. The Weight is set by HAAD, and may be reviewed by HAAD, at its sole discretion, from time to time.
- Base Rate – is the established reimbursement rate that is used to multiply against the DRG Relative Weight to determine the reimbursement amount on a per case basis.
- Base Payment – Base Rate x Weight, or the specific payment made for a DRG, excluding Outlier payments.
- Cost – for the purposes of this standard Cost is the total value of all activities for the encounter, as per the Fee-for-Service Basic Product Price List published by HAAD including all drugs and medical devices, irrespective of whether the service is covered by
- Gap – is the segment of cost to be borne by the provider that is above the calculated DRG reimbursement amount before the account becomes eligible for an outlier payment. It is a set amount that should be reviewed periodically in conjunction with updates to the base rate by the facility.
- Marginal – is the established percentage applied to the Costs above the Base Rate plus the Gap that will be reimbursed to a provider as the outlier payment. If the sum of the Base Rate plus the Gap equal more than the total Costs, there is no provision for an outlier payment.
- Outlier payment = (Cost – Base Payment – Gap) x Marginal. Cost for outlier may be established by coding all services provided within the CPT Coding Manual.

4.2.2. **Coding Definitions for Standard Contract and IR DRGs** *(see HAAD Claims and Adjudication Rules)*

V.

Coding References, Policies, Processes, Audit & Arbitration

Chapter One

5.1 Coding References

5.1.1 **ICD-9-CM Official Guidelines for Coding and Reporting**

- The Centers for Medicare and Medicaid Services (CMS), the National Center for Health Statistics (NCHS), U. S. Federal Government's Department of Health and Human Services (DHHS); ***approved by*** the four organizations that make up the Cooperating Parties for the ICD-9-CM: the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), CMS, and NCHS.

5.1.2 **The Educational Annotation of ICD-9-CM**, Craig D. Puckett, Channel Publishing

5.1.3 **Codefinder Software - 3M Encoder**

5.1.4 **Coding Clinic**, American Hospital Association

5.1.5 **Grant's Atlas of Anatomy, 9th Edition**, Anne M.R. Agur

5.1.6 **Anatomy and Physiology in Health and Illness, 9th Edition**, Anne Waugh and Alison Grant

5.1.7 **Dorland's Medical Dictionary**

5.1.8 **ICD-9-CM Coding Handbook, With and Without Answers**, Faye Brown, In Cooperation with the Central Office on ICD-9-CM of the American Hospital Association, American Hospital Publishing, Inc.

5.1.9 **Health Information Management**, Huffman, 10th Edition, Revised by AHIMA, Physicians' Record Company

5.1.10 **The Merck Manual of Diagnosis and Therapy, Seventeenth Edition**, edited by M. H. Beers, MD and R. Berkow, MD, Merck Research Laboratories

5.1.11 **Current Procedural Terminology, 4th Edition,** American Medical Association

Chapter Two

5.2 Coding Policies

5.2.1 **Coders must review the medical record documentation for the entire visit they are coding before finalizing the coding process.** The purpose of this is to provide the most accurate and specific coding possible, by reviewing all the pertinent notes, exams and tests before completing the coding assignment. Special care should be given in reviewing the listed documents:

- Discharge Summary
- Operative Report
- Progress notes
- Lab reports, i.e. microbiology
- Consultation reports
- Radiology reports
- Special procedure reports such as endoscopy
- Histopathology reports
- Emergency visit notes
- Day care visit notes

5.2.2 **If in doubt, consult with the attending physicians.** There will be times when the Coder is unable to assign the correct code because of unclear or conflicting documentation in the medical record. In those instances, it is best practice to consult with the attending physician for that visit to get clarification before assigning the final codes.

5.2.3 **Code specificity as documented in laboratory and radiology reports.** It is recommended best practice for the Coder to refer to the laboratory and/or radiology reports to obtain the specificity necessary for accurate coding. If, for example, the physician documents a UTI (urinary tract infection) but does not identify the organism, you can code the organism from the microbiology report, such as E. Coli. The same applies to radiology reports; if the physician documents a fracture of the femur but does not identify the site, you can refer to the radiology report to find the specific site, such as the shaft of the femur. This does not mean, however, that the Coder should code everything directly from the

reports, if the physician has not documented the condition in the medical record, then he/she must be consulted before coding it. For example if the blood culture lists staph aureus as an organism found on the test, you cannot assume that the patient has sepsis, the physician must be consulted first. The same applies to the radiology report; if the chest X-ray shows a slight pleural effusion but the doctor has not documented this in his notes, you cannot code it without consulting him/her first.

5.2.4 **If the patient has a neoplasm that was excised or biopsied and sent to Pathology, code the specific diagnosis from the pathology report.** The pathology report is the best reference for the Coder when coding any type of neoplasm such as cancer, tumor or other abnormal growth. The pathology report will give the final, definitive diagnosis of the specific type of neoplasm and the specific site of the neoplasm for accurate coding.

5.2.5 **Review the pathology report for specificity of diagnosis.** Whenever a specimen is sent to the Pathology Department for analysis, it is best practice for the Coder to review the pathology report before coding. The pathology report will provide the specificity needed for more accurate coding of the diagnosis. For example if the physician documents that the patient had appendicitis, the pathology report may more accurately document acute, gangrenous appendicitis, which is a different diagnosis code.

5.2.6 **Code all significant procedures.** If in doubt, Coders should always code those procedures that were performed in the Operating Room; were performed under any type of anesthesia, including local anesthesia; where any tissue was removed and sent to Pathology; and any excisional or sharp debridement of a wound.

Chapter Three

5.3 Coding Processes

5.3.1 Inpatient/Day patient Coding

5.3.1.1 Inpatient

- Retrieve discharged record from hospital ward`
- Assemble record in pre-defined order, attaching all loose sheets as appropriate
- Analyze record for deficiencies, i.e. missing documentation, dictated discharge
- Summary, dictated operative reports, missing signatures.
- Send record to Coding Section
- Match record to discharge list
- Check record for discharge summary if available and/or required and review it for diagnoses and procedures performed during visit
- Review Facesheet and discharge note for diagnosis and procedures
- Review admission record for additional information regarding diagnoses, procedures and external causes, while taking notes on key points. Documents to be reviewed include:
    - History and Physical Exam
    - Operative Report
    - Procedure Reports such as Endoscopy and Cardiac Catheterization
    - Consultation Reports
    - Medical Reports
    - Progress Notes
    - Radiology Reports
    - Lab Reports
    - Other Clinical Services Reports

  - Emergency Record, if applicable
  - Anesthesia Record
  - Determine sequencing of principal diagnosis and principal procedure
- Code text using 3M encoder or coding books
- Verify sequencing
- Enter codes in coding database
- Abstract record with remaining information such as date of surgery and type of anesthesia

5.3.2 Emergency Patient Coding

5.3.2.1 Emergency Visit Coding

- Receive or retrieve emergency documentation for encounter
- Review all emergency documentation including labs, radiology reports, consultations, if
- applicable – taking notes of diagnoses and procedures
- Determine sequencing of principal diagnosis and principal procedure
- Code text using 3M encoder or coding books
- Verify sequencing
- Enter codes in coding database
- Abstract record with remaining information such as date of procedure and Emergency Physician's Name

5.3.3 Outpatient Coding

5.3.3.1 Outpatient Visit Coding

- Receive or retrieve medical record from clinic
- Review Clinic Note for diagnoses and procedures, if applicable or reason for visit if diagnosis is not determined at that time

- Review all pertinent investigations from clinic visit to further refine diagnoses, such as lab reports and radiology reports

- Take notes of applicable diagnoses and procedures, ensuring that only procedures done during the visit are coded as a part of the clinic visit

- Determine sequencing of principal diagnosis and principal procedure – Note that the principal diagnosis may be a symptom or suspected condition not yet determined at the time of the visit.

- Code text using 3M encoder or coding books

- Verify sequencing

- Enter codes in coding database

- Abstract record with remaining information such as name of clinic physician

5.3.4 **Locating Codes in the ICD 9 CM**

- The first step in coding is to locate the main term in the Alphabetic Index. In volume 2, the condition is listed as the main term, usually expressed as a noun. General terms such as "admission," "encounter," and "examination" are used to locate code entries for the supplementary V code section.

- Some conditions and procedures are indexed under more than one main term. For example, anxiety reaction can be located in either of the following index entries:

    - Anxiety (neurosis) (reaction) (state) 300.00

    - Reaction . . . anxiety 300.00

- If a main term cannot be located, the coder should consider a synonym, eponym, or other alternative term.

- Once the main term is located, a search should be made of subterms, notes, or cross-references. Subterms provide more specific information of many types and must be checked carefully, following all the rules of alphabetization.

- The main term code entry should not be assigned until all subterm possibilities have been exhausted.

- During this process, it may be necessary to refer again to the medical record to determine whether any additional information is available to permit assignment of a more specific code.

- If a subterm cannot be located, the nonessential modifiers following the main term should be reviewed to see whether the subterm may be included there. If not, alternative terms should be considered.

- The first coding principle is that both the Alphabetic Indexes and the Tabular Lists must be used to locate and assign appropriate codes. The condition or procedure to be coded must first be located in the index, and the code provided there must then be verified in the Tabular List.

- The coder must follow all instructional notes to determine that more specific subterms or important instructional notes are not overlooked.

- Experienced coders sometimes rely on their memory for commonly used codes, but consistent reference to the Alphabetic Index and the Tabular Lists is imperative, no matter how experienced the coder is.

5.3.5 **Locating Codes in the CPT Codebook**

- Select the name of the procedure or service that accurately identifies the service performed. Do not select a CPT code that merely approximates the service provided.
  If no such specific code exists, then report the service using the appropriate unlisted procedure or service code. In surgery, it may be an operation; in medicine, a diagnostic or therapeutic procedure; in radiology, a radiograph.

- Other additional procedures performed or pertinent special services are also listed. When necessary, any modifying or extenuating circumstances are added. Any service or procedure should be adequately documented in the medical record.

- Instructions, typically included as parenthetical notes, with selected codes indicate that a code should not be reported with another code or codes. These instructions are intended to prevent errors of significant probability and are not all inclusive. For example, the code with such instructions may be a component of another code and therefore it would be incorrect to report both codes even when the component service is performed.

- These instructions are not intended as a listing of all possible code combinations that should not be reported, nor to indicate all possible

code combinations that are appropriately reported. When reporting codes for services provided, it is important to assure the accuracy and quality of coding through verification of the intent of the code by use of the related guidelines, parenthetical instructions, and coding resources, including CPT Assistant and other publications resulting from collaborative efforts of the American Medical Association with the medical specialty societies (i.e., Clinical Examples in Radiology).

Chapter Four

5.4 Clinical Coding Audit

5.4.1 Objective:

5.4.1.1 This coding audit will endeavor to build trust between payers and providers by:

- Creating a shared understanding of the facility's coding quality.
- Giving the payers confidence that a facility is coding accurately.
- Giving the facility the right, if certified, to bill for Evaluation and Management (E&M) codes and potentially achieve higher levels of reimbursement and/or lower payer scrutiny.
- Providing the facility with an action plan of recommendations to improve the quality of coding.

5.4.1.2 The coding audit will give

5.4.1.2.1 A coding accuracy score for the facility, which will range from 0-100.

5.4.1.2.2 A coding completeness score for the facility, which will range from 0-100.

5.4.2 Criteria for Auditing Companies

- The Clinical Coding Steering Committee will qualify Auditors and Auditing companies to be authorized to conduct coding audits, as defined by the Audit & Arbitration sub-committee of the Clinical Coding Steering Committee.
- Auditing Companies must provide all relevant verification of the requirements set out below to be qualified by the Clinical Coding Steering Committee as well as successfully pass an intensive interview by the Audit and Arbitration Sub-committee:

5.4.2.1 **Qualifications of each Auditor:**

- Active and current AHIMA (American Health Information Management Association) CCS coding certificate with ICD9-CM and CPT-4.

- The Lead Auditor will have a minimum of 2 years experience (after certification) in external clinical coding audits, incorporating ICD 9 CM and CPT 4, as evidenced by a CV and sample audits for Inpatient, Outpatient and Emergency Department coding auditing.

- Must be able to generate the Coding Audit in the required Excel format in coherent English, as evidenced by a sample summary of a previous audit.

5.4.2.2 **Knowledge of UAE Rules and Regulations:**

- Auditors must understand the Coding Audit methodology and current coding and documentation standards in the Emirate, as ascertained in an interview by a Payer and a Provider representative of the CCSC Audit & Arbitration sub-committee.

- Auditing Company must submit a declaration of intent to follow all requirements within the Abu Dhabi Clinical Coding Audit Methodology.

5.4.2.2.1 **Conflict of Interest:**

- Auditing Company must submit a declaration not to audit any facility in which either the Auditor or the Auditing Company has any involvement in supporting any aspect of the revenue cycle within the past 12 months.

5.4.2.3 Please see the *Clinical Coding Steering Committee Audit Methodology 2012* for further information.

5.4.3 **Reference Websites for Clinical Coding Steering Committee Coding Audit**

5.4.3.1 Coding Audit: Audit Methodology, Addendum to the Audit Methodology, Criteria for Auditing Companies, Sample Audit, and List of Auditing Companies:

5.4.3.1.1 https://www.shafafiya.org/ *(See below)*

- Dictionary
- Transactions
- Standards
  - Data Standard
  - Business Rules
  - Validation rules
  - Coding Standard
  - Coding Audit
    - Methodology January 2012
    - Methodology
    - Sample
    - Criteria for Auditing companies
    - List of Auditing companies
  - Coding Arbitration
  - Reporting Health Statistics
  - Claims and Adjudication
- Governance

5.4.3.2 List of Coding Certified Facilities: https://www.shafafiya.org/ *(See below)*

- Dictionary
  - Introduction
  - Data elements (alphabetical)
  - Codes
  - Licenses
    - Facility Licenses
    - Clinician Licenses
    - Insurer Licenses
    - DHA Licenses
    - MOH Licenses
    - Coding Certified Facilities

5.4.3.3 HAAD Policy, *Implementation of Circular 33 on E&M Codes* and Further *Implementation of Circular 33 on E&M Codes*: http://www.haad.ae/haad/tabid/82/Default.aspx

Chapter Five

5.5 Clinical Coding Arbitration

5.5.1 Objective:

- Create and maintain the Coding Arbitration Panel membership.
- Ensure that all time specifications within the arbitration process set by the Data Standards Panel and/or HAAD are strictly adhered to.
- Review cases related to disagreements between payers and providers regarding coding.
- Provide coding reference material to support decisions made during Panel review of the cases.
- Provide coding decision recommendations to HAAD at the end of the Panel review
- No Panel member will participate in the arbitration process for any healthcare entity for whom they are employed or have such other involvement. If this involves the Chair of the Coding and Arbitration Sub-committee, the Chair of the CCSC will then Chair.
- Publish coding case studies with clarification of coding rules, based on results of coding arbitration process after carefully removing any details that may identify the facility and/or patient.
- Make recommendations to Education Sub-committee regarding continuing coding education based on cases being brought to the Panel for resolution.

5.5.2 Process of the Coding Arbitration

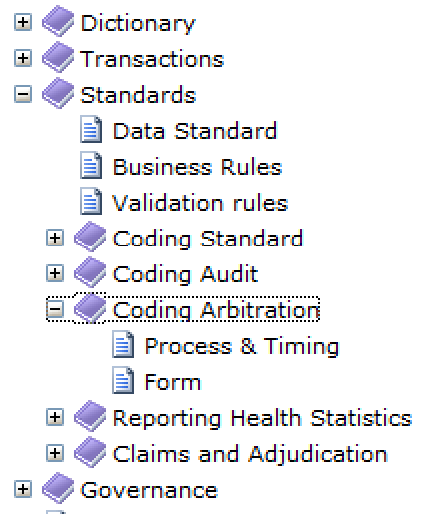
- The Petitioner must first review the "Coding Arbitration Decisions" List on the HAAD website https://www.shafafiya.org/ *(See below)*. If the coding issue has not been addressed, and if the Claims or Pre-Approval Process (including proof of dialogue concerning the codes in question) has been completed, the Petitioner will then:

5.5.2.1 Complete the "Request for Clinical Coding Arbitration" form. The form is available on the HAAD website https://www.shafafiya.org/ *(See below)*.

5.5.2.2 Forward all relevant documents as stated on this Form

5.5.2.3 The CCSC, Audit and Arbitration Subcommittee will:

- Conduct a preliminary review to ensure eligibility
- Inform Petitioner of Reference Number and decision to go to Arbitration
- Upon Arbitration commencement, the CCSC will inform the Second Party of said Arbitration
- Coordinate with the independent review panel (IRP) made up of two independent members, ensuring that they have the appropriate skills and credentials to perform the review
- The petitioning healthcare entity must send all relevant additional medical and treatment records requested by the IRP representative within 15 calendar days of notice. Failure to provide requested information may result in a delayed decision or cancellation of said Arbitration. The IRP representative may request additional information from the Payer or Provider, who can independently submit information even if the representative has not requested specific information.
- Ensure the IRP renders a decision within 15 calendar days of receiving all relevant information.
- The report of this decision must include reasons for the decision including the clinical coding rules and guidelines applied in the decision.
- Make every reasonable effort to achieve resolution of said arbitration within 30 calendar days of receipt.
- Notify all involved parties in writing within 15 calendar days of a decision rendered by the IRP.
- Notify HAAD in writing within 10 calendar days of said decision. This decision is final.
- Update “Coding Arbitration Decisions” List on the HAAD website at website at www.haad.ae in the Data Dictionary/Standards/CCSC.



Chapter Six

5.6 Clinical Coding Steering Committee

5.6.1 Objective

5.6.1.1 To provide optimal quality data for reimbursement and for informed, fact-based decision making, through the standardization of coding and DRG assignment practices in all Abu Dhabi Emirate healthcare organizations, based on international best-practice in coding and grouping processes

5.6.2 Voting Membership

5.6.2.1 **Provider Representatives:**

5.6.2.1.1 Two Private Hospital: will be elected by open forum of Licensed Providers on an annual basis, after the email submissions of potential candidates.

5.6.2.1.2 Two Seha: to be appointed by Seha

5.6.2.2 **Payer Representatives:**

5.6.2.2.1 Two Daman: to be appointed by Daman

5.6.2.2.2 Two Private Payers: to be elected in an open forum of Licensed Payers on an annual basis, after the email submissions of potential candidates.

5.6.2.3 Guests: Guests are allowed to attend meetings, upon invitation or approval by the Chairman.

5.6.3 **Membership Profile**

5.6.3.1 As this committee is representing the Clinical Coders in the Abu Dhabi Emirate, members should be involved with coding in their daily work as coding supervisors, coding lead workers, coding coordinators or others serving as the coding leadership in their organization.

5.6.4 **Membership**

5.6.4.1 The Chair of the CCSC reports to:, Head of Strategy, Health Authority of Abu Dhabi

- Chairman: Michelea D Peech CCS, CCS-P – Clinical Coding Consultant
  - Voting Members:
- **SEHA Hospital Representatives:**
  - Jameel Ahmed, Medical Record Manager (HIM) Ambulatory Health Care, SEHA; Chairman of Audit and Arbitration Subcommittee of CCSC
  - Ann Webster – Tawam, SEHA
- **Private Hospital Representatives:**
  - Dr. Samina Ashiq, Al Noor Hospitals Group
  - Emmanuel Suganand CCS, CPCManager - Medical Insurance & Medical Coding, Dubln Health Group
- **Private Payer Representatives:**
  - Mohanned Al Makhamreh – Quality Performance Manger / Medical Claim. Adnic Insurance Co
  - Lavanya Nagarajan - Assistant Manager, Audit & Regulatory Compliance, NAS
- **Daman Insurance Representatives**
  - Dr Ali Anees – Manager Medical Investigation Unit, Daman Insurance Co

- Sunil Krishnamma, Integration & Standardization Specialist , Daman Insurance Co

5.6.5 CCSC Voting Representatives Contact Email Addresses:

1. Michelea Peech, Chair CCSC ccsc@haad.ae
2. Jameel Ahmed, Seha Rep jaahmed@ahs.ae
3. Ann Webster, Seha Rep awebster@rcms.seha.ae
4. Dr. Samina Ashiq, Private Hospital Rep
   SAshiq@alnoorhospital.com
5. Emmanuel Suganand, Private Hospital Rep
   esuganand@dublinhealthservices.com
6. Dr Ali Anees, Daman Rep
   ali.anees@damanhealth.ae
7. Sunil Krishnamma, Daman Rep
   sunil.krishnamma@damanhealth.ae
8. Mohanned Al Makhamreh, Non-Daman Insurance Rep
   Mohanned_Al_Makhamreh/MEDICALCL/adnic@adnic.ae
9. Lavanya Nagarajan, Non-Daman Insurance Rep
   lavanya.nagarajan@nas.ae

5.6.6 Audit and Arbitration Subcommittee

5.6.6.1 The Chair of the Audit and Arbitration Subcommittee reports to Chair of the CCSC

5.6.6.2 Members of the Audit and Arbitration Subcommittee are as follows:

1. Michelea Peech, Chair of CCSC - Voting
   ccsc@haad.ae
2. Jameel Ahmed, Chair of Subcommittee of Audit & Arbitration - Non-Voting
   jaahmed@ahs.ae
3. Ann L Webster, Seha Voting
   ann@tawamhospital.ae
4. Emmanuel Suganand,- Private Hospital Voting
   esuganand@dublinhealthservices.com

5. Sunil Krishnamma, Daman - Voting
   sunil.krishnamma@damanhealth.ae
6. Lavanya Nagarajan, Non-Daman Insurance Rep - Voting
   lavanya.nagarajan@nas.ae

5.6.7 **Education Subcommittee**

5.6.7.1 The Chair of the Education Subcommittee reports to Chair of the CCSC

5.6.7.2 **Members are as follows:**

- Michelea D Peech, Chair of CCSC ccsc@haad.ae
- Ann Webster, Chair of Education Subco. ann@tawamhospital.ae
- Sarina Siyavudeen, Daman Ins.
  sarina.siyavudeen@damanhealth.ae
- Susan Young, 3M seyoung@mmm..com
- Jameel Ahmed, AHS jaahmed@ahs.ae
- Binu Paul, Al Mafraq Hospital bpaul@mafraqhospital.ae
- Pamela Gyles, Zyed Military g_pamela@hotmail.co.uk
- Muna Al Saedi, AHS malaedi@ahs.ae
- Christina Manuel Cmanuel@Oasishospital.org
- Patricia Visosky, HCT pvisosky@hct.ac.ae
- Malda Bashi, Accumed mbashi@accumed.ae
- Subashnie Devkaran, Al Noor Hospital subashnie_d@hotmail.com
- Sameera Al Hashemi , SKMC saalhashemi@skmc.ae
- Emmanuel Suganand,- Dublin Health
  esuganand@dublinhealthservices.com
- Sunil Krishnamma, Daman
  sunil.krishnamma@damanhealth.ae
- Lavanya Nagarajan, NAS lavanya.nagarajan@nas.ae

VI.

ICD 10 CM

Chapter One

6.1. ICD 10 CM

6.1.1. Implementation of ICD 10 CM

- The CCSC passed Decision, 032 to implement ICD 10 CM as the Code Set for diagnostic coding as of Service Date 1st Jan 2015.

- This time-frame was supported by the Data Standard Panel on Agenda Item 184: Implement ICD 10 CM 2015 as the Code Set for diagnostic coding as of Activity. Start >= 1st Jan 2015 contingent on availability of DRG grouper for testing 6 months prior to the implementation date

6.1.2. Rationale for the implementation of ICD 10 CM

- The United States is implementing ICD 10 CM as of 1st October, 2013, due to this, the ICD 9 CM will no longer be updated after 2011. Therefore, in order to maintain accurate statistics with diagnostic coding, the progression to the ICD 10 CM code set is imperative. It was decided by the CCSC that it would be advantageous to allow the US a period of time to correct any issues or problems, thus the reason for waiting until 2015. The following are some of the reasons to progress to ICD 10 CM:

  - ICD-10-CM offers greater specificity in reporting diagnoses. (This gives more information for the Payers as well as greater statistical information)

  - Every G7 nation (once the US has implemented ICD 10 CM) uses a version of ICD-10, which makes comparing data worldwide much more efficient and accurate. (The urgent need for international comparability of diseases is obvious. AIDS, SARS, H1N1 and other infectious diseases are not confined by borders, furthermore, there is much to be learned about chronic diseases and their treatment.)

  - The structure of Volume 3 ICD-9-CM codes does not allow for proper expansion of the code set in order to report new technologies whereas the ICD 10 CM has ‘’plenty of room to grow’’. (ICD-9-CM is obsolete. It was developed nearly 30 years ago and does not accurately reflect current medical knowledge or practice. In fact, the WHO no longer even supports or maintains the parent system, ICD-9)

- The quality of healthcare data in this country is dependent upon remaining current with the growth and changes in the healthcare industry. It is absolutely imperative that ICD-10-CM be adopted as the replacement for ICD-9-CM as soon as it is feasibly possible.

6.1.3. **What is ICD 10 CM**

- ICD-10-CM is a clinical modification of the World Health Organization's ICD-10 consists of a diagnostic system consists of more than 68,000 codes, compared to approximately 13,000 ICD-9-CM codes incorporates greater specificity and clinical detail to provide information for clinical decision making and outcomes research.

6.1.4. **What is the difference between ICD 9 CM and ICD 10 CM**

6.1.4.1. ICD-9-CM

- Consists of 3 to 5 characters
- First digit is numeric or alpha (E or V)
- Second, third, fourth, and fifth digits are numeric
- Always at least three digits
- Decimal placed after the first three characters

6.1.4.2. ICD-10-CM

- Consists of 3 to 7 characters
- First digit is alpha
- All letters used except U
- Second and third digits are numeric
- Fourth, fifth, sixth, and seventh digits can be alpha or numeric
- Decimal placed after the first three characters g.
- V codes now Z codes – no longer SUPPLEMENTAL
- Sense organs have been separated from nervous system disorders.
- Injuries are grouped by anatomical site rather than injury category.
- Postoperative complications have been moved to procedure-specific body system chapter.

6.1.5. **ICD-10-CM has numerous new features allowing for a greater level of specificity and clinical detail.**

6.1.5.1. Combination codes for conditions and common symptoms or manifestations

6.1.5.2. Combination codes for poisonings and external causes

6.1.5.3. Added extensions for episode of care

6.1.5.4. Expanded codes (injury, diabetes, alcohol/substance abuse, postoperative complications)

6.1.5.5. Inclusion of trimester in obstetrics codes and elimination of fifth digits for episode of care

6.1.5.6. Expanded detail relevant to ambulatory and managed care encounters

6.1.5.7. Changes in timeframes specified in certain codes

6.1.5.8. External cause codes no longer a supplementary classification

6.1.5.9. There are expansions for certain codes to enable more specificity

- There are expansions to certain codes to enable high specificity. Expanded codes include codes for injury, diabetes, alcohol/substance abuse, postoperative complications. For example: Diabetes mellitus codes are expanded to include the classification of the diabetes and the manifestation. The category for diabetes mellitus has **been updated to reflect the current clinical classification of diabetes and is no longer classified as controlled/uncontrolled**:
    - E08.22, Diabetes mellitus due to an underlying condition with diabetic chronic kidney disease
    - E09.52, Drug or chemical induced diabetes mellitus with diabetic peripheral angiopathy with gangrene
    - E10.11, Type 1 diabetes mellitus with ketoacidosis with coma
    - E11.41, Type 2 diabetes mellitus with diabetic mononeuropathy

6.1.5.10. Added laterality (indicate right side versus left side. (Don't panic—there are still codes available for unspecified "sides)

- C50.212, Malignant neoplasm of upper-inner quadrant of left female breast
- H02.835, Dermatochalasis of left lower eyelid
- I80.01, Phlebitis and thrombophlebitis of superficial vessels of right lower extremity
- L89.213, Pressure ulcer of right hip, stage III

VII.

Suggested Coder Requirements

Coding Job Summary & Suggested Qualifications

Section One - Model Coding Job Duties Summary

- Apply ICD-9-CM coding rules to code all diagnoses and CPT codes to all procedures, as applicable, to inpatient, daypatient, emergency patient and outpatient visits at the designated facility.
- Perform data entry function of codes as well as other demographic and visit specific information into facility coding database.
- Utilize automated encoder (if applicable) to facilitate coding function, applying all appropriate coding rules.
- Perform quality improvement techniques to coding process in the form of audit and other techniques to improve coding skills and outcomes, utilizing recognized benchmarks and resources.
- Prepare statistical and analytical reports of coded data for facility administration and other requestors as appropriate.
- Participate in continuing education activities to maintain and improve coding skills as well as to stay current with annual coding updates and changes, including coding seminars, articles, and conferences.

Section Two - Model Coding Suggested Qualifications – One of the below is required

- Bachelor of Science Degree in Health Information Management or Medical Records
- Higher Diploma in Health Information Management or Medical Records
- Coding Certificate in ICD-9-CM from institute recognized by the American Health Information Management Association in the United States. (Including internet courses.)
- Coding Certificate in ICD-10 from institute recognized by government of home country, with ability to learn ICD-9-CM.
- Five years experience coding ICD-9-CM or ICD 10 with a high school diploma. (For hospital based Coders, three years of this must have been in a hospital.)

Model Coder Skills Requirement <u>in English</u>

- Fluent in medical terminology
- Good foundation in anatomy and physiology
- Understanding of pathophysiology

- Knowledge of procedures and drugs
- Good computer skills
- Excellent knowledge of the English language
- Full knowledge of the relevant coding manuals

VIII. CDT Dental Codes

Section One – American Dental Association (ADA), Current Dental Terminology (CDT)

- All ADA coding rules, guidelines and descriptors will be followed explicitly, and any questions and issues will be addressed to the ADA
- The following issues have been addressed:
  - Rules as published by ADA and in the full descriptor will be followed. All Unbundling coding rules as specified in the Coding Manual and Claims Adjudication will be followed. Unbundling rules within the Coding Manual will be updated to include the CDT codes
  - The process for coding '' Unlisted Codes" is clarified in the Claims Adjudication and also in Coding Manual and will be updated to be specified as" including CDT unspecified coded"
  - Reply from ADA on Temporary Crown and to be added to the Coding Manual: “There is no CDT Code if the prosthesis is placed for temporization during crown fabrication. Such a “temporary” is considered an integral component of the restorative crown procedure. However, there are two situations where there are discreet codes.” The CDT code descriptors states they D2970 and D2799, are not applicable for temporization.
  - Reply from ADA on Temporary Pontic: “Neither CDT 2010-2011 nor CDT 2014 include an entry for temporary pontic as such a prosthesis is considered an integral component of the applicable fixed prosthodontic procedure. D6999 is the available code for special circumstances