ICD-9-CM Official Coding Guidelines
(effective October 1, 2008)
Summary of Differences between 2007 and 2008

Table of Contents

Section I
Conventions, general coding guidelines and chapter specific guidelines

B. General Coding Guidelines

4. Code or codes from 001.0 through ~~V84~~V89

14. Reporting Same Diagnosis Code More than Once

15. Admissions/Encounters for Rehabilitation

16. Documentation for BMI and Pressure Ulcer Stages

C. Chapter-Specific Coding Guidelines

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

c. **Methicillin Resistant Staphylococcus aureus (MRSA) Conditions**

2. Chapter 2: Neoplasms (140-239)

i. Malignant neoplasm associated with transplanted organ

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

~~c. Acute Respiratory Failure~~

~~d. Influenza due to identified avian influenza virus (avian influenza)~~

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

a. Pressure ulcer stage codes

18. Classification of Factors Influencing Health Status and Contact with Health Service (Supplemental V01-~~V86~~

Section I
Conventions, general coding guidelines and chapter specific guidelines

B. General Coding Guidelines

4. Code or codes from 001.0 through ~~V86.1~~ V89.09

The appropriate code or codes from 001.0 through ~~V86.1~~ V89.09 must be used to identify diagnoses, symptoms, conditions, problems, complaints or other reason(s) for the encounter/visit.

14. Reporting Same Diagnosis Code More than Once

Each unique ICD-9-CM diagnosis code may be reported only once for an encounter. This applies to bilateral conditions or two different conditions classified to the same ICD-9-CM diagnosis code.

15. Admissions/Encounters for Rehabilitation

When the purpose for the admission/encounter is rehabilitation, sequence the appropriate V code from category V57, Care involving use of rehabilitation procedures, as the principal/first-listed diagnosis. The code for the condition for which the service is being performed should be reported as an additional diagnosis.

Only one code from category V57 is required. Code V57.89, Other specified rehabilitation procedures, should be assigned if more than one type of rehabilitation is performed during a single encounter. A procedure code should be reported to identify each type of rehabilitation therapy actually performed.

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

C. Chapter-Specific Coding Guidelines

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

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

3. Sepsis/SIRS with Localized Infection

If the reason for admission is both sepsis, severe sepsis, or SIRS and a localized infection, such as pneumonia or cellulitis, a code for the systemic infection (038.xx, 112.5, etc) should be assigned first, then code 995.91 or 995.92, followed by the code for the localized infection. If the patient is admitted with a localized infection, such as pneumonia, and sepsis/SIRS doesn't develop until after admission, see guideline ~~I.C.1.~~2b).

~~If the localized infection is postprocedural, *see Section I.C.10 for guidelines related to sepsis due to postprocedural infection.*~~

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

10. *Sepsis due to a Postprocedural Infection*

Sepsis resulting from a~~) Documentation of causal relationship~~

~~As with all~~ postprocedural ~~complications, code assignment~~ infection is ~~based on~~ a complication of care. For such cases the ~~provider's documentation of the relationship between the infection and the procedure.~~

~~(b) Sepsis due to~~ postproceduralinfection

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

12. *Sepsis and Severe Sepsis Associated with Noninfectious Process*

~~(a) Sequencing of sepsis/severe sepsis associated with non-infectious process~~

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

~~(b)~~ Only one SIRS ~~(subcategory 995.9)~~ code ~~should be assigned~~

~~Only one code from subcategory 995.9~~, representing the sepsis or severe sepsis, should be assigned for ~~SIRS~~patients with sepsis or severe sepsis associated with trauma or other non-infectious condition. ~~Assign the SIRS code (subcategory 995.9) that corresponds~~Do not assign codes 995.93, Systemic inflammatory response syndrome due to ~~the principal diagnosis. That is, if trauma or a non-infectious condition is the underlying cause, assign code 995.93~~non-infectious process without acute organ dysfunction, or 995.94. ~~If an infection is the underlying cause, assign code~~, Systemic inflammatory response syndrome due to noninfectious process with acute organ dysfunction, in addition to 995.91, Sepsis, or 995.92, Severe sepsis, if the patient has sepsis or severe sepsis associated with a non-infectious condition.

c. Methicillin Resistant Staphylococcus aureus (MRSA) Conditions

1. *Selection and sequencing of MRSA codes*

a. *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.

See Section C.1.b.1 for instructions on coding and sequencing of septicemia.

b. *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.

c. *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).

d. *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. Chapter 2: Neoplasms (140-239)

General guidelines

a. 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.

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

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

If a patient admission/encounter is solely for the administration of chemotherapy, immunotherapy or radiation therapy assign code V58.0, Encounter for radiation therapy, or V58.11, Encounter for antineoplastic chemotherapy, or V58.12, Encounter for antineoplastic immunotherapy as the first-listed or principal diagnosis. If a patient receives more than one of these therapies during the same admission more than one of these codes may be assigned, in any sequence. The malignancy for which the therapy is being administered should be assigned as a secondary diagnosis.

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

i. 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.

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

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

a. Diabetes mellitus

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

See I.C.3.a.7 for secondary diabetes.

7. Secondary Diabetes Mellitus

Codes under category 249, Secondary diabetes mellitus, identify complications/manifestations associated with secondary diabetes mellitus. Secondary diabetes is always caused by another condition or event (e.g., cystic fibrosis, malignant neoplasm of pancreas, pancreatectomy, adverse effect of drug, or poisoning).

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

b. 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.

c. 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.

d. 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 category 249 is sequenced as the principal or first-listed 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.

i. Secondary diabetes mellitus due to pancreatectomy
For postpancreatectomy diabetes mellitus (lack of insulin due to the surgical removal of all or part of the pancreas), assign code 251.3, Postsurgical hypoinsulinemia. A code from subcategory 249 should not be assigned for secondary diabetes mellitus due to pancreatectomy. Code also any diabetic manifestations (e.g. diabetic nephrosis 581.81).

ii. Secondary diabetes due to drugs
Secondary diabetes may be caused by an adverse effect of correctly administered medications, poisoning or late effect of poisoning.

See section I.C.17.e for coding of adverse effects and poisoning, and section I.C.19 for E code reporting.

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

a. Pain - Category 338

1. General coding information

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

a. Category 338 Codes as Principal or First-Listed
Diagnosis Category 338 codes are acceptable as principal diagnosis or the first-listed code for reporting purposes:

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

~~• 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 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. Pain due to devices~~, implants and grafts~~

Pain associated with devices~~, implants~~ or ~~grafts~~foreign bodies 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~~ (for example painful retained suture).

3. Postoperative Pain

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

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

~~(a) Postoperative pain not associated with specific postoperative complication~~

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

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

~~(b) Postoperative pain associated with specific postoperative complication~~

Postoperative pain associated with a specific postoperative complication (such as ~~painful wire sutures~~a device left in the body) is assigned to the appropriate code(s) found in Chapter 17, Injury and Poisoning. ~~If appropriate, use~~Since the complication represents the underlying (definitive) diagnosis associated with the pain, no additional code~~(s)~~ should be assigned 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 in accordance with Section I.C.6.a.1.a above.

~~(c) 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.

~~(d) 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.

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

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

a. Hypertension

3. Hypertensive Chronic Kidney Disease with Chronic Renal Failure

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

The terms stroke and CVA are often used interchangeably to refer to a cerebral infarction. The terms stroke, CVA, and cerebral infarction NOS are all indexed to the default code 434.91, Cerebral artery occlusion, unspecified, with infarction. Code 436, Acute, but ill-defined, cerebrovascular disease, should not be used when the documentation states stroke or CVA. *See Section I.C.18.d.3 for information on coding status post administration of tPA in a different facility within the last 24 hours.*

d. Late Effects of Cerebrovascular Disease

3. Code V12.~~54~~59

Assign code V12.~~54, Transient ischemic attack (TIA), and cerebral infarction without residual deficits~~59 (and not a code from category 438) as an additional code for history of cerebrovascular disease when no neurologic deficits are present.

e. Acute myocardial infarction (AMI)

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. *See Section I.C.18.d.3 for information on coding status post administration of tPA in a different facility within the last 24 hours.*

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

See I.C.17.f. for ventilator-associated pneumonia.

c. Acute Respiratory Failure

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 (Section II, C.) may be applied in these situations.

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

~~*d. Influenza due to identified avian influenza virus (avian influenza)*~~

~~Code only confirmed cases of avian influenza. This is an exception to the hospital inpatient guideline Section II, H. (Uncertain Diagnosis).~~

~~In this context, "confirmation" does not require documentation of positive laboratory testing specific for avian influenza. However, coding should be based on the provider's diagnostic statement that the patient has avian influenza.~~

~~If the provider records "suspected or possible or probable avian influenza," the appropriate influenza code from category 487 should be assigned. Code 488, Influenza due to identified avian influenza virus, should not be assigned.~~

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

c. Fetal Conditions Affecting the Management of the Mother

1. Codes from category 655

Known or suspected fetal abnormality affecting management of the mother, and category 656, Other fetal and placental problems affecting the management of the mother, are assigned only when the fetal condition is actually responsible for modifying the management of the mother, i.e., by requiring diagnostic studies, additional observation, special care, or termination of pregnancy. The fact that the fetal condition exists does not justify assigning a code from this series to the mother's record. *See I.C.18.d. for suspected maternal and fetal conditions not found.*

f. Diabetes mellitus in pregnancy

Diabetes mellitus is a significant complicating factor in pregnancy. Pregnant women who are diabetic should be assigned code 648.0x, Diabetes mellitus complicating pregnancy, and a secondary code from category 250, Diabetes mellitus, or category 249, Secondary diabetes to identify the type of diabetes.

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

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

12. Chapter 12: Diseases Skin and Subcutaneous Tissue (680709)

~~Reserved for future guideline expansion~~

a. Pressure ulcer stage codes

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. Unstageable pressure ulcers

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.

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.

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.

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.

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.

7. Patients admitted with pressure ulcers documented as healed

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

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.

9. Patient admitted with pressure ulcer 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.

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

j. Newborn sepsis

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

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

e. Adverse Effects, Poisoning and Toxic Effects

2. Poisoning

d. 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.

e. Sequencing of poisoning

f. Complications of care

1. Complications of care

a. 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. Transplant complications

a. Transplant complications other than kidney

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

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

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

~~b. Kidney~~

See I.C.18.d.3) for transplant organ removal status

See I.C.2.i for malignant neoplasm associated with transplanted organ.

Post-transplants surgical complications that do not relate to the function of the transplanted organ are classified to the specific complication. For example, a surgical wound dehiscence would be coded to the wound dehiscence, not as a transplant complication.

~~Code 996.81~~Post-transplant patients who are seen for treatment unrelated to the transplanted organ should be assigned a code from category V42, Organ or tissue replaced by transplant, to identify the transplant status of the patient. A code from category V42 should never be used with a code from subcategory 996.8.

b. 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.

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

3. Ventilator associated pneumonia

a. 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.

b. 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.

18. Classification of Factors Influencing Health Status and Contact with Health Service (Supplemental V01-~~V86~~V89)

a. Introduction

ICD-9-CM provides codes to deal with encounters for circumstances other than a disease or injury. The Supplementary Classification of Factors Influencing Health Status and Contact with Health Services (V01.0-~~V86.1~~V89.09) is provided to deal with occasions when circumstances other than a disease or injury (codes 001-999) are recorded as a diagnosis or problem.

d. Categories of V Codes

3. Status

V07.5X Prophylactic 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.

V45 Other postsurgical 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.

See section I.C17.f.2. for information on the coding of organ transplant complications.

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.

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.~~

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

V58.6~~*~~ Long-term (current) drug use

Codes from this subcategory indicate~~s~~ a patient's continuous use of a prescribed drug (including such things as aspirin therapy) for the long-term treatment of a condition or for prophylactic use. It is not for use for patients who have addictions to drugs. 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.

4. History (of)

V87 Other specified personal exposures and history presenting hazards to health

6. Observation

There are ~~two~~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. The observation codes are to be used as principal diagnosis only. The only exception to this is when the principal diagnosis is required to be a code from the V30, Live born infant, category. Then the V29 observation code is sequenced after the V30 code. Additional codes may be used in addition to the observation code but only if they are unrelated to the suspected condition being observed.

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. See Section I.C.18.d., Screening).

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

7. Aftercare

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

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

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.

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.

See Section I. B.16 Admissions/Encounter for Rehabilitation.

The aftercare V category/codes:

V51.0 Encounter for breast reconstruction following mastectomy

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

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

For encounters specifically for prophylactic removal of breasts, ovaries, or another organ due to a genetic susceptibility to cancer or a family history of cancer, the principal or first listed code should be a code from subcategory V50.4, Prophylactic organ removal, followed by the appropriate genetic susceptibility code and the appropriate family history code. If the patient has a malignancy of one site and is having prophylactic removal at another site to prevent either a new primary malignancy or metastatic disease, a code for the malignancy should also be assigned in addition to a code from subcategory V50.4. A V50.4 code should not be assigned if the patient is having organ removal for treatment of a malignancy, such as the removal of the testes for the treatment of prostate cancer. Miscellaneous V code categories/codes:
V07 Need for isolation and other prophylactic measures
Except V07.5, Prophylactic use of agents affecting estrogen receptors and estrogen levels

V Code Table

~~1st Dx only – Generally for use as first listed only but may be used as additional if patient has more than one encounter on one day or there is more than one reason for the encounter~~

The V code table below contains columns for 1st listed, 1st or additional, additional only, and non-specific. Each code or category is listed in the left hand column, and the allowable sequencing of the code or codes within the category is noted under the appropriate column.

1st Dx only – Generally intended to be limited for use as a first-listed only diagnosis, but may be reported as an additional diagnosis in those situations when the patient has more than one encounter on a single day and the codes for the multiple encounters are combined, or when there is more than one V code that meets the definition of principal diagnosis (e.g., a patient is admitted to home healthcare for both aftercare and rehabilitation and they equally meet the definition of principal diagnosis). The V codes designated as first-listed only should not be reported if they do not meet the definition of principal or first-listed diagnosis.

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

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

V07.0	~~Need for isolation and other prophylactic measures~~ Isolation		X		
V07.1	Desensitization to allergens		X		
V07.2	Prophylactic immunotherapy		X		
V07.3X	Other prophylactic chemotherapy		X		
V07.4	Hormone replacement therapy (postmenopausal)			X	
V07.5X	Prophylactic use of agents affecting estrogen receptors and estrogen levels			X	
V07.8	Other specified prophylactic measure		X		
V07.9	Unspecified prophylactic measure				X
V15.2X	Personal history of surgery to other ~~major~~ organs	~~X~~		X	
V26.8~~1~~	~~Encounter for assisted reproductive fertility procedure cycle~~ Other specified procreative management	~~X~~	X		
~~V26.89~~	~~Other specified procreative management~~		~~X~~		
V46.3	Wheelchair dependence			X	
~~V49.85~~	~~Dual sensory impairment~~			~~X~~	
V51.0	Encounter for breast reconstruction following mastectomy	X			
V51.8	Other aftercare involving the use of plastic surgery				X
V85.~~X~~	Body mass index			X	
V86.~~X~~	Estrogen receptor status			X	
V87.0X	Contact with and (suspected) exposure to hazardous metals		X		
V87.1X	Contact with and (suspected) exposure to hazardous aromatic compounds		X		
V87.2	Contact with and (suspected) exposure to other potentially hazardous chemicals		X		
V87.3X	Contact with and (suspected) exposure to other potentially hazardous substances		X		
V87.4X	Personal history of drug therapy			X	
V88.0X	Acquired absence of cervix and uterus			X	
V89.0X	Suspected maternal and fetal anomalies not found		X		

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

a. General E Code Coding Guidelines

1. Used with any code in the range of 001-~~V84.8~~V89

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

Section II

Selection of Principal Diagnosis

H. Uncertain Diagnosis

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

Section III

C. Uncertain Diagnosis

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

Section IV

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

The appropriate code or codes from 001.0 through ~~V86.1~~V89 must be used to identify diagnoses, symptoms, conditions, problems, complaints, or other reason(s) for the encounter/visit.

F. Encounters for circumstances other than a disease or injury

ICD-9-CM provides codes to deal with encounters for circumstances other than a disease or injury. The Supplementary Classification of factors Influencing Health Status and Contact with Health Services (V01.0- ~~V86.1~~V89) is provided to deal with occasions when circumstances other than a disease or injury are recorded as diagnosis or problems.

Appendix I

These guidelines are not a substitute for the provider's clinical judgment as to the determination of whether a condition was/was not present on admission. The provider should be queried regarding issues related to the linking of signs/symptoms, timing of test results, and the timing of findings.

Reporting Options

Y - Yes
N - No
U - Unknown
W – Clinically undetermined
Unreported/Not used (or "1" for Medicare usage) – (Exempt from POA reporting)
For more specific instructions on Medicare POA indicator reporting options, refer to
http://www.cms.hhs.gov/HospitalAcqCond/02_Statute_Regulations_Program_Instructions.asp#TopOfPage

Timeframe for POA Identification and Documentation

There is no required timeframe as to when a provider (per the definition of "provider" used in these guidelines) must identify or document a condition to be present on admission. In some clinical situations, it may not be possible for a provider to make a definitive diagnosis (or a condition may not be recognized or reported by the patient) for a period of time after admission. In some cases it may be several days before the provider arrives at a definitive diagnosis. This does not mean that the condition was not present on admission. Determination of whether the condition was present on admission or not will be based on the applicable POA guideline as identified in this document, or on the provider's best clinical judgment.

If at the time of code assignment the documentation is unclear as to whether a condition was present.

Combination Codes

Same Diagnosis Code for Two or More Conditions

When the same ICD-9-CM diagnosis code applies to two or more conditions during the same encounter (e.g. bilateral condition, or two separate conditions classified to the same ICD-9-CM diagnosis code):
Assign "Y" if all conditions represented by the single ICD-9-CM code were present on admission (e.g. bilateral fracture of the same bone, same site, and both fractures were present on admission)
Assign "N" if any of the conditions represented by the single ICD-9-CM code was not present on admission (e.g. dehydration with hyponatremia is assigned to code 276.1, but only one of these conditions was present on admission).

Categories and Codes Exempt from Diagnosis Present on Admission Requirement

~~412 Old myocardial infarction~~
V15.01-V15.09 Other personal history, Allergy, other than to medicinal agents
V15.1 Other personal history, Surgery to heart and great vessels
V15.2 Other personal history, Surgery to other major organs
V15.3 Other personal history, Irradiation
V15.4 Other personal history, Psychological trauma
V15.5 Other personal history, Injury
V15.6 Other personal history, Poisoning
V15.7, Other personal history, Contraception
V15.81 Other personal history, Noncompliance with medical treatment
V15.82 Other personal history, History of tobacco use
V15.88 Other personal history, History of fall
V15.89 Other personal history, Other
V15.9 Unspecified personal history presenting hazards to health
V87.4 Personal history of drug therapy
V88 Acquired absence of cervix and uterus
V89 Suspected maternal and fetal conditions not found
E919~~.0-919.1~~ Accidents caused by machinery
~~E919.3-919.9 Accidents caused by machinery~~
E981.0-~~E981.8~~E980.9 Poisoning by gases in domestic use, undetermined whether accidentally or purposely inflicted

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

POA Examples

General Medical Surgical

15. A urine culture is obtained on admission. The provider documents urinary tract infection when the culture results become available a few days later.

    Assign "Y" to the urinary tract infection since the diagnosis is based on test results from a specimen obtained on admission. It may not be possible for a provider to make a definitive diagnosis for a period of time after admission. There is no required timeframe as to when a provider must identify or document a condition to be present on admission.

16. A patient tested positive for Methicillin resistant Staphylococcus (MRSA) on routine nasal culture on admission to the hospital. During the hospitalization, he underwent insertion of a central venous catheter and later developed an infection and was diagnosed with MRSA sepsis due to central venous catheter infection.

    Assign "Y" to the positive MRSA colonization. Assign "N" for the MRSA sepsis due to central venous catheter infection since the patient did not have a MRSA infection at the time of admission.

Obstetrics

5. Pregnant female was admitted in labor and fetal nuchal cord entanglement was diagnosed. Physician is queried, but is unable to determine whether the cord entanglement was present on admission or not.

    Assign "W" for the fetal nuchal cord entanglement.

Newborn

3. A newborn born in the hospital, birth complicated by nuchal cord entanglement.

    Assign "Y" for the nuchal cord entanglement on the baby's record. Any condition that is present at birth or that developed in utero is considered present at admission, including conditions that occur during delivery.

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